## Counties Manukau District Health Board
### Community & Public Health Advisory Committee Meeting Agenda

**Wednesday, 20 January 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>1.30pm</td>
<td><strong>1. Welcome</strong></td>
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<tr>
<td>1.30 – 1.40pm</td>
<td><strong>2. Governance</strong></td>
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<tr>
<td></td>
<td>2.1 Attendance &amp; Apologies</td>
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<td>2.2 Disclosure of Interests/Specific Interest</td>
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<td></td>
<td>2.3 Confirmation of Public Minutes (16 December 2015)</td>
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<td>2.4 Action Items Register</td>
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<td>1.40 – 2.00pm</td>
<td><strong>3. Director of Primary Health &amp; Community Services Report</strong> (Benedict Hefford)</td>
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<tr>
<td></td>
<td>3.1 Executive Summary</td>
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<td>3.2 National Health &amp; IPIF Targets</td>
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<td>3.3 Primary Health</td>
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<td>3.4 Mental Health &amp; Addictions</td>
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### Afternoon Tea

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>2.15 – 2.25pm</td>
<td><strong>Director of Primary Health &amp; Community Services Report</strong> (continued)</td>
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<tr>
<td>2.25 – 3.25pm</td>
<td>3.5 Adult Rehabilitation &amp; Health of Older People (Dana Ralph-Smith)</td>
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<td>3.6 Child Youth &amp; Maternity</td>
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<td>3.7 Intersectoral Initiatives</td>
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<td>3.8 Progress with Systems Integration</td>
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<td>3.9 Financial Report</td>
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<td>3.25 – 3.55pm</td>
<td>3.10 Locality Reports</td>
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<td>3.10.1 Manukau Locality Presentation (Lynda Irvine)</td>
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<th>Time</th>
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<tr>
<td>3.55 – 4.00pm</td>
<td><strong>4. Resolution to Exclude the Public</strong></td>
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<td>4.00 – 4.30pm</td>
<td><strong>5. Confidential Items</strong></td>
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<tr>
<td></td>
<td>5.1 Confirmation of Confidential Minutes (16 December 2015)</td>
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<td>5.2 Suicide Prevention (Peter Watson)</td>
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**Next Meeting: Wednesday 2 March 2016**  
**Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau**
## BOARD MEMBER ATTENDANCE SCHEDULE 2015 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>21 Jan</th>
<th>Feb</th>
<th>4 Mar</th>
<th>15 Apr</th>
<th>27 May</th>
<th>June</th>
<th>8 July</th>
<th>19 Aug</th>
<th>30 Sept</th>
<th>Oct</th>
<th>11 Nov</th>
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<tr>
<td>Lee Mathias (Board Chair)</td>
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<td>Colleen Brown</td>
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<td>Sandra Alofivae (CPHAC Chair)</td>
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<td>David Collings</td>
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<td>George Ngatai</td>
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<td>Dianne Glenn</td>
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<td>Reece Autagavaia</td>
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<td>Mr Sefita Hao‘uli</td>
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<td>Ms Wendy Bremner</td>
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<td>Mr Ezekiel Robson</td>
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<tr>
<td>Mr John Wong**</td>
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** Newly appointed to Committee from 15 April.
<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Dr Lee Mathias, Chair  | • Chair Health Promotion Agency  
                          • Chairman, Unitec  
                          • Deputy Chair, Auckland District Health Board  
                          • Director, Health Innovation Hub  
                          • Director, healthAlliance NZ Ltd  
                          • Director, New Zealand Health Partners Ltd  
                          • External Advisor, National Health Committee  
                          • Director, Pictor Limited  
                          • Director, John Seabrook Holdings Limited  
                          • MD, Lee Mathias Limited  
                          • Trustee, Lee Mathias Family Trust  
                          • Trustee, Awamoana Family Trust  
                          • Trustee, Mathias Martin Family Trust |
| Colleen Brown          | • Chair, Disability Connect (Auckland Metropolitan Area)  
                          • Member of Advisory Committee for Disability Programme Manukau Institute of Technology  
                          • Member NZ Down Syndrome Association  
                          • Husband, Determination Referee for Department of Building and Housing  
                          • Chair IMuch Trust  
                          • Director, Charlie Starling Production Ltd  
                          • Member, Auckland Council Disability Advisory Panel |
| Sandra Alofivae        | • Member, Fonua Ola Board  
                          • Board Member, Pasefika Futures  
                          • Board Member, Housing New Zealand  
                          • Member, Ministerial Advisory Council for Pacific Island Affairs |
| David Collings         | • Chair, Howick Local Board of Auckland Council  
                          • Member Auckland Council Southern Initiative |
| George Ngatai          | • Chair Safer Aotearoa Family Violence Prevention Network  
                          • Director Transitioning Out Aotearoa  
                          • Director BDO Marketing  
                          • Board Member, Manurewa Marae  
                          • Conservation Volunteers New Zealand  
                          • Maori Gout Action Group  
                          • Nga Ngaru Rautahi o Aotearoa Board |
<table>
<thead>
<tr>
<th><strong>Dianne Glenn</strong></th>
<th><strong>Reece Autagavaia</strong></th>
<th><strong>Sefita Hao’uli</strong></th>
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</thead>
</table>
| • Transitioning Out Aotearoa (provides services & back office support to Huakina Development Trust and provides GP services to their people).  
• Chair of Restorative Practices NZ. | • Member – NZ Institute of Directors  
• Member – District Licensing Committee of Auckland Council  
• Life Member – Business and Professional Women Franklin  
• Member – UN Women Aotearoa/NZ  
• Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust  
• Life Member – Ambury Park Centre for Riding Therapy Inc.  
• CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership  
• Vice President, National Council of Women of New Zealand  
• Member, Disabled Women’s Group  
• Member, Pacific Women’s Watch (NZ) Ltd  
• Justice of the Peace | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Member, Auckland Council Pacific People’s Advisory Panel  
• Member, Tangata o le Moana Steering Group  
• Employed by Tamaki Legal  
• Board Member, Governance Board, Fatugatiti Aoga Amata Preschool  
• Trustee, Epiphany Pacific Trust  
• Trustee Te Papapa Pre-school Trust Board  
• Member Tonga Business Association & Tonga Business Council  
• Member ASH Board  
• Board member, Pacific Education Centre Advisory roles:  
  • Tongan Community Suicide Prevention Project (MoH)  
  • Tala Pasifika (NZ Heart Foundation Pacific Tobacco Control)  
• Member Pacific People’s Advisory Panel, Auckland Council  
• Consultant:  
  • Government of Tonga: Manage RSE scheme in NZ  
  • NZ Translation Centre: Translates government and health provider documents.  
  • Promotus GSL on Rheumatic Fever campaign (HPA)  
  • Taulanga U Society Rheumatic Fever Innovation project (MoH).  
• Member, Ministerial Advisory Council for Pacific Island Affairs. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles and Memberships</th>
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</thead>
</table>
| Wendy Bremner             | • CEO Age Concern Counties Manukau Inc  
                          | • Member of Health Promotion Advisory Group (7 Age Concerns funded by MOH)  
                          | • Member Interagency Suicide Prevention Group                         |
| Ezekiel Robson            | • Department of Internal Affairs Community Organisation Grants Scheme Papakura/Franklin Local Distribution Committee  
                          | • Be.Institute/Be.Accessible ‘Be.Leadership 2011’ Alumni  
                          | • Member, CM Health Patient & Whaanau Centre  
                          | Care Consumer Council                                                 |
| John Wong                 | • Director, Asian Family Services at The Problem Gambling Foundation of New Zealand (PGF), also part of the PGF national management team  
                          | • Member, National Minimising Gambling Harm Advisory Group  
                          | • Chairman and Trustee, Chinese Positive Ageing Charitable  
                          | • Chairman, Chinese Social Workers Interest Group of the Aotearoa New Zealand Association of Social Workers  
                          | • Chairman, Eastern Locality Asian Health Group  
                          | • Founding member and council member, Asian Network Incorporation (TANI)  
                          | • Board member, Auckland District Police Asian Advisory Board  
                          | • Member, Auckland and Waitemata DHBs Suicide Prevention Advisory Group  
                          | • Board member, Manukau Institute of Technology (MIT) Chinese Community Advisory Group  
                          | • Member, CADS Asian Counselling Service Reference Group  
                          | • Member, Waitemata DHB Asian Mental Health & Addiction Governance Group  
                          | • Member, Older People Advisory Group (ACC)  
                          | • Member, University of Auckland Social Work Advisory Group  
                          | • Member, Community Advisory Group of Health Care New Zealand  
                          | • Member, Auckland Regional Public Health Service – Asian Public Health External Reference Group  
                          | • Member of the Advisory Committee for the School of Social Sciences &Public Policy at AUT University |
### COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS’
### REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 20 January 2016

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tbody>
<tr>
<td>Mr George Ngatai</td>
<td>CMH Quit Bus</td>
<td>Mr Ngatai is a Director of Transitioning Out Aotearoa who is a partner provider along with CMDHB and Waitemata PHO in the Quit Bus.</td>
<td>26 March 2014</td>
<td>That Mr Ngatai’s specific interest is noted and the Committee agree that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.</td>
</tr>
<tr>
<td>Ms Colleen Brown</td>
<td>Richmond NZ Trust Ltd</td>
<td>Ms Colleen Brown has been involved with the family of the Richmond NZ Trust.</td>
<td>22 October 2014</td>
<td>That Ms Brown’s specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee in relation to this matter because she is able to assist the Committee with relevant information, but is not permitted to participate in any decision making.</td>
</tr>
<tr>
<td>Ms Dianne Glenn</td>
<td>Liquor Licensing</td>
<td>Ms Glenn is a member of the District Licensing Committee of Auckland Council</td>
<td>15 April 2015</td>
<td>That Ms Glenn’s specific interest is noted and the Committee agree that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making.</td>
</tr>
<tr>
<td>Ms Margie Apa</td>
<td>Integrated Home &amp; Community Support Services Redesign</td>
<td>Ms Apa is Chair of the Northern Presbyterian Support Services Network who are a current provider of home-based services.</td>
<td>8 July 2015</td>
<td>Ms Apa specific interest is noted and the Committee agreed that she will excuse herself from the room if and when any items in relation to this Conflict are discussed.</td>
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Minutes of Counties Manukau District Health Board
Community & Public Health Advisory Committee

Held on Wednesday, 16 December 2015 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau

Present: Dr Lee Mathias (Board Chair), Ms Sandra Alofivae (Committee Chair), Ms Colleen Brown, Ms Dianne Glenn, Mr George Ngatai, Mr David Collings, Mr Sefita Hao’uli, Mr Ezekiel Robson, Ms Wendy Bremner, Mr John Wong.

In attendance: Mr Geraint Martin (Chief Executive), Mr Benedict Hefford (Director, Primary Health & Community Services), Ms Karyn Sangster (Chief Nurse Advisor, Primary Care), Dr Campbell Brebner, Ms Margie Apa (Director, Strategic Development) and Ms Dinah Nicholas (Minute Taker).

Apologies: Apulu Reece Autagavaia, Mr George Ngatai, Mr Geraint Martin & Ms Wendy Bremner (for leaving early).

1. Welcome
The Chair opened the meeting with a timely reminder for us all as we head into the very busy time of Christmas and into 2016 to...
2.3 **Confirmation of Public Minutes – 11 November 2015**

**Resolution**
That the Public Minutes of the Counties Manukau District Health Board Community & Public Health Advisory Committee meeting held on Wednesday 11 November 2015 were taken as read and confirmed as a true and accurate record.

**Moved:** Ms Dianne Glenn  **Seconded:** Ms Colleen Brown  **Carried:** Unanimously

2.4 **Action Item Register Public**

Noted.

3  **Diabetes Management in the Community** (Dr Campbell Brebner)

Dr Brebner provided the Committee with a presentation on the upcoming changes within the Diabetes Care Improvement Package (DCIP) highlighting the following:

(Mr Ezekiel Robson arrived 1.44pm)

- We are good at identifying people with diabetes, although this is relatively new.
- Overall control appears to be improving but not fast enough. We are not winning/bending the curve because we are not managing the more at risk or poorly controlled patients as well as perhaps we could:
  - we have 33,504 people with diabetes enrolled in CM Health practices.
  - 25% (8,316) of these are poorly controlled, or at risk compared with 7,513 in 2013. This is a 10% increase – we would have expected a 4% increase.
- Pacific is the most at risk population.
- Otara/Mangere has the largest percentage of poorly controlled or at risk patients who are concentrated in a few GP practices.
- The proposed changes to the DCIP will allow us to identify and target where there are concentrations of at risk diabetics. The intent is to start with a small number of practices in the Otara and Mangere areas to allow evaluation prior to expanding further. ARI will remain available for the more complex patients who require additional support and CCM depression will remain for those with significant mental health issues.
- The goals are to reduce the number of at risk patients, to improve consistency of care and to increase general practice capability and capacity. Success will be measured by the reduced number of at risk diabetics.
- Modelling and financials still need to be finalised with roll-out expected in March 2016.
- The new model will change the funding from going to incentivising the GP team to improve the diabetic’s control to funding them to focus and target at risk diabetics.
- Learning’s gained from targeting the poorly controlled diabetic patients will transfer across to all diabetes patients.

The Committee asked Dr Brebner to report back next year on progress with this initiative.
4. **Director of Primary Health & Community Services Report** (Mr Benedict Hefford)

4.1 **Executive Summary**

Mr Hefford & Dr Brebner gave the Committee an update on the deportee’s arriving from Australia.

**Actions Arising Responses**

Dr Mathias commented that she felt the conclusion in the paper that the current target for infants at 6-months of age to be receiving breast milk alongside complementary food was unacceptable and queried why the MoH are setting these targets so low and should we be more aspirational with our targets.

It was unclear whether the information provided in this paper was actually a response from the MoH to the Board’s letter asking them to require all Well Child providers to have a target for exclusive breastfeeding at six-months or whether this was just MoH policy that was quoted. Mr Hefford undertook to look into this and to also discuss with the Child Youth & Family team what our organisational targets for infant nutrition in general and breastfeeding in particular should be and to report back in March as part of the deep dive into this service.

4.2 **National Health & IPIF Targets** (Louise McCarthy, Senior Portfolio Manager, Primary Care)

**Better Help for Smokers to Quit** – October 89.8% (target 90%). A drop was expected in October due to the change in the target parameters with the November results shows we have gone back up a few percentage points. We now also have an additional focus on cessation support and plans in place with all PHOs aiming to achieve a 50% target for cessation support over the next year.

**Cervical Screening** – activity in October has included ongoing discussion with the National screening Unit and the MoH to improve the quality, timeliness and availability of cervical screening data for both PHOs and DHBs. Action plans are in place to improve performance in this high priority area.

4.3 **Primary Health** (Louise McCarthy)

**After Hours** – a ROI was initiated in March this year for the provision of After Hours and Overnight Services for the Auckland Metro region. A total of 12 proposals were received and a shortlist was identified. In June, the procurement panel met to discuss the RFP and it was identified that two clauses in the service specification were not consistent with the Commerce Act – directing providers on how co-payments should be set; restricting after hour’s service providers from enrolling patients. The legal advice received was that those clauses had to be removed therefore, the procurement process would have to restart.

However, since then the DHBs have come up with some options as a way forward:

The preferred option is that the DHBs develop a set of specifications and requirements in terms of what they need for after hours services for the region and for Counties specifically around localities (ie) coverage, free under 13’s, subsidised care for Maaori and Pacific and older people and ensuring that we have access for our population. The service specifications are going to be put together and will go out to PHOs asking them to come back to us by March next year with proposals on how they might achieve those service specifications.
The second option was that the DHBs contract directly with any provider who wishes to provide after hours services across the region. This option has challenges, particularly around budget.

Both options will be worked up at the same time as the second option will be the fall back option should the PHOs not be able to meet the specifications in option one.

Aiming for 1 July to start the new contracting arrangements.

The Committee asked Mr Hefford to submit a paper to the Board for noting on this and to include this on the Risk Register as a financial risk to the organisation.

4.4 Localities Reports

Penny Magud, GM Eastern provided the Committee with a presentation on developing the integrated health & social care Community Independence Service within the London borough of Hammersmith & Fulham.

Franklin Locality – The Rapid Response service recently competed in the Health Roundtable Innovation Awards in Sydney and won the Avoiding Unplanned Admissions stream.

Resolution
That the Board send a letter of congratulations to the Franklin Locality GM.

Moved: Ms Dianne Glenn    Seconded: Ms Sandra Alofivae    Carried: Unanimously

(Mr George Ngatai, Mr Geraint Martin and Ms Wendy Bremner left at 3.25pm)

4.5 Adult Rehabilitation & Health of Older People
The report was taken as read.

4.6 Child Youth & Maternity
The report was taken as read.

4.7 Mental Health & Addictions

ARI Update – the development of Phase Two of the ARI programme includes a dedicated mental health and addictions work stream. The workstream’s overarching aim is the development of mental health capability within primary care with a particular focus on increasing primary care capability to optimise mental wellbeing for all and increasing shared care, between primary and secondary, of patients with severe and enduring mental health needs. The Mental Health Service has committed 50% of community full time equivalent staff working alongside primary care as the integration agenda progresses and see this as a significant opportunity to develop capacity, capability and joint working opportunities. We are looking to set up initially three practices in three different localities that have good experience working with people with mental health issues. We have started small as we will need to demonstrate that this has been successful, what’s different. Experience overseas shows that the benefits of having better access to speciality mental health in practices isn’t around mental health it’s around reduced ED presentations for people with chronic conditions and reduced admissions.

For children, young people and adolescents – the district health board has been working on its wait times and access and over the last year and has had 1200 more young people accessing
specialist services within the same resources and has continued to meet the MoH target for wait times. Instead of turning people away as they didn’t meet the threshold, they are doing better at finding out what they could do and what is available.

The Chair commented on the interface with Whirinaki and the Child & Youth adolescent service advising that she has heard consistently over the last year, but more so recently, concern from the community that there are not enough services for children and young people in the community therefore everyone gets referred to Whirinaki which causes a backlog and clog in the system; and, that there are issues even getting Whirinaki to the table to discuss assessments and information flow back and forth etc. Ms Ahern confirmed that priorities for 2016 for our young people will be:

- Our contribution to the children’s action team.
- Making sure the existing services are the right ones for youth.
- Primary care access for youth.
- Youth AOD
- Prime Minister’s Youth Mental Health project.
- Youth whole system strategy.

4.8 Intersectoral Initiatives
The report was taken as read.

4.9 Progress with Systems Integration
The report was taken as read.

4.10 Financial Report
The report was taken as read.

5. Resolution to Exclude the Public
Individual reasons to exclude the public were noted.

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000, the public now be excluded from the meeting as detailed in the above paper.

Moved: Dr Lee Mathias        Seconded: Ms Colleen Brown        Carried: Unanimously

3.52pm Public Excluded session.

3.54pm Open meeting resumed.

6. General Business

6.1 It was agreed that the formal review of the Board being undertaken in the New Year will include evaluation of the community representative’s contributions on the sub-committees.

6.2 It was agreed to schedule a CPHAC meeting in the community in 2016.

The Chair closed the meeting with a message of thanks to the management team in making a concerted effort to bring clarity to each and every meeting and thanked the community representatives who have added colour and vitality to the conversations throughout the year.
The meeting closed at 4.00pm. The next meeting of the Community & Public Health Advisory Committee will be held on Wednesday, 20 January 2016 in the Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.

The Minutes of the meeting of the Counties Manukau District Health Board Community & Public Health Advisory Committee held on Wednesday, 16 December 2015 are approved.

Signed as a true and correct record on Wednesday, 20 January 2016.

(Moved /Seconded )

Chair Ms Sandra Alofivae 20 January 2016 Date
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

**Community & Public Health Advisory Committee Meeting – Action Items Register – 20 January 2016**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tr>
<td>8.7.2015</td>
<td>4.0</td>
<td>Update from Auckland Regional Public Health Service every 6 months on current issues.</td>
<td>2 March</td>
<td>Mr Hefford</td>
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<td>15.4.2014</td>
<td>4.4</td>
<td>Mental Health &amp; Addictions – 2016 Suicide Prevention plan.</td>
<td>20 January</td>
<td>Mr Hefford/Ms Ahern</td>
<td>✔️</td>
</tr>
<tr>
<td>27.5.2015</td>
<td>3.2</td>
<td>Update on Rapid Response from the Franklin Primary Care Practices.</td>
<td>2 March</td>
<td>Ms Sangster</td>
<td></td>
</tr>
<tr>
<td>19.8.2015</td>
<td>5.5</td>
<td>Child Youth &amp; Maternity – undertake a deep dive into childhood oral health (looking at service access, the sugar debate, links to immunisations, Plunket, Well Child checks), infant nutrition in general and breastfeeding in particular and come back to the Committee with a plan going forward outlining the journey to get there.</td>
<td>2 March</td>
<td>Mr Hefford</td>
<td></td>
</tr>
</tbody>
</table>
| 19.8.2015 | 5.10 | Localities
Update on how the Southern Initiative is working from a DHB perspective (ie) issues/hurdles.
Locality update presentations:
East
West
South
Lynda Irvine                                                                                                   | 2 March  | Dates TBC      | Mr Hefford       |
| 30.9.2015 | 5.6  | Mental Health – deep dive into Mental Health & Addictions (incl. alcohol & smoking) looking at the breadth and scope and how well we are placed overall to address the needs of our population. Key Worker Review Implementation – full briefing on this review. | 13 April | Ms Ahern       |                  |
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tbody>
<tr>
<td>16.12.2015</td>
<td>3.0</td>
<td>DCIP Changes – report back on progress.</td>
<td>13 April</td>
<td>Dr Campbell Brebner</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>16.12.2015</td>
<td>7.2</td>
<td>General Business – schedule a CPHAC meeting in the community in 2016</td>
<td>Date TBC</td>
<td>Mr Hefford</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Community & Public Health Advisory Committee
Director’s Report

Recommendation

It is recommended that the Community & Public Health Advisory Committee receive the report of the Director Primary Health & Community Services.

Prepared and submitted by: Benedict Hefford, Director Primary Health & Community Services

Executive Summary

- The final result from the Ministry of Health for Better Help for Smokers to Quit for Quarter one was 86.9%. Although we are still working hard towards the National Target of 90%, Counties Manukau Health was the third highest DHB. There is also significant work going into raising the percentage of people referred to cessation support.

- Counties Manukau Health is working together in a multi-agency collaborative to support New Zealand Citizens deported from Australian detention centres. Thirty deportees were met and assessed at the airport in December. They were given information about how to access health care in NZ, medication supplies were checked and advice given on obtaining further medication. It is expected that between 450 to 600 deportees will be returned to New Zealand in the next few months. The agencies are working together to set up a business as usual process for those deportees due to arrive.

- The Te Rito Ora Improving Infant Nutrition pilot is fully operational in the Manukau Locality. This involves a Drop in Clinic and Whanau Fono space providing free drop-in baby feeding support for Mothers and Whaanau, a Community based Lactation Consultant service providing specialist support for Mothers with complex breastfeeding issues and volunteers (Mother-to-Mother Peer Supporters) providing baby feeding support and encouragement.

- The Safety in Practice initiative was presented at the Health Roundtable Innovation Awards in Sydney in November by Andrew Jones, an Improvement Specialist from Waitemata District Health Board, representing the project team. The work was very well received, with a number of organisations from Australia and New Zealand acknowledging the work completed. Additionally the second Safety in Practice learning session at Counties Manukau Health recorded excellent attendance with 111 attendees attending the event in November. In addition to the excellent attendance the evening was very well received by general practice participants and invited guests. In the week leading up to the Learning Session Dr Neil Houston visited several participating practices with Dr Vikas Sethi and the Safety in Practice improvement Advisors and he was very impressed with the work being done.
3.2 National Health and Integrated Performance & Incentives Framework Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>15/16 Target</th>
<th>14/15 Q3</th>
<th>14/15 Q4</th>
<th>15/16 Q1</th>
<th>Nov 15</th>
<th>On Track</th>
</tr>
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<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>90%</td>
<td>91.2%</td>
<td>92.3%</td>
<td>92.1%</td>
<td>90.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>90%</td>
<td>95.1%</td>
<td>96.1%</td>
<td>86.9%</td>
<td>85.7%</td>
<td>Improvement required</td>
</tr>
<tr>
<td>Increased immunisations - 8 months</td>
<td>95%</td>
<td>93.0%</td>
<td>95.2%</td>
<td>93.6%</td>
<td>94.6%</td>
<td>Improvement required</td>
</tr>
<tr>
<td>Increased immunisations - 24 months</td>
<td>95%</td>
<td>95.0%</td>
<td>95.3%</td>
<td>95.2%</td>
<td>95.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cervical screening coverage (Enrolled population: Connex/DHBSS)</td>
<td>80%</td>
<td>74.7%</td>
<td>76.0%</td>
<td>76.1%</td>
<td>N/A</td>
<td>Improvement required</td>
</tr>
</tbody>
</table>

Note: November results are provisional only, based on calculation from PHO data. Monthly cervical screening data is not available.
Better Help for Smokers to Quit reporting on unadjusted numbers from 1 July 2015

**PROGRESS**

There has been an improvement in performance for all of the Integrated Performance and Incentive Framework target results in November except for the eight month immunisation target. Dr Yaw Moh has committed to the Integrated Performance and Incentive Framework Clinical Champion role at 0.2 FTE for a further six months. The other 0.2 FTE will be invested into a quality collaborative role which will initially focus on supporting practices to improve their cervical screening results.

A Maaori Health and Annual Planning Workshop has been scheduled with primary care for the 17th of December with four key areas of focus involving three of the Integrated Performance and Incentive Framework targets: Cervical Screening, Better help for Smokers to Quit and More Heart and Diabetes Checks. This session will focus on improving equity in health outcomes and committing to actions and milestones to ensure the targets can be met in a sustainable manner.
## More Heart and Diabetes Checks

<table>
<thead>
<tr>
<th></th>
<th>Historical Quarters</th>
<th>Current Month</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2015-Q3</td>
<td>2015-Q4</td>
</tr>
<tr>
<td>PHO</td>
<td></td>
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</tr>
<tr>
<td>Alliance Health Plus</td>
<td>92.0</td>
<td>93.9</td>
</tr>
<tr>
<td>East Health</td>
<td>90.4</td>
<td>91.5</td>
</tr>
<tr>
<td>NHC</td>
<td>87.7</td>
<td>89.8</td>
</tr>
<tr>
<td>ProCare</td>
<td>92.3</td>
<td>93.0</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>89.3</td>
<td>90.7</td>
</tr>
<tr>
<td>CM Health</td>
<td>91.2</td>
<td>92.3</td>
</tr>
<tr>
<td>National</td>
<td>87.7</td>
<td>89.0</td>
</tr>
<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
</tr>
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</table>

November 15 results are provisional only, based on calculations from PHO data
Quarterly data for PHOs is MOH published

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Graph One: CM Health Cardiovascular Disease Risk Assessment Performance at November 2015
November 2015 results are provisional only, based on calculations from PHO data
Quarterly data for PHOs is MOH published
Progress

Quarter one final Ministry of Health results for More Heart and Diabetes checks was 92.1% for the total population (second highest DHB), 88.3% for Maaori and 92.2% for Pacific. On the 30th of June 2016 More Heart and Diabetes Checks will cease to be a health target, however it will continue to be an Integrated Performance and Incentive Framework target and part of the Annual Plan as a health priority. The Ministry of Health has stated that this priority will have a stronger focus on risk factor management and align with the long term conditions work in the primary care sector. Primary care will need to ensure patients who should be recalled for appointments or need additional support to manage their health are able to be identified and proactively followed up. There is also an expectation that community driven outreach programmes, including nurse-led support of self-management and removal of identified barriers such as cost will continue.

The Counties Manukau Health result for November is 90.7% for the total population and 86.5% for Maaori and 90% for Pacific. None of the PHOs have met the target in November for their high needs populations, however four are currently at 89%. PHOs were asked for their strategies for targeting Maaori patients at the November Integrated Performance and Incentive Framework meeting. Most PHOs are offering free Cardio Vascular Disease risk assessments for Maaori and Pacific patients as well as phlebotomy or point of care testing at the practice if up to date blood results are required. An issue was raised with accessing support from Raukura for community outreach services which will be followed up. Reaching the target for our Maaori populations will be a focus during the Maaori Health Plan and Annual Planning workshop on the 17th of December with the PHOs.

Management of high risk patients will also be a key area for discussion at the planning workshop and all PHOs have received the request for data, for an ethnicity breakdown for each Cardio Vascular Disease risk band. Primary care teams will be focusing on active recall via text and phone calls and ensuring patients are offered culturally appropriate nutrition and exercise advice as well as prescription of dual or triple therapy. Shared management decisions and access to self-management support and education will be highlighted in the plan.

PHOs are continuing to target low performing practices and are offering support packages with the aim of ensuring sustainable performance. Dr Yaw MoH, Integrated Performance and Incentive Framework Clinical Champion has offered his support to PHOs and practices to assist with resolving issues and barriers.
Better Help For Smokers To Quit

<table>
<thead>
<tr>
<th></th>
<th>Historical Quarters</th>
<th>Current Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHO</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>94.7</td>
<td>98.6</td>
</tr>
<tr>
<td>East Health</td>
<td>95.5</td>
<td>95.1</td>
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<td>NHC</td>
<td>81.4</td>
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<tr>
<td>ProCare</td>
<td>99.7</td>
<td>100.2</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>90.1</td>
<td>89.2</td>
</tr>
<tr>
<td>CM Health</td>
<td>95.1</td>
<td>96.1</td>
</tr>
<tr>
<td>National</td>
<td>88.6</td>
<td>90.5</td>
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<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

November 15 results are provisional only, based on calculations from PHO data
Quarterly data for PHOs is MOH published results.
Note: reporting is for unadjusted numbers from 1 July.

Progress

The final MoH result for Quarter one was 86.9% (third highest DHB) for the Better Help for Smokers to Quit health target which was a significant improvement on the preliminary results of 84.2%. This was due to a resubmission of Total Healthcare data because of previous data inaccuracies due to the complexity of extracting data from Medtech EVOLUTION and the change in target definition. The percentage of people referred to cessation support was 22% for the first quarter which was below the New Zealand average of 28%. There are a number of activities underway to improve the number of smokers accessing cessation support. Communication documents will be circulated outlining the most effective components of cessation support which are multi-session behavioural support and stop-smoking medicines. Using these components together is associated with the highest long-term abstinence rates. Behavioural support involves advice, discussion, encouragement and other targeted activities designed to:

(1) maximise motivation to remain smokefree,
(2) minimise relapse,
(3) enhance the skills and capacity needed to avoid and resist urges to smoke and
(4) optimise effective use of stop smoking medication.

Behavioural Support guidance has recently been released by the Ministry of Health to ensure evidenced based approaches are followed. PHOs have also been sent pharmacotherapy advice and guidance to distribute to practices along with the number needed to treat.

The Ministry of Health has recently highlighted the ways audit tools can be used within practice to identify patients in need of extra support after having been prescribed cessation medication. Dashboards and query tools enable a targeted approach to identified high needs populations and are being utilised by all practice staff.

During the October to December 2015 Quarter, some PHOs will be carrying out a mail out on behalf of the Counties Manukau Health Practices. The mail out will target 100 patients within each named Practice whose phone number is no longer correct. Each of the patients will be sent a customised
Christmas card with a Christmas message inside including a request to the patient to text their name to a specified cell phone number to the PHO. It is hoped that this mail out will result in a number of hard to reach patients providing their phone number details via a relatively easy, quick method of contact. If successful, this will provide both the Practice and PHO with a number for contacting the patients.

Counties Manukau Health has approached the Ministry of Health for advice and guidance on the wording that is used in text messaging campaigns in order to improve the response rate as some text wording is difficult to interpret.

All participants who attended the Group Based Training session in November will be provided with support and mentorship so they can begin running the first courses early 2016.

**Immunisations**

The Immunisation target for June 2016 requires 95% of all eligible children aged eight months and two years of age to have completed their scheduled course of immunisation.

Progress is discussed monthly with PHOs and Immunisation Working Group meetings and where immunisation is delayed by families they are referred to the outreach immunisations team and where needed to the Well Child Tamariki Ora provider.

**Eight months Immunisations coverage**

Our latest data for eight Months immunisation for November is 94.6%, and by ethnicity shows coverage for Maaori at 89%, Pacific at 97%, Asian at 99%.

![Children fully immunised at 8 months by Ethnicity](chart)

Data by locality shows lower achievement in the Franklin practices at 92.5% for eight month immunisations. PHOs under target are NHC and Alliance Health+. (Locality is the enrolled service locality.)
Twenty four months Immunisations coverage

24 Months immunisation for November is 95.1%, and by ethnicity shows coverage improved for Maaori at 93%, Pacific at 98%, Asian at 99%, Other at 92%

Data by locality shows lower achievement in the Franklin practices at 90% for 24 month immunisations. PHOs under target are NHC and Alliance Health+. (Locality is the enrolled service locality.)
Cervical Screening – Total Population three year Coverage

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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>CMDHB ‘enrolled’ population</td>
<td>74.7%</td>
<td>76.0%</td>
<td>76.1%</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>CMDHB ‘resident’ population</td>
<td>71.4%</td>
<td>72.5%</td>
<td>72.6%</td>
<td>62.4%</td>
<td>75.3%</td>
<td>64.1%</td>
<td>80.4%</td>
</tr>
<tr>
<td>National Performance</td>
<td>71.4%</td>
<td>72.6%</td>
<td>76.6%</td>
<td>63.3%</td>
<td>73.9%</td>
<td>63.8%</td>
<td>82.2%</td>
</tr>
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</table>

Source: National Cervical Screening Programme Register – women aged 25-69 years for CMDHB resident population and Connex (DHB Shared Services for PHO enrolled population)

Note: Monthly reporting on cervical screening coverage at DHB level (including ethnicity breakdown) will shortly be available from NCSP.

Progress

Cervical screening activity for November has included ongoing discussion with the National Screening Unit and the MoH to improve the quality, timeliness and availability of cervical screening data for both PHOs and DHBs. From December PHOs will have access to their monthly data match lists from the Ministry of Health (previously obtained via the DHB Sector Services). The lists will provide screening status of all eligible women enrolled in the PHO. These lists include ethnicity breakdown and identify women who are overdue for a cervical smear. The data can be ‘matched’ with the practice management system so that practices have a correct, up to date record and can use the lists to recall and invite women to screening in a more timely way.

At a regional level, work is progressing to further develop the Work Base Training Programme ‘train the trainers’ sessions. There will be two workshops with the first focusing on upskilling practice staff. The training will help with how to have the conversations, in particular by supporting a more culturally meaningful approach. Workshop two will involve clinical staff and will focus on a health literacy technique called the Three Step Model which was developed for the Health Quality and Safety Commission New Zealand by Work Base. These workshops can contribute to the practice’s Cornerstone accreditation.
To date, the Counties Manukau Health Cervical Screening High Needs Coordinator has screened over 300 women mostly via weekend and afterhours clinics as well as through special community clinics organised in local marae and temples. The vast majority of these screens were for women who were overdue for their smear test. Many had not been screened for 5-10 years. The Coordinator is also doing a survey with women to ask about why they have not completed their regular screening. Feedback to date shows that some of the issues are a lack of understanding about cervical screening, lack of access to afterhours/weekend clinics, embarrassment and having a previous negative experience. In addition to the above, the Coordinator continues to work closely with PHOs to assist them with improving systems and processes for identifying, recalling and inviting women for cervical smears as well as offering opportunistic screening and educating on the importance of screening.
3.3 Primary Health

Objective: To deliver comprehensive in and out of hours primary health care which is ‘Better, Sooner, and More Convenient’.

Progress

After hours and overnight services procurement process update

The DHBs have spent some time discussing the various options to progress with the After Hours Network model. A paper was prepared for the Regional Funding Forum and was used in discussions with the Board Chairs. Three options were identified for consideration:

1. Work with the PHOs to develop a revised After Hours model
2. Make After Hours contracts available to all service providers
3. Re-run a procurement process for a network of providers.

It has been agreed to develop options one and two simultaneously with a view to approach the boards again in March 2016 with more detailed proposals.

PHOs have been provided with a copy of the paper and have been asked to develop a proposal that meets all of the DHBs’ requirements. These include:

a) Coverage – the service model must be responsive and available to the entire populations in the three DHBs (Counties Manukau, Auckland, and Waitemata) irrespective of enrolment status
b) Coverage – the service model must be available to 95% of patients within 60 minutes travel time. For Counties Manukau, there must be at least one clinic providing after hours care to 95% of patients within 60 minutes travel time within each identified locality
c) Coverage – the service model must provide after-hours coverage from 5pm to 10pm Monday to Friday and on weekends and public holidays.
d) Coverage – The service model must provide an appropriate level of overnight services from 10pm to 8am 7 days a week to service the Auckland metro region.
e) Coverage - an appropriate level of geographical coverage by ensuring there is at least one clinic providing after hours care in each identified locality to service the needs of that population.
f) Cost – the service model must be free for all under 13s utilising the service.
g) Cost – the service model must have consistent pricing within a provider for both PHO enrolled and non-enrolled patients using the service.
h) Cost – the service model must provide a subsidised cost for Maori, Pacific, and Quintile five populations plus; high User Health Card holders, and Community Service Card holders.
i) Cost – The service model should consider a subsidised cost for the over 75 years of age population.
j) Cost – Pricing must be set in a manner consistent to the requirements of the Commerce Act.
k) After Hours Alliance – All PHOs and providers must agree to be a member of an After Hours Alliance that will also include the three DHBs.
l) Quality, Safety, and Performance – all providers must agree to provide the appropriate data to ensure that the Quality, safety and performance of the after-hours services can be measured and managed.
m) Financial Transparency – All PHOs and providers must agree to full transparency of the use of the funding.
n) Affordability – affordable within available funding over the duration of the agreement.
o) Process- A Fair and contestable process must be employed when selecting After Hours Providers.

PHOs have been asked to provide a response by the end of February 2016. The DHBs and PHOs will then consider each other’s models with a view to submitting a collectively agreed model to the boards in March 2016. The proposal development process will need to include consultation with each of the Counties Manukau Health Locality Leadership Groups. Proposals will need to demonstrate how service delivery models will be responsive to the needs of each locality within the Counties Manukau region.

Current After Hours Agreements
Some of the clauses that have been considered to be in breach of the Commerce Act are also included in the current After Hours Provider Consortium and Auckland Regional After Hours Network Agreements (the Agreements). These agreements have been extended in draft until the end of February 2016. It has been recommended to PHOs that this date is extended to either June or December 2016 to allow sufficient time for an alternative model for future service provision to be developed. This means the current agreements need to be amended to comply with the Commerce Act. There are two options to consider around management of the current contracts:
a) Remove the clauses from the existing contract and create a variation to extend the agreement out to a preferred date (June/December 2016)
b) If consortium providers do not agree with an extension in this manner, the DHB will need to enter into individual agreements with individual providers until a revised model is in place.

The options outlined above will be further discussed with the sector in Jan / Feb 2016.

Diabetes Care Improvement Package
Counties Manukau Health has engaged a number of clinical and management leadership groups on the proposal to refocus some of the Diabetes Care Improvement Package funding to people with poor diabetes control. The feedback has generally been supportive of the strategy to modify the Diabetes Care Improvement Package programme and to use a co-design process through the implementation of a collaborative approach. This will enable practices to identify the support they will need, design practice processes and responsibilities as well as address specific practice issues.

TestSafe data has been used to identify potential practices who may wish to participate. There are up to 20 practices located in the Manukau, Mangere/Otara and Franklin localities that have more than 100 people enrolled with poor diabetes control. It is anticipated that the change processes will be run over several months (dependant on Diabetes Nurse Specialist and Specialist Medical Officer capacity) and that multiple virtual consults will be used in each practice before the practice is comfortable that less support or advice is provided in a different way. The intention is to up skill practice nurses and medical practitioners in the management of diabetes as well as continuing to offer nurses scholarships to the Manukau Institute of Technology Diabetes Care and Management course.

A project structure is being used to implement the modified DCIP programme that has a small project steering group to advise on project progress. In addition, a Diabetes Service Level Alliance Team is being established and will be provided with progress reports and invited to provide advice on implementation issues as well as monitoring project progress and population diabetes outcomes over time.
Regional Clinical Pathways Programme

Static pathways
The Auckland Region community membership of the Health Pathways (Canterbury model) was completed in December 2014. Progress to date includes:

- Alignment of the 54 pathway developed through GAIHN (2011-2014) to the new site
- Localisation of an additional 62 pathways from the Health Pathways content
- Localisation of an additional 89 pages of information including referrals to secondary services, regional programs i.e. Healthy Homes

Utilisation
- 1597 clinicians registered for access since go live on 24th August 2015
- 30,268 pages viewed over this time
- Returning visitor rate of 65%

Dynamic pathways
The dynamic pathways pilot (Nexxt) continues. Progress to date includes:

- 1630 patients enrolled on a pathway
- 416 clinicians utilising the pathways across the target of 92 practices.

The pilot is due to be completed in March 2016.

The Clinical Pathways Business case outlining the next phase of implementation for both the static and dynamic pathway tools was approved by all PHO and Auckland DHB stakeholders in late December 2015. Northland DHB and the National IT Board have yet to approve the dynamic clinical pathways component of this business case. This is due to be presented in January/February 2016. In early 2016 detailed implementation planning will begin for the next phase of this project lasting 31 months.

CM Health support for New Zealand citizens deported from Australian detention centres

Counties Manukau Health is working with the Ministry of Health and other agencies (Police, Corrections, Ministry of Social Development/Work and Income, Ministry of Foreign Affairs and Trade, Prisoners Aid and Rehabilitation Society) to support the return of New Zealand citizens deported from Australia. It is expected that up to 1,000 people may return to New Zealand over the next 12 months.

Deportees can arrive on commercial flights or charter flights. In December 2015 12 deportees arrived on commercial flights. If health dossiers are available for the deportees they are reviewed and referrals are made to the appropriate services. If mental health issues are identified, triage is provided by Counties Manukau Health Community Mental Health team. All charter flight detainees are met by a team at Auckland International Airport including Corrections, Ministry of Social Development, NZ Police, Probation services and Prisoners Aid and Rehabilitation Society who support integration into the community.

Two charter flights arrived in December each with 15 deportees. Both flights were met by a Counties Manukau Health Primary Health Care nurse specialist and two Counties Manukau Health Community Mental Health nurse specialists. All were triaged and notes reviewed for potential health related issues. Most deportees are young fit men with minor health problems however some have been seen and assessed by Counties Manukau Health Community Mental health team. One required ongoing Community Alcohol and Drug Treatment Services support.
To date thirty deportees have been met and assessed at the airport and given information on how to access health care in NZ and Healthline details. If deportees are on medication their supply is checked and advice given on obtaining additional medication. Arrangements have been made with Primary Options for Acute Care to provide acute medical care in Auckland. The Ministry of Social Development has agreed to reimburse deportees for the cost of medical care if this is sought independently. Charter flights are expected to resume weekly commencing mid-January 2016. Each charter flight will have up to 15 deportees which is full capacity for NZ Customs and the Auckland International Airport arrivals area. The process for each deportee takes up to two hours including welfare applications, health checks, fingerprinting, police interview and Corrections assessment. Advice from the Ministry of Health and Australian Consulate is that between 450 and 600 deportees will be returned to New Zealand over the next few months.

Coordination for the services has been led through the Ministry of Health, with further liaison with New Zealand Police deportee Coordinator/Interpol. There have been issues regarding lack of information, assessment dossiers and logistics. These agencies are setting up a business as usual process for individual arrivals and a draft process will be available in the coming weeks.
3.4 Mental Health and Addictions

**VISION:** That the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community.

**PROGRESS**

**Service Access Rates and Waiting Times**  
*Note that there is a three month report lag due to national data assurance requirements:*

---

**Maori and Non-Maori clients seen by DHB of Domicile, Ethnicity - Total**

![Graph showing access rates for mental health services from October 2014 to September 2015 (NGO & DHB services).](image)

*Figure 1:* Graph showing access rates for mental health services from October 2014 to September 2015 (NGO & DHB services).

---

**Counties Manukau DHB - NGO MH: Ethnicity, (All), All Gender, (All) Age**

![Pie Chart showing wait times for mental health services from October 2014 to September 2015 (NGO & DHB services).](image)

*Figure 2:* Pie Chart showing wait times for mental health services from October 2014 to September 2015 (NGO & DHB services).

Mental Health and Addictions services continue to meet the Ministry of Health wait time targets despite ongoing increased access rates.
Whole of system integration and future service design update

On 30th November the Integrated Mental Health and Addictions Leadership Group hosted a session with key partner groups to discuss its vision; to share what had been heard throughout the co-design process; and to discuss ideas for what that could mean for the mental health and addictions sector in Counties Manukau. Participants included the collaborative and clinical governance groups representing consumers, Mental Health and Addictions Non-Government Organisation providers, Kāpapapa Māori Non-Government Organisation providers, and primary and secondary mental health providers.

Attendees were supportive of the concepts and principles and eager to continue to work together to develop detailed proposals. The main ideas discussed were:

- An alignment with the wider Counties Manukau locality approach, developing a mental health and addictions system that builds effective relationships focussed on primary care clusters. Named individuals from specialist Mental Health and Addictions teams will be connected to clusters/hubs, working in a way that moves past the traditional approach to referrals, enabling professionals and individuals to connect far more easily;
- Non-Government Organisation partners will be a core component of local provision, ensuring that each locality has access to a range of services that are responsive to their needs. Alongside locality-focussed provision, will still remain the need for a number of specialist services, such as eating disorders or maternal mental health, which will be Counties-wide;
- A focus will continue on people with severe and enduring mental health needs and extend to support the wider population with early intervention and easy access;
- In addition to its connection to locality clusters, the Mental Health and Addictions workforce will have a significant mobile component, taking services into the community and engaging with partners such as schools, marae and churches. Working closely with other sectors beyond health will be crucial in supporting the overall well-being of our communities;
- A strong focus on building community resilience and providing education and coaching around self-management.

With this endorsement from key stakeholder groups, the next step will be to take the proposal to Counties Manukau Health leadership in early 2016 for a mandate to work towards achieving the above.

Suicide Prevention and Postvention Plan 2016 - 2020

A new Counties Manukau Suicide Prevention and Postvention Plan is being developed. The first draft is being worked up by the Interagency Suicide Prevention Governance Group. The new Plan will take a multi systemic approach merging local post and prevention with some regional initiatives. The plan needs to incorporate government directives, be evidence based, responsive to local need, sustainable, effective whilst utilising and maximising current resources. The plan has been developed using comparative local and national data, workshops with the Interagency Suicide Prevention Governance group, meetings with the postvention group and the DHB Provider Arm Suicide Prevention Action group.

Within Counties Manukau there is a high rate of Māori suicide. To specifically address this we have engaged with both Te Rau Matatini, the Māori arm of Waka Hourua, the National Suicide Prevention Programme, and Te Puni Kokiri, to work with us on creating strategies that will make a difference for Māori. Part of this strategy includes the formation of a Māori Expert Advisory Group that will develop a strengths based plan for Māori that will align with and sit within the developing District Health Board Suicide Prevention and Postvention Plan. An expression of interest document is currently being circulated for applications to join the group.
There are five areas of activity proposed within the new plan:

- **Mental health promotion:** Resilience building activities in the district - activities to respond to early risks, promote mental health and wellbeing, especially with regards to at risk groups and vulnerable populations. Key activities include:
  - Working with local communities to foster and support local Mental Health promotion projects
  - Establishing a local expert advisory group with a specific focus on Maori suicide prevention
  - Mapping parenting support services and building on teen parenting support
  - Build on mental health literacy in our communities with the continuation of the roll out of Mental Health First Aid
  - Expanding the ‘Handle the Jandle’ programme across our Maori and Pacific youth

- **Access to Help When needed**:
  - Consistent messaging that includes access to help for those feeling suicidal or concerned about some they know on multiple media (websites, apps, posters) at multiple levels e.g. help lines, key local agencies and emergencies services.
  - Build on the existing electronic resource of mental health and social services
  - Improving access to ‘youth friendly’ primary care and links into secondary schools
  - Redesigned Mental Health and Addiction services to reflect a locality approach and whole of system approach with outcome measures

- **Workforce development:** Develop a Metro DHB Suicide Prevention Training Framework to support workforce development that aligns with international best practice to enable key health and front line professionals to have suicide prevention training as part of core training.

- **Quality Improvement**:
  - Support the national move to establish local Suicide Mortality Review Committees that can be utilised for both prevention planning and to identify potential postvention clusters.
  - Working across agencies to review root cause analysis post suicide and implement quality initiatives from learnings

- **Postvention**:
  - Building on work currently undertaken in Counties Manukau to develop an accountability framework in relation to postvention activities for both:
    - immediate response
    - anniversaries / significant events
  - Support and self-care within the postvention workforce
  - Consistent response to families and whaanau in the event of a sudden death of a service user of Mental Health and Addiction services within Counties Manukau

Governance for the plan will sit with the Interagency Suicide Prevention Governance group. The terms of reference have been established to enable feedback at the quarterly meeting on milestones. The framework for governance is shown in the diagram below.
3.5 Adult Rehabilitation and Health of Older People

**STRATEGIC OBJECTIVE:** To support older people in their homes and communities with integrated, locality based services that maximise independence through rehabilitation and quality care.

The New Zealand Health Strategy refresh that is underway has also initiated the refresh of the National Health of Older People Strategy. There has been good engagement from groups. Early themes coming from stakeholders around Health of Older People strategic priorities include: social isolation/social connectedness, oral care needs, flexibility of funding, balance between home support and residential support needs. It is anticipated a draft strategy for Health of Older People will come out in 2016

**PROGRESS:**

**Needs Assessment Service Co-ordination**

Needs Assessment Service Co-ordination by locality referral to complex assessments within five days:

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>22.0%</td>
<td>25.0%</td>
<td>31.8%</td>
<td>13.5%</td>
<td>28.6%</td>
<td>20.5%</td>
<td>22.0%</td>
<td>20.0%</td>
<td>20.9%</td>
<td>26.3%</td>
<td>41.3%</td>
</tr>
<tr>
<td>Franklin</td>
<td>25.0%</td>
<td>23.5%</td>
<td>23.4%</td>
<td>20.0%</td>
<td>23.5%</td>
<td>33.3%</td>
<td>53.3%</td>
<td>50.0%</td>
<td>21.4%</td>
<td>18.1%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>14.3%</td>
<td>10.0%</td>
<td>24.0%</td>
<td>27.3%</td>
<td>35.0%</td>
<td>12.5%</td>
<td>38.5%</td>
<td>37.9%</td>
<td>38.5%</td>
<td>39.1%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Manukau</td>
<td>34.1%</td>
<td>40.7%</td>
<td>34.9%</td>
<td>25.5%</td>
<td>35.4%</td>
<td>21.2%</td>
<td>28.6%</td>
<td>33.3%</td>
<td>32.3%</td>
<td>41.0%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Other</td>
<td>76.9%</td>
<td>64.3%</td>
<td>25.0%</td>
<td>44.4%</td>
<td>50.0%</td>
<td>28.6%</td>
<td>14.3%</td>
<td>20.0%</td>
<td>37.1%</td>
<td>0.0%</td>
<td>45.3%</td>
</tr>
<tr>
<td>CM Health</td>
<td>30.3%</td>
<td>35.1%</td>
<td>28.7%</td>
<td>23.3%</td>
<td>33.1%</td>
<td>22.4%</td>
<td>28.5%</td>
<td>31.4%</td>
<td>29.0%</td>
<td>31.6%</td>
<td>28.6%</td>
</tr>
</tbody>
</table>

Needs Assessment Service Co-ordination by locality referral to non-complex assessments within 15 days:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>80.9%</td>
<td>77.1%</td>
<td>77.7%</td>
<td>72.9%</td>
<td>58.3%</td>
<td>55.9%</td>
<td>82.0%</td>
<td>74.0%</td>
<td>69.0%</td>
<td>47.4%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Franklin</td>
<td>76.2%</td>
<td>88.9%</td>
<td>72.2%</td>
<td>95.0%</td>
<td>70.0%</td>
<td>70.0%</td>
<td>75.0%</td>
<td>81.0%</td>
<td>58.8%</td>
<td>81.8%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>91.7%</td>
<td>90.0%</td>
<td>66.7%</td>
<td>78.6%</td>
<td>44.4%</td>
<td>36.4%</td>
<td>56.0%</td>
<td>52.4%</td>
<td>26.1%</td>
<td>25.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Manukau</td>
<td>82.3%</td>
<td>77.8%</td>
<td>61.3%</td>
<td>62.7%</td>
<td>41.4%</td>
<td>70.5%</td>
<td>67.3%</td>
<td>57.4%</td>
<td>32.1%</td>
<td>73.9%</td>
<td>58.8%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>30.8%</td>
</tr>
<tr>
<td>CM Health</td>
<td>79.6%</td>
<td>77.0%</td>
<td>63.7%</td>
<td>69.3%</td>
<td>49.0%</td>
<td>67.0%</td>
<td>68.7%</td>
<td>62.2%</td>
<td>57.0%</td>
<td>59.6%</td>
<td>57.7%</td>
</tr>
</tbody>
</table>

Percentage of patients entering Aged Residential Care who had a Home Care Assessment in the six months prior to admission:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>33.3%</td>
<td>23.8%</td>
<td>50.0%</td>
<td>33.3%</td>
<td>60.7%</td>
<td>33.3%</td>
<td>60.0%</td>
<td>50.0%</td>
<td>60.0%</td>
<td>33.3%</td>
<td>41.3%</td>
</tr>
<tr>
<td>Franklin</td>
<td>50.0%</td>
<td>54.5%</td>
<td>66.7%</td>
<td>75.0%</td>
<td>60.7%</td>
<td>49.2%</td>
<td>42.9%</td>
<td>62.3%</td>
<td>61.5%</td>
<td>50.0%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>62.5%</td>
<td>66.7%</td>
<td>62.5%</td>
<td>50.0%</td>
<td>60.0%</td>
<td>44.4%</td>
<td>40.0%</td>
<td>50.0%</td>
<td>72.7%</td>
<td>73.1%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Manukau</td>
<td>21.7%</td>
<td>42.9%</td>
<td>25.8%</td>
<td>51.3%</td>
<td>44.4%</td>
<td>20.0%</td>
<td>54.8%</td>
<td>62.3%</td>
<td>79.2%</td>
<td>37.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Outside CM/MHB</td>
<td>100.0%</td>
<td>85.3%</td>
<td>75.0%</td>
<td>75.0%</td>
<td>81.8%</td>
<td>75.0%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>79.6%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>CM Health</td>
<td>37.5%</td>
<td>44.6%</td>
<td>66.2%</td>
<td>53.3%</td>
<td>58.8%</td>
<td>45.4%</td>
<td>56.8%</td>
<td>57.8%</td>
<td>68.3%</td>
<td>31.0%</td>
<td>47.0%</td>
</tr>
</tbody>
</table>

From 1 July the Aged Related Residential Care agreement requires an interRAI home care assessment be not more than six months old when a person is entering Aged Related Residential Care. Needs Assessment Service Co-ordination have been reminded of this requirement and meetings with General Managers of Localities to discuss process improvements activities to increase timeliness have occurred and actions planned include: Staff education on using ‘community forms on line’ and ‘to do list tracking’, prioritisation of annual reviews of high and complex clients and improved accuracy of Ministry of Health forms and client care plans.

**Percentage of Home and Community Support Services client interRAI assessments complete by locality** (Reported Quarterly in arrears) – Number and percentage of clients who have received home and community support services during the last quarter, and have had an interRAI assessment at some point.
Between August and October 2015 92.3% of patients receiving home based support services have had an InterRAI assessment.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Clients</th>
<th>w/InterRAI</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>1138</td>
<td>965</td>
<td>84.8%</td>
</tr>
<tr>
<td>Franklin</td>
<td>713</td>
<td>681</td>
<td>95.5%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>640</td>
<td>615</td>
<td>96.1%</td>
</tr>
<tr>
<td>Manukau</td>
<td>1605</td>
<td>1519</td>
<td>94.6%</td>
</tr>
<tr>
<td>CM Health</td>
<td>4096</td>
<td>3780</td>
<td>92.3%</td>
</tr>
</tbody>
</table>

The Community Stroke Early Supported Discharge

The Early Supported Discharge and Community Based Rehabilitation Team have combined and will be known as ‘Community Stroke Rehabilitation Service’. In addition to stroke patients this service will also provide support to adults under 65 with neurological impairment such as Multiple Sclerosis, impairment following infection, tumour and other conditions on a case by case basis where other services are not able to be accessed.

**STRATEGIC OBJECTIVE:** To improve integration of services for Older People across District Health Board, Primary Health Organisations, Non-governmental Organisations, and others such as St John Ambulance and Community Support Groups.

Community Specialists Health of Older People Teams (reported quarterly)

During the month of November the Community Geriatric Service continued to provide support to multiple Primary Care practices and residential care providers. 44 aged residential care facility staff attended the November education forum; which was focused on the Whole Person Approach – “Do you see “me”?

Community Geriatric Services:

**Target <100 Emergency Care presentations from residential facilities per month**

**<15 Potentially Avoidable Admissions**

December 2015 saw 98 Aged Related Residential Care Clients present to Emergency Care. Of these, 13 presentations were falls related and 17 were potentially avoidable, year to date average 13.4

Memory Team (Dementia Care Pathway)

The outreach programme in Franklin has commenced with the Cognitive Impairment framework and Memory Team support to Waiuku being established. Ten patients using the Cognitive Impairment framework are engaged. Early feedback includes challenges for people with cognitive decline living in parts of Franklin and the loss of their driving licence. There is little alternative transport available.
### Memory Team (Dementia Care Pathway) Activity December 2015:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals (all for cognitive assessment this month)</td>
<td>77</td>
<td>868 cumulative accepted referrals (June 2013)</td>
</tr>
<tr>
<td>Number declined (due to out of Memory team catchment area)</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Referrals managed by Memory Team</td>
<td>49</td>
<td>64% (target 30%)</td>
</tr>
<tr>
<td>Referrals from General Practice</td>
<td>Data incomplete</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td>381</td>
<td>From 40 GP Practices</td>
</tr>
<tr>
<td>Caseload – open cases</td>
<td>252</td>
<td>Cases deemed appropriate to keep open for future action. MT monitor and close as appropriate</td>
</tr>
<tr>
<td>Caseload – active cases</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Cases under Alzheimer’s Auckland</td>
<td>117</td>
<td></td>
</tr>
<tr>
<td>Number of clinicians</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Diagnosis made</td>
<td>407 – total dementia, 195 - total non-dementia diagnosis</td>
<td>602</td>
</tr>
</tbody>
</table>
3.6 Child, Youth and Maternity Services

**OBJECTIVE(s)**
To integrate maternal and child health services; reduce perinatal mortality; improve care in the First 2,000 Days of life; intervene early to support vulnerable children; reduce Rheumatic Fever by two-thirds to 1.4 cases per 100,000; and improve youth services.

Maternity

The Child Youth Maternity Team is pleased to announce the appointment of two Lead Maternity Carer Liaisons to work on a range of strategic initiatives within the maternity portfolio. The scope of these roles will include:

1. Improved communication and collaboration with Primary Care to enable well early engagement and registration with a Lead Maternity Carer by 12 weeks gestation
2. Integration of the self-employed midwifery model into Primary Care
3. New-born enrolment with a PHO

These positions will be incorporated within the Locality structures and will work alongside PHO’s to influence change within General Practice.

**Childhood Obesity Plan - Introduction of a new Health Target**

The Government announced their Childhood Obesity Plan on 19th October 2015. This package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age.

It has three focus areas made up of 22 initiatives which are either new or an expansion of existing initiatives. The focus is on food, the environment and being active at each life stage, starting during pregnancy and early childhood. The package brings together initiatives across government agencies, the private sector, communities, schools, families and whaanau. The strategy includes:

1. Targeted interventions for those who are obese
2. Increased support for those at risk of becoming obese
3. Broad approaches to make healthier choices easier for all New Zealanders.

To support the package of initiatives in the Childhood Obesity plan, a new health target is to be implemented from 1 July 2016. The target is: By December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. A procurement process will be undertaken to support the implementation of these new services.

**Te Rito Ora – Improving Infant Nutrition**

The Te Rito Ora community pilot is now fully operational providing breastfeeding and baby feeding support to Mums and Whaanau in the Manukau locality. Two Community Based Baby Feeding Clinics have been established in Manurewa (Raukura Hauora O Tainui) and Papakura (Red Hill Community Centre) with each clinic running twice weekly. The following services and support is available:

- Te Rito Ora Drop-in Clinic and Whanau Fono Space provides free drop-in baby feeding support for mothers and whaanau
- Te Rito Ora Community-based Lactation Consultant Service provides specialist support to mothers with complex breastfeeding issues via community-based clinics and electronic/telephone follow up as required. Referral from Lead Maternity Carer, General Practitioner, Well Child Tamariki Ora or La Leche League is required;
- Te Rito Ora Kaitipu Ora Volunteers (Mother-to-Mother Peer Supporters) provide baby feeding support and encouragement to mothers and whaanau.

**Well Child Tamariki Ora**

The Counties Manukau Health Child Health forum was developed in 2015 with a purpose to share quality improvement initiatives and support training to providers relating to the key priority areas within the child portfolio. These programmes include Sudden Unexplained Death of Infants, Infant nutrition, Immunisations and preschool dental strategy. A number of initiatives are being trialled which are showing improvements and contributing to the achievement of targets relating to breastfeeding, Immunisations, smokefree environments, maternal mental health and oral health.

**Before School Checks**

Before School checks are conducted in Counties Manukau by Plunket and Well Child Tamariki Ora Maaori Providers. Plunket also provide clinical leadership and training to the Well Child Tamariki Ora providers. The 2015/16 Ministry of Health targets for the year are for 8,025 Before School checks to be completed overall, with 3,565 of these from quintile five (high deprivation). At the 30th of December the Before School check programme was at 58% overall and 54% for Quintile five (high deprivation). Of note is achievement of the ethnicity target for Maaori and Pacific targets which are both at 52%.

**Oral Health - Preschool**

The key target is to increase enrolment of preschool children aged zero to four years to 95 percent by 30 June 2016. We have improved our Preschool enrolment to 76.2 percent at 31st December 2015 with 30,847 preschool children enrolled. This is a tremendous improvement from 70% in December 2014.

We still have a gap, being children aged zero to two years, particularly Maaori and Pacific children however Well Child providers are assisting with enrolment of preschool children earlier so they can be seen in dental clinics at 12 to 15 months.

Our Preschool Mighty Mouth Toothbrushing programme continues to get enrolments in their 150 preschools with high Maaori and Pacific rolls.

**Oral Health – School Dental Service**

The key target is to reduce arrears (children not seen within 30 days of their recall date). The target is seven percent. Due to staff vacancies the arrears are at 31st December 14.1 percent at 14,087 children not seen on time for their annual check-up. The increase in arrears is due to reduced capacity due to unfilled vacancies of dental therapists during 2015 caused by resignations, maternity leave, transfers, and reduced capacity due to two transportable dental units not being replaced.

Counties Manukau Health are working with the Auckland Regional Dental Service to fill vacancies, restore capacity, improve service and reduce arrears; Auckland Regional Dental Service have recruited a net additional six Dental therapists as new grads from the December graduating pool of Dental Therapists.

**Youth Health**

Work continues on the development of comprehensive and integrated school-based health services. A pilot will be trialled at Papakura High School in the New Year and builds on the existing school-based health service and incorporates the development of a new teen parent unit at the school. The workstream around young people with high and complex needs is focused on young people and their whaanau attending Alternative Education facilities.
The work will align with existing service co-ordination initiatives such as At Risk Individuals and the upcoming Children’s Team. The third workstream focusses on a quality improvement initiative for primary care and will involve an audit and improvement programme for general practices linked to a high school or those with an interest in improving their ‘youth friendly’ capability. All workstreams are on track, with no known risks.
3.7 Intersectoral Initiatives

**OBJECTIVE**
Target populations/communities with high health, housing, social, employment and education needs to improve the health status and reduce health inequalities.

**PROGRESS**

Project Outcomes for the Warm up – Counties Manukau Project (1 July 2015-30 December 2015)

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Number of Referrals</th>
<th>Total Number of Homes Insulated</th>
<th>Total Number of Home Visits completed post install</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>217</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>August 2015</td>
<td>172</td>
<td>55</td>
<td>36</td>
</tr>
<tr>
<td>September 2015</td>
<td>121</td>
<td>68</td>
<td>28</td>
</tr>
<tr>
<td>October 2015</td>
<td>115</td>
<td>61</td>
<td>32</td>
</tr>
<tr>
<td>November 2015</td>
<td>162</td>
<td>104</td>
<td>31</td>
</tr>
<tr>
<td>December 2015</td>
<td>77</td>
<td>77</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Total number of referrals generated to date</strong></td>
<td><strong>864</strong></td>
<td><strong>404</strong></td>
<td><strong>155</strong></td>
</tr>
</tbody>
</table>

Please note: There is a time delay between referrals being received by the provider and the completion of the insulation install.

**TheProviding Access to Health Solutions Programme**

Providing Access to Health Solutions is an intersectoral programme resulting from a partnership between Counties Manukau Health, and the Ministry of Social Development that was established in 2004 in an effort to help tackle the growing problem of long-term benefit dependency. The aim of the Providing Access to Health Solutions programme is to assist people in receipt of certain benefits to return to work (the programme is voluntary), using an intensive individualised case management model aimed at reducing health barriers to employment.

**Total Number of Voluntary Participant Enrolled onto the PATHS Programme**

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>18</td>
</tr>
<tr>
<td>August 2015</td>
<td>15</td>
</tr>
<tr>
<td>September 2015</td>
<td>16</td>
</tr>
<tr>
<td>October 2015</td>
<td>17</td>
</tr>
<tr>
<td>November 2015</td>
<td>16</td>
</tr>
<tr>
<td>December 2015</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total Number</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>
3.8 Progress with Systems Integration

**Objective:** That by December 2019 every Counties Manukau resident will have a more local, integrated experience

**Community Health Service Integration**

**Objective:** To increase the capability and capacity of community services, facilitating integration with primary, Non-Government Organisation and speciality services.

**Programme Update**

A comprehensive work plan is being developed to ensure the key milestones of the Community Health Service Integration programme are met between January 2016 and December 2016. The workplan will detail the steps needed for roll out and further development of Reablement, Community Central implementation and Re-contracting of Non-Government Organisations Community Providers. The workplan includes development and implementation of key performance indicators, capacity enablers and benefits realisation.

Engagement and consultation has begun in December 2015 with the development of an initial discussion document to outline the broad intent of the Community Health Service Integration program and invite comprehensive feedback from directly affected teams and key stakeholders across primary and secondary care. This process runs from December to early February. Unions have been briefed and support the concept of a discussion document with change proposals developed once informed by the general feedback. Teams and stakeholders have multiple methods and opportunities to provide feedback including survey monkey, forms, group meetings and workshops.

**Reablement Workstream**

The reablement workstream is focussing on the development of an implementation plan to roll out the Reablement Service to all areas of the hospital in preparation for Winter 2016. Key focus areas will include:

- Moving from supported discharge to early supported discharge
- Review and consolidation of liaison roles
- Development of clinical champions in Reablement for older people and adults with long term conditions
- Development of a “go to” person in each ward or department to assist with championing Reablement
- Identification of patient cohorts to focus on to drive uptake such as heart failure and respiratory
- Review of locality Senior Medical Officer roles and medical support needed for the community health teams going forward

Planning is also underway to set up an additional clinical group to develop the Rapid Response/Admission Avoidance component of Reablement. This will involve a co-design process with primary care, St Johns and community pharmacists. Planning for implementation of this response is set for October 2016.
Community Central

Community Central development continues to focus on the centralised manual intake process within the four locality teams. Data on referrals rates per team and discipline have been analysed, as has current effort required in each base to achieve the triage process. This work has informed the development of a draft roster to be trialled in a centralised intake team approach commencing February 2016. This process has been well supported by the Clinical Leads, Operations Managers and nursing leadership roles such as Clinical Charge Nurse for District Nursing and District Nursing Liaison.

Next steps include further development of the core competencies and interventions provided by each discipline. This will inform how to assign referrals to the “first best responder” and identify when a specific discipline is required to best meet the patients need. The development of the core competencies and interventions will also demonstrate where there is current overlap such as between physiotherapy and occupational therapy and the potential for developing skills within the community teams to reduce the numbers of disciplines involved with individual patients.

This centralised intake process will also support the Transfer of Routine Wound Care project to Primary care which went live on 30th of November 2015. Currently referral rates for this project remain low which is to be expected over the Christmas and New Year break.
At Risk Individual (ARI) dashboard

Supporting patients with long term conditions to live well through more planned and proactive care and improved self management.

At Risk Current Snapshot
Key numbers & stats about our current programme:

16,145
PATIENTS BENEFITING FROM ARI PROGRAMME
Patients with long term conditions are receiving more planned, proactive care with care co-ordination and goal based care plans.

MORE THAN
60,000
PATIENTS WITH A LONG TERM CONDITION IN COUNTIES MANUKAU

16,440
SHARED CARE PLANS
Patients with a goal based care plan that is electronically shared with the care team members.

PERCENTAGE OF ENROLLED POPULATION

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>4.1%</td>
</tr>
<tr>
<td>Mangere/OTara</td>
<td>6.6%</td>
</tr>
<tr>
<td>Eastern</td>
<td>8.5%</td>
</tr>
<tr>
<td>Manukau</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

ARI ETHNICITY

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>24.1%</td>
</tr>
<tr>
<td>European</td>
<td>30.0%</td>
</tr>
<tr>
<td>Maori</td>
<td>14.0%</td>
</tr>
<tr>
<td>Pacific</td>
<td>18.1%</td>
</tr>
<tr>
<td>Other</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

210
SELF MANAGEMENT REFERRALS
Patients have been supported through a formal programme to help them better manage their long term condition.

What does success look like?

<table>
<thead>
<tr>
<th>Enrolled Patients</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>16,145</td>
<td>30,000</td>
</tr>
<tr>
<td>14,594</td>
<td>50,000</td>
</tr>
<tr>
<td>16,145</td>
<td>30,000</td>
</tr>
</tbody>
</table>

- Patients with a shared care plan by July 2016
- People living with long term conditions in CM will receive self-management support by December 2016
- Patients per year enrolled in ARI programme by July 2017

MDTs are occurring within general practice cluster networks to support care planning for complex patients.
General practice clusters have broad networks of healthcare professionals supporting them.
Improved self-management means patients feel more in control and understand their health condition.

For further information www.countiesmanukau.health.nz/integrated-care
Quality and Safety – *Safety in Practice*

**Performance**
Monthly each practice completes their audit on their selected area of focus. Each audit consists of three to five key process measures plus an overall composite measure. The results are used at a local level to focus change efforts within the practice and see whether the changes tested using the Plan Do Study Act cycles are making a difference. The teams are all submitting their data to the project team on time with the overall compliance for all bundles showing signs of improvement.

![Medication Reconciliation immediately post discharge - Overall Compliance](chart1)
![Results Handling - Overall Compliance](chart2)
![Opioid Management Overall Compliance](chart3)
![Warfarin Management Overall Compliance](chart4)

**Communications**
The Safety in Practice initiative was presented at the Health Roundtable Innovation Awards in Sydney in November by Andrew Jones, an Improvement Specialist from Waitemata District Health Board, representing the project team. The work was very well received, with a number of organisations from Australia and New Zealand acknowledging the work completed. The work was different to much of what was presented and demonstrated the innovation of working in the primary care setting and the primary/secondary care interface.

**Learning Session Two**
There was excellent attendance noted for the second Safety in Practice learning session with 111 attendees registered and attending the event in November. In addition to the excellent attendance the evening was very well received by general practice participants and invited guests. The feedback via evaluation forms was predominantly positive and it was noted that the engagement of the project team into the practices early on has made a great difference and ensured that the project remained on task and focused with the regular reporting on improvements with monthly data. This has ensured that there has been a good momentum.
Dr Neil Houston and Safety in Practice Improvement Team Practice Visits
In the week leading up to the Learning Session Neil visited several participating practices with Dr Vikas Sethi and the Safety in Practice improvement Advisors. Dr Houston stated he was very impressed with the work being done, and noted the marked increase in people’s improvement skills, process mapping, and the involvement of the wider teams in improvement work and data. He added that there was good robust credible data being submitted monthly. He acknowledged that some of the smaller practices are struggling with the work due to time constraints but were being well supported by the PHO facilitators and the Improvement Advisors and Vikas, and was pleased to see that some practices are now also utilising the skills in other improvement work in the practice not related to the SiP bundles. Dr Houston said that he was received some very positive feedback about the value of the Improvement Advisors and the invaluable support that they are providing to the practices.

Masterclasses
Ko Awatea’s external Senior Improvement Advisor Brandon Bennett facilitated a masterclass in November on “exploring the human side of change and how to achieve sustainability “with PHO facilitators. The masterclass was well received and attended.

Safety in Practice Future Strategic Direction
Dr Houston’s attendance at the various regional forums to discuss the future of the Safety in Practice initiative has seen good alignment and agreement from the District Health Board’s as to future direction.
3.9 Primary and Community Finance Report

Summary

Primary Health and Community Services had a small favourable variance to budget for November of $190k and $479k year to date. Most expenditure budget variances have matching contra revenue variances. There are a few highlights exceptions noted below.

15/16 financial reporting now includes the Home Healthcare and Needs Assessment Service Coordination budgets in the Locality structure and also includes Public Health Nurses within Child, Youth and Maternity portfolio. All previously included within Hospital reporting in 14/15.

Localities (YTD $92k favourable variance)

In total, the Locality budget shows a relatively small favourable variance but there are concerning trends in the Home Healthcare budgets in each locality with a year to date unfavourable variance total of $146k. When this is annualised it amounts to full year forecast of $358k greater than budget. These variances are largely driven by what has been a busy winter with higher acuity from earlier hospital discharge, high staff illness, higher use of casual nursing staff and budgets that have little allowance for vacancy backfill. Early supported discharge also has a high cost impact on clinical supplies. Fortunately these have largely been offset by underspends elsewhere within the Locality area of responsibility.

Community Pharmaceuticals (YTD $379k unfavourable variance)

This variance is offset by additional funding on the revenue line for under 13s. So net spend is back on budget.

Health of Older People (HoP) (YTD $535k favourable variance)

The 14/15 trend of flat growth against an over 65 population growth of over 4% continues albeit at a slower rate. When the next surge in demand will start is unknown but the budget savings here will fund the investment now underway in the Community Health Services Integration implementation.

Primary & Community – Management (YTD $176k unfavourable)

Increased activity relating, in particular to the Community Health Services Integration implementation, has meant spend above budget. This was anticipated and conditional on the continued budget underspend from over 65s Home based and aged residential care costs. See Health of Older People comment above.

Mental Health ($2,975k favourable variance)

Typical slow start in procuring mental health services to ensure our ring fence requirement is maintained. The below budget spend is matched by a corresponding deferral on the revenue line.
## CPHAC Financial Report

As at 30 November 2015

<table>
<thead>
<tr>
<th></th>
<th>Mth Actual</th>
<th>Mth Budget</th>
<th>Mth Var.</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>YTD Var.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
</tbody>
</table>

### Total Revenue

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>33,598</td>
<td>34,000</td>
<td>(402)</td>
<td>167,159</td>
<td>170,002</td>
<td>(2,843)</td>
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</tbody>
</table>

### Expenditure

#### Primary Care Demand Driven Costs

<table>
<thead>
<tr>
<th>Costs Description</th>
<th>Mth Actual</th>
<th>Mth Budget</th>
<th>Mth Var.</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>YTD Var.</th>
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<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>8,795</td>
<td>8,523</td>
<td>(272)</td>
<td>42,994</td>
<td>42,615</td>
<td>(379)</td>
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<tr>
<td>PHO/GMS/Rural Retention</td>
<td>7,056</td>
<td>6,954</td>
<td>(101)</td>
<td>35,434</td>
<td>34,772</td>
<td>(662)</td>
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<tr>
<td>Other PC Demand Driven costs</td>
<td>752</td>
<td>754</td>
<td>2</td>
<td>3,779</td>
<td>3,768</td>
<td>(12)</td>
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<tr>
<td>ARI / DCIP / Depression / VHIU Health Targets</td>
<td>1,062</td>
<td>1,036</td>
<td>(26)</td>
<td>5,141</td>
<td>5,179</td>
<td>38</td>
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<tr>
<td>POAC</td>
<td>147</td>
<td>181</td>
<td>34</td>
<td>871</td>
<td>907</td>
<td>37</td>
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<td>Regional After Hours</td>
<td>631</td>
<td>607</td>
<td>(24)</td>
<td>3,209</td>
<td>3,035</td>
<td>(174)</td>
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<tr>
<td>Access to Diagnostics</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>494</td>
<td>500</td>
<td>6</td>
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<tr>
<td>Primary Care NGOs</td>
<td>914</td>
<td>929</td>
<td>15</td>
<td>4,541</td>
<td>4,646</td>
<td>105</td>
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<tr>
<td>Primary Care - Management</td>
<td>208</td>
<td>274</td>
<td>66</td>
<td>1,001</td>
<td>1,372</td>
<td>372</td>
</tr>
<tr>
<td>Primary Care - Other Services</td>
<td>71</td>
<td>73</td>
<td>2</td>
<td>374</td>
<td>366</td>
<td>(8)</td>
</tr>
<tr>
<td>Locality - Franklin</td>
<td>174</td>
<td>179</td>
<td>5</td>
<td>837</td>
<td>891</td>
<td>54</td>
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<tr>
<td>Locality - Mangere/Otara</td>
<td>322</td>
<td>445</td>
<td>123</td>
<td>2,179</td>
<td>2,213</td>
<td>34</td>
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<tr>
<td>Locality - Eastern</td>
<td>209</td>
<td>216</td>
<td>7</td>
<td>1,026</td>
<td>1,073</td>
<td>47</td>
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<tr>
<td>Locality - Manukau</td>
<td>343</td>
<td>329</td>
<td>(14)</td>
<td>1,718</td>
<td>1,634</td>
<td>(85)</td>
</tr>
<tr>
<td>Locality - General</td>
<td>74</td>
<td>90</td>
<td>16</td>
<td>404</td>
<td>445</td>
<td>42</td>
</tr>
<tr>
<td>PATHS / Warm Up Campaign</td>
<td>66</td>
<td>69</td>
<td>3</td>
<td>330</td>
<td>346</td>
<td>16</td>
</tr>
<tr>
<td>Child, Youth &amp; Mortality - Management</td>
<td>227</td>
<td>251</td>
<td>24</td>
<td>1,036</td>
<td>1,256</td>
<td>219</td>
</tr>
<tr>
<td>Maternity Services &amp; Review Group</td>
<td>41</td>
<td>79</td>
<td>38</td>
<td>245</td>
<td>396</td>
<td>151</td>
</tr>
<tr>
<td>Mana Kidz</td>
<td>196</td>
<td>112</td>
<td>(84)</td>
<td>980</td>
<td>560</td>
<td>(420)</td>
</tr>
<tr>
<td>HVT / HPV</td>
<td>86</td>
<td>100</td>
<td>14</td>
<td>492</td>
<td>499</td>
<td>7</td>
</tr>
<tr>
<td>Child, Youth &amp; Mortality - Other Services</td>
<td>250</td>
<td>244</td>
<td>(6)</td>
<td>1,267</td>
<td>1,222</td>
<td>(45)</td>
</tr>
<tr>
<td>Public Health Nurses</td>
<td>261</td>
<td>229</td>
<td>(32)</td>
<td>1,271</td>
<td>1,151</td>
<td>(120)</td>
</tr>
<tr>
<td>Maori Health</td>
<td>420</td>
<td>554</td>
<td>134</td>
<td>1,855</td>
<td>2,772</td>
<td>917</td>
</tr>
<tr>
<td>Pacific Health</td>
<td>204</td>
<td>182</td>
<td>(22)</td>
<td>892</td>
<td>908</td>
<td>15</td>
</tr>
<tr>
<td>Primary &amp; Community - Management</td>
<td>248</td>
<td>190</td>
<td>(58)</td>
<td>1,124</td>
<td>948</td>
<td>(176)</td>
</tr>
<tr>
<td>CHSI</td>
<td>8</td>
<td>0</td>
<td>(8)</td>
<td>8</td>
<td>0</td>
<td>(8)</td>
</tr>
<tr>
<td>20k bed day Initiatives</td>
<td>(402)</td>
<td>102</td>
<td>504</td>
<td>(972)</td>
<td>512</td>
<td>1,484</td>
</tr>
<tr>
<td>Savings Initiatives</td>
<td>(684)</td>
<td>(1,053)</td>
<td>(368)</td>
<td>(3,619)</td>
<td>(5,263)</td>
<td>(1,644)</td>
</tr>
<tr>
<td>HOP - LTS CHC</td>
<td>395</td>
<td>345</td>
<td>(50)</td>
<td>1,732</td>
<td>1,727</td>
<td>(4)</td>
</tr>
<tr>
<td>HOP - Home Based Support Services</td>
<td>1,754</td>
<td>1,651</td>
<td>103</td>
<td>8,088</td>
<td>8,254</td>
<td>(167)</td>
</tr>
<tr>
<td>HOP - Rest Home</td>
<td>1,725</td>
<td>1,784</td>
<td>(59)</td>
<td>8,966</td>
<td>8,919</td>
<td>47</td>
</tr>
<tr>
<td>HOP - Private Hospital</td>
<td>4,267</td>
<td>4,276</td>
<td>9</td>
<td>21,120</td>
<td>21,381</td>
<td>262</td>
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<tr>
<td>HOP - Other Services</td>
<td>367</td>
<td>380</td>
<td>(74)</td>
<td>1,761</td>
<td>1,901</td>
<td>378</td>
</tr>
<tr>
<td>HOP - Management</td>
<td>53</td>
<td>59</td>
<td>6</td>
<td>277</td>
<td>295</td>
<td>18</td>
</tr>
<tr>
<td>Mental Health NGOs</td>
<td>3,791</td>
<td>4,490</td>
<td>698</td>
<td>19,413</td>
<td>22,449</td>
<td>3,037</td>
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<tr>
<td>Mental Health - Management</td>
<td>41</td>
<td>29</td>
<td>(12)</td>
<td>209</td>
<td>147</td>
<td>(61)</td>
</tr>
</tbody>
</table>

### Total Expenditure

|                      | 34,172     | 34,765     | 592      | 170,474    | 173,796    | 3,322    |

### Net contribution

|                      | (574)      | (784)      | 190      | (3,315)    | (3,794)    | 479      |
3.10 Locality Reports

Eastern Locality

1. Acute Demand

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.1 Unplanned readmissions (28 days)</td>
<td>5.6%</td>
<td>6.3%</td>
<td>5.8%</td>
<td>5.3%</td>
<td>6.6%</td>
<td>6.4%</td>
<td>6.8%</td>
</tr>
<tr>
<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>1.4%</td>
</tr>
<tr>
<td>1.3 Average bed day usage in last 6 months of life</td>
<td>10.2</td>
<td>6.4%</td>
<td>9.1%</td>
<td>13.8%</td>
<td>13.0%</td>
<td>12.2%</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

Notes: Numbers for previous months may change as additional mortality data is received for 1.3 and as coding is modified for 1.1 and 1.2.
Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for 1.3 - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Children fully immunised at 8 months (Target = 90%)</td>
<td>94.9%</td>
<td>95.6%</td>
<td>94.9%</td>
<td>95.2%</td>
<td>95.8%</td>
<td>96.2%</td>
<td>94.7%</td>
</tr>
<tr>
<td>2.2 Children fully immunised at 24 months (Target = 95%)</td>
<td>94.7%</td>
<td>93.9%</td>
<td>93.9%</td>
<td>95.1%</td>
<td>95.1%</td>
<td>95.6%</td>
<td>95.3%</td>
</tr>
<tr>
<td>2.3 Middlemore Radiology &lt; 6 week wait time for GP Referrals</td>
<td>91.6%</td>
<td>94.2%</td>
<td>94.9%</td>
<td>98.7%</td>
<td>94.1%</td>
<td>86.6%</td>
<td>91.3%</td>
</tr>
</tbody>
</table>

3. Shared Accountability Services

<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.1 ED presentations not admitted</td>
<td>208</td>
<td>230</td>
<td>255</td>
<td>244</td>
<td>245</td>
<td>227</td>
<td>3006</td>
</tr>
<tr>
<td>3.2 Acute medical bed days</td>
<td>1263</td>
<td>1346</td>
<td>1193</td>
<td>1322</td>
<td>1306</td>
<td>1383</td>
<td>16474</td>
</tr>
<tr>
<td>3.3 Acute casemix-funded non-medical bed days</td>
<td>885</td>
<td>940</td>
<td>1038</td>
<td>1028</td>
<td>953</td>
<td>971</td>
<td>12237</td>
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<tr>
<td>3.4 Medical outpatient attendances</td>
<td>2111</td>
<td>2391</td>
<td>1934</td>
<td>2009</td>
<td>1946</td>
<td>1952</td>
<td>25682</td>
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4. Other

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<tbody>
<tr>
<td>4.1 E-referrals as % of all referrals</td>
<td>27.5%</td>
<td>26.1%</td>
<td>25.9%</td>
<td>28.4%</td>
<td>29.8%</td>
<td>30.5%</td>
<td>24.4%</td>
</tr>
<tr>
<td>4.2 Medical Outpatient DNA rate</td>
<td>4.1%</td>
<td>2.8%</td>
<td>3.4%</td>
<td>4.2%</td>
<td>3.7%</td>
<td>3.7%</td>
<td>9.1%</td>
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Performance

The Eastern Locality as a whole has a total of 3,199 patients enrolled on the At Risk Individual programme with a shared care plan. This is across all three Primary Health Organisations who have practices in the locality.

The Eastern Community Health Team (not including the Needs Assessment Service) provided 1828 face to face patient contacts, with a combined caseload of 1,412 patients across the team.

Interdisciplinary triage was launched across each of the localities as part of the Community Central rollout. Each new referral is reviewed and allocated to the best first responder and are no longer on multiple waiting lists. All the waiting lists were reviewed and combined into one allocation list. There continues to be a number of patients who are awaiting an assessment from a member of the team from an allied health background or for a continence assessment. With the wider implementation of community central and workforce competencies developed over the coming months it is envisaged that the need for lengthy waiting times will be eliminated.

The provision of non-complex wound care management by Primary Care via the Primary Options for Acute Care schedule’s was launched in December 2015.
Ministry of Health Mobility Action Programme & Accident Compensation Corporation Falls Prevention

The Ministry of Health have awarded Active Plus the contract for the Mobility Action Programme across the Counties Manukau area. The General Manager for the Eastern Locality has worked extensively with Active Plus to ensure the proposed programme meets the needs of the Counties Manukau population as well as ensuring the five Primary Health Organisations in the area fully endorsed the programme.

Melinda Gardner from East Health Primary Health Organisation commenced with Counties Manukau Health to project lead the Accident Compensation Corporation Falls Prevention development on behalf of the District Health Board, as well as to oversee the Active Plus’ implementation of the Mobility Action Plan deliverables.
Franklin Locality

1. Acute Demand

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</thead>
<tbody>
<tr>
<td>1.1 Unplanned readmissions (28 days)</td>
<td>7.0%</td>
<td>6.7%</td>
<td>7.9%</td>
<td>7.4%</td>
<td>4.7%</td>
<td>5.1%</td>
<td>6.8%</td>
</tr>
<tr>
<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>0.8</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.2</td>
<td>0.9</td>
<td>1.4</td>
</tr>
<tr>
<td>1.3 Average bed day usage in last 6 months of life</td>
<td>12.7</td>
<td>12.2</td>
<td>24.1</td>
<td>12.8</td>
<td>13.4</td>
<td>11.7</td>
<td>11.4</td>
</tr>
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Notes: Numbers for previous months may change as additional mortality data is received for 1.3 and as coding is modified for 1.1 and 1.2.

Aged Residential Care Bed Days in Pukehoke and Franklin Memorial Hospitals are included in the figures for 1.3 - this will primarily affect Franklin as ARC facilities are independently located in all other localities.

2. Quality

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</thead>
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<tr>
<td>2.1 Children fully immunised at 8 months (Target = 90%)</td>
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<td>90.3%</td>
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<td>92.2%</td>
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<tr>
<td>2.2 Children fully immunised at 24 months (Target = 95%)</td>
<td>93.3%</td>
<td>89.5%</td>
<td>87.8%</td>
<td>84.6%</td>
<td>86.2%</td>
<td>90.2%</td>
<td>95.3%</td>
</tr>
<tr>
<td>2.3 Middlemore Radiology &lt; 6 week wait time for GP Referrals</td>
<td>96.8%</td>
<td>86.7%</td>
<td>97.7%</td>
<td>95.1%</td>
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<td>82.0%</td>
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3. Shared Accountability Services

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<td>3.2 Acute medical bed days</td>
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<td>956</td>
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<td>3.3 Acute casemix-funded non-medical bed days</td>
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<td>1050</td>
<td>1170</td>
<td>1088</td>
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4. Other

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<td>5.5%</td>
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Reductioning Unplanned Admissions/ Self-Management:

Winter Planning

The 2015 Winter Plan won the Counties Manukau Health Project of the Year Award which was run by the Strategic Project Office.

Planning is well underway for the Winter Plan in 2016. We have valuable lessons to replicate and expand, and areas for improvement that need reviewing. We have expanded our school focus to four low decile schools from one in 2015. School Principals have been contacted and are keen to be involved. A workshop is planned in early February to engage more of the Social Service providers following a successful presentation the Franklin Health Forum. It is anticipated that they will be able to assist with some of the initiatives.

Immunisation

A multi-disciplinary group met to review the local situation. The meeting had received detailed information of immunisation “decliners” enrolled with Alliance health Plus PHO practices in Franklin. There is a significant cluster around Waiuku. It was noted that local networks (coffee groups) and social media (Grapevine) are very influential and some anti-immunisation messages have appeared in these forums.
Services Closer to Home:
Dementia Pathway Outreach Pilot - Waiuku Health Centre

Ten patients have now been enrolled on the dynamic pathway at the pilot Practice. Two more education sessions have been completed to the wider practice on the role of Alzheimer’s Auckland Charitable trust and the specifics of the pilot patient journey, identification, enrolment on the At Risk Individual’s programme and further cognitive testing using standardised tools, handover to Alzheimer’s Auckland key workers for a home visit and carer support. The next stages of a multi-disciplinary team meeting and family meeting and the on-going support from the practice and Key Worker have still to be tested yet, as the patients’ progress through this pathway.

Monitoring and outcome measures have been developed and will report monthly to the Practice and Counties Manukau Health reporting channels.

The Pilot Pathway had been developed with a view to further spread to other Practices both within Franklin and to the other Localities. All education sessions have been recorded for future use.

Integration
Mental health and Addiction Service

The Mental health Team met with the Locality Clinical Advisory group to brief them on their proposed direction of travel. The intent is a partnership approach with primary care and for Mental Health and Addiction Services (specialist and Non-Government Organisation) to be part of the Locality Hub. New generic roles will emerge and there will be a shared-care approach with primary care and Non-Government Organisation support. This will require a move away from complex referral criteria.

Diabetes Clinics

All Franklin practices have responded to the survey of services and needs. The results need to be viewed in the context of the Diabetes care Improvement Package and At Risk Individuals. Stand-alone clinics are probably not the model of choice, though there may be a place for them in very large practices. Work will commence next year to review the Clinical Nurse Specialist role and the support provided to Localities. Alliance Health Plus is developing a diabetes and Long Term Conditions position to support Alliance Health Plus practices across Counties.

In early 2016 practice nurse representatives will get together to discuss their education and support needs and what will work for each of their practices.

Wound Care

Non-Complex management of wounds in primary care went live 30th November. There has been one referral from Franklin so far.

Review of Locality Group Roles

A regular review of the Terms of Reference of all of Franklin Locality Groups was provided for within each Terms of Reference. The current Chairperson of the Locality Leadership Group, Fiona Horwood, is stepping down from the role. This makes it timely to commence this review of the Locality Groups. At the same time it is an opportunity to ensure the membership of each group properly reflects the expanding role of the Locality.
Mangere/Otara Locality

1. Acute Demand

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<td>651</td>
<td>724</td>
<td>774</td>
<td>689</td>
<td>615</td>
<td>654</td>
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<td>1265</td>
<td>1545</td>
<td>18858</td>
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<td>3.4 Medical outpatient attendances</td>
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<td>2749</td>
<td>2767</td>
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Better Support Self-Management

An action plan for better integrated approaches to self-management support was agreed by the co-design group of clinical and community stakeholders, service providers and consumer.

Integrate and improve service delivery to at risk individuals

The workforce continues to operate and enhance relationships and integrated model of care focussing on individuals and families living with complex, chronic disease. More time was invested in engaging key stakeholders in the co-design of integrated health and social services; involving primary, community and hospital service providers and all Localities. Locality representatives participated in the Maaori Health annual planning process.

Enablers: Service Hubs

Further planning pertaining to the Haemodialysis Unit at 10 Waddon Place, opening in February, took place. Planning continues to be focussed on shared services hubs for Mangere and Otara with the Mangere Hub being the priority.
Manukau Locality

Clinical Priorities

Diabetes Collaborative - Aim statement

To improve diabetes control, in 50% of patients with poorly controlled HbA1c, identified from primary healthcare practices, who are willing to participate in supported self-management activities by 1 December 2016.

- 129 patients have been discussed at Multi-disciplinary meetings
- 42 patients have been reviewed at the Marae’s Clinic at Papakura
- There have been 20 Multi-disciplinary team meetings held
- Nine Practices are involved so far

Work is planned to collect data around the barriers patients’ face that may contribute to poor control of diabetes. The team confirmed the list below represents the common barriers.

Engagement
- Family issues
- Financial
- Health literacy
- Language
- Social issues
• Transport
• Work commitments

The following is a list of interventions that the Senior Medical Officers have agreed would form the bulk of the recommendations.

• Access local food preparation courses/food label education/supermarket tours
• Daily/alt day phone or txt contact with practice nurse/diabetes nurse for insulin dose titration
• Diabetes Consultant clinic review
• Diabetes Nurse Specialist clinic
• Enrol in ARI programme
• Fanau Ola involvement to engage patient
• Fund prescription costs
• Fund primary care visits
• GP practice proactively to call patient back
• Insulin initiation advised
• Letter to patient from Locality SMO
• Oral medication increase advised
• Practice Nurse titration of insulin
• Referral to PHO Dietician
• Referral to PHO Health Psychologist
• Referral to PHO podiatrist
• Referral to PHO Self-Management Group
• Referral to Retinal Screening Programme
• Referral to secondary care clinic
• Specific interventions available through ARI – eg home visit, budgeting advice,
• Weekly visit to diabetes nurse in primary care for next 6 weeks to reinforce/titrate medication
• Whaanau Ora involvement to engage patient


This project has experienced barriers to successful uptake from multiple areas and requires a concerted effort to ensure progress. This project will assist to release capacity within district nursing for the development of Reablement as well as linking well with the transfer of non-complex wound care to Primary Care.

Staffing shortage has impacted on the project and a plan is in place to recruit back fill of 0.5 from project funding to enable staff to participate. Staff will also use the e-shared care platform for care planning now that they have all been trained. This will increase opportunity for integration with Primary Care which is also one of the objectives of the project. Staff have also found that patients have been reluctant to participate and if patients are known to the district nursing service this is more problematic. Focus is on new patients and some of the clinic patients will be included as well. Re-training will also take place around goal setting and motivational interviewing to support staff with patient engagement and participation. Work is also underway to ensure all team members are involved in the project and support the patient centred care plan approach. This will ensure all staff support the continuity of the plan and the patients participation.
The Manukau Locality Clinical Partnership
Lynda Irvine
GM Manukau Locality

Date: Jan 2016
Manukau – Opportunity with ASH Rates

ASH Rate per 1,000 Enrolled Patients

- Eastern
- Franklin
- Mangere/Otara
- Manukau

Graph showing the ASH rate per 1,000 enrolled patients for different areas from November 2014 to November 2015.
Consistent performance

![Consistent performance graph showing percentage of children fully immunised at 8 months with data points for November 2014 to November 2015, with separate lines for Eastern, Franklin, Mangere/Otara, and Manukau areas.]
Consistent Performance

Children Fully Immunised at 24 Months

- Eastern
- Franklin
- Mangere/Otara
- Manukau

Graph showing the percentages of children fully immunised at 24 months from November 2014 to November 2015, with lower percentages visible in August 2015 and September 2015.
At Risk Individuals Program

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Franklin</td>
<td>4.3%</td>
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<tr>
<td>Mangere/Otara</td>
<td>3.6%</td>
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<tr>
<td>Manukau</td>
<td>3.0%</td>
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<tr>
<td>Eastern</td>
<td>3.0%</td>
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<table>
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<tr>
<th>Locality</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Franklin</td>
<td>142.5%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>121.5%</td>
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<tr>
<td>Manukau</td>
<td>101.4%</td>
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<tr>
<td>Eastern</td>
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</table>
At Risk Individuals Program

- All practices are participating in ARI
- Progress in enrolments for the locality reflects the make up of the practices: size, structure, enrolled population and model of care
- ARI has been a useful program to leverage integration and build practice relationships
- Opportunity exists to support the smaller practices by sharing nursing resources
Front Door Project Aims

- To improve transition of care from acute to community care settings
- To support development of ARI and management of long term conditions
- Develop communications that ensure patients understand the options for acute care
- Focus on Manukau and Otara and Mangere
Progress to Date

• Combined intake meetings for Whaanau Ora, Fanual Ola, VHIU and Locality Co-ordinators
• Follow up for patients who have presented 3 times to EC in the previous calendar year
• Facilitating enrolments onto ARI
• Developing partnerships with community teams to provide co-ordinated and integrated care – patients not passed from one team to the other or seen by multiple teams
Key Performance Indicators

- EC presentation rates – all of CMH compared with Manukau/Otara and Mangere
- Representation rates – 7 and 28 days
- Readmission rates within 28 days (medicine)
- Triaged patients already enrolled in ARI
- Subsequent ARI enrolment post triage
- Referral rates of triaged patients to Whaanau Ora, Fanau Ola, VHIU and Locality Co-ordinators
- Teams contact hours and volumes
Indicative Results for first two weeks of triage

• 203 patients triaged between the 1st - 14th July 2015 – 19 Deceased, 184 Remaining
• In the three months prior the group had
• 313 presentations
• In the three months post intervention
• 223 presentations
• 29 % less presentations in the second three months for the specific group we intervened with.
Next Steps

- Winter planning for Manukau including Manurewa and Clendon has high users of EC – After Hours Service access
- Communications work on patient options for acute care
- Community Health Service Integration will support this project – integrated MDT’s, development of rapid response
Diabetes Project - Aim Statement

• To improve diabetes control in 50% of patients with poorly controlled HBA1c, identified from primary care practices who are willing to participate in supported self management activities

• Measured by:
  • Clinically significant reduction in HBA1c
  • Numbers of patients successfully completing interventions
Progress to date:

- 129 patients have been reviewed via MDT’s in primary care
- 42 patients have been reviewed in clinics on the marae
- 9 practices have participated
- 20 MDT’s have occurred with some practices now on their third or fourth MDT
- Other practices are starting to request to participate
Benefits to date:

• Practices willing to participate due to clarity of purpose and a defined patient group
• Provides solid starting point to build integration and relationships
• Supports practice teams with skills and knowledge development and self management support options
• Build the local tool kit for addressing patient barriers to achieving good health outcomes
Patient Barriers Identified

• Engagement
• Competing family priorities
• Financial barriers
• Health literacy
• Social issues
• Transport
• Work commitments
Reablement – Demonstrator

Reablement referrals by ethnicity (all enrolled)
- Pacific, 14, 13%
- Maori, 11, 10%
- Asian, 13, 12%
- European, 71, 65%

Reablement referrals by age band (all enrolled)
- <65
- 65-74
- 75-79
- 80-84
- 85-89
- 90+

Reablement referrals by locality (all enrolled)
- Eastern, 24, 22%
- Franklin, 17, 16%
- Manukau, 68, 62%
Reablement in Manukau

- Lead by locality co-ordinators
- Home Healthcare teams will be trained ready for Winter 2016
- Future focus areas include: moving from supported discharge to early supported discharge, ensuring the approach works for all cultures, development of liason roles and clinical experts to support the community teams and to ensure patients with more complex needs are supported
Manukau Locality – Well Networked

- Papatoetoe Community Network
- Manurewa Community Network
- Papakura Community Network
- Connecting Papakura
Benefits of Community Networks

- Community representative now on the leadership group
- Identification of key stakeholders for co-design processes
- Distribution of health promotion material – Winter Wellness Initiatives
- Identification of venues for community clinics and group education and integration of Better Breathing into the community
- Community Health Expo participation (4 expos in 12 months)
- Development of local social service directory used by Community Health Teams and Primary Care teams
- Supporting CMH initiatives such as Infant Nutrition
2016 Priorities

- Further development of integration with primary care – cluster development
- Planning for hub development
- Winter plan – next steps for the “Front Door” project
- Implementation of Community Health Service Integration work plan – benefits for the locality will include rapid response/admission avoidance which will assist to address ASH rates particularly in the areas of skin infection, respiratory and heart failure
- Social service integration
Resolution to Exclude the Public

Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

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

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<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Minutes of CPHAC meeting 16 December 2015 with public excluded</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>5.2 Suicide Prevention presentation</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</td>
<td>Privacy That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</td>
</tr>
</tbody>
</table>

NZPH&D Act 2000 Schedule 3, S.32 (a)