## Counties Manukau District Health Board

### Community & Public Health Advisory Committee Meeting

**Agenda**

**Wednesday, 25 May 2016 at 1.30 – 4.30pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau**

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<thead>
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<th>Time</th>
<th>Item</th>
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<tr>
<td>1.30pm</td>
<td>1. Welcome</td>
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<td>1.30 – 1.45pm</td>
<td>2. <strong>Governance</strong></td>
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<tr>
<td></td>
<td>2.1 Attendance &amp; Apologies</td>
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<td>1.45 – 2.00pm</td>
<td>3. <strong>Reports</strong></td>
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<tr>
<td>2.00 – 2.15pm</td>
<td>3.1 TSI &amp; CM Health Update</td>
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<td>2.15 – 2.30pm</td>
<td>3.2 2nd Draft 2016-17 Asian Health Plan (Margie Apa)</td>
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<td>3.3 2nd Draft 2016-17 Pacific Health Plan (Margie Apa)</td>
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<td>2.45 – 3.45pm</td>
<td><strong>Afternoon Tea</strong></td>
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<td>(3.00 – 3.10pm)</td>
<td>4. <strong>Director of Primary Health &amp; Community Services Report</strong> (Benedict Hefford)</td>
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<td></td>
<td>4.1 Executive Summary/Responses to Action Items</td>
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<td>4.2 National Health &amp; IPIF Targets</td>
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<td>4.3 Primary Health</td>
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<td>4.4 Systems Integration (Claire Naumann)</td>
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<td>4.5 Locality Reports</td>
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<td>4.6 Child Youth &amp; Maternity</td>
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<td>4.7 Mental Health &amp; Addictions</td>
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<td>4.8 Adult Rehabilitation &amp; Health of Older People</td>
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<td>4.9 Intersectoral Initiatives</td>
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<td>4.10 Finance Report</td>
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<td>3.45 – 3.50pm</td>
<td>5. <strong>Resolution to Exclude the Public</strong></td>
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<td>3.50 – 4.00pm</td>
<td>6. <strong>Confidential Items</strong></td>
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<td>4.00 – 4.05pm</td>
<td>6.1 After Hours Services – Verbal Update (Benedict Hefford)</td>
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<td>4.05 – 4.10pm</td>
<td>6.2 Confirmation of Confidential Minutes (13 April 2016)</td>
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<td>6.3 Action Items Register Confidential</td>
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**Next Meeting: Wednesday 6 July 2016**

Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau
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<tr>
<th>Name</th>
<th>20 Jan</th>
<th>Feb</th>
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<th>June</th>
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<td>Lee Mathias (Board Chair)</td>
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<td>Sandra Alofivae (CPHAC Chair)</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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<td>Mr John Wong</td>
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## COMMITTEE MEMBERS’ DISCLOSURE OF INTERESTS
### 25 May 2016

<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  
• Acting Chair, New Zealand 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 IIMuch Trust  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group |
| Sandra Alofivae             | • Member, Fonua Ola Board  
• Board Member, Pasifika Futures  
• Director, 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 |
<table>
<thead>
<tr>
<th>Counties Manukau District Health Board – Community &amp; Public Health Advisory Committee  25 May 2016</th>
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</table>
| • Maori Gout Action Group  
• Nga Ngaru Rautahi o Aotearoa Board  
• Transitioning Out Aotearoa (provides services & back office support to Huakina Development Trust and provides GP services to their people).  
• Chair of Restorative Practices NZ. |
| Dianne Glenn  
• Member – NZ Institute of Directors  
• Member – District Licensing Committee of Auckland Council  
• Life Member – Business and Professional Women Franklin  
• Member – UN Women Aotearoa/NZ  
• President – Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member – Ambury Park Centre for Riding Therapy Inc.  
• Vice President, National Council of Women of New Zealand  
• Member, Auckland Disabled Women’s Group  
• Member, Pacific Women’s Watch (NZ)  
• Justice of the Peace |
| Reece Autagavaia  
• 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 |
| Sefita Hao‘uli  
• 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>Background and Memberships</th>
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| 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 ‘BeLeadership 2011’ Alumni  
• Member, CM Health Patient & Whaanau Centred 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 |
<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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<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>
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<tr>
<td>Ms Colleen Brown</td>
<td>Emerge Aotearoa (formerly Richmond NZ Trust Ltd)</td>
<td>Ms Colleen Brown has been involved with the family.</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>
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<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 8 July 2015 2 March 2016</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>
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<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>
</tr>
<tr>
<td>Mr Sefita Hao‘uli</td>
<td>Suicide Prevention</td>
<td>Mr Hao‘uli is a paid advisory for the Toko Collaboration Project (suicide prevention for Tongan community) funded under MOH Innovation.</td>
<td>20 January 2016</td>
<td>That Mr Hao‘uli’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>
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Minutes of Counties Manukau District Health Board
Community & Public Health Advisory Committee

Held on Wednesday, 13 April 2016 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 Ezekiel Robson, Ms Wendy Bremner, Mr John Wong, Mr Sefita Hao’uli and Apulu Reece Autagavaia.

In attendance: Mr Benedict Hefford (Director, Primary Health & Community Services), Ms Karyn Sangster (Chief Nurse Advisor, Primary Care), Dr Campbell Brebner (Chief Medical Advisor, Primary Care) and Ms Dinah Nicholas (Minute Taker).

Apologies: Mr Geraint Martin & Ms Margie Apa.

1. Welcome
   Ms Dianne Glenn opened the meeting with her reflections on a recent Asia/Pacific conference she attended, the theme of which was ‘Equity for Women’ and noted that as a district health board we should be aware of all aspects of diversity as we come to conclusions and strive for equitable outcomes for our community.

2. Governance
   2.1 Attendance & Apologies
      Noted.
   2.2 Disclosure of Interest/Specific Interests
      The Disclosures of Interest were noted with no amendments.
   2.3 Confirmation of Public Minutes (2 March 2016)
      Resolution
      That the Public Minutes of the Counties Manukau District Health Board Community & Public Health Advisory Committee meeting held on Wednesday 2 March 2016 were taken as read and confirmed as a true and accurate record.

      Moved: Mr George Ngatai  Seconded: Ms Colleen Brown  Carried: Unanimously
2.4 Action Item Register Public

Noted.

Community CPHAC meeting 28 September – Mr Hefford to look into whether it can be held at the Star Centre at the Total Healthcare Clinical Hub and advertise the meeting in some local community papers.

3. Presentation

3.1 Rapid Response – Franklin Locality
Ms Helen Lees and Ms Karen Ballard from the Franklin Rapid Response Team took the Committee through their presentation highlighting the following:

- The aim of the unit was to develop a coordinated network that links primary and secondary services within the Franklin locality in a timely manner to reduce avoidable hospital admissions and grew initially out of the 20,000 Bed Days programme.
- When first set up it was difficult to sell the concept as it was only a pilot but has now become permanently funded through CM Health with 1.5FTE.
- Response times to 1st contact are usually within the 0-1hour timeframe where a full nursing assessment is undertaken.
- Patients only remain active with the Team for that particular contact and are always handed back to the GP so they are aware of what supports they have put in place.
- Areas for improvement – being able to administer IV antibiotics and take bloods.

The Chair thanked the presenters for their presentation.

3.2 Mental Health Deep Dive
Ms Tess Ahern, GM Mental Health, Mr Pete Watson, Clinical Director and Ms Wendy Brown, Service Development Manager took the Committee through their presentation highlighting the following:

Transformation - we want people in our communities with mental health and addictions to live longer, healthier lives and we believe that by working together we can improve access to a range of services and supports, be better able to care for people when they are unwell and help them maintain their wellbeing when they are well. There will be a ‘shift to the left’ away from a Mental Health & Addiction centric service delivery model to a community located person & whaanau centric model.

Model of Care Reviews & Development - next steps will include ongoing service development through whole of system projects and model of care reviews with detailed business cases and implementation plans for transformation covering sector reconfiguration, workforce development, system infrastructure and community development.

The Chair thanked the presenters for their informative deep dive into our Mental Health service.

3.3 Northern Region Clinical Pathways in Primary Care
Dr Campbell Brebner, Ms Kathryn de Luc, GM Franklin Locality and Dr Charlotte Harris, Clinical Lead took the Committee through their presentation highlighting the following:

- The Auckland Regional Health Pathways is a repository of information.
- The Static website (a pathway represented in a fixed format such as an algorithm on paper or in non-interactive form on a computer) went live on 24 August 2015 and is funded 50/50 by the 3 Auckland metro DHBs and 7 PHOs. All GPs can access and utilise
the website, with some 300+ practices currently doing that. The site has 560+ clinical
pages; 95+ being localised for the CM Health community.

- The Dynamic platform (a pathway represented in an interactive form on a computer
and changes in response to data entered) is integrated with practice management
systems (PMS) although is not integrated with Concerto e-referrals yet. This platform is
funded by the 4 Northern region DHBs only. It has only rolled out to 92 practices to
date and has 10 pathways currently available.

- The objective of the pathways is to standardise primary care management of common
conditions and enable primary care to work at the top of its scope, reduce variation of
care and inequities in outcome.

- Clinical pathways need to be seen in the context of the wide integration strategy being
pursued by the DHBs. The pathways can only realise their potential benefit if they
become an integral component of other system-wide programmes of work, especially
those seeking to establish more integrated and collaborate models of care.

- The benefits are many:
  
  o From a patient perspective – they receive consistent care and increased
    engagement with decision-making
  o From a provider perspective – easy access agreed standards of care, efficient
    referral process, a culture change
  o From a system perspective – more care right place, right time, working at top of
    scope
  o Future costs avoided with breakeven by FY2020/21.

The Chair thanked the presenters noting that this is certainly the way forward, focussing on
quality and providing our community with something that has the ability to impact
meaningfully on their lives.

3.4 Diabetes Care Improvement Package (DCIP) Changes Update

Dr Campbell Brebner took the Committee through his presentat ion highlighting the
following:

DCIP is a package worth around $1.2m (50/50 MoH/DHB).

In 2012 the pre-existing programme (DCS) changed from an annual check to start
incentivising practices for improved Hba1c and provided some allied health resource for the
practices. We have started to see slow improvement in control but not at a rate that we
would like to see and we are also unfortunately seeing an increase in the number of poorly
controlled diabetics.

We have currently 33,000+ enrolled diabetic patients – 25% with Hba1c greater than 75
with 66% being Maaori/Pacific. We have therefore had to look to remodel the package to
focus on patients with poorly controlled diabetes to optimise their clinical management.

The approach being used is an ARI-type approach, developing MDT case reviews, using a
collaborative improvement methodology, care planning and interventions. The aim is to
recruit up to 20 practices who have around 5100 of the poorly controlled diabetics out of a
total of 8300. The prior funding to the practices will be reshaped - they will no longer get
the incentivisation payment but they will be paid to participate in the collaborative and the
MDT care planning activity.

Progress to date – 12 practices recruited with 2500 poorly controlled diabetics. An
inaugural learning session is planned for May which will include practices, the diabetes
services, allied health providers and PHO improvement facilitators.
In response to a question whether the incentivisation payment could change so it didn’t go to the practice but went to the patient, Dr Brebner advised that that is not what is being factored in at this point but it could possibly be looked at.

Initial data from patients that have been through ARI, including diabetic patients, shows on just about every score in terms of how much confidence and understanding patients have about their condition and how to manage that, after 12 months that has gone up. Procare have also undertaken some analysis that shows that patients in ARI at CM Health are doing better in terms of their glucose control after 12 months.

As long as this is patient-centred and based around patient goals it should give us a crack at shifting the curve in this area.

4. **Director of Primary Health & Community Services Report**

Mr Hefford took the Committee through some highlights of the Report.

4.1 **Executive Summary**

The Children’s Team launched 22 March but has challenges. As background, in CM Health we have approximately 600-700 children at any one time who are under formal CYF care and intervention. We also have 3,500 children just below that level who are at risk of being seriously abused and neglected and it will be these children that are targeted by the Children’s Team. They will need to be referred into the service. The team is a virtual team joining up access to social services to better proactively support these children. Each family will have a Lead Professional appointed to them however, the family does not have to accept the services offered, it is voluntary unlike a CYFs intervention. There are concerns if the referrals don’t come in or the family don’t accept the services offered. There are also concerns whether the Team would turn down a referral if it came from outside the Manurewa/Clendon/Papakura area. It is early days and there is a genuine interest and energy to make this work. Further updates will be provided to the Committee in the coming months.

Winter Planning – this was reviewed last year in light of the Franklin locality’s stand out performance in terms of success (ie) ED attendances, flu vaccinations. One of the key learning’s was to communicate a very simple message to contact your family doctor first and we will be pushing this concept this winter and will also be looking to roll out Rapid Response to the other localities. Some communications will be going out in two weeks including the back of buses, Google search pop-ups (ie) if someone Google’s ‘flu’ a pop-up from CM Health will say to contact your family doctor first.

Falls – we have received some money from ACC for Falls prevention. Further information on this will be included in the next Director’s Report.

4.2 **National Health & IPIF Targets**

The report was taken as read.

4.3 **Primary Health**

The report was taken as read.

4.4 **Systems Integration**

The report was taken as read.

4.5 **Locality Reports**

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

4.7 Mental Health
The report was taken as read.

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

4.9 Intersectoral Initiatives
The reports were taken as read.

4.10 Finance Report
The report was taken as read.

Resolution
That the Community and Public Health Advisory Committee receive the report of the Director of Primary Health & Community Services.

Moved: Ms Sandra Alofivae    Seconded: Dr Lee Mathias    Carried: Unanimously

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: Ms Sandra Alofivae    Seconded: Dr Lee Mathias    Carried: Unanimously

4.35pm Public Excluded session.

4.40pm Open meeting resumed.

6. General Business
7.1 TV1 6pm tonight Toto Ora piece is being shown.

7.2 Dr Mathias advised that the DHBs have been delegated the decisions about fluoride and would like this item on the next agenda for discussion with a view to sending a Recommendation to Board that CPHAC support fluoridated water. The Committee asked that Julia Peters, ARPHs attend the next meeting to provide an update in this area.

The meeting closed at 4.45pm. The next meeting of the Community & Public Health Advisory Committee will be held on Wednesday, 25 May 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, 13 April 2016 are approved.

Signed as a true and correct record on Wednesday, 25 May 2016.

(Moved:    /Seconded:     )

Chair  25 May 2016
Ms Sandra Alofivae  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/Resolution Register – 25 May 2016**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
</tr>
</thead>
<tbody>
<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>6 July - TBC</td>
<td>Mr Hefford</td>
<td></td>
</tr>
<tr>
<td>19.8.2015</td>
<td>5.10</td>
<td>Localities Update on how the Southern Initiative is working from a DHB perspective (ie) issues/hurdles. Presentations: Eastern Franklin Mangere/Otara Manukau</td>
<td>25 May Dates TBC</td>
<td>Mr Hefford</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>28 September</td>
<td>Mr Hefford</td>
<td></td>
</tr>
<tr>
<td>20.1.2016</td>
<td>2.3</td>
<td>Presentation from the Plunket Society.</td>
<td>17 August</td>
<td>Mr Hefford/Ms Sangster</td>
<td></td>
</tr>
<tr>
<td>20.1.2016</td>
<td>2.4</td>
<td>Asian Health update – quarterly update.</td>
<td>25 May</td>
<td>Ms Apa</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific Health update – quarterly update.</td>
<td>25 May</td>
<td>Ms Apa</td>
<td>✓</td>
</tr>
<tr>
<td>20.1.2016</td>
<td>3.5</td>
<td>ARHOP – national Health of Older People Strategy draft.</td>
<td>25 May/17 August</td>
<td>Mr Hefford/Ms Ralph-Smith</td>
<td></td>
</tr>
<tr>
<td>20.1.2016</td>
<td>2.3</td>
<td><strong>Resolution</strong> That the Board request of Ministry of Health that all Well Child providers are required to meet defined breastfeeding targets as indicated by Government policy which is underpinned by the Innocenti Declaration. <strong>Moved</strong> Dr Lee Mathias/Seconded Ms Sandra Alofivae/Carried Unanimously</td>
<td>Pending</td>
<td>27.1.2016 - Passed to Board Secretary. 25.5.2016 – Ms Ellis &amp; Dr Pip Anderson are meeting with Dr Mathias on 15 June to discuss.</td>
<td></td>
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</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

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<tr>
<th>DATE</th>
<th>ITEM</th>
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<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tbody>
<tr>
<td>23.3.2016</td>
<td>-</td>
<td>Women’s Health – provide some objective analysis on the 4 major programmes (HT, SIB, CT, Papakura) as to which will provide the DHB with the best spend and how quickly we can evaluate the outcomes.</td>
<td>Date TBC</td>
<td>Mr Hefford/Ms Carmel Ellis</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>13.4.2016</td>
<td>4.1</td>
<td>Director’s Report – update on funding received from ACC for Falls Prevention.</td>
<td>25 May</td>
<td>Mr Hefford</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>13.4.2016</td>
<td>7.2</td>
<td>General Business – ARPHs update on the fluoridation of water with a view to a Recommendation going to Board.</td>
<td>6 July</td>
<td>Mr Hefford</td>
<td></td>
<td></td>
</tr>
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</table>
Recommendation

It is recommended that the Community & Public Health Advisory Committee:

Receive this update on how the Southern Initiative is working from a DHB perspective.

Prepared and submitted by: Jude Woolston, General Manager Intersectoral & Doone Winnard, Clinical Director Population Health

Purpose

An update on how The Southern Initiative (TSI) is working from a DHB perspective was an action item from the CPHAC meeting of 19 August 2015. This paper provides that update.

Update

Counties Manukau Health (CM Health) and Southern Initiative staff have established a communication pathway and a foundation to build the relationship further; this provides the potential to explore joint projects where there is value-add from such a collaboration. Current TSI projects have the potential to impact wider social determinants of health (ie) youth employment, community and economic development, which would have positive impacts on health and well-being for the population served by CM Health.

Current ongoing projects for TSI include:

- The Southern Initiative Māori and Pasifika Trades Training Infrastructure Consortium are contracted as a Training Education Organisation for the Māori and Pasifika Trades Programme (MPTT).
- TSI is partnering with Auckland Airport job/skills hub to link job searchers with employers, and employees to job training and employment opportunities.
- TSI has a contract to work with the Auckland-wide healthy Housing Initiative (AWHI, part of the government’s programme to address Rheumatic Fever) to develop a range of community-led solutions to make homes healthier.

TSI has and/or is also working with the Auckland Co-Design Lab on a number of research projects:

- Exploring the barriers to people obtaining driving licenses.
- Studying the gap between employer’s expectations of job readiness and youth expectations of work preparedness.
- Working with Kotuitui Trust to develop a framework and strategy to improve outcomes for Papakura whaanau.
- The “Early Years Challenge” to explore how to improve outcomes for young children (0-5 years), along with their families and whaanau in South Auckland. This includes a piece of co-design work looking at ways to boost Kohanga Reo enrolments.
There will be opportunities to draw on these qualitative studies to help inform the social investment work that CM Health is involved in.

TSI are also actively engaged in supporting social entrepreneurship in South Auckland, in various forms and were part of the Ko Awatea-organised TED-X event to create new ideas that could result in positive social change.
**Recommendation**

It is recommended that the Community & Public Health Advisory Committee:

**Receive** the second draft 2016/17 Asian Health Plan.

**Note** that the 2016/17 Asian Health Plan aims to complement, not duplicate CM Health’s 2016/17 Annual Plan with a core focus on our Healthy Together health equity goal.

**Endorse** the second draft 2016/17 Asian Health Plan go forward to the 15 June 2016 Board meeting for final approval to implement and publish.

**Prepared and submitted by:** Marianne Scott, Master Planner on behalf of Margie Apa, Director Strategic Development

**Executive Summary**

The 2016/17 Asian Health Plan is a continuation of the 2015 three-year work plan with additional actions identified through consultation and literature review in 2016.

To avoid unnecessary duplication with CM Health’s 2016/17 Annual Plan, this Asian Health Plan focuses on health system improvements *with a health equity lens*. This complements, not duplicates our strategic integrated care initiatives and focus on prevention and early intervention in the community. It acknowledges the ongoing Asian health promotion activities led by the Primary Health Organisations and collaborative actions with the Regional Asian and MELAA Primary Care Group.

The plan focuses on three areas of action:

- building cultural capability through health literate systems and people;
- enhancing service delivery in areas of emerging health disparities; and
- establishes a *new Asian Health Coordinator role* to build linkages with existing PHO Asian health improvement approaches and connections with the many Asian community networks, groups and service providers.

**Purpose**

To approve the second draft 2016/17 Asian Health Plan for 15 June 2016 Counties Manukau District Health Board.

**Background**

*What does the term “Asian” mean in New Zealand?*

The term ‘Asian’ is used in New Zealand to describe culturally diverse communities of over 40 ethnicities with origins from the Asian continent. This definition excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. Asian and migrant people are a very diverse population group that come from a variety of different geographic areas and have widely varying cultures and languages.
An additional diversity factor relates to the number of years lived in New Zealand and their understanding of how and where to access the health system. This issue is common to people from Middle Eastern, Latin American, African (termed MELAA) countries and refugees. For this reason actions for this population group have been included as part of a Northern regional approach.

This plan is a continuation of the Asian health work plan started in 2015

The 2015 work plan was reviewed and supported by ELT and related sub-committees and CPHAC. A summary of the 2014 community and staff views regarding “what matters for Asian Health and wellbeing” is provided in Appendix 1.

In late 2015, the Counties Manukau District Health Board requested the Strategic Planning team review this work plan. Our 2016 review includes analyses of population data and information and engagement with local and regional stakeholders with a focus on emerging health disparities.

Our Asian population is fast growing with emerging health disparities in some groups

In Counties Manukau, approximately 25 percent of people have identified themselves as ‘Asian’ and this is due to increase to 26 percent by 2020. Life expectancy at birth of people identified as Asian in CM Health is higher at 87 years than NZ European/Other ethnic groups at 81.3 years. Despite this seemingly favourable health measure, service leaders across the district suspected that the true story of health morbidity was likely to be different for some Asian communities.

Available data identified health disparities below was the focus of stakeholder engagement, i.e.:

- Persistent low levels of physical activity and intake of fruit and vegetables in South Asian and Chinese adults alongside growing prevalence of hypertension, cholesterol and diabetes telling us that ill-health prevention and treatment approaches are not working equitably.
- In 5 year old Auckland children, Chinese and Indian burden of dental caries is about mid-way between New Zealand European and Other and Pacific groups.
- Indian people have a high age-specific prevalence of diabetes similar to Pacific people, who have the highest levels. Chinese prevalence is slightly higher than 'NZ European and Other' ethnicities who are lowest prevalence.
- For Asian people, mental health and addiction service access can be especially difficult – there are practical, cultural and systemic barriers similar to those for health services in general.

Proposal

This plan reflects an action focus on building workforce cultural capability to improve the experience of care for Asian people. This was a core requirement for action identified by the community and DHB staff. This was not such a strong theme with the PHOs consulted in 2014, as in general practice people have the option to choose that is not the same for hospital services.

Our Healthy Together strategic goal provides a lens to consider current or emerging health disparities and inequities across our vibrant and diverse residents of Counties Manukau. This means we need to be regardful of the constrained health funding realities and explore targeted resources where they will have the most meaningful contribution to our strategic goal. To achieve this, our Asian health improvement, prevention and experience of care opportunities were developed with our Healthy Together strategic goal and objectives (Figure 1) as our main objective.

To avoid unnecessary duplication with CM Health’s Annual Plan, this Asian Health Plan focuses on service improvements with a health equity lens. This complements our strategic Alliance priorities for integrated care initiatives and enhanced general practice that focus on prevention and early intervention in the community. We have included refugee and migrant health actions as part of our
collaboration with the regional Asian and MELAA Primary Care Group and other DHB Asian health leaders.

Figure 1: Healthy Together strategic objectives and Asian health priorities for 2016/17

- **Healthy Services** - more effective information, communication and experience of health services for Asian people and those new to New Zealand and culturally capable workforces.

- **Healthy People, Whaanau & Families** - targeted support for those services that are best placed to reduce emerging Asian health disparities such as mental health and addictions, oral health in children, prevention and management of cervical cancer, cardio metabolic disease and diabetes in adults.

- **Healthy Communities** - stronger voice and dedicated resource to promote, coordinate and support the health and wellbeing of our Asian and migrant communities with key stakeholders in the community, primary care and the Auckland region.

**Discussion**

**Stakeholder Engagement – Asian community views**

We engaged with community members during our ‘2016 Lunar New Year Celebration’. Their views about ‘what mattered’ in the health and wellbeing of Asian communities remained consistent across the 2014 and 2016 reviews, i.e.:

- understanding how and when to use the health system,
- language and communication barriers, particularly for older more isolated Asian people, and
- how best for health to connect with existing community groups and networks.

In addition, community members wanted to see ‘action now’ that would specifically target Asian health improvement. Recommendations included an Asian champion to lead an Asian health plan implementation and ensure an appropriate and timely link with Asian communities. A focus on addressing language and culture barriers and support for Asian people to navigate the health system to help themselves continue to be strong themes. *Our planned cultural capability actions and regional collaboration seeks to progress these requirements.*

**Stakeholder Engagement – regional views**

CM Health is a participant in regional Asian health forums. This has involved building collegial networks with Auckland and Waitemata DHB Asian health leaders and related forums. Notable forums include the Auckland Regional Public Health Service Asian Health group and the regional Asian and MELAA Primary Care Group. *Our planned Refugee and Migrant Health actions align with the region. In addition, there is an intention to collaborate on shared Asian health targets and health promotion materials in 2016/17.*

**Stakeholder Engagement – internal views**

Mental Health and Addictions services have well established stakeholder forums to guide planning and initiatives. In addition, we established CM Health-led Pan Asian Health Interest Group (PAHIG) in 2014.
and sought service leader input. *Our planned mental health and addictions, new Asian Health Coordinator role, enhanced service delivery and health literate systems actions reflect their input.*

*An important development approach for CM Health over 2016/17 year will be to build linkages with existing PHO Asian health improvement approaches, identify and build connections with the many Asian community networks, groups and service providers.*
Appendix 1: 2014/15 stakeholder feedback on ‘what matters for Asian health and wellbeing’

Our Asian community views

Auckland Region Settlement Strategy

For people that are Culturally and Linguistically Diverse (CALD) with a focus on migrants and refugees of different cultures, religions, language, backgrounds and ‘health system experience’

‘Asian’ people

(including MELAA - Middle Eastern, Latin American or African)

Length of time in NZ matters this impacts on their social and health support needs and outcomes

“Coming to NZ to enjoy a good life; a better life”

22% (114,810) ‘Asians’ living in CM

11.8% ‘Asians’ living in NZ

“The NZ health system is very good and less expensive than where I come from; the people are friendly, caring, compassionate”

CM Health staff views

What matters to CM Health staff and PHO perspectives?

“Culture sometimes disallows a voice ….. if they don’t speak English they tend not to communicate or very little ”

“Get diverse staff in the right place to make a difference”

“Opportunity for cross-district approaches for some Asian subgroups … some groups will travel for (social) networks they enjoy”

Information

“I don’t understand the NZ health system, where or how to find the right doctor”

“I do not see health as important unless I feel sick”

“I rely on my community for support and advice in finding where to go”

“I am not familiar with the idea of home based care”

Communication

“Asian people mostly have phones and want text reminders and emailed health results”

“Communicating my concerns is really hard and I rely on my family and community to help me”

“They (doctors, nurses) will impress me if they try a few words and take time understand my concerns.

“I am afraid or not confident to ask questions and am not likely to complain”

“I want the whole health team to know about me and give the same messages about what is important”

“I am more comfortable with people I am familiar with and want my family involved”

Workforce

Better everyday communications
- Time to listen and understand
- Staff to simplify language complexity and jargon
- Coaching staff on difficult conversations
- Build staff confidence where English is limited
- More accessible information
- Technology/tools enablers to support ‘everyday activities’
- Interpreters (complex situations) vs cultural support vs ‘simple communication

Better information access and education
- Culturally appropriate and accessible health information and NZ health system information in multiple settings
- More visible and accurate ethnicity coding
- Health education and health promotion collaboration with a focus on the practical realities for patients and families
- Evaluation and research that engages patients and family more effectively – ‘do services work for them?’

More workforce diversity ‘language/culture matched’
- Name diversity as a core strategy (hospital service focus)
- Competency (mentoring and coaching) to manage diversity
- More diversity in leadership positions, key occupational groups and roles where it matters the most

Organisational change
- Interpreters vs cultural support – they are not the same
- Leverage available community/social networks
- Target interventions for conditions/services of highest risk/poor outcomes
- Asian Advisory Groups (like to Police) have to sustain an open community voice (locally based?)
- Extended CALD competency requirements for all staff
- Informed consent – clarify legal position on need for interpreters

Note: The need for a more diverse workforce was a strong theme from hospital based staff but was not considered a significant issue by the PHOs consulted, i.e. the range and location of general practice workforce meant there was sufficient flexibility for people to choose a practice that is best for them.
Counties Manukau Health
Asian Health Plan 2016/2017

DRAFT VERSION 2.1
12 May 2016

This is the second draft of the 2016/17 Asian Health Plan for consultation and feedback.
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Foreword

To be completed when the plan content is endorsed

Dr Lee Mathias
Chair

Geraint A Martin
Chief Executive
1.0 Executive Summary

The term ‘Asian’ is used in New Zealand to describe culturally diverse communities with origins from the Asian continent.1 This definition excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. Asian and migrant people are a very diverse population group that come from a variety of different geographic areas and have widely varying cultures and languages. An additional diversity factor relates to the number of years lived in New Zealand and their understanding of how and where to access the health system. This issue is common to people from Middle Eastern, Latin American, African (termed MELAA) countries and refugees. For this reason a number of actions in this plan support this group as part of a Northern regional approach.

In Counties Manukau, approximately 25 percent of people have identified themselves as ‘Asian’ and this is due to increase to 26 percent by 2020. Across the Auckland and North Region, Counties Manukau is home to the largest local board population of over 52,000 Asian people living in Howick, our largest Chinese community. Our second largest Asian population of almost 25,000 that live in the Otara-Papatoetoe local board has a significant Indian population.

Counties Manukau Health (CM Health) contributes to the national health vision of the future for “all New Zealanders to live well, stay well and get well”.2 We need to look deeper than the combined ‘Asian’ health statistics to identify health disparities in some of our Asian communities. Useful health data at a sub-ethnicity level is still evolving with gaps across key health measures. Despite this, we have enough information to know where we could invest energy, time and resources to make a meaningful and positive impact now. What we do know is that there are common and unique health disparities across our South Asian and Chinese communities that have either not improved or worsened since 2006.

The New Zealand Health Survey comparisons of 2006 to 2013 tell a story of opportunities to work with others to do better for Asian people living in Counties Manukau, i.e.

- Persistent low levels of physical activity and intake of fruit and vegetables in South Asian and Chinese adults alongside growing prevalence of hypertension, cholesterol and diabetes telling us that ill-health prevention and treatment approaches are not working equitably.
- In 5 year old Auckland children, Chinese and Indian burden of dental caries is about mid-way between New Zealand European and Other and Pacific groups.
- Indian people have a high age-specific prevalence of diabetes similar to Pacific people, who have the highest levels. Chinese prevalence is slightly higher than ‘NZ European and Other’ ethnicities who are lowest prevalence.
- Compared to Europeans, Asian people are more likely to experience being treated unfairly by health professionals at work, renting or buying a house. This requires us to consider how we develop and support health workforce capability through the perspectives of values, culture and language.

We considered in 2014/15 the potential health issues and opportunities to make the most meaningful impact on the health status of today and tomorrow’s Asian and migrant communities. The themes arising from health data and conversations with community members and health staff in 2014/15 remain consistent with our review of 2016. This 2016/17 plan reflects ongoing action commitments from 2014/15 and new actions identified for 2016/17.

Primary Health Organisations (PHOs) were consulted in 2014 as part of our first Asian Health work plan development. Their feedback was that there are a range of Asian groups and networks in place to support community lifestyle and health improvement approaches, e.g. Auckland Indian Association. In addition, their local community based health promotion activities were well established. The opportunity they identified in working together related to sharing health promotion materials in the key languages, learning for the PHO experience of what works and reduce unnecessary duplication of information. This theme was supported by the regional Asian and MELAA Primary Care Group and actions in this plan will further explore sharing of available resources.

This plan also reflects action focus on build workforce cultural capability to improve the experience of care for Asian people. This was a core requirement for action identified by the community and DHB staff. This was not such a strong theme with the PHOs consulted, as in general practice people have the option to choose that is not the same for hospital services.

Our Healthy Together strategic goal provides a lens to consider current or emerging health disparities and inequities across our vibrant and diverse residents of Counties Manukau. This means we need to be regardful of the constrained

2 Draft New Zealand Health Strategy is available from http://www.health.govt.nz
health funding realities and the need to explore targeted resources where they will have the most meaningful contribution to our strategic goal. To achieve this, our Asian health improvement, prevention and experience of care opportunities were developed with our Healthy Together strategic goal and objectives (Figure 1) as our main objective.

To avoid unnecessary duplication with CM Health’s Annual Plan, this Asian Health Plan focuses on service improvements with a health equity lens. This complements our strategic Alliance priorities for integrated care initiatives and enhanced general practice that focus on prevention and early intervention in the community.

Figure 1: Healthy Together strategic objectives and Asian health priorities

Our strategic goal:
“Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Māori, Pacific and communities with health disparities by 2020.”

- **Healthy Services** - more effective information, communication and experience of health services for Asian people and those new to New Zealand and culturally capable workforces.
- **Healthy People, Whaanau & Families** - targeted support for those services that are best placed to reduce emerging Asian health disparities such as mental health and addictions, oral health in children, prevention and management of cervical cancer, cardio metabolic disease and diabetes in adults.
- **Healthy Communities** - stronger voice and dedicated resource to promote, coordinate and support the health and wellbeing of our Asian and migrant communities with key stakeholders in the community, primary care and the Auckland region.

The 2016/17 year represents an opportunity to progress a core set of actions that will make a meaningful progress towards achieving health equity and improve the experience of care. An important development approach for CM Health over this year will be to build linkages with existing PHO Asian health improvement approaches, identify and build connections with the many Asian community networks, groups and service providers.

2.0 **Asian Health Planning Context**

2.1.1 ‘Asian’ as Defined in New Zealand

The New Zealand health and disability sector classifies ethnicity data according to the Ethnicity Data Protocols for the Health and Disability Sector formulated by the Ministry of Health. The level one category ‘Asian’ term, used in Census and other data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the USA.3

This definition includes over 40 sub-ethnicities and these communities have very different cultures and health needs. Reviewing health data using this broad classification is problematic if the health status of Chinese, Indian and Other Asian communities are ‘averaged’. This risk is that averaged results appear ‘healthy’, but potentially masks true health disparities such as cardiovascular disease (CVD) and diabetes in sub-ethnicity groups. Furthermore, many people classified as being ‘Asian’ do not identify with the term which may lead to under-utilisation of ‘Asian’ targeted services.

In recognising this limitation, we actively started working in 2014/15 to identify health data at a sub-ethnicity level across available data sets. The support of general practices and Primary Health organisations to record and report against level 2 ethnicity is critical to identifying the true status of health indicators in our populations.

Improving the visibility of health data at an Asian sub-ethnicity level for stakeholders across Counties Manukau is an ongoing focus on accuracy and access to health information.

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2.1.2 Our Asian Health Planning Approach

Life expectancy at birth of people identified as Asian in CM Health is higher at 87 years than NZ European/Other ethnic groups at 81.3 years\(^4\). Despite this seemingly favourable health measure, service leaders across the district suspected that the true story of health morbidity was likely to be different for some Asian communities.

In October 2014, the CM Health Strategic Development Directorate was tasked with exploring planning approaches which would take into account the health of the district’s growing and diverse Asian population. At this time, we reviewed available literature, population data, spoke with a range of people. This included regional health experts and leaders, CM Health staff forums and selected Asian community members about ‘what mattered the most’ for Asian health and wellbeing. This process acknowledged but sought not to duplicate the existing Asian mental health service coordination work and related forums. We sought to learn from their experience and integrate where it was most meaningful into our planning.

A 3-year Asian Health work plan was developed and approved by CM Health’s Community and Public Health Advisory Committee in late 2014. The work plan was shaped by executive expectations of ‘working within existing budget and resources’ through a range of stakeholders to:

- Increase recognition of Asian health and wellbeing needs within the Counties Manukau health system.
- Build organisational capacity so that the workforce has the ability and confidence to work cross-culturally to respond to the health needs of the Counties Manukau Asian population (and other Culturally and Linguistically Diverse [CALD] communities).
- Build and strengthen Asian health networks within the Counties Manukau health system and in the Auckland region.
- Support and enable service planning and delivery for the Counties Manukau Asian population.

In 2016, CM Health’s Strategic Development Directorate was asked to review this plan with a greater focus on service delivery based actions. In a review of the demographic data and related publication, we found the key drivers for Asian Health Plan actions remained consistent with that of our 2014 findings, i.e.:

- Recognising the super-diversity and changing demographic and health profile of people living in Counties Manukau.
- Asians are now the second largest ethnic group in Counties Manukau and will continue to be the fastest growing group in the next 10 years.
- Looking at the health literacy of our health system and workforce to make a difference to our patients/service users and their families’ health and experience of care.

2.1.3 Integrating Asian Mental Health and Addictions Work Plan into this Asian Health Plan

This plan includes key Asian mental health service improvement actions. Asian mental health service development work started in 2007 and has culminated in the establishment of the:

- Intersectoral Steering Group for Asian Mental Health and Addictions Service Development (LOTUS Group)
- Asian mental health service development plans
- The Asian Mental Health & Addictions Staff Forum
- Establishment of the Asian mental health interagency groups (The LONG GAME Group)

In 2015, the Asian Clinical Governance Committee was established to support development of cultural responsive clinical services for Asian communities. The Asian Mental Health and Addiction Service Development Action Plan 2016/17 – 2017/18 were developed to enable CM Health mental health services to improve outcomes for Asian people.

The barriers that prevent Asian people accessing and utilising health services are the very same barriers that prevent access and utilisation to mental health and addiction services. For Asian people, mental health access can be especially difficult. The barriers to access can be divided into practical barriers, cultural barriers and systemic barriers.\(^5\)

---


This Asian Health Plan seeks to learn from the Asian mental health and addiction services experience and add to, not duplicate their work in our planning. We will look into the opportunity for mental health services to extend its LOTUS Group, the Asian Clinical Governance Committee, the Asian Mental Health & Addiction Staff Forum and the LONG GAME Group to widen CM Health services to share expertise and resources. This will support CM Health moving towards an integrated care model.

2.1.4 Applying a Health Equity Lens
CM Health’s population health team looked across health indicators to better understand potential health disparities and opportunities to focus our engagement with health service leaders on the actions that they could commit to in 2016/17. In addition, we contracted an independent resource to engage with key stakeholders to assess where the will and opportunities were to make gains in Asian health. The collective planning findings led us to focus this 2016/17 Asian Health Plan on the following priority action areas:

- Continuing the organisational capacity and capability building focus of the existing 3-year Asian Health work plan and Asian Mental Health plan with the addition of a new Asian Health Coordinator role to drive progress.
- Key population health areas of potential service improvement in mental health, oral health of children and diabetes in adults (refer to section 5.1 for demographic and health service information related to these health focus areas).
- Additional focus areas provided by service leaders to improve the early detection and early intervention of cervical cancer and engagement with refugee and migrant health.
- Integrated focus on Asian mental health and addictions.

This plan complements our on-going strategic integrated care initiatives and focus on prevention and early intervention in the community.

2.1.5 Local and Regional Engagement
Asian community views
Community views about ‘what mattered’ in the health and wellbeing of Asian communities remained consistent across the 2014 and 2016 reviews, i.e.:

- understanding how and when to use the health system.
- language and communication barriers, particularly for older more isolated Asian people.
- how best for health to connect with existing community groups and networks.

We engaged further with community members during our ‘2016 Lunar New Year Celebration’. Asian community and staff participants were invited to write down and share with us their thoughts and experiences in two areas: 1) What is most important to you and your family to live and stay well in your community, and 2) What are the most important ways we can improve your experience of health services.

Their feedback included those themes from 2014 plus an additional request for ‘action now’ that would specifically target Asian health improvement. Recommendations included an Asian champion to lead an Asian health plan implementation and ensure an appropriate and timely link with Asian communities. A focus on addressing language and culture barriers and support for Asian people to navigate the health system to help themselves were strong themes.

Internal views
In April 2015, a CM Health-led Pan Asian Health Interest Group (PAHIG) was established to initiate a formal means by which health stakeholders with an Asian health interest were able to input into CM health systems planning. PAHIG consists of 13 members of mainly CM Health staff members, plus members of the community from the education sector and non-governmental organisations such as The Asian Network Inc. (TANI) and Plunket (see section 5.3). This group continues to provide advice to CM Health on Asian health matters. For example, this group provided input into the 2015 strategy and value refresh process, advice for community communications on the 2016 Winter Wellness Plan and development of this 2016/17 Asian Health Plan.

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6 LOTUS group is for community development; ACGC is for developing cultural appropriate clinical services; AMH&ASF is for developing leadership skills among Asian staff; LONG GAME Group is for community development among each Asian sub-group. At the moment, Chinese Group, Korean Group and South Asian Group are active. The Filipino Group is currently on hold and the Japanese Group is no longer involved.
The Pan Asian Health Interest Group continues to provide opportunities for the DHB to engage with the wider Asian communities. Members are connected with their communities and provide advice on how and where to engage with the Asian communities.

**Regional views**

CM Health is a participant in regional Asian health forums. This has involved building collegial networks with Auckland and Waitemata DHB Asian health leaders and related forums. This includes the Auckland Regional Public Health Service Asian Health group and the regional Asian and MELAA Primary Care Group.

In 2016, we approached this group with a view to sharing planning intentions and identifying where it could be most useful to work together. Agreement was reached to align ‘action areas’ and targets across DHBs where they mattered the most. In addition, Northern DHBs will share our processes and learning’s, taking into account the geographical differences in our Asian population. Identified by the Group for regional collaboration included data quality, translating educational materials and key health messages for health prevention programmes. Our commitment to regional work is through this group that meets monthly.
3.0 Health Profile of Asian people living in Counties Manukau

3.1 Population Profile

Across New Zealand our diverse Asian and migrant communities are growing faster than any other population group with two thirds of the Asian population of New Zealand living in the Auckland region. Almost a quarter (23.1 percent) of Auckland residents identified with an Asian ethnicity in the 2013 Census, a much higher proportion than for New Zealand as a whole at 11.8 percent (estimated at 471,711 people) and higher than 18.9 percent recorded at the last census (2006). By 2018, about 1 in 3 people living in Auckland will be of Asian ethnicity1. Socio-demographic and health status information tells us that life in New Zealand is changing for these communities. The increasing Asian population is still largely driven by net migration and to a lesser extent natural increases.8

Figure 2: Distribution of Asian people in CM Health district, by census area unit and locality (2013 census)9,10.

In Counties Manukau, the Howick local board in our Eastern Locality (seen in Figure 2) is home to the largest Asian population (estimated at 52,400 in 2013) per local board or territorial authority in New Zealand.

To provide some perspective, this is greater than the combined Asian populations of Wellington, Upper Hutt, Lower Hutt and the Kapiti coast and is about 15 percent of the Auckland region’s entire Asian population.9 The largest Asian ethnic groups in Counties Manukau, based on Census 2013 total response ethnicity, consist of Indian and Chinese people. Indian people comprise 47 percent (almost half) and Chinese 34 percent (a third) of all ‘Asian’ people in the district (refer Figure 3).

Recognising the super-diversity within the CM Health system matters in terms of patient, whaanau and family experience of health care. In some areas of Counties Manukau, more than 1 in 2 people you meet will have been born overseas, with areas like Papatoetoe, Manukau, Dannemora and Botany being more than 50 percent Asian. Indian communities are the largest in Papatoetoe, Ormiston and surrounding suburbs and Mangere South; whereas Chinese communities live more commonly in the Eastern suburbs such as Ormiston, Millhouse, Meadowland, Highland Park and Murvale. From a health service point of view, how these groups engage with health services will make a big difference to the health of our population.

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7 It is important to note that the census ethnicity data reflects group or groups that people identify with, and can be different from ancestry, birthplace and nationality.
9 Maps are interactive and available online at the following URLs (best viewed in either a Mozilla Firefox or Google Chrome web browser):
   - Total Asian: https://www.google.com/maps/d/edit?mid=z2Vzcf4Y968.z2Vzcf4Y968.kidYVx5pPy
   - South Asian: https://www.google.com/maps/d/edit?mid=z2Vzcf4Y968.kkMO5019Gw8WM
   - Chinese: https://www.google.com/maps/d/edit?mid=z2Vzcf4Y968.koh0QF-7gAM8up=sharing
   - Filipino: https://www.google.com/maps/d/edit?mid=z2Vzcf4Y968.klkvqPbNz0c8
10 Densely populated Asian regions are represented by darker shades of maroon. Interactive maps are available online
In addition to ethnicity, we cannot lose sight that many of these people are migrants to New Zealand and as such language and familiarity with the New Zealand health system can affect access to health services when they are needed. In general, Asian people who live in Counties Manukau have high levels of English ability at younger ages, but this falls to 40% or less in older Korean and Chinese peoples. Indian and Filipino people report higher proportions of English speakers at all ages, compared to Chinese and Korean people. Conversely, older Asian people are more likely than younger ones to speak a selected language from their country of origin. Older people of Chinese, Korean and Indian ethnicities have relatively limited ability to speak English (refer Figure 4).

One of the actions for 2016/17 includes analysing health service access by Asian sub-ethnicity to assess opportunities to reduce language and communication barriers.

3.2 Socio-demography and Lifestyle

A recent report regarding Asian health in New Zealand in 2011-2013 highlighted both favourable and unfavourable health status and disparities in the health of Asian sub groups compared to other populations. In general the Asian community is highly educated, with all three Asian ethnicities being more likely to have a University bachelor or postgraduate degree than non-Asian groups. However, Asian people along with Maaori and Pacific peoples, were distributed more towards low household income categories than European.

Of the people living in Counties Manukau that utilised health services in 2013, 18 percent of the Counties Manukau Asian population lived in areas classified as being the most socio-economically deprived (Quintile 5) in New Zealand, compared to 11 percent for European/Other and 69 percent for Pacific people and 56 percent of Maaori people. Health data for people living in areas of high deprivation are more likely to experience health inequities.

Lifestyle factors such as being smokefree, eating well and regular physical activity protect from long term health problems like obesity, diabetes and cardiovascular disease. All Asian ethnicities, along with Maaori and Pacific, had lower proportions of people eating the recommended daily number of serves of fruit and vegetables (≥5) than Europeans. The proportion of Asian men and women eating the recommended daily number of 5 or more serves of fruit and vegetables did not change over the three survey periods from 2002/03 to 2011/13.

Adults from all three Asian ethnic groups, along with Maaori and Pacific, were less likely to be physically active than European & Other. Activity levels for Asian men and women have changed little over the three survey periods from 2002/03 to 2011/13.

Overall, smoking prevalence at the time of census 2013 for the prioritised Asian population, was estimated at 6.6 percent: the lowest of all large reported ethnic categories. Within this group, male smoking prevalence (11.7 percent) was much higher than female (1.8 percent).

Given the relatively young age of our Asian communities compared to Europeans, focusing on opportunities to improve lifestyle choices is a particularly important role within mainstream health services. Achieving improvements requires a whole of district approach across the life course of our population.

12 Census 2013 total response ethnicity; 2013 ‘Usually Resident’ population
13 Census 2013; CM Health usually resident population; total response ethnicity.
### 3.3 Barriers to Mental Health Service Access

Practical barriers refer to the lack of English language proficiency and inadequate knowledge and awareness of existing mental health services. These factors prevent migrants, refugees and minority groups from accessing and utilising services.¹⁵

Cultural barriers are brought about by cultural differences. They include the intense stigmatisation around mental illness that exists among many Asian cultures. In addition, religious beliefs and cultural differences in the presentation and treatment of mental illness can act as barriers to accessing and utilising the mental health system by migrants, refugees and ethnic minority groups.²⁶

Systemic barriers are the policies, procedures or practices within the mental health system that unfairly discriminate and can often prevent vulnerable populations from fully utilising services.²⁷

Key systemic barriers include lack of interpreter services or culturally/linguistically appropriate mental health information, lack of bilingual mental health professionals, incompatible Western mental health treatment models, and lack of cultural competence in mental health care.

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4.0 **Priority Actions**

Given what the evidence tells us about the current and growing needs of the Asian community, together with our commitment to our strategic health equity goal, this Asian Health Plan outlines **targeted actions that focus on enhancing (not duplicating)** current work programmes and projects. This plan therefore does not outline all actions across primary, community and hospital services that will improve Asian health outcomes. Rather, it highlights complementary actions outlined in our 2016/17 Annual Plan and Alliance approaches.

The Asian Health Plan incorporates previous work carried out by CM Health including collaboration with Waitemata and Auckland DHBs and Auckland Regional Public Health Service and CM Health’s Pan Asian Health Interest Group (PAIHG).

### 4.1 Build Cultural Capacity and Capability

<table>
<thead>
<tr>
<th><strong>4.1.1 Asian Health Improvement Coordination</strong></th>
<th><strong>Who will we work with?</strong></th>
</tr>
</thead>
</table>
| **Aim:** To increase health system capacity to address the growing needs of Asian people and to contribute to achieving the DHB’s strategic goal on achieving health equity for our Asian population. | ▪ CM Health Alliance PHOs  
▪ Auckland Regional Dental Service  
▪ Service Providers  
▪ Pan Asian Health Interest Group (PAIHG)  
▪ Asian Community Groups |

<table>
<thead>
<tr>
<th><strong>Establish an Asian Health Coordinator role within CM Health</strong></th>
<th><strong>Monitoring Processes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Q1: Recruit an Asian Health Coordinator to support a whole of system approach.</td>
<td>▪ Table report findings and recommendations for ongoing improvement with key forums</td>
</tr>
<tr>
<td>▪ Q2: Carry out a stocktake of all Asian Health initiatives across Counties Manukau Health.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Continue to increase recognition of Asian health and wellbeing needs and planning responses within the CM health system</strong></th>
<th><strong>Who will we work with?</strong></th>
</tr>
</thead>
</table>
| ▪ Q1-4: Increase visibility and availability of Asian Health information and data across CM Health leadership groups. | ▪ Present to new staff every 2 weeks on CM Asian health at the Welcome Days.  
▪ Complete presentation on Asian Health issues and activities across CM Health leadership groups.  
▪ Expand scope of Asian health and wellbeing cultural champions in the health system.  
▪ Link existing work programmes for improving PHO enrolment data in primary care.  
▪ Enhance Asian health status information across CM Health leadership groups. |
| ▪ Q1-4: Complete a communications plan for Asian health improvement. | |
| ▪ Q1-4: Link health service development (population and personal health initiatives) to At Risk Asian individuals, families and communities. | |
| ▪ Q1-4: Work with service leaders and data analysts to improve data collection for the major Asian ethnic groups (level 2). | |

<table>
<thead>
<tr>
<th><strong>Develop links between CM Asian communities and CM Health</strong></th>
<th><strong>Who will we work with?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ PAIHG to provide advice and support to groups such as Locality Leadership Groups on engagement with relevant Asian community leaders, community groups.</td>
<td>▪ Patient/service users are engaged where an Asian perspective is required for evaluation of existing health services or planning of additional or new health services.</td>
</tr>
<tr>
<td>▪ Ongoing membership drive for more members to become engaged with PAIHG issues.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Collaborate with regional and central agencies working for Asian health and wellbeing improvement</strong></th>
<th><strong>Who will we work with?</strong></th>
</tr>
</thead>
</table>
| ▪ Work to enhance CM Health participation in regional Asian Health forums relevant to Asian people in Counties Manukau. | ▪ Improved regional and national collaboration.  
▪ Where appropriate, alignment of key Asian health targets |
### 4.1.2 Health Literate Workforce and Systems

**Aim:** Increase recognition of Asian health and wellbeing needs within the CM health system.

**Who will we work with?**
- CM Health Alliance PHOs
- Regional leaders and resources with expertise in Asian health needs
- Pan Asian Health Interest Group
- Asian Community Groups
- Service providers

**Monitoring Processes**
- Quarterly progress reports to ALT and ELT
- Six monthly progress reports to CPHAC

<table>
<thead>
<tr>
<th>Build health system capability so that the workforce has the ability and the confidence to work cross culturally to respond to the health needs of the Culturally and Linguistically Diverse (CALD) CM Asian population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1-Q4: Work alongside key stakeholders responsible for the proposed initiatives (diabetes and oral health).</td>
</tr>
<tr>
<td>Q2-Q3: Complete a stocktake of CALD training with staff at locality level.</td>
</tr>
<tr>
<td>Q1-Q4: Work with locality leaders to increase CALD training uptake for staff both at locality level and at general practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enhance access to health information in the major Asian languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey key clinical services about the top 3 information sheets that would be most beneficial in additional languages.</td>
</tr>
<tr>
<td>Develop generic translated information resources in main languages with appropriate cultural context.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluate service access and language barriers across health services delivered in Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1-2: Analyse CM Health service access by Asian sub ethnicity within available data sets</td>
</tr>
<tr>
<td>Q1-2: Analyse CM Health Interpreter and Translation Service utilisation by ethnicity and requesting service to engage leaders and patients regarding potential language barrier improvements</td>
</tr>
</tbody>
</table>

**Prepare report for service leader review and consideration of potential 2017/18 service improvements**

<table>
<thead>
<tr>
<th>Support development of a Bilingual Support Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3-4: Work with Ko Awatea to develop capability for more day-to-day language assistance within teams/services when working with CALD patients and families.</td>
</tr>
</tbody>
</table>

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### 4.2 Enhance Service Delivery and Health Outcomes

#### 4.2.1 Asian Mental Health and Addictions


The Asian Plan includes initiatives that enable CM Health mental health services achieve the expected outcome (Big Dot Goal) “75% of assessments will demonstrate cultural capability across Counties Manukau Mental Health Services by 2017” and initiatives delivered directly to the Asian communities.

**Who will we work with?**
- CM Health Mental Health Services
- Mental Health NGOs
- CM Health Alliance PHOs
- Asian NGOs
- Asian Communities
- Asian Mental Health Services at Waitemata DHB, Auckland DHB and other DHBs
The initiatives are categorised into four broad national mental health policy directions including: 1) building culturally appropriate and responsive services, 2) workforce development, 3) research and 4) community development to address the needs of Asian communities living in Counties Manukau.

In 2016 – 2017, Mental Health Services aim to achieve:
- Mental Health workforce is competent in working with Asian service users and their families
- Mental Health workforce receives clinical cultural advice when assessing and treating Asian service users
- Asian community develops capability and leadership to address their mental health and addictions needs.

### Action 1: CALD Training
- Q1: Stocktake of Mental Health Services staff completed CALD Cultural Competency training (Modules 1 & 4).
- Q2: All new Mental Health Services staff completed CALD Cultural Competency training (Modules 1 & 4).
- Q3: 20% of Mental Health Services staff completed CALD Cultural Competency training (Modules 1 & 4).
- Q4: 30% of Mental Health Services staff completed CALD Cultural Competency training (Modules 1 & 4).

### Action 2: Asian Clinical Cultural Advisor Role
- Q1: Gap analysis of current procedure for providing clinical cultural advice for Asian service users
- Q2: Proposal to establish the Asian Clinical Cultural Advisor role for Asian service users is documented
- Q3-Q4: Proposed Asian Clinical Cultural Advisor role is piloted

### Action 3: Community Development
- Q1-Q4: The LONG GAME Group is supported to develop, coordinate, deliver, and evaluate Asian community mental health initiatives to be held in Sept-Oct. in 2016.

#### 4.2.2 Diabetes Management

Diabetes has been identified as one of the area of focus for the Asian people living in Counties Manukau. Although Pacific people have the highest prevalence of diabetes (almost a third of people aged 55 to 59 years and 45% in those aged 65 to 74 years), our Indian population has a similar prevalence. In contrast, Chinese people have a lower prevalence, similar to that of NZ European/Other groups (about 1:10 people age 55 to 59 years) while ‘Other Asian’ group have a prevalence that is similar to Maaori.

The actions outlined aim to increase visibility of Asian Health needs and contribute to achieving health equity for Asian people with diabetes. These actions acknowledge existing initiatives to better support women with diabetes in pregnancy and that requiring care coordination support through their general practice.

**NOTE:**
The Metro Auckland Clinical Governance Forum has agreed 5 cardiovascular disease and diabetes indicators. The PHOs have agreed to send population level data on these indicators to support baseline and ongoing performance monitoring. A quality improvement process is underway and by 30 June 2016, we anticipate a confirmed baseline and reporting capability.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c Glycaemic control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 75 years) who have good or acceptable glycaemic control with HbA1c ≤ 64 mmol/mol.</td>
<td>TBA</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Blood pressure control:</strong> Percentage of enrolled patients with diabetes (aged 15 to 75 years) whose latest systolic blood pressure measured in the last 12 months is &lt; 140.</td>
<td>TBA</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Management of Microalbuminuria:</strong> Percentage of enrolled patients with diabetes (aged 15 to 75 years) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker.</td>
<td>TBA</td>
<td>90%</td>
</tr>
</tbody>
</table>
Who will we work with?
- Northern Region Diabetes Network
- Primary health, community and hospital clinicians and Clinical Champions
- Diabetes Service Level Alliance Team
- Pan Asian Health Interest Group
- Existing Indian Community Groups
- Wider Asian Community Groups

Monitoring Processes
- Quarterly report to Diabetes SLAT, ELT and ALT

Actions
- Q1: Implementation of a new targeted model of care, to focus on patients with poor glycaemic control, and introducing virtual reviews between primary and secondary care.
- Q1: Five diabetes indicators will be reported by ethnicity so performance can be monitored and analysed with the aim of reducing variation between practices and variation between ethnicities.
- Q1-Q4: Ensuring Asian peoples are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.
- Q1: Ensure Asian peoples who have high risk feet are identified proactively within primary care and referred to a podiatrist for on-going care.
- Q1-Q4: Practices will work to identify Asian people who have not had a retinal screen, or who are overdue for a retinal screen and ensure they are referred to the service or follow up.
- Q1-Q4: Ensure improved access to self-management support services, including self-management education, to enhance health literacy, healthy lifestyles, adherence to medication and overall health and wellbeing for Asian patients.

Measures
- Reduction in the proportion of patients with HbA1c above 64,80 and 100 mmol/mol.

4.2.3 Oral Health Services

Increase early detection and intervention for improved oral health among Asian preschool children aged 0-4 years

The population based measure of caries free proportion by age of pre-schoolers shows large differences by ethnicity. The incidence of early childhood caries before primary teeth are fully erupted at 2.5 years indicates that risk of caries is high in children at very young ages, probably due to an excessive early intake of sugar and low engagement in dental hygiene behaviours.

2016/17 objectives:
- To improve access and engagement for children aged 0-4 years to Community Oral Health Services (COHS).
- To prevent Early Childhood Caries thus reducing prevalence of early DMFT in ages 0-4 years and improving the percentage of childhood caries free at five years.

All activities and services are expected to contribute to these outcome measures.

<table>
<thead>
<tr>
<th>Enrolment children aged 0-4 years</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maaori</td>
<td>64%</td>
<td>95%</td>
</tr>
<tr>
<td>Pacific</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>76%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage children Caries free at age 5 years</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maaori</td>
<td>37.3%</td>
<td>55%</td>
</tr>
<tr>
<td>Pacific</td>
<td>29.6%</td>
<td></td>
</tr>
<tr>
<td>All Other (includes Asian)</td>
<td>63.6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>48.7%</td>
<td></td>
</tr>
</tbody>
</table>

Who will we work with?
- Auckland Regional Dental Service
- Service Providers
- Well Child Providers, e.g. Plunket
- Intersectoral / Education
- Pan Asian Health Interest Group
- Asian Community
- Early Childcare Centres
### Actions
- **Q1-Q2:** Develop a targeted engagement strategy with the three main Asian groups which are Indian, Chinese and Filipino communities that will link to the following initiatives (Asian Health Coordinator):
  - Early enrolment in Community Oral Health Services of babies at 5 months with associated oral health education of tooth brushing and nutrition before solids start followed by examination in a dental clinic at 1 year of age.
  - An initiative to promote milk or water versus sugar drinks is key for preschool children to prevent early childhood caries by 2 years, e.g. 2015 data shows 13% of Asian children at 2 years have caries (dental decay), at 4 years 42% have caries.
  - **Q1-Q2:** Translated oral health pamphlet in three different languages of Hindi, Mandarin and Korean.
  - **Q2-Q3:** Translated brief key messages on the three local papers in the above three different languages.
  - **Q2-Q3:** Translated poster about the initiative promoting milk or water versus sugar drinks (Advertorial type poster).
  - **Q2-Q4:** A 15 minutes on air weekly – education and reinforcing key messages on the above translated material in the different languages.

### Outcome Measures
- Percentage of children caries-free at age five years.
- Number of children <5 treated under general anaesthetic.

### Output Measures
- Percentage of infants at 6 months of age enrolled in DHB funded oral health service.
- Percentage of preschool children 0-4 years enrolled in DHB funded oral health service.
- Reduction in Did Not Attend (DNA) rates.

### 4.2.4 Cervical Cancer

**Improve early detection and early intervention for cervical cancer in Asian women**

Cervical cancer is preventable. The National Screening Unit recommends cervical screening for early identification of cervical cancer and prevention of invasive disease. Asian women have a lower coverage rate for cervical screening compared with non-Asian women. Improving cervical screening coverage rate for Asian women will support a reduction in cervical cancer mortality.

During the 2015/16 year CM Health and PHOs in the district worked together on key activities to improve cervical screening coverage. This included development of a district-wide cervical screening action plan which was approved by the Alliance Leadership Team. Each PHO then developed a PHO-specific cervical screening action plan. A High Needs Cervical Screening Coordinator has been working with PHOs and within community settings such as temples, mosques and outreach clinics to deliver smear taking services for Priority Group Women (including Asian women).

In addition, the DHB and PHOs have taken a leadership role within the sector to improve the quality, accuracy and timeliness of cervical screening coverage data. Activity during the 2016/17 year will build on the achievements to date with the expectation that this will translate into real improvements in cervical screening coverage, particularly for Asian women who are overdue for a cervical smear or who have never been screened.

**Actions**
- **Q1:** CM Health and the PHOs in the district will work together

**Monitoring Processes**
- Service Contracts (CM Health / Regional)
- Ethnic specific data on Asian enrollees
- Primary care data / Well Child Tamariki Ora
- Hospital data
- Quarterly reporting to ELT, ALT, Ministry of Health

**Outcome Measures**
- Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 mths.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>65.7%</td>
<td>80%</td>
</tr>
<tr>
<td>Total</td>
<td>74.1%</td>
<td></td>
</tr>
</tbody>
</table>

**Who will we work with?**
- CM Health Alliance PHOs
- Independent Service Providers

**Measures**
- CM Health district-wide and PHO-level cervical
to update the district-wide and PHO level cervical screening action plans. The plans will focus on improving screening coverage for Asian and other Priority Group Women, particularly those who are unscreened and under-screened.

- Q1-4: PHOs will ensure there is a named coordinator in the PHO and cervical screening champions in practices who are responsible for actions to improve cervical screening coverage.
- Q1-4: CM Health will improve access to cervical screening for Asian women by contracting with PHOs to provide free smears for Priority Group Women.
- Q1-4: Each PHO will access the monthly cervical screening data match reports and will use the reports to carry out data matches, to identify women who are overdue for their three yearly cervical smears and to target recall, invite, engagement and smear-taking activity at this group.
- Q1-4: Work with PHOs to provide training for practice staff on how to have the conversations about cervical screening.
- Q1-4: Work with PHOs, practices and Independent Service Providers (ISP) to implement the cervical screening referral pathway for Priority Group Women.
- Q1-4: Employ a High Needs Cervical Screening Coordinator to work with general practice teams that have low screening coverage rates for Asian women and to assist with smear-taking, recall and invite and quality improvement systems.
- Q1-4: The High Needs Cervical Screening Coordinator will work closely with independent service providers and PHOs to deliver smear-taking clinics in settings that are appropriate and acceptable for Asian women.
- Q1-4: The High Needs Cervical Screening Coordinator will work within community settings and with local media to raise cervical screening awareness and to ensure messages are targeted at Asian women.

**Cervical Screening Action Plans**

- Cervical Screening Action Plans prioritise actions and outcomes for Asian and other Priority Group Women.
- Each PHO has a dedicated cervical screening coordinator and PHOs work with their general practices to support the establishment of a cervical screening champion role by the end of Q4.
- Contracts with each PHO for free smears for Priority Group Women are in place by the end of Q1.
- PHOs are accessing and actively managing monthly cervical screening data match lists on a quarterly basis.
- Number of training sessions provided for CM Health practices on how to have the conversations about cervical screening by Q4.
- Quarterly description of activity related to the ISP cervical screening referral pathway for Priority Group Women.
- Quarterly description of support provided within practices.
- Three yearly cervical screening coverage rates for Asian women.
- Quarterly description of smear taking activity / clinics provided in community settings.
- Quarterly description of activity to raise cervical screening awareness, particularly amongst Asian women.

### 4.2.5 Refugee & Migrant Health

Improve access to and utilisation of primary health services for Asian, migrant & refugee groups by providing early opportunities for interventions that are culturally and linguistically responsive.

**Note:**

The regional Asian and MELAA Primary Care Group has recommended that each DHB align targets in this area and as such, the baseline and targets for these actions are pending regional advice.

<table>
<thead>
<tr>
<th>Who will we work with?</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health Locality General Managers</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>CM Health PHOs</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Independent Service Providers</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Auckland DHB / Waitemata DHB</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>Asian communities</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

**Monitoring Processes**

- Quarterly reporting from PHOs on the Refugee Wrap around Services contract.

**Actions**

- Q1-3: Determine what resources are available to promote GP enrolment for Asian, Refugee and Migrants groups.
- Q2-4: Raise awareness amongst the Refugee community of the services available through primary care for refugees and work with other stakeholders to increase access to and uptake of the services amongst the eligible refugee population.
- Q2-4: Offer and promote information about Primary Health

**Measures**

- Stocktake completed and information used to improve promotion and access to care.
- Increase in number of Refugees enrolled with refugee primary care services in CM Health.
| Interpreting Services (PHI services) to non-English speakers about PHO Services and Primary Care Organisation (PCO) Services. |
| Q3-4: Encourage and promote CALD training within the Refugee services contract. |
| Number of PHOs/GPs aware of PHI services offered. |
| Increase the number of practice staff attending CALD 3 – Working with Refugees training. |
5.0 Appendices

5.1 Asian Health Status in Counties Manukau

5.1.1 Diabetes Prevalence

Diabetes is an important disease due to its high prevalence, the high likelihood of complications, high mortality, and significant costs associated with treatment. The prevalence of diabetes can be calculated by aggregating diabetes-related test results available in the Auckland region. Figure 5 below shows the prevalence of diabetes in Auckland by age and (prioritised) ethnic group. Diabetes prevalence is strongly related to age with prevalence increasing up to the age of 70 years from a very low prevalence in the early 20s.

Pacific people have the highest prevalence of the disease (almost a third of people aged 55 to 59 years and 45 percent in those aged 65 to 74 years) however, Indian people also have a high prevalence. In contrast, Chinese people have a lower prevalence, similar to that of NZ European/Other groups (about 1:10 people aged 55 to 59 years). People in the ‘Other Asian’ group have a prevalence similar to Māori.

Figure 5: Diabetes prevalence, by age and ethnicity (Auckland, 2013)\textsuperscript{18}.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{diabetes_prevalence}
\caption{Diabetes prevalence, by age and ethnicity (Auckland, 2013)\textsuperscript{18}.}
\end{figure}

5.1.2 Child Oral Health

Dental caries (tooth decay) is a diet and saliva-modified bacterial disease which can have a negative impact on oral health as well as general health and well-being. Caries is a disease process that ends in decayed, filled or missing teeth (DMFT).

Disease in primary teeth results in disease being three times more likely in permanent teeth. The implication is that caries status in the primary teeth can be used as a risk indicator for predicting caries in permanent teeth. Caries may cause years of discomfort and pain before requiring treatment or extraction.

Our data indicates opportunities to improve for young Asian children (0-4 years of age), as evidenced by the low rates of enrolment with oral health services (refer Table 1) and relatively high rates of dental disease in Chinese and Indian children compared with NZ Europeans (Figures 6 & 7).

\textsuperscript{18} Derived from TestSafe data, personal communication Wing Cheuk Chan.
Table 1: CM Health total oral health service enrolments by age by ethnicity in Counties Manukau

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Asian</th>
<th>European</th>
<th>Maori</th>
<th>Other</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 years enrolled</td>
<td>3,306</td>
<td>3,448</td>
<td>3,061</td>
<td>975</td>
<td>3,972</td>
<td>14,762</td>
</tr>
<tr>
<td>0-2 years % enrolled</td>
<td>62%</td>
<td>89%</td>
<td>44%</td>
<td>50%</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>3-4 years enrolled</td>
<td>3,038</td>
<td>3,587</td>
<td>3,771</td>
<td>805</td>
<td>4,908</td>
<td>16,109</td>
</tr>
<tr>
<td>3-4 years % enrolled</td>
<td>80%</td>
<td>145%</td>
<td>84%</td>
<td>93%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Total 0-4 years enrolled</td>
<td>6,344</td>
<td>7,035</td>
<td>6,832</td>
<td>1,780</td>
<td>8,880</td>
<td>30,871</td>
</tr>
<tr>
<td>Total 0-4 years % enrolled</td>
<td>69%</td>
<td>102%</td>
<td>64%</td>
<td>73%</td>
<td>76%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Auckland Regional Dental Service (ARDS) Titanium reporting, 2015

In 5 year old Auckland children during 2014 (n = 3,072), Chinese and Indian burden of dental caries (mean number of decayed, missing from caries, or filled primary teeth: 1.9 and 1.5 respectively) were about mid-way between New Zealand European and Other (mean 0.7; lowest), and Pacific (mean 3.2; highest) ethnic groups.

Figure 6: Counties Manukau Preschool mean DMFT by age year, 2015

Figure 7: Counties Manukau Preschool percentage of population caries free by age year, 2015

Asian children who enrolled at the Counties Manukau preschools in 2015:
- at age 2 years 87 percent were caries free,
- at age 3 years 58 percent were caries free, and
- at age 4 years 58 percent were caries free.

This highlights our opportunity to focus on oral hygiene improvement, e.g. tooth brushing, at an early age.

5.1.3 PHO Enrolment

Comparisons suggest that ethnicity data derived from both PHO and National Health Index (NHI) datasets underestimate Maori and Asian populations, while over estimating Pacific and European/Others. It seems likely that some people identified as Pacific or European/Other in the PHO registers would be identified and prioritised as Maori or Asian in census-based population projections.

It is also important to be aware that there are different ‘views’ of the enrolled population. Presented here is the enrolment data for Asian people who are resident in the Counties Manukau area and who are enrolled with any PHO (some practices and PHOs are outside the Counties Manukau area). Another ‘view’ is that of Asian who are enrolled with practices within the Counties Manukau area and who may live inside or outside the Counties Manukau area boundary.

Based on PHO enrolment data for January - March 2016, 105,489 Asian people living in Counties Manukau are enrolled in a PHO, 83 percent of the estimated resident Asian population for 2016. Table 2 shows that the majority

---

19 Data for the period Jan - March 2016, sourced from PHO Register.
20 Source: Auckland Regional Dental Service (ARDS) Titanium reporting.
21 Denominator used for this calculation is the estimated resident population for 2015 (n=83,160), based on the 2013 Census (Stats NZ 2015 update of Population Projections).
are enrolled with Procare (44 percent) or East Health practices (23 percent), therefore practices with the most engagement with Asian residents for health improvement actions.

**Table 2: PHO enrolment for Asian resident in Counties Manukau**

<table>
<thead>
<tr>
<th>PHO</th>
<th>Number of Asian enrolled</th>
<th>Percentage of total Asian enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procare</td>
<td>46,290</td>
<td>44%</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>16,627</td>
<td>16%</td>
</tr>
<tr>
<td>National Hauora Coalition</td>
<td>5,869</td>
<td>6%</td>
</tr>
<tr>
<td>Alliance Health+</td>
<td>10,659</td>
<td>10%</td>
</tr>
<tr>
<td>East Health</td>
<td>24,770</td>
<td>23%</td>
</tr>
<tr>
<td>Other PHOs</td>
<td>1274</td>
<td>1%</td>
</tr>
</tbody>
</table>

Table 3 shows the breakdowns by PHO for Level 1 Asian Ethnicity (Jan – Mar 2016 quarter). This is done by using the enrolled practice view (therefore includes patients enrolled in CM Health practices but living outside the DHB) so will look different to the resident view above.

**Table 3: Counties Manukau PHO enrolments by ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Alliance Health+</th>
<th>East Health</th>
<th>National Hauora Coalition</th>
<th>Procare</th>
<th>Total Healthcare</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian (No Further Defined)</td>
<td>368</td>
<td>1,441</td>
<td>37</td>
<td>1,885</td>
<td>1,236</td>
<td>4,967</td>
</tr>
<tr>
<td>Chinese</td>
<td>775</td>
<td>17,169</td>
<td>4,129</td>
<td>6,615</td>
<td>1,487</td>
<td>30,175</td>
</tr>
<tr>
<td>Indian</td>
<td>39,06</td>
<td>3,771</td>
<td>215</td>
<td>17,771</td>
<td>13,218</td>
<td>38,881</td>
</tr>
<tr>
<td>Other Asian</td>
<td>861</td>
<td>2,509</td>
<td>79</td>
<td>3,205</td>
<td>4,108</td>
<td>10,762</td>
</tr>
<tr>
<td>South East Asian</td>
<td>687</td>
<td>1,596</td>
<td>484</td>
<td>4,590</td>
<td>215</td>
<td>7,572</td>
</tr>
<tr>
<td>Grand Total</td>
<td>6,597</td>
<td>26,486</td>
<td>4,944</td>
<td>34,066</td>
<td>20,264</td>
<td>92,357</td>
</tr>
</tbody>
</table>

Primary health analysts have suggested Asian ethnicity accuracy would need to be reviewed before any conclusions could be drawn from these data. PHO enrolment is an action area of interest to the Auckland and Waitemata DHBs therefore CM Health will explore this further with a regional collaboration approach.

### 5.2 Asian Mental Health Status in Counties Manukau

A detailed Asian mental health needs analysis has been completed by our Population Health team in consultation with service and clinical leaders. This information is accessible through the CM Health website.

---

22 Data for the period Jan - March 2016, sourced from PHO Register; provided by Bede Oulaghan, Business Analyst CM Health.

5.3 Pan Asian Health Interest Group (PAHIG) – Terms of Reference

Version Date: 22 April 2015

Purpose
The inaugural Counties Manukau Pan-Asian Health Interest Group is focussed on the health and wellbeing of Asian people and the development of healthy Asian communities in Counties Manukau, with the purpose of:

- Bringing together the perspectives of our diverse Counties Manukau Asian communities in a coherent and constructive manner to input into health planning within the Counties Manukau health system.
- Linking key Asian community stakeholders, community and professional networks to ensure a broad perspective is brought to consideration of health planning issues.

Reporting Line
PAHIG reports to the Master Planner, Strategic Development, CM Health.

Membership
Membership was confirmed through an Expression of Interest process to identify and select the relevant mix to ensure Pan-Asian representation.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role/ Affiliations/Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health</td>
<td>Senior Medical Officer, Women’s Health</td>
</tr>
<tr>
<td>CM Health</td>
<td>Violence Intervention Programme Coordinator, CMDHB; Social work background</td>
</tr>
<tr>
<td>CM Health</td>
<td>Senior Medical Officer, Medicine. Auckland Chinese Medical Association and Chinese Health Awareness Initiative</td>
</tr>
<tr>
<td>CM Health</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>CM Health</td>
<td>Asian Mental Health; links with Asian groups in the Eastern/ Botany areas and metro-Auckland.</td>
</tr>
<tr>
<td>CM Health</td>
<td>Child and Adolescent Mental Health Service; links with Japanese Mental Health Interest group and community cross-cultural interest group</td>
</tr>
<tr>
<td>CM Health</td>
<td>Nurse Educator, Child Health</td>
</tr>
<tr>
<td>CM Health</td>
<td>Needs Assessor and Service Coordinator; links with Manukau East Council of Social Services, Shanti Nivas, Asian Health Foundation, The Asian Network, Manukau East multi-ethnic panel</td>
</tr>
<tr>
<td>CM Health</td>
<td>Nurse, South Asian Mental Health Inter-Agency Group</td>
</tr>
<tr>
<td>Education</td>
<td>School Guidance Counsellor; links to South Auckland School GC cluster; Catholic parenting network and Catholic Filipino community</td>
</tr>
<tr>
<td>Primary Health</td>
<td>GP registrar, Auckland Chinese Medical Association, Royal NZ College of General Practice Trainee Chapter</td>
</tr>
<tr>
<td>Provider</td>
<td>The Asian Network Inc. (TANI); links with Asian community groups across metro-Auckland</td>
</tr>
<tr>
<td>Provider</td>
<td>Plunket; Chinese New Settlers Services Trust (Trustee), and the Centre for Asian and Ethnic Minority Health Research (CAHRE) (Advisory Committee Member)</td>
</tr>
</tbody>
</table>

Meeting Frequency
Up to four meetings per year will be held. Meeting frequency will be contingent on demand for the Group’s services.
The Group will operate for an initial term of 12 months upon which time a review will be undertaken to determine effectiveness and value added.

**Conflicts of interest**
Prior to the start of any meetings, conflicts of interest will be stated and recorded in a Conflicts of Interest register.
Where a conflict of interest exists, the member will advise the Chair and withdraw from all discussion.

**Support**
PAHIG will be convened by CM Health’s Planning Advisor (until an Asian Health Coordinator is appointed) who will manage its agenda and ensure provision of administrative support for its meetings.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT</td>
<td>Counties Manukau Health Alliance Leadership Team; comprising PHO and Counties Manukau DHB clinical and executive leaders.</td>
</tr>
<tr>
<td>CAHRE</td>
<td>Centre for Asian and Ethnic Minority Health Research</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse (CALD)</td>
</tr>
<tr>
<td>CM Health</td>
<td>Counties Manukau Health, representing all service provision within the Counties Manukau district.</td>
</tr>
<tr>
<td>COHS</td>
<td>Community Oral Health Services</td>
</tr>
<tr>
<td>DMFT</td>
<td>Decayed, filled or missing teeth</td>
</tr>
<tr>
<td>ELT</td>
<td>CM Health’s Executive Leadership Team</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>PAHIG</td>
<td>CM Health’s Pan Asian Health Interest Group</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>TANI</td>
<td>The Asian Network Incorporated</td>
</tr>
<tr>
<td>MELAA</td>
<td>Middle Eastern, Latin American, African</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Community & Public Health Advisory Committee:

Receive the second draft 2016/17 Pacific Health Plan.

Note that the Pacific Health Progress Trends Report 2013/14 – 2015/16 Q1 & Q2 formed the basis of the priority action areas for 2016/17

Agree the priority action areas in the second draft 2016/17 Pacific Health Plan.

Endorse the second draft 2016/17 Pacific Health Plan to go forward to the 15 June 2016 Board meeting for approval to publish.

Prepared and submitted by: Elizabeth Powell, GM Pacific Health Development & Margie Apa, Director Strategic Development

<table>
<thead>
<tr>
<th>This paper has been through HMT/P&amp;CLT</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Implications</td>
<td>No</td>
</tr>
<tr>
<td>HR Implications</td>
<td>No</td>
</tr>
</tbody>
</table>

Purpose

This paper describes activities that we will undertake and measures we will use to show improvement in health outcomes for Pacific people living in Counties Manukau. In line with the Healthy Together 2020 Strategy and the goal of achieving health equity, the paper identifies priority action areas that will contribute to achieving this goal for Pacific peoples in Counties Manukau.

This paper recommends priority action areas and activities for accelerating Pacific health gains and achieving health equity. National and local indicators are identified as measures for improving Pacific people’s health and achieving health equity.

Executive Summary

The 2016/17 Pacific Health Plan was developed through workshop based engagement with key stakeholders including internal areas owners who are responsible for potential action areas. These workshops were informed by the Pacific Health Progress Trends Report 2013/14 – 2015/16 Q1 & Q2 (Pacific Health Progress Trends Report) that provided a helpful picture of the ‘health equity gap’ between the Pacific population compared with the total CM Health population.

Through this process, responsible action owners were able to shape the actions outlined in this second draft Pacific Health Plan. A first draft plan was consulted more broadly with ELT subcommittees (Primary and Community Leadership Team; Hospital Management Team). Feedback
from those committees was incorporated into the second draft of the plan now being distributed to ALT to review, provide feedback and endorse.

This Pacific Health Plan will enhance visibility of our health improvement actions and how we perform against these. This will form the basis of how we communicate our performance story and learnings for our Pacific communities about how their health is being impacted.

The Pacific Health Progress Trends Report significantly informed key stakeholder workshops regarding 2016/17 actions and progress measures. This report described our progress performance against Pacific Health Plan selected measures across that period.

In line with our Healthy Together Strategy and health equity goal, this report provides a helpful picture of the ‘health equity gap’ Pacific population compared with the total CM Health population. Addressing health equity is fundamental to our population health approach. Achieving health equity means that all groups have the necessary opportunities to support them to achieve equal health outcomes.

**Pacific Health Plan Priority Action Areas**

Taking a life course approach, key actions areas to improve the health and wellbeing of Pacific patients and fanau include improving access to and early engagement with healthcare. Such actions would expect to see the following results contribute to better health outcomes for Pacific peoples with a goal of reducing health equity and will be measured using National and local indicators.

**National Indicators include:**
- Access to care – Newborn Enrolment and Ambulatory Sensitive Hospitalisations (ASH)
- Breastfeeding
- Child Health – Well Child Tamariki Ora
- Smoking (Pacific Mothers who are smokefree two weeks postnatal)
- Rheumatic Fever
- Child Oral Health
- Sudden Unexpected Death in Infancy (SUDI)
- Childhood Obesity

**Local Indicators include:**
- Workforce Development
- CVD Risk Assessment & Management
- Lotu Moui, Pacific community and Provider engagement
- Working with the Pacific Oceania Region

We must shape our expectations of how we can enable access and improved experiences to reflect the change in Pacific demography from the emphasis of migration to the increase number of New Zealand born – now comprising more than half of the Pacific population. Equally important to this change is to address the impact of economic and social determinants on the health of Pacific people. This change in focus takes into account the importance of ensuring multiple approaches to addressing Pacific people’s health needs.

The Pacific Health Plan should be read in conjunction with CM Health’s District Annual Plan (DAP) and its companion pieces – Maori Health Plan, Asian Health Plan – to put in context the wider actions CM Health is undertaking to improve health.
## Plan Development and Approval Timeline

<table>
<thead>
<tr>
<th>Pacific Plan Stages</th>
<th>Committee / Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key stakeholder engagement</td>
<td>Key stakeholder workshops held in key potential indicator areas for debate and formation of actions and measures. This was informed by the 2015 describes our progress performance against Pacific Health</td>
<td>February 2016</td>
</tr>
<tr>
<td>Consultation draft</td>
<td>Based on workshop discussions and alignment with Annual and Maaori health plan indicator definitions, potential actions were circulated for review and confirmation of commitment.</td>
<td>March 2016</td>
</tr>
<tr>
<td>First draft</td>
<td>Review and feedback by broader stakeholders:</td>
<td>13 April 2016</td>
</tr>
<tr>
<td></td>
<td>• Primary &amp; Community Leadership Team (P&amp;CLT)</td>
<td>15 April 2016</td>
</tr>
<tr>
<td></td>
<td>• Hospital Management Team (HMT)</td>
<td></td>
</tr>
<tr>
<td>Second draft</td>
<td>ALT Endorsement to forward to ELT</td>
<td>19 May 2016</td>
</tr>
<tr>
<td></td>
<td>CPHAC Approval to forward to Board</td>
<td>25 May 2016</td>
</tr>
<tr>
<td>Final draft</td>
<td>Counties Manukau District Health Board approval to publish</td>
<td>15 June 2016</td>
</tr>
</tbody>
</table>

*Note: As the ALT April meeting was cancelled, the first draft plan was circulated by email for review and with some feedback received at this time. The second draft of the plan will be discussed further at the 19th May meeting of ALT.*
Counties Manukau Health
Pacific Health Plan 2016/17

DRAFT VERSION 2.0
16 May 2016

This is the second draft of the 2016/17 Pacific Health Plan for consultation and feedback.
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Foreword

To be completed when the plan content is endorsed

Dr Lee Mathias    Geraint A Martin
Chair               Chief Executive
1.0 Executive Summary

There are more than forty different Pacific ethnic groups in New Zealand. Each ethnic group has its own unique and widely varying culture, language and history. Despite degree of diversity, there are similarities in some of their cultural values. Another important factor to the diversity is the varying length of time Pacific peoples have lived in New Zealand.

The experiences of Pacific peoples and their engagement with the health sector in Counties Manukau is an evolving one. Previously, the main concern for Pacific peoples was migration and knowledge of how to access the healthcare system was minimal. Overtime, however; Pacific demography has changed with an increase in the number of Pacific peoples born in New Zealand now comprising more than half – Pacific peoples are no longer regarded as a recent migrant population with challenges typical of migrants (e.g. English as second language). Therefore we must shape our expectations of how we can enable access and improved experiences to reflect that change. This change in focus takes into account the importance of ensuring multiple approaches to addressing Pacific people’s health needs.

In 2014, the total estimated resident population of Counties Manukau was 528,340 with 131,737 identifying as Pacific people. This makes up approximately 21% of the CM Health estimated resident population or 38% of the total New Zealand Pacific population. This makes CM Health the largest Pacific DHB population in New Zealand.

The Pacific Health Progress Trends Report 2013 to 2015 describes our progress against the Pacific Health Plan 2016/17 selected measures across that period. We used learnings from these reports to identify potential opportunities to focus effort in accelerating health gains for the Pacific population in CMH. We consulted with key stakeholders about these key areas to confirm our findings but also to discuss our approach to address those areas.

These actions areas include national and local indicators. The national indicators are access to care for newborn enrolment and Ambulatory Sensitive Hospitalisations (ASH), Breastfeeding, Child Health – Well Child Tamariki Ora, Smoking, Rheumatic Fever, Child Oral Health, Sudden Unexpected Death in Infancy (SUDI) and Childhood Obesity. The local indicators are Workforce Development, CVD Risk Assessment and Management, Diabetes Management, Lotu Moui and Pacific community engagement and Working in the Pacific Oceania Region.

CM Health’s Healthy Together 2020 Strategy and health equity goal provide the lens to consider current and emerging health disparities and inequities across Counties Manukau’s Pacific populations. This Plan should be read in conjunction with CM Health’s District Annual Plan (DAP) and its companion pieces – Māori Health Plan, Asian Health Plan – to put in context the wider actions CM Health is undertaking to improve health. The Pacific Health Plan 2016/17 describes the activities that we will undertake and measures we will use to show improvement in health outcomes for Pacific people living in Counties Manukau. These measures will be reflected in the organisation’s overall performance reporting to the Board. This Pacific Health Plan will enhance visibility of our health improvement actions and how we perform against these. This will form the basis of how we communicate our performance story and learning’s to our Pacific communities about how their health is being impacted.
2.0 Healthy Together 2020

CM Health’s refreshed Healthy Together 2020 Strategy sets as our goal that:
“Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020.”

We will assess how we do this by measuring the impact we have on healthy life years every year. This is our commitment to act and be deliberate in our choices and priorities.

We will achieve Healthy Together 2020 through three strategic objectives:

- Healthy Communities: Together we will help make healthy options easy options for everyone
- Healthy People, Whaanau and Families: Together we will involve people, whaanau and families as an active part of their health team
- Healthy Services: Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner.

Together means collaboration and partnership with people, whaanau, families, communities, health and other providers.

At the same time, we refreshed our organisation values. We aspire to live and breathe our values every day as the foundation of our strategic actions.

<table>
<thead>
<tr>
<th>In other words:</th>
<th>Make everyone feel welcome and valued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuing everyone</td>
<td></td>
</tr>
<tr>
<td>Kind</td>
<td>Care for other people’s wellbeing</td>
</tr>
<tr>
<td>Together</td>
<td>Include everyone as part of the team</td>
</tr>
<tr>
<td>Excellent</td>
<td>Safe, professional, always improving</td>
</tr>
</tbody>
</table>
2.1 How will we accelerate and achieve Pacific health gain under Healthy Together 2020?

Healthy Together 2020 builds on three key initiatives that will strengthen our response to Pacific populations:

- **Healthy Communities:** Localities and Community Health Service Integration (CHSI) are the cornerstone primary healthcare initiatives that will leverage and accelerate Pacific health improvement where:
  - Alignment of support for high and complex social and health need Pacific Fanau with CHSI, ARI, Manaaki Hauora and other locality initiatives to reduce likelihood of duplication and/or high need Fanau falling through the gaps
  - Preventing ill health means a high proportion of CM Health’s Pacific population live in the Mangere/Otara locality area. Of the 110,000 people enrolled in General Practices in the locality, 68% are Pacific. This presents an opportunity to build and expand on this locality as the centre of expertise for Pacific health improvement that then supports Pacific health in the wider District through a refreshed LotuMoui and Pacific community engagement action plan
  - Learnings from activating health and social service co-ordination in Mangere/Otara including working with schools, churches and other important social capital creates a scale of transformation for community organising focusing on Pacific populations through a whole of system Fanau Ola service that targets highly complex health/social need Pacific families
  - Activating and engaging Pacific people to create healthier environments within Mangere/Otara provides an opportunity for the spread of community organising tools to equip Pacific people with the power to change their local environments through spread of Ko Awatea

- **Healthy People, Whaanau and their families:** improving Pacific enrolment and engagement in initiatives that strengthen their engagement with their healthcare team includes but is not limited to:
  - All high risk Pacific people with complex needs will have a care plan and care co-ordination within primary care and related social agencies through Fanau Ola;
  - More Pacific people are accessing health literacy resources and more than 2/3rds of health professionals have undertaken health literacy training;
  - Increased engagement of Pacific mums in pregnancy in maternity services with seamless connection to early infant care and the proportion of ARI enrolments reflect the Pacific proportion of high and complex need patients;
  - Pacific people are at a minimum proportionally represented in Manaaki Hauora and accessing their own health information.

- **Healthy Services:** Pacific people experience excellent services that are well supported to treat those who need us safely, with compassion and in a timely manner as reflected in:
  - improved engagement in patient satisfaction reporting
  - accessing technology that will enable access to their own records
  - infrastructure is designed to increase affordable access for Pacific people
  - values led organisation culture is reflected in Pacific people experiencing improved quality of care through a refreshed and modernised Pacific cultural competency training programme
  - increased access by Pacific people to primary care based services through Community Central and Restorative Home and Community Services
  - all key equity targets and performance against them are the same or better for Pacific populations.
2.2 Applying a Health Equity Lens

The Pacific Health Progress Trends Report 2013 to 2015 describes our progress performance against Pacific Health Plan selected measures across that period. In line with our Healthy Together Strategy and health equity goal, this report provides a helpful picture of the ‘health equity gap’ Pacific population compared with the total CM Health population. Addressing health equity is fundamental to our population health approach. Achieving health equity means that all groups have the necessary opportunities to support them to achieve equal health outcomes. This requires targeting our planned actions in a way that best meets the needs of Pacific people who have a poorer health status compared to non-Maori/non-Pacific people. Our focus is to achieve health equity for Pacific people living in Counties Manukau.

We used this information to work with key stakeholders on meaningful actions that they could commit to in 2016/17, while at the same time recognising and learning from where we performed well, e.g. immunisations at 8 months and breast screening rates. These actions and measures will be included in the CM Health Annual Plan (reporting performance by ethnicity), while more specific and targeted health equity interventions are the focus of this plan.

What we learnt from this performance trend data is that we have more work to do to achieve health equity for pregnant mums, infants, children and adults with potentially avoidable hospital admissions. Some of the specific indicators highlighting areas to focus actions in 2016/17 include:

- 78% of Pacific newborns are enrolled with a GP by 3 months [Target = 98%]
- The percentage of pregnant women who are smokefree at 2 weeks postnatal is low where current reach is 67% [Target = 95%]
- Exclusive breastfeeding remains at 49% at 6 weeks [Target = 75%] and 43% at 3 months [Target = 60%]
• Estimated 47% of Pacific infants have not received all of their core Well Child Tamariki Ora (WCTO) core contacts in their first year of life [Target = 95]
• Enrolment in oral health services for Pacific children at 2 years of age is 59% [Target = 73%], and only 34% are caries-free at 5 years [Target = 55%]
• The Pacific rate of Ambulatory Sensitive Hospitalisations (ASH) for all ages, at 3,651/100,000 is still significantly higher than the total rate of 2,380/100,000 for CM Health.
• The percentage of Pacific employees in CM Health is 11%, considerably less when compared to population proportion of 21%.

3.0 Working with our Pacific communities

3.1 Engagement with Pacific communities
CM Health has a long history of engagement with Pacific communities. In 2008 we formally developed a Lotu Moui Programme that has been the main platform of engaging with over 100 Pacific Island churches. Over the past several years a Ministers Advisory Group and a Youth Advisory Group have provided invaluable input into the ongoing work of CM Health in relation to improving better health not only for their own constituents, but also for their wider communities. They have prioritised the need to build capability and skills among Pacific people, with targeted initiatives driven through church leadership and community group based health committees. A shifting demographic among Pacific people is the increased diversity of faith based and community based settings that expand beyond churches e.g. ethnic specific island groups with networks into the Pacific Region itself, sport and fitness networks. Ongoing engagement has continued and in 2015 the Lotu Moui programme was refreshed to increase its reach to other community entities such as social, sports, and cultural groups.

Approximately 1,000 Pacific people from Pacific women’s, men’s, youth groups, Pacific church groups, sports groups, Pacific community leaders, and Pacific community health and social service providers were engaged and asked how best to connect with them. Our goal is for healthy choices to be part of the fabric of community life and CM Health as an enabler rather than a leader. Key issues and enablers were analysed using our Fanau Ola community strengths based approach. Health and financial literacy and management were identified as priorities and having activities that continue to contribute to better health outcomes so families can be healthy and well at home and in their communities.

Table 1: Pacific People and Pacific Health - Snapshot

<table>
<thead>
<tr>
<th>Pacific People and Pacific Health - Snapshot</th>
</tr>
</thead>
<tbody>
<tr>
<td>131,737 living in Counties Manukau</td>
</tr>
<tr>
<td>14,356 enrolled in PHO outside Counties Manukau</td>
</tr>
<tr>
<td>21% of total CM Health population</td>
</tr>
<tr>
<td>22% newborns not enrolled with GP by 3 months</td>
</tr>
<tr>
<td>34% of all live births in CM Health</td>
</tr>
<tr>
<td>47% babies do not receive WCTO core contacts by 1 yr</td>
</tr>
<tr>
<td>75% live in high deprivation areas</td>
</tr>
<tr>
<td>66% children have dental caries by age 5</td>
</tr>
<tr>
<td>65% of Otara and Mangere population</td>
</tr>
<tr>
<td>3651 ASH discharges in one year (0-74 yrs)</td>
</tr>
<tr>
<td>103,840 Enrolled in Primary Care within CM Health</td>
</tr>
<tr>
<td>7% 25-44; 30% 45-64; 48% &gt; 65 yrs diag. diabetes</td>
</tr>
<tr>
<td>22,570 Enrolled in Primary Care outside CM Health</td>
</tr>
<tr>
<td>7 years less (shorter life expectancy)</td>
</tr>
</tbody>
</table>

1 Pacific patients domiciled in CM Health but enrolled anywhere in NZ - Per PHO enrolment data – provided by Bede Oulaghan 12.05.2016
3.2 Pacific Provider and Workforce Development in the Health Care Sector

Pacific providers will continue to be part of the healthcare landscape in offering Pacific people with choices of provision. Building on the success of earlier engagement with Pacific community and primary care providers, CM Health continues to invest in Integrated Services for Pacific people with complex needs funded through Alliance Health+.

CM Health support the priorities of ‘Ala Mo‘ui – the Ministry of Health’s Pacific Health Action Plan - that “it is essential to not only build the capacity and capability of the Pacific health and disability workforce but to also increase the responsiveness of the non-Pacific health workforce to Pacific health needs.”. CM Health has continued to invest significantly in growing Pacific healthcare workforce at all stages of the workforce pipeline – High School Academies and career promotion programmes in secondary schools, scholarship in tertiary studies and facilitated mentoring into employment. These are critical enablers to increase the proportion of Pacific workforce.

4.0 Profile of Pacific peoples in Counties Manukau

4.1 Population Profile

The Pacific population is youthful. An estimated 29% are under the age of 15 years of age. Figure 2 show that the Pacific population within CM Health is a young population. The largest number of Pacific people in the 0-14 year old age bracket, followed by the 15-24 age group, and then the 25-44 age group.

![Figure 2: Pacific Peoples in CMH 2013](image)

Amongst Pacific peoples who reside in the CM Health area, 54,300 or 46.2% identify themselves as Samoan at the time of the 2013 Census. 24,950 or 21.2% identify as Tongan and 22,810 or 19.4% as Cook Islands Maori. This is illustrated in figure 3 below. A third of young Pacific people in CM Health identify with more than one ethnicity. More Pacific people tend to have dual residency and live in both New Zealand and the Pacific Islands.

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1 The ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014-2018 page 8
2 Counties Manukau Health,(2015)
3 Metro Auckland, 2012
4.2 Health Determinants

The factors that promote and protect good health are known as the determinants of health. In 1998 the National Health Committee of New Zealand stated that:

“Social and economic factors that have been shown in a variety of settings to have the greatest influence on health are income and poverty, employment and occupation, education, housing, and culture and ethnicity.”

More recently the World Health Organization’s Commission on the social determinants of health has described these factors as the ‘conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life’. The social determinants of health are described as the key drivers for health inequities – unfair and avoidable differences in health.

There has been much debate in the last decade with regards to the influence of income inequalities on population health. One view suggests that it is not the absolute material deprivation that shapes health at a population level but the effects such inequalities have on psychosocial outcomes such as the degree of control over work, anxiety, depression and social affiliations.

However there is another argument that it is not the psychosocial effects of income inequality which play the greatest role, but rather the lack of material resources (for example differentials in access to adequate nutrition, housing and healthcare), together with a systematic underinvestment in human, physical, health and social infrastructure (for example the types and quality of education, health services, transportation, recreational facilities and public housing available). The latter view also suggests that the combination of those negative exposures is particularly important for the health of the most disadvantaged (who have the fewest individual resources and that in this context, the association is between income inequality and health are not inevitable but rather are dependent on the level of public infrastructure and resources available.

The Annual Update of the New Zealand Health Survey 2014/15 tells a story of opportunities to work with others to do better for Pacific people and in particular Pacific children:

- Thirty percent of Pacific children and 15% of Māori children were obese
- One in five children living in the most socioeconomically deprived areas (21.1%) was obese compared with two in a hundred children living in the least deprived areas (2.1%). The childhood obesity rate was five times higher in children

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5 Counties Manukau Health (2015)
living in the most deprived areas than it was for children living in the least deprived areas. This link between obesity and neighbourhood deprivation was far stronger for children than for adults.

- One in ten Pacific children (10%) and 9% of Māori children had been physically punished in the past four weeks.
- Māori and Pacific children were 1.8 times as likely to have been physically punished as non-Māori and non-Pacific children. In contrast, only 2.4% of Asian children had been physically punished.

The following sections describe the distribution of some of the key social determinants of health for the CM Health population as identified in the 2013 Census.

Unemployment for Pacific people were (10%) in CMH was approximately three times higher than NZ European/other groups (3.4%). More than 60% of Pacific peoples who are 15 years and over earn less than $30,000 a year. Low income, unemployment, limited education, and low social connectedness and cohesion impact significantly on Pacific people’s physical, mental, and emotional health. The impact of low income for Pacific peoples was reflected in the results from the Annual Update of the New Zealand Health Survey 2014/15 where 17% of Pacific adults and 15% of Māori adults had not collected a prescription due to cost. Pacific adults were 2.8 times as likely as non-Pacific adults and Māori adults were 2.6 times as likely as non-Māori adults not to have collected a prescription due to cost, after adjusting for age and sex differences. In contrast, only 5% of Asian adults were unable to fill a prescription due to cost at some point in the past 12 months.

Housing is described as a key determinant of health and ‘an important mediating factor in health inequalities and poverty’. Overcrowding and cold damp housing can have direct detrimental effects on physical and mental health. High housing costs leave less money for other expenses such as heating, nutritious food, education, and access to health services. Rental housing is recognised as generally being in poorer condition that owner occupied housing and lack of stable tenure can impact on education and employment.

Almost half of the Pacific populations live in overcrowded households and 53% of Pacific children live in overcrowded households. This could be a possible explanation as to why there is significantly higher rate of acute hospital admissions particularly for Pacific children ages 0 – 4.

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12 University of Otago, Wellington (2014) New Zealand Indexes of Deprivation, 2013; NZDep2013 Area Concordance File; analysed by CM Health
5.0 Pacific Health Profile

5.1 Acute Demand
The biggest percentage increases in ED presentations have been among Asian children and Pacific children whom are highly over-represented – Pacific children are estimated to be 28% of the resident population but represent 46% of ED presentations.

This pattern of high percentages of Pacific children presenting need further analysis and may reflect to a certain extent the different health systems in the countries of origin of these groups, the limited availability of primary care in those settings and hence a higher reliance on hospital services. For Pacific populations who have been in New Zealand for much longer, it may also reflect a lack of confidence to manage conditions at home.

5.2 Avoidable Hospitalisations and Mortality
Figure 6 below shows the ASH rate for Counties Manukau DHB 0 – 4 years. The equity gap is widening in ASH rate for Pacific children age 0-4 year old and while there is a decrease in ASH rate for other ethnic groups particularly in the past 12 months, that was not the case for Pacific children.

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13 Regional Acute Demand by Rosie Whittington, Doone Winnard, Wing Cheuk Chan. May 4, 2016
14 Provided by Bede Oulaghan 12.05.2016 Counties Manukau Health (2015).
Furthermore, the following figure below (figure 7) shows the top ten conditions for hospital admissions in age 0-4 year old. It shows Pacific children are significantly higher than any other ethnic group in all conditions.

5.3 Child Oral Health

Dental caries (tooth decay) is a diet and saliva-modified bacterial disease which can have a negative impact on oral health as well as general health and well-being. Caries is a disease process that ends in decayed, filled or missing teeth (DMFT). Disease in primary teeth results in disease being three times more likely in permanent teeth. The implication is that caries status in the primary teeth can be used as a risk indicator for predicting caries in permanent dentition. Caries may cause years of discomfort and pain before requiring treatment or extraction. Oral Health for Pacific is extremely poor. High numbers of Pacific families in the Counties Manukau area have diverse and complex health needs. A flexible model of care that is patient and family focused is needed across the services including for on-site examinations.

Table 2: CM Health total oral health service enrolments by age by ethnicity in Counties Manukau

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Asian</th>
<th>European</th>
<th>Māori</th>
<th>Other</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 years enrolled</td>
<td>3,306</td>
<td>3,448</td>
<td>3,061</td>
<td>975</td>
<td>3,972</td>
<td>14,762</td>
</tr>
<tr>
<td>0-2 years % enrolled</td>
<td>62%</td>
<td>89%</td>
<td>44%</td>
<td></td>
<td>50%</td>
<td>59%</td>
</tr>
<tr>
<td>3-4 years enrolled</td>
<td>3,038</td>
<td>3,587</td>
<td>3,771</td>
<td>805</td>
<td>4,908</td>
<td>16,109</td>
</tr>
<tr>
<td>3-4 years % enrolled</td>
<td>80%</td>
<td>145%</td>
<td>84%</td>
<td></td>
<td>93%</td>
<td>97%</td>
</tr>
<tr>
<td>Total 0-4 years enrolled</td>
<td>6,344</td>
<td>7,035</td>
<td>6,832</td>
<td>1,780</td>
<td>8,880</td>
<td>30,871</td>
</tr>
<tr>
<td>Total 0-4 years % enrolled</td>
<td>69%</td>
<td>102%</td>
<td>64%</td>
<td></td>
<td>73%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Pacific children carry a high burden of dental disease with only 34% being caries free at age 5 years. While the target for enrolment in oral health services is 95% by age 4, the focus for oral health will be to enrol infants by 6 months, with their first dental check conducted by one year of age.

15 Provided by Bede Oulaghan 12.05.2016 Counties Manukau Health (2015).
16 Data for the period Jan - March 2016, sourced from PHO Register.
5.4 Community and Primary Healthcare Engagement

While the majority of Pacific people are enrolled with PHOs within Counties Manukau, 22,616 patients enrol in practices outside our district. Many of these are of Tongan ethnicities who are enrolled with practices based in Otahuhu.

Table 3: CM Health residents enrolled in Counties Manukau practices, all ages combined

<table>
<thead>
<tr>
<th>PHO NAME</th>
<th>Domiciled in Counties Manukau &amp; enrolled anywhere in NZ</th>
<th>Domiciled in Counties Manukau &amp; enrolled in CMH located practice</th>
<th>Domiciled anywhere &amp; enrolled CMH located practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Health Plus Trust</td>
<td>29,350</td>
<td>19,924</td>
<td>21,806</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>2,272</td>
<td>2,272</td>
<td>2,501</td>
</tr>
<tr>
<td>National Hauora Coalition</td>
<td>5,519</td>
<td>2,829</td>
<td>2,987</td>
</tr>
<tr>
<td>Procare Networks (GAIHN)</td>
<td>44,068</td>
<td>34,281</td>
<td>36,517</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>49,815</td>
<td>49,815</td>
<td>53,570</td>
</tr>
<tr>
<td>Others</td>
<td>713</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>131,737</td>
<td>109,121</td>
<td>117,381</td>
</tr>
</tbody>
</table>

5.5 Access to Care

Despite high PHO enrolment, access to health care remains an issue for many Pacific fanau. Numerous barriers have been identified including financial barriers such as cost of transport, doctors’ fees, and medication; as well as opportunity costs including the cost of time off work and childcare. Low health literacy, low English proficiency and cultural barriers have been called a ‘triple threat’ to effective health communication.

Reviews in New Zealand and internationally show that “although poor, vulnerable and ethnic minority populations are most likely to require enhanced chronic care and coordination services, the needs of these groups are inadequately addressed in current health systems”\(^\text{20}\). Research has also identified that ethnicity is a significant factor associated with poor health, after controlling for a range of socioeconomic, health risk and demographic variables. To improve issues related to access to healthcare, the voice and influence of Pacific patients / fanau / consumers’ needs to be elevated and included in the design of services, processes, and systems, including in primary and secondary care. PHOs, NGOs and the funded organisations in the system also need to review, develop and deliver services based on the insights of the Pacific fanau.

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\(^{17}\) Auckland Regional Dental Service (ARDS) Titanium reporting

\(^{18}\) Auckland Regional Dental Service (ARDS) Titanium reporting

\(^{19}\) Provided by Bede Dulaghan 12.05.2016 Counties Manukau Health (2015).

\(^{20}\) See also Ovretveit, 2011; Sheridan, 2011; quoted in Pacific Perspectives Research Report (2015): Experiences of Pacific patients who have used Fanau Ola Services p.38
5.6 Diabetes

Diabetes is an important disease due to its high prevalence, the high likelihood of complications, high mortality, and significant costs associated with treatment. The prevalence of diabetes can be calculated by aggregating diabetes-related test results available in the Auckland region. Figure 10 shows the prevalence of diabetes in Auckland by age and (prioritised) ethnic group. Diabetes prevalence is strongly related to age with prevalence increasing up to the age of 70 years from a very low prevalence in the early 20s. Pacific people have the highest prevalence of the disease (almost 1/3 of people aged 55 to 59 years and 45 percent in those aged 65 to 74 years)

![Figure 10: Diabetes prevalence, by age and ethnicity (Auckland, 2013)](image)

Table 4: Number of Pacific people domiciled in Counties Manukau with Diabetes up to September 2015\(^21\) (based on TestSafe)

<table>
<thead>
<tr>
<th>Age</th>
<th>no diabetes</th>
<th>Diabetes</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-44</td>
<td>33,669</td>
<td>2,401</td>
<td>36,070</td>
<td>7%</td>
</tr>
<tr>
<td>45-64</td>
<td>16,877</td>
<td>7,290</td>
<td>24,167</td>
<td>30%</td>
</tr>
<tr>
<td>65+</td>
<td>4,115</td>
<td>3,793</td>
<td>7,908</td>
<td>48%</td>
</tr>
</tbody>
</table>

5.7 Mental Health

CM Health is taking a broad strategic approach to the planning of youth mental health services, which includes meeting the objectives of the Prime Minister’s Youth Mental Health project. Work will focus on:

- Improving the responsiveness of primary care to youth [PP25 Initiative 5] by undertaking a programme of continuous quality improvement in general practice;
- Continuing to improve access to CAMHS and AOD services.

**Actions**

- Increase the number of Pacific youth accessing Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions

\(^{21}\) Derived from TestSafe data, personal communication Wing Cheuk Chan

\(^{22}\) Derived from TestSafe data, personal communication Wing Cheuk Chan
• Work closely with general practice teams linked to high schools to ensure they are ‘youth friendly’, by introducing an appropriate audit tool and appointing a Primary Care Youth Health Quality Advisor to assist practices with implementing an agreed quality improvement plan.

5.8 Ethnicity Data
Evaluating and monitoring Pacific health and wellbeing outcomes includes identifying patterns and trends, determining genuine change and transformation, developing appropriate policies, programmes, services and processes, and driving improvements across the health sector. Accurate ethnicity data is important for informing the public and the health sector, identifying health need, service planning and funding, and monitoring activities. However there is currently inconsistency in the quality of health sector ethnicity data collection.
6.0 *Priority Actions Areas*

6.1 *National Indicators*

This section describes the priority actions to be undertaken by the CM healthcare system during the 16/17 year. These actions should be read in conjunction with the CM Health District Annual Plan.

### 6.1.1 Access to Care - Newborn Enrolment

**Increase Pacific newborn enrolment in primary health care**

Increasing Pacific newborn enrolment in primary health care organisations (PHOs) is important so they can access health services, and health and social interventions to give them the best start in life. While rates have improved over the past several months there are still a significant number of babies who are not enrolled, and we need to increase this rate to 98%.

Current issues include:

- Nomination of GP and enrolment not being prioritised at birth (e.g. in maternity ward)
- Nominations sitting in GP inboxes and not being actioned (either accepted or declined) in a timely manner
- Need for parent to nominate GP at birth (e.g. in maternity ward)
- Confusion with nomination when GP may be working at multiple practices
- Lack of follow through where nomination has been declined by GPs

Note: Once enrolled, newborns are assigned a ‘B’ Code which allows for funding to be generated prior to full enrolment at 3 months. In addition, for the first quarter that a newborn is funded under a pre-enrolment code, MoH and DHBs have agreed not to offset (or claw back) general medical subsidy claims for newborns who may make a casual visit elsewhere. The enrolment system is expected to improve with the introduction of the National Enrolment System (NES), scheduled to start from 1 July, where the register is submitted monthly.

<table>
<thead>
<tr>
<th>Percentage of Pacific newborn infants enrolled with a GP by three months</th>
<th>2015/1 6 Q2 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>98%</td>
<td></td>
</tr>
</tbody>
</table>

**Who will we work with?**

- CM Health PHOs

**Monitoring Processes**

- Pacific enrolment rates via Trendly
- Quarterly reporting to ELT, ALT & MoH

**Actions**

- Q1-4: Work with PHOs to review each PHO’s newborn enrolment plan, activities and performance on a quarterly basis

- Q1-4: Support PHOs to identify and address issues where performance is not improving sufficiently to meet the target of 98% of newborn infants enrolled by 3 months.

- Q1-4: Co-design and develop an improved newborn enrolment processes and protocols, engaging health sector stakeholders including LMCs, antenatal, maternity, GPs, PHOs, and WCTO providers

**Measures**

- Newborn enrolment plans and performance reviewed on a quarterly basis

- Quality improvement initiatives developed and implemented on a quarterly basis where relevant
6.1.2 Access to Care – Ambulatory Sensitive Hospitalisations (ASH)

Reduce Ambulatory Sensitive Hospitalisations (ASH) for Pacific fanau, and in particular for children 0-4 yrs old

Currently the ASH target is not achieved for Pacific, and the equity gap is considerable (1271/100,000). Access to care for Pacific people remains an issue - from birth, in childhood and throughout their lifespan.

Bacterial skin infections are a common cause of hospitalisation in children resident in CM Health. The most common agents are Staphylococcus aureus and Streptococcus pyogenes. Infections are more likely to be established in skin that is already damaged often from eczema, abrasions or insect bites.

Social factors impacting on skin infections include overcrowding; low income; poor transport access to services; lack of hot water and low access to washing machines, and families having debts with their GPs thus creating an issue for them to access primary care.

Skin infection prevention and treatment is a priority area for our region with NRA focussing resources on implementation of the skin pathway in their annual priorities for 2015-2016. Primary care approach is described in the NRA child health plan to reduce the burden of skin infections for children in the Northern Region with a focus on high needs to achieve equity in outcomes. This will result in less bed days used for children with skin infections through improved access to early intervention and increased awareness of factors impacting on skin infections.

Other actions to improve the ASH rate will include improved Paediatric pathways for respiratory disease. For older patients free vaccines will be included for all patients with long-term conditions (e.g. rheumatic fever, diabetes, cancer). Flu kits will be provided for primary care practitioners. An autumn drive to increase vaccination for vulnerable Pacific people will continue. Vaccinations for all staff, including in primary care will be offered to those who train on hospital sites.

### Ambulatory Sensitive Hospitalisation Rates

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Q2 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1 ASH Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific for Age 0-4</td>
<td>TBA</td>
<td>↓</td>
</tr>
<tr>
<td>4.2.2 ASH Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific for Age 45-64</td>
<td>TBA</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Who will we work with?**
- PHOs / Practices
- NRA – Child Health

**Monitoring Processes**
- Service Contracts (CM Health / Regional)
- Primary care data / WCTO
- Hospital data
  Quarterly reporting to ELT, ALT, MoH

### Actions

**Skin infections**
- Q1: Deliver training to WCTO providers on early identification and treatment of skin infections and key messages for families for preventing skin infections (‘clean, cut, cover’)
- Q1-Q4: Promote the regional clinical pathways and skin resources to primary care and WCTO providers for skin infections
- Q4: Clinical nurse specialist to provide clinical advice to WCTO providers around the management of skin conditions

### Measures

- Clinical pathways and resources promoted, and training provided to the 4 WCTO providers

**Asthma and respiratory**
- Q1-Q4: Identification of Pacific children with asthma and ensure families have access to self-management support and action plans
- Q1-Q4: Provide admission data to Practices which identifies Tamariki under 5 years who are eligible for funded flu

- Tamariki identified and families contacted
Several actions outlined in this plan are expected to contribute to a reduction in ASH rates including targeted actions to:

- Increase newborn enrolment rates with PHOs
- Increase rates of children receiving WCTO core contacts
- Increase the percentage of Pacific infants breastfed
- Improve Oral Health
- Reduce Childhood Obesity
- Improve CVD Risk Assessment & Management
- Improve Diabetes Management

Refer to:
- Section 4.1
- Section 4.4
- Section 4.3
- Section 4.7
- Section 4.9
- Section 5.2
- Section 5.3

### 6.1.3 Breastfeeding

**Increase the percentage of Pacific infants breastfed**

Breastfeeding has numerous benefits, supporting infant development and immune protection, protecting against sudden unexpected death in infancy (SUDI), respiratory illness and chronic otitis media, childhood obesity, and diabetes.

Unfortunately current data indicates that only one in two babies is exclusively breastfed at 6 weeks. Small improvements have been made in the 3 month rate, and the DHB is on target for infants at 6 months. There is a complexity of social, cultural and economic factors impacting on breastfeeding that require innovative solutions.

The DHB is committed to increasing breastfeeding rates for Pacific women. A consistent standard of breastfeeding knowledge and skills needs to be available for women and their family in the wider community, so that they will be encouraged to initiate and continue breastfeeding, and view it as the best food source for their infants.

<table>
<thead>
<tr>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>49%</td>
<td>75%</td>
</tr>
<tr>
<td>43%</td>
<td>60%</td>
</tr>
<tr>
<td>58%</td>
<td>65%</td>
</tr>
</tbody>
</table>

**Who will we work with?**

- WCTO Providers

**Monitoring Processes**

- Six monthly report to ELT, Board
- External evaluation of Te Rito Ora services

**Actions**

- Q1-Q4: Provision of Te Rito Ora community based breastfeeding and baby feeding services: drop in breastfeeding clinics, Kaitipua Ora volunteers (mother-to-mother peer supporters), and community and home based lactation consultant service
- Work collaboratively with WCTO providers to strengthen the support they provide breastfeeding mothers and whaanau
  - Q1: Meet with WCTO to discuss support requirements and develop breastfeeding action plan

**Measures**

- Breastfeeding action plans developed
- Plans implemented
- Improvement in breastfeeding rates at WCTO providers
- Q2-4: Support implementation of the action plans

- Q1: Identify and implement (Q2-4) ways to improve referral processes and communication between hospital/birthing facilities and community breastfeeding support services (Te Rito Ora and B4Baby) to ensure women and whaanau are supported and connected with services as they transition from DHB care back to the community

- Improved referral processes

### 6.1.4 Child Health – Well Child Tamariki Ora

CM Health is not achieving this target and performance is declining over the past few years with only about half of Pacific infants receiving their core contacts in their first year of life (51% at Sep 2015 – per ‘Ala Moui Progress Report Dec 2015, p.15). This implies that an improved approach and model of engagement / care is needed.

<table>
<thead>
<tr>
<th>2015 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>(*MOH WCTO 2014)</td>
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</tbody>
</table>

#### 4.4.1. WCTO Enrolment by 4-6 weeks age

<table>
<thead>
<tr>
<th></th>
<th>Maaori</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>56.4%</td>
<td>58.5%</td>
<td>62.9%</td>
</tr>
<tr>
<td>2016/17</td>
<td>98%</td>
<td>95%</td>
<td>One target</td>
</tr>
</tbody>
</table>

#### 4.4.2. Infants receive all WCTO core contacts due in 1st year

<table>
<thead>
<tr>
<th></th>
<th>Maaori</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>43.5%</td>
<td>44.8%</td>
<td>52.9%</td>
</tr>
<tr>
<td>2016/17</td>
<td>95%</td>
<td></td>
<td>One target</td>
</tr>
</tbody>
</table>

Who will we work with?
LMCs/ Midwives
Well Child Tamariki Ora Providers
NIR team

Monitoring Processes
NIR report on WCTO enrolment

**Actions**

By Q1: Co-design and disseminate improved engagement resources to be provided within antenatal care, including ‘Welcome to Child Health Services’ brochure

Q1-Q4: Implementation of the WCTO quality improvement framework to achieve all core contacts due in 1st year

Q1-Q4: Targeted intensive WCTO contacts to high needs Fanau including earlier contact at 2 weeks, additional contacts between core visits, and support groups

Q1-Q4: Improved model of engagement shared between WCTO and LMC/midwives to target intensive services to high needs Fanau

**Measures**

Percentage of infants WCTO indicator 3, completeness of core contacts due in 1st year achieves 85%

WCTO indicator 2, referral of babies from LMC/MW to WCTO

Improved model of engagement results in consistency of WCTO services and achievement of WCTO indicators
6.1.5 Smoking

**Promote and deliver across South Auckland to Pacific populations**

While the current priority population group for this programme continues to be Wahine Māori due to the significant higher prevalence they have in comparison to other populations, CM Health will still have a targeted approach to delivering the service to Pacific populations. The intention is to continue working with a Pregnancy Pacific Provider to deliver the service (pending continuation of MoH funding).

The smoking prevalence graph of women delivering in CM facilities by ethnicity shows that while prevalence has declined for a number of ethnicities, a clear disparity remains for Māori.

![Smoking prevalence graph](image)

People who smoke are at increased risk of cardiovascular disease, chronic lung disease and a wide variety of cancers. Smoking also affects young children and other family members who don’t smoke. Passive smoking and smoking in pregnancy is a risk factor for sudden unexplained death in infancy (SUDI), glue ear, and lung disease in early childhood.

All pregnant women who are smokers should be referred to stop smoking services as soon as their pregnancy is confirmed.

### Actions

**Smokefree Pregnancy Incentives Programme**

- Q1-4: Promote and deliver across South Auckland to Pacific populations, delivering smokefree services to pregnant Pacific Women and their fanau (pending MOH agreement with tobacco realignment process)

### Referring at time of birth

- Q1-Q4: Implement strategies to ensure all women at time of birth are supported to engage with Smokefree support regardless of whether they managed to stop smoking during pregnancy or not
- Q1-Q4: Implement an alert process that all women who stopped smoking through pregnancy are referred for a follow up conversation to ensure they have continued support post-natal

### Measures

- Pending MOH agreement, the pregnancy incentive pilot is moved into business as usual and delivered as Smokefree Pregnancy Incentives Programme Q1, Q2, Q3, Q4
- Postnatal referrals to be increased by 25% by Q1, by 50% by Q2, 75% by Q3 and 100% by Q4
- Alert process is developed and implemented for Pacific women by Q2

### 4.5.1 Percentage of Pacific mothers who are smokefree at 2 weeks postnatal

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### Who will we work with?

- Counties Manukau Health DHB employed Midwives
- Counties Manukau Health Lead Maternity Carers
- Counties Manukau Health Well Child Tamariki Ora Providers (Plunket, Raukura Hauora o Tainui, Papakura Marae, South Seas)
- Counties Manukau Health SUDI Governance Group

### Monitoring Processes

- Quarterly review of performance data from MOH and audits of systems other than MMPO (My Practice, Patrac)
- Monthly review of referral rates by ethnicity and referral source
- Monthly monitoring of incentives programme outcomes including 4 and 12 week quit outcomes as defined by National Tier One service specs
- Qualitative analysis from focus groups with clients and midwives scheduled over the quarters.
- Service data from providers working with pregnant women via monthly reports to the DHB
- Report against each quarter’s measures presented to quarterly Smokefree Governance Group meeting
- Quarterly report to ELT, ALT
Collaboration with specialist midwifery teams

- Q2: Implement strategies to increase referrals from specialist midwifery teams for Pacific women finding it difficult to remain smokefree following birth to achieve equity

- Referrals to smokefree services for Pacific women increase Q1, Q2, Q3, Q4

6.1.6 Rheumatic Fever

Reduce rheumatic fever rates in Pacific children
This is still far from achieving the target, with an equity gap of over 20/100,000. Further targeted intervention is needed to reduce this rate.
The MoH have agreed to continue funding school based throat swabbing services until the end of the 2016/17 financial year.
The reduction in GAS positive throat swabs has reduced to approximately 5%
Consent rates remain high at 98%, demonstrating acceptability of the school based programme.
Need to continue to work in partnership with the Ministry of Health to agree funding for sore throat swabbing services when contracts end in 2015. Need to review the school based throat swabbing service, in view of evaluation findings and the withdrawal of MOH funding, with the aim of developing a sustainable model within funding constraints.

<table>
<thead>
<tr>
<th>Who will we work with?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health, PHOs, Primary Care, Pacific Health Providers, Maaori Health Providers, Northern Region DHBs, Ministry of Education, Ministry of Social Development, Housing providers (AWHI, Warm up Counties)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly updates to CPHAC</td>
</tr>
<tr>
<td>Quarterly reporting to MHAC and MOH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td>A number of activities are in progress, including:</td>
</tr>
<tr>
<td>Working with the National Hauora Coalition to deliver sore throat swabbing services to 61 schools in Counties Manukau until December 2015</td>
</tr>
<tr>
<td>Working with CM localities to enhance the delivery of the school based rheumatic fever prevention programme</td>
</tr>
<tr>
<td>Continuing with the rapid response clinics as agreed between the MOH and the Rheumatic Fever Alliance Leadership Group</td>
</tr>
<tr>
<td>Working with the provider arm and primary care to develop systems to identify families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and/or Pacific) living in crowded housing with 100% being referred to AWHI</td>
</tr>
<tr>
<td>Working with the provider arm to ensure that the notification of acute rheumatic fever to the Medical Officer of Health occurs within 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.6.1</th>
<th>Acute Rheumatic Fever first hospitalisations rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>2015/1</td>
</tr>
<tr>
<td>28.1</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2015/16 Rheumatic Fever first hospitalisations rate per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.1</td>
</tr>
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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>28.1</td>
</tr>
</tbody>
</table>
Oral Health for Pacific is extremely poor. High numbers of Pacific families in the Counties Manukau area have diverse and complex health needs. A flexible model of care that is patient and fanau focused is needed across the services including for on-site examinations. Actions outlined herein are tailored to address a number of issues and barriers including:

- Patients / fanau lack time to engage with multiple services
- Patient access (e.g. location) / affordability (e.g. fees; petrol)
- Poor Oral Health literacy of Pacific fanau
- Lack of cultural competency in Oral Health service providers

**2016/17 objectives:**

To improve access and engagement for children aged 0-4 years to Community Oral Health Services (COHS)

To prevent Early Childhood Caries thus reducing prevalence of early DMFT in ages 0-4 years and improving the percentage of tamariki caries free at five years

| 4.7.1 Percentage of children enrolled in oral health services aged 0-4 years |
|---------------------------------|--------|--------|
| Maaori                          | 64%    | 95%    |
| Pacific                         | 73%    | one    |
| Asian                           | 69%    |        |
| Total                           | 76%    |        |

| 4.7.2 Percentage children Caries free at age 5 years |
|---------------------------------|--------|--------|
| Maaori                          | 37.3%  | 55%    |
| Pacific                         | 34.0%  | one    |
| All Other                       | 63.6%  |        |
| Total                           | 48.7%  |        |

| 4.7.3 Number of children < 5 years treated under general anaesthetic |
|---------------------------------|--------|--------|
| Maaori                          | TBA    | ↓      |
| Pacific                         | TBA    | ↓      |
| Total                           | TBA    | ↓      |

**Who will we work with?**

- Auckland Regional Dental Service
- Service Providers
- Intersectoral / Education

**Monitoring Processes**

- Service Contracts (CM Health / Regional)
- Primary care data / WCTO
- Hospital data
- Quarterly reporting to ELT, ALT, MoH

**Actions**

Improve eligibility and enrolment systems between fanau, primary care, and WCTO providers and Oral Health services to increase enrolment by six months of age, including:

- Q1: Improving the ARDS eligibility system to withdraw barriers to enrolment.
- Implementation of data sharing protocol and agreement to increase data sharing of lists of children accessing Well Child Providers with CM Health hospital data systems
- Q1: Implementation of enrolment by 5 months into COHS by Well Child Tamariki Ora Providers
- Q1-Q4: Clinical examination of tamariki by 1 year of age with prioritization of Pacific and Maaori children
- Q1-Q2: Implementation of referrals process to refer preschool DNAs back to WCTO or Fanau team
- Q1-Q4: Follow-up of persistent DNAs in preschool patient group through WCTO, PHN or Fanau Ola health workers

**Measures**

- Percentage of infants at 6 months of age enrolled in DHB funded oral health service
- Percentage of preschool children 0-4 years enrolled in DHB funded oral health service
- Reduction in DNAs
- ARDS eligibility system (improvement measures)
- Data sharing protocol developed (development measures)
- Data sharing of lists implemented (improvement measures)
<table>
<thead>
<tr>
<th>Review Pre-School Brushing Programme with potential to expand from 150 currently servicing high deprivation communities with high Māori and Pacific rolls</th>
<th>Number of high needs preschool groups implementing daily toothbrushing programme, reported quarterly by number Preschool, by number of children and ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase accessibility to dental care through a flexible model for better access, engagement and attendances: Dentist therapist specific screening time at a Well Child Tamariki Ora clinic – use a smaller screening van and/or portable equipment; specific weekdays and possible Saturdays to catch the working parents, or, Larger preschools – using screening van and/or portable equipment, or, At the COHS dental clinics/ mobile vans/ TDUs Extending hours at hub clinics, pilot one clinic for Saturday morning by end Q1 Co-locating Oral Health appointments for preschool children with other services e.g. WCTO and immunisations, provided on Saturdays and ‘Open Days’ at the SuperClinic, Browns Road dental and other organisations Taking services to families / communities / churches / including provision of home based education groups Q1: Pilot increased access hours for hub dental clinics through a Saturday trial at Browns Road Hub Clinic for preschoolers</td>
<td>Number of clinics providing extended hours, including Saturday mornings, reported quarterly Service linkages / collaborations (improvement measures) Number of service visits &amp; education sessions to families / community groups / churches, reported quarterly</td>
</tr>
<tr>
<td>Q1–Q4: Oral Health education is provided to parents and caregivers by WCTO Providers at all core contacts, and includes Lift the Lip exam, advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments Distribute Oral Health Enrolment packs to Pacific families and include in appropriate languages. Explore resources currently available by Q1. Expand packages where necessary.</td>
<td>Oral Health Enrolment packs sent to Pacific families (need ↑)</td>
</tr>
<tr>
<td>Q1–Q4: Increase Pacific workforce in Oral Health services</td>
<td>Pacific workforce in Oral Health services, reported 6 monthly</td>
</tr>
<tr>
<td>Identify and increase the number of Oral Health champions through collaboration with Pacific groups and communities (by Q1)</td>
<td>Number of identified and engaged Oral Health Champions, reported 6 monthly</td>
</tr>
</tbody>
</table>
### 6.1.8 Sudden Unexpected Death in Infancy (SUDI)

**Reduce SUDI rates in Pacific infants**

While this target has not been achieved a considerable amount of work to decrease SUDI in Pacific and high-risk population continues, with the following activities aimed to contribute to achieving this target.

**Workforce development and training / online learning (CM Health antenatal and postnatal services / midwifery / WCTO providers)**

- Safe Sleep Coordinator engaged to support and implement SUDI initiatives
- Implementation of Safe Sleep policy in all primary birthing units, maternity post-natal wards, Kidz First medical, and Neonatal care
- Implementation of Safe Sleep Audits aligned to NRA Safe Sleep audit criteria has been added into the weekly audit schedule for CM Health maternity facilities using the CM Health “Point of Care measurement Tool”.

The safe sleep baby bed programme continues to provide pepi-pods and Wahakura to whanau with newborn babies in unsafe sleeping environments. All referrals receive safe sleep education.

**Noted increase in SUDI information provided at Well Child Tamariki Ora Core Contact 1, reported for 2014 at 58% up from 45% in 2013 (Maori). Early indications show improvements in 2015 however consolidated data is not yet available.**

**Issues and barriers include:**

- Delay in development of antenatal education curriculum development – and consequently the Hapu Waananga procurement process (discussions continue regarding Pacific-specific programme for Pacific women)
- Need to secure funding and/or sponsorship to fund provision of safe baby beds for babies in unsafe sleeping environments at risk of SUDI

**Actions**

- SUDI online learning / Safe Sleep education - a requirement for all staff and contracted organisations 2016
- Safe Sleep Champions in all Maternity and Child Health providers

**Measures**

- Providers / staff completing SUDI training reported as Q&S monitor, non-participants tracked

| 4.8.1 SUDI deaths per 1,000 live births (² MOH five year annualised 2010-2014) |
|------------------------|-----------------|-----------------
| Maori                  | 2.13 (1.38 - 3.14) | 0.4 |
| Non-Maori (all Pacific) | 0.52 (0.30/0.84)  | 1000 |
| Total                  | 0.96 (0.69 - 1.30) | one |

| 4.8.2 Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1. (² MOH WCTO 2014) |
|------------------------|-----------------|----------------|
| Maori                  | 58.0%           | 70% |
| Pacific                | 68.4%           |     |
| Total                  | 62.7%           |     |

**Who will we work with?**

- LMC / Midwives
- Well Child Tamariki Ora providers
- Community Health Workers
- Maternity and Birthing units
- Social Services sector
- Whakawhetu/ TAHA

**Monitoring Processes**

- Service-level reporting
- Quarterly reporting to ELT & ALT

<table>
<thead>
<tr>
<th>Identification process of all babies in unsafe sleeping environments at Safe Sleep Interventions: aim to promote Safe Sleeping environment up to 12 months of age; referrals from MCS/ Midwives - Families receive Safe Sleep Messaging and baby bed - Pepi-pod or Wahakura with bedding pack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a range of Baby Bed options - Wahakura, Pepi-pod, ‘Pregnancy Help bassinet’ or Portacot Support whanau where unsafe sleeping environments and no other options</td>
</tr>
<tr>
<td>Implementation of follow-up survey to parent/caregivers who have received safe sleep intervention</td>
</tr>
<tr>
<td>Safe Sleep Policy &amp; Audits implemented in all birthing units, maternity wards, Neonatal care, Kidz First medical; point of care audits reported as quality and safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals to Safe Sleep team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up with Fanau (development measure)</td>
</tr>
</tbody>
</table>

| Units complying with Safe Sleep policy, weekly audit tool, monthly feedback to unit (development and improvement measures) |
# 6.1.9 Childhood Obesity

CM Health has been identified as one of the DHBs with a high rate of children identified as overweight, and specifically obese (>98 percentile at the B4Sc check, and who are referred for care and advice.

Unhealthy diets linked to childhood obesity and lack of physical activity are a key determinant of health both in childhood and the long-term impacts of obesity, poor nutrition and lack of healthy active lifestyles.

A number of health streams have identified overweight / obesity as an issue beginning in childhood, and are linking preventative programs to prevent childhood obesity and the downstream impact on general health and well-being, and long-term chronic disease such as diabetes and CVD.

Children receive a comprehensive check before they start school (B4Sc check) and if >98 percentile are referred to primary care services relevant to a number of conditions including childhood obesity when identified against criteria.

A new initiative of a culturally acceptable Family-based Nutrition, Activity and Lifestyle Intervention Service has been identified to refer families of obese children identified in the Before School Check (B4SC) programme.

CMDHB will undertake activity in working towards a reduction in childhood obesity, including through contribution to the health sector actions in the Childhood Obesity Plan. This work will link to wider outcomes to improve health for all population groups, across different provider and funder groups. We will ensure that initiatives support a reduction in obesity for Māori and Pacific families and whanau, and children living in high deprivation areas.

The referral target has been achieved, however an indicator for the intervention and outcomes is needed in future planning.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the Northern Regional (Childhood) Obesity pathway to ensure Primary Care have access to appropriate resources to support conversations with families, identify metabolic complications of obesity, and are clear when referral to Secondary and/or Family Nutrition, Activity and Lifestyle Intervention services is appropriate. Q1: Implementation of regionally consistent guideline and electronic growth chart solution for Primary Care and B4Sc providers, consistent with MoH advice Q1: Implementation of appropriate referrals pathways for Overweight and Obese children identified in B4 School check to Primary Care for clinical assessment Q1 - Q4: Implement and monitor guidelines for clinical staff working in secondary or tertiary care response when children are assessed as obese Sector review:</td>
<td>Progress against the Health Target: by December 2017, 95 percent of obese children identified in the Before School Check (B4SC) programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Reported quarterly. PHO training module for primary care, reported quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators to be established</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will we work with?</td>
<td>GPs</td>
<td>LMC WCTO</td>
</tr>
<tr>
<td>Early Childhood Education sector</td>
<td>Church health committees</td>
<td>Provider of Family-based Nutrition, Activity and Lifestyle Intervention Service</td>
</tr>
<tr>
<td>Monitoring Processes</td>
<td>Quarterly reporting to ALT, ELT</td>
<td></td>
</tr>
<tr>
<td>Q1 – Q2: Review stocktake of current physical activity and nutrition programmes available in the region, and review evidence of effectiveness for such programmes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1-Q4: Liaising with other initiatives both within and outside the health sector such as Healthy Auckland Together, Healthy families, family based diabetes prevention programmes such as H.O.P.E (healthy options positive eating), and H.E.A.L.S (healthy eating active lifestyles) Childhood obesity Family Healthy Active Lifestyles initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1: Implement provider/s of culturally acceptable Family-based Nutrition, Activity and Lifestyle Intervention Services including post-intervention framework, specifically targeted to Maaori, Pacific, and families from high deprivation communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sector Workforce development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1-Q4: Liaising with WCTO providers to upskill workforce on infant and family nutrition using health literacy model, and develop family-based healthy nutrition initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2: Training module for Primary Care to upskill workforce on infant and nutrition family discussions using health literacy module</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1-Q4: liaising with Community Oral Health services for consistent nutritional advice for parents and caregivers of preschool children Training module and resources for ECE, preschools, language nests, Kohanga reo to up skill staff and volunteers using the health literacy module and aligned to the curriculum Te Whaariki for healthy nutrition and exercise. The initial module will target ECE centres in high deprivation localities with high roll of Maaori and Pacific children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sector alignment Refer linkages to Oral Health section 4.7, Breastfeeding, Healthy Weight In Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation culturally acceptable Family-based Nutrition, Activity and Lifestyle Intervention Services including post-intervention framework in locality based provider/s 100% of children referred to primary care assessment are referred to the Family based intervention; family engagement and participation with Intervention; reported quarterly by ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of WCTO and COHS workforce trained in health literacy model of healthy family-based nutrition Number of ECE/preschools/ Kohanga reo/ language nests resourced with healthy nutrition module and resources, reported by deprivation level and locality.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7.0 Local Indicators

The actions in this section represent priority work that CM Health will progress locally and specific to Counties Manukau Health Pacific populations. These indicators reflect our local priorities for Pacific people living in Counties Manukau.

7.1.1 Workforce Development

Increase Pacific workforce across whole of CMDHB to reflect Pacific population

What are we trying to do?
Increase the number of Pacific in the CM health and disability workforce everywhere from 11% to 21% by 2020.

The Counties Manukau DHB vision is to develop the local workforce to serve the health needs of its community and reflect the diversity of the area. While Pacific make up 21 percent of the resident population serviced by CM Health, only 11 percent of employees identify as Pacific, a variance or gap of 10 percent (Table 5).

<table>
<thead>
<tr>
<th></th>
<th>Pacific</th>
<th>Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of workforce</td>
<td>11%</td>
<td>7.1%*</td>
</tr>
<tr>
<td>CMDHB population</td>
<td>21%</td>
<td>16.3%</td>
</tr>
<tr>
<td>Variance</td>
<td>-10%</td>
<td>-9.2%</td>
</tr>
</tbody>
</table>

Table 5: Ethnicity of workforce by headcount compared to CMDHB population in 2014

The Pacific Workforce target has not been achieved, has plateaued for the last few years, and is a considerable distance from where it should be. This means that the current number of Pacific employees would need to at least double to reflect the estimated population today.

The Grow Our Own initiatives will contribute some growth to this proportion - but at a very slow rate. Additional activities to ‘widen the workforce pipeline’ will be explored. Furthermore a whole of systems approach with targeted initiatives encompassing CM Health Workforce Development and Human Resources will be required to increase in Pacific employment.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC</td>
<td>823</td>
<td>1035</td>
<td>1250</td>
<td>1470</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>11</td>
<td>14</td>
<td>17</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Recruit</td>
<td>212</td>
<td>215</td>
<td>220</td>
<td>230</td>
<td>TBC</td>
</tr>
</tbody>
</table>

Who will we work with?
Improvement in workforce disparities takes time, and requires leadership and commitment from a range of stakeholders. To achieve our objectives we will work with:

- Pacific students and their fanau who are interested in a career in health
- Secondary schools in the CM Health region
- Tertiary education providers including Joint Venture Partners the Manukau Institute of Technology, Auckland University of Technology and University of Auckland
- Professional/ clinical leaders, clinical educators, HOD’s and school/ faculty staff
- ADHB and Waitemata Pacific and Maaori workforce teams
- External funders including the Tindall Foundation
- CM Health Recruitment Centre team, HR staff and Communication team
- PHO’s, Pacific providers/NGO’s and Primary Care providers
- CM Health clinical teams and services including the Volunteer Service
- Ministry of Health

Monitoring Processes
- Quarterly reporting to ELT

Actions
- Q1-Q4: Implementation of the MoH funded Regional Pacific contract for three Health Science Academies (Onehunga High School, Waitemata College, De La Salle College)

Measures
- Ongoing implementation measures of Health Science Academies
- Number of students engaged in the HSA programme
  Target = 200 students

22 Note the estimate of 7.1% in 2014 is higher than the 5.6% reported in 2015
| Q1-Q2: Review and develop letters of agreements and plans of Tindall Foundation-funded Health Science Academies (Tangaroa College and James Cook High School) | Letters of Agreement and plans developed for two academies |
| Q1-Q4: Implementation of the MoH funded Pacific Tertiary Student Support Programme (Programme W&AT!) from Yr 13 to graduation and first year of employment (University of Auckland, Unitec, MIT, Massey, Auckland University of Technology) | Ongoing implementation measures of Programme W&AT! including engagement of five universities |
| Q1-Q4: Review and refresh Health Could B4U Programme, including increasing the number of schools engaged (target = 15 schools) | Revised Health Could B4U Programme |
| Q1-Q2: Review Ko Awatea Scholarships Programme from ‘end-to-end’ including scope, eligibility criteria, review processes, interviewing, acceptance and support to Pacific students receiving Ko Awatea scholarships | Review completed |
| Engage Pacific Health Development Workforce Manager as panel assessor for scholarships | Number of Pacific students receiving Ko Awatea scholarships |
| Q1-Q4: Support Pacific Midwifery Students to be awarded scholarships for Year 2-3 | Number of Pacific Midwifery students awarded scholarships |
| By Q1: Employ and engage 1 FTE Pacific Midwife / Clinical Educator to provide academic support and mentoring for Pacific students | Number of Pacific Midwifery students on support pathway |
| Q1-4: Work with HR team to co-design, develop, and implement the values-based recruitment strategy organisation-wide, with ethnicity-specific targets to increase Pacific workforce | Number of Pacific Midwifery students employed by CMDHB |
| Q1-Q4: Deliver tailored workplace literacy and numeracy programme [TEC funded] targeting 350 Pacific and Maori employees | Number of Pacific people employed by CMDHB |

Number of Pacific staff and community health workforce engaged in programme
# 7.1.2 CVD Risk Assessment & Management

Cardiovascular Disease (CVD) is the leading cause of death in CM Health. People with CVD and diabetes are associated with high level of health care costs and have a significant impact on the health and social and economic wellbeing of Pacific patients and fanau. Focus on the prevention and cardiovascular disease, screening for CVD risk and appropriate management of CVD, including diabetes and alongside other chronic health conditions such as gout is important for Pacific.

Opportunistically linking the CVDRA, primary care providers will be encouraged to include other screening (e.g. Diabetes, Gout, Hepatitis B) as part of their business-as-usual.

<table>
<thead>
<tr>
<th>5.3.1 Percentage of eligible population who have had their cardiovascular risk assessed in the last five years</th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>92.3%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.3.2 Percentage of eligible population who have a risk greater than 20%</th>
<th>Baseline to be established</th>
<th>Not yet established</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3.3 Percentage of eligible population who have a risk greater than 20% and are on dual therapy</td>
<td>Baseline to be established</td>
<td>70%</td>
</tr>
</tbody>
</table>

**Who will we work with?**
- Northern Region Cardiac Network
- Primary Care and Secondary Care clinicians and Clinical Champions
- Integrated Care Clinical Governance Group
- CM Health IPIF Working Group

**Actions**

**Q2:** Work closely with Pacific churches and community groups who have linkages to primary care to encourage Pacific patients to have a CVD risk assessment with appropriate follow up.

**Q1:** Utilisation of electronic decision support tools to ensure Pacific receive evidence based care

**Q1:** Active recall of all Pacific patients with a CVD risk >10% by text and phone calls

**Q1:** Pacific patients with a CVD risk >20% will be prescribed triple therapy

**Q1:** Pacific patients with a low to high risk will be offered a referral to a culturally appropriate Self-Management Education group

**Q1:** Utilisation of culturally appropriate resources on topics such as healthy eating in Samoan and Tongan

**Q1:** Shared management decisions based on discussions between clinicians and Pacific patients

**Q1:** Address transport barriers and time barriers by offering support with accessing primary care through the provision of weekend and after-hours clinics

**Q2:** Implementation of communication training for primary care staff to support trusting and effective relationships including patient led decision making and goal setting via the At Risk Individuals Quality Improvement programme

**Monitoring Processes**

Quarterly reporting to ELT, ALT, MoH (data from PHO monthly reports)

Monthly CVD risk assessment data sent by the PHOs to the DHB by ethnicity

Weekly monitoring at PHO level of practice performance

Monthly data evaluation at DHB and PHO level

Monthly reporting to CPHAC, ELT and Board

Quarterly reporting to the MoH

Monitoring of DHB performance by the Northern Region Cardiac Network members
### 7.1.3 Diabetes Management

As prevalence, morbidity and mortality rates from diabetes are higher for Pacific and Māori than other groups, targeted initiatives are required to address the risk factors for the development of diabetes, improve identification of people with diabetes, implement virtual reviews between primary and secondary care, increase screening, and improve management of diabetes, particularly to achieve good glycaemic control.

Living Well with Diabetes 2015-2020 is a plan for people at high risk of or living with diabetes. Key to the plan is the Diabetes Care Improvement Package (DCIP) which been redesigned to focus on those who have been identified as having poor glycaemic control and implementing a range of interventions, including access to allied health, retinal screening, green prescription and self-management education.

Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance which will be improved through application of a quality improvement approach and Diabetes Work Plan with specific actions and deliverables.

Integration with key services, including podiatry, retinal screening, health psychology and other social services will be important in order to achieve better health outcomes.

Five Diabetes Indicators will be reported by Pacific ethnic group so performance can be monitored and analysed with the aim of increasing equity.

The At Risk Individual Programme will also be integral to the improvement of diabetes management. The ARI programme measures process, including enrolments of Pacific patients into the programme, interventions provided, and outcomes such as glycaemic control.

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1 HbA1c Glycaemic control:</td>
<td>TBA</td>
<td>80</td>
</tr>
<tr>
<td>Percentage of enrolled patients with diabetes (aged 15 to 75 years) who have good or acceptable glycaemic control with HbA1c ≤64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4.2 Blood pressure control:</td>
<td>TBA</td>
<td>80</td>
</tr>
<tr>
<td>Percentage of enrolled patients with diabetes (aged 15 to 74 years) whose latest systolic blood pressure measured in the last 12 months is &lt;140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4.3 Management of Microalbuminuria:</td>
<td>TBA</td>
<td>90</td>
</tr>
<tr>
<td>Percentage of enrolled patients with diabetes (aged 15 to 74 years) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Who will we work with?**
- Northern Region Diabetes Network
- Primary Care and Secondary Care clinicians and Clinical Champions
- Integrated Care Clinical Governance Group
- Diabetes Service Level Alliance Team
- Diabetes Projects Trust

**Monitoring Processes**
- Service level reporting
- Quarterly reporting to Diabetes SLAT, ELT, ALT & MoH

**Actions**
- Q1: Implement a new targeted model of care through the Diabetes Care Improvement Package, to focus on patients with poor glycaemic control to improve their HbA1C levels; lower their blood pressure and reduce the risk of renal damage due to unmanaged microalbuminuria through treatment with medication.
- Q1: Implementation of a diabetes collaborative with a selected group of practices (practices with large numbers of patients with poorly controlled diabetes will be targeted) to test new models of care
- By Q4: Increase Pacific referrals and access to:
  - Podiatry services
  - Retinal screening services
  - Green Prescription

**Measures**
A range of measures will be included in the Diabetes Care Improvement Package
7.1.4 Lotu Moui and Pacific community engagement

Lotu Moui will undergo a refresh to explore how community engagement may better reflect the changing demographics of Pacific communities with particular reference to:

- Broader reach and diversity of faith based organisations where Pacific people attend church outside the existing Lotu Moui group;
- Some segments of the Pacific population access a broader range of ‘community’ e.g. sports clubs and networks, ethnic specific community groups
- Pacific populations concentrated in key geographic areas may benefit from a ‘place based’ and concentrated focus of community organising approaches that supports mobilisation and civil action in localities.

### 5.4.1 Expanded reach of Pacific communities and groups

<table>
<thead>
<tr>
<th>2015/16 Baseline</th>
<th>2016/17 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>200</td>
</tr>
</tbody>
</table>

### 5.4.2 Community Organising:

Through an expanded Lotu Moui, community organising tools will be spread through to additional networks of Pacific people in Mangere/Otara

**Who will we work with?**
- Locality networks of clinical and provider partnerships
- Primary Care and Secondary Care clinicians and Clinical Champions
- Pacific churches, community networks and groups

**Monitoring Processes**
- Quarterly reporting to ELT

**Actions**
- Q1: Complete Lotu Moui refresh and relaunch programme including priority areas for capability building
- Q2/3/4 Delivery of agreed capability programmes in the community (e.g. financial and health literacy)
- Q1: Evaluation of Community Organising Tools and agree target group for spread

**Measures**
- Number of Lotu Moui events providing capability action for Pacific communities
- Rate of satisfaction and leadership to action from events

By Q4: Pacific communities increased civil action and effort to achieve one improvement in community settings that enable healthy choices to be the easy choice
### 7.1.5 Working in the Pacific Oceania Region

Counties Manukau Health acknowledges the strong connections of its Pacific population with their islands, and has supported the development of healthcare systems in a number of Pacific Island Nations over the past decade including Niue, the Cook Islands, Samoa, Fiji, and Kiribati. Support has included coordinating overseas referrals of patients, Visiting Medical Specialists; clinical training such as neonatal, infection control, radiology; health governance and management support including health policy advice, strategic development, and evaluation; and emergency response through the NZ Medical Assistance Team.

CM Health has developed excellent collaborative partnerships with these nations and remains committed to contributing to improving the health and wellbeing outcomes of their people and communities.

| 5.4.1 Implementation of current development contracts with Niue, Cook Islands, Samoa, Fiji and Kiribati | As agreed in contract | As agreed in contract |
| 5.4.2 Expanded programme with additional countries: Through an expandedLotu Moui, community organising tools will be spread through to additional networks of Pacific people in Mangere/Otara | 5 | 7 |

**Who will we work with?**
- MFAT and other Development Aid Donors
- Country healthcare system leaders
- Partner organisations in New Zealand

**Monitoring Processes**
- Reporting as required by MFAT and donors

<table>
<thead>
<tr>
<th>Actions</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>By Q4: successful delivery of contracts as agreed with MFAT and development donors in Pacific countries; By Q4 measureable satisfaction of delivery as reported by countries.</td>
<td>MFAT, Donor and Pacific country satisfaction and completion measures as set out in contracts.</td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Community & Public Health Advisory Committee
Primary Health & Community Services Directorate

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

Glossary of Terms

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;D / AOD</td>
<td>Alcohol and Drug</td>
</tr>
<tr>
<td>ARI</td>
<td>At Risk Individuals</td>
</tr>
<tr>
<td>CHSI</td>
<td>Community Health Services Integration</td>
</tr>
<tr>
<td>DCIP</td>
<td>Diabetes Care Improvement Package</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HOP</td>
<td>Health of Older People</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>NHC</td>
<td>National Hauora Coalition</td>
</tr>
<tr>
<td>NZQA</td>
<td>New Zealand Qualification Authority</td>
</tr>
<tr>
<td>PATHS</td>
<td>Providing Access to Health Solutions Programme</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>POAC</td>
<td>Primary Options to Acute Care</td>
</tr>
<tr>
<td>THO</td>
<td>Total Healthcare PHO</td>
</tr>
</tbody>
</table>

Executive Summary

- The Accident Compensation Corporation has confirmed a three year funding package from 1 July 2016 to help address falls prevention in Counties Manukau. This funding will support general practices to screen all people over 75 years living in the community (and Maaori and Pacific Island people aged between 65-74 years with a fall related claim in the previous 12 months) to identify older people who are at risk of falls due to poor balance and muscle weakness. Those identified will be referred to a group or home based strength and balance programme. The funding will also provide physiotherapy resource to locality community teams.

- There is a final push to achieve all health targets for Quarter four. We are working closely with Primary Health Organisations who are confident they will achieve the targets for Quarter four. We are maintaining a strong focus on those areas with a lower than expected performance. Resource and activity are being directed at priority groups of women for cervical screening. Strategies have been implemented to engage with Maaori men in relation to improving coverage of More Heart and Diabetes checks. The Counties Manukau Smokefree advisor is ensuring that Primary Health Organisations are utilising all of the tools they have to improve Better Help for Smokers to Quit. Maaori babies who are our lowest immunisation group are being referred to Kaiawhina in Plunket or the Well Child Tamariki Ora and Mokopuna Ora nurses for follow up if their immunisation has been delayed by families.
The Counties Manukau Children’s Team is progressing well with a total of 51 referrals received in its first two months of operation. The main referrers have been Health and Education. The ethnic make-up of referrals is 57% Maaori, 27% NZ European, 6% Pacifica, 4% Indian and 5% not stated. The breakdown by age has been 31% of referrals for children aged zero to five, 63% for ages six to 15 and 6% for those aged 16 to 18.

Winter planning is well advanced with various communication strategies rolling out across Counties Manukau. Winter wellness brochures have been distributed, presentations have been given at various community networks, and community expos and road shows have been held with good feedback received. Flu vaccinations have had a good uptake and a pilot has commenced with a small number of Pharmacies offering flu vaccinations for subsidised customers. Reablement is progressing well with all four Localities now involved. 212 Patients are enrolled and 169 patients have transitioned from Reablement. Reablement training and the streamlining of pathways continues as part of a continuous improvement programme.

Responses to Action Items

Actions and Responses

CPHAC Meeting 30.9.2015 – Health Targets
It was noted that at the Finance & Audit Committee meeting this morning they talked about making the train and bus station areas at Middlemore smokefree and that Auckland Transport will be approached so our entire campus, including the stations are smokefree. There was talk in the past from Auckland Council (through the Southern Initiative) about having a ‘smokefree precinct’ from Manukau City centre out in a large rectangle however, nothing has come of this yet. It was noted that we should work collaboratively with other agencies (ie) Auckland Council, Kiwi Rail, NZ Police so we are all promoting the same message. We all live in the same space and should interact where and when we can.

Resolution
That the Board determine how we can ensure a smokefree precinct which includes all of the Middlemore campus including the rail and bus stations.

Moved: Ms Sandra Alofivae Seconded: Ms Colleen Brown Carried: Unanimously

The Counties Manukau Health Living Smokefree Team are key stakeholders working with the Auckland Council in the review of their Smokefree Policy. The policy review has commenced and stakeholder interviews were undertaken in March 2016. Key findings and messages from various consultation rounds and advisory groups are:

1. Evidence shows that Council’s voluntary Smokefree Policy needs strengthening (currently low compliance, low awareness and high confusion)
2. Council has strong grounds and a range of legal mechanisms to strengthen their Smokefree Policy through bylaws and smokefree conditions in leases, licences, grants and contracts.
3. Smokefree bylaws have been successfully adopted overseas, have been highly effective and easy to enforce without the need for fines.
4. Aucklanders support a smokefree bylaw and want a clear and consistent approach across Auckland.
5. Sufficient Council budget and comprehensive communication and engagement are necessary to ensure effective implementation of the Smokefree Policy regionally.

The Social Policy and Bylaws team will complete a Smokefree Policy review report by June 2016. The primary outcomes of Auckland Council’s Smokefree Policy Review are:

1. Recommendations for improved effectiveness of the existing policy
2. Identify any additional areas of support Council can provide to reach the 2025 Smokefree goal

Council have also updated their Improved Compliance Model.

We will continue to support and work collaboratively at this level and progress conversations regarding the Middlemore Train Station and Bus stops accordingly.
4.2 National Health and Integrated Performance & Incentives Framework Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>15/16 Target</th>
<th>15/16 Q1</th>
<th>15/16 Q2</th>
<th>15/16 Q3</th>
<th>April 16</th>
<th>On Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Heart and Diabetes Checks</td>
<td>90%</td>
<td>92.1%</td>
<td>92.1%</td>
<td>92.0%</td>
<td>89.9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit</td>
<td>90%</td>
<td>86.9%</td>
<td>87.6%</td>
<td>88.6%</td>
<td>85.3%</td>
<td>Improvement required</td>
</tr>
<tr>
<td>Increased immunisations - 8 months</td>
<td>95%</td>
<td>93.6%</td>
<td>94.7%</td>
<td>94.2%</td>
<td>93.6%</td>
<td>Improvement required</td>
</tr>
<tr>
<td>Increased immunisations - 24 months</td>
<td>95%</td>
<td>95.2%</td>
<td>96.0%</td>
<td>95.9%</td>
<td>95.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>Cervical screening coverage (resident population)</td>
<td>80%</td>
<td>72.6%</td>
<td>73.2%</td>
<td>74.4%</td>
<td>74.4%</td>
<td>Improvement required</td>
</tr>
</tbody>
</table>

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

Performance for More Heart and Diabetes Checks, and Better Help for Smokers to Quit has dropped significantly in April 2016 due to the changes in the Primary Health Organisation register enrolments, which have altered the eligible populations, with ProCare particularly affected. This is expected at the start of each quarter.

We are working closely with the Primary Health Organisations, who are confident that their results will increase by the end of this quarter. Performance for the 24 month immunisation targets is tracking well however performance for the eight month immunisation target has decreased due to a drop in performance from both ProCare and Total Healthcare. We are maintaining a strong focus on meeting the cervical screening target, with resource and activity directed at priority group women and Primary Health Organisations with lower than expected performance. Coverage for Pacific women in the district has met the target for the first time.

More Heart and Diabetes Checks

<table>
<thead>
<tr>
<th>PHO</th>
<th>2016-Q1</th>
<th>2016-Q2</th>
<th>2016-Q3</th>
<th>Apr-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Health Plus</td>
<td>93.0</td>
<td>94.1</td>
<td>94.3</td>
<td>90.6</td>
</tr>
<tr>
<td>East Health</td>
<td>91.7</td>
<td>91.2</td>
<td>90.6</td>
<td>90.6</td>
</tr>
<tr>
<td>NHC</td>
<td>89.7</td>
<td>89.8</td>
<td>89.7</td>
<td>87.7</td>
</tr>
<tr>
<td>ProCare</td>
<td>93.2</td>
<td>92.8</td>
<td>92.6</td>
<td>89.7</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>89.8</td>
<td>90.5</td>
<td>90.8</td>
<td>89.3</td>
</tr>
<tr>
<td>CMDHB</td>
<td>92.1</td>
<td>92.1</td>
<td>92.0</td>
<td>89.9</td>
</tr>
<tr>
<td>National</td>
<td>89.7</td>
<td>90.0</td>
<td>90.3</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
<td>90.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

April-16 results are provisional only, based on calculations from Primary Health Organisation data. Quarterly data for Primary Health Organisations is Ministry of Health published.
Final More Heart and Diabetes Checks 2016 Quarter three results are now available. For Maaori, preliminary results were 88.2%, 92.3% for Pacific, and 92.7% for other ethnicities. Overall Counties Manukau Health was at 92.0%, ranked second out of all DHBs nationally. Counties Manukau Health received good feedback on this. The Ministry noted that “it is encouraging to see your innovative focus on priority populations for early identification and risk factor management.”

Engagement has begun with the Ministry regarding the national Cardio Vascular Disease Guidelines update.
Better Help For Smokers To Quit

<table>
<thead>
<tr>
<th></th>
<th>Historical Quarters</th>
<th>Current Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-Q1</td>
<td>2016-Q2</td>
</tr>
<tr>
<td>PHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>85.0</td>
<td>87.1</td>
</tr>
<tr>
<td>East Health</td>
<td>86.3</td>
<td>83.9</td>
</tr>
<tr>
<td>NHC</td>
<td>83.7</td>
<td>80.9</td>
</tr>
<tr>
<td>ProCare</td>
<td>88.5</td>
<td>89.4</td>
</tr>
<tr>
<td>Total Healthcare</td>
<td>86.3</td>
<td>87.8</td>
</tr>
<tr>
<td>CMDHB</td>
<td>86.9</td>
<td>87.6</td>
</tr>
<tr>
<td>National</td>
<td>83.2</td>
<td>85.0</td>
</tr>
<tr>
<td>Target</td>
<td>90.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

April-16 results are provisional only, based on calculations from Primary Health Organisation data. Quarterly data for Primary Health Organisations is Ministry of Health published.

Better Help for Smokers to Quit reports on unadjusted numbers from 1 July 2015.

Primary Health Organisations continue to work with their low performing practices and providing additional resources to support these practices. The Counties Manukau Health Smokefree advisor – Primary Care is working closely with Primary Health Organisations to ensure that all strategies in the Ministry’s ‘toolkit’ for this target have been considered including:

- Involving reception in updating contact details and targeted smoking questionnaires,
- Ensuring that practices are aware of the Counties Manukau Health centralised referral service for cessation support, and
- Offering practices Smokefree training/refreshers regularly.

**Immunisations**

The Immunisation target for June 2016 requires 95% of all eligible children aged eight months, twenty-four months and five years of age to have completed their scheduled course of immunisations. Where immunisation is delayed by families they are referred to the Clinical Nurse Specialist then the Outreach Immunisation Service team.

This is particularly important for Maaori babies as our lowest immunisation group by ethnicity who may have their immunisation delayed and immunise late, or decline late. We are referring to the Kaiawhina in Plunket or the Well Child Tamariki Ora and Mokopuna Ora nurses for follow-up conversations to make sure whanau have as much information as possible to make a decision.

We are also conducting an audit of all practices to ensure that immunisation appointments are available at parent’s convenience for access with babies and preschool children. We are noting increasing demand for Saturday appointments, and the current Manukau SuperClinic Saturday clinic for Before School checks continues to offer outreach immunisations where required for hard to reach families including the four years immunisation and any siblings who require to be immunised.
Counties Manukau Health is well positioned to achieve the target for eight months currently at 93.6%, and twenty-four months immunisation currently at 95.6%. However Maaori babies continue to lag for eight months immunisation at 88.1%. This is due to 15 babies not being immunised in April by their due date and these babies are being followed up.

The five Months immunisation milestone (which includes the four years immunisation) is undergoing renewed focus and our result is still lagging at 84% for April and 75% at 12 months data. This is an improvement over the last quarter as we have included the five year milestone in overdue reporting to practices and are getting faster turnaround of the response plan of Completed, Declined, Referred-to-Outreach. The four year immunisation is included as a focus in Before School checks and we have printed a sticker to go on all Well child / Before School pamphlets to remind parents and caregivers to go to their family doctor / GP for the free four year immunization.

**Eight months Immunisations coverage**

Current data for eight months immunisation to 30th April shows 93.6% achievement, with Maaori at 88.1%, Pacific at 96.2% and Asian at 95.4%. Coverage by locality shows Franklin is under target at 91.3%
Table Four: CM Health PHO eight month Immunisations Performance Total Population to April 2016

<table>
<thead>
<tr>
<th>Historical Quarters</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO</td>
<td></td>
</tr>
<tr>
<td>2016-Q1</td>
<td>2016-Q2</td>
</tr>
<tr>
<td>Alliance</td>
<td>93.7</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>94.3</td>
</tr>
<tr>
<td>NHC</td>
<td>96.7</td>
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<tr>
<td>ProCare</td>
<td>95.2</td>
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<tr>
<td>THO</td>
<td>96.5</td>
</tr>
<tr>
<td>Target</td>
<td>95.0</td>
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There is a three month data lag on National Performance due to national data assurance requirements.

Trend shows improvement in NHC and Total Healthcare.

Twenty-four months Immunisations coverage

Current data for 24 Months immunisation to 30th April shows 95.6% achievement, with Maaori at 93.9%, Pacific at 98.1% and Asian at 97.4%, with a drop in Others at 92.4%. Coverage by locality shows Franklin is under target at 90.9%.
Table Five: CM Health PHO 24 Month Immunisations Performance Total Population to April 2016

<table>
<thead>
<tr>
<th>PHO</th>
<th>historical Qtrs</th>
<th>current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-Q1</td>
<td>2016-Q2</td>
</tr>
<tr>
<td>Alliance</td>
<td>92.6</td>
<td>93.3</td>
</tr>
<tr>
<td>East Health Trust</td>
<td>94.0</td>
<td>95.6</td>
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<tr>
<td>NHC</td>
<td>92.6</td>
<td>92.5</td>
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<tr>
<td>ProCare</td>
<td>94.4</td>
<td>95.8</td>
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<tr>
<td>THO</td>
<td>95.7</td>
<td>96.8</td>
</tr>
<tr>
<td>Target</td>
<td>95.0</td>
<td>95.0</td>
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Three month data lag on National Performance due to national data assurance requirements
Quarterly trend shows improvement overall for twenty-four month immunisations particularly in NHC and Alliance

Cervical Screening – Total Population three year Coverage

<table>
<thead>
<tr>
<th>PHO</th>
<th>historical Qtrs</th>
<th>current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016-Q1</td>
<td>2016-Q2</td>
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<tr>
<td></td>
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<tr>
<td>NHO 'Enrolled' population</td>
<td>76.1%</td>
<td>76.6%</td>
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<tr>
<td>'Resident' population</td>
<td>72.6%</td>
<td>73.2%</td>
</tr>
<tr>
<td>National Performance</td>
<td>76.6%</td>
<td>76.7%</td>
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</table>

Source:
From Quarter two quarterly data has been provided by the Ministry IPF team. Using the monthly datamatch reports sent to the PHOs we anticipate being able to provide monthly reports from June 2016.
From February 2016 the National Cervical Screening Programme has used prioritised ethnicity and domicile recorded on the National Health Index instead of the previously sourced demographic information from the National Cervical Screening Programme Register for women aged 25-69 years and resident in CMDHB. As a result, performance for the DHB as a whole and in particular Maaori, Pacific and Asian ethnicities has improved.

Three-year coverage for Pacific women in the Counties Manukau Health area has now reached the target, at 80.1%. Overall coverage is slowly increasing and is now at 74.4%. It is difficult to predict whether the target will be reached by 30 June 2016. A significant amount of work continues in Primary Health Organisations to improve systems/processes and coverage for their enrolled women. In particular, Total Healthcare (who is currently the lowest performing Primary Health Organisation) is investing significant resource into daily monitoring of cervical screening output and whether opportunistic screening has been carried out for women presenting to clinics who are due.
4.3 Primary Health

After hours services update

Primary Health Organisations and District Health Boards are continuing their work together to advance planning for after hours services. More detailed modelling and risk profiling is being completed to ensure the service model is effective, affordable, accessible and equitable.

Palliative Care – Innovations Fund

Hospices have now received feedback on the hospice-led Innovations Fund service development proposals that were submitted for evaluation in March 2016. The national evaluation panel informed hospices and District Health Boards that none of the seven proposals submitted from the metro Auckland region were approved for implementation. The panel noted that while a number of the proposals had merit, the overall process in the region lacked coordination leading to a lack of clarity about whether proposals would be regional or district-specific, who the service partners would be and how the funding would be allocated. A workshop to refine and better coordinate the proposals process will be held in late May with participation from hospices of Auckland, District Health Boards and the Ministry of Health. Members of the Counties Manukau Health Palliative Care Clinical Working Group will also attend the session. Prior to the workshop, Counties Manukau Health, Totara and Franklin hospices will work together on a collaborative approach to inform next steps.

Accident Compensation Corporation and Counties Manukau Health Falls Prevention Initiative

Falls are the most common and costliest cause of injury in older people.1 Around 30% to 60% of people aged ≥ 65 years fall each year and 10% to 20% of those events result in injury such as hip fracture hospitalisation or death. Falls are an independent predictor of premature admission to aged related residential care, even if there is no injury.2 For many older people, a fall results in a dramatic loss of independence and confidence.3

The Accident Compensation Corporation has confirmed a three-year funding package at $408,202 per annum, from 1 July 2016 to help address falls prevention in Counties-Manukau.

The available funds will be used in two important ways:

1. To support general practices to screen all community dwelling people aged 75 years and older (and Maaori and Pacific Island people age 65-74 years with a fall-related Accident Compensation Corporation claim in the previous 12 months)
2. To resource locality community teams with additional physiotherapy resource.

General practice screening will identify which older people are at risk of falls, in relation to poor balance and muscle weakness. Those identified as being at risk of falls will then be referred by the general practice to either:

• An Accident Compensation Corporation credentialed strength and balance community group programme or

---
- A home based individually tailored strength and balance programme.

General Practitioners tell us they want to be able to refer older community dwelling people to credentialed local strength and balance training programmes that are effective at lowering falls risk, or have the option of a home-based programme for those unable to attend a group based programme. These options therefore address a current service need. It is expected that the programme will be implemented early in the 2016/17 financial year.

**Regional Clinical Pathways Programme**

*Static pathways*

The Auckland Region community membership of the HealthPathways (Canterbury model) was completed in December 2014. Progress to date includes:
- Alignment of the 54 pathway developed through Greater Auckland Integrated Health Network (2011-2014) to the new site
- Localisation of an additional 94 pathways from the HealthPathways content
- Localisation of an additional 105 pages of information including referrals to secondary services, regional programs i.e. Healthy Homes.

**Utilisation**
- 2654 clinicians registered for access since go live on 24th August 2015
- 59,078 pages viewed over this time
- returning visitor rate of 73%.

*Dynamic pathways*

The pilot in 92 practices has completed.
- 1982 patients were enrolled on a pathway
- 461 clinicians utilised the pathways across the target of 92 practices.

The Business Case for further development of Pathways over the next three years has been presented and endorsed by various stakeholder groups. The static element of the business case has been approved and the dynamic element will be presented to Boards in April/May.
4.4 Progress with Systems Integration

Quality and Safety – Safety in Practice

April has seen Roadshows delivered across the Primary Health Organisation’s about the Year three programme which commences in July 2016. We are introducing two new care bundles which are: Reliable management of chronic obstructive pulmonary disease patients and Reliable system for managing Cervical Smears.

A short presentation, video and pamphlet on Safety in Practice Year three has been well received by the Primary Health Organisations and General Practices as a brief introduction to the programme and all are available on the Safety in Practice website, www.kowatea.co.nz

We are delighted that the Year two Safety in Practice programme has delivered excellent results with increased number of General Practices and real change in clinics and for patients. As seen by graphs below for March 2016 there is improvement in compliance with all care bundles. Currently we are discussing with Green Cross Health for community pharmacy to link with the work of the care bundles.
Reablement

Reablement training is set for the middle of May for all four Community Health Teams and members of the Very High Intensive Users team. The Otara/Mangere locality will commence Reablement as of 18 May 2016.

The Community Health Team’s will have sufficient clinicians trained to meet the Reablement demand from inpatient services. Meetings have been held with the Home and Community Support Providers to ensure their ability to meet demand. Three of the four providers believe they will have sufficient capacity with one provider limited for larger support packages especially at weekends. The employment of Community Health Assistants in Franklin will alleviate this risk.

Enrolment onto the Reablement pathway continues to be streamlined with the Acute and Post Acute nursing team leading this for Medicine.

Reablement Service Dashboard

Supporting individuals to ‘do things for themselves, rather than having things done for them’.

Dashboard # 5: April 2016

Reablement Approach Snapshot

212 Patients Enrolled
169 Transitioned From Reablement

Reablement Enrolments by Gender
Female 64%
Male 36%

Number of Reablement Referrals & Enrolments by Ethnicity
Pacific 32
Maori 16
Asian 31
European 182

% of Enrolments compared with % Share of CM Health Est. Population

Referrals to Reablement by Locality
Community Central

Planning is well advanced to co-locate Community Central with Primary Options for Acute Care. A service development manager has been appointed to lead the implementation of the centralised service which has commenced with combined referral and triage across the four localities.

Mobility tablets with new clinical notes software, access to Concerto and email have been distributed to 20 clinical staff, with further roll out planned over the next period. All locality community teams will have received their mobile working solution by 15 June 2016. Staff feedback has been extremely positive –

“Today when I was out doing my home visits for Reablement and Rapid Response I was able to email my notes to APAC about a patient of concern. I was able to apply for short term POAC supports while I was at a patient’s house as well as order the urgent equipment that was required for them. I was also able to look up the clinic notes while out and about as well as check if somebody was in hospital when they didn’t answer the door. Just thought you might my first day's feedback as it made life really easy.”

The capacity release as a result of utilising the mobility solution will be monitored closely, with capacity being redirected to support the reablement response.
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:

- **19,299**
  Patients benefiting from ARI programme

- **60,000**
  Patients with a long term condition in Counties Manukau

- **19,802**
  Shared care plans
  Patients with a goal based care plan that is electronically shared with the care team members.

- **427**
  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:

- **19,299**
  Patients with a shared care plan

- **50,000**
  People living with long term conditions in our will receive self management support by December 2016

- **30,000**
  Patients per year enrolled in ARI programme by July 2017

- **30,000**
  People living with long term conditions in our will receive self management support by December 2016

For further information www.countiesmanukau.health.nz/integrated-care
4.5 Locality Reports

Eastern Locality

1. Acute Demand

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<tbody>
<tr>
<td>1.1 Unplanned readmissions (28 days)</td>
<td>6.6%</td>
<td>6.4%</td>
<td>6.4%</td>
<td>6.9%</td>
<td>7.5%</td>
<td>5.7%</td>
<td>6.3%</td>
</tr>
<tr>
<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>0.9</td>
<td>1.0</td>
<td>1.2</td>
<td>0.9</td>
<td>0.7</td>
<td>0.8</td>
<td>1.9</td>
</tr>
<tr>
<td>1.3 Average bed day usage in last 6 months of life</td>
<td>11.1</td>
<td>9.3</td>
<td>11.2</td>
<td>10.1</td>
<td>6.2</td>
<td>7.7</td>
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2. Quality

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<tbody>
<tr>
<td>2.1 Children fully immunised at 8 months (Target = 90%)</td>
<td>95.8%</td>
<td>96.2%</td>
<td>95.5%</td>
<td>96.7%</td>
<td>96.8%</td>
<td>96.3%</td>
<td>94.8%</td>
</tr>
<tr>
<td>2.2 Children fully immunised at 24 months (Target = 95%)</td>
<td>95.1%</td>
<td>95.6%</td>
<td>96.7%</td>
<td>97.2%</td>
<td>97.2%</td>
<td>96.1%</td>
<td>95.4%</td>
</tr>
<tr>
<td>2.3 Middlemore Radiology &lt; 6 week wait time for GP Referrals</td>
<td>94.1%</td>
<td>86.6%</td>
<td>94.9%</td>
<td>89.9%</td>
<td>91.3%</td>
<td>90.5%</td>
<td>92.0%</td>
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3. Shared Accountability Services

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<tbody>
<tr>
<td>3.1 ED presentations not admitted</td>
<td>243</td>
<td>228</td>
<td>279</td>
<td>279</td>
<td>288</td>
<td>251</td>
<td>3152</td>
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<td>3.2 Acute medical bed days</td>
<td>1307</td>
<td>1384</td>
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<td>1104</td>
<td>1479</td>
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<td>3.3 Acute casemix-funded non-medical bed days</td>
<td>953</td>
<td>971</td>
<td>1020</td>
<td>889</td>
<td>776</td>
<td>883</td>
<td>12291</td>
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<td>3.4 Medical outpatient attendances</td>
<td>1985</td>
<td>2008</td>
<td>1736</td>
<td>1692</td>
<td>1931</td>
<td>2107</td>
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4. Other

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</thead>
<tbody>
<tr>
<td>4.1 E-referrals as % of all referrals</td>
<td>28.3%</td>
<td>29.4%</td>
<td>29.8%</td>
<td>33.5%</td>
<td>33.7%</td>
<td>35.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>4.2 Medical Outpatient DNA rate</td>
<td>3.6%</td>
<td>4.3%</td>
<td>2.8%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>3.4%</td>
<td>9.5%</td>
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Performance

The Eastern Locality as a whole continues to have a total of 3,867 patients enrolled on the At Risk Individual programme with a shared care plan. This has increased by 280 over the month. The Eastern Locality has enabled 3.4% of its enrolled population to benefit from being enrolled on the At Risk Individuals programme. As this percentage is still lower than the other three localities the Locality Clinical Advisory Group have committed to undertaking a major review of how the programme can be used, and in what groups, to ensure the clinical benefits of the programme are driven through this group.

The Eastern Community Health Team (not including the Needs Assessment Service) provided 2,143 face to face patient contacts, with a combined caseload of 1,516 patients across the team.

Centralised Interdisciplinary triage continued throughout April, ensuring all referrals were centrally triaged before being forwarded to each base as part of the Community Central roll out, an extension of this will take place in June 2016.

A stocktake of the allied health services provided across Counties Manukau Health and East Health Primary Health Organisation has been completed, agreeing ways of integrated working, and the skill set required to ensure unnecessary lengthy waits are eliminated, particularly for physiotherapy and occupational therapy.
Work with the short term home care provider who is supporting the reablement model in the Eastern Locality continued in March/April to ensure, that workforce and the systems required are in place for increased activity to support early supported discharge/ reablement from May 2016.

**Strategic**

**Accident & Medical service provision**

The aim is to deliver extended Accident and Medical provision to a wider cohort of patients, who are currently being referred onto the Middlemore Emergency Department from the Eastern Locality. If successful this approach will be extended to the other localities once the model of care has been tested. The scope and costs for adapting the facilities is underway.

Identification of the indicative conditions and potential volumes has been developed to allow a clinical audit of emergency department presentations to be completed by the Emergency Department Senior Medical Officer allocated to this project. The Clinical Stakeholder group has been formed to recommend clinical parameters and staffing model.

**Locality Hub Development**

Preparation for site planning event with master planner took place. It is planned to have a proposal to the Board for approval in August 2016.

**Falls Prevention**

We continue to make progress with Active Plus (the Ministry of Health funded rehabilitation provider) and with the Accident Compensation Corporation on a comprehensive, community based falls prevention approach for older people as well as the Fracture Liaison Service
Franklin Locality

1. Acute Demand

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<tbody>
<tr>
<td>1.1 Unplanned readmissions (28 days)</td>
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<td>7.2</td>
<td>8.3</td>
<td>13.0</td>
<td>17.0</td>
<td>21.5</td>
<td>18.3</td>
<td>10.8</td>
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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.

2. Quality

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<td>112</td>
<td>145</td>
<td>145</td>
<td>114</td>
<td>124</td>
<td>1500</td>
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<tr>
<td>3.2 Acute medical bed days</td>
<td>811</td>
<td>753</td>
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<td>793</td>
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<td>525</td>
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<td>589</td>
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<tr>
<td>3.4 Medical outpatient attendances</td>
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Note: All SAS volumes for previous months may change as IDF updates are received and coding is modified.

4. Other

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<td>2.4%</td>
<td>7.9%</td>
<td>9.5%</td>
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Reducing Unplanned Admissions/ Self-Management

Winter Planning

- Approx. 6,000 winter wellness packs have been prepared and distributed to various locations across the Locality.
- Flu Vaccination has had a good uptake at Pukekohe Hospital with over 100 vaccinations completed using our peer vaccinator. In addition twenty-five local home based support workers have also taken up the offer of the vaccination and education session developed by the winter planning team.
- The roadshows have commenced this month with the General Practitioner Lead and Rapid Response team visiting all general practices in the Locality plus the Drury GP Practice (located in Manukau Locality).
- The five targeted schools for the Winter Plan have their pyjama orders in and will be running the colouring in / design a logo competition over the next month. This doubles as in introduction to the Warm-up insulation service.
- Three local pharmacists, who are accredited, are piloting offering flu vaccinations for subsidised customers. Reporting and recording has been approved back to the local General Practice.
- Auckland third year nursing students, under the mentorship of the Locality Operations Manager, have developed a programme on safe sneezing for children that will be used in our winter campaign next year.
Services Closer to Home

Dementia Pathway Outreach Pilot - Waiuku Health Centre

- 30 patients have now been enrolled on the Dynamic Pathway at the Pilot Practice with a number on the waiting list.
- The group is exploring the possibility of the development of a Memory Clinic led by a primary care General Practitioner with Special Interest, with support from Memory Team, Community Geriatrician and Psychiatrist. This would assist primary care capacity to identify and manage mild cognitive impairment and assist secondary services and support a wider role out of the dynamic cognitive pathway.

Locality Hub Planning

- We are developing a concept design with the assumptions from the completed planning work for developments at Pukekohe Hospital. This will continue to progress to a wider stakeholder workshop and architect design during May 2016.

Mental Health Service and Social Services Integration

- A follow up meeting with the mental health team was held, they are currently visiting all GP Practices in Franklin to familiarise themselves with the geography and the current services provided and what primary care identify as their priorities.
- A wider community and a co-design stakeholder meeting will be held next month to discuss the future model of care.

Key Indicators

- As with the rest of Counties Manukau Health there was a marked increase in Emergency Department presentations in March in Franklin. This resulted in an increase in acute admissions in our 80+ year’s population but not in the zero to four’s (though zero to 14 admissions did increase). North Pukekohe was identified as an area with a disproportionately high presentation rate. There was no increase in respiratory admissions pointing to other causation.
- Primary Options for Acute Care referrals were down, as were referrals to Rapid Response, most especially from primary care.
Mangere/Otara Locality

1. Acute Demand

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<td>1.2 ASH rate (per 1,000 enrolled patients)</td>
<td>2.5</td>
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<tr>
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3. Shared Accountability Services

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<td>3.1 ED presentations not admitted</td>
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<td>686</td>
<td>735</td>
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<td>3.4 Medical outpatient attendances</td>
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<td>2341</td>
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Community Integrated Self-Management Support Initiative

The community-provider stakeholder group continues to drive the self-management support service improvement plan. A stakeholder group meeting is scheduled for 24th May to table the Terms of Reference and draft strategic plan.

Integrated Service Delivery

a) Community Integrated Health & Social Service Initiative: A Steering Group continues to drive the whole of system service design and development process of an integrated model of care.

b) Community Integrated Foot Care: The Diabetes Service Level Alliance Team has endorsed the Work Plan for Podiatry activity over the coming 12 months. The Locality action is to plan a Practice Nurse Diabetes Foot Check training session with a podiatrist. Planning is underway.

c) Diabetes Care Improvement Package: Eight General Practices in the Locality have enrolled in the Diabetes Care Improvement Package Collaborative with a view to improvement in the management of people with diabetes.

d) Community Health Team: Workforce changes are underway to integrate service provision and extend services to include Reablement, Early Supported Discharge, Rapid Response and Community Central. Recruitment of a number of positions for new staff have been advertised.
e) **Multidisciplinary Team Meetings:** Meetings number nineteen per month hosted by General Practices in either a practice specific or cluster based meetings. There is regular attendance by General Practitioners, Practice Nurses, Social Workers, Pharmacists, Senior Medical Officers and Clinical Nurse Specialists.

**Shared Service Hubs**
The detailed design of shared service hubs in Mangere and Otara has started is well advanced.
Manukau Locality

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Self-Management Collaboratives

Diabetes Collaborative

Summary of Progress

- 133 patients discussed at Multi-Disciplinary Team meetings to date
- Of the patients with more than one HbA1c recorded, 43% have had >10% reduction in HbA1c (shown in graph below)
• Due to limited resources only one Multi-Disciplinary Team meeting was held in April at Papakura Marae. It was the first Multi-Disciplinary Team meeting held there and it went very well. The Locality Senior Medical Officer has been doing weekly clinics at the Marae so the Multi-Disciplinary Team meeting is an important extension of this to ensure integration and practice team development rather than just having clinics provided on site.

• A survey has been drafted to gain feedback from practice staff about the experience of the Multi-Disciplinary Team meeting and how they think it might be improved. This will be sent out via survey monkey this month.

Huff and Puff Collaborative

The Huff and Puff collaborative, in conjunction with the Quit Bus is targeting people with a desire to stop smoking with resources and direct contact with a Quit Bus team member.

Spirometry testing is being used to engage smokers in a discussion about quitting.

Reablement

The Locality Care Coordinators are now meeting fortnightly for Peer Review. Their clinical support network is growing and lead clinicians for Occupational Therapist, Physiotherapist, Needs Assessment and Service Co-ordination, Very High Intensive Users team and more recently Community Stroke and Rehabilitation, have joined this fortnightly meeting.

Patients on the Reablement programme are benefiting from additional support at home and many are transitioning off the programme sooner than expected.

Winter Wellness Campaign –Focussing on Manurewa

Focus on the campaign to date has been on the distribution of Information sheets, posters and HealthLine magnets. The approach for this year has been to provide these resources to individuals who have the opportunity to discuss the brochure content with Patients/Clients/Consumers and families. A “hand and understand” approach as opposed to relying on people to choose to read the written material.

To date over 20,000 Winter Wellness information sheets have been distributed to over 80 government and not for profit health and social service organisations.

Opportunities for winter wellness presentations at Community Network meetings have been considerable and to date Manukau Locality has presented at the Manurewa and Papakura Community Network meetings along with the Community Service Network meeting on the Winter Wellness campaign. As a result of the presentations a wide range of Health and Social service organisations have offered to share resources with their consumers.

The Locality will also provide a presentation to the Papatoetoe Community Network when the Locality hosts this network meeting in the Lambie Drive office on 9th June. Grey Power has also requested a presentation for July.

• Age Concern will be including the Winter Wellness brochures to in its quarterly newsletter mail out (2000 members)
• Fanau Ola high risk patients (4000 individuals)
• Enliven (1200 info sheets)
• WINZ (700 info sheets and HealthLine Magnets)
Community Expos in Manukau Locality

Manukau Locality is working with Community Expos in health promotion, in particular, around sharing the Winter Wellness messages.

Clendon Community Expo Thursday 28th April

With minimal resource, and the support of a volunteer the locality got a lot of value out of the Clendon Community Expo and networked with some key organisations who are keen to share our Winter Wellness Messages including organisations such as Family Start, Enliven, Pregnancy Care, Frame Work, PORSE, Arthritis NZ and others. This Expo also provided opportunities to discuss the upcoming Manukau Locality Health and Social service integration workshop for Manurewa/Clendon and again there was good interest in this event.

The voting activity as usual around preferred health services over winter months, was used to engage attendees along with a competition “Guess how many Kiwi fruit in the basket?” (Large basket with over 100 large Kiwi fruit). The winner won the basket of Kiwi fruits which incidentally had a police escort home, as it was won by the wife of a local policeman.

Papakura Marae Expo Thursday 18th May

The Locality will have a Winter Wellness stand at the Papakura Marae Community Services expo and will be supported by Respiratory nurse specialists and Health science graduates (volunteering) focusing on sharing Winter Wellness messages and raising the awareness of treatment and prevention of Respiratory disease at the community level.

Health Literacy Collaborative with English Language Partners

A recent meeting with management of the NZ English Language Partners in Papatoetoe led to Health literacy support for 120 home tutors working for the organisation. This visit was initially around sharing the Winter Wellness message and it became an opportunity for collaboration with an education service which is keen to support clients in improving their health care.

As a result ‘Health Quality and Safety Commission” resources have been arranged for each home tutor including a set of template forms for support people with limited literacy to get optimal outcomes from their General Practice visits. The organisation also included a Winter Wellness message in its monthly newsletter.
University of Auckland Student Nurse Community Protect

Three Bachelor of Nursing students from University of Auckland will commence on a community project in Manukau Locality from 12th May. This project will provide a stock take of self-management resources in Manukau Locality.
4.6 Child, Youth and Maternity Services

Maternity

The development of the Mokopuna Ora pregnancy and parenting education programme has commenced. The Mokopuna Ora curriculum supports pregnancy and parenting preparation and has been developed with a specific focus on engagement and uptake by Māori and teenage parents to be. This curriculum will complement the current Tapuaki curriculum which was devised for our Pacifica community. The delivery of the programme will be locality focused and therefore accessible to a wider cohort. The curriculum information available to pregnant women and parents to be is also supported by a website and a mobile app so delivery of the education can be accessed by a variety of methods.

Sudden Unexplained Death of Infant

We continue to make progress with implementation of the Sudden Unexplained Death of Infant Action Plan and the Safe Sleep Policy. The Safe Sleep audits continue weekly in all birthing units, post-natal wards, neonatal, Kidz First medical and surgical, and are conducted weekly to check safe sleeping position for baby and safe sleep education to mothers and care-givers.

We are still providing baby beds to whānau identified as requiring access to a safe sleep space for their infant/s within a high risk environment. We provide average of 30 baby beds with a bedding pack each month which are funded via philanthropic sponsorship.

Well Child Tamariki Ora

The Well Child Tamariki Ora quality improvement project continues in Counties Manukau Health to focus on the key indicators where improvement is needed. These include:

- Enrolment of new born babies in General Practice and Well Child Tamariki Ora Providers by two weeks to enable General Practitioner six week check and immunisation and well child provider first core check between four and six weeks. All Well Child Tamariki Ora providers are also focussing on collaboration with Lead Maternity Carers/ midwives to enable earlier transfer of care after baby is born, and joint care planning where required from late pregnancy.
- Enrolment in oral health services at five months of age aligned to provision of healthy nutrition advice for first foods and good oral hygiene. This will also enable appointment for the child at twelve months for their first dental examination to assist with the prevention of early childhood caries in baby teeth.
- Supporting exclusive breast-feeding at milestone ages two weeks, six weeks, three months, and at six months. This includes training in breast-feeding education in collaboration with Te Rito Ora, and providing additional support to whānau.

Te Rito Ora – Community Breastfeeding Support

The Te Rito Ora community pilot is fully operational providing breastfeeding and baby feeding support to Mums and whānau in Manurewa and Papakura through a peer support programme, drop-in baby feeding clinics, and community based lactation consultant service. The Ministry of Health have indicated that the funding for the service will be extended for a further one to two years, enabling the service to be extended into the full Manukau locality and Mangere/Otara locality. The service delivery model for the expanded service is being finalised.

Before School Checks

Before School checks are conducted in Counties Manukau by Plunket and Well Child Tamariki Ora 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).

We are well-positioned to meet target by 30 June as year to date a total of 7,044 checks have been completed and 2,974 of these are Quintile five.

Saturday outreach clinics at the Manukau SuperClinic are still proving to be very popular for our community. Due to the success we now provide a range of universal services including the delivery of the four year immunisations and Well Child core checks.

Caregivers and whaanau have provided overwhelming feedback regarding the convenience of a one stop shop. Future plans are to open the adjacent Browns Road dental clinic on Saturday to enable the dental catch-up at four years where children may not have attended prior appointments.

**Children’s Team**

The Counties Manukau Children’s Team is into its second month of operation. Referrals have been steady with a total of 51 received to date. The two main referrers have been Health and Education.

Of the 51 referrals received, six were declined, four escalated to Child, Youth and Family and the remaining two were considered below the threshold. The ethnic make up of referrals is 57% Māori, 27% NZ European, 6% Pacifica, 4% Indian and 5% not stated.

The breakdown by age has been 31% of referrals for children aged zero to five, 63% for those aged six to fifteen and 6% for those aged sixteen to eighteen.

The Local Governance Group are pleased with progress to date and will continue to monitor the implementation of the programme.

**Mana Kidz**

The Mana Kidz programme is currently being delivered in a third of Primary and Intermediate schools in Counties Manukau. Approximately 25,000 children (>95% of whom are Māori and Pacific) aged five to 12 years have access to the Mana Kidz programme which includes a throat swabbing service to identify and treat Group A streptococcal throat infections in order to prevent rheumatic fever. The programme is currently targeted at schools with students at greatest risk of developing Rheumatic Fever. Mana Kidz resulted in 14,380 Group A streptococcal positive swabs being treated last year in students attending Mana Kidz schools and their household contacts. In addition, 16,279 skin conditions were identified and managed. The Ministry of Health has reported a 53% reduction in Rheumatic Fever rates in Counties Manukau since the beginning of the rheumatic fever prevention programme.

The latest data released from Auckland Regional Public Health Service indicates a further reduction for the first quarter of the calendar year, compared with previous years.

**Cumulative ARF Initial Attack Notifications by Admission Month in 0-19 year olds, CM Health**
Oral Health

Counties Manukau contract the Auckland Regional Dental Service to deliver District Health Board funded oral health services for children aged zero to 12 years old at our community and District Health Board based clinics and mobile dental facilities. Governance is through monthly service metrics reports, annual oral health outcome reports, and regional meetings.

Due to vacancies, limited additional appointment capacity, decommissioning of ageing and non-compliant facilities, and our growing patient group in the Counties Manukau area, the arrears (volume of children not seen on time for their annual check-up) increased to 19% and 16,768 enrolled children. We are discussing a resolution plan with the Auckland Regional Dental Service to address this situation with urgent actions to increase appointments capacity through increased hours at dental clinics and trial of Saturday at Browns Road Dental Clinic, and resolve the replacement of the decommissioned facilities.

Youth Health

The comprehensive and integrated school-based health service at Papakura High School will commence in full on 1st July 2016. The onsite General Practice clinic and services to the Alternative Education Activity Centre commenced in early May. A co-design exercise is underway with staff and students.

The quality improvement initiative for primary care is underway and the Youth Health Quality Improvement Advisor commenced on 4th April. The initiative involves an audit and improvement programme for general practices to improve their ‘youth friendly’ capability. All Primary Health Organisations are engaged and practices are being approached to participate in the initiative. The project is aligned with existing quality improvement initiatives in primary care such as At Risk Individuals and Safety in Practice.

The District Health Board is undertaking a Request for Proposals for health services delivered in Child, Youth and Family Care and Protection and Youth Justice residences. The chosen provider will commence on the 1st July 2016.
4.7 Mental Health and Addictions

Service Access Rates and Waiting Times

Total clients seen by DHB of Domicile, Ethnicity - All

Annual unique Counties Manukau Health resident access rates to Programme for Integrated Mental Health Data (PRIMHD) reporting mental health services from February 2015 to January 2016 (NGO & DHB services). Note that there is a 3 month report lag due to national data assurance requirements.

This Ministry of Health performance measure provides a view on the whole of population access to specialist mental health and addiction services.

Clients seen by Organisation Type, Ethnicity - All

Total number of unique CMH residents seen by Programme for Integrated Mental Health Data (PRIMHD) reporting mental health and addiction services by service type from February 2015 to January 2016.
Counties Manukau are currently meeting all targets for Alcohol and Drug wait times across services. Waiting times reflect the length of time between the day when a client is referred to a service and the day when the client is first seen by the service.

Refugees as Survivors Update

Refugees as Survivors New Zealand are the lead mental health agency for all incoming United Nations quota refugees entering New Zealand. Under international humanitarian conventions, Refugees as Survivors New Zealand also delivers specialist mental health services for asylum seekers either in detention or with cases before the Refugee Appeals Authority.

The National Refugee Intake Centre is based in Mangere, a one stop shop, delivered by several agencies including Immigration New Zealand, the Red Cross and Refugees as Survivors New Zealand. Refugees and their families reside at the centre for approximately six weeks. During this time they are supported to acclimatise to their new environment and to establish relevant health, education and social support networks that will better enable them to transition into the community.

Following the New Zealand Government’s agreement to increase the annual quota of refugees in response to the crisis in Syria, Counties Manukau Health and the Ministry of Health have worked to identify the additional service provision and associated funding needed in order to support the increased volume of refugees accessing the service. A contract increase of approximately 30% has been agreed to ensure the needs of this group are met.

Whole of System Integration Update

The next stage for the integration transformation agenda is to better develop our understanding around the needs of our population and how an integrated model of care could function. This work
will form a core component of the implementation plan, and will be the focus of our next phase of co-design with stakeholders.

The initial co-design engagement process clearly identified the importance of easily accessible, local services and supports that take an integrated approach to physical and mental wellbeing. The emphasis on this direction provides a strong alignment with the broader Counties Manukau Health integration focus across the localities and an opportunity to engage in wider work on the development of locality hubs and clusters. The design and development of integrated mental health and addiction teams will explore the range of service functions that could be accessible within each locality, e.g. clinical assessment, care planning, consult liaison, skills development, support with social inclusion etc., and how the teams will work alongside primary care and other health professionals to provide early intervention and access, whilst continuing to care for those with severe and complex needs.
4.8 Adult Rehabilitation and Health of Older People

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.

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.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Clients</th>
<th>w/InterRAI</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>1072</td>
<td>934</td>
<td>87.1%</td>
</tr>
<tr>
<td>Franklin</td>
<td>674</td>
<td>667</td>
<td>99.0%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>590</td>
<td>573</td>
<td>97.1%</td>
</tr>
<tr>
<td>Manukau</td>
<td>1496</td>
<td>1444</td>
<td>96.5%</td>
</tr>
<tr>
<td>CM Health</td>
<td>3832</td>
<td>3618</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

Needs Assessment Service Co-ordination

NASC by locality referral to complex assessments within five days:

<table>
<thead>
<tr>
<th>Domicile Locality</th>
<th>01/03/2015</th>
<th>01/04/2015</th>
<th>01/05/2015</th>
<th>01/06/2015</th>
<th>01/07/2015</th>
<th>01/08/2015</th>
<th>01/09/2015</th>
<th>01/10/2015</th>
<th>01/11/2015</th>
<th>01/12/2015</th>
<th>01/01/2016</th>
<th>01/02/2016</th>
<th>01/03/2016</th>
<th>1 Mth Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>52.0%</td>
<td>82.8%</td>
<td>74.2%</td>
<td>60.0%</td>
<td>47.4%</td>
<td>40.0%</td>
<td>46.7%</td>
<td>56.0%</td>
<td>42.0%</td>
<td>36.4%</td>
<td>10.8%</td>
<td>32.0%</td>
<td>11.1%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Franklin</td>
<td>58.4%</td>
<td>65.0%</td>
<td>75.0%</td>
<td>81.0%</td>
<td>58.8%</td>
<td>81.0%</td>
<td>61.0%</td>
<td>47.0%</td>
<td>32.0%</td>
<td>30.0%</td>
<td>41.1%</td>
<td>76.9%</td>
<td>75.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Mangere/Otara</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>
<td>50.0%</td>
<td>60.0%</td>
<td>54.5%</td>
<td>60.0%</td>
<td>100.0%</td>
<td>60.0%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Manukau</td>
<td>37.0%</td>
<td>50.0%</td>
<td>67.3%</td>
<td>57.4%</td>
<td>52.1%</td>
<td>53.0%</td>
<td>58.0%</td>
<td>60.0%</td>
<td>66.7%</td>
<td>46.7%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>57.6%</td>
</tr>
<tr>
<td>CM Health</td>
<td>100.0%</td>
<td>50.0%</td>
<td>100.0%</td>
<td>50.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

NASC by locality referral to non-complex assessments within 15 days:

<table>
<thead>
<tr>
<th>Comm Domicile Locality</th>
<th>01/03/2015</th>
<th>01/04/2015</th>
<th>01/05/2015</th>
<th>01/06/2015</th>
<th>01/07/2015</th>
<th>01/08/2015</th>
<th>01/09/2015</th>
<th>01/10/2015</th>
<th>01/11/2015</th>
<th>01/12/2015</th>
<th>01/01/2016</th>
<th>01/02/2016</th>
<th>01/03/2016</th>
<th>1 Mth Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>65.4%</td>
<td>43.5%</td>
<td>56.3%</td>
<td>50.0%</td>
<td>42.9%</td>
<td>32.1%</td>
<td>42.9%</td>
<td>31.8%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>27.3%</td>
<td>54.5%</td>
<td>63.2%</td>
<td>46.8%</td>
</tr>
<tr>
<td>Franklin</td>
<td>61.5%</td>
<td>30.0%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>66.7%</td>
<td>31.3%</td>
<td>51.6%</td>
<td>75.0%</td>
<td>46.7%</td>
<td>50.0%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>54.1%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>53.0%</td>
<td>44.4%</td>
<td>40.0%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
<td>43.9%</td>
<td>42.6%</td>
</tr>
<tr>
<td>Manukau</td>
<td>46.2%</td>
<td>28.9%</td>
<td>56.7%</td>
<td>62.5%</td>
<td>65.5%</td>
<td>40.0%</td>
<td>51.4%</td>
<td>54.5%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Outside CMDHB</td>
<td>62.0%</td>
<td>63.3%</td>
<td>75.0%</td>
<td>100.0%</td>
<td>75.0%</td>
<td>5.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>71.9%</td>
</tr>
</tbody>
</table>

The manual snapshot of the complex data was analysed to understand referral to assessment timeframes, which identified a gap in the standardised process for contacting and calling patients back. This is a significant barrier to meeting the timeframes and options to address this are currently being explored.

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

<table>
<thead>
<tr>
<th>Domicile Locality</th>
<th>01/03/2015</th>
<th>01/04/2015</th>
<th>01/05/2015</th>
<th>01/06/2015</th>
<th>01/07/2015</th>
<th>01/08/2015</th>
<th>01/09/2015</th>
<th>01/10/2015</th>
<th>01/11/2015</th>
<th>01/12/2015</th>
<th>01/01/2016</th>
<th>01/02/2016</th>
<th>01/03/2016</th>
<th>1 Mth Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>32.6%</td>
<td>37.7%</td>
<td>58.0%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Franklin</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Mangere/Otara</td>
<td>53.0%</td>
<td>44.4%</td>
<td>40.0%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Manukau</td>
<td>46.2%</td>
<td>28.9%</td>
<td>56.7%</td>
<td>62.5%</td>
<td>65.5%</td>
<td>40.0%</td>
<td>51.4%</td>
<td>54.5%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
</tr>
<tr>
<td>CM Health</td>
<td>56.8%</td>
<td>45.5%</td>
<td>54.3%</td>
<td>57.8%</td>
<td>48.1%</td>
<td>32.6%</td>
<td>51.1%</td>
<td>57.0%</td>
<td>46.8%</td>
<td>33.3%</td>
<td>42.9%</td>
<td>58.7%</td>
<td>63.3%</td>
<td>52.0%</td>
</tr>
</tbody>
</table>

Community Health Service Integration - Reablement

Further work with Community Health teams has identified that key roles to improve the identification of reablement patients in the hospital is needed. Clear clinical criteria are being
refined to be used by hospital liaison roles to ensure clear handover to reablement team and community central. Collection of early data is currently being explored as part of this pilot.

**Community Specialists Health of Older People Teams (reported quarterly)**

During the month of March the Community Geriatric Service team continued to provide support to multiple Primary Care practices and residential care providers. 28 aged residential care facility staff attended the March education forum; which was focused on Continence Management.

**Community Geriatric Services**

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

**<15 Potentially Avoidable Admissions**

April 2016 saw 84 Aged Related Residential Care Clients present to Emergency Care. Of these, 19 presentations were falls related and 10 were potentially avoidable admissions.

**Memory Team (Dementia Care Pathway)**

Twenty six patients have now been enrolled on the dynamic pathway at the pilot Practice with a number on the waiting list. The six-month review of the pilot has been completed and discussed at the working group meeting. The Waiuku Health Centre has been chosen and the team agreed to the practice piloting the collection of outcome measures through the Nexxt pathway.

The Project Manager met with the Chief Medical Advisor to Primary Care to discuss issues relating to the pilot, in particular, support for roll out of the Nexxt Cognitive Impairment Pathway in other Counties Manukau Health regional practices, as appropriate.

**Memory Team (Dementia Care Pathway) Activity April 2016:**

<table>
<thead>
<tr>
<th>April 2016</th>
<th>Number of referrals (all for cognitive assessment this month)</th>
<th>79</th>
<th>1044 cumulative accepted referrals (June 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number declined (due to out of Memory team catchment area)</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals managed by Memory Team</td>
<td>34</td>
<td>43% (target 30%)</td>
<td></td>
</tr>
<tr>
<td>Referrals from General Practice</td>
<td>20</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td>454</td>
<td>From 29 GP Practices</td>
<td></td>
</tr>
<tr>
<td>Caseload – open cases</td>
<td>224</td>
<td>Cases deemed appropriate to keep open for future action. MT monitor and close as appropriate</td>
<td></td>
</tr>
<tr>
<td>Caseload – active cases</td>
<td>103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cases under Alzheimer’s Auckland</td>
<td>121</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clinicians</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis made</td>
<td>448 – total dementia, 224 - total non-dementia diagnosis</td>
<td>672</td>
<td></td>
</tr>
</tbody>
</table>
4.9. Intersectoral Initiatives

Warm Up – Counties Manukau (Retrofitting Home Insulation Project)

Warm Up Counties Manukau is a free home insulation programme that retrofits insulation into the homes of low income families with high health needs. This programme is funded and delivered through a working partnership between the Energy Efficiency Conservation Authority, Autex Industries Limited, Installed (formerly known as The Insulation Company), Counties Manukau Health and the Middlemore Foundation. We insulate the homes of low-income families with health issues that may be related to housing, creating ‘healthier homes’ which are more energy efficient, thus ensuring that the home contributes to the health of the family. In addition, we offer a comprehensive health and social assessment for participating families to ensure that they are accessing appropriate health and social services. This approach ensures that we can address both housing and health issues.

Referral Generation

Counties Manukau Health is responsible for referral generation. Families/households can self-refer or may have the programme suggested to them by their health professional. We target the programme through information accompanying outpatient clinic appointments and by working in partnership with health professionals, government agencies, the non-government sector and the local community.

Project Outcomes for the Warm up – Counties Manukau Project (1 July 2015-30 April 2016)

<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>13</td>
</tr>
<tr>
<td>January 2016</td>
<td>67</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>February 2016</td>
<td>58</td>
<td>88</td>
<td>34</td>
</tr>
<tr>
<td>March 2016</td>
<td>67</td>
<td>118</td>
<td>36</td>
</tr>
<tr>
<td>April 2016</td>
<td>61</td>
<td>27</td>
<td>74</td>
</tr>
<tr>
<td><strong>Total number of referrals generated to date</strong></td>
<td><strong>1117</strong></td>
<td><strong>714</strong></td>
<td><strong>312</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.
Self-identified ethnicity by household for the current financial year (total referrals received 1 April 2016 – 30 April 2016):

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number of referrals</th>
<th>Percentage of total referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>11</td>
<td>14%</td>
</tr>
<tr>
<td>European</td>
<td>25</td>
<td>31%</td>
</tr>
<tr>
<td>Indian</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Maori</td>
<td>12</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Pacific</td>
<td>22</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

Programme Status

The Warm Up-Counties Manukau programme is currently on hold as we have no funding to continue with installing insulation into homes. We were unsuccessful in gaining additional funding from the Energy Efficiency Conservation Authority which would have enabled us to continue the programme until the 30th of June 2016.

We are awaiting the outcome of the upcoming Government budget on May 26th 2016 which will determine whether the retrofitting insulation programmes will be funded post June 2016.

Social Housing Training Session

A successful training session on Social Housing was undertaken at Ko Awatea on the 27th of April. The session was undertaken in conjunction with the Housing Assessment Team from the Ministry of Social Development. The session was attended by over 75 staff including Social Workers and a range of Allied Health staff. The session resulted in the establishment of a joint process with the Ministry of Social Development to assist our clients’ access social housing.

The Providing 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 Providing Access to Health Solutions 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>January 2016</td>
<td>6</td>
</tr>
<tr>
<td>February 2016</td>
<td>12</td>
</tr>
<tr>
<td>March 2016</td>
<td>11</td>
</tr>
<tr>
<td>April 2016</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total Number</strong></td>
<td><strong>134</strong></td>
</tr>
</tbody>
</table>
4.10 Finance Report

Summary

Primary & Community Services had a small favourable variance to budget for March of $348k and favourable $1,024k YTD.

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

Service Development and Primary Care (YTD favourable $629k)

“At Risk Individuals” programme interventions budget underspend due to a slow start in claiming, $324k. Also Diabetes ophthalmology retinal screening volumes are down $147k.

Planning & Funding – Governance (YTD $277k unfavourable)

Community Health Service Integration implementation costs not budgeted have been covered as planned by Health of Older People, Aged Residential Care and Home Based Support Services underspend (see below).

Health of Older People (YTD $766k 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 Care – Non Government Organisation/Demand Driven (YTD $291k unfavourable variance)

Most negative expenditure variances have been offset by additional revenue as seen in the revenue variance. They mostly relate to Under 13 MoH funding/spend not budgeted. Most of the net variance relates to unbudgeted Non Government Organisation contracts put in place to help achieve national health targets.

Localities (YTD $238k favourable variance)

A mix of overspends more than netted off by underspends. Overspends in Home Healthcare budgets driven by what has been a busy spring with higher acuity from supported hospital discharge, high staff illness, and higher use of casual nursing staff. Supported discharge also has a high cost impact on clinical supplies. Fortunately these have largely been offset by underspends in Mangere facility lease cost delays and Needs Assessment Service Co-ordination vacancies.
## CPHAC Financial Report
### As at 31 March 2016

<table>
<thead>
<tr>
<th>Service Development &amp; Primary Care</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>Revenue</td>
<td>2,071</td>
<td>2,103</td>
<td>(32)</td>
<td>18,665</td>
<td>18,926</td>
<td>(261)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>2,003</td>
<td>2,172</td>
<td>169</td>
<td>18,666</td>
<td>19,546</td>
<td>890</td>
</tr>
<tr>
<td>Contribution</td>
<td>68</td>
<td>(69)</td>
<td>137</td>
<td>9</td>
<td>(620)</td>
<td>629</td>
</tr>
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<th>Intersectorial</th>
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<td>Revenue</td>
<td>70</td>
<td>73</td>
<td>(2)</td>
<td>641</td>
<td>654</td>
<td>(13)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>68</td>
<td>69</td>
<td>1</td>
<td>597</td>
<td>622</td>
<td>25</td>
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<tr>
<td>Contribution</td>
<td>3</td>
<td>4</td>
<td>(1)</td>
<td>44</td>
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<table>
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<tr>
<th>Child, Youth &amp; Maternity</th>
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<tbody>
<tr>
<td>Revenue</td>
<td>692</td>
<td>597</td>
<td>95</td>
<td>5,977</td>
<td>5,369</td>
<td>608</td>
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<tr>
<td>Expenditure</td>
<td>1,034</td>
<td>905</td>
<td>(129)</td>
<td>9,247</td>
<td>8,089</td>
<td>(438)</td>
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<td>Contribution</td>
<td>(342)</td>
<td>(309)</td>
<td>(34)</td>
<td>(3,270)</td>
<td>(3,440)</td>
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<table>
<thead>
<tr>
<th>Localities</th>
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<tr>
<td>Revenue</td>
<td>83</td>
<td>111</td>
<td>(27)</td>
<td>1,073</td>
<td>995</td>
<td>78</td>
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<td>Expenditure</td>
<td>1,236</td>
<td>1,258</td>
<td>22</td>
<td>11,071</td>
<td>11,231</td>
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<tr>
<td>Contribution</td>
<td>(1,153)</td>
<td>(1,148)</td>
<td>(5)</td>
<td>(9,998)</td>
<td>(10,236)</td>
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<table>
<thead>
<tr>
<th>Planning &amp; Funding - Governance</th>
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<td>78</td>
<td>78</td>
<td>0</td>
<td>78</td>
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<tr>
<td>Expenditure</td>
<td>253</td>
<td>190</td>
<td>(63)</td>
<td>2,062</td>
<td>1,707</td>
<td>(356)</td>
</tr>
<tr>
<td>Contribution</td>
<td>(175)</td>
<td>(190)</td>
<td>15</td>
<td>(1,984)</td>
<td>(1,707)</td>
<td>(277)</td>
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<table>
<thead>
<tr>
<th>P&amp;C Savings Programme</th>
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</thead>
<tbody>
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<td>Revenue</td>
<td>0</td>
<td>29</td>
<td>(29)</td>
<td>175</td>
<td>263</td>
<td>(88)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(989)</td>
<td>(850)</td>
<td>139</td>
<td>(7,517)</td>
<td>(7,653)</td>
<td>(136)</td>
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<tr>
<td>Contribution</td>
<td>989</td>
<td>879</td>
<td>110</td>
<td>7,692</td>
<td>7,915</td>
<td>(223)</td>
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</table>

<table>
<thead>
<tr>
<th>Primary Care - NGO/Demand Driven</th>
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<tbody>
<tr>
<td>Revenue</td>
<td>17,842</td>
<td>17,177</td>
<td>664</td>
<td>157,600</td>
<td>154,597</td>
<td>3,003</td>
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<tr>
<td>NGO Contract Expenditure</td>
<td>958</td>
<td>929</td>
<td>(29)</td>
<td>8,481</td>
<td>8,363</td>
<td>(118)</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>8,523</td>
<td>8,523</td>
<td>0</td>
<td>77,260</td>
<td>76,707</td>
<td>(553)</td>
</tr>
<tr>
<td>PHO/GMS/PNS</td>
<td>7,530</td>
<td>6,931</td>
<td>(599)</td>
<td>64,999</td>
<td>62,379</td>
<td>(2,619)</td>
</tr>
<tr>
<td>Other</td>
<td>786</td>
<td>777</td>
<td>(9)</td>
<td>6,996</td>
<td>6,992</td>
<td>(4)</td>
</tr>
<tr>
<td>Contribution</td>
<td>45</td>
<td>17</td>
<td>28</td>
<td>(136)</td>
<td>155</td>
<td>(291)</td>
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</table>

<table>
<thead>
<tr>
<th>Health of Older People</th>
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</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>8,737</td>
<td>8,512</td>
<td>225</td>
<td>76,833</td>
<td>76,608</td>
<td>225</td>
</tr>
<tr>
<td>LTS - CHC</td>
<td>326</td>
<td>345</td>
<td>20</td>
<td>3,113</td>
<td>3,109</td>
<td>(3)</td>
</tr>
<tr>
<td>Home Based Support Services</td>
<td>1,805</td>
<td>1,651</td>
<td>(154)</td>
<td>14,537</td>
<td>14,857</td>
<td>320</td>
</tr>
<tr>
<td>Rest Homes</td>
<td>1,790</td>
<td>1,784</td>
<td>(7)</td>
<td>15,978</td>
<td>16,054</td>
<td>77</td>
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<tr>
<td>Private Hospitals</td>
<td>4,293</td>
<td>4,276</td>
<td>(16)</td>
<td>38,451</td>
<td>38,487</td>
<td>35</td>
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<tr>
<td>Other</td>
<td>408</td>
<td>439</td>
<td>31</td>
<td>3,839</td>
<td>3,952</td>
<td>112</td>
</tr>
<tr>
<td>Contribution</td>
<td>115</td>
<td>17</td>
<td>98</td>
<td>914</td>
<td>149</td>
<td>766</td>
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<table>
<thead>
<tr>
<th>Mental Health</th>
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</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>3,872</td>
<td>4,539</td>
<td>(667)</td>
<td>34,935</td>
<td>40,849</td>
<td>(5,914)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>3,852</td>
<td>4,519</td>
<td>667.0</td>
<td>34,760</td>
<td>40,674</td>
<td>5,914.1</td>
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<tr>
<td>Contribution</td>
<td>19</td>
<td>19</td>
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<td>175</td>
<td>175</td>
<td>(0)</td>
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</table>

<table>
<thead>
<tr>
<th>Total Primary &amp; Community</th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Revenue</td>
<td>33,445</td>
<td>33,140</td>
<td>305</td>
<td>295,977</td>
<td>298,259</td>
<td>(2,283)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>33,876</td>
<td>33,919</td>
<td>43</td>
<td>302,531</td>
<td>305,838</td>
<td>3,307</td>
</tr>
<tr>
<td>Total Contribution</td>
<td>(431)</td>
<td>(779)</td>
<td>348</td>
<td>(6,554)</td>
<td>(7,578)</td>
<td>1,024</td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board

5.0 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:

<table>
<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>
</table>
| 6.1 After Hours Services Verbal Update    | 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. | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [NZPH&D Act 2000 Schedule 3, S32(a)] |
| 6.2 Minutes of CPHAC meeting 13 April 2016 with public excluded | 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. | Confirmation of Minutes
For the reasons given in the previous meeting. [NZPH&D Act 2000 Schedule 3, S32(a)] |
| 6.3 Action Items Register Confidential    | 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. | Confirmation of Action Items Register
For the reasons given in the previous meeting. [NZPH&D Act 2000 Schedule 3, S32(a)] |