Waitematā
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committee Meeting

Wednesday 19 February 2020

10.00am

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

WAITEMATĀ DISTRICT HEALTH BOARD
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING
19 February 2020

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

COMMITTEE MEMBERS	MANAGEMENT
Kylie Clegg – Committee Chair (WDHB Board member)	Dale Bramley - WDHB, Chief Executive
Max Abbott - WDHB Board member	Tim Wood – Acting WDHB, Director Funding
John Bottomley - WDHB Board member	Karen Bartholomew - WDHB, Director Health Outcomes
Chris Carter - WDHB Board member	Peta Molloy- WDHB, Board Secretary
Sandra Coney - WDHB Board member	Deanne Manuel – WDHB, Committee Secretary
Warren Flaunty - WDHB Board member	
Judy McGregor – Ex-officio as WDHB Board Chair	
Allison Roe - WDHB Board member	
Arena Williams – WDHB Board member	
cc: All Board Members	

Apologies:

AGENDA

KARAKIA
ACKNOWLEDGEMENTS
DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
10.00am	2.1	Confirmation of Minutes of the meeting held on 30/10/2019 Actions Arising from previous meetings
	3.	**DECISION PAPER**
	4.	**INFORMATION PAPER**
10.05am	4.1	Diabetes Retinal Screening Update
10.30am	4.2	Healthy Weight Action Plan for Children
	5.	**STANDARD REPORTS**
11.00am	5.1	Planning, Funding and Outcomes Update - Executive Summary - Planning - Primary Care - Child, Youth and Women - Health of Older People - Mental Health and Addictions - Māori Health Gain - Pacific Health Gain - Asian, Migrant and Refugee Health Gain
	6.	**GENERAL BUSINESS**

Auckland and Waitematā District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2020

Member	February	May	August	October
Kylie Clegg (Committee Chair)				
Max Abbott				
John Bottomley				
Chris Carter				
Sandra Coney				
Warren Flaunty				
Judith McGregor				
Allison Roe				
Arena Williams				

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

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Kylie Clegg (Committee Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies, but less than 1% of shares of these companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, Next Minute Holdings Limited). Orion Health has commercial contracts with Waitematā District Health Board and healthAlliance. Director of High Performance Sport New Zealand Limited	05/02/20
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board member - Rotary National Science and Technology Forum Trust	19/03/14
John Bottomley	Consultant Interventional Radiologist – Waitematā District Health Board	17/12/19
Chris Carter	Chairperson – Henderson-Massey Local Board, Auckland Council Trustee – Lazarus Trust	18/12/19
Sandra Coney	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust	18/12/19
Warren Flaunty	Chair – Trust Community Foundation Trustee (Vice President) – Waitakere Licensing Trust Shareholder – EBOS Group Shareholder – Green Cross Health Director – Life Pharmacy Northwest Chair – Three Harbours Health Foundation Director – Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role)	05/02/20
Judy McGregor	Chair – Health Workforce Advisory Board Associate Dean Post Graduate - Faculty of Culture and Society, AUT Member - AUT's Academic board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	11/09/19
Allison Roe	Chairperson – Matakana Coast Trail Trust Member – Rodney Local Board, Auckland Council Member – Wilson Home Committee of Management (past role)	22/08/18
Arena Williams	Director – Kōwhiri Elections Services Limited Trustee – Jacqueline Allan Family Trust Beneficiary – Ngāi Tahu and Whai Rawa Savings Limited Beneficiary – Te Aitanga-a-Mahaki	18/12/19

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
	Family member is an Associate of Meredith Connell Admitted Barrister and Solicitor of the High Court of New Zealand Member – Te Rūnanga o Wairaka (Unitec)	

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

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

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

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

IMPORTANT

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

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

Note: This sheet provides summary information only.

2.1 Minutes of the Community and Public Health Advisory Committees meeting held on 30 October 2019

Recommendation:

That the draft Minutes of the Community and Public Health Advisory Committees held on 30 October 2019 be approved.

Draft Minutes of the Meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 30 October 2019

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10.00a.m.

Items considered in Public Meeting

COMMITTEE MEMBERS:

Sharon Shea (Committee Chair - ADHB Board member)
Max Abbott (WDHB Board member)
Judith Bassett (ADHB Board member)
Edward Benson-Cooper (WDHB Board member)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair - WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)
Allison Roe (WDHB Board member)

ALSO PRESENT:

Debbie Holdsworth (ADHB and WDHB, Director Funding)
Karen Bartholomew (ADHB and WDHB, Acting Director Health Outcomes)
Tim Wood (ADHB and WDHB, Deputy Director Funding)
Stuart Jenkins (ADHB and WDHB, Clinical Director, Primary Care)
Joy Christison (Project Manager, Primary Care)
Peta Molloy (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:

Christine Maslasomua (Te Puna Manawa HealthWest)
Aroha Hudson (Te Puna Manawa HealthWest)
Kelsy Wheaton (Te Puna Manawa HealthWest)
Gaylene Sharman (Te Puna Manawa HealthWest)
Hiki Wihongi (Te Puna Manawa HealthWest)
Cheryl Hamilton (Auckland Womens Health Council)
Nelson Wahanui (Healthy Babies Healthy Futures, HealthWest)
Jody Yeats (Rangitoto Observer)
Kirsty Gover (Comprehensive Care PHO)
Emily Hughes (The Fono Health Trust)
Cherrill Rave (Healthy Babies Healthy Futures, HealthWest)
Maria Kumitau (Healthy Babies Healthy Futures, HealthWest)
Lorraine Symons (Te Whānau O Waipareira)

KARAKIA:

The Committee Chair opened the meeting with the karakia.

WELCOME:

The Committee Chair welcomed those in attendance. She also acknowledged outgoing Board members at the end of the current term.

Lee Mathias also congratulated the Board members elected and re-elected for the new term, commencing December 2019.

APOLOGIES:

Apologies were received from Matire Harwood, Judy McGregor, Pat Snedden and Ailsa Claire.

DISCLOSURE OF INTERESTS:

There were no disclosures of interests with matters on the agenda.

There were no amendments or additions to the current disclosure of interests.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda except Item 4.3 which was considered before Item 4.2.

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 07 August 2019 (agenda pages 9-15)

Resolution (Moved Lee Mathias/Seconded Warren Flaunty)

That the Draft Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 07 August 2019 be approved.

Carried

Matters Arising (agenda page 16)

The schedule was noted.

3. DECISION PAPERS

There were no decision papers.

4 INFORMATION ITEMS

4.1 Auckland Regional Public Health Service (ARPHS) update (agenda pages 17-37)

Jane McEntee (Service Change Manager, Planning and Funding) and Maria Poynter (SMO, ARPHS Management) were present for this item and introduced the report.

The report was summarised. Matters covered in discussion and response to questions included:

- That a review of the response to the Measles outbreak will occur. The IMT will have an opportunity to provide feedback.
- Acknowledged the social media aspect of promoting Measles vaccinations and information during the outbreak.
- Cases of Measles has been reducing weekly over the past six weeks, it is expected that the outbreak will reduce, but there continues to be risk from international and other areas of the country.
- Noted a previous request for a report on Vaping.

The Committee Chair acknowledged the work undertaken and asked that the next report highlight equity and its impact; while it is implicit in the report, the Committee would like to support the work being done.

The report was received.

4.2 Health Needs Assessment Update (agenda pages 38-148)

This item was considered after item 4.3.

Wendy Bennett (Manager, Planning and Health Intelligence) and Jean Wignall (Health Outcomes Analyst) were present for this item.

Wendy Bennett introduced the paper. Matters covered in discussion and response to questions included:

- Suggest that the Auckland DHB and Waitematā DHB Chief Executives consider writing to the Minister of Statistics requesting that the next census be brought forward to assist the DHBs with regard to their population and growth.
- Noting discussions held about broader health issues and that there is good research about cultural identity, which contributes to improved health status and wellbeing.

The report was received.

4.3 Healthy Babies Healthy Futures Programme (agenda pages 149-159)

This item was considered before item 4.2.

Scott Abbott (Māori Health Portfolio Manager), Nelson Wahanui (Programme Manager), Maria Kumitau (Health Babies Healthy Futures, HealthWest), Emily Hughes (The Fono Health Trust) and Cherrill Rave (Healthy Babies Healthy Futures, HealthWest) were present for this item.

Scott Abbot introduced the paper. The coordinators in attendance each talked about their experiences in this area with young mothers, new mothers, families and whanau and the difference they could make.

In response to a question about the evaluation component of the programme and whether non-health benefits and mitigating social isolation are being captured, it was noted that these aspects are being captured and there is a lot of work in these areas. Three evaluations capture what is being done on the ground; whānau is now included, with 'parents' a focus rather than only mothers.

The Committee Chair acknowledged the work in this area.

A presentation was given on 'Kāinga Ora – Healthy Housing Initiative' in ADHB and WDHB – providing a brief description of the local programme and overview of the results from the national evaluation.

Matters covered in the discussion and response to questions included:

- Health Home Standards are to be in place by 2021.
- A similar programme trialled in Wellington had not been successful as there has not been an inspection process or an entity tracking the programme. MBIE is now assisting for Healthy Homes.
- The programme commenced in 2013, improvements have been sent with landlords being actively responsible for their properties.
- Checks are also made of sleep-outs/cabins and the like.

The report was received.

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 160-187)

The report was taken as read. Matters covered in discussion and response to questions included:

- That the Commerce Commission has clearly advised the DHB cannot impede any 'competition' between entities in the community, such as pharmacies and the number of pharmacies that open in any specific area.
- Noting the need for adequate clinical advice that is provided by community pharmacies; which is not monitored by the DHB.

The report was received.

The meeting concluded at 11.51 a.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATĀ DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 30 OCTOBER 2019

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 12 February 2020

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
		There are no matters arising from previous meetings			

4.1 Diabetes Retinal Screening Update

Recommendation:

That the report be received.

Prepared by: Dr Carol Barker (Public Health Physician, Primary Care) and Joy Christison (Acting Senior Programme Manager, Primary Care)
Endorsed by: Tim Wood (Acting Director Funding)

Glossary

ALT	-	Alliance Leadership Team
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
GP	-	General Practitioner
PHO	-	Primary Health Organisation
RSCGG	-	Retinal Screening Clinical Governance Group

1. Executive summary

Diabetic retinopathy is a chronic eye disorder which causes visual impairment and blindness in people with diabetes. Diabetic retinopathy can be detected by retinal screening where the retina is photographed and assessed for signs of disease. People with significant disease can then be referred for treatment to reduce the risk of visual loss. The Ministry of Health recommends people with diabetes undergo regular retinal screening.

The Ministry of Health target for diabetes retinal screening coverage is 90%. Retinal screening coverage for Auckland and Waitematā District Health Boards (DHBs) is below this target. For Auckland DHB coverage at three years is 61.8% for the total diabetic population, 61.4% for Māori and 56.0% for Pacific. For Waitematā DHB coverage at three years is 63.8% for the total diabetic population, 57.4% for Māori and 57.8% for Pacific.

There is considerable focus within Auckland and Waitematā DHBs on both improving diabetes retinal screening coverage, and on approaching this in the right way, so as to achieve equity of outcomes, particularly for Māori and Pacific peoples. Several activities are currently underway in support of these goals. Chief among them are the 'Metro Auckland Retinal Screening Data Match Project' and the 'Auckland and Waitematā Retinal Screening Service Redesign Project'.

The Metro Auckland Retinal Screening Data Match Project is a collaboration between the three metro Auckland DHBs and seven Primary Health Organisations (PHOs). The project is an enabler for early detection and treatment of preventable diabetic eye disease. This will be achieved using regular data matching of DHB retinal screening data with PHO data to identify people with diabetes who are not engaged with retinal screening services.

PHOs will download prioritised lists of people with diabetes enrolled with their PHO who are not engaged with retinal screening. PHOs will work with practices to contact and refer people with diabetes to retinal screening services, starting with those at highest risk of diabetic eye disease. Service planning is being undertaken to manage increase in demand generated through the data match project, and a monitoring and reporting framework will monitor the impact on retinal screening coverage and service capacity.

The proposed redesign of the diabetes retinal screening services is informed by extensive engagement with service users and other stakeholders. It takes account of international evidence, and the evidence specific to diabetes in Aotearoa. The new service will offer screening appointments much closer to where people live and work, whilst maintaining a high level of quality assurance, ensuring accurate and consistent grading.

2. Strategic alignment

Community, whānau and patient centred model of care	The redesign of diabetes retinal screening services, to achieve equity and coverage gains, was driven by a strong service user voice, and consequently the model of care is entered on the needs of service users. The new model will have: • Multiple access points in the community close to where people live and work • Locations that take into account availability of public transport routes and free parking • Extended hours • Consumer choice of a screening location and time that is most convenient for them The 'Retinal Screening Data Match' project aims to improve retinal screening coverage and equity of coverage, to enable early detection and treatment of potentially preventable diabetic eye disease.
Emphasis and investment on both treatment and keeping people healthy	Diabetes retinal screening and subsequent treatment of disease prevents vision loss and blindness and has been shown to be cost effective. Screening is important because diabetic retinopathy causes no symptoms in its early stages.
Service integration and/or consolidation	The redesigned service model will see all screening images being sent to a central hub for grading and all recalls overseen by the central hub. This consolidation of the grading and recall functions will support quality assurance and failsafe processes. The retinal screening data match project is a collaboration between the three metro Auckland DHBs and seven PHOs which enables integration of primary and secondary care data to identify people who are not known to screening services.
Intelligence and insight	The redesigned service model requires and profits from flexible thinking. It facilitates improved equity and coverage through a dispersed service model, whilst assuring quality and efficiency. It is poised to leverage further efficiencies in the future, as the science of grading assisted by machine learning develops. The retinal screening data match project uses primary and secondary care data to identify people who need a retinal

		screening referral. Demographic and clinical data are used to prioritise those at highest risk of diabetic eye disease to ensure they are referred and screened first.
	**Evidence informed decision making and practice**	The proposed redesign of the diabetes retinal screening services is informed by the international literature, the literature specific to diabetes in Aotearoa, and local evidence, sourced directly from service users within Auckland and Waitematā DHBs. The retinal screening data match project has been informed by clinical expertise and input from stakeholders. Prioritisation and triage of the unscreened population has been informed by a literature review and analysis of local data to understand risk factors for diabetic eye disease.
	**Outward focus and flexible, service orientation**	The redesigned service takes screening services into the community at an expanded range of locations and makes appointment booking flexible and fitted to the needs of service users.
	**Operational and financial sustainability**	The redesigned service will see variable pricing and allocative arrangements across the two DHBs being replaced with a consistent pricing model. Greater transparency will be achieved for existing funding streams, resulting in an increased contribution towards the desired coverage and equity goals.

3. Background

Diabetic retinopathy is a chronic eye disorder which causes visual impairment and blindness in people with diabetes. All people with diabetes are at risk of developing diabetic retinopathy. Risk increases with duration of diabetes, poor diabetic control, being unable to access health services, pregnancy, uncontrolled hypertension and renal impairment.[1] Approximately 20–25% of New Zealanders living with diabetes have some form of diabetic retinopathy, with 10% having sight-threatening retinopathy.[2,3,4] Māori and Pacific people living with diabetes have higher incidence of moderate and severe diabetic retinopathy compared with New Zealand Europeans and are less likely to access screening.[5]

Diabetic retinopathy is often asymptomatic, with symptoms only arising at the advanced stage. Fortunately, diabetic retinopathy can be detected by retinal screening where the retina is photographed and assessed for signs of disease. People with significant disease can then be referred for treatment to

[1] Ministry of Health, *Diabetes Retinal Screening, Grading, Monitoring and Referral Guidance*. 2016, Ministry of Health: Wellington.
[2] Coppell, K.J., et al., *The quality of diabetes care: A comparison between patients enrolled and not enrolled on a regional diabetes register.* Primary care diabetes, 2011. **5**(2): p. 131-137.
[3] Frederikson, L.G. and R.J. Jacobs, *Diabetes eye screening in the Wellington region of New Zealand: characteristics of the enrolled population (2002-2005).* The New Zealand Medical Journal (Online), 2008. **121**(1270).
[4] Papali'i-Curtin, A.T. and D.M. Dalziel, *Prevalence of diabetic retinopathy and maculopathy in Northland, New Zealand: 2011-2012.* The New Zealand Medical Journal 2013. **126**(1383).
[5] Ramke, J., et al., *Diabetic eye disease and screening attendance by ethnicity in New Zealand: A systematic review.* Clinical & Experimental Ophthalmology, 2019. **47**(7): p. 937-947.

reduce the risk of visual loss. There is good evidence that retinal screening and subsequent treatment reduces preventable blindness in people with diabetes and that retinal screening is cost effective.[1,6]

The Ministry of Health recommends that all people with diabetes undergo regular screening for diabetic eye disease. The Ministry of Health's target for diabetic retinal screening coverage is 90% for all ethnicities. This target assumes that 10% of people with diabetes are ineligible for screening (e.g., already under ophthalmology care for treatment of disease or blind). The standard screening interval is two years. For low risk individuals, this screening interval can be extended to three years and for higher risk individuals the interval is shortened. Diabetic retinal screening should be conducted as part of an organised screening programme, in which all activities along the screening pathway are planned, coordinated, monitored and evaluated.

4. Retinal Screening Coverage

Table 1 outlines the proportion of adults coded as diabetic and enrolled with an Auckland or Waitematā PHO who have been screened in the past two and three years, as at March 31st 2019. Results are presented for Auckland and Waitematā DHB, by DHB of practice.

Table 1: *Diabetic retinal screening coverage for adults coded as diabetic and enrolled with an Auckland or Waitematā PHO, by DHB of practice and ethnicity.*

DHB of practice	Ethnicity	Percentage screened in the past two years	Percentage screened in the past three years
Auckland	Māori	54.8	61.4
	Pacific	48.7	56.0
	Asian	60.6	65.7
	Other	58.6	62.8
	Total	**56.2**	**61.8**
Waitematā	Māori	48.0	57.4
	Pacific	48.1	57.8
	Asian	56.1	64.0
	Other	57.6	66.5
	Total	**55.0**	**63.8**

Diabetic retinal screening coverage in the past two years and past three years for Auckland and Waitematā DHBs is below the Ministry of Health target of 90%. For Auckland DHB, coverage for the total enrolled diabetic population is 56.2% at two years and 61.8% at three years. There are ethnic inequities for Māori and to a greater extent for Pacific, whose retinal screening coverage is 54.8% and 48.7% at two years, respectively and 61.4% and 56.0% at three years, respectively.

For Waitematā DHB, the coverage for the total enrolled diabetic population is 55.0% at two years and 63.8% at three years. Again there are marked ethnic inequities for Māori and Pacific whose retinal

[6] Jones, S. and R.T. Edwards, *Diabetic retinopathy screening: a systematic review of the economic evidence.* Diabetic Medicine, 2010. **27**(3): p. 249-256

screening coverage is 48.0% and 48.1% at two years, respectively and 57.4% and 57.8% at three years, respectively.

5. Current Diabetes Retinal Screening Services

5.1 Provider Configuration

Auckland DHB currently provides services through two contracted providers:

- Auckland DHB Diabetes Service, providing screens at Greenlane Clinical Centre
- Auckland Eye, providing screens at five locations, as outlined in Figure 1, below.

Waitematā DHB also has two contracted providers:

- HealthWest, providing screens at Totara House, Whānau House, and The Fono (Henderson)
- Comprehensive Care, providing screens at seven locations, as outlined in Figure 1, below.

(Note: HealthWest commenced screening at The Fono, Henderson in November 2018, in response to findings from consumer interviews conducted by Planning, Funding and Outcomes in 2018 to inform the redesign of diabetes retinal screening services.)

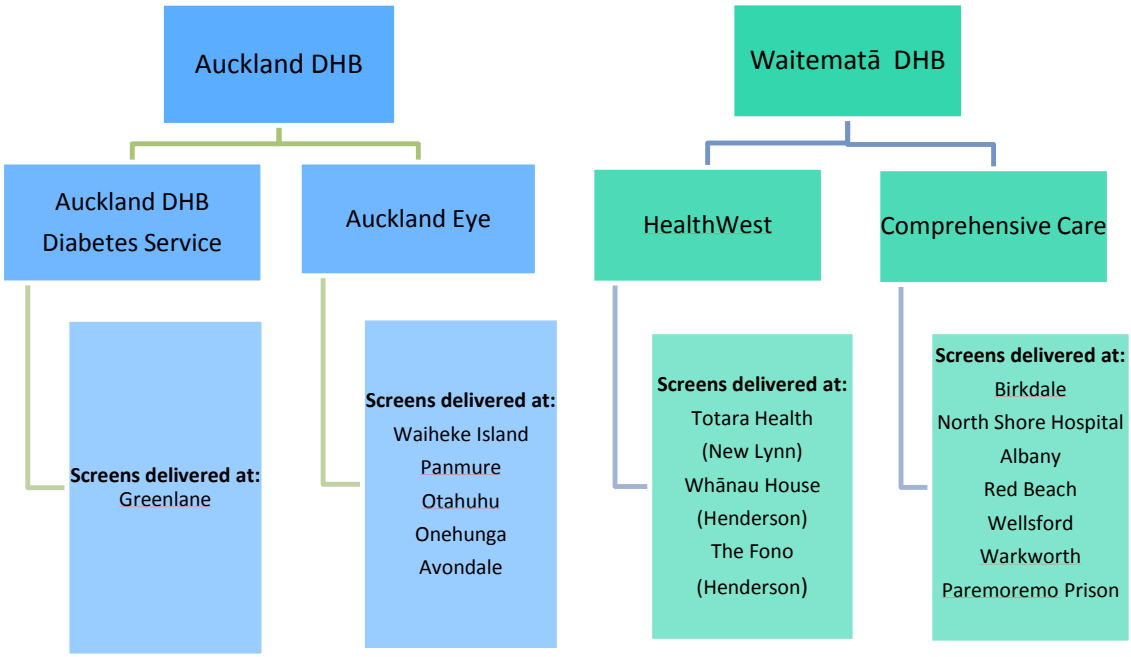


Figure 1. Contracted Diabetes Retinal Screening Providers

5.2 Pathway for Auckland and Waitematā DHBs

Referral
Primary care clinicians are responsible for referring people to the service. A small number of referrals come from secondary care e.g., diabetes, paediatrics, obstetrics, and medicine.

Triage
Referrals are triaged by service providers to ensure that they meet the service criteria. Auckland DHB triages all referrals for Auckland DHB and Auckland Eye, while Waitematā DHB receives e-referrals and forwards these to the appropriate provider. Both Waitematā providers also receive direct referrals and triage these.

Appointment scheduling
Providers allocate patients' appointments (Auckland Diabetes Centre is introducing patient centred booking).

Screening test
A digital photograph is taken of the retina by one of the contracted providers.

Screening result (grade)
The retinal photograph is graded by each provider according to presence/absence of disease**.**

Screening outcome
Determined by the screening result, outcomes include routine recall or referral for treatment or more intensive monitoring.

Documenting and communicating results
Screening results and outcomes are communicated by contracted providers to the patient, General Practitioner (GP), and any other referring health professionals in writing. Preliminary results may also be discussed with the patient at the time of screening.

6. Metro Auckland Retinal Screening Data Match Project

6.1 Project purpose and overview

The purpose of the Metro Auckland Retinal Screening Data Match Project is to improve retinal screening coverage and equity of coverage across metro Auckland to enable early detection and treatment of potentially preventable diabetic eye disease. This will be achieved using regular data matching to identify people with diabetes, who are not engaged with retinal screening services, so they can be offered referral for screening.

The Metro Auckland Retinal Screening Data Match Project is a collaboration between the three metro Auckland DHBs and seven PHOs. The project is being overseen by the Northern Region Diabetes Retinal Screening Clinical Governance Group (RSCGG) and Auckland and Waitematā Diabetes Service Level Alliance (DSLA). These groups include representation from retinal screening providers, diabetes and ophthalmology clinicians, PHOs, DHB provider arm and funder, and Treaty partners.

6.2 Project workstreams

The data match project includes four workstreams outlined below:

1. Regular data match to identify and prioritise people not engaged with retinal screening services

Auckland, Waitematā and Counties Manukau DHBs retinal screening and ophthalmology data is matched with PHO data, for people coded as diabetic and who are enrolled with a metro Auckland PHO. The data match is being undertaken using the Metro Auckland Data Sharing Framework and approvals have been sought from DHB privacy groups.

The aim of the data match is to identify people who are not known to retinal screening services i.e., those people with diabetes who should be offered a retinal screening referral. Patient lists are only available to the respective PHOs that people with diabetes are enrolled with. A prioritisation framework has been developed to prioritise patient lists by ethnicity and latest HbA1c result (a measure of diabetes control). Prioritisation of the unscreened population supports a strong focus on equity and clinical risk to ensure those people, at highest risk of diabetic eye disease, are offered a retinal screening referral first.

2. Offer of screening for people who are not currently engaged with services

PHOs will download prioritised lists of people with diabetes who are enrolled with their practices who are not currently known to services, i.e., people who should be offered a referral for retinal screening. PHOs will work with practices to contact patients, starting with those at highest risk first, to offer them a retinal screening referral. Following the discussion and obtaining consent from the person with diabetes, practices will refer people to the diabetic retinal screening services.

The project team worked in partnership with the PHOs to develop an agreed process for generating retinal screening referrals in primary care including agreed actions, roles and responsibilities. DHB data analysts are working closely with their PHO counterparts to provide information on construction of the patient lists and contents of the data fields to support interpretation of the data.

3. Service planning

Service planning has been undertaken, with retinal screening service providers and clinicians, to develop a triage framework for new referrals and recalls, to manage any increase in demand generated through the data match project. Triage of referrals, by retinal screening providers, will be based on clinical risk factors and ethnicity to ensure those at highest risk of diabetic eye disease is screened first.

Measures to improve service capacity include additional screening volumes funded for Auckland DHB retinal screening providers in 2018/19 being continued for 2019/20 and for Waitematā DHB, a review of the funding model for retinal screening services, to determine if funding can be re-directed to support increased community based screening volumes.

In addition to service planning within the current model of care, Auckland and Waitematā DHBs are developing and procuring a new model of care for retinal screening (outlined later in this paper). This offers the opportunity to redesign services to better support participation and improve diabetic retinal screening coverage.

4. Monitoring and reporting

Data matching will be conducted every three months to allow on-going identification and referral of people who are not engaged with retinal screening services. A monitoring and reporting framework is being developed to monitor the impact of the data match project. This will allow reporting to stakeholders including: Alliance Leadership Teams, Northern Region Diabetes RSCGG and Auckland Waitematā DSLA. The Framework will monitor retinal screening coverage and the number of people with diabetes who are not known to retinal screening services. In order to support service planning the Framework will also monitor retinal screening referral volumes and service level capacity and demand.

6.3 Next steps

In December 2019, the first data match was performed and patient lists of the unscreened population were downloaded by the respective PHOs. The next data match is planned for April 2020 and every three months thereafter. The next steps for the project include finalising and implementing the Monitoring and Reporting Framework and exploring options to refine the prioritisation process for the unscreened population who do not have a recent HbA1c result.

7. Service Redesign

Under the direction of the Auckland and Waitematā Alliance Leadership Team, the Auckland and Waitematā Diabetes Service Level Alliance, and the Northern Region Diabetes Retinal Screening Clinical Governance Group, a new service design for diabetes retinal screening services across Auckland and Waitematā DHBs has been developed. The redesign work was underpinned by a considerable body of work which has supported previous internal and external documents, particularly:

- *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance* (2016) Ministry of Health
- *Review of Retinal Screening Services: Summary Report* (2016) presented to Auckland Waitematā Alliance Leadership Team (ALT) (based on a 2015 review of retinal screening services in Auckland and Waitematā DHBs conducted by Carol Barker, Public Health Registrar)
- *Essential Components for a Retinal Screening Service* (2018) Carol Barker, Public Health Physician, Auckland and Waitematā DHBs.

There has been extensive engagement with stakeholders to review existing services and develop the new service model. The project team undertook additional consumer engagement work in late 2018 to inform the design of the new model. This engagement focused on Māori and Pacific people, and people with diabetes who were not well engaged with the current diabetes retinal screening services.

Through these interviews, it became apparent that diabetes retinal screening clinics need to be available in numerous locations throughout the Auckland and Waitematā districts, much closer to where people with diabetes live and work. It was also evident from these interviews that trusted, familiar providers (Māori providers for Māori and Pacific providers for Pacific) have a very positive effect on uptake of services.

In May 2019, Auckland and Waitematā District Health Boards approved a plan to consult on an equity focused redesign of the diabetes retinal screening service model.

7.1 Proposed new service model

Through the process of engagement with service users and other stakeholders, it became apparent that there was an inherent tension between two things:

- The need to significantly increase the number of screening locations in the community (potentially leading to multiple providers), and
- The need to have very strong quality assurance so that there is confidence that
    - Retinal screening grades are accurate, and
    - Grading of retinal screening images is consistent.

This tension has been resolved by designing a service with three aspects:

- A central hub
- Multiple access points for retinal imaging at dispersed locations
- An outreach service.

Functions of the central hub include:

- Receiving referrals
- Checking eligibility
- Ensuring clinical information has been provided (e.g. glycaemic control and blood pressure)
- Triaging referrals
- Monitoring and administering recall intervals
- Oversight of all grading
- Retaining all clinical details (including images and grades)
- Providing first-level follow up for people overdue for screening
- Managing quality and fail-safe processes
- Providing slit lamp examinations for screening candidates when a clear photograph of the retina cannot be obtained.

Functions of access points for retinal imaging include:

- Visual acuity tests
- Photographic image capture of the retina
- Patient discussion to explain the reason for taking the photograph
- Education about diabetes and eye health.

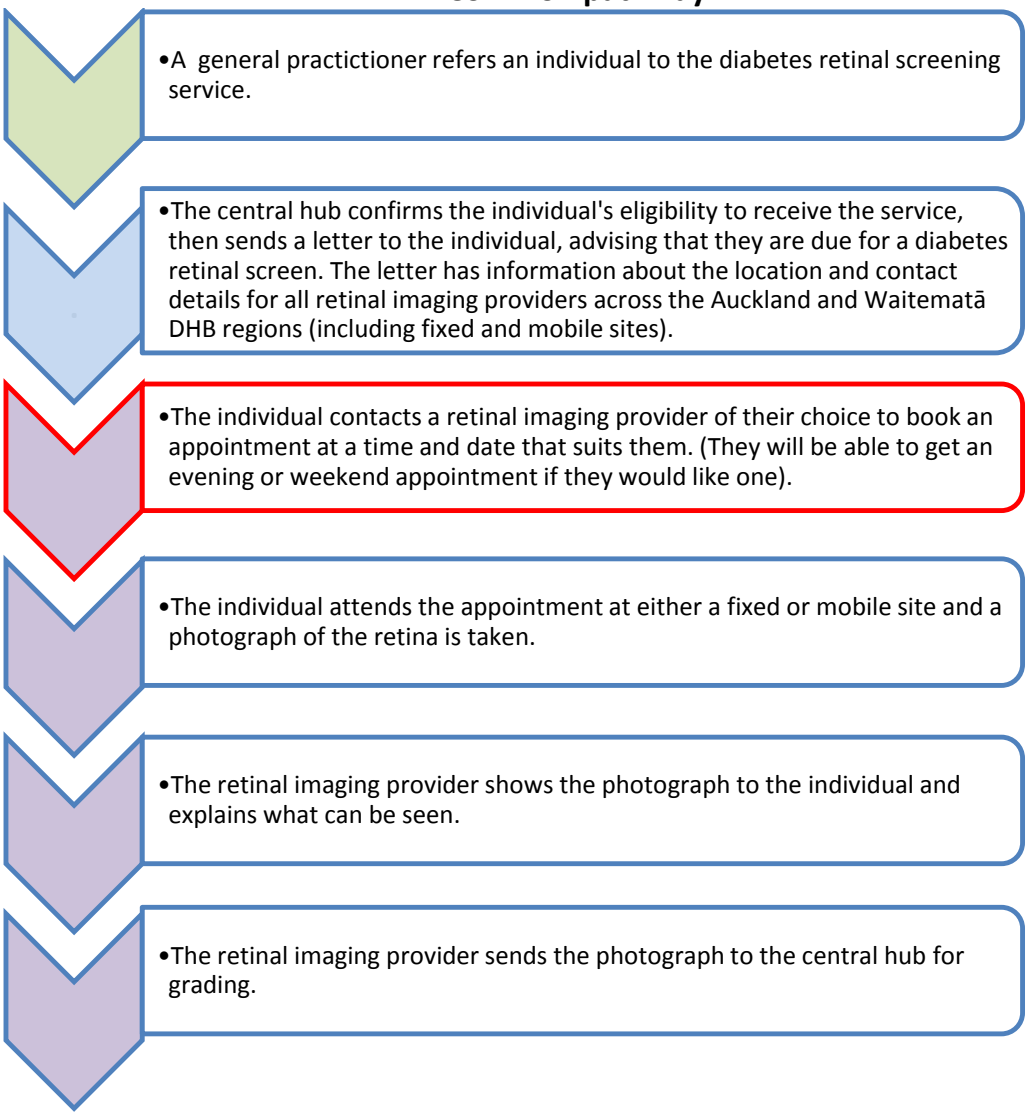
Functions of the outreach service include:

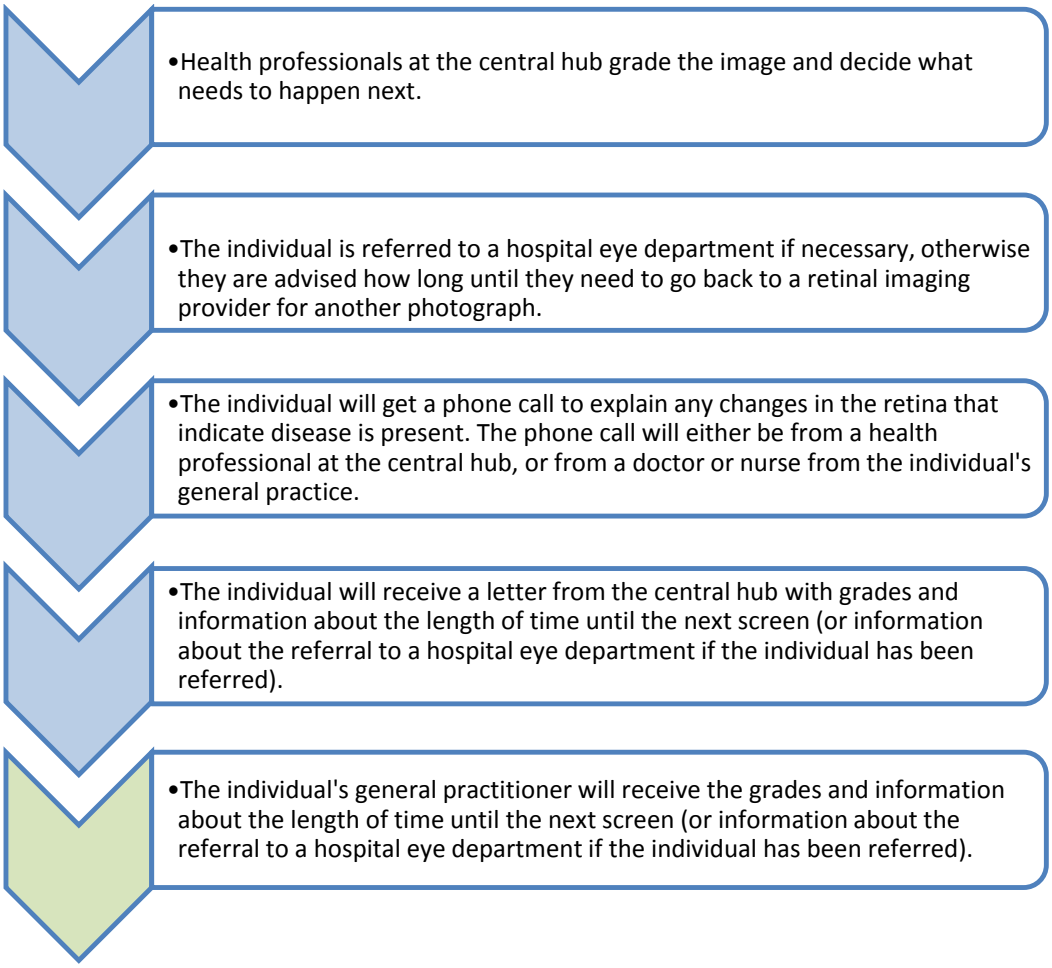
- Intensive follow up for people significantly overdue for screening.
- All functions of access points outlined above, to be provided:
    - At Auckland Prison (Paremoremo) and Mt Eden Correction Facility
    - At rural locations
    - At sites designed to maximise coverage for high priority populations, such as:
        - Māori providers
        - Marae
        - Pacific providers

- Churches, Temples, and Mosques
- General practices with a high proportion of Māori, Pacific, or South Asian people living with diabetes

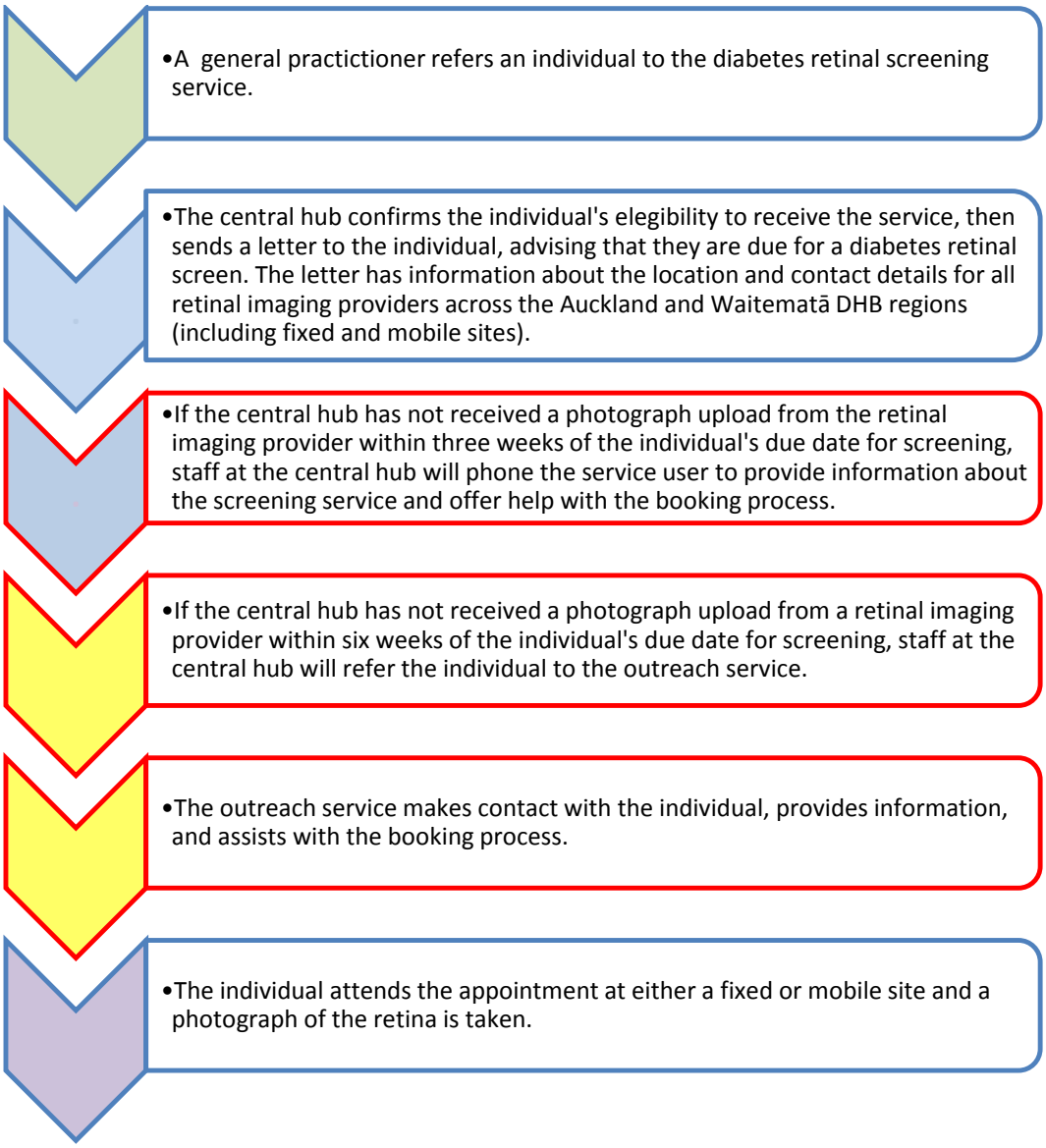
The redesigned service model will offer a consumer-oriented pathway, with consumers choosing the screening location that is most convenient for them and booking appointment times and dates that best suit their schedules. Most people will follow a straightforward pathway (described below as the "Common pathway"). Some may need more contact from the screening service (including contact from the outreach service) before a screen is booked and completed. This second pathway is described below under the heading "Supported pathway".

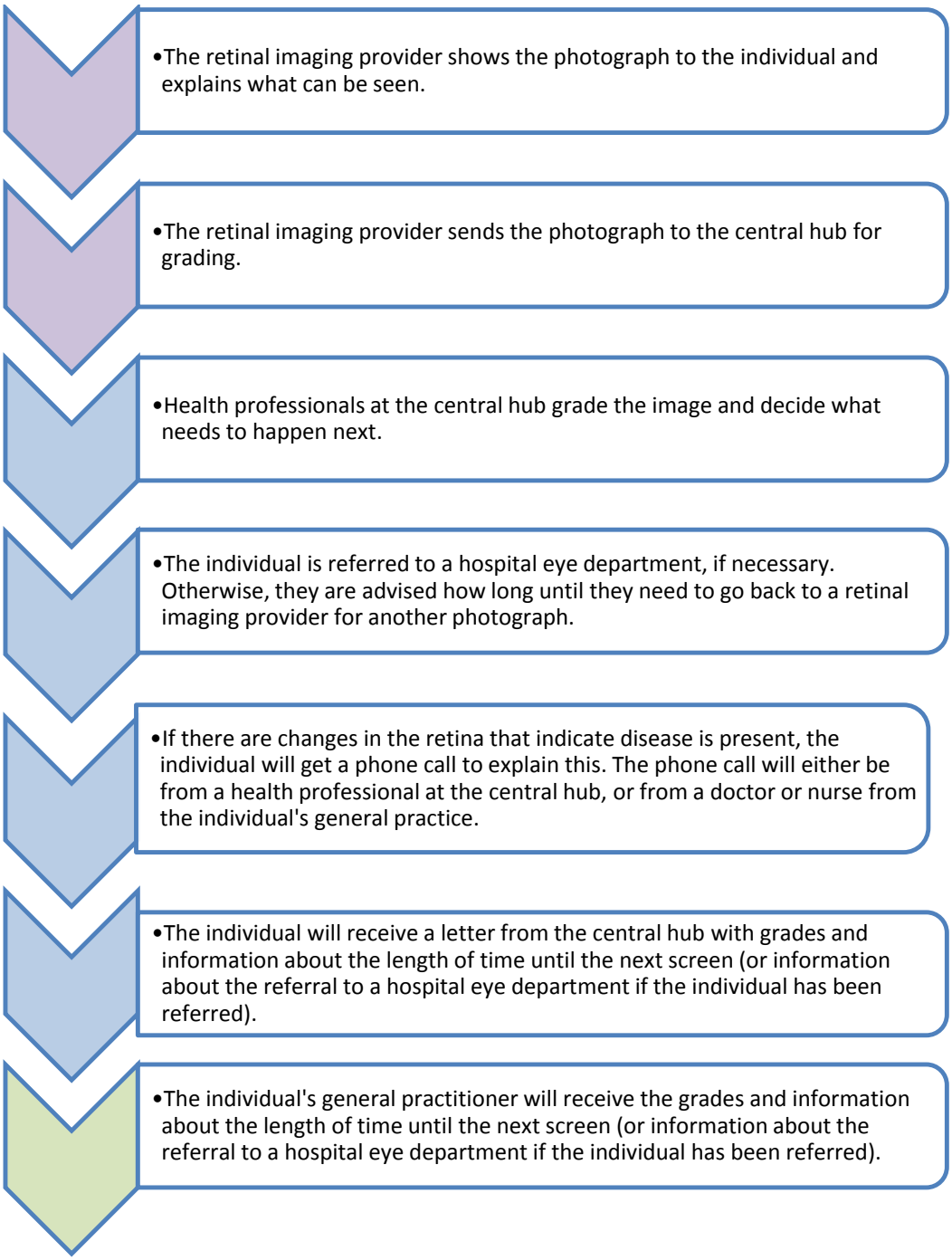
Common pathway




•Health professionals at the central hub grade the image and decide what needs to happen next.
•The individual is referred to a hospital eye department if necessary, otherwise they are advised how long until they need to go back to a retinal imaging provider for another photograph.
•The individual will get a phone call to explain any changes in the retina that indicate disease is present. The phone call will either be from a health professional at the central hub, or from a doctor or nurse from the individual's general practice.
•The individual will receive a letter from the central hub with grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).
•The individual's general practitioner will receive the grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).

Supported pathway




•The retinal imaging provider shows the photograph to the individual and explains what can be seen.
•The retinal imaging provider sends the photograph to the central hub for grading.
•Health professionals at the central hub grade the image and decide what needs to happen next.
•The individual is referred to a hospital eye department, if necessary. Otherwise, they are advised how long until they need to go back to a retinal imaging provider for another photograph.
•If there are changes in the retina that indicate disease is present, the individual will get a phone call to explain this. The phone call will either be from a health professional at the central hub, or from a doctor or nurse from the individual's general practice.
•The individual will receive a letter from the central hub with grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).
•The individual's general practitioner will receive the grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).

7.2 Consultation process

In the second half of 2019, Auckland and Waitematā District Health Boards consulted service users and other stakeholders about the proposed new service model for diabetes retinal screening. The consultation form for general stakeholders outlined the proposed changes to diabetes retinal screening services and asked seven guided questions. This was followed by a general opportunity for respondents to comment on any other aspect of the proposed changes. This form was distributed by email to current providers of diabetes retinal screening, Māori providers, and mana whenua, Pacific organisations, Asian, migrant, and former refugee organisations, Primary Health Organisations, relevant non–government organisations, and members of both the Auckland and Waitematā Diabetes Service Level Alliance and the Northern Region Diabetes Retinal Screening Clinical Governance Group.

Recipients were encouraged to forward the email and consultation documents to their networks. There was an open invitation for any stakeholders to request a face to face meeting with the redesign team in lieu of (or in addition to) submitting a written response.

A shorter, hard copy consultation document was distributed to service users in diabetes retinal screening clinics for a two week period in August 2019. Service users had the option of dropping the completed consultation form into a collection box in the clinic waiting room, or using the stamped and addressed envelope supplied to return it by post. The consultation form explained the proposed changes, and guided service users through six questions. This was followed by a general opportunity for service users to comment on any other aspect of the proposed changes.

7.3 Consultation Feedback

The feedback summarised below came from the following sources:

- 173 written submissions on the service user consultation form
- 12 written submissions on the general stakeholder consultation form
- 5 face to face meetings with stakeholders who were representing an organisation or group.

A total of 120 service users provided an answer to the question about ethnicity. These responses are summarised in Figure 2, below.

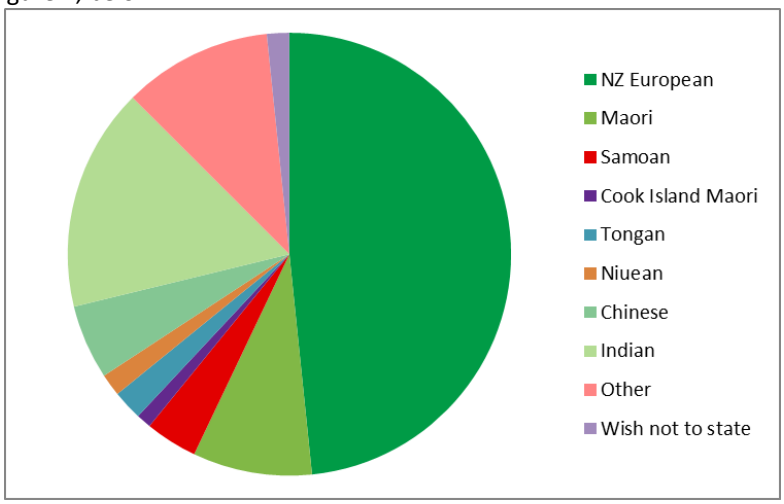


Figure 2. Ethnicity of service users who provided feedback

A total of 162 respondents provided information about their age. As shown in Figure 3 below, the majority of these (82 respondents) were aged 65+. The second largest group (65 respondents) was the 45-64 range. There were 13 responses from the 25-44 years range and two respondents aged 24 years or under.

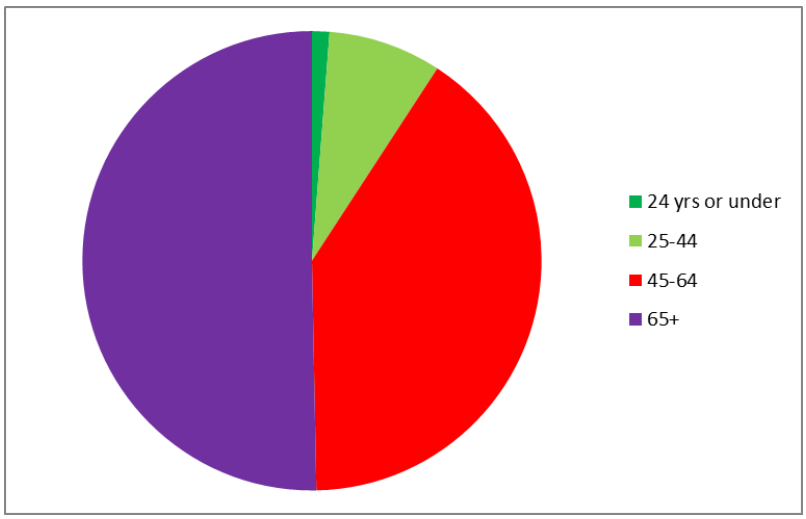


Figure 3. Ages of service users who provided feedback

Feedback gathered from submissions

The sections below cover each of the consultation questions in turn, and gather together the content received via written submissions on the service user consultation form, written submissions on the general stakeholder form, and at face to face meetings with stakeholders.

Proposal to increase the number of clinics

Responses from service users

As shown in Figure 4, below, a strong majority of service users agreed with the proposal to increase the number of clinics in the community for diabetes eye checks , with 141 responding "yes", 7 responding "no", and 25 responding "not sure".

The strong support indicated by the number of "yes" responses was frequently backed up by additional comments for this question. A representative sample is provided below:

"What a good idea. This would make it easier for more people to access this service".
"This is so important; everyone who needs screening should be able to get one easily."
"More sites across Auckland would mean less travel, especially as you have to arrange transport home."

Responses from general stakeholders

A majority of general stakeholders were in favour of the proposal to increase the number of clinics, with ten agreeing with the proposal while two are not sure. Support for increasing the number of clinics was very firmly expressed for many respondents, as is illustrated in the comment below.

"We agree that the increase of fixed sites and inclusion of mobile sites across Auckland & Waitematā is imperative to increase the chances of our whānau being able to access the screening service."

Feedback on this topic from the face to face meetings was in accord with the responses above, with comments such as "*It's a no brainer. We need to double the number of clinics.*"

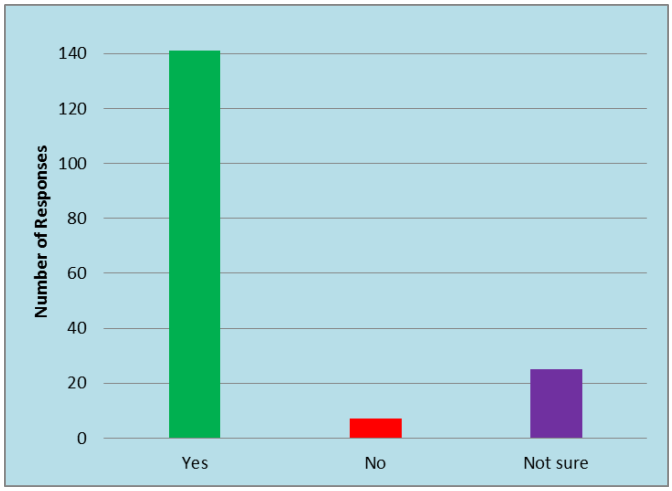


Figure 4. Service user responses to "Do you agree that we should increase the number of clinics in the community for diabetes eye checks?"

Importance of having free parking at the clinic

Responses from service users

As shown in Figure 5, below, most respondents placed a high priority on free parking at the clinic, with 141 rating it as "very important", 55 rating it as "important" , 26 rating it as "not important" and 2 "not sure".

Comments provided by service users reinforced the importance of free parking at the clinic, with one respondent simply stating:
"If I don't have the money I don't go."

Other respondents explained the interaction between parking fees and the logistics of clinic attendance:
"It makes it a lot easier otherwise it can be quite expensive as I already have to get a family member to take time off work to drive me to and back from the appointment."
"The fact that you should not drive for two hours after the appointment makes parking very expensive. Appointments are not always on time and it's understandable. But this means you are paying for longer parking and some people just avoid appointments for this reason."

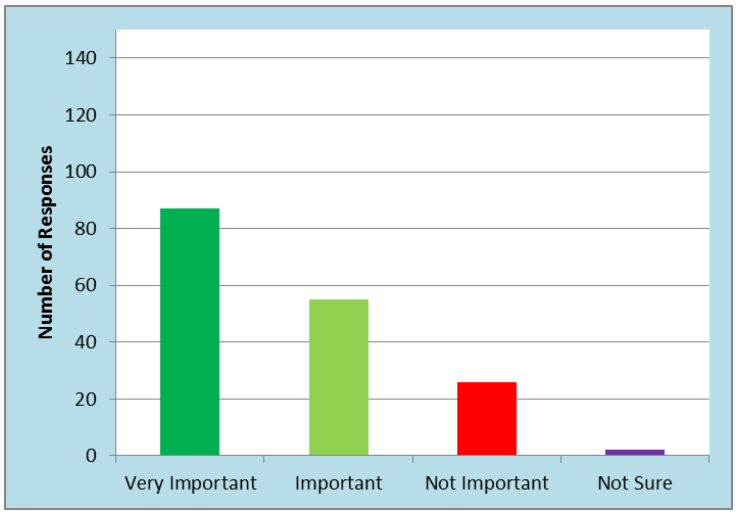


Figure 5. Service user responses to "How important is it to you to have free parking at the clinic?"

Responses from general stakeholders

Written responses from general stakeholders were similar, with nine respondents rating free parking at clinics as "very important", and three rating it as "important". One respondent commented:
"One of the main reasons people are not attending screening is due to the cost of parking at the hospital and accessibility if they do not own a car."

The importance of free parking was also stressed in several of the face to face meetings, where stakeholders recalled prior conversations with service users about parking availability and cost.

How important is it to have a clinic that is easy to get to by public transport?

Responses from service users

As shown in Figure 6 below, responses from service users on the question relating to public transport were more mixed, with 64 rating public transport ease as 'very important', 47 rating it as "important", 54 rating is as "not important" and 3 "not sure".

In keeping with the way this question was phrased, respondents generally answered based on their individual circumstances. Comments such as "Have own transport" or "I have a car" were common for those who rated ease of public transport as "not important". On the other hand, those who indicated it was "very important" to have a clinic that is easy to get to by public transport provided comments such as:
"Very important as I use public transport to get to my appointment."
"I use public transport a lot. In wet weather, helpful if not too far to walk from the train station or bus stop."
"Very important for us, since we get [there] by public transport."

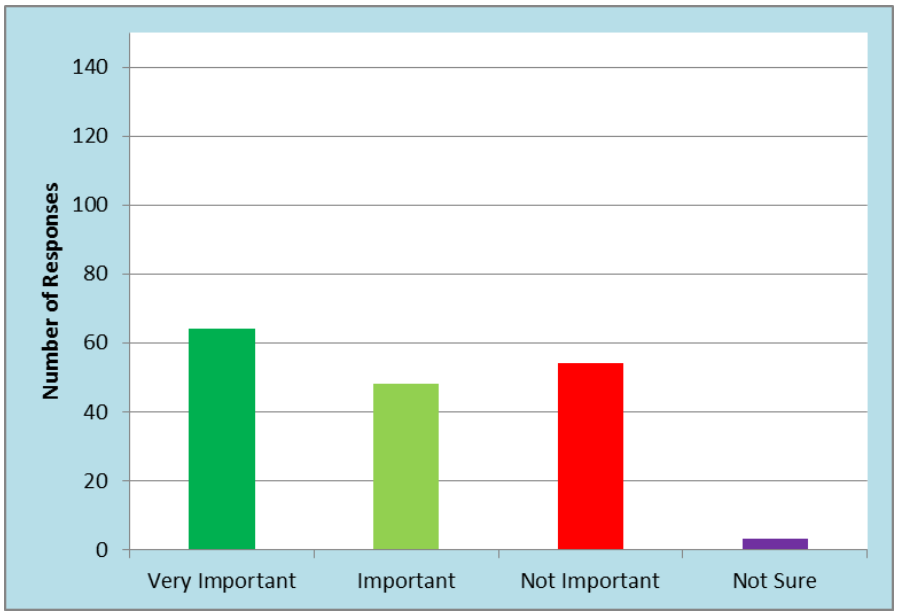


Figure 6. Service user responses to "How important is it to you to have a clinic that is easy to get to by public transport?"

Responses from general stakeholders

Among those responding on the general stakeholder form, nine rated ease of public transport as "very important" and three rated it as "important". A sample of their reasons is provided below:
"Patients are advised not to drive to screening appointments as they will be administered mydriatics. Other transport options must be available."
"Transport is cited as a barrier to healthcare access by many so it is important that people can easily get to clinics even if they don't have a car."
"Highly important, particularly for whānau that use public transport as their main mode of transport."
"Again, increasing any and all opportunities to make access easier is of high importance. We therefore support that every clinic is easy to get to by public transport."

Conversations on this topic in some face to face meetings covered the need for alternative forms of transport assistance for whānau, particularly for those in rural areas at a distance from public transport routes.

Further comments about clinic locations

Service users were asked if there was anything else they would like to say about the location of clinics for diabetes eye checks. There were specific requests for clinics at Westgate, Te Atatu, Hibiscus Coast, and Birkdale. There were also more general requests for clinics "close to where people live" and "as close as possible to the shopping malls of each suburb." Satisfaction was expressed with some current locations (e.g. the location on Waiheke Island).

Do you like the idea of booking your own appointment for a diabetes eye check?

Responses from service users

Responses were also mixed on the topic of service users booking their own appointment for a diabetes eye check. As shown in Figure 7, below, the majority (85) responded positively to this idea, although a substantial minority (59) did not like the idea, and 23 respondents were not sure about it.

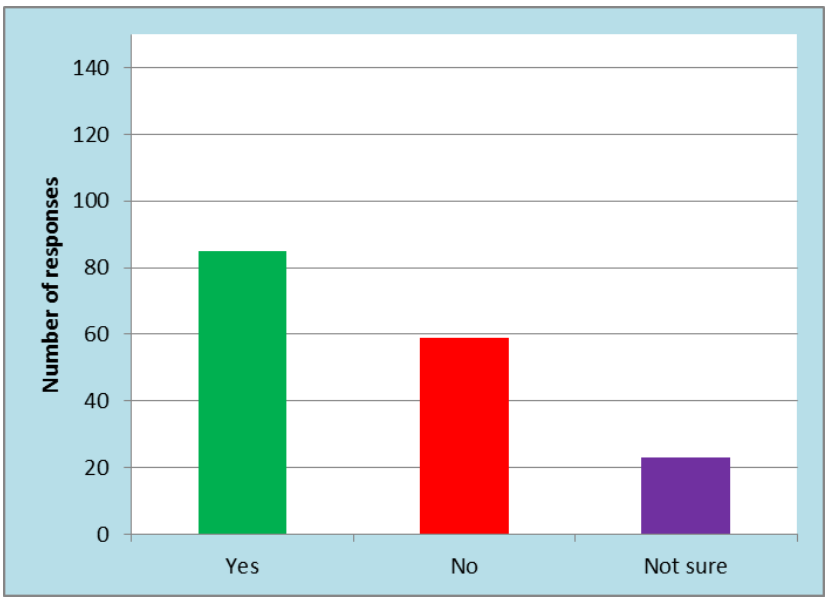


Figure 7. Answers to "Do you like the idea of booking your own appointment for a diabetes eye check?"

Those in favour provided comments such as:
"It would be easier to schedule it around my work as often I have to wait a long time on the phone to speak to an operator."
"Saves the getting of a booking I can't attend."
"This would be great! Would be much easier to arrange transport for everyone and to fit around other commitments."

Those not in favour provided comments such as:

"I am happy to take appointment that is given to me."
"I would forget."
"We would never get around to it."

Responses from general stakeholders

Similarly, those responding to this question on the general stakeholder form were divided between five who agreed with the proposal, four who did not agree with the proposal, and two who were not sure. Some stakeholders at face to face meetings focused on the risks associated with this approach. Would it result in a lack of engagement, particularly from high needs populations?

Communication about the grading result

Responses from service users

Both consultation documents explained the proposal to have all photographs graded at a central location. The proposed service plan includes a phone call from a health professional to explain the result if there is disease present that could require treatment. Service users were asked who they would prefer to receive the call from. The largest group (82) responded "I do not mind who calls me." The next most popular choice, with 46 responses was "my doctor or my practice nurse", followed by "a health professional from the service that checks the photographs" (36 responses).

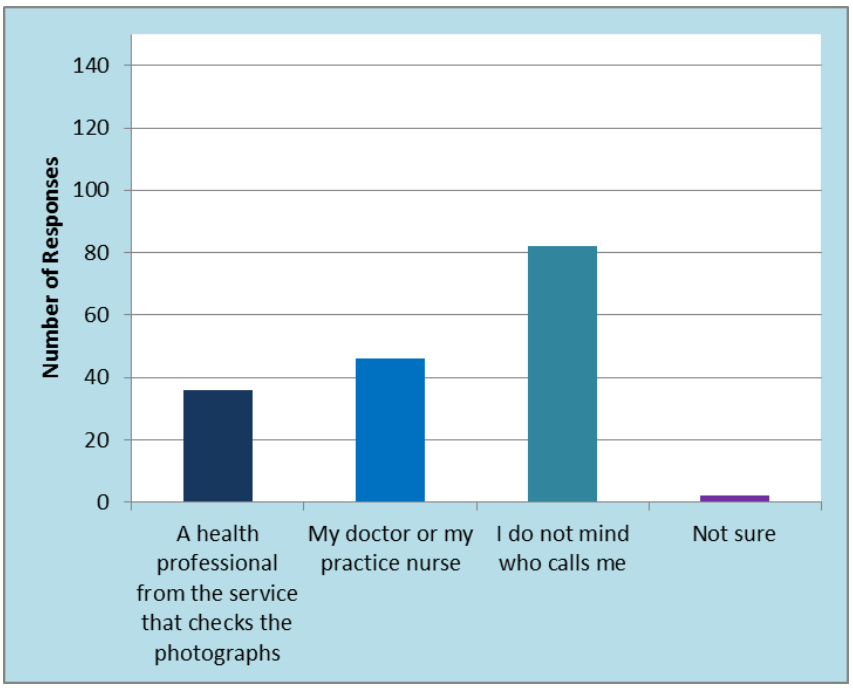


Figure 8. Answers to "We are planning for all photographs to be graded at a central location. We are proposing that a health professional from the central location will phone you if there is disease that could require treatment. In some cases, it may be your doctor (from your general practice) or your practice nurse who phones you. Who would you prefer to receive the phone call from?"

A sense of the reasoning sitting behind these preferences is provided in the following two comments from service users:

"I think it is better if my doctor or practice nurse phones me as I already have a prior relationship with them and it is easier to discuss things with them."
"I tend towards the photographic service phoning me. I understand that my GP should be informed of any results but I prefer my diabetes to be managed by the Diabetes Clinic mostly and it can get confusing if my GP is involved as well."

One respondent took the opportunity to record their appreciation of the service received with this comment:

"I find their service very reliable and prompt. I had my eye screening test on 8 August and got the results on 12 August. That's awesome, thanks."

Responses from general stakeholders

Responses on the general stakeholder form also showed a slightly stronger preference for general practice communicating the result, with seven respondents agreeing that it would be beneficial to have general practices involved in communicating diabetes retinal screening results, three disagreeing, and one not sure.

One respondent who disagreed offered this alternative:

"The letters should contain sufficient information and be communicated in a way that most people who have eye disease can understand. We should offer a way for people to contact someone from the eye team is they have any questions or concerns."

Outreach services

In the face to face meetings, there were mixed views about the value of mobile screening services. The importance of using venues with sufficient privacy for patients was stressed. One stakeholder raised concerns about the logistical challenges of mobile screening and offered the view that the investment of time and resource was too great for a minimal result. Another stakeholder noted the huge potential for community outreach, and stressed the important role that outreach workers have in securing the trust of service users.

Written submissions were unequivocal on this topic. The general stakeholders' consultation form included two questions about a proposed outreach service:

Do you agree with the proposal to establish an outreach service to follow up people who are very overdue for a diabetes retinal screen?

Do you agree with the proposal to have an outreach service offering a travelling service that would set up temporary clinics at Māori health providers, Pacific health providers, rural clinics, and other sites that would make it easier for people with diabetes to get a retinal screen?

All respondents selected "agree" for both of these questions.

Comments such as the following reinforced the strong consensus on this topic:

"A must and should not be negotiable."

Further comments

Both service users and general stakeholders had the opportunity make additional comments about any aspect of the proposed changes.

The importance of information and education about the reasons for diabetes eye checks was raised in face to face meetings, and in written submissions. The comments below are representative.

"The real benefit of screening lies in the patient being educated on their screening. Currently the patient is only informed whether the screening highlighted any issue and when the next screening will be done. I was never told of the effects of negative screening results…." (Service user response)

"Health literacy plays a key role in patient engagement. For patients referred by general practices, we expect that the general practice will provide education and explain the process before making referrals." (General stakeholder response)

"It would be beneficial to outline relevant language or cultural support services on the letter from the central hub." (General stakeholder response)

Some general stakeholders offered alternative views about how slit lamp screening could be managed, such as the following suggestion:

"*…slit lamp screening is not in the patient pathway. It is only mentioned at the central hub. For the number of patients who require slit lamp screening, there should be a pathway that doesn't involve them needing two appointments every time they are screened, or having to be referred to ophthalmology to complete their screening. Screening by slit lamp should be available peripherally. OCT is now clinical tool frequently used for decision in screening and could also be available peripherally."*

There was a push to modernise the way appointments are managed and results are communicated:

"I personally like to do things online. So online booking at a clinic of my choice would be great. Emailed results would also be great". (Service user response)

There were many expressions of appreciation for the service currently provided. Respondents were also positive about having the opportunity to have their say about the proposed changes. Finally, a lot of support was expressed for the redesign. The sentiment in the following comment was frequently expressed:

"I think the proposed changes are a great idea." (Service user response)

7.4 Next steps

The consultation findings will be presented to the Auckland and Waitematā Boards alongside a business case and a request for approval to procure the redesigned service.

8. Other activities

There are a number of other activities underway to improve retinal screening services within Auckland and Waitematā Districts. Other activities include: offering retinal screening at new community locations following feedback from consumers (e.g. The Fono Medical Centre, Waitakere Union, Apollo Dialysis Unit), establishing and refining e-referrals for both DHBs, an upgrade of retinal screening Patient Management Systems to better support patient management and reporting, measures to improve retinal screening coding in primary care and a review of patient information and consent processes.

4.2 Metro-Auckland Healthy Weight Action Plan for Children: Third Report

Recommendation:

That the Community and Public Health Advisory Committee:

a) Notes the progress against the Healthy Weight Action Plan, and that the plan is refreshed annually.
b) Notes that this plan sits alongside the Healthy Auckland Together (HAT) Plan 2015 – 2020.

Prepared by: Caitlin Donaldson (Public Health Dietitian), Ruth Bijl (Funding Manager- Women, Children and Youth), Leani Sanford (Acting Pacific Health Gain Manager), Shayne Wijohn (Māori Health Gain Manager).
Endorsed by: Dr Karen Bartholomew (Director Health Outcomes) and Tim Wood (Acting Director Funding)

Glossary

ARPHS	-	Auckland Regional Public Health Service
BMI	-	Body Mass Index
CPHAC	-	Community and Public Health Advisory Committee
DHB	-	District Health Board
ESBHS	-	Enhanced School Based Health Services
GPs	-	General Practitioner
HAT	-	Healthy Auckland Together
HBHF	-	Healthy Babies Healthy Futures

Executive Summary

The Metro-Auckland DHB Healthy Weight Action Plan for Children was developed in accordance with our vision that "*All Tamariki in the Auckland Region of New Zealand are of a healthy weight*". Health sector led actions were established in the plan, to contribute to the cross-sectoral response required to address childhood weight management. This third report, on the previously agreed Action Plan Indicators, is being presented to CPHAC to provide an update pm progress made in the implementation of the plan for the period 1 January – 31 December 2019. Actions and indicators are presented by DHB and target population: women of childbearing age, pregnant women, infancy and pre-school/school aged children and adolescents.

1. Background

This is the third Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children. The second report, detailing progress made in the period 1 July – 31 December 2018, was presented to CPHAC in February 2019. This follow-on report, details the progress made in the period 1 January – 31 December 2019. That the reporting cycle for this period is 12 months, compared with the previous six-month cycle.

Monitoring and reporting on the Healthy Weight Action Plan for Children will continue to occur at regular intervals, or as requested by CPHAC. For indicators that are already reported on elsewhere, information on progress toward meeting the indicator(s) is provided. For some individual programmes instituted as part of the plan, more rigorous monitoring and evaluation plans have been developed. For

this round of reporting the indicators will be reviewed and updated to ensure actions, which have been fully achieved, are replaced with new actions, or closed as appropriate. Work is underway to refresh the plan from 2020. In addition, annual monitoring of the current and future health of Aucklanders continues to be undertaken by Healthy Auckland Together (HAT).

2. Highlights

From this third report on the Action Plan Indicators, the following highlights have emerged.

- Good progress has been made toward fully implementing the National Healthy Food and Drink Policy across the three metro-Auckland DHBs. There has been a 14% and 10% increase in overall compliance with the policy in Auckland and Waitematā DHBs, respectively and the National Healthy Food and Drink Policy is included within all locally contracted providers, for both Waitematā and Auckland DHBs.
- Green Prescription referral targets for Pacific clients were exceeded during this reporting period.
- There has been an increase in the number of referrals of pregnant women, into Green Prescription for healthy weight management, since the last reporting period.
- The number of bariatric surgeries has increased for both Māori and Pacific patients since the last reporting period. At Auckland DHB, 17 Māori, and 25 Pacific patients received surgery, and 38 patients from 'other' ethnicities also received the surgery. At Waitematā DHB, 19 Māori, and 10 Pacific patients received surgery, and 108 patients from 'other' ethnicities also received the surgery.
- Culturally appropriate antenatal education is available which supports and promotes breastfeeding. Prioritisation of delivery to Māori, Pacific and Quintile 5 groups is on-going.
- Three randomised controlled trials (TARGET, GEMS and HUMBA studies[1]) related to healthy eating during pregnancy, including women with Gestational Diabetes Mellitus, are progressing well and on track. These will be used to provide improved information resources for pregnant women and health professionals.
- General Practitioners (GPs), primary care nurses, public health nurses, and other healthcare workers have been trained across the region on how to have conversations about healthy weight, with families with overweight children; 98% of participants identified an increase in confidence following these sessions. Auckland and Waitematā DHBs have extended the healthy conversations training target to Well Child Tamariki Ora providers and public health nurses this year.
- Both DHBs have been exceeding the B4 School Check health target, with 100% of children identified as obese at their B4 School Check being referred to a health professional. There has been no change in the percentage of declines for health professional support for both Māori and Pacific families in both Auckland and Waitematā DHBs.
- Improving food environments at identified 'high needs' early childhood centres has been achieved through professional development nutrition workshops delivered by a dietitian.
- The number of Māori and Pacific children referred to the Active Families (whānau-focused physical activity and nutrition programme for overweight/obese school aged children) has increased in both DHBs.

[1] GEMS: Gestational Diabetes Mellitus Study of Diagnostic Thresholds; Liggins Institute, the University of Auckland. Funder: HRC
TARGET: Optimal Glycaemic Targets for Gestational Diabetes: the randomised trial – TARGET; Liggins Institute, The University of Auckland. Funder: HRC
HUMBA: Healthy Mums and Babies Trial; Department of Obstetrics and Gynaecology, the University of Auckland. Funders: Counties Manukau Health, Cure Kids, Lottery Health Research, RANZCOG Mercia Barnes Trust, Gravida National Centre for Growth and Development, and the University of Auckland Faculty Development Research Fund and Reinvestment Fund

- Auckland and Waitematā DHB are rolling out consistent oral health and healthy weight promotion messages with production of a health professional guideline and magnets for consumers.
- Progress has been made to ensuring schools with contracted School Based Health Services have a healthy food and beverage policy. Further work is planned on auditing the content against the Ministry of Health guidelines.

5. Off track

The following actions are currently off track.

- Scoping of an adult obesity service as part of the bariatric pathway is now in the Māori Health Pipeline, however, this project is delayed from its original timeline. A high level draft was completed but additional full scoping and costing work needs to be completed. This activity is aligned with Counties Manukau DHB's work on Adult Healthy Weight, and will be a focus for this year.
- There has been no progress since the last reporting cycle on the implementation of the National Healthy Food and Drink Policy for Organisations in the community. The Policy went under review in 2019 and therefore implementation was put on hold. The Policy is currently in the process of editing and design, and is proposed to be released in the next quarter.
- The pregnancy and parenting education smartphone app and website is still receiving good feedback regarding utilisation from target groups; however, the content and promotion of the resource is still to be reviewed.
- The Positive Parenting and Lifestyle (PPAL) Programme (whānau-focused parenting, physical activity and nutrition programme for overweight/obese pre-school aged children) was launched in July 2018. There are two providers, both of whom are experiencing limited engagement of families attending the programme. A community engagement plan has been developed and both DHBs are implementing a quality improvement approach, including an evaluation plan. Improvements that have been implemented include widening the eligibility criteria, course redesign following community feedback and starting a home-visiting model. A second review is planned for 2020.
- Nutrition workshops (developed and delivered by Early Childhood Education (ECE) staff and health agencies i.e. Starship Community, the Heart Foundation and Healthy Families NZ) did not meet the target attendance rate for ECE staff, and no whānau attended in either DHB. At Auckland DHB 40 ECE staff and no whānau attended the workshops (target: 60 staff, 20 whānau), and at Waitematā DHB 15 ECE staff and no whānau attended the workshops (target: 50 staff, 15 whānau). The contract for these workshops ended in June 2019.

6. Conclusion

This third Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children presents an overview of activity during the calendar year 2019. The Action Plan indicators have been developed collaboratively across the region, with consistency in data collection and reporting, where possible. The indicators will be reviewed and updated before the next round of reporting and updates will occur annually to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. Regular updates to the CPHAC will continue. While many actions remain on track, it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole towards achievement of healthy weight.

Attachment

Appendix 1 - Healthy Weight Action Plan for Children Reporting: Calendar Year 2019

APPENDIX 1
Healthy Weight Action Plan for Children Reporting: Calendar Year 2019

Women of Childbearing Age							
Actions	**Time-frame**	**Measures**	**Priority Popn**	**ADHB**	**WDHB**	**CMDHB**	**Notes**
Investigate access barriers to bariatric surgery for Māori and Pacific women of child bearing age	Dec-19	# of Bariatric surgeries in 2019:	Māori	17	19		**ADHB/WDHB:** Data was not yet available for Dec 19 for WDHB and Nov-Dec 19 for ADHB. Total Surgeries for 2019, WDHB: 137; ADHB: 80. Total surgeries Jul-Dec 18, ADHB: 42 (9 Māori; 15 Pacific) WDHB: 63 (6 Māori, 0 Pacific).
			Pacific	25	10		
Scope what an Adult Obesity Service (intensive lifestyle intervention Tier2-3 service) might look like as part of the bariatric pathway	Dec-17	Complete (Y/N)		In pipeline	In pipeline		In Māori health pipeline
Promote Green Prescription to primary care and identify and address barriers to primary care referrals	Dec-20	# of adults enrolled in Green Prescription by ethnicity	Māori (Target x%)	10.2% (target 11%)	15.9% (target 13%)	24.8% (target 23%)	CM Health has reported on the percentages referred rather than engaged. The providers will begin reporting engaged data from January 2020
			Pacific (Target x%)	21.9% (target 17%)	17.8% (target 12%)	33.1% (target 32%)	
			South Asian (Target x%)	16% (Target 18%)	6.7% (target 9%)	7.8% (target 5%)	
Implement the National Healthy Food and Drink Policy in DHB-owned sites Complete baseline audit Complete follow-up audits	Jul-18, Jul-19	50% compliant 100% compliant		Jul-18: 75% compliant Jul-19: 89% compliant	Jul-18: 75% compliant Jul-19: 85% compliant	Jul 18: 57% Compliant Jul 19: 50% compliant	**ADHB/WDHB:** Compliance figures are an estimation based on the April'19 audit and subsequent improvements made since then. **CM Health:** Baseline audits completed in May 19, there has been slow progress with implementation however further consultation with retailers has been planned for February 2020

Work with ARPHS and Healthy Families NZ through Healthy Auckland Together (HAT) to implement the National Healthy Food and Drink Policy for Organisations in the community.	Ongoing	# of organisations who have begun implementing the Policy		See notes	See notes	See notes	The National Healthy Food and Drink Policy for Organisations went under review last year so implementation was put on hold. In 2019, Auckland city council main cafeteria made changes to incorporate a modified version of the guidelines. ARPHS also worked alongside Healthy families south to see the bronze standard of the Health promoting environments (based on National guidelines) being implemented into the Auckland council leisure centres in south Auckland which involved the ECE and afterschool care programs (Kauri Kids) that are run from these leisure centres.
Work with DHB contracted providers to support implementation of aligned healthy food and drink policies	Ongoing	# of providers who have the Policy in their contract		198 providers	162 providers	100% of local Funder Arm Contracts	**ADHB/WDHB:** Last reporting period: ADHB 179, WDHB 151 providers CM Health has included the Policy clause in the 100% majority of funder arm contracts renewed in the 2017/18 year (from July 2017) except for those providers who sit under national contracts, i.e. Age Related Residential Care, Primary Health Organisations (PHO) Services Agreements, Combined Dental Agreements and Community Pharmacy Services Agreements

Pregnant Women							
Actions	**Time-frame**	**Measures**	**Priority Popn**	**ADHB**	**WDHB**	**CMDHB**	**Notes**
Ensure culturally appropriate antenatal education available to promote and support breastfeeding	On-going	Deliver contracted volumes of breastfeeding related programmes with 80% of services delivered to the priority populations (Māori, Pacific and Quintile 5)	Māori	On Track	On Track	On Track	**ADHB/WDHB:** Culturally appropriate antenatal education is available which supports and promotes breastfeeding. Prioritisation of delivery to these identified groups is on-going. Healthy Babies, Healthy Futures groups also continue to provide this support to targeted groups postnatally. **CM Health:** Over the reporting period the 3 funded providers of pregnancy and parenting education have reported 27% Māori, 40% Pacific and 88% of women/mothers residing in Q5 attending pregnancy and parenting programmes. Breastfeeding education is a component part of the sessions with access to referral to home based antenatal education and community based postnatal support for breastfeeding and infant nutrition.
			Pacific	On Track	On Track	Achieved/ Completed	
			Quintile 5	On Track	On Track	Achieved/ Completed	
Providing women and their families with key breastfeeding messages through textMATCH messaging, community promotion, and teaching practical skills for better nutrition and increased physical activity	Ongoing	% of 6-monthly target (450) and of people receiving textMATCH service		Jul-Dec '18: 114% (n=512) 2017-18: 93.6% Jan-Jun 19: 85% (n=381) Jul-Dec '19: 133% (n=576)			Data not reported per DHB.

Further strengthen HBHF connections with maternity services, Kohanga reo, Churches and ECEs to increase access to the HBHF programme	Dec-17	# of Community Learning Programme (CLP) groups held within community settings (6-monthly target: 24)		Jul-Dec '18: 35 2017-18: 13 Jan – Jun ’19 (n=15) Jul - Dec ’19 (n= 17)	Jan – Jun ‘19: (n=11) Jul-Dec ‘19: (n=20)		
Establish a baseline figure for the number of children cared for by women who complete the Community Learning Programme	Jun-20	# of children		Jan – Jun 19 :331 Jul - Dec 19: 136			
Continue the development of Te Rito Ora service and B4 baby services which engage with women in antenatal period to support breastfeeding	Jun-18	70% women accessing the service will be fully/exclusive breastfeeding at 6 weeks (aligned to the WCTO indicator targets)				Not Achieved	Te Rito Ora has a 63% breastfeeding rate at 6 weeks antenatal and 57% postnatal , which is lower than the overall rate of 66% across CM Health regions Well Child Tamariki Ora providers using the same indicator (SOURCE: December 2019, WCTO data set).
Incorporate referrals to Green Prescription and healthy weight gain in pregnancy conversations into existing Auckland Regional Health Pathways	Dec-18	Health Pathways updated to include referral options for pregnant women, e.g. Green Prescription (Y/N)				Complete	**CM Health**: The first antenatal care pathway has been updated including referrals to Green Prescription. An early pregnancy assessment tool will be rolled out which also includes referral prompts to various services
Increase referrals of pregnant women into Green Prescription for healthy weight management	Dec-19	# pregnant women enrolled in Green Prescription		Jul-Dec '18: 11 2017-18: n=52 Baseline ('16-'17):n=24 Jan-Dec '19: 89	Jul-Dec '18: 5 2017-18: n=13 Baseline ('16-'17):n=3 Jan-Dec '19: 20	Baseline 2017-2018 n=20 (number of referrals) Jan-Dec '19 = 16 (number of engaged pregnant women)	An RFP was held in 2019 within CM Health for Adult Green Prescription services with an emphasis on support for pregnant women which will be included in the contract from January 2020

Develop Pathway for management of pregnant women with high BMI	Dec-18	Pathway developed and implemented (Y/N)				Achieved	A guideline for the management of obesity in pregnancy has been reviewed and updated, based on local data and evidence based best practice. Care management plans have been integrated into MCIS. Antenatal-first consult: BMI has been updated to reflect the guideline.
Undertake research (RCTs) related to healthy eating during pregnancy and Gestational Diabetes Mellitus	Dec-20	Feedback from study Principle Investigator of the progress of the 3 studies:		See notes	See notes	See notes	TARGET: data collection complete. Data currently being analysed. GEMS: recruitment targets are being met. HUMBA: recruitment complete; results analysed; follow-up studies on-going.
TARGET* (study on how GDM should be treated) Recruit women for multisite study		TARGET: to complete recruitment by Oct 2017		Achieved/ Complete	Achieved/ Complete	Achieved/ Complete	
Gestational Diabetes Mellitus Study of diagnostic thresholds (GEMS)** Recruit women for multisite study		GEMS: to have 50% recruitment by Dec 2018		Achieved/ Complete	Achieved/ Complete	Achieved/ Complete	
Healthy Mums and Babies Study (HUMBA)*** Undertake the study in partnership with UoA, Recruit women into the HUMBA study, Implement findings into practice		HUMBA: to finish data collection by Dec 2018					

Infancy							
Actions	**Time-frame**	**Measures**	**Priority Popn**	**ADHB**	**WDHB**	**CMDHB**	**Notes**
Enhance the pregnancy and parenting education smartphone app and website to encourage all women, particularly Māori, Pacific and Asian, to breastfeed for at least the first 6 months of their baby's life	Ongoing	% of Māori and Pacific women who breastfeed at 3 months (Target of 70% of babies are exclusively or fully breastfed at 3 months)	Māori	On Track	On Track		Note: website and app available, good feedback regarding utilisation from target groups for website. However, content and promotion of resource due for review.
			Pacific	On Track	On Track		
Postnatal support through Titifaitama and Wahakura Wananga including peer support and breastfeeding support groups		# who attend support groups	Māori	Achieved	Achieved		
			Pacific	Achieved	Achieved		Healthy Babies, Healthy Futures provides Pacific support group postnatally. This includes health nutrition and breastfeeding.
Intensive post-natal support through Te Rito Ora service including peer support and home visits	Jun-18, Dec-18, 6-monthly report	# of visits in 6 month period (Target - Kaitipu Ora Workers will engage with clients a minimum of 3x in Week 1 postnatally, and then weekly until Week 12)				Achieved	A guideline for the management of obesity in pregnancy has been reviewed and updated, based on local data and evidence based best practice. Care management plans have been integrated into MCIS. Antenatal-first consult: BMI has been updated to reflect the guideline.
Community cooking courses to support pregnant women and parents and whānau of 0-2 year olds to make healthy, affordable and culturally appropriate meals which meet the nutrition needs of pregnant women and infants and toddlers	Ongoing	# of participants that complete the course				Achieved	A guideline for the management of obesity in pregnancy has been reviewed and updated, based on local data and evidence based best practice. Care management plans have been integrated into MCIS. Antenatal-first consult: BMI has been updated to reflect the guideline.

Enhance the training plan for GPs, nurses and other relevant health professionals to increase their confidence in having culturally appropriate conversations about child weight and healthy lifestyles with families.	Ongoing	90% of participants who identified an increase in confidence with having conversations about healthy weight following the sessions		Achieved	Achieved	Achieved	**ADHB/WDHB:** 98% of participants identified an increase in confidence with having conversations about healthy weight following the Raising Healthy Kids training sessions. Education for GPs and nurses was completed in 18/19. New providers can join on-going training as required. The main effort has moved to provide education for Well Child Tamariki ora providers and Public Health Nurses in 19/20 **CM Health**: Analysis of survey data shows that most participants left the training feeling confident to have a healthy weight conversation, with almost all health professionals (98%) reporting that they were quite confident or very confident to have a healthy weight conversation after the training. Additionally, 99% of participants said they were quite or very confident to monitor children's growth post training.

Pre-School and School-Aged Children and Adolescents							
Actions	**Time-frame**	**Measures**	**Priority Popn**	**ADHB**	**WDHB**	**CMDHB**	**Notes**
Strengthen support for schools to implement healthy food and beverage policies by achieving an 80% adherence	Dec-19	WDHB/ADHB: 80% of contracted schools have a healthy food and drink policy. CM Health: Introduce a healthy food and drink policy in Mana Kids schools		On Track	On Track	On Track	**ADHB/WDHB:** **WDHB:** 83% of Enhanced School Based Health Services (ESBHS) schools have healthy food and beverage policies in place. **ADHB:** 50% of ESBHS schools have healthy food and beverage policies in place. Next steps: The Nurse Educator and Youth Health programme manager are working with the remaining schools to ensure an appropriate policy is put into place this year. review all school food / beverage policies, where possible, to ensure quality / adherence to MoH guidelines, including schools new to the Programme in 2019. **CM Health:** Healthy food and drink education incorporated into school health plans across Mana Kidz network.
In collaboration with HAT and Healthy Families NZ , engage intersectorally to support a gap analysis of healthy food environments in and around Kohanga reo, Pacific Language nests and ECEs to determine areas for future DHB support	Jun-18	Gap analysis complete		Achieved/ Complete	Achieved/ Complete	At risk	**ADHB/WDHB:** A dietitian has been providing professional development nutrition workshops for ECE teachers **CM Health:** There is little capacity within the DHB to complete this work at present

Engage with high-priority ECEs and schools to support development and implementation of food policies and healthy food environments.	Jun-19	# of ECEs and schools prioritised for support; # of ECEs and schools supported		7-8 of ECEs and schools prioritised for support; 10 (all ECEs decile 1-3) of ECEs and schools supported	7-8 of ECEs and schools prioritised for support; 5 (2x ECEs decile 1 to 3, 3x ECEs decile 4 to 5) of ECEs and schools supported	On Track	**CM Health**: Healthy food and drink education incorporated into school health plans across Mana Kidz network. Worked with Counties Manukau Kindergarten Association and the Cause Collective to develop ECE teachers understanding of nutrition and healthy food.
Work alongside ECE staff and health agencies i.e. Starship Community, the Heart Foundation and Healthy Families NZ to develop and deliver nutrition workshops to high priority ECE's and whānau of children from ECEs.	Jun-19	# of ECE staff attended workshops and # of whānau members attended workshops		40 ECE staff, no whānau	15 ECE staff, no whānau		ADHB target: 60 ECE staff, 20 whānau; WDHB target: 50 ECE staff, 15 whānau
Contract a provider to deliver a whānau-focused physical activity, nutrition and parenting programme for pre-school children identified as being ≥98th centile, including a psychological component and development of specific approaches for Māori and Pacific populations	WDHB/ ADHB Dec-18 CM Health Jun-18	# of children enrolled; # of Māori and Pacific children enrolled (baseline)	Māori	Achieved/ Complete	Achieved/ Complete	Achieved/ Complete	**ADHB/WDHB:** The Positive Parenting and Lifestyle (PPAL) Programme was launched in July-18. Both providers are experiencing limited engagement of families attending the programme. A community/ engagement plan has been developed and both DHBs are implementing a quality improvement approach. A second review is planned for 2020. **CM Health:** Otara Health Charitable Trust deliver Active Futures to priority population groups - 75% of children engaged in the programme are Maori or Pacific.
			Pacific	Achieved /Complete	Achieved /Complete	Achieved /Complete	

Contract a provider to deliver a whānau-focused physical activity and nutrition programme for overweight/obese school aged children and adolescents, including specific approaches for Māori and Pacific communities	Jun-18	# of children enrolled; of Māori and Pacific children enrolled	Māori	Jul-Dec '18: 19 2017-18: 34 Jan-Dec '19: 35	Jul-Dec '18: 31 2017-18: 51 Jan-Dec '19: 61	Jul-Dec '18: 22 2017-18: 59 Jan-Dec '19: 53	**ADHB/WDHB/CM Health:** # referred provided as opposed to # enrolled.
			Pacific	Jul-Dec '18: 45 2017-18: 132 Jan-Dec '19: 125	Jul-Dec '18: 53 2017-18: 603 Jan-Dec '19: 74	Jul-Dec '18: 74 2017-18: 170 Jan-Dec '19: 131	
Undertake communication activities to promote and familiarise primary care / WCTO partners with target	Ongoing	By December 2017, 95% of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions		Achieved	Achieved	Achieved	**ADHB/WDHB:** Both DHBs continue to exceed the health target with 100% for Maori, Pacific and Total Population **CM Health:** CM Health continues to achieve 100% for Maori, Pacific and Total Population
Ensure referral process for referrals from B4 school provider to primary care for children with BMI>98th centile is in place and all obese children are referred to primary care and that referral is acknowledged (electronic referral process in CM Health, paper based in ADHB/WDHB).	Ongoing	Percentage of declined referrals to primary care programmes	Māori	19%	17%	45%	**CM Health:** 39% (Total percentage of declines) SOURCE Before School Checks Monthly Report to end of December 2019
			Pacific	8%	7%	35%	

Provide community, primary and secondary care training by dietitian on use of Be Smarter brief intervention and goal setting healthy lifestyles tool and other resources so health professionals are confident to initiate conversations with families and talk about healthy weight to enable families to be as healthy as they can be	On-going	# of training sessions delivered		**Jul-18 to Dec-18:** 85 people trained. **Jan-18 to Jul-18:** 31 people trained. **Jul-16 to Jul-18:** 83/138 GP practices received training **May - Dec 2019:** There were 2 practice based sessions and 2 other group sessions. 5 practice Nurses and health care workers were trained and 44 WCTO Nurses and health care workers. In total so far, 109 GP practices have been trained since the start of this activity.	**Jul-18 to Dec-18:** 148 people trained. **Jan-18 to Jul-18:** 42 people trained. **Jul-16 to Jul-18:** 74/107 GP practices received training **May - Dec 2019:** There was 1 practice based sessions and 3 other group sessions. 3 practice Nurses and health care workers were trained and 56 WCTO Nurses and health care workers. In total so far, 90 GP practices have been trained since the start of this activity.	**1 Jul 18 - 31 Dec 18:** 60 people trained. **1 Jul-17 to 31 Jun-18:** 369 people trained **Jan-Dec '19:** 48 people trained face to face (data not yet available for those who have accessed the video modules)	Staff trained include: GPs, primary care nurses, Well Child Tamariki Ora staff, healthcare workers, Starship community staff (public health nurses), practice managers, Active Futures coordinators and clinical assistants. *Note: 6 month reporting period this reporting cycle compared to 12 month reporting cycle previous cycle* **ADHB/WDHB:** Training in the primary care setting is changing to focus on high deprivation areas, high amounts of B4SC BMI referrals, and high areas of Maori and Pacific peoples. Therefore a new and relevant evaluation form will be designed.

Design and implement an evaluation of families and health professional engagement with Raising Healthy Kids referral pathway.	Dec-18	Evaluation plan complete with recommendations (Y/N)		On Track	On Track	Achieved/ Completed	**ADHB/WDHB:** A formative and outcome evaluation was conducted for the PPAL programme and recommendations were made. Currently the recommendations are being implemented in collaboration with the Dietitians. Post implementation review is planned for Q3 to evaluate improvements in engagement. **CM Health:** 70% of health professionals agreed or totally agreed that the B4SC referrals to a GP for clinical assessment is acceptable. Of those who had referred children to Active Futures, only 31% agreed or totally agreed that most parents/caregivers were open to a referral (mostly due to the challenges of committing to the programme within families' busy lives).
Support the implementation of the regional growth chart solution for use in secondary care in metro Auckland DHBs	Dec-18	An electronic growth chart is implemented in the metro Auckland DHBs		Achieved/ Complete	Achieved/ Complete	Achieved/ Complete	

Work with ARDS and the Northern Region DHBs to develop consistent health promotion messages using the common risk factor approach for obesity and oral health Investigate translation into priority languages	Jun-18	Message alignment complete with 5 key messages agreed upon. Priority languages identified and translation services costed.		On Track	On Track	Achieved/ Complete	A health professional's guide for Oral Health and Healthy Weight messages has been developed based on the Northland DHB guide. The final draft is currently being edited following feedback from the Northern Region Child Health Steering Group and will be ready for publishing by the end of Jan-19.
Roll-out consistent health promotion messages for oral health and healthy weight. Investigate translation of consumer resource(s) into priority languages	Jan-20	Messaging guide and consumer resource(s) disseminated. Priority languages identified and translation services costed.		See notes	See notes	At Risk	Auckland and Waitematā DHB have committed $10,000 each to contribute towards the printing of these magnets. Currently awaiting final print ready files from the designer to get these printed. **CM Health:** Difficulties accessing funding for the developing of the resources into priority languages

Scope the feasibility for a pilot to assess measuring weight and height at the year eight dental check. The aim is to facilitate collection of data for population level monitoring of trends and to feedback to parents information on their child's weight and growth. This pilot could potentially assess: - Consenting of children - Impacts on clinic flow and staffing - Scalability - Data collection requirements and utility - Communication of outcomes to parents - Staff and consumer perspectives - Identification of any adverse or unexpected outcomes This would inform the assessment of whether this could be implemented across the region and the trade-off of costs compared to the potential impact of the information gained for children, their families and the sector as a whole.	Dec-18	Pilot complete					

5.1 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Jean-Marie Bush (Senior Portfolio Manager Mental Health and Addiction Services), Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Vicki Scott (Acting Funding & Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Shayne Wijohn (Manager Māori Health Gain), Leani Sandford (Acting Manager Pacific Health Gain), and Samantha Bennett (Manager Asian, Migrant and Former Refugee Health Gain)
Endorsed by: Tim Wood (Acting Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ACC	-	Accident Compensation Corporate
ACE	-	Angiotensin-converting-enzyme
ADHB	-	Auckland District Health Board
ARC	-	Aged Residential Care
ARPHS	-	Auckland Regional Public Health Service
ARRC	-	Aged Related Residential Care Agreement
BP	-	Blood Pressure
CDA	-	Combined Dental Agreement
CPHAC	-	Community and Public Health Advisory Committee
CSCS	-	Cervical Screening Coordination Service
CVD	-	Cardiovascular Disease
DHB	-	District Health Board
DSME	-	Diabetes Self-Management Education
DSLA	-	Auckland Waitematā Diabetes Service Level Alliance
DSS	-	Disability Support Services
GP	-	General Practitioner
HbA1c	-	Glycated Haemoglobin
HLC	-	Hobsonville Land Company
IUD	-	Intra Uterine Device
IUCD	-	Intra Uterine contraceptive Devices
LARC	-	Long Acting Reversible Contraception
MACGF	-	Metro Auckland Clinical Governance Forum
MELAA	-	Asian & Middle Eastern Latin American and African
MoH	-	Ministry of Health
MSD	-	Ministry of Social Development
NCHIP	-	National Child Health Information Platform
NGO	-	Non-Government Organisation
NIR	-	National Immunisation Register
OIS	-	Outreach Immunisation Service
PFO	-	Planning, Funding and Outcomes Team
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
Q	-	Quarter
RFP	-	Request for Proposals
ROI	-	Requests of Interest

SME - Self-Management Education
SMILE - Smoke and Alcohol Free, Mental Health Matters, Immunise, Lie on Your Side, Exercise, Eat Healthy
WDHB - Waitematā District Health Board

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitematā DHBs' (DHB) planning and funding activities and areas of priority, since its last meeting on 30 October 2019. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting's agenda.

Highlights

- Transition of the National Immunisation Register (NIR) has occurred, with it successfully repatriated to DHB management on 1 November 2019. The support of general practices and immunisation providers as well as comprehensive change management planning has ensured a smooth transition. It is most pleasing there has been no drop in immunisation coverage during the change period, despite the additional demands of the Measles outbreak. Maintaining and even making gains in coverage is a huge achievement.
- The Child Health Connection Centre and the Kainga Ora have been gifted names. The name Noho Āhuru – Healthy Homes has been chosen to replace Kainga Ora – Healthy Homes, with the support of the DHB Tikanga Advisor Dame Naida Glavish and the Te Runanga o Ngāti Whātua have gifted the Child Health Connection Centre a name and whakataukī: ***Uri Ririki – he taura o te ate;*** *The young progeny – the strings to the seat of ones emotions.*
- An audit of hospital discharge documentation when a person enters Aged Residential Care has documentation was completed well and the relevant information was given on discharge.
- The Board of the Accident Compensation Corporation (ACC) has approved funding, up to December 2020, for its 'Live Stronger for Longer' programme; this funding matches the DHB funding to deliver the 'In Home Strength and Balance Programme' and the Fracture Liaison Service. These are important services that a meet a previous gap in preventative care for older people.
- A unanimous endorsement for the partnership agreement from iwi and DHB Boards has been achieved, and we have reached agreement for a Chairperson for this Board – Ms Gwen Tepania-Palmer.
- Under the Māori Health Pipeline projects, the High Grade cervical screening project has completed a full audit and offer of intensive follow up support with one practice, and has two further practices underway. The audit tool has been presented to the College of GPs as an example of good practice in equity quality improvement. Learnings from the project are being built to further support primary health care clinics to improve engagement with the National Cervical Screening Programme, and particularly for quality work around the follow up of women who are overdue.
- A Pacific Abdominal Aortic Aneurysm (AAA) screening research project has been initiated with a Pacific clinical lead, and will begin with a pilot for Tongan men with screening planned from March. Based on the learnings from the Māori AAA research programme, the Pacific work has been initiated with a focus group, and the learnings directly incorporated into the project materials and processes.
- The Pacific health pipeline is in early stages of development and continues to be refined.

2. Planning

2.1 Annual Plans

The 2019/20 Waitematā District Health Board (DHB) Annual Plan has been approved by and signed by the Minister of Health. It is available on the Waitematā DHB website. Waitematā DHB's 2019/20 Statement of Intent and Statement of Performance Expectations (subset of the Annual Plan) have been tabled in parliament. The 2019/20 Auckland DHB Annual Plan is likely to be revised before being signed by the Minister. A revised 2019/20 budget will be presented to the Auckland DHB Finance Risk and Assurance Committee Meeting on 14 February 2020 for approval.

The 2020/21 Annual Planning advice was provided to DHBs by the Ministry of Health on 18 December 2019. The guidance is again focused on the key activities that reflect the Minister's specific planning priorities:

- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes supported by a strong and equitable public health and disability system;
- Achieving health equity and wellbeing for Māori through the Māori Health Action Plan;
- Better population health outcomes supported by primary health care;
- Strong fiscal management.

There are enhanced priorities focused on Māori health and on sustainability, therefore two new sections are included in the guidance.

This year there is a stronger focus on integration and collaboration with other sectors. The Public Health Unit annual plan is to be integrated into the DHB annual plan in 2020/21. The DHBs and Auckland Regional Public Health Services (APRHS) need to engage with relevant stakeholders when developing their 2020/21 actions to strengthen the integration of DHB efforts with those of primary care, community, other sectors and with iwi.

The Ministry expects that achieving equity in health and wellness is a focus for all DHBs. DHBs are expected to include evidenced-based equity actions focused on their Māori and Pacific populations within each identified planning priority. This will include an explicit focus on addressing racism and discrimination, in all its forms, across all aspects of the DHB's operations.

There are new priority areas in 2020/21 around our delivery of He Korowai Oranga – the Māori Health Strategy and Pacific Health Action Plan (once agreed). DHBs are also asked to develop a Disability Action Plan to improve access to quality health services and improve the health outcomes of disabled people.

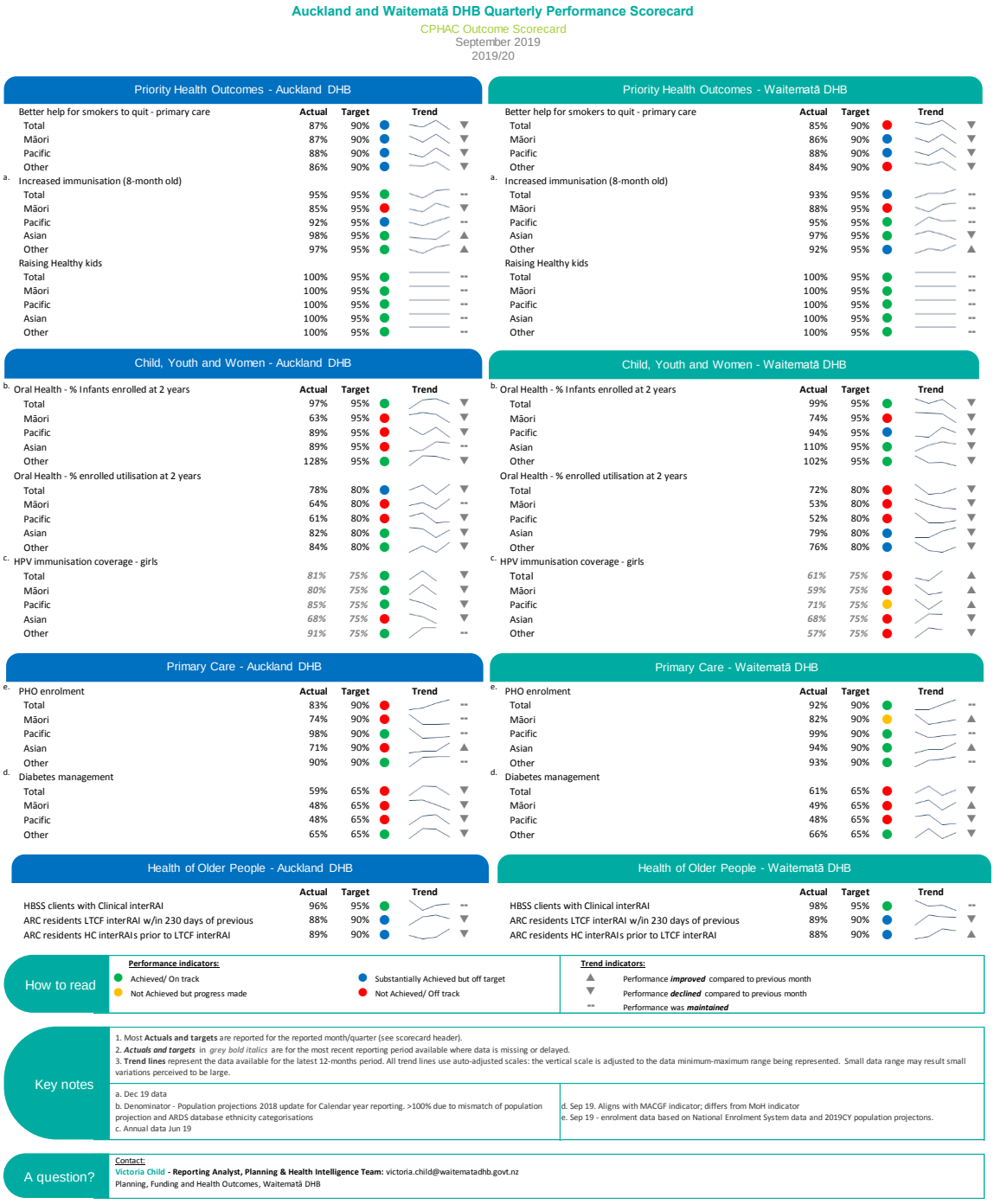
Information has been supplied to all contributors to enable development of each section for both the Auckland and Waitematā DHB 2020/21 Annual Plans.

2.2. Annual Reports

Both Auckland and Waitematā DHB 2018/19 Annual Reports have been finalised and submitted to the Ministry of Health (MoH). The Waitematā DHB 2018/19 Annual Report has been tabled in parliament and has been published to the Waitematā website. The Auckland DHB 2018/19 Annual Report has also been tabled.

2.3. Auckland and Waitematā DHB Quarterly Performance Scorecard

The Auckland and Waitematā DHBs' CPHAC Scorecard is a standardised tool used to internally review and track performance against a range of measures. The Scorecard below shows indicator performance against target for each DHB for Quarter 1 of the 2019/20 year. The scorecard is intentionally reported by ethnicity and in areas of known priority and focus.



Auckland and Waitematā DHB Quarterly Performance Scorecard

CPHAC Outcome Scorecard
September 2019
2019/20

Priority Health Outcomes - Auckland DHB

Better help for smokers to quit - primary care	Actual	Target	Trend
Total	87%	90%	▼
Māori	87%	90%	▼
Pacific	88%	90%	▼
Other	86%	90%	▼
a. Increased immunisation (8-month old)			
Total	95%	95%	--
Māori	85%	95%	▼
Pacific	92%	95%	--
Asian	98%	95%	▲
Other	97%	95%	▲
Raising Healthy kids			
Total	100%	95%	--
Māori	100%	95%	--
Pacific	100%	95%	--
Asian	100%	95%	--
Other	100%	95%	--

Priority Health Outcomes - Waitematā DHB

Better help for smokers to quit - primary care	Actual	Target	Trend
Total	85%	90%	▼
Māori	86%	90%	▼
Pacific	88%	90%	▼
Other	84%	90%	▼
a. Increased immunisation (8-month old)			
Total	93%	95%	--
Māori	88%	95%	--
Pacific	95%	95%	--
Asian	97%	95%	▼
Other	92%	95%	▲
Raising Healthy kids			
Total	100%	95%	--
Māori	100%	95%	--
Pacific	100%	95%	--
Asian	100%	95%	--
Other	100%	95%	--

Child, Youth and Women - Auckland DHB

b. Oral Health - % Infants enrolled at 2 years	Actual	Target	Trend
Total	97%	95%	▼
Māori	63%	95%	▼
Pacific	89%	95%	▼
Asian	89%	95%	--
Other	128%	95%	▼
Oral Health - % enrolled utilisation at 2 years			
Total	78%	80%	▼
Māori	64%	80%	--
Pacific	61%	80%	▼
Asian	82%	80%	▼
Other	84%	80%	▼
c. HPV immunisation coverage - girls			
Total	*81%*	*75%*	▼
Māori	*80%*	*75%*	▼
Pacific	*85%*	*75%*	▼
Asian	*68%*	*75%*	▼
Other	*91%*	*75%*	--

Child, Youth and Women - Waitematā DHB

b. Oral Health - % Infants enrolled at 2 years	Actual	Target	Trend
Total	99%	95%	▼
Māori	74%	95%	▼
Pacific	94%	95%	▼
Asian	110%	95%	▼
Other	102%	95%	▼
Oral Health - % enrolled utilisation at 2 years			
Total	72%	80%	▼
Māori	53%	80%	▼
Pacific	52%	80%	▼
Asian	79%	80%	▼
Other	76%	80%	▼
c. HPV immunisation coverage - girls			
Total	*61%*	*75%*	▲
Māori	*59%*	*75%*	▲
Pacific	*71%*	*75%*	▲
Asian	*68%*	*75%*	▼
Other	*57%*	*75%*	▼

Primary Care - Auckland DHB

e. PHO enrolment	Actual	Target	Trend
Total	83%	90%	--
Māori	74%	90%	--
Pacific	98%	90%	--
Asian	71%	90%	▲
Other	90%	90%	--
d. Diabetes management			
Total	59%	65%	▼
Māori	48%	65%	▼
Pacific	48%	65%	▼
Other	65%	65%	▼

Primary Care - Waitematā DHB

e. PHO enrolment	Actual	Target	Trend
Total	92%	90%	--
Māori	82%	90%	▲
Pacific	99%	90%	--
Asian	94%	90%	▲
Other	93%	90%	--
d. Diabetes management			
Total	61%	65%	▼
Māori	49%	65%	▲
Pacific	48%	65%	▼
Other	66%	65%	▼

Health of Older People - Auckland DHB

	Actual	Target	Trend
HBSS clients with Clinical interRAI	96%	95%	--
ARC residents LTCF interRAI w/in 230 days of previous	88%	90%	▼
ARC residents HC interRAIs prior to LTCF interRAI	89%	90%	▼

Health of Older People - Waitematā DHB

	Actual	Target	Trend
HBSS clients with Clinical interRAI	98%	95%	--
ARC residents LTCF interRAI w/in 230 days of previous	89%	90%	▼
ARC residents HC interRAIs prior to LTCF interRAI	88%	90%	▲

How to read

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

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

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

a. Dec 19 data
b. Denominator - Population projections 2018 update for Calendar year reporting. >100% due to mismatch of population projection and ARDS database ethnicity categorisations
c. Annual data Jun 19
d. Sep 19. Aligns with MACGF indicator; differs from MoH indicator
e. Sep 19 - enrolment data based on National Enrolment System data and 2019CY population projectons.

A question?

Contact:
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Planning, Funding and Health Outcomes, Waitematā DHB

3. Primary Care

3.1 Focus Area: Better Help for Smokers to Quit

DHB Target: 90% of Primary Health Organisation (PHO) enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

The 'Better Help for Smokers to Quit' result is reported as a priority health outcome. In quarter one 2019/20, both DHBs missed achieving the target with Auckland DHB performance at 86.5% and Waitematā DHB at 84.9%. There has been the usual drop in results from quarter four to quarter one. The national average for quarter one (Q1) 2019/20 is 82.9%.

At the beginning of each new financial year there is a drop in performance against measure. This is due to a cohort of patients who had been contacted in the previous 15 months now needing to be contacted again.

At a Primary Health Organisation (PHO) level, only Total Healthcare in Auckland DHB achieved the primary care 'Better Help for Smokers to Quit' health target. Table 1 shows the results by PHO for Q1.

Table 1: PHO Results for Better Help for Smokers to Quit 90% Target (Q1, 2019/20)

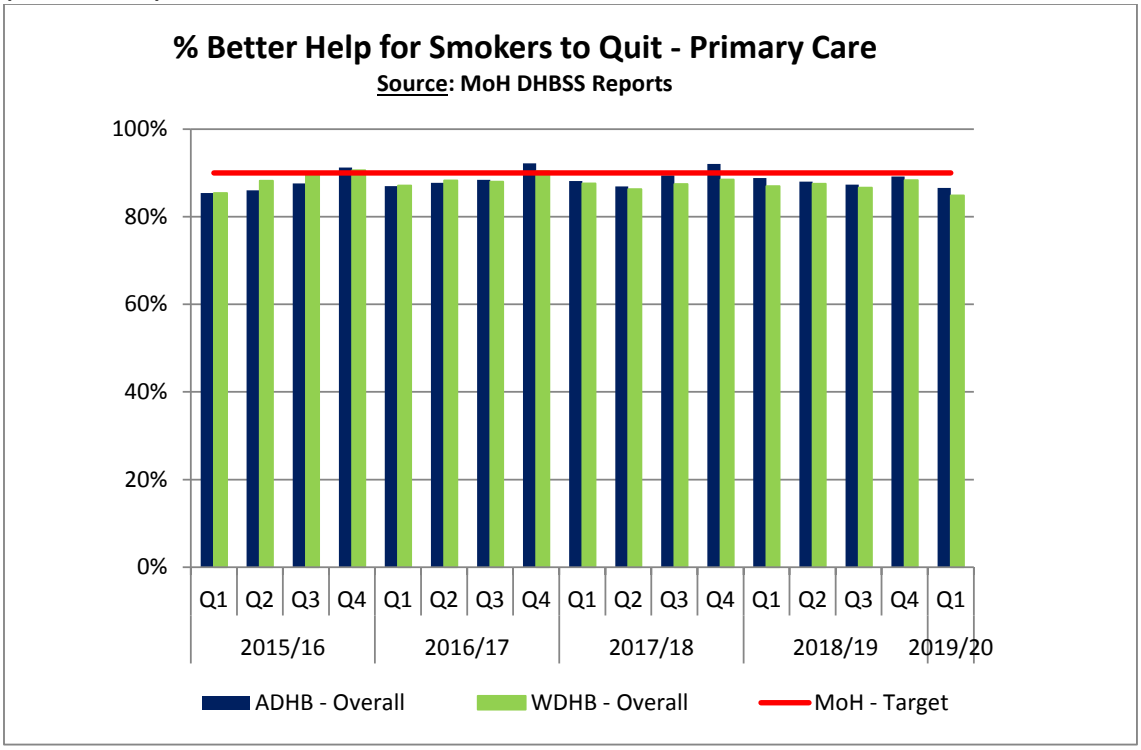
DHB	PHO	Performance %
Auckland DHB	Auckland PHO	84.9%
	Alliance Health Plus	80.8%
	National Hauora Coalition	88.6%
	ProCare	85.2%
	Total Healthcare	92.6%
Waitematā DHB	Comprehensive Care	81.4%
	ProCare	87.6%

All PHOs have set up systems and provided support to encourage general practices to provide brief advice directly to patients themselves. The goal has been for general practices to become self-sufficient in the routine provision of brief advice about stopping smoking. However, some practices are still not routinely providing and documenting advice and support. Some PHOs provide direct assistance to general practices that are not meeting the target. This is done by PHO staff contacting patients, on behalf of the practice, to offer brief advice. While this approach leads to a higher health target result, it does not, of itself, embed the offer of brief advice into everyday consultations. Total Healthcare PHO has good systems in place to support practices by running regular data queries to identify patients that have missed receiving brief advice. Their Integrated Care Team then follows up these patients with phone and text support on behalf of their practices. Total Healthcare has thus achieved a higher result than other PHOs that are not doing this or are doing less of it.

The results are shown in the scorecard under health targets as well as in Figure 1 below:

- Auckland DHB – 86.5%, ↓2.6% from the previous quarter
- Waitematā DHB – 84.9%, ↓3.5% from the previous quarter

Figure 1: Auckland and Waitematā DHBs 'Better Help for Smokers to Quit' performance (Q1, 2019/20)



3.2 Diabetes Management

Metro Auckland DHBs and PHOs are committed to improving population health outcomes for people with diabetes. To help achieve this goal, five regionally agreed diabetes and cardiovascular disease (CVD) clinical indicators have been prioritised for monitoring performance. All metro Auckland PHOs (seven) have been reporting anonymised practice level data relating to these five clinical indicators since June 2017. Performance against these indicators is being reported to the Metro Auckland Clinical Governance Forum (MACGF) and the Auckland Waitematā Diabetes Service Level Alliance (DSLA).

Tables 2 and 3 below outline the results for the five MACGF diabetes and the CVD clinical indicators, as at 30 September 2019 against performance as at 30 June 2019 to highlight changes in the intervening quarter.

3.2.1 Auckland DHB Diabetes Clinical Indicators

Small drops in performance are shown across all metrics in Auckland DHB relative to last quarter's report. Decreased performance is shown in microalbuminuraia management in Māori (reduction of 8%), Pacific (reduction of 5%) and total population groups (reduction of 6%). As noted in section 3.2.3, below, the DSLA resolved, at its meeting on 18 December 2019, to provide the leadership and support required to ensure achievement of the microalbuminuria management target across all ethnicities by 30 June 2020.

An increase in the total numbers required to reach target is found across all indicators with the exception of CVD primary prevention.

Table 2: Auckland DHB performance against the MACGF diabetes and CVD clinical indicators as at 30 September 2019[1] compared to performance as at 30 June 2019.

Clinical Indicator	Goal	Auckland DHB			
		Māori	Pacific	Total	Total number required to reach the indicator target
Clinical Indicators – Long Term Conditions Management – Diabetes					
Glycated Haemoglobin (HbA1c) Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months	**80%**	48% (↓ 3%)	48% (↓ 1%)	**59%** (↓ 2%)	**5,198** (+739)
Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure (BP) recorded in the last 15 months is <140mmHg	**80%**	60% (↓ 1%)	63% (↓ 1%)	**65%** (↓ 1%)	**3,552** (+122)
Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an Angiotensin-converting-enzyme (ACE) inhibitor or Angiotensin Receptor Blocker	**90%**	67% (↓ 8%)	74% (↓ 5%)	**72%** (↓ 6%)	**807** (+65)
Clinical Indicators – Long Term Conditions Management – CVD					
CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)	**70%**	56% (↓3%)	66% (no change)	**62%** (no change)	**858** (+21)
CVD Primary Prevention[2]: Percentage of enrolled patients with cardio-vascular risk ever recorded >20%, (aged 25 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)	**70%**	43% (↓3%)	51% (↓4%)	**48%** (↓ 1%)	**964** (-541)

[1] Data Source: Numerator and denominator are extracted from the PHO enrolled data.

3.2.2 Waitematā DHB Diabetes Clinical Indicators

Some improvements can be seen in Waitematā DHB. Additionally, there has been a reduction in the total number required to reach targets for all indicators. The most significant improvements were found in the Pacific population's CVD secondary and primary prevention indicators (both had an increase of 11% relative to the last quarter). Improvements for the Māori population were found across all indicators with the exception of CVD primary prevention (which decreased by 1%).

Table 3: Waitematā DHB performance against the MACGF diabetes and CVD clinical indicators as at 30 September 2019[2] compared to performance as at 30 June 2019.

Clinical Indicator	Goal	Waitematā DHB			
		Māori	Pacific	Total	Total number required to reach the indicator target
Clinical Indicators – Long Term Conditions Management – total population with diabetes					
HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months	**80%**	49% (↑ 4%)	48% (no change)	**61%** (↑ 2%)	**3,236** (-268)
Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg	**80%**	63% (↑ 6%)	62% (↓ 1%)	**63%** (↑ 2%)	**2,934** (-300)
Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker	**90%**	77% (↑ 3%)	77% (↓2%)	**77%** (↑ 2%)	**388** (-175)
Clinical Indicators – Long Term Conditions Management – total population with CVD or with a >20% risk of CVD					
CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)	**70%**	60% (↑ 5%)	67% (↑ 11%)	**61%** (↑ 3%)	**1,073** (-214)
CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded >20%, (aged 25 to 74	**70%**	45% (↓1%)	55% (↑ 11%)	**46%** (↑ 1%)	**896** (-606)

[2] Data Source: Numerator and denominator are extracted from the PHO enrolled data. The denominator is different than that for previous CPHAC reports and Ministry of Health reports.

years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)					

3.2.3 Activities to improve performance against the MACGF diabetes and CVD clinical indicators

At the 18 December 2019 meeting of the Diabetes Service Level Alliance, the membership endorsed a recommendation to concentrate efforts across the sector to meet the management of microalbuminuria target by 30 June 2020. The goal is to meet the target for all ethnic groups, but efforts will be prioritised in the first instance to Māori and Pacific peoples. The learnings that have been gained from the achievement of this target will then be applied to reaching the targets for the other four prioritised clinical indicators.

All PHOs are undertaking a number of activities designed to improve equity of health outcomes. These activities are briefly summarised below:

- Providing practices with information on Māori and Pacific who are not reaching the MACGF clinical indicator targets and encouraging practices to focus their efforts on working with these patients.
- Supporting practice staff to complete cultural competency training, including training on the Treaty of Waitangi.
- Support for improving the health literacy of patients and their whānau.
- Implementing nurse led clinics which aim to improve equity specifically by increasing consultation time with the aim of improving patient relationships with health professionals and the general practice.
- Workforce development to recruit Māori clinical staff across the PHO network and support Māori staff into leadership roles.
- Service reviews to understand barriers to achieving equity of outcomes, and updating programmes to address gaps.

As illustrated below in Figures 2 to 9, despite PHOs providing strong leadership to improve equity of outcomes, there continues to be disparities in health outcomes by ethnicity across the MACGF diabetes and CVD clinical indicators.

At a strategic level, there are a number of actions being taken to resolve these issues. The flagship example is the Diabetes Service Level Alliance's co-design project, which seeks to transform the way care is provided for priority populations, inclusive of:

- Māori with type 2 diabetes
- Pacific with type 2 diabetes
- Asian with type 2 diabetes
- People newly diagnosed with type 2 diabetes
- People with poorly controlled (HbA1c >75mmol/mol) type 2 diabetes
- Quintile 5 population with type 2 diabetes.

3.2.4 Summary of each indicator by DHB and ethnicity

3.2.4.1 Auckland DHB - by Ethnicity

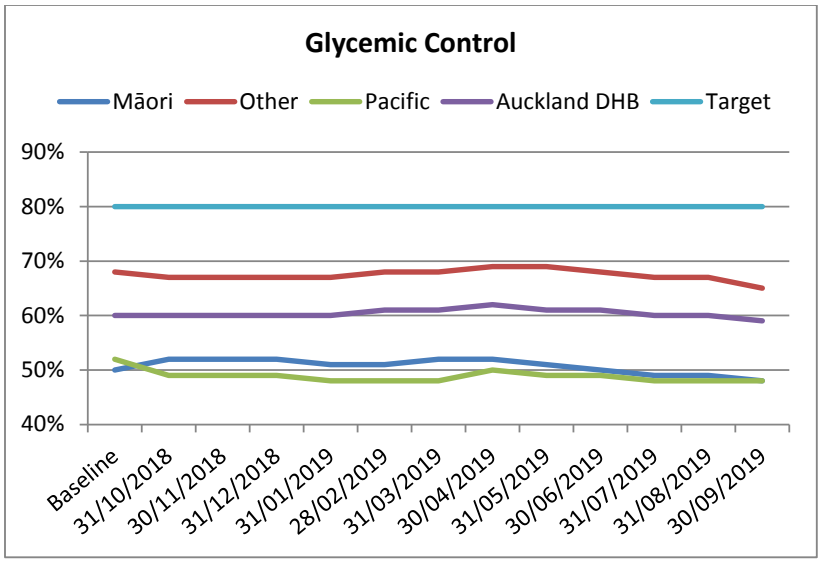


Figure 2: Auckland DHB Glycaemic Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

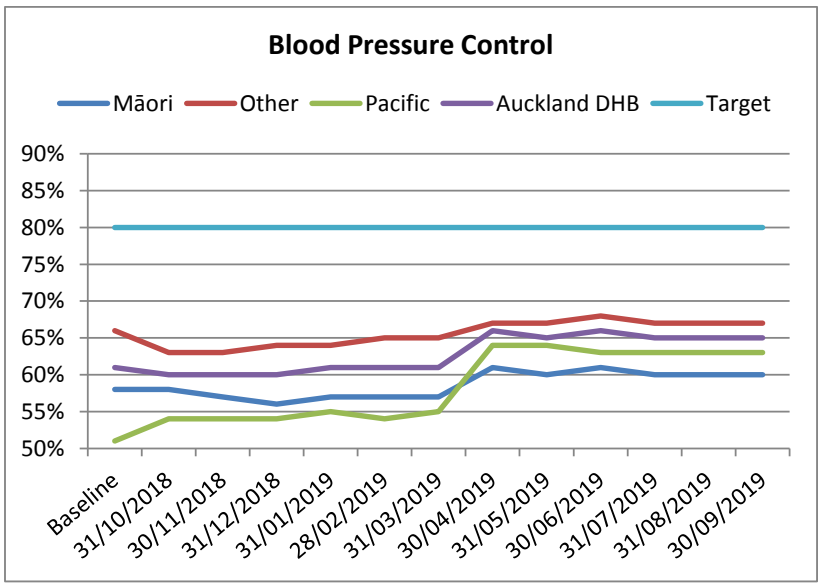


Figure 3: Auckland DHB Blood Pressure Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

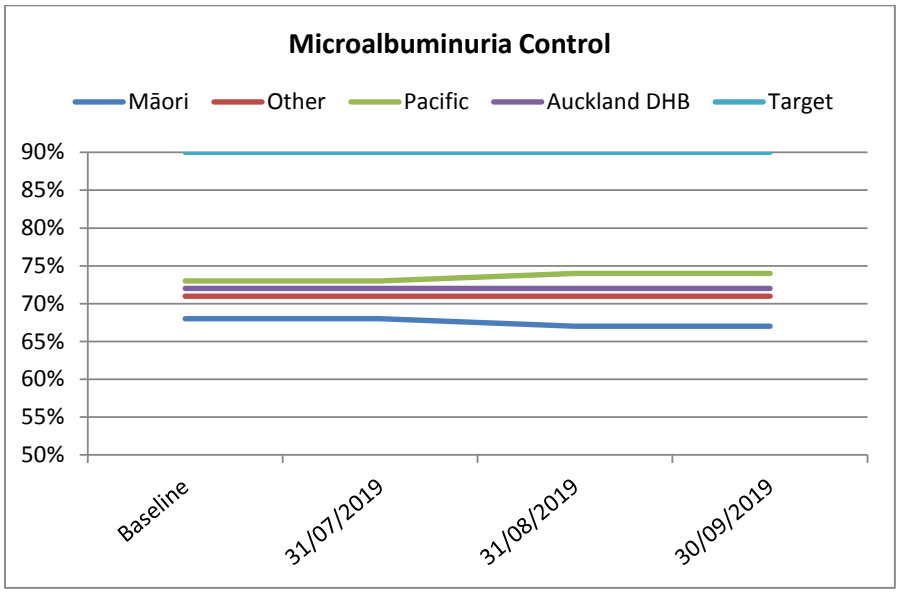


Figure 4: Auckland DHB Microalbuminuria Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 July 2019) to September 2019)

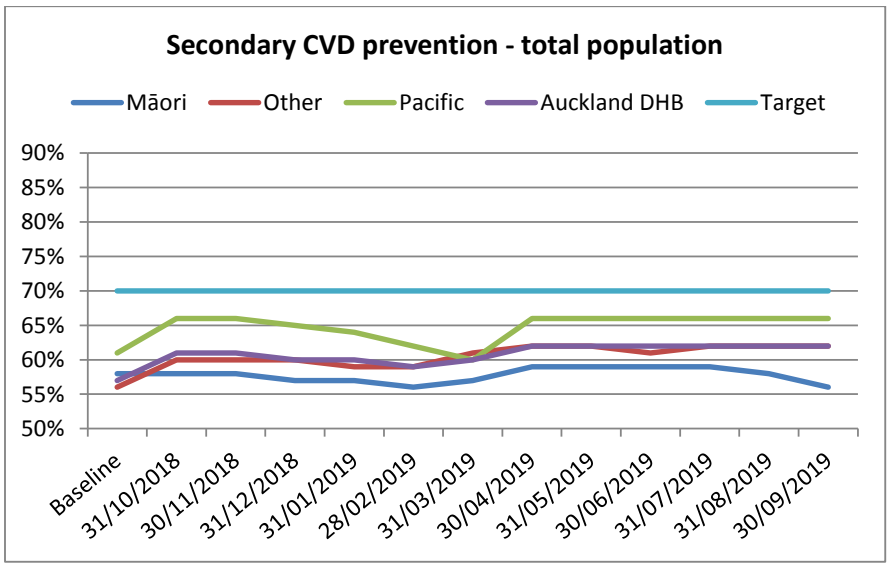


Figure 5: Auckland DHB Secondary CVD prevention, total population, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

3.2.4.2 Waitematā DHB - by Ethnicity

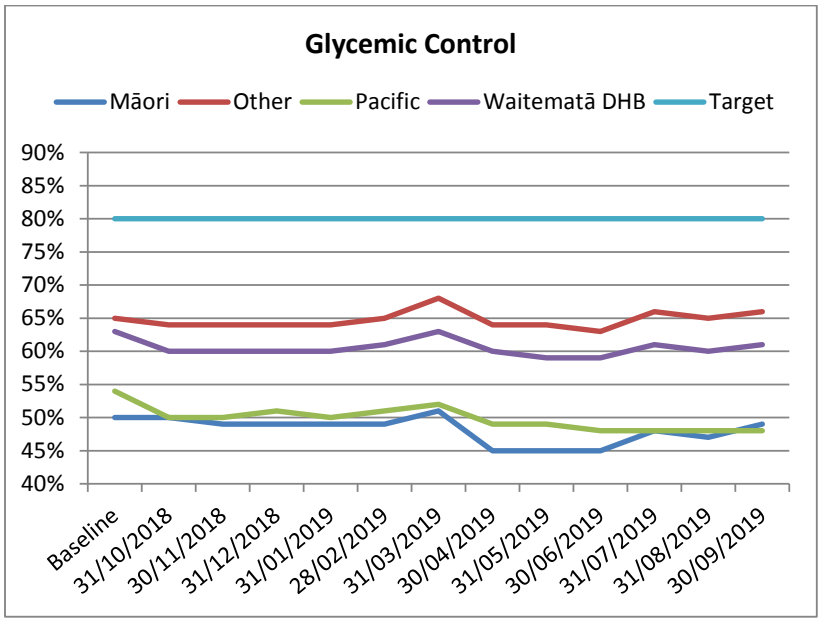


Figure 6: Waitematā DHB Glycaemic Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

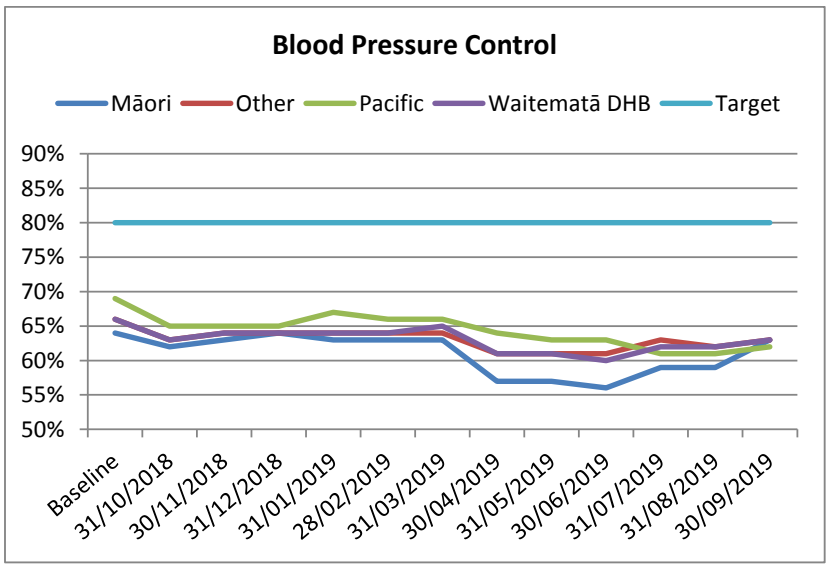


Figure 7: Waitematā DHB Blood Pressure Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

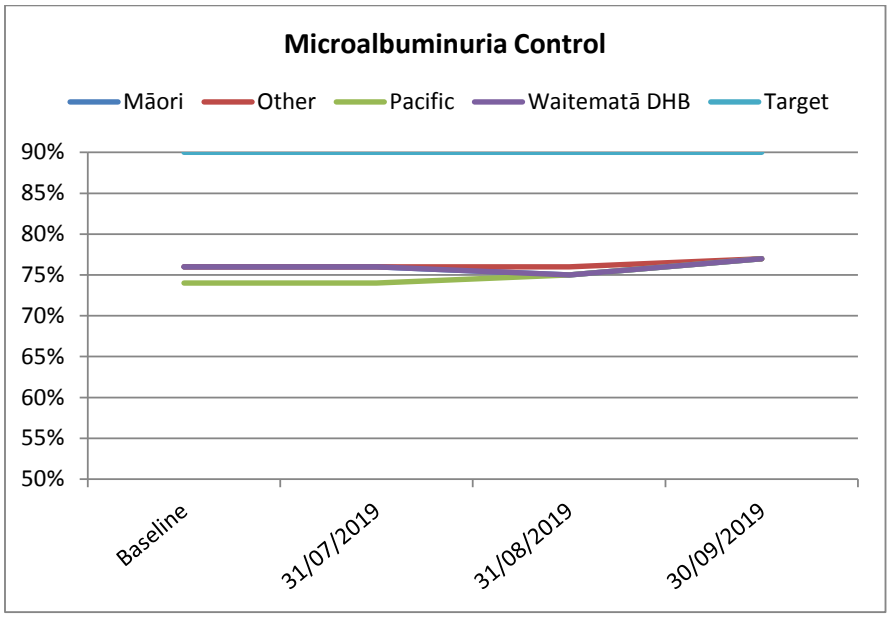


Figure 8: Waitematā DHB Microalbuminuria Control, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 July 2019) to September 2019)

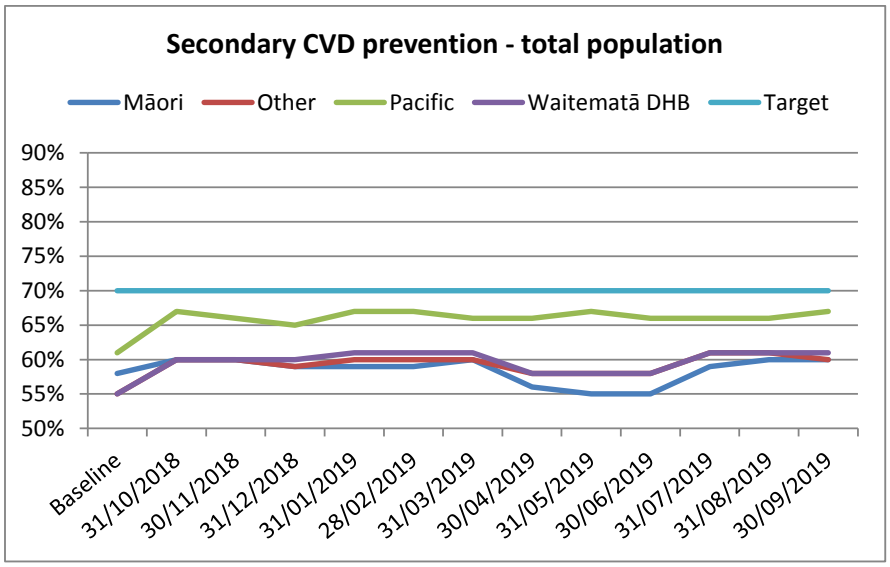


Figure 9: Waitematā DHB Secondary CVD prevention, total population, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (Baseline (31 December 2017) to September 2019)

4. Child, Youth and Women's Health

4.1 Immunisation

4.1.1 Childhood Immunisation Schedule Vaccinations

Provisional results for the Immunisation Focus Area for Quarter 2 2019/20 indicate that Auckland DHB achieved the 95% target for babies being immunised by 8 months of age, sustaining the gains made last quarter. Despite this overall improvement, an equity gap remains with Māori coverage of 85% and Pacific coverage of 91%. Waitematā DHB also sustained previous gains with 93% of babies

immunised by 8 months of age in Quarter 2 2019/20. This is in line with the national average of 92%. Pacific children reached the 95% target and Tamariki Māori coverage was 88%.

Auckland DHB's coverage at 24 months of age has increased to 95%, an increase from 93% last quarter, while 5 year old coverage remains stable at 88%. Further improvement is evident in Waitematā DHB, with coverage at 24 months reaching 93%, and at 5 years of age reaching 89%, a good improvement from 86% last quarter. Both DHBs are in line with, or above, the National average coverage at the key milestones of 24 months (92%), and 5 year old (89%).

These immunisation coverage results occurred during the transition of the National Immunisation Register (NIR) which was successfully repatriated to DHB management on 1 November 2019. The support of general practices and immunisation providers as well as comprehensive change management planning has ensured a smooth transition. It is most pleasing to note that there has been no drop in immunisation coverage during the change period despite the additional demands of the Measles outbreak. The last time the NIR was transitioned (from Auckland DHB to HealthWEST) there was a temporary drop of 10% coverage. Maintaining and even making gains in coverage is a huge achievement. Our thanks go to all our immunisation partners, including HealthWEST, immunisation coordinators and primary care, for their efforts to maintain high quality immunisation services over this challenging time.

The NIR team continues to serve both Auckland and Waitematā DHB populations which brings benefits in coordinating processes, reducing duplication and streamlining access to care for families. The NIR is among the first services to go live in Uri Ririki – Child Health Connection Centre, based at Greenlane Clinical Centre. Planning is underway for other register-based services to join Uri Ririki including the new National Child Health Information Platform (NCHIP) and Kāinga Ora - Healthy Housing (which is being renamed Noho Āhura as detailed below).

Auckland and Waitematā DHBs have reached agreement with Te Manawa Puna - HealthWEST to continue to deliver the Outreach Immunisation Services (OIS). The scope of the OIS service has extended to include actively following up 4 year old immunisations. In addition, opportunistic immunisations will be provided for whānau members of any age who are eligible for funded vaccine when the OIS is attending a home visit for a child.

4.1.2 Measles

In addition to business as usual for immunisation, the measles outbreak placed considerable pressure on primary care and our hospitals (particularly in Counties Manukau). A number of innovative delivery approaches were trialled such as 'pop-up' clinics. However, these struggled to engage the highest priority groups – Pacific and Māori young people aged 15 – 29 years. Importantly the decision was taken by the Ministry to firstly decrease the age of eligibility for MMR1 from 15 months to 12 months; then to add in a third dose between 6 and 12 months (MMR0). This was in response to the impact of the illness on infants aged under 2 years of age – the group most commonly hospitalised.

As of 2020, cases have tailed off. However, it is essential that efforts to achieve coverage of 95% are maintained.

4.2 National Child Health Information Platform and NIR Transition

The early adopter go-live phase is progressing implementation of NCHIP. NCHIP will provide a point-of-care view of each child's progress through the universal health milestones from 0 to 6 years of age.

Following a consultation process in January 2019, Auckland and Waitematā DHBs' Boards approved proceeding with changes to the coordination support for universal child health services. This included

the DHBs forming the Child Health Connection Centre (formerly referred to as Child Health Information Link (CHIL) Hub) to connect health services with families. Te Runanga o Ngāti Whātua have gifted the Centre a name and whakataukī.

Uri Ririki – he taura o te ate
The young progeny – the strings to the seat of ones emotions

Communications are rolling out now to inform parents, caregivers and health providers about the launch of Uri Ririki – Child Health Connection Centre. This includes the distribution of posters and information leaflets through health providers, social media and online. Details can be located on the health point page which is being updated with new information for health providers and whānau as the project is rolled out.

A small team of administrators to manage NCHIP have been appointed starting late January 2020. The NCHIP IT system is available for the administrators in a pre-production stage. The next phase is to run testing, evaluate the data quality and develop reporting systems. The project team is working with the Ministry of Social Development and Ministry of Education to review the privacy and security processes and develop safe information sharing methods. Coordination is underway with all child health providers to understand how NCHIP can be used at various points of care.

4.3 Adolescent Oral Health in Auckland and Waitematā DHBs

Oral Health Services for Adolescents and Special Dental Services for Children and Adolescents is provided by private oral health providers that hold a Combined Dental Agreement (CDA). There are 216 dental providers across Auckland (97) and Waitematā (119) DHBs. The Ministry of Health has set an utilisation target of 85% for adolescents from school year 9 – 17 years to receive annual dental care. Waitematā DHB's service coverage is at 69% and Auckland DHB's at 65%. While the service coverage is below national target of 85% for both DHBs, it is in line with National averages. In addition, there have been improvements over most metrics between 2017 and 2018 (2019 data is not yet available). However, there is also a significant disparity in dental coverage for Māori teenagers. Tables 3 and 4 show 2017 and 2018 utilisation for Auckland and Waitematā DHBs by ethnicity.

Table 3: 2017 and 2018 Adolescent Dental Coverage - Auckland DHB

Ethnicity	2017 Coverage	2018 Coverage
Māori	48%	52%
Pacific	69%	70%
Asian	61%	65%
Other	66%	66%
Total	**63%**	**65%**

Table 4: 2017 and 2018 Adolescent Dental Coverage - Waitematā DHB

Ethnicity	2017 Coverage	2018 Coverage
Māori	47%	50%
Pacific	68%	72%
Asian	67%	69%
Other	77%	75%
Total	**69%**	**69%**

While some young people may have accessed services privately (non CDA-funded) it is apparent that access by Māori adolescents is low compared to other ethnic groups. There has been some

improvement in uptake by Māori adolescents in 2018, but significant further improvement is required across the sector to achieve equity. Steps are being taken to make improvements.

Youth consumer group feedback has been obtained and indicates a low awareness of free dental care. In addition to health promotion, creating awareness of the availability of free publically funded oral health service is needed. Feedback, received by dental providers at a recent hui organized by the Metro Auckland DHBs, also highlighted the need for support and coordinated efforts to increase the awareness of the availability of free oral health service, alongside effective collaboration with schools, Māori and Pacific providers and other key stakeholders. Regular liaison and communications with contracted dental providers will be required to strengthen recall systems and follow up appointments. A regional Adolescent Oral Health Coordination Service Plan is in development. The plan will outline a range of actions to improve the uptake and on-going participation of adolescents in publically funded oral health services with a particular focus on Rangatāhi Māori.

4.4 Maternity

Very positive feedback has been received on the Funder initiated SMILE campaign. One Auckland practice got in touch to say:

"In a word – WOW! Brilliant - already got the posters up and only opened the mail 5 minutes ago. We make up maternity packs for our new Mums - can we have some more brochures to add to them please? Can you spare another 50 for us? If not that many - as many as you can spare."

As previously communicated to the Committee, the SMILE campaign started with the goal of increasing antenatal immunisation. However, it was recognised that immunisation needed to be 'normalised' as one of a number of key messages for pregnant women. Five key messages are now covered through the poster and booklets as shown in the poster below.

Waitematā DHB and Auckland DHB fund the provision of maternity care in several community locations (Parnell, Wellsford, Helensville and Warkworth). Warkworth Birthing Centre, has been providing maternity care for two decades. For the year 2019, Warkworth Birthing Centre supported 145 births; vaginal birth rate for women who commenced labour at the centre of 94% (including those who later transferred to hospital); with a transfer rate of 10%. These are very positive results.

4.5 Maternal Oral Health Project

The maternal oral health project in Tamaki has been named *Hapu Māmā Oranga Niho ki Tāmaki, Free dental care for pregnant women in Tamaki.* Recruitment for the clinical and support staff has continued over the last two month period and now all but one administrative position has been filled. The delay in recruiting staff impacted the start date for this project but the service is now expected to start on 3 February 2020. Initial results from this project will be brought to the next Committee meeting.

4.6 Healthy Housing

The Auckland DHB and Waitematā DHB Healthy Housing Initiative has been named Kāinga Ora since it was established 3 years ago. The service has built a good reputation and identity under this name. On 1 October 2019, Housing New Zealand combined with Kiwibuild and the Hobsonville Land Company (HLC) to form a new government owned entity Kāinga Ora - Homes and Communities. These very similar names are causing some confusion for clients and members of staff interfacing with the local Healthy Housing Service. Consequently, we are re-branding our service with a new name. The name 'Noho Āhuru – Healthy Homes' has been chosen with the support of the DHB Tikanga Chief Advisor, Dame Naida Glavish. Communications are assisting with the development of new materials for the service which have a launch date of March 2020.

Kāinga Ora continue to focus on supporting pregnant women and new parents as part of an early intervention approach. Work to ensure all eligible pregnant women are referred to the service is ongoing, building upon steady referrals over the past 2 years. Working on completeness of referrals for eligible women from Auckland DHB maternity is a priority.

As at 31 December 2019, Auckland and Waitematā DHBs had received 2,249 referrals to Kāinga Ora. This included 9,277 family members getting access to healthier home interventions. Of the referrals received, 760 (34%) were for families with a newborn baby or hapu woman. As at 31 December 2019, Auckland DHB received 1,158 referrals to Kāinga Ora. This included 4,841 family members. Of the referrals received, 356 (31%) were for families with a newborn baby or hapu woman. As at 31 December 2019, Waitematā DHB received 1,091 referrals to Kāinga Ora. This included 4,436 family members. Of the referrals received, 404 (37%) were for families with a newborn baby or hapu woman.

As part of the social work interventions, these women may be referred to smoking cessation services or immunisation, amongst other interventions, such as entitlements available through the Ministry of Social Development (MSD) as well as receiving support to improve the warmth and dryness of the home. This information was detailed in a presentation to the Committee in its meeting of 30 October 2019.

4.7 Cervical and Breast Screening

The Cervical Screening Coordination Service (CSCS) has been working with the PHOs to significantly improve the usability of the data match lists provided by the National Cervical Screening Programme (NSCP) to PHOs. Improved access to and usability of these lists helps the clinics to use the tool to review and clinically prioritise recall and follow up for women in their enrolled population. As well as working with the PHOs to improve the presentation and availability of the lists, the CSCS service is

supporting with communications to primary health clinics, as well as communication to be used by clinics with women. Targeted specialist nursing and general practitioner support is available to assist clinics.

A project is being conducted in collaboration between the Māori Health Pipeline in several clinics to trial the use of quality improvement tools. This work has a focus on improvement of recall and follow up of women, with a previous high grade result in their cervical screening history, who are overdue. Learning from the pilot is being built into further support for primary health care clinics to improve engagement with the NCSP, and particularly for quality work around the follow up of women who are overdue.

The National Cervical Screening Programme (NCSP) implemented a change in the age of entry to the programme from 20 to 25 years in November 2019. The CSCS continues to promote and link communications from the National Screening Unit to primary care and other cervical screening providers and stakeholders. Where primary care and other providers have experienced challenges in the implementation of the age change, the CSCS has connected them with the NCSP change leads for technical support. Cervical Screening Coordination Services are planning to provide updates for cervical screen takers in Quarter 3 and will also promote and support the use of the communications material, expected to be released by the Health Promotion Agency, in support of the age change for the programme.

4.8 Contraception

Several streams of work are underway to improve access for women to high quality Long Acting Reversible Contraception. Long Acting Reversible Contraception (LARCs) are the most effective form of contraception but access to LARCs for women has been challenging due to a number of barriers including cost, awareness or advice and also the availability of health professionals who can provide them.

Long acting contraception includes sub-cutaneous devices, such as Jadelle, which are implanted under the surface of the skin in the upper arm. Jadelle provides contraception through slow release hormones for around 5 years. Other long acting devices are intra uterine contraceptive devices such as the copper intra uterine devices (IUD) or intra uterine devices that also release a hormone, such as Mirena which lasts for 5 years. Mirena has been in use for many years and provides relief of conditions such as heavy bleeding. Pharmac funding criteria for Mirena have been structured around a number of indicators and illnesses. On 1 November 2019, Pharmac widened the access to Mirena and another long acting intra uterine contraceptive devices (IUCD) (Jaydess (3 years contraception)) to all women.

In addition to the increased availability of Mirena and Jaydess, the Ministry has been working to address the cost barriers for women to access LARCs. A Ministry contract with the DHBs to improve access to LARC has been in place for nearly one year. The priorities for this contract include providing improved access to LARCs for women who are most financially deprived (Quintile 5), Māori and Pacific women as well as post-partum services in maternity, improved access for specific groups such as those with mental health and addictions challenges. Auckland and Waitematā DHBs have been working to increase the number of trained LARC providers within their services, increase access through maternity services, after termination and in community clinics in targeted locations.
Most recently, the Child, Youth and Women team have undertaken a formal request for interest (ROI) process (which closes 14 February 2020) for providers of Long Acting Reversible Contraception in community settings. Appropriately qualified health practitioners such as General Practitioners, Nurses and Midwives are able to respond if they are appropriately skilled and qualified to provide Long Acting Reversible Contraception in community settings.

Other activity in this area includes the development of national guidelines on contraception which the Ministry have commissioned from Allen and Clarke. The Planning, Funding and Outcomes Team has been participating in the development of these guidelines. The Ministry has also commissioned Family Planning Association to develop a programme of health professional training for provision of LARCs. Both of these pieces of work are currently under development.

5. Health of Older People

5.1 Aged Residential Care (ARC)

The annual review of the national Aged Related Residential Care Agreement (ARRC) (A21 Review) is progressing. Currently DHB and ARC representatives are reviewing issues that have been submitted. However, the recommendations from the ARC Funding Model Review are also being considered and if these were to proceed a likely requirement would be a complete re-write of the ARRC Agreement. Therefore, DHBs are being asked to be pragmatic and only submit issues that are important to, and realistically could be resolved through changes to, the ARRC Agreement for 2020-21.

One issue that DHBs have agreed to submit, and have already signalled to the ARC sector, is transparency and disclosure of premium charging by facilities. In advance of finalising the changes from the A21 Review a joint working group has been set up with ARC representatives to establish a process/mechanism for publishing premium charge rates so they can be easily accessed by the public when considering options for residential care.

A review has been completed on the transition from acute hospital to ARC for older adults in Waitematā and Auckland DHBs. The findings showed that, the process, as it stands poses challenges for the older adult and their family/whānau, for hospital based health professionals and for aged residential care facilities. Recommendations from the review are currently being prioritised and implemented. An audit of hospital discharge documentation when a person enters ARC has been completed in Auckland and is underway in Waitematā. Overall, the Auckland discharge documentation was completed well and the relevant information was given on discharge.

The table below provides an overview of the ARC audits undertaken in the first six months of 2019/20.

	Quarter 1		Quarter 2	
	ADHB	**WDHB**	**ADHB**	**WDHB**
Total number of audits	21	15	10*	13
Number of unannounced (surveillance) audits	8	5	5	9
Average number of corrective actions per audit	2.2	6.6	2.1	2.7
Number of facilities > 5 corrective actions	2	4	1	2
Number of facilities with no corrective actions	9	3	3	5
Number of facilities achieving continuous improvement	10	3	2	2
Number of complaint the DHB received on ARC	2	5	4	1

*3 /10 audit reports are still to be received from the MoH

5.2 Falls Prevention

The Accident Compensation Corporation (ACC) Board has approved funding up to December 2020 for its 'Live Stronger for Longer' programme; this funding matches the DHB funding to deliver the In Home Strength and Balance Programme and the Fracture Liaison Service. These are important services that a meet a previous gap in preventative care for older people. Falls, injury and fragility fractures cause a significant burden of disease in older people. Falls in older people also lead to loss

of confidence, which reduces mobility and therefore further increases risk of falls and loss of independence. For example, falls are an independent predictor of premature admission to ARC even if there is no injury. It is extremely positive that this partnership work with ACC will continue.

5.3 Funded Family Care

There have been further announcements concerning the changes to Funded Family Care. Eligibility of funded family carers will expand to include partners and spouses of those with high or very high support needs, children and young people under 18 years, and the minimum age to be a family carer will lower to 16 years. This will be effective from June 2020 for DHBs.

The Ministry will remove the requirement in its Disability Support Services (DSS) policy for an employment relationship between the disabled person and their funded family carer. In addition the pay rate for DSS funded family carers will increase from the minimum wage to $20.50 - $25.50 per hour.

There will be no change to the employment arrangements or pay rates for funded family carers under DHB policies, as they are currently employed by providers and, already receive pay rates consistent with the wider care and support workforce, as a result of the pay equity settlement.

6. Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction Services (He Ara Oranga) and the Wellbeing Budget

6.1.1 Improved Access and Choice Integrated Mental Health

A metropolitan Auckland response to the MoH Request For Proposals (RFP) for Improved Access and Choice Integrated Mental Health was submitted to the MoH on 24 October 2019. The response included expansion of Awhi Ora, Te Tumu Waiora, by Māori and by Pacific services along with a programme to up skill general practice teams. This response was endorsed by all parties involved in the oversight of the development of the response. The MoH have confirmed that they wish to enter in to an agreement with the metro Auckland DHBs to deliver proposal.

A collaborative group for metro Auckland is in place to oversee the implementation of the programme, which comprises of the involved parties and includes clinical and managerial expertise. The co-chairs will be MOU partner (John Tamihere) and Ailsa Claire (Chief Executive Officer, Auckland DHB).

The MoH met on 21 January 2020, with representatives of the collaborative group to begin contract negotiations for service delivery in 2020.

6.1.2 Expansion and Replication of Existing Kaupapa Māori and Pacific Primary Level Interventions

The MoH also released two further RFPs in late October 2019 for the expansion and/or replication of existing Māori or Pacific Primary Mental Health and Addiction services currently funded either directly by the Ministry of Health, or through a DHB. For services currently funded by a DHB, proposals were required to be jointly developed by the DHB and the Māori or Pacific Non-Government Organisation (NGO) Provider.

Four proposals for Māori services and two for Pacific services were submitted to MoH on 26 November 2019.

6.1.3 Financial Sustainability of NGO Alcohol and Drug services

The Ministry of Heath released $10.5million per annum nationally, to fund DHBs to improve the financial sustainability of NGO Alcohol and Drug services. $3 million is allocated to the Northern region. A regional approach was taken to develop this proposal, in collaboration with the Alcohol and Drug sector. The key principle agreed for the allocation of the funding was that all NGOs should receive a fair and similar price for the same service. The MoH have agreed to the Northern region proposal to:

- Increase the non-clinical and clinical Full Time Equivalent minimum rates.
- Introduce minimum service level amounts for each residential service type.
- Apply a proportional uplift for all Alcohol Or Drug services

6.2 Haven: Recovery Café

The Haven (Recovery Café) located on Karangahape Road in Auckland Central continues to experience high levels of utilisation, with 1,835 visits to the service between 11 October 2019 and 13 January 2020. The Haven is funded via the acute drug harm discretionary fund and offers after hours drop in care and support to those who may be experiencing a crisis with the specific aim to respond to acute drug harm related episodes. The Haven is peer led and staffed by a mix of addiction, mental health and homeless peer support workers with on-call support provided by clinically trained staff. The service aims to provide an accessible alternative to attending the emergency department and seeks to provide interventions to avert a crisis particularly for those who are sleeping rough or who are homeless. The partner agencies are Odyssey Trust (who holds the funding), Lifewise and Mind and Body (Emerge Aotearoa).

7. Māori Health Gain

7.1 Iwi-DHB Partnership Board

A unanimous endorsement for the partnership agreement from iwi and DHB Boards has been achieved, and we have reached agreement for a Chairperson for this Board – Ms Gwen Tepania-Palmer.

We are currently awaiting a response from the Minister of Health to formally recognise this group and its members.

Members:

- Rick Witana, Chair, Te Rūnanga nui o Aupōuri
- Hayden Edmonds, Chair, Ngāti Wai
- Wallace Rivers, Chair Te Rūnanga o Ngāi Takoto
- Harry Burkhardt, Chair Northland DHB
- Professor Judy McGregor CNZM, Chair Waitematā DHB
- Pat Snedden MNZM, Chair Auckland DHB

7.2 Whānau House Health Needs Assessment

7.2.1 The Enhanced Well Child Service

This service aims to improve immunisation rates for tamariki Māori enrolled in Te Whānau o Waipareira's Well Child Tamariki Ora services, as well as improve the wellbeing of mothers and babies enrolled in their services, through the provision of an antenatal and newborn health navigator role.

As we move into the third year of this service, we have completed an analysis of the programme to date. One key issue that we will improve in this upcoming year is to provide staff members more

opportunities to address wider social needs (like housing and employment) to meet increasing demand. This will mean a small shift in focus, from one of unarranged immunisations, to working longer term with whānau. This is largely because Waipareira have achieved high rates of immunisation amongst their enrolled whānau, and through engagement with the OIS, have kept their enrolled whānau up to date with immunisations. We have proposed that they increase their engagement with the OIS.

We are in the process of working with Waipareira to re-develop the service. This will include support to four of their current nurses, who have completed vaccinator training, but need to complete their assessments. From there, we will be able to look at how the service progresses with accredited vaccinators and update the service specifications.

7.2.2 Taitamariki Substance Misuse Prevention Service

The service employs one Social Worker (and will seek to employ two additional youth workers). The social worker role will have an on-going caseload of between 20 - 25 clients. At present, the service is managing and supporting 8 complex taitamariki (youth aged between 12-14 years) and their whānau. Referrals over summer have been slow, but we expect these to increase early in 2020, as key referral pathways are through schools in West Auckland. It is anticipated that the numbers will significantly increase over the next 3 months. In December 2019, the service also ran an Expo for 40 youth that was called the Game Zone and this hui run key themes and messages revolved around drugs and alcohol and informed choices.

The service is constantly working on strategies or practices that can be used to encourage hard to reach clients and their whānau, to engage with the service. For instance the Taitamariki service has:

- Adopted a positive youth development framework which is strengths-based and endeavours to provide opportunities for young people to undertake activities that promote positive youth development. This model helps to build resilience in youth and gives them confidence to overcome a plethora of life challenges thus, reducing the negative impacts and attraction of substance use,
- Worked on growing its close links with other mental health and addiction services. An example of this is, Tupu services (Waitematā DHB Pacific addiction services) have delivered training to Waipareira Youth services to use the substance screening tool. Staff regularly invite other services to share their work to increase coordination across the whole system
- Supported clients to access the wide variety of supports Waipareira can deliver - such as the parenting programmes, Whānau direct ($1,000 support grants), mental health support, and health and wellbeing supports, and
- Reviewed its cases within the wider Rangatahi services of Waipareira. This has shown to be an effective way of obtaining other perspectives and strategies.

7.3 Māori Pipeline Projects

The Māori health pipeline is currently progressing proposal development in a range of areas. A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening - Study 1 is well underway with two of the three focus group hui completed and the survey aiming to recruit 300 Māori, potentially eligible for screening and approximately 100 whānau is in the field for hospital inpatients. Planning is underway for community survey recruitment with support from Māori providers and local kuia and kaumatua roopu. The equity re-analysis of the cost effectiveness model for lung cancer screening in New Zealand is being submitted for publication, and the workstreams for the larger demonstration trial (Study 2) are proceeding at pace. There has been a lot of interest in the project from around the country, which has led to the proposal for a national meeting on the issue (hosted by Auckland DHB and Waitematā DHB, supported by Hei Ahuru Mowai (National Māori Cancer

Leadership Group) and TeORA (Māori Medical Practitioners Association) with the Lung Foundation and potentially other support. The meeting is planned for April-May 2020.

- Alternative community cardiac rehabilitation model – a business case is nearly complete.
- Alternative community pulmonary rehabilitation model – opportunities for staff to participate in kapa haka have been progressed, and joint working to develop options of how to integrate of pulmonary rehab and kapa haka (while maintain the integrity of both) have begun. Research protocol development is currently on hold awaiting the clinical lead, Dr Sandra Hotu, to complete her PhD.
- Northern region breast screening datamatch ('500 Māori women campaign') – contacting the women has been underway since 1 October and is expected to continue for up to 6 months. The datamatch, to identify Māori women not enrolled in a PHO and also offer breast screening within this project, will be finalised shortly.
- Māori provider and PHO datamatch – Data sharing agreements with the nominated iwi representatives have been drafted and approved. A privacy impact assessment was completed and approved by DHB and regional privacy groups. The new project Māori data governance group has been established and has met. Tailored approaches with individual providers for data extraction will be undertaken from February.
- Facilitated PHO enrolment – Maternity services have been identified as the initial pilot location with the potential for automated data matching to identify women not enrolled in a PHO and develop an offer of service.
- High grade cervical screening project – The Māori GP clinical lead has completed the audit tool process and offer of an intensive supported engagement at the first pilot practice. This model is based on identified Māori values and seeks to centralise women and whānau centred care, shared decision making and tailored support approaches including specific cultural support as required. Rolling out the project in two further practices is planned. The audit tool has been presented to the College of GPs as an example of practical equity quality improvement processes. Broader work with practices, to facilitate access to data and resources to support practice level action, has been undertaken in parallel with the cervical screening coordination service. A steering group is being established, led by Pania Coote. A research sub-project, where human papilloma virus (HPV) self-testing is offered to women who decline, has been funded by the A+ Trust and will now be included in the project. Ethics approval is currently being sought This will offer, as far as we are aware, a world first opportunity to test this approach for women who are at high clinical risk. The work is a collaborative with pathology and clinical colleagues.

Additional areas of work will be included over time.

8. Pacific Health Gain

8.1 Pacific Health Action Plan (PHAP) Priority 3 – Pacific people eat healthy and stay active

The seventy-seven Healthy Village Action Zones and Enua ola church and community groups have recently completed a weight loss challenge competition called the Aiga Challenge. An analysis is underway about how many people took part, the diverse range of healthy eating and activities that were actioned and the total participant weight loss achieved.

8.2 Diabetes Co-design project

Two Pacific focus groups have been organised to take place in February. The groups, which include patients and carers, will be invited to review the summary of insights received from Phase 1 of the Diabetes Care Improvement co-design project, and provide feedback. The purpose of this approach is to ensure the voice and experience of Pacific patients or carers is accurately captured and to provide

an opportunity for further insights if they are missing. Key insight themes include the role of the family and carers, travelling and parking costs and health literacy.

8.3 Self-management and Diabetes self-management education programmes

Ten Self-Management Education (SME) / Diabetes SME (DSME) programmes will be implemented across Auckland DHB region before 30 June 2020. Each programme consists of eight weeks of SME & DSME that can be delivered in English, Samoan or the Tongan language. Four programmes will be delivered in partnership with the Samoan Methodist Auckland Synod that looks after 12 church groups in the Auckland and Waitematā DHB areas. These programmes are due to begin in February 2020.

8.4 Healthy Village Action Zones and Enua ola programmes

The final report for the Service Review of the Healthy Village Action Zones / Enua Ola Programmes was completed in December 2019. The review highlighted the programme has many strengths, including being well embedded in, and accepted by, many Pacific communities. Furthermore, the programmes have the potential to address health inequities by taking a holistic and sustainable approach to family and community-level social change. There are however, some areas to improve and strengthen the programme for sustainable success. The review recommendations are currently being considered.

8.5 Pacific Abdominal Aortic Aneurysm

The aim of the Pacific Abdominal Aortic Aneurysm (AAA) Screening Research Project is to find out the prevalence of AAA amongst Pacific, targeting Pacific men, 60-74 years old domiciled through their GP clinics. A Pacific clinical lead has been appointed, and together with the Pacific Health Gain Team a focus group discussion with Tongan men was conducted last month on resource materials and recruitment processes. Learnings from the Māori AAA research has been applied, and the focus group discussion has directly influenced the research project materials. Pacific brochure and resources using Pacific context and an AAA survivor story are being finalised. Ethical approval has been provisionally granted, and screening is planned to be underway from March.

8.6 Pacific Pipeline projects

A range of work has been developed under the Pacific Pipeline. A collaborative project involving the Pacific Health gains teams, ARPHS and Auckland DHB Communications team about communicating urgent public health issues with Pacific peoples and communities in Auckland is now complete under the Pipeline. A draft report including the key findings and recommendations is being finalised.

9. Asian, Migrant and Former Refugee Health Gain

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

We are developing a new Asian, migrant, former refugee and current asylum seeker health plan 2020-2023 to be submitted to CPHAC in May.

9.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 73% (Auckland DHB) by 30 June 2020.
- 80% of eligible Asian women will have completed a cervical sample by 2020.

The Asian PHO enrolment rate for Quarter 2 2019/20 was 71% (Auckland) and 94% (Waitematā). The Asian cervical screening rates for Quarter 2 2019/20 was 50% (Auckland) and 69% (Waitematā). It is noted that Asian women have the lowest rates of cervical cancer of any ethnic group, therefore the focus of cervical screening work overall is on improving participation for Māori and Pacific women.

A suite of targeted efforts are planned in 2020 to increase awareness of new migrants, particularly from Filipino and Latin American communities. Census 2018 has informed prioritization of these two ethnic groups, as they experienced the greatest population growth for Asian & Middle Eastern Latin American and African (MELAA) communities in both districts. We will leverage Asian partner platforms such as WeChat to promote health information including role of a family doctor/general practitioner (GP); refreshing the New Zealand Health & Disability System videos to add in subtitles for: English, Arabic, Farsi, Korean, Japanese, Spanish, Portuguese, and Burmese; and developing New Zealand Health & Disability System online materials for Rohingya, Cambodian, Farsi, Urdu, Tamil, Somali, Amharic, Tigrinya, Swahili, and Punjabi. Communities settling and resettling in metro Auckland DHBs are increasing for the languages aforementioned.

We are planning a regional effort to promote uptake of the influenza vaccination to Asians over 65 years.

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

We are engaging with Chinese NGOs and the Asylum Seekers Service Trust to discuss approaches to support increasing numbers of Chinese asylum seekers living in the Auckland district who are claiming refugee status.

We are continuing to work closely with Ministry of Business Innovation and Employment on the national Quota Refugee Health Service Model roll out to primary care.