COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)
Wednesday, 5 December 2018

Venue: Ko Awatea, Room 105, Middlemore Hospital, Otahuhu, Auckland
Time: 9.00am

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

CMDHB Management
Ms Margie Apa – Chief Executive
Jenny Parr – Chief Nurse and Director of Patient & Whaanau Experience
Dr Kate Yang – Business Manager
Vicky Tafau - Secretariat

AGENDA

PART I – Items to be considered in public meeting

1. AGENDA ORDER AND TIMING

2. GOVERNANCE

2.1 Apologies

2.2 Register of Interests

2.2.1 Does any member have an interest they have not previously disclosed?

2.2.2 Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

9.05am

2.3 Confirmation of Public Minutes of the Community & Public Health Advisory Committee Meeting – 7 November 2018

9.10am

2.4 Action Items Register

3. PRESENTATION

9.15am

3.1 Southern Corridor Planning with a focus on Primary and Community Developments (joint presentation from Tony Phemister, Portfolio Manager, Regional Planning & Service Delivery, NRA and Kathryn de Luc, General Manager Specialised Care Funding and Development CM Health)

4. BRIEFING PAPER

10.00am

4.1 ARPHS Briefing for CM Health (Jane McEntee, General Manager, Auckland Regional Public Health Service, ARPHS & Dr Doone Winnard, Clinical Director Population Health, CM Health)

MORNING TEA – 10.30am to 10.40am

5. PRESENTATION

10.40am

5.1 SUDI Workplan Briefing Paper (Christine McIntosh, GP Liaison & Tina Higgens, Youth Health Service Development Manager)

5.1.1 CM Health SUDI Prevention Plan 2018/19

5.1.2 SUDI Update Presentation

Next Meeting:
Wednesday, 27 February 2019 at Ko Awatea, Room 101 (9am to 12.30pm)
## 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>
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<tr>
<td>Colleen Brown (Chair)</td>
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<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>John Wong - External Appointee (appointed 13/9/17)</td>
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## CPHAC MEMBERS
### DISCLOSURE OF INTERESTS
5 December 2018

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| **Colleen Brown**       | • 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  
                          • Board Member, Neighbourhood Support NZ                                                                                                     |
| **Dr Ashraf Choudhary** | • 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 NZ  
                          • 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)  
                          • Lotteries Community (Auckland)  
                          • Board Member, Counties Manukau Rugby League Zone  
                          • Member, NZ Maori Council  
                          • Member, Tamaki kit e Tonga District Maori Committee                                                                                           |
<table>
<thead>
<tr>
<th>Katrina Bungard</th>
<th>Apulu Reece Autagavaia</th>
<th>John Wong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairperson MECOSS – Manukau East Council of Social Services.</td>
<td>Member, Pacific Lawyers' Association</td>
<td>Board member, Asian Family Services (a subsidiary of Problem Gambling Foundation of NZ).</td>
</tr>
<tr>
<td>Deputy Chair Howick Local Board</td>
<td>Member, Labour Party</td>
<td>Chair and Trustee, Chinese Positive Ageing Charitable Trust.</td>
</tr>
<tr>
<td>Member of Amputee Society</td>
<td>Trustee, Epiphany Pacific Trust</td>
<td>Founding member and council member, Asian Network Incorporation (TANI).</td>
</tr>
<tr>
<td>Member of Parafed Disability Sports</td>
<td>Trustee, The Good The Bad Trust</td>
<td>Board member, Auckland District Police Asian Advisory Board.</td>
</tr>
<tr>
<td>Member of NZ National Party</td>
<td>Member, Otara-Papatoetoe Local Board</td>
<td>Board member, Chinese Mental Health Consultation Service Trust.</td>
</tr>
</tbody>
</table>
## COMMUNITY and PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS’
REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 7 November 2018

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Margie Apa</td>
<td>Item 3.1 on the CPHAC agenda – Aged Related Residential Care Overview</td>
<td>Ms Apa is Chair of Presbyterian North who provide older people services.</td>
<td>3 May 2017</td>
<td>That Ms Apa’s specific interest is noted and the Committee agreed that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
</tr>
<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>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 7 November 2018 at 9.00am – 12.30pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

**PART I – Items considered in Public Meeting**

**BOARD MEMBERS PRESENT**

Colleen Brown (Committee Chair)
Dr Ashraf Choudhary
Dianne Glenn
Apulu Reece Autagavaia
John Wong

**ALSO PRESENT**

Margie Apa (Chief Executive)
Karyn Sangster (Deputy Chief Nurse)
Kate Yang (Business Manager, Primary Care)
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**

There were no public or media representatives present at this meeting.

**APOLOGIES**

Apologies were received from Katrina Bungard, George Ngatai and Jenny Parr (Karyn Sangster is attending on her behalf) and Margie Apa for lateness, Apulu Reece Autagavaia for early departure.

**WELCOME**

The meeting commenced at 9.07am with a welcome from the Chair, Ms Brown.

The Chair thanked Kate Yang, Kitty Ko and the rest of the team that put together the Asian Health CPHAC meeting on Monday, 5 November. Was a very successful meeting and CPHAC appreciated the candour of the community that engaged with the committee and the wonderful musical presentation at the end.

A CPHAC Youth meeting will be organised for early 2019.
DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted, including a change for Ms Brown and Apulu Reece Augatavaia.
There were no amendments to the Disclosure of Specific Interests.

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 26 September 2018.

An amendment to the spelling of Apulu Reece Autagavaia’s name was noted.

Resolution (Moved: Dianne Glenn /Seconded: Dr Ashraf Choudhary)

That the minutes of the Community and Public Health Advisory Committee meeting held on 26 September 2018 be approved.

Carried

2.2 Action Items Register/Response to Action Items

Action Item
Women in Prisons: Health Services not providing Vision and Hearing screening tests. Report back on health services that are provided to all Prisons in SA – breast screening, cervical, prostate, bowel, vision & hearing. Early next year.

Action Item
The Chair would like to meet with at least three to four Youth leaders, prior to a more extensive meeting in 2019. Ms Yang will investigate the possibility of convening a meeting prior to Christmas for The Chair to attend.

Dr Choudhary and Ms Yang will look to organise an additional CPHAC meeting in early 2019 for the South Asian community.

Community Hub Vaccinations Update: These hubs are an extension of MSC. In order to vaccinate in any space, there are a lot of legalities to be sorted before this can be done. Ms Sangster mentioned that there are many clinics that can already vaccinate in walking distance from all of the Hubs.

3. BRIEFING PAPER

3.1 Fluoridation Position Paper (Dr Doone Winnard, Clinical Director, Population Health, CM Health & David Sinclair, Medical Officer of Health, ARPHS)

The paper was taken as read.

This is an important issue from an equity perspective and for oral health. Dr Winnard advised that this paper was not asking for any decisions, it is a position statement. Fluoridation will become a hot topic. CM Health is clear around the evidence base and the importance for the Counties Manukau population.
Whilst most Watercare supplies are already fluoridated the DHB support the fluoridation of all community water supplies to ensure that the non-fluoridated communities get fluoridated water.

Work is being undertaken around the promotion of the message that tap water is safe, healthy and good for your teeth. ARPHS are working with Watercare, Auckland Transport and Auckland Council.

Reviews of research sometimes produces questions around Fluoride Safety. No solid evidence has been produced in regard to any health issues with the level of fluoride used in New Zealand. For those that stand against fluoride, it is mostly a long-held personal belief, rather than fact based.

Resolution
The Community & Public Health Advisory Committee:
Recommended to the CM Health Board that they endorse the position on Community Water Fluoridation in Appendix 1.

Moved: Dr Ashraf Choudhary/Seconded: Ms Dianne Glenn/Passed: Unanimously

4. PRESENTATIONS

4.1 Franklin Locality Update (Penny Magud, GM Locality Services)

Geographically the largest locality. Since 2013 the population has grown by a further 9,000. 15% of the population is over 65, and this number is expected to double in the next 20 years. 34% are under 25 yrs. The overall Franklin population is expected to grow 30% by 2033. A population the size of Hamilton will be in Franklin over the next 30 years – estimated 140,000 people.

Locality leadership – it was advised that one General Manager now works across four localities. Each locality does have Champions. This allows the DHB to meet local requirements and provide services with a local flavour.

Locality Leadership Group (Andy Baker): are currently reviewing their TOR to reflect the changes that are happening within the locality.

Ms Magud advised that the Principles Meeting (Dr Mark Eustace) has been reconvened – looking at the role of Primary Care and working around how we manage the community and deliver care (even acute care) closer to home.

There are also nursing forums and social work forums for the Franklin locality. Ms Magud is looking to replicate this type of activity in other localities.

Community Central – this is the single point of referral for all four localities. 3000 requests for service per month. An emerging trend is the number of patients needing to be seen between 2 to 48 hours (33%). The acuity of the patients that are being managed in the community would previously have been admitted to hospital. Mastectomy patients now only require a night in hospital and are then managed at home. Patients that would normally have had their chemo ports deactivated in hospital, can now be managed at home.

Transition of care from hospital to home is seamless. This information is disseminated to the patients.
Establishing relationships with current health providers in the Franklin area is key to the success of treating patients in their home.

Community central requests for referrals average approximately 160 per week day, less over the weekend. Peak of over 200 per day was in May 2018.

Routine/Low risk referrals need to be transferred from Community Central back to Primary Care. Work will be undertaken in the localities to help this. If we introduce more services into Franklin, eg orthopaedics, the DHB would need to consider the cost of this.

Innovative thinking is being undertaken across all services around how we can provide better, more convenient services closer to home, if not in the home. This will allow the hospital to be used effectively, and to understand the acute patient flow better.

There is a need to remember that Franklin does have pockets of serious deprivation, when looking at the whole of the locality. There is also a need to look at more out-patient services, up-skill the local providers and ensure they are sustainable in order to take from the DHB those services that can easily be managed by Primary Care.

The DHB is moving away from some of the original perceptions - make our resources flexible and agile, be smart around what questions we are asking in order to be able to collect the data that we require in order to make smart decisions.

4.2 Engaging with the Asian Community (Kate Yang, Business Manager, Primary Care)

There are those within Asian communities that are isolated and have no support. The level of engagement from Asian communities is low. New migrants can be seen to be healthy however may not have disclosed all health issues prior to coming to New Zealand and this can create stress for families.

Discussion took place around:
- How does CPHAC want to engage in a sustainable and meaningful way?
- How can CPHAC support and leverage already existing infrastructure?
- How can CPHAC take lessons from engaging with Maaori and Pacific to become leaders in innovation when working with the Asian community?

Local Council flats, look to ensuring that Councils know best how to engage and support the tenants.

4.3 Asian Health Overview (Kitty Ko, Asian Health Gain Advisory)

Ms Ko spoke to the committee around her own health journey as part of her presentation.

Some common barriers to accessing health care for the Asian communities are:
- Oral health of Asian children - lower percentage of Asian children aged 5 years who are caries free;
- Cancer screening - lower percentage of Asian women aged 25-69 years received a cervical screen;
- Primary care - lower percentage of Asian population enrolled in a PHO;
- Long Term Condition (Cardiovascular disease) - Indian people have a higher prevalence of risk factors associated with cardiovascular disease, and Indian aged 35-74 years had higher CVD hospitalisation rates as compared to the European/Other group in Counties Manukau;
• Long Term Condition (Diabetes) - Prevalence, morbidity and mortality rates from diabetes are higher for Indian than other groups; and
• Mental health & Addictions - lower access rate to mental health services.

• Practical barriers - lack of English language proficiency, inadequate knowledge and awareness of existing health services
• Cultural barriers - intense stigmatisation around mental illness that exists among many Asian cultures, religious beliefs, and cultural differences in the presentation as well as treatment of mental illness
• Systemic barriers - lack of interpreter services or culturally / linguistically appropriate health information, lack of bilingual health professionals, incompatible Western health treatment models, and lack of cultural competence in health care

CM Health has a 33% Asian workforce, which is reflective of the population. There is a need to think innovatively around a culturally responsive workforce and culturally responsive services.

As mentioned at Monday’s Asian Health meeting, there is a strong need to produce resources that demystify the health service and allow new migrants access to the services that they require. The committee was advised that there are resources out there.

Action
A report back to the committee on what resources are already out there, is it factually correct and how we can disseminate this information on a larger scale to the Asian communities.

5. BRIEFING PAPER

5.1 Quarter 4 2017/2018 Non-Financial Summary Report (Alanna Soupen, Planning & Reporting Advisor)

The Report was taken as read.

Not a lot of new data. CM Health have achieved four out of six health targets. As a result of ongoing work by various teams, equitable achievement was gained too.

Maaori immunisations, breast screening and cervical screening continue to be a struggle to achieve higher rates.

Cervical outcomes – the last needs assessment was undertaken in 2008. Asian women are similar to Pacific women. Asian women have lower hospitalisation. The committee was advised that Asian/South Asian women may return to the country of origin to have their women’s health needs looked after.

New work is being undertaken looking at innovations to boost immunisation results.
(Note: if numbers are very small they aren’t recorded as not meaningful on a quarterly basis.)

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Colleen Brown/Seconded: Dr Ashraf Choudhary)

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:

 Counties Manukau District Health Board – Community & Public Health Advisory Committee 5 December 2018
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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| 2.1 Minutes of the CPHAC meeting (Public Excluded) held on 26 September 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. [NZPH&D Act 2000 Schedule 3, S32(a)] | 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. [Official Information Act 1982 S9(2)(i)] |

Carried

Meeting concluded at 12.00pm.


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 – 7 November 2018

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<tr>
<th>DATE</th>
<th>ITEM</th>
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<td><strong>Standing Items</strong></td>
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<td>19.8.15</td>
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<td>Locality Updates: Eastern</td>
<td>5 December</td>
<td>Penny Magud</td>
<td>This item has been replaced by the South Corridor Planning presentation from Kathryn de Luc/Tony Phemeister (NRA).</td>
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<td></td>
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<td>Manukau</td>
<td>27 February</td>
<td>Penny Magud</td>
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<td></td>
<td>Otara/Mangere</td>
<td>22 May</td>
<td>Penny Magud</td>
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<td>Franklin</td>
<td>14 August</td>
<td>Penny Magud</td>
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<td>Eastern</td>
<td>6 November</td>
<td>Penny Magud</td>
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<td>14.6.17</td>
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<td>ARPHS – six-monthly update.</td>
<td>5 December</td>
<td>Doone Winnard</td>
<td>Refer to Item 4.1 on this agenda.</td>
</tr>
<tr>
<td>29.11.2017</td>
<td></td>
<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
<td>27 February 2019</td>
<td>Kate Dowson</td>
<td>There is no new data from the MoH for the SLMs this financial year. New data will be available in the new year.</td>
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<tr>
<td>29.11.2017</td>
<td>3.1</td>
<td>Every 5 Counts – Project team to present an update on this project.</td>
<td>22 May 2019</td>
<td>Sarah Sharpe</td>
<td>Deferred in agreement with the Chair (Colleen Brown)</td>
</tr>
<tr>
<td>6.9.2017</td>
<td>3.1</td>
<td>Owning my Gout – 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>TBA</td>
<td>Trevor Lloyd</td>
<td>Will come to CPHAC when the Business Case has been finalised.</td>
</tr>
<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>10 April</td>
<td>Matt Hannant</td>
<td>Green Prescription is currently undergoing a re-procurement process and will update once this process has concluded.</td>
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<td>23.5.18</td>
<td>3.1</td>
<td>Mental Health &amp; Addictions Update: with regard to homelessness for MH&amp;A whaanau, Housing First to be invited to present to CPHAC.</td>
<td>27 February</td>
<td>Kate Yang</td>
<td>Kate Yang to confer with Dr Pete Watson to prepare this for early 2019.</td>
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<tr>
<td>4.7.2018</td>
<td></td>
<td>Youth One Stop Shop: Provide basic information/data</td>
<td>2019</td>
<td>TBC</td>
<td>To be discussed at CPHAC in 2019</td>
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<tr>
<td>4.7.2018</td>
<td>5.1</td>
<td>Mangere/Otara Community Hubs: Mr Greenslade to return to CPHAC with a community hub update.</td>
<td>13 March 2019</td>
<td>TBC</td>
<td>To be organised in early 2019.</td>
</tr>
<tr>
<td>19.9.2018</td>
<td>Board</td>
<td>MoH Letter – Strengthening the DHB Healthy Food &amp; Drink Policy - Doone Winnard and Stella Welsh are looking at what the DHB is currently doing and what this letter means and will report back via HAC and CPHAC.</td>
<td>27 Feb 2019</td>
<td>Doone Winnard/Stella Welsh</td>
<td>A brief will be submitted to ELT in December 2018 and an update will be provided to this committee early 2019.</td>
</tr>
<tr>
<td>26.9.2018</td>
<td>3.1</td>
<td>Healthy Families New Zealand: Update to CPHAC in 6 months’ time.</td>
<td>10 April 2019</td>
<td>Carmel Ellis</td>
<td></td>
</tr>
<tr>
<td>26.9.2018</td>
<td>5.1</td>
<td>Maaori Immunisations: The paper that has been submitted to ELT to be made available to CPHAC.</td>
<td>5 December</td>
<td>Colleen Brown</td>
<td>CPHAC to confirm with Ms Apa at the meeting on 5 December if this paper is ready for release to Board Sub-committees.</td>
</tr>
<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>Women in Prisons: Report back on health services that are provided to all Prisons in South Auckland – breast screening, cervical, prostate, bowel, vision &amp; hearing.</td>
<td>10 April 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>Youth Leaders: The Chair would like to meet with at least three to four Youth leaders, prior to a more extensive meeting in 2019. Ms Yang will investigate the possibility of convening a meeting prior to Christmas for the Chair to attend.</td>
<td>TBC - 2019</td>
<td>Kate Yang</td>
<td>Due to the time of the year, this will be planned for some time in the first half of 2019.</td>
</tr>
<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>South Asian Community Meeting</td>
<td>TBC – early 2019</td>
<td>Kate Yang &amp; Dr Ashraf Choudhary</td>
<td></td>
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<tr>
<td>7.11.2018</td>
<td>4.3</td>
<td>Asian Health: A report to be brought back to the committee on what resources are already out there, is</td>
<td>TBC – 2019</td>
<td>Kate Yang/Kitty Ko</td>
<td></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>
<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></td>
<td></td>
<td>it factually correct and how we can disseminate this information on a larger scale to the Asian communities.</td>
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The Southern Corridor A2H

Health Service Planning in Southern Corridor

Community and Public Health Advisory Committee

5th December 2018

Tony Phemister (NRA), Kathryn De Luc (CMDHB)
The Southern Corridor
Overview - Southern Corridor ‘Planning’ has many plans.

A2H (H2A)

- What is it?
- Who participating / who are the key players?
- Why Now?
- Context
- Timeframes

A2H - Objective

“To better support growth and increase connectivity in a way that realises its social, economic, cultural and environmental potential”
The Auckland–Hamilton Corridor – What is it?
The ‘Corridor’ is defined by the transport links. The ‘zone’ extends 5km to east and to west of the Road and Rail links.

- Includes areas of Auckland City, the Waikato District and Hamilton City
- Features industrial areas, freight hubs, towns centres and areas of primary production
- Is home to a significant existing population – c.200k within 5km of key transport corridor
- Includes State Highway 1 and the North Island Main Trunk Line
- Is a key driver of growth in both Auckland and the Waikato

The corridor is seen as a driver of growth in both Auckland and the Waikato.
Key Players / Participants (The Corridor Project)
A structured Government / Council initiative with MBIE supporting a multi sector approach

Governance Leadership
- Hon Phil Twyford (Chair)
- Hon David Parker
- Hon Nanaia Mahuta
- Hon Jenny Salesa
- Hon Julie Anne Genter
- Jamie Strange MP
- Cr. Alan Livingston, Chair Waikato Regional Council
- Cr Hugh Vercoe, Waikato Regional Council, Chair RTC
- Mayor Andrew King, Hamilton City
- Cr David MacPherson, Hamilton City
- Mayor Allan Sanson, Waikato District
- Cr Bill Cashmore, Auckland Deputy Mayor
- Cr Chris Darby, Auckland Council
- Rukumoana Schaafhausen, Chair Waikato Tainui Te Arataura
- Hayden Solomon, Chair Ngati Paoa

And officials in support

A Joint Steering Group, with officials representing:
- Waikato-Tainui,
- Auckland Council,
- Waikato Regional Council,
- Hamilton City Council,
- Waikato District Council,
- NZTA,
- MoT,
- Treasury
- MBIE

Multi Sector - Areas of Focus
- Waters
- Social Infrastructure Agencies
  - Roads
  - Utilities
  - Housing
  - Social Services (Education, Health, Police, Fire etc)
- Joint South Auckland and Waikato Settlement Planning
- Road Transport
- Rail Service Business Case
Increasing Pace and Scale requires some fundamental changes

‘Centre’ Perspective 2 – Potential solutions

Identified six key (and simultaneous) changes that will address the factors that are hindering delivery at pace and scale:

1. Establishing consensus around the shared spatial plan and shared priorities for Auckland
2. Significantly better integration and coordination of planning, programming (the pipeline of work), procurement and delivery
3. Urgently scaling up in many key areas: land, labour, materials, organisational capacities
4. A much higher degree of standardisation of key processes (including business case development), procurement, programme management – and the actual housing or infrastructure solutions
5. Shifting some risk and liability from Council to the Crown and private sector, to better match returns from growth
6. Increased funding and financial tools and certainty to agencies and developers - to help unlock development potential.

Potential for BOLD investment in a few select areas
The Strategy recommends a proactive planning approach
- Focused future growth on existing towns of Tuakau, Pokeno, Te Kauwhata and Huntly
- Shared services for Tuakau and Pokeno to cater for the north, Increase of services in Huntly to support the south
- Some localised essential services in Te Kauwhata

The strategy will cater for up to 50,000 residents, within the north Waikato towns, and nearly 18,000 jobs. (2016 – 2045)

Settlement Pattern

- Takanini – 5,310 dwellings
- Hingaia – 3,070 dwellings
- Drury West – 11,200 dwellings
- Rural Settlements – 7,552 dwellings
- Opaheke/Drury – 8,200 dwellings
- Drury South – 1,000 dwellings
- Pukekohe – 7,920 dwellings
- Paerata – 6,350 dwellings

Drury, Paerata and Pukekohe – 33,670 dwellings
Total – 50,602 dwellings

**Significant change from 2015 plans has left sector agencies catching up**

Dwellings total:
- Drury – 9,500 dwellings
- Paerata – 6,500 dwellings
- Pukekohe – 7,600 dwellings
- Takanini – 4,500 dwellings
- Karaka – 10,800 dwellings

Drury, Paerata and Pukekohe – 23,600 dwellings
Total - 38,900 dwellings
NZ Transport Agency Info

Changed estimated growth, 2015-2017, has raised the need to bring various Auckland plans forward by 4 years.

Our NRLTIP, (Jan 2018)
Reflects 2.2m population estimate by 2036/37.
ie we currently have consistent growth assumptions

<table>
<thead>
<tr>
<th></th>
<th>NDHB</th>
<th>WDHB</th>
<th>ADHB</th>
<th>CMH</th>
<th>Northern Region</th>
<th>NZ</th>
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<td>Total population '000s 16/17</td>
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<td>599</td>
<td>515</td>
<td>540</td>
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<td>Projected population '000s 36/37</td>
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<td>804</td>
<td>697</td>
<td>694</td>
<td>2,390</td>
<td>5,719</td>
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<td>Population growth '000s</td>
<td>22</td>
<td>204</td>
<td>182</td>
<td>154</td>
<td>562</td>
<td>982</td>
</tr>
<tr>
<td>% change</td>
<td>13%</td>
<td>34%</td>
<td>35%</td>
<td>28%</td>
<td>31%</td>
<td>21%</td>
</tr>
</tbody>
</table>
Auckland Plans – Other Plans - ‘Structural Plans ‘
Structural plans are Council future ‘land use’ plans. These are being finalised now (public consultation closed in October)

LAND USE VISION FOR DRURY-OPĀHEKE
The 2018 vision for Drury-Opāheke is set out in Auckland Council’s Drury-Opāheke Draft Land Use Plan below:

LAND USE VISION FOR PUKEKOHE-PAERATA
The 2018 vision for Pukekohe-Paerata is set out in Auckland Council’s Pukekohe-Paerata Draft Land Use Plan below:
Transport Plans – Issues
Key current bottleneck areas

With Manukau and Auckland Airport being key employment centres, SH1 / SH20 interchange is a **bottleneck** in the existing network.

SH1 north of Drury interchange has heavy congestion throughout the day. All traffic from Pukekohe, Drury and south of Auckland goes through this point.
Transport Plans – Issues
SH1 average travel time, and variability, between Pokeno and Manukau has been increasing over recent years; This is a significant access issue.

Travel time along SH1 south has deteriorated over the years – the current average travel time northbound is equivalent to 2012’s worst case travel time, and can take more than an hour to travel from Pokeno to Manukau — i.e. deteriorating accessibility.

Source: TomTom Journey Times
Auckland Plans
Transport developments in South Auckland

Transport : ATAP Update.
(Auckland Transport Alignment Project)

Rapid Transit:
Committed
• City Rail
• Additional electric trains
• Light Rail - City airport

New projects
• Airport Puhinui bus improvements
• Pukekohe electrification, 3rd main, other rail upgrades
• More electric trains

Strategic Road Projects
New
• Southern Motorway widening
  Manukau - Papakura
• Mill Road (Phase one)
The Hamilton-Auckland corridor plan

Emerging direction as on 8 October 2018

...2. with significant long term development potential...

The Papakura-Pokeno string of rail facing towns has feasible development capacity in next 20 years in the range of 40-50k that could be potentially accelerated in areas such as Drury West, Drury and Pokeno. Some of the short, medium and longer term potential is subject to the natural constraints and infrastructure capacity issues being addressed.

The River Towns all have potential and key opportunities for community-led revitalisation and targeted growth subject to various natural constraints and infrastructure capacity issues being addressed.

The emerging metropolitan area from Ngaruawahia to Cambridge and Hamilton airport has significant feasible development capacity (still being calculated) that could potentially be accelerated in areas such as Rotokauri, Ruakura, Peacocke, Hamilton South and Hamilton CBD. Some of the longer term potential is subject to infrastructure capacity issues being addressed e.g. Hamilton south, and north west/north east Hamilton.

08/10/2018

NOT GOVERNMENT POLICY OR THE VIEW OR POSITION OF ANY ONE ORGANISATION OR AGENCY
The Hamilton-Auckland corridor plan

Emerging direction as on 8 October 2018

... 3. but also enduring limits to growth and with immediate needs.
The Hamilton-Auckland corridor plan
Emerging direction as on 8 October 2018

4. Successful development will require investment...
The Hamilton-Auckland corridor plan

**Emerging direction as on 8 October 2018**

6. The emerging five-part corridor development strategy

An analysis of the corridor’s assets, constraints, opportunities, needs and requirements generate five possible focus areas:

**ONE**

**THE PAPAKURA-POKENO CORRIDOR**

Support and unlock the significant residential and employment development potential of this string of well-defined, rail-linked settlements through integrated growth management and key transformational projects.

**TWO**

**THE RIVER COMMUNITIES**

Support community and mana whenua-led revitalisation and targeted growth that will realise the full value of the natural, transport, marae and recreational networks that braid the area together as an asset for its people and many others who can visit and travel through.

**THREE**

**THE HAMILTON-WAIKATO METRO AREA**

Support and unlock the residential and employment development potential of this fast-developing metropolitan area through joint planning, integrated growth management and key transformational projects.

**FOUR**

**STRONGER CORRIDOR CONNECTIONS**

Support the realisation of the above three area-based strategic directions with improved transport, green open space and recreational networks along the entire corridor.

**FIVE**

**NEW TOOLS AND OPTIONS TO UNLOCK THE FULL POTENTIAL**

Supporting the realisation of full development potential in the above three areas through new housing, social and network infrastructure planning, funding and financings tools and options for local authorities, iwi, central government, developers and land owners.
**Hamilton Auckland Corridor – October messages**

Some of the key antecedents and key opportunities to influence

<table>
<thead>
<tr>
<th>NEW: Government’s Urban Growth Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN PROGRESS:</strong> Tools and opportunities to accelerate pace and scale, including KiwiBuild, Urban Development Agenda, and funding &amp; financing of infrastructure</td>
</tr>
<tr>
<td><strong>IN PROGRESS:</strong> national policies to increase protection of highly productive soils; promote urban intensification; more transit orientated development; transition to low carbon economy; greater access to employment, services</td>
</tr>
<tr>
<td><strong>NEARING COMPLETION</strong> Southern Motorway widening and Waikato Expressway</td>
</tr>
<tr>
<td><strong>IN PROGRESS</strong> investment planning for rail freight and rail passenger services and infrastructure; <strong>interim rail business case</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPLETED: Auckland Development Strategy</th>
<th><strong>IN PROGRESS:</strong> Waikato FutureProof Development Strategy review</th>
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<tbody>
<tr>
<td><strong>Includes</strong> Capacity Assessment under the National Policy Statement on Urban Development Capacity</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>IN PROGRESS: Supporting Growth transport planning in southern part of Auckland</th>
<th><strong>IN PROGRESS:</strong> Hamilton-Waikato metro area mass transit plan</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>IN PROGRESS: Structure planning for Drury-Opaheke, Paerata-Pukekohe; Papakura town centre planning</th>
<th><strong>IN PROGRESS:</strong> Blueprints and Plan reviews for Tuakau Pokeno, Meremere, Huntly, Ngaruawahia</th>
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</thead>
<tbody>
<tr>
<td><strong>IN PROGRESS:</strong> Hamilton growth strategy</td>
<td><strong>TO BE REVIEWED:</strong> Cambridge west planning</td>
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<tr>
<td><strong>NEW:</strong> Three waters solutions review</td>
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<tr>
<th><strong>KEY INFLUENCE:</strong> River restoration strategies</th>
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| IN PROGRESS: location of new regional hospital |
Hamilton Auckland Corridor Plan - Project Timelines

- By end October 2018 – First Draft of the Corridor Plan 20 proposed projects and partnership design
- November more workshops on each of the proposed areas of focus;
- By December 2018 A first spatial plan for the Corridor that sets out 20 or so priority transformational projects
- By March 2019 Establishment of a new and enduring growth management partnership
Health Service Planning in A2H Corridor
Counties-Waikato DHB boundaries & Socio-economic Deprivation and North Waikato District Council Northern Boundary
Cross Boundary Enrolments
CMDHB resident and enrolled in Waikato General Practice = 784 with 45% 2 practices
Waikato DHB resident and enrolled in CMDHB General Practice = 2,538 with 52 practices having at least 10 enrolled
Pharmacies & Palliative/Hospices

Franklin Hospice – Pukekohe
- Services Franklin Locality – approx. 70,000
- Community based service
- 7 day a week telephone cover
- IPU – 2 bed Pukekohe hospital
- Limited access to specialist SMO palliative advice

Totara Hospice – Manurewa
- Services majority of CMDHB
- IPU
- access to specialist SMO palliative advice
- Multi-disciplinary specialist

MMH Palliative I/P service
Aged Residential Care Facilities

Funded by Northern Region DHBs.
Radius of circle represents bed capacity
(per DHBSS qtrly survey)
After Hours Urgent Care

Note: For full details on the after-hours clinics listed above, please visit countiesmanukau.health.nz.
A Vision for the Future
Delivering care through an integrated, collaborative, patient centred web of primary, community and hospital based healthcare settings

- In the future we will adopt a new model of care where all service providers, DHB owned or otherwise, are ‘nodes’ within a more integrated Regional health system.

- These nodes include all components of the health delivery system such as patient self-care, primary and community care, private and NGO services and DHB hospital, public health and community services.

- Boundaries between care settings will become increasingly blurred with the focus being on providing care in the most appropriate setting. Increasing collaboration with other care providers, will improve the overall health of our population, increase access to care and reduce inequities.

- We will identify what services should be centralised and what services can be localised to improve quality, safety and outcomes of care.

- Our delivery mechanisms will still be sensitive to the requirements of our populations and local needs.
Metro Auckland - Geospatial
Heatmap view of where additional bed demand arises between 2016/17 and 2036/37

- Population growth, combined with current patterns of service demand by demographic group, can be used to forecast demand ‘hot-spots’.
- The ‘hot-spots’ highlight those areas and locations that will particularly generate additional demand for health services in future
- The mesh blocks vary in size, so care must be taken interpreting red areas.
Potential Impact of Demand from North Waikato

Locating a facility south of Manukau City could generate demand for 40 beds from North Waikato

The attractiveness of Northern Region facilities to Waikato residents will be influenced by the location of any new services developed south of Manukau City

Based on proximity, the areas in North Waikato with residents who may access Northern Region services (mainly those of CMH) are highlighted on the map:
- Red are relatively closer to Pokeno/Drury than Waikato Hospital/Thames Hospital
- Blue are still within reasonable travel time to Pokeno/Drury but cover large geospatial areas (meaning some residents may find it easier to travel to Hamilton)

The likely additional demand for inpatient beds arising in the Waikato equates to 40 beds (red) or 60 beds (across both red and blue areas), covering a population of 26,000 people in twenty years’ time

<table>
<thead>
<tr>
<th>Area Unit Name</th>
<th>Beds</th>
<th>Population</th>
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<tbody>
<tr>
<td>Meremere</td>
<td>1</td>
<td>500</td>
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<tr>
<td>Maramarua</td>
<td>2</td>
<td>1,103</td>
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<tr>
<td>Te Kauwhata</td>
<td>5</td>
<td>1,979</td>
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<td>Waerenga</td>
<td>4</td>
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<td>Whitiwhiti</td>
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<tr>
<td>Te Akau</td>
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<td>989</td>
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<td></td>
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<td>Area Unit Name</td>
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<td>6</td>
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<td>Huntly West</td>
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<td>39</td>
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<td>21,223</td>
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Preferred Investment Path
Concurrently to: remediate current infrastructure; future proof to our medium growth scenario (existing and new sites); invest to support model of care changes

Developing hospital capacity

Following the preferred path will ensure the resilience of our current facilities and develop new acute capacity while also allowing investment in our necessary population health initiatives, community and primary care, workforce sustainability and IS/IT.

- We will remediate, reconfigure and expand our current sites, particularly in the short term to meet anticipated demand.
- We will rapidly grow Waitakere Hospital to meet the needs of West Auckland and decongest both North Shore and Auckland City Hospitals.
- We will build a new 350-400 bed acute site south of Metro Auckland within the next 20 years.
- We will land bank north of Metro Auckland to ensure the sustainable delivery of healthcare in the Region beyond the duration of the LTIP.

Accelerating model of care changes

By only investing in our current sites and one additional new acute site we will be able invest remaining capital in accelerating model of care changes to improve regional population health.

‘Accelerating-change’ related investments will include:

- Public health interventions, patient activation and proactive care
- Developing our primary and community care settings and hubs to enable patients to be supported outside of hospital settings
- Strengthening of our workforce, ensuring they have the capacity and capability required to deliver on our population health strategy
- Modernising our IS/IT systems to enable interoperability and communication across all sectors of the health system
Alignment of DHB Plans with the NRLTIP ‘Target’ Capacity Plan

We still have challenges in the short term, and need to consider how we can bring some capacity development forward in our capex plan.

The current DHB phasing:

- To year 2023/24, leaves the Region with a capacity shortage against the modelled capacity requirement. The gap is about 125 beds in 2019/20.

- Over period from 2024/5 to 2032/33, provides surplus capacity against the plus 1,600 bed moderated NRLTIP target. This surplus is about 250 beds at its peak.

Endorsement to progress planning for a new South Site, with capacity available from year 2026, would likely impact on aspects of DHB current site development plans. This would likely reduce the potential surplus indicated 2027-2030.
Community hubs as part of the health service delivery network

- NRLTIP’s delivery model describes delivering care through an integrated, collaborative network of primary, community and hospital based healthcare settings where the patient is put at the centre of our wider healthcare system.

- Community Hub development progressing since 2015 (Sapere Report: Counties Manukau Health Master Localities Service Plan)

- Intention hubs will operate as part of a broader health service delivery network connecting general practice, community care, specialist services, Middlemore Hospital and Manukau Super Clinic.

- Hubs will operate as integrated units not constrained by existing organisational boundaries and will develop new models of care across professional and organisational boundaries.

- Provide a ‘neutral space’- non-enrolling local population.

- Access resources to keep people well, support from other services such as work and income, housing and other agencies.

- Hub strategy will be different in each Locality based on local population need, pre-existing local service models, service mobility needs, operating models, existing ownership models of facilities/buildings and optimal service location.
Community hubs as part of the health service delivery network

**Key Drivers:**

- Growing and ageing population in all localities
- Delivering services closer to home/improving access to local services (for youth health, elder services, MH etc.)
- More services provided in the Locality to reduce demand on ED, Manukau Super Clinic and Middlemore Hospital (bend the demand curve)
- Support from the community
- Leveraging Locality capability that already exists on Community Hub sites e.g. urgent care clinics, radiology, pharmacy, Labs, therapies, private specialists and PHO services
- Capacity – land and buildings available for expansion and reconfiguration to support integration and maximise utilisation.

**Original proposed Core suite of services (to be reviewed):**

- Diagnostics – e.g. Radiology/Phlebotomy/ECG/Spirometry
- Short-term observation beds
- Oncology infusion services using nurse-led models of care in line with the Northern Regional cancer strategic framework
- A base for the Community Health and Mental Health ILOC teams
- Space to deliver health prevention/health literacy approaches.
- Outpatients
Considerations

- Need to plan for new hospital in the South
- Services located in the Hospital in the South will have impact on provision of services in nearby hubs
- Provision and location of primary/community care services (GP/pharmacy/radiology etc.) to a scale required and in the right place
- Stepped approach to growth of primary/community/palliative services as population grows
- Growth of private providers in area
- Need to plan service provision agnostic of DHB boundaries (Waikato DHB & CMDHB)

*Fantastic opportunity!*
Counties Manukau Health
Auckland Regional Public Health Service Briefing

Recommendation

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

1. Receive this update from Auckland Regional Public Health Service on key pieces of work that are underway and/or completed since our last update.

Prepared and submitted by Jane McEntee, General Manager, Auckland Regional Public Health Service (ARPHS)

Purpose

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

1. Communicable disease outbreak management.
2. Ill traveller notification
3. Updated Tuberculosis (TB) Guidelines
4. BCG Programme restart and demand
5. Notice of aerial 1080 drop in Hunua Ranges
6. Hamilton - Auckland Corridor design workshop
7. Safeswim awards
8. Drinking water
9. Exit strategy for small water self-supplies work
10. Community water fluoridation position statement
11. Wai Auckland (an obesity prevention initiative which will support improved oral health).
12. Smokefree
13. Alcohol presentation
14. Healthy Auckland Together (HAT)
15. Submissions

1. Communicable Disease Outbreak Management

1.1 Mumps Outbreak Update

ARPHS is continuing to manage the mumps outbreak in the Auckland region that began in January 2017, although new mumps case notifications have slowed significantly over the last four months, with an average of one-three cases per week. ARPHS is monitoring notifications and providing advice as needed. To 30 September 2018, 1323 confirmed and probable mumps cases have been notified to ARPHS since the outbreak began.

1.2 Dengue Fever

Towards the end of 2017 and beginning of 2018 ARPHS received an increase in dengue fever notifications. As part of our response ARPHS developed an information sheet for people travelling to the Pacific Islands providing advice on how to avoid mosquito bites. ARPHS communications team is developing a plan on how to communicate these messages more widely and for this resource to be translated. The current information can be found on the ARPHS website: http://www.arphs.govt.nz/health-information/communicable-disease/dengue-fever-zika-chikungunya
1.3 Enteric Diseases – Gastroenteritis Outbreak

ARPHS has been involved in the investigation and management of a number of gastroenteritis outbreaks at residential care and other institutions in the six months from April to September 2018. As is the case with other years the main cause was most often determined to be norovirus, a known source for widespread institutional outbreaks that can be difficult to control due to its virulence.

While most outbreaks involved less than ten people ARPHS has been involved with a small number of larger outbreaks, including a large outbreak at a single aged-care facility where close to 100 staff and residents were affected, a private hospital facility with 80 cases, and a school campus where 75 children were symptomatic.

Following notification of these outbreaks, ARPHS undertakes the following actions:

- a triage response including a risk assessment based on outbreak details;
- immediate prevention advice;
- working closely with the residential care or institution to support control of the outbreak;
- daily surveillance of the outbreak;
- conducting site audit assessments if required to ensure compliance with the institution’s illness policy or relevant outbreak management protocols.

To support some enteric disease investigations, rather than face-to-face interviews, when appropriate, ARPHS is now using a web-based data collection tool. This will improve the efficiency of capturing information on exposures to risk factors associated with development of enteric illnesses. This information is supporting timely public health action.

1.4 Meningococcal Disease

ARPHS worked closely with St Johns Ambulance Services, providing public health management and support following the death of a 16 year old male in Auckland City Hospital on 20 October 2018 due to confirmed meningococcal disease.

The young person involved resided in a region outside of Auckland where he may have been exposed to meningococcal bacteria. He became unwell while at a youth cadet camp on Motutapu Island, therefore ARPHS staff were sent to provide antibiotics, health education and support to those who were also attending the camp. The incident generated a lot of media interest with ARPHS responding to multiple media inquiries.

There has been a random cluster of 8 cases of meningococcal disease over the last four weeks in the Auckland region, however, no outbreak has been identified. There has been an observed increase in non B meningococcal disease nationally and in the Auckland region, which is being monitored by the Ministry of Health.

2. Ill Traveller Notification

Medical Officers of Health are responsible for granting or withholding pratique in ill traveller events. On 9 September, ARPHS was notified of a potential ill traveller event where 100 passengers on an international flight from Australia were reported unwell by the airline. There was a high level of concern because the potentially symptomatic passengers were reportedly returning from Saudi Arabia, where a serious infectious disease MERS (Middle East Respiratory Syndrome) is circulating.
Pratique was withheld while St John Ambulance staff screened all the passengers on board the plane to identify unwell passengers and assess whether further medical treatment was required. No passengers were identified as seriously unwell and all passengers were allowed to disembark and leave the airport without further medical treatment.

ARPHS worked closely with St John Ambulance and Auckland International Airport to ensure that the event was managed as efficiently as possible, with the entire response completed within two and a half hours.

An internal and external debrief has been conducted to review the response. The external debrief included all key stakeholders from Auckland Airport. Recommendations will be developed as part of this process.

3. Updated Tuberculosis (TB) Guidelines

New Zealand has previously adopted the World Health Organisation’s End TB Strategy, which sets global targets to eliminate TB as a public health problem by 2035. This includes:

- a 95% reduction in the number of TB deaths compared with 2015;
- a 90% reduction in the TB incidence rate compared with 2015; and
- zero TB-affected families facing catastrophic costs due to TB.

The global strategy emphasises the need for all countries, including low-incidence countries like New Zealand, to progress towards pre-elimination (< 10 cases per million) and eventually elimination.

The Ministry of Health has reviewed and redrafted the New Zealand TB guidelines to align them with the priority action set by the WHO. ARPHS coordinated discussions with key clinicians working in TB control including ID services, TB Respiratory and Microbiology within the Auckland and Northland regions. Feedback was collated and a coordinated regional response to the draft guidelines was sent to the Ministry.

4. BCG Programme Restart and Demand

The Bacille Calmette Guerin (BCG) programme is free to eligible at risk children under five years to protect them from tuberculosis. Due to an international vaccine shortage, there has been a two year break. The programme re-commenced in August 2018. The demand for the vaccine has exceeded expectations. Over August and September 50 clinics have been run across the three DHB regions, vaccinating around 1100 children. Around 1600 children are waiting for clinic appointments and additional clinics have been set up to help manage the workload.

5. Notice of Aerial 1080 Drop in Hunua Ranges

Sodium fluoroacetate (1080) is regulated as a Vertebrate Toxic Agent (VTA). VTAs are used for protection of native animals and forests against introduced pest animals, control of bovine tuberculosis, rodent control in rural and urban environments and control of rooks and invasive introduced fish species.
The Environmental Protection Agency has delegated the function of assessing and granting permissions for the use of selected VTAs (including 1080) under the Hazard Substances and New Organisms Act (HSNO) to Medical Officers of Health and Health Protection Officers who are also warranted HSNO enforcement officers. The delegation includes authority to add, delete or otherwise varying any condition of a permission; and to revoke a permission.

In 2015 ARPHS assessed and audited the first application of aerial 1080 operation in Auckland in a decade. The operation covered the Hunua Ranges and some private lands in the surrounding area with property owners’ consent. Auckland Council anticipated that pest numbers (rats, possums, stoats) would need to be addressed on a three- five yearly basis with repeating operations.

The application for the second operation was received on 16 July and a final permit condition was issued by ARPHS on 27 August following a full risk assessment. In September, the aerial 1080 operation was challenged in the Environment Court due to concerns raised by Friends of Sherwood Trust and the Ngati Paoa Trust about the perceived public health risk of the operation to contaminate Auckland’s southern drinking water reservoirs. A temporary injunction was sought by and issued on 6 September by the Environment Court.

An interim hearing was subsequently held on 13 September 2018. Judge Smith, who issued the temporary injunction, asked that ARPHS submit an affidavit and attend the hearing as a ‘friend of the court’.

On 21 September, the Court made the decision to allow the operation. In its decision document, the Court provided analysis of the material before it, including reviewing the evidence about the HSNO approval. It was favourable in its findings in respect of the proposal and the permit conditions, which reflected well on the ARPHS’ processes. The Court had a clear understating of the evidence presented by ARPHS as to how the risk assessment and permit conditions work to protect the water supply.

On 22 September, subsequent to the court decision, Auckland Council proceeded with the 1080 aerial application in the Hunua Ranges. ARPHS has conducted an operational audit in accordance with permit conditions.

6. Hamilton - Auckland Corridor Design Workshop

ARPHS participated in the Hamilton – Auckland Corridor design workshop held in Tuakau on 27 August, organised by NZTA. The objectives of the workshop were to identify key elements in the corridor relevant to a variety of disciplines represented by participants and come up with some key opportunities/initiatives for the corridor. At the workshop ARPHS advocated for the inclusion of a wellbeing/health impact assessment of preferred corridor options, to give decision makers the ability to consider population health implications as part of their decision making. An update from the NZTA project team on the inclusion of a health impact/wellbeing assessment and options for the corridor is yet to be provided.

7. Safeswim Awards

From February to November 2017, Auckland Council (the lead agency) worked in partnership with ARPHS and Surf Life Saving Northern Region to upgrade their Safeswim programme. The aim of the programme was to provide accurate predictive information about swimming conditions in the region. In response, Council is focusing on mitigating pollution sources.
In July 2018 Safeswim was the winner in the Smart Water Category of the Smart Cities Asia Pacific Awards. With respect to the award, IDC Market Analyst Jefferson King says, "What stood out about the Safeswim project was the high level of collaboration between the different organisations and the increased accuracy it delivers. The positive outcomes of the project itself are clear, helping locals make better informed decisions regarding swimming safety."

Additional accolades were received from the 2018 TVNZ-NZ Marketing Awards (Public Sector award) and Surf Life Saving Northern Region (SLSNR) Awards of Excellence judged the programme to be ‘Innovation of the Year’.

8. **Drinking Water**

An annual audit was conducted by IANZ in September and ARPHS were re-accredited as a Drinking Water Assessment Unit (DWAU). Additionally, three ARPHS Drinking Water Assessors were audited and have received new, three year, individual IANZ accreditations.

9. **Exit Strategy for Small Water Self-Supplies Work**

ARPHS has previously been involved with reviewing the water quality test results from specified self-supplies each year. This information has then been included in the Ministry of Health’s annual drinking water survey, which is used to monitor the quality of drinking water around the country.

From 1 July 2018 ARPHS discontinued this work following a request from the Ministry of Health that Public Health Units no longer be involved with specified self-supplies of drinking water.

This work will now be done by Auckland Council. ARPHS is in the process of providing handover training to compliance officers in Auckland Council to ensure efficient and consistent continuation of the work.

10. **Community Water Fluoridation Position Statement**

ARPHS is leading the development of a DHB position statement on community water fluoridation, to provide a regional statement for the three Auckland DHBs. The draft position statement has been included on the agenda for this meeting as an item for consideration before going to each of the Boards for approval. The position statement will provide transparency on the DHB’s position on community water fluoridation ahead of the possible transfer of decision-making on fluoridation from local government to DHBs. Northland DHB has an existing position statement which they have shared to inform this work.

11. **Wai Auckland**

Work has commenced on the “Wai Auckland” programme aimed to displace sugar sweetened beverages with tap water. The programme includes the DHBs, ARPHS, Auckland Council, Auckland Transport and Watercare. This programme will include increased access to public drinking water fountains. The Project Manager for Wai Auckland has recently been appointed. A consumer research stocktake has also been completed to inform whether additional consumer research should be undertaken. Wai met with Coca-Cola Oceania and
Coca-Cola Amatil NZ who shared baseline water consumption data and related consumer insights to support the monitoring of Wai Auckland.

12. Smokefree

The ARPHS Health Improvement Team shared their preliminary findings from a study on Auckland Tobacco Retailers in a letter to the editor of the New Zealand Medical Journal on 21 September 2018. The article was published following the Director-General of Health’s Report on the state of Public Health and other recent publications that had sparked interesting debates in the media about reducing tobacco retailers.

In the study, 19 dairy owners were randomly selected from six local boards in Auckland. The letter focussed on the retailers support of Government taking action to reduce the availability of tobacco, and suggested that a voluntary approach wouldn’t be sufficient. The letter received media attention with coverage in Stuff, National radio, radionz.co.nz and NewstalkZB.

ARPHS Smokefree Compliance Officers recently ran 96 controlled purchase operations (CPO’s) over the October school holidays. The CPO’s were conducted in:

- Manurewa 27
- Papakura 25
- Otahuhu 25
- Glen Innes 13
- Panmure 3
- Mt Wellington 3

The CPOs resulted in a total of eight sales of tobacco to minors. Of these eight sales, three were in Manurewa, three in Papakura, one in Otahuhu and one in Glenn Innes. Four of the non-compliant retailers were petrol stations and four were dairies, and all eight of these retailers were issued with infringement notices by the Ministry of Health. Following these sales, ARPHS makes a recommendation to the Ministry. Infringements ($500 per individual seller) are issued by the Ministry. ARPHS is considering potential future projects to reduce the availability of tobacco and address non-compliance on a larger scale.

13. Alcohol Presentation

ARPHS presented at the seventh Alcohol Action NZ annual conference (co-hosted by Massey University’s SHORE & Whariki Research Centre) at Te Papa, Wellington, on ‘Who should pay for all the harm from alcohol?’ Dr Julia Peters and Jessica Bowers were keynote speakers exploring the range of alcohol-related harms in New Zealand.

The presentation ‘Harm from alcohol – Impact on the health sector’ explored:

- the wide-ranging impacts of alcohol use;
- the stress that the health system is under;
- some key health information (including that alcohol use is the risk factor that creates the single largest health loss in New Zealand for 15-49 year olds);
- the high proportion of DHBs with evidence-based position statements relating to alcohol; and
- suggestions for ways forward, including implementing recommendations from the Law Commission Report.
Media coverage of the conference centred mostly on BERL’s (Business and Economic Research Limited) estimation of alcohol-related harm costing New Zealand $7.85 billion per year.

CM Health staff from the Alcohol Harm Minimisation programme were also present at this conference.

14. Healthy Auckland Together (HAT)
Healthy Auckland Together is a coalition of 27 partners committed to making it easier for Aucklanders to eat better, be physically active and maintain a healthy weight. HAT partners include health entities, local government, iwi-based organisations and non-governmental organisations. The Auckland Dental Association and the Diabetes Project Trust have recently joined as HAT partners.
During April to October 2018 HAT has undertaken the following:

14.1 Marketing to Children
Representatives of HAT met with McDonalds senior executive members to discuss their policy on marketing to children following HAT’s complaint to the Advertising Standards Authority (ASA). Following the meeting McDonalds NZ has removed the happymeal.co.nz site which included games for children. They have also removed an advertisement in Manurewa that targeted children (“I want a Cheese Burger Daddy”). HAT’s marketing to children project work has been highlighted as successful in changing industry practices. At a University of Otago symposium in September, Simon Kenny, McDonald’s communications manager, publicly acknowledged that HAT has been strongly influential in McDonalds’ reconsidering their advertising approaches.

In collaboration with HAT partners, key messages were developed for a novel and engaging communication tool to raise awareness and stimulate public discourse on the issue of unhealthy food marketing to children. The resulting graphic comic will be disseminated widely through HAT partners and social media channels.

A communications tool has been developed that supports organisations and communities to make complaints to the Advertising Standards Authority (ASA). This tool will accompany the release of a Marketing to Children Snapshot written by Dr Louise Signal of the University of Otago. HAT partially funded the update which will be published by Activity and Nutrition Aotearoa (ANA) and distributed through their networks.

A complaint about a Kinder Surprise advertisement has been submitted to ASA and has been accepted by the Chairman to go before the Complaints Board.

14.2 2018 Monitoring Report
The 2018 Monitoring Report (for the 17/18 period) was released in June and received extensive coverage including the front page of the NZ Herald, with a strong media focus on environmental issues and inequities. A research event is being held in late October. This event will be the springboard for a research platform to bring together researchers and HAT partners working on the translation of research and evaluation into practice.
14.3 **Food and Drink Policy**

The healthy events work continues in partnership with Auckland Council and Healthy Families Waitakere. A healthy food and drink workshop for Diwali stallholders was held with The Chip Group and Procare and was attended by nine stallholders and two Auckland Tourism, Events and Economic Development (ATEED) event organisers. The stalls at the Festival were audited and prizes awarded to the three healthiest stalls. A $15,000 grant was received from HAT partners, the Health Protection Agency, to develop stall holder information for healthy food and drinks at these Auckland Council events.

HAT attended a meeting with Frucor and ATEED about the possibility of an exclusive beverage supplier contract for ATEED and Auckland Council events. It was agreed that negotiations would align with the healthy food and drink work being done at these events.

HAT has provided public health input for an Auckland Transport vending procurement (100 machines across Auckland) and achieved agreement on vending proposals that align with Auckland Council food and drink guidelines. HAT was pleased with an agreement that there will be 45-50% water in all beverage vending.

HAT staff met with Coca-Cola Oceania and Coca-Cola Amatil NZ about what they are doing to reduce the sugar content of drinks and marketing to children. As a result, the organisations have committed to change the imagery on children’s juice bottles from the current cartoon imagery.

14.4 **Auckland Conversation on Healthy Streets**

On Thursday 2 August, Dr Michael Hale, ARPHS Urban Planning and Healthy Environments and HAT portfolio lead, was a panellist on Auckland Council’s Auckland Conversation on Healthy Streets. Dr Hale answered questions alongside UK expert Lucy Saunders, who has developed the Healthy Streets indicators, councillor Richard Hills and Auckland Transport CE Shane Ellison, on making Auckland easier to walk around and improving health gains for everyone. The Conversation was videoed and can be viewed on [https://conversations.aucklandcouncil.govt.nz/events/healthy-streets-auckland](https://conversations.aucklandcouncil.govt.nz/events/healthy-streets-auckland).

The evening was also a chance for HAT staff members to engage with stakeholders at the HAT stand, share HAT's work and the 2018 HAT monitoring report. Maps showing our Walkability Access To Destinations (WADE) Index data for Auckland encouraged some useful conversations on what needs to be done to get people out of their cars. Auckland Council is investigating using the WADE walkability tool to monitor changes in the environment at the local board level.

Dr Julia Peters and Dr Michael Hale are members of Auckland Transport’s Road Safety Leadership and Working Groups providing public health input.

15. **Submissions**

ARPHS has completed and submitted ten formal submissions between April and October 2018.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>25 June</td>
<td>Proposal for reducing the Health Act notifiable blood lead level for lead absorption</td>
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<td>ARPHS supported the proposal to reduce the notifiable level for non-occupational</td>
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<td>6 July</td>
<td>Heat Health Plan</td>
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<td>The &quot;Heat Health Plan Guidelines&quot; provide information about the risks to health during periods of hot weather, and to encourage and support organisations to prepare and plan for hot weather events.</td>
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<td>ARPHS provided a background paper and position statement on heatwaves and public health. ARPHS sees value in a formal heatwave definition and warning system, ideally coordinated by a central agency.</td>
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<td>6 July</td>
<td>The Environmental Protection Authority’s proposed risk assessment methodology for hazardous substances</td>
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<td>Hazardous substances have inherent risks for human health. The guide is designed to improve transparency around how it assesses hazardous substances.</td>
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<td>Recommendations related to: aligning with internationally endorsed risk assessment methodology terminology, as well as ensuring that the risk assessment process is independent, relies on best practice methods, and accurately conveys health risk information.</td>
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<td>19 July</td>
<td>Zero Carbon Bill</td>
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<td>ARPHS has a number of priority work areas and statutory obligations relevant to climate change. Health Services are major end-users of carbon and energy intense products and services. ARPHS supported the introduction of a statutory long-term emission reduction target. There are significant implications of climate change on health and wellbeing.</td>
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<td>The following recommendations were included in the submission:</td>
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<td>• The establishment of a net zero target for 2050</td>
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<td>• Adequate safeguarding provisions to ensure viability of the legislation in the future</td>
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<td>• Emissions budgets need to take into account a significant number of co-benefits from a public health perspective and; the impact on lower socio-economic households.</td>
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<td>• Overall responsibility for preparing national climate risk assessments should reside with the government.</td>
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<td>• The establishment of a health sector Sustainable Development Unit (SDU) similar to that of the UK National Health Service (NHS), with links to the Climate Change Commission.</td>
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<td>1 August</td>
<td>Consumer credit law review</td>
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<td>ARPHS supported the intent of the consumer credit law review to provide greater protection from predatory and high-interest lending practices that create significant hardship for lower-income families and communities.</td>
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<td>1 August</td>
<td>Notice of Requirement by Auckland International Airport to alter the designations of the Auckland Unitary Plan – Operative in part, regarding the second runway.</td>
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<td>ARPHS provided a statement of evidence and attended the hearing on the Notice of Requirement by Auckland International Airport Limited to alter the designations 1100 and 1102 in the Auckland Unitary Plan – Operative in Part. These alterations relate to the provision of and operations of the second runway. The statement of evidence covered:</td>
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<td>• health effects of noise;</td>
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<td>• the request of an extension of the noise mitigation programme;</td>
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<td>• the removal of asbestos in the noise mitigation programme;</td>
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<td>• the noise mitigation fund;</td>
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<td>ambient air quality and aircraft emissions.</td>
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<tr>
<td>30 September</td>
<td><strong>Wellbeing Indicators</strong></td>
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<td>Statistics NZ is developing 'Indicators Aotearoa New Zealand' to track New Zealand’s progress using a well-being and sustainable development lens. The indicators will enable the government, councils, businesses, communities, and individuals to make choices around well-being and sustainability. The indicators are being built drawing on international best practice, tailored to New Zealand by including cultural and te ao Māori perspectives. ARPHS supported co-design of the indicators with Māori and ensuring the indicators are appropriate for our diverse population and are aligned with other important wellbeing work.</td>
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<td>16 October</td>
<td><strong>Health and Hygiene Bylaw 2013</strong></td>
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<td>The bylaw aims to minimise health risks to people using services that have contact with their bodies beauty and health treatments, tattoo, body piercing and swimming pools.) The proposed Bylaw aimed to better protect public health through expanding the services it covers and addressing enforcement. ARPHS supported most of the proposed changes and made additional recommendations in relation to sunbeds, swimming pools and spa pool hygiene, exercise equipment and sleep pods</td>
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<tr>
<td>21 October</td>
<td><strong>Healthy Homes Standards</strong></td>
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<td>The submission sets out the Auckland health sector’s strong, collective support for action to improve the quality of New Zealand’s rental housing through the introduction of the Healthy Homes Standards covering heating, insulation, ventilation, moisture ingress and drainage, and draught stopping. The Healthy Homes Guarantee Act (No 2) passed into law in December 2017, amending the Residential Tenancies Act 1986 and enabling the government to create regulations that set minimum standards to create warmer, drier rental homes (the healthy homes standards). The submission was signed by ARPHs, the Chief Executives of the three metro Auckland DHBs, the Chair of the Metro Auckland Clinical Governance Forum and the Chairs of the Alliance Leadership Teams.</td>
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<tr>
<td>21 October</td>
<td><strong>Reform of the Residential Tenancies Act 1986</strong></td>
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<td>The Government has signalled that changes are required in the provision and standards of housing in New Zealand to improve security for tenants. The lack of affordable housing options and the poor condition of some housing is having an inequitable effect on health. As part of these changes, the Government is proposing a targeted reform of the Residential Tenancies Act 1986. This Act governs the nature of the relationship between landlords and tenants. The objectives of the reforms include:</td>
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<td>• to improve security and stability for tenants while maintaining adequate protection of landlords’ interests</td>
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<td>• to ensure the appropriate balancing of the rights and responsibilities of tenants and landlords to promote good faith tenancy relationships and help renters feel more at home</td>
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<td>ARPHS’ Submission supports these proposals and focuses on improving security of tenure, increasing and enforcing the obligation of landlords to provide reasonable living conditions, strengthening tenant rights, addressing inequities and improving the quality of boarding houses.</td>
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</table>
Recommendation

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

Receive the Counties Manukau Health SUDI Prevention Plan 2018/19

Note the progress to date on the work plan for Sudden Unexpected Death in Infancy prevention

Prepared and submitted by: Tina Higgins, SUDI Prevention Project Manager and Christine McIntosh, SUDI Clinical Lead, on behalf of Carmel Ellis, General Manager Child Youth and Maternity

Glossary
CM – Counties Manukau
SUDI - Sudden Unexpected Death in Infancy
NZ – New Zealand
LMCs – Lead maternity Carers
AWHI – Auckland Wide Housing Initiative
NGO – Non Government Organisations
WCTO – Well Child Tamariki Ora

Purpose

Provide an overview and update of the Sudden Unexpected Death In Infancy (SUDI) programme within CM Health to the Community & Public Health Advisory Committee.

Executive Summary

Counties Manukau (CM) Health encompasses an area where there are existing SUDI prevention interventions. There has been a 29% reduction in SUDI in the CM Health area since the introduction of a Safe Sleep Programme in 2012, however, the rate remains higher than the national average (0.98 compared to 0.78 per 1000 live births; 2010-14 five-year annualised rate) and SUDI claims the lives of 8-10 babies living in CM Health area every year.\textsuperscript{1,2}

Continuing to address key modifiable risk factors to reduce the rate of SUDI is a critical target of SUDI prevention going forward and at its centre is the acknowledgement that all SUDI prevention initiatives must have an equity focus to reduce the disparity that exists in SUDI for infants of Māori and Pacific Islands ethnicities.

The highlights of the developing SUDI prevention work in CM Health are; the first weaving whaananga being held at Papakura Marae led by Donna Fane from Plunket and secondly, the Safe Sleep Calculator, a SUDI risk assessment tool, is being implemented as a universal screening tool for all babies in CM Health. The purpose of this is to identify the babies with the greatest need of SUDI protection so that their families can be provided with comprehensive, well communicated wrap around SUDI prevention care.
Background

New Zealand has one of the highest rates of SUDI deaths in developed nations with around 45 deaths per year. SUDI is the leading cause of post-neonatal mortality in New Zealand. There is considerable inequality in the burden of SUDI deaths in New Zealand with rates almost seven times higher for Māori infants and four times higher for Pacific infants and higher for infants living in socioeconomic deprivation.

Evidence from the National Mortality Collection data demonstrates that considerable impact has been made on SUDI rates over the last 30 years, in the 1980s SUDI rates in New Zealand were around 4.4 per 1000 live births, or 250 babies per year. Whereas in 2015, the national SUDI rate was 0.92 per 1000 live births, 44 babies.

However, despite this significant reduction, SUDI rates have not fallen equitably. Key disparities are evident:

- SUDI is more common amongst Māori babies, around 7x more than non-Māori, non-Pacific babies.
- SUDI is more common amongst Pacific babies, around 4x more than non-Māori, non-Pacific babies.
- SUDI is much more common among babies of mothers under 25.
- SUDI is more prevalent in deprived areas, 75% of cases of SUDI between 2002-2015 were in locations which fall into decile 7-10 of the NZ Deprivation Index.

Continuing to address key modifiable risk factors to reduce the rate of SUDI amongst all populations is a critical target of SUDI prevention going forward.

Risk factors

- Infant sleeping position – side or prone (tummy) sleeping
- Bed Sharing
- Maternal smoking in pregnancy and postnatal
- Paternal smoking
- Young maternal age
- Maternal alcohol & drug use in pregnancy and postnatal
- Premature birth
- Low birthweight

Off-setting some of the modifiable risks are a range of protective factors including breastfeeding, immunisation, infant back sleeping and baby being in their own bed.

Progress to date on the workplan

CM Health has an established and evolving SUDI prevention programme with a remit dedicated to improving the health outcomes for both Māori and Pacific infants.

Collaborative working with the Northern region DHBs has been a strong focus this year to ensure consistancy of planning, messaging and sharing of innovative initiatives. Additional to a regional approach has been engagement with the new National SUDI coordination service provided by Hāpai te Hauora.

Within CM Health there are a number of initiatives taking place to effectively reduce the incidence of SUDI; the following provides an overview of our current status to date:
Safe Sleep programme

1. Ongoing provision of safe sleep beds (pepi-pods & wahakura) to those infants identified at risk; currently CM Health is receiving 100 – 125 pepi-pods per month and ~15 wahakura. Safe sleep beds are available at all three birthing units (Botany, Papakura & Pukekohe), maternity wards, with community midwives, Lead Maternity Carers (LMC’s), Neonatal Care, Kidz First Homecare & Well Child Tamariki Ora Providers.
2. Safe Sleep Policy, Modelling & Audit continue to be adhered to following the regional Safe Sleep Policy and the CM Health Safe Sleep for Babies guidelines. Safe Sleep Modelling and weekly audits continues to take place within the DHB across the maternity wards, KidzFirst Surgical, Medical & Neonatal Care unit as well as the three birthing units.
3. Workforce development – we continue to promote SUDI education via Hāpai te Hauora as well as face to face education and promotion both for DHB staff and community/NGO providers.
4. Smokefree incentivisation continues for pregnant women, postnatal women and whaanau. A recently trialled opt-out system has been successful for the community midwife team which saw referrals and engagement double. This has now been rolled out into the practice of LMCs and Plunket staff.
5. Breastfeeding service providers continue to be well utilised and supported by midwives, LMCs, WCTO and NGO/community organisations.
6. Relationship building with the WCTO providers, Oranga Tamariki, Family Success Matters, the Alcohol Minimisation programme, Maternal Mental Health and Auckland Wide Housing Initiative (AWHI) continue to be forged.
7. Ascertaining consumer feedback has been sought around SUDI/Safe sleep knowledge and practices, ‘next bed’ preferences and thoughts around the use of a risk assessment tool (Safe Sleep Calculator - as mentioned below in ‘developing initiatives’). Several focus groups have taken place, currently awaiting the final report to better inform around these areas.
8. Updating resources to reinforce consistent messaging, participating in promotional events within community settings and ensuring community engagement are all ongoing activities.

Developing Initiatives

9. Weaving wahakura programme -
   o A Whanau Ora – Raranga Wahakura pilot has recently taken place in the Papakura community with 13 participating āpuu mama & whaanau. This was a five week project immersed in Māori tikanga culminating in the weaving of a wahakura. An evaluation is currently being completed which will inform around progressing this style of weaving programme into the near future.
   o A two day weaving wahakura pilot will also be progressed to start early next year; this will provide an option of a more condensed version of the above but maintaining the integrity of Māori tikanga and health messages.

10. Next Bed Options –
    o For some families the pepi-pod or wahakura are too small, and not all families find these options appropriate when a bassinet or cot may be a preferable. The need for a safe ‘next bed’ for the period up to the age of 1 year has been identified and will be regionally progressed.

11. Wrap Around Care support for babies & whaanau at increased risk of SUDI -
    o Crown funding agreement has acknowledged that for babies at greater risk of SUDI, support to whaanau via a wrap around care model would be most effective. In CM Health this will not just be limited to the provision of a safe sleep bed and referral to smokefree services but how we can engage and facilitate interagency collaboration to provide appropriate comprehensive services which engage well and meet the needs of parents with babies at higher risk of SUDI, such as AWHI, Family Success Matters, and Primary Care.
The below Safe Sleep Calculator model can provide an objective targeting tool to prioritise SUDI prevention ‘wrap around care’ to the individuals who stand to benefit most from modifying risks and will have the most impact on reducing SUDI numbers.

Co-designing this service framework is currently taking place with mutual providers, inclusive of identifying who is best placed to provide and have oversight of this service.

12. SUDI risk assessment tool –
   - In 2017 CM Health Investment and Change Steering Group agreed and committed to implementation of a web-based Safe Sleep Calculator (funded by Cure Kids independently from the MoH budget) which will be the standardised risk assessment tool used in CM Health.
   - The Safe Sleep Calculator will estimate absolute risk of SUDI during the antenatal phase, at birth and postnatally, for individual infants, by evaluating sixteen contributory factors. It will identify families most in need of wrap around support enabling easy access to referrals, connectiveness of information between agencies and oversight that any referrals made have been attended and completed.
   - Further development of the Safe Sleep Calculator is progressing at touchpoints of the first antenatal check and at the six week postnatal check within Primary Care. This will provide comprehensive continual assessment of the baby and mother throughout the pregnancy journey and further support early registration and engagement of women with an LMC enabling access to additional services and support they may require. It will also be an avenue for promotion and encouragement around continuing to breastfeed, immunisations and being smokefree.

13. Education Workforce –
   - Development and trialling of a High School SUDI education package to Year 10 students has been well received by both school and students. Philanthropic funding is being sought to further develop and finalise this education package to be potentially offered to further schools.
   - Re-engaging with Early Childhood Educators and Private Training Establishments will commence early next year appropriate for educators, parents and children.

The above initiatives have been agreed by the CM Health SUDI Governance Group, and are by no means the limit of our work programme. We continue to evolve our SUDI programme and ensure inclusiveness within primary, community and secondary care services. At the forefront of our prevention plan is our commitment to reducing the incidence of SUDI which disproportionately affects Māori and Pacifica whānau within the CM health catchment area.

Discussion: Feedback is sought from the committee on the CM Health SUDI prevention programme

Attachments: CM Health SUDI Prevention Plan 2018/19

References:


Programme Logic: Ensure easy and well defined access to appropriate Safe Sleep Bed options for infants up to the age of one year that meets the needs of our priority population

### Safe Sleep Beds Programme

**Rationale:**
1. The combination of maternal smoking in pregnancy and then bed sharing is extremely hazardous leading to babies being 32 times more at risk of SUDI compared to babies not exposed to either risk factor (NZ Nationwide Case –Control Study).
2. Prematurely born infants and those born small for gestational age are at increased risk of SUDI which is further increased in a bed sharing situation.
3. SUDI risk is highest for the youngest infants and risk reduces with increasing infant age.
4. A 29% reduction in SUDI in NZ 2011-2015 has been at least partially attributed to the implementation of Safe Sleep programmes with Pepi-pod and wahakura by DHB’s.
5. 25% of families with babies at higher risk in South Auckland do not have a baby bed. (McIntosh et. Al. Pepi-pod RCT 2012-14)
6. The provision of safe sleep beds targeted at enabling safe sleep for more vulnerable infants is essential to meet the health target of reducing the incidence of SUDI to 0.1 in 1000 infants by 2025 (MoH target 2017).

**Current situation in CM HEALTH:**
Safe Sleep Beds (Pepi-pods and wahakura) have been provided, as part of the Safe Sleep Programme since 2012 for babies with risk factors for SUDI. 2017/18 year approx. 850 safe sleep baby beds have been distributed through the Safe Sleep Programme.
Audit of the Safe Sleep Programme has shown that improved targeting of the programme is required to prioritise infants who have the highest risk.
Some high risk infants and their whaanau are not being offered the Safe Sleep Programme. Pepi-pod and wahakura are not meeting the needs of all of the babies more vulnerable to SUDI, especially Pacific ethnicity infants and infants who outgrow their bed. Other options for safe sleep beds need to be explored.

**Equity focus:**
- CM Health birth cohort approx. 8,000 births per year (based on 2015 National Minimum dataset);
- 20% of Māori ethnicity;
- 30% Pacific ethnicity;
- 26% <25 years;
- 67% decile 7-10.

In CM Health there is a disproportionate amount of SUDI deaths for both Māori & Pacific ethnicities. Over 2011-2016 45 babies in total died, 27 Māori and 18 Pacific. We need to ensure our focus remains on our Māori and Pacific populations, young mothers and those of our women disadvantaged by living in low socio-economic areas.

**Alignment to CFA requirement:**
- Rationales and evidence to support investment into this activity?
- Links to other MoH/DHB activity?

**Action areas for 2018-19**
1. Continue with the provision of safe sleep beds
2. Improve targeting of the Safe Sleep beds and programme for infants at the highest risk (≥0.4/1000 risk).
3. Improve recording and reporting of safe sleep beds provided.
4. Increase supply of wahakura to meet the needs of our Māori population.
5. Scoping & funding of alternative baby beds for our Pacific women and for larger babies.
6. Review & scoping around the safe sleep bed coordination and distribution to ensure ease of accessibility & appropriate timing.
7. Further review of pod study to better inform around Māori & Pacific engagement.
8. Review utilisation of the safe sleep bed within the home and continued engagement of whaanau around the safe sleep messages.

**Links to the needs of the DHBs population**
- How does the activity link to population needs?

**Service coverage**
- Culturally appropriate and accessible services provided to our women, whaanau and communities

**Responsibility**
- CM Health SUDI Prevention Team:
  - Dr Christine McIntosh – Clinical Lead;
  - Estelle Mulligan – Safe Sleep Coordinator;
  - Tina Higgins – Project support
- Carmel Ellis – CH&M GM.

**Economic focus**
- SUDI Prevention Programme:
  - An independent whakahū producer
  - Pepi-pod producer
  - Pacific & Māori Research organisation & consumer representation

**Quality focus**
- CM Health Annual Plan 2018/19

**Monitoring & Evaluation**
- SUDI Governance Group
- Quality Monitoring and Improvement Group (formerly Safety, Experience, Certification & Measurement Operational Group)
- Regional SUDI Working Group

**Stakeholders**
- An independent whakahū producer
- Māori & Pacific Mātauranga
- Pacific & Māori Research organisation & consumer representation

**Predictive Budget**
- $408,629.21

Toiora
- Enabling healthy decision making by whaanau
- Waiora, Waiora – empowering women to implement traditional solutions with harakeke.
### Activity Title: Next Bed Initiatives

<table>
<thead>
<tr>
<th>Title</th>
<th>Rationale/evidence</th>
<th>Links to the needs of the DHBs population</th>
<th>Service coverage (culturally appropriate and accessible services provided to our women, whaanau and communities)</th>
<th>Alignment to CFA requirement – links to other Moh/DHB activity</th>
<th>Action areas for 2018-19</th>
<th>Responsibility</th>
<th>Monitoring &amp; Reporting</th>
<th>Stakeholders</th>
<th>Predictive Budget</th>
<th>Links to Te Pae Mahutonga</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In CM Health not all families find the Pepi-pod or Wahakura appropriate and for some families, a bassinet or cot would be preferable. Some infants are bigger (especially Pacific ethnicity) and quickly outgrow (within weeks) either the pepi-pod or wahakura. Average age of discontinuing Pepi-pod use was 8 weeks old for babies in the Pepi-pod RCT with most common reason given that they had grown too big for the Pepi-pod. Pepi-pods and wahakura are suitable for small infants for the first few months of life. A need for a safe 'next bed' for the period up to the age of 1 year has been identified.</td>
<td>No current alternative baby beds offered by the Safe Sleep Programme in CM HEALTH</td>
<td>CFA has acknowledged that the SUDI Prevention Plan covers the period up to 1 year of age; therefore options need to be available to ensure our high risk population have accessibility to safe sleep beds. To ensure this happens we need to integrate and coordinate systems with other similar programmes such as Family Start, Oranga Tamariki, MSD etc. to enhance opportunities for interventions/next bed initiatives.</td>
<td>5. Provide Safe Sleep Beds and relevant guidelines for their safe use. 6. Improved DHB collaboration to ensure integrated contributions to improved child health interventions and outcomes such as appropriate referrals and access to Family Start, Teen Parent Units and Oranga Tamariki.</td>
<td>1. Consumer engagement will be sought to ensure next bed options are culturally-appropriate, and safe for baby and whaanau. 2. Investigation into next bed options with a regional focus to ensure a multi-agency collaborative approach.</td>
<td>SUDI Prevention Programme Team with collaboration with the SUDI regional working group</td>
<td>SUDI Governance group Regional SUDI Working Group Child Health Steering Group</td>
<td>DHB Healthcare professionals Primary &amp; WCTO providers Community Care MSD / WINZ Charitable Organisations Philanthropic funding opportunities Consumers - women/whaanau</td>
<td>Teiora Enabling healthy decision making by whaanau Waiora - empowering women to implement traditional solutions – Pacifika in this instance.</td>
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Safe Sleep Risk Assessment Framework

Current situation in CM HEALTH:
SUDI risk assessment is expected to occur both antenatally and in early infancy provided by midwife, Well Child and primary care however the level of documentation and universality of this assessment is uncertain.
The current CM Health Safe Sleep Programme Referral Form comprising of a Safe Sleep Risk Assessment Framework is based on a list of SUDI risk factors but does not account for interactions between factors nor the overall risk.

Equity:

All infants should be assessed for SUDI risk but there needs to be priority of SUDI wrap-around for the infants and their whanau who carry the higher risk through objective measurement.
SUDI prevention services; smoking cessation, breastfeeding support and the Safe Sleep Programme are not consistently being offered to mothers of babies at higher risk.
Some lower risk infants and families are receiving the Safe Sleep Programme through a lack of accurate targeting.

This tool will better determine the population most at risk and allow a culturally appropriate package of care to be provided. In one year period ~850 safe sleep devices were provided, however there is poor visibility around the SUDI preventative care provided to those 850 women who received a safe sleep bed.

1. Introduce a national framework for early pregnancy, the third trimester, birth and the postnatal period to standardise SUDI risk assessment and care planning across maternity, primary care and WCTO services.
2. Provide a package of care to women which address the key modifiable risk and protective factors for SUDI that is suitable during both antenatal and postnatal periods.
3. Provide a package of care to women/babies at higher risk through a lack of accurate targeting.

An evidence based SUDI risk assessment tool:
The Safe Sleep Calculator is a web-based risk assessment tool that estimates absolute risk of sudden unexpected death in infancy, for individual infants, by evaluating sixteen contributory factors. It has been developed from meta-analysis of five international case-control studies and been validated (unpublished) using the NZ SUDI Nationwide Case-control data.
The Safe Sleep Calculator in primary care pilot study data (McIntosh unpublished) estimates that 23% (1680 infants) of the infant population will have a higher SUDI risk ≥ 0.4/1000 and that targeting this group for a SUDI prevention care package has the potential to prevent 91% of SUDI deaths.
In 2017 CM Health Investment and Change Steering Group agreed and committed to implementation of a web-based Safe Sleep Calculator (funded by Cure Kids independently from the MoH budget) which will be the standardised risk assessment tool in CM Health. This tool will enable evidence-based assessment of risk, provide an educational aid for use with parents and allow for more accurate allocation of Safe Sleep Beds to the babies at higher risk and identify those women/whanau most in need of wrap around services and facilitate easy monitoring and reporting on the programme.

1. Implementation of universal assessment using the Safe Sleep Calculator for all babies born in CM Health.
2. Provide a communications plan (inclusive of education roll out) around implementation.
3. Develop and integrate a SUDI prevention wrap-around care package targeted to infants, objectively determined to be at higher risk through better communication and integration of existing DHB and community providers.
4. Explore opportunities to implement a version of the Safe Sleep Calculator assessment tool within Primary Care at the 1st antenatal appointment and at the postnatal 6 week check.

SUDI prevention Wrap Around Care Package

In order to further support women/whanau and babies who are at increased risk of SUDI we need to ensure that a cohesive, comprehensive package of care which addresses the key modifiable risk and protective factors for SUDI is readily available and accessible for these women/whanau and that it is culturally appropriate. We realise that to a limited extent this currently takes place albeit via a fragmented approach.
Via the developing risk assessment framework of the Safe Sleep Calculator we will be able to better define a package of care and more importantly, who will be best placed to deliver and follow up on appropriate care to ensure health gains for the women, baby and whanau.

1. Scoping & agreement of who is best placed to provide wrap-around support
2. Progressing links with DHB and community providers around extent of services included in the package of care & socialisation.
3. Ensuring cultural appropriateness &
### Extension of engagement with SUDI Prevention Activity, Education, Workforce and aligned services

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<tr>
<td>Education of workforce:</td>
<td>Many of our healthcare professionals are now competent around the PEPE/Safe Sleep messaging having completed the SUDI online education and face to face messaging. However we recognise the need to continue to refresh our DHB workforce, and broaden &amp; strengthen our reach further into NGOs, Community, OT, MoH, MoE and MSD organisations.</td>
<td>With 8000 women giving birth each year in CM Health our objective is to ensure that every door is the right door. We want to ensure that every touch point a woman has she receives consistent information and is enabled and empowered to make positive behaviour change. Integration of the SUDI programme is necessary with those services for e.g. Oranga Tamariki, Family Success Matters, Start Well, TPU, AOI &amp; Mental Health services that connect with women/whānau who are at increased risk.</td>
<td>To ensure our healthcare professionals are culturally competent and responsive when engaging women/whānau, and are aware of the SUDI context and trained in the PEPE/Safe Sleep messaging, health literacy and behavioural change.</td>
<td>1. Support SUDI education &amp; engagement for healthcare providers.</td>
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<td>Extension of education &amp; aligning services:</td>
<td>Teen Parent Units (TPU), Early Childhood Education facilities and Educators are additional avenues to pursue. Current engagement with one TPU (there are two currently in CM Health catchment area) and one Private Training Establishment (delivering Early Childhood courses to 16-18 year old school leavers) have proved positive to include SUDI education and Safe Sleep messaging within their curriculum. Further training opportunities to be pursued within Early Childhood learning facilities to ensure messaging is aligned, consistent and appropriate. Development of a training package will be progressed with the intention to rolling out to other ECE training facilities.</td>
<td>Many of our women are working mothers utilising Kōhanga Reo &amp; Early Childhood Facilities, this would be an invaluable opportunity to tap into, promoting directly with the workforce looking after young babies and children, but also sharing with parents and whānau within our communities</td>
<td>To ensure our healthcare professionals are culturally competent and responsive when engaging women/whānau, and are aware of the SUDI context and trained in the PEPE/Safe Sleep messaging, health literacy and behavioural change.</td>
<td>2. Support and expand SUDI education to other healthcare providers to further integrate SUDI prevention.</td>
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<td>Behavioural Change &amp; Health Literacy:</td>
<td>Although the SUDI rate is reducing within CM Health we still have too high a number of SUDI. Education around health literacy and 'behavioural change' will be scoped to test if this approach will enable health professions to be more effective in enabling women/whānau to make positive behaviour change.</td>
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<td></td>
<td>3. Progress engagement with Kōhanga Reo, Early Childhood Education facilities &amp; educators</td>
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**Programme Logic:** Develop, enable and support a skilled workforce aligned across our service providers integrated with the SUDI Prevention programme

### Extension of engagement with SUDI Prevention Activity, Education, Workforce and aligned services

- **Education of workforce:** Many of our healthcare professionals are now competent around the PEPE/Safe Sleep messaging having completed the SUDI online education and face to face messaging. However we recognise the need to continue to refresh our DHB workforce, and broaden & strengthen our reach further into NGOs, Community, OT, MoH, MoE and MSD organisations.

- **Extension of education & aligning services:** Teen Parent Units (TPU), Early Childhood Education facilities and Educators are additional avenues to pursue. Current engagement with one TPU (there are two currently in CM Health catchment area) and one Private Training Establishment (delivering Early Childhood courses to 16-18 year old school leavers) have proved positive to include SUDI education and Safe Sleep messaging within their curriculum. Further training opportunities to be pursued within Early Childhood learning facilities to ensure messaging is aligned, consistent and appropriate. Development of a training package will be progressed with the intention to rolling out to other ECE training facilities.

A trial is currently taking place at a rural high school providing education to all Year 10 students around the SUDI education. This has been successfully supported by both school and students and will be reviewed with the potential to roll out through South Auckland Schools within a training package.

**Behavioural Change & Health Literacy:** Although the SUDI rate is reducing within CM Health we still have too high a number of SUDI. Education around health literacy and 'behavioural change' will be scoped to test if this approach will enable health professions to be more effective in enabling women/whānau to make positive behaviour change.

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**Responsibility:**
- SUDI Prevention Programme team
- SUDI Governance Group
- Maternal Strategic Forum
- Child Health Strategic Forum
- Teen Parent Units
- High Schools

**Monitoring & Reporting:**
- SUDI Prevention Programme team
- SUDI Governance Group
- Maternal Strategic Forum
- Child Health Strategic Forum
- Teen Parent Units
- High Schools

**Stakeholders:**
- Health care providers (DHB, LMCs, Family Success Matters, Start Well, Well Child Providers, Oranga Tamariki)
- Early Childhood Education providers
- Teen Parent Units
- High Schools

**Predictive Budget:**
- $25,000

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**Ngi manukura Health promotion leadership through SUDI champions**

- **Mauriora - Enabling/ facilitating secure cultural identity.**
- **Whaiora - Increasing participation in SUDI education and knowledge in health workforce and wider education sector and society.**
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<tr>
<td>Safe Sleep Policy, Modelling &amp; Audit</td>
<td>We continue to adhere to the regional Safe Sleep Policy and the CM Health Safe Sleep for Babies guidelines. Safe Sleep Modelling and weekly audits continues to take place within the DHB across the maternity wards, KidzFirst Surgical, Medical &amp; Neonatal Care unit as well as the three birthing units at Botany, Papakura &amp; Pukekohe.</td>
<td>Ensuring that Safe Sleep messaging and modelling is consistent in all healthcare facilities.</td>
<td>Ensuring women and whānau are engaged in culturally effective ways.</td>
<td>5. Provide Safe Sleep Beds and relevant guidelines for their safe use.</td>
<td>1. Continuous promotion/education required for the workforce. 2. Scope opportunities to further implement within Kidz First ED</td>
<td>Clinical Quality and Risk Manager Kids First and Women's Health Divisions (Leesa Freeman)</td>
<td>- SUDI Governance Group - Maternal Strategic Forum - Maternity Quality &amp; Safety Forum - Quality Monitoring and Improvement Group</td>
<td>- DHB Healthcare professionals/ Birthing Units etc.</td>
<td>Whaiora - increasing participation in SUDI education and knowledge in health workforce and wider education sector and society</td>
<td></td>
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<tr>
<td>Weaving Waananga</td>
<td>Context of a weaving waananga: The weaving wahakura waananga has been demonstrated to be a culturally appropriate solution to enable and empower women/whānau to weave their own safe sleep bed for their baby using traditional methods and techniques. In addition throughout the waananga the safe sleep, smoke free cessation and breastfeeding messages are promoted and reinforced. Interest in a weaving waananga programme has been noted by our population and has been ongoing within other DHBs for a number of years.</td>
<td>20% of CM Health birth cohort is of Māori ethnicity. Weaving wahakura waananga have been very popular and very much in demand in other DHB areas, they have not been currently been available in CM Health. Within other DHBs they foster connections and relationships with whānau, iwi and local communities.</td>
<td>The opportunity to pilot and evaluate weaving waananga in CM Health for our population is critical to enable their success and assist with the building blocks to engage women, whānau, iwi and communities in this cultural tradition.</td>
<td>SUDI Prevention Programme team - Māori Health Team</td>
<td>1. Piloting a Marae based waananga led by Plunket at Papakura Marae over a 5 week period. 2. Further weaving waaanga will also be scoped covering a shorter duration with more emphasis on weaving wahakura.</td>
<td>- SUDI Prevention Programme team - Māori Health Team</td>
<td>- Ongoing evaluation will take place with participants, educators and weavers and reported to: - SUDI Governance group - Maternal Strategic Forum - Māori Health Team</td>
<td>- Marae based services - Teen Parent Unit services - Waananga facilitators - Consumers - women/whānau participating</td>
<td>$58,000</td>
<td>Whaiora, empowering women to implement traditional solutions with harakeke; Mā ori - Enabling/facilitating secure cultural identity; Ngā Manukura - community leadership, encouraging the community to engage in waananga with the support of the DHB</td>
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</table>
| Hapū Waananga                      | The transitional phase between life before children and becoming a parent is a period when pregnant women and expectant fathers are particularly responsive to and proactive in, seeking health information. Having the knowledge and information required to have a healthy pregnancy that leads to having a healthy mother and baby is critical. This knowledge is the foundation for building on parenting skills and subsequently improving infant and maternal health outcomes. First-time parents in particular will benefit from receiving information and education with groups of other new parents. | Not all women are able to access quality antenatal education and support which meets their needs. A New Zealand study (Dwyer, S, 2009) found that just over 41% of pregnant women attended childbirth education in New Zealand. Māori and Pacific women were under-represented, mainly because of cultural, transport, child | The Hapū waananga is delivered by both Māori and Pacific providers and targets Māori, Pacific and young mothers/whānau. The programme provides advice and support around pregnancy and parenting issues of specific cultural significance for Māori, and are delivered in a manner that takes account of Māori cultural values and | SUDI Prevention Programme team - Maternity Services Development Mgr. (Anamda Hinks) | 1. Scoping around increasing attendance at hapū waananga and how better to support mothers/whānau with babies at increased risk into wrap around/packages of care. | - SUDI Prevention Programme team - Maternity Services Development Mgr. (Anamda Hinks) | - SUDI Governance Group - Maternal Strategic Forum - Māori Health Team | - Providers of Hapū waananga - Māori Health Team - Consumers – women/whānau participating. | $20,000.00 | Waioara - empowering women to implement traditional solutions with harakeke; Māori - Enabling/ facilitating secure cultural identity;
### Activity Title

**Breastfeeding support**

Breastfeeding has many infant and maternal benefits and is a protective against SUDI. The protective effect is stronger for exclusive breastfeeding over a longer period of time, particularly up until the 6 month period when the SUDI risk is greatest.

In CM Health 72% of babies are fully/exclusively breastfed at two weeks (national target is 85%) this drops to 53% at three months. For Pacific babies at three months this drops to 45% with a further drop to 43% for Maori babies (WCTO Quality Indicator Data Set March 2018).

In CM Health we currently have a number of high risk women receiving breastfeeding support (for e.g. young women, smokers, low birth weight infants etc.) for these women there is an opportunity to further support them through SUDI prevention wrap-around care.

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Links to the needs of the DHBs population</th>
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<td>Breastfeeding support</td>
<td>Breastfeeding has many infant and maternal benefits and is a protective against SUDI. The protective effect is stronger for exclusive breastfeeding over a longer period of time, particularly up until the 6 month period when the SUDI risk is greatest.</td>
<td>In CM Health 72% of babies are fully/exclusively breastfed at two weeks (national target is 85%) this drops to 53% at three months. For Pacific babies at three months this drops to 45% with a further drop to 43% for Maori babies (WCTO Quality Indicator Data Set March 2018). In CM Health we currently have a number of high risk women receiving breastfeeding support (for e.g. young women, smokers, low birth weight infants etc.) for these women there is an opportunity to further support them through SUDI prevention wrap-around care.</td>
<td>In CM Health we have specific community breastfeeding services: Te Rito Ora &amp; B4Baby (Kapapa Maori Provider), referrals can be made antenatally for these services, and the DHB Lactation consultants based at Middlemore Hospital and the Primary Birthing Units.</td>
<td>CM Health Annual Plan 2018-19</td>
<td>1. Scoping around engaging and incentivising women breastfeeding and extending the duration of their breastfeeding. 2. Explore opportunities around Pacific women accessing breastfeeding services</td>
<td>• Te Rito Ora  • B4 Baby  • Lactation Support Services/Midwives/LMCs  • SUDI Prevention Programme team</td>
<td>• Broadcastin...</td>
<td>• Breastfeeding service providers  • DHB Healthcare professionals  • Consumers - women /whaanau</td>
<td>• Enabling...</td>
</tr>
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## Activity Title

### Rationale/evidence
(Why is the activity needed? Is there any evidence to support investment into this activity?)

### Links to the needs of the DHB's population
(How does the activity link to population needs)

### Service coverage
(culturally appropriate and accessible services provided to our women, whānau and communities)

### Alignment to CFA requirement
= links to other Moh/DHB activity

### Action areas for 2018-19

### Responsibility

### Monitoring & Reporting

### Stakeholders

### Predictive Budget

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</table>
| **Alcohol & Other Drugs** | Data on alcohol use in pregnancy is not routinely well captured in CM Health in pregnancy. Research evidence (Ho and Jacquemard, 2009) suggests that advice regarding abstinence from alcohol consumption during pregnancy is inconsistent from health professionals. There are a number of services and programmes for referral of women in pregnancy and parenting who are affected by alcohol and substance abuse. However there is very little visibility around how well engaged women are and how well utilised and successful these programmes are. The Alcohol Minimisation programme is progressing activity in the following areas:  
- Alcohol ABC approach within Primary Care (which records women consuming alcohol in pregnancy with appropriate referral pathways)  
- Inclusion of Alcohol screening within the Smokefree service.  
- Capturing alcohol consumption on the booking form within Maternity Clinical Information System (MCIS). It has been noted within the DHB that IT capability is proving a barrier to being able to record this information. Within the current Safe Sleep referral form AOD has been included and acknowledged as a risk factor. Recording this information for women/whānau most vulnerable to SUDI will allow us to ascertain the level of utilisation, however it is acknowledged that this area does need to be further investigated, and be supported by a package of care. | Alcohol and Drug usage is currently poorly documented within primary and maternity services, as is the demand and utilisation of those services and if they do in fact meet the needs of our population. The impact of alcohol & drug use during pregnancy and postnatally as a risk factor of SUDI may be poorly understood in the community. Clear, consistent communication is required around the advice presented to women on drinking and drug use during pregnancy. | There is a number of ethnic, age and pregnancy specific providers with a variety of community or residential programmes on offer to best meet the individuals needs and maximise positive outcomes. | Provide a package of care to women that addresses the key modifiable risk and protective factors for SUDI that is suitable for use during early pregnancy, the third trimester, birth and the postnatal period. | 1. Ensure AOD referrals are facilitated during SUDI risk assessment using the Safe Sleep Calculator with appropriate links to the Auckland Regional Pathways.  
2. Explore opportunities within the midwife workforce around the alcohol ABC approach and if further education is required. | Alcohol Harm Minimisation Team (Hinewai Pomare)  
SUDI Prevention Programme team  
Maternity Services Development Mgr. (Amanda Hinks)  
Community Midwife Manager (Isabella Smart) | SUDI Governance group  
Maternity Quality & Safety Forum | DHB Healthcare professionals  
LMCs  
Smokefree Team  
Primary & Community Care  
Consumers - women/whānau | Te Toira  
Enabling healthy decision making by whānau  
Waiora - Increasing participation in SUDI education and knowledge in health workforce and wider education sector and society |
| **Maternal Mental** | There is research evidence of an association between SUDI and perinatal depression, particularly antenatal depression (Galland et al. 2014). In CM Health there are two streams around accessing Maternal Health services; secondary services which covers moderate to severe cases and primary care which serves mild to moderate cases; both cover early pregnancy through to the baby reaching 12 months of age. Referrals to the Maternal Mental Health team are triaged via the Intake & Assessment unit into the streams, various programmes are available from home/domiciliary or GP visits (for mild to moderate cases) to respite care/mother & baby unit facilities (for more severe cases) depending on the need. The Maternal Health team consists of psychologists, psychiatrists, social workers and nurses who work closely with midwives/LMCs around care planning/birth plans etc. | The Maternal Mental Health team currently have approximately 200+ women active within their care, with around 8 to 12 new referrals per week. The majority of women seen are 18 years and over but young women are also seen if cared for under the Adolescent Mental Health team. | 3. Provide a package of care to women which address the key modifiable risk and protective factors for SUDI that is suitable for use during early pregnancy, the third trimester, birth and the postnatal period. | 1. Build relationships with this team to improve connections & enable collaborative working opportunities.  
2. Ensure referrals are facilitated during SUDI risk assessment using the Safe Sleep Calculator | Maternal Mental Health Team (Anna Hawkins)  
Maternity Services Development Mgr. (Amanda Hinks) | Maternal Strategic Forum  
SUDI Governance group | Primary & Community Care  
Consumers - women/whānau | Waiora - Increasing participation in SUDI education and knowledge in health workforce and wider education sector and society |
### Infant Mental Health

Infant Mental Health covers the postnatal period to the baby reaching 4 years of age.

Whakatu Ora is a multi-disciplinary team who see infants with social, emotional and/or behavioural problems. The focus of their work is supporting the infant and caregiver relationship through a number of treatment modalities. They can also see women in pregnancy.

### Early Registration & Engagement

Registration and Engagement of women in pregnancy with a Lead Maternity Carer (LMC) is a cornerstone of maternity care in New Zealand and represents the best opportunity for women to access skilled, specific antenatal, intra-partum and postnatal care. This also provides women with access to additional services and supports they may require, which may include specialist reviews for medical complexity, but also might include social supports and referrals, education for pregnancy and parenting, smoking cessation and others. This evidenced based, tailor made care is a strength of New Zealand’s maternity system. However, unfortunately access to this care is not consistent. In some locations and according to workforce fluctuations, being able to secure individual care with an LMC may be challenging. Further, the time at which a mother registers with an LMC is quite variable.

The timeliness of engagement with an LMC has been an area of focus for some years, and has been a priority for the Maternity Quality and Safety Programme. In 2017 registration with an LMC in the first trimester became a Better Public Service Target. Registration with an LMC in the first trimester enables women to access the full first trimester care including health advice and screening.

The potential to develop a comprehensive first antenatal check tool for primary care incorporating an antenatal version of the Safe Sleep Calculator, risk assessment tool to be integrated into practice will help identify women who may require wrap around care as well as highlighting the importance to register with a midwife.

### Action areas for 2018-19

<table>
<thead>
<tr>
<th>Action area</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Build relationships with this team to improve connections &amp; enable collaborative working opportunities.</td>
<td>• Infant Mental Health (Anna Hawkins) • SUDI Prevention Programme team • Maternity Services Development Mgr. (Amanda Hinkis)</td>
</tr>
<tr>
<td>2. Ensure referrals are facilitated during SUDI risk assessment using the Safe Sleep Calculator.</td>
<td>• DHB – Infant Mental Health team • Midwifes/LMCs • Primary &amp; Community Care • Consumers - women/whanau</td>
</tr>
<tr>
<td>3. Provide a package of care to women which address the key modifiable risk and protective factors for SUDI that is suitable for use during early pregnancy, the third trimester, birth and the postnatal period.</td>
<td>• DHB Healthcare professionals • LMCs • Primary &amp; Integrated Care • PHO’s • Consumers - women/whanau</td>
</tr>
</tbody>
</table>

### Links to the CFA requirement – links to other MoH/DHB activity

1. Identify the requirements for implementing & supporting a nurse led advanced form tool including antenatal SUDI risk assessment at the first Antenatal appointment within Primary Care to ensure that women at increased risk of SUDI receive the early care and support they need (As per action point 4. within the Safe Sleep Risk Assessment Framework Activity). 2. Support early registration & engagement activities | • SUDI Governance Group • Maternal Strategic Forum • SUDI Prevention Programme team • Maternity Services Development Mgr. (Amanda Hinkis) • DHB Healthcare professionals • LMCs • Primary & Integrated Care • PHO’s • Consumers - women/whanau |

### Links to the CFA requirement – links to other MoH/DHB activity

1. Order by SUDI Governance Group
2. Develop new or update existing tools and resources
3. Implement & support

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**SUDI Prevention Plan 2018/19**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**SUDI Governance Group**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**SUDI Prevention Programme team**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**Maternity Services Development Mgr. (Amanda Hinkis)**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**DHB Healthcare professionals**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**LMCs**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**Primary & Integrated Care**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**PHO’s**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**Consumers - women/whanau**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

---

**Waora - Increasing participation in SUDI education and knowledge in health workforce and wider education sector and society**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support

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**Toiora - Enabling healthy decision making by whanau**

- **1.** Order by SUDI Governance Group
- **2.** Develop new or update existing tools and resources
- **3.** Implement & support
### Programme Logic: Provide appropriate resources & pursue community engagement opportunities to better meet the needs of our priority populations

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>Rationale/evidence</th>
<th>Links to the needs of the DHBs population</th>
<th>Service coverage (culturally appropriate and accessible services provided to our women, whaanau and communities)</th>
<th>Alignment to CFA requirement = links to other Moh/DHB activity</th>
<th>Action areas for 2018-19</th>
<th>Responsibility</th>
<th>Monitoring &amp; Reporting</th>
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<th>Predictive Budget</th>
<th>Links to Te Pae Mahutonga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources, Promotional Events &amp; Communications</td>
<td>As SUDI deaths in CM Health have affected Maori and Pacific whaanau, we need to ensure that our resources, promotions and how we communicate and engage with Maori and Pacific whaanau is appropriate and will reach those most difficult to engage. We need to review how we currently do this and further engage whaanau, iwi and community to ensure we achieve improved health gain of mother and baby and reduce SUDI. In consideration of the current Safe Sleep Programme which noted that over a 14 month period 53% of safe sleep beds were provided to Pacific whaanau and 32% to Maori whaanau we need to ensure our resources and promotional events reflect these two ethnic groups and are culturally appropriate for these groups.</td>
<td>Ensure the resources used, social media and promotions are appropriate and actively inclusive of Maori, Pacific and other cultural values.</td>
<td>6. Improved DHB collaboration to ensure integrated contributions to improved child health interventions and outcomes such as appropriate referrals and access to Family Start, Teen Parent Units and Oranga Tamariki.</td>
<td>1. Ensure our resources are culturally appropriate for Maori and Pacific whaanau. 2. Consideration of a communications plan to inform &amp; include all stakeholder engagement around SUDI activity</td>
<td>• SUDI Prevention Programme team  • SUDI Governance Group  • Maternal Strategic Forum  • DHB Healthcare professionals/ Birthing Units etc.  • LMCs  • DHB Communications team  • Community and NGOs  • Consumers - women/ whaanau  • Maori &amp; Pacific Health teams</td>
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<td>$47,250.00</td>
<td></td>
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<tr>
<td>Community Development &amp; Partnerships</td>
<td>Community events offer the opportunity to raise awareness of SUDI and associated risk factors, undertake health and risk assessment of SUDI and can link women with Hapi waananga, breastfeeding support, smoking cessation support as well as providing a voice to our consumers. They also offer the prospect to develop partnerships and effectively engage with our local community organisations and groups. The possibility of ‘SUDI champions’ within communities and community organisation to help integrate SUDI prevention messages should be explored to ensure partnerships and a presence within communities is achieved. It is important that we build a presence and partner with communities to raise awareness on SUDI and risk factors and options for addressing interventions that best meets the needs of community.</td>
<td>Ensure our engagement with communities and our partnerships are appropriate and inclusive of Maori, Pacific and other cultural values.</td>
<td>3. Provide a package of care to women which addresses the key modifiable risk and protective factors for SUDI that is suitable for use during early pregnancy, the third trimester, birth and the postnatal period.</td>
<td>1. Exploration around securing appropriate ‘champions’ within our communities to voice the SUDI messages and assist with entry into community events and groups. 2. Engaging within community events where possible.</td>
<td>• SUDI Prevention Programme team  • SUDI Governance Group  • Maternal Strategic Forum  • DHB Healthcare professionals/ Birthing Units etc.  • LMCs  • DHB Communications team  • Community and NGOs  • Consumers - women/ whaanau  • Maori &amp; Pacific Health teams</td>
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<td>$818,879.21</td>
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</tr>
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### References:

1. Edwin A Mitchell, John MD Thompson, Jane Zuccollo, Melanie MacFarlane, Barry Taylor, Dawn Elder, Alistair W Stewart, Teula Percival, Nick Baker, Gabrielle McDonald, Beverley Lawton, Martin Schlaud, Peter Fleming. The combination of bed sharing and maternal smoking leads to a greatly increased risk of sudden unexpected death in infancy: the New Zealand SUDI Nationwide Case Control Study. NZMJ. 2nd June 2017, Volume 130 Number 1456
Counties Manukau District Health Board
Community & Public Health Advisory
Committee
Sudden Unexpected Death in Infancy Update

Counties Manukau Health: Estelle Mulligan Safe Sleep Co-ordinator, Tina Higgins Project Support
Ko Awatea: Tracey Popham Project management, Cindy Blackwell Improvement advisor
University of Auckland: Christine McIntosh, John Thompson, Edwin Mitchell, Ken Leech (Procon)
Sudden Unexpected Death in Infancy

The death of an infant that was not anticipated as a significant possibility 24 hours before the death.

- Also known as ‘Cot-death’ or SIDS
- Leading cause of death in babies 1 month – 1 year old
- NZ has the highest rate in the developed world
- 45-50 babies per year in NZ
- Māori (7 x) and Pacific (4 x) families, young mothers and families living in poverty
- 8-10 babies per year in Counties Manukau Health area.
SUDI mortality by DHB 2002-2015
SUDI is Preventable

Figure 4.1: Post-neonatal SUDI mortality (number of deaths, rate per 1,000 live births and 95% confidence intervals) by year, Aotearoa/New Zealand 2002–16 (n=722 deaths)

1. Safe Sleep programmes
2. Smoke-free programmes
3. Consistent messaging

Target 0.1/1000 by 2025 & eliminate disparity in Māori and Pacific

Sources: Numerator: Mortality Review Database; Denominator: Ministry of Health Live Birth Registrations 2002–16.
Unsafe Sleep

Sleep
- Hypoxaemia/hypercarbia mechanisms:
  - Airway obstruction: positional asphyxia, wedging, overlaying, gastric contents, foreign bodies
  - Reflex apnoea: laryngeal chemoreflex
  - Thermal stress: excessive bedding and/or clothing, infection, fever
  - Rebreathing: face down, face covered

Failure of Arousal
- Abnormal brainstem response
- Risk factors: Maternal smoking, prone sleeping, formula feeding, prematurity, low birth weight

Failure of Auto-resuscitation
- Inadequate cardio-respiratory response

Hypoxia/hypercarbia

Death

Recovery

Bradycardia +/− gasping

Auto-resuscitation

Vulnerable baby

Recovery
CMHealth SUDI prevention

• Safe Sleep Baby beds (Wahakura and Pepi-pod)
• Safe sleep policy, guideline and audit
• Smokefree Incentives programme
• Breastfeeding services
• Building multiagency relationship
• Updating resources
• Workforce education
CMHealth SUDI prevention

New!!!

- Consumer focus groups
- Wahakura weaving waananga
- Universal SUDI risk assessment and targeted SUDI prevention wrap-around care
SUDI is Preventable

1. Safe Sleep programmes
2. Smoke-free programmes
3. Consistent messaging

Target 0.1/1000 by 2025 & eliminate disparity in Māori and Pacific
Effective SUDI interventions

1. Multi-pronged, consistent (safe sleep) messaging across multiple levels.
2. Safe sleep interventions should be crafted specifically for higher risk groups.

Using the Safe Sleep Calculator to target care

- 91% of cases
- 23% of population

Risk per 1000 (log scale)

NZ Nationwide SUDI Study Cases
Safe Sleep GP Practice Data
Universal SUDI assessment & targeted care

Web tool aided care

Antenatal Safe Sleep Calculator ➔ Birth ➔ Full Safe Sleep Calculator ➔ Higher risk ➔ SUDI Protection Care

Low risk “usual care”

SUDI Prevention Care
- A care co-ordinator
- Safe sleep Baby Bed
- Face to face SUDI tailored education
- Breastfeeding support
- Smokefree support
- Primary care and Well child and oral health enrolment and engagement
- Whanau ora/ Fanau ola
- Social worker
- Alcohol and drug services
- Mental health services

Monitoring and reporting of SUDI prevention care

Pre/post implementation evaluation: maternal/infant observational data
The Safe Sleep Calculator - Empowered to make choices

Risk at birth for infant for mother aged 22 years, first baby, single, male infant, birthweight 2850g, not breastfeeding, bed sharing, baby side sleeping, mother smokes, no alcohol or drugs.

- All risks modified: 0.24
- Not smoking only: 2.8
- Not bedsharing only: 1.21
- Back sleeping only: 7.49
- Breastfeeding only: 7.51
- Total risk: 14.78

Risk per 1000 live births
SUDI Prevention

Is an opportunity for a child to thrive