**Communities and Public Health Advisory Committee Meeting (CPHAC)**

**Wednesday, 6 September 2017**

**Venue:** Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

**Time:** 9.00am

**Committee Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Colleen Brown</td>
<td>Committee Chair</td>
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<tr>
<td>Dr Ashraf Choudhary</td>
<td>CMDHB Board Member</td>
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<tr>
<td>George Ngatai</td>
<td>CMDHB Board Member</td>
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<tr>
<td>Dianne Glenn</td>
<td>CMDHB Board Member</td>
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<td>Katrina Bungard</td>
<td>CMDHB Board Member</td>
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<td>Rabin Rabindran</td>
<td>CMDHB Board Member</td>
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<tr>
<td>Apulu Reece Autagavaia</td>
<td>CMDHB Board Member</td>
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</tbody>
</table>

**CMDHB Management**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Gloria Johnson</td>
<td>acting Chief Executive</td>
</tr>
<tr>
<td>Benedict Hefford</td>
<td>Director Primary Community and Integrated Care</td>
</tr>
<tr>
<td>Margie Apa</td>
<td>Director Population Health Strategy and Investments</td>
</tr>
<tr>
<td>Jenny Parr</td>
<td>Director of Patient Care, Chief Nurse &amp; Allied Health Professions Officer</td>
</tr>
<tr>
<td>Dinah Nicholas</td>
<td>Secretariat</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am</td>
<td><strong>AGENDA ORDER AND TIMING</strong></td>
<td></td>
</tr>
<tr>
<td>9.05am</td>
<td><strong>CONFIRMATION OF MINUTES</strong></td>
<td>6-9</td>
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<tr>
<td>9.10am</td>
<td>2.1 Confirmation of Public Minutes of the Community and Public Health Advisory Committee Meeting – 26 July 2017</td>
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<td></td>
<td>2.2 Action Items Register</td>
<td>10-11</td>
</tr>
<tr>
<td>9.15am</td>
<td><strong>BRIEFING PAPERS</strong></td>
<td></td>
</tr>
<tr>
<td>10.00am</td>
<td>3.1 Owing my Gout (Diana Phone, Louise McCarthy, Trevor Lloyd)</td>
<td>12-20</td>
</tr>
<tr>
<td></td>
<td>3.2 Mana Kidz Presentation/School Health Network Business Case (Phil Light, David Rawiri-Jansen &amp; Carmel Ellis)</td>
<td>21-86</td>
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<td></td>
<td><strong>Morning Tea Break (10.30 – 10.45am)</strong></td>
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<tr>
<td>10.45am</td>
<td><strong>FOR INFORMATION</strong></td>
<td>87-105</td>
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<tr>
<td>11.00am</td>
<td>4.1 Q4 Population Health Plans Progress Report</td>
<td></td>
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<td></td>
<td><strong>RESOLUTION TO EXCLUDE THE PUBLIC</strong></td>
<td>106</td>
</tr>
</tbody>
</table>
## BOARD MEMBER ATTENDANCE SCHEDULE 2017 – CPHAC

<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>
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<tbody>
<tr>
<td>Ashraf Choudhary (Deputy Chair)</td>
<td>No Meeting</td>
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<td>Colleen Brown (Chair)</td>
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<td>Dianne Glenn</td>
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<td>Katrina Bungard</td>
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<td>Rabin Rabindran</td>
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<tr>
<td>Reece Autagavaia</td>
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<tr>
<td>External Appointee TBC</td>
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</tbody>
</table>
## CPHAC MEMBERS
### DISCLOSURE OF INTERESTS
**6 September 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  
• 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  
• Huakina Development Trust (Partnership Clinic)  
• Community Organisation Grants Scheme (Auckland)  
• Lotteries Community (Auckland)  
• Member Counties Rugby League Board |
| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
|                | • Deputy Chair Howick Local Board  
|                | • Member of Amputee Society  
|                | • Member of Parafed disability sports  
|                | • Member of NZ National Party |
| Rabin Rabindran| • Chairman, Bank of India (NZ) Ltd  
|               | • Director, Auckland Transport  
|               | • Director, Solid Energy NZ Ltd  
|               | • Director, Swift Energy NZ Ltd  
|               | • Director, Swift Energy NZ Holdings Ltd  
|               | • Director, Kowhai Operating Ltd  
|               | • Director, NZ Liaoning International Investment & Development Co Ltd  
|               | • Singapore Chapter Chairman – ASEAN New Zealand Business Council |
| Reece Autagavaia | • Member, Pacific Lawyers’ Association  
|                | • Member, Labour Party  
|                | • Member, Tangata o le Moana Steering Group  
|                | • Trustee, Epiphany Pacific Trust  
|                | • Trustee, The Good The Bad Trust  
|                | • Member, Otara-Papatoetoe Local Board  
|                | • Member, District Licensing Committee, Auckland Council |
| External Appointee TBC |
## 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 6 September 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 14 June 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, 26 July 2017 at 9.00am
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
George Ngatai
Katrina Bungard
Rabin Rabindran
Apulu Reece Autagavaia

ALSO PRESENT

Matt Hannant (for Benedict Hefford)
Doone Winnard (for Margie Apa)
Annelize de Wet (for Jenny Parr)
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 Gloria Johnson, Benedict Hefford, Margie Apa, Jenny Parr and Katrina Bungard (for lateness).

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with the following amendments:

George Ngatai – Board Member, Manurewa Marae – delete; Member Counties Rugby League Board – add.
There were no Specific Interests in regards to any items on today’s agenda.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 14 June 2017.

Resolution (Moved: Colleen Brown/Seconded: Dianne Glenn)

That the minutes of the Community and Public Health Advisory Committee meeting held on 14 June 2017 be approved.

Carried

Matters Arising from the Minutes

Page 7 Healthy Mums and Babies - ‘Ms Scott was asked whether she could provide both sets of information to the Committee in future reports (ie) one set pertaining to the women registered with an LMC and another set pertaining to the women registered with a DHB midwife’. Dianne Glenn expressed concern that as the Ministry won’t be changing the national definition it will be important for the DHB to be consistently reporting both the national data and our local picture. The Committee asked that every time the national targets are published, they also receive a local picture.

Page 9 The Mumps Outbreak – ‘Fiji does not provide MMR as part of their vaccinations regime. MoH will liaise with the World Health Organisation (WHO) who will work with the Fiji Government in regard to making Mumps part of their immunisation regime. A question was raised in relation to what information is provided to immigrants around immunisations and its availability and it was suggested that perhaps this information could be provided on the ARPHS website. Mr Hefford also suggested that an update could be provided in the next Primary Care e-mailout’.

Dr Winnard advised that she is aware that the Ministry of Health is working with the World Health Organisation in terms of international health regulations and what happens across borders and agreed to follow up with them and report back to the Committee.

Matt Hannant was asked to follow up to ensure that something is being put in the next Primary Care e-mailout in relation to this issue.

Action Items Register

Noted.

3. BRIEFING PAPERS

3.1 Otara/Mangere Locality Briefing

Sarah Marshall provided a presentation to the Committee highlighting the following:
Estimated resident population – high Pacific population, a good number of Maori, Asian and European/Other so is a diversely ethnic community. The ethnicity figures on page 19 were taken from the 2013 census and extrapolated by the DHB on the basis that people will still be living in the same kind of distribution as they were at the time of the 2013 census - this does make a lot of assumptions.

Doone Winnard advised that a paper has been through the ELT and ARF meetings that will be sent to the Ministry of Health advising that according to the DHB health records, we have an additional 25,000 people living here at a particular point in time than the Stats NZ records show. If the PPBF funding share were done according to the people that our health records tell us are living in our area and we are providing services for rather than an estimate, we would funded better. There is an opportunity with Stats NZ for the next census, to try and really count our population properly. We will still run into the problem of people not recording the actual number of people living at a residence (ie) confirming 3 people live there when in fact there are 12.

Localities by prioritised ethnicity – it was noted that Health is the only government department that groups European & Other (African/Middle Eastern) together. In terms of the health profile they are more akin to Asian rather than European. Doone Winnard advised that we could certainly raise this nationally with the Ministry and express concern about it.

Mangere/Otara Strategy - it was felt that the strategy would benefit from having the joint initiatives with the Social Investment Board highlighted (ie) Maternal & Child Nutrition. It was also noted that the strategy has no outcomes for disability and could be strengthened in this area. Because the Mangere/Otara locality has a high Pacific population, would there be any benefit in having a Pacific-led localities programme that would focus on Pacific issues and what is best for them. We have to find better and more innovation ways of engaging with high needs communities.

Locality Leadership Team – Maori Health leadership has been identified as a gap and needs strengthening because it is a priority of the LLT to focus on particular communities. If there are issues with Maori or Pacific representation, as a DHB we should find resources to fill those gaps if we really want to address specific issues. It is not the responsibility of the Maori Health team to fill this gap, it is the responsibility of the DHB to fill the gap. Equity is actually everyone’s business and is mainstream for our DHB. Now is the time for us to sit down and focus on what the important issues are - making a 10% improvement in 60,000 families would be huge.

Service delivery - there was discussion about whether there needed to be specific Maori-focused and Pacific-focused locality strategies, with acknowledgement that delivering for Maori and Pacific communities is everyone’s business, not just Maori and Pacific providers. The Committee were concerned about the lag in being able to deliver to the Maori & Pacific communities at a grassroots level. They are also sufficiently concerned about the ratio between specific targeted community services for Maori & Pacific and those which are mainstream and would like a re-examination and explanation about how this ratio is determined, why it is done this particular way, what the outcomes are and have we got the ratios right. Concern that our current service design isn’t reaching individuals and families who are most vulnerable. The Committee felt that this was a wider issue for the Board to consider.

(Katrina Bungard arrived at 10.00am)

Resolution (Moved: Colleen Brown/Seconded: George Ngatai)

The Community and Public Health Advisory Committee recommend that the Board examine the community funding ratio against mainstream delivery for Maori and Pacific as separate entities.

Carried
The Chair thanked Sarah for her presentation which gave the Committee a deeper understanding of what is going on and congratulated Sarah on the significant achievements the Mangere/Otara locality have undertaken. Localities are a total community investment and a long term plan.

4. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: George Ngatai /Seconded: Katrina Bungard)

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 14 June 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 Self-Management Support in Counties Manukau</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>
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Carried

The meeting concluded at 10.42am.


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 – 6 September 2017**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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</thead>
<tbody>
<tr>
<td><strong>Standing Items</strong></td>
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<tr>
<td>19.8.15</td>
<td>19.8</td>
<td>Locality Updates: Franklin Eastern Manukau Otara/Mangere</td>
<td>18 October 29 November TBC TBC</td>
<td>Kathryn du Luc Penny Magud Lynda Irvine Sarah Marshall</td>
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<tr>
<td>14.6.17/26.7.17</td>
<td>14.6.17</td>
<td>Population Health Plans (Asian, Pacific &amp; Maaori) – quarterly update including a local picture as well as national data on the Healthy Mums &amp; Babies target.</td>
<td>6 September</td>
<td>Marianne Scott</td>
<td>✓</td>
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<tr>
<td>14.6.17</td>
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<td>ARPHS - six-monthly update.</td>
<td>29 November</td>
<td>Mr Hefford</td>
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<tr>
<td>14.6.17</td>
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<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
<td>18 October</td>
<td>Mr Hefford</td>
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<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.</td>
<td>6 September/18 October</td>
<td>Mr Hefford</td>
<td>Work in progress</td>
<td></td>
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<tr>
<td>14.6.17</td>
<td>3.1</td>
<td>Mana Kidz - present on what it is they are providing to enable a more focused discussion around what is done with the information they collect. Dr Brebner to also attend. Statistics to be collected and presented on Public Nurses in schools, according to decile. Further information to be provided on the government funded pepi-pod idea.</td>
<td>6 September</td>
<td>Mr Hefford</td>
<td>✓</td>
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<td>6 September</td>
<td>Mr Hefford</td>
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<td>6 September/18 October</td>
<td>Mr Hefford</td>
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Counts Manukau District Health Board – Community & Public Health Advisory Committee

6 September 2017
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<table>
<thead>
<tr>
<th>DATE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>14.6.17</td>
<td>3.4</td>
<td>SLM Improvement Plan - pleased to see MH, AOD &amp; Sexual &amp; Reproductive health included for Youth Health – provide some baseline data in the next quarterly report.</td>
<td>18 October</td>
<td>Mr Hefford</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>26.7.2017</td>
<td>2.1</td>
<td>Matters Arising from Previous Minutes Mumps – follow up with the MoH in relation to their work with the WHO in terms of international health regulations and what happens across borders and report back to the Committee. Information provided to Immigrants around Immunisations - ensure something is being put in the next Primary Care e-mailout in relation to this issue.</td>
<td>18 October</td>
<td>Dr Winnard</td>
<td>Matt Hannant</td>
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Owning My Gout
Developing a Collaborative Gout Management Model
Counties Manukau- gout capital of the world

> 24,000 people with gout aged 15+

Most affected are:
- Men
- Maori
- Pacific

~ 360 admissions/year into Middlemore Hospital

Cost of admission ~ $1,152,000/year
What are we trying to achieve?

Using a collaborative model of care to:

• **Optimise therapy**
  - Point of care serum urate testing
  - Titrate allopurinol and prophylaxis doses to decrease serum urate levels below target (0.36mmol/L)
  - Reduce the risk of further gout attacks

• **Education and self-management support**
  - Improve adherence and lifestyle modifications
  - Enable patients to self manage their gout

• **Integration** between primary care service providers in line with the CMH and NZ Health Strategy 2020
What are we doing?

- GP/nurse/pharmacist refers patient to project (opportunistic, audit)
- Patient and GP consent
- Nurses provide gout education
- Serum urate POC testing in pharmacy - monitoring more accessible for patients
- Pharmacist titrate allopurinol dose using Standing Order
- Tailored education and self management support
- Communication via Shared Care portal
- 3 pilot sites (Ti Rakau, Manurewa and Turuki) + 2 pilots SiP
- 70 patients
- P value <0.0001
% patients with urate <0.36 by visit number

% Urate results <0.36

Visit number

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

1 2 3 4 5 6 7 8 9 10 11 12
Feedback

“I have more knowledge about my gout. I’ve had no bad attacks and I really understand why I am taking my allopurinol and how long it takes to get my dose adjusted to the right level - its been 3-4 months”.

• Owning My Gout project participant

“We find it rewarding to be part of the clinical team - helping the patients achieve good outcomes for their gout condition. Having patients that appreciate our time and effort by this service to them. We are also able to do the finger prick test without much problems.”

• Jasmine Yap, Pharmacist at Turuki Pharmacy
“Highlight of the project has been getting patients to the pharmacy and seeing the uric acid levels come down. We now rarely involve the GPs and the patients bypass the practice. We now do a lot of work by phone. Our nurses are now upskilled in gout and are fairly autonomous.”

- Dr. Bruce Arroll, Greenstone Medical

- Dr. Lily Fraser, Turuki Healthcare
Where to next?

- Counties Manukau wide funded service
- Regional Service (SiP CMH, SiP WDHB/ADHB?)
- National- Community Pharmacy Services Contract
- (Interest from the Nelson/Marlborough and the Capital & Coast DHBs / pharmacies)
- Adapt this model of care to other LTC (e.g. diabetes)

Questions?
Mana Kidz

School-based health services | September 2017
59 schools
24,000 children
1,012 classroom visits every day

→ School Health Network
88 schools
~34,000 children
connected care
ALL CHILDREN HAVE THE BEST START TO LIFE

SOCIAL SERVICES   MENTAL HEALTH

OTHER SPECIALIST SERVICES

PRIMARY CARE

WHANJAU & TAMARIKI

• Connection with primary care & other community services
• Timely advice & information
• Escalation pathway for high needs children
• School health plan
• Immunisations at school
<table>
<thead>
<tr>
<th>Components</th>
<th>That means...</th>
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</table>
| Intensive clinics                              | Skin infection management  
Respiratory health support (including asthma)  
Sore throat clinics (rheumatic fever prevention)  
Hearing and vision assessments and interventions |
| Child health activities                        | Behavioural and developmental assessments  
Identifying and responding to vulnerability and child abuse  
Supporting children and their whānau with on-going management of chronic/emerging health conditions  
New entrant and Y7/8 immunisation follow up and coordination  
Other health assessments, referrals and follow up as required |
| Health promotion                               | Health promotion activities with children, whānau and the school community |
| Connecting children and whānau with services   | Collaborative approach with services in the school (including social worker) to meet the varying needs of children and their whānau  
Coordination with other services within the school and the wider community  
Assessment and referral activity for social services |
Activity in Term 2, 2017

- Individual children seen: 21,345
- Consent rate: 96%
- Presentations at clinics:
  - 36,295 sore throat
  - 2,738 skin infections
  - 2,884 other child health
  - Ear health
  - Immunisations
  - Hygiene
  - Head lice
  - Encopresis
  - Other...

- Children seen (Māori & Pacific): 88%
- Treated for GAS+ or skin infection: 5,189
Activity snapshot
Two decile 1 schools in Otara
In the week of 14-18 August 2017

760 children
97% consent rate

133 sore throat assessments
13 children treated for Group A Strep including home visits and education
16 follow-ups with parents for antibiotic adherence

7 skin infection assessments
3 immunisation follow-ups
1 neurological assessment
1 child and their whanau engaged for head lice (treatment/education)
56 children assessed for hygiene with health education

17 nutrition assessments with on-referrals to South Seas Healthcare
physical activity and nutrition programme

1 health promotion event on rheumatic fever at school assembly
Children are physically healthy

Children are socially and emotionally healthy

Children succeed academically

Children thrive in safe, supportive and stable environments

All children have the best start in life
Programme development
Network coordination
Communications
Clinical oversight/best practice
Standardised tools and processes
Quality improvement initiatives
Education & training (workforce development)
22 schools
9,996 children
Turuki Healthcare
Tongan Health Society
L1:18
L2:4

15 schools
4,812 children
Total Healthcare
South Seas
L1:14
L2:1

8 schools
3,901 children
Kidz First
L1:0
L2:8

25 schools
9,806 children
Kidz First
Health Star Pacific
Te Hononga
L1:18
L2:7

6 schools
2,285 children
Kidz First
Papakura Marae
L1:3
L2:3

7 schools
964 children
Kidz First
L1:0
L2:7

7 providers
L1:54
L2:29

83 schools
32,243 children
Papakura Kootuitui
5 schools
884 children
Papakura Marae
Outcomes

- Increased access to primary care
- Increased health literacy
- Better care experiences
- Reduction in ARF
- Reduction in skin infection hospitalisations
BUSINESS CASE

CM Health School Health Network

Submitted by the Alliance Leadership Group on behalf of the Child Health Alliance Forum
Contents

07 Executive summary

Why is this required?
10 Introduction
11 Strategic case
15 Case for change

What will be different?
31 Child’s perspective
34 Other benefits
37 Financial benefits

What is the proposal?
24 Service summary
25 Options considered
27 Budget

How will it function?
40 Making it happen
42 Implementation
43 External dependencies

Supporting information
44 Abbreviations
45 References
46 Appendix 1

48 Appendix 2
51 Appendix 3
55 Appendix 4
Children matter. Improving health and developmental outcomes for children contributes to improved outcomes in later years; influencing a person’s ability to engage in work, family and community life.

This business case seeks the implementation of a School Health Network, for 5-12 year olds, in CM Health. It builds upon the successful Mana Kidz programme to ensure that all primary and intermediate school aged children in South Auckland have access to appropriate and high-quality health services to meet their health needs.

The School Health Network operates at the intersection of primary health care, public health, and education. Health teams engaged within the school community are one of the best resources we have at our disposal to ensure that children are healthy and ready to learn. With constrained funding, every effort must be made to maximise resources and eliminate barriers to care.

School based health services should be an important part of Counties Manukau Health’s Healthy Together strategy and goal of working together to achieve health equity.
Executive Summary

This business case seeks endorsement for the implementation of a School Health Network in Counties Manukau. There is currently a recognised gap in access to quality primary care services for many of our children. The School Health Network builds upon the successful Mana Kidz programme and will ensure that all primary and intermediate aged children in South Auckland can access appropriate, quality health services in a setting that facilitates health, education and social services working in an integrated way to best meet the needs of children and whaanau.

What is the proposal?

<table>
<thead>
<tr>
<th>Establish a School Health Network to provide appropriate services for all primary and intermediate schools in CM Health. This network will facilitate better integration of health, education and social services in schools to address the needs of children with high health and social needs and decrease demand on general practice and hospital based services.</th>
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<tbody>
<tr>
<td>• Maintain an intensive school based health service in the highest needs schools¹</td>
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<td>• Develop a moderately intensive service for high needs schools</td>
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<tr>
<td>• Develop a less intensive service for schools with low health need delivered by primary health care workforce.</td>
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<tr>
<td>• Maintain a population based school vaccination programme</td>
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Why is it required?

Currently children living in Counties Manukau have high health needs, difficulties accessing primary care and have among the highest hospitalisation rates in New Zealand with marked ethnic inequities in health outcomes. There is variable integration across health, education and social services with potential for significant improvement.

| Currently defined by children’s risk of developing acute rheumatic fever |

¹ Estimated 54,000 children, in CM, aged 0-14 years live in the most deprived areas (quintile 5)"
Well documented barriers to accessing primary care \cite{2,3}. These include family debt at a practice, opening hours of general practice, logistical issues (such as transport, childcare and time off work for parents), health literacy, cultural appropriateness as well as variable child health expertise of the primary care workforce.

- CM Health has some of the highest hospitalisation admission rates in the country for childhood infectious diseases such as skin infections, pneumonia and rheumatic fever (which is triggered by an infectious disease)
- There are marked ethnic inequities in health outcomes for most infectious diseases. For example admissions for rheumatic fever occur almost exclusively in Māori and Pacific children in Counties Manukau and hospitalisation rates for skin infections over three times higher for Pacific and over two times higher for Māori compared to European/Other \cite{4}

What will be different?

<p>| | |</p>
<table>
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<tr>
<td>Children will be able to access timely primary and preventative health services in a school setting, by a workforce that is culturally appropriate and skilled at working with children and whānau. There will be a more integrated health service linked to existing programmes which will decrease duplication.</td>
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<td>There will be improved working relationships between education and social services.</td>
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<tr>
<td>- The School Health Network will be integrated with primary care. It will work within the locality framework and support the direction of CM Health towards enhanced community services</td>
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<tr>
<td>- Children and whānau at the highest risk of infectious diseases will be able to access comprehensive primary care services in school settings ensuring that health conditions are identified and treated early.</td>
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<tr>
<td>- Health promotion will be delivered to children within school, community and home settings</td>
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<tr>
<td>- School health teams will connect with social service agencies and school staff to support the best outcomes for children</td>
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<tr>
<td>- Family and whānau will develop trusting, enduring relationships with school health team</td>
<td></td>
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<tr>
<td>- Better engagement with complex families with whom health services has difficulty engaging in care</td>
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<tr>
<td>- Proportionate universalism enables a mechanism to identify children with high needs in low risk schools</td>
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</table>
• **Services are connected and integrated** within communities making it easier for children and their whaanau to access care and support when they need it

• The school health team can **visit families at home** and provide care to younger and older siblings

• A **fit-for-purpose, highly trained integrated workforce** within schools able to deliver a range of health interventions. Staff are child and family focused and skilled in dealing with child health issues

• A well-established network will allow children who change schools, within the district, to be followed up by other network members

• Technology will allow efficiencies within the school setting. Whaanau Support workers will be able to share information with Registered nurses (RN) and receive direction for action via mobile technologies (currently being trialled in Mana Kidz). Likewise RNs can use technology to support communication with the child’s general practice or obtain GP support.

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**What are the benefits?**

Improved health, educational and social outcomes for children and whaanau.

- Improved health equity for Maaori and Pacific children
- A decrease in the unmet need within our primary and intermediate aged school children
- An effective school-based network that is integrated with primary care and able to provide better care for more children
- Infrastructure within schools to address identified priorities as they arise, for example, obesity
- Lower hospitalisation rates for some conditions such as rheumatic fever, PSGN with potential to reduce other admissions such as asthma
- Less pressure on overstretched services by addressing acute issues early thus preventing the need for GP care or preventing escalation to secondary services
- Improved engagement in education with better educational achievement
- Better alignment with Community Health Integration Strategy and integration with existing programmes such as At Risk Individuals (ARI). School settings become part of the community health service network
- Improved health literacy of children and whanau which will have life-long impacts
Introduction

The School Health Network will improve children’s health and quality of life now, strengthen whaanau resiliency and contribute to improving the longer health trajectory of our population. This business case will outline the rationale for investment in school based services and how it supports the strategic direction of CM Health; describe the service model; quantify the level of investment required as well as the potential benefits of this service.
Why is it required?

Strategic Context

It is accepted that primary healthcare has a central role in reducing inequalities in health. The traditional primary care model of visiting a family doctor when you are sick, works well in some parts of New Zealand. This model, however, does not provide the level of access to healthcare required by many of the children living in our district. Counties Manukau is different from many parts of the rest of New Zealand because of the social complexity which drives the health needs in our community.

Primary care currently receives capitation funding for first line primary care services which includes, for all practices in Counties Manukau, a free Under 13’s programme. This means all children should be able to be seen by primary care without being charged a fee. Despite this we continue to have unmet need and significant inequalities in health outcomes such as hospitalisation rates for infectious diseases.

One of the factors contributing to this are the significant non-financial barriers many of our families face when trying to access primary care services. This is underlined by the minimal impact of the Under 13s rollout on utilisation in CM Health with a 9% increase compared to between 15-25% across most other DHBs.

As an example Pukekohe North School, a decile 1 school in Franklin that did not meet the threshold for Mana Kidz, was so concerned about the health of their children that they developed a relationship with Northland GP Lance O’Sullivan. The Vmoko programme has been established in the school in an attempt to ensure that the health needs of their students are met. At the time the Vmoko programme was established in the school 24% children’s parents did not identify a GP. The school roll was matched to the PHO register which confirmed only 80% were enrolled with a PHO.

The importance of working with families to address the upstream drivers of health outcomes is also recognised. Linking families with social services is a key activity to improve health outcomes. In some instances there is also an opportunity for primary and community services to prevent or treat conditions and therefore avoid admissions to hospital.

If we are serious about achieving equity in health outcomes, as articulated in our strategic vision, then services need to be delivered differently. Schools provide a well-defined community of children and whaanau for whom access to primary and preventative care can be enhanced while also building on health literacy and improving engagement with other parts of the health sector.

This business case proposes to extend the primary and intermediate school based service both to schools with high numbers of students at risk of poor outcomes as well as a much less intensive service for schools with less students at risk of poor outcomes. Proportionate universalism enables a mechanism to identify children with high needs in low risk schools. While much of the interest in Mana Kidz has centered on the Rheumatic Fever (RF) prevention work, the programme has been developing a broader school based service with the intention of overcoming the barriers many children face in assessing adequate primary health care. The need for accessible primary
health care extends beyond the current 25,000 children covered by the programme.

The School Health Network supports the development of nursing skills and provides the opportunity for nurses to develop an extended practice through the use of standing orders and ongoing professional development. The School Health Network provides career pathway with opportunity to develop future skills such as a clinical nurse leader role.

CM Health currently has the lowest ratio of General Practitioners to population in New Zealand according to the 2014 Health Workforce report. [7] Having a well-trained and well supported child focused health team in schools should help manage the expected challenges in maintaining an adequate GP workforce in the coming years.

This business case proposes we take services into the community to a place children and whaanau visit most days, schools. School based health services have a pivotal part to play in the wider primary health care network.

Children matter. Improving health and developmental outcomes for children contributes to improved outcomes in later years; influencing a person’s ability to engage in work, family and community life. All children in our community have the right to thrive, belong and achieve.

The School Health Network is an opportunity to build a network of trained professionals capable of delivering innovative solutions to emerging issues.

For example, childhood obesity has been recognised nationally as a priority with the Child Obesity Plan released in October 2015. To date Mana Kidz has not had a focus on working with schools to address the food and physical activity environment. The school based services proposed in this business case, provides an infrastructure within schools that could be utilised to support schools to develop a food policy as well as supporting the delivery of health promotion messages regarding physical activity and nutrition. Recent evidence from Yendarra School suggests oral health benefits from the implementation of a food policy. There will also be opportunities for the School Health Network to work with Healthy families in a school setting.
Alignment to existing strategies

The School Based Network has a key role to play in CM Health’s Healthy Together strategy. The Network will contribute to achieving the goal of “Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Māori, Pacific and communities with health disparities”. One of the key system wide actions, articulated in the Strategic Plan, of ‘advancing integration of healthcare for children and young people in schools as an important point of access for children and young people’ is achieved through developing school based health services. ²

Achieving CM Health’s strategic goal requires CM Health to make investment decisions that prioritises programmes that impact on outcomes for Māori and Pacific. The intensive and moderate levels of service target schools with high numbers of Māori and Pacific students.

CM Health has been reshaping the way it delivers services with a focus on developing community hubs within a geographical locality model. There has been an emphasis on keeping people well and ensuring the development and integration of community health and wider social services. Healthy Together 2020 Delivery identifies the importance of “shifting services to the left” by investing more in primary and community based settings and providers. School based services expand our frame of integrated care by working with whaanau in a community setting with other sectors.

Developing the School Health Network is aligned to this strategy as it develops health service capacity in the community, enables better integration with social services and overcomes barriers to accessing preventative and primary care services. This will also complement the work proposed in the Enhanced Primary Care business case.

A School Health Network also supports key priorities highlighted in the letter of Expectation which include a number of the themes of the draft NZ Health Strategy, working across social sector organisations and integrating services.

There is also a requirement for CM Health to achieve a reduction in incident cases of RF as articulated in the Better Public Service Target.³ Reducing the rate of RF is also a key in indicator in the CM Health Māori Health plan.

² School based health services support other identified goals of the strategy including achieve equity in key health indicators for Māori, Pacific and communities with health disparities by 2020 and enabling people to live longer healthier lives in the community.

³ Better Public Service target is to reduce the incidence of ARF by two thirds by 2017 (all ages)
Providing primary prevention activities through the school based programme has been major focus of the RF prevention work in CM Health to date. Rates of RF have been declining in the district since the implementation of school based primary prevention services with a 53% reduction in incident cases from baseline (further detail Appendix 1). [8]

While rheumatic fever prevention is currently a priority within the existing school based programme the infrastructure the school based network creates could be used to focus on other areas such as asthma education and management4, mental health support (through mindfulness training)5 or working with schools to create supportive food environments.

The Children’s Action Plan (CAP) is also heralding a new way of working with an expectation health professionals work together with professionals from other sectors, to one plan, to improve outcomes for children facing adversity. Members of the school based network will become key players in the Child’s Action Network.

In addition the Middlemore Foundation for Health Innovation (MFHI) has taken the Mana Kidz model, built on it and developed Kootuitui. This programme includes digital learning package and a whaanau navigator role in addition to school based health services. Kootuitui is a pilot in Papakura involving 6 schools looking to quantify the value of a multipronged, community development programme and the impact such a programme can have on a range of outcomes for whaanau. MFHI has successfully raised funds to support the programme and launched it in October last year.

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4 Good evidence form USA about benefits of this in terms of reducing emergency department admissions-add references
5 Currently being proposed by ETHC with PHO funding.

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Doing things differently

The establishment of a diverse provider network in Mana Kidz has created opportunities to explore ways of working differently; smarter and better. The provider network is increasingly collaborative which is leading to innovative solutions to dilemmas. Here are three examples;

In response to changing resourcing constraints, the sore throat management protocol has been reduced to three days per week for active case finding. This allows more time for the health team to address other issues while maintaining gains in rheumatic fever prevention.

Working with one of our primary care providers, we are exploring an alternative workforce configuration (decreasing RN time and increasing WSW time) which is more cost-effective and places emphasis on engagement with children, whaanau and schools.

Telehealth innovations have been trialled in limited ways and there is considerable opportunity for exploring further utilisation of this and other technologies to increase care quality and reduce associated costs.

Longer term funding and settled collaborations provides fertile ground for innovation and sector transformation.
## Case for change

<table>
<thead>
<tr>
<th>Significant inequities in health outcomes</th>
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<tbody>
<tr>
<td>• ~60% of babies born in Counties Manukau live in Quintile 5</td>
</tr>
<tr>
<td>• Approximately 120,000 children 0-14 years living in Counties Manukau DHB and of these ~64,000 are aged 5-12 years with over 50% Maori or Pacific.</td>
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<table>
<thead>
<tr>
<th>Schools recognise students have unmet health needs</th>
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<tbody>
<tr>
<td>• Counties Manukau Health has some of the highest hospitalisation admission rates in the country for childhood infectious diseases such as bronchiolitis, skin infections and pneumonia as well as rheumatic fever</td>
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<tr>
<td>• Poor health can impact school attendance and educational achievement</td>
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<thead>
<tr>
<th>Challenges to accessing primary health care</th>
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<tr>
<td>• There are marked ethnic inequities with admissions for rheumatic fever occurring almost exclusively in Maori and Pacific child in Counties Manukau and hospitalisation rates for skin infections over 3 times higher for Pacific and over 2 times higher for Maori compared to European/Other</td>
</tr>
<tr>
<td>• Barriers to accessing primary health care including unavailability of appointments, transport, child care, health literacy. This translates to well documented unmet need.</td>
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<tr>
<th>Variable expertise in traditional primary care to deal with child health conditions</th>
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<tbody>
<tr>
<td>• No requirement for general practitioners to have any paediatric experience prior to working in general practice, minimal paediatric experience during medical training in New Zealand, no medical council requirement for general practitioners to participate in specific paediatric continuing medical education</td>
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<tr>
<th>Poor engagement by health and social services with families with complex needs</th>
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<tbody>
<tr>
<td>• Some models of primary care delivery do not facilitate a whanau ora approach</td>
</tr>
<tr>
<td>• Many families have high needs and multiple risk factors to their health (e.g., poor housing, low incomes, family violence, smoking and other factors). Some have not historically experienced good engagement with mainstream health services.</td>
</tr>
<tr>
<td>• Health services are not always able to engage families. For example in a pilot of the B4 school check a significant number of CM Health parents (50%) declined, did not attend appointments or could not be contacted further intervention when concerns were raised</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Better integration across health, schools and social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognised through Productivity Commission’s report that social services are currently poorly integrated</td>
</tr>
</tbody>
</table>
What is the proposal?

This business case is asking for investment to secure the current intensive school based service (Mana Kidz) and expand the network of school based services to include a more intensive service in low decile schools with high health needs as well as engage primary care to work with lower needs schools to provide services in schools to support students with high health needs.

A sustainable School Health Network will provide quality, school-based primary healthcare services to contribute to equitable health and social outcomes across the district.

The School Health Network will consist of a network of primary care and community health organisations working together to deliver high quality primary care services in primary and intermediate schools.

- A fit-for-purpose, highly trained, integrated workforce within schools able to deliver a range of health interventions
- An effective school-based network that is integrated with primary care and able to provide enhanced care with better reach to more children
- Services that are connected and integrated within communities will make it easier for children and their whaanau to access care and support when they need it

The level of Service will vary depending of the level of need in the school and the service design includes Intensive, Moderate, Low and Support level services.

Sometimes we overlook that children can’t access primary care... it has to be with an adult. This way we are accessing the children that aren’t accessing healthcare. (Mana Kidz provider)

The preferred service delivery model includes both contracted providers, the current Public Health Nurse (PHN) workforce, PHOs and primary care practices delivering services in school. This workforce will be co-ordinated within each of the four localities and then networked across the district. A small operating team which will be the backbone of the network responsible for coordination, facilitating collaboration, performance accountability, reporting and quality.
The service design includes utilising technology to support the efficient use of clinical expertise to support the programme. While not included in this business case there are important linkages between the health services delivered with primary and intermediate schools and those currently provided in low decile secondary schools. It is expected that the School Health Network will evolve to connect all school health services. There are opportunities to explore connecting with early education settings in the future.

The preferred option is to develop a comprehensive service that covers all primary and intermediate schools in the district. The intensive and moderate programme would be made available to schools which are recognised as having students at high risk of poor health outcomes. This will extend beyond the current reach of Mana Kidz which identified schools based on the risk of RF only. This will address concerns previously voiced at ELT about the impact of redirecting PHN workforce away from schools which did not meet the threshold for Mana Kidz, despite having students with very high health needs.

In addition it is proposed to develop a network across schools with students who are generally accepted to be at lower risk. The rationale for this is that there will be students at high risk of poor health outcomes at schools considered to have students with low health needs. This principle of proportionate universalism underpins most universal programmes. The development of the network across all schools also allows students to be “followed” if necessary if they move schools i.e. there will be a named person to hand child over to. The marginal cost of providing services to the low risk schools is low compared to the overall cost of the programme. It also has the additional benefit of engaging primary care in the School Health Network which in turn will build capacity in primary care to be involved with delivering school based health services.

Case study 1

Strong relationships provide children with an opportunity to identify issues

A six year old child presented to the Mana Kidz clinic with multiple localised skin infections. Treatment included daily dressings and oral antibiotics. The child disclosed to the Mana Kidz team an experience of family violence over the weekend. On discussion with school staff it was discovered that the child often came to school late and rarely had lunch. Discussions with the child’s sister confirmed all of the above. A joint home visit was made with Social Worker in School (SWiS) to talk with the whaanau. The father was solo parenting and struggling to cope. The father was offered support from local social support agencies including participating in a parenting course.
FIGURE 1. SCHEMATIC OF THE SCHOOL HEALTH NETWORK

School Health Network

The Solution

193 Schools / 68,392 Children

The Challenge

Currently:
- Health inequities
- Poor health outcomes
- Poor primary care access
- Fragmented health 
  & social services
- High hospitalisations 
  for infectious diseases

The Outcomes

All children have the best 
start in life

High quality
- Innovative
- High

Engaged in education

Social Support Services

Outcomes focused

Community health promotion

Collaborative & integrated

Locality aligned

Trained 
workforce

Child centered

Tech enabled

Immunised

Healthy
- Hearts
- Teeth
- Skin
- Lungs

Happy & well

Strong 
& resilient
Universal services

There are some key activities which will be provided to all children in all schools across the School Health Network. These include:

- **Support for the development of school health plans** to assist in development and coordination of health promotion and education activities within the school setting
- **A vaccination programme** for year 7-8 children (Boostrix and Gardasil)
- **Access to ear health services** (by referral)
- All schools will be connected with local primary care clinics (to promote access for wider whaanau) and locality initiatives.
- Service delivery is underpinned by evidence-informed clinical framework
- Child protection interventions and engagement with Children’s Action Teams

Intensive/moderate

The intensive service provides a comprehensive primary health care service to schools which currently have the successful Mana Kidz model. Non Mana Kidz schools, decile 1-3, schools will receive a very similar service with a reduction in model intensity to better align service provision with identified health need. The key difference will be in Mana Kidz schools the teams will be based at the school every school day (as opposed to two days per week for other decile 1-3 schools). Intensive schools also have a whaanau support worker working under direction and delegation of the registered nurse.

Note that within clusters of schools there will be some flexibility to ensure that we are meeting health needs. Some schools needs may be slightly less and others slightly more. The all-important focus is better health outcomes.

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### Case study 2

**Connecting whaanau with primary care and mental health services**

10 year old child presented to the Mana Kidz clinic for an assessment of an open lesion on lip. The clinician observed tic-like behaviour. Follow-up with teacher and whaanau identified that the child was known to Whirinaki but was having difficulty coping and their tic had deteriorated. The Mana Kidz team supported parent to see their primary care provider (who waived co-payment), which resulted in significant changes to medication regimen, and also liaised with Whirinaki. The child’s Whirinaki appointment was brought forward and they were seen by specialist and medication changed. Whirinaki provided education sessions about the child’s condition involving teachers, SWiS and Mana Kidz team. The child no longer presents with tic-like behaviour and parent and school are coping well with child’s condition.
The health teams will provide the following services within these schools:

- Health and wellbeing interventions (addressing a range of health issues including respiratory, hearing, vision, immunisation catch-ups, child protection, behavioural issues)
- Sore throat management (rheumatic fever prevention)
- Skin infection management
- Referrals to social services providers (including AWHI)

Nurses work under standing orders and all treatment options will be offered free of charge to families. Health teams are supported by a range of critical support systems including clinical oversight, accessible advice from senior clinicians. This is aligned to the Enhanced Primary Care business case.

You can see difference in children’s health. Skin infections used to get so bad that kids were not able to walk. That way it was obvious. We do not see this anymore. (School staff at Mana Kidz school)

In addition to linking in with the child’s medical home there are a range of escalation pathways for complex issues are in place including support from senior nursing clinicians, general practitioner and paediatrician.

As part of a whaanau –centred approach, whaanau are engaged in the process for all interventions which develops and strengthens trusting relationships. Home visits for the drop-off of medication and education, as well as housing assessments and sibling follow-ups will be undertaken as per existing Mana Kidz protocols.

The health teams working across decile 1-3 schools will be part of a larger, primary health care school-based team supporting the 68,392 children across 183 schools.
Figure 2. Schematic of the Intensive/Moderate Service in the School Health Network

87 Schools
34,085 Children

All children have the best start in life

Whānau & Tamariki

Connect whānau with:
- Primary care + ARI
- Social support services
- Specialist health services

School health plans
Health promotion
Sore throat management
Skin infections
Immunisation

Home & sickness checks

Health & well being assessments
Low and support

The decile 4-10 schools will have a lower intensity service that is provided by local primary care providers. Each school will have a registered nurse assigned who will visit regularly over the school year and be available by telephone/email for advice.

In decile 4-7 schools, the registered nurse will be available to follow up on referrals from school staff where they have identified potential health issues with a particular child. The registered nurse will visit the school on a fortnightly basis through the school term to;

- Support the development and implementation of the school health plan
- Engage in health promotion activities
- Follow-up on referrals received from the school
- Engage with staff, children and parents
- Referring issues to specialist services as required including social support services
- The regularity of these visits will be flexible based on the needs of the school and may occur weekly, fortnightly or monthly.

In decile 8-10 schools, this support will be less frequent with the registered nurse available at the school up to two hours per fortnight. Practically, this is likely to be condensed to four hours per month but will be flexible based on school requirements. The registered nurse will;

- Support the development and implementation of the school health plan
- Engage in health promotion activities support staff, children and parents to identify the right place to go to address their health concerns

Across these schools, there will be a strong emphasis on ensuring children and their whaanau are better engaged with their primary care home. There will be clear support/escalation pathways for high needs children within these schools with support from the wider School Health Network teams where appropriate.
Figure 3. Schematic of the Low/Support service in the School Health Network

- 96 schools
- 34,725 children

- All children have the best start to life
- Social services
- Mental health
- Other specialist services

- Connection with primary care & other community services
- Timely advice & information
- Escalation pathway for high needs children
- School health plan
- Immunisations at school

Whānau & Tamariki

School

Primary care

Regular school visits

GP RN
## Service summary

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Intensive</th>
<th>Moderate</th>
<th>Low</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>Nurse-led team running comprehensive school-based clinics</td>
<td>Registered nurse running twice weekly comprehensive school-based clinics</td>
<td>Schools regularly visited by registered nurse and available for advice as required</td>
<td>Schools visited by registered nurse and available for advice as required</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Five days per week during school term</td>
<td>Two days per week during school term</td>
<td>Four hours per fortnight (frequency flexible based on school requirements)</td>
<td>Four hours per month (frequency flexible based on school requirements)</td>
</tr>
<tr>
<td><strong>Key Activities</strong></td>
<td>• Child health and wellbeing assessments, interventions &lt;br&gt; • Sore throat management (intensive protocol) &lt;br&gt; • Skin infection management &lt;br&gt; • Regular health promotion and education at school/home</td>
<td>• Child health and wellbeing assessments, interventions &lt;br&gt; • Sore throat management &lt;br&gt; • Skin infection management &lt;br&gt; • Regular health promotion and education at school/home</td>
<td>• Child health and wellbeing assessments, interventions (by referral only)</td>
<td>• Regular communication regarding service availability within community &lt;br&gt; • Escalation pathway for high needs children within school population</td>
</tr>
<tr>
<td><strong>Health Promotion</strong></td>
<td>Health promoting schools &lt;br&gt; School health plan</td>
<td>Health promoting schools &lt;br&gt; School health plan</td>
<td>School health plan</td>
<td>School health plan</td>
</tr>
<tr>
<td><strong>Immunisations</strong></td>
<td>Y7 Boostrix &lt;br&gt; Y8 Gardasil (girls)</td>
<td>Y7 Boostrix &lt;br&gt; Y8 Gardasil (girls)</td>
<td>Y7 Boostrix &lt;br&gt; Y8 Gardasil (girls)</td>
<td>Y7 Boostrix &lt;br&gt; Y8 Gardasil (girls)</td>
</tr>
<tr>
<td><strong>Specialist Services</strong></td>
<td>Access to ear nursing services by referral</td>
<td>Access to ear nursing services by referral</td>
<td>Access to ear nursing services by referral</td>
<td>Access to ear nursing services by referral</td>
</tr>
<tr>
<td><strong>Coordination Activities</strong></td>
<td>Enhanced primary care integration &lt;br&gt; Enhanced locality coordination &lt;br&gt; Referrals to social service providers</td>
<td>Enhanced primary care integration &lt;br&gt; Enhanced locality coordination &lt;br&gt; Referrals to social service providers</td>
<td>Enhanced primary care integration &lt;br&gt; Enhanced locality coordination</td>
<td>Enhanced primary care integration &lt;br&gt; Enhanced locality coordination</td>
</tr>
<tr>
<td><strong>Schools Serviced</strong></td>
<td>55 schools (excl Papakura Kootuitui) 22,794 children Selected decile 1-2 schools</td>
<td>29 schools 10,873 children Non-intensive decile 1-3 schools</td>
<td>56 schools 16,839 children Decile 4-7</td>
<td>38 schools 17,545 children Decile 8-10</td>
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</table>
Options considered

The ALG/CM Health team have tested a number of options with stakeholders. The preferred option is outlined in detail in this business case. The tables below summarise the alternate options and note the pros and cons of each option considered. Please note that this excludes the five schools in Papakura Kootuitui.

<table>
<thead>
<tr>
<th>Option 1.</th>
<th>School Health Network with service intensity based on health need (recommended option)</th>
</tr>
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</table>
| **Summary** | A graduated service intensity model based on need; ensuring primary care access for all children.  
As described in this business case. |
| **Pros** |  
- Achieve health outcomes for all children, improving equity  
- Progressive, transformative DHB  
- Leverages off existing success of Mana Kidz to deliver more services to more children  
- Integration of primary care (incl. ARI), localities initiatives, and better coordination with social services means better health outcomes  
- Innovation becomes normalised across high quality provider network  
- Builds on health gains made in Mana Kidz  
- Provides child health capacity within primary care  
- Provide services for high risk children in low risk schools |
| **Cons** |  
- Requires additional investment from CM Health |
| **Additional investment required:** | $2,987,194 |

<table>
<thead>
<tr>
<th>Option 2.</th>
<th>Mana Kidz plus moderate service other decile 1-3 schools, limited service in decile 4-10 schools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>Continue to fund comprehensive model (Mana Kidz) in 55 schools with enhanced service in non-Mana Kidz decile 1-3 schools. No service in higher decile schools. No development of provider network. Including immunisations.</td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td></td>
</tr>
</tbody>
</table>
- Comprehensive service provided to more children at risk of poor health outcomes |
| **Cons** |  
- High risk children in decile 4-10 schools will not have adequate access to services  
- There will be less opportunity to integrate with primary care (incl. ARI), localities initiatives, and social services in decile 4-10 schools  
- No development of school network which limits ability to address inequities  
- No development of child health capacity within primary care  
- Requires additional investment from CM Health |
| **Additional investment required:** | $2,052,842 |
### Option 3. Maintain status quo with Mana Kidz and very limited service in some low decile schools

**Summary**
Continue to fund comprehensive model (Mana Kidz) in 55 schools only with limited service in decile 1-3 non-Mana Kidz schools; immunisation and child protection only in decile 4-10 schools. No development of provider network. Including immunisations.

*Additional investment required: $763,662*

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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</thead>
<tbody>
<tr>
<td>o Comprehensive service provided to some children</td>
<td>o A number of schools have no service provision; children miss out</td>
</tr>
<tr>
<td>o Small additional financial investment from CMH</td>
<td>o Limited opportunity to integrate with primary care (incl. ARI), localities initiatives, and social services</td>
</tr>
<tr>
<td>o Maintains health gains made in Mana Kidz</td>
<td>o High needs children have very limited service access in non-Mana Kidz decile 1-3 schools and none at all in higher decile schools</td>
</tr>
<tr>
<td></td>
<td>o No service in decile 4-10 schools</td>
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</tbody>
</table>

### Option 4. Revert to traditional Public Health nursing visiting service

**Summary**
Stop Mana Kidz. Return to a PHN school visiting model and implement a revised sore throat management programme in 55 schools three times per week. Little to no service in higher decile schools. No development of provider network. Including immunisations.

*Additional investment required: $0*

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>o No further investment required.</td>
<td>o A number of schools have no service provision; unmet need. Those that do have service have limited service utilising a model that is increasingly outdated that does little to improve equitable health outcomes</td>
</tr>
<tr>
<td></td>
<td>o Loss of health gains from Mana Kidz including increases in rheumatic fever rates and increased skin infections</td>
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<tr>
<td></td>
<td>o Disestablishment of successful Mana Kidz programme and loss of investment in provider network and workforce development</td>
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<td></td>
<td>o Loss of learnings from Mana Kidz</td>
</tr>
<tr>
<td></td>
<td>o Stakeholder unhappiness/disenfranchisement particularly school communities</td>
</tr>
<tr>
<td></td>
<td>o Revised sore throat management programme may not be effective</td>
</tr>
</tbody>
</table>
Budget

The total cost of the School Health Network is $9,802,194. Current funding amounts to $6,815,000.

The additional investment requested from this business case is $2,987,194.

[Note that additional detailed financials were provided to CMH ELT]

Figure 4. Graph showing resource allocation by locality and service intensity.
What will be different?

What are the benefits?

There are a range of benefits that are likely to arise from increasing access to primary health care services through nurse led school based services for children with unmet health needs and better con-ordination of health and social services.

Benefits for the child and whaanau

- Children have healthy skin, good hearing and vision, good oral health, are immunised and are free of illness
- Able to access timely primary care services for common childhood issues
- Better attendance and engagement in learning
- Health promotion delivered in schools setting
- Services working better together
- Whaanau have culturally appropriate services
- Improved health literacy and connection to health services at a young age which will continue into later life
- Teachers supported and better understand children’s health needs
- Contribute to ensuring children live in warm, safe houses

How will we measure these benefits?

In order to measure the impact of the School Health Network, the contribution of each of the activities will be mapped. Figure 5 illustrates an aspirational outcomes map for the School Health Network. This will enable us to measure the performance of the network and monitor population level outcomes. It will also allow us to measure equitable outcomes for children across the network with standardised measures.

Mana Kidz is an important and effective programme that is making a substantial contribution to healthcare for vulnerable children (Mana Kidz evaluation report)
FIGURE 5. SCHOOL HEALTH NETWORK: ASPIRATIONAL OUTCOMES MAP

Activity

- Health and wellbeing interventions: (modifiable primary care)
  - School attendance rates are 98%
  - 95% of children have completed immunisations
  - 95% of asthmatic children are managing their asthma appropriately
  - 50% reduction in the number of children presenting with severe oral health issues

- Health promotion and education
  - 100% of children reach health literacy standard
  - 90% of whānau reach health literacy standard

- Strep throat clinics
  - Rate of ARF reduced to 70% of baseline

- Skin infection clinic
  - 50% reduction in serious skin infections

- Obesity prevention intervention
  - Health promotion and education

- Injury prevention intervention
  - 50% reduction in hospitalisations for injury

- E.g. mindfulness programme and/or cultural connectedness?
  - 55% of children rate themselves as happy and well

- Social support assessments
  - 50% of whānau are connected with social services

Indicators

- Engaged in education
- Free of (immunisable) communicable diseases
- Healthy respiratory system
- Good oral health
- Are health literate
- Free of rheumatic heart disease
- Free of serious skin infections
- Healthy weight
- Injury-free
- Positive self-worth
- Whānau using appropriate social support services

Outcome

- All children have the best start in life
Child perspective – intensive service

How will the School Health Network look from a child’s perspective?

Tessa is a 10 year old Maaori girl living in Manurewa. She lives with her mother, stepfather and 2 younger half siblings. Tessa spends every second weekend with her father and his wife. The diagram below summarises Tessa’s experience with the School Health Network and a hypothetical example of what often happens when children don’t have access to these services.

School Health Network: Tessa has access to a health clinic at her school

- Tessa has a sore throat and puts her hand up when her class is asked if anyone has a sore throat
- Tessa has her throat swabbed and the swab comes back positive for GAS
- RN talks to Tessa’s Mum and explains the importance of treating her sore throat.
- Tessa’s Mum has heard about sore throats being linked to rheumatic fever from a health education session at school
- The RN arranges for Tessa’s Mum to pick up the antibiotics when she collects Tessa from school
- Tessa takes the antibiotics. The RN checks adherence reminding Mum to ensure Tessa takes the meds to dad’s house
- Tessa completes the 10 days of oral antibiotics

No School Health Network

- Tessa has a sore throat but doesn’t tell anyone. She’s has them before and knows they get better eventually
- Tessa’s mum notices Tessa is not 100% but she is busy with work and other children so doesn’t take Tessa to the doctor
- Tessa has recurrent sore throats over the years but doesn’t think they are important
- 15 years later, Tessa has a planned pregnancy. Her midwife notices a heart murmur
- Tessa has severe RHD and shortly after the birth of her daughter she requires valve surgery
- Tessa has a mechanical valve replacement and is required to be on warfarin
- Tessa frequently forgets to take her warfarin as she is busy with her new baby
- Tessa has a stroke and requires inpatient rehabilitation for several weeks
Child perspective – moderate service

How will the moderate service look from a child’s perspective in a decile 1-3 school?

John is an 8 year old boy living in Mangere with his family. Despite being enrolled, John’s family tend not to visit their local primary care clinic. The diagram below summarises John’s experience with the School Health Network and a hypothetical example of what often happens when children don’t have access to these services. John’s experience is a recent, real life case study taken from a Mana Kidz clinic in Mangere.

School Health Network: John has access to a health clinic at his school

- John has a sore throat and knows it is important to get it checked
- The health team identifies that John has sores on his leg that are inflammed
- Registered nurse treats the sores and meets the whaanau at home to discuss care and hygiene
- RN identifies a range of issues for whaanau including housing, food and sibling health
- Additional support provided to whaanau including immunisations and social service support and whaanau are re-engaged with medical home
- John has no more skin infections and his whaanau are supported to improve their situation

No School Health Network

- John is not engaged with a health professional. He has sores that become infected
- Family unable to get time off work to visit a GP. Sores worsens and John is taken to ED
- The sores are treated but no ongoing support so they become reinfected
- John is off school. He becomes systemically unwell and is hospitalised for cellulitis
- John’s sibling also develops impetigo. Family have debt at practice and do not take sibling
- John and siblings have high absenteeism. Whaanau remain disempowered
- John develops post strep glomerulonephritis and is admitted to hospital for 1 week
- This compounds John’s difficulties keeping up at school because of frequent absences
- John becomes disengaged in school

CM Health School Health Network
Child perspective – low and support

How will the low/support services look from a child’s perspective in a decile 4-10 school?

Sue is a 9 year old girl living in Howick with her grandmother. Sue’s previous home environment included exposure to parental mental health issues, drug abuse and violence. Sue’s grandmother has diabetes with a number of complications. The diagram below summarises Sue’s experience with the School Health Network and a hypothetical example of what might happen if a child doesn’t have access to these services.

**School Health Network: Sue has a visiting nurse at her school**

- Sue’s teacher notices that Sue has behavioural issues. Grandmother confirms that she is struggling to cope with Sue’s behaviour & has health issues of her own.
- The teacher contacts school RN who identifies that Grandmother is likely to qualify for ARI programme.
- RN contacts Sue’s grandmother’s medical home and the practice proactively engages with Sue’s grandmother.
- Practice identifies Sue & her Grandmother are eligible for ARI programme - diabetes management support & links grandmother to parenting programme.
- The medical home liaises with RTLB, SENCO to develop plan to support Sue’s needs.
- Sue’s behaviour at school improves and she becomes more engaged.

**No School Health Network**

- Sue’s teacher notices that Sue has behavioural issues and becomes aggressive easily. A phone call to her grandmother doesn’t change the situation.
- The teacher struggles to deal with Sue’s behaviour and she is constantly sent out of class.
- Sue’s school performance worsens and her Grandmother is struggling with her health and has trouble supporting Sue.
- CYFs is involved due to Sue’s worsening violent behaviour and she is put into CYFs care.
- Sue is separated from her grandmother and moves school 5 times over the next two years.
- By the time Sue reaches secondary school she is into drugs and has been expelled from school.
Other benefits

For the health system

- Improve health outcomes for Maaori and Pacific children and their whanau
- Increased equities in health outcomes
- Reduced emergency care visits and hospital admissions due to prevention and early management of skin infections and acute rheumatic fever (and potentially other conditions e.g., asthma)
- Improved health literacy of children and whanau, enabling them to actively seek healthcare
- The development of an effective, integrated primary care-led provider collective and extension of ARI
- Workforce benefits such as
  - Decrease workload on GPs allowing them more time to deal with more complex health needs
  - Increased primary care child health practitioners
  - Pathway for nursing development
- More integrated working across education and social services
- Provides an important addition to the network of primary care and community services. Strengthens this network by providing a setting children and whaanau interact with on a daily basis for most of the year.
- Reductions in current and future burden of disease
- Improved visibility on system performance with enhanced outcomes measurement
- Building primary care capacity and capability

Case study 3

Strong relationships provide children with an opportunity to identify issues

A 12 year old child visited the Mana Kidz clinic at the end of the school day and disclosed that they were fearful of returning home that evening as their father was being released from prison which was related to his abuse of the child and their sibling. The team worked with the Social Worker in School (SWiS) and the whaanau to facilitate alternative emergency accommodation for the child. The whaanau were connected with a local social support agency and are receiving ongoing support. The strong relationship between the child and the Mana Kidz team enabled the child to seek appropriate help.
For Schools

- Healthy children who are ready to learn
- Decreased absenteeism
- Better understand children’s health issues and how best to support children and whaanau
- Support to deliver key health promotion messages

There is anecdotal evidence of wider benefits for children’s education and development resulting from improved health and wellbeing (e.g., through improved attendance and engagement at school). Feedback from school staff indicates that they believe Mana Kidz is improving engagement of students in education and whaanau in the school community. School staff can point to individual cases where attendance had been an ongoing issue that had been resolved after Mana Kidz involvement with the child and/or family/whaanau.

Improving Health literacy of children, giving them a positive introduction to primary care and building the confidence to interact with health services will have many benefits into the future. There are examples from Mana Kidz where children, who have a trusting relationship with the school team have disclosed unsafe home environments which has led to protective action.
Achieving the goal of “Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maori, Pacific and communities with health disparities” requires CM Health to make investment decisions that prioritises programmes that impact on outcomes for Maori and Pacific. The intensive and moderate levels of service are the most expensive component of the proposal and targets schools with high numbers of Maori and Pacific students.

The evaluation of the school based programme concluded that Mana Kidz reduces health inequalities for these children and their families/whaanau, by:

- Addressing practical barriers to accessing primary health care and prescription medicines for sore throats and skin infections
- Increasing awareness and knowledge about sore throats, rheumatic fever and skin infections, including their prevention and treatment
- Referring and linking families/whaanau to primary care providers and other community services to meet a range of needs
- Providing children with a positive introduction to primary health care and how to engage in seeking care when they are sick

Mana Kidz providers contribute to reducing health inequalities by engaging families/whaanau in ways that are appropriate to their cultures and circumstances. Many families have high needs and multiple risk factors to their health (e.g., poor housing, low incomes, family violence, smoking and other factors). Some have not historically experienced good engagement with mainstream health services. Given these realities, engaging effectively with high needs whaanau can at times be time-intensive and therefore addressing inequities will require investment.

A Principal’s Perspective: Gus Klein, Cosgrove School, Papakura

From an educational perspective, Mana Kidz is impacting learning at this school. Our school is Decile 1, mainly Maori and Pacific, with most children coming from low socioeconomic backgrounds. Mana Kidz is assisting this school to improve attendance and create healthier children and therefore assisting improving the learning outcome. The Mana Kidz team work collaboratively with other services within the school including the dental service and SWIS. The school has regular meetings with the health team (SWIS, student support worker and the nurse) to ensure children at risk get the support needed. I strongly believe that healthy children will learn.

For years we have been trying to reduce the percentage of children who are “at risk”, that is, being away 20% or more per year (one day or more per week on average). In this school it was regularly over 20% of the children, for example, in 2012 it was 22% and 2013 it was 21%. In 2015 this figure reduced to 16%. This is the first year we have seen the figures fall below 20%. We have several initiatives in the school over the years to reduce the number of children “at risk”, but it is interesting that the year we have Mana Kidz team, we see this figure reduce.

For that reason I opted to keep our dental clinic and I am currently refurbishing a space to have a dedicated Mana Kidz clinic. At Cosgrove we want all those that will create healthy children at our finger tips and as a result we believe it is having an impact on learning.
Financial benefits

The implementation of a School Health Network will have a range of benefits. The School Network, as proposed, will have an almost daily view of 34,000 children, with the ability to link with primary care and work with Education and Social services in a new way to ensure children do not get “lost to the system”. These benefits are difficult to quantify in financial terms.

The table below attempts to quantify, as requested, some of the green dollar savings that could be attributed to the School Health Network. The modelling includes some benefits from introducing an asthma education programme, which has not yet been implemented but could be at no extra cost. There is evidence in the literature that the introduction of a case management approach in a school setting can improve asthma management. The RF projections use both the lifetime cost saved to the system of preventing incident RF cases as well as the annual direct admissions costs saved. This analysis is reasonably conservative as it focuses on the impact on 5-12 year olds only when it is possible the programme influences the wider whaanau and community level understanding regarding RF. Also children exposed to the school based programme will transition to high school and adulthood with an understanding of sore throat management that is likely to persist and influence their behaviour when they become parents. While the attribution of the reduction in RF can be argued ALG believes, on balance, that the school based programme has made the biggest contribution to the decrease in RF observed in CM Health. In the modelling below it has been estimated that 80% of the reduction in RF seen in this age group is attributable to the school based service.

The biggest saving to the health system is the lifetime costs saved if a person does not get RF. This is not an actual saving in the financial year but rather is accumulated over the lifetime of the cohort. The anticipated bed costs savings are comparatively small but it is reasonable to expect some long term benefits of school based network as a result of better understanding about how to stay healthy, improved health literacy and engagement with health services in the future. These savings have not been modelled. Also no attempt was made to model the impact improved identification of child protection concerns will have on long term outcomes for children.
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<tbody>
<tr>
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<td>40</td>
<td>41</td>
<td>41</td>
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<td>Lost to follow-up (%)</td>
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<td>Lost to follow-up (%)</td>
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<tr>
<td>Mortality (per case)</td>
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<td>$481,816</td>
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<td>$489,845</td>
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<td>462</td>
<td>466</td>
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<td>292</td>
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<tr>
<td>Lost to follow-up (%)</td>
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<td>981,771</td>
<td>865,314</td>
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<td>851,927</td>
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<td>864,617</td>
<td>876,974</td>
<td>889,302</td>
<td>901,012</td>
<td>912,000</td>
<td>924,713</td>
<td>935,179</td>
<td>944,267</td>
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Qualifications and Assumptions:
1. Estimated population and projections for 5-12 years old and 5-14 years old are sourced from Statistics New Zealand 2015 updates.
2. Cost per admission for various conditions is sourced from Auckland Support at Middlemore Hospital.
4. Reduction rates for various conditions based on literature or expert opinion to data with the programme.
How will it function

Management case

The School Health Network will utilise existing structures and primary care providers to deliver high quality primary health care across South Auckland.

The School Health Network will be made up of three key components.

1. **School Health Network Leadership and Governance Group**: providing governance this group will determine the vision and strategy for the network and population-level outcomes. The group will be made up of representatives from CM Health, primary care and the community. This group will report to the Alliance Leadership Team.

2. **Operational team**: supporting the functioning of the School health Network, the core team will be the backbone of the network responsible for coordination, facilitating collaboration, performance accountability, reporting and quality. The small core team will include positions from the locality network leads and lead providers.

3. **Locality network leads and lead providers**: high performing primary care and community health providers who deliver the services within the schools. They will be connected directly with the school communities and other service providers and contribute to the core team.
How it will function

Governance
A leadership and governance group will be established and will be made up of representatives from CM Health, primary care and the community. This group will build a persuasive shared vision of what the School Health Network will achieve and establish relationships where power-sharing and shared leadership are possible. The group will also be a leadership mechanism for the advocacy/prioritisation of children’s health, supporting clinical and community leadership.

Contracting and operations
The implementation of the School Health Network will see the continuation of a flexible funding and contracting model that focuses on results. The operational team will be the backbone of the network responsible for coordination, facilitating collaboration, performance accountability, reporting and quality.

The operational team will;
- Provide centralised non-clinical support and back-office functions
- Support clinical standardisation by the use of shared processes, guidelines and protocols
- Facilitate the sharing of resources and information including how resources (including staff) are deployed
- Include DHB management to allow reporting lines of DHB employed staff to be achieved

This small core team will include positions from the locality network leads and lead providers to facilitate greater level of integration. Mana Kidz has developed increasing trust and increasing capacity among its provider network of primary care and community health providers; building relationships, readiness, and capability. The School Health Network is an opportunity to further develop and expand this network.

There is an expectation that after an initial contract period (2-3 years) that the School Health Network will sit within, be managed by and financially supported by primary care.

Reporting and outcomes
The performance of the network will be closely monitored by an integrated dataset with agreed performance (organisation) and outcomes (population-level) indicators.

A set of indicators and an outcomes framework will ensure that the School Health Network is achieving the outcomes. These provider and population-level indicators will be measured across the system. This will allow us to;

1. Monitor performance of the School Health Network and its providers
2. Identify areas for service improvement
3. Ensure that the service level provided to each school/area is appropriate to the level of need
4. Evidence the achievement of health outcomes

The School Health Network will commit to the development of an outcomes framework and indicator set to track progress.

Flexibility and future-proofing
The School Health Network does not have a large fixed infrastructure. This will enable the system to develop, evolve, and change in response to changes in health needs. It
will be responsive to the needs of children and whaanau rather than to health structures, organisations and staffing.

The School Health Network will facilitate the process whereby previously unnoticed solutions and resources from inside and outside the community are identified and adopted.

There is increasing evidence that provider collectives (often termed collective impact efforts) can achieve positive and consistent progress on complex problems at scale. In many cases, without the need for revolutionary new practices or large increases in funding. Mana Kidz is testament to the possibilities of this approach.

Innovations such as telehealth have been trialled in limited ways and there is considerable opportunity for exploring further utilisation of this and other technologies, aligned to the Enhanced Primary Care proposal, to increase care quality and reduce associated costs.

**Better coordination and integration with other services**

This is an opportunity to further integrate with primary care by proactively working within primary care (and secondary specialist) services to identify and manage health issues and improve accessibility. Build capacity and capability including referral pathways

There is an opportunity to work across sectors. One of the key strategies for the School Health Network will be strengthening links with other sectors.
Implementation timeline and key activities

Implementation of the School Health Network will occur over a six month period. The Network will be fully operational by February 2017 in readiness for the new school year. Existing high performing Mana Kidz providers will continue to provide services in high needs schools until 31 December 2016. A contestable procurement process will be run over this time.

The following outlines the high-level activities for the implementation of the School Health Network. Comprehensive project planning will be undertaken on confirmation of funding. The current providers of the Mana Kidz programme, PHOs and primary care providers engaged with as part of the consultation process (Appendix 5) are all very supportive that delivering school based services is the right thing to do. A medium term (3-5 year) commitment to funding this programme is needed to provide some level of certainty to providers who have been struggling to maintain and develop the capability of their workforce in the context of short term funding.

<table>
<thead>
<tr>
<th>Preparatory phase</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Development and engagement</strong></td>
<td><strong>Provider engagement</strong>&lt;br&gt;Outcomes framework development&lt;br&gt;Communications strategy&lt;br&gt;Localities engagement&lt;br&gt;Co-design process with schools and providers</td>
<td><strong>Relationship building with providers, schools</strong>&lt;br&gt;Training&lt;br&gt;Communications with key stakeholders&lt;br&gt;Augmentation of governance structures</td>
</tr>
<tr>
<td><strong>Contracting</strong></td>
<td><strong>Six months rollover of existing services</strong>&lt;br&gt;Initiate design process&lt;br&gt;Finalise project planning</td>
<td><strong>Contestable RFP process for all services within network.</strong>&lt;br&gt;Procurement process (EOI)&lt;br&gt;Services contracted&lt;br&gt;CM Health PHN change management</td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td><strong>Continuation of Mana Kidz</strong></td>
<td><strong>Clinical protocols review</strong>&lt;br&gt;Quality improvement processes&lt;br&gt;Learning needs analysis and workforce development planning&lt;br&gt;Information systems development</td>
</tr>
</tbody>
</table>
## External dependencies and constraints

<table>
<thead>
<tr>
<th>DESCRIPTION/COMMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government funding of DHBs</strong></td>
<td>The MoH health has currently committed to funding RF prevention in Counties Manukau until 2022. Currently CM Health has some flexibility with how this money is spent. CM Health has decided, through ALG based on the available evidence, to prioritise the school based programme. Should the evidence in regards to the impact of RF of the school programme change there is a possibility the DHB will be directed not to spend MoH money on a school based programme.</td>
</tr>
<tr>
<td><strong>Capability of National Hauora Coalition’s operational team</strong></td>
<td>NHC’s Mana Kidz team has been responsible for operationalising the successful Mana Kidz programme. They have excellent relationships with providers as well as contract management and project management expertise that makes them ideally placed to lead the development of the broader programme. Should a decision be made not to go with NHC as the provider of the operating team or there was significant change over in staff then the implementation of the school based network could be significantly delayed or incur additional costs.</td>
</tr>
<tr>
<td><strong>General Practice interest and capacity</strong></td>
<td>Primary care and Localities have indicated significant interest in the development of the school based network. This is particularly important for the implementation of the low and support intensity programmes.</td>
</tr>
</tbody>
</table>
Abbreviations

**BPS** Target- Better Public Service Target

**CM Health-Counties Manukau Health** previously CMDHB

**MoH** Ministry of Health

**PHN** Public Health Nurse

**PSGN** Post streptococcal glomerulonephritis

**RF** Rheumatic Fever

**RN** Registered Nurse

**WSW** Whaanau Support Worker
References

[1] Census 2013, Statistics New Zealand


Appendix 1

Impact of Mana Kidz

The Ministry of Health (MoH) Rheumatic Fever Prevention Programme (RFPP) was established in 2011 to prevent and treat streptococcal throat infections, which can lead to RF. The Programme was expanded significantly from 2012 following the introduction of the RF Better Public Services (BPS) target. The RFPP identified a number of work streams that were funded in areas with high rates of RF including the Counties Manukau District. There has been an expectation that DHBs will actively engage and invest in this key results area.6

This was the impetus to establish a highly targeted school based programme in schools which were identified to have students at the highest risk of developing RF. Mana Kidz provides a team of a registered nurse and a whaanau support worker (WSW) who are based in school during term time. The service includes daily assessment and treatment of sore throats and skin infections. In addition, other health care needs can be addressed effectively, e.g., hearing and vision and child protection issues. The model also provides the opportunity for wider family/whaanau to be assessed. A Manual of Operations is used by all providers and Standing Orders are in place for the registered nurses for of defined conditions by a delegated authority.

Mana Kidz was established in 2012 and is a targeted and intense school based nursing service, operating in 61 schools in Counties Manukau (~25,000 students). The National Hauora Coalition led the implementation of the service, coordinating a provider network made up of PHOs, primary care providers, community health providers and Kidz First Community Health.

The service includes daily assessment and treatment of sore throats and skin infections. In addition, other health care needs can be addressed effectively, e.g., hearing and vision and child protection issues. The model also provides the opportunity for wider family/whaanau to be assessed.

An external evaluation was completed at the end of 2014 which concluded that based on evidence from a range of sources Mana Kidz is an important and effective programme that is making a substantial contribution to health care for children in the age group evaluated.

6 Letter from Minister of Health to DHB chief executives, January 2013
Outcomes achieved

While attribution of this change can be argued the Alliance Leadership Group (ALG)\(^7\) believe, on the basis of the proportion of swabbing done in the school based service compared to primary care and secondary schools and the low throughput of AWHI, it is likely to be Mana Kidz which is having the biggest impact on RF rates. CM Health is currently on track to achieve to achieve the MoH target of a 2/3 reduction in ARF by July 2017.

The Mana Kidz programme has led to the development of a functional network of providers who work together supported by National Hauora coalition (NHC). Relationships and trust has developed over the past three years and with different providers working very closely together. Mana Kidz has strengthened relationships and developed collaborative partnerships across primary care, the DHB and community health providers. There is an opportunity to build upon this effective and functional network to provide better care for more children. A huge amount has been learnt about how to maximise the efficiencies of this programme.

Benefits of the programme are being seen in terms of improvements in health literacy and engagement of families with primary care services as well as linking child and whaanau with other sectors.\(^{[10]}\) The funding for the nurse led, school based health services has been significantly reduced. With the current level of funding the current service cannot be maintained. During the time the programme has been in place we have seen a significant reduction in the incidence of acute rheumatic fever.

\(^{[7]}\) Alliance Leadership Group has been delegated governance of RF plan in Counties Manukau. The group consists of David Jansen (chair), Nettie Knetsch, Carmel Ellis, Pip Anderson, Anna Bailey and Lorraine Hetaraka-Stevens.
Appendix 2

Service design detail

The School Health Network (SHN) will support the delivery of high quality primary care services across all 183 schools in South Auckland. It is a virtual provider network that utilises existing providers who are experts in both the delivery of primary care services and the community in which they work.

How will this look at a school level? The School Health Network will provide different levels of service varying from an intensive service (i.e. Mana Kidz) to a minimal support service. The level of service a school will receive depends on the health needs of the school.

School health need has been determined by a combination of quantitative (decile rating; risk analysis) and qualitative (principal surveys; interviews with clinical teams). The financial modelling undertaken to inform this business case uses the Ministry of Education’s decile rating to calculate estimated costs of delivering a school based service. It is acknowledged that decile rating is a reasonably blunt tool to understand a school’s health needs.8

It is envisaged that providers working within a locality will have some flexibility with the resources allocated from the available funding to develop a more nuanced service once local engagement has been undertaken and the health needs of the schools in an areas are more accurately understood.

The locality approach

The proposed model varies by locality acknowledging the different distribution of high needs schools varies across the district as well as other differences such as the rurality vs urban, PHO predominance in some localities and the development, to date, of locality infrastructure.

For example in Franklin there is a well-developed Locality network with some infrastructure to support the co-ordination and development of school based services. The network currently has good relationships with PHOs, primary care providers and other social agencies. They have a rapid response coordination function established and have the desire to take a lead in developing school based health services. There are primary care practices with a strong interest and clinical expertise in child health e.g. Healthy Tomorrows clinic at Pukekohe Family Health Centre. In the Eastern locality there is a predominance of schools with lower health

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8 Determining school health need is not easy and this is considered the best way to do this at this stage. The School Health Network will need to be flexible to respond to increased (or decreased) health need over time. The measurement framework will help us to do this; it will give us a significantly better picture of health and wellbeing across all schools in CM HEALTH. In addition, there will be clear escalation and support pathways if a high needs child/whānau is identified within a low needs school to ensure that all children receive appropriate support.

9 There are 5 factors that make up the decile rating which include household income, occupation, household crowding, educational qualifications and education support.

http://www.minedu.govt.nz/Parents/AllAges/EducationInNZ/SchoolsInNewZealand/SchoolDecileRatings.aspx. It is worth noting the decile system is the reverse scale to the commonly used for NZdep area level measure of socio economic deprivation. Decile 1 schools have the highest proportion of students from low socio-economic communities, whereas decile 10 schools are the 10 percent of schools with the lowest proportion of these students.
needs compared to the rest of the district and a dominant PHO with good relationships and a commitment to school based service development.

In Manukau and Mangere/Otara localities where there are a large number of schools with students with high health needs, existing Mana Kidz providers and developing locality infrastructure, service provision should be co-ordinated through the operational team contracting directly with lead providers.

In summary, there are two broad approaches to the development and implementation of the School Health Network. In both instances, a collaborative co-design process which engages the existing locality structures will be undertaken to ensure the approach is the best fit for the communities we are serving.

A. **Locality network lead**: in Franklin and Eastern, a locality network lead will be appointed to collaborate in the development, implementation and ongoing coordination of the (largely primary care) provider network in those localities but may not be involved in direct service provision. The Locality network lead will maintain strong links with both locality structures and the operational team supporting the wider School Health Network.

B. **Lead provider**: in Manukau and Mangere/Otara, lead providers will be contracted to provide services across the identified schools. All lead providers will be directly involved in service provision and will work closely with the operational team supporting the wider School Health Network.
Mana Kidz Model of Care

Mana Kidz Model of Care: Key principles

Whaanau-centred
- Tamariki-focused and whaanau centred
- Strengths-based approach
- Culturally appropriate and competent

Service excellence
- Evidence-informed clinical framework underpins service delivery
- Systemic support for safety, continuous learning and efficiency
- Measureable outcomes and performance indicators to demonstrate impact

Transformative
- Proactive approach to primary healthcare barriers—intensive, relational, free, community based, mobile
- Catalyst for delivering better services. Challenge and disrupt traditional ways of delivering health and social services

Collaboration and integration
- Collaboration for collective impact; shared goals, decision-making and resourcing
- Coordination/Integration with a range of health and social service providers

Enablers
- Integrated PMS plus associated information support systems
- Delivery of services from primary care providers
- Locality approach to procurement
- Outcomes measurement
- Enhanced performance measurement
- Primary care integration
- Better referral pathways
- Locality relationships
- Funded alliance team
- Quality improvement group
- Health service co-design with consumer/client/whaanau input
- Integrated approach across schools and health providers
- Greater engagement of social service providers
- Systematic implementation of a ‘whole of school’ approach to health promotion
- Education and competency framework (with quals) for WSW
Appendix 3

Financial costings

The investment required in the programme has been determined by the number of schools included and the intensity of the service provided. There are a number of ways a school based service could be configured. These range from continuing with a highly targeted programme specifically focused on rheumatic fever prevention to a universal programme across all schools with a broader remit. The intensive programme in school with children who have high health needs accounts for the largest proportion of the investment. The marginal cost of the lower needs schools is comparatively small.

The preferred option is to provide a district wide service reflecting the differing level of needs in different schools it is estimated there is a requirement for investment additional to the funding currently available from the Ministry of Health, Middlemore Foundation and that already allocated to the Public Health Nursing Service.

<table>
<thead>
<tr>
<th>Service intensity</th>
<th>Eastern</th>
<th>Franklin</th>
<th>Mangere/Otara</th>
<th>Manukau</th>
<th>Total</th>
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<tbody>
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<td><strong>Total</strong></td>
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<td>46</td>
<td>40</td>
<td>51</td>
<td>178</td>
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</table>

Note: Total schools is 178 as Middlemore Foundation is currently funding five schools in Papakura
Table 2. Number of children by service type and locality

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<th>Service intensity</th>
<th>Eastern</th>
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<th>Mangere/Otara</th>
<th>Manukau</th>
<th>Total</th>
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<tr>
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<td>9429</td>
<td>16697</td>
<td>22164</td>
<td>68051</td>
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Table 3. Cost per child by service type and locality

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<th>Service intensity</th>
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<th>Mangere/Otara</th>
<th>Manukau</th>
<th>Average</th>
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<td>$94.36</td>
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Table 5. Number of children per service intensity (by ethnicity)

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<th>Service intensity</th>
<th>NZ European</th>
<th>Maaori</th>
<th>Asian</th>
<th>Pacific</th>
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Figure 5 Graph of Number of children per service intensity (by ethnicity)
Table 5. Number of schools by decile (including Papakura Kootuitui)

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<td>3</td>
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<td>4</td>
<td>11</td>
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<td>4</td>
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Table 6. Number of children by decile

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<th>Manukau</th>
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<td>3</td>
<td>532</td>
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<td>1,750</td>
<td>2,912</td>
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<tr>
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<td>20,348</td>
<td>9,304</td>
<td>15,972</td>
<td>22,821</td>
<td>68,445</td>
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Appendix 4

Summary of Consultation

There has been overwhelming support from all stakeholders for continuation and further development of school based health services

Stakeholder engagement

There was wide stakeholder engagement undertaken to inform this business case. This included;

- Meeting with all the current providers of the Mana Kidz programme.
  - There was general agreement that the programme is running well and all providers expressed the strong view that the school based programme has made a difference to the health status of children in Mana Kidz schools.
  - All of the providers described a positive relationship with National Hauora Coalition (NHC) as the lead provider for the Child Health Alliance and the contract manager for the programme.

- Meeting individually with all PHOs operating in the Counties Manukau District.
  - All of the PHOs were supportive of the Mana Kidz programme and expressed a strong desire for the programme to continue. Having said this only one PHO was prepared to consider contributing financially to the continuation of the programme during discussions.

- Facilitating two workshops
  1. One with PHOs, primary care providers and DHBs representatives to discuss school based services, what they should deliver and how this could be achieved.
  2. One with Public Health Nurses to understand their experience of delivering the more intensive school based programme and maintaining a level of service to the other schools. There were a range of ideas expressed, some of which appear contradictory. It is likely the experiences of individual staff members vary depending on which schools they are working in, whether they have a mixed workload (Mana Kidz and non Mana Kidz schools) as well as which geographical location they are working in. There was an overall feeling that Mana Kidz schools were better off since the introduction of the more intensive service while there was concern expressed about the impact on non-Mana Kidz schools.

- Meet with other sectors
  - Ministry of Social Development
    - Ken Allen identified an opportunity to better integrate the work of the Social Workers in Schools with the school based programme
Education

- Kevin Emery (Ministry of Education) identified there may be some opportunity for the Ministry of Education to support the programme through facility development.

- Principal cluster groups where Mana Kidz has not been operating (Howick/Pakuranga executive, Hunua, Papatoetoe, Papakura). Overall from the face to face meetings there was a recognition that lower decile schools need more intensive support and many of the higher decile school principals supported targeting health resource. Principals from higher decile areas did note that the issues facing them were different. Infectious diseases were not so prominent but they reported allergies as a big issue as well as emotional issues due to family break ups and reconstituted family groups. Principals were realistic about the amount of health resource that would be available but valued highly relationships with a named person who visited the school (once a term suggested as frequently enough to maintain a relationship), who they could call as needed.

- Principals from lower decile schools on the cusp of meeting the criteria for Mana Kidz expressed their frustration at the lack of service and expressed a strong desire to be able to access more intensive health services. Principals with a Mana Kidz service were effusive about the positive benefits to their schools both in terms of health benefits as well as improved attendance.
Counties Manukau District Health Board
Community and Primary Health Advisory Committee
2016/17 Quarter 4 Population Health Plans Covering Paper

Recommendation

It is recommended that the Community and 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 Quarter 4 Summary Progress Reports are appended.

Notes the key discussion points contained within.

Prepared and submitted by: Marianne Scott and Fepulea’i Margie Apa

| This paper has been through HMT/P&CLT/CGG/ISGG | No |
| Financial Implications | No | Finance have been consulted | No |
| HR Implications | No | HR have been consulted | No |

Glossary

ASH: Ambulatory Sensitive Hospitalisations
BFCI: Baby-friendly Community Initiative (Accreditation programme)
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 4 (Q4) 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 Q4 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 - Maaori (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) has surpassed the 95% target for Maaori (98%) and Pacific (98%) 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 among Maaori and Asian women. Culturally-appropriate services to better link women to cancer screening are in progress to address this.

**Background**

The 2016/17 Maaori 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**

1. **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>Maaori living in Counties Manukau</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matua, Pepi and Tamariki (Parents, Infants and Children)</td>
<td>Oral Health – The proportion of preschool-aged tamariki enrolled in the service has increased 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 doubled since beginning of the financial year to 98%.</td>
<td>89% 98%</td>
</tr>
<tr>
<td>Pacific peoples living in Counties Manukau</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matua, Pepi and Tamariki</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</td>
<td>98%</td>
</tr>
</tbody>
</table>
### Action Focus

<table>
<thead>
<tr>
<th>Results</th>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>65% percent since Q1. The Q4 figure of 98% has surpassed the annual target of 95%. The proportion of new born infants enrolled in General Practice has increased for 66% in Q3 to 70% in Q4</td>
<td>71%</td>
</tr>
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</table>

### Asian peoples living in Counties Manukau

| 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 target at 56.1%. | 89% (enrolment) 55% (caries free) |

2. **Action areas of concern and persistent health equity challenge**

#### Maaori living in Counties Manukau

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Results</th>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rohe Whaanui (District Wide)</td>
<td>Maaori participation in the DHB employed workforce has declined from a Q3 2015/16 peak by 0.3 percentage points. Currently, 6.9% of the Counties Manukau Health workforce is Maaori (refer Insights section 3h below for further information) Cervical Screening rates have steadily declined over the past financial year, from a peak of 69% in Q4 2015/16 to 65% in Q4 2016/17. Glycaemic control for Maaori adults with diabetes has worsened in the region from 63% in Q2 2016/17 to 61%.</td>
<td>16% (total population) 77% 73%</td>
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#### Pacific peoples living in Counties Manukau

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Results</th>
<th>Health Equity Target</th>
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</thead>
<tbody>
<tr>
<td>Matua, Pepi and Tamariki (Parents, Infants and Children)</td>
<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%. 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 by 11% between Q1 and Q4 while the 45-64 rates increased over that same period.</td>
<td>65% 4720 (0-4) 2963 (45-64)</td>
</tr>
</tbody>
</table>

#### Asian peoples living in Counties Manukau

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Results</th>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakeke and Whaanau (Adults and Family Group)</td>
<td>The percentage of eligible Asian women who have had a cervical smear in the last 36 months (67%) remains 5% lower than the equity target and 12% below the 80% target.</td>
<td>73%</td>
</tr>
</tbody>
</table>

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1 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.
1. Raising Healthy Kids Health Target/Child Obesity

As at the end of Quarter 4 the 95% target for the percentage of Obese children referred for Clinical Assessment was exceeded for Tamariki Maaori (98%) and Pacific children (98%). The rates for Tamariki Maaori and Pacific children were also equal to the equity target of 98%. In the last period activities were focused 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 24% (national average is 29%), however the decline rate for Maaori remains higher at 33%. Pacific declines are the lowest at 18% (the national Pacific average is 20%). We continue to actively monitor and address the decline rate.

2. 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 (which represent the end of the 2016 Calendar Year) 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. ARDS is currently working on recruitment strategies to arrest significant workforce shortages experienced in the 2016/17 Financial Year.

A challenge is emerging regarding the utilisation of DHB-funded oral health services by young people between the ages of 14 and 17. By Q4 only 72% of young people were accessing services, against a target of 85%. We believe that resistance by some local secondary schools to hosting Mobile Dental Clinics is a significant contributing factor to the low rates of utilisation. We also believe that approximately 2500 young people aged 16-17 are outside of the education system and therefore aren’t reached by current school-based engagement strategies. ARDS will meet with the Ministry of Health Oral Health Team in September 2017 to progress engagement strategies for young people classified as NEET (Not in Education, Employment or Training). While the 72% utilisation result is not further defined by ethnicity, there may be a possibility that ethnic-specific strategies may support engagement with youth NEET populations, as has been experienced in the education and social services sectors.

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.
3. Diabetes Care

The Modified DCIP and DCIP programs are being rolled over for 4 months with a view to amalgamating with Planned proactive Care program from 1 November 2017. Evaluation of the Modified DCIP program is progressing with qualitative interviews and analysis of data supplied directly by the PHOs for metro Auckland.

Data from metro Auckland PHOs allows the tracking of 5 indicators by ethnicity.
- 227 Pacific patients were referred for podiatry in quarter 4.
- There were 88 Dietetic referrals in Q4
- There were 585 Pacific patients referred for a Green Prescription in Quarter 4

Retinal screening numbers for the year are lower than anticipated but this is mainly due to changes in provider services and we expect a significant increase in numbers for the 2017/18 year as we are training more screeners and purchasing equipment. We are also looking at further fixed community clinics to improve access for clients.

4. 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 Māori (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 (≥ 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 (≥20%) or prior CVD event

5. Pacific Breastfeeding - 6 weeks, 3 months and 6 months

Breastfeeding rates at 6 weeks, 3 months and 6 months are well below the MOH target rates, and minimal progress has been made increasing breastfeeding rates for a number of years despite a lot of work being done in this space.
The following results were recorded for each key indicator

**Percentage of Infants exclusively or fully breastfed at 6 weeks (Target 75%)**
- Māori – 34%
- Pacific – 53%
- Non Māori/Non Pacific – 66%

**Percentage of Infants exclusively or fully breastfed at 3 months (Target 60%)**
- Māori – 34%
- Pacific – 42%
- Non Māori/Non Pacific 57%

**Percentage of Infants receiving breast milk at 6 months (Target 65%)**
- Māori – 49%
- Pacific – 57%
- Non Māori, Non Pacific – 66%

From a health gains perspective we want to be able to understand the barriers to gaining accurate and timely breastfeeding data. The most recent data we have is 12 months olds and we don’t get any local level data breakdown (CM wide only). There are a number of complex issues impacting on breastfeeding, many of which are outside of the influence of the health sector. In 2014, we undertook an in-depth community and health provider needs assessment was to understand the barriers and enablers to breastfeeding for whānau in Counties Manukau and to investigate ways of improving breastfeeding rates. Feedback from Mama and Whaanau is listed below:

**Health Provider Barriers**
- Conflicting and confusing messages
- Lack of information antenatally and support provided postnatally
- Lack of understanding from providers on whānau life realities’
- Rushed appointments and a fractured and fragmented system
- Low staffing levels on Maternity Ward along with high acuity of women is resulting in a larger number of babies receiving formula before discharge

**Complex whānau life realities**
- Financial barriers with the return to work (#1 reason Mama stop breastfeeding)
- Whaanau advice different from ‘health best practice advice’
- Embarrassment and judgment about breastfeeding in public
- Conflicting family obligations

Current breastfeeding support services available in CMH include; LMC’s WCTO providers, pregnancy and parenting services and general practice. Specific community-based breastfeeding support services provided and funded by CMH are the B4Baby and Te Rito Ora programmes.

In the next 12 months we will look to achieve the following with the aim of increasing our rate of breastfeeding. These are:
- Strengthen and realign community breastfeeding service models
- Scope a whole-of-system approach to providing breastfeeding support services in Counties Manukau with a focus improving integration of services, delivery of culturally appropriate services and continuity of care for mothers and whaanau
- Provide breastfeeding education and training sessions to priority workforces to reduce conflicting messages being given to whaanau
- Work collaboratively with WCTO providers to strengthen the support they provide breastfeeding Mama and whaanau
• Increase LMC, WCTO, primary care and community awareness about services and referral processes
• Support organisations in Counties Manukau who are BFCI accredited or working towards BFCI to maintain/achieve their accreditation

6. 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: 37%, Q2: 37%, Q3: 57%, Q4: 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. Education 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

7. Cervical Screening for Asian Women

The June 2017 Asian coverage rate is 67.6% down from June 2016 68.2%, but there has been a 0.8% drop in coverage for Asian women due to the impact of the NCSP 2016 update to the 2013 census populations projections. In addition what is pleasing to see (but doesn’t reflect in the coverage rates due to the increase in population) is that in the 16/17 year 26,443 Asian women were screened in the last 3 years. In the 15/16 year 24,555 Asian women were screened, therefore there has been an increase in 1,888 screened.

In addition as of June 2016, 5517 Asian women required screening to reach target whereas in June 2017, 4869 Asian women required screening to reach target.

In summary, our activity has gone up and we are screening more Asian women but due to the population changes this is not reflected in the coverage rate. The PHO action plans are being completed and are on target to be completed by the end of 2017/18 Q1. Each plan will have a focus on increasing coverage for priority group women and initiatives will be shared across PHOs.

Each PHO has a dedicated cervical screening coordinator, who attends the Metro-Auckland Cervical Screening Operations group meeting to ensure initiatives and outcomes are shared on increasing coverage for priority group women. Contracts have not yet been finalised, due to waiting for an organisational decision on adding CCP to contracts. The allocation of funded cervical smears to each PHO has been amended according to their enrolled population of priority group women and the previous year’s utilisation. Meetings are occurring with each PHO on an individual basis to discuss the use of the NSU data match lists (including how they are being used and how their use can be increased). Support is then being offered to specific Practices, as prioritised by the PHO. The CMDHB Support to Screening Practice Nurse Liaison staff have been trained to use the NSU data match lists so can support Practices as required.

Radio Tarana and Humm FM have been funded to provide a cervical screening promotion campaign for April – June 2017. This has included the Cervical Screening Coordinator being available for women to call the radio stations and ask questions related to cervical screening. This has resulted in an increase in Asian women contacting the Support to Screening service requesting detail on accessing cervical screening, specifically for the younger age group < 40 years, which nationally have the lower screening rates in the Asian community.
The Cervical Screening Coordinator works closely with the Support to Screening service to provide out of hours and opportunistic screening for Asian women and other priority group women. Cervical screening is also offered to women at the same sites as the mobile breast screening van. Well Women and Family Trust are also contracted to work alongside General Practice to increase screening opportunities for Asian women. This service predominantly provides screening for women from the Asian community.

8. ASH rates 0-4 years and 45-64 years

Training sessions have been provided to Pacific early childhood centres in Mangere in development to train teachers on skin infections. The planned proactive care program has developed training packages for primary care nurses on the following topics: eczema management and children with asthma and constipation.

A list of children admitted to Kidz First over past 12 months is being provided to primary care practices. System Level Measures for ASH rates remain under development. A skin infection training package developed for community groups has been trialed in Rawiri community centre. The training package will also be delivered in other community centres in the Manukau Locality.

9. Population Plan Specific Programmes

LotuMoui

LotuMoui and Community have worked to align its focus to the 2016/17 Pacific Health Plan which showed a big emphasis on Pacific child health. It has achieved this through the creation of a Pacific Child Health Network which 17 ECE’s and home-based education providers. In Q4, LotuMoui in collaboration with Pacific heartbeat delivered a Nutrition Education Programme to representatives of the Pacific Child Health Network. This was to inform and increase awareness amongst teachers (which are now hopefully able to deliver the message to parents and children) on the importance of good nutrition for our children’s learning and development. The programme also showcased number of ways to prepare nutritious food and participants were able to get practical and practice preparing these meals.

In addition, LotuMoui and Community further collaborated with TAHA (Well Pacific Mother and Infant Service) and were able to secure and provide funding for ECE’s to run health projects within their centers. An opportunity through a Fono or meeting was held where projects shared their work and learned ideas from each other. Projects included teaching the kids about fruit and vegetables through curating a vegetable garden.

Seven churches successfully completed the Train The Trainer (TTT) physical exercise program, both the workshops and the exercises. Our ongoing focus will be to support church members to implement learning’s among their congregations.

LotuMoui and Community collaborated with Vaka Tautua, a Pacific Organisation to provide a financial literacy workshop to the community. A total of 40 community participants attended the workshop and many have now kept in contact with Vaka Tautua for further guidance and training in financial literacy.

In Q4, LotuMoui and Community engaged local church communities on typhoid awareness. In response to a suspected typhoid outbreak that occurred earlier in the calendar year. Posters and pamphlets in the Samoan language were distributed informing the community on symptoms and what to do if symptoms are shown.

FanauOla

The FanauOla team continues to work closely with Pacific patients and their fanau/families who have been identified to be high complex and high users of the health system. 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 Q4 the FanauOla service attended to 342 high complex and high users Pacific families (Nurses: 214, Social Workers: 128).
The majority of these patients were referred from the EC triage, Kidz First, Cancer patients, Medical Wards, Smokefree services and self-referral. The social issues which FanauOla workers navigated included; housing needs, family violence, mental health issues, WINZ dependency, 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.

**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 Māori 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 Māori 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 Māori health providers to become NZQA accredited workplace assessors for Whaanau Ora qualifications.

**Pacific Integrated Service Agreements (ISA)**

Under this Agreement, Alliance Health Plus (AH+) is contracted by Counties Manukau Health (CMH) to implement a contract integration strategy in relation to Pacific Health services. The contract has seen the following occur:

- AH+ was devolved a tranche of Pacific Health services in 2013
- AH+ engaged with Pacific Health Providers to establish sub-contracts for the delivery of the Pacific Health services
- AH+ provides the management services required to support the continued implementation / reconfiguration and delivery of the services sub-contracted to the Pacific Health Providers via an outcomes based service model

The services are being reconfigured to focus on health outcomes for Pacific high needs and vulnerable families. The contracts devolved to AH+ included mobile nursing outreach, well child, school based GP services, radio promotion and child obesity intervention services. The reconfiguration of the sub-contracted services into integrated outcomes based models focused on families commenced on 1 July 2015. Pacific health services is contracted to provide 339 packages of care for high needs and vulnerable families. These packages of care include Best Start to Life (BSTL) 0-4years, Life Launch (LL) age 5-14 years, Strong and resilient youth (SRY) age 15-24 years and Healthy Adult 25-64years.

Q4 marks the end of two years of the delivery of this agreement. Target for the 2016/2017 were achieved in relation to number of Pacific patients and families received care as per shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Actual</th>
<th>Annual Target</th>
<th>% enrolled</th>
<th>2016/17 Actual</th>
<th>Annual Target</th>
<th>% enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bader Drive Doctors (BDD)</td>
<td>168</td>
<td>117</td>
<td>143</td>
<td>127</td>
<td>117</td>
<td>108</td>
</tr>
<tr>
<td>South Seas Healthcare (SSH)</td>
<td>348</td>
<td>221</td>
<td>157</td>
<td>226</td>
<td>221</td>
<td>102</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>516</strong></td>
<td><strong>339</strong></td>
<td><strong>152</strong></td>
<td><strong>353</strong></td>
<td><strong>339</strong></td>
<td><strong>104</strong></td>
</tr>
</tbody>
</table>
Outcomes achieved this quarter include:

- 155 referrals to health lifestyle programme
- 21 referrals to an ante-natal programme
- 40 referrals to rheumatic fever prevention education programme
- 48 youth referrals to personal development services
- 37 health education sessions completed
- 212 healthy lifestyle action plans developed
- 9 asthma action plans developed
- 2 parent education program plans developed
- 15 HEADDSS assessments completed

**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 Q4 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)
- Worked with the Critical Complex Care unit to support them in identifying resources that require translation into key Asian community languages.

**Asian Health Plan – Health Literate Workforce and Systems**

The Asian Health Gain Advisor had been working alongside key stakeholders responsible for diabetes and oral health initiatives especially during the development of the Asian Health Plan 2017/18. The Asian Health gain advisor has challenged current thinking on levels of need in the community and increased focus on Asian communities needs is reflected in the 2017/18 Asian Health Plan.

Data inaccuracies were discovered during a stock take of CALD training data. An accurate recording system was proposed and implementation through 2017/18 Asian Health Plan actions. Actions to support the increase in uptake of CALD training will rely on a new data recording system to establish baselines before engagement with locality leaders. This action has been included into the Asian Health Plan 2017/18.

**Asian Health Plan – Health Literate Workforce and Systems**

Stocktake of Mental Health Services staff completed CALD Cultural Competency training (Modules 1 & 4) has been completed via student placement. Data inaccuracies have been discovered and an accurate recording system was proposed and implementation through 2017/18 Asian Health Plan actions. Student placements have also supported the completion of a Gaps analysis of current procedures for providing clinical cultural advice for Asian service users.
Appendices

Māori Health Plan Quarter 4 Summary Progress Report
Pacific Health Plan Quarter 4 Summary Progress Report
Asian Health Plan Quarter 4 Summary Progress Report
### CMH 2016/17 Summary Progress Report at the end of Quarter 4. Maaori 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)

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Actuals 2015/16 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 or Non-Maori Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Percentage of Maaori enrolled in a PHO</td>
<td>Quarterly</td>
<td>100%</td>
<td>95%</td>
<td>93.1%</td>
<td>93.3%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>3.7%</td>
<td>0%</td>
</tr>
<tr>
<td>ASH rates</td>
<td>(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>6,620</td>
<td>6,529</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>8,648</td>
<td>8,953</td>
</tr>
<tr>
<td>Breastfeeding</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>19.8%</td>
<td>-4.5%</td>
<td>↑</td>
<td>65.8%</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>6.8%</td>
<td>-2.9%</td>
<td>↑</td>
<td>57.2%</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>17.5%</td>
<td>3.7%</td>
<td>↑</td>
<td>66.3%</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>90%</td>
<td>88.1%</td>
<td>88.3%</td>
<td>88.1%</td>
<td>88.2%</td>
<td>88.7%</td>
<td>88.4%</td>
<td>87.9%</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Actuals 2015/16 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>
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</tr>
<tr>
<td>Priority</td>
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<td>Actuals 2015/16 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>Percentage of eligible population who have a risk greater than 20% and are on dual therapy</td>
<td>Quarterly</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</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 breast screening 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>Smoking</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></td>
<td>72%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td>Percentage of eight months old children 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>89%</td>
<td>91%</td>
<td>89%</td>
<td></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></td>
<td>44%</td>
<td></td>
<td></td>
<td></td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</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></td>
<td></td>
<td>6.1</td>
<td></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>61%</td>
<td></td>
<td>67%</td>
<td></td>
<td></td>
<td>68%</td>
<td>73.5%</td>
<td></td>
</tr>
</tbody>
</table>

2 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>Actuals 2015/16</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 or Non-Maori Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</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>
<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>7%</td>
<td>Change from Q2 +15</td>
<td>↑ 80%</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>N/A</td>
<td>3,764 (NZ Euro/Other)</td>
<td>↑ 49.0%</td>
<td>(NZ Euro/Other)</td>
</tr>
<tr>
<td></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>7%</td>
<td>1.1 (last year)</td>
<td>↓ 1.2</td>
<td></td>
<td></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>
</tr>
<tr>
<td></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>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td></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>
</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>61%</td>
<td>12%</td>
<td>-2%</td>
<td></td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Actuals 2015/16 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>
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</tr>
<tr>
<td></td>
<td>Percentage of people with diabetes with an up-to-date retinal screen&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Quarterly</td>
<td>90%</td>
<td>87.8%</td>
<td>New indicator</td>
<td></td>
<td>0.6%</td>
<td>N/A</td>
<td>N/A</td>
<td>↑</td>
<td>88.4%</td>
</tr>
<tr>
<td></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>↑</td>
<td>N/A</td>
</tr>
<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>29%</td>
<td>65%</td>
<td>90.2%</td>
<td>98%</td>
<td>0%</td>
<td>+7.8%</td>
</tr>
</tbody>
</table>

<sup>3</sup> To be added to All Localities Indicator Dashboard

Counties Manukau District Health Board – Community & Public Health Advisory Committee 6 September 2017
<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Actuals 2015/16 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 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>98%</td>
<td>63%</td>
<td>79%</td>
<td>85%</td>
<td>69%</td>
<td>-1%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td></td>
<td>83%</td>
<td>79%</td>
<td>66%</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ASH rates</td>
<td>Six monthly</td>
<td>9,751 per 100,000</td>
<td>12,702 per 100,000</td>
<td>12,627</td>
<td>12,702</td>
<td>12,900</td>
<td>11,977</td>
<td>-6,683</td>
<td>4,720 (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td></td>
<td>Age 0 to 4 years</td>
<td>Six monthly</td>
<td>6,242 per 100,000</td>
<td>9,247 per 100,000</td>
<td>9,416</td>
<td>9,247</td>
<td>9,726</td>
<td>9,545</td>
<td>-6,467</td>
<td>2,963 (Non-Maori &amp; Non-Pacific)</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</td>
<td>9,416</td>
<td>9,247</td>
<td>9,726</td>
<td>9,545</td>
<td>-6,467</td>
<td>2,963 (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Percentage of infants exclusively or fully breastfeed</td>
<td>Six monthly</td>
<td>75%</td>
<td>50%</td>
<td>52%</td>
<td>52%</td>
<td></td>
<td></td>
<td>-15%</td>
<td>67% (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td></td>
<td>Age 6 weeks</td>
<td>Six monthly</td>
<td>53%</td>
<td>50%</td>
<td>52%</td>
<td>52%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age 3 months</td>
<td>Six monthly</td>
<td>60%</td>
<td>39%</td>
<td>42%</td>
<td>42%</td>
<td></td>
<td></td>
<td>-14%</td>
<td>56% (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td></td>
<td>Percentage of infants being fed breast milk</td>
<td>Six monthly</td>
<td>65%</td>
<td>59%</td>
<td>59%</td>
<td>57%</td>
<td></td>
<td></td>
<td>-9%</td>
<td>66% (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td></td>
<td>Age 6 months</td>
<td>Six monthly</td>
<td>59%</td>
<td>59%</td>
<td>57%</td>
<td>57%</td>
<td></td>
<td></td>
<td>-2%</td>
<td>93% (Non-Maori &amp; Non-Pacific)</td>
</tr>
<tr>
<td>CVD</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>92%</td>
<td>91%</td>
<td>91%</td>
<td>-2%</td>
<td>0%</td>
</tr>
<tr>
<td>Smoking</td>
<td>Percentage of pregnant Pacific mothers who are smokefree at 2 weeks</td>
<td>Quarterly</td>
<td>95%</td>
<td>67%</td>
<td>92%</td>
<td>92%</td>
<td></td>
<td></td>
<td>+1%</td>
<td>N/A</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Actuals 2015/16 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 or Non-Maori Pop.</td>
</tr>
<tr>
<td>---------------------</td>
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<tr>
<td>postnatal</td>
<td></td>
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<td></td>
<td></td>
<td></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>21.5</td>
<td>23.2</td>
<td>-23.2</td>
<td>-1.7</td>
<td>N/A</td>
<td></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>75.5%</td>
<td>85.0%</td>
<td>80.1%</td>
<td>-4.5%?</td>
<td>-4.9?</td>
<td>89.5% (Non-Maori and Non-Pacific)</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>34%</td>
<td>30%</td>
<td>30%</td>
<td>-45%?</td>
<td>-4%?</td>
<td>75% (European?)</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>67%</td>
<td>93%</td>
<td>+3%</td>
<td>+5%</td>
<td>95% (Non-Maori and Non-Pacific)</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>-0.44</td>
<td>N/A</td>
<td>0.96</td>
<td></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>-6.8%</td>
<td>N/A</td>
<td>79.5%</td>
<td></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>12.53%</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>955</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Diabetes Management</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>65%</td>
<td>58%</td>
<td>60%</td>
<td>-14%</td>
<td>-1%</td>
<td>73% (Non-Maori and Non-Pacific)</td>
</tr>
<tr>
<td></td>
<td>Percentage of enrolled</td>
<td>Quarterly</td>
<td>TBC in Q2</td>
<td>TBC in Q2</td>
<td>New indicator</td>
<td>TBC in Q2</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Actuals 2015/16 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 or Non-Maori</td>
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</tr>
<tr>
<td></td>
<td>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 TBC in Q2</td>
<td>TBC in Q2</td>
<td>New Indicator TBC in Q2</td>
<td>TBC in Q2</td>
<td>TBC in Q2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</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></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></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>24</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Actuals 2015/16 AHP</td>
<td>Performance 2016/17</td>
<td>Equity Gap</td>
<td>Change from previous quarter</td>
<td>Trend</td>
<td>Desired Trend Direction</td>
<td>Total or Non-Maori</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>79%</td>
</tr>
<tr>
<td>Oral Health</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>87%</td>
<td>8%</td>
<td>N.A.</td>
<td>N.A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of children caries free at age 5 years (PP11)</td>
<td>Annually</td>
<td>55%</td>
<td>63.6% (all other ethnicities including Asian)</td>
<td>56%</td>
<td>7.7%</td>
<td>N.A.</td>
<td>N.A.</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 months</td>
<td>Quarterly</td>
<td>80%</td>
<td>65.7%</td>
<td>65.5% 67% 66.8% 67.6%</td>
<td>-6.8% -0.2%</td>
<td></td>
<td></td>
<td></td>
<td>73.6%</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Percentage of patients with HbA1c &lt;=64 mmol/mol (PP20)</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A</td>
<td>N.A.</td>
<td></td>
<td>69%</td>
</tr>
<tr>
<td></td>
<td>Percentage of patients with blood pressure measures &lt;140 mmHg</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A</td>
<td>N.A.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of patients are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td>Quarterly</td>
<td>TBC</td>
<td>TBC</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A</td>
<td>N.A.</td>
<td></td>
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</tr>
</tbody>
</table>
Counties Manukau District Health Board

5.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Minutes of CPHAC Public Excluded meeting 26 July 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>
</tbody>
</table>