



Waitemata
District Health Board
Best Care for Everyone

Community and Public Health Advisory Committees Meeting

Wednesday 23 November 2016

2.00pm

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

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

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

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

Well Being to All.



**AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
23 November 2016**

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

Time: 2.00pm

COMMITTEE MEMBERS

Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Board member
Jo Agnew - ADHB Board member
Peter Aitken - ADHB Board member
Judith Bassett – ADHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren Flaunty - Committee Deputy Chair (WDHB Board member)
Lee Mathias - ADHB Deputy Chair
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Elsie Ho - Co-opted member
Rev Featunai Liuaana – Co-opted member
Tim Jelleyman - Co-opted member

MANAGEMENT

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

Apologies: Lester Levy and Warren Flaunty

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	
2.05pm	2.1 Confirmation of Minutes of the meeting held on 12/10/2016 Actions Arising from previous meetings
3. INFORMATION PAPERS	
2.10pm	3.1 Prevalence and management of diabetes
2.25pm	3.2 Auckland DHB Integrated Child and Youth Mental Health & Addictions Directions 2013-23 Update
2.40pm	3.3 Cervical Screening Update - Primary HPV screening
4. STANDARD REPORTS	
2.55pm	4.1 Planning, Funding and Outcomes Update
3.10pm	4.2 Primary Care Update
5. GENERAL BUSINESS	

**Auckland and Waitemata District Health Boards
Community and Public Health Committees
Member Attendance Schedule 2016**

NAME	FEB	MAR	APRIL	JUNE	JULY	AUG	OCT	NOV
Gwen Tepania-Palmer (ADHB / WDHB combined CPHAC Committees Chair)	✓	✓	✓	✓	✓	✓	✓	
Warren Flaunty (ADHB / WDHB combined CPHAC Committees Deputy Chair)	✓	✓	✓	✓	✓	✓	✓	
Dr Lester Levy (ADHB and WDHB Chair)	+	+	+	+	+	+	+	
Max Abbott	✓	✓	✗	✓	✓	✓	✓	
Jo Agnew	✓	✓	✓	✓	✓	✓	✓	
Peter Aitken	✓	✓	✗	✓	✓	✓	✓	
Judith Bassett	✓	✓	✓	✓	✓	✓	✓	
Chris Chambers	✓	✓	✓	✓	✓	✗	✓	
Sandra Coney	✓	✓	✓	✓	✗	✓	✓	
Lee Mathias (ADHB Deputy Chair)	✓	✓	✓	✗	✓	✓	✓	
Robyn Northey	✓	✓	✓	✓	✓	✓	✓	
Christine Rankin	✗	✗	✓	✓	✓	✓	✗	
Allison Roe	✓	✓	✗	✓	✓	✓	✓	
Co-opted members								
Elsie Ho	✓	✓	✗	✓	✓	✓	✓	
Rev. Featunai Liuaana	✗	✓	✓	✗	✓	✗	✓	
Dr Tim Jelleyman	✓	✓	✓	✓	✓	✓	✓	

✓ *attended*
✗ *absent*
* *attended part of the meeting only*
^ *leave of absence*
absent on Board business
+ *ex-officio member*

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Chair – Auckland District Health Board Chairman – Auckland Transport Chairman – Health Research Council Independent Chairman – Tonkin + Taylor Chief Executive – New Zealand Leadership Institute Professor of Leadership – University of Auckland Business School Trustee - Well Foundation (ex-officio member) Lead Reviewer - State Services Commission, Performance Improvement Framework (currently undertaking a review of MBIE)	02/11/16
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board Member - The Rotary National Science and Technology Trust	19/03/14
Jo Agnew	Professional Teaching Fellow - School of Nursing, Auckland University Trustee Starship Foundation Casual Staff Nurse - ADHB	01/03/14
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Shareholder/Director - Pharmacy New Lynn Medical Centre	15/05/13
Judith Bassett	Nil	09/12/10
Chris Chambers	Employee - Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer- Anaesthesia Auckland Clinical School Associate - Epsom Anaesthetic Group Member - ASMS Shareholder - Ormiston Surgical	20/04/11
Sandra Coney	Elected Member - Waitakere Ranges Local Board, Auckland Council	02/11/16
Warren Flaunty	Member – Henderson-Massey Local Board, Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder – Green Cross Health Owner – Life Pharmacy North West Director – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Director - Trusts Community Foundation Ltd	31/10/16
Lee Mathias	Chair - Counties Manukau District Health Board Chair – Unitec Director – Health Innovation Hub Director – healthAlliance Director – New Zealand Health Partnerships Managing Director - Lee Mathias Ltd Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Director - Pictor Ltd Director - John Seabrook Holdings Ltd Chair - Health Promotion Agency	03/02/16
Robyn Northey	Project management, service review, planning etc - Self-employed Contractor Board member - Hope Foundation Northern Region Trustee - A+ Charitable Trust	18/07/12

Register of Interests continued...

Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director - The Transformational Leadership Company	15/07/15
Allison Roe	Member - Rodney Local Board, Auckland Council Chairperson - Matakana Coast Trail Trust	02/11/16
Gwen Tepania-Palmer	Chairperson - Ngatihine Health Trust, Bay of Islands Life Member - National Council Maori Nurses Alumni - Massey University MBA Director - Manaia Health PHO, Whangarei Board Member - Auckland District Health Board Committee Member - Lottery Northland Community Committee	10/04/13
Co-opted Members		
Elsie Ho	Associate Professor - School of Population Health, University of Auckland Member - Waitemata DHB Asian Mental Health and Addiction Governance Group Member - Problem Gambling Foundation of New Zealand Advisory Board Trustee – New Zealand Chinese Youth Trust	03/09/14
Rev Featunai Liuaana	Chairperson – Congregational Christian Church Samoa Sandringham Trust Board Trustee – Congregational Christian Church Samoa Trust Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB) Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB) Member – MIT Pasifika Students Forum Secretary - Negotiation Committee – EFKSNZ Trust Secretary – EFKSNZ Trust	29/04/15
Dr Tim Jelleyman	Clinical Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland President elect – Paediatric Society of New Zealand Member-Board of Kaipara Medical Centre Community Paediatrician, Waitakere Hospital Member – ASMS	18/01/16

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 12 October 2016

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 12 October 2016 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 12 October 2016

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 2.02pm

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (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)
Tim Jelleyman (Co-opted member)
Elsie Ho (Co-opted member)
Rev Featunai Liuaana (Co-opted member)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Tim Wood (Deputy Director Funding)
Peta Molloy (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Tracy McIntyre, Waitakere Health Links
Wiki Shephard, Health Link North
Te Hau Apaopa-Timu, Te Rununga o Ngati Whatua
Lorraine Symons, Waipareira Trust
Lynda Williams, Auckland Women's Health Council

WELCOME: The Committee Chair gave a warm welcome to all those present.

PRAYER: At the invitation of the Committee Chair, Rev. Featunai Liuaana provided an opening prayer.

APOLOGIES:

Resolution (Moved Jo Agnew/Seconded Judith Bassett)

That apologies be received and accepted from Lester Levy, Christine Rankin, Ailsa Claire and Debbie Holdsworth.

Carried

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

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 the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held 31 August 2016 (agenda pages 7-13)

Resolution (Moved Judith Bassett/Seconded Peter Aitken)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 31 August 2016 be approved.

Carried

Matters Arising (agenda page 14)

There were no further updates related to the matters raised.

3 INFORMATION ITEMS

3.1 Waitemata DHB and Auckland DHB Suicide Prevention and Postvention Action Plan 2015-17 Update (agenda pages 15-27)

Manu Fotu (Portfolio Manager Suicide Prevention, Mental Health and Addictions) and Trish Palmer (Development Manager, Mental Health and Addictions) were present for this item. Manu Fotu introduced the item.

Matters highlighted and response to questions included:

- That the advisory group proactive in implementing the plan have been involved in four focus groups with attention directed at the objectives detailed in the

report; some of the objectives have been achieved with progress being made on others.

- That a series of training sessions had been completed with further training scheduled within the next six months.
- That in alignment with other programmes (Nursing Workforce Development and the Our Health in Mind project) there is an improvement in support for primary health to achieve better outcomes. Support for families is also vital.
- The plan also looks at improvement of mental health services that support people who enter into and access the DHB services (especially for those who self-harm and/or voice suicide thoughts).
- That it is a requirement for all DHBs to have a suicide prevention plan. It was noted that Auckland DHB has had a suicide prevention coordinator in post for some time and that Manu Fotu was appointed across both Auckland DHB and Waitemata DHB to provide support.
- That in response to a query about those in the community that require assistance but are not known to the DHBs services, it was noted that there was training provided in addition to the DHB and a number of community activities underway. There is a broader mental health programme that will have a wider impact in the community with both the Auckland DHB and Waitemata DHB being very active in Our Health in Mind and other initiatives. It was suggested that up to 40 per cent of people who suicide are known to the DHB and a vast majority are known to health services. The DHBs are focussed on what can be done to better support people within the DHBs services and an equally significant area of work is better support for primary care.
- That safeTalk is being rolled out to various community groups as well as being made available to provide families with tools to identify family, whanau, friends or colleagues that may be at risk.
- That there are other economic and social determinants beyond the DHBs control, including housing and unemployment that have an impact on people's mental wellbeing and that the Boards could drive an inter-sectoral conversation on this matter.
- That the data provided does not specify suicide rates amongst DHB staff.
- That the Committee would be provided with data on suicide rates where the person has been taking particular medication/s such as anti-depressants.
- That the data detailed in the report is up until 2013 and is data that has been nationally reported to-date. It was noted that the DHBs do monitor other data sources including a suicide facts report, coronial data, child youth mortality reviews and the mental health service users group. A six monthly report is also provided to the DHBs Hospital Advisory Committees.
- That the DHBs do act quickly if a cluster (or group of deaths) is noted to have occurred in the community, with Manu Fotu providing support.
- That ultimately the DHBs would like to report a decrease in suicide rates, and that the Plans impact and progress will be reported to the Committee.

Max Abbott noted that the key theme for the World Mental Health Day this year was mental health first aid; while not directly focussed on suicide prevention it provides tools for the basics of mental health first aid and assists people to know what to do if they notice a change or have concern with somebody showing signs of psychological distress.

Dale Bramley noted that as Chair of the Chairs Mortality Review Committees an area of focus for the Committee is suicide, particularly of young Maori men, young men and mental health clients.

Trish Palmer noted that the Auckland DHB funds the 'Big White Wall,' an online self-help service that monitors for warning signs and contacts a GP when there are concerns identified.

The Committee Chair thanked those involved in preparing the report and noted the Committees comments to assist in gaining more intelligence and insight of key messages.

Resolution (Moved Jo Agnew/Seconded lee Mathias)

The report was received.

Carried

3.2 Child, Youth and Women's Health (agenda pages 28-43)

Ruth Bijl (Funding and Development Manager - Child, Youth and Women's Health), Dr Alison Levershea (ADHB Community Paediatrician) and Dr Karen Bartholomew (Public Health Physician) were present for this item.

Matters highlighted and response to questions included:

- That the provisional coverage for immunisation is approximately 94% for both the Auckland DHB and Waitemata DHB. It was noted that some families delay the choice around immunisation.
- That both the Auckland DHB and Waitemata DHB are leading nationally for the 'raising healthy kids' target.
- That reaching the Rheumatic Fever target continues to be a challenge. The DHBs are looking at additional processes to assist in increasing results for this target. In response to a question later in the meeting, it was noted that rheumatic fever is non-existent in most developed countries. It was further noted that with regard to detecting rheumatic fever, a sore throat is a precursor in only 50 per cent of cases. A vaccine is being developed, but is likely many years away.
- That with regard to childhood obesity, approximately 600 – 700 children are seen as part of the B4 School Check programme. The DHBs are investigating what can be done to assist and/or educate mothers on nutrition both during pregnancy and up to four years of age for the child. When the Committee discussed whether other programmes targeted at reducing obesity had been successful, it was noted that the target is one aspect of a broader strategy with a number of actions. Dale Bramley noted that a recent published article stated that no country had reduced its obesity rates in the last 30 years; there is a degree of 'trial and error' in finding solutions to reduce obesity.
- That with regard to cervical screening rates, particularly for Auckland DHB, there has been some challenge in increasing the rate with Asian women.
- A further report will be provided to the committee regarding national screening changes.

- Noting that from a DHB perspective there was an interest in the population on views of HPV knowledge, with a framework for Maori women developed around health literacy so that information can be captured.
- In response to question it was noted that multiple studies have determined that HPV vaccine for boys is safe.
- That with regard to the new Vulnerable Childrens Act, it was noted that the DHB still has a target requirement from the Ministry of Health. The DHBs report quarterly to the Ministry. A more comprehensive screening process is in its early stages and is identifying a range of indicators (including housing) and will assist the DHB in providing the right support at the earliest possible time.
- It was noted that a child information platform is being developed to assist the DHB where there is concern expressed for a child; the platform will also show what health checks a child has or has not had, such as immunisation.

The report was noted.

4. STANDARD REPORTS

4.1 Planning, Funding and Outcomes Update (agenda pages 44-54)

Simon Bowen (Director Health Outcomes) introduced this item.

Matters highlighted and response to questions included:

- That at the Mental Health Awareness week hosted by AUT, Waitemata DHB had formally launched its 'Our Health in Mind' plan. Simon Bowen acknowledged and thanked Max Abbot for his support and role in the launch and week.
- That the Auckland DHB and Waitemata DHB have both submitted bids as part of the Ministry of Health's 'Fit for Future – A systems approach to primary and community mental health and addiction services'.
- That the AAA pilot had identified seven people with AAA. It was noted that the age bracket for screening had been reduced. It was anticipated that the programme would save four to five lives from AAA.
- That ARPHS had provided an update on costs associated with fluoridation, noting that the outlay of \$1 had a return of approximately \$9.
- The submissions lodged by ARPHS were noted and are detailed in the report (from page 53 of the agenda).
- That the Committee would be provided with clarification on the differentiation between standard and premium rooms in aged residential care.
- It was noted that with regard to connecting initiatives with localities, the Auckland DHB had a group in place to oversee locality development. The group is in the process of aligning work programmes together within Auckland DHB under a locality approach.
- That the Committee had previously been provided information on fluoridation of water and whether the Ministry of Health would consider controlled doses of fluoride in tablet form. This information will be sent to Allison Roe.
- That it was noted that up to 95 per cent of the Auckland region population receives fluoridated water.

- That clarification will be sought and the Committee provided information on dental services for children and how proactive the DHBs are being in identifying children who are not receiving fluoride via water sources.
- Further information will be provided to the Committee on the rate of utilisation of health services by the Asian population.
- Noting that both Auckland DHB and Waitemata DHB had translation services available.

The Committee Chair thanked those that prepared and presented the report.

Resolution (Moved Warren Flaunty/Seconded Allison Roe)

The report was received.

Carried

5. GENERAL BUSINESS

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

The meeting concluded at 3.28pm.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA
DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES
HELD ON 12 OCTOBER 2016

_____ CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 16 November 2016

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 16/03/16	5.1	Regional After Hours Services – the Boards to be kept informed on what approach the PHOs support, when that is known.	Tim Wood	12/10/16 (WDHB) 26/10/16 (ADHB)	The model for the metro-Auckland after hours services is progressing, a full report has been presented to the WDHB Audit and Finance Committee and the ADHB Board detailing a proposed pathway forward.
CPHAC 31/08/16	3.1	Diabetes Service - a presentation to the Committee from regional public health looking at broader determinants.	Tim Wood	23/11/16	See agenda item 3.1 which provides an update on diabetes prevalence, assessment and management of those with diabetes and the progress on the Diabetes Service Level Alliance Work Programme to date.
CPHAC 31/08/16	3.2	Mental Health and Addictions – evaluation of the Look Up Event to be presented to the Committee.	Lee Reygate/ Trish Palmer	23/11/16	This is provided within the ADHB Integrated Child and Youth Mental Health and Addictions Direction 2013-23 Update
CPHAC 31/08/16	3.2	Asian International Benchmarking report	Samantha Bennett	07/12/16	The benchmarking report has now been completed and an internal review process underway before being presented to the ADHB and WDHB Board meetings scheduled in December 2016.
CPHAC 12/10/16	3.1	Suicide Prevention and Postvention Action Plan 2015-17 – provide further data on suicide rates where the person has been taking particular medication/s such as anti-depressants	Manu Fotu	23/11/16	See note below.
CPHAC 12/10/16	3.2	Child, Youth and Women's Health – cervical screening: provide further report on national screening changes.	Ruth Bijl	23/11/16	See agenda item 3.3.
CPHAC 12/10/16	4.1	Aged Residential Care – provide clarification on the differentiation between standard and premium rooms in aged residential care.	Tim Wood/Kate Sladden	14/11/16	<p>The definitions for premium room and standard room in the Age Related Residential Care (ARRC) Agreement are:</p> <p><i>Premium room: a room with additional features of a permanent or fixed nature, which constitute Premium Room services under this agreement</i></p> <p><i>Standard Room: a room without the additional features of a permanent or fixed nature that constitute a Premium Room under this Agreement</i></p> <p>We have raised concerns about these definitions due to being asked on a regular basis to provide advice on what people can expect to receive under the ARRC Agreement.</p>

CPHAC 12/10/16	4.1	Dental Services for children – provide clarification on how dental services for children are responding to children who are not receiving fluoride via water sources.	Simon Bowen	23/11/16	See note below.
CPHAC 12/10/16	4.1	Accessing health services – information to be provided on Asian PHO enrolment rates and trends from 2012-16 across both DHBs.	Raj Singh	23/11/16	Information provided to the November 23 CPHAC meeting as part of the PFO update, explaining trends in the Asian PHO enrolment data for Auckland and Waitemata DHB's for the last 5 years.

Ref item 3.1: *Suicide Prevention and Postvention Action Plan 2015-17 – provide further data on suicide rates where the person has been taking particular medication/s such as anti-depressants*

This information is not available in a dataset.

Studies suggest antidepressants do not always have a beneficial effect on the risk of suicidal behaviour (for adolescents), although they may reduce both suicidal ideation and other depressive symptoms generally. Peculiar responses, often emerging early in the course of antidepressant treatment, require close clinical follow-up in order to assess the risk of suicide. When this risk is present, treatment should be appropriately modified, e.g. by changing antidepressant medication, adding sedating, antipsychotic or mood-stabilising treatments, and providing additional individual support.

When people are started on antidepressants the normal best practice guidance is to follow up more frequently when there is any risk of suicide.

The SIRP process for people under Mental Health service at the time of their suicide will include consideration of the medication people are on or any changes but this does not give rates for all people on antidepressants.

Data on suicide rates for those on antidepressants by definition will be higher than they general population as they have been put on antidepressants for an indication that makes them at higher risk of suicide.

Ref item 4.1 *Dental Services for children – provide clarification on how dental services for children are responding to children who are not receiving fluoride via water sources.*

Based on the Auckland Regional Dental Services Clinical Guidelines, a general caries (decay) risk assessment is carried out for each patient by the examining clinician. Each patient is designated a high, medium or low caries risk status based on several determinants, one of which is whether the patient resides at an address which receives a fluoridated mains water supply.

The risk status then determines:

- 1) the examination recall interval (6/12/18 monthly)
- 2) the exact preventative treatment or advice given
- 3) 3) the specific management of any carious lesions (decay) present.

Just because a child does not receive fluoridated mains water does not automatically put them into a high risk category, since the risk assessment is made on the basis of several factors, e.g. diet, other fluoride exposure, presence of caries, family history of caries, vulnerability.

Regarding category 2) above: topical fluoride treatments and advice on the use of fluoride supplements/other preventative measures for these patients are specific to each patient and based on other fluoride exposure (e.g. may attend a school on fluoridated mains water) and are also based on the patient's risk status as a whole. It is not appropriate to have a single strategy for all patients who do not receive a fluoridated water supply.

Each patient's digital clinical record on Titanium is supposed to record their fluoride exposure from the water supply in order to facilitate the above process. Unfortunately, in reality this is not a reliable record due to digital errors. It also relies on the clinician remembering to ask the parent if they receive fluoridated mains water, and also relies on whether the parent actually knows this information. It has been highlighted to ARDS staff by the dental therapists that it would be extremely useful if Titanium can automatically alert the clinician to fluoride status based on the patient's address.

3.1 Prevalence and management of diabetes

Recommendation:

That the report be received.

Prepared by: Sarah Gray (Public Health Physician) and Jagpal Benipal (Senior Programme Manager)
Endorsed by: Tim Wood (Deputy Director Funding)

Glossary

ALT	- Alliance Leadership Team
DAR	- Diabetes Annual Review
DSL A	- Diabetes Service Level Alliance
DSME	- Diabetes Self Management Education
DHB	- District Health Board
LTC	- Long Term Conditions
MACGF	- Metro Auckland Clinical Governance Forum
MOH	- Ministry of Health
NHC	- National Hauora Coalition
NZHS	- New Zealand Health Survey
PHO	- Primary Health Organisation
SMS	- Self Management Support
VDR	- Virtual Diabetes Register

1. Executive Summary

This paper provides an update on diabetes prevalence, assessment and management of people with diabetes and progress with the Diabetes Service Level Alliance Work Programme to date including the plan for the remaining 2016/17 year.

Diabetes is a serious long-term condition which affects 50,000+ people in Auckland DHB and Waitemata DHB and causes significant morbidity and mortality. The prevalence of diabetes is the highest among Pacific (approximately 15%) and Indian (approximately 11%) people in both DHBs. It is of paramount importance that health services are reconfigured to better provide a holistic and patient-centred approach. Improved patient education and more proactive management, including better access to services which support well-being are vital.

The quality of the data used to determine the performance of our health system with regards to diabetes assessment and management is recognised to be sub-optimal. One of the priorities for the Diabetes Service Level Alliance is improvement of data quality. Due to data quality limitations, our exact performance levels are difficult to assess, however, it is recognised that performance against the measures reported in the primary care update could be improved.

The Auckland Waitemata Alliance Leadership Team (ALT) has directed the Diabetes Service Level Alliance (DSL A) to develop and lead a comprehensive work programme in order to optimise population level diabetes outcomes. There are five work streams:

- System redesign
- Clinical Optimisation and Care Planning

- Self Management Support and Diabetes Self Management Education
- Workforce Development
- Mana Tu

Each work stream is leading a key set of related activities. Once these activities are complete, the DSLA will develop a future model of service delivery, incorporating all the essential components identified by the work streams, to achieve people living well with diabetes.

2. Diabetes

Diabetes is a progressive disease, with disabling long-term complications if not properly managed. Type 1 diabetes is characterised by deficient insulin production. Type 2 diabetes occurs when either the body does not produce enough insulin, or the cells in the body do not recognise the insulin that is present. Type 2 diabetes comprises 90% of people with diabetes and is associated with obesity. Tight control of blood sugar levels can reduce or delay disease progression.

The adverse health outcomes that people with diabetes suffer are largely due to complications such as vascular disease. Over 50% of people with diabetes will die of heart disease and strokes. People with diabetes also suffer from 'microvascular' complications of which the three most important are:

- kidney disease
- diabetic eye disease
- diabetic foot disease.

2.1 Diabetes Prevalence

Planning services for diabetes is challenging as the exact number of people diagnosed with diabetes is unknown. Unlike some other conditions, notably cancers, there is no national register of people with diabetes. There are three main sources of information that can be used to estimate the prevalence of diabetes; the virtual diabetes register (VDR), the New Zealand Health Survey (NZHS) and primary care records. Unfortunately estimates obtained from each source vary significantly (table 1). These data sources and their limitations are described below.

Table 1: Diabetes rates and numbers in the DHB domiciled populations aged 15+				
Data Source	Auckland		Waitemata	
VDR	7.4%	30,262	7.2%	33,363
VDR PHO* enrolled	6.7%	27,380	6.7%	30,770
Maori	6.5%	1,924	6.1%	2,332
Pacific peoples	15.8%	6,194	14.3%	4,133
Indian	10.7%	4,366	11.1%	2,375
Other	5.0%	14,896	5.9%	21,930
NZHS	5.0%	20,318	4.0%	18,445

*= includes all NZ PHOs. Denominator for rates = 2015 Projected DHB populations age 15+

Nationally the VDR PHO enrolled prevalence is estimated to be 7.0% in those age 15 and over.

In recent years the prevalence of diabetes, as estimated by the VDR, has been reported as rising at an average of 7% per year. In part this reflects the diagnosis of people who have truly, newly developed diabetes. It also reflects the diagnosis of the large pool of people who were previously living with undiagnosed diabetes who have been identified through the successful *More Heart and*

Diabetes Checks programme. It appears that the PHOs have largely screened their eligible enrolled populations and have identified a large majority of undiagnosed people. Therefore, it is anticipated that the steep rise in prevalence will now level off.

Prevalence varies significantly with ethnicity. Pacific peoples and Indian are the ethnicities with the highest rates of diabetes in both DHBs (table1).

2.1.1 Virtual Diabetes Register

Each year the Ministry of Health provide the DHBs with a virtual diabetes register (VDR). Information from major administrative datasets is used to identify people who are *suspected* to have diabetes based on the type of care they have received from the health system. Types of care that are included are:

- publicly funded hospital admissions coded for diabetes (from 1999 onwards)
- outpatient attendances for diabetes and attendances for diabetes retinal screening (2002 onwards)
- subsidised community dispensing of specific medications that are most usually used for diabetes
- community laboratory tests ordered in the last two years (need to have at least four HbA1c tests and at least one urinary albumin/creatinine ratio (ACR) test).

Some people identified in this way, will not have diabetes and will therefore be incorrectly included in the VDR. Others, with diabetes who are not engaged with the health system may not be identified and will be excluded.

It is generally accepted that on balance the VDR is overestimating the numbers of people with diabetes. Estimates of the degree of over counting vary.

The main reasons for VDR over counting are:

1. Metformin may be used to treat a range of conditions other than diabetes, including, pre-diabetes, polycystic ovarian syndrome and gestational diabetes.
2. Multiple HbA1c tests may be carried out in people without permanent diabetes such as during screening for diabetes, or monitoring of people with pre-diabetes or gestational diabetes. The potential for incorrect identification has increased recently as the use of HbA1c for screening and monitoring people with prediabetes has become more common over time.

The Ministry of Health and sector representatives are currently working together to improve the algorithm used to calculate the Virtual Diabetes Register (VDR).

2.1.2 The New Zealand Health Survey

The NZ Health Survey asks respondents if they have diabetes diagnosed by a doctor. A sample of approximately 14,000 adults per year, across New Zealand is surveyed, results are extrapolated to calculate population prevalence of diabetes. It is recognised that this methodology likely undercounts the true prevalence, but again the degree of error is unknown.

2.1.3 Primary Care records

Primary Care records if a patient has diabetes within the practice management system. However, obtaining accurate data extracts from practice management systems can be difficult. Such a data extract would need to be done for all practices in metropolitan Auckland as patients often see a

general practice outside the DHB of which they reside, so there is no robust mechanism to obtain this data set reliably and regularly.

2.2 Diabetes management

The development of complications can be prevented, or onset delayed, by good Primary Care management. Good management is focussed around trying to keep blood glucose levels in a reasonably normal range and identifying complications early so that appropriate additional treatment can be started.

Blood glucose levels are affected by nutrition and physical activity. People with diabetes can improve their blood glucose levels by making lifestyle changes but will also need to take medication to achieve satisfactory blood glucose control.

The HbA1c blood test measures the average amount of glucose in a person's blood over the previous two to three months. A level of 64mmol/mol or less represents good diabetes management and a level of over 64mmol/mol represents poor management. DHBs are required to report quarterly on the proportions of people with diabetes that have 'good management'. On a population level diabetes management is monitored in people aged 15 to 74 inclusive.

Ideally the Ministry of Health would like DHBs to monitor diabetes management across the whole domiciled population aged 15-74 who have diabetes. However, HbA1c levels are currently only reported by our PHOs in people who are enrolled with the PHO and who have had a diabetes annual review in the last quarter. Further work with the PHOs is required to ensure that data on 'the latest HbA1c in the past 12 months' for all people with diabetes enrolled with each PHO can be reported and used as a numerator, with the improved VDR as a denominator. This will still miss the proportion of the DHB domiciled populations that are non-enrolled with our PHOs.

There are recognised issues with the quality of data on HbA1c at every level from data entry, data extraction, data reporting and data compilation. The degree to which these issues are affecting results is still being quantified.

2.2.1 Diabetes Annual Reviews

The diabetes annual review (DAR) is the opportunity for primary care to assess a person's glucose control and risk of complications and to adjust their management accordingly. The PHOs provide DHBs with the number of DARs completed in a quarter. The total population of people with diabetes (VDR) is divided by four to estimate a denominator. This methodology is based on the assumption that the numbers of DARs completed each year are fairly uniformly spread throughout the year. This is not necessarily the case. Fluctuations should cancel each other out over the course of a year but in any one quarter it is possible that more than 100% of the denominator may appear to have had a DAR. Another factor is the numerator includes all people with a DAR enrolled within practices in the DHB regardless of DHB of domicile but the denominator is based on DHB of domicile.

Current performance for the diabetes management and diabetes annual review measures is provided to CPHAC in the primary care quarter 1 2016/17 update.

3. Diabetes Service Level Alliance

Based on the high prevalence and poor patient outcomes related to diabetes, the Waitemata Auckland District Alliance Leadership Team (ALT) identified diabetes as a key area of focus. Consequently, the Diabetes Service Level Alliance (DSLA) was established under the directive of the ALT and was tasked with developing, overseeing and advising the ALT on an appropriate work

programme and the investment decisions required to achieve agreed outcomes for people living with type 2 diabetes.

During 2015, the DSLA developed a comprehensive work programme which was endorsed by the ALT.

The work programme is designed to address the key issues highlighted by the 'Waitemata and Auckland DHB Services for People with Diabetes – A Stocktake and Gap Analysis' namely:

- Geographical and DHB variation in service provision and utilisation
- Lack of coordination, integration and communication between services and providers
- Lack of outcomes data to establish the quality, appropriateness and effectiveness of services
- Sub-optimal management of diabetes and cardiovascular disease
- Workforce sustainability issues
- Significant inequalities by ethnicity leading to poorer health outcomes of the Maori and Pacific populations
- Lack of clarity around funding allocations
- Under delivery of some current services.

The DSLA established the following principles:

- All people, including those living with diabetes, should have a reasonable ability to live, work, contribute to and be part of New Zealand society
- People with diabetes should have appropriate access to services that fosters equity of health outcomes across all population groups
- Services for people with diabetes should be patient and whānau centred
- Services for people with diabetes should be comprehensive, safe and sustainable
- Services for people with diabetes should be configured to support the delivery of integrated services and to better align incentives across the primary and secondary sectors
- Advice and information provided by the DSLA should be data driven; evidence based, guided by expert opinion and includes consideration and actions relating to health equity improvement.

To further address the inequalities that exist in diabetes and health, the DSLA Work Programme identified the following priority populations:

1. People with newly diagnosed type 2 diabetes
2. People with poorly controlled (HbA1c > 75 mmol/mol) type 2 diabetes
3. Maori with type 2 diabetes
4. Pacific with type 2 diabetes
5. Asian with type 2 diabetes
6. Quintile 5 populations with type 2 diabetes.

4. DSLA Work Programme

The DSLA Work Programme is comprised of five work streams each leading a key set of related activities. Although the work streams are presented separately, they do have strong linkages, overlaps and dependencies with each other.

4.1 Work stream 1: Systems Redesign

The purpose of the Systems Redesign work stream is to create a 'system' that is patient-centred, better integrated, accountable, and maximises outcomes. The aims of this work stream are to:

1. understand better the current state (investments, activities and outcomes)
2. reorganise and align the funding and delivery of diabetes services
3. restructure the system and alter system incentives such that desired performance is encouraged and promoted.

The system redesign work stream has initiated and is leading the following activities:

a. Co-Design - Lived experience of patients – to be completed by December 2016

DSLA has contracted **innovate change** to help create a model of care that would better support people and families living with type 2 diabetes. This process is being undertaken through the method and mind-set of Co-Design.

Co-Design involves gathering different perspectives, insights and experiences from people directly affected by an issue to create solutions. This project aims to empower and engage people with diabetes and their carers to actively problem solve. As a *part of diabetes Co-Design project, **innovate change** has completed the following work:*

- Carried out field research with people and families living with type 2 diabetes with a focus on hearing from Maori, Pacific people and those from lower socioeconomic areas (as these groups have relatively higher rates of diabetes, poorer access to health care, and poorer health outcomes)
- Have interviewed a range of professionals across primary and secondary care, who work with people and families living with type 2 diabetes
- Consolidated the learning into a set of insights to identify the current problems and opportunities and act as a guide for the Co-Design of the new model of care
- Hosted the first of two Co-Design workshops, where the model of care will be developed.

At this stage, **innovate change** have an early draft of what the model of care might contain, what value it could offer, an understanding of the barriers that need to be addressed, as well as what some of the key systems enablers may be.

Over the following weeks, **innovate change** will verify the emerging model of care with a small number of key stakeholders, as well as facilitating a second Co-Design workshop where the model of care will be further developed. This project should be completed by December 2016.

b. Review of Retinal Screening Services – Completed October 2016

The review comprised a literature review, key stakeholder interviews and data analysis. Findings of the review revealed that, whilst there was a high degree of customer satisfaction and positive feedback about the passionate, committed and skilled workforce, there were also components of the services that required improvement. The review found that not all people with diabetes were having regular screening. It also highlighted significant issues with accessing appropriate information from one of the current information management systems. The review also found that there was a lack of a robust governance and accountability framework with clearly defined roles and responsibilities.

The key findings of this review present significant opportunities for a major overhaul of the current retinal screening services across both districts. Overall, the review recommends adopting a 'whole of systems' approach that allows for a *consistent and community based* service delivery model/s across both DHBs, especially targeting Maori, Pacific and other high needs populations.

It is planned to undertake a comprehensive demand and capacity review to establish the future retinal screening contract volumes and resourcing of the screening services. It is of note that outcomes of the Co-Design process are also likely to influence the development of a retinal screening services model. Therefore, a paper detailing the implementation plan of recommendations of the retinal screening review report including incorporating outcomes of the Co-Design work will be tabled at the ALT meeting in February 2017. The paper will also include financial analysis of the proposed retinal screening model.

c. Review of Podiatry Services – to be completed in November 2016

The purpose of this review is to make recommendations that could improve the quality of experience and health outcomes for people with diabetes who have, or are at risk of developing active diabetes-related foot disease. Two secondary care podiatrists and a public health physician are undertaking this review.

The literature review, stakeholder interviews, focus group meetings with community podiatrists, data collection and analysis have all been completed. The information is currently being synthesised and the draft report will be reviewed by the DSLA in November with the final report due to be tabled at the Waitemata Auckland Alliance Leadership Team meeting in December 2016.

d. Update of the Stocktake and Gap Analysis of Services for People with Diabetes in Auckland and Waitemata DHBs – to be completed November 2016

An initial document, 'A Stocktake and Gap Analysis for People with Diabetes in Auckland and Waitemata DHBs' was compiled in March 2015 and detailed services across the two DHBs. This document provided clarity of the spectrum of diabetes care available in the region. This subsequent report was commissioned to update the original and attempt to bring further visibility to the financial investment and outcomes, particularly at primary care level.

The final report will be tabled for endorsement at the December 2016 Waitemata Auckland Alliance Leadership Team meeting. It is anticipated that the findings of this report will assist the Funding and Planning team to better understand the current state of investments and associated activities being undertaken across the whole system of diabetes care. This will inform the restructuring of investments to achieve optimal patient outcomes.

4.2 Work stream 2: Clinical Optimisation including Care Planning

This Work stream aims to implement a range of strategies targeted at improving the clinical management of patients with diabetes in primary care.

In recent years, there has been a drive to increase screening for diabetes and CVD through the More Heart and diabetes checks, and to improve assessment of people with diabetes through the diabetes annual review. A review of all existing investments is underway. The review will inform any re-alignment to incentivise improved management of diabetes and better outcomes for patients.

The Auckland Waitemata Alliance developed a performance and quality framework for diabetes and CVD that has 22 measures. Five indicators were prioritised in the first wave of measures to be captured and reported against. Following are the prioritised indicators:

- HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 – 74 years) who have good or acceptable glycaemic control (HbA1c ≤ 64).
- BP Control: Percentage of enrolled patients with diabetes (aged 15 – 74 years) whose latest systolic blood pressure is <140 .

- Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 – 74 years) who have microalbuminuria (ACR >2.5 for males; > 3.5 for females) and are on an ACE inhibitor or Angiotensin Receptor Blocker.
- CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy.
- CVD Primary Prevention: Percentage of enrolled patients with 5 year cardio-vascular risk >20%, (aged 35 – 74 years, excluding those with a previous CVD event) are on dual therapy (statin + BP Lowering agent).

Currently, the PHOs are establishing their processes and systems to report data from January 2017 on the five prioritised measures. The DSLA will then be able to identify aspects of care that are suboptimal and feedback this information to individual practices to inform improvement initiatives. The DSLA Chair requested that PHO Chief Executives agree to share practice level data. However this request was rejected, and the PHOs have only agreed to report data at a PHO level. In the absence of comprehensive practice level data, it will be difficult for the DSLA to support PHOs to identify the individual practices that would benefit from additional input to improve diabetes outcomes. This is a matter for ongoing discussion.

a. Demonstration projects

Two demonstration projects aiming to improve diabetes management are currently being undertaken. One is taking a quality improvement approach. This project is particularly focused on improving the outcomes of Maori, Pacific and other high risk populations. Ten general practices in West Auckland had their diabetes management data benchmarked. Each practice then made decisions to trial and test new processes as indicated by their data. Most of the participating practices have completed two to three cycles of improvement. Formal evaluation of this initiative is to be completed by mid-2017.

The second project is a collaborative between Auckland DHB and Auckland PHO. It aims to develop and implement an integrated model of care for diabetes involving the Hospital Specialist team (all disciplines) and General Practice teams. A secondary care diabetes specialist nurse has been working with seven general practices of Auckland PHO to help build the capability of the primary care workforce and enable providers to maximise their skill base and to expand their scope of practice to best meet the needs of their diabetic population. Formal evaluation of this initiative is underway and is likely to be completed early in 2017.

Going forward the Clinical Optimisation work stream will also start working on care planning with a view that all people with diabetes have an annual care plan.

4.3 Work stream 3: Self-Management Support (SMS) & Diabetes Self-Management Education (DSME)

Self-management refers to ways in which a person with a long-term condition (LTC) manages their condition by themselves (Ministry of Health, 2016). Self-management support (SMS) in turn refers to ways the health sector enables a person to manage their own condition. This can be achieved by providing people with diabetes with knowledge and/or motivating and empowering them to care for themselves better.

Diabetes Self-Management Education (DSME) is specifically designed to educate people with diabetes on how to manage their condition including improving blood glucose control, weight,

dietary management, physical activity and psychological wellbeing. It is considered most useful for people with newly diagnosed type 2 diabetes and those with poor control.

This work stream has completed a literature review related to SMS, DSME and education delivery models including a stocktake of education programmes offered regionally. It is recognised that a suite of different self-management support options need to be available to cater for different patient preferences. It is envisaged that the co-design project will provide insights into the best mix of options therefore, this work stream has been put on hold until such time the findings of the Co-Design project are available.

4.4 Work stream 4: Workforce Development

The workforce development work stream aims to adopt a systems approach to get the right people, in the right jobs, with the right skills, at the right time to improve the health and wellbeing of people with diabetes. An integrated workforce for diabetes across the two DHBs is envisaged. A critical dependency for this work is the Co-Design work which may influence the workforce skills, knowledge and competency requirements. The initial focus is on workforce development for practice nurses and GPs. In the next phase this will extend to allied health and unregulated workforce as required.

A stocktake of diabetes education materials and programmes that are currently available for practice nurses and GPs across the northern region is being finalised.

4.5 Work stream 5: Mana Tu

This work stream is exploring opportunities around the Mana Tu approach to the management of diabetes and prediabetes as proposed by the National Hauora Coalition (NHC). The mandate for this project includes addressing the social determinants of diabetes. A business case for a rapid deployment model to prototype under the direction of NHC is currently being developed. The business case will describe what the model will look like from a practice perspective, such as how Kaimanāki would work with individuals, whanau, practices and services for better outcomes. If approved, the model would be deployed across a limited number of NHC practices. Formal evaluation will be required.

This work stream has not progressed as per schedule due to the unexpected death of a key NHC member of staff. New timelines are currently being determined.

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

Recommendation:

That the report be received.

Prepared by: Trish Palmer (Funder Mental health and Addictions and Chair of the Implementation Governance Group) and Sheryl Jury (Public Health Physician)

Glossary

ABI	-	Alcohol Brief Intervention
ADHB	-	Auckland District Health Board
Alt Ed	-	Alternative Education
AOD	-	Alcohol and other Drugs
Asian MELAA	-	Asian and Middle Eastern, Latin American and African
C&Y	-	Child and Youth
CADS	-	Community Alcohol and Drug Services
CAMHS	-	Child and Adolescent Mental Health Services
CAYAD	-	Community Action Youth and Drugs, Auckland Council
CPHAC	-	Community Public Health Advisory Committee
CYMHAD	-	Auckland DHB Integrated Child and Youth Mental Health & Addictions Direction 2013-23
ED	-	Emergency Department
ESBHS	-	Enhanced School-Based Health Services
HoNOSCA	-	Health of the nation Outcome Scales Child and Adolescent
KPI	-	Key Performance Indicators
MHA	-	Mental Health and Addictions
MHC	-	Mental Health Commission
MoE	-	Ministry of Education
MSD	-	Ministry of Social Development
NGO	-	Non-Government Organisation
NYHRN	-	Northern Youth Health Regional Network
PHO	-	Primary Health Organisations
PHP	-	Public Health Physician (Planning, Funding and Outcome, Auckland DHB)
PMHA	-	Primary Mental Health and Addictions
PMYMHPP	-	Prime Minister's Youth Mental Health Project
POC	-	Packages of Care
PRIMHD	-	Programme for the Integration of Mental Health Data
SACS	-	Substances and Choices Scale
TRC	-	Tamaki Redevelopment Company
WDHB	-	Waitemata DHB
YSALT	-	Auckland DHB Youth Health Service Alliance

1. Executive Summary

This report is the annual update to CPHAC on the implementation of Auckland DHB Integrated Child and Youth Mental Health & Addictions Direction 2013-2023 (CYMHAD). It also provides information on other projects, which are not directly stated in the Plan, but contribute to achieving the objectives of the Plan. Good progress has been made in the implementation of the 2015/16 priorities. The report is presented under the following headings:

- Introduction
- Strategic alignment
- CYMHAD Highlights 2015/16
- Comments on Performance and Outcomes Scorecard
- Look Up 2016 and 2017
- Youth Peer Support Service – co-design and business case development
- CYMHAD Priorities for 2016/17
- Performance and Outcomes Scorecard
- Conclusion

2. Introduction

CYMHAD's vision is that "children, young people and families of Auckland experience and enjoy good mental health and emotional wellbeing". CYMHAD was co-developed with young people and Auckland DHB's agency partners in 2012/13. CYMHAD's Governance Group was established to guide the implementation with a Project Manager and a Youth Consumer Advisor assigned to work on the plan part time until September 2016.

CYMHAD action plan identifies the opportunities, benefits, key performance indicators (KPI), deliverables, and key actions against a timeline. One of the work streams worked for the first two years to draft the Performance and Outcomes with the establishment of a baseline to mark the progress of outcomes against. Post CYMHAD completion the Prime Minister's Youth Mental Health Project (PMYMHPP) was introduced and the Auckland DHB Mental Health (Addiction) services prioritised 'Intervening Earlier' in their strategic planning. These initiatives have increased the focus on youth services and the role of the Governance group to support any new child and youth MHA initiatives.

CYMHAD has six priorities and they are:

- Strengthening the Voice
- Intervening Earlier
- Addressing Inequalities
- Fostering Innovation
- Workforce Development
- Working Better Together

CYMHAD Governance group developed three work streams to achieve specific actions, these are:

1. Develop the Performance and Outcomes Scorecard to measure the impact of CYMHAD on the health of Auckland DHB's Child and Youth population
2. Fostering Innovation with Look Up as a Youth-led Innovation Forum
3. Workforce development by co-developing a business case with Youth Advocates, to develop a sustainable Youth Peer Support service and workforce.

3. Strategic Alignment

Table 1. CYMHAD Summary Strategic Alignment

Community, whanau and patient centred model of care	CYMHAD places young people, children and their whanau/ families at the centre of the model of care and brings services to where it is easy for young people, children and family/ whanau to access. It also covers strategies and processes to better support their on-going involvement.
Emphasis and investment on both treatment and keeping people healthy	The intention of the CYMHAD is to influence service delivery to focus on “earlier the better” with provision of support, tools and techniques when MHA issues are low to moderate in intensity
Intelligence and insight	By co-development of CYMHAD and establishment of Governance, including youth advocates and service users, ensures that the plan and its implementation captures the youth voice and strengthens processes that work for them as well as identifying what does not so these can be changed.
Outward focus and flexible, service orientation	CYMHAD focus on the whole of system approaches and feedback to include Auckland DHB funded Mental Health (Addiction), Altered High Addiction, Schools, Primary Care and Community services.

3.1 CYMHAD Highlights 2015/16

The following highlights were achieved in 2015/16 and further detail is contained within the report:

- CYMHAD Governance Group membership includes three young people members and the Clinical Director of Kari Centre (CAMHS)
- A successful Look Up 2016 was held on 11 August 2016
- Completed Expression of Interest to allocate project to Co-design and Business Case-development of Youth Peer Support Service workforce for Community, Primary Care and Specialist services
- Alternative Education Navigation Pilot Project commenced during 2016 with multiple funders (DHB, MSD and MoE) to support two full time social worker positions in Youth Navigator roles
- Youth Suicide data show decline
- Referrals to ED for self-harm show a sharp rise
- Rates of suspensions and exclusions from schools are showing that Maori are less likely to be excluded
- 2015 Altered High introduced Substances and Choices Scale (SACS) as new AOD screening tool that can measure outcomes and changes as young people progress through the treatment process
- 2016 Enhanced School Based Health Services (ESBHS) were increased into 10 schools with school nurses, visiting GPs and Psychologists and use school's Facebook pages to promote and support health services and topics
- 2015 Youth Forensic e-learning tool launched and 2016 Auckland University includes this in post graduate diploma papers on Youth Forensic Psychiatry.

4. Comments on Performance and Outcomes Scorecard

The current scorecard, developed in 2014/15, has provided a baseline and needs to be read in the context of a working document. The challenges outlined in last year's report on the quality, quantity and availability of data have not been resolved yet.

Challenges include:

- Establishing reliable data as a baseline that will reflect the impact of the implementation rather than the continuation of the current state
- Existing targets and data collection do not necessarily reflect the direction signalled
- Accessing reliable consistent data that reflects the whole system rather than the individual services
- In some cases there is no data, these have been left in the outcomes framework as aspirational
- Some indicators have changed and are no longer meaningful.

4.1. Population Accountability Measures

- Youth Suicides show a decline. It must be recognised that the numbers here are small, so it is hard to identify this result as a consequence of any actions taken. A priority action for the coming year is to understand the issues around youth suicide and to include a youth centred action in the Auckland DHB Suicide Prevention Plan as part of 2017 review.
- The referrals to ED for self-harm show a sharp rise. This data needs to be understood in more detail to establish why this increase is occurring and what clinical pathways are in place to address this concern. There has been incrementally larger numbers of youth presenting to CAMHS each year for the past few years, which might account for some increase in numbers needing emergency care. The other big change in the past 12 months is the Police are increasingly bringing clients to ED for assessment under s109 rather than being assessed at the Police station. This change in practice could account for an increase in numbers as well. Referrals to ED for self-harm need to be investigated to understand the increase in numbers. Interventions and clinical pathways to be reviewed based upon findings.
- The 2015 rates of suspensions and exclusions from schools are showing that Maori are less likely to be excluded. Research shows that flow on effects of young people remaining in school is significant in terms of their whole mental wellbeing and their access to services. Auckland DHB continues to support the Ministry of Education in this area with the Health Navigator role for young people in Alt Eds, the School Nurse for Alt Eds, Teen parent Unit and North Health School. These services are part of the Enhanced School Based Health Service.

4.2. Performance Accountabilities

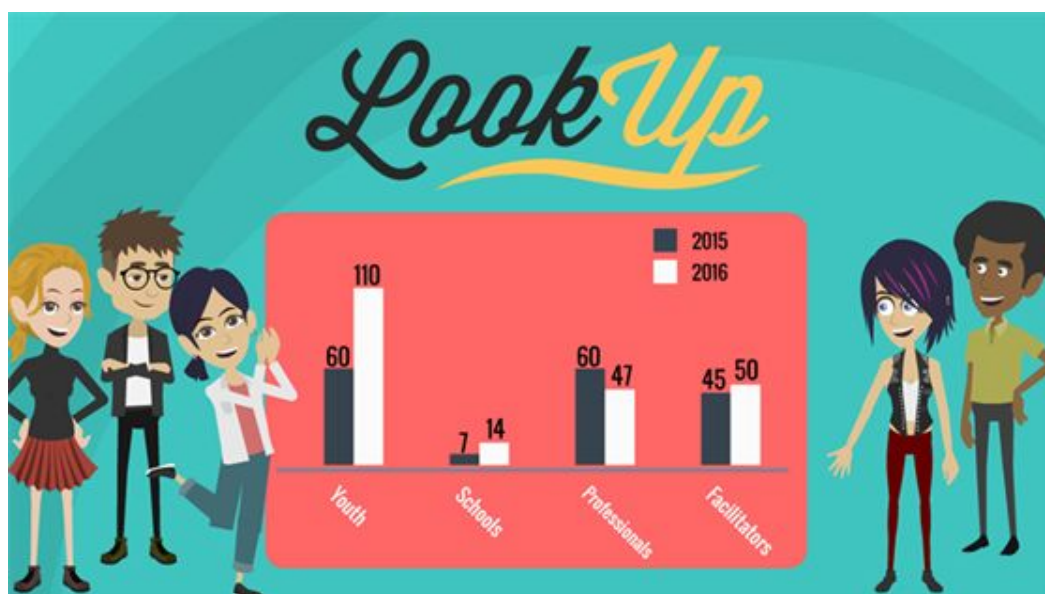
Below are some comments and actions for the measures for each work stream:

- **Strengthening the Voice** - Data in this domain has been challenging with the MOH stopping their consumer survey which all consumers were supposed to complete. This has been replaced by the Mental Health Commission's real time feedback tool Marama, which consumers can choose to complete or not. To date most people chose not to complete this, however, those who have tended to provide positive feedback. We will be actively looking to find an additional source of data for this measure.
- **Intervening earlier** – The data for access to Primary Mental Health & Addiction services and referrals from the Enhanced School Based Health Services has been refined. Subsequent reporting periods will give more comparable results. The number of NZ European accessing Primary Mental Health & Addiction service has increased sharply. This will be monitored to see if it is a trend and

if inequity of service is occurring. The number of Pacific accessing services is steadily increasing. The two types of interventions increasing are Packages of Care (POC) and Alcohol Brief Interventions (ABI).

- **Addressing Inequalities** - The HoNOSCA severity scores are becoming more reliable as data is now matched. The focus here is to decrease the number of “not rated” patients so the data can become more meaningful. This will also help us to understand the changes by ethnicity.
- **Fostering Innovation** – Look Up 2016 showed a steady increase over Look Up 2015, indicating that changes made as a result of feedback worked. Additional targets have been set for Look Up 2017. The uptake of e-therapy tools, in this case Sparx, shows that many young people start the process but need support to finish the course. This will be addressed with those starting young people on this process. There is also an increasing number of Maori accessing the tool.
- **Workforce Development** – This will be updated when the Werry Centre issue their next two yearly report in 2017.
- **Working Better together** - These measures need to be refined as better data becomes available.

5. Look Up 2016 and Look Up 2017



Metric	Look Up 2015	Look Up 2016	Target 2017
# Youth people attending	60	110	150
# schools	7	14	20
# professionals	60	47	50
# Action team, Volunteers, Facilitators	45	50	50

Look Up 2016 built on the success of Look Up 2015 with more youth and professionals attending, the theme was “Wellbeing around Alcohol and other Drugs”. Look Up provides an opportunity to explore and be inspired by different ways of working with young people to address their mental wellbeing. To do this CYMHAD created a participatory event with young people and those providing

services to young people learning and exploring the issues together. Youth AOD providers advised the event needs to foster genuine reflection and address the whole AOD spectrum (prevention, harm reduction, treatment), rather than defaulting to service promotion/information giving in order to change thoughts and behaviour.

An Action Team made up of skilled young professionals aged 22-29 from partner organisations designed and pulled together the work plan and ran the event. A youthful Project Manager was funded to lead the work (aged 22 years). With a Steering Group that included young people, NGOs, Primary Care, and DHB staff providing the mentoring, strategic guidance and sourcing the funding.

Look Up's intention was threefold:

1. To engage a diverse group of 100 or more young people in activities that would foster reflection on the spectrum of substance use, and equip them with tools and resources, in a youth-development and strengths-focused manner, leading to positive health outcomes. Achieved.
2. To engage 50 or more professionals to learn alongside young people, be positively influenced by a youth-leadership approach, to gain a deeper understanding of what is important to young people around substance use and to be exposed to new tools and resources, leading to an increase in youth participation in the sector and youth-friendly approaches. Achieved.
3. To capture young people's experiences and common themes on the day, to be used for systemic advocacy, leading to services that better meet young people's needs. Achieved.

Feedback that sums up 2016 day: "I did follow up with all the students who attended...they learnt the recovery position and how to save lives, they remembered all the workshops and took information home with them to share with their families and friends. I was very impressed with how focused they stayed and what was available for them on the day. I also came back and stressed the importance of this programme to our Team Leader and Senior Management Team".

Some key feedback as ongoing issues from workshop facilitators to consider how to respond with future planning and priority actions:

- Normalised binge drinking culture in place
- Expulsions are outcomes of last resort with harm reduction and more creative approaches to AOD issues rather than abstinence
- More education around supplying alcohol for adults/parents
- Engage youth in AOD help before standing down or expulsions
- Develop peer support and leadership and groups around safety and healthy life styles
- Develop youth roles/youth peer support roles
- Co-design and co-development of systems and responses to issues.



The Crowd



Reflective workshops: St John's cadets providing training in AOD related first aid



Beer Goggles - How straight can you walk after a few beers?



Hall of Inspiration: People's choice winner

6. Youth Peer Support service co-design and business case development

The development of a business case for youth Peer Support service workforce and service delivery was a 2016 priority action. Youth Peer Support for young people experiencing distress is an emerging and beneficial area of service development, which makes a difference to young peoples' recovery journeys. Nationally there are a small number of youth Peer Support services, however, there is no accepted model or best practice guidelines that can be readily adopted, either nationally or internationally. Auckland DHB currently does not provide such a service however the Kari Centre has trialled this in an ad hoc way in the past.

The intention is:

- To co-design a Youth Peer Support Service for young people experiencing distress in the Auckland DHB catchment. This is a whole of system approach including community, schools and primary care
- To pilot the co-designed service
- To amend the design as a result of the pilot and seek feedback on the changes
- To prepare the draft business case for the Funder to finalise.

This work will be contracted out to an organisation with a track record in Peer Support and is required to be led by a young person. Expressions of Interest (EOI) completed, with the project commencing at the end of 2016, funded until 30 June 2017.

7. CYMHAD Priorities for 2016/17

- Youth led project to identify on-line and social media based intervention (with evidence base) that would have high uptake from C&Y and develop processes to increase the likelihood of successful uptake and engagement (CYMHAD Youth Advocates and other partners)
- Include how to promote and support on-line and "e" based initiatives
- Kari Centre lead a project with other key stakeholders and agency partners to develop a central repository of evidence based resources, tool and options and identify with Youth advocacy groups how to use and increase likelihood of successful referral and engagement (Kari Centre (CAMHS))

- Look Up 2017, save a date for Thursday 10 August 2017 at Fickling Centre, Three Kings with “relationships” as the theme. This includes relationships that are romantic, sexual, friends, parents, caregivers, intergenerational, siblings, teachers, professionals and others
- Review of Supporting Parents Healthy Children approaches
- Develop “child and youth MHA” training and learning in Primary Care Nurse MHA Credentialing programme
- Map all workforce initiatives and programmes in place and develop a strategy to engage relevant agency partners in conversations about workforce challenges and opportunities
- Agency partners managing project to co-design and business case development of Youth Peer Support Services and Workforce
- Ensure child and youth needs and responses are part of Equally Well project
- Develop strategies to increase utilisation of the Marama feedback tool to increase meaningful results and identify other ways or tools to strengthen feedback on service provision across the care continuum (not just specialist CAMHS)
- To increase our understanding of the issues around youth suicide and to include a youth centred action in the Auckland DHB Suicide Prevention Plan as part of 2017 review
- Investigate the referrals to ED for self-harm to understand increase in numbers and review interventions and clinical pathways based upon findings (PHP and ED and CAMHS)
- Continue to review and strengthen the Performance and Outcomes Scorecard:
 - Paired HoNOSCA
 - Paired SACS
 - Monitor Family Violence screening rates in CYMHA service providers.
 - Monitor utilization of Marama feedback tool
 - Across the service continuum (primary to specialist) data sharing and reporting framework.

8. Performance and Outcomes Scorecard September 2016

Auckland DHB Integrated Child & Youth Mental Health and Addictions Direction

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Key:

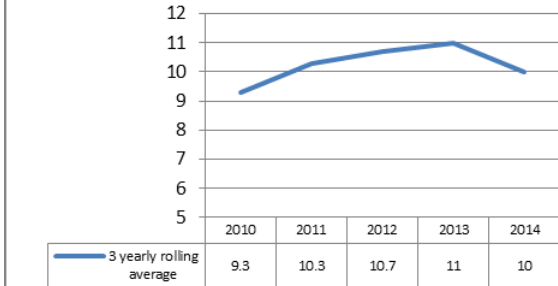
	On Target		Being monitored		Off Target		Not Assessed
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* No new data since 2015 scorecard

1. Health Outcomes: Overall Youth Population Mental Health

Vision/Population Outcome: All children, young people and their families living in the Auckland DHB area experience and enjoy good mental health and emotional wellbeing.

Opportunity: To enable children and youth to have improved mental health and to fully engage in school and community life.

1.1 Number of youth suicides														
Rationale: Suicide numbers can be an indicator of health status at a population level. Some suicides may be prevented through the implementation of the Direction.														
Target: Downward trend over time.	Status:													
Definition: Number of deaths in those aged 24 years or under determined by the Child and Youth Mortality Review group to be suicides.														
Data Source: Child and Youth Mortality Review Database, 11th Data Report.														
Analysis <div><p>3 yearly rolling average annual number of youth suicides in ADHB</p><table><thead><tr><th></th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th></tr></thead><tbody><tr><td>3 yearly rolling average</td><td>9.3</td><td>10.3</td><td>10.7</td><td>11</td><td>10</td></tr></tbody></table></div> <ul style="list-style-type: none">• The average annual number of youth suicides 2012 – 2014 was 10. The youngest was 14 years of age.• Approximately 2/3 of all cases in 2014 were NOT known to the CAMHS or addiction services.• These numbers include some undetermined cases or those where the coroner had determined the threshold for suicide has not been met. This may possibly result in over estimation of the number of suicides.			2010	2011	2012	2013	2014	3 yearly rolling average	9.3	10.3	10.7	11	10	Comments <p>There are several limitations in using suicide numbers to measure the effectiveness of the CYMHA Direction. These include these numbers being subject to:</p> <ul style="list-style-type: none">• small number variation• influence by factors outside the control of the health sector• changes due to variation in size and composition of the population over time. <p>The Child and Youth Mortality Review Group database was used as the source of suicide data as there is a significant delay before validated data becomes available from the Coroner/ Ministry of Health.</p> <p>The three yearly rolling average annual numbers of suicides has been calculated. 2015 data will become available in October 2016.</p> <p>Numbers are too small to show trends by ethnicity. Approximately one third of suicides are female and two thirds male.</p>
	2010	2011	2012	2013	2014									
3 yearly rolling average	9.3	10.3	10.7	11	10									

1.2 Number of referrals from ED for child and youth intentional self-harm

Rationale: Intentional self-harm numbers can be an indicator of health status at a population level. Some instances of self-harm may be prevented through the implementation of the Direction. Presentation to ED with self-harm may be influenced by factors such as availability, or otherwise, of community support for the individual.

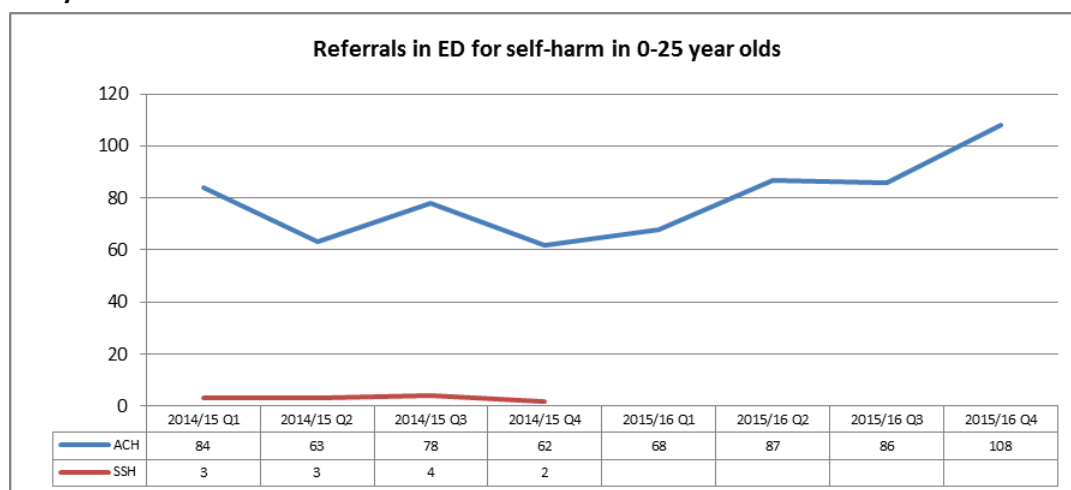
Target: Downward trend over time.

Status:

Definition: Number of ED referrals to adult liaison psychiatry or the Starship consult liaison team for intentional self-harm for 0-24 year olds inclusive.

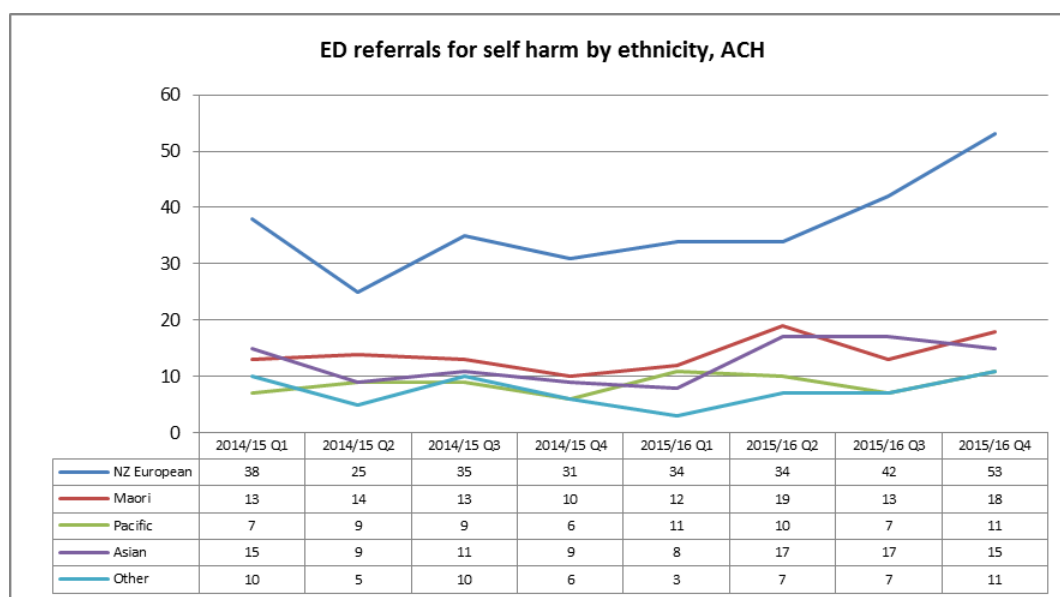
Data Source: Auckland DHB data.

Analysis



ACH - Adult liaison psychiatry

SSH - Starship consult liaison team



Comments

Self-harm can be an event in its own right, or can be a precursor to suicide.

The majority of referrals for self-harm are seen by adult liaison psychiatry. A quick review by the service suggests self-harm referrals to liaison psychiatry Nurse Specialists are broadly the same: 298 and 307 cases respectively. However, the numbers seen over the same time periods for self-harm by the overnight Psychiatric Registrars shows a marked increase – 77 in 2015, 137 in 2016. There has not been a change in referral patterns. ED has always referred 100% of self-harm presentations. The Urgent Response Service started up mid-April 2015 which has been the only recent change in service provision.

Approximately three quarters of ED referrals for self-harm are for females and one quarter males.

Limitations of using this data include:

- self-harm behaviour can be influenced by factors outside of the control of the health sector
- numbers may change with underlying changes in size and composition of the population over time.

1.3 Rates of suspensions and exclusions from school

Rationale: The rates of school suspensions and exclusions help provide an indication of student engagement in productive learning which is critical to student wellbeing and achievement. It is well documented that once a student is out of formal education the propensity for mental health and addiction issues to manifest increases significantly. The measures also provide an indication of the prevalence of certain behavioural issues in the school age population.

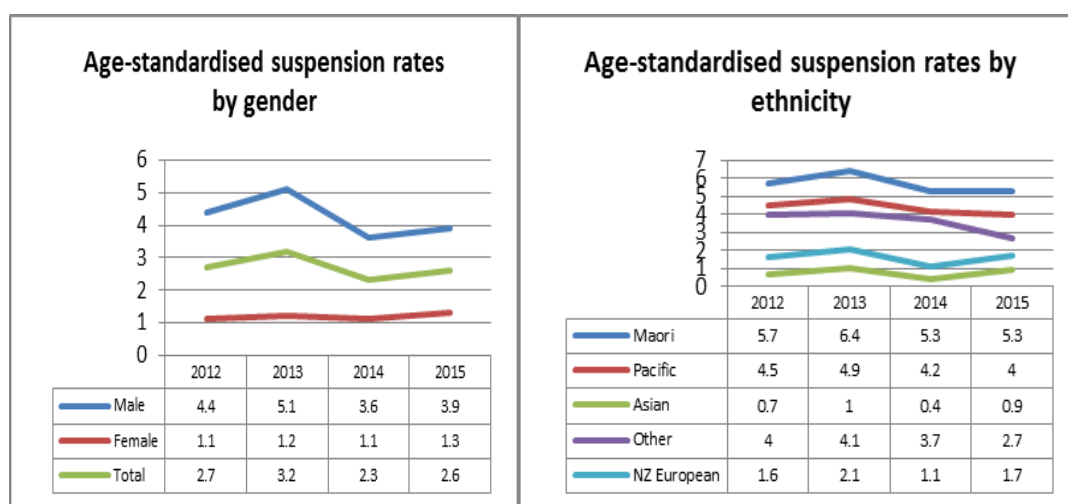
Target: Downward trend over time.

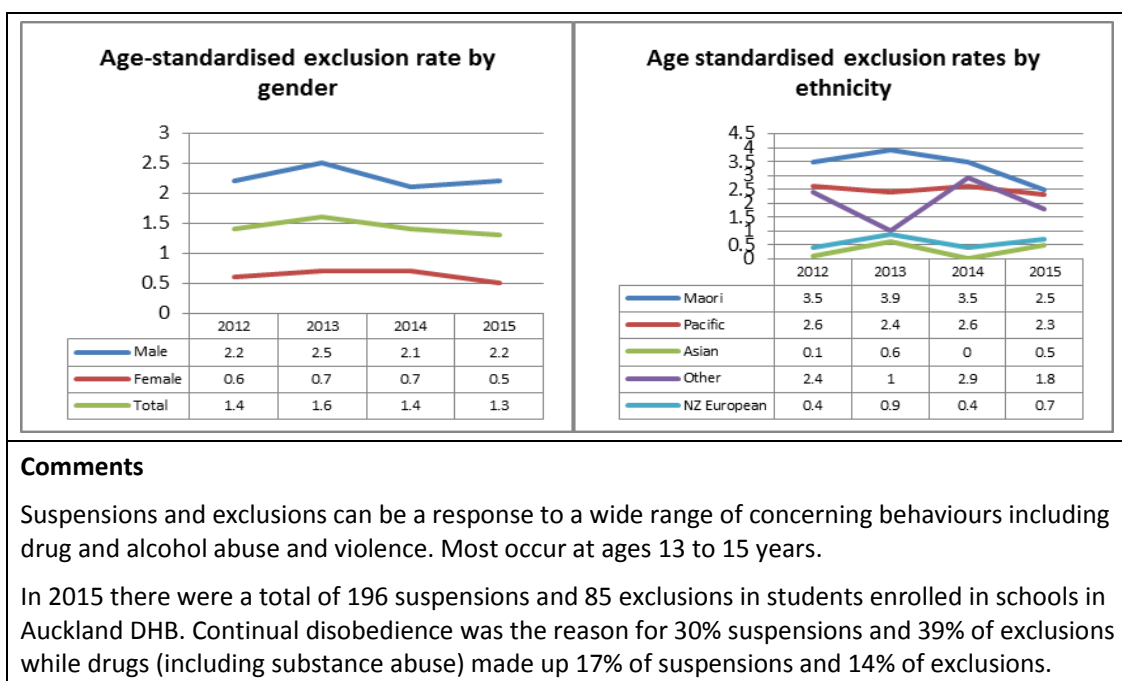
Status:

Definition: A *suspension* is a formal removal of a student from a school until a school Board of Trustees decides the outcome at a suspension meeting. If the student is aged under 16, the Board may decide to *exclude* the student from the school, with the requirement that the student enrolls elsewhere.

Data Source: Ministry of Education, educationcounts.govt.nz website.

Analysis





2. Strengthening the Voice

Outcome: Child, youth and family/whanau voices should be authentically listened to and engaged in improving services.

Opportunity: Services are seen as more accessible and responsive by children, young people and their families/whanau.

2.1 Child and Youth satisfaction with their ability to influence their own care

Rationale: Services are more likely to be effective if child and youth service users are able to have input into their own care.

Target: 95% of children and youth report satisfaction at their ability to influence their own care.

Status:

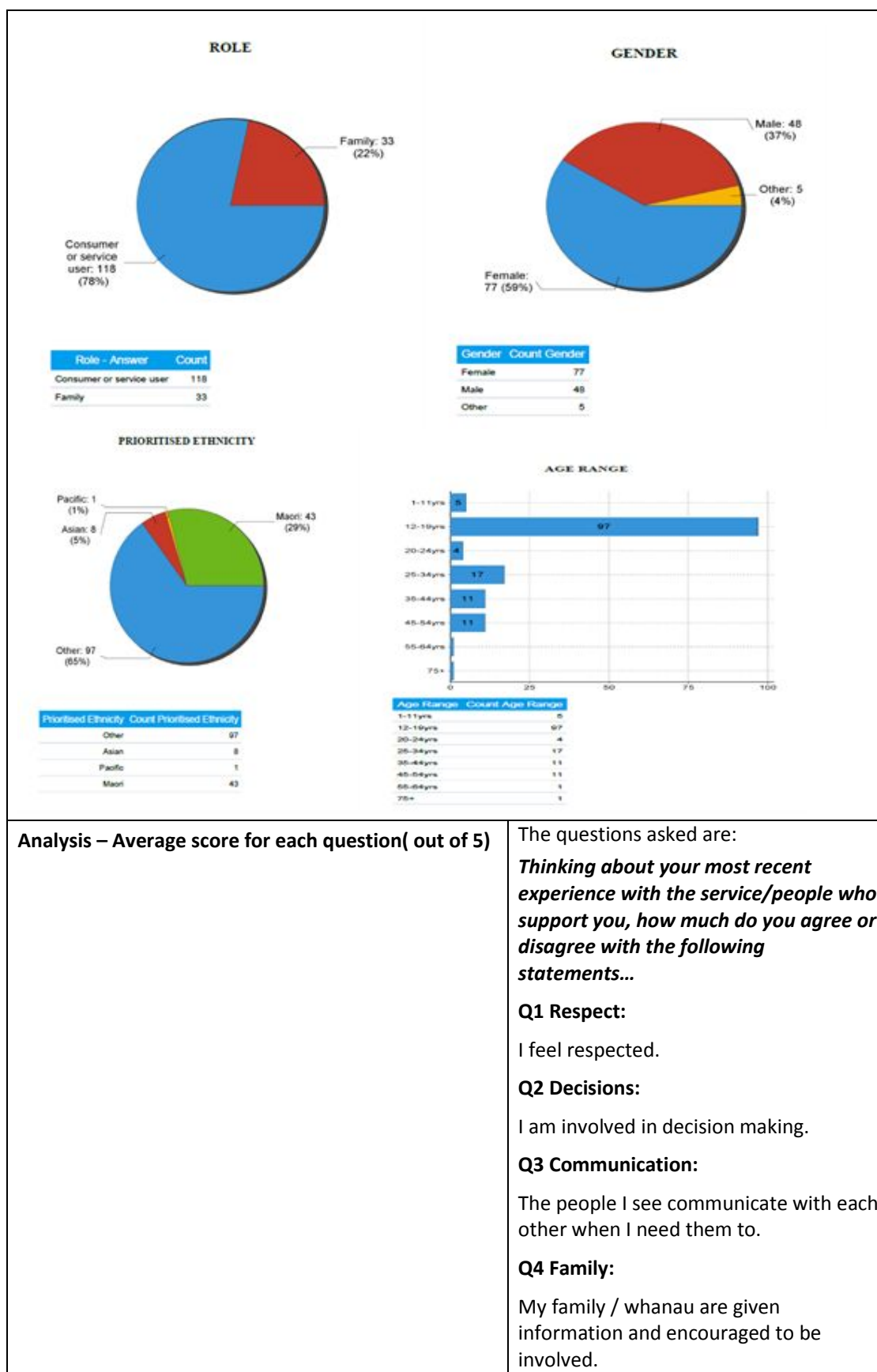
Definition: Questions 2 and 4 of the Marama real-time feedback tool pertain to child and youth service user input.

Q2 Decisions: I am involved in decision making.

Q4 Family: My family/whanau are given information and encouraged to be involved.

Data Source: HDC Marama Survey.

Analysis Only the collated results of the 156 responses are currently available. Respondent characteristics are presented first, then the question panel.



Analysis – Average score for each question(out of 5)

The questions asked are:

Thinking about your most recent experience with the service/people who support you, how much do you agree or disagree with the following statements...

Q1 Respect:

I feel respected.

Q2 Decisions:

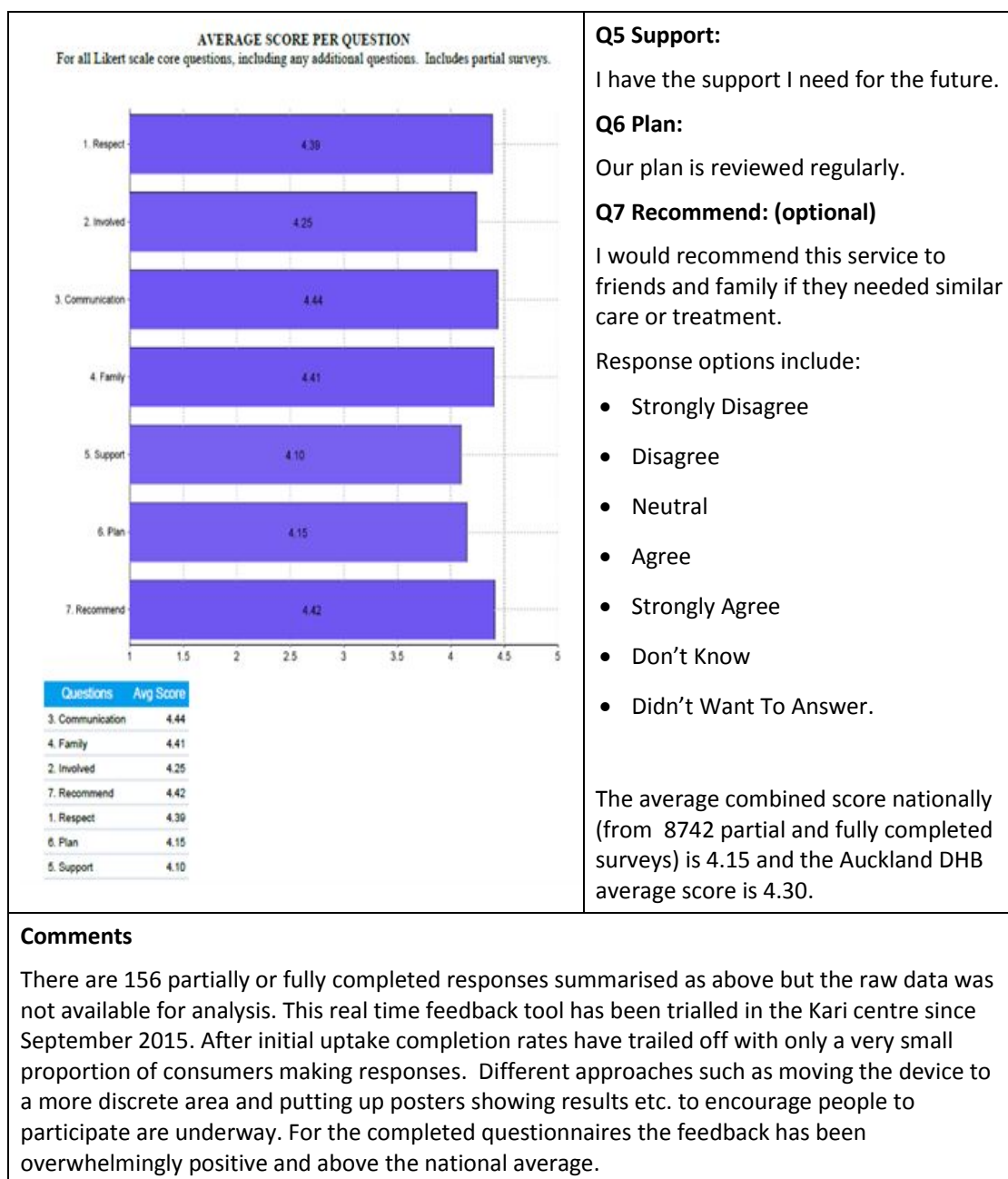
I am involved in decision making.

Q3 Communication:

The people I see communicate with each other when I need them to.

Q4 Family:

My family / whanau are given information and encouraged to be involved.



3. Intervening Earlier

Outcome: Children and Youth can access services earlier in the life course and early where there is a need.

Opportunity: There will be a decreased incidence of mental health and addiction issues later in life.

3.1 Number of young people accessing the PMH&A PHO based services

Rationale: The PMH&A funding enables youth to access care closer to home, therefore reducing some of the known barriers to accessing care.

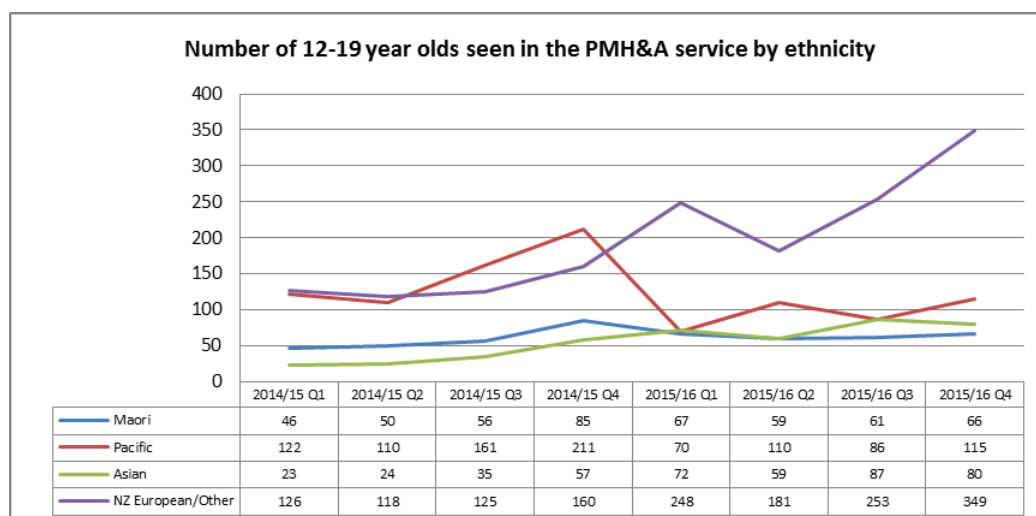
Target: Increasing trend of service utilisation.

Status:

Definition: Number of 12 to 19 year olds inclusive seen in the PMH&A service per quarter.

Data Source: Quarterly PMH&A reporting template data from PHOs.

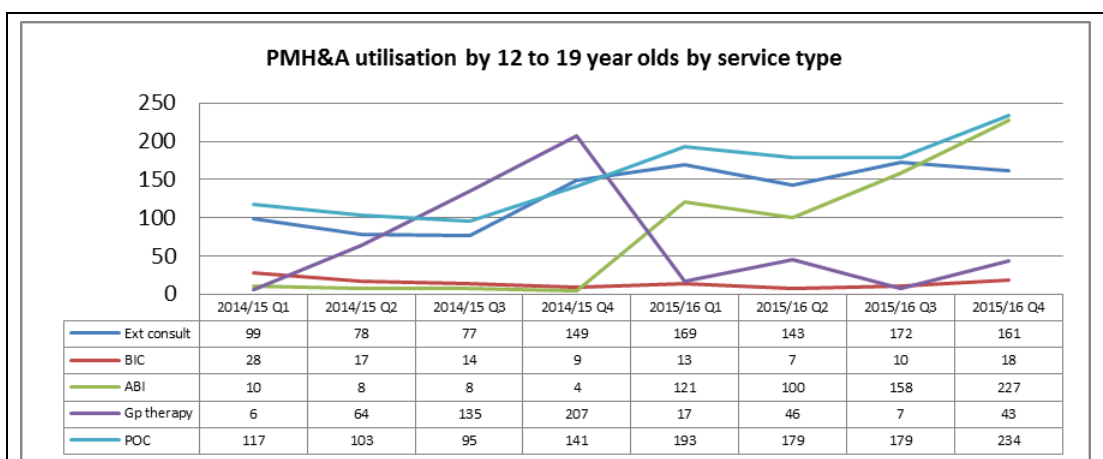
Analysis



Comments

The total number of 12 to 19 year olds seen in the PHO PMH&A service was 1506 in 2014/15 and has increased to 1964 for 2015/16. School based Youth Services have increased the number of schools the service visits and the number of hours. Services to Increase Access (SIA) funding will likely be contributing to the growth seen in the NZ European/Other category.

The PMH&A service is provided to both adults and youth. Total service capacity is capped by contract volumes. There is no specific target volume for Child and Youth.



BIC - Brief Intervention Counselling

ABI - Alcohol Brief Intervention

Gp therapy - Group Therapy

POC - Packages of care

Ext Consult - Extended Consultations (Nurse or GP) YSALT - Auckland DHB Youth Health Service Alliance

PHO PMH&A - PHO based Primary Mental Health & Addictions service

In 2015, Procure developed an IT pathway able to extract data in a way that captures more accurately ABI episodes.

Interventions at a GP Primary Care level including young people seen, POC, Groups & BIC remain low and relatively constant over the four quarters. ProCare however has experienced significant growth in the delivery of POC in the final quarter (does not include school based psychologist services) and overall Alcohol Brief Intervention.

3.2 Number of young people referred for mental health / alcohol or drug related issues via enhanced school-based health services

Rationale: The purpose of the Enhanced School Based Health Service (ESBHS) is to assist youth in reaching their full potential and to thrive in their communities. Assessing and advising youth in a school setting reduces some of the known barriers to accessing care.

Target: Not applicable

Status:

Definition: Number of 12 to 19 year olds inclusive that are seen by the Enhanced School-Based Health Services for mental health / drug and alcohol issues per quarter.

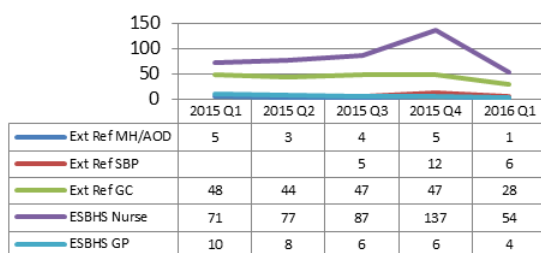
Data Source: Quarterly ESBHS reporting template.

Analysis

Comments

Enhanced school based health services (ESBHS) are provided in designated schools in Auckland DHB (primarily schools that are decile 1- 3). Existing ESBHS cater for nearly 9,000 young people through 10 defined mainstream schools, alternative education facilities and teen parent units.

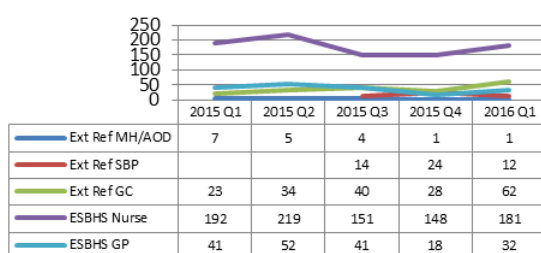
ESBHS Year 9



The majority of Mental Health/Alcohol or Drugs (AOD) issues are managed by the nurse. Other options are to be seen by the ESBHS GP or the school guidance counsellor.

In Quarter 2, 2015/16 the reporting template changed. Intervention data is now aggregated into four categories (Sexual Health, Mental Health, ACC and General Health/Other) and no longer reported by year levels. There were 46 Mental Health Interventions in Quarter 2 which will be the indicator moving forward.

ESBHS Years 10-13



Ext Ref MH/AOD = External referral for mental health/AOD related issues

Ext Ref SBP = External referral to School –based Psychologist

ESBHS Nurse = Nurse-led advice for mental health/AOD related issues

ESBHS GP= GP-led advice for mental health/AOD related issues

3.3 HoNOSCA severity scores on admission to MH&A services

Rationale: The Health of the Nation Outcome Scales Child and Adolescent (HoNOSCA) score can measure the severity of mental illness at the time of admission. If children and young people can be seen earlier in the course of their illness on a population level then this may be reflected by a reduction in HoNOSCA scores on admission over time.

Target: A downwards trend in the proportion scoring severe in the HoNOSCA severity score on admission, over time.

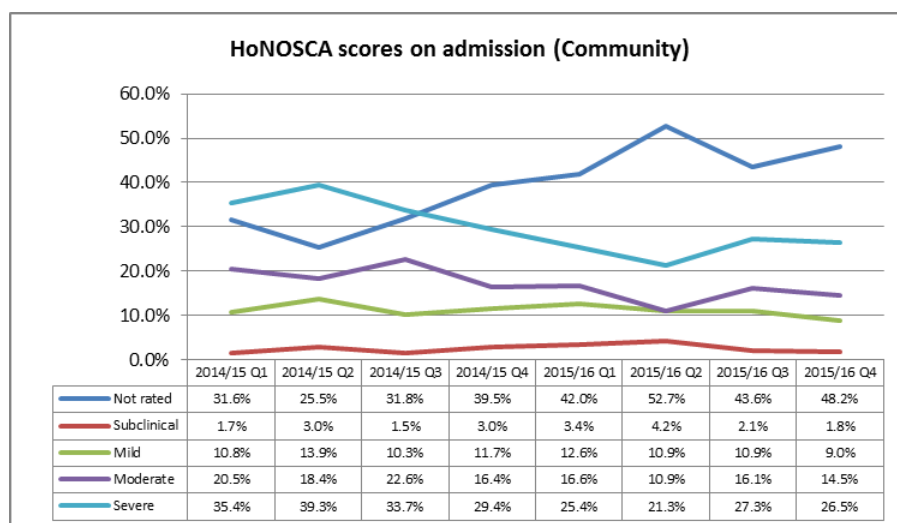
Status:

Definition: Proportion of admissions in each HoNOSCA severity score range.

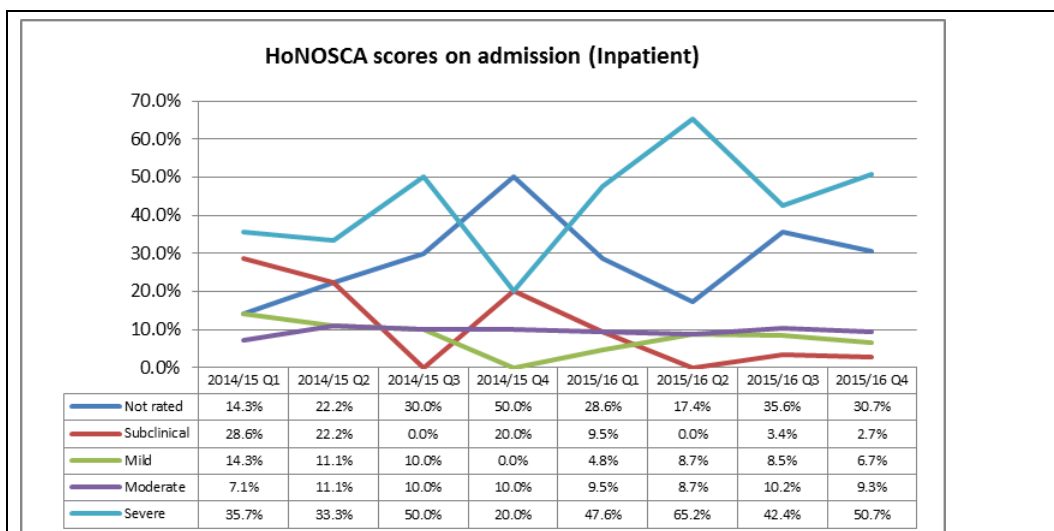
Subclinical = all items <2, mild = at least 1 item >1 and all <3, moderate = at least 1 item >=3, severe = at least 2 of the first 13 items >=3. Not rated = HoNOSCA score not completed.

Data Source: Auckland DHB PRIMHD data.

Index of Severity on Admission



Community = Kari Centre



Inpatient = the Child and Family Unit

Comments

The proportion of both inpatient and community admissions with a severe HoNOSCA score appears to be inversely related to the proportions of admissions who are not rated.

There has been an increase in the proportion of admissions that are not rated.

Changes in completion rates of HoNOSCA over time may result in changes to overall severity scores.

Factors other than children and young people being seen earlier in the course of their illness may result in a decrease in average HoNOSCA severity scores over time. Proportions of admissions in each severity score range would be expected to differ across services.

3.4 Waiting times for secondary care C&Y MHA services

Rationale: Intervening earlier is about being able to offer timely access to care.

Target: 80% new referrals seen within 3 weeks (MoH).

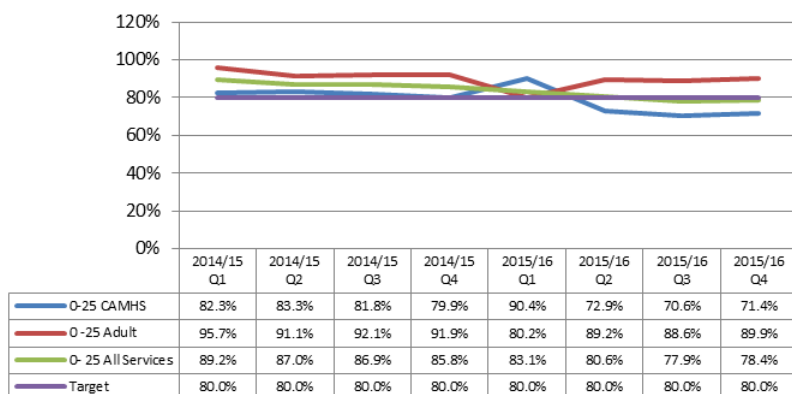
Status:

Definition: The proportion of all new referrals for those aged 25 years and under, to secondary care mental health services, that are seen within 3 weeks. (New referrals are referrals for individuals who have not been seen by any mental health service nationwide in the past year).

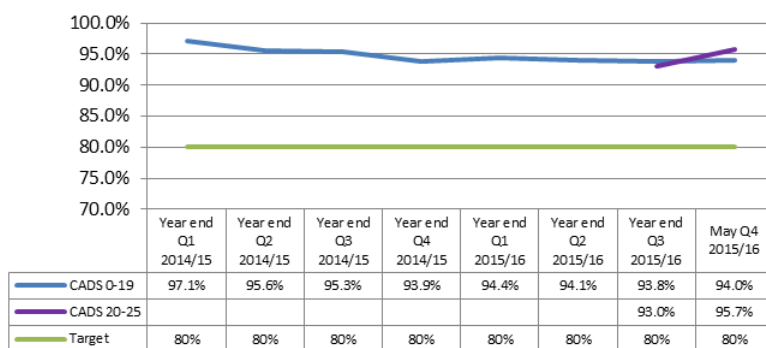
Data Source: Auckland DHB and Waitemata DHB (CADS) data.

Analysis

ADHB mental health service new referrals seen within 3 weeks



CADS ADHB residents new referrals seen within 3 weeks



Comments

Within Auckland DHB in 2015/16 the target of 80% has been met for all services combined but referrals to CAMHS have remained below 80% for the last three quarters. A slightly higher proportion of referrals of 0-25 year olds to Adult services are seen within 3 weeks.

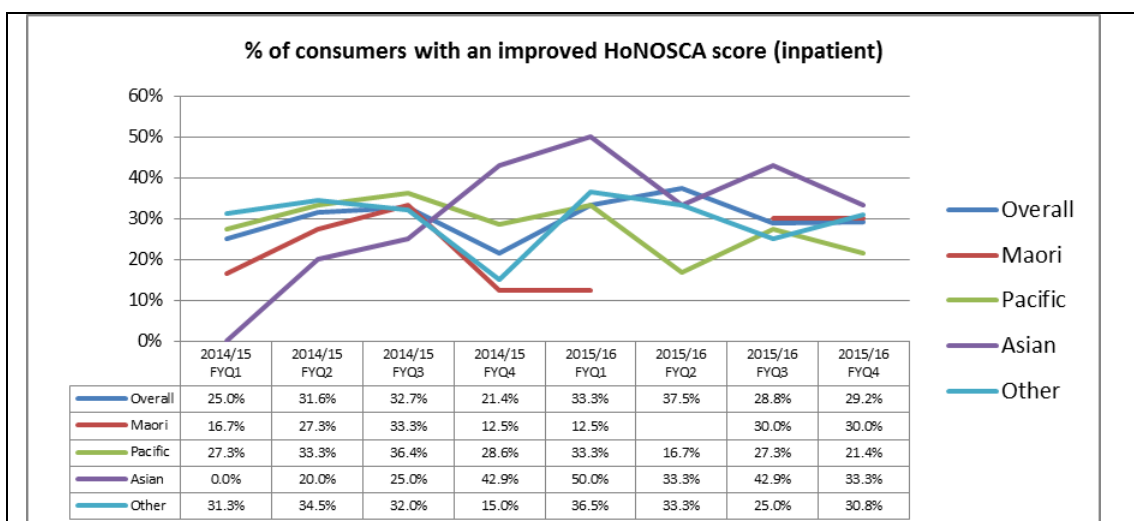
CADS also met this target for Auckland DHB residents. The ability to separate out 20-25 year olds waiting times has been added (data shown to the end of May as MoH data for June is not available yet).

4. Addressing Inequalities

Outcome: Maori, Pacific and other minority groups can access age and culturally appropriate services when and where they are needed.

Opportunities: To ensure that the unique societal structures, primarily in Maori and Pacific communities do not act as a barrier to access services. Services will be more responsive to Maori and Pacific.

4.1 Change in average number of clinically significant HoNOSCA items during a care episode by ethnicity																																																											
Rationale: Change in the HoNOSCA scores at admission and discharge for different ethnic groups provides an indication of outcomes achieved by ethnicity.																																																											
Target: Equal outcomes across ethnic groups.			Status:																																																								
Definition: Change in the HoNOSCA score range between admission and discharge by ethnicity (Maori, Pacific, Asian, Other).																																																											
Data Source: Auckland DHB PRIMHD data.																																																											
Analysis The upper lines reflect the 'Not Rated' percentage and the correlating drop in the percentage 'Improved' in the last two quarters with a move to reporting true Admission and Discharge pairs.																																																											
<div> <p>Change in Severity Rating (Community) % Not Rated vs % Improved</p> <table border="1"> <thead> <tr> <th></th><th>2015/16 FYQ1</th><th>2015/16 FYQ2</th><th>2015/16 FYQ3</th><th>2015/16 FYQ4</th></tr> </thead> <tbody> <tr> <td>Overall % Improved</td><td>41.1%</td><td>36.4%</td><td>20.6%</td><td>21.2%</td></tr> <tr> <td>Overall Not Rated</td><td>48.9%</td><td>53.6%</td><td>71.2%</td><td>71.2%</td></tr> <tr> <td>Māori % Improved</td><td>33.7%</td><td>32.7%</td><td>14.1%</td><td>17.2%</td></tr> <tr> <td>Māori Not Rated</td><td>54.9%</td><td>63.6%</td><td>79.5%</td><td>78.7%</td></tr> <tr> <td>Pacific % Improved</td><td>38.9%</td><td>28.1%</td><td>12.7%</td><td>13.7%</td></tr> <tr> <td>Pacific Not Rated</td><td>50.8%</td><td>65.6%</td><td>81.4%</td><td>80.3%</td></tr> <tr> <td>Asian % Improved</td><td>43.4%</td><td>37.0%</td><td>19.6%</td><td>20.0%</td></tr> <tr> <td>Asian Not Rated</td><td>48.5%</td><td>51.9%</td><td>73.2%</td><td>72.0%</td></tr> <tr> <td>Other % Improved</td><td>43.2%</td><td>39.3%</td><td>24.4%</td><td>24.2%</td></tr> <tr> <td>Other Not Rated</td><td>47.0%</td><td>48.0%</td><td>66.1%</td><td>66.9%</td></tr> </tbody> </table> </div>						2015/16 FYQ1	2015/16 FYQ2	2015/16 FYQ3	2015/16 FYQ4	Overall % Improved	41.1%	36.4%	20.6%	21.2%	Overall Not Rated	48.9%	53.6%	71.2%	71.2%	Māori % Improved	33.7%	32.7%	14.1%	17.2%	Māori Not Rated	54.9%	63.6%	79.5%	78.7%	Pacific % Improved	38.9%	28.1%	12.7%	13.7%	Pacific Not Rated	50.8%	65.6%	81.4%	80.3%	Asian % Improved	43.4%	37.0%	19.6%	20.0%	Asian Not Rated	48.5%	51.9%	73.2%	72.0%	Other % Improved	43.2%	39.3%	24.4%	24.2%	Other Not Rated	47.0%	48.0%	66.1%	66.9%
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Inpatient – CFU – Child & Family Unit
Community – Kari Centre

There has been a change in methodology which is reflected in the graphs above. Previous analysis had simply matched the first and last HoNOSCA's but from FYQ3 a true Admission and Discharge pairing is looked at. This is a truer indication of paired completion rates and in line with the MoH direction moving to gradually tighten up reports. However, the impact is that it reduces the numbers able to be rated and the volume that can show improvement. The impacts of this are particularly noticeable in the community data as the inpatient cohort has smaller numbers.

Only the percentage improvement is shown for the inpatient data. The 'Not Rated' percentage here varies from 33.3-60%.

4.2 Respect secondary MH&A service users experience

Rationale: Consumers that perceive that they are being treated with respect will feel more engaged with the service delivering their care.

Target: Increasing trend over time.

Status:

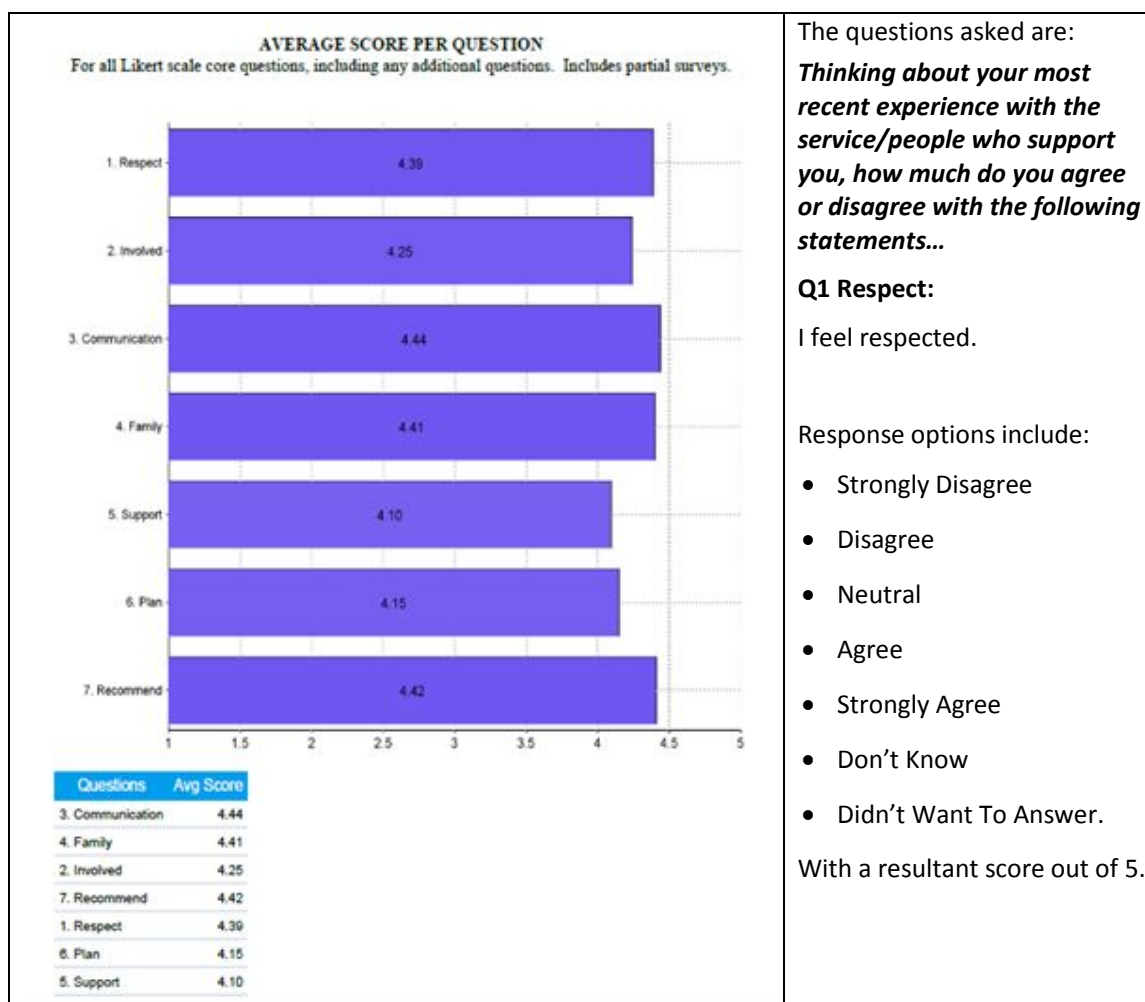
Definition: The proportion Child and Youth service users who feel they are treated with respect, by ethnicity.

Data Source: HDC Marama Survey (as outlined in 2. Strengthening the voice).

Analysis

Comments

This real time feedback tool has been trialled in the Kari centre since September 2015, after initial uptake completion rates have trailed off with only a very small proportion of consumers making responses. There are 156 partially or fully completed responses available for analysis.



4.3 Access to Services by ethnicity

Rationale: Access is a key contributor to health inequalities.

Target: To meet the MOH targets.

Status:

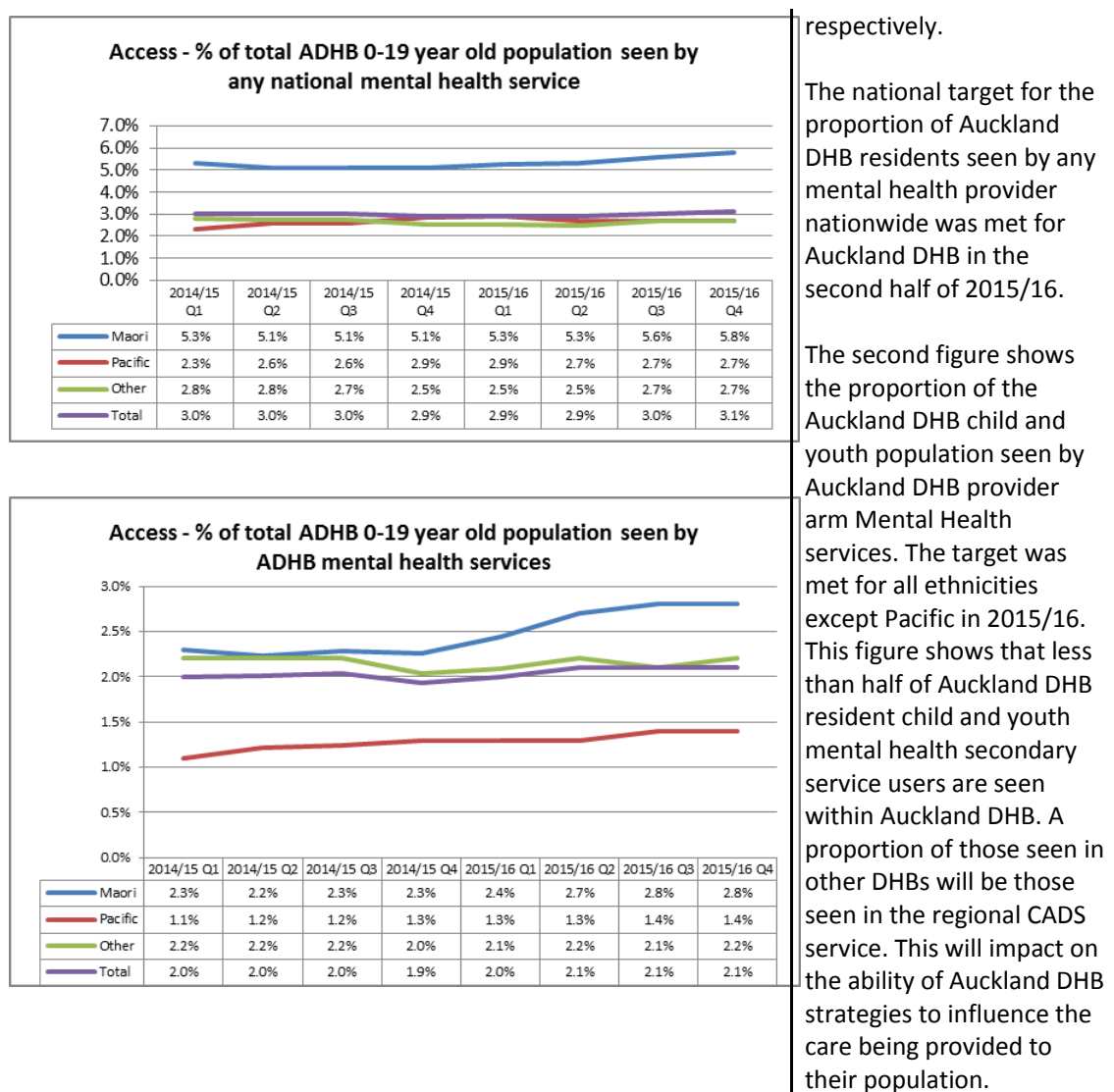
Definition: The proportions of the total 0-19 year old Auckland DHB population seen by mental health services nationwide and by Auckland DHB mental health providers.

Data Source: Ministry of Health.

Analysis

Comments

The Ministry of Health monitors the proportion of 0-19 year olds that are accessing Mental Health services nationwide and within each DHB. The national and Auckland DHB targets for Maori are 5.5% and 2.58% respectively and for other ethnicities and total are 3.0% and 2.05%



5. Fostering Innovation

Outcome: Children, Young people and family/whanau experience services as innovative and child and youth centric.

Opportunity: Children, young people and their families/whanau will directly benefit from a culture of innovation and new approaches.

5.1 C&Y MHA service delivery settings		
Rationale: Providing services where children and young people feel comfortable in attending and that are easy to attend will improve engagement		
Target: Increase in services provided in community	Status:	
Definition: A count of all contacts with service users and/or their families by location of the contact.		
Data Source: Auckland DHB MHA Quarterly data		

Analysis**CAMHS Contacts by Setting**

	01/07/2014-31/12/2014	01/01/2015-30/06/2015	01/07/2015-31/12/2015	01/01/2016-30/06/2016
Kari Centre	5921	5272	5757	5072
YTP House	830	605	861	769
Home	432	398	461	400
Other Community	276	281	333	348
Waiheke Island	26	22	23	36
School	245	182	144	171
Emergency Depart	5	9	9	19
Inpatient	28	48	32	43
Telephone	3340	2813	2898	2972
SMS/TEXT	15	169	231	324
Letter	2	7	22	21
Email	1172	1313	1361	1312
Grand Total	12292	11119	12132	11487

Comments

This data reflects the settings that the CAMHS Clinicians work in. The data does not reflect unique clients. Some clients may have had multiple contacts with multiple CAMHS Clinicians. It does not include the contacts made by the Enhanced School Based Health Service. The most noticeable change is the increase use of SMS/TXT. There has also been an increase in the number of 'Other Community' contacts.

CADS are able to provide the following setting information for the Auckland DHB 0-19 and 20-25 year people seen.

5.2 Innovative ways to work with young people

Rationale: To provide a forum where young people and professionals can explore and experience different ways of working and learning.

Target: Annual event with an increase of 50 young people per year.

Status:

Definition: Number of young people attending the event. Number of schools that students attended from.

Data Source: Look Up.

Analysis

Metric	Look Up 2015	Look Up 2016
# Youth people attending	60	110
# schools	7	14
# professionals	60	47
# Action team, Volunteers, Facilitators	45	50

A steady increase in number of students and the number of different schools represented. Schools represented included Alt Eds, PTE, and other schools. This was due to the youth focus of the event Action Team.

5.3 Uptake of e-therapy tools

Rationale: E-tools are an innovative and cost-effective way of providing care to young people and engage them with effective care.

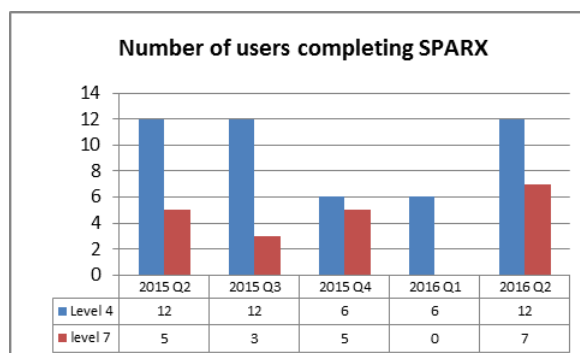
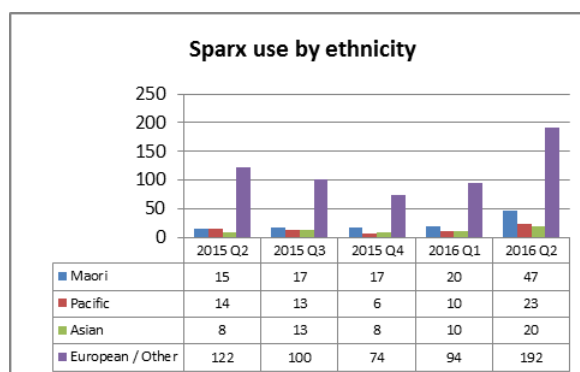
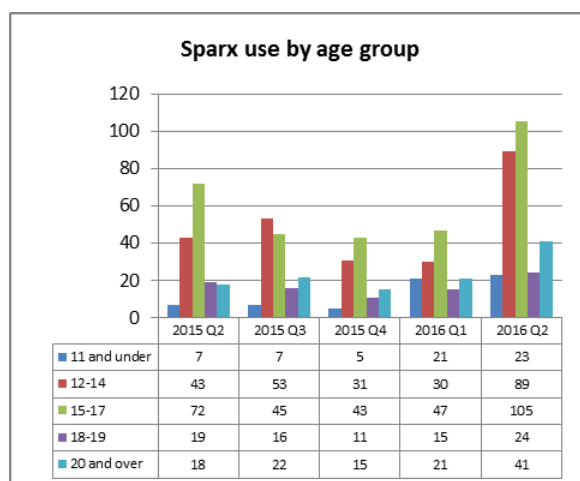
Target: Increase in uptake and completion of the programme from previous quarter.

Status:

Definition: SPARX is a self-help e-therapy tool that teaches young people the key skills needed to combat depression and anxiety.

Data Source: Ministry of Health.

Analysis



SPARX - is a self-help initiative, provided by the University of Auckland

Comments

SPARX was developed by a team of researchers from the University of Auckland and has been made freely available through the PM Youth Mental Health Project.

The number of self-identified 'young person' new users of SPARX has increased in the last quarter from 134 in 2016 Q1 to 282 in Q2. The numbers of Maori and Pacific remain low and have increased relatively. The target age range is 12 to 19 years.

There is no ability to split out DHBs within the Auckland Region as SPARX registration only asks residing location by region.

There are 7 levels that can be completed. Completing level 4 or higher is considered to have a therapeutic effect. In total just 12 young people completed level 4 in Q2 and 7 completed level 7.

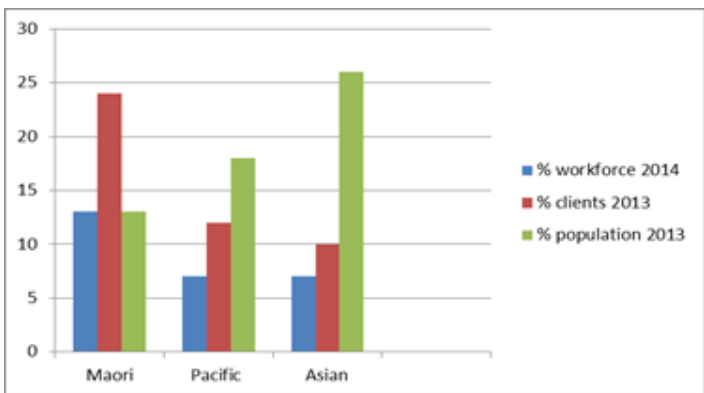
SPARX is now accessible via Chrome browsers, it went live 21 January 2016. At present SPARX is not compatible with mobile devices but an app is in development. The lack of compatibility here is a barrier and could reflect the lower than desired numbers with many youth. Promotional activities directed at youth have been implemented with participation in Polyfest, Youth expos and Facebook ad promotions.

6. Workforce Development

Outcome: To grow and develop the workforce so it reflects the diversity of our population and so we have the right people with the right skills in the right places.

Opportunities: There is a workforce that has the skills mix and diversity that is sustainable into the future. It is confident to work fluidly across organisational boundaries and with virtual tools.

The lived experience of children, young people and families/whanau is a valued contributor to personal resilience and recovery, peer support and other forms of help and treatment.

6.1 Workforce Competency																		
Rationale: Aspirational																		
Target:	Status:																	
Definition:																		
Data Source:																		
Analysis	Comments Currently we do not have data to provide a baseline.																	
6.2 Workforce Diversity																		
Rationale: A diverse workforce that reflects the population it services will be well placed to deliver services appropriate and responsive to that population.																		
Target: tbc	Status:																	
Definition: Workforce as a % of population and clients.																		
Data Source: Werry Centre Workforce Survey on Child and Adolescent Mental Health/AOD Services 2014. 2016 Survey to be next published in April 2017.																		
Analysis																		
Auckland DHB 0-19 year Workforce compared to proportions of clients and population																		
 <table><caption>Auckland DHB 0-19 year Workforce compared to proportions of clients and population</caption><thead><tr><th>Group</th><th>% workforce 2014</th><th>% clients 2013</th><th>% population 2013</th></tr></thead><tbody><tr><td>Maori</td><td>13</td><td>24</td><td>13</td></tr><tr><td>Pacific</td><td>7</td><td>12</td><td>18</td></tr><tr><td>Asian</td><td>7</td><td>10</td><td>26</td></tr></tbody></table>			Group	% workforce 2014	% clients 2013	% population 2013	Maori	13	24	13	Pacific	7	12	18	Asian	7	10	26
Group	% workforce 2014	% clients 2013	% population 2013															
Maori	13	24	13															
Pacific	7	12	18															
Asian	7	10	26															
Comments																		
Workforce compared to clients and population show a considerable disparity. This will need to be addressed in the regional workforce development plan.																		
LGBTI data to be added when available.																		

6.3 Number of youth and peer support advisors		
Rationale: The lived experience of children, young people and families/whanau is a valued contributor to personal resilience and recovery.		
Target: Growth in peer support roles.	Status:	Aspirational
Definition: See comment below on the definition of Peer support.		
Data Source: Werry Centre two yearly workforce survey - next expected to publish in April 2017.		
Analysis <p>One source of data is the Performance Monitoring returns – Affinity, Mind and Body, Provider Arm.</p>	Comments <p>Work needs to be done on defining what roles Peer Support include so they can be counted and a baseline established – the current data is collected as “Other Non-Clinical Support for Clients”. In the DHB they are called Peer Support and in Non-Government Organisations (NGOs) Youth Workers, Youth Consumer Advisors or Advocacy/Peer Support Whanau roles. The numbers being too small to separate out. The additional question is the number in Adult MHA services available for 18-24 year old. The total number in Adult services is 7 (2014 data as reported by Te Pou).</p>	

7. Working better Together

Outcome: To achieve integrated processes and access to appropriate services across our partner agencies and organisations.

Opportunity: The whole system works together to improve process and access for children, young people and their family/whanau to the appropriate services at the right time.

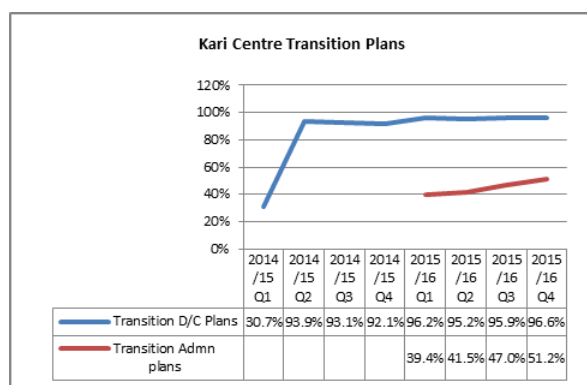
7.1 Discharge transition plans signed off		
Rationale: Transition planning ensures that: <ul style="list-style-type: none"> • service provision is matched as closely as possible to the needs of the young person and delivered by the most appropriate service/s to meet those needs • the young person and their family/whānau are the key decision-makers regarding the services they receive • care is delivered across a dynamic continuum of specialist and primary level services with decisions based on the needs and wishes of the young person and their family/whānau and not service boundaries • Processes are in place to identify and respond early should the young person experience a re-emergence of any mental health or AOD concern. 		
Target: The MOH target for discharge transition plans is 95%.	Status:	

Definition: % of discharges or admissions where a transition plan is in place on discharge from or admission to the Kari Centre.

This graph also measure the number of transition plans completed on admission and shared with GPs, client and family.

Data Source: Auckland DHB data.

Analysis



Comments

Formal discharge transition plans include referral and support to Primary Care as well as other agencies. The target for completed discharge transition plans is 95% and is being met. Data on admission transition plans has started to be collected in 2015/16 and is now over 50%.

Note: The admission transition initial letter/ plan is written to the referrer, their GP whether they referred or not, and the client. It is sent after the client has been seen by the clinicians for treatment. Except currently where that treatment is brief and by intake where a transition discharge is done instead.

7.2 Proportion of TRC relocation assessments that have a health assessment

Rationale: Tamaki Redevelopment Company are taking a holistic approach to the redevelopment project – health is a key part of this needs map.

Target: **Status:** **Aspirational**

Definition:

Data Source:

Analysis

Data and its source yet to be determined.

Comments

It has been proposed that a health assessment be included in the socioeconomic assessment that each family will participate in before they are moved. This will reflect a true partnership with our agency partners in looking at the holistic needs of a family/ individual.

3.3 Cervical screening update - Primary HPV screening

Recommendation:

That the report be received.

Prepared by: Dr Karen Bartholomew (Public Health Physician, Health Gain Team)

Endorsed by: Simon Bowen (Director Health Outcomes)

Glossary

DHB	- District Health Board
HPV	- Human papilloma virus
HRC	- Health Research Council
hrHPV	- High risk HPV
ISPs	- Independent Service Providers
LBC	- Liquid Based Cytology
NCSP	- National Cervical Screening Programme
NPV	- Negative Predictive Value
PCR	- Polymerase chain reaction
RCT	- Randomised controlled trial

1. Executive Summary

The Ministry of Health are implementing a change in the National Cervical Screening Programme (NCSP) from Liquid Based Cytology to a primary human papilloma virus (HPV) test from late 2018. This follows similar planning processes by European countries, Australia and the UK.

Evidence review and development of the implementation framework for this change has been underway for two years. International evidence and modelling work undertaken on New Zealand cervical screening programme data demonstrate that the change to primary HPV screening is effective at detecting more pre-cancer and invasive cancer than cytology, is cost-effective (likely cost-saving), with high confidence in a negative test such that the time between tests can be safely extended to five years. Co-testing (using two tests (both HPV and cytology) to test all women) is highly cost-ineffective for a population screening programme, however targeted (selective) co-testing for high risk women (women who test positive for HPV) is a very cost-effective strategy. Selective co-testing also reduces the number of unnecessary colposcopy visits for women.

The Ministry of Health 2018 programme change is to a primary HPV programme with selective co-testing of high risk women, with screening cycles every five years. Key staff from both Auckland and Waitemata District Health Boards (DHBs) have been involved nationally in planning for the 2018 change across a range of levels. The DHB investment in the two HPV self-sampling studies (focused on improving participation for priority women), enabled by the planned move to primary HPV screening, is occurring in parallel with DHB implementation planning. HPV self-sampling may be the vehicle needed to improve equity of access for Māori women.

2. Strategic Alignment

Community, whanau and patient centred model of care	Cervical screening is a women-centred primary care activity.
Emphasis and investment on both treatment and keeping people healthy	Incremental improvements to the ability to detect pre-cancerous changes and continue to reduce the incidence and mortality of cervical cancer in the era of vaccination.
Service integration and/or consolidation	Steps towards best practice harmonisation of cervical screening policy internationally.
Intelligence and insight	Use of international evidence and multidisciplinary international and local expertise.
Evidence informed decision making and practice	As above.
Outward focus and flexible, service orientation	
Operational and financial sustainability	Cost-effectiveness, cost saving, and resource implications (colposcopy volumes, laboratory impacts) are part of the Ministry of Health technical background documentation.

3. Background: Cervical cancer and HPV

Cervical cancer is caused by the human papilloma virus (HPV). HPV is a skin-contact and sexually transmitted virus that is very common for men and women, it is mostly asymptomatic and usually the infection clears on its own within 12-18 months. There are over 100 types of HPV and 15 of these are cancer causing types (High Risk or hrHPV). The hrHPV types occasionally persist, and persistence increases the risk of cell changes that may lead to cancer. Even when HPV causes pre-cancerous cell changes (CIN2/3) these cell changes can regress. In persistent infections with hrHPV cervical cancer remains a rare event, and we currently cannot tell which infections will lead to cancer. A range of research is underway on new molecular markers of persistent infections with higher cancer risk.

Because cervical cancer is caused by HPV it is a virtually preventable cancer, with high coverage HPV vaccination programmes and high quality cervical screening programmes. The Pap smear itself was not a screening test introduced based on Randomised Controlled Trial (RCT) evidence. It is a test that has relatively low sensitivity (but relatively high specificity), that when introduced in organised screening programmes internationally, has resulted in the dramatic reduction of incidence and mortality of cervical cancer. New Zealand has one of the most successful cervical screening programmes in the world.

Like elsewhere in the world women who have received the HPV vaccination are now coming up to the age of cervical screening. Evidence from Australia, where the vaccine was implemented first, shows there are substantially lower rates of genital warts and pre-cancerous cervical changes in vaccination age cohorts. While this is very good news, the current cervical screening test (cytology) will not be as good at detecting cell changes when there is substantially less disease (lower prevalence setting).

4. Changes to the National Cervical Screening Programme

In March 2016 the Minister of Health announced that the screening test used in the National Cervical Screening Programme (NCSP) would change from the current Liquid Based Cytology (LBC) to a primary human papilloma virus (HPV) test.

The Papanicolaou test (abbreviated as Pap test, Pap smear, cervical smear, or smear test) is where cervical cells are collected by a health professional and placed on a slide for examination in the laboratory. The purpose of the test is to detect potentially pre-cancerous and cancerous cell changes in order to prevent the development of cancer or detect and treat cancer early.

Similar to the UK, the NCSP has been a programme that has evolved with changes in the evidence base.^a There have been two changes to the screening test since the programme was initiated in New Zealand. The test was changed from a Pap smear to Liquid Based Cytology (LBC) from 2008, with all laboratories changed over to LBC in 2010. LBC is a change to the preparation method where the cervical cell sample is put in a vial containing preservative liquid rather than on a slide. The advantage of LBC is that it reduces the unsatisfactory test rate (and therefore repeat tests for women), allows some efficiency improvements in the laboratory including allowing automation to be introduced (New Zealand laboratories use automation-assisted technology). LBC also allows HPV testing on the same cytological sample, and this adjunctive strategy was introduced in the NCSP 2008 guidelines for triaging women with low grade cytology samples. Introduction of HPV adjunctive testing was the second test change introduced in the NCSP. HPV testing is also used in the NCSP as a 'test of cure' for treatment of cervical pre-cancerous lesions. There are two molecular testing platforms used in the NCSP for HPV testing in the current NCSP programme.

Internationally it is accepted that even with HPV vaccination programmes, cervical screening programmes are still necessary because not all women have been vaccinated (and vaccinated before HPV exposure) and the current vaccine does not cover all cancer causing HPV types. Since the early 2000s alternate ways to improve the cervical screening programme's ability to detect pre-cancerous changes have been pursued internationally, and it is acknowledged that assessment of the evidence relevant for population screening is complex. This has resulted in a series of Randomised Controlled Trials (RCTs; four in Europe, one in India) a prospective registration based study in the United States and one in Canada, longitudinal cohort studies and sentinel site investigations (UK sites and the large scale COMPASS study in Australia and New Zealand) of the use of HPV testing compared with the current cytology test (either co-testing or HPV primary testing).^b Studies include LBC technology comparable to New Zealand.¹ The most recent evidence from long term follow up (up to 12 years; more than 176,000 women) of the European RCTs² allows determination of impact on cervical cancer outcomes, not just on the cancer precursors of CIN2/3, which has been the point of greatest discussion as the trial results have been reported.

The evidence base for primary HPV testing is robust and has been examined in a series of systematic reviews and meta-analyses internationally. The changes proposed to the New Zealand NCSP are based on large scale assessments in the Netherlands, the UK, US, Canada and Australia. The

^a Unlike the UK the NCSP has maintained a start age of 20 years. In 2003 the UK increased its start age to 25, and retained this after review in 2009, due to the evidence that screening this low cancer incidence age group did not result in less cancers, and did result in high rates of cervical treatment with the small but real potential for impact on birth outcomes.

^b Most of this evidence is using the first generation HPV testing (e.g. the Hybrid Capture 2 (HC2) test) rather than the second generation polymerase chain reaction (PCR) testing or the third generation PCR testing that allows differentiation of hrHPV types (HPV type 16, 18 and 'other' hrHPV).

Australian Medical Services Advisory Committee³ evidence review released in 2015^c is considered to be one of the most thorough (including by the Royal College of Obstetricians and Gynaecologists in the UK as they consider implementation of the announced primary HPV testing rollout),⁴ and the advisors to the Australian programme renewal (where primary HPV testing will be implemented from May 2017) have been involved in advice to the Ministry of Health over the last two years of discussion and planning. A recent expert scientific panel discussion run by the Ministry of Health (PowerPoint presentation of the speakers are available in the Diligent Boardbooks resource centre) presented the range of evidence and scientific and screening policy discussion points. These include:

- Primary HPV screening results in better detection of pre-cancerous lesions (CIN 2/3) and reduction in cervical cancer incidence (Figure 1). In addition the preferred pathway of partial HPV genotyping is highly cost-effective (and probably cost-saving) using New Zealand NCSP registry and vaccination data (Incremental cost effectiveness ratio (ICER) of \$34,000 where a threshold of approximately \$50,000 is considered to be cost-effective).
- Primary HPV screening does result in more investigations (colposcopy) because it detects infection rather than cell changes (it is more sensitive, but less specific). Most programmes internationally are examining ways to reduce unnecessary testing for women (in order to maximise the disease detected per colposcopy referral, but not to miss disease). Triage methods are generally accepted to be the best way to do this. The NCSP approach of using reflex cytology for HPV positive women is the same pathway as Australia. This approach can be considered to be a high-risk co-testing approach, or selective co-testing (HPV and cytology).
- Primary co-testing (doing both HPV and cytology) on all women also results in better detection than cytology alone, however there is little improvement over primary HPV screening (Figure 2). Co-testing is slightly more sensitive but is less specific than cytology or primary HPV testing. The cost-effectiveness assessment for co-testing indicates an ICER of \$700,000 (<\$50,000 being considered cost-effective); therefore co-testing is highly cost-ineffective.
- In terms of safety the very high Negative Predictive Value (NPV) of HPV testing allows safe extension of the screening interval. Early evidence of the length of interval (2-3 screening cycles) suggested safety to 5-6 years, recent Dutch evidence proposes a 10 year interval for women over 40 years. The Netherlands is implementing primary HPV screening from January 2017, with different intervals for different age groups. The current NCSP proposal is moving from a 3 year to 5 year interval for all women.
- Use of HPV typing can further risk stratify women, with evidence from the large trial in the US⁵ (Figure 3) demonstrating that HPV 16 and 18 are high risk for pre-cancerous changes, other hrHPV positive test are intermediate risk and negative tests very low risk. The pathway proposed by the NCSP is for women with HPV 16/18 to be referred to colposcopy, with a repeat test in 12 months for women with 'other' hrHPV.

Graphical representation of the key findings are provided below (further detail is available in the attached scientific expert presentations available in the Diligent Boardbooks resource centre).

^c See: <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/content/MSAC-recommendations>

HPV screening is better than cytology at detecting cancer:

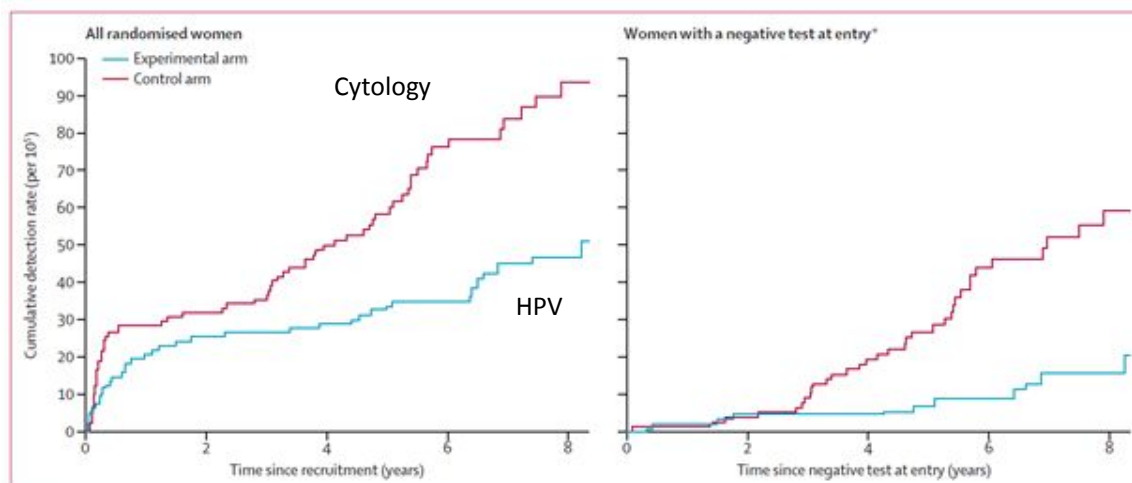


Figure 2: Cumulative detection of invasive cervical carcinoma
*Observations are censored 2.5 years after CIN2 or CIN3 detection, if any.

Figure 1. Pooled meta-analysis of the four European RCTs examining the endpoint of the detection of invasive cervical cancer (left; *comparative effectiveness*) and the long term protection demonstrated by cytology (red line) and an HPV test (blue line) (right; *comparative safety*).²

The additional benefit of co-testing is small and mostly due to the HPV component:

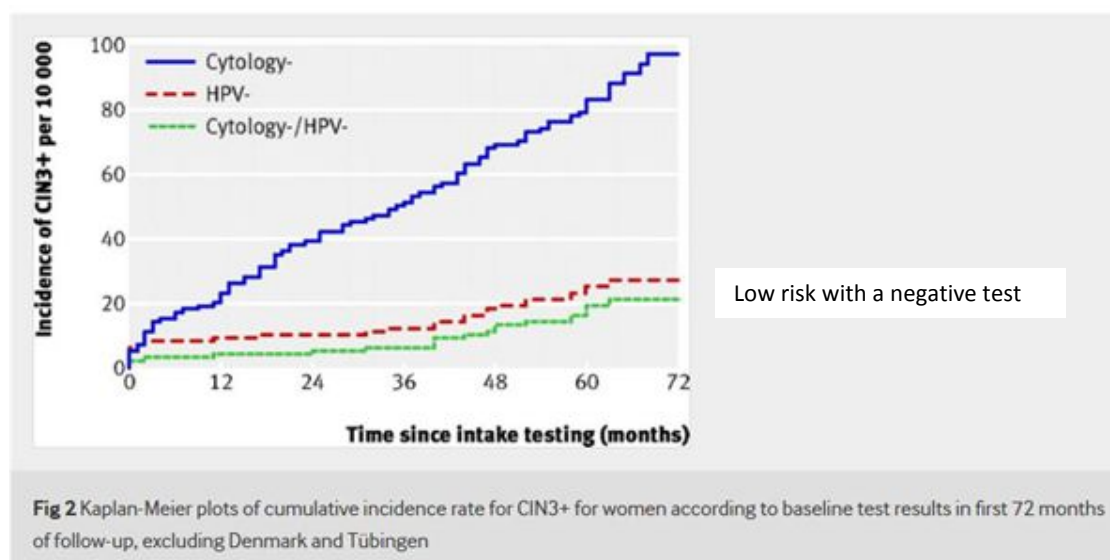


Figure 2. Six European studies combined results. Safety comparison three strategies (cytology primary screening, HPV primary screening and co-testing). Protective benefit of a negative HPV test (red line) and negative co-testing (green line) both low risk.⁶

Women can be identified as a high, intermediate and low risk based on HPV type (and then managed differently):

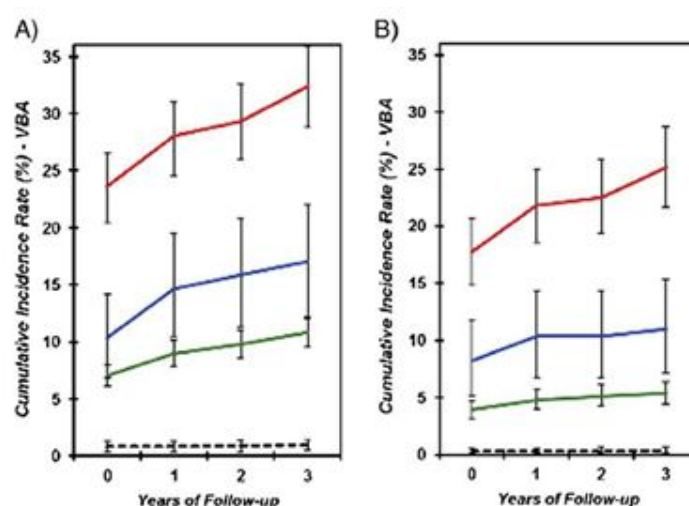


Fig. 2. Verification bias-adjusted (VBA) cumulative incidence of consensus pathology cervical intraepithelial neoplasia 2+ (CIN2+) (A) and CIN3+ (B) during 3 years of follow-up stratified by baseline human papillomavirus (HPV) status. Red solid line, HPV-16 positive; blue solid line, HPV-18 positive; green solid line, 12 other HPV genotypes positive; black dotted line, HPV-negative.

Figure 2. Cross-sectional FDA registration ATEHNA study (US) using HPV typing for risk stratification. Increase risk of CIN2 (left, A) and CIN3 (right B) demonstrated with HPV 16 (red, top line) and HPV 18 (blue line), intermediate risk ('other' hrHPV types, green line) and negative HPV (dotted black line).⁵

There has been debate about a number of scientific and policy issues in HPV and cervical screening more generally in the HPV vaccination era including the start age, exit age, optimal interval, screening technology, co-testing, information (register) requirements, cost-effectiveness, impact on the laboratory/cytology workforce and the use of self-sampling technology.

5. DHB planning for the programme changes

Key staff members with in-depth experience of the NCSP at Auckland DHB and Waitemata DHB have participated in discussions, working groups and forums at a range of levels related to the proposed NCSP changes (governance, technical, equity and clinical/operational advice). Implementation planning for the impact on primary care providers, Independent Service Providers (ISPs), laboratories and colposcopy services are all relevant. Ensuring informed conversations between smear taker providers and women in the changeover is a critical element and provider education and access to information is fundamental to this. Management of current colposcopy volumes and planning for future volume flexibility is underway at both sites.

The two HPV self-sampling studies being undertaken in the Auckland DHB and Waitemata DHB areas – the feasibility study for Māori women and the larger Health Research Council (HRC) funded study for all NCSP priority women, led by Massey University Professor John Potter with DHB co-investigators – is a useful mechanism for determining the education requirements of providers, the best way to present and discuss HPV primary screening with women, local planning for the new colposcopy pathways and further planning ways to improve equity in the programme going forward. Working closely with primary care (including the new Safety In Practice cervical screening bundles), the Cervical Screening co-ordination service and Well Women and Families Trust (the new ISP for Auckland and Waitemata) is also fundamental to the success of the self-sampling studies and for extending this to the whole of pathway planning for implementing HPV primary screening.

6. Summary

The NCSP is moving to primary HPV testing for cervical screening in 2018. Over the last two years the Ministry of Health have undertaken an assessment of international evidence, modelling, cost-effectiveness assessment and implementation planning with support and advice from the Australian renewal programme (where primary HPV testing will be implemented from May 2017). Revised Guidelines and National Policy Standards are currently out for consultation and implementation planning is ongoing. Auckland DHB and Waitemata DHB have substantial expertise at all levels of the cervical screening pathway and are involved in national and regional planning discussions. Equity of coverage remains a DHB concern and the HPV self-sampling study has been a vehicle to undertake local implementation work using the new pathway, including the ability to assess the education needs of providers and women and develop tailored information.

7. References

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2. Ronco G, Dillner J, Elfström KM, Tunesi S, Snijders PJF, Arbyn M, et al. Efficacy of HPV-based screening for prevention of invasive cervical cancer: follow-up of four European randomised controlled trials. *The Lancet*. 383(9916):524-32.
3. Medical Services Advisory Committee (MSAC). National cervical screening program renewal: Evidence review. Commonwealth of Australia, 2015.
4. Royal College of Obstetricians and Gynaecologists. Progress in Cervical Screening: Scientific Impact paper number 7. London 2016; Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/scientific-impact-papers/sip_7-progress-in-cervical-screening.pdf.
5. Wright TC, Stoler MH, Behrens CM, Sharma A, Zhang G, Wright TL. Primary cervical cancer screening with human papillomavirus: End of study results from the ATHENA study using HPV as the first-line screening test. *Gynecologic Oncology*. 2015;136(2):189-97.
6. Dillner J, Rebolj M, Birembaut P, Petry K-U, Szarewski A, Munk C, et al. Long term predictive values of cytology and human papillomavirus testing in cervical cancer screening: joint European cohort study. *BMJ*. 2008;337.

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), Kate Sladden (Funding and Development Manager Health of Older People), Aroha Haggie (Manager Maori Health Gain), Lita Foliaki (Manager Pacific Health Gain), Samantha Bennett (Manager Asian Health Gain) and Jane McEntee (General Manager Auckland Regional Public Health Service)
 Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

AAAQS	-	Auckland Ambient Air Quality Standards
ACC	-	Accident Compensation Corporation
AH+	-	Alliance Health Plus Trust
ARC	-	Aged Residential Care
ARPHS	-	Auckland Regional Public Health Service
ATEED	-	Auckland Tourism, Events and Economic Development
CPHAC	-	Community and Public Health Advisory Committee
CWF	-	Community water fluoridation
DHB	-	District Health Board
DWSNZ	-	Drinking Water Standards for New Zealand
ED	-	Emergency Department
EOI	-	Expression of Interest
ESR	-	Environmental Science and Research services
FLC	-	Fracture Liaison Services
GETS	-	Government Electronic Tenders Service
HBHF	-	Healthy Babies, Healthy Futures
HAT	-	Healthy Auckland Together
HCSS	-	Home and Community Support Services
HIND	-	Health Infectious Notifiable Diseases
HPAA	-	Health Protection Amendment Act
HVAZ	-	Healthy Village Action Zones
IBT	-	In-between Travel
ITO	-	Industry Training Organisation
MALT	-	Māori workforce Alliance Leadership Team
MoH	-	Ministry of Health
MOoH	-	Medical Officer of Health
NCHIP	-	National Child Health Information Platform
NES-AQ	-	National Environmental Standard on Ambient Air Quality
NGO	-	Non-Governmental Organisation
MSD	-	Ministry of Social Development
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
RFP	-	Request for Proposal
RNZAF	-	Royal New Zealand Air Force
SILs	-	Specific Impurity Limits

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards' (DHB) planning and funding activities and areas of priority, since its last meeting on 12 October 2016. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting's agenda.

Highlight of the month: Auckland and Waitemata DHBs' 2015/16 Annual Reports received 'very good' ratings from the audit consistency review panel.

2. Planning

2.1 Annual Plans

Auckland DHBs 2016/17 Annual Plan has been signed by the Minister and Waitemata DHB's Annual Plan is expected to be signed shortly. The 2017/18 draft Planning Guidance was released by the MoH for consultation. Feedback is required by 30 November. There is a requirement for shorter Annual Plans.

2.2 Annual Reports

Both Auckland and Waitemata DHBs' 2015/16 Annual Reports have received a 'very good' rating for service performance information, systems and controls, when assessed by an audit consistency review panel. This is a great achievement

The panel's feedback showed they found the reporting to be of the highest standard, particularly with regard to the range of performance measures and their presentation. Comments highlighted the Annual Report stands out in telling a performance story very well, based on a mix of good and relevant context, reporting of hard data and relevant case studies. They were impressed with how it weaves together the story about the DHB's performance and broader developments and trends for readers. Points noted:

- a logical link between components, no disconnect between the narrative and statement of performance section
- good context on the operating environment and key developments, with useful context on demographics, and national/regional trends, meaningful benchmarks and trends
- The front section tailors to different audiences
- There is a logical structure to the performance framework which is replicated throughout the report.
- There is a comprehensive set of well-presented measures in the statement of performance section, including colour coding and variance reporting
- The statement of performance is structured around four outputs which represent a clear, logical aggregation and cover key activities.

The 'very good' grade is reserved for reporting that the Office of the Auditor-General would happily hold up as an example of good practice.

Printer's proofs of the reports are currently being prepared and they will be published later this month.

The Statement of Performance Expectations (SPE – module of the Annual Plan) scorecard has been developed, will be provided to the Board on a quarterly basis

3. Children, Youth and Women

3.1 Immunisation Health Target

We are currently on track to achieve the immunisation health target in Auckland. We are not on track in Waitemata, where we have a current decline/opt off rate of 3.9%. At this level, achieving the target is highly unlikely. To address this, a whole of service approach is being embedded. Every child and family who has declined immunisation is asked again at each contact with the health system. We are rolling out a programme of work with health professionals to improve their understanding and confidence in addressing vaccine hesitancy concerns of parents. This includes Primary Care providers and increasingly Lead Maternity Carers as well as paediatric staff in secondary care services.

The new service vaccinating pregnant women has increased to two days per week at antenatal clinics at Waitakere. Initial uptake amongst mothers is high, those not yet eligible for immunisation have a discussion with the dedicated nurses about the importance of protection starting even before baby is born.

We are scoping an EOI for a social media campaign to promote immunisation, particularly targeted to those communities with higher decline rates. This is based on the successful short term campaign of June/July 2016. It will likely focus on the good news and success stories about vaccines, be refreshed monthly and require sustained support over an extended period of time.

There is an equity gap for Maori infants in Auckland, Waitemata and Counties Manukau Health. The Ministry has requested a metro Auckland meeting to discuss and better understand this equity issue. Locally, a targeted social media communications proposal is being considered.

For the current quarter, (October - December 2016) to date (27 October 2016), in Auckland:

- 1,365 children are eligible for vaccination before they turn 8 months of age
- 91% of the eligible cohort are fully immunised
- A further 48 children needed to be vaccinated to achieve the 95% target by 30 December 2016
- 83 children may be immunised and are on active follow up by General Practice and the outreach immunisation service.

In Waitemata:

- 1857 children are eligible for vaccination before they turn 8 months of age
- 88% of the eligible cohort is already fully immunised
- A further 121 children needed to be vaccinated to achieve the 95% target by 31 December 2016
- 105 children may be immunised and are on active follow up by General Practice and the outreach immunisation service.

3.2 Obesity Health Target – ‘Raising Healthy Kids’

Auckland and Waitemata DHBs continue to make very good progress against the ‘Raising Healthy Kids’ health target. Provisional results for Q2 suggest the DHBs may achieve this target (95%) a year in advance of the date set by the Minister (December 2017). The Q1 provisional are: 83% in Waitemata and 81% in Auckland.

The decline rate for referral is relatively high (approaching 1 in 5) and will be an area for future work over the course of 2017. Associated with this target, the breast-feeding peer support programme has now been established.

3.3 National Child Health Information Platform

The draft business case for a National Child Health Information Platform (NCHIP), for the northern region, is being submitted to the regional Child Health Steering Group and other governance groups for sign off. NCHIP has the potential to better identify children who are missing out on the health services they are entitled to and to drive system and service design around meeting the health needs of vulnerable children.

3.4 Healthy Housing Initiative

Procurement is now open on GETS for community based providers for this new service in Auckland and Waitemata. The community based service will complement a service provided by both DHBs' provider arm services and provide social work services to patients who have or are at risk of developing housing related health conditions.

3.5 Oral health emergency dental services

The funder is in the process of entering into contract with providers selected through the procurement process. The start date for the new services is 1 January 2017. The additional providers identified will increase access to services within high needs areas.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

Auckland DHB is participating in a virtual pilot to inform work on achieving guaranteed hours for HCSS support workers, which is a key element of a regularised workforce. Data collection for the pilot started on 3 October and is recording all client visits that are cancelled alongside workers' rostered hours. This is a significant area to understand and quantify when preparing for guaranteed hours and the funding implications of guaranteed hours. Information collected from the pilot will be used to inform a budget bid the Ministry of Health is preparing. The Settlement Agreement requiring a regularised workforce requires guaranteed hours to be rolled out across the workforce from 1 April 2017.

Four of our HCSS providers have had audits on In-between Travel (IBT) payments undertaken by Audit and Compliance. The audits have focused on verification of travel claims and ensuring that the IBT payments have been passed on to support workers. No issues of consequence have been identified.

Work is progressing on the Medication Management Guidelines, a Waitemata DHB HCSS provider driven project for the Home and Community Support Sector, these are being developed to provide a standardised, best practice guideline to support the medication management of clients in their home. The guidelines have information for the organisation, Registered Nurse and support worker to guide them around their role and responsibilities in this area. We have had discussions with the Ministry of Health and HealthCERT about an appropriate review of this work when the initial draft is completed.

4.2 Aged residential Care

Two new large facilities are opening in Waitemata DHB in November. Bert Sutcliffe (Ryman) in Birkenhead will have a staged opening but when fully operational will have 150 beds covering rest home, hospital and dementia levels of care. Hugh Green (Bupa) in Albany will have 100 beds covering hospital and dementia levels of care.

The Maori Health Gain Team has developed Tikanga Best Practice Guidelines for Aged Residential Care (ARC). These guidelines were presented at the Waitemata ARC Forum for feedback in October and were well received. They are currently being finalised.

A national process is underway requesting ARC facilities to submit exemplars of good dementia unit design. These examples will be used in conjunction with the new information resource Secure Dementia Care Home Design. The Waitemata Health of Older People Programme Manager is a member of the advisory panel.

4.3 Falls Prevention

Waitemata DHB and Auckland DHB have been working with Accident Compensation Corporation (ACC) to plan and implement a range of services to prevent injurious falls under the guidance of the Auckland DHB/Waitemata DHB/ACC Falls Prevention Steering Group. The Falls Prevention Programme aims to reduce injury falls and fragility fractures in people aged 65 years and over living in Waitemata and Auckland DHBs, specifically to reduce hospitalisations and ACC injury claims.

Recruitment is underway to expand the Fracture Liaison Services (FLS) at Auckland DHB. Waitemata DHB plans to recruit in the New Year. FLS systematically identify and manage hospital inpatients or outpatients with fragility fractures and have been shown to lead to a 50% reduction in subsequent fractures.

Progress is being made with setting up the in-home strength and balance exercise programmes based on the Otago Exercise Programme. Applications have been assessed from a Request for Proposals (RFP) and a provider will be finalised in mid-November for Waitemata DHB. Recruitment is underway for the Auckland DHB service.

ACC is working nationally to facilitate development of community group strength and balance exercise programmes. Locally these programmes will be linked to the Auckland DHB/Waitemata DHB/ACC Falls Prevention Steering Group. ACC is undertaking an RFP for a lead provider in November.

5. Mental Health and Addictions

5.1 Youth Peer Support Service and Workforce – co-design and business case development Project

Auckland DHB has completed an Expression of Interest (EOI) to allocate a project to develop youth peer support service design and identify workforce competency framework. This is one of the 2015/16 key actions of the Integrated Child and Youth Mental Health Addiction Strategy 2013-2023. The project scope broadly defines “youth peer support service” as a formalised or semi-formalised system of younger people with lived experience of distress providing some form of support to young people currently experiencing distress. There is little published research about youth peer support services, but according to the available research at-risk young people are less intimidated by traditional services when they are supported (Mayber, 2006) (Olsson, 2005, pp. 78-87)). This is a

staged project, with the service design and work force competency framework as stage one, being completed by end of June 2016 and includes the development of the business case to identify funding required for the next stage of the project that is piloting the service, evaluating and up scaling as appropriate.

5.2 Primary Mental Health Addiction Services

Review of Primary Mental Health Addiction Services is currently in progress with an interim report due at the end of November 2016.

In WDHB “Our Health in Mind” Business Case 1 a number of actions are in progress to improve support in Primary Care by increasing the volume of non-pharmaceutical treatments (support and care packages) for Primary Mental Health programmes (this includes extended consults, brief interventions, individual and group based psychological interventions) with existing contracted Primary Mental Health service providers until 30 June 2017. Further actions are in place to allocate NGO provision of support hours for Primary Care (direct access by GPs), up-scaling pilot completed in Tamaki locality (Auckland DHB).

6. Maori Health Gain

6.1 Māori workforce Alliance Leadership Team

The Māori workforce Alliance Leadership Team (MALT) had its third meeting in late September 2016. Critical to monitoring progress for MALT is the introduction of a Māori Workforce scorecard for Auckland and Waitemata DHB. The focus of the scorecard for 2016/17 is achievement of the annual workforce targets for overall workforce and ethnicity data quality. Data from this scorecard and the 2016/17 action plan will be used to report regularly to the Māori Health Gain Advisory Committee.

6.2 Ethnicity Data

The main issue for ethnicity data is ensuring quality ethnicity data collection and reporting for new and existing staff, that is aligned with Ministry of Health ethnicity data protocols (to collect to level 4). The target is to achieve capture Waitemata DHB ethnicity for 95% or more of our workforce. The main activities in this area are:

- Collecting ethnicity information from current Waitemata DHB staff who have not specified ethnicity
- Updating recruitment and on-boarding system processes of ethnicity data capture (including Taleo and Leader systems)
- Undertake an anonymised data match against NHI to determine the level of accuracy of current Waitemata DHB workforce ethnicity data.

Work has been completed, across both Auckland and Waitemata DHBs, to coordinate resourcing to carry out projects in the MALT action plan for 2016/17. The Māori Workforce Development Consultant is bringing the team together and assigning the projects.

6.3 Youth Connections

At the most recent MALT meeting, the Team received a presentation from the Youth Connections Team, which discussed the challenges for youth employment locally, nationally and globally. This presentation included a proposal to become a Youth Connections pledge partner. MALT subsequently discussed and endorsed the request with a recommendation to be taken to the Auckland and Waitemata DHBs to become a Pledge partner. This document outlines the potential

development of a Pledge partnership between Youth Connections, Waitemata, and Auckland District Health Boards.

Youth Connections is an initiative championed by Mayor Len Brown and Deputy Mayor Penny Hulse. It is supported by [Auckland Council](#), [Tindall Foundation](#), [Mayors Taskforce for Jobs](#), [Hugh Green Foundation](#) and [Auckland Airport Community Trust](#). Youth Connections' vision is to have all young people either working and earning, or learning and training. The goal of Youth Connections is to ensure that every young person has a plan and a direction to help them reach their potential. Youth Connections works with businesses, communities, youth services and schools to create connections between young people and employers.

Youth Connections provide leadership and solutions to local issues and encourage the business community to take a leading role for the future of their workforce. Youth Connections has worked collaboratively with the Metro Auckland District Health Boards to identify and initiate activation of youth employment opportunities and to seek District Health Board support as Pledge partners through the development of a pledge partnership (Counties Manukau Health is also in the process of considering becoming a Pledge partner). The focus of the Pledge is to work together to grow the Māori and Pasifika workforce with particular emphasis on building entry level opportunities for both academically and non-academically skilled youth.

7 Pacific Health Gain

7.1 Renewing Pacific Health Action Plan (PHAP)

A summary of the findings of the consultation meetings regarding renewing the Pacific Health Action Plan has been emailed back to those who had given their email address during the consultation meetings.

96 Pacific people have now been added to the Waitemata DHB current Reo Ora membership (identified through the PHAP consultation) this has significantly boosted the number of Pacific participants in Reo Ora from 5.3% of the membership to 21.3%.

The actions from the eight priorities of the new plan are being negotiated with other Planning and Funding Teams as well as NGOs. The focus is not on new actions but better linking services in specific areas to Pacific people and seeking better outcomes. This process is organic and on-going.

7.2 PHAP Priority 1 – Children are safe and well and families are free of violence

Parenting and Living without Violence programmes are being negotiated for implementation in Q3 and Q4 of the current financial year.

We continue to participate in the development of Waitemata DHB's pre-school oral health strategy, as well as continuing involvement in intersectoral forums for family violence prevention. We also participated in consultation facilitated by ACC specifically about preventing and reducing harm from sexual violence.

In relation to rheumatic fever, we have participated in a number of meetings with the Ministry of Health Pacific providers and are working on developing a Pacific cultural best practice module for sore throats rapid response clinics, to be offered to clinics through their PHO. In relation to the Healthy Babies and Healthy Futures (HBHF) programme, in the last quarter, 110 people have been trained to brief eligible mothers about engaging with the programme, 161 mothers have had direct conversations with HBHF Co-ordinators, 97 people have enrolled onto the

TextMatch component of the programme and 26 mothers completed the face-to-face 6 module workshop.

We continue to work with Healthy Families West Auckland, and will focus on improving linkages between the seven Pacific ECE centres in West Auckland and all Child Health services offered by Waitemata DHB as well as other providers.

7.3 PHAP Priority 2 –Pacific People are smoke-free

The report from the consultation with Tongan male smokers is being written and will be completed by the end of November.

Healthy Village Action Zones (HVAZ) and Eヌua Ola co-ordinators are working with new churches that have recently joined the programme to get them to smoke-free status.

7.4 Priority 3 – Pacific people are active and eat healthy

The fourth Aiga Challenge (annual 8 week weight loss competition) for Eヌua Ola, West Auckland is now complete, data analysis is now occurring, prize giving is scheduled for 3 December. The HAVZ Challenge will be completed on 19 November, with prize giving on 6 December. The North Shore Challenge will be completed on 30 November.

A proposal is being developed for submission to Skills Active for 30 Eヌua Ola and HVAZ participants to be trained to National Level 3 Sports and Recreation Certificate. Skills Active is New Zealand's Industry Training Organisation (ITO) for the recreation, sport and exercise industries.

7.5 PHAP Priority 4–People seek medical and other help early

We are continuing to work closely with AH+ to ensure that data collected by the Fanau Ola integrated services contract is correct and that we can use this data as a basis for reviewing the funding formula for the service. The focus of the data review now, is the number and type of activities that were delivered to individuals and families, the number of hours that it took and the outcomes that were achieved. The current contract was renewed until 31 December 2016 based on current service specifications, we will work towards new service specifications for a contract from 1 July 2017.

7.6 PHAP Priority 5 - Pacific people use hospital services when needed

The Pacific General Manager for Hospital Services reports on this priority.

7.7 PHAP Priority 6 – That Pacific people live in houses that are warm and are not over crowded

The recent consultation undertaken for renewing PHAP strongly supported the need to continue to focus on housing. This was priority number six in the last plan, but became priority number four in the consultation. This is perhaps no surprise in the current housing crisis in Auckland. We have made contact with Housing NZ and we will work towards using the HVAZ and Eヌua Ola networks as a mechanism of linking Housing NZ to the community.

8 Asian, Migrant and Refugee Health Gain

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

The Final draft of the Asian International Benchmarking Report has now been completed and is currently going through internal review processes before final sign off with the two Boards. A launch will follow in February 2017 as part of Chinese New Year celebrations.

8.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 75% (Auckland DHB) and 85% (Waitemata DHB) targets by 30 June, 2017 (current rates 73% (Auckland DHB) and 84% (Waitemata DHB) as at Q4 2016)

The Asian PHO enrolment rate sits at 84% for Waitemata DHB and 73% for Auckland DHB, as at Q4 2016 (Figure 1). During 2012, the Asian rates were close between the two DHBs around 80%, but started to diverge at Q1 2013. At that time point, the rate began to progressively decrease for Auckland and increase for Waitemata DHB.

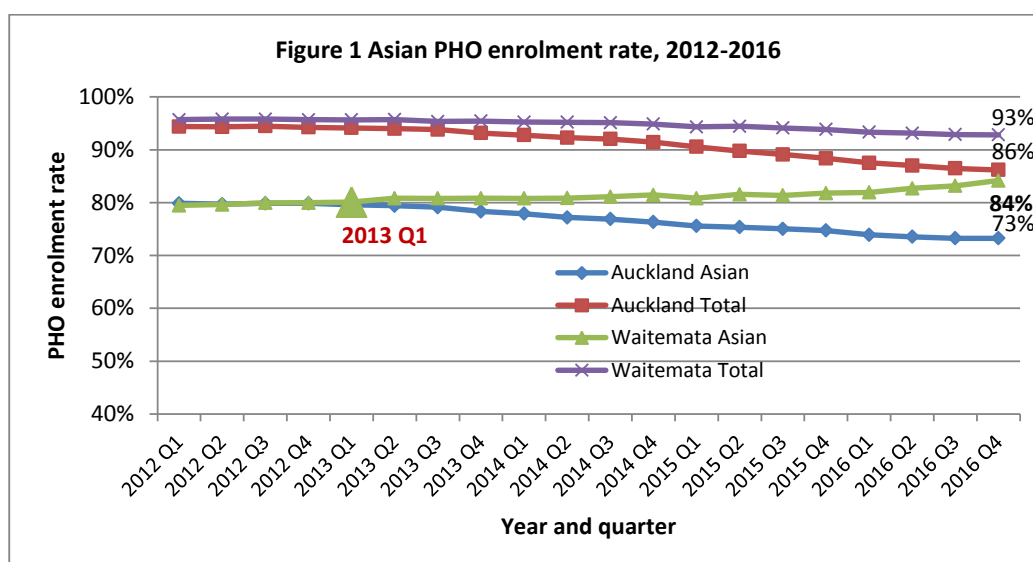
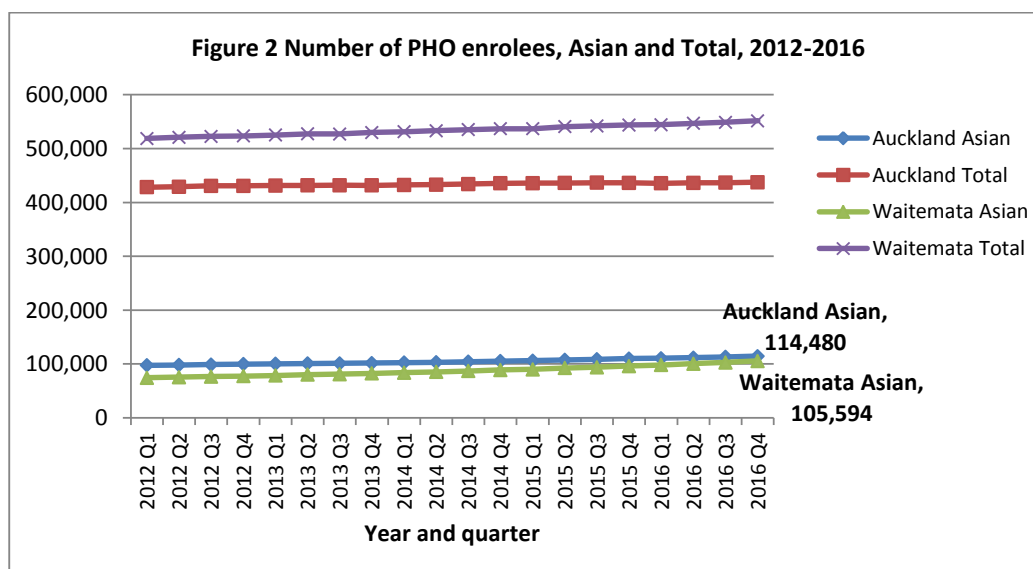
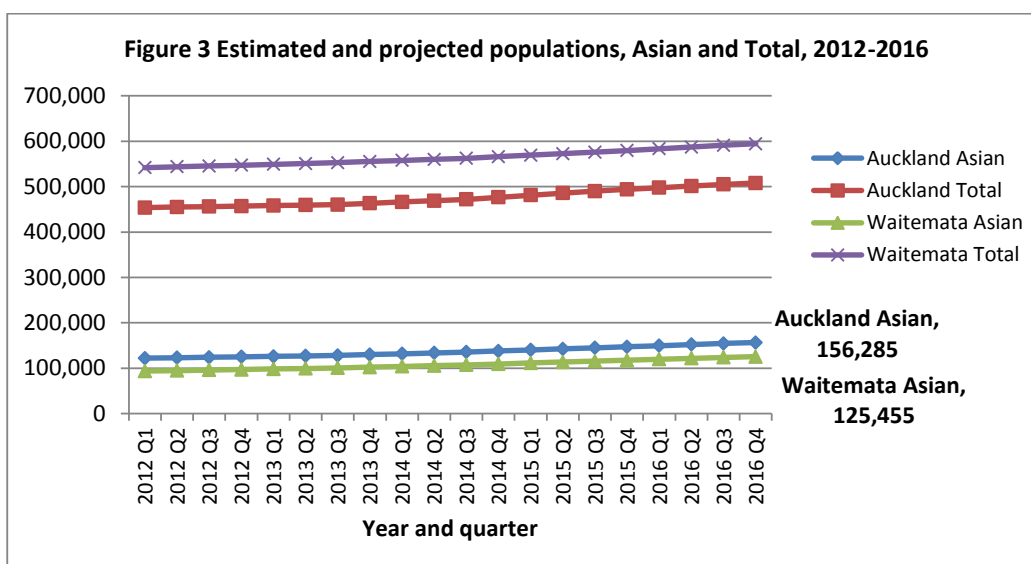


Figure 2 shows the number of PHO enrollees of Asian and total population for both DHBs between Q1 2012 and Q4 2016. There are 114,480 and 105,594 Asian PHO enrollees respectively in Auckland and Waitemata DHBs. The associated populations are shown in Figure 3.

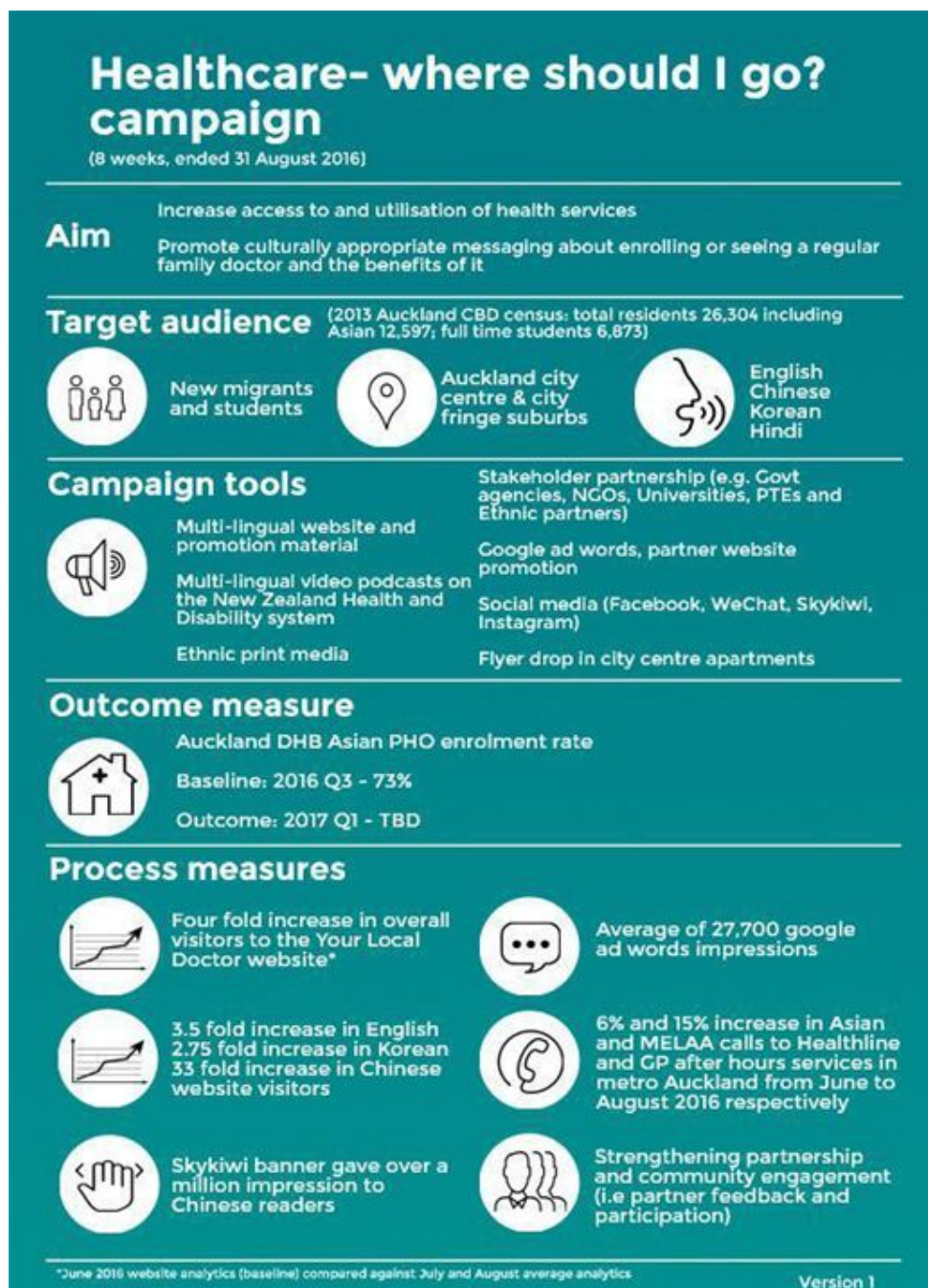




The lower Asian PHO enrolment rate for Auckland DHB cannot be simply explained by the increase of the Asian population, as Waitemata DHB has also had a significant increase between Q1 2013 and Q4 2016. It is thought a significant driver of the difference is the both the transient nature of the Asian population of Auckland DHB and the greater proportion of younger age-groups (20-24yrs, 25-29yrs) than that of Waitemata.

In response to the difference, we undertook a *“Healthcare – where should I go?”* campaign in Q3 2016 targeting Asian migrants and students of Auckland DHB living in the city centre and inner city fringe suburbs. Results to date are promising and are shown in Figure 4. There has been a positive increase in process measures however we won’t know the impact on enrolment until Q1 2017.

Figure 4 Results to date of the Phase 1 Healthcare – where should I go? Campaign (Auckland DHB)



Next steps

- Explore the PHO enrolment data trends related to better understand any age and gender differences for both DHBs to inform further targeted key messages and campaigns. Phase 2 of a tailored and targeted Asian *Healthcare- where should I go?* campaign across Auckland and Waitemata DHBs is planned for roll out after Chinese New Year 2017 (Q1 2017).
- A small working group led by Ailsa Claire (Chief Executive, Auckland DHB) has been established with membership by key DHBs across the country and MBIE is tasked with exploring issues and costs related to over utilisation of health services by migrant communities. We are working with

MBIE's Chief Medical Officer on a project exploring PHO enrolment and visa type to understand visa type groups and enrolment behaviour to identify particular groups to target.

- Inputs have been added to the development of a draft New Zealand International Student Wellbeing Strategy with a key focus on: 1) increasing awareness of the NZ health & disability system, and 2) access to and utilisation of health services, as well as, a Critical Response Workflow as part of membership with the Auckland Agency Group led by the Ministry of Education.

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

The Refugee Primary Care Wrap Around Service Agreements continue to roll out for 2016/17. Professional development opportunities for primary health and the frontline workforce to up skill them on the soft skills and cultural competencies required to support refugee families at the practice level include:

- Receptionists cross-cultural training to frontline primary health staff was delivered on 19 October (19 pax).
- A refugee health network forum was delivered to primary health professionals on 'former refugee child mental health' on 9 November (50 pax).

A 1-year pilot oral health service to adult former refugees with the Oral Health Department and Clinic at the Auckland University of Technology's (AUT) North campus (Northcote) in the Waitemata DHB catchment area will roll out in March 2017. It will aim to deliver routine dental service only, excluding pain relief. A research component has been included in the pilot to measure the efficacy of the pilot and generalisability to scale up the service to include other vulnerable groups as phase 2.

9 Auckland Regional Public Health Service (ARPHS)

9.1 Clinicians' Challenge wins at HiNZ 2016 Awards

On 2 November 2016, ARPHS and Auckland DHB won the *Clinicians' Challenge – Active Project* at the Health Informatics New Zealand (HiNZ) 2016 Awards for its project providing TeleDOT¹ for TB patients. The telehealth system enables patients receiving TB treatment to record taking their medication on their smartphone, with a nurse confirming dosage remotely at a later time during their work day. Through the telehealth project ARPHS has been able to increase the number of patients receiving directly observed therapy from 30% of TB patients to 60% with the same level of resource, while at the same time greatly improving the experience for patients.

The award includes an \$8,000 grant from the Ministry of Health, which will be used to develop an app so patients can use the TeleDOT service even if their phone is not connected to the internet. Opportunities to share this technology with other DHBs will be explored.

TeleDOT is also a finalist in the Auckland DHB Health Excellence Awards to be announced on 1 December 2016.

¹ TeleDOT stands for tele direct observed therapy. This technology allows patients and nurses to communicate via a secure and confidential live video feed on their tablets, iPads, laptops or smart phones.

9.2 Health Protection Amendment Act

The Health (Protection) Amendment Act (HPAA) comes into effect on 4 January 2017. The HPAA will become part of the Health Act 1956. All Notifiable Infectious Diseases will come under the same, consistent law and regulations. The Tuberculosis (TB) Act 1948, TB Regulations and Venereal Diseases Regulations are being replaced and brought under the Health Act, and the Health (Infectious and Notifiable Diseases) Regulations (HIND) are being re-written. Artificial UV tanning is also covered.

The main provisions in the HPAA cover:

- Notification of some sexually transmitted infections – HIV, AIDS, syphilis, gonorrhoea
- Contact tracing
- Public Health Directions (issued by Medical Officers of Health (MOoHs))
- Public Health Orders (issued by the Court or by MOoHs if urgent).

The implications for ARPHS for implementing the HPAA are mostly administrative, and require the updating of protocols, processes, templates, training, certification and reporting. Work is underway to complete these requirements.

Guidance from the Ministry of Health on the detailed interpretation of the Regulations is expected in November. ARPHS is recommending the Ministry of Health should produce information material for the public (e.g. for people under Directions).

9.3 Pandemic exercise

ARPHS participated in a multi-agency exercise at RNZAF Base Auckland (Whenuapai Airbase) on 27 October to practice the management of a suspected quarantinable disease on board a RNZAF flight. The day commenced with an interagency table top, followed by a live role-play exercise involving a P-3K2 aircraft landing with 15 'affected' personnel on board. Medical Officer of Health, Dr Shanika Perera, participated in the exercise, while Richard Simpson attended as an official observer on behalf of ARPHS. This exercise provided a valuable networking opportunity for ARPHS to connect with partner agencies including RNZAF Base Auckland, New Zealand Customs Service, St John Ambulance, Auckland International Airport and Ministry of Primary Industries. As an outcome of this exercise, ARPHS plans to revise our protocols, clarify the process for handling media queries, and create opportunities to orientate ARPHS staff on-site at Whenuapai Airbase.

9.4 Proposed Unitary Plan appeals

ARPHS, with endorsement from the three Auckland regional DHB CEOs as well as the Chair of each Board, has become a party to proceedings for Environment Court appeals on the Proposed Unitary Plan. ARPHS is supporting Auckland Council's decision to retain Auckland's Ambient Air Quality Standards (AAQS) and minimum dwelling size standards in the Proposed Auckland Unitary Plan.

During the hearings process ARPHS advocated for the AAQS to be retained because the 2004 National Environmental Standard on Ambient Air Quality (NES-AQ) does not cover all pollutants relevant to Auckland. ARPHS also favoured the retention of the minimum dwelling standard in selected residential zones, noting that dwellings with an internal floor area below this standard are likely to be non-complaint with existing housing regulations, and potentially create negative health outcomes. ARPHS will be taking this same position into the appeals process.

At this stage timelines are unclear, but proceedings could extend through to the end of 2017. Legal representation will be sought, and ARPHS intends to engage an expert witness for the AAQS

appeal, procuring the services of an air quality specialist previously used during the council hearings process.

9.5 Communicable disease - Yersinia outbreak investigation

ARPHS continues to investigate the high number of Yersiniosis cases notified in our region since early this year. Yersinia is a gastroenteritis illness, caused by either eating contaminated food, drinking contaminated water or contact with affected animals, mainly pigs. This is further to a sustained increase in notifications of *Y. enterocolitica* biotype 2 over the past year where Auckland, Wellington and Canterbury regions are primarily affected, although other DHBs are also experiencing higher than expected cumulative notifications for the year as advised by the Institute of Environmental Science and Research (ESR). There has been a request for the main regions to use a standard questionnaire in order to provide more detailed information on case exposures and risk factors to assist in identifying potential sources of illness. We continue to liaise with the Ministry of Health, Ministry for Primary Industries, ESR and other Public Health Units on this matter via regular teleconferences.

9.6 Community water fluoridation (CWF) update

ARPHS previously advised that it had contacted Watercare for further information on the nature of the fluoride it uses after a question was raised at the September Auckland DHB and Waitemata DHB CPHAC about whether the fluoride added to the water supply is pharmaceutical grade. ARPHS has now received a response from Watercare, who advise that Water New Zealand's *Good Practice Guide for the Supply of Fluoride for Use in Water Treatment* defines the quality requirements of the products used for water supply fluoridation in New Zealand.

The Good Practice Guide sets Specific Impurity Limits (SILs) for each chemical based on Drinking Water Standards for New Zealand 2005 (Revised 2008) (DWSNZ) at a dose rate of 1 mg of fluoride per litre of water, including a safety factor² of 10. SILs are set to ensure that the quality of treated drinking water complies with the limits of DWSNZ. Chemical suppliers undertake quality assurance checks to ensure that manufactured batches of water fluoridation chemicals do not exceed the defined SILs, supplying the purchaser with a certificate of compliance with each delivery.

The Ministry of Health held the first 'DHB fluoride working group' meeting on 22 September 2016. Key messages from this meeting include:

- The Ministry is progressing the next phase of work to move decision-making on fluoridation coverage from local government to DHBs. A Bill remains on track for introduction to Parliament before the end of 2016.
- The Bill will describe the powers and duties of DHBs in relation to the decision-making process, the powers and duties of water suppliers and local authorities in relation to implementing the DHB directives about water fluoridation, and the information DHBs must consider when determining whether to fluoridate a water supply.
- Over the next few months the working group will be reviewing the draft Bill and provide advice on the development of decision making materials.

9.7 Healthy Auckland Together (HAT) update

HAT is supporting the Ministry of Health's DHB Food and Nutrition Policy by promoting it through various channels. These include:

- Healthy Families Manukau, Manurewa, Papakura are following the beverage criteria for the removal of sugar-sweetened beverages in Auckland Council leisure centres.

² A safety factor of 10 reflects the view that no more than 10 percent of a Maximum Acceptable Value of a determinand should be contributed by a given impurity in a water supply chemical.

- Healthy Families Sport Waitakere using the policy to make an approach to their local boards suggesting they adopt the policy.
- ARPHS supporting Auckland Tourism, Events and Economic Development (ATEED) with adopting and implementing the policy for their organisation, starting with major events such as Diwali and the Chinese Lantern Festival.

9.8 Submissions

ARPHS completed and submitted two submissions during mid-September to October 2016.

Date	Topic	Brief note
27 October	<i>Aged care facility proposal at 455 Taupaki Road, Taupaki (resource consent application lodged with Auckland Council)</i>	The reuse of treated wastewater is proposed as part of this application. There is no reticulated wastewater in the vicinity so the applicant proposes to discharge treated wastewater to land, as well as reuse wastewater that is tertiary treated for irrigation, toilet flushing and potentially laundering purposes. ARPHS is not lodging a formal consultation but writing to Council to advise that it is available to offer advice on the reuse of treated wastewater aspect of the application if Council deems this necessary. ARPHS recognises that Council has its own assessment criteria and has previously dealt with these issues in other resource consents.
31 October	<i>New Zealand General Social Survey 2018 (NZGSS): Objectives of the Housing and Physical Environment supplement (Ministry of Health)</i>	Every two years, the NZGSS takes a snapshot of the well-being of people in New Zealand. Since 2014, the survey includes a rotating supplementary module, allowing the survey to focus on a theme of high public interest. Housing and the physical environment has been identified as the most suitable topic for the 2018 NZGSS. ARPHS submitted in support of the survey but recommended that more information be collected on homelessness. It was suggested that Statistics New Zealand's existing definition of 'homelessness' be used.

4.2 Primary Care Update Quarter 1, 2016/17

Recommendation:

That the report be received.

Prepared by: Tim Wood (Deputy Director and Funding and Development Manager - Primary Care, Waitemata and Auckland DHB), Dr Stuart Jenkins (Clinical Director – Primary Care, Waitemata and Auckland DHB) and Trish Palmer (Funding & Development Manager, Mental Health and Addictions).
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen, (Director Health Outcomes).

Glossary

ALT	- Alliance Leadership Team
ASH	- Ambulatory Sensitive Hospital Admissions
CMDHB	- Counties Manukau District Health Board
CVD	- Cardiovascular disease
DAR	- Diabetes Annual Review
DSLA	- Diabetes Service Level Alliance
DSME	- Diabetes Self Management Education
DHB	- District Health Board
GPs	- General Practitioners
IPIF	- Integrated Performance Incentive Framework
MACGF	- Metro Auckland Clinical Governance Forum
MoH	- Ministry of Health
NZCMHN	- New Zealand College of Mental Health Nurses
NHT	- National Health Target
PHO	- Primary Health Organisation
PMHI	- Primary Mental Health Initiatives
PMS	- Patient Management System
RA	- Risk Assessment
SIA	- Services to Improve Access
SLMs	- System Level Measures
VDR	- Virtual Diabetes Register
WSN	- Waitemata Stakeholder Network

Summary

This report provides an update on specific Primary Care activities across the Auckland and Waitemata District Health Boards (DHBs), which have shown variance during the first quarter (Q1) of the 2016/17 financial year.

1. Primary Care Highlights (Q1), 2016/17 Annual Plan

1.1 System Level Measures Framework

1.1.1 Background

In March 2016, the Minister of Health announced the move from the Integrated Performance and Incentive Framework (IPIF) to System Level Measures (SLMs), in order to provide a system-wide view of performance in line with the New Zealand Health Strategy. The SLMs also resonate with the care closer to home, people-powered and smart system themes of the New Zealand Health Strategy. It is the Minister's expectation for DHBs to work jointly in Alliances to agree a set of contributory measures and develop Improvement Plans, with the necessity to change local service models accordingly in order to meet the SLMs. A copy of the 'System Level Measures Improvement Plan 2016-17' is attached (attachment 1).

SLMs aim to be indicators that are easy to capture and are designed to provide organisational leaders with data that:

- Show performance of the health system over time
- Allow the organisation to compare its performance relative to strategic Improvement Plans
- Allow the organisation to compare itself to similar organisations
- Contribute to ongoing strategic quality improvement planning.

The four new System Level Measures, to be implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates.

The following two SLMs will be developed during 2016/17 (implementation is planned for 2017/18), including definitions and identification of data sets:

5. Number of babies who live in a smoke-free household at 6 weeks post-natal
6. Youth access to and utilisation of youth appropriate health services.

These measures and associated 2016/17 targets are summarised in Table 1, which also includes 'contributory measures'. Robust contributory measures have been developed for each SLM, to help drill-down to identify measures that influence SLM performance (i.e. process and outcome indicators at a programme or unit level).

Table 1: Summary of SLM and Selected Contributory Measures and Targets

SLM	SLM Target	Contributory Measure	2016/17 Milestone/Target
Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds	No anticipated reduction in 2016/17. In 2017/18 - an annual reduction in ASH rates for 0-4 year olds of 5%.	1. Newborns enrolled with a PHO within the first three months of life	The national target is 98%. 2016/17 – Aim for PHOs to achieve 90% by 30 June 2017. Develop a measure for enrolment with a PHO by 6 weeks of age.
		2. Babies fully immunised by 8 months of age	This is a National Target. 95% of babies fully immunised by 8 months of age each quarter.

Acute hospital bed days per capita	The target for 2016/17 is to aim for a 2% reduction in this rate to 447.6 bed days/1,000 population by June 2017 from 456.7.	3. Emergency department Presentation Rate	49.3/1000 population by quarter ending 30 June 2017
		4. Acute Re-admission Rates at 28 days 2016/17	The target is to have a reduced re-admission rate at 28 days to 7.7% by 30 June 2017
Patient experience of care	Maintain current state and continue to improve on the DHB Adult Inpatient Survey - Maintenance of an aggregated 8/10 score for all four domains across the three DHBs.	5. The DHB Adult Inpatient Survey	Maintain and continue to improve response rates for the DHB inpatient survey. Maintenance of an aggregated score for the 4 domains of 8 out of 10 for each of the 3 Auckland DHBs (Current National response rate 27%, ADHB 17%, CMDHB 13% and WDHB 34%).
		6. E-Portal (PHC Specific)	40% of PHO practices are registered with a portal and 10% of the PHO population have access to a portal.
Amenable Mortality rate	Maintain the overall current status at the current rate of: WDHB: 2352 deaths – Rate of 84.9% per 100,000 ADHB: 2007 deaths – Rate of 98.7% per 100,000 CMDHB: 3001 deaths – Rate of 135.6% per 100,000	7. Decrease in mortality associated with Cardiovascular Disease	Increase coverage of Maori to 90%. Increase triple therapy by 5% for those with a prior CVD event, those with a CVD RA of $\geq 20\%$ and with a particular focus on patients with diabetes.
		8. Decrease in mortality associated with smoking related diseases through increased quit attempts and increased support to quit	Increase support to quit - 10% from the baseline/DHB
		9. Decrease in mortality associated with Breast Cancer	The target for 2016/17 is to increase coverage in Maori women to reach 70%
		10.Reducing Mortality from Hepatitis C	By June 2018: 10% of those identified in PMS will be treated (measured through quarterly reports) 30% of those identified in secondary care will be treated (measured through quarterly reports)

SLMs have nationally consistent definitions and will be reported nationally. Contributory measures will have nationally consistent definitions and data sets, but will be selected locally and will not need to be reported nationally. Contributory measures have a quality improvement and equity focus and are frontline service level measurements that show a tangible and meaningful result of the interaction between clinicians and patients.

The jointly-developed Improvement Plan will include:

- Improvement milestones for the four SLMs (total acute hospital bed days, ASH rates for 0–4 year olds, patient experience of care and amenable mortality)
- Contributory measures for each of the four SLMs
- District Alliance stakeholder agreement.

1.1.2 PHO Financial Incentives for 2016/17

A mixed approach to PHO financial incentives will be implemented in 2016/17. This includes two capacity and capability payments, acknowledging primary care's concern about the lack of quality improvement infrastructure in their sector, and one 'at risk' performance payment. The \$23 million primary care performance funding will continue to be used to build the necessary primary care (PHOs and their contracted providers) capacity and capability to enable performance improvement.

To successfully build this required capacity and capability, it is important that this funding flows easily and freely to PHOs via current payment routes. Achievement of the SLMs is reliant on the contributions of a variety of providers. DHBs are expected to consider how the participation of other stakeholders (e.g. pharmacy, aged care services and midwives) are resourced to participate in developing and implementing Improvement Plans, and incentivised to improve performance.

The following table shows the payment process for the approach to financial incentives in 2016/17.

Table 2: PHO Financial Incentives for 2016/17

Size of Payment	Purpose	When Paid
25%	'Up front' capacity/capability payment to PHOs	20 July 2016
50%	Capacity/capability payment to PHOs on Ministry approval of Improvement Plan including Improvement Milestones for SLMs, a suite of contributory measures and evidence of stakeholder agreement with the Improvement Plan (as evidenced by PHO and DHB signatures).	20 November 2016 OR 20 December 2016 (for those whose Improvement Plans needed rework and/or external facilitation)
25%	'At risk' and paid to PHOs on achievement of incentivised measures, based on Q4 performance.	20 September 2017

1.1.3 SLM Update for Metro Auckland

The Auckland-Waitemata Alliance Leadership Teams (ALT/Alliance), and Counties Manukau DHB have undertaken a joint approach in developing a SLM Improvement Plan. Building on the one team theme in the New Zealand Health Strategy, the Alliances have co-developed a single Improvement Plan to ensure streamlined activity and reporting, and best use of resources within the health system. Milestones and contributory measures for each of the SLMs have been carefully considered for 2016/17, in the recognition that there will be a very short timeframe for implementation. The

Alliances are firmly committed to including more meaningful measures from 2017/18 and over the medium to longer-term, once the structures, systems and relationships to support improvement activities are more firmly embedded.

The DHBs accountable to this Improvement Plan are:

- Auckland DHB
- Waitemata DHB
- Counties Manukau DHB

The PHOs accountable to this Improvement Plan are:

- Alliance Health Plus Trust
- Auckland PHO
- East Health Trust
- National Hauora Coalition
- ProCare Health
- Total Healthcare
- Waitemata PHO

1.1.4 Process for developing the Auckland SLM Improvement Plan – progress to date across the Metro Auckland DHBs

The Metro Auckland DHBs and PHOs have established an overarching SLM Steering Group to guide the development of SLM improvement across Auckland. Metro Auckland SLM Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs (see Table 3). The steering group is accountable to the two ALTs (Counties Manukau DHB and Auckland DHB/Waitemata DHB), and provides oversight of the overall process. In addition, four working groups have also been established to develop the indicators and interventions that will make up the Improvement Plans that will be approved by the Auckland DHB and Waitemata DHB Alliance and the Counties Manukau Health District Alliance.

Working groups are responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a PHO lead and supported by a DHB Public Health Physician. Working group membership consists of senior Primary Care and DHB clinicians, personnel and portfolio managers (see Table 4). A Project Manager is appointed to work across all of the SLMs and will focus on developing the Improvement Plan on behalf of the Steering Group. The purpose of the SLM working group is to provide advice to the SLM Steering Group on their respective SLM and the associated contributory measures, identify the contributory measures that will have the biggest impact on the overall SLM and then consider the data quality for these measures.

Table 3: Metro Auckland SLM Steering Group Members

Name	Organisation & Role
Tim Wood (Chair)	Auckland & Waitemata DHBs Deputy Director Funding
Sarah Gray	Auckland & Waitemata DHBs Public Health Physician
Louise McCarthy	Counties Manukau Health Senior Programme Manager
Yaw Moh	Counties Manukau Health IPIF Advisor
Mataroria Lyndon	Counties Manukau Health Clinical Fellow
Rachael Calverley	Waitemata PHO Nurse Director
Allan Moffitt	ProCare Networks Clinical Director

Charlotte Harris	Auckland PHO Clinical Director
Jim Primrose	Alliance Health Plus Clinical Director
Tereki Stewart	National Hauora Coalition Director of Operations
Kate Moodabe	Total Healthcare General Manager Central & West
Loretta Hansen	East Health Trust CEO
Rachel Mattison	Auckland & Waitemata DHBs Primary Care Programme Manager
Mohammad Abu-Obeid	SLM Project Manager

Table 4: Metro Auckland SLM Working Group Members

	ASH Rates	Smokefree households	Youth Access	A Bed Days	Patient Experience	Amenable Mort
PHO Lead	Alliance Health Plus	National Hauora Coalition	Auckland PHO	ProCare	Waitemata PHO	Total Healthcare & East Health
PHO Lead Person (Chair)	Kim Letford (with support from Jim Primrose)	Yaw Moh	Charlotte Harris / Barbara	Allan Moffitt / Gabrielle Lord	Rachael Calverley / Dr Ajay Makal	Kate Moodabe / Kwee Goh
DHB Public Health Physician	Karen Bartholomew	Alex Greig	Sheryl Jury	Tom Robinson	Dr Corina Grey / Stuart Jenkins	Peter Sandiford /
Project Manager supporting all working groups: Mohammad Abu-Obeid <i>Note that others stakeholders are included but not represented in this list</i>						

The working groups have completed in-depth analytics to inform development of the Improvement Plan. This included a review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition-specific approach for the SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, GP visits, DHB inpatient experience survey rates, condition specific amenable mortality rate recent trends, evidence to support improvement activities and most importantly, the ability to address equity gaps.

Working groups have engaged more broadly with key stakeholders in the process of drafting and selecting contributory measures. Stakeholder engagement included a sector-wide socialisation workshop and a presentation of draft measures, milestones and interventions to the ALTs. Feedback received from the engagement sessions was incorporated into the development of the Improvement Plan.

A single Improvement Plan has been developed for the two ALTs / three Metro Auckland DHBs. The rationale for this is that a number of PHOs across Metro Auckland DHB boundaries are members of both Alliances. It was not considered to be practicable or achievable, given limited resources, to have two Improvement Plans with different contributory measures. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region.

1.1.5 Next Steps

Individual local Improvement Plans for both Alliances are currently being developed. These plans will include district-specific targets and measures to ensure that contributory measures and SLM

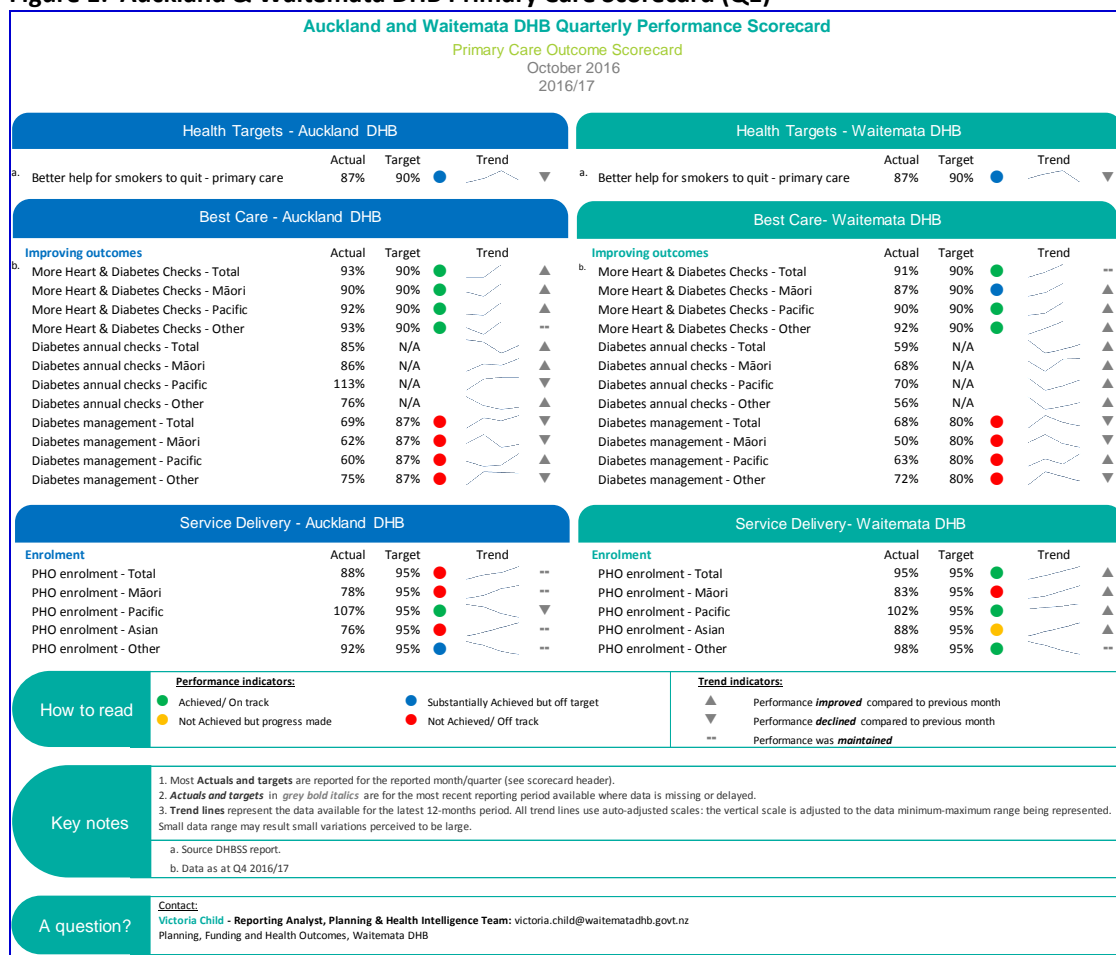
milestones are met. Reporting processes, both for the local Improvement Plans and the overall regional Improvement Plan are also in development, with a clear line of sight to performance-level reporting requirements for Quarter 4, 2016/17.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. Contributory measures and SLM milestones have been chosen for the current year to reflect the fact that realistically there will only be 6-8 months in which to implement initiatives leading up to 20 June 2017. The intention is to build on the 2016/17 Improvement Plan, with additional measures and activities (e.g. by including a diabetes-specific contributory measure for the amenable mortality SLM, in the 2017/18 year).

2. National Health Targets

The Primary Care Scorecard (Figure 1) is a standardised tool that is used by both Auckland and Waitemata DHBs to internally review and track performance against a range of measures including the National Health Target (NHT). The Scorecard shows for each measure the actual performance of both DHBs during Quarter 1, 2016/17, against the NHT. Note that this scorecard shows preliminary data.

Figure 1: Auckland & Waitemata DHB Primary Care Scorecard (Q1)



2.1 Better Help for Smokers to Quit

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 (NHT). Both Auckland and Waitemata DHBs have not achieved the primary care 'Better Help for Smokers to Quit' health target in Quarter 1. Based on the preliminary results provided by the PHOs, Auckland and Waitemata DHBs have achieved 87%. Auckland DHB is ranked 8th nationally and Waitemata DHB is ranked 6th nationally for Quarter 1.

None of the PHOs achieved the 90% target, with results by PHO as follows:

Table 5: PHO Results for Better Help for Smokers to Quit 90% Target, Q1

Auckland DHB	Auckland PHO	85%
	Alliance Health Plus	87%
	National Hauora Coalition	82%
	ProCare	88%
Waitemata DHB	ProCare	88%
	Waitemata PHO	86%

The PHOs are claiming that they are undertaking similar activities to the previous quarters to support their practices, but have failed to achieve the target. The Primary Care team are monitoring PHO performance closely and have requested for the PHOs to provide weekly reports on activities. All of the PHOs have written a Smokefree Plan for 2016/17, the DHBs are reviewing these plans and providing feedback to the PHOs where there are improvements that can be made to the plans.

The results are also shown in the Primary Care Scorecard under Health Targets, as well as in Figure 2:

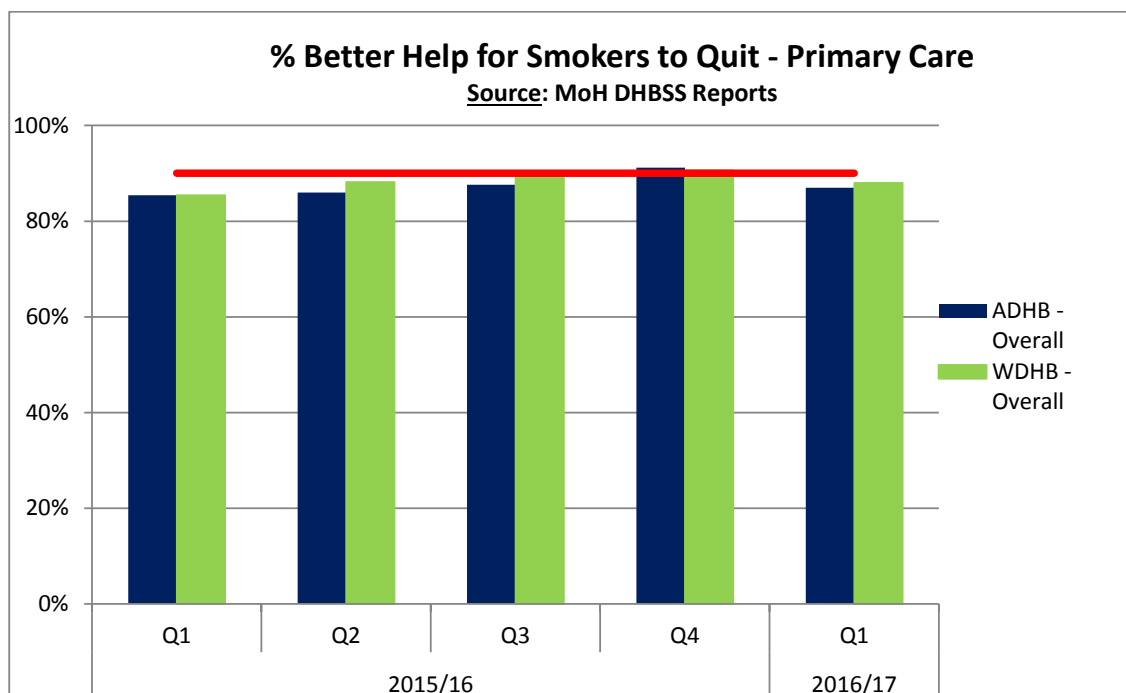
- Auckland DHB - 87%, decrease of 4% from the previous quarter
- Waitemata DHB – 87%, decrease of 3% from the previous quarter.

Ethnicity data for this health target is obtained from the MoH and is always reported one quarter behind. In Quarter 4, 2015/16 the DHBs achieved results for Maori and Pacific as shown in Table 6:

Table 6: Auckland and Waitemata DHBs 'Better Help for Smokers to Quit' Ethnicity Data (Quarter 4)

	Maori	Pacific	Total Population
Auckland DHB	91.6%	91.9%	91.8%
Waitemata DHB	90.7%	91.0%	90.6%

Figure 2: Auckland and Waitemata DHBs 'Better Help for Smokers to Quit' Quarter 1 Performance



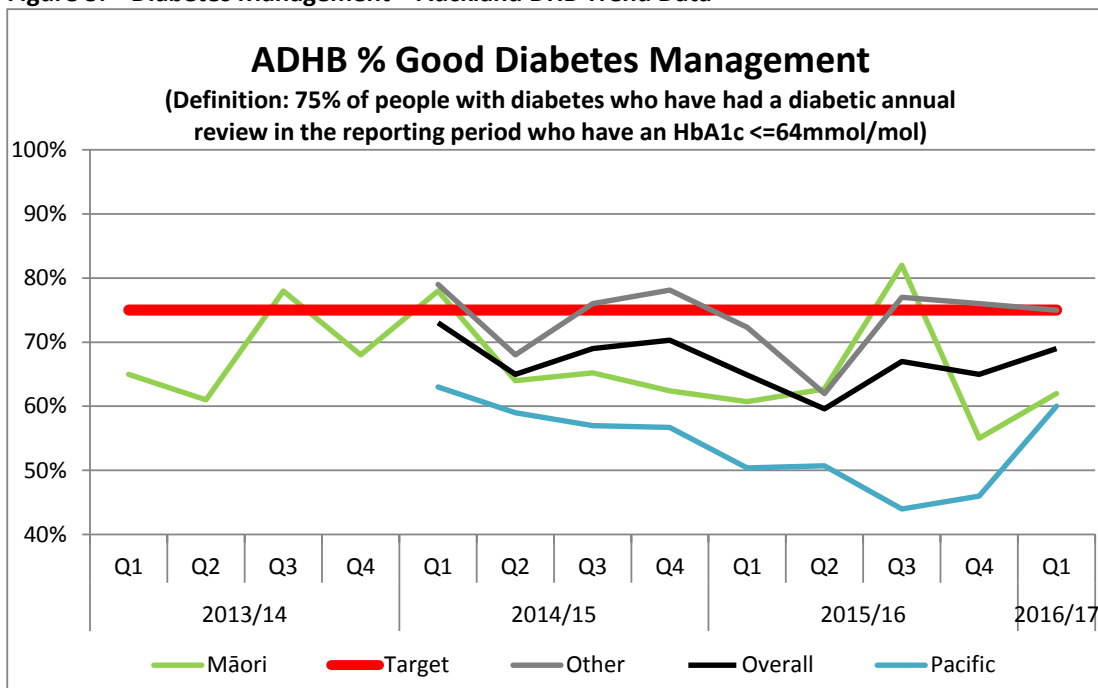
Note: preliminary data for Q1

2.3 Improving Population Health - Diabetes Management

DHB Target: A minimum of 75% of people who have had a Diabetes Annual Review (DAR) will have an HbA1c of $\leq 64\text{mmol/mol}$.

In Auckland DHB, 69% of those who have had a Diabetes Annual Review (DAR) in Quarter 1 showed 'good diabetes management' (see Figure 4). This is 6% below the target. However, the good diabetes management rate in the 'Other' group did reach the target (i.e. 75%). The 6% variance is potentially due to the lower rates in Maori and Pacific (achieving rates of 62% and 60% respectively).

It is of note that the Maori and Pacific good diabetes management rate in Auckland DHB has shown an overall decline during the 2015/16 year. A separate briefing paper is provided to update on diabetes prevalence, assessment and management of people with diabetes and progress with the Diabetes Service Level Alliance (DSLAA) Work Programme to date. The DSLAA Work Programme has been developed to identify and implement some specific initiatives targeted at improving diabetes related outcomes of Maori, Pacific and other high needs populations.

Figure 3: Diabetes Management – Auckland DHB Trend Data

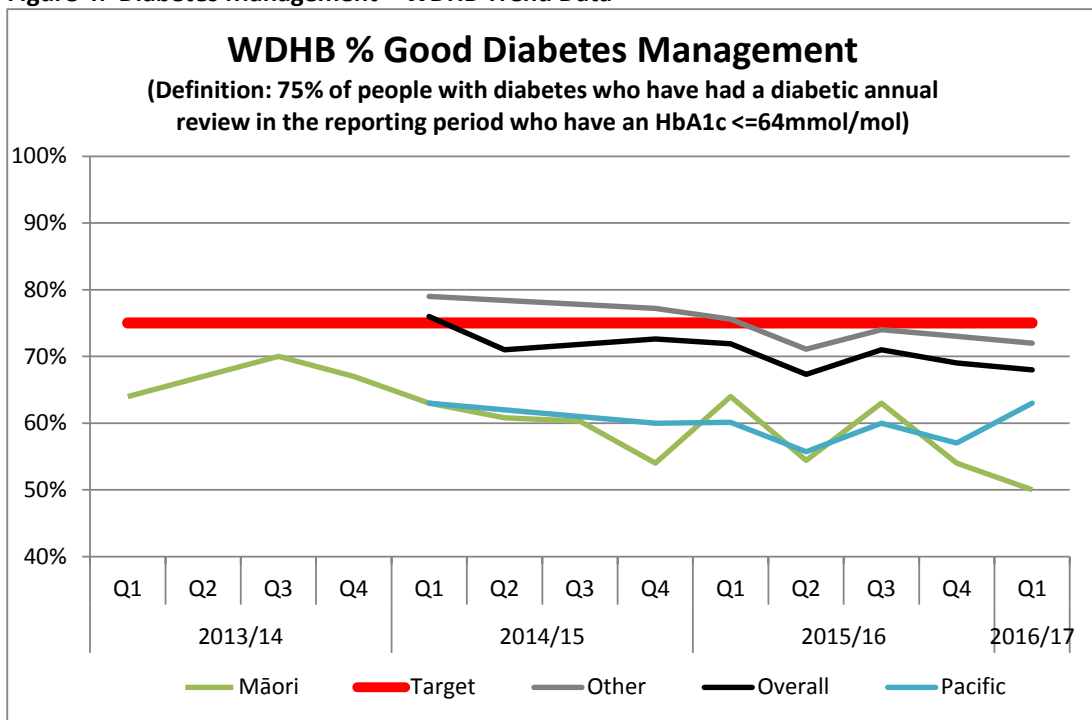
In Waitemata DHB, 68% of those who have had a DAR in Q1 2016/17 showed 'good diabetes management' (see Figure 4). This is 7% below the target. However, the good management rate was 72% in the 'Other' group. The variance of 7% is likely to have been caused by lower rates in Maori and Pacific populations (i.e. 50% and 63% respectively).

The drop in performance this quarter for Maori with good diabetes management is a result of a substantive increase in the number of DARs completed for Maori, identifying more people who have poor control.

Two demonstration projects aiming to improve diabetes management are being undertaken in WDH. Both of these focus on Maori, Pacific and quintile 5 populations with type 2 diabetes. The Whanau House project focuses on Maori patients with type 2 diabetes who are not engaged with Primary Care. It involves nurses visiting patients in their home, to engage them in care. It is too early to know if this project is having a positive impact. The West Auckland Diabetes Quality Improvement project works with 10 general practices to improve diabetes outcomes of peoples with ≥ 74 HbA1c. Preliminary findings indicate improvements in the HbA1c levels of this group, however, it will take at least 12 months before HbA1c levels are expected to move to the range associated with good management.

Planning, Funding and Outcomes is also working closely with the PHOs to improve Maori diabetes outcomes. PHOs' practice engagement teams are visiting their poorly performing practices and encouraging them to use available diabetes related services optimally. In addition Waitemata PHO's Clinical Advisory Group is developing an action plan to improve Maori diabetes outcomes.

Figure 4: Diabetes Management – WDHB Trend Data



3. Progress against the 2016/17 Annual Plan Deliverables

3.1 Primary Mental Health

3.1.1 Stepped Care Model

The Primary Mental Health services delivered by the PHOs are based on the stepped care model, as articulated in *Rising to the Challenge* (the Mental Health and Addictions Service Development Plan, 2012–2017), with interventions matched to service user needs. These services, with the exception of the Prime Minister's Youth Mental Health Initiative, are targeted to Maori, Pacific and quintile 5 populations. Auckland and Waitemata DHBs use similar service specifications for the adult primary mental health Agreements with the PHOs, and apply the available funding to the PHOs weighted towards the Maori, Pacific and quintile 5 populations.

3.1.2 Auckland DHB

The Primary/Secondary Integration Strategic Group and the linked Tamaki Locality Mental Health Project continue to look at opportunities for increased integration between primary and secondary mental health services. Additionally, the Youth Alliance, led by ProCare, provides primary mental health interventions to youth (aged 12 to 19 years).

The Q1 volumes for Auckland DHB are shown in Table 7.

Table 7: Auckland DHB Primary Mental Health Initiatives, 2016/17

	APHO	Procare	AH+	NHC	Youth Alliance
Ethnicity	Q1	Q1	Q1	Q1	Q1
NZ European	64	2,517	89	105	172
Maori	40	431	48	11	70
Pacific	22	402	98	11	107
Asian	24	656	65	59	48
Other	29	117	48	15	14
Unknown	0	0	0	0	0
Totals	179	4,123	348	201	411
Expected Volume	76	388	85	79	104

The high totals compared to expected volumes shown in Table 7 is in line with previous 2015/16 CPHAC reporting, and is largely due to PHOs utilisation of Services to Improve Access (SIA) funding for primary mental health initiatives (PMHI).

3.1.3 Waitemata DHB

The Waitemata DHB Board has approved the initial business case for the 'Our Health in Mind' Action Plan (2016-2021); this includes additional funding for PMHI. The Our Health in Mind Governance Group is currently reviewing how this additional funding will be applied to achieve the greatest benefit in 2016/17.

HealthWest provide primary mental health interventions to youth (aged 10 to 24 years), as part of the Waitemata DHB Youth Health Hub. The Youth Health Hub is currently going through a competitive tender process, which may result in a new provider from 1 January 2017. Raeburn House provides 12 group programmes per annum with access prioritised to GP referrals. Group programmes offered include Mindfulness, depression and anxiety. The Quarter 1 volumes for Waitemata DHB are shown in Table 8.

Table 8: Waitemata DHB Primary Mental Health Initiatives, 2016/17

	WPHO	Procare	HealthWest	Raeburn House
Ethnicity	Q1	Q1	Q1	Q1
NZ European	432	1,857	362	61
Maori	91	668	164	2
Pacific	38	371	54	1
Asian	35	281	30	5
Other	31	111	66	8
Unknown	0	0	0	0
Totals	627	3,288	676	77
Expected Volume	322	551	357	N/A*

* Raeburn House is contracted to deliver group programmes

The high ProCare total compared to expected volumes shown in Table 7 is in line with the 2015/16 reporting, this is largely due to ProCare's utilisation of SIA funding within PMHI. High utilisation by HealthWest is due to the organisation's contingency planning with regards to exiting the Youth Health Hub service - all of these providers' Packages of Care will be allocated by late October, to allow interventions to be completed prior to the potential exit date of 31 December 2016.

3.1.4 Review of Primary Mental Health Initiatives

The current Auckland DHB and Waitemata DHB primary mental health services have been in place for over 10 years. There are increasing demands on this service, changing priorities and a need to demonstrate health gains and outcomes for investment.

In September 2016 Auckland and Waitemata DHBs began a review of primary mental health initiatives in collaboration with primary care providers. The purpose of this review is to develop a consistent service delivery model that:

- is aligned to new initiatives and the direction of national policy
- is aligned to each DHBs strategic directions and local priorities
- meets the requirements of the PMHI service specifications
- demonstrate health gains and outcomes for investment.

Consultation is currently underway with service users, Maori and Pacific service providers, PHOs, GPs, non-government organisations (NGOs) and DHB Provider Arms. Following the completion of this process, a draft report will be distributed to stakeholders for review. The final report is due in February 2017.

3.1.5 Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot, which links three NGOs with two GP practices, has led to significant learning and further Tamaki practices requesting to join the trial.

Currently, a further ten practices and four NGOs have been linked to the Tamaki pilot. The expanded pilot includes all four Auckland DHB PHOs and all the Auckland DHB contracted NGO support hours providers. Other practices have indicated that they wish to be part of the expansion of this pilot and it is expected that over 10% of Auckland DHB practices will be involved by June 2017.

SYSTEM LEVEL MEASURES IMPROVEMENT PLAN 2016-17

Auckland Waitemata & Counties Manukau Health Alliances

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1. EXECUTIVE SUMMARY

The Counties Manukau Health (CM Health) and Auckland Waitemata Alliance Leadership Teams (ALT / Alliance) have undertaken a joint approach to the development of a System Level Measures (SLM) improvement plan. Building on the *one team* theme in the New Zealand Health Strategy, the Alliances have co-developed a single improvement plan to ensure streamlined activity and reporting and best use of resources within the health system. Milestones and contributory measures for each of the SLMs have been carefully considered for the 2016-17 year in the recognition that there will be a very short timeframe for implementation. The Alliances are firmly committed to including more meaningful measures from 2017-18 and over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded.

The DHBs included in this improvement plan are:

- Auckland DHB
- Waitemata DHB
- Counties Manukau DHB

The PHOs included in this improvement plan are:

- Alliance Health Plus Trust
- Auckland PHO
- East Health Trust
- National Hauora Coalition
- ProCare Health
- Total Healthcare PHO
- Waitemata PHO

2. SUMMARY OF SELECTED CONTRIBUTORY MEASURES AND TARGETS

SLM	SLM Target	Contributory Measure	2016-17 Milestone/Target
Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds	Maintain current performance against ASH rates for each DHB for 2016-17. WDHB: 2112 ADHB: 2448 CMDHB: 3061 In 2017-18 - an annual reduction in ASH rates for 0-4 year olds of 5%.	Newborns enrolled with a PHO within the first three months of life	The National Target is 98%. 2016-17 – Aim for PHOs to achieve 90% by 30 June 2017. Develop a measure for enrolment with a PHO by 6 weeks of age.
		Babies fully immunised by 8 months of age	This is a National Target. 95% of babies fully immunised by 8 months of age each quarter.
Acute Hospital Bed Days per Capita	The target for 2016/17 is to aim for a 2% reduction in this rate to 447.6 bed days/1,000 population by June 2017 from 456.7	ED Presentation Rate	Maintain current performance 49.3/1000 population by quarter ending 30 June 2017. Therefore the target in year one is to establish the baseline and ongoing methodology in order to set a target for ED presentations in the 2017-18 year.
		Acute Readmission Rates at 28 days 2016-17	The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017

SLM	SLM Target	Contributory Measure	2016-17 Milestone/Target
Patient Experience of Care	Maintain current state and continue to improve on the DHB Adult Inpatient Survey - Maintenance of an aggregated 8/10 score for all four domains across the three DHBs.	The DHB Adult Inpatient Survey	Maintain and continue to improve response rates for the DHB inpatient survey. Maintenance of an aggregated score for the 4 domains of 8 out of 10 for each of the 3 Auckland DHBs (Current national response rate 27%, ADHB: 17%, CMDHB: 13% and WDHB 34%).
		E-Portal (PHC Specific)	40% of PHO practices are registered with a portal and 10% of the PHO population have access to a portal.
Amenable Mortality Rate	Maintain the overall current status at the current rate of: WDHB: 2352 deaths – at Rate of 84.9% per 100,000 ADHB: 2007 deaths – at Rate of 98.7% per 100,000 CMDHB: 3001 deaths – at Rate of 135.6% per 100,000	Decrease in mortality associated with Cardiovascular Disease	Increase coverage of Maori to 90% Increase triple therapy by 5% for those with a prior CVD event, those with a CVD RA of $\geq 20\%$ and with a particular focus on patients with diabetes
		Decrease in mortality associated with smoking related diseases through increased quit attempts and increased support to quit	Increase support to quit - 10% from the baseline/DHB
		Decrease in mortality associated with Breast Cancer	The target for 2016-17 is to increase coverage in Maori women in particular to reach 70%
		Reducing Mortality from Hepatitis C	By June 2018: 10% of those identified in PMS' will be treated (measured through quarterly reports) 30% of those identified in secondary care will be treated (measured through quarterly reports)

3. INTRODUCTION

3.1 Purpose

The purpose of this document is to provide the Ministry of Health (MoH) with the SLMs improvement plan for the CM Health and Auckland Waitemata Alliances. The document outlines the improvement milestone and contributory measures for each SLM. A description of the joint process taken by the CM Health and Auckland Waitemata Alliances is provided along with the Rationale for developing a single plan for the region.

4. BACKGROUND

The New Zealand Health Strategy outlines a new high-level direction for New Zealand's health system over the next ten years to ensure that *all New Zealanders live well, stay well, get well*. One of the five themes in the Strategy is *value and high performance*. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the MoH has been working with the sector to develop a suite of SLMs that provide a system-wide view of performance. Alliances are required to develop an improvement plan in accordance with MoH guidelines and one or more local plans for the year to 30 June 2017. The improvement plan will include:

- a) four SLMs to be implemented from 1 July 2016:
 - Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
 - Acute hospital bed days per capita
 - Patient experience of care
 - Amenable mortality rates.
- b) for each SLM, an improvement milestone to be achieved in 2016-17. The milestone must be a number that either improves or maintains performance from the district baseline or reduces variation to achieve equity;
- c) for each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

The CM Health and Auckland Waitemata Alliances agreed to a joint approach to the development of a SLMs improvement plan. This includes the establishment of an Auckland Metro Steering Group and Working Groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two ALTs and provides oversight of the overall process. Working Groups are responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a PHO lead and supported by a DHB public health physician. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers.

The Working Groups completed in-depth analytics to inform development of the improvement plan. This included review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition specific approach for the SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, GP visits, DHB inpatient experience survey rates, condition specific amenable mortality rate recent trends, evidence to support improvement activities and most importantly the ability to address equity gaps.

Working groups have engaged more broadly with key stakeholders in the process of drafting and selecting contributory measures. Stakeholder engagement included a sector-wide socialisation workshop and a presentation of draft measures, milestones and interventions to the ALTs. Feedback

received from the engagement sessions was incorporated into development of the improvement plan.

A single improvement plan has been developed for the two ALTs / three Auckland Metro DHBs, on the rationale that a number of PHOs cross Auckland Metro DHB boundaries and are members of both Alliances. It was not considered to be practicable or achievable given limited resources, to have two improvement plans with different contributory measures. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. Individual local improvement plans for both alliances are currently being developed. These plans will include district-specific targets and measures to ensure that contributory measures and SLM milestones are met. Reporting processes, both for the local improvement plans and the overall regional improvement plan are also in development, with a clear line of sight to performance-level reporting requirements for Quarter 4 2016-17.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. Contributory measures and SLM milestones have been chosen for the current year to reflect the fact that realistically there will only be six to eight months in which to implement initiatives leading up to 20 June 2017. The intention is to build on the 2016-17 improvement plan with additional measures and activities, e.g. by including a diabetes-specific contributory measure for the amenable mortality SLM, in the 2017-18 year.

5. COUNTIES MANUKAU AND AUCKLAND WAITEMATA ALLIANCE LEADERSHIP TEAM SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

The following section of this document describes each SLM outcome measure and its selected contributory measures in details along with justifications for setting targets and the activities/initiatives identified to achieve stated targets.

5.1 Ambulatory Sensitive Hospitalisations (ASH) Rates per 100,000 for 0 – 4 year olds

5.1.1 Definition

ASH are admissions considered potentially preventable through prophylactic or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis assigned. Children counted in this measure are in the preschool ages of 0-4 years and are assigned to a DHB based on their place of domicile. 'Hospitalisation' includes any discharge coded ED or inpatient stay of greater than three hours. Ministry of Health data does not differentiate between ED and inpatient admission. The measure is expressed as a rate (per 100,000 children in the census population).

5.1.2 Context and Rationale

ASH is a challenging indicator as it is heavily driven by the Social Determinants of Health. The amount realistically amenable to timely access to quality Primary Care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges the Working Group recognise that there are many promising approaches that could be taken. To support decision making the Working Group analysed regional data on ASH for the last five years, by DHB and facility, ethnicity, deprivation and condition. The group considered both an overarching approach and a condition specific approach. The group considered factors such as the

number of hospitalisation events (as well as rates), readmission proportions, recent trends, evidence to support improvement activities, work currently underway and equity issues. Stark ethnic disparities exist, with Pacific children experiencing significantly higher rates than all other ethnicities. Māori also have higher rates than non-Māori non Pacific children. Therefore, activities that may reduce these disparities are prioritised. There was vigorous debate about whether the milestone for this indicator should be a reduction in Pacific and Māori ASH only or a total population reduction.

5.1.3 Improvement Milestone

Maintain current performance against ASH rates for each DHB for 2016-17.

Current performance (12 months to March 2016)

	Waitemata	Auckland	Counties
Number of ASH events	2,112	2,448	3,061
Rates	5,427	8,265	7,348

For 2017-18, the overall improvement milestone recommended will be an annual reduction in ASH rates for 0-4 year olds of 5%. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported and interrogation of approach to ensure that interventions reduce not worsen inequalities.

5.1.4 Selected Contributory Measures

Two contributory measures have been selected for 2016-17:

1. **Percentage of newborns enrolled with a PHO within the first three months of life.** The national target is 98%. However, given current PHO performances, an achievable goal would be for all PHOs to **reach 90% by 30 June 2016-17, by ethnicity**. Another milestone for the 2016-17 year is to develop a process measure for the timeliness of enrolment with a PHO by 6 weeks of age, to align with the timing of the first set of childhood immunisations. Associated activities are for work to occur in PHOs, general practice and DHBs to improve timely B code and full enrolment; significant work is already underway. A project to implement multi-enrolment with WCTO and oral health will also have an impact.
2. **(Health Target) Percentage of babies fully immunised by 8 months of age each quarter.** The goal would be to achieve the national target of **95% coverage** per quarter, for all ethnicities. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue.

5.1.5 Contributory Measures 2016-17 - Analysis and Justifications

1. Newborns enrolled with a PHO within the first three months of life

Item	Details
Name	Newborns enrolled with a PHO within the first three months of life
Definition	Numerator: Number of infants under three months enrolled with a PHO Denominator: Number of births reported to the NIR
Rationale & Justification	Babies not enrolled with General Practitioners have less access to and engagement with primary care. Newborn enrolment is also an important factor in timely immunisation
Data Collection	The Ministry of Health currently collects data on this measure using

Item	Details				
	the National Immunisation Register (NIR) and PHO Age Sex Registers.				
Target & Target Justification	The National Target is 98% 2016-17: Aim for PHOs to achieve 90% by 30 June 2017 Develop a measure for enrolment with a PHO by 6 weeks of age (which would be a more useful measure as it aligns with the timing of the 6 week immunisations) by 30 June 2017.				
Current Performance	Results for the Auckland Metro PHOs for 2015-16 are shown below:				
	PHO	Q1 Sept 2015	Q2 Dec 2015	Q3 Mar 2016	Q4 Jun 2016
	Alliance Health Plus	85%	62%	78%	79%
	ProCare	79%	66%	78%	80%
	Total Healthcare	76%	73%	94%	80%
	National Hauora Coalition	89%	66%	81%	86%
	East Health Trust	77%	83%	80%	80%
	Waitemata PHO	76%	66%	84%	79%
	Auckland PHO	82%	71%	86%	75%
Reporting Frequency	Quarterly				
Improvement Activities	2016-17: Work in PHOs, general practice, DHBs and with midwives to improve timely B code and full enrolment at practices. CMDHB and the PHOs in its Alliance are developing a joint action plan for completion in November 2016. Similar activities to be considered in Auckland Waitemata Alliance.				

2. Babies fully immunised by 8 months of age

Item	Details
Name	Babies fully immunised by 8 months of age
Definition	Percentage of eight months olds who will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. Numerator: PHO enrolled children who are enrolled on the NIR in the CI Programme and have completed the last dose of their age appropriate vaccinations on the day they turn 8 months Denominator: PHO enrolled children who are enrolled on the NIR in the CI Programme who have turned 8 months
Rationale & Justification	Immunisations are required to prevent serious communicable childhood illnesses, which can lead to hospitalisations. In the last few years coverage in the Auckland region has hovered near 95%, however, consistent energy and focus is required to maintain these levels. Furthermore, rates of hospitalisations for partially vaccine preventable illnesses such as pneumonia and gastroenteritis remain high.
Data Collection	The Ministry of Health currently collects and reports on this measure using data from the National Immunisation Register (NIR)

Item	Details				
	at a DHB and PHO level each quarter. No changes to the current data collection system would be required.				
Target & Target Justification	95% of babies fully immunised by 8 months of age each quarter. This is a National Target.				
Current Performance	Results for the Auckland Metro DHBs for 2015/16 are shown below:				
	DHB	Q1 September 2015	Q2 December 2015	Q3 March 2016	Q4 June 2016
	ADHB	95.0%	93.8%	94.4%	93.7%
	CMDHB	95.2%	94.7%	94.2%	94.9%
	WDHB	93.2%	94.9%	93.1%	92.4%
Reporting Frequency	Quarterly				
Improvement Activities	2016-17 and subsequent years - The current immunisation programme to continue as business as usual. Specific activity to improve Maori coverage should continue to be developed. Coordinate and embed systems across the Auckland region to increase the coverage of influenza immunisation for children aged 0-5 who are eligible for the free vaccine.				

5.1.6 Remarks

Additional Contributory Measures for 2017-18:

1. **Reduced rate of hospitalisations for serious skin infections.** There is a high and growing rate of hospitalisations for serious skin infections in this age group. To date, skin infections have not received sufficient attention in primary care and community settings. There is a lack of consistent messaging and educational resources for families on how to manage skin infections. Activity to achieve reduced hospitalisations during the first year will include the distribution of a recently developed (Skin Infection working group; Regional Child Health Network), consistent, health literacy based resource. It will take some time to implement and embed the improvement activities, therefore a target for reduced hospitalisations will not be in place until 2017-18. A reporting system will be developed and an improvement milestone agreed during 2016-17.
2. **Improved oral health.** Rates of poor oral health in this age group are worsening; hospitalisations due to dental conditions are significant and increasing. Furthermore, there are large disparities across ethnicities - rates for Pacific children are much higher than other groups. There are currently several measures of oral health, but none give a sufficiently clear view of the oral health of all 0-4 year olds. During 2016-17, enrolment with oral health services will be monitored as a placeholder. The improvement activity will be to develop a regional pre-school oral health strategy, which will include a suitable contributory measure and improvement activities for subsequent years.

5.1.7 Overarching Activities

There are opportunities for a set of overarching and disease-specific activities to address the ASH System Level Measure. There is already substantive activity in business-as-usual and projects underway; leveraging expertise and current programmes of work to accelerate progress will be a focus of the remainder of year one activities. From year two there will be further disease-specific and educational activity underway with further development of process and outcome indicators

associated with these. The working group recognises that the contributory measures selected for year one include enrolment measures rather than outcome measures, however, PHO enrolment is an important facilitator of timely and quality care, and is important to recognise in year one. The immunisation Health Target is incorporated into ASH as a recognition for the specific contribution that immunisation makes and the large programme of work across the system to maintain and incrementally improve immunisation coverage and equity.

5.1.8 Intervention Logic

Please refer to [5.2.1](#)

5.2 Acute Hospital Bed Days Per Capita

5.2.1 Definition

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between Primary and Secondary care, can all help reduce unnecessary acute demand. Good access to Primary and Community Care and Diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

5.2.2 Context and Rationale

Data contributing to understand the bed days were examined and performance analysed. It is vital that the current state is fully understood so that the best interventions can be identified to have an impact on the indicator.

Conditions which result in unplanned hospitalisation and other contributory factors i.e. referral process to ED (self, provider variation, ambulance etc.) were identified as below:

- Mental health conditions
- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure
- Respiratory infections
- Abdominal pain
- Kidney and Urinary Tract Infections
- Chest Pain

Primary care interventions attributes to practice level and have impact on hospitals are likely to have a much larger impact in the short term particularly the decisions made at the 'front door' of the hospital:

- The use of POAC – reducing variability and increasing targeting of certain conditions
- Planned proactive care – predictive risk modelling, risks stratification, care planning, action plans, Advance Care Plans (ACP) and a framework to ensure clinical pathway implementation for those at the highest risk of acute hospitalisation.

- Contact by a GP Team within 48 hours of discharge

5.2.3 Improvement Milestone

The overall improvement milestone recommended for this SLM is modest in year one because we believe it will take some time for the initiatives to have an impact. We have calculated the Auckland Metro acute bed days rate per thousand population is **456.7 in 2016**. We believe it is reasonable to aim for a **2% reduction** in this rate to **447.6 bed days/1,000** population by June 2017. In out-years we would plan for a more ambitious reduction in real terms. However, it must be noted that any new beds opening will need to be adjusted for as supply side changes will impact this indicator in a stepwise fashion.

Two measures with associated targets have been decided for the 2016-17 year and they are:

- ED presentation Rate/1,000 population
- Readmission rate at 28 days

5.2.4 Selected Contributory Measures

The first two contributory measures and associated activities are identified for 2016-17; there will be a placeholder the following year for the other four, as follows:

1. **ED presentation rates.** This will provide practices with a sense of their relative utilisation and to be able to track whether the trend is changing. Overall reduction in ED presentations will result in less admissions and bed day use. There is some complexity involved in this measure however we believe that this will directly correlate with actual admissions and also potentially avoidable admissions so it is a good marker. The difficulty will come from wide confidence intervals for the measurement at a practice level. It is likely that we may use proxies (e.g. Access (timely urgent care), POAC utilisation rates, planned proactive care) for practice level reporting but that the ED presentation rates is still the best measure at a system/PHO level. We will establish the best methodology and set a target for the 2017-18 year based on this. The target in year one is to establish an accurate baseline and methodology for ongoing reporting.
2. **Acute readmission rates at 28 days – current measure (acute readmission).** Avoidance of readmission to hospital following a recent discharge from hospital. The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017.

The remaining four measures will be monitored over the 2016-17 year with a view to setting targets for the 2017-18 year, should they prove a useful way to monitor impact on the SLM:

- Average length of stay
- Stranded patients at 21 days
- 5% of risk stratified patients on a structured care plan
- Ratio of arranged admission/acute admission

5.2.5 Contributory Measures 2016-17 - Analysis and Justifications

1. ED presentation rate

Item	Details
Name	ED presentation rates
Definition	The number of ED events in Auckland public hospitals expressed as a rate per 1000 patients domiciled in ADHB, WDHB and CMDHB
Rationale & Justification	<p>For every 100 people in New Zealand, 15 were ED patients at least once during the year.</p> <p>The Pacific population had the highest age-standardised rate of ED use in 2014/15 (193 per 1,000 population per quarter), followed by Māori (180 per 1,000 population per quarter).</p> <p>The rate of ED use increased with each level of neighbourhood deprivation.</p> <p>One in three ED events ended with the patient being admitted to hospital.</p>
Data Collection	Data source: The data is derived from NNPAC
Target & Target Justification	<p>The current quarterly ED presentation rate for Auckland Metro is 49.3/1000 population per quarter. However this figure is not adjusted for DHB of domicile and there is seasonal variation and also wide confidence intervals (large standard error to the mean), so further work is required. The analysts are working on an autoregressive integrated moving average (ARIMA) methodology to be able to negate some of these effects and we feel that this may provide greater utility for this measure. Clearly further work is required to fully understand the best methodology and trends using DHB of domicile data. We don't believe in this current year that this can be changed dramatically and the trend has been increasing each year. Therefore the target in year one is to establish the baseline and ongoing methodology in order to set a target for ED presentations in the 2017-18 year.</p> <p>Future targets will be monitored by ethnicity to prevent increasing inequalities and to ensure that high needs populations (Maori, Pacific Island, and high deprivation) have the appropriate access to health services.</p> <p>By national standards, the Auckland DHBs perform relatively well in terms of lower use of emergency department.</p> <p>What is known, is that the rate of growth in ED attendance rates is not only higher than the rate of population growth, but is also variable across DHBs and the causes of this variation need to be better understood, however may not be easily addressed.</p>
Current Performance	49.3/1000 population/quarter (Auckland Metro population – raw data)
Reporting Frequency	Proposed quarterly reporting of this indicator

Improvement Activities	POAC Planned Proactive Care Improving access and after hours services
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2. Acute readmission rates at 28 days 2016-17

Item	Details										
Name	Acute readmission rates at 28 days 2016-17										
Definition	An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives while receiving better care closer to home.										
Rationale & Justification	Reducing unplanned readmissions can therefore be interpreted as an indication of improving quality of care in the hospital and/or primary care ensuring that people receive better health and disability services.										
Data Collection	Numerator: Total number of acute readmissions within 28 days per DHB of domicile per year Denominator: Inpatient discharged events Data Source: The data is derived from NN PAC This Ministry of Health KPI is currently under development										
Target & Target Justification	The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017. The target has been decided to reduce the variation across the three DHB's to align to the best performing DHB.										
Current Performance	Standardised readmission rate 12 months to March 31 (NN PAC): <table border="1"> <thead> <tr> <th>DHB/Country</th><th>Rate 2016</th></tr> </thead> <tbody> <tr> <td>ADHB</td><td>8.1%</td></tr> <tr> <td>CMDHB</td><td>7.7%</td></tr> <tr> <td>WDHB</td><td>8.0%</td></tr> <tr> <td>NZ</td><td>7.9%</td></tr> </tbody> </table>	DHB/Country	Rate 2016	ADHB	8.1%	CMDHB	7.7%	WDHB	8.0%	NZ	7.9%
DHB/Country	Rate 2016										
ADHB	8.1%										
CMDHB	7.7%										
WDHB	8.0%										
NZ	7.9%										
Reporting Frequency	Data will be released by the Ministry of Health quarterly										
Improvement Activities	Patients contacted by primary care within 48 hours of discharge										

5.2.6 Remarks

Some of the interventions listed to support the contributory measures (especially Care Planning and POAC utilisation) represent both direct opportunities to affect the SLM, but also indirect opportunities to implement infrastructure or platforms that can be leveraged for more efficient implementation of subsequent initiatives such as clinical pathway implementation, integrated health & social services, targeted intense care through risk stratification and others.

Other initiatives not clearly described in this plan also will affect this SLM over the longer term. These initiatives include implementation of the Health Care Home model in general practice. This model

will increase general practice capacity and promote more effective and fit for purpose models of care within practices, specifically targeting acute care, planned proactive care and preventative care in tailored and person-centred ways. Another initiative is the potential implementation of the Northern Electronic Health Record, which has the potential to improve the safety and efficiency of care delivered across the entire patient journey if fully implemented.

Measures in Placeholder

1. **Average Length of Stay – current measure.** This will be monitored; however will not be included in the selected contributory measure for this SLM.
2. **Stranded patients whose stay is 21 days or longer.** Tracking this will allow us to see if we are being effective at preventing the very long admissions which are often complicated by social factors. This should be measured and tracked, but is not recommended as a contributory measure in the current plan.
3. **Top 5% of patients on risk stratification reports are in a structured care programme.** Planned proactive approach to long-term condition management. Recent data has demonstrated that patients who are in the top 5% of the risk stratification reports are six times more likely to have an acute medical admission within six months. With a planned proactive care approach we believe many of the patients in this 5% will have reduced acute hospital admissions, therefore we recommend this as a third contributory measure, noting that in order for it to be viable, the planned proactive care programme must be in place. Therefore this measure is contingent upon the selection of the recommended interventions in section 1.2 of the plan.
4. **Ratio of Arranged Admission (AA)/Acute Admission (AC).** This indicates better linkages between Primary Care and the hospital to improve the outcome. We believe more work should be undertaken to better understand the use of this measure, but note that it could in future be considered as a contributory measure.

5.2.7 Intervention Logic

Please refer to [5.2.2](#)

5.3 Patient Experience of Care

5.3.1 Definition

MoH definition for “Person centred care”; how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

5.3.2 Context and Rationale

The DHB Adult Inpatient Survey: Nationally applied and conducted quarterly since 2014 and. For the first year, the SLM milestone for patient experience should focus on the Adult Inpatient Experience Survey. This survey captures 4 measured domains-**communications, partnership, coordination, physical and emotional needs.**

Related interventions to improve patient experience scores in the 4 domains to promote survey uptake and use the results to improve quality. Individual DHBs need to improve the survey uptake results, particularly equity aspects and foster greater regional collaboration. This may include working with Maori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

Primary Health Care Patient Experience Survey (PHC PES) is currently in pilot phase. In Auckland ProCare (38 practices) and National Hauora Coalition (12 practices) PHOs are currently involved in the pilot. According to the HQSC, this will be implemented in all practices by May 2017, but it is critically dependent on establishment of the National Enrolment System, which has not yet been implemented in any practices.

E-Portals - patient portal is defined as “a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection” Data are managed by health care organisations, and enable patients to access information like recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results. They may also enable patients to request prescription refills, schedule non-urgent appointments, and exchange secure messaging with their providers. Patient portals are still in their infancy in New Zealand, and most primary care portals only currently have the functionality for patients to access lab results, book appointments, and order repeat prescriptions. Research has shown that the use of patient portals is associated with higher patient retention rates (which is related to continuity of care) and lower appointment no-show rates. Studies have documented high rates of patient satisfaction with portals, improvements in patient-provider communications and an increase in patients feeling that they were able to take a more active role in medical decision making. For those with a chronic illness such as diabetes, patient portals can also provide a vehicle to receive ongoing self-management support. Considering this measure, as it is clearly indicated in the measures library, more general practices are offering patient portals and there is scope within PHC to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling **coordinated** self-managed care provision; maintaining and providing online **communication**; and **partnering** with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-**physical needs**).

5.3.3 Improvement Milestone

Improvement milestone for the 2016-17 year is as follows:

The DHB Adult Inpatient Survey - Maintenance of an aggregated 8/10 score for all four domains across the three DHBs. It is suggested to maintain current state and continue to improve.

5.3.4 Selected Contributory Measures

1. The **DHB Adult Inpatient Survey** This is consistent with MoH patient experience, captured via nationally applied patient feedback survey.
2. **E-Portals** - 40% of PHO practices are registered with a portal and 10% of the PHO population have access to a portal.

5.3.5 Contributory Measures 2016-17 - Analysis and Justifications

4.2

1. The DHB adult inpatient survey

Item	Details																																				
Name	The DHB adult inpatient survey																																				
Definition	The HQSC has designed a 20 item adult inpatient survey (commenced July 2014) which is routinely used within hospitals to measure patient experience on a quarterly basis. The 4 key domains of patient experience are: communication, partnership, co-ordination, and physical and emotional needs. A selection of adults (n=400) who have spent at least one night in hospital are sent an invitation via email, text or post inviting them to participate in the survey. Responses are anonymous, unless patients choose otherwise.																																				
Rationale & Justification	A nationally applied measure, therefore uniform across the 3 DHBs and has been directed by the MoH. A focus on the 4 domain areas and the scoring for these will maintain the intervention for the first 12 months and start to highlight areas within each of the domains that need attention and intervention. For example, a CQI focus on the domain of communication may be fostered through a customer service training initiative for frontline staff. The challenge for equity allowance needs addressing, so by targeting this as a CM we may actively start to consider options to support the diverse Auckland Metro population, such as survey translation into other languages; survey via APPs.																																				
Data Collection	(1) Aggregated score for the 4 domains (out of 10) for each of the 3 Auckland DHBs; (2) No. of hospitalised patients aged ≥15y that provided feedback via the adult in-patient survey/No. of hospitalised patients aged ≥15y who are surveyed. Source: DHBs/HQSC Responsible persons: Jo Rankine (Quality Assurance Manager, CMDHB); Sarah Devine (Online Participation Manager, ADHB); David Price (Director, Patient Engagement, WDHB)																																				
Target & Target Justification	Maintenance of an aggregated score for the 4 domains of 8 out of 10 for each of the 3 Auckland DHBs; Maintain and continue to improve response rates for the DHB inpatient survey. Maintain current state for next 12 months. Focus on 1-2 domains, e.g. Communication to address risk areas tabled above and broaden equity lens.																																				
Current Performance	Results as at May 2016: <table><tr><th></th><th></th><th colspan="4">Score out of 10</th></tr><tr><th></th><th>Response Rate</th><th>Communica-tion</th><th>Coordi-nation</th><th>Partnership</th><th>Physical & emotional needs</th></tr><tr><td>National</td><td>27%</td><td>8.3</td><td>8.3</td><td>8.4</td><td>8.3</td></tr><tr><td>ADHB</td><td>17%</td><td>8.3</td><td>8.3</td><td>8.4</td><td>8.3</td></tr><tr><td>CMDHB</td><td>13%</td><td>8.2</td><td>8.0</td><td>8.4</td><td>8.0</td></tr><tr><td>WDHB</td><td>34%</td><td>8.4</td><td>8.4</td><td>8.3</td><td>8.7</td></tr></table>			Score out of 10					Response Rate	Communica-tion	Coordi-nation	Partnership	Physical & emotional needs	National	27%	8.3	8.3	8.4	8.3	ADHB	17%	8.3	8.3	8.4	8.3	CMDHB	13%	8.2	8.0	8.4	8.0	WDHB	34%	8.4	8.4	8.3	8.7
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WDHB	34%	8.4	8.4	8.3	8.7																																

Reporting Frequency	Quarterly Review of aggregated score for each of the four domains (communication, coordination, physical and emotional needs, partnership) each of the 3 DHBs of $\geq 8/10$ is achieved
Improvement Activities	Related interventions to improve patient experience scores in the 4 domains include investing in formal quality improvement methods such as Continuous Quality Improvement, widely promoting survey results among managers and front-line staff to encourage quality improvement, holding more frequent patient experience events (such as listening events), encouraging patient stories. The need to build on individual DHB endeavours to improve on the survey, particularly equity aspects (noted later) and foster greater regional collaboration. This may include working with Maori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives. Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

2. E-Portal (PHC Specific)

Item	Details
Name	E-Portals (PHC specific)
Definition	A single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records.
Rationale & Justification	E-Portals are clearly indicated in the measures library, more general practices are offering patient portals and there is scope within PHC for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).
Data Collection	(1) no. of practices with access to online GP portals/no. of GP practices; (2) pts that have an active username & login to use GP portals/no. of enrolled pts Source: Provider dependent PHO/MoH Responsible persons: PHO/MoH (Judy Eves (MoH))
Target & Target Justification	40 % of PHO Practices are registered with a portal 10 % of PHO population who have access to a portal (appt; labs/results; repeat Rx; clinical notes) Not all Auckland Metro PHOs have uptake, so applying this improvement milestone to achieve an increase in practices offering a portal and patients registered to use one will support patient

	<p>experience.</p> <p>With a focus on 1-2 domains of the SLM Milestone, e.g. Communication, gains can be made via an alternative communication point for patients with their General Practice Team (GPT), for blood result monitoring, repeat prescriptions, appointment bookings, and similarly with coordination, it may support reducing travel for some elderly patients or those with long term conditions to obtain information (www.patientportals.co.nz)</p>				
Current Performance					
	PHO	Practices with portal	%	Pts with login access	%
	Waitemata	20/50	40	12838/247727	5.2
	Total Health Care	7/7	100	309/101059	0.3
	NHC	0/26	0	0/84420	0
	East Health	8/22	36.4	16323/100282	16.3
	ProCare	88/182	48.4	45713/819432	5.6
	Auckland	10/25	40	4256/68814	6.2
	AH+	23/33	39.4	1675/106354	1.6
Reporting Frequency	Quarterly				
	Review of Number of Practices with a portal (and total number of practices)				
	Review of % of practices with a portal				
	Review of Patients with access to a Portal (and total number of enrolled Patients)				
	Review of % of patients with portal access.				
Improvement Activities	Activities in this area are not currently coordinated, number of e-portal ambassadors appointed by the National Health IT board who are able to talk with GPs and practices about the benefits of e-portals, but there is no current regular, structured programme for championing e-portals. Individual practices have their own procedures for notifying patients of available e-portals and giving out login instructions, but there is no regional/structured procedure.				

5.3.6 Remarks

The patient experience of care improvement approach is limiting in this first phase/year. The SLM milestone and associated two contributory measures have been identified, based on the MoH preferred direction. This includes an SLM milestone for Adult Inpatient Survey and E-Portal uptake (specific in this period to primary health care activity).

For associated contributory measure activity, refer to the Patient experience of Care Logic model ([Appendix 5.2.3](#)). It is critical to note this year's improvement planning focuses on maintenance of the DHB inpatient survey (with further exploration on refining this more appropriately) and expansion of E-Portal uptake specific to PHC.

Mapping for ongoing 2-5 year proposed activities in the areas of NES, PHC PES and Compassionate Care is provided. This work can only be enabled through the commitment, drive and review of a regional collaborative group (already established with patient experience position holders and experts across Auckland Metro) with the recommendation they meet at least on a monthly basis.

5.3.7 Intervention Logic

Please refer to [5.2.3](#)

5.4 Amenable Mortality

5.4.1 Definition

Premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75)

5.4.2 Context and Rationale

Amenable mortality contributory measures for the 2016-17 have been selected based on the following criteria;

1. To improve current gaps in equity
2. Have evidence based interventions available to reduce mortality
3. Have gaps in current performance,
4. Will align with regional activities already being undertaken in these areas,
5. Ability for sector to deliver on

Literature review confirms that early mortality could be prevented with early screening, adequate coverage of screening, access to evidence based interventions, access to newly funded treatment and use of evidence based clinical pathways would lead to a reduction in mortality in the contributory measures selected.

List of 35 amenable mortality conditions have been grouped into six super-categories:

1. Infections
2. Maternal and infant conditions
3. Injuries
4. Cancers
5. Cardiovascular diseases and diabetes
6. Other chronic diseases.

5.4.3 Improvement Milestone

Improvement milestone for the 2016-17 year is as follows:

It is recommended to maintain the overall current status at the current rate of:

DHB of Domicile	Deaths	Rates per 100,000
Waitemata	2352	84.9
Auckland	2007	98.7
Counties Manukau	3001	135.6

MoH-Amenable mortality, ages 0-74, 2009-2013 (Calculated using projected 2011 population data)

The main focus of the work will be condition specific, which will impact positively on the overall amenable mortality rate.

5.4.4 Selected Contributory Measures

The following contributory measures will be implemented in the 2016-17 year:

1. **CVD Risk Assessment** – to increase coverage of Maori to 90%
2. **CVD Management** - to increase triple therapy by 5% for those with a prior CVD event, those with a CVD RA of $\geq 20\%$ and with a particular focus on patients with diabetes
3. **Reduction in smokers** through increase support to quit - 10% from the baseline/DHB
4. **Increase in Maori breast screening** rates to reach 70% in all 3 DHBs
5. **Identification and treatment for patients with Hepatitis C**

The working group acknowledge that there are other areas of focus which will have a greater impact on amenable mortality at a population level and these are listed as placeholders to develop as resources and sector ability to implement matures:

5.4.5 Contributory Measures 2016-17 - Analysis and Justifications

1. Decrease in mortality associated with cardiovascular disease

Item	Details												
Name	CVD risk assessment and management – primary and secondary prevention												
Definition	90% CVD RA for all ethnicities with a particular focus on Maori coverage Improved CVD management for Secondary and Primary Prevention												
Rationale & Justification	Equity gap is clear for Maori CVD risk assessment for Maori is lower than 90% National Target NRA reports have shown a marked gap in CVD management.												
Data Collection	NRA benchmarking reports and PHO quarterly reports.												
Target & Target Justification	By June 2018: 90% coverage for Maori – National target which has not yet been achieved. By June 2018: 5% increase in dual/triple therapy for those with a high CVD risk (≥ 20%), those with a prior CVD event and a particular focus on diabetes status. This target reflects the Northern Region Cardiac KPI goal. By June 2017 a 2.5% increase in dual/ triple therapy for primary and secondary prevention cohorts. (2017 Target to be confirmed)												
Current Performance	Māori CVD risk assessment rates for CMDHB: 88.8% ADHB: 89.3 % WDHB: 86.9% Young male Māori screening rates are well below the target with CMDHB currently screening only 72.6% of the eligible population, while ADHB have screened 76.2% and WDHB 71.2% as at the 30th of June 2016. CVD Management of patients with a prior CVD event: <table><tr><td>NRCN results (12mo ended 31Mar16)</td><td></td><td></td><td></td></tr><tr><td>PRIOR CVD ON TRIPLE</td><td>ADHB</td><td>CMDHB</td><td>WDHB</td></tr><tr><td>Numerator</td><td>4018</td><td>5975</td><td>6565</td></tr></table>	NRCN results (12mo ended 31Mar16)				PRIOR CVD ON TRIPLE	ADHB	CMDHB	WDHB	Numerator	4018	5975	6565
NRCN results (12mo ended 31Mar16)													
PRIOR CVD ON TRIPLE	ADHB	CMDHB	WDHB										
Numerator	4018	5975	6565										

	Denominator		7610	10,356	12,157		
	Percentage		52.8%	57.7%	54.0%		
	NRCN Prior CVD on Triple						
	Māori	Pacific	Asian	Indian	Other	People with Diabetes	
	Auckland						
	Denominator	623	1004	819	770	4394	2620
	Percentage	49.3%	57.0%	49.0%	62.3%	51.4%	62.6%
	Counties Manukau						
	Denominator	1627	2107	595	866	5161	4207
	Percentage	54.1%	60.8%	50.9%	67.8%	56.6%	67.5%
	Waitemata						
	Denominator	803	764	825	479	9286	3461
	Percentage	55.5%	59.7%	46.2%	62.4%	53.6%	65.9%
	NRCN results (12mo ended 31Mar16)						
	CVDRA OVER 20% ON DUAL		ADHB		CMDHB	WDHB	
	Numerator		3303		7180	4126	
	Denominator		8017		14563	9918	
	Percentage		41.2%		49.3%	41.6%	
	NRCN Prior CVD on Triple						
	Māori	Pacific	Asian	Indian	Other	People with Diabetes	
	Auckland						
	Denominator	833	1918	919	885	3462	4671
	Percentage	40.1%	48.2%	44.7%	43.5%	36.0%	53.0%
	Counties Manukau						
	Denominator	2442	5002	903	1503	4712	9902
	Percentage	48.8%	54.9%	42.0%	51.9%	42.2%	59.2%
	Waitemata						
	Denominator	946	1214	1024	583	6151	5085
Percentage	42.8%	49.4%	38.9%	44.9%	40.0%	54.9%	
Reporting Frequency	Quarterly PHO reports, 6 monthly Northern Region Cardiac Network reports Evaluation will be determined by the movement towards the goals through quarterly PHO reports and 6 monthly						
Improvement Activities	CVD RA access improvement & Improving CVD management for those with a high CVD risk (≥ 20%) , those who have had a prior CVD event 2° prevention management and patients with diabetes						

2. Decrease in mortality associated with smoking related diseases through increased quit attempts and increased support to quit

Item	Details
Name	Reduction in smoking rates
Definition	A documented increase in smoking cessation attempts using the following Cessation Support codes: ZPSC10 – Referral to smoking cessation support

Item	Details
	ZPSC20 – Prescribed smoking cessation medication ZPSC30- Provided smoking cessation behavioural support.
Rationale & Justification	The Auckland Metro DHBs have achieved the 'brief advice 'better help for smokers to quit health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. The rate for Cessation Support for quarter 4 2015-16 was 24.1% for CMDHB 26.8% for ADHB 33.7% for WDHB
Data Collection	The codes above are collected through PHO PMS data extraction Data will also be provided by the new smoking cessation providers
Target & Target Justification	Working towards the 2025 Smoke Free Target : ADHB Currently estimated there's 47,000 smokers aged 15+ in ADHB (based on 2013 smoking prevalence). By 2025 we need to reduce this to around 24,500 to be below 5%. This equates to around 2,500 smokers each year that need to quit. For Maori and Pacific there are around 16,500 adult smokers and we need to reduce this number to 4,100 by 2025 to reach 5% within this group. This equates to around 1,400 Maori and Pacific adults needing to quit each year. However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 26.8%) WDHB Currently estimated there's 57,000 smokers aged 15+ in WDHB (based on 2013 smoking prevalence). By 2025 we need to reduce this to around 27,700 to be below 5%. This equates to around 3,350 smokers each year that need to quit. For Maori and Pacific there are around 16,600 adult smokers and we need to reduce this number to 4,300 by 2025 to reach 5% within this group. This equates to around 1,400 Maori and Pacific adults needing to quit each year. However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 24.1%) CMDHB Current quit activity is unlikely to achieve a Smokefree CMDHB district by 2025, based on recent Census data. To achieve this goal, increased quit volumes are needed to encourage Maori and Pacific people who smoke to quit. Between 2016 and 2025, an average of about 2,400 Maori and Pacific people who smoke are required to quit each year. In terms of volume of supported quit attempts this is approximately 7,200 extra

Item	Details			
	supported quit attempts/year. However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 33.7%)			
Current Performance		Current smoker or recently quit	Eligible population with recorded smoking status	Rate
	WDHB			
	Maori	10,156	29,411	35%
	Pacific	4,767	22,083	22%
	Other	34,858	303,840	11%
	ADHB			
	Maori	8,692	25,527	34%
	Pacific	12,011	55,040	22%
	Other	29,204	313,874	9%
	CMDHB			
	Maori	21,878	51,688	42%
	Pacific	21,677	80,875	27%
	Other	25,859	231,031	11%
Reporting Frequency	Quarterly from PHO Quarterly from smoking cessation providers Analysis on a quarterly basis on movement towards the target of baseline activity + 10% for each DHB			
Improvement Activities	Smoking Cessation			

3. Decrease in mortality associated with breast cancer

Item	Details																																																																
Name	Increasing the coverage rate of breast screening across the Auckland Metro region with a particular focus on Maori women.																																																																
Definition	Number of women accessing breast screening by ethnicity																																																																
Rationale & Justification	Breast screening programmes achieving coverage of 70% eligible women can reduce mortality from breast cancer by 30-35% for women who are screened compared to those who were not.																																																																
Data Collection	Quarterly data from Breast screen providers in WDHB, ADHB and CMDHB.																																																																
Target & Target Justification	<table><tr><th>DHB June 2016</th><th>Ethnicity</th><th>Census projection number of women</th><th>Women screened in last 2 years</th><th>2 year coverage %</th><th>Number of women required to reach 70% target</th></tr><tr><td rowspan="4">Waitemata</td><td>Maori</td><td>4,380</td><td>2,813</td><td>64.2%</td><td>253</td></tr><tr><td>Pacific</td><td>3,310</td><td>2,540</td><td>76.7%</td><td></td></tr><tr><td>Other</td><td>60,220</td><td>40,287</td><td>66.9%</td><td>1,867</td></tr><tr><td>Total</td><td>67,910</td><td>45,667</td><td>67.2%</td><td>1,870</td></tr><tr><td rowspan="4">Auckland</td><td>Maori</td><td>3,400</td><td>2,035</td><td>59.9%</td><td>345</td></tr><tr><td>Pacific</td><td>4,520</td><td>3,365</td><td>74.4%</td><td></td></tr><tr><td>Other</td><td>42,710</td><td>27,270</td><td>63.8%</td><td>2,627</td></tr><tr><td>Total</td><td>50,630</td><td>32,772</td><td>64.7%</td><td>2,669</td></tr><tr><td rowspan="2">Counties</td><td>Maori</td><td>6,210</td><td>4,091</td><td>65.9%</td><td>256</td></tr><tr><td>Pacific</td><td>8,340</td><td>6,274</td><td>75.2%</td><td></td></tr></table>						DHB June 2016	Ethnicity	Census projection number of women	Women screened in last 2 years	2 year coverage %	Number of women required to reach 70% target	Waitemata	Maori	4,380	2,813	64.2%	253	Pacific	3,310	2,540	76.7%		Other	60,220	40,287	66.9%	1,867	Total	67,910	45,667	67.2%	1,870	Auckland	Maori	3,400	2,035	59.9%	345	Pacific	4,520	3,365	74.4%		Other	42,710	27,270	63.8%	2,627	Total	50,630	32,772	64.7%	2,669	Counties	Maori	6,210	4,091	65.9%	256	Pacific	8,340	6,274	75.2%	
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Item	Details					
		Other	41,290	28,076	68.0%	827
		Total	55,840	38,464	68.9%	624
	National	Maori	58,860	38,385	65.2%	2,817
		Pacific	22,830	16,527	72.4%	
		Other	475,975	342,921	72.0%	
		Total	557,665	398,440	71.4%	
	<p>The target for 2016-17 is to increase coverage in Maori women, in particular to reach 70%.</p> <p>Over the coming years the focus will then shift towards supporting women to treatment – particularly Pacific women.</p>					
Current Performance	As above					
Reporting Frequency	<p>Quarterly reporting from Breast Screen Providers</p> <p>Movement towards the goal of 70% coverage by June 2018, particularly for Maori women.</p>					
Improvement Activities	Three Hundred Campaign - Improving Breast Screening Rates across Auckland					

4. Reducing mortality from Hepatitis C

Item	Details
Name	Identification and treatment for patients with Hepatitis C
Definition	<p>Identification and Treatment for patients with Hepatitis C – targeting the following communities at risk:</p> <ul style="list-style-type: none"> • People whom inject drugs • Tattooing or piercing in an unlicensed parlour • Ever been in prison • Medical procedure overseas or in NZ pre-1992 (blood screening started) • Lived in high risk countries (Middle Eastern, Indian Subcontinent, Southeast Asia, Eastern Europe, Russia) • Born to a mother with Hep C
Rationale & Justification	<ul style="list-style-type: none"> • Harm from illicit drugs makes up 1.2% of NZ's health loss and there are significant productivity losses from chronic liver diseases. • There are very large ethnic and deprivation inequalities in Hep C harm. • Hepatitis C affects 1.1% of population in NZ with 50,000 patients infected nationally. • Auckland Metro has approximately 18,000 patients, • In the Northern Region there are 2,100 patients identified in secondary care, with another estimated 8-10,000 patients identifiable within primary care PMS audits. (i.e. 40-60% of people are not aware they have HCV) • There were 580 new patients in Auckland Metro area in 2015. • It is anticipated that in this first year of having Treatment for genotype 1's (57% of all Hep C) available this will increase to somewhere between 4,000-4,500 new diagnosis for year 1 of the project • There is new funded Direct Acting Antivirals available

Item	Details
	<ul style="list-style-type: none"> There is a new clinical pathway for the identification and management of Hepatitis C available There is a simplified process of screening through reflex blood testing on positive results There will be an e-referral mechanism for liver elastography scan referrals
Data Collection	Obtained from PHO PMS, testsafe and DHB reporting systems
Target & Target Justification	By June 2018: 10% of those identified in PMS' will be treated (measured through quarterly reports) 30% of those identified in secondary care will be treated (measured through quarterly reports)
Current Performance	Currently there is less than 1% access to interferon based funded treatment.
Reporting Frequency	PHO quarterly reports DHB quarterly reports Evaluated by Movement towards the primary care and the secondary care targets.
Improvement Activities	Hep C Treatment

5.4.6 Remarks

The contributory measures chosen for the first year relied on activities already underway and the ability of sector to deliver on given the short time frame. Some contributory measures have had to be delayed until further analysis is completed. Challenges to collect PHO data will need to be addressed to reduce variations amongst selected contributory measures.

Additional contributory Measures for 2017-18:

There are other areas of focus which will have a greater impact on amenable mortality at a population level. In particular a diabetes suite of indicators will be incorporated into the 2017 and 2018 work plan. The ADHB/WDHB Diabetes Service Level Alliance and the evaluation of the CMDHB Modified Diabetes Care Improvement Programme are to be used to inform the 2017-18 improvement plan. Similarly, 2017 will also be used as a research and analysis year for strategies to improve HPV Vaccination coverage.

1. Diabetes *

- HbA1c glycaemic control
- Blood pressure control
- Management of microalbuminuria

* Diabetes as a contributory measure will be included in the 2017/2018 out years. The reason for the delay is awaiting the completion of the evaluation of the modified Diabetes Care Improvement Package in CMDHB and the ADHB/WDHB Diabetes Service Alliance Business Case completion, both of which are due in March/April 2017.

In the meantime, in 2016-17 there will be a particular focus on CVD management for patients with diabetes who have had a prior CVD event or have a CVD Risk Assessment of $\geq 20\%$.

2. **HPV vaccination coverage** – although the numbers of deaths associated with cervical cancer are low as a result of the cervical screening programme, the vaccine is a preventative measure for oropharyngeal cancer associated with HPV and will reduce the frequency of cervical screening. The coverage rate for HPV vaccination in CMDHB and WDHB is low (61.7% and 60.2%) respectively compared with ADHB (83.3%). It is proposed that 2017 will be used as a research and analysis year to understand the discrepancy and improve visibility of declines to primary care.
3. **Bowel Cancer** identification and screening – awaiting the National roll out of the bowel screening programme
4. **Mental health** – improved screening coverage for high risk patient populations and for those at risk of suicide
5. **Endometrial Cancer** identification and treatment
6. **Melanoma** identification and treatment
7. **Atrial fibrillation** will need consideration in future years

5.4.7 Intervention Logic

Please refer to [5.2.4](#)

6. APPENDIX

6.1 Glossary

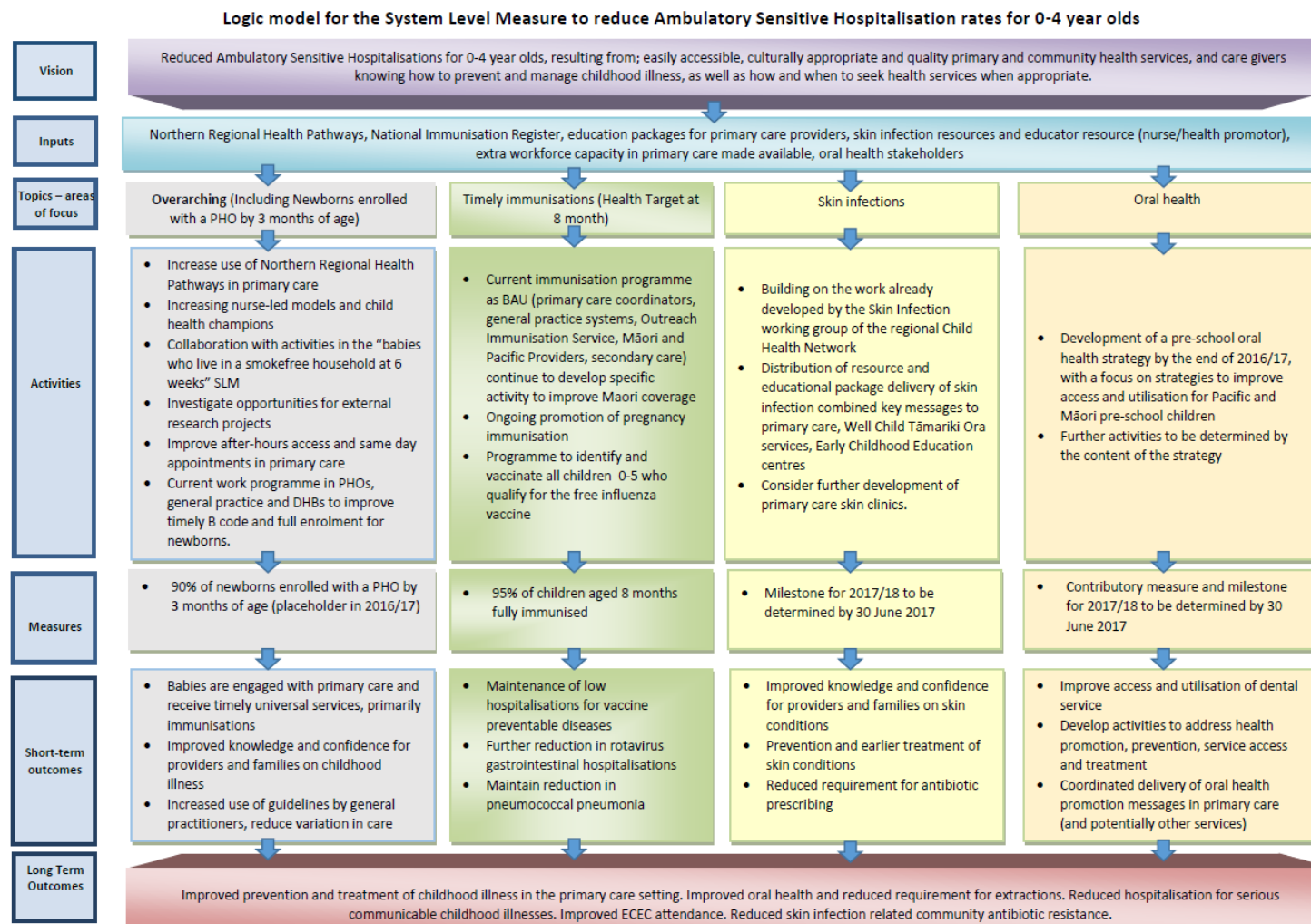
ACP	Advanced Care Plan
ADHB	Auckland District Health Board
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ARDS	Auckland Regional Dental Services
ARI	At Risk Individuals
ASH	Ambulatory Sensitive Hospitalisation
CMDHB	Counties Manukau District Health Board
CM Health	Counties Manukau Health
DHB	District Health Board
FFT	Family and Friends Test
GP	General Practitioner
HCV	Hepatitis C virus
HPV	Human Papilloma Virus
HQSC	Health Quality and Safety Commission
IPIF	Integrated Performance and Incentive Framework
MoH	Ministry of Health
NCHIP	National Child Health Information Platform
NES	National Enrolment System
NNPAC	National Non-Admitted Patient Collection Data Mart (NNPAC DM)
PHC PES	Primary Health Care Patient Experience Survey
PHO	Primary Health Organisation
POAC	Primary Options for Acute Care
SLMs	System Level Measures
UK	United Kingdom
WDHB	Waitemata District Health Board

6.2 Intervention Logic

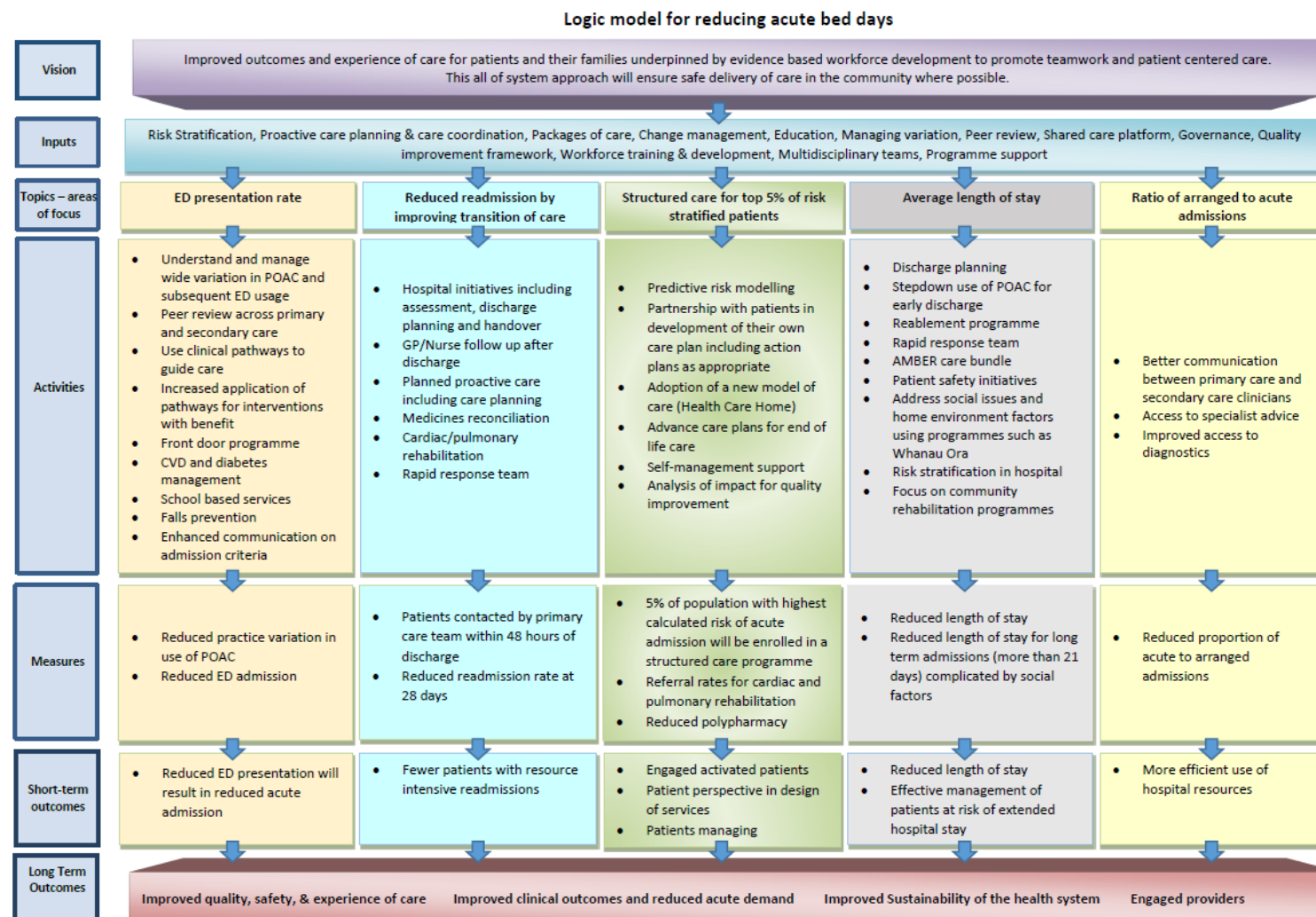
The intervention logic and outcomes framework summarises the key priorities that inform this 2016/17 Annual Plan, including the key measures we monitor to ensure that we are achieving our objectives. Our outcomes framework enables the DHB to ensure it is achieving its vision and delivering the best possible outcomes across the whole system for our population.

6.2.1 Ambulatory Sensitive Hospitalisations (ASH) Rate	See following.
6.2.2 Acute Hospital Bed Days Per Capita	See following.
6.2.3 Patient Experience of Care	See following.
6.2.4 Amenable Mortality	See following.

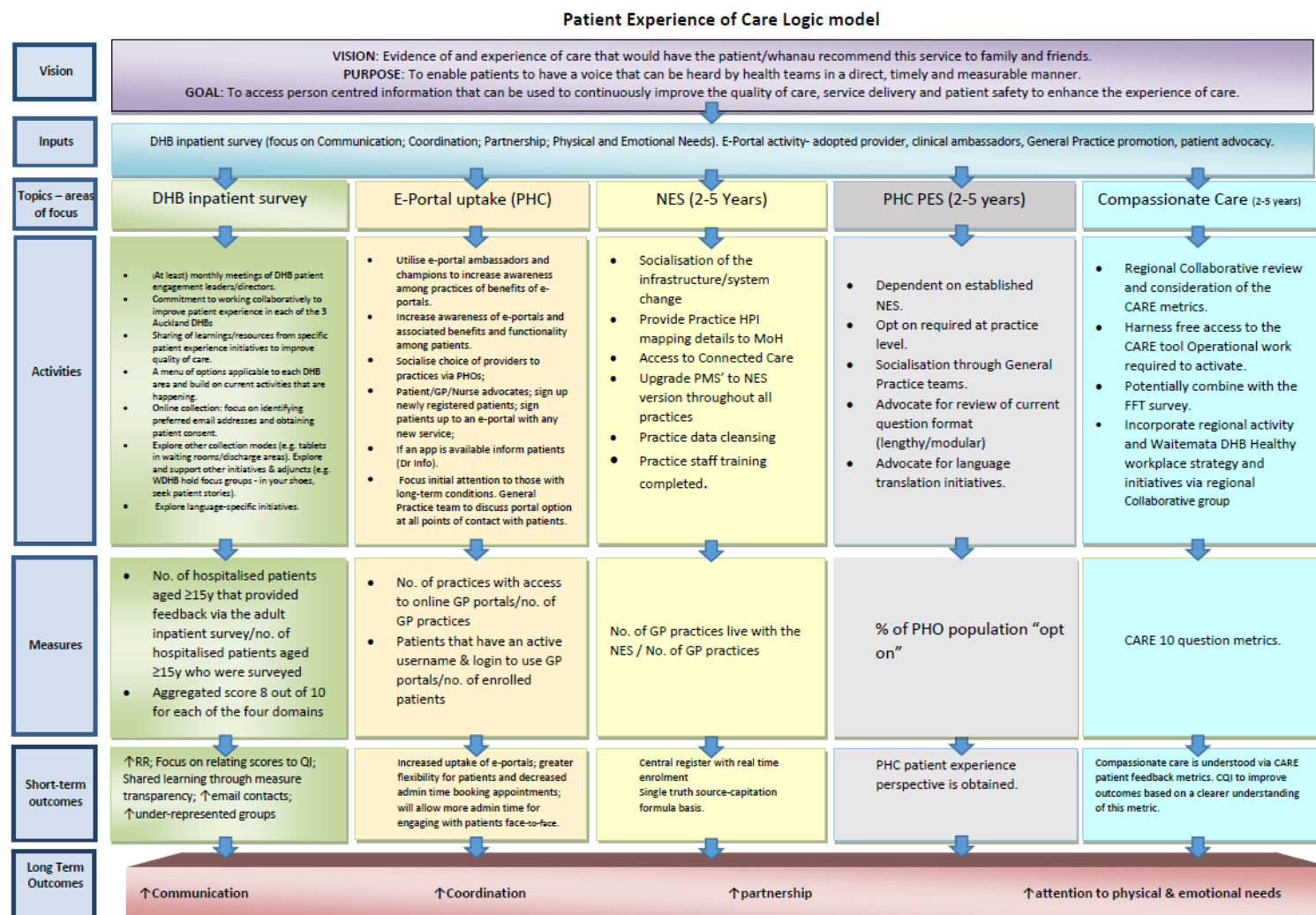
6.2.1 Ambulatory Sensitive Hospitalisations (ASH) Rate



6.2.2 Acute Hospital Bed Days Per Capita



6.2.3 Patient Experience of Care



6.3.4 Amenable Mortality

