COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)
Wednesday, 14 June 2017

Venue: Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland
Time: 9.00am

Committee Members
Colleen Brown – Committee Chair
Dr Ashraf Choudhary – CMDHB Board Member
George Ngatai – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Katrina Bungard – CMDHB Board Member
Rabin Rabindran – CMDHB Board Member
Apulu Reece Autagavaia – CMDHB Board Member

CMDHB Management
Gloria Johnson – acting Chief Executive
Benedict Hefford – Director Primary Community and Integrated Care
Margie Apa – Director Population Health Strategy and Investments
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dinah Nicholas - Secretariat

APOLOGIES

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

PART 1 – Items to be considered in public meeting

AGENDA

1. AGENDA ORDER AND TIMING
Page No.

2. CONFIRMATION OF MINUTES

9.05am
2.1 Confirmation of Previous Minutes of the Community and Public Health Advisory Committee Meeting – 3 May 2017
2.2 Action Items Register

3. BRIEFING PAPERS

9.15am
3.1 Q3 Population Health Plans 2016-17 (Margie Apa)
9.30am
3.2 Auckland Region Public Health Service Update (Jane McEntee)
10.00am
3.3 Manukau Locality (Lynda Irvine)
11.00am
3.4 System Level Measure Framework (Kate Dowson/Benedict Hefford)

11.30am 4. RESOLUTION TO EXCLUDE THE PUBLIC
Page No.

Morning Tea Break (10.45 – 11.00am)
<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>Feb</th>
<th>22 Mar</th>
<th>April</th>
<th>3 May</th>
<th>14 June</th>
<th>26 July</th>
<th>August</th>
<th>6 Sept</th>
<th>18 Oct</th>
<th>29 Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashraf Choudhary (Deputy Chair)</td>
<td>No Meeting</td>
<td>No Meeting</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleen Brown (Chair)</td>
<td>No Meeting</td>
<td>No Meeting</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Ngatai</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katrina Bungard</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabin Rabindran</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reece Autagavaia</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Appointee TBC</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend: ✔️ = Present, X = Absent
## CPHAC MEMBERS
### DISCLOSURE OF INTERESTS
#### 14 June 2017

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Colleen Brown (CPHAC Chair)                | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, 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 |
| Dr Ashraf Choudhary (CPHAC Deputy Chair)    | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| 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  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group |
| George Ngatai                               | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Board Member, Manurewa Marae  
• Huakina Development Trust (Partnership Clinic)  
• Community Organisation Grants Scheme (Auckland)  
• Lotteries Community (Auckland) |
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katrina Bungard</td>
<td>• Chairperson MECOSS – Manukau East Council of Social Services.</td>
</tr>
<tr>
<td></td>
<td>• Deputy Chair Howick Local Board</td>
</tr>
<tr>
<td></td>
<td>• Member of Amputee Society</td>
</tr>
<tr>
<td></td>
<td>• Member of Parafed disability sports</td>
</tr>
<tr>
<td></td>
<td>• Member of NZ National Party</td>
</tr>
<tr>
<td>Rabin Rabindran</td>
<td>• Chairman, Bank of India (NZ) Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director, Auckland Transport</td>
</tr>
<tr>
<td></td>
<td>• Director, Solid Energy NZ Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director, Swift Energy NZ Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director, Swift Energy NZ Holdings Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director, Kowhai Operating Ltd</td>
</tr>
<tr>
<td></td>
<td>• Director, NZ Liaoning International Investment &amp; Development Co Ltd</td>
</tr>
<tr>
<td></td>
<td>• Singapore Chapter Chairman – ASEAN New Zealand Business Council</td>
</tr>
<tr>
<td>Reece Autagavaia</td>
<td>• Member, Pacific Lawyers’ Association</td>
</tr>
<tr>
<td></td>
<td>• Member, Labour Party</td>
</tr>
<tr>
<td></td>
<td>• Member, Tangata o le Moana Steering Group</td>
</tr>
<tr>
<td></td>
<td>• Trustee, Epiphany Pacific Trust</td>
</tr>
<tr>
<td></td>
<td>• Trustee, The Good The Bad Trust</td>
</tr>
<tr>
<td></td>
<td>• Member, Otara-Papatoetoe Local Board</td>
</tr>
<tr>
<td>External Appointee TBC</td>
<td></td>
</tr>
</tbody>
</table>

Counts Manukau District Health Board – Community and Public Health Advisory Committee 14 June 2017 004
## COMMUNITY and PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS’
## REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

### Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 14 June 2017

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Dianne Glenn</td>
<td>Item 5 on the CPHAC agenda - hazardous alcohol use.</td>
<td>Ms Glenn is a member of the District Licensing Committee of Auckland Council</td>
<td>22 March 2017</td>
<td>That Ms Glenn’s specific interest is noted and the Committee agreed 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, if applicable.</td>
</tr>
<tr>
<td>Ms Margie Apa</td>
<td>Item 3.1 on the CPHAC agenda – Aged Related Residential Care Overview</td>
<td>Ms Apa is Chair of Presbyterian North who provide older people services.</td>
<td>3 May 2017</td>
<td>That Ms Apa’s specific interest is noted and the Committee agreed 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, if applicable.</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 3 May 2017 at 9.00am – 12.30pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Ashraf Choudary
Dianne Glenn
Katrina Bungard
Rabin Rabindran

ALSO PRESENT

Benedict Hefford (Director Primary, Community and Integrated Care)
Gloria Johnson (acting Chief Executive)
Jenny Parr (Director Patient Care, Chief Nurse and Allied Health Professions Officer)
Margie Apa (Director Population Health Strategy and Investments)
Dinah Nicholas (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present.

APOLOGIES

Apologies were received and accepted from George Ngatai and Apulu Reece Autagavaia and from Jenny Parr and Colleen Brown (for lateness).

WELCOME

The Deputy Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

The Committee noted Margie Apa’s specific interest in relation to Item 3.1 on today’s agenda in regards to Aged Residential Care.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 22 March 2017.**

   **Resolution** (Moved: Dianne Glenn/Seconded: Rabin Rabindran)

   That the minutes of the Community and Public Health Advisory Committee meeting held on 22 March 2017 be approved.

   **Carried**

2.2 **Action Items Register/Response to Action Items**

   Noted.

   (Colleen Brown arrived at 9.25am)

3. **BRIEFING PAPERS**

3.1 **Aged Related Residential Care Overview**

   Benedict Hefford introduced the report.

   Strategically, there are two issues for this Committee:

   1. We need to ensure that if people go into aged residential care it is the right solution for them. There have been, in the past, incidents where we have missed opportunities to get older people back home because we haven’t started the rehabilitation early enough, we have assessed them at the wrong time when they are still recovering etc. There is quite a science about how and where we provide support rehabilitation and reablement to ensure that people are getting the right kind of long term support. Sometimes that is residential care but the evidence is often that it can be provided at home.

   2. Dementia, particularly Alzheimer’s. This is a very complicated issue and hard to get right and is one where residential care is the right option. We need to make sure we have the right kinds of facilities, staff training etc is very important.

   Counties Manukau doesn’t have a massive over or under supply of aged residential care facilities in the district, we seem to have a good balance although there is a lot of development ongoing in the Franklin area.

   It was noted that given the diversity in the district, there is an increasing need to have culturally supportive facilities available. The DHBs role is, at the moment, one or two degrees away from being able to influence how providers respond to consumer need but we can focus on encouraging workforce development because most of the boutique residential facilities employ a lot of ethnically diverse staff.
The DHBs strategy is around reablement and supported discharge and we no longer assess older people for long term conditions when they are still unwell in hospital. They are now assessed six weeks after discharge so they have time to recover and reable.

Dianne Glenn commented that she felt the DHB needed to be more cognisant of what the needs of the family care givers are who are usually providing the out of hours and weekend care for a family member. Families typically over promise and then can’t deliver and feel ashamed or embarrassed about backing back.

(Jenny Parr arrived at 9.45am)

3.2 Before School Check Overview

Carmel Ellis and Dr Pip Anderson introduced the report.

This overview is provided as a result of the last CPHAC meeting where the Chair put forward the issue around vision testing. There are concerns that this programme is not meeting the needs of people in our community, particularly Maori & Pacific.

The aim of the programme is to identify and address any health, behavioural, social or development concerns that could hinder a child’s ability to learn at school. This is a tricky area as child development is hard, there is a range of ‘normal’ and understanding that within a cultural context can be complex. The programme was piloted in 2007 by Counties Manukau and Whanganui with full implementation in September 2008. The DHB receives $1.2m pa to provide the checks. The check covers 7 components; 5 are provided by Well Child providers and 2 are provided by the DHBs Kidz First team (vision and hearing). The MoH only consider the check complete once all seven components are completed:

1. Child Health questionnaire - immunisation status, height, weight – medical history
2. Hearing screen – sweep audiometry followed by tympanometry
3. Vision screen – distance visual acuity
4. Oral Health check – Lift the lip
5. Strengths and difficulties questionnaire – Parent
6. Strengths and difficulties questionnaire – Teacher
7. Parental evaluation on development (PEDS)

The programme was audited in 2014, some of the issues raised have since been addressed locally but there are still some big issues that could be pushed through to the Ministry to negotiate further change in the programme:

- Timing of the check
- Children don’t get checked - issues not identified – coverage reasonable
- Children get checked but issues are not identified – under recognising issues
- Children get checked, issues identified but children don’t get services they need – issues with eligibility, DNA, declines.
- Children get checked, issues are identified, children get services they need and outcomes are improved – does this impact on school readiness.
The following are issues that have been identified:

2. Hearing – hearing is changing with the newborn screening programme and we would expect that less children will be picked up as they are older. Hearing does change for children and doesn’t mean it will be normal forever. By quintile of deprivation, 57.5% of children referred for hearing issues lived in a quintile 5 area.

*Issue: Documentation is a significant barrier for hearing referral/eligibility.*

For the six months to the end of 2012, 117 children were referred to Audiology, only 68% were given an appointment - the reason being the referrals were not received by Audiology.

Nearly a quarter of those had issues with eligibility. There is a long standing issue around having a systematic approach to identifying eligibility for our population. We have some local workarounds where the technicians and nurse will take pictures of birth certificates and forward those with the referral to try and circumvent some of the eligibility issues but it has been raised in various forums over the years, both nationally and locally, about the fact that there are probably children, and adults, who are eligible for services who are not receiving them because they do not provide the appropriate documentation. *This has been identified as a significant barrier for a number of our families for accessing services.*

3. Vision Screen – there is a high referral rate for children who fail their vision test however, the majority of children pass the test – 83%.

*Issue: False Positives*

From an Ophthalmology point of view, that there are a lot of false positives and a lot of children that go on for a more formal screen actually have normal vision. This can be an issue for the family point if they think their child has a vision problem, the time it takes families to get to appointments, the opportunity cost related to that and the opportunity cost to the service of not being able to see perhaps people with a higher degree of concern about a vision problem.

*Issue: The type of test used is confusing/timing of the check.*

The vision test uses confusion bars which a lot of children report confusing. If you do vision testing on older children using this method you get a much lower false positive rate and this again, comes back to the timing of the check. Ideally you do want to pick up vision problems early but the test currently been used is not particularly good for the age group it is currently being used for.

4. Dental – as everyone knows, we have a real issue around oral health and children in our district. We have high rates of caries and issues with enrolment and access to service through the regional dental service.

*Issue: Pathway issue.*

The 2014 audit identified that a number of children with decay were referred for treatment. Of those that were referred who had decay at the most extreme end, a year later only half had completed treatment.
5&6 Strengths and Difficulties Questionnaire (SDQ) - there was low recognition of issues again compared to international comparisons but there was still a high number of children identified with potential issues. Again, the SDQ has not been validated in New Zealand or in our populations.

1,647 children (23.5%) had at least one abnormal parental score, mostly related to conduct, with 402 children with at least one abnormal teacher score, mostly related to pro-social behaviour.

**Issue: Difficulty getting teachers to complete this questionnaire.**

Although ECE participation has improved, a lot of feedback from ECE centres is that it is not strengths-based and therefore not aligned to their philosophy.

When the audit was carried out in 2014, the two questionnaires identified completely different children so the overlap between the two was very small.

**Issue: Low referral rate when as issue was identified.**

65.4% of the children with an abnormal parental score and 76.4% with an abnormal teacher score were neither referred or under care. We believe there are issues with clinical people knowing what to do when this particular questionnaire comes back positive (ie) if you have a child that is lighting fires, where do you send them, what is the service.

The main thing we look at is parenting programmes of which we have some in the district. Mostly funded through MoE but have limited starting times per year into the programmes so if you are identified between the start times, you have to wait a long time before you can engage in the programme.

In terms of referral to the programme, acknowledgement of the referral, whether the family attended and completed the programme at this stage is not done. The programmes are generally 16 weeks in length.

7. Parental Evaluation on Development (PEDS A – 2 or more significant issues are identified) – there was low recognition of issues by parents (3.4%) compared to international comparison (11%). We are unsure of the reason why, the tool has not been validated in New Zealand nor with Maaori and Pacific but we believe it is likely to do with the fact that English is a second language for a lot of our parents and often Maaori and Pacific parents often don’t want to admit or acknowledge issues with their children because it reflects poorly on them and the shame associated with that.

**Issue: Whether this type of assessment is as useful for our Maaori and Pacific populations is a question that needs answering.**

When the tool was initially used, the Ministry acknowledged this and the talk was that they would validate the tool in New Zealand but as far as we understand this has not occurred. The data here suggests that given we know that socio-economic deprivation is associated with poor childhood development, we would expect our numbers to be higher that international standards.
**Issue:** Whether or not children who have been identified as having a problem are then referred.

When the audit was undertaken in 2014 there was an issue with children not being assigned to the right pathway and an issue with those children then not referred for a further diagnostic assessment and follow-up. The majority of the referrals made where for Ministry of Education special education and in 2013 the waitlist was 3-7 months. That is important when we think about the timing of the check (ie) if the check is done between 4-5 years of age and children are waiting months for services, they are often starting school at 5 and their eligibility for services changes before any intervention has been able to be put in place to address the issues to make sure they are ready to start school.

**Issue:** The B4SC data is not shared with the schools or GPs.

Some results are shared on a case by case basis if they know which school the child is going but often when the check is done at 4-years of age, they don’t know what school the child will be going to or that decision may change by the time they start school.

Because this is the 12th and final core check, once it is completed there is no on-going relationship between the person and the family so they won’t necessarily know that things have changed.

The other issue is that currently the information from the check is not well communicated to primary care, the national system does not have a way of messaging directly from the B4SC database to primary care systems.

And finally, there is no consent to share the information.

It was noted there is a fundamental flaw with the programme if the screening tools are not validated. Pip advised that they have tried through the audit to raise these issues with the Ministry who have done some quality review work that looked at the PEDS which identified issues but they did not validate it, they commissioned a study around the validation of the DSQ but this was never published, and they expressed concerns about the methodology that was used and that maybe the findings were not valid and was squashed.

There is a real problem that this national screening programme does just not work. In its current format the programme appears to be very costly in terms of the effort expended for the impact on health achieved. Many of the issues identified need to be resolved at a national level and are not unique to Counties Manukau Health.

The following recommendations were made.

**Recommendations**

- Repeat the audit in 2017/18 to understand how the programme is currently functioning and what impact it is having on outcomes at a population level for CM Health.
- That the Ministry of Health reviews the timing of the B4SC.
- That the Ministry of Health reviews the tools used in the check and that they are appropriate for Maori and Pacific Island children and whaanau, migrants or other groups that have English as a second language.
- That the Ministry of Health improves the functionality for the B4SC database so primary care can be notified of significant findings from the check.
• That the DHB ensures better linkages between the B4SC team and the Mana Kidz school based nurses and other education/primary schools/ECEs including Kihikatea.
• That the DHB has adequate resources in place to address needs identified in the B4SC:
  ▪ Assessment for ASD – 7 month waiting list
  ▪ That the DHB advocates for additional resource for other sectors
  ▪ Parenting programmes
  ▪ More MoE resource and connection to other sectors.
• That capturing eligibility at an organisational level is prioritised resource.
• Have some “work arrounds” in place but this should be a systematic response to ensure establishing eligibility is not a barrier to accessing services.

Resolution
The Community and Public Health Advisory Committee:

Accept in principle the recommendations above noting they will need further work undertaken on them prior to going to Board.

Agreed the Chair will provide a verbal briefing at the next CM Health Board meeting to signal the issues with this programme and that this paper is on the way to them for their consideration.

Actions
Pip Anderson and Carmel Ellis to:
• go back and relook at some of the 2014 audit findings (ie) ECE referrals to specialist education.
• progress regional discussions, within the next three months, to see whether they also have an interest in developing a collective regional paper with recommendations to go to all three metro-Auckland DHB Boards simultaneously. It could include a recommendation about repeating the audit and whether that is worthwhile and if so, what is the best way to do it, how to resource it, would it be done only here or collectively etc.
• work up a standard paper for all the three metro-Auckland DHB Boards.

Colleen to:
• work on the recommendations with Pip, Carmel and Ben in the interim.
• meet with the ADHB/WDHB CPHAC Chairs, along with Pip and Carmel, so they are fully prepared and on board.

3. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Rabin Rabindran)

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>
| 2.1 MH&A System Overview and Integrated 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 | 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 |
<table>
<thead>
<tr>
<th>2.2 Population Health Plans</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Activities</td>
<td>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.</td>
</tr>
</tbody>
</table>

Carried

The open session of the meeting concluded at 11.05am.

The open session of the meeting recommenced at 12.10pm.

3.3 Localities and Integrated Care Overview

Benedict Hefford introduced the report. Matters highlighted or updated included:

One of the big issues facing all health systems around the world is the rise of chronic disease combined with ageing populations. People don’t just come with one type of problem now, they have multiple complex issues. So, the question is how do we create a system that is responsive to that because the current system grew up with a different set of issues.

Because of that complexity, continuity and a comprehensive holistic approach and working at the preventative end, both in terms of trying to prevent the chronic illnesses in the first place but also trying to prevent them getting worse, is a core set of issues and only really primary health care, in the broader sense of the word, can do that effectively because it has a holistic view, has continuity over time and has the ability to coordinate, signpost and gate keep to other services.

The DHB has been progressively implementing an integrated ‘localities’ approach since 2012/13. Localities is a term used to describe an approach to joining up services at a local level to help people better manage their health and stay well in the community. In the new system, patients receive planned and coordinated care via locality based multi-disciplinary teams (MDTs). The MDTs are centred around clusters of general practice but include specialists, community nursing, allied health, pharmacist and other workers from various organisations and disciplines.

There are two myths to dispel:

1. That the DHB has spent millions of dollars on localities – this is simply not true, in fact a relatively modest investment has been put in to try and create the infrastructure necessary.

2. Is it working - we are unsure as there are lots of different parts to the change. In terms of what we track (clinical and system indicators, levels of demand etc) mostly what we
see is a positive trend. So far there is nothing that is saying we are on the wrong path. At times we’ve had to change tact but with any emerging strategy, that is normal. It is normal to compare ourselves to our geographic neighbours but we need to be cautious as our population is very different to our neighbours – 45% of our children are growing up in poverty, Dep 9 and 10 and 38% of our adults are as well.

We have a responsibility to evaluation all the component pieces as some will be working better than the others and this will be a major focus for us this year. It is important that ongoing evolution is guided by us evaluating properly what is working and what isn’t.

We also need to get a clear understanding of how much value there has been in dividing the DHB up into these four localities and how worthwhile that has been because if we can satisfy ourselves and other people that that in itself has been an important enabler, that is something that the rest of the metro-Auckland might want to look at.

The Committee asked Benedict Hefford to report back to the next meeting on the development and timeframe for the community hubs. The hubs are important to create a centre of gravity that is not Middlemore Hospital.

The meeting concluded at 12.35pm


___________________________
Colleen Brown, Committee Chair
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 – 14 June 2017**

<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><strong>Standing Items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.8.15</td>
<td>Locality Updates: Manukau Otara/Mangere Franklin Eastern</td>
<td></td>
<td>14 June 26 July 6 September 18 October</td>
<td>Lynda Irvine Sarah Marshall Kathryn du Luc Penny Magud</td>
<td>Refer Item 3.3 on today’s agenda.</td>
</tr>
<tr>
<td>25.5.16</td>
<td>Population Health Plans (Asian, Pacific &amp; Maaori) – quarterly update.</td>
<td></td>
<td>14 June</td>
<td>Marianne Scott</td>
<td>Refer Item 3.1 on today’s agenda.</td>
</tr>
<tr>
<td>6.7.16</td>
<td>ARPHS - six-monthly update.</td>
<td></td>
<td>14 June</td>
<td>Mr Hefford</td>
<td>Refer Item 3.2 on today’s agenda.</td>
</tr>
<tr>
<td>3.5.17</td>
<td>3.2</td>
<td>Before School Check – progress regional discussions and work on a standard paper for joint metro-Auckland DHB Board submission highlighting the issues with this programme. Report back on the development and timeframe for the community hubs.</td>
<td>6 September 14 June</td>
<td>Mr Hefford</td>
<td>Refer Item 3.1 on today’s confidential agenda.</td>
</tr>
</tbody>
</table>

<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>COMPLETE</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Community & Primary Health Advisory Committee
2016/17 Quarter 3 Population Health Plans

Recommendation

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

Receive this paper outlining the key improvement issues against the Maaori, Pacific and Asian Health Plans.

Note that the Maaori, Pacific and Asian Q3 Summary Progress Reports are appended.

Note the key discussion points contained within.

Prepared and submitted by: Filipo Katavake-McGrath, Planning Advisor in consultation with, Dr David Schaaf, Pacific Health Gains Lead, Fakavamoeatu Lutui, Pacific Health Gains Advisor, Namoe Tu’ipulotu, Analyst, Health Intelligence and Informatics, Kitty Ko, Asian Health Gains Advisor and Bede Oulaghan, Senior Strategic Business Analyst, on behalf of Elizabeth Powell, Marianne Scott and Fepulea’i Margie Apa, Director Population Health Strategy & Investment.

Glossary
ASH: Ambulatory Sensitive Hospitalisations
COPD: Chronic Obstructive Pulmonary Disease (tobacco related)
DCIP: Diabetes Care Improvement Package
DNA: Did Not Attend
EC: Emergency Care
ED: Emergency Department
IP: Inpatient
ISA: Integrated Service Agreement (Maaori & Pacific)
IT: Information Technology
ITO: Industry Training Organisation
LMC: Lead Maternity Carer
LOS: Length of Stay (hospital)
NBE: New Born Enrolment (Percentage of Pacific newborn infants enrolled with a GP by three months)
PAHIG: Pan Asian Health Interest Group
PHO: Primary Health Organisation
PHP: Pacific Health Plan 2016/2017
SUDI: Sudden Unexpected Death in Infancy
WCTO: Well Child Tamariki Ora (provider)

Purpose

The purpose of this paper is to report progress and highlight key insights from service delivery leaders in Quarter 3 (Q3) against the 2016/17 Maaori, Pacific and Asian Health Plans.

Executive Summary

This paper informs CM Health’s progress toward health equity for Maaori, Pacific and Asian peoples through targeted health gain areas outlined in the respective 2016/17 health plans. The paper is organised with performance highlights and lowlights for Q3 and supported by appended results for each population group against health gain targets.
Health gain performance highlights:

- Significant increase from 1 July 2016 to 31 December for pre-school children enrolment in DHB funded oral health services - Māori (74%), Pacific (85%) and Asian (87%) – with a lag before we will see an increase in the proportion of 0-4 year olds that are caries free.
- Percentage of obese tamariki in B4 School Check referred to health professional (and acknowledged) is close to reaching the 95% target for Māori (90.5%) and Pacific (93%) children. The next focus will be to progress these referrals into successful healthy weight interventions (Active Futures - family based nutrition, activity and lifestyle programme).

Areas of persistent or worsening health inequities are ASH rates for Pacific 0-4 and 45-64 years and cervical screening in Māori and Asian women. Culturally-appropriate services to better link women to cancer screening are in progress to address this.

**Background**

The 2016/17 Māori Health Plan has twelve national, and five local indicators. In 2016, new indicators relate to childhood obesity referrals, the proportion of people with cardiovascular disease who are taking drug treatment, and in the care of people with diabetes. Ambulatory sensitive hospitalisations, breastfeeding and immunisation coverage in infancy are the principal indicators of concern for tamariki in Counties Manukau. Some of the data for some new indicators are not yet available (including Diabetes Management data for Retinal Screening and Podiatrist Visits).

The 2016/17 Pacific Health Plan outlines priority actions and commitments in regards to improving the health of Pacific populations of Counties Manukau Health. There are twelve indicators (eight national ‘Ala Mo‘ui, and four local indicators) that aim to progress health gain in selected areas of concern.

The 2016/17 Asian Health Plan contains four key health gain focus areas (Diabetes Management, Oral Health Services, Cervical cancer and Refugee Health) and two health system improvement action areas (Asian Health Improvement Coordination and Health Literate Workforce and Systems). This includes commitment to recruitment of a new Asian Health Gain Advisor, Kitty Ko, who started in January 2017. The following sections of this report address achievements and progress against the stated actions and goals of the plan.

**Discussion**

### Action areas with evidence of improvement and key achievements

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Results</th>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Māori living in Counties Manukau</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Matua, Pepi and Tamariki (Parents, Infants and Children)</em></td>
<td>Immunisation coverage for 8 month old tamariki has increased two percentage points to 91%. <strong>Oral Health</strong> – The proportion of preschool-aged tamariki enrolled in the service has increased five percentage points since Q2, and 13 percentage points since the beginning of the last financial year. The proportion of tamariki identified as obese referred in the B4 School Check has tripled since beginning of the financial year to 90%.</td>
<td>92% 89%</td>
</tr>
<tr>
<td><strong>Pakeke and Whaanau (Adults and Family Group)</strong></td>
<td>Glycaemic control for Māori adults with diabetes has improved in the region from 61% in Q4 2015/16 to 63%. This is important for reducing the complications of the disease.</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Pacific peoples living in Counties Manukau</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Matua, Pepi and Tamariki (Parents, Infants)</em></td>
<td>The proportion of Pacific children identified as obese referred to health professionals for clinical assessment has improved by 36% in the last quarter and 65 percent since Q1</td>
<td>90%</td>
</tr>
</tbody>
</table>
### Action Focus

<table>
<thead>
<tr>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>89%</td>
</tr>
</tbody>
</table>

#### and Children

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of children aged 0-4 enrolled in DHB funded oral health services has risen 9% to 85% in Q3</td>
</tr>
</tbody>
</table>

#### Asian peoples living in Counties Manukau

<table>
<thead>
<tr>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>89% (enrolment)</td>
</tr>
<tr>
<td>65% (caries free)</td>
</tr>
</tbody>
</table>

### Oral Health

- **Matua, Pepi and Tamariki (Parents, Infants and Children)**
  - **Oral Health** – the percentage of preschool aged children enrolled in Oral Health services has risen to 87% and the percentage of 5-year olds who are caries free is now above the 2016/17 Asian Health Plan target (of 55%) at 56.1%.

### Action areas of concern and persistent health equity challenge

#### Action Focus

<table>
<thead>
<tr>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td>16% (total population)²</td>
</tr>
</tbody>
</table>

#### Maaori living in Counties Manukau

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maaori participation in the DHB employed workforce has declined from a Q3 2015/16 peak by 0.7 percentage points. Currently, 6.5% of the Counties Manukau Health workforce is Maaori (refer Insights section 3h below for further information)</td>
</tr>
</tbody>
</table>

#### Cervical Screening rates have steadily declined over the past financial year, from a peak of 69% in Q4 2015/16 to 66% in Q3 2016/17. |

#### Pacific peoples living in Counties Manukau

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the year to Q3 the percentage of Pacific children who are caries free at 5 years has reduced from 34% to 30%. These results are well short of the 2016/17 target of 55%.</td>
</tr>
<tr>
<td>Persistently high ASH rates among Pacific children aged 0-4 and adults aged 45-64 remain an on-going concern. The 0-4 rate has decreased slightly between Q1 and Q2 while the 45-64 rates increased over that same period.</td>
</tr>
</tbody>
</table>

#### Asian peoples living in Counties Manukau

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of eligible Asian women who have had a cervical smear in the last 36 months has reduced from 67% to 66.8%</td>
</tr>
</tbody>
</table>

---

1. The current 2016/17 Asian Health Plan target for Oral Health enrolments for children aged 0-4 is 55% and reflects the national target across all ethnicities. Note that this is below the more aspirational local health equity target (European/Other) as outlined above for health equity (not accountability) reporting purposes.

2. Regional workforce planning in 2017 has set population group specific targets by occupation group. The denominator is population aged 15-64 years; a change from the 2016/17 total population comparator.
Raising Healthy Kids Health Target/Child Obesity

We continue to make good progress towards the Raising Healthy Kids Health Target and are on track to achieve the target by May 2017 (7 months ahead of the December 2017 target). The overall result for Q3 for Pacific was 93%. Focus in the last period continues to be on:

- delivering training and mentoring to help health professionals have conversations with families of overweight and obese children;
- monitoring and addressing declines; roll-out of Active Futures, a family based nutrition, activity and lifestyle programme developed for pre-school aged children and their families identified through the B4SC; and
- ensuring the systems and processes established to support achievement of the health target continue to function well.

Encouragingly, over the past month we have seen a small decrease in the number of parents/caregivers of obese children declining the offer of a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. The overall rate of referrals being declined rate in Counties Manukau is 25% (national average is 31%), however the decline rate for Maaori remains much higher at 43%. Pacific declines are the lowest at 16%. We continue to actively monitor and address the decline rate.

Child Oral Health Care

Significant progress has been made in growing the proportion of Maaori, Pasifika and Asian children enrolled in DHB-funded oral health services. While the Q3 2016/17 results for enrolments remain below target the rates of enrolment for Maaori, Pacific and Asian under-5s are the highest since the 2012/13. The current enrolment strategy sees WCTO core-contacts being leveraged to ensure that providers’ enrol children at 5 months of age and provide oral health education to parents.

While enrolment rates are increasing, the Auckland Regional Dental Service (ARDS) is facing challenges in ensuring access to check-ups, especially for Maaori and Pacific children and their families. The main challenges has been improving the total headcount of the clinical workforce to handle the volume of patients, as well as opening services at times convenient to families. A Saturday clinic located in Brown’s Road Manurewa was opened in November 2016, with future Saturday services being planned for Botany, Mangere, Papakura and Pukekohe.

A targeted Asian community engagement strategy will be included in the Preschool Strategy which is to be completed and approved (currently in progress with ARDS / ADHB / WDHB). Marketing collateral and oral health information has already been translated into Korean with Simplified Chinese and Hindi resources to be developed as per agreements with ARDS. Local advertising in Hindi, Korean and Chinese Language newspapers and sugary drinks poster translations has been deferred to 2017/18.

Diabetes Care

In Q3, 11 practices with large numbers of patients with poorly controlled diabetes (> 64 mmol/mol) are participating in a Modified DCIP programme that is supported by collaborative quality improvement methodology. Practices are regularly meeting with SMOs at multi-disciplinary team meetings and virtual consults to discuss complex cases and agree an approach which often includes improved self-management support. Practices are supplying register data so that analysis across the Modified group can be undertaken. Evaluation of the current Modified DCIP is being undertaken and some initial results are expected before second quarter of next year.

Diabetes dashboards have been developed for Modified DCIP practices to summarise and compare performance/ progress. Dashboard information will be discussed at collaborative practice meetings.
including facilitators and Secondary care services.

Additional community Podiatry services are now in place at Mangere Hub where people with high risk feet can be referred to see a podiatrist.

**Cancer (Breast and Cervical) Screening**

Cervical cancer screening coverage has declined slightly in the past two quarters. Coverage for Maaori is expected to increase through a range of activities to promote screening and improve systems within primary care. Our new Support to Cervical and Breast Screening Service is focussed on improving coverage for Maaori women. This provides culturally-appropriate services to link women to screening (such as transport), raises cervical screening awareness in the community, and provides outreach and mobile services for 'hard-to-reach' women, including after-hours clinics. Already there has been very good uptake by Maaori women of free weekend and evening screening at the Manukau SuperClinic and other community locations.

BreastScreen coverage has dropped slightly for all population groups. This has been due mainly to a shortage of medical radiation technologists to do the screening. The service is now fully staffed and the screening volume projections for the second half of 2016/17 have increased on previous months, this is reflected in the slight increase between Q2 and Q3.

**Rheumatic Fever**

The Auckland Regional Public Health Service (ARPHS) has been unable to update data on follow-ups of identified cases for this report. This is due to staff changes at ARPHS as well as recent outbreaks of Mumps and Typhoid requiring staff in Auckland to reprioritise their work. There were 11 cases reviewed in the last quarter of these 4 had a history of a sore throat and 2 were seen by a health professional (school nurse). One of these cases had a positive swab and was treated with appropriate antibiotics.

Between the 2013/14 and 2016/17 financial years there has been an overall downward trend in the rate of acute rheumatic fever first hospitalisations of Pacific peoples per 100,000 of population. Over the same period, the rate of hospitalisations among Maaori has remained stable, but following a decrease in the year to 2014/15 has trended upwards in the two years to 2016/17. Despite an overall downward trend for both key groups over the past six financial years, the rates remain stubbornly high and significantly over the national target and its own downward trajectory. There is a significant equity gap in the figures reported for both Maaori and Pacific peoples when compared to hospitalization rates for New Zealand European and Other ethnicities.

**Acute rheumatic fever first hospitalisations, rates per 100,000**

![Graph showing acute rheumatic fever hospitalisations rates per 100,000 population by financial year (Q1)](image-url)
Activities to improve Rheumatic Fever outcomes

NHC have re-tendered the provision of the Mana Kidz service which has resulted in 6 Māori and Pacific community health providers contracted (plus 2 mainstream providers). This has further strengthened the Māori and Pacific input into the operations of the programme with clinical and non-clinical managers contributing to the ongoing implementation of the programme. The implementation of the Rheumatic Fever Māori community fund work has seen the engagement of local Māori providers in health promotion events within key local communities. The key engagement forum with local stakeholders continues to be the Child Health Alliance Forum. Meetings now include regular Rheumatic Fever activity updates from organisations involved in the Auckland Wide Healthy Homes Initiative (AWHI), Pacific engagement strategy, secondary schools and the school programme (Mana Kidz).

PHO clinical directors have been engaged by Dr Rawiri Jansen (NHC) to workshop methods of support for sore throat management guideline implementation. NHC offers quarterly training on sore throat management to health professionals based in schools (including secondary schools). Other health professionals are able to attend also.

The school-based programme commenced again for the new school year at the start of term 1. Sore throat management is available on a daily basis for approx. 24,000 children. A further 8,000 children have a registered nurse (RN) in the school once or twice per week and throat swabbing is available. General promotion of the importance of sore throats and going to the GP in case of a sore throat is one of the key activities in these lower intensity schools. Each provider is required to undertake school-specific health promotion activities each term. Training was undertaken in January to give health professionals the knowledge and skills to deliver effective health promotion. This includes the importance of sore throats and taking the full course of antibiotics. Supporting resources have been provided which includes antibiotic adherence cards developed in conjunction with health literacy experts.

A three day training symposium was held in January to support the sore throat management work. In March, schools were given newsletter inserts to raise awareness of importance of sore throats and directing children and whaanau to their GP clinic when schools are closed. There is a requirement that all children on course of antibiotics are followed up at 5 and 10 days. NHC is including this in the next iteration of the Mana Kidz performance report to measure how well this is being done. Additional training was provided in January to give health workers (as well as registered nurses) the skills, knowledge and confidence to assist in following up with children and whaanau.

Rapid response continues to be available across secondary schools in the district. The service has expanded beyond the 17 schools the DHB directly contracts with. The DHBs clinical nurse managers, in conjunction with the NHC team, continue to support the expansion of the service availability with training, support for standing orders (including regular audits) and reporting. CM Health does not contract for primary care-based rapid response services. There is still some activity occurring across the district; as evidenced by the reporting data from the submission of advanced forms. However, this is not representative of the true level of activity as a) practices are no longer obligated to use the advanced form, and b) PHOs are no longer obligated to provide the data generated from these forms.

Cardiovascular Disease (CVD) Risk Assessment

These indicators are a key focus of the Regional System Level Measures Improvement Plan. Ongoing activities in this area include PHOs sharing barriers to and enablers of success; total population and specific interventions for Māori to improve uptake and adherence to therapy (and including lifestyle intervention on nutrition, physical activity and stopping smoking); and ongoing medication counseling by community pharmacists. Coverage should continue to improve as these activities become embedded. We also plan to have a project which focuses on CVDRA and management in Māori men aged 35-44, focusing on engaging this group in the community rather in primary care, in July/August 2017.
Given that most of our PHOs are meeting the 90% target for total population, we have focused on improving equity for high risk populations over the past quarter. This has been aided by the inclusion of CVDRA (and management) being included as contributory measures under the Amenable Mortality SLM for 16/17 for metro Auckland. As laid out in this Improvement Plan, planned activities include:

- Increase in targeting Maori (especially men)
- Post event medication counseling and other rehabilitation services
- Clarification and implementation of discharge advice in primary care
- On-going monitoring of patient adherence
- Patient activation
- Identification of patients who have a high CVD risk ($\geq 20\%$) or prior CVD event and are not prescribed triple therapy
- Particular focus on patients with diabetes
- Monitoring through Metro Auckland Clinical Governance and NRA CVD/Diabetes data set

The aim is that this will result in:

- 2.5% increase in triple therapy in the primary and secondary prevention cohort by June 2017
- 90% Risk Assessment for all ethnicities by June 2018
- Five percent increase in triple therapy by June 2018 for those with high CVD risk ($\geq 20\%$) or prior CVD event

**Pacific Breastfeeding - 6 weeks, 3 months and 6 months**

At discharge from birthing facility, breastfeeding rates in Counties Manukau exceed the MOH and Baby Friendly Hospital Initiative (BFHI) targets; however following discharge there is a significant drop in breastfeeding rates. Breastfeeding rates at 6 weeks and 3 months fall below the MOH targets and reported national rates. Breastfeeding rates between January to June 2016 (most recent data available) for Pacific at 6 weeks are 52%, at 3 months 42% and at 6 months 57%.

In the last quarter, the community based breastfeeding service Te Rito Ora supported 63 Pacific women, and 300 Pacific women saw a Breastfeeding Advocate for breastfeeding support while they were on the Maternity ward. We are continuing to see an increase in antenatal enrolments into the Te Rito Ora service and are working closely with LMCs to promote the service. Te Rito Ora run a weekly clinic at Springlife Midwifery Centre which has a high numbers of Pacific women attending.

Other activities this quarter have included delivering 20-hours of breastfeeding training and education to Well Child Tamariki Ora Whaanau Support Workers. We are continuing to progress the actions in the Breastfeeding Action Plan to increase breastfeeding rates in Counties Manukau.

**Smoking - Pregnant Pacific mothers smoke-free at 2 week postnatal**

The pregnancy Incentives programme was moved into business as usual at the start of the year and has been delivered across South Auckland through a locality model, prioritising Manukau for Maaori women and Otara/Mangere for Pacific women and their fanau. Pacific women account for 30% of the referrals and 30% of the successful quitters. The 4 week quit rate (MOH measure) is the same for Pacific women, Maaori women and non Maaori/non-Pacific. The referral rate (referrals out of estimated pacific smoking population during pregnancy): Q1: 35%, Q2: 32%, Q3: 48%

Approximately 330 Pacific women smoke each year during pregnancy (14% smoking prevalence rate). There are two Samoan practitioners within the team delivering the incentives intervention Educations sessions are held at birthing units each quarter for midwives to encourage referrals. The postnatal referrals have remained at a minimum and feedback is that women are stating that they have already been referred or not able to remain Smokefree once baby has been born. However, 2 weeks Postnatal rates indicate that 90% of Pacific women are smokefree.
ASH rates 0-4 years and 45-64 years

In Q3 a training session on skin infection was delivered to Well Child providers and a training package for Primary Care nurses on the Proactive Care Programme has been developed. A Nurse Educator has now been confirmed and is supporting the implementation of the skin pathways work. The work programme on scabies has been temporarily delayed due to the departure of Dr Simon Thornley and is now being integrated into the Proactive Care programme. A Skin Infection training package is now being delivered at community centres in the Manukau locality.

Population Plan Specific Programmes

LotuMoui

In Q3 LotuMoui continued to work with Pacific churches and the Pacific community of Counties Manukau. A number of events requested by the community were held this quarter including LotuMoui hosting a Cardiac Community workshop. The LotuMoui team teamed up with Leilani Ioelu a nurse specialist in the Cardiac ward and ran a community workshop held at the Manurewa Alfriston Marae - over 80 Pacific people attended. The workshop involved information in regards to high blood pressure and diabetes. Blood pressures were taken in this workshop and a number of people were referred to their respective GP as a result of this workshop. LotuMoui also continue to develop the Pacific Child Health Network with TAHA as it is seen as a great avenue to link with the community especially our Pacific children and fanau.

FanauOla

The FanauOla team continues to work closely with high complex and high users of the health system, Pacific patients and their fanau/families. These are Pacific patients and their fanau/families which have been admitted to hospital three or more times with co-morbidities in the last six months and patients who do not attend clinic and/or follow up appointments. In Q3 the FanauOla service attended to 279 high complex and high users Pacific families (Nurses: 171, Social Workers: 108). Majority of these patients were referred from the EC triage, Kidz First, Cancer patients, Medical Wards, Smokefree services and self-referral. Social issues of which these patient have includes housing, family violence, mental health issues, WINZ dependent, advocating for Pasifika patients through communicating with hospital staff, non-compliance with medication, high DNAs and EC admissions, family relationships. Social isolation, frequent admission, CYF involvement and medications – lack of finance.

Whaanau Ora Integrated Service Agreements (ISA)

Approximately 1300 referrals for patients identified with high needs and with complex issues have been received between the 10 Maaori health providers between Q1-3. Of these, around 1,270 identified as high-needs with complex issues are in the process of receiving Whaanau ora comprehensive packages of care within the key age-group and life-course categories:

- Matua pepi tamariki (Parents, babies and Children)
- Oranga ki Tua (long term conditions)
- Rangatahi ora (Young people)
- Kaumatua oranga (Elders)

CM Health is currently reviewing 18 ISA Maaori Health agreements and beginning procurement of future services. As part of this process one provider has been identified as delivering significantly below contracted numbers, and this is being actively resolved directly with the provider. As part of the wider procurement process CM Health is engaging an ITO to support Maaori health providers to become NZQA accredited workplace assessors for Whaanau Ora qualifications.
**Pacific Integrated Service Agreements (ISA)**

289 Fanau Ola assessments have been completed in Q3 by the two contracted providers, of Pacific families that have been identified as high needs. Alongside referrals, Bader Drive Healthcare reported completing 411 health education sessions, the largest number were for diabetes (94), high blood pressure (78) and high cholesterol (76). South Seas Healthcare reported completing 40 referrals to rheumatic fever prevention programmes, 37 health education sessions and developing 30 healthy lifestyle action plans.

**Asian Health Gains Development**

The focus for the Asian Health Gains Advisor has been to work with programme managers, service providers and regional partners to raise awareness of the CM Health commitment to supporting Asian Communities’ health gains. This has been achieved through prioritising forward planning for the 2017/18FY and engaging stakeholders in the planning process.

In Q3 the Asian Health Gains advisor has:

- developed relationships with key stakeholders responsible for Asian health gain
- developing relationships with PHOs that have high Counties Manukau Asian populations; with particular support from East Health in developing 2017/18 actions to better support Asian young people
- is working with Auckland and Waitemata DHB leaders to collaborate on health gain areas of mutual concern
- supported organization and presented at the CM Health Asian Health Day (held in Papakura with over 100 attendees – approx. 70 community and 30 Asian health service providers)
- worked with the Critical Complex Care unit to support them in identifying resources that require translation into key Asian community languages.

**Appendices**

- Maaori Health Plan Quarter 3 Summary Progress Report
- Pacific Health Plan Quarter 3 Summary Progress Report
- Asian Health Plan Quarter 3 Summary Progress Report
### CMH 2016/17 Summary Progress Report at the end of Quarter 3. Māori Health Plan

#### Key
- **Green** = target achieved
- **Black** = data not available
- **Yellow** = within 10% of target (1.1-1.5 times target rate)
- **Blue** = data available, but no target for comparison
- **Orange** = 10-20% away from target (1.5-2 times target rate)
- **Grey** = sample size < 20, too small to provide meaningful percentage
- **Red** = more than 20% away from target (more than 2 times target rate)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Baseline 2016/17 MHP</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Equity Gap</th>
<th>Change from previous quarter</th>
<th>Trend</th>
<th>Desired trend direction</th>
<th>Total Pop. or Non-Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Care</strong></td>
<td>Percentage of Māori enrolled in a PHO</td>
<td>Quarterly</td>
<td>100%</td>
<td>95%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>3.7%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>ASH rates (number of admissions per 100,000 people per year)</td>
<td>Age 0 to 4 years</td>
<td>Six monthly</td>
<td>5,650</td>
<td>6,811</td>
<td>6,604</td>
<td>6,811</td>
<td>6,575</td>
<td>6,264</td>
<td>1,475</td>
<td>-311</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 45 to 64 years</td>
<td>Six monthly</td>
<td>6,029</td>
<td>8,457</td>
<td>9,081</td>
<td>8,457</td>
<td>8,491</td>
<td>8,161</td>
<td>5,294</td>
<td>-330</td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>Percentage of infants exclusively or fully breastfeed (Trendly)</td>
<td>Age 6 weeks</td>
<td>Six monthly</td>
<td>75%</td>
<td>46.0%</td>
<td>50.5%</td>
<td>46.0%</td>
<td>48.8%</td>
<td>45.1%</td>
<td>48.8%</td>
<td>17.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age 3 months</td>
<td>Six monthly</td>
<td>60%</td>
<td>34.4%</td>
<td>37.3%</td>
<td>34.4%</td>
<td>34.4%</td>
<td>34.4%</td>
<td>34.4%</td>
<td>22.8%</td>
</tr>
<tr>
<td></td>
<td>Percentage of infants fed breast milk (Trendly)</td>
<td>Age 6 months</td>
<td>Six monthly</td>
<td>65%</td>
<td>48.8%</td>
<td>45.1%</td>
<td>48.8%</td>
<td>48.8%</td>
<td>48.8%</td>
<td>48.8%</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Percentage of eligible population who have had their cardiovascular risk assessed in the last 5 years</td>
<td>Quarterly</td>
<td>90%</td>
<td>88.1%</td>
<td>88.3%</td>
<td>88.1%</td>
<td>88.2%</td>
<td>88.7%</td>
<td>88.7%</td>
<td>88.4%</td>
<td>87.9%</td>
</tr>
<tr>
<td></td>
<td>Percentage of eligible population who have a risk greater than 20% and are on dual therapy</td>
<td>Quarterly</td>
<td>70%</td>
<td>New indicator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Baseline 2016/17 MHP</td>
<td>2015/16</td>
<td>2016/17</td>
<td>Equity Gap</td>
<td>Change from previous quarter</td>
<td>Trend</td>
<td>Desired trend direction</td>
<td>Total Pop. or Non-Maori</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>---------</td>
<td>---------</td>
<td>------------</td>
<td>----------------------------</td>
<td>-------</td>
<td>--------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>Percentage of eligible women who received a three yearly cervical screen</td>
<td>Monthly</td>
<td>80%</td>
<td>62%</td>
<td>62.4%</td>
<td>63.3%</td>
<td>67.2%</td>
<td>68.9%</td>
<td>66.8%</td>
<td>66.6%</td>
<td>65.8%</td>
</tr>
<tr>
<td></td>
<td>Percentage of eligible women aged 50-69 who have had a breastscreen within last 24 months</td>
<td>Monthly</td>
<td>70%</td>
<td>66.0%</td>
<td>65.1%</td>
<td>64.8%</td>
<td>63.5%</td>
<td>65.9%</td>
<td>64.2%</td>
<td>63.7%</td>
<td>64.3%</td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>Percentage of pregnant Maori wahine who are smokefree at 2 weeks postnatal (from Trendly)</td>
<td>Six-monthly</td>
<td>95%</td>
<td>69%</td>
<td>72%</td>
<td>Data unavailable</td>
<td></td>
<td></td>
<td>19%</td>
<td>+3%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td>Percentage of eight months olds who have had their primary course of immunisation on time</td>
<td>Quarterly</td>
<td>95%</td>
<td>89%</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td>90%</td>
<td>86%</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>Percentage of eligible population 65 years and over who have had an influenza vaccination</td>
<td>Annually</td>
<td>75%</td>
<td>66%</td>
<td>44%</td>
<td>Data unavailable</td>
<td></td>
<td></td>
<td>-3%</td>
<td>N/A</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Rheumatic Fever</strong></td>
<td>Acute rheumatic fever first hospitalisation rates per 100,000 population</td>
<td>Six monthly</td>
<td>4.5 (Total pop.)</td>
<td>8.5</td>
<td>10.9</td>
<td>8.4</td>
<td>13.1</td>
<td>6.1</td>
<td>Change from Q3 15/16 +4.7</td>
<td>↓</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>Percentage of preschool children 0-4 years enrolled in DHB funded oral health service</td>
<td>Annually</td>
<td>95%</td>
<td>61%</td>
<td>67%</td>
<td>68%</td>
<td>73.5%</td>
<td>11.2%</td>
<td>Change from last year +6.5%</td>
<td>↑</td>
<td>84.3%</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Mental health Act: section 29 community treatment order indefinite (rate per 100,000)</td>
<td>Quarterly</td>
<td>No MoH target yet</td>
<td>149.2</td>
<td>149.2</td>
<td>139.1</td>
<td>131.8</td>
<td>128.6</td>
<td>136.0</td>
<td>142.2</td>
<td>146.9</td>
</tr>
</tbody>
</table>

1 Source: Numerator: NMDS extracted CM Health. ARF ICD code I00-I02. Primary diagnosis of ARF. Excludes any admissions where that person has been admitted with any ARF diagnosis or Rheumatic Heart Disease from 1990-2005. Denominator uses the 2013 Census as a base.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Baseline 2016/17 MHP</th>
<th>2015/16 Q1</th>
<th>2015/16 Q2</th>
<th>2015/16 Q3</th>
<th>2016/17 Q1</th>
<th>2016/17 Q2</th>
<th>2016/17 Q3</th>
<th>Equity Gap</th>
<th>Change from previous quarter</th>
<th>Trend</th>
<th>Desired trend direction</th>
<th>Total Pop. or Non-Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden Unexpected Death in Infancy</td>
<td>SUDI rate per 1,000 live births</td>
<td>Annually</td>
<td>0.4</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
<td>1.1</td>
<td>3.3</td>
<td>1.2</td>
<td>1.1</td>
<td>0.3% (last year)</td>
<td>↓</td>
<td></td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1</td>
<td>Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1</td>
<td>Six monthly</td>
<td>100%</td>
<td>45%</td>
<td>58%</td>
<td>73%</td>
<td>1.1</td>
<td>0.3% (last year)</td>
<td>↓</td>
<td></td>
<td>1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce Development</td>
<td>Number of CMH employees who are Maori</td>
<td>Quarterly</td>
<td>570</td>
<td>New indicator</td>
<td>503</td>
<td>N/A</td>
<td>N/A</td>
<td>49.0% (NZ Euro/Other)</td>
<td>↑</td>
<td></td>
<td>49.0% (NZ Euro/Other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of CMH employees who are Maori</td>
<td>Percentage of CMH employees who are Maori</td>
<td>Quarterly</td>
<td>7.7%</td>
<td>6.0%</td>
<td>6.7%</td>
<td>6.2%</td>
<td>7.2%</td>
<td>7.1%</td>
<td>6.8%</td>
<td>6.7%</td>
<td>6.5%</td>
<td>N/A</td>
<td>↑</td>
<td>-0.2%</td>
<td>49.0% (NZ Euro/Other)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Percentage of rangatahi accessing Alcohol Brief Interventions (12-19 year olds)</td>
<td>Quarterly</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>1.1%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>5.3%</td>
<td>↑</td>
<td>0.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Percentage of rangatahi accessing Mental Health Brief Interventions</td>
<td>Percentage of rangatahi accessing Mental Health Brief Interventions</td>
<td>Quarterly</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.9%</td>
<td>↑</td>
<td>0.0%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Depression – measure in development</td>
<td>Depression – measure in development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Percentage of population with diabetes who have an HbA1c ≤ 64 mmol/L</td>
<td>Six monthly</td>
<td>69%</td>
<td>60%</td>
<td>60%</td>
<td>61%</td>
<td>63%</td>
<td>14%</td>
<td>+2%</td>
<td>14%</td>
<td>14%</td>
<td>+2%</td>
<td>↑</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>Percentage of people with diabetes with an up-to-date retinal screen*</td>
<td>Percentage of people with diabetes with an up-to-date retinal screen*</td>
<td>Quarterly</td>
<td>90%</td>
<td>87.8%</td>
<td>New indicator</td>
<td>N/A</td>
<td>0.6%</td>
<td>N/A</td>
<td>0.6%</td>
<td>N/A</td>
<td>0.6%</td>
<td>+2%</td>
<td>↑</td>
<td>88.4%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Number of people with diabetes who have seen a podiatrist</td>
<td>Number of people with diabetes who have seen a podiatrist</td>
<td>Quarterly</td>
<td>To be set</td>
<td>Not available</td>
<td>New indicator</td>
<td>20</td>
<td>130</td>
<td>N/A</td>
<td>+110</td>
<td>N/A</td>
<td>+110</td>
<td></td>
<td>↑</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* To be added to All Localities Indicator Dashboard

Counties Manukau District Health Board – Community and Public Health Advisory Committee 14 June 2017
<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Baseline 2016/17 MHP</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Equity Gap</th>
<th>Change from previous quarter</th>
<th>Trend</th>
<th>Desired trend direction</th>
<th>Total Pop. or Non-Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Obesity</td>
<td>Percentage of obese tamariki in B4 School Check referred to health professional (and acknowledged).</td>
<td>Quarterly</td>
<td>95%</td>
<td>Not available</td>
<td>New indicator</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>90.2%</td>
<td>+25%</td>
<td>↑</td>
</tr>
</tbody>
</table>
### 26/17 Summary Progress Report as at the end of Quarter 3- Pacific Health Development

**Key**

- **Green** = target achieved
- **White** = data not available
- **Yellow** = within 10% of target
- **Blue** = data available, but no target
- **Orange** = 10-20% away from target
- **Grey** = sample size < 20, too small

- An increasing trend means improvement
- An decreasing trend means no improvement
- Flat-lining or plateauing

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Baseline as per published 2016/17 PHP</th>
<th>Performance 2015/2016</th>
<th>Performance 2016/17</th>
<th>Equity Gap</th>
<th>Change from previous quarter</th>
<th>Trend</th>
<th>Total Pop. or Non-Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Percentage of Pacific newborn infants enrolled with a GP by 3 months</td>
<td>Quarterly</td>
<td>98%</td>
<td>83% 78% 63% 79%</td>
<td>+4% +16</td>
<td>➡️ 75%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASH rates</td>
<td>Age 0 to 4 years</td>
<td>Six monthly</td>
<td>9,751 per 100,000</td>
<td>12,702 per 100,000 13,028 12,900 11,977</td>
<td>-7,188 -923</td>
<td>➡️ 4,789 (Non-Maori &amp; Non-Pacific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age 45 to 64 years</td>
<td>Six monthly</td>
<td>6,424 per 100,000</td>
<td>9,247 per 100,000 9592 9416 9247 9,726 9,545</td>
<td>-6,678 +181</td>
<td>➡️ 2,867 (Non-Maori &amp; Non-Pacific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Percentage of infants exclusively or fully breastfeed</td>
<td>Age 6 weeks</td>
<td>Six monthly</td>
<td>75% 53% 50% 52%</td>
<td>+17% -3</td>
<td>➡️ 67% (Non-Maori &amp; Non-Pacific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age 3 months</td>
<td>Six monthly</td>
<td>60% 39% 44% 39% 42%</td>
<td>+17% -5</td>
<td>➡️ 56% (Non-Maori &amp; Non-Pacific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of infants being fed breast milk</td>
<td>Age 6 months</td>
<td>Six monthly</td>
<td>65% 59% 59% 57%</td>
<td>+7% 0</td>
<td>➡️ 66% (Non-Maori &amp; Non-Pacific)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Baseline as per published 2016/17 PHP</td>
<td>Performance 2015/2016</td>
<td>Performance 2016/17</td>
<td>Equity Gap</td>
<td>Change from previous quarter</td>
<td>Trend</td>
<td>Total Pop. or Non-Maori</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>--------------------------------------</td>
<td>------------------------</td>
<td>---------------------</td>
<td>------------</td>
<td>----------------------------</td>
<td>-------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Percentage of eligible population who have had their cardiovascular risk assessed in the last 5 years</td>
<td>Quarterly</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
<td>-2%</td>
<td>0</td>
<td>93%</td>
</tr>
<tr>
<td>Smoking</td>
<td>Percentage of pregnant Pacific mothers who are smokefree at 2 weeks postnatal</td>
<td>Quarterly</td>
<td>95%</td>
<td>67%</td>
<td>92%</td>
<td></td>
<td></td>
<td>+1%</td>
<td>N/A</td>
<td>91%</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>Acute rheumatic fever first Hospitalisations rates per 100,000 Population</td>
<td>Six monthly</td>
<td>4.5 per 100,000</td>
<td>21.5 per 100,000</td>
<td>28.2</td>
<td>21.5</td>
<td>23.2</td>
<td>+23.2</td>
<td>-1.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Percentage of preschool children 0-4 years enrolled in DHB funded oral health service</td>
<td>Annually</td>
<td>95%</td>
<td>75.5%</td>
<td>76%</td>
<td>76%</td>
<td>85%</td>
<td>-1.5%</td>
<td>0</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>Percentage children caries free at age 5 years</td>
<td>Annually</td>
<td>55%</td>
<td>30%</td>
<td>36%</td>
<td>34%</td>
<td>30%</td>
<td>-30</td>
<td>-2</td>
<td>64%</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>Percentage of obese Tamariki identified at B4SC referral to a health professional for clinical assessment</td>
<td>Quarterly</td>
<td>95%</td>
<td>TBC</td>
<td>New Indicator</td>
<td>28%</td>
<td>67%</td>
<td>93%</td>
<td>+23%</td>
<td>+39%</td>
</tr>
<tr>
<td>Sudden Unexpected Death in Infancy</td>
<td>Sudden Unexpected Death in Infancy (SUDI) rate per 1,000 live births</td>
<td>Annually</td>
<td>0.4 per 1,000 live births</td>
<td>0.52 per 1,000 live births</td>
<td>0.52</td>
<td></td>
<td></td>
<td>-0.44</td>
<td>N/A</td>
<td>0.96</td>
</tr>
<tr>
<td></td>
<td>Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1</td>
<td>Quarterly</td>
<td>100%</td>
<td>72.5%</td>
<td>72.7%</td>
<td></td>
<td></td>
<td>-6.8%</td>
<td>N/A</td>
<td>79.5%</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>Percentage of CM Health employees who are Pacific – whole organisation</td>
<td>Quarterly</td>
<td>21%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of new Pacific employees by head count total</td>
<td>Quarterly</td>
<td>1052</td>
<td>904</td>
<td>New Indicator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>955</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Baseline as per published 2016/17 PHP</td>
<td>Performance 2015/2016</td>
<td>Performance 2016/17</td>
<td>Equity Gap</td>
<td>Change from previous quarter</td>
<td>Trend</td>
<td>Total Pop. or Non-Maori</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>---------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
<td>------------</td>
<td>-------------------------------</td>
<td>-------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Diabetes Management</strong></td>
<td>Percentage of enrolled Pacific patients with diabetes (aged 15-74 years old) who have a good/acceptable glycemic control with HbA1c</td>
<td>Quarterly</td>
<td>69%</td>
<td>58%</td>
<td>Q1: 65% Q2: 58%</td>
<td>Q1: 60% Q2: 60%</td>
<td>-3%</td>
<td>+2%</td>
<td>↑</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Percentage of enrolled Pacific patients with diabetes (age 15-74 years) whose latest systolic blood pressure measures in the last 12 months is &lt;140 mmHg</td>
<td>Quarterly</td>
<td>TBC in Q2</td>
<td>TBC in Q2</td>
<td>New indicator TBC in Q2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of enrolled Pacific patients with diabetes (aged 15 to 74 years) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td>Quarterly</td>
<td>TBC in Q2</td>
<td>TBC in Q2</td>
<td>New Indicator TBC in Q2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Lotumou</strong></td>
<td>Expanded reach of Pacific Communities and groups (number of organisations)</td>
<td>Quarterly</td>
<td>20</td>
<td>15</td>
<td>New Indicator</td>
<td>12</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
## CM Health 2016/17 Summary Progress Report as at the end of Quarter 3 – Asian Health

**Key**

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Target achieved</td>
</tr>
<tr>
<td>Black</td>
<td>Data not available</td>
</tr>
<tr>
<td>Yellow</td>
<td>Within 10% of target (1-1.5 times target rate)</td>
</tr>
<tr>
<td>Blue</td>
<td>Data available, but no target for comparison</td>
</tr>
<tr>
<td>Orange</td>
<td>10-20% away from target (1.5-2 times target rate)</td>
</tr>
<tr>
<td>Grey</td>
<td>Sample size &lt; 20, too small to provide meaningful percentage</td>
</tr>
<tr>
<td>Red</td>
<td>More than 20% away from target (more than 2 times)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Baseline as per published 2016/17 AHP</th>
<th>Performance 2016/17</th>
<th>Equity Gap</th>
<th>Change from previous quarter</th>
<th>Trend</th>
<th>Desired Trend</th>
<th>Direction</th>
<th>Total Pop. or Non-Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Health</strong></td>
<td>Percentage of preschool children 0-4 years enrolled in DHB funded oral health service (PP13)</td>
<td>Annually</td>
<td>95%</td>
<td>69%</td>
<td>Q1: 87%</td>
<td>+8%</td>
<td>N.A.</td>
<td>N.A.</td>
<td></td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q2: 87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q3: 87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q4: 87%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                   | Percentage of children caries free at age 5 years (PP11)                   | Annually               | 55%            | 63.6% (all other ethnicities including Asian) | Q1: 56%              | +7.7%      | N.A.                             | N.A.  |               | 65%       |                        |
|                   |                                           |                        |                |                                        | Q2: 56%              |            |                                 |       |               |           |                        |
|                   |                                           |                        |                |                                        | Q3: 56%              |            |                                 |       |               |           |                        |
|                   |                                           |                        |                |                                        | Q4: 56%              |            |                                 |       |               |           |                        |

| **Cervical Cancer** | Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 months | Quarterly             | 80%            | 65.7%                                  | Q1: 65.5%             | -6.8%      | N.A.                             | -0.2% |               | 73.6%     |                        |
|                   |                                           |                        |                |                                        | Q2: 65%              |            |                                 |       |               |           |                        |
|                   |                                           |                        |                |                                        | Q3: 66.8%             |            |                                 |       |               |           |                        |
|                   |                                           |                        |                |                                        | Q4: 66.8%             |            |                                 |       |               |           |                        |

| **Diabetes Management** | Percentage of patients with HbA1c <=64 mmol/mol (PP20) | Quarterly | TBC | TBC | N.A. | N.A. | N.A. | N.A. |
|                       | Percentage of patients with blood pressure measures <140 mmHg | Quarterly | TBC | TBC | N.A. | N.A. | N.A. | N.A. |
|                       | Percentage of patients on an ACE inhibitor or Angiotensin Receptor Blocker | Quarterly | TBC | TBC | N.A. | N.A. | N.A. | N.A. |
Counties Manukau Health
Community and Public Health Advisory Committee
Auckland Regional Public Health Service Briefing

Recommendation

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

Receive this update from ARPHS on key pieces of work that are underway and/or completed since our last update.

Prepared and submitted by: Jane McEntee, General Manager, Auckland Regional Public Health Service (ARPHS) and Julia Peters, Clinical Director, ARPHS

Purpose

ARPHS is providing this update to Counties Manukau Health CPHAC on key pieces of work that are underway and/or completed since our last update. This report contains the following updates:

1. Community water fluoridation.
2. Local Alcohol Policy appeal.
3. Healthy Auckland Together update.
4. Project Auaha (an obesity initiative) update.
5. ARPHS’s response to Watercare’s Ardmore Water Treatment Plant production issues.
6. Typhoid and mumps outbreaks in the Auckland region.
9. Submissions (Appendix A contains the key points for each submission).

Community Water Fluoridation

The National-led Government is proposing to amend legislation to transfer the decision-making for community water fluoridation (CWF) from territorial local authorities (TLAs), to district health boards (DHBs). The aim of this change is to increase the proportion of New Zealanders with access to fluoridated water.

The majority of the reticulated water in the Auckland region is already fluoridated. Currently, 96% of Aucklanders on a reticulated supply receive fluoridated water. The non-fluoridated parts of the region are typically the satellite towns and Onehunga, along with more rural areas without reticulated supply.

To support the proposed legislative change, the Health (Fluoridation of Drinking Water) Amendment Bill was released for consultation in December 2016. The Bill provides that a district health board may direct a local government drinking-water supplier to add or to not add fluoride to drinking water supplied by that supplier within the district health board’s geographical area.

In deciding whether to make a direction, a district health board must consider:

- scientific evidence on the effectiveness of adding fluoride to drinking water in reducing the prevalence and severity of dental decay; and
• whether the benefits of adding fluoride to the drinking water outweigh the financial costs, taking into account: the state of the oral health of its resident population; the number of its resident population to whom the local government drinking-water supplier supplies drinking water; and
• the likely financial cost and savings of adding fluoride to the drinking-water supply, including any additional financial costs of ongoing management and monitoring.

The Cabinet Paper released as part of the consultation indicates that the Ministry of Health will create standardised tools to assist DHBs in the decision-making process.

ARPHS, with endorsement from the three Auckland regional DHB CEOs, lodged a submission on the Bill in February 2017 (refer Appendix A). Dr Julia Peters, ARPHS Clinical Director, has participated on the Ministry of Health convened DHB fluoride working group, and did an oral presentation to the Bill on 23 March 2017.

The Bill has yet to progress to its second reading, and could be amended during the Select Committee process.

Local Alcohol Policy (LAP) Appeal

Auckland Council’s proposed local alcohol policy (LAP) will influence when, where and how alcohol is sold across the region and will be in place for six years, then reviewed. Once in place, the LAP will have the ability to influence the trading hours and density of licensed premises throughout Auckland.

ARPHS has appealed two key elements of the LAP in order to strengthen the final policy. The Alcohol Regulatory Licencing Authority (ARLA) set aside four weeks for hearing all parties’ appeals of the LAP in February and March 2017. Toward the end of the first week the Police and Medical Officer of Health (MOH) made a joint opening statement on the matters jointly appealed:
  • proposed on licence hours, and;
  • seeking further additions to the list of priority areas in Auckland to receive additional restrictions.

Health, police and social sector appellants and interested parties continued to provide a coordinated approach to the Auckland appeal with supporting witnesses giving evidence for the majority of the second week. Evidence given on behalf of the MOH focused on ARPHS and Auckland City Hospital Emergency Department’s study, which highlights the nature of Auckland’s alcohol related harm, as well as interpreting relevant local and international research for the Auckland context.

With the completion of the appeals hearing, ARPHS has developed a closing submission and reply, and are now awaiting ARLA’s decision. ARPHS will notify DHBs once the decision is available.

(We note also that ARPHS is working with CM Health staff as part of progressing the DHB work programme to reduce alcohol related harm in Counties Manukau communities. This includes building the data picture of alcohol related harm to support ongoing and future alcohol harm reduction operational and policy work.)
Healthy Auckland Together (HAT) Update

Healthy Auckland Together (HAT) partners are continuing to collaborate on a range of initiatives throughout the Auckland region. Over the last eleven months there have been a number of highlights for HAT, including:

- **Healthy Families Manukau, Manurewa-Papakura** (partner of HAT) announced the removal of sugar sweetened beverages from vending machines at the leisure centres Council operates. This is a positive step in the right direction and shows Auckland Council is serious about the health and wellbeing of its people. HAT supported this by attending the announcement and writing a supportive media release, which was picked up by NewsHub and World TV.

- On 25 August 2016, HAT presented to 78 individuals representing various organisations at the Manukau East Council of Social Services Community Safety Breakfast meeting. This provided an opportunity for HAT to engage with the Howick community. Attendees were asked to endorse the HAT Plan 2015-2020 and consider some of the projects HAT are doing in the six action areas of the Plan, and how Howick could support these.

- HAT partners were involved in the development of the national district health boards and Ministry of Health’s healthy food and beverage environments policy. This was signed off in July 2016. HAT is supporting the policy by promoting it through various channels. These include:
  - Healthy Families Manukau, Manurewa, Papakura are following the beverage criteria for the removal of sugar-sweetened beverages in Auckland Council leisure centres.
  - Healthy Families Sport Waitakere using the policy to make an approach to their local boards suggesting they adopt the policy.
  - ARPHS supporting Auckland Tourism, Events and Economic Development (ATEED) with adopting and implementing the policy for their organisation, starting with major events such as Diwali and the Chinese Lantern Festival.

- HAT presented at an Auckland Council local board plan advisors’ workshop in February 2017. HAT suggested ways of including health and wellbeing outcomes into board plans that are currently being developed. These strategic three-year plans reflect the priorities and preferences of the local board’s community. This offered an opportunity to work more closely with local boards to offer strategic advice on health planning at a local government level. Draft Local Board Plans will be available for public comment on 22 May 2017.

- Following on from last year’s first Baseline Monitoring Report, the second annual HAT monitoring report has been completed and released on 3 May 2017. Results from the report have been presented to the HAT interagency group, and requests made for members to integrate the results into their work. An illustrated summary was developed to assist with communicating the key findings. Key findings from the monitoring report include:
  - There has been a decline in rates of children who are overweight or obese from 22% to 20%. However, there has also been a decline in the percentage of children who usually bike, walk or scoot to school. Only 43% of all children aged 5-14 years old used active transport to get to school. Almost all genders and ethnicities are being driven to school in greater numbers. There has been no change in the rates of child tooth decay in the past decade, with persistently high rates for Pacific and Māori children.
  - The overall proportion of obese adults in Auckland is now 27.8%, up from 24% in 2006. The percentage of adults meeting both fruit and vegetable guidelines is now 36.3%. This is a very small increase from last year, but most adults are still not eating enough fruit and vegetables.
  - The number of trips taken on public transport per person continues to rise. There has been huge growth in expenditure on cycle and walking infrastructure. It is noted that 39% of Aucklanders can walk to a suburb park in five minutes.
The release of the monitoring report received good media coverage and was picked up by several major print and radio news media outlets. The full monitoring report can be accessed via: [http://www.healthyaucklandtogether.org.nz/reports/summary-report/](http://www.healthyaucklandtogether.org.nz/reports/summary-report/)

**Project Auaha Update**

Project Auaha was instigated by ARPHS in response to the chair of Auckland’s three DHBs invitation for Healthy Auckland Together to present a proposal for addressing obesity in the Auckland region. The initiative needs to be collaborative, capable of being delivered at scale and able to connect hearts and minds to achieve meaningful change.

Eight options were considered by a working group. After reviewing the proposals the working group agreed to endorse the ‘displacing sugary beverages with water’ and the ‘building a prevention system for Auckland’ proposals. The ‘displacing sugary beverages with water’ proposal, titled “Wai Auckland”, has been developed into a business case in consultation with key stakeholders. In July 2017 the business case will be progressed through management processes for submission to the four boards for approval and funding (Auckland, Waitemata and CM Health DHBs and Auckland Transport). Further consideration is being given to the ‘prevention system’ proposal.

**Watercare Ardmore Water Treatment Plant**

The Ardmore Water Treatment Plant (WTP), which draws on raw water from the Hunua Ranges, contributes up to 65% of Auckland’s metropolitan drinking water supply. Between 3pm on Tuesday 7 March and 3pm on Wednesday 8 March 2017 the Hunua Ranges received over 250 mm of rain. This event resulted in a significant increase in the turbidity of the raw water supplied to the Ardmore WTP, severely impacting its production capacity. The reduced capacity at Ardmore increased the risk of the system being over-loaded. As a result, Watercare asked customers to reduce their water consumption by 20 litres per person per day until 1 April 2017.

Following the rainfall event ARPHS worked with Watercare Services Ltd to mitigate risks to the Drinking Water Supply for the Auckland Region. ARPHS attended emergency meetings, reviewed operations, and collaborated with Watercare to provide technical input into messaging regarding the security of Auckland’s water supply.

**Typhoid Fever and Mumps Outbreaks**

The Auckland region is experiencing concurrent outbreaks which are requiring careful management.

**Typhoid Outbreak**

ARPHS continues to follow up the typhoid outbreak, which was initially identified in March 2017. To date, all cases in this outbreak are connected to the same church group, the Mt Albert Samoan Assembly of God church which met at a school hall in Mt Roskill.

As at 23 May 2017, two new cases have been identified that are associated with the Auckland typhoid outbreak, bringing the number of confirmed cases to 24 (20 symptomatic, four asymptomatic). There is one probable case. There are no cases under investigation. There has been one death.

The two new cases are being managed outside of Auckland, but are linked to the same families and church group as the other cases associated with this outbreak. There is no evidence of anyone from outside these groups being infected. The new cases are in line with the expected pattern of a...
typhoid outbreak. ARPHS still considers the outbreak is waning but the two new cases do reinforce the importance of continued vigilance and follow up. Prior to the two new cases, there had been no new symptomatic cases confirmed since 5 April 2017.

APRHS is continuing to work with colleagues in the wider health sector and those affected by the outbreak, ensuring appropriate testing, advice and treatment. The outbreak investigation has revealed a relatively high proportion of asymptomatic carriers within the affected population. Management of these individuals is being undertaken in consultation with infectious disease physicians.

ARPHS has undertaken some general media messaging across Pacific radios to distribute some general messages about typhoid. Translated information was also sent to Pacific churches across Auckland on 9 April. As a result of the typhoid outbreak the public has become more aware of and interested in public health.

ARPHS has established a landing page on its website where all media updates and information is located: [http://www.arphs.govt.nz/typhoid-response](http://www.arphs.govt.nz/typhoid-response)

**Mumps Outbreak**

ARPHS is also dealing with an outbreak of mumps in the Auckland region, which started in January 2017. The burden of mumps is borne by those aged 10 to 19 years, those residing in West Auckland (including a large outbreak in a secondary school), and those who are living in the most socioeconomically deprived areas (based on NZDep13 index).

As of 25 May 2017, there were 92 confirmed/probable cases notified to ARPHS, with three of these notified over the previous week. Massey High School has 18 cases with two of these being fourth generation mumps cases. Cases arising in the community who have been associated with Massey High School (household or social contact) number seven, two of whom have documented two doses of the MMR vaccine, and three who are fourth generation cases. There have been four mumps cases that have developed orchitis, and all required hospitalisation.

Despite public health advice to immunise with MMR, the proportion of partially vaccinated (15%) or non-vaccinated (62%) mumps cases remains high, making management of this outbreak challenging. At least half of the mumps cases are epidemiologically linked i.e. students, household contacts, or friends, while almost 20% are incursions from overseas (mostly Fiji where mumps is not included in their vaccine programme).

Due to the ongoing extent of this outbreak, in liaison with the Ministry of Health and the Auckland DHBs ARPHS is implementing the ARPHS Mumps 2017 Outbreak ‘Manage it’ phase. This primarily means ARPHS will focus on directing health sector and public health resources to those actions likely to be most effective in limiting further community spread of mumps. This includes identifying cases, provision of public health information, and promotion of MMR vaccination.

**Health Protection Amendment Act**

The Health (Protection) Amendment Act (HPAA) came into effect on 4 January 2017, updating the Health Act 1956. All notifiable infectious diseases now come under the same, consistent law and regulations. The Tuberculosis (TB) Act 1948, TB Regulations and Venereal Diseases Regulations have

1 i.e. 4 passes through the local population
2 Orchitis is an inflammation of the testis, accompanied by swelling, pain, fever, and a sensation of heaviness in the affected area.
been replaced and brought under the Health Act, and the Health (Infectious and Notifiable Diseases) Regulations (HIND) have been re-written. Artificial UV tanning services can now not be offered to people aged under 18.

The main changes in the infectious disease provisions in the HPAA cover:

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

The Ministry of Health has produced a guide for implementation. ARPHS has been updating its protocols, processes, templates, training, certification and reporting.

**Auckland Plan Refresh**

The Auckland Plan, first adopted on 29 March 2012, sets the region’s strategic direction over the next 30 years. Auckland Council is now in the beginning stages of updating the Auckland Plan (named the Auckland Plan refresh) to help guide the Long-term Plan 2018-2028 review.

The Auckland Plan refresh is being progressed through five work streams: protect and restore; skills and jobs; homes and places; belonging and access; and connectivity. ARPHS, with the support from the three DHBs, has ongoing input into the Refresh, in particular the belonging, and access and connectivity work streams. Critical strategic directions for the work streams were reviewed by councillors at the Planning Committee on 28 March 2017, and at this meeting the committee recommended a “streamlined spatial approach”. The Plan refresh will now focus on spatial components while ensuring these are strongly connected to the achievement of high-level social, economic, environmental and cultural objectives. The new approach closely aligns to the legislation that governs the Plan. Council staff have also been directed to the NRA to link the Refresh process with the DHBs’ Long Term Investment Plan work programme.

A progress report on the Plan refresh will go back to the Planning Committee on 20 April 2017.

ARPHS and the DHBs support a closer working relationship with Auckland Council on strategic planning issues and, over time, aim to assist planners to make it easier for Aucklanders to lead healthy lives. ARPHS will work closely with Counties Manukau locality staff to help planners, developers and communities work towards creating healthier streets, towns and cities.

**Submissions**

ARPHS has completed and submitted 19 submissions during July 2016 – May 2017. The table below lists the submissions and Appendix A briefly summarises the key points for each submission.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>• Housing for older people (Auckland Council)</td>
</tr>
<tr>
<td></td>
<td>• Standardised Tobacco Products and Packaging Draft Regulations (Ministry of Health)</td>
</tr>
<tr>
<td></td>
<td>• New Zealand Health Research Strategy (Ministry of Health)</td>
</tr>
<tr>
<td>August</td>
<td>• Proposed new Wastewater Treatment Plant at Snells Beach/Algies Bay (resource consents lodged with Auckland Council) - Watercare Services Limited</td>
</tr>
<tr>
<td>September</td>
<td>• Ethnicity Data Protocols for the Health and Disability Sector (Ministry of Health)</td>
</tr>
<tr>
<td></td>
<td>• Policy Options for the Regulation of Electronic Cigarettes: A consultation document (Ministry of Health)</td>
</tr>
<tr>
<td>Month</td>
<td>Events</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| October | • Aged care facility proposal at 455 Taupaki Road, Taupaki (resource consent application lodged with Auckland Council)  
• New Zealand General Social Survey 2018 (NZGSS): Objectives of the Housing and Physical Environment supplement (Ministry of Health) |
| December| • Proposals for changes to food safety regulations (Ministry for Primary Industries)  
• Consultation on proposed F9/AS1 and F9/AS2 Acceptable Solutions for residential pool barriers (Ministry of Business, Innovation and Employment)  
• Consultation for update of Te Whāriki (Ministry of Education) |
| February| • Energy Innovation (Electric Vehicles and Other Matters) Amendment Bill (NZ Parliament)  
• Health (Fluoridation of Drinking Water) Amendment Bill (NZ Parliament)  
• Testing and decontamination of methamphetamine-contaminated properties – Draft New Zealand Standard (Standards New Zealand) |
| March   | • Proposed Waikato Regional Plan Change 1 - Waikato and Waipā River Catchments (Waikato Regional Council)  
• Draft Air Quality Bylaw for Indoor Domestic Fires (Auckland Council)  
• Auckland Council’s 2017/2018 Annual Budget consultation  
• Draft Government Policy Statement on Land Transport (Ministry of Transport) |
| May     | • Urban Development Authorities discussion document (MBIE) |
### Appendix A - Summary points for ARPHS submissions during July 2016 – May 2017:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing for Older people</strong></td>
<td>Auckland Council owns 1,412 units across Auckland, providing homes for older people with a housing need. The Council proposed to partner with a third party social housing provider to form a new Community Housing Provider (CHP). The new CHP will have expert input from the chosen partner and will be entitled to access the government Income Related Rent Subsidy (IRRS). ARPHS recommended that Council include a clause in the proposed service agreement that requires all housing managed under the contractual agreement to meet and maintain the rental Warrant of Fitness standard.</td>
</tr>
<tr>
<td><strong>Standardised Tobacco Products and Packaging Draft Regulations</strong></td>
<td>Feedback was sought on the draft Regulations for the Smoke-free Environments (Tobacco Plain Packaging) Amendment Bill. Tobacco product design, appearance, packaging and labelling, improved graphic warnings, and standardised pack quantities are all to be set out in the Regulations. ARPHS’s submission recommended use of dissuasive sticks, the inner surface of cigarette packs matching the proposed outside colour of the pack, restrictions on the ability of tobacco companies to use misleading variant names and slogans, and standardising shisha product packaging.</td>
</tr>
<tr>
<td><strong>New Zealand Health Research Strategy</strong></td>
<td>New Zealand’s first health research strategy will guide decisions on the health research and innovation system over the next ten years. The initial discussion document outlined a proposed vision, mission and guiding principles, as well as strategic priority examples. ARPHS’s submission supported the intent of the Strategy, but outlined what may be some underlying challenges including, workforce instability and funding uncertainty. ARPHS suggested more emphasis could be placed on how particular aspects of the health research and innovation system will work, and advocated for a greater research focus on preventative health measures and the wider social determinants of health.</td>
</tr>
<tr>
<td><strong>Proposed new Wastewater Treatment Plant at Snells Beach/Algies Bay</strong></td>
<td>Watercare propose to construct a new wastewater treatment plant (WWTP) to provide ongoing service to the communities of Warkworth, Snells Beach, Algies Bay and Martins Bay. ARPHS supported the proposal as it will cater for the expected population growth in the Warkworth and Snells Beach areas, and eventually result in the complete removal of treated wastewater discharges from the upper Mahurangi Harbour once the Warkworth WWTP is decommissioned. This will have a long term positive impact on the commercial oyster farms in Mahurangi Harbour. ARPHS did request that the hearings panel give careful consideration to what is the optimal location of the new outfall off Martins Bay, as well as additional monitoring requirements.</td>
</tr>
<tr>
<td><strong>Ethnicity Data Protocols for the Health and Disability Sector</strong></td>
<td>ARPHS recommended: that there be a standardised process for updating the NHI should user of health services indicate their recorded ethnicity is incorrect, any ethnicity data shared should be at level 4 (level 4 means any person can have up to 6 ethnicities from a list of 239 ethnic codes), and to develop a statistical method to handle multiple ethnicities instead of using prioritised ethnicity. ARPHS also noted that implementation will require IT modifications and training.</td>
</tr>
<tr>
<td><strong>Policy Options for the Regulation of Electronic Cigarettes: A consultation document</strong></td>
<td>ARPHS’s submission recommended that EC are legalised in New Zealand for the purpose of smoking cessation and tobacco harm minimisation, but also recommended that the EC and e-liquid packaging be standardised to acknowledge the unknown long-term health effects, and help buffer against future (somewhat unknown) unintended consequences.</td>
</tr>
<tr>
<td><strong>Aged care facility proposal at 455 Taupaki Road, Taupaki</strong></td>
<td>The reuse of treated wastewater was proposed as part of this application. There is no reticulated wastewater in the vicinity so the...</td>
</tr>
<tr>
<td>New Zealand General Social Survey 2018 (NZGSS): Objectives of the Housing and Physical Environment supplement</td>
<td>Every two years, the NZGSS takes a snapshot of the well-being of people in New Zealand. Since 2014, the survey includes a rotating supplementary module, allowing the survey to focus on a theme of high public interest. Housing and the physical environment has been identified as the most suitable topic for the 2018 NZGSS. ARPHS submitted in support of the survey but recommended that more information be collected on homelessness. It was suggested that Statistic New Zealand’s existing definition of ‘homelessness’ be used.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Proposals for changes to food safety regulations | The Ministry sought feedback on the Proposals for changes to food safety regulations. ARPHS recommended:  
  a) Amending Food Regulations 2015 ensuring all food businesses (including vehicles) should be kept clean, hygienic and free from pest.  
  b) Reduced record keeping for lower-risk businesses was not advisable.  
  c) As not all cases of infectious disease are notified through the Health Act 1956, MPI need to ensure adequate mechanisms are in place to explicitly manage the exclusion of food handlers with diarrhoea or other infectious diseases.  
  d) it should be up to the food manufacturers to ensure that the chemical composition of the reticulated water they use is appropriate for their product. |
| Consultation on proposed F9/AS1 and F9/AS2 Acceptable Solutions for residential pool barriers | In line with the Building (Pools) Amendment Act (which came into effect on 1 January 2017) and the Building Code, MBIE proposed new ‘Acceptable Solutions (AS)’ for barriers that restrict young children from accessing residential pools and small heated pools. Along with other stakeholders, ARPHS provided feedback to Watersafe Auckland on the proposed AS. Watersafe Auckland incorporated stakeholders’ comments into a joint submission. |
| Consultation for update of Te Whāriki | Te Whāriki is the national curriculum document for early childhood education. ARPHS supported the development of a comprehensive, online website to support teachers, and via this platform, expressed a willingness to share information and resources on nutritional environments in early childhood centres and preventing communicable childhood illness |
| Energy Innovation (Electric Vehicles and Other Matters) Amendment Bill | Part of this omnibus bill introduced measures to encourage the uptake of electric vehicles (EVs). ARPHS supported the Bill’s intent to introduce incentives to encourage the uptake of EVs, but did not support the specific policy of allowing EVs to access special vehicle lanes. ARPHS is concerned that this policy would adversely affect the efficiency of existing transport networks and strategies designed to enhance overall mobility. |
| Health (Fluoridation of Drinking Water) Amendment Bill | The proposed Bill amends Part 2A of the Health Act 1956 by inserting a power for DHBs to make decisions and give directions about the fluoridation of local government drinking water supplies in their areas. ARPHS and the three Auckland district health boards recommended that:  
  - Section 69ZJA(3) of the Bill be reworded to operate as intended, and ensure that agreement between DHBs to fluoridate a water supply is not necessary when the water |
supply system in question does not cross DHB boundaries.

- DHB assessments to determine whether to fluoridate a drinking water supply are restricted to the assessment of health benefits.
- Greater consideration be given to the financial implications of the Bill for DHBs.

**Testing and decontamination of methamphetamine-contaminated properties**

The purpose of this standard is to provide guidance on reducing people’s risks of exposure to harm caused by the presence of unacceptable levels of methamphetamine (MA) residues in properties and other assets.

ARPHS outlined the importance of the Ministry’s 2010 guideline clean-up level of 0.5 µg/100cm², which has been applied throughout the Auckland region for all premises found to be contaminated with MA (regardless of whether there is existing evidence of MA production). However, the NZS proposed interim approach is for TLAs to use the lower level of 0.5 µg/100cm² only when there is existing evidence of MA production. ARPHS did not support adopting the interim approach, and recommended guidance on appropriate testing/criteria to determine MA manufacture, such that in the absence of visible signs or Police records, human health continues to be adequately protected.

**Proposed Waikato Regional Plan Change 1 - Waikato and Waipā River Catchments**

The proposed plan change seeks to reduce key contaminants (nitrogen, phosphorus, sediment and microbial pathogens) entering water bodies in the Waipa and Waikato river catchments, with much of the emphasis on reducing contaminant losses from pastoral farm land, and better management of diffuse discharges to land and water. ARPHS supports the overall intent of the proposed plan change to maintain and improve the overall quality of the freshwater resources, as well as a number of specific initiatives such as the application of farm management plans and a registration system. ARPHS considered farming activities should be required to fence off water bodies much sooner than proposed.

**Draft Air Quality Bylaw for Indoor Domestic**

ARPHS supported the adoption of a proposed bylaw to re-establish the regional rules for indoor domestic fires previously contained in the former Auckland Council Regional Plan: Air, Land and Water. ARPHS also supported the proposal to update the Auckland Urban Air Quality Areas to reflect the urban zones in the Unitary Plan and the Hauraki and Gulf Islands District Plan. ARPHS advocated that more needs to be done to reduce harmful emissions from indoor domestic fires.

**Auckland Council Annual Budget 2017/2018**

The 2017/18 budget had no smokefree implementation budget identified, despite the 2016 review of Council’s smoke-free policy that highlighted areas for further improvement. As such, ARPHS’s comments on the budget were restricted to Auckland Council’s leadership role on tobacco control, and, in particular, the implementation budget for the smoke-free policy.

ARPHS emphasised:

- the importance of continuing action in tobacco control, and
- the need for strengthening and effective implementation of Auckland Council’s smoke-free policy – which aims to increase smoke-free public outdoor spaces across the region.

Furthermore, ARPHS recommended that the implementation budget be included in baseline budgets from 2017/2018 onward. The finalised Annual Budget 2017/2018 will be adopted at the Governing Body meeting on 29 June 2017.

**Draft Government Policy Statement on Land Transport**

The Government Policy Statement on Land Transport (GPS) sets out the government’s priorities for expenditure from the National Land Transport Fund over the next 10 years.

ARPHS recommended:

- The investment class allocations in the GPS should be reassessed.
to prioritise public transport and active transport above state highways and local roads in New Zealand’s cities.

- For Auckland, alleviating congestion and increasing travel time reliability should be the main focus of the GPS funding and policy outcomes. This will require increased investment in the Public Transport allocation class.
- There is a need for the GPS funding and policy outcomes to better recognise the different transport demands of cities and regional areas – especially in the case of Auckland.

**Urban Development Authorities discussion document**

New legislation is being considered that will enable local and central government to:

- empower nationally or locally significant urban development projects to access more enabling development powers and land use rules; and
- establish new urban development authorities to support these projects where required.

ARPHS recommended that UDA projects prioritise:

- Meeting housing needs.
- Building liveable, functioning, healthy neighbourhoods that establish links to public transport as part of robust infrastructure.
- Integration of housing within local community facilities and services, and local employment.
Counties Manukau District Health Board  
Community & Public Health Advisory Committee  
System Level Measures Framework

**Recommendation**

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

**Receive** the current System Level Measures (SLM) framework and current performance report.

**Agree** that the Community & Public Health Advisory Committee will review quarterly reporting on the 2017/18 Metro Auckland Improvement Plan going forward. This reporting will outline progress made against SLMs and contributory measures and improvement activities undertaken.

**Recommend** to the Board that it receive quarterly reporting on progress against the 2017/18 Metro Auckland Improvement Plan.

**Prepared and submitted by:** Kate Dowson, Primary Care Programme Manager on behalf of Benedict Hefford, Director Primary Care and Community Services.

**Purpose**

The purpose of this paper is to provide the CPHAC with an overview of the SLMs framework process.

**Executive Summary**

The Ministry of Health has been working with the sector to co-develop a suite of System Level Measures (SLMs) that provide a system-wide view of performance. The SLMs are high-level aspirational goals for the health system that align with the five strategic themes of the New Zealand Health Strategy 2016 and other national strategic priorities such as Better Public Service Targets. The SLMs have a focus on children, youth and vulnerable populations.

From 1 July 2016 the SLMs framework replaced the Integrated Performance and Incentive Framework, and required Alliance Leadership Teams to develop an improvement plan outlining planned activity. The Counties Manukau and Auckland Waitemata Alliance Leadership Teams agreed to work together on a Metro Auckland SLMs improvement plan. A regional SLMs steering group and working groups were established to support this process. The 2016/17 Metro Auckland SLMs Improvement Plan was approved by the Alliance Leadership Teams and the Ministry of Health for implementation. Counties Manukau Health is currently on track to meet the improvement milestones in this plan.

The 2017/18 Metro Auckland SLMs Improvement Plan has been drafted and will be submitted to the Alliance Leadership Teams for approval in early June. The Board will receive the plan once agreed by the alliances. It is also proposed that the Board and CPHAC review quarterly regional reporting on the improvement plan going forward. This reporting will outline progress made against SLMs, contributory measures and improvement activities undertaken.
Background

The New Zealand Health Strategy outlines a new high-level direction for New Zealand’s health system over the next ten years to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has been working with the sector to develop a suite of SLMs that provide a system-wide view of performance. In late 2016 alliances were required to develop an improvement plan in accordance with Ministry of Health guidelines for the 2016/17 year.

The approach to the development of the Metro Auckland SLM Improvement Plan is outlined in the diagram below. In particular, Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of an SLMs improvement plan. The rationale for a single improvement plan is that a number of Primary Health Organisations cross Auckland Metro District Health Board boundaries and are members of both alliances.

The intention is that a local implementation plan will sit under the regional improvement plan. This will provide a higher level of detail around activities and will aim to act as a framework bringing together both SLM activity and other existing activity. This will outline alignment with the Counties Manukau Health Healthy Together 2020 Strategic Plan.
2017/18 Improvement Plan

A 2017/18 plan is now in the final stages of development. The working groups completed in-depth analytics to inform development of the plan, and key stakeholders (including equity partners) have also been engaged through socialisation workshops. The intention is to build on the 2016/17 improvement plan with additional measures and activities, in line with Ministry expectations for 2017/18.

The 2017/18 improvement plan includes:

a) Six SLMs which are mandated by the Ministry of Health;

b) For each SLM, an improvement milestone to be achieved in 2017-18. The milestone must be a number that either improves performance from the baseline or reduces variation to achieve equity;

c) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution, and have been validated locally.

Presented below is an overview of the milestones and contributory measures chosen for each of the SLMs in this improvement plan.
### AMBULATORY SENSITIVE HOSPITALISATIONS 0-4 YEARS

**Improvement Milestone**
- 5% reduction in rate by June 2018

- Children Fully Immunised by 8 Months of Age
- Skin Infections
- Oral Health
- Respiratory Conditions Prevented by Special Immunisations

**Keeping children out of hospital**
- Using health resources effectively

### ACUTE HOSPITAL BED DAYS

**Improvement Milestone**
- 2% reduction – 438.7 standardised acute bed days/1000 by June 2018

- Emergency Department Attendance Rate
- Acute Readmission Rates in 28 Days

**Patient Experience of Care**

- PHC PES: 50% of PHO practices participating in the PHC PES by June 2018
- Hospital Inpatient Survey: Aggregate score of 8.5 across all 4 domains measured

- District Health Board Inpatient Survey
- E-portals
- Participation in PHC Patient Experience Survey

**Ensuring patient centred care**

### AMENABLE MORTALITY

**Improvement Milestone**
- 3% reduction by June 2018

- Cardiovascular Disease Management
- Smoking Cessation

**Preventing and detecting disease early**
- Youth are healthy, safe and supported

### YOUTH ACCESS TO AND UTILISATION OF YOUTH APPROPRIATE HEALTH SERVICES

**Improvement Milestone**
- Sexual and Reproductive health: 80% of pregnant women are screened for chlamydia during pregnancy

Other domains: Establish baselines

- Sexual and Reproductive Health
- Youth Experience of the Health System
  - Mental Health and Wellbeing
  - Alcohol and Other Drugs
  - Access to Preventive Services

### BABIES IN SMOKE-FREE HOUSEHOLDS

**Improvement Milestones**
- Establish baseline referral to smoking cessation services for pregnant women identified as current smokers

- Better help for smokers to quit – pregnancy health target
- Maternal Smoke-free Services
- Smoking Cessation
- Maternal Smoking Prevalence Data

**Healthy start**
Overview of each SLM

Ambulatory Sensitive Hospitalisations (ASH) 0-4 year olds

ASH are hospital admissions which are considered as potentially preventable if the patient had received timely preventative intervention or treatment in primary care. In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year.

ASH rates can serve as a proxy for primary care access and quality. ASH rates are also determined by other factors such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with reducing health inequities.

Acute Hospital Bed Days Per Capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services, and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary, and secondary care.

Patient Experience of Care

‘Person centred care’ or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. The intended outcome for this SLM is improved health outcomes for patients through improved patient safety and experience of care. There are two improvement measures chosen for this SLM:

- The Hospital Inpatient Patient Experience Survey has been in place since 2014. This survey captures four measured domains - communications, partnership, coordination, and physical and emotional needs.
- The Primary Care Patient Experience Survey, which has only been developed more recently and is currently being implemented in general practices.

Amenable Mortality

Amenable mortality is defined as premature deaths that could potentially have been avoided if the patient had received effective and timely healthcare. That is, deaths from diseases for which effective health interventions exist that might prevent death.

Two areas have been chosen to focus on: cardiovascular disease and smoking cessation. Cardiovascular disease is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions has been shown to significantly reduce premature death and disease. Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health.

Youth access to and utilisation of youth appropriate health services

This measure will be implemented in 17/18 and is considered developmental.
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or ‘risk factors’. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes. The Ministry of Health have set five domains for this measure, and have asked alliances to focus on one domain in the first year:

- Youth Experience of the Health System;
- Sexual and Reproductive Health;
- Mental Health and Wellbeing;
- Alcohol and Other Drugs, and
- Access to Preventive Services.

For 2017/18, metro Auckland will focus on sexual and reproductive health (in particular, chlamydia testing coverage).

**Babies Who Live in a Smoke-free Household at Six Weeks Post-natal**

This measure will be implemented in 17/18 and is considered developmental.

The definition of a smokefree household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whaanau environment. It emphasises the need to focus on the collective environment that an infant will be exposed to - from pregnancy, to birth, to the home environment within which they will initially be raised.

**Current Performance**

The following scorecard includes the latest available data for each District Health Board for the four 2016/17 SLMs. One regional scorecard has been developed for the Boards of the three metro Auckland District Health Boards.

It is proposed that the CPHAC review quarterly reporting on the 2017/18 Metro Auckland Improvement Plan going forward. This reporting will outline progress made against SLMs and contributory measures, and improvement activities undertaken.
### Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds

<table>
<thead>
<tr>
<th>District / Region</th>
<th>Target 2016/17: Maintain current (baseline) rate for each DHB</th>
<th>Performance</th>
<th>Actual</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>8,265</td>
<td>$\bullet$</td>
<td>7,465</td>
<td></td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>7,348</td>
<td>$\bullet$</td>
<td>7,352</td>
<td></td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>5,427</td>
<td>$\bullet$</td>
<td>5,650</td>
<td></td>
</tr>
<tr>
<td>Metro Auckland Region</td>
<td>6,916</td>
<td>$\bullet$</td>
<td>6,767</td>
<td></td>
</tr>
</tbody>
</table>

*Measure: Rate per 100,000 domiciled 0-4 year-olds.*

*Year ending: Dec-16*

### Acute Hospital Bed Days Per Capita

<table>
<thead>
<tr>
<th>Measure: Age-standardised rate per 1,000 domiciled population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
</tr>
<tr>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>Metro Auckland Region</td>
</tr>
</tbody>
</table>

*Target 2016/17: Two percent reduction in standardised rate*

*Year ending: Dec-16*

### Patient Experience of Care

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
</tr>
<tr>
<td>Waitemata DHB</td>
</tr>
</tbody>
</table>

*Target 2016/17: Maintain an aggregated domain score of 8 (/10) across the three DHBs*

*Quarter ending: Mar-17*

### Amenable Mortality

<table>
<thead>
<tr>
<th>Measure: Aged-standardised rate per 100,000 domiciled 0-74 year-olds.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
</tr>
<tr>
<td>Waitemata DHB</td>
</tr>
<tr>
<td>Metro Auckland Region</td>
</tr>
</tbody>
</table>

*Target 2016/17: Maintain current (baseline) standardised rate for each DHB:*

*Year ending: Dec-13*

---

**Legend**

- Green: Target met / on track
- Yellow: Improvement needed
- Red: Significant improvement needed

- Gray: Metro Auckland Region
- Dark Blue: Auckland DHB
- Blue: Counties Manukau DHB
- Purple: Waitemata DHB
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>
<tbody>
<tr>
<td>2.1 Minutes of CPHAC Public Excluded meeting 3 May 2017</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>3.1 Community Hubs – Draft Strategic Assessment</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>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.</td>
</tr>
</tbody>
</table>