

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)
Wednesday, 29 November 2017

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

Time: 10.15am

<p><u>Committee Members</u> Colleen Brown – Committee Chair Dr Ashraf Choudhary – CMDHB Board Member George Ngatai – CMDHB Board Member Dianne Glenn – CMDHB Board Member Katrina Bungard – CMDHB Board Member Rabin Rabindran – CMDHB Board Member Apulu Reece Autagavaia – CMDHB Board Member John Wong – Community Representative</p>	<p><u>CMDHB Management</u> Gloria Johnson – acting Chief Executive Benedict Hefford – Director Primary Community and Integrated Care Margie Apa – Director Population Health Strategy and Investments Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer Dinah Nicholas - Secretariat</p>
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APOLOGIES

REGISTER OF INTERESTS

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

PART 1 – Items to be considered in public meeting

AGENDA

1. AGENDA ORDER AND TIMING	
2. CONFIRMATION OF MINUTES	
10.15am	2.1 Confirmation of Public Minutes of the Community and Public Health Advisory Committee Meeting – 18 October 2017
10.20am	2.2 Action Items Register
<i>Morning Team (10.25– 10.35am)</i>	
3. PRESENTATION	
10.35am	3.1 Every \$ Counts (Sarah Sharp)
11.00am	3.2 Eastern Locality Update (Penny Magud)
4. BRIEFING PAPERS	
11.30am	4.1 System Level Measure Quarterly Report (Benedict Hefford)
11.40am	4.2 Q1 2017-18 Population Health Plans (Margie Apa)
11.50am	4.3 Community Nurse Prescribing Update (Karyn Sangster)
Next Meeting: 2018, Date TBC	

Minutes of Counties Manukau District Health Board Community and Public Health Advisory Committee

Held on Wednesday, 18 October 2017 at 9.00am – 12.30pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dianne Glenn
Katrina Bungard
Rabin Rabindran
Reece Autagavaia
John Wong

ALSO PRESENT

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

Sue Claridge, Auckland Women's Health Council.

APOLOGIES

Apologies were received and accepted from Ashraf Choudhary and George Ngatai.

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with the following amendments:

Colleen Brown - District Representative, Neighbourhood Support New Zealand – add.
Dianne Glenn – now Member, National Council of New Zealand, stepped down as VP.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 6 September 2017.

Resolution (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

That the minutes of the Community and Public Health Advisory Committee meeting held on 6 September 2017 be approved.

Carried

2.2 Action Items Register/Response to Action Items

A brief discussion was held around Gout and its potential link to family violence. Margie Apa agreed to follow up with Lily Fraser, GP to see if there is any evidence to support this.

Rheumatic Fever target - CPHAC was in agreement that the current number of 4.5 is aspirational for this community.

3. BRIEFING PAPERS

3.1 Franklin Locality Update (Kathryn du Luc)

Kathryn du Luc, GM Franklin Locality took the Committee through her presentation highlighting:

- The population of Franklin is set to double by 2023.
- Franklin's integrated model of care is the "one cluster" locality supported by an enhanced virtual team of:
 - specialists and community health professionals who work collaboratively to support complex patients;
 - palliative care – hospice, GPs, community hospital, community health team;
 - connecting with social services and social welfare
- Next steps for Franklin Locality include:
 - Pukekohe Hospital – the integrated model and development of the Locality Hub
 - Phase Two of the Mental Health Integration
 - Social Service Integration – Children's Team to Franklin
 - Supporting the System Level Measures
 - Supporting Planned Proactive Care including children
 - Health Coach support self-management
 - Supporting Enhanced Primary Care
 - Developing Clinical Networks

The Chair thanked Kathryn for her presentation and the continued locality efforts in the Franklin area.

3.2 SUDI National Programme Update (Benedict Hefford)

The overall goal of the national SUDI prevention programme (NSPP) is to reduce the incidence of SUDI to 0.1 in 1000 infants by 2025.

The national programme will target two key modifiable risk factors for SUDI which are:

1. being exposed to tobacco smoke during pregnancy; and
2. bed sharing.

A range of other evidence-based key modifiable risk and protective factors including alcohol and drug use will also be addressed along with encouraging immunisation, breastfeeding and infant sleep position.

All DHBs have been apportioned an annual funding amount based on a weighted funding formula of the SUDI key modifiable risk factors within the DHB's population (smoking during pregnancy, maternal age under 25, pre-term births and artificial feeding at six weeks). DHBs will be contracted to deliver services that at a minimum meets the needs of the high risk population estimated by the funding formula. The funding formula has estimated the high risk population in Counties Manukau DHB to be 1,629 babies and their whaanau/families.

DHBs are expected to undertake a stocktake of current activities to identify local strategies and initiatives aligned with the NSPP priority areas. The purpose of the stocktake will be to identify gaps within service, identification of areas for regional collaboration and the development of programme logic model to guide decision making around the use of the additional investment.

CM Health is currently undertaking the stocktake with the expectation that a local plan will be completed by November 2018.

The Committee requested that this paper be submitted to the next MHAC meeting for their information.

3.3 Mumps Outbreak Update (Margie Apa)

Mumps Outbreak – ARPHS have been managing the Auckland region mumps outbreak since January 2017. The initial cases identified in January were acquired overseas. Over 400 cases have now been notified, community spread is established and seeding from cases bring infection in from overseas continues. Of the 415 cases notified to ARPHS from January-September, 155 cases (37%) have been living in Counties Manukau.

Mumps outbreaks are occurring throughout New Zealand.

The majority of cases are in people aged 10 – 29 years. This cohort has a low vaccination rate due to a historically poor vaccination recall and supply systems and the publicity surrounding the disproven link in the media between autism and MMR from 1998 onwards.

The suggested link between MMR and autism has now been thoroughly disproven by the scientific community. It is unknown how many people still maintain this perception in Counties Manukau however, immunisation coverage is high in Counties Manukau (94% at 2 years and 92% at 5 Years) with declines at 2 years sitting at only 2.4%, suggesting, reassuringly, that concern about the spurious link between MMR and autism is not a major issue for our population.

3.4 Healthy Weight Action Plan for Children/Draft Action Plan (Margie Apa/Benedict Hefford)

The Metro-Auckland DHB Healthy Weight Action Plan for Children has been developed to contribute to our vision that “All Tamariki in the Auckland Region of New Zealand are of a healthy weight”.

The plan has been developed collaboratively across the region and intends to clarify the role of the three metro-Auckland District Health Boards (DHBs) and Healthy Auckland Together (HAT) in preventing and reducing the rates of unhealthy weight through to 30 June 2020. The plan takes a life-course approach with identified actions for key target populations, including women prior to and during pregnancy, pre-school and school aged children and adolescents. We also place particular importance on ensuring the actions meet the needs of our Maori and Pacific populations who are disproportionately affected by this issue.

Margie Apa advised that CM Health has opted to go with region in developing this plan and each DHB is trying and testing different things, so there has opportunities to share learning's. The continuum approach is very important, from pregnancy to infant, through to school age children.

It was noted that the Committee would like to see the region have a child obesity pathway for GPs.

Mr Hefford advised that the Committee will receive a further update on the Action Plan in six-month's time.

The Committee asked Mr Hefford to come back to them with responses to the following questions:

- Page 43 1st bullet point – what does *the constitution* refer to.
- Has there been any link with Counties Manukau Sport in relation to this work.
- Page 59 – provide some further information in relation to the smartphone app and website.
- Page 71 - what are the actions associated with the plan and how will they be driven in Counties Manukau, where is the money coming from.

The Committee requested that this paper be submitted to the next MHAC meeting for their information.

The Committee asked Mr Hefford to arrange a presentation from Healthy Families NZ for the New Year.

Resolution (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

The Community & Public Health Advisory Committee:

Noted the Metro Auckland District Health Board Healthy Weight Action Plan for Children was endorsed by the Executive Leadership Team on 5 September to go forward to CPHAC.

Endorsed the Metro Auckland District Health Board Healthy Weight Action Plan for Children with the changes mentioned above in the above actions, that it was agreed will be reported on in six months' time.

Carried

4. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

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:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.1 Confirmation of the Public Excluded Minutes of the Community and Public Health Advisory Committee Meeting – 6 September 2017	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)]
2.2 Response to Action Item	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)]
3.1 Community Hub Network Strategic Assessment	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

The open session of the meeting concluded at 11.20am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING OF 18 OCTOBER 2017.

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 – 29 November 2017

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
Standing Items						
19.8.15		<u>Locality Updates:</u> Eastern Manukau Otara/Mangere Franklin	29 November TBC TBC	Penny Magud Lynda Irvine Sarah Marshall	Refer Item 3.2 on today's agenda.	✓
26.9.17		<u>Population Health Plans (Asian, Pacific & Maaori)</u> – quarterly update including a local picture as well as national data on the Healthy Mums & Babies target.	29 November	Margie Apa	Refer Item 4.2 on today's agenda.	✓
14.6.17		<u>ARPHS</u> - six-monthly update.	2018 – date tbc	Benedict Hefford		
14.6.17		<u>17/18 Metro Auckland SLM Improvement Plan</u> – quarterly report.	29 November	Benedict Hefford	Refer Item 4.1 on today's agenda.	✓
6.9.2017	2.2	<u>Action Item Register</u> <i>School Based Nurses in Secondary Schools</i> - stats to be collected and presented on School Based Nurses in Secondary Schools according to decile and how those contracts are managed and reported against. The collated information is to be emailed to CPHAC (via Dinah Nicholas) prior to the next meeting, but also included on the next agenda.	29 November	Carmel Ellis	Refer Item 4.1 on today's confidential agenda.	✓
6.9.2017	3.1	<u>Owning my Gout</u> – the project team were asked to return in 6 months' time to update the Committee on their progress, particularly how they have got on working with A/WDHB as they have the balance of the 31,000 Gout sufferers.	March 2018	Trevor Lloyd/ Benedict Hefford		

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
		What would the next size & scale look like to inform the move to regionalisation on this project.	29 November/2018 – date tbc	Benedict Hefford		
		Approach MoH in order to determine what an appropriate target number would be in order for them to become involved, particular with funding.	29 November/2018 – date tbc	Benedict Hefford		
		Put together the beginnings of a business case to take to ELT with a view to progressing to the Board.	29 November/2018 – date tbc	Benedict Hefford		
		Nursing work plan for presentation early next year – include community input into this work.	Early 2018 – date tbc	Karyn Sangster		
6.9.2017	3.2	<u>Mana Kidz</u> Undertake some work to see how this programme could be grown to cover all Decile 1-3 schools with a view to presenting this to the Board, along with a Mana Kidz presentation.	29 November	Benedict Hefford	Refer Item 4.2 on today's confidential agenda.	✓
		Engage with MoH officials about increasing their contribution to this programme.	29 November	Benedict Hefford		✓
18.10.2017	2.2	<u>Gout</u> – follow up to see whether there is any evidence between Gout and a potential link to family violence.	2018 - date TBC	Margie Apa		
18.10.2017	3.4	<u>Health Weight Action Plan for Children</u> Confirm: <ul style="list-style-type: none"> ○ Page 43 1st bullet point – what does <i>the constitution</i> refer to. ○ Has there been any link with Counties Manukau Sport in relation to this work. ○ Page 59 – provide some further information 	2018 - date TBC	Benedict Hefford		

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
		<p>in relation to the smartphone app and website.</p> <ul style="list-style-type: none"> ○ Page 71 - what are the actions associated with the plan and how will they be driven in Counties Manukau, where is the money coming from. <p>Arrange a presentation from Healthy Families NZ.</p> <p>Provide a six-monthly update on the Action Plan.</p>	<p>2018 - date TBC</p> <p>April 2018 – date tbc</p>	<p>Benedict Hefford</p> <p>Benedict Hefford</p>		

The Eastern Locality



Agenda

- Eastern Locality
 - Community Health Services
 - Admission Avoidance, rapid response & community based reablement
- Increasing Utilisation of the Botany Superclinic & Developing the Eastern Locality Hub

The Eastern Locality

Development of **localities** – grounding our work in place and helping us to understand our local communities

Otara & Mangere Locality

Of the 100,000 plus people living in this locality in 2013, almost 59,000 are Pacific and 17,500 Maaori. Nearly 30% of residents are aged under 15 years. About 77% of people are living in areas of high socio economic hardship.

Franklin Locality

Our most rural locality with over 67,000 residents in 2013. Approximately 13% of people are aged 65 years and over, with a significant Maaori population, making up about 17% of the residents living in Franklin.



Eastern Locality

Our second largest locality with over 146,000 residents in 2013. This includes more than 51,000 people of Asian ethnicities and over 18,000 people aged 65 years and over.

Manukau Locality

Our largest locality of over 181,000 residents in 2013. This includes almost 40,000 Pacific people, 42,000 Maaori people and 41,000 people of Asian ethnicities. A quarter of the population are aged under 15 years. About 50% of people are living in areas of high socioeconomic hardship.

Eastern Locality Demographics



116,000 people are enrolled with one of the **27** general practices within the Eastern Locality

30%

resident population expected increase by 2033

Resident Population

151,255

Eastern Locality comprises

28% of Counties

Manukau Health Population

15%

Of Eastern Locality
are over

65 yrs

This is expected to double in the next 20 yrs

32%

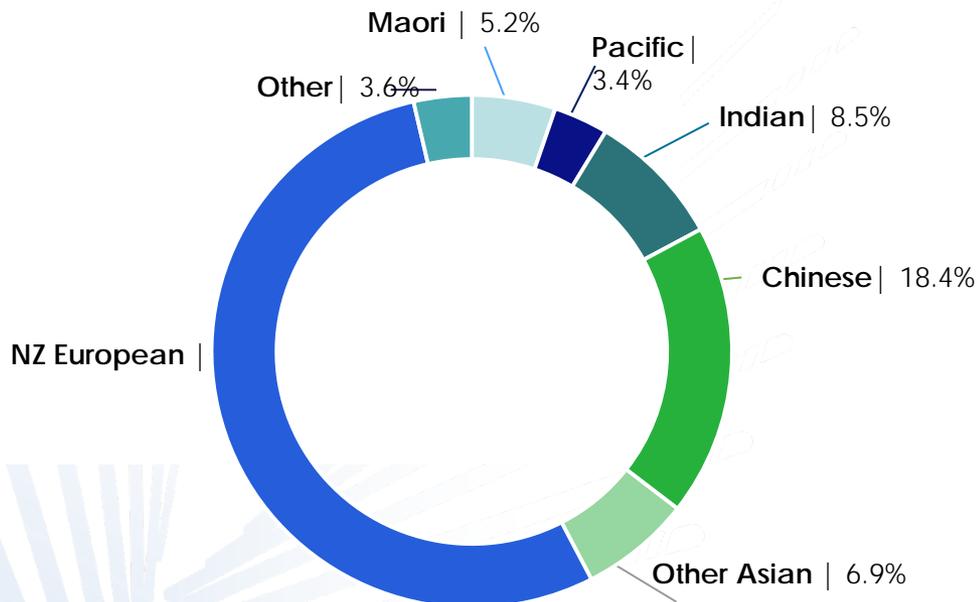
Of Eastern Locality
are under

25 yrs



Eastern Locality Demographics

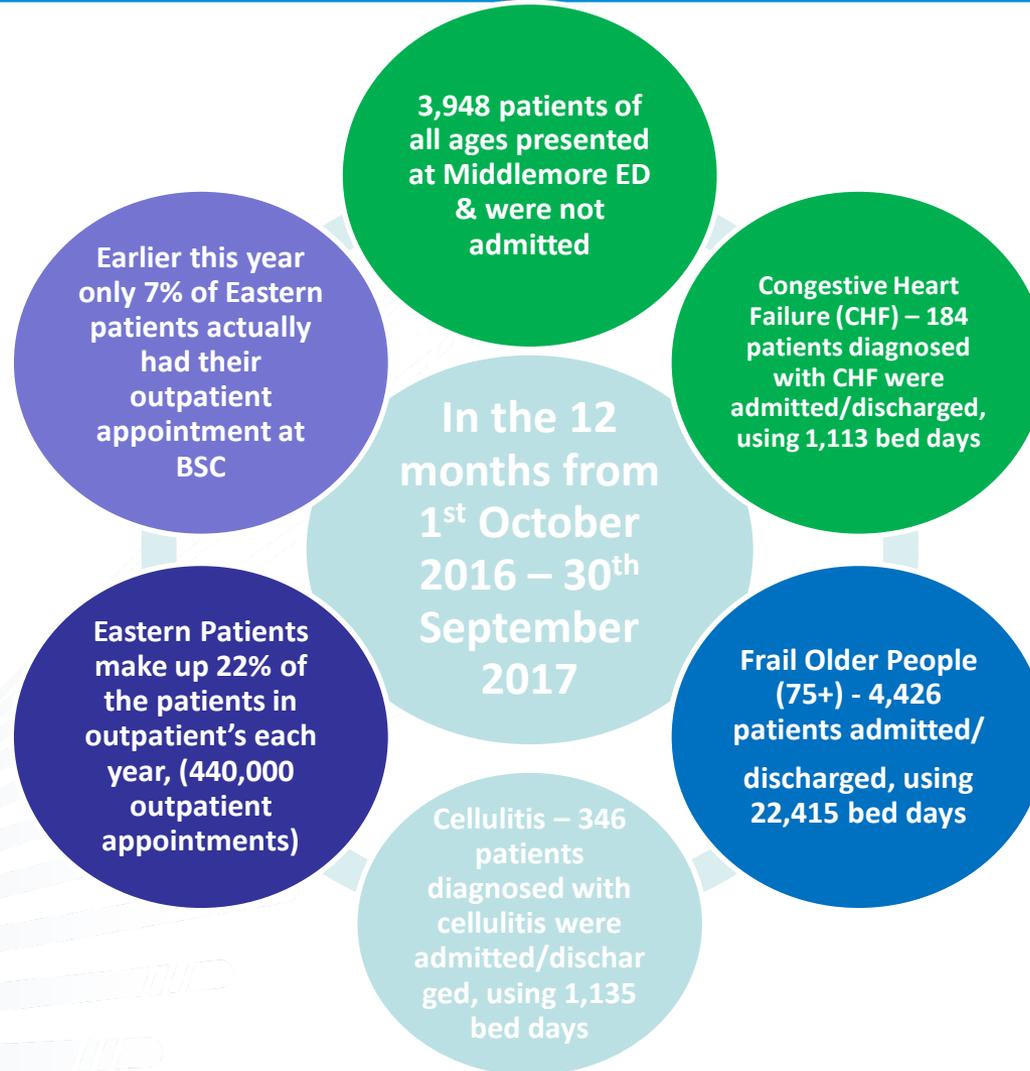
59,968 Asian population
(40%)



70%
of total CMH Chinese
Population reside in the
Eastern Locality

35%
of our Chinese
Population are enrolled
with a GP outside of
Counties

Picture of Eastern patients in Middlemore & Outpatients



Community Health Service Integration

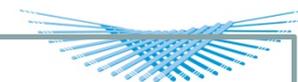


Further development of Rapid Response & Reablement Services

Initial focus and outcomes 2017/18

- Increased number of older people receiving acute treatment within their homes and community as part of a locality rapid response service avoiding unnecessary admissions to hospital or when admitted providing earlier supported discharge.
- A reduction of non-elective/unplanned admissions in the Eastern locality domiciled population 65 years and older
- Provision of rapid access assessments and treatment requested by primary and community health integrated MDT via home based or clinic based observation & treatment, telehealth or telephone consultation
- Provision of sub-acute medical cover/intervention
- Eastern locality residents over the age of 65 are supported to remain living in their own homes & communities with a 20% reduction in admission to permanent aged residential care
- Increased number of frail older people being appropriately supported to remain in aged residential care facilities, negating the need for an Emergency Department presentation
- Better management of end of life and palliative care in the community.





Specialty	Appointments NOT AT BOTANY
Ophthalmology	13596
Cardiology	9848
Orthopaedic Surgery	7861
Allied Health and other	7578
Plastic Surgery [excluding burns]	6043
General Surgery	5640
Gastroenterology	5394
Respiratory Medicine	5163
Otorhinolaryngology (ENT)	4309
Haematology	3888
Gynaecology	2837
Paediatric Medicine	2261
Urology	1932
Dermatology	1857
Geriatric A, T & R (active rehabilitation)	1800
Maternity services - mother [no community LMC]	1625
Rheumatology	1454
Anaesthesia Services(s) and Pain Management	1338
Renal Medicine	1337
General Medicine	928
Diabetology	861
Specialist Interventionist Radiology	725
Infectious Diseases	253
Not specified	253
Maternity services - mother [with community LMC]	204
Endocrinology	168
Neurology	118
Oncology	111
Dental Surgery	104
Physical disability A,T & R sub-series	78
Emergency Medicine	38
Specialist Paediatric Neurology	31
Paediatric neonatal special / intensive care [Level III]	2
Specialist medical genetics	2
Grand Total	89637

7% of appointments for patients who live in Eastern are currently provided at Botany SuperClinic (excl Botany Maternity Unit)

Specialty	Attended	Cancel led	Did not attend	Did not wait	Not specified	Grand Total
Allied Health and other	658	70	66		14	808
Cardiology					4	4
Diabetology	834	155	111	6	77	1183
Endocrinology	364	35	22		20	441
General Medicine	498	61	29		6	594
General Surgery	209	12	6		10	237
Geriatric A, T & R (active rehabilitation)	251	41	20	1	1	314
Gynaecology	599	42	11		4	656
Oncology	321	45	29		6	401
Paediatric Medicine	68	12				80
Renal Medicine	279	50	15		15	359
Respiratory Medicine	683	80	30	2	21	816
Rheumatology	785	93	28	1	17	924
Grand Total	5549	696	367	10	195	6817

The remaining appointments are provided at other facilities e.g. MMH, MSC, others.

Some top services e.g. Cardiology, Allied Health, General Surgery, Resp Medicine, Gynae are delivered from Botany SuperClinic, yet the majority of appointments for Eastern patients are accessed from other facilities.

Any Questions



Counties Manukau District Health Board

Community & Public Health Advisory Committee

System Level Measures Quarterly Regional Report and Scorecard

Recommendation

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

Receive the System Level Measures Quarterly Update Report.

Prepared and submitted by: Benedict Hefford, Director Primary, Community & Integrated Care.

Purpose

This scorecard presents regional progress towards meeting the 2017/18 Metro Auckland System Level Measures (SLMs), by District Health Board. Please note that the Infants Living in Smokefree Households and Youth Health measures are developmental for 2017/18.

Introduction

The New Zealand Health Strategy outlines a new high-level direction for New Zealand's health system over the next ten years to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health worked with the sector to develop a suite of System Level Measures to provide a system-wide view of performance. Building on the work outlined in the 2016/17 System Level Measures Improvement Plan, in 2017/18 improvement milestones and contributory measures for each of the SLMs have been prioritised in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Counties Manukau (CM) Health and Auckland Waitemata Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Maaori health gain and the elimination of inequity for Maaori.

The steering group and working groups have continued to meet in 2017/18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven Primary Health Organisations and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams and provides oversight of the overall process. Working groups were responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a Primary Health Organisation lead and supported by a DHB public health physician. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers.

This second improvement plan (2017/18) includes the additional two SLMs:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2017/18. The milestone must be a number that either improves performance from the district baseline or reduces variation to achieve equity. For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

This report includes the latest available data for each DHB for both the SLMs and their contributory measures. It also outlines each working group's progress against the improvement activities identified in for each SLM in the Improvement Plan.

Scorecard

	District / Region	Target	Performance		
			Actual	Period	Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds					
Measure:	Rate per 100,000 domiciled 0-4 year-olds.				
	Auckland DHB	7,278 (max.)	● 6,543	12-monthly	
	Counties Manukau	6,754	● 6,918	to	
Target 2017/18:	Waitemata DHB	5,409	● 5,369	Jun-17	
	Metro Auckland	6,420	● 6,258		
	Region				
2. Acute Hospital Bed Days					
Measure:	Age standardised rate per 1,000 domiciled population.				
	Auckland DHB	425 (max.)	● 410	12-monthly	
	Counties Manukau	451	● 452	to	
Target 2017/18:	Waitemata DHB	414	● 423	Jun-17	
	Metro Auckland	429	● 429		
	Region	429	● 429		
Target 2017/18:	3% reduction for Māori population by June 2018				
	Auckland DHB	578 (max.)	● 594	12-monthly	
	Counties Manukau	670	● 676	to	
	Waitemata DHB	538	● 546	Jun-17	
	Metro Auckland	605	● 613		
	Region				
Target 2017/18:	3% reduction for Pacific population by June 2018				
	Auckland DHB	826 (max.)	● 799	12-monthly	
	Counties Manukau	689	● 715	to	
	Waitemata DHB	709	● 721	Jun-17	
	Metro Auckland	730	● 738		
	Region				
3. Patient Experience of Care					
Measure:	DHB Adult Inpatient Experience Survey: Aggregated Domain Score (/10).				
	Auckland DHB	8.5 (min.)	● 8.3	Quarterly	
	Counties Manukau	8.5	● 8.9	to	
Target 2017/18:	Waitemata DHB	8.5	● 8.3	Jun-17	
	Region				
Measure:	Practices participating in Patient Experience Survey.				
	Alliance Health Plus	50% (min.)	● 1%	Total	
	Auckland PHO	50%	● 0%	to	
	Comprehensive Care	50%	● 28%	Aug-17	
	East Health	50%	● 24%		
	National Hauora Coalition	50%	● 76%		
	Procure	50%	● 33%		
	Total Healthcare	50%	● 0%		
Target 2017/18:	Fifty percent of each PHO's practices				
4. Amenable Mortality					
Measure:	Age standardised rate per 100,000 domiciled 0-74 year-olds.				
	Auckland DHB	71.4 (max.)	● 79.2	12-monthly	
	Counties Manukau	102.3	● 101.4	to	
Target 2017/18:	Waitemata DHB	64.3	● 68.9	Dec-14	
	Metro Auckland	64.3	● 68.9	draft data	
	Region	78.6	● 83.0		
5. Youth Health					
Measure:	Chlamydia testing coverage for 15-24 year-olds.				
	Auckland DHB	80% (max.)	● 45%	Quarterly	
	Counties Manukau	80%	● 55%	to	
Target 2017/18:	Waitemata DHB	80%	● 32%	Dec-16	
	Metro Auckland	80%	● 47%		
	Region	80%	● 47%		
6. Babies Living in Smokefree Households					
Measure:	Percentage of babies for whom smoke free household status is not recorded by 6 weeks.				
	Auckland DHB	10% (min.)	● 10%	6-monthly	
	Counties Manukau	10%	● 14%	to	
Target 2017/18:	Waitemata DHB	10%	● 12%	Dec-16	
	Metro Auckland	10%	● 12%		
	Region	10%	● 12%		

Legend

- Target met / on track
- Improvement needed
- Significant improvement needed
- Metro Auckland Region
- Auckland DHB
- Counties Manukau
- Waitemata DHB

Overall Progress Report

Overarching activities for Q1:

- Final submission and approval of the 2017/18 Improvement Plan to the Ministry
- Q4 reporting for 16/17 approved, with payment processed on 15 September to all Primary Health Organisations without impediment
- Stocktake of existing, new, planned and boosted activity under SLMs, which has been developed into a Regional Action Plan (Implementation Plan), with a plan to present to the Alliance Leadership Teams after Q2
- Consideration of the business-as-usual stage for SLMs, with a plan for operation agreed and preparation in progress
- First steps to business-as-usual, development of a consolidated governance structure: data panel, Primary Health Organisation implementation group and acute hospital bed days working group reporting to steering group, with a view to the permanent home of the other SLM working groups in negotiation
- Formation of quarterly static and on-going dynamic reporting and a formal workshop to launch these reports, explain the process for data requests and discuss the attributes and limitations of SLM related data
- SLMs have become core business for the metro-Auckland Data Sharing Data Stewards during embedding of the data release and governance processes, also presented at Regional Privacy Advisory Group (RPAG)
- Some data has been delivered for almost all milestone and contributory measure data sets. Those that have not been received have been formally requested. There is some lag from Ministry data sets and where there is lag, wait times range from 3 to 6 months
- Several improvement activities requiring data have also had the Metro-Auckland Data Sharing Framework (MADSF) user request completed and have either received data or is in the approval process. Some further improvement activity-related data sets are currently being defined with a view to analysis shortly.

Ambulatory Sensitive Hospitalisations 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting.

In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

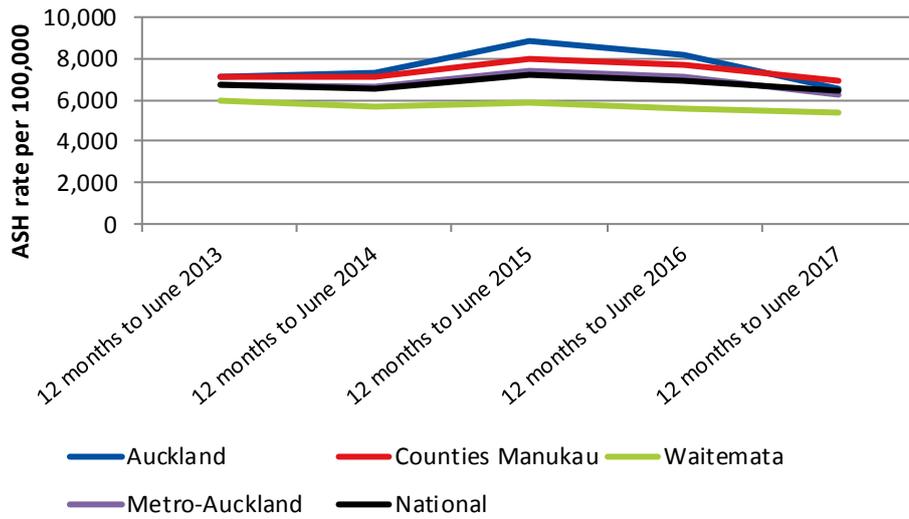
It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

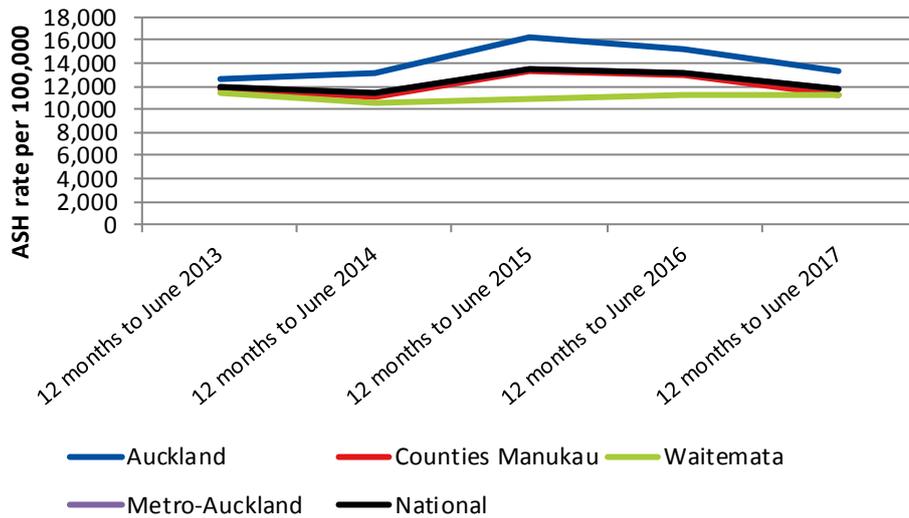
A composite ASH measure is preferred because it gathers up more conditions and aligns with the intention of using measures that operate at a system level rather than ones that focus on a specific condition or service.

In 2017/18, the overall improvement milestone is to achieve a reduction in ASH rates for 0-4 year olds of 5% by June 2018. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported and interrogation of approach to ensure that interventions reduce not worsen inequity. Metro Auckland's rate is 6,258 per 100,000 for the 12 months to June 2017 (latest results). This is more than a 5% reduction on the results to September 2016 (baseline) of 6,758 per 100,000 population.

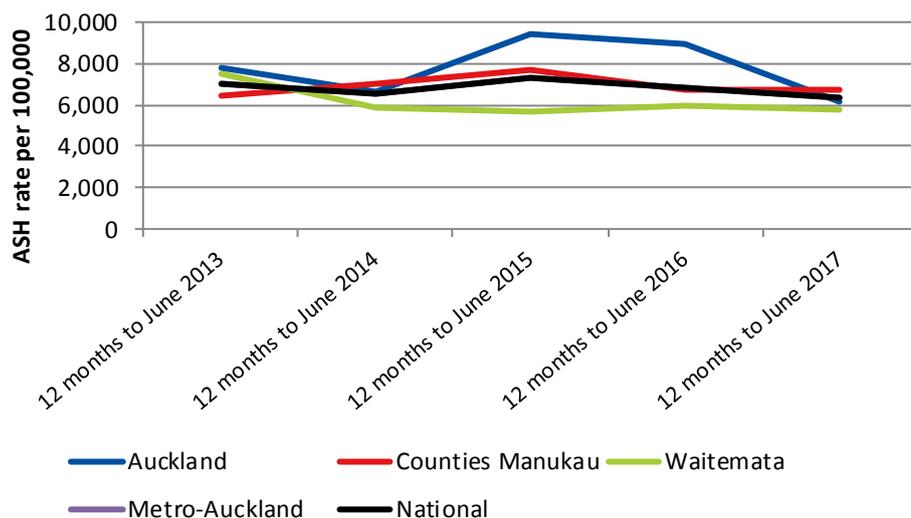
Non-standardised (age specific) ASH rate by DHB: 0-4 year olds, all conditions



Non-standardised ASH rate by DHB: 0-4 year olds, all conditions: Pacific



**Non-standardised ASH rate by DHB: 0-4 year olds, all conditions:
Maori**

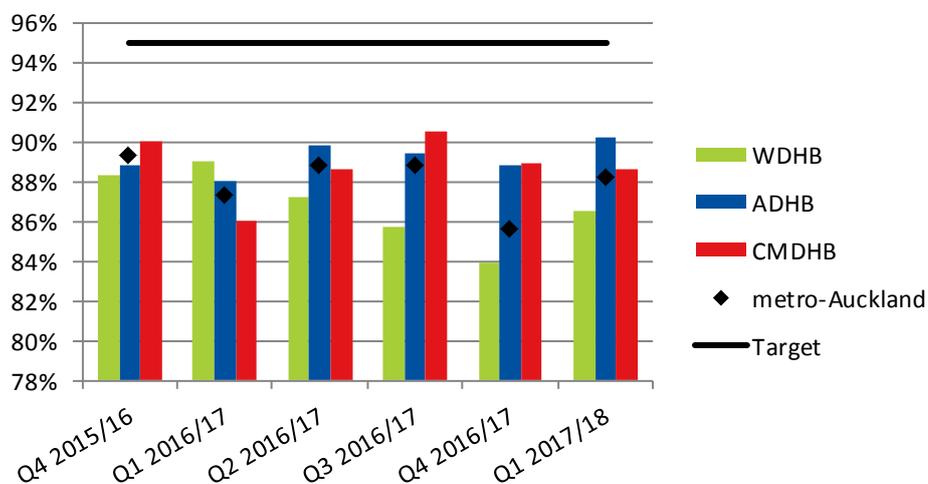


Contributory Measures

1. Maaori babies fully immunised by 8 months of age

The goal for 2017/18 is to achieve the national target of 95% coverage per quarter. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue. For Quarter 1 2017/18, none of the metro-Auckland DHBs met the target overall, with a metro-Auckland result of 88.2%.

Immunisation rates - 8 months: Maori by DHB



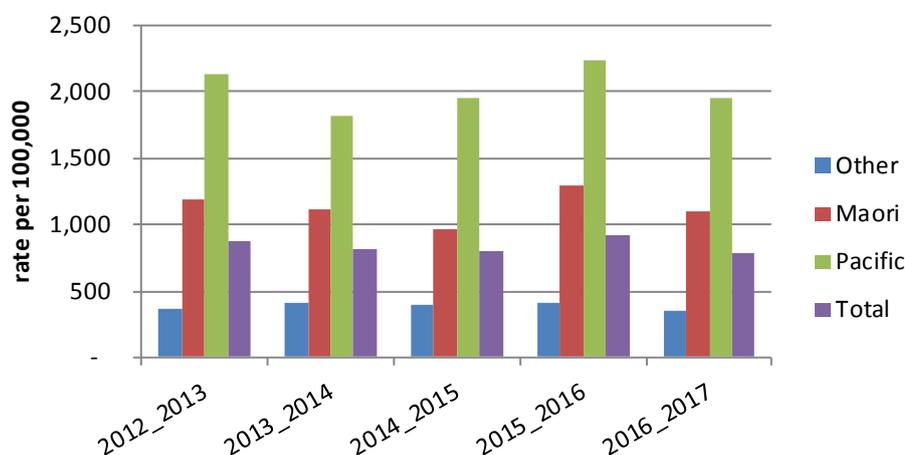
Improvement Activities	Progress Report
<ul style="list-style-type: none"> Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Maaori and Pacific providers, secondary care). Continue to develop specific activity to improve Maaori coverage (including ways to improve timeliness of immunisation), with leadership from Maaori health gain teams and Maaori leaders within primary care. Develop links between immunisation 	<p>All DHBs and Primary Health Organisations continued with business as usual activities throughout the quarter.</p> <p>Closing the equity gap and targeting high risk children are priorities for DHBs, and scoping activities have begun for in-hospital immunisation monitoring and documentation.</p> <p>There is activity in each of the named improvement activities, although Well Child/Tamariki Ora immunisers and Whanau Ora service utilisation has not yet been addressed.</p> <p>The Primary Health Organisation implementation meeting on 6 September addressed the contribution of Primary Health Organisations to this measure, with identification of barriers to immunisation and a set of</p>

Improvement Activities	Progress Report
<p>outreach services and Maori Tamariki Ora providers to improve immunisation coverage for their enrolled children.</p> <ul style="list-style-type: none"> Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation. Utilise Whaanau Ora services for immunisation of hard to reach children. Promote immunisation in antenatal classes. Investigate whether significant numbers of Maori babies are not engaged with general practice, with a view to include improvement activities to connect Maori whaanau into the current newborn enrolment work. 	<p>strategies developed to identify and engage high risk children.</p>

2. Skin infections

The goal is a reduction in hospitalisation rates by 5% by June 2018, from a baseline of 907 per 100,000 0-4 population as at September 2016. To achieve this goal, there are a number of targeted activities around promotion of key prevention messages, in various community settings. The latest data is for the 12 months to June 2017 and shows a result of 791 per 100,000 0-4 population, a more than 12% reduction on baseline. However, results are much higher for Maori and Pacific populations and also typically fluctuate between quarters.

Metro-Auckland unstandardised skin infection rate 0-4 year olds to June



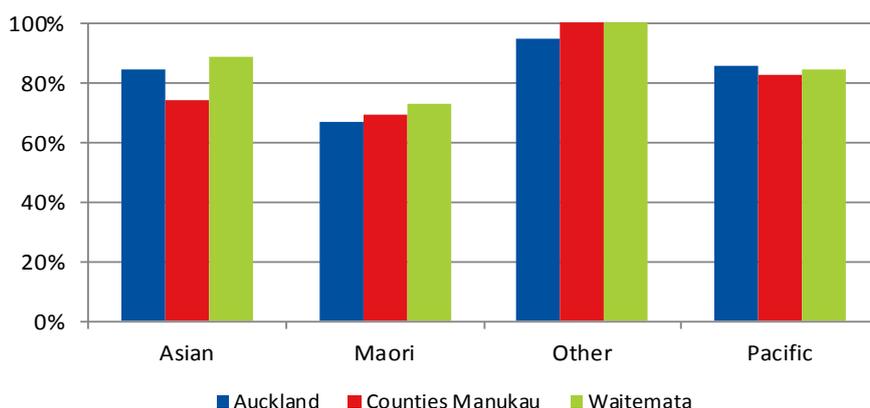
Improvement Activities	Progress Report
<ul style="list-style-type: none"> Improve distribution of resources to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres Deliver an educational package 'skin infection combined key messages' to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well 	<p>There is ongoing work in this area as detailed in the activities.</p> <p>There is a Primary Health Organisation implementation meeting scheduled for 15 November to support the activities in Primary Care. Several Primary Health Organisations are taking a lead in this area by working on primary care skin clinics and related identification of higher risk skin infections, which will be treated in primary care, reducing hospitalisations.</p> <p>The new national pharmacy plan should link this work to interventions in pharmacy shortly.</p>

Improvement Activities	Progress Report
<p>Pacific Mother and Infant Service) to reach community groups.</p> <ul style="list-style-type: none"> • Use DHB nurse educators and other health promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not. • Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service. • Consider further development of primary care skin clinics. (Working group suggest this is an analysis or discussions document activity about reinstatement of primary care skin clinics) • Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses. • Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products. • Consider targeted outcomes for Pacific and Maaori children. 	

3. Oral Health

The goal is 95% enrolment with oral health services amongst preschool children. The newly finalised Oral Health Strategy is the basis of the improvement, with SLMs aligning and supporting this work. As at October 2017, the metro-Auckland result shows that around 88% of 0-4 year olds are enrolled with the Auckland Regional Dental Service. This is much lower for Maaori at 70%. Counties Manukau have the lowest rate of enrolment overall at 81.5%, Waitemata the highest at 95%.

Percentage of preschool children enrolled in DHB funded oral health services - as at October 2017 (rolling 12 months)



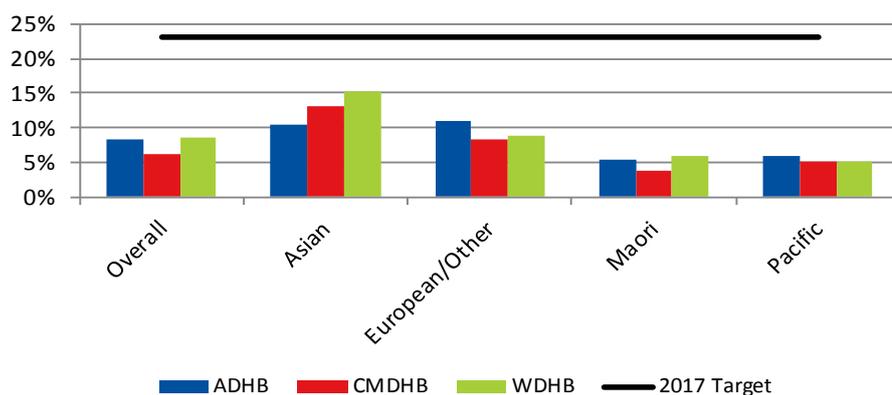
Improvement Activities	Progress Report
<p><i>From the 2017 Pre-school Oral Health Strategy:</i></p> <ul style="list-style-type: none"> • Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups. 	<p>The Oral Health strategy has been finalised and is now moving toward implementation.</p> <p>There is a Primary Health Organisation implementation meeting for this area scheduled for 15 November 2017 to agree interventions in Primary care.</p>

Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Messaging to align with Raising Healthy Kids National Health Target. • Increase awareness of free dental services. • Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes. • Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services. • Increased number of extended hours and Saturday dental clinics in appropriate locations. • Consider a targeted intervention for Pacific and Maaori children to address inequity. 	<p>Early adopters are working toward promotion of lift-the-lip assessments and clarification of the referral pathway.</p> <p>Many of the activities in this measure are the agreed responsibility of Auckland Regional Dental Service (ARDS) under the Pre-School Oral Health Strategy.</p>

4. Respiratory Conditions Potentially Preventable by Immunisations

The goal is to increase flu vaccination coverage by 10% (from a baseline of 13% at December 2016) for children who are hospitalised with a respiratory illness. To achieve this goal, there is a focus on provision of information in a timely manner and improved key messages around flu vaccine for eligible children. This measure is across the calendar year in line with the flu season May to December. So the cohort is established at 1 March and vaccination rates are measured for these children at 31 May, 31 July and 30 September, with the final measure as at 31 December. The rates below are as of 31 July 2017. Rates were highest for Waitemata DHB and lowest for Counties. Maaori and Pacific rates are lowest.

Flu vaccination rates for children hospitalised with a respiratory condition aged under 5 years - as at 31 July 2017



Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine. • Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities. • Undertake activities in primary and secondary care: <ul style="list-style-type: none"> <i>Secondary care</i> <ul style="list-style-type: none"> ○ Develop a documented, consistent system for providing lists of hospitalised children to Primary Health Organisations and monitoring through the Influenza season (when the vaccine is available); ○ Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations, and ○ Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations. <i>Primary care</i> <ul style="list-style-type: none"> ○ Immunisation coordinators in Primary Health Organisations provide education to general practice staff on special immunisations while visiting practices, and ○ The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions. • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness. • Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years. • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points. 	<p>There has been very good engagement with this measure in both primary and secondary care. It was discussed at the Primary Health Organisation implementation meeting on 6 September and Primary Health Organisations agreed to develop specific queries to determine eligible patients and plan to liaise with NIISG to improve promotional material. DHBs have agreed to provide lists of eligible children as early as possible to facilitate early engagement.</p> <p>An education programme was agreed for later in the year, with key messages at conferences and on web based platforms to decrease barriers to access.</p> <p>Conversations about the feasibility of offering influenza vaccination to all children 0-4 years have been postponed until the key actions in this SLM have been undertaken.</p> <p>Data for pregnancy related immunisation has been requested from the Ministry of Health and is due in November 2017.</p>

Acute Hospital Bed Days Per Capita

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between primary and secondary care, can all help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

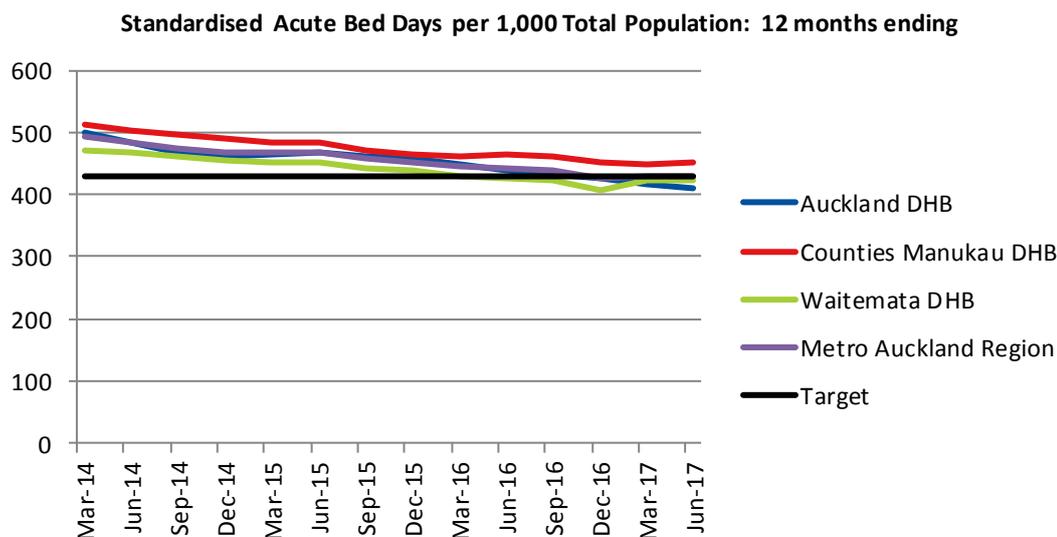
Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to Emergency Department (self, provider variation, ambulance etc.). Primary care interventions are key and can have significant impact on hospital admission rates.

The Auckland Metro age standardised acute bed day rate per thousand population was calculated to be 437.7 as at September 2016 with a target set to reduce the rate by:

- 2% for the total population – 428.9 standardised acute bed days/1000 by June 2018
- 3% for the Maaori population – 604.6 standardised acute bed days/1000 by June 2018
- 3% for the Pacific population – 729.6 standardised acute bed days/1000 by June 2018

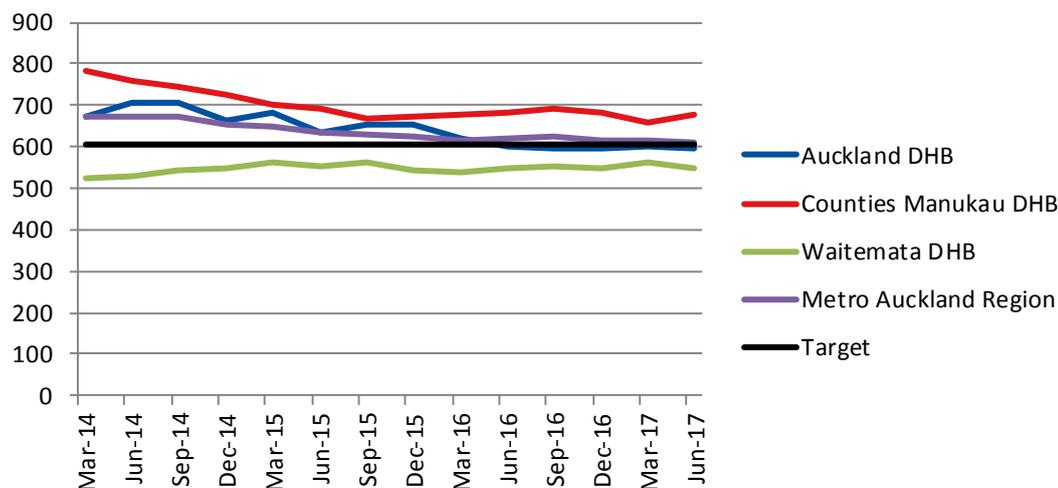
It must be noted that any new beds opening will need to be adjusted for, as supply side changes will impact this indicator in a stepwise fashion.

When standardised, overall rates are generally declining for all DHBs as they are nationally. The metro-Auckland overall rate is nearing the June 2018 target at 429.1 standardised acute bed days/1000.

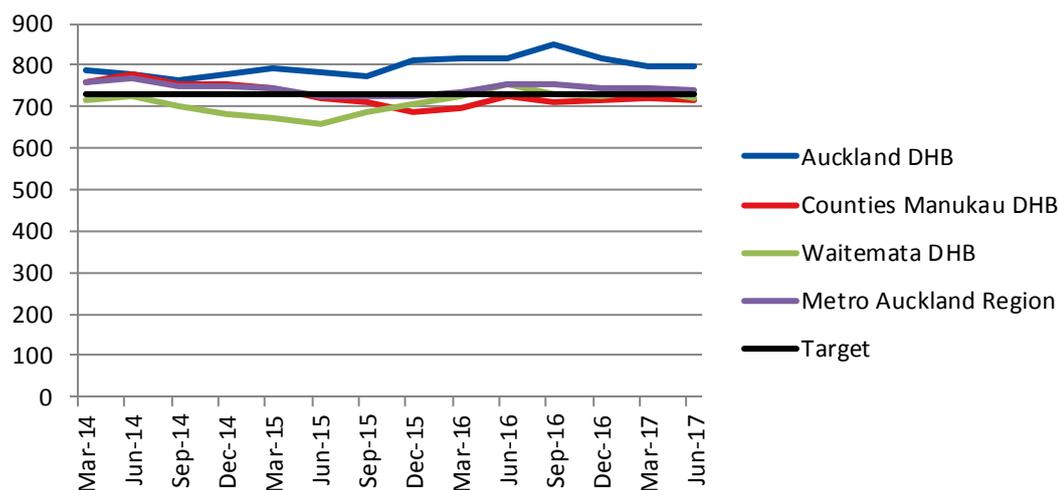


However, rates are much higher and more static for Maaori and Pacific populations. While Auckland has met target for Maaori and Waitemata is better than target, Counties Manukau are some way from the achieving. For Pacific, both Counties and Waitemata are now within the target, but Auckland remains above.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



Contributory Measures

1. Emergency Department Presentation Rates.

Overall reduction in Emergency Department presentations will result in less admissions and bed day use. There is some complexity involved in this measure however it is a good marker due to its correlation with actual admissions and also potentially avoidable admissions. The difficulty will come from wide confidence intervals for the measurement at a practice level. Other measures such as Primary Options for Acute Care utilisation rates are also being developed.

The methodology for calculating this measure has only recently been finalised and approved and a baseline established of 214.3 Emergency Department attendances per 1000 population (standardised), for the 12 months to 30 September 2016. The 2017/18 SLM Improvement Plan set a target of reduction of 2% by June 2018. Data is yet to be released to determine performance.

These rates are per 1,000 of the population and age standardised to the New Zealand population 2013 and presented as a moving 12 month rolling figure. Note that the data will be refreshed retrospectively for each reporting period, so previously reported figures may change.

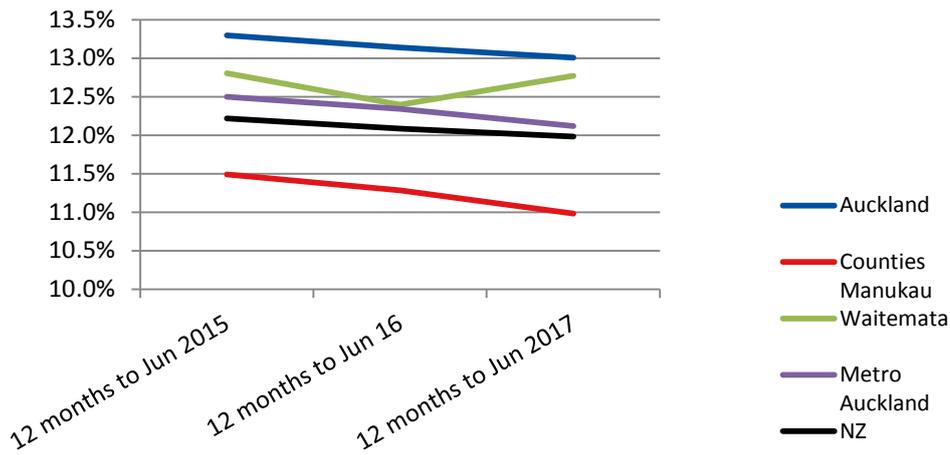
Improvement Activities	Progress Report
<p>Primary Options for Acute Care activities:</p> <ul style="list-style-type: none"> • Determine baseline utilisation of Primary Options for Acute Care across the region, including an ethnicity-level and a practice-level analysis. • Identify gaps and areas for potential improvement. • Convene expert group to determine and agree consistent interventions. • Monitor Primary Options for Acute Care utilisation, intervention rate and impact. • Develop and implement an education programme to promote appropriate use of Primary Options for Acute Care. • Explore current barriers to general practices using Primary Options for Acute Care. • Develop practice-level reports showing Primary Options for Acute Care usage relative to peers. • Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care. 	<p>Data definitions have been completed and discussed with Primary Options for Acute Care. These have been approved by the Data Custodians and Steering Group and a source request sent to Primary Options for Acute Care. This data was discussed by the expert group on 19th October.</p> <p>Practice level reporting is also in development for the region. Development of the education programme is scheduled for the Primary Health Organisation implementation meeting to discuss Primary Options for Acute Care on 1 November 2017.</p> <p>CMDHB is currently developing an application to show emergency wait times and may give out vouchers to redirect patients should wait times prove lengthy for low acuity.</p>

2. Acute readmission rates at 28 days

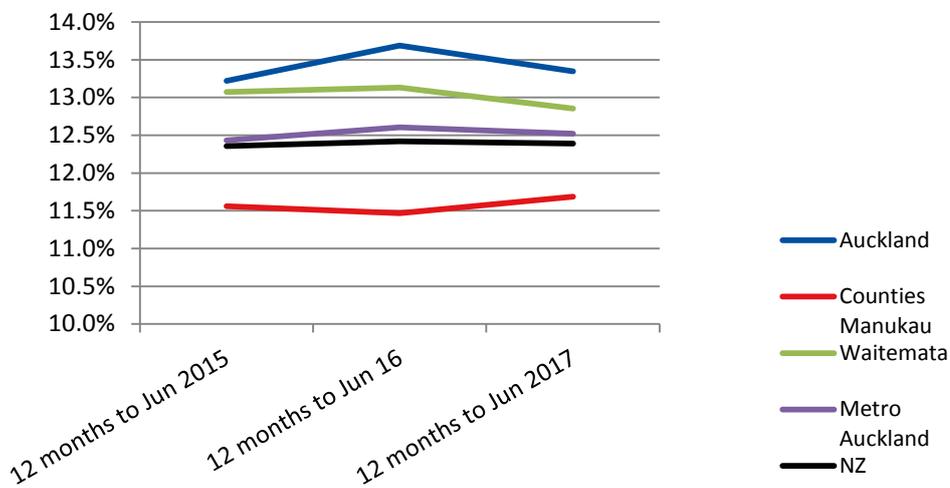
Avoidance of readmission to hospital following a recent discharge from hospital. The Ministry of Health have recently changed the methodology for calculating acute readmission rates at 28 days significantly. Therefore the data presented below cannot be compared to previous datasets. The latest Ministry results (to June 2017) for metro-Auckland show performance at 12.1% standardised for the total population. Within this, Auckland DHB has a result of 13%, Counties Manukau 11% and Waitemata DHB 12.8%. There has been little movement across the three data points, though a general decline is evident for all except Waitemata DHB. Only Counties Manukau is below the New Zealand rate.

For both Maaori and Pacific, readmission rates for Auckland are highest and lowest for Counties Manukau. Readmission rates for Maaori are also generally static though higher than that for the total population, whereas there is a marked decline across the data points for Pacific, except for Waitemata which has increased between this and last reporting period.

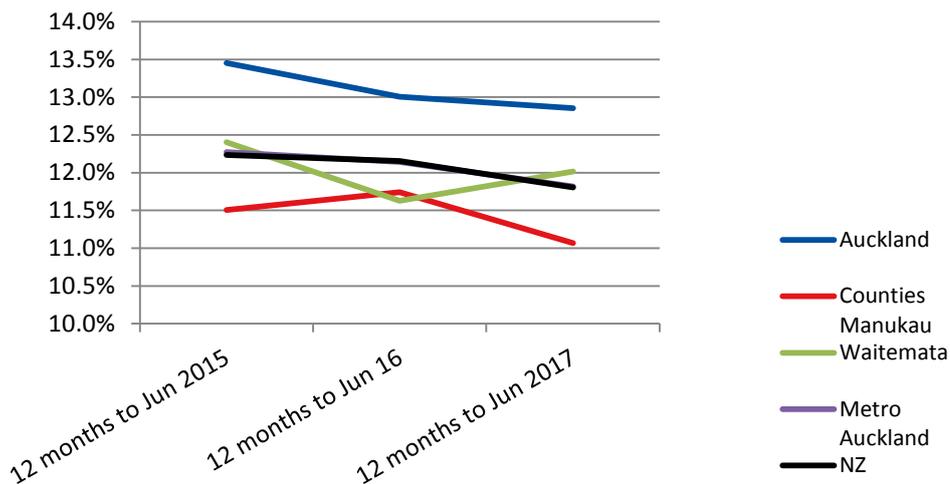
Standardised acute readmission rates within 28 days - Total Population



Standardised acute readmission rates within 28 days - Maori



Standardised acute readmission rates within 28 days - Pacific



Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Determine baseline readmission rates by ethnicity, by Primary Health Organisation and across the region. • Explore the potential of risk stratification to identify patients at highest risk of readmission. • Review discharge planning processes across the hospital systems. • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly. • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly • Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans are in place, with a focus on initiating them in primary care settings. 	<ul style="list-style-type: none"> • Awaiting Ministry data using new methodology, first set delivered late September but was returned due to low quality. • AHBD working group is creating linkages between the DHBs and their ongoing projects in this area. • CMDHB has four working groups newly created to address the condition-based issues – specifically, chronic obstructive pulmonary disease, heart failure, stroke and cellulitis. • ADHB has ‘Using the Hospital Wisely’ programme and a specific consideration of chronic obstructive pulmonary disease. • WDHB has the TransforMED programme which has a bed day reduction focus, and a frail and elderly emphasis. • The three programmes above are linking up with the AHBD working group and sharing ideas and successes. • Risk stratification is ongoing at CMDHB as part of the Planned Proactive Care model of care. • A/WDHB are reviewing and focusing on discharge planning.

Patient Experience of Care

‘Person centred care’ or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Measures

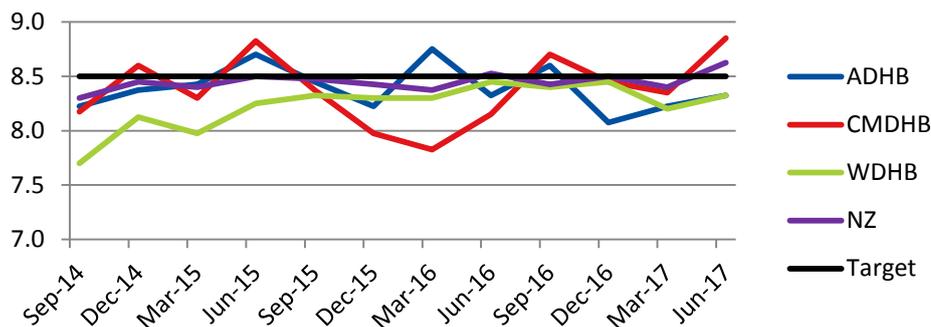
1. DHB Adult Inpatient Survey

The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and for 2016/17 the SLM milestone for patient experience focused on the Adult Inpatient Experience Survey. This survey captures 4 measured domains - communications, partnership, coordination, physical and emotional needs. The 2016/17 target was to achieve an aggregate score of 8.0/10 across all four domains measured, this has been increased to 8.5/10 for 2017/18.

Interventions are aimed at improving patient experience scores in the 4 domains along with promoting the survey to improve participation and using the results to improve quality. Individual DHBs need to improve survey participation, particularly with respect to equity and foster greater regional collaboration. This may include working with Maaori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

DHB Adult Inpatient Experience Survey: Aggregated Domain Score (/10)



Improvement Activities	Progress Report
<ul style="list-style-type: none"> Individual DHB focus areas via annual planning will be worked on at a local level. For 2017/18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered. A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group. Develop long-term strategies in response to specific equity challenges (Pacific and Maaori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care. Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland. 	<p>This work is ongoing in DHBs. Regular joining-up occurs, with lessons learnt contributing to initiatives in primary care.</p> <p>The Patient Experience of Care Primary Health Organisation implementation meeting was held on 20 September with contribution from regional and DHB representatives.</p>

2. The Primary Health Care Patient Experience Survey

The Primary Health Care Patient Experience Survey) is currently being rolled out across Auckland. In Auckland 5 Primary Health Organisations with a total of 95 practices participated in the August Primary Health Care Patient Experience survey week prior to setting up ongoing survey capability. The survey was conducted in the first week of August. There were some technical issues which meant that around 15 practices set to participate did not have the survey sent to patients. A plan for remediation was made, with the survey week extended for these practices and a technical patch in place.

According to the Health Quality and Safety Commission, this will be implemented in all practices, but it is critically dependent on establishment of the National Enrolment System (NES), which has not yet been implemented in any practices. The 2017/18 target is to ensure 50% of each Primary Health Organisation’s practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey by June 2018.

Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Ensure socialisation of resources and support for practice-related activities, such as, Primary Health Organisations follow Health Quality and Safety Commission/Ministry of Health 'Getting Started' resource pack and advice. • Primary Health Organisations advise Cemplicity of Primary Health Organisation name and contact for survey, and IT key contact to enable log on via email address. • Practices are supplied with and follow getting started guide and resources. • Practices provide Primary Health Organisation with details to appear on survey invitation email, text message and online survey. • Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled. • Practices check email addresses of all patients 15 years and over and save preferences. • Follow up by Primary Health Organisation and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required. • Once survey is closed, practices and Primary Health Organisations will review the final results of the survey. 	<p>The survey week was held in the first week of August. There were some technical issues which meant around 15 practices from various Primary Health Organisations were not able to have patients complete the survey. The survey week was extended for these practices in order to overcome the issue.</p> <p>A further patch of Medtech is expected just before the next survey week in November, and this will need to be implemented quickly, but should solve several technical issues.</p> <p>We note some Primary Health Organisations did not participate in survey week due to delays in NES completion at their sites.</p>

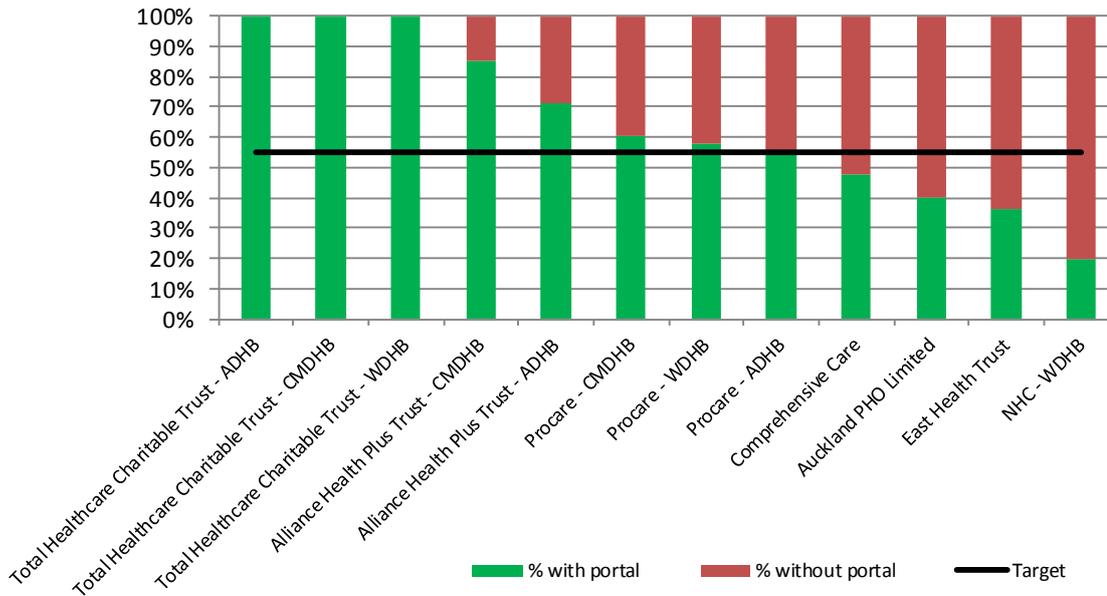
Contributory Measures

1. E-Portals.

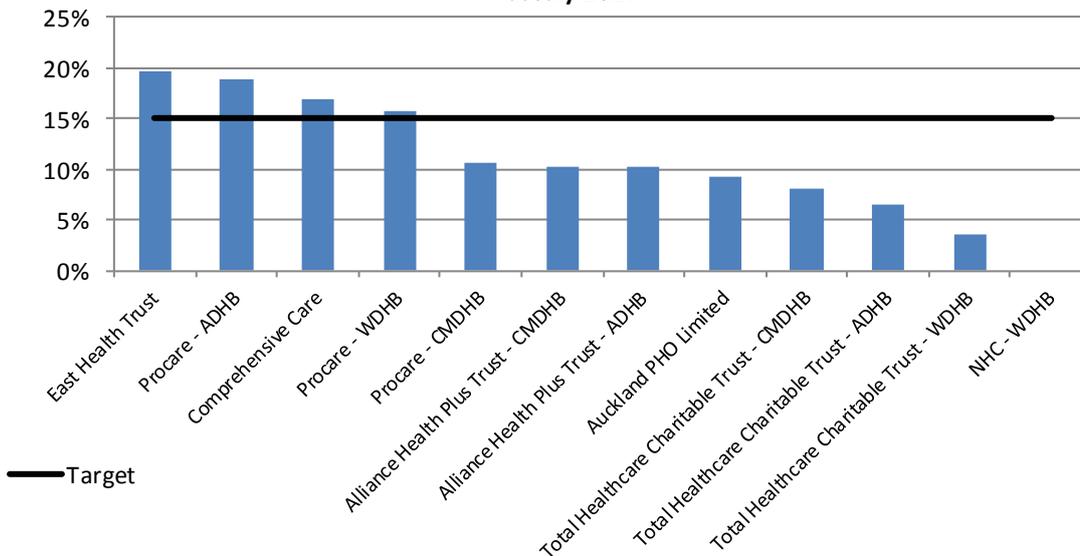
E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

For 2017/18 the target is that 55% of each Primary Health Organisation's practices are registered with a portal and 15% of each Primary Health Organisation's population have access to a portal. The latest (July 2017) results show that only 4 Primary Health Organisations (when split by DHB boundaries) have still to meet the 55% target for having portals in place (noting NHC has only one practice – in Waitemata – with a portal). However, most Primary Health Organisations have yet to meet the 15% target of enrolled patients registered to use portals.

Percentage of practices with/without patient portal - by practice location PHO: as at July 2017



Percentage of enrolled patients with e-portal login - by practice location PHO: as at July 2017



Improvement Activities	Progress Report
<ul style="list-style-type: none"> E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via Primary Health Organisations and practices. Primary Health Organisation teams will provide support to practices to implement e-Portal enrolment systems. Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include: <ul style="list-style-type: none"> access to clinical data – diagnoses, notes, allergies, 	<p>Update of e-portals is now increasing and Primary Health Organisations are generally using a tranche approach to engage groups of practices per quarter.</p> <p>There is wide variation in the number of practices engaged in e-portals with some Primary Health Organisations having 100% of practices engaged, and some at 0. Those with 0 e-portals have a plan to implement imminently.</p> <p>The Patient Experience of Care Primary Health Organisation implementation meeting was held on 20 September with discussion on how Primary Health Organisations are implementing the E-portals, techniques to overcome barriers and a commitment from most to meet the target by year end.</p>

Improvement Activities	Progress Report
immunisations, lab results; <ul style="list-style-type: none"> ○ access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling; ○ access to education – condition specific information, websites with merit, self-management activities, and ○ Primary Health Organisations will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients. 	

Amenable Mortality

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75).

For 2017/18 the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease management and smoking cessation.

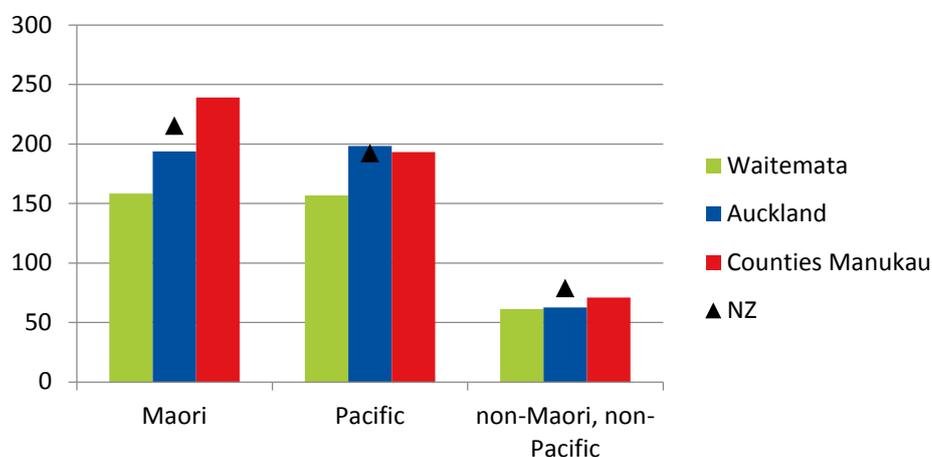
Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30 was used as baseline:

DHB	2013	2009-2013
Auckland	72.9	87.5
Counties Manukau	104.4	113.0
Waitemata	65.6	74.6
Metro Auckland	80.2	89.4

The goal is to achieve a 6% reduction for each DHB (on 2013 baseline) by June 2020, noting that changes in rates would generally only be seen over an extended timeframe of at least 3-5 years.

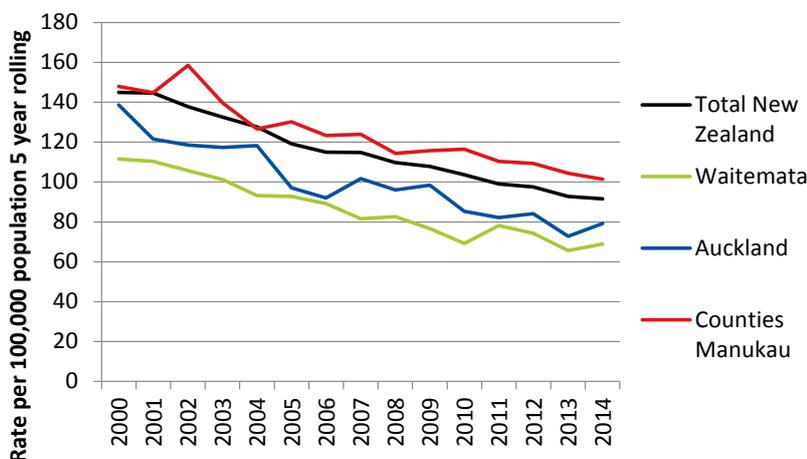
The current level of inequity in amenable mortality indicates the scope for health gain.

Standardised amenable mortality rates per 100,000 by ethnicity:
2010-2014



Based on five year trends, all three Metro Auckland DHBs show consistently declining rates as per graph below, despite an increase between 2013 and 2014 for Auckland and Waitemata DHBs. Given that there will always be some annual fluctuation and that the target extends to 2020, we should be on track to meet the 6% reduction by 2020.

Amenable mortality age standardised rates 0-74 year olds 2000-2014

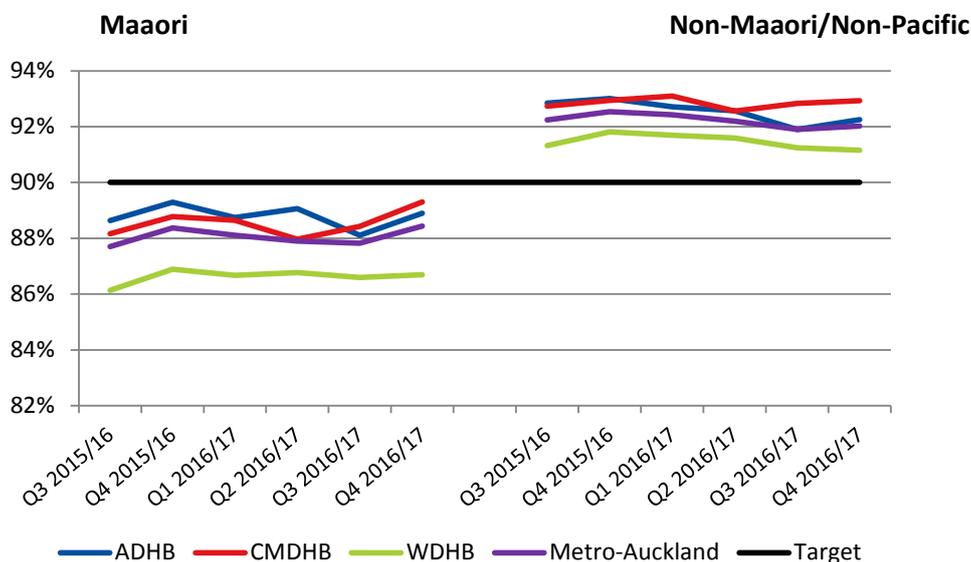


Note: 2010-2014 and 2014 data are draft/interim

Contributory Measures

1. Cardiovascular Disease Risk Assessment – to increase coverage of Maaori to 90%

As at March 2017, Maaori screening rates were slightly below the target with Counties Manukau DHB screening 88.4% of the eligible population, while Auckland DHB had screened 88.1% and Waitemata DHB 86.6%. Results for the quarter ending June 2017 show a small improvement in performance: 89.3% for Counties Manukau DHB, 88.9% for Auckland DHB and 86.7% for Waitemata DHB.



Improvement Activities	Progress Report
<ul style="list-style-type: none"> Follow up Primary Health Organisation calls (evenings) for practice generated cardiovascular disease RA recall letters to Maaori. Pilot of phlebotomy services in the practices or point-of-care testing when Maaori males visit opportunistically. 	<p>These activities were discussed in the Primary Health Organisation implementation meeting on 23rd August, with agreement from all Primary Health Organisations to participate in data mining to find Maaori patients, and recall.</p> <p>Several practices are piloting use of the Cobas machines to opportunistically test Maaori males on presentation to clinics, with an informal evaluation to follow in early 2018.</p>

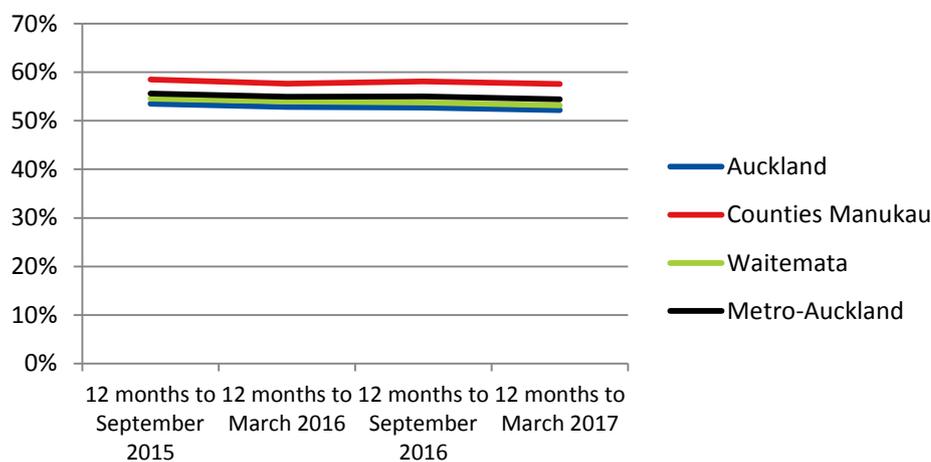
2. Cardiovascular Disease Management - to increase triple therapy by 5% (relative) for those with a prior cardiovascular disease event and for those with a cardiovascular disease risk assessment of $\geq 20\%$

Baseline for 2017/18 was set on performance as at the twelve months ended September 2016.

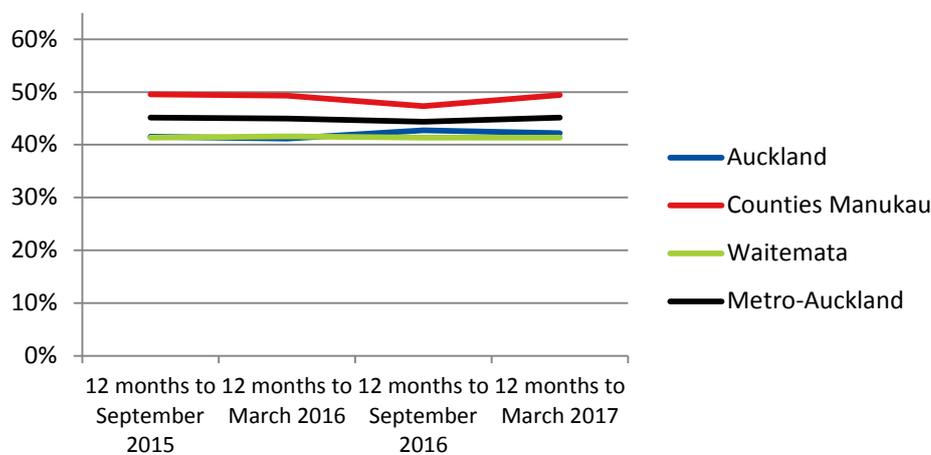
For triple therapy baseline results, Counties Manukau DHB recorded 58.1%, Auckland DHB 52.7% and Waitemata 53.8%. Latest performance (for the 12 months ended March 2017) shows deterioration in results for all DHBs – 52.2% for Auckland, 57.6% for Counties Manukau and 53.1% for Waitemata, with a metro-Auckland rate of 54.4%. Rates are lowest for Asian at 47.5% across the metro-Auckland region, followed by Other ethnicities at 52.8%.

For the twelve months ended September 2016, dual therapy pharmaceuticals dispensed to those with a cardiovascular disease risk assessment score greater than 20% were 41.6% for Auckland DHB, 49.1% for Counties Manukau and 41.4% for Waitemata DHB. Little change in rates for any of the DHBs can be seen in the twelve months ended March 2017, with results recorded as 42.2% for Auckland DHB, 49.4% for Counties Manukau and 41.3% for Waitemata DHB, or 45.2% for the metro-Auckland region. Across metro-Auckland, rates are lowest for Other ethnicities at 40.6%, followed by Asian at 43%.

Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals - Total Population



Percentage of enrolled patients with a CVD risk assessment score $\geq 20\%$ dispensed dual therapy pharmaceuticals - Total Population

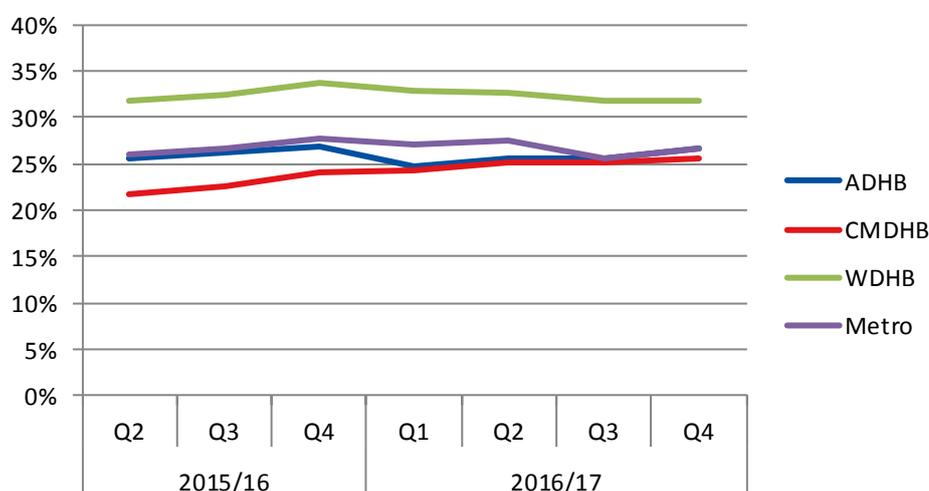


Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Identification of patients at a NHI level who have had a cardiovascular disease event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via Primary Health Organisations. • Total population and specific interventions for Maaori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy. • Post-event medication counselling and other rehabilitation services in hospital. • Ongoing medication counselling by community pharmacists. • Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments. • Establish a single process to report cardiovascular disease indicators from PRIMARY HEALTH ORGANISATION practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions. 	<p>There are regionally agreed definitions and standardised format of reporting for cardiovascular disease dispensed medications is available from the Northern Region Cardiac Network. Primary Health Organisations have given approval to share the aggregated dispensing reports for regional reporting.</p> <p>All Primary Health Organisations have agreed to identify patients who are not on optimal therapy and feedback these results to GPs.</p> <p>The Primary Health Organisation implementation meeting on 26th August discussed opportunities to improve in this area, and a tutorial on the reporting was delivered.</p> <p>Work on the cardiovascular disease indicators is ongoing.</p>

3. Increase rate of cessation support provided to enrolled smokers by 10%

The Auckland Metro DHBs have achieved the Better Help for Smokers to Quit health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. For 2017/2018 the target is an increase in cessation support by 10% disaggregated by ethnicity. Baseline data, for the quarter ended September 2016 showed rates of cessation support provided to smokers enrolled in Primary Health Organisations was 24.7% for Auckland DHB, 24.4% for Counties Manukau DHB and 32.9% for Waitemata DHB – with a metro-Auckland result of 27%. Latest results show a small improvement in these rates (for the quarter ended June 2017) for Auckland DHB with a result 26.7% and Counties Manukau DHB showing a small increase to 25.6%. However, Waitemata DHB recorded a small decrease to 31.8%. Overall metro-Auckland rate was slightly better at 27.8%. The Ministry of Health is not currently able to provide ethnic specific results. Agreement has been sought from the Primary Health Organisations to provide the data locally from next quarter.

Enrolled smokers who received cessation support



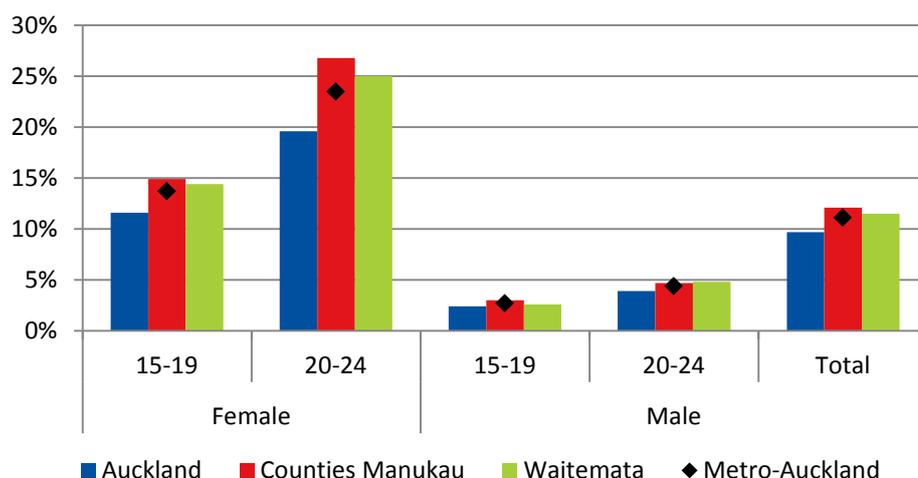
Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Analyse reasons for historical low referrals to smoking cessation providers. • Improve referral pathways to smoking cessation providers. • Improve feedback to referrers from smoking cessation providers. • Access aggregated data for Auckland population. • Establish a single process to report smoking from Primary Health Organisation practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions. • Benchmark 'access to smoking cessation' READ codes across Primary Health Organisations : i.e. the number of patients with codes 1, 2 and 3: <ol style="list-style-type: none"> 1. ZPSC10 – referral to smoking cessation support; 2. ZPSC20 – prescribed smoking cessation medication, and 3. ZPSC30 provided smoking cessation behavioural support. 	<p>Regionally agreed definitions have been developed which have been approved by the data custodian group. These have also been approved by the SLM steering group, with source requests delivered to organisations in late September and the first data upload held on 12 October.</p> <p>A second data definition for referrals to smoking cessation with data coming from smoking cessation providers is in progress and will be presented to the data custodians in November.</p>

Youth Access to and Utilisation of Youth-appropriate Health Services

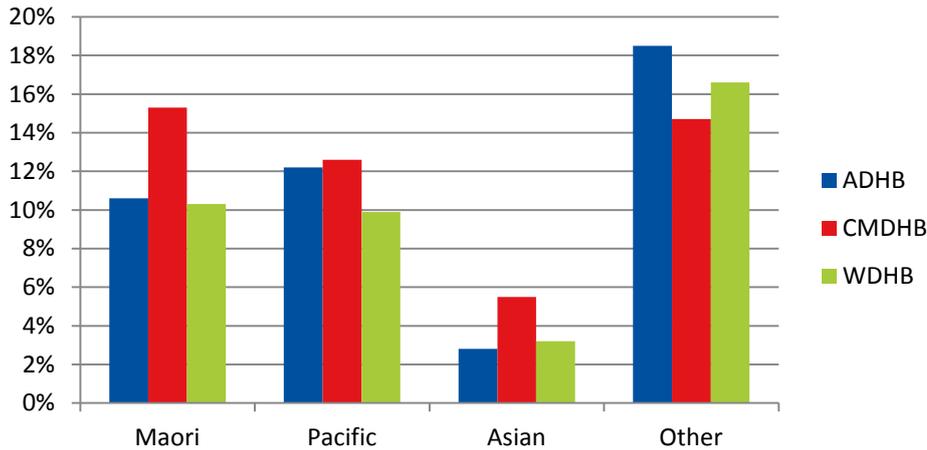
The Youth Domains are 5 separate areas of youth health which combine to support a positive youth experience of health care. The focus this year is on Sexual and Reproductive Health. The overarching milestone is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

There is work on-going in the contributory measures to set up other domains in preparation for next year.

Chlamydia testing coverage in 2016 by domiciled DHB



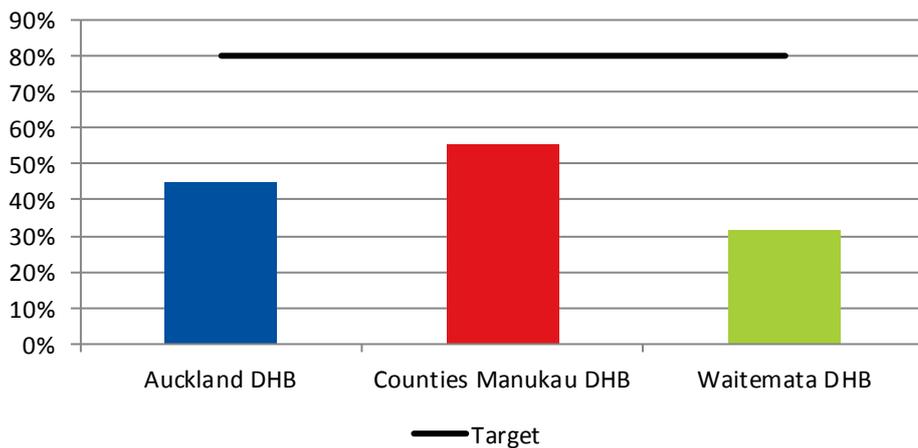
Chlamydia testing coverage 15-24 year olds in 2016 by domiciled DHB and ethnicity



All Pregnant Women are Screened for Chlamydia

The target for this year is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

Chlamydia test rate of the women who delivered in Q4 2016 aged 15-24 years



Improvement Activities	Progress Report
<ul style="list-style-type: none"> Workforce development activities for lead maternity carers. Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy. Data analysis looking for the potential to report back screening rates to lead maternity carers. 	<ul style="list-style-type: none"> Data definition for this measure is underway and completion is anticipated by March 2018.

Contributory Measures

1. Development of Future Sexual and Reproductive Health Contributory Measures

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
<ul style="list-style-type: none">• Analysis of SLM data by age, ethnicity, and Primary Health Organisation.• Identify gaps and potential areas for improvement.• Review the literature to identify options for improving access to chlamydia testing for Maaori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.	<ul style="list-style-type: none">• The data definition for the SLM has been completed, as has analysis.• There is ongoing work to identify gaps and promote improvement, particularly in primary care and sexual health service providers.

2. Chlamydia Burden of Disease

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
<ul style="list-style-type: none">• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.	<ul style="list-style-type: none">• This data definition is in progress and has been approved by the Data custodians in September. The SLM Steering Group approved this data request in September, and the user request form was submitted in late September.• It is anticipated that data for this measure be released and analysed by early 2018.

3. Healthcare Utilisation by 15-24 year olds

The target for this year is to complete the analysis detailed in the activities.

Improvement Activities	Progress Report
<ul style="list-style-type: none">• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to explore systems-wide youth health service utilisation and identify gaps.• Baseline primary health care enrolment and utilisation.	<ul style="list-style-type: none">• A baseline analysis is anticipated by June 2018.

4. Participation in the Child and Adolescent Mental Health Services Marama Real-Time Survey

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
<ul style="list-style-type: none">• Analysis of SLM data.• Engage with Marama, the regional child and adolescent Mental Health Service group, and service providers to identify gaps and potential areas for improvement.	<ul style="list-style-type: none">• A baseline analysis is anticipated by end June 2018.

5. Development of Baseline Data for Youth Domains:

- a. Alcohol and Other Drugs
- b. Access to Preventative Services
- c. Mental Health and Well-being

The target for this year is to establish a baseline in these domains.

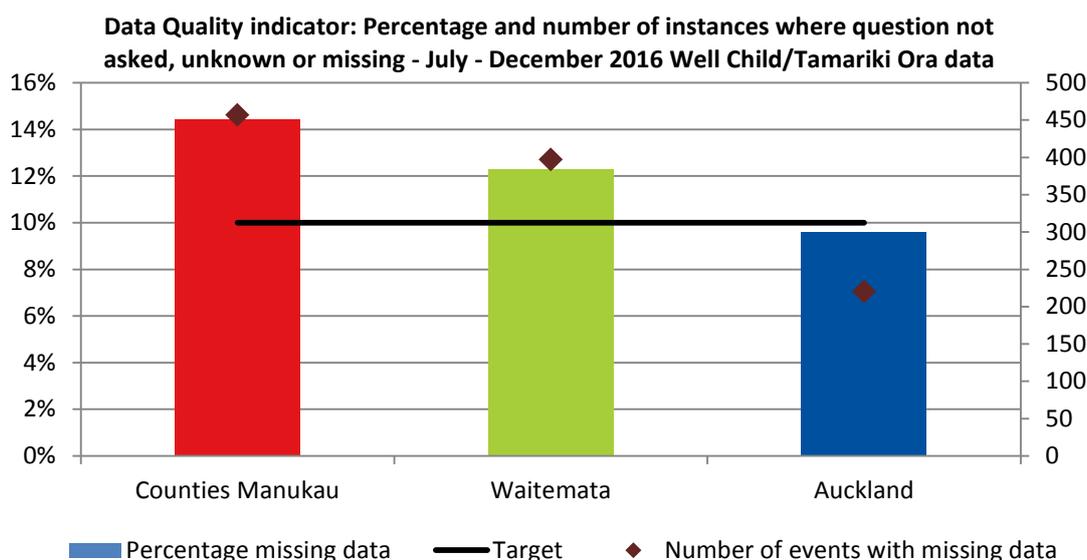
Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Analysis of SLM data by age, ethnicity, and PRIMARY HEALTH ORGANISATION. • Identify gaps and potential area for improvement. 	<ul style="list-style-type: none"> • A baseline analysis is anticipated by end June 2018. The Ministry has signalled data will be available from March 2018.

Proportion of Babies Living in Smokefree Homes at 6 weeks postnatal

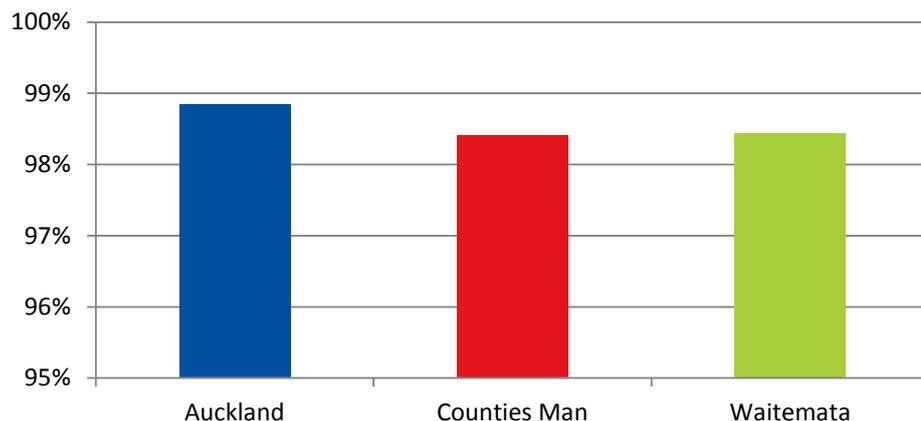
Baseline data from Well Child Tamariki Ora providers suggests that 98% of babies lived in a smokefree household at 6 weeks post-partum during Q1-2 of 2016/17. Given current smoking prevalence this is unlikely to be accurate. In addition, nearly 1 in 5 babies in Metro Auckland did not have smokefree household data recorded. Therefore, Well Child Tamariki Ora activities in the 2017/18 plan focus on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term.

Caution should be taken when drawing conclusions from this data. Data quality is questionable. The data below covers the period July – December 2016. Data prior to this time period is not of sufficient quality to include. While the percentage of babies living in smokefree households appears to be quite good, there are a significant proportion of instances where the question has not been asked, the field is blank or the response recorded is 'unknown', particularly for Counties Manukau DHB domiciled patients.

The milestone target for this measure is to reduce missing smokefree household data to <10% by June 2018.



Babies who live in a smokefree household at 6 weeks post natal by DHB of domicile: July-December 2016 (Well Child/Tamariki Ora data)



Contributory Measures

1. Maternal Smokefree Services

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
<ul style="list-style-type: none"> • Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored. • Analyse reasons for historical low referrals to smoking cessation providers, particularly for Maaori women. • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Maaori women. • Facilitate early enrolment of pregnant women with lead maternity carers. • Provide lead maternity carers and GP training on smoking cessation. • Provide feedback to lead maternity carers on their referral rates. • Provide pregnancy SSS incentives programme. • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Maaori and Pacific). • Explore innovative ways of engaging pregnant smokers to quit, with a focus on Maaori women, e.g. through use of a Sudden Unexpected Death in Infancy App. 	<ul style="list-style-type: none"> • The Primary Health Organisation implementation meeting on 4 October focused on smoking cessation with activities in primary care identified as: further promotion of the referral pathway and promotion of optimal pharmacological interventions for smoking cessation. Continued prioritisation of Maaori and Pacific was discussed, as were opportunities for more consistent reporting from referrers • Smoking cessation incentives programmes are close to starting • A meeting with regional Midwifery representatives has been organised for 10 November to begin conversations about increased communication between primary care and midwifery.

2. Household Smoking Cessation

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
<ul style="list-style-type: none">Well Child Tamariki Ora Data Quality Improvement: Review and align data collection processes for SLM measure across Well Child Tamariki Ora providers and provide SOPs for data collectors.Provide Well Child Tamariki Ora providers feedback on missing smokefree data rates.Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes.Explore opportunities to offer smoking cessation support to whaanau of newborn inpatients and outpatients, and paediatric ED attendances.Explore additional ways of offering smoking cessation support to whaanau of young children, e.g. pharmacy initiatives, Well Child providers.Support the work undertaken in the Amenable Mortality SLM.	<ul style="list-style-type: none">The Ministry have notified this working group that they will undertake data collection improvement nationallyThe first data set has been received, however, the quality of the data is poor and the collection time frame is not currentThe data has been socialised with Well Child Tamariki Ora providers at various Well Child Tamariki Ora forums regionally to explain the connection and seek engagement.We anticipate some further data in March 2018The Primary Health Organisation implementation meeting on 4 October focused on smoking cessation.

Counties Manukau District Health Board

Community & Public Health Advisory Committee

2017/18 Q1 Performance and Outcomes Report for Population Health Plans

Recommendation

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

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

Note the performance data and narrative contained within.

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

Glossary

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

Purpose

The purpose of this paper is to report progress and highlight key insights from service delivery leaders in Quarter 1 (Q1) against the 2017/18 Maaori, Pacific and Asian Health Plans.

Executive Summary

Counties Manukau Health has set a goal as outlined in the Healthy Together 2020 strategy:

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

The organisation’s strategic direction to achieve this goal is illustrated in the Maaori, Pacific and

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

Background

The 2017/18 Maaori, Pacific and Asian Health plans focus on the life-course of people in these communities. Indicators of wellbeing are grouped into; Parents, Infants and Children, Young people, Adults and the wider health system in the district.

Discussion

1. Action areas with evidence of improvement and key achievements

Action Focus	Results	Health Equity Target
Pacific peoples living in Counties Manukau		
<i>Matua, Pepi and Tamariki (Parents, Infants and Children)</i>	99.3% of Pacific children identified as obese in their B4School check have been referred for assessment and support services.	<u>100%</u>

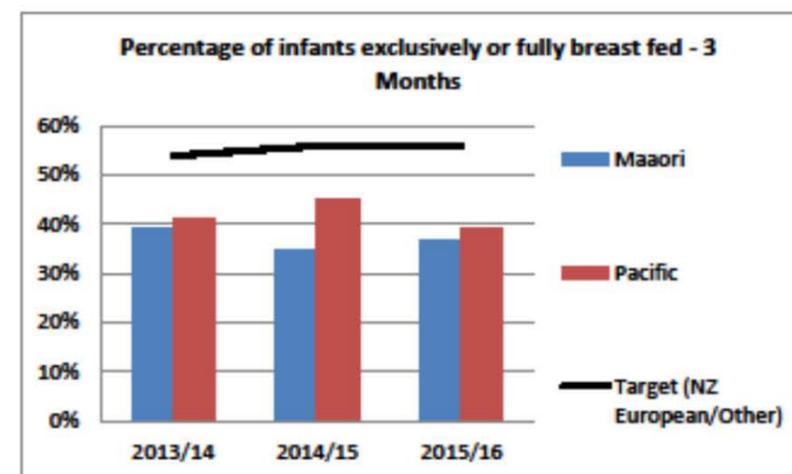
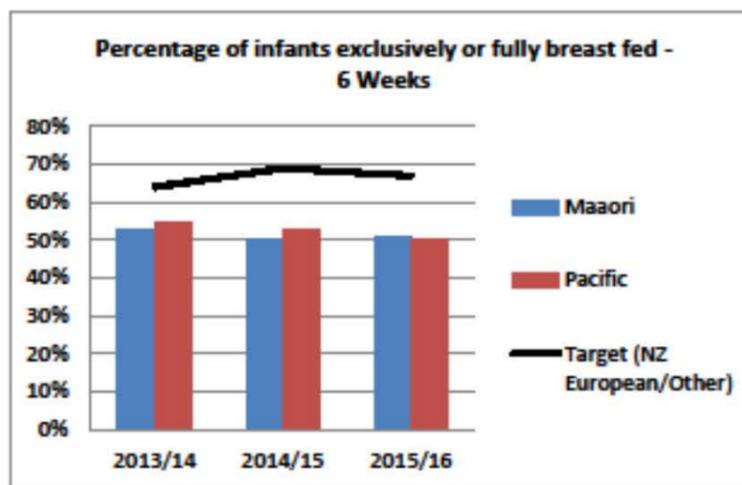
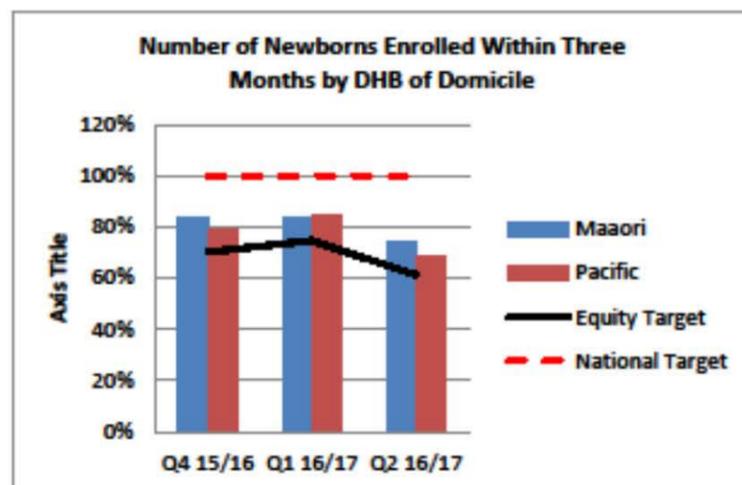
2. Action areas of concern and persistent health equity challenge

Action Focus	Results	Health Equity Target
Maaori living in Counties Manukau		
<i>Matua, Pepi and Tamariki (Parents, Infants and Children)</i>	89% of 8 month old children have had their full course of immunisation on time. This has worsened from 91% at Q3 2016/17.	93%
<i>Pakeke and Whaanau (Adults and Family Group)</i>	The rate of people with an HbA1C below 60mmol/mol remains stubbornly below the equity comparator at 61%	73%
Pacific peoples living in Counties Manukau		
<i>Matua, Pepi and Tamariki (Parents, Infants and Children)</i>	The ASH rate for Pacific children remains stubbornly high, with a rate of 11280 in Q1.	4441

Appendices

1. Trend graph: Maatua, pepi me tamariki – Parents, infants and Children
2. Trend graph: Paakeke me whaanau – Adults and families
3. Population Health Performance Scorecard
4. Q1 Population Health performance narrative

Counties Manukau Health - Population Health (Maaori & Pacific results) Performance. Category 1 - Matua, Pepi, Tamariki - Parents, babies and children

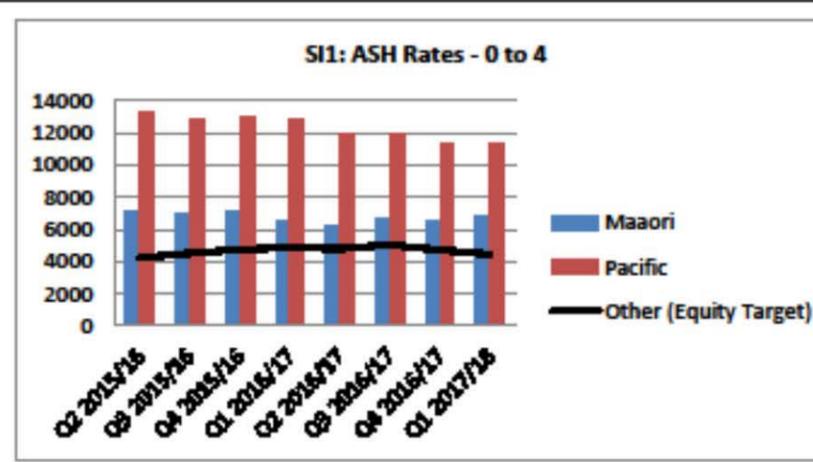
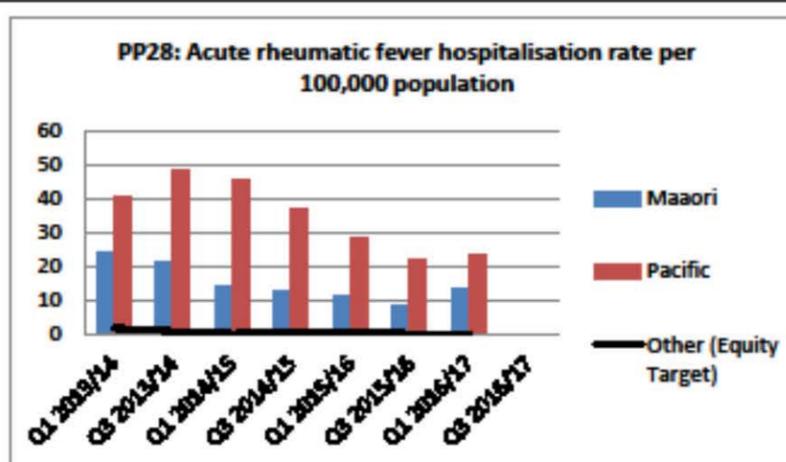
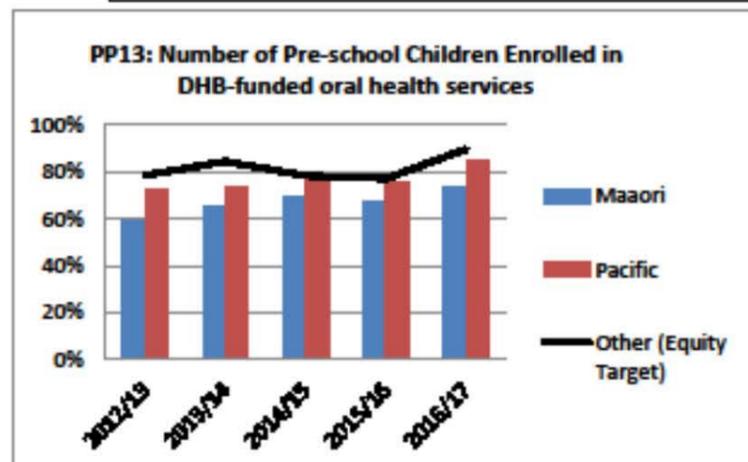


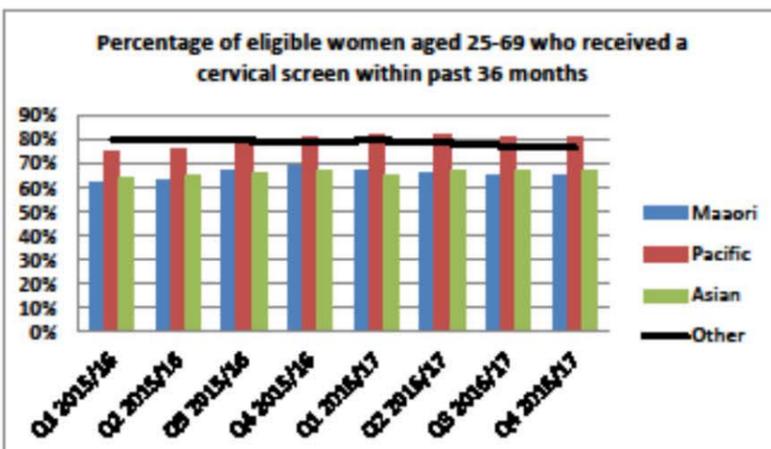
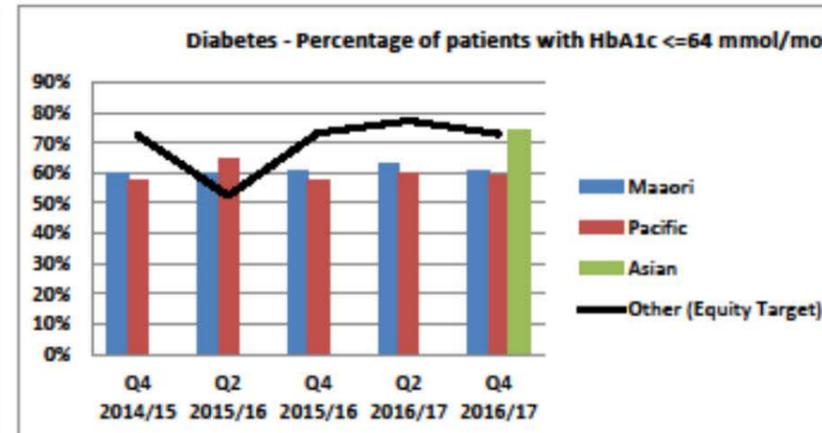
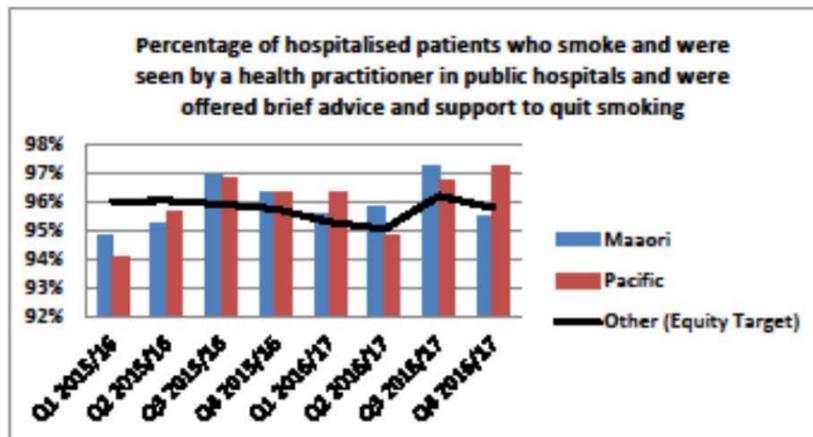
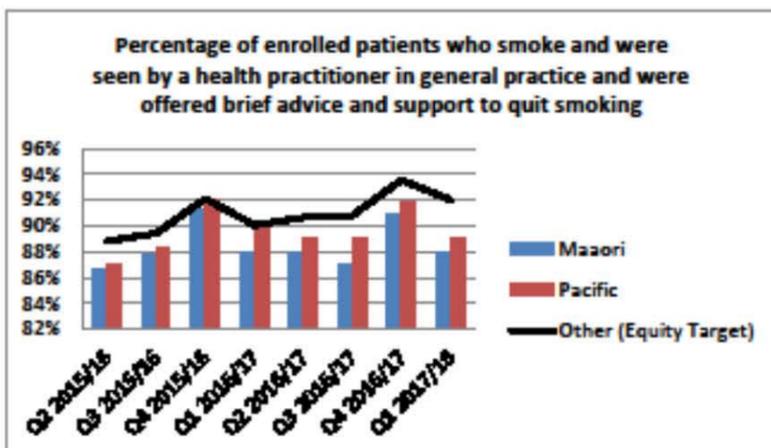
Maatua, Pepi me Tamariki - Parents, Infants and Children - Key Insights to Q1 2017/18

- Breastfeeding Data continues to be worked on with MOH and WCTO. Updated data received in Q1 does not include comparator populations.
- Equity gap widened between 2015/16 and 2016/17 in data about preschool children enrolled in oral health services. The equity gap for Pacific children rose from 1.5% to 5.5% and for Maaori children it rose from 10.3% to 16%.

- Pacific children continue to have the highest hospitalisation rates for Acute Rheumatic Fever and other conditions.
- The Equity Gap for Pacific children experiencing Rheumatic Fever hospitalisation grew from a rate of 21.7 in Q3 2015/16 to 23.2 (per 100,000) in 2016/17.
- The Equity for Maaori children hospitalised with Rheumatic Fever grew from a rate of 8.4 to 13.1 (per 100,000).

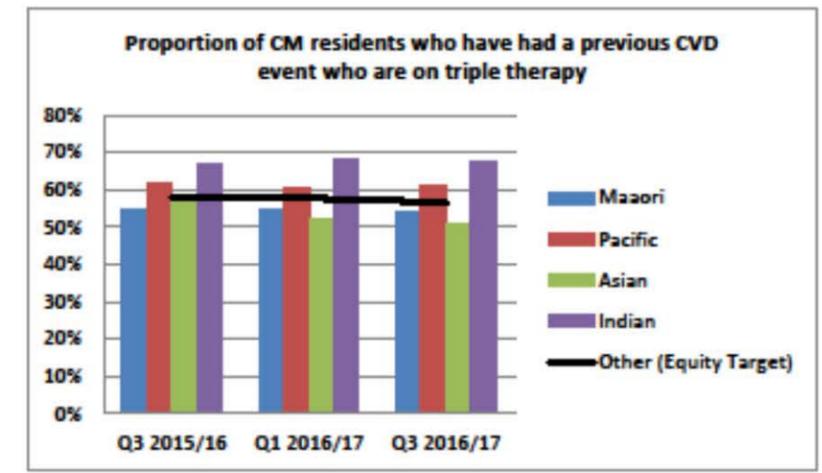
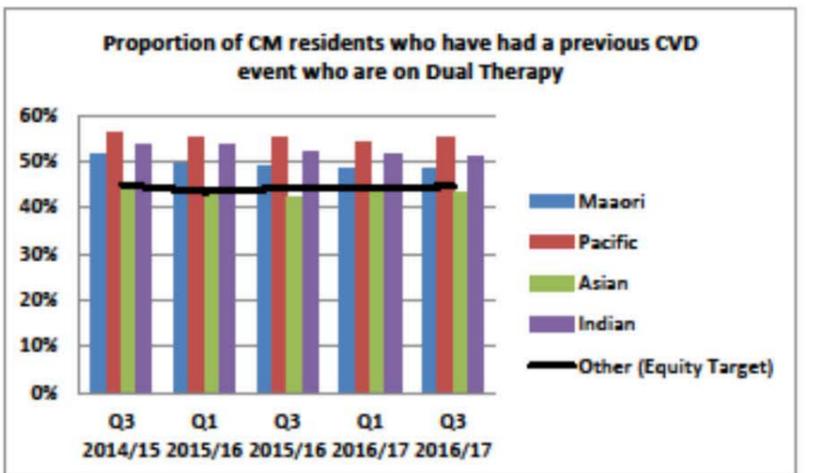
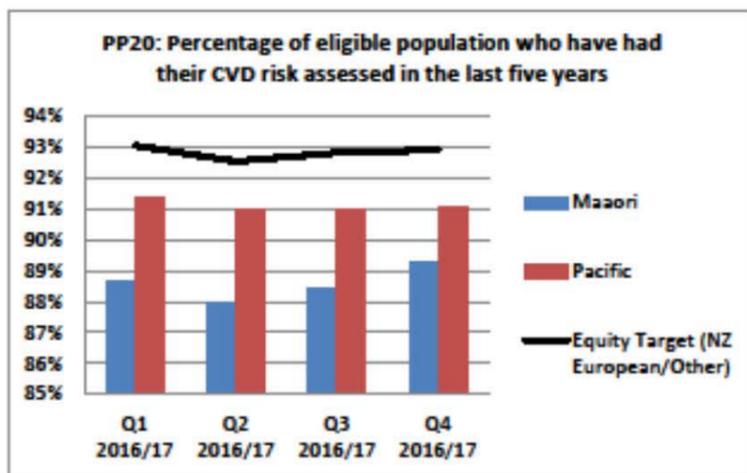
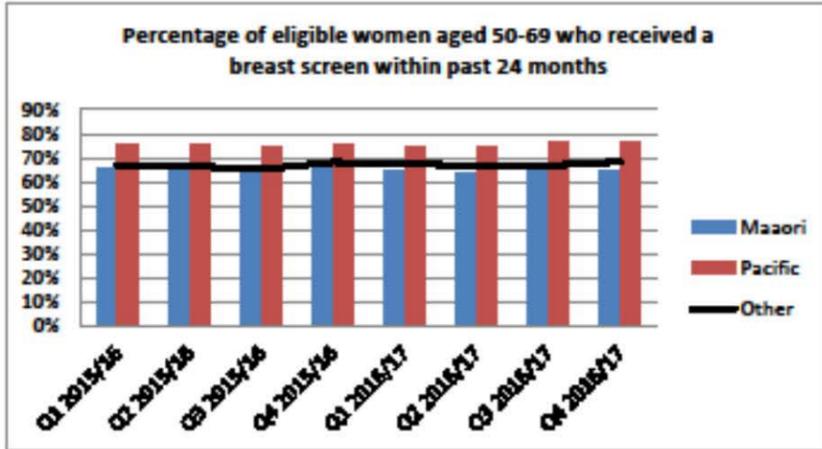
- The ASH rate for Pacific children steadily dropped over FY 2016/17 from a rate of 12900 in Q1 2016/17 to 11280 in Q1 2017/18. The equity gap also decreased from 8039 to 6831 in the year to Q1. The gap increased between Q4 and Q1 17/18 by 156
- The ASH rate for Maaori children rose from 6575 to 6761 in the year to Q1 17/18. The corresponding drop in the comparator rate saw the equity gap rise from 1714 to 2320 (or 35%) over the same period.





Key Insights - Adults Q1 2017/18

- The percentage of Maaori and Pacific populations with an HbA1c level below 64 remains significantly below that of the comparator population.
- Slight drop (91 and 91.5% to 88 and 89% respectively) in the number of Maaori and Pacific people offered smoking cessation support



Counties Manukau Health – Population Health Performance Scorecard for Q1 2017/18

Key to Colour coding

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

Key Indicators	Links to government/MOH/regional priorities	Result Maaori	Result Pacific	Result Asian	Equity Target
Maatua, Pepi me Tamariki (Parents, Infants and Children)					
Percentage of babies fully or <i>exclusively</i> breastfed at 6-weeks					
Percentage of infants fully or exclusively breastfed at 3-months		39%	45%		
Percentage of infants fully, exclusively or <i>partially</i> breastfed at 6-months					
Proportion of babies, infants and children fully immunised on time at:					
12 months old		89%	95%	98%	94%
18 months old		89%	95%	98%	94%
24 months old		87%	92%	96%	91%
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with LMC who are offered brief advice and support to quit smoking		93%	N/A	N/A	N/A ¹
Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services ²		73.5%	85%	NA	89.5%
Percentage of population of children aged 5 years who are caries free ³		38.1%	30%	NA	65%
Mean DMFT of year 8 school children (12/13 years) ⁴		1.29	1.42	NA	0.61
Acute rheumatic fever first hospitalisations rates per 100,000 population					
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years ⁵		6761	11280	NA	4441
Sudden unexpected deaths in infants per 1,000 live births		2.38	NA	NA	0.58 ⁶
Proportion of newborns enrolled with a PHO		7			

¹ Comparator population data is not available for this indicator

² Data for this measure is received annually in Q3. This data is for Q3 2016/17

³ Data for this measure is received annually in Q3. This data is for Q3 2016/17

⁴ Data for this measure is received annually in Q3. This data is for Q3 2016/17

⁵ Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the Auckland, Waitemata and Counties Manukau Health Alliances 2017/18 System Level Measures Improvement Plan.

⁶ The comparator for the SUDI measure is Non-Maori, unlike other measures where the comparator is NZ European/Other

Key Indicators	Links to government/MOH/regional priorities	Result Maaori	Result Pacific	Result Asian	Equity Target
by 3 months old					
Percent of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		100%	99.3%	NA	100%
Well Child Tamariki Ora Services		A measure, baseline and target is being developed in 2017/18			
Rangatahi (Young People)					
Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)		8			
Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)		9			
Sexual and Reproductive Health		A measure, baseline and target is being developed in 2017/18			
Percentage of eligible girls fully immunised with HPV vaccine ¹⁰		63%	72%	60%	53%
Pakeke me Whaanau (Adults and Family Group)					
Ambulatory sensitive hospitalisations in adults aged 45-64 years per 100,000 population		9284	9314	NA	2901
Percentage of people who smoke and are enrolled in General Practice are offered brief advice and cessation support		88%	89%	90%	92%
Percentage of people who smoke and are hospitalised are provided brief advice and offered cessation support		96.4%	95.7%	NA	NA ¹¹
Percentage of eligible population receiving cardio-vascular risk assessment in the last five years		12		NA	92%
Percentage of eligible Maaori men aged 35-44 years who have had their cardio-vascular risk assessed in the last five years		13			
Percentage of eligible population who have a risk greater than 20% and are on dual therapy (dispensed)		14			
Percentage of eligible population who have had a prior CVD event who are on triple therapy (dispensed)		15			
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol) ¹⁶		61%	59%	NA	73%
Percentage of enrolled patients (aged 15-74)	<i>The baseline and target is in development as part of a regional</i>				

⁷ CMDHB is currently awaiting audited data from the MOH

⁸ CMDHB is currently awaiting audited data from the MOH

⁹ CMDHB is currently awaiting audited data from the MOH

¹⁰ Data for this measure is received annually in Q4. This data is for Q4 2016/17

¹¹ Comparator population data is unavailable for this indicator

¹² CMDHB is currently awaiting audited data from the MOH

¹³ CMDHB is currently awaiting audited data from the MOH

¹⁴ CMDHB is currently awaiting audited data from the MOH

¹⁵ CMDHB is currently awaiting audited data from the MOH

¹⁶ Data for this measure is received twice per annum in Q2 and Q4. This data is for Q4 2016/17

Key Indicators	Links to government/MOH/regional priorities	Result Maaori	Result Pacific	Result Asian	Equity Target
whose latest systolic blood pressure measured in the last 12 months is <140 mmHg	<i>collaboration.</i>				
Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker	<i>The baseline and target is in development as part of a regional collaboration.</i>				
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months		17			
Proportion of women aged 20 - 69 years who have had a cervical smear in the last three years		18			
Percentage of people aged over 65 years receive free flu vaccinations ¹⁹		49%	69%	51%	47%
Mental Health Act: Section 29 Indefinite Community Treatment Orders rates per 100,000 population		20			
Percentage of the population enrolled in a PHO		93%	116%	88%	95%
Te Roopu Whaanui o Counties Manukau (District Wide)					
The Fanau Ola Programme	A measure, baseline and target is being developed in 2017/18				
Mental Health for Pacific Peoples	A measure, baseline and target is being developed in 2017/18				
Total packages of care per annum delivered through Whaanau Ora Integrated Services		2466 ²¹			
Workforce headcount for prioritised occupational groups by ethnic groups	A measure, baseline and target is being developed in 2017/18				

¹⁷ CMDHB is currently awaiting audited data from the MOH

¹⁸ CMDHB is currently awaiting audited data from the MOH

¹⁹ Data for this measure is received annually in Q4. This data is for Q4 2016/17

²⁰ CMDHB is currently awaiting audited data from the MOH. We have not received an updated figure since Q1 2016/17

²¹ This data set is incomplete as providers are developing a unified ISA data collection system and protocols.

Population Health Plans

Performance Narrative to Q1 2017/18

Filipo Katavake-McGrath (CMDHB)

10/25/2017

This report outlines the actions taken and challenges faced by services in delivering actions outlined in the Maaori, Pacific and Asian Health plans for 2017/18. Data has been gathered from Ministry of Health reporting as well as discussions held by the Maaori, Pacific and Asian Health Gains leads with service and programme managers.

Narrative Report – Healthy 2020 Performance Measurement Framework

To support executives with decision-making to achieve the Healthy Together 2020 strategic goal of equity in health indicators for Maaori, Pacific and other populations with significant health conditions, this narrative report will be framed around the Healthy Together Health Equity Performance Measurement Framework.

1 . Smoking Prevalence

Source – NZ Health Survey

Smoking Cessation - Maternity

In Q1, the Maternity Smoking Cessation Service received referrals for 54% of the total smoking population with 162 referrals. This was a 2% increase on last quarter. 78 were received for Maaori women equating to 49% of the estimated smoking population and 51% for Pacific women.

An analysis of referral sources from Jan to June 17 was conducted. 28% come from community midwives, 33% from self-employed midwives, 19% from primary care and 8% were self-referrals. The distribution of referral sources did not change when Maaori data was interrogated. Community midwives are referring 30% of their cases and self-employed midwives 35%.

Activities in Q1 2017/18

Drop-in clinics are now business as usual with over half the referrals booking into one.

Practitioner Targets were set in Q4 2016/17 and performance management has been established to ensure targets are met.

Smokefree pregnancy incentives programme

Out of the 162 referrals received, 152 (94%) were eligible for the incentives programme which is the highest eligibility rate to date. In Q1, 31 out of 46 pregnant women who set a quit date the previous quarter were Smokefree at 4 weeks.

Networking

The service continues to maintain good referring relationships with services offering breastfeeding and safe sleep programmes which results in cross referring. Work is being conducted with Green Prescription to focus on cross-referring for pregnant mothers in Mangere.

The Smokefree maternity advisor has attended the following in Q1 to continue feeding back target progress and keeping Smokefree on the agenda:

- 3 x SUDI/Smokefree champion meeting (1 at a maternity birthing unit)
- 2 x SUDI project board meeting
- Key messages out via maternity and internal newsletters

Postnatal indicator

The SUDI regional working group will continue the development of the Smokefree Households at 6-weeks System Level Measure improvement plan work indicated in the 2017/18 Improvement Plan

The postnatal incentives have been adopted as business as usual and the results for the quarter are as follows:

- 43 referrals received
- 19 quit dates set in the quarter, and
- 12 smokefree, (3 more awaiting validations)

Neonatal ward has appointed two champions working to support other nurses to have brief interventions and make referrals for parents of babies admitted to the ward.

Next Quarter

- Obtain another list of pregnant smoking women from a GP practice to contact and offer programme.
- Follow up recommendation by Mortality Review team to re-explore the opt-out system
- Work with newly appointed health promoter to target promotional opportunities and dedicate more time to looking for pregnant women in the community.
- Work with Healthy families on their new hub in a high prevalence suburb to generate referrals.
- Finalise a referral pathway to link to new pharmacy project enabling direct referrals for pregnant women.

Primary care smoking cessation

Preliminary PHO results indicate that CM Health has just met the 90% target for Better Help for Smokers to Quit. Performance has continued to increase over the quarter due to PHOs' sustained focus on this target. Those PHOs which have not met the target (in particular NHC) have performance improvement plans in place, and report that this is due to a number of competing demands over winter.

We note that performance is slightly lower for Maaori and Pacific patients, but expect that this will continue to improve over the coming three quarters as it did in 2016-17.

Q1 Activity

Active Clinical Leadership/Clinical Champions

We are focusing on improving PHO provision of ABC to transient patients without up-to-date contact details. The National Target Clinical Champion's advice has informed the Smokefree Advisor – Primary Care engagement with PHOs to strategise opportunistic engagements, appointment scanning and improvements to coding systems. We are seeing improvements, especially with PHOs who have struggled in this area.

Attention has also been paid to improving the volume of cessation support referrals into CM Health's support provider. The focus group in this case are patients who are prescribed pharmacotherapy to support evidence which suggests that behavioural support enhances success for this group. This focus has been supported by the inclusion of Smoking Cessation as a contributory measure to the Metro Auckland Regional System Level Measures Improvement Plan for 16/17 (and 17/18).

Active, Dedicated Management to Support ABC Activities in General Practice

All PHOs have committed staff responsible for ensuring this health target is achieved. Most practices have an identified Smokefree target champion who leads practice activity and ensures the practice is aware of their performance and activities that are needed to either reach the target or maintain the current level of performance.

The Smokefree Advisor – primary care supports PHOs and practices in the implementation of ABC by; testing strategies, providing resources, discussing referral options, cessation support, and offering support for smokefree target work. This work also focuses on appropriate programmes for high-need Maaori and Pacific communities.

We are also in discussions with East Health PHO around potentially funding a within-practice Stop Smoking Service trial. A regional training plan is being developed with DHBs and primary care (with the support of Dr John McMenamin) which is likely to incorporate face-to-face and online support mechanisms.

Reminder, Prompting and Audit Tools

All of our PHOs support their practices to use audit tools and dashboards to indicate if patient smoking status is recorded, and whether brief advice has been given. Many practices are utilising appointment scanners to identify patients who are among the list of daily appointments and who need an updated smoking status or brief advice and cessation support. Audit tools are often used to identify patients who were prescribed pharmacotherapy, or high-needs patients such as newly pregnant women previously recorded as smokers. These patients are then contacted (sometimes after-hours) to be offered extra support and possibly referred to appropriate services.

Staff Support

Most PHOs have provided extra resource (FTE) to practices to offer evening/weekend (moonlight) calling for brief advice. PHOs have noted that although this is very effective it is very resource intensive. However it has proven effective for practices which 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.

We are currently working with our Community Pharmacy Portfolio Manager to discuss pharmacy services and referral to cessation support, in line with other national initiatives around this.

PHO Activities to Increase Delivery of ABC in General Practice

Our Smokefree advisor has held a number of meetings with NHC as they consistently have a low number of referrals to the cessation support service. This has led to successfully supporting a number of practices which previously did not engage with the DHB support resources. We hope this will lead to improved coverage for these practices and an improvement in equity of Smokefree outcomes as they all have high number of enrolled Maaori patients.

Challenges and next steps

Although the target has (just) been met, we believe continued effort is required to sustain momentum and ensure the target is met over the next 9 months. Ensuring that ABC activity is seen

as business as usual and using the System Level Measures as a vehicle to maintain focus will be crucial for success.

Continued effort is also required on improving cessation support referral rates (as included in the regional Amenable Mortality SLM Improvement Activities).

Hospital Smokefree

Below activities were implemented to sustain the achievement of the secondary care target and to ensure that patients identified as currently smoking are provided with support to be smokefree:

Smokefree training options made available for staff in wards/units

- Smokefree Best Practice training for existing clinical and non-clinical staff who have not attended any training yet.
 - In Q1, 1 x 1hr session to 5 existing nursing staff.
- One-hour Smokefree Best Practice training for new nurses and allied health staff as part of Counties Manukau Health on-boarding programme.
 - In Q1, 7 x 1hr sessions conducted for a total of 129 participants.
- Other smokefree training
 - 1 x 1hr session to 8 Bureau Health Care Assistants,
 - 2 x 1-hr sessions to two 3rd year Nursing Students and
 - 3 x 1hr sessions to 34 Bureau Nurses.
 - Thirty-minute refresher for those staff who attended the smokefree best practice training more than a year ago.
- On-going support of trained staff to implement best practice in wards and units.

Other activities in Q1

- Coordination with Smokefree Champions to lead smokefree best practice amongst their colleagues in the wards/units
- Weekly two-hour smokefree clinic at Manukau SuperClinic to support outpatients to become smokefree.
- Review of Missed-Patients reports by Charge Nurse Managers and Smokefree Champions of target wards
- Continuing to report on the Preliminary and Final smokefree result by ward monthly
- Monitoring of Month-to-Date smokefree results by Nurse Managers and Ward Charge Nurse Managers
- Coordination with e-vitals working group and coaches regarding electronic smokefree assessment/documentation implementation in the wards
- Working with a couple of wards in regards to trialling a referral system of text messaging

Next steps

- Twice-monthly 1-hour Smokefree Best Practice session during the on-boarding of nurses and Allied Health staff to orientate them to the importance of implementing and documenting the Smokefree ABC
- Training need analysis completed in coordination with the Nurse Educators and Smokefree Champions

- Smokefree Champions are leading smokefree best practice in their respective wards/units to strengthen implementation of Smokefree ABC
- Strong collaboration between the Smokefree Advisor-Secondary Care, Smokefree Advisor-Inpatients, Smokefree Referral Coordinator and the wider Smokefree Team towards achievement of the target
- Orientation of health care professionals to the use of e-vitals (electronic patient charts) which will soon be implemented in the wards/units to include the electronic documentation of the Smokefree ABC.

2. CVD & Diabetes Management

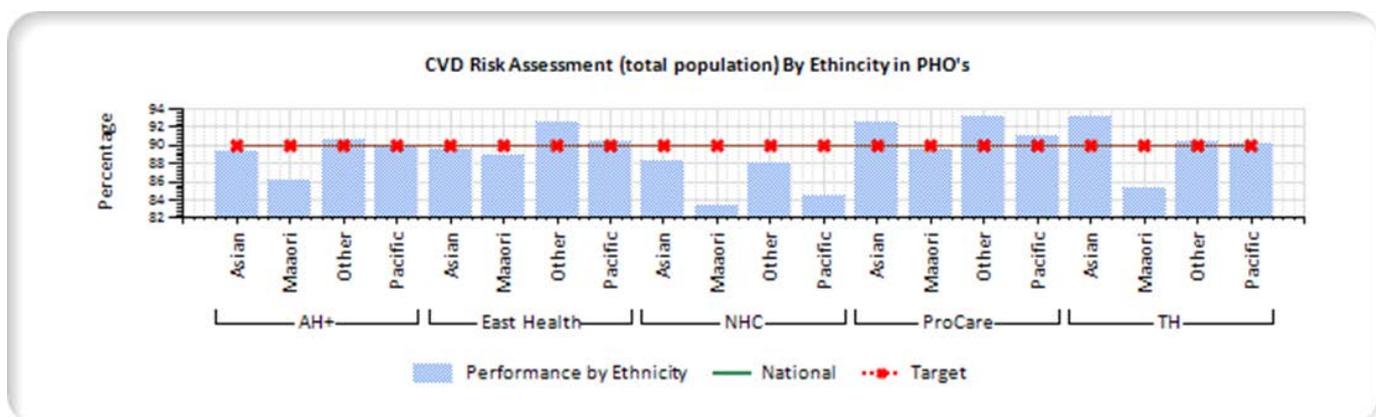
Source – proportion of people with CVD dispensed triple therapy

Source – The absolute number of people in Counties Manukau with poorly controlled diabetes

CVD

Performance this quarter has continued to exceed the 90% target. The overall performance demonstrates that this activity remains embedded in general practice teams despite its removal as a national Health Target. To build on this, focus is shifting towards risk factor management for high CVD risk populations (and interventions which promote behaviour change), as part of the SLM and other local work.

There are on-going differences in performance between Maaori and other ethnicities. As discussed in previous reports, this has been difficult to shift despite the DHB actively working with PHOs and practices to target activities at Maaori groups. We are pleased that there will be further More Heart and Diabetes Checks funding to support this. We will be focussing on potential strategies within the community, as well as in primary care. This also supports the focus of the System level measures for metro Auckland.



Given that equity of coverage has not been achieved yet, our DHB and PHOs have committed to a number of actions regarding this measure under the Maaori Health Plan. For example, all of our PHOs provide monthly reporting to their practices regarding this measure. We use prioritised

ethnicity reporting for this; with Maaori and Pacific coverage reported at the top of the page. We believe regular feedback and the use of good quality data is integral to meeting this target. PHOs also continue to share innovative ways of thinking in order to reach high risk populations. For example, practices with high numbers of Maaori men aged 35-44 were identified by PHOs and have together (as part of the SLMs) discussed strategies to improve coverage. For example, appointment scanning (if these men are attending with family members), using Test Safe data, and opportunistic screening at urgent care appointments.

Given that most of our PHOs are meeting the 90% target for total population, we have focussed on improving equity for high-risk populations over the past quarter. This has been aided by the inclusion of CVDRA (and management) being included as contributory measures under the Amenable Mortality SLM for 16/17 for metro Auckland. For 2017/18, CVDRA for Maaori and CVD management will continue as contributory measures for the region. Agreed improvement activities (some continuing from the current year) include:

- Follow up phone calls (evenings) for practice generated CVD RA recall letters to Maaori.
- Pilot of phlebotomy services in the practices or point-of-care testing when Maaori males visit opportunistically.
- Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs.
- Total population and specific interventions for Maaori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy.
- Post-event medication counselling and other rehabilitation services in hospital.
- On-going medication counselling by community pharmacists.
- Utilising phlebotomy training available for primary care via DHB Outpatient Services.
- Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments.
- Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.

We frequently engage with other DHBs as part of the Northern Regional Cardiac Clinical Network and have been involved in the consultation for the update to the CVD Risk Management Guidelines later in the year. We have distributed relevant information from these forums to our PHOs. The Northern Regional Alliance has identified that Maaori and Pacific communities in Counties Manukau experience a lack of access to Cath Labs. This deficit is currently being addressed through work prioritised as part of other DHB business.

Diabetes

In 2017/18, substantive reporting on actions towards supporting Diabetes programmes happens in Q2 and Q4.

3. Hazardous Use of Alcohol

Source – NZ Health Survey: Hazardous Alcohol Use Prevalence

It is important to note that Counties Manukau Health does not actively monitor the Hazardous Use of Alcohol in its populations as part of the 2017/18 Maaori, Pacific or Asian Health Plans. It does

however monitor the rate per 100,000 of Maaori young people/rangatahi who seek Alcohol Brief Interventions in Primary Care. Q1 data for this measure is currently unavailable due to delays in Ministry of Health data verification.

4. Childhood Obesity

Source – B4School Check data: BMI

B4 School Check (B4SC) programme

The B4 School Check programme showed good progress at the end of Quarter 1, a total of 2364 checks were closed/completed, 947 of these checks were Q5 (high deprivation). This equates to 31% of the target population (6% over target) and 28% for Q5 (3% over target).

We are achieving well for Māori and Pacific with the Māori target at 31% (6% over target), and Pacific at 28% (3% over target). Progress is discussed monthly between Kidz First Community Health Service Manager, Kidz First Community Health Operations Manager, Kidz First Community Health B4Sc coordinator, Well Child Clinical Service Manager and the Plunket B4SC coordinator/ WCTO providers of B4SC, B4SC and at the quarterly Child Health Forum. Actions to address issues/barriers impacting on performance

Factors affecting coverage in the quarter

- Quarter 1 has been very busy with the emphasis on locating Q5 families. This work is reflected in the target which is currently at 3% over target for Q5 and 6% over target overall.
- As reported previously there have been changes to Quintiles (Q) on the B4 School data base. Streets in Papakura, Manurewa and Mangere that were previously geo coding as Q5 are now geo coding as Q4 or below.
- The B4S check administrators have prioritized bookings for Maori, Pacific and Q5 children.
- As reported previously there may be some confusion over ethnicity recorded between Māori and Pacific, and prioritized versus identified ethnicity. This issue has been addressed on a number of occasions with MoH and we are yet to receive a response.
- As noted in previous reports there is a health service access issue for children referred to CMDHB following a B4S check in that the referral is declined if they do not provide proof of citizenship within 14 days.

Current initiatives to ensure access for B4 School checks

- CMH sends out letters to all parent/caregivers of 4 years old children reminding of the free B4 School check (invitation to Saturday opportunistic clinic).
- In August the B4Sc Nurse and OIS Vaccinator worked with Plunket Kaiawhina two days a week to home visit quintile 5 children when they needed both the B4S check and 4 year Immunisation. Whaanau reported that they appreciated the option of being able to have both services (B4Sc and OIS) in the home at the same time.
- The B4Sc Coordinator is matching children from the National Immunisation data base (NIR) who are overdue their 4 year old Immunisations against the B4Sc data base to help find updated addresses.
- Saturday outreach clinics continue
- Hearing & Vision collaborate with Plunket to ensure that the B4Sc check is delivered in a timely manner

- Plunket Outreach Immunisations team offer 4 year old immunisations to children attending the Saturday outreach B4SC clinics at Manukau SuperClinic, and include opportunistic immunisations for all siblings where due or overdue
- The Children's community dental clinic adjacent to the Manukau SuperClinic is open on Saturdays to maximise the opportunity to get preschool dental up to date. The clinic is seen as a very important place in the community, families like the venue and there are no issues with parking. Clinical staff noted that both parents often attended the weekend clinics compared to one at weekly clinics or only one present at home visits. Families report that they view MSC Saturday Clinics as a one stop shop, having nurse, the vision and hearing screen and the option to have immunisations and dental checks completed at the one visit.

Actions to address these factors

- Much time is used in tracing families through alternate contacts as phone numbers change, children are not at preschool, and families may be moving house.
- On-going action of sending translated version of the B4 School information to all Samoan and Tongan families
- Working on the lists of Pacific children not started their B4Sc and looking for contact numbers.
- Utilise Samoan and Tongan staff to develop relationship, promote B4SC to the families, book appointments and arrange home visits
- Monitoring daily output reports for Nurses/VHT's that quantifies total numbers and Q5 numbers. This showed number of completed checks and those in progress that needed to be prioritised

New initiatives and successes

- Prioritising booking of appointments to focus more on Pacific Children and on Q5 children
- Nurses/VHT's to work off an 'opportunistic list' of children if appointments are cancelled
- On-going engagement with the Pacific Health team to develop initiatives to use their health connections with ECE, home-based childcare, and churches health committees to improve awareness and appreciation of the importance of this health check in readiness for school.

The Raising Healthy Kids Healthy-Weight Target

Progress with getting referrals acknowledged from the B4 School Check (B4SC)

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

- Progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions
- A dual referral processes for children identified as obese at their B4SC has been set up. The B4SC provider is referring children to both primary care for clinical assessment and to the family based nutrition, activity and lifestyle interventions.
- Decline notification letters being sent to GP to notify them with a child has been identified as being >98th centile and the parent/caregiver has declined a referral
- Decline notification letters being sent to GP to notify them with a child has been identified as being >91st centile and the parent/caregiver has declined a referral

Activity to ensure DHBs, PHOs and other primary care and community partners work together to ensure families experience seamless transition and support post referral from the B4SC

- Feedback loop to GP and referrer from Active Futures and Plunket B4SC CHW Visiting Service post referral
- 6 weekly RHK operational meeting with B4SC, Active Futures, Plunket & DHB
- Ongoing communications and newsletter to PHOs, primary care and community partners
- Scoping regional evaluation activities including touch points for families following referral and post service review

Activity to support primary care and community partners having the conversation with families.

- Training and mentoring opportunities to help health professionals have conversations with families are being offered to primary care, B4SC, WCTO and other health professionals. In 2016/17, 398 health professionals have completed this training.
- Distribution of Healthy Lifestyle Packs of resources to primary care and B4SC
- We are in the initial planning stages of developing a CME/CNE video and podcast to support primary care and other health professionals working with children and families to deliver effective brief healthy weight interventions. The purpose of the video and podcast will be to:
 - Engage primary care about taking on weight management as core primary care business
 - Build motivation to take action – why this is important, and the difference they can make
 - Present how to effectively deliver a brief healthy weight intervention i.e. how to have the conversation (including 5 min modelled conversation)
- Increase awareness about what resources, training and support is available

A draft action plan to support children living in Counties Manukau to be a healthy weight was developed however this has now been amalgamated into the Metro Auckland Healthy Weight Action Plan for Children. This plan identifies actions that the health sector will contribute towards the cross-sectorial response to address childhood weight management.

5. Health-literate system and people (workforce)

Source: Patient experience survey, primary and secondary care: Communication Measures

It is important to note that Counties Manukau Health does not actively monitor the Communications measures in the Patient Experience survey as part of the 2017/18 Maaori, Pacific or Asian Health Plans.

6. People Capability and Capacity

Source - TBC

This strategic goal requires further definition to be able to be monitored as part of a performance measurement framework.

7. Other Activities

Integrated Service Agreements (ISA) – Maaori Health

From 1 July 2017 Maaori Health Providers have had their Agreements renewed for the next 2 years in delivering whaanau ora outcomes based services. Integration Services Agreement (ISA) purchases whaanau centric services and integrated case-management. The Services are to be targeted at high need, vulnerable and hard to reach adults, in particular those that identify as Maaori.

The 2466 Packages of care delivered between July and October 2017 is broken down by life-course age groups, outcomes and Health Provider below.

Integrated Services Agreement	Maaori Health providers	Total Number of packages 2017-19
Mama Pepi Tamariki <i>All children have the best start in life</i>	Turuki Health care	402 Mama Pepi Tamariki
	Te Kaha o te Rangatahi	
Rangatahi Oranga <i>All rangatahi realize their potential</i>	Te Kaha o te Rangatahi	124 Rangatahi Oranga
Whanau Oranga <i>All whānau have control of their quality of life</i>	Health through the marae	1014 Whanau Oranga
	Manurewa marae	
	Huakina Trust	
	Raukura Hauora o Tainui	
	Port Waikato	
Oranga ki Tua <i>Living well with a long term condition</i>	Papakura marae	762 Oranga ki Tua
	Turuki Health care	
	Raukura Hauora o Tainui	
	Te Hononga o Tamaki me Hoturoa	
Kaumatua Kuia Oranga Kaumatua and Kuia are living healthy	Te Oranga Kaumatua Kuia	164 Kaumatua Kuia Oranga
Total		2,466 packages of care over 2 year period

Integrated Maaori health Agreements were finally signed off by CMH and Maaori Health providers end of 18 September 2017 and have been given an extension to Q 1 reporting due to the delay in agreement signing and also the transitioning to a new reporting template aimed at measuring key impacts in alignment with Maaori Health plan priorities.

Recommendations and Key areas of action

We are continuing to improve the completeness of data we collect from Maaori Health Providers to better understand the value proposition that the ISA offers in connecting hard to reach, vulnerable and high need people with health services and support. More complete data will enable us to demonstrate the benefits that ISAs bring to achieving Maaori Health Plan priorities and indicators. This is achieved through continuing to partner with providers.

A programme review of data from the 16/17 year found that PHOs, General Practice, NGOs, Providers of ARI or Planned Proactive Care, DHB Funded Services were reluctant to refer their hard to reach Maaori families into Maaori Health Providers for ISA approaches to achieving health

outcomes. We are seeking mandate, in the Maaori Health Plan 2018/19 to influence providers to increase the volume of referrals into ISA providers.

We will maintain and grow our relationship with Primary Care service funders and planners to increase their comfort and confidence in enabling their providers to refer their hard to reach whaanau Maaori into ISA providers.

We will engaged Mana Whenua I Tamaki Makaurau to support reviews and evaluations of key services with a focus in the Mama, Pepi, Tamariki (Maternity and Child health services) space.

Rheumatic Fever

Our target for 2017/18 is 4.5/100,000. We did not meet this target with 50 cases identified by the MoH from the National Minimum dataset. On review of these NHIs it appears 46 of these were actual cases. Using the official number of 50 the rate for CM Health for Q1 2017_2018 is 9.2/100,000. This has increased from 8.1/100,000 for the 2016 calendar year and is above the target of 4.5/100,000.

Consistent with last quarter's report we are reporting notification data from the previous quarter. In Q4 (April-June 2017) there were 17 cases of RF notified to Auckland Regional Public Health Service. Of these 11 were aged 0-14 years. Of these 8 were notified to ARPMS within 7 days (73%). Three (27%) were not notified within the 7 days (time to notification was 9,10 and 58 days). The child not notified until 58 days was a possible case it could be argued this case should not be included in the data. There were six cases of RF notified to ARPMS who were >14 years of age. Three of these cases were notified within 7 days (50%) and three were not (time to notification was 30, 40 and 70 days).

FCT – Faster Cancer Treatment

From 1 July the MoH has implemented technical changes to the FCT Health target, excluding patients who breach for patient choice or clinical considerations. The net impact of the technical changes means CM Health has met the 90% level for 2 of the past 3 months. For the year to date CMH has 94% performance. The FCT data is reported by the MoH on a 6 month rolling basis, for the period 1.4.17 – 30.9.17 CMH has 94% performance with technical changes applied.

Key FCT Activity

A heat map is being used to identify performance issues in tumour streams.

Analysis on performance by equity has identified Maori having a higher number of capacity related breaches. Plans are in place to improve care coordination of Maori patients. This will be trialled in the tumour streams with the highest volume of Maori patients initially with a further rollout once the model of care has been developed.

The pathway tracker roles have been redeveloped to provide greater support to services. This enables real-time tracking of patients on the pathway to ensure timely treatment. Cancer Nurse Coordinators and trackers are closely monitoring patients and early detection of patients at risk of breaching enables micromanagement to bring them back on track. This has had a positive effect on performance between August and September.

System Level Measures - Acute Hospital Bed Days *(Metropolitan Auckland DHBs Combined)*

Note – this measure is not featured in the Māori or Pacific health plans, but has high-needs community focus

The region is on track to meet the agreed improvement milestone for total population (2% reduction of 428.9 standardised acute bed days/1000) at 429.1 standardised acute bed days per 1000 population (year to June 2017).

However the region has not met the Māori and Pacific targets (3% reduction on 604.6 standardised acute bed days per 1000 population and 729.6 standardised acute bed days per 1000 population respectively) and are at 612.6 standardised acute bed days per 1000 population for Māori and 737.6 standardised acute bed days per 1000 population for Pacific (year to June 2017).

In terms of implementation, this SLM is tracking well. The various activities noted in the plan are underway and continue to move forward. Each DHB has initialised a programme of work based on the SLM priorities, which are linked up by the regional working group. As a result of this, collaboration has occurred and the working group will meet monthly to continue to facilitate this moving forward. This working group will continue to focus on equity in order to reduce rates for Māori and Pacific.

Activity in Q1

Activities in Q1 have included defining data and sourcing, and stocktaking activities in DHBs to identify gaps and engagement with key stakeholders. This work will contribute to a PHO implementation meeting in early Q2, which will promote development of primary care and hospital-discharge related activities.

Counties Manukau District Health Board

Community & Public Health Advisory Committee

Registered Nurse Community Prescribing Trial and Evaluation

Recommendation

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

Receive this briefing paper on progress of registered nurse community prescribing trial and evaluation in CM Health.

Note that the evaluation of the trial is now in progress and due to be completed at end of March 2018 prior to any further courses being held.

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Purpose

The purpose of this paper is to provide the Community & Public Health Advisory Committee with an update on the progress of the trial and evaluation of community nurse prescribing. The programme has been designed to test a blended learning programme, embedded in clinical practice with support from the employers. The programme has been developed internally with a blended learning model of face to face teaching by local clinical experts and on line learning modules hosted on Ko Awatea. The design of the programme has utilised existing on line learning sites both national and international. These will be made available to other organisations that will also provide the programme as it rolls out nationally following the independent evaluation.

Executive Summary

Thirty three nurses have just completed the first Registered Nurse prescribing in Community Health: Trial and Evaluation. Counties Manukau Health and Family Planning New Zealand are the only sites for the trial and evaluation for this new scope of prescribing. The initial group includes nurses working in the following clinical areas: Secondary schools, Primary Care, Mana Kidz and Public Health Nursing.

The nurses are now able to prescribe from a limited list of medicines using Auckland Regional Health Pathways for clinical decision support for common skin, ear, and sore throat conditions as well as over the counter medicines. Nurses who have completed the Family Planning Certificate as well in Sexual Health and Contraception are also able to prescribe a limited range of medicines in this area as well. The education programme has a significant focus on pharmacology, health literacy and antimicrobial stewardship.

The benefits of nurse prescribing in community nursing allow greater access to medicines at the point of care. The nurses have stated they have greater assessment skills and critical thinking, and improved team relationships with their prescribing mentors. This will provide a more comprehensive approach to health service delivery from nurses working in the community.

Background

In 2013 The Nursing Council New Zealand consulted on a registered nurse prescribing. One option New Zealand Nursing Council proposed was for suitably qualified registered nurses working in the community setting to be able to prescribe a limited number of medicines for certain health conditions. There was a

high level of support for the proposal (from 90% of submitters) with many supporting NCNZ's view that designated prescribing for a limited range of medicines would enhance the health services registered nurses deliver and make it easier for patients to obtain the medicines they need.

Comparison of nurse prescribing models in New Zealand

Registered nurse prescribing in community health	Registered nurse prescribing in primary health and specialty teams	Nurse practitioner Prescribing authority
Designated prescriber: Able to prescribe from a limited schedule of Medicines.	Designated prescriber: Able to prescribe from a schedule of common Prescription medicines.	Authorised prescriber: Able to prescribe any Prescription medicine.
Scope of practice Must be credentialed on a recertification programme for registered nurse prescribing in community health. Uses clinical pathways/ guidelines to treat a small number of conditions for normally healthy people.	Scope of Practice Must work in a collaborative team with an authorised prescriber available for consultation. Able to diagnose and treat common conditions (e.g. asthma, diabetes, hypertension) within a collaborative team.	Scope of Practice Able to independently assess, diagnose and treat a range of conditions for a population group in an area of practice. May work autonomously or within a health care organisation. Consults with health professional colleagues
Additional Qualification Recertification programme including education, supervision in practice and credentialing.	Additional Qualification Post graduate diploma in registered nurse prescribing for long term conditions and common conditions	Additional Qualification Clinical Master's degree in nursing.

The table describes the scope and education preparation for the three prescribing scopes. Please note the community prescribing does not include a post graduate qualification.

This Programme is the first stage roll out of registered nurse prescribing in community health in partnership with New Zealand Nursing Council, Family Planning association and Counties Manukau Health. The Medicines list for registered nurses working in the community setting has been developed by New Zealand Nursing Council in consultation with Counties Manukau Health and Family Planning New Zealand. Currently most of these medicines can be supplied by nurses under standing orders.

The population of people living in Counties Manukau District Health Board (CMDHB) is growing at 1 - 2% each year and is changing, both youthful and ageing, and is estimated to reach over 560,000 people by 2020. The population is ethnically diverse and by 2020 is estimated to be 15% Maori, 22% Pacific and 26% Asian people.

CMDHB has the largest population of children compared to any District Health Board in New Zealand with *an estimated 54,000 out of almost 121,000 children living in poverty. 23% of the population is aged 14 or under (120,770 in 2015): 13% of New Zealand children aged 14 or under live in Counties Manukau Health.*

Our older population will increase by approximately 22% with an estimated 70,000 people aged 65 years and over by 2020.

The programme will demonstrate improved patient care by enabling registered nurses to make prescribing decisions so patients receive more accessible, timely and convenient healthcare. This will encourage a more comprehensive approach to health service delivery.

The rationale for registered nurse prescribing in community health is to:

- Improve patient care without compromising patient safety;
- Make it easier for patients to obtain the medicines they need;
- Increase patient choice in accessing medicines; and
- Make better use of the skills and education of health professionals

Registered Nurses provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings in partnership with individuals, families, whanau and communities (New Zealand Nursing Council, 2016).

The programme supports registered nurses to maximize their scope of practice.

Registered nurses have a broad scope of practice that covers the lifespan and most health conditions. They are the largest group of regulated health professionals and they work alongside doctors and within multidisciplinary teams. They already have a role in administering medicines to patients/clients operating under Standing Orders and providing patient education and rationale for medicines.

The preparation required to become registered nurse prescribers in community health within Counties Manukau Health region includes education, clinical supervision and credentialing of competence to prescribe in preparation for New Zealand Nursing Council approval to be a prescriber within this scope. Existing clinical pathways are used to guide decision making and medication selection. The ability to prescribe a limited number of medicines will build on existing nursing practice, knowledge and enhance the health services registered nurses are able to provide to normally well patients in schools, community and clinic settings.

Values and Objectives

This framework of the programme is guided by the values and objectives of Counties Manukau Health strategic vision. The vision highlights the commitment to work 'Together' with other sectors to achieve equity in health outcomes for Maaori, Pacific and communities with health disparities. Connected community and primary care has a central role in reducing inequalities in health for our community. Included as well is the provision of safe, quality healthcare services by professionals who are well trained and fit for purpose.

The programme framework identifies the three aspects as being critical to the success of the programme these are: regulatory frameworks, continuing competence and clinical practice.

The regulatory framework considers the standards and legislative requirements that surround the role. Continuing Competence includes the knowledge, skills, and judgment and attributes to the RN requires performing the role safely and ethically and Clinical Practice is being able to deliver safe and effective services by utilizing the clinical decision support tools available.

Regulatory Framework (Pou Tarāwaho Ture)

New Zealand Nursing Council is the authority responsible for the registration of nurses. Its primary function is to protect the health and safety of members of the public by ensuring that nurses are competent and fit to practice. The roles and responsibilities of New Zealand Nursing Council are outlined

in the Health Practitioners Competence Assurance Act (2003). Council is responsible for setting the 'Standards for the Registered Nurses Prescribing in Community Health Course'.

The Medicines Act (1981) regulates the prescribing of medicines. The Medicines (Designated Prescriber – Registered Nurses) regulations 2016 authorizes registered nurses who meet specified requirements for qualifications, training, and competence to be designated prescribers for the purpose of prescribing specified prescription medicines. The purpose of the regulation is also to provide the qualifications, training and competence requirements for Registered Nurses and to prohibit them from prescribing specified medicines if they fail to comply with the requirements.

The standards for education, training, supervision and credentialing are set by the Nursing Council. Nursing Council also has the responsibility to approve of the schedule of medicines list for Community Nurse Prescribing.

Clinical governance is provided by the Panel of assessors who have reviewed and approved the registered nurses' portfolio and determine safety to prescribe a limited formulary of medicines. The panel consists of Chief Medical Officer or delegate, Chief Nurse Advisor Primary and Integrated Care, Pharmacist, Programme Co-ordinator and Primary Health Organisation Nurse Leader.

Overarching governance is provided through the CM H Drug and Therapeutic Governance Group. Quarterly reports on the number of nurses undertaking the programme and number of prescriptions generated by the nurse prescribers will be provided by the Programme Coordinator.

Following evaluation of the first roll out the programme will be available as an E-Learning package on Ko Awatea Learn and will be available nationally.

Continuing Competence (Pūkenga Auroa)

Registered nurses participating in the programme will have completed three years of clinical practice with at least one year in the area of practice she/he will be prescribing. The registered nurse is required to have completed education and competency requirements for the use of standing orders and be currently using standing orders. The registered nurse must have access to a Clinical Supervisor and have a current approved portfolio. The registered nurses have undergone six months education which consisted of a blended learning approach. This included twelve hours of face to face study days and online learning of 30 hours. The registered nurses completed a portfolio that included:

- Evidence that New Zealand Nursing Council competencies have been met
- Provided two case studies to demonstrate clinical decision making, assessment, treatment recommendations and evaluation of treatment plan.

The portfolio was assessed by the Programme Co-ordinator and presented to the Panel of assessors who verified and approved the portfolio. The panel of assessors include a range of health care professionals including the Chief Medical Advisor Primary Care, Chief Nurse Advisor, Primary and Integrated Care, Pharmacist, Nurse Prescriber Programme Co-ordinator and Primary Health Organisation Nurse Leader. Following the approval of the portfolio by the panel the registered nurses then applied to Nursing Council for prescribing rights in community health.

The course aims were to adequately prepare the nurse in pharmacology, medication management, clinical assessment and appropriate diagnostic reasoning skills. The potential health conditions for this type of prescribing include common skin conditions such as simple eczema, impetigo, fungal infections and parasites, common aches and pains, ear infections, sore throats and rheumatic fever prophylaxis and ongoing treatment, common forms of contraception and the treatment of common sexually transmitted infections, urinary tract infections and constipation. The course themes included health literacy, antimicrobial stewardship and use of Auckland Regional Health Pathways.

Continuing competence requirements will be monitored three yearly by NCNZ within the recertification programme and include:

- Evidence that prescribing is incorporated into current practice
- Regular professional development to update prescribing knowledge
- A regular peer review, audit or credentialing of prescribing

The authorisation would restrict the nurse to prescribing only from the approved community schedule of prescription medicines.

Clinical Practice (Ngā Ritenga Haumanu)

Registered nurses who undertake this course have the support of their employer/umbrella organisation with access to a Supervisor within the workplace. A learning contract was completed and signed by both the registered nurse and Supervisor. The Supervisor met fortnightly with the RN to discuss progress and identify any learning needs. The registered nurse maintained a logbook that was taken to each meeting with their Supervisor. These were viewed as part of the assessment process.

Evaluation

The evaluation of the programme will determine the quality, safety and cost benefits to the health system and consumers. It will also determine the training and support needed by the RN to prescribe medicines safely and appropriately. This is an independent evaluation carried out by Ko Awatea. The findings of the evaluation will inform the national roll out of the course.

Registered Nurse Prescribing in Community Health

Karyn Sangster Chief Nurse Advisor
Primary and Integrated Care

- Executive Leadership Team support MOU
- Clinical governance (Drug and Therapeutic Governance group)
- Policy and Guidelines
- Working Group established
- Clinical Pathways

Nursing Council

- PHARMAC
- Minister of Health
- GPNZ
- Medical Council

Three prescribing scopes

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CMH Project Brief

- Identify patient/nurse groups, conditions and medicines
- Identify clinical guidelines, policies and governance processes for safe prescribing
- To develop resources for education, training and supervision
- Agree list of medications
- Identify and agree clinical pathways or guidelines
- Develop support for clinical supervisors/mentors
- Ensure appropriate referral and communication processes to primary care and other health care teams
- Develop an assessment/credentialing framework

42 Applicants with 33 completing the programme



Registered nurses authorised to prescribe will have:

- a minimum of three years' clinical experience with at least one year in the area of prescribing practice.
- completed a Nursing Council approved recertification programme for registered nurse prescribing in community health.
- completed a period of supervised practice with a designated authorised prescriber (a medical practitioner or nurse practitioner) or a suitably qualified senior nurse, as part of the recertification programme.
- a limited list of medicines from which they can prescribe within their competence and area of practice.
- on-going competence requirements for prescribing.

Framework

- Legislative Requirements (Pou Tarāwaho Ture)
- Continuing Competence (Pūkenga Auroa)
- Clinical Practice (Ngā Ritenga Haumanu)

Blended Learning Programme

- Six months of preparation: aims to adequately prepare/upskill the nurse in pharmacology, medication management, clinical assessment and appropriate diagnostic reasoning skills
- Twelve hours of face to face learning
- An additional 2 and half study days if opting to complete contraception and sexual health module
- E-learning modules through Ko Awatea Learn
- Completion of a learning contract with an allocated Clinical Supervisor
- Regular meetings with a Clinical supervisor
- Completion of a portfolio of work that demonstrates that learning outcomes and competencies have been met
- Two case studies

Elearning

- Design programme to be transferrable to other organisations
- LEARN Programme Application
- Utilize existing on line learning programme

Course arranged in modules:

Module one: Health Assessment & Clinical Reasoning

Module two: Dermatology

Module three: Ear Infections

Module four: Primary and Secondary Prevention of Rheumatic Fever

Module five: Legal aspects of Prescribing

Module six: Principles of Pharmacotherapeutics

Study Days

- Pre-reading: NZ formulary resources – Guide to good prescribing, Prescription writing
- Subject experts: ENT, Paediatrician, Microbiologist, NPs (Eczema and child and youth health) Pharmacist, RN
- Antimicrobial Resistance/Stewardship input
- Clinical skills workshops: Health literacy, Ear examination
- Interactive sessions

Committment

Estimated time commitment : 60 hours:

- Study Days: 12 hours
- Online Learning (includes readings, formative assessments): 30 hours
- Clinical Supervision: 12 hours
- PDRP: 6 hours

- March 2017: NCNZ and UoA
- Interviews with stakeholders
- Recommendations:

Online learning – Pharmacology aspects needs to show knowledge consolidation and application

Embed antimicrobial stewardship following internal feedback

Health literacy emphasis more visible

Clinical Supervision

- Fortnightly meetings with clinical supervisor
- Case study Learning Log: Record of clinical interventions
- Regular meetings with mentor
- Ongoing communication with programme co-ordinator

Additional resources

- Resources available to nurse on a Shared Drive
- Clinical supervisors: programme documents and information on a shared drive

Final assessment

- Post course assessment – AMS
- Portfolio assessed by Nurse Educator or CNAP&IC
- Endorsed by panel
- RN apply to NCNZ for authorisation to prescribe
- Demonstrate ongoing competence through PDRP (3 yearly)

Initial findings

- Increased clinical assessment skills
- More critical thinking
- Improved health literacy skills
- Improved team relationships with supervisors
- Great learning
- Improved job satisfaction

Next steps

- Meeting with employers to discuss model of care and any concerns
- Evaluation
- Spread across Auckland region and other DHB's
- Safety in practice module