Waitemata
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committees Meeting

Wednesday, 15th October 2014

2.00pm

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

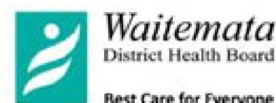
Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.



AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
15th October 2014

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

COMMITTEE MEMBERS	MANAGEMENT
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)	Dale Bramley - WDHB, Chief Executive
Lester Levy - ADHB and WDHB Board Chair	Ailsa Claire - ADHB, Chief Executive
Max Abbott - WDHB Deputy Chair	Debbie Holdsworth - ADHB and WDHB, Director Funding
Jo Agnew - ADHB Board member	Simon Bowen - ADHB and WDHB, Director Health Outcomes
Peter Aitken - ADHB Board member	Naida Glavish - ADHB and WDHB Chief Advisor, Tikanga
Judith Bassett – ADHB Board member	Paul Garbett - WDHB, Board Secretary
Pat Booth - WDHB Board member	
Chris Chambers - ADHB Board member	
Sandra Coney - WDHB Board member	
Warren Flaunty - Committee Deputy Chair (WDHB Board member)	
Lee Mathias - ADHB Deputy Chair	
Robyn Northey - ADHB Board member	
Christine Rankin - WDHB Board member	
Allison Roe - WDHB Board member	
Elsie Ho - Co-opted member	
Tim Jelleyman - Co-opted member	

Apologies:

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

All recommendations/resolutions are subject to approval of the ADHB and WDHB Boards.

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

2.00pm PRESENTATION AND DISCUSSION: Quality Outside of the Hospital

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES

3.00pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 03/09/14 7

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3 DECISION ITEMS

4 INFORMATION ITEMS

3.05pm 4.1 Auckland DHB Child and Youth Mental Health and Addiction Direction 2013-2023 18

3.35pm 4.2 Non Traumatic Lower Limb Amputations with Diabetes 25

5 STANDARD MONTHLY REPORTS

3.45pm 5.1 Planning, Funding and Outcomes Update 33

4.00pm **6 GENERAL BUSINESS**

4.05pm 7 **RESOLUTION TO EXCLUDE THE PUBLIC** 40

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2014

NAME	FEB	MAR	APRIL	JUNE	JULY	SEPT	OCT	NOV
Gwen Tepania-Palmer (ADHB / WDHB combined CPHAC Committees Chair)	✗	✓	✓	*11th June meeting cancelled due to power cut*	✓	✓		
Warren Flaunty (ADHB / WDHB combined CPHAC Committees Deputy Chair)	✓	✓	✓		✓	✓		
Dr Lester Levy (ADHB and WDHB Chair)	✓	✓	✓		✗	*		
Max Abbott	✓	✓	✓		✓	✓		
Jo Agnew	✓	✓	✓		✓	✓		
Peter Aitken	✓	✓	✓		✓	✓		
Judith Bassett	✗	✓	✓		✓	✓		
Pat Booth	✓	✓	✓		✓	✓		
Chris Chambers	✓	✓	✓		✓	✓		
Sandra Coney	✓	✓	✓		✗	✓		
Lee Mathias (ADHB Deputy Chair)	✓	✓	✓		✓	✗		
Robyn Northey	✓	✓	✓		✗	✓		
Christine Rankin	✓	✗	✓		✗	✓		
Allison Roe	✓	*	✗		✓	✓		
Co-opted members								
Elsie Ho	N/A				N/A	✓		
Dr Tim Jelleyman	✓	✓	✓		✓	✓		

✗ absent
** attended part of the meeting only*
 # absent on Board business

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Chair - Auckland District Health Board Chairman - Auckland Transport Deputy Chair - Health Benefits Limited Independent Chairman - Tonkin & Taylor Chief Executive - New Zealand Leadership Institute Professor of Leadership - University of Auckland Business School Trustee - Well Foundation (ex-officio member) Director - Orion Health Ltd	20/08/14
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board Member - The Rotary National Science and Technology Trust	19/03/14
Jo Agnew	Professional Teaching Fellow - School of Nursing, Auckland University Trustee Starship Foundation Casual Staff Nurse - ADHB	01/03/14
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Shareholder/Director - Pharmacy New Lynn Medical Centre	15/05/13
Judith Bassett	Nil	09/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Chris Chambers	Employee - Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer- Anaesthesia Auckland Clinical School Associate - Epsom Anaesthetic Group Member - ASMS Shareholder - Ormiston Surgical	20/04/11
Sandra Coney	Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council	12/12/13
Warren Flaunty	Member - Henderson - Massey and Rodney Local Boards, Auckland Council Trustee - West Auckland Hospice Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Westgate Pharmacy Ltd Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd	30/07/14
Lee Mathias	Chair - Counties Manukau District Health Board Chair - Unitec Managing Director - Lee Mathias Ltd Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Director - Pictor Ltd Director - John Seabrook Holdings Ltd Chair - Health Promotion Agency Director - iAC IP Ltd Advisory Chair - Company of Women Ltd	30/04/14
Robyn Northey	Project management, service review, planning etc. - Self employed Contractor Board member - Hope Foundation Northern Region Trustee - A+ Charitable Trust	18/07/12
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director - The Transformational Leadership Company CEO - Conservative Party	17/05/13

Register of Interests continued…

Allison Roe	Member - Devonport-Takapuna Local Board, Auckland Council Chairperson - Matakana Coast Trail Trust	02/07/14
Gwen Tepania-Palmer	Chairperson - Ngatihine Health Trust, Bay of Islands Life Member - National Council Maori Nurses Alumni - Massey University MBA Director - Manaia Health PHO, Whangarei Board Member - Auckland District Health Board Committee Member - Lottery Northland Community Committee	10/04/13
Co-opted Members		
Elsie Ho	Associate Professor - School of Population Health, University of Auckland Member - Waitemata DHB Asian Mental Health and Addiction Governance Group Member - Problem Gambling Foundation of New Zealand Advisory Board Trustee – New Zealand Chinese Youth Trust	03/09/14
Dr Tim Jelleyman	Member - Active Clinic Network for Greater Auckland Integrated Health Network Member - ASMS Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland Member-Board of Kaipara Medical Centre	22/04/13

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 03rd September 2014

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 03rd September 2014 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 03 September 2014

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

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Lester Levy (ADHB and WDHB Board Chair) (present from 2.18p.m to 3.05p.m.)
Max Abbott (WDHB Board member) (present from 2.08p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
Robyn Northey (ADHB Board member)
Allison Roe (WDHB Board member) (present from 2.15p.m.)
Elsie Ho (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Naida Glavish (ADHB and WDHB Chief Advisor, Tikanga)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Tracy Walters (ADHB and WDHB, Maori Health Analyst)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Tracy McIntyre, Waitakere Health Link
Lorelle George, Comprehensive Care/Waitemata PHO
Craig Murray, Waitemata PHO
Aroha Hudson, Health West
Gayle Sharman, Health West

LEAVE OF ABSENCE: Christine Rankin

APOLOGIES: Lee Mathias, Dale Bramley and Ailsa Claire, with apologies for late arrival from Lester Levy and Allison Roe.

KARAKIA: Naida Glavish led the meeting in the karakia.

WELCOME: The Committee Chair welcomed all those present, including the Committee's new member, Associate Professor Elsie Ho, Scott Leonard (NZ Police) and Barbara Thompson (Child, Youth and Family).

DISCLOSURE OF INTERESTS

With regard to the Interests Register, Elsie Ho has advised her interests as : Associate Professor, School of Population Health, University of Auckland; Member, Waitemata DHB Asian Mental Health and Addiction Governance Group; Member, Problem Gambling Foundation of New Zealand Advisory Board; Trustee, New Zealand Chinese Youth Trust.

There were no declarations of interest relating to the agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 30th July 2014 (agenda pages 7-17)

Resolution (Moved Judith Bassett/Seconded Tim Jelleyman)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 30th July 2014 (including the public excluded minutes) be approved.

Carried

Matters Arising (agenda pages 18-19)
It was noted that with the Chart attached to the Matters Arising report showing corrected workforce numbers for hospices, the staff numbers for West Auckland Hospice are FTE. No other issues were raised.

3 DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 Changing the Landscape of Childhood Vulnerability – An Inter-Agency and Community Challenge (agenda pages 20-28)

Ruth Bijl (Funding and Development Manager, Women, Children and Youth, Auckland and Waitemata DHB), Dr Alison Leversha (Community Paediatrician, Auckland DHB) Dr Tim Jelleyman (Community Paediatrician, Waitemata DHB), Tracy Walters (Maori Health Analyst,

Auckland and Waitemata DHB), Scott Leonard (New Zealand Police) and Barbara Thompson (Child, Youth and Family) were present for this item.

Simon Bowen introduced the item, commenting that this was a new approach being trialled to invite outside parties for a discussion with the committee on key themes and issues. It was intended to be an opportunity to ask questions and think about the strategic approach. This was a trial and the approach could be refined according to experience.

The Committee Chair noted that the report builds on previous work and reflects some keen interests of CPHAC members, including Pat Booth's advocacy for vulnerable children.

2.08p.m – Max Abbott present.

Ruth Bijl conveyed an apology from Jenny Janif (Ministry of Social Development, Family and Community Services). She advised that Barbara Thompson would talk to some of the issues on behalf of Jenny.

Ruth Bijl, Tim Jelleyman and Alison Leversha summarised some of the key themes relating to this issue, including:

- The concept of proportionate universalism.
- The overview of recent government initiatives related to child vulnerability.
- The concepts that to an extent every child is "vulnerable", but some are much more so due to the circumstances that they are born into; that circumstances for individual children change over time; and that the longer children are exposed to adverse circumstances, the more likely there will be adverse outcomes.
- The importance of the health sector in this issue; health is the one agency that all children are likely to have contact with.
- Transition from one provider to another can often be the point at which a family gets lost to the support system.
- To improve outcomes it is important not to just focus on risk, but also to positively promote good health and development.
- The importance of co-ordination between all services with a role in supporting children, including the Police.

2.15p.m – Allison Roe present.

Matters outlined by Barbara Thompson (Programme Manager, Waitakere CYFS) included:

- It is critical that services deal with children at the high end of risk. As already pointed out, transition points between providers can be critical points for vulnerable children.
- It is important that there is a triage process that gets children to the right service at the right time.
- CYFS is working with other agencies: the police, other government agencies and NGOs and is discovering ways of safely and properly sharing information.

2.18p.m. – Lester Levy present.

Matters outlined by Scott Leonard (District Family Violence Co-ordinator, Auckland City District, N.Z. Police) included:

- An initiative in Avondale is underway at present, providing an integrated family violence response. This involves not only the Police, but also a representative from

CYFs and a representative from a referral agency (the NGO Shine). Also they have had Probation Officers and Mental Health staff members attend some of their meetings when available.

- Auckland City has 7,000 family violence events reported annually; nationally there are just over 100,000 reported. It is estimated that only about 20% of family violence events are actually reported. They are working with other agencies to bridge the gap to those children that have missed being reported. Some of these children would come through health services.
- What is needed is timely and effective response, looking at the safety of young people and also the rest of the family members.
- Vulnerability starts at a very young age; issues are "in ground" in families.

Ruth Bijl outlined the success in the area of child immunisation, with 95% of Auckland DHB children and 93% of Waitemata DHB children immunised at 8 months. Also this had been a success story with Maori and Pacific children.

Tracy Walters advised that he believes the approach taken to vulnerable children needs to encompass the whanau ora approach. In the past the approach had been too episodic and now a more sustained approach is needed.

Matters covered in discussion and response to questions included:

- Of the 5% of children not immunised by 8 months at Auckland DHB, the decline/opt out rate is 1.9%. Across the two DHBs there are about 14,500 births per annum.
- There is a process for children overdue a vaccination which looks at each child individually and asks do we know where they are and what else may they be missing? The approach is to have a team of professionals tuned into this issue and knowing what to do.

Aroha Hudson (Chief Executive, Health West) was invited to comment. She noted that while they know every child, they don't always know where to find them. There is a lot of movement of families in south and west Auckland. When they go into homes they look for other ways in which they can help. Once a rapport has been developed, there is a whole range of other services that families can be linked to. A lot of multi-agency work occurs. An area that could improve would be if all of Auckland was on the same system.

Further discussion and response to questions included:

- The age range of children supported as vulnerable children is up to seventeen and in certain circumstances up to twenty.
- With regard to the Avondale initiative, Scott Leonard advised that mental health professionals attend meetings on occasions, but are also engaged via phone and e-mail. They are always involved where appropriate, but not always on a face to face basis. For Auckland City there is a Mental Health contact who provides that link. This is definitely better than what was previously available.
- Barbara Thompson commented that the nature of the work that they are all involved in is somewhat in siloes. There had not been a very consistent approach to working together in the past, but they are trying to see how they can enhance cooperation. It is important to have information shared across agencies; for example one would not want a Plunket nurse going into a violent home unaware.
- Recently there has been some progress with Mental Health services for adolescents, with agreement that services provided can continue from the same provider when

the client shifts to another DHB area. Previously they had to go through a transfer process.

- In answer to a question, Ruth Bijl advised that recognition is given to the importance of choices women make in their family planning. In the last ten years the pregnancy termination rate has reduced by one third, and it is understood that the reason for this is use of long acting contraceptives. It was appreciated that birth control needs to be part of overall strategy.
- There was discussion of what the term ‘proportionate universalism’ really means. A simple way of looking at that was suggested to be universal provision of a service, but “beefed up” for some who need it more. Tim Jelleyman suggested that the issue was getting the right balance; how thin do you spread limited resources, how do you focus what you are doing? Should the focus be on early years or should resources be spread more evenly across the childhood years? This was an issue that needed robust discussion.
- The importance of getting families involved in the discussion of what they need and want was raised.
- Tracy Walters spoke of how the whanau ora approach looked at the totality of a family’s situation. A lot of what they see right now is not working, with people continuing to work in silos. Health can take a leading role.
- Concern was expressed that the needs of women in a family setting that are distinct to the woman are not lost sight of. In response to that Ruth Bijl referred to the relationship between lead maternity carers and women, based on both the woman’s and the baby’s needs. The Vulnerable Pregnant Womens Group also identified the significant needs of women and how to support them.
- Naida Glavish emphasised that with whanau ora, the whanau plans for wellness and the agencies then support that. The important role of grandparents should not be overlooked. Support should be at the top of the cliff and not the bottom of it.
- The Committee Chair commented that where a child is vulnerable it is up to all of us to meet the responsibility to keep eyes open, hearts open and minds open about what happens to the child.
- Waitemata PHO is piloting a child protection policy with seven of its practices, working with the Child Protection Coordinator for Waitemata DHB. The aim is to review this and look at rolling out to all of the PHO’s practices next year. In answer to a question, Tim Wood advised that the issue of privacy and reporting is dealt with in training.
- It is intended to continue ongoing reporting to CPHAC on this issue. A scorecard for Children’s Health is being prepared, to help in assessing where the DHBs are at. Some interim performance measures will be developed.
- Max Abbott noted a sense of déjà vu, in that there had been a similar initiative about 30 years previously. Barbara Thompson suggested that two things had blocked progress: the lack of a national health recording database that can be accessed and the privacy laws which had prevented sharing of information in a timely and fulsome way. These underlying difficulties had remained over those 30 years.

The presenters were thanked.

Resolution (Moved Max Abbott/Seconded Pat Booth)

That the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees:

a) Note that the Vulnerable Children Act 2014 has been passed.
b) Note that Auckland and Waitemata District Health Boards are undertaking work in preparation for the advent of Children's Teams.
c) Note that reducing childhood vulnerability requires a whole of society response.

Carried

4.2 Progress Update – Healthy Eating and Physical Activity in the Auckland Region (agenda pages 29-36)

Dr Julia Peters (Clinical Director ARPHS) and Maggie McGregor (Public Health Contractor ARPHS) were present for this report.

Julia Peters introduced this progress report on the implementation of CPHAC resolutions of February 2014 which supported greater priority being given to the promotion of healthy nutrition and physical activity, and asked that a co-ordinated and strategic approach be taken to the planning and delivery of these activities. The Auckland Regional Public Health Service had been asked to lead the development of a regional inter-sectoral action plan. She commented that they are making some progress, but it will be a long journey. They are getting their own programmes in order while getting agreement on the approach to be taken from other organisations.

3.05p.m. – Lester Levy retired from the meeting, on Board business.

Matters covered by Julia Peters included:

- The establishment and role of the regional interagency group and the tentative list of priorities agreed (detailed in Section 3.1 of the report).
- The collaborative process across the region on DHB Nutrition Policies (Section 3.2 of the report). Currently some tracking of the guidelines in practice is taking place in three hospital canteens (two at Auckland DHB and one at Counties Manukau DHB).
- The early childhood work (page 32 of the agenda).
- Workplace Health and the Heartbeat Challenge (page 32-33 of the agenda).
- Next steps planned (page 34 of the agenda) – they would like to see the DHBs taking a lead with nutrition policy and achieving a culture change in their organisations. If successful this can probably be exported out to other organisations. While they don't yet know who the Healthy Families New Zealand contractors will be (a new community based programme focused on obesity prevention in ten development sites), they would be working with them to help get programmes up and running. They would also be coming back to CPHAC in November with the requested report on opportunities for interventions in the production and promotion of products that influence levels of obesity.

Matters covered in discussion and response to questions included:

- Julia Peters was not able to comment on the quality of food provided in schools under the Kids Can programme, as the work that ARPHS is connected with relates to

early childhood education centres; however they could engage with Kids Can on this. Simon Bowen advised that in the provisional plan presented to CPHAC, they had allocated various responsibilities between ARPHS and the DHBs. How to support of the whole school environment with regard to healthy food would come within the range of a dietician position to be recruited by the DHBs.

- Julia Peters confirmed that the expert advice is that the biggest gains in addressing obesity can be made with children.
- To date Auckland Council has not approved any financial resource towards this issue, other than staff time, however there is a whole range of Council activities such as providing parks, reserves and cycle ways which contribute to physical activity. The Council is very keen on getting DHB advice in developing policy on healthy living.
- The importance of getting a consistent approach across the region and not "pepper potting" was highlighted and affirmed.
- In response to a question on the approach that had been taken to prioritised populations, Simon Bowen advised that there had been programmes focused on schools, workplaces, sports clubs and churches. For example a Waitemata DHB programme focused on Pacific Island churches had achieved a significant improvement in levels of physical activity.
- It was noted that in addition to the Council, approaches to local boards would be useful; they have funding allocated to them and may be interested in supporting particular projects and programmes.

Resolution (Moved Sandra Coney/Seconded Robyn Northey)

That the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees:

1. **Note the approach being taken to revise Waitemata DHB and Auckland DHB nutrition policy and guidelines, as approved by the respective senior management teams for implementation within each DHB.**
2. **Note that this paper summarises progress in implementing resolutions resulting from the paper: *- Healthy Eating and Physical Activity in the Auckland Region* presented to the committee on 5 February 2014.**
3. **Note that this paper reports against resolutions 2 and 3, which provide for a co-ordinated, strategic approach to promoting healthy nutrition and physical activity, co-ordinated by the Auckland Regional Public Health Service.**

Carried

5. STANDARD MONTHLY REPORTS

5.1 Primary Care Update Quarter 4, 2013/14 (agenda pages 37-57)

Tim Wood (Funding and Development Manager Primary Care, Auckland and Waitemata DHBs) introduced the report. Matters that he highlighted included:

- With health target results there had been a slight drop for the start of the 2014/15 year, but he expected them to get back up quite quickly.
- The after hours business case is currently going to the three Auckland metropolitan DHB Boards and is close to getting approval.

Matters covered in discussion and response to questions included:

- The Committee Chair emphasised that for the Maori and Pacific populations there is a need to keep the focus on diabetes. Tim Wood advised that once the current planning process with the PHOs on diabetes has been gone through, there would be a report back to CPHAC on that.
- The report by Dr Tim Tenbensel on his independent evaluation of the Regional After Hours Network should be released publicly shortly. Key findings include that free service for under six year olds had made a big impact with increased utilisation of A&Ms and a reduction in use of Emergency Departments, particularly at Waitakere Hospital and in Counties Manukau DHB. With 65 years and above patients, there had been a modest increase in use of A&Ms and there may have been a slight flattening in use of Emergency Departments. There had been no material impact on Maori and Pacific populations, with quite low usage of A&Ms compared to Emergency Departments. This was certainly an area for improvement. The recommendation from the report had been to continue with and develop the Regional After Hours Network. This was aligned with overseas experience, for example a recent NHS review in the United Kingdom.
- In answer to a question relating to the relatively low enrolment with PHOs for the Asian population, Tim Wood advised that there had been a programme for a couple of years to increase enrolment. There had been an improvement, but there was still work to do. This is a complex process to educate that community about the role of the general practitioner.
- Primary Mental Health (page 44 of the agenda) – demand far exceeds capacity. Recalculation of funding following the Quintile 5 targeting meant that Waitemata PHO suffered a significant decrease in funding. The big feedback from the Tamaki locality planning had been the need for lower cost mental health services in the community. Tim Wood advised that they are looking to develop some solutions with regard to both the stepped care model being run through Totara Health and the Tamaki Mental Health project and he will be reporting back to CPHAC on this.
- A request was made for information on the number of migrants by ethnicity to Auckland last year. This will be obtained and provided to members.
- It was noted that the Asian Health Service at Waitemata DHB helps support the Asian migrant population develop an understanding of how the health system works and services available. Information was sought on what is available in this respect for the Asian migrant population in the Auckland DHB area.
- With regard to the child health working group in west Auckland (page 51 of the agenda), as noted in the report the reason that it has "parked" the project is that much of the work was progressing through the Greater Auckland Integrated Health Network, which has now transferred into a regional work programme. As Chair of the Regional Child Network, Tim Jelleyman advised that a focus is on getting systems implementation, involving stronger involvement of primary care.

Resolution (Moved Jo Agnew/Seconded Judith Bassett)

That the report be received.

Carried

5.2 Planning, Funding and Outcomes Update (agenda pages 58-65)

Simon Bowen (Director Health Outcomes ADHB/WDHB) and Debbie Holdsworth (Director Funding ADHB/WDHB) introduced the report.

The Committee Chair asked that her satisfaction with some good work being done in Maori and Pacific health across both the DHBs be noted.

In discussion, concern was expressed that much emphasis had been given to providing advice to quit smoking without that being reflected in referrals to stop smoking services. The measures now being taken to increase referrals to such services were outlined (described on page 61 of the agenda). While providing brief advice does actually lead to quit attempts, this is more likely to succeed if followed up by offers of support to quit. This is being worked on and will be a focus for the future. The Committee Chair noted that the current stage involves behaviour change for clinicians and consumers.

Resolution (Moved Pat Booth/Seconded Robyn Northey)

That the report be received.

Carried

6. General Business

There was no general business.

The meeting concluded at 4.05p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 03 SEPTEMBER 2014

____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 7th October 2014

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 05/02/14	3.1	Healthy Eating and Physical Activity – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.	William Rainger	CPHAC 26/11/14	
CPHAC 30/04/14	4.4	Palliative Care – information relating to Eastern Bays Hospice to be obtained and reported to Auckland DHB.	Stephanie Muncaster/ Sarmila Gray	ADHB Board 29/10/14	Report prepared for ADHB Board.
CPHAC 30/04/14	4.5	Preparing Consumer Information for Different Ethnicities – report to be provided on how this is done, including information on websites and resource materials, and advising on whether how this is done needs more attention.	Tim Wood	CPHAC 15/10/14	Short update included in the Planning, Funding and Outcomes Update.
CPHAC 30/07/14	2.1	Diabetes – regional statistics relating to amputation of feet of diabetic patients to be brought back to CPHAC.	Stephanie Muncaster	CPHAC 15/10/14	Refer report on this agenda.
CPHAC 03/09/14	4.2	Food Quality – quality of food provided in schools under Kids Can to be looked at.	William Rainger		To be looked at as part of Action Plan.
CPHAC 03/09/14	5.1	Migrants – information on number of migrants last year to the Auckland Region by ethnicity to be obtained and provided to CPHAC members.	Simon Bowen	CPHAC 26/11/14	Will be reported back in conjunction with following request.
CPHAC 03/09/14	5.1	Health Information for Asian Migrants – information on what services are available at Auckland DHB to help Asian migrants to be provided to CPHAC members.	Samantha Bennett	CPHAC 26/11/14	

4.1 Auckland DHB Child and Youth Mental Health and Addiction Direction 2013-2023 - Progress Update

Recommendation

That the report be received.

Prepared by: Hilary Carlile (Project Manager), Tim Wood (Chair of Child and Youth Mental Health and Addictions Direction Implementation Governance Group, Acting Funding and Development Manager Mental Health and Addictions), Michelle Atkinson (Youth Voice, ADHB Consumer Leader), Kirsty Fong (Youth Voice, ADHC Consumer Leader) and Nicole Simons (Youth Voice, PM's Youth Mental Health Project Expert Group)
Endorsed by: The Auckland DHB Child and Youth Mental Health and Addictions Direction Implementation Governance Group

Glossary

ADHB	-	Auckland District Health Board
DHB	-	District Health Board
CAMHS	-	Child and Adolescent Mental Health Services
NGO	-	Non-Government Organisation
Direction	-	The Integrated ADHB Child and Youth Mental Health and Addictions Direction 2013-2023

1. Introduction/ Background

The Auckland District Health Board (ADHB) Board approved the implementation of the ADHB Integrated Child and Youth Mental Health and Addictions Direction 2013-2023 (Direction) at their December 2013 meeting.

This Direction addresses the gap in ADHB services identified in 2012 by the ADHB Mental Health and Addictions Strategic Leadership Group. The resulting Direction is the result of a yearlong multiagency working group. The group included representatives from ADHB Child and Adolescent Mental Health Services (CAMHS), Young People, Maori Health Gains Manager, NGOs, Women and Children's Health, Education, Child, Youth and Family, Ministry of Social Development (MSD) and the Ministry of Youth Development. The working group was chaired by Paul Ingle of the Wise Group and the Sponsor was Helen Wood, General Manager Mental Health and Addictions ADHB and Waitemata District Health Board (DHB).

Our Vision is:

"Children, young people and families of Auckland experience and enjoy good mental health and emotional wellbeing. "

What does this actually mean?

It means that children, young people and families feel:

- able to fully participate in their community
- hopeful about their future
- they live in a community that understands and accepts the part it can play in ensuring more children and young people get a better start in life
- free, or supported to be free, from the harmful impacts of addiction and mental distress; and
- able to lead, or be supported to lead, positive changes in their own lives.

The Direction's Principles are:

- Meaningful co-design with children and youth
- Authentic engagement
- Responsiveness
- Diversity
- Community
- Intervening early.

The opportunities of this Direction are grouped into six work streams each with a set of actions. The work streams and the opportunities are:

Work stream	Opportunity
Strengthening the Voice	Services are seen as more accessible and responsive by children, young people and their families
Intervening Earlier in the life course and earlier when there is a need	• There will be a decrease in incidence of mental health and addiction issues later in life • There will be increased access and early response
Addressing Inequalities	• Ensure the unique societal structures, primarily in Maori and Pacific communities, and the place of religion do not act as a barrier to access services • Services to be more responsive to Maori and Pacific • To increase Mental Health and Addiction literacy of young Maori and Pacific, their families and whanau and reduce stigma and discrimination
Fostering Innovation	Children and young people and their families / whanau will directly benefit from a culture of innovation and new approaches
Workforce Development	• The lived experience of children, young people and families/ whanau is a valued contributor to personal resilience and recovery, peer support and other forms of help and treatment • There is a workforce that has the skills mix and diversity that is sustainable into the future. It is confident to work fluidly across organisational boundaries and with virtual tools
Working Better together	The whole system works together to improve process and access for children, young people and their family/ whanau to the appropriate services at the right time

2. Governance

The Governance Group was established in June 2014 after a period of consultation on the proposed governance and implementation structure. Membership is based on the roles below:

Role	Name
Acting Funding and Development Manager, Mental Health and Addictions, representing Director Funding (Chair)	Tim Wood
Youth Voice, ADHB Consumer Leader	Michelle Atkinson
Youth Voice, ADHB Consumer Leader	Kirsty Fong
Youth Voice, PM's Youth Mental Health Project Expert Group, Lead for Affinity Youth Reference Group	Nicole Simons
Director Mental Health	Clive Bensemann
General Manager Mental Health	Maria West
Allied Health Director, Mental Health	Mike Butcher
General Manager, Pacific Health	Bruce Levi
Maori Health Gains	Karl Snowden
Consumer Voice, ADHB Consumer Leader	Rod Flower
Funding and Development Manager - Women, Children and Youth	Ruth Bijl
Community Paediatrician - child and infant voice, clinical and population health focus	Alison Levesha
Group Strategic Development, WiseGroup, represents Mental Health NGOs	Paul Ingle
CEO Odyssey House Trust, represents AOD sector and AOD NGOs	Phil Grady
Business Development Manager ProCare Psychological Services, represents Primary Care	Stewart Eadie
Project Manager	Hilary Carlile
Youth Health Specialist – clinical and population health focus	appointment in progress

The Governance Group meets monthly and the focus to date has been on ensuring that the right people are at the table and the youth voice is an authentic and integral part of the governance process. The Governance Group and the workstreams are supported by a stakeholder reference group who will be invited to contribute to the implementation on specific topics.

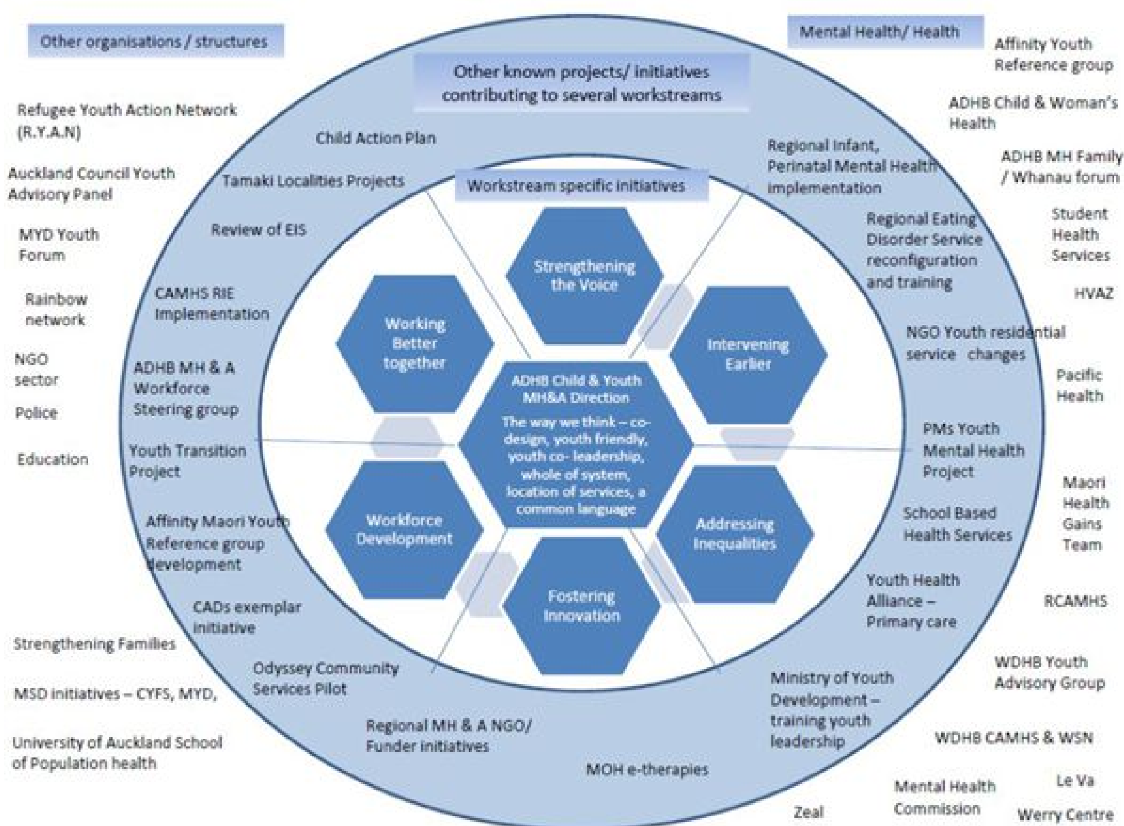
3. Way forward

The next step was to determine how to work with the large number of existing projects, many of which have their own Governance Group. Existing work and projects are being undertaken:

- Within Mental Health and Addictions Services – within ADHB, Regionally and Nationally
- In other parts of Health
- Through other organisations and Government initiatives

All will have an impact on the successful achievement of the Direction. All are generally trending in a similar direction. In planning the way forward we needed to ensure that the existing projects we can influence are aligned to the Direction's principles and any new initiatives did not duplicate existing

structures and work. The challenge is summarised in the diagram below which shows some of the existing projects and initiatives.



It was decided to focus on the priority projects that would implement the Direction and which the Governance group had some ability to influence. It was important to ensure that the principles were integrated into the way the project was run and in the resulting service. We also needed to be able to track outcomes.

4. Progress to date

4.1 Communications

The reach of this Direction and the way young people access information has meant we need to look at a broader approach to communications than usual. There are a large number of stakeholders and stakeholder groups. We need to utilise the appropriate media for the audience. Currently we are exploring a number of channels with social media being a key channel:

- Child & Youth 101 - an introductory in person briefing to groups and team meetings
- Social media – Facebook and Twitter to engage youth in discussion and feedback
- Webpage – with information of interest and to direct people to the discussion and feedback forums
- E-Newsletters – to update the wider stakeholder group and young people's forums e.g. Rainbow Youth

- Blogs with opportunities for feedback and discussion
- Stakeholder reference group to look at specific issues for discussion and feedback

We are working with ADHB Communications and Community Engagement teams to help reach our audience in a meaningful way. We are also looking at ADHB online feedback tools as a means of generating feedback and discussion. The Child and Youth 101 briefing is seen as an introduction to the Direction and its implementation. At the end of the presentation we will direct people to our webpage so that they can immediately engage and connect.

4.2 Priority Projects - Status

1. **Perinatal and Infant Mental Health**
   This regional project was initiated as a result of a Ministry of Health's priority and came with additional funding.
   - A model of care was agreed by the region that included an inpatient unit and community respite services.
   - ADHB agreed to host the Mother and Baby Inpatient Unit in Starship. The Unit is completed and is expecting to welcome its first mothers and babies at the end of October 2014.
   - ADHB has issued an RFP for Community Respite services. A decision on this will be made shortly.
   - An integral part of the project was the workforce development plan and its implementation. A new approach was adopted and sets a precedent for the Direction's Workforce Development Workstream Opportunities.

2. **ADHB Youth Health Alliance**
   - The Youth Health Alliance while covering all of health includes Primary Mental Health and holds the associated budget.
   - The Alliance has funded a travelling psychologist to visit schools which has been very well received by schools and is a valuable contribution to the School Based Health Services funded under the Prime Minister's Youth Mental Health Project.
   - Building resilience in young people and providing them with tools to cope is an important initiative. The Alliance has funded a trial in high schools to give young people DBT (Dialectical behaviour therapy) type resilience tools. There are two groups – one focussing on girls and relationships and the other on supports available to young people.
   - The other piece of work, which is also a priority for young people, is "What is a Youth friendly practise"? Feedback suggests GPs are good when you are sick but School Based Health Services, with their associated GPs, is a better option. Young people do tend to "snack" and go to the person that is appropriate for their needs of the moment.
   - The Alliance is starting to look at what they can do to provide services to young people with mental health issues beyond the GP's surgery.

3. **Tamaki Localities Project**
   - The Tamaki community identified Mental Health and Wellbeing as its number one health priority.
   - The project's focus is on primary care provision of services, the authentic engagement of the community and building a resilient community so they can support each other.

- This project was stalled while a key resource was on leave. It is now building momentum and they have greater clarity in their way forward.

4. **CAMHS (Child and Adolescent Mental Health Services) Wait times**
    - As a result of participating in the National Child and Youth KPI Benchmarking Project CAMHS chose to carry out a three day rapid intervention event to look at their wait times. CAMHS was not meeting their targets and despite efforts to do so they could not impact this. The event was very successful and the new approach was implemented. Since it was fully implemented earlier this year CAMHS has met the MOH's wait time targets for the last two quarters.

5. **Youth Services in Secondary Care**
    - This project was initiated in 2013 to develop a policy and practices for youth transitioning from paediatrics to adult services. The draft report has been signed off by the Steering Committee. Mental Health is an important part of this and has been identified as one of the possible services to implement the policy first.

6. **Regional agreement to work better with our multiagency partners**
    - This work is to make it easier for those children and young people with complex needs requiring a multiagency approach to have their needs met more effectively.
    - Principles of working together have been agreed and are operating at a senior level.
    - The next step is to flow this down to the workforce working with the children and young people.

7. **Maori and Pacific Workforce Development**
    - There is a considerable amount of work being completed by other agencies e.g. Te Pou and Le Va which ADHB can leverage off.
    - A MOH funded initiative is the Pacific Health Sciences Academy which is mentoring 20 Pacific Year 12 and 13 students through the ADHB and WDHB Rangatahi Project, giving them an opportunity to learn more about a career in health including mental health.

4.3 Key Priorities going forward

1. **Governance**
   Continue to ensure that the Youth voice is an authentic part of the Governance process and the Governance group focusses on the priority projects and processes.

2. **Youth Peer Support**
   This is an important part of the Direction's Strengthening the Voice and Workforce Development workstreams, but it is a piece of work we do not manage. This has not started.

3. **Health Literacy**
   This work is important in Addressing Inequalities and in building resilience in young people. This has not started although other agencies are doing some work in the area in providing materials. The ADHB and WDHB Funders are working on a Health Literacy framework that will provide a structure for Health Literacy and training young people to deliver Health Literacy training. This will help start this project.

4. **Communications**
   Starting implementing the communications plan with the Child and Youth Direction 101 presentations and setting up and keeping active the associated web page and social media links to engage with and build our community of young people and other stakeholders.

5. **Priority Projects Scorecard**
   Develop a scorecard for the priority projects so that deliverables and outcomes can be tracked.

6. **Establishment of Workstreams**
   The governance work to sort out priorities needed to be done before the workstreams were established. Some work has started in Fostering Innovation and Workforce Development. In the next period other workstreams will be started as their priorities are confirmed.

5. Conclusion

In conclusion progress has been made in four key areas:

- Establishment of the Governance Group and the Youth voice being an authentic part of it.
- Communications planning and preparation for stakeholder engagement.
- Establishment of how to work with the multitude of existing projects.
- Selecting the priority projects.

Work for the next period builds on this strong foundation with the initiation of work streams and the completion of some key projects such as the ADHB part of the Perinatal and Infant Mental Health project.

4.2 Non Traumatic Lower Limb Amputations with Diabetes

Recommendation:

That the report be received.

Prepared by: Dr Mazin Ghafel (Public Health Physician)
Endorsed by: Dr Tom Robinson (Public Health Physician), Dr Sarah Gray (Public Health Physician), Stephanie Muncaster (Programme Manager) and Tim Wood (Funding and Development Manager Primary Care)

Glossary

CPHAC	-	Community and Public Health Advisory Committee
DHB	-	District Health Board
Indirect standardisation:	-	using New Zealand amputation age specific rates and our local District Health Board population by age group to calculate the expected number. This technique is used whenever there is small number per category.
PFO	-	Planning Funding and Outcomes

1. Executive Summary

The Community and Public Health Advisory Committee (CPHAC) has asked for regional statistics on lower limb amputations. This request arose from the 30 July 2014 meeting when the Committee received a paper on diabetes services which included a section on community podiatry for high risk feet.

The purpose of this paper is to provide CPHAC with information about the incidence of non-traumatic lower limb amputation for both the general population and people with diabetes. The analysis includes graphs that show the rates and trends in amputations for each metro Auckland District Health Board (DHB) based on:

- age
- deprivation
- ethnicity
- gender
- medication for diabetes

The outcomes of the analysis showed that:

- Waitemata DHB had the lowest amputation rates when compared to metro Auckland and New Zealand
- between 2006 and 2013 the *total population* amputation rates for both Waitemata and Auckland DHBs had increased by 40% and 22% respectively
- between 2001 and 2013, despite *the population with diabetes* in Waitemata DHB increasing in number from 10,000 to 30,000, the lower limb amputation rate for people with diabetes remained stable

- between 2001 and 2013, despite *the population with diabetes* in Auckland DHB increasing from 11,000 to nearly 26,000, the lower limb amputation rate for people with diabetes also remained stable
- Amputation percentages in the total medicated diabetic population varied from 0.20% to 0.25% between 2006 and 2013

The amputation rates for people with diabetes in metro Auckland are lower than the national rate. Maori have a higher rate of amputation than other ethnicities. Men also have a higher rate of amputation than women.

It is recommended that the DHBs and their Podiatry services should review service use by Maori and men as there are potential health gains to be achieved for these groups.

2. Introduction and Background on diabetes and foot disease

At the CPHAC meeting of 30 July 2014 the Planning, Funding and Outcomes Team (PFO) was asked to provide information regarding lower limb amputation rates for people with diabetes. This paper has been prepared in response to that request.

2.1 Adverse health outcomes for people with diabetes

The adverse health outcomes that people with diabetes suffer are largely due to vascular disease. Over 50% of people with diabetes die of heart disease and strokes. People with diabetes also suffer from 'microvascular' complications of which the three most important are:

- kidney disease
- diabetic eye disease
- diabetic foot disease

The development of these complications can be prevented, or onset delayed, by good primary care management. This includes early detection of the complications and effective intervention at an early stage.

2.2 Preventing diabetes foot disease

Diabetes foot disease may eventually lead to lower limb amputation. This progression can be prevented by:

- providing the patient with good education on how to care for their feet
- good education of the primary care workforce to undertake a foot check
- early detection of 'high risk feet'
- timely intervention according to the level of risk
- timely referral to and treatment by a podiatrist or a specialist diabetes foot team

2.3 Analysing amputation rates

The rate of lower limb amputation in the diabetic population is used as a health indicator in many countries including the USA, Australia and other OECD countries as well as New Zealand.

When examining amputation rates in people with diabetes, two different perspectives were used in this paper:

- the incidence of diabetic lower limb amputation in the general population of metro Auckland. This provides information on the burden of disease in our communities.

- the incidence of lower limb amputation in a population of patients with diabetes. This is more useful to measure the quality of diabetes care.

3. Methods use to analyse amputation rates and trends

A range of methodologies from different countries was considered to determine the most appropriate for this paper. The different methodologies use a range of inclusion and exclusion criteria for amputation cases. The Health Quality and Safety Commission of New Zealand's methodology has been used for defining the numerator of cases of diabetes related lower limb amputations. This includes all hospital discharges for people with any diagnosis of diabetes who also have one of a group of specific operation codes for amputations.

There were three population denominators used in the calculation of rates. For the general population the population projections from census 2006 were used. For the population of people with diabetes the New Zealand Health Survey data was used. For those on medications for diabetes the Pharm warehouse database was used. In all cases, the numbers and the outcomes need to be treated with caution. This is because of the small number effect and because all the populations were estimated using many assumptions.

The New Zealand Virtual Diabetes Register was not used as a source of denominator data as this was not in existence in 2001. Consequently, we would not have been able to demonstrate trends over time.

We are not able to robustly compare the results of our analysis with other countries because of the differences in definition of either the numerator or the denominator.

4. Results

4.1 Diabetes related lower limb amputation in the general population

The analyses show the total impact of diabetes related lower limb amputations in the total adult population. This reflects both the prevalence of diabetes in the population and the incidence of foot complications in people who do have diabetes.

Between 2001 and 2013 the number of people who self-reported as having diabetes in Waitemata District Health Board (DHB) increased from 10,000 to nearly 30,000. This increase in the number of people with diabetes has also occurred within the other metro Auckland DHBs and nationally. For the same period Auckland DHB had increased from 11,000 to nearly 26,000. Figure 1 shows the rate of amputation per 100,000 people over the last 7 years.

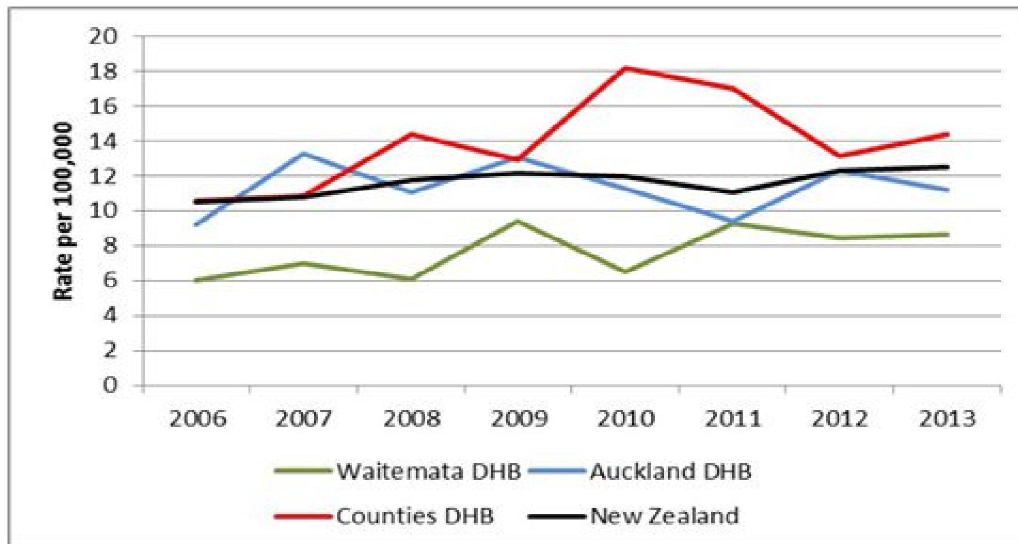


Figure 1: Diabetes related non-traumatic lower limbs amputation age standardised rate, Auckland region District Health Boards and New Zealand, 2006-2013

Waitemata DHB has seen the rate of amputation rise from 6 per 100,000 to 8.5 per 100,000. Auckland DHB has seen the rate of amputation rise from 9 per 100,000 to 11 per 100,000. Both DHBs however had amputation rates lower than the total New Zealand rate of 12.25 per 100,000 in 2013.

Between 2006 and 2013, Waitemata DHB had a lower age standardised amputation rate than metro Auckland and New Zealand. Although the age standardised rate trend had increased in all the comparators, this increase could be explained by the sharp increase in number of newly diagnosed people with diabetes. The Auckland DHB rates were similar to the New Zealand rates.

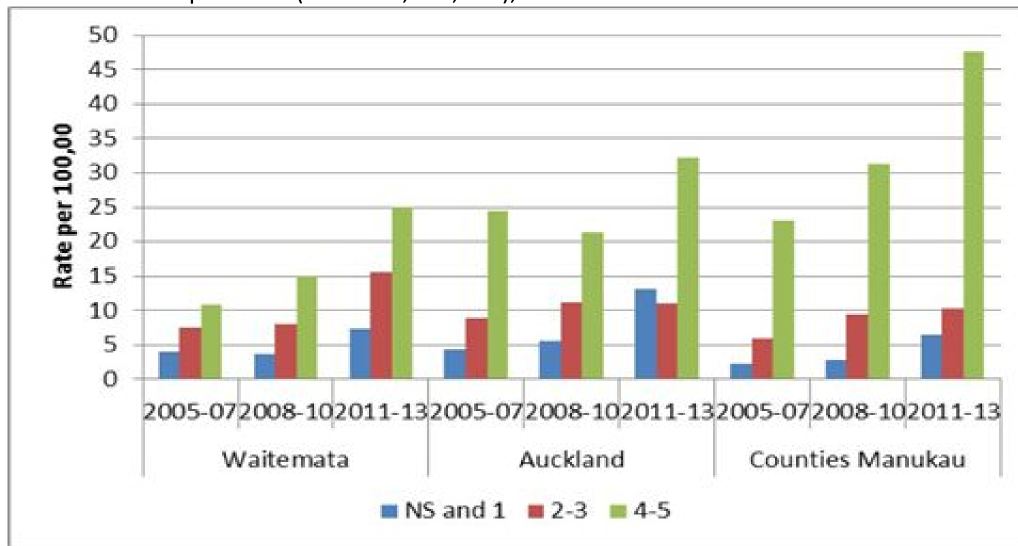
4.2 New Zealand deprivation

The small number of amputations made it difficult to use the standard New Zealand Deprivation scale. For the purposes of this analysis the data was aggregated for each three consecutive years starting from year 2005: 2005-07, 2008-10 and 2010-2013. The NZ Deprivation scale was adjusted to a scale of three;

- 1 = least deprived (0-1 NZ deprivation)
- 2 = medium deprived (2-3 NZ deprivation)
- 3 = Most deprived (4-5 NZ deprivation).

The rates of amputation by deprivation are shown in Figure 2.

Figure 2: Diabetes related non-traumatic lower limbs amputations rate, Auckland region DHBs, by New Zealand deprivation (NS and 1, 2-3, 4-5), 2005-07 to 2011-13.

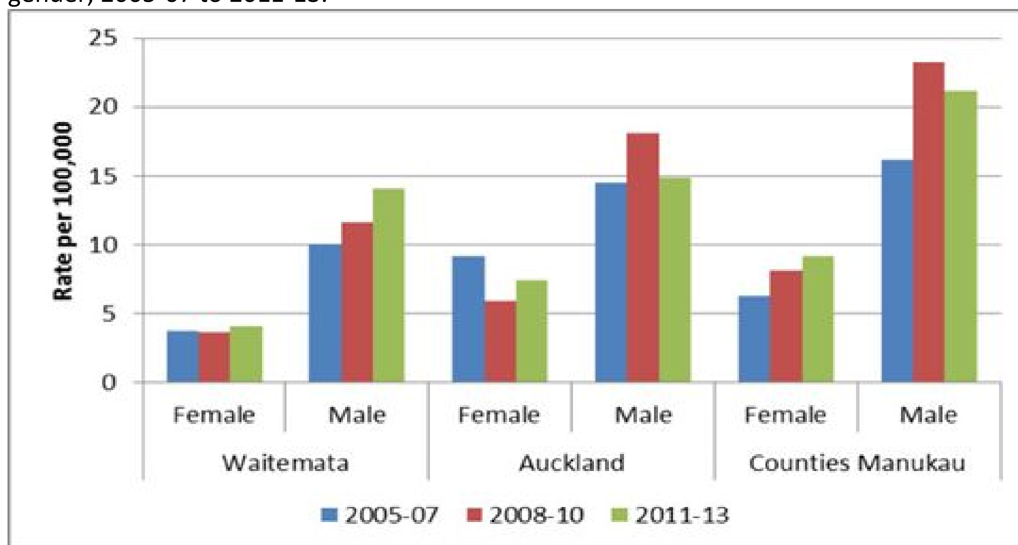


People living in the most deprived areas have higher amputation rates. This is consistent across all metro Auckland DHBs.

4.3 Gender

Figure 3 shows the amputation rates for males and females for each of the three metro Auckland DHBs. The same three consecutive years as that used for deprivation were used.

Figure 3: Diabetes related non-traumatic lower limb amputation rates, Auckland region DHBs, by gender, 2005-07 to 2011-13.



The male amputation rates were more than double that of the female rates in all metro Auckland DHBs between 2005 and 2013. The amputation rates for both male and females in Waitemata DHB were lower than the other DHBs. There has been an increase in the amputation rates for both Waitemata males and Counties females over the last 7 years. No trends were detected for the other groups.

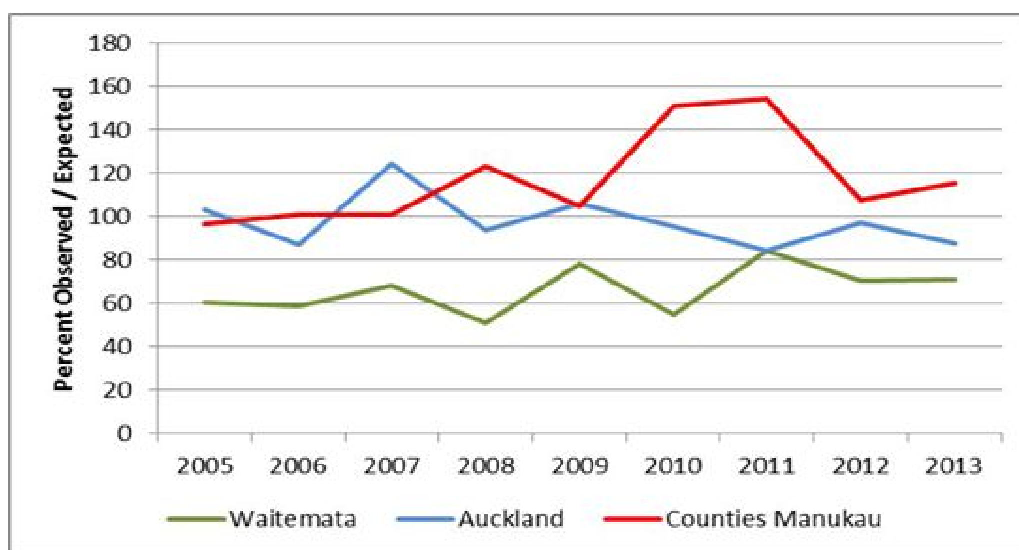
4.4 Ethnicity

The number of amputations was very small and even aggregating data or standardisation would not give reliable information on rates of amputation. For that reason, an ethnicity age-standardised rate analysis is not provided and only the amputation percentage is provided by ethnicity in section 4.6 below.

4.5 Indirect standardisation

The national population age specific rates were used to calculate the expected number of amputations for the three DHBs (Figure 4). Where the number of observed amputations is smaller than the expected, the ratio will be less than 100. A ratio of less than 100 indicates the DHB is performing relatively well compared to national performance for the indicator.

Figure 4: Proportion of expected to observed diabetes amputations, Auckland DHBs, 2005-2013



Between 2005 and 2013, Waitemata District Health Board had the lowest amputation ratios. Auckland DHB was close to their expected number of amputations and hence similar to the national rate. The general trend for all the DHBs showed no major changes through time.

4.6 Diabetes related lower limb amputation in the population of people with diabetes

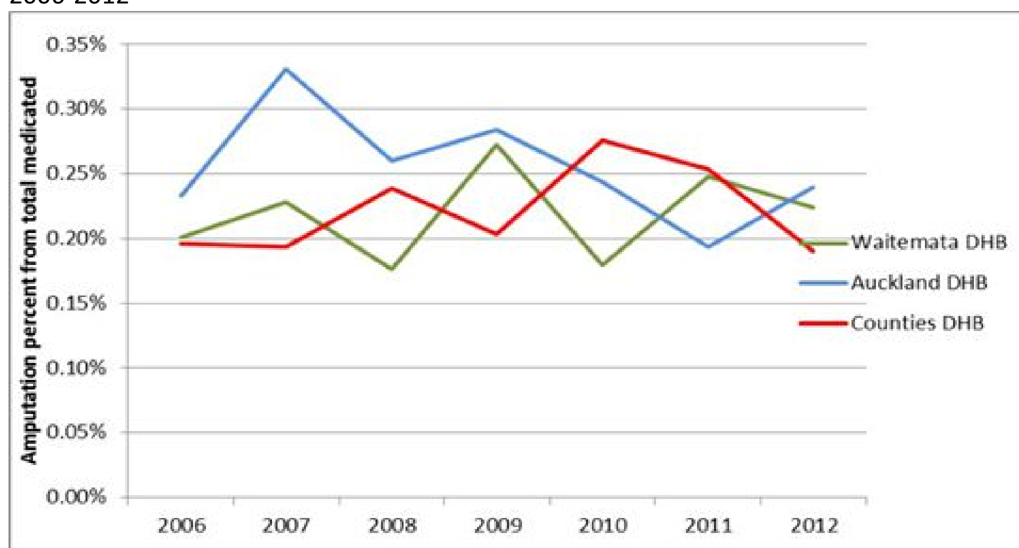
Two population denominators were constructed for this analysis:

1. The first denominator included patients with prescribed diabetes medication (on diabetes medications and/or diabetes management) from pharmaceutical data.
2. The second denominator was constructed using New Zealand Health Survey data from 1996 to 2011. The number was adjusted using the 2013 Virtual Diabetes Registry number.

The same technique was used to construct the ethnicity figure.

Figure 5 shows the trend of amputations as a percentage of the total medicated diabetic population by DHB, years 2006 - 2013.

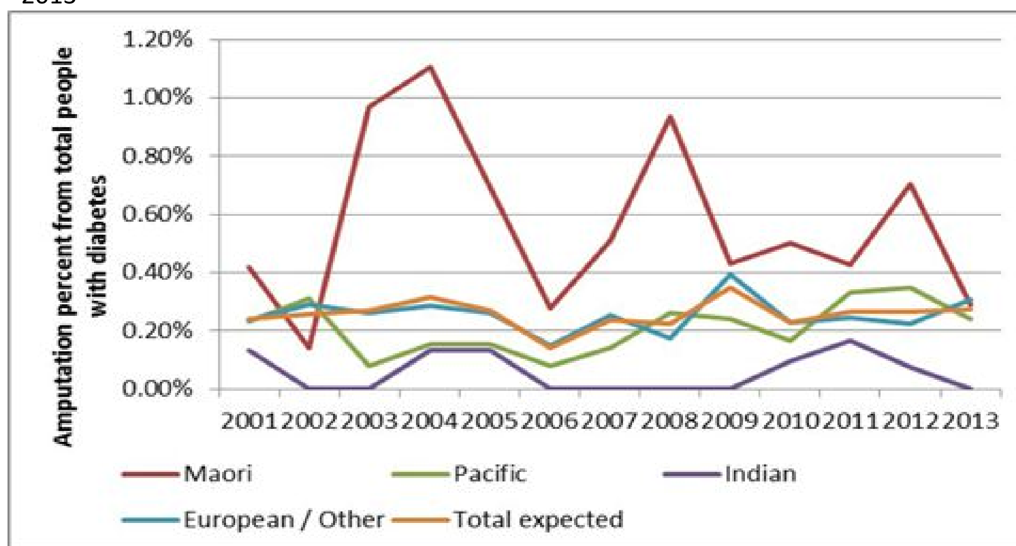
Figure 5: Amputation percentage in total medicated people with diabetes, Auckland region DHBs, 2006-2012



There were no clear trends for either Waitemata or Counties DHBs. Auckland DHB however, showed a slight decline over time. Almost all the yearly DHB amputation rates were between 0.20% and 0.25% of the total medicated diabetes population.

Figure 6 shows the percentage of amputations in the total population with diabetes, by ethnicity, 2001-13. This was constructed using the NZ Health Survey data.

Figure 6: Percentage of amputations in the total estimated people with diabetes by ethnicity, 2001 – 2013



Indians had the lowest percentage of amputations (small number effect). For Europeans / Others and Pacific people the rates were between 0.20% and 0.30%. There were no major changes during the last 13 years. Maori had the highest rates with no clear trend direction.

These results are very similar to what we found in our diabetes cohort study i.e. Maori rates are high, Pacific rates are similar to European, and Asian rates (both Indian and other Asians) much lower. This might be a healthy migrant effect.

5. Conclusion

The lower limb amputation rates for people with diabetes in Metro Auckland are lower than the national rate. Maori have a higher rate of amputation than other ethnicities. Men also have a higher rate of amputation than women.

The DHBs and their Podiatry services would need to review service use by Maori and men as there are potential health gains to be achieved for these groups.

5.1 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Deputy Director Funding Waitemata DHB/ADHB) and Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Marty Rogers (Maori Heath Gain Manager) and Lita Foliaki (Pacific Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding Waitemata DHB/ADHB), Simon Bowen (Director Health Outcomes Waitemata DHB/ADHB),

Glossary

ADHB - Auckland District Health Board
DHB - District Health Board
LMC - Lead Maternity Carer
PHAP - Pacific Health Action Plan
PACTRANS - Pacific International Translations
PHO - Primary Health Organisation
RFP - Request for Proposals
WATIS - Waitemata Auckland Translation and Interpretation Services
WCTO - Well Child Tamariki Ora

1. Introduction

This report updates the Committees on Auckland and Waitemata DHBs' Planning and Funding activity for September 2014.

2. Planning

The 2013/14 Annual Reports have been re-drafted, in line with auditor feedback, for both DHBs. This included reformatting by the graphic designers. The WDHB Annual Report was presented to the Waitemata DHB 24 September Board meeting and received positive feedback. The ADHB Annual Report is scheduled to be presented to the 8 October Audit and Finance meeting and then the 29 October Board meeting.

3. Transition

Recruitment to the new roles and vacancies has been the focus of recent months. 25 appointments have been made out of the 46 roles being recruited. These appointments have included existing staff who have moved to permanent or new roles as well as new staff to Waitemata and Auckland DHBs. Values based interviews have been key to the recruitment process.

Additional desks are being installed at Level 1 15 and 17 Shea Terrace as a medium term solution to accommodate the Planning, Funding and Outcomes Team. The team is down-sizing its presence at

Greenlane by moving from level 8 to hot desks on level 4. Shea Terrace will become the base for all Planning, Funding and Outcomes Team staff. This transition will occur over the next month.

Systems and processes will remain a priority over coming months. The ADHB/WDHB contract management system was on track to Go-Live in late August, however has been put on hold due to overarching network issues. Also the team is continuing to progress the details of the service level agreement.

Support for the team's development includes organisation development work with the senior management team and a business writing programme for many in the team.

4. Primary Care

4.1 Preparing Consumer Information for Different Ethnicities

The diversity of cultures and ethnicities within the Auckland population provides an on-going challenge as to how information can be presented appropriately. There is increasing demand to make information available in a range of languages.

The Ministry of Health can and do provide support for development of materials for the three official languages of New Zealand (Maori, Sign Language and English). For other languages the DHBs need to develop these materials locally.

The process for development and delivery of information in a culturally sensitive manner is challenging. For example there may not be appropriate words in a particular language for some of the terms that need to be communicated.

Both Auckland and Waitemata DHBs have processes in place to support the appropriate translation of documents. Waitemata DHB has a guideline for translation of documents. All translation of documents is to be completed by Waitemata Auckland Translation and Interpretation Services (WATIS). Auckland DHB requires documents needing translation to go through the communications team who contract with Pacific International Translations (PACTRANS). Both WATIS and PACTRANS have processes to ensure the translated document is translated back in to English to ensure the key messages are not lost.

Auckland DHB is revising its core patient and visitor leaflets and as this happens, these will be translated into Tongan, Samoan, Maori, Korean, Hindi, and simplified and traditional Chinese. The first leaflet to be revised is Your Rights, a summary based on the Code of Health and Disability Consumer's Rights.

Auckland and Waitemata DHBs have a small working group that is developing a health literacy framework. This framework will include elements for preparing information for the needs of our increasingly ethnic diverse population. This will be presented to CPHAC for consideration in due course.

4.2 Alliance Update

On 10 September the Alliance Agreement was formally signed by all parties. This was a significant event in strengthening relationships between our organisations, Mana Whenua and Mataawaka, and PHOs. There has been good coverage in New Zealand Doctor.

The Ministry attended the event and presented Ailsa Claire, the ADHB Chief Executive, with a certificate recognising achievement of the More heart and diabetes checks health target, one of only two DHBs to do so. A similar presentation is being organised to recognise Waitemata DHB's performance in leading the country in the better help for smokers to quit health target.

The Alliance Leadership Team is meeting monthly and is in the final stages of confirming priority areas.

5. Women's, Children's and Youth Health

5.1 Immunisation

The immunisation health target to be achieved by the end of December 2014 is 95% of 8 month old infants have received their full course of immunisations. Auckland is on track to achieve this target, Waitemata remains slightly behind.

One of the factors contributing to the gap in Waitemata is the decline rate. Families that decline an immunisation for their child have had a conversation with a health professional but have declined immunisation. The child remains in the denominator for the target. For Waitemata, the decline rate is currently 3.2%. Families also have the ability to opt off. This is when they may or may not have been immunised but do not want their information on the national register. The child however remains in the denominator. The opt off rate is currently 0.6% which combined with the decline rate is 3.8%.

Other infants may not be able to receive the full course of immunisations (6 weeks, 3 months and 5 months) for a number of reasons including some who are medically compromised and others who may have come into the country and are on a 'catch up' programme, but in either case, cannot be fully immunised within the timeframe. Achieving the 95% target will be a significant achievement.

The current rates are shown below.

Immunisation (8 months)	Auckland	✓ / ✗	Waitemata	✓ / ✗
Total (95%)	95%	✓	92%	✗
Maori (95%)	93%	✗	89%	✗

The plan to achieve the target has included a range of activities which are either already underway or are currently being planned.

1. Reduce decline rate
    - Development of an antenatal DVD for parents regarding the benefits of immunisation in collaboration with all Northern DHBs.
    - Waitemata PHO drafting an education package that will encourage practice nurses to review declines processes and support conversations with concerned parents.
    - T-shirts promoting positive immunisation messages to be worn by practice staff.
    - Consideration of promoting immunisation messages on DHB fleet cars.

2. Improve timeliness of immunisation
    - on-going vigilance by PHOs supporting practices to identify infants who have not been fully immunised and recalling them or referring them to the outreach service.
    - Working with PHOs to improve new born enrolments.
    - Increasing the support available to practices in Waitemata DHB to match those available for ADHB.
    - Training continues for Procare, Waitemata PHO and Auckland PHO data analyst and immunisation coordinator on the identifiable data report. This new report allows PHOs to identify children who are overdue the 3 and 5 month immunisations and offer early, targeted support to practices to increase on-time immunisation rates and encourage early referral to OIS.

5.2 The B4 School Check

The provider of the B4 School Check in both Auckland and Waitemata is now Plunket. Plunket sub-contracts some smaller Well Child Tamariki Ora (WCTO) providers but maintains quality across the programme and delivers the Check to the majority of children. Performance after the first two months of the new contracting arrangement in Auckland is extremely positive with monthly targets exceeded for both the total population and for the 'high deprivation' population. This is an extremely pleasing result. We congratulate Plunket for this achievement and also congratulate the PHOs for working closely to ensure the hand-over of service and transition was as smooth as possible.

B4School Check Target 90%	Auckland	✓ / ✗	Waitemata	✓ / ✗
Total YTD Target 15%	16%	✓	16%	✓
High Dep YTD Target 15%	17%	✓	16%	✓

5.3 Maternity

We are in the process of establishing a Pregnancy and the First Year of Life Service Alliance with primary care, midwifery and Well Child Tamariki Ora (WCTO) providers. Lead CEO Women's and Children's Health, Ailsa Claire, will co-chair this group with a PHO CEO. This umbrella advisory group will work to improve outcomes for mother and baby.

A number of work-streams will sit under this Alliance such as: early engagement with maternity carer; pregnancy and parenting information and education; antenatal WCTO, and; multi-provider (immunisation register, general practice, WCTO and oral health) newborn enrolment. Improving the connection between primary care and the Lead Maternity Carer (LMC) and improving transitions of care between providers is a key to this work.

In relation to pregnancy and parenting information and education, a well-attended workshop was held with Counties Manukau DHB for stakeholders on Friday 26 September. The purpose of the workshop was to inform the content of a Request for Proposals (RFP) process. The DHBs will jointly request providers of the information component. We expect to find innovative solutions to getting pregnancy and parenting information to pregnant women and their families and whanau in ways in which people can dip back in as required. Technology is expected to be the key to delivering a flexible package of information that engages more effectively with people from our diverse

communities. Once the Information component has been finalised we will go out to the market for providers of pregnancy and parenting education. We expect to have provider agreements in place in the next financial year.

6. Maori Health Gain

6.1 Smoking and pregnant mothers

Smoking prevalence for Māori pregnant mothers at time of booking to birth is significantly higher than other ethnicities in both Waitemata and Auckland DHBs. In Auckland DHB at the time of recorded booking to birth the 2013 smoking rates for Māori were 35% compared to 13% for Pacific, and 3% for NZ European. In Waitemata DHB at the time of recorded booking to birth the 2014 smoking rates for Māori are 51% compared to 19.5 % for Pacific, and 6.7% for European.

Progress towards achieving a 90% quit rate among Māori pregnant women who identify as smokers is a priority for 2014/15 in both DHBs.

The Māori Health Gain Team is in the process of identifying strategies and activities to support Māori pregnant mothers to become and stay smoke-free. Current activities include:

- Orakei Health (Auckland DHB) and Waipareira Health (Waitemata DHB) support maternal health through their 'mother and Pepi' programmes. Both programmes provide support for pregnant women to register early with an LMC and/or a GP, raise awareness about smokefree homes and environments and provide advice to quit smoking with an offer of cessation support.
- A wrap - around campaign led by the DHB smoke-free teams to include smoking cessation in the 'healthy babies healthy futures' programme is underway. The aim of the campaign is to utilize the text messaging component of the healthy babies healthy futures programme to provide support and advice for pregnant women who want to quit smoking.

6.2 Maternal health

The Māori Health Gain team is supporting a new joint project between Waitemata and Auckland DHB Maternity Services with the aim to increase registration rates of Māori pregnant mothers with Lead Maternity Carers (LMC).

Current activities to improve Māori early enrolment with an LMC service and to encourage greater participation in antenatal care education include:

- Promote the Greenlane 'walk in centre' that offers support, advice and assistance for pregnant women who want to enrol with an LMC. Work to implement the revised MoH pregnancy and parenting service specifications, to provide more effective and targeted education, through a request for proposal process which is planned for 2015
- Maternity Services are leading a project to increase Māori and Pacific early enrolments with LMCs. An investigation into other DHB models of practice such as the Counties Manukau DHB and independent LMC 'high deprivation model of care' is being considered for adaptation.
- Plans to support targeted strategies for antenatal care and early enrolment with an LMC are being led by the Planning and Funding maternal health team. The aim is to utilise and initiate the 'Waitemata Early Engagement Survey Report' recommendations such as adaptation of the Wanganui DHB poster '5 things to do in the first 10 weeks'. The project will look to increase registration rates of Māori pregnant mothers with Lead Maternity Carers.

6.3 Tamariki ora

The Māori Health Gain Team are developing a project to improve tamariki Māori health gain (0-14) and reduce inequities in the top five ASH conditions in Waitemata and Auckland DHBs. The project will look to build capability in the Māori unregulated workforce to improve the health literacy and expectations of whānau and tamariki when they are engaging with the health system. The initial focus of the project will be on the top five ASH (Ambulatory Sensitive Hospitalisations) conditions for both DHBs although it is expected that this could be expanded in the future.

7. Pacific Health

7.1 Implementation of the Pacific Health Action Plan (PHAP) 2013 – 2016

The Pacific Health Action Plan has six priorities and an update on the progress of implementation of the priorities is as follows:

In relation to the first priority ***that children are safe and well and that families are free of violence*** the initial work is to establish connection to and participation in existing forums addressing family violence. The following are underway:

- Participation in the ADHB Family Violence Steering Group, Auckland Family Violence Project Board (with Police, Justice, Corrections and Ministry of Social Development) continues.
- Consultation with providers of parenting education and family violence programmes that have capacity to respond to Pacific communities has been completed. The next stage to be undertaken in this second quarter is to hold workshops where the providers present their programmes, in terms of content and methodology to church and community leaders who will be asked to provide input into the programmes. It is then intended that a programme will be delivered to at least two church/communities within this financial year.

The second priority of the Plan is that ***Pacific people are smoke free*****.** The following are underway:

- The first round of the WERO group smoke free competitions (in the 2014/15 financial year) has been completed. Fifty Pacific people from 5 HVAZ and Enua Ola groups participated. 21 people (42%) quit smoking during the competition. Maria Assumpta, a Catholic parish from Beachaven, won the competition with 8 out of the 10 people from the church quitting smoking. The next specific Pacific competition will be held in March and other groups are being prepared to participate.
- Of the 42 HVAZ churches, 33 or 80% are completely smoke free, i.e. both church halls and grounds are smoke free.
- Both HVAZ and Enua Ola co-ordinators have been promoting the "Stoptober" competition amongst churches and communities.
- The Pacific smoking cessation service as well as Pacific staff of mainstream cessation services are participating in the development of Waitemata DHB's Tobacco Control Plan.

The third priority is that ***Pacific people eat healthy and stay active*****.** The weekly physical activities and nutrition training is continuing. The Aiga Challenge which is the annual 8 week weight loss competition ends on 5 October. The major activity of the next couple of weeks is analysing the data. An event will be held in early December to announce the results and the winners of the competition. The data will then be used to inform a process that will be undertaken with the HVAZ / Enua Ola churches /communities to review the current programme.

The fourth priority is that ***we seek help early***. Monthly meetings with AH+ to monitor that the new service model of addressing the health needs of families works in through the provision of packages

of care is now occurring. Although Pacific providers have attempted to work this way in the past, AH+ reports that the input of data by frontline workers is a challenge, yet this is vital for allowing the PHO and funders to assess the effectiveness and cost effectiveness of the approach. Workforce development is an important role for AH+ at this is their focus currently.

The fifth priority is that ***Pacific people use hospital services when needed*.** The General Manager for Pacific Hospital Services reports on this priority.

The sixth priority is that ***Pacific families live in warm healthy houses that are not overcrowded.*** The intention of the Pacific team is to link to housing advocacy groups in West Auckland and part of Central Auckland and to facilitate participation of Pacific community leaders in these groups.

7.2 Inaugural Waitemata District Health Board Pacific Week

The inaugural Waitemata DHB Pacific week is being held the week beginning 6th October. The theme is “Launch Pasefika” profiling and celebrating Pacific peoples and the respective community services and achievements of our Pacific staff. The Pacific Best Practice modules and the Pacific allied health/nursing/medical networks will be launched. We anticipate high level of staff engagement from the Pacific staff and an improved literacy of the services available in the community for patients and staff. We will launch the Pacific Health Science Academies also with the performances from the respective schools. Currently the Communications team is profiling the Pacific staff in up and coming healthlines and producing posters to be hung up on the wall.

7. Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Co-opted member appointment	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]