COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)
Wednesday, 11 April 2018

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

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

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

APOLOGIES

REGISTER OF INTERESTS

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

PART 1 – Items to be considered in public meeting

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Page No.</th>
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<tbody>
<tr>
<td>9.00am</td>
<td>AGENDA ORDER AND TIMING</td>
<td>Page No.</td>
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<tr>
<td></td>
<td>2. CONFIRMATION OF MINUTES</td>
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<tr>
<td>9.05am</td>
<td>Confirmation of Public Minutes of the Community and Public Health Advisory Committee Meeting – 21 February 2018</td>
<td>006</td>
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<td>9.10am</td>
<td>Action Items Register</td>
<td>012</td>
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<td>3. PRESENTATIONS</td>
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<tr>
<td>9.15am</td>
<td>Manukau Locality Update (Sarah Marshall &amp; Kaye Dennison)</td>
<td>015</td>
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<td>9.45am</td>
<td>Advanced Care Planning and End of Life Care (Matt Hannant and Karen Long)</td>
<td>021</td>
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Morning Team (10.15am – 10.20am)

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Page No.</th>
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<tbody>
<tr>
<td>10.20am</td>
<td>Primary &amp; Community Nursing Workforce Update (Karyn Sangster)</td>
<td>039</td>
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<tr>
<td>10.40am</td>
<td>Q2 2017/18 Population Health Performance Report (Filipo Katavake-McGrath)</td>
<td>050</td>
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11.00am 5. RESOLUTION TO EXCLUDE THE PUBLIC 063
## BOARD MEMBER ATTENDANCE SCHEDULE 2018 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>21 Feb</th>
<th>Mar</th>
<th>11 Apr</th>
<th>23 May</th>
<th>June</th>
<th>4 Jul</th>
<th>15 Aug</th>
<th>26 Set</th>
<th>Oct</th>
<th>7 Nov</th>
<th>5 Dec</th>
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<td>Colleen Brown (Chair)</td>
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<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>Dianne Glenn</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
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<td>Reece Autagavaia</td>
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<td>John Wong - External Appointee (appointed 13/9/17)</td>
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## CPHAC MEMBERS

### DISCLOSURE OF INTERESTS

**21 February 2018**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</thead>
</table>
| Colleen Brown (CPHAC Chair) | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Chair, Rawiri Residents Association  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ |
| 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.  
• Member, 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)  
• Board Member, Counties Manukau Rugby League Zone |
| 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 (Board Chair)                    | • Chairman, Bank of India (NZ) Ltd  
|                                                | • 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  
|                                                | • Director, New Zealand Health Partnerships  
|                                                | • Singapore Chapter Chairman – ASEAN New Zealand Business Council |
| Apulu Reece Autagavaia                           | • Member, Pacific Lawyers’ Association  
|                                                | • Member, Labour Party  
|                                                | • Trustee, Epiphany Pacific Trust  
|                                                | • Trustee, The Good The Bad Trust  
|                                                | • Member, Otara-Papatoetoe Local Board  
|                                                | • Member, District Licensing Committee of Auckland Council  
|                                                | • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation |
| John Wong                                        | • Board member, Asian Family Services (a subsidiary of Problem Gambling Foundation of NZ).  
|                                                | • Chair and Trustee, Chinese Positive Ageing Charitable Trust.  
|                                                | • Founding member and council member, Asian Network Incorporation (TANI).  
|                                                | • Board member, Auckland District Police Asian Advisory Board.  
|                                                | • Board member, Older People Advisory Group of the Accident Compensation Corporation.  
|                                                | • Board member, Chinese Mental Health Consultation Service Trust.  
<p>|                                                | • Member, AUT Centre for Active Ageing Advisory Group. |</p>
<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tr>
<td>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>
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<tr>
<td>Mr Reece Autagavaia</td>
<td>Item 4.1 on the CPHAC agenda – New Government’s health Policies &amp; Priorities</td>
<td>Mr Autagavia is a member of the District Licensing Committee of Auckland Council</td>
<td>21 February 2018</td>
<td>That Mr Autagavaia’s specific interest is noted and the Committee agreed that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
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</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 21 February 2018 at 9.00am – 10.45pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Ashraf Choudary
Dianne Glenn
Katrina Bungard
George Ngatai
John Wong
Reece Autagavaia

ALSO PRESENT

Margie Apa (Director, Population Health & Strategy)
Benedict Hefford (Director Primary, Community and Integrated Care)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Vicky Tafau (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

Pauline Brown of the Auckland Women’s Health Council was present.

APOLOGIES

Apologies were received and accepted from Rabin Rabindran, Gloria Johnson and Margie Apa and Katrina Bungard for lateness.

WELCOME

The Chair welcomed all those present to the meeting. Ms Brown advised the forum that she had met with Mr Hefford in regard to organising a meeting with Maaori Providers in order for the DHB to work more closely with them to enable a change in the health statistics for the community. This will be a workshop style meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 29 November 2018.**

**Resolution** (Moved: Colleen Brown/Seconded: John Wong)

That the minutes of the Community and Public Health Advisory Committee meeting held on 29 November 2017 be approved.

**Carried**

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

Noted.

Ms Brown and Mr Hefford to have an offline conversation in regard to what is to be kept on for 11 April agenda or deferred to 23 May agenda.

3. **BRIEFING PAPERS**

3.1 **Green Prescriptions (GRx) in Counties Manukau (Pippa van Paauwe)**

The initiative consists of two components: GRx (for adults) and the GRx Active Families programme which aims to increase physical activity for children, young people and their families, and was introduced in 2004.

GRx began in 1998. The initiative was transferred from Sport and Recreation New Zealand (SPARC) in 2009 to the Ministry of Health with the expectation in future that funding would be more closely aligned with other services helping manage long term conditions.

In 2013 there was an additional $7.2 million allocated, over the next four years, to the GRx budget to increase adult referrals, particularly for patients with pre-diabetes or diabetes.

Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing physical activity.

Research published in the British Medical Journal found that a Green Prescription can improve a patient’s quality of life over 12 months, with no evidence of adverse effects.

Research published in the British Medical Journal on the cost-effectiveness of physical activity in primary care stated that ‘community walking, exercise and nutrition, and brief advice with exercise on prescription (Green Prescription) were the most cost-effective with respect to cost-utility.’

Usually the programme is delivered through a Regional Sports Trust. CM Health maintains a contract with Sports Auckland to deliver its Adult programmes.
CM Health has a separate provider – Otara Health Charitable Trust - delivering the Active Futures and Families programme. For Active Futures, we are one of 10 DHBs that have this kind of programme.

Most referrals for GRx are to support prevention and management in patients with chronic disease and long term conditions such as cardiovascular disease and diabetes. In particular, GRx encourages patients to manage their own conditions by increasing physical activity and improving nutrition.

The majority of referrals are from General Practice Teams and the majority of people are referred due to diabetes and weight issues.

Ms van Paauwe advised the forum of relevant statistics pertaining to the CM Health community:
- Around 21% of children and young people (5-18) in CM are overweight and 19% are obese. For children under 5 it is 19%
- Higher rates for Māori (23.6%) and Pacific 28.9%
- Obese children are more likely to be obese in adult hood, have abnormal blood pressure and are have an increased risk of developing diabetes and heart disease as adults
- High body mass index (BMI) has now overtaken tobacco as the leading risk to health in New Zealand

The Childhood Obesity Plan consists of a package of initiatives that aim to prevent and manage obesity in children and young people up to 18 years of age by focusing on:
- targeted interventions for those who are obese;
- increased support for those at risk of becoming obese; and
- broad approaches to make healthier choices easier for all New Zealanders.

Long term goals of the programme are to:
- be involved in regular physical activity – at least 60 minutes on most days of the week;
- eat a wide range of healthy food options; and
- be healthier overall.

Referral is usually from a GP or health professional, however, people can also self-refer but this requires (like GRx) sign off from a GP. Priority is given to 5-12 year olds.

The emphasis of the programme is on food, behaviour change, the environment and being active at each life stage, starting during pregnancy and early childhood. Comprehensive lifestyle action involves the child’s whānau and combines healthy eating, increased physical activity, less sedentary activity and behavioural support. Referrals also obtained from GP or other Health Professional.

As of the most recent Quarter, GRx families are now transitioned through to the Ponga stage and Active Futures are transitioned to the silver stage. BMI maintenance and reduction is now being monitored.

100% felt the staff is fully trained and capable
78% felt their life is now better and healthier since working with Otara Health
89% overall, were satisfied with the AF programme 20% of Active Futures participants were satisfied with their overall health and wellbeing in their baseline assessment. This increased to 60% by their final assessment
70% of Active Futures participants said they had a good understanding of the benefits of physical activity/ exercise/ movement by their final assessment
CM Health is looking to share their reporting template with ADHB and WDHB in order to look at collecting data together.

CM Health is also engaging with local marae and churches to connect families with activities within their communities.

The Committee thanked Ms van Paauwe for the very informative presentation.

**Action**

The CPHAC committee would like Ms van Paauwe to return in the latter half of year to provide an update on progress.

### 4. BRIEFING PAPERS

#### 4.1 New Government’s Health Policies & Priorities

The Minister has stated that the government intends to implement Labour’s health policy and coalition agreements in full. Key commitments include:

**Primary Care:** From 1 July 2018, lowering the cost of GP visits by $10 through:
- lowering the Very Low Cost Access (VLCA) fee cap by $10 to $8 for adults and $2 for teens (under 13s are already free), with a funding increase to VLCA practices to cover this
- increasing government funding for all practices that lower their fees by $10, lowering the average non-VLCA fee from $42 to $32 and the maximum fee from $69 to $59
- annual free health checks for seniors with the SuperGold card
- free doctors' visits for all under 14s
- increasing funding for GP training places, taking the intake to 300 per year
- carrying out a review of primary care funding to further reduce barriers to primary care and ensure the financial sustainability of practices
- increasing the age for free breast screening to 74.

**Mental Health:**
- increasing resources for frontline health workers and co-locating mental health and primary care teams
- re-establish the Mental Health Commission
- extend School Based Health Services to all public secondary schools so all schools have a comprehensive youth (mental) health service.
- Free counselling for under 25s, and ensure everyone has timely access to quality mental health services
- boost funding for alcohol and drug addiction services
- initiating a review of mental health and addiction services to identify gaps in services (the Terms of Reference for this review are attached).

In many of these areas, such as integrated mental health services, CM Health is already at the forefront of implementing new locality based models of care and the learning from our experience can potentially feed into national policy developments and pilots. In other areas, such as lower primary care part charges for low income earners, the additional funding could have a disproportionately positive impact for our high needs population in South Auckland. Although it is still early days, various CM Health clinicians and managers are engaged with
national policy activity to ensure we lend influence and expertise where appropriate. We will update the Committee as the policy details emerge.

CPHAC queried where the trained personnel will come from and Mr Hefford advised that this is on the radar, and clarified that concerns don’t just lie with budget issues.

In response to a funding query re VLCA practices, Mr Hefford advised that the capitation amount will increase for those services that have $0 fees.

**Decision**
The Community & Public Health Advisory Committee:

- **Noted** that the new Coalition Government is in the relatively early stages of planning implementation of key health policies agreed by Cabinet, therefore operational details about how those policies will be funded and rolled out is still being determined.

- **Noted** that the Minister of Health has confirmed the Government’s commitment to key coalition policy initiatives, including lowering the cost of GP visits; re-establishing the Mental Health Commission; annual free health checks for seniors; free doctors’ visits for all under 14s; increasing the age for free breast screening to 74; free counselling for under 25s, and ensuring everyone has timely access to quality mental health and alcohol and drug addiction services.

- **Noted** that key clinical and managerial leaders from Counties Manukau Health are engaging with the Ministry and national groups and programmes to lend expertise and influence to the operationalisation of these policies over the next three years.
5. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Dianne Glenn/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>
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<tbody>
<tr>
<td>2.1 Confirmation of the Public Excluded Minutes of 29 November 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><strong>Commercial Activities</strong> 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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| 3.1 Social Investment Board | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | **Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |

**Carried**

The open session of the meeting concluded at 10.20am.


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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 – 11 April 2018

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<td><strong>Standing Items</strong></td>
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<td>19.8.15</td>
<td>Locality Updates:</td>
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<td>Manukau</td>
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<td>11 April 4 July 26 September 5 December</td>
<td>Sarah Marshall Sarah Marshall Kathryn deLuc Penny Magud</td>
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<td>14.6.17</td>
<td>ARPHS – six-monthly update.</td>
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<td>11 April/23 May</td>
<td>Benedict Hefford</td>
<td>Please note that this report is a ‘local picture’. There is no ‘Healthy Mums &amp; Babies target’ – this may be a referral to the Smokefree Maternity Health Target and the Immunisations by 8 months Health Target, these are both covered in the narrative.</td>
</tr>
<tr>
<td>29.11.17</td>
<td>Population Health Plans (Asian, Pacific &amp; Maaori) – <strong>quarterly update</strong> including a local picture as well as national data on the Healthy Mums &amp; Babies target.</td>
<td></td>
<td>11 April</td>
<td>Margie Apa</td>
<td>Please note that this report is a ‘local picture’. There is no ‘Healthy Mums &amp; Babies target’ – this may be a referral to the Smokefree Maternity Health Target and the Immunisations by 8 months Health Target, these are both covered in the narrative.</td>
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<td>29.11.17</td>
<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
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<td>11 April/23 May</td>
<td>Benedict Hefford</td>
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<td>29.11.17</td>
<td>Q1 2017/18 Population Health Plans - 99.3% of Pacific Children Identified as Obese in their B4School Check have been referred for Assessment/Support Services. The Committee is interested to determine if these referrals are being acted upon and requested an update be provided on follow through and information on the child obesity pathway that gives guidance to the practitioners.</td>
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<td>11 April</td>
<td>Benedict Hefford</td>
<td>Covered by the Green Prescription presentation by Pippa van Paauwe on 21/02/2018.</td>
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Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

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<tr>
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<tbody>
<tr>
<td>29.11.2017</td>
<td>3.1</td>
<td><strong>Every $ Counts</strong> – Project team to present an update on this project.</td>
<td>26 September 2018</td>
<td>Sarah Sharpe</td>
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<td>29.11.2017</td>
<td>4.1</td>
<td><strong>School Based Health Services</strong></td>
<td>11 April/23 May</td>
<td>Benedict Hefford/Carmel Ellis</td>
<td>Kooituitui frontline staff unavailable on 11/4/2018.</td>
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<td></td>
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<td>Invite the Papakura Initiative to present on the Papakura Kooituitui Initiative</td>
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<td>Undertake an investigation into a model for a ‘one-stop’ shop in Mangere/Otara and report back.</td>
<td>11 April/4 July</td>
<td>Benedict Hefford</td>
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<td>Confirms:</td>
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<td>o Page 43 1st bullet point – what does the constitution refer to.</td>
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<td>o Has there been any link with Counties Manukau Sport in relation to this work.</td>
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<td>o Page 59 – provide some further information in relation to the smartphone app and website.</td>
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<td></td>
<td>o Page 71 - what are the actions associated with the plan and how will they be driven in Counties Manukau, where is the money coming from.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Arrange a presentation from Healthy Families NZ.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Provide a six-monthly update on the Action Plan.</td>
<td>11 April/15 August</td>
<td>Benedict Hefford</td>
<td></td>
</tr>
<tr>
<td>6.9.2017</td>
<td>3.1</td>
<td><strong>Owning my Gout</strong> – the project team were asked to return in 6 months’ time to update the Committee on their progress, particularly how they have got on working with A/WDHB as they have the balance of the 31,000 Gout sufferers.</td>
<td>11 April/4 July</td>
<td>Trevor Lloyd/Benedict Hefford</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nursing work plan including community input into this work.</td>
<td>11 April</td>
<td>Karyn Sangster</td>
<td></td>
</tr>
</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tbody>
<tr>
<td>21.2.2018</td>
<td>3.1</td>
<td>Green Prescriptions in Counties Manukau - The CPHAC committee would like Ms van Paauwe to return in the latter half of year to provide an update on progress.</td>
<td>21 November</td>
<td>Carmel Ellis</td>
<td></td>
</tr>
<tr>
<td>21.2.2018</td>
<td></td>
<td>Mental Health - CPHAC has asked Ms Tess Ahern (General Manager, Mental Health) to look at how we can provide Mental Health &amp; Addiction services to the homeless.</td>
<td>23 May</td>
<td>Tess Ahern</td>
<td></td>
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</tbody>
</table>
Integrating Care for Community Wellbeing in Manukau Locality

Wednesday, 11 April 2018
## Strengthening Primary Prevention Initiative Papatoetoe Cluster Manurewa Cluster Papakura Cluster

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Papatoetoe Cluster</th>
<th>Manurewa Cluster</th>
<th>Papakura Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith Avenue Community House Health Promotion Family Hauora Event</td>
<td>24&lt;sup&gt;th&lt;/sup&gt; March</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clendon Community House - Health Promotion</td>
<td></td>
<td>9&lt;sup&gt;th&lt;/sup&gt; April</td>
<td></td>
</tr>
<tr>
<td>Clendon Pride Bilingual Hikoi and Hauora Market (25 Health related stands)</td>
<td></td>
<td></td>
<td>14&lt;sup&gt;th&lt;/sup&gt; April</td>
</tr>
<tr>
<td>Immunization Project</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; March</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; March</td>
<td>16&lt;sup&gt;th&lt;/sup&gt; March</td>
</tr>
<tr>
<td>Alcohol Harm Minimisation Project (HPA funded) in collaboration with Family Start Manukau</td>
<td></td>
<td></td>
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## Strengthening Secondary Prevention

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Complex Case Managers supporting Planned Proactive Care Programme</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Promoting Health for Homeless People via Rawiri Community House</td>
<td></td>
<td>April 2018</td>
<td></td>
</tr>
<tr>
<td>CM Kindergarten Association Play Truck – skin care support for vulnerable children</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Hydrotherapy opportunities for severely disabled people – Susan Blewett Swimming School</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-design admission avoidance services in the “System Level Measures” initiatives</td>
<td>Y</td>
<td>Y</td>
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## Strengthening Tertiary Prevention

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Papatoetoe Cluster</th>
<th>Manurewa Cluster</th>
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</thead>
<tbody>
<tr>
<td>Connections for Community Health Team</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Reablement – Improvement Cycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralise Triage and Screening of Referrals to Community Health Services</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Support Early Discharge from Hospital</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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</table>
## Building Community & Clinical Networks

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Papatoetoe Cluster</th>
<th>Manurewa Cluster</th>
<th>Papakura Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Networks – wound care, managing COPD</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Manukau Social Worker’s Network - provider mix</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Podiatry Network – managing diabetic foot</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Papatoetoe Community Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manurewa Community Network</td>
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<td></td>
<td></td>
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<tr>
<td>Papakura Community Network</td>
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<td></td>
<td></td>
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<tr>
<td>Manukau Central Network</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Manurewa Youth Workers Network</td>
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## Design, Develop & Implement Integrated Models of Care

### Initiative

<table>
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<th>Initiative</th>
<th>Papatoetoe Cluster</th>
<th>Manurewa Cluster</th>
<th>Papakura Cluster</th>
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</thead>
<tbody>
<tr>
<td>Support Formation of GP Clusters by Procare</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Support roll-out of brief liaison and advice to General Practice Teams working with People diagnosed with Mental Health disorder - ILoC Implementation</td>
<td></td>
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<td>Y</td>
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</table>
Advance care planning (ACP)

It’s always too early until it’s too late!

CPHAC Presentation April 2018
What is advance care planning?

- ACP is a process of thinking about, talking about and planning for future health care and end-of-life.

- It is the voice of the person when they are no longer able to speak for themselves.

I hear your voice and suddenly all feels right with the world again.

j. m. green
• ACP gives people the opportunity to develop and express their preferences for future care based on:
  ➢ their values, beliefs, concerns, hopes and goals
  ➢ a better understanding of their current and likely future health
  ➢ the treatment and care options available
Benefits

For the person – Should help lessen anxiety about what lies ahead.

For the person’s loved ones – They know what choices the person would likely have made if they were capable.

For health care workers – Members of health care team will feel more comfortable providing care that is in accordance with the persons wishes.
It is not about a good death – it is about a good life right to the end.

https://www.youtube.com/watch?v=JD_Wr17PlBE
Non-beneficial treatments at the end of life: a systematic review (2016)

• 38 studies comprising 1.2 million people
• On average 33-38% of patients received non-beneficial treatments in the last year of life
  – Renal dialysis
  – Radiotherapy
  – Chemotherapy (last 6 weeks of life)
  – Blood transfusions
  – Cardiorespiratory support in ICU
  – I.V. antibiotics

Average bed days last 6 months of life for CM Health residents
## Total deaths and bed days

<table>
<thead>
<tr>
<th>CALENDARYEAR</th>
<th>CALENDARMONTH</th>
<th>Deaths</th>
<th>Bed Days Last 6 Months of Life</th>
<th>Average Bed Days Last 6 Months of Life</th>
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<tr>
<td>2017</td>
<td>4</td>
<td>246</td>
<td>2080</td>
<td>8.5</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>269</td>
<td>2354</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>313</td>
<td>2508</td>
<td>8.0</td>
</tr>
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<td></td>
<td>7</td>
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<td></td>
<td>12</td>
<td>238</td>
<td>2283</td>
<td>9.6</td>
</tr>
<tr>
<td>2018</td>
<td>1</td>
<td>246</td>
<td>2162</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>211</td>
<td>1997</td>
<td>9.5</td>
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<tr>
<td></td>
<td>3</td>
<td>119</td>
<td>1344</td>
<td>11.3</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>3102</td>
<td>28397</td>
<td>9.2</td>
</tr>
</tbody>
</table>
Research tells us ...

- 82% of people say it’s important to put their wishes in writing ......

- 23% have actually done it.

Source: Survey of Californians by the California HealthCare Foundation (2012)
History of ACP

• In 2010 ACP NZ cooperative established after interested health providers attended Australian conference including CMDHB staff
• 2011 – established ACP in one rest home and one general practice
• Initially used CMDHB designed ACP (paper only)
• Now using National ACP document (can be recorded electronically in Shared Care Plan)
Current activity

• ACP working group developing implementation plan
• Advertising for 2 x Locality Facilitators to support primary care
• Collaborating with System Level Measure (SLM) working group
• Secondary Care Special Interest Group
• High risk anaesthetic clinic project
• Shared Care Planning
• Consumer engagement
• Quality improvement
Numbers of Plans

ACPs created between Apr 2017 - Mar 2018

- Primary Care: 53
- DHB (renal): 27
- DHB: 26
- Franklin Hospice: 24
- Totara Hospice: 4
ACP – Level 1 training (one day)
ACP Level 2 Training (two days)
Palliative Outcomes Initiative (POI)

- An Auckland wide approach to primary palliative care
- Patients are identified in the community who are nearing the end of life
- Aim of POI to build capacity, capability and confidence of GP and Residential Care providers in the identification and management of palliative need
- ACP taken in to consideration when developing patient palliative care plan
Challenges

• Lack of systematic processes

• Provider centric development of IT tools rather than patient journey

• Cultural assumptions

• Capability of workforce
Hopes for the future

• Integrated advance care planning across the care continuum
• Patient/person driven initiation and planning
• Support and education for having ‘difficult conversations’ – staff and students
• Resources available in multiple languages
• One IT system!
Some day, we will all die, Snoopy!

True, but on all the other days, we will not.
Recommendation

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

Receive this Primary and Community Nursing Workforce Update

Note that this report is in response to a request from CPHAC. The report focusses on nursing roles in the community that are funded by vote health funding this has excluded corrections, ACC contracted providers, Occupational Health Nurses employed by workplaces, Aged Related Residential Care and home based care providers.

Prepared and submitted by Karyn Sangster, Chief Nurse Advisor Primary & Integrated Care on behalf of Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer

ARI – At Risk Individual
PPC – Planned Proactive Care
COPD – Chronic Obstructive Pulmonary Disease
CVD – Cardiovascular Disease
CHF – Congestive Heart Failure
GP – General Practitioner
CNS – Clinical Nurse Specialist
FTE- Full Time Equivalent
DN – District Nurse
CM – Counties Manukau
CMH- Counties Manukau Health
ACC – Accident Compensation Corporation
DHB – District Health Board
PHO – Primary Health Organisation

Executive Summary

There are many nursing roles across the primary and community workforce. For the purpose of this paper I have excluded those roles not funded by vote health. These include nurses working in corrections, ACC contract holders, and Occupational Health Nurses working in industries. The numbers of nurses working across the region has remained relatively static. In 2006 the total primary care nursing workforce was 349 FTE in 2015 when asked to provide a comparison Primary Health Organizations nurse leaders identified 371 nurses working in primary care. The growth in the number of practice nursing roles has not increased greatly compared to the growth in the population. Public health nurses have reduced from 40 to 28 with other contracts now providing basic nursing in high decile schools. The district nursing FTE was 43 in 2006 and 48 in 2015 a small increase and about 1 or less DN FTE for every 10,000 people in our district.
The long term investment plan for the Northern regions states that the anticipated demand for health care for our growing, aging and changing population will outstrip our ability to deliver services. A more agile and flexible workforce with capability and diversity to meet the care health needs of our local population will be needed. This change is needed now by strengthening collaboration and integration across the care continuum to provide care closer to home. We need to reshape the workforce to provide innovative integrated models of care that can to respond to our changing population needs. Nurses will need to expand and advance their clinical practice across our current workforce including unregulated carers. This will allow our professional workforce to reach more people through directing and delegating care tasks to skilled others.

This will be supported by key enablers such as technology, education, inter-professional practice, community central providing central coordination of requests for service, and integration to allow nurses to respond to the workforce and population challenges. As these continue to develop we will explore new ways of providing care within the community using existing and new workforces.

The funding of new roles and models of care remains uncertain with the review of primary care funding and DHB budgets. The funding remains uncertain as we are challenged to provide more with the existing workforce. The profession continues to respond to support more advanced nursing practice through prescribing scopes and post graduate nursing programs.
Appendix: Report on Nursing Roles in Community & Primary Care

General Practice

Registered nurses working within General Practices are employed by the business owner often a General Practitioner. Their roles can vary depending on the enrolled population needs and level of capitation funding. The higher the co-payment often there is less focus on advanced nursing roles. The lower cost access practices have a different focus with often more nursing activities and clinics to meet the high volume of patient care required. Those who have mainly older people in their enrolled population will provide different range of services than those who have a high needs population with a high proportion of young people. We do have one Primary Health Care Organisation that employs their clinical staff directly this is an exception not the norm.

The role of the practice nurse is across the life span and all health conditions. They are generalists and provide the following range of services:

- population health screening and interventions such as immunisations, cervical screening, cardiovascular risk screening, smoking cessation, wound care, blood pressure monitoring, diabetes checks, health promotion, long term condition management, care coordination for planned proactive care, palliative care, falls risk assessments, intravenous antibiotic administration and cannula insertion, ear checks, throat swabs as per sore throat guidelines, patient recalls for health screening or laboratory results.

All registered nurses employed as practice nurses have individual employment arrangements with their business owner. The rate of pay and terms and conditions is influenced by the Primary Health Care Multi Employer Collective Agreement (MECA) it remains voluntary for employers to join. Most practices follow the MECA pay rates but not all. There is no consistent job description across Primary Care. Professional development leave and financial incentives are inconsistent depending on the employer. Most nurses attend professional development in their own time after hours except for post graduate education provided within Universities through Health Workforce New Zealand funding. Any time away from their work place is considered a revenue loss for their employer. With the introduction of larger business owners purchasing practices this may change.

We currently have five primary health organisations and approximately 371 nurses are working as practice nurses in CM region. The increase in workforce is slow having increased by 22 from 2006-2015. Workforce growth is often restricted due to physical space. This impacts on capacity General Practices staff to increase. Funding is often a barrier to employing more nursing staff. There is very small recognition for registered nurses advanced practice skills and knowledge in the current funding model.

Impact of ARI/PPC on building capability in primary nursing workforce

The introduction of at risk individual now renamed planned proactive care programme (PPC) in CMH in 2014 replaced the chronic care management programme (CCM) that provided comprehensive care for people with COPD, CVD, Diabetes or CHF. CCM provide four funded visits to the GP and up to six hours of nursing time, templates were submitted and payment provided. The new programme was introduced following evaluation that did not show demonstrable improved health outcomes for people with long term conditions in CMH.

The PPC was designed in partnership with primary care organisations along with users of the programme (GP, Practice Nurse and Practice Managers). The programme users wanted to have more flexibility and a greater choice of interventions to improve health outcomes for individuals and the population.

Four compulsory areas were included to enable access to flexible funding for the general practice these were:
• A partner in health assessment
• An active care plan
• An e-shared summary
• A named care coordinator who is a regulated health care professional

The decision to have these core areas as compulsory fields was to focus on areas that evidence showed would be valuable for programme success and to improve coordinated care.

Care coordinator training was provided for all nurses assigned as care coordinators this was also extended to other care team members such as GP, CNS and other community nurses. The training was funded by the programme initially the training was offered monthly this then was reduced to quarterly as the demand decreased each course was attended by 20 people. As our skills increased we provide more training using local resources and other modules already developed.

During the establishment phase a care coordination steering group supported the development of the training package and provided feedback to ensure the training was fit for purpose. Nurses also feedback on difficulties with the IT enablers and this provided the IT developer with rich informed user experience.

The training has extended into additional areas of focus that care coordinators have highlighted as areas requiring strengthening. The provision of introduction to mental health, care planning master classes, health literacy and motivational interviewing were developed in response to nurse’s requests for more knowledge. This has increased the capability and confidence of the nurses. The importance of confidence in mental health has been raised as an area that nurses want more information and education.

CMH and PHO are partnered to implement the programme using resources across all the partners to provide consistent training and supporting technology skills in accessing the e-shared care programme. This has developed good working relationships and long lasting relationships that have stood the test of time.

Diabetes care and management have also featured highly in request for additional knowledge and skills 120 nurses have been sponsored to complete the Manukau Institute of Technology (MIT) diabetes care and management course since 2013. We have funding for 20 nurses each year to undertake the diabetes care and management course. The course is well supported by practice nurses.

The number of post graduate applications for nurses requesting health workforce NZ funding working in primary health care has increased from 35 in 2015 in semester one to 67 in 2017 for semester one.

<table>
<thead>
<tr>
<th>Year</th>
<th>Semester 1</th>
<th>Semester 2</th>
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<tbody>
<tr>
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<td>37</td>
<td>35</td>
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<tr>
<td>2016</td>
<td>59</td>
<td>74</td>
</tr>
<tr>
<td>2017</td>
<td>64</td>
<td>65</td>
</tr>
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</table>
There has been increased interest of post graduate education opportunities across the sector this coincides with the introduction of planned proactive care and more focus on the value of nursing in primary care.

The PPC programme has also enabled nurses to work collaboratively across organisations as nurses facilitate a connected care team around the individual patient needs. The flexibility of interventions available has also allowed the individual to access supportive services that have not been visible to the nurses before.

Nurses feel they are providing a holistic service that respects the person and is person centred. The locality approach has enabled development of closer connection of nursing team members across organisations. Additional training is provided on locality basis via nursing networks and in locations that are easy to access for nurses who may live and work in different locations.

Practice nurses have presented at Community Public Health Advisory Committee on their experience as service providers and also shared patient stories about changes that individuals have made to improve their health.

Schools

Primary school and Intermediate Schools have services provided by Mana Kidz and Public Health Nurses within the Child Health Network. The development of the skin and sore throat management programmes in high needs schools has provided the opportunity to develop a primary care model of school health nurses. The child health network contracts providers to deliver services in low decile schools for five days per week throat swabbing, skin assessment and interventions.

The public health nurses have retained decile 3-5 schools and provide differing level of service depending on school decile rating. Enuresis is still managed by public health nurses across all schools. There has been a reduction of FTE in public health nursing to reflect the reduced role. There are currently 28 FTE this is a decrease from 40 in 2006. In February this year 6 nurses were recognised for successful submission of an expert portfolio. Four public health nurses are approved community nurse prescribers.

This workforce is important for long term health of our most at risk children to help them achieve at school. The Public Health Nurse are also our first responders to epidemics and pandemics as demonstrated in their integral roles in responding to the H1N1 pandemic response and also the Pukekohe Dental Clinic incident in 2017.

Secondary School based health services are funded across decile 1-4 schools. The nurses are employed within the school with a one nurse to 750 enrolled students. They provide comprehensive assessments to year 9 students and opportunistic assessments to other students and first response for accidents and illnesses. All schools utilise a range of standing orders to provide sore throat management and a wider range of other medicines. Increasingly the school nurse is seen as a key worker within the interdisciplinary team across the health system. The funded school nurses are supported to undertake youth health papers to support their learning and development. Two Clinical Nurse Specialists support the nurses in funded schools with direct professional and clinical support. All of the nurses have current portfolios of a high standard.
Most funded secondary schools have either a nurse practitioner or general practitioner clinics weekly. The school based health service is often based within an interdisciplinary team including social workers, school counsellors, and visiting health services such as mental health clinicians. They are a trusted health care professional for young people at school and engage young people in health seeking behaviour.

Non funded secondary schools are also supported by CMH Clinical Nurse Specialist team to support their professional development, supervision and networking opportunities.

Special Character Schools- within Counties we also have a range of full immersion schools, private faith based schools, and two boarding schools. Full immersion Maaori schools have school nurse support funded through direct contracts with Turuuki Health Care.

Teen Parent Units are associated with two schools James Cook High School and Tangaroa College. These units support teen parents to complete their education while providing child care and health education. The service is holistic and has good outcomes for young mums to complete education and therefore increase employment opportunities with improved social determinants for the family.

**Child health**

Plunket nurses are funded directly from the Ministry of Health centrally and provide well child services as per their national contract to families in Counties. They have 55 cars on the road each day. As a national service they have strong professional infrastructure and a quality improvement focus. Plunket is also our contracted provider for our immunisation outreach service which has contributed to our immunisation targets. We contract directly to our local Plunket team for this service not centrally and not all Plunket staff provides this service regionally. There are three tamariki ora services contracted outside of Plunket and these are delivered by Papakura Marae, South Seas and Raukura who provide culturally appropriate well child services as an alternative to Plunket. Training support for Plunket and Tamariki Ora providers is through Health Workforce New Zealand Post Graduate funding and delivered thorough a National Contract with Whitireia Polytechnic. All nurses providing well child services are trained at a post graduate certificate qualification level.

The establishment of the social investment board has enabled a new service focussing on supporting young mothers in Mangere with a well-child and child health mixed role with integrated with social workers. The service has developed guidelines and is now recruiting the final staff members. The vision is to provide a well-child service with a keeping well context supporting and navigating young families through the health and social services. This includes a multi- agency team working with a family for an extended length of time.

Kidz First home care nurse specialists provide in home care to medically complex and fragile 0-16 year olds. They provide discharge support for neonates following time spent in Neo Natal Intensive Care during transition home and on-going clinical interventions for supportive treatments. During the winter they provide home based follow up assessment and continuation of treatment following discharge from emergency care or hospital for respiratory conditions. They provide case management and advocacy for families with challenging health conditions. This service is accessed via a Paediatrician referral only.
Community Health teams

District nurses we have 57 FTE across four local bases located at Botany, Franklin, Papakura and Mangere. The nurses work within an interdisciplinary team including needs assessors and allied health professionals. They provide a range of home based care nursing care to people of all ages that includes the following:

- Continence assessment and management including catheter management and trial removal of catheters
- Palliative care in collaboration with Hospices and primary care
- Per cutaneous gastrostomy tubes
- Leg ulcer assessment and management
- Complex wound care
- Accident Compensation Corporation short and long term care contracts
- Intravenous antibiotic administration long term through peripheral inserted central cardiac catheters or porta caths
- Chemotherapy de-accessing
- Case management of rheumatic fever secondary prophylaxis administration – 600 injections per month
- Additional care is provided to support admission avoidance and early supported discharge through technological advances such as ascites drainage via abdominal ports or pleural effusion via rocket drains.
- Post-operative care for stomas following bowel surgery or bladder surgery
- Post-operative care for mastectomy monitoring redivac drains and removing when appropriate.
- Medication administration for sub cut or IM medicines

District nurses work across seven days a week including reduced services on public holidays.

District nurses are supported by a clinical charge nurse manager 0.9FTE, stoma therapist 2 FTE, continence nurse specialist 0.8FTE, rheumatic fever liaison nurse 0.8FTE and a Liaison nurse coordinator 0.9FTE. They report to operations managers who report to Locality General Managers.

Locality nurses have been employed in each locality in a variety of roles. Their focus is on supporting complex case management people who are frequent users of our hospital services. They provide advanced holistic assessment of social supports and clinical management in collaboration with the persons general practice team. Each locality has invested in different workforce models. Manukau have provided a model that includes a Nurse Practitioner and a Clinical Nurse Specialist. This model is working well with other localities wanting to develop Nurse Practitioner roles to support the complex needs of their local communities.

The 2018 winter demand plan impacts on district nurses and those that are employed in the community health teams. The establishment of community central which provides coordination of referrals for community health teams has enabled consistent outcome and flow of referrals to the best person to respond to the request for service. Rapid response nurses will support transition of care from hospital to home. This will be coordinated within a hospital in the home (HITH) service coordinated by community central. The transition of care will be supported by SMO’s allocated to the team and use of evital technology continuing from hospital to home. The patients in HITH will have home visits completed by the community health teams with electronic information visible across the hospital and community teams. Initially for 2018, the focus will be on the system level measures for reducing acute bed: cellulitis, COPD and heart failure. There will be capacity for 30 patients per day initially this could support up to 70 people in total per week. The ward will operate 7 days per week.
Palliative Care

Hospice nurses provide community specialist palliative care from Totara Hospice South Auckland and Franklin Hospice. Both hospices operate independently. They are jointly funded by Counties Manukau and donations from fundraising or donations. Totara provides inpatient beds for complex symptom management and provides a wide range of associated services. Franklin is a community nurse based specialist service with no inpatient beds.

Both hospices work in partnership with primary care, aged residential care and community health teams to provide a full range of services. Additional innovation funding is supporting the training of primary care clinicians in palliative care management.

Community health teams have memorandum of understanding with both hospices to provide shared care.

Gerontology Clinical Nurse Specialists support primary, community and aged residential care with specialist nursing support and advice. They are placed within Adult Rehabilitation and Health of Older Peoples Service. They are geographical based supporting older people within the localities.

Whanau Ora Team

Whanau Ora nurses are located within Te Kaahui Ora. The Whaanau Ora Service will work with Maaori patients and their Whaanau admitted to Middlemore Hospital to identify their needs during hospitalisation and support achievement of Whaanau goals post-discharge for a period of up to 12 months.

Using this information, a nominated Whaanau Ora Key Worker provides co-ordination and/or case management services for consenting Whaanau and work with primary care providers, community services and local government and NGO agencies to meet identified goals. Interventions may include but are not limited to assisting the client and their Whaanau with health literacy; education; housing/accommodation; budgeting; advocacy; entitlements; engagement with health/community providers and/or programmes.

Fanau Ola team

Fanau Ola provides a pacific health focussed service for complex families who have had more than 3 admissions to Middlemore in 6 months with additional complexities. All referrals are triaged, patients contacted, fanau ola assessment completed, care plan developed, patients are followed up and monitored, reviewed and a transitional plan developed to integrate return to primary care.

Enablers

Nurse Entry to Practice graduates are supported by the Counties Manukau team, additional funding provided supports 20 nurses per year. Unfortunately we are not increasing the nursing workforce just refreshing the existing numbers of nurses in primary care. New grads are also employed within Hospice, aged residential care, district nursing, public health nursing and Plunket. The programme provides a career opportunity in primary health care. We have had over 200 nurses through the programme with good retention rates and feedback from employers.
Education is also provided through locality nursing networks for local series of clinical updates to build local relationships to enable collaborative care. Locality sessions are open to all nurses who provide care within the local area. This is not restricted to the nurse’s occupational grouping. Shared learning is an evidenced based way to develop collaborative clinical practice relationships.

Nurses who work for an employers funded through vote health are able to access our in house education programmes. They are also able to access all courses on Ko Awatea Learn which is valuable to grow a capable workforce across the care continuum.

Clinical Nurse Specialists 10 FTE provided from within hospital teams to work across the system to support building capability among the primary and community nursing workforce. These nurses are accessible to provide clinics in community hubs. They are also available to support nurses with complex patients.

Postgraduate funding is prioritised for nurses working outside of the hospital they are seen as a priority workforce to access post graduate education. All applications are signed off by the Chief Nurse Advisor Primary and Integrated Care as well as the employer. Career plans are provided as part of the application process. In semester one 2018, 58 nurses received Health Workforce New Zealand funding to undertake post graduate education.

Nurse prescribing for community nurses is part of a trial and evaluation with New Zealand Nursing Council along with Family Planning. The course will enable to registered nurses working in a community setting to prescribe over the counter medicines along with skin and sore throat antibiotics using Auckland Regional Health Pathways to guide decision making. We currently have 33 community nurse prescribers and one Registered nurse prescriber in primary and speciality teams.

Enhanced Primary Care is a quality improvement initiative working with nine general practices to increase capacity and capability along with business efficiency. The nine selected practices are working through a series of modules where they redesign their current model of care to be more responsive to their enrolled population and utilise their workforce more effectively. The nine practices are testing processes and systems that will eventually be offered to other primary care practices. The development of nursing leaders and nursing workforce is in the process of being designed. A working group of primary health care nurse leaders and Chief Nurse Advisor Primary and Integrated Care are working with the programme lead to progress this module.

We have 16 memorandum of understanding with health and disability service providers in the region for CMH Professional Development Recognition Programme. As a New Zealand Nursing Council Accredited provider we provide support for the establishment of the programme and on-going mentoring support. The programme recognises the competency of the registered and enrolled nurses allowing them to be exempt from the audit process by Nursing Council. Nurses demonstrate their competency to practice against the Nursing Council domains of clinical practice by completing a portfolio. This is assessed by a registered nurse who has completed the CMH assessor’s course. If the portfolio meets the requirements the nurse’s details are added to our list of approved nurses for Nursing Council. All current users of the programme will have access to e-portfolios hosted on the Ko Awatea Learn site.
Future state 2023

Technology will support referral management and safe workload allocation to nurses and allied health staff in the community. E health records are available across the health system there is no duplication of information. Care planning is enabled by the whole care team who are employed across the health system. The patient is included as an integral part of the health care team.

E health is normal business with virtual consults happening in people’s home providing multidisciplinary team approaches and decisions.

All community health staff will work with virtual health teams to manage more complex and less stable patients safely in their own homes. Staffs are well supported with advanced clinical roles that enable provision of technological supported interventions including access to medicines as prescribers or administrators. The community staffs have collaborative relationships across the health system that facilitate and initiate treatment interventions to keep people well and in their own homes. The regulated workforce is supported by non-regulated staffs that provide safe supported care work under delegation frameworks. All care provided is patient centred with patient experience as key indicator for the services. Care provided is of a consistent quality with good outcomes as measured by key indicators.

Inter-professional practice is enabled by shared skills and training to maximise each interaction provided in the home. All staff are able to provide consistent core assessments and screening for common health or environmental concerns. Order equipment and provide advice and support to reduce number of clinicians involved in the care team. They are also to provide comprehensive information to inform care needs for advanced clinicians providing easy access to care pathways in a timely manner.

All community staff provides safe culturally competent care in peoples home that acknowledges and supports equity goals to be reached. There is one service for all home based care in the community that is coordinated, effective, evidence based, integrated and consistent. The need for niche services is no longer required as the generalist service is able to deliver high quality effective services. There is a flexible agile workforce that consists of health care professionals and kaiawhina that support person centred care across the primary and community setting.

Hospital in the home

Patients are safely transitioned from hospital to home through the hospital in the home this provide supported care post discharge until they transition to their enrolled primary care provider. The hospital in the home also supports people when they have exacerbations of a long term condition to assist in preventing them needing to go to hospital. There is a connected care team where the person’s health status is visible to all clinicians involved in their care. There is one electronic medical record which ensures the person and their family are receiving all of the care they need to keep well and stay well. They have a key care coordinator that they are able to contact at any time to ask questions, receive an update on their progress and any planned care appointments. They do not need to attend many outpatient appointments often as they can connect with specialists via technology that includes all of their care team.
Conclusion
Our current workforce is working hard to provide care to our population. They are not resourced to the optimum level required to have capacity to meet demand for the care needs of our population. New ways of working are being developed to meet the changing needs of the population these include community central and hospital in the home. Primary care has shown interest in improving their capacity and demand with the enhanced primary care programme. Nurses in the community and primary care sector have shown interest in increasing their skills through community nurse prescribing and completing post graduate education. Integration and collaboration are key indicators as evidenced in the response to the Pukekohe dental incident where nurses across the hospital, community and primary care became involved.
Counties Manukau District Health Board  
Community & Public Health Advisory Committee (CPHAC)  
Q2 2017/18 Population Health Performance Reporting

Recommendation

It is recommended that the Executive Leadership Team:

Receive this report detailing progress for the indicators listed in the 2017/18 Maaori Health Plan, Pacific Peoples Health Plan and Asian Peoples Health Plan

Note the performance data and narrative contained within.

Recommend this paper be submitted to the Community and Primary Health Advisory Committee (CPHAC)

Prepared and submitted by: Filipo Katavake-McGrath for Marianne Scott – Master Planner on behalf of Fepulea’i Margie Apa – Director Population Health and Strategy

Glossary

ABC – Ask, Brief Interventions and Counseling
ARI – At Risk Individuals – now known as Planned Proactive care
B4SC – Before School Check
CHW – Community Health Worker
CM – Counties Manukau
CME – Continuing Medical Education
CND – Continuing Nursing Education
DHB – District Health Board
DMFT – Decay, Missing, Filled teeth index score
FCT – Faster Cancer Treatment
FTE – Full Time Equivalent (Human Resource)
ISA – Integrated Service Agreement
LMC – Lead Maternity Carer
MoH – Ministry of Health
NHC – National Hauora Coalition
NIR – National Immunisation Register
NRA – Northern Regional Alliance
PHO – Primary Health Organisation
SLM – System Level Measure
SUDI – Sudden Unexplained Death of an Infant

Purpose

The purpose of this paper is to report progress and highlight key insights from service delivery leaders in Quarter 2 (Q2) against the 2017/18 Maaori, Pacific and Asian Health Plans.
Executive Summary
Counties Manukau Health has set a goal as outlined in the Healthy Together 2020 strategy:

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

The organisation’s strategic direction to achieve this goal is illustrated in the Māori, Pacific and Asian Health plans for the financial year 2017/18. This performance report summarises performance listed by indicator for Q1, trend graphs for the 2 years to Q1 and a narrative about progress. The narrative report is structured around the Healthy Together 2020 Performance Management Framework key objectives. The report is formatted into three appended sections. The first is a dashboard of indicators material to the strategy to improve health equity for Children, Young People and Adults. The second section is a scorecard which shows the performance in each indicator for each population plan in this quarter. The quarterly performance results are compared to that of the “equity target” which is set as the New Zealand European/Other population group. The third section is a narrative which discusses the indicators in each health plan grouped according to the objectives of the Healthy Together 2020 Performance Management Framework.

Background
Following consultation in November 2017, the substantive content of this report focuses on the stubborn inequities experienced by population groups in the Maternity to child-health life-course groups. This is the focus of the trend graphing and the narrative report.
Please also note that in order to maintain performance reporting obligations, a scorecard of all measures identified in the Māori, Pacific and Asian Health plans is attached.

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>Matua, Pepi and Tamariki (Parents, Infants and Children)</td>
<td>99.5% of Pacific children identified as obese in their B4School check have been referred for assessment and support services.</td>
<td>100%</td>
</tr>
</tbody>
</table>

2. Action areas of concern and persistent health equity challenge

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Results</th>
<th>Health Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matua, Pepi and Tamariki (Parents, Infants and Children)</td>
<td>86% of 8 month old children have had their full course of immunisation on time. This has worsened from 89% at Q1 2017/18. The ASH rate for Pacific children remains stubbornly high, with a rate of 11048 in Q2.</td>
<td>93% 4447</td>
</tr>
</tbody>
</table>
Appendices

- Trend graph: Maatua, pepi me tamariki – Parents, infants and Children
- Population Health Performance Scorecard
- Q2 Population Health performance narrative
** Counties Manukau Health – Population Health Performance Scorecard for Q2 2017/18**

**Key to Colour coding**

- Green – Equity Target Achieved/Exceeded
- Orange – Within 10% of Equity Target
- Red – More than 11% away from Equity Target
- Black – Data unavailable
- Blue – Relationship to target undefined

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
<th>Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maatua, Pepi me Tamariki (Parents, Infants and Children)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of babies fully or exclusively breastfed at 6-weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of infants fully or exclusively breastfed at 3-months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of infants fully, exclusively or partially breastfed at 6-months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of babies, infants and children fully immunised on time at:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 months old</td>
<td>86%</td>
<td>94%</td>
<td>98%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>2 year olds</td>
<td>89%</td>
<td>95%</td>
<td>97%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>5 year olds</td>
<td>86%</td>
<td>90%</td>
<td>95%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with LMC who are offered brief advice and support to quit smoking</td>
<td>TBC(^1)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A (^2)</td>
<td></td>
</tr>
<tr>
<td>Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services (^3)</td>
<td>73.5%</td>
<td>85%</td>
<td>NA</td>
<td>89.5%</td>
<td></td>
</tr>
<tr>
<td>Percentage of population of children aged 5 years who are caries free (^4)</td>
<td>38.1%</td>
<td>30%</td>
<td>NA</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Mean DMFT of year 8 school children (12/13 years) (^5)</td>
<td>1.29</td>
<td>1.42</td>
<td>NA</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Acute rheumatic fever first hospitalisations rates per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years (^6)</td>
<td>6791</td>
<td>11048</td>
<td>NA</td>
<td>4447</td>
<td></td>
</tr>
</tbody>
</table>

---

1. As at 02/02/2018 Data was not yet available for this indicator
2. Comparator population data is not available for this indicator
3. Data for this measure is received annually in Q3. This data is for Q3 2016/17
4. Data for this measure is received annually in Q3. This data is for Q3 2016/17
5. Data for this measure is received annually in Q3. This data is for Q3 2016/17
6. Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the Auckland, Waitemata and Counties Manukau Health Alliances 2017/18 System Level Measures Improvement Plan.
### Key Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maaori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
<th>Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden unexpected deaths in infants per 1,000 live births</td>
<td></td>
<td>2.38</td>
<td>NA</td>
<td>NA</td>
<td>0.58&lt;sup&gt;7,8&lt;/sup&gt;</td>
</tr>
<tr>
<td>Proportion of newborns enrolled with a PHO by 3 months old</td>
<td></td>
<td>63%</td>
<td>65%</td>
<td>NA</td>
<td>65%</td>
</tr>
<tr>
<td>Percent of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.</td>
<td></td>
<td>100%</td>
<td>99.3%</td>
<td>NA</td>
<td>100%</td>
</tr>
<tr>
<td>Well Child Tamariki Ora Services</td>
<td></td>
<td>A measure, baseline and target is being developed in 2017/18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Rangatahi (Young People)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maaori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
<th>Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)</td>
<td></td>
<td>0.6%</td>
<td>NA</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)</td>
<td></td>
<td>0%</td>
<td>0.3%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Sexual and Reproductive Health</td>
<td></td>
<td>A measure, baseline and target is being developed in 2017/18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of eligible girls fully immunised with HPV vaccine&lt;sup&gt;11&lt;/sup&gt;</td>
<td></td>
<td>63%</td>
<td>72%</td>
<td>60%</td>
<td>53%</td>
</tr>
</tbody>
</table>

#### Pakeke me Whaanau (Adults and Family Group)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maaori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
<th>Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory sensitive hospitalisations in adults aged 45-64 years per 100,000 population</td>
<td></td>
<td>9012</td>
<td>8904</td>
<td>NA</td>
<td>2870</td>
</tr>
<tr>
<td>Percentage of people who smoke and are enrolled in General Practice are offered brief advice and cessation support</td>
<td></td>
<td>88%</td>
<td>89%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of people who smoke and are hospitalised are provided brief advice and offered cessation support</td>
<td></td>
<td>96%</td>
<td>97%</td>
<td>NA</td>
<td>97%</td>
</tr>
<tr>
<td>Percentage of eligible population receiving cardio-vascular risk assessment in the last five years</td>
<td></td>
<td>12</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Percentage of eligible Maaori men aged 35-44 years who have had their cardio-vascular risk assessed in the last five years</td>
<td></td>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of eligible population who have a risk greater than 20% and are on dual therapy (dispensed)</td>
<td></td>
<td>48%&lt;sup&gt;14,15&lt;/sup&gt;</td>
<td>55%</td>
<td>49%&lt;sup&gt;16&lt;/sup&gt;</td>
<td>44%</td>
</tr>
</tbody>
</table>

---

<sup>7</sup> The comparator for the SUDI measure is Non-Maaori, unlike other measures where the comparator is NZ European/Other

<sup>8</sup> This indicator is currently receiving information on an annual basis, this data was recorded in Q3 2016/17

<sup>9</sup> The comparator population for this indicator is the total population

<sup>10</sup> The comparator population for this indicator is the total population

<sup>11</sup> Data for this measure is received annually in Q4. This data is for Q4 2016/17

<sup>12</sup> CMDHB is currently awaiting audited data from the MOH

<sup>13</sup> CMDHB is currently awaiting audited data from the MOH

<sup>14</sup> CMDHB is currently awaiting audited data from the MOH

<sup>15</sup> This data is received six-monthly, this data was recorded for Q1 2017/18

<sup>16</sup> Please note, this figure does not represent the Indian subgroup (Q1 17/18 51.3%)
### Key Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
<th>Equity Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of eligible population who have had a prior CVD event who are on triple therapy (dispensed)</td>
<td></td>
<td>53%&lt;sup&gt;17&lt;/sup&gt;</td>
<td>63%</td>
<td>49%&lt;sup&gt;18&lt;/sup&gt;</td>
<td>56%</td>
</tr>
<tr>
<td>Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)&lt;sup&gt;19&lt;/sup&gt;</td>
<td></td>
<td>58%</td>
<td>57%</td>
<td>NA</td>
<td>71%</td>
</tr>
<tr>
<td>Percentage of enrolled patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 months is &lt;140 mmHg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The baseline and target is in development as part of a regional collaboration.</td>
</tr>
<tr>
<td>Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The baseline and target is in development as part of a regional collaboration.</td>
</tr>
<tr>
<td>Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20&lt;sup&gt;20&lt;/sup&gt;</td>
</tr>
<tr>
<td>Proportion of women aged 20 - 69 years who have had a cervical smear in the last three years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage of people aged over 65 years who receive free flu vaccinations&lt;sup&gt;22&lt;/sup&gt;</td>
<td></td>
<td>40%</td>
<td>45%</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>Mental Health Act: Section 29 Indefinite Community Treatment Orders rates per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage of the population enrolled in a PHO</td>
<td></td>
<td>93%</td>
<td>116%</td>
<td>89%</td>
<td>94%</td>
</tr>
</tbody>
</table>

**Te Roopu Whaanui o Counties Manukau (District Wide)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Links to government/MOH/regional priorities</th>
<th>Result Maori</th>
<th>Result Pacific</th>
<th>Result Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fanau Ola Programme</td>
<td>A measure, baseline and target is being developed in 2017/18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health for Pacific Peoples</td>
<td>A measure, baseline and target is being developed in 2017/18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total packages of care per annum delivered through Whaanau Ora Integrated Services</td>
<td>2466&lt;sup&gt;24&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce headcount for prioritised occupational groups by ethnic groups</td>
<td>A measure, baseline and target is being developed in 2017/18</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<sup>17</sup> This data is received six-monthly, this data was recorded for Q1 2017/18

<sup>18</sup> Please note, this figure does not represent the Indian subgroup (Q1 17/18 66.2%)

<sup>19</sup> Data for this measure is received twice per annum in Q2 and Q4. This data is for Q4 2016/17

<sup>20</sup> CMDHB is currently awaiting audited data from the MOH

<sup>21</sup> CMDHB is currently awaiting audited data from the MOH

<sup>22</sup> Usually this data set is provided annually in Q4, these figures are from an update received for Q1 17/18, we do not expect updated figures until Q4 17/18

<sup>23</sup> CMDHB is currently awaiting audited data from the MOH. We have not received an updated figure since Q1 2016/17

<sup>24</sup> This data set is incomplete as providers are developing a unified ISA data collection system and protocols.
Counties Manukau Health - Population Health (Māori & Pacific results) Performance. Category 1 - Matua, Pepi, Tamariki - Parents, babies and children

Maatua, Pepi me Tamariki - Parents, Infants and Children - Key Insights to Q2 2017/18

- The percentage of Māori 8 month olds who've received their primary course of immunisations on time has reduced between Q1 and Q2 in FY 17, as well as year on year. In the 3 months to Q2, the rate has dropped from 89% to 86% - and this is the same percentage drop in the year on year figure. By contrast the equity comparator group's rate has remained stable both between Q1 and Q2 as well as in the year to Q2.

- The ASH rate for Pacific children steadily dropped over the past year from a rate of 11977 in Q2 2016/17 to 10948 in Q2 2017/18. The equity gap also decreased from 7188 to 6601 in the year to Q2. The gap reduced between Q1 and Q2 17/18 by 232.

- The ASH rate for Māori children rose from 6264to 6791 in the year to Q2 17/18. The corresponding drop in the comparator rate saw the equity gap rise from 1475 to 2344 (or 37%) over the same period.

PP13: Number of Pre-school Children Enrolled in DHB-funded oral health services

PP28: Acute rheumatic fever hospitalisation rate per 100,000 population

SI1: ASH Rates - 0 to 4
Q2 Population Health Report

Focus: Persistent inequities faced by Maori, Pacific and Asian communities in the Maternity to 5 year old age group.

Ambulatory Sensitive Hospitalisations (0-4)

The gap between the total CM Health ASH rate compared to the national total rate for this age group has decreased by 2.5% in the last year (+5.7% in the 12 months to September 2017 vs. +8.2% in the 12 months to September 2016). This is due to improvements in both Other (-12% compared to the September 2016 result) and Pacific (-9% compared to the September 2016 result) exceeding the 5.1% reduction in the national total rate. Despite this improvement, the Pacific rate is still 71% above the national total rate and the Maori rate has also moved back above the national total rate after being below this rate in the 12 months to September 2016.

For Pacific, seven of the top ten ASH conditions for this age group – Asthma, Cellulitis, Dermatitis and eczema, Gastroenteritis/dehydration, Lower respiratory infections, Pneumonia, and Upper respiratory and ENT infections, are all at least 40% above the national total rate with Cellulitis more than three times higher than the national total rate and Pneumonia and Dermatitis and eczema more than twice the national total rate. For Maori, Cellulitis is twice the national total rate and Pneumonia and Dermatitis and eczema are both almost 40% higher than the national total rate but these are offset by below national total rates for Dental conditions, Gastroenteritis/dehydration, GORD, and Upper respiratory and ENT infections.

ASH rates are to a significant extent linked with social determinants of health, health literacy, self-management capability and access. The following CMDHB programs are designed to reduce acute hospital admissions, and as such should positively impact ASH rates:

- The Planned Proactive model of care being implemented has included a focus on enhancing the ability of people with LTCs to self-manage, as well as improving access to clinical care for these people. Recently Planned Proactive Care for children has been added. This involves targeting specific paediatric conditions such as eczema and constipation both of which contribute in some way to ASH.
- The Social Investment approach being tested in Mangere will look to establish an integrated cross-sectoral response addressing social factors that influence health outcomes.
- Planning for implementation of System level Measures is well underway. Areas of focus include Heart Failure, Cellulitis, Stroke and COPD, improved management of which will contribute to better ASH results.
- The Front Door Project focuses on people who present to ED frequently, by providing multidisciplinary assessment and linkage back to the primary care team.

In the last six-months training has been held with representatives of 11 local early childhood centres, home-based early childhood educators, playgroups and churches on the management of skin infections. The training was delivered in a train-the-trainer manner. Attendees were encouraged to take their newly acquired knowledge back to their workplaces and train their colleagues. The centres attended represented more than 400 children in the local area, and due to the interdisciplinary demography of the attendees (ECE teachers and church group leaders as an example), this represented an opportunity for children to have multiple opportunities to be exposed to good infection management support in the life course of a week’s activities. The centres who attended are listed below:
This was the last event of its type for the short-term due to the disestablishment of the role responsible for setting up these events.

Immunisations

The Immunisation target for both total population as well as Māori infants at eight months of age has not been achieved. The challenge of maintaining or continued progress is more evident for Māori than the other ethnicities at eight months.

A total of 1268 referrals were sent to Outreach Immunisation services (OIS) this quarter, 629 referrals were for eight month olds of which 261 were Māori pepi. All whaanau were contacted and 145 pepi were successfully immunised contributing 32% to Māori Eight month immunisation coverage.

Achieving equity with Māori at 8 months, 24 months and 5 years milestone ages is still a work in progress and has not currently been achieved.

Progress is discussed weekly with the Outreach Immunisation team and bi-monthly with PHOs at the Immunisation Working Group meetings.

Where immunisation is delayed by families, linkages to the Well child Tamariki Ora nurse are utilised to support engagement with the Outreach immunisations team.

Overdue reports of all milestone immunisations are sent to GP practices monthly and the turnaround from practices to Complete or Decline or Refer to Outreach Immunisations Services as well as identify and correct messaging issues occurs weekly for most.

Rheumatic Fever

CMDHB was tasked with achieving a two thirds reduction of new Rheumatic fever cases as measured by ICD discharges as per the Ministry of Health’s algorithm at end of the formal Rheumatic Fever Prevention Programme in July 2017.
We did not meet this target with 50 cases identified by the MoH from the National Minimum dataset. On review of these NHIs it appears 46 of these were actual cases. Using the official number of 50 the rate for CM Health for is 9.2/100,000. While we are awaiting official data from the MoH for the 2017 Calendar year for the last eleven months of 2017, using DHB provider arm discharge data (January-November 2017), we have identified 87 discharges were identified with an ARF code.

Of these discharges, 44 appear to be new cases of ARF. Three of these cases were living in another DHB (one of whom was non-resident) at onset of illness and four, while living in Counties Manukau are non-residents.

The other admissions were recurrences or a readmission with a prolonged initial illness or had an alternative diagnosis.

This preliminary analysis would suggest we are likely to have a similar (or possibly slightly lower) number of cases to the 2016_2017 FY.

In the past three months, using the same data source, which only includes October and November data, there were three cases captured with an ARF diagnosis code. Of these cases one was a confirmed case of RF but the child was domiciled to Waikato DHB at the time of diagnosis. One case was determined not to be ARF and one case was a readmission with on-going symptoms from June.

The key engagement forum with local stakeholders continues to be the Child Health Alliance Forum. Meetings include updates from organisations involved with Awhi, secondary schools and the school programme (Mana Kidz). Active engagement with schools continues. This included sending out school score cards to all schools on the 10 November and letters to all principals in December 2017 with a summary of the Rheumatic Fever prevention activity throughout the year in their schools.

There was only one confirmed new case notified to ARPHS from Middlemore Hospital during this quarter (awaiting December month ie only 2 months of data included). This case was a Waikato resident at the time so shouldn’t be included in the final DHBs numbers. The time to notification was 3 days.

There were 4 cases reviewed during this same period (ie 2 months as December cases not reviewed at time of writing), all of which were not determined to have ARF therefore no key actions to report.

In terms of this work much of it is similar to the last quarter report ie

- Receiving weekly reports with any mention of “rheumatic” in the patient diagnosis on the discharge summary to ensure all documentation & referrals have been completed correctly
- Education provided on the wards and to the persons concerned if a systems failure has been identified
- A working group has been established to discuss the internal pathway for RF patients to build an IT system that can navigate all the services required to provide follow up care
- In addition we continue to work within the DHB service to ensure that once patients are referred they received timely prophylaxis.

We are:

- Continuing to follow up RF patients using the non-concordance process
- Using Bicillin Standing orders which have now been in place for one year and prove to be an effective way of providing prophylaxis in a timely manner.
• Referring rheumatic fever patients with multiple medical needs to complex case nurses within each locality to link them back to their GP and support self-management
• Ensuring Community Health Teams in each locality hold regular MDT (multidisciplinary team) meetings and include primary care which provides an opportunity to case review RF patients and keep GP’s more informed.

RF liaison nurse has been working with Community Central, who triages all Community Health Teams referrals, to engage with HealthPathways so referrers have a guide when referring as to what information is required. To really progress this work we need confirmation of the regional ADHB RF form.

Smokefree – Maternity

<table>
<thead>
<tr>
<th>Number of events</th>
<th>Number of Smokers</th>
<th>Smokers' gestation (weeks)</th>
<th>% offered brief advice</th>
<th>% offered advice and support to quit</th>
<th>% accepted cessation support</th>
<th>Smoking prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>22</td>
<td>20</td>
<td>91%</td>
<td>64%</td>
<td>86%</td>
<td>54%</td>
</tr>
</tbody>
</table>

According to the 100 pregnant smoking women per month estimate, the service received referrals for 51% of the total smoking population with 152 referrals (10 less than previous quarter). 86 were received for Maori women equating to 54% of the estimated smoking population.

In comparison to the other stop smoking services across New Zealand, Counties continues to achieve the highest number of pregnant women smokefree at 4 weeks the third highest in terms of Maori 4 week quitters.

The below activities were conducted during the quarter to continue to increase the number of women offered advice and supported to quit smoking:

Smokefree pregnancy incentives programme
Out of the 152 referrals received, 148 (97%) were eligible for the incentives programme. In Q2, 47 out of 48 pregnant women who set a quit date the previous quarter were Smokefree at 4 weeks, biochemically validated (69% 4 week quit rate).
Drop in clinics continue to attract half the referrals and the $40 attendance incentive has continued.
Drop in clinics and workplace interventions have been located in areas of high Maori prevalence areas with less resources put into clinics in other localities.
Targets for practitioners continue to be monitored, are ethnicity driven and ongoing supervision and monthly meetings address when these targets are not being met.

Training
9 midwives underwent Smokefree Best practice on orientation and a refresher session was conducted for 15 midwives and nurses working on the hospital maternity ward.
Networking
Smokefree maternity advisor continues to attend and feedback on progress at monthly Access holder’s meetings, SUDI/Smokefree champion meetings, SUDI project board meetings and SLM meetings. Key messages and referral pathways continue to be distributed via an internal newsletter and Midwifery newsletter.

New initiatives
Work continues with the development of the regional maternity e learning tool.

Proposal tabled at the November Maternity Strategic group discussing the feasibility of an opt out referral system (potentially prioritising Maaori women) after presenting deficit and inequities with proportion referred compared to numbers smoking in pregnancy. Issue is being taken to legal consultant with an update in Q3.

Postnatal indicator
SLM (Smokefree households at 6 weeks) now moving to SUDI regional working group to continue work on contributory measures.

The postnatal incentives have been adopted as business as usual and received 34 referrals for the quarter.

Raising Healthy Kids

Progress with getting referrals acknowledged from the B4 School Check (B4SC)
An electronic referral process from B4SC to primary care through generation of a concerto letter has been implemented and operational since 30 September. 100 percent of referrals since the implementation of the electronic referral process are being acknowledged.

Progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions
A dual referral processes for children identified as obese at their B4SC has been set up. The B4SC provider is referring children to both primary care for clinical assessment and to the family based nutrition, activity and lifestyle interventions.

- Decline notification letters being sent to GP to notify them with a child has been identified as being >98th centile and the parent/caregiver has declined a referral
- Decline notification letters being sent to GP to notify them with a child has been identified as being >91st centile and the parent/caregiver has declined a referral

Activity to support primary care and community partners having the conversation with families.
Training and mentoring opportunities to help health professionals have conversations with families are being offered to primary care, B4SC, WCTO and other health professionals. In 2017/18 so far, 289 health professionals have completed this training.

A CME/CNE video and podcast was delivered on the 31 October 2017 via the Goodfellow Unit (175 people attended the live session), to support primary care and other health professionals working with children and families to deliver effective brief healthy weight interventions. The purpose of the video and podcast was to:
• Engage primary care about taking on weight management as core primary care business
• Build motivation to take action – why this is important, and the difference they can make
• Present how to effectively deliver a brief healthy weight intervention i.e. how to have the conversation (including 5 min modelled conversation)
• Increase awareness about what resources, training and support is available.

No barriers identified – we have achieved the health target and have the systems in place to maintain achievement of the target going forward. We continue to closely monitor the decline rate and have strategies in place to support a reduction in declines. The overall rate of referrals being declined rate in Counties Manukau this quarter is 38% (national average is 29%), the decline rate for Maaori is 42% (national average 28%) and for Pacific 26% (national average 21%). We will need to examine the factors surrounding the Maaori decline rate and reconsider our approaches/efforts to address this as there is some slow incline of declined referrals. It is intended that we will conduct focus groups to help understand the experience of whaanau who declined a referral from the B4SC to their GP. We are working on drafting up protocol and questions as well as identifying if we require ethics approval.
Counties Manukau District Health Board

5.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Minutes of CPHAC Public Excluded meeting 21 February 2018 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes
For the reasons given in the previous meeting. |

[NZPH&D Act 2000 Schedule 3, S32(a)]