Community and Public Health Advisory Committees Meeting

Wednesday, 22nd July 2015

2.00pm

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
22nd July 2015

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
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	
Rev Featunai Liuaana – Co-opted member	
Tim Jelleyman - Co-opted member	

Apologies: Sandra Coney

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

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

1 AGENDA ORDER AND TIMING

2 CONFIRMATION OF MINUTES

2.05pm 2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 10/6/15 7
Matters Arising from Previous Meeting 28

3 DECISION ITEMS

4 INFORMATION ITEMS

2.10pm 4.1 Mental Health and Addictions Updates - 2014/15 Actions 30
2.30pm 4.2 Waitemata and Auckland District Health Boards' Pacific Health Plan 2013-2016: Progress Update 36
2.45pm 4.3 Child, Youth and Women's Health Scorecard 48

5 STANDARD REPORTS

3.00pm 5.1 Planning, Funding and Outcomes Update 59

3.15pm **6 GENERAL BUSINESS**

3.17pm **7 RESOLUTION TO EXCLUDE THE PUBLIC** 76

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2015

NAME	FEB	MAR	APRIL	JUNE	JULY	SEPT	OCT	NOV
Gwen Tepania-Palmer (ADHB / WDHB combined CPHAC Committees Chair)	✓	✓	✓	✓				
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	✓	✓	✓	✗				
Rev. Featunai Liuaana	✗	✓	✓	✓				
Dr Tim Jelleyman	✓	✓	✓	✓				

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

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Chair - Auckland District Health Board Chairman - Auckland Transport 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 (includes Director – Orion Corporate Trustee Ltd) Member – State Services Commission's Performance Improvement Framework Review Panel	04/02/15
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 Forum 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
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 (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	26/11/14
Lee Mathias	Chair - Counties Manukau District Health Board Chair – Unitec Director – Health Innovation Hub Director – healthAlliance Director – New Zealand Health Partnerships Managing Director - Lee Mathias Ltd Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Director - Pictor Ltd Director - John Seabrook Holdings Ltd Chair - Health Promotion Agency Director - iAC IP Ltd Advisory Chair - Company of Women Ltd	13/07/15
Robyn Northey	Project management, service review, planning etc - Self-employed Contractor Board member - Hope Foundation Northern Region Trustee - A+ Charitable Trust	18/07/12

Register of Interests continued…

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

Co-opted Members

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
Rev Featunai Liuaana	Chairperson – Congregational Christian Church Samoa Sandringham Trust Board Trustee – Congregational Christian Church Samoa Trust Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB) Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB) Member – MIT Pasifika Students Forum Secretary - Negotiation Committee – EFKSNZ Trust Secretary – EFKSNZ Trust	29/04/15
Dr Tim Jelleyman	Clinical Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland Member-Board of Kaipara Medical Centre Community Paediatrician, Waitakere Hospital Member – ASMS	14/04/15

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 10th June 2015

Recommendation:

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

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 10 June 2015

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

All items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member) (present from 2.05p.m.)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (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)
Allison Roe (WDHB Board member)
Rev Featunai Liuaana (Co-opted member) (present until 3.15p.m.)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Stuart Jenkins (ADHB and WDHB, Clinical Director - Primary Care)
Andrew Old (ADHB, Chief of Strategy/Participation and Improvement)
Carol Hayward (Community Engagement Manager, Waitemata DHB)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Wiki Shepherd-Sinclair, Health Link North
Lorelle George, Comprehensive Care/Waitemata PHO
Brian O'Shea, Pro Care

APOLOGIES:
Resolution (Moved Jo Agnew/Seconded Peter Aitken)

That the apologies from Lester Levy, Pat Booth (leave of absence), Chris Chambers, Elsie Ho, Christine Rankin and Ailsa Claire, together with an apology for early departure from Rev. Featunai Liuaana, be received and accepted.

Carried

WELCOME: The Committee Chair made special mention of the passing of Sir Peter Williams QC, remembering his many contributions to the nation and to community justice. She gave a warm welcome to all those present, including PHO representatives, the representatives from the Auckland Womens Health Council and Health Link North, Committee members and staff.

PRAYER: Rev. Liuaana provided an opening prayer for the meeting.

2.05p.m. – Max Abbott present.

DISCLOSURE OF INTERESTS

With regard to the Interests Register, Lee Mathias advised that there would be some changes to her interests effective from 1 July 2015. She would confirm these with the Secretary.

There were no declarations of interests relating to the agenda at this point in the meeting. Subsequently, when Item 5.1 Primary Care Update was considered, Warren Flaunty noted that he had an interest as a pharmacist in the section of the report relating to the Community Pharmacy Services Agreement Extension. He also advised that as no decision relating to this issue was being made at the meeting, he would like the opportunity to comment. The Committee agreed that this was appropriate.

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 29th April 2015 (agenda pages 7-17)

Resolution (Moved Tim Jelleyman/Seconded Allison Roe)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 29th April 2015 be approved.

Carried

Matters Arising (agenda pages 17-18)

With regard to the presentations to be arranged for CPHAC on the Maori Health Plans and the Pacific Health Action Plan, Simon Bowen advised that following approval of the Maori Health Plans by the Minister of Health, and a stakeholders' event on the Pacific Health Action Plan, due to take place on 12 June, they would be in a position to provide presentations on these plans to CPHAC. The Committee Chair noted that the presentations need not necessarily be to the same CPHAC meeting, but it would be useful to have them early in the new financial year.

Lee Mathias raised the question of whether it might be preferable not to have separate plans such as these, but to have one plan with very identified comment on the differing communities of interest in it. Discussion on this suggestion included:

- Simon Bowen noted that the Maori Health Plans are required by the Ministry of Health, while the Pacific Health Action Plan had been developed in some ways as for other key areas of work that they are engaged in. That Plan had been developed based on extensive consultation with the Pacific community on what they saw their health needs to be.
- Lee Mathias advised that the thinking behind her suggestion included that by pulling a particular population group out of an overall plan, they sometimes end up getting less than they would have. She considered that it might be an appropriate time to debate the most appropriate way to target needs of disadvantaged groups. There are arguments for and against targeting of particular ethnic groups as opposed to targeting particular health issues.
- Sandra Coney commented that she did not see how individual DHBs could consider departing from a national requirement to have a Maori Health Plan. There had been a very long history leading to the current approach. The track record of integrating Pacific population needs into the bigger picture had not been particularly successful in the past. She suggested that DHBs should be looking to take any lead from stakeholder leaders on this issue, rather than raising it in this way.
- In answer to a question on how the DHBs receive assurance that the plans put in place are achieving gains, Debbie Holdsworth noted that the Pacific Health Action Plan is quite different, in that it is a plan owned by the Pacific communities, reporting against their priorities and accountable to those communities. They are going back to those communities on 12 June to report on progress and receive feedback. With the Maori Health Plan, there is now a single plan for the two DHBs and they are moving towards a collective agreement on approach with stakeholders. Simon Bowen also noted that in each CPHAC agenda information and performance data by ethnicity is provided where appropriate. Progress on the objectives in the Maori Health Plans is reported to Manawa Ora. With these plans, generally they are seeing progress in terms of indicators, but simply achieving that is not enough to overcome disparities. He suggested that the time for CPHAC to consider this subject might be when the presentations are given on the Maori and Pacific plans.
- In answer to a question on what Maori health leaders think about this issue, the Committee Chair commented that their views are as diverse as anyone's, however they do expect respect for the Treaty of Waitangi, based on principles of partnership and allocation of resources to address inequalities. Leadership is diverse and takes many forms from traditional tribal leadership to contemporary urban leadership. Some Maori authorities have their own health plans and services. To change the current approach to addressing Maori health needs would be a very big decision to make. She did expect to see more courageous steps in future in response to what communities ask for.
- Max Abbott spoke about the very diverse needs of Asian and migrant communities. He considered that the time has come when it is very important to be more explicit about these communities and their health needs. Attention needs to be paid to different expectations, as in many Asian countries there is not a primary healthcare system. For many years (until about five years ago) he had co-led a team which had carried out a number of surveys of Chinese and Pacific communities which had found a very high rate of hidden health needs and some important issues. There needs to be a lot of work focussing on particular groups before bringing their needs back into

part of an overall plan. Thought needs to be given to future population composition in ten, twenty and thirty years from now.

3 DECISION ITEMS

There were no decision items.

4. INFORMATION ITEMS

4.1 **Community Engagement Update** (agenda pages 19-23)

Andrew Old (Chief of Strategy/Participation and Improvement ADHB), Carol Hayward (Community Engagement Manager WDHB), and Wiki Shepherd-Sinclair (Health Link North) were present for this item. Andrew Old conveyed apologies from Dr Sue Copas and Dr Tony O'Connor.

Carol Hayward introduced the paper. She commented that they are looking to develop an online engagement framework with the community for both DHBs. They are trying to develop this from the basis of Auckland DHB's Reo Ora Health Voice as a co-design process and are working with the community on this.

Andrew Old commented on the Tamaki Mental Health and Wellbeing Initiative (pages 20-21 of the agenda). An innovative and different approach had been used for this, involving the "social labs" method, outlined in the report. The process had been approved by the District Alliance recently. He also commented on the fridge magnet initiative (pages 21-22 of the agenda) which advised the public on how to find health services information and information on public transport links. This is a joint project involving Auckland DHB, Healthpoint, Auckland Transport and the Maungakiekie Health and Wellbeing Group.

Sandra Coney advised of her concerns relating to Special Housing Areas, which she said tended to be in outlying areas involving intensive residential development at high speed, with streamlined approval processes and little thought given to the services that these communities will need. As an example the Waitakere Ranges Local Board is opposed to a Special Housing Area at Swanson, not on a transport route and not near schools, and for which there is no comprehensive planning. She had been told at a meeting recently that "the market will provide". She considered that this issue in particular affects Waitemata DHB, both in terms of trying to ensure essential services are provided and also to support the creation of communities which are good places to live in.

Discussion on the above issue included:

- Robyn Northey commented that in the past voluntary agencies had helped support new communities such as Massey that were lacking in services, but those agencies no longer had the capacity to do so.
- Andrew Old advised that Tim Wood and he had met with the Tamaki Development Company and one of the concerns that they had expressed to the company was the focus on housing, but not on planning for health and other services. That conversation is continuing now.
- Tim Wood advised that he had met with the Council on a couple of occasions about special housing areas. They present a real challenge to DHBs as primary care, aged residential care etc. traditionally are allowed to set up how they want to and have not been actively planned for. The outcome in the end is reliant on private providers'

decisions on whether the business models that they are considering will work. Another issue when talking to the Council is that it is really difficult to anticipate what the demographics will be in each area and to understand what is being planned for.

- Sandra Coney commented that it would be good to have a report at some point including who is taking responsibility for planning services, including such things as schools, day care centres and kindergartens (as well as health facilities) that these new communities will need. She thought that the DHBs might have a role in putting more pressure on the Government and Council to plan for this.
- The Committee Chair noted that there had been experience with the type of problems Sandra Coney had described over long periods in South Auckland.
- Lee Mathias commented that normally schools are planned for, but almost never primary healthcare centres. She also noted the large amount of work that had been done with the community in Tamaki and the need to be informed on the future plans for development at Tamaki.
- In answer to a question, Tim Wood advised that the Council specified for each special housing area a percentage of the housing that needed to be "affordable". This meant different things in different contexts. There is also a risk (which the Council had identified) of developers developing ten to twelve houses at a time and avoiding the requirement for "affordable housing" by that approach. Sandra Coney commented that a lot of developers who had been sitting on land are now taking advantage of the special housing areas provisions to avoid going through a resource consent process. They were also not required to provide public open space, as the Council had changed the requirement so that a financial contribution was required rather than provision of land.
- In conclusion the Committee Chair noted that this was an issue for each of the Boards to consider. She would leave it with the team to advise when they could provide an overall view of this issue for Waitemata DHB.

Other matters covered in the course of discussion and response to questions on the agenda report included:

- Robyn Northey advised that she had been receiving really positive feedback from the community about the Tamaki initiative and particularly about the work of Dr Sue Copas.
- Making the connection with Auckland Transport on the fridge magnet was commended.
- It was agreed that a link to the Auckland DHB Reo Ora Health Voice website be provided to CPHAC members. (This site is www.healthvoice.org.nz). In response to a question, Andrew Old advised that they had not been actively pursuing getting new members recently as they had been discussing how best to use the panel and who to target for membership of it. They had a clear view of what is wanted from it once the panel is signed up.
- In answer to a question on consumer review by Health Links of DHB material (page 23 of the agenda), Wiki Shepherd-Sinclair confirmed that this is an ongoing process; there is always a lot of material to be reviewed.

The Committee Chair welcomed Wiki Shepherd-Sinclair to her new role.

Resolution (Moved Robyn Northey/Seconded Jo Agnew)

That the report be received.

Carried

4.2 Nga Painga Hauora – Maori Health Outcomes Framework (agenda pages 24-62)

Aroha Haggie (Manager, Maori Health Gain) and Dr Karen Bartholomew (Public Health Physician) were present for this item.

Aroha Haggie introduced the report, providing a PowerPoint presentation covering the process used; the framework developed and some examples of how it can be applied. A copy of this presentation is attached as Appendix 1 to these minutes. She emphasised that the indicators shown are indicative only; there is an ongoing iterative process to establish them.

3.15p.m – Rev. Liuaana retired from the meeting.

Matters covered in discussion and response to questions included:

- Aroha Haggie advised that they are currently talking to providers of services about revisiting contracts, looking at what needs reconfiguring to better meet the needs of communities. Outcomes may be wider than health outcomes.
- It was noted that on page 39 of the agenda "Auckland City" should read "Auckland Council".
- In answer to a question, Aroha Haggie advised that the references in the report to health insurance being considered a good health indicator was an example of something that is unlikely to stay following the process of reviewing proposed indicators. The Committee Chair noted that health insurance was associated with prosperity and as such belonged more in a discussion about future possibilities.
- Lee Mathias advised that her main concern is that measurement tends to be very transactional and not really linked to good health. She suggested that a referral is not really a measure of health, but of ill health, and that it is time to think of positive measures of health which might possibly include such things as percentage of people in fulltime employment in a particular cohort and percentage of people playing sport in a particular cohort. Simon Bowen referred to measures such as increased use of Te Reo; participation in health education programmes and participation in sport and leisure activities. Lee Mathias also commented that the Blue Zone project which is currently with the Minister and Ministry of Health for consideration would provide a fundamental basis for saying what good health looks like.
- Karen Bartholomew noted that the domains in this framework are much broader than most other outcomes frameworks. There is a challenge to get useful indicators, but there will be a lot to learn from in this process.
- Simon Bowen commented that the level of support and enthusiasm generated by Sir Mason Durie through this process will be important and have a positive effect, galvanising stakeholders.

The Committee Chair thanked Aroha Haggie and Karen Bartholomew and noted that the Committee will look forward to regular updates.

Resolution (Moved Lee Mathias/Seconded Robyn Northey)

That the report be received.

Carried

5. STANDARD REPORTS

5.1 Primary Care Update Quarter 3, 2014/15 (agenda pages 63-82)

Tim Wood (Deputy Director Funding and Funding and Development Manager – Primary Care) and Dr Stuart Jenkins (Clinical Director – Primary Care) were present for this item.

Tim Wood introduced the report. Matters that he highlighted included:

- The Better Help for Smokers to Quit Target will be challenging for PHOs in Q4, 2014/15. A huge amount of effort had been needed by them in this quarter last year and it had been realised then that this would need to be replicated this year. The PHOs are confident that they will hit the 90% target by 30 June and most are well on the way to achieving the target or are very close, however it is very challenging for two of the PHOs. NHC had experienced a very significant drop when it had come into this quarter. Procare was at 82.5% at the end of May, but remained confident it could reach 90%.
- With Heart and Diabetes Checks all the PHOs are around 90% and confident of meeting the target at the end of the financial year.
- The Immunisation target is challenging for both DHBs and a huge effort is being made to try and achieve it.
- CPHAC had previously been advised that a new IPIF (Integrated Performance and Incentive Framework) would be introduced from 1 July 2015. This is not now occurring and the existing framework will continue. The Cervical Screening component of the IPIF is still challenging many of the PHOs.
- The Auckland Waitemata District Alliance is working with Francis Group International to define what success for the Alliance looks like (discussed on pages 72-73 of the agenda). The Diabetes Service Level Alliance had been formed to further develop and oversee the District Alliance diabetes work.
- The first meeting of the Auckland Waitemata Rural Service Alliance had been held. They were still at the stage of defining the work programme to go forward with. There was a lot of enthusiasm from the participants.
- With the Community Pharmacy Services Agreement Extension, about 30 of the 120 pharmacies had now signed. There was still work required to get agreement. A number of contracts coming back from pharmacists talked of expectations going forward.
- A report on Primary Options for Acute Care is being prepared for the next CPHAC meeting.

In answer to a question on the feedback received from over 270 pharmacists to the Community Pharmacy Services Agreement extension, Tim Wood advised that the biggest issue was the margin attached to pharmaceuticals in terms of pharmacists covering their costs. A national Task Force had been set up to review this issue. The pharmacists are advocating for an interim agreement, while the DHBs prefer to wait for the findings of the

Task Force. The pharmacists also express concern at the level of the funding increase at 1.07%. Overall there was a level of disquiet in the feedback.

Warren Flaunty noted that he had an interest in this matter as a pharmacist, however no decision relating to this issue is being made at the meeting and he would therefore like the opportunity to comment. The Committee agreed that this was appropriate.

Warren Flaunty advised that one of the main concerns is that upwards of 50% of prescriptions are being dispensed at a loss. The $750,000 national fund referred to in the report (for DHBs to agree local community pharmacy initiatives focused on quality improvement and patient-centred services) only equated to $750 per pharmacy.

Other matters covered in discussion and response to questions included:

- With regard to POAC (Primary Options for Acute Care) Tim Wood advised that there is a commitment to do a full review across the region of the marked variations in level of use. Even in Waitemata DHB (which had the highest level of use) there was huge variability within the district. A significant number of general practices never used POAC, while others used it frequently. Another factor is that the three DHBs invest at different levels in POAC. Part of the analysis to be provided to the next CPHAC meeting would be to provide more detail on variability and what is driving that.
- In answer to a question, Tim Wood advised that in Primary Mental Health, Quintile 5 is based on the area people live in. Max Abbott commented that there are a large number of people in disadvantaged circumstances who live in higher ranked neighbourhoods. Tim Wood advised that a comprehensive look is being taken at Primary Mental Health. They know that there is a gap between the service provided to those who are directly funded and those who don't meet the criteria. Part of the challenge is looking at what options are available at the moment and how to cover gaps in the future. They are trying to understand what the mix should be going forward. He also noted that direct access to Mental Health support for Primary Care is being trialled through the Tamaki initiative and recently Waitemata DHB had opened up Mental Health support for Primary Care. The issue is complex and they are trying to overcome historical barriers, taking clinicians outside their comfort zones. Lindy Matthews is working with G.Ps in West Auckland on this, and Kristin Good at Auckland DHB is exploring other models that exist around the country. There remains considerable work to get clarity on where the best investment opportunities lie. The Committee Chair noted that this is a significant piece of work and it is really important that the Committee is kept up to date on this. It would be good to establish timelines for this work.
- Sandra Coney raised her concern that the Cervical Screening target is still not been achieved, 25 years after the national programme was launched. Previously there had been discussions about some programmes that provided free screening for some women and a couple of years ago it had been identified that these were not being utilised. She asked for an update on this issue. Tim Wood advised that more detailed information could be provided at the next CPHAC meeting as part of the Child Women and Family report. Karen Bartholomew advised that the national data matching process underway is a key to making sure each PHO knows which women need to be screened. This process would provide that certainty for the first time. The other area where progress is being made is at practice level support, with co-ordinators visiting practices and a lot of work occurring with systems and processes.

The Committee Chair thanked Tim Wood and Stuart Jenkins for the report. She noted the expectation of additional information on Cervical Screening for the next CPHAC agenda and reporting on Primary Mental Health reconfiguration on an ongoing basis.

Resolution (Moved Judith Bassett/Seconded Peter Aitken)

That the report be received.

Carried

5.2 Planning, Funding and Outcomes Update (agenda pages 83-91)

Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes), Tim Wood (Deputy Director Funding), Aroha Haggie (Manager-Maori Health Gain) and Dr Karen Bartholomew (Public Health Physician) presented this report.

Matters that were highlighted or updated included:

- Submission of the Annual Plans for both DHBs to the National Health Board on 26 May 2015.
- The two significant announcements in the Budget (pages 83-84 of the agenda) : extension of funding for the Waitemata DHB Bowel Screening Pilot until December 2017 and additional funding for Palliative Care.
- Approval of the 2015/16 Maori Health Plans for both DHBs has been received from the National Health Board.
- Initial work on the 2014/14 Annual Reports has commenced.
- The extensive work that ARPHS has been doing on Auckland Council's Provisional Local Alcohol Plan, particularly with regard to issues of trading hours for on-licences and changes to Priority Overlay Areas (detailed on pages 88-90 of the agenda).
- The excellent progress with implementing the Ethnicity Data Audit Tool in general practices across Auckland and Waitemata DHBs. This had now reached 97% against the target of 95% of general practices. It had been achieved in one year against the Ministry expectation of three years, which was very pleasing. It is now possible to undertake quality improvement activities based on correct data.
- Max Abbott advised that with the report on alcohol sponsorship and advertising which he had spoken to the Committee previously about, the Minister has requested some impact statistics and costings. The report makes some far reaching recommendations about changes to alcohol advertising and sponsorship along the lines of those from the Law Commission a few years previously.

The Committee Chair acknowledged the work of ARPHS in maintaining the focus on alcohol policy. She advised that a letter of thanks and encouragement will be sent to ARPHS on behalf of CPHAC.

Resolution (Moved Lee Mathias/Seconded Max Abbott)

That the report be received.

Carried

6. General Business

The Committee was advised of the new New Zealand Health Innovation Hub website innovation.health.nz and invited to visit that.

7. Confirmation of the Public Excluded Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 29th April 2015

Resolution (Moved Jo Agnew/Seconded Judith Bassett)

That the Public Excluded Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 29th April 2015 be approved.

Carried

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

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 10 JUNE 2015

_____CHAIR

APPENDIX 1

- Nga Painga Hauora -
Maori Health Outcomes Framework

10 June 2015

Reasons for the Framework

- To enable the Boards to contribute to the development of a sustainable and strategic approach to Maori health that includes measurements of the effectiveness of health interventions
- A particular interest in interventions by Māori Health Providers.
- Coincided with plans to integrate contracts with Maori health Providers
- Opportunity to shape the new contracts around outcome goals
- The framework to contribute to:
  - a reduction in health inequities
  - improving the quality of measuring Maori health gains
  - opportunities to establish and then review inputs, outputs and outcomes
  - development of Maori Provider contracting and procurement process

Process (1)

- Engagement of Sir Mason Durie (Jan 2015)
  - Maori clinician
  - Significant academic/research contribution
  - Key Architect of key Maori health strategies Te Whare Tapa Wha, He Korowai Oranga and Whanau Ora
- A combined orientation session (18 February)
  - A broad discussion on outcomes, service expectations, Maori health provider organisations, and Maori Health plans provided a rounded background for considering the framework
- The first Maori Provider Hui (17 March)
  - An open discussion on the current models of care:
- Second Provider Hui (1 April)
  - A discussion on the initial parameters for the outcomes framework, to examine alignment between the framework and models or care

Process (2)

- Third Provider/DHB Hui (1 May)
  - A discussion on the draft framework to explore and test the pathways, intermediary outcome goals, indicators and fit with the original intent ie:
    - enable the Boards to contribute to the development of a sustainable and strategic approach to Māori health that included ***measurements of the effectiveness of health interventions***?
  - Significant support from MoU partners and Maori health providers
- Currently
  - Seeking Manawa Ora sign-off (July 2015)
  - Looking to share framework across different levels of ADHB/WDHB

Key Framework Considerations

- Takes into account:
  - The Ministry of Health Maori Health Strategy
  - The population served by the Providers
  - Health inequalities & inequities across the two Boards
  - DHB processes, strategies and plans
  - the distinctive contributions of Māori Health Providers
  - the expectations of communities and service users
  - the significance of cultural dimensions to best outcomes
  - distinctions between goals related to wellness and goals related to sickness
  - the need for outcomes and indicators as a basis for measuring health gains over time

Other Relevant Strategies & Outcome Frameworks

- Ministry of Health (*He Korowai Oranga*)
- DHBs Outcome Frameworks
  - Prevention
  - Early detection and management
  - Intensive assessment and treatment
  - Rehabilitation and support
- DHB Māori Health Plans
- Whānau Ora - 6 Outcome Goals
- Te Pou Matakana (Whanau Ora Commissioning Agent North Island)
- Auckland City Indpendent Maori Statutory Board
  - Māori Plan for Tamaki Makaurau
- Hua Oranga
- Ngati Whātua strategic plans (TRONW and Orakei)

Over-arching Aims

Pae Ora – Māori Health Horizons

Mauri Ora – healthy individuals
Whānau Ora – healthy families
Wai Ora – healthy environments

He Korowai Oranga
Refreshed Māori Health Strategy 2014
Ministry of Health

Framework Dimensions

- **Outcomes**
  high level & intermediary outcomes goals
- **Indicators**
  Proximal & Distal
  Progression over time
  Proxy indicators
  Attribution of results
- **Māori Health Providers**
  Interventions
  5 pathways

Maori Health Gains

- Gains in the level of wellness
- Gains from the prevention or alleviation of disease and injury
  - Primary prevention
  - Secondary prevention
  - Tertiary prevention
- Gains from an amelioration of living circumstances
  - Reduction in risk factors
  - Increase in protective factors

Intermediary Outcome Goals

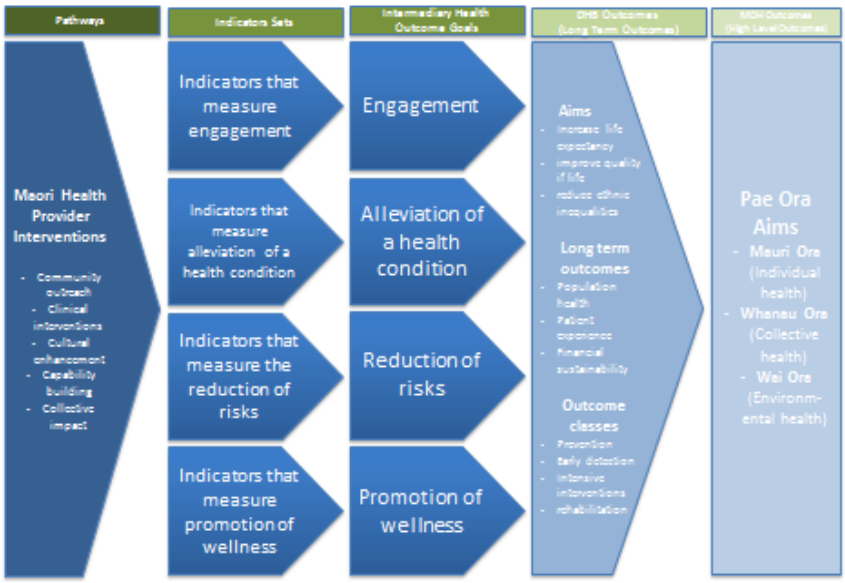
Goals that will lead towards the high level Goals and are relevant to Maori Health Provider outputs:

- Engagement
- Alleviation of health conditions
- Reduction of factors that are risks to health
- Promotion of wellness

Māori Health Providers
Scope of Practice

A combination of five overlapping intervention pathways:

- Community outreach
- Clinical interventions
- Cultural Enhancement
- Capability Building
- Collective impact.



Application of the Framework

- Can be used to guide and inform:
  - MHP/DAP
  - indicator/measurement development
  - support improved clinical governance
  - Cross sectoral discussions regarding Whanau Ora
- Aligns with other accountability frameworks
- Will begin to influence minimum standards of service provision across a range of services

Indicators

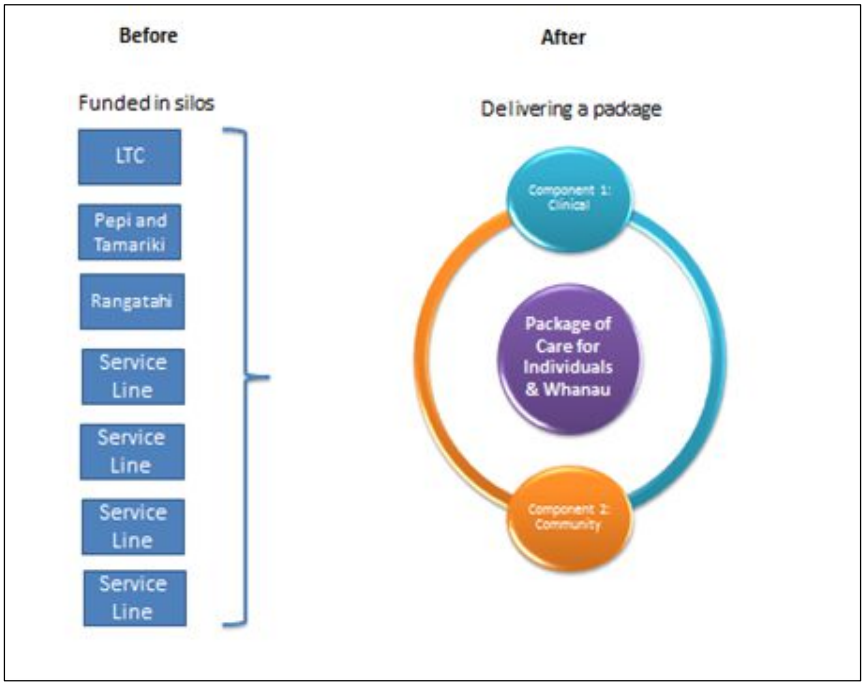
- ***Examples only*** in Framework
- Benefits will evolve and will take time
- Expect the ability to measure:
  - Quality of effort
  - Quantity of effort
  - Is anyone better off

Integrated Contracts – example of framework application

- 3 year – 3 phase process
- Clinical Advisory Group
- Why Integrated contracts
  - Improved performance
  - Ability to achieve equity
  - Outcomes-focus
  - Integrated
  - Simplified
  - Collaborative
  - Value for money
  - Evidence and celebrate success of Maori provider service delivery

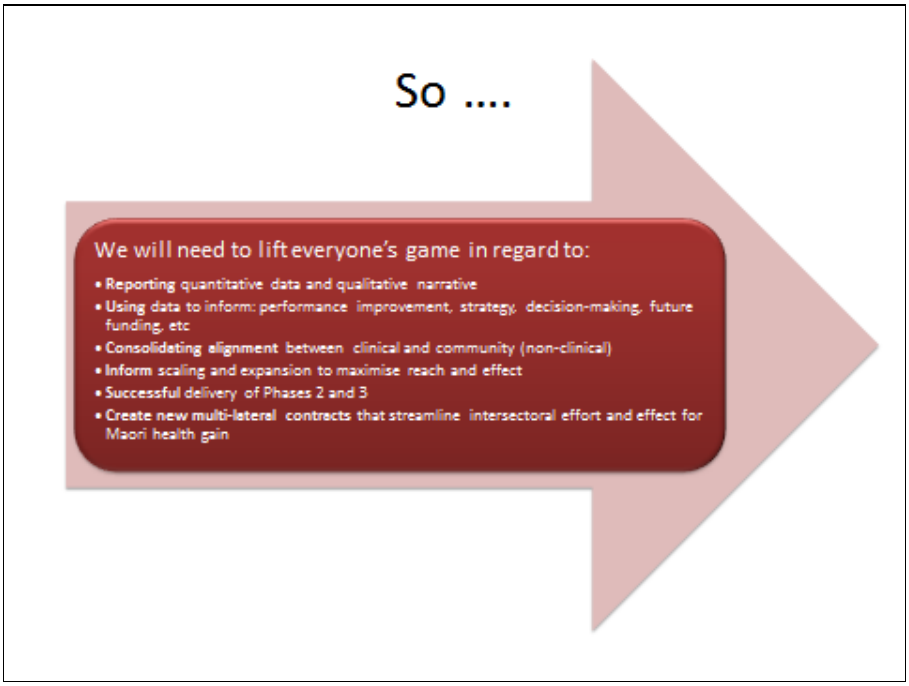
What's different? What's better?

Before	After
Historical and/or ad hoc based on priorities of the day	Strategic and future-focused priorities
Prescriptive (i.e. model name)	Flexible (i.e. Package of Care)
Mixed accountabilities	Clear accountabilities
Outputs-heavy data	Better balance between outputs (how much, how well) and outcomes (better off) data
Mixed alignment between clinical and non-clinical	Clear alignment between clinical and community (non-clinical)
Reference to clinical standards	Updated and clearer clinical standards
Harder to scale	Easier to scale
Repetitive and lots of reporting	Streamlined and 'vital few' reporting



Examples of Indicators relevant to Engagement

- New enrolments
- Whānau enrolments
- Home visits
- Missed appointments (DNA)
- Health management plans (Goals achieved at 6/12 months)
- **Client satisfaction surveys**
- **Health literacy**


So ....
We will need to lift everyone's game in regard to:
• Reporting quantitative data and qualitative narrative
• Using data to inform: performance improvement, strategy, decision-making, future funding, etc
• Consolidating alignment between clinical and community (non-clinical)
• Inform scaling and expansion to maximise reach and effect
• Successful delivery of Phases 2 and 3
• Create new multi-lateral contracts that streamline intersectoral effort and effect for Maori health gain

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 13th July 2015

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 04/02/15	4.1	Rheumatic Fever Programme Evaluation/Public Nurse Role in Schools – that the regional evaluation results for the rheumatic fever programme be reported back to the Community and Public Health Advisory Committee when available and that the public/community health nurse role in schools and the appropriate model of care related to that then be reviewed by the Committee.	Ruth Bijl	CPHAC 02/09/15	The RhF team is working with Dr Tom Robinson on an initial evaluation, and expect to present the results of this to the 02/09/15 meeting. Refer section 3.2 of the CYW Health Scorecard Report on this meeting's agenda.
CPHAC 18/03/15	5.1	Primary Care Update – more information on the issue of under-utilisation of POAC to be brought to CPHAC. Time frame for doing this to be advised.	Debbie Holdsworth	CPHAC 22/07/15	Included in Planning, Funding and Outcomes update report 22/07/15.
CPHAC 29/04/15	4.2	Child, Youth and Women's Scorecard – work to be done on what it is considered the target for breast feeding at 6 months should be and report back to CPHAC for possible recommendation to the Ministry of Health.	Ruth Bijl	CPHAC 22/07/15	Refer section 3.5 of the CYW Health Scorecard Report on this meeting's agenda.
CPHAC 29/04/15	5.1	Planning, Funding and Outcomes Update – to check whether ARPHS has made any submissions supporting sealing of unsealed roads for health reasons – Warren Flaunty to be advised.	Simon Bowen	CPHAC 22/07/15	Referred to ARPHS. Their response is in the note below.
CPHAC 29/04/15	1.1 (Pub Excluded)	Maori Health Plans/Pacific Health Action Plan - when the Maori Health Plans have been finalised a presentation to be arrange for CPHAC on them and also covering the Pacific Health Action Plans.	Simon Bowen		Pacific Health to be presented 22/07/15. Maori Health to be presented 02/09/15.
CPHAC 10/06/15	4.1	Special Housing Areas – issues with planning services for these – overview to be provided at some point.	Simon Bowen/Tim Wood		To be picked up in Health Services Plan
CPHAC 10/06/15	5.1	Cervical Screening – additional information to be provided (including on utilisation of free screening programmes) as part of the Child, Youth and Women Update to the July CPHAC meeting.	Ruth Bijl/Karen Bartholomew	CPHAC 22/07/15	Refer section 7.1 of the CYW Health Scorecard Report on this meeting's agenda.
CPHAC 10/06/15	5.1	Primary Care Update – to include reporting on Primary Mental Health reconfiguration on an ongoing basis.	Tim Wood	CPHAC 02/09/15	

Note: Impacts of Exposure to Dust from Unsealed Roads (response from ARPHS)

There have been a number of queries regarding impact of exposure to dust from unsealed roads and has been raised at different fora.

The New Zealand Transport Agency has commissioned work by Golder Associates to look at impacts of exposure to dust from unsealed roads. There have been a number of high profile complaints in Northland, Hawke's Bay and Marlborough. A report is expected later this year.

Project objectives include:

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

The steering group includes:

Jon Cunliffe (Marlborough District Council)
Frances Graham (Ministry of Health)
Rob Hannaby (New Zealand Transport Agency)
Iain McGlinchy (Ministry of Transport)

4.1 Mental Health and Addictions Update - 2014/15 Actions

Recommendation:

That the report be received.

Prepared by: Cate Wallace (Portfolio Manager, Mental Health and Addictions), Jean-Marie Bush (Portfolio Manager, Mental Health and Addictions), Lee Reygate (Portfolio Manager, Mental Health and Addictions) and Manu Fotu (Portfolio Manager Suicide Prevention, Mental Health and Addictions)
Endorsed by: Tim Wood (Acting Funding and Development Manager, Mental Health and Addictions)

Glossary

AOD	-	Alcohol and Other Drug
CADS	-	Community Alcohol and Drug Service
CEO	-	Chief Executive Officer
CMO	-	Chief Medical Officer
DAP	-	District Annual Plan
DHB	-	District Health Board
EOI	-	Expression of Interest
Funder	-	Term used to describe the joint Auckland DHB/Waitemata DHB funding team established in July 2013
MBU	-	Mother Baby Unit
MoH	-	Ministry of Health
Navigate	-	Peak body for Northern Region Mental Health NGOs
NGO	-	Non-Government Organisation
NRA	-	Northern Regional Alliance
PHO	-	Primary Healthcare Organisation
PRIMHD	-	Ministry of Health single national mental health and addiction information collection of service activity and outcomes data
SPPAP	-	Suicide Prevention and Postvention Action Plan
SST	-	Social Sector Trial
WSN	-	Waitemata Stakeholder Network

Executive Summary

This report provides an update to the Community Public Health and Advisory Committee (CPHAC) on key initiatives and achievements in the Mental Health and Addictions portfolio for Auckland and Waitemata District Health Boards (DHB) during quarter 3 and 4 of 2015. The update is set out under six headings, which reflect the Government priorities and strategic directions underpinning the 14/15 DAP actions.

1. Rising to the Challenge – The Mental Health and Addictions Service Development Plan 2012-2017

This plan sets the national direction for mental health and addiction service delivery across the health sector until 2017. Two overarching goals of the plan are to:

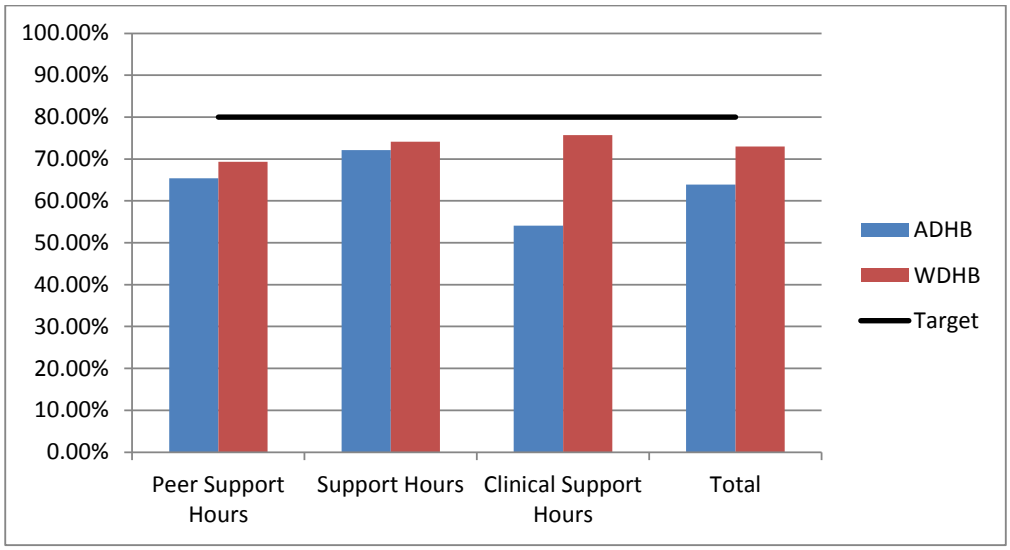
- use current resources more effectively
- build infrastructure for integration between primary and specialist services

1.1 Use resources more effectively - support hours implementation

There has been continued progress in reconfiguring a range of different support service specifications into one service line of Support Hours. The model and payment methodology was moved from FTE input to output, based on purchase of direct delivery of support hours. The methodology was based on buying "productive hours" with the expectation that 80% of productive time be spent in face-to-face delivery (including travel time). Pooling these services enables more flexible and responsive services.

Figure 1 is a snapshot of the combined Q1, Q2 and Q3 2014/15 face to face data for both Auckland and Waitemata DHB NGOs. This shows an average of 63.8% face to face time for ADHB and 73.1% for Waitemata DHB (target 80%).

Figure 1: Q1, Q2 and Q3 Snapshot of Auckland and Waitemata NGO Face to Face Percentage of Contact Time



Note that Auckland DHB NGOs have only been using the reporting template since 1 July 2014 and issues have been identified with the reliability of data.

1.2 Build infrastructure for integration -Tamaki Locality Project

Initiatives that continue to be developed include:

- **NGO integration with Primary Care and Navigation Service**
  An Expression of Interest (EOI) process was launched for Mental Health NGOs to release some of their workforce to be involved in the 'NGO Support Hours for Primary Care' and the 'Linkage service' pilots. Recommendations have been made by the evaluation panel to the Alliance Leadership Team on the preferred providers.

- **Primary-Secondary Integration**
  The focus of this work is to support better integration through relationships and technology enablers. A review of primary mental health initiatives in Wellington, Midlands and Canterbury has been arranged for Dr Kristin Good (Clinical Director for Primary Mental Health ADHB to inform the options to be trialed.

- **Youth Innovation Forum**
  The event will be hosted at the Glen Innes Music and Arts Centre in October 2015. It is focused on engaging youth in discussing access to the appropriateness of services focused on young people.

- **Wellbeing Hubs**
  The Wellbeing Hub concept has a focus on coordinating activities that support wellbeing and improved access to services for the community.

2. Government Welfare Reforms

Welfare reforms are driving changes in the mental health and addictions sector. Supporting service users into employments is considered integral to recovery and wellbeing. The collection of social outcome indicators is also necessary to measure change.

2.1 Auckland DHB and Waitemata DHB Employment Workgroup

A plan, "Everyone's Business: A Mental Health and Employment Strategy for the Waitemata and Auckland DHB regions" is now in draft form.

2.2 Social Outcomes Indicator Workgroup

In 2013, the National Adult Key Performance Indicator (KPI) forum agreed that all DHBs would be required to collect social indicator data to compliment clinical indicators (e.g. Health of the Nation Outcome Scale). Social outcomes reported are employment, housing, Primary Healthcare Organisation (PHO) enrolment, and psychological interventions. Both Auckland and Waitemata DHB are represented on the National Social Outcomes Indicator Workgroup. This group, led by the National Regional Alliance (NRA) and Platform Trust (the national mental health NGO peak body), was established to develop a set of social outcomes indicators and a reporting framework to guide the national collection of this data. Currently a set of recommendations is being drafted based upon Waitemata and Auckland DHBs experience in reporting on social outcomes indicators for the MoH PRIMHD working group.

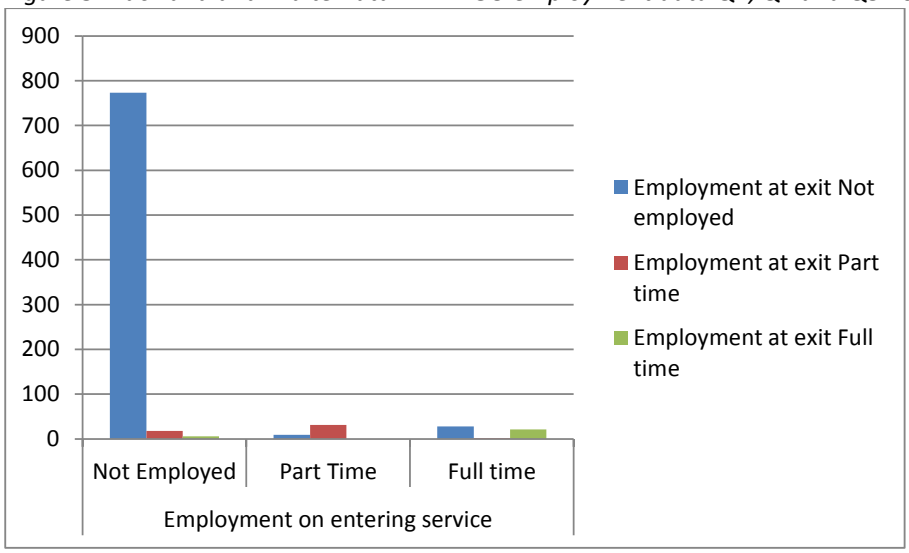
2.3 Waitemata and Auckland DHB Social Outcomes Indicators

Quarterly reporting by NGOs was introduced to record the delivery of Support Hours services and some of the major social determinants of health. The DHB mental health provider is updating its collection of social outcomes to align with the Waitemata Stakeholder Network reporting format. The provider arm will report this data for Q1 2015/16.

Figure 3 shows employment status at entry and exit of Auckland and Waitemata NGO services for service users who exited in Q1, Q2 and Q3 2014/2015. This employment data highlights that the majority of people enter and exit NGO services without employment.

This information is being used to inform the development of strategies to improve employment outcomes by the Auckland and Waitemata DHB Mental Health Employment Project.

Figure 3: Auckland and Waitemata DHB NGO employment data Q1, Q2 and Q3 2014/2015



3. Addressing the Drivers of Crime

The Ranui Social Sector Trial (SST) is one of 16 trials in New-Zealand. Social Sector Trials are a collaborative initiative between the Ministries of Social Development, Justice, Education, Health and the New Zealand Police. The focus of these trials is to support decision making at the local level, build on existing networks and strengthen the co-ordination between Ministry services and communities.

The Waitemata DHB led work stream to reduce alcohol and other drug use has completed four actions of the 2015 plan:

- Provide a platform for a new more effective team approach
- Provide positive drug and alcohol free events for young people
- Encourage young people's leadership in issues around alcohol and drugs
- Increase the capacity and knowledge of professionals working with youth in Ranui

A major achievement of the completed action plan has been a significant reduction in Waitakere College and Massey High Schools' stand down and expulsion rates. Both rates have come down from nearly twice the national average in 2013 to now be at the national average.

4. Suicide Prevention and Postvention Planning

A final draft of this plan will be submitted to the MoH by the 20th of July ready for implementation. The SPAAP has a focus on 3 priority areas:

- Development of the Suicide Prevention and Postvention Inter-agency Working Group
- Development of a centralised suicide and self-harm data collection process
- Workforce development including primary care focusing on at risks clients and postvention support.

5. Healthy Beginnings Maternal Mental Health Services/enhanced acute continuum

He Kakano Ora (which translates to 'Seeds of Life') the new Auckland DHB and Waitemata DHB Crisis Respite and Support Hours Service, was officially opened by Hon. Dr Jonathan Coleman on Friday 26 June 2015. The Service provided by WALSH Trust began providing support hours to women in their own homes on 15 June and the residential respite service commenced on 22 June. As an interim measure the residential respite service is operating from a four bedroom rental property in Te Atatu, while the purpose-built six bedroom house is completed (expected completion date is mid 2016).

6. Regional Activities

6.1 Waitemata DHB High and Complex Needs Project

Waitemata DHB approved funding of $2 million per annum, in July 2014 to develop and implement two High and Complex Needs Long Term Community Residential Services. Following a Registration of Interest advertised in November 2014, shortlisted providers were invited to respond to a Request for Proposals. This process has identified a preferred provider and negotiations have commenced.

The purpose of these new community based residential services is to provide safe, effective accommodation and support for up to 16 people whose needs cannot be met by less intensive mainstream adult mental health services. Patients for this service are long-term users of inpatient services, adult acute units and Regional Forensic Psychiatry Services.

6.2 NGO sustainability

Auckland and Waitemata DHBs recognise that sustainability of Mental Health NGOs is fundamental to the provision of appropriate care to people in the community. Consequently, the Funder is working with Navigate, a representative body of the NGOs, to develop an agreed approach and framework to sustainability.

6.3 Alcohol and other Drugs

Increasing demand on NGO AOD treatment beds

A number of regional Alcohol and Other Drug (AOD) treatment providers, contracted by the metro DHBs have reported a sustained upward trend in demand for treatment beds. Two of the largest providers of residential AOD treatment report approximately 80 people on wait-lists per service. Providers report an increased number of referrals from the Criminal Justice Sector particularly from the Probation Services and Drug Court which may be driving up wait lists. This demand is projected to increase further in response to the opening of the Auckland South Corrections Facility located in Wiri.

Compulsory treatment - current demand for AOD treatment is also predicted to increase further in response to the introduction of compulsory addiction assessment and treatment legislation which is anticipated to be introduced in Parliament in mid-late 2015. Under the new legislation, estimates from Susanna Galea (CADS Clinical Director) suggest that there will be an increase in demand for treatment beds under compulsion, by 10 to 15 beds for the Northern region. At this stage the exact nature of the legislation is unclear however MoH representatives have indicated that it is likely that the involuntary treatment will be:

- short term in nature (28 days)
- restricted to people with severe substance dependence who have experienced, or are at risk of serious harm

- restricted to people whose decision making capacity is considered to be compromised due to their substance use

The introduction of this legislation will have a significant impact on the AOD sector. In particular a new model of care will be required including the need for locked treatment facilities which has logistical, service design and financial implications. The MoH has indicated that the introduction of the legislation is imminent however there is a lack of clarity about what is required and when and the funds (est. $840k nationally) appear to be insufficient to establish new treatment services of this nature.

4.2 Waitemata and Auckland District Health Board Pacific Health Action Plan 2013 – 2016: Progress Update

Recommendation

That the report be received.

Prepared by: Lita Foliaki (Manager Pacific Health Gain)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ACH	-	Auckland City Hospital
AH+	-	Alliance Health Plus Primary Health Organisation
Aiga Challenge	-	Enua Ola and HVAZ weight loss competition
ARPHS	-	Auckland Regional Public Health Service
CPHAC	-	Community and Public Health Advisory Committee
CYF	-	Children Youth and Family
DHB	-	District Health Board
Enua Ola	-	WDHB Pacific health promotion programme
HVAZ	-	Healthy Village Action Zones, Auckland DHB's Pacific Health promotion programme
IY	-	Incredible Years parenting education programme
MSD	-	Ministry of Social Development
PCN	-	Parish Community Nurse
PHO	-	Primary Health Organisation
PHAP	-	Pacific Health Action Plan 2013 – 2016
SME	-	self-management education
Plan	-	Pacific Health Action Plan 2013 - 2016
WERO	-	group quit smoke competition

Note: Currently the Pacific Team is accountable for the implementation of the Pacific Health Action Plan while other managers are accountable for health targets e.g. immunisation, but the Pacific Team contributes to those activities. Those managers do report on Pacific outcomes in relation to their area of responsibility or accountability.

What we do not have currently is a specific Pacific Health Outcomes Framework / scorecard where all managers' report on Pacific outcomes in one place.

The health outcomes team intends to work on establishing Pacific specific key outcome indicators and report on this quarterly with the first report on 2015/16 Quarter 1 performance.

1. Background – the Plan

The Pacific Health Action Plan 2013 – 2016 (Plan) was approved by Waitemata DHB and Auckland DHB in April 2014. The Plan is the first joint Pacific health plan for Waitemata DHB and Auckland DHB.

The Plan was developed by a working group that included three people from the community, representatives of Procare and AH+ PHOs, representatives of Pacific providers, DHB Planning and Funding, and DHB provider arm personnel. Community consultation meetings were undertaken in Auckland, West Auckland and the North Shore. DHB Pacific staff were also consulted. In total about 300 people attended consultation meetings.

The community members of the working group made a number of recommendations and observations in relation to the development of the Plan. These included:

- the Plan be jointly owned by the DHBs and the Pacific communities (as represented by church and community groups that are part of the HVAZ and Enua Ola programmes but not excluding others)
- the Plan be easily understood by people in the community and not just by DHB personnel
- negative Pacific health statistics that are presented in many health sector documents, and comparisons with other ethnic communities, have a demoralising impact on Pacific people in the community
- DHBs need to seriously consider recommendations from the community, even if the recommendations do not have identified funding.

The working group took these community observations and recommendations into account when developing both the style and content of the Plan.

The Vision of the Plan is that:

"Pacific families live longer and healthier lives. "

The Plan has six priorities, that:

- Pacific children are safe and well and that families are free of violence
- Pacific people are smoke free
- Pacific people eat well and stay active
- Pacific people seek medical and other help early
- Pacific people use hospital services when needed
- Pacific people live in warm houses that are not overcrowded.

2. Progress to date

2.1 Pacific children are safe and well and that families are free of violence

Table 2.1 identifies the actions that were required by the plan in relation to Priority 1, and progress on their implementation in the 2014/15 financial year:

Table 2.1

Priority 1 – That children are safe and well and that families are free of violence		
	Action	Implementation 2014-2015
2.1.1	Deliver the maternal and infant nutrition and physical activity programme	Fifty workshops promoting improved nutrition and increased levels of physical activity to Pacific pregnant women, families, communities in ADHB and WDHB have been delivered by Pacific providers. A website has been established specifically for Pacific pregnant mothers. Text messaging, developed by the National Institute of Health Innovation and tailored by Pacific providers, is also part of this programme.

Priority 1 – That children are safe and well and that families are free of violence		
	Action	Implementation 2014-2015
2.1.2	Trial the Pacific pregnancy and parenting education programme TAPUAKI with the maternity services at Waitemata DHB	The Pacific pregnancy and parenting education programme TAPUAKI pilot was successfully trialled.
2.1.3	Explore expansion of TAPUAKI programme to Waitemata and Auckland DHB maternity services	A 'Request For Proposal' process is currently occurring for pregnancy and parenting education across Auckland and Waitemata DHBs that will specifically incorporate the TAPUAKI resource. The RFP requires specific responses to Maori, Pacific and Asian populations.
2.1.4	Review maternity and child health services provided by Alliance Health + and link to Auckland DHB maternity services	Completed – an increasing number of referrals are now being received by AH+ PHO from the high risk pregnancy clinic at Auckland City Hospital (ACH). The high risk clinic provides clinical management and AH+ through its Fanau Ola integrated services contract with its Pacific providers, undertake a social needs support analysis of the woman and her family/household and provide services and facilitates access to other services that responds to those needs.
2.1.5	Waitemata DHB to develop a community education programme for children, for dental health and asthma	Pictorial Asthma Medication Plan is available. A community education programme for dental has not been developed.
2.1.6	Explore resources for delivery of programme for children on dental health in conjunction with other child health related programmes	Further collaboration to be undertaken with the Auckland Regional Dental Health services to develop appropriate dental health resources.
2.1.7	Explore appropriateness of Incredible Years parenting programme for Pacific families	The Incredible Years (IY) programme is an Evidence Based Programme (EBP) that has been proven to reduce harsh parenting, increase positive discipline and nurturing parenting, reduce conduct problems and improve children social competence. There is also preliminary evidence that IY is an effective intervention for families involved in child welfare. IY is a 14 week programme and parents are required to attend two and a half hours of parenting education session every week. Parents must attend at least 10 sessions out of the 14 sessions in order to graduate. Evaluation of the programme showed that it • Changed parenting behaviour of Maori and Pacific participants • Improved Maori/Pacific parents interactions with their children and whanau

Priority 1 – That children are safe and well and that families are free of violence		
	Action	Implementation 2014-2015
2.1.8	Find resources to implement IY parenting programmes through HVAZ and Enua Ola churches / communities if appropriate	Two programmes were funded by WDHB and delivered to Ranui Tongan Methodist Church and the Samoan Methodist Church at Birkenhead. 26 parents and grandparents enrolled in the Tongan IY programme and 18 of them graduated. The Samoan Methodist Church programme will be finished on 1 August 2015. 22 parents have enrolled with an average attendance of 18 parents per session. The programmes were facilitated by bi-lingual English/Tongan and English /Samoan speaking trained IY facilitators. Feedback from participants: *"The programme helped me to connect with my children. I no longer shout at my children and I don't hit them. I do feel I am a better mum"* *"I viewed them as naughty kids and I hit them when they didn't listen, but now I know how to talk and listen to them. I cried when I received a card of appreciation from them when I praised them for their good works "* *"I have 9 children and I get stressed out when I tried to do everything in the house. Now I know how to communicate with them and set daily routine and tasks to help me out, I just realised that I have not shouted or hit them over the last three months since I joined the programme"*
2.1.9	Establish working relationship with Ministry of Social Development (MSD) to identify current work being undertaken to support violence free families	WDHB and ADHB Pacific family violence work is framed by the Nga Vaka o Tapu, which is the framework developed by the MSD to address Pacific ethnic specific family violence issues.
2.1.10	Establish links to MSD's Proud Pasefika Campaign	The Pacific Health team has established relationship with MSD's Pasefika Proud Family Violence Advisory Committee and the Director of the Pacific Community Investment from MSD.
2.1.11	Participate in the inter-sectoral forums that focus on violent free family programmes	The Pacific Health Team is representing WDHB and ADHB in the following inter-sectorial forums: • Auckland Family Violence Project Board: This forum is made up of programme managers from Police, MSD, CYF, WDHB, ADHB, Corrections and Ministry of Justice • Auckland Multi-Sector Family Violence Action Plan: A regional Primary Family Violence Strategic Framework was developed by central Auckland City Council together with government agencies and NGOs to address regional family violence issues • HEART: Health Relationship in Tamaki • Safer Auckland Families Through Intervention Network • Waitakere Family Violence Free Network.

Priority 1 – That children are safe and well and that families are free of violence		
	Action	Implementation 2014-2015
2.1.12	Link HVAZ and Enua Ola churches/communities to violence free family programmes	Established ADHB/WDHB Pacific Family Violence Advisory Committee in partnership with church ministers and community leaders from Enua Ola/HVAZ. Established a partnership with an experienced Pacific psychotherapist and family counsellor from Catholic Social Services to create a six-module "Living Without Violence" programme. Delivered family violence free "train the trainer" workshops to 35 church ministers/ leaders and professionals from Enua Ola/HVAZ. The workshop was very well received by the participants.
2.1.13	Establish relationship with Early Childhood Education to explore areas of collaboration	A number of meetings have taken place; common objectives need to be agreed.
2.1.14	Participate in the network of senior Pacific managers to help-inter-sectorial collaboration	Pacific Health is participating and providing secretariat work for the quarterly meetings of the Auckland Pacific Public Service Network. The network is working closely with State Services Commission to increase number of Pacific personnel in the public sector including health to reflect the growth of the Pacific population.

There is demand from the churches / community for parenting and living without violence programmes. The main constraint is the availability of trained facilitators; so the focus for this year, in addition to delivering programmes, is to train and mentor new facilitators and continue to participate in the inter-sectorial forums.

2.2 Pacific people are smoke free

Table 2.2 identifies the actions that were required by the plan in relation to Priority 2, and progress on their implementation in the 2014/15 financial year:

Table 2.2

Priority 2 – That we are smoke free		
	Action	Implementation 2014-2015
2.2.1	Continue to fund the Pacific Quit Smoke Service	A service contract is currently in place and will expire 30 June 2016.
2.2.2	Support quit smoking competitions each year with the WERO competition	Two churches participated in the competition in 2014-15 (eight have participated in previous years).

Priority 2 – That we are smoke free		
	Action	Implementation 2014-2015
2.2.3	DHBs will work with other agencies eg WINZ to see what more can be done to refer people to smoking cessation services	ARPHS is leading this work.
2.2.4	All HVAZ and Enua Ola church halls and grounds to be smoke free	42 of the 59 churches (71%) who own their own church properties are smoke free (halls and grounds).

The focus has been on supporting churches to be smoke free and supporting smokers to access quit smoke services. In the 2015/16 contract with churches, they are required to be completely smoke free by June 2016. The fact that 42 out of 59 churches have already reached this shows that this objective can be achieved and we are aiming to reach 100% by June 2016. The Pacific Health Team will also actively participate in the Ministry of Health's realignment of smoke free services to improve the accessibility of quit services to Pacific smokers.

2.3 Pacific people eat well and stay active

Table 2.3 identifies the actions that were required by the plan in relation to Priority 3, and progress on their implementation in the 2014/15 financial year:

Table 2.3

Priority 3 – That we eat well and stay active		
	Action	Implementation 2014-2015
2.3.1	Continue to fund Enua Ola and HVAZ programmes	The current Enua Ola contracts are in place and will expire June 2016. HVAZ grants to churches is baseline from 1 July 2015.
2.3.2	Work with other organisations to promote healthy lifestyle	Ongoing.
2.3.3	Collaborate with PHOs to implement annual weight loss competitions	Procare and AH+ actively support the Aiga Challenge weight loss competition.
2.3.4	Develop and implement a Pacific Wellness at Work programme for Pacific employees at WDHB and ADHB	A Pacific wellness men's group has been initiated; a number of workshops have been held to address issues raised by men that include drug and alcohol abuse, mental health, suicide prevention and seeking help early. A group of 27 Pacific DHB staff participated in the 2014 HVAZ Aiga Challenge.

The third Aiga Challenge will be held in Q1 and Q2 of the current financial year. We will work with those participants who continue to lose weight over the three years to explore whether they can be mentors of others who need and want to lose weight. If they do, we will assist them to "tell their story of change" in a way that can provide inspiration and support to those who want/need to lose weight.

2.4 Pacific People seek medical and other help early

Table 2.4 identifies the actions that were required by the PHAP in relation to Priority 4 of the Plan and the progress on their implementation in the 2014/15 financial year:

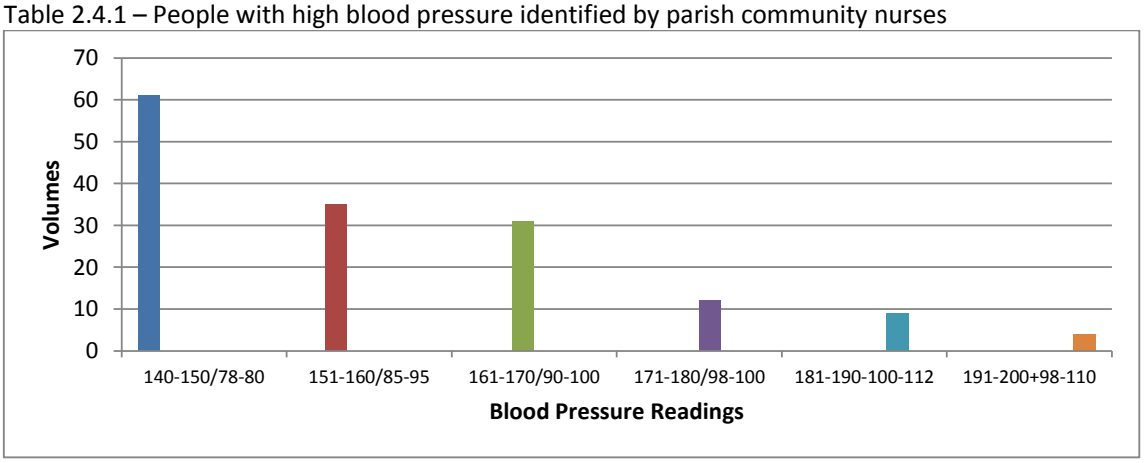
Table 2.4

	Priority 4 – That we seek medical and other help early	
	Action	Implementation 2014-2015
2.4.1	ADHB to continue to fund parish community nurses	Continuing
2.4.2	WDHB to explore option of funding community parish nurses as part of the Enua Ola programme	Three PCNs have been funded by WDHB and Procare. Two are employed by West Fono Health Trust and work with the Enua Ola churches in West Auckland and one is employed by Pacific Integrated Healthcare and works with Enua Ola churches on the North Shore
2.4.3	WDHB child health specialists services work with West Fono to identify and respond to the needs of families whose children DNA appointments	Paediatrician, Dr. Meia Uili-Schmidt now delivers clinics at West Fono once a week. Further work needs to be done for children not enrolled at The Fono.
2.4.4	Explore the development of community based education to address child health issues especially the need to seek medical help early	This objective is intended to address preventable admission to hospital for conditions such as respiratory illnesses, cellulitis, and other primary care preventable conditions. This has not been done.
2.4.5	WDHB child health services will reconfigure service delivery mechanisms if required	This is ongoing work and may involve holding more outpatient clinics in primary care or community settings, as is being trialled at The Fono.
2.4.6	Actively participate in the work of the Northern Regional Diabetes Network and in the development of service delivery models	Ongoing
2.4.7	Explore mechanisms to improve compliance with diabetes and CVD medication	The self-management education sessions for people with chronic conditions including those with diabetes appears to be effective in improving compliance with medication and improving clinical indicators
2.4.8	Adopt a model that responds to the issues experienced by Pacific people with diabetes	The church exercise and nutrition programme, the weight loss competitions, the diabetes self-management education workshops, the parish community nursing are all necessary components of a model that is suitable for Pacific diabetic patients.
2.4.9	Run 10 self- management education/diabetes self-management education groups	167 participants attended 10 workshops.
2.4.10	Translate Stanford University SME Manual into Tongan and Samoan	Tongan translation completed Samoan translation to be completed by end of July 2015.
2.4.11	Implement SME in Tongan and Samoan languages	Ongoing

The PCNs at The Fono have screened 375 individuals from March 2015 – June 2015 and identified 152 with elevated / high blood pressure. They are very concerned with working

aged people who are identified with high blood pressure that they did not know about. They provide education and strongly recommend that they consult their general practitioner but they cannot ensure that this happens.

Table 2.4.1 – People with high blood pressure identified by parish community nurses



2.5 Pacific people use hospital services when needed

This priority is the responsibility of the Pacific General Manager and he reports through Corporate Services.

2.6 Pacific people live in warm houses that are not overcrowded

The Ministry of Social Development, Business, Innovation and Employment, Pacific Island Affairs and Housing NZ held specific meetings for Pacific people interested in the government's social housing policy. A number of Pacific health providers, church ministers, community leaders and Pacific public servants attended the meetings. Housing NZ stated that they need Pacific providers to be involved. However many of the people who attended the meetings concluded that the requirements of potential providers, in terms of their own capital and expertise in housing provision, was far higher than what Pacific churches or organisations could provide.

Other than what current health providers do in terms of referring families for housing insulation, providing medical support letters for people applying for Housing NZ houses, providing advocacy and support for individual families, there has been no progress in addressing this priority.

It is not clear what the DHBs and the community can do in this area through the Plan.

3. PHAP Implementation 2015/16

Table 3 sets out the deliverables and process activities that will take place in relation to each of the six priorities of the Plan in the 2015/16 financial year.

Table 3.1

Priority	Deliverables	Process Activities
P1 – That children are safe and well and that families are free of violence	Community education programme on preventing hospital admissions for children. 4 Incredible Years parenting education programmes in WDHB and 2 at ADHB. 6 "Living Without Violence" programmes in WDHB and 3 at ADHB. Provide mentoring to facilitators of the "Living Without Violence" programmes.	Collate existing information and develop programme. Review impact of paediatric outpatient clinic at West Fono. Identify IY Pacific trained facilitators and train more to enable more programmes to be delivered. Further enhance relationship with MSD specifically in relation to joint response to Pacific high needs families. Continue to participate in family violence inter-sectorial forums.
P2 – That we are smoke free	All HVAZ and Enua Ola church halls and grounds will be smoke free. More churches / community groups to participate in WERO competition.	Connect churches / community groups to services that can provide support. Identify support that church / community members require in order to increase participation in the WERO competition and negotiate support from other smoke free services. Negotiate with Pacific Quit Smoke Service to provide quit service when and where it suits church / community members. Participate in the Ministry of Health process of re-aligning quit smoke services to ensure better community responsiveness in terms of how services are delivered.
P3 – That we eat well and stay active	Weekly group physical activity sessions. All groups participate in the Aiga Weight Loss competition.	Develop training workshops for individuals who lose weight over three years (identified through the Aiga Challenge) so that they are able to mentor and support others who need to lose weight.

Priority	Deliverables	Process Activities
		Continue to improve data collection and present results back to churches / groups in a motivational way. Further develop wellness programme for Pacific employees of DHBs.
P4 – That we seek help early	Maintain breast screening coverage rates at above national target. Maintain cervical screening rates at above national target at ADHB. Further improve cervical screening rate from 71% towards the national target at WDHB. Improve participation of Pacific people with bowel screening at WDHB. Deliver 10 self-management education sessions in church / community settings at WDHB. Deliver 10 self-management education sessions at ADHB.	Continue to deliver breast and cervical screening education and support to access further investigation at WDHB. Parish community nurses continue to include education and support at ADHB. Incorporate into health checks undertaken by WDHB parish community nursing service. Continue with follow-up telephone calls, Samoan language radio interviews, inclusion on GPs patient dashboard, community education.
P5 – That we use hospital services when needed	(Responsibility lies with the Pacific General Manager who reports through Corporate Services and to the respective HAC Committes)	
P6 – That we live in warm houses that are not overcrowded		Keep informed of developments in the government's social housing policy. Decide whether involvement of Pacific health providers, churches and community groups is a realistic option.

4. Issues

There are now many and a growing number of programmes offered to churches /community groups. These are set out in table 4.1.

Table 4.1

Programme	Length of programme
Healthy Babies and Healthy Futures (workshops promoting improved nutrition and increased levels of physical activity to Pacific pregnant women)	6 weeks
Incredible Years parenting programme	14 weeks
Living Without Violence programme	6 weeks
WERO competition	3 months
Group exercise	Weekly for 48 weeks / year
Aiga Challenge Weight Loss Competition	8 weeks
Self-Management Education for those with chronic conditions with additional two weeks for people with diabetes	6 or 8 weeks
Health education on bowel screening, breast and cervical screening	One off sessions but repeated over time
Increasing financial capability workshops delivered by Retirement Commission	Being negotiated
Programmes from other agencies	

The implementation of the programmes in the churches / community groups is the responsibility of health committees. There are two views emerging from health committees:

- That addressing health and social issues are a core part of the church's pastoral care for its congregation and so any financial assistance from the DHBs is appreciated
- That there is too much expectation of the health committees and remuneration for committee members should be considered by the DHB.

The former view is expressed by older members of health committees and the latter by younger people, as a generalisation.

The parish community nurses are picking up young / middle aged people with unidentified elevated/high blood pressure and blood sugar levels, who do not feel sick and are therefore not going to doctors. Although the nurses actively encourage these people to see their GPs, they are concerned that they are not. Further exploration of this issue will be undertaken.

At the same time there is increasing admission of Pacific people to hospital, the onset of diabetes is occurring at a younger age and diabetes that is not well managed continues to be a serious issue.

In the current financial year, in addition to delivering the specific outputs in the Plan, the following will also be done:

- review the capability of church health committees to undertake their function voluntarily

- explore the option of adding prescribing capability (through a prescribing nurse or doctor) for certain conditions, to the current Enua Ola and HVAZ model which already has health education, behavior change support programmes, self-management.

The nature of the relationship between churches and WDHB and ADHB has evolved over the last decade. It now appears as more than just a contractual relationship. For example, the signing of the Pacific Health Action Plan 2013 - 2016 on the altar of a church.

5. Conclusion

The Pacific Health Action Plan was developed as a partnership between Auckland and Waitemata DHBs and the Pacific community as represented by churches and groups that participate in the HVAZ and Enua Ola programmes. Of the six priorities of the Plan two were strong recommendations from the community (Priority 1 and 6). Progress has been made in five of the six priorities of the Plan, excepting Priority 6.

The DHBs reported back to the community on the progress of implementation at an event on 12th June. About 240 people attended including the CEO of ADHB and Director Funding, with apologies from Waitemata DHB CEO. The response from the community was positive. They appreciate the progress that has been made, the DHBs reporting back, and the on-going work that the DHBs are committing to.

However, serious health issues continue to face Pacific people as well as the DHBs. The model of the partnership between the community/churches, Pacific providers, PHOs and the DHBs is an important part of the response to the problem. How this can be done on a bigger scale will be the focus of continuing conversation with churches/communities, providers/PHOs this year, with further recommendations to be presented to CPHAC as part of renewing the Pacific Health Action Plan from June 2016 onwards.

4.3 Child, Youth and Women's Health

Recommendation:

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

Prepared by: Ruth Bijl (Funding and Development Manager - Child, Youth and Women's Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Programme Manager - Women's Health), Dr Karen Bartholomew (Public Health Physician) and Dr Alison Leversha (Community Paediatrician)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

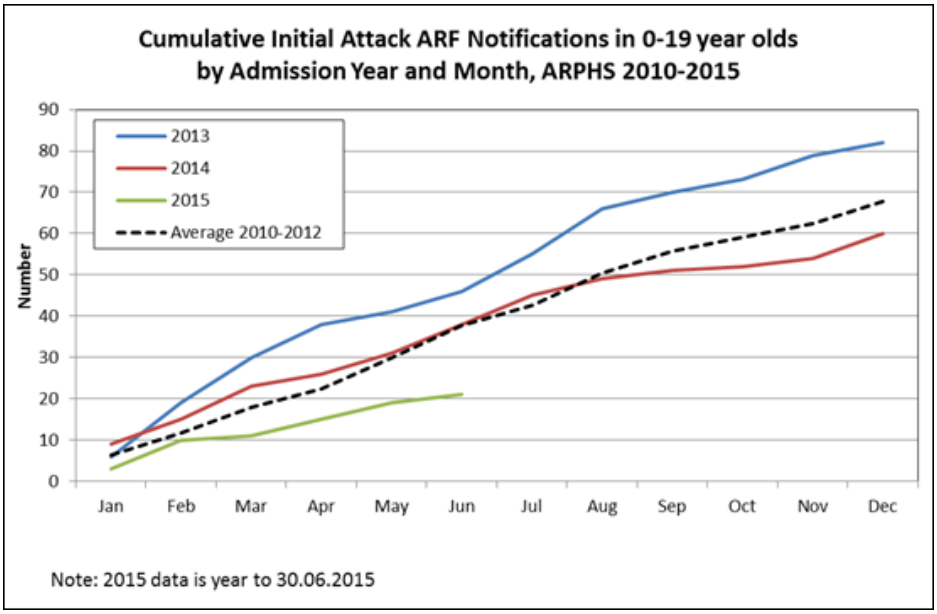
ARDS	-	Auckland Regional Dental Service
BPS	-	Better Public Service
CHIP	-	Child Health Improvement Plan
CPHAC	-	Community and Public Health Advisory Committee
CYF	-	Child, Youth and Family
DHB	-	District Health Board
DHW	-	Design for Health and Wellbeing (DHW) Lab
EEG	-	Early Engagement in Pregnancy Care Group
HEEADSSS	-	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HPV	-	Human Papilloma Virus
IPIF	-	Integrated Performance Incentive Framework
ISP	-	Independent Service Providers for cervical and breast screening
LMC	-	Lead Maternity Carer
MACSAG	-	Metropolitan Auckland Cervical Screening Advisory Group
MQSP	-	Maternity Quality and Safety Programme
NIR	-	National Immunisation Register
NMMG	-	National Maternity Monitoring Group
NSU	-	National Screening Unit
OIS	-	Outreach Immunisation Service
PHO	-	Primary Health Organisation
PMS	-	Practice Management System
RhF	-	Rheumatic Fever
SALT	-	Service Alliance Leadership Team
SBHS	-	School Based Health Service
WCTO	-	Well Child Tamariki Ora

1. Summary

This report presents information on significant health outcomes for children, youth and women. The report is in the form of a scorecard (see Appendix) and is being presented for the third time. The indicators cover the life-course of maternity, child and youth health, as well as women's health. All indicators are presented as a Total with breakdowns by Maori, Pacific and Asian ethnicity. The narrative presents highlights, key issues and discussion in relation to items that are not on track.

2. Highlights and key issues for – Children, Youth and Women

- The year end results for the immunisation health target saw ADHB achieve 94% against the target of 95% and WDHB 93% of all 8 months old infants fully immunised. Nationally, four DHBs achieved the health target. Rates are lowest for Maori infants with coverage of 86% in ADHB and 88% in WDHB. While neither DHB achieved the health target, these results reflect a huge effort by the sector to protect our infants against vaccine preventable disease. Efforts continue and are detailed more fully in section 3.1 below.
- It remains too early to determine whether the Rheumatic Fever programme is effective in reducing first hospitalisation with acute Rheumatic Fever, however data produced by the Auckland Regional Public Health Service (ARPHS) for the metro Auckland region suggests a positive downward trend in acute RhF notifications. The majority of cases are in CMDHB. Further information regarding activity to achieve the Rheumatic Fever Better Public Service target is provided in section 3.2.



- Oral health enrolment data is not reported in this report due to data issues.
- The year end result for the B4 School Check confirms previously reported trends for both ADHB and WDHB. The 90% target was exceeded for all four year old children, including those from highly deprived communities, and for Maori and Pacific children. Coverage to 31 June 2015 is shown in the table below. Our thanks to Plunket and to the Vision and Hearing Screening Team for these tremendous results.

Breakdown	ADHB	WDHB
Total	96%	93%
High Deprivation	91%	92%
Maori	91%	95%
Pacific	93%	92%

- The AHDB HPV immunisation rate for girls in school year 9 is the best in the country, at 78% Total, 75% Maori, 89% Pacific and 70% for Asian. Results for WDHB have been improving but remain below target, at 56% Total, 57% Maori, 67% Pacific and 57% for Asian.

- Strategically, we have a particular interest in the implementation of Children's Teams. Neither ADHB nor WDHB is yet required to implement a Children's Team however we continue to consider the implications for services and the DHBs. As the Immunisation programme demonstrates, 'knowing' our child population in relation to the most up-to-date contact information is a necessary platform in order to engage families in services. With our northern region DHB counterparts, we are about to explore the possibilities offered through the National Child Health Information Platform (NCHIP). This is currently being implemented in the Midlands region. Early indications are that this system could significantly enhance our understanding of the universal services accessed by individuals and better help with locating families who are missing out on services they are entitled to. While the NCHIP system is not national, a northern region NCHIP could potentially provide an important tool to support service delivery to vulnerable children.
- The Minister of Health has signalled a focus towards reducing obesity in children. DHBs are likely to see new requirements and possibly related targets in the coming year. A northern region response will focus initially on a shared measurement approach.

3. Activity in detail

3.1 Immunisation

The 8 months immunisation health target (to complete three immunisations due at six weeks, three months and five months to protect against diphtheria, tetanus, pertussis, polio, hepatitis B, haemophilus and pneumococcal diseases) is 95%. The target is reported at each three-monthly period, against all infants who turn 8 months in that quarter as recorded by the NIR. As of 31 June 2015, Auckland DHB achieved 94% (no change) and Waitemata DHB achieved 93% (no change).

Delayed availability of influenza vaccine this year added to workforce pressure for primary care and other immunisation services to achieve rapid rollout of vaccinations prior to influenza season. Sustaining previous gains in immunisation coverage is a good result for the quarter, while recognising there is further improvement to be made.

Waitemata DHB had concerns over the immunisation coverage rates and commissioned a rapid review of existing data, systems and processes with the aim of identifying areas/issues that could be improved to support timeliness of delivery of the childhood immunisation programme. The review was undertaken by the Immunisation Advisory Centre (IMAC), University of Auckland.

Key themes identified by the review included:

- Pockets of higher immunisation decline rates
- More delayed immunisations in Maori and 'Other' ethnicities and some practices
- Volume of infants moving into the area a few months after birth
- Missed opportunities to vaccinate in hospital Emergency Departments and Accident and Medical centres
- Recommendation for workforce capacity building and training within PHOs and practice systems.

Recommendations included those where immediate intensive action may improve coverage in the short term, such as for children with delayed immunisations, and others that will require longer term actions to establish sustained improvements, such as for those who decline immunisation.

It is noted that many of the activities recommended within the review are already underway. These provide a platform to deliver further work. Activities already underway include:

- Appointment of 2 FTE Immunisation Coordinator roles based in PHOs from 1 Jan 2015
- Education regarding strategies for practices to support vaccine hesitant parents
- Review of systems and practice level processes to increase newborn enrolments
- Introduction of the Safety Net Referrals (SNR) at 10 weeks and 6 months of age to ensure non-enrolled/non-engaged children are referred to Outreach Services in a timely manner if required
- Waitakere Hospital Emergency Department and Rangatira Unit are developing processes for opportunistic immunisation.

Further work with the Immunisation Governance Group and Immunisation Operations Group will drive continued quality improvement across the whole of service.

There is a small cohort of children with delayed immunisations (they are fully immunised by 12 months of age but miss the 8 month milestone). These children are consented but delayed for immunisation. A strategy to reach them earlier and address vaccine hesitancy is the immediate focus.

The review highlighted a large population of 'other' ethnicities within Waitemata DHB. This is also an issue in ADHB. Whilst this population is not well understood, we are aware some children arrive in the DHB shortly after being born elsewhere. Once known, the practice works with the family to translate their international immunisations record and plan catch-up vaccination to meet the NZ schedule. Auckland and Waitemata DHBs will consider ways to improve information for primary care and the NIR around early engagement with 'other' ethnicities, translating international immunisations and calculating catch-up programmes.

In a new initiative this winter, Auckland and Waitemata DHBs linked with Primary Care providers to offer targeted influenza immunisations to over 6,000 children who had been hospitalised with respiratory conditions such as bronchiectasis. Starship is also developing a programme to offer immunisation for family members of high-risk children and Waitemata paediatrics service is investigating a similar enterprise.

3.2 Rheumatic Fever

Both the Ministry of Health (MoH) and the DHBs are conducting evaluations of the school swabbing service. It should be noted that the length of time the school swabbing programme has been running makes it difficult to draw meaningful conclusions as to its efficacy in reducing rheumatic fever. Consequently the MoH has indicated that they will continue funding the primary school-based sore throat swabbing and management programme until the end of June 2016 (previously funding went to 31 December 2015). The DHBs are expected to decide if they want to continue to provide the service, and if so, to fund it themselves beyond this date.

Preliminary analysis in a sub-sample of schools with school-based health clinics has identified a significant reduction in both Group A Strep load (the necessary precursor of RhF) and skin infections. The RhF team is working with Dr Tom Robinson on an initial evaluation, which will focus on implementation of the programme (to be presented in September CHPAC).

Work continues on the Rheumatic Fever register. However, to gain traction, this needs to be undertaken as a regionally driven and owned initiative. Secondary prophylaxis compliance is excellent for children and young people in the paediatric community nursing services, however, falls off for young people and adults. An unknown proportion of people are receiving bicillin in primary

care, and no reporting mechanisms are in place for this group. An ADHB led project tracking patients and a single primary care practice quality audit both identify significant issues for young people and adults requiring bicillin. The ADHB RhF SALT is proposing a specific project to resolve these issues. This will occur across metro Auckland.

The RhF team won a Healthcare Hackathon for their work on an app that assists self-management for young people with RhF, and have subsequently received seed funding from the New Zealand Health Innovation Hub. AUT digital design students have been engaged via the Design for Health and Wellbeing (DHW) Lab to portray the concept of 'heart damage' from RhF in a meaningful way. Workshops are planned with young people with RhF to understand their lived experiences and understanding of RhF and treatment. Design-thinking workshops will follow with a contracted design group. Curekids are assisting with additional fund raising.

3.3 Early Pregnancy Care Engagement

The early pregnancy care indicator is the percentage of women who register with a Lead Maternity Carer (LMC) in the first trimester of their pregnancy. The target has been set at 80%. Data is only available annually from the Ministry of Health, and is not timely (2013 data is the latest available, which has been reported previously). The data also currently only reflects care provided by self-employed LMCs and not hospital provided care (approximately 10% for Waitemata DHB and 20% for Auckland DHB).

This indicator was proposed to be included as a new Integrated Performance Incentive Framework (IPIF) measure; however this has recently been removed for 2015/16. Because approximately 70% of women see a GP prior to finding a LMC in their pregnancy, GPs play a pivotal role in early engagement. The focus on promoting the role of GPs in helping women to find and register with an LMC will continue even though the IPIF measure has not been progressed.

Activities to improve engagement with an LMC within the first trimester are coordinated under the regional Early Engagement in Pregnancy Care Group (EEG). The focus of the group is to ensure all women receive quality early pregnancy care, particularly priority women. This goes beyond LMC registration and includes care provided by GPs and the relationship between GPs and LMCs.

EEG has prioritised the following four activities, all with a focus on priority group women:

1. Progression of the first trimester clinical pathway – this is adapted from the Health Pathways model of clinical pathways, initially developed in Canterbury. The pathway and its three dependent pathways have been localised for the Auckland region, and will proceed through the EEG and established primary care clinical governance forum before further consultation.
2. Survey of GP current practice (service delivery, models of care and funding) has been developed and is currently being distributed via PHOs.
3. The development of narratives demonstrating examples of successful GP/LMC relationships, referral pathways and models of care.
4. Advertising campaign promoting early engagement key messages to women and their whānau.

Because GPs are central to early pregnancy care, and to assisting women engaging with an LMC, two activities relevant to GPs have been prioritised:

1. Clarification of the funding for early pregnancy care - this has been sought and the MoH expectation is that GPs will provide all services outlined in Section 88 (Primary Maternity Services Notice 2007), as well as assisting women to register with a LMC.
2. GP survey to provide baseline information - claiming and service expectations (under Section 88) are not well understood by GPs leading to variable practice and provision of maternity services. The EEG is conducting a baseline survey of GP knowledge and practice in order to

develop education material to be released and promoted alongside the clinical pathway. The EEG believes there is opportunity for GPs and LMCs to work more collaboratively and better understand how their roles fit within an integrated programme.

3.4 Maternal Smokefree

The current focus of activity is on strategies for Māori women (as noted in the scorecard the percentage of Māori women smoke free at delivery is much lower than for the total population 66% for Auckland compared to 95% and 73% for Waitemata compared to 93%). The smokefree coordinator now sits in the Māori Health Gain Team and is focussing on the project to incentivise pregnant women to quit smoking. A steering group is being developed and a draft proposal will be circulated for consultation and review.

A maternal smoking audit of Māori and Pacific pregnant women has been conducted to investigate issues with the capture of data and to explore if there are differences between the different data sources. This is an important quality improvement activity prior to the establishment and monitoring of the incentives project. The provision of interventions to pregnant women by an LMC is also included in the audit scope, such as brief advice, medication and referrals to smoke free services. The audit report with recommendations is currently being compiled.

3.5 Breastfeeding

Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond.

Breastfeeding rates on discharge from LMC are positive but there is a significant decline following this, especially at 3 months. Whilst the overall 3 month rate (60%) is above the 54% target for both Auckland DHB and Waitemata DHB there are differences by ethnicity with only 51% of Māori infants fully breastfed at 3 months in Auckland DHB and 47% in Waitemata DHB. The Pacific rates are also below target at 44% in Auckland DHB and 49% in Waitemata DHB.

In response to a query at the April CPHAC Meeting regarding the 6-month target of 59%, we can now report this is 90% of the June 2016 target of 65% (all the interim targets are 90% of the 2016 targets except where current government policy dictates higher). The target of 65% by June 2016 was decided by an external Well Child Tamariki Ora (WCTO) Expert Advisory Group in 2013. It was based on a combination of national performance at the time, driving equity with the best local and/or population subgroup performance and the group's aspirational goal of increasing breastfeeding rates in New Zealand. The WCTO Expert Advisory Group will be reviewing the indicators and their targets in the 2015/16 year.

Our goal is to achieve equity and understand what support our community needs to maintain breastfeeding rates up to and beyond 3 and 6 months. A WCTO Quality Improvement Project Manager has been funded by the MoH; her first quality improvement initiative focuses on increasing breast-feeding rates. Increased rates will be achieved by LMCs and WCTO nurses providing women with consistent, evidence based information. MAMA Aroha talk cards will support LMCs and WCTO nurses educating pregnant women and new mothers. Evidenced based information will also be provided through the revised pregnancy and parenting programme. This will include providing information using modern technology such as applications and web based information.

3.6 Oral health

We are unable to report against the oral health enrolment indicator this quarter due to data integrity problems. Work is underway with ARDS to resolve the data issues.

3.7 Knowing every child

Connecting infants with healthcare providers is a focus for a number of areas, though the Funder reports in this scorecard on enrolment with PHOs and community oral health only. The Funder has established a multi-enrolment project until such time as electronic linkages can be put in place. The Northern Regional Child Health Plan updated in March 2015 identified a new priority area of *Knowing Every Child*. Work is planned with the four Northern DHBs to establish whether the NCHIP would provide a useful and cost effective platform to support programmes of work particularly for infants and children aged 6 years of age and younger.

The NZ Child and Youth Epidemiology Service provide data and annual workshops to support planning for Child Health. The meeting held June 2015 presented an increasing requirement for collaborative work across agencies with a drive to reduce duplications and solve complex problems. Children's Teams and developing systems to share information are two strands key to our future child health direction.

3.8 Cervical screening

The cervical screening rates are stable after the introduction of the new census denominators in December 2014. Auckland DHB is at 78.7%, close to the target of 80%. Waitemata DHB is 76.1%.

Cervical Screening 3 year coverage trend for women 25-69 years, by DHB

DHB	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15
National	77.0%	77.0%	76.6%	76.5%	76.5%	76.3%
Auckland	76.9%	76.2%	75.3%	75.2%	78.9%	78.7%
Counties Manukau	69.8%	70.0%	69.8%	69.6%	71.5%	71.4%
Waitemata	76.2%	76.4%	76.3%	76.5%	76.1%	76.1%

Source: NSU

The table below shows that 1,752 more women need to be screened in Auckland DHB, and 5,931 women in Waitemata DHB to reach 80%. A significant inequality gap remains for priority group women, with the exception of Pacific women in Auckland DHB. Māori coverage remains at 56.3% for Auckland DHB and 55.4% for Waitemata DHB. Also of note approximately 6,000 Asian women need to be screened to reach the 80% target.

Number of priority group women required to reach 3 year coverage target for cervical screening (at March 2015), by DHB

DHB	Priority population	Hysterectomy adjusted population	3 year coverage % 25-69 yrs	3 year coverage number of women 25-69yrs	Increased number of women to reach 80% target*
Auckland	DHB Total	130,335	78.7%	102,526	1,742
	Maori	9,407	56.3%	5,294	2,231
	Pacific	12,213	80.1%	9,785	-
	Asian	40,365	65.1%	26,276	6,016
Waitemata	DHB Total	150,722	76.1%	114,647	5,931
	Maori	12,265	55.4%	6,797	3,015
	Pacific	9,045	71.2%	6,441	795
	Asian	33,311	62.4%	20,776	5,873

Source: NSU

Key activities to improve coverage

- The Metropolitan Auckland Cervical Screening Advisory Group (MACSAG) has reviewed and updated the Strategic Plan which is currently out for consultation. The focus for the plan is improving coverage for priority women. MACSAG has been changed to a strategic group aligned with the cervical screening pathway scorecard. This included an initial session on moving to primary Human Papilloma Virus (HPV) screening. The next two meetings will focus on workforce and strategies to improve coverage; and on colposcopy, cervical cancer and treatment.

- The pilot PHO datamatch project is currently providing general practices with the second round of datamatched lists, now in the 'best practice' template informed by practice level clinical staff and advisors. The response to the second lists will form part of the project evaluation. The pilot has also informed the national PHO level datamatch process, where all PHOs now have access to timely (monthly) and secure updated lists of women who are overdue and those who have never been screened. These lists are prioritised by clinical priority (previous history) and length of time overdue, and discussion is underway to see whether prioritisation by PHO ethnicity may also be possible and options for updating the register with hysterectomy information. This is the first time that general practice has had access to timely data from the cervical screening register to assist in the prioritisation of women for invitation and recall. Access to this data is critical to PHOs ability to reach their IPIF target coverage.

- The Operations Group under MACSAG have released the referral pathway from practices to Independent Service Providers (ISPs; for support to screen and support to colposcopy services) which is currently being tested. Most PHOs are on track to fully utilise their allocated volume of free smears (targeted by unscreened and length of time overdue) for 2014/15.

- The Regional Coordination Service continues to provide practice level implementation support using the 'How To' Guide to optimise, and prioritise, invitation and recall systems. The Service is also providing assistance in using the datamatched lists for invitation and recall activities, and to PHOs and practices to assist in innovative activities including Saturday drop in clinics and after-hours clinics.

- Workbase has been contracted to develop and deliver a train-the-trainer package, which will see the development of an innovative model to assist general practice with invitation and recall, involving non-clinical staff. The Coordination Service identified this as a key component in high performing areas, and is designing the package with Workbase, ensuring the protection of women's clinical safety and privacy.

- A health promotion campaign is being developed with a focus on increasing the awareness of cervical screening for Maori and Asian women. This campaign will be run in conjunction with September cervical screening month. The development of a face book page will be one activity within the health promotion package.

3.9 Breast screening (50-69 years: 2 year coverage)

In Q2 the new census denominator was introduced which resulted in a reduction in coverage particularly for Māori and for Pacific women. In Q3 coverage has been stable for Māori and Pacific women, in Auckland DHB Maori coverage is 63% down 1% and in Waitemata DHB 60% unchanged from Q2. For Pacific women coverage in Auckland DHB is 76% and in Waitemata DHB 77%, both rates are unchanged from Q2. Pacific rates are meeting the 70% target but extra activity is required to engage with Māori women.

Number of Māori women required to reach 2 year coverage target for breast screening (at March 2015), by DHB

DHB	Eligible women	2 year coverage 50-69 years %	2 year coverage actual number of women	Number of women needed to reach 70% target
Auckland	3,255	63.3%	2,059	220
Waitemata	4,180	60.0%	2,506	420

Source: National Screening Unit (NSU)

Asian coverage rates are not reported routinely but have been provided by the NSU on request from the Funder. Table 2 shows the Asian coverage for the last 3 years, showing that Asian rates in Waitemata DHB are nearly 10% lower than Auckland DHB.

Breast screening coverage for Asian women December 2012, 2013 and 2014, by DHB

DHB		Dec-12	Dec-13	Dec-14
Auckland	**Women screened**	7,259	8,082	8,632
	Coverage	73.9%	77.1%	74.2%
Waitemata	**Women screened**	5,426	6,037	6,726
	Coverage	65.0%	66.3%	65.2%

Source: Data extracted from BreastScreen Aotearoa Reporting Services on 8 May 2015; Asian women screened in the 24 months to 31st December 2014 (NSU)

The Lead Providers for breast screening are actively working on data matching with PHOs and practices as a key strategy to identify, and invite or recall eligible women. Breast Screen Waitemata Northland (BSWN) is also data matching their register with the hospital (PIMS) database to identify eligible women who are admitted. The purpose of data matching is to enable higher numbers of Māori women to be identified and screened in a timelier manner. Lead providers then make contact with eligible women by phone; it is recognised that this first phone contact is crucial in supporting engagement of women. Breast Screen Auckland Ltd (BSAL) is also engaging workplaces identified with high Māori female employees and making the breast screen mobile bus available.

Auckland and Waitemata DHBs Child, Youth and Women's Health Scorecard

July 2015

Priority 1: Health Targets - Auckland DHB

	Actual	Target		Period
Fully immunised by 8 months	94%	95%	▼	Q4 14/15

Priority 1: Health Targets - Waitemata DHB

	Actual	Target		Period
Fully immunised by 8 months	93%	95%	▲	Q4 14/15

Priority 2: Better Public Service Target - Auckland DHB

Rheumatic Fever rate*	2.80	1.90	--	CY 2014

*acute cases per 100,00 population

Priority 2: Better Public Service Target - Waitemata DHB

Rheumatic Fever rate*	2.70	1.40	--	CY 2014

*acute cases per 100,00 population

Priority 3: Other Targets - Auckland DHB

Children

Fully immunised by 8 months				
Total	94%	95%	▼	Q4 14/15
Maori	86%	95%	▼	Q4 14/15
Pacific	94%	95%	▲	Q4 14/15
Asian	97%	95%	▲	Q4 14/15
Other	94%	95%	▲	Q4 14/15
Fully immunised at 2 years				
Total	94%	95%	▼	Q4 14/15
Maori	94%	95%	▼	Q4 14/15
Pacific	97%	95%	▲	Q4 14/15
Asian	95%	95%	--	Q4 14/15
Other	92%	95%	▼	Q4 14/15
Fully immunised at 5 years				
Total	83%	90%	▲	Jun-15
Maori	84%	90%	▲	Jun-15
Pacific	80%	90%	▲	Jun-15
Asian	85%	90%	▲	Jun-15
Other	84%	90%	▲	Jun-15
% of women booking with a LMC before 12 weeks				
Total	64%	80%	--	CY 2013
Maori	50%	80%	--	CY 2013
Pacific	36%	80%	--	CY 2013
Asian	63%	80%	--	CY 2013
Other	76%	80%	--	CY 2013
% of women smokefree at delivery				
Total	95%	86%	--	Q3 14/15
Maori	66%	86%	▲	Q3 14/15
Pacific	89%	86%	▲	Q3 14/15
Asian	99%	86%	--	Q3 14/15
Other	97%	86%	--	Q3 14/15
Breastfeeding - % exclusive or fully breastfed at discharge from LMC				
Total	81%	68%	--	Jul-Dec 13
Maori	81%	68%	--	Jul-Dec 13
Pacific	76%	68%	--	Jul-Dec 13
Breastfeeding - % fully breastfeeding at 3 months				
Total	60%	54%	--	2013/14
Maori	51%	54%	--	2013/14
Pacific	44%	54%	--	2013/14
Asian	60%	54%	--	2013/14
Other	66%	54%	--	2013/14
Breastfeeding - % receiving breast milk at 6 months				
Total	75%	59%		2013/14
Maori	69%	59%		2013/14
Pacific	61%	59%		2013/14
Asian	79%	59%		2013/14
Other	78%	59%		2013/14
% babies enrolled with a PHO by 3 months				
Total	80%	98%	▲	Mar-15
Oral health - % infants enrolled in dental service by 1 year				
Total	0%	98%	▼	not available
Maori	0%	98%	▼	not available
Pacific	0%	98%	▼	not available
Asian	0%	98%	▼	not available
Other	0%	98%	▼	not available
Oral health - % utilisation by 1 year				
Total	0%	100%	▼	not available
Maori	0%	100%	▼	not available
Pacific	0%	100%	▼	not available
Asian	0%	100%	▼	not available
Other	0%	100%	▼	not available
Before School Check coverage rates				
Total	96%	90%	▲	Jul-15
Maori	91%	90%	▲	Jul-15
Pacific	93%	90%	▲	Jul-15
Other	97%	90%	▲	Jul-15

Priority 3: Other Targets - Waitemata DHB

Children

Fully immunised by 8 months				
Total	93%	95%	▲	Q4 14/15
Maori	88%	95%	▼	Q4 14/15
Pacific	94%	95%	▼	Q4 14/15
Asian	97%	95%	--	Q4 14/15
Other	92%	95%	▲	Q4 14/15
Fully immunised at 2 years				
Total	93%	95%	▲	Q4 14/15
Maori	93%	95%	▲	Q4 14/15
Pacific	96%	95%	▲	Q4 14/15
Asian	98%	95%	▲	Q4 14/15
Other	90%	95%	▲	Q4 14/15
Fully immunised at 5 years				
Total	81%	90%	▲	Jun-15
Maori	74%	90%	▼	Jun-15
Pacific	81%	90%	▲	Jun-15
Asian	84%	90%	▼	Jun-15
Other	82%	90%	▲	Jun-15
% of women booking with a LMC before 12 weeks				
Total	67%	80.0%	--	CY 2013
Maori	52%	80.0%	--	CY 2013
Pacific	41%	80.0%	--	CY 2013
Asian	64%	80.0%	--	CY 2013
Other	78%	80.0%	--	CY 2013
% of women smokefree at delivery				
Total	93%	86%	--	Q3 14/15
Maori	73%	86%	▼	Q3 14/15
Pacific	89%	86%	--	Q3 14/15
Asian	99%	86%	--	Q3 14/15
Other	96%	86%	--	Q3 14/15
Breastfeeding - % exclusive or fully breastfed at discharge from LMC				
Total	79%	68%	--	Jul-Dec 13
Maori	75%	68%	--	Jul-Dec 13
Pacific	78%	68%	--	Jul-Dec 13
Breastfeeding - % fully breastfeeding at 3 months				
Total	60%	54%	--	2013/14
Maori	47%	54%	--	2013/14
Pacific	49%	54%	--	2013/14
Asian	60%	54%	--	2013/14
Other	63%	54%	--	2013/14
Breastfeeding - % receiving breast milk at 6 months				
Total	71%	59%		2013/14
Maori	57%	59%		2013/14
Pacific	62%	59%		2013/14
Asian	76%	59%		2013/14
Other	70%	59%		2013/14
% babies enrolled with a PHO by 3 months				
Total	70%	98%	▼	Mar-15
Oral health - % infants enrolled in dental service by one year				
Total	0%	98%	▼	not available
Maori	0%	98%	▼	not available
Pacific	0%	98%	▼	not available
Asian	0%	98%	▼	not available
Other	0%	98%	▼	not available
Oral health - % utilisation by 1 year				
Total	0%	100%	▼	not available
Maori	0%	100%	▼	not available
Pacific	0%	100%	▼	not available
Asian	0%	100%	▼	not available
Other	0%	100%	▼	not available
Before School Check coverage rates				
Total	93%	90%	▲	Jul-15
Maori	95%	90%	▲	Jul-15
Pacific	92%	90%	▲	Jul-15
Other	92%	90%	▲	Jul-15

Priority 3: Other Targets - Auckland DHB

Youth

HPV immunisation coverage (dose 3)				
Total	78%	65%	▲	May-15
Maori	75%	65%	▲	May-15
Pacific	89%	65%	▲	May-15
Asian	70%	65%	▲	May-15
Other	80%	65%	▲	May-15
Oral health: Adolescent utilisation rates				
Total	85%	80%	--	CY 2013
HEEADSS coverage in DHB funded school health services				
Total	21%	95%	▼	T1 2015

Women

Cervical screening rate (25-69 years: 3 year coverage)				
Total	79%	80%	▼	Mar-15
Maori	56%	80%	▲	Mar-15
Pacific	80%	80%	--	Mar-15
Asian	65%	80%	▲	Mar-15
Other	90%	80%	--	Mar-15
Breast screening rate (50-69 years: 2 year coverage)				
Total	67%	70%	▼	Mar-15
Maori	63%	70%	▼	Mar-15
Pacific	76%	70%	--	Mar-15
Other	66%	70%	▼	Mar-15

Priority 3: Other Targets - Waitemata DHB

Youth

HPV immunisation coverage (dose 3)				
Total	56%	65%	▲	May-15
Maori	57%	65%	▲	May-15
Pacific	67%	65%	▲	May-15
Asian	57%	65%	▲	May-15
Other	53%	65%	▲	May-15
Oral health: Adolescent utilisation rates				
Total	65%	80%	--	CY 2013
HEEADSS coverage in DHB funded school health services				
Total	14%	95%	▼	T1 2015

Women

Cervical screening rate (25-69 years: 3 year coverage)				
Total	76%	80%	--	Mar-15
Maori	55%	80%	▲	Mar-15
Pacific	71%	80%	▲	Mar-15
Asian	62%	80%	▲	Mar-15
Other	84%	80%	--	Mar-15
Breast screening rate (50-69 years: 2 year coverage)				
Total	68%	70%	▲	Mar-15
Maori	60%	70%	▼	Mar-15
Pacific	77%	70%	▲	Mar-15
Other	68%	70%	▲	Mar-15

How to

Indicator Title 85% 100% ▲

Actual DHB Performance

Improvement against previous result

Target DHB performance achieving or above the target will display as a solid green line.

5.1 Planning, Funding and Outcomes Update

Recommendation

That the report be received.

Prepared by: Wendy Bennett (Manager - Planning and Health Intelligence), Kate Sladden (Funding and Development Manager - Health of Older People), Aroha Haggie (Manager - Maori Health Gain) and Jane McEntee (General Manager - Auckland Regional Public Health Service)
Endorsed by: Dr Debbie Holdsworth (Director Funding), Simon Bowen (Director Health Outcomes)

Glossary

ARLA	-	Alcohol Regulatory and Licensing Authority
ARPHS	-	Auckland Regional Public Health Service
CPHAC	-	Community and Public Health Advisory Committee
DHB	-	District Health Board
FSA	-	First Specialist Appointment
HBSS	-	Home Based Support Services
ICS	-	Interim Care Services
LAPP	-	Local Approved Products Policy
MoH	-	Ministry of Health
RFP	-	Request for Proposals
Tumu Whakarae	-	Māori GM Network

Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs' planning and funding activities and areas of priority. It is generally limited to matters not already dealt with by other Board committees or elsewhere on the CPHAC meeting agenda.

1. Planning

1.1 Annual Plans

The content of the 2015/16 Auckland and Waitemata District Health Board (DHB) Draft 2 Annual Plans has been verbally approved by the Ministry of Health and is to be submitted to the Minister.

1.2 Annual Reports

The 2014/15 Auckland and Waitemata DHB Annual Report process has commenced. It involves ongoing discussions with AuditNZ, working on a new report format, updating content as available and gathering of data and supporting information.

1.3 Health Needs Assessment

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

1.4 Engagement

Development of the Community and Patient and Whanau Engagement Strategy continues.

2. Health of Older People

2.1 Home Based Support Services

The Home Based Support Services (HBSS) contracts for Auckland and Waitemata DHBs are being rolled over for 2015/16; during this time a Request for Proposals (RFP) will be undertaken for an aligned HBSS model across both DHBs. A draft service specification for a proposed model across Auckland and Waitemata DHBs is currently being reviewed by the clinical directors at both DHBs.

2.1 In-between Travel Time

In-between travel time (paying health care assistants for their time travelling between clients) started on 29 June 2015. Initially the funding will be dispersed centrally (MoH) as part of an interim approach that will end on 28 February 2016. This interim process is to allow time to develop a robust and sustainable payment mechanism.

2.3 Aged Residential Care

All Auckland and Waitemata DHB aged residential care facilities are engaged in interRAI (standardised clinical assessment) training as detailed in the table below.

interRAI Training	ADHB % (n)	WDHB % (n)
Fully competent (required number of nurses trained)	62% (44)	60% (37)
Competent (at least one nurse trained)	32% (23)	38% (23)
Currently training	6% (4)	2% (1)

The Funder has requested an analysis of corrective actions from ARC audit reports in order to identify areas of focus for the Planning and Funding Quality and Monitoring Managers.

A RFP is near completion for provision of an Interim Care Service (ICS). ICS is designed to provide temporary support for eligible people in a contracted residential care setting.

2.4 Health of Older People Strategy

The MoH is updating the Health of Older People Strategy (2002) to provide a direction for future services to meet the health and disability support needs of older people, and the development of services in the medium term.

3. Maori Health Gain

3.1 Ethnicity Data Audit Tool

The Māori Health Gain Team has led the implementation of the Ethnicity Data Audit Tool (EDAT) in general practitioner practices across Auckland and Waitemata DHB. The tool is designed to improve ethnicity data collection in primary care. We are pleased to announce that we have exceeded the target of 95% of general practitioner practices implementing EDAT by 30 June 2015 with implementation currently at 98%. This represents 234 practices. We would like to acknowledge the support received by PHOs and general practitioner staff in achieving the target. We would also

like to acknowledge the EDAT Programme Manager's tenacious and ongoing efforts which have substantially contributed to the successful achievement of the target.

3.2 Annual Planning

The 15/16 Māori Health Plans for Auckland and Waitemata DHBs have been pre-approved by the Ministry of Health. The final version of the plans has been submitted and we are expecting final approval from the Ministry shortly.

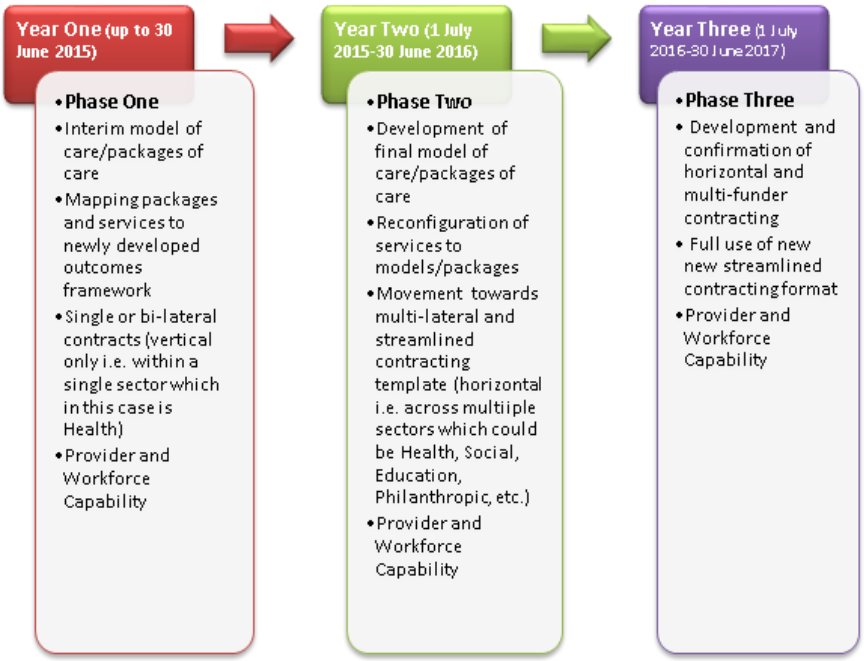
3.3 Integrated contracts

The Māori Health Gain Team is working closely with MoU partners and Māori providers to implement an integrated contracting strategy that will support a more flexible approach to service delivery and improved health outcomes for Māori. Figure 1.0 provides an overview of the Strategy. The following achievements in year one of the Integrated Contract Three-Year Strategy are:

- development of a Package of Care which includes a clinical and community component
- completion of three-year integrated contracts with Māori providers
- development of a performance measuring framework based on Results Based Accountability principles
- completion the mapping of services to the newly developed Māori Health Outcomes Framework – Ngā Painga Hauora
- building reporting and monitoring capacity of providers

This sees the completion of stage one of the Strategy. Work has already commenced on areas in stage two.

Figure 1.0 Integrated Contract Three-Year Strategy



3.4 Family violence

The procurement process for the Hohourongo Family Violence Intervention is nearing completion. A Request of Interest was released which saw the evaluation panel shortlist potential providers. These providers were given the opportunity to present additional information to the evaluation panel. The panel has put forward a recommendation for consideration by senior management.

3.5 Whanau ora

We are establishing the necessary process to advance the whanau ora business cases in both Auckland and Waitemata DHBs. The process includes:

- the establishment of a Governance Group to lead the development and implementation of the whānau ora network business cases across both Auckland and Waitemata DHBs
- the establishment of two steering groups to support the development and implementation of individual whānau ora network business cases. One steering group will oversee the Maungakiekie-Tamaki business case and the other will oversee the South Kaipara and North Shore business cases.
- the provision of appropriate financial and human resource to complete the required tasks within the specified timeframe.

It is acknowledged that the progress of this work has not been as rapid as desired. We believe that the establishment of an appropriate structure will provide the required decision making and support to complete the required work in a timely fashion.

3.6 Māori DNA strategy

The higher rates of DNA for First Specialist Appointment (FSA) and Follow up appointments for Māori (and for Pacific) has been noted for many years. A large project at Waitemata DHB was undertaken in 2014, which was presented to Manawa Ora. A number of other projects and approaches have been undertaken across both DHBs to try and reduce DNAs, with some successes; however the rates for Māori remain twice the total rates.

Tumu Whakarae (Māori GM Network) has undertaken a literature review and review of relevant New Zealand information. A subgroup under Tumu Whakarae has been established in early 2015 to develop a national approach, however this work has not yet been initiated. The Māori Health Gain Team are undertaking a review of the DHB level data, any available current or recent project information, and key initiatives undertaken in other DHBs. This work dovetails with the work initiated under the Auckland DHB Hospital Advisory Committee (HAC) where a fuller analysis of the data has been requested, which is being led by Margaret Wilshire. The purpose of the strategy is to clearly articulate the current knowledge about DNAs within the local DHB context, and to propose actions to reduce the inequalities in DNA rates.

4. Primary Care - POAC

A comprehensive report on primary care was provided to the previous meeting. At the 10 June 2015 Community and Public Health Advisory Committee (CPHAC) meeting, CPHAC requested information regarding the variation in utilisation of Primary Options for Acute Care (POAC) in the Auckland District Health Board (DHB) area. A summary of the analysis undertaken to date is provided below.

POAC coordinate services and facilitate access to existing infrastructure, processes and resources in the community in order to provide a range of alternatives that:

- prevent an acute hospital attendance, or

- shorten the length of hospital stays for patients who do attend or are admitted.

The POAC service has been specifically designed to:
- enable primary care providers to maximise the management of patients in the community
- create opportunities to improve the primary - secondary interface
- develop and implement new care pathways to reduce acute demand
- link with other community services that support the overall purpose
- reduce number of bed days with an early discharge service.

87% of POAC referrals are managed in the community without needing an admission to hospital. The current Agreement with Clinical Assessments Limited (CAL) has the target for managing without admission at 85%.

4.1 2014/15 POAC Funded Volumes and Budget

POAC funding is comprised as follows. Table 1 shows the total funding available for the 2014/2015 year and how this is currently divided by DHB.

Table 1

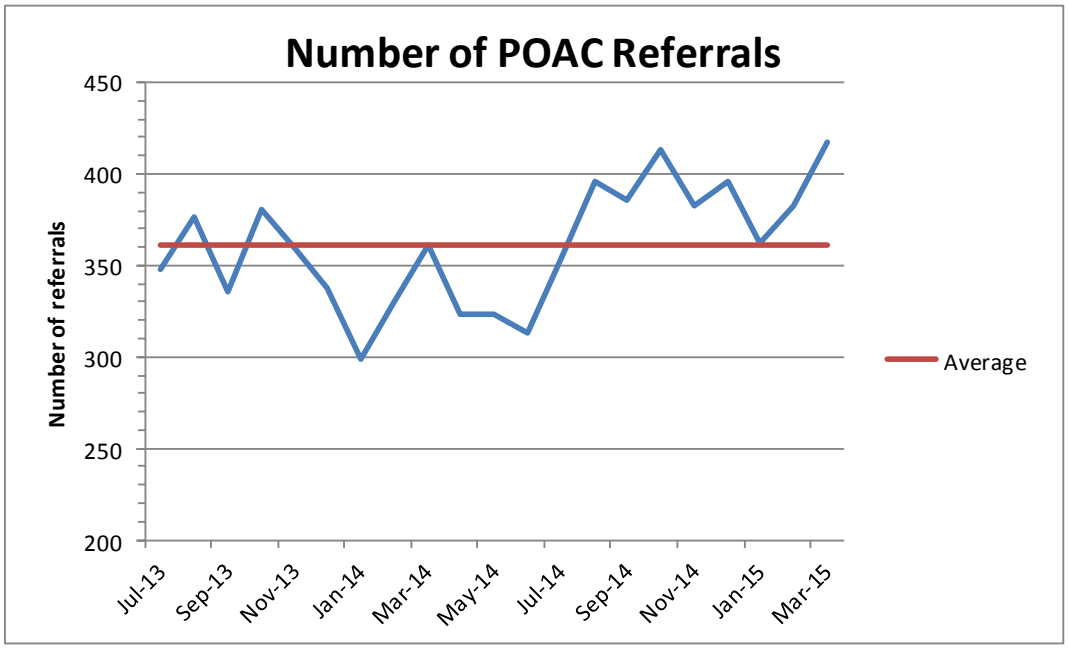
DHB	2014/15 Volume	Management / Coordination costs ($)	Clinical Costs ($)	Total ($)	Population	Clinical Cost per head of population ($)
WDHB	6,519	224,786	1,303,758	1,528,544	574,500	$2.27
ADHB	6,042	229,109	1,208,317	1,437,426	475,765	$2.54
CMDHB	12,320	410,666	2,464,000	2,874,666	525,120	$4.69
Total	*24,881*	*$864,560*	*$4,976,075*	*$5,840,636*	*1,575,385*	

The estimated average cost per case is calculated at $200, whereas the actual average cost per case in the Auckland DHB area is $177.79 including GST. This is 23% below the estimated average cost per case. In terms of the relative investment in POAC relative to the population, the figure for ADHB (excluding management costs) is slightly higher than Waitemata, however, both are significantly less than Counties (see table 1). Relative investment will be considered in the planned evidence based review.

4.2 Auckland DHB POAC Referrals

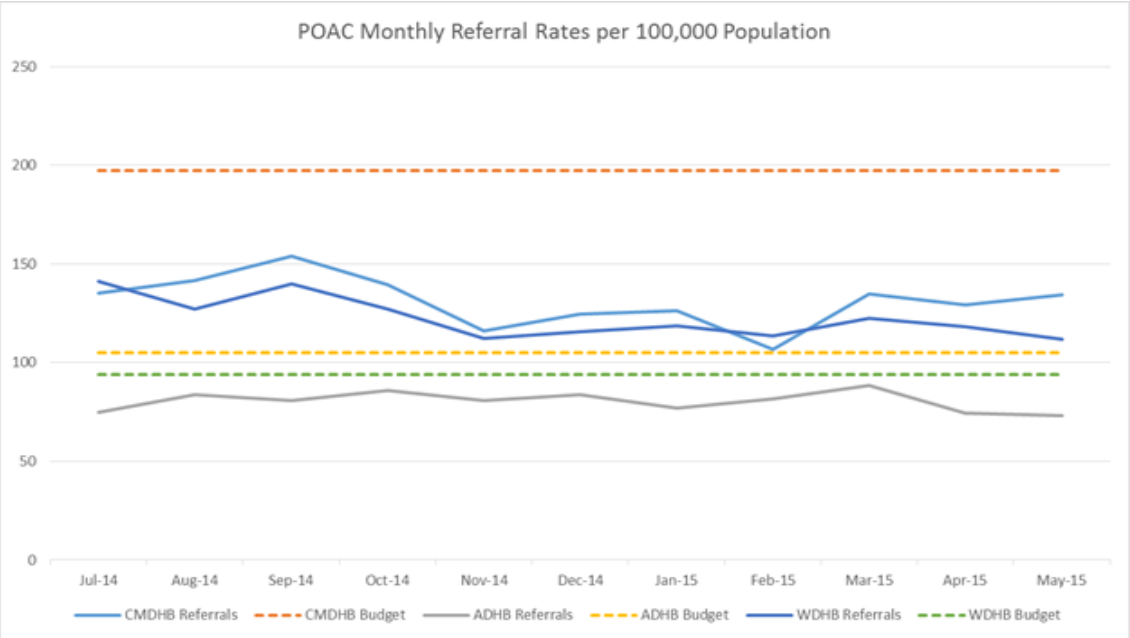
Figure 1 below shows the increasing trend over a 21-month period (1 July 2013 to 31 March 2015), of the number of Auckland DHB POAC referrals. The average number of referrals per month by Auckland DHB practices is 361. Referrals do fluctuate seasonally throughout the year. Year-to-date performance shows that the service is operating 24% below budgeted volumes, however showing an increase of 12% compared to the previous year.

Figure 1



In terms of the monthly referral rate for POAC (per 100,000 population), Figure 2 shows the most recent data up to May 2015. Although this graph is based on a different timeline (July 2014 to May 2015), the trend is consistent with the number of referrals in Figure 1.

Figure 2



In Auckland DHB the primary reason for referral (by provisional diagnosis) is Cellulitis, followed by Respiratory conditions, Deep Vein Thrombosis (DVT) and Dehydration. Cellulitis accounts for 19% of the total number of ADHB POAC referrals. The top ten reasons for referral and consequent clinical interventions are shown in Figure 3 overleaf.

The main reasons for referral are relatively consistent with Counties Manukau and Waitemata DHBs. Clinical pathways/guidelines have been developed to support best practice in primary care, including for Cellulitis, Respiratory Conditions, DVT and Dehydration (the top four reasons for referral to POAC).

Figure 3

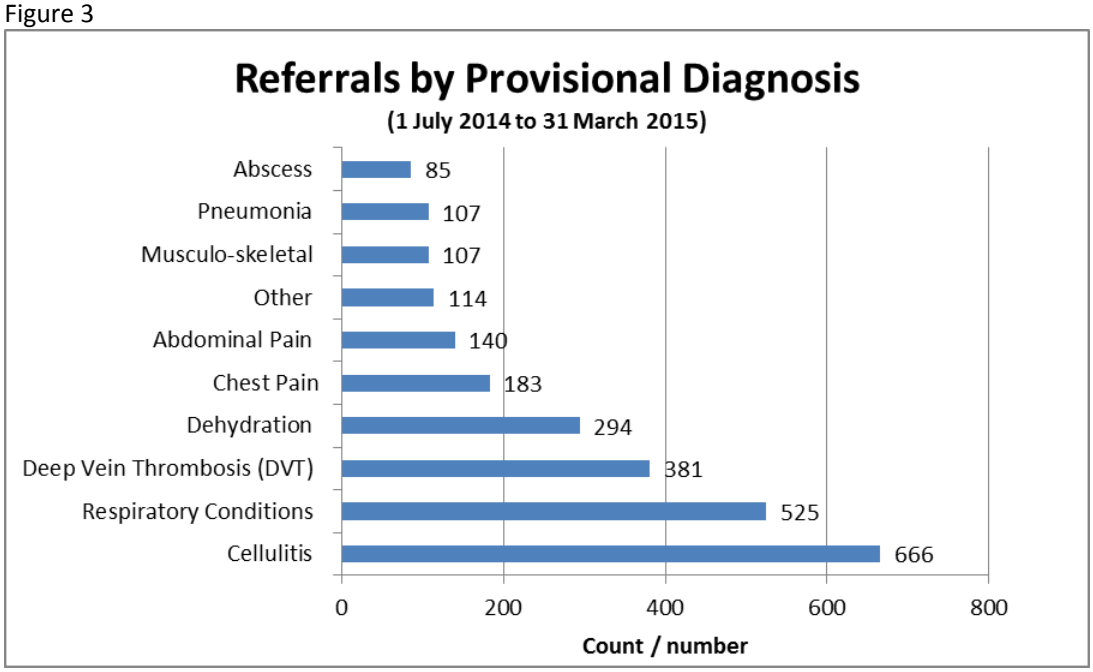


Figure 4

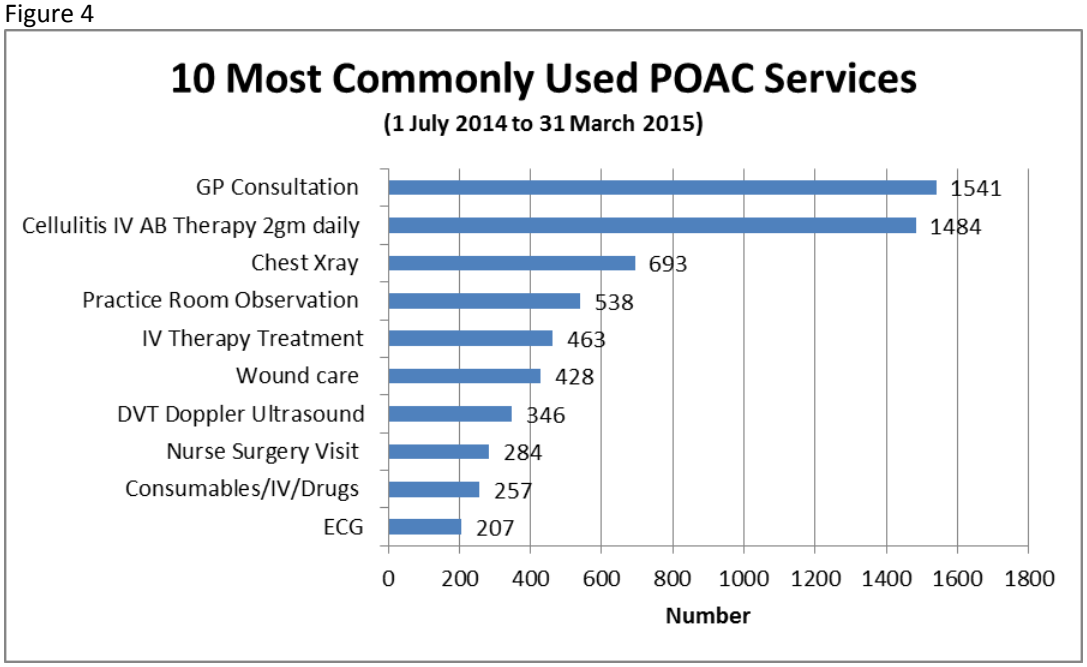


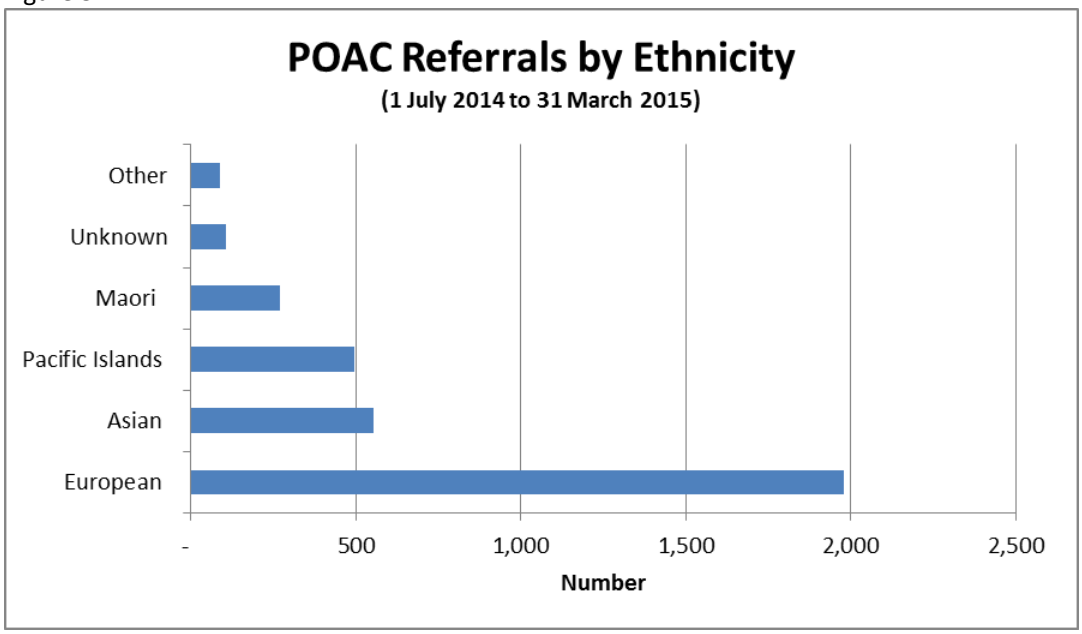
Figure 4 above shows the ten most frequently used POAC services/interventions – which accounts for 59% of all POAC services (1 July 2014 to 31 March 2015). Note "GP consultation" are all subsequent follow-up or extended GP/ Urgent Care Clinic appointments. The patient pays the co-payment for the initial consultation unless referred by St John (the patient pays the ambulance fee), or by the hospital.

Figure 5 below identifies the number of referrals by ethnicity. It shows that the majority of patients accessing POAC are:

- European (n= 1979, 57%)
- Pacific (n=494, 14%)
- Maori (n=270, 8%)
- Asian (n=552, 16%).

Utilisation for Maori is almost equal to the Auckland DHB proportion of population by ethnicity, and Pacific utilisation is higher than the Auckland DHB proportion of population percentages which are 8.2% and 11.0% respectively. Asian utilisation is lower at 16% POAC referrals compared with a 29% proportion of the population.

Figure 5



4.3 Auckland DHB - General Practice and Practice Utilisation

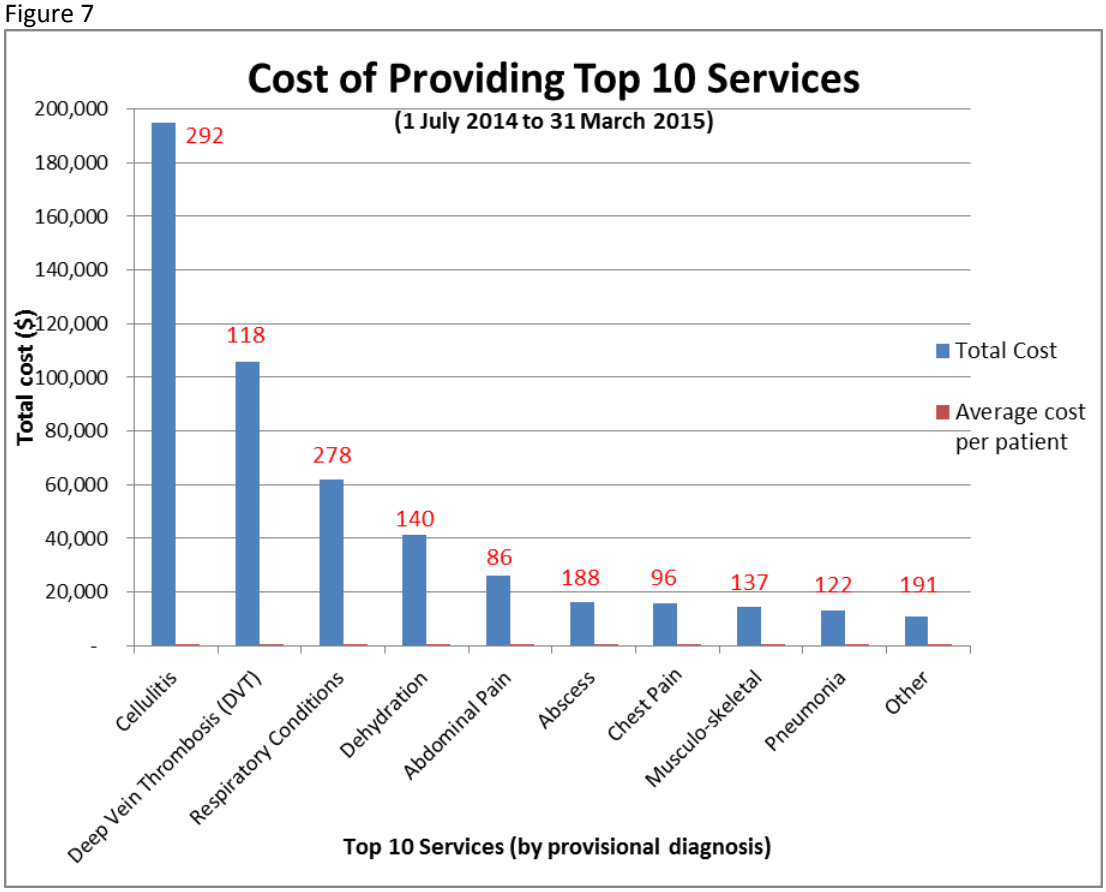
In Auckland DHB, there are 139 general practices, 136 of which have referred to POAC in the last twelve months equating to 98% of Auckland DHB practices having utilised the POAC service. A total of 474 individual General Practitioners have referred to POAC in the last twelve months; this does not include referrals received from Urgent Care Clinics. This figure is higher than the 457 Auckland DHBs registered GPs and is likely to include GPs based in either Counties Manukau or Waitemata DHB who have ADHB enrolled patients.

An analysis by individual GP practice has been undertaken which has identified variation in use of the service. There are a couple of outlying practices who are heavy users of the service however further work needs to be undertaken to standardise for population demographics and hours of opening before meaningful conclusions can be drawn.

Figure 7 below describes the total cost of the interventions provided per condition/diagnosis, together with the average individual cost per intervention from 1 July 2014 to 31 March 2015. Cellulitis has the highest cost of $292 per episode of care. Patients are managed in the community for between 3-5 days on average for treatment with intra-venous antibiotics following the Cellulitis

pathway. This is considerably lower cost than when comparing the cost of an admission. A fixed fee schedule has been developed for managing cellulitis under POAC funding.

Figure 7



In comparison to Counties Manukau and Waitemata DHBs, it has been anecdotally reported by the POAC service that for Auckland DHB:

- Patients are often reported to be able to privately fund or have insurance cover, negating the need for POAC
- Geographically there are fewer Urgent Care Clinics in close proximity to the Auckland City Hospital
- Patient demographics may contribute to the type of referrals and the need for services
- Lower rate of social referrals for this region
- POAC is often used as a resource for linking to the appropriate services. The POAC coordination team are able to use existing relationships and resources to support hospital avoidance for the patient, without this resulting in a funded POAC case. These cases are therefore excluded from any reporting
- Ongoing clinical governance activity has seen a focus on evidence-based management. Through this ongoing education, POAC have seen a change in some of the clinical practice. Hospital admissions are avoided and POAC referrals reduced by providing early intervention and education for preventative care
- To avoid rapid growth with a risk of inappropriate referrals, a more targeted approach is required. There is a need to understand the areas of demand for ADHB hospitals and identify where there may be opportunity to support change in practice.

The Auckland metro DHBs are due to commence an evidence-based review of POAC which is a key deliverable in the 2015/16 Annual Plan. The review will provide more detailed advice regarding utilisation, clinical outcomes aligned to clinical case review, reduced admissions to hospital, current investment and what future investment and service configuration should be in place, to meet the needs of the population across the Auckland metro DHB's. It will also provide recommendations regarding an overarching quality framework.

5. Auckland Regional Public Health Service

5.1 Submissions

Auckland Regional Public Health Service (ARPHS) has made two submissions during June 2015.

Date	Topic	Brief note
03 June 2015	Consultation on New Zealand's Climate Change Targets	• Climate change is an important public health issue. • There are a number of priority work areas and statutory obligations relevant for climate change, including promoting healthy built environments, lifting health equity, communicable disease control, water quality and emergency planning and response.
12 June 2015	Eliminating Illicit trade in tobacco products	• Tobacco control is an important public health issue • ARPHS supports NZ becoming a party to a protocol to eliminate illicit trade in tobacco products • Enforcement officers have found individuals selling illicit tobacco through Facebook, Asian Language newspapers and buy and swap forums. • Protocols to disrupt illicit trade in tobacco supports public health initiatives

Submissions anticipated for July are as follows:

Date	Topic	Brief note
1 July	Property and Nuisance By-Law	This bylaw will have public health implications in addressing legionnaire's disease and fouling by animals. We have provided advice to Auckland Council Officers to include in the materials or things definitions in clause 5 of the proposed bylaw – explicit reference to Asbestos.

	We are also recommending to Auckland Council to adopt the findings of the 2007 Christchurch coroner's report into the management of legionella. We will be making an oral submission at the hearings currently scheduled for August.

There may be more submissions identified for July through our screening process.

5.2 Proposed Auckland Unitary Plan

ARPHS continues to be engaged in the Unitary Plan process. ARPHS's full submission on the Proposed Auckland Unitary Plan is in three parts and available here or at http://www.arphs.govt.nz/about/submissions.

During June ARPHS has been in mediations regarding the following topic areas:

- Discharges, Stormwater and Wastewater
- Retirement (and Housing) Affordability
- Centre Zones, Business Parks, Activities & Controls
- Aquifers and Ground Water
- Major Recreation Zones and Precincts
- Natural Hazards and Flooding (Round 2).

In June, ARPHS was involved in the Hazard Substances hearing.

ARPHS will be involved in the following hearings throughout July:

- Public Open Spaces
- Transport Objectives, Policies, Rules and Other
- Retirement and Housing Affordability
- Water Quality and Quantity.

5.3 The Provisional Local Alcohol Plan

The Auckland Council developed a draft LAP in 2014 and this was consulted on under the Special Consultative Procedure outlined in the Local Government Act. Following further extensive consultation processes including orals submissions to the Hearings Panel, the Regional Strategy and Policy Committee of Auckland Council adopted the PLAP and publically notified it on 19th May.

A Medical Officer of Health has a statutory right of appeal to the licensing authority, under section 81(2) of the Sale and Supply of Alcohol Act 2012[1]. Grounds for appeal can only be made on elements within the PLAP policy that are "*unreasonable in light of the object*" of the Sale and Supply of Alcohol Act 2012, s4 (1). The object of the Act is that:

(a) The sale, supply and consumption of alcohol should be undertaken safely and responsibly
(b) The harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

[1] The appeal can be against any element within the PLAP.

ARPHS[2] has identified two areas of concern that form a basis for an appeal, and from a public health perspective, may be *"unreasonable in light of the object"* of the Act.

These are:

- a) Maximum trading hours – for on-licences in the Auckland region, are 8am to 3am the following day Monday to Sunday.

  This element is seen as unreasonable because:
  - It fails to respond in an appropriately proportionate way to the particular alcohol related harm in the Auckland region
  - It increases opening hours for all on-licences outside the city centre despite evidence indicating only 24% of non-city centre premises are trading after 1am. Research indicates that when hours and days of sale are increased, consumption and harm increase and vice versa.

  b) Maximum trading hours – for on licences in the city centre are 8am to 4am the following day Monday to Sunday.

  This element is seen as unreasonable because:
  - It fails to respond in an appropriately proportioned way to the particular alcohol related harm in the Auckland city centre
  - It fails to minimise the relatively high level of, and increasingly serious, alcohol related harm occurring in the Auckland City centre, including significant increases in alcohol related attendances to the Auckland City Hospital emergency department after midnight.

- The PLAP sets out the Council's general policy positions for the Auckland region by providing differently for the following areas:
  a) The city centre
  b) The priority overlay, which comprises the following areas:
     i. It omits areas where there is evidence of high levels of alcohol related harm, including Point Chevalier, Onehunga, Orewa, Takapuna and Warkworth. Furthermore Point Chevalier is a location containing addiction treatment facilities. These are sensitive sites relevant for local impact reports
     ii. The effect of exclusion from the Priority Overlay is that areas shown to have high levels of alcohol related harm will not receive the benefits of the policies anticipated in the PLAP. The exclusion of Point Chevalier, Onehunga, Orewa, Takapuna and Warkworth amounts to an unequal or partial response to alcohol harm in those areas when compared with the city centre overlay.

The notice of appeal is to the Alcohol Regulatory and Licensing Authority (ARLA). Should the appeal be successful, Auckland Council will be required to reconsider its position on the PLAP and either:

- Resubmit with the element deleted; or
- Resubmit with the element amended; or
- Appeal the ARLA's decision to the High Court
- Abandon the provisional policy.

Further information:

[2] ARPHS engaged and consulted extensively with partner agencies including NZ Police, Alcohol Healthwatch, Hapai Te Hauora and Te Whanau O Waipareira Trust.

Key policies in the Provisional Local Alcohol Policy

- Opening hours:
  - regional off-licence hours of 9am to 9pm (e.g. bottle stores, supermarkets)
  - regional on-licence hours of 8am to 3am (e.g. bars, restaurants, cafes, nightclubs) except
  - City Centre on-licence hours of 8am to 4am (no change from the national default hours introduced on 18 December 2013)
  - club licence hours of 9am to 1am (e.g. sports clubs), with an allowance for RSAs to open at 5am on ANZAC Day and
  - special licence hours to be decided on a case-by-case basis.

- Restrictions on the location of new licences:
  - a Local Impacts Report for higher-risk licence applications, which will include reporting on local schools and land uses
  - a two-year freeze on new off-licences in the Priority Overlay and the City Centre
  - a presumption against granting new off-licences in Neighbourhood Centres, and in the Priority Overlay and the City Centre once the freeze expires.

- A Local Impacts Report for the renewal of higher-risk licences in the Priority Overlay to help with setting conditions.
- A range of discretionary conditions able to be applied to licences[3].

5.4 Psychoactive Substances

Background

The Psychoactive Substances Act (PSA) 2013 regulates the content and quality of psychoactive products (through a product approval process), and the entire distribution chain (through licences for importation, manufacturing, research, retail and wholesale). The PSA is administered by the Psychoactive Substances Regulatory Authority within the Ministry of Health. Enforcement and compliance activities are undertaken by the Police and PSA enforcement officers from local Public Health Units.

May 2014 Amendment to PSA

The PSA was enacted in 2013 without the necessary regulations; therefore an interim regime was implemented where interim licences and product approvals could be issued until the regulations were available. An amendment to the PSA was passed in May 2014 that prematurely ended this interim regime. As a result, all interim licences and interim product approvals were revoked, so that all psychoactive products were removed from sale and all retail premises were no longer licensed.

Development of Regulations

The first set of regulations was enacted in July 2014 and covers all aspects of the PSA except for retail premises. As a consequence, it is now possible to apply for and obtain licenses for importation, manufacturing, research and wholesale, as well as to obtain approval for specific psychoactive products. No psychoactive products are currently approved.

Regulations regarding retail premises were delayed in order to allow local authorities time to develop a Local Approved Products Policy (LAPP). These regulations are expected later this year, after which time it will be possible to apply for and obtain licences for retail premises to sell approved psychoactive products. This approval will be dependent on the LAPP for the local authority involved.

[3] www.aucklandcouncil.govt.nz/EN/licencesregulations/alcohol/alcoholpolicies/Pages/helpshapeaucklandsalcoholpolicy.aspx#overview

Development of Auckland Council LAPP
The PSA allows local authorities to develop a LAPP in order to restrict the location of licensed retail premises. The LAPP can determine the overall zoning, proximity to sensitive sites (such as schools, health services, etc), and the density of licensed retail premises.

As part of the development of the draft LAPP, Auckland Council consulted stakeholders, including ARPHS who (by arrangement) represented the three DHBs in the Auckland region. The LAPP was opened for public consultation in October 2014 and adopted by Auckland Council in April 2015. Below is the link to the Auckland Council LAPP and maps:

http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/councilpolicies/localapprovedproductspolicy/Pages/localapprovedproductspolicy.aspx

Current Availability of Psychoactive Products
Since the May 2014 amendment to the PSA, there are products being sold that are marketed as legal alternatives to psychoactive products. These alternative products are technically legal until tested and proven to contain known psychoactive substances or illicit drugs. It is possible that some of these alternative products may solely contain legal substances such as tobacco and herbal supplements. The Police and the Psychoactive Substances Regulatory Authority are involved in the investigation and testing of these alternative products. In addition to the alternative products that are officially sold, psychoactive substances may also be obtained on the black market.

6. Service Enhancement to the Western Park Village Caravan Park

The Western Village Caravan Park provides temporary and long term accommodation for arguably the most vulnerable people within the Waitemata district.

A number of Waitemata DHB staff have raised concerns about the conditions in the caravan park and the health of the residents living there. As a result, the DHB allocated additional funding to enhance the services provided within the park until 30 September 2015, via four service enhancement initiatives:

- The public health nursing hours allocated to park increased. This has enabled the adoption of a broader population approach and has increased the visibility and presence of nurses in the park. Feedback to date indicates that the services provided by the public health nurses have been well received and are acceptable to residents.
- Residents have been supported to access to primary care and prescriptions.
- The hub co-ordinator role was extended until the 30 June 2015.
- 'Welcome packs' have been developed and have been provided to new residents.

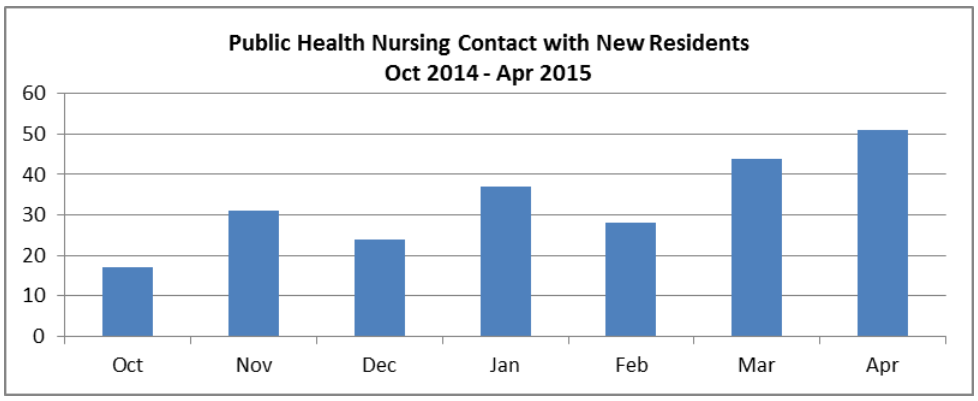
The progress and achievements to date in each of the four initiatives are outlined below.

6.1 Increase the scope of the public health nursing service

Historically, the Child and Family Service has provided approximately 8-hours a week of public health nursing support to the residents of the park. This support has been targeted to families/whanau with children and pregnant women.

As a result of the service enhancement, in October 2014 the public health nursing hours allocated to park increased. This has enabled the adoption of a broader population approach, preventative health response and has improved the visibility and presence of the nurses within the park. An additional public health nurse has been identified to work in the park and a regular visiting schedule has been established. The mobile clinic is being used to provide a private space for the nurses to meet with residents. Feedback received indicates that the increased presence and regular availability of the public health nurse in the park has resulted in increased trust and improved relationships with residents.

Since October 2014 the public health nurses have had contact with 232 residents. New residents seen per month are detailed in the graph below (please note the graph only details new residents seen, follow ups are not included).



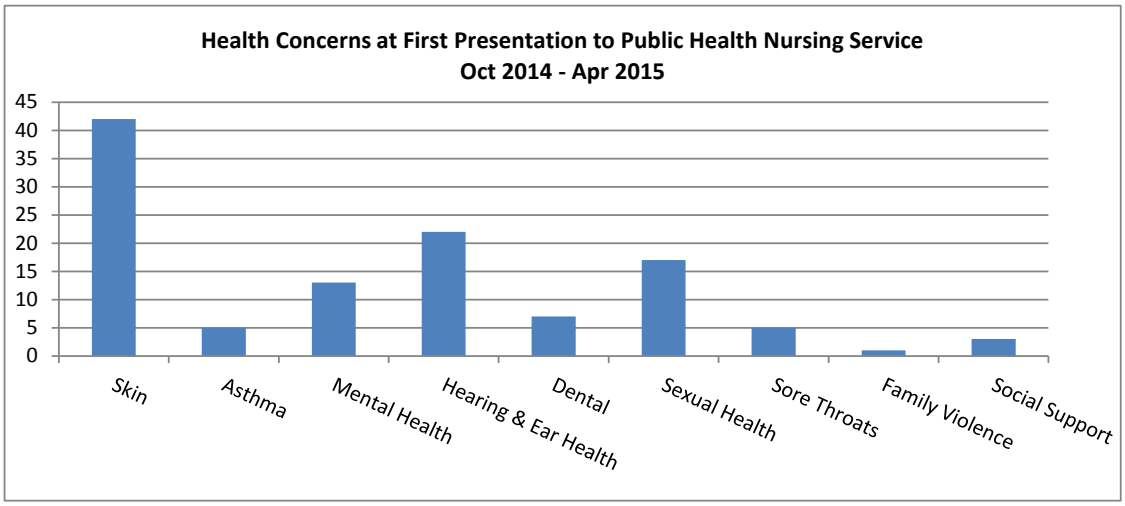
To date, 47% of the residents seen were Maori and 6% were Pacific. This is representative of the ethnicity of residents in the park.

Public health nurses are now providing services residents of all ages. This is demonstrated in the table below.

Age	New Residents Seen (Oct 14 – Apr 15) (n)	%
0 – 5 years	35	15%
6 – 10 years	14	6%
11 – 16 years	15	6%
17 – 24 years	27	12%
25+ years	141	61%
TOTAL	***232***	***100%***

The public health nurses have taken a strong advocacy role and have proactively been referring and supporting residents to access a range of other health and social service providers, including primary care, mental health services, housing, dental services and Child, Youth and Family.

Data kept by the public health nurses indicate that over the last six months residents have initially presented with a wide range of health concerns. However, the predominant concerns relate to skin infections, hearing and ear health and sexual health (including gynaecological concerns).



The increased allocation of public health nursing hours has also enabled:

- Further strengthening of the relationship with the managers and owners of the park. The owners have stated that they feel that residents are engaging well with the services provided by the public health nurses and that they have observed an improvement in the overall health of residents. The park managers are also now referring individuals and families to the public health nursing service when they believe that there are health issues impacting on the resident's wellbeing.

- The identification of specific health needs of groups of residents in the park and locating services to meet these. For example, following the birth of four babies in the park, Plunket and the outreach immunisation service were approached to provide services in the park to ensure that these families accessed care.

- An increased presence of mental health services in the park. The public health nurse has established a relationship with a liaison nurse from the Adult Mental Health Services. The liaison nurse is providing brief interventions to residents of the park, support and advice to staff working in the park and is now regularly attending stakeholder meetings.

The public health nurses recently completed a satisfaction survey with residents to provide them with an opportunity to provide feedback on the health services that they receive in the park and any improvements required. To date, the survey has been completed by 75 residents. The feedback received indicated that quality of services provided are excellent and have met residents' needs. Residents indicated that they are recommending the service to other people residing in the park. They also stated that they would like the public health nurses to have an increased presence in the park.

This service will continue at the same level during 2015/2016.

6.2 Improve access to primary care by subsidising and/or providing free care

Prior to the implementation of the service enhancement it was identified that there were few residents who were registered with the Ranui Medical Centre (which is across the park). The public health nurses have supported residents to access practices that offer free or very low cost consultations. They have also identified a pharmacy that offers free prescriptions to high need users and have utilised this for residents who are unable to fill their prescriptions because of the cost.

The public health nurses have supported and encouraged residents to enrol with the Ranui Medical Centre or the practice at Whanau House. This has resulted in twenty new enrolments. The nurses are also routinely referring and supporting residents who have an identified general practitioner to access care for specific health concerns.

The public health nurse will continue to orient residents to engage with local primary care services.

6.3 Support and fund the hub co-ordinator

An interagency group has been operating at the caravan park for some time and together they have funded and established a hub. The hub is based in the park and open five days a week. It offers residents free telephone, computer and internet access, co-ordinated support services and, importantly, a place to meet. It promotes resident-led action and advocates for housing and social justice.

A hub co-ordinator is employed by Monte Cecilia and is a vital member of the team. The co-ordinator works closely alongside the public health nurses and orients new residents to the services available within the park and the local community.

Maintaining funding for the hub was a continuing challenge, particularly for the co-ordinator. Funding for this role for 2015/2016 has now been confirmed by the Ministry of Social Development.

6.4 Provide 'welcome packs'

'Welcome packs' have been developed and are provided to new residents as a way of introducing the public health nursing service within the park. Packs include basic hygiene items (such as soap, toothpaste and a hand towel) and information about health and social services in the local area.

To date 55 welcome packs have been distributed to residents. These have been provided by the public health nurse, where appropriate, as a way of introducing themselves and the service. They have been very much appreciated and feedback received is that they are very useful, as some of the new residents arrive in the park with just the clothes they are wearing.

This approach will continue during 2015/2016.

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. Draft Plan	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 S.9 (2) (ba)]