Community and Public Health Advisory Committees Meeting

Wednesday 06 December 2017

10.00am

Venue

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

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.
AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING  
06 December 2017

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

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

MANAGEMENT
Dale Bramley - WDHB, Chief Executive  
Ailsa Claire - ADHB, Chief Executive  
Debbie Holdsworth - ADHB and WDHB, Director Funding  
Karen Bartholomew - ADHB and WDHB, Acting Director Health Outcomes  
Peta Molloy - WDHB, Board Secretary

Apologies: Ailsa Claire

AGENDA

KARAKIA

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

Items to be considered in public meeting

1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES

10.00am  
2.1 Confirmation of Minutes of the meeting held on 13/09/2017  
Actions Arising from previous meetings

3. INFORMATION PAPERS

10.10am  
3.1 Suicide Epidemiology update

10.20am  
3.2 Green Prescription effectiveness of Service Delivery

4. STANDARD REPORTS

10.30am  
4.1 Planning, Funding and Outcomes Update

5. GENERAL BUSINESS

5.1 Academic Paper of Interest to the Committee:

Achieving health equity in Aotearoa: strengthening responsiveness to Maori in health research
## Auckland and Waitemata District Health Boards
### Community and Public Health Committees
#### Member Attendance Schedule 2017

<table>
<thead>
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<th>NAME</th>
<th>MAR</th>
<th>JUNE</th>
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<td>Sharon Shea</td>
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<td>Allison Roe</td>
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 ✓ attended  
 ✗ absent  
 * attended part of the meeting only  
 ^ leave of absence  
 # absent on Board business  
 + ex-officio member
**Community and Public Health Advisory Committee (CPHAC)**

**REGISTER OF INTERESTS**

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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<tbody>
<tr>
<td>Max Abbott</td>
<td>Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology&lt;br&gt;Patron – Raeburn House&lt;br&gt;Advisor – Health Workforce New Zealand&lt;br&gt;Board Member, AUT Millennium Ownership Trust&lt;br&gt;Chair – Social Services Online Trust&lt;br&gt;Board member – Rotary National Science and Technology Forum Trust</td>
<td>19/03/14</td>
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<tr>
<td>Judith Bassett</td>
<td>Trustee – A+ Charitable Trust&lt;br&gt;Shareholder - Fisher and Paykel Healthcare&lt;br&gt;Shareholder - Westpac Banking Corporation&lt;br&gt;Husband – Fletcher Building&lt;br&gt;Husband - shareholder of Westpac Banking Corporation&lt;br&gt;Granddaughter - shareholder of Westpac Corporation&lt;br&gt;Daughter – Human Resources Manager at Auckland DHB</td>
<td>17/05/17</td>
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<tr>
<td>Edward Benson-Cooper</td>
<td>Chiropractor – Milford, Auckland (with private practice commitments)</td>
<td>07/12/16</td>
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<tr>
<td>Zoe Brownlie</td>
<td>Community Health Worker – Auckland DHB&lt;br&gt;Member – PSA Union&lt;br&gt;Board member - RockEnrol&lt;br&gt;Partner – Youth Connections, Auckland Council&lt;br&gt;Partner – Aro Arataki Children’s Centre Committee&lt;br&gt;Son – Aro Arataki Childcare Centre</td>
<td>09/06/17</td>
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<td>Sandra Coney</td>
<td>Member – Waitakere Ranges Local Board, Auckland Council&lt;br&gt;Patron – Women’s Health Action Trust&lt;br&gt;Member – Portage Licensing Trust&lt;br&gt;Member – West Auckland Trusts Services</td>
<td>15/12/16</td>
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<td>Warren Flaunty</td>
<td>Member – Henderson–Massey Local Board Auckland Council&lt;br&gt;Trustee (Vice President) - Waitakere Licensing Trust&lt;br&gt;Shareholder - EBOS Group&lt;br&gt;Shareholder – Green Cross Health&lt;br&gt;Director – Life Pharmacy Northwest&lt;br&gt;Director – Westgate Pharmacy Ltd&lt;br&gt;Chair – Three Harbours Health Foundation&lt;br&gt;Director - Trusts Community Foundation Ltd</td>
<td>06/12/16</td>
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<tr>
<td>Dr Matire Harwood</td>
<td>Senior Lecturer – Auckland University&lt;br&gt;Board Director – Health Research Council&lt;br&gt;Director – Ngarongoa Limited, which is contractor providing services to National Hauora Coalition.&lt;br&gt;GP at Papakura Marae Health Clinic&lt;br&gt;Advisory Committee Member – State Foundation NZ (Maori Health)&lt;br&gt;Member Te Ora, Maori Medical Practitioners</td>
<td>09/12/16</td>
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| Lee Mathias      | Chair - Health Promotion Agency  
                  Chair - Unitec  
                  Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment)  
                  Director - Health Alliance Limited (ex officio Auckland DHB)  
                  Director/shareholder - Pictor Limited  
                  Director – Pictor Diagnostics – Pictor India Ltd  
                  Director - Lee Mathias Limited  
                  Director - John Seabrook Holdings Limited  
                  Trustee - Lee Mathias Family Trust  
                  Trustee - Awamoana Family Trust  
                  Trustee - Mathias Martin Family Trust  
                  Member – New Zealand National Party | 25/10/17 |
| Robyn Northey    | Shareholder of Fisher & Paykel Healthcare  
                  Shareholder of Oceania  
                  Member – New Zealand Labour Party  
                  Husband - member Waitemata Local Board  
                  Husband – shareholder of Fisher & Paykel Healthcare  
                  Husband – shareholder of Fletcher Building  
                  Husband – Chair, Problem Gambling Foundation  
                  Husband – Chair, Community Housing Foundation | 05/07/17 |
| Sharon Shea      | Principal - Shea Pita Associates Ltd  
                  Provider - Maori Integrated contracts for Auckland and Waitemata DHBs  
                  Provider – Plunket outcomes implementation framework  
                  Project member – Auckland and Waitemata DHB Maori Workforce Development project  
                  Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency  
                  Board member – Alliance Health Plus  
                  Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua  
                  Husband - Part owner Turuki Pharmacy Ltd, Auckland  
                  Husband - Board member - Waitemata DHB  
                  Husband – Director Healthcare Applications Ltd | 14/09/17 |
| Allison Roe      | Chairperson – Matakana Coast Trail Trust  
                  Member - Rodney Local Board, Auckland Council | 02/11/16 |
2.1 Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee Meeting 13 September 2017

Recommendation:

That the draft minutes of the Community and Public Health Advisory Committee meeting held on 13 September 2017 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 13 September 2017

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 10am

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS:

Sharon Shea (Committee Chair - ADHB Board member)
Max Abbott (WDHB Board member) (from 10.03am, item 2.1)
Judith Bassett (ADHB Board member)
Edward Benson-Cooper (WDHB Board member)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair - WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)
Allison Roe (WDHB Board member)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer)
Ailsa Claire (ADHB Chief Executive Officer) (from item 4.1)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Karen Bartholomew (ADHB and WDHB, Acting Director Health Outcomes)
Catherine Joseph (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Marie Thompson (ProCare)
Aaron van Delden (New Zealand Doctor)

WELCOME:

The Committee Chair welcomed those in attendance at the meeting.

KARAKIA:

The Committee Chair invited Aroha Haggie (Manager Maori Health Gain) to open the meeting with a Karakia.

APOLOGIES:

Apologies were received from Matire Harwood and for late arrival from Max Abbott and Ailsa Claire.
DISCLOSURE OF INTERESTS

The Committee Chair advised that she is now a member on the board of Alliance Health Plus PHO. She also disclosed potential interest in papers associated with Māori Health integrated projects and standing interests in papers covering Māori Health.

There were no declarations of interests relating to the agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting held on 21/6/17 (agenda pages 7 to 15)

Resolution (Moved Robyn Northey/Seconded Edward Benson Cooper)

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 21 June 2017 be approved.

Carried

Matters Arising (agenda pages 16)

Matters were noted.

Sandra Coney was provided a printed copy the Cervical Screening trends.

In response to a query from Lee Mathias regarding risks to DHBs that may arise due to the closure of smaller aged residential care units, as a result of the impact of pay equity, Debbie Holdsworth (Director, Funding) clarified that the primary DHB responsibility is to maintain service coverage and she does not believe that the DHBs face a service risk due to the potential closure of smaller providers linked to pay equity issues.

3 DECISION ITEMS

3.1 Preschool Oral Health Action Plan for Metropolitan Auckland Region (agenda pages 17 to 64)

Corina Grey (Public Health Physician), Stephanie Doe (General Manager Child, Women and Family) and Dr Meia Schmidt-Uili (Division Head, Child, Women and Family) were present for this item.

Corina Grey summarised the report.

Lee Mathias thanked the team for the Oral Health Plan and requested the team consider engagement of promotional activities for oral health across all age groups. Lee Mathias noted the ‘Tooth Fairy’ promotion and ‘No Child Left Behind’ programme were well received and targeted at the Pacific community.
In response to the reassurance sought by Lee Mathias that all children will be checked, Dale Bramley responded that whilst it is difficult to provide an assurance that everyone will be checked, he can provide assurance of the commitment to deliver the best service. Stephanie Doe noted a significant comprehensive improvement plan was in place that included a model of care. The team have also been carrying out an extensive review and working closely to deliver the services including improving access.

Judith Bassett commended the efforts of the team and requested an update in the future. She expressed concern that the Pacific community sometimes miss receiving appropriate care.

In response to a question, Stephanie Doe advised there were 83 dental service sites across metro Auckland with fixed clinics from Wellsford to Tuakau. There is a combination of clinics including fixed, diagnostic, transportable and fully mobile clinic.

Max Abbott queried the alignment of oral health and nutrition. Stephanie Doe advised that the team were exploring this area further and using multiple opportunities to leverage shared messages across, and promote closer relationships with promotional activities.

Max Abbott also asked if there was an issue around recruitment and retention of therapists. Stephanie Doe noted that it is a challenge in Auckland and they are working with Counties Manukau to address this issue. She also advised that the DHB was looking at the model of care and means to attract therapists and provide job satisfaction. The DHB was also looking at how support could be provided to graduate therapists and hygienists.

In response to a question from Max Abbott as to whether therapists work in both private and public sector, Stephanie Doe advised that majority of the therapists work for the DHB and that the DHB has a flexible work environment. The DHB also has a large part time workforce.

Max Abbott recommended having adult oral health as an agenda item at a future meeting (as oral health can have significant impact on physical and mental health), with particular focus on the Māori and Pacific population.

Edward Benson Cooper said he supports the paper and queried how this plan would change oral health care in the future. In response, Corina Grey advised that there has been a restructure and review of the dental service. There has been a focus on promotional activities, a water only policy in schools, and a healthy eating policy. Dr Meia Schmidt-Uili reiterated that the review analysed what happened in the past, analysed the gaps and what can be done to make a difference in the future. Implementing the strategy would require commitment including a cultural change. The team are committed to providing the best care in the Auckland region.

Allison Roe queried how multiple agencies connect to deliver the plan. In response, Stephanie Doe explained that services had worked in isolation on their respective core business; however, they connect and integrate to work across a spectrum of child health care. She further advised that the DHBs are recruiting outreach consultants who would not be based in the clinics but work in the community.

Debbie Holdsworth congratulated the team and acknowledged their efforts. She emphasised the significance of metro Auckland agreement coming together in a short period
and also the alignment of providers and the delivery of messages across other programmes such as water only in schools.

Robyn Northey recounted her experiences working as school dental nurse. Dr Meia Schmidt-Uili confirmed that the team were passionate about delivering the best oral health care in the community.

Dale Bramley advised that dental services cannot operate in isolation. That the new strategy is a significant departure from the previous strategy, as a population health approach has been taken to ensure that emphasis is placed on health promotion, nutrition, Māori and Pacific health, mothers, pregnant women and early childhood centres. He welcomed reframing the issue and emphasised the importance of monitoring the progress and providing the committee with updates at future meetings.

The Committee Chair acknowledged the significance of formal collaboration and asked that an update be provided at a future meeting emphasising on the importance of transparency and prioritising equity across the sector.

Allison Roe requested that it be noted that she does not support the section of the paper covering fluoridation, however, she does support the rest of the paper.

Lee Mathias suggested and the committee agreed that an additional recommendation be added to the recommendation as point (d), that the Board:

   d) Establish and assure co-operative and co-ordinated services to implement the Child Oral Health plan. Include KPIs which reflect inter-professional working arrangements.

Resolution (Moved Lee Mathias/Seconded Robyn Northey)

That the Committee recommends to the Auckland and Waitemata District Health Boards:

That the Board:

   a) Note a Preschool Oral Health Action Plan has been developed for the Metropolitan Auckland region to address marked ethnic and other inequities in preschool oral health.
   c) Note the Plan will be presented to the Counties Manukau District Health Board Community and Public Health Committee for endorsement.
   d) Establish and assure co-operative and co-ordinated services to implement the Child Oral Health plan. Include KPIs which reflect inter professional working arrangements.

Carried

4 INFORMATION ITEMS

4.1 Health Mums and Babies; Health Kids – New Better Public Service Targets (agenda pages 65 to 70)

Ruth Bijl (Funding Manager, Child, Youth and Women’s Health) summarised the report.
Lee Mathias noted that the paper did not reference breastfeeding and said it was important to highlight the significance of breastfeeding. She requested that a more graphic representation of data on child health care be included in future reports. Ruth Bijl confirmed that breastfeeding is an integral part in all child health activity under this plan and that this could be more explicit. Karen Bartholomew noted that work had begun in mapping System Level Measures data from multiple stakeholders.

Judith Bassett noted the importance of lowering the rate of unplanned pregnancies. Ruth Bijl advised that rate of unplanned terminations have reduced by 30% in the last 10 years.

Allison Roe acknowledged the fantastic work with pregnant women to help them quit smoking and queried the incentives and engagement with young pregnant women. Ruth Bijl noted that the team are working on a business case and working with Counties Manukau Health.

Allison Roe requested information on both boostrix and flu vaccinations for pregnant women; Ruth Bijl will provide additional information. Karen Bartholomew noted that the Board will be receiving a business case outlining all components of the model in detail.

In response to a query from Sandra Coney on how the target fits within the wider gender perspective and the responsibility of fathers, Ruth Bijl advised that the promotional message on breastfeeding focussed on people around the mother including fathers and wider whānau to provide support to mothers.

The Committee Chair sought confirmation from Ruth Bijl that if the situation arose, providers in this area would adopt an inclusive delivery approach and ensure fathers were part of service delivery (where appropriate). Ruth Bijl advised that it is about community development, engagement with the community and the whānau.

Resolution (Moved Judith Bassett/Seconded Lee Mathias)

That the Committee note the two new Better Public Service Targets and associated programme of work:

a) Healthy Mums and Babies
b) Healthy Kids

Carried

4.2 Metro Auckland DHB Healthy Weight Action Plan for Children (agenda pages 71 to 161)

Ruth Bijl (Funding Manager, Child, Youth and Women’s Health), Dr Philippa Anderson (Public Health Physician Counties Manukau Health) and Dr Karen Bartholomew (Acting Director, Health Outcomes) were present for this report.

Ruth Bijl summarised the report and acknowledged the collaborative efforts of the team as well as Rebecca McCarroll (Public Health Dietitian), Dr Philippa Anderson (Public Health Physician Counties Manukau Health) and Hannah Gentile (Programme Manager Well Child Tamariki Ora).
Karen Bartholomew further endorsed the acknowledgement of the team in producing the action plan and also acknowledged the stakeholders. Similar to the oral health strategy, this is a population health strategy with multiple stakeholders focussed on health led DHB action.

Edward Benson Cooper commended the plan for taking a life course approach and appreciated the message in the paper.

Sandra Coney noted that whilst it a good plan, the paper does not highlight the role of advocacy to the local government or working with private sector. Sandra Coney enquired about the governance role in the broader scope and requested feedback on Board advocacy. Subsequent to this discussion, Dale Bramley advised that specific evidence and gaps in the policy can be looked into and scope developed.

Max Abbott noted the role of Universities and professional bodies who also play an important role with regard to advocacy.

Dr Julia Peters (Clinical Director ARPHS) advised that Healthy Auckland Together have strong engagement with local government and are having a significant impact on the Auckland Plan and Auckland cycle ways, and on how money is being spent. Dr Peters further advised that a complaint was submitted to the Advertising Standards Authority on advertising of Pepsi max targeting children in sporting arenas.

Ailsa Claire noted the plan focused on specific work and emphasised the importance of moving this plan forward.

In response to a query from Allison Roe about medication used in the treatment of obesity, Philippa Anderson advised that some studies have shown that medication used in adults can lead to weight loss.

Allison Roe queried if there is benefit in obese children working together to lose weight. In response Ruth Bijl advised of a similar concept at Tamaki College where a peer group was formed called ‘Big Boys Club‘ to do activities together and lead a healthy lifestyle.

Allison Roe noted the importance of sleep in weight loss. Philippa Anderson confirmed that there had been positive feedback from families with regards to this approach to weight management.

In response to question from Zoe Brownlie about consultation with young people on the plan, Philippa Anderson advised there had been broad consultation with health provider stakeholders some of whom were young people, however, young people were not specifically consulted and this can be considered in the future.

The Committee Chair summarised the discussion and noted that it would be helpful to have a visual representation of the activities under this plan and broader actions under Healthy Action Together similar to Child Health. This would support the ability for stakeholders to easily see how the strategies and actions are linked and support each other.

The Committee Chair noted additional feedback can be provided to the email address (as per details on page 74 of the agenda).
Resolution (Moved Lee Mathias/Seconded Max Abbott)

That the Community and Public Health Advisory Committee:

a) Receive the plan and provide feedback

b) Note final plan will be considered by the Auckland and Waitemata DHB Boards for endorsement.

Carried

5. STANDARD REPORTS

5.1 Planning, Funding and Outcomes Update (agenda pages 161 to 193)

Debbie Holdsworth (Director Funding) introduced the report noting that the changed indicators on the scorecard focussed on areas meeting equity needs.

The Committee Chair took the report as read and requested that the committee members highlight any areas for discussion.

The Committee Chair requested the Chief Executives respond to a question from Warren Flaunty on whether the DHBs lack funds to address the issue of Rheumatic Fever. Dale Bramley advised that significant work has been carried out in addressing the issue and that Rheumatic Fever has plateaued in Waitemata. Counties Manukau has successfully intervened, however, rates are now rising. Housing issues and ineffectiveness to reach all people are the main difficulty in addressing this issue.

Tim Jelleyman and Ruth Bijl discussed the proposed changes to the Rheumatic fever programme including improvement to primary care throat swabbing and broadening the housing programme to include vulnerable children.

Ruth Bijl advised that the DHB has a significant programme which funds community awareness. She advised that many children do not experience a sore throat and did not know they had a sore throat. Changes to the proposed Rheumatic Fever programme include the option of a one off antibiotic injection, which parents informed they prefer in some cases rather than taking tablets for a week. Warren Flaunty appreciated the work carried out and was pleased that all GPs are on board.

Warren Flaunty noted a number of points in the report including that he was pleased to see the alliance formed by the hospices, and that the DUMP campaign was working well. In addition, he requested that the results for spot audits carried out in pharmacy be provided to the Committee.

While covering the section on Mental Health, Warren Flaunty further advised that he had emailed the Chief Executive to address the issue of community having access to CADS (Community Alcohol and Drug Services).

In response to a question from Judith Bassett on the disposal of controlled drugs and environmental risks to waterways, Daniel Tsai (Programme Manager Community Pharmacy) advised that controlled drugs were disposed of through dilution as per current practices. The team is in discussion with Ministry of Health about alternative solutions.
In response to the question from Sandra Coney about dissolved drugs going into the waste water system, Jagpal Benipal (Senior Program Manager Primary Care) advised that the controlled drugs cannot be shipped to Australia and they are crushed and recorded in a register. Daniel Tsai noted that the DUMP campaign was well received by pharmacies with 30 tonnes of waste collected since the campaign commenced.

The Committee received the report

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

The meeting concluded at 11.35 am.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS’ COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 13 SEPTEMBER 2017

_______________________________ CHAIR
### Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 13 September 2017

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<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
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<tr>
<td>13/09/17</td>
<td>4.1</td>
<td>Health Mums and Babies; Health Kids – New Better Public Service Targets Request for further representation of data on child health care to be provided in future reports.</td>
<td>Ruth Bijl</td>
<td></td>
<td>Actioned. Noted for future reporting.</td>
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<tr>
<td>13/09/17</td>
<td>4.1</td>
<td>Health Mums and Babies; Health Kids – New Better Public Service Targets Allison Roe requested further information on boostrix and flu vaccination for pregnant women.</td>
<td>Ruth Bijl</td>
<td>06/12/17</td>
<td>Actioned. Further information sent to Allison Roe.</td>
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<tr>
<td>13/09/17</td>
<td>5.1</td>
<td>Planning, Funding and Outcomes Update Results from the spot audits carried out in pharmacy.</td>
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<td>06/12/17</td>
<td>Actioned. Uploaded to Diligent Resource Centre for Committee reference.</td>
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### Action Point 1

**Preschool Oral Health Action Plan for Metropolitan Auckland Region - Update on the Oral Health Plan**

Response: A focus of the preschool oral health strategy is to support early engagement with the Auckland Regional Dental Service (ARDS). Work has occurred to make it easier for families to be aware of the Service, including development of a simplified enrolment form, which is being rolled out to Well Child Tamariki Ora providers and other community providers. This rollout will also be used to raise awareness of ARDS and support communication between ARDS and other service providers.

To support families Saturday clinics have started at Puinui, Point England, Browns Road and Wesley Community Dental Clinics. Saturday opening of further Community Dental Clinics is being considered for other sites including Papakura and Glen Eden.
Prevention is a strong component of the Strategy, this includes developing a Fluoride Varnish programme for delivery in preschools. The programme will be trialled prior to Christmas in three Kohunga Reo and one Pacific language nest. Lessons learnt from these trials will be used to further develop the programme for rollout in 2018. As part of the programme children will be provided with free toothbrushes and toothpaste.

Oral health is also a component for the ASH Service Level Measure. To support this programme there has been initial engagement with PHOs on how oral health and primary care can work together. This will include updating the oral health pathway and providing Lift the Lip training for primary care.

Action Point 2

**Metro Auckland DHB Health Weight Action Plan for Children** - Provide an update on broader actions under Healthy Action Together similar to Child Health

Response: Healthy Auckland Together (HAT) is a coalition of organisations committed to making Auckland the world’s most liveable city - where its people can live a full and healthy life. HAT’s vision is a social and physical environment that supports people living in Auckland to eat well, live physically active lives and maintain a healthy body weight within their communities.

In relation to child healthy weight, the HAT Action Plan 2015-2020 has specified children and young people as a priority population. Almost all projects in the HAT Plan relate to children in some way, as they are focused on improving the food and physical activity environment and reducing ethnic and socio-economic inequalities. Projects which specifically relate to children include:

- Assess level of marketing of unhealthy food and drink to children and advocate for a review of current controls and stronger protection
- Collectively promote healthy food environments in decile 1-4 schools and ECE services, both inside and outside the school gate and extend their reach
- Build relationships with school decision-makers (e.g. Boards of Trustees Association, Principals Associations, Ministry of Education) to promote healthy food environments
- Build relationships with key players to strengthen teacher training on nutrition and physical activity and its inclusion within the curriculum
- Promote introduction of compulsory guidelines that limit the provision of unhealthy food within schools and ECEs
- Negotiate for strengthened healthy eating and physical activity policies in the ECE services as part of the health and safety pre-licensing assessments carried out by ARPHS
- Celebrate leaders within schools and ECE services that are guiding the way in providing healthy environments
- Partner with Healthy Families New Zealand to increase the number of schools and ECE services taking action to improve nutrition and physical activity
- Develop the capacity of educators around healthy eating and physical activity through delivery of professional development sessions
- Map the ECE sector to understand the services provided and the organisations involved to identify areas for collaboration and to provide the ECEs with a guide to available resources
- Support active transport initiatives to encourage participation in active commuting, walking school buses and skill development for biking (in high-risk communities)
- Build a basic, baseline system model to help describe the food and physical activity environment experienced by pre-school children attending early childhood centres in Auckland.
• Support and upskill food preparers, caterers and/or food technologists in nutrition and production of healthy food and or products
• Work with Ministry of Education, School Boards of Trustees and school clusters to form better partnerships to improve access to existing recreation and sport assets and align planning for future provision of community facilities.

Progress on some projects within the HAT plan is dependent on coalition member resources. The HAT ‘backbone team’ at Auckland Regional Public Health Service intends to lead a review of the Action Plan in 2018.
3.1 Suicide Epidemiology Update

Recommendation:

That the paper be received.

Prepared by: Trish Palmer (Funding and Development Manager, Mental Health and Addictions), Dr Sheryl Jury (Public Health Physician) and Manu Fotu (Programme Manager, Suicide Prevention)
Endorsed by: Dr Debbie Holdsworth (Director, Funding)

1. Executive Summary

This paper provides the Community and Public Health Advisory Committees’ with an update on Suicide Data specific to Auckland and Waitemata DHB over the last year. A full report on the suicide prevention/postvention activities and scorecard was tabled in the middle of the year.

The Ministry of Health (MoH) has just released the provisional 2015 data ahead of the full 2014 Suicide Facts update. The following key points are sobering and to be noted:

- For every female suicide there were 2.68 male suicides
- The highest rate of suicide was among people aged 15–24 years
- The rate of suicide among Māori continues to be higher than among non-Māori for both males and females

This update provides an overview on suicide data collection processes and then sets out the high level data available currently at the national level.

In respect to our action plan in response to this, we are facilitating a workshop on 1 December 2017 with Dr Kathryn Turner (Psychiatrist and currently Clinical Director of Mental Health and Specialist Services in the Gold Coast Hospital and Health Service.) Two sessions are planned, one focused on DHB clinical staff and another on DHB Management and Leadership. The intent and plan of these workshops is to understand the Zero Suicide Framework for people known to specialist mental health services and the system and infrastructure change required to achieve and target Zero Suicide from this population group. The aim of theses workshops is to consider the Zero Suicide Framework in conjunction with the Auckland DHB and Waitemata DHB review of Suicide Prevention and Postvention Action Plan 2015-2017. The outcome of this work will be reported back to the Committee next year.

2. Background

Suicide Data Collection Processes
There are two main sources of national suicide data; the Coronial data and MoH data.

Any deaths suspected to be suicides must be reported to a coroner who will investigate the cause of death. The Coronial data on deaths due to “suspected” suicide is available nationally by financial year with an approximate six month delay (see Coronial Suicide Data – Provisional Figures, August 2017 later in this report). There may be a significant delay in the time taken for the inquiry to be heard. Consequently, a provisional suicide classification may exist in the MoH data for some years before the coroner has reached a finding.
The MoH produces a report titled “Suicide Facts”, annually by calendar year based upon data from two to three years ago. This data is the most accurate official information available on suicide deaths (as most coronial investigations are complete) and self-harm incidents. The subsequent section - MoH Suicide Data New Zealand includes data from Suicide Facts 2014, and 2015 provisional data, released online ahead of the annual update expected late November/December 2017.

In addition, at a local level, details of suspected suicides in Auckland DHB or Waitemata DHB areas are provided by the Coroner, to the suicide prevention programme manager, as soon as information becomes available. This information is then disseminated to the inter-agency group as part of the notification pathway so that coordinated local support and actions can be taken, including the consideration of clusters.

If the death occurred in a public hospital, information about it will also flow into electronic hospital discharge data - the National Minimum Dataset. Additionally the National Minimum Dataset is where hospitalisation data for self-harm exists. Note that up until recently this excluded Emergency Department stays (less than one day) and admissions within two days of a previous intentional self-harm hospitalisation. Most people who present to ED following an intentional self-harm event do not require hospitalisation so the data in the National Minimum Dataset represents the more severe presentations for self-harm. It is also important to recognise that the motivation for intentional self-harm varies, and therefore hospitalisation data for self-harm is not a measure of suicide attempts.

Ministry of Health Suicide Data New Zealand (Suicide Facts 2013)
The annual MoH Suicide Facts publications typically find suicide rates per 100,000 population are slightly lower in both Auckland DHB and Waitemata DHB than the national average (Table 3). We expect a detailed 2014 update of the DHB specific rates in late November or December 2017. Where there is provisionally available national 2014 and 2015 data this is also presented below.

<table>
<thead>
<tr>
<th></th>
<th>2011 Number</th>
<th>Rate per 100,000 (2007 – 2011)</th>
<th>2012 Number</th>
<th>Rate per 100,000 (2008 – 2012)</th>
<th>2013 Number</th>
<th>Rate per 100,000 (2009 – 2013)</th>
<th>2014 Number</th>
<th>Rate per 100,000</th>
<th>2015 Number</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>- 8.5</td>
<td>- 8.9</td>
<td>- 8.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WDHB</td>
<td>- 9.3</td>
<td>- 9.4</td>
<td>- 9.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ</td>
<td>493 10.9*</td>
<td>550 12.1*</td>
<td>514 11.0*</td>
<td>510 10.8*</td>
<td>527 11.1*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* = rate for that individual year.
Sources: Suicide Facts 2013 published 2016, and provisional 2014/15 data from Ministry of Health Mortality Collection (data last extracted 29 September 2017)

The rate of suicide is highest amongst males and Māori
In 2015, 527 people died by suicide in New Zealand, which equates to an age-standardised rate of 11.1 per 100,000 (Figure 1). There were 384 male suicides and 143 female suicides (16.4 per 100,000 and 6.1 per 100,000 respectively). For every female suicide there were 2.68 male suicides (Figure 2).
Suicide rates by life-stage age group
The highest rate of suicide was amongst young people aged 15–24 years (16.9 per 100,000). In 2014 the rate of youth suicides had dropped below the rate of suicide among people aged 25–44 years for the first time since 2007 (Figure 3) but these positions have now reversed again.

Figure 3: Age-standardised suicide rates, by life-stage age group (years), 2006–2015
Suicide rates for Māori
In 2015, the rate of suicide among Māori was higher than among non-Māori for both males and females. Among Māori males the suicide rate was 25.3 per 100,000; 1.5 times that of non-Māori. For Māori females (11.5/100,000), the suicide rate was 2.4 times that of non-Māori females (Figure 4).

Figure 4: Age-standardised suicide rates, by sex, for Māori and non-Māori

Coronial Suicide Data – Provisional Figures, August 2017
Coronial data on deaths due to suicide is available nationally by financial year with an approximate six month delay. Consequently this provides us with information about the most recent trends. This is displayed below, showing 606 people died by suicide in the 2016/17 year – the third year in a row that the number has increased.

This is the highest number of suicide deaths since the provisional statistics were first recorded for the 2007/08 year and follows last year’s total of 579 (2015/16) and 564 in the year before that (2014/15). However, the suicide rate per 100,000 people for the year (12.64), while higher than last year (12.33) was similar to that in 2010/11 (12.65).
This year’s figures show:

- The 20-24 year-old age cohort recorded the highest number of suicide deaths (n=79), followed by 64 people each in both the 25-29 and 40-44 year-old cohorts. Last year, the 25-29 year-old age cohort recorded the highest number of suicide deaths (n=66), followed by the 20-24 year-old cohort (n=60) and 45-49 age group (n=57).

- Māori suicide death numbers are up by one from last year with 130 people, which was the same as two years earlier. Māori continue to have the highest suicide rate of all ethnic groups at 21.73/100,000.

Table 2: Provisional Suicide Deaths – Auckland DHB, Waitemata DHB and NZ (Chief Coroner’s Provisional Data Report 2016/17)

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per 100,000</td>
<td>Number</td>
<td>Per 100,000</td>
</tr>
<tr>
<td>ADHB</td>
<td>41</td>
<td>-</td>
<td>48</td>
<td>-</td>
</tr>
<tr>
<td>WDHB</td>
<td>52</td>
<td>-</td>
<td>63</td>
<td>-</td>
</tr>
<tr>
<td>NZ Total</td>
<td>529</td>
<td>(11.7)</td>
<td>564</td>
<td>(12.3)</td>
</tr>
<tr>
<td>Male</td>
<td>385</td>
<td>(17.5)</td>
<td>428</td>
<td>(19.0)</td>
</tr>
<tr>
<td>Female</td>
<td>144</td>
<td>(6.3)</td>
<td>136</td>
<td>(5.8)</td>
</tr>
<tr>
<td>Māori</td>
<td>108</td>
<td>(18.1)</td>
<td>130</td>
<td>(21.7)</td>
</tr>
<tr>
<td>Non-Māori</td>
<td>421</td>
<td>-</td>
<td>434</td>
<td>-</td>
</tr>
</tbody>
</table>

Figure 4: Provisional suicide deaths reported to the Coroner by age and gender between July 2016 and June 2017 (n=606)

<table>
<thead>
<tr>
<th>Age Group (years)</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>19-24</td>
<td>6</td>
<td>3.89</td>
<td>7</td>
</tr>
<tr>
<td>25-29</td>
<td>48</td>
<td>26.22</td>
<td>16</td>
</tr>
<tr>
<td>30-34</td>
<td>36</td>
<td>22.63</td>
<td>12</td>
</tr>
<tr>
<td>35-39</td>
<td>34</td>
<td>24.67</td>
<td>8</td>
</tr>
<tr>
<td>40-44</td>
<td>48</td>
<td>33.90</td>
<td>16</td>
</tr>
<tr>
<td>45-49</td>
<td>34</td>
<td>22.04</td>
<td>14</td>
</tr>
<tr>
<td>50-54</td>
<td>47</td>
<td>30.98</td>
<td>12</td>
</tr>
<tr>
<td>55-59</td>
<td>36</td>
<td>24.47</td>
<td>15</td>
</tr>
<tr>
<td>60-64</td>
<td>25</td>
<td>19.45</td>
<td>6</td>
</tr>
<tr>
<td>65-69</td>
<td>17</td>
<td>14.84</td>
<td>5</td>
</tr>
<tr>
<td>70-74</td>
<td>15</td>
<td>17.13</td>
<td>4</td>
</tr>
<tr>
<td>75-79</td>
<td>3</td>
<td>4.73</td>
<td>1</td>
</tr>
<tr>
<td>80-84</td>
<td>6</td>
<td>23.38</td>
<td>2</td>
</tr>
<tr>
<td>85+</td>
<td>11</td>
<td>33.67</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>457</td>
<td>19.36</td>
<td>149</td>
</tr>
</tbody>
</table>
Figure 5: Provisional Suicide rates by ethnicity per 100,000 population between July 2007 and June 2017 (n=5536)

Note: The per 100,000 population rate shown has been calculated using Statistics New Zealand annual population information as published following the 2006 and 2013 censuses. Ethnic groups have been classified in the following groups: Māori, Pacific peoples, Asian, European and Other (including European, Not Elsewhere classified and New Zealand European). The small numbers and volatile nature of this data for Pacific and Asian peoples makes reliable estimation of the patterns very difficult and may be misleading.

Figure 6: Provisional Suicide deaths by method used between July 2016 and June 2017 (n=606)
3. Conclusion

There are two main sources of national suicide data; the Coronial data and MoH data. The Coronial data on deaths due to "Suspected" suicide is available nationally by financial year with an approximate six month delay. The MoH produces a report titled "Suicide Facts", annually by calendar year based upon data from three years ago. At a local level, details of suspected suicides in Auckland DHB or Waitemata DHB areas are provided, by the Coroner, to the suicide prevention programme manager as soon as information becomes available.

The most recent data reported above, shows 606 people died by suicide in the 2016/17 year, the third year in a row that the number has increased. This is the highest number of suicide deaths since the provisional statistics were first recorded for the 2007/08 year, and follows last year’s total of 579 (2015/16), and 564 in the year before that (2014/15).

However, the suicide rate per 100,000 people for the year (12.64), while higher than last year (12.33) was similar to that in 2010/11 (12.65). The rates of suicide are highest for Māori and males. The age group with the highest rate of suicide is seen in young people aged between 15–24 years.

The annual MoH Suicide Facts publications find suicide rates per 100,000 populations are slightly lower in both Auckland DHB and Waitemata DHB than the national average.
3.2 Green Prescription Effectiveness of Service Delivery

Recommendation:

That this report be received.

Prepared by: Leanne Catchpole (Programme Manager, Primary Care Team) and Dr Felicity Williamson (Public Health Registrar)
Endorsed by: Debbie Holdsworth (Director, Funding) and Tim Wood (Deputy Director Funding)

Glossary

GP - General Practitioner
GRx - Green Prescription

1. Executive Summary

This paper responds to a request from the Community and Public Health Advisory Committee (CPHAC) meeting on 21 June 2017 for the DHB to provide an “update on the effectiveness of the service delivery of Green Prescription”.

Waitemata DHB contracts with Harbour Sport and Auckland DHB contracts with Sport Auckland to deliver a national Green Prescription (GRx) programme for inactive adults and an Active Families programme for inactive children and their families.

The GRx has evolved nationally and regionally over the last 20 years making it difficult to compare effectiveness. In past research, the programme has been shown to be effective at increasing independent activity (as well as cost effective), with face to face support more acceptable for Māori and Pacific people.

The provider reports do not include any outcome measures except for the number of enrolled clients that are discharged independently active. The criteria for ‘independently active’ that has been used to date was not consistent across providers, so the results between providers cannot be compared.

The Ministry of Health (MoH) conducts a national patient survey to measure the performance of providers against nine Key Performance Indicators (KPIs). In 2016 Sport Auckland achieved all nine KPIs and Harbour Sport achieved eight.

2. Introduction

In NZ, the nationally funded Physical Activity referral programme is the GRx programme, developed in the Northern region by the Hillary Commission in 1997 and rolled out nationally in 1998. It was funded initially by PHARMAC, before being transferred first to Sport and Recreation New Zealand (now known as Sport New Zealand) in 2002 and then to the MoH in 2009. In 2012 the MoH devolved the contracts to DHBs, but remained actively involved in overseeing the programme and undertaking a national patient survey.

The programme provides referrers, usually General Practitioners and practice nurses the option of prescribing physical activity where it may be considered beneficial to patients who are inactive and/or overweight. Patients often have medical conditions such as hypertension, obesity, diabetes, osteoporosis, anxiety and depression. The GRx is envisioned to play a much larger role in promoting
physical activity in NZ, through supporting research, evaluation, resource development, relationship building and training; addressing health inequities in physical activity participation, and promoting physical activity in primary care.1

Patients who receive a GRx are referred to the GRx provider in their area. Over a period of three months, trained advisors give basic nutrition advice and help patients to set goals and get into regular appropriate physical activities, such as walking or going to a gym, in their local community. The advisors also provide encouragement, monitor progress and provide feedback to referring GPs on progress. The service is predominantly provided over the phone, though providers have recently enhanced the service by providing some face-to-face consultations, and exercise groups and nutrition education in community venues.

Auckland and Waitemata DHBs have recently revised the service specification and undertaken a procurement process for Active Families and GRx. Sport Auckland was selected as the provider for Auckland DHB and Harbour Sport as the provider for all of Waitemata DHB.

Prior to the recent procurement process the DHBs added additional clauses to the national service specification. These clauses included adding:

- face-to-face consultations and group sessions in high needs communities
- targets for Maori, Pacific and South-Asian populations, the targets are weighted at 2 or 2.5 times their prevalence in the population
- identified pregnant/child-bearing age women as priority populations.

The contracted providers are responsible for quarterly reporting (using a national standard template) to DHBs, who in turn is reported to the MoH for collation of national results.

3. Past Green Prescription Research and Evaluation

There have been numerous studies done on different aspects of the GRx, including the 1997 pilot study which used a physical activity screening process and intervention by General Practice.1 In the following randomised trial, patients were screened by receptionists for inactivity and during a GP consultation physical activity was discussed using motivational interviewing techniques with goal setting and a green prescription given.3 Referrals to sports trusts were made for three follow up motivational phone calls. GPs received four hours of motivational interviewing training as part of the intervention, which is no longer provided.3 Results for this model were positive at 12 months with the number of participants achieving 2.5 hours of moderate to vigorous activity 10% higher than controls (p value=0.003)3. The number needed to treat was 10.3. The GRx was also shown to be cost-effective compared to similar international interventions, with the cost of an additional active person being NZ$1,756.4

The most recent study, carried out in Canterbury, looked at the long-term effectiveness of the GRx and found those that engaged in the GRx were doing an additional 64 minutes physical activity per week, although there was little difference in the number meeting recommended guidelines 2-3 years post programme5. Additions to the original GRx model have included psychosocial support over 12 months, which has resulted in some additional weight loss6.

Research has also been undertaken with specific groups. Qualitative research with Pacific women demonstrated health improvements and enjoyment of the social aspects of physical activity7. Studies with GPs looking at older adults found that this population face specific barriers including chronic health conditions, transportation issues, set routines, and lack of confidence8. The GRx is associated with lower depressive symptoms in older adults8. Phone based versus community based GRx models
were comparable in cost and outcomes, although Māori and Pacific engaged more with the community based programme\textsuperscript{10}.

4. Auckland DHB/Waitemata DHB Reporting

The MoH has a standard reporting template that all GRx providers complete, data includes; numbers referred by age and ethnicity, referral source, if the person is pregnant or diabetic. The template does not include any outcomes data. For the new service specification the DHB has changed the target from ‘number of people referred’ to ‘number of people enrolled’, and added another field of ‘percentage of enrolled people that graduated independently active’ i.e. the person reports being active for a minimum of 30 minutes five times a week. As the service is often provided by phone it is not possible for the provider to take pre and post programme measurements.

Comparison of outcomes between providers prior to July 2017 is complicated by the fact that each provider uses different inclusion criteria for those graduating independently active. This has been reviewed for Auckland and Waitemata DHBs to ensure consistent criteria are used going forward.

**Sport Auckland GRx July 2016 – June 2017**

<table>
<thead>
<tr>
<th># people referred</th>
<th># people enrolled</th>
<th># people graduated independently active</th>
<th>% of enrolled people that graduated independently active</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,390</td>
<td>3,219</td>
<td>1,359</td>
<td>42%</td>
</tr>
</tbody>
</table>

**Harbour Sport GRx July 2016 – June 2017 (North Shore and Rodney only)**

<table>
<thead>
<tr>
<th># people referred</th>
<th># people enrolled</th>
<th># people graduated independently active</th>
<th>% of enrolled people that graduated independently active</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,101</td>
<td>2,366</td>
<td>1,662</td>
<td>70%</td>
</tr>
</tbody>
</table>

5. MoH Patient Survey

The MoH’s national patient survey measures programme success against nine self-reported Key Performance Indicators using mixed methods online, telephone and paper-based surveys\textsuperscript{11}. The 2016 survey of over 2,500 participants reported participants being more active (64%), having better nutrition (71%) and generally feeling that they had been provided with enough information and support, with different regions performing differently\textsuperscript{11}.

Up until 2016 the patient survey was conducted annually, from 2017 onwards the survey is being undertaken bi-annually with the next one in 2018.

In 2016 Sport Auckland achieved all of the nine KPI targets and Harbour Sport achieved eight of the nine targets.
<table>
<thead>
<tr>
<th>Your KPI results for the 2016 GRx Patient Survey Goal</th>
<th>Indicator</th>
<th>National average result</th>
<th>Harbour Sport</th>
<th>Achieved?</th>
<th>Sport Auckland</th>
<th>Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants report they…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1…Are more active since receiving their GRx.</td>
<td>Minimum of 50% of GRx participants are more active after 6-8 months of receiving their GRx.</td>
<td>64%</td>
<td>85%</td>
<td>Achieved</td>
<td>64%</td>
<td>Achieved</td>
</tr>
<tr>
<td>2…Adopt better nutritional habits.</td>
<td>Minimum of 55% of GRx participants have made changes to their diet since receiving their GRx.</td>
<td>71%</td>
<td>71%</td>
<td>Achieved</td>
<td>73%</td>
<td>Achieved</td>
</tr>
<tr>
<td>3…Receive effective support to maintain activity.</td>
<td>Minimum of 70% of GRx participants feel more confident about doing physical activity.</td>
<td>77%</td>
<td>78%</td>
<td>Achieved</td>
<td>77%</td>
<td>Achieved</td>
</tr>
<tr>
<td>4…Have a choice of activities that are relevant and appropriate for them.</td>
<td>Minimum of 85% of GRx participants felt the physical activity suggested was appropriate for them.</td>
<td>86%</td>
<td>85%</td>
<td>Achieved</td>
<td>88%</td>
<td>Achieved</td>
</tr>
<tr>
<td>5…Are motivated to participate in and follow their GRx.</td>
<td>Minimum of 75% of GRx participants are motivated to get/stay physically active.</td>
<td>81%</td>
<td>81%</td>
<td>Achieved</td>
<td>80%</td>
<td>Achieved</td>
</tr>
<tr>
<td>6…Are aware of and understand the benefits of physical activity.</td>
<td>Minimum of 80% of GRx participants are aware of and understand the benefits of physical activity.</td>
<td>81%</td>
<td>79%</td>
<td>Not Achieved</td>
<td>83%</td>
<td>Achieved</td>
</tr>
<tr>
<td>7…Have noticed positive health changes since being more active.</td>
<td>Minimum of 70% of GRx participants have noticed positive health changes.</td>
<td>73%</td>
<td>75%</td>
<td>Achieved</td>
<td>72%</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

Note: The KPIs as detailed in the Executive Summary exclude those respondents who did not answer a particular question for some reason. However, in the body of the report non-responses are included. While this has been done to maintain consistency with how the survey has historically been reported, it does result in some discrepancies between figures in the Executive Summary and those reported in the chapters that follow.
8... Are supported to sustain behavior changes.

Minimum of 75% of GRx participants are encouraged to continue physical activity by their referrer.

<table>
<thead>
<tr>
<th>Minimum of 75% of GRx participants are encouraged to continue physical activity by their referrer.</th>
<th>80%</th>
<th>81%</th>
<th>Achieved</th>
<th>80%</th>
<th>Achieved</th>
</tr>
</thead>
</table>

9... Receive consistent high quality services and support.

Minimum of 80% of GRx participants are satisfied with the overall service and support provided.

<table>
<thead>
<tr>
<th>Minimum of 80% of GRx participants are satisfied with the overall service and support provided.</th>
<th>85%</th>
<th>87%</th>
<th>Achieved</th>
<th>80%</th>
<th>Achieved</th>
</tr>
</thead>
</table>

6. Conclusion

The GRx programme delivered by Sport Auckland and Harbour Sport is based on evidence from research undertaken in New Zealand. The programme has evolved over time with new features, for example face to face consultations and group exercise and nutrition being added recently.

The only outcome measure that is reported by the providers is the number of people enrolled in the programme that have graduated independently active. The providers’ results are comparable though as to date they have used different criteria for categorising someone as graduated independently active.

The MoH Key Performance Indicator survey of participants of the Auckland and Waitemata DHB programmes show that the majority of GRx participants report that they have increased their physical activity and are satisfied with the support that they have received.
References


4.1 Planning, Funding and Outcomes Update

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Trish Palmer (Funding and Development Manager Mental Health and Addiction Services), Ruth Bijl (Funding and Development Manager Child, Youth and Women’s Health), Tim Wood (Funding and Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Aroha Haggie (Manager Maori Health Gain), Lita Foliaki (Manager Pacific Health Gain), Bruce Levi (Pacific General Manager), Samantha Bennett (Manager Asian Health Gain) and Jane McEntee (General Manager, Auckland Regional Public Health Service)

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

Glossary

ARC  - Aged Residential Care
ARDIS - Auckland Regional Dental Service
ARPHS - Auckland Regional Public Health Service
BPS  - Better Public Services
CVD  - Cardiovascular Disease
FFtF - Fit for the Future
HAT  - Healthy Auckland Together
MELAA - Middle Eastern, Latin American and African
MMR  - measles, mumps and rubella
PHAP - Pacific Health Action Plan
PHO  - Primary Health Organisation
PMHI - Primary Mental Health Initiatives
SUDI - Sudden Unexplained Death in Infancy

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs planning and funding activities and areas of priority, since its last meeting on 13 September 2017. It is limited to matters not already dealt with by other Board or elsewhere on this meeting’s agenda.

Highlights

- Implementation of the Health Literacy Programme is underway with positive progress in a number of areas. Engagement workshops have occurred with key stakeholders and the Health Literacy Working Group are actively working to develop a quality control process and guidance for developing and communicating written information.
- The 2017/18 DHB diabetes management target has changed to align with the regionally agreed diabetes clinical indicator. The target has changed to ‘a minimum of 75% of people with diabetes (aged 15 to 74 years) have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months.
- Auckland DHB has achieved the Immunisation Health Target for two consecutive quarters with 95% of babies fully immunised by eight months of age by 30 September 2017.

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/12/17
• Auckland and Waitemata DHBs both continue to exceed the Raising Healthy Kids target for all ethnicities.
• Preliminary data from the HPV school based programmes shows that uptake for boys is exceeding expectations. The consent rate in Auckland DHB is 70% for girls and 78% for boys, and in Waitemata DHB, 54% girls and 59% boys.
• Evaluation completed for the Primary Care Refugee Wrap Around Service Agreements (metro Auckland DHBs), 2013 – 2017 findings indicate the Service has shown gains in implementation commitment in terms of adherence; exposure; quality of delivery; participant responsiveness; and programme differentiation.

2. Planning

2.1 Annual Plans
The finalisation of the Annual Plans requires approval and signature from the newly appointed Minister of Health. We will work through this process with the Ministry of Health (MoH), once the new government is fully established.

2.2 Annual Reports
Draft 2 of the 2016/17 Auckland DHB and Waitemata DHB Annual Reports were presented to each Board and/or its Finance, Risk and Assurance Committees for final approval in October. The Annual Reports have been finalised and printed copies sent to Wellington for presentation to Parliament.

2.3 System Level Measure Improvement Plans
A Quarter 1 update on progress against the System Level Measures included in the 2017/18 System Level Measures Improvement Plan was presented to the November Board.

First phase work to update StatPlanet – the dynamic reporting tool – is almost complete. A number of analyses of NHI level MoH and other datasets are ongoing. Further indicator definitions are still being developed as required.

2.4 Auckland and Waitemata DHB Quarterly Performance Scorecard
The Auckland and Waitemata DHB CPHAC scorecard is a standardised tool used to internally review and track performance against a range of measures including National Health Targets for both Auckland and Waitemata DHBs. The scorecard below shows indicator performance against target for each DHB for Quarter 1 of the 2017/18 year.
Auckland and Waitemata DHB Quarterly Performance Scorecard

1. Most actuals and targets are reported for the reported month/quarter (see monthly format).
2. Actuals and targets in grey bold italics are for the most recent reporting period available where data is missing or delayed.

Key notes

1. How to read
- Achieved: On track
- Substantially achieved but off target
- Not achieved: Off track

2. Total indicators
- Δ: Performance improved compared to previous month.
- ▲: Performance declined compared to previous month.
- 0: Performance maintained

3. Contact
- victoria.child@waitematadhb.govt.nz
- 09 307 7500

Auckland and Waitemata DHBs Quarterly Performance Scorecard

Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/12/17
3. Primary Care

3.1 Health Literacy Programme Update

Background

In October 2015, CPHAC agreed to support the implementation of a consistent Health Literacy Framework across both Auckland and Waitemata DHBs. This approach is consistent with the New Zealand Health Strategy theme of People Power - making New Zealanders 'health smart'; that is, they can get and understand the information they need to manage their care.

Once endorsement of the health literacy programme was received from CPHAC, Manawa Ora and the Disability Advisory Committee, a programme steering group was established to support programme implementation.

Programme Implementation

The Health Literacy Steering Group developed a Project Charter which outlines programme priorities and timeframes. Andrew Old (Chief of Strategy, Participation and Improvement, Auckland DHB) is the Project Sponsor.

Progress to date includes:

- Running engagement workshops with key stakeholders to identify what they feel should be prioritised for action
- Identifying the health literacy projects already underway within Auckland DHB, Waitemata DHB and nationally
- The formation of a Health Literacy Working Group to consider how patient documents and patient information is developed, and to identify a process that could incorporate a health literacy “tick” to show documents have been developed with an approved quality control process. The Working Group has found that for each DHB, there are some processes and guidance in place but no consistent processes for developing and communicating written information.

The working group identified that the MoH has provided guidance, see following graphic, for developing and communicating written information for patients. This guidance will fill some of the existing gaps in our DHB processes and is consistent with the approach taken by some internal stakeholders as well as key partners such as Health Navigator.

![Health Literacy Process Diagram](image_url)

The next phase of this project will be to use the information gathered, and the steps outlined above, to inform the development of organisational Health Literacy Policy and Guidelines to be

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1 NZ Health Strategy, MoH, 2016
implemented across both DHBs. It is expected that the implementation of these will be time consuming and complex given the huge number of documents, digital and hard copies, produced by both DHBs:

- The successful introduction of a health literacy component into the Waitemata DHB Health Excellence Awards programme. The winning entry of last year’s inaugural health literacy award concerned the safer use of opioids, focusing on the importance of staff training and engagement when implementing a patient-focused health literacy programme. The winning project also demonstrates the value of a collaborative approach when developing health literacy programmes, with key learning occurring when people from different disciplines come together to implement a change process. Auckland DHB have also committed to introducing a health literacy component into their Award programme.

- Developing linkages with the Counties Manukau Health Literacy group and creating ongoing opportunities for joint planning and initiatives.

3.2 National Health Targets

‘Better Help for Smokers to Quit’ DHB Target: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

The ‘Better Help for Smokers to Quit’ result is reported as a National Health Target. The Auckland and Waitemata DHBs did not achieve the primary care ‘Better Help for Smokers to Quit’ health target in Q1, 2017/18. Preliminary results provided by the MoH showed Auckland DHB performance at 88.1% and Waitemata DHB at 87.6%. Auckland DHB is ranked 13th and Waitemata DHB is ranked 15th nationally for Q1, 2017/18.

Based on the PHO preliminary results received from the MoH, both Auckland PHO (90.6%) and Alliance Health Plus (89.9%) have met the target. ProCare showed performances at 89.4% for Waitemata DHB and 89.6% for Auckland DHB. Both National Hauora Coalition (76.8%) and Comprehensive Care (formerly Waitemata PHO) achieved 85.6%. Both of these PHOs are prioritising activities and events as per their smokefree plans to proactively reach more smokers and achieve the target. For example, PHOs are reviewing their practice level data to identify underperforming practices to encourage and support them to improve their performance. PHOs are also texting and making phone calls to patients’ who have not received brief advice.

Results by PHO are as follows:

| Table 1: PHO Results for ‘Better Help for Smokers to Quit’ 90% Target, Q1, 2017/18 |
|---------------------------------|-----------------|-----------------|
| Auckland DHB                    | Auckland PHO     | 90.6%           |
|                                 | Alliance Health Plus | 89.9%           |
|                                 | National Hauora Coalition | 76.8%           |
|                                 | ProCare          | 89.6%           |
| Waitemata DHB                   | ProCare          | 89.4%           |
|                                 | Comprehensive Care (formerly Waitemata PHO) | 85.6%           |

The results are also shown in the Scorecard under Health Targets as well as in Figure 1 below:

- Auckland DHB – 88.1%, ↓4.0% from the previous quarter
- Waitemata DHB – 87.6%, ↓2.8% from the previous quarter
3.3 Diabetes Management

DHB Target: A minimum of 75% of people with diabetes (aged 15 to 74 years) have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months.

The DHBs and PHOs are committed to improving the health outcomes of people with diabetes, as measured by increasing numbers of people with diabetes with an HbA1c less than 64mmol/mol. It is expected that the work of the Auckland Waitemata Diabetes Service Level Alliance will support improving the health and well-being of our population with diabetes.

One of the ongoing barriers to improving health outcomes for people with diabetes is inconsistent reporting on diabetes management across the region. In January 2017 all metro Auckland DHBs and PHOs endorsed reporting on five diabetes and CVD clinical indicators from Q3 2016/17 (table 2). These five clinical indicators will enable the monitoring of diabetes and CVD related health outcomes and identify areas for improvement. From now on our reporting will align with these indicators.
Table 2: Metro Auckland Diabetes and Cardiovascular disease clinical indicators

<table>
<thead>
<tr>
<th>No.</th>
<th>Clinical Indicators – Long Term Conditions Management - Diabetes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months</td>
<td>80%</td>
</tr>
<tr>
<td>2</td>
<td>Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is &lt;140</td>
<td>80%</td>
</tr>
<tr>
<td>3</td>
<td>Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Clinical Indicators – Long Term Conditions Management – Cardiovascular disease</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>CVD Secondary Prevention: Percentage of enrolled patients with known cardiovascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)</td>
<td>70%</td>
</tr>
<tr>
<td>5</td>
<td>CVD Primary Prevention: Percentage of enrolled patients with cardiovascular risk ever recorded &gt;20%, (aged 35 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)</td>
<td>70%</td>
</tr>
</tbody>
</table>

Quarterly data reporting goes through the Metro Auckland Clinical Governance Forum (MACGF) where performance against these indicators is monitored and discussed.

DHB performance against these five diabetes and CVD clinical indicators will be reported on in future CPHAC papers. Quarter one 2017/18 performance against these indicators shows:

- Diabetes data was available for 81% of practices across metro Auckland.
- CVD data was available for 83% of practices across metro Auckland.
- 11% of Auckland DHB and 13% of Waitemata DHB diabetic patients between 15-74 years have not had an HbA1c in the last 15 months.
- Asian, excluding Southeast Asians, have the highest proportion of people with diabetes with good glycaemic control (HbA1c<64mmol/mol).
- All PHOs across metro Auckland have at least 60% of people with diabetes with a systolic blood pressure under 140mmHg.
- Across the three metro Auckland DHBs 71% of people who have diabetes and microalbuminuria (indicator of risk of diabetic kidney disease), in the last 18 months, are on appropriate medication (data is missing for one PHO). However, the presence of microalbuminuria may be underreported. Once a more complete data set is available this will need to be further reviewed.
- CVD management, for people with both known CVD and CVD risk >20%, is better in those with diabetes compared to the total population (data is missing for one PHO).

At the end of Q1 2017/18, it is estimated that the percentage of people with good or acceptable diabetes control, aged 15-74 years, within the last 15 months is 58% in the Auckland district and 44% in Waitemata. For the Māori population, this percentage is 46% in Auckland DHB and 41% in Waitemata DHB.

Q1 performance is impacted by the ongoing data extraction and coding issues reported on in the quarter four 2016/17 CPHAC update. These issues include:

- Alliance Health Plus PHO is moving to a new data warehouse, during this transition period the PHO is unable to provide HbA1c data. It is expected that this issue will be resolved when the new data warehouse is set up in early 2018.

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Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/12/17
- PHOs were not able to extract data from ten Auckland district practices’ and eight Waitemata district practices. PHOs are actively working to extract data from these practices’ patient management systems.
- There was a significant variation in one PHO’s enrolment data when compared to the MoH’s Virtual Diabetes Registrar. This affected the data across both DHBs. The reasons for this variance are currently being investigated.

Quality control and validation checks are being implemented by PHOs to improve the quality of data.

It is expected that by 30 June 2020, both Auckland and Waitemata DHBs will achieve the goal of 80% of people with diabetes (15 to 74 years old) having good control of their diabetes. This allows time for the Diabetes Service Level Alliance workplan to be fully implemented and the impact of this workplan to be realised.

### 3.4 Cardiovascular Disease

Since September 2014, both Auckland and Waitemata DHBs have achieved and sustained the 90% More Hearts and Diabetes Checks target at a total population level. However, both DHBs have yet to achieve this target for the Māori population. Based on the PHO reports, Māori men aged 35-44 years are the group less likely to receive a CVD risk assessment.

To help achieve the 90% More Hearts and Diabetes Checks target in Māori, dedicated funding has been allocated for 2017/18 to achieve the 90% target in Māori men aged 35-44 years by 30 June 2018. The current screening rate at the end of Q1 2017/18 for Māori men aged 35-44 years was 74.4% and 69.1% for Auckland and Waitemata DHBs respectively.

*Figure 2: Auckland and Waitemata DHBs ‘More Heart & Diabetes Checks’ 90% target performance (Q1, 2017/18)*
3.5 Healthy Families Water Pledge

The Water Pledge is part of an effective community mobilisation approach led by Healthy Families Waitakere to normalise water as the first choice, particularly for our children and youth. The ultimate result is to create a large scale population shift in the consumption of sugary drinks which are contributing to the obesity situation especially in certain population groups.

We want the people of West Auckland to lead a call to action that empowers positive change so that the healthy choice is the easy choice and people chose it – one simple way, is to pledge to drink more water. Positive change is contagious. When one person or group stands up and takes action, it inspires others to follow, creating a ripple of positive change in our communities.

Labour MPs Phil Twyford and Deborah Russell and others members of the Healthy Families Waitakere Strategic Leadership Group such as Sport Waitakere and The Fono have signed the pledge and committed to disseminating it throughout their networks.

Supporting organisations can display their pledge where they wish and it can be profiled on the Healthy Families Waitakere website and Facebook page, people are also encouraged to share their story on their social media and website platforms too.

4. Children, Youth and Women

4.1 Better Public Service Targets and alignment of work programmes

In September, CPHAC requested a diagram showing the various child health priorities and work programmes. These have been aligned to the two new Better Public Service (BPS) targets: Healthy Mums and Babies and Keeping Kids Healthy (which were presented to CPHAC at the September meeting). The intent is also to align programmes of work around the Systems Level Measures, being led by primary care. Activity is associated with a third BPS regarding vulnerable children. Health is a contributor to this BPS, not the lead agency.
Activity is supported and monitored by a joint Auckland DHB and Waitemata DHB BPS Service Alliance which is co-chaired by Ailsa Claire (Chief Executive Officer, Auckland DHB) and Barbara Stevens (Chief Executive Officer, Auckland PHO).

The goals established though the Child Health Improvement Plan 2012 – 2017 remain valid.

**Goal 1:** We will achieve equitable health outcomes for all populations.

**Goal 2:** Infants have the highest attainable standard of health and equity of life expectancy. Parents are confident, knowledgeable and supported to nurture.

**Goal 3:** Children have the highest attainable standard of health and are engaged in learning in Early Childhood Education and the first school year.

**Goal 4:** Young people have the highest attainable standard of health and are engaged, resilient and poised to fulfil their potential.

**Goal 5:** The right people, working to the best standards of care, are supported by structures and systems that allow them to deliver the best health care to every child.

### 4.2 National Sudden Unexplained Death in Infancy (SUDI) Prevention Programme.

A National SUDI Prevention Programme has been funded by the MoH this year. A new National Coordination Service provider for the programme, Hapai te Hauora, has been engaged by the MoH through a competitive tender process. Regional co-ordination is being provided jointly by the Northern Region DHBs. A Northern Region Plan for SUDI prevention is in development.

The focus of the local programme shifts from previous efforts centred on ‘safe sleep’ to maternal risk factors from pregnancy. Gains associated with ‘safe sleep’ will be maintained. The priorities of the
National SUDI Prevention Programme include addressing two key risk factors in particular, smoking in pregnancy and bed sharing. Provision of safe sleep education and devices is a key component of the programme. Local maternal smoking cessation programmes are in the early phase of development (under the leadership of the primary care team). In addition to the two key risk factors of smoking and bed sharing, there are many other risk and protective factors for SUDI. Working to provide consistent messaging, appropriate support and education earlier in pregnancy as well as integrating priorities for SUDI prevention with a wide range of services supporting hapu mama and whanau are key directions for the new programme.

A regional SUDI prevention programmes stock take and gap analysis has been undertaken. This was supported by a regional workshop which included experts and staff involved in developing previous SUDI prevention work. Further engagement with stakeholders is planned as programme development continues. Currently each of the Northern Region DHBs has a framework for the distribution of safe sleep devices alongside education around Safe Sleep. These will continue. A draft Northern Region Plan was submitted to MoH by 30 November.

4.3 Healthy Housing Initiative Kainga Ora
The Kainga Ora Healthy Housing Initiative for Auckland and Waitemata DHBs has continued to grow in strength. The Kainga Ora team have worked hard to build awareness of the service, referral criteria and processes with a wide range of organisations. To date, the service has received 456 whanau and 691 individual referrals (both DHBs) from a range of providers including Family Start, inpatient services for child health and maternity, Well Child Tamariki Ora, Before School Check and others. The service has achieved some very positive outcomes for whanau. These have included some families being re-homed to social housing or more suitable private rentals. Minor repairs or improvements such as insulation have been obtained. Kainga Ora also works closely with Housing New Zealand to obtain minor repairs and other improvements to create warmer, dryer homes. In addition to housing, the social workers who work with families to assess their homes provide links to other agencies for a variety of psychosocial services. The Starship and Well Foundations have kindly sponsored a supply of blankets and pyjamas to be distributed to families next autumn.

4.4 Immunisation Health Target
Auckland DHB has achieved the Immunisation Health Target for two consecutive quarters, achieving 95% of babies fully immunised by eight months of age by 30 September 2017. Achieving the target continues to be a challenge for Waitemata DHB (93%), however, there was a 1% improvement this quarter compared with the 2016/17 Quarter 4.

A 90 Day Action Plan has been led by the Maori Health Gain Team over quarter 1 2017/18, with a number of activities targeted to improve immunisation uptake in Maori tamariki. The work has particularly focused on quality improvement activities in general practices with large Maori tamariki populations. Supporting positive immunisation conversations in the community has also been progressed, with a number of community champions and Te Whanau o Waipareira health support workers receiving immunisation education from IMAC. The focus for the next quarter is on progressing the co-design project which involves working with the whanau champions and Mama and Pepe groups to develop communication encouraging on-time immunisation. Quality improvement support activates in general practices will be ongoing.

An online consumer survey on how to make immunisation easier has been undertaken and is currently being analysed. The findings of this survey, along with the focus groups earlier in 2017 will help shape strategies for improving coverage.
The Immunisation position statement which was endorsed by the Waitemata Board in August has now been published on the Waitemata DHB website with other immunisation information.

4.5 Obesity Health Target – ‘Raising Healthy Kids’
Auckland and Waitemata DHBs both continue to exceed the Raising Healthy Kids target for all ethnicities. In 2017/18, both DHBs received the first MoH allocation of funding for work to support this target. (Previously, the Board approved funding to progress activities to support this programme). Providers have been contracted to continue the successful training programmes for General Practices and Primary care providers, and to provide a brief intervention service. A pre-commissioning co-design process has started which will inform the design of the future positive parenting and active lifestyle services for pre-school children, pregnant women and their whanau.

4.6 Mumps catch-up programme
Since early 2017, Auckland has been experiencing an outbreak of Mumps, with over 740 cases to 3 November. This outbreak started in West Auckland and has particularly affected those aged 10-29 years living in lower socioeconomic areas. The highest case numbers continue to occur in Pacific and Maori people. Auckland Regional Public Health Service is leading the general communications around the outbreak and has moved to a ‘Manage It’ phase in which they provide advice and follow-up for higher risk contacts.

The Waitemata DHB Board approved a targeted immunisation catch-up programme involving the re-orientation of existing workforces to provide a targeted mumps immunisation catch-up programme prioritising under vaccinated Maori and Pacific youth in:
1. Five high needs high-schools in West Auckland.
2. Pacific Island Church communities.

One dose of MMR (measles, mumps and rubella) vaccine will be offered to all students without a documented history of two doses of MMR vaccine:
- In term 4, the catch-up programme will be for students in Years 9 and 10, as well as an open invitation to Year 13s
- In term 1, the programme will be extended to Year 12 and 13 students, as well as the new Year 9 students.

Students without a documented history of two MMR doses will need to obtain a second dose of MMR from their general practice.

Most young people will have been given at least one dose of MMR in early childhood, however changes to the Immunisation Schedule in 2001 and less effective reminder systems before 2005 mean that many teenagers and young adults are not fully protected. Many Pacific children may not be protected against mumps as the majority of Pacific nations do not include mumps in their immunisation schedules.

Other schools in the area are being asked to inform their communities and encourage students and whanau to go to their usual medical practice for MMR vaccination

This pragmatic outbreak response has required training and re-deploying existing school nurses and parish nurses to administer vaccinations in the schools from 1 October 2017 until 30 May 2018. In addition, a dedicated support team has been established. The risks associated with re-orienting school and parish nurse workforces include the reduced delivery of other health and wellbeing checks.
Options for Auckland DHB are being analysed by Dr Catherine Jackson. A related paper will be provided to the Auckland DHB Board in early 2018.

### 4.7 HPV vaccine for Boys

HPV vaccine has been funded for males since 1 January 2017. The school-based vaccination programme has rollout out in conjunction with the girls Year 8 programme. Males up to 26 years of age can also access the vaccine free from any General Practice. Preliminary data from the school based programmes shows that uptake for boys is exceeding expectations. The consent rate in Auckland DHB is 70% for girls and 78% for boys, and in Waitemata DHB, 54% girls and 59% boys.

The MoH have reported limited supply of Gardasil 9 (HPV) vaccine until late November 2017. The shortage is due to multiple factors, including demand exceeding the forecast uptake for the vaccine during 2017, and a delay to the scheduled arrival of new stock into New Zealand as a result of global supply constraints. Until the release of new stock in late November, distribution of the remaining stock will be limited to school based programmes only. Distribution to general practices and other vaccinators has been postponed until new stock is available.

Delaying a final vaccine dose by a few weeks is unlikely to affect the protection it offers.

### 4.8 Cervical Screening

Coverage targets for cervical screening of 80% have not been achieved. In particular, Maori coverage for both DHBs remains significantly lower than the target. Education, practical support and promotion of the use of National Screening Unit data match lists for use by General Practices to recall women for screening continues to be provided. This supports more targeted recall efforts by primary care. We support and encourage PHOs and practices to promote screening and to utilise opportunistic screening strategies as well as broadening available clinic hours (such as weekend clinics). Funding for cervical screening to PHOs targeted to high priority women continues to be provided.

We collaborate with Well Women and Family Trust (the nationally funded ‘independent service provider’) to promote outreach screening in community locations as well as support to services for screening for women who have proven difficult to recall for primary care. Additional support for community engagement with Maori communities in particular is planned for the new year.

### 5. Health of Older People

#### 5.1 Age Residential Care – Pay Equity

The Pay Equity funding for Age Residential Care (ARC) has been included in the bed day prices, which means some providers have been disadvantaged whilst others are better off due to the fact that the bed day price is based on averages. Although all parties agreed to this payment mechanism, a number of providers disadvantaged by the approach have been canvassing the DHBs, MoH and Peak bodies.

Subsequently all parties agreed that some form of Pay Equity transitional support should be considered and the MoH has now confirmed that they will fund the cost of transitional support based on a set of agreed principles. The principles are: a provider will be eligible for transitional funding if their deficit is due specifically to pay equity, group/multi-owner providers will be considered as a whole not individually, the pay equity deficit must be material to the provider i.e. 1.5% or more of a provider’s eligible support worker cost; and there is 30 November deadline for providers to notify...
their DHB. Transitional payments will be in the form of a one-off full and final payment; the period covered will be the 1 July 2017 to 30 June 2018.

To date Planning and Funding have met with four ARC providers claiming disadvantage due to pay equity.

DHBs submitted issues for the A21 Review (review of the national ARRC Agreement) at the end of October. An emerging issue is around managing premium rooms; the Northern Region raised this as an issue for 2017/18 and restated it for 2018/19. In Auckland and Waitemata it is apparent that new builds are geared to the premium room market leading to future concerns around the availability of standard rooms. Lack of information around premium charges is also causing confusion to residents and families.

5.2 Aged Residential Care Audits

The table below identifies the number of surveillance audits undertaken each quarter in 2016/17. Surveillance audits are unannounced/spot audits that occur around the middle of a facility’s certification period. The unannounced audit focuses on service delivery including: complaints management, adverse event reporting, medication management, nutrition, safe food and fluid management, clinical service delivery, restraint, infection control surveillance and review of criteria not fully attained at the previous certification audit. The DHB also provides pre audit feedback on any specific areas we want viewed as part of the audit.

<table>
<thead>
<tr>
<th>2016/17</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
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<td></td>
<td>ADHB</td>
<td>WDHB</td>
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<td>Certification audits</td>
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<td>Unannounced audits (surveillance)</td>
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<td>8</td>
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<tr>
<td>Average number of corrective action per audit</td>
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<td>5</td>
<td>2.5</td>
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<tr>
<td>Facilities &gt; 5 corrective actions</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Corrective actions relating to health &amp; safety (% of total CAs)</td>
<td>4 (22%)</td>
<td>21 (49%)</td>
<td>16 (59%)</td>
<td>16 (42%)</td>
</tr>
<tr>
<td>Facilities with no corrective actions</td>
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<td>1</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Facilities achieving a continuous improvement*</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>3</td>
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<tr>
<td>Number of complaints the DHB received on ARRC</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

* The gold standard attainment against an audit criterion is ‘continuous improvement’ (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.

** Health and safety corrective actions (17) related to two new builds and prior to occupancy as the buildings were still under construction at the time of the audit.
5.3 Home and Community Support Services
Home and Community Support Services providers are now receiving three additional payments over and above their DHB contract funding: In-between Travel, Guaranteed Hours and Pay Equity. Initial meetings have been scheduled at a national level to start the process of incorporating these funding streams into DHB contracts. In theory this should be in place for 1 July 2018, however it appears to be an ambitious timeframe with the number of issues that are currently emerging.

5.4 Other Health of Older People Activity
The following two reviews are underway to guide future investment and service delivery:

- Respite Care Review – to achieve better outcomes for patients and carers through a more transparent and sustainable system incorporating choice
- Intermediate Care Review - support in the community to avoid acute hospital admissions and allow early discharge from hospital.

6. Mental Health and Addictions

6.1 Fit For the Future (Primary Care Initiatives for those with moderate mental health distress)
Fit for the Future (FFtF) is a MoH initiative providing funding for 15 months until 30 September 2018 for service delivery and evaluation to Auckland and Waitemata DHBs. It will help better meet the needs of people presenting to primary care with moderate mental health needs and contribute to a robust evidence base around what works in practice for these people. The DHBs have aligned FFtF activity to existing strategies and primary mental health initiatives in primary care, using the funding to evaluate, enhance and/or expand these. Of particular interest is the interface between primary (including NGO) and specialist mental health and addiction services working together and the delivery of better outcomes.

FFtF evaluations will identify baseline measures and outputs and outcome measures, alongside analysis of qualitative interviews with key stakeholders. The final reports will be completed by 30 September 2018, identifying what worked in the implementation stage, and what outcomes and outputs have shown an improvement throughout the 15 months evaluation timeframe. The MoH are collecting this information to enable identification of initiatives to support people with moderate mental health needs which can be upscaled, commissioned, and implemented nationally. Both DHBs contracted Synergia (after a Registration of Interest procurement process) to conduct the evaluations with the following reporting and monitoring:

| Table 1: Reporting and monitoring for Auckland DHB and Waitemata DHB Fit For the Future: |
|---------------------------------------------|-----------------|----------------|
| Action                                      | Date            | Status         |
| Initial teleconference                      | 30 June 2017    |                |
| Formal progress report #1                   | 15 November 2017|                |
| Formal progress report #2                   | 15 February 2018|                |
| Formal progress report #3 + Draft Evaluation Report | 15 May 2018 |                |
| Formal progress report #4 + Draft Final Evaluation Report | 15 August 2018 |                |
| Final Evaluation Report                     | 30 September 2018|                |

6.1.1 Auckland DHB:
Auckland DHB applied for Fit for the Future with the Tāmaki Mental Health & Wellbeing initiative as the basis. Funding is provided to upscale and evaluate the Awhi Ora – Supporting Wellbeing service and provide expanded and new primary mental health interventions, including:

- Providing access to community support options without having to refer to secondary/specialist Mental Health services and care
• Developing integrated service navigators
• Increasing the range and depth of support available at primary and community level
• Developing wrap-around services (co-ordinated approaches) for those with complex (or multiple) needs
• Integrating mental health and addiction professionals into primary care and community settings
• Ensuring the workforce is well equipped and supported to design and deliver integrated responses. This includes a specific Mental Health credentialing training programme for 30 practice nurses in ADHB.

The Auckland DHB FFtF project group has been established, meetings and planning sessions were held to set the priorities and timeframes for the work programme over 15 months from 1 June 2017. Auckland DHB activities include:

• Expansion of Awhi Ora (supporting wellbeing) with three NGOs and two local practices (in Glen Innes and Panmure) to 13 practices and seven NGOs participating in the Auckland DHB area. Awhi Ora includes support from peer and non-peer support workers. It is person-centred and relational, Support Workers have the time to support people to identify what is important to them and walk alongside them to achieve their goals. Functionally this includes navigation, advocacy, peer support, coaching, support to develop plans, budgeting and housing support and delivers diverse outcomes such as gaining employment, improving community or Whānau connections, resolving problems with social agencies, improved attention to primary care focus on physical/medical issues and appropriate referrals to specialist mental health and addiction services

• A behavioural health consultant designed to work together with the existing workforce and NGOs as an integrated practice team (Framework). The integrated practice teams are initially being implemented at three practices to enable the evaluation to support the refinement of the model before broader roll out. Integrated practice teams have evolved from co-designing the framework to guiding the prototype of a person-centred primary and community mental health model of care through integrated practice teams

• The Framework describes a high-level model to guide the prototype of a new model of care to meet mental health need in primary care and the community. This will be operationalised across pilot sites and includes a range of existing and new interventions, roles and relationships with Awhi Ora Providers, Practice Staff and the additional workforce of Behavioural Health Consultants and Peer/Non-Peer Health coaches

• The evaluation involves multiple health agencies. These are:
  o Auckland DHB
  o ProCare (University of Auckland Health Services and Grey Lynn Primary Health Practices)
  o East Tamaki Health Care (Glen Innes Primary Health Practice)
  o NGOs (Kahui Tū Kaha, Emerge Aotearoa, Framework Trust, Mahi Tahi Trust, Mind & Body, Pathways and Vaka Tautua)
The illustration below shows the framework in action with Manu from an integrated general practice team (who provide timely, effective support to people with health, wellbeing and social needs):

**Illustration 1: Manu in the centre of an integrated general practice team:**

A middle aged Māori male who lives in emergency housing after losing his job due to severe depression. He feels isolated and doesn’t feel comfortable reaching out for support.

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**6.1.2 Waitemata DHB and Our Health in Mind five year strategy:**

Waitemata DHB’s Our Health in Mind five year strategy is to enable people to live well with ongoing health concerns by improving health equity, health status and quality of life for them and their family/whānau, through promotion, secondary prevention, recovery and relapse prevention (tertiary prevention). The first business case “Improving Support to Primary Care for Better Outcomes” was approved in July 2016, has been implemented and is currently being evaluated as part of the FFtF programme. The elements of this business case are shown in Table 2 below:

- Increased direct funding to PHOs for Primary Mental Health Initiatives.
- Increased direct funding to NGOs to provide Awhi Ora – Supporting Wellbeing Services (up scaling Auckland DHB initiative into Waitemata DHB).
- Recruitment of a psychiatrist to provide consultant liaison services to GPs.
- Provision of a GP phone line with direct access to a senior psychiatrist.
- Recruitment of fixed term Maori and Pacific fellow roles to develop enhanced resources to improve access for Maori and Pacific populations.
- Recruitment of an alcohol and drug clinical leader to develop improved pathways with a focus on pregnant women.
- Improved regional pathways for primary mental health.
- Improved navigation tools to improve referrals for GPs.

**Table 2: Summary of Improving Support for Primary Care for Better Outcomes (BC1)**

<table>
<thead>
<tr>
<th>Increased capacity to treatment programmes and assessment</th>
<th>Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased capacity for psychological therapies, groups extended consults</td>
<td>Funding provided</td>
<td></td>
</tr>
<tr>
<td>Increased capacity for NGO support hours</td>
<td>RFP completed, funding available in September 2017</td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5 FTE SMO Enhanced support to primary care</td>
<td>Appointments made, GP phone line operational</td>
<td></td>
</tr>
<tr>
<td>Support for Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space rental in primary care for consults and groups</td>
<td>Models being finalised</td>
<td></td>
</tr>
<tr>
<td>One off</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Navigation generic</td>
<td>Development of tools underway</td>
<td></td>
</tr>
<tr>
<td>Innovation fund tools Maori and Pacific</td>
<td>Research underway</td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.8FTE (0.4FTE x 2) Cultural Fellows 12 months</td>
<td>Appointments made</td>
<td></td>
</tr>
<tr>
<td>0.2 FTE Clinical Lead Alcohol (9months)</td>
<td>Advertisement, no appointment made</td>
<td></td>
</tr>
<tr>
<td>0.2 FTE (12 months) Clinical Advisor external Maori/Pacific</td>
<td>Supervision provided</td>
<td></td>
</tr>
<tr>
<td>Support for Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees for GP and Consumer leadership to attend leadership and Governance</td>
<td>Fees paid when necessary</td>
<td></td>
</tr>
<tr>
<td>Communications and engagement- programme IT set up and in year costs: mobile devices, comms, x fellows, SMO</td>
<td>Used when necessary</td>
<td></td>
</tr>
</tbody>
</table>

**6.2 Review of Primary Mental Health Initiatives (PMHI)**

The current Auckland DHB and Waitemata DHB primary mental health services have been in place now for over 10 years. There are increasing demands on this service, changing priorities and a need to demonstrate health gains and outcomes for investment. Auckland DHB and Waitemata DHB, in collaboration with current primary care service providers, completed a project from August 2016 to September 2017 to review primary mental health initiatives to focus future planning efforts on developing a consistent service delivery model that:

- Aligns with new initiatives and the direction of national policy
- Aligns with each DHBs strategic directions and local priorities
- Meets the requirements of the Primary Mental Health Initiative service specifications
- Demonstrates health gains and outcomes for investment.

A consultative approach was employed to engage key stakeholder groups (including representation from all contracted primary mental health providers across Auckland DHB, Waitemata DHB, NGO representatives and other key stakeholders engaged in Primary Mental Health Initiatives. Meetings and workshops were held with key stakeholders to gather feedback and information on current practices/service delivery models. Documentation was also reviewed so we could understand what
the current reporting information is telling us and ultimately utilise this to assist us to plan for future primary mental health initiative developments and improvements. The final project report describes overarching themes based on the consultation to date, and developed a set of recommendations that will inform an Implementation approach and work plan going forward.

The overarching outcome themes of the project are:

- All PMHI providers deliver consistent service models that meet targeted people’s needs informed by an improved understanding of our local population needs
- The DHBs and PMHI providers are competent and are committed to early access for interventions and services
- Integration, coordination and accountability across the continuum resulting in collaborative care delivery and service evolution resulting in safe and sustainable services match demand
- Transparent sharing of information underpinned by value for money.

Table 3 below identifies the recommendations associated with the overarching themes to inform the development of an implementation plan.

**Table 3: Review of Primary Mental Health Initiatives Overarching Themes and Recommendations**

<table>
<thead>
<tr>
<th>Overarching Theme</th>
<th>Associated Recommendations (to inform Implementation Plan)</th>
</tr>
</thead>
</table>
| 1. All PMHI providers deliver consistent service models that meet targeted people’s needs informed by an improved understanding of our local population needs | 1.1 The Stepped Care model is understood by contracted PMHI providers and a full range of services are delivered (including sub-contracting and referral on arrangements if appropriate or indicated).
1.2 Both DHBs are explicit in their expectations that a broad range of PMHI assessment, treatment and intervention options are available across the districts and all stakeholders work to ensure equitable access and equity of service provision – in line with locality approaches.
1.3 PMHI Providers work together to look at opportunities to share information and improve consistency and clarity in service delivery models.
1.4 Explore, understand and quantify unmet need and the changing population profiles and social complexities across each DHB to ensure we are ‘future focussed’ and actively use this information to inform planning and funding activity for seamless service provision.
1.5 Achieve greater ability to track the ‘moderate’ need group of clients with complex needs, to ensure adequate service provision is in place, especially Maori, Pacific, Young people and Long term Conditions. |
| 2. The DHBs and PMHI providers are competent and are committed to early access for interventions and services | 2.1 Provide services in a timely manner, at first point of access.
2.2 Strengthen working relationships and collaboration with Specialist services, NGOs and Multi-agency providers, including shared care arrangements where indicated.
2.3 Actively support and invest in a skilled, capable and competent workforce. |
| 3. Integration, coordination and accountability across the continuum resulting in collaborative care delivery and service evolution resulting in safe and sustainable services match demand. | 3.1 PMHI Providers and Specialist services to work through opportunities and challenges (including how the interface works) with the respective DHB Primary/Secondary forum in place.
3.2 Explore the potential to upscale and strengthen ‘hub & spoke’ approach. Need to ensure consistency across both DHBs and equitable access for the population served regardless of where people live. Focusing on ‘closer to home’ service delivery opportunities.
3.3 Develop clear expectations for client pathways, and move to consistent clinical pathways for PMHI across DHBs (e.g. Service Level Agreement with PMH Coordinators and Primary Care Liaison). |
Overarching Theme | Associated Recommendations (to inform Implementation Plan)
--- | ---
clinicians). | 3.4 Map sector activity and interfaces. Review the ToR, membership and functions of these stakeholder groups, and establish cross-district Leadership and Governance structures. 3.5 Make better use of existing resources and put new evidence and evaluation outcomes into practice in line with the stepped care approach. 3.6 Review of reporting domains to include evaluating effectiveness and changes in health outcomes. 3.7 Early Intervention access targets are agreed and met. 3.8 Monitor and review specialist services response for clients requiring psychological therapies, including eligibility criteria and the threshold for access (subject to presenting needs).
  | 4.1 Review current reporting domains in alignment with the MoH quarterly report, and future Outcomes and Reporting Framework. 4.2 Introduce “benchmarking” for across PMHI Providers – consider and review the reporting domains based on current template in order to help to encourage transparency, consistency of service delivery models, client outcomes, value for money and monitor trends over time. 4.3 Ongoing review of current funding mechanisms to ensure equity, and return on investment based on improved client outcome and quality measures. 4.4 Ensure consistent data is reported and reviewed quarterly, in order to plan to address the service gaps via reconfiguration or additional service investment (subject to additional funding/resources) in the identified priority areas.
  | 4.1 Review current reporting domains in alignment with the MoH quarterly report, and future Outcomes and Reporting Framework. 4.2 Introduce “benchmarking” for across PMHI Providers – consider and review the reporting domains based on current template in order to help to encourage transparency, consistency of service delivery models, client outcomes, value for money and monitor trends over time. 4.3 Ongoing review of current funding mechanisms to ensure equity, and return on investment based on improved client outcome and quality measures. 4.4 Ensure consistent data is reported and reviewed quarterly, in order to plan to address the service gaps via reconfiguration or additional service investment (subject to additional funding/resources) in the identified priority areas.

The implementation and priority actions for 2017/18 are to:

- Develop a co-designed model of care across both Auckland and Waitemata DHBs.
- Develop a meaningful outcomes and data framework.
- Alignment of any actions/activity with the FFtF Project and the evaluation framework being completed.

Although there is an overlap in some of the deliverables and outcomes of the range of activities and projects, the sector should be acknowledged and thanked for their continued enthusiasm and work. The FFtF Project has come at a good time, with funding to complete the evaluation of key interventions (and new interventions) within PMHI areas; it will provide information and evidence for future investment and up scaling nationally by the MoH. The focus of FFtF differs within each DHB and this will lead to a wider understanding of not only system improvement initiatives (Our Health in Mind in Waitemata DHB) but also an increased range of PMHI interventions (in Auckland DHB). In the complex competing demands of the GP consultation there is a tension involved in responding to mental health concerns that take increased time. In New Zealand this is compounded by the part fee-for-service system, which means that from the service user’s perspective there are financial barriers to present to, and continue their engagement with, health professionals for mental health problems. It is clear that the focus on PMHI needs to continually identify options that can enhance the existing effort of individual GPs, primary care teams and general practices. Also it needs to be stated that given the multiple competing demands within primary care, it is extremely unlikely that primary mental health initiatives could be further prioritised without the additional investment in infrastructure in the future.
7. **Maori Health Gain**

7.1 **Cancer Navigation Service Evaluation**
The Maori Health Gain team are working with Te Whānau o Waipareira and the University of Auckland to undertake an evaluation of the Te Whānau o Waipareira community Cancer Navigation Service, with a focus on determining the effectiveness of the Service. We are utilising a mixed method approach for the evaluation including quantitative data analysis and focus group and key informant interviews. We have completed the focus group and key informant interviews and conducted thematic analysis and are continuing to conduct data analysis. The findings of the evaluation will be used to inform the future delivery of this service.

7.2 **Toi Tu Kids Evaluation**
The Maori health gains team are working with Te Hononga and the Auckland DHB Starship to evaluate the service effectiveness of the current Toi Tu Kids Service. This will give all parties an opportunity to understand and improve the model of care provided and better align with the recent service configuration within Starship Child and Community services.

7.3 **HPV Self Sampling feasibility study update**
As at 27 November 2017, 61 Māori women have completed HPV self-testing from five West Auckland practices (three PHOs) in the Waitemata DHB and Auckland DHB funded feasibility study. A range of different approaches to invitation and clinics have been tested, including pre-invitation letters and text messages, calling by the research nurse, a PHO call process using a modified app and contact with a Māori nurse, and direct calling by a trained kaiawhina. Participating women are universally positive about the new test and approach, and participating practices have also been very positive and supportive. The ability to contact eligible women has been challenging (42% able to be contacted), and a high DNA rate of women who agree to participate has been noted. Mechanisms are being investigated to optimise participation, including support to services and the testing of an opportunistic offer of testing in a clinic setting through the development of electronic consent mechanisms (with information provided by video). This approach is in development.

The evaluation of women’s experience and the cultural appropriateness of the feasibility study by WaiResearch is nearly complete and will provide valuable learnings for implementation of the larger Randomised Controlled Trial with Māori, Pacific and Asian women. The Randomised Controlled Trial continues to be directly informed by other feasibility study learnings, including the recently completed additional four focus groups with Pacific and Asian under screened women, facilitated by the same health literacy expert as the Māori focus groups. The Randomised Controlled Trial design has been amended to test the opportunistic offer of self-sampling with a subset of general practice clinics, which is the approach being implemented in Australia and found to be successful in a pilot with Aboriginal women in Melbourne. The Randomised Controlled Trial has now received ethical approval and approval by the metro Auckland Clinical Governance Forum and is awaiting localities approval. The supporting IT system and laboratory management processes are being developed. It is expected to commence the Trial from February 2018.
8. Pacific Health Gain

8.1 PHAP Priority 1 – Children are safe and well and families are free of violence
We are currently working with the Child Health Team to design and implement the Positive Parenting and Active Lifestyle programme.

In relation to the Pacific component of the Healthy Babies Healthy Futures programme, the annualised results are identified below (across Waitemata and Auckland DHB areas). The table below shows actual numbers in relation to targets for each component for the first four months of the 2017 – 2018 year:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual</th>
<th>% of Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion Forms</td>
<td>232</td>
<td>145%</td>
</tr>
<tr>
<td>Healthy Conversations</td>
<td>177</td>
<td>177%</td>
</tr>
<tr>
<td>TextMATCH Enrolments</td>
<td>69</td>
<td>61%</td>
</tr>
<tr>
<td>CLP Enrolments</td>
<td>187</td>
<td>150%</td>
</tr>
<tr>
<td>CLP Completions</td>
<td>85</td>
<td>177%</td>
</tr>
<tr>
<td>Lifestyle Reviews</td>
<td>57</td>
<td>100%</td>
</tr>
</tbody>
</table>

Much of the success at engaging mothers is the result of partnering with community groups who host a group at their venue. This is a new initiative to support eligible mothers through Healthy Babies Healthy Futures in a familiar environment. Direct community engagement continues to be the major source of women for the service.

While the Fono has engaged a high number of mothers at this stage, many of these mothers have no children aged two or under and therefore are not eligible for the TextMATCH service.

Healthy Babies Healthy Futures is currently being evaluated by COGO Consulting. The final report is due March 2018 for MoH consideration for extending the current contract. Currently, the three main lifestyle changes mothers are making after the programme are: increase in physical activities, a reduction in consuming fizzy drinks and increase in home cooked meals.

8.2 PHAP Priority 2 – Pacific People are smoke-free
A meeting was held with the MoH, Auckland DHB, Waitemata DHB, Counties Manukau Health and Inspiring about how to increase Pacific smoking cessation rates across Auckland, through implementing Pacific ethnic specific approaches. The parties have agreed to a number of actions and will continue to work collaboratively.

8.3 Priority 3 – Pacific people are active and eat healthy
Ongoing weekly exercise programmes continue to be run for free in Healthy Village Action Zones churches.

8.4 PHAP Priority 4–People seek medical and other help early
Alliance Health Plus presented to the Primary Care team about the integrated services Fanau Ola services. They also presented to Regional Funding Forum and will present to members of Planning and Funding SMT. Input from above will inform further analysis in relation to clinical and social support outcomes.
8.5 PHAP Priority 5 - Pacific people use hospital services when needed

Did Not Attend (DNA) rates
Pacific peoples Outpatient DNA rate at Waitemata DHB is 11.9% (target 10%), i.e. 316 out of 2,660
Did Not Attend their appointments.

Auckland DHBs rate is 17.87% (target 9%). The Tautai Fakataha Pacific team are focussing on high readmission diabetes patients in an assertive outreach approach for Waitemata DHB and Oncology clinics and clubfoot cases in Auckland DHB. Approximately 1,000 calls are made per month to remind patients from clinics with high DNA rates. This would contribute to the lower DNA rates for Medical and Hospitalisations of Older People.

Waitemata DHB

<table>
<thead>
<tr>
<th>Waitemata DHB September 2017</th>
<th>Pacific total admissions</th>
<th>Total Admissions</th>
<th>Pacific total Admissions %</th>
<th>Total DNA rate</th>
<th>Pacific DNA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Women and Family</td>
<td>303</td>
<td>2,594</td>
<td>11.7%</td>
<td>8%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Surgical and Ambulatory</td>
<td>472</td>
<td>6,572</td>
<td>7.2%</td>
<td>9.5%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Medical, Health of Older People</td>
<td>1,467</td>
<td>10,780</td>
<td>13.6%</td>
<td>8.7%</td>
<td>10.9%</td>
</tr>
</tbody>
</table>

Auckland DHB

The overall Pacific DNA rate shows reduction from previous 19.28% to 17.87% with five of the nine directorates showing a decrease in DNA rate. The Tautai Fakataha team continues to contact Pacific patients in Oncology clinics which appear to be having a collective positive impact on the DNA rate which is sitting at 9.87%.

A meeting was held with the Long Term conditions team to progress the recommendations of the Pacific diabetes project completed late 2016.

The Auckland DHB Surgical services are undergoing a Ministry of Pacific Peoples led Kapasa quality improvement framework workshop, to be executed in the next quarter. The outcome would be a Pacific responsiveness policy developed to improve equitable outcomes for Pacific peoples in surgery.
Faster Cancer treatment (62 days)

The FCT 62-day indicator improved in Auckland DHB over the last quarter, but at 70% remains below the 90% target. The Pacific provider and funding teams met with Dr Richard Sullivan and Barbara Cox from the Auckland City Hospital Cancer service to discuss Faster Cancer Targets for Pacific to better understand the barriers and identify potential areas of intervention. Recommendations moving forward include investigating how the Waitemata DHB Pacific cancer nurse role could be used as a model for care across both DHBs to improve access for Pacific people across the cancer pathway.

Mental Health access

0-19 year olds access to mental health services for Pacific is below target levels for both DHBs. The 20-64 year olds access to mental health services above target for both DHBs. We can attribute this to the Pacific services responding positively, concentrated in the

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**Health Targets - Auckland DHB**

- **Mental Health access**
  - Pacific: 68% (90% target)
  - Other: 74% (80% target)

- **Exclusive breastfeeding at 3 months (Plunket)**
  - Pacific: 72% (80% target)
  - Other: 70% (80% target)

- **Oral health - % utilisation by 2 years**
  - Pacific: 61% (80% target)
  - Other: 65% (80% target)

- **POAC Referrals**
  - Pacific: 4.1 (5.0 target)
  - Other: 4.2 (5.0 target)

- **Faster cancer treatment (62 days)**
  - Pacific: 70% (90% target)
  - Other: 74% (90% target)

- **B4 school 4 year old checks for 4 year olds**
  - Pacific: 89% (95% target)
  - Other: 91% (95% target)

- **Oral Health - Children caries free at 5 yr**
  - Pacific: 63% (80% target)
  - Other: 61% (80% target)

- **Cervical screening**
  - Pacific: 83% (94% target)
  - Other: 77% (94% target)

- **Raising Healthy Kids**
  - Pacific: 94% (95% target)
  - Other: 94% (95% target)

- **Breast screening**
  - Pacific: 84% (95% target)
  - Other: 80% (95% target)

- **Faster cancer treatment (62 days)**
  - Pacific: 72% (90% target)
  - Other: 75% (90% target)

- **Oral Health - Mean rate DMFT at school yr 8**
  - Pacific: 5.7 (6.7 target)
  - Other: 6.2 (6.7 target)

- **Oral Health - % utilisation by 2 years**
  - Pacific: 63% (80% target)
  - Other: 65% (80% target)

- **POAC Referrals**
  - Pacific: 3.6 (4.0 target)
  - Other: 3.3 (4.0 target)

**How to read**

1. **Target** - the target number reported by the measure (e.g. 90% for the FCT 62-day target).
2. **Actual** - the actual number reported by the measure (e.g. 70% for the FCT 62-day target).
3. **Achieved** - the measure is achieved if it is equal to or greater than the target.
4. **Not achieved** - the measure is not achieved if it is less than the target.
5. **Trend** - whether the measure is improving or declining over time.

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**A question?**

- Improving Outcomes
  - Exclusive breastfeeding at 3 months (Plunket)
  - Oral Health - % utilisation by 2 years
  - Oral Health - Children caries free at 5 year
  - Cervical screening
  - Raising Healthy Kids
  - Breast screening
  - Faster cancer treatment (62 days)
  - B4 school 4 year old checks for 4 year olds
  - Oral Health - Mean rate DMFT at school yr 8

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**Auckland and Waitemata DHBs Community and Public Health Advisory Committee Meeting 06/12/17**
Auckland area. More work still needs to be done to improve the access to mental health services for Pacific youth.

**Primary Options for Acute Care referrals**
Primary Options for Acute Care referrals have improved for both DHBs for Pacific people. We can attribute this to the better working relationship with Auckland Hospital ED and with inner city general practices facilitating improved utilisation of POAC services in the Auckland population.

**Ambulatory Sensitive Hospitalisations 0-4 and 45-64 years**
Waitemata DHB and Auckland DHB have an integrated primary care approach to improve Ambulatory Sensitive Hospitalisations rates in four areas: improving acute care; better long term condition management; better preventive care; improving integration between primary care and other areas of the health and non-health sector that impact on Ambulatory Sensitive Hospitalisations.

**Oral health – Enrolments by 1 year, Caries free at age 5, Mean DMFT at school year 8**
An Auckland regional Preschool Oral Health Action Plan has been developed to address disparities in oral health outcomes for Pacific and Māori children and is considered elsewhere on the agenda.

An automatic enrolment process into the service from birth across all three DHBs' will make it easier for families to have their children examined. ARDS is currently working with Plunket to look at opportunities to deliver services together (e.g. have a mobile clinic on site when a well-child clinic is being provided) so families can access both services at the same time. ARDS has begun collaborating with child health providers to refer children on who have not attended appointments (and where there are concerns about their oral health).

ARDS is also developing an outreach programme where staff provide fluoride varnish (a preventative treatment) to high needs children and a role where a staff member proactively follows up children who have not attended appointments. Extended hours clinics are currently being provided by 11 ARDS sites across the metro Auckland area. In late 2016, the Browns Rd Dental Clinic in Manurewa introduced a weekly clinic each Saturday to improve access to the service. Given the success of this clinic, planning is currently underway to extend Saturday clinic provision to other communities.

**8.6 Other Health Science Academy**
Waitemata DHB Malcolm Andrews, Health Science Academy Programmes Coordinator speaking to students interested in health sciences at the 2017 NZMA Vocational Careers Expo Wednesday 13 September, Vodafone Events Centre, Manukau City, Auckland.

Waitakere College Prize giving: A successful year for the Pacific Health Science Academy students receiving many awards and scholarships to continue Health Science journey. Health Science Academy
student and Head Girl of Onehunga High Siulangapo takes top Science award and scholarship for tertiary studies.

Proud Tuvaluan family with Health Science Academy year 13 student Alapeti Tepapaoatua receiving Otago scholarship to study medicine in Otago. Younger cousin on his right year 11 Health Science Academy student Tiatia Iloni receives a Waitemata DHB scholarship as well as takes the top student award in maths.

Health Science Academy year 13 students Asal Aziziyan receives First Foundation scholarship $16K to study medicine, Isabel Jones, receives Waitakere College Foundation Scholarship $5K to study. Year 11 students Ashley Ahchong and Malena McCullogh-Iuta receive Waitemata DHB scholarship $250.

**Pacific week**
Pacific Week was held at Auckland DHB from 27 November – 1 December at Auckland DHB and from 4 to 8 December at Waitemata DHB. “Authentic Communication” is the theme, a time to view challenges and raise awareness of how we communicate with staff and the Pasifika Communities we serve, also an opportunity to celebrate our cultural diversity. This embellishes the strength of our cultural identity as well as acknowledging the diverse Pacific community in the region. Sessions will be about awareness and understanding how the ethnic, generational, economic, language, beliefs or differences can impact our communication and tools we use.
9. **Asian, Migrant and Refugee Health Gain**

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

We have completed an evaluation of the Primary Care Refugee Wrap Around Service Agreements (Metropolitan Auckland DHBs), 2013 – 2017. The findings of the evaluation indicate that the Service has shown gains in implementation fidelity in terms of adherence; exposure; quality of delivery; participant responsiveness; and programme differentiation. Quality of service was cited as one of the key enablers to ongoing uptake of the Service in general practice by former refugees and asylum seekers. It also highlights gains in overall processes; partner collaborations; professional development; and the ability to target the funding to the patient for those who choose to disclose their refugee status to access the no or low cost Service.

A regional Asian and Middle Eastern, Latin American and African (MELAA) Primary Care Action Plan 2017/18 has been ratified in partnership with Counties Manukau Health and the Auckland Regional Asian & MELAA Primary Care Working Group.

The Asian & MELAA Health Plan 2017/18 (Waitemata and Auckland DHBs) has been ratified by the Asian & MELAA Health Governance Group (Waitemata and Auckland DHBs).

### 9.2 Increase Access and Utilisation to Health Services

**Indicators:**

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 71% (Auckland DHB) and 87% (Waitemata DHB) target by 30 June, 2018 (current rates 69% in Auckland DHB and 85% in Waitemata DHB as at Q1 2017/18)
- 80% of eligible Asian women will have completed a cervical sample by 2020 (current rates 56% in Auckland DHB and 69% in Waitemata DHB as at June 2017)

The Asian PHO enrolment rate remains unchanged for both DHBs between Q1 and Q2 2017/18 with 1,439 new enrollees in Auckland DHB; and 2,360 in Waitemata DHB.

We have published article in the Ministry of Business, Innovation and Employment Settlement ACTIONZ magazine to promote ethnic specific social media strategies that reach out to new migrants about the NZ health system.

We continue to deliver various health seminars/events to increase awareness of the health system and enrolment with a family doctor (GP) for Asian sub-groups including Rohingyans. We are planning an Asian Health and Wellbeing day (27 February 2018) in Waitemata DHB in partnership with The Asian Health Incorporated, Asian Health Service (Waitemata DHB) and PHOs.

**Indicator: Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding**

We have delivered a targeted asylum seeker health forum to primary health professionals (8 November), and are engaging with Immigration New Zealand to strengthen asylum seeker pathways to health services.

We have submitted to the Director of Funding the ‘Evaluation of the Refugee Primary Care Wrap Around Service Agreements (Metropolitan Auckland DHBs), 2013 – 2017’ report.
9.3  Patient Experience of Care
We are developing a report to identify factors for the downward trend in Auckland DHB inpatient survey for Asian (level 1), Chinese (level 2) and Indian (level 2) rating ‘excellent’ and ‘very good’ for treatment of care across targeted services.

10.  Auckland Regional Public Health Service (ARPHS)

10.1  Disease Management

Mumps outbreak update
ARPHS has been managing a mumps outbreak in the Auckland region since January 2017. The community spread of mumps is established both in the Auckland region and other parts of New Zealand. Since the beginning of 2017, over 750 confirmed and probable cases have been notified to ARPHS. Of these, approximately:

- 75% of cases are occurring among those aged 10-29 years
- 75% are not fully vaccinated with the measles-mumps-rubella (MMR) vaccine
- 60% of cases are occurring among Pacific peoples, and 12% among Māori
- 70% of cases are occurring in our most socio-economically deprived communities.
High MMR vaccination coverage is crucial to bring the mumps outbreak under control as it reduces the number of susceptible individuals. ARPHS and the three Auckland metro DHB Chief Executive Officers recently wrote to the Director-General of Health requesting that the MoH consider implementing a national MMR catch-up campaign. The Director-General has acknowledged receipt of the letter.

As a region we continue to implement our ‘manage it’ strategies including enhanced public communications and encouraging MMR immunisation. There is ongoing media interest in the mumps outbreak which ARPHS have responded to. Waitemata DHB is providing a targeted mumps immunisation catch-up programme, prioritising under vaccinated Maori and Pacific youth in five high needs high schools in West Auckland and Pacific Island church communities (see section 4.6 for further details).

Pertussis update
In the four weeks to 9 November 2017, there have been 53 confirmed/probable or suspected pertussis notifications to ARPHS, with seven further cases still under investigation. Cases have occurred in all three metro Auckland DHB areas, with West Auckland (Waitemata DHB) having the most cases in the last 12 months. The increase is largely driven by more cases in the school-aged (5-19 years) population. The numbers and demography do not point to an epidemic situation at this stage, but it is apparent that case numbers have risen and there are some household and school-based clusters occurring, which have been contributors to the increase. As widespread pertussis outbreaks occur approximately every five years, this increase may represent the start of the next epidemic (the last in Auckland being 2011-2013).
In addition to the protocol management of pertussis notifications, ARPHS has increased surveillance and control efforts including:

- Cases under 18 are contacted to investigate if a school/early childhood centre setting is involved. If so, letters and management advice are provided to the school to distribute to potential contacts – this covers immunisation, exclusion and prophylaxis. A school bulletin will be distributed to primary school and early childhood centres informing parents of the outbreak and promoting vaccination.
- Communication to healthcare: Liaison with immunisation coordinators and PHO representatives is ongoing. An HPA advising of the situation and asking for vigilance for pertussis was sent to all West Auckland practices on September 26 via Medinz. The Institute of Environmental Science and Research (ESR), Ministry of Education and MoH have been informed.
- Public communications: ARPHS has responded with a statement, as well as audio and video interviews, with Dr Michael Hale promoting vaccination. A pertussis communications strategy is under development and will target increasing public/practitioner awareness, and promote vaccination.

10.2 Safeswim Programme
ARPHS is collaborating with Auckland Council at a strategic level in a refinement of their Safeswim programme. Safeswim is Council’s programme for monitoring and reporting on water quality at Auckland’s bathing beaches. An independent review of the current programme recommended an upgrade of the programme that shifts from weekly reporting of retrospective monitoring results to a forecasting approach that aligns with international best practice. This recommendation was endorsed by Council’s Environment and Community Committee, and the upgraded programme was officially launched at Mission Bay on 3 November 2017. SafeSwim can be located at www.safeswim.org.nz.

Safeswim will significantly increase access to public information on bacterial water quality, tidal rips, jellyfish, shark sightings and sun-smart advice. A ‘real-time’ alert function will inform the public of unpredictable risk events as soon as they are detected. Careful consideration is being given to messaging as it will take time for the public to become used to the new information format. ARPHS is part of the governance and communications groups.

10.3 Onehunga asbestos fire
On 30 September 2017 ARPHS responded to a major asbestos fire at PSI Print and Supply, 63-65 Victoria Street, Onehunga. ARPHS took the lead role in managing and communicating public health risks for this incident until WorkSafe took over. ARPHS distributed an incident specific suspected asbestos fire fact sheet to over 200 local Onehunga residential addresses. The fact sheet was personally handed to residents, and it was explained to them what they could do to minimise their exposure risk. ARPHS independently took environmental asbestos samples downwind from the incident site, which confirmed no detectable asbestos in any of the indicative swab samples taken in likely public settings.

10.4 Update on Auckland Council’s smokefree policy review
Council’s smokefree policy 2017-2025 was adopted on 17 September 2017. The finalised policy reflected the suggestions to strengthen the policy made by ARPHS, the Cancer Society, Hapai te Hauora and the Pacific Smokefree Network at the 8 August Environment and Community Committee meeting, and also at the 11 October councillor arranged meeting.

The strengthened policy amendments include:
- A commitment that all settings identified in the policy will become smokefree in November 2017.
• The addition of smokefree clauses to all Council commercial agreements on approval or as they come up for renewal
• A reduction in the number of actions in the implementation plan allowing Council to focus on areas that have the greatest impact.

E-cigarettes have been excluded from the smokefree policy, contrary to ARPHS advice. The ARPHS team decided that it was in the interest of best public health gain to ensure that a strong tobacco policy was adopted rather than risk not having a policy by continuing conversations about e-cigarettes where there were differing positions.

ARPHS will continue to work alongside partners to support Council in implementing the smokefree policy.

On 9 November 2017 ARPHS presented at the Regulatory Committee meeting in support of developing a smokefree bylaw. Unfortunately this was not passed by Council. ARPHS considers a bylaw would have provided an extra lever to help Council stop smoking in public places outlined in the smokefree policy.

ARPHS is pleased to see councillors re-commit to an annual smokefree policy review. ARPHS recommends the bylaw is reconsidered as part of the review process if the smokefree policy does not provide the desired outcomes.

10.5 Submission to Productivity Commission’s Low-emissions Economy – Issues Paper
New Zealand has committed to reducing its greenhouse gas emissions by 30% below 2005 levels by 2030. The Productivity Commission is considering how this might be achieved, and is currently undertaking an inquiry into how New Zealand can maximise the opportunities and minimise the costs and risks of transitioning to a lower net-emissions economy. The Productivity Commission published an issues paper, containing specific questions to which responses were invited. DHB staff reviewed and provided input into the submission, and it was signed and endorsed by ARPHS and the four Northern Region DHB Chief Executive Officers.

Key messages included:

• Health services are major end-users of carbon and energy-intense products and services, and therefore have the potential to play an important role in climate change mitigation and adaptation
• Factors affecting the demand for emissions, and the way in which policies and institutional arrangements can reduce consumption of high emission goods and services by end-use sectors, is an important consideration when seeking to create a low emissions economy
• The Commission should incorporate Nicholas Stern’s detailed analysis of why the economics, ethics and equity of climate change mitigation and adaptation cannot be separated

10.6 Healthy Auckland Together (HAT) update
• HAT made a complaint to the Advertising Standards Authority against the Pepsi Max All Blacks campaign. The complaint was settled rather than upheld because the advertiser removed the bus shelter adverts six weeks before the end of the campaign. The Advertising Standards Authority did not rule on whether the campaign breached the Code in the ways outlined in HAT’s complaint
• The HAT team supported Council to improve the policy attached to the Auckland Transport vending RFP. Agreement was reached to align the Auckland Transport policy with the National Healthy Food and Drink Policy.
• In their three-yearly local board plan, the Puketapapa Local Board nominated a health action plan as one of their major initiatives. This plan is to prioritise action in the areas of walkability, access to water, the food environment, drug use and housing. Development of the health action plan will start in the second half of 2018, and will be a community-led initiative, with support and mentoring provided by HAT partners.
• The New Zealand Transport Agency has joined HAT.

10.7 Submissions
ARPHS completed and submitted two formal submissions between August and October 2017 (see the ARPHS website for copies of submissions: http://www.arphs.govt.nz/about/submissions).

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Brief note</th>
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<tbody>
<tr>
<td>22 August</td>
<td>Residential Tenancies Amendment Bill (No:2)</td>
<td>The aim of the Bill is to amend the Residential Tenancies Act 1986 (the Act) in relation to the following issues: liability for damage to rental premises caused by a tenant; methamphetamine contamination in rental premises; and tenancies over rental premises that are unlawful for residential use. ARPHS offered in principle support for measures that ensure a landlord does not provide premises to a tenant if they are methamphetamine-contaminated, and a strengthening of the law to regulate landlords who tenant unsuitable living spaces. The submission recommended that the Committee consider: • a threshold of negligence rather than carelessness for the Bill, and clarify whose responsibility it is to provide the burden of proof for the consequences for damage to rental properties caused by carelessness • regulating the processes to test for and remediate premises following methamphetamine contamination • a sliding scale so that the Tribunal has discretion to impose a penalty that reflects the human health risk involved • Clarifying roles and responsibilities around compliance and enforcement for regulating landlords who tenant unsuitable properties.</td>
</tr>
<tr>
<td>12 October</td>
<td>Low-emissions Economy – Issues Paper (Productivity Commission)</td>
<td>See earlier comments.</td>
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Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research

Papaarangi Reid, Sarah-Jane Paine, Elana Curtis, Rhys Jones, Anneka Anderson, Esther Willing, Matire Harwood

ABSTRACT

Excellent health research is essential for good health outcomes, services and systems. Health research should also build towards equity and in doing so ensure that no one is left behind. As recipients of government funding, researchers are increasingly required to demonstrate an understanding of their delegated responsibilities to undertake research that has the potential to address Māori health needs and priorities. These requirements form the basis of responsiveness to Māori in health research, and several research institutions have implemented systems to support their organisational approach to this endeavour. However, many health researchers have a narrow view of responsiveness to Māori and how it might be relevant to their work. In this viewpoint paper we provide an overview of existing frameworks that can be used to develop thinking and positioning in relation to the Treaty of Waitangi and responsiveness to Māori. We also describe an equity-based approach to responsiveness to Māori and highlight four key areas that require careful consideration, namely: (1) relevance to Māori; (2) Māori as participants; (3) promoting the Māori voice, and; (4) human tissue. Finally, we argue for greater engagement with responsiveness to Māori activities as part of our commitment to achieving equitable health outcomes.

Health research has an extensive reach into health practice from evidence-based medicine and clinical trials through to systems monitoring and data reporting. As a result, health professionals are required to adhere to the policies, protocols and ethical parameters associated with research in Aotearoa New Zealand. Inherent within these processes are responsibilities for and responsiveness to Māori health development.

What is responsiveness to Māori?

Responsiveness to Māori reflects the Government’s view that health research conducted in New Zealand should contribute to improving Māori health and eliminating health inequities. 

Researchers must therefore consider how their processes can better reflect Māori health needs and priorities. Responsiveness to Māori recognises the Government’s accountabilities under the Treaty of Waitangi, which flow on to research organisations receiving government funding. The Crown expects these accountabilities to be made transparent and they are explicit in administration agreements between research funders and providers.

Health researchers are required to demonstrate an understanding of these delegated responsibilities, including whether the research:

- is a strategic priority for Māori;
- makes the most of opportunities to inform the elimination of ethnic inequities;
- incorporates traditional or contemporary Māori processes;
- supports Māori development, including workforce development;
- team has any explicit relationships with Māori, and;
- actively protects Māori rights, including cultural and intellectual property rights.
Health researchers must also consider a range of Māori expectations,\(^1\)\(^-\)\(^7\) including:

- that researchers respect and uphold the Treaty of Waitangi;
- that the research will impact positively on Māori and improve Māori health;
- that Māori rights and interests, including Māori ethical principles, are best protected through Māori involvement in research governance;
- that researchers will invest in research processes that facilitate greater communication and transparency; and,
- that accountability to Māori is demonstrated through sound reporting mechanisms and consultation-to-dissemination pathways.

### Approaching responsiveness to Māori in health research

A number of ‘Responsiveness to Māori’ frameworks are available to health researchers such as those used by the Waitangi Tribunal and the Ministry of Health (Table 1). Both position the Treaty of Waitangi at the forefront of health research in New Zealand with the Waitangi Tribunal emphasising the Crown’s role in upholding and protecting Māori rights and the delegation of these responsibilities to health researchers funded from government agencies. In addition, some iwi have developed their own frameworks and criteria for assessment of research to be conducted within their regions and/or with their people. In addition, some iwi have developed their own frameworks and criteria for assessment of research to

### Table 1: Summary of Treaty of Waitangi frameworks and responsiveness to Māori.

<table>
<thead>
<tr>
<th>Framework</th>
<th>Principles</th>
<th>Application to responsiveness to Māori in research</th>
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<tbody>
<tr>
<td>Waitangi Tribunal Treaty Principles</td>
<td>Partnership</td>
<td>The Treaty requires each party to act with the utmost good faith towards the other. It includes the duty to consult with Māori and obtain the full, free and informed consent.</td>
</tr>
<tr>
<td></td>
<td>Reciprocity</td>
<td>The partnership is reciprocal for mutual advantage and benefit.</td>
</tr>
<tr>
<td></td>
<td>Autonomy</td>
<td>The Crown guaranteed to protect Māori autonomy in recognition of the promises of kawanatanga and tino rangatiratanga, including Māori rights to determine Māori processes and priorities.</td>
</tr>
<tr>
<td></td>
<td>Active protection</td>
<td>The Crown’s duty to protect Māori rights and interests. The duty is not passive but active and requires honourable conduct, full consultation and, where appropriate, decision-making by those whose interests are to be protected.</td>
</tr>
<tr>
<td></td>
<td>Options</td>
<td>Māori have options stemming from both traditional/customary practices and modern possibilities.</td>
</tr>
<tr>
<td></td>
<td>Mutual benefit</td>
<td>The Treaty was signed for mutual benefit and Māori were to retain resources to ensure the colonisation of New Zealand was not detrimental.</td>
</tr>
<tr>
<td></td>
<td>Equity</td>
<td>The obligations that require the Crown to act fairly so that Māori were/are not disadvantaged. Where Māori have been disadvantaged, the Crown is required to take active measures to restore the balance.</td>
</tr>
<tr>
<td></td>
<td>Equal treatment</td>
<td>Requires the Crown to act fairly between Māori groups.</td>
</tr>
<tr>
<td></td>
<td>Redress</td>
<td>Where the Crown has acted in breach of its obligations and Māori have suffered prejudice, the Crown has a clear duty to set matters right. In respect of historical grievances, this usually requires compromise on both sides and redress should not create a fresh injustice.</td>
</tr>
<tr>
<td>Ministry of Health—He Korowai Oranga</td>
<td>Partnership</td>
<td>Working with Māori individuals and communities to develop strategies for Māori health gain and access to appropriate services.</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td>Requires Māori involvement in all levels of the health and disability sector from delivery to planning and decision-making.</td>
</tr>
<tr>
<td></td>
<td>Protection</td>
<td>Involves the Crown working to ensure Māori health equity and safeguarding Māori cultural concepts, values and practices.</td>
</tr>
</tbody>
</table>

Sourced from:
http://www.ngaitahuresearch.co.nz/about/
be conducted within their regions and/or with their people (eg, Ngati Porou Hauora and Ngai Tahu Research). Regardless of the source, frameworks are most effective for responsiveness to Māori if they are incorporated in a comprehensive manner.

An equity-based approach to responsiveness to Māori

Responsiveness to Māori in research is not new\(^8,9\) and many institutions have implemented systems to support their organisational approach. Others promote equity as a starting point for responsiveness to Māori as this focus requires researchers to consider Māori health priorities based on inequities, develop appropriate relationships with Māori and commit to undertaking research that mitigates rather than extends health inequities. An equity-based approach encourages health researchers to consider responsiveness to Māori in relation to four main areas:

1. **Relevance to Māori**
   Research that seeks to improve Māori health and reduce inequities is a Government priority.\(^1\) Thus, researchers need to establish whether the topic is important for Māori health and/or whether inequities exist. Opportunities to enhance relevance to Māori include:
   a. **Consultation with Māori**
      Consultation with Māori is a fundamental obligation of Treaty responsiveness, and many researchers engage in this process. The Treaty Principles focus on quality relationships with Māori and acting with the utmost good faith. Researchers ought to consider and reflect on all of the different layers of research relationships they have with Māori, including as colleagues, students, advisors, partners, governors and participants. Consultation requires respectful information sharing and dialogue; it is not a one-way conversation or an opportunity for researchers to tell Māori what they want or need. Furthermore, consultation is very context-specific, thus some projects will require more in-depth consultation strategies than others.\(^10\)
   b. **Dissemination**
      This goes hand-in-hand with consultation. It closes the consultation loop and as such it is an important standard of ‘good faith’. Ideally, the project should be part of the development of a research relationship and the feeding back of results provides an opportunity to discuss further action. Dissemination to a broader Māori audience should be considered as part of the consultation process, and worked towards as part of the research.

c. **Enabling relationships with Māori individuals and communities**
   Good relationships can be mutually beneficial and enabling to both researchers and Māori. Ideally researchers should invest in and start this process during the conception of a research project and well in advance of research deadlines. Successful interactions happen when researchers engage in genuine, respectful and mutual relationships with Māori, and when common goals are enunciated, processes agreed and resources shared.

d. **Māori health research workforce development**
   Addressing ethnic inequities in the health research workforce is a strategic priority across the sector.\(^15\) Researchers should take opportunities to contribute to Māori health research workforce development by actively recruiting Māori students, researchers and support staff, and ensure that these individuals are supervised and mentored in a culturally safe environment.

e. **Theoretical space**
   The advancement of Kaupapa Māori Theory (KMT) and Research (KMR)\(^12\) has drawn many Māori researchers into this developing and contested theoretical space.\(^13\) The term KMR often signals Māori-led research that has a series of philosophical aims, including promoting Māori at the centre of the inquiry, developing research questions that Māori partners have signalled are important, appropriate sampling, utilising Māori processes where appropriate, resisting ‘victim-blame’ analyses, partnering with Māori with aligned objectives, Māori health research workforce development and contributing to the elimination of ethnic inequities.\(^14\) Other Māori researchers may use the terms KMR and KMT but focus primarily on Māori knowledge and traditional processes. It is important to note that KMR can encompass a broad range of epistemologies so researchers using KMR should reference their philosophical aims, objectives and theoretical positioning.
Non-Māori research teams should consider ways to support Māori research staff and students as they grow their theoretical identities and research capabilities. Not all Māori researchers agree to their work being classified as KMR. Non-Māori researchers may wish to familiarise themselves with KMT and KMR when partnering with KM researchers. The terms Kaupapa Māori-consistent or Kaupapa Māori-partnered research have been used for projects led by non-Māori but aligning with KM objectives.

2. Māori as participants

Health researchers should familiarise themselves with the concepts of Māori ethnicity, ancestry and descent and consider the relative strengths and limitations of each variable in relation to particular research questions. A range of tools are available for measurement of these constructs within the health sector.

a. Ethnicity

Ethnicity is a socio-demographic variable that is routinely collected across national health datasets to quite high levels of completeness. Because of this, ethnicity data in New Zealand are strong by international standards. However, it is important to carefully consider what we are measuring when using ethnicity as a variable. Ethnicity is a social construct. It is not about how we look or act or what others think. It is not the same as ancestry or descent but rather it is about self-identifying the social group or groups with whom we affiliate and therefore how we might live our lives and experience society. Ethnicity is not fixed and people may change their ethnicity at different times of their lives.

b. Ethnicity data standards

Ethnicity should be collected using the standard ethnicity question that is used in the NZ Census and most official datasets. Failure to use the standard question introduces uncertainty into the research analysis and impacts on the comparability of data.

c. Māori ancestry and descent

The Māori descent question in the New Zealand Census simply asks if one is descended from a New Zealand Māori, and for some research questions a family history or genealogy may be more relevant. This information should be gathered directly from the participant(s). Whakapapa (genealogy) information is considered by many to be tapu (sacred) and there may be restrictions on how this information is gathered, stored, used and governed. Ethnicity data is an inappropriate proxy for descent as a small proportion of people who identify Māori ethnicity do not report Māori ancestry and a larger proportion of those who report Māori ancestry do not identify Māori ethnicity. In the 2013 Census, 0.8% of people who reported Māori ethnicity did not report Māori descent. In contrast, 16.1% of those who reported Māori descent did not identify Māori ethnicity.

3. Promoting Māori voice

The Treaty guarantees that the Crown will act in such a way that Māori will not be disadvantaged, and if disadvantage is demonstrated, the Crown will take measures to correct the imbalance. The Māori population is 16% of the total New Zealand population, and few researchers think about the impact of a numerically minority voice on policy and programmes generated from research, especially the impact on further inequity and marginalisation. A random population sample will often contain fewer than 15% Māori, so the dominant ‘voice’ generated largely tells the ‘story’ of non-Māori: their strengths, risks, needs and preferred ways of being. The Māori ‘story’ could be very different. Researchers should be aware of this in the construction of their research. Promoting Māori voice is relevant to both qualitative and quantitative studies.

a. Qualitative research

If ethnic inequities exist in the research topic, it is important that priority be given to the group with the inequity—their ‘voice’ should be heard and their reality understood. A project that prioritises Māori ‘voice’ may require additional consideration, planning and perhaps staffing/supervision, but will add significantly to research impact and utility (eg).

b. Quantitative research

Equal explanatory power means that research has either prioritised Māori participation in quantitative research or is constructed so that the Māori sample is equally powered to answer the research question in simple and/or complex analyses.
(eg,24). It is not ‘over-sampling’ Māori, rather it is appropriate sampling and respect for the Māori ‘voice’. Constructing a sample with equal power to answer the research question for Māori as well as non-Māori will provide multiple opportunities for dissemination.

c. Data analysis

Researchers should be wary of common errors made when analysing Māori data. If Māori data are different, do not assume that the ‘difference’ lies within Māori (bodies, culture or behaviours). This tendency to ‘victim-blame’ peoples is called ‘deficit theorising’25 and shows superficial knowledge of the determinants of health and health inequities.26 Instead, consideration should be given to the structural or system-level factors likely to be involved (eg27,28).

4. Human tissue

The term human tissue covers all physical samples, regardless of size (eg, blood samples, tissue biopsies and cells, molecules and genetic profiles) or source (eg, commercial cell lines, pathological specimens, research samples and those from tissue collections or biobanks). No matter the source, Māori, and indeed many New Zealanders, consider human tissue to be tapu, meaning it comes with a set of restrictions. These restrictions are usually managed by informed consent processes and the formal information made available to prospective participants, including:

- Agreed parameters surrounding the use of human tissue including possible future use;
- Agreement on storage, management and governance of samples. Many samples are now stored for future use that may extend beyond the career, or indeed life of the primary investigator or project. Samples may also be requested by international research partners. Thus, it is critical to consider who has governance over the future decision-making in respect of samples and the data generated by them;
- Processes for return or destruction of samples;
- Feedback to participants or their whānau on pertinent health information obtained from the samples.4,29

a. Genetic samples

In addition to the issues noted above, researchers who collect human tissue for the specific intention of, or potential for, genetic analysis must also consider the following:

- Genetic material not only provides information about the donor, but also information about whānau of the donor. Because of this, there is growing interest in obtaining whānau consent in addition to individual consent. While not current practice, researchers planning to take samples for genetic analysis should consider ‘future proofing’ their samples by incorporating family into the consent process. Although there is no ‘best practice’ yet for gaining whānau permission, at the very least, researchers should note whether other ‘genetic relatives’ were consulted during the process of informed consent and whether their permissions were also gained.

- Some researchers consider the physical sample and the data generated from human tissue as different. Usually significant consideration is given to the ethical and secure storage, management and sometimes governance of the genetic material without similar attention given to the data it generates. Good research practice ought to include due consideration to the governance and secure storage of an individual’s tissue and generated data. Although this is not current practice we urge researchers to plan for this in future projects.

- Genetic samples are often sent overseas for sequencing or analysis by collaborators or commercial companies. Research teams need to consider how they will maintain their Treaty responsibilities once the samples are outside New Zealand’s jurisdiction. The likelihood of genetic material or data leaving New Zealand, now or in the future, should be reflected in the researcher’s governance plan and outlined as part of the informed consent process.

b. Data

Issues surrounding ownership and guardianship of research datasets have become more urgent with the growth of ‘big data’ and international collaborative research. Once integrated into large datasets, it is unclear how Māori data will be treated in terms of groupings, analyses and interpretations. Significant work on ‘data sovereignty’ by indigenous researchers here and overseas is underway,28 so researchers should stay abreast of developments.
c. Working with genetically modified organisms

Many New Zealanders, including Māori, are concerned about the use of genetically modified organisms including in research. The Hazardous Substances and New Organisms (HSNO) Act 1996 requires that the principles of the Treaty of Waitangi are considered in applications. Because of this obligation, it can be important to acknowledge this concern and note relevant accreditation and regulation of laboratory facilities.

d. The special case of transgenic animals and xenotransplantation

The Royal Commission on Genetic Modification (2001) noted that a number of concerns were raised by Māori (and other New Zealanders) to xenotransplantation and transgenic animals. The Commission noted that there were research benefits to these technologies but recommended strict regulation. Researchers should demonstrate an understanding of the range of views held by Māori and describe how the research will be conducted in accordance with appropriate standards and regulation.

Conclusion

All health researchers in New Zealand should be accountable to our delegated responsibilities under the Treaty of Waitangi and be able to enact issues of responsiveness to Māori. This paper proposes key elements to consider in this respect. In addition, researchers will need to consider what the standards of excellent practice will be in the future, especially as they train junior and emerging researchers and gather data and tissue samples. We encourage all researchers to engage in the work of ‘future proofing’ health research to ensure that responsiveness to Māori is achieved.

Competing interests:

Dr Paine is a previous Science Assessing Committee member for the Health Research Council of New Zealand, a co-opted member of the Māori Health Committee for the Health Research Council of New Zealand, and is currently involved in research projects that are funded by the Health Research Council of New Zealand and by the Ministry of Health.

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