Community and Public Health Advisory Committees Meeting

Wednesday 21 November 2018

10.00am

Venue

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

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

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

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

Well Being to All.

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitemata District Health Board
Best Care for Everyone

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
21 November 2018

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

COMMITTEE MEMBERS	MANAGEMENT
Sharon Shea – Committee Chair (ADHB Board member) Max Abbott - WDHB Board member Judith Bassett – ADHB Board member Edward Benson Cooper - WDHB Board member Zoe Brownlie - ADHB Board member Sandra Coney - WDHB Board member Warren Flaunty - Committee Deputy Chair (WDHB Board member) Matire Harwood - WDHB Board member Lee Mathias - ADHB Board member Robyn Northey - ADHB Board member Allison Roe - WDHB Board member Board chairs: Judy McGregor – Ex-officio as WDHB Board Chair Pat Snedden – Ex-officio as ADHB Board Chair	Dale Bramley - WDHB, Chief Executive Ailsa Claire - ADHB, Chief Executive Debbie Holdsworth - ADHB and WDHB, Director Funding Karen Bartholomew - ADHB and WDHB, Director Health Outcomes Nicole Song - WDHB, Board Secretary

Apologies: Max Abbott

AGENDA

KARAKIA

ACKNOWLEDGEMENTS

DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
10.00am	2.1	Confirmation of Minutes of the meeting held on 29/08/2018
		Actions Arising from previous meetings
	2.2	Circulated Resolution 25 September 2018
	3.	**DECISION PAPER**
10.05am	3.1	Community Water Fluoridation Position Statement
	4.	**INFORMATION PAPER**
10.35am	4.1	Oral Health in the Auckland Region
11.05am	4.2	Auckland Regional Public Health Service (ARPHS) update
	5.	**STANDARD REPORTS**
11.35am	5.1	Planning, Funding and Outcomes Update - Executive Summary - Planning - Primary Care - Child, Youth and Women - Health of Older People - Māori Health Gain - Pacific Health Gain - Asian, Migrant and Refugee Health Gain
	6.	**GENERAL BUSINESS**

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2018

NAME	April	June	August	November
Sharon Shea	✓	✓	✓	
Max Abbott	✓	✓	✓	
Judith Bassett	✓	✓	✗	
Edward Benson Cooper	✓	✓	✓	
Zoe Brownlie	✓	✓	✗	
Sandra Coney	✓	✗	✗	
Warren Flaunty	✓	✓	✗	
Matire Harwood	✓	✗	✓	
Lee Mathias	✓	✓	✓	
Robyn Northey	✓	✓	✓	
Allison Roe	✗	✓	✗	

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

Community and Public Health Advisory Committee (CPHAC)

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Advisor – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board member – Rotary National Science and Technology Forum Trust	19/03/14
Judith Bassett	Trustee - A+ Charitable Trust Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Corporation Granddaughter - shareholder of Westpac Corporation Daughter – Human Resources Manager at Auckland DHB (past role)	19/09/18
Edward Benson-Cooper	Chiropractor – Milford, Auckland (with private practice commitments)	07/12/16
Zoe Brownlie	Programme Supervisor at Auckland Regional Public Health Service Member – PSA Union Board member - RockEnrol Partner – Youth Connections, Auckland Council Partner – Aro Arataki Children's Centre Committee Son – Aro Arataki Childcare Centre	26/06/18
Sandra Coney	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust Member – Portage Licensing Trust Member – West Auckland Trusts Services	15/12/16
Warren Flaunty	Member - Henderson–Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role)	12/09/18
Dr Matire Harwood	Senior Lecturer - Auckland University Director - Ngarongoa Limited, which is contractor providing services to National Hauora Coalition GP at Papakura Marae Health Clinic Advisory Committee Member - State Foundation NZ (Maori Health) Member Te Ora, Maori Medical Practitioners Step-daughter is a surgical registrar at Waitemata DHB	10/05/18
Lee Mathias	Chair - Health Promotion Agency Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment) Chair – Medicines New Zealand Director/shareholder - Pictor Limited Director – Pictor Diagnostics India Private Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party Director - Health Alliance Limited (ex officio Auckland DHB) (past role)	07/08/18

Committee Member	Involvements with other organisations	Last Updated
Robyn Northey	Shareholder of Fisher & Paykel Healthcare Shareholder of Oceania Member – New Zealand Labour Party Husband - member Waitemata Local Board Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Community Housing Foundation	05/07/17
Sharon Shea	Principal - Shea Pita Associates Ltd Provider - Maori Integrated contracts for Auckland and Waitemata DHBs Provider – Hapai Te Hauora Board member – Alliance Health Plus Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua Sub-contractor - Te Ha Oranga/Te Runanga o Ngati Whatua Director – Healthcare Applications Ltd Husband - Part owner Turuki Pharmacy Ltd, Auckland Husband - Board member - Waitemata DHB Husband – Director Healthcare Applications Ltd	09/07/18
Allison Roe	Chairperson - Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council Member - Wilson Home Committee of Management (past role)	22/08/18
Judy McGregor	Head of School, Social Science and Public Policy - Auckland University of Technology Associate Dean Post Graduate - Faculty of Culture and Society Member - AUT's Academic board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	28/06/18
Pat Snedden	Director and Shareholder – Snedden Publishing & Management Consultants Limited Director and Shareholder – Ayers Contracting Services Limited Director and Shareholder – Data Publishing Limited Trustee - Recovery Solutions Trust Director – Recovery Solutions Services Limited Director – Emerge Aotearoa Limited and Subsidiaries Director – Mind and Body consultants Ltd Director – Mind and Body Learning & Development Ltd Shareholder – Ayers Snedden Consultants Ltd Executive Chair – Manaiakalani Education Trust Chair – National Science Challenge Programme – A Better Start Chair – The Big Idea – Not-for-profit-trust Director – Te Urungi o Ngati Kuri Ltd Director – Wharekapua Ltd Director – Te Paki Ltd Director – Ngati Kuri Tourism Ltd Director – Waimarama Orchards Ltd Chair – Auckland District Health Board Director – Ports of Auckland Ltd Board member – Counties Manukau DHB Chair – Counties Manukau Audit, Risk and Finance Committee	09/10/18

2.1 Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee Meeting 29 August 2018

Recommendation:

That the draft minutes of the Community and Public Health Advisory Committee meeting held on 29 August 2018 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 29 August 2018

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

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS:

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

ALSO PRESENT:

Judy McGregor (WDHB Board Chair)
Dale Bramley (WDHB Chief Executive Officer)
Ailsa Claire (ADHB Chief Executive Officer) (joined at 10:20 am, item 3.1)
Debbie Holdsworth (ADHB and WDHB Director Funding)
Karen Bartholomew (ADHB and WDHB Acting Director Health Outcomes)
Meg Poutasi (Auckland DHB Chief Strategy, Participation and Improvement)
Nicole Song (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:

Sue Claridge (Auckland Women's Health Council)
Tracy McIntyre (Waitakere Health Link)
Gaylene Sharman (Te Puna Manawa HealthWest Ltd)
Christine Masiasomua (Te Puna Manawa HealthWest Ltd)
Hayley Marshall (Te Puna Manawa HealthWest Ltd)
Sheena Fatialofa (Te Puna Manawa HealthWest Ltd)

KARAKIA:

The Committee Chair opened the meeting with a prayer.

WELCOME:

The Committee Chair welcomed those in attendance at the meeting. The Chair confirmed that the quorum is met with 6 members in attendance.

APOLOGIES:

An apology was received and accepted from Sandra Coney, Judith Bassett, Zoe Brownlie, Allison Roe, and Warren Flaunty.

DISCLOSURE OF INTERESTS

There were no declarations of interests relating to the agenda. Lee Mathias advised that her directorship ceased at healthAlliance Limited as of 30 July 2018.

ACKNOWLEDGEMENTS

Matire Harwood acknowledged Professor Papaarangi Reid who has had inaugural professorial lecture earlier this month as the first Māori Health professor at the University of Auckland.

This was acknowledge and endorsed by the Chair.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 06/06/18 (agenda pages 7 to 12)

Resolution (Moved Lee Mathias/Seconded Robyn Northey)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 06 June 2018 be approved.

Carried

Matters Arising (agenda pages 13)

Debbie Holdsworth (Director, Funding) summarised the matters arising reported.

In respect of adolescent oral health update provided in the PFO Update Report for this meeting, it was commented that this has improved greatly but work is still required to reach children in primary and secondary schools. Debbie Holdsworth

advised that for the next meeting there will be a more detailed report on oral health strategy.

3. STANDARD REPORT

3.1 Planning, Funding and Outcomes Update (agenda pages 14 to 57)

Executive Summary

Debbie Holdsworth introduced this item and went through the highlights in the Executive Summary. Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health) was present for this part of the meeting.

It was commented that in respect of HPV immunisation coverage, some practices are still waiting for supply of the vaccine. Ruth Bijl advised that there was some delay for vaccine in primary care but the programme for intermediate schools has been well maintained. It was noted that over 65% is considered as the percentage for herd immunity.

Planning

The following matters were discussed and responded to:

- The first draft of 2018/19 Auckland and Waitemata DHB Annual Plan has now been submitted to the Ministry of Health awaiting feedback on 13 September. In the meantime, work on the annual report continues. The first draft will be presented to the DHBs' respective Audit and Finance Committees.

- Ministry of Health Achieving Equity in Health Outcomes work programme - joint Ministry and sector co-leadership and governance arrangements have been established to advance the Government's priorities. Dale Bramley (Waitemata DHB Chief Executive Officer) advised that this is a jointly-led programme with Alison Thom (Māori Leadership, Ministry of Health) with the aim to make rapid progress on the identified priority areas. Engagements with key stakeholders have commenced including Māori academics, NGOs and Iwi, with Sir Mason Durie acting as a peer reviewer. Following the initial Cabinet briefing in the last few weeks, the outline of the framework is expected to be confirmed by the end of this year. This programme is well underway and received good support.

- Debbie Holdsworth advised that there were a lot of "red" (not achieved/off-track) on the Auckland and Waitemata DHB Quarterly Performance Scorecard. The scorecard focuses on equity and data is reported in a transparent manner to support performance improvement and/or maintain high levels of performance.

Primary Care

Tim Wood (Deputy Director Funding, Auckland and Waitemata DHB) joined the meeting and introduced the report.

He highlighted that the Nurse led x-ray service was well received in Great Barrier Island. With digitally upgraded radiography equipment and well-trained nursing team, it is expected to be a resilient and frequently-used service. The Committee acknowledged Lis Cowling for her special effort in delivering this service.

The Committee then discussed whether there is room for opportunities for the DHBs to undertake a review of the role of nurses based on the notion that nurses' services can be used more widely. The Committee agreed that this case of nurse led x-ray service sets a precedent for further development in the role of nurses in the community. Dale Bramley advised that Waitemata DHB is commencing a deep dive with SMT in this area. Ailsa Claire (Auckland DHB Chief Executive Officer) advised that Auckland DHB already has a nursing strategy in place as part of its deep dive looking at what workforce is needed to meet its LTIP.

Tim Wood advised that acceptance of nurses having expanded roles was variable and poses a challenge when introducing these expanded roles. There are more opportunities for nurses in rural areas to expand their roles. It was noted that at Auckland DHB, there are more nurses who engage in consultant-level and specialist roles.

The Committee agreed in principle that the example of using Nurses in more diverse and 'top-of-scope' clinical ways, should be explored and expanded across community and public health services. The importance of ensuring Nurses are valued was highlighted as an ongoing issue of top importance.

Following discussion from the CEs that ongoing nursing workforce strategy development and/or implementation is underway, it was noted that the Committee would pay attention to strategy that supports (i) the scope of nurse practice; (ii) associated models of care; and (iii) ensuring that Nurses are fully valued. In addition, the Committee will have an opportunity give feedback to the two Boards on the matter.

Diabetes Management

A member commented that the CVD clinical indicators (Table 2) show a decline in many areas. It was queried whether enough demands are being made on the PHO to get Māori and Pacific patients better serviced.

Tim Wood responded as follows:

- The co-design work with Māori and Pacific people showed that they were not sufficiently engaged with primary care and felt that they were not heard by GPs
- It also showed that many of them were unaware of their condition until GPs intervened. Many will then, however, not follow-up with GP visits (or vice versa).
- Putting pressure on the PHO without changing the culture is unlikely to achieve the desired outcome.

The Committee queried what strategies might be implemented to address the findings from the co-design. Tim Wood advised that a work/coaching programme

(expected to take 18 months to 2 years) is in place to work with 12 GP teams who have high Māori and Pacific people as their patients and will collate responses received from that programme to work out specific strategies to make changes. So far, the preliminary findings show that there is room for improvement in GPs' knowledge about their enrolled patients as many did not know that they had diabetes or how frequently they visit the practices. Overall, it was found that the systems many practices have are not fit for purpose.

Debbie Holdsworth noted that updates on this plan will be reported to the Committee but that the Committee should note that change is difficult and the resources are constrained given the respective DHB's financial status.

Matire Harwood shared her views as a GP that many GPs are aware of the issue and feel time-constrained to engage better with patients. Others feel that patients need to manage their long term conditions and be responsible to visit their GPs more frequently. It is a complex problem and will take time to implement any meaningful change.

The Committee thanked Tim Wood for his work and requested his reporting to the Committee include a more detailed work plan about the initiatives.

Children, Youth & Women

Ruth Bijl was present for this part of the meeting.

A member queried the impact of the electoral census data on the data used for this report. Ruth Bijl explained that the DHBs only recently obtained dental National Health Index (NHI) level of data and that it still requires much analysis. Any findings from that analysis will continue to be reported back to the Committee.

Judy McGregor (Chair, Waitemata DHB) commented that the problem with approx 10-20% underreporting of the census data was discussed at the recent DHB Chairs meeting. The Committee agreed that the health sector, in general, needs to be more active about the problem associated with underreported statistics and that a follow-up survey and engagement with Statistics NZ may be necessary.

Karen Bartholomew (ADHB and WDHB Acting Director Health Outcomes) advised that there is technical work being undertaken on this matter and that there will be opportunities to share the findings with the DHBs. Dale Bramley suggested that the DHBs wait until this further work is completed.

The Committee agreed that once the post-survey results are produced then Statistics NZ should be engaged based on the findings.

Matters covered in discussion and response to questions included:

- Mumps vaccination is not in the Immunisation Schedule for the Pacific Islands and it will require a national decision to ensure that Pacific Peoples' are immunised when arriving in New Zealand.

- The new dental school in Counties Manukau is a great initiative to meet high health needs in the local community and is supported by the metro Auckland DHBs. There was a view that this service would be provided for all of Auckland city.
- Maternal health area requires early intervention to support access to child/infant care well before a child reaches school age. Ruth Bijl advised that a concept is being developed to better identify the needs and rapid entry into 'wrap around' services but that this is not yet ready for reporting. She further advised that the current system is fragmented and may require additional investment.
- A query was raised about maternal suicide and DHB actions. The maternal service group is working closely with the mental health service with respect to understanding and addressing this issue.
- Child wellbeing is one of four key priorities and the two DHBs are working in partnership with the Department of Prime Minister and Cabinet to redesign healthcare system for child well-being.

Mental Health and Addictions

Judy McGregor noted that a new directory has been set up within the Ministry of Health to prepare for results of the Government's inquiry into mental health and addictions. Trish Palmer (Funding and Development Manager Mental Health and Addiction Services) advised that the Ministry has a national leadership group to set up a structure for a clear direction for inter-sectoral collaboration and to prepare a platform for the inquiry requiring a system transformation.

In terms of the level of preparedness, Trish Palmer advised that Auckland DHB is continuing its cross-sector workshop to identify all changes that are expected to be developed in its 3-year action plan.

Ailsa Claire advised that equal-pay did not initially apply to mental health workers in the private sector and the NGO contractual terms varied significantly across the country. Work has now commenced by Auckland DHB to ensure consistency in measuring context and outcomes, especially for small NGOs where obligations can be more onerous. It was found that there are areas (in NGO contracts) where there is also a contract with ACC for the same work. There were also some concerns about quality and viability of smaller NGOs.

Dale Bramley added that, other than the current Government inquiry, there is also a national programme run by the Health Quality and Safety Commission for mental health and addiction quality improvement, which will focus on service transition from DHB specialist services to DHB community teams, from DHB specialist services to primary care and/or NGO services and from youth to adult services (three work streams on transition); in addition to a national survey assessing patient experience with mental health care. Further, using seclusion units for mental health patients is being looked at by Auckland DHB with the aim to reach 'zero-seclusion'.

Debbie Holdsworth advised that the Health Workforce Development Fund may create an opportunity for investment in non-clinical staffing in mental health and addiction area, which went unrecognised for some time.

Pacific, Asian, Migrant and Refugee Health Gain

Lita Foliaki (Manager Pacific Health Gain), who was present at the meeting, was asked by the Committee to share her views on this topic. Lita stated that:

- that Alliance Health Plus PHO's services are helpful in situations where there are combinations of factors contributing to unmanaged diabetes (e.g. domestic violence, depression, etc). The PHO provides a multidisciplinary team approach with Pacific Peoples'. The Team comprises community health workers, social workers and nurses who are mobile and can visit families at home to identify a number of connected issues.

- Findings on these services could be added to Tim Wood's update on diabetes.

Raj Singh (Project Manager Asian, Migrant and Refugee Health Gain) highlighted the rolling out of the Refugee Primary Care Services Agreements as outlined in his report (p56) and that the Waitemata DHB Asian PHO enrolment rate has increased to 89%, surpassing its target of 87%.

In relation to section 7 of the report (Māori Health), Matire Harwood acknowledged the work of Te Whanau o Waipereira in the area of youth mental health and the pipeline approach to Māori health by Karen Bartholomew and the team.

4.1 Metro ADHB Healthy Weight Action Plan for Children (agenda pages 58 to 70)

Rebecca McCarroll (Public Health Dietician) and Ruth Bijl were present for this part of the meeting.

The Committee was pleased to note that overall most of the actions are on-track so far. It was noted that this plan was designed to sit alongside Healthy Auckland Together Plan.

A breast feeding peer support initiative action being off-track was discussed. Ruth Bijl advised that lactation support services are provided by trained midwives but that this peer support pilot (which is about women supporting women) introduced by the two DHBs did not reach its target. Further options are being explored at present.

Judy McGregor mentioned that at the recent Waitemata DHB CEO Lecture Series featuring Rt Helen Clark, prevalence of fast food outlets around schools was mentioned. It was queried whether this aspect is captured by the Report on Action Plain Indicators, which shows that in relation to school aged children it is 'achieved/on-track'.

Rebecca McCarroll advised that the research on that matter forms part of Healthy Auckland Together Plan. The results showing in the report is in relation to schools that have nurses only (representing approximately half). It was acknowledged that many schools do not currently have healthy eating policies and the problem extends to what convenient food is available at dairies near schools.

The Committee agreed that the Boards of Auckland DHB and Waitemata DHB should take a clear position on some of these matters discussed and that doing so would be consistent with the DHBs' functions and duties, provided that any such position taken is based on clear evidence.

It was further agreed that at the Committee's next deep dive, members will consider what matters should be publicly advocated and the appropriate timing for that advocacy. It was suggested that access to alcohol is also considered.

It was commented that the majority of NGOs do not have an advocacy role included in their contracts and Healthy Auckland Together Plan is significantly under-resourced.

The meeting concluded at 11.15am.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 29 AUGUST 2018

_____CHAIR

DRAFT

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 13 November 2018

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
29/08		Diabetes Management A more detailed update on diabetes plan about the initiatives and progress.	Tim Wood	February 2019	Noted
29/08		Oral Health Strategy A more detailed report on Oral Health Strategy to include any findings from analysis of dental National Health Index (NHI)	Ruth Bijl	November 2018	See agenda item 4.1

2.2 Circulated Resolution 25 September 2018 - Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees Circulated Resolution – Equity

Resolution passed

That the Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees recommend:

That the Auckland DHB and Waitemata DHB Board:

1. **Note that the Community and Public Health Advisory Committees have undertaken a series of equity deep dives in 2017/18 about the following topics: System Level Measures (SLMs), breast and cervical screening and comparison of equity approaches.**
2. **Support that moving forward the Community and Public Health Advisory Committees focuses on equity in community and public health within its priority areas of oral health, child health, mental health and prevention.**
3. **Support that moving forward the Community and Public Health Advisory Committees has a special focus on equity in the Long Term Investment Plan Community and Primary Care and Population Health deep dives.**
4. **Require all Board Committees to have an equity focus with alignment back to the respective Board equity framework(s).**
5. **Ensure that current workforce strategies in place are measured by positive increases in Maori and Pacific clinical and non-clinical workforce.**
6. **Endorse convening of the metro Auckland Disability Support Advisory Committees with urgency.**
7. **For Auckland DHB, continue to develop an equity framework, noting the Waitemata DHB framework and leveraging regional and national opportunities.**

Prepared by: Nicole Song (WDHB Board Secretary)

A workshop was held for the Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees following the meeting on 29th August. The focus of the workshop was on equity and the Committee agreed to consider recommendations via circular resolution for both the Boards of Auckland and Waitemata DHBs for consideration.

The circular resolution was distributed on 21 and 25 September and passed unanimously.

The matter was considered under urgency to provide the recommendations to Auckland and Waitemata DHB Boards ahead of the next schedule Committee meeting on 21 November 2018.

The resolution is being submitted to the Committee for endorsement.

3.1 Community Water Fluoridation Position Statement

Recommendation:

That the Community and Public Health Advisory Committee recommends to the Auckland DHB and Waitemata DHB Boards that they endorse the position on Community Water Fluoridation as follows:

1. **The DHB confirms that tooth decay is an important population health issue that causes significant avoidable harm and health inequities**
2. **The DHB supports the Ministry of Health's position that community water fluoridation is an important, safe and effective component of a population health approach to protect against tooth decay**
3. **The DHB supports fluoridating community water supplies to the level recommended by the Ministry of Health**
4. **The DHB notes these recommendations are based on scientific evidence that community water fluoridation:**
   - **Is established best practice both in New Zealand and internationally**
   - **Is effective at reducing tooth decay**
   - **Is safe at recommended levels of fluoridation**
   - **Is cost saving in community water supplies for more than 1000 people**
   - **Has an important role in reducing inequities in tooth decay as it reaches all groups in a community equally**
   - **Has been found by the Courts to be legal and not a medication.**

Prepared by: Auckland Regional Public Health Service: Julia Peters (Clinical Director), David Sinclair (Medical Officer of Health) and Delvina Gorton (Senior Policy Analyst); Auckland Regional Dental Service: Sathananthan Kanagaratnam (Clinical Director), Dr Helen Tane (Professional Leader); Auckland Regional Dental and Oral Health: Hugh Trengrove (Service Clinical Director); Auckland & Waitematā DHBs: Karen Bartholomew (Clinical Director Health Gain), Ruth Bijl (Funding & Development Manager Womens/Child & Youth Health), Stacey Strang (Programme Manager Child & Maternity), Riki Nia Nia (General Manager Māori Health), Shayne Wijohn (Māori Portfolio Manager); Counties Manukau Health: Doone Winnard (Clinical Director Population Health), Philippa Anderson (Public Health Physician), Carmel Ellis (General Manager Integrated Child, Youth & Maternity), and Aroha Haggie (General Manager Māori Health Development)
Endorsed by: Karen Bartholomew (Clinical Director Health Gain) and Debbie Holdsworth (Director Planning and Funding)

Glossary

DHB – District Health Board
RSNZ/OPMCSA – Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor

1. Purpose

The Health (Fluoridation of Drinking Water) Amendment Bill proposes a transfer of decision-making on community water fluoridation from Territorial Authorities to District Health Boards (DHBs). The

Select Committee Report was presented to Parliament in May 2017 and the Bill is waiting for its second reading.

A joint Auckland region DHB position will confirm that oral health is a key priority for equity and will provide transparency on the DHB's position on community water fluoridation prior to any Board decision on fluoridation.

This is an issue of public health significance. There are substantial inequities in oral health outcomes. Community water fluoridation is equally available to all people in our communities on reticulated water supplies, and has the most benefit for people experiencing higher rates of tooth decay. It is therefore a pro-equity strategy to improve oral health.

2. Executive Summary

Fluoride is a trace element widely present in soil, food and water.[1] Community water fluoridation adjusts the level of naturally-occurring fluoride in drinking water to an optimal level for protection against tooth decay.

The New Zealand Oral Health Survey shows that New Zealanders living in areas with community water fluoridation have significantly less lifetime risk of tooth decay than those in non-fluoridated areas.[2] This is supported by numerous reviews of international data.

Community water fluoridation is an effective, safe, equitable, and highly cost-saving strategy for improving dental health. It has been safely implemented in New Zealand, and around the world, for over sixty years. A review by the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor (RSNZ/OPMCSA) concluded that community water fluoridation creates no health risks and provides protection against tooth decay at the concentration recommended by the New Zealand Ministry of Health.[3] The courts have established the legality of community water fluoridation and that it is not medication.

3. DHBs role in reducing the burden of tooth decay

The Health and Disability Act 2000 requires District Health Boards (DHBs) to improve, promote, and protect the health of communities. Tooth decay is the most prevalent chronic and irreversible disease in New Zealand,[4] responsible for one per cent of all health loss.[5]

DHBs are also required to improve Māori health and reduce inequities in health status. Children and adults from lower socio-economic areas, in which Māori and Pacific peoples are over-represented, have higher rates of tooth decay and untreated tooth decay. Community water fluoridation is socially equitable. It reaches all households on fluoridated community water supplies regardless of income,

[1] Moore D, Poynton M, Broadbent JM, Thomson WM, (2017). The costs and benefits of water fluoridation in NZ. BMC Oral Health 17:134.
[2] Ministry of Health (2010). Our oral health: key findings of the 2009 New Zealand Oral Health Survey. Ministry of Health: New Zealand.
[3] Gluckman P, Skegg D. (2014) Health effects of water fluoridation: A review of the scientific evidence. A report on behalf of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor: Wellington.
[4] Ministry of Health (2010). Our oral health: key findings of the 2009 New Zealand Oral Health Survey. Ministry of Health: New Zealand.
[5] Ministry of Health (2013). Health loss in New Zealand: a report from the New Zealand burden of diseases, injuries and risk factors study 2006-2016. Ministry of Health: Wellington.

ethnicity, or age. Thus, the greatest benefits are likely to be for children from lower socio-economic communities.[6]

Children bear a significant burden from tooth decay. Direct effects include pain, infection, disfigurement, loss of sleep, altered behaviour, and missed school. Longer term it can adversely affect growth, development and general health.[7] Tooth decay is a leading cause of avoidable hospital admissions for children. Over 7% of hospital admissions for children aged up to 14 years are for dental conditions.[8] [9] Children aged 3-4 years have significantly higher rates of admission to hospital than any other age group.[10]

While the greatest benefits in oral health may be for children, the benefits of community water fluoridation continue throughout the lifespan. For older adults, drinking fluoridated water is associated with less root decay and greater retention of natural teeth into old age.[11]

4. Community water fluoridation in the northern region (Auckland and Northland)

Three out of five New Zealanders receive fluoridated drinking water.[12] In the three Auckland DHB regions, approximately 85% of the population are on Watercare's reticulated (piped) water supply. The remaining 15% have individual rainwater supplies, or small bore or surface water supplies.

Nearly all Aucklanders on a reticulated water supply receive fluoridated water. The non-fluoridated areas are typically the satellite towns, such as Warkworth and Helensville, and Onehunga (for historic reasons). Pokeno and Tuakau (in the Counties Manukau DHB but Waikato District Council area) receive Watercare's fluoridated water supply.[13]

In the Northland DHB region, half the population is on reticulated community water supplies and none are fluoridated. Fluoridation of community water supplies was trialled in Kaikohe and Kaitaia in 2007-2009. Despite leading to improved dental outcomes for children over that time frame, the

[6] Lee M, Dennison PJ. (2004). Water fluoridation and dental caries in 5- and 12-year-old children from Canterbury and Wellington. NZ Dent J.100(1):10–5

[7] Bach K, Manton DJ. (2014). Early childhood caries: a New Zealand perspective. J Prim Health Care 6(2):169–174.

[8] Craig E, Anderson P, Jackson G, Jackson C. (2012). Measuring potentially avoidable and ambulatory care sensitive hospitalisations in New Zealand children using a newly developed tool. NZ Med J. 125(1366):38–50

[9] Craig E, Adams J, Oben, G, et al (2013). The health status of children and young people in New Zealand. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago. http://dnmeds.otago.ac.nz/departments/womens/paediatrics/research/nzcyes/pdf/Rpt2011_NZReport.pdf

[10] Whyman R, Mahoney EK, Stanley J, Morrison D. (2012). Admissions to New Zealand Public Hospitals for Dental Care A 20 Year Review. Wellington: Hutt Valley DHB

[11] Gluckman P, Skegg D. (2014) Health effects of water fluoridation: A review of the scientific evidence. A report on behalf of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor: Wellington.

[12] Environmental Health Indicators New Zealand. (2017). Access to fluoridated drinking-water. Available from: http://www.ehinz.ac.nz/assets/Factsheets/Released-2017/AccessToFluoridatedWater2010-2016-released201704.pdf

[13] Available from: http://www.ehinz.ac.nz/indicators/drinking-water-quality/access-to-fluoridated-drinking-water/

community voted against its continuation.[14] This is in contrast to Auckland, where 88% of those surveyed in 2014 either supported or were neutral about adjusting levels of fluoride in drinking water.[15]

Rural communities who are not on reticulated supplies rely on fluoridated toothpaste, fluoride varnishes and/or fluoride supplements. Māori are more likely than non-Māori to live in non-fluoridated areas.[16]

5. Community water fluoridation delivers population health benefits

Fluoride is a nutrient essential to human health.[17] New Zealand has lower levels of fluoride than other parts of the world.[18] It is naturally present in water and food, with common food sources being tea, beer, grain-based foods such as bread, and animal products.[19] When teeth are developing, fluoride acts systemically through incorporation into tooth enamel. For permanent teeth, it acts topically when fluoridated water and saliva pass around the teeth.[20] [21]

International and New Zealand data shows that community water fluoridation is associated with fewer decayed, missing and filled teeth; and fewer children with tooth decay.[22] [23] [24] [25] [26] [27] The New Zealand Oral Health Survey found a 40% reduction in risk of tooth decay in fluoridated compared to non-fluoridated areas.[28]

[14] National Fluoridation Information Service (2014). Environmental Scan: The status of community water fluoridation in New Zealand March 2013 – July 2014. Wellington, New Zealand: National Fluoridation Information Service.
[15] UMR Research. (March 2014). Auckland Regional Public Health Service Water Fluoridation Research.
[16] National Fluoridation Information Service (2014). Environmental Scan: The status of community water fluoridation in New Zealand March 2013-July 2014
[17] Department of Health and Ageing, National Health and Medical Research Council and Ministry of Health (2017), New Zealand Government. Nutrient Reference Values for Australia and New Zealand. [Online].
[18] Moore D, Poynton M, Broadbent JM, Thomson WM, (2017). The costs and benefits of water fluoridation in NZ. BMC Oral Health 17:134.
[19] Cressey P, Gaw S, Love J. (2010). Estimated dietary fluoride intake for New Zealanders. Journal of Public Health Dentistry 70: 327–336
[20] Expert Working Group for Fluoride (2015). Australian and New Zealand Nutrient Reference Values for Fluoride: A report prepared for the Australian Government. Department of Health; Canberra.
[21] O'Mullane (2016). Fluoride and oral health. Community Dental Health 33, 69–99
[22] Iheozor-Ejiofor Z, Worthington HV, Walsh T, et al (2015). Water fluoridation for the prevention of dental caries. Cochrane Database of Systematic Reviews, Issue 6. Art. No.: CD010856
[23] Rugg-Gunn AJ, Do L. (2012) Effectiveness of water fluoridation in caries prevention. Community Dent Oral Epidemiol 40 (Suppl. 2): 55–64.
[24] McDonagh M, Whiting P, Bradley M et al. (2000) A systematic review of public water fluoridation. York: University of York, NHS Centre for Reviews and Dissemination.
[25] Lee M, Dennison PJ. (2004). Water fluoridation and dental caries in 5- and 12-year-old children from Canterbury and Wellington. N Z Dent J.100(1):10–5
[26] Kanagaratnam S, Schluter P, Durward C, Mahood R, Mackay T (2009). Enamel defects and dental caries in 9-year-old children living in fluoridated and nonfluoridated areas of Auckland, NZ. Community Dent Oral Epidemiol; 37:250–9.
[27] Mackay TD, Thomson WM (2005). Enamel defects and dental caries among Southland children. N Z Dent J; 101:35–43.
[28] Ministry of Health (2010). Our oral health – key findings of the 2009 NZ oral health survey. Wellington (NZ): Ministry of Health.

6. Community water fluoridation is safe

The safety of community water fluoridation has been studied extensively over many years.[29] [30] [31] [32] [33] [34] The review by RSNZ/OPMCSA found:

> *"From a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in the communities where it is used".* [35]

They also found that:

> *"... no effects on brain development, cancer risk or cardiovascular or metabolic risk have been substantiated, and the safety margins are such that no subset of the population is at risk because of fluoridation".*

The only substantiated potential adverse effect of fluoride at levels used in New Zealand is dental fluorosis. This is a mild cosmetic issue causing white flecks on the teeth. The Oral Health Survey found a low prevalence of mild to moderate fluorosis, often difficult to see, and no cases of severe fluorosis.[36] The level of fluoridation set in New Zealand's Drinking Water Standards 2005 is well below the threshold where severe fluorosis would occur.[37]

The RSNZ/OPMCSA report concludes that it is safe to use fluoridated water with infant formula. A low level of mild fluorosis has been found in both areas with fluoridated and non-fluoridated water supplies, indicating fluoridated toothpaste as a contributing source.[38] [39] The consensus expert opinion is that the benefit of fluoride in formula-fed children exceeds the small risk of minor fluorosis that may occur.[40]

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[29] Gluckman P, Skegg D. (2014) Health effects of water fluoridation: A review of the scientific evidence. A report on behalf of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor: Wellington.

[30] National Health and Medical Research Council. (2017). Information Paper – Water fluoridation: dental and other human health outcomes. Report prepared by the Clinical Trials Centre at University of Sydney, NHMRC; Canberra.

[31] O'Mullane (2016). Fluoride and oral health. Community Dental Health 33, 69–99

[32] Broadbent J M, Thomson W M, Ramrakha S et al (2015). Community water fluoridation and intelligence: prospective study in New Zealand. Am J Public Health; 105: 72–76

[33] National Fluoridation Information Service. (2013). NFIS Advisory A review of recent literature on potential effects of CWF programmes on neurological development and IQ attainment. Available from: www.moh.govt.nz

[34] National Fluoridation Information Service. (2011) Fluoride Neurotoxicity: Review of Evidence from Drinking Water Studies. Wellington, New Zealand: National Fluoridation Information Service Advisory.

[35] Office of the Prime Minister's Chief Science Advisor and the Royal Society of New Zealand (2014). Health effects of water fluoridation: A review of the scientific evidence.

[36] Ministry of Health. (2010). Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. Wellington: Ministry of Health.

[37] Expert Working Group for Fluoride (2015). Australian and New Zealand Nutrient Reference Values for Fluoride: A report prepared for the Australian Government. Department of Health; Canberra

[38] Office of the Prime Minister's Chief Science Advisor and Royal Society of New Zealand. (2014, updated 2015). Health effects of water fluoridation: A review of the scientific evidence. Auckland]; Available from: http://royalsociety.org.nz/assets/documents/Health-effects-of-water-fluoridationAug-2014-corrected- Jan-2015.pdf.

[39] Department of Health and Ageing, National Health and Medical Research Council and Ministry of Health, New Zealand Government (2017). Nutrient Reference Values for Australia and New Zealand.

[40] Ministry of Health and Medsafe (2015). Proposed Amendment to Regulations under the Medicines Act 1981 Report of the Analysis of Submissions.

7. The Health (Fluoridation of Drinking Water) Amendment Bill would transfer decision-making on fluoridation to DHBs

Public Health Units are currently required by their service specifications to "*engag[e] with councils to promote water fluoridation as a safe, effective mechanism to reduce the burden of dental decay*."[41] Public Health Units provide public health services for DHBs. The Health (Fluoridation of Drinking Water) Amendment Bill, if passed, will transfer decision-making on adjusting levels of fluoride in community water supplies from territorial authorities to DHBs. The aim of the Bill is for more consistency in fluoridation decisions across New Zealand and to extend community water fluoridation coverage.

The Bill would authorise DHBs to direct local authorities whether or not to fluoridate water supplies owned by the local authority. For water supplies which are already fluoridated, the Bill would require water fluoridation to continue unless directed otherwise by the DHB. Where a water supply crosses DHB boundaries, as with most of Auckland's metropolitan water supply, any change in fluoridation must be approved by all affected DHBs.

The legality and ethics of community water fluoridation have been well considered not only by the courts but by organisations such as the UK Nuffield Council on Bioethics. The courts in New Zealand have ruled that community water fluoridation is lawful, and is not medication. The Nuffield ethics review found that community water fluoridation contributed to the central goals of public health stewardship by reducing inequities, reducing disease through environmental measures, and benefiting child health. Nevertheless, the review recommended the ethics and effects of both fluoridating and not fluoridating community water supplies be considered when local decisions are made, in a similar way to decisions about water chlorination.[42] [43]

This paper is not seeking a decision on whether or not community water fluoridation is extended in Auckland. The purpose of the position statement is to confirm oral health as a key equity priority, to provide transparency on the DHBs' position, and support the Ministry of Health's position on community water fluoridation. Manawhenua have provided support for the DHBs' community water fluoridation position statement. Any consideration of changes to community water fluoridation would only occur if the Bill is passed, and should be undertaken through collaboration with iwi and Māori health providers.

8. Conclusion

- Adjusting levels of fluoride in community water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years
- Fluoridation of community water supplies delivers better health and saves money. It is particularly beneficial for low-income families for whom there are disparities in dental health
- The courts have supported the legality of fluoridating community water supplies and ruled that it is not medication
- Adjusting levels of fluoride in drinking water to recommended fluoride levels is an effective and safe measure to improve the oral health of everyone in our communities.

[41] Ministry of Health (2014) Public Health Services Tier Level One Service Specification. Available from: https://nsfl.health.govt.nz/service-specifications/current-service-specifications/public-health-service-specifications

[42] Jiany Y, Foster Page LA, McMillan J et al. (2014) Is New Zealand water fluoridation justified? NZMJ Vol 127 No 1406

[43] Nuffield Council on Bioethics. (2007). Public Health Ethical Issues. Chapter 7 – fluoridation of water. Available from: http://nuffieldbioethics.org/report/public-health-2/water-fluoridation

APPENDIX 1: Community Water Fluoridation Position Statement

Community water fluoridation is a safe and effective way to reduce tooth decay for everyone in our communities. The District Health Board (DHB) supports fluoridating community water supplies to the level recommended by the Ministry of Health.

Position statement
2. The DHB **confirms** that tooth decay is an important population health issue that causes significant avoidable harm and health inequities
3. The DHB **supports** the Ministry of Health's position that community water fluoridation is an important, safe and effective component of a population health approach to protect against tooth decay
4. The DHB **supports** fluoridating community water supplies to the level recommended by the Ministry of Health
5. The DHB **notes** these recommendations are based on scientific evidence that community water fluoridation: • Is established best practice both in New Zealand and internationally • Is effective at reducing tooth decay • Is safe at recommended levels of fluoridation • Is cost saving in community water supplies for more than 1000 people • Has an important role in reducing inequities in tooth decay as it reaches all groups in a community equally • Has been found by the Courts to be legal and not a medication.

Rationale for the DHB's position

Fluoride is a trace element naturally present in food and water.[44] It plays an important role in preventing tooth decay. New Zealand's natural fluoride levels are lower than in other parts of the world.[45]

Tooth decay is the most prevalent chronic and irreversible disease in New Zealand,[46] responsible for one per cent of all health loss.[47] Community water fluoridation adjusts the natural content of fluoride in water to a level that helps prevent tooth decay. It does this by:

- making tooth enamel more resistant to decay
- interfering with the growth of bacteria that cause cavities
- repairing the early stages of tooth decay.

Community water fluoridation is an effective, safe, and highly cost-saving strategy for improving oral health. It has been used to varying degrees in New Zealand since 1954. Children and young people in areas with fluoridated water have a 40 per cent reduction in risk of dental decay.[48] The scientific consensus is clear that community water fluoridation at recommended levels benefits dental health

[44] Department of Health and Ageing, National Health and Medical Research Council and Ministry of Health, New Zealand Government. (2017). Nutrient Reference Values for Australia and New Zealand. [Online]
[45] Moore D, Poynton M, Broadbent JM, Thomson WM, (2017). The costs and benefits of water fluoridation in NZ. *BMC Oral Health* 17:134.
[46] Ministry of Health (2010). Our oral health: key findings of the 2009 New Zealand Oral Health Survey. Ministry of Health: New Zealand.
[47] Moore D, Poynton M. (2015). Review of the benefits and costs of water fluoridation in New Zealand. Sapere Research Group, Wellington.
[48] Moore D, Poynton M, Broadbent JM, Thomson WM. (2017). The costs and benefits of water fluoridation in NZ. *BMC Oral Health* 17:134.

and is safe.[49] [50] [51] The Ministry of Health recommends 0.7 to 1ppm fluoride in drinking water as a level that improves oral health and is well below thresholds where severe fluorosis could occur.

There are substantial inequities in oral health outcomes; oral health is a key equity priority for the DHB. This is demonstrated in rates of tooth extraction due to decay, infection or disease, which are one-and-a-half to two times higher for Māori and Pacific adults, and for people living in the most socio-economically deprived areas.[52] Inequities in rates of tooth extraction are even greater for Māori and Pacific children. Admissions to hospital for dental care show similar inequities.[53] The greatest benefits of community water fluoridation are for lower socio-economic communities who have higher rates of tooth decay.[54]

Community water fluoridation is international best-practice. It is recommended by the World Health Organization and many other organisations around the world as one of the most effective public health measures for prevention of dental decay. There is no health risk from community water fluoridation at the concentration recommended by the New Zealand Ministry of Health.[55]

Most of Auckland's reticulated water has been fluoridated for many years, covering 85% of the region's water supply. No water supplies in Northland are fluoridated.

Legal rulings support community water fluoridation

The High Court, Court of Appeal, and Supreme Court in New Zealand have made judgments on community water fluoridation in recent court cases.[56] Together, these judgments have established that:

- Local authorities have the statutory authority to fluoridate water supplies
- Community water fluoridation is legal and permitted by Part 2A of the Health Act 1956
- Community water fluoridation is not medical treatment for the purposes of section 11 of the New Zealand Bill of Rights Act 1990, and even if it were, community water fluoridation is justified under section 5 of the Bill of Rights

[49] Office of the Prime Minister's Chief Science Advisor and Royal Society of New Zealand. (2014 [updated 2015]) Health effects of water fluoridation: A review of the scientific evidence. Auckland; Available from: http://royalsociety.org.nz/assets/documents/Health-effects-of-water-fluoridationAug-2014-corrected- Jan-2015.pdf.

[50] Jack, B., Ayson, M., Lewis, S., Irving, A., Agresta, B., Ko, H., Stoklosa, A. (2016). Health Effects of Water Fluoridation: Evidence Evaluation Report, report to the National Health and Medical Research Council, Canberra.

[51] National Fluoridation Information Service reviews. Available from: https://www.health.govt.nz/our-work/preventative-health-wellness/fluoride-and-oral-health/water-fluoridation/national-fluoridation-information-service

[52] Ministry of Health. (2016). Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health

[53] Whyman R, Mahoney EK, Stanley J, Morrison D. (2012). Admissions to New Zealand Public Hospitals for Dental Care A 20 Year Review. Wellington: Hutt Valley DHB

[54] Lee M, Dennison PJ. (2004). Water fluoridation and dental caries in 5- and 12-year-old children from Canterbury and Wellington. NZ Dent J.100(1):10–5

[55] Office of the Prime Minister's Chief Science Advisor and Royal Society of New Zealand. (2014 [updated 2015]) Health effects of water fluoridation: A review of the scientific evidence. Auckland; Available from: http://royalsociety.org.nz/assets/documents/Health-effects-of-water-fluoridationAug-2014-corrected- Jan-2015.pdf.

[56] *New Health New Zealand Inc v South Taranaki District Council [2014]; Safe Water Alternative New Zealand Inc v Hamilton City Council [2014]; New Health New Zealand Inc v South Taranaki District Council [2016]; New Health New Zealand Inc v South Taranaki District Council [2017]; New Health New Zealand Inc v Attorney-General [2014]; New Health New Zealand Inc v Attorney-General [2015]; New Health New Zealand Incorporated vs South Taranaki District Council and the Attorney-General for and on behalf of the Minister of Health [2018]*

- Fluoride added to community water supplies at recommended levels are not medicines in terms of the Medicines Act 1981

Community water fluoridation is consistent with Māori values
Te Aō Marama, the NZ Māori Dental Association, supports fluoridation of reticulated water supplies. It states that fluoridation does not "*diminish the mauri of water, because it improves health and wellbeing for all*."[57] The DHB's position statement has the support of manawhenua.

Community water fluoridation is cost-effective
Community water fluoridation is highly cost-effective for water supplies serving more than 1,000 people. On average, each dollar invested in fluoridation in New Zealand saves nine dollars. Thus, fluoridation provides health gains and a net return to society.[58] [59]

Community water fluoridation is one component of dental health
Community water fluoridation is one important component of good dental health. Ideally it is combined with twice-daily teeth brushing with fluoridated toothpaste, regular dental checks, and healthy eating with reduced consumption of sugars.[60]

Conclusion
- Adjusting levels of fluoride in drinking water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years
- The Courts have supported the legality of adjusting levels of fluoride in community water supplies
- Fluoridation of community water supplies delivers better health and saves money
- It is particularly beneficial for low-income families and individuals for whom there are disparities in oral health.

[57] Te Aō Marama. Community Water Fluoridation. Available from: https://teaomarama.org.nz/resources/community-water-fluoridation
[58] Moore D, Poynton M., (2016). The benefits and costs of water fluoridation – a summary for DHBs. Sapere Research Group: Wellington.
[59] Moore D et al. (2017). The costs and benefits of water fluoridation in NZ. BMC Oral Health 17:134
[60] Ministry of Health (2018). Fluoride and oral health. Available from: https://www.health.govt.nz/our-work/preventative-health-wellness/fluoride-and-oral-health

4.1 Oral Health in the Auckland Region

Recommendations:

That the Community and Public Health Advisory Committee:

a) **Note that oral health is a vital component of general health and that there are persistent inequities in oral health outcomes.**

b) **Note a range of activities are now underway to address inequities, particularly focusing on the pre-school cohort.**

c) **Note the importance of prevention initiatives including fluoridation of water, health promotion, teeth brushing and protective treatments including the application of fluoride varnish.**

d) **Note there are capacity issues resulting in delays in time to treatment for hospital-based (secondary) dental care. Work is currently being done to understand these challenges and support hospital and community oral health services.**

Prepared by: Corina Grey (Public Health Physician), Ruth Bijl (Funding & Development Manager, Womens/Child & Youth Health), Stacey Strang (Programme Manager, Oral Health), Hugh Trengrove (Service Clinical Director, Auckland Regional Dental and Oral Health), Stephanie Doe (General Manager, Child Women and Family Services), Meia Schmidt-Uili (Division Head, Child Women and Family Services), Patsy Prior (Service Manager, Auckland Regional Dental Service), Alison Leversha (Community Paediatrician, Starship Community), and Tracy Walters (Portfolio Manager, Māori Health Gain Team)
Endorsed by: Karen Bartholomew (Director Health Outcomes), Debbie Holdsworth (Director Funding), Shayne Wijohn (Māori Health Gain Manager), and Lita Foliaki (Pacific Health Gain Manager)

Glossary

ARDS	-	Auckland Regional Dental Service (Community Oral Health Service)
ARDOH	-	Auckland Regional Dental & Oral Health Service (Hospital-based Dental Services)
CDA	-	Combined Dental Agreement
CPHAC	-	Community and Public Health Advisory Committee
DHB	-	District Health Board
dmft	-	decayed, missing or filled teeth (a measure of severity of dental disease) at age five
ECE	-	Early Childhood Education Centre
FSA	-	First Specialist Appointment
GA	-	General Anaesthesia
NCHIP	-	National Child Health Information Platform
PHO	-	Primary Health Organisation
WCTO	-	Well Child Tamariki Ora

1. Executive Summary

This information paper describes the current state of oral health, oral health promotion and dental services in the metro Auckland region for children, adolescents and adults. It sets out specific actions that services are taking to improve oral health overall and address longstanding inequities in oral health outcomes, particularly for preschool children.

Oral health is a complex issue and reflective of the distribution of the social determinants of health, with marked inequities in outcomes seen at all ages. By the age of five, approximately 60% of Māori and 70% of Pacific children examined by the Auckland Regional Dental Service (ARDS) have dental decay, compared to 30% of non-Māori non-Pacific children. Māori and Pacific preschool children also have more severe dental disease at examination, with an average of 3 to 3.5 decayed, missing or filled teeth by the age of five, compared to 1.3 for non-Māori non-Pacific children. These inequities are still evident at School Year 8 (ages 12-13), with 50% of Māori and Pacific children found to have dental decay in their baby and/or adult teeth at examination, compared to 30% of non-Māori non-Pacific children. These statistics are likely to underestimate the true prevalence of dental disease and the extent of inequities in our population, as they do not include children not examined by ARDS. Children who have been unable to access this free dental service are likely to have poorer health outcomes than those who have been examined and/or received treatment.

In addition, dental admission rates for children aged 17 years and younger are highest in Pacific children in the Auckland region. Dental admissions (mainly dental extractions under general anaesthesia [GA]) are an important cause of ambulatory sensitive hospitalisations (i.e. hospitalisations considered potentially reducible through preventive or treatment strategies deliverable in a primary care setting), and childhood dental admission rates have not declined over the past ten years.

The Auckland Regional Dental & Oral Health Service (ARDOH) is managed by Auckland DHB and provides secondary oral health care services to the metro Auckland region. This service currently has 2,455 children on the waiting list for a first specialist appointment or dental treatment under GA. The ARDOH service receives approximately 200 new referrals for paediatric treatment per month. Patients also face long waiting periods (upwards of 8 months) and limited access to dental treatment under GA, with a maximum of 140-150 GA treatments available per month. Urgent attention is needed to assist this service to reduce waiting times and ensure children are being managed in a timely fashion. Work is currently being done to qualify, quantify and better understand the challenges of supporting this demand.

The long-standing oral health inequities experienced by Māori and Pacific children are unacceptable. Preschool inequities in particular have not narrowed over time, despite a significant reorientation of all community oral health services in New Zealand almost a decade ago. The purpose of the reorientation was to increase access for all children, especially those with the highest needs. Over the past couple of years there has been a lot of work done to better understand and address these inequities, and in August 2017 a *Preschool Oral Health Action Plan for the Metropolitan Auckland Region* was finalised. This Plan set out a series of recommended actions to improve oral health, including oral health promotion and the prevention, early detection and treatment of dental disease in preschool children. ARDS, Well Child Tamariki Ora (WCTO) and primary care providers have been involved in the implementation of this plan over the last 12-18 months, and specific actions are outlined in the body of this document.

Oral health has also been identified as a particular target for the System Level Measures workplan in primary care, where the focus has been on increasing the number of children enrolled in ARDS. Other actions that have been implemented to increase enrolments include the automatic pre-enrolment of children into ARDS from birth lists since mid-2017 (Waitemata and Auckland DHBs only), data-matching with Māori providers to enrol and update contact details and working with WCTO providers to enrol pre-schoolers new to the region. The implementation of the National Child Health Information Platform (NCHIP), an electronic system enabling the sharing of data on key childhood health milestones will further support enrolment once it is in place.

Improving access to care has been a particular focus for ARDS, especially for Māori and Pacific whanau. Actions in this area have included a systematic process to match the length of a child's dental recall period to the level of dental health need, opening five ARDS clinics for a full day every Saturday (approximately 4200 children seen since January 2018), trialling a model of care to provide group-based first appointments for preschool children, and trialling centralised and family-focused bookings. Supporting very high needs children to access dental care through the Oranga Tamariki Gateway programme has also continued, with the addition of a systematic process of topical fluoride application at Starship Community Gateway Clinics.

Oral health promotion activities include aligning healthy weight and oral health message for child health providers to use with their clients, the development of community engagement coordinator roles at ARDS, and promotion of ARDS and oral health and lift the lip assessments through primary care and WCTO providers.

As part of its focus on prevention, ARDS is rolling out a policy to apply topical fluoride to all children at their recall appointment, particularly Māori and Pacific children. Māori, Pacific and other children identified as high needs receive fluoride six-monthly. A community-based programme of topical fluoride application to pre-schoolers in high-needs ECEs is also being systematically rolled out across the metro Auckland region. The model was successfully piloted in four Kohanga Reo and two Pacific Language Nests on the North Shore between March and July of this year, resulting in all children being enrolled with ARDS and receiving treatment plans. There are also plans to explore innovative ways of targeting high-needs children, such as providing fluoride varnish application during other health appointments or procedures.

The recruitment and retention of the dental workforce has been identified as an issue, with approximately one-third of dental therapists aged 55 years and older. ARDS has developed a strategy to attract and retain therapists and assistants, including strengthening its new graduate programme, working with staff to address issues that impact on job satisfaction and identifying opportunities for staff to be involved in the development and implementation of new models of care. There is an opportunity for ARDS and/or the DHB to work more closely with dental training schools (Auckland University of Technology [AUT] and Otago) to encourage more Māori and Pacific people to embark on dental therapy careers. AUT does not currently have a programme to promote dental therapy or actively recruit Māori or Pacific students.

Auckland DHB has also approved funding for a new oral health service for 300 pregnant women/new mothers in the Tamaki area to receive free maternal oral health care. The service is currently in the planning phase. The aim of the service is to restore pregnant women's oral health, improve mothers' and babies' overall health and wellbeing, and reduce inequities in preschool oral health outcomes. The service will have a focus on Māori, Pacific and low-income pregnant women.

The aforementioned actions are all part of a systematic process to eliminate long-standing inequities and improve preschool oral health outcomes, particularly for Māori, Pacific and other children with high dental needs. However, it will take some time for these actions to have a noticeable effect on long-term outcomes, and may in fact increase the number of children identified as requiring dental treatment in the short-term. Good oral health is everyone's business, not just that of dental services. Achieving these goals will require a concerted effort among health promoters, primary care and WCTO providers, and primary and secondary dental services. ARDS has implemented a number of strategies over the last 18 months to address issues. There is currently an urgent need to address the large number of children awaiting dental treatment at ARDOH.

2. Strategic Alignment

Community, whānau and patient centred model of care	Oral health service delivery has undergone significant changes over the last 10 years. Increasing access for community members and whanau was the impetus for these changes. Further work is required to strengthen the patient centred model of care.
Emphasis and investment on both treatment and keeping people healthy	There are marked ethnic inequities in oral health at all ages. Oral health services have a focus on reducing these inequities, particularly for preschool children. The Auckland Regional Dental Service (ARDS) has a focus on preventing and detecting dental decay at an early stage. It has introduced interventions aimed at ensuring that fewer children will require dental treatments, or extractions under general anaesthetic.
Service integration and/or consolidation	Work is being done to better connect primary health and dental services, and community dental services with hospital based dental services.
Intelligence and insight	Evaluation and evidence are used in implementation and on-going service development.
Evidence informed decision making and practice	ARDS has implemented a fluoride varnish programme in high needs Early Childhood Education Centres (ECEs) based on a large body of evidence demonstrating a positive effect on preschool oral health outcomes.
Outward focus and flexible, service orientation	ARDS has recently implemented a number of service changes to improve access and utilisation for those most in need, including Saturday clinics, outreach services and ECE-based topical fluoride application.
Operational and financial sustainability	There are large numbers of children referred to, and treated by, ARDOH. Currently, the numbers referred exceed capacity, and a high proportion of people wait for months to be seen by a specialist and then to receive definitive treatment. Work is already being done in the community to prevent children developing dental disease that will require surgical intervention. However, work is also needed to better integrate primary and secondary/tertiary dental services.

3. Introduction/Background

This information paper describes the current state of oral health and of oral health promotion and dental services in the metro Auckland region for children, adolescents and adults. It sets out specific actions that services are taking to improve oral health overall and address longstanding inequities in oral health outcomes. It also outlines current issues and challenges that dental services are facing, as well as proposed solutions to overcome these challenges.

3.1 Why oral health is important

Oral health is a vital component of general health. Poor oral health affects general health by causing considerable pain and suffering, limiting what people can eat, and affecting overall quality of life and

well-being. There is also a growing body of evidence linking poor oral health to specific medical conditions, including heart disease, diabetes, and pre-term and low birth weight babies.[123] Poor oral health can be particularly devastating for children, significantly affecting their physical, psychological and social development. Dental decay in infants and children can lead to pain and infection in teeth and gums, poor nutrition, difficulties sleeping, speech impairments and delayed language development, crooked or crowded permanent teeth, and low self-esteem and confidence.[4]

Dental decay is one of the most prevalent health issues in New Zealand across all ages, including very young children.[5] It is largely preventable through the early establishment of good oral hygiene practices, reduced sugar consumption, effective oral health promotion and good access to primary dental care. Dental disease is a leading cause of potentially preventable admissions to hospital for young children, as well as a significant source of inequity for Māori and Pacific, compared to other, populations.[6] A review of public hospitalisations for dental care from 1990-2009 found that admissions were greatest in 3-4 year olds, for Māori and Pacific people and for people living in the 20% of neighbourhoods considered most deprived.[6] These admissions also come at significant cost. In the 2016/17 financial year, 1867 children under the age of 15 years required dental extraction or restoration under general anaesthesia (GA) at Greenlane hospital. The average cost of each procedure was $2306 – a total of $4.3 million. There are currently 12 lists per week for dental care and/or extraction under GA.

3.2 Oral health outcomes for children

Two oral health outcomes are reported annually by DHBs to the Ministry of Health: (i) caries free rates (i.e. the proportion of children with no evidence of dental decay) and (ii) mean number of decayed, missing or filled teeth (dmft). These two outcomes are measured and reported in all children examined by community oral health services at the age of five years and in School Year 8 (ages 12-13). In the metro Auckland region, the community oral health service is known as the Auckland Regional Dental Service (ARDS).

Caries free rates reflect the prevalence of dental decay in the community (higher caries free rates are better) and mean dmft the severity of disease (lower mean dmft is better). However, these rates are likely to underestimate the true prevalence of dental disease and the extent of inequities in our population, as they do not include children not examined by ARDS. Children who have been unable to access this free dental service are likely to have poorer health outcomes than those who have been examined and/or received treatment.

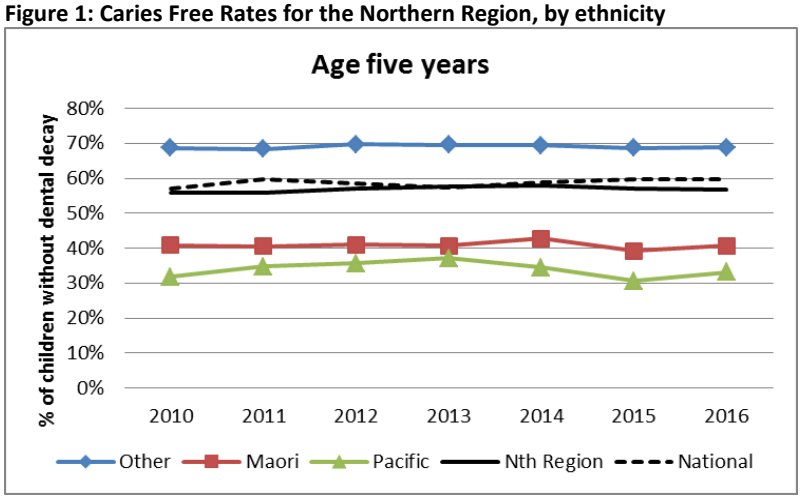
Figures 1 and 2 show caries free and mean dmft at the age of five and at school Year 8 for children in the Northern region by ethnicity from 2010-2016. Data from 2017 is currently unavailable at a regional level. Caries free rates and mean dmft at age five have not changed significantly since 2010, while corresponding figures for children at School Year 8 have improved. This suggests that school dental services have made progress in improving the oral health outcomes of school-aged children, but more work needs to be done for pre-schoolers. There are also significant ethnic inequities, particularly for Māori and Pacific children. Approximately 60% of Māori and 70% of Pacific pre-

[1] Seymour GJ, Ford PJ, Cullinan MP, et al. Relationship between periodontal infections and systemic disease. Clin Microbiol Infect 2007;13 Suppl 4:3-10.
[2] Khader YS, Ta'ani Q. Periodontal diseases and the risk of preterm birth and low birth weight: a meta-analysis. J Periodontal 2005;76(2):161-5.
[3] Williams RC, Barnett AH, Claffey N, et al. The potential impact of periodontal disease on general health: a consensus view. Curr Med Res Opin 2008;24(6):1635-43.
[4] Sheiham A. Oral health, general health and quality of life. Bulletin of the World Health Organization 2005;83(9):641-720.
[5] Bach K, Manton DJ. Early childhood caries: a New Zealand perspective. J Prim Health Care 2014:6(2):169-74
[6] Whyman RA, Mahoney EK, Morrison D, et al. Potentially preventable admissions to New Zealand public hospitals for dental care: a 20-year review. Community Den Oral Epidemiol 2014;42:234-44.

schoolers have evidence of dental decay, compared to 30% of non-Māori non-Pacific children. This level of inequity has not changed over time.

Caries free and mean dmft rates for Māori and Pacific children in the Northern region are similar to rates for Māori and Pacific children nationally.

Figure 1: Caries Free Rates for the Northern Region, by ethnicity



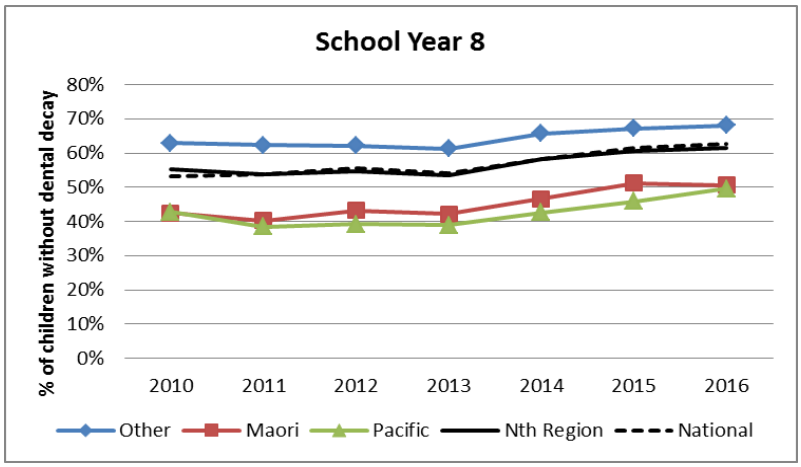
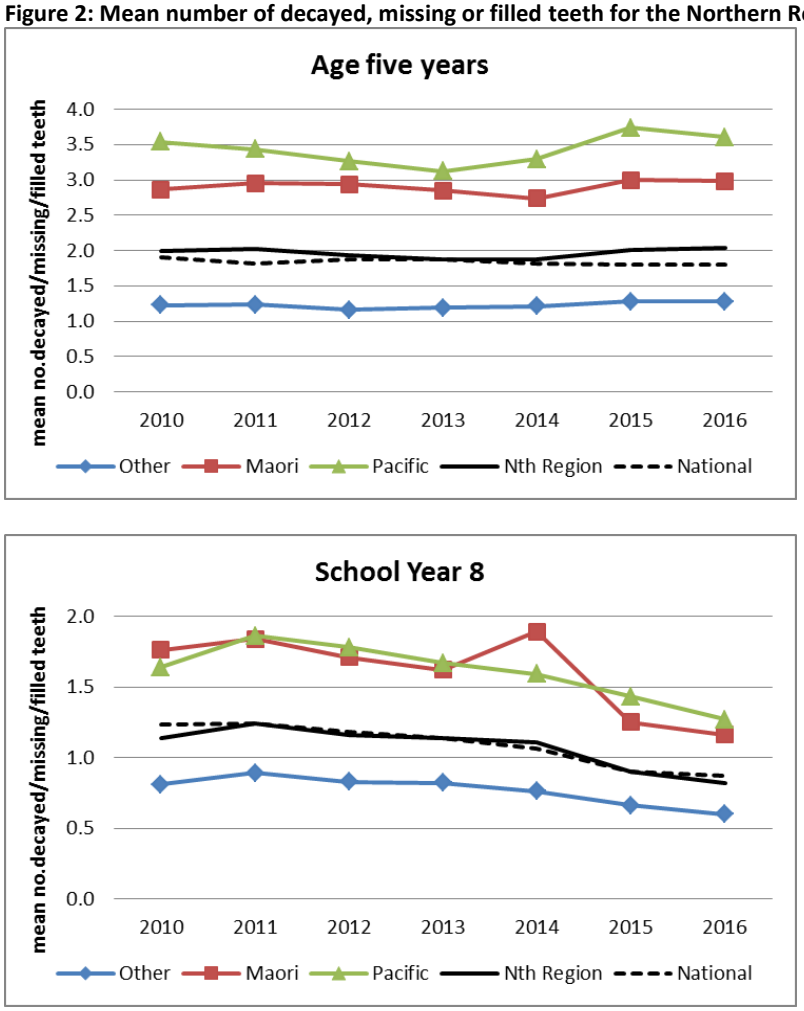
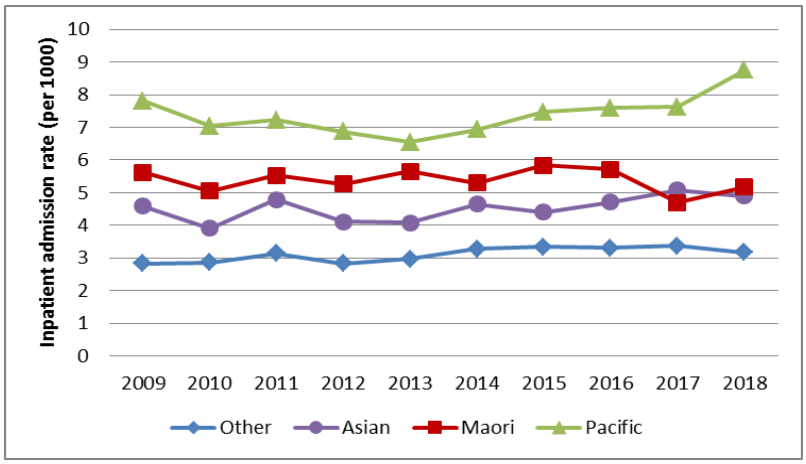


Figure 2: Mean number of decayed, missing or filled teeth for the Northern Region, by ethnicity



Dental admission rates in children aged 17 years and younger are also highest in Pacific children (Fig 3). Rates for Māori children are higher than for other children, but not as high as expected, given caries-free and mean dmft rates, suggesting that there may be issues with access to secondary care.

Figure 3: Dental admission rates for children aged <18 years in the Auckland region, 2010-2018



3.3 Oral Health Outcomes for Adolescents and Adults

Unlike children, there are no standardised outcome indicators (such as caries free or dmft) available for adolescents or adults. However, data from national surveys indicates that ethnic and socioeconomic inequities in oral health outcomes persist into adulthood. Pooled data from recent New Zealand Health Surveys (2014-17) show that there is a high prevalence of dental disease, particularly for Māori and Pacific adolescents and adults and those living in more deprived neighbourhoods. In that dataset, 12% of Pacific, 9% of Māori and 9% of adults living in quintile 5 reported having one or more teeth removed due to decay, infection or gum disease in the previous 12 months, compared to 3.5% of quintile 1 adults and 6% of adults overall.[7]

There is also evidence of significant unmet need for dental care in adults, with more than half of adults reporting that they have never visited a dental health worker or only visited for toothache or problems.[8] Māori and Pacific adults are significantly more likely to report unmet need for dental care than other adults, as are those living in the most deprived neighbourhoods. Even after adjusting for age, sex and ethnicity, those living in quintile 5 neighbourhoods are twice as likely as those living in quintile 1 neighbourhoods to have not visited a dentist. In the New Zealand Oral Health Survey, conducted in 2009, nearly half of adults reported that they felt they currently needed dental care, but had avoided it due to cost.[8]

4. Dental Services in the Auckland Region

In New Zealand, dental services are publicly funded for children from birth until their 18th birthday. Until School Year 8, children primarily receive dental care from dental therapists within the Community Oral Health Service. In Auckland, this service is referred to as ARDS. From School Year 9 until a person's 18th birthday, dental care is provided by private dental practices contracted under the Combined Dental Agreement (CDA). Once a person turns 18, there is a very limited range of publicly funded dental services available for adults. These services include dental treatment due to an accident or injury and specialist oral health care for people with needs that prevent them from accessing community-based dental care. In the Auckland region these services are provided by Auckland Regional Oral Health Service (ARDOH). All Auckland DHBs also fund limited emergency dental care for low income adults, which provides treatment for the immediate relief of pain and infection but no preventative or basic dental care.

4.1 The Auckland Regional Dental Service

ARDS provides screening, early detection, preventive and restorative dental services for preschool and school-aged children. It also provides a triaging service for secondary oral health services. Any child requiring treatment outside the scope of ARDS is referred to either ARDOH (if treatment is required by a paediatric specialist including the use of GA) or a primary care dentist with a Combined Dental Agreement.

ARDS is managed by Waitemata DHB on behalf of all three Auckland metro DHBs. Service provision extends from Wellsford to the Bombay Hills and is delivered in 82 facilities, including 42 fixed clinics and 40 mobile units (1 fully mobile clinic, 18 diagnostic vans and 21 Transportable Dental Units). ARDS has undergone a significant upgrade in facilities and equipment since 2008. This was part of a national reconfiguration of Community Oral Health Services in New Zealand in response to the 2006 publication of the Ministry of Health's *Good Oral Health for All, for Life: the Strategic Vision for Oral*

[7] Ministry of Health (2018). Regional Data Explorer 2014–17: New Zealand Health Survey [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update.

[8] Ministry of Health (2010). Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey. Wellington: Ministry of Health.

Health in New Zealand'.[9] Prior to this time, the free children's dental service was based in schools and primarily focused on dental treatment in school-aged children. The new vision required services to be re-oriented to focus on prevention and the promotion of good oral health.

Addressing oral health inequities, particularly in relation to Māori and Pacific children, was a priority for the new model of care.[9] To improve access, the new model of service delivery used a hub and spoke model, in which services were provided for preschool and school-aged children from a range of fixed and mobile clinical units. However, a formal evaluation of the national dental service reorientation by ESR in 2014 reported that equity was still an issue. Many dental therapists had concerns that those with the most need (including Māori and Pacific children) were still less likely to access clinical services due to the unavailability of transport or parents being unable to take time off work to bring their children.[10]

In 2016, a service review of ARDS was undertaken to better understand whether the service was meeting Ministry of Health and District Annual Plan targets and deliverables, and to identify areas of improvement, particularly in terms of equity.[11] The review reported examination rates of 64-78% of the enrolled population, but treatment completion rates of 54-70% and non-attendance rates consistently above 20%, particularly for Māori and Pacific children and those living in Counties Manukau DHB. Furthermore, chair utilisation was found to be lower than that recommended by the Ministry of Health (eight appointments per day per chair, compared to the recommended 11 appointments per day per chair). Recommendations from the review included the development of a preschool oral health action plan to focus the service on preventative practices for this population, the establishment of a preschool workforce to apply fluoride varnish treatments to Māori, Pacific and high needs preschool children in community locations, and changes to systems and team structures to improve access to care and appointment attendance rates.

Following the review, ARDS developed a service improvement programme to guide the achievement of improved patient experience, improved oral health outcomes and improved service performance. Five primary components were identified within the programme – each with a number of initiatives/projects (Fig 4). At present, there are multiple streams of work underway across all five components within the programme.

Figure 4: ARDS Service Improvement Programme

[9] Ministry of Health. *Good Oral Health for All, for Life: The Strategic Vision for Oral Health in New Zealand.* Wellington: Ministry of Health. 2006

[10] Institute of Environmental Science and Research Limited (ESR). *An Evaluation of the Reorientation of Child and Adolescent Oral Health Services*. Wellington: Ministry of Health; 2014.

[11] Harun L. *Auckland Regional Dental Service Review Report.* ARDS; October 2016.

4.2 Dental Care for Adolescents: The Combined Dental Agreement

Dental care for adolescents is funded via a nationally standardised CDA. The agreement also covers special dental services for children in Year 8 and younger who have been referred from ARDS due to treatment requirements beyond the scope of a dental therapist (for example, some treatments of oral disease, the restoration of dental tissue, or extractions). Care under the CDA in Auckland is primarily provided by three large mobile providers and other private dentists contracted to DHBs. A small number of high-risk adolescents continue to receive services from ARDS.

There are two components of service for adolescents:

- A standard (capitated) package of care for all adolescents which covers an annual examination and all other necessary consultations, diagnostic services, single surface restorations and preventative treatment within the 12-month period.
- Services outside of the capitated package are paid on a fee for service basis.

The CDA excludes services that are not within the scope of practice of a general dentist, dental therapist or dental hygienist, such as sedation and orthodontic treatment.

4.3 The Auckland Regional Dental & Oral Health Service

ARDOH is the regional hospital dental service, providing secondary oral health care services to people living in Auckland, Waitemata and Counties Manukau DHBs. It is funded by the three metro Auckland DHBs, and is managed by Auckland DHB.

ARDOH provide clinical services to a large and growing group of: medically complex and special care patients, children requiring care under GA and patients who require dental or oral health services as an essential part of in- and out-patient hospital medical and surgical treatment. ARDOH also provide very limited emergency dental care for low income adults service, as do dentists in the community who hold a contract with the DHB. In order to access this service, adults must hold a valid Community Service Card. There is a $40 co-payment for this service.

ARDOH provide outpatient services from clinics at Greenlane Clinical Centre, Auckland City Hospital, Starship Children's Hospital, Buckland Road Community Clinic (relief of pain service) and Middlemore Hospital. Day-stay and inpatient operating sessions are provided from Greenlane, Starship, Auckland and Middlemore Hospitals, Quay Park Surgical Centre and, recently, Waitakare Hospital. No outpatient oral health services are provided from North Shore or Waitakere Hospitals. Children referred from ARDS are seen in outpatient clinics. Children requiring care under GA are treated mainly at Greenlane and Quay Park, with smaller numbers at Waitakare. Medically complex children requiring GA are treated as inpatients or via daystay at Starship Hospital. General child orthodontic services are not provided.

The demand for dental treatment for children at ARDOH currently exceeds capacity (Section 6.1).

4.4 Expenditure on Oral Health

Auckland DHB currently spends $17.3 million on oral health and Waitemata DHB spends approximately $21.1 million. A breakdown of this expenditure is shown in Table 1.

Table 1: Expenditure on Oral Health

DHB	ARDS	CDA	Emergency Dental *	Hospital Dental - Outpatients	Hospital Dental - Inpatients	Total
Auckland	$8,790,610	$4,967,819	$828,989	$1,128,301	$1,661,169	$17,376,888
Waitemata	$12,161,080	$5,014,525	$654,352	$1,140,485	$2,145,585	$21,116,027

Note: all expenditure is based on 2018/19 forecast except CDA, which is based on 2017/18 actual.
***includes hospital and community services**

5. The Preschool Oral Health Action Plan

The *Preschool Oral Health Action Plan for the Metropolitan Auckland Region* was developed and finalised in August 2017 in response to marked ethnic inequities in preschool oral health outcomes across the region, which had been evident for years. This is a living plan focused on improving preschool outcomes, particularly for Māori and Pacific children. It takes a systems level view and many of the actions within it will also impact on oral health access and outcomes for school-aged children. The Plan's actions are broadly divided into (i) oral health promotion and (ii) the prevention, early detection and treatment of caries. Oral health promotion activities include the delivery of oral health promotion messages in the community and primary care. These activities are the responsibility of multiple organisations and providers, including ARDS, primary care and WCTO providers. Preventive and treatment activities fall mostly within the scope of ARDS. Activities implemented as part of the Preschool Oral Health Action Plan are being closely monitored and evaluated as they are being implemented. Section 7 provides a more detailed description of the activities where there has been the most focus.

6. Risks/Issues

In addition to significant ethnic inequities in childhood oral health outcomes, which are well recognised and for which there are a number of activities planned and ongoing, there are also a number of challenges in this area that need to be addressed.

6.1 High numbers of referrals and waiting times for children referred to the ARDOH

The ARDOH currently has 2,455 children (aged 17 years and younger) on the waiting list for a first specialist dental appointment (FSA) or dental treatment under general anaesthetic. ARDOH receives approximately 200 referrals per month for specialist assessment, and a significant proportion are subsequently placed on the waiting list for a procedure. With operating theatres working under full capacity, approximately 140 children can receive dental treatment under general anaesthetic per month. Reports from the service indicate that it is challenged in achieving compliance with ESPI requirements that all children are seen at FSA within four months of referral and receive treatment within four months of FSA. This means that many children with severe dental problems wait more than eight months, from the time of referral to completion of definitive treatment. ARDOH cannot consistently meet ESPI requirements, with current referral numbers exceeding its capacity to see and treat these children.

Work is currently being done to address this issue, including the following:

- Developing a more detailed understanding of the patient demographic requiring dental treatment under GA so preventive interventions can be better targeted
- Streamlining the referral process from ARDS/primary care to ARDOH to ensure that all required information is included on the initial referral form to expedite the triage process

- Developing accurate and timely information for Health Pathways to help primary health and dental care providers to better support children, adults and families awaiting treatment
- Evaluating ARDOH clinical service delivery models to improve efficiency and effectiveness of care
- Exploring options to increase clinical capacity of ARDOH
- Developing better data capture, audit and reporting tools
- Actively exploring ways that ARDS and the ARDOH can work together so that children do not need to be referred for extractions and other dental treatment in the first place. Much of the work that ARDS is currently doing, as outlined in Section 6, is focused on prevention and the early detection of decay to prevent the need for major treatment.

6.2 A high proportion of dental therapists will be at retirement age in the next 10 years

The recruitment of dental therapists is an issue across New Zealand, with many centres reporting difficulties filling vacancies. An analysis of the 2015 dental therapy workforce (at which time there were 875 practising therapists) reported that one-third are aged 55 years and older.[12] Retirement of these therapists will therefore have a significant effect on Community Oral Health Services. As at September 2018 ARDS has approximately 20 dental therapy positions vacant across metro Auckland.

Recent analysis undertaken by ARDS indicates that there are a number of reasons that dental therapists are choosing to leave the service. These include retirement, moving out of Auckland and moving into private practice. ARDS has developed a strategy to attract and retain therapists and assistants, including:

- Reviewing the content of advertisements and ensuring roles are advertised in local media
- Implementing additional supports for new and recent graduates
- Partnering with staff to offer more flexibility in location and hours of work
- Encouraging dental assistants to participate in Career Force training
- Addressing issues that are identified impacting on job satisfaction
- Identifying opportunities for staff to be involved in the development and implementation of new models of care
- Identifying strategies to enable dual trained (dental therapy and hygiene) therapists to maintain competency across both scopes of practice.

The dental therapy workforce also needs to reflect the population it serves, and in 2015, 11% of dental therapists identified as Māori and 5% Pacific, most of whom identified as Fijian or 'Other Pacific'. Specific programmes have been used to raise awareness of dental therapy as a profession to Māori and Pacific secondary school students (such as the Pacific Health Science Academies) and to mentor Māori and Pacific oral health students to be more 'employment ready' for DHBs (such as Programme W&AT – Working & Achieving Together). However, more work needs to be done to actively recruit more Māori and Pacific people into dental therapy training at the Auckland University of Technology (AUT) or Otago University. AUT, based on the North Shore, does not currently have a programme to promote dental therapy or actively recruit Māori and Pacific students. There is an opportunity for ARDS and/or the wider DHB to work more closely with the team at AUT to achieve this.

[12] Dental Council Workforce Analysis 2013-2015. New Zealand Dental Council; July 2017. Available at https://www.dcnz.org.nz/assets/Uploads/Publications/workforce-analysis/Workforce-Analysis-2013-2015incl-2012-updated-demographics.pdf.pdf

7. Progress and Activity for Preschool and School Aged Children

This section reports progress on key performance indicators, developed specifically to measure the progress of implementation for the Preschool Oral Health Action Plan. It also provides a more detailed description of other activities that have been implemented over the past 12-18 months.

7.1 Prevention, Early Detection and Treatment

7.1.1 Preschool ARDS Enrolments

Ensuring that all children are enrolled in ARDS is a crucial first step in ensuring that all children are able to access the service. Figures 5 and 6 show the percentage of children in the metro Auckland region enrolled in ARDS by the age of two and all children up to the age of four. Percentages for Asian and Other ethnic groups exceed 100% at some points because of a mismatch in ethnicity data between the Census (used for the denominator) and health data (used for the numerator). Work is being done to ensure ethnicity is being reported correctly within the Titanium system that is used by ARDS.

Figure 5: Percentage of children in the Auckland region enrolled in ARDS by the age of 2 years

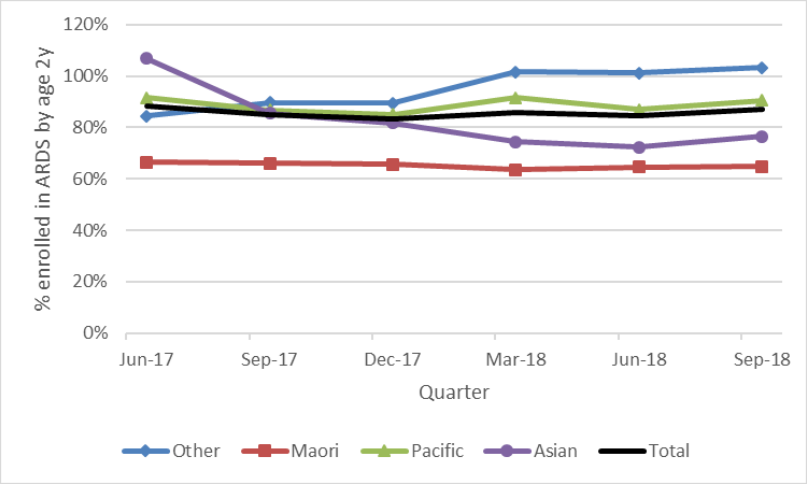
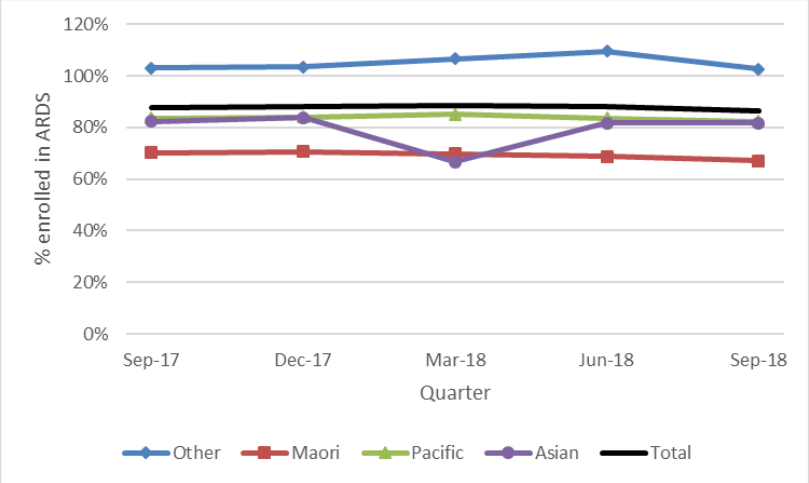


Figure 6: Percentage of 0-4 year olds in the Auckland region enrolled in ARDS



ARDS has been automatically pre-enrolling children into its service from birth lists since mid-2017 in Auckland and Waitemata DHBs. As a result, the proportion of children enrolled in ARDS by the age of one year has increased steadily, and in June 2018 was 77% at Auckland DHB and 92% at Waitemata DHB. ARDS is currently working closely with Counties Manukau Health to introduce a similar process. Testing is currently being completed and it is anticipated automated enrolments from birth lists will be operational by December 2018. In September 2018, 26% of children at Counties Manukau DHB were enrolled in ARDS by the age of one. Automatic enrolment at birth for Counties Manukau DHB will also have an effect on increasing Auckland DHB enrolments of babies younger than one year due to the number of Auckland DHB domiciled babies born in Counties Manukau facilities.

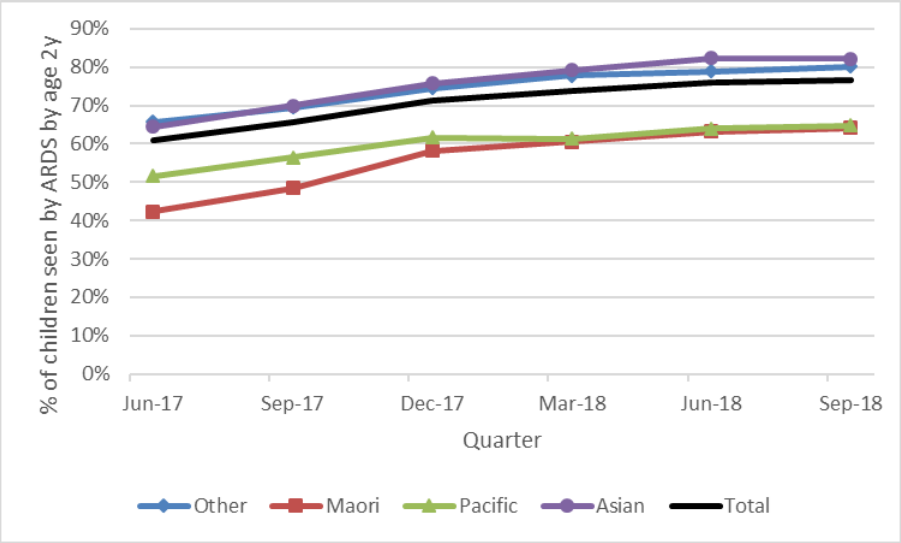
Māori children continue to have lower enrolment rates than children of other ethnicities. The reasons for these lower enrolment rates are unclear, and as mentioned previously, work is currently underway to ensure ethnicity data in the ARDS system is accurate. At Auckland and Waitemata DHBs, ARDS is also working closely with the Māori Health Gain team and Māori providers to conduct a data matching process to identify children enrolled with a Māori health provider not currently enrolled in ARDS and/or have not received an examination. Across five Māori providers, the percentage of preschool children not enrolled in ARDS ranged from 12-88%. This is also part of a wider engagement process aimed at strengthening working relationships between ARDS and other health providers.

The National Child Health Information Platform (NCHIP), an electronic system enabling the sharing of information on key childhood health milestones, will also be a vehicle through enrolments and contact information details for all children up to the age of six years can be kept up-to-date. ARDS is working closely with the NCHIP development team to ensure that key dental health milestones are included in the system.

7.1.2 Access to care

Improving access to care has been a particular focus for ARDS, particularly for Māori and Pacific families. There has been a marked increase in utilisation of the service (ie. the number of children enrolled who are seen) for all ethnic groups over the past 18 months (Fig 7). However, utilisation rates remain lower in Māori and Pacific, compared to other, children, so an ongoing focus on increasing access for these children is necessary to close the equity gap. ARDS has implemented a number of interventions to do this. These are detailed in the sections below.

Figure 7: Percentage of children examined by ARDS by the age of 2 years



Apart from enrolment and utilisation, ARDS is also required to report arrears (a measure of timeliness of access) to the Ministry of Health. Arrears measures the proportion of children who are overdue for their scheduled examination. The national target is that 10% or less children are in arrears. As shown in Table 2, the national target has not been met for any group at Waitemata and Auckland DHB. However, the strategies to increase access to the service, outlined below, particularly the work around recall periods, will support a reduction in arrears.

Table 2. Total Arrears in 2017

DHB	Total	Māori	Pacific	Other
Waitemata	18%	20%	20%	18%
Auckland	16%	16%	16%	16%

7.1.3 Matching the length of the recall period to the level of dental health need

ARDS runs a model of individualised dental care, which allows children to be seen (recalled) at 6, 12- or 18-month intervals, depending on their clinical needs and oral health status. In early 2017, analyses were conducted of oral health outcomes at age five years and time between dental appointments. These analyses clearly showed that most children using the ARDS service were being placed on 12-month recalls without due consideration of the risk of dental decay. This meant that resources were not being used efficiently to cater to children most in need.

To ensure all children are seen in a timely fashion and based on clinical need, a careful process to estimate the proportions of children that should have been on six-, 12- and 18-month recall periods was conducted. Alongside this process, a simplified needs assessment tool was developed to support dental therapists to determine appropriate recall periods for each child in their clinical practice. This included a directive to put all Māori and Pacific children on six-month recalls unless clinical assessment indicated otherwise.

Between November 2017 and January 2018, a pilot of the simplified needs assessment tool and new recall period guidelines for preschool children was undertaken in three ARDS teams (one in each of the three metro Auckland DHBs). Following consultation with ARDS team leaders, this new system was implemented across all teams. A similar process is currently being developed for school-aged children.

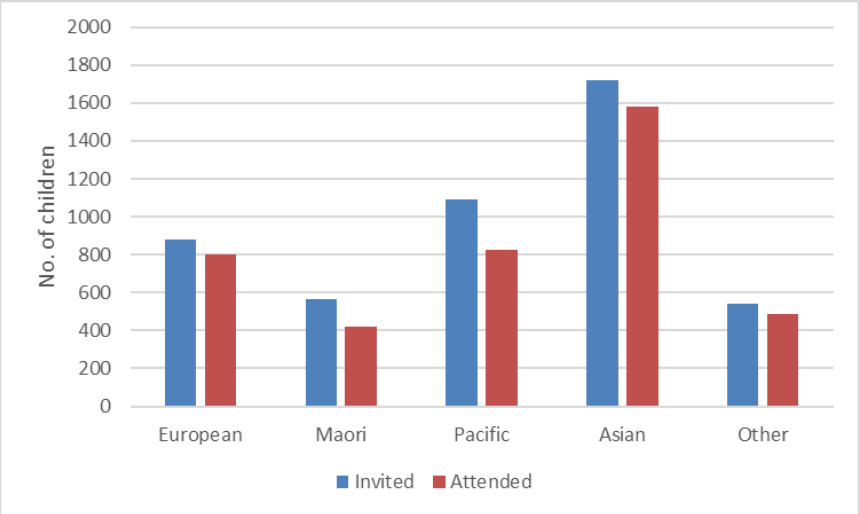
Prior to this intervention, approximately 20% of children at Auckland and Counties DHBs and 10% of children at Waitemata DHB were being seen six-monthly and 10% of children across all DHBs were being seen every 18 months. Following implementation of this new recall system, similar proportions of children are on six-month recall periods and across the three metro Auckland DHBs there has been a 50% increase in the number of low needs children being appropriately assigned an 18-month recall date. This system has allowed ARDS to shift resources to children at highest risk of dental decay. Feedback has indicated that the new process has been well received by staff.

7.1.4 Saturday Clinics

ARDS is the only Community Oral Health Service in the country that offers Saturday clinics for families unable to access services during the working week. Saturday clinics were trialled in the Browns Road (Manukau) clinic in late 2017 to increase access, particularly for pre-schoolers. Following high interest and utilisation, five other clinics are now open on Saturdays from 8am to 430pm: Puinuhi Road (Papatoetoe), Botany, Wesley, Pt England and Glen Eden. These clinics were chosen because of their location in areas of high-need or close to public transport and amenities. They have been well attended, with average chair utilisation rates of 20-22 children per clinic. Between January and September 2018, 4117 children (mainly pre-schoolers) received dental assessments at Saturday clinics, approximately one-third of whom were Māori or Pacific (Fig 8).

More work needs to be done to ensure this service is accessed by Māori and Pacific whanau in order to ensure that we do not inadvertently increase inequity.

Figure 8: Number of children who were invited and attended Saturday clinics, Jan-Sep 2018



7.1.5 Group-based first appointments for infants

ARDS has been working closely with parents to better understand the barriers and enablers to attendance. In 2017, 53,464 appointments were made for children aged one year. Of these, approximately 41,500 (77%) were either rescheduled or not attended. Previous feedback from parents of toddlers strongly indicated that many people did not see the value in their child's first ARDS appointment, as it frequently only involved a dental therapist looking in their child's mouth. There also did not seem to be a good understanding of the importance of baby teeth. ARDS is therefore trialling a new model of care for first appointments, using a small group-based approach with a focus on oral health promotion. These sessions, which started in late September 2018 in the Chapel Downs clinic, involve groups of six toddlers and their parents, who receive oral health promotion and dental examinations in the community. The sessions will follow a Plan-Do-Study-Act cycle, where feedback from parents will be used to tailor and continuously improve the sessions.

7.1.6 Centralised and family-focused bookings

ARDS is trialling centralised and family-focused bookings in four clinics. Family-focused bookings will allow parents to choose a convenient appointment time and all children in the same family can be seen at the same appointment. ARDS is also one of the first services to be part of the Waitemata DHB Email Project, which will allow appointment letters and reminders to be emailed to everyone with a registered email address.

7.1.7 Integration of dental examinations into the Gateway Programme

The Oranga Tamariki Gateway Programme is a national programme that provides health assessments and support to services for children in the care of Oranga Tamariki – Ministry for Children. ARDS has been working closely with the Starship Community team and the Waitemata DHB Gateway Assessment team to integrate oral health assessments and the application of fluoride varnish into these health assessments, as well as supporting children in need of further management to attend appointments and complete all dental treatments through the ARDS supportive treatment pathway.

7.2 Preventive interventions and oral health promotion

7.2.1 Project to align healthy weight and oral health messages for child health providers

Dietary sugar is a common risk factor for both dental caries and obesity. A common set of key health messages that can be used by health professionals working in the area of oral health and/or healthy weight is being developed. This project is building on the significant work undertaken in Northland DHB and will be rolled out in Quarters 2 and 3 to ARDS, WCTO providers, primary care and other key child health professionals.

7.2.2 Development of Community Engagement Coordinator roles within ARDS

ARDS has developed Community Engagement Coordinator roles within each DHB to help deliver the topical fluoride outreach programme (see next section) and support other outreach and oral health promotion activities in the community. ARDS is currently recruiting a Community Engagement Project Lead, who will work with Māori and Pacific families, community groups, marae, churches, key community leaders and school Board of Trustees to promote oral health and raise awareness of ARDS in high-needs communities.

7.2.3 Primary care and WCTO oral health promotion activities

The Ministry of Health has developed the System Level Measures Framework to support DHBs and primary care to work together. The Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds is one of the System Level Measures with dental conditions being one of the key causes of ASH. Primary care and DHBs have therefore been working together and in 2017 the focus was on increasing enrolments into ARDS. In 2018 the focus moved onto training practice nurses to undertake 'Lift the Lip' assessments, provide oral health promotion and refer children to ARDS for further examination/treatment.

To further strengthen the relationship between ARDs and primary care, two representatives from primary care (one from Alliance Health Plus, a PHO with a high proportion of Pacific patients, and one from Procare, the largest PHO in Auckland) were recruited to the Preschool Oral Health Strategy Steering Group. This group meets bimonthly to discuss important oral health and dental service issues.

Both Alliance Health Plus and Procare PHOs have been working closely with practice nurses to ensure that opportunities to check that children are enrolled with ARDS and that families are aware of the ARDS service are utilised in primary care. Alliance Health Plus also conducted a brief intervention in 2017 that involved practice nurses checking the dental health of Māori and Pacific pre-schoolers attending primary care through 'Lift the Lip' checks.

WCTO providers also play a key role in oral health promotion and ensuring preschool children receive oral health care. Oral health is included in core Well Child checks from the time a child is age 5-7 months. Mean dmft at age five is also included in the WCTO Quality Improvement Framework. To support WCTO providers in their provision of oral health promotion, ARDS provides workshops to providers as required. ARDS has also been collaborating closely with WCTO providers to ensure that the contact details of all children are up-to-date and to enable providers to connect directly with ARDS booking coordinators to obtain urgent ARDS appointments close to home.

7.2.4 Topical Fluoride Varnish for all children and outreach to High Needs ECEs

As part of its focus on prevention, ARDS introduced a policy in July this year to apply topical fluoride to all children at their recall appointment, particularly Māori and Pacific children, who are at high risk of dental decay. Auckland and Waitemata DHBs also have implemented a target for 80% of Māori and Pacific children to have received topical fluoride by the age of two years. The change in practice has been concerningly slow by dental therapists as shown in Table 3. To ensure fluoride

varnish application occurs it is also included in the ARDS clinical prioritisation tool as an expected intervention for all children and monitored in dental therapists' clinical audits. Data recording systems are also being upgraded to ensure that all fluoride varnish applied at appointments or during outreach are recorded easily and able to be reported.

Table 3: Application of Topical Fluoride Varnish by age 2 years

Ethnicity	Auckland DHB	Waitemata DHB
Māori	15%	7%
Pacific	18%	8%
Total	**12%**	**5%**

A programme of topical fluoride application to pre-schoolers in high-needs ECEs is also being systematically rolled out across the metro Auckland region. This was piloted successfully in four Kohanga Reo and two Pacific Language Nests on the North Shore (where ARDS staff had pre-existing relationships with ECE staff) between March and July of this year. The programme is led by a dental therapist and supported by dental assistants and Community Engagement Coordinators. The programme is also an opportunity to enrol children not previously known to the service, complete 'lift the lip' examinations and facilitate ARDS appointments for those not previously seen or overdue for assessments. All children also receive a toothbrush and oral health promotion pack and opportunities are taken to engage with whanau, addressing issues or concerns and promoting oral health. All participating ECEs will be visited every six months to ensure these children receive regular preventive therapy. This programme has provided an opportunity for Māori and Pacific ARDS staff in particular to establish and strengthen relationships with their communities and to utilise their language and cultural skills.

Since the Fluoride Varnish Programme started this year, 149 preschool children from nine different centres (six on the North Shore, one in Ranui and two in Glen Innes) have been seen. These nine centres include two Samoan language nests, two Tongan language nests, four Te Kohanga Reo and one ECE with a high proportion of Māori and Pacific children.

Ten more centres have been contacted, and there are plans to visit them this year or early next year. These include five Tongan language nests, three Samoan language nests, one Te Kohanga Reo and one ECE learning centre with a with a high proportion of Māori and Pacific children. The Māori Health Gain Team, Te Whanau o Waipareira Trust and ARDS are currently working together to develop a plan for Waipareira to support ARDS to deliver topical fluoride to the eight West Auckland Kohanga Reo and ensure that all children there are enrolled and have current oral health management plans.

7.2.5 Health Promotion Agency Child Oral Health Promotion Initiative

In 2016, the Ministry of Health funded the Health Promotion Agency (HPA) to develop a Child Oral Health Promotion Initiative to raise awareness of the importance of looking after children's teeth. The priority populations for this initiative were Māori, Pacific and low-income whanau of children under the age of five years. The initiative had two components: (1) a national campaign to encourage parents and caregivers of children under five to brush teeth twice a day with fluoride toothpaste and (2) the development of tools and resources to support parents and caregivers of pre-schoolers to establish and maintain good oral health behaviours.

The national campaign focused on three key messages:

(1) Baby teeth are important and necessary for the health of permanent teeth

(2) Under five-year-olds need to have their teeth brushed by an adult

(3) Baby teeth should be brushed twice a day with fluoride toothpaste.

The campaign was initially launched on social media in November 2016, with television and radio advertisements starting in February 2017. HPA undertook research on the effectiveness of the campaign and found that, of those surveyed, almost 9 in 10 Pacific and Māori respondents had seen the campaign, significantly higher than those of other ethnic groups.[13] Furthermore, 35% of Pacific and Māori parents reported that they had made changes to their child's dental care as a result of seeing the campaign, mostly ensuring that their child brushed their teeth twice daily. 7% of Māori and 15% of Pacific parents who made changes reported that they had bought a toothbrush as a direct result of the campaign.

Importantly, this evaluation also found misconceptions about tooth brushing were still common – for example, 40-50% of parents either agreed or were not sure about the following statements: 'you should use low strength fluoride toothpaste for children', 'many children under 5 years can brush teeth by themselves', and 'when baby is breastfed they don't need their teeth brushed'. These misconceptions can be dispelled through community awareness raising and accurate messages reinforced at WCTO, primary health care and dental care visits and also through community initiatives. For example, ARDS and Te Whanau o Waipareira Trust are currently developing a plan to include oral health promotion into Waitangi Day community celebrations in 2019.

8. Progress and Activity for Adolescents and Adults

8.1 Adolescents

The Ministry of Health sets a utilisation target of 85% of adolescents from school year 9 to 17 years of age to receive annual dental care. Utilisation in the Northern region has been consistently at around 70% since 2011, but is much lower for Māori adolescents – less than 50% in both Auckland and Waitemata DHBs (Table 4).

Table 4: 2017 Adolescent Dental Coverage for Auckland DHB

Ethnicity	Auckland DHB	Waitemata DHB
Māori	48%	47%
Pacific	69%	68%
Asian	61%	67%
Other	66%	77%
Total	**63%**	**69%**

Work is planned to develop some quality assurance indicators that will be able to be shared with contracting dental providers. DHBs also now have two years of raw claims data. This means we are able to track adolescent use of the service from transfer from ARDS to where adolescents are being seen each year. A focus of this analysis will be trying to understand why Māori adolescents are not accessing the service and what is working well in low decile schools with high service uptake that can be replicated in the other schools to improve Māori and Pacific utilisation. Analysis will also be undertaken to explore whether local services are available to all adolescents, whether they are in school or not.

A workshop to consider possible actions to improve access and utilisation of adolescent oral health services was held in September. Some key actions from this workshop included:

[13] Health Promotion Agency. (2018). *'Baby Teeth Matter': Insights and impacts of the 2016-2017 Oral health campaign*. Health Promotion Agency: Wellington.

- Working with Māori and Pacific organisations to promote oral health and access to services
- Looking to develop systems to ensure adolescents receive the oral health care
- Reviewing communication when adolescents change service provider from ARDS to a community dentist
- Working with Māori and Pacific providers to talk to adolescents on their knowledge, perceptions and use of the service.

8.2 Adults: Maternal Oral Health

One of the recommendations from the Preschool Oral Health Action Plan was the implementation of a free/low-cost maternal oral health service for high needs or expectant/new mothers. Pregnancy can increase the risk of poor oral health outcomes for women, and poor oral health can lead to pregnancy complications, such as prematurity and low birth weight.[2] Pregnancy also provides an important opportunity to promote the importance of good oral health and the establishment of oral hygiene habits for their offspring.

From 2012 to 2015 Counties Manukau Health and Waitemata DHB received funding from the Ministry of Health to trial a low-cost maternal oral health service for pregnant women in their regions.14 More than 800 women participated in the trials, which found a high degree of oral health need. On average, women required six appointments to complete treatment. An evaluation of the trials reported improvements in self-care behaviours, increased satisfaction with oral health status, reduced pain and self-consciousness, and less disruption to diet and eating. Child enrolment in ARDS also increased as a result.13 Unfortunately, both services were discontinued when the trials finished, as there was no further funding available.

In May 2018, funding for a new oral health service for 300 pregnant women/new mothers in the Tamaki/Glen Innes area was approved at Auckland DHB. This service, currently in the planning stages, will be delivered by ARDS. The aims of the service, targeted at Māori, Pacific and low-income women, are to restore pregnant women's oral health, improve mothers' and babies' overall health and wellbeing, and reduce inequities in preschool oral health outcomes. The service will be formally evaluated and indicators developed to measure progress and monitor quality.

9. Conclusion

Inequities in preschool oral health outcomes are being addressed via the implementation of actions from the Preschool Oral Health Action Plan over the last year. These will continue to be monitored. Quality assurance and outcome measures for adolescents are currently being investigated. There are still high numbers of children being referred for dental treatment under GA to the ARDOH. It will take some time for the preventive actions from the preschool plan to have a noticeable impact on oral health outcomes. In the meantime, other ways of supporting the service and other providers of care for these patients is being investigated.

[14] Litmus. Evaluation of the Low-cost Oral Health Trials Final Report. Prepared for The Ministry of Health Manatu Hauora, September 2016.

4.2 Auckland Regional Public Health Service (ARPHS) update

Recommendation:

That the Community and Public Health Advisory Committee:

(a) Receives this update from Auckland Regional Public Health Service.

(b) Notes the key pieces of work that are underway and/or completed since the last update in May 2018.

Prepared and submitted by: Jane McEntee (General Manager, Auckland Regional Public Health Service (ARPHS))
Endorsed by: Dr Margaret Wilsher (ADHB Chief Medical Officer)

Purpose

ARPHS is providing this update to Waitemata and Auckland CPHAC on key pieces of work that are underway or have been completed since the last update in May 2018. The report contains the following updates:

1. Communicable disease outbreak management.
2. Ill traveller notification
3. Updated Tuberculosis (TB) Guidelines
4. BCG Programme restart and demand
5. Notice of aerial 1080 drop in Hunua Ranges
6. Safeswim awards
7. Drinking water
8. Exit strategy for small water self-supplies work
9. Community water fluoridation position statement
10. Wai Auckland (an obesity prevention initiative which will support improved oral health).
11. Smokefree
12. Alcohol presentation
13. Healthy Auckland Together (HAT)
14. Saltmarsh mosquito Kaipara operation
15. Submissions

1. Communicable disease outbreak management

1.1 *Mumps outbreak update*

ARPHS is continuing to manage the mumps outbreak in the Auckland region that began in January 2017, although new mumps case notifications have slowed significantly over the last four months, with an average of one-three cases per week. ARPHS is monitoring notifications and providing advice as needed. To 30 September 2018, 1323 confirmed and probable mumps cases have been notified to ARPHS since the outbreak began.

1.2 *Dengue Fever*

Towards the end of 2017 and beginning of 2018 ARPHS received an increase in dengue fever notifications. As part of our response ARPHS developed an information sheet for people travelling to the Pacific Islands providing advice on how to avoid mosquito bites. ARPHS communications team is developing a plan on how to communicate these messages more widely and for this resource to be translated. The current information can be found on the ARPHS website:

http://www.arphs.govt.nz/health-information/communicable-disease/dengue-fever-zika-chikungunya

1.3 Enteric Diseases - *Gastroenteritis outbreak*

ARPHS has been involved in the investigation and management of a number of gastroenteritis outbreaks at residential care and other institutions in the six months from April to September 2018. As is the case with other years the main cause was most often determined to be norovirus, a known source for widespread institutional outbreaks that can be difficult to control due to its virulence.

While most outbreaks involved less than ten people ARPHS has been involved with a small number of larger outbreaks, including a large outbreak at a single aged-care facility where close to 100 staff and residents were affected, a private hospital facility with 80 cases, and a school campus where 75 children were symptomatic.

Following notification of these outbreaks, ARPHS undertakes the following actions:

- a triage response including a risk assessment based on outbreak details;
- immediate prevention advice;
- working closely with the residential care or institution to support control of the outbreak;
- daily surveillance of the outbreak;
- conducting site audit assessments if required to ensure compliance with the institution's illness policy or relevant outbreak management protocols.

To support some enteric disease investigations, rather than face-to-face interviews, when appropriate, ARPHS is now using a web-based data collection tool. This will improve the efficiency of capturing information on exposures to risk factors associated with development of enteric illnesses. This information is supporting timely public health action.

1.4 Meningococcal Disease

ARPHS worked closely with St Johns Ambulance Services, providing public health management and support following the death of a 16 year old male in Auckland City Hospital on 20 October 2018 due to confirmed meningococcal disease.
The young person involved resided in a region outside of Auckland where he may have been exposed to meningococcal bacteria. He became unwell while at a youth cadet camp on Motutapu Island, therefore ARPHS staff were sent to provide antibiotics, health education and support to those who were also attending the camp. The incident generated a lot of media interest with ARPHS responding to multiple media inquiries.

There has been a random cluster of 8 cases of meningococcal disease over the last four weeks in the Auckland region, however, no outbreak has been identified. There has been an observed increase in non B meningococcal disease nationally and in the Auckland region, which is being monitored by the Ministry of Health.

2. Ill traveller notification

Medical Officers of Health are responsible for granting or withholding pratique in ill traveller events. On 9 September, ARPHS was notified of a potential ill traveller event where 100 passengers on an international flight from Australia were reported unwell by the airline. There was a high level of concern because the potentially symptomatic passengers were reportedly returning from Saudi Arabia, where a serious infectious disease MERS (Middle East Respiratory Syndrome) is circulating.

Pratique was withheld while St John Ambulance staff screened all the passengers on board the plane to identify unwell passengers and assess whether further medical treatment was required. No passengers were identified as seriously unwell and all passengers were allowed to disembark and leave the airport without further medical treatment.
ARPHS worked closely with St John Ambulance and Auckland International Airport to ensure that the event was managed as efficiently as possible, with the entire response completed within two and a half hours.

An internal and external debrief has been conducted to review the response. The external debrief included all key stakeholders from Auckland Airport. Recommendations will be developed as part of this process.

3. Updated Tuberculosis (TB) Guidelines

New Zealand has previously adopted the World Health Organisation's End TB Strategy, which sets global targets to eliminate TB as a public health problem by 2035. This includes:

- a 95% reduction in the number of TB deaths compared with 2015;
- a 90% reduction in the TB incidence rate compared with 2015; and
- zero TB-affected families facing catastrophic costs due to TB.

The global strategy emphasises the need for all countries, including low-incidence countries like New Zealand, to progress towards pre-elimination (< 10 cases per million) and eventually elimination.

The Ministry of Health has reviewed and redrafted the New Zealand TB guidelines to align them with the priority action set by the WHO. ARPHS coordinated discussions with key clinicians working in TB control including ID services, TB Respiratory and Microbiology within the Auckland and Northland regions. Feedback was collated and a coordinated regional response to the draft guidelines was sent to the Ministry.

4. BCG Programme restart and demand

The Bacille Calmette Guerin (BCG) programme is free to children under five years to protect them from tuberculosis. Due to an international vaccine shortage, there has been a two year break. The programme re-commenced in August 2018. The demand for the vaccine has exceeded expectations. Over August and September 50 clinics have been run across the three DHB regions, vaccinating around 1100 children. Around 1600 children are waiting for clinic appointments and additional clinics have been set up to help manage the workload.

5. Notice of aerial 1080 drop in Hunua Ranges

Sodium fluoroacetate (1080) is regulated as a Vertebrate Toxic Agent (VTA). VTAs are used for protection of native animals and forests against introduced pest animals, control of bovine tuberculosis, rodent control in rural and urban environments and control of rooks and invasive introduced fish species.

The Environmental Protection Agency has delegated the function of assessing and granting permissions for the use of selected VTAs (including 1080) under the Hazard Substances and New Organisms Act (HSNO) to Medical Officers of Health and Health Protection Officers who are also warranted HSNO enforcement officers. The delegation includes authority to add, delete or otherwise varying any condition of a permission; and to revoke a permission.

In 2015 ARPHS assessed and audited the first application of aerial 1080 operation in Auckland in a decade. The operation covered the Hunua Ranges and some private lands in the surrounding area with property owners' consent. Auckland Council anticipated that pest numbers (rats, possums, stoats) would need to be addressed on a three- five yearly basis with repeating operations.

The application for the second operation was received on 16 July and a final permit condition was issued by ARPHS on 27 August following a full risk assessment. In September, the aerial 1080 operation was challenged in the Environment Court due to concerns raised by Friends of Sherwood Trust and the Ngati Paoa Trust about the perceived public health risk of the operation to contaminate Auckland's southern drinking water reservoirs. A temporary injunction was sought by and issued on 6 September by the Environment Court.

An interim hearing was subsequently held on 13 September 2018. Judge Smith, who issued the temporary injunction, asked that ARPHS submit an affidavit and attend the hearing as a 'friend of the court'.

On 21 September, the Court made the decision to allow the operation. In its decision document, the Court provided analysis of the material before it, including reviewing the evidence about the HSNO approval. It was favourable in its findings in respect of the proposal and the permit conditions, which reflected well on the ARPHS' processes. The Court had a clear understating of the evidence presented by ARPHS as to how the risk assessment and permit conditions work to protect the water supply.

On 22 September, subsequent to the court decision, Auckland Council proceeded with the 1080 aerial application in the Hunua Ranges. ARPHS has conducted an operational audit in accordance with permit conditions.

6. Safeswim awards

From February to November 2017, Auckland Council (the lead agency) worked in partnership with ARPHS and Surf Life Saving Northern Region to upgrade their Safeswim programme. The aim of the programme was to provide accurate predictive information about swimming conditions in the region. In response, Council is focusing on mitigating pollution sources.

In July 2018 Safeswim was the winner in the Smart Water Category of the Smart Cities Asia Pacific Awards. With respect to the award, IDC Market Analyst Jefferson King says, "What stood out about the Safeswim project was the high level of collaboration between the different organisations and the increased accuracy it delivers. The positive outcomes of the project itself are clear, helping locals make better informed decisions regarding swimming safety."

Additional accolades were received from the 2018 TVNZ-NZ Marketing Awards (Public Sector award) and Surf Life Saving Northern Region (SLSNR) Awards of Excellence judged the programme to be 'Innovation of the Year'.

7. Drinking Water

An annual audit was conducted by IANZ in September and ARPHS were re-accredited as a Drinking Water Assessment Unit (DWAU). Additionally, three ARPHS Drinking Water Assessors were audited and have received new, three year, individual IANZ accreditations.

8. Exit strategy for small water self-supplies work

ARPHS has previously been involved with reviewing the water quality test results from specified self-supplies each year. This information has then been included in the Ministry of Health's annual drinking water survey, which is used to monitor the quality of drinking water around the country. From 1 July 2018 ARPHS discontinued this work following a request from the Ministry of Health that Public Health Units no longer be involved with specified self-supplies of drinking water.

This work will now be done by Auckland Council. ARPHS is in the process of providing handover training to compliance officers in Auckland Council to ensure efficient and consistent continuation of the work.

9. Community water fluoridation position statement

ARPHS is leading the development of a DHB position statement on community water fluoridation, to provide a regional statement for the three Auckland DHBs. The draft position statement has been included on the agenda for this meeting as an item for consideration before going to each of the Boards for approval. The position statement will provide transparency on the DHB's position on community water fluoridation ahead of the possible transfer of decision-making on fluoridation from local government to DHBs. Northland DHB has an existing position statement which they have shared to inform this work.

10. Wai Auckland

Work has commenced on the "Wai Auckland" programme aimed to displace sugar sweetened beverage with tap water. The programme includes the DHBs, ARPHS, Auckland Council, Auckland Transport and Watercare. This programme will include increased access to public drinking water fountains. The Project Manager for Wai Auckland has recently been appointed. A consumer research stocktake has also been completed to inform whether additional consumer research should be undertaken. Wai met with Coca-Cola Oceania and Coca-Cola Amatil NZ who shared baseline water consumption data and related consumer insights to support the monitoring of Wai Auckland.

11. Smokefree

The ARPHS Health Improvement Team shared their preliminary findings from a study on Auckland Tobacco Retailers in a letter to the editor of the New Zealand Medical Journal on 21 September 2018. The article was published following the Director-General of Health's Report on the state of Public Health and other recent publications that had sparked interesting debates in the media about reducing tobacco retailers.

In the study, 19 dairy owners were randomly selected from six local boards in Auckland. The letter focussed on the retailers support of Government taking action to reduce the availability of tobacco, and suggested that a voluntary approach wouldn't be sufficient. The letter received media attention with coverage in Stuff, National radio, radionz.co.nz and NewstalkZB.

ARPHS Smokefree Compliance Officers recently ran 96 controlled purchase operations (CPO's) over the October school holidays which resulted in a total of eight sales of tobacco to minors. The majority of these sales were in South Auckland which has the highest smoking prevalence in

Auckland. Four of the non-compliant retailers were petrol stations and four were dairies. ARPHS is considering potential future projects to reduce the availability of tobacco and address non-compliance on a larger scale.

12. Alcohol presentation

ARPHS presented at the seventh Alcohol Action NZ annual conference (co-hosted by Massey University's SHORE & Whariki Research Centre) at Te Papa, Wellington, on 'Who should pay for all the harm from alcohol?'. Dr Julia Peters and Jessica Bowers were keynote speakers exploring the range of alcohol-related harms in New Zealand.

The presentation 'Harm from alcohol – Impact on the health sector' explored:

- the wide-ranging impacts of alcohol use;
- the stress that the health system is under;
- some key health information (including that alcohol use is the risk factor that creates the single largest health loss in New Zealand for 15-49 year olds);
- the high proportion of DHBs with evidence-based position statements relating to alcohol; and
- suggestions for ways forward, including implementing recommendations from the Law Commission Report.

Media coverage of the conference centred mostly on BERL's (Business and Economic Research Limited) estimation of alcohol-related harm costing New Zealand $7.85 billion per year.

13. Healthy Auckland Together (HAT)

Healthy Auckland Together is a coalition of 27 partners committed to making it easier for Aucklanders to eat better, be physically active and maintain a healthy weight. HAT partners include health entities, local government, iwi-based organisations and non-governmental organisations. The Auckland Dental Association and the Diabetes Project Trust have recently joined as HAT partners.

During April to October 2018 HAT has undertaken the following:

13.1 *Marketing to Children*

Representatives of HAT met with McDonalds senior executive members to discuss their policy on marketing to children following HAT's complaint to the Advertising Standards Authority (ASA). Following the meeting McDonalds NZ has removed the happymeal.co.nz site which included games for children. They have also removed an advertisement in Manurewa that targeted children ("I want a Cheese Burger Daddy"). HAT's marketing to children project work has been highlighted as successful in changing industry practices. At a University of Otago symposium in September, Simon Kenny, McDonald's communications manager, publicly acknowledged that HAT has been strongly influential in McDonalds' reconsidering their advertising approaches.

In collaboration with HAT partners, key messages were developed for a novel and engaging communication tool to raise awareness and stimulate public discourse on the issue of unhealthy food marketing to children. The resulting graphic comic will be disseminated widely through HAT partners and social media channels.

A communications tool has been developed that supports organisations and communities to make complaints to the Advertising Standards Authority (ASA). This tool will accompany the release of a Marketing to Children Snapshot written by Dr Louise Signal of the University of Otago. HAT partially

funded the update which will be published by Activity and Nutrition Aotearoa (ANA) and distributed through their networks.

A complaint about a Kinder Surprise advertisement has been submitted to ASA and has been accepted by the Chairman to go before the Complaints Board.

13.2 *2018 Monitoring Report*

The 2018 Monitoring Report (for the 17/18 period) was released in June and received extensive coverage including the front page of the NZ Herald, with a strong media focus on environmental issues and inequities. A research event is being held in late October. This event will be the springboard for a research platform to bring together researchers and HAT partners working on the translation of research and evaluation into practice.

13.3 *Food and Drink policy*

The healthy events work continues in partnership with Auckland Council and Healthy Families Waitakere. A healthy food and drink workshop for Diwali stallholders was held with The Chip Group and Procare and was attended by nine stallholders and two Auckland Tourism, Events and Economic Development (ATEED) event organisers. The stalls at the Festival were audited and prizes awarded to the three healthiest stalls. A $15,000 grant was received from HAT partners, the Health Protection Agency, to develop stall holder information for healthy food and drinks at these Auckland Council events.

HAT attended a meeting with Frucor and ATEED about the possibility of an exclusive beverage supplier contract for ATEED and Auckland Council events. It was agreed that negotiations would align with the healthy food and drink work being done at these events.

HAT has provided public health input for an Auckland Transport vending procurement (100 machines across Auckland) and achieved agreement on vending proposals that align with Auckland Council food and drink guidelines. HAT was pleased with an agreement that there will be 45-50% water in all beverage vending.

HAT staff met with Coca-Cola Oceania and Coca-Cola Amatil NZ about what they are doing to reduce the sugar content of drinks and marketing to children. As a result, the organisations have committed to change the imagery on children's juice bottles from the current cartoon imagery.

13.4 *Auckland Conversation on Healthy Streets*

On Thursday 2 August, Dr Michael Hale, ARPHS Urban Planning and Healthy Environments and HAT portfolio lead, was a panellist on Auckland Council's Auckland Conversation on Healthy Streets. Dr Hale answered questions alongside UK expert Lucy Saunders, who has developed the Healthy Streets indicators, councillor Richard Hills and Auckland Transport CE Shane Ellison, on making Auckland easier to walk around and improving health gains for everyone. The Conversation was videoed and can be viewed on https://conversations.aucklandcouncil.govt.nz/events/healthy-streets-auckland.

The evening was also a chance for HAT staff members to engage with stakeholders at the HAT stand, share HAT's work and the 2018 HAT monitoring report. Maps showing our Walkability Access To Destinations (WADE) Index data for Auckland encouraged some useful conversations on what needs to be done to get people out of their cars. Auckland Council is investigating using the WADE walkability tool to monitor changes in the environment at the local board level.

Dr Julia Peters and Michael Hale are members of Auckland Transport's Road Safety Leadership and Working Groups providing public health input.

14. Saltmarsh mosquito Kaipara operation

In March 2018, the Ministry for Primary Industries (MPI) National Saltmarsh Mosquito Surveillance Programme found two larvae and six pupae from an exotic mosquito species, *Culex sitiens*, in the Kawau Parua Inlet near the Kaipara Harbour. No adult mosquitos have been detected. The mosquito poses a very low risk to humans as the diseases it may be able to transmit (Ross River virus, Kunjin and Japanese encephalitis virus) are not present in New Zealand.

On 13 November 2018, MPI began a targeted aerial spraying programme in the Kaipara Harbour to eradicate the exotic mosquito, and will continue weekly after that for a total of four weeks. The treatment will extend in a 5km radius around the sites where larvae have been found, but will only be applied to brackish water habitat. There will be no direct application over any residential areas or houses, schools, or other habited areas.

The treatment product used is 'Vectobac 12AS', which contains the active ingredient Bti (Bacillus thuringiensis subspecies israelensis). Bti has undergone a full health impact assessment, which shows that it poses no appreciable risk to mammals, including humans. According to MPI, there are no known human or animal health concerns from using Vectobac. It may cause eye irritation and skin sensitisation from prolonged contact with undiluted product, although this is unlikely for members of the public, as contact could only occur with the diluted treatment product being applied, for a brief time period.

ARPHS has developed a Health Professional Advisory and will follow normal protocol if notified of a patient reporting health effects potentially attributed to the spray.

15. Submissions

ARPHS has completed and submitted ten formal submissions between April and October 2018.

Date	Subject
25 June	*Proposal for reducing the Health Act notifiable blood lead level for lead absorption* ARPHS supported the proposal to reduce the notifiable level for non-occupational exposure for all ages to 0.24 µmol/L. This level is based on national monitoring data and some key assumptions, and would bring it closer to recommendations in the US and Australia.
6 July	*Heat Health Plan* The "Heat Health Plan Guidelines" provide information about the risks to health during periods of hot weather, and to encourage and support organisations to prepare and plan for hot weather events. ARPHS provided a background paper and position statement on heatwaves and public health. ARPHS sees value in a formal heatwave definition and warning system, ideally coordinated by a central agency.
6 July	*The Environmental Protection Authority's proposed risk assessment methodology for hazardous substances* Hazardous substances have inherent risks for human health. The guide is designed to improve transparency around how it assesses hazardous substances. Recommendations related to: aligning with internationally endorsed risk assessment methodology terminology, as well as ensuring that the risk assessment process is independent, relies on best practice methods, and accurately conveys health risk information.

19 July	*Zero Carbon Bill* ARPHS has a number of priority work areas and statutory obligations relevant to climate change. Health Services are major end-users of carbon and energy intense products and services. ARPHS supported the introduction of a statutory long-term emission reduction target. There are significant implications of climate change on health and wellbeing. The following recommendations were included in the submission: • The establishment of a net zero target for 2050 • Adequate safeguarding provisions to ensure viability of the legislation in the future • Emissions budgets need to take into account a significant number of co-benefits from a public health perspective and; the impact on lower socio-economic households. • Overall responsibility for preparing national climate risk assessments should reside with the government. • The establishment of a health sector Sustainable Development Unit (SDU) similar to that of the UK National Health Service (NHS), with links to the Climate Change Commission.
1 August	*Consumer credit law review* ARPHS supported the intent of the consumer credit law review to provide greater protection from predatory and high-interest lending practices that create significant hardship for lower-income families and communities.
1 August	*Notice of Requirement by Auckland International Airport to alter the designations of the Auckland Unitary Plan – Operative in part, regarding the second runway.* ARPHS provided a statement of evidence and attended the hearing on the Notice of Requirement by Auckland International Airport Limited to alter the designations 1100 and 1102 in the Auckland Unitary Plan – Operative in Part. These alterations relate to the provision of and operations of the second runway. The statement of evidence covered: - health effects of noise; - the request of an extension of the noise mitigation programme; - the removal of asbestos in the noise mitigation programme; - the noise mitigation fund; - ambient air quality and aircraft emissions.
30 September	*Wellbeing indicators* Statistics NZ is developing 'Indicators Aotearoa New Zealand' to track New Zealand's progress using a well-being and sustainable development lens. The indicators will enable the government, councils, businesses, communities, and individuals to make choices around well-being and sustainability. The indicators are being built drawing on international best practice, tailored to New Zealand by including cultural and te ao Māori perspectives. ARPHS supported co-design of the indicators with Māori and ensuring the indicators are appropriate for our diverse population and are aligned with other important wellbeing work.
16 October	*Health and Hygiene Bylaw 2013* The bylaw aims to minimise health risks to people using services that have contact with their bodies beauty and health treatments, tattoo, body piercing and swimming pools.) The proposed Bylaw aimed to better protect public health through expanding the services it covers and addressing enforcement. ARPHS supported most of the proposed changes and made additional recommendations in relation to sunbeds, swimming pools and spa pool hygiene, exercise equipment and sleep pods.

21 October	*Healthy Homes Standards* The submission sets out the Auckland health sector's strong, collective support for action to improve the quality of New Zealand's rental housing through the introduction of the Healthy Homes Standards covering heating, insulation, ventilation, moisture ingress and drainage, and draught stopping. The Healthy Homes Guarantee Act (No 2) passed into law in December 2017, amending the Residential Tenancies Act 1986 and enabling the government to create regulations that set minimum standards to create warmer, drier rental homes (the healthy homes standards). The submission was signed by ARPHs, the Chief Executives of the three metro Auckland DHBs, the Chair of the Metro Auckland Clinical Governance Forum and the Chairs of the Alliance Leadership Teams.
21 October	*Reform of the Residential Tenancies Act 1986* The Government has signalled that changes are required in the provision and standards of housing in New Zealand to improve security for tenants. The lack of affordable housing options and the poor condition of some housing is having an inequitable effect on health. As part of these changes, the Government is proposing a targeted reform of the Residential Tenancies Act 1986. This Act governs the nature of the relationship between landlords and tenants. The objectives of the reforms include: • to improve security and stability for tenants while maintaining adequate protection of landlords' interests • to ensure the appropriate balancing of the rights and responsibilities of tenants and landlords to promote good faith tenancy relationships and help renters feel more at home ARPHS' Submission supports these proposals and focuses on improving security of tenure, increasing and enforcing the obligation of landlords to provide reasonable living conditions, strengthening tenant rights, addressing inequities and improving the quality of boarding houses.

5.1 Planning, Funding and Outcomes Update

Recommendation:

That the Community and Public Health Advisory Committee receives this report.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Trish Palmer (Funding and Development Manager Mental Health and Addiction Services), Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Tim Wood (Funding & Development Manager Primary Care), Kate Sladden (Funding and Development Manager Health of Older People), Shayne Wijohn (Manager Māori Health Gain), Lita Foliaki (Manager Pacific Health Gain), and Raj Singh (Project Manager Asian, Migrant and Refugee Health Gain)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Acting Director Health Outcomes)

Glossary

AH+	-	Alliance Health Plus
ACE	-	Angiotensin-converting-enzyme
AOD	-	Alcohol and Other Drugs
ARRC	-	Age Related Residential Care
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ARPHS	-	Auckland Regional Public Health Service
ARSHS	-	Auckland Regional Sexual Health Services
ACH	-	Auckland City Hospital
BP	-	Blood Pressure
CADS	-	Community Alcohol and Drug Service
CDA	-	Combined Dental Agreement
CELT	-	Commissioning Executive Leadership Team
CLP	-	Community Learning Programme
CPHAC	-	Community and Public Health Advisory Committee
CTO	-	Community Treatment Orders
CVD	-	Cardiovascular Disease
CfYH	-	Centre for Youth Health
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
HBHF	-	Healthy Babies Healthy Futures
HCSS	-	Home and Community Support Services
HPV	-	Human Papilloma Virus
HVAZ	-	Healthy Village Action Zones
IPS	-	Individual Placement and Support
IWaS	-	Intensive Wrap around Service
MACGF	-	Metro Auckland Clinical Governance Forum
MHUD	-	Ministry of Housing and Urban Development
MMR	-	Mumps, Measles and Rubella
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding
NCHIP	-	National Child Health Information Platform
NGO	-	Non Governmental Organisation
NHC	-	National Hauora Coalition

NIHI - National Institute of Health Innovation
OIS - Immunisation Outreach Service
PHAP - Pacific Health Action Plan
PHO - Primary Health Organisation
SLM - System Level Measures
SPE - Statement of Performance Expectations
TWOW - Te Whanau O Waipereira

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs' (DHB) planning and funding activities and areas of priority, since its last meeting on 29 August 2018. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting's agenda.

Highlights

- There has been a steady gain in immunisation coverage over the past 6 months by Waitemata DHB, with both Waitemata and Auckland DHB exceeding the national average of 91%.
- The 'your local doctor' website has been updated and is available in English, simplified Chinese, and Korean.
- There have been improvements in the number of people with diabetes with blood pressure <140mmHg, the number of people with microalbuminuria on medication management (ACE inhibitor or Angiotensin Receptor Blocker) and the number of people with known CVD on triple therapy (CVD secondary prevention).

2. Planning

2.1 Annual Plans

The final drafts of the Annual Plans are due for submission to the Ministry of Health (MoH) on 1 November 2018. These will have been sent via email to Board members for circular resolution approval prior to submission. Updates and amendments in line with MoH feedback have been incorporated, alongside updated financial content. Due to legislative requirements, the Statement of Performance Expectations (SPE) may be submitted as a separate document this year.

2.2 Annual Report

2017/18 Annual Reports are due for completion by 31 October. Drafts have been submitted to the Ministry for Ministerial review. The final drafts were presented to the October Finance, Risk and Assurance and Audit and Finance Meetings and approval sought from Board members via circular resolution prior to submission.

2.3 System Level Measure Improvement Plans

Implementation of activities in the 2018/19 SLM Improvement Plan is ongoing. The Quarter 4 2017/18 SLM report was presented to November Board meetings.

2.4 Cancer Equity Planning

Analyses of cancer data to support the regional cancer work programme is currently being undertaken – considering mortality, registrations, cancer survival rates, screening rates and timeliness of treatment.

2.5 Auckland and Waitemata DHB Quarterly Performance Scorecard

The Auckland and Waitemata DHB CPHAC Scorecard is a standardised tool used to internally review and track performance against a range of measures including National Health Targets for both Auckland and Waitemata DHBs. The Scorecard below shows indicator performance against target for each DHB for Quarter 1 of the 2018/19 year.

Auckland and Waitemata DHB Quarterly Performance Scorecard

CPHAC Outcome Scorecard
June 2018
2017/18

Health Targets - Auckland DHB

	Actual	Target	Trend
a. Better help for smokers to quit - primary care			
Total	92%	90%	▲
Māori	92%	90%	▲
Pacific	92%	90%	▲
Other	92%	90%	▲
Increased immunisation (8-month old)			
Total	94%	95%	--
Maori	86%	95%	--
Pacific	94%	95%	▲
Asian	97%	95%	▼
Other	93%	95%	▼
Raising Healthy kids			
Total	100%	95%	--
Maori	100%	95%	--
Pacific	100%	95%	--
Asian	100%	95%	--
Other	100%	95%	--

Health Targets - Waitemata DHB

	Actual	Target	Trend
a. Better help for smokers to quit - primary care			
Total	89%	90%	▲
Māori	88%	90%	▲
Pacific	89%	90%	▲
Other	89%	90%	▲
Increased immunisation (8-month old)			
Total	92%	95%	▲
Maori	86%	95%	▲
Pacific	90%	95%	▼
Asian	96%	95%	▼
Other	91%	95%	▲
Raising Healthy kids			
Total	99%	95%	--
Maori	100%	95%	--
Pacific	100%	95%	--
Asian	100%	95%	--
Other	98%	95%	▲

Child, Youth and Women - Auckland DHB

	Actual	Target	Trend
Oral Health - % Infants enrolled at 2 years			
Total	84%	95%	▼
Māori	65%	95%	▲
Pacific	87%	95%	▼
Asian	72%	95%	▼
Other	101%	95%	▼
Oral Health - % enrolled utilisation at 2 years			
Total	76%	75%	▲
Māori	63%	75%	▲
Pacific	64%	75%	▲
Asian	82%	75%	▲
Other	79%	75%	▲
HPV immunisation coverage - girls			
Total	83%	70%	▲
Maori	84%	70%	▲
Pacific	87%	70%	▼
Asian	72%	70%	▼
Other	91%	70%	▲

Child, Youth and Women - Waitemata DHB

	Actual	Target	Trend
Oral Health - % Infants enrolled at 2 years			
Total	90%	95%	▲
Māori	73%	95%	▼
Pacific	86%	95%	▲
Asian	77%	95%	▲
Other	105%	95%	▼
Oral Health - % enrolled utilisation at 2 years			
Total	74%	75%	▲
Māori	62%	75%	▲
Pacific	58%	75%	▲
Asian	80%	75%	▲
Other	78%	75%	▲
HPV immunisation coverage - girls			
Total	60%	70%	--
Maori	56%	70%	▼
Pacific	58%	70%	▼
Asian	69%	70%	▲
Other	58%	70%	▲

Primary Care - Auckland DHB

	Actual	Target	Trend
PHO enrolment			
Total	82%	90%	▼
Māori	76%	90%	--
e. Pacific	101%	90%	▼
Asian	70%	90%	--
Other	88%	90%	▼
d. Diabetes management			
Total	62%	75%	▼
Māori	53%	75%	▼
Pacific	51%	75%	▼
Other	70%	75%	▼

Primary Care - Waitemata DHB

	Actual	Target	Trend
PHO enrolment			
Total	91%	90%	▼
Māori	83%	90%	--
e. Pacific	101%	90%	--
Asian	89%	90%	▲
Other	93%	90%	--
d. Diabetes management			
Total	63%	75%	▼
Māori	49%	75%	▼
Pacific	53%	75%	▼
Other	67%	75%	▼

Health of Older People - Auckland DHB

	Actual	Target	Trend
c. HBSS clients with Clinical interRAI in last 2 yr	*91%*	*95%*	--
ARC residents LTCF interRAI w/in 230 days of previous	84%	85%	▼
ARC residents HC interRAIs prior to LTCF interRAI	89%	98%	▲

Health of Older People - Waitemata DHB

	Actual	Target	Trend
c. HBSS clients with Clinical interRAI in last 2 yr	*69%*	*85%*	▼
ARC residents LTCF interRAI w/in 230 days of previous	84%	80%	▲
ARC residents HC interRAIs prior to LTCF interRAI	80%	98%	▼

How to read

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

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

Key notes

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

a. Jun 18. Source prelim MOH quarterly report
b. December 2017
c. Mar 2018

d. May 18. Aligns with MACGF indicator; differs from MoH indicator
e. >100% due to mismatch of the underlying population projections and primary care database ethnicity categorisations.

A question?

Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team:** victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitemata DHB

3. Primary Care

3.1 National Health Targets

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

The 'Better Help for Smokers to Quit' result is reported as a National Health Target. Auckland DHB was close to achieving the primary care 'Better Help for Smokers to Quit' health target in Quarter 1, 2018/19. Preliminary results from the PHOs showed Auckland DHB performance at **89%**. Waitemata DHB preliminary result shows the DHB at **87%**.

At a PHO level National Hauora Coalition and Auckland PHO successfully achieved the primary care 'Better Help for Smokers to Quit' health target. Although the target has not been reached it is good to see that all of the PHOs have achieved 85% or above this quarter (performance for some PHOs has historically been low in Quarter 1). Table 1 below has the results by PHO for Quarter 1, 2018-19.

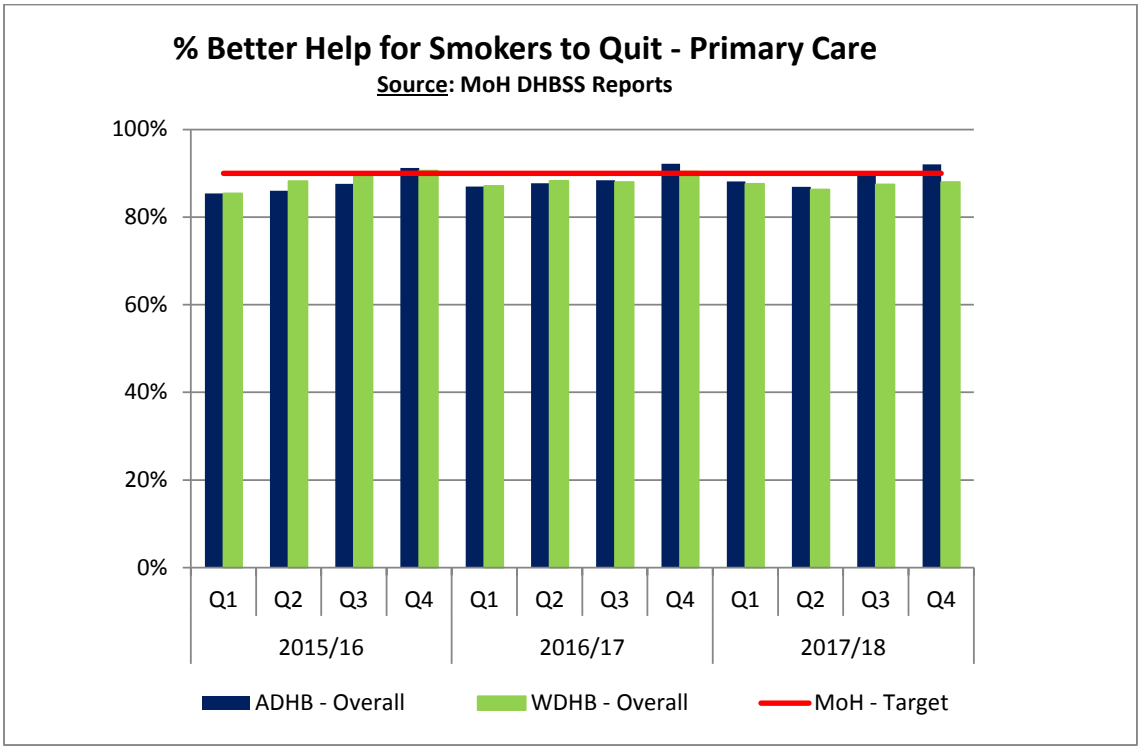
Table 1: PHO Results for Better Help for Smokers to Quit 90% Target (Quarter 1, 2018/19)

DHB	PHO	Target %
Auckland DHB	Auckland PHO	89.9%
	Alliance Health Plus	85.6%
	National Hauora Coalition	91.2%
	ProCare	88.6%
Waitemata DHB	Comprehensive Care	85.3%
	ProCare	88.4%

The PHOs have set-up systems and provided support to encourage general practices to provide brief advice directly to patients themselves. The PHOs have not provided text and phone call support to patients on behalf of practices this quarter. Having brief advice provided directly by the general practice makes it more sustainable in the long term.
Ministry of Health data for 'Better Help for Smokers to Quit 90% Target' for Primary care was not available at the time of finalisation of this report. Therefore, results for Q4, 2017/2018 are shown in the Scorecard under Health Targets as well as in Figure 1 below:

- Auckland DHB – 91.8%, ↓2.8% from the previous quarter
- Waitemata DHB – 88.5%, ↓1.5% from the previous quarter

Figure 1: Auckland and Waitemata DHBs 'Better Help for Smokers to Quit' performance



Note: Ministry of Health Q1, 2018/19 data was not available.

3.2 Diabetes Management

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

Metro Auckland DHBs and PHOs are committed to improving population health outcomes for people with diabetes. To help achieve this goal, five regionally agreed Diabetes and Cardiovascular disease (CVD) clinical indicators have been prioritised for monitoring performance. All metro Auckland PHOs (seven) have been reporting anonymised practice level data relating to these five clinical indicators and the performance is being reported to the Metro Auckland Clinical Governance Forum (MACGF) (Table 2) since June 2017.

Due to the complex nature of diabetes management and ongoing data extraction issues we have seen very little change in the number of people with diabetes, aged 15-74 years, with an HbA1c <64mmol/mol. However, improving diabetes outcomes, with a specific focus on reducing the gap between Māori and non-Māori, is a focus of the PHOs and DHBs.

Over this quarter, we have seen improvements in the number of people with diabetes with blood pressure <140mmHg, the number of people with microalbuminuria on medication management (ACE inhibitor or Angiotensin Receptor Blocker) and the number of people with known CVD on triple therapy (CVD secondary prevention). These improvements reflect improved data quality within primary care and also the result of targeted activities in the previous months

Table 2: Auckland and Waitemata DHB performance against the MACGF Diabetes and CVD Clinical Indicators 30 September 2018[1]

Clinical Indicator	Goal	Auckland DHB			Waitemata DHB		
		Māori	Pacific	Total	Māori	Pacific	Total
Clinical Indicators – Long Term Conditions Management - Diabetes							
HbA1c Glycaemic control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have good or acceptable glycaemic control (latest HbA1c less than or equal to 64mmol/mol) recorded in the last 15 months	**80%**	51.74% (↓ 0.2%)	49.78% (↓ 0.4%)	**60.6%** (↓ 1%)	51.84% (↓ 2.7%)	51.64% (↓3.3%)	**61.36%** (↓ 4.2%)
Blood pressure control: Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure recorded in the last 15 months is <140mmHg	**80%**	60.44% (↑ 4.6%)	61.39% (↑10.9%)	**64.16%** (↑6.1%)	62.55% (↓ 0.3%)	64.96% (↓2.1%)	**63.14%** (↓ 1.2%)
Management of Microalbuminuria: Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria in the last 18 months and are on an ACE inhibitor or Angiotensin Receptor Blocker	**90%**	73.24% (↑ 2.6%)	78.33% (↑ 7.2%)	**76.97%** (↑5.2%)	71.64% (↓ 0.8%)	74.45% (↑1.3%)	**69.54%** (↓ 3.5%)
Clinical Indicators – Long Term Conditions Management – CVD							
CVD Secondary Prevention: Percentage of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant)	**70%**	58.94% (↓ 2.8%)	66.08% (↑ 1%)	**61.06%** (↑0.5%)	58.77% (↑ 2.3%)	64.5% (↑0.8%)	**57.73%** (↑ 2.6%)
CVD Primary Prevention: Percentage of enrolled patients with cardio-vascular risk ever recorded >20%, (aged 25 to 74 years, excluding those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)	**70%**	44.75% (↑ 1%)	49.57% (↓ 1%)	45.72% (↑0.5%)	47.43% (↓ 1.4%)	56.79% (↓ 1%)	45.01% (↓ 0.3%)

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

Data quality issues affecting this quarter's data

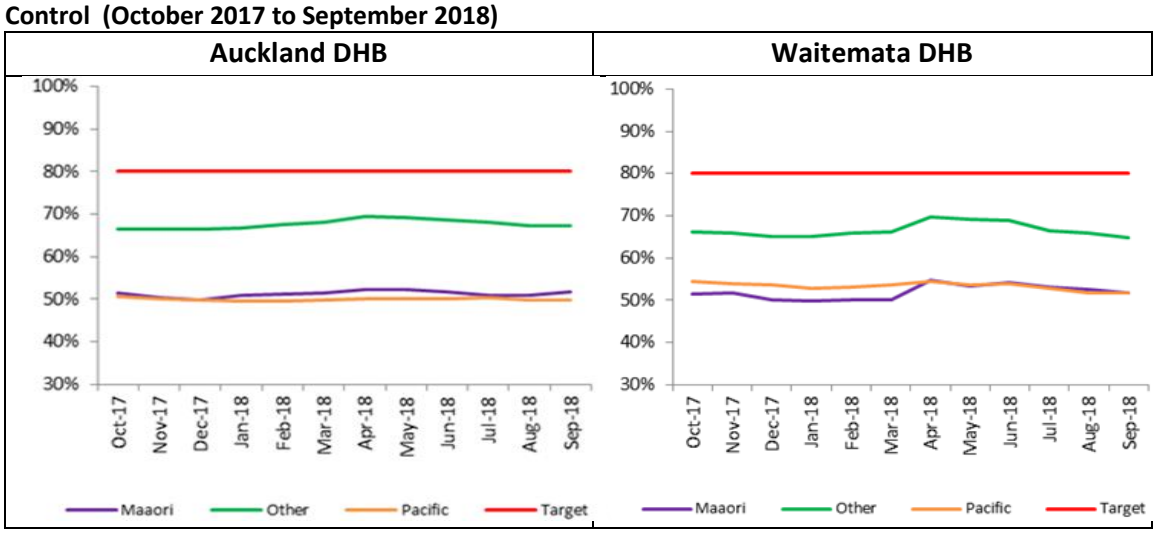
Each quarter, we are seeing more complete dataset with a greater than 90% of general practices across Auckland and Waitemata DHB providing their CVD and diabetes data. Each PHO is also working to improve the quality of the data provided as evidenced by Alliance Health Plus undertaking the coding of their data. However, there continues to be data extraction issues affecting the completeness of data received from the PHOs. These extraction issues include:

- ProCare are now providing data from their data warehouse and it is hoped this will imrpove the quatlity of the data received going forward
- Data is still not able to be extracted from the *Profile for Mac* Patient Management System (PMS)
- Issues still exist for extraction data from the PMS *My Practice*
- Data is not provided by all general practices within Auckland and Waitemtata district.

Performance against the five regionally agreed clinical indicators at a DHB level

Overall, there continues to be significant performance variations between ethnic groups across all indicators (Figures 2, 6-7). For example, there is a 8%-11% variation in the number of Māori and Pacific people with good or acceptable diabetes control when compared to non-Māori and Pacific populations with diabetes. These ethnic variations have remained consistent since April 2017. A focus of the DHB and PHOs this year is to reduce the gap between Māori and non- Māori.

Figure 2: DHB performance, by ethnicity, against the MACGF diabetes clinical indicator – Glycaemic Control (October 2017 to September 2018)



Practice level data shows a large variation in perforance against this target between practices (Figures 3 & 4). It should be noted that practices with outlying performance (either poor or good) may have data quality issues or contain very small enrolments of people with diabetes, rather than true outlying performance.

PHOs are working with their practices to identify both high and poor performing practices to institute specific activities to improve diabetes outcome. This information will also be reported to the DSLA, and shared across PHOs with the aim that this will improve performance across all practices.

Figure 3: HbA1 Glycaemic Control: Percentage of enrolled diabetic patients (aged 15-74 years) with an HbA1c <64mmol/mol recorded in the last 15 months – Auckland DHB, September 2018

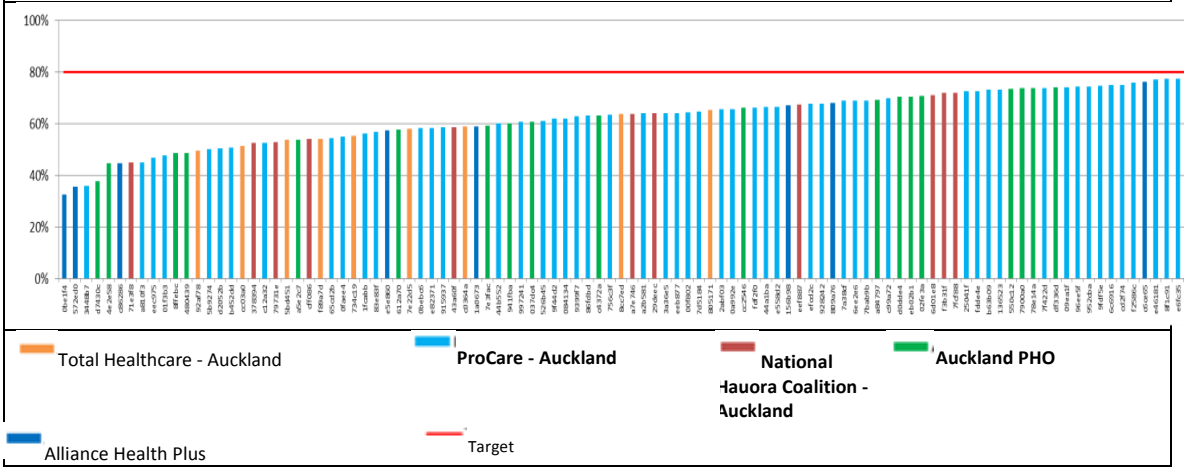
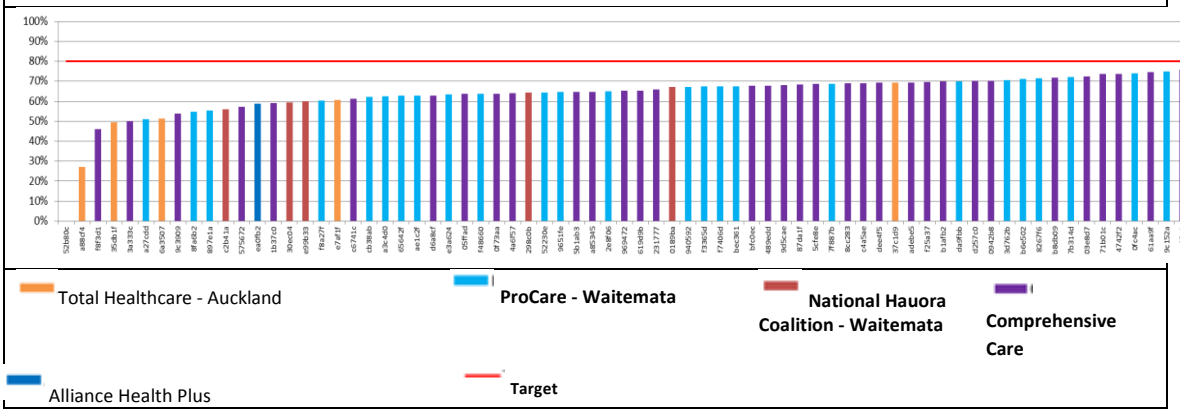


Figure 4: HbA1 Glycaemic Control: Perentage of enrolled diabetic patients with <=64 (aged 15-74 years) HbA1c recorded in the last 15 months – Waitemata DHB, September 2018



3.3 Cardiovascular Disease (CVD)

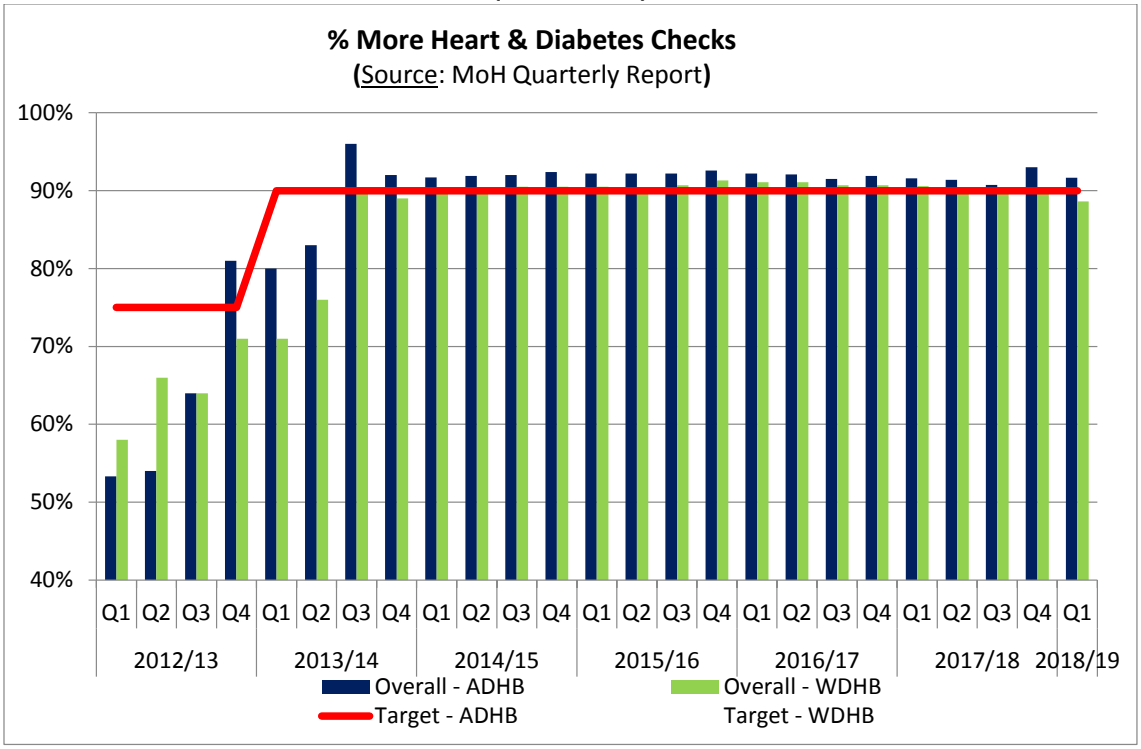
Auckland DHB has achieved and sustained the 90% CVD risk assessment target at a total population level since September 2014 (Figure 5).

Although Waitemata DHB has achieved and sustained the 90% CVD risk assessment target level since September 2014 (Figure 5), the DHB has failed to achieve it during quarter one, 2018-19. This is due to a significant number of people who were last screened between July and September 2014, in order to meet the target in 2014. This group of people are now due for their reassessment. The result of this is a decrease in Waitemata DHB's CVD risk assessment rate to 88.6%. It is expected that performance will improve in the coming quarter as practices work through this backlog.

CVD risk assessment in Māori men aged 35-44years

To support achieving the CVD risk assessment target in Māori, the Ministry of Health has focused on achieving this target in Māori men aged 35-44 years. The current screening rate for Māori men aged 35 to 44 years is 76.7% (↑0.5%) and 68.1% (↑0.1%) for Auckland and Waitemata DHBs respectively. The DHB is working with the PHOs to develop an implementation plan that identifies activities to support achieving this target by June 2019.

Figure 5: 'More Heart & Diabetes Checks' performance for Auckland DHB and Waitemata (Q1, 2018-19)

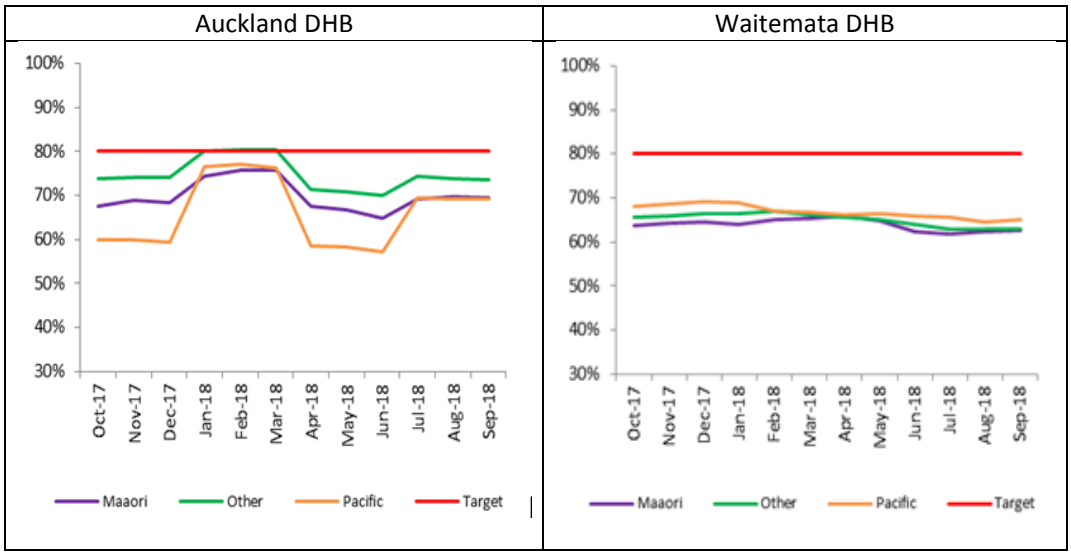


***Note**: More Heart and Diabetes Checks Q1, 2018/19 – Preliminary PHO data as Ministry of Health data not available yet.*

Blood Pressure Control in patients with diabetes:

In quarter one in Auckland DHB, the percentage of enrolled patients with diabetes (aged 15-74 years) whose latest systolic blood pressure recorded was <140mmHg in the last 15 months has improved in. This improvement is a result of the resolving data issues experienced by Alliance Health Plus and ProCare (Figure 6).

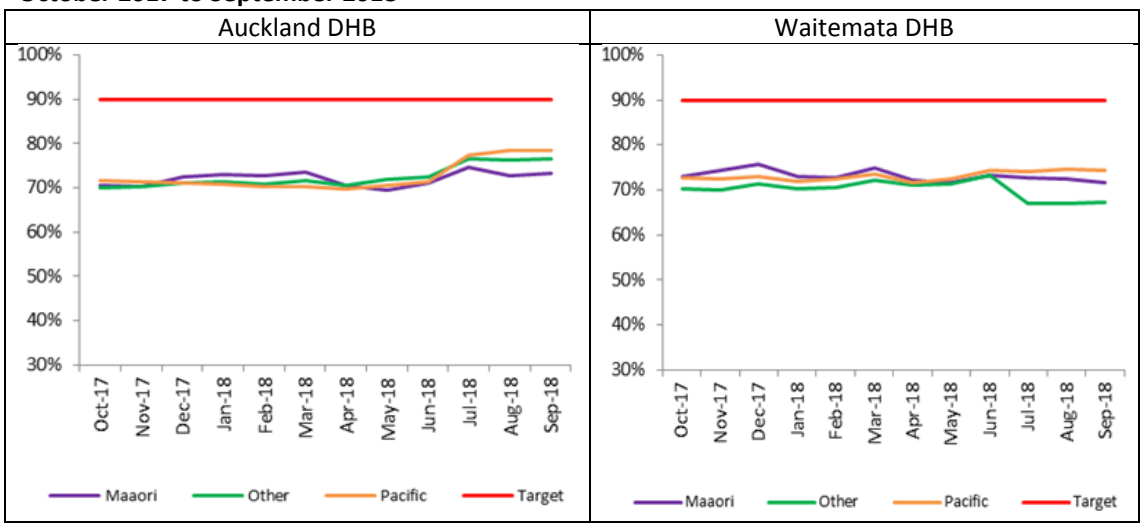
Figure 6: Blood pressure control of patients with diabetes – October 2017 to September 2018



Management of microalbuminuria in patients with diabetes

In quarter one, Auckland DHB saw an improvement in the number of people with diabetes and microalbuminuria, in the last 18months, who are on an ACE inhibitor or Angiotensin Receptor Blocker (Figure 7). This improvement is suspected to be as a result of the data quality improvement activity. Similarly, Waitemata DHB saw a decline in the Māori, Other and total population with diabetes and microalbuminuria, who are on an ACE inhibitor or Angiotensin Receptor Blocker. This decline is likely to be related to the data quality improvement activity.

Figure 7: Management of microalbuminuria in patients with diabetes October 2017 to September 2018



Secondary CVD risk prevention

The secondary CVD risk prevention clinical indicator is defined as the percentage of enrolled patients with known CVD who are prescribed triple therapy (Statin + BP lowering agent + Antiplatelet/Anticoagulant) (Figure 8).

Improving secondary CVD risk management rates is a focus area for PHOs and Auckland and Waitemata DHBs as this is an area where there can be significant and rapid improvements in population health by reducing the number of people experiencing a second or subsequent CVD events. Improving secondary CVD risk management rates will have the roll-on benefit of improving blood pressure management in our diabetic populations as the prescribing of triple therapy will have a flow on effect on this clinical indicator.

Across both Auckland and Waitemata DHB Pacific people continue to have the highest rates of secondary CVD risk prevention management and management rates for this group continued to improve over this quarter.

Secondary CVD risk management rates in people with diabetes are significantly higher than those seen in the total population and the 70% management target in this population continues to be achieved (Figure 9).

Figure 8: Secondary CVD risk prevention in the total enrolled population by ethnicity October 2017 to September 2018

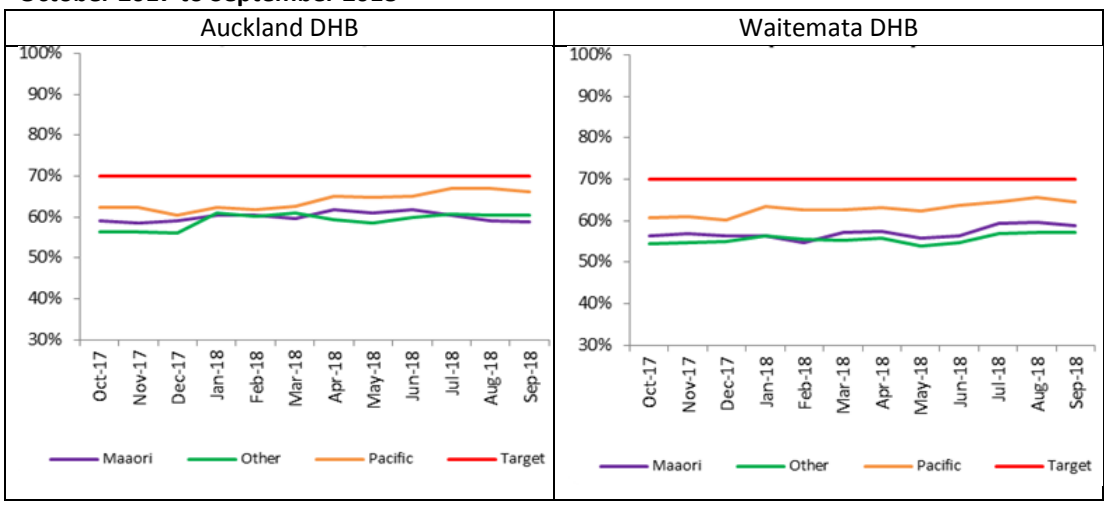
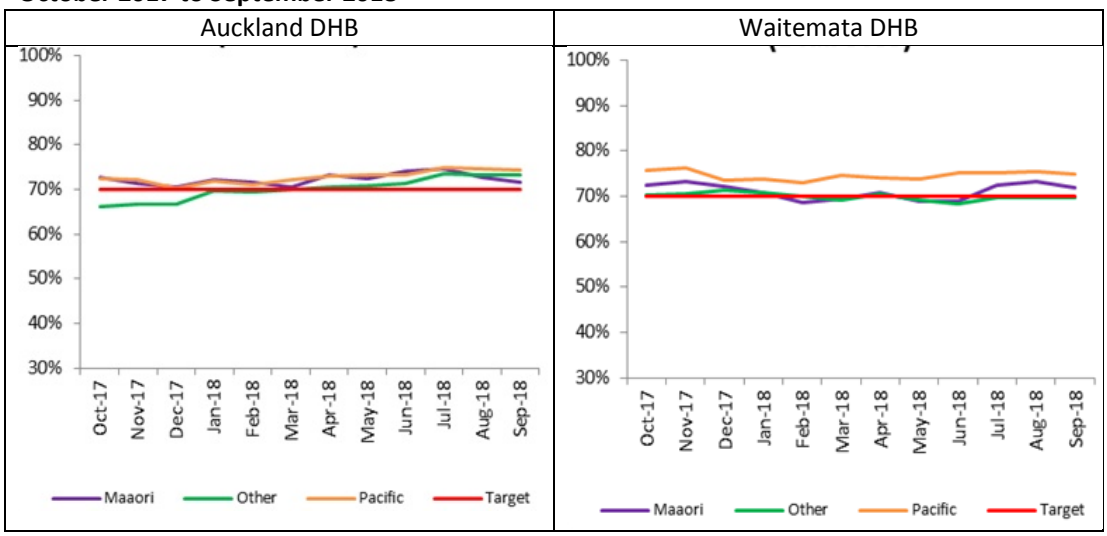


Figure 9: Secondary CVD prevention in patients with diabetes by ethnicity, October 2017 to September 2018



Primary CVD risk prevention

The primary CVD risk prevention clinical indicator is defined as the percentage of enrolled patients, aged 35 to 74years, with a CVD risk ever recorded >20% and who are prescribed dual therapy (statin + BP lowering agent). This excludes those who have experienced a CVD event.

Over quarter one, primary CVD risk prevention rates have remained steady. It is expected that primary CVD risk management will remain unchanged or reduce slightly until the new CVD risk equations are released. The Ministry of Health is overseeing the implementation of these new risk equations.

Figure 10: Primary CVD risk prevention in total enrolled population by ethnicity October 2017 to September 2018

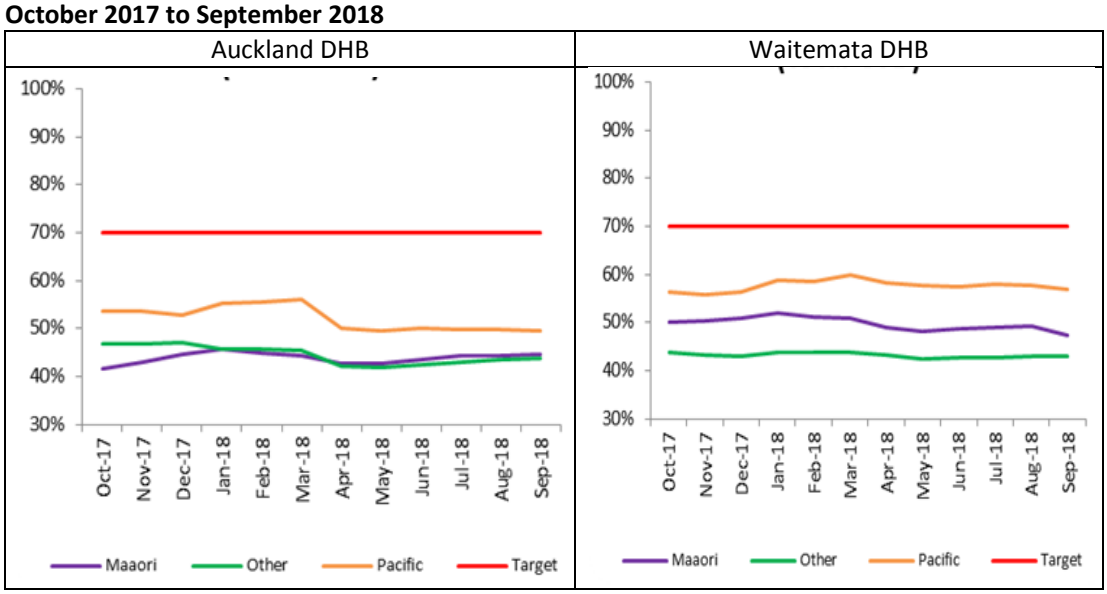
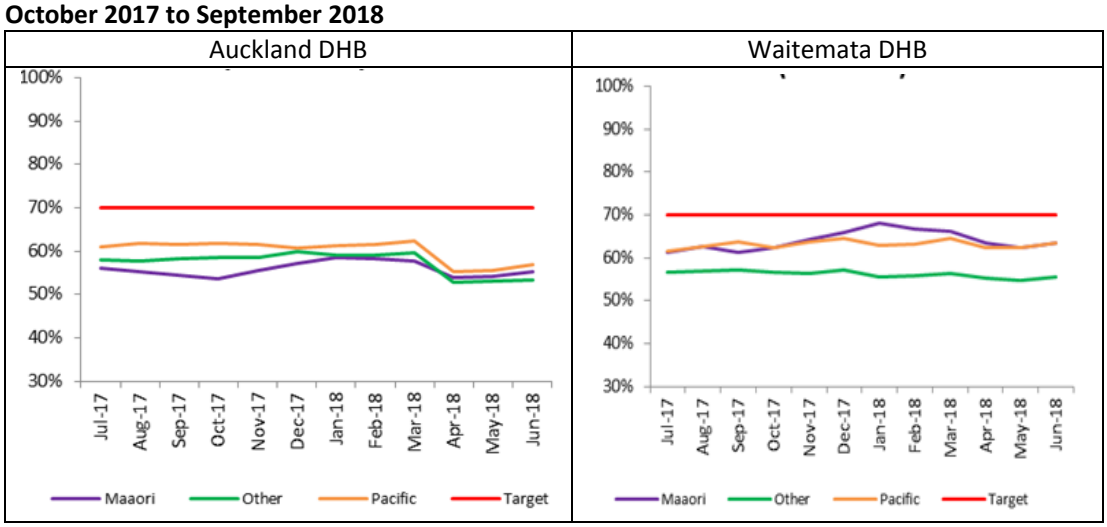


Figure 11: Primary CVD risk prevention in those with diabetes by ethnicity October 2017 to September 2018



4. Child, Youth and Women's Health

4.1 Immunisation

4.1.1 Immunisation Health Target

The Immunisation Health Target was met in Auckland in Quarter 1, with 95% of babies fully vaccinated by eight months of age. Pacific results are particularly pleasing at 97%. The equity gap for Māori however has widened again, with coverage back at 86%.

Waitemata DHB continues the steady gain in immunisation coverage over the past 6 months but did not reach the health target for Q1 2018/19, achieving 92%. The national average of 91% was exceeded however.

Immunisation Coverage for infants turning 8 months – Q1 2018/19 Waitemata DHB

Turning 8 months in Q4	Last quarter Q4 17/18	This quarter Q1 18/19	Decline and opt off
Total	91.7%	92.3%	4.1%
Māori	85.9%	85.9%	4.8% (estimated)

The previous improvement in Waitemata DHB for Māori has been sustained and latest analysis shows an improvement in the Māori decline rate, now 4.8% compared with 7.7% in the previous quarter. A Māori focused work programme continues with the aim of eliminating the equity gap. It is pleasing to note the Pacific coverage has increased over 6% in Waitemata DHB during this quarter and at 96% now exceeds the health target.

Development of an assertive contact algorithm is progressing – data has now been analysed and the algorithm developed. This is currently being written up, after which it will be tested with the immunisation outreach service (OIS) before implementation.

Analysis of newborn enrolment has been finalised for discussion with PHOs. A strategy for babies not enrolled with a GP will be developed, particularly with a focus for OIS to help guide the family to a practice for on-going primary care.

An active anti-immunisation campaign is running in the month of October. It was pleasing to see the strong public and health response supporting immunisation. 140 complaints to the Adverting Standards Authority in 48 hours resulted in an anti-immunisation billboard on the Southern Motorway being removed.

4.1.2 Mumps catch up programme

The school based MMR vaccine catch up programme has now been completed across both Auckland and Waitemata (Counties Manukau did not run a school based programme). The offer to 15 low decile/high Pacific schools was accepted in 14 schools across Auckland and Waitemata. Results will be provided next report.

4.2 NCHIP

The project team is progressing the design phase to implement the National Child Health Information Platform (NCHIP) in the Northern region DHBs. NCHIP will provide a point-of-care view of each child's progress through the 29 health milestones from 0 to 6 years of age. This month Memorandums of Understanding were agreed in principle with Plunket and the Ministry of Education to obtain contact details for children who are lost-to-service. Discussion with the Ministry of Social Development is scheduled.

4.3 Oral Health – including maternal oral health

Implementation of the maternal oral health service in Tamaki, previously reported, has been delayed by staff shortages in Auckland Regional Dental Service (ARDS). It is now expected to be implemented from 1 April 2019. A dedicated project manager will develop the service from the start of the new calendar year. A comprehensive report on oral health is being tabled at CPHAC. A full information paper on Oral Health is provided as a separate paper.

4.4 Youth Health

The Ministry of Health has confirmed funding for an increase in health services into decile 4 secondary schools. Auckland DHB has developed and implemented enhanced school based health services inclusive of full time nursing resources embedded in the school community and

proportionate to the size and complexity of the school role. Provision of nursing services in all Alternative Education, Teen Parent Units and Decile 1- 3 schools has been a requirement for a number of years. Auckland DHB has funded additional services with visiting General Practitioners, and visiting Clinical Psychologists. Waitemata DHB has the same model, expect for the visiting Psychologists. There is additional nursing and general practitioner leadership across the programme. The result is delivery of high quality, youth friendly, comprehensive primary care services in school settings. These minimise disruption from learning, and maximise both health and educational attainment.

With the extension to decile 4 schools, Auckland DHB has three additional schools we are required to provide services in, one of which (Mt Roskill Grammar) we had already established services in. Selwyn College and Avondale College have been approached regarding the establishment of enhanced school based health services and are keen to have services in place for the start of the 2019 calendar year. In total, this will mean services are delivered to 12 mainstream secondary schools to around 12,500 students and Auckland DHB.

In Waitemata DHB, there are four additional schools we are required to provide services in, one of which (Massey High School), we already had established services in. Rodney College, Vanguard Military Academy and Middle School West have been approached regarding the establishment of school based health services and are keen to have services in place for the start of the 2019 calendar year. In total, this will mean services are delivered to nine mainstream secondary schools to around 6,400 students in Waitemata DHB. (Note that Vanguard Military Academy and Middle School West were partnership or charter schools that are becoming designated character State schools, and will have a visiting nursing service due to low roll numbers.)

In Auckland DHB, an evidence-based mindfulness and resilience programme for pre-teens (intermediate school age) has been selected and will be rolled out in the new year. The agreed model has been led by a Clinical Psychologist and is called Pause, Breathe, Smile. In addition, a review of health services provided at Tamaki College has been undertaken. Amongst other factors, a small increase in nursing FTE will be provided by the DHB based on findings of the review.

4.5 Transgender Healthcare

The Planning, Funding and Outcomes (PFO) team hosted a project focused on improving access to gender affirming healthcare for transgender peoples for the northern region DHBs. The main body of work is nearing completion and moving into business as usual activities. Highlights from the project include development of health pathways, provider education, development of clinical guidelines, establishment of services for youth (provided by the Centre for Youth Health (CfYH)) and improved specificity regarding services provided by Auckland Regional Sexual Health Services (ARSHS). The work has been supported throughout by a strong Clinical and Consumer Advisory Group.

As the work moves to business as usual, the Advisory Group will be replaced by a Clinical Governance Group led jointly by CfYH and ARSHS. The group will continue to have consumer representation. The group is expected to consider and address issues such as equity of access, quality and consumer satisfaction with services. Planning and Funding representative from both Counties Manukau Health and PFO will continue to have input. One piece of work has yet to be completed, namely establishing a peer support service. A tendering process will be undertaken to contract an NGO provider/s to manage the service. It is expected to have a significant voluntary component for delivery. The intent is to enter into an agreement from 1 July 2019, following the tendering process.

4.6 Maternity Services

Changes have been made to maternity services at Auckland City Hospital (ACH). This may result in an increase in post-natal transfers to Birthcare, within the scope of their existing contract. Birthcare has

consistently expressed a desire for increased post-natal transfers and have confirmed that they have capacity to provide care to more women. Eligibility for a postnatal transfer as specified in the contract has been discussed with ACH senior midwifery staff and management. The impact of changes will be monitored.

The funder is working collaboratively with the communications team and the provider arm around developing an information campaign for women in pregnancy, SMILE. The key messages target third trimester care. Consumer testing of resources is currently underway. SMILE's key messages are Smoke and Alcohol Free, Monitor baby's movements, Immunise, Lie on your side, Exercise and Eat Healthily.

4.7 Maternal and Infant Well-being Assessment and Proto-typing of an Intensive Wrap Around Service

Auckland DHB Commissioning Executive Leadership Team (CELT) approved seed funding for development of an electronic tool to support routine enquiry across a range of domains. Pregnant women and new mothers should routinely be asked about a range of psycho-social factors known to negatively impact on mothers' and babies' health and well-boing. Factors include such domains as family violence and depression. However, information obtained as part of the Maternal and Child Services Alliance (MaCSA) show that women are not routinely asked, and that there is no standardisation. Complexity is increased with a range of professional groups involved throughout the pregnancy including GPs, midwives, obstetricians and Well Child Tamariki Ora nurses. An electronic tool will help address this. A set of validated questions has been drafted for finalisation and inclusion into an electronic tool. Responses to questions on the tool will support clinicians to identify appropriate pathways to services, and highlight unmet need.

In considering this approach, it was recognised that a group of women need to be guided through this in a more supported manner, and rapidly engaged in more intensive services. This includes women who are eligible for maternal mental health or Community Alcohol and Drugs Pregnancy and Parenting Services. Evidence also shows that young pregnant women (under 20 years of age) and some other groups of women may need more intensive services to achieve the best outcomes. Auckland DHB CELT has approved prototyping an intensive wrap-around service (IWaS) for those not eligible for the secondary mental health and AOD (Alcohol and Other Drugs) services. This would start as soon as the pregnancy was confirmed (ideally in the first trimester) and continue until at least the child's 2nd birthday. Women's Health and Child Health leadership have endorsed this approach which will be co-designed and have a strong equity focus.

While there are a number of international models that will be considered, New Zealand's specific cultural context needs to shape the service design. A similar service is also being piloted in Counties Manukau and learnings will be taken from their experiences. An evaluation will be built into the proto-type from the outset.

4.8 Healthy Housing

The Kāinga Ora (Healthy Housing) service has a priority focus on pregnant women and those with young babies. As at September 30 Auckland and Waitemata DHBs, have received 1178 referrals to Kainga Ora. 2663 family members have had access to healthier home interventions. Of the referrals received 387 were for families where there was a newborn baby or hapu woman. As part of the social work interventions, these women may be referred to smoking cessation services or immunisation, amongst other interventions such as entitlements available through the Ministry of Social Development. The Kāinga Ora team supported ARPHS's submission on the Healthy Homes Guarantee Act to the new Ministry of Housing and Urban Development (MHUD).

4.9 Cervical and Breast Screening

An initiative to invite women to enrol in the Breast Screening programme is in progress as part of the Māori Health Pipeline. Sharing information from primary care to systematically invite women into the Breast Screen service within their DHB will be trialled. Learning from the success of the initiative will inform future processes for improving systematic invitation to Breast Screening Aotearoa and can provide valuable information to the Ministry of Health for future development of a Breast Screen population register. The key focus of the programme is to improve enrolment and screening coverage for Māori women.

In cervical screening some promotion activities around the 'Smear your Mea' campaign were successful in August. Work is ongoing with the Cervical Screening Register at Auckland Regional Public Health Service to investigate the needs of women who are more than 12 months overdue for follow up, where they have a history including a high grade result. Once we have a better understanding of the follow up required, we can work with primary care, independent service providers (Well Women and Family Trust) and others as required to target support to achieve the required follow up for these women.

We are pleased to have strong uptake of our planned cervical screening update for October at Whenua Pupuke with over 50 nurses registered.

5 Health of Older People

5.1 Age Residential Care (ARC)

Transitional funding for ARC providers with a material pay equity deficit is continuing for 2018/19. As pay equity funding is included in the bed day price it is based on averages, which means some providers are disadvantaged whilst others are better off. Therefore, providers who have a pay equity deficit greater than 1.5% of their eligible support workers' wage costs pre 30 June 2017 are able to apply for transitional funding. Twelve facilities across Auckland DHB and Waitemata DHB have applied for transitional funding and Planning and Funding will work with them using the ARC Analysis Tool to determine if there is a material deficit. The MoH has a $3 million capped transition fund and if necessary funding to providers will be pro-rated to stay within this limit.

Submissions for the A21 Review that is the review of the national Age Related Residential Care (ARRC) Agreement are due at the end of October 2018. It is reasonable to expect that there may be changes to the ARRC Agreement as a result of the ARC Funding Model Review (currently underway, initial report due in December 2018) but these are unlikely to come into effect for 1 July 2019. From engagement to date, the areas of focus for the Funding Model Review are:

- a more refined case mix approach
- accommodation payment / financing arrangements
- mechanisms for procuring and funding primary care, pharmacy and allied health for ARC residents
- funding settings relating to short-stay and long-stay care
- mechanisms to support appropriate access to ARC for rural populations.

When considering issues for the annual review we've been asked to be mindful of issues that have been captured within the Funding Model Review engagement process.

5.2 Aged Residential Care Audits

The table below has the audits undertaken in quarter 1 of 2018/19 and the resulting corrective actions.

	Quarter 1 2018/19	
	ADHB	**WDHB**
Total Number of audits	9	13
Unannounced audits (surveillance)	6	4
Average number of corrective action per audit	4	3
facilities > 5 corrective actions	3	2
Facilities with no corrective actions	1	4
Facilities achieving a continuous improvement* 1	1	1
Number of complaints the DHB received on ARRC	3	4

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

5.3 Home and Community Support Services (HCSS)

The Waitemata HCSS Working Group is developing a new HCSS model of care. A patient pathway to achieve a timelier service has been developed. A revised entry to HCSS to reduce bottle necks is currently being piloted for a cohort of people. Through this entry, lower need clients receive a standardised six week packages of care focusing on maximising independence. After this they will either be discharged from the service or receive an interRAI assessment for longer term HCSS. The DHB is also working with the MoH on the National HCSS Framework and is cognisant of aligning with this framework, where appropriate, when it is finalised.

A review of the cost model for the Auckland DHB HCSS case mix is underway. The University of Auckland (Department of Accounting & Finance) developed the original cost model using an activity-based costing approach and are undertaking the review. An initial workshop has been held with providers, and templates agreed for data collection (to be completed by the end of October 2018). Aspects covered by the review are: assumptions and, practices and policies built into the model; amendments required due to the introduction of in-between travel, guaranteed hours and pay equity; and changes required due to changes in the model of care. This review is not to renegotiate the price but changes could be relativities between case mix categories.

6 Māori Health Gain

6.1 Cardiac Rehabilitation Prototype

The Whanau House based Cardiac Rehabilitation Prototype completed recruitment phase successfully recruiting 20 clients on to the programme. This included 4 Māori and 6 Pacific clients. A total of 5 clients have completed their course of treatment with positive results. Secondary risk factors have improved on average by 30% for each client, which tracks above international benchmarks for similar interventions which sit at 20-25% improvement. Attendance at key face to face meetings was at 90-95% for the five clients who have completed. This is a marked increase from the average of 60% for the current service.

WaiResearch have started interviewing clients about their experience and self-reported outcomes. This will add further context to the Prototype report due to be completed in late December for circulation early in the new year. The Prototype is due to end in December and will likely inform a service change initiative for Cardiac Rehabilitation and long term condition contracts in the community managed by the Māori Health Gain Team, PFO.

6.2 Taitamariki

The Taitamariki Substance Misuse Service is a youth focused/whanau inclusive substance misuse prevention service aimed at complimenting existing services in West Auckland by filling a gap in intensive youth and whanau focused addiction counselling, out of school positive messaging and development programmes, packages of care for direct positive youth development, and connecting a range of services operating in this space and locality.

We have met with Te Whanau o Waipareira who will provide the service for 3 years to workshop the service specifications for the upcoming first phase of the service – due to start 1 January 2019. These were agreed in principle, and we are currently aligning these to our outcomes framework before confirming them with them provider. Waipareira have also identified potential social workers for this phase of the programme who will be responsible for confirming service protocols, referral pathways and service level agreements with local providers.

6.3 Māori Health Pipeline Projects

The Māori health pipeline is currently progressing proposal development in a range of areas:

- Lung cancer screening: development of specific workstreams, including a qualitative proposal to explore Māori views on lung cancer screening, potential pathways and materials and the process of shared decision making.
- Kapa haka pulmonary rehab: Scoping and establishment of a steering group underway including kapa haka and respiratory experts.
- Northern region breast screening datamatch ('500 Māori women campaign') : Proposal to offer screening to Māori women enrolled with a PHO across the region. Second steering group meeting held and agreement on systematic processes, key monitoring indicators and elements of evaluation. Awaiting primary care approval to share data and will then proceed.
- PHO/Māori provider datamatch: Discussions with Counties Manukau Māori providers are nearly complete. PHO and other relevant permissions have been obtained. This project is split into a phase one data match analysis followed by a phase two of co-designing an offer of service to groups enrolled with a Māori provider but not a PHO.
- Intensive support for women with a history of high grade lesions in cervical screening: Project outline and options drafted with initial positive discussions with the National Screening Unit. Metro Auckland Clinical Governance Forum very supportive of proposal. To progress to full proposal.
- Pre-bariatric adult weight management pathway: Consideration and early scoping.

Additional areas of work will be included over time.

6.4 Community Treatment Orders (CTO)

To date Auckland and Waitemata DHB mental health teams have audited various parts of the CTO pathway and identified a number of areas that require improvement. Auckland DHBs Kaupapa Māori mental health services completed an audit with 39 Māori service users under a CTO. This audit found that Māori were not being reviewed to come off a CTO. The audit also found minimal whānau inclusion in CTO progress meetings with clients. A further analysis carried out by the Health Outcomes team found that current CTO rates were being negatively affected by Māori not being released from their CTOs.

Both DHB provider arm mental health teams are refocusing their efforts to address their Māori CTO rates. In Auckland, the Director of Mental Health services is leading and overseeing projects being planned for 2018 and 2019. Auckland DHBs CTO steering group will meet in November to finalise their activity for the next 6 months. Auckland DHBs activity for the next 6 months will focus on

getting a better understanding of why Māori are not coming off CTOs. The actions Waitemata DHB Mental Health services initially planned for June 2018 have been delayed while the unit scopes up an improvement project in this area. The following actions have been planned for next six months:

1. Gather and review baseline data
2. Scope project and engage appropriate stakeholders
3. Present baseline data and findings of Auckland DHB and Waitemata DHB audits to service meetings for adult and kaupapa Māori mental health services
4. Project group to determine immediate and sustainable change ideas (possible change ideas already identified include registrar training, DAO training, regular audit of new CTOs, review of indefinite CTOs).

7 Pacific Health Gain

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

The Pacific Team is actively involved with the Child Health Team in the implementation of the Positive Parenting and Active Lifestyle for children identified at the BS4C as being obese. At the end of Q1 2018, 125 children from Waitemata DHB and 71 from Auckland DHB were eligible for the programme; 94 of these children are Pacific, 50 from Waitemata DHB and 44 from Auckland DHB. Engagement in the programme is very low. Although this is mostly normal in the early days of new programmes, we and the child health team work very closely with the Waitemata DHB provider, Wai Health and the Auckland DHB provider, AH+PHO to be clear of the barriers and to continuously improve service delivery at every point.

7.2 PHAP Priority 2 –Pacific People are smoke-free

As part of developing a training programme for smoke-free champions in HAVZ and Enua Ola churches and communities, a survey of 200 members of these churches and communities was undertaken. The majority of survey respondents were women (131), of Samoan ethnicity (125). 73 were current smokers. Three main themes emerged from the response to the question why *Pacific* people smoke, and these are addiction, stress relief and peer pressure. For people who had smoked but have stopped, the two main reasons for stopping were concern about their health and their family and the cost of smoking. Consequently, their response as to what would motivate them to stop smoking were health of their family, including improving the health of their children, being good role models for their children and financial benefits for their families. Church and religious reasons can be appealing as reasons for some people.

Providing health messages and education were the least likely method to encourage people to stop smoking. As to possible methods to assist Pacific people to stop smoking, respondents were provided with a list of possible methods and were asked to rate each on a scale of 'not helpful' to 'very helpful'. Group support or "quitting together" was the top preference.

In response to a question on effective of methods to encourage Pacific people to stop smoking, the four top preferences were:

i. Having smoke-free support at church, youth, sport or community group
ii. Information from church leaders
iii. Information from community leaders and smoke-free champions with mana
iv. Information provided to children at Sunday School

In relation to the training for church/community smoke-free champions, the survey results suggest the following:

- Information needs to be tailored to guide smoke free-champions and church and community leaders so that they increase their effectiveness in their support of people to stop smoking, specifically people in their sphere of influence
- Further information of the harmful effects of smoking and specifically the harm of second hand smoking on children and family members
- Strengthen the importance and impact of smoke-free environments on both smokers and non-smokers
- Enable members of the smokers' community to be appropriately supportive i.e. negative comments to smokers may not be helpful
- Strong focus on the impact on family finances
- Identify the triggers and behavioural substitutes for smoking
- Explore whether friendly competition between groups of smokers, with support within the church / community
- Explore opportunities to provide stop smoking support in the context of social activities
- Promote access to stop smoking services and NRT

The results of this survey further confirm observations that we have of Pacific people in general, in that in terms of behaviour change, the support of a group of people known to them within a community that matters to them is the preferred approach.

The current system largely relies on clients being referred as individuals to a provider not known to the client. The engagement that results from this process is low.

This work is being done collaboratively by the smoke free programme manager, the Pacific Team in the DHBs, with the co-ordinators of the HVAZ and Enua Ola programmes and the health committees of the churches and community groups.

Our current Pacific Health Action Plan 2016 – 2020 has smoke-free environments as its second priority. We would like to offer stop-smoke support within the church environment as the next step.

7.3 Priority 3 – Pacific people are active and eat healthy

The 14 community members from HVAZ & Enua Ola programmes undertaking the Personal Trainer Level 4 NZIS training have completed Module 3. They are currently working with individual clients, providing nutrition and physical activity education as well as supporting them to adopt what they are learning. This training will place these 14 students in a good position to be further trained to be health coaches for both groups and individuals. Their Pacific language and cultural skills will enable them to work with Pacific people with diabetes at an individual, family and group contexts.

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

An inaugural full day workforce development workshop was held for parish community nurses, fanau ola nurses, Enua Ola (and HVAZ) co-ordinators and managers. West Fono, Tongan Health Society, AH+ PHO and Procare were represented. The workshop resulted from a review of the parish community nursing service. A Steering Group was established to oversee the review and to oversee the implementation of the recommendations of the review. The Steering Group includes WAITEMATA DHB Director of Nursing, Dr Jocelyn Peach, Director of Nursing Primary Care, Jean McQueen, Pacific Nursing Director Abel Smith, AH+ and Procare nurse leaders and other DHB personnel. The workshop was led by Abel Smith and Celeste Gillmer, Team Leader for the Primary Health Care Nursing Development Team at WAITEMATA DHB.

A number of recommendations resulted from the workshop and these will be implemented in the coming year. The workshop will be held quarterly.

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

Continue to work on the actions from the Asian, migrant and refugee health plan 2017-2019.

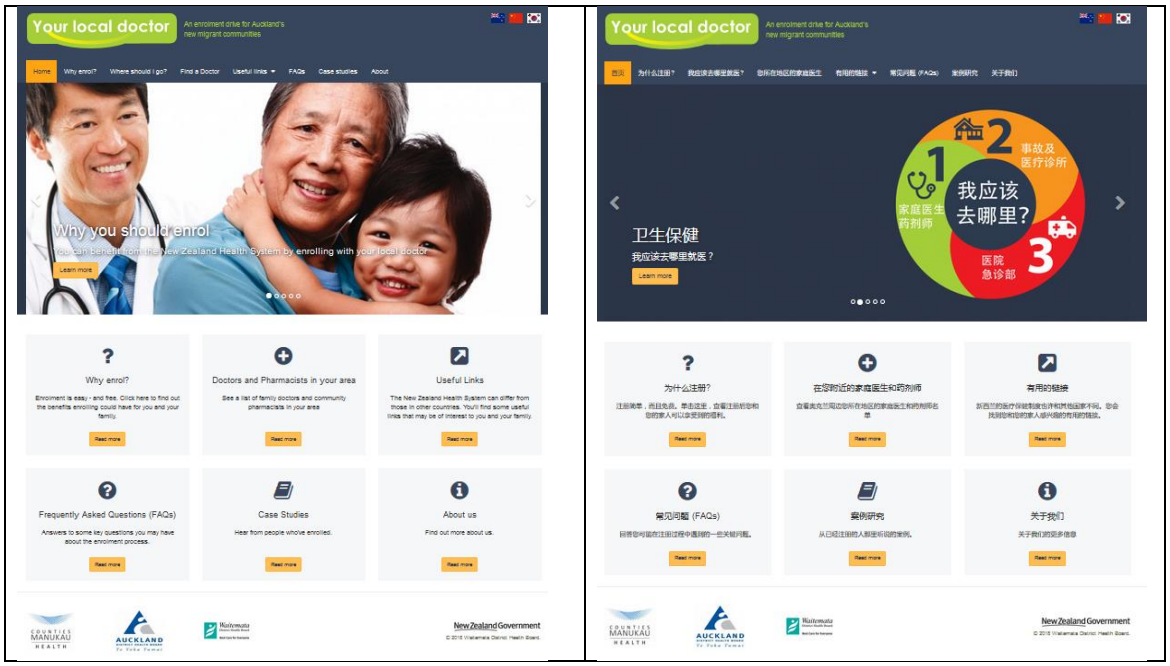
We are a member of the Diabetes Service Level Alliance (DSLA) co-design project working group and provide advice and expert opinion that informs the DSLA flagship co-design project, improving diabetes outcomes for people with diabetes through a co-design approach.

Increase Access and Utilisation to Health Services
Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 87% target (Waitemata) and 71% target (Auckland) by 30 June, 2018. Current rate 89% (Waitemata) and 69% (Auckland) as at Q2 2018/19)
- 80% of eligible Asian women will have completed a cervical sample by 2020 (current rate 67.5% (Waitemata) and 51.7% (Auckland) as at June 2018.

There were 2,426 new Asian enrolees at Waitemata DHB and 1,219 new Asian enrolees at Auckland DHB.

We have updated the 'your local doctor' website (www.yourlocaldoctor.co.nz) with assistance from healthAlliance. The refurbished website has a fresh modern look and feel to it, it is more user friendly across various media platforms than the previous version. We will continue to promote the website among stakeholders and settlement partners. It is promoted as a dedicated one-stop resource website that has information available in a range of formats, e.g. video podcasts, factsheets, brochures and web links with the aims to increase awareness of the New Zealand health & disability system among new migrants. The website is available in English, Simplified Chinese and Korean.



We are working with the Women's Health - Pregnancy & Parenting Service Team and the Regional Refugee Community Health Workers to explore avenues as to how best we can engage and encourage former refugees to attend pregnancy and parenting education sessions.

We have met with the Child and Family Team, Public Health nurses working in the Warkworth area to identify ways we can encourage the Kiribati community living in that area to enrol with their local doctor. A community survey is being planned to identify challenges and how the community can be assisted in accessing health services.

We continue to promote the role of the family doctor and importance of enrolling with a family doctor (GP) by delivering various health seminars/events to increase awareness of the health system and enrolment with a family doctor, including education establishments and settlement partners.

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

- Planning to deliver the third **Refugee Health Forum** to primary care health professionals on 1st November on the topic: 'Family Harm' – looking at ways professionals can address these issues in their daily work and provide culturally safe support. The Forum will be held at the Mangere Refugee Resettlement Centre.