Community and Public Health Advisory Committees Meeting

Wednesday, 27th November 2013

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
27th November 2013

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

COMMITTEE MEMBERS
Lee Mathias - Committee Chair (ADHB Deputy Chair)
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Judith Bassett – ADHB Board member
Pat Booth - WDHB Board member
Susan Buckland - ADHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Rob Cooper - ADHB and WDHB Board member
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Gwen Tepania-Palmer – WDHB Board member
Tim Jelleyman - Co-opted member
Eru Lyndon - Co-opted member

MANAGEMENT
Dale Bramley – WDHB, Chief Executive
Ailsa Claire – ADHB, Chief Executive
Debbie Holdsworth – ADHB and WDHB, Director Funding
Simon Bowen – ADHB and WDHB, Director Health Outcomes
Naida Glavish – ADHB and WDHB Chief Advisor, Tikanga
Paul Garbett - WDHB, Board Secretary

Apologies: Rob Cooper (leave of absence)

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

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

2.00pm *(please note agenda item times are estimates only)*
* Timing due to commitment of reporting manager

		PRESENTATION:	
2.00pm		**Co-design to Improve Participation and Bleed Reporting in Haemophilia (**Ian d'Young, Physiotherapy Practitioner, National Clinical Lead, Haemophilia Physiotherapy, Auckland DHB**)**	
	1	**AGENDA ORDER AND TIMING**	
	2	**CONFIRMATION OF MINUTES**	
2.15pm	2.1	Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 16/10/13	1
	3	**DECISION ITEMS**	
3.10 pm*	3.1	Child and Youth Mental Health Services Update	10
3.25 pm*	3.2	Auckland DHB Child and Youth Mental Health and Addiction Direction 2013 - 2023	20
2.20pm	3.3	2014/15 Annual Plan Approach	121
	4	**INFORMATION ITEMS**	
2.30pm	4.1	A Model of Care for Adult Palliative Care Services in the Waitemata District	127
3.00pm	4.2	Rheumatic Fever Prevention and Intervention Programme	133
	5	**STANDARD MONTHLY REPORTS**	
3.50pm	5.1	Primary Care Update Quarter 1, 2013/2014	139
4.10pm	5.2	Planning and Funding Update	162
4.20pm	**6**	**GENERAL BUSINESS**	
4.25pm	**7**	**RESOLUTION TO EXCLUDE THE PUBLIC**	169

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Professor (Adjunct) of Leadership – University of Auckland Business School Co-Director – New Zealand Leadership Institute Deputy Chair – Health Benefits Limited Independent Chairman – Tonkin & Taylor Chair – Auckland District Health Board Chair – Waitemata District Health Board Chairman – Auckland Transport	01/11/12
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28/09/11
Jo Agnew	Professional Teaching Fellow – University of Auckland Casual Staff Nurse – Auckland District Health Board	12/10/11
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Shareholder/Director – Pharmacy New Lynn Medical Centre	15/05/13
Judith Bassett	Nil	09/12/10
Pat Booth	Consulting Editor – Fairfax Suburban Papers in Auckland	24/06/09
Susan Buckland	Self employed – Writing, editing and public relations services Professional Conduct Committee member – Medical Council of New Zealand Professional Conduct Committee member – Occupational Therapy Board Member – Northern Regional Ethics Committee	12/10/11
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	Member – Waitakere Ranges Local Board	21/10/13
Rob Cooper	Board Member – Auckland District Health Board Board Member – Waitemata District Health Board Chief Executive – Ngati Hine Health Trust Advisory Board Member – James Henare Research Centre, University of Auckland	19/09/12
Warren Flaunty	Member of Henderson – Massey and Rodney Local Boards, Auckland Council Trustee - West Auckland Hospice Trustee - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder – Pharmacy Brands Ltd Shareholder – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Director – Trusts Community Foundation Ltd	21/10/13
Lee Mathias	Managing Director – Lee Mathias Ltd Director – Midwifery and Maternity Providers Organisation Ltd Shareholder/Director – Pictor Ltd Director – John Seabrook Holdings Ltd Governance Advisor – AuPairlink Ltd Council member – NZ Council of Midwives Chair – Tamaki Transformation Transitional Board Chair – Health Promotion Agency Board Chair – iAC IP Ltd Governance Advisor – Health Vision Ltd	18/07/13

Robyn Northey	Project management, service review, planning etc. – Self employed Contractor Board member – Hope Foundation Northern Region Trustee, A+ Charitable Trust	18/07/12
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director – The Transformational Leadership Company CEO – Conservative Party	17/05/13
Allison Roe	Member – Devonport-Takapuna Local Board, Auckland Council Shareholder – Optimisewellbeing.com Founding member – Breast Health Foundation Director – Spiritus NZ Trustee – Allison Roe Trust Founder – Takapuna 2020 Community Group Board member – North Shore Hospital Foundation	21/10/13
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

Dr Tim Jelleyman	Head of Division (Medical) - Child Women and Family Services, WDHB Member - Active Clinic Network for Greater Auckland Integrated Health Network Member - ASMS Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland	13/03/13
Eru Lyndon	Honorary Research Fellow – Auckland University Member – AUT Business School Industry Advisory Committee Regional Commissioner, Social Development, Northland - Ministry of Social Development Director – Tamaki Development Company	01/05/13

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2013

NAME	FEB	MAR	MAY	JUNE	JULY	SEPT	OCT	NOV
Lee Mathias (ADHB / WDHB combined Committees Chair and ADHB Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	
Warren Flaunty (ADHB / WDHB combined Committees Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	
Dr Lester Levy (ADHB and WDHB Chair)	✓	✓	✓	✓	✗	✓	✗	
Max Abbott (WDHB Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	
Jo Agnew	✓	✓	✓	✓	✓	✓	✓	
Peter Aitken	✗	✓	✓	✓	✓	✓	✓	
Judith Bassett	✓	✓	✓	✓	✓	✗	✓	
Pat Booth	✓	✓	✓	✓	✗	✓	✓	
Susan Buckland	✓	✗	✓	✓	✓	✓	✗	
Chris Chambers	✓	✓	✓	✓	✓	✓	✓	
Sandra Coney	✓	✓	✓	✓	✗	✓	✓	
Rob Cooper	^	^	✓	✓	✗	^	^	
Robyn Northey	✓	✓	✓	✓	✓	✓	✓	
Christine Rankin	✓	✓	✓	✓	✓	✓	✓	
Allison Roe	✗	✓	✓	✓	✓	✓	✗	
Gwen Tepania-Palmer	✓	✗	✗	✓	✗	✗	✓	
Co-opted members								
Dr Tim Jelleyman	✓	✓	✗	✓	✓	✓	✓	
Eru Lyndon	✗	✗	✓	✗	✗	✓	✗	

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

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 16th October 2013

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 16th October 2013 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 16 October 2013

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.02p.m.

COMMITTEE MEMBERS PRESENT:

Lee Mathias (Committee Chair) (ADHB Deputy Chair)
Warren Flaunty (Deputy Committee Chair) (WDHB Board member)
Max Abbott (WDHB Deputy Chair)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Pat Booth (WDHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Gwen Tepania-Palmer (WDHB Board member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT: Ailsa Claire (ADHB, Chief Executive)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Naida Glavish (ADHB and WDHB, Chief Advisor Tikanga)
Ruth Bijl (ADHB and WDHB, Funding & Development Manager, Women's, Child and Youth Health)
Tim Wood (ADHB and WDHB, Funding & Development Manager, Primary Care)
Stuart Jenkins (ADHB and WDHB, Clinical Director, Primary Care)
Jean McQueen (ADHB and WDHB, Primary Care Nursing Director)
Rachel Mattison (ADHB and WDHB, Associate Planning and Funding Manager, Primary Care)
Stephanie Muncaster (WDHB, Programme Manager, Chronic & Palliative Care)
Andrew Old (ADHB, Medical Advisor, Public Health Medicine)
Imelda Quilty-King (WDHB, Community Engagement Co-ordinator)
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 Women's Health Council
Tracy McIntyre, Waitakere Health Link
Brian O'Shea, ProCare
Jude Sprott, ProCare
Charlotte Harris, Auckland PHO

Lorelle George, Comprehensive Care/Waitemata PHO
Bruce Lim, Pacific Health
Craig Murray, Waitemata PHO
Jeremy Olds, NZ Doctor Magazine

APOLOGIES: Apologies were received and accepted from Lester Levy, Susan Buckland, Rob Cooper (leave of absence) and Allison Roe.

KARAKIA Pat Booth led the Committee in the English version of the karakia.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interest with regard to the agenda for this meeting.

WELCOME

Lee Mathias welcomed those present and congratulated re-elected Board members.

1. AGENDA ORDER AND TIMING

Items were taken in the order 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 04 September 2013 (agenda pages 1-9)

Resolution (Moved Warren Flaunty/Seconded Robyn Northey)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 04 September 2013 be approved.

Carried

Matters Arising:

It was noted that Allison Roe had requested that for the next meeting on 27 November she have the opportunity to address the matters that had been covered in discussion and response to questions re water fluoridation on 4 September. The Committee Chair advised that she would give permission for that. Allison Roe had also asked if there had been an Official Information Act inquiry into water fluoridation in New Zealand since the 1980's. Lee Mathias suggested as the best source of information on fluoridation the website fluoridationfacts.govt.nz. The Health Promotion Agency had gone to considerable trouble to ensure that the information there is the most current available.

In relation to the action from the July meeting to look at including Oral Health arrears and DNA in the Primary Health Dashboard, Tim Wood advised that he would be working with the newly appointed Manager for Women's, Child and Youth Health on this to determine what this will look like. He hoped to have something for the next Primary Health report. Debbie

Holdsworth advised that there is information in the Waitemata DHB Hospital Advisory Committee scorecard that should be relatively easy to adapt. An additional request was made at the meeting for information on adolescent enrolments to also be included in the Dashboard and that will be considered.

With regard to the Review of Child Services referred to in the "actions arising", the Committee Chair noted that it is particularly important for Auckland DHB to have that review sooner rather than later, because of decisions that need to be made.

3 DECISION ITEMS

3.1 Cervical Screening Update (agenda pages 10-23)

Ruth Bijl (Funding and Development Manager, Women's, Child and Youth Health, Auckland and Waitemata DHBs), Dr Karen Bartholomew (Public Health Physician, Waitemata DHB) and Stephanie Muncaster (Programme Manager Chronic and Palliative Care, Waitemata DHB) were present for this item.

Ruth Bijl introduced the report, providing an overview which included:

- The positive but only slowly improving upward trend in results.
- The focus being given to supporting primary care to undertake cervical screening.
- The recognition of the need to address unacceptably low coverage in Maori and Asian populations.
- The literature is being reviewed in an effort to understand the issues better. It is anticipated that there needs to be a change in messaging to women. This needs to be addressed with the National Screening Unit.

Dr Karen Bartholomew referred to the work of the sub-group on a range of other projects being considered and prioritised, as mentioned in the report.

Stephanie Muncaster noted that the free cervical smears targeted for priority group women are increasingly being used by the PHOs. Some PHOs are also providing funding themselves.

Matters covered in discussion and response to questions included:

- The Committee Chair expressed concern that while the process is being improved, it remains too complex and bureaucratic. Ruth Bijl advised that they are trying to make the process easier for primary care; it is overly complicated and very structured. They want to get the National Screening Unit involved in this issue. Karen Bartholomew also noted that a Best Practice Manual is being worked on, with the aim of promoting standard practice across primary care.
- With regard to women in the priority groups, the majority are enrolled with PHOs and most screening is done in primary care.
- In answer to a question on the PHO viewpoint, Ruth Bijl advised that the PHOs are involved in the governance groups, and that they consider the complexity of the system a big issue with cervical screening participation, but that there are also other issues such as embarrassment.
- A factor in the success of Auckland DHB with the Pacific population is considered to be the parish nursing model and the encouragement given by those nurses for women to go and have smears. Another factor mentioned later in the discussion is the achievements of Alliance Health Plus with the Pacific population.

- The two Maori provider ISPs (Independent Service Providers) referred to on page 12 of the report are contracted by the National Screening Unit in an arrangement that pre-dates the establishment of PHOs. Part of the conversation with the National Screening Unit is about ensuring that the best structure for delivering cervical screening is in place.
- Sandra Coney advised of some relevant recent research in this area by Professor Charlotte Paul. The team presenting this item will follow up with Professor Paul.
- With regard to the question of including performance data in the quarterly Primary Care report, the problem is timeliness of data from the NCSP. The register is currently not functioning and they are looking at moving it, but that process may take some time. Another issue that causes delay is the requirement that data be approved by the National Kaitiaki Group, which usually results in a six month delay. Members agreed that this situation is entirely unsatisfactory and requested that Ruth Bijl draft a letter to the Ministry of Health, for the Committee Chair to sign on the Committees' behalf, requesting that the issues causing significant delays in release of cervical screening results be addressed as a matter of urgency.
- There was a discussion about the differing results with different types of screening programme (for example breast screening and cervical screening). Delivery mechanisms are very different, but any learning that can be applied from one programme to another is taken up.
- In answer to a question, Ruth Bijl advised that Maori and Pacific representatives sit on the Auckland Cervical Screening Governance Group, advising on appropriate strategy for consultation. These are DHB employees. With regard to ensuring the co-design project does take into account how to address the needs of high needs women, Karen Bartholomew advised that the co-design work will involve a relevant practice to ensure that voice is heard. The scope of the work includes looking at any factors affecting women's ability to access the service.
- A representative of one of the PHOs attending the meeting advised that they have a good working relationship with the Pacific ISP provider, but they don't have the same relationship with the Maori providers. That would be good to achieve.
- Karen Bartholomew advised that the purpose of data matching is to create a population based register from PHO based information, so that they can invite the relevant women for screening. There is some interest from the National Screening Unit in the idea of creating a national population based register.

In summary, the Committee Chair commented that the overall picture of what is being done sounds promising, although possibly not moving as fast as the Boards would like.

The Committee Chair advised of a comment received from Allison Roe that the wording of the report women receive following a normal smear suggests that the test may be inaccurate. Allison has suggested that the wording needs review. Lee Mathias requested that the wording be located and circulated to Committee members, and considered at the next meeting if necessary.

Resolution (Moved Lee Mathias/Seconded Jo Agnew)

(a) That the Committee notes that the activity under the Metropolitan Auckland Cervical Screening Governance Group (MACSGG) is progressing according to the strategic plan and notes:

- **That cervical screening coverage is available to March 2013, and the three year coverage for Auckland and Waitemata DHB is stable; Auckland DHB 77.5% and Waitemata DHB 75.5%.**
- **Coverage rates for priority group women remain below the national target of 80%, with the exception of Pacific women in Auckland DHB.**
- **Improving overall coverage and coverage for priority group women are key drivers for MACSGG activity.**
- **The focus of MASCGG to date has been three activities: addressing the data quality (the platform of which is the data-matching project), development of the Best Practice Resource and the provision of free smears to priority group women.**
- **That the PHO Performance Management Programme (PPP) target will be increased from 75% to align with the national target of 80%, effective January 2014. This will require a step-change in volume of women screened in primary care, and provides an opportunity to strengthen primary care involvement in MACSGG.**

(b) That the Committee endorses current and planned activities to be undertaken by MACSGG to improve cervical screening coverage and reduce inequalities.

Carried

4. INFORMATION ITEMS

There were no information items.

5. STANDARD MONTHLY REPORTS

5.1 Planning and Funding Update (agenda pages 24-30)

Debbie Holdsworth and Simon Bowen introduced the report.

Debbie Holdsworth commented on the progress with Auckland and Waitemata DHB Planning, Funding and Outcomes Collaboration, including the work of the Project Director and the five Tier 3 appointments listed on page 24 of the agenda.

Simon Bowen advised that work is about to commence on the planning round for 2014/15 and they would be looking for a consistent approach across the two DHBs. It was intended to work as closely as possible with the PHOs and other affected parties and an update would come to the Committee, probably to its next meeting, on how it was proposed to do that.

Debbie Holdsworth noted that the full quarterly Primary Care report will come to the November meeting, but that the October report contains brief updates on progress with the Alliance Agreements, the review of primary care clinical governance and on the Localities Approach. Tim Wood advised that action on the primary care health targets is ongoing, with regular meetings with the PHOs on this. The feedback from the PHOs is that achieving the CVD and Smoking Advice targets will both be challenging. The PHOs are focusing on how to get sustainable systems change.

Ailsa Claire briefed the Committee on the issue recently raised by Audit New Zealand at the two Boards' Audit and Finance Committees regarding what assurance can be given of the reliability of non-financial performance data relating to primary care national health target

performance, for example percentage of smokers given advice to stop smoking. The anxiety of the auditors is that there is not a clear line of sight. The concern of the DHBs is that they will never be able to give the kind of assurance being sought. They have argued that the information being sought remains part of a clinical process, but had not won that argument.
In answer to a question, it was confirmed that having a CVD check in primary care still involves paying a co-payment. One of the PHO representatives at the meeting confirmed that co-payments are a barrier to encouraging checks, but there are a lot of low cost access practices where that barrier is reduced. PHOs provide subsidised funding to reduce obstacles.

The Committee Chair commented that it is now well established that such services as CVD screening are within the normal gamut of primary care, not extras. The standard contract with PHOs is generally consistent with that.

Debbie Holdsworth highlighted the information on Community Pharmacy (pages 26-27 of the agenda), noting the implications of the commencement of the third phase of the national Community Pharmacy Services agreement and also the establishment of the Metro Auckland Pharmacy Advisory Group.

In answer to a question, Tim Wood advised that Counties Manukau DHB's moratorium on the establishment of new pharmacies in its area had been intended as an interim measure while it was developing a policy framework about access to new contracts. They had not come up with a viable basis for a new policy. DHBs generally have been unsuccessful in trying to manage the market. When he had last discussed the issue with Counties Manukau staff two months ago, the moratorium on new pharmacies was still in place, but they were thinking of lifting it. He would advise the Committee if that occurred.

Other matters discussed included:

- The impact of the increase in pharmacy script fees on prescriptions not being collected was raised. Ailsa Claire cautioned on assuming an impact. In the United Kingdom it had been found that the most common reasons for people not picking up prescribed medicines were that they didn't want the medicine in the first place or that they did not understand what the medicine was prescribed for. Tim Wood advised that he did not have hard data to show a connection. Overall the volume of scripts had not changed. Warren Flaunty commented that at his pharmacy affordability was an issue for customers; often the medicines are given out on trust that they will be paid for sometime later.
- The opening of Hospice West Auckland's Kowhai Unit (page 28 of the agenda) – in addition to the attendees listed, Warren Flaunty had attended both the opening and the blessing at 6a.m.
- The Waitemata District Palliative Model of Care has been signed off by the governance group and is going to the next Waitemata DHB Board meeting for approval. It should be possible to provide a presentation on it to the next CPHAC meeting.
- With regard to the immunisation percentages given on page 28 of the agenda, it was agreed that in future the actual number would also be given in brackets with the percentages. Tim Wood advised that the number of eight month old babies whose parents have not opted out and who may still be immunised is about 20. The Immunisation Outreach Service is following up on each individual case, but this is a time consuming process.

- Home insulation - there remain a number of free or subsidised services, with different policies applying. It is possible for landlords to be subsidised to insulate under some schemes. Information on the various schemes will be brought to the next meeting.

The report was received.

6. General Business

No issues were raised.

7. Resolution to Exclude the Public

Resolution (Moved Jo Agnew/Seconded Warren Flaunty)

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting with Public Excluded 04/09/13	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)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.

3.02p.m – 3.06pm – Public excluded session.

3.06p.m – open meeting resumed.

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

The meeting concluded at 3.07 p.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 16 OCTOBER 2013

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 18th November 2013

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 24/07/13 16/10/13	3.1	Oral Health – look at including performance results e.g. for arrears and DNA in the Primary Health Dashboard. (Added 16/10/13 – also look at including information on adolescent enrolments.)	Tim Wood/Ruth Bijl	CPHAC 27/11/13	Arrears included in the Primary Health Scorecard. DNA discussed in the Planning and Funding Update.
CPHAC 04/09/13	2.1	Review of Child Health Services - engagement with Wilson Centre to occur as part of the Review - report on the Review to come to February 2014 CPHAC meeting, when a proposal is expected to be ready.	Tim Jelleyman/ Linda Harun	CPHAC 05/02/14	
CPHAC 16/10/13	2.1	Fluoridation – Allison Roe will be given an opportunity at the November meeting to address matters that had been covered in discussion and response to questions on this topic at the September CPHAC meeting.	Allison Roe	CPHAC 27/11/13	
CPHAC 16/10/13	3.1	Cervical Screening - Data – letter to the Ministry of Health to be drafted for the Committee Chair's signature requesting that the issues causing significant and unacceptable delays in release of cervical screening data be addressed as a matter of urgency. -Letter women receive following a normal smear – to be located and circulated to Committee members and to be considered at next CPHAC meeting if necessary.	Ruth Bijl Ruth Bijl/Paul Garbett		Letter not required as meeting has taken place with the Group Manager, National Screening Unit, who has agreed that they will provide monthly reports once a formal application for that is received. Letters e-mailed to Committee members on 6/11/13.
CPHAC 16/10/13	5.1	Planning and Funding Report - information on the various free or subsidised insulation schemes to be brought to the next meeting.	Debbie Holdsworth	CPHAC 27/11/13	Details on this will be provided as part of the Rheumatic Fever item on the CPHAC agenda.

3.1 Child and Youth Mental Health Services Update - The approach to designing common systems and processes across both the Auckland and Waitemata DHBs

Recommendation:

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

a) Receive this report describing the work undertaken to date in aligning prioritised common systems and processes.
b) Endorse the approach described.

Prepared by: Helen Wood, General Manager, Mental Health and Addictions, Waitemata DHB and Auckland DHB), Selena Griffith (Mental Health and Addictions Project Coordinator, Waitemata DHB and Auckland DHB)

Glossary

CADS	-	Community Alcohol and Drug Services
CAPA	-	Choice and Partnership Approach
COPMIA	-	Children of parents with a mental illness/addiction issue
CPHAC	-	Community and Public Health Advisory Committee
CYF	-	Child Youth and Family
DAP	-	District Annual Plan
DHB	-	District Health Board
ICSS	-	The Youth Intensive Clinical Support Service

1. Executive Summary

This information paper provides a response to the request from the Auckland and Waitemata District Health Board (DHB) Community and Public Health Advisory Committees (CPHAC) on the 12th June 2013. Further information was sought on the potential of aligning some systems and processes after both DHBs presented their child and youth plans. CPHAC was particularly interested in understanding where common systems and processes for both Auckland DHB and Waitemata DHB Child and Youth Mental Health Services could be developed.

An outline of current work programmes that will assist with achieving this objective across Auckland DHB and Waitemata DHB Child and Youth Services is provided.

The initial areas of focus are:

1) Auckland DHB/ Waitemata DHB Mental Health and Addiction Service collaboration work programme
2) Common areas of focus for both Auckland DHB/Waitemata DHB child and youth strategic planning i.e. multi-agency working and early intervention and includes how we are implementing Government policy
3) Recent Coroner recommendations that impacted on services across both DHBs.

This paper will not address the interface with primary care across both services as the locality developments will be shaping much of this future work.

2. Introduction/Background

2.1 Mental Health Services collaboration programme

Auckland DHB and Waitemata DHB Mental Health and Addiction Service leaders identified seven key work streams to focus on as part of the collaboration programme. The child and youth work stream was identified as a key priority area and a working group consisting of senior leaders from both services was established.

Workshops held in April 2013 with clinical leaders and managers identified key project focus areas that support the principles of collaboration. Using an investment logic mapping model as a framework, benefit maps were developed for child and youth services. These maps outlined opportunities, deliverables, key actions, resources and benefits (see Appendices 1 and 2).

The three key initial opportunities for collaboration were identified as:

- **Children of parents with a mental illness/ addiction issue (COPMIA)** will receive equitable access to services regardless of whether they reside in the Auckland DHB or Waitemata DHB region. The deliverable was that both DHBs will have a common understanding of the model of service and the strategies in place for delivery. This also includes the sharing of expertise, training, supervision and future potential of merged approach as this is vulnerable to skill shortage (only one or two staff in each area).
- **The Youth Intensive Clinical Support Service (ICSS)** is a service to young people with multi-agency involvement and high and complex needs. The service was previously a regional service then devolved to local provision three years ago. The Auckland DHB service is still in the establishment phase and growing the staff numbers and skills mix. Waitemata DHB has a strong base of skills, works to the internationally recognised fidelity model and is currently being evaluated. The key deliverables are that both DHBs will work together to explore the potential to integrate the Intensive Clinical Support Service to form a sub-metro service. This will also include the possibility of shared roles across both DHBs and looking at opportunities to share expertise.
- **Sharing projects and service development activities** across both DHBs to ensure efficient use of expertise and resource. The key deliverables are that both DHBs will utilise the opportunity to share training, professional development and supervision resource.

2.2 Aligned approaches for multi-agency involvement

The strategic plans for both services have prioritised working better together across agencies to deliver better outcomes, experience of care and better value for money. This particularly involves how they work with the Ministry of Social Development, Child Youth and Family (CYF), Education, Primary Care and the Non-Government Organisation (NGO) sector. They also share access to Addiction Services for youth provided by Waitemata DHB Community Alcohol and Drug Services (CADS) i.e. Altered High and NGO providers, such as Odyssey.

Child and Youth Mental Health Services have historically had a strong interface with CYF and Education, however the differences in service provision and approaches can be challenging for agencies. When young people are involved in multiple services, the transition across

boundaries or across agencies may result in the young person being particularly vulnerable. This may result in relapse or deterioration in their situation due to the interruptions in consistency of care, or becoming lost to services.

Greater interagency collaboration and partnership working is a key focus area in recent National Mental Health strategy and Government agencies' priorities such as Better Public Services.

2.3 Recent Coroner Recommendations

A recent Coronial inquiry highlighted the need to strengthen an aligned approach – especially when young people are living between separated parents who live in different DHB areas.

The coronial inquiry resulted in the following recommendations:
1) That the MSD (in consultation with Auckland DHB and Waitemata DHB) reviews whether arrangements between CYF and Auckland DHB and Waitemata DHB are sufficiently robust to enable a properly collaborative response between CYF and the DHBs' mental health services in order to meet the complex needs of young people (up to 17) who have both mental health needs and care and protection issues.

2) That the DHBs review whether further collaborative processes are required to better manage the community mental health care of children and young persons whose living arrangements include both DHB areas.

3. Progress to date

3.1 Collaboration Programme

An overall description of all the programmes of work in the child and youth collaboration work stream is outlined in Appendix 3.

For the purpose of this paper, the key areas prioritised for alignment are mainly related to service development to meet expectations of Blueprint II and Rising to Challenge (Government Mental Health plan). They are primarily focused on intervening earlier in the life course to achieve better longer term outcomes and include:

- Better services for children with a parent who has a mental illness/ addiction issue
- Better services for mothers (and fathers) with mental health and addiction issues and their infants.

The primary focus at this stage is on improved acute responses as outlined in Section 4.

The leadership of both services are working on other areas of mutual collaboration and benefit. A number of task areas are being looked into where there is a clear opportunity for sharing of expertise, resources, and aligning processes:

- **Shared Nurse Leadership role**: Auckland DHB does not have such a role for Child and Youth Mental Health. Nursing development in this workforce is a priority area to attract more nurses. The shared role is supported by both Directors of Nursing Mental Health and can be jointly funded. The role currently exists at Waitemata DHB and is being covered by a secondment until details of the joint role can be finalised.
- **Sharing of process improvements and sharing of expertise** in the area of the Choice and Partnership Approach (CAPA) and Lean Six Sigma rapid improvement events. This work is to assist both service improvement and achieve greater alignment around their "front

door" processes. It is also focused on improving capacity to meet the National Health targets for access and waiting times and enhance overall productivity. This will be achieved with the development of effective systems for managing the impact of increased demand on staff workloads.

3.2 Strategic Plans

Identifying common areas of strategic change across the plans for Waitemata DHB / Auckland DHB and from the Government have clearly indicated two key priorities to focus our approach for the alignment of systems and processes.
These two areas are

I. Working better together (multiagency work) particularly for young people with high and complex needs
II. Intervening earlier.

Waitemata DHB Child and Youth Mental Health Services - Multi-Agency Strategy
In April 2012, the Child and Youth work stream of the Waitemata Stakeholder Network commenced a project to develop and implement a plan to improve services for children and youth with multiple health and social agency involvement. This assists in meeting the District Annual Plan (DAP) objectives (13/14) and the Prime Minister's Youth Mental Health Initiative expectations.

The following key principles for multi-agency work with children and youth have now been endorsed by the sector reference group. These principles are drawn from and are consistent with the principles developed for Gateway services:

- the welfare, interests and safety of the children and young people are paramount
- act honestly and in good faith
- communicate openly and in a timely manner that ensures understanding and contributes to identification and meeting the needs of the child or young person
- work in a collaborative and constructive manner recognising the different skills and models of practice between different agencies while respecting each agency's responsibilities
- encourage quality and innovation to achieve positive outcomes for children and young people.

The following guidelines for inter-agency initiatives in relation to Waitemata child and youth mental health have been proposed by the reference group:

- There are clearly defined joint governance and leadership structures including an agreed process for conflict resolution
- Adequate lead-in time is given to the establishment phase of any new initiatives
- Practitioners' respective roles and responsibilities are agreed and understood and a common professional language and terminology is agreed and used between agencies
- There is mutual respect, trust and goodwill between agencies and practitioners
- Principles and processes for appropriate safe information sharing are agreed and implemented
- There is agreement between agencies regarding the resources that will be committed to the work (venues, coordination time, etc)
- Where agencies or services have committed to be involved in a multiagency meeting or initiative managers will ensure that there is protected staff/practitioner time to attend to the duties associated with that meeting/initiative
- Outputs and outcomes of the work will be reviewed and monitored.

Auckland DHB Child and Youth Mental Health and Addiction Direction 2013-2023
This Auckland DHB Child and Youth plan is being presented to CPHAC on 27th November for endorsement.

The key actions of this strategy include:

i. **Strengthening the voice**
Authentically engage with children, young people, and their family/whānau who use our services or who may need to use our services.

ii. **Intervening earlier**
- This means we will look at our systems and service design so that children, young people, and their family/whānau can access services early and this will be integrated with primary care and a range of online options.

iii. **Addressing inequalities**
- This means listening to the Maori and Pacific voices to hear what types of services children, young people, and family/whānau would access and designing the services to meet those criteria.

iv. **Fostering Innovation**
- This means we have the opportunity by listening to voice of children, young people, and their family/whānau and taking them on as partners in design and leadership to work innovatively.
- We will do this by investigating and trying new models of care, working with young people to design services, allow them to design and lead services for those with less severe mental distress.
- We will develop new ways to deliver services especially developing online options. This will require us to make decisions on where to invest and where to divest resources so we live within our means.

v. **Workforce**
- This means we will focus on two areas: growing and maintain our workforce so it reflects the diversity of our population. We will also train our staff to understand the cultural diversity of the Auckland DHB population.

vi. **Working better together**
- This means building on the strengths of existing services and developing new services through listening to the voice of children, young people, and their family/whānau.
- Auckland DHB is committed to building on the strengths of existing services and integrating the ways in which children and young people like to work.
- We will continue to work with our colleagues across agencies to improve processes and access to the appropriate services at the right time.

Ministry of Health National Policy and Priorities
A range of recent policy initiatives as outlined below place significant attention on improving multiagency working and getting better outcomes for infants, children, youth and their family/whanau through earlier intervention and better access to integrated service responses.

These include

- The Prime Minister's Youth Mental Health Project 2012
- Multi-Agency drivers
- Better Public Services
- Vulnerable Children
- Health Beginnings: Developing perinatal and infant mental health services in NZ 2011
- MH Commission Blueprint II 2012
- Ministry of Health 'Rising to the Challenge: Service Development Plan' 2013
- Whānau Ora.

Recent Coroner Recommendations

A working group consisting of representation from Child, Youth and Family (CYF) and Auckland DHB / Waitemata DHB Child and Youth has been working together to strengthen the collaboration between services to better meet the needs of youth with complex needs. This work has explicitly responded to the Coroner's recommendations but has not limited to those recommendations.

Activity includes:

- Compiling a register of all current joint agency forums. This includes the development and review of complex care packages and improvements to the way agencies work together.
- A new process for escalating issues requiring resolution to senior staff has been agreed and when there is a particular complex or urgent transition for young persons that needs agreement.
- Agreed improvements to processes for better continuity and co-ordination at points of time of risk for young people i.e. time of transition across services or districts including transition from Youth Justice Residences, discharge from Child and Family Unit, transition to CYF temporary placement and moving across DHB catchments between family members.

4. Priorities for current work on aligned systems and processes

4.1 Multi-Agency Work (Working Better Together)

Implementing agreements made with CYF around improving transitions and escalation processes including revised aligned referral, joint care planning, joint orientation of staff and training for care givers.

Strengthening quarterly management meeting across both agencies for planning and ensuring escalation processes are operating effectively through regular communication in existing forums.

4.2 Service Development for Intervening Earlier

Children of parents with a mental illness/addiction issue (Intervening Earlier)

The leaders of both services are working together to look into the sharing of expertise, training, supervision and the future potential of a merged approach. This service is vulnerable to skill shortage as the service only has one or two people in each area.

Infant and Perinatal Mental Health (Intervening Earlier)

I. Secure Beginnings

Secure Beginnings is a partnership opportunity between Marinoto West and Dayspring Trust to pool resources in order to provide a community based, in-home delivered parent/infant attachment service. It is well underway, with the service being called *Secure Beginnings*. The joint service involves the allocation of a Marinoto Infant Mental Health specialist clinician to work alongside Dayspring Trust to deliver an innovative service targeted for teen parents/infants and parents with mental illness and their infants. The service will utilise the Marinoto West Child Services specialist dyadic assessment room including audio visual recording equipment and will share specialist training and supervision costs.

II. Regional Maternal Mental Health Acute Options

Auckland DHB and Waitemata DHB are currently collaborating with regional partnership on enhancing our options for responding to the acute mental health needs of mothers and infants. This requires developing agreed common clinical pathways and sharing of resources to establish the following services:

- Additional clinical roles in each of the community maternal mental health teams to support community and inpatient acute services for mothers and infants. This includes improved access to residential respite in NGO providers, additional community packages of care to support people in the home (and in respite). They will also provide a regional response for consultation and expert advice to DHB maternity wards out of hours.
- Three new acute inpatient beds based as Child and Family mental health unit at Auckland DHB in the medium term where the mother's mental health needs cannot be met in other environments but can still have the infant with her. Where the mother's mental health needs are so significant that she requires an intensive care environment, she will admitted to her local DHB mental health unit ICU but without the infant and with highly supervised access to the infant if appropriate.

Workforce Development

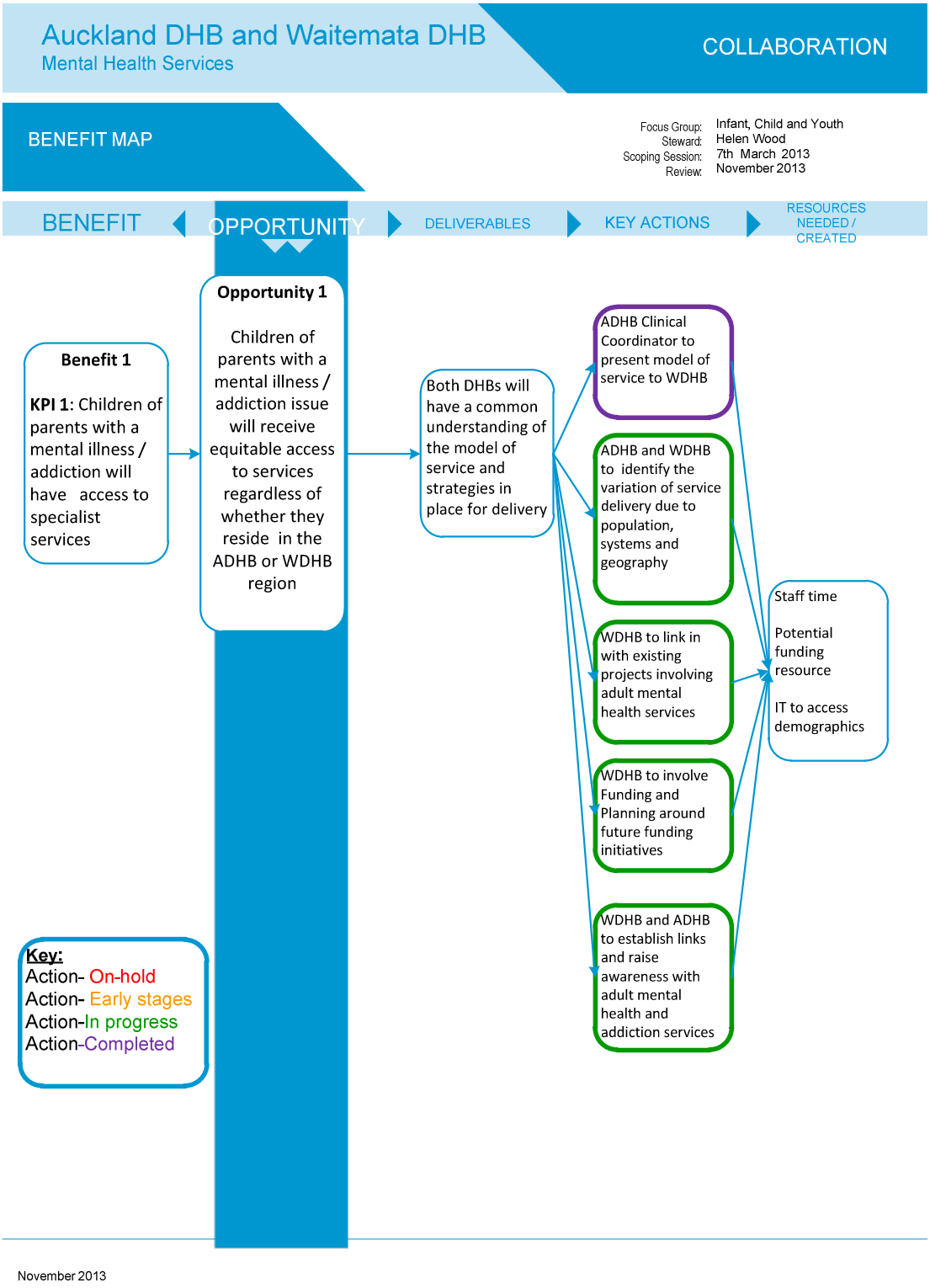
The key on-going pieces of work for both Waitemata DHB/Auckland DHB Child and Youth Services include:

- Intensive Clinical Support Service
- Circle of Security
- Shared internal expertise (shared calendar, shared roles, across service supervision and mentoring).
- Sharing of expertise around supply and demand to better assist in meeting health targets, access and timeliness.

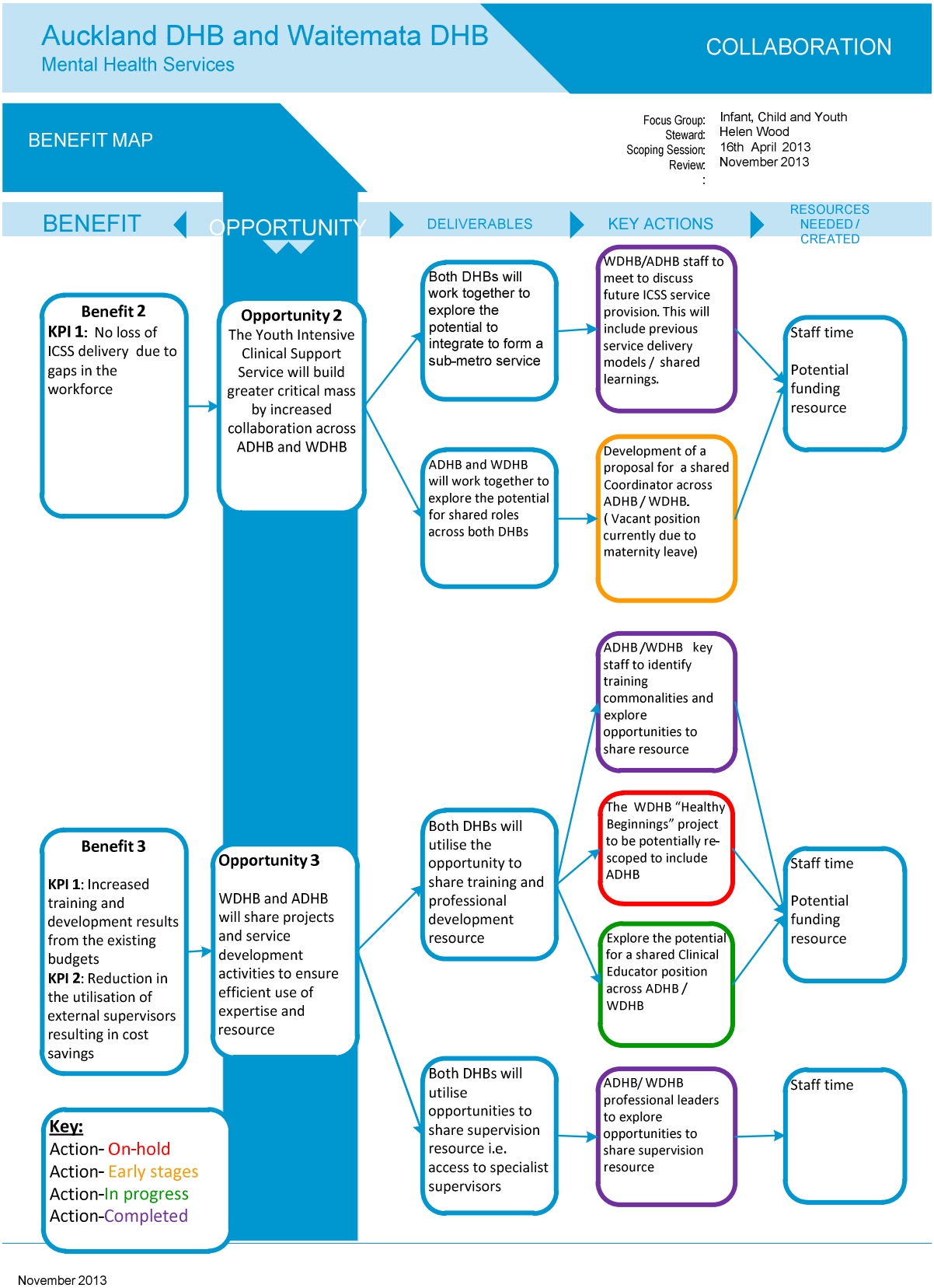
5. Conclusion

This information paper has outlined a range of prioritised approaches that build on current work programmes that assist in the objective of designing common systems and processes across both the Auckland and Waitemata Child and Youth Services. We recommend the committee endorse this approach.

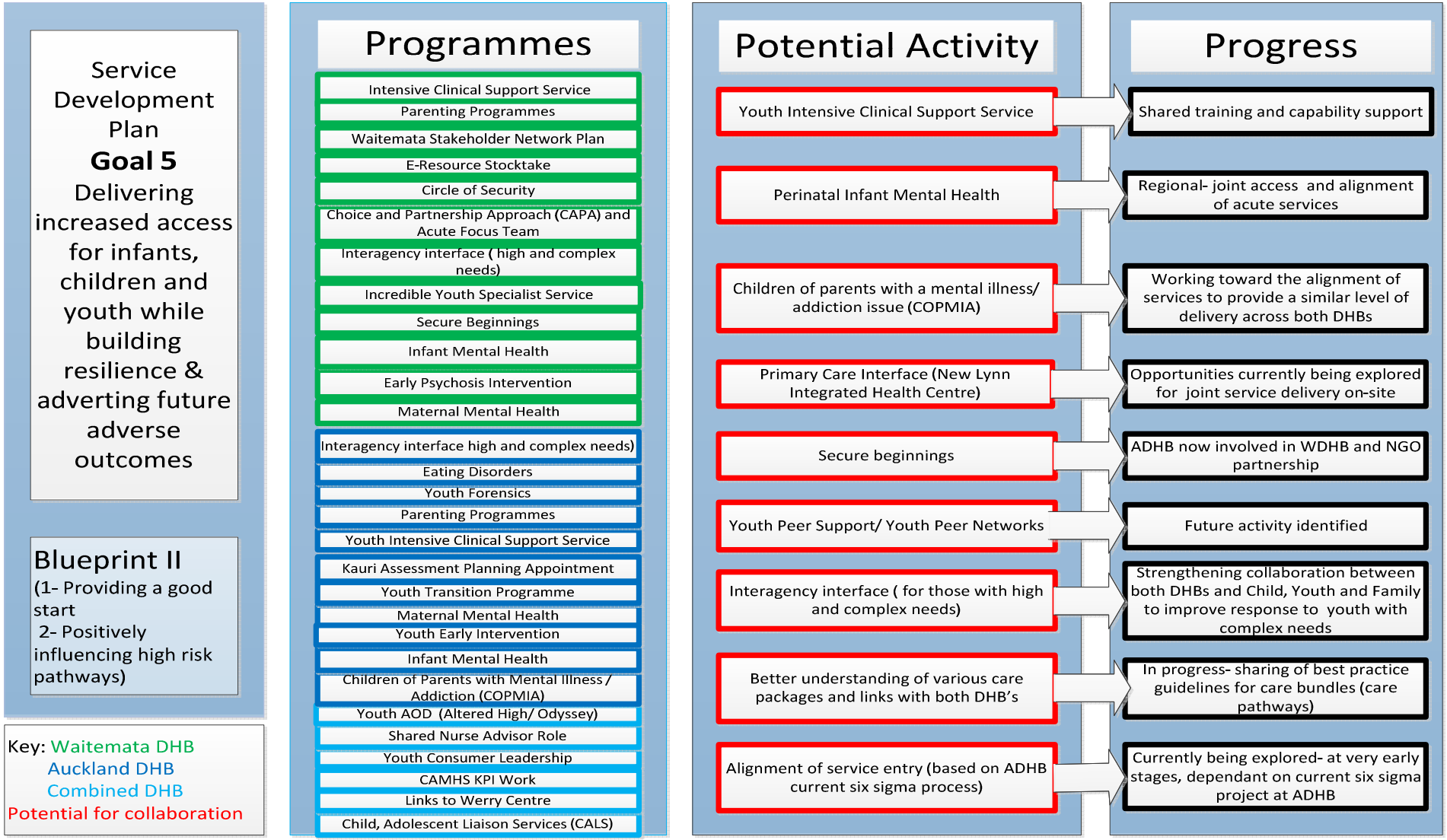
Appendix 1 - Infant, Child and Youth Benefit Map



Appendix 2- Infant, Child and Youth Benefit Map



Appendix 3


Service Development Plan
Goal 5
Delivering increased access for infants, children and youth while building resilience & adverting future adverse outcomes
Blueprint II
(1- Providing a good start
2- Positively influencing high risk pathways)
Key: Waitemata DHB
Auckland DHB
Combined DHB
Potential for collaboration
Programmes
Intensive Clinical Support Service
Parenting Programmes
Waitemata Stakeholder Network Plan
E-Resource Stocktake
Circle of Security
Choice and Partnership Approach (CAPA) and Acute Focus Team
Interagency interface (high and complex needs)
Incredible Youth Specialist Service
Secure Beginnings
Infant Mental Health
Early Psychosis Intervention
Maternal Mental Health
Interagency interface high and complex needs)
Eating Disorders
Youth Forensics
Parenting Programmes
Youth Intensive Clinical Support Service
Kauri Assessment Planning Appointment
Youth Transition Programme
Maternal Mental Health
Youth Early Intervention
Infant Mental Health
Children of Parents with Mental Illness / Addiction (COPMIA)
Youth AOD (Altered High/ Odyssey)
Shared Nurse Advisor Role
Youth Consumer Leadership
CAMHS KPI Work
Links to Werry Centre
Child, Adolescent Liaison Services (CALS)
Potential Activity
Youth Intensive Clinical Support Service
Perinatal Infant Mental Health
Children of parents with a mental illness/ addiction issue (COPMIA)
Primary Care Interface (New Lynn Integrated Health Centre)
Secure beginnings
Youth Peer Support/ Youth Peer Networks
Interagency interface (for those with high and complex needs)
Better understanding of various care packages and links with both DHB's
Alignment of service entry (based on ADHB current six sigma process)
Progress
Shared training and capability support
Regional- joint access and alignment of acute services
Working toward the alignment of services to provide a similar level of delivery across both DHBs
Opportunities currently being explored for joint service delivery on-site
ADHB now involved in WDHB and NGO partnership
Future activity identified
Strengthening collaboration between both DHBs and Child, Youth and Family to improve response to youth with complex needs
In progress- sharing of best practice guidelines for care bundles (care pathways)
Currently being explored- at very early stages, dependant on current six sigma project at ADHB

3.2 Auckland DHB Child and Youth Mental Health and Addiction Direction 2013 - 2023

Recommendation:

a) That the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees receive and endorse this Auckland DHB Child and Youth Mental Health and Addictions Direction 2013-2023.

b) That the Committees recommend to the Auckland DHB Board that the Auckland DHB Child and Youth Mental Health and Addictions Direction 2013-2023 be adopted and implemented.

Prepared by: Hilary Carlile (Planning and Funding Manager Mental Health and Addictions, Auckland DHB), Paul Ingle (Project Manager, Wise Group and Chair of the Working Group) and Helen Wood (General Manager Mental Health and Addictions, Auckland DHB and Waitemata DHB and Sponsor of the Work stream)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ADHB - Auckland District Health Board
DHB - District Health Board
CAMHS - Child & Adolescent Mental Health Services
NGO - Non-Government Organisation

1. Executive Summary

Auckland District Health Board's (ADHB's) Mental Health and Addictions leadership identified that the child and youth services needed to be reviewed and brought into line with current need and more importantly better prepared to respond to future, changing need. It was seen as a multiagency challenge as many of the children, young people and their family/ whanau access services from multiple agencies and hence a multiagency working group was formed in September 2012. This strategy, the associated detail and actions, is the result of this work.

This paper summaries the process and the resulting strategy. The attached document is in two parts: part 1 the Direction and associated Action Plan and part 2 Delving into the Detail.

1.1 Why was this strategy needed?

The facts speak for themselves:

- The incidence of mental illness in young people is now well documented and shown to be the highest of any age group.
- Recently the National Comorbidity Survey Replication in the United States indicated that 75 percent of people suffering from an adult-type mental disorder (including psychosis, substance use, mood and anxiety disorders) had an age of onset by 24 years (Kessler, Bergland, Demler et al, 2005). This makes the issue of youth mental health critical within the community, and its effective management an urgent priority for mental health services (Pat McGorry).

- Maternal and early life mental health and addiction issues are estimated to affect 15-20% of early childhood environments
- Infant mental health issues affect between 16-18% of infants
- Māori infants and whānau disproportionately experience environments and risk factors associated with the development of severe emotional and behavioural problems, for example, low birth weight, low levels of maternal education, parental AOD abuse and pre-existing mental illness
- 16 percent of two-year-olds in the Pacific Islands Families study, a longitudinal study of 1,398 infants born to Pacific families in South Auckland, were in the clinical range for behaviour problems
- 18% of New Zealand children aged 11 are affected by a mental health disorder
- By secondary school 27% of students are affected by depression and anxiety
- Conduct disorders or severe antisocial behavior disorders affect up to 10% of youth and are characterised by aggressive, delinquent and disruptive behaviours. The majority are male
- The prevalence of hazardous drinking exceeds 50% for 18-24 year old males
- The prevalence of cannabis use is approximately 40% for 16-18 year olds
- New Zealand youth are amongst the highest at risk of suicide in the OECD, especially those aged 15-19…….and especially young Maori men
- ADHB investment in Mental Health and Addiction services has focused on Adult services rather than Child and Youth services

Apart from the facts there were clear national drivers influencing the need to look at child and youth services across the health continuum and across agencies.

National drivers are:

- Prime Minister's Youth Mental Health Project
- Blueprint II June 2012 published by the Mental Health Commission
- Rising to the Challenge - the Ministry of Health's Mental Health and Addictions Service Development Plan which DHBs are bound to deliver
- Vulnerable Children's White Paper, 2012, Ministry of Social Development
- Social Sector Trials
- Cross Government initiatives such as Better Public Service
- The aim to reduce long term Welfare dependency by reducing the number of people on a working age benefit for more than 12 months
- Supporting Vulnerable Children
- Boosting Skills and Employment
- Reducing crime
- Improving interaction with Government

1.2 Who – which segment of our population are we talking about?

The ADHB child and youth population is projected to grow at a much slower rate (4%) than the national average (19%) by 2021.
However:

- Within this population the 0-4 (8%) and 5-14 (12%) age group have greater increases than the 15-24 age group (-3%)
- Maori youth aged 5 – 14 are projected to increase substantially
- The Asian ethnic group is the fastest growing group for the ADHB region with a 35% increase in population size by 2021

- There will be twice as many ADHB residents living in an area of deprivation (Q4 or Q5), than those living in less deprived areas (Q1 and Q2)
- There will be substantial variation between Council wards/localities in terms of both ethnic mix and deprivation
- Some Council wards/localities are and will keep growing at a much faster rate.

1.3 How did we do it – the Process?

ADHB undertook a multiagency and across ADHB process to carry out the stocktake of current services, identify gaps and define future actions. The process started in September 2012 and has resulted in this ADHB Child and Youth Mental Health and Addictions Strategy.
Who has been on our Working group?

- Paul Ingle (Chair, Wise group, member of HSGL)
- Helen Wood (GM Mental Health and Addictions ADHB and WDHB, member of HSGL)
- Hilary Carlile (Planning and Funding Manager Mental Health and Addictions, member of HSG, Project Manager)
- Kirsty Fong (Consumer Leader, Affinity)
- Michelle Atkinson (Consumer Leader, Affinity)
- Mike Butcher (Clinical Director ADHB)
- Sarah Wallbank (Service Manager, Kari Centre, ADHB)
- Carol Stott (Children, Youth and Women, Planning and Funding ADHB)
- Fionnagh Dougan (GM Clinical Services - Child Health)
- Alison Leversha (ADHB West Kids Paediatrics)
- Marty Rogers (Manager Maori Health Gains ADHB and WDHB)
- Rose Hawkins (Regional Child Disability Advisor, MSD)
- Nigel Kapa (Regional Youth Development Officer, MYD)
- Jennifer Leigh (Regional Relationship Manager, FACS)
- Angela Drake (Social Development Manager, Work and Income)
- Marilyn Mitchell (Regional Manager Ministry of Education)
- Grant Malins (Regional Manager, Ministry of Education)

As part of the process we consulted with the following stakeholders:

- Young people
- Maori youth
- Maori involved in providing services to Maori youth
- Pacific youth
- Pacific health professionals
- Rainbow youth
- Family Whanau
- Asian health professionals
- Clinical teams – Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services
- ADHB funded Non Government Organisation (NGO) providers of mental health and addiction services to children and young people
- Interagency partners including MSD, Police, Education, Housing and Council

1.3.1 The Process

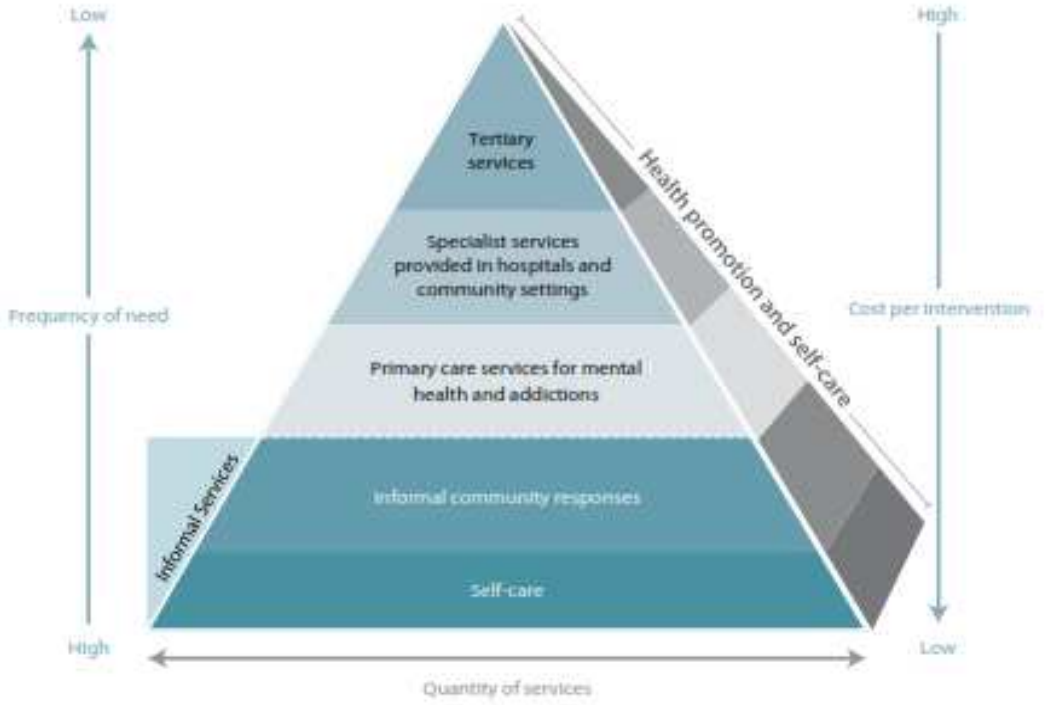
The process started with the collaborative interagency process to identify all the current services and resources available to young people between the ages of 0 and 25. For ADHB services we also collected access rates and wait times. Part of this process was understanding

what each agency meant by their service definitions and when and how they could be accessed and by whom. Consumer leaders were an integral part of the process.

The decision was made to use the Blueprint II first four life courses as a way of grouping the children and young people. The age range was extended to 25 from 18 to work in with our other agencies (as time went on this provided a wise extension). They are:

- Families and Whanau at risk – includes -1 to 3 years, pregnancy, post natal, maternal, infant well being and parenting)
- Children with mental health and behavioural problems – less than 12 years
- Youth/ adolescents with emerging mental health, behavioural and addiction issues – 12-25
- Youth/ adolescents at high risk (including forensic).

The decision was also made to use the stepped care model in Blueprint II to try and group the services.

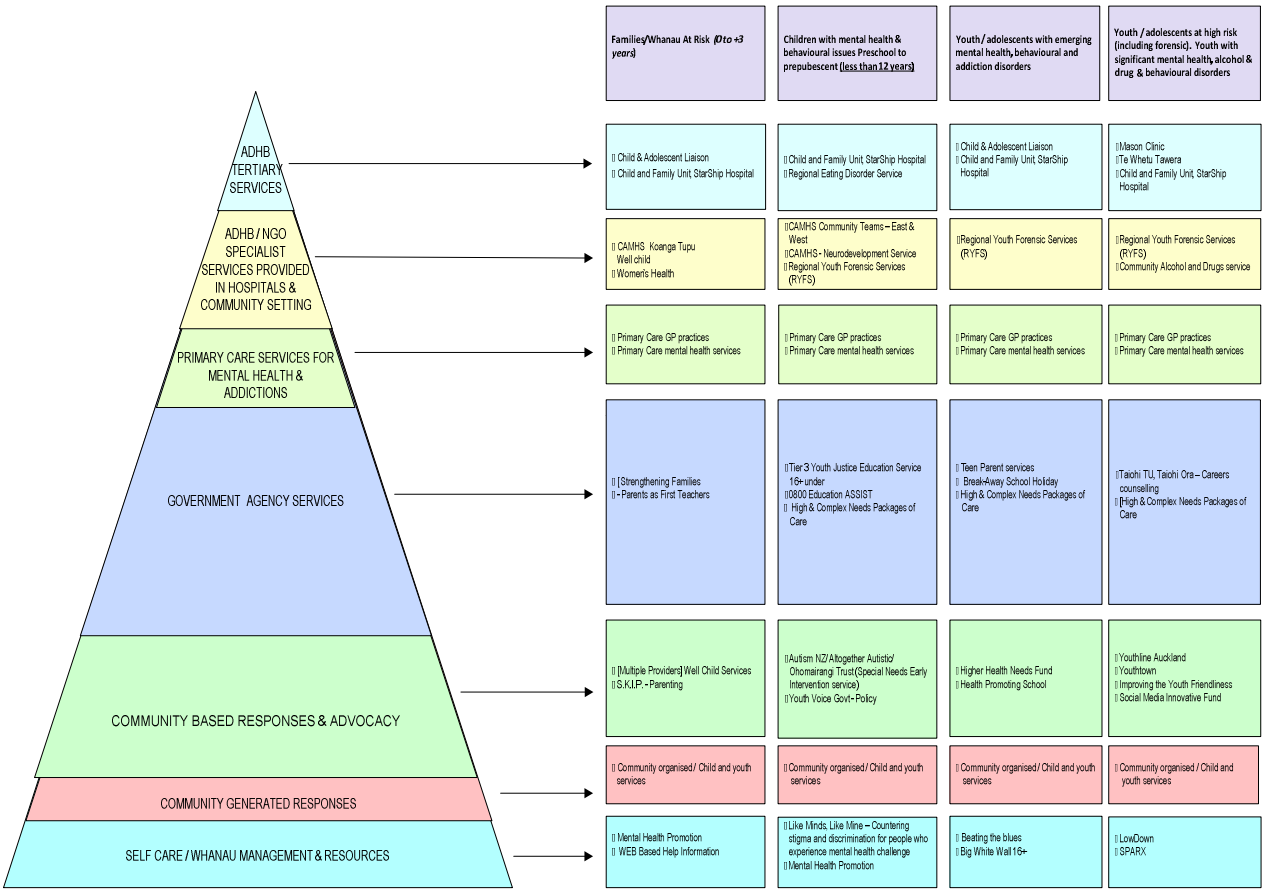


Source: Adapted from the World Health Organization.[1]

Vigorous discussion took place as the group worked to understand each other's services and fit them into the life course approach and the stepped care model. The result was an expanded stepped care model and a greater understanding of each other's services.

Services available to child, youth and families to address mental health and general wellbeing provided by both ADHB and other agencies – the high level

An **INDICATIVE** range of the services for each life course



The detail for each life course is in the detailed document – "Delving into the detail".

The next step was to identify the gaps. Again this was done as a group but also we carried out a wide range of consultations to hear young people and clinical views and concerns on the services and the gaps.

This was also informed by government policy documents and models from overseas – both of these helped inform our view of the gaps. Six areas were identified as gaps.

- Strengthening the voice
- Intervening earlier
- Addressing inequalities
- Fostering innovation
- Workforce development
- Working better together

The final step was to identify the concrete actions we could take – this was done again as a group. For each of the gaps actions were defined.

1.3.2 Our Vision

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

1.4 What does this mean?

Children, young people and families feel:

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

2. Actions

Strengthening the voice

- This means authentically engaging with children, young people and their whanau in the co-design of a truly effective, responsive system, services and model of care.

Intervening earlier in life course and early when there is a need

- This means orientating our focus to the critical early years ensuring fewer children and young people go on to need adult mental health and addiction services later in life. This means we may need to disinvest in other parts of the system.

Addressing inequalities

- This means listening to the voice of Maori and Pacific to truly understand what types of responses are needed to ensure health literacy increases, self directed care becomes more possible and organised mental health and addiction services truly meet need.

Fostering innovation

- This means sharing and learning from our successes as well as listening to the voice of children, young people and their whanau; taking them on as partners in design and service leadership.

Workforce Development

- This means growing and developing our workforce beyond the traditional roles we have now.
- This is about having the right staff, with the right skills and experience, in the right place at the right time.
- It is about knowing when to seek advice from more appropriately skilled staff when children and young people present with complex issues.

Working better together

- This means building on the strengths of existing effective services
- This also means working better with our colleagues across agencies to improve care pathways and access to the right services at the right time
- As well as ensuring the workforce reflects the diversity of our changing population.

The detailed actions are found in both the strategy document and the detailed document.

The Integrated Child and Youth Mental Health and Addiction Direction **2013-2023**

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

"We need to learn that having emotions and talking about them can and should be the norm"

By secondary school 27% of students are affected by depression & anxiety

"We want to have a say in our well being while under the care of mental health workers"

"We need role models and promotion: "so we know where to go, and we don't need to be in crisis first. Also there needs to be more exposure in the mainstream media"

18% of NZ children aged 11 are affected by a mental health disorder

Maternal mental health & addictions issues affect 16% of women

Same sex attracted youth 5 x more likely to attempt suicide than opposite sex

"We do not want to go through doctor after doctor after doctor"

"We need services that support our diversity"

"We need tools that help us look after ourselves"

The greatest growth in prevalence is between the ages of 15-18 which peak at 29% for mental health distress and 7% for serious disorders

"We need services that are easier to access"

Prevalence of hazardous drinking exceeds 50% for 18-24 year old males

NZ Youth are at highest risk of suicide in the OECD especially 15-19 years olds

Maori male living in deprived areas highest rate of suicide

Maternal & early life mental health & addiction issues are expected to affect 15-20% of early childhood environments

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

TABLE OF CONTENTS

1. The Integrated Child and Youth Mental Health and Addiction Direction 2013-2023
2. Delving into the detail
3. Getting started

The first section of this document provides a summarised overview of the direction. The second provides a more comprehensive understanding of what has helped inform the direction.

1. OUR CHALLENGE

Increasingly we are hearing that:

1. Some children and young people are facing significant challenges in terms of mental health, addiction and behavioral challenges or a combination of all three
2. More, better and integrated services are needed if we're to meet the challenge, especially services that support resilience and intervene earlier when problems emerge
3. Young people want a greater say in how services are designed and delivered. They expect services to be more diverse, contemporary and responsive
4. While the overall population of children and young people will not increase much over the next ten years within the ADHB boundaries; for us the greater challenge will be the changing mix of ethnicity, areas where young people and children live and the predicted types of services that will be needed
5. We need to broaden the traditional 0-18 years age range to 0-25 years to align with our interagency partners. This will also include the years that young people transition to adulthood which are particularly crucial
6. Services for children and young people have been developing at a much slower rate than adult services. The focus must now shift if we're to see fewer young people go on to need adult mental health and addiction services
7. It is critical we get the interface between the health, social and education sectors working more effectively so services know the pathway to the right door. In doing so we have a far greater chance of meeting the challenges experienced by children and young people and their experience is that any door is the right door.

2. OUR VISION

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

What does this mean?

Children, young people and families feel:

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

3. OUR THINKING?

People have shaped our thinking

- The voice of children and young people
- Family/whanau
- Maori
- Pacific
- Asian
- People who shape and provide services.

Policy has shaped our thinking

Local

- This is a key priority area for ADHB mental health and addictions services over the next five to ten years
- ADHB's Child Health Improvement Plan 2012-2017 and the ADHB Youth Health Improvement Plan was available for consultation and comment in 2012
- ADHB has just released a discussion paper on self directed care which is being implemented
- ADHB is working with communities to determine future health needs and to inform the provision of services.

Regional

- Regional mental health and addiction services planning
- Strengthening our response to address the needs of maternal, early years and infant mental health and children of parents with mental illness
- Improving access for young people to Community Drug and Alcohol treatments
- Better access to youth forensics services

National

Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand 2011

Healthy Beginnings provides guidance to district health boards (DHBs), and other health planners, funders and providers of perinatal[1] and infant mental health and alcohol and other drug (AOD) services, on ways to address the mental health and AOD needs of mothers[2] and infants.

1 The term **perinatal** means relating to the period immediately before and after birth. The internationally accepted timeframe is from pregnancy to one year postpartum.

2 Throughout *Healthy Beginnings* the term **mother** is used for the simplicity as mothers are most mothers are most commonly in the role of primary caregiver for their infants. However, fathers, grandparents, adoptive parents, foster parents and others may also undertake this role and may access services if eligible.

The Prime Minister's Youth Mental Health Project April 2012

The project aims to significantly improve the way the Government supports young people with mild to moderate mental health problems. These include measures ranging from increased school based health services, more youth workers in low decile schools, expanded primary mental health services, e-therapy tools and social media, one stop youth health shops and importantly reviewing how well services are integrated across the different settings and making recommendations for improvement.

New Zealand Suicide Prevention Action Plan 2013 – 2016

This is an across government action plan, bringing together the work of eight agencies. This plan strengthens support for family, whanau and communities to address the impact and build the evidence base around what works, specifically for Maori and Pacific people. The plan extends existing services, strengthening suicide prevention targeted to high risk populations.

The Mental Health Commission's Blueprint II, 2012

The Blueprint II vision "mental health and wellbeing is everyone's business" sets the stage for a future where everyone plays their part, recognising mental health and wellbeing plays a critical role in creating a well-functioning and productive society. Additionally Blueprint II introduces a 'life course' approach from before birth through to older people and looks at the critical points in the development of mental health, addiction and behavioural issues where we can intervene earlier and more effectively.

The Ministry of Health Service Development Plan "Rising to the Challenge" 2013

Rising to the Challenge sets out the Ministry of Health's (MOH) plan for the direction of mental health and addiction service delivery across the health sector over the next five years. It articulates the Government's expectations about the changes needed to build on and enhance gains made in the delivery of mental health and addictions services in recent years." This plan was informed by Blueprint II. Rising to the Challenge focuses specifically on intervening earlier in the lives of young people in order to strengthen their resilience and avert future adverse outcomes.

The Ministry of Justice Youth Crime Action Plan 2013 – 2023

This is a ten year plan to reduce crime by children and young people and help those affected to turn their lives around.

Whanau Ora

Whanau Ora provides an intra and inter- sectorial strengths –based approach to supporting whanau to achieve their maximum potential in terms of health and wellbeing during their interaction with health services. It provides a catalyst for improving the capability of health providers and hospital – based services to deliver high quality, integrated and responsive services to whanau and communities they live in.

Other

Other key NZ government strategies and policy documents that impact children and youth and the determinant of health, including such policy documents as the Child Action Plan, the Youth Development Strategy 2002 and the work of the Children's Commissioner Advisory Group.

Align with Better Public Service Targets

The key areas are:

- Reducing long-term welfare dependence
- Supporting vulnerable children
- Boosting skills and employment
- Reducing crime
- Improving interaction with government.

International

We have learnt from others experience of working in a different way both from our New Zealand colleagues, including child and youth strategies from other DHBs, and from our international colleagues. The overseas work that has particularly influenced this direction includes the Ontario's Ministry of Children and Youth Services, Reachout.com and headspace Australia. Overwhelmingly the evidence points to youth involvement in design and leading of services, more evidence based psychological interventions to address mild to moderate mental distress and addictions, development of e-therapies and a strengthening of agencies working together.

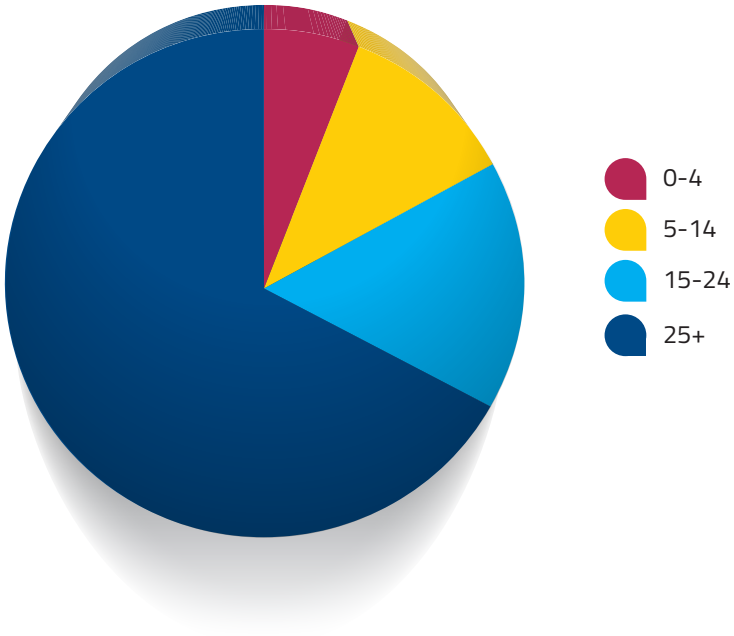
Partners have shaped our thinking

Central and local government and NGOs; as well as other parts of health were around the table during this process. We will continue to work with our partners. Our stakeholder engagement process included young people, Maori, Pacific, Asian, NGO providers, child, youth and adult health services.

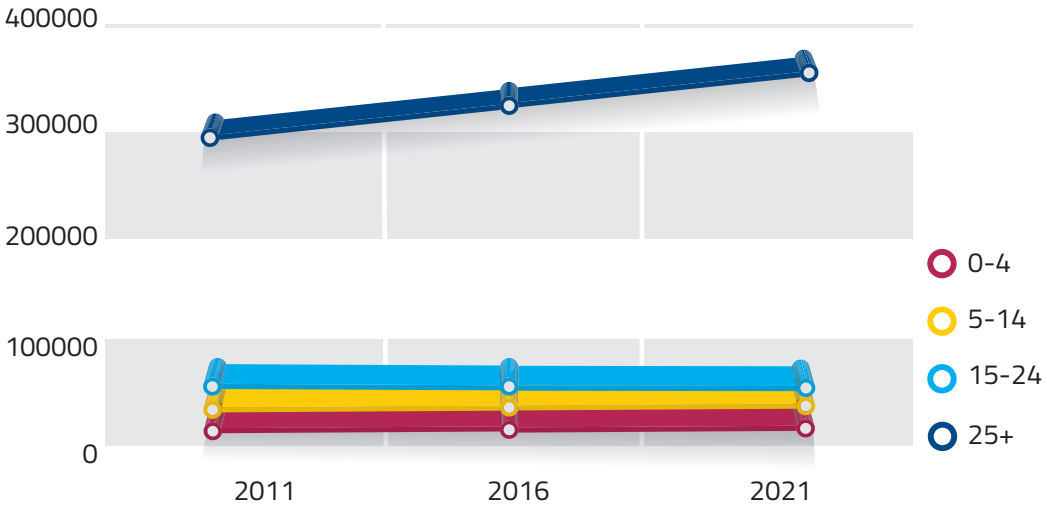
4. OUR POPULATION

The whole of Auckland is expected to grow faster than the rest of New Zealand over the next 10 years, and the ADHB population is no exception. While the overall population of children and young people won't increase materially over this period we will see a significant change in their ethnic mix, where they live and deprivation rates. The youthful Asian population is predicted to increase three times faster than other ethnicities over the next ten years. The Asian population is predicted to move to the western wards while the Maori and Pacific population are predicted to move to the southern wards. The diagrams below help illustrate that. This analysis is based the statisticians best guess using the 2006 Census data from the NZ Department of Statistics. It is expected that the results of the 2013 census will change the patterns.

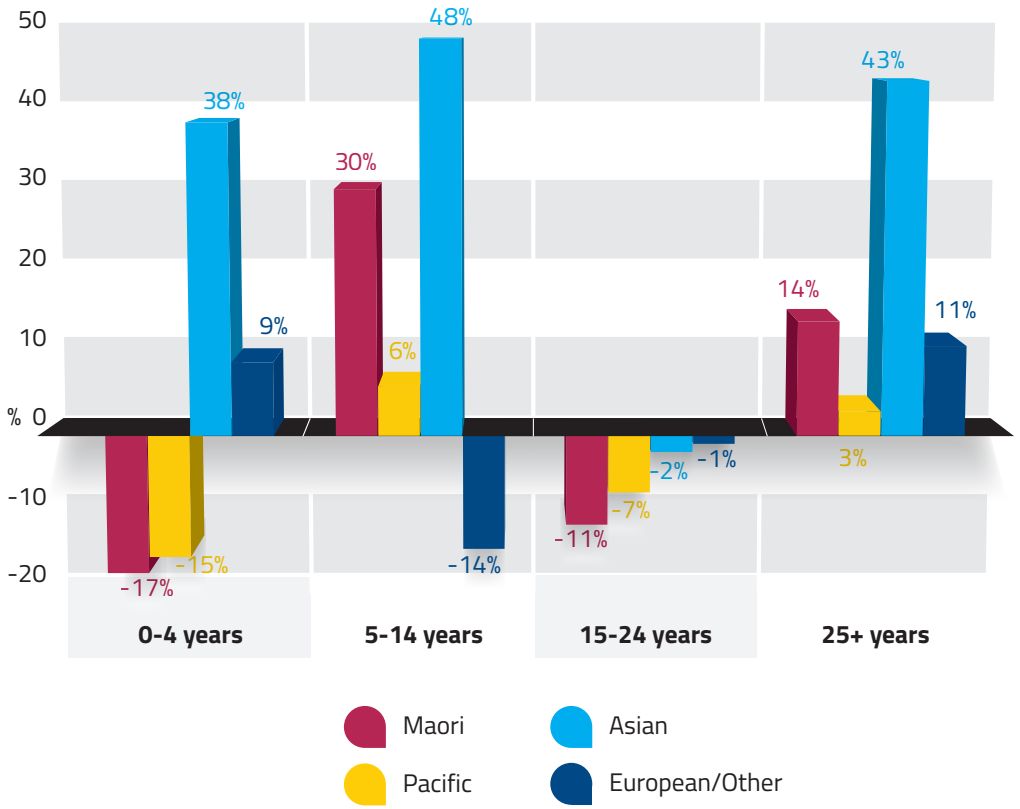
ADHB population age breakdown (2011)



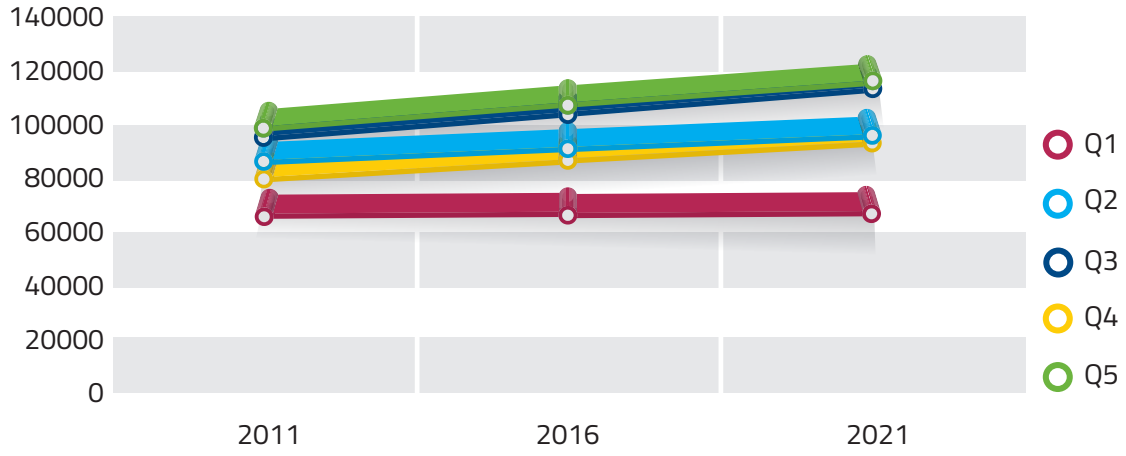
Projected population growth by age group (2011-2021)



Projected changes in ethnic mix of ADHB age groups (2011-2021)



Projected ADHB population growth by deprivation quintile (2011-2021)



Note: The higher the quartile the poorer the area. So quartile 5 are the poorest areas and quartile 1 are the least deprived.

In summary we will see:

- Our overall populations aged 0-25 will not increase significantly
- Increase in ethnic mix specifically with a predicted increase in the number of young Asians
- The areas they live in will change.

5. OUR INTENTION

Design

- In partnership with children, young people, families and providers we will develop a cohesive and measureable action plan that sits alongside this direction.
- Together we will design an improved model of care that focuses on building greater personal resilience and support for young people.
- We will develop a more responsive system to intervene earlier in the life course of children and young people.
- We will develop a range of more contemporary and diverse mental health and addiction services.
- We will make changes to service provision to address our increasingly diverse ethnic mix.

Deliver

- We will deliver on our promises in the action plan and ultimately our vision in partnership with children, young people, families and providers.
- This means we must be courageous when investing in the new, recognizing this may mean disinvesting in some of what we offer now that no longer best meets the needs.
- We must build on our existing partnership with the social and education sectors to ensure we deliver a more integrated and responsive system to children, young people and families.
- To deliver on our vision we must also partner with other agencies and groups and the community itself, ensuring more children and young people get a better start in life.

What does this mean?

We have to change…

- **The way we plan things**
  We need to genuinely listen to what children, young people and family have to say about the services they need, as well as how and where they want to access them.
- Co-design must become the new norm and not the exception.
- **The way we do things**
  We need to provide more timely service and support. We will draw on the expertise of a more diverse workforce and do things in a way that children and young people relate to.
- Ultimately we must do things in a way that children, young people and their families feel more in control.
- With children, young people and their family/whanau we will review and establish health and interagency care pathways and shared care protocols as a priority.
- Due to complexity of need, the services will do the linking to ensure there is an easy process to get to the right door.
- **Where we do things**
  While face to face support and service is really important, we need to recognize and respond to children and young people's reality of also living in the virtual world and direct resources there too. In particular, we need to focus on things that enable young people to build personal resilience through self-directed learning.
- **Who we work with**
  We can't meet the challenges alone. Beyond working in partnership with children, young people and their families, and our partners in the social and education sector agencies. We also need to find ways of partnering with other organisations, iwi and groups, including the wider community who have a vested interest in seeing more young people get a better start in life. When we do that we have a far greater chance of achieving our vision.

6. OUR APPROACH

Recognition

- Draw attention to the challenges faced by children and young people
- Through the approval of this direction by ADHB and the endorsement of it by our partners we will drive change.

Action

We will meaningfully engage with youth and children in active co-design to create a more detailed action plan with our multiagency governance group, focused on things like:

- virtual services and resources
- youth designed and developed services
- stepped care and early intervention services.

Partnership

We will seek to partner with:

- children, young people and their family/whanau
- mental health and addiction providers
- other health services
- primary care providers
- social and education sector agencies
- other government agencies – central and local
- Iwi
- community organisations and groups and the wider community
- Director of Vulnerable Children and Child Action Teams.

Structural

We will:

- invest where changes need to occur over the next five to ten years
- make the best use of our skilled and capable workforce, ensuring the right part of the workforce is doing the right thing at the right time, and
- be courageous in disinvesting where services no longer best meet need.

System

We will:

- build on the strengths we have within our child and youth mental health and addiction services
- develop an improved model of care for child and youth mental health and addiction services
- better demonstrate the links to primary care
- work better together with key agencies and in doing so ensure a more integrated and responsive system where the services can do the linking to ensure children, young people and whanau get to the right door
- stimulate innovation in the virtual and electronic world of service provision to extend our reach and impact, and
- use known partnership approaches and models, like Whanau Ora and youth leadership, to improve all we do.

7. WHAT IS THIS GOING TO LOOK LIKE

The future model must place the child or young person, and their family and whanau, at the centre, and provide a more diverse range of responsive options that are orientated towards the community end of the continuum.

Our Principles are:

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

8. GETTING STARTED

Strengthening the voice

This means authentically engaging with children, young people and their family/whanau who use our services or who may need to use our services.

Intervening earlier in life course and early when there is a need

This means we will look at our systems and service design. So that children, young people and their family/whanau can access services early there will be a range of e-therapy and primary care services.

Addressing inequalities

This means listening to the Maori and Pacific voice to hear what types of services children, young people and family/whanau would access and designing the services to meet those needs.

Fostering innovation

This means we have the opportunity to work innovatively by listening to the voice of children, young people and their family/whanau and taking them on as partners to design and leadership.

We will do this by investigating and trying new models of care, working with young people to design services, and allowing them to design and lead services for those with less severe mental distress. We will develop new ways to deliver services especially developing the electronic and virtual world. This will require us to make decisions on where to invest and where to divest resources so we live within our means.

Workforce

This means we will focus on growing and maintaining our workforce so it reflects the diversity of our population. Also we will train our staff to understand the cultural difference and practices of our diverse population.

We will develop our workforce so that we have the right people with the right skills in the right place at the right time.

Working better together

This means building on the strengths of existing services and developing new services through listening to the voice of children, young people and their family/whanau.

ADHB is committed to building on the strengths of existing services and integrating the ways young people and children like to work.

We will continue to work with our colleagues across agencies to improve process and access to the appropriate services at the right time.

9. HOW WILL WE KNOW WE ARE GETTING THERE?

Now

Current data, detailed in the section "Delving into the Detail" provides us with a current view but it is not a picture that reflects the data needed to measure the success of this direction.

The data being recorded for the child and youth mental health and addictions KPIs and the improvement in primary care data will make a big difference. In addition the results of the 2013 Census will give an indication how useful the population projections are. A way will be found to include relevant data from other agencies.

In future

Experiential

Through engagement with:

- **Children and young people**
  ADHB will engage with children and youth utilising a youth development participation model. We will further develop our child and youth forums.
- **Family and whanau**
  We will utilise existing ADHB family/whanau forums.
- **The community**
  ADHB will engage with communities and develop local health partnerships.
- **People providing services**
  ADHB Mental Health and Addictions service has an existing structure for engagement with both their clinical staff and the social and education sector. These forums will continue to be used for clinical and health sector engagement.
- **Our partners**
  Other agencies and providers will be engaged through existing forums.

Hard data

- We will agree a common set of outcomes to be achieved by 2018, both client directed and clinical
- Monitor access rates to child and youth specialist mental health and AOD services
- Collect and better understand the circumstances by which 18 – 25 years old are accessing child and youth mental health addiction services compared to that same age range accessing adult services.
- The spread of our investment
- Access and wait times for different segments of our population
- Wait times reported separately for mental health and AOD services
- Increase in the number of mental health clients of working age in employment
- Demonstrate the shift in resources to reflect this direction
- In the future it will be easy to combine data across the health, social and education sector agencies reflecting the whole continuum.

Evaluation

- We and our partners **will** show we are working in a more integrated way
- System changes will be evaluated to determine if the outcomes are being delivered
- We will produce an online report card.

10. ADHB Child & Youth Mental Health & Addictions Action Plan 2013 -2023

Opportunity	Benefits/ KPIs	Deliverable	Key Actions	Timeline
1. Strengthening the Voice				
Services are seen as more accessible and responsive by children, young people and their families	KPI 1: Improved access to: · Specialist Services · On-line tool resources · Primary care · School · Self referral clinics	Processes and opportunities are established for children, young people and their families to influence the service framework as well as the co-design of and peer-lead services and the evaluation of services	Establishment of Youth Leadership initiative and other appropriate forums	14/15
	KPI 2: 95% of children, young people and their families report satisfaction regarding their ability to influence services		Youth Leadership initiative/ Youth forums to report into strategic networks e.g. Health Services Group	14/15
	KPI 3: Establishment of Youth Leadership initiative		Establish on-line opportunities for real-time feedback – linking with ADHB projects & MH Commission	14/15 ongoing
	KPI 4: 95% of Young people, children and family/ whanau report satisfaction with services		Young people to contribute to the in-service training for clinicians	14/15 ongoing
	KPI 5: Young people are active partners in the evaluation of all Child and Youth Mental Health & Addiction services		Establish standards for choice and partnership between young people/ whanau and mental health and addiction workers	14/15
			Establish links to on-line peer support initiatives	14/15 ongoing
			Young people and family/whanau are involved in service evaluation	14/15 ongoing
			Work in partnership to strengthen existing processes to hear the voice of young people, children and family/ whanau	14/15 ongoing

			Work with young people, children and family/whanau to develop signposts to navigate services	14/15 ongoing

Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific

2. Intervening Earlier

There will be a decreased incidence of mental health & addiction issues later in life	KPI 1: Reduced demand on Specialist services	There are clear mechanisms and a skilled workforce to provide screening and early identification for: · Pregnant women · At-risk families · Children of parents with mental illness and addictions (COPMIA) · At risk infants and children · At risk youth and young adults	Agreement from key agencies/ providers regarding the implementation of screening within existing age-related health checks	14/15 and fully implemented 15/16. Reviewed 16/17
	KPI 2: Better range and access of services		Agreed pathways regarding clinical management	14/15 pathways reviewed and implemented. 17/18 better range & access evidenced
	KPI 3: Earlier access to services		Agreed set of age-related screening tools. This will be implemented alongside the training of workforce	14/15 and fully implemented 15/16
	KPI 4: Achievement of all screening targets			
	KPI 5: Fewer young people and families experience a Mental health and Addictions emergency that is distressing.			
	KPI 1: Reduced demand on Specialist services	There will be increased access and early response	Better promotion of existing resources for self-management using social media as a primary means to connect with young people & families/whanau	14/15 ongoing

Opportunity	Benefits/ KPIs	Deliverable	Key Actions	Timeline
2. Intervening Earlier (continued)				
			Increased range of options for self-management e.g. on-line resources and social media	14/15 ongoing
			Resilience programmes in schools e.g. Prime Ministers Youth Mental Health Project	14/15 ongoing
			Positive parenting	14/15 ongoing
Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific				
3. Addressing Inequalities				
To increase Mental health & Addiction literacy of young Maori and Pacific, their families and whanau and reduce stigma and discrimination	KPI 1: Number and mix of people attending MH101	Delivering health literacy training face to face or on-line by Maori & Pacific for Maori & Pacific children & young people	Develop or source culturally appropriate material that is available to use in a variety of settings	14/15 develop and fully implemented 15/16
	KPI 2: De-stigma programme for Maori & Pacific young people by Maori & Pacific using social media as a vehicle within two years		Access to learning opportunities made readily available in a variety of settings and formats e.g. courses or short sound bites	15/16
	KPI 3: Percentage of existing & new health initiatives include culturally appropriate content		In partnership with agencies e.g. La Va ensure young people are appropriately trained or sourced to deliver the material	14/15
	KPI 4: Survey Maori, Pacific and other vulnerable groups of young people to establish their access to services and the service effectiveness		Each learning opportunity includes a feedback cycle which will inform future delivery & content of materials	14/15 ongoing
			Aligning with the actions in Working Better Together utilising materials and programmes that are relevant and initiated by other agencies	15/16

Ensure the unique societal structures, primarily in Maori and Pacific communities and the place of religion do not act as a barrier to access services	KPI 1: Increase the access rates for Maori and Pacific and other minority groups to match national targets for: · Specialist services · On-line tools resources · Primary care · Schools · School referral	Data collected to accurately measure access	Work to improve quality of PRIMHD data and include Primary Care, HVAZ and Kaupapa Maori and student health services	14/15 ongoing
Service to be more responsive to Maori & Pacific	KPI 1: 95% of children, young people and their families report satisfaction with services	Increase in satisfaction level with services	Implement Mental Health Commission's real time service assessment	14/15
	KPI 2: 95% of children, young people and their families report satisfaction regarding their ability to influence services		Utilise feedback from consumer satisfaction survey & general feedback to improve general responsiveness	15/16
4. Fostering Innovation				
Children, young people and their families/ whanau will directly benefit from a culture of innovation and new approaches	KPI 1: Number of new e-health initiatives that improve access to seeking help/ support	Experiment with different technologies that remove barriers and improve access to those seeking help/ support	Proactively link with national child & youth e-health related initiatives	14/15
	KPI 2: Percentage on-line service hits		Develop resource of e-self-help tools / resource links	15/16
	KPI 3: Number of learning events held and feedback		Establish links to on-line peer support initiatives	14/15 ongoing
	KPI 4: Number of new contracting models evaluated and trialled			
		Create an annual learning symposium (regional)	Link with other regional child & youth mental health networks	14/15 ongoing
			Link with Werry Centre and other groups to explore the opportunity to support at least three learning events over the next 2 years e.g. RCAMHS	15/16

Opportunity	Benefits/ KPIs	Deliverable	Key Actions	Timeline
4. Fostering Innovation (continued)				
			We will link into virtual learning networks in this field	14/15 ongoing
		Explore models for contracting that support innovation, strengthen outcomes and enables a partnership approach	Identify appropriate contract models e.g. results based accountability or social bonds	15/16
			Partner with other health & social care agencies to identify joint contracting opportunities	15/16
			Different models are trialled and evaluated	15/16 trial, evaluation concludes 17/18
Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific				
5. Workforce Development				
The lived experience of children, young people and families/whanau is a valued contributor to personal resilience and recovery, peer support and other forms of help and treatment	KPI 1: Year on year growth in peer support roles	Increased opportunities for employment and peer support for those with lived experience	Establish a workforce plan for peer support	14/15
	KPI 2: Percentage of people in workplace with identified lived experience (whole workforce) through an annual anonymous survey		Actively work with Werry Centre to develop peer support training	14/15 develop. 15/16 deliver
	KPI 3: All job descriptions include a lived experience as desirable		Work with funding & planning to explore employment opportunities for young people	15/16
	KPI 4: Training & orientation to include peer support experience	Lived experience is reframed as a valuable life skill base for resilience recovery, service planning & provision	Provide more training opportunities for primary care, nursing/ medical training programmes	15/16 ongoing

	KPI 5: Number of staff trained in the use of virtual tools		Work with training providers (internal) & under/ post graduate providers	15/16 ongoing
	KPI 6: Number of staff with cross agency experience		Establish youth and family reference groups	14/15
	KPI 7: Annual workforce profile reflects population diversity both cultural and age		Reinforce self / whanau directed care	14/15 ongoing
There is a workforce that has the skills mix and diversity that is sustainable into the future. It is confident to work fluidly across organisational boundaries and with virtual tools		Workforce plan is developed and implemented that reflects future workforce requirements and Health Workforce New Zealand's national plan	Implement a workforce plan that includes: · Definition of potential shift in workforce required to meet the diversity of our population · Definition of who does what and where so we work in different ways and in different places · Confirmation of role of young people with lived experience in relation to in-service training for staff · Across agency and continuum work experience · Increasing skills and use of on-line tools · Reflection of youth and cultural diversity / identity · Orientation and internship programmes that prepare and equip staff to know how they can contribute to address our key six priorities	14/15
			Develop staff skill mix so that the core set of competencies enables us to have "the right staff at the right place at the right time with the right skills"	14/15 develop, fully implemented 16/17
Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific				

6. Working Better Together

The whole system works together to improve process and access for children, young people and their family/ whanau to the appropriate services at the right time	KPI 1: Track number of agreed multi-agency shared plans	There will be agreed referral pathways for various levels of need - especially those with high need and multi-agency involvement	Establish a working group between ADHB, WDHB, MSD & Education for multiagency referral / pathways and discharge/ transition	2013/14
	KPI 2: Reduced wait times for reaching agreed shared care plan		Use existing coordination processes more effectively e.g. Gateway and Strengthening Families	2013/14
	KPI 3: Agreed referral pathway		Joint care planning and prioritisation for those with high need and multi-agency involvement	2013/14
	KPI 4: Annual sample audit of shared care plans	Whanau ora initiatives will be used as basis for the whole family approach	Links will be strengthened with ADHB Whanau ora initiatives and Pacific & Maori Health Plans	14/15
			Joint care plan & prioritisation for those with high need and multiagency involvement	14/15 ongoing
		Whole of system resources and contacts are well understood by all agencies so for the public "any door is the right door"	Clear list of stakeholders and key contact points	14/15 ongoing update
			Use of web-based tools to assist in linking with services and referral pathways	15/16
			Strengthening of consult liaison services form ADHB Child & Youth Mental health	14/15 ongoing

	Services know how to navigate these services rather than the young people or family/ whanau needing to know	14/15 ongoing
	Learn from, and where appropriate participate in initiatives started by our agency partners or from overseas	15/16
Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific		

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

www.adhb.govt.nz

Draft
Part 2
DELVING INTO THE DETAIL

1. OUR CHALLENGE - THE DETAIL?

The transition to adulthood is the period during which nearly all the potentially serious mental disorders that disable or kill during the ensuing decades of adult life have their onset. Pat McGorry Schizophr Bull. 2011 May; 37(3): 524–530

Recently the National Comorbidity Survey Replication in the United States indicated that 75 percent of people suffering from an adult-type mental disorder (including psychosis, substance use, mood and anxiety disorders) had an age of onset by 24 years (Kessler, Bergland, Demler et al, 2005). This makes the issue of youth mental health critical within the community, and its effective management an urgent priority for mental health services

The mental health of young people in transition from childhood to adulthood has been steadily declining over recent decades.

The incidence pattern for mental and substance use disorders is now almost the mirror image of that seen for physical disorders, with 75% emerging before the age of 25 years and emerging adults (16–24 years) showing the peak 12-month prevalence for any disorder across the lifespan.

Mental ill-health is the major source of burden of disease in otherwise healthy young people, being responsible for over 50% of this.

The consequences even for mild and transient disorders are significant; for more severe disorders, they can be enduring and catastrophic.

A recent New Zealand study estimated that up to 50% of young people in this transition age will experience at least 1 diagnosable episode of mental ill-health with a directly proportionate negative impact on earning potential, educational outcomes, and social integration at age 30 years. The scene for this erosion of life chances is often set in childhood, but more commonly, it takes the ever-changing climate of adolescence and emerging adulthood to release the variety of overlapping clinical phenotypes we recognize as clinicians, the incidence of which surges through adolescence and peaks between 18 and 25 years

1.1 Families and whānau at risk

Impact of Health determinants

1. The Dunedin Multidisciplinary Health and Development Study and two other large epidemiological studies (Danese A, Moffitt E, & Harrington H, 2009; Felitti VJ, Anda RF, & Nordenberg D, 1998) have found that experience of poverty, mental and physical abuse, parental mental illness, family and whānau conflict and abandonment was associated with risky health behaviours and chronic illnesses such as asthma, diabetes, cancer and high blood pressure.

Maternal Mental health

2. Maternal and early life mental health and addiction issues are estimated to affect 15-20% of early childhood environments (MHC, 2012b).
3. Recent clinical studies have noted maternal eating disorders (active or during childhood or adolescence) as a risk factor for feeding disorders (Von Hofacker, Papousek, & Wurmser, 2008).

Early Years

4. Early life and infant years have a direct impact on later success in life (MHC, 2012a).
5. Infant mental health issues affect between 16-18% of infants (MOH, 2011).

Maori

6. Māori infants and whānau disproportionately experience environments and risk factors associated with the development of severe emotional and behavioural problems, for example, low birth weight, low levels of maternal education, parental AOD abuse and pre-existing mental illness (Tipene-Leach, 2000).
7. The outcomes for and impact of unmet need in Māori maternal health and infant mental health are evident in the high numbers of Māori children in out of home care, in justice settings, with conduct disorders, and experiencing earlier onset of anxiety and AOD problems (MOH, 2011).

Pacific

8. The prevalence of behaviour problems in a New Zealand sample of Pacific Island families, as reported by the mother, was found to be higher than other international populations that used similar measures. Almost 16 percent of two-year-olds in the Pacific Islands Families study, a longitudinal study of 1398 infants born to Pacific families in South Auckland, were in the clinical range for behaviour problems (Paterson, Carter, Gao, & Perese, 2007).

Children with Disabilities

9. The prevalence of any psychiatric disorder in children with disabilities ranges from 40 to 64 percent.
10. Parents of 64 percent of preschoolers with severe intellectual disability have reported challenging behaviours (Roberts, Mazzucchell, Taylor, & Reid, 2003).

1.2 Children with mental health and behavioural issues (<12)

1. 18% of New Zealand children aged 11 are affected by a mental health disorder (Dunnachie, 2007).
2. It is estimated that 15% of children are “particularly vulnerable. That is, without significant support and intervention they will not thrive, belong or achieve” (NZ Government, 2011).

1.3 Youth

Prevalence

1. By secondary school 27% of students are affected by depression and anxiety, with 10.6% experiencing significant symptoms. The figures are substantially higher for female as opposed to males (Dunnachie, 2007).
2. The period of greatest growth in prevalence is between the ages of 15-18 where prevalence peaks at 29% for any mental health disorder and 7% for serious disorders, this is substantially higher than any other period in life (Dunnachie, 2007).
3. More than half of people with mental health disorders experience them before they reach 18 years of age (MHC, 2011).
4. Mental distress in 16-24 year olds is 9% higher than the national average (Oakley Browne, Wells, & Scott, 2006).
5. Youth are less likely to see a health professional (MHC, 2011).

Co-existing – mental health & addictions

6. Mental health issues co-exist with alcohol or drug issues in youth (Dunnachie, 2007).
7. The prevalence of hazardous drinking exceeds 50% for 18-24 year old males (Gluckman, 2011).
8. The prevalence of cannabis use is approximately 40% for 16-18 year olds (Gluckman, 2011).

Conduct disorders

9. Conduct disorders or severe antisocial behavior disorders affect up to 10% of youth and are characterized by aggressive, delinquent and disruptive behaviours. The majority are male (MHC, 2012b).

Risk of suicide & self harm

10. Research indicates that New Zealand youth are amongst the highest at risk of suicide in the OECD, especially those aged 15-19 (Beautrais, Collings, & Ehrhardt, 2005).
11. Those at highest risk are male Maori living in the most deprived areas compared to young females, or to non Maori youth living in less deprived areas (Beautrais et al., 2005).
12. Those at highest risk of experiencing self harm hospitalization are female Maori youth living in higher socioeconomic deprivation compared to all other groups (Beautrais et al., 2005).

Vulnerable groups

13. The national Youth '07 report shows that same or both sex attracted youth are three times more likely to exhibit significant depressive symptoms, more than twice as likely to have deliberately self-harmed, and are five times more likely to have attempted suicide compare to opposite sex attracted youth (Rossen, Lucassen, Denny, & Robinson, 2009).
14. Migrant & Refugee youth are over represented in experiencing mental distress and are underrepresented when it comes to access (ASB/Affinity Youth Project – Scoping Report & Recommendations – 2012).
15. Homelessness is an issue especially for those 17 and under – they are too young for Boarding house accommodation. (ASB/Affinity Youth Project – Scoping Report & Recommendations – 2012).

Secondary school students

An Auckland University survey of 8500 students in 91 secondary schools in 2013 found that:

1. 29.1 per cent of girls harmed themselves deliberately in the year before the survey last year, up from 26 per cent in the previous survey, done in 2007.
2. Binge-drinking in the past four weeks has almost halved from 40.1 per cent of teens in 2001 to 34.4 per cent in 2007 and 22.6 per cent in 2012. Boys (23 per cent) and girls (22.2 per cent) are now almost equally likely to binge-drink.
3. Teens who have deliberately harmed themselves in the past year have risen since 2007 from 26 per cent to 29.1 per cent of girls, and from 15.5 per cent to 17.9 per cent of boys.
4. However those who attempted suicide in the past year were stable at 6.2 per cent of girls and 2.4 per cent of boys.
5. The number of boys who harmed themselves also increased, from 15.5 per cent to 17.9 per cent.
6. One-seventh (14.4 per cent) of girls and one in 11 boys (9.2 per cent) received nasty or threatening messages on their mobile phones in the past year; 10.8 per cent of girls and 7 per cent of boys received such messages via the internet. The numbers were similar in 2007.
7. One in six girls (16.2 per cent) and one in 12 boys (8.6 per cent) show significant depressive symptoms. These numbers have fluctuated with no obvious trend over the three surveys.

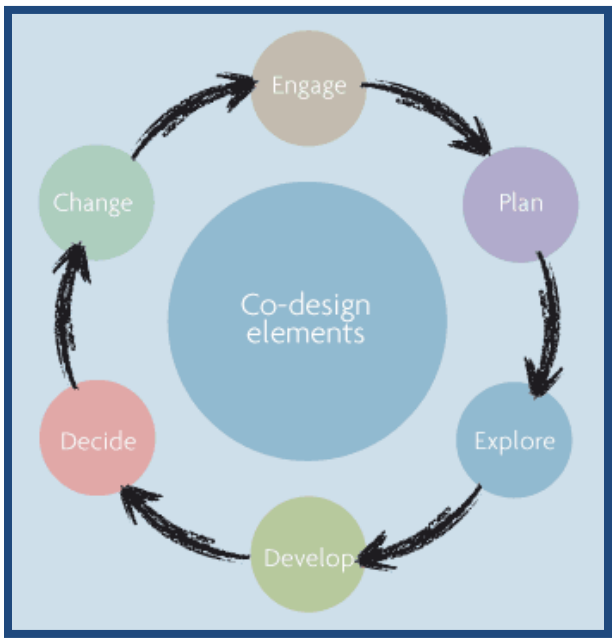
2. OUR THINKING - THE DETAIL?

2.1 Process enabled our thinking

We used a 'co-design' process with a range of people that included young people, other agencies and community groups. They became partners in the design process helping us to shape the definition and direction of the strategy.

Co-design can be described as a joint venture between service providers and service users and their families, it is a way of improving healthcare services with service users.

The "co- design" process is accompanied by four principles:
1. Prioritise the service user's experience
2. Trust the process
3. The 'means' is as important as the 'ends'
4. Acknowledge the service e users' contributions throughout the process



The framework used in co-design is outlined below, it involves 6 steps that are used in a continual development cycle so that services continue to be developed and improved over time. (http://www.healthcodesign.org.nz/index.html).

There are six steps:

1. **Engage** - Establishing and maintaining meaningful relationships with service users to understand and improve healthcare services. This critical element underpins all improvement work and is continuous throughout.
2. **Plan** - Working with service users and staff to establish the goals of improvement work and how to go about achieving them.
3. **Explore** - Learning about and understanding service users experiences of services and identifying improvement ideas.
4. **Develop** - Working with service users to turn ideas into improvements that will lead to better service user experiences.
5. **Decide** - Choosing what improvements to make and how to make them. Its success depends on an understanding of the service user journey and the insights about service improvement this offers.
6. **Change** - Turning improvement ideas into action. Remember that it is not necessary to make all the changes by one organisation, make as many improvements in partnership with other stakeholders .

At the beginning of the process our goal was to:
- Understand the current state and interagency spread of services
- Gain insights and explore possibilities

- Understand what the proposed strategy would mean for the people impacted…what are the opportunities and challenges

The decision was made to use the Blueprint II first four life courses. The decision was also made to use the stepped care model in Blueprint II to try and group the services.

The process started with a collaborative interagency process to identify all the current services available to young people between the ages of 0 and 25, access rates and weight times. Part of this process was understanding what each agency meant by their services and when and how they could be accessed. ADHB Consumer Leaders have been involved throughout the process.

Vigorous discussion took place as the group worked to understand each other's services and fit them into the life course approach and the stepped care model. The result was an expanded stepped care model and a greater understanding of each other's services.
The next step was to identify the gaps. Again this was done as a group.

We carried out a wide range of consultations to hear young people's and clinical views and concerns on the services and the gaps. Young people were an integral part of the Working group and facilitated us meeting with young people to hear their voices including Rainbow youth. We also held a hui with Maori which included both Maori youth and a cross section of people. We help three small Pacific fono with young people one school based and two church based.

The final step was to identify the concrete actions we could take – this was done again as a group. For each of the gaps actions were defined.

Young people have been key partners in developing this strategy and in expanding our thinking.

2.2 People have shaped our thinking

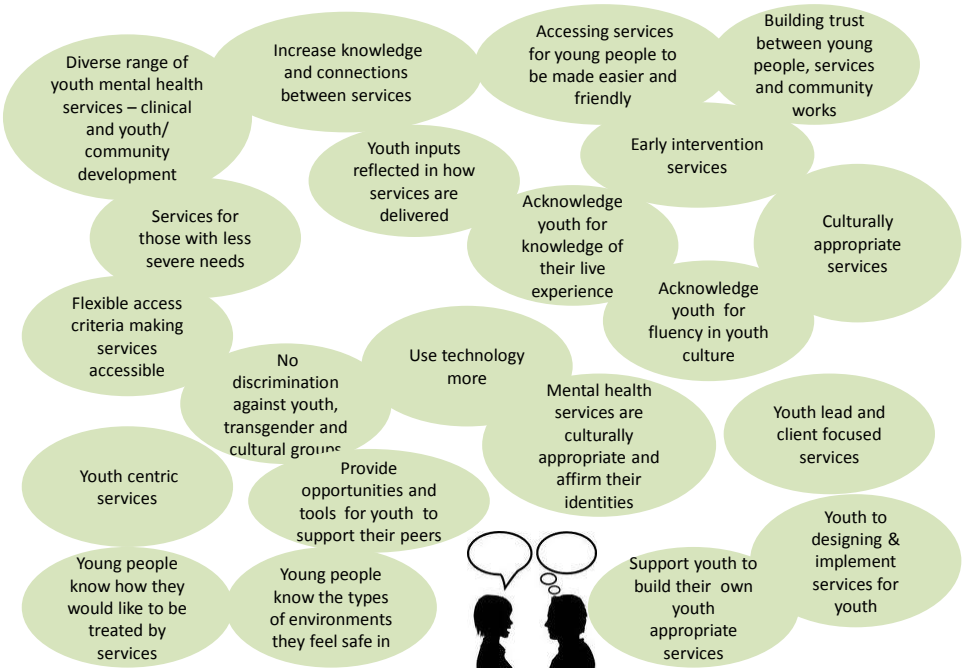
This is what people told us.

In each consultation the same questions were asked: What was / are your experiences of the child and youth mental health services, what works, what could be improved, what could be started and what could be stopped.

The messages were similar from each group and are set out below.

WHAT YOUNG PEOPLE HAD TO SAY

"Things have to change!"

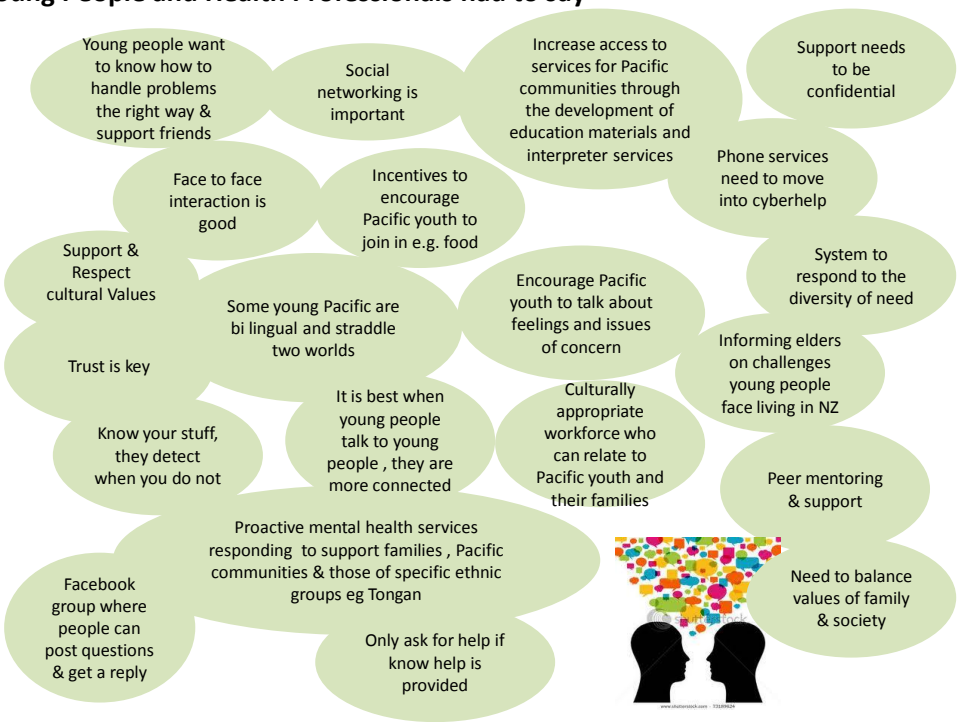

Diverse range of youth mental health services – clinical and youth/ community development
Increase knowledge and connections between services
Accessing services for young people to be made easier and friendly
Building trust between young people, services and community works
Youth inputs reflected in how services are delivered
Early intervention services
Services for those with less severe needs
Acknowledge youth for knowledge of their live experience
Culturally appropriate services
Flexible access criteria making services accessible
Acknowledge youth for fluency in youth culture
No discrimination against youth, transgender and cultural groups
Use technology more
Mental health services are culturally appropriate and affirm their identities
Youth lead and client focused services
Youth centric services
Provide opportunities and tools for youth to support their peers
Young people know how they would like to be treated by services
Young people know the types of environments they feel safe in
Support youth to build their own youth appropriate services
Youth to designing & implement services for youth

What Family & whanau had to say

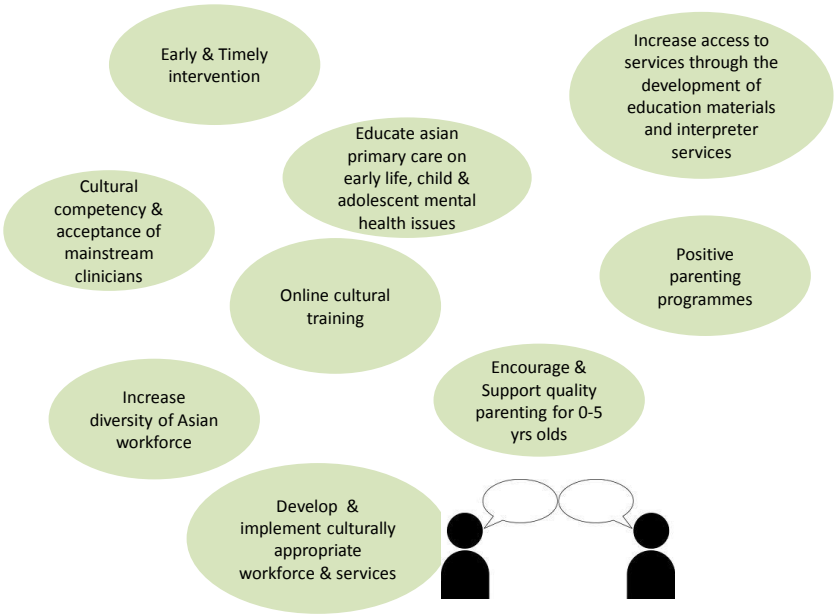
- Need crisis help; adult crisis team are not expert in children and youth crisis help
- Need e-therapies
- Clinical staff to meet young people and families in homes
- Send out information and resource to family/ whanau while young people are on the waiting list to engage them
- If the young person does not want their family involved need to be able to agree what the family can be told rather than going behind the young person's back – could possible involve a grandparent or close family friend

What Maori had to say

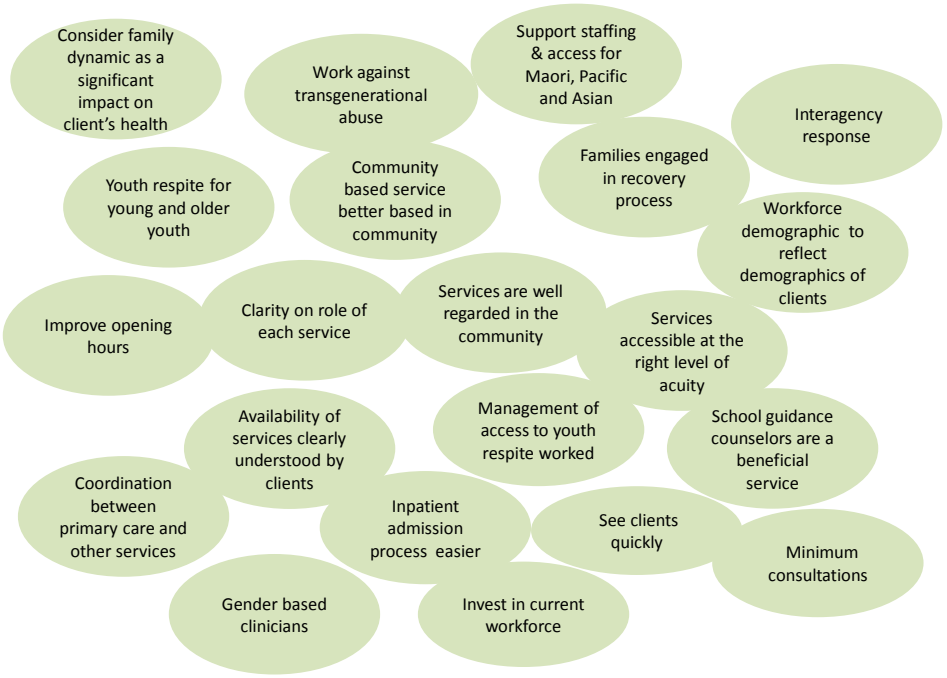
What Pacific Young People and Health Professionals had to say



What Asian had to say

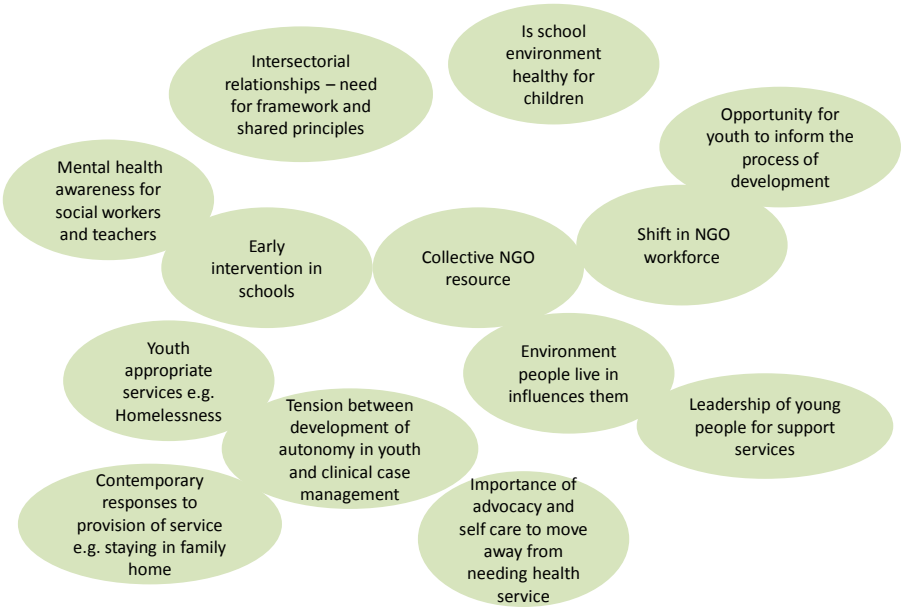


What the Clinical teams had to say
Child & Adolescent Mental Health Service (CAMHS)

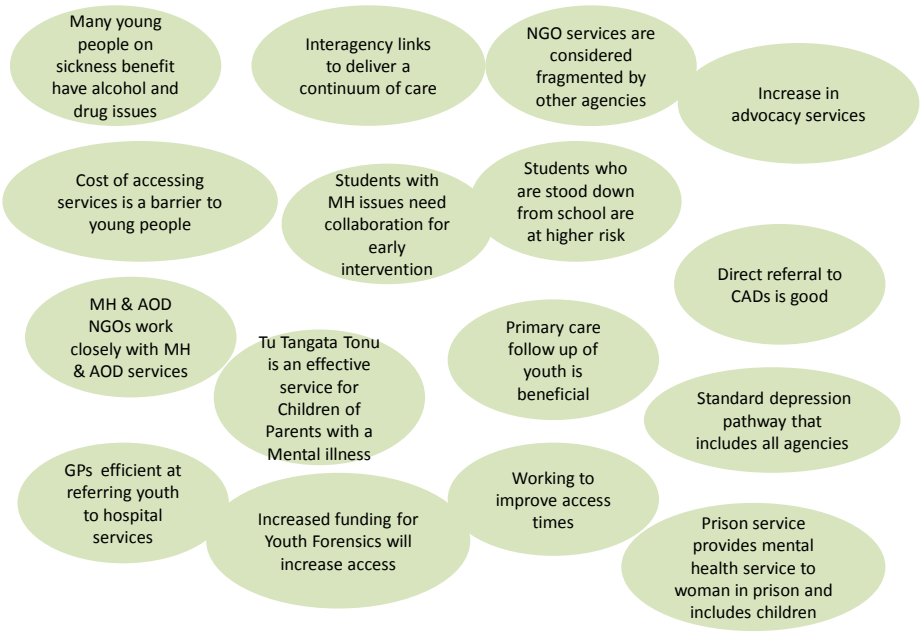


Adult Mental health services

What our Non Government Organisations (NGOs) Providers had to say



What our Interagency partners had to say



2.3 Policy has shaped our thinking

Local – ADHB

- **Mental Health and Addiction Services Priority Areas**
  The Mental Health & Addictions Health Services Group have identified Child & Youth as a priority area for review of service needs and development of services over the next five to ten years.

- **ADHB response to Prime Ministers Youth Mental Health Project**
  Relative to other age groups in Aotearoa, our young people experience higher rates of: mental illness; alcohol and drug abuse; suicide and self harm, and sexually transmitted infections. Relative to their international peers, young people in New Zealand have higher rates of: suicide; injuries; teen pregnancy and abortion (Craig, Adams, & Oben, 2011).

  School based health services (SBHS) have been shown to improve access to health care(Craig et al., 2011), improve health (Denny et al., 2012) and improve educational outcomes (MOH, 2009).

  ADHB is enhancing the ADHB SBHS to include general practitioner services and primary mental health elements. It is planned to extend the programme to include additional schools (Avondale, Selwyn and Auckland Girls) in future years.

- **ADHB's Child Health Improvement Plan 2012-2017 was available for consultation and comment in 2012**
  The foreword states "The determinants of child health outcomes extend beyond the traditional boundaries of Paediatrics. Issues such as maternal mental health, parental smoking, family diet and exercise behaviour and cultural beliefs challenge us to think more broadly about solutions. Problems such as overcrowded and unhealthy housing contribute to unacceptable rates of diseases such as skin sepsis and rheumatic fever. Improving the health of children in Auckland will require us to work collaboratively with the wider education and social services sectors in central and local government".

  Central Government initiatives are directing us to align community and hospital health services more closely to achieve "better, sooner, more convenient" care for patients. Integrated Family Health Centres and the Whanau Ora model of service delivery provide opportunities to provide health care for children in more accessible ways. At the same time we face increasing demands on health services, limited resources and competition within health services for funding. This environment challenges us to make smart choices about the services we invest in to achieve the greatest health gains for children (ADHB, 2012).

- Self Directed Care
  In order to maximise the health and wellbeing of Aucklanders, Auckland DHB is working towards a model of self-directed care. This has been described as "an alternative way of delivering services that seeks to empower participants by expanding their degree of choice and control" (Alakeson, 2010).

- Localities
  ADHB is working with communities to determine future health needs and to inform the provision of services.

Regional

The key regional challenges associated with mental health and addiction relates to:

- The relationship of adverse life events early in childhood and adolescents on the development of psychological issues and the potential longer term impacts for the individual
- The loss of functioning so frequently associated with severe mental illnesses that impacts on peoples' engagement in relationships, in employment and in society.
- The complexity of needs that arise from co-morbidity of mental health issues, general health issues and other complicating social factors.

Actions are focused on increasing service responsiveness to children and youth at risk by:

- Increasing specialist AOD services access to agreed levels
- Deploying new Youth Forensic Community workers
- A regional response for Youth Forensic Secure Inpatient services

Other planning priorities are:

- Strengthening our response to address the needs of Maternal, Early years & Infant mental health and Children of Parents with Mental Illness.
- Improving access for young people to Community Drug and Alcohol treatments
- Better access to Youth Forensics services
- Working to ensure the Eating Disorders service meets the needs of our population. This service has both an inpatient component and a community based component
- Implementation of the Drug & Alcohol Court

http://www.waitematadhb.govt.nz/PlanningConsulting/Northernregionhealthplan.aspx

Other DHBs

Waitemata DHB
Waitemata carried out a Child & Youth stocktake from which they developed their five year stakeholder plan. Now their focus is on in-depth detail on the specifics. Waitemata have established a Youth One Stop Shop.

Counties Manukau DHB
Counties Manukau have a similar focus on working with social and education sector agencies to address mental health and addiction issues earlier and more effectively. The core outcome of their Youth Health project is to develop a new **youth health model of care.** This includes primary health (inclusive of) primary mental health, and referral pathways into secondary youth mental health and addiction services.

Taranaki DHB
Taranaki is another DHB that has just completed their Child and Youth Health Strategy and are working through the implementation process.

National

Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand 2011

Healthy Beginnings provides guidance to district health boards (DHBs), and other health planners, funders and providers of perinatal1 and infant mental health and alcohol and other drug (AOD) services, on ways to address the mental health and AOD needs of mothers2 and infants (MOH, 2012a). The document is not a clinical guideline but it is informed by current literature and experience in clinical best practice.

Why invest in perinatal and infant mental health services?

The rationale for developing comprehensive, integrated perinatal and infant mental health services comes from an extensive body of research. Its findings include the following:

- The onset of mental illness for women has been shown to be higher around the time of childbirth. During this period women are particularly at risk for the onset or recurrence of mood disorders.
- Maternal mental illness during pregnancy and the postpartum period has been shown to have a detrimental effect on the emerging mother–infant relationship and other family and whānau relationships.
- The disruption of this relationship in the absence of other nurturing primary caregiving relationships can result in delayed social and emotional development and/or significant behavioural problems for the infant.
- Poor early social, emotional and behavioural development predicts early school failure which in turn predicts later school failure.
- Social, emotional and/or behavioural problems that emerge during early childhood have been associated with mental illness, chronic health problems, unemployment and offending that may persist into adulthood.
- Early adverse environments often have a cluster of risk factors that co-occur with maternal mental illness and/or AOD problems, such as prematurity, poverty and domestic violence. These risk factors threaten the mother's psychological wellbeing and, in turn, the emerging mother–infant relationship.
- Early intervention builds strength and resilience, which can reduce the need for later high-cost interventions for both mother and infant.

http://www.health.govt.nz/publication/healthy-beginnings-developing-perinatal-and-infant-mental-health-services-new-zealand

[1] The term **perinatal** means relating to the period immediately before and after birth. The internationally accepted timeframe is from pregnancy to one year postpartum.

[2] Throughout *Healthy Beginnings* the term **mother** is used for the simplicity as mothers are most commonly in the role of primary caregiver for their infants. However, fathers, grandparents, adoptive parents, foster parents and others may also undertake this role and may access services if eligible.

Ministry of Health Suicide Prevention Strategy and Action Plan 2013-2016

New Zealand Suicide Prevention Strategy 2006–2016
The New Zealand Suicide Prevention Strategy 2006–2016 (launched in June 2006) provides a framework for New Zealand's suicide prevention efforts over the next 10 years. Its overarching aim is to reduce the rate of suicidal behaviour and its effects on the lives of New Zealanders, while taking into account that suicide affects certain groups more than others.

The strategy has seven goals.
1. Promote mental health and well-being, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour by the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about the rates, causes and effective interventions.

New Zealand Suicide Prevention Action Plan 2013–2016
The New Zealand Suicide Prevention Action Plan 2013–2016 outlines a programme of actions that the Government will implement over the next four years. It is a cross-government Action Plan bringing together the work of eight agencies. The Action Plan builds on the previous action plan covering 2008–2012. Both action plans reflect the goals of the New Zealand Suicide Prevention Strategy 2006–2016.

The Action Plan includes actions designed to:
- address the impact of suicide on families, whānau and communities by strengthening support for family, whānau and communities
- build the evidence base, specifically around what works for Māori and Pasifika
- extend existing services, specifically addressing geographical gaps in the coverage of services
- strengthen suicide prevention targeted to high risk populations who are in contact with agencies.

http://www.health.govt.nz/our-work/mental-health-and-addictions/suicide-prevention/suicide-prevention-strategy-and-action-plans

Prime Minister's Youth Mental Health Project

The Government is investing more than $12.2 million over the next four years from the Social Development Vote in the Prime Minister's Youth Mental Health package of initiatives starting in 2012 (MOH, 2012c).

Youth Workers in low decile secondary schools
Youth workers trained in mental health issues will be employed in selected low decile secondary schools.
This initiative builds on the current Multi-Agency Support Services in Secondary Schools (MASSiSS) service currently provided in 17 schools in South Auckland, Porirua and Flaxmere, with the additional requirement that the workforce has training in working with young people with mental health issues (note: these trial are not in schools in the ADHB area).

The youth workers will be contracted by existing community NGO providers through funding from central government. The service will be available to students and their families and whānau, at no cost

to them. The youth workers will work closely with existing school-based services and will link to community-based services.

By year three, an estimated 20,000 students in 27 schools will have access to a school-based youth worker or social worker. The youth workers and social workers will also be trained in using the Ministry of Education's evidence-based Check and Connect programme, which targets young people who have, or are at risk of, disengaging from school.

Social Media Innovations Fund
The Government has launched a public-private partnership (PPP) Social Media Innovations Fund. This PPP fund will help youth service providers keep their services' technologically up to date and use social media to help young people access information on mental health.

Contributions from corporates and philanthropists are being sought, alongside Government funding of $2 million over four years, to fund good ideas which could bring breakthroughs in youth mental health services.

The Fund will foster innovation and the fast tracking of ideas, and help existing helplines and websites to improve their use of social media technology to engage with young people.

Information for Parents, Families and Friends
Parents, families and friends play a key role in identifying and encouraging young people with mental health issues to seek help and they need good access to authoritative information.

A contestable fund will be established that will allow non-government organisations to bid for funding to provide information to parents, families and friends. There will be an annual funding round for interested NGOs.

Social Support in Youth One Stop Shops (YOSS)
Youth One Stop Shops (YOSS) provide free, youth-friendly health and social services to young people. Community-based, they share a philosophy of positive youth development. YOSS have developed in response to young people's preferences.

The central government agencies in the social and health sectors will provide separate time limited support for existing effective YOSS. The social development sector will focus on social support services and may include building youth worker capacity or capability.

Alcohol and other Drug Strategies

The government has a number of policies which focus on the impacts of alcohol and other drug use on youth in addition to the Prime Ministers Youth Mental Health Project which spans both mental health & addictions
The Fresh Start reforms, introduced in October 2010, aim to improve community safety and help address the underlying causes of offending by children and young people. Youth Court judges now have more options to deal with offenders, including powers to order mentoring, alcohol and drug rehabilitation, and parenting education programmes, and the ability to impose longer sentences for our most serious offenders. Family Group Conferences now have access to these programmes to better respond to the offences they deal with.

These reforms saw the development of:

- Community based programmes for young people who are assessed as having hazardous and/or harmful AOD use
- Residential based programmes for young people who are assessed as being AOD addicted or dependent.

The drivers of crime initiative focus on the reducing resdivism rates by 25%. In order to achieve this whole of government target a cohesive and coordinated approach will be required and include a response from health, particularly in the area of youth. Specifically there is aim to deliver nationally consistent, enhanced alcohol and drug services for youth. These could reach an additional 2000 young people a year and reduce the waiting time between referral and treatment, leading to lower risk of harm, suicide, and offending related to alcohol and drugs.

Blueprint II

The first Blueprint, published in 1998, promoted the recovery approach and provided services for the estimated 3% suffering from severe mental health and addiction issues. This has resulted in NZ having one of the better mental health & addiction service sectors in the world (MHC, 1998).

Blueprint II, published 2012, takes a broader approach to building services to meet New Zealand's future needs (MHC, 2012a). It is government independent and cross sector. Blueprint II reinforces and strengthens the recovery principle alongside the principles of resilience and a people centered and directed approach.

The principles are:

Figure 1: Principles underpinning Blueprint II

Blueprint II takes a life course approach. These are critical points in the development of mental health, addiction and behavioural issues where it is possible to intervene earlier and more effectively. The four life courses that impact children and young people are:

- Families/ whanau at risk (-1 to +3 years, pregnancy, post natal, maternal and infant wellbeing)
- Children with mental and behavioural issues (less than 12)
- Youth/ adolescents with emerging mental health, behavioural and addiction disorders
- Youth adolescents at high risk including forensics

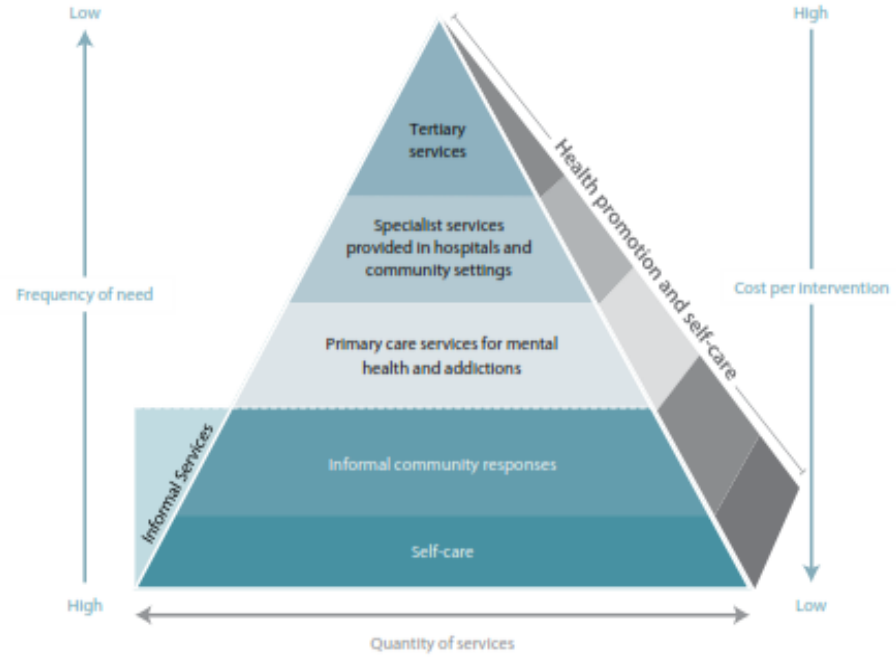
Blueprint II saw eight clear priorities:

- **Providing a good start:** Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact.
- **Positively influencing high risk pathways:** Provide earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.
- **Supporting people with episodic needs:** Support return to health, functioning and independence for people with episodic mental health and addiction issues.
- **Supporting people with severe needs:** Support return to health, functioning and independence for people most severely affected by mental health and addiction issues.
- **Supporting people with complex needs:** Support people with complex combinations of mental health issues, disabilities, long term conditions and/or dementia to achieve the best quality of life.
- **Promoting well being, reducing stigma and discrimination:** Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental health and addictions.
- **Providing a positive experience of care:** Strengthen a culture of partnership and engagement on providing a positive experience of care.
- **Improving system performance:** Lift system performance and reduce the average cost per person treated while at the same time improving outcomes.

To implement the principles requires:

- Responding earlier and more effectively to mental health, addiction & behavioural issues
- Improving equity of access of outcomes for different populations
- Increasing access to mental health & addiction responses
- Increasing system performance and our effective use of resources
- Improving partnerships across whole of government

One of the successful implementation strategies has been the stepped care model. This has enabled the most effective use of available resources. Stepped care is intervening in the least intensive way to get the best possible outcomes.



Source: Adapted from the World Health Organization.[37]

This Work stream used this stepped care approach and the life course points of intervention to look at the services provided and the different needs across the population.

Data Source: Blue print II Improving mental health and well being for all New Zealanders – Making change happen

MOH "Rising to the Challenge" Mental Health & Addictions Service Development Plan (SDP) 2013

"Rising to the Challenge sets out the Ministry of **Health's (MOH) plan** for the direction of mental health and addiction service delivery across the health sector over the next five years (MOH, 2012b). It articulates the Government's expectations about the changes needed to build on and enhance gains made in the delivery of mental health and addictions services in recent years." This plan was informed by Blueprint II.

For child and youth Rising to the Challenge focuses specifically on intervening earlier in the lives of young people in order to strengthen their resilience and avert future adverse outcomes. They have listed the following priority actions:

Building resilience and averting future adverse outcomes for infants, children and youth

Action	Accountability
Continue to support health promotion activities to raise awareness of the importance of healthy social and emotional development for infants and toddlers	Ministry of Health
Pilot evidence-informed parenting programmes	Ministry of Health
Lead the cross-agency Youth Mental Health Project	Ministry of Health

Enhance the delivery and integration of specialist mental health and AOD services within primary care, schools and other child health services	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Enhance the responsiveness and flexibility of specialist child and youth mental health and AOD services	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Support a coordinated response to meeting the needs of children in care	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Support a coordinated, multi-agency response for youth with complex interagency needs	DHB and NGO providers of specialist infant, child and youth mental health and AOD services
Improve the responsiveness of schools and primary care, maternal, child and youth health services	Primary care, maternal, child and youth health service providers
Implement youth-centred models of care within primary care	Primary care providers

Page 46 Rising to the Challenge, Ministry of Health

DHBs are required to implement Rising to the Challenge.

Whānau Ora (Kōkiri, 2013)

Whānau Ora is an inclusive interagency approach to providing health and social services to build capacity of all New Zealalnd families in need. It empowers whānau as a whole rather than focusing separately individual family members and their problems.

The following principles underpin this Tool and reflect factors that contribute to the development of successful programmes that achieve Maori aspirations for Whānau ora.

- Whānau ora is a priority for reducing inequalities between the health outcomes of Maori and other New Zealanders.
- Maori will be fully involved in the design, delivery and evaluation of services.
- Maori providers will be identified and resourced to work with services to design, deliver and evaluate programmes.
- Maori will be supported to implement Maori models of health.
- Building Maori staff capacity and capability to improve the uptake of services is a long term commitment.
- There is a commitment to build the non Maori staff capability to improve the uptake of services by Maori.
- Proposed programmes increase Whānau ora by fostering Maori community development and utilise assets already present in the community.
- Proposed programmes improve access to general services for Maori.
- Proposed programmes utilise accurate ethnicity data to ensure effective service delivery for Maori.

PATHWAY ONE **Development of Whānau, hapu, iwi and Maori communities**	The Crown will work collaboratively with Whānau, Hapu, and iwi and Maori communities to identify what is needed to encourage health as well as prevent or treat disease. This includes supporting whānau development and participation in both tea o Maori and wider New Zealand society, to improve health and wellbeing.
PATHWAY TWO **Maori participation in the health and disability sector**	The goal is active participation by Maori at all levels of the health and disability sector in decision- making, planning, development and delivery of health and disability services. This pathway supports Maori provider and workforce development.
PATHWAY THREE **Effective health and disability services**	This pathway aims to ensure that whānau receive timely, high quality, effective and culturally appropriate health and disability services to improve whānau ora and reduce inequalities.
PATHWAY FOUR **Working across sectors**	This pathway directs the health and disability sectors to take a leadership role across the whole of government and its agencies to achieve the aim of whānau ora by addressing the broad determinants of health.

2.4 Other documents have shaped our thinking

Vulnerable Children (White Paper) (NZ Government, 2012)

The White Paper for Vulnerable Children sets out a programme of change that will shine a light on abuse, neglect and harm by identifying our most vulnerable children and targeting services to them to ensure they get the protection and support that they need.

The Government will pass legislation, and enact policies and practices so that:

- Parents, caregivers, family, whānau, and communities understand and fulfil their responsibilities towards children
- Professionals identify vulnerable children and act earlier
- Communities identify and meet the needs of vulnerable children as early as possible
- Government education, health, care and protection and justice agencies, professionals, community organisations and workers share information appropriately to protect vulnerable children
- The lives of vulnerable children in state care is made a priority across government departments and agencies
- People and organisations working with children identify and respond to the needs of vulnerable children
- Tough new measures are in place to protect children from adult abusers who are likely to continue to hurt children.

This white paper will directly impact the health sector, and so needs to be considered in this strategy. The actions are encapsulated in the Child Action Plan.

The Child Action Plan actions that particularly impact this strategy are:

- The Local Children's Team which are multiagency virtual teams providing a systematic response to vulnerable children. These teams could be hosted by DHBs. The Lead professional assigned to all identified vulnerable children will be the key point of contact. There will be a single multi-agency plan for each child agreed with accountabilities.
- Service investment will be led from outside of health and will ensure that funding is aligned to outcomes for vulnerable children. It is yet to be determined what will be available in Auckland.
- Supporting and improving the Children's workforce across all sectors with minimum standards and core competencies tailored to different roles and sectors. Mandatory worker safety checks.
- Better quality services for children in state care – health is to be more involved and there will be greater support for caregivers including iwi pre-approved caregivers. Support for the transition to adulthood of the 16/17 year olds moving out of care.
- Qualification of workers – will need to be safety checked and qualified.

Better Public Service Targets 2012
Better Public Service Targets 2012 are to be achieved by June 2017 as outlined on the State Service Commission website www.ssc.govt.**nz .** Central Government agencies are following the Better Public Service programme to:

- Reduce long term Welfare dependency by reducing the number of people on a working age benefit for more than 12 months
- Support Vulnerable Children
    - Increase participation in early childhood education
    - Increase immunization rates and reduce incidence of Rheumatic Fever
    - Reduce number of assaults on children
- Boost Skills and Employment
    - Increase number of 18 year olds with NCEA L2
    - Increase the proportion of 25-34 yr olds with qualifications
- Reduce crime
    - Reduce the rates of total crime, violent crime and youth crime
    - Reduce reoffending
- Improve interaction with Government
    - One stop on-line shop for businesses for government support and advice
    - NZers can complete their business with Government in a digital environment

These pieces of work are ongoing and are being done across the country.
Under this umbrella valuable and exciting initiatives are being trialed by the Ministry of Education around keeping kids in school and different ways to engage with youth and children as in South Auckland through sports clubs and schools. In the Alcohol and Addiction area this includes a Peer Support programme in schools.

Youth Development Strategy 2002

This strategy is about how government and society can support young women and men aged 12 to 24 years inclusive to develop the skills and attitudes they need to take part positively in society, now and in the future (MYA, 2002).

The Youth Development Strategy (YDSA) consists of a vision, principles, aims and goals, and also suggests actions that can be taken to support the positive development of young people.

The principles of "youth development" outline what the youth development approach is all about. They can be used as a checklist and a tool for developing youth policies and programmes and in working alongside young people.

The Government has a keen interest in the healthy development of all children and young people in New Zealand/Aotearoa. In addition to the Youth Development
Strategy Aotearoa, the Government has also been developing the 'Agenda for Children' which focuses on issues for the 0-17 age group. The aim of the Agenda for Children is to make New Zealand a great place for children to grow up and live in.

The Youth Development Strategy Aotearoa and the Agenda for Children are two separate but closely related Strategies. Both propose fundamental changes to the way we think about children and young people. Both seek to enhance the wellbeing of children and young people by:

- building a common understanding of what is needed to support their healthy development
- promoting a broad whole person approach to addressing their issues and needs
- raising their status and profile in government business
- encouraging a multi-sector response by government.

The principles of Youth Development are:

1. Youth development is shaped by the 'big picture'
By the 'big picture' we mean: the values and belief systems; the social, cultural, economic contexts and trends; the Treaty of Waitangi and international obligations such as the United Nations Convention on the Rights of the Child.

2. Youth development is about young people being connected
Healthy development depends on young people having positive connections with others in society. This includes their family and whānau, their community, their school, training institution or workplace and their peers.

3. Youth development is based on a consistent strengths-based approach
There are risk factors that can affect the healthy development of young people and there are also factors that are protective. 'Strengths-based' policies and programmes will build on young people's capacity to resist risk factors and enhance the protective factors in their lives.

4. Youth development happens through quality relationships
It is important that everyone is supported and equipped to have successful, quality relationships with young people.

5. Youth development is triggered when young people fully participate
Young people need to be given opportunities to have greater control over what happens to them, through seeking their advice, participation and engagement.

6. Youth development needs good information

Effective research, evaluation, information gathering and sharing is crucial.

Together, these six principles can help young people to gain a:

- sense of contributing something of value to society
- feeling of connectedness to others and to society
- belief that they have choices about their future
- feeling of being positive and comfortable with their own identity.

Refer to www.myd.govt.nz for resources on youth participation.

Youth Crime Action Plan 2013-2023, Ministry of Justice

The Youth Crime Action Plan (YCAP) is a 10-year plan to reduce crime by children and young people and help those who offend to turn their lives around. It takes a practical approach to support youth justice services, frontline workers, service providers and volunteers. Government agencies will work together more closely and partner with Māori, communities, parents, schools and others to tackle youth crime and the factors that lead to offending.

YCAP sets out to make a difference to the children and young people behind the statistics. It aims to stop problems before they develop, deal with young offenders fairly but firmly when necessary and put systems in place to stop re-offending.

Why

We know the earlier young people begin offending, the greater the odds they will re-offend.

Steering young people away from a life of crime – and ensuring they don't get caught up in the justice system – increases the chance they will reach their full potential.

Existing initiatives to tackle youth crime are paying off. Police apprehensions, court appearances and serious offending statistics are trending down. But challenges remain, such as making sure we turn young lives around at the earliest opportunity and addressing the fact that young Māori are over-represented in the youth justice system.

YCAP will also play a key role in delivering the Government's Better Public Services (BPS) target of reducing youth crime by 25 percent by 2017, and the wider BPS goals of reducing offending and victimisation rates.

How

YCAP is centred around:

- three overarching strategies
    - partnering with communities
    - reducing escalation
    - early and sustainable exits
- three key building blocks
    - Governance
    - Workforce
    - Information Sharing
- thirty practical actions.

The three strategies shape how we will tackle youth crime. The three building blocks provide essential support, such as leadership, coordination and information, to those on the frontline. The 30 practical actions are a 'to-do list' of initiatives and milestones that government agencies will put in place.

YCAP also includes useful 'best practice' guidelines for those working with children and young people, and information resources for the public.

YCAP builds on existing initiatives, such as the 2010 Fresh Start reforms, the Children's Action Plan, Whānau Ora and the Prime Minister's Youth Mental Health Project.
http://www.justice.govt.nz/publications/global-publications/y/youth-crime-action-plan-factsheet-2013-2023

International

Ontario's Ministry of Children and Youth Services report "A Shared responsibility. Ontario's Policy Framework for Child and Youth Mental health", 2009 provides a framework for all child and youth up to 18 years of age and a framework for interagency cooperation (MCYS, 2009).

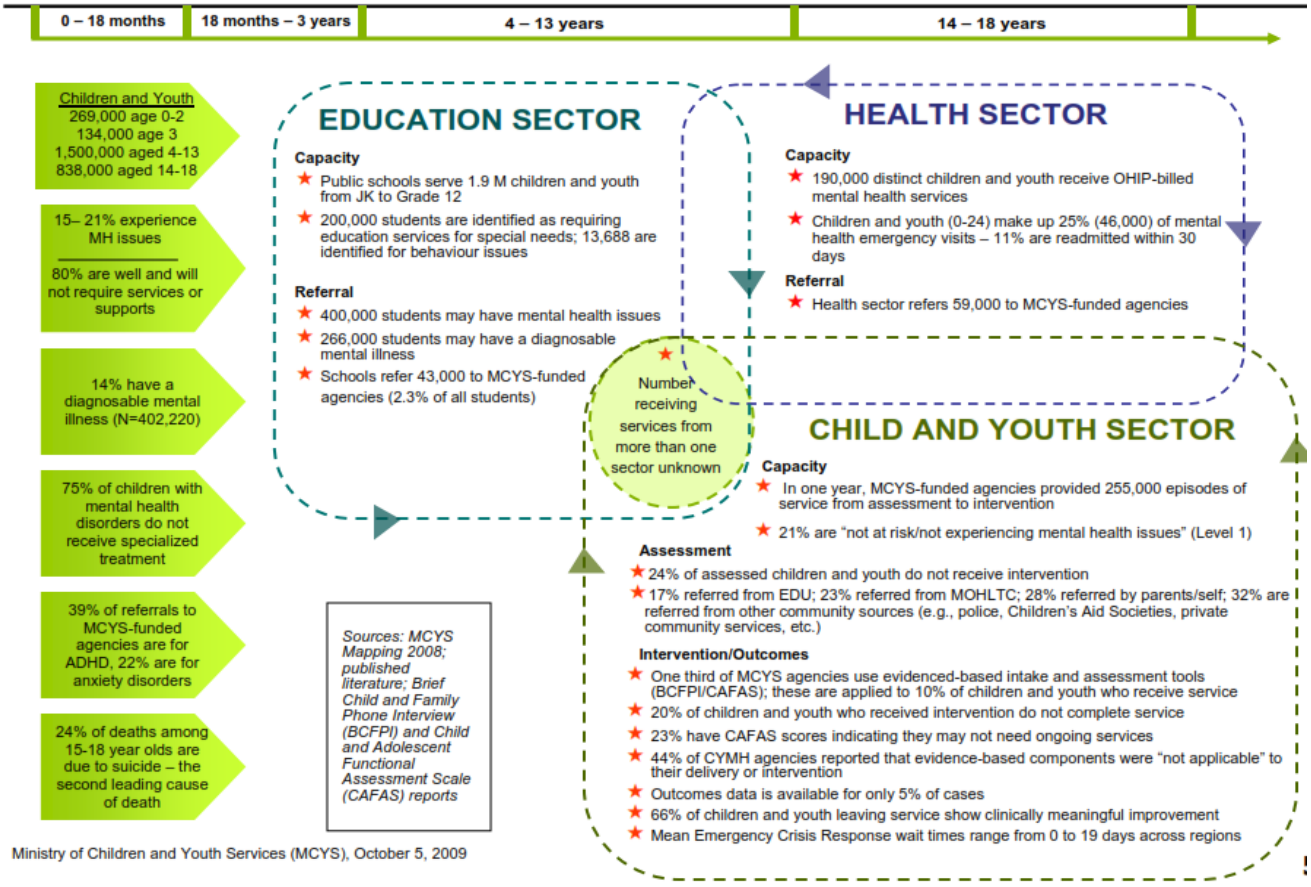
Mental health problems of Ontario's children and youth are a significant public health issue. Studies suggest 15 to 21 per cent of children and youth, approximately 467,000 to 654,000 children and youth in Ontario, have at least one mental health disorder. The consequences can affect children and youth now and into adulthood, their families/caregivers, schools, communities, employers and the province as a whole.

While significant progress has been made in recent years, a number of areas requiring further improvement have been identified:

- enhanced timeliness in the provision of services for children and youth
- increased emphasis on health promotion, illness prevention and earlier identification
- enhanced collaboration across child- and youth-serving sectors, and with the adult mental health sector
- increased consistency in service provision
- enhanced use of "what works" in practice
- social inclusion of children and youth with mental health problems
- Enhancements in accountability.

The framework recognizes that child and youth mental health is a shared responsibility. It is designed to foster collaboration amongst everyone who shares responsibility for the healthy development of Ontario's children and youth: families/caregivers, communities, service providers, government and all child- and youth-serving sectors.

Map of the Child and Youth Mental Health (CYMH) System



Ministry of Children and Youth Services (MCYS), October 5, 2009

CALMEND

- **A partnership initiative of the California Departments of Mental Health (DMH) and Health Care Services (DHCS) to improve quality and outcomes for publicly funded mental health services (CAGov, 2013).** Community-level partnerships and collaborations support recovery by not only providing integrated services within the mental health system, but also through the coordinated inclusion of community resources and other services, such as supportive housing, employment, meaningful activity and social activities. Accordingly, it is imperative that the mental health system direct outreach efforts to the broad array of diverse communities in which clients are a part (i.e. support groups, educational, religious and cultural centers, wellness centers, advocacy support, etc.) in order to promote understanding and responsiveness to the needs of clients and families on their recovery journeys, create awareness of stigma and discrimination, and further, work consistently to reduce it for persons with mental illness.

- **An articulated vision and design of a transformed mental health service delivery system committed to person/family centered wellness, recovery and community integration.** Person-centeredness is a comprehensive approach to understanding each individual and their family's history, common needs, strengths, recovery, culture and spirituality. Using a person-centered approach means service plans

and outcomes are built upon respect for the unique preferences, strengths and dignity of each whole person. "Person-Centered" from CalMEND's Philosophies and Principles, defined by the Client and Family Subcommittee Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. "Recovery" from CalMEND's Philosophies and Principles, defined by the Client and Family Subcommittee Interdependence is the dynamic of being mutually dependent upon and responsible to others. Like independence, interdependence is a cultural value that instills dignity and self worth in an individual by allowing him/her to fulfill a unique role in family, culture and/or community. It is essential that each client's preference for interdependent participation with community, family and/or individuals is respected and incorporated throughout all services.

- **A community of individuals** and organizations committed to the continuous improvement of the mental health services system; and

- **A set of resources** designed to help manage and improve the current mental health service delivery system.

CalMEND's role in achieving this dynamic performance standard is to promote and support change in systems that improve practice and, as a result, the experience of consumers and familes seeking mental health services. The overarching aim of CalMEND is to help mental health care organizations and providers of mental health services to provide *continuously improving, person-centered, and recovery oriented services* to individuals with mental illness. **CalMEND is predicated on the belief that we can and must always strive to do better** - and that there is always room for improvement. **Our clients and communities expect and deserve nothing less.**

CALMEND's Guide for Person Centred Mental Health Services and Supports: Transforming Care to promote Wellness and Recovery, October 2008 while focusing on person centred decision making for Adult services has a whole of system model of care and documented flow through the system.

Lincolnshire NHS

Purpose	To improve therapeutic efficiency, for example through reducing did not attends (DNAs), dropout rates, average length of treatment, and improving patient satisfaction for those attending outpatient Child and Adolescent Mental Health Services (CAMHS).
Description (including scope)	The Outcome Orientated Child and Adolescent Mental Health Service (OO-CAMHS) is the first CAMHS development that is designed to incorporate session-by-session measurements of outcomes evidence into a whole service model that can improve outcomes for all attending, at the same time as maximising efficient use of resources. Patient experience is likely to be improved through monitoring the patient's perspective of progress and if appropriate changing the therapeutic approach. This in turn can lead to patients attending their appointments regularly as they have confidence in the care they will receive. Four 'CORE' guiding principles underpin OO-CAHMS: Consultation (with other agencies and families to address extra-therapeutic factors such as social context) Outcome (using session-by-session outcome ratings, with discussions with families and team members if no improvement is found after five sessions) Relationship (using session-by-session ratings of the alliance) Ethics of care (building a supportive whole team ethic). The service uses a formal rating scale, which allows clinicians to assess practice and improve outcomes.

www.**lincolnshire**.**nhs**.uk/

headspace

headspace is the National Youth Mental Health Foundation in Australia. They help young people who are going through a tough time (Headspace, 2013).

It caters for a young person looking for someone to talk to. If they are 12-25 they can get health advice, support and information. They have centres all around Australia.
headspace can help young people with:

- General health
- Mental health and counselling
- Education, employment and other services
- Alcohol and other drug services.

If they are:

- are feeling down, stressed or can't stop worrying
- haven't felt like themselves for a long time
- can't deal with school or finding it difficult to concentrate
- are feeling sick or worried about their health
- want to cut down on their drinking or drug use
- want to talk about sexuality, identity or relationships
- are having difficulties with friendships

- have sexual health issues or want to find out about contraception
- are being bullied, hurt or harassed
- are worried about work or study or if they are having money troubles

headspace is a place they can go to talk to someone about any of these issues.

headspace was established and funded by the Commonwealth Government of Australia in 2006. Their primary focus is the mental health and wellbeing of all Australians. They know that getting help early is the key to resolving these problems quickly. headspace is making a difference where it is needed most – Australia's young people.

Young and Well CRC
The Young and Well Cooperative Research Centre unites young people with researchers, practitioners, innovators and policy-makers from over 70 partner organisations across the non-profit, academic, government and corporate sectors (AusGov, 2013).

The Young and Well CRC explores the role of technology in young people's lives, and how technology can be used to improve the mental health and wellbeing of young people aged 12 to 25.

ReachOut.com
ReachOut.com aims to help young people with all kinds of situations, from everyday stuff, through to coping with tough times. By helping people understand what they are going through, showing them that they are not alone in their experience, and explaining the different help options that are available, ReachOut.com directs young people to the support that is right for them. This includes finding and accessing professional help, such as counseling, as well as learning about and using "self-help" strategies, like the missions offered in our WorkOut app. Everything they do is developed with input from experts to ensure that ReachOut.com is effective and safe.

They recognise that mental health is more than just an absence of illness and see it as a state of wellbeing in which every person can fully realise their abilities and achieve their full potential to live an awesome, fulfilling life. ReachOut.com therefore also focusses on promoting wellbeing by offering opportunities that build self confidence, create new social connections, develop new skills, and provides a sense of purpose. These same outcomes also help prevent mental health problems like depression and anxiety from developing in the first place (and, for those who have these conditions already , can help improve quality of life).

http://au.reachout.com

3. OUR POPULATION – THE DETAIL?

3.1 Current Population and what the population will be in 2022 – key differences?

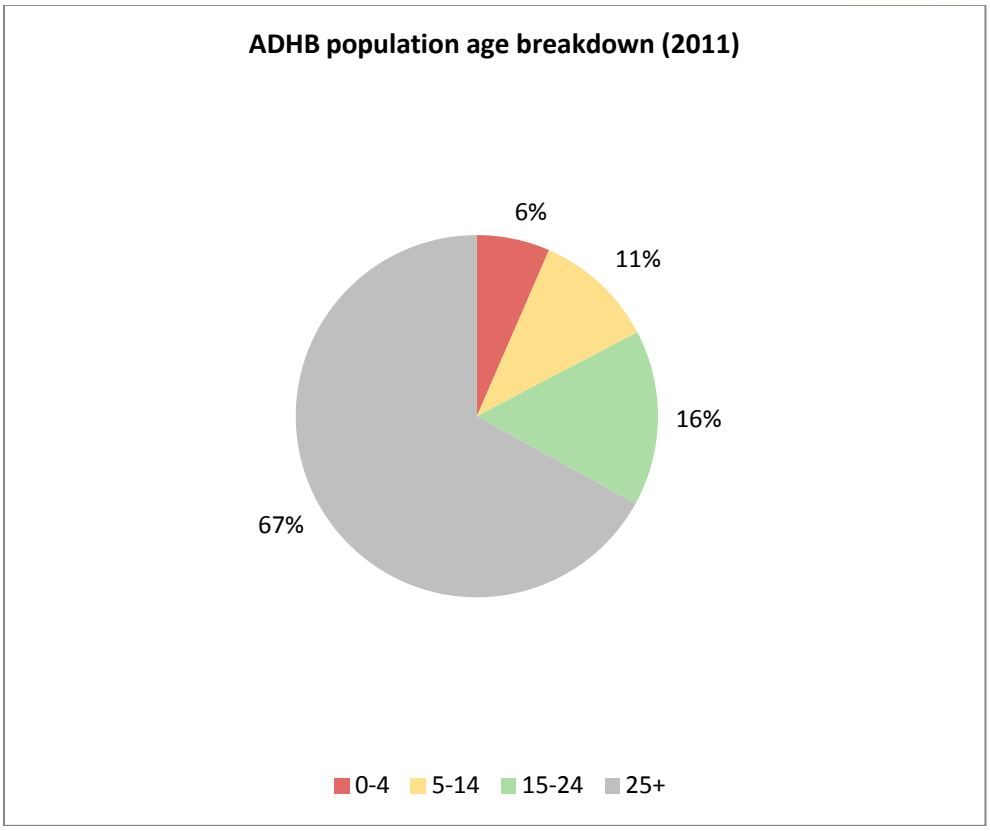
Summary of current and future projections

- The ADHB child and youth population is projected to grow at a much slower rate (4%) than the national average (19%) by 2021
- Within this population, the 0-4 (8%) and 5-14 (12%) age group have greater increases than the 15-24 age group (-3%)
- There is substantial variation between wards
- The main locality focus for the 0-4 age group could be the Waitemata ward
- Wards in the south have higher Maori and Pacific populations
- Wards in the west have higher Asian populations
- Waiheke consistently has zero or negative growth across all age groups
- The Asian ethnic group is the fastest growing group for the ADHB region with a 35% increase in population size by 2021
- Maori and Pacific populations tend to be younger with approx 30% under 15
- Maori youth aged 5 – 14 are projected to increase substantially
- Maori children under 5 are projected to decrease
- Asian has a higher proportion of 15-24 year olds
- Asian is the fastest growing across all age groups
- The ethnic populations seem to be based in definite geographical regions which can assist targeted ethnic based interventions and funding. The south Auckland wards have a high proportion of Pacific and Maori. The western wards have a high proportion of Asians. The central wards have a high proportion of European/Other
- There is projected to be increased social deprivation in the ADHB population by the year 2021. There will be twice as many ADHB residents living in an area of deprivation (Q4 or Q5), than those living in less deprived areas (Q1 and Q2)

Age

- The under 25 year old population is expected to grow by 4% (from 19,7162 in 2012 to 20,3301 in 2022)
- The 0-4 age group is predicted to grown by 8% (from 40,503 in 2012 to 41,996 in 2022)
- The 5 -14 age group by 12 % (from 67,388 in 2012 to 71,966 in 2022)
- The 15 – 24 age group is expected to have a small decline
- 37% of ADHB's current population (2011) is 24 or under years of age. This is consistent with the national average of 35% (2011).
- Within this population there are differing growth rates for the population groups over this 10 year period:
    - The 0-4 year age group is projected to have an 8% increase
    - The 5-14 years a 12% increase
    - The 15-24 years a 3% decrease

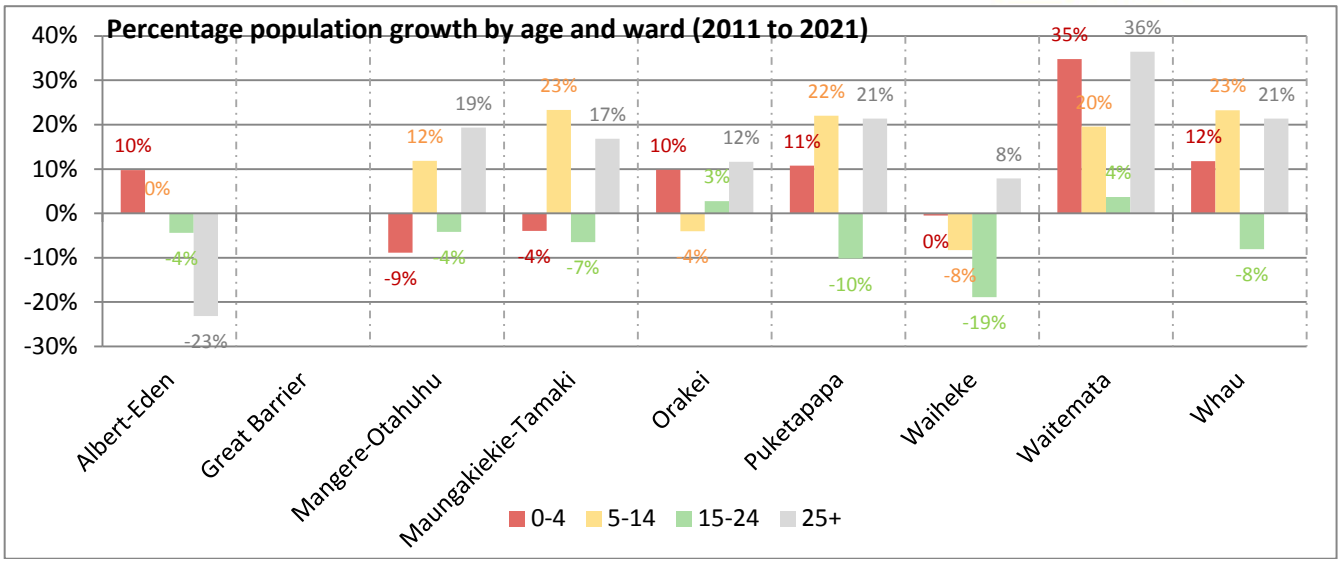
Data Source: (K. Wang, 2012)



Data Source: (K. Wang, 2012)

Where young people will live

- Waitemata ward is the fastest growing ward with the 0-4 age group predicted to increase by 35% (from 2,704 in 2012 to 3,577 in 2022, a increase of 873)
- In south and west there is less predicted growth but the population is trending to a younger age mix than currently with 5-14 year olds predicted to grow at similar rates to over 25 years old while the 15-24 age group is predicted to decrease
- In Puketapapa, Whau and Manugakiekie – Tamaki the 5-14 age group is projected to increase, while the 15-25 age group is predicted to decrease
- The 15-24 year population growth will be 3-4% for Orakei and Waitemata. The rest of the wards all have negative growth from 4 to 19%
- Waiheke will consistently have zero or negative growth across all age groups



Data Source: (K. Wang, 2012)

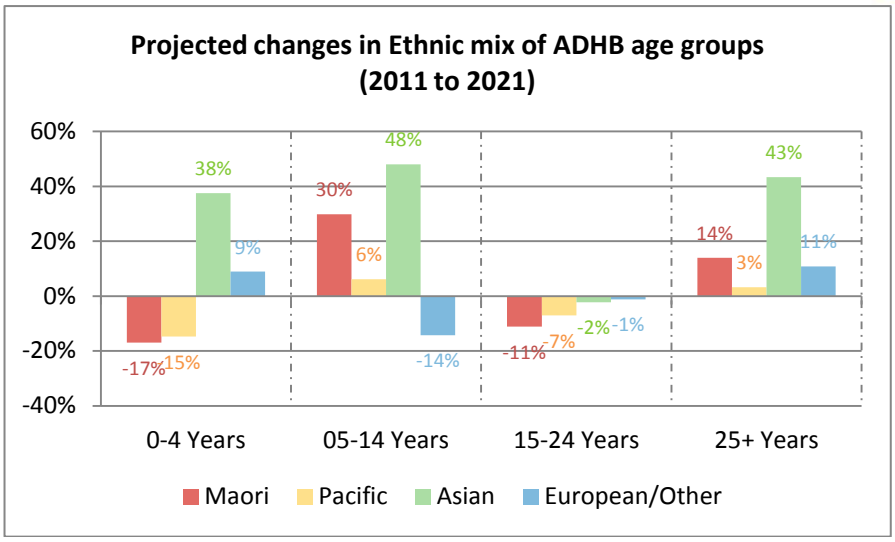
Ethnicity

The current (2011) ethnic mix of the ADHB population is substantially different from the New Zealand average, with a much larger proportion of residents identifying with as Asian. 28% of ADHB identified as Asian compared to the national average of 10%. The other main nationalities were closer to the national averages (Maori ADHB: 8%, National: 14%; Pacific ADHB: 10%, National: 7%; European/other ethnic group: ADHB 52%, National 69%).

The Asian ethnic group is also projected to increase over three times faster than the other ethnicities over the next 10 years. By 2021 there will be a 35% increase in the ADHB Asian population which will represent 33% of the overall ADHB population. The Maori population will have grown by 8%, the European/Other by 7% and Pacific will decline by 0.3%.

Ethnicity & Age

- The fastest growing population across all age groups is the Asian population
- Many Asian ethnic groups have youthful age structures
- In the 0-4 year age group there will be decline in the Maori (-17%) and Pacific (-15%) population which will be counteracted by a rise in the Asian (38%) and European/other (9%) population
- In the 5-14 year age group there will be a decline in European/Other (-14%) populations with large increases in the Asian (48%) and Maori (30%) populations
- In the 15-24 year age group, all populations will decrease however the European/other (-1%) and Asian (-2%) populations will have minimal decline



Data Source: (K. Wang, 2012)

Ethnicity & Where young people will live

- The localities based in the southern part of the ADHB region have a high proportion of Pacific & Maori. Mangere-Otahuhu has 16% that identify as Maori and 40% that identify as Pacific. Maungakiekie-Tamaki has 16% that identify as Maori and 24% that identify as Pacific. These two wards represent 2/3rds of all Pacific in the ADHB region
- The western wards have a high proportion of Asians. Almost half of the residents in Puketapapa and Whau identify as Asian (47% and 41% respectively). Albert-Eden and Waitemata wards also have substantial Asian populations (30% and 23% respectively)
- Orakei and Albert-Eden contain the largest population of European/Other and together contain 48% of the ADHB population

Gender

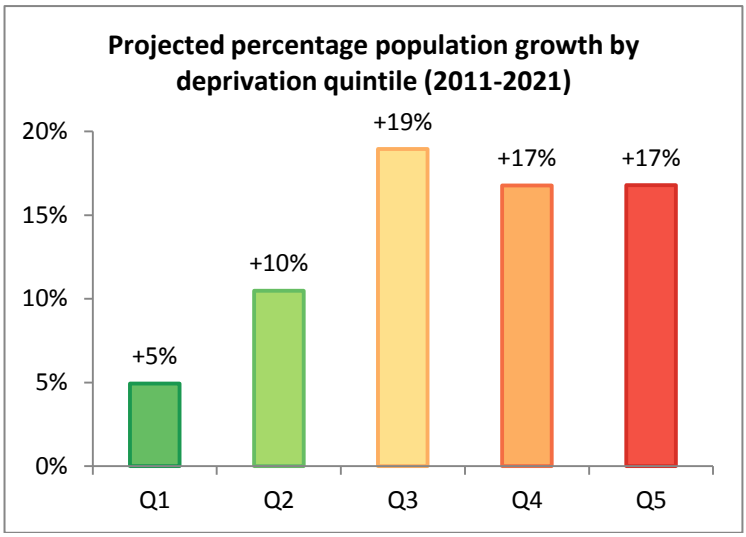
- There were no substantial gender difference between the ADHB population and the national average – males accounted for 49% of the population and females 51%
- Similarly, there is no effective difference in the projected growth rates by gender over the 2011-2012 period

Socioeconomic deprivation

The distribution of socioeconomic deprivation in ADHB is relatively similar to the national average.

- 23% of the ADHB population live in Quintile 5 areas (the most deprived areas) as compared to the national average of 20%
- 16% live in Quintile 1 areas (least deprived) which is less than the national average of 20%

It is projected that there will be increased social deprivation in the ADHB population by the year 2021. There is projected 17% increase in both Quintile 5 (the most deprived areas) and Quintile 4 areas while there will only be a 5% and 10% rise in Quintile 1 and Quintile 2 areas respectively. These projections indicate that there will be twice as many ADHB residents living in an area of deprivation (Q4 or Q5), than those living in less deprived areas (Q1 and Q2) (DPH, 2006).



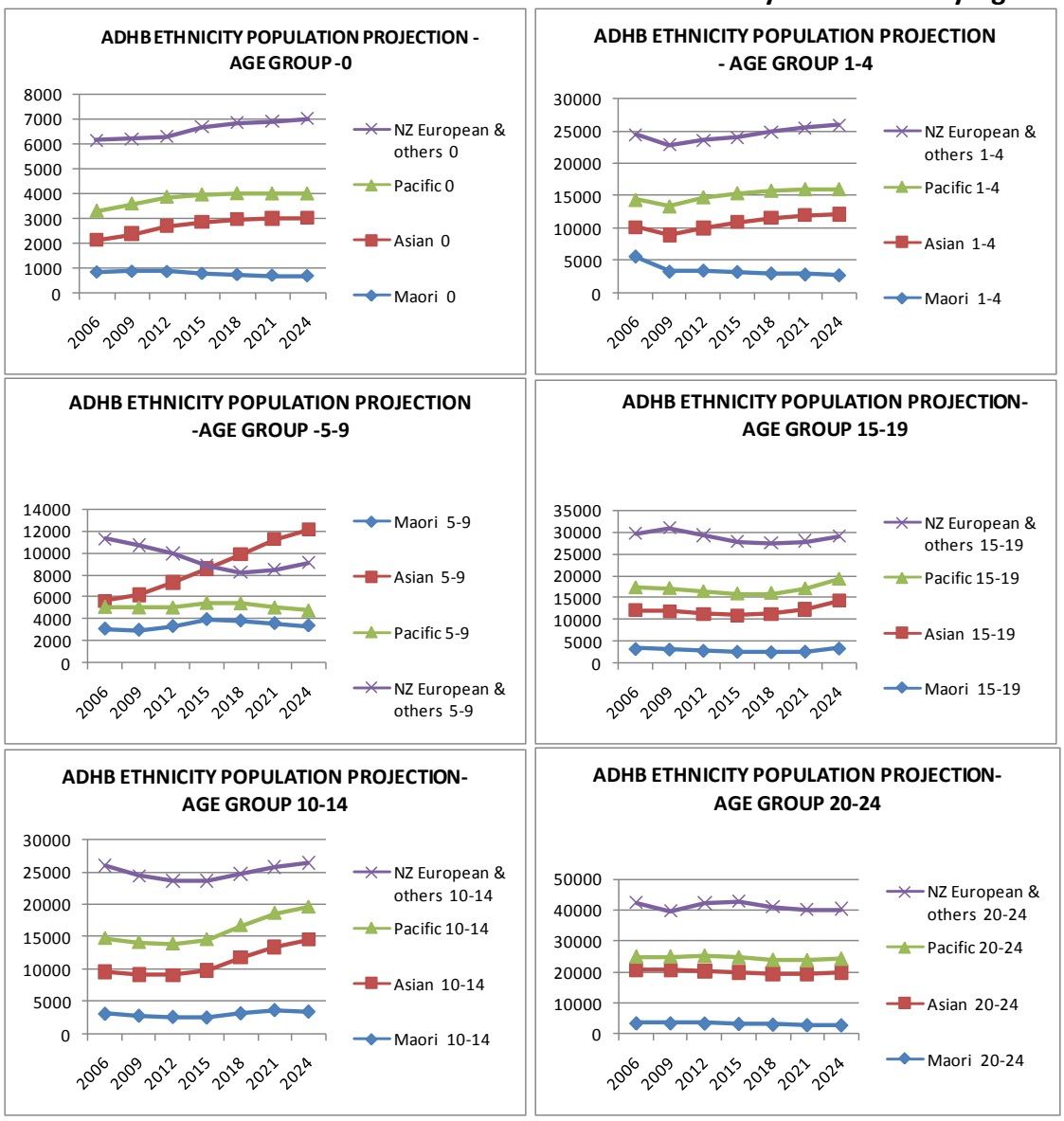
Data Source: (K. Wang, 2012)

Other Statistical facts:

- The unemployment rate in 2011 was approximately 7% for the Auckland region (including ADHB, CMDHB and Waitemata DHB)
- The ADHB specific data available is for 2006 which indicated a 4% unemployment rate for this region
- In 2011, 7% of the ADHB population was identified as having a high or very high probability of having an anxiety or depressive disorder (K-10 score of 12 or more) and 17% of the population was identified as having a hazardous drinking problem

What this looks like

Auckland District Health Board Ethnicity Breakdown by Age



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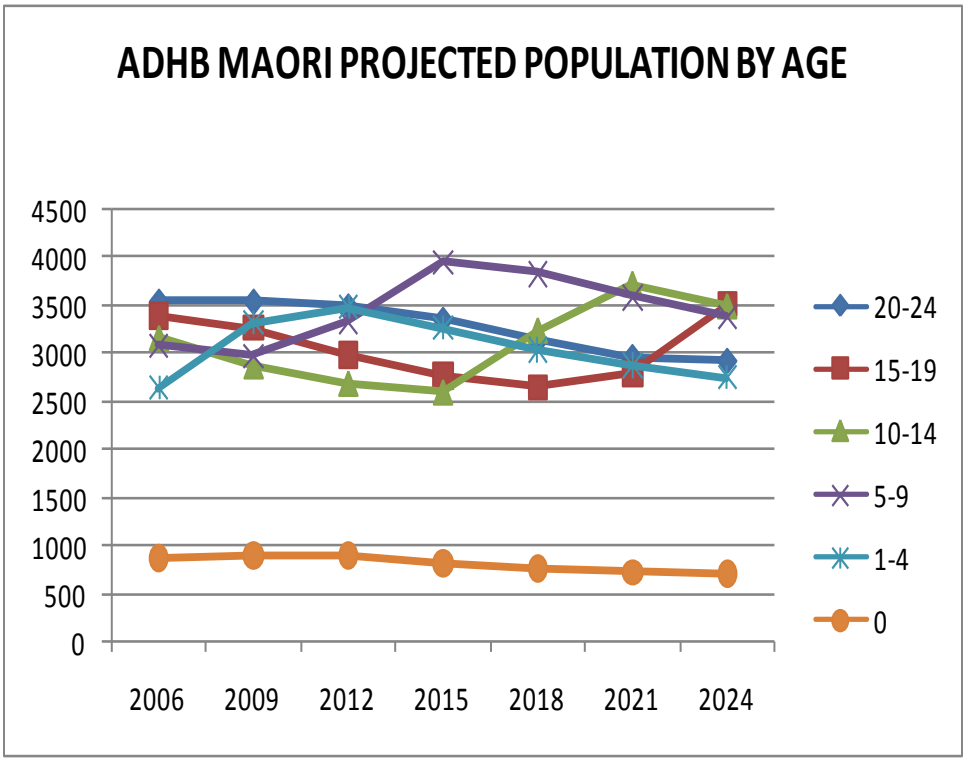

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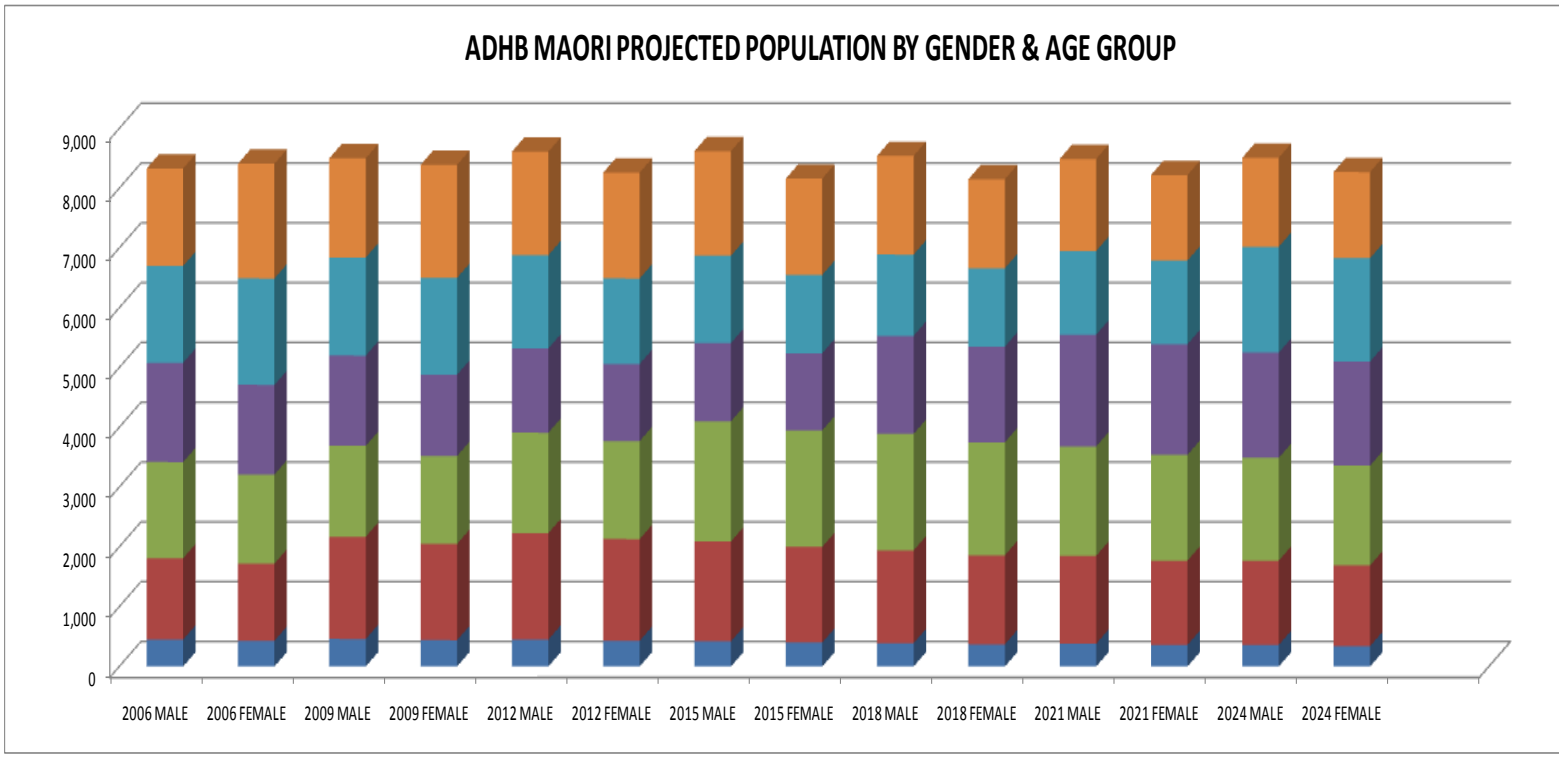

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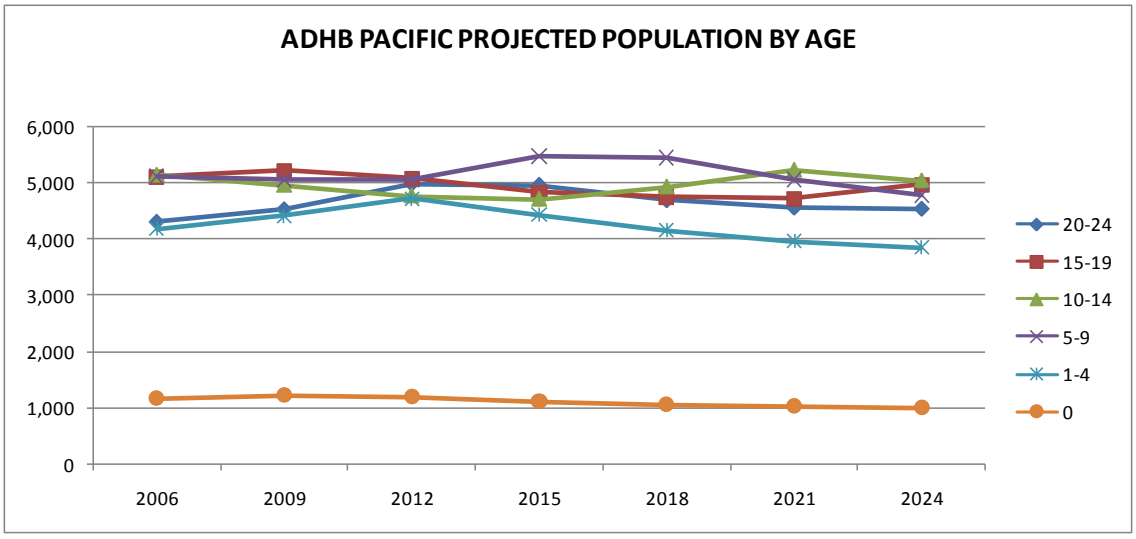

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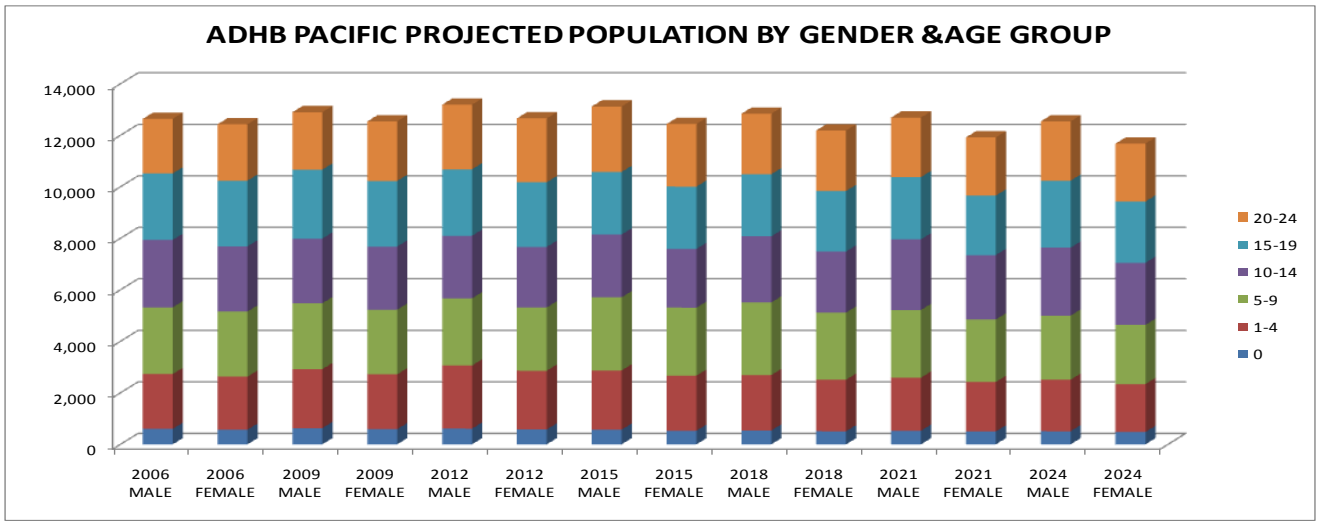

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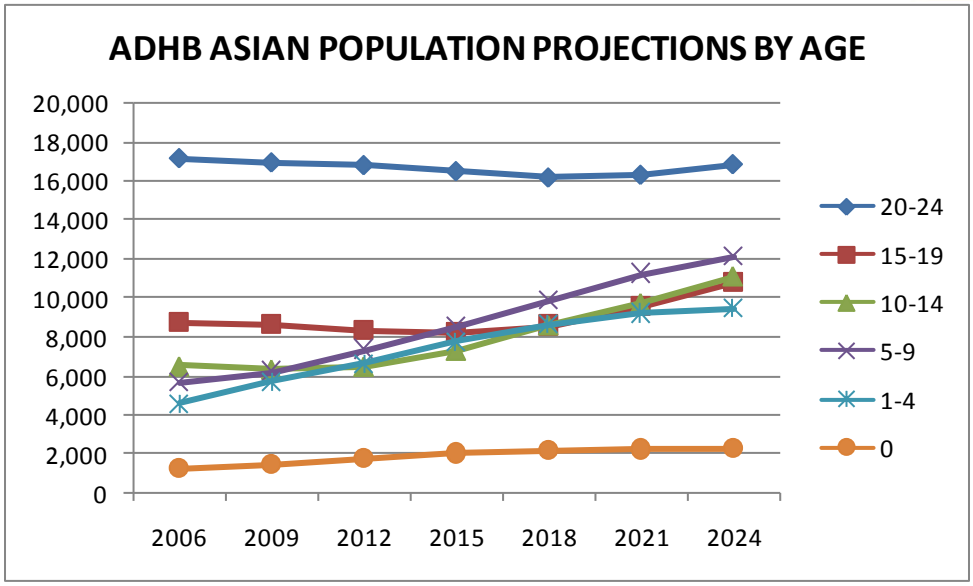

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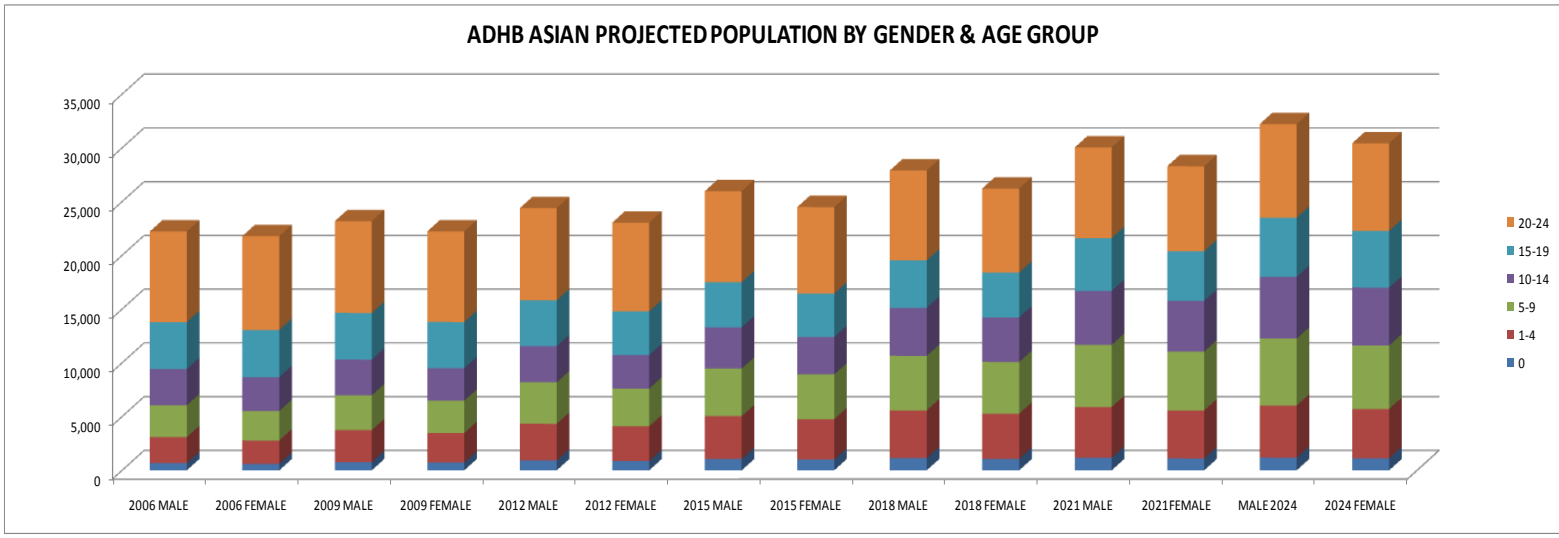

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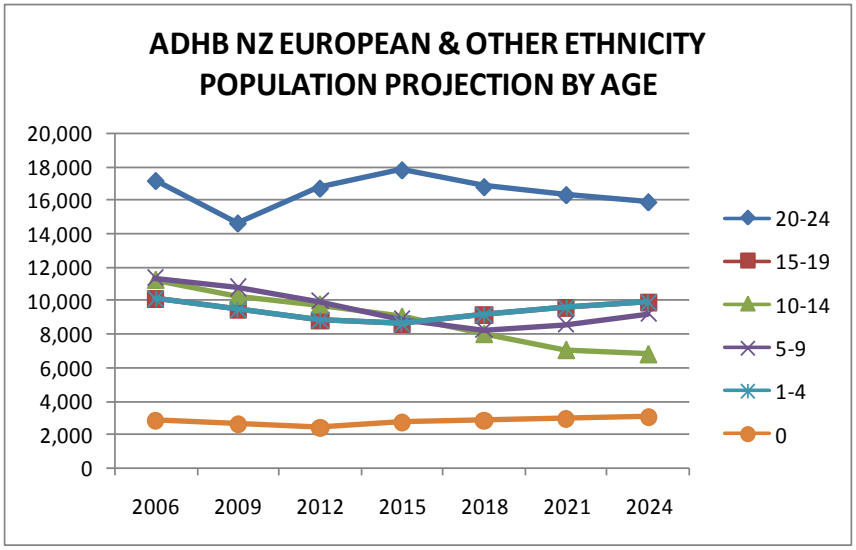

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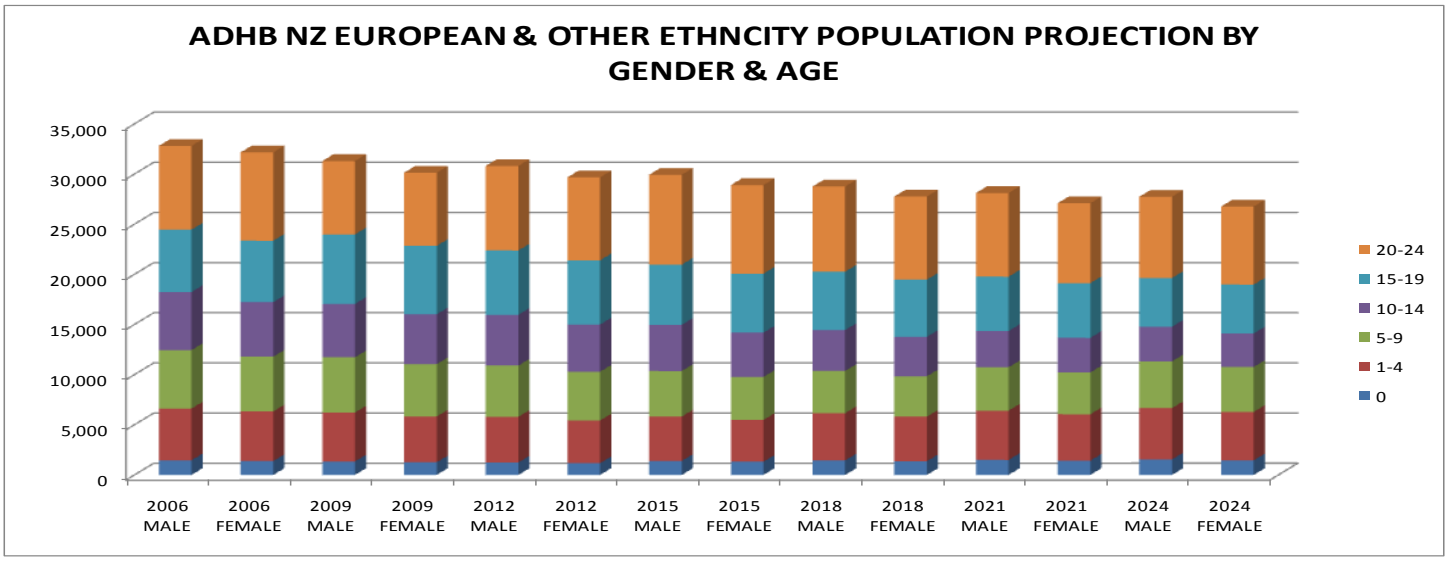
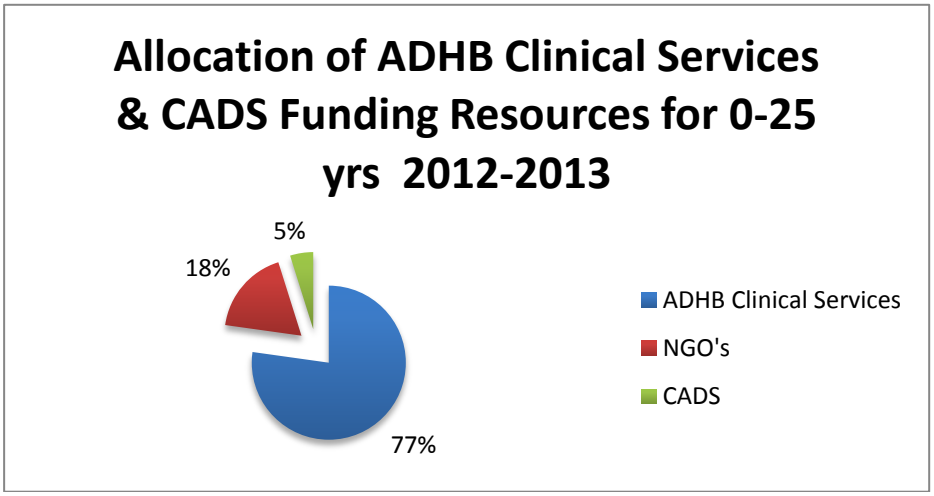


Data Source: (StatsNZ, 2011a)

3.2 How we arrange our services at ADHB

The majority of ADHB child and youth mental health & addictions funding is utilised to provide ADHB specialist services to those with severe mental health & addiction issues. A small percent of the funding is utilised by NGOs who also provide services to this client group.



Data Source: Community Alcohol and Drugs Service – CADS Auckland

How ADHB Services are used – the Summary

Following are the significant points from the breakdown of the utilisation of services within the service groups outlined above:

- 94% of Kari Centre services are provided by the community team
- 77% of the MH Inpatient adult services are provided by Liaison Psychiatry
- The Taylor Centre (27%), St Lukes Centre (24%), Cornwall House (19%) and Maanaki House (17%) provide the majority of the MH Community Adult Services
- The Regional Eating Disorder Service (44%) and the Regional Youth Forensic Service (38%) provided the majority of the Regional Services (these numbers include the ADHB clients utilisation of the services)
- 94% of CADS services was provided by their Counselling Services arm

How our services are used – the detail

On average 4,733 children and young people access ADHB clinical services a year. The breakdown is as follows.

Total Child & Youth seen 20011-2012	0-4y	5-14y	15-17y	18-25y
Total	66	925	1368	2374

(Note: this does not include Maternal Mental Health)

A total of 221 child and youth accessed regional services from the ADHB area (excluding CADS).

Service Groups	Age from 00 - 25			
	5-14yrs	15-17yrs	18-25yrs	Total
Regional Services				
Regional Eating Disorders Service	11	23	64	**98**
Buchanan Rehabilitation Centre	0	0	14	**14**
Community Neuro-Behavioural Service	0	0	3	**3**
Segar House-Rauaroha	0	0	17	**17**
Regional Youth Forensic Service (RYFS)	**7**	**75**	**2**	**84**
Child & Adolescent Liaison Service	**1**	**4**		**5**
TOTAL	**19**	**102**	**100**	

Data Source ADHB Mental Health Clinical Analyst, 2011-2012

A total of 1184 ADHB residents accessed the CADS services from the ages 5 to 25.

CADS: Child & Youth Data 1.7.2011 – 30.6.2012 for ADHB Area

CADS Services	5-14 No. Clients	15-17 No. Clients	18-25 No. Clients
Tupu	**1**	**25**	**131**
Youth	**2**	**108**	**178**
Te Atea Marino		**13**	**54**
CADS Mt Eden Intensive Outpatient			**14**
Auckland Opioid Treatment Service			**25**
Community & Home Detox Service			**24**
Dual Diagnosis			**25**
Detox IPU			**15**
CADS Counselling			**556**
Pregnancy & Parental Service			**13**
Total	**3**	**146**	**1035**

Data Source: Community Alcohol and Drugs Service – CADS Auckland

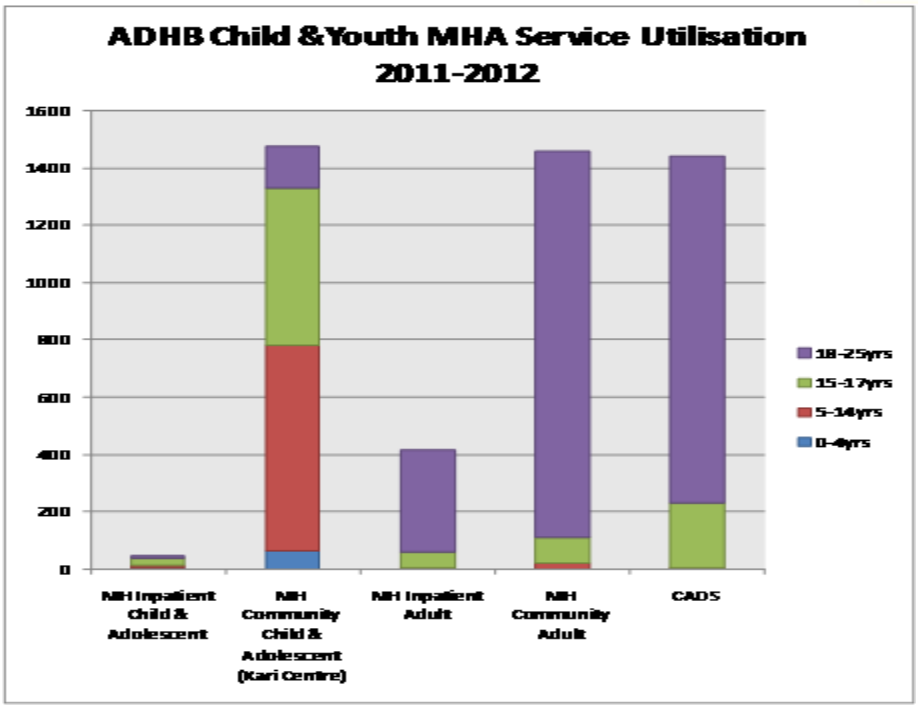
In any one day 19% of the people receiving services from ADHB are in the 0-19 year age group.

Service	Team	Open cases	People seen to day	Contacts made today
Children & Youth Services	Community	493	62	82
	Youth Early Intervention	19	6	8
	Youth Transition	17	6	8
	Youth Forensic	92	11	17
Child & Family Unit	Child & Youth Acute	23 beds	12 inpatients on this day	

Data Source ADHB Mental Health Clinical Analyst, 2011-2012

The detail

- Of the 62 0-4 years old annually accessing ADHB services they are most likely to access the Kari Centre services
- Of the 763 5-14 years olds annually accessing ADHB services 718 access the Kari Centre services
- Of the 612 15-17 years old annually accessing ADHB services they are most likely to access Mental Health Community Child & Adolescent services
- Of the 710 18-25 year olds annually accessing ADHB services they are most likely to access the Mental Health Community Adult services, and
- 1365 18-25 year olds access CADS services.



Data Source ADHB Mental Health Clinical Analyst, 2011-2012

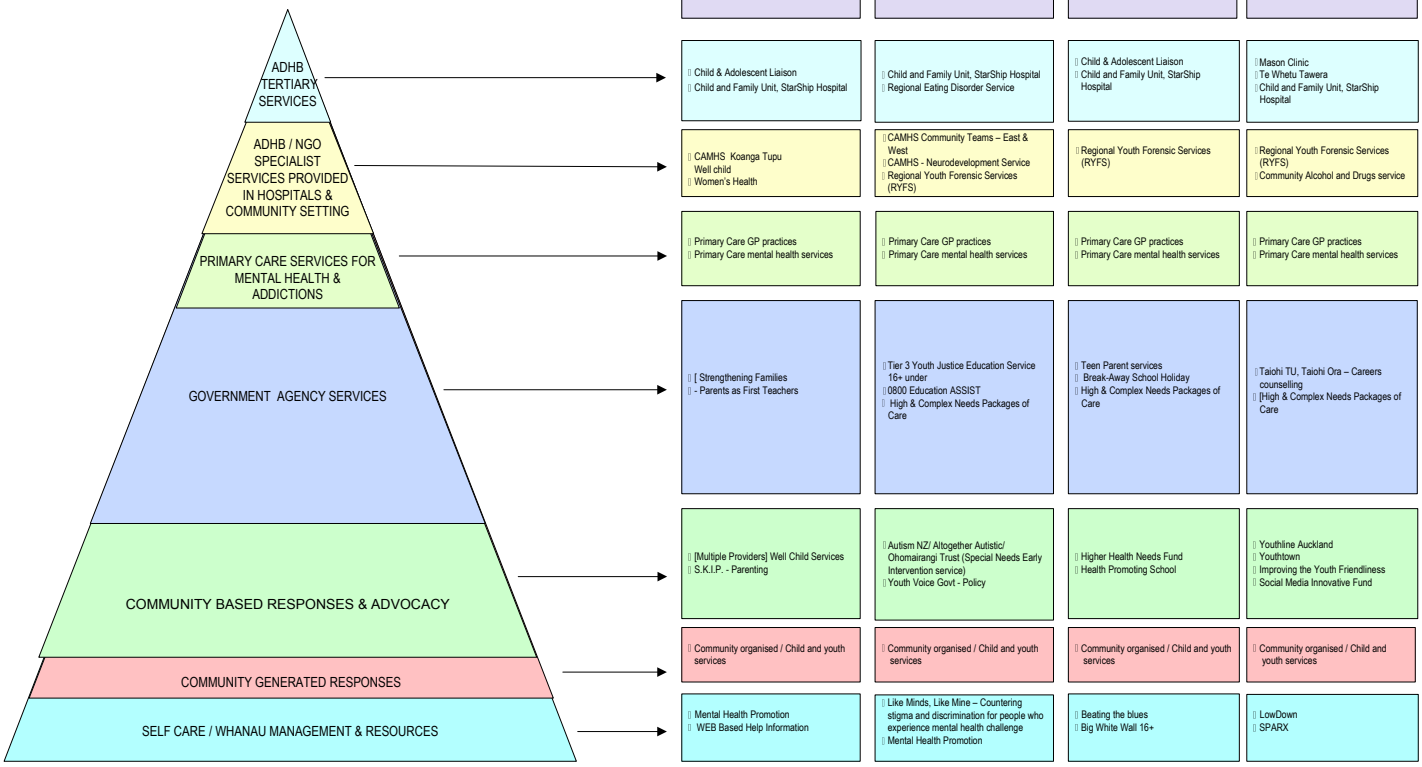
3.3 How services are arranged across agencies

There are a plethora of services available to children and youth across the agencies, all have their role to play in a persons or families recovery. The challenge for both those seeking assistance and those trying to find appropriate services is knowing what is available, the services provided and what are the referral criteria.

Using the Blueprint II stepped care model as a basis, services were grouped into the following steps and the first four life courses were used as a way to group services. The services listed below are an example of the services available across the agencies; the charts with the fuller list of services are in the Appendix 2.

Services available to child, youth and families to address mental health and general wellbeing provided by both ADHB and other agencies – the high level

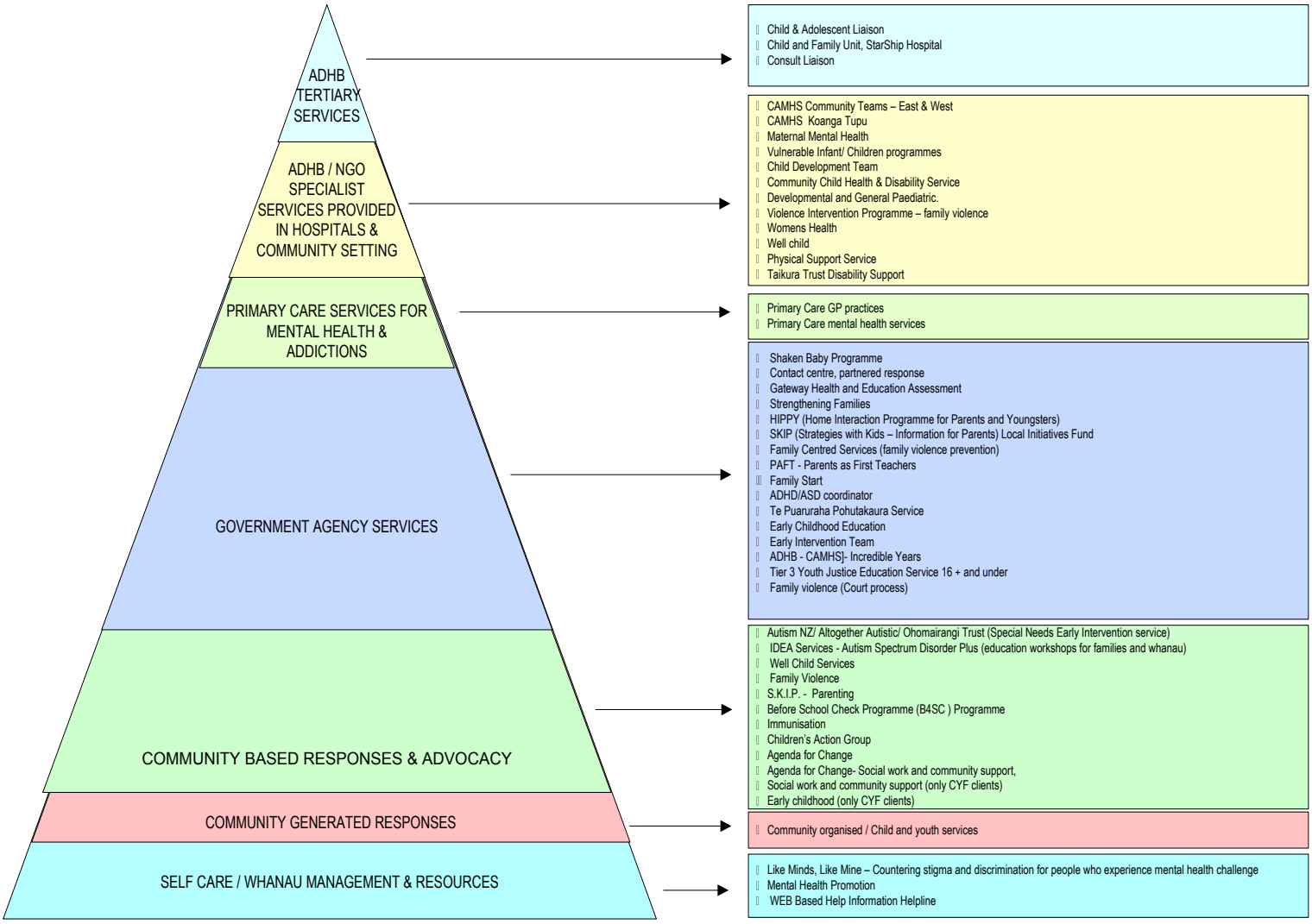
An **INDICATIVE** range of the services for each life course



Families/Whanau At Risk *(0 to +3 years)*	Children with mental health & behavioural issues Preschool to prepubescent (less than 12 years)	Youth / adolescents with emerging mental health, behavioural and addiction disorders	Youth / adolescents at high risk (including forensic). Youth with significant mental health, alcohol & drug & behavioural disorders
• Child & Adolescent Liaison • Child and Family Unit, StarShip Hospital	• Child and Family Unit, StarShip Hospital • Regional Eating Disorder Service	• Child & Adolescent Liaison • Child and Family Unit, StarShip Hospital	• Mason Clinic • Te Whetu Tawera • Child and Family Unit, StarShip Hospital
• CAMHS Koanga Tupu Well child • Women's Health	• CAMHS Community Teams – East & West • CAMHS - Neurodevelopment Service • Regional Youth Forensic Services (RYFS)	• Regional Youth Forensic Services (RYFS)	• Regional Youth Forensic Services (RYFS) • Community Alcohol and Drugs service
• Primary Care GP practices • Primary Care mental health services	• Primary Care GP practices • Primary Care mental health services	• Primary Care GP practices • Primary Care mental health services	• Primary Care GP practices • Primary Care mental health services
• [Strengthening Families • - Parents as First Teachers	• Tier 3 Youth Justice Education Service 16+ under • 0800 Education ASSIST • High & Complex Needs Packages of Care	• Teen Parent services • Break-Away School Holiday • High & Complex Needs Packages of Care	• Taiohi TU, Taiohi Ora – Careers counselling • [High & Complex Needs Packages of Care
• [Multiple Providers] Well Child Services • S.K.I.P. - Parenting	• Autism NZ/ Altogether Autistic/ Ohomairangi Trust (Special Needs Early Intervention service) • Youth Voice Govt - Policy	• Higher Health Needs Fund • Health Promoting School	• Youthline Auckland • Youthtown • Improving the Youth Friendliness • Social Media Innovative Fund
• Community organised / Child and youth services	• Community organised / Child and youth services	• Community organised / Child and youth services	• Community organised / Child and youth services
• Mental Health Promotion • WEB Based Help Information	• Like Minds, Like Mine – Countering stigma and discrimination for people who experience mental health challenge • Mental Health Promotion	• Beating the blues • Big White Wall 16+	• LowDown • SPARX

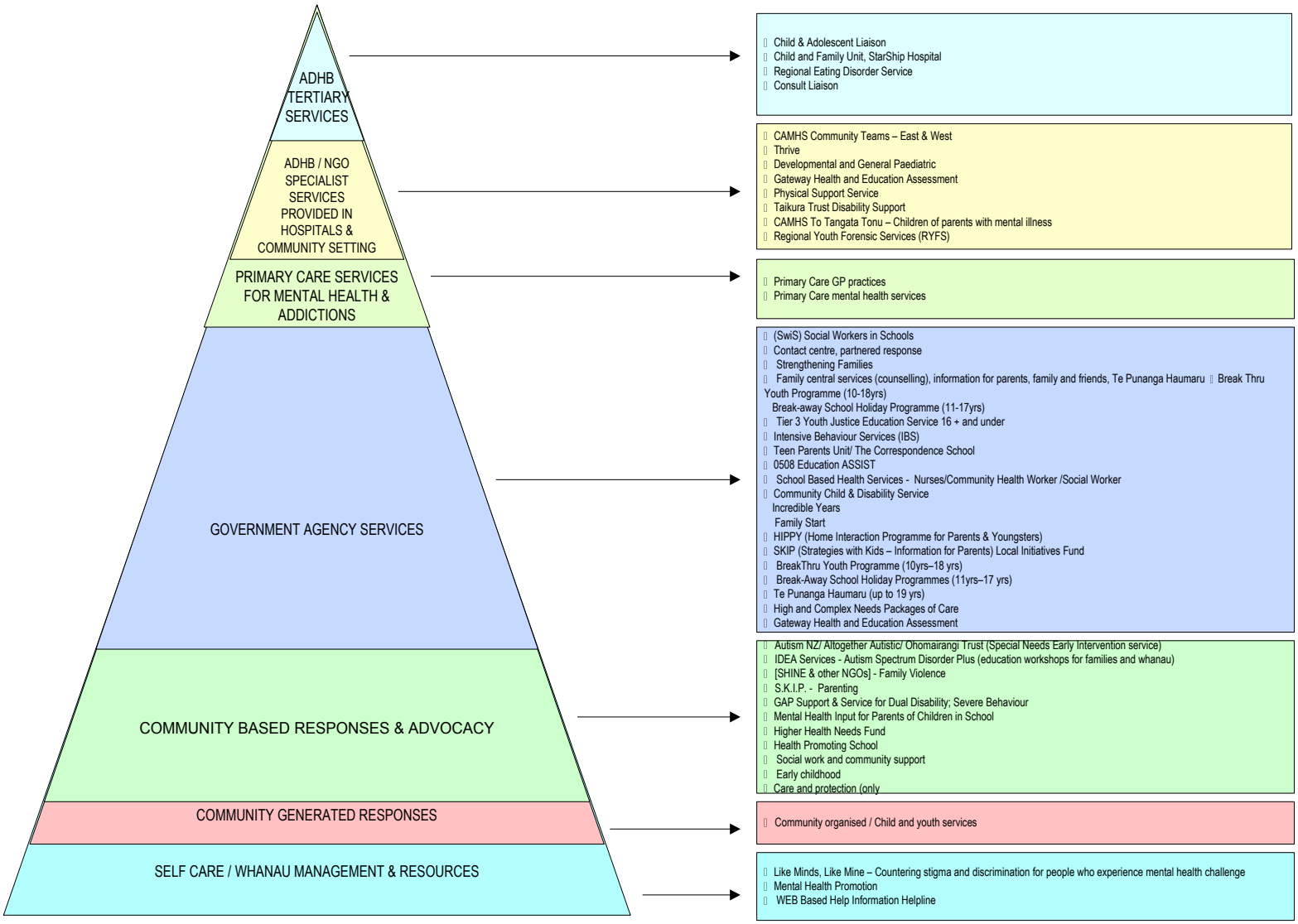
Services available to child, youth and families to address mental health and general wellbeing provided ADHB and other agencies – the detail

Families/Whanau At Risk ***(0 to +3 years)***



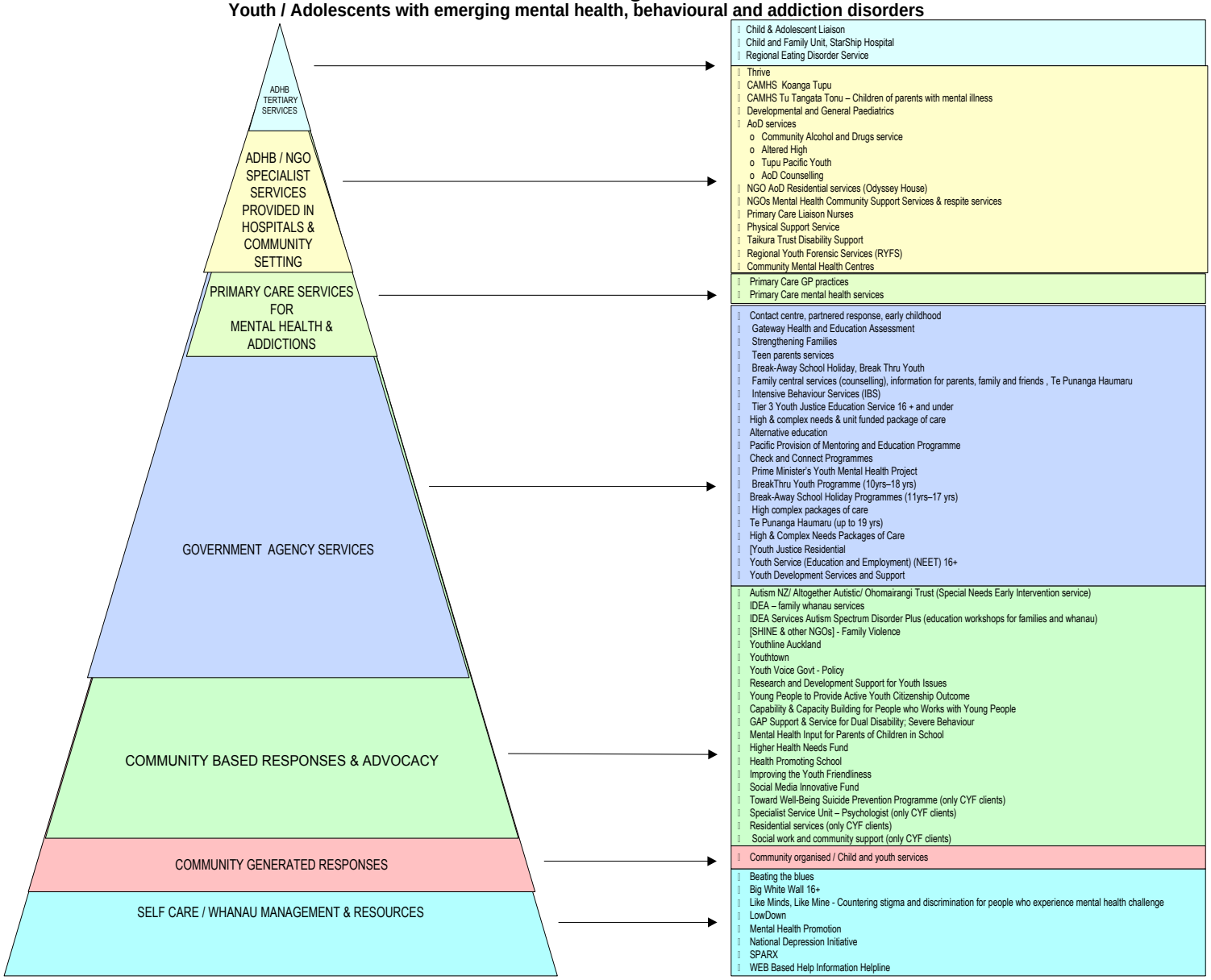
Services available to child, youth and families to address mental health and general wellbeing provided by both ADHB and other agencies – the detail

Children with mental health & behavioural issues Preschool to prepubescent (less than 12 years)



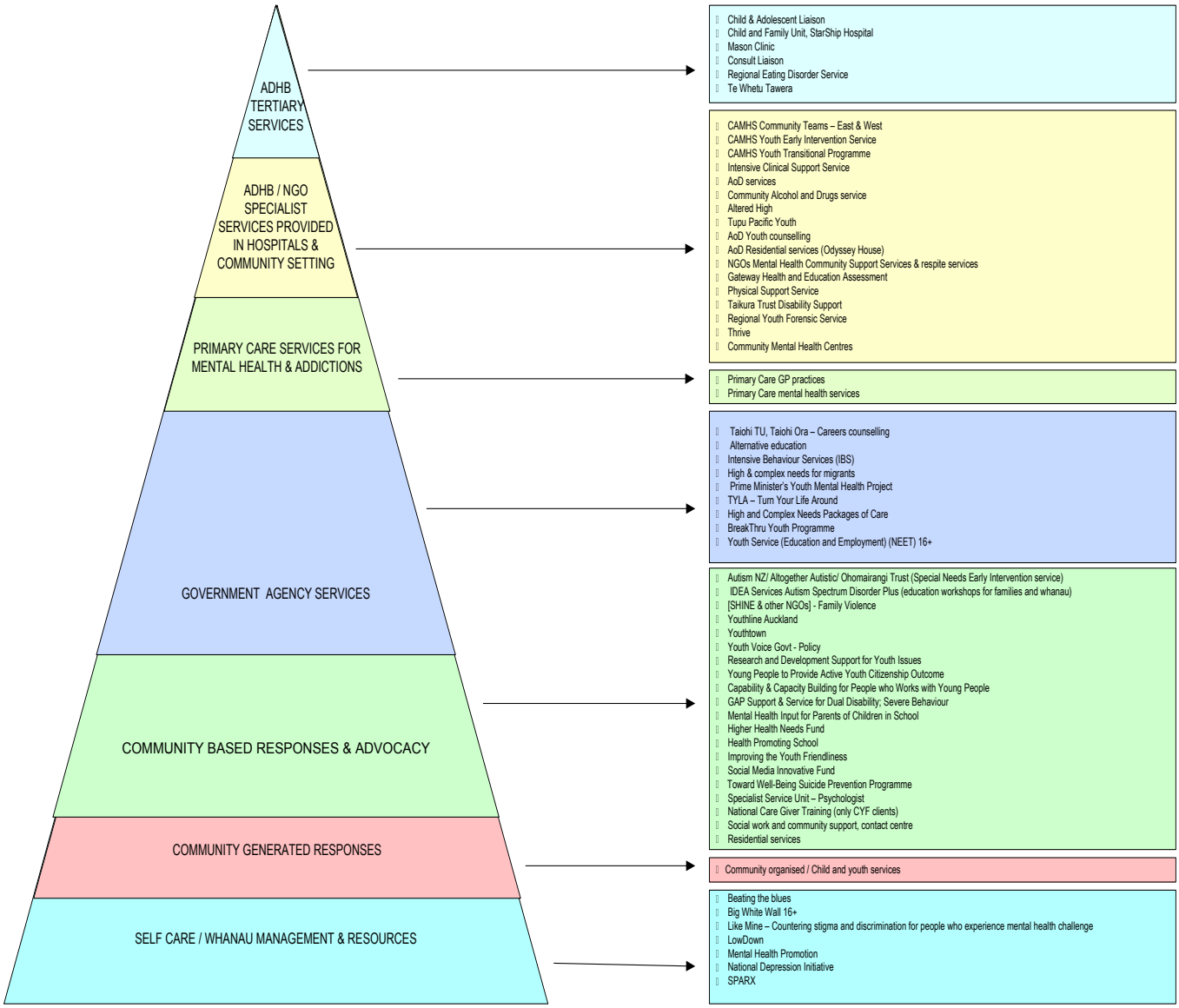
Services available to child, youth and families to address mental health and general wellbeing provided by both ADHB and other agencies – the detail

Youth / Adolescents with emerging mental health, behavioural and addiction disorders



Services available to child, youth and families to address mental health and general wellbeing provided by both ADHB and other agencies – the detail

Youth / adolescents at high risk (including forensic) Youth with significant mental health, alcohol & drug & behavioural disorders



4. HOW WILL WE KNOW WE ARE GETTING THERE?

Translating Strategy in Action – making it real

Now

Current data, detailed in this section provides us with a current state but does not reflect the data needed to measure the success of this strategy.

The data being recorded for the child and youth mental health and addictions KPIs and the improvement in primary care data will make a big difference. In addition the results of the 2013 Census will give an indication how useful the population projections are. A way will be found to include relevant data from other agencies.

Opportunity	Benefits/ KPIs	Deliverable	Key Actions	Timeline
1. Strengthening the Voice				
Services are seen as more accessible and responsive by children, young people and their families	KPI 1: Improved access to: • Specialist Services • On-line tool resources • Primary care • School • Self referral clinics	Processes and opportunities are established for children, young people and their families to influence the service framework as well as the co-design of and peer-lead services and the evaluation of services	Establishment of Youth Leadership initiative and other appropriate forums	14/15
	KPI 2: 95% of children, young people and their families report satisfaction regarding their ability to influence services		Youth Leadership initiative/ Youth forums to report into strategic networks e.g. Health Services Group	14/15
	KPI 3: Establishment of Youth Leadership initiative		Establish on-line opportunities for real-time feedback – linking with ADHB projects & MH Commission	14/15 on going
	KPI 4: 95% of Young people, children and family/ whanau report satisfaction with services		Young people to contribute to the in-service training for clinicians	14/15 on going
	KPI 5: Young people are active partners in the evaluation of all Child and Youth Mental Health & Addiction services		Establish standards for choice and partnership between young people / whanau and mental health and addiction workers	14/15
			Establish links to on-line peer support initiatives	14/15 on going
			Young people and family/ whanau are involved in	14/15 on going

			service evaluation	
			Work in partnership to strengthen existing processes to hear the voice of young people, children and family/ whanau	14/15 on going
			Work with young people, children and family/whanau to develop signposts to navigate services	14/15 on going
	Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific			

2. Intervening Earlier

There will be a decreased incidence of mental health & addiction issues later in life	KPI 1: Reduced demand on Specialist services	There are clear mechanisms and a skilled workforce to provide screening and early identification for: • Pregnant women • At-risk families • Children of parents with mental illness and addictions (COPMIA) • At risk infants and children • At risk youth and young adults	Agreement from key agencies/ providers regarding the implementation of screening within existing age-related health checks	14/15 and fully implemented 15/16. Reviewed 16/17
	KPI 2: Better range and access of services		Agreed pathways regarding clinical management	14/15 pathways reviewed and implemented. 17/18 better range & access evidenced
	KPI 3: Earlier access to services		Agreed set of age-related screening tools. This will be	14/15 and fully implemented 15/16

			implemented alongside the training of workforce	
	KPI 4: Achievement of all screening targets			
	KPI 5: Fewer young people and families experience a Mental health and Addictions emergency that is distressing.			
	KPI 1: Reduced demand on Specialist services	There will be increased access and early response	Better promotion of existing resources for self-management using social media as a primary means to connect with young people & families/ whanau	14/15 on-going
			Increased range of options for self-management e.g. on-line resources and social media	14/15 on-going
			Resilience programmes in schools e.g. Prime Ministers Youth Mental Health Project	14/15 on-going
			Positive parenting	14/15 on-going
	Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific			

3. Addressing Inequalities

To increase Mental health & Addiction literacy of young Maori and Pacific, their families and whanau and reduce stigma and discrimination	KPI 1: Number and mix of people attending MH101	Delivering health literacy training face to face or on-line by Maori & Pacific for Maori & Pacific children & young people	Develop or source culturally appropriate material that is available to use in a variety of settings	14/15 develop and fully implemented 15/16
	KPI 2: De-stigma programme for		Access to learning	15/16

	Maori & Pacific young people by Maori & Pacific using social media as a vehicle within two years		opportunities made readily available in a variety of settings and formats e.g. courses or short sound bites	
	KPI 3: Percentage of existing & new health initiatives include culturally appropriate content		In partnership with agencies e.g. La Va ensure young people are appropriately trained or sourced to deliver the material	14/15
	KPI 4: Survey Maori, Pacific and other vulnerable groups of young people to establish their access to services and the service effectiveness		Each learning opportunity includes a feedback cycle which will inform future delivery & content of materials	14/15 on going
			Aligning with the actions in Working Better Together utilising materials and programmes that are relevant and initiated by other agencies	15/16
Ensure the unique societal structures, primarily in Maori and Pacific communities and the place of religion do not act as a barrier to access services	KPI 1: Increase the access rates for Maori and Pacific and other minority groups to match national targets for: • Specialist services • On-line tools resources • Primary care • Schools • School referral	Data collected to accurately measure access	Work to improve quality of PRIMHD data and include Primary Care, HVAZ and Kaupapa Maori and student health services	14/15 on going
Service to be more responsive to Maori & Pacific	KPI 1: 95% of children, young people and their families report satisfaction with services	Increase in satisfaction level with services	Implement Mental Health Commission's real time service assessment	14/15

	KPI 2: 95% of children, young people and their families report satisfaction regarding their ability to influence services		Utilise feedback from consumer satisfaction survey & general feedback to improve general responsiveness	15/16
4. Fostering Innovation				
Children, young people and their families/ whanau will directly benefit from a culture of innovation and new approaches	KPI 1: Number of new e-health initiatives that improve access to seeking help/ support	Experiment with different technologies that remove barriers and improve access to those seeking help/ support	Proactively link with national child & youth e-health related initiatives	14/15
	KPI 2: Percentage on-line service hits		Develop resource of e-self-help tools / resource links	15/16
	KPI 3: Number of learning events held and feedback		Establish links to on-line peer support initiatives	14/15 on going
	KPI 4: Number of new contracting models evaluated and trialled			
		Create an annual learning symposium (regional)	Link with other regional child & youth mental health networks	14/15 on going
			Link with Werry Centre and other groups to explore the opportunity to support at least three learning events over the next 2 years e.g. RCAMHS	15/16
			We will link into virtual learning networks in this field	14/15 on going
		Explore models for	Identify appropriate	15/16

		contracting that support innovation, strengthen outcomes and enables a partnership approach	contract models e.g. results based accountability or social bonds	
			Partner with other health & social care agencies to identify joint contracting opportunities	15/16
			Different models are trialled and evaluated	15/16 trial, evaluation concludes 17/18
	Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific			

5. Workforce Development

The lived experience of children, young people and families/whanau is a valued contributor to personal resilience and recovery, peer support and other forms of help and treatment	KPI 1: Year on year growth in peer support roles	Increased opportunities for employment and peer support for those with lived experience	Establish a workforce plan for peer support	14/15
	KPI 2: Percentage of people in workplace with identified lived experience (whole workforce) through an annual anonymous survey		Actively work with Werry Centre to develop youth peer support training	14/15 develop. 15/16 deliver
	KPI 3: All job descriptions include a lived experience as desirable		Work with funding & planning to explore employment opportunities for young people	15/16
	KPI 4: Training & orientation to include peer support experience	Lived experience is reframed as a valuable life	Provide more training opportunities for primary	15/16 on going

		skill base for resilience recovery, service planning & provision	care, nursing/ medical training programmes	
	KPI 5: Number of staff trained in the use of virtual tools		Work with training providers (internal) & under/ post graduate providers	15/16 on going
	KPI 6: Number of staff with cross agency experience		Establish youth and family reference groups	14/15
	KPI 7: Annual workforce profile reflects population diversity both cultural and age		Reinforce self / whanau directed care	14/15 on going
There is a workforce that has the skills mix and diversity that is sustainable into the future. It is confident to work fluidly across organisational boundaries and with virtual tools		Workforce plan is developed and implemented that reflects future workforce requirements and Health Workforce New Zealand's national plan	Implement a workforce plan that includes: • Definition of potential shift in workforce required to meet the diversity of our population • Definition of who does what and where so we work in different ways and in different places • Confirmation of role of young people with lived experience in relation to in-service training for staff • Across agency and continuum work experience • Increasing skills and use of on-line tools • Reflection of youth and	14/15

			cultural diversity / identity • Orientation and internship programmes that prepare and equip staff to know how they can contribute to address our key six priorities	
			Develop staff skill mix so that the core set of competencies enables us to have "the right staff at the right place at the right time with the right skills"	14/15 develop, fully implemented 16/17
	Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific			

6 Working Better Together

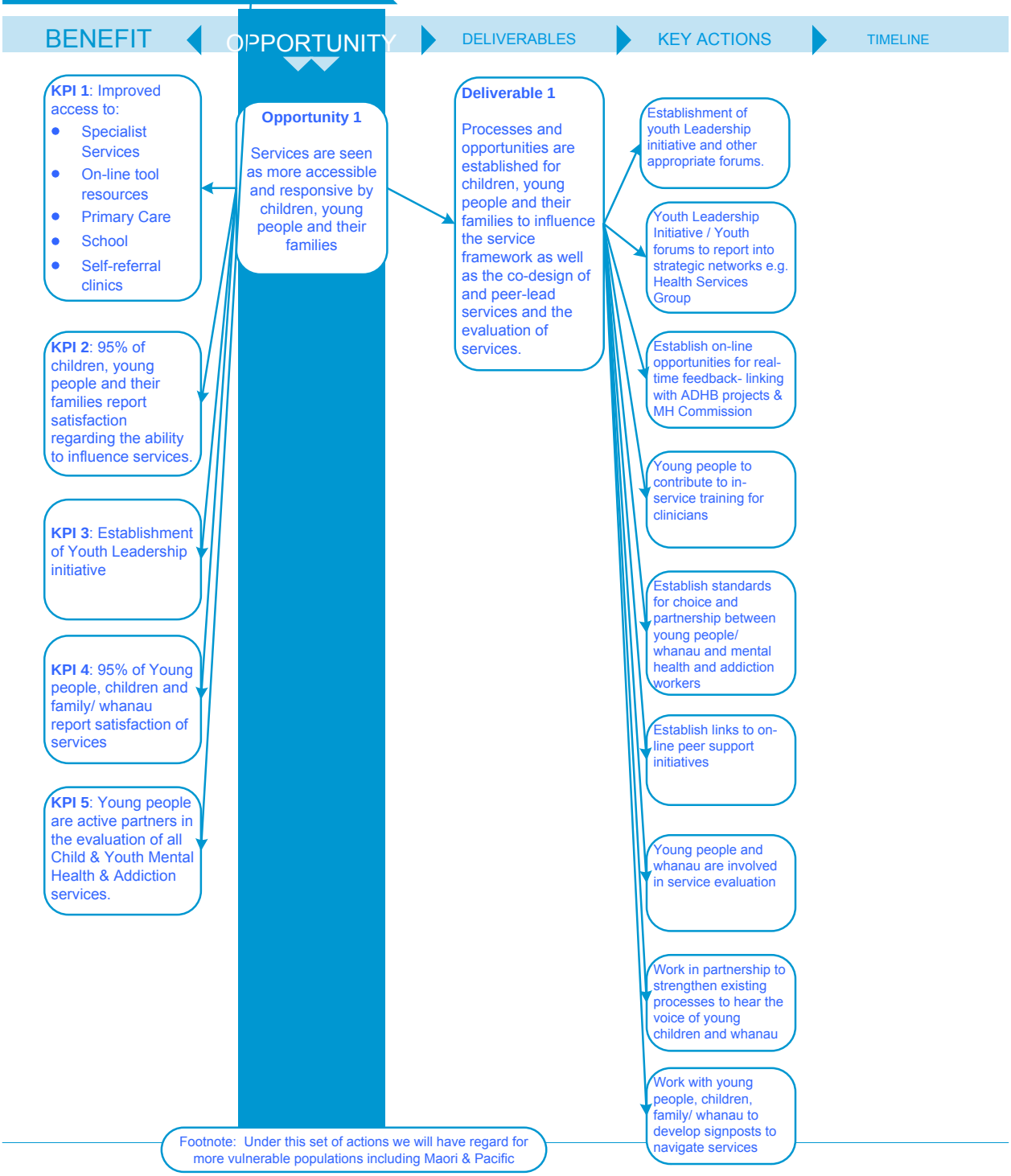
The whole system works together to improve process and access for children, young people and their family/ whanau to the appropriate services at the right time	KPI 1: Track number of agreed multi-agency shared plans	There will be agreed referral pathways for various levels of need - especially those with high need and multi-agency involvement	Establish a working group between ADHB, WDHB, MSD & Education for multiagency referral / pathways and discharge/ transition	2013/14
	KPI 2: Reduced wait times for reaching agreed shared care plan		Use existing coordination processes more effectively e.g. Gateway and Strengthening Families	2013/14
	KPI 3: Agreed referral pathway		Joint care planning and prioritisation for those with high need and multi-agency	2013/14

			involvement	
	KPI 4: Annual sample audit of shared care plans	Whanau ora initiatives will be used as basis for the whole family approach	Links will be strengthened with ADHB Whanau ora initiatives and Pacific & Maori Health Plans	14/15
			Joint care plan & prioritisation for those with high need and multiagency involvement	14/15 on going
		Whole of system resources and contacts are well understood by all agencies so for the public "any door is the right door"	Clear list of stakeholders and key contact points	14/15 on going update
			Use of web-based tools to assist in linking with services and referral pathways	15/16
			Strengthening of consult liaison services form ADHB Child & Youth Mental health	14/15 on going
			Services know how to navigate these services rather than the young people or family/ whanau needing to know	14/15 on going
			Learn from, and where appropriate participate in initiatives started by our agency partners or from overseas	15/16
	Under this set of actions we will have regard for our more vulnerable populations including Maori and Pacific			

Auckland DHB
Mental Health And Addiction Services

The Integrated Child and Youth Mental Health & Addiction Strategy 2013-2023

Strengthening the Voice



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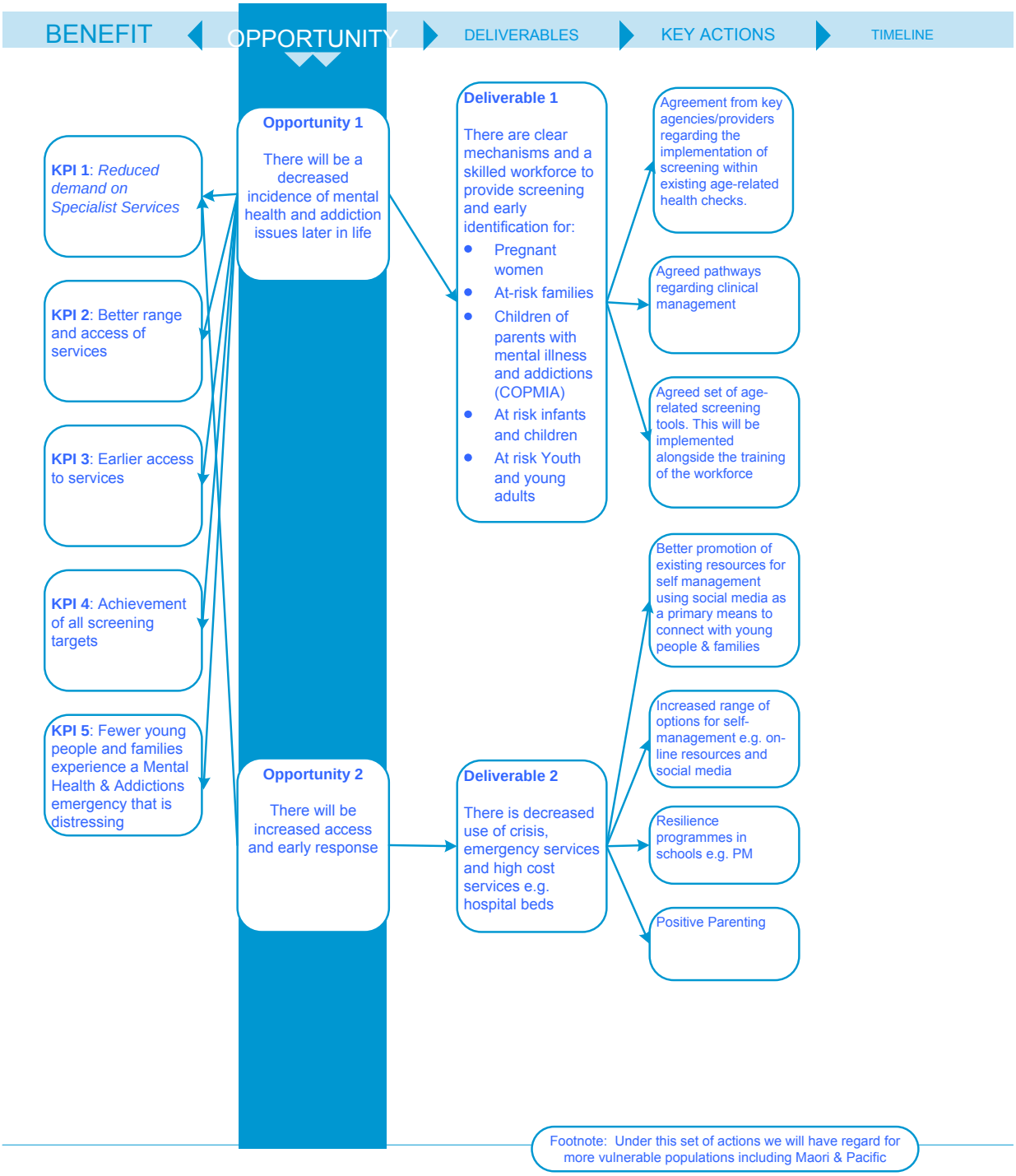
Mental Health And Addiction Services

The Integrated Child and Youth Mental Health & Addiction Strategy 2013-2023

Intervening Earlier



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Mental Health And Addiction Services

The Integrated Child and Youth Mental Health & Addiction Strategy 2013-2023

Addressing Inequalities

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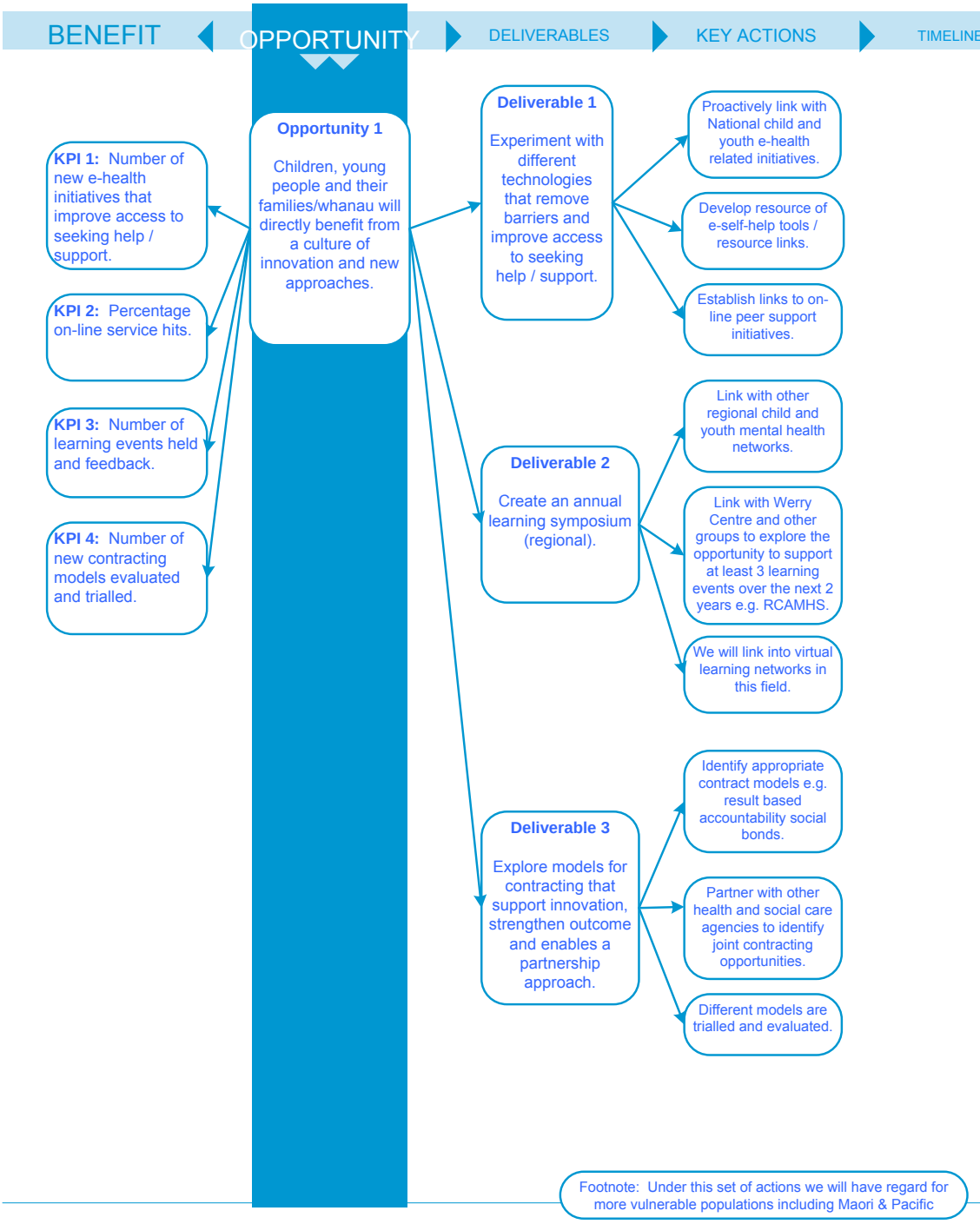
Mental Health And Addiction Services

The Integrated Child and Youth Mental Health & Addiction Strategy 2013-2023

Fostering Innovation



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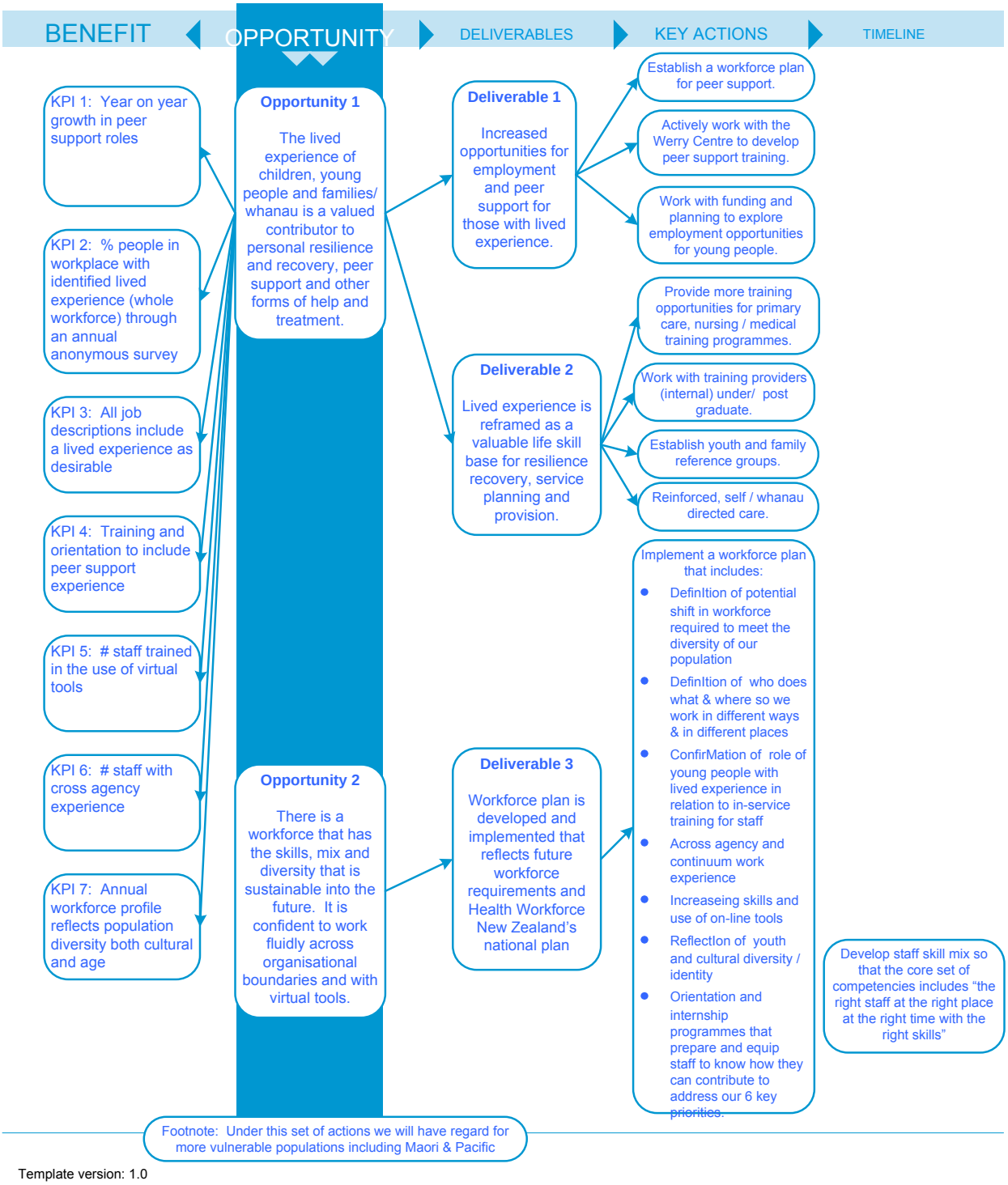
Workforce Development



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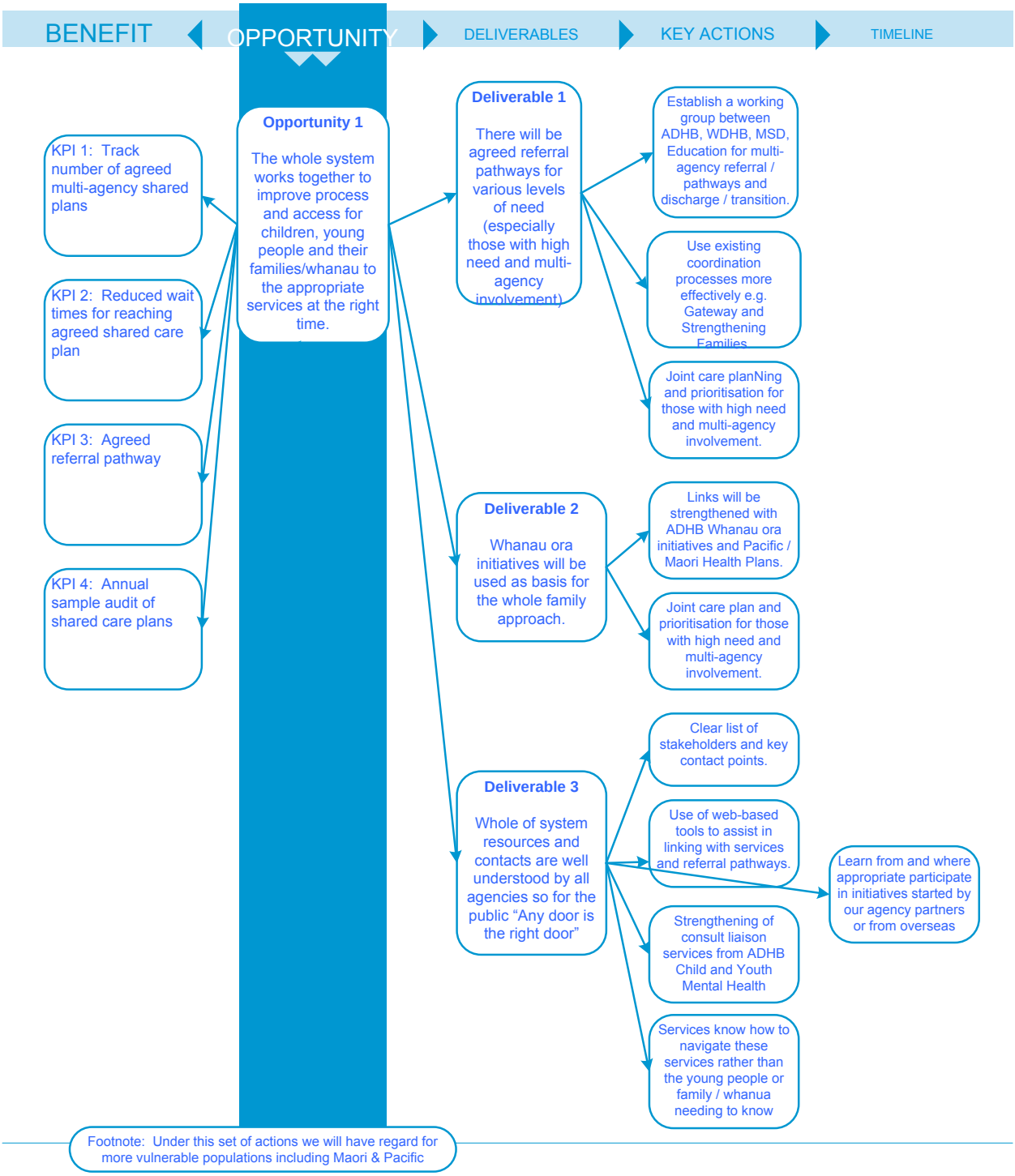
Working Better Together



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5. WHO HAS BEEN ON OUR WORKING GROUP?

Paul Ingle (Chair, Wise group, member of HSGL)

Helen Wood (GM Mental Health & Addictions ADHB & WDHB, member of HSGL)

Hilary Carlile (Planning & Funding Manager Mental Health & Addictions, member of HSG, Project Manager)

Kirsty Fong (member of HSGL, Consumer Leader, Affinity)

Mike Butcher (Clinical Director ADHB)

Sarah Wallbank (Service Manager, Kari Centre, ADHB)

Carol Stott (Children, Youth & Women, Planning & Funding ADHB)

Fionnagh Dougan (GM Clinical Services - Child Health)

Alison Leversha (ADHB West Kids Paediatrics)

Marty Rogers, (Manager Maori Health Gains ADHB & WDHB)

Rose Hawkins (Regional Child Disability Advisor, MSD)

Nigel Kapa (Regional Youth Development Officer, MYD)

Jennifer Leigh (Regional Relationship Manager, FACS)

Angela Drake (Social Development Manager, Work and Income)

Marilyn Mitchell (Regional Manager Ministry of Education)

Grant Malins (Regional Manager, Ministry of Education)

6. WHO HAS CONTRIBUTED?

The Working Group
ADHB Mental Health & Addictions Health Services Group
ADHB CAMHS Team
ADHB Adult Mental Health Services
Lotofale Pacific Mental Health Service ADHB
Pacific Counselling Service (Tupu) - Community Alcohol and Drug
ADHB/ WDHB Pacific Planning & Funding Team
ADHB Asian Mental health Service
Participants in Maori Hui
ADHB & WDHB Maori Health Gains Team
St Paul's College Ponsonby
Soalaupule WDHB/ADHB
Epsom Methodist Tongan Group
ADHB Pacific Young Leaders Group
Affinity Youth Forum
ADHB Senior Management Team
ADHB Planning & Funding Team

And many others who have been part of our many conversations and shared our passion for this strategy.

APPENDIX 1 DEFINITIONS

Abandonment	desertion
Addictions	The term addiction relates to a state of physiological or psychological dependences on alcohol and other drugs.
ADHB	Auckland District Health Board
Anxiety	Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth, somatic complaints and rumination.[2] It is the subjectively unpleasant feelings of dread over something unlikely to happen, such as the feeling of imminent death.[
AOD	Alcohol & Drugs
Asthma	Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction, and bronchospasm.
CALMEND's	A partnership initiative of the California Departments of Mental Health (DMH) and Health Care Services (DHCS) to improve quality and outcomes for publicly funded mental health services.
CADS	Community Alcohol and Drug Services
CAMHS	Child & Adolescents Mental Health Services
Cancer	known medically as a malignant neoplasm, is a broad group of diseases involving unregulated cell growth
Chronic	chronic condition is a human health condition or disease that is persistent or otherwise long-lasting in its effects.[1] The term *chronic* is usually applied when the course of the disease lasts for more than three months
Counseling	Counseling services include a focus on assets and strengths, person–environment interactions, educational and career development, brief interactions, and a focus on intact personalities
Crisis Team	Crisis Services team provide on-site crisis assessment and intervention services
Delinquent	also known as juvenile offending, or youth crime, is participation in illegal behavior by minors (juveniles)
DHB	District Health Boards
DMH	Departments of Mental Health
Depression	Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being
Diabetes	diabetes, is a group of metabolic diseases in which a person has high blood sugar, either because the pancreas does not produce enough insulin, or because cells do not respond to the insulin that is produced
Disabilities	Disability is the consequence of an impairment that may be physical, cognitive, mental, sensory, emotional, developmental, or some combination of these. A disability may be present from birth, or occur during a person's lifetime.
Eating disorders	Eating disorders are conditions defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of an individual's physical and mental health
Epidemiological	Epidemiology is the study (or the science of the study) of the patterns, causes, and effects of health and disease conditions in defined populations.
E-therapies	Electronic therapy programmes aimed at helping people to resolve mental health, alcohol and other drugs or addiction issues.
Homelessness	Homelessness describes the condition of people without a regular dwelling. People who are homeless are most often unable to acquire and maintain regular, safe, secure, and adequate housing, or lack "fixed, regular, and adequate night-time

	residence.
Inpatient	Inpatient care is the care of patients whose condition requires admission to a hospital
KPI	Key performance indicator
Maternal Mental health	Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality
MOH	Ministry of Health
Multi –agency response	A situation in which one person, family or Whanau is involved with a number of services across the health and social sector
Refugees	People who are either applicants for refugee and protection status or appealing against refusal of refugee or protect status, where does people are eligible foe publicity funded health services.
Parental Mental illness	
Perinatal or Early Years	The term perinatal or Early Years means relating to the period immediately before and after birth. The internationally accepted timeframe is from pregnancy to one year postpartum
Person-Centered Care	Person-centered care supports active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment
Populations	population is a summation of all the organisms of the same group or species, who live in the same geographical area
Poverty	Poverty is the state of one who lacks a certain amount of material possessions or money and[1]refers to the deprivation of basic human needs, which commonly includes food, water, sanitation, clothing, shelter, health care and education.
Recovery	The process of change through which people improve their health and wellness, live a self – directed life and strive to reach their full potential
Self Directed Care	Self Directed Care supports active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment
Stepped - Care	An integrated and seamless approach to service delivery that involves intervening in the least intrusive way, from self care right across the NGO central & local agencies, primary care and DHB service continuum, in order to get the best possible outcomes, enabling entry and exit at any point based on need.
Social Support in Youth One Stop Shops (YOSS)	YOSS provides free, youth- friendly health and social services to young people. Community – based, and shares a philosophy of positive youth development.
Suicide	Suicide is the act of intentionally killing oneself
WDHB	Waitemata District Health Board
Whānau	Whanau is a Māori-language word for extended family
Youth	Youth is the time of life when one is young, but the term is often used in the more restricted sense of the time between childhood and adulthood(0 to 24 years of age)
Young and well CRC	The Young and Well Cooperative Research Centre unites young people with researchers, practitioners, innovators and policy-makers from over 70 partner organisations across the non-profit, academic, government and corporate sectors. (AUSTRALIA)

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3.3 2014/15 Annual Plan Approach

Recommendation:

That it be recommended to the Auckland and Waitemata DHB Boards:

That the Board:

a) Approve the approach to annual planning for 2014/15, including the longer term direction and timetable.
b) Note the national planning guidance, including updates and changes.

Prepared by: Simon Bowen (Director – Health Outcomes), Wendy Bennett (Planning and Health Intelligence Manager)

Glossary:

ACS - Acute Coronary Syndrome
DHB - District Health Board
HBSS - Home Based Support Services
HSGs - Healthcare Service Groups
NHB - National Health Board
SOI - Statement of Intent
SPE - Statement of Performance Expectation

1. Background

DHBs are required to have a finalised Annual Plan by 28 June 2014.

We are also required to contribute to the development of the revised Northern Region Health Plan which is being co-ordinated by the Northern Regional Alliance (NRA) on our behalf. Instructions regarding the plans are released each year by the National Health Board in a suite of policy and guideline documents, known as the Planning Package. The DHB has collated and provided feedback on this draft to the NHB. The final pack will be released late November/early December 2013.

2. Planning guidance – updates and changes

Recent changes to the Crown Entities Act (CE Amendment Act 2013) mean that the Statement of Intent (SOI) – which was previously a subset of the sections of the Annual Plan – will now become a high level, strategic document with a four year focus. While the Minister may, on occasion, require a more frequent SOI, in general this will only need to be tabled at least once every three years from 2014/15. As part of the Annual Plan, there will now be a requirement to develop an annual Statement of Performance Expectations (SPE). This will replace the previous Statement of Forecast Service Performance and will include Financial Performance and Stewardship sections which were previously separate modules.

Apart from the changes described above, requirements for the 2014/15 year are very similar to the last planning round, although a proportion of the detail of some of the components has yet to be finalised. A few other changes/items of note:

- Crown entity subsidiaries (DHBs' Shared Support Agencies) are not required to table an SOI, unless the Minister of Finance requires that subsidiary to continue to provide the SOI. The default is that parent DHBs are to report on the activity of their respective shared support agency in their own SOI. This default also applies to the incorporation of subsidiary information in the annual DHB SPE.
- Early signals are there is likely to be the continuation of existing priorities for Regional Service Plans. In 2014/15 the emphasis is expected to be the further advancement of 'enablers' (IT and workforce) and greater traction for existing priorities across electives, cancer, cardiac (ACS), stroke and mental health and addictions.
- The Health Sector Forum (a Ministry of Health instituted forum, which provides an opportunity for sector organisations to discuss and align their work programmes) has endorsed a prioritisation process for national entity initiatives in 2014/15, and it is intended that the guidance for DHBs will cover an extended period of three years, and have both non-financial as well as financial impacts. When the detail of the requirements have been finalised, a national entities priority initiatives template will be included as part of the guidance for annual planning for 2014/15.
- There are a small number of potential new performance measures for 2014/15 that are currently under discussion, but have not yet been released. These are:
    - measures of patient experience and/or Health quality and safety markers
    - DHB measures identified within the Integrated performance and incentive framework (primary care) that are not currently included in the DHB accountability framework
    - measures of access/quality to respite and/or HBSS for older people

  There may also be further review of other measures.
- DHBs are required to demonstrate engagement with PHO partners, including a letter of support for the Maori Health Plan and certain aspects of the Annual Plan, including Primary Care, the Prime Minister's Youth Mental Health Project, Maternal and Child Health and Long-term Conditions.

3. Proposed approach to Waitemata and Auckland Annual Planning

The proposed approach to the annual plan, focused on the increased alignment between Auckland DHB and Waitemata DHB, and the timetable of key activities required to complete the plan has been developed based on the draft guidance provided by the National Health Board.

Ongoing discussions will be required throughout the process with the National Health Board, NRA, PHOs, MoU partners and other DHBs to ensure the requirements are being met in a way that is appropriate for all stakeholders. To encourage broad discussions and wide input into the planning process, we will again be holding a Waitemata DHB Planning Day and initiating a similar day for Auckland DHB early in 2014:

- WDHB Planning Day: 16 January 2014
- ADHB Planning Day: 21 January 2014

Auckland and Waitemata DHBs will continue to have their own Annual Plans although these will be as identical in format and layout as possible. The majority of the content will be consistent, with only minor and appropriate differences for each DHB. The financial component of the Plan would be specified for each DHB within each Annual Plan, making clear how each DHB's finances map to objectives in the Plan. Some shared financial content may be

possible, such as the financial assumptions for the financial year in question and any high level expectations from the Minister of Health and the Government such as savings targets or efficiency gains. Essentially the documents will follow last year's process and format, but with further alignment where possible.

Engagement with PHO partners regarding the planning approach has commenced and both Auckland and Waitemata PHOs were represented at the recent Ministry of Health Planning workshop in Wellington. Respective PHOs for each DHB will be invited to both the Auckland and Waitemata Planning Days in January to ensure consistency. In addition, specific engagement is planned to occur outside of the DHB Planning days at the PHO Alliance meetings and the PHO CEO forum.

4. Sign Off Process and Timelines

Draft 1 of the Annual Plan will be presented to the February board meetings of both ADHB and WDHB (19 February and 26 February 2014 respectively) for consideration, with approval sought for final sign off of the document via CPHAC on 19 March 2014. The final draft will be presented for consideration to CPHAC on 30 April, with sign-off of the final Annual Plan likely to be via special meetings early in May. Endorsement of the Annual Plan will also sought at these critical stages from our MoU and other partners: Te Runanga o Ngati Whatua, Te Whānau o Waipareira Trust and designated primary care partners.

The final Annual Plan and Maori Health Plan will require the signatures of the following:

- Board Chair
- One other Board member from each Board (for the Statement of Intent only)
- The two CEOs
- The Chair of Te Runanga o Ngati Whatua
- The CEO of Te Whānau o Waipareira Trust (Waitemata DHB)

Demonstration of engagement with and approval of each PHO throughout will be provided, including their letters of support.

As in past years, it is proposed that any amendment or last minute changes to the Annual Plan, Statement of Performance Expectations and Statement of Intent be delegated to the Board Chair and the respective CEOs. This provision allows flexibility to accommodate late information.

Regular oversight of the Annual Plan, the Statement of Performance Expectations and Statement of Intent while under development is the responsibility of the Director – Health Outcomes and the Director - Funding.

Provisional Timeframe

Note this timetable focuses on the non-financial elements of the planning process and does not include the budgeting process deadlines and milestones.

Date	Activity	Responsibility
10 October 2013	• Release of draft Planning Package by NHB • Provide input to National Health Board pre-planning round activity/feedback on draft Planning Package • Commence planning and process work for 2014/15 planning round	Director Health Outcomes DHB Planners

Date	Activity	Responsibility
November 2013	• Brief key stakeholders and contributors i.e. Boards, Executive Teams, primary care, Planning and Funding, provider arms etc • Planning Package and Funding Envelope released late November	
December 2013 11 December 12 December	• Staff provided with clear instructions about the expectations and process for 2014-15 planning. Objective templates available to staff (key contributors) • Prioritisation work, consideration of asset development and capital works and service changes • Organisational priorities and high-level drivers clear to staff • Minister's Letter of Expectations released • ADHB Board meeting: Approach approved • WDHB Board meeting: Approach approved	Executive Team DHB Planners
January 2014 16 January 2014 21 January 2014	• Contributors prepare planning content • WDHB Planning Day • ADHB Planning Day	Contributors
February 2014 19 February 26 February	• Planners develop annual plans to meet requirements in the planning package • First draft provided for consideration: o ADHB Board o WDHB Board	DHB Planners
19 March 2014 21 March 2014 (TBC)	• CPHACs meeting: sign off Annual Plans • First draft of the Annual Plan due with the NHB for review (date TBC) • First draft of the Statement of Intent/Statement of Performance Expectations due with the NHB (and ideally with Audit NZ) for review	DHB Planners Director – Health Outcomes Director - Funding
April 2014 30 April 2014	• Feedback received from NHB (date TBC) • Amendments made to the plan, SPE and SOI as required • CPHACs meeting: first draft provided for consideration	DHB Planners Chief Financial Officers
Early May 2014 Early May 2014	• Probable Special meeting/s for final sign off both ADHB and WDHB Annual Plans, SoIs and SPEs • Final board, PHO and MoU partners-approved Annual Plan due with the NHB (date TBA)	DHB Planners Chief Financial Officers
On or before 28 June	Final Annual Plans, MHPs and RSPs signed by Minister/signed SoI/SPE extract to Bills Office	DHB Planners Chief Financial Officers
July 2014	• Statement of Intent submitted to House of Representatives and posted on our respective websites • Documents made widely available to staff and others	DHB Planners

5. Risks, Opportunities and Mitigations

Risk area	Specifically	Mitigation
Agreeing the right format, approach and content for Annual Plans	In 2013-14 the ADHB and WDHB Annual Plans' format, approach and content were better aligned than in previous years. However, there is still opportunity to further align information where it makes sense to while accurately representing each separate entity and their constituent population and financial situation.	It will be important to work closely with restructured teams to ensure that content is identical or very similar wherever it can be, while retaining local content appropriately.
Ensuring accountability for and monitoring of Annual Plan deliverables	There is a Board and Ministry of Health expectation that we achieve the deliverables set out in our respective annual plans. Many of these are currently reported through to Board committees, but some are not. We intend to review current reporting processes to ensure that each deliverable is correctly assigned to the person/s responsible and expectations re: reporting are clear to ensure that all deliverables are monitored and reported appropriately.	Ensuring deliverables are reasonable, achievable and reflective of the work being carried out while being aligned to government priorities takes considerable involvement/engagement and work-shopping with staff. Staff will need more help to see how the Annual Plan content relates to them at the point of service delivery. Planning will review reporting processes and ensure alignment across the DHBs as appropriate and also that all deliverables are being monitored and reported through appropriate committee meetings.
Impact of the collaboration process and the review and restructure of tier 4&5 roles within Planning & Funding	While Tier 3 restructure is now almost complete, many newly merged teams are still developing and there are some gaps in resource that still need to be resolved. Review and restructure of levels 4 and 5 is still to be completed and responsibility and workload appropriately assigned. This work will coincide with many of the key milestones of the planning timetable. Staff may be distracted during this process and embedding of new roles and responsibilities will still be occurring at the time key planning activity occurs.	Early advice to staff and regular communication that keeps everyone up to date with planning expectations for 2014/15 throughout a time of great transition. Clear roles and responsibilities identified early in the process and contingency plans identified where authorship likely to change over course of planning cycle.

Risk area	Specifically	Mitigation
Too many stakeholders/ delays in sign-off	Each DHB Annual Plan involves between 55 and 70 contributing authors. In turn, each author must liaise with a great many staff within and across teams in order to arrive at a sensible and tested suite of objectives. While efficiencies have been gained through the merging of some teams, the workload has still increased as there is now one Planning Team across the two DHBs. The Planning Team must ensure sign off of both Annual Plans, Statements of Intent and Statements of Performance Expectations by two Boards as well as engagement across two sets of executive teams, clinical leads, PHOs and other stakeholders who will all need to participate in the planning process. This introduces risk in achieving sign off at critical steps.	Responsible authors identified at the start of the process and their role clear in December. Ensuring enough resource is available to complete the work. Clear roles and responsibilities identified early in the process.

6. Conclusion

2014/15 will present some challenges as we develop Annual Plans, Statements of Intent and Statements of Service Performance for both DHBs. Key to our success is gaining endorsement from both DHB Boards for the proposed planning process for both DHBs and agreeing a clear plan regarding service and priority areas. We will also need to make sure that all key stakeholders are informed about the approach and have an opportunity to provide input into the planning process, ensuring activity continues to run smoothly through the ongoing Planning and Funding transition period.

4.1 A Model of Care for Adult Palliative Care Services in the Waitemata District

Recommendation:

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

a) The recently developed model of care for adult palliative care services in the Waitemata district as endorsed by the Waitemata DHB Board.

b) The requirement by the Board for the Waitemata DHB Planning, Funding and Outcomes team to develop an implementation plan including a funding model for consideration by the Board prior to commencing implementation.

Prepared by: Sarmila Gray (Project Manager, Planning and Funding, Waitemata DHB)
Endorsed by: Tim Wood (Funding and Development Manager, Primary Healthcare, Auckland and Waitemata DHBs)

Glossary

ARRC - Age Related Residential Care
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
DSME - Diabetes Self Management Education
ELT - Executive Leadership Team
GP - General Practitioner
GPTs - General Practice Teams
NASC - Needs Assessment Service Coordination
PCT - Local Palliative Care Team
PHO - Primary Health Organisation

1. Executive Summary

The purpose of this paper is to advise the Community and Public Health Advisory Committees (CPHAC) of Auckland and Waitemata District Health Boards of the recently developed model of care for adult palliative care services in the Waitemata district as endorsed by the Waitemata District Palliative Care Clinical Working Group, the Waitemata District Palliative Care Clinical Governance Group, the Waitemata DHB Executive Leadership Team (ELT) and the Board of Waitemata DHB. The directive from the Waitemata DHB Board is that implementation planning is initiated and an implementation plan including a funding model is developed and presented to the Board for consideration prior to commencing implementation.

This paper presents a brief overview of the project management structure and the findings of current state analysis in terms of key issues and gaps. It also identifies the potential drivers of future palliative care need. Then the core principles, key elements and enablers of the proposed model of care are described. The paper concludes with recommendations regarding the model of care.

2. Background/Introduction

The Waitemata DHB is committed to ensuring timely access to high quality, equitable, cost-efficient and sustainable palliative care services for its population. In late 2012, to realise this objective, the Waitemata DHB commissioned a project to develop a standard model of care for adult palliative care services in the district in conjunction with key stakeholders. The brief for this project was to develop a model of care based on best practice independent of funding considerations in the first instance.

This project is underpinned by the Waitemata DHB's Statement of Intent that recognises and respects the Te Tiriti o Waitangi as the founding document of New Zealand and as a conceptual and consistent framework for Māori health gain across the health sector. It is also underpinned by the memoranda of understanding between Waitemata DHB and Te Runanga o Ngati Whatua, and Te Whānau o Waipareira Trust.[1]

The Waitemata DHB's organisational purpose 'to relieve suffering of those entrusted to our care' and its value around acting 'with compassion' have been fundamental to this work.

3. Project Management Structure

The project management resource was supplied by Planning and Funding, Waitemata DHB.

3.1 Appointment of Independent Chair

It was felt from stakeholder feedback that an independent chair would ensure that all stakeholder views were considered in a fair and unbiased fashion and would facilitate constructive discussions and promote an approach that focused on meeting the needs of patients, families and Whanau by the right people in the right place and at the right time. The Waitemata DHB in conjunction with the hospices in the district undertook a joint recruitment process and in March 2013 appointed an independent chair, John Robertson to lead the governance group.

3.2 Establishment of Project Groups

To guide, review and facilitate the project, two project teams were established as described below:

3.2.1 Waitemata District Palliative Care Clinical Governance Group

The main purpose of this group was to provide guidance and oversight of the development of the model of care and ensure that the project was successfully completed on time. This is a relatively small group consisting of seven members who were invited to join the group based on the contributions they could make in guiding and leading this work, and not as a representative of any particular stakeholder. This group was chaired by the independent chair. The membership included:

1. Gina Langlands, Director, Quality and Risk, Bupa NZ
2. John Hurihanganui, Maori Health Gain Portfolio Manager, Planning and Funding, Auckland/Waitemata DHB
3. John Robertson (Independent Chair)
4. Jonathan Christiansen, Head of Division, Medicine and Health of Older People, Waitemata DHB
5. Lannes Johnson, Clinical Director, Waitemata PHO
6. Linda Cooper, Chair, Hospice West Auckland

7. Tim Wood, Funding and Development Manager, Primary Health Care, Auckland and Waitemata DHB (Project Sponsor).

3.2.2 Waitemata District Palliative Care Clinical Working Group

The primary responsibility of this group was to work out the clinical and practical details of the model of care. Reporting to the governance group this group consisted of a range of senior clinicians directly involved with the provision of primary and specialist palliative care on a day to day basis. Members were selected to join the group based on their clinical and technical knowledge and expertise representing their clinical discipline not any particular stakeholder. The membership included:

1. Annette Ogles, Clinical Service Development and Quality Manager, Hibiscus Hospice
2. Carol Frankson, Manager, Anne Maree Court
3. Gail Keane, Practice Nurse, Dodson Medical Centre; DSME Coordinator, Waitemata PHO
4. John Wellingham, General Practitioner, Apollo Medical Centre (ProCare PHO)
5. Karen Talbot, Director Clinical Services, Hospice West Auckland
6. Maxine Pye, Family Support Team Leader, Hospice North Shore
7. Mike Harris, Medical Leader, Hospice North Shore (Chair)
8. Moira Camilleri, Palliative Medicine Specialist, Hospice West Auckland, Hospice North Shore, and University of Auckland
9. Paula Garner, Clinical Nurse specialist and Clinical Team Leader, Warkworth Wellsford Hospice
10. Rowanne Bridge, Unit Manager, Home Health and NASC , Older Adults and Home Health Waitemata DHB
11. Sandra Notley, Clinical Nurse Specialist, Palliative Care, Waitemata DHB.

The working group also engaged with the following individuals as clinical experts and sought their feedback with the development of the model of care:

1. Cathy Miller, Clinical Leader, Palliative Care Service, Department of Medicine and Health of Older People, Waitemata DHB; Palliative Medicine Specialist, Hospice North Shore
2. Michal Boyd, Sr. Lecturer, Freemasons' Dept. of Geriatric Medicine, University of Auckland; Nurse Practitioner, Medicine and Health of Older People, Waitemata DHB.

4. Current State Analysis and Drivers of Future Palliative Care Need

At the outset a current state analysis was undertaken to identify key issues and gaps based on the feedback from key stakeholders, including clinical experts and service users. The analysis revealed that in the Waitemata district there is inequity of access for patients with palliative care needs due to the lack of:

1. A district wide clinical governance framework
2. Shared vision and goals
3. Standardised referral criteria, assessment tools, and pathways
4. Clear roles and responsibilities and consistent after-hours General Practitioner (GP) and specialist support
5. Integration and coordination of care
6. Collaboration and sharing of resources amongst service providers
7. District wide organised and coordinated palliative care education
8. Recognition of and support for Age Related Residential Care (ARRC) as a provider of palliative care
9. Sufficient capacity and capability, and a sustainable workforce development plan

10. Compatible information systems
11. An outcomes measurement framework
12. Co-design incorporating voice of the patient and family and whānau
13. Robust economic analysis to inform strategic planning and transparency around funding.

Overall population growth along with an aging population and rising incidence of chronic non-malignant illnesses including dementia are likely to be the most significant drivers of future palliative care need in the Waitemata district. It is estimated that between 2006 and 2026 the number of adults (20 years+) per year who would benefit from palliative care in the Waitemata district will jump from approximately 1,576 in 2006 to 2,174 in 2026, representing an increase of 37.9%.[2]

5. The Proposed Model of Care

Based on the key issues and gaps together with the drivers of future palliative care need, it was evident that a consistent, coordinated, efficient and integrated model of care is needed to cope with increasing future demand in a sustainable manner.

5.1 Definition

For the purpose of this paper the definition of 'model of care' developed by Queensland Health (2000) and Waikato DHB (2004) has been adopted. A 'model of care' refers to a multidimensional concept that defines and describes the way in which patient care is delivered across identified clinical streams and patient flow continuums within the broader context of the health system.[3,4]

5.2 The Underpinning Principles

The following **Core Principles** that guide the model of care are in line with the Ministry's Resource and Capability Framework for Adult Integrative Palliative Care Services in New Zealand (2013)[5] as well as the [a]organisational purpose and values of the Waitemata DHB.

1. Palliative care aims to affirm and optimise the quality of life for patients who, with family and whānau, are at the centre of care delivery
2. Family and whānau are respected as providers as well as recipients of palliative care
3. All palliative care patients have timely access to high quality, evidence based care (primary as well as specialist) twenty four hours a day, seven days a week
4. The disciplines of care supplied are offered in a culturally safe and sensitive manner according to need, including supporting patient choices with respect to place of death
5. The patient experience is of a seamless and coordinated healthcare system, irrespective of diagnosis, setting, or location.

[a] The organisational purpose of the Waitemata DHB are: [a]

- *To prevent, ameliorate and cure ill health*
- *To promote wellness*
- *To relieve suffering of those entrusted to our care*

The Waitemata DHB values are:

- *Everyone matters*
- *With Compassion*
- *Connected*
- *Better, Best, Brilliant*

At the heart of it is the need to respect the dignity of every single person.

5.3 The Key Elements of the Model of Care

Below is a summary of the **Key Elements** of the proposed model of care.

1. *Collaboration and Integration between all Service Providers* - this is fundamental to the model of care and is underpinned by Formal Partnership Agreements amongst providers to ensure clarity of roles and responsibilities and facilitate improved collaboration and sharing of resources to address need and gain efficiency;
2. *Need Based Service Provision* - the majority of palliative care needs are non-complex to moderately complex which can be adequately met by primary palliative care providers themselves with indirect or direct involvement of specialist providers. Only a relatively small proportion of patients with complex needs require direct specialist involvement;
3. *Led by Primary Care supported by Specialists* - the proposed model is led and driven by primary palliative care providers. The patient's general practitioner (GP) is regarded as the 'lead carer' twenty four hours seven days a week.[b] A member of the general practice team (preferably a practice nurse) is the designated 'lead palliative care coordinator' if the patient lives at home. If the patient lives in an age related residential care (ARRC) facility a registered nurse from the facility is the designated 'lead palliative care coordinator';
4. *Locality Based Clinical Governance Framework* - this will be in line with the Waitemata and Auckland DHBs' locality based health service planning. Each locality will have one or more local palliative care team(s) (PCTs) who will be the 'link' between primary and specialist providers and will provide ongoing support and education to primary providers. PCT(s) will be accountable to the Locality Palliative Care Governance Groups who will report to the Waitemata DHB Palliative Care Clinical Governance Group;
5. *A Nodal Network Approach* – this refers to a shared approach to scarce resources supported by Formal Partnership Agreements whereby specialist palliative care providers work in a collaborative and flexible manner to maximise utilisation of scarce resources to achieve efficiency and address need. 'Single employer' could be one mechanism to achieve this. However there could be alternative options that require further exploration;
6. *After-hours Palliative Medicine & Nursing Specialist Support* – an agreement is required with regards to a district wide twenty four hours seven days a week palliative medicine and nursing specialist cover including telephone support;
7. *Inpatient Beds* – Finding an equitable, efficient and sustainable solution to future configuration of inpatient beds in the district will require detailed economic analysis and transparency around current funding before a sustainable future state can be proposed;
8. *Clinical Pathways* – standard pathways and clear roles and responsibilities need to be defined and agreed to; and
9. *Clinical Services* – these need to be underpinned by a robust clinical governance framework to ensure equity of access and evidence based practice.

5.4 The Enablers of the Model of Care

The following **Enablers** have been identified as critical to the overall success of the proposed model of care:

1. Robust governance and leadership
2. Senior managerial support
3. Shared goal and accountability
4. Improved collaboration and partnership amongst providers to reduce duplication, improve sharing of resources and maximise utilisation of resources across the district

[b] Or, Nurse Practitioner if applicable e.g. in age related residential care facilities.

5. Appropriate information technology to access shared care plan by multiple providers as and when needed
6. Sustainable workforce development plan – building appropriate capacity and capability within primary as well as specialist providers
7. Education strategy to build capacity and capability acknowledging the role of specialist providers as educators
8. Education of all palliative care providers around non-malignant conditions is critical considering future drivers
9. A funding model that takes into consideration the key elements of the model of care and is transparent and based on sound economic analysis
10. Community engagement plan to raise awareness, seek feedback , provide education and to build capacity and capability in the community involving services users, carers and volunteers
11. Effective partnership between the DHB and palliative care providers in the district.

6 Recommendation

It is recommended that CPHAC notes: 1) the recently developed model of care for adult palliative care services in the Waitemata district as endorsed by the Waitemata DHB Board and, 2) the requirement by the Board for the Waitemata DHB Planning, Funding and Outcomes team to develop an implementation plan including a funding model for consideration by the Board prior to commencing implementation.

7 Conclusion

This project has delivered within the agreed timeframe a model of care for palliative care services in the Waitemata district. The model has been endorsed by the Waitemata DHB Board. The Board directive is that implementation planning is initiated with the development of an implementation plan including a funding model to be presented the Board for consideration prior to commencing implementation.

References

[1] Waitemata DHB Annual Plan 2013/14. Retrieved 09 October, 2013 from http://www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=rcrre_H_9z0%3d&tabid=81

[2] Palliative Care Council. (2011). National Health Needs Assessment for Palliative Care, Phase 1 Report: Assessment of palliative care need.

[3] Waikato Health Board. (2004). Child & Adolescent Clinical Stream: Proposed Model of Care, New Zealand, Health Waikato Division.

[4] Queensland Health. (2000). Changing Models of Care Framework, Queensland, Queensland Health.

[5] Palliative Care Council. (2013). Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand. Wellington: Ministry of Health.

4.2 Rheumatic Fever Prevention and Intervention Programme Update for Auckland and Waitemata DHBs

Recommendation

That the report be received.

Prepared by: Ruth Bijl (Funding and Development Manager, Auckland DHB and Waitemata DHB), Alison Leversha (Community Paediatrician, Auckland DHB), Alison Hudgell (Project Manager, Planning and Funding, Auckland DHB), Leani Sandford (Pacific Health Manager, Auckland DHB and Waitemata DHBs), Marty Rogers (Māori Health Gain Manager, Auckland DHB and Waitemata DHB), Vicki Scott (Programme Manager, Waitemata DHB), Tim Jelleyman (Head of Division (Medical), Waitemata DHB), Sue Crengle (Māori Health Advisor, Auckland DHB and Waitemata DHBs), and Martin Dawe (Project Manager, Waitemata DHB).

Glossary

ADHB - Auckland District Health Board
ARF - Acute Rheumatic Fever
AWHHI - Auckland-wide Healthy Housing Initiative
CHW - Community Health Worker
CMDHB - Counties Manukau District Health Board
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
ECCA - Energy Efficiency Conservation Authority
GAS - Group A Streptococcus
GP - General Practitioner
HPA - Health Promotion Agency
MoH - Ministry of Health
NHC - National Hauora Coalition
PHN - Public Health Nurse
PHO - Primary Health Organisation
RhF - Rheumatic Fever
RHD - Rheumatic Heart Disease

1. Introduction

This paper provides an update on the implementation of the Rheumatic Fever (RhF) prevention and intervention programmes across Auckland and Waitemata District Health Boards (DHBs).

2. Background

In June 2012, the Government announced 10 Better Public Service targets. Reducing the incidence of RhF by two thirds to 1.4 cases per 100,000 nationally by 2017 is one of those targets. The New Zealand incidence of Acute Rheumatic Fever (ARF) is currently 4.1:100,000. Local targets have been set by the Government at 1.2:100,000, down from 3.5:100,000, and 0.8:100,000, down from 2.3:100,000, by 2017/18 for Auckland and Waitemata respectively.

The Ministry of Health (MoH) Rheumatic Fever Response Strategy identifies three levels of intervention to achieve this goal within the next five years.

1. *Primordial prevention*: Reduce levels of crowding in houses and reduce the transmission of streptococcal bacteria in schools.
2. *Primary prevention*: Ensure Group A Streptococcus (GAS) sore throats in all high risk children are identified and treated early. Promote effective and timely management of sore throats in children at high risk of developing ARF.
3. *Secondary prevention*: Prevent the recurrence of ARF. Review cases of ARF to identify reasons and take action to improve prevention strategies.

3. Summary of progress to 12 November 2013

Auckland and Waitemata DHBs are taking an integrated whole of population approach to reducing the incidence of ARF as endorsed by CPHAC in November 2012. The incidence of RhF across populations is variable. To address this, a multi faceted prevention and intervention programme, which addresses the geographically dispersed incidence of RhF, is now underway.

Ministry of Health (MoH) funding was provided to DHBs to firstly develop primary school based sore throat management programmes. In 2013, further initiatives were funded with a targeted focus on the Auckland region for the next four years. Initiatives include:

- Nurse-led rapid response services/clinics in primary care settings (DHBs via PHOs)
- Pacific health literacy/community awareness raising (MoH regional contract with Alliance Health + (AH+))
- Healthy homes advice and referral (MoH regional contract with National Hauora Coalition (NHC) and AH+).

The target populations for the programme are Māori, Pacific and Quintile 5 children and young people. Strategies for engaging Māori and Pacific include:

Pacific Strategy: The Ministry has commissioned AH+ to develop and implement a Pacific Engagement Strategy (PES) targeting Pacific communities in the Auckland Region. The PES is in the early stages of implementation and both DHBs are working with AH+ to integrate this stream of work with the Rapid Response programme and other RhF work streams.

Māori Strategy: Although the Ministry of Health is providing specific guidance in relation to a Pacific Engagement Strategy, a key local/regional focus within the RhF programme must be to ensure that a range of options are available to Māori Tamariki and their whanau. These include: an outreach service delivered under contract by Te Whanau o Waipareira; a Rapid Response plan in Waitemata that includes a range of Māori and community providers engaging with schools to provide community awareness raising, and; access to whanau support to access GP services. In Auckland DHB, National Hauora Coalition (NHC) are part of the service alliance and provide leadership regarding local approaches. Within the Rapid Response programme, community health workers will be engaged to provide swabbing and family engagement services linked to the three decile one secondary school (Tamaki College, Otahuhu College and McAuley College).

Providers are working closely together to provide a comprehensive and integrated response. Each DHB provided a detailed RhF Prevention Plan to the MoH for approval on the 20 October 2013. The plans outline the DHBs' approach to implementing interventions at primordial, primary and secondary levels.

3.1 Primordial - Housing and Social Issues

The Ministry of Health has funded the development and implementation of the Auckland-Wide Healthy Housing Initiative (AWHHI). The MoH has contracted directly with NHC and AH+ to deliver this. Members of both DHBs' RhF Steering Groups have been involved in both the working and steering groups in the development of AWHHI. AWHHI will be delivered by AH+ and NHC across the Auckland region to 3,500 households a year. The main mechanism for delivery is through the establishment of a healthy homes hub and family support programme. Families with children who have defined health, housing and social needs will be referred to the hub for assessment and access to the family support programme. AWHHI will link families to housing services including free insulation, free curtains, reduced electricity costs and minor repairs whether they are in public or private rental properties. The Energy Conservation Authority (EECA) has been funded to provide insulation and other services to 60,000 homes across New Zealand over four years. Where other needs are identified, referrals will be made to a range of relevant social service agencies.

Both DHBs are working collaboratively with AH+ and NHC to develop tools, criteria, resources and referral pathways to ensure eligible families are identified and referred. Documentation about housing and social conditions will be integrated into the clinical records to support assessment, planning and action.

Referrals to AWHHI will be accepted from:

- clinicians caring for children with RhF identified through the bicillin prophylaxis programme
- the school-based swabbing programme where household transmission of GAS has been identified
- secondary care clinicians caring for children hospitalised with respiratory illnesses such as bronchiolitis, pneumonia and bronchiectasis.

Referral criteria will be extended early in 2014 to include a range of conditions that are identified in primary care.

3.2 Primary Prevention

3.2.1 Primary School Based Programmes

Early identification and treatment of GAS is essential for the prevention of ARF. Both Auckland DHB and Waitemata DHB have implemented a school-based sore throat swabbing programme in selected high risk primary and intermediate schools. This includes four schools in West Auckland, one in Northcote, and nine schools in the Auckland DHB area, with a roll-out to seven more schools planned for early 2014.

The school-based programme has an emphasis on improving health literacy and families'/whānau awareness of key health messages. As such, early and timely access to health providers is encouraged with strong linkages back to the usual primary care provider.

The impact of a targeted school-based throat swabbing programme depends on the density of the disease burden. In contrast to Counties Manukau DHB where more than 83% of cases of RhF affected children attend decile 1 schools, Auckland DHB and Waitemata DHB have more

dispersed disease with identifiable clusters of dense disease. A school-based throat swabbing programme in the high risk schools in Auckland DHB is estimated to reach 35% of vulnerable children and less than 10% in Waitemata DHB. The school-based programme is therefore only one component of an overall RhF prevention plan in both Auckland and Waitemata DHBs.[1]

In Waitemata DHB, the school programme is supplemented by outreach initiatives which Te Whanau o Waipareira Trust has been contracted to deliver.

However, children are only in school for 40 weeks of the calendar year. The Rapid Response programme (described below) is designed to provide throat swabbing and treatment services for at risk children and youth who are not in designated schools with school-based clinics, and for all at risk children outside of school hours and during school holidays.

3.2.2 Rapid Response Programmes

Both DHBs have developed implementation plans for their Rapid Response services, submitted to the Ministry in early October. The aim of the Rapid Response programme is to provide open access to sore throat management to children and young people (4 – 19 years) outside of school hours, in school holidays and to Māori and Pacific and Quintile 5 children and young people not attending one of the high needs schools involved in the primary school-based programme. The target is to ensure that 80% of vulnerable children have open access to services. For this programme 'vulnerable children' are defined by the Ministry of Health as the target populations of Māori and Pacific children, and also children living in quintile 5 NZ Deprivation Index.

The implementation of the Rapid Response programme across the two DHBs reflects the geographical location of the RhF target population and existing service provision. Work in both DHBs with primary care and community providers, including Māori and Pacific providers, involves training of nursing and community health workers to support the delivery of the programme and implementation of the National Heart Foundation Sore Throat Guidelines. As there is little evidence as to 'what works' in delivering RhF Rapid Response programmes, a variety of approaches are being implemented across the region. Effectiveness will be monitored, with the more effective delivery models continued and extended as appropriate.

Both DHBs are using a range of localised approaches. These include additional outreach approaches in community locations; contracting with primary care practices with a large numbers of enrolled target group children; engaging further through secondary schools, and; trialling innovations such as pharmacy delivered throat swabbing.

In Auckland DHB, RhF cases are concentrated in three main geographical areas; Tamaki-Glen Innes, Otahuhu, and Wesley. However, cases are also spread across other areas within Auckland DHB, in particular Avondale. In Waitemata DHB, over half the cases have previously occurred in Massey-Henderson, with the remainder distributed widely across the district geographically.

Auckland DHB has entered into a Service Alliance with the four local PHOs to manage the school-based and Rapid Response programmes. AH+ is the lead provider of the primary care

[1] In addition to throat swabbing and sore throat management, the nurses are providing early identification and treatment of skin sepsis in the schools. This is one of the top three reasons for admission to Starship Hospital and an important cause of avoidable hospitalisations.

based rapid response programme, supported by the three other PHOs. Auckland DHB's approach to delivering Rapid Response includes:

- Nurse-led rapid response clinics in 15 general practices with up to a further 25 practices being considered for inclusion
- Community Pharmacies - trialling a clinic in a community pharmacy in Glen Innes where a significant amount of awareness raising has been done through the school-based programme
- Supplementary services in the decile 1 enhanced secondary school based health services programme including swabbing and treatment services.

Waitemata DHB's approach to delivering Rapid Response includes a direct contracting arrangement with the two Primary Health Organisations for the provision of:

- Nurse-led rapid response clinics in 10 sentinel general practices
- Primary care outreach services in a range of schools and community locations to be determined.

Together these approaches are expected to reach 80% of the target children and young people in both DHBs.

3.3 Secondary Prevention

Secondary prevention refers to the on-going management of RhF to prevent recurrences. Approximately 60% of people affected with ARF have Rheumatic Heart Disease (RHD). Recurrences increase the risk and severity of RHD and thus significantly affect life time outcomes. The most important activity is compliance with long term antibiotic treatment. This is provided by Public Health Nurses (PHNs) for children and young people still at school and by primary care and/or the district nursing service for young people and adults.

Both DHBs are involved in the review of bicillin follow-up, the development of a standardised case review form (i.e. RF cases admitted to hospital) and other processes to improve assessment, management and follow-up of RhF cases. This includes ensuring that activities are delivering intended results and reinforcing appropriate messages to the family/whānau as well as linking them with appropriate medical, social and housing services.

3.4 Communications and Awareness Raising

Public awareness raising is fundamental to the success of the overall RhF programme. The MoH, Health Promotion Agency (HPA) and DHBs have developed communication strategies to raise awareness about sore throat management as well as key messages about the links between sore throats and RhF.

The DHBs are working with local stakeholders, including providers from health and other sectors, to engage with the RhF target population, and communities, to promote the programme. The MoH has commissioned AH+ to develop and implement a Pacific Engagement Strategy (PES) targeting Pacific communities in the Auckland Region. The PES is in the early stages of implementation and both DHBs are working with AH+ to integrate this stream of work with the Rapid Response programme and other RhF workstreams.

On 25 October, ADHB successfully launched the RhF programme at Ruapotaka Marae. Minister Ryall attended along with MPs Paul Hutchinson, Peseta Sam Lotu-Iiga, Alfred Ngaro

and Claudette Hauiti. Dr Lester Levy, Ailsa Clare, Naida Glavish, Dr Richard Aickin, Dr Debbie Holdsworth and PHO alliance partners as well as other key supporters of the programme were present. The launch was covered on primetime news by TVNZ and featured a very good natured Minister Ryall encouraged by Community Paediatrician Dr Alison Leversha to have his throat swabbed as part of the education session.

In the school throat-swabbing programmes there has been active engagement with the school communities. For example, in the West Auckland primary school programmes prior to commencement there were public meetings and a survey of existing knowledge and health literacy. Follow up surveys demonstrated an increase in awareness of Rheumatic Fever.[2] Auckland DHB has undertaken similar surveys of children's knowledge and awareness of the importance of sore throats, skin infections and hand washing prior to starting the clinics, driving the required health promotion messages. The team has also presented at several parent:school fono/hui and attended three local community events raising the awareness of the importance of strep throats in preventing Rheumatic fever.

4. Conclusion

To a large extent, ARF is the outcome of a combination of crowded living conditions, socio-economic deprivation, the presence of rheumatogenic GAS and access barriers to primary health care services. High risk families are Māori, Pacific and those in low socio-economic areas. To be effective, the programme needs to focus on these families and achieve high levels of engagement. Both DHBs have engaged with local communities and providers to ensure improved access of high risk children to sore throat management programmes and improved housing conditions.

The delivery of the programme requires a pragmatic, integrated and adaptive approach. Relationships with and integration between local Māori, Pacific and primary care providers as key influencers and service delivery agents remain fundamental to the success of the programme. Active progress is being made across the spectrum of prevention strategies. We expect to be able to report positive gains by mid 2014.

[2] A Public Health Nurse poster won an award in the recent Awhina poster presentations. See http://www.awhinahealthcampus.co.nz/Portals/0/Documents/Research/WHEA2013/ePosters/WHEA222.pdf

5.1 Primary Care Update Quarter 1, 2013/14

Recommendation:

That the report be received.

Prepared by: Tim Wood (Funding and Development Manager Primary Care, Waitemata and Auckland DHBs) and Dr Stuart Jenkins (Clinical Director Primary Care, Waitemata and Auckland DHBs)

Glossary

A&M - Accident and Medical Centre
AH+ - Alliance Health Plus
APHO - Auckland Primary Healthcare Organisation
ARC - Aged Residential Care
ATD - Access to Diagnostics
CFA - Crown Funding Agreement
CT - Computed tomography [radiology imaging]
DAP - District Annual Plan
DAR - Diabetes Annual Review
DCIP - Diabetes Care Improvement Package
DHB - District Health Board
GAIHN - Greater Auckland Integrated Health Network
HML - Health Medical Limited
HRI - High Risk Individual
IFHC - Integrated Family Health Centre
LHP - Local health profile
MoH - Ministry of Health
MRI - Magnetic resonance imaging
NHC - National Hauora Coalition
NIR - National Immunisation Register
OIS - Outreach Immunisation Services
PARR - Patients at risk of readmission
PHO - Primary Health Organisation
PIMS - Patient Information Management System
PMH - Primary Mental Health
PMS - Patient Management System
PNL - ProCare Networks Limited
POAC - Primary Options for Acute Care
POC - Packages of Care
PPP - PHO Performance Programme
RAPD - Risk of admission based on primary care data
VDR - Virtual Diabetes Register

1. Summary

This report provides an update on matters relating to Auckland and Waitemata District Health Board (DHB) primary care for quarter one 2013/14. The report is presented in the following sections:

- primary care scorecard with additional commentary on the three primary care health targets
- objectives set in our annual plan and other key primary care projects
- primary care nursing
- PHO operational issues

2. Primary Care Scorecard

The scorecard presented on the following page is a standardised performance scorecard which aligns to the overall organisational scorecard where possible. The scorecard shows how each District Health Board (DHB) is tracking against a wide range of measures. Given the DHBs' focus on health targets, these are presented first in the scorecard as priority measures. Where appropriate, indicators are presented with performance by ethnicity. For each measure, the green bar reflects how well we are doing against the target for the period presented.

The progress green bar is weighted for each measure based on the degree of concern of any short fall in meeting the target. For the most part, these weightings reflect those used in the overall organisational scorecard. However, this element of the scorecard is still work in progress for some of the measures. For example, this weighting is noticeable for Health Targets where the scale is very sensitive so that any variance is deemed to be significant. If performance is achieving or better than target, the bar will display as a solid green line. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.

Summary Performance Against Targets

Priority One Targets

The scorecard provides a snapshot of the three primary care health targets. Further detail on Auckland and Waitemata DHB's performance against these targets is provided directly after the scorecard.

Service Delivery Targets

For PHO enrolment, Auckland DHB is sitting at 92% and Waitemata DHB 94%. Asian enrolment rates (70% and 74% for Auckland and Waitemata DHB respectively) and Māori enrolment rates (79% and 78% respectively) are lower than those of other ethnicities.

Improving Māori Population Health Targets

The Māori cervical screening rates remain lower than the other ethnicity groups. The metro Auckland Cervical Screening group has activities underway to address this (such as the regional data matching project). DHB discussions have progressed about pieces of work to improve coverage for Māori women and more recently for Asian women. An update on progress against our cervical screening plan activities was provided at the last meeting as a separate agenda item.

Auckland and Waitemata DHBs are currently at 9.1% and 8.5% arrears respectively for child oral health which are above the target of 10% arrears. More information on oral health can be found in the Funder Update paper.

Auckland and Waitemata DHB Primary Health Care Scorecard

2013/14 Q1

Priority One - Waitemata DHB

Health Targets	Actual	Target
Better help for smokers to quit (primary care) - Total	47%	90%
More Heart and Diabetes Checks - Total	71%	90%
More Heart and Diabetes Checks - Maori	67%	90%
More Heart and Diabetes Checks - Pacific	71%	90%
More Heart and Diabetes Checks - Other	71%	90%
Immunisation - fully immunised by 8 months - Total	90%	90%
Immunisation - fully immunised by 8 months - Maori	82%	90%
Immunisation - fully immunised by 8 months - Pacific	94%	90%
Immunisation - fully immunised by 8 months - Asian	97%	90%
Immunisation - fully immunised by 8 months - Other	86%	90%

Priority One - Auckland DHB

Health Targets	Actual	Target
Better help for smokers to quit (primary care) - Total	51%	90%
More Heart and Diabetes Checks - Total	80%	90%
More Heart and Diabetes Checks - Maori	78%	90%
More Heart and Diabetes Checks - Pacific	82%	90%
More Heart and Diabetes Checks - Other	80%	90%
Immunisation - fully immunised by 8 months - Total	94%	90%
Immunisation - fully immunised by 8 months - Maori	89%	90%
Immunisation - fully immunised by 8 months - Pacific	94%	90%
Immunisation - fully immunised by 8 months - Asian	97%	90%
Immunisation - fully immunised by 8 months - Other	91%	90%

Service Delivery - Waitemata DHB

Enrolment		
PHO enrolment - Total	94%	95%
PHO enrolment - Maori	78%	95%
PHO enrolment - Pacific	98%	95%
PHO enrolment - Asian	74%	95%
PHO enrolment - Other	100%	95%

Service Delivery - Auckland DHB

Enrolment		
PHO enrolment - Total	92%	95%
PHO enrolment - Maori	79%	95%
PHO enrolment - Pacific	100%	95%
PHO enrolment - Asian	70%	95%
PHO enrolment - Other	100%	95%

Improving population health - Waitemata DHB

Key Conditions		
Diabetes annual checks - Total	44.0%	51.0%
Diabetes annual checks -Maori	59.0%	51.0%
Diabetes annual checks - Pacific	44.0%	51.0%
Diabetes annual checks - Other	43.0%	51.0%
Diabetes management - Total	77.0%	75.0%
Diabetes management -Maori	64.0%	75.0%
Diabetes management - Pacific	61.0%	75.0%
Diabetes management - Other	82.0%	75.0%
Immunisation - fully immunised at 2 years - Total	91.0%	95.0%
Immunisation - fully immunised at 2 years - Maori	91.0%	95.0%
Immunisation - fully immunised at 2 years - Pacific	95.0%	95.0%
Immunisation - fully immunised at 2 years - Asian	97.0%	95.0%
Immunisation - fully immunised at 2 years - Other	85.0%	95.0%
Screening - to March 2013 (25-69 years: 3 year coverage)		
Cervical screening rate - Total	75.5%	75.0%
Cervical screening rate - Maori	52.8%	75.0%
Cervical screening rate - Pacific	65.8%	75.0%
Cervical screening rate - Asian	60.3%	75.0%
Cervical screening rate - Other	83.9%	75.0%
Oral Health		
Oral Health Arrears	8.5%	10.0%
Oral Health Arrears - Maori	9.3%	10.0%
Oral Health New Enrolments (Preschool)	6,148	10,414

Improving population health - Auckland DHB

Key Conditions		
Diabetes annual checks - Total	67.0%	60.0%
Diabetes annual checks -Maori	64.0%	60.0%
Diabetes annual checks - Pacific	97.0%	60.0%
Diabetes annual checks - Other	58.0%	60.0%
Diabetes management - Total	72.0%	80.0%
Diabetes management -Maori	65.0%	80.0%
Diabetes management - Pacific	60.0%	80.0%
Diabetes management - Other	79.0%	80.0%
Immunisation - fully immunised at 2 years - Total	95.0%	95.0%
Immunisation - fully immunised at 2 years - Maori	92.0%	95.0%
Immunisation - fully immunised at 2 years - Pacific	96.0%	95.0%
Immunisation - fully immunised at 2 years - Asian	98.0%	95.0%
Immunisation - fully immunised at 2 years - Other	93.0%	95.0%
Screening - to March 2013 (25-69 years: 3 year coverage)		
Cervical screening rate - Total	77.5%	75.0%
Cervical screening rate - Maori	57.4%	75.0%
Cervical screening rate - Pacific	87.2%	75.0%
Cervical screening rate - Asian	61.6%	75.0%
Cervical screening rate - Other	87.9%	75.0%
Oral Health		
Oral Health Arrears	9.1%	10.0%
Oral Health Arrears - Maori	9.4%	10.0%
Oral Health New Enrolments (Preschool)	10,097	13,045

How to read

Indicator Title

85.0% (Actual) — DHB Performance — 100.0% (Target) ← Improvement against previous result

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

Immunisation Q1 2013/14

Target: 90 percent of eight months olds will have their primary course of immunisation on time by July 2014

Māori have traditionally been high users of the Outreach Immunisation Services (OIS). The Waitemata DHB National Immunisation Register (NIR) and OIS provider rolled out the integrated services to Auckland DHB from July 1.

The quarter one results were:

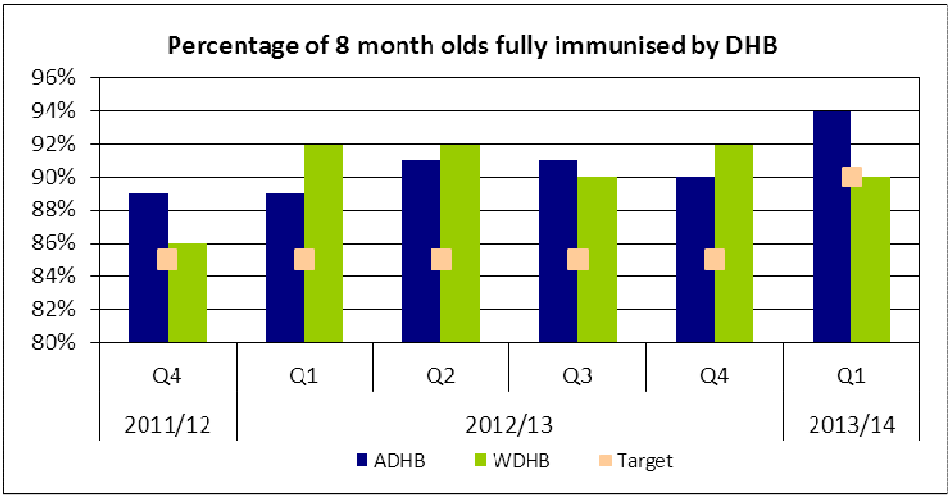
- Auckland DHB 94%, an increase of 4% from the previous quarter.
- Waitemata DHB 90%, a decrease of 2% from the previous quarter.

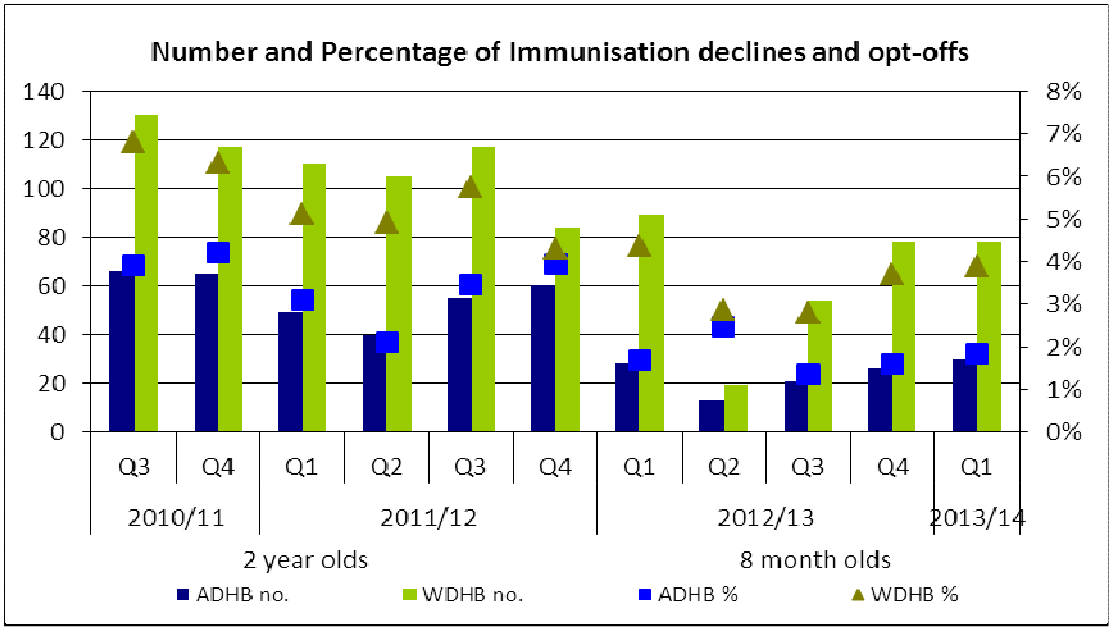
Immediate actions

- Working with Waitemata DHB PHOs and practices with overdue vaccination episodes to improve timeliness.
- Targeted support for practices with low coverage rates to encourage newborn enrolment, precalls and recalls and identify overdue infants for immunisation. This includes ongoing targeted support for practices with high Māori enrolments and low coverage rates.
- Work with PHOs to up-skill PHO advisors' immunisation capacity.
- NIR sourced, PHO/clinic level coverage is monitored monthly in Auckland DHB. Monthly monitoring will be extended to Waitemata DHB in quarter two.
- A performance based agreement is in place with the new provider to facilitate high coverage for all ethnicities including specific performance based measures for Māori.
- Maternity services across Auckland and Waitemata DHBs provide early identification of Māori newborns with no GP to flag these infants for early OIS referral. The OIS team work to locate the family, offer immunisation and enroll them with a GP and other WellChild services.

Plan

- Education evening with practice nurses scheduled for November.
- Workshop with providers to review and update the immunisation target annual plan.
- Workshop with key providers to map the healthcare journey for Māori women and infants from pregnancy diagnosis through to primary care/ Well child care service delivery. This will identify key factors contributing to successful access and engagement as well as barriers to services, and develop strategic advice for the governance group.





Please note the immunisation coverage for two year olds is reported in the final section of this report under the PHO Performance Programme (PPP).

More Heart and Diabetes Checks Q1 2013/14

Target: 90 percent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years by July 2014.

The 'More Heart and Diabetes Checks' result is produced by the PHO Performance Programme (PPP) and are as reported in the Ministry of Health (MoH) DHB performance tables. The quarter one denominators are 136,491 for Waitemata DHB and 152,266 for Auckland DHB. The denominator increased from quarter four 2012/13 for both DHBs, 1350 for Waitemata DHB and 5,748 for Auckland DHB. The preliminary quarter one results were:

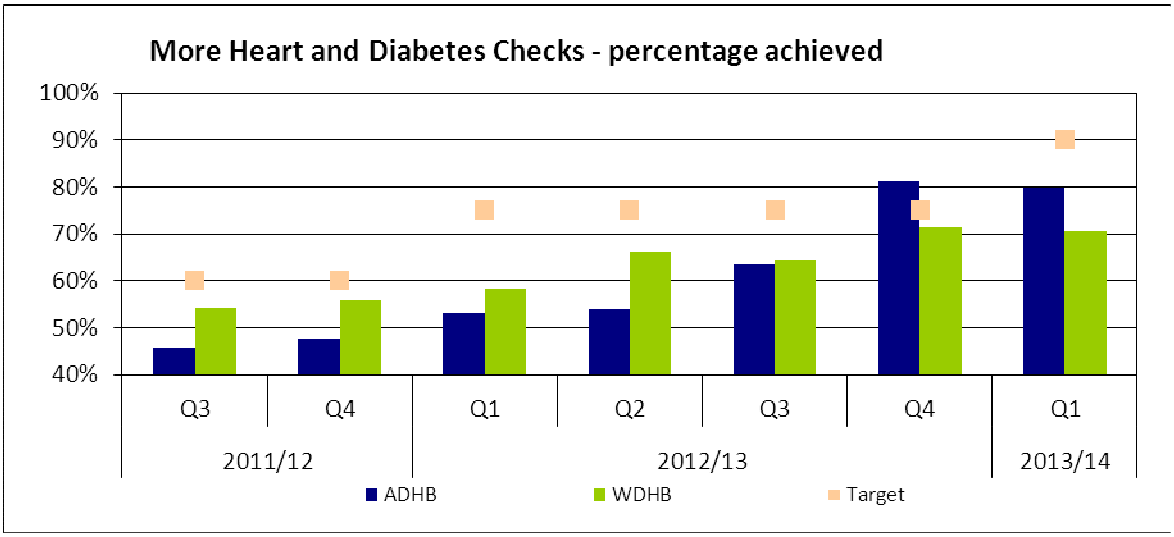
- Auckland DHB 121,838 people assessed (80.0%)[1].
  - Total coverage increased by 1.6% from quarter four 2012/13.
  - Coverage for Māori people has decreased to 78.2% (🡻0.9%) and for Pacific people 82.2% (🡻4.3%).
- Waitemata DHB 96,483 people assessed (70.7%).
  - Total coverage decreased by 0.7% from quarter four 2012/13.
  - Coverage for Māori people has decreased to 67.4% (🡻 0.5%) and for Pacific People to 71.5% (🡻 0.5%).

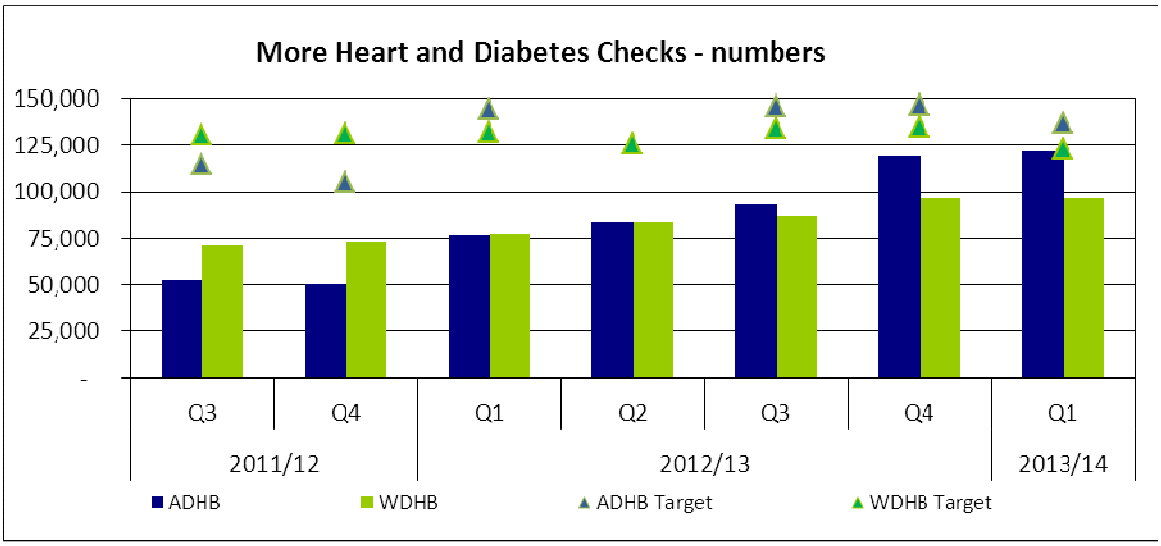
An additional 2,702 more people are recorded as having had an assessment in quarter one than the previous quarter (2,663 for Auckland DHB and 39 for Waitemata DHB). The impact of the rolling cohort means that people moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments. Collectively the PHOs are not assessing enough people to ensure the target is met by June 30.

[1] Please note the Auckland DHB quarter four MoH results reported in the previous CPHAC primary care report have decreased from 81.3% to 78.4% due to incorrect practice allocation at DHBSS.

The DHBs and PHOs continue to meet to ensure that the health target remains a focus of primary care work. All PHOs have provided a plan on how they will work with practices to ensure they will meet this target. Quarterly monitoring returns will be reviewed against the plan and ongoing management meetings will provide the DHB with information about both progress against the plan and any issues.

All PHOs continue to report weekly to the DHBs.





Better Help for Smokers to Quit – Primary Care Q1 2013/14

Target: 90% of enrolled patients who smoke and are seen by a health practitioner in primary care are offered with advice and help to quit by July 2014.

The 'Better Help for Smokers to Quit' results are produced by the PHO Performance Programme (PPP) and are as reported in the MoH DHB performance tables.

The preliminary quarter one results were:

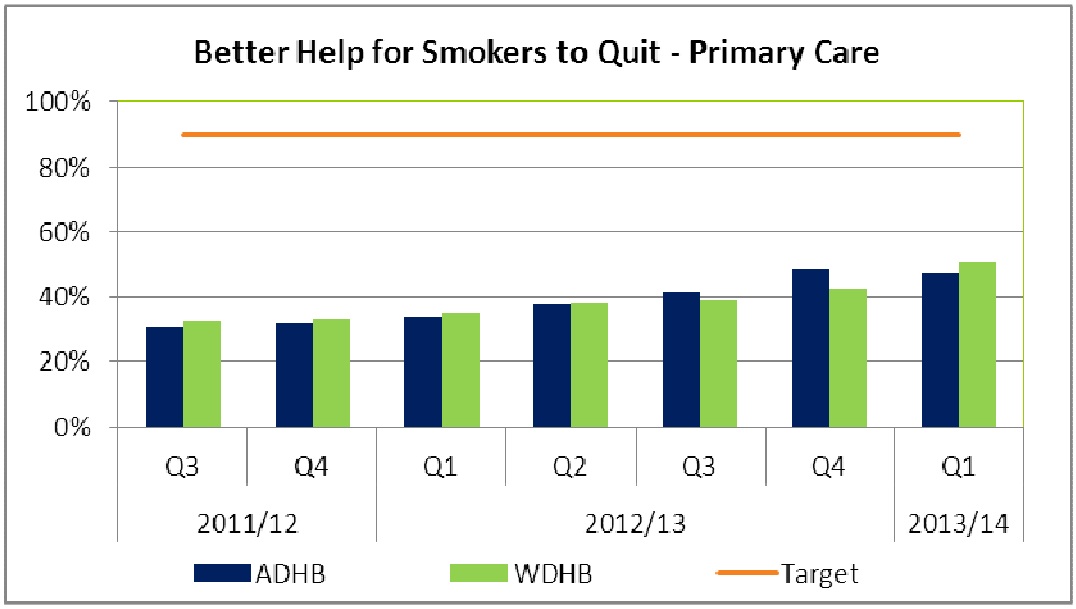
- Auckland DHB 51.1%, an increase of 3% from the previous quarter.
- Waitemata DHB 47.3%, an increase of 4.7% from the previous quarter.

Results for the Māori and Pacific populations are not available.

PHOs report monthly to the DHBs on their performance against this target. More frequent reporting is not possible.

The sub-target of '90% of pregnant women are offered advice and support to quit smoking at confirmation of pregnancy with an LMC' is not yet being nationally reported. Work is underway to ensure this target can be reported upon.

In early August, NHC employed a new Smokefree Coordinator who will focus on the development of the 2013/14 smokefree plan and connecting with providers. This dedicated resource will help effectively administer the "Better Support for Smokers to Quit" programme and work towards the Government's Smokefree Aotearoa 2025 goal. The Coordinator also works across Alliance Health Plus (AH+) and Auckland PHO.



3. Objectives set in our annual plan and other key primary care projects

Diabetes annual reviews

The diabetes annual review (DAR) targets for 2013/14 are: • A minimum of 51% of people with diabetes will have a DAR. • A minimum of 75% of people who have had a DAR will have an HbA1c of <64mmol/mol. DARs are measured against the MoH Virtual Diabetes Register (VDR).	
Waitemata DHB	• Waitemata VDR population is 26,535. • 44% of the total population have had a DAR. • 80% of the total population have an HbA1c of <64 mmol/mol. • The DHB has seen a marked drop in the number of reviews reported since the MoH stopped the free annual review service.
Auckland DHB	• Auckland VDR population is 23,649. • 68% of the total population have had a DAR. • 74% the total population have an HbA1c of <64 mmol/mol. • All four PHOs have submitted their DCIP plans for the year.

Primary mental health

As of July 1 the MoH provided further funding for primary mental health initiatives for one year. The new service specification outlines a stepped care model to be delivered which is regionally consistent across Waitemata DHB and Auckland DHB where possible. The service is targeted to Māori, Pacific and quintile 5 patients. Waitemata DHB and Auckland DHB have used similar service specifications, for the adult primary mental health initiatives contracts with the PHOs. Additional funding has also been provided by the MoH to target alcohol screening and brief interventions in primary care settings. This funding supports and extends interventions that are already in place as part of existing primary mental health initiatives. In Auckland DHB; Auckland PHO, NHC, and ProCare PHOs have contracts. AH+ did not apply for this funding. In Waitemata DHB, a meeting is being set up with the PHOs and the Clinical Director of the Community Alcohol and Drugs service for expert advice on a model of care to be implemented.	
Waitemata DHB	Work is ongoing with the Waitemata PHOs, to ensure the stepped care model is fully implemented, and the target population prioritised. A steering group has been established, including PHOs, secondary services, and mental health

<table>
<tr><td></td><td>funding/planning team, to oversee implementation of stepped care across primary and secondary services. Gaps have been identified at the interface between primary and secondary services, and work is underway to address this.

2013/14 Q1 volumes are as follows:
<table>
<tr><th>Ethnicity</th><th>Waitemata PHO</th><th>Procare</th><th>Total</th></tr>
<tr><td>NZ European</td><td>236</td><td>1263</td><td>1499</td></tr>
<tr><td>Māori</td><td>47</td><td>146</td><td>193</td></tr>
<tr><td>Pacific</td><td>11</td><td>56</td><td>67</td></tr>
<tr><td>Asian</td><td>22</td><td>20</td><td>42</td></tr>
<tr><td>Other</td><td>36</td><td>571</td><td>607</td></tr>
<tr><td>Q1 Total</td><td>354</td><td>2122</td><td>2476</td></tr>
<tr><td>Q1 Expected Total</td><td>407</td><td>432</td><td>839</td></tr>
</table>

Please note that ProCare has significantly over-delivered this quarter. Procare had carried an under-spend in primary mental health options from 11/12, into 12/13. The cumulative effect was that going into 13/14, ProCare packages of care were oversubscribed. Contractually they are expected to manage volumes in such a way as to make packages available throughout the full year. ProCare, on advice from their board, are managing this situation internally.</td></tr>
<tr><td>Auckland DHB</td><td>2013/14 Q1 volumes are as follows:
<table>
<tr><th>Ethnicity</th><th>APHO</th><th>ProCare</th><th>AH+</th><th>NHC</th><th>Youthline</th><th>Total</th></tr>
<tr><td>NZ European</td><td>178</td><td>1,688</td><td>0</td><td>99</td><td>18</td><td>1,983</td></tr>
<tr><td>Māori</td><td>50</td><td>1</td><td>6</td><td>26</td><td>2</td><td>85</td></tr>
<tr><td>Pacific Island</td><td>17</td><td>0</td><td>14</td><td>12</td><td>9</td><td>52</td></tr>
<tr><td>Asian</td><td>40</td><td>195</td><td>0</td><td>38</td><td>3</td><td>276</td></tr>
<tr><td>Other</td><td>8</td><td>51</td><td>14</td><td>12</td><td>8</td><td>93</td></tr>
<tr><td>Q1 Total</td><td>293</td><td>1935</td><td>34</td><td>187</td><td>40</td><td>2489</td></tr>
</table>

Please note that this contract has now been changed to require PHOs to re-orientate services to high needs populations.</td></tr>
</table>

Regional after hours and urgent care

A Network of 11 Accident and Medical (A&M) clinics open until at least 10pm, 365 days per year with reduced co-payments for under 6s, over 65s, high user health card, community services card and those living in quintile 5. The Auckland Region After Hours Network contract runs until June 30.
• As of November 1, two new A&M clinics are now providing free after hours care for children under six years old from 6pm till 8am. The new clinics are Shore Care in Takapuna and White Cross Ascot in Remuera. This means that all of the A&Ms part of the Network are now providing free after hours care for children under six. • The Network now obtains greater detail from the A&Ms and the telephone triage service regarding patient access and what the funding is being used for. • All of the Auckland Metro PHOs are now contributing equally to the Network at $1.42 per enrolled person. • Work has been initiated in the development of a business case for the 2014/15 year.

Access to Diagnostics-Radiology

A regional Access to Diagnostics-Radiology steering group has been in operation since 2010/11. The group help to ensure timely and regionally consistent access for primary care, to DHB funded imaging procedures. Clinical triage criteria have been developed by a cross-regional group of primary care and secondary care clinicians and radiology specialists. These criteria support general practice decision making to improve appropriate access to diagnostic investigations. The triage criteria have been incorporated into both the Regional CareConnect e-Referrals solution and ProCare's ProExtra form. ProExtra forms can be used by GPs for Auckland DHB and Counties Manukau DHB funded x-ray and ultrasound in community private practices. A budget is notionally allocated per practice to manage private practice referral spend. All other imaging is referred to the DHB Radiology department using CareConnect e-Referrals or faxed referrals.
• The regional wait time targets for routine community referred radiology are 85% of x-ray and CT, and 75% of MRI and ultrasound requests provided within 6 weeks. The table shows the percentage of patients who waited less than six weeks for their imaging to be done in September. This includes a signed-off report back to their GP. The figures highlighted in red show diagnostic investigations that did not meet the target by >10%. • The three DHBs did not meet the target for MRI imaging in September. However there is currently a shortage of hospital MRI scanners and both Auckland and Waitemata DHBs have new MRI scanners going in within the next six months. Counties Manukau DHB is renegotiating contracts with local private providers for additional capacity. • There is a well recognised nationwide shortage of sonographers which restricts ultrasound capacity in both public and private sectors. All three DHBs need to supplement capacity through private provided ultrasounds. Auckland and Counties Manukau have longer-standing arrangements with private providers which help them with the 6-week ultrasound wait target. Waitemata has funded additional ultrasounds through local private providers for the last six months and wait times have accordingly improved from 36% in February.

Table: Wait times for accepted routine community referred radiology are presented below.

DHB	Month: Sept 2013	CT	X-ray	MRI	Ultrasound
Waitemata	% Validated within the 6 week indicator	84%	97%	**36%**	**57%**
Auckland	% Validated within the 6 week indicator	95%	88%	**63%**	**76%**
Counties Manukau	% Validated within the 6 week indicator	**72%**	**99%**	**60%**	**71%**

Primary Options for Acute Care (POAC)

The Primary Options for Acute Care (POAC) service provides responsive coordinated acute care in the community with an aim to reduce acute demand on hospital services and allowing patient care to be managed close to home.

Funded by the three Auckland DHBs, POAC offers a safe and effective alternative to a hospital presentation or admission. Clinical pathways and policies support consistent practice and drive greater safety and quality of care. The annual target of POAC referrals is 5,700 for Auckland DHB, 6,150 for Waitemata DHB and 11,623 for Counties Manukau DHB. 85% of POAC interventions will avoid the patient needing to go to hospital.

- The number of Auckland and Counties Manukau DHB POAC referrals were below the target for quarter one (see table below). However ongoing education and training within Auckland and Middlemore hospitals is occurring. This has resulted in a significant increase in POAC referrals from both hospitals.
- St John transport service has expanded their service to include transporting patients to the GP/medical home.
- Work continued this quarter with Auckland DHB aged residential care (ARC) facilities to provide education and support to access POAC services. This included piloting an ARC IV service. An audit of avoidable ARC hospital referrals was undertaken to inform ongoing work in this area.
- The cellulitis pathway was revised and implemented and has resulted in a drop in acute cellulitis referrals.
- The renal colic pathway using CT scans was also implemented.

Number of POAC referrals for Metro Auckland DHBs in quarter one

DHB	Target number of POAC referrals	Actual number of POAC referrals
Auckland	1,510	1,064
Waitemata	1,630	1,876
Counties Manukau	3,080	2,110

e-Referrals

Increase uptake of e-Referrals by general practitioners and implement referral templates for remaining procedures
• There are three remaining services awaiting the roll-out of e-Referrals. By the end of November 2013, the older adult service and allied health services will have e-Referrals available. The roll-out to the remaining service (mental health), is expected by the end of January. • The use of e-Referrals is increasing steadily by general practice. Currently approximately 51% of all referrals sent by general practice to Waitemata DHB are by e-Referral. Comparable data for Auckland DHB has proved difficult to obtain because of how referrals are recorded in the patient management system. • The use of e-Referrals is expected to increase. This will be supported by the introduction of electronic triage and rapid messaging capability to GPs, and continuing to improve and simplify the design and functionality of the e-Referrals form.

Localities

Earlier in 2013 the Locality Establishment Governance Group (LEGG) approved the boundaries of localities as those of local board areas. Maungakiekie-Tāmaki, West Rodney and West Auckland were identified by the LEGG as the three focus areas across Auckland and Waitemata DHBs.	
General update	• The LEGG has a high level governance and leadership role across the developing localities in the Auckland and Waitemata District. The group consists of Iwi, PHO CEO's, Auckland and Waitemata DHB senior management and Healthlink community representation. The group is chaired by the Lead CEO for primary care. • A strategy paper for a localities approach across Auckland and Waitemata has been reviewed and approved by LEGG. We are now waiting on final sign off from the PHO Boards.
Central Auckland	• Engagement has occurred at a community level particularly in the Glen Innes and Onehunga areas with the establishment of Local Health Partnerships (LHP). • The proposed approach for the implementation of a mental health work stream in Tāmaki has been agreed. Key stakeholders include DHB planners and funders, PHOs, secondary clinicians, local GPs, NGO providers, other mental health providers in the locality and community representatives. A co-design approach will be used. The mental health work stream will form the basis of a clinical network with the aim of forming ongoing local provider relationships. • On 20th November a workshop to bring the stakeholders together will be held to explore the priorities in mental health to be targeted.
North Auckland	• The North Auckland locality plan (work plan) was signed off by the North Auckland localities operational group in August. The plan includes health information activity, including building a health profile for the area, community engagement, provider engagement and identifying and establishing priority worksteams. • We are continuing to inform and update existing community networks in the West Rodney area around locality planning.

	Waitemata DHB staff are also participating with the local community and NGOs in four workshops facilitated by local board staff to discuss the establishment of a South Kaipara Wellbeing forum. The forum will be another vehicle for us to engage with the West Rodney community around locality planning. • Engagement with the West Rodney provider network, the NGO sector and the West Rodney communities is planned for quarter two. We plan to ask this community what health services are working well for the area, what health services are not working so well, and what health services we can improve on in the next 12-24 months. We will use the outcome of this engagement to help formulate work programmes going forward.
West Auckland	• The West Auckland Diabetes working group have agreed to focus on improving diabetes care within the New Lynn cluster. A plan is being developed for socialisation with the wider practice cluster. A pilot Diabetes Clinic started in October at the Totara Health. This clinic combines general practice educational sessions and joint primary/secondary diabetic patient reviews. • The child health work stream is focusing on two key areas: Asthma at Whānau House and Cellulitis at Totara Health. This involves reviewing and agreeing clinical guidelines, and a shared care model between primary and secondary care. Work is beginning to see how the shared care plan tool can support this work. • Both these projects are currently being developed and expected implementation is in February 2014.

Greater Auckland Integrated Health Network

Greater Auckland Integrated Health Network (GAIHN) was established in 2010. It is a partnership between the Auckland, Waitemata, and Counties Manukau DHBs, and ProCare, Auckland, East Health and Total Healthcare PHOs. The purpose of GAIHN is to strengthen integration between primary and secondary care, and the regional capacity of primary care to reduce avoidable hospital admissions. The work programme has three work streams: Identification and management of high risk individuals, better response to acute events in the community, enablers of better individual care. Child health is a key focus across the work streams.
Work stream 1: Better management of high risk individuals a) Develop a predictive risk algorithm The purpose of the algorithm is to identify patients who have a high risk of having a readmission to hospital. There are three phases to this project. - Phase 1: Development of the patients at risk of readmission (PARR) tool using secondary care data, and distribution of patient lists to PHOs. Lists are now distributed from the DHBs to the PHOs identifying which patients have a high risk of readmission. - Phase 2: Risk of admission based on primary care data (RAPD) tool. GAIHN commissioned a report which found the algorithm did not reach the expected predictive performance. Further development is on hold while the algorithm is developed further. - Phase 3: Development of an algorithm utilising primary and secondary care data. Sapere Research Group has been commissioned to develop the algorithm. A data collection plan has been developed, and approval from the Regional Privacy Advisory Group will be required before proceeding with data collection.

b) Enhanced integrated care for patients at high risk of admission

- Pilot projects to enhance the integration of care for patients at high risk of admission are being implemented across the region. Counties Manukau DHB has pilots in Manukau, Mangere, Otara, Franklin and East at different stages of development. This includes work to transition several projects (High Risk Individual, CarePlus and Chronic Care Management) into the 'At Risk Individual Work Programme' and developing local multi-disciplinary teams. Auckland DHB commenced analysis to inform the development of a pilot in Maungakiekie-Tāmaki and Waitemata DHB is developing a project focused on adults aged over 75 years.
- An initial toolkit (model of care) has been developed to support the implementation of the pilots. The toolkit includes tools to facilitate amenability assessment, needs assessment, care planning, care coordination, delivery of a range of services and review.
- A literature review about the effectiveness of identification methods and the associated interventions has been commissioned.

c) Evaluation

- The National Institute of Health Innovation has been commissioned to develop an evaluation methodology. The first draft has been developed following a workshop with GAIHN partners.

Work stream 2: Better response to acute events in the community

a) Urgent Care Network

- The Urgent Care Network was established as an extension of the After Hours network to include in-house care, St Johns and ACC. The network has developed a 12-month work programme and a three year strategic plan. Key areas of focus include after hours, St Johns service delivery plan, metrics, primary care model of care, communications, telephone triage and governance.
- St Johns has identified areas of development in the service delivery plan.
- A metrics framework has been developed.
- Primary care model of care – review of a international primary care capacity tool for application in the Auckland context.
- Completed practice visits to identify urgent care processes, and shared information with the Network.
- Commenced work with Mangare locality to support their priority focus on urgent care, including a stocktake and patient flow analysis.
- A home visiting sub-group has been established.
- Telephone triage - agreement reached on reporting from Health Medical Limited (HML).
- Extension of referrals to POAC from St John, HML and ARC.

b) IV service for aged residential care residents in the Auckland district

- A review of the pilot has been completed.
- Commenced response to review recommendations, including audit of admitted ARC patients, further development of communications, and

review of the Community Acquired Pneumonia regional pathway.

c) Ambulance transporting options: alternatives to emergency department

- St Johns ambulance across Auckland is now able to transport patients to their medical home (e.g., GP) if the patient can be appropriately treated in the community. This initiative was launched in September.

Work stream 3: Enablers of better care

Pathways

- 30 pathways have been completed and uploaded to the Healthpoint website. Pathways include paediatric skin disorders, paediatric acute respiratory illness, sore throat, adult cellulitis, depression and gout.
- Implementation planning for pathways with specific focus on sore throat management to align with rapid response clinics has commenced.
- Initial prioritisation of the next tranche of pathways has been prioritised. The top five are type 2 diabetes, congestive heart failure, palliative care, asthma in children and chest pain.

4. Primary Care Nursing

Auckland DHB and Waitemata DHB both run a Nurse Entry to Practice (NETP) programme for nurses wanting to begin their career in a primary health setting. The programme is approved by the Nursing Council of New Zealand and is focused on helping the new graduate to achieve competence as soon as possible.	
Waitemata DHB	• 12 primary health care new graduates started in the NETP programme in February and four started in September. The graduates continue in their general practice, hospice, plunket and aged residential care (ARC) settings. The new graduates are supported by the primary health care nurse educators. The February intake is now completing their AUT post graduate paper as part of the new graduate programme. • Preceptor training was run for 18 primary health care registered nurses in September to be able to precept students and new graduate nurses in primary care settings. • Two education days for 19 new graduate nurses were run in June. This training is for nurses employed in primary care settings but not in a new graduate programme. Further days are planned for March next year. Attendees are also invited to attend the NETP study days for primary care as well. The nurses who are employed in primary care but did not get a place in the September NETP programme have an open invitation to attend the NETP study days in November and December.
Auckland DHB	• Four new graduate nurses started in February and one in September in general practice settings. They are supported on the NETP Programme. • The February intake is completing their Auckland University post graduate paper. • Auckland DHB offer primary health care nurses places on their regular preceptor programmes as required.

5. Primary care operational issues

PHO Performance Programme

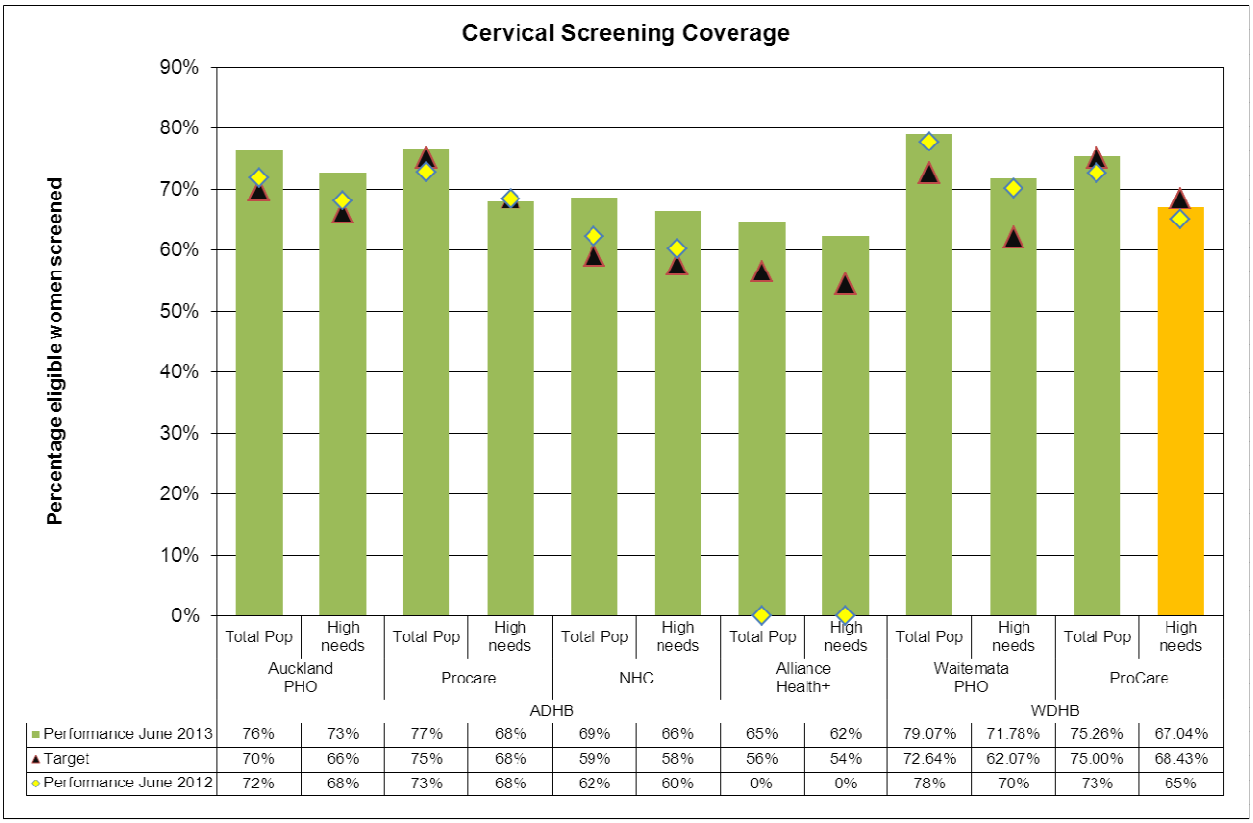
The PHO Performance Programme (PPP) has been designed by primary care representatives, DHBs and the Ministry of Health to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs. Improvements in performance against the indicators result in performance payments to PHOs.

The purpose of the PPP report is to provide information on how a PHO performs against the nationally consistent indicators.

The graphs below show performance at quarter four 2012/13, compared to target and historical performance (quarter four 2011/12). Quarter one 2013/14 data is not available at the time of writing this report and neither is historical data for AH+.

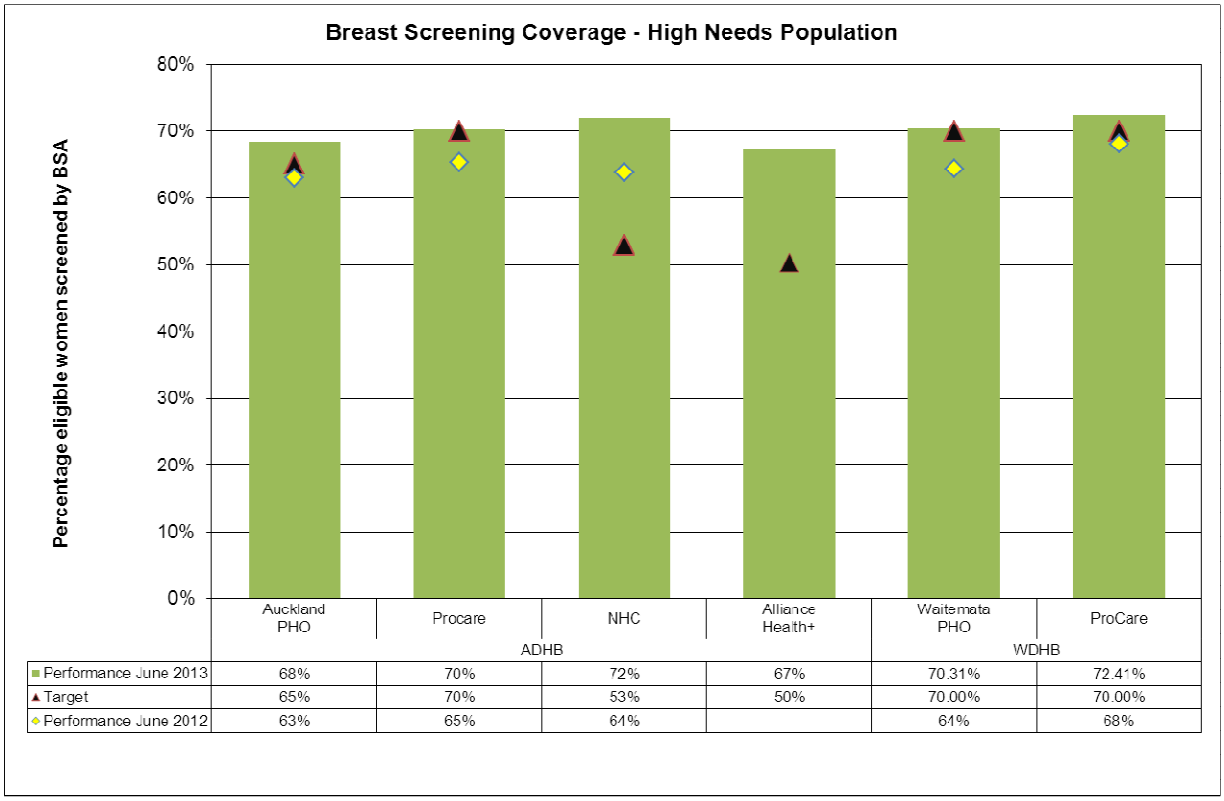
The bars on the graphs below are coloured green, orange and red. Green shows if the PHO met the target, orange shows if the PHO almost met the target (within 10%) and red shows if the PHO was outside the target by more than 10%.

The graph below shows that with the exception of ProCare high needs population; all other PHOs met the 'Cervical Screening Coverage' target in quarter 4 2012/13. ProCare was 1.39% below the target.



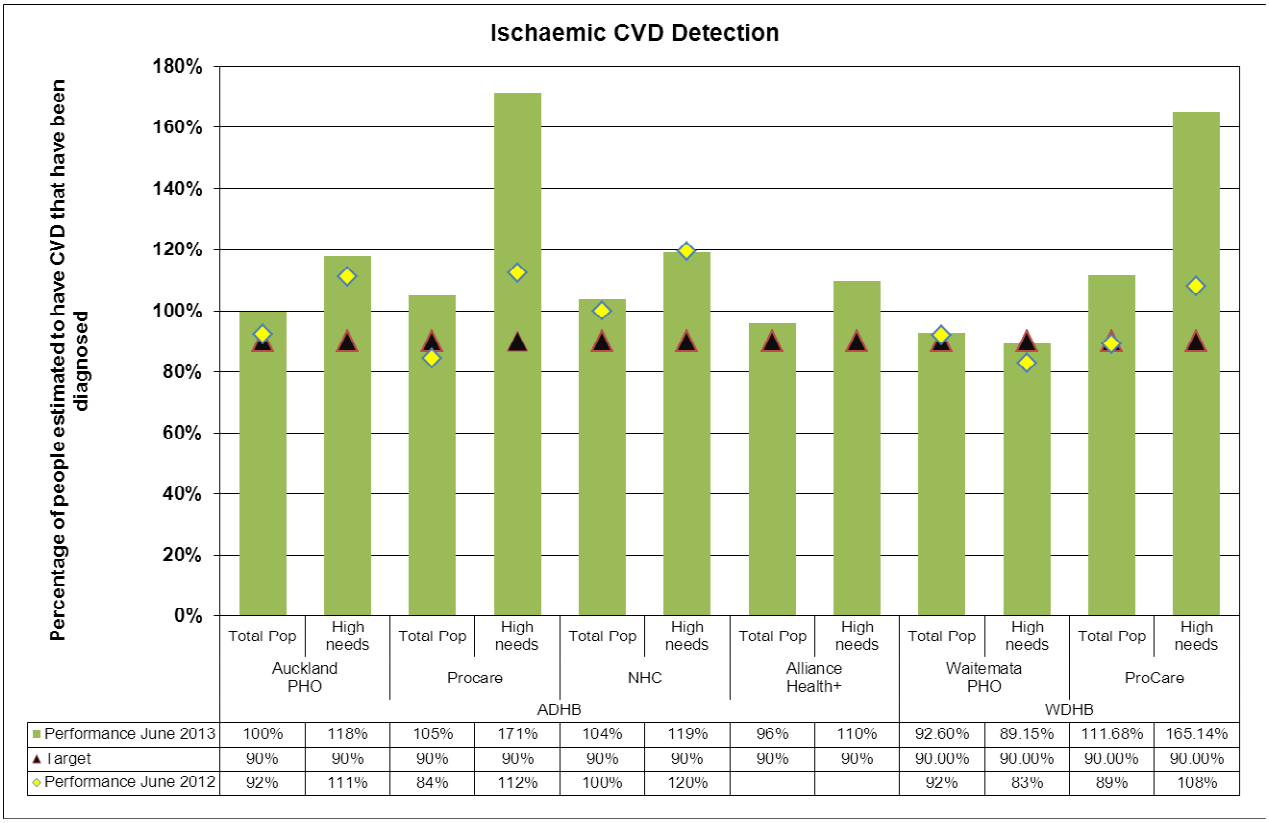
	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs
	Auckland PHO		Procare		NHC		Alliance Health+		Waitemata PHO		ProCare	
	ADHB								WDHB			
Performance June 2013	76%	73%	77%	68%	69%	66%	65%	62%	79.07%	71.78%	75.26%	67.04%
Target	70%	66%	75%	68%	59%	58%	56%	54%	72.64%	62.07%	75.00%	68.43%
Performance June 2012	72%	68%	73%	68%	62%	60%	0%	0%	78%	70%	73%	65%

The graph below shows 'Breast Screening Coverage' across the six Auckland and Waitemata PHOs for high needs populations. All PHOs met this target in quarter 4 2012/13 and improved on their performance from the same time in the previous financial year.



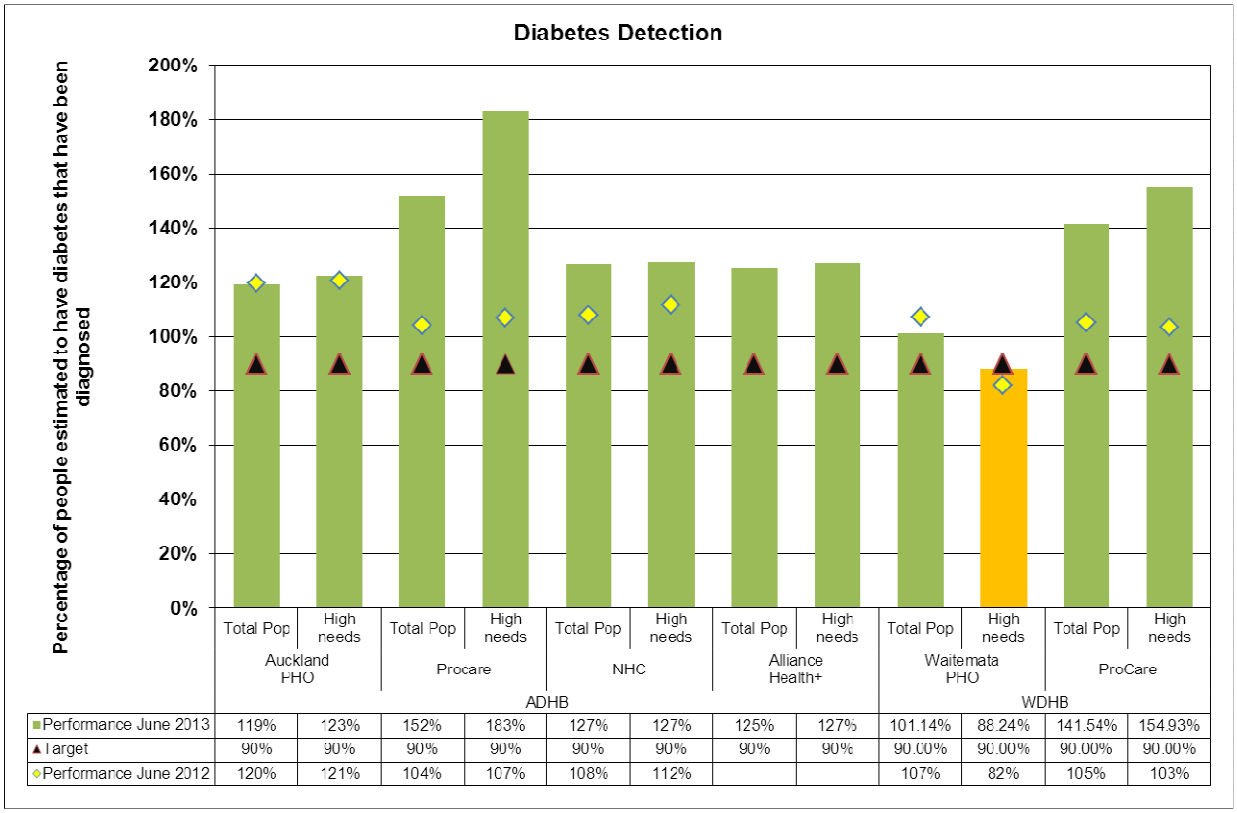
	Auckland PHO	Procare	NHC	Alliance Health+	Waitemata PHO	ProCare
Performance June 2013	68%	70%	72%	67%	70.31%	72.41%
Target	65%	70%	53%	50%	70.00%	70.00%
Performance June 2012	63%	65%	64%		64%	68%

The graph below shows 'Ischaemic CVD Detection' across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter 4 2012/13. ProCare significantly improved their performance from the same period in the previous financial year for their Auckland and Waitemata high needs populations.



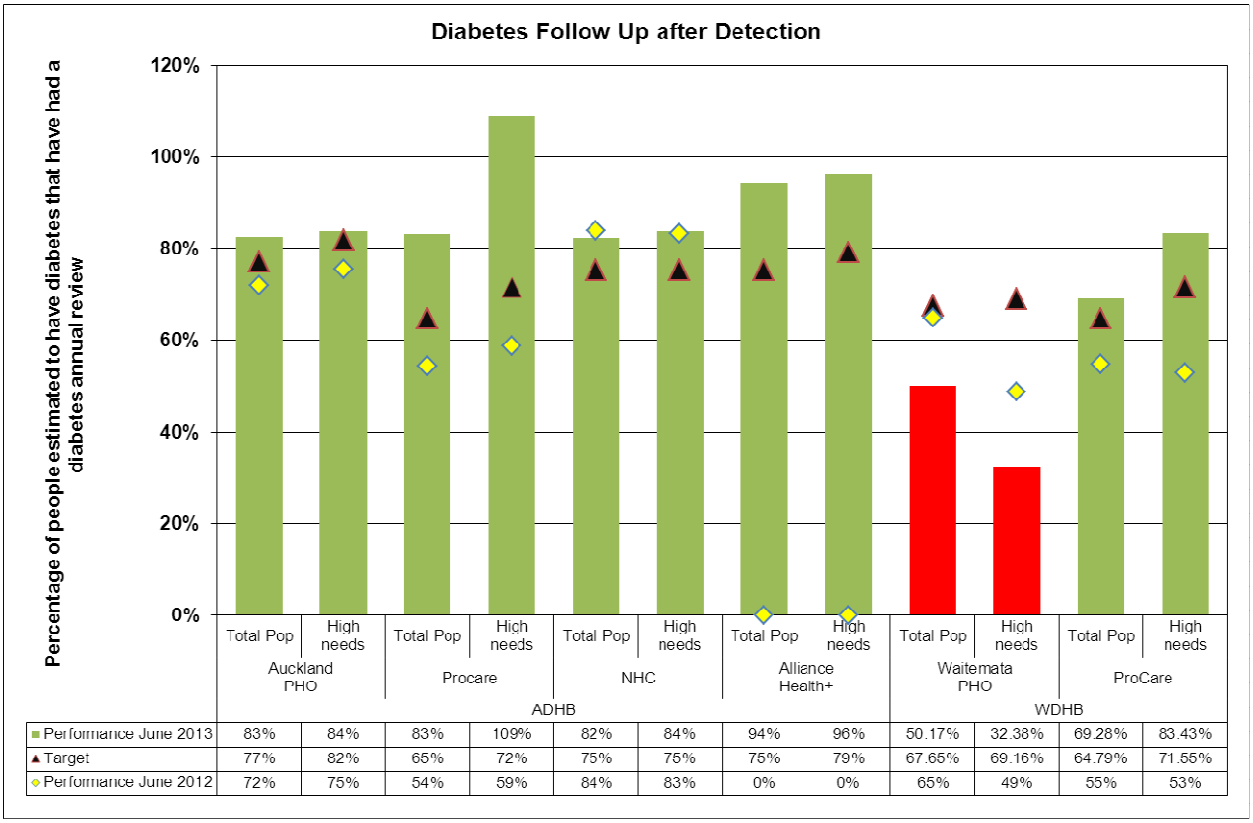
Performance June 2013	100%	118%	105%	171%	104%	119%	96%	110%	92.60%	89.15%	111.68%	165.14%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90.00%	90.00%	90.00%	90.00%
Performance June 2012	92%	111%	84%	112%	100%	120%			92%	83%	89%	108%

The graph below shows that with the exception of Waitemata PHO high needs population, all PHOs met the 'Diabetes Detection' target. Waitemata PHO was 1.76% below the target. Waitemata PHO's performance in this target however has improved by over 6% for the same period in the previous financial year.



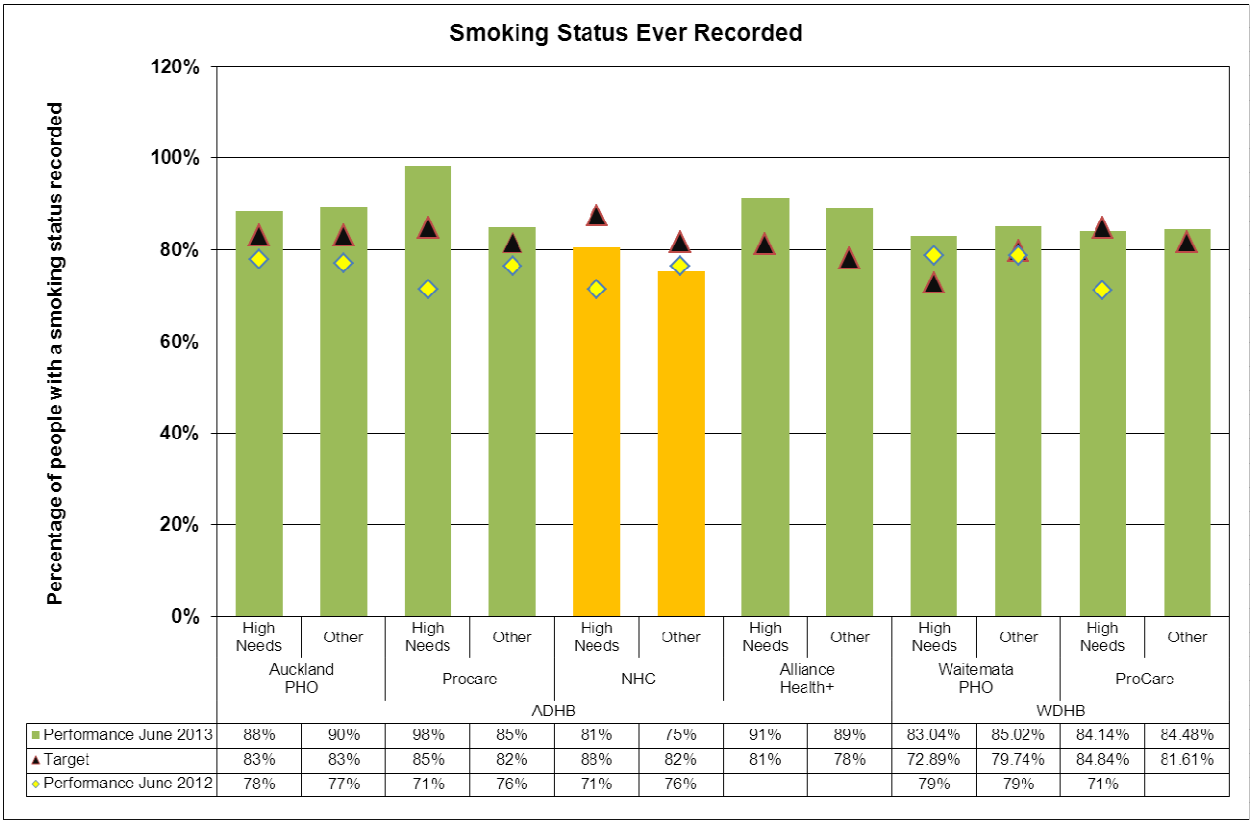
Performance June 2013	119%	123%	152%	183%	127%	127%	125%	127%	101.14%	88.24%	141.54%	154.93%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90.00%	90.00%	90.00%	90.00%
Performance June 2012	120%	121%	104%	107%	108%	112%			107%	82%	105%	103%

The graph below shows that with the exception of Waitemata PHO, all PHOs met the 'Diabetes follow-up after Detection' target for quarter four, 2012/13. Waitemata PHO was 17% below the target for the total population and 37% below the target for their high needs population.



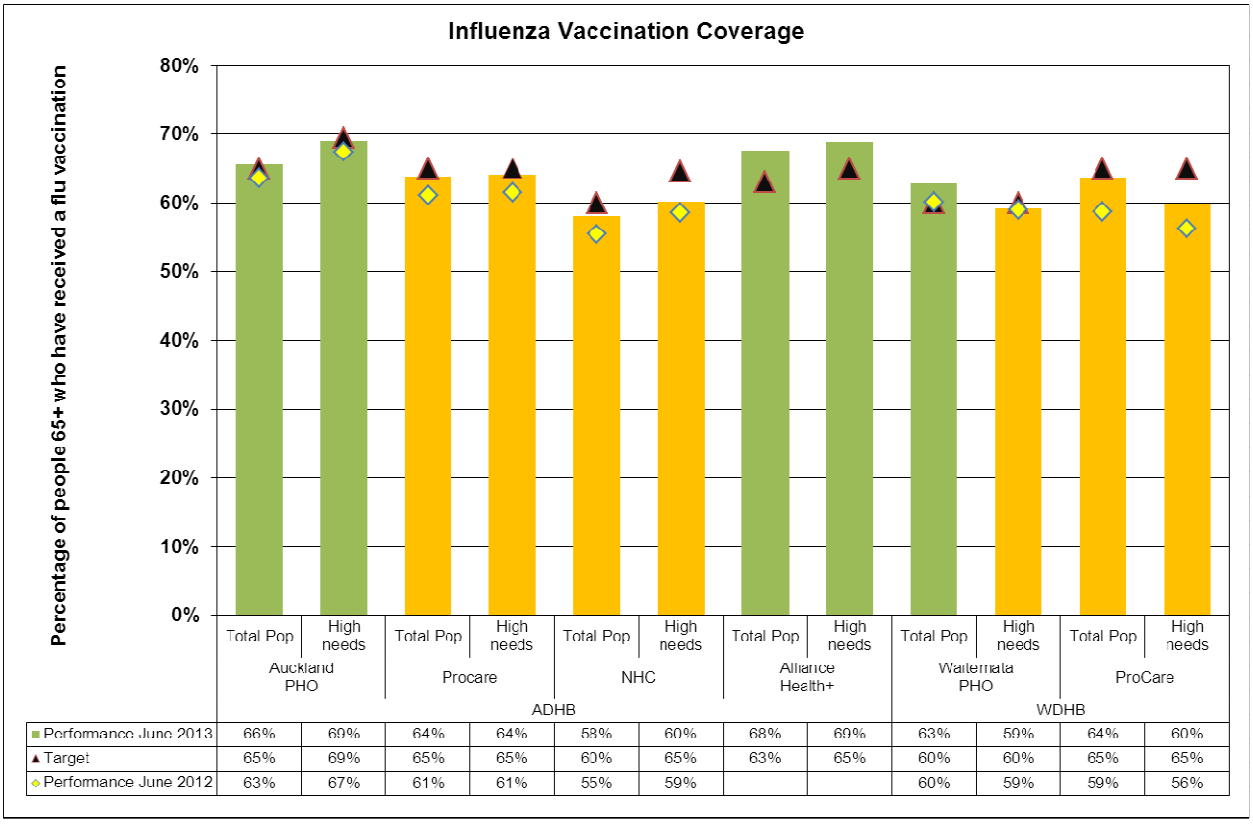
	Auckland PHO Total Pop	Auckland PHO High needs	Procare Total Pop	Procare High needs	NHC Total Pop	NHC High needs	Alliance Health+ Total Pop	Alliance Health+ High needs	Waitemata PHO Total Pop	Waitemata PHO High needs	ProCare Total Pop	ProCare High needs
Performance June 2013	83%	84%	83%	109%	82%	84%	94%	96%	50.17%	32.38%	69.28%	83.43%
Target	77%	82%	65%	72%	75%	75%	75%	79%	67.65%	69.16%	64.79%	71.55%
Performance June 2012	72%	75%	54%	59%	84%	83%	0%	0%	65%	49%	55%	53%

The graph below shows that with the exception of NHC, all PHOs met the 'Smoking Status Ever Recorded' target for quarter four, 2012/13. NHC were 7% below the target for both their total population and their high needs population.



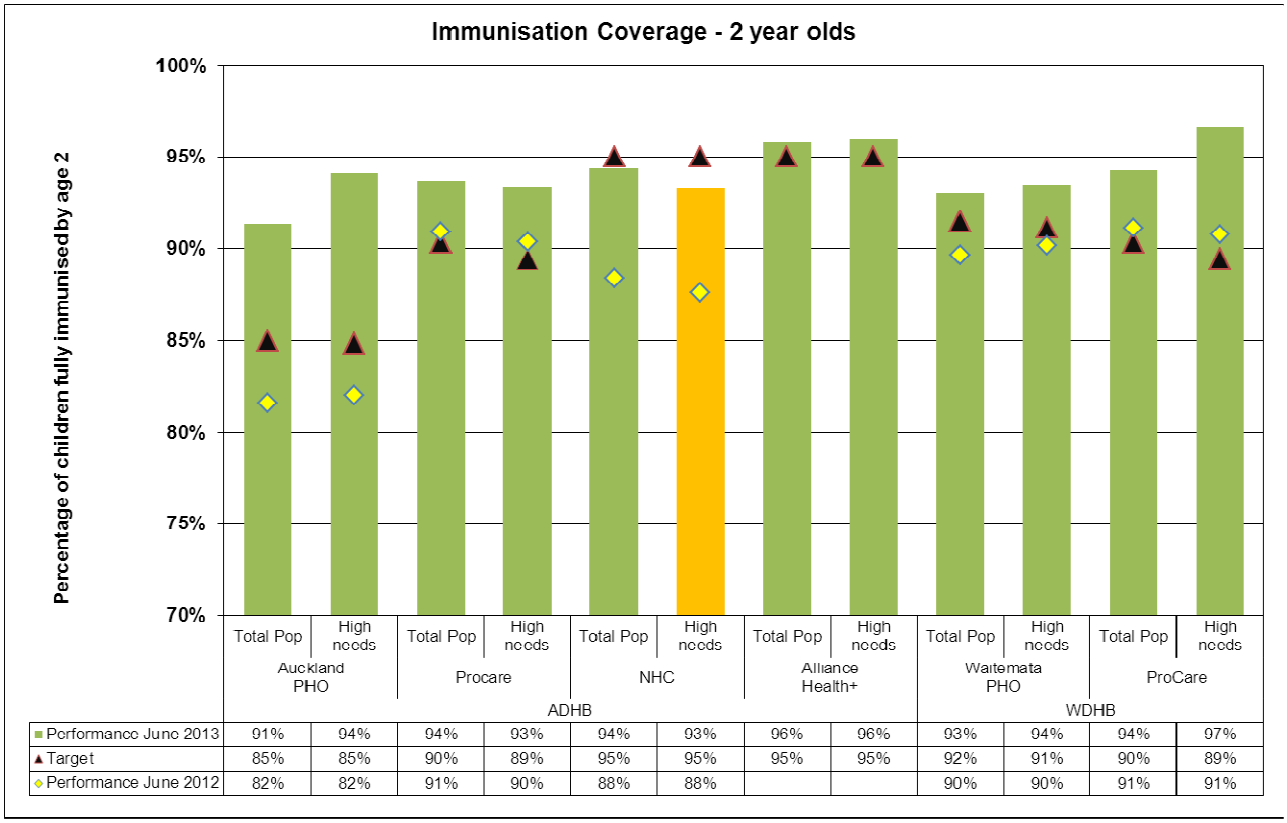
	High Needs	Other	High Needs	Other	High Needs	Other	High Needs	Other	High Needs	Other	High Needs	Other
	Auckland PHO		Procare		NHC		Alliance Health+		Waitemata PHO		ProCare	
	ADHB								WDHB			
Performance June 2013	88%	90%	98%	85%	81%	75%	91%	89%	83.04%	85.02%	84.14%	84.48%
Target	83%	83%	85%	82%	83%	82%	81%	78%	72.89%	79.74%	84.84%	81.61%
Performance June 2012	78%	77%	71%	76%	71%	76%			79%	79%	71%	

The graph below shows 'Influenza Vaccination Coverage' across the five Auckland and Waitemata PHOs. ProCare and NHC did not meet this target for both their total and high needs populations. In addition, Waitemata PHO did not meet this target for their high needs populations. All these PHOs were between 1 and 5% below the target.



	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs
	Auckland PHO		Procare		NHC		Alliance Health+		Waitemata PHO		ProCare	
	ADHB								WDHB			
Performance June 2013	66%	69%	64%	64%	58%	60%	68%	69%	63%	59%	64%	60%
Target	65%	69%	65%	65%	60%	65%	63%	65%	60%	60%	65%	65%
Performance June 2012	63%	67%	61%	61%	55%	59%			60%	59%	59%	56%

The graph below shows that with the exception of NHC high needs population, all PHOs met the 'Immunisation Coverage for 2 year olds' target for quarter four, 2012/13. NHC were 2% below the target for their high needs population.

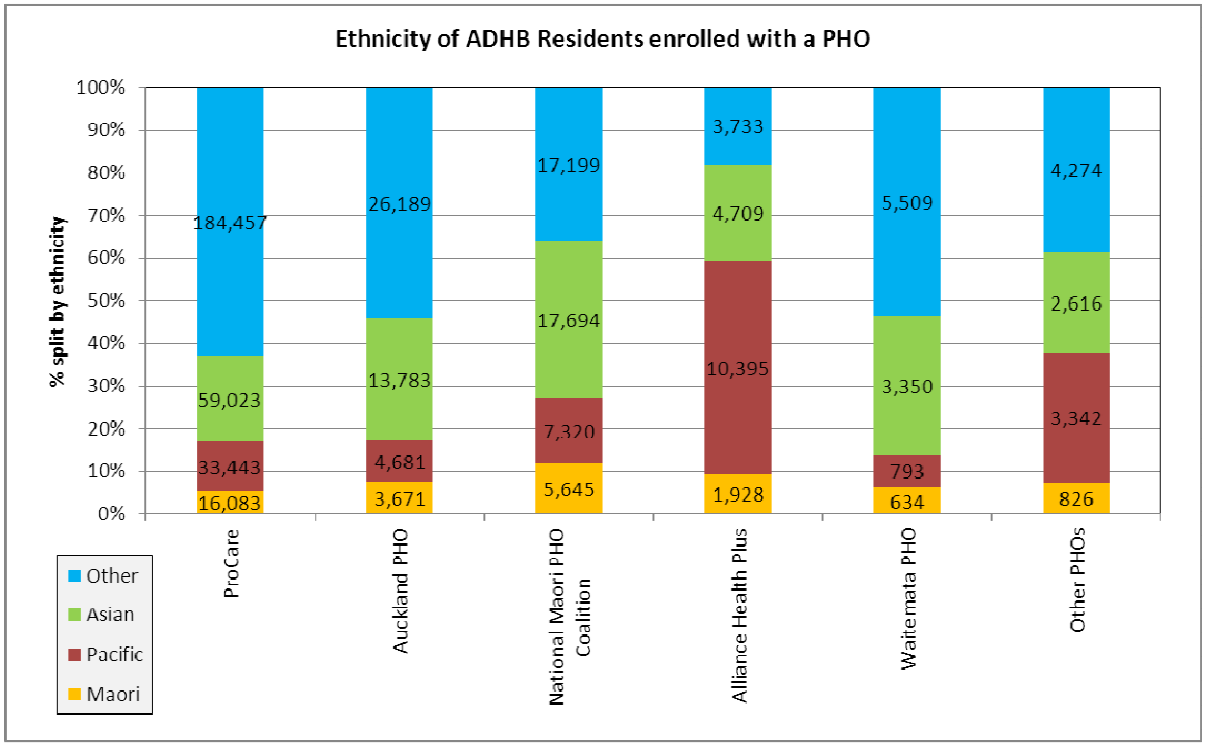


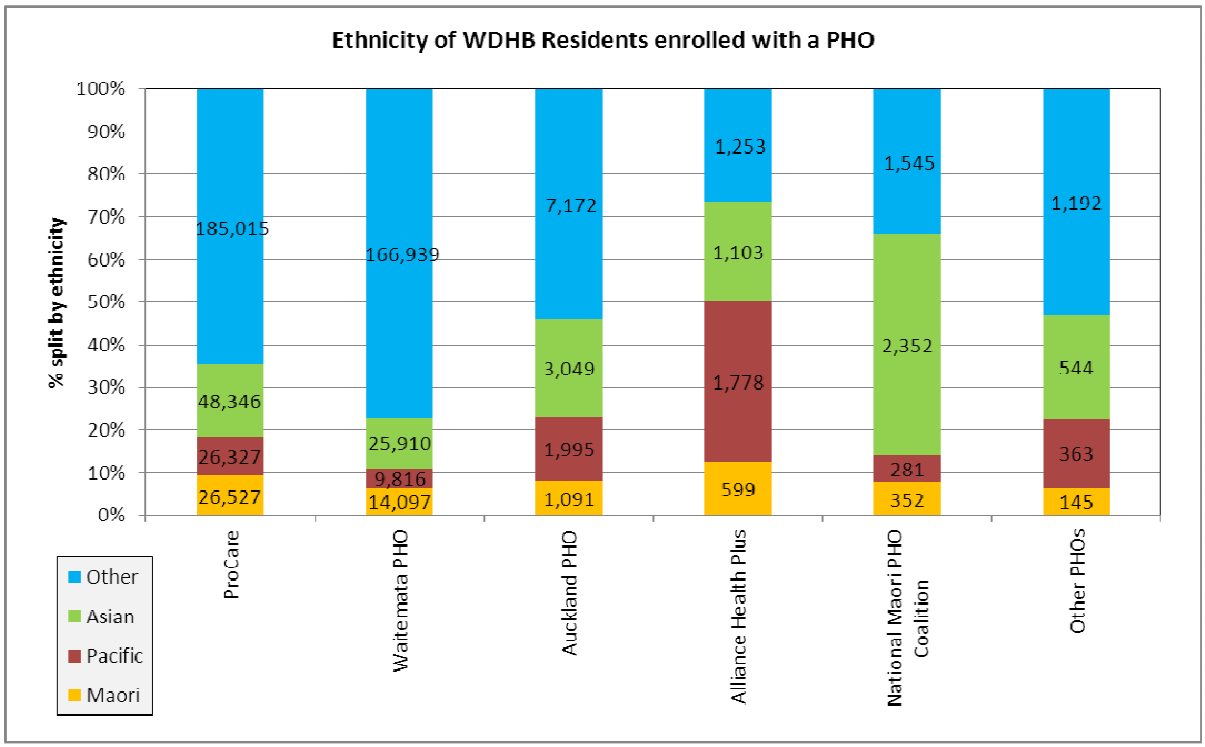
	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs	Total Pop	High needs
	Auckland PHO		Procare		NHC		Alliance Health+		Waitemata PHO		ProCare	
	ADHB								WDHB			
Performance June 2013	91%	94%	94%	93%	94%	93%	96%	96%	93%	94%	94%	97%
Target	85%	85%	90%	89%	95%	95%	95%	95%	92%	91%	90%	89%
Performance June 2012	82%	82%	91%	90%	88%	88%			90%	90%	91%	91%

PHO enrollment data

The graphs below show the ethnicity enrolled with each PHO for Auckland and Waitemata DHB residents respectively. Using 2013 population projections, it is estimated that 82% of Māori living in the Auckland DHB area and 79% of Māori living in the Waitemata area are registered with a PHO.

Some of the under-enrolment will be due to data quality issues with misclassification of Māori as other ethnic groups – most commonly as NZ European. We are not able to accurately quantify the extent of this misclassification at the moment. Auckland and Waitemata DHBs have recently received confirmation that their proposal to implement the primary care ethnicity data audit tool has been accepted by the MoH. This tool will assist general practices to improve the quality of their ethnicity data through an audit process. The audit process will identify where improvements to their systems, protocols and processes for collecting, inputting and outputting ethnicity data can be made. If these changes are implemented, the quality of ethnicity data in primary care will improve over time. Please note that the audit process will not provide quantification of the extent of misclassification currently.


Ethnicity of ADHB Residents enrolled with a PHO
% split by ethnicity
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
184,457
59,023
33,443
16,083
26,189
13,783
4,681
3,671
17,199
17,694
7,370
5,645
3,733
4,709
10,395
1,928
5,509
3,350
793
634
4,274
2,616
3,342
826
ProCare
Auckland PHO
National Maori PHO Coalition
Alliance Health Plus
Waitemata PHO
Other PHOs
Other
Asian
Pacific
Maori


Ethnicity of WDHB Residents enrolled with a PHO
% split by ethnicity
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
185,015
48,346
26,327
26,527
166,939
25,910
9,816
14,097
7,172
3,049
1,995
1,091
1,253
1,103
1,778
599
1,545
2,352
281
352
1,192
544
363
145
ProCare
Waitemata PHO
Auckland PHO
Alliance Health Plus
National Maori PHO Coalition
Other PHOs
Other
Asian
Pacific
Maori

5.2 Planning and Funding Update

Recommendation:

That the report be received.

Prepared by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes WDHB/ADHB), Wendy Bennett (Manager Planning and Health Intelligence WDHB/ADHB), Tim Wood (Funding and Development Manager Primary Care WDHB/ADHB) and Cliff La Grange (Manager Finance and Support Services)

Glossary

DHB - District Health Board
PHO - Primary Health Organisation

1. Summary

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

2. Summary of activities in common

2.1 Collaboration in Planning and Funding

Auckland DHB and Waitemata DHB are working together to achieve a concentration of Planning and Funding expertise, and enhancement of the Planning and Funding capacity and capability of both DHBs through the implementation of a joint PFO Team structure across both DHBs. This proposal received sign off from the Boards of both Auckland DHB and Waitemata DHB in May 2013.

Work is now underway, led by the newly appointed Tier two and Tier three Managers, to develop a suitable structure at Tier four and five to support optimal outcomes for both DHBs in term of delivery and service provision. It is expected that this structure will be ready for consultation with affected employees in January 2014, with a view to implementation in March / April 2014.

Space has now been leased at 17 Shea Terrace to allow the teams to co-locate (teams will be spread across level one of 15 Shea Terrace and level one of 17 Shea Terrace). Work is underway to make the 17 Shea Terrace site ready for the teams (IS connections in place, additional fit out, etc). It is expected that the first teams will be able to move into the new building in mid-December.

2.2 Planning

The Annual Report has been completed for both DHBs and sent to the Minister and the Bills Office. It will be published once it has been presented in Parliament.

The second draft of the 2014/15 Annual Planning Package has been released by the National Health Board. The final version should be released by the end of the month/beginning of December along with the funding envelope. Planning days will be held at both ADHB and

WDHB early next year to enable stakeholders to engage in the planning process and contribute to the content of plan sections.

2.3 Community Pharmacy

Community Pharmacy Anti-Coagulation Management Service (CPAMS) is the provision of point-of-care testing by accredited community pharmacists and adjustment of warfarin (a type of medicine to thin the blood) doses according to agreed Standing Orders. Pharmacists use an approved decision-support system that assists them to make decisions about the patients' warfarin dose depending on the results.

The 20 DHBs have made a commitment to fund this service, which comes out of the national funding envelope for the Community Pharmacy Services Agreement (CPSA). The quantum of funding allocated nationally was $1.5 million in 2012/13, and will be $2.5 million in 2013/14 and $3.5 million in 2014/15.

Following the first round in 2012, CPAMS agreements were entered into with six Waitemata DHB providers, in addition to two national pilot sites. As of September 2013, Waitemata DHB had 193 patients across these eight providers (against a contracted volume of 392 patients). Auckland DHB entered into four agreements in 2012; as of September 2013 there were 34 patients registered across the sites.

All DHBs are currently following a nationally-agreed process to select new CPAMS providers for this second round. Additional agreements, if entered into, will fund up to 50 patients per pharmacy per annum. Successful applicants from this round will start providing the service in early 2014. Training sessions for new providers is currently being arranged for the New Year.

Further, the national Community Pharmacy Services Programme is proposing a third and final round next year (for 2014/15).

In response to the current Expression of Interest Waitemata DHB has received 19 applications, and Auckland DHB received nine. Both DHBs are finalising the selection of the providers to be offered an agreement.

2.4 Primary Care

Integrated Performance and Incentive Framework

The Integrated Performance and Incentive Framework (IPIF) is a co-production between the Ministry and the sector. The intention of the framework is to enable districts, through their Alliance Partnerships, to identify and use locally relevant measures that target the needs of their population and for these to contribute with a clear "line of sight" to nationally reported system-level measures.

The proposed approach to structuring the measures is as follows - through co-production with the sector a small set of national system level measures will be selected that it is proposed all districts will need to report on. It is intended that system level measures will focus on issues that indicate effective integration. Further, a broader menu of nationally standardised contributory measures will be available for districts to choose from to measure local activity that is relevant, and a priority for the local population and that contributes to the system level measures.

It is important to note that existing Health Targets and Better Public Service result areas form part of the national reporting.

In creating the long-list of potential measures, the project has attempted to ensure that:

1. System-level measures are specific and measurable (although as mentioned there may be some potential system level measures that do not lend themselves to a specific target)
2. Contributory measures are a balance of performance indicators and "tin opener" measures (i.e. driving discussion around variation without needing specific targets or thresholds)
3. There is a balance of input, output and outcome measures
4. That the collection and reporting of these should not increase the reporting burden on providers.

Consultation with the sector on the draft is underway. More information can be found at: http://www.hiirc.org.nz/page/42610/draft-integrated-performance-and-incentive/?section=9097

2.5 Oral Health Achievement against Arrears Target (=<10%)

As of September 2013, the Oral Health Service achieved the target of seeing 90% of children on time (see Table 1). The MoH arrears target is =<10%. Auckland achieved 91.6% (8.4% arrears) and WDHB 91.2% (8.8% arrears). This is a significant improvement over the year. It is also encouraging to see that arrears for Maori children have improved from over 15% in both ADHB and WDHB in July to 9.3% in for both ADHB and WDHB in October (Table 2).

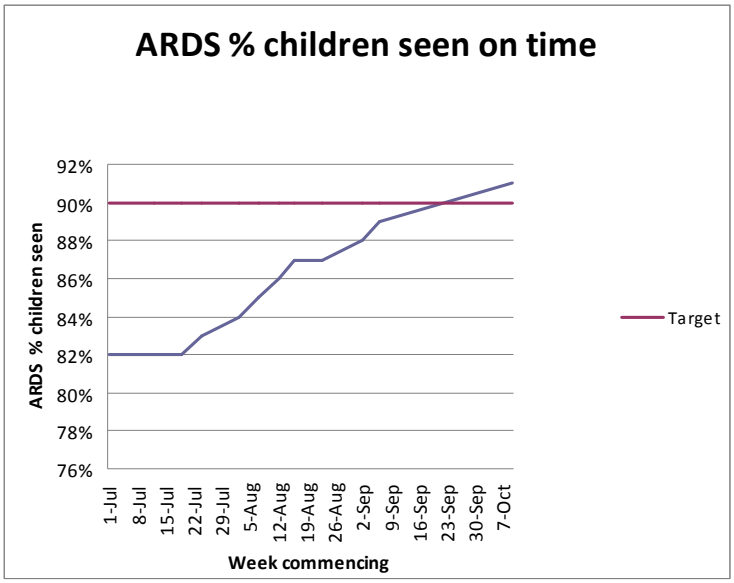


Table 1

Sum of Arrears %			DHB			Total
Year	Month	EthnicGroup2	ADHB	CMDHB	WDHB	
2013	July	Maori	15.6%	11.2%	15.5%	13.3%
		Other	17.7%	10.7%	13.4%	13.9%
		Pacific Island	13.6%	14.0%	14.5%	14.0%
	July Total		16.6%	11.8%	13.9%	13.8%
	September Total		9.1%	10.1%	8.5%	9.3%
	October	Maori	9.3%	11.8%	9.3%	10.6%
		Other	7.7%	9.2%	8.6%	8.5%
		Pacific Island	10.0%	12.2%	9.3%	11.1%
	October Total		8.4%	10.7%	8.8%	9.4%

Table 2

Specific strategies are in place for Maori and other high risk groups. The preschool programme targets preschools in areas of high risk. Regular onsite visits are made to provide examinations and preventive treatments to targeted high needs Child Care Centres, Kohanga Reo and Pacific Language Nests. The on site treatment provided at schools in high needs areas via transportable dental units and extended hours are improving accessibility.

All areas have achieved considerable improvement since July 4 this year when the new business rules were implemented. The new business rules include:

- Individualised dental care (IDC) is being audited regularly. IDC is an assessment tool that informs the recall period. High risk has a six month recall; medium risk a one year recall period and low risk an eighteen month recall period. IDC is designed to spread the demand of the service by the use of recall times to suit the risk status of the child. A higher than expected number of children are being recalled after six months and less than expected are being recalled at eighteen months. This is contributing to an over demand on the service.
- A production plan for chair utilisation is being developed, with assistance from decision support. This will clearly demonstrate capacity and ensure chairs are used optimally. This planning approach has not been used before by ARDS. Currently the plan has been tailored to one team; the next stage will be to apply it to the remaining South teams for use. Adjustments and tailoring will occur prior to roll out.
- Targeted clinics have been opened for extended hours to provide more appointments and increase accessibility. Extended hours are being offered at a number of clinics across the region (Edmonton, Westgate, Forest Hill, Glen Eden, Buckland Road, Sylvia Park and Greenlane).
- The Operations Manager continues to monitor the arrears situation weekly.

2.6 Maori Health

Integrated Contracts:
Discussions with all providers (across both DHB's) have been held; these discussions have been positive and clarity was reached regarding:

- For change
- Timelines
- Requirements (reporting and delivery)

Ethnicity Data Audit Tool
The MOH only received 6 proposals for this kaupapa. Waitemata will be leading the training package development and delivery nationally (agreement in principle from the GM Maori forum).

The contract is currently being negotiated with MOH regarding the dollar value. Agreement has been reached with Counties Manukau that the ETHC and Alliance Health Plus practices in their area will be included in the work that we do. Discussions have been held with each of the PHOs and Auckland and Alliance Health Plus have agreed to go first. We are planning to begin this in January.

Cardiac Rehab review
This analysis has been completed and is currently being reviewed. It is expected that this analysis will inform current delivery and performance requirements and also identify potential gaps in the delivery and relationships.

2.7 Pacific Health

The development of a joint ADHB/WDHB Pacific Strategic/Action Plan is in progress for the period 2014 – 2018. Health targets, DAP objectives and specific projects such as rheumatic fever are not included, as this Plan is not a duplication of other Plans but is expected to contribute towards the achievement of those objectives.

The plan is intended to be joint Plan between DHBs, PHOs and Pacific community (as represented by 72 churches and communities that are part of HVAZ and Enua Ola programs).

Eight approaches have been identified (worded from Pacific family perspective):

- Our children are safe, well, and loved
- No one in our family is ever subjected to violence or abuse
- We're Smokefree
- We eat healthy: more fruit and veg; much less fat, salt and sugar
- We stay active
- We seek help early
- We access specialist help when needed
- Our family lives in warm healthy house

Consultation to date has been widespread involving a range of external and internal stakeholders and is ongoing.

Specific actions are being finalised in relation to some of the approaches, but for others, the main objective for the current financial year is to establish working processes, especially with organisations outside the DHBs.

Community consultation will commence in the second week of November and the aim is to present the plan to the Committee in the New Year.

3. Waitemata DHB

3.1 Funder Finance

The October 2013 consolidated core result for the Waitemata Funder was $223k favourable to budget for the month and $431k favourable to budget for the year to date.

Funder NGOs

The October 2013 core result for Funder NGO was $260k favourable to budget for the month and $372k favourable to budget for the year to date. The favourable net year to date position is mostly the result of a favourable Community Pharmacy spend against budget. The adverse variance previously reported against Oral Health services continues to reduce and is no longer of concern.

Funder IDFs

The October 2013 core result for Funder IDF was $38k adverse to budget for the month and $59k favourable to budget for the year to date. The impact of the national inpatient wash-up position receivable/payable at year end through the MOH process is being calculated but not accounted for. The net year to date impact is favourable with lower IDF outflows and higher IDF inflows both contributing to the indicative year to date wash-up expectation.

4. Auckland DHB Update

4.1 Funder Finance

For the month of October 2013 the funding accounts show a deficit of $0.9M compared to a budget deficit of $2.5M, a favourable variance of $1.5M. The variance is split between a favourable variance for the "funder" of $0.3M combined with a "provider" unfavourable variance of $0.1M.

YTD the funding accounts show a deficit of $7.6M compared to a budget deficit of $11.9M, a favourable variance of $4.4M. The variance is split between a favourable variance for the "funder" of $5.8M combined with a "provider" unfavourable variance of $1.5M.

The main features of the YTD result are a favourable budget variance in Personal Health and Med/Surg of $4.2M, a Mental Health favourable to budget by $0.3M, Health of Older Peoples is favourable to budget by $1.3M and an unfavourable variance of $1.5M in Provider services.

Most Personal Health costs are not significantly different from the budget although some late project starts are giving a favourable variance in other expenditure as well as the savings in the National Haemophilia Management Group payments which are now funded by Pharmac.

Health of Older People is favourable for the YTD by $1.3M. Most costs are not significantly different from the budget except Day Programmes and Software Maintenance are proportionally very favourable.

For the Saving Programme the target for Elective Services revenue has been reduced by $742k following receipt of the CFA from the MOH for this service. This downside has been offset by upsides of expected receipt of from Lab Test Auckland of a Community Laboratory term extension rebate of $550k to ADHB ($2m for the region) and the avoidance of payments to the National Haemophilia Management Group of $2.5M as this expenditure is now being met by Pharmac from within the Community Pharmaceutical Budget. Therefore a net upside to the forecast of $2.3M

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. Minutes of the Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting with Public Excluded 16/10/13	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)]	**Confirmation of Minutes** As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.