Waitematā
District Health Board

Best Care for Everyone

Community and Public Health Advisory Committee Meeting

Wednesday 5 August 2020

10.00am

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

Waitematā District Health Board
Best Care for Everyone

WAITEMATĀ DISTRICT HEALTH BOARD
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) MEETING
05 August 2020

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

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

Apologies: Dale Bramley

AGENDA

KARAKIA
ACKNOWLEDGEMENTS
DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
10.00am	2.1	Confirmation of Minutes of the meeting held on 19/02/20 Actions Arising from previous meetings
	3.	**DECISION PAPER**
	4.	**INFORMATION PAPER**
10.05am	4.1	Integrated Primary Mental Health and Addictions Services
10.30am	4.2	HPV Self-Testing for Cervical Screening Update
	5.	**STANDARD REPORTS**
10.55am	5.1	Planning, Funding and Outcomes Update - Executive Summary - Planning - Primary Care - Health of Older People - Child, Youth and Women - Mental Health and Addictions - Pacific Health Gain - Māori Health Gain - Asian, Migrant and Refugee Health Gain
11.15am	**6.**	**GENERAL BUSINESS**
11.20am	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitematā District Health Board

Community and Public Health Advisory Committee

Member Attendance Schedule 2020

Member	February	May	August	October
Kylie Clegg (Committee Chair)	✓	Meeting Cancelled due to COVID-19		
John Bottomley	✓			
Chris Carter	✓			
Sandra Coney	✓			
Warren Flaunty	✓			
Judith McGregor	✓			
Allison Roe	✗			

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

REGISTER OF INTERESTS

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

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

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

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

IMPORTANT

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

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

Note: This sheet provides summary information only.

2.1 Minutes of the Community and Public Health Advisory Committee meeting held on 19 February 2020

Recommendation:

That the draft Minutes of the Community and Public Health Advisory Committee held on 19 February 2020 be approved.

Draft Minutes of the Meeting of the Waitematā DHB

Community and Public Health Advisory Committees

Wednesday 19 February 2020

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 10.01a.m.

Items considered in Public Meeting

COMMITTEE MEMBERS:

Kylie Clegg – Committee Chair
Warren Flaunty – Committee Deputy Chair
Max Abbott - Board member
John Bottomley - Board member
Chris Carter - Board member
Sandra Coney - Board member
Judy McGregor – Ex-officio as Board Chair
Arena Williams –Board member

ALSO PRESENT:

Karen Bartholomew (Director Health Outcomes)
Tim Wood (Acting Director Funding)
Stuart Jenkins (Clinical Director, Primary Care)
Joy Christison (Project Manager, Primary Care)
Peta Molloy (WDHB Board Secretary)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Simon Maude (New Zealand Doctor)
Tracy McIntyre (Waitakere Health Link)
Kirsty Gover (Comprehensive Care PHO)
Lorraine Symons (Te Whānau o Waipareira)

KARAKIA:

A Karakia was led in an earlier meeting.

WELCOME:

The Committee Chair welcomed those in attendance. As this is the first Community and Public Health Advisory Committee meeting attended by some of the newly elected/appointed members of the Board, an introduction was made by all the members present in the meeting. The Chair also acknowledged the public and media representatives in attendance.

APOLOGIES:

Apologies was received and accepted from Allison Roe.

DISCLOSURE OF INTERESTS:

Warren Flaunty requested that his registered interest as Director for Trust Community Foundation be removed.

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

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda, except Item 5.1, which was considered before Item 4.1.

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 30 October 2019 (agenda pages 8-12)

In relation to item 5.1, Warren Flaunty noted the discussion on the sustainability of pharmacies as a result of discounting of co-payments for medicines. He also noted a request for information related to the number of pharmacies that have closed.

Tim Wood clarified that the $5 co-payment is set as a cap not a minimum and that the DHB cannot impede competition amongst pharmacies.

A bullet point under Item 5.1 of the Minutes shall be included as follows:

- Sustainability of pharmacies as a result of co-payment discounting by other pharmacies was raised.

Resolution (Moved Max Abbott /Seconded Warren Flaunty)

That the Draft Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 30 October 2019 be appended as follows and approved:

- **Sustainability of pharmacies as a result of discounting of co-payment by other pharmacies was raised.**

Carried

Matters Arising (agenda page 13)
There were no matters arising from previous meeting.

3. DECISION PAPERS

There were no decision papers.

4 INFORMATION ITEMS

4.1 Diabetes Retinal Screening Update (agenda pages 14-35)

This Item was considered after Item 5.1

Dr Carol Barker (Public Health Physician, primary Care) and Joy Christison (Acting Senior Programme Manager, Primary Care) were present for the discussion of this item.

Carol provided a summary of the paper noting the following:

- The programme is a service alliance amongst the metro-Auckland DHBs to provide regular checks for patients to reduce the risk of visual loss.
- Coverage for Waitematā DHB is 64% of the total population. The figure for Pacific has increased to 63% from 58%.
- The data sharing between the DHBs and PHOs is to identify patients who have not had a retinal screen and supporting them to have the screen completed. There is a particular focus on Māori and Pacific people who have lower rates of screening.

Matters covered in the discussion and response to questions included the following:

- New service model is a work in progress. Feedback received from the consultation process highlighted the need for the location/services to be accessible.
- A focus on ensuring consistency and quality of the service model. Work is on-going with the other DHBs to share best practices for service redesign.
- Diabetes retinal screening is not a national screening programme, but is part of the expectations of the MoH related to Quality Standards for diabetes care. Other national screening programmes include bowel screening, breast screening and cervical screening.
- In response to a question pertaining to the programme's ability to capture those who are not enrolled in a General Practice (GP), it was noted that referral pathways (other than GP) are being studied to ensure equity of access. In parallel, the current pathway is being optimised through data matching and ensuring coverage to the programme of those who are enrolled and eligible.

Action Items

- A recommendation from the Committee will be put to the Board to write a letter to the MoH to make diabetes retinal screening a national screening programme and /or issue national guidelines to be adopted for retinal screening for consistency of approach.
- A health needs assessment study was commissioned by Auckland DHB on eye health and will be provided to the Committee.

The Chair thanked work of the group.

The report was received.

4.2 Metro-Auckland Healthy Weight Action Plan for Children: Third Report (agenda pages 36-52)

Caitlin Donaldson (Public Health Dietitian), Natalie Desmond (Senior Programme Manager) and Nelson Wahanui (Programme Manager) were present for this item.

Caitlin provided a summary of the report to the committee highlighting the progress made on the National Healthy Food and Drink policy across the metro-Auckland DHBs.

Matters covered in the discussion and response to questions included:

- More information on the 'Healthy Auckland Together' (HAT) programme particularly the work on healthy food and drink will be provided in the succeeding report.
- Work is on-going on 'Healthy Active Learning' which is aimed at providing education in schools around food and beverage. The MoH has completed its consultation on Healthy Food and Drink Guidance as part of this initiative and it is expected to be released soon.
- The need to align efforts with the work made by the Regional Governance Group and National Chief Executives advocacy on obesity (by Nick Chamberlain, Chief Executive Northland DHB).

The report was received.

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 53-77)

This item was considered before Item 4.1

Karen Bartholomew (Director Health Outcomes) presented an overview of the equity framework for the Committee, in particular the previous focus of the Committee as well as how equity is addressed using the five-element framework based on Institute for Healthcare Improvement (IHI) Model.

The Committee thanked Karen for the presentation and commended the efforts in achieving equity in the existing programmes. They also noted the need to apply an equity lens to ensure visibility of programmes not yet identified or not yet implemented.

Tim Wood (Acting Director Funding) provided a summary of the report. He highlighted the continuous focus on equity and the collaborative work with community groups.

<u>Primary Care</u>

Tim provided an overview of the work of the primary care group and summarised this section of the report highlighting the following:

- The work alliance between the Waitematā and Auckland DHBs, the PHOs and treaty partners to elevate equity discussions.

- The work around Coronavirus (COVID-19) has focused on communication with the community.
- Other work programmes include community pharmacy, smoking cessation, safety in practice for pharmacy and general practice. The diabetes improvement programme works closely with GPs to ensure responsiveness and engagement with community. A service redesign is in progress for diabetes care delivered through general practice.

Matters covered in the discussion and response to questions included:

- Regular meetings are conducted to support PHOs to meet performance targets. There are also processes and mechanisms in place in the agreement to support this.
- The service is focused on improving the model of primary care by working with GPs.
- The need to be agile and to capitalise on the learning and success of other programmes such as nurse-led clinics and Awhi Ora to better engage with communities.
- The final report of the Health and Disability System Review is due in the next few months. The Committee could be guided by specific issues related to Māori which are expected in the final report.

Child, Women and Youth

Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Jesse Solomon (Senior Programme Manager) and Natalie Desmond (Senior Programme Manager) were present for this section of the report.

Ruth gave an overview of the division noting that their collaborative work with the Māori Health Gain team. Other matters covered in the discussion included the following:

- A recap was provided on the benefits of the Healthy Housing initiative Kāinga Ora specifically the positive impact of early intervention on reducing hospitalisation.
- In response to a question, the service is prioritising work to cover all referrals received particularly for pregnant women.
- Work is on-going to identify population not currently captured. This includes looking into statistics, ethnicity data, location and deprivation index as well as decile ratings of schools in the community.
- Increase in the uptake of vaccine as a result of the measles outbreak is yet to be determined.

  Action Item
- The technical advice on the provision of MMR vaccine for children between 6-11 months will be provided to the Committee.

Health of Older People

Karla Powell (Programme Manager) and Katie Daniel (Programme Manager) were present for this section of the report.

An overview of the service was provided by Karla Powell noting that the profile of patients in the service is changing. People presenting are more frail with multiple co-morbidities with a median length of stay at 18 months. The service is focused on continuous improvement through audits and compliance follow-ups. A review of the transition process from the hospital to aged residential care has been completed and further changes and improvements are in progress. Katie Daniel also highlighted the continued funding by the ACC for the Falls prevention programme.

Matters covered in the discussion and response to questions included:

- The DHB will continue to support transparency in premium charging which have already been signalled to the sector.
- The DHB is also supportive of the change towards a case mix model. However, noted this will be a complex transition and work on how this can be completed effectively is being done nationally for all DHBs.
- Providers of home support workers for the DHB are receiving pay rates consistent with the equity payment scheme.

Mental Health and Addictions

This section of the report was taken as read.

Māori Health Gain, Pacific Health Gain and Asian, Migrant and Former Refugee Health Gain

Shayne Wijohn (Manager Māori Health Gain), Leani Sandford (Portfolio Manager, Pacific Health), Samantha Bennett (Manager, Asian, Migrant and Former Refugee Health) and Raj Singh (Project Manager, Asian, Migrant and Former Refugee Health) were present for these sections of the report

Shayne Wijohn summarised the functions of the Māori Health Gain team noting collaborative work across the planning, funding and outcomes team to provide inputs. He also highlighted work around the DHB's two MOU partners (Te Runanga o Ngāti Whātua and Te Whānau o Waiparera) ensuring their inputs and oversight of the planning work by the DHB. He also provided an update on the development of the Iwi-DHB partnership board awaiting ministerial approval and noted that work is needed to support the development of Māori providers particularly to support sustainability.

Samantha Bennett highlighted that a new 'Asian, Migrant, Former Refugee and Current Asylum Seeker Health Plan' is in progress and will be presented to the Committee in May. Focus of the service is on identifying needs and disparities and equity of access to primary care and mental health services.

Leani Sandford noted the focus on updating the Pacific Action Plan and this will be aligned to the MoH's new Action Plan. Once released it will be tailored to the DHB's population.

Matters covered in the discussion and response to questions included:

- Clarifying that the HPV screening project falls outside the broader Māori Health pipeline, however there is a project (High Grade Cervical Screening project) which includes a research sub-study on self-sampling. In response to a query, more information will be provided around the HPV self-testing and the screening

research particularly for Māori, Asian and Pacific people within Waitematā DHB and Auckland DHB's population.

- In relation to the response of the service related to the Covid-19, the team worked with different partner groups to ensure that culturally appropriate responses and resources are made available.

Action Item

- Papers related to the development of the Iwi-DHB partnership board will be made available at the Board Correspondence folder.

The report was received.

6. GENERAL BUSINESS

This was discussed after Item 4.2

The Chair requested Committee members provide suggestions for deep dive topics to contribute to better outcomes. The aim is to develop a work plan for the year, which will include topics for the Auckland DHB and Waitematā DHB combined CPHAC meetings. The following areas were suggested at the meeting:

- Deep dives and focus on Mental Health and Addictions
- Community engagement best practices and effective outreaches, which we could apply to other work around immunisation and nutrition. In relation to this, a suggestion was made for the Consumer Council to put forward their thoughts and recommendations as to what will constitute an effective community engagement and/or outreach programme.

Action item

- Committee to be provided with more information on the work related to violence (towards women, children and workforce) and how more can be done.

The members will be requested additional inputs by email.

The closing karakia was led by Arena Williams.

The meeting concluded at 12.08 p.m.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE HELD ON 19 FEBRUARY 2020.

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 30 July 2020

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
19/02/20	4.1	<u>Diabetes Retinal Screening Update</u> • Committee to submit a Recommendation to the Board to write a letter to the MoH to make diabetes retinal screening a national screening programme and /or issue national guidelines to be adopted for retinal screening for consistency of approach. • Committee to be provided with the health needs assessment study on eye health.	 Karen Bartholomew	 Done	Recommendation to be submitted to the scheduled Board 19 August 2020. Available in Diligent Resource Centre
	4.2	<u>Metro-Auckland Healthy Weight Action Plan for Children</u> • Committee to be provided with more information on the 'Healthy Auckland Together' (HAT) programme on succeeding report.	 Karen Bartholomew		
	5.1	<u>Planning, Funding and Outcomes Update</u> • Committee to be provided with copy of technical advice related to the provision of MMR vaccine for children between 6-11 months. • Committee to be provided with information around HPV self-testing and screening research • Papers related to the development of the Iwi-DHB partnership Board to be made available in Diligent Boardbooks.	 Karen Bartholomew Karen Bartholomew Peta Molloy	 Done Done Done	 Available in Diligent Resource Centre Item 4.2 of this Agenda
	6.	<u>Deep Dive topics</u> • Committee to be provided with more information on the work related to violence (towards women, children and workforce) and how more can be done.			Noted for action

4.1 Integrated Primary Mental Health and Addictions Services

Recommendation:

That the Community and Public Health Advisory Committee:

a) **Receives the report.**
b) **Notes that the Integrated Primary Mental Health and Addiction Services programme is currently being rolled out across practices in metro Auckland.**

Prepared by: Brendan Short (Portfolio Manager, Mental Health and Addiction Services)
Endorsed by: Meenal Duggal (Funding & Development Manager, Mental Health & Addition Services), Tim Wood (Deputy Director Funding), Dr Debbie Holdsworth (Director Funding), Dr Karen Bartholomew (Director Health Outcomes)

Glossary

Awhi Ora	-	Awhi Ora Supporting Wellbeing
DHB	-	District Health Board
HIPs	-	Health Improvement Practitioners
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
MHAS	-	Mental Health and Addiction Services
MoH	-	Ministry of Health
MSP	-	Managing Successful Programmes
NGO	-	Non-Governmental Organisation
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
RFP	-	Request for Proposal

1. Background

He Ara Oranga, the report of the government inquiry into mental health and addiction, noted that mental health and addiction services need significant change to meet the needs and expectations of the community. Expanding access to, and choice of, primary mental health and addictions services is the flagship initiative for the Government on wellbeing and the cornerstone of the Wellbeing Budget 2019. There is particular emphasis on expanding access to services for people with mild to moderate mental health and addiction needs who are unable to access secondary mental health and addiction services. The Wellbeing Budget 2019 makes available $455 million over a four year period. This is allocated to expand access to and choice of primary mental health and addictions support and will provide access to 325,000 people by 2023/24. Integrated Primary Mental Health and Addiction Services (IPMHAS) is the initial response to this investment.

Key stakeholders within the Metro-Auckland region elected to establish a collaborative Integrated Primary Mental Health and Addiction Services (IPMHAS) proposal to provide greater consistency and integration of service. The resulting collaborative (Auckland Wellbeing Collaborative) includes the three Auckland DHBs, Treaty Partners, seven Primary Health Organisations (PHOs), Māori and Pacific health organisations and a significant number of Non-Government Organisations (NGOs).

Planning, Funding and Outcomes (PFO) worked collaboratively with providers and the community using co-design principles to develop Awhi Ora Supporting Wellbeing (Awhi Ora) and Te Tumu Wiaora. Te Tumu Waiora is the name of the model placing Health Improvement Practitioners (HIPs) and Health Coaches within a general practice setting. These models were further tested and refined through interim investment via Fit For the Future, a Ministry of Health (MoH) programme, to test and upscale a range of initiatives to better meet the needs of people with mild to moderate mental health and addiction issues within primary care settings.

An independent evaluation was undertaken as part of Fit For the Future. The evaluation utilised both qualitative and quantitative data and found these interventions effective. The key findings noted that these interventions are:

- Effective at reducing distress and increasing ability to cope.
- Provided navigation and access to a wide range of support services.
- Are positively viewed by people engaged in the service as well as primary care providers.
- Provide timely preventative support for people whose needs would have likely to be unmet.
- Effectively engage people with short-term interventions and support.
- Are effective at reducing missed appointments.

Awhi Ora is a co-designed preventative and early intervention approach to support people with mild to moderate mental health and addiction issues. Significantly, from an equity perspective, Awhi Ora was shown to successfully engage Māori and Pasifika populations at high rates when compared to DHB demographics.

The testing and evaluation of Awhi Ora, HIPs and Health Coaches within Auckland and Waitematā provided evidence of their efficacy and subsequently led to their adoption as key requirements by the MoH for national delivery of IPMHAS. The partnership developed within Fit For the Future included DHBs, PHOs and NGOs (including Pasifika and kaupapa Māori providers) and formed the basis of the collaborative that responded to the Ministry request for proposals and who now oversee the Metro-Auckland solution.

2. The Proposal

The MoH have been running a series of procurement processes, through Request for Proposal (RFP), to confirm funding levels and rate of roll out of the IPMHAS. There are separate procurement processes for kaupapa Māori, Pasifika, youth and mainstream IPMHAS services. The aim of the funding is to expand on current service delivery to:

- Increase access and equity of access,
- Increase choice in addressing people's holistic needs,
- Reduce wait times, and
- Improve outcomes and equity of outcomes.

The Auckland Wellbeing Collaborative's response to the RFP, based on our previous experience, has resulted in us being an early recipient of funding to roll out the model.

As noted above, Awhi Ora is a co-designed preventative and early intervention approach to support people with mild to moderate mental health and addiction issues. This is achieved through the integration of NGO support services within general practice and other community settings to deliver psychosocial support and navigation services. Both HIPs and Health Coaches are based in general

practices and offer easy access to psychosocial support and goal setting. HIPs are registered mental health practitioners (usually psychologists) who provide brief support to people with a wide range of behavioural issues. Health Coaches are non-clinical positions that help people build knowledge, skills and confidence to manage health conditions that are often co-morbid and chronic.

In addition to the models above, Waitematā and Auckland DHB received a small investment for secondary mental health services to support general practice. This investment is designed to assist confident and competent general practice and better link general practice with specialist services. This is built upon the model initially developed in Waitematā DHB under the 'Our Health in Mind' programme. Counties Manukau received funding for Wellness Support for their general practice support model. As additional funding becomes available, consideration will be given to implementing the Counties Manukau Wellness Support model.

In total, $15.6 million of service delivery and a further $3.1 million for enablement costs is available for the initial 15-month period across Metro-Auckland. This will support 54 regional general practices. These practices have been chosen primarily based on the enrolled Māori and Pasifika populations. Service delivery regionally includes approximately 49 HIP full time equivalent positions, 38 Health coaches and 38 Awhi Ora support workers. In addition to the range of NGO and PHO providers, the Whānau Ora Commissioning Agency will lead the kaupapa Māori response, for which 10% of service delivery funding has been set aside, so that the models can be implemented within eight identified Metro-Auckland Māori practices.

Within the initial term, Waitematā DHB receives service investment of $3,541,594.35 which supports ten general practices within the area with 12.1 HIPs, 8.6 Health Coaches and 8.6 Awhi Ora workers.

Enablement is contracted on behalf of the region by Auckland DHB and covers a range of positions and functions. These positions will assist the implementation and ongoing provision of the services described above. The Enablement team will drive the roll out of the programme, support recruitment and set up of robust data capture and management functions.

3. Current Situation

We are drawing on the methodology for managing successful programmes (MSP) which outlines three levels of governance and oversight with addition of a Taumata (see diagram). These are:

- Strategic Sponsorship and Governance.
  This is a high level sign off and escalation point if all else fails in resolving issues at programme board level. It has a role in monitoring broader developments both across the health sector (beyond the mental health and addictions space) and across other sectors (for example, changes in Ministry of Social Development, Whānau Ora or Oranga Tamariki, which may have a bearing on the health system).

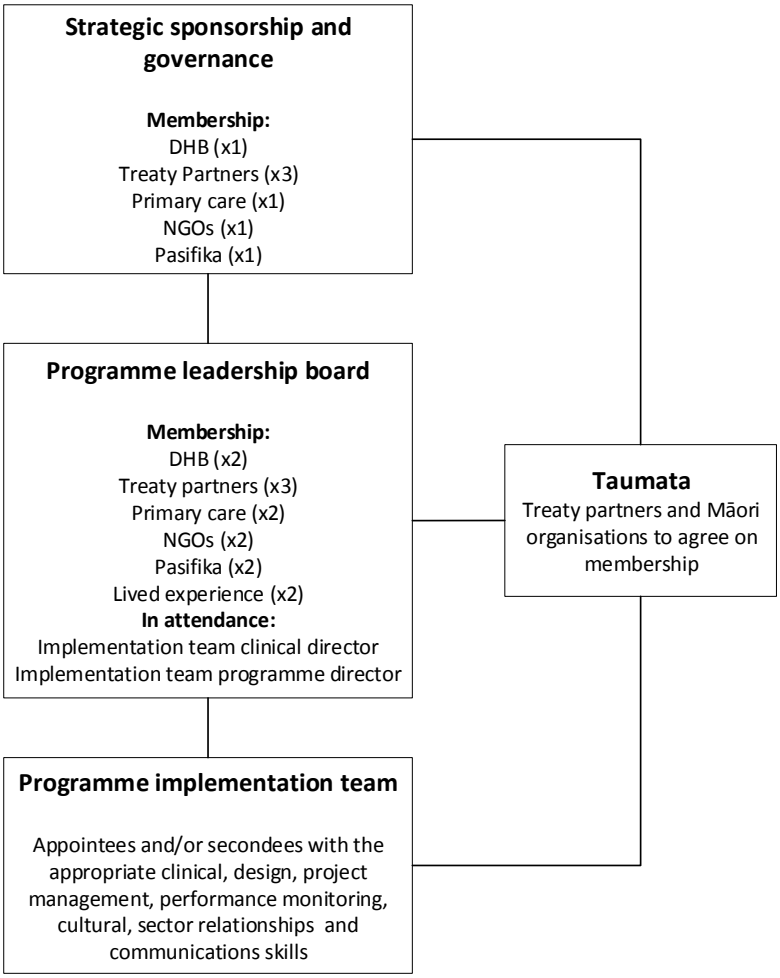
- Programme Leadership Board
  This is the decision making group where oversight and management of the collaborative programme occurs at a collective level. Its functions include resolution of any issues, driving equity, ensuring that inter-organisational connections are maintained, clinical governance and monitoring of risk. The Programme Leadership Board has a role to play in being aware of and attending to future opportunities.

- Operational Implementation

This take the form of the enablement / implementation team charged with standing up responsive, high quality IPMHAS for the population, to realise benefits, and deliver the contracted services, on behalf of the Auckland Wellbeing Collaborative.

- Taumata
  The role of the Taumata is to act as the cultural safe keepers for the Auckland Wellbeing Collaborative, where stakeholders will be able to access collective expertise. There are three tiers of activity for the taumata to maintain Te Kawa, Ngā Tikanga and Ngā Whakaritenga.

Auckland Wellbeing Collaborative – Leadership structure



The Terms of Reference and meetings schedules are in place for both the Strategic Sponsorship and Governance Group and the Programme Leadership Board.

The Taumata is led by the treaty partners and they are meeting regularly.

Positions within the interim enablement team have been filled. Recruitment to more permanent placements is underway. They are rolling out delivery of all models in line with the agreed schedule. HIPs and Health Coaches are presently in approximately 18 Metro-Auckland practices and Awhi Ora is in many more practices. Contracts have been drafted for all providers in the initial phase of delivery (22 contracts within Auckland and Waitematā) and more will follow as expansion continues.

The timing of the rollout schedule means new providers will join the collaborative at various points during the 2020/21 financial year.

As noted above, the MoH has separate procurement processes for kaupapa Māori, Pasifika and youth primary mental health and addiction services. Successful providers will be invited to join the collaborative as such integration of all services can occur without duplication. In Waitematā, Pasifika Futures, in partnership with The Fono, have been initially selected to implement services in the Fono general practices and within the Pacific communities of Waitematā DHB.

An evaluation will be undertaken, nationally by MoH, of all IPMHAS investment.

4.2 HPV Self-Testing for Cervical Screening Update

Recommendation:

That the Community and Public Health Advisory Committee note:

a) **That the equity focused Research Programme on human papilloma virus (HPV) Self-Testing is now complete with results awaiting publication.**
b) **The HPV Self-Testing research programme has demonstrated that the approach is acceptable and will improve equity of access, including for those women who are most underserved in the current screening programme. This research aligns well with similar work undertaken by research colleagues in Northland District Health Board.**
c) **The Parliamentary Review Committee, in 2018, strongly recommended that HPV Self-Testing alongside primary HPV screening is implemented with urgency in the New Zealand national cervical screening programme.**
d) **On the basis of the successful local research and the clear international evidence, there is increasing support in metro -Auckland for local implementation of HPV self-testing, ahead of national programme implementation, to address low coverage and worsening inequities. The volume of deferred screens related to COVID-19 has provided further urgency. It is likely that the national implementation of a primary HPV programme will be further delayed; noting that supportive infrastructure such a new national cervical screening register is not yet in place.**

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Study Advisors: Dr Sue Crengle (University of Otago) and Dr Nina Scott (Waikato DHB)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

DHB	-	District Health Board
HPV	-	Human papillomavirus
HRC	-	Health Research Council
PHO	-	Primary Health Organisation
RCT	-	Randomised Controlled Trial

1. Executive summary

This report updates the Waitematā District Health Board (DHB) Community and Public Health Advisory Committee (CPHAC) on the human papilloma virus (HPV) self-testing for cervical screening research programme. In New Zealand, the National Cervical Screening Programme (NCSP) has indicated its intention to move to primary HPV screening for cervical cancer, which would potentially enable HPV self-testing. Substantive national policy work, led by the NCSP, has been undertaken on this policy change. However, the planned implementation date originally 2018, pushed out to 2021, now seems unlikely. The work of our own research programmes (and that of other research colleagues) indicates that HPV self-testing is safe and acceptable and will result in equity positive improvements in coverage if well implemented. This paper notes the key lessons learned in the

research relevant for implementation and the urgency highlighted both by our research and by the large volume of deferred screens due to COVID-19.

2. Background

There are inequities in cervical screening coverage for Māori, Pacific and Asian women. The large coverage gap, particularly for Māori women, is persistent and longstanding. No population group is reaching the coverage target of 80% in Waitematā DHB, with coverage for Māori women remaining at 60%.

Table 1. NCSP 3 year cervical screening coverage for Waitematā DHB, women aged 25-69 years to March 2020, by ethnicity

Ethnicity	Population	Women screened in last 3 years	3-year coverage	Additional screens to reach target*
Māori	14,189	8,525	60.10%	2,826
Pacific	11,032	6,746	61.10%	2,079
Asian	45,636	31,278	68.50%	5,230
Other	105,854	75,492	71.30%	9,191
Total	**176,711**	**122,041**	**69.10%**	**19,327**

**For the total population the number of additional screens is the number required to move from the total population coverage to 80%. This may not be the same as the sum of additional screens required for each ethnic group to reach 80%.*

Multiple evidence-based activities have been undertaken by the DHB, Primary Health Organisation (PHO) and support to screening partners to address coverage. Despite this activity, coverage has been dropping over the last several years in metro-Auckland and many other places around the country. Dropping coverage is likely to be multifactorial including the cervical screening ceasing to be a target in the primary care performance programme (called IPIF) and effects of the 2016 consultation by the NCSP on their intention to move to a primary HPV programme. The programme change is still scheduled to commence from 2021, however, the infrastructure to support a major programme change (including a new cervical screening register) is not currently in place and we anticipate a further delay.

Cervical screening with testing for high risk types of HPV as the primary test will be an important step forward for the programme. HPV is a better test (more sensitive) and is modelled to reduce the currently plateaued mortality by a further 12-16% in New Zealand.[1] Primary HPV testing also allows the screening interval to be increased from three to five years, meaning fewer tests for women. Locally women and providers report confusion about the timing of introduction of the change and the impetus for improving coverage ahead of the rollout of a major programme change. Similar feedback was reported in Australia ahead of the Australian NCSP 'Renewal' primary HPV programme change.

The current NCSP has been successful over the last three decades at reducing cervical cancer incidence and mortality so that cervical cancer is now a relatively rare cancer. However, inequities

[1] Lew, J. B., Simms, K., Smith, M., Lewis, H., Neal, H., & Canfell, K. (2016). Effectiveness modelling and economic evaluation of primary HPV screening for cervical cancer prevention in New Zealand. PLoS One, 11(5), e0151619. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0151619

persist with mortality for Māori women twice that of non-Māori women. Cancer incidence and mortality is strongly linked to a history of never screening or being under-screened.[2]

In 2018, the World Health Organization (WHO)[3] Director-General issued a call for action to eliminate cervical cancer as a public health problem. Elimination is possible because cervical cancer is a preventable cancer almost entirely caused by HPV, and there are two highly effective complementary prevention strategies – HPV vaccination and cervical screening with a primary HPV test (followed by treatment of precancerous lesions). Australia, being the first country to introduce HPV vaccination, and to have introduced primary HPV screening in 2017, is on track to be the first country in the world to eliminate cervical cancer (by 2020 using the rare disease definition of elimination of 6 new cases per 100,000 women per year or 2028 if using the 4/100,000 definition).[4] A range of international areas of focus to accelerate vaccination and screening efforts are noted, including, specifically, the need for strategies to introduce cervical screening HPV self-collection.[5]

A simple, safe, and convenient self-test (cotton swab, similar to a STI self-test)[6] has been demonstrated internationally to improve access for women who are currently not participating in cervical screening.[7] HPV self-tests have been validated in a meta-analysis[8] as comparable to HPV clinician-taken samples (current screening method to sample cervical cells, but testing for HPV rather than looks for abnormal cells). HPV screening has already been established as superior to cytology as a primary cervical screening test.[9]

3. DHB Research Programme

In order to understand how to best optimise the technology and robustly test potential approaches focused on equity, Waitematā DHB and Auckland DHB undertook a research programme, which contains a series of interconnected implementation research projects (Figure 1 below).

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[2] Only 13% of women with cervical cancer had been adequately screened. Reference: University of Otago, for the Ministry of Health. Review of Cervical Cancer Occurrences in relation to Screening History in New Zealand for the years 2008-2012. May 2018. https://www.nsu.govt.nz/publications/review-cervical-cancer-occurrences-relation-screening-history-new-zealand-years-2008--0

[3] Simms, K. T., Steinberg, J., Caruana, M., Smith, M. A., Lew, J. B., Soerjomataram, I and Canfell, K. (2019). Impact of scaled up human papillomavirus vaccination and cervical screening and the potential for global elimination of cervical cancer in 181 countries, 2020–99: a modelling study. The Lancet Oncology, 20(3), 394-407 https://www.sciencedirect.com/science/article/abs/pii/S1470204518308362, and Brisson, M., Kim, J. J., Canfell, K., Drolet, M., Gingras, G., Burger, E. A et al. (2020). Impact of HPV vaccination and cervical screening on cervical cancer elimination: a comparative modelling analysis in 78 low-income and lower-middle-income countries. The Lancet, 395(10224), 575-590. https://www.sciencedirect.com/science/article/pii/S0140673620300684

[4] Hall, M. T., Simms, K. T., Lew, J. B., Smith, M. A., Brotherton, J. M., Saville, M., ... & Canfell, K. (2019). The projected timeframe until cervical cancer elimination in Australia: a modelling study. The Lancet Public Health, *4*(1), e19-e27. https://www.sciencedirect.com/science/article/pii/S246826671830183X

[5] Canfell, K. (2019). Towards the global elimination of cervical cancer. *Papillomavirus Research*, *8*, 100170. https://www.sciencedirect.com/science/article/pii/S2405852119300369

[6] Note that women do not need to find their cervix to conduct a HPV self-test, this is a high vaginal sample. Sexually Transmitted Infection (STI) self-tests have been in clinical practice for more than a decade, and are safe and acceptable diagnostic modality.

[7] Racey, C. S., Withrow, D. R., & Gesink, D. (2013). Self-collected HPV testing improves participation in cervical cancer screening: a systematic review and meta-analysis. Canadian Journal of Public Health, 104(2), e159-e166. https://link.springer.com/article/10.1007/BF03405681

[8] Arbyn, M., Verdoodt, F., Snijders, P. J., Verhoef, V. M., Suonio, E., Dillner, L et al. (2014). Accuracy of human papillomavirus testing on self-collected versus clinician-collected samples: a meta-analysis. The Lancet Oncology, 15(2), 172-183. https://www.sciencedirect.com/science/article/abs/pii/S1470204513705709

[9] Dillner J, Rebolj M, Birembaut P, Petry K-U, Szarewski A, Munk C, et al. Long term predictive values of cytology and human papillomavirus testing in cervical cancer screening: joint European cohort study. BMJ. 2008;337.

The focus groups, initial feasibility study (Study 1), and evaluation were funded by the DHBs with support from Awhina Trust. The CPHAC has previously received updates on the HPV self-testing research programme in 2016 and the results of the focus groups, evaluation and feasibility study in 2018. The feedback from the focus group participants directly informed the changes to the study materials (including written, graphic design, instructions, video content and including of QR codes) as well as informing support pathways.

Figure 1. HPV Self-Testing Research Programme

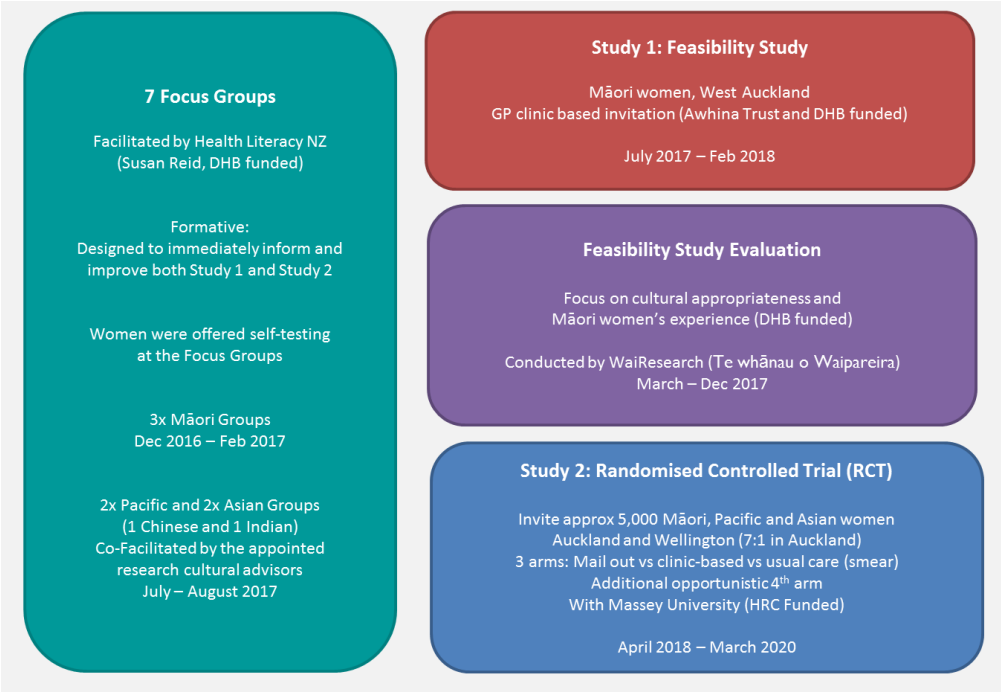


Figure 2. Schematic of the focus Group and Study 1 approaches

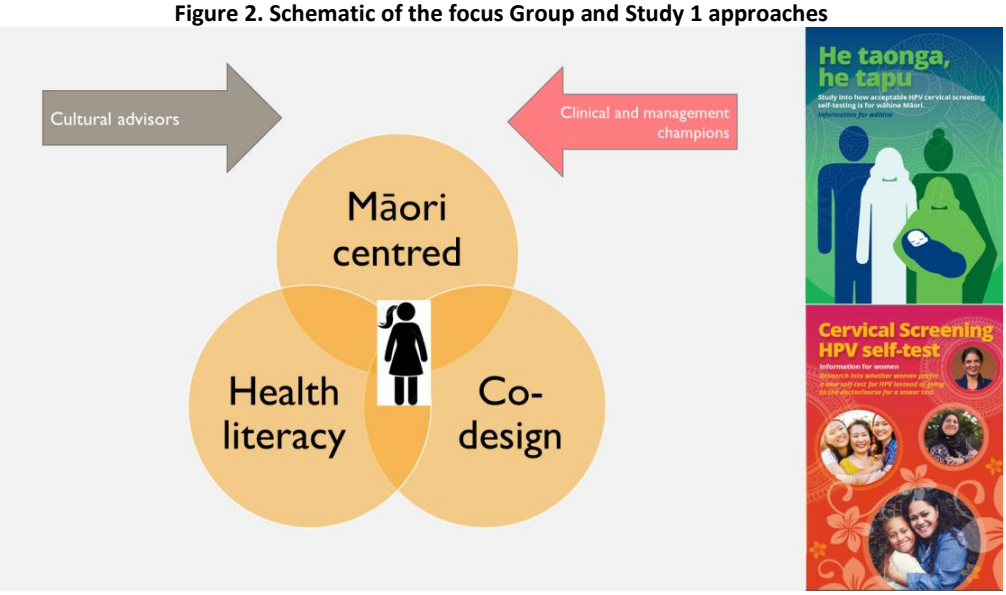
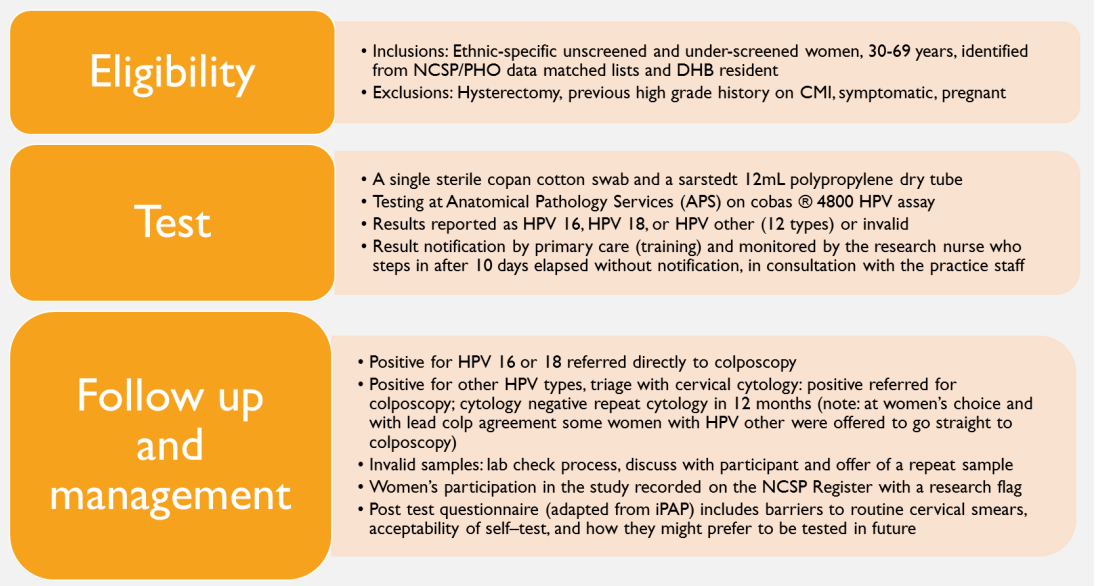
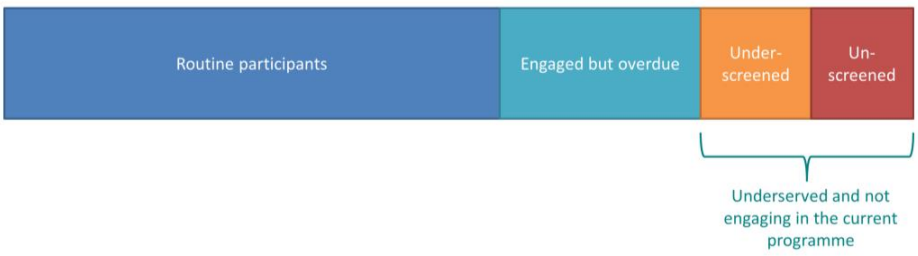


Figure 3. Key elements of the HPV Self-Test RCT protocol



In Study 2, the DHB team worked with Massey University (Centre for Public Health Research) on a community Randomised Controlled Trial (RCT) comparing mail out to clinic-based invitation. This work was funded by the Health Research Council (HRC). Key elements of the trial protocol are described in Figure 3 above, and have been published.[10] Recruitment has been completed. Building on the user-centred and health literacy supported qualitative work, and our feasibility study with Māori women, Study 2 focused on the ethnic groups with the lowest coverage Māori, Pacific and Asian women. Within this ethnic-specific focus, the research team was further focused on a subgroup of women who were never-screened (no record on the NCSP-register) or under-screened (very overdue at >5 years). These groups are shown as the orange and red groups in the schematic in Figure 4 below. The literature often describes this group the most 'hard-to-reach.' Our research team do not approve of the use of this term as it is victim-blaming and deficit-focused,[11] we refer to our target group as underserved or the least served by the delivery of the current NCSP programme.

Figure 4. Schematic of screening participant characteristics and focus of RCT



Our research purpose was to robustly test whether particular modes of invitation might work better for this group of women, who are the least served by the programme but have the most to gain from

[10] Brewer, N., Bartholomew, K., Maxwell, A., Grant, J., Wihongi, H., Bromhead, C., ... & Potter, J. D. (2019). Comparison of two invitation-based methods for human papillomavirus (HPV) self-sampling with usual care among un-and under-screened Māori, Pacific and Asian women: study protocol for a randomised controlled community trial to examine the effect of self-sampling on participation in cervical-cancer screening. *BMC cancer*, *19*(1), 1-10. https://bmccancer.biomedcentral.com/articles/10.1186/s12885-019-6401-y

[11] This point is raised because of the importance of narrative in the setting of inequities research. It is aligned to the Waitematā DHB Board approved Equity Framework, where it stately explicitly the requirement to '*consciously move in language away from deficit focus*.'

participation in screening. In particular, we wanted to test whether women in our target groups would respond to an offer of screening via a mailed kit. Our previous work (and our broader DHB experience in the mailed-invitation Bowel Screening pilot) has clearly demonstrated that multiple access methods are required to address equity of access, therefore, we also included in our study design a nested sub-study for women who did not take up the RCT offer of self-testing, providing an further period of six months to be offered self-testing opportunistically (when attending the clinic for any other reason).

We cannot yet report on the quantitative results as they are awaiting publication, however, we found increased participation, particularly for Asian and Māori women, and that the mail out arm achieved a higher uptake. A second offer opportunistically was also successful, particularly for Pacific women. In both our feasibility study and the RCT, we found comparable proportions of HPV types as reported internationally, and within the group of women who screened positive for HPV, we found both precancerous disease and early cancer. Through a highly intensive follow up support approach and close relationships with colposcopy leads, more than 90% of women achieved follow-up for a positive HPV test. This is higher than international benchmarks.

Feedback from women throughout the study was positive, and women reported being supported to make their own decision about follow-up and supported at colposcopy.

> *"….I really liked doing the test this way – I hope I can do it this way next time."*
> *"…hope all women can have this test one day I'm glad I could be involved."*
> *"this test kept my dignity intact."*
> *"I like this test for me as it's my body."*
> *"if it was this easy I would have done it a long time ago."*
> *"thanks so much good to hear my result is normal looking forward to the next test"*
> *"thank you so much I really appreciated being able to self test. It had actually been nearly 30 years since had a smear test because of embarrassment and bad experiences so I think this study is amazing."*
> *"Oh … thanks for this opportunity. I believe this self testing is a great idea and it will really benefit so many women like me."*
> *"Thank you for choosing me for this test – I would never have had another smear – I am so glad that my doctor and nurse gave me this test, another 2 years and I would not be here – this test saved my life."*
> *"I don't mind going to the specialist if I know I have to after doing my own test - I can suck that up knowing there's a risk there."*
> *"the doctor was amazing couldn't have asked for better … I was able to relax – thank you for everything."*

4. Other New Zealand HPV self-testing research

A small study examining different types of self-test kits available overseas was conducted with Pacific and Māori women in Wellington by members of the Massey University research team.[12]

[12] Brewer, N., Foliaki, S., Bromhead, C., Viliamu-Amusia, I., Pelefoti-Gibson, L., Jones, T., Pearce, N., Potter, J and and Douwes, J. Acceptability of human papillomavirus self-sampling for cervical-cancer screening in under-screened Māori and Pasifika women: a pilot study. The New Zealand Medical Journal 132, no. 1497 (2019): 21-31. https://researchonline.lshtm.ac.uk/id/eprint/4653873/

HPV self-testing has also been examined in New Zealand by research colleague Professor Beverly Lawton through kaupapa Māori hui-based qualitative research,[13] and through a primary care based study in Northland DHB inviting all women, due or overdue for screening, and comparing uptake with usual care at a practice level. Professor Lawton's work indicates clearly the acceptability of self-testing for Māori women, and she has championed the urgency for immediate implementation of HPV self-testing to address current NCSP inequities for Māori.[14] Professor Lawton has recently been successful in further funding to extend her work to investigate point-of-care HPV testing for rural women.[15]

5. Key implementation lessons learned from HPV research

The key lessons learned from our research programme have been that self-testing is safe and acceptable, and will increase participation and coverage. Multiple methods of access to the test would be preferable to ensure women least served in the current programme can access the test. In Australia, self-testing is only enabled via a health professional (GP) visit. We similarly tested invitation methods based on current NCSP primary care-based model through primary care enrolment, however, we are well aware that there are women who are not enrolled (or present as casual visits), and that there is opportunity to consider alternative health providers and offer through support to services or potentially non-clinical roles (e.g. community health workers). Further development and research of this option in a local context would be useful.

We also found that women do respond to mailed-offer, including Māori women. Given the level of issues with contactability (we previously reported that approximately 30% of the sample had incorrect or out of date contact details) and the mailed/return of result ratio, there is likely to be programme level concern about cost of a primary mailed invitation approach. However, the study team consider that it is important to keep mail-out as an option to access the test. This could be managed through ascertaining women's preferences to receive and return the kit. Alternatively there could be a 'mail-order' approach for example a kit could be mailed after a consultation discussion with a health professional or provider. The consultation could include a virtual or telehealth appointment. We collected preference in our study and found that many would prefer to be mailed a kit when they are due for a screen (the survey results will provide useful baseline preference data). We do note that 'mail out' is actually courier services (mailed parcels no longer available) which does introduce some complexity. We allowed a laboratory (learning from the Bowel Screening Pilot) and primary care drop-off process for women mailed a kit to optimise return of a sample.

In Primary HPV testing, there are concerns about the management of colposcopy volumes given that HPV is a more sensitive test. Internationally the implementation of primary HPV screening has seen an increase of in colposcopy referrals; with English results including referrals after early recall showing an 80% increase in colposcopies[16] and the first six months of the Australian Renewal programme showing that 2.6% of women were referred for colposcopy compared to 0.8% in the

[13] Adcock, A., Cram, F., Lawton, B., Geller, S., Hibma, M., Sykes, P., ... & Mataki, T. (2019). Acceptability of self-taken vaginal HPV sample for cervical screening among an under-screened Indigenous population. Australian and New Zealand Journal of Obstetrics and Gynaecology, 59(2), 301-307. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/ajo.12933
[14] https://www.rnz.co.nz/national/programmes/ninetonoon/audio/2018753377/cervical-cancer-smearing-smears
[15] https://www.hrc.govt.nz/news-and-events/study-aims-improve-outcomes-more-one-10-nz-births
[16] Rebolj, M., Rimmer, J., Denton, K., Tidy, J., Mathews, C., Ellis, K et al. (2019). Primary cervical screening with high risk human papillomavirus testing: observational study. BMJ, 364. https://www.bmj.com/content/364/bmj.l240.full.

cytology based programme.[17] Management of colposcopy service waiting lists raises similar concerns as colonoscopy waiting lists in the implementation of bowel cancer screening. Modelling work has been undertaken on the impact of a total programme shift to primary HPV, noting an initial increase in colposcopies which reduces as vaccinated cohorts enter the screening age. The projected 15% colposcopy impact[18] appears an underestimate compared to the international data. However, we are not aware of modelling on a regional or time staggered implementation approach, or a HPV self-test approach only. Primary HPV programmes use a triage system to manage colposcopy impacts, reduce unnecessary invasive testing and treatment, and also allowing time with repeat HPV testing for the virus to regress or resolve. The proposed New Zealand primary HPV triage system, like Australia, is to conduct a reflex cytology test on a HPV positive clinician-taken sample. A 'limitation' of the self-test is that cervical cells are not collected which could enable reflex cytology.[19]

The clinical pathway our research team followed for a positive HPV screen was the Australian 2017 recommendations by the Medical Services Advisory Committee (MSAC),[20] where a HPV 16/18 (high risk or oncogenic HPV type) was referred straight to colposcopy, and women with HPV Other (12 lower risk HPV types) were recommended to have a cytology and referred if this was abnormal. From the experience of implementing the trial, with an interest in ensuring equitable and high access to follow up, we noted that many women in our study reported negative experiences of smears in the past. We found that intensive support was required from our research nurse and at times the colposcopy service for a number of participants, including the occasional need for double appointments and time to defer an appointment until the woman had decided to proceed. This included the ability, on a case by case basis, for women with HPV Other to attend colposcopy without a cytology test where this is more acceptable to them. The flexibility of this approach was very important for achieving high follow up, and adequate resourcing for both additional colposcopy service wrap-around and intensive support-to-service is required.

Our colposcopic colleagues note the concern in the sector about the increase in colposcopy volumes and resource requirements, particular given the service is only partially funded by the programme currently. The Waitematā DHB colposcopy service is currently preparing a paper on impact of the implementation of primary HPV screening and the implications for workforce development to manage the increased workload. Following the publication of the ARTISTIC[21] trial follow up data, the NCSP Primary HPV screening guidelines group have recommended a variation to an initial proposed pathway which was originally based on the Australian guidelines. The ARTISTIC trial follow up data has shown the risk of high grade disease is significantly lower in women with HPV 16/18 positive test and normal cytology and regression of HPV may occur within 12 months. There is currently a proposed change to the primary HPV NCSP guidelines which recommend women with positive HPV 16/18 and normal cytology will have a repeat HPV test in 12 months. If the follow up test is HPV positive, referral to colposcopy is recommended. The proposed change will reduce the number of women referred to colposcopy. Data from Australia has reported 63.6% of women with HPV 16/18

[17] Machalek, D. A., Roberts, J. M., Garland, S. M., Thurloe, J., Richards, A., Chambers, I et al (2019). Routine cervical screening by primary HPV testing: early findings in the renewed National Cervical Screening Program. Medical Journal of Australia, 211(3), 113-119. https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.50223.

[18] Lew, J. B., Simms, K., Smith, M., Lewis, H., Neal, H., & Canfell, K. (2016). Effectiveness modelling and economic evaluation of primary HPV screening for cervical cancer prevention in New Zealand. *PLoS One*, *11*(5), e0151619. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4871332/

[19] It is likely in the future that there will be full molecular triage approaches that can be completed without the need for cytology (for example methylation or full HPV genotyping). However this is not currently available.

[20] MASC 2017 recommendations: https://wiki.cancer.org.au/australiawiki/images/f/f0/Cervical_screening_pathway_for_self_collection.pdf

[21] Gilham, C., Sargent, A., & Peto, J. (2020). Triaging women with human papillomavirus infection and normal cytology or low-grade dyskaryosis: evidence from 10-year follow up of the ARTISTIC trial cohort. *BJOG: An International Journal of Obstetrics & Gynaecology*, *127*(1), 58-68. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15957

had normal cytology, accounting for a significant proportion of colposcopy referrals[16]. The Australian programme will publish, in the near future, the updated clinical risk of different approaches for different HPV types. Proposed revisions to the guidelines might require this cytology step and repeat screen for all women who self-test positive for HPV. This is to ensure women are triaged to the appropriate follow up stream to reduce the risk unnecessary colposcopy. If this approach is followed, the results from the study indicate the importance of including a case-by-case ability to be flexible for women with ensure equity of access to follow up.

Effective introduction of HPV self-testing starts with considered presentation or 'promotion' of the test to women. This should align with communications about the HPV immunisation programme, which is an ideal opportunity for parents/young women to make the connection with screening for HPV. Despite having a long-standing HPV immunisation programme, we found that many women in our studies had a low level of knowledge of HPV as the cause of cervical cancer, consistent with international findings. We also found, in parallel research, that there were gaps in health professional knowledge.[22] For informed consent to a HPV self-test (which is a primary HPV test) women and health professionals need to understand what an HPV test is and what a positive result means, including the recommendation for follow up which will include a vaginal examination for a positive test. Mechanisms to address knowledge gaps, ensure equitable access to information, and health promotion approaches will be needed.

We excluded women in this study who were pregnant, symptomatic, or had a high grade cervical screening history. However we now have evidence and clinical guidance that HPV testing can be safely offered alongside self-testing for STI during pregnancy. There have been several recent cases of young women with cervical cancer who could have been screened in pregnancy, suggesting this is important. Our team also want further consideration of the offer of HPV self-testing to women with a High-Grade cervical screening history, particularly those very overdue for screening, and this is a focus of further research under the Māori Health Pipeline.

Table 2. Key implementation elements to consider for primary HPV testing

Element	Comment
Knowledge about HPV and HPV primary screening	• Target audience, providers and wider sector • Appropriately targeted public messaging in key translated languages • Linkage with the HPV vaccination programme
Invitation processes	• Written, online and video communication options available in key translated languages • Multiple access methods inclusive of primary care text portal and opportunistic offer, a mail-out option tailored to women's preferences and language and/or request and alternative providers • Multiple return of sample options including mail, laboratory or primary care drop off • Further research on options for delivery with alternate providers/roles
Informed consent	• Tailored written materials and instructions in key translated

[22] Sherman, S. M., Bartholomew, K., Denison, H. J., Patel, H., Moss, E. L., Douwes, J., & Bromhead, C. (2018). Knowledge, attitudes and awareness of the human papillomavirus among health professionals in New Zealand. PLoS One, 13(12), e0197648. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0197648

Element	Comment
	languages • For target audiences drawing on the learning from the research (women were very clear about how they wished to be communicated with) • Ensure that women undertaking a self-test are aware that it is a primary HPV test not a cytology test and are aware that a vaginal examination will be recommended for a positive test • Ensure that the legislative informed consent requirements are met[23]
Test device	• Our research and Professor Lawton's used a simple flocked cotton swab (e.g. Copan). There are other proprietary devices internationally although these are not recommended for performance and cost reasons. We note that there has been an international shortage of Copan swabs over COVID-19. Swabs can be used dry or in wet transport media. This is relevant for at-home use (dry swabs preferred) and mail out. • Cost of swabs
Laboratory test	• Validation of HPV tests on appropriate platforms acceptable to laboratory standards is required. There is recent published data from an Australian validation series[24] • Confirmation of appropriate HPV platforms in New Zealand and the cost for HPV self-testing (not currently in the programme)
Clinical pathway	• Confirm a clinical pathway particularly follow up of HPV positive women at colposcopy • Ensure that equity of access to diagnostic services and support required for underserved women is considered in the pathway, including the resourcing requirement
Appropriate increase in resourcing and change in model of support to services	• Appropriate increase to resourcing for an intensive model for some groups of women to ensure high follow up (>90%) • Support to services will need to include a more intensive supported and shared-decision making follow up model to ensure equity of access to diagnostic services • Linkage and wrap-around to cancer treatment services (if required) could be strengthened • Service commitment to cultural competency and cultural safety training to their workforce • Linkages to interpreter services to ensure access to language

[23] The NCSP is under the Health Act (Part 4A) which includes a range of requirements on sample takers and related to screen test results and data.

[24] The cobas HPV test for use on the 6800 and 8800 systems was approved by the FDA in April for primary screening https://www.fda.gov/medical-devices/recently-approved-devices/cobas-hpv-use-cobas-68008800-systems-p190028. Australian validation studies: Saville, M., Hawkes, D., Keung, M. H. T., Ip, E. L. O., Silvers, J., Sultana, F., ... & Brotherton, J. M. L. (2020). Analytical performance of HPV assays on vaginal self-collected vs practitioner-collected cervical samples: the SCoPE study. Journal of Clinical Virology, 104375. https://www.sciencedirect.com/science/article/abs/pii/S1386653220301177 and a review Hawkes, D., Keung, M. H., Huang, Y., McDermott, T. L., Romano, J., Saville, M., & Brotherton, J. M. (2020). Self-Collection for Cervical Screening Programs: From Research to Reality. *Cancers*, *12*(4), 1053. https://www.mdpi.com/2072-6694/12/4/1053

Element	Comment
	support
Appropriate increase in resourcing for colposcopy	• Fully address the current underfunding of colposcopy services within the programme • Allow flexibility for some underserved women who need an additional level of support • To address the potential workforce development implications of increased referrals following primary HPV screening
Clinical safety and monitoring Safe data management	• Monitoring key indicators such as HPV positivity rate, HPV type, referral and attendance at colposcopy requires appropriate clinical and data systems. • Visibility of women across the screening pathway is a key element of quality screening programme management;[25] this is currently undertaken with the national NCSP-register. There is concern that the current NCSP-register may be destabilised by an increase in volumes of results through the inclusion of more never-screened and under-screened women. • Results of a screening test are legislatively required to be reported to the register. • A new register, population based such as the bowel screening register, is planned as infrastructure for the move to primary HPV screening. The timeline on this is unknown. • There are alternatives available although they would require appropriate investigation including the bespoke IT system used for the HPV studies and cloud based registers used internationally. The NCSP have raised concerns about risk with parallel information systems. • Māori data sovereignty issues are critical to address in terms of safe data management
Legislative requirements	• As noted cervical screening is the only programme under legislation and there are a range of legislative requirements to consider in terms of self-testing. The NCSP are developing communications to the sector on this currently.

6. COVID-19 deferred cervical screens

The Cancer Control Agency has undertaken analyses on a range of cancer screening, diagnostic and treatment services nationally across COVID-19. The delays to screening programmes have been noted as a concern with 'deferred screens' and catch-up processes having impacts on services along the screening pathway and on cancer registrations. Deferred colonoscopies and mammographies were noted as a particular concern, as was the large volume of cervical screens missed through

[25] We note that the current NCSP-register does not interface with primary care and does not perform safety-net functions well in terms of women who do not attend colpsoscopy after a positive screen. It is also not a population register and has incomplete data due to a change from opt on to opt off in 2008. The register does not hold complete or quality information on exclusions such as hysterectomies. There are therefore many opportunities for improvement to the current NCSP-register.

COVID-19 primary care cessation of most face-to-face interaction. Although deferral of screens is a concern, it is more likely that the clinical risk of missed cancers sits in the group of women never-screened and under-screened than in those women engaged in the programme and due a routine screen. Similarly, there is clinical risk in the group of women with a previous high grade history and overdue for a screen, which is a project in the Māori Health Pipeline. HPV self-testing as a mechanism to improve reach and to manage the volume of deferred screens is attractive to the sector, metro-Auckland PHOs are very supportive of local implementation, particularly those involved in the research.

7. Parliamentary review recommendations

In the third Parliamentary Review of the NCSP (2018)[26] the review committee's first recommendation (p3) is:

> Primary HPV screening, including self-sampling, should be funded and implemented as a matter of urgency. Delays in implementing the primary HPV screening programme will result in a significant number of otherwise preventable cervical cancers in New Zealand women and continuing inequities.

Describing our DHB research programme they further recommend (p5) that:

> The PRC believes it is essential that self-sampling be included in the initial implementation of the new primary HPV programme as this will lead to improved equity for and the increased participation of priority group women. A pilot programme should be developed to examine the feasibility of 'whole population self-sampling for cervical screening'.

In relation to the need for primary HPV screening to be supported by an upgraded national register, the Review Committee states (p6-7):

> The development of the new NCSP-R, as part of the NSS, should occur in parallel with the National Bowel Screening Programme Register, if this is logistically possible, and not be delayed until after the National Bowel Screening Programme Register has been developed. This would reduce the risk of unnecessary further delay to implementation of the new HPV screening programme. Effective and appropriate integration of Practice Management Systems (PMS) must be considered as part of any design for a new technology solution for cervical screening. This will enable real-time access to cervical screening data to optimise clinical decision-making.

In regard to colposcopy funding the Review Committee recognises the current underfunding and states (p108-109):

> The Parliamentary Review Committee was interested to learn that DHBs receive a significantly lower payment for NCSP colposcopies than for non-NCSP colposcopies. For DHBs that are struggling to contain burgeoning deficits, this inequity in funding would suggest there is limited incentive for DHBs to prioritise NCSP colposcopies. It was suggested to the Parliamentary Review Committee during stakeholder interviews that some DHB's may choose not to continue providing NCSP. The Parliamentary Review Committee recommends that funding for NCSP colposcopies be reviewed to ensure that pricing supports the maintenance of quality services.

[26] Ministry of Health. 2019. Report of the Parliamentary Review Committee Regarding the National Cervical Screening Programme, April 2019. Wellington. Ministry of Health. https://www.nsu.govt.nz/system/files/page/prc_final_report_2019.pdf

8. Conclusion

Our main HPV self-testing research programme is now complete and many lessons have been learned relevant to implementation of self-testing, particularly on ensuring equitable reach and benefit. The urgency to address current (and worsening) programme inequities with self-testing was already clear in the Parliamentary Review recommendations of 2018 and has been magnified post-COVID-19, adding the large volume of deferred screens to the urgency. There is substantive national policy work on primary screening and HPV self-testing already undertaken. However, the current timelines for the national primary HPV programme change appear unlikely to be met (given key infrastructure such as a new register are not available) and the preparatory implementation work has not yet been initiated. This creates a tension given the maturity of New Zealand and international research, the current urgency and a primary care sector enthusiastic about local HPV self-testing implementation and keen to build on COVID-19 opportunities for change and doing things differently.

5.1 Planning Funding and Outcomes Update

Recommendation:

That the Community and Public Health Advisory Committee notes the key activities within the Planning, Funding and Outcomes Unit.

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Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ALT	-	Alliance Leadership Team
AOD	-	Alcohol and Drug
ARC	-	Aged Residential Care
ASH	-	Ambulatory Sensitive Hospitalisation
ARRC	-	Aged Related Residential Care
CADS	-	Community Alcohol and Drug Services
CALD	-	Culturally and Linguistically Diverse Communities
CASA	-	Clinical Advisory Services Aotearoa
CBACs	-	Community Based Assessment Centres
CPHAC	-	Community and Public Health Advisory Committee
CVD	-	Cardiovascular Disease
CWF	-	Child, Women and Family
DHB	-	District Health Board
ESBHS	-	Enhanced School Based Health Services
GP	-	General Practitioner
HCSS	-	Home and Community Support Services
HEEADSSS	-	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HPV	-	Human papillomavirus
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
IMT	-	Incident Management Team
LAS	-	Language Assistance Services
MADS	-	Metro Auckland Data Sharing
MADSG	-	Metro Auckland Data Stewardship Group
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MRRC	-	Mangere Refugee Resettlement Centre
MSD	-	Ministry of Social Development
NCHIP	-	National Child Health Information Platform
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NHI	-	National Health Index
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre

OIS	-	Outreach Immunisation Service
PCV	-	Pneumococcal Vaccine
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
PPE		Personal Protective Equipment
SMILE	-	Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily
UR-CHCC	-	Uri Ririki - Child Health Connection Centre
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Waitematā DHB's Community and Public Health Advisory Committee (CPHAC) on Planning and Funding and Outcomes (PFO) activities and areas of priority.

2. Planning

2.1 Annual Plans

The second draft of the 2020/21 Annual Plan was submitted to the Ministry of Health on 10 July 2020 and feedback (including that of performance measures) was received on 13 July 2020. Revisions and amendments were made to the Annual Plan in response to this feedback, noting that this did not include any amendments to the financial information. A further draft was submitted to the Ministry on 17 July 2020.

The review and updating of the Annual Plan will continue, once further information is received from the Ministry of Health and other actions, measures and targets are finalised. The financial content and templates will continue to be updated as and when any amendments are agreed.

It should be noted, that as per the modification to the Crown Entities Act (149CA), DHBs are required to have a final, signed 2020/21 Statement of Performance Expectations (including the financial position at that time) published at the DHB's website by 15 August 2020. Notice to take up this extension, in line with the modification to the legislation, has been published at the DHB's website, as required.

2.2 2019/20 Annual Reports

The 2019/20 audit has commenced and we are working with the auditors to complete initial requirements. Audit New Zealand, the Ministry of Health and the DHB have agreed to the production of a 'scaled-down version of the Annual Report this year, due to COVID-19 response activities which have impacted on service delivery and this, in turn, will be reflected in performance against many of the indicators/targets presented in the Annual Report. Audit NZ have requested the completion of a COVID-19 Questionnaire to get an overview of:

- COVID-19's impact on Waitematā DHB (Both Financial and Service Performance); and how best to report and reflect this in the Annual Report,
- What new services were developed as part of the response work and how these will be reported on.

The recently updated population estimates (from StatsNZ and the Ministry of Health) will also impact some indicators. These impacts are being discussed with the auditors.

3. Primary Care

3.1 Response to COVID-19

The primary care team continues to be involved in the Northern Region Health Coordination Centre (NHRCC). The role of Community Based Assessment Centres (CBACs) remains a key priority to support both swabbing of people with symptoms and surveillance swabbing, in accordance with the national guidance. The CBAC function is likely to be needed for up to another six months. As a consequence, the number and locations of the CBACs has been reviewed, as have the mobile testing clinics. The mobile testing clinics are primarily swabbing people in the Managed Isolation Facilities.

As at 14 July 2020, CBACs and mobile clinics have swabbed over 100,000 while another 53,000 have been swabbed through their general practitioner across metropolitan Auckland.

Table 1. Proportion of tests taken at CBACs and mobile testing clinics by ethnicity (Source: e-notifications)

Māori	12%
Pacific	18%
European	44%
Asian	20%
MELAA*	2%
Other	3%

* Asian & Middle Eastern Latin American and African

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units across metropolitan Auckland. Social housing providers are working on finding permanent housing for those temporarily placed into motel units and this process may take up to six months to complete. Many are not enrolled with a primary care provider and have untreated or unmet health need. The DHBs have funded an interim health service to address their health needs and to support enrolment and engagement with a general practice.

The government announced an $18 million support package for community pharmacy. The $18 million fund is in addition to the $15 million government funding paid to all pharmacies during COVID-19 Alert Level 4 Lockdown period, and the advanced payments made by DHBs to support pharmacy cashflow in April and May. Funding will be held centrally by the Ministry of Health, but the application process will be managed by DHBs. A nationally consistent approach for the allocation of these funds has been developed by the DHBs. There are some caveats on the use of the funds as specified by Cabinet; (i) the fund is not universal and targets pharmacies that meet a set of eligibility criteria and, because of COVID-19, require financial support to remain viable, (ii) the DHB assesses that the pharmacy is critical based on factors including location; provision of specific services; and servicing high needs or vulnerable populations, (iii) critical pharmacies will be required to demonstrate to the DHB, through an 'open book' process, that they have exhausted all other funding avenues, including government COVID-19 business support packages and other financial supports, to remain open, i.e. there is no reduction in service provision.

3.2 Flexible Funding Pool

The Flexible Funding Pool is a revenue stream within the Primary Health Organisation (PHO) Services Agreement that allocates funding based on the demographics of the enrolled population of a PHO and is weighted for deprivation. The Auckland-Waitematā Alliance and the Counties Manukau Health Alliance have worked on the development of a revised framework for the Flexible Funding Pool. The

revised framework is being presented to a joint Alliance Leadership Team meeting at the end of July. The revised frame work will be presented to the DHB Boards for endorsement.

Historically the application of the Flexible Funding Pool has been determined, with some DHB input, individually by PHOs. This has led to variation in the type and range of service invested in. The new framework will provide a consistent approach for allocation while allowing some flexibility to address a particular need within any given PHO.

The next step in development is an outcomes measurement framework to assess impact on health outcomes. This will enable an effective mechanism to identify programmes that provide better outcomes, support a continuous improvement approach and maximise investment over time.

3.3 Metro Auckland Data Sharing Framework

The Metro Auckland Data Sharing programme (MADS programme) is a partnership initiative between the Metro Auckland PHOs and DHBs to enable the secure sharing of health data between the stakeholders for the purpose of population health improvement.

It is supported by a Framework (suite of guidelines, policies and processes) that was setup by the Metro Auckland Data Stewardship Group (MADSG) and directs exchange of health data between the stakeholders in the Metro Auckland area and ensures its compliance with the requirements of the Privacy Act and the Health Information Privacy Code. The Framework was endorsed by Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (ALTs) in August and September 2015 respectively.

Examples of data sharing include information that forms the after-hours dashboard (includes urgent care clinic, emergency department and St John data) and the diabetes data set. Since the development of the framework the scope of data sharing has expanded and the exchange of data is now supported by a secure portal known as HealthSafe which was developed in 2018. Considering the rate of change in the effective management of data, a review of the framework has been undertaken. The review and the associated recommendations are now being considered by the Alliance Leadership Team and implementation planning is underway. Some key findings of the review were:

- The Metro Auckland Data Sharing Framework and HealthSafe are sound concepts with significant potential to support improvements in health services delivery and outcomes. Metro Auckland greatly benefits from having robust data sharing processes in place between primary and secondary care (and other users).
- This programme is an important regional resource, both in its people, the range of technical infrastructure available and also the knowledge that has been attained with the operational experience over the framework.
- Technical capabilities have evolved along with sector aspirations for data sharing opportunities with potential to improve care both at the population and individual level.
- There is a growing appreciation for how data generated in primary care can be used to monitor change at a population level. Originally, the focus was on data exchange whereas now the focus is far more on enabling a wide range of information sharing which involves matching datasets for various programmes and situations.
- It is worth the investment of time and effort to improve and update the Framework and to consider any extensions to the HealthSafe functionality required.

This framework, and the development of HealthSafe, better places the DHBs and PHOs to measure performance, and identify if interventions are delivering on improve health outcomes. Thus, enabling improved reinvestment and or new invest decision making as based on metrics of outcomes.

3.4 Diabetes

The following are some key facts from the latest (April 2020) diabetes quarterly report for Waitematā DHB. At the end of quarter three 2019/20 the following can be noted:

- Five of the seven indicators, with the exceptions being: systolic blood pressure control (-3%), Cardiovascular Disease (CVD) secondary prevention for people with diabetes (-3%) are within +/- 1% of their December 2019 result.
- Across the last 12 months, there have been increases in CVD primary prevention for people with diabetes (+5%), CVD primary prevention for the total CVD cohort (+3%) and HbA1c glycaemic control (+3%) along with a decrease in systolic blood pressure control (- 2%) - the other two indicators (excluding management of microalbuminuria where there is only nine months of data) are +/- 1% of their April 2019 result.
- Waitematā DHB has the highest percentage of patients with diabetes that have good glycaemic control (63%) and (equally with Auckland) the highest percentage for secondary prevention for patients with diabetes (72%).

The following graphs present the performance over the first three quarters for 2019/20, noting the target is represented by the red line.

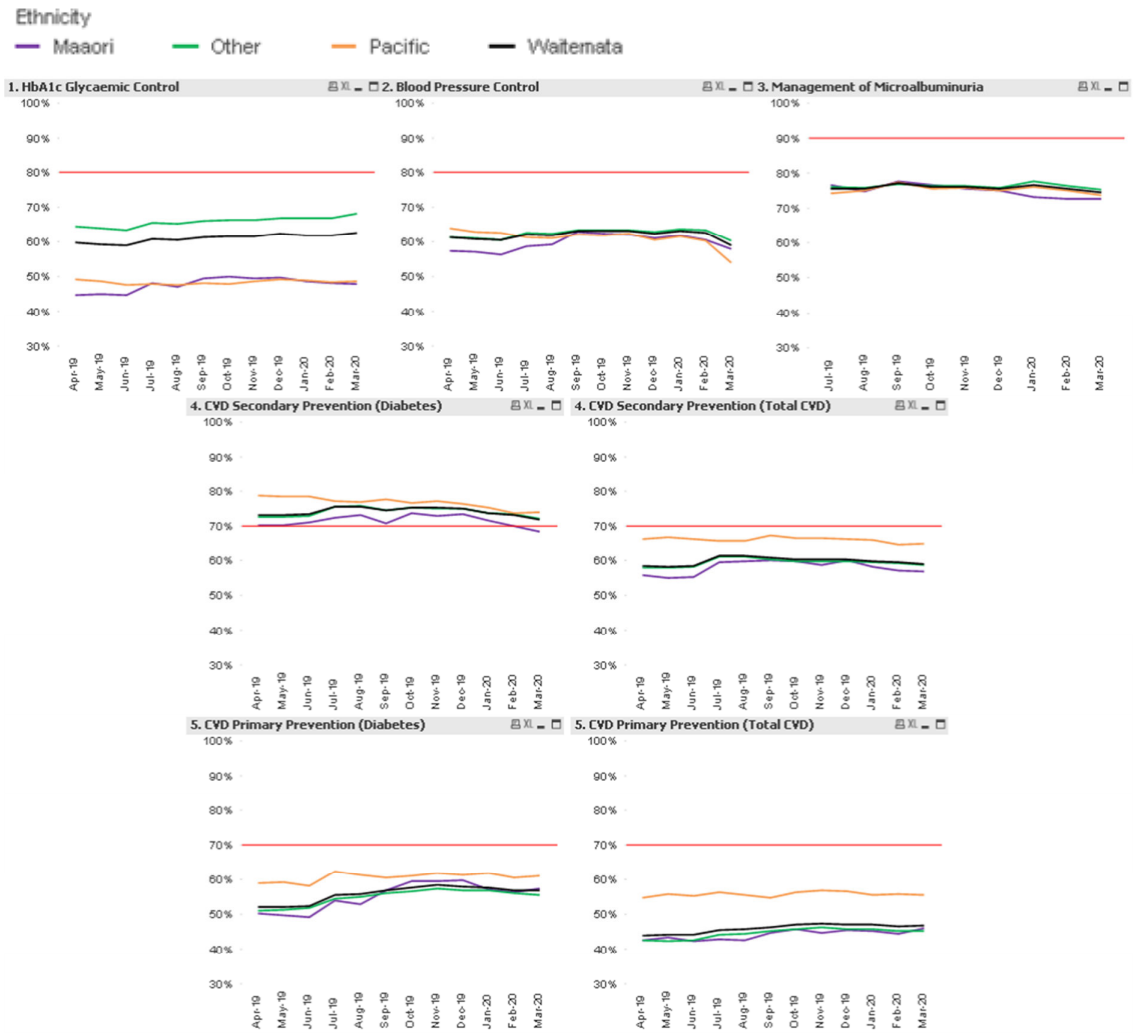

Figure 1. Metro Auckland Clinical Governance Forum Clinical Indicators for CVD and Diabetes

4. Health of Older People

4.1 Aged Residential Care

The offer from the DHBs to increase 2020/21 service level prices for aged residential care (ARC) by 3% was initially rejected by the sector. The main reason for the rejection was that the offer failed to adequately address the issue of pay parity for nurses working in ARC with their counterparts in DHBs. The offer was subsequently accepted when the DHBs committed to working with the sector over the coming months, as a priority, to establish a clear position on pay parity with the view that this work will be used to inform any budget bid considerations if indicated by government. It was acknowledged that the pay equity issues extend beyond ARC and government interest is in understanding the broader picture.

It had previously been agreed that ARC providers would start publishing their minimum and maximum charges for rooms on the 1 July 2020. However, the work to prepare and reach an agreement on how room charges would be notified was paused due to COVID-19. The sector has now requested that this be addressed at the same time as the 'opt out' clause for premium room charging is reviewed in the national Aged Related Residential Care (ARRC) Agreement since the sector 's view is that the clause is not always being used for cases of financial hardship. A deadline has been set to resolve these two issues by 1 October 2020. A variation to the ARRC Agreement will be issued then if required.

Maintaining ARC COVID-19 preparedness and planning for an outbreak remains a priority. The DHB quality and monitoring manager will review a facility's preparedness assessment if there is a change in manager or any other significant change at a facility. Relevant information from the COVID-19 preparedness assessments will also be provided as pre-audit feedback to the independent auditors. A Waitematā DHB outbreak management process has been developed for ARC in conjunction with a regional approach to prevention and management. The issue of staffing a facility during an outbreak remains a critical and more work is being undertaken to understand staffing options e.g. availability of agency nurses and health care assistants, and training that may be required.

4.2 Home and Community Support Services

Home and Community Support Service (HCSS) visiting guidelines have been updated for HCSS providers when a client or household member: is a suspected, probable or confirmed case of COVID-19; has acute respiratory symptoms; or has been in contact with a confirmed case of COVID-19 in the last 14 days. The Northern Region DHBs' approach to supporting HCSS providers during the COVID-19 Alert Levels 4, 3 and 2 worked well and are able to be quickly re-established if required.

5. Child, Youth and Women's Health

5.1 Immunisation

5.1.1 Waitematā DHB Quarter 4 2019/20

There has been a significant primary healthcare disruption over the last two quarters due to COVID-19. The provisional results for the eight-month immunisation focus area for Quarter 4 are 92% Total, 83% Māori and 86% Pacific. There was also a drop in coverage for Deprivation 9-10, with provisional coverage of 84%. Contributing factors include parental concerns around social distancing for children at healthcare sites and various access issues such as:

- reduction in general practice services with several large high-needs practices not routinely taking booked appointments and closed satellite clinics resulting in some parents having to adapt rapidly,

- absence of opportunistic immunisation, and
- the pause of outreach immunisation services from around 25 March -17 April (it was reported that home visiting uptake in the community was slow despite safety protocols, access to Personal Protective Equipment (PPE)).

Overall, the recovery has been better than expected given the drop in on-time coverage over Quarter 3 and Quarter 4. In February 2020, Waitematā DHB was tracking ahead of the same time last year, provisional coverage is approximately 1% behind the same time last year for total coverage and 1.5% for Māori – this was an improvement on the 2% and 6% lag identified in May 2020.

One month rolling coverage rates as a "real time" indicator are being monitored and compared at four-weekly intervals with Māori most impacted. These coverage rates are more prone to fluctuation due to smaller population size than the three-month rolling coverage usually used for reporting.

Māori Immunisation Coverage as at	**6m**	**8m**	**18m**	**24m**
23/03/20	76%	89%	64%	92%
20/04/20	47%	84%	69%	89%
18/05/20	52%	91%	67%	91%
15/06/20	52%	80%	73%	89%
13/07/20	66%	83%	63%	84%

The DHB has a number of initiatives underway including:

- Development of a call to action graphic for use on social media. A video message from Dame Naida Glavish was also commissioned to encourage whānau to immunise.
- Working with PHO colleagues on their endeavours to support General Practitioner (GP) practices in their recalls.
- Identifying the Māori and Pacific cohort who were due immunisation during lockdown to ensure priority follow up by our National Immunisation Register (NIR) team to get prompt referral to Outreach Immunisation Service (OIS).

Achieving the results that have been attained for Quarter 4 is a credit to all providers, though it is recognised that providers remain under pressure.

As at 1 July 2020, the Immunisation Schedule has dropped the three-month pneumococcal vaccine (PCV-10) dose (now only given at 6 weeks and 5 months), high risk PCV schedule remains at three doses and other changes are brand only.

The migration of the NIR to a new platform is still causing some issues for both the DHB administration and also for providers. The Ministry of Health and Orion (as platform provider) are rapidly addressing the issues.

The NIR and the Missed Event team continue to refine processes to ensure data accuracy and that children requiring outreach immunisation services are referred on time. The service now has access to the Before School Check database as a contact detail source.

Influenza immunisation highlights include:

- Demand for the influenza vaccine has settled, following significant uptake in March and April.
- Uptake for 0-4 year old Ambulatory Sensitive Hospitalisation (ASH) children eligible for influenza vaccination (a Systems Level Measure) has shown a significant improvement from last year, as at 30 June 2020, 27.3% of eligible 0-4 year olds had been immunised, compared to

15% at the same time last year. Coverage for Māori has more than doubled at 18.2% compared to 7.4% last year. Coverage for Pacific children also doubled from 6.1% to 15.2%.

- The DHB rapid response team concluded at the end of May. In the four-week period, 420 people, were immunised across Auckland and Waitematā DHB, representing those that were eligible due to pregnancy, <5 year olds with an ASH condition, >65 year olds and those eligible due to other conditions.

The DHB has funded a revision of the antenatal reminder card to reflect the Smoke and Alcohol Free, Mental wellbeing Matters, Immunise, Lie on Your Side and Eat Healthily (SMILE) resource. The SMILE resource is also in the process of being translated into Te Reo, Samoan and Tongan.

5.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) is now established. Uri Ririki comprises teams of administrators tasked with management of the NIR, National Child Health Information Platform (NCHIP) and Noho Āhuru – Healthy Homes (formerly called Kāinga Ora). The full complement of administrators have been appointed and the service management level is being further developed. An operations manager has been seconded for six months to oversee the next stage of service development and a new clinical lead role is being proposed to work across the three register-based services with a focus on improving continuity of care for children with the highest needs.

During the COVID-19 Alert Level 2 restrictions, the teams returned to work at the Greenlane offices after having provided business as usual activities from their homes in Alert Levels 4 & 3. The repatriation of the NIR into Uri Ririki - Child Health Connection Centre continues to be a success, providing ongoing support to general practices and immunisation providers.

Work is underway to harness information from NIR and NCHIP to help understand the impact of COVID-19 disruptions on the uptake of childhood immunisations. Additional follow-up is being provided to GP practices regarding children whose immunisations were due/overdue during the lock down period.

Linkage with the Ministry of Social Development (MSD) continues to evolve, with business processes now in place for the one-way sharing of contact details for children who are overdue immunisations and unable to be located by *any* child healthcare organisation (including home visits). This is the first quarter of operation. In summary, 134 children were identified as 'lost-to-services' and request for contact details were made to MSD. A total of 52 (39%) were known to MSD, of whom, new contact information was provided for 36 (27%) children, including six who had gone overseas or out of the DHB areas. The Uri Ririki service is working with HealthWEST OIS, to provide immunisation access for

these 52 children this quarter. This new process will continue to be closely monitored to ensure privacy and security standards are maintained.

One of the objectives of NCHIP and Uri Ririki is to reduce duplication of effort in the sector and reduce complexity for parents in accessing service. An early benefit of NCHIP has been the discovery of duplicate National Health Index numbers that were previously unknown. In these cases the same baby is being followed up and caregivers are offered duplicate services at least twice by all the different care providers. In this quarter 21 babies less than eight months old were discovered with duplicate NHI numbers that required merging by the Ministry of Health. One infant already had 3 NHI numbers.

A new release of NCHIP this month has added features that improve identification of high needs children who may have missed several milestones. Intensive data quality work is continuing such as flagging and disabling historical records for more than 900 deceased children under six years of age.

Socialisation of Uri Ririki – Child Health Connection Centre continues. In the next phase, the service is starting to work via the Well Child Equity and Excellence Group with Well Child Tamariki Ora providers, PHO child health representatives and Oral Health to develop systematic pathways to re-engage those who are identified as 'lost-to-service'. Future NCHIP enhancements are planned that will provide look up access to the child's milestone information for these providers.

Some of the UR-CHCC team members were redeployed in part to support to the Auckland and Waitematā DHBs 'Flu Rapid Response' Project. This temporary service ran for six weeks taking an intentional approach to increase access for Māori, Pacific and those living in quintile 5 areas. Throughout April and May the small team delivered in-home 'flu vaccinations and street level clinics for those unable to attend a primary care provider. A whole of whānau approach was taken so while flu immunisation was the entry point, people of all ages in the household were offered any immunisation they were due. More than 450 people were given at least one immunisation by the team with about half delivered in the home. The project ended on 31st May 2020 and discussion is underway to continue some of the successful approaches with the Māori and Pacific-led mobile clinic planners. Further review and analysis will be provided in the next funder report.

The Noho Āhuru – Healthy Homes service is now able to progress most components as per usual. Ministry of Social Development have re-started housing assessments for our whānau, after a significant delay during the COVID-19 response due to their capacity. A small backlog of assessments to work through remains. Referrals to the service have increased steadily as other health services have resumed seeing normal volumes and are now tracking above the comparable time last year. As at 30 June 2020, Waitematā DHB received 1,330 referrals to Noho Āhuru – Healthy Homes. This included 5,150 family members getting access to healthier home interventions. Of the referrals received, 528 (40%) were for families with a newborn baby or hapu woman.

5.3 MMR Catch-up Programme

In February 2020, the Ministry of Health announced funding of a national measles campaign, with a focus on 15-29 year olds, particularly Māori and Pacific. Waitematā DHB has submitted a plan to the Ministry for the allocated funding with a focus on utilising the relationships with schools through the Enhanced School Based Health Service (as per the successful Measles, Mumps and Rubella (MMR) catch up during the mumps outbreak), tertiary institutes, workplaces (alongside 'flu vaccination in 2021), sexual health clinics, community pharmacies and other community settings such as marae and Pacific churches.

5.4 Well Child Tamariki Ora

All Well Child Tamariki Ora (WCTO) providers in Waitematā DHB have resumed face to face WCTO services. The WCTO providers are focusing on catching up those Tamariki that could have missed their core visits during the COVID-19 lock down period, with pre-screening contacts before home visits. Te Ha Oranga continues to provide immunisation services to their Tamariki.

5.5 Youth Health

5.5.1 Enhanced School Based Health Services

Young people attending lower decile secondary schools are less likely to access youth appropriate primary and mental health care when they need to. This can result in missed opportunities for preventive health care and poorly managed health conditions. As well as the negative impact on health, it also affects their educational outcomes. The Enhanced School Based Health Services (ESBHS) programme offers youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner. Services in schools provide an opportunity to increase health literacy and to identify and address unmet health needs for an identified population of young people with higher needs, risk and complexities. Currently about 6,000 secondary school students have improved access to primary healthcare in Waitematā DHB through ESBHS.

All Year 9 students are offered a bio-psychosocial HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) assessment to identify unmet health needs. The Ministry of Health target for HEEADSSS assessments is 95% by the end of the school year.

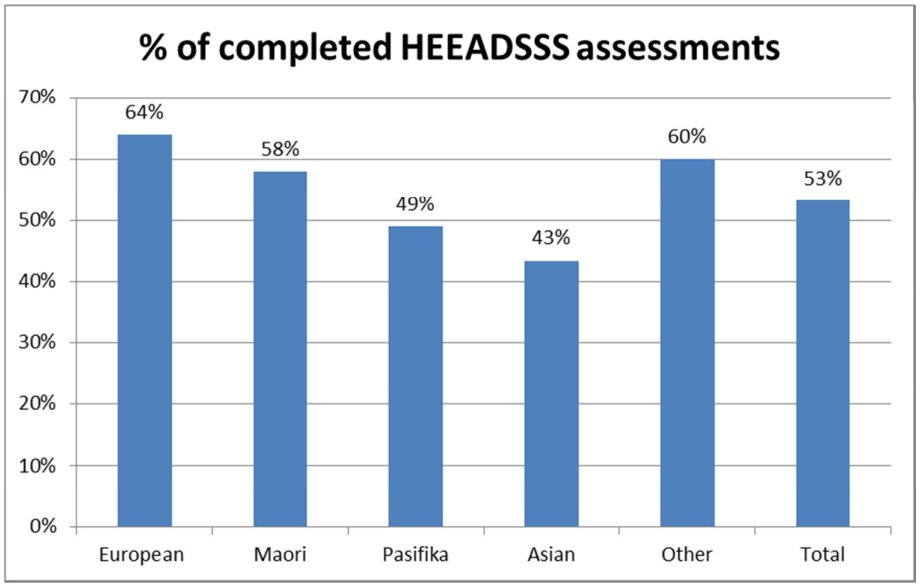

Figure 2. HEEADSSS assessments percentage completed in Year 9 by ethnicity

Even with service disruption caused by COVID-19, the school nurses in Waitematā DHB have completed on average 53% of HEEADSSS assessments for Year 9 students. To further enable nurses to complete psychosocial/wellbeing assessments for all students in Year 9, the DHB is implementing YouthChat, a self-completed psycho-social assessment for students in secondary schools. Face-to-face interview based HEEADDSSS assessment takes around an hour to complete. With YouthChat the assessment takes less nurse time (less than 50% of the time required for face to face) and in some domains has been demonstrated to elicit more honest responses.

5.5.2 Decile 5 expansion

Funding for decile 5 schools was provided in 2019 by Ministry of Health. Locally, the decision was taken to not include the GP service into decile 5 schools. This required an adjustment to enable nurses to continue working under standing orders. The WDHB provider arm, Child, Women and Family (CWF) Services is contracted to deliver the ESBHS at decile 5 schools. This service is delivered by DHB-employed youth health nurses who are based at these schools. The required professional development, clinical supervision and support for these nurses will be provided through the CWF service. The three decile 5 schools in Waitematā district are supportive of this model and the CWF service is currently recruiting registered nurses to provide this service.

With this expansion of ESBHS, a further 2477 students will have improved access to primary healthcare services in their school setting.

5.5.3 Catch-up Immunisation Service within ESBHS

The Ministry of Health has identified that older children and young adults are less likely to be fully immunised against MMR. This age group was heavily affected by recent outbreaks, mumps in 2017 and measles in 2019/20. Many of these children and young people missed weeks of school, either while they were sick, or while the disease circulated in their community and they were quarantined at home.

In line with the directive from the Ministry of Health, Waitematā DHB has submitted a plan to implement catch-up immunisations as part of ESBHS to ensure those who have missed out of vaccination events are fully immunised. A dedicated roaming nurse will be employed as part of ESBHS, to offer vaccination for those students who have missed out of routine vaccination events. We are looking at offering a comprehensive immunisation service to support all missed vaccinations including MMR, Human papillomavirus (HPV) and Boostrix to all year groups during 2020- 2021. From 2022, it is anticipated that catch up immunisation will be offered alongside the HEADDSSS assessment.

5.6 Women's Health

As previously reported, concern remains around the delivery of timely fertility services. In particular, consideration is being given as to how to ensure the prioritisation of services for those who have rare genetic conditions that may be passed on. Timelines are outside of expectations and consideration of additional funded volumes or service restrictions is needed to meet Ministry of Health timeline expectations. Patient satisfaction feedback for the Northern Region Fertility Service has reported satisfying results. Areas for further consideration include patient suggestions around access to results similar to the Patient Portal mechanisms now used in primary care.

Abortion legislation reform came into force on 24 March 2020. This changed who and where services could be provided by. Service provision has adjusted to accommodate the new legislation but much of the former status quo remains intact. Abortion services for first trimester are provided in a centralised service at Greenlane Clinical Centre, second trimester services are sourced by each DHB. A metro Auckland process regarding the configuration of services has been led by PFO.

6. Mental Health and Addictions

6.1 Response to COVID-19

6.1.1 Semi-independent Supported Step-down Accommodation service

In the early stages of COVID-10 Alert Level 4, a group of service users who could not be discharged from acute mental health services (as they could not return to a flat / boarding house or to live with elderly and frail parents) were identified. The Northern Region Health Coordination Centre (NRHCC) approved an interim accommodation service for these service users in metro-Auckland. The service was contracted to a Non-Governmental Organisation (NGO) Kāhui Tū Kaha from 20 April 2020 to 30 June 2020. The service has been well utilised and during COVID-19 Alert Level 1, it actively worked with service users to find alternative housing in preparation for the contracting ending 30 June 2020. Two service users have moved to independent accommodation; two have moved to live with whānau and the remaining three are being supported to access social housing.

6.1.3 Infection Prevention and Control Assessments of Mental Health and Addiction Services residential facilities

In the Waitematā DHB area, seven NGO providers have submitted self-assessments across a total of 18 residential sites. The self-assessments were reviewed by a Clinical Nurse Specialist (Mental Health Provider Arm) and a Mental Health and Addictions specialist in audit as well as an infection control and prevention nurse. The review will identify sites that require a virtual visit to follow-up on identified risk areas, and establish requirements and time frames to address any risk. Twelve of the 13 sites identified have received a virtual site visit by two senior nurses from the DHB Specialist Mental Health Service. Summary documents with any required actions will be sent to each provider by mid-July, and the PFO team will follow up on required actions regarding COVID-19 infection prevention and control preparedness.

Additionally, NGO providers regionally will be provided feedback on themes which have emerged from the virtual site visits, and will be reported to the NRHCC.

The Ministry of Health devolved responsibility to the DHBs to assess their contracted Disability Support Services' residential sites. The Ministry of Health provided Waitematā DHB with a sample of 29 sites across 16 providers for review. Waitematā DHB engaged the services of a quality and audit expert to review all self- assessments and associated documented evidence, and provide recommendation to the Incident Management Team (IMT) about priority areas and providers for follow-up virtual or site visits. The IMT has established two teams of clinical nurse specialists and link nurses to undertake the visits commencing July 2020.

6.1.4 Alcohol and Drug residential rehabilitation and detoxification services

Alcohol and drug (AOD) residential rehabilitation services have opened to new admissions, with the majority commencing admissions in COVID-19 Alert Level 3. Social Detox at Auckland City Mission commenced operation with a smaller intake of five on 11 May. The service is now fully operational with a full intake commencing at COVID-19 Alert Level 1. The inpatient medical detoxification service located at Pitman House closed on 23 March 2020 and opened at full capacity at COVID-19 Alert Level 1. Community Alcohol and Drug Services (CADS) have proposed a revised model of care for medical withdrawal management involving short admissions to hospital with the remainder of the detox completed at home with support of the re-deployed medial detox clinicians. This requires dedicated hospital beds and the provider arm is negotiating with Auckland DHB and Counties Manukau Health to seek endorsement of this approach.

National and local anecdotal evidence, inpatient admissions and emergency department presentations indicate that during the rahui, manufacture of synthetic drugs and methamphetamine

may have increased. The cost of these substances have dropped from $100 to between $20- $30 for a unit. Emergency Department presentations and demand for AOD treatment is expected to increase as a result.

For some people the rahui was an opportunity to reduce or abstain from alcohol, however for many alcohol consumption increased further complicated by unemployment, pressure on relationships and uncertainty regarding the economic outlook.

We may therefore start seeing a new cohort requiring residential rehabilitation and other treatment options, placing further pressure on a system that is already under considerable demand. New models of care need to be explored in order to better respond to the range of needs of our population. This may require exploration of new ways of providing services. For example, Zoom, online platforms, tele-health, expansion of harm reduction and peer support.

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

6.2.1 Integrated Primary Mental Health and Addiction Services (IPMHAS)

As previously advised, work continues on the IPMHAS project with the current focus on putting contracts in place. To date, 22 contracts have been drafted for PHOs, NGOs and the Whānau Ora Commissioning Agency. This continues to represent a significant workload for the Mental Health and Addictions Services team in carrying out both the contracting process as well as supporting the Enablement Team with implementation.

6.3 Suicide Prevention and Postvention

The suicide prevention and postvention governance group will reconvene to sign off the draft Suicide Prevention and Postvention Action Plan 2020 – 2023. A working group has completed the work on revising this action plan. One of the focus areas in the action plan is to provide a more effective coordination in postvention support and enable whānau, loved ones and friends to access the appropriate bereavement support at the right time and right place.

Funding for additional 1.25FTE was recently made available by the Ministry of Health to support postvention efforts and services across Auckland and Waitematā DHBs. This funding is for a fixed terms of 18 months. A job description is being developed and recruitment process will commence soon.

7. Pacific Health Gain

7.1 MMR Vaccination plan

The Ministry of Health has provided positive feedback to the proposed MMR vaccination catch-up plan for Waitematā and Auckland DHBs. The goal of the plan is to equitably improve measles immunity and will focus on engaging Pacific and Māori, especially those between 15-29 year olds. Removing barriers and encouraging the target group to get vaccinated will be instrumental in reducing the risk of future measles outbreaks. The Pacific Team will be actively involved in implementing the diverse range of Pacific specific activities within the plan.

7.2 Pacific Regional response to COVID-19 Mobile service

Pacific peoples are disproportionately affected by inequities in the social determinants of health. These factors make Pacific particularly vulnerable to the effects of COVID-19, both direct (e.g. transmission of disease) and indirect (e.g. welfare consequences). Although there is no community transmission of COVID-19, it remains a global pandemic and further surges are still possible.

As part of the Northern Pacific regional COVID-19 response to support Pacific peoples and communities, a Pacific mobile service has been established to support vulnerable Pacific populations in Waitematā DHB. The Fono Health and Social services is delivering the Pacific mobile service from July to December 2020. The service will provide focused mobile capacity to ensure any COVID-19 cases are rapidly identified and managed appropriately to reduce the risk of community transmission. It will also provide surveillance swabbing if requested by the DHB, primary care assessment and care and social service support as needed.

7.3 Pacific Health Action Plan 2020-2025

The Pacific Health team is in the process of drafting a plan to refresh the Waitematā and Auckland DHBs Pacific Health Action Plan 2020-2025. The plan will reassess current health needs, build upon the previous activities and align with Ola Manuia: Pacific Health and Wellbeing Action Plan 2020.

8. Māori Heath Gain

8.1 COVID-19 specific responses and service

Kaimanaaki programme

The Kaimanaaki programme, largely funded by Ministry of Health, is nearing completion. This programme sought to employ Māori into non-clinical roles to support Māori health providers to find whānau in need and coordinate care. Two programmes were implemented; one led by our Iwi partners and the other led by Māori health providers.

In lieu of formal reports, anecdotally we know that these services were able to engage with a number of whānau in need across the region. The overwhelming majority of needs that Kaimanaaki found were welfare related with many whānau losing jobs, or trying to make do with reduced incomes. Many of the Kaimanaaki were able to work with community trusts and Auckland City Council to ensure whānau received food pack deliveries. The whānau support budget was utilised largely to provide whānau with supermarket vouchers, and to purchase household items like blankets, and warm clothing for winter.

A formal review will be carried out by the Māori Health Gain Team once final reports are received in mid-July.

Māori mobile units

Three mobile units have started delivering care to whānau in high needs communities via Māori health providers (two for Waitematā DHB and one for Auckland DHB). These services are focused on flu vaccinations for eligible Māori in homes, or other community settings via pop-up clinics. They will seek to engage Māori enrolled in primary care who have not been vaccinated yet. The Māori Health Gain Team is working with three PHOs to coordinate access to their registers and to support outreach to these individuals. Pop-up clinics in deprived communities and opportunistic care will also support these mobile units to reach individuals who are not enrolled with primary care.

Mobile units will be nurse-led, with support from a GP, and complimented by community support workers and a social worker. This will ensure that health and welfare checks can be carried out, referrals made, and any opportunistic care can be completed while the team is in a home.

Funding for these units is due to conclude in early October. An evaluation will be carried out, while these services are underway, to assess how effective this investment has been for Māori health gain.

8.2 Post COVID-19 learning preparation

Provider pandemic planning
In early March, the Māori Health Gain Team engaged pandemic planning expert Richard Simpson to support the review of Māori provider pandemic plans. The analysis of the plans revealed that provider preparedness varied significantly between organisations. Richard went on to provide a comprehensive template and structure to Māori provider pandemic plans that builds on their key strengths and how they responded during the outbreak. For example, how enrolled patients would be categorised into high needs (needing weekly engagement by staff during lock down) to low needs (patients requiring only a monthly check up and review). The template covers major areas that would require each provider to assess their level of preparedness and address any gaps that this process would identify, as the sector prepares for COVID-19 recovery and future pandemics. The Māori Health Gain Team are working with each provider to update their current pandemic plans, review what worked during this time and glean any relevant learning from these providers.

Public health response
The recent pandemic exposed several issues within and the health system's responsiveness to Māori needs and aspirations of self-determination. The response in metro-Auckland has provided some learning that can and should be applied to future system and organisation responses. One such learning was the need to provide specific cultural responses and support services to different parts of our population affected by the pandemic.

For Māori, this saw the development of the 'Pae Ora Public Health Approach' by the Māori Health Gain Team and Auckland Regional Public Health Service (ARPHS). This service essentially builds upon what was learnt by ARPHS during the recent pandemic, and sets up a more responsive and Māori-centred approach for a metro-Auckland public health response. The Māori Health Gain Team are leading the implementation of this approach/service within ARPHS, which involves supporting learning and feedback across the organisation, building and preparing the right foundations to ensure future responses to outbreaks will have a strong Māori focus as and when needed, and cementing the good work that has already occurred to date.

Components of the Pae Ora approach include:

- **Improved ethnicity data capture and reporting protocols**
  This will allow for quick decisions to be made by ARPHS, DHBs and other agencies based on ethnicity data that is captured at each point of contact with members of the community by the health workforce. This includes the establishment of a Māori oversight team (for future outbreaks) who will support with the coordination of responses by health, community, iwi and social support sectors. In the future, this team would work closely with DHB-based coordination centres and their Māori teams to ensure they are getting ethnicity data quickly and responding to need and issues amongst Māori accordingly.

- **Māori-led contact tracing**
  Employing/seconding Māori staff to contact trace Māori cases is another component of this service. A key learning from the pandemic is the need to quickly build an open and honest relationship with individuals and their whānau who are infected in order to carry out contact tracing. In future outbreaks, Māori may also provide insights about community events and facilities that could prove vital for tracing community contacts and transmission.

- **Māori community based responses**
  The final component is a community based response led by Māori. This will include scoping of the Māori community based health and social support network to understand who could

potentially be called upon to support efforts to prevent and minimise future outbreaks. A lot of this work was carried out by individual DHB funder teams but a more systematic and purposeful approach will be needed in the future. This could include on-going training for community workers and organisations to ensure they are prepared by understanding what to do, and where they would fit in a future pandemic.

On-going training by ARPHS and regular engagement between their public health experts and Māori organisations will be provided to ensure there is a workforce on hand in the future that we could call upon when needed. Potentially, having access to this workforce in the future to support the staffing of critical roles across ARPHS, and more broadly across the sector, is important for the Pae Ora approach.

Building stronger connections between ARPHS and the Māori health sector, iwi and social support providers will have several benefits for our future preparedness. It will also establish strong lines of communication through which key messages and clinical protocols can be disseminated quickly and efficiently.

8.2 Māori Pipeline Projects

A summary of recent Māori Health Pipeline activity is below:

- Lung cancer screening – the focus groups and surveys are now complete (305 potentially eligible Māori and more than 100 whānau in the surveys). Surveys have been extended to Northland as the Iwi-DHB Partnership Board requested that Northland be included in the work. This will provide useful information on whether there are differences for rural Māori. Several grant applications are being completed for the next phase of work which is a pilot trial aiming to screen 500 eligible Māori. Additional components such as smoking cessation and optimisation of co-morbidities are being developed.
- Alternative community cardiac rehabilitation model – work on the business case was put on hold during COVID-19.
- Alternative community pulmonary rehabilitation model – Dr Sandra Hotu has now completed her PhD and is supporting the prototype and feasibility development. A workshop is planned with kapa haka and physiotherapy pulmonary rehab experts to design the intervention.
- Northern region breast screening datamatch ('500 Māori women campaign') – interim reporting has been completed, due to COVID-19 response, a further six weeks has been allowed for final reporting.
- Māori provider and PHO datamatch – Data sharing agreements with the nominated Iwi representatives have been drafted and approved. A privacy impact assessment was completed and approved by DHB and regional privacy groups. The new project Māori data governance group has been established and has met. Data extraction is underway in Auckland and Waitematā DHBs, meetings have been held with Counties Manukau Māori health providers and further support will be offered as a metro-Auckland match process would be optimal.
- Facilitated PHO enrolment – Maternity services have been identified as the potential pilot location to identify women not enrolled in a PHO and develop an offer of service. A project team is being set up to scope the next phases of work.
- High grade cervical screening project – The Maori GP clinical lead has completed the audit tool process and offer of an intensive supported engagement at two pilot practices. A review will now be undertaken and a report provided to the steering group on next steps for the project. Ethics approval to complete the A+ Trust funded HPV sub-study will progress in parallel.

9. Asian, Migrant and Former Refugee Health Gain

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

An Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023 has been developed and will be tabled at the joint metro-Auckland Community Public Health Advisory Committee at the September meeting.

The Asian, Migrant & Former Refugee Health Gain Manager has been working in the NRHCC Communications team to ensure COVID-19 planning, dissemination of information to Asian, new migrant, former refugee and current asylum seeker communities are included in the regional response. A coordinated Asian Campaign was rolled out across metro-Auckland in mid-February, and a targeted Communication Plan, in partnership with ethnic partners, to ethnic communities in over 31 languages has been implemented as part of the launch of the ARPHS front facing communities webpage, https://www.arphs.health.nz/covid-19-information-for-our-communities.

The team continue to provide support when needed to COVID-19 related cases that are referred to the ARPHS Welfare Team.

9.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 90% (Waitematā DHB) by 30 June 2020

The Waitematā DHB, Asian PHO enrolment rate for Quarter 2 2020 was 90%, an increase of 1% between Quarter 1 2020 and Quarter 2 2020. The number of Asian enrolees increased by 2,828.

We continue to work with community stakeholders and promote the updated resources and flyers, virtual presentations on the NZ Health and Disability System.

The New Zealand Health & Disability System video in English has been refreshed. The video is also being updated in simplified Chinese, and a similar video is being developed in Korean. Online New Zealand Health & Disability System materials for Thai, Khmer, Farsi, Urdu, Somali, Tamil, Amharic, Tigrinya, Swahili, and Punjabi are also being developed to support the increasing communities settling and resettling in metro-Auckland in these languages.

The Asian, Migrant & Former Refugee Health Gain Manager was invited as a guest speaker to the Waitakere Ethnic Board's AGM to share the team's learnings and reflections on the Northern Region COVID-19 response for the Culturally and Linguistically Diverse Communities (CALD) Communities. The presentation was very well received.

As part of the Language Assistance Services Programme (LAS), the national procurement of Face to Face interpreting services is underway, with a metro-Auckland regional lead response planned to coordinate and streamline processes, and identify cost savings within the delivery of interpreter services.

Work has been undertaken with the Clinical Advisory Services Aotearoa (CASA) to guide a coordinated approach with key Filipino and Asian partners to better understand the cultural and/or settlement issues that may have impacted on a cluster of suspected suicide cases for Filipino individuals living in both Auckland and Waitematā DHBs.

A concurrent Influenza Campaign message to Asian & MELAA over 65 years communities has been rolled out during COVID-19 outreach in the NRHCC Communications team.

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

The new arrivals of quota refugee have been put on hold due to the COVID-19. As part of the changes to the Quota Health Service Model (due to the increase in the annual refugee quota from 1,000 to 1,500 from 1 July 2020) and how it will work with current and new resettlement regions, the health service provided at the Mangere Refugee Resettlement Centre (MRRC) is being currently developed. The new service model will consist of five main components:

Offshore

1. Immigration medical examinations (visa medical assessments) to be completed outside of New Zealand during, or directly following, the quota refugee selection mission.
2. Once the visa is approved, a full health assessment is offered, including a full health screen, immunisation and treatment of any identified health needs.
3. A pre-departure health check will be offered to ensure health needs are met before leaving for New Zealand.

Onshore

4. Primary health and other health services such as mental health and urgent health needs are provided when a person arrives at the MRRC.
5. Health and other services are provided when a quota refugee resettles in their new region within New Zealand.

The 'New Zealand Health & Disability System and Healthcare-Where Should I go?' is being developed in new minority languages for former refugee communities settling and resettling in metro Auckland. Around six families from the March 2020 intake were resettled in metro-Auckland.

The 'Improving access to general practice services for former refugees and current asylum seekers' agreement' for the PHOs is being rolled over.

7. Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Termination Services	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Conduct of Public Affairs** The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 S.9 (2) (g)(ii)]