



## **Community and Public Health Advisory Committees Meeting**

**Wednesday, 03<sup>rd</sup> September 2014**

**2.00pm**

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### **Venue**

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

## **Karakia**

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

## **Creator and Spirit of life**

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind

As we seek to be of service to those in need.

Give us the courage to do what is right and help us to always be aware

Of the need to be fair and transparent in all we do.

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

Well Being to All.



**AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS  
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING  
03<sup>rd</sup> September 2014**

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

**Time: 2.00pm**

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

**Apologies: Lee Mathias and Dale Bramley**

**Leave of Absence: Christine Rankin**

## AGENDA

### KARAKIA

#### DISCLOSURE OF INTERESTS

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

#### Items to be considered in public meeting

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

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

	<b>1 AGENDA ORDER AND TIMING</b>	
	<b>2 CONFIRMATION OF MINUTES</b>	
2.05pm	2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 30/07/14 .....	7
	Matters Arising from Previous Meeting .....	18
	<b>3 DECISION ITEMS</b>	
	<b>4 INFORMATION ITEMS</b>	
2.10pm	4.1 Changing the Landscape of Childhood Vulnerability: an Inter-Agency and Community Challenge.....	20
2.40pm	4.2 Progress Update – Healthy Eating and Physical Activity in the Auckland Region .....	29
	<b>5 STANDARD MONTHLY REPORTS</b>	
3.00pm	5.1 Primary Care Update .....	37
3.25pm	5.2 Planning, Funding and Outcomes Update .....	58
3.40pm	<b>6 GENERAL BUSINESS</b>	

**Auckland and Waitemata District Health Boards'  
Community and Public Health Committees  
Member Attendance Schedule 2014**

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

*x absent*

*\* attended part of the meeting only*

*# absent on Board business*

## REGISTER OF INTERESTS

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

Register of Interests continued...

<b>Allison Roe</b>	Member – Devonport-Takapuna Local Board, Auckland Council Chairperson – Matakana Coast Trail Trust	02/07/14
<b>Gwen Tepania-Palmer</b>	Chairperson – Ngatihine Health Trust, Bay of Islands Life Member-National Council Maori Nurses Alumni – Massey University MBA Director – Manaia Health PHO, Whangarei Board Member – Auckland District Health Board Committee Member – Lottery Northland Community Committee	10/04/13
<b>Co-opted Members</b>		
<b>Elsie Ho</b>	To be advised.	
<b>Dr Tim Jelleyman</b>	Member - Active Clinic Network for Greater Auckland Integrated Health Network Member - ASMS Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland Member-Board of Kaipara Medical Centre	22/04/13

## **2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 30th July 2014**

### **Recommendation:**

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

Note: the public excluded minutes of the above meeting are included under separate cover. It is suggested that, unless there are any issues which require discussion, approval of the public excluded minutes could be incorporated in the above resolution, without moving into public excluded session.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

**Community and Public Health Advisory Committees**

**Wednesday 30 July 2014**

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,  
commencing at 2.03p.m.

**PART 1 – Items considered in public meeting**

**COMMITTEE MEMBERS PRESENT:**

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)  
Max Abbott (WDHB Board member)(present from 2.08p.m.)  
Jo Agnew (ADHB Board member)  
Peter Aitken (ADHB Board member)  
Judith Bassett (ADHB Board member)  
Pat Booth (WDHB Board member)  
Chris Chambers (ADHB Board member)  
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)  
Lee Mathias (ADHB Deputy Chair)  
Allison Roe (WDHB Board member)  
Tim Jolleyman (Co-opted member)

**ALSO PRESENT:**

Dale Bramley (WDHB, Chief Executive)  
Debbie Holdsworth (ADHB and WDHB, Director Funding)  
Simon Bowen (ADHB and WDHB, Director Health Outcomes)  
Tim Wood (ADHB and WDHB, Deputy Director Funding)  
Imelda King (WDHB, Community Engagement Co-ordinator)  
Paul Garbett (WDHB, Board Secretary)  
(Staff members who attended for a particular item are named at the start of the  
minute for that item)

**PUBLIC AND MEDIA REPRESENTATIVES:**

Lynda Williams, Auckland Women's Health Council  
Tracy McIntyre, Waitakere Health Link  
Anne Curtis, Health Link North  
Jude Sprott, Procare  
Kate Moodabe, East Tamaki Healthcare  
Dr Charlotte Harris, Auckland PHO  
Barbara Stevens, Auckland PHO  
Lorelle George, Comprehensive Care/Waitemata PHO  
Craig Murray, Waitemata PHO

**APOLOGIES:**

**Resolution** (Moved Warren Flaunty/Seconded Allison Roe)

**That the apologies from Lester Levy, Sandra Coney, Robyn Northey, Christine Rankin, Ailsa Claire and Andrew Old be received and accepted.**

**Carried**



**KARAKIA:** Gwen Tepania-Palmer led the meeting in the karakia.

**WELCOME:** The Committee Chair welcomed all those present.

2.05p.m-2.25p.m – Pat Booth retired from the meeting.

#### **DISCLOSURE OF INTERESTS**

With regard to the Interests Register, Warren Flaunty has advised that his interest listed as “Shareholder-Pharmacy Brands Ltd” should be updated to read “Shareholder-Green Cross Health”.

With regard to the open agenda for this meeting, Warren Flaunty advised of interests relating to: Item 3.1 Tobacco Control Update, as a pharmacist holding a contract with Waitemata DHB relating to this issue; Item 4.2 relating to Palliative Care, as a Trustee of West Auckland Hospice; and Item 4.3 ARPHS Local Alcohol Policy Submission to Council, as a Trustee of the Waitakere Licensing Trust.

The Committee agreed that for these items it would be useful, in terms of sharing expertise and experience, for Warren Flaunty to remain in the meeting while the item was discussed and participate in the discussion. Items 4.2 and 4.3 are information only items and with Item 3.1, Warren Flaunty advised that he would not participate in the voting on the resolution.

Lee Mathias also noted that the Health Promotion Agency has a significant involvement in alcohol related advice and research.

2.08 p.m. – Max Abbott present.

#### **1. AGENDA ORDER AND TIMING**

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

#### **2. COMMITTEE MINUTES**

##### **2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 30<sup>th</sup> April 2014 (agenda pages 8-19)**

**Resolution** (Moved Jo Agnew/Seconded Lee Mathias)

**That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 30<sup>th</sup> April 2014 be approved.**

##### **Carried**

With regard to the CPHAC meeting cancelled on 11 June 2014 due to a power cut affecting Waitemata DHB, it was noted that if there was a power failure in the future, an attempt should be made to change the venue to an Auckland DHB meeting room.

With regard to the comment on page 17 of the minutes about the Health Promotion Agency, Lee Mathias advised that the expertise referred to related more to directing how to use HPA resources. The Agency commissioned other parties to undertake work, for example the ASH Ten Year Snapshot Survey is commissioned by the HPA but carried out by ASH.

Matters Arising (agenda page 20):

No issues were raised with the items listed on page 20 of the agenda..

Papers from Cancelled Meeting on 11 June 2014

An opportunity was provided to Jo Agnew to ask questions relating to the Long Term Conditions Paper (attached as Item 7.1 to the 30 July agenda). In response to questions relating to the community podiatry service that has started for Auckland DHB for diabetic patients with “at risk feet” (pages 136-137 of the agenda), Stephanie Muncaster advised that Auckland DHB community podiatry had commenced on 1 April 2014, with first referrals receiving treatment from May 2014. People with diabetes and a high risk foot condition can be referred by their general practice to a community podiatry. The PHOs manage the referral process. Planning, Funding and Outcomes are also working with Podiatry NZ to develop and implement a clinical quality programme through clinical governance and audit of podiatrists and facilities.

In answer to a question, Debbie Holdsworth advised that she was aware that the regional statistics relating to amputation of feet of diabetic patients had improved, but she would bring the actual figures back to CPHAC.

### **3 DECISION ITEMS**

#### **3.1 Tobacco Control Update** (agenda pages 21-33)

Leanne Catchpole (Programme Manager, Primary Care Team) and Tracy Walters (Maori Health Analyst) presented this item.

The meeting was advised of the exceptional results achieved by the PHOs for the advice to quit smoking national health target: 99% for Auckland DHB and 101% for Waitemata DHB.

Leanne Catchpole outlined some key features of the report, including work to develop a combined tobacco control plan for 2015-18 for the two DHBs and the intention to now put more emphasis on the quality of advice to quit smoking and the conversion rate from attempts to quit to successfully quitting long term. She also noted the positive trends concerning a decline in smoking in the 2013 census results and the reduction in Maori and Pacific smoking rates for Auckland and Waitemata DHBs shown in Figure 3 of the agenda report.

Matters covered in discussion and response to questions included:

- Research on smoking commissioned by the Health Promotion Agency includes an insight survey that 180 schools have been invited to participate in.
- Agreement that the emphasis needs to now shift to “embedding” interventions.
- With regard to the Ministry of Health not being able to report on the maternity health target for advice and support to quit smoking, it was noted that the NMPO has data for about 80% of the Lead Maternity Carers in New Zealand, but this is not a full data set. The Ministry is working on a way to report results for the target. In the meantime the DHBs are working with the midwives to ensure that they have appropriate training on giving advice to quit smoking.
- The Community Pharmacy support to quit programme (Waitemata DHB) is quite an innovative service. Some further training is being done with pharmacies to ensure that they are well skilled for this.

- Quitline has had a huge increase in the number of referrals to it, primarily because of the work that primary care has been doing.
- Mental Health Services are an area of focus, particularly for Waitemata DHB. A lot of work is being done to promote a culture of change with staff. A project has just commenced for Auckland DHB Community Mental Health Services. With the three projects underway in mental health, there is really good coverage across mental health services and also a consistency being achieved about the messages on the importance of quitting smoking.
- Tracy Walters confirmed that a number of providers are working closely with Maori Health on this issue and commented that the efforts of the PHOs are to be applauded.
- Tim Wood advised that another angle to this issue is being looked at, that of the child in a smoking environment, particularly in houses and cars. The literature supports the view that children provide a lever as a motivation for people to quit smoking. Tracy Walters advised that he had attended a recent presentation relating to this, which he would forward to Tim Jelleyman.
- In answer to a question, Leanne Catchpole advised that smokers who had been given advice to quit in the hospitals are not subsequently followed up through the hospital system, however the information is provided back to primary care.
- With regard to data on long term adherence following a decision to quit smoking, an indication is provided by the census data and PHO smoking status data on ex-smokers and smokers. Simon Bowen advised that there is contractual reporting information available on maintenance of quit rates at four weeks and three months. It was agreed that information based on this would be provided to the Committee.

Warren Flaunty took no part in voting on the following resolution.

**Resolution** (Moved Lee Mathias/Seconded Jo Agnew)

**That the report be received and the Auckland and Waitemata DHBs' CPHAC Committees:**

- Endorse the current and planned tobacco control activity in Auckland and Waitemata DHBs.**
- Note that Auckland and Waitemata DHBs expect to achieve both the hospitals and primary care 'better help for smokers to quit' health targets for 2013-14.**
- Note that the Planning, Funding and Outcomes Unit are developing a combined tobacco control plan for 2015-18 for Auckland and Waitemata DHBs.**

**Carried**

#### **4. INFORMATION ITEMS**

##### **4.1 Rheumatic Fever Prevention and Intervention Programme in Auckland and Waitemata District Health Boards (agenda pages 34-47)**

Ruth Bijl (Funding and Development Manager), Alison Leversha (Community Paediatrician, Auckland DHB) and Alison Hudgell (Programme Manager, Planning and Funding) were present for this item.

Ruth Bijl outlined the report. She noted a correction to 3.3.1 on page 39 of the agenda. To date 5,672 children have had throat swabs taken by the school – based health service in Auckland DHB and the GAS rate for them has been 13%.

Matters covered in discussion and response to questions included:

- In school based clinics, following swabs being taken, where use of antibiotics is indicated, the families are asked if they would like the antibiotics through the school-based service or through their GP. In primary care and rapid response, the decision depends on the clinician. If the clinician considers that there is a very high risk of the child not coming back, antibiotics may be provided straight away.
- Tim Jelleyman confirmed that prophylactic antibiotic treatment is vital for those children who have had rheumatic fever already; this is different to the prevention programme.
- Nurses involved in the rheumatic fever programme are also geared up to provide treatment for skin sepsis. Alison Leversha advised that dealing with skin sepsis depended a lot on health literacy, understanding the very early signs, early first stage management and going to primary care.

**Resolution** (Moved Lee Mathias/Seconded Peter Aitken)

**That the updated information provided on the implementation of the Rheumatic Fever prevention and intervention programme for Auckland and Waitemata District Health Boards be noted.**

Carried

#### **4.2 Specialist Palliative Care – Community Services Provided by Hospices** (agenda pages 48-55)

Stephanie Muncaster (Programme Manager) presented this report. Present for this item were: Lynda Smith (CEO Mercy Hospice), Barbara Williams (CEO Hospice West Auckland), Winsome Stretch (CEO Hibiscus Hospice) and Dr Mike Harris (Medical Leader Hospice North Shore). Also present were Catherine Spence and Trish Fleming (both Hospice West Auckland).

Corrections were noted to Figure 2 regarding Hospice workforce on page 51 of the agenda. A corrected chart will be circulated to CPHAC members.

Matters outlined by Lynda Smith (CEO Mercy Hospice) included:

- The joining up of the two DHBs' Planning and Funding teams had provided the opportunity to be part of this forum.
- Mercy Hospice had a 13 bed inpatient unit and an extensive community team. They are dealing with between 250 and 300 patients at any one point in time. Of these about 30% die at home; 30% in the hospice and 20% in a public hospital.
- There are a high percentage of Asian patients who tend to have a different focus, seeking acute medical care even in the last stages of life.

Matters outlined by Winsome Stretch (CEO Hibiscus Hospice) included:

- Hibiscus Hospice in Red Beach has been operating for 22 years. It supported a mix of rural and urban dwellers.

- A lot of time is spent in educating families about palliative care. There is also a comprehensive programme for educating GPs in the area.
- The incidence of death at home is quite high.
- Recently they had opened more and more outpatient clinics, with patients seeing the Hospice's specialist doctor there. Also they had developed a number of clinics at the hospice to save patients having to travel to hospitals, particularly for matters such as blood transfusions.
- A major focus is raising funds through events, appeals and functions. They also run four charity shops. Without them they would not be able to survive financially. Fortunately the local community is supportive.

Matters outlined by Barbara Williams (CEO Hospice West Auckland) included:

- The Hospice now has four specialist palliative care beds, which had been a big and significant step forward for them. They are very grateful for the people that support the Hospice, which is alive and well.
- They are starting to provide more extensive community services for the West.

Warren Flaunty advised the meeting that Barbara Williams has been CEO of Hospice West Auckland for ten years.

Matters outlined by Dr Mike Harris (Medical Leader, Hospice North Shore) included:

- The Hospice has been providing a service to the community since the 1980s.
- There had been a big change in the last 18 months, with a focus on increasing capacity and capability as best they can.
- About 39% of their patients die at home; 10 % in public hospitals and 20% in private hospitals.
- Progress has been made in restructuring teams and improving medical support. Having a pharmacist had made a big difference to them. They are generally using technology better than in the past, including iPads. There is closer, developing collaboration with community pharmacy.

The question was raised of the reliance on local fund raising and whether that is sustainable?

In response:

- Winsome Stretch advised that for the Hibiscus Hospice, Government funding is 42% and they have to raise 58% of their budget. Their inpatient unit is funded at 28%. This is not sustainable, despite the fantastic support from the community.
- Lynda Smith advised that Mercy Hospice is now having to raise at least 45% of their budget. They are looking at new models of care, such as a hub and spoke model of inpatient care. They are trying to provide a type of step down unit. Their biggest cost is staff.
- Barbara Williams advised that the Hospice West Auckland Board had approved a deficit budget of \$1.5M. They need to find a sustainable way of providing specialist palliative care. The volunteers want to support the Hospice, but fundraising is very hard and very competitive. They are working on new models of care.
- Mike Harris said that a key issue that they are facing is the increase in the older age groups on the North Shore, which will be astronomical over the coming years. The challenge is to increase capacity and capability and to do so by working smarter. Funding is a big issue and has been for a long time. The model is shaky, being so reliant on community donations.

Stephanie Muncaster advised that there would be further reports on Palliative Care, as part of a regular reporting cycle. Tim Wood advised that in future reports there would be more focus on clinical governance.

The Committee agreed to a suggestion from Lee Mathias that there be a recommendation to the DHB Boards that a report be prepared on the issue of ongoing sustainable funding for hospice services.

**Resolution** (Moved Lee Mathias/Seconded Max Abbott)

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

**That the Board request that a report be prepared for its consideration on the issue of ongoing sustainable funding for hospice services.**

**Carried**

The Hospice representatives were thanked for their attendance and for addressing the meeting.

#### **4.3 Report on ARPHS Local Alcohol Policy Submission to Council** (agenda pages 56-90)

William Rainger (Service Manager, Auckland Regional Public Health Service) and Angela Culpin (Programme Supervisor Health Promotion, Auckland Regional Public Health Service) were present for this item. An apology was conveyed from Dr Dennis Barnfather (Medical Officer of Health) who was unwell.

William Rainger outlined the background to the submission. He referred to the survey that ARPHS had commissioned in 2013, to inform policy and promote public engagement in the issues. He then outlined the substance of the submission as summarised on pages 56-58 of the agenda. The Council would now consider its decisions on submissions and those decisions would be open to appeal. ARPHS would be interested in members' views on how to influence the Council. They would also like to collate better data relating to the distribution of harm, including more information from Emergency Departments.

The meeting was advised of health promotion grand rounds being organised by ARPHS for DHBs. The second of these will be in November, featuring Professor Doug Sellman, Professor of Addiction Studies at Otago University.

Matters covered in discussion and response to questions included:

- The suggestion was made that ARPHS might wish to try to influence the Council through Open Forums held by local boards.
- It was noted that DHBs do have to work within the framework of the policies of the Government of the day, which includes a moderate stance on the issue.
- It was also noted that public health practitioners sometimes need to challenge the status quo in the interests of public health.
- As light relief Judge Noah Sweat's views on the "whisky Issue" were quoted (available on You Tube).

**Resolution** (Moved Jo Agnew/Seconded Judith Bassett)

**That the report be received.**

**Carried**

## **5. STANDARD MONTHLY REPORTS**

### **5.1 Planning, Funding and Outcomes Update** (agenda pages 91-127)

Debbie Holdsworth and Simon Bowen briefly highlighted some aspects of the report, including:

- The Fraud Hot Line update (pages 91-92 of the agenda).
- The great progress made towards achieving the national health targets by the PHOs.
- The first meeting of the new Alliance Leadership team had taken place on 24 July, moving forward constructively.
- The follow up review of the Office of the Auditor-General on their 2010 report into the availability of after hours services (attached to the agenda report as an appendix for information).
- The Primary Mental Health Project (pages 93-94 of the agenda).
- The DHBs' annual plans are currently with the Ministry of Health, with financial details being finalised.
- Annual reports are in the process of being compiled for both Boards.
- The work being done on obesity (page 99 of the agenda).
- The Unitary Plan Submission from ARPHS (attached to the agenda report).

In discussion of the report, the choice of the term "Health Integrity Line" for the Fraud Hotline was queried. Tim Wood said that the Audit and Compliance Team of the Ministry of Health had advised that they had gone through a community consultation process and found that this was a name that people could relate to.

**Resolution** (Moved Warren Flaunty/Seconded Allison Roe)

**That the report be received.**

**Carried**

## **6. General Business**

There was no general business.

## **7. PAPERS FROM CANCELLED MEETING ON 11<sup>TH</sup> JUNE 2014**

### **7.1 Long Term Conditions** (agenda pages 128-142)

**Resolution** (Moved Judith Bassett/Seconded Peter Aitken)

**That the report be received.**

**Carried**

**7.2 Community Engagement Update for Auckland and Waitemata DHBs** (agenda pages 143-146)

Imelda King (Community Engagement Co-ordinator, Waitemata DHB) asked for an opportunity for Anne Curtis (Health Link North) and Tracy McIntyre (Waitakere Health Link) to update the Committee.

Anne Curtis referred to:

- Working closely with the 18 consumer representatives that they have trained.
- The South Kaipara Festival of Health and Wellbeing (to be held on 20 September 2014) – this had come out of the locality planning and community engagement done in 2013. A community meeting at Helensville had wanted to know how they could help themselves and the idea had arisen of a festival bringing together all local health providers.

The Committee Chair thanked Anne Curtis and Tracy McIntyre for the work done by the health links, including coordinating the consumer review of DHB health information.

**Resolution** (Moved Max Abbott/Seconded Jo Agnew)

**That the report be received.**

**Carried**

**7.3 Primary Care Update Quarter 3, 2013/14** (agenda pages 147-172)

Tim Wood (Funding and Development Manager, Primary Care) updated the meeting by advising that for the Primary Health CVD target as at the end of the 2013/14 year, Auckland DHB had achieved 91.3%, the second highest of the DHBs, and Waitemata DHB had achieved 89.2%, the seventh highest. There had been a big push by the PHOs and the results reflected a huge amount of work.

Appreciation was expressed of the contribution by Ailsa Claire to this in terms of developing the relationship with the PHOs.

Dale Bramley advised that acknowledgement had been sent to the PHOs and the meeting agreed that this should also come formally from the Boards.

**Resolution** (Moved Lee Mathias/Seconded Allison Roe)

**a) That the report be received.**

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

**That letters of appreciation on behalf of the Board be sent to the PHOs for their work on the national Primary Health targets.**

**Carried**



**8. Resolution to Exclude the Public**

**Resolution** (Moved Warren Flaunty/Seconded Lee Mathias)

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
<p><b>1. Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting with Public Excluded 30/04/14</b></p>	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</p>	<p><b>Confirmation of Minutes</b></p> <p>As per resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</p>
<p><b>2. Co-opted member appointment</b></p>	<p>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</p> <p>[NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</p>	<p><b>Privacy</b></p> <p>The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.</p> <p>[Official Information Act 1982 S.9 (2) (a)]</p>

**Carried**

3.47p.m – Pat Booth retired from the meeting.

3.47p.m - 4.00p.m - Public excluded session.

The meeting concluded at 4.00p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 30 JULY 2014

\_\_\_\_\_ CHAIR

## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 26<sup>th</sup> August 2014

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 05/02/14	3.1	<u>Healthy Eating and Physical Activity</u> – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.	William Rainger	CPHAC 26/11/14	
CPHAC 30/04/14	4.4	<u>Palliative Care</u> – information relating to Eastern Bays Hospice to be obtained and reported to Auckland DHB.	Stephanie Muncaster/ Sarmila Gray	ADHB Board 17/09/14	Report prepared for ADHB Board.
CPHAC 30/04/14	4.5	<u>Preparing Consumer Information for Different Ethnicities</u> – report to be provided on how this is done, including information on websites and resource materials, and advising on whether how this is done needs more attention.	Tim Wood	CPHAC 15/10/14	
CPHAC 30/07/14	2.1	<u>Diabetes</u> – regional statistics relating to amputation of feet of diabetic patients to be brought back to CPHAC.	Stephanie Muncaster	CPHAC 15/10/14	Regional data not currently available. Should be completed by October or November meeting.
CPHAC 30/07/14	3.1	<u>Tobacco Control</u> - presentation attended by Tracy Walters relating to children and smoking to be forwarded to Tim Jelleyman. - information on contractual reporting on quit rates at four weeks and three months to be provided to CPHAC.	Tracy Walters  Leanne Catchpole	  CPHAC 03/09/14	Actioned.  Included in Planning and Funding Update
CPHAC 30/07/14	4.2	<u>Hospices</u> – corrected workforce chart to be circulated to CPHAC members.	Stephanie Muncaster		Please refer to corrected chart on next page.

	<b>Mercy Hospice</b>	<b>Hibiscus Hospice</b>	<b>Hospice North Shore (includes Warkworth and Wellsford)</b>	<b>Hospice West Auckland</b>	
Medical officers	60.5 FTE Clinical and support staff	2 FTE	4.8 FTE includes (pharmacist)	2 includes (pharmacist)	
Nursing		10 FTE	11.9 FTE	18	
Clinical Administrator		2 FTE	4.63 FTE	7	
Counsellor		0.8 FTE			
Social Worker		0.7 FTE			
Spiritual care		0.6 FTE			
Bereavement care		0.2 FTE	9.2	19.1	10
Support services. Education and Administration					
Lymphoedema massage		0.1 FTE			
Kaiawhina		Contracted as required			
Fundraising and Retail staff	17.4 FTE		22.56 FTE / staff		
Community patient support	555 volunteers with 2/3 as retail staff within shops	Volunteers	1106 volunteers	432 volunteers	
Massage therapy		Volunteers			
Volunteer drivers		Volunteers			

## 4.1 Changing the Landscape of Childhood Vulnerability – An Inter-Agency and Community Challenge

### Recommendation:

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

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

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Prepared by: Ruth Bijl (Funding and Development Manager, Women, Children and Youth, Waitemata and Auckland DHBs), Dr Alison Leversha (Community Paediatrician, Auckland DHB) and Dr Tim Jelleyman (Community Paediatrician, Waitemata DHB)

Endorsed by: Dr Debbie Holdsworth (Director Funding Waitemata and Auckland DHBs)

### Glossary

ADHB	– Auckland District Health Board
CAP	– Children’s Action Plan
CYF	– Child, Youth and Family (a department of the Ministry of Social Development)
CYPF Act	– Children, Youth Persons, and their Families Act, 1989
DHB	– District Health Board
FACS	– Family and Community Services (a department of MSD)
HAC	– Hospital Advisory Committee
LMC	– Lead Maternity Carer (midwife of obstetrician)
MBIE	– The Ministry of Business, Innovation and Enterprise
MSD	– The Ministry of Social Development
NZ	– New Zealand
VC Act	– The Vulnerable Children Act 2014
ViKI	– Vulnerable Kid’s Information System
WCTO	– Well Child Tamariki Ora (e.g. Plunket)

### 1. Executive Summary

This paper provides an overview of recent government initiatives that aim to address childhood vulnerability. This includes the Vulnerable Children Act 2014. The paper describes implications for Auckland and Waitemata District Health Boards including our readiness to provide meaningful shifts in relation to childhood vulnerability. The presentation to the Committee includes a verbal brief from some partner agencies including New Zealand Police and Ministry of Social Development. It should be recognised that all babies and infants are vulnerable, though some are at significantly higher risk of poor outcomes due to the environment in which they live or other factors. Hence we need to ensure we have effective universal programmes along with other targeted initiatives to provide the support families and children need to thrive.

## 2. Introduction/Background

### 2.1. Childhood vulnerability

Childhood vulnerability is associated with factors that increase susceptibility to poor developmental and health outcomes. *Growing up in New Zealand* identifies twelve of these associated factors in their most recent report. Factors such as maternal depression, relationship status, maternal education, financial stress and over-crowding are examples of risk factors associated with vulnerability.<sup>i</sup>

Cabinet has defined vulnerable children as:

*“Children who are at significant risk of harm to their wellbeing now and into the future, as a consequence of the environment in which they are being raised, and in some cases, due to their own complex needs. Environmental factors that influence child vulnerability include not having their basic emotional, physical, social, developmental and/or cultural needs met at home or in their wider community.”*<sup>ii</sup>

The Government’s White Paper on Vulnerable Children outlined the complex relationship between risk and outcomes and noted that vulnerability may change over time as children’s circumstances change. It is also argued that vulnerability is cumulative with children exposed to multiple risks having an increased chance of poor outcomes.

### 2.2. The Green and White Papers

The Waitemata DHB’s Hospital Advisory Committee (HAC) was provided with information on the White Paper on Vulnerable Children in December 2012. CPHAC was provided with a paper on the main changes and new initiatives contained in the Children’s Action Plan that arose from the White Paper for Vulnerable Children in March 2013. To recap on these, the key themes from the current National Government’s Green and White papers on Vulnerable Children include:

- Defining vulnerability in relation to children and an agenda of reform to better protect vulnerable children.
- Development of an inter-agency Vulnerable Children’s Action Plan (CAP) requiring the Ministers and Chief Executives of Health, Education, Social Development, Justice, Police, Te Puni Kokiri and Business, Innovation and Enterprise (particularly Housing) to work together.
- Systems’ changes such as:
  - o A Vulnerable Kids Information System (ViKI)
  - o Legislated requirements regarding child protection policies for agencies, including DHBs and their contracted providers, including mandatory staff checks
  - o Shifting public opinion and attitudes regarding protecting and nurturing children
  - o Improved inter-agency working through local Children’s Teams.
- A legislative framework through passing of a Vulnerable Children Act (the VC Act) and amending the Children, Young Person’s and Their Families Act, 1989.

### **2.3. The Children’s Action Plan: Identifying, Supporting and Protecting Vulnerable Children**

The Ministries responsible for the Children’s Action Plan (CAP) set the programme for change in 2012 through an action plan. This lists ten primary actions “designed to reduce the impact of exposure to early life vulnerability so that every child born in New Zealand today can ‘thrive, belong and achieve’”<sup>iii</sup>. It should be noted that children who are subjected to maltreatment and/or where there are clear child protection issues will still be managed under the Children, Young Persons and Their Families Act 1989 by Child, Youth and Family, as they are currently.

The actions contained in the CAP are:

1. Children at the centre of what we do
2. Working together, sharing the responsibility
3. Finding, checking and connecting
4. Focusing on what works
5. Protect and respond
6. Professionals helping children
7. Dealing with abusers
8. Mentoring and supporting
9. When agencies get it wrong
10. Reporting child abuse.

In March 2013, CPHAC was provided with an update of progress by the DHBs against these domains. This update also provided an overview of additional activities in ADHB and Waitemata DHB that align to and support the implementation of the Children’s Action Plan.

Activities included the Shaken Baby Prevention programme (ADHB) and Crying Baby programme (Waitemata DHB); information that both DHBs had child protection policies and procedures in place; and that both DHBs had a family violence screening programme in place which included child protection training.

Also embedded in the CAP was a legislative agenda “which puts in place a child-centred approach and tough new laws to protect children”<sup>iv</sup>. Under the heading “children at the centre of what we do” is the introduction of the Vulnerable Children’s Bill.

### **2.4. The Vulnerable Children Act 2014**

The Vulnerable Children’s Act was passed into law on 30 June 2014. Provisions come into force on 1 July 2014 with a staged approach over the next four years for some provisions. The Act has three parts:

1. Governance priorities for vulnerable children and a vulnerable children’s plan
2. Child protection policies
3. Children’s worker safety checking.

#### **Part 1: Governance and the vulnerable children’s plan**

The purpose of part one of the Vulnerable Children’s Act is to “support the Government’s setting of priorities for improving the well-being of vulnerable children; and ensure that children’s agencies work together to improve the well-being of vulnerable children” (Part 1, section 4). In the interpretation, the Vulnerable Children’s Act clarifies that “improving the

well-being of vulnerable children ... means promoting the best interests of vulnerable children (having regard to the whole of their lives), including ... taking measures aimed at:

- Protecting them from abuse and neglect
- Improving their physical and mental health and their cultural and emotional well-being
- Improving their education and training and their participation in recreation and cultural activities
- Strengthening their connection to their families, whanau, hapu, and iwi, or other culturally recognised family group
- Increasing their participation in decision making about them, and their contribution to society
- Improving their social and economic well-being.” (Part 1, section 6).

The Chief Executives of the children’s agencies must agree a vulnerable children’s plan and report on its implementation annually.

### **Part 2: Child protection policies**

District Health Boards (DHBs) are required to have a child protection policy which covers identification and reporting of suspected abuse or neglect. (Mandatory reporting was not passed in legislation). DHBs must also require contracted providers of children’s services to develop and implement child protection policies.

### **Part 3: Children’s worker safety checking**

Children’s worker safety checking aims “to reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked” (Part 3, section 21). Contact need not be face-to-face (i.e. it may be electronic). Safety checks for new staff are now a requirement. For existing staff, checks must be performed within three years. If a children’s worker has been convicted of a specified offence, they cannot be employed as children’s workers and if they are employed, their employment must be terminated, following a brief suspension. The person’s identity must be checked and a risk assessment undertaken. The legislation, in so far as it relates to health services, covers: staff employed in public hospitals; publicly funded medical practices or facilities including outreach clinics and mental health services; medical practices associated with PHOs; services provided by health practitioners; Well Child Tamariki Ora (WCTO) services; home-based disability support services; residential disability support services; ambulance services; and maternity services including midwives and lead maternity carers (LMCs).

There is a range of specified offences listed under the Act. Specified offences which necessitate a children’s worker’s dismissal or ineligibility for employment include offences such as sexual assault related convictions including grooming, abandoning a child, murder, manslaughter, killing an unborn child, wounding with intent, assault on a child, discharging a fire-arm (with intent), possession of objectionable material (Schedule 2).

In addition to the Vulnerable Children’s Act 2014, the Children, Young People, and their Families Act, 1989 has been amended. In the situation where a baby is born to a parent who has previously been seriously abusive, the parent will have to “demonstrate that they are safe to parent the new child. ... CYF will make a safety assessment”.<sup>v</sup>

## **2.5. Establishment of Children’s Teams**

Children’s Teams are being introduced under the Children’s Action Plan with two demonstration sites in year 1 (2013) and rolled out fully by the end of Year 3 (2015). The first two sites, Rotorua and Whangarei, have been assessed by the Social Policy Evaluation and

Research Unit (SuPERU).<sup>vi</sup> Further sites were identified for implementation in 2014/2015 including Clendon / Manurewa / Papakura in the Counties Manukau district. CMDHB is expected to have their site operating in March 2015.

The SuPERU assessment identified five components for success including:

1. *“Planning and Development: establishing a collective vision and agenda*
2. *Partnership: building strong connections within and across sectors*
3. *Implementation: building a service that can operate effectively and have support at the local level*
4. *Systems change: making the necessary big changes in key areas of the system to enable holistic children-centred practice*
5. *Scaling up: working on the longer term changes needed to make the model sustainable and effective.”*

The assessment concludes that the model requires “a lot of energy to activate because change is required *within* existing agency/service and professional systems as well as *between* these systems”<sup>vii</sup>. In particular the assessment concludes that:

*“Significant changes are required to current systems and structures to support a successful national integrated service. While there is evidence that progress on information-sharing is occurring, the importance and degree of challenge in addressing resourcing and accountability measures should not be under-estimated.”*

The assessment identifies particular issues associated with workforce capacity and with integration of information systems, funding arrangements and workforces.

For the metro Auckland district there is concern in relation to scaling Children’s Teams, with estimates of vulnerable children ranging from 1000 – 3,000 and upwards per DHB. Current pilot sites have been actively case managing around 30 children. Other estimates suggest that all children who are notified to CYF and a number who do not meet that threshold can be defined as vulnerable and benefit from the intensive case management provided through a Children’s Team response. In that case, well over 5,000 children and young people in each DHB would need this intensive approach in order to mitigate the impact of their environment. If required, this level of intensive intervention is considered to be beyond current child health programme investment.

## **2.6. Auckland and Waitemata DHBs’ readiness to positively change the landscape of childhood vulnerability**

### ***Current work programmes***

A significant amount of work has been going on to prepare the DHBs for the Vulnerable Children’s Act and the Children’s Action Plan (CAP). Examples of this, rather than an exhaustive list of activities, follow.

### ***Inter-agency collaboration:***

- **Whanau ora** – an interagency response to the provision of health and social services designed to build the capacity of families and whanau. Whanau ora empowers whanau as a whole, rather than focusing on individuals and their problems.<sup>viii</sup>
- The **Child Health Stakeholder Advisory Group (CHSAG)** has been sharpening its focus under the umbrella of the Children’s Action Plan (CAP). Police, MSD, CYF, Education as well as health stakeholders participate in this metro Auckland group. Recent meetings



under the CAP heading have included family violence; childhood information systems and information sharing; Waitemata DHB Te Aka Ora - Vulnerable families forum and ADHB vulnerable pregnant women's groups; and updates on the Children's Teams pilots. This group was also instrumental in shaping the ADHB and WDHB Child Health Improvement Plan. The Plan's goals include that: "Infants and children have the highest attainable standard of health and equity of life expectancy," and that, "Parents are confident, knowledgeable and supported to nurture".

- **Child and Youth Mortality review groups (CYMRG)** – an interagency group which reviews factors around a death that may reflect system issues and which, if amended, could reduce the risk of the same event occurring in the future. The CYMRGs involve people from the DHB including mental health services, Police, Ambulance, Ministry of Education, CYFs, Victim support, Shine\*, Well Child Tamariki Ora services and other agencies as required.
- **School-based health services** - delivering health services in low decile secondary school settings.
- **Social Sector Trial** in Ranui – an inter-agency response including Police, Justice, Health and Education focused on improving youth health outcomes.
- **Child protection teams** – working with CYF and Police in hospital settings
- **CYFS liaison workers** – working in hospital settings to provide advice and an immediate response if required.
- **The Gateway programme** – health needs assessments undertaken on children and young people entering care.
- The **Rheumatic Fever** Prevention and Intervention Programme (a Better Public Service Target).
- **Cross sectoral CYFs & Metro CAMHS Governance Group** The group have agreed and implemented principles of working together and meet regularly to address the needs of specific children and young people with complex needs.

*Better intra-agency connectivity:*

- **Te Aka Ora - Vulnerable families Forum and Vulnerable Pregnant Women's Group** - identifying high need families during pregnancy, sharing information between providers and supporting families by linking them with key local agencies.
- Midwifery/ WCTO transition and Family Start group – a pilot to better connect services and transitions for vulnerable pregnant women.

*Increasing the effectiveness of universal and targeted programmes*

- The **Immunisation coverage target** – designing a primary care system around making every child count
- The **Well Child Tamariki Ora** Quality Improvement Framework – shifting the focus to deliver core checks to all children and provide additional contacts where indicated
- **Violence Intervention Programmes** (Child Protection, Family Violence Screening and Elder Abuse)
- **Shaken Baby/Crying Baby/Gentle hands** programmes
- **Early engagement** in pregnancy care project
- Health and Addictions (COPMIA), improving access to youth alcohol and other drug (AOD) services through GPs, support for mothers of young children and pregnant women who have alcohol and drug issues has doubled and the Perinatal and Infant Mental Health work stream. Using the Children's Action Plan as an umbrella for redirecting service priorities is an opportunity for mental health services. Mental health is considered a key participant in positively changing the landscape of childhood vulnerability.

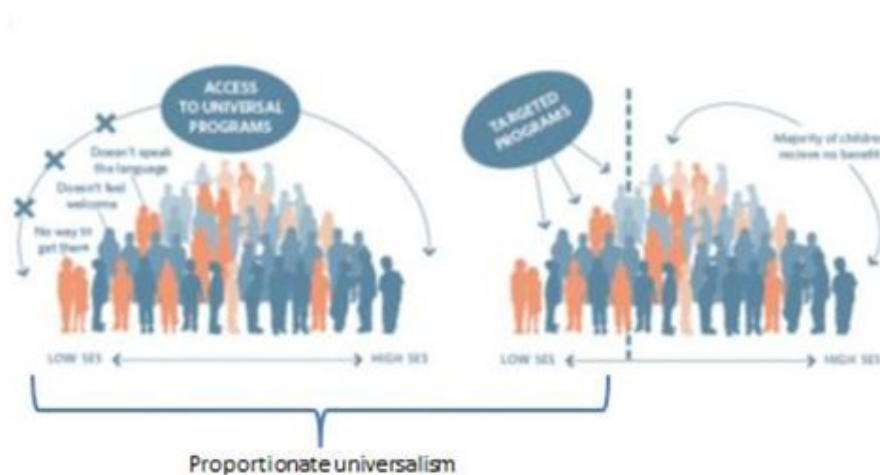
## 2.7. Getting our house in order – the challenge of re-orienting services within health

The Ministry of Health has been strongly encouraging DHBs to maximise access to and the effectiveness of our universal programmes. Effectiveness requires a shared vision, clarity of purpose, strong working relationships and meaningful communication between the DHB, PHOs, primary care, maternity and WCTO providers, and our Maori and Pacific Health Gain and Maori and Pacific providers. We have a solid foundation to work from in this regard. The increased focus on the effectiveness of our universal programmes is evident across the Maternity Quality and Safety Programme agenda in relation to early engagement in antenatal care (with a Lead Maternity Carer (LMC)); newborn enrolment with primary care initiatives; the immunisation target; the Well Child Tamariki Ora (WCTO) programme; and the B4 School Check programme.

Improving universal access to these programmes requires intensive review of the design, systems and processes as well as the introduction of targeted approaches to increase access for higher needs groups in the community. An example of this is the outreach component of the immunisation programme which supports primary care in finding, offering and administering immunisations to families who may not be engaged with a general practice.

This approach is described as proportionate universalism. Proportionate universalism aims to reduce inequity. Proportionate universalism, a concept proposed by Sir Michael Marmot, recognizes that there are vulnerable children in every socio-economic group, though a greater proportion live in the most deprived communities<sup>x</sup>. Cultural factors are also recognised as playing a very significant role in New Zealand. The investment associated with supporting the ten to twenty percent that are less readily engaged in health programmes is also proportionately higher. Getting the last few percent involves intensive efforts of teams in additional and generally more costly delivery models. This is a current focus of the DHBs. The concept of proportional universalism is shown diagrammatically below.<sup>x</sup>

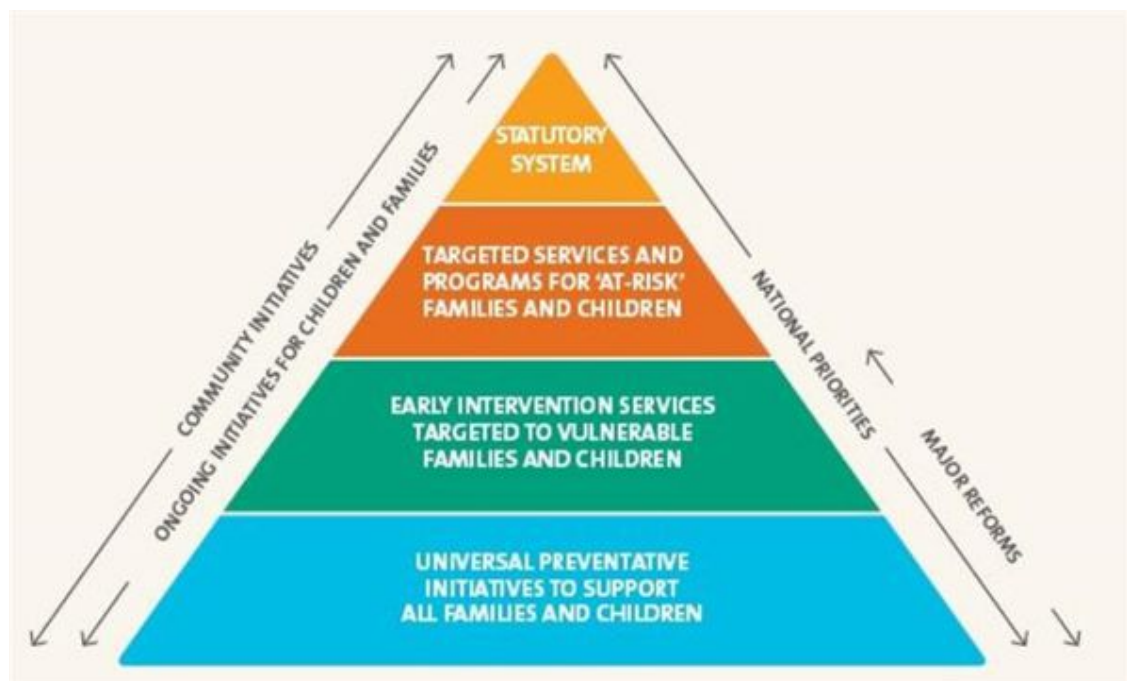
### Proportionate Universalism



In addition to ensuring that the more vulnerable are receiving the benefits of universal programmes, there are a range of targeted programmes. Examples of this include additional WCTO visits for children in families with high identified needs or the Rheumatic Fever prevention and intervention programme. Other examples include mental health services that target women with substance abuse problems.

In other countries, nurse-family partnerships have been used successfully to achieve better outcomes for infants living in higher needs communities. However, the success of the various home-visiting models is quite variable with only some having evidence of effectiveness.<sup>xi</sup> In New Zealand a similar programme to the nurse-family partnership is Family Start which is managed by MSD and delivered by NGO social work providers. The DHB is actively trying to better identify families that could benefit from this service and refer them to it.

At the highest end of need and targeting are children who have come under the statutory guardianship of the state under the Children, Young People and their Families Act. This pyramid of intervention and of risk is shown diagrammatically below.



### 3. Issues/Risks

It could be argued that our greatest challenge is in reducing levels of vulnerability. That is, through our universal programmes, intensive intervention programmes and inter-agency and community action, the very biggest achievement we could make is in reducing (eliminating) vulnerability such that children need not be removed from the care of their biological parent/s. This is what is signalled by the Better Public Service Target “Reduce the number of assaults on children”.

For health working with other sectors to deliver a strengths based response against this goal, a multipronged approach is required. This requires optimal functioning of the universal programmes for which we are responsible, improved targeting of activities and resources and

potentially the development of additional programmes such as parenting programmes, family violence prevention programmes, and nurse visiting programmes (in addition to effective information sharing). The community also needs to make the shift to collective responsibility for our most vulnerable by actively supporting the people around them; offering practical support when people are experiencing significant stress and speaking out before things go irreversibly wrong. This requires a whole of government (and whole of community) response. Healthcare teams have many people who want to make this difference and are doing so every day. But we cannot do it alone. Every agency and every individual needs to play a role if we truly want to live in a society where our most vulnerable do not experience the worst life has to offer.

We have asked colleagues from Child, Youth and Family, the New Zealand Police and from The Ministry of Social Development – Family and Community Services (FACS) to give you a brief verbal update on the role their organisations are playing in reducing childhood vulnerability and the challenges the Children’s Action plan presents their organisations.

Jenny Janif (FACS), Scott Leonard (NZ Police) and Barbara Thompson (CYF) will be in attendance.

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<sup>i</sup> Morton, SMB. Atatoa Carr, PE. Grant, CC. et al 2014. Growing up in New Zealand: A longitudinal study of New Zealand children and their families. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days. Auckland. Growing Up in New Zealand. University of Auckland.

<sup>ii</sup> Minister of Social Development. Publicly released Cabinet Paper on the White Paper for Vulnerable Children.

<sup>iii</sup> Morton, SMB. Atatoa Carr, PE. Grant, CC. et al 2014. Growing up in New Zealand: A longitudinal study of New Zealand children and their families. Vulnerability Report 1: Exploring the Definition of Vulnerability for Children in their First 1000 Days. Auckland. Growing Up in New Zealand. University of Auckland.

<sup>iv</sup> Children’s Action Plan. 2012. The Children’s Action Plan. <http://childrensactionplan.govt.nz/action-plan> accessed 07/08/14

<sup>v</sup> Children’s Action Plan. Legislation – Q and As. <http://childrensactionplan.govt.nz/legislation-/faqs> accessed 07/08/14

<sup>vi</sup> Social Policy Evaluation and Research Unit. 2014. *Assessment of the Design and Implementation of the Children’s Teams* to January 2014. Families commission. Komihana a Whanau.

<sup>vii</sup> SuPERU. 2014. Assessment of the Design and Implementation of the Children’s Teams Summary Report May 2014.

<sup>viii</sup> <http://www.tpk.govt.nz/en/in-focus/whanau-ora/>

<sup>ix</sup> Human Early Learning Partnership. 2011. Proportional Universality. Policy Brief.

<sup>x</sup> Human Early Learning Partnership. 2011. Proportional Universality. Policy Brief. Diagram.

<sup>xi</sup> See for example, <http://www.nursefamilypartnership.org/about/news/journals-and-reports> particularly “Which Program Models Identified by HHS As “Evidence-Based” Are Most Likely To Produce Important Improvements in the Lives of Children and Parents?” This concludes that “the Coalition for Evidence-Based Policy says Nurse-Family Partnership is the program model that has earned a “strong” level of confidence in producing meaningful outcomes among all HHS home visiting programs.”

## 4.2 Progress Update - Healthy Eating and Physical Activity in the Auckland Region

### Recommendation:

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

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

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Prepared by: Simon Bowen (Director Health Outcomes WDHB/ADHB), Dr William Rainger (Service Manager ARPHS), Dr Julia Peters (Clinical Director ARPHS), Dr Michael Hale (Project clinical leader) and Maggie McGregor (Public Health Contractor ARPHS)

### Glossary

ARPHS	–	Auckland Regional Public Health Service
DHB	–	District Health Board
ECE	–	Early Childhood Education
HBC	–	Heartbeat Challenge (Workplace Health Programme)
HFNZ	–	Healthy Families New Zealand
HPA	–	Health Promotion Agency
MoH	–	Ministry of Health
TANI	–	The Asian Network Incorporated
WHO	–	World Health Organisation

### 1. Executive Summary

- 1.1 This paper provides a progress report on the implementation of CPHAC resolutions of 5 February 2014 which supported greater priority being given to the promotion of healthy nutrition and physical activity, and asked that a co-ordinated and strategic approach be taken to the planning and delivery of these activities. Auckland Regional Public Health Service was asked to lead the development of a regional inter-sectoral action plan.

- 1.2 Over the past six months the priority has been given to developing collaborative working relationships with the range of partners involved, as building this foundation is essential in order to maximise available resources over the long term. The work has focused on five themes: strengthening leadership and co-ordination; improving food environments; prioritising children and young people; intersectoral policy work; and innovation and development.
- 1.3 Achievements of the period include:
- agreement to a shared healthy nutrition environments policy and guideline across the three Metro Auckland DHBs, developed as a result of a regional collaborative process (attached)
  - establishing a coalition of health service providers in the Auckland region to work towards the common goal of reducing the long-term impact of obesity on morbidity, disability and mortality
  - working with senior representatives from Auckland Council to develop mechanisms to collaborate on reducing obesity rates across Auckland at both policy and operational levels
  - further development of services in early childhood education settings and workplace health programme 'Heartbeat Challenge', and progress on new nutrition promotion services in each of the three DHBs' maternal and child health settings
  - public health submissions on a number of policy documents which will have an impact on supporting healthy nutrition and physical activity including:
    - The Auckland Unitary Plan
    - Guidelines for Preparing Regional Transport Plans
    - Inquiry into the determinants of health and wellbeing for Māori children
    - Options to reduce sugar sweetened beverage consumption in New Zealand
- 1.3 With the project now up and running, further investment will be made to ensure the momentum continues and to leverage new opportunities available through the establishment of the Healthy Family NZ programmes.

## 2. Introduction

This paper provides a progress report on the implementation of the resolution resulting from the committee's discussion on 05 February 14, as follows:

1. Note this paper follows on from, and is consistent with, a previous CPHAC paper "Improving Population Nutrition through Environmental Change" (18 July 2012).
2. Support greater priority being given to activities which promote healthy nutrition and physical activity and that a co-ordinated and strategic approach be taken to the planning and delivery of these activities.
3. Request that the Auckland Regional Public Health Service takes the lead in co-ordinating and drafting a regional intersectoral action plan.
4. Support applications for funding to the Ministry of Health and others in response to new funding opportunities being made available.
5. Request that the Auckland Regional Public Health Service bring back a report to CPHAC on opportunities for interventions in the production and promotion of products that influence levels of obesity. (*NOTE: this will be provided at the November meeting of CPHAC.*)

### **3. Summary of progress**

#### **3.1 Leadership and interagency/intersectoral collaboration**

Auckland Regional Public Health Service (ARPHS) is leading the development of a regional inter-sectoral action plan. Discussions with potential health sector and Auckland Council representatives (sport and recreation, cycling and walking networks, community development and safety) over the six months showed considerable support for collaboration. Senior representatives from Auckland Council have indicated they would like the Auckland Plan priorities to be more closely aligned with health sector priorities.

An ARPHS/DHB steering group has overseen the establishment of an interagency group which met in late July and will meet again in early September. The first formal meeting of this group was held on 29 July and was attended by representatives from the Ministry of Health, Auckland Council, Auckland Transport, the Heart Foundation, the Health Promotion Agency (HPA), Hapai te Hauora Tapui, the Asian Network, and Professor Boyd Swinburn from the University of Auckland. There was considerable support for working collaboratively to lead and enhance efforts to improve healthy eating and physical activity in the region through building coalitions and strengthening collective advocacy. A tentative list of priorities was identified, as follows:

- Healthy nutrition environments policies
- A focus on children and children's settings
- Supporting Healthy Families New Zealand once this new Ministry of Health programme is established in Auckland
- Increasing physical activity through environmental change.

These initial priorities are closely aligned with the priorities for action identified in the CPHAC paper of 5 February and included in the indicative workplan.

#### **3.2 DHB nutrition policies**

Over the last 18 months, representatives from all three of the Metro Auckland DHBs have developed an Auckland Region DHB Nutrition Environments Policy (the Policy) which will replace existing policy within the DHBs. The Policy demonstrates leadership by promoting health and well-being for all visitors and employees, strengthening an environment consistent with making healthy choices easy choices. Implementation of the Policy will mean DHB facilities in the Auckland region become healthier role models for the community with healthy food and beverage policies and other practices.

The Policy has been operationalised into the Auckland Regional District Health Boards' Guidelines for Healthy Food and Beverage Environments Policy 2014 (the Guidelines). The Guidelines have been prepared by the Food Service Managers of each DHB in conjunction with the ARPHS' public health dietitians. They are designed to enable the policy to be practically implemented in all vendors and premises across the DHBs.

On 30 July 2014, the DHB Nutrition Environments Working Group endorsed the Policy and approved the Guidelines pending a 3-month trial with three food vendors. The working group will meet again in mid-October to review the findings of these trials and make any improvements to the Guidelines necessary. The Policy and the Guidelines will be reviewed in August 2015.

Each DHB now needs to formally endorse and implement the Policy and the Guidelines. Counties Manukau DHB and Waitemata DHB representatives have indicated they would be implementing these immediately. Auckland DHB is in the process of determining its implementation process.

For Waitemata DHB, existing policy already contained most elements of the new policy. The old policy is now being updated to include the new areas.

### **3.4 Priority populations**

#### **(a) Early Childhood**

The *Pūrerehua* Co-ordinating Health Promotion for Early Childhood programme was developed following a review of ECE health promotion services, and has been operating from ARPHS for one year now. *Pūrerehua* aims to improve the health and wellbeing of children (0-5 years) through building service capacity.

Health outcome priorities are smokefree environments, good nutrition, oral health, increased physical activity and preventing childhood illnesses. This framework was also utilised in the successful Australian *Romp and Chomp: Increasing Community Capacity to prevent childhood obesity programme for early childhood*<sup>1</sup> which saw significant reduction in childhood obesity outcomes for programme participants, and which has informed the new Ministry of Health programme, Healthy Families NZ.

In its first year, the *Pūrerehua* team has lead and co-ordinated Phase 1 (November 2013 – June 2014) of the new Kahuku Professional Development Project (PDP) for teachers and the implementation of follow up support to improve health outcomes for children. Phase 1 outcomes include:

- 51 high need mainstream ECES prioritised for participation in the programme
- 2893 high need children enrolled in the prioritised ECES<sup>2</sup> participating in the programme.
- 48 (94%) prioritised ECES agreed to participate in the programme
- 39 (81%) ECES have participated in the first phase PDP
- 31 (61%) participated in baseline needs assessment,
- 37 (95%) ECES having developed Health Promotion ECE action plans
- 33 (72%) of action plans identified policy changes on key public health outcomes.

#### **(b) Workplace Health**

Heartbeat Challenge was established by the Heart Foundation in 1992 and ARPHS has delivered this workplace health programme since 2004. To join the programme, workplaces need to meet a number of eligibility criteria including: 50+ workers, a workforce with a high proportion of Maori, Pacific, and South Asian workers, and an average wage of NZ\$50k or less. The programme focuses on five areas: nutrition, physical activity, smoke-free, workplace wellbeing (which include work life balance and stress), and alcohol and other drugs. Workplaces/organisations work towards an achievement award by making robust sustainable health promoting interventions in all five areas.

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<sup>1</sup> De Groot, F.P., Robertson, N.M., Swinburn, B.A. and de Silva-Sanigorski, A.M. (2010) Increasing community capacity to prevent childhood obesity: challenges, lessons learned and results from the Romp & chomp intervention. *BMC Public Health* [online]. 10 (522), pp. 1-8 [Accessed 1 August 2012].

<sup>2</sup> <http://www.educationcounts.govt.nz/statistics/ece2>



There are currently 112 workplaces participating, with a total of approximately 57,750 workers in high deprivation areas throughout Auckland. Over half are manufacturing or industrial workplaces.

**(c) Maternal and Child Nutrition Services**

Over the past year seven public health services that promote maternal and child nutrition and physical activity have been established around New Zealand, including in each of the three DHBs in Auckland. The services focus on the following three public health priority areas:

- improving women’s health during pregnancy and the postnatal period through promotion of healthy eating and physical activity
- promoting healthy feeding of babies including encouraging and supporting breastfeeding
- promoting healthy feeding (including the introduction of healthy first foods) and physical activity of children at pre-school age.

**(d) Public health input to policy**

In collaboration with representatives from the three DHBs, ARPMS has made submissions to policy processes with potential for improving nutrition and increasing physical activity. These submissions have resulted in considerable improvements to public health-related policy and regulation, for example:

- 6 of the 8 recommendations on the South Auckland Public Transport Plan were adopted
- 11 of the 16 recommendations on the Draft Auckland Regional Public Transport Plan were adopted
- The majority (74.07%) of ARPMS recommendations on the Draft Auckland Plan were either fully or partially successful
- Over half (52%) of ARPMS recommendations on the first round of the Proposed Unitary Plan were either fully or partially successful.

**(e) Healthy Families New Zealand**

In May 2014 the Government announced it would be allocating \$10m per annum over four years for Healthy Families New Zealand (HFNZ), a new community-based programme with an initial focus on obesity prevention. Three of the ten development sites are in the Auckland region: Manukau Ward, Manurewa-Papakura Ward, and Waitakere Ward. A total of 430,581 individuals are covered by these sites, 30.43 per cent of the 1.415m people living in Auckland, and about half of those estimated to be covered by all ten HFNZ sites. The three pilot sites in Auckland were selected on the basis of “higher than average rates of preventable chronic diseases (such as diabetes), higher than average rates of risk factors for these diseases (such as smoking) and/or high levels of deprivation.”<sup>3</sup> However there are quite large areas of high deprivation, mainly in the Auckland DHB catchment, not included in the Auckland sites.

There are opportunities for using the ‘systems prevention’ approach underpinning HFNZ pilots, in developing the regional healthy nutrition and physical activity promotion approach. The significant increase in capacity that will result from the new programme will also present opportunities.

District health boards and public health units were excluded from the tendering process, but will be actively supporting and working alongside the new HFNZ providers. The aim is for programmes to commence in October this year.

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<sup>3</sup> Excerpt from Ministry of Health ROI material for Healthy Families New Zealand, March 2014.

## 4. Next steps

Following the successful initial meeting of the interagency group for addressing obesity, the priority over the next 6 – 12 months is to unite the group around raising the profile of healthy physical activity and nutrition in Auckland. The group shall give visibility to and raise the profile of the environmental causes of obesity, which in turn will provide leverage to address these proximal causes. This will be achieved through:

- Implementation of Metro Auckland DHBs' revised nutrition policy and guidelines, and promotion of adoption of organisational food policies by selected social sector agencies
- Development of regional inter-sectoral nutrition and physical activity planning
- Forging links from existing services to Healthy Families New Zealand. Identify opportunities to provide support and leverage activities
- Identifying population health indicators for physical activity and nutrition as part of the regional planning process
  - Developing a system for the monitoring of such indicators to follow progress in addressing obesity
  - A formal evaluation to track progress will be developed at a later stage in the process, using this initial work to inform development
- Improving connectivity and collaboration amongst the group to better align current approaches
- Production of a paper for CPHAC examining different options for supply-side interventions to improve nutrition in Auckland
- Develop a shared approach to communications and advocacy. This will include:
  - clear and consistent messaging from each organisation to reinforce the agreed messages
  - Conduct market research into motivating factors for behaviour change and key barriers and enablers to improve physical activity and nutrition

The key goal for the group in this timeframe is to improve the perception of the importance of healthy physical activity and nutrition in Auckland. This will provide impetus for action on obesity from all group members, but especially foster public support which will enable action on more proximal drivers of the obesity epidemic (e.g. creating a healthy nutrition environment, increasing physical activity as a part of daily transportation).

## 5. Conclusion

In the six months since CPHAC agreed to supporting a greater priority being given to planning for and promotion of healthy nutrition and physical activity, progress has been made in terms of building working relationships and establishing mechanisms for engagement. It is now important to build on existing services and identify new opportunities for impacting on rising levels of obesity in Auckland.

## APPENDIX ONE: Summary of progress

**Strategic Intent:** to reduce the long term impact of obesity on morbidity, disability and mortality rates.

**Strategic Approach:** to establish a regional framework and mechanisms for health and non-health agencies to collaborate on promoting healthy eating and physical activity.

Objective	Actions	Target / Milestone	Progress
1. Establish regional obesity prevention framework and interagency coordination group.	Initial workshop of key agencies	By 30/4/14	Completed
	Shared framework drafted to include:	By 30/6/14	Completed
	<ul style="list-style-type: none"> <li>• existing opportunities for greater collaboration,</li> <li>• programmes for enhancement or development,</li> <li>• shared key messages, and</li> <li>• a common approach to evaluation.</li> </ul>	Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures.	Completed
2. Promote and establish organizational food policies.	Food policy plans established and implementation initiated in all DHBs.	30/6/14	Completed
	Agreement to develop food policy plans with selected agencies.	30/6/14	
	Food policy plans drafted by selected agencies for sign off	31/12/14	
	Food policy plans commence implementation in selected agencies.	31/3/15	
3. Promote healthy eating and physical activity to prioritized populations.	Priority populations, settings, agencies and programmes identified.	30/4/14	Completed
	Support needs identified, agreed and resourced.	30/6/14	Under way
	Support and enhancement activities commenced.	Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures.	

<p>4. Promote healthy eating and physical activity through regional policy work.</p>	<p>Submission on Auckland unitary plan</p> <p>Agree priorities for collaboration with Auckland Council and Auckland Transport.</p> <p>Implementation of agreed priorities.</p>	<p>1/3/14</p> <p>30/6/14</p> <p>Agreed actions for implementation from 1/7/14 with quarterly reporting on agreed performance measures.</p>	<p>Completed</p> <p>Completed</p> <p>Under way</p>
<p>5. Develop and test innovative approaches to promoting healthy eating and physical activity.</p>	<p>Monitor regional activities and outcomes</p> <p>Evaluate specific programmes as resources allow.</p> <p>Develop funding proposals.</p>	<p>Quarterly reports.</p> <p>On case by case basis.</p> <p>Proposals submitted to DHBs (and other agencies) by 31/11/14 for consideration in 2015/16 funding process.</p>	

## 5.1 Primary Care Update Quarter 4, 2013/14

### Recommendation:

**That the report be received.**

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

### Glossary

A&M	- Accident and Medical Centre
AH+	- Alliance Health Plus
ALT	- Alliance Leadership Team
ARI	- At Risk Individual
ATD	- Access to Diagnostics
CAMHS	- Child and Adolescent Mental Health Services
CT	- Computed Tomography [radiology imaging]
DAR	- Diabetes Annual Review
DCIP	- Diabetes Care Improvement Package
DHB	- District Health Board
DVT	- Deep Vein Thrombosis
ED	- Emergency Department
GAIHN	- Greater Auckland Integrated Health Network
GP	- General Practitioner
IFHC	- Integrated Family Health Centre
IPIF	- Integrated Performance and Incentive Framework
LEGG	- Locality Establishment Governance Group
MoH	- Ministry of Health
MRI	- Magnetic Resonance Imaging [radiology imaging]
NETP	- Nurse Entry to Practice
NHC	- National Hauora Coalition
PHO	- Primary Health Organisation
PMS	- Patient Management System
POAC	- Primary Options for Acute Care
PPP	- PHO Performance Programme
QIT	- Quality Improvement Team
VDR	- Virtual Diabetes Register
VLCA	- Very Low Cost Access

### 1. Summary

As previously reported to the Boards a major highlight for this quarter was the extraordinary performance with regard to CVD/smoking advice targets for primary care and the exceptional contribution by the PHOs. This has been celebrated and acknowledged.

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

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

The immunisation and cervical screening performance has been removed from the score card along with the commentary. From now on they will be reported in a Child, Youth and Women scorecard and report which will be reported to the next Committee meeting.

## 2. Primary Care Scorecard

### **How to read the scorecard**

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

The bar will begin to show green when the target has been partially achieved. For most indicators, this is once 60% of the target has been met. If performance is achieving or better than target, the bar will display as a solid green line. For the Health Targets, the scale is more sensitive as any variance is deemed to be significant. The bar will only begin to show green once 80% of the target is achieved. Where the bar is blank, this reflects very poor performance against the target or where no data is available or no target has been set.

### **Summary Performance Against Targets**

#### *Priority One Targets*

Further detail on Auckland and Waitemata DHB's performance against these targets is provided directly after the scorecard.

#### *Service Delivery Targets*

For PHO enrolment, Auckland DHB is at 92% and Waitemata DHB 95%. Waitemata's total enrolment has increased by 1% on the last quarter. Asian enrolment rates (72% and 79% for Auckland and Waitemata DHB respectively) have seen a slight increase for both DHBs. However their enrolment is lower than those of other ethnicities. Māori enrolment rates have also increased slightly with Auckland DHB on 84% (up from 82%) and Waitemata DHB on 83% (up from 81%) since the last quarter.

## Auckland and Waitemata DHB Primary Health Care Scorecard

2013/14 Q4



### Improving Population Health Targets

For Diabetes Annual Reviews, Auckland DHB is sitting at 72% - which is a 5% increase from the previous quarter. Waitemata DHB is at 43% - which is a 2% increase from the previous quarter.

Diabetes Management has decreased slightly across both DHBs since quarter three. The % of Māori at Auckland with good diabetes management has decreased since last quarter's unusually high result. However overall there has been a significant increase since the beginning of the year. The results for Pacific at Waitemata DHB have also dropped after a particularly high quarter three result.

The DHBs continue to support service within general practice to improve health outcomes for Māori and Pacific people with diabetes. The DHBs will continue to work with the PHOs to ensure that the available resources are accessible to general practice and Māori and Pacific people.

## More Heart and Diabetes Checks Health Target Q4 2013/14

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

The 'More Heart and Diabetes Checks' results are produced by the PHO Performance Programme (PPP) and are as reported in the Ministry of Health (MoH) DHB performance tables. The quarter three denominators are 142,072 for Waitemata DHB and 152,894 for Auckland DHB. The denominator increased from quarter three by 1,081 for Waitemata DHB and 841 for Auckland DHB. The quarter four preliminary results are:

Auckland DHB 91.9% (139,537 people assessed)

- Total coverage ↑5.7% from quarter three. This is second in the country.
- Coverage for Māori ↑7.6% (to 88.3%) and for Pacific ↓6.7% (to 91.1%). Auckland DHB is third in the country for Māori coverage and is second in New Zealand for Pacific coverage.

Please note that the quarterly data and last  
Waitemata DHB 89.2% (126,768 people assessed)

- Total coverage ↑8.4% from quarter three. This is fourth in the country.
- Coverage for Māori ↑9.1% (to 83.4%) and for Pacific ↑8.9% (to 87.4%). Waitemata DHB is fifth in the country for Māori coverage and is third in New Zealand for Pacific coverage.

An additional 21,302 people are recorded as having had an assessment in quarter four than quarter three (8,431 for Auckland DHB and 12,875 for Waitemata DHB). The impact of the rolling cohort means that people are moving in and out of the age bands, and people assessed more than five years ago are adding to the number of required assessments.

The increase in assessments has been achieved through:

- Practice support to run outreach clinics
- Providing funding for phlebotomy and extra nurse resource
- Purchasing a Point of Care testing machine to collect blood results easily and used tools to identify patients who have not had a risk assessment
- Weekly target meetings at the PHO and practice level
- Virtual assessments through Patient Management Systems and Dr Info queries
- Text to remind and home visits to complete assessments.

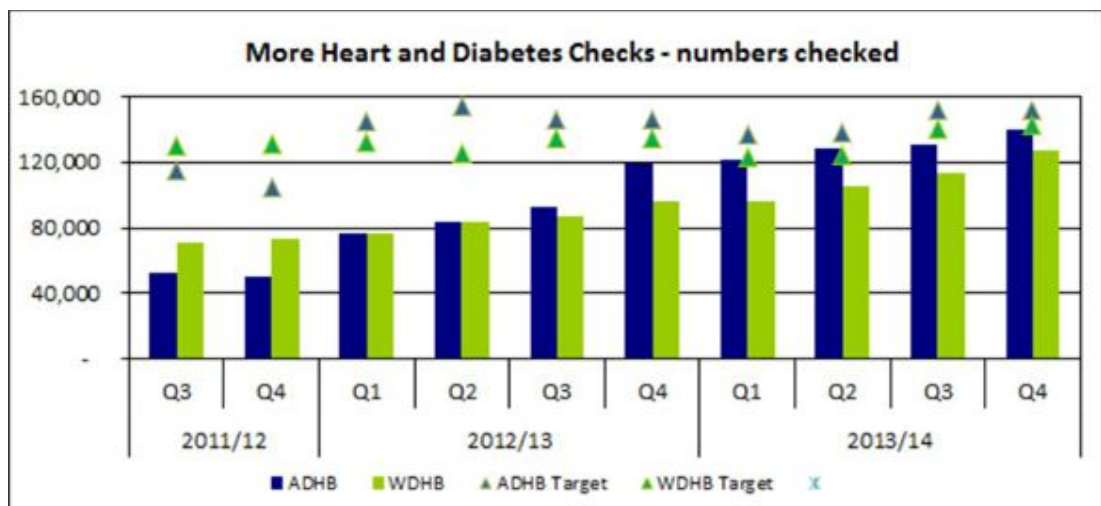
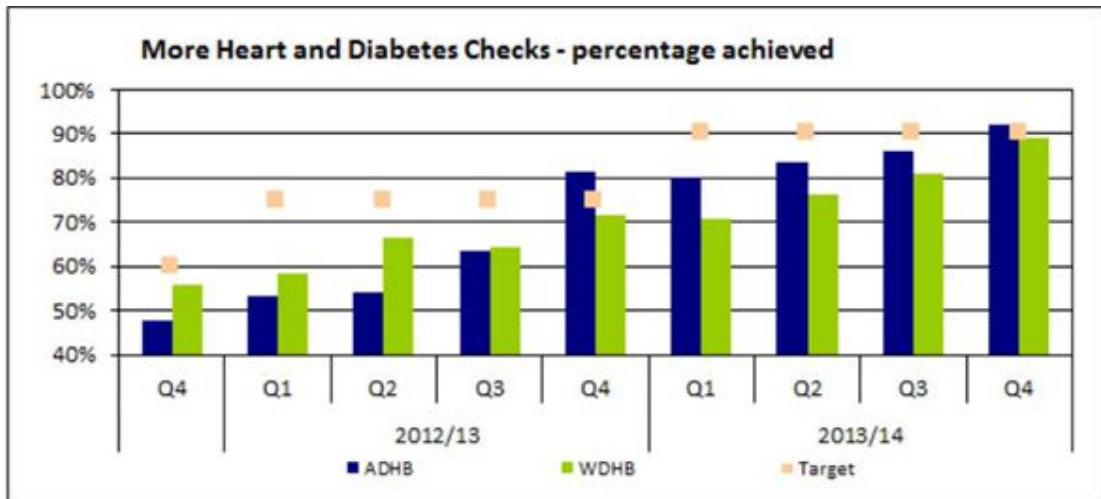
All PHOs will provide a plan to the Planning, Funding and Outcome team by September 1 on how they will work with practices to maintain the 90% and achieve the 90% target for Māori and Pacific people.

The latest estimated result for Auckland DHB coverage (July 1 to August 8) is 84%.

The latest estimated result for Waitemata DHB coverage (July 1 to August 8) is 87%.

Both of these results show a slight decrease on the quarter four results. This is due to a change in the eligible population. We expect the performance to get back to 90% by the end of the quarter. The Planning, Funding and Outcomes team continues to meet with the PHOs on a monthly basis to discuss coverage and activities undertaken to maintain the 90% target.





### Better Help for Smokers to Quit – Primary Care Health Target Q4 2013/14

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

The 'Better Help for Smokers to Quit' results are produced by the PHO Performance Programme (PPP) and are as reported in the MoH DHB performance tables. Both Auckland and Waitemata DHBs have achieved the primary care 'better help for smokers to quit' health target for the first time. All of the PHOs had a focus on achieving the target. They had project teams dedicated to ensuring that people that smoke received advice and help to quit. Their efforts have resulted in Waitemata DHB being ranked number one and Auckland DHB being ranked number two in the country for quarter four.

The final quarter four results were:

- Auckland DHB 99.7%, ↑32.6% from the previous quarter; and
- Waitemata DHB 101.5%, ↑37.4% from the previous quarter.

All PHOs are prioritising high needs populations in their programmes to support people to quit smoking. They are achieving a higher rate of advice and support to quit to their Māori and Pacific populations than the total population in both DHBs (see table below for actual results).

DHB	Māori	Pacific	Total Population
Auckland DHB	102.4%	100.92%	99.7%
Waitemata DHB	102.3%	103.5%	101.5%

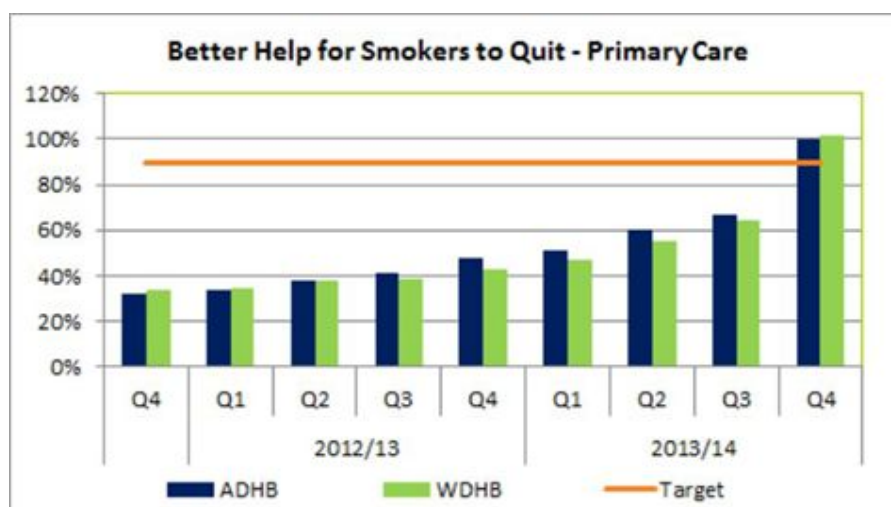
The PHOs are now planning their activities for 2014-15 to ensure sustainable achievement of the target. A focus of the plans will be on embedding providing support to quit as a clinical intervention that is part of 'usual care' for general practices.

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

The latest estimated result for the month of July for Auckland DHB and Waitemata DHB coverage is 95%.

As this target requires advice and support to be given annually, the number of people reached drops at the beginning of each quarter. This is because some people are now due to be given advice and support to quit again, and also a new cohort of younger people is added to the data base.

The sub-target of '90% of pregnant women are offered advice and support to quit smoking at confirmation of pregnancy with an LMC' is not yet being nationally reported. Waitemata DHB has set-up a DHB data reporting mechanism for this target and the result for quarter three was 99%. Auckland DHB is now working on implementing the same reporting mechanism, so that in future they will also be able to monitor their results.



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

#### Diabetes annual reviews

The diabetes annual review (DAR) targets for 2013/14 are:

- A minimum of 51% of people in Waitemata DHB with diabetes will have a DAR.
- A minimum of 90% of people in Auckland DHB with Diabetes will have a DAR.
- A minimum of 75% of people who have had a DAR will have an HbA1c of <64mmol/mol. HbA1c is a measure of blood glucose, and provides information of the control of the blood glucose over a three month period. Fasting blood glucose will provide information on what a person's blood glucose is at the time of the test.

DARs are measured against the MoH Virtual Diabetes Register (VDR). The VDR is an estimated population of people with diabetes calculated from health information, lab tests and pharmacy prescriptions.

The Diabetes Care Improvement Package (DCIP) provides people with diabetes and their primary health care providers with specific resources to assist in care. Each PHO has funding to provide services to their populations and they have worked with the DHB and practices to determine the most effective way to assist people in primary care. Each PHO service differs for this reason.

#### Waitemata DHB

- Waitemata VDR population is 26,535.
- 43% of the total population have had a DAR.
- 74% of the total population have an HbA1c of <64 mmol/mol.
- The DHB has seen a 2% increase in DAR since the previous quarter. However there has been a 4% decrease in good diabetes control as measured by HbA1c over the last quarter.
- There is an 8% difference between current performance and target for DAR. However this is an under estimate of actual performance. The DHB and PHOs continue to discuss reporting for DAR. As general practices move to the use of an 'advanced form' for diabetes within their patient management system, we will expect to see the number of recorded DARs increase. This may not be evident until the 2014/15 year.
- Services for the management of people with complex health needs related to diabetes continue in general practice through the Diabetes Care Improvement Packages. Both PHOs have services to assist general practice to initiate insulin. Additional education and support for people needing in-depth nutrition and self-management assistance is also available.

#### Auckland DHB

- Auckland VDR population is 23,649.
- 70% of the total population have had a DAR.
- 70% of the total population have an HbA1c of <64 mmol/mol.
- The number of annual reviews increased by 3% in the last quarter. However there has been a 3% decrease in good diabetes control as measured by HbA1c over the last quarter. We would expect to see an improvement in reported volumes once general practices move to the use of an 'advanced form' for diabetes within their patient management system.
- All four PHOs continue to implement their DCIP plans. The PHO's have been focused on ensuring people have their annual review. This includes meeting their PHO Performance Programme targets. The annual review includes a plan of care for the next year noting what medical and self-care activities will be worked on. This approach encourages general practice to work to improve diabetes control.

## Primary Mental Health

The service specification outlines a stepped care model to be delivered which is regionally consistent across Waitemata and Auckland DHBs where possible. The service, with the exception of the Prime Minister's Youth Mental Health Initiative, is targeted to Māori, Pacific and quintile 5 patients. The Prime Minister's Youth Mental Health Initiative is not targeted. Waitemata DHB and Auckland DHB have used similar service specifications for the adult primary mental health initiatives contracts with the PHOs.

Additional funding has also been provided by the MoH to target alcohol screening and brief interventions in primary care settings. This funding supports and extends interventions that are already in place as part of existing primary mental health initiatives. In Auckland DHB; Auckland PHO, NHC, and ProCare PHOs have contracts to develop the reporting mechanisms and practice nurse training to deliver alcohol screening and brief interventions. Alliance Health Plus (AH+) did not apply for this funding. In Waitemata DHB; Waitemata and Procure PHOs have contracts to develop the reporting mechanisms and practice nurse training to deliver alcohol screening and brief interventions. HealthWest utilised alcohol screening and brief intervention funding to deliver interventions.

### Waitemata DHB

- Work is on-going with the Waitemata PHOs to ensure the stepped care model is fully implemented, and the target population prioritised. A draft project implementation plan has been completed in partnership with ProCare, Waitemata DHB and Auckland DHB for establishment and refinement of a collaborative stepped care model, pilot in the New Lynn Integrated Family Health Care Centre. This will be evaluated to inform the potential to roll out across primary care.
- Work to increase integration between primary, secondary and NGO services is continuing. A pilot test for the collection of base-line data for the number of consult-liaison sessions delivered to primary is complete. Full testing with Child and Adolescent Mental Health Services (CAMHS) started in April 2014.

2013/14 quarter four volumes are as follows:

Ethnicity	Waitemata PHO	Procure	HealthWest	Total
NZ European	383	187	426	996
Māori	59	183	190	432
Pacific	14	60	73	147
Asian	37	15	16	68
Other	31	34	41	106
<b>Q4 Total</b>	<b>524</b>	<b>479</b>	<b>746</b>	<b>1,749</b>
<b>Q4 Expected Total</b>	<b>407</b>	<b>432</b>	<b>382</b>	<b>1,221</b>

- HealthWest provide primary mental health interventions to youth aged 10 to 24 years as part of the Waitemata Youth Health Hub.
- Please note that ProCare had significantly over-delivered during quarter one. Procure had carried an under-spend in primary mental health options from 2011/12 into 2012/13. The cumulative effect was that going into 2013/14, ProCare packages of care were oversubscribed. Contractually they are expected to manage volumes in such a way as to make packages available throughout the full year. ProCare, on advice from their board, are managing this situation internally.

### Auckland DHB

- The Primary/Secondary Integration Strategic Group and the linked Tāmaki Locality Mental Health Project continue to look at opportunities for increased integration between primary and secondary mental health services.

2013/14 quarter four volumes are as follows:

Ethnicity	Auckland PHO	ProCare	AH+	NHC	Youth Alliance	Total
NZ European	134	423	17	114	26	714
Māori	27	411	11	24	18	491
Pacific Island	22	292	19	12	11	356
Asian	38	150	8	60	7	263
Other	6	172	0	6	2	186
<b>Q4 Total</b>	<b>227</b>	<b>1,448</b>	<b>55</b>	<b>216</b>	<b>64</b>	<b>2,010</b>
<b>Q4 Expected Total</b>	<b>105</b>	<b>385</b>	<b>89</b>	<b>86</b>		<b>703</b>

- The Youth Alliance, led by ProCare PHO, provides primary mental health interventions to youth aged 12 to 19 years.
- Please note that this contract has now been changed to require PHOs to re-orientate services to Māori, Pacific and quintile 5 populations.

### Regional After Hours Network

A Network of 11 Accident and Medical (A&M) clinics open until at least 10pm, 365 days per year with reduced co-payments for under 6s, over 65s, high user health card, community services card and those living in quintile 5.

- The contracts associated with the Auckland Region After Hours Network have all been extended for a further 12 months until June 30, 2015.
- The After Hours business case has been completed and is in the process of being presented to the DHB Boards for consideration.
- There has been an independent evaluation of the After Hours Network. This has been undertaken by Dr Tim Tenbenschel, Health Systems, School of Population Health, Faculty of Medical and Health Sciences, The University of Auckland. The report is expected to be released soon.
- Utilisation data through to June 30, 2014 was not available for inclusion in this report.
- The following table shows the current opening hours of each of the 11 A&M clinics and the fees charged for eligible patients.

Current opening hours and fees for 11 A&Ms within the Regional After Hours Network

Suburb	A&M Clinic	Opening hours	Fees <sup>1</sup>			
			0-5	6-18	18-64	65 plus
Pukekohe	Pukekohe Family Healthcare	Closes 10pm	\$0.00	\$25.00	\$50.00	\$50.00
Takanini / Papakura	Takanini Care	Closes 10pm	\$0.00	\$17.00	\$34.50	\$29.50
Otara	East Tamaki Healthcare (Bairds Road)	Closes 11pm	\$0.00	\$11.00	\$17.00	\$17.00
Otahuhu	Whitecross Otahuhu	Closes 10pm	\$0.00	\$15.00	\$28.00	\$28.00
Botany	East Care	24 hours	\$0.00	\$35.00	\$39.00	\$40.00
Henderson	Whitecross Henderson	24 hours	\$0.00	\$30.00	\$38.00	\$38.00
New Lynn	Whitecross New Lynn	Closes 10pm	\$0.00	\$25.00	\$38.00	\$38.00
Remuera	Whitecross Ascot	24 hours	\$0.00	\$45.00	\$50.00	\$50.00
Three Kings	Three Kings A&M	Closes 10pm	\$0.00	\$35.00	\$43.00	\$40.00
Takapuna	Shorecare	24 hours	\$0.00	\$44.00	\$49.00	\$50.00
Glenfield	Whitecross Henderson	Closes 10pm	\$0.00	\$44.00	\$48.00	\$48.00

### Access to Diagnostics-Radiology

A regional Access to Diagnostics-Radiology steering group has been in operation since 2010/11. The group helps to ensure timely and regionally consistent access for primary care, to DHB funded imaging procedures. Clinical triage criteria have been developed by a cross-regional group of primary care and secondary care clinicians and radiology specialists. These criteria support general practice decision making to improve appropriate access to diagnostic investigations. The triage criteria have been incorporated into both the Regional CareConnect e-Referrals solution and ProCare's ProExtra form. ProExtra forms can be used by GPs for Auckland DHB and Counties Manukau DHB funded x-ray and ultrasound in community private practices. A budget is notionally allocated per practice to manage private practice referral spend. All other imaging is referred to the DHB Radiology department using CareConnect e-Referrals or faxed referrals.

### Primary Options for Acute Care (POAC)

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

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

- The total number of Auckland and Counties Manukau DHB POAC referrals (July 2013 – June 2014) were 22% below the target (see table below).
- Overall, the total referrals received increased by 5% from previous year.

<sup>1</sup> The fees for 0-5 years olds and 65 plus are for all patients within those age bands. The fees presented for 6-18 year olds and 18-64 year olds are for patients who are quintile 5, and/or high user health card or community service card holders.

- GP referrals have reduced and the lower volumes can be attributed to:
  - quality improvement processes
  - implementation of new and revised clinical pathways and policies
  - improved access to diagnostics across the region. This has resulted in reduced referrals to POAC for radiology requests. There is a risk however that these referrals to POAC will increase again as practices exceed their individual budget for Access to Diagnostics.
- Training and education in Auckland and Middlemore hospitals will continue. This has resulted in a significant increase in POAC referrals from the hospitals.
- Waitemata DHB volumes and budget were closely monitored and managed in quarter four to avoid budget overrun.
- St John transport expanded their service to include transporting patients to the GP/medical home in quarter one. The volumes for quarter two and three have been lower than anticipated. In response to this a 0.5 FTE position has been appointed for a period of six months. This role supports St John’s internal process development and education and acts as a clinical advisory role for the service. This will include reviewing of cases to identify missed opportunities and provide a feedback loop with the ambulance crews. The St John transport guidelines have been amended to support managing patients in a primary care location.  
At the end of quarter four St John referrals had increased in Waitemata and Auckland DHBs, however referrals decreased in Counties Manukau DHB. Overall, this was a 3% regional increase.
- The average cost per referral remains lower across the whole region compared with the same time last year. This can be attributed to changes in clinical policies and revised provider agreements. In addition, the percentage of lower cost St John pathway patients being referred has kept the average costs down.
- 86-87% of patients were safely managed in the community and avoided hospital presentation.
- The number of POAC referrals from the Auckland regional hospitals to support discharge continues to steadily grow. At the end of quarter four this has increased 41% across the region.

POAC referrals for Metro Auckland DHBs (July 2013 – June 2014)

<b>POAC referrals</b>	<b>Auckland</b>	<b>Waitemata</b>	<b>Counties</b>	<b>Total</b>
Target number of POAC referrals	6,036	6,519	12,312	24,881
Actual number of POAC referrals	4,105	7,891	7,499	18,123
Difference between target and actual	-1,931	1,372	-4,813	-6,758
Avg cost per referral (budget \$200.00)	\$181.94	\$167.53	\$189.67	

## e-Referrals

Phase 1: Increase uptake of e-Referrals by general practitioners and implement referral templates for remaining procedures.

Phase 2: Switch on electronic triaging of GP referrals to specialist services.

- Phase 1 of the eReferrals project was to develop GP forms across the Auckland region. This phase is complete. Forms for all services have been regionally agreed. The only exception to this is Mental Health forms, which are being discussed this quarter.
- In Waitemata, electronic forms are being used by GPs in increasing numbers to make referrals to secondary care. Trend analysis reporting is currently being developed which will track GP uptake of eReferrals. Services that are receiving a high proportion of eReferrals (about 75%) are Dermatology, Gynaecology and Rheumatology.
- The eReferrals project is now in Phase 2 which is enabling electronic triaging of referrals generated by GPs to specialist services. This will deliver significant benefit to GPs by improving triaging times, and messages back to GPs about the outcome of triage. It is also possible to request and receive specialist clinician advice via the eReferrals messaging function.
- Rheumatology and Paediatrics were the first services to adopt electronic triage. Cardiology and Skin Lesion will be adopting electronic triaging within the next few weeks.
- A phased plan for electronic triage has been agreed. The next services to go live will include Fertility, Midwifery, Gynaecology, Varicose Veins, and the Addictions service.
- Gastro, ORL, Respiratory, Infectious Diseases, Renal and General Medicine services plan to adopt electronic triage before the end of 2014.
- This will improve efficiencies in the hospital for referral management. It will result in faster turnaround and great visibility of referral outcomes for GPs.
- The Regional eReferrals Group has signed off plans for Phase 2.3 which will deliver functionality for Inter and Intra referrals.
- The group has also signed off a number of enhancements to the current system. Enhancements include better messages to GPs and the ability to add an Addendum to an existing referral.

## Northern Region Clinical Pathways

Clinical pathways are a tool to promote and optimise organised and efficient care. This allows for patient focused evidence based best practice. By application of agreed process management, pathways provide continuous quality improvement and standardise care processes. This re-centres focus on the patient's overall journey and stands as an indicator of the care a patient is likely to receive.

- 45 pathways have been completed and uploaded to the live site [www.healthpointpathways.co.nz](http://www.healthpointpathways.co.nz)
- An additional 12 pathways are currently in development.
- The At Risk Individual (ARI) pathway has gone live for Counties Manukau Health to support the ARI programme.
- The evaluation of the Deep Vein Thrombosis (DVT) pathway is still underway.
- The pilot of the clinical pathway enabler tool commenced August 11 for eight practices (2 per DHB). Milford Family Medical Centre and Whangaparaoa Medical are the two practices in Waitemata DHB. Marsden Medical and Avondale Family Doctor are the two practices in Auckland DHB.



## Localities

Earlier in 2013 the Locality Establishment Governance Group (LEGG) approved the boundaries of localities as those of local board areas. Tāmaki, West Rodney and West Auckland were identified by the LEGG as the three focus areas across Auckland and Waitemata DHBs.

### Tāmaki

- Following a pause in the project work through May and June, work is now underway to put the project through the co-development phase.
- Taking the content from the extensive co-design process, an expanded working group has been formed consisting of leaders from the NGO, Mental Health, Primary Care sectors and the community.
- A co-production framework is currently being developed to ensure that the development and implementation of service improvements is authentically co-produced from the outset.
- Community partners are currently being recruited to join the working group to ensure a balance between providers and community. Funding resource has been made available to support the community's participation in this work.
- A submission has been lodged with the Council Local Board for consideration around the 'Wellbeing Hub' that was proposed during the co-design process. The Local Board Plan for the next three years is currently going through a final submission process. The 'Hub' concept needs to be included for consideration.
- An evaluation framework is currently in development. This will likely be comprised of a hybrid between developmental evaluation running alongside a Plan, Do, Study, Act (PDSA) process.

### West Rodney

- The Auckland North Clinical Director resigned from post and finished at the end of May. Consideration is now given to what skills are needed to support the locality work.
- Progress continues against the two initial West Rodney projects: child oral health and access to services
- Child Oral health project
  1. The goal is to connect services and inform families/whānau of the importance of oral health and services available to them. The aim is to improve child oral health outcomes for West Rodney communities.
  2. A literature review was completed to help inform this project. The review focused on reviewing community based oral health initiatives with a focus on rural, isolated, Māori, indigenous, low socio-economic population. The review also included speaking with the Helensville District Health Trust and reviewing models of health promotion relevant to Maori.
  3. We continue to work with the Auckland Regional Dental Service and decision support to establish appropriate baseline data and agree on-going reporting.
  4. A health literacy process is underway to review the oral health information provided to this community.
  5. Initial work has begun in investigating the feasibility and benefits of implementing a single new-born enrolment process. This would raise awareness for families about services they are entitled to and enable services to work together to support families. The enrolment process would cover general practice, NIR, oral health, well child providers and new born hearing screening.

- Access to services project
  1. This project needs to be further scoped; however the broad goal is to improve access to hospital services for West Rodney communities.
  2. All six West Rodney practices were visited during quarter four to further scope this work. These meetings were well received and a number of areas identified by the GPs to focus on improved access. A further combined meeting was held at the end of July to further discuss and prioritise the services identified.
  3. Implementation Support Group (ISG) funding has been made available from the Ministry of Health to support integration between primary and secondary care. Meetings have been facilitated by the DHB between the West Rodney practices and the Implementation Support Group (ISG) Sapare to understand what is required and decide whether they would like to participate. At this stage three of the six practices are interested in participating.
  4. A follow up forum was held in Parakai on June 17. The forum provided an opportunity to feedback to this community what they told us last time and how the feedback supports the two initial locality projects. Additional topics included health literacy, the Auckland Regional Dental Health Services and the upcoming changes to the Healthpoint website. Two workshops were run to help inform the child oral health project and the redevelopment of the Healthpoint site. This was a great event and we well received by those that attended.
  5. Members of the team met with the Rodney Local Board and the Helensville District Health Trust Board to further engage with locality planning.

#### **West Auckland**

- The focus continues to be the two clinical workstreams: diabetes and child health. The secondary care specialists involved in the workstreams are providing governance and leadership for the integration work. LEGG has requested that the clinical workstreams are put forward to the Metro Clinical Governance Forum once established. The first meeting occurred at the end of June.
- The West Auckland Diabetes working group continue to support three priorities with a focus in New Lynn initially;
  1. *The implementation of the Quality Improvement Team (QIT)*. Recruitment was finally successful with a Registered Nurse accepting the position and starting in July. An orientation plan has been put in place. A project plan for the implementation of the QIT is underway. Twelve West Auckland practices have been prioritised to work with the QIT to improve diabetes care focusing on Māori and Pacific populations. The project and the nurse have been introduced to the practices through a letter and site visits accompanied by the PHO.
  2. *The development of an integrated diabetes model of care*. A number of lunchtime educational sessions have been held in Totara Health, New Lynn since the pilot began in October 2013. Practice GPs and nurses are invited to attend the consultation with the specialist to support up skilling. To date these have not been well attended, therefore alternate options are being considered for patients and practices within the wider cluster. Options include virtual clinics or chart reviews, the use of care plans and shared care tool and nurse specialist clinics. There are now Diabetes Nurse Specialists offering clinics within Whānau House, Henderson and Totara Health, New Lynn. The Whānau House service has a particular focus on Māori patients. Work is underway to support wider integration between the DHB diabetes service with the primary care practice in the centre, and social services provider Waipareria. There has been agreement to share the list of patients who have high HBA1C. This will enable all providers to work collectively to provide consistent messages and wrap-around support for these patients.

- The child health working group has parked its project scopes as much of the work was progressing through the Greater Auckland Integrated Health Network (GAIHN). This is in terms of development and the implementation of the asthma and cellulitis pathways. Since the closure of GAIHN in June the work programme has transferred into a regional work programme led out of Counties Manukau Health. To gain wider stakeholder engagement, work has since shifted to:
  1. the development of an outcomes framework
  2. focus on the required interventions to improve child health (such as improve access to care, improve health literacy, reduce exposure to smoke and improve insulation).

#### 4. Primary Care Nursing

Auckland DHB and Waitemata DHB both run a Nurse Entry to Practice (NETP) programme for nurses wanting to begin their career in a primary health setting. The programme is approved by the Nursing Council of New Zealand and is focused on helping new graduates to achieve competence as soon as possible.

##### Waitemata DHB

- 12 primary health care new graduates started with the NETP programme in February in a variety of primary care settings. These graduates are now commencing the Auckland University of Technology post graduate paper. Three of these are funded by the MoH very low cost access (VLCA) funding to support new graduate nurses in VLCA practices. One is funded with MoH aged residential care funding.
- The four new graduate nurses who started in September 2013 have submitted their level two portfolios for assessment. This completes their new graduate programme.
- The recruitment process is underway for the September 2014 intake. All the new graduates are supported by the Waitemata DHB Primary Health Care Nurse Educators.

##### Auckland DHB

- Four new graduate nurses started in February with three supported by the MoH VLCA funding. These new graduates are commencing the University of Auckland post graduate paper. All these graduates are supported by the Auckland DHB NETP Programme.
- Recruitment is underway for the September 2014 new graduate intake.

##### Combined Auckland and Waitemata DHB Primary Health Care Nursing Reference Group

- This group is now well established and includes nursing leaders across the Primary Health Care sector. This includes representatives from PHOs, NGOs, School Nursing, District Nursing, Public Health Nursing, University Schools of Nursing and Plunket. The group is currently working on developing a Primary Health Care Nursing strategy.

#### 5. Primary care operational issues

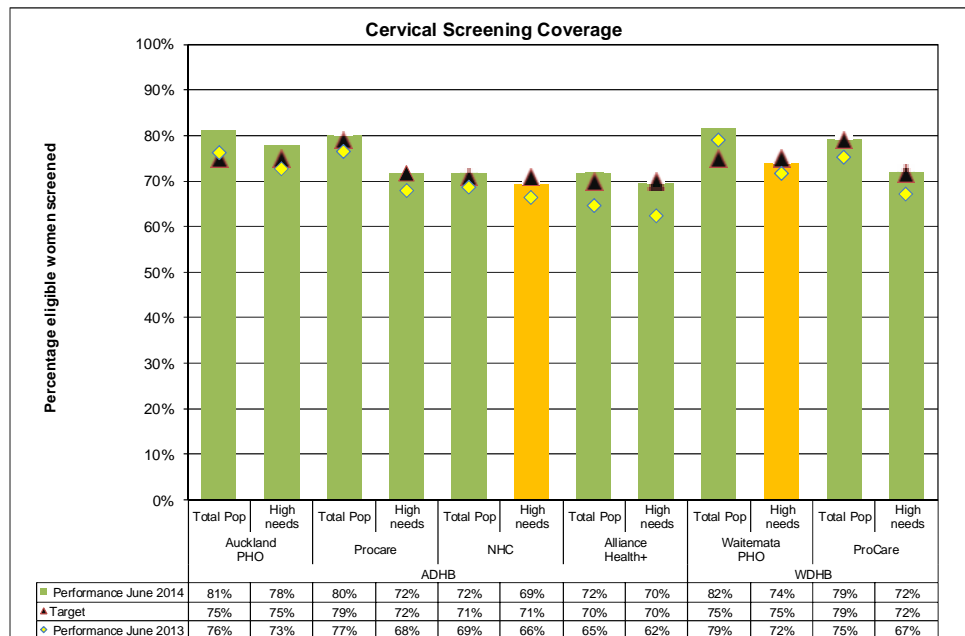
##### PHO Performance Programme

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

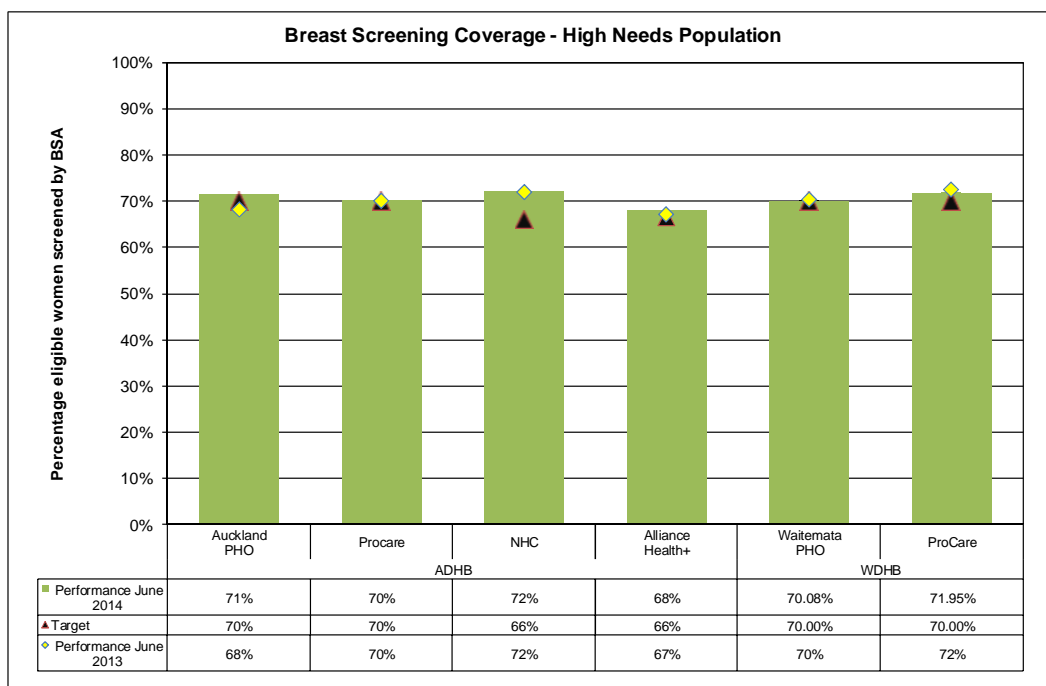
This performance programme is soon ending and will be replaced by the Integrated Performance and Incentive Framework (IPIF).

The graphs below show performance at quarter four 2013/14, compared to target and historical performance (quarter four 2012/13).

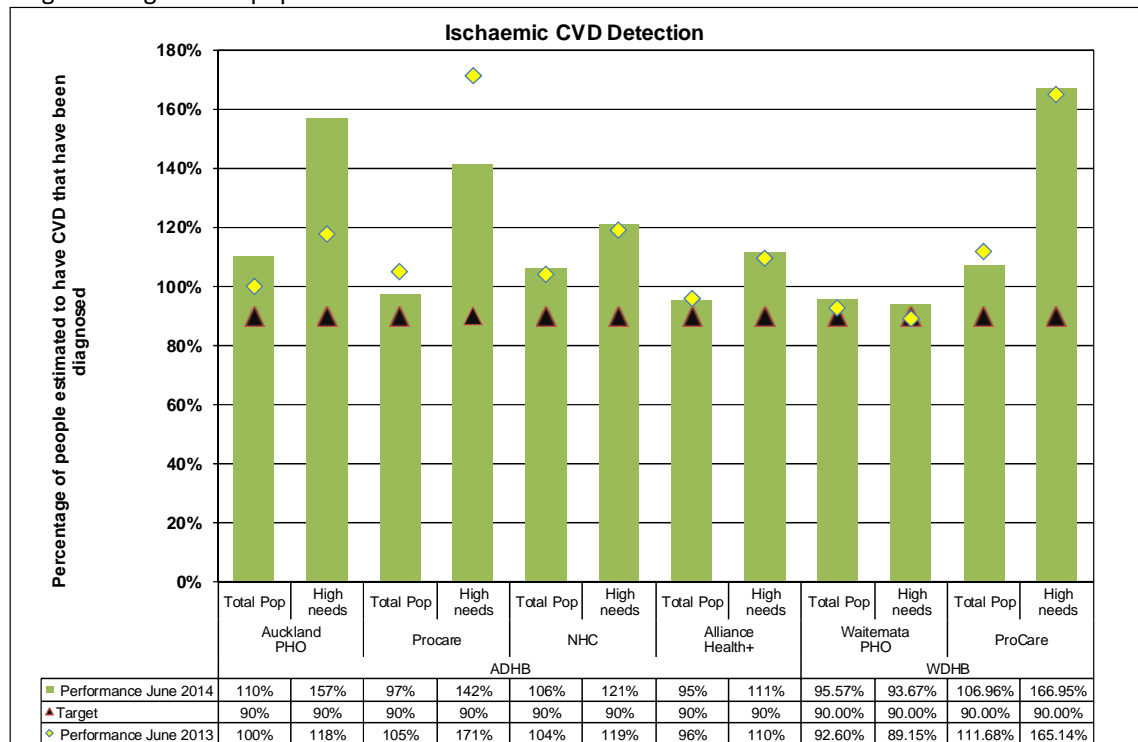
The graph below shows 'Cervical Screening Coverage' across Auckland and Waitemata DHB PHOs. All PHOs met the total population target in quarter four, however the National Hauora Coalition (NHC) and Waitemata PHOs' high needs populations were slightly under target.



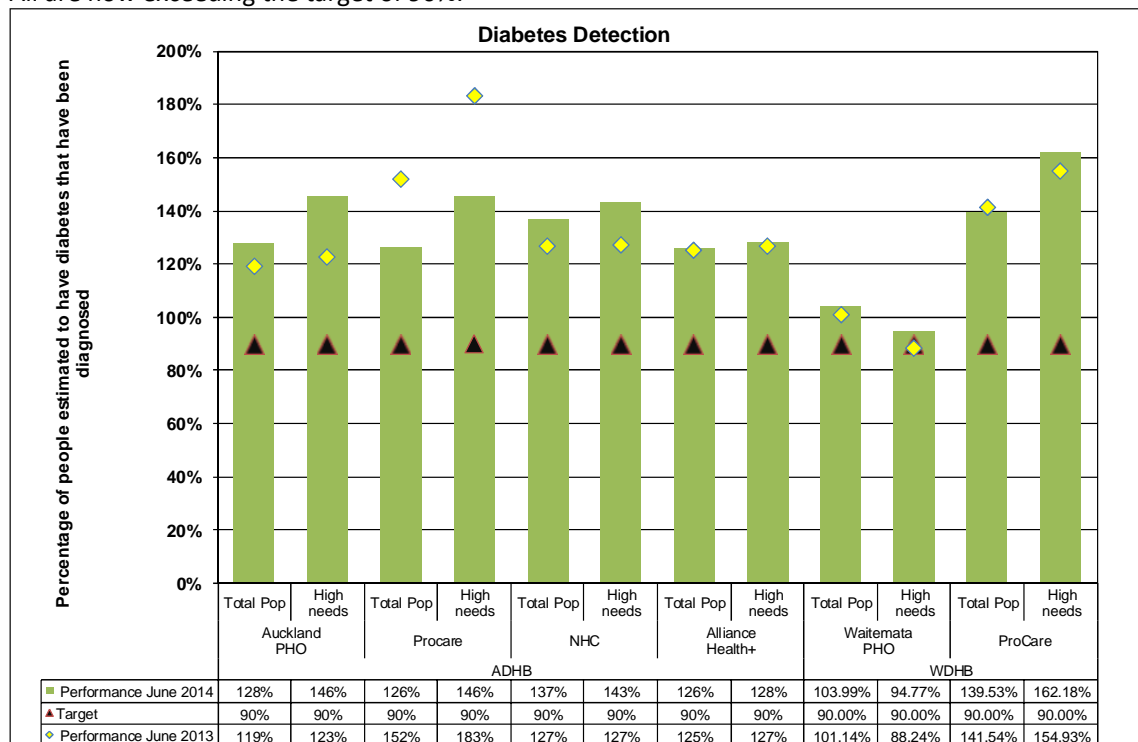
The graph below shows 'Breast Screening Coverage' across the six Auckland and Waitemata DHB PHOs for high needs populations. All PHOs met this target in quarter four.



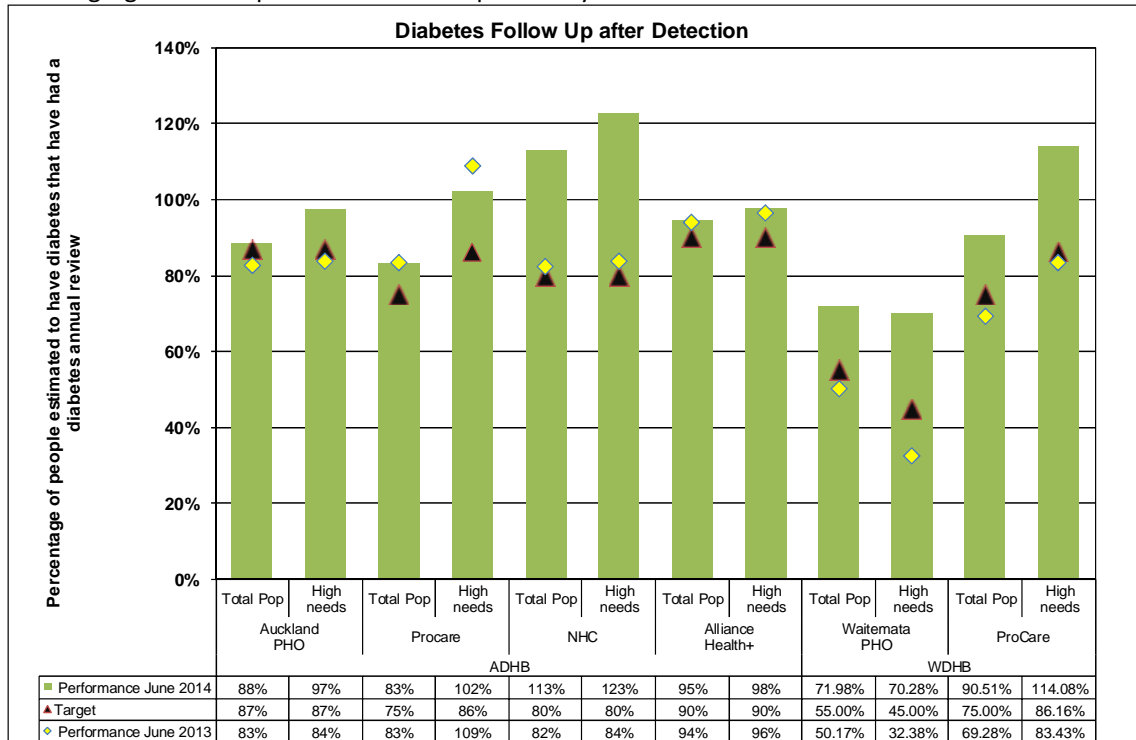
The graph below shows 'Ischaemic CVD Detection' across Auckland and Waitemata DHB PHOs. All PHOs met this target in quarter four and most PHOs are significantly exceeding the target for high needs populations.



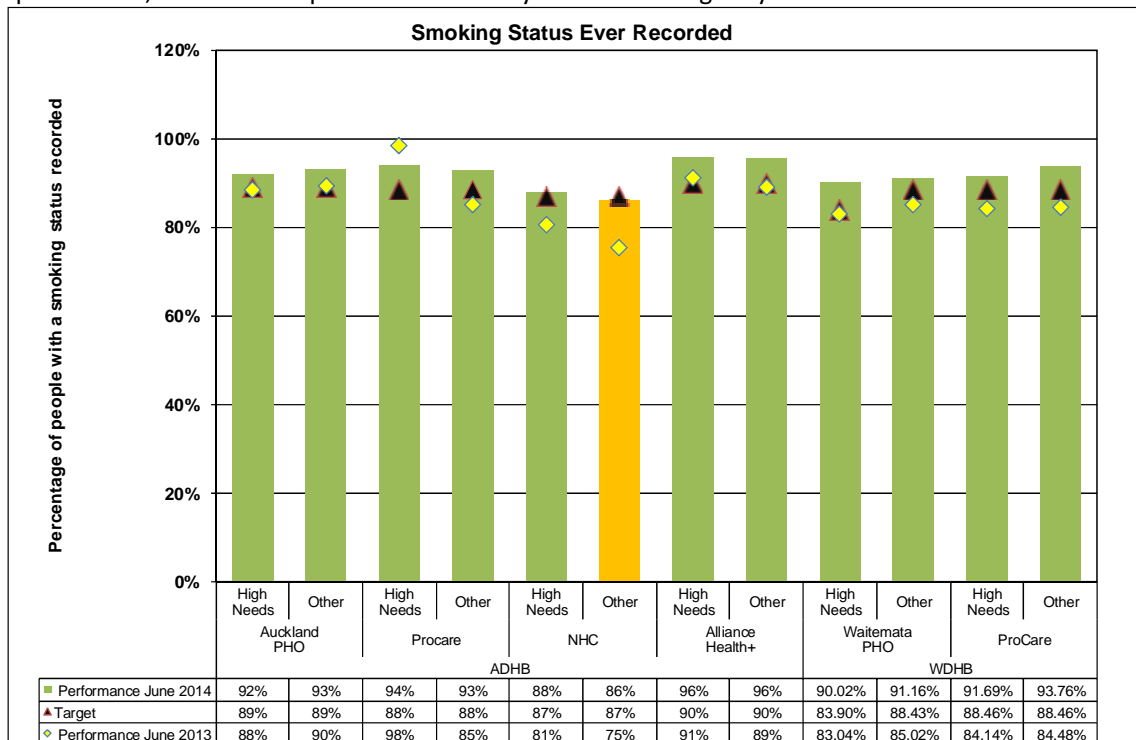
The graph below shows 'Diabetes Detection' target for Auckland and Waitemata DHB PHOs. All are now exceeding the target of 90%.



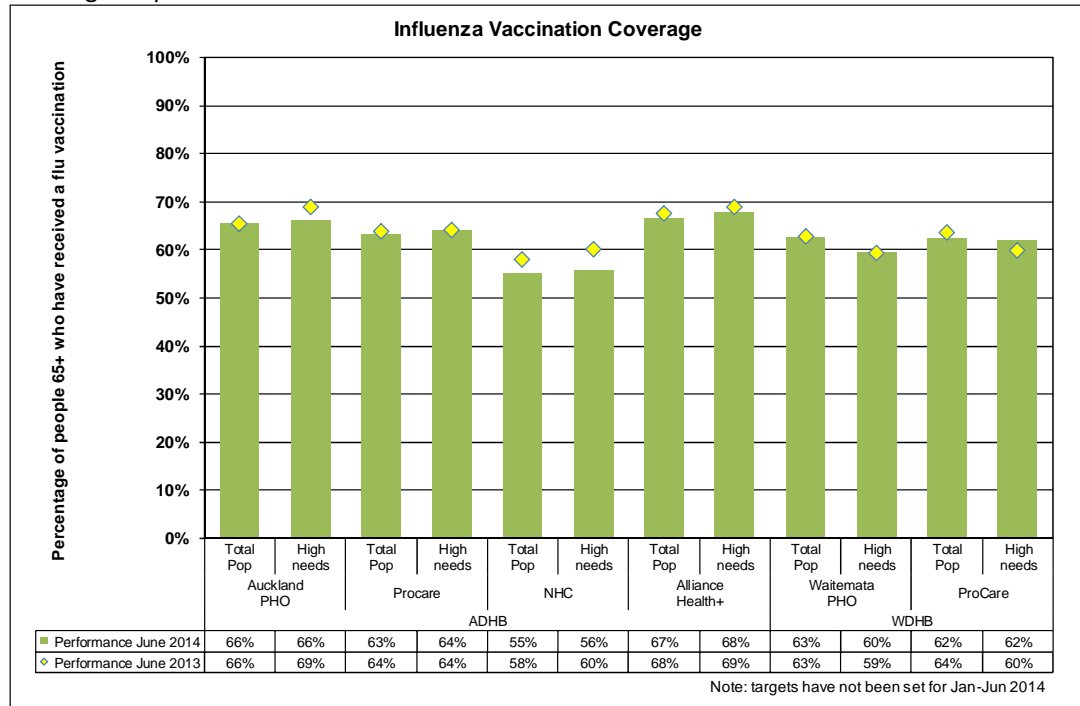
The graph below shows 'Diabetes follow-up after Detection' across Auckland and Waitemata DHB PHOs. All PHOs are now meeting this target, with NHC and the two Waitemata PHOs showing significant improvements on the previous year.



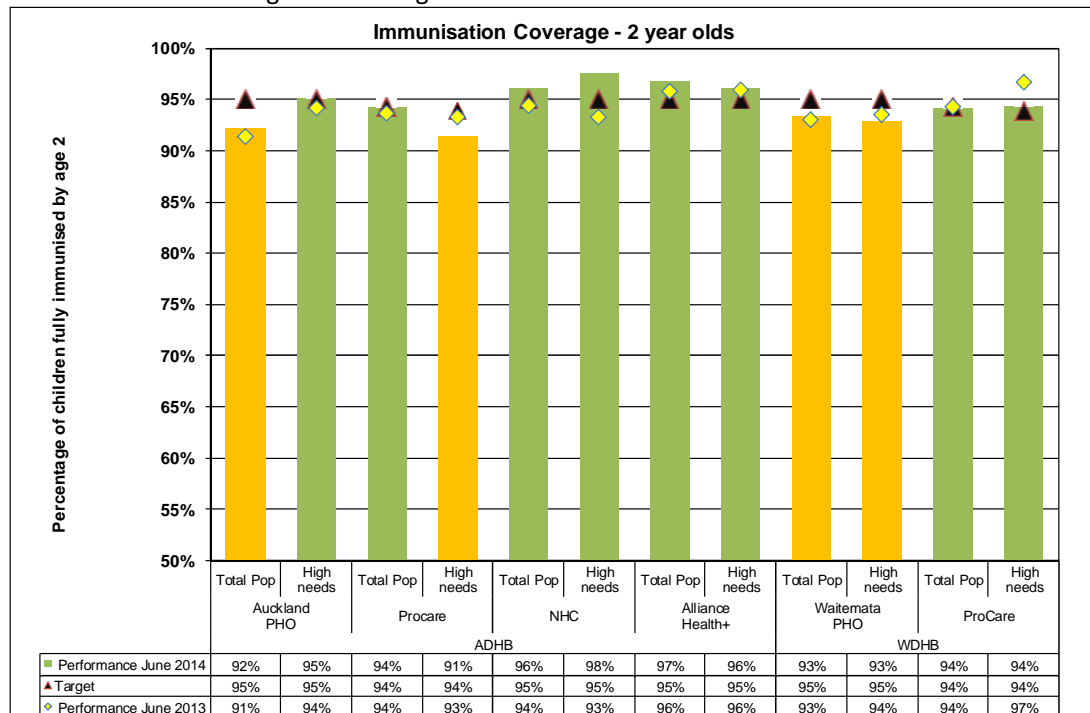
The graph below shows that all PHOs met the 'Smoking Status Ever Recorded' target for quarter four, with the exception NHC who only missed the target by 1%.



The graph below shows 'Influenza Vaccination Coverage' across Auckland and Waitemata DHB PHOs. Targets are only set for this indicator for July-December, so quarter four performance is not shown against a target. All PHOs have achieved over 50% vaccination coverage in quarter four.



The graph below shows 'Immunisation Coverage for 2 year olds'. With the exception of Auckland PHO (total population), Procure Auckland (high needs), and Waitemata PHO, all other PHOs are meeting the 95% target.



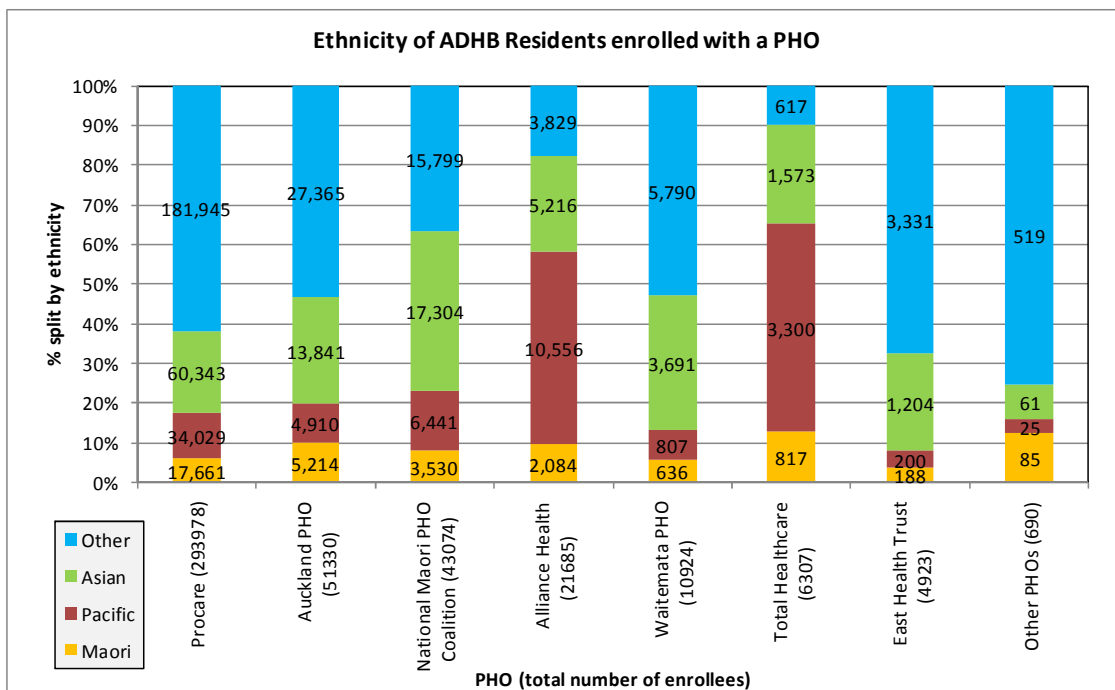
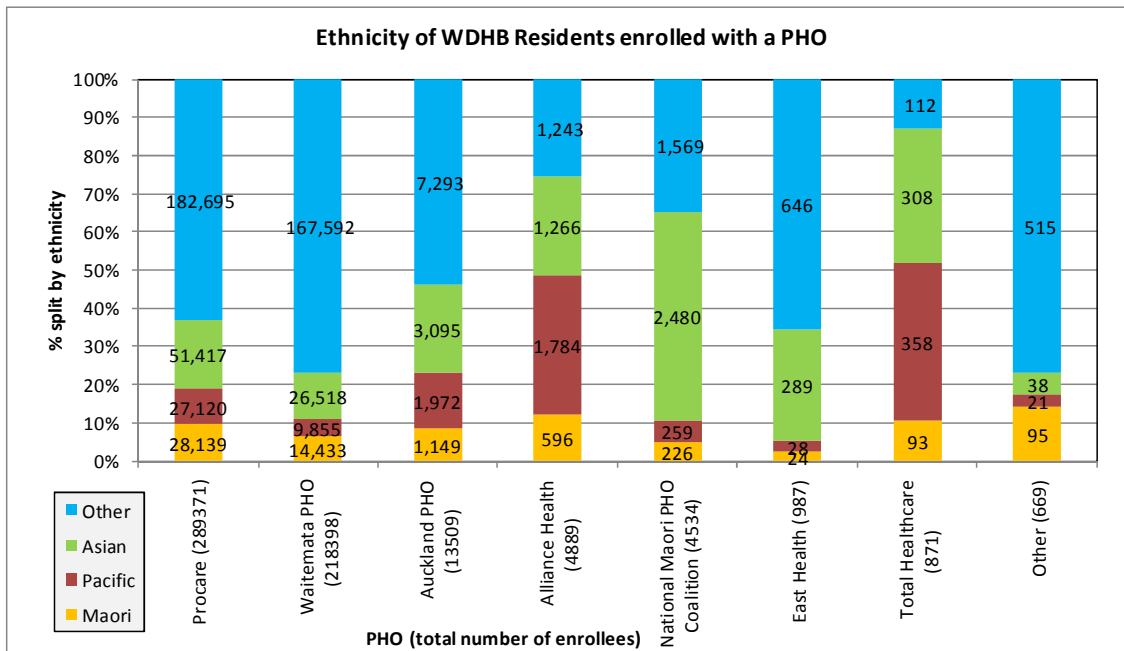
### **PHO enrolment data**

The graphs below show the number of people enrolled with each PHO, by ethnic group, for Auckland and Waitemata DHB. Using 2013/14 population projections, it is estimated that 84% and 83% of Māori living in the Auckland and Waitemata DHB areas respectively are registered with a PHO. This is an increase from 80% reported for both DHBs last quarter. Total population enrolment rates are 92% and 95% for Auckland and Waitemata DHBs.

Some of the under-enrolment will be due to data quality issues with misclassification of Māori as other ethnic groups – most commonly as NZ European. We are not able to accurately quantify the extent of this misclassification at the moment. Auckland and Waitemata DHBs currently hold a contract with the Ministry of Health to implement the primary care ethnicity data audit tool. This tool will assist general practices to improve the quality of their ethnicity data through an audit process. The audit process will identify where improvements to their systems, protocols and processes for collecting, recording and outputting ethnicity data can be made. If these changes are implemented, the quality of ethnicity data in primary care will improve over time. The audit process will not provide quantification of the extent of the misclassification in ethnicity that currently exists at primary care.

The project started in April and ends in June 2015. The tool needs to be implemented in 240 general practices under Auckland and Waitemata catchment areas. This project sits under Māori Health and Primary Care at Waitemata DHB. The project envisages a strong collaboration with PHOs, whereby DHB staff will train key PHO staff with a train-the-trainer approach. PHO staff would then guide and supervise the implementation of the ethnicity tool in their general practices. To date all five PHOs have received the training and all primary care packages to enable the tool implementation have been distributed. Implementation should already have started in some general practices. Waitemata DHB will regularly monitor progress via collaborations with the PHO and, if needed, direct access to general practices.





## 5.2 Planning, Funding and Outcomes Update

### Recommendation:

**That the report be received.**

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Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Tim Wood (Funding and Development Manager Primary Care WDHB/ADHB), Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Marty Rogers (Maori Health Gain Manager) and Lita Foliaki (Pacific Planning and Funding Manager)

Endorsed by: Dr Debbie Holdsworth (Director Funding WDHB/ADHB), Simon Bowen (Director Health Outcomes WDHB/ADHB)

### Glossary

DHB - District Health Board

PHO - Primary Health Organisation

### 1. Summary

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

### 2. Transition

We are in the process of recruitment to our final structure. This is being undertaken in waves as there are approximately 40 new positions to recruit to which includes reconfiguration of existing roles in addition to new roles. We are currently half way through this process with a number of positions already recruited to and others about to be advertised. It is anticipated the full structure will be implemented by the end of October.

### 3. Planning

The Auckland DHB Annual Plan 2014/15 has been updated and resubmitted to the NHB. We are awaiting feedback.

The Waitemata DHB Annual Plan 2014/15 has also been updated and resubmitted to the National Health Board. Feedback is awaited.

Both Auckland and Waitemata DHB Annual Reports 2013/14 are currently being prepared. The first drafts will be presented to the next respective Audit and Finance Committee meetings. First drafts of financials have been submitted to the auditors and the finance team are responding to feedback.

We are also awaiting auditor feedback on the Statement of Service Performance draft.

## 4. Stop Smoking Services Update

### Background

A Tobacco Control update was presented at the 30 July 2014 CPHAC meeting. Following discussion on the paper CPHAC requested that “information on contractual reporting on quit rates at four weeks and three months to be provided to CPHAC”.

### Reporting on Client Quit Rates

After enrolling in the service some clients go on to set a ‘target quit date’. A client’s quit rate is measured by asking them at four weeks after their target quit date “over the past two weeks have you smoked at all?” and at three months “over the past four weeks have you smoked at all?” Only those clients that have not had a single puff are recorded as having quit. If the client has had a puff or more, or been lost to follow-up, they are recorded as a smoker. Note some clients drop off the programme prior to setting a target quit date.

The Planning, Funding and Health Outcomes team have analysed the data in monitoring reports for 2013-14 provided by the contracted providers to produce the tables below.

**Table 1: Services contracted by the MOH**

Service and coverage	Provider	Service description	Enrolments 2013-14	4 week quit rate	3 month quit rate
Aukati Kai Paipa (Auckland and Waitemata DHBs)	Ngati Whatua O Orakei and Te Ha O Te Oranga O Ngati Whatua	Face-to-face, text and NRT targeted to Maori	Clients: 626 Target: 640	36%	26%
Pregnancy Smokefree Communities (Waitemata DHB only)	Waitemata PHO	Face-to-face, text, email targeted to pregnant women and their partners	Clients: 266 Target: 420	37%	28%

**Table 2: Services contracted by Auckland and Waitemata DHBs**

Service and coverage	Provider	Service description	Enrolments 2013-14	4 week quit rate	3 month quit rate
Pacific Quit Service (Auckland and Waitemata DHBs)	Auckland Regional Public Health Service	Face-to-face, text and NRT by Pacific language speakers	Clients: 283 Target: 360	58%	58%
Elect Service (Waitemata DHB only)	Waitemata DHB	All smokers referred to Elective Surgical Services are provided with advice and support to quit prior to surgery	Clients: 132 Target: 75	68%	44%

Service and coverage	Provider	Service description	Enrolments 2013-14	4 week quit rate	3 month quit rate
Hospital Outpatient Services (Waitemata DHB only)	Waitemata DHB	Face-to-face or group counselling and NRT, targeted to patients that have a smoking related illness	Clients: 262 Target: 300	40%	33%
Whanau Smokefree Communities (Waitemata DHB only)	Waitemata PHO	Face-to-face, phone, text, NRT targeted to families with children	Clients: 448 Target: 300	33%	17%
Asian Smokefree Communities (Waitemata DHB only)	Waitemata PHO	Face-to-face, text and email by Asian language speakers	Clients: 393 Target: 420	71%	66%
Community Pharmacy (Waitemata DHB only)	16 community pharmacies	Face-to-face support and NRT provided by pharmacy staff	Clients: 242 Target: 550	41%	44%
Pregnancy Smokefree Communities (Auckland DHB only)	Auckland DHB	Face-to-face, text, email targeted to pregnant women and their partners	Clients: 206 Target: 360	27%	15%

### Commentary

The target quit rate at three months is 35% when self-reported and 25% when carbon monoxide validated. All of the services (except community pharmacies) use carbon monoxide monitoring when the client comes in for their three month follow-up visit. If the client is contacted by phone at this time, then self-reported smoking status is recorded. In the table above the self-reported and carbon monoxide validated figures have been combined to form the overall percentage for each service.

For those clients that set a target quit date their ethnicity is recorded as: Maori 415, Pacific 316 and other 1,127.

The 'better help for smokers to quit' health target reports on the rate of 'brief advice' provided. Meeting this target has been the focus for health professionals for the past few years. To date, the advice has not often been followed through with a referral to a stop smoking service. Most of the stop smoking services get few referrals from primary and secondary care. The number of referrals from primary care to Quitline recently increased with the introduction of a one-click electronic referral mechanism. Improving the low referral numbers is being addressed in the DHB's planning for 2014-15.

Quit rates vary depending on how motivated the client is to quit. Elective surgery patients (utilising the Elect service) may be highly motivated to quit to ensure a good recovery from surgery. Whereas the Whanau service that has recently been recruiting people from Work and

Income offices, has found that these clients are often lost to follow-up and have a lower quit rate.

The pregnancy stop smoking services struggle to get referrals and also to achieve the desired quit rates. Women that are motivated to quit have usually done so by the early weeks of their pregnancy, prior to seeing a Lead Maternity Carer (LMC). Hospital midwives and LMCs are kept informed of new evidence and developments to support pregnant women to quit smoking through a variety of means, including newsletters, training sessions and some midwife clinic visits. Both the pregnancy quit smoking services regularly promote their services to midwives. They have also developed information to be given to pregnant women to encourage them to quit. However referrals to the pregnancy quit smoking services from Lead Maternity Carers remains low.

The community pharmacy quit smoking service was managed by ProCare prior to 30 June 2014; by mutual agreement the DHB is administering this service directly with community pharmacies from 1 July 2014. Waitemata DHB has contracted with 16 pharmacies, predominantly in high need neighbourhoods. The pharmacy recruits the patient and provides face to face counselling and NRT. The DHB has provided refresher training and will provide additional coaching over the next six months, and expects utilisation to improve over the 2014-15 year.

#### **Next Steps**

The Planning, Funding and Health Outcomes Team is working with primary and secondary care to encourage more supported quit attempts and referrals to stop smoking services. The DHBs are setting a target with the PHOs for 2014-15 to increase the number of people that receive support to quit, including a referral to stop smoking services. The possibility of e-referrals from primary care to DHB stop smoking services, such as the Auckland DHB Pregnancy Service, is also being investigated.

In Auckland DHB Smokefree Services provides a triage service for patients wanting support to quit smoking; they receive between 80-100 referrals a month and refer these patients to community providers for support to quit. In Waitemata DHB very few patients have been referred on to community based support to quit smoking upon discharge. To increase the number of hospitalised smoking patients being referred for support to quit post- discharge, as in Auckland DHB, a central referral and triage service is being developed. Patients wanting support to quit smoking will be referred to the Smokefree Team who will then assess and refer to the most appropriate service for them. Both DHBs are developing a process for Māori and Pacific patients who would like support to quit smoking to be proactively followed-up on post-referral to ensure that they have had every opportunity to engage with a stop smoking service.

The DHBs are continuing to develop initiatives to increase the number of pregnant women that are supported to quit smoking. One of these initiatives is including advice and support to quit smoking in the new Healthy Babies Healthy Families programme.

## 5. Maori Health Gain

### 5.1 Maori Health Plans 14/15

The Maori Health Plans 14/15 for Waitemata and Auckland DHBs has been approved by the Ministry of Health, Memorandum of Understanding partners, PHOs and relevant internal parties. The plans are available on Auckland and Waitemata DHB websites.

### 5.2 Maternal and Infant Nutrition and Exercise Project

In the past few months the Healthy Babies Healthy Futures Project has made significant progress. Contracts for all of the providers have been signed (Maori, Chinese, Indian and Pacific) and the implementation phase has started. Enrolment of pregnant mothers has begun and the text messaging support for this group has been finalised. The official launch of the Project will occur on Monday 18th August at the Grey Lynn Community Centre.

### 5.3 Family Violence

Family violence is a persistent and on-going issue as shown by the *The Glen Inquiry: The People's Report – The People's Inquiry into Addressing Child Abuse and Domestic Violence* and the recent spate of violence-related deaths in the district. A business case for a Maori focused family violence programme which focuses on supporting victims, perpetrators and their families to be violence-free is being developed and will be presented to the Waitemata DHB Audit and Finance Committee in October.

### 5.4 Ethnicity Data Audit Tool

Implementation of the Ethnicity Data Audit Tool Project is well underway. Project governance and management structures have been established, engagement with PHOs and DHBs and the development of training packages has been completed. There has been agreement for us to deliver the EDAT training to Canterbury and West Coast DHBs. Training has been delivered to four of the five local PHOs with the last training scheduled for mid-August.

### 5.5 Whānau ora

The Maori Health Gain Team is in the process of investigating options for establishing a Whānau Ora centre in the North Shore.

### 5.6 Integrated Contracts

The integration of contracts for Maori providers has proven to be more challenging than originally anticipated. This has led to a three month extension of current contracts to allow the required time to complete the integration process. The provision of integrated contracts is the initial step in facilitating an environment that allows the providers to develop their services to be responsive and deliver in a Whanau Ora paradigm.

## 6. Child Health

### 6.1 Immunisation Update

#### Performance against the National Health Target

The National Immunisation Health Target has increased from 1 July 2014. The target is 95% of eight months old infants will have their primary course of immunisation on time by December 2014. The July 2014 results are:

#### Immunisation Coverage 31 July 2014

Auckland DHB	Total	Maori	Pacific	Asian	Other	Decline/opt off
8 month	94%	90%	96%	97%	93%	2.5%
24 month	95%	96%	97%	98%	88%	2.5%

Waitemata DHB	Total	Maori	Pacific	Asian	Other	Decline/opt off
8 month	92%	89%	94%	98%	90%	4.4%
24 month	94%	93%	98%	96%	92%	4.1%

- Auckland DHB 8 month Health Target
  - This is an increase of 1% overall and 6% Maori in the month since June 2014.
- Waitemata DHB 8 month Health Target
  - This is an increase of 1% overall and 2% Maori in the month since June 2014.
- Challenges to meeting the new target include a relatively high decline rate for immunisation in Waitemata DHB (>4%), and delayed immunisations for medically fragile children.
- The oral rotavirus vaccine was introduced to the National Childhood immunisation schedule from 1 July 2014. The vaccine protects against rotavirus disease which is the most common reason for child gastro-enteritis admissions to hospital. The immunisation has 3 doses to be given at allocated ages (6 weeks, 3 months, 5 months). The first dose must be given by 14 weeks and 6 days. If the infant has not had the first dose by 15 weeks it is contraindicated to vaccinate for rotavirus, and it will not be possible to catch up the child. This presents a future risk to meeting the 8 month and 2 year vaccination targets.

#### Current activity

- We are working with PHOs and practices rolling out a training programme on the rotavirus vaccine and encouraging early enrolment for new born infants.
- The Ministry of Health has approved additional funding for increased immunisation coordination services in the Auckland region as well as cold chain accreditation for pharmacies and clinical assessments for trained vaccinators. The DHBs are developing a regional plan to promote a consistent model for coordination in Metro Auckland.

#### In addition we are:

- Working with PHOs to provide targeted support to practices with low coverage rates and high Maori population to encourage new born enrolments, precalls and recalls and identify infants overdue for immunisation.
- Working with primary care partners and the Maori health team to develop a multi-provider case review group to identify opportunities for collaboration and service improvements for Maori infants in West Auckland.
- Working with PHOs to improve access to real-time information on children overdue the 3 month and 5 month immunisations.

#### Other planned activity includes:

- Maternity / PHO enrolment data-match audit proposal underway, outcomes will inform strategies to increase new born enrolments with primary healthcare.

## Measles

The last confirmed Measles case in Auckland was in the week of 1 June 2014

## 7. Pacific Health Gain - Implementation of the Pacific Health Action Plan (PHAP) 2013 – 2016

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

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

- Participation in the ADHB Family Violence Steering Group, Auckland Family Violence Project Board (with Police, Justice, Corrections and Ministry of Social Development ) continues.
- The Ministry of Social Development’s Pacific antiviolence campaign project manager and the Chairperson of the Pacific Advisory Committee to the Ministerial Group on Family Violence suggested that we develop a Memorandum of Understanding as a specific way of clarifying and aligning MSD’s approach and actions towards family violence prevention in Pacific communities with our own. They also offered to input into the development of our family violence prevention work plan. One of the priorities of MSD’s Pacific family violence prevention work is to influence other government agencies to prioritise work against family violence so they congratulated the DHB on its Pacific Health Action Plan because of the high priority that we have placed on family violence prevention and safety of children.
- The Catholic Social Services of the Diocese of Auckland employs a registered psychotherapist, MSD approved and is a fluent speaker of Fijian and Tongan languages and she has developed three programmes; one addresses and challenges the traditional belief systems of Pacific men specifically in relation to their status and exercise of authority within the family context; one on impulse control and one of positive parenting. She uses a “train the trainer” approach in relation to the delivery of the programme where people from Catholic parishes are identified and trained and they run cell groups based on the programmes she has developed. She is willing to work with the Enea Ola and HVAZ churches and to start the work, if the churches agree, immediately without waiting for funding. We intend to call a meeting with the Catholic churches who are part of the HVAZ/Enea Ola network and she will present her programme to them. If they agree to work with her, then she and them will identify the cell group leaders to be trained and she will start the training. We think that we will start with the Catholic communities because they are very likely to accept the theological basis of her programme as she is also a nun. We would introduce her to non-Catholic church ministers and if they find her programme acceptable they may wish to work with her as well.
- We do need to explore funding sources to enable a sustainable approach to family violence. We think that this will be easier if applications to funding sources are based on specific programmes with number of participants identified.

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

- The WERO group smoke free competition is continuing and another competition will start in September.



- In the last report we said that we intended to undertake a survey of HVAZ and Enea Ola churches to establish the number of churches that are totally smoke free, the number that have smoke free church halls but not church grounds and the number of churches where there no prohibition on smoking at all. We have started to do this and initial results are encouraging. The Tongan Health Society works with 14 churches and they report that all the halls are smoke free and 11 out of the 14 are totally smoke free, with hall and church grounds being smoke free.
- We will complete this work and report to CPHAC in our next report including targets that the churches will work towards in the 2014/15 financial year.

**7.3** The third priority is that ***Pacific people eat healthy and stay active***. The weekly physical activities and nutrition training is continuing. The Aiga Challenge which is the annual 8 week weight loss competition started on 11<sup>th</sup> August. Because this is the second year that the competition is being held, data will show whether the weight loss from last year's competition is sustained. The competition, as well as helping participants, also provides quantitative data about the programme.

**7.4** The fourth priority is that ***we seek help early***. Although data confirms that Pacific people are enrolled in PHOs in very high numbers and that there is good coverage in some areas such as immunisation and breast screening, hospital ASH rates show that there are still high hospital admissions for conditions that are primary care preventable. Currently contracts held by Alliance Health + (AH+) that provide support for pregnant mothers and mothers and children in their first year of life are being reviewed. New contracts effective from 1 July 2014 will attempt to better connect these services and ADHB's maternity and child services, not just to provide a service but to better understand the families' needs and the barriers that they continue to experience so that we are better placed to address them.

We have agreed with AH+ that we will meet monthly to monitor how the new service model of addressing the health needs of families works in reality. The contract buys packages of care for certain number of families. The package of care is developed for each family tailored for their specific needs. The service is delivered by a team including nurses, youth workers, community health workers, GPs and includes education, assistance to access health and social services.

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

**7.6** The sixth priority is that ***Pacific families live in warm healthy houses that are not overcrowded***. Some Pacific providers such as the Fono Henderson are currently contracted by Waitemata DHB to provide social work support for their enrolled patients with both high clinical and social support needs. People in poor housing are a priority for this service. When social workers are involved in an advocacy role for clients, their housing needs are better responded to by Housing NZ and the private sector. It is acknowledged that this does not resolve the fundamental issue of the shortage of affordable good quality housing especially for low income people in Auckland.

We will also link to intersectoral forums on housing and our first meeting is on 2<sup>nd</sup> September.