AGENDA - PART I – Items to be considered in public meeting

9.00am 1. AGENDA ORDER AND TIMING

2. GOVERNANCE

9.00am 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 CPHAC Meeting – 22 May 2019

9.10am 2.4 Action Items Register

9.15am 2.5 CPHAC Workplan 2019

3. UPDATE

9.20am 3.1 ARPHS Update including the Measles Strategy, particularly as it pertains to the Pacific community, and what is being done to counter the ‘anti-vaccine’ campaign. (Jane McEntee, General Manager, Auckland Regional Public Health Service & Doone Winnard, Clinical Director, Population Health, CM Health)

4. PRESENTATION

10.05am 4.1 After Hours Care in CM Health (Kate Dowson, Programme Manager, Primary Care)

Morning Tea (10.30am to 10.40am)

5. BRIEFING PAPERS

10.40am 5.1 Quarter 3 2018/19 Non-financial Summary Report (Kitty Neill, Planning Advisor)

11.00am 5.2 Youth Health (Julia Burgess-Shaw, Service Development Manager Youth Health)

6. HEALTHCARE EVIDENCE UPDATE

11.30am 6.1 Stroke Prevention, Pathophysiology and the Hyperacute Stroke Pathway (Dr Geoff Green, Consultant) – discussion only, no paper/presentation

11.50am 6.2 Evidence based treatments for Obesity: Update for CPHAC (Dr Gary Jackson, Director, Population Health Directorate) – presentation to be tabled

7. INFORMATION PAPER

7.1 Ministry of Health’s Well Child Tamariki Ora Review

12.10pm 8. RESOLUTION TO EXCLUDE THE PUBLIC

Page No.

002

003

005

006

012

014

015

039

050

081

086

106
## BOARD MEMBER ATTENDANCE SCHEDULE 2019 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>27 Feb</th>
<th>Mar</th>
<th>10 Apr</th>
<th>22 May</th>
<th>June</th>
<th>3 Jul</th>
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<th>Oct</th>
<th>6 Nov</th>
<th>18 Dec</th>
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<tr>
<td>Colleen Brown (Chair)</td>
<td>No Meeting</td>
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<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>Apologies</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
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<td>Apulu Reece Autagavaia</td>
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<td>Dr Lyn Murphy</td>
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<td>Apologies</td>
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<tr>
<td>John Wong - External Appointee (appointed 13/9/17)</td>
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</tbody>
</table>
| Colleen Brown               | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• District Representative, Neighbourhood Support NZ Board  
• Chair, Rawiri Residents Association  
• Director and Shareholder, Travers Brown Trustee Limited                                                                                   |
| 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 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  
• Life Member of Business and Professional Women NZ  
| George Ngatai               | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Board Member, Counties Manukau Rugby League Zone  
• Member, NZ Maori Council  
• Director & Shareholder, Ngatai Bhana Limited  
• Director & Shareholder, Family Care Limited  
• Board Member, Restorative Justice Aotearoa  
• Director, BDO Marketing & Business Solutions Limited  
• Board Member, Social Services Providers Association  
• Director, Huakina Development Trust (Partnership Clinic)                                                                                           |
| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
|                | • Deputy Chair Howick Local Board  
|                | • Member of Amputee Society  
|                | • Member of Parafed disability sports  
|                | • Member of NZ National Party  
| Apulu Reece Autagavaia | • Member, Pacific Lawyers’ Association  
|                     | • Member, Labour Party  
|                     | • Trustee, Epiphany Pacific Trust  
|                     | • Trustee, The Good The Bad Trust  
|                     | • Member, Otara-Papatoetoe Local Board  
|                     | • Member, District Licensing Committee of Auckland Council  
|                     | • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation  
|                     | • Member, Workforce Development Early Childhood Education Advisory Committee  
| Dr Lyn Murphy | • Director and Shareholder, Bizness Synergy Training Ltd  
|                | • Director and Shareholder, Synergex Holdings Ltd  
|                | • Trustee, Synergex Trust  
|                | • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
|                | • Member, New Zealand Association of Clinical Research (NZACRes)  
|                | • Senior Lecturer, AUT University School of Interprofessional Health Studies  
|                | • Member, Public Health Association of New Zealand  
| John Wong | • Board member, Asian Family Services (a subsidiary of Problem Gambling Foundation of NZ).  
|           | • Chair and Trustee, Chinese Positive Ageing Charitable Trust.  
|           | • Founding member and council member, Asian Network Incorporation (TANI).  
|           | • Board member, Chinese Mental Health Consultation Service Trust. |
## 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 22 May 2019

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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Counties Manukau District Health Board – Community & Public Health Advisory Committee

3 July 2019

005
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 22 May 2019 at 9.00am – 12.30pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

Fepulea‘i Margie Apa (Chief Executive)
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)
Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Katherine Yang (Executive Advisor to the CE)
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.
Dr Mariam Parwaiz (CM Health Public Health Registrar) attended as a learning experience.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown and a prayer from Apulu Reece Autagavaia.

1. AGENDA ORDER AND TIMING

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

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from George Ngatai, Katrina Bungard, Dr Gary Jackson and Elizabeth Powell and Apulu Reece Autagavaia for lateness.
2.2 Register of Interests

The amendments to the Disclosures of Interest were noted by Ms Tafau. There were no amendments to the Disclosure of Specific Interests.

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 10 April February 2019.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 10 April 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

3. BRIEFING PAPERS

3.1 Metro Auckland Healthy Weight Action Plan for Children Progress Report (Carmel Ellis, GM Integrated Child, Youth & Maternity, Primary Care)

Paper was taken as read.

Plan now in its second year. DHBs are delivering different programmes, not all the same. Ms Ellis made a note to advise that the report be amended to read more clearly.

Overall, CM Health is tracking well against the actions.

The Healthy Weight Management for B4SC data shows that for the whaanau involved, BMIs are stabilised for the children. Engagement is solid for the 12 months with the first three months being quite intensive; meal planning and mentoring. Provider continues support post the first three months, but not so intensively.

Each DHB is measured on the number of kids identified as needing intervention. Not all families take up the service when it is offered. The decline of Maaor is on the increase and the reasons for this are being investigated. Analysis of the data is being undertaken with B4SC providers.

The Metro Auckland Clinical Group Forum (MACGF) will be discussing the B4SC programme. The Primary Care response may not be as focussed as we would like for overweight children (not the case for obese children), so how this can be changed within Primary Care will be a focus.

CPHAC would like to know if GPs have the necessary information on hand to pass to parents of overweight children. The committee was advised that this is a PHO responsibility, there is a Health Pathway. Whilst the information is to hand and the data shows that this is being
used, however, this is not to say that every GP knows about Health Pathways and is using them.

**Action**
Dr Brebner will raise CPHACs concerns to the next MACGF around overweight children. CM Health CPHAC would appreciate if Dr Brebner could convey to PHOs that Clinical Pathways uptake is important and that all GPs should be using this regularly.

B4SC providers can refer overweight children directly to Otara Health (Healthy Weight provider). Otara Health will advise the GP of the referral.

Ms Ellis and her team are working with GPs to ensure they have the tools and the confidence to have these conversations, even earlier than B4SC. Professional development has been engaged to assist with this training.

Ms Ellis advised CPHAC that the information provided in the report is a Health response. This second Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children presents an overview of activity during Q1&2. The Action Plan indicators have been developed collaboratively across the region, with consistency in data collection and reporting, where appropriate. The indicators will be reviewed and updated before the next round of reporting; updates will occur annually to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. Regular updates to CPHAC will continue. While many actions remain on track, it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole towards a healthy weight.

The BMI measuring tool has been standardised across the DHBs in secondary care. It is hoped that this tool till filter down into primary care, which will be most beneficial.

95% of CM Health providers and their sub-contractors must have a Healthy Eating Policy. This is written into contracts, so is a signed obligation.

**Action**
Bariatric Surgery for Women of child bearing age – update the notes to reflect that this is not an issue for CM Health.

**Action**
Well Child Review – Ms Ellis will provide a report for Ms Tafau to circulate to the committee via Diligent resource. It has been acknowledged that the B4SC is not working for our communities and in fact, if continued to be followed, will increase inequities.

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

*The Community & Public Health Advisory Committee:*

*Received* this update report on the progress CM Health has made against the Metro-Auckland Healthy Weight Action Plan for Children.

*Noted* that this plan sits alongside the Healthy Auckland Together (HAT) Plan 2015 – 2020.

**Carried**

3.2 **Addressing Inequity in Māori Childhood Immunisation Coverage Update** (Katarina Komene, Programme Manager, Māori Child Health & Dr Mataroria Lyndon & Carmel Ellis, GM Integrated Child, Youth & Maternity, Primary Care)
Paper was taken as read.

The committee were advised that it can take between seven to 14 txts to whaanau to track children that require immunisations. Incentives are showing signs of improving engagement.

1.5 to 2% decrease for CM Health, however, the anti-vaccination campaign has seen the decline rate increase to approx. 3%.

When whaanau do decline, they are followed up with and offered a conversation to ensure the choice they are making is informed.

The vast majority of Maaori don’t decline. It is a matter of timing. Improving timeliness is a targeted pilot and this is why the incentive is being offered. These are whaanau that have indicated they do want their children immunised.

Homelessness, if advised, is followed up and the whaanau are provided support.

The incentive pilot is being monitored every three months with an evaluation to be undertaken after 12 months. It is hoped that positive results will see a continuation of the incentive scheme.

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

The Community & Public Health Advisory Committee:

Noted the progress made on the initiatives to address the disparities in Maaori immunisation coverage.

Noted the design process and plan for these initiatives and the next steps for piloting.

Carried

4. UPDATES

4.1 Pacific Health Overview

The provided presentation will be included in the next agenda as an information item.

Dr Schaaf is confident that the team is making a difference for the community, but that improvement is only a small part of what needs to be done as a whole to better improve health outcomes for Pacific.

There is a network of eight to ten providers that are available to provide after-hours care. Dr Schaaf advised that the knowledge that coming to Emergency Care gives fanau comfort that they will be seen, if x-rays are required, it can be done onsite, etc. The fanau will leave the hospital feeling as though they have been cared for.

4.2 Hospital in the Home Update (Penny Magud, GM Locality Services & Dr Carl Eagleton, Clinical Director, Medicine)

Numbers to date are small but this has allowed the Pathway to be fully tested. The main population is Mangere/Otara and Manukau with a few in Franklin. 55% are from the high needs population. This work is in support of rising acute care in the community, supporting District Nurses in order to avoid readmission and transition from secondary to primary care.
Dr Eagleton advised that the District Nurses have been great and having a Nurse Practitioner available is most beneficial.

Mr Eagleton provided information around specific cases and the success of the patients being able to be treated in their home. The information provided by the District Nurses to the hospital based clinicians gave confidence that these patients are receiving excellent care.

Heart failure patients are the biggest recipients of Hospital in the Home. This group of patients can frequently readmit due to not seeing their GP in a timely manner, for a variety of reasons. Being able to be seen in their homes eases the burden on hospital based clinicians and eases the anxiety of the patient when they can maintain their health at home and don’t require readmission.

Intelligent support is also being utilised by the hospital. Scales for diabetic patients can Bluetooth results to the clinician.

Ms Tafau to pass on the suggestion to the Secretariat of the Board in regard to Hospital in the Home Patient – provide a patient story to the Board.

Nurses can visit the home more than once per day if the patient requires that level of care. The handover to the GP for high needs patients is extremely important for their continuity of care.

Hospital in the Home provides that layer of clinical support that allows a qualifying patient to be looked after in their home, after an appropriate transition.

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

The Community & Public Health Advisory Committee:

*Noted* the information provided in this update.

*Carried*

5. **DISCUSSION**

5.1 **Asian & South Asian Health**

Barriers to access included financial constraints, transport, language and cultural barriers.

The general consensus was that it was the Older People of these communities (recent migrants) who are experiencing the most difficulty in navigating the health system.

**Action**
Create a paper that provides a link to resources and distribute to those we have met with already in order for the information to be disseminated.
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:

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Health of Older People – Non Renewal of Day Activity Projects</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
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**Carried**

This first part of the meeting concluded at 11.15am.


______________________________
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 – 22 May 2019**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tr>
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<td><strong>Standing Items</strong></td>
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<td><strong>Locality Updates:</strong> Provide updates for Locality Hubs in general until established enough to provide individual deep dives.</td>
<td>14 August (to discuss alongside EPC business case)</td>
<td>Alan Greenslade, Matt Hannant and Penny Magud</td>
<td>Date TBC for EPC business case.</td>
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<td><strong>ARPHS — six-monthly update.</strong></td>
<td>3 July</td>
<td>Doone Winnard</td>
<td>Item 3.1 on the Agenda</td>
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<td><strong>Quarterly Non-Financial Summary:</strong> Quarterly report.</td>
<td>3 July</td>
<td>Alanna Soupen</td>
<td>Item 5.1 on the Agenda</td>
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<td><strong>17/18 Metro Auckland SLM Improvement Plan — quarterly report.</strong></td>
<td>25 September</td>
<td>Kate Dowson</td>
<td>As per the Workplan.</td>
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<tr>
<td>21.2.2018</td>
<td>3.1</td>
<td><strong>Green Prescriptions in Counties Manukau - Green Prescription</strong></td>
<td>14 August</td>
<td>Ryan Stangroom and Matt Hannant</td>
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<td>23.5.18</td>
<td>3.1</td>
<td><strong>Mental Health &amp; Addictions Update:</strong> with regard to homelessness for MH&amp;A whaanau, Housing First to be invited to present to CPHAC.</td>
<td>6 November</td>
<td>Kate Yang</td>
<td>Confirmed Julie Nelson’s attendance at CPHAC, 6 November 2019.</td>
</tr>
<tr>
<td>4.7.2018</td>
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<td><strong>Youth Services:</strong> Provide basic information/data around the youth in this community and what services they are accessing and how they are accessing them. Oranga Tamariki – provide information around how many youth are in vulnerable situations that may lead to them being adults that are unaware around how to navigate health services.</td>
<td>3 July</td>
<td>Julia Burgess Shaw and Carmel Ellis</td>
<td>Item 5.2 on the Agenda</td>
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<td>19.9.2018</td>
<td>Board</td>
<td><strong>MoH Letter – Strengthening the DHB Healthy Food &amp; Drink Policy</strong></td>
<td>TBC</td>
<td>Doone Winnard</td>
<td>Doone Winnard will notify Ms Tafau when there is updated information to report to the committee.</td>
</tr>
<tr>
<td>26.9.2018</td>
<td>3.1</td>
<td><strong>Healthy Families New Zealand:</strong> Update to CPHAC in 6</td>
<td>TBC September</td>
<td>Amy Carter and</td>
<td>Deferred until September 2019.</td>
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</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
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<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
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</thead>
<tbody>
<tr>
<td>5.12.2018</td>
<td>3.1</td>
<td><strong>Southern Corridor Planning with a focus on Primary &amp; Community Developments</strong>: provide update to CPHAC in 2019 when there is updated information.</td>
<td>25 September</td>
<td>Kate Yang</td>
<td>HFNZ have issued an invitation to host CPHAC at Amersham Way, Manukau.</td>
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<td>5.12.2018</td>
<td>5.1</td>
<td><strong>SUDI Workplan Briefing</strong>: The Sudi Sleep Calculator tool will swing into action in the New Year, mid-January. Come back to the Committee with a preliminary report on the findings (3 July), including some more information on why the rates for Pacific women increased in the 1990’s.</td>
<td>6 November</td>
<td>Christine McIntosh &amp; Tina Higgens</td>
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<tr>
<td>22.05.2019</td>
<td>3.1</td>
<td><strong>Metro Auckland Healthy Weight Action Plan for Children Progress Report</strong>: Dr Brebner will raise CPHACs concerns to the next MACGF around overweight children. CM Health CPHAC would appreciate if Dr Brebner could convey to PHOs that Clinical Pathways uptake is important and that all GPs should be using this regularly. Bariatric Surgery for Women of child bearing age – update the notes to reflect that this is not an issue for CM Health. Well Child Review – Ms Ellis will provide a report for Ms Tafau to circulate to the committee via Diligent resource. It has been acknowledged that the B4SC is not working for our communities and in fact, if continued to be followed, will increase inequities.</td>
<td>14 August</td>
<td>Campbell Brebner</td>
<td>Dr Brebner was away for the month of June and will raise at the MACGF in July.</td>
</tr>
<tr>
<td>22.05.2019</td>
<td>5.1</td>
<td><strong>Asian &amp; South Asian Health</strong>: Create a paper that provides a link to resources and distribute to those we have met with already in order for the information to be disseminated.</td>
<td>TBC</td>
<td>Kate Yang</td>
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<tr>
<td>Meeting Date</td>
<td>Strategic Deep Dive</td>
<td>Operational Deep dive</td>
<td>Site Visit (not necessarily on same day)</td>
<td>External/Regional presentations</td>
<td>Public Excluded</td>
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<tr>
<td>27.2.2019</td>
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<td>Owning My Gout business case Locality hubs</td>
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<td>10.4.2019</td>
<td>None. Need to make time for MH Workshop</td>
<td>Update on Long Term Conditions Co-design ((Matt Hannant) LTC Discovery Phase Report</td>
<td>South Asian Community Papatoetoe (March)</td>
<td>None. Need to make time for MH Workshop</td>
<td>Workshop to discuss Mental Health NGO Procurement (2 hours)</td>
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<td>22.05.2019</td>
<td>Pacific Health (Elizabeth Powell)</td>
<td>Healthy Weight Action Plan for Children Hospital in the Home (Penny Magud)</td>
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<td>ARHOP – Non Renewal of Day Activities (Dana Ralph-Smith)</td>
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<td>3.7.2019</td>
<td>Youth (Carmel Ellis, Julia Burgess Shaw) After Hour Care (Kate Dowson)</td>
<td>Quarterly Non-Financial Summary Report (Kitty Neill)</td>
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<td>People Living with Disability (Sanjoy Nand) Older People (Dana Ralph-Smith)</td>
<td>ARC/Home Based Care (Dana Ralph-Smith) EPC Business Case (Matt Hannant)</td>
<td>Tamaki Health (Otara) Date TBC</td>
<td>Pharmacy ALT update (Trevor Lloyd)</td>
<td>Primary Care Procurement Pipeline (Matt Hannant)</td>
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<td>25.9.2019</td>
<td>Women’s Health, including Reproductive Health (Mary Burr)</td>
<td>The Falls &amp; Fracture Prevention Steering Group (Matt Hannant, Ryan Stangroom)</td>
<td>Healthy Families NZ Update</td>
<td>SLM Presentation (MoH Report – Kate Dowson) Southern Corridor Planning with a focus on Primary &amp; Community Developments</td>
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<td>6.11.2019</td>
<td>Maori Health (Aroha Haggie, Leigh Henderson)</td>
<td>Primary Care Deep Dive (Matt Hannant) SUDI Workplan Update (Christine McIntosh, Tina Higgens)</td>
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<td>Housing First (Julie Nelson) School Based Services (Julia Burgess Shaw)</td>
<td>Equity in Procurement</td>
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<td>18.12.2019</td>
<td>Pacific Health (Elizabeth Powell) Child Wellbeing (Carmel Ellis)</td>
<td>Living Smokefree Update (Basil Fernandes &amp; Sarah Sharpe)</td>
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<td>Auckland Regional Public Health Service (Doone Winnard)</td>
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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 areas of work that are underway and/or completed since our last update in December 2018.

**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 areas of work that are underway and/or completed since our last update in December 2018. This report contains the following updates:

1. Disease notifications and management, including measles
2. BCG vaccine update
3. Drinking water standards
4. Speed management bylaw
5. Healthy Auckland Together (HAT)
6. Wai Auckland update
7. Smokefree
8. Alcohol
9. Local board health planning
10. Refugee health

1. **Disease notifications and management**

ARPHS receives notifications of 48 notifiable diseases as defined under the Health Act, 1956. ARPHS role includes receiving the disease notifications, case confirmation, risk assessment and ensuring appropriate public health actions are undertaken, daily and weekly monitoring and surveillance of these notifications, and investigation and follow-up of any disease outbreaks. Below is a summary of disease notifications received between 1 December 2018 – 31 May 2019 for measles, syphilis, pertussis, tuberculosis, acute rheumatic fever, and meningococcal with accompanying tables showing confirmed, probable and suspected cases (red), and cases under investigation (yellow) compared with the historical three yearly average for that week (grey shaded bar). **Appendix A** contains additional disease notifications.

1.1 **Measles**

Since the 22 February 2019 ARPHS has been managing a measles outbreak across the Auckland region. As at 19 June 2019, there have been 117 confirmed measles cases in this calendar year. The 117 cases have generated over 4,400 contacts which have required individual follow up and management. There is now significant spread through the community. This includes more recently, a substantial increase in the Counties Manukau (CM) Health region, where 38 of these cases reside in the CM area. Around half of the notifications are not linked with a previous case. The table below provides a summary of the situation.
Status of measles cases as at 19/06/19, 0830 hours:

<table>
<thead>
<tr>
<th>Case type</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Confirmed</td>
<td>117</td>
</tr>
<tr>
<td>Cases under active management</td>
<td>23</td>
</tr>
<tr>
<td>Under investigation</td>
<td>23</td>
</tr>
<tr>
<td>Awaiting serology</td>
<td>2</td>
</tr>
<tr>
<td>Currently hospitalised</td>
<td>0</td>
</tr>
<tr>
<td>Hospitalised YTD</td>
<td>60</td>
</tr>
<tr>
<td>Fatalities</td>
<td>0</td>
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</tbody>
</table>

Confirmed measles cases by week (February – June 2019)

Confirmed cases by week – by DHB (February – June 2019)
Measles is a serious disease, notifiable under the Health Act 1956. There are currently outbreaks of measles in different parts of the world and, earlier in the year, in Christchurch. The best protection from measles is two vaccinations with the combined Measles, Mumps, Rubella vaccine (MMR) – but current coverage levels of MMR2 are lower than the 95% considered necessary to prevent community spread.

Pacific peoples are over-represented in the measles outbreak, which is primarily due to pockets of lower immunisation. For example, an extended Pacific family in the Waitemata DHB area had 16 cases across April. To date 42 cases have identified as Pacific, 42 as European and 26 as Maori. ARPHS has offered a face-to-face case interview for all confirmed cases identifying as Pacific, including cultural support if requested. ARPHS have also translated key measles messages into Pacific languages on our website and is working with CM Health communications advisors to better reach local Pacific audiences.

To support the intensive demands on managing this outbreak, ARPHS has established an internal incident management structure to ensure a coordinated approach. Until mid-June ARPHS’ approach was intensive management of cases and contacts to prevent further cases (known as phases one and two, the ‘stamp it out’ response phase followed by a more focussed risk management approach to contact tracing). Key activities included:

- assessment and management of suspected cases (i.e. isolation and contact management); according to likely risk of case being confirmed
- advice on isolation and public health management of confirmed cases
- advice on quarantine, treatment and management (including immunisation) of contacts
- monitoring and surveillance
- advice to laboratories and clinical services to notify all measles cases on suspicion
- advice to facilities such as emergency departments, early childhood education centres, schools, urgent care centres, and general practices where cases have been during the infectious period
- public information messaging especially in regard to symptoms, advance notice when attending medical facilities and immunisation advice
- weekly stakeholder updates.

Due to the fact there is now significant spread through the community and most notifications are not linked with a previous case, in consultation with DHBs and PHOs, ARPHS has moved to the next stage (Phase 3) of the public health response in– outbreak management. This focuses on working to improve population immunity, and providing information support to cases and their contacts primarily through front line health services. ARPHS will continue to support institutional settings such as early learning centres and schools with their response to any notification. ARPHS is developing a ‘whaanau measles pack’ for people with measles which will be available through primary care and on ARPHS’ website.

Increasing vaccination rates is key to reducing the impact of this outbreak. ARPHS has worked with the Ministry, DHBs and primary care providers to introduce the following changes:

- The 15 month MMR1 vaccination has been brought forward to 12 months. This will increase immunity in an age group at most risk of hospitalisation and complications.
- Primary care has been asked to recall any child under five years (and over 12 months) who has not had one MMR vaccination
• Primary care has been asked to offer catch up MMR vaccination to anyone between five and 50 years who has not had one dose.

ARPHS promoted these changes through a media release with good media uptake. This included being the leading story on TVNZ 6pm news and Dr Julia Peters was interviewed by Tangata Pasifika (TV) and Pacific Media Network (radio). The Ministry of Health has offered to work with CM Health on communication and engagement with Pacific communities to promote vaccination uptake.

On 12 June 2019, the Auckland metro DHB Chief Executives and ARPHS sent a letter to the Director General of Health requesting a national MMR catch up campaign for 15-29 year olds.

ARPHS continues to work closely with clinical services, Pacific Health, DHBs’ Funding and Planning teams, Primary Health Organisations and the Ministry of Health to provide updates and inform future activities.

1.2  Syphilis

As at 31st May 2019, there have been 140 syphilis cases for this calendar year diagnosed across the Auckland region of which 116 infectious cases have been reported to Auckland Regional Sexual Health Services (ARSHS). CMDHB cases make up 29% of the cases (n=41). This number is currently similar to this time last year. However, based on the recent trend, 2019 numbers are expected to exceed 2018 and as in the chart below, numbers have been increasing since 2015.

Syphilis weekly cumulative case chart (2015-2019)

ARPHS and ARSHS are working in partnership to manage the outbreak. Strategy and outbreak management plans have been developed and are being implemented along with a communications plan. These have been shared with the national Public Health Clinical Network.

Key activities in place include:
• an enhanced surveillance system and reporting
• prioritisation of case finding and management
• enhanced contact tracing of sexual partners of those who have been diagnosed with syphilis
• increased initial health screening in prisons
• increased opportunistic testing in high risk primary care settings such as some health and community alcohol and drug services.
Of concern in Counties Manukau, there have been a small number of cases of congenital syphilis (infection of babies while in utero). Congenital syphilis is potentially life-threatening to the unborn child and has a range of other serious consequences. Testing for syphilis is part of routine antenatal blood testing in early pregnancy (assuming women present for care in early pregnancy) and work is being undertaken to scope repeat testing at 28 weeks for women in the CM district and potentially across the Auckland metro.

1.3  **Pertussis**

There was a second wave of pertussis cases in spring 2018 after an earlier tailing off gradually last winter. However, winter 2019 notifications have returned to base line levels. The proportion of pertussis cases aged under one year has decreased from 17% in 2009 to 8% in 2018. This would suggest the focused strategy of protecting under one year old infants is working despite nearly 1,200 notifications over the last two years.

1.4  **Tuberculosis (TB)**

In the Auckland region there has been a higher number of cases for the six monthly period December – May (47) compared to the average for the same period across three years (30). Most of the cases are based in the CM Health area (see Figure Two).
1.5 **Acute rheumatic fever**

Acute rheumatic fever notifications were similar compared with the same period last year (59 cases during Dec 2018 – 31 May 2019 compared to 65 in the same period last year).

The largest burden of disease in 2018 was in the CM Health region with very high rates in Pacific children under the age of 19. Of all acute rheumatic fever cases, 84% occurred in Auckland’s most deprived areas (NZDEP 8, 9, 10).
1.6 Meningococcal

There were 17 cases of meningococcal disease across the Auckland region 1 Dec 2018 - 31 May 2019, the same incidence as the year prior. Of the 15 typed cases notified in the last six months, five were MenW, nine were MenB and one was MenC.

The Ministry of Health issued a national advisory on 6 November 2018 regarding a significant increase in Neisseria meningitidis serogroup W (MenW) in New Zealand since mid-2017. MenW can present atypically with gastro-intestinal symptoms, as well as pneumonia, septic arthritis, endocarditis or epi/supraglottitis. The advisory identified Northland as the region most affected in 2018. A targeted vaccination programme was subsequently implemented in Northland. ARPHS provided some public health nursing and communications resources to support Northland DHB.

While the total number of meningococcal cases in the Auckland region has remained relatively stable the proportion of these cases identified as MenW has markedly increased over this time. The overall rates of meningococcal disease and MenW disease in the Auckland region are consistent with national figures, unlike Northland where higher rates have been observed.

ARPHS is conducting ongoing surveillance of this issue based on regional and national data, as well as continuing to provide public health management of meningococcal cases and their contacts.
2. **BCG vaccine update**

The Bacille Calmette Guerin (BCG) programme (free to eligible1 children under five years to protect them from TB) re-commenced in August 2018. Since the programme commenced in August 2018 nearly 300 clinics have been held and around 6,300 children vaccinated. This includes 46 clinics in the month of May, the highest number to date. The number of children waiting for a clinic appointment continues to reduce (currently around 1,200 down from 2,100 children in mid-April). Children aged six months and under continue to be prioritised on this waitlist with an average wait time of two-three months. Additional clinics have been set up to manage the demand.

3. **Drinking water standards**

Revisions approved in 2018 to New Zealand drinking water standards came into effect on 1 March 2019. For ARPHS, this means there is a need for ARPHS drinking water assessors to carry out more in-depth risk assessment when determining drinking water standard compliance, for networked water supplies, when responding to notifications. These revisions do not currently apply to specified self-suppliers, and therefore at this time do not apply to Maraes’.

The Standards continue to be reviewed, led by an independent Drinking-Water Advisory Committee reporting to the Minister of Health, and proposed changes are expected to be released for consultation in mid-2019.

3.1 **Three Waters Review**

The Government is currently reviewing how to improve the regulation and supply arrangements of drinking water, wastewater and stormwater (three waters). The review was prompted by the Havelock North drinking water contamination incident but “three waters” recognises that there are interactions between these different water streams.

Policy work is underway on the shape and form of proposed new regulatory arrangements to ensure drinking water safety has been identified as an immediate priority, along with improved

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1 Eligibility criteria includes one or more of the following for a child under five who (a) will be living in a house or family/whaanau with a person with either current TB or a past history of TB (b) have one or both parents or household members or carers, who within the last five years lived for a period of six months or longer in countries with a TB rate of >40 per 100,000 (c) during their first five years will be living for three months or longer in a country with a TB rate of >40 per 100,000 and are likely to be exposed to those with TB.
environmental performance of wastewater and stormwater systems. The review is being led by the Minister of Local Government with a review team including representatives from the Ministry of Health, the Ministry for the Environment and the Department of Internal Affairs. A targeted engagement process is underway on high-level policy proposals in which ARPHS is participating.

4. **Speed management bylaw**

Reducing speed limits is an important public health issue because slowing traffic significantly reduces traffic crashes, serious injuries, and deaths. In 2017, 64 people died and 771 were seriously injured on Auckland’s roads. As well as injury prevention, there are also potential co-benefits through reduced harm from air pollution, noise pollution and greenhouse gas emissions. Lower speeds also increase perceptions of safety and the likelihood that adults and children will cycle, walk or take public transport.

Auckland Transport (AT) has been working on the implementation of a Safe Speeds programme and has been consulting on its Draft Speed Limits Bylaw 2019 during March. If successful, AT will reduce speed in the Auckland CBD to 30km/h first, and then introduce new limits in some town centres and on 770km of high-risk rural and urban roads.

ARPHS has been working proactively with AT in this area in the lead up to, and following, the release of the draft bylaw by:

- sharing ARPHS submission and brief of evidence with key stakeholders on the impacts of speed limit reduction on road crashes, injuries and deaths, road safety risk in Auckland, the impact on sustainable transport modes and other public health co-benefits
- providing a media spokesperson, Medical Officer of Health Dr Michael Hale, and contributing opinion pieces and media releases, and posts on social media
- participating in a panel discussion on speed management organised by AT at Auckland City Hospital, which was followed up by Auckland Council with an article outlining the link between public health and speed, published on the Our Auckland – Auckland Council news website
- co-ordinating with the ADHB Communications team and Safekids to offer public statements and spokespeople on the harm from Auckland road accidents, including DHB trauma specialists and Starship clinical staff. Children, especially those in high socioeconomic deprivation areas, are disproportionately killed or injured as a result of current speed limits.
- presenting on the ARPHS Speed Limits Bylaw 2019 submission at the public hearings in April 2019.

5. **Healthy Auckland Together (HAT)**

Healthy Auckland Together (HAT) 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 including CM Health, local government, iwi-based organisations and non-governmental organisations. During November 2018 - May 2019, HAT has undertaken the following:

5.1 **Meeting with Minister Genter**

The Hon Julie Anne Genter asked to meet with HAT to better understand how the coalition works. At the 18 December meeting ARPHS represented HAT, joined by ADHB Board Chair Pat Snedden and CE
Ailsa Claire. HAT representatives (Drs Michael Hale and Julia Peters, and Jane McEntee) talked with the Minister about what policy change might be possible in transport planning and in the food environment around advertising of unhealthy food and zoning of fast food outlets. The Minister expressed support for the coalition’s work, encouraging the public health voice to be heard in the debate around cycling and active transport.

5.2 Marketing to children

HAT is submitting complaints to the Advertising Standards Authority (ASA) to identify inconsistencies with the way the current self-regulatory code is being considered. Complaints that are upheld help create a new standard for the industry, whereas complaints that are not upheld help build the case for policy/regulatory changes. HAT is also role modelling and encouraging communities to make complaints. HAT has lodged two recent complaints with the ASA (outlined below), and is preparing a third complaint regarding a Tiny Teddy bus shelter and website advertisement.

- One complaint related to a Kinder Surprise Advertisement. This has not been upheld. Although the ASA panel determined that Kinder Surprise is an occasional food and the advertisement was aimed at children, the panel ruled that a significant proportion of children would not see it, as the advertisement was not shown in children’s YouTube content.
- The second complaint in March 2019 was on a digital advertisement by Cookie Time due to breaches of the general Advertising Standards Code and the Children and Young People’s Code. The advertisement promotes the consumption of a large quantity of cookies as a breakfast meal through the image of milk and cookies in bowls, as well as the corresponding wording of the post. This complaint was upheld in part by the Complaints Board. The Board determined the ad breached the general code by promoting an unhealthy lifestyle by promoting a bowl of cookies and milk for breakfast. The complaint was not upheld in relation to targeting children or young people. The team are currently exploring opportunities to express concerns with advertising codes via an article in the Spin Off.

The HAT marketing to children working group has revised its action plan, with priorities for the next 12 months including:

- developing a unified and clear set of recommendations for policy and regulatory changes in relation to marketing of unhealthy food and beverages
- continuing to reframe the conversation and build and demonstrate public support for restricting the marketing of unhealthy food and beverages by developing and promoting communication/advocacy tools.

5.3 Food Environments

The ‘Good Food Kai Pai’ initiative to strengthen healthy food environments at events has been extended beyond ATEED major cultural festivals (Lantern, Pasifika, Diwali) to include Auckland Council events such as Pacific in the Park, Christmas in the Park and Waitangi Day events, and most recently Polyfest. ARPHS has made significant progress in working with events teams to implement no-sugary drink policies at events and workshops with stallholders. HAT partners Healthy Families Waitakere and Healthy Families South worked with local boards in the south and west Auckland areas to mandate the ‘Good Food Kai Pai’ guidelines at their funded events.
HAT has continued to support the implementation of the National Food and Drink Policy at the Auckland metropolitan DHBs via chairing the metropolitan DHBs network, participating in national teleconferences and supporting evaluation of policy implementation. A joint workshop was held in May 2019 with the Ministry of Health, Heart Foundation and Health Promotion Agency. As a result of the workshop HAT are looking at designing a toolkit of resources for use in organisations across New Zealand, including other government agencies supported by MOH and HPA.

The group at present is also reviewing the wording of the Food and Drink Policy for Organisations, and reframing it so it can be used in a broad range of organisations. HAT is working on developing a set of principles that not only talk about food but the environmental influence and sustainability aspect of it. Resources are also being developed that will support the toolbox.

5.4 *Research, Monitoring & Evaluation*

The 2019 HAT monitoring report will be released shortly. This was developed with contributions from partners from University of Auckland, WDHB, ADHB, CM Health, Aktive and Hapai te Hauora. The key findings of the monitoring report include:

- Obesity continues to rise in both adults (30%) & children (15%). However, the number of pre-schoolers (under 5) who are obese continues to decline. This trend is consistent nationally. The reason for this trend is not entirely clear but changes to nutrition and physical activity once children begin school is a likely factor. Socioeconomic deprivation and ethnic disparities are still heavily present in obesity outcomes both for children and adults in Auckland.

- Dental health has not improved in the last decade and has worsened overall for children aged 5 and under.

- Overall, only half of all Auckland adults meet physical activity guidelines and there has been no change in this over time.

- Maori and Samoan children spend the highest number of hours engaged in physical activity and Asian children are the least physically active.

- Trends in physical activity change as children transition to adulthood with Samoan adults being the least physically active and European adults being the most physically active.

- Aucklanders are using more public transport with the per capita rate increasing 4.4% every year from 2006. However, active and public transport modes accounted for only 17% of share of journeys, with the rest being accounted for travel by car.

ARPHS is undertaking the following actions as part of our day-to-day work and in collaboration with HAT partners:

- Improving the availability of affordable and healthy food at major cultural festivals, Auckland Council events and in workplaces.

- Reducing the exposure of children and young people to the marketing of unhealthy food. We are developing a set of recommendations for policy and regulatory change and advocacy tools to build public support for restricting the marketing of unhealthy food through changing from a self-regulatory to a regulatory code.
• Working across Auckland to increase the number of public drinking fountains and displace sugar sweetened beverages with tap water.
• Sharing HAT monitoring report data in accessible formats to Auckland Council to inform the Auckland Council's 2020 long term plan and local board planning cycle.
• Supporting the work of the Healthy Puketapapa Action and the Healthy Families MMP to enable Auckland Council to enact health promoting environments.
• Supporting the Ministry of Health’s draft Healthy Food and Drink Policy for Education Settings to ensure that children have healthy choices in the places that they learn.
• Exploring opportunities to support the work of Aktive in promoting physical activity for all across the life span

5.5 Nutrition and Physical Activity

HAT and the Heart Foundation co-hosted a meeting for school providers including frontline staff who deliver nutritional and physical support in Auckland schools to increase the opportunities for collaboration. The meeting concluded with a presentation of Wai Auckland.

6. Wai Auckland

The “Wai Auckland” programme aims to displace sugar sweetened beverage with tap water. The programme includes the ADHB, CM Health, ARPHS, Auckland Council, Auckland Transport and Watercare. This programme will include increased access to public drinking water fountains.

A University of Auckland summer student has completed an audit of a large sample of public drinking fountains to assess their quality, including features, accessibility and cleanliness. 282 fountains were sampled. This included 17 new fountains found during the field survey. The survey results included the following:

• 96% of fountains sampled were functioning
• only 70% all fountains were drinkable (this takes in account flow of water, water height enough to drink, and also accessibility to the fountain)
• only 62% fountains were classed as clean (no significant discolouration or mould within 1 cm of the spout and no rubbish found in the fountain).
• there were three fountains with vandalism which was very minor
• a number of public areas did not have water fountains.

Key partners (Auckland Council and Auckland Transport) are addressing the identified cleanliness and drinkability issues and the findings will be used to inform future infrastructure activities. An overall baseline evaluation report for the project is also being finalised with the University.

7. Smokefree update

7.1 Smokefree court hearing

A Smokefree court hearing against The Longroom in Ponsonby took place on 25 February 2019. ARPHS compliance officers had observed the premises allowing smoking in an area which was assessed as an ‘internal area’ by ARPHS compliance officers, as defined under the Smokefree Environments Act. ARPHS compliance officers gave evidence at the hearing, with technical support from Professor Nick Wilson, a second hand smoke expert. There are multiple factors that must be considered in defining an internal vs outdoor area where smoking may be permitted. Due to these factors and in considering the design of the premises, the judge decided that he could not prove
beyond reasonable doubt that the premises was an internal area, and therefore acquitted the defendant. The judgement on this case will provide a useful example for the Ministry of Health when reviewing the Smokefree Environments Act later this year.

7.2 ARPHS submission - Auahi Kore Hapori Whanui Action Plan

On 9 April 2019 ARPHS made a public submission to the Auckland Council Environment and Community Committee meeting on the Auahi Kore Hapori Whanui Action Plan – a plan that derives from Auckland Council’s smokefree policy ARPHS has previously advocated for. ARPHS’ submission recommended that the action plan be strongly connected to the wider council smokefree implementation plan and that both receive sufficient implementation funding. This was to support a systems approach to achieving the goal of a Smokefree Auckland by 2025. ARPHS requested the plan be amended so that vaping was promoted as one of a suite of smoking cessation tools, rather than the main cessation method, and this was adopted. ARPHS offered expertise to further collaborate with Council on the development of the detailed activities.

7.3 Sale of tobacco to minors

ARPHS Smokefree Enforcement Officers recently ran 96 controlled purchased operations (CPOs) over the April school holidays. The CPOs resulted in a total of nine sales of tobacco to minors. This brings the 2018/19 financial year total to a record 29 sales to minors, of which 17 of these premises were in South Auckland, three in East Auckland and the remaining in Auckland CBD. All premises receive an education visit in the lead up to the CPO advising the retailer of their requirements under the Smokefree Environments Act and to give notice that they will be coming back to undertake a CPO in the near future.

Following these sales, ARPHS makes a recommendation to the Ministry. Infringements ($500 per individual seller) are issued by the Ministry.

7.4 Vaping regulation

In November 2018 the Government announced its intention to amend the Smoke-free Environments Act 1990 to improve smokers’ access to quality vaping and smokeless tobacco products, while protecting children and young people from the risks associated with them. In summary the Government has agreed to:

- regulate all nicotine and nicotine-free vaping liquid, devices and components
- regulate flavours and colours
- prohibit vaping in legislated smokefree areas (indoor workplaces, early childhood centres, schools)
- agree to exempt notified specialist R18 retailers from the prohibition on vaping indoors.

ARPHS considers that the proposed approach largely manages the balance of concerns between allowing the use of vaping as a cessation option and potential risks to vulnerable populations. It is anticipated that Government will call for submissions on the proposed amendments to the Smokefree Environments Act to support these intentions later in 2019.

The Health Promotion Agency has been working with the Ministry of Health, at the request of the Government, to develop a website and media campaign to support smokers to switch successfully to
vaping. The website has now gone live. ARPHS will link to this information for Aucklanders seeking advice on vaping or cessation support.

The Ministry of Health position statement on vaping can be found here: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/vaping-and-smokeless-tobacco

8. Alcohol update

8.1 Judicial Review of the Provisional Local Alcohol Policy

On behalf of the Medical Officer of Health, ARPHS has led the submission for the Judicial Review of the Provisional Local Alcohol Policy (PLAP), held on 20 February 2019. ARPHS is awaiting the outcome of this hearing. If the outcome is not in favour the only party that has the right to appeal is Council due to ARPHS appearing only as an interested party.

8.2 ADHB Health Excellence Awards

In November, the ARPHS Alcohol team won the ADHB Health Excellence Team Living our Values Award for their collaborative work with the Maori Wardens Ki Otara Trust. This work has enabled the Maori community to have more voice in the alcohol licence process.

9. Local board health planning

Auckland Council’s 21 local boards produce plans every three years that set out each Board’s strategic direction and priorities. As a Healthy Auckland Together (HAT) partner, ARPHS has worked with Council to seek opportunities for wellbeing promotion at the local board level. The Puketāpapa Local Board is demonstrating wellbeing planning through the Healthy Puketāpapa Action Plan. The plan will identify ways to promote access to water, healthy food and active transport like walking and cycling. It is anticipated that the Healthy Puketāpapa Action Plan model and associated learnings will inform future work and could be replicated by other local boards in the 2020 planning cycle. Puketāpapa also serves as a demonstration project to showcase some of the wellbeing outcomes that might be achieved through the Government’s commitment to a broad agenda of wellbeing and specifically the focus on wellbeing in Budget 2019.

10. Refugee Health

From June 2020 New Zealand’s refugee quota will increase from 1,000 to 1,500 people per year and the time newly arrived refugees spend at the Mangere Refugee Resettlement Centre (MRCC) will be reduced from six weeks to five weeks. In preparation for this, MBIE and Ministry of Health are leading a project to develop a new model of care for refugee health services. ARPHS and CM Health are represented on the project steering group.

Under the new model of care health screening will be completed off shore and only refugees identified with high health needs will be seen at MRCC. A continuum of care will be provided by primary care on resettlement in the regions. Due to the change in focus at MRCC it is unlikely ARPHS will be providing the screening or related health service from 1 July 2020.

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2 www.vapingfacts.health.nz
11. Submissions

ARPHS has an important role in developing policy submissions to represent the public health view for the Auckland region on behalf of the three Auckland metro DHBs. ARPHS has completed and submitted 16 formal submissions between December 2018 and May 2019. The table below lists the submissions and Appendix B briefly summarises the key points for each submission.

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<tr>
<th>Date</th>
<th>Topic</th>
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<tr>
<td>December</td>
<td>Public Safety and Nuisance Bylaw 2013 review</td>
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<td>Child and Youth Wellbeing Strategy</td>
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<td></td>
<td>Submission on the Regional Public Transport Plan</td>
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<td></td>
<td>Submission on the Health (Drinking Water) Amendment Bill</td>
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<tr>
<td>February</td>
<td>MARPOL Annex VI: treaty to reduce air pollution in ports and harbours</td>
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<td>April</td>
<td>Our Water Future: Auckland’s water strategy – discussion paper</td>
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<td>Drury-Opaheke and Pukekohe-Paerata draft structure plans</td>
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<td></td>
<td>Draft Healthy Food and Drink – Education Settings</td>
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<tr>
<td>June</td>
<td>Proposed Trade Waste Bylaw 2013</td>
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<tr>
<td></td>
<td>Proposed Waste Management and Minimisation Bylaw 2015</td>
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</table>
Appendix A

Disease Notifications

Mumps
The mumps epidemic has significantly reduced over the last six months. There were 28 cases across the three Auckland DHBs in the six months to May 31 2019.

Weekly Mumps surveillance chart

Invasive pneumococcal disease
Invasive pneumococcal disease (IPD) is a seasonal disease with the 2019 notifications similar to the same period in 2018.

Weekly Invasive pneumococcal disease surveillance chart

Campylobacteriosis
Campylobacteriosis increased in the six month period with 1,064 notifications compared with 947 during the same period in 2017-18. There were particularly high rates in December 2018 and January 2019. Initial review of the risk factor data from the campylobacteriosis study did not reveal any particular risk factor. In response to the increase, ARPHS actively promoted public health advice in social media, focussing on how to hygienically prepare, cook and store food. This was in addition to the advice provided by the Ministry for Primary Industries (MPI) through its annual summer food safety campaign.
Salmonellosis

Rates of salmonellosis in 2019 have increased by 15 percent. There have been 181 notifications over the last six months compared to 158 in the same period in 2018.

CM Health notifications increased from 48 cases to 67 cases. This was largely attributable to Salmonella Typhimurium phage type 108/170 of which there were 23 cases in the Auckland region. Case investigation found a range of risk factors and serotypes. ARPHS informed and liaised with ESR and MPI who is responsible for leading investigation in food related outbreaks to undertake further analysis of potential causes related to specific foods. The analysis of the data implicated alfalfa sprouts as the likely food source. MPI is still working with the commercial manufacturer whose premises remain closed.

Shigellosis

Rates of shigellosis were stable for the period Dec 2018-May 2019 (78 to 77 cases). A significant proportion was overseas acquired with the most common countries of origin being India, Tonga and Samoa. Of the locally acquired cases consumption of raw fish was a common risk factor. Relevant public health messaging and advice has been circulated.
VTEC

There was an increase in confirmed VTEC/STEC cases during Dec 2018 – May 2019 (161) compared to the same period in 2017-18 (134). Levels in ADHB and WDHB were elevated but this was not matched in CM Health.

There were particularly high levels in March 2019 which was thoroughly investigated but no common source was identified. ESR was kept informed throughout the investigation.

There has been a revision to the response to cases of confirmed VTEC in line with the revision of the Ministry of Health’s Communicable Disease Control Manual. ARPHS has implemented a change in the response to confirmed cases of VTEC by reducing the level at which people cannot attend childcare or return to work, for both cases and close contacts. The new exclusion recommendation reflects the evidence which shows that while the illness has the potential to be very serious (especially in children under five), there is very little person-to-person transmission. This change provides a better balance between the previously known and often significant burden to cases/contacts from public health interventions, versus the risk to public health from the spread of disease.
Legionellosis notifications have been within the usual range during the December 2018 - May 2019 period compared with the same period in 2017-18. Autumn numbers have been lower in 2019 compared to recent years.

The predominant serotype for 2018 was L. pneumophila which is typically associated with aerosolised water and man-made warm water systems, especially cooling towers. The second most common was L. longbeachae typically associated with soil and landscaping products. In February, Auckland Council following a request from ARPHS, asked owners of all known cooling towers to proactively shock dose (i.e. disinfect) their installations, in anticipation of the usual autumnal increase of L. pneumophila notifications. The results of the additional dosing and any changes to legionella statistics are yet to be confirmed.
## Appendix B

Summary points for ARPHS submissions during July 2016 – May 2017:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Safety and Nuisance Bylaw 2013 review</strong></td>
<td>Auckland Council proposed changes to its Public Safety and Nuisance Bylaw 2013, which seeks to protect people from nuisance or unsafe behaviours and activities in public places. ARPHS recommended the insertion of a smokefree provision in the bylaw to strengthen existing smokefree policies for Council run events and public transport hubs. ARPHS also recommended that the existing public health purpose of the bylaw be retained.</td>
</tr>
</tbody>
</table>
| **Child and Youth Wellbeing Strategy** | A key requirement of the child poverty reduction legislation, passed in 2018, is the creation of New Zealand’s first Child and Youth Wellbeing Strategy. It is proposed that the Strategy will provide a framework to drive government policy and action on child wellbeing. ARPHS supported the framework’s principles and provided the following considerations:  
  - strengthening the emphasis on Te Tiriti o Waitangi and Te Ao Māori;  
  - increased emphasis on the drivers and determinants of health and wellbeing;  
  - the inclusion of a systems approach;  
  - co-designing the Strategy’s indicators with Māori;  
  - inclusion of a strength based approach;  
  - focus on addressing inequities in the justice system;  
  - strengthening of the data collection and information sharing across agencies, to inform service delivery and measurement of the Strategy’s effectiveness;  
  - investment in the Māori and Pacific workforce;  
The Strategy to come with a full implementation plan to maximise its impact. |
| **Submission on the Regional Public Transport Plan** | The Regional Public Transport Plan (RPTP) describes the public transport network that Auckland Transport (AT) proposes for the Auckland region, identifies the services that are integral to that network over a 10-year period, and sets out the policies and procedures that apply to those services. Two focus areas in the plan relevant to public health are:  
  - expanding and enhancing the Rapid and Frequent Networks;  
  - improving customer access to public transport (walking, cycling, park and ride)  
ARPHS supported the actions in the RPTP that create a shift towards public and active transport modes. |
| **Submission on Health (Drinking Water) Amendment Bill** | The Amendment Bill follows the Government’s Havelock North Drinking Water Inquiry – Stage 2 report with the objectives of improving the effectiveness and efficiency of Part 2A of the Health Act 1956, without |
materially affecting any party or imposing new or additional costs. The proposed amendments will have a direct impact on the operation of Auckland’s Drinking Water Assessment Unit (DWAU).

ARPHS supported the policy objectives of the Bill noting a number of areas that could be strengthened.

**ARPHS also supported the Public Health Clinical Network Submission on Health (Drinking Water) Amendment Bill**

In December 2018, ARPHS led the development of a joint submission on the Health (Drinking Water) Amendment Bill, on behalf of the Public Health Clinical Network (PHCN). The PHCN submission supported the policy objectives of the Bill noting that the Bill could be strengthened in a number of areas including strengthening of the provision around Water Safety Plans through management and control of critical points, the provision of an alternative national quality management system, inclusion of an additional section which requires specified self-suppliers to comply with the Drinking Water Standards, and the strengthening of Water Safety Plans implementation and compliance processes.

**MARPOL Annex VI: treaty to reduce air pollution in ports and harbours**

This International Maritime Organisation treaty, Annex VI of the International Convention for the Prevention of Pollution from Ships (MARPOL), regulates emissions that are harmful to public health, deplete the ozone layer and contribute to climate change. This has not been regulated in the past. Sulphur emissions from ships at the Auckland port drift across the central city, and Auckland Council data shows elevated sulphur levels around the port area.

ARPHS supported New Zealand’s accession to Annex VI.

**Submission on Watercare Services Limited application: Army Bay Wastewater Treatment Reconsenting Project**

ARPHS’s submission recommended that EC are legalised in New Zealand for the purpose of smoking cessation and tobacco harm minimisation, but also recommended that the EC and e-liquid packaging be standardised to acknowledge the unknown long-term health effects, and help buffer against future (somewhat unknown) unintended consequences.

**Submission on Speed Limits Bylaw 2019**

ARPHS made a submission in support of the draft bylaw – see item 4 in the report for more information.

**Our Water Future: Auckland’s water discussion**

The water strategy reviews how Council should take care of natural waterbodies, the changing water needs due to population growth and preparations required in relation to climate change.

ARPHS’ submission fully supported Council’s intent to move towards the development of an integrated framework for water decisions. The framework will help Council to work through potentially controversial decisions about water management that often result from competing stakeholder demands for Auckland’s water resources and the variety of values that each stakeholder applies to this particular resource. ARPHS’ main recommendations included:

- Ensure the framework moves beyond a theoretical concept, and is practically applied to help determine which water
infrastructure, initiatives, and policies are implemented, operationalised and funded.

- Due to funding constraints prioritise initiatives that make the biggest difference.
- Focus on activities that mitigate the effects of climate change.
- Any future water strategy should align with existing plans managing Auckland’s growth.
- Place equal weight on ecology, human, cultural, historical, social and wellbeing values versus technical and commercial values.
- Support the implementation of the Te Mana o te Wai concept.

**Drury-Opāheke and Pukekohe-Paerata draft structure plans**

- The Auckland Unitary Plan has set aside land around Drury-Opāheke and Pukekohe-Paerata for future development. It is anticipated that these areas will experience significant urban growth over the next 20 years.
- As part of the structure planning exercise a health topic paper had been developed to provide a rapid assessment of the draft structure plans from a health and well-being lens. The health topic paper summarised the current health provision in the Drury and Pukekohe structure plan areas, and provided a brief, high-level assessment of possible health impacts from the draft Drury-Opāheke and Pukekohe-Paerata structure plans.
- Council invited comment on the draft structure plans for these areas, which have been developed over the last few of years, with a final opportunity to have input before the plans are finalised. ARPHS and a CM Health representative previously attended a public workshop on the structure plan development.
- ARPHS’ submission supported the development of the health topic paper and encouraged Council to further use healthy urban planning frameworks and resources such as those from the World Health Organisation (WHO). ARPHS’ submission also suggested that future health topic papers should consider a wider range of health impacts.
- ARPHS’ submission welcomed any opportunity to have a discussion with relevant Council staff to support the further development of the content and methodology for carrying out an assessment of the impacts of urban planning on health in the future.

**Proposal for reducing the notifiable level for lead absorption under the Health Act 1956**

The aim of the Ministry of Health’s position paper was to seek comment on the proposal to reduce the current notifiable blood level of 0.48 mol/l to 0.24 mol/l for all ages. ARPHS submitted in favour of the reduction of the notifiable blood levels.

**Submission on the Health and Disability System Review**

ARPHS’ submission noted that the future holds significant challenges for public health and the health system including the unsustainable burden from non-communicable diseases, an ageing population, emerging and re-emerging diseases, underlying social and environmental determinants, health impacts of climate change and the threats associated with
antimicrobial resistance. ARPHS’ submission recommended:

- Strengthening central government agency alignment and ensuring cross government decisions consider public health, wellbeing and equity implications.
- Investing in public health capacity, capability, consistency and coordination; recognising that investment in public health interventions is cost-effective for New Zealand.

Building strong system enablers through workforce planning and development (including a review of the Public Health Workforce Development Plan), public health intelligence and technology.

<table>
<thead>
<tr>
<th>Proposed changes to funded vaccines in the National Immunisation Schedule</th>
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<tr>
<td>Pharmac proposed several changes to the funding of vaccines in the National Immunisation Schedule, including replacing the adult diphtheria and tetanus vaccine (ADT Booster) with Tdap (Boostrix), and changing the eligibility criteria for the Meningococcal C conjugate vaccine (Neisvac-C) to limit use to children under nine months of age who are too young to receive the Meningococcal ACWY conjugate vaccine.</td>
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<tr>
<td>ARPHS supported the proposal and noted that changing Td to Tdap means that there will be more opportunities for boosting immunity to pertussis in the New Zealand population.</td>
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<tr>
<td>APRHS also recommended an additional quadrivalent Meningococcal C conjugate vaccine be approved for infants less than nine months of age without conditions such as asplenia, HIV and complement deficiency. ARPHS noted there is an ACWY vaccine that is licensed from six weeks of age in the form of NimenRix which could provide superior protection for this age cohort.</td>
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<tr>
<th>Proposal to widen access to pertussis (whooping cough) vaccine</th>
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<tbody>
<tr>
<td>PHARMAC sought feedback on a proposal to widen access to funded pertussis (whooping cough) vaccine for all pregnant women at any time during their pregnancy, as well as for parents of infants admitted to a Neonatal Intensive Care Unit or Specialist Care Baby Unit for more than three days.</td>
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<tr>
<td>ARPHS supported the proposal with some amendments to ensure the benefit is maximised and unintended consequences are mitigated. ARPHS noted the following:</td>
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<td>- Biological evidence would suggest that from 27-30 weeks is the optimal time for pregnant women to receive the pertussis booster, and maternal IgG does not cross the placenta until the second trimester. Therefore, ARPHS recommended that funding be restricted to the second trimester onward, and that consideration be given to promoting a ‘recommended time’.</td>
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<tr>
<td>- The delivery of the influenza vaccine is recommended early in pregnancy to protect the mother. Therefore clear communications about the timing of both the influenza and pertussis vaccinations in pregnancy is required.</td>
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<th>Draft Healthy Food and Drink -</th>
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<tr>
<td>The MoH sought feedback on a draft ‘Healthy Food and Drink Policy for...”</td>
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</table>
### Education Settings

Education Settings’. The Policy represents MoH’s recommended advice for food and drink available in schools and early learning settings.

ARPHS’ submission strongly supported the MoH’s work to develop national policies that will improve influential food environments for children. While appreciating the consultation centred on the proposed nutrient criteria in the Policy, ARPHS’ considers there are wider process considerations that will contribute greatly to the effectiveness and relevance of any policies developed, including:

- ensuring a collaborative approach to both policy development and implementation.
- basing policy development on existing, effective work such as the Food and Beverage Classification System and associated programmes at the Heart Foundation of New Zealand.
- resources should be prioritised on a needs basis to ensure successful implementation of the policy.
- There are opportunities for MoH and Ministry of Education to jointly leverage existing contracts and funding to ensure implementation is adequately resourced.

With a view to eliminating inequities, ARPHS’ strongly advocated for making the proposed policy mandatory.

### Proposed Trade waste bylaw 2013

Auckland Council is proposing a new bylaw to make the Trade Waste Bylaw easier to understand through introducing clearer rules around trade waste activities that are low-risk, and activities that require a trade waste agreement.

ARPHS supported the proposed changes and recommended a few additional wording changes to strengthen some provisions.

### Proposed Waste Management and Minimisation by-law

Auckland Council is proposing a new bylaw to:

- Better manage and minimise waste
- Protect the public from health and safety risks
- Manage the use of council-controlled public spaces

The Waste Management and Minimisation Bylaw will help achieve the nine key actions set out in the Waste Management and Minimisation Plan (ARPHS has previously comment on this). ARPHS supported the proposed bylaw, while emphasised the need to keep waste disposal for households and individuals as seamless and as straightforward as possible. ARPHS also recommended a few minor edits to several sections.
Urgent and After Hours Care in Counties Manukau
Urgent Care

Medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require a prolonged assessment or admission. The urgency of the care can be from the patient’s or health professional’s perspective, or both.

It is usually:

• episodic without an appointment, and
• delivered in the community.

Therefore, improved urgent access is about supporting an increasing number of people who (perceive or do) have an urgent but non-life-threatening complaint to get quality care, in an appropriate setting, in a timely manner.
• Co-payment capped at $39 for eligible patients regionally (eligible = >65, CSC, HUHC, living in Q5 area).
• Free for <14s
• Eight clinics funded across CMDHB (up from four)
  – Eight funded 5-8pm weekdays and 8-8pm weekends/public holidays
  – Four (one in each locality) funded from 8pm up until 11pm
  – Expecting 120,000 volumes per year
1. BOTANY/HOWICK
Eastcare
260 Botany Road
$30
277 1516
5pm-11pm weekdays
8am-11pm weekends

2. OTARA
Local Doctors Otara
3 Watford Street
$30 or $15 if enrolled
274 3414
5pm-11pm weekdays
8am-11pm weekends

3. MANGERE
ETHC Mangere
10 Wadden Place
$37.50 or $15 if enrolled
274 9354
5pm-8pm weekdays
8am-8pm weekends

4. OTARA
ETHC Dawson Rd
124 Dawson Rd, Clover Park
$37.50 or $15 if enrolled
274 3468
5pm-8pm weekdays
8am-8pm weekends

5. MANUREWA
ETHC Browns Rd
235 Browns Road
$37.50 or $15 if enrolled
264 1640
5pm-8pm weekdays
8am-8pm weekends

6. TAKANINI/PAPAKURA
Takanini Care
106 Great South Road
$35
299 7670
5pm-8pm weekdays
8am-8pm weekends

7. PAPAKURA
Counts Urgent Care Papakura
6-18 O'Shannessey Street
$35
299 9380
5pm-10pm weekdays
8am-10pm weekends

8. PUKEKOHE
Urgent Care Franklin
149 Manukau Road
$39
238 6610
5pm-9pm weekdays
8am-9pm weekends

Note: For full details and fees for the out-of-hours clinics listed above, please visit countiesmanukau.health.nz/poi-services/ths-rights-care-for-you

KNOW WHERE TO GO: countiesmanukau.health.nz
2019 Winter Demand

• Unusually high demand for this time of the year (and earlier in the season):
  ‘Lots of gastro, flu like illness, and medical cases. Down on accidents and ACC. Lots of children.’

• Clinics are putting on additional staff, utilising Primary Options for Acute Care and calling hospital Specialty staff to prevent hospital admission, and looking at how they can improve flow, but they are also dealing with high levels of illness within their own workforce.
Dashboard
Improvement Priorities

1. Utilise Clinical Pathways throughout the system for consistent care;
2. Accurately refer patients from the community to hospital;
3. Accurately discharge patients from the hospital back to the community - information is transferred back to the referring clinician;
4. Increasingly use of Primary Options for Acute Care (or rapid response) in both the community and hospital;
5. Create a feedback loop in a timely manner for those who are seen in the hospital after the community with a high morbidity disease
6. Increasingly facilitate ambulance to non-ED referral.
Emergency Q Pilot
Sick of Waiting?

Download Emergency Q
- Faster treatment and closer to your home
- Tells you where to go and gives directions

Point your phone camera at this poster and then click on the link to download the app.
Or search ‘Emergency Q’ in AppStore or Google Play.
• We have extended the pilot over winter until September.
• To date (since September 2018) almost 3500 patients have chosen to leave ED to attend one of the two local A&Ms involved in the pilot.
• Average per month = 543 pts (and rising), ~24% of eligible triage 4 and 5s.
• Next steps:
  – Reducing age range to include older children/teens.
  – Additional A&Ms on the app.
  – A volunteer in ED to help patients download app when busy.
Recommendation

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

Receive this Quarter 3 2018/19 Non-Financial Summary Report.

Note and review the results for Quarter 3 progress against draft planned 2018/19 actions and performance expectations, including key challenges and resolution plans for those measures where performance was low.

Note the appended Northern Region Health Plan Quarter 3 2018/19 summary report provided by the Northern Regional Alliance (Appendix 2).

Prepared and submitted by Kitty Neill, Planning Advisor on behalf of Parekawhia McLean, Director Strategy & Infrastructure

Glossary
ARDSD Auckland Regional Dental Service
B4SC B4 School Check
CAMHS Child and Adolescent Mental Health Service
CCDM Care Capacity Demand Management
CT Computed Tomography
CTO Compulsory Treatment Order
CVDRA Cardiovascular Risk Assessment
DMFT Decayed, Missing and Filled Teeth (index)
ED Emergency Department
FCT Faster Cancer Treatment
MRI Magnetic Resonance Imaging
NCHIP National Child Health Information Platform
NIR National Immunisation Register
OIS Outreach Immunisation Service
PHO Primary Health Organisation
Q Quarter (3 month period)
RMO Resident Medical Officer
WCTO Well Child Tamariki Ora

Purpose

To provide a summary picture of how we are progressing against our planned commitments outlined in the final draft 2018/19 CM Health Annual Plan.
Discussion

SIGNIFICANT ACHIEVEMENTS

CM Health has sustained performance in Quarter 3 and, as in Quarters 1 and 2 2018/19, continued to exceed the target for the Better Help for Smokers to Quit – Maternity (for whānau Māori and the total population) and the Raising Healthy Kids targets (for Māori, Pacific and the total population).

Other key areas of achievement in Quarter 3 included:

- **All colonoscopy targets (urgent, diagnostic and surveillance colonoscopy targets) met**: Performance against these targets has been sustained over the 2018/19 year with all targets having been met in all quarters.

KEY CHALLENGES

- **The elective surgery discharge target has not been met this quarter**: For the first time in the 2018/19 year, performance against this measure has dropped below target (Quarter 1 performance: 102.1%, Quarter 2 performance: 100.4%, Quarter 3 performance: 98.1%). Against the year to date total planned volumes of 15,448 ESD, actual delivery was 15,159. There was a negative variance of 289 or 98.1% of planned. Barriers to achievement of the target this quarter included:
  - **Industrial action** by resident medical officer (RMO) staff;
  - **High acute volumes** causing cancellation of elective theatre lists;
  - **Staff shortages** (particularly anaesthetists); and
  - **Increasingly tight private sector capacity** making access to additional operating capacity and outsourcing difficult.

- **62-day faster cancer treatment target**: Performance against this target has dropped further, from 89% in Quarter 1 2018/19 to 85% in Quarter 2 2018/19, to 76% in Quarter 3 (target: 90%). Performance has declined since 2017/18 during which CM Health achieved the 62-day target in all quarters. The following are among the challenges identified to achieving the target:
  - **Rising demand as part of overall increased capacity restraints**
  - **Delays to radiation oncology due to demand exceeding capacity**. Despite best efforts to refer patients within agreed timeframes there are breaches occurring as a result of this. Advice from ADHB on options to turnaround radiation oncology wait times is in progress under the governance of the Regional Cancer Board.
  - **Care coordination and tracking of patients**. Tumour stream pathways are in place to enable a patient to move well through the system, however this still requires consistent and sustained navigation and coordination to ensure the system operates in a timely manner. The Cancer Nurse Coordinator (CNC) role is pivotal in navigating patients from entering cancer pathways until they are either excluded or reach cancer treatment. This resource is currently stretched.

- **Emergency Department (ED) 6-hour target**: Performance is down 1% from Quarter 2 for all ethnicity groups and remains significantly below the 95% target (Quarter 3 performance: 86% total population, 85% Māori, 86% Pacific). The ED Health target has not been met since Q3 2016/17. There are multiple initiatives underway to improve patient flow and work towards achievement of the target, including:
  - **Every Hour Counts**: ‘ED flow’ is one of seven quality improvement programmes included in the Every Hour Counts portfolio. Inpatient capacity is currently one of the barriers to achieving the ED target. Currently medical and surgical wards aim to get 30% of patients to the discharge lounge by
11am although results are variable. A home-based ward model of care in acute medicine began in December 2018 with the aim of improving flow to inpatient wards. Under this model purposefully collocated patients are cared for by a team of doctors, nurses and allied health staff based on the ward, rather than by different teams who move around the hospital with the objective of creating geographical efficiencies and avoiding “safari ward rounds”. Progress on this model, however, has been hampered by high hospital occupancy resulting in constrained ability to relocate patients to create efficiencies.

- The Emergency Q pilot began in September 2018. Emergency Q is a digital information system designed to help patients make informed choices about the most appropriate care for their condition. Emergency Q aims to alleviate demand pressure on the ED through encouraging eligible patients to attend alternative urgent care providers. Between September 2018 and March 2019, 1,689 (20%) eligible patients chose to use Emergency Q and attend a local A&M clinic for free. The effectiveness, including cost effectiveness, of the service is currently being evaluated with an interim evaluation report due to be released in June and a final evaluation, covering a full year of utilisation data through to September 2019, to be completed later this year.

- Recruitment of Care Capacity Demand Management (CCDM) FTE has been approved by the DHB and the Ministry of Health and is currently underway.

- Oral Health: CM Health has not met the target for any of the three child and youth oral health measures in 2018 (oral health measures are reported annually) with performance either unchanged or worse than in 2017. There are also significant equity concerns, with Māori and Pacific children in Counties Manukau having higher rates of caries, more decayed, missing and filled teeth (DMFT), and high rates of arrears (delays in appointment schedule) than non-Māori, non-Pacific children.

There have been performance challenges with the oral health service provided by Auckland Regional Dental Service (ARDS) for some time now, with performance against all measures sitting below targets and significant equity gaps apparent. This is a regional issue with ARDS providing oral health services for Auckland, Waitemata and Counties Manukau. Quality improvement and change is required across the service in order to improve performance against all targets and lift the quality and coverage of oral health services provided to our children and young people in Counties Manukau. CM Health has recently employed a new Service Development Manager for oral health (February 2019) who is currently identifying key issues within the service provided and exploring a range of improvement opportunities. It is likely that many of these opportunities for change and improvement will involve a regional approach. Consideration is also currently being given to the development of a regional Oral Health Strategy. A decision on this is expected in next few months.

Please refer to the oral health performance measures PP10, 11 and 13 in Appendix One for full detail of the 2018 results and the specific activity underway to improve performance.

Appendices
1. CM Health 2018/19 Quarter 3 Non-Financial Summary Report
2. Northern Regional Health Plan Quarter 3 Summary Report (detailed report available on request)
Appendix 1: 2018/19 Quarter 3 Summary Progress Report

Please note that results by ethnicity have been provided where these are routinely reported.

The Planning Team is working with our services and the Ministry of Health on providing routine reporting by ethnicity for all measures, including for our Asian population.

<table>
<thead>
<tr>
<th>Dashboard Key</th>
<th>Green = Achieved</th>
<th>Orange = Partially achieved</th>
<th>Red = Not achieved</th>
<th>NR= Not reported</th>
<th>N/A= Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority</td>
<td>Performance measure</td>
<td>Report frequency</td>
<td>Target</td>
<td>MoH rating</td>
<td>Total</td>
</tr>
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<td>------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
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</table>
| Faster Cancer Treatment      | Percentage of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks | Quarterly        | 90%    |            | 76%   | NR     | NR      | NR    | NR    | CM Health has not achieved the 62-day Faster Cancer Treatment (FCT) target in Quarter 3 of 2018/19 with performance trending down and a final result of 76% against a target of 90%. The target was also not met in Quarters 1 (Q1 performance: 89%) and 2 (Quarter 2 performance: 85%). Note that performance did improve in the month of March (to 81% for a single month result). Performance has declined since 2017/18, during which CM Health achieved the 62-day target in all quarters.  
**Specific barriers affecting performance include:**  
**Volumes and capacity constraints** – Four key tumour streams - gynaecology, lower gastrointestinal (GI), lung and head and neck - have been identified as contributing to more than 50% of the total 62 day patient volumes and 80% of the capacity breaches. Volumes entering the 62 day pathway for gynaecology and head and neck tumour streams have more than doubled compared to same date range in the previous year. For gynaecology, the volumes increases in the past 6 months are due to a change in grading practices to bring CM Health in line with the region against the FCT business rules. CM Health is the lowest performing DHB in the region for gynaecology.  
Regarding lower GI volumes, both 62 day and 31 day lower GI patients access the same surgical services and resource. With the National Bowel Screening Pilot now in place at CM Health, 31 day volumes are increasing (bowel screening patients are 31 day patients) which in turn places increased pressure and competing demands on outpatient clinics and theatre lists.  
**Regional Radiation Oncology Capacity Constraint** - Capacity constraints in ADHB radiation oncology continue to create additional delays for patients requiring radiation treatment regardless of when they are referred to this service.  

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**Countsies Manukau District Health Board – Community & Public Health Advisory Committee**  
3 July 2019  
054
<table>
<thead>
<tr>
<th>Priority</th>
<th>Performance measure</th>
<th>Report frequency</th>
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<th>Notes</th>
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</table>
|          |                     |                  |        |            |       |        |         |       |       | **Stretchied Cancer Nurse Coordinator (CNC) resource** – The CNC role is pivotal in navigating patients from entering cancer pathways until they are either excluded or reach cancer treatment. The CNC is responsible for expediting and escalating appointments to ensure this happens in a timely manner.  
**Activity underway to address these barriers and improve performance:**  
**Gynaecology tumour stream:** The FCT team is currently working with regional colleagues to review and compare pathways at other Metro Auckland DHBs to try and understand key differences and potential for improvement to CM Health processes.  
**Regional capacity constraint:** Advice from ADHB on options to turnaround radiation oncology wait times is in progress under the governance of the Regional Cancer Board.  
**Diagnostics:** Improvements in MRI wait times are expected to flow into FCT.  |
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<tr>
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</thead>
<tbody>
<tr>
<td>Elective Surgery</td>
<td>Volume of elective surgery will increase by at least 4000 discharges per year (previous National Health Target)</td>
<td>Quarterly</td>
<td>Increase of 4,000 discharges per year</td>
<td><img src="image" alt="98.1%" /></td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>For the first time in the 2018/19 year, performance against this measure has dropped below target (Quarter 1 performance: 102.1%, Quarter 2 performance: 100.4%). Against the year to date total planned volumes of 15,448 ESD, actual delivery was 15,159. There was a negative variance of 289 or 98.1% of planned.</td>
</tr>
</tbody>
</table>

**Barriers to achievement of the target**
*RMO Strikes:* Since the New Year the industrial action by resident medical officer (RMO) staff is compromising service provision not only on strike days but also in the lead up to the strike days to preserve patient safety during the industrial action.

*Increased surgical case complexity* associated with comorbidities and patient compliance.

*High acute volumes* causing cancellation of elective theatre lists and clinics to create acute capacity. Current theatre numbers and resources are inadequate to complete the work in a timely manner - for both acute and elective.

*Staff shortages:* Anaesthetists shortage which has been restricting access to theatres but which is slowly improving. Senior medical staffing shortages in other services reducing capacity to deliver greater volumes.

*Private sector capacity* is tighter than ever making access to additional operating capacity difficult. We continue to outsource through subcontracting processes however, despite contracts, the private sector is struggling to accommodate the volumes being sent and are declining and returning patients to CM Health for our management.

**Activity underway to address these barriers and improve performance:** CM Health remains committed to further improving the elective delivery for Q4 to meet end of year targets.
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<tr>
<td>Shorter stays in ED departments</td>
<td>Percentage of patients admitted, discharged, or transferred from an ED within six hours</td>
<td>Quarterly</td>
<td>95%</td>
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**Admission processes and referral pathways:** An arranged admission process for clinically appropriate acute cases is being trialled to assess its impact on use of resource. There is continuous scrutiny on access and clinical referral pathways to manage volumes.

**Recruitment and resourcing:** Active and on-going recruitment of anaesthetists and completion of a service sizing. There are start date horizons of 6-36 months for those accepting employment offers. Interim locum cover is being employed where possible to cover staffing shortfalls. Where theatre lists are unable to be staffed by anaesthetists or technicians, local anaesthesia resource is being used as able to increase throughput of small cases to boost discharges. Proposals for additional clinical staff are being developed and submitted by services for employment consideration.

**Theatre capacity:** Private sector theatres are being leased where available. Planning for the development of additional clinic and theatre capacity reignited, with the benefit horizon being medium term rather than immediately available.

**Performance is down 1% from Quarter 2 for all ethnicity groups and remains significantly below the 95% target (Quarter 2 performance: 87% total population, 86% Maaori, 87% Pacific). The ED Health target has not been met since Q3 2016/17.**

**Barriers to achievement of the target:** Key barriers include increased volumes, resource constraints, and lack of inpatient capacity (hospital occupancy). A review of Emergency Department resources is underway as part of Winter Plan and following a benchmarking exercise of provider (or clinical staffing) resources. Acute presentations are increasing in volume and complexity. In combination with more patients is the lack of inpatient capacity resulting in overcrowding of the ED.
Activity underway to address these barriers and improve performance:

*Every Hour Counts*: ‘ED flow’ is one of seven quality improvement programmes included in the Every Hour Counts portfolio. Inpatient capacity is currently one of the barriers to achieving the ED target. Currently medical and surgical wards aim to get 30% of patients to the discharge lounge by 11am although results are variable.

*Home-based wards*: A home-based ward model of care in acute medicine began in December 2018 with the aim of improving flow to inpatient wards. Under this model purposefully collocated patients are cared for by a team of doctors, nurses and allied health staff based on the ward, rather than by different teams who move around the hospital with the objective of creating geographical efficiencies and avoiding “safari ward rounds”. Progress on this model, however, has been hampered by high hospital occupancy resulting in constrained ability to relocate patients to create efficiencies.

*The Emergency Q pilot*: The Emergency Q pilot began in September 2018. Emergency Q is a digital information system designed to help patients make informed choices about the most appropriate care for their condition. Emergency Q aims to alleviate demand pressure on the ED through encouraging eligible patients to attend alternative urgent care providers. Between September 2018 and March 2019, 1,689 (20%) eligible patients chose to use Emergency Q and attend a local A&M clinic for free. The effectiveness, including cost effectiveness, of the service is currently being evaluated with an interim evaluation report due to be released in June and a final evaluation, covering a full year of utilisation data through to September 2019, to be completed later this year.

**Resourcing**: Recruitment of Care Capacity Demand
Management (CCDM) FTE has been approved by the DHB and the Ministry of Health and is currently underway.

**ED Trigger Tool:** A trigger tool has been established and work is currently underway with IT to provide a transparent view of the trigger tool and code response to ED capacity. The trigger tool aims to identify early when ED is not coping and enable an escalation plan to be developed to cope with the demand.

### Immunisation

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</table>
| Immunisation   | Percentage of eight-month olds who have had their primary course of immunisation on time | Quarterly        | 95%    |            | 92%   | 83%    | 95%     | 98%   | 91%  | The total coverage at eight months has dropped by 1% from last quarter. Maaori coverage remains unchanged while Pacific has increased slightly (1%). There has been a decrease in Maaori coverage since this time last year (Q3 2017/18 performance: 86%) and we are not achieving equity for Maaori babies.

**Barriers to achievement of the target:**

- **Lower immunisation rate for OIS over the holiday period** - The mobility of families during the holiday season resulted in the Outreach Immunisation Service (OIS) immunising fewer babies. More families declined OIS appointments due to other commitments, not wanting to upset children over the holiday season and not being home.

- **Increased declines** - More families were declining immunisations during Quarter 3 with the decline rate increasing to 3.2% (from 2.7% in quarters one and two). Some families spoke of their fears regarding the Samoan babies who have died in Samoa, others wanted to do further research into immunisation and some did not want to be contacted.

- **Homelessness and transiency** - Issues of homelessness and transiency continue to be a challenge. Of the referrals for Maaori babies received by OIS for the quarter, 5% (14) were “gone no address”.

Counts Manukau District Health Board – Community & Public Health Advisory Committee
Activity underway to address these barriers and improve performance:

**Māori pepe prioritised** - OIS prioritise Māori pepe for home visits and, if not engaging or available in the week, a Saturday visit is attempted. Māori babies who have missed the opportunity of an OIS visit will continue to be offered the service as well as an invitation to the Saturday clinic.

**New incentives programme** - A pilot will start next quarter utilising incentives to encourage engagement with Māori whānau and pepe in the eight month old cohort for 2018/2019. This will last a year and will be evaluated.
### Priority: Smoking (primary)

#### Performance measure
Percentage of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking.

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<tbody>
<tr>
<td>Quarterly</td>
<td>90%</td>
<td></td>
<td>88%</td>
<td>87%</td>
<td>89%</td>
<td>92%</td>
<td>93%</td>
<td>CM Health has narrowly missed the 90% target again in Quarter 3 with no improvement in performance since Quarter 1 (Quarter 1 performance: 89%). However we believe that, as in previous years, performance will increase to meet the target before the end of the financial year. We are concerned to note that performance for Maaori continues to be lower than other ethnicities and did not reach the target. Barriers to achievement of the target: Quarters 2 and 3 are always challenging with many different priorities competing for practice time/attention. There are challenges around ensuring general practices maintain focus on the target, particularly given uncertainty around the National Health Targets based on public comments from the Minister. We continue to push the importance of this activity with our PHOs and practices. Activity underway to address these barriers and improve performance: ABC for transient patients: An on-going area of focus has been on improving ways in which PHOs can provide ABC to patients who are transient and do not have up to date contact details. Work is underway with PHOs to discuss strategies such as appointment scanning, improved coding systems, ensuring opportunities are not missed if the patient attends the practice with a family member. Active, dedicated management to support ABC activities in General Practice: All PHOs have committed staff responsible for ensuring this health target is achieved. Although for most practices this activity is now part of BAU and sustained throughout the year, these staff are used to sustain momentum towards the end of each quarter and year. Most PHOs have continued providing extra resource (FTE) to practices to offer evening/weekend (moonlight) calling for brief advice. PHOs have noted that although this is very relevant to their practices, it is increasingly difficult to maintain the level of activity required to meet the target.</td>
</tr>
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</table>
effective it is very resource intensive. However it has proven effective for practices that were struggling to reach target, and has led to the significant increase seen over the last quarter for some PHOs. We will continue to work with our PHOs and practices to ensure that this activity is seen as year-round and is sustainable.
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<tr>
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<tbody>
<tr>
<td>Smoking (maternity)</td>
<td>Percentage of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice and support to quit smoking</td>
<td>Quarterly</td>
<td>90%</td>
<td></td>
<td></td>
<td>94%</td>
<td>99%</td>
<td>NR</td>
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<tr>
<td>Raising Healthy Kids</td>
<td>Percentage of children identified as obese the Before School Check who are referred to a health professional for a clinical assessment and family based nutrition, activity and lifestyle interventions</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
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<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>NR</td>
<td>100%</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>PP7: Improving mental health services using transition (discharge) planning and employment</td>
<td>Percentage of clients with transition (discharge) plan</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
<td>91%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>Percentage of clients with a wellness plan</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
<td></td>
<td>99%</td>
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<td>Percentage with a transition</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
<td></td>
<td>36%</td>
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<td>Percentage of files audited that have a wellness plan of acceptable standard</td>
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<tr>
<td>PP8: DHBs report alcohol and drug service waiting times and waiting lists for 0-19 year olds (Provider Arm)</td>
<td>&lt;3 weeks Quarterly 80%</td>
<td></td>
<td></td>
<td></td>
<td>70%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>CM Health continues to be below target for the within three weeks waiting time target for 0-19 year olds accessing mental health provider arm services (70% seen within three weeks; target 80%). Performance is largely unchanged from Quarters 1 and 2. Note performance against this measure is low across the country; in Quarter 3 all but three DHBs (Mid Central, Tairawhiti, Whanganui) fell below the target.</td>
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<td></td>
<td>&lt;8 weeks Quarterly 95%</td>
<td></td>
<td></td>
<td></td>
<td>91%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Barriers to achievement of the target:</td>
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<td>Demand v Resource: Demand for CAMHS services has continued to grow with limited growth in FTE. Meeting service demand has been challenging due to staff vacancies; there is a national shortage of CAMHS clinicians with a significant amount of our CAMHS vacancies being in our nursing workforce. This has meant that those with acute and complex needs have been prioritised over routine and non-urgent cases. The impact of this is that CAMHS has been functioning like an acute response service leaving very little time for psychological or therapeutic interventions.</td>
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<td>Activity underway to address these barriers and improve performance:</td>
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<td>Highest need prioritised: At present, CM Health has a process where the referrals are triaged and those with the highest need are prioritised and those needing urgent intervention are seen within 48 weeks.</td>
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Counties Manukau District Health Board – Community & Public Health Advisory Committee 3 July 2019 064
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<tbody>
<tr>
<td></td>
<td>PP8: Alcohol and drug service waiting times and waiting lists for 0-19 year olds (Provider Arm &amp; NGO)</td>
<td>Quarterly</td>
<td>80%</td>
<td>98%</td>
<td></td>
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<td>hours. It is also worthy of note that CM Health consistently meets the targets in the 12-19 age group and it is the 0-11 age group that brings the overall percentage down and sometimes the wait is longer while further information is sourced from schools etc.</td>
</tr>
<tr>
<td></td>
<td>PP25: Prime Minister’s youth mental health project</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>PP26: Rising to the Challenge: The Mental</td>
<td>Focus Area 1: Primary Mental health</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>Focus Area 2:</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>Health and Addiction Service Development Plan FA1: Primary Mental Health</td>
<td>District Suicide Prevention and Postvention</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>Focus Area 3: Improving Crisis Response Services</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>Focus Area 4: Improve outcomes for children</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Mental Health and Addictions</td>
<td>Focus Area 5: Improving employment and physical health needs of people with low prevalence conditions</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td></td>
<td>PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders</td>
<td>Quarterly</td>
<td>Reduction of 10% or greater from baseline by Q4 (baseline = 406.7 per 100,000)</td>
<td>95 per 100,000 population</td>
<td>356 per 100,000 population</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Note that results are reported one quarter in arrears and represent twelve months rolling data e.g. Q3 results are for the period January 2018 to December 2018. The number of Māori clients under a section 29 CTO decreased this quarter from 321 in quarter 2 to 315 in quarter 3. The number of Māori under s29 CTOs does appear to be dropping slowly however the numbers are small and it is too early to tell if this will be sustained. Our actions to reduce the rate of Māori on CTOs include: Visual management of the data in the form of the monthly Balanced Scorecard and the DAMHS Report which are widely circulated to, reviewed by, and discussed with Mental Health and Addictions Clinical Leaders and District Inspectors. Regular meetings of the Responsible Clinicians</td>
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<td>Priority</td>
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<tr>
<td></td>
<td>OP1: Mental health output delivery against plan</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>facilitated by the Acting Clinical Director where this data is discussed and the requirements for the ongoing use of CTOs is considered.</td>
</tr>
</tbody>
</table>
|          | Oral health | PP10: Mean DMFT (Decayed Missing or Filled Teeth) score at Year 8 | Annually | 0.81 | ⚫0.83 | ⚫1.03 | ⚫1.17 | NR | ⚫0.57 | Result of 0.83 mean DMFT for 2018 is slightly higher (i.e. worse than) the DHB’s target of 0.81. However, the result shows an improvement on the 2017 result of 0.88. There is a significant equity concern however with results for Maaori and Pacific children being well over target. This poor outcome reflects both wider contributory factors (e.g. consumption of high sugar drinks) and poor service performance. CM Health is working with the Auckland Regional Dental Service (ARDS) to implement a range of activities to improve oral health outcomes including a range of improved booking processes and a Supportive Treatment Pathway. The Supportive Treatment Pathway provides clear guidance for ARDS in engaging with children and whaanau to attend appointments and includes collaborative input from others in community and schools. Other key CM Health activities underway to increase performance include: Engaging with service provider (ARDS) to address...
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<th>Other</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>PP11: Children caries free at five years</td>
<td>Annually</td>
<td>51%</td>
<td>46%</td>
<td>32%</td>
<td>31%</td>
<td>NR</td>
<td>63%</td>
<td>specific service concerns.</td>
<td></td>
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</tbody>
</table>

Increasing capacity of services by scoping alternate service providers for intermediate aged children in college settings.

Working with ARDS to better target high needs communities and in particular Maaori and Pacific children and whaanau.

Consideration is being given to developing a regional Oral Health Strategy to improve the current performance and outcomes. CM Health have recently appointed a Service Development Manager (Phil Light) to work on oral health which will give CM Health greater capacity to explore a range of improvement and development issues underpinning the current performance and outcomes.

The DHB’s result of 46% does not meet the 2018 target of 51% and is lower than the 2017 result of 49%. Results for Maaori and Pacific children are again significantly lower for this measure.

ARDS have an on-going improvement plan in place which includes:
- Extension of after hours and Saturday clinics including commencing in Pukekohe
- Extending outreach fluoride varnish programme to Mangere and Manurewa.
- Implementation of prioritised recommendations from the Metro Auckland Preschool oral Health Action Plan.
- Improving utilisation and reducing vacancies

Other key CM Health activities underway to increase performance include:

Engage with service provider (ARDS) to address specific service concerns including better targeting of high needs areas and better service modelling.

Further funding for the tooth brushing programme in 150 South Auckland ECE. This includes extending
### Performance Measure: PP13

**Performance Measure:** Improving the number of children under 5 years enrolled in DHB funded dental services

<table>
<thead>
<tr>
<th>Priority</th>
<th>Performance measure</th>
<th>Report frequency</th>
<th>Target</th>
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<th>Total</th>
<th>Maaori</th>
<th>Pacific</th>
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<th>Other</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>PP13: improving the number of children under 5 years enrolled in DHB funded dental services</td>
<td>Annually</td>
<td>≥95%</td>
<td>80%</td>
<td>68%</td>
<td>82%</td>
<td>NR</td>
<td>85%</td>
<td></td>
<td>the service to include fluoride varnish application</td>
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</tbody>
</table>

**Notes:**
- Pre-school enrolment of 80% is significantly below the target of 95%, with the enrolment rate for Maaori children being particularly low.
- The number of children enrolled from CM Health has continued to increase as a system has been implemented to automatically enrol children from birth lists. Further work is required to meet the target and we are in discussions with the Auckland Regional Dental Service about how we increase this number to 95%.
- To further note that the arrears rate (the percentage of children who have not been examined according to their planned recall period) is very high at 29% for total population, 32% for Maaori, and 28% for Pacific. The target's arrears rate is <10%.
- ARDS have made some progress in increasing productivity (as measured by average chair utilisation) and decreasing non-attendance rates through a range of improvement activities. However, the arrears rate is concerning and is getting worse.
- ARDS have identified that the factors contributing to the performance being off-track are:
  - On-going dental therapy vacancies
  - Implementation of a new preschool clinical prioritisation matrix, which has resulted in an increase of high needs children being appropriately assigned a 6-month recall date.
  - Discontinuing the practice of ‘administratively completing’ children who have not attended appointments. These children are now showing in arrears.
  - Data quality issues
- CM Health are meeting with ARDS shortly to seek clarification on how they intend to rectify this performance and identify ways in which CM Health...
<table>
<thead>
<tr>
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<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term conditions</td>
<td>PP20: Improved management for acute heart service</td>
<td>Quarterly</td>
<td>&gt;70%</td>
<td></td>
<td></td>
<td>75%</td>
<td>61%</td>
<td>83%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>Indicator 1: Percentage of ACS patients undergoing coronary angiogram who have door to cath within 3 days</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>can support ARDS to improve this critical measure. Our colleagues at ADHB and WDHB have expressed similar concerns and a regional approach is likely.</td>
</tr>
<tr>
<td></td>
<td>Indicator 2: Percentage of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection</td>
<td>Quarterly</td>
<td>&gt;95% (within 30 days of discharge)</td>
<td></td>
<td></td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>≥ 99% (within 3 months of discharge)</td>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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</tbody>
</table>

Note that this quarter’s poor result for Maaori appears to be an anomaly – performance against this target for Maaori patients is usually consistent with total population performance.

Whilst the result exceeds the target, Cath Lab capacity remains an issue. A single Cath Lab in a busy acute hospital is insufficient to meet the needs of the population. A second Cath Lab is unlikely to be on stream until 2023. Our ability to extend the hours of the existing Cath Lab has been hampered by vacancies in the nursing and MRT teams and we continue to focus on filling the vacancies whilst exploring other ways to staff to meet demand.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Indicator 3: Percentage of ACS patients who undergo coronary angiogram and have pre-discharge assessment of LVEF</td>
<td>Quarterly</td>
<td>≥85%</td>
<td></td>
<td></td>
<td>92%</td>
<td>92%</td>
<td>94%</td>
<td>79%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Indicator 4: Percentage of ACS patients who undergo coronary angiogram and who are prescribed, at discharge secondary prevention medication</td>
<td>Quarterly</td>
<td>&gt;85%</td>
<td></td>
<td></td>
<td>82%</td>
<td>95%</td>
<td>86%</td>
<td>71%</td>
<td>79%</td>
<td>Inconsistent junior doctor rostering has resulted in less than ideal adherence to post discharge processes. Education of medical staff regarding this goal is on-going.</td>
</tr>
<tr>
<td>Long-term conditions</td>
<td>PP20</td>
<td>Percentage of the eligible adult population who have had their cardiovascular disease risk assessment (CVDRA) in the last five years</td>
<td>Quarterly</td>
<td>90%</td>
<td>91%</td>
<td>89%</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
<td>The district has been able to exceed the 90% target for all population groups other than Maaori (1% below target with a result of 89%) at the end of the quarterly period. There has been a slight increase in performance for Maaori men aged 35-44 years (from 74% in Q1 to 72.9% in Q2 to 73.2% in Q3). The change in performance is unlikely to be statistically significant. There are on-going differences in performance.</td>
</tr>
<tr>
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<tr>
<td></td>
<td>Percentage of eligible Māori men in the PHO aged 35-44 years who have had a CVDRA in the last five years</td>
<td>Quarterly</td>
<td>90%</td>
<td>N/A</td>
<td>73%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>between Māori and other ethnicities. We have been focussing on potential strategies within the community, as well as in primary care, which supports the focus of the System Level Measures for Metro Auckland. This includes regional review of the use of More Heart and Diabetes Checks Funding. It was agreed that funding would be distributed on enrolled Māori Men 35-44 years of age and plans will be developed to develop innovative models of care to reach this population. A number of strategies were discussed including initiation of focus groups to understand the needs and barriers of this population and greater integration with accident and medical clinics, where patients within this target population may more readily access.</td>
</tr>
<tr>
<td>PP20</td>
<td>Percentage of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway</td>
<td>Quarterly</td>
<td>80%</td>
<td>81%</td>
<td>72%</td>
<td>87%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Note: stroke results are reported one quarter in arrears (i.e. Q2 results for period 1 October 2018 to 31 December 2018 reported in Q3). Performance has improved since Q2 (Q2 performance - total population: 76%, Māori: 72%, Pacific: 71%). After several months of not meeting this target, the last three reported months (Oct– Dec) CM Health has met this target. The 12 month average remains above the indicator target at 82% (as at Dec 2018). Charge Nurse Manager, Clinical Nurse Specialists and Stroke SMOs continue to develop a strong relationship with the emergency department and Clinical Nurse Specialist (CNS) cover is over 6 days meaning that strokes that are potentially eligible for intervention are identified, investigated and treated in an appropriate time frame. This relationship also opens doorways for the stroke unit to ‘pull’ appropriate patients to the ward in a more timely manner thus reducing potential risk for complications such as aspiration pneumonia or misdiagnosis of aphasia (speech disturbance) for confusion. This strengthens lines of communication with whaanau, and is a building block for a positive relationship for the journey of...</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>14%</td>
<td>7%</td>
<td>30%</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of potentially eligible stroke patients thrombolysed 24/7</td>
<td>Quarterly</td>
<td>10%</td>
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<tr>
<td>Long-term conditions</td>
<td>Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services within 7 days of acute admission</td>
<td>Quarterly</td>
<td>80%</td>
<td></td>
<td>47%</td>
<td>0%</td>
<td>50%</td>
<td>NR</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Improving system integration and SLMs</td>
<td></td>
<td>Quarterly</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Healthy Ageing</td>
<td>PP23: Implementing the Healthy Ageing Strategy</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Please refer to the section on immunisation under the previous health targets.</td>
</tr>
<tr>
<td>Child Health</td>
<td>PP21: Immunisation coverage at 2 and 5 years of age</td>
<td>Quarterly</td>
<td>95%</td>
<td>93%</td>
<td>87%</td>
<td>93%</td>
<td>97%</td>
<td>93%</td>
<td>93%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>5 years</td>
<td>95%</td>
<td>90%</td>
<td>84%</td>
<td>91%</td>
<td>95%</td>
<td>88%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SI18: Percentage of newborns enrolled with General Practice at 3 months</td>
<td>Quarterly</td>
<td>85%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Data and feedback was not available from the MOH this quarter due to a technical issue at their end.</td>
</tr>
<tr>
<td></td>
<td>PP37: Improving breastfeeding rates at three months</td>
<td>Six monthly</td>
<td>70%</td>
<td>49%</td>
<td>42%</td>
<td>44%</td>
<td>NR</td>
<td>NR</td>
<td></td>
<td>Note that breastfeeding rates have decreased since Quarter 3 last year, with the exception of Maaori rates which have increased by 1 percent (Q3 17/18 results- total population: 51%, Maaori: 41%, Pacific: 46%).</td>
</tr>
</tbody>
</table>

CM Health has contracted the services of Turuki Health Care in the delivery of ‘B4Baby’ services to all ethnicities but specifically Maaori mama, pepe and whaanau. The model is delivered from a Kaupapa Maori perspective and works collaboratively with an internal DHB service Te Rito Ora (TRO) to offer services to priority groups. Both services are given access to the hospital birthing units to provide continuity of face to face care and culturally appropriate support for mothers who have enrolled with them antenatally and whom they have established relationships with.

CM Health also continues to engage with universal providers such as Plunket to ensure there is continuous engagement and alignment in efforts to target priority populations in the Counties Manukau region. With upcoming contract renewals, specific community breastfeeding services contracted and provided by CM Health are collaborating with one another and liaising with other local providers, to develop respective service specifications that ensure seamless service provision and targeted approaches for Maaori, Pacific and high deprivation whaanau.
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>CFA B4 School Check</td>
<td>Quarterly</td>
<td>90%</td>
<td></td>
<td>76%</td>
<td>75%</td>
<td>75%</td>
<td>NR</td>
<td>78%</td>
<td></td>
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<tr>
<td></td>
<td>CFA Well Child / Tamariki Ora Services</td>
<td>Quarterly</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>CFA DHB level service component of the National SUDI Prevention Programme</td>
<td>Annually</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Improving wait times for diagnostic services</td>
<td>PP29a: Coronary angiography – within 3 months (90 days)</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
<td>95%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td></td>
<td>PP29b: CT – within than 6 weeks (42 days)</td>
<td>Quarterly</td>
<td>95%</td>
<td></td>
<td>93%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>PP29c: MRI – within 6 weeks (42 days)</td>
<td>Quarterly</td>
<td>90%</td>
<td></td>
<td>29%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>NR</td>
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</tbody>
</table>

CT performance has not shifted since Q2 and remains just below target. Key issues are a number of cardiac CTs on the waitlist with a shortage of cardiologists and cardiology RNs available to undertake the list – this has been partially resolved and the list is now reducing. There is an on-going issue of increased demand and acuity of acute patients which is affecting outpatient, GP lists and wait times. Our focus remains on recruiting CT trained staff and increasing capacity through evening sessions where staffing allows.

MRI figures remain significantly below target and performance has not improved since Q2 (Q2 result: 29%).

**Barriers to achievement of the target:**
Staffing issues continue to affect performance however are now improving. The issue of increased demand and acuity of acute patients is also having an impact on MRI performance.

**Activity underway to address these barriers and improve performance:**
*Outsourcing* – we continue to outsource MRI patients.

*CMDHB Improvement team (Ko Awatea)* commenced an Improvement plan in March: this is going well and the process has identified some areas for improvement/change. This is a work in progress.
progress currently but some early examples of areas identified for improvement are:
- Utilisation of health care assistants to reduce time that MRT tech spends on non-scanning time
- Introduction of new rostering model that has 3 MRI techs running 2 scanners where it used to be 4. This is only possible now in the new suite due to the 2 scanners being co-located side by side.
- Optimising the booking process for inpatients to ensure we can scan more patients within the day

**Weekend Sessions:** From mid-April we have alternate weekend sessions running all day Sat/Sun utilising trained staff from outside of CMDHB who have been employed for weekends specifically.

3 trainees now in place – historically we have had 2 due to nature of small team. Staffing model has been altered to optimise use of nursing staff and health care assistants
<table>
<thead>
<tr>
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<th>Asian</th>
<th>Other</th>
<th>Notes</th>
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<tbody>
<tr>
<td></td>
<td>data submitted to National Collections</td>
<td>Programme for the Integration of Mental Health data (PRIMHD)</td>
<td></td>
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<tr>
<td>Average length of stay (ALOS)</td>
<td>OS3 Inpatient average length of stay (ALOS)</td>
<td>Acute</td>
<td>Quarterly</td>
<td>2.5</td>
<td>2.77</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Both acute and elective length of stay are down slightly since Q1 (Q1 performance – Acute: 2.78 days, elective 1.63 days). We have two large projects underway related to acute and elective pathways. The Every Hour Counts project is focused on moving patients efficiently and safety through the acute pathway with focus areas such as the 6 hour target in Emergency Care, looking at over 10 day stayers and identifying reasons for delays plus the proactive planned discharge project. ED will continue to work in three main areas: 1. Decreasing demand (e.g. emergency Q etc.) 2. Improve ED efficiency (e.g. care bundles and work with the orderlies) 3. Improve outflow (e.g. early bed requests) Elective Pathways work includes a preadmission project identifying optimal preadmission which sets up the elective pathway optimally, elective theatre efficiency project and continuing work on the post-surgical unit pathway (promoting early discharge).</td>
</tr>
<tr>
<td></td>
<td>OS8: Reducing acute admissions to hospital – 0-28 days</td>
<td>Quarterly</td>
<td>≤10.7%</td>
<td>10.8%</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>CMH are continuing to keep readmission rates at a sustainable and reasonable level and below the national rate. We are continuing to work in areas where readmission levels may be higher such as congestive heart failure, where we have employed transition nurses to follow up on CHF patients to monitor weight and educate to reduce further admissions.</td>
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<td></td>
<td>SI3 Ensuring delivery of Service Coverage</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>SI4 - Standardised intervention rates</td>
<td>Angiography</td>
<td>Quarterly</td>
<td>34.70</td>
<td>29.76</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Cardiac angiography and angioplasty results have improved on the previous year, partly due to extended hours of operation. However, staffing vacancies have hampered the ability to perform</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Angioplasty</td>
<td>Quarterly</td>
<td>12.50</td>
<td>12.84</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td></td>
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<tr>
<td>Priority</td>
<td>Performance measure</td>
<td>Report frequency</td>
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<td>Maaori</td>
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</tr>
<tr>
<td></td>
<td>Cardiac Surgery</td>
<td></td>
<td>6.50</td>
<td></td>
<td>5.70</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>longer days on a consistent basis. Recruitment to these positions is actively being pursued. Funding has been approved within the DHB for a second Cath Lab at Middlemore Hospital. However, issues relating to the cladding of existing buildings will delay this project such that the implementation of the additional Cath Lab will not be until January 2023. The cardiac surgery rates have dropped (this is noted across the metro Auckland region) below previous years and this appears related to a number of factors at ADHB; a high acute load, lack of ICU beds and staffing issues.</td>
</tr>
<tr>
<td></td>
<td>Major Joints</td>
<td></td>
<td>21.00</td>
<td></td>
<td>23.02</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cataracts</td>
<td></td>
<td>27.00</td>
<td></td>
<td>44.94</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>CFA Electives Initiative and Ambulatory Initiative Variation</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>See comments at Elective Surgery (previous health target PP45) above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability support services</td>
<td>CFA: Disability Support Services Funding Increase</td>
<td>Six-monthly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SI13: Ensuring delivery of local service coverage</td>
<td>Six-monthly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS Supporting delivery of the New Zealand Health Strategy</td>
<td>Quarterly</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary of Key Achievements

Cancer – The Region’s Head and Neck Cancer (HNC) framework, as agreed in Q2, has now commenced socialisation. The patient co-design group has re-convened and is progressing the MDM process definition.

Stroke – Phase 2 of the Hyperacute Stroke pathway implementation continues to go well, with the expectation that approximately 220 PSI (clot retrieval) procedures will be completed by the end of 2018/19.

Further development work has been done on the Regional Stroke Report so that 3 key indicators are now reported by ethnicity. Further work will continue in this area as part of the network’s focus on health equity for Maori.

Cardio Vascular Disease – An Accelerated Chest Pain Pathway has been supported by the Network and is intended to replace the existing pathway. The Network has worked with ED physicians to support understanding of the changes developed by Martin Than. As a result of these discussions, Martin Than is now working with clinicians in each of the DHB EDs to implement this new pathway.

Cardiac Community Arrest continues to be progressed with both the project manager and the clinical lead of the network co-authors in a paper which has been published in the European Resuscitation Journal. This material is now being presented at various key conferences and meetings to assist in further promoting the use of AEDs and bystander CPR. Additional work is planned for this area.

An Electrophysiology after-hours roster for Auckland hospital has been endorsed both by management and clinicians and been given support for funding of an ‘after-hours phone only’ roster for EP services. These services have become increasingly complex, requiring specialist expertise, whilst not incurring significant additional cost.

Child Health – The Northern Region Child Health Steering Group has strengthened Maori and Pacific leadership.

The ‘six week infant check roles and responsibilities project’ has been completed and the working group has now closed. The final report was endorsed by the Child Health Steering Group and forwarded to the Ministry of Health; with the hope the recommendations will be considered in the Well Child Tamariki Ora Review.

The Northern Region Neonatal System Quality Improvement project has made good progress. There is now an agreed neonatal cot escalation plan in place to ensure all options are explored before a neonate is transferred out of region. The first regional KPI report was collated in February. This report provides information about neonatal bed capacity, occupancy and flow across the region during the month.

Frail Elderly - Clinical Lead and Project Manager are now established in roles and progressing the Frail and Elderly workstream. A current state analysis is being compiled of the projects already planned or taking place with regard to frail and elderly patients. A regional workshop is planned for May. This workshop will identify priority projects for Region collaboration with the intent that a lead DHB be appointed to each regional project.

Primary and Community Care Deep Dive - The Project Steering Group has good involvement from DHBs, MOH, PHOs, NGOs, and community representatives, and good engagement from project members. Key achievements include:

- Development of the current state has been largely completed covering the following areas:
  - Northern Region Context
  - Achievements and Challenges
  - Approaches in the Northern Region
  - Evidence, Trends and Models in Primary and Community Care.
- Development of a health equity review
- Completion of a stocktake of community feedback on healthcare in the Region
- The first provider workshop was held in conjunction with the Health and Disability System Review on the 8th of March
- A second provider workshop is being held on the 12th April.

Public and Population Deep Dive - The Project Steering Group has good involvement from DHBs, ARPHS, MOH, Iwi, NGOs and the University of Auckland and good engagement from project members. Key achievements include:

- Development of the current state has been largely completed covering the following areas:
- Northern Region Context
- Health Outcomes in the Northern Region
- Public Health Programmes in the Northern Region
- Evidence base for public health interventions.

- Work is underway on the development of the future state. Initial priorities identified to date include:
  - Strengthening Core Public Health Services
  - Developing / strengthening a Public Health / Prevention System – reorienting the system to a focus on prevention and determinants of health
  - Investing in Priority Areas that will deliver shorter term gains in equity and health outcomes.

**Mental Health & Addictions** - The review of Consult Liaison Psychiatry services in the Northern Region has been completed. The paper and recommendations will be tabled at the first meeting of the Northern Region’s Health Service Design Authority. The literature review to inform the Model of Care for Withdrawal Management services (Alcohol and other Substances) has been completed.

**Workforce** - The second regional workforce hui has occurred. High level goals(s) and key initiatives have been drafted for the eight workforce equity and enabler areas of focus. Stakeholder consultation is continuing as the first overarching workforce strategy paper is developed for the region.

**Hepatitis C** - 124 ‘new’ HCV patients have been seen this quarter. Of the 800+ patients in our Region, previously identified as awaiting treatment, 295 Patients have now received pangenotypic DAA treatment. Work is well underway to refer approximately 650+ patients (from the 800+ identified patients) back to primary care for treatment. The remainder, either cirrhotic or comorbidities, need secondary care intervention.

**Capital Plan** - The Region is working to provide project information and Business Cases for initiatives indicated in the Northern Region Long Term Investment Plan and consistent with funding signals provided by the CIC for the 2018/20 financial years. The Capital Investment Programme is making progress in each of its three work-streams, and is on track to deliver the outputs indicated during 2018/19.

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1 A large number of these patients referred back to their GPs are likely to have been captured in the National Laboratory Look back project.
Counties Manukau District Health Board
Community & Public Health Advisory Board (CPHAC)
Youth Health

Recommendation

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

Receive the following report.

Prepared and submitted by: Julia Burgess Shaw (Youth Health Service Development Manager) on behalf of Carmel Ellis.

CM Health – Counties Manukau Health
OT – Oranga Tamariki
SBHS – School-Based Health Services
AE – Alternative Education
TPU – Teen Parent Unit
MOH – Ministry of Health
AOD – Alcohol and Other Drugs
LARC – Long acting reversible contraceptive
CFYH – Centre for Youth Health
ASHS – Auckland Sexual Health Service
MDT – Multi-Disciplinary Team

Purpose

The purpose of this paper is to inform CPHAC of the current state and configuration of community-based youth Health service delivery in the Counties Manukau Health (CM Health) area, including services for transgender young people and young people under the care and protection of Oranga Tamariki (OT).

Executive Summary

This paper provides information about the current state and configuration of community-based youth Health service delivery in the Counties Manukau Health area, with a focus on school-based Health services (SBHS), sexual Health, oral Health, primary mental Health and transgender Health services, and primary Health services for young people in an OT residence.

Background

It is important to recognise that young people have different needs, issues and preferences compared to younger children and the broader adult population. Importantly, young people are not a homogenous group and have developmental transitions across the age range 10 to 24 years. These can be opportunities for influencing positive development, but this developmental period can also be characterised by vulnerability, risk taking and experimentation, where important life choices have long-term consequences. There is increasing evidence about the effectiveness of public health and health promotion approaches, positive youth development activities and primary youth health care (particularly school-based Health services and community-based youth specific Health services). This evidence informs the configuration of youth Health service provision in the Counties Manukau catchment.

It is estimated that there are approximately 120,000 young people aged 10-24 years living in the CM Health area. Approximately 29% young people identified as 29% as of Pacific ethnicity, 21% as Maaori, NZ European or Other, and 21% as Asian. Approximately 42% of CM Health young people live in areas
defined as the most socio-economically deprived quintile (NZDep2013).  

Secondary School-aged population

In the CM Health enrolled state secondary school population, there are approximately 32,000 students, of which 19% are Māori, 29% are Pacific, 23% Asian and 29% are NZ European/Other ethnicity. The percentage of CM Health young people enrolled in a decile 1-5 state secondary school is 55 %, of which 26% are Māori, 47% are Pacific, 17% Asian and 10% are NZ European/Other ethnicity.

Mental Health

Although a high number (93%) of CM Health students reported feeling okay, satisfied or very happy with their life, 21% of CM Health young people had seen a Health professional in the previous 12 months due to emotional worries (compared to 18% for NZ), 27% had deliberately harmed themselves (compared to 24% for the rest of NZ), and 7.4% had attempted suicide in the past 12 months (significantly more than 4.5% in the rest of NZ). More recent figures show that, in 2018, 529 young people domiciled in the CM Health catchment were admitted to hospital for self-harm.

Alcohol and Other Drugs

In the Youth survey, 33% of CM Health students stated they drink alcohol and 15% reported having engaged in binge drinking (five or more alcoholic drinks within four hours) in the last four weeks. In addition, students who were current drinkers reported a range of problems that had occurred after drinking alcohol, including unsafe sex (12%), unwanted sex (5%), or injuries (15%). Eleven percent of current drinkers had been told by friends or family that they needed to cut down their drinking. In 2018, 5.8% of emergency department presentations for young people in CM Health were for alcohol-related reasons, higher than the national average of 3.4%.

In addition to alcohol, the Youth survey showed 23% of students have ever used marijuana and 13% currently use marijuana. Three percent of students reported using marijuana weekly or more often.

Sexual Health

In 2012, 46% of 17-year-old secondary school students reported having ever had sex, and 37% were currently sexually active. CM Health students reported lower rates of always using contraception to prevent pregnancy (45%) and lower rates of reporting always using condoms to prevent sexually transmitted diseases (38%) than reported nationally (58% and 46%, respectively). There was also a difference in contraception use by school decile—young people attending more socio economically deprived schools were less likely to use contraception than those in less deprived schools. The number of teenage pregnancies in CM Health has been steadily dropping. In 2009, there were 779 teenage deliveries, compared to 371 in 2017.

Access to primary Healthcare

Adolescence is a period where young people are transitioning from accessing Health services with the support of a parent or guardian, to accessing Health services and making Healthcare decisions.
independently. Young people do not readily access Health services independently. In 2012, 18% of secondary school students reported not being able to access Healthcare when they needed to, and this was more pronounced in areas of higher deprivation (22%). The most frequently identified barriers to accessing Health care included not wanting to make a fuss (46%), hoping it would go away or get better by itself (51%), embarrassment (29%), no transport (28%), fear (27%), and cost (26%). In addition, nearly 1 in 5 students were afraid their condition wouldn’t be kept a secret. Of those accessing health care, 18% accessed health care through a school health clinic.

Discussion

Configuration of Youth Primary Health Services in CM Health
CM Health provide a range of primary Health services for young people in education and community settings including:

- School Based Health Services (SBHS) in deciles 1-5 state secondary schools, Alternative Education (AE) settings and Teen Parent Units (TPU);
- Sexual health services;
- Oral health services;
- Primary mental health services;
- Transgender health care services;
- Primary health care services to young people living in an Oranga Tamariki (OT) residence;

School Based Health Services
CM Health initially began delivering SBHS in 2006. SBHS are currently delivered in 34 (out of 36) deciles 1-5 secondary schools, AE settings and TPU in the CM Health catchment. Additional funding from the Ministry of Health (MOH) in 2018-19 allowed CM Health to extend SBHS into its one decile 5 high school (an additional 1800 students). MOH has indicated that funding may be made available to further high schools over the next two years. Twenty six schools with SBHS also have visiting weekly General Practitioner or Nurse Practitioner clinicians, who support the school nursing teams to work at the top of their scope, with access to medical practitioner supplies and the provision of standing orders. All Year 9 students are eligible to receive a HEEADSSS assessment. In 2018, the SBHS nurses completed ~3000 of these assessments. The SBHS programme is supported by a CM Health Programme Manager, two Clinical Nurse Specialists (clinical supervision and professional development for school based nurses) and a Youth Health Nurse Practitioner.

A recent focus for SBHS has been the introduction of youth-appropriate alcohol and other drug (AOD) screening. Nurses screen young people as part of the HEEADSSS assessment process using an electronic Substances and Choices tool (eSACS). The purpose of the tool is to improve short and long term outcomes for young people with AOD problems by providing a quick and easy brief screening tool that provides brief intervention, harm reduction and the ability to refer on to specialist services if needed. During a six month period, 2400 young people in the CM Health catchment were screened, with 136 young people requiring brief intervention and 61% of this cohort requiring onward referral.

Sexual Health Services
Young people can access sexual Health services through a general practice, their school (if the school allows sexual Health services to be delivered onsite) or other community sexual Health clinics (e.g. Family Planning clinics, Auckland Sexual Health Service). Most schools in CM Health with SBHS offer a full range of sexual Health contraception services. CM Health’s Mangere Contraception clinic also provides free sexual health and contraception services, with approximately one third of its patients being under 25 years.


\[10\] One school declined the service but is supported by an on-call nurse and GP and another school will be funded by MOH for the first time in 2019/20.

\[11\] HEEADSSS is a youth psycho-social assessment tool (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety).

\[12\] Some schools do not allow sexual health services to be delivered on-site due to their ‘special character’ status.
There is currently a national focus on increasing access to contraceptive services, particularly Long Acting Reversible Contraception (LARC), for women at risk of unplanned pregnancy. CM Health has received MOH funding via the Contraceptive Access contract to provide and deliver contraceptive and sexual Health services for young women attending secondary schools, AEs, TPUs and other community settings in the CM Health catchment. This service will support existing SBHS services by upskilling nurses around sexual Health, contraceptive counselling and provide improved access to LARCs.

**Oral Health**

Free oral Health services for young people cease on their 18th birthday. One of the options being considered for improving the utilisation and ultimately improving oral Health outcomes for young people aged 18–24 years is by offering a free dental service at the upcoming Otago Dental School. Further work is underway to determine the scope of this service (i.e., if it is targeted at young people living in Quintile 5).

**Primary Mental Health Services**

Many common mental Health problems, such as depression, anxiety and substance abuse emerge during adolescence and can have life-long consequences. SBHS and community-based primary mental Health care services (e.g. CM Health-funded Youthline services) help address some of these issues by providing accessible, youth-appropriate primary mental Health care. CM Health has also recently implemented a new approach to providing primary mental Health care in general practice. The Wellness Support programme provides access to support for any enrolled young person with a mental Health need by way of extended consults, referral to psychology or cognitive behavioral therapy if clinically appropriate. The programme also links up with the CM Health specialist mental Health and addictions workforce as required – known as Integrated Locality Care (ILoC).

**Transgender Health Care**

Transgender Health services in the Auckland Region are provided for transgender young people and their whanau by the CM Health Centre for Youth Health (CFYH) and Auckland Sexual Health Services (ASHS), as well as access to a range of services such as peer support, fertility, mental Health and surgical services. The CFYH provides gender-affirming Health care to young people aged 10-20 ASHS provides gender-affirming Health care for transgender people aged 18+ years. The service includes an initial assessment, discussion and review by a multi-disciplinary team (MDT), follow-up appointments as clinically indicated, support to engage long-term in primary care, and mental Health assessment at clinically indicated points in the treatment pathway. During 2018 calendar year, CFYH had 227 active cases, with 39% of these cases domiciled in CM Health = 39%.

**Young People Domiciled in an Oranga Tamariki Residence**

Young people living in the Whakatakapaokai and Korowai Manaaki residences under the care of Oranga Tamariki often have high levels of unmet Health need. Comprehensive primary Health services are delivered on-site to residents and consist of broad range of primary health care, mental Health and allied Health services and Health promotion. Services are delivered by a MDT, which consists of registered nurses, General Practitioner, Youth Health Specialist and Allied Health provision. Other specialist Health services on-site include community AOD practitioner and youth forensic specialists.

The following data gives a snapshot of the unmet Health needs of young people on admission to the residences:

- 42% had dental issues requiring treatment on admission
- 15% failed their hearing screening and 7% failed vision screening;
- 72% had a mental Health issue identified;
- 59% reported using cannabis and 69% using alcohol;
- 27% presented with an sexually transmitted infection;
- 106 immunisations were administered.

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13 Schools in Quintile 5 areas and those with large Maaori and Pacific enrolled populations will be prioritised, in accordance with Ministry of Health criteria.

14 Data is for the period Jan–March 2019 for Korowai Manaaki residents, with the exception of sexual health data (2017-18)
The above data highlights the immediate and ongoing Health needs of these young people. Their Health needs are often complex due to a range of factors, which may include a traumatic history, comorbidities of health issues and the lack of primary health services previously accessed.

**Conclusion**

The paper highlights the broad range of primary Health care services available to young people, as well as the unique health needs of young people and the unmet Health needs of young people in Oranga Tamariki residences.
WCTO Review Purpose

To review and redesign a WCTO programme that:

- Contributes to improved and equitable outcomes for tamariki and whānau
- Supports tamariki and whānau at important points across the lifecourse
- Delivers an accessible and integrated whānau-centred service offering to support tamariki and their whānau
- Has the right supports to delivery a high quality and sustainable programme
WCTO Review Rational

- Equity in coverage and outcomes
- Population and demographic changes
- Evidence and Government direction
- Opportunities for integration
- Quality and sustainability concerns
- Inadequate data and insights
WCTO Review Questions

• What outcomes should a WCTO programme contribute to for tamariki and whānau?

• What services should be delivered within the WCTO programme to support tamariki and whānau across the lifecourse?

• How should the WCTO service offering be delivered to best support tamariki and whānau?

• What are the critical enablers to deliver a high quality and sustainable WCTO programme?
E rima ngā pou o Well Child Tamariki Ora Review

Ways of working

Poutokomanawa: Whakatauki

Achieving equity

Co-lead (Māori –MoH/DHB)

Healthy futures – Pae ora
Approach to answering the Review Questions

Engagement – across voices of *Experience, Evidence and Intent*

1. Voice of Intent: Cross Government, DHB Sector
3. Voice of Experience: Consumer and Provider insights work
Coverage/access of new babies

Percentage of babies not receiving any contacts 2017/18

- Māori: 14%
- Pacific: 9%
- Non-Māori/Pacific: 11%
- Quintile 5: 12%

Percentage of babies referred from maternity to WCTO by 28 days 2017/18

- Māori: 57%
- Pacific: 64%
- Non-Māori/Pacific: 72%
- Quintile 5: 63%
Timeliness and Completeness of Core Contacts

Percentage of babies that receive WCTO Core 1 by 50 days 2017/18

- Māori: 76%
- Pacific: 77%
- Non-Māori/Pacific: 84%
- Quintile 5: 78%

Percentage of infants that receive all core contacts in the first year of life 2017/18

- Māori: 66%
- Pacific: 63%
- Non-Māori/Pacific: 80%
- Quintile 5: 68%
Coverage of Core Contacts

Core coverage by ethnicity and deprivation 2017/18
Core Contact timing

Core coverage by actual vs age band 2017/18

- Actual Core
- Core by age band
## Core Assessments and Referrals

<table>
<thead>
<tr>
<th>Area</th>
<th>% completed</th>
<th>% referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital Hip Dysplasia</td>
<td>96.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>97.2%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Undescended Testes</td>
<td>91.1%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Growth</td>
<td>90.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Immunisation</td>
<td>89.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Oral Health</td>
<td>86.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Vision</td>
<td>85.7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Smoking</td>
<td>81.5%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Hearing</td>
<td>77.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>SUDI</td>
<td>68.6%</td>
<td>-</td>
</tr>
<tr>
<td>Postnatal Depression</td>
<td>66.5%</td>
<td>-</td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>66.5%</td>
<td>-</td>
</tr>
<tr>
<td>Family Violence</td>
<td>57.2%</td>
<td>-</td>
</tr>
<tr>
<td>Parenting Support</td>
<td>56.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>PEDS</td>
<td>53.0%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
Additional Contacts

Percentage of children receiving any additional contacts 2017/18

- Any Additional Contacts: 59%
- No Additional Contacts: 41%

Numbers of additional contacts delivered per child 2017/18

- 1 to 2: 43.9%
- 3 to 5: 17.3%
- 6 to 9: 5.4%
- 10+: 1.2%

098
## Current State of Programme Enablers

<table>
<thead>
<tr>
<th></th>
<th>LMC Contacts</th>
<th>WCTO Contacts</th>
<th>B4SC</th>
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</thead>
<tbody>
<tr>
<td><strong>LMC Contacts</strong></td>
<td><strong>Birth to 4 weeks</strong></td>
<td><strong>WCTO Core Contacts</strong></td>
<td><strong>B4 School Check</strong></td>
</tr>
<tr>
<td><strong>Number of Cores</strong></td>
<td>4</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>Midwives</td>
<td>WCTO nurses and kaiawhina</td>
<td>B4SC nurses</td>
</tr>
<tr>
<td><strong>Organisations</strong></td>
<td>Mostly self-employed, some work for practices/DHBs</td>
<td>Plunket and 63 Tamariki Ora providers</td>
<td>Mixed model across general practice, WCTO and Public Health</td>
</tr>
<tr>
<td><strong>Caseloads</strong></td>
<td>1: 40-50</td>
<td>1:200-300</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total funding</strong></td>
<td>$30.8 million</td>
<td>$64.1 million</td>
<td>$10.5 million</td>
</tr>
<tr>
<td><strong>Price per output</strong></td>
<td>$54 to $84</td>
<td>$69 to $521</td>
<td>$194 average</td>
</tr>
<tr>
<td><strong>Contract method</strong></td>
<td>Section 88</td>
<td>National contract (Plunket); CFA variation (DHB-WCTO)</td>
<td>CFA variation</td>
</tr>
<tr>
<td><strong>Information system</strong></td>
<td>National Maternity Collection and NMR</td>
<td>WCTO NHI reporting (no system)</td>
<td>B4SC IT system</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>MQSP</td>
<td>WCTO QIF</td>
<td>WCTO QIF</td>
</tr>
</tbody>
</table>
Overarching Issues

• Inequality and inequity in outcomes, coverage, access, funding and resources

• Lack of information on outcomes, services and delivery wanted by parents/whānau

• Change in focus required based on evidence and Government direction

• Need for greater alignment of WCTO outcomes, services and delivery across between services and cross-agency
Outcomes Framework

• Need to address social determinants and growing complexity

• Clarity on programme scope required
  • Birth to five years or Conception to Transition to Adulthood
  • Delivery of both screening/assessment and education/support outcomes

• No agreed outcomes framework or intervention logic

• Difficult to measure contribution of WCTO to population outcomes
Service Schedule

• Core contact timing, content and assessment tools need reviewing

• Consider including other services in the Schedule

• Concern about availability of referred services

• Additional visit assessment, intensity, timing and content need reviewing

• Parent Education and Whānau Support elements not clearly defined or resourced
Service Delivery

- Programme is too one-size fits all and not proportionate enough to need
- Programme needs improved focus on relationships and beign whanau-centred
- Need to improve cultural responsiveness and access to kaupapa Māori and Pacific services
- More choice needed in service hours, models, delivery modes and settings
- Service handovers not well supported
- Increased cultural and multidisciplinary diversity in workforce needed
Programme Enablers

• Funding & Contracting
  • pressure, complexity, funding formula needed
  • outputs vs outcomes, mixed models, short term rollovers

• Workforce
  • multidisciplinary, professional development sustainability

• Quality
  • no consumer or workforce measures, minimal monitoring

• Information and Monitoring
  • shared IT platform, better quality data

• Infrastructure
  • clinical governance, coordination, standardised guidelines and referral pathways
Workshop

• We would like your feedback on some key questions across these areas

• How could these issues discussed today be addressed in the future programme?
8.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Confirmation of Public Excluded Minutes, 22 May 2019 | 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)] |