COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)

Wednesday, 7 November 2018

Venue: Ko Awatea, Room 213, Middlemore Hospital, Otahuhu, Auckland
Time: 9.00am

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

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

PART I – Items to be considered in public meeting

AGENDA

9.00am 1. AGENDA ORDER AND TIMING

2. GOVERNANCE
9.00am 2.1 Apologies
2.2 Register of Interests
   2.2.1 Does any member have an interest they have not previously disclosed?
   2.2.2 Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
9.05am 2.3 Confirmation of Public Minutes of the Community & Public Health Advisory Committee Meeting – 26 September 2018
9.10am 2.4 Action Items Register
   2.4.1 Response to Action Item: Vaccinations in Community Hubs
   2.4.1.1 Appendix 1: PHARMAC Letter re Flu Season 2018

3. BRIEFING PAPER
9.30am 3.1 Fluoridation Position Paper (Dr Doone Winnard, Clinical Director, Population Health, CM Health & David Sinclair, Medical Officer of Health, ARPHS)

4. PRESENTATION
10.00am 4.1 Franklin Locality Update (Penny Magud, GM Locality Services)

Morning Tea (10.30am – 10.40am)

10.40am 4.2 Why Asian Health? (Kate Yang, Business Manager)
11.00am 4.3 Franklin Locality Update (Kitty Ko, Asian Health Gain Advisor)

5. BRIEFING PAPER
11.30am 5.1 Quarter 4 2017/18 Non-Financial Summary Report (Marianne Scott, Master Planner, Alanna Soupen, Planning & Reporting Advisor)

6. INFORMATION PAPER
6.1 Auckland Metro SLM Improvement Plan

12.00pm 7. RESOLUTION TO EXCLUDE THE PUBLIC

Next Meeting
Wednesday, 5 December 2018, Ko Awatea, Room 105
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<th>Name</th>
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## CPHAC MEMBERS
### DISCLOSURE OF INTERESTS
#### 7 November 2018

<table>
<thead>
<tr>
<th>Member</th>
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<tr>
<td><strong>Colleen Brown</strong>&lt;br&gt;(CPHAC Chair)</td>
<td>• Chair, Disability Connect (Auckland Metropolitan Area)&lt;br&gt;• Chair, Rawiri Residents Association&lt;br&gt;• Member, Advisory Committee for Disability Programme Manukau Institute of Technology&lt;br&gt;• Member, NZ Down Syndrome Association&lt;br&gt;• Husband, Determination Referee for Department of Building and Housing&lt;br&gt;• Director, Charlie Starling Production Ltd&lt;br&gt;• Member, Auckland Council Disability Advisory Panel&lt;br&gt;• Member, NZ Disability Strategy Reference Group&lt;br&gt;• District Representative, Neighbourhood Support NZ</td>
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<tr>
<td><strong>Dr Ashraf Choudhary</strong>&lt;br&gt;(CPHAC Deputy Chair)</td>
<td>• Board Member, Otara-Papatoetoe Local Board&lt;br&gt;• Member, NZ Labour Party&lt;br&gt;• Chairperson, Advisory Board Pearl of Island Foundation&lt;br&gt;• Co-Patron, Bharatiya Samaj Charitable Trust</td>
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<td><strong>Dianne Glenn</strong></td>
<td>• Member, NZ Institute of Directors&lt;br&gt;• Life Member, Business and Professional Women NZ&lt;br&gt;• Life Member, Business and Professional Women Franklin&lt;br&gt;• Member, UN Women Aotearoa/NZ&lt;br&gt;• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust&lt;br&gt;• Life Member, Ambury Park Centre for Riding Therapy Inc.&lt;br&gt;• Member, National Council of Women of New Zealand&lt;br&gt;• Justice of the Peace&lt;br&gt;• Member, Pacific Women’s Watch (NZ)&lt;br&gt;• Member, Auckland Disabled Women’s Group</td>
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<td><strong>George Ngatai</strong></td>
<td>• Director, Transitioning Out Aotearoa&lt;br&gt;• Director, The Whanau Ora Community Clinic&lt;br&gt;• Chair, Safer Aotearoa Family Violence Prevention Network&lt;br&gt;• Huakina Development Trust (Partnership Clinic)&lt;br&gt;• Lotteries Community (Auckland)&lt;br&gt;• Board Member, Counties Manukau Rugby League Zone&lt;br&gt;• Member, NZ Maori Council&lt;br&gt;• Member, Tamaki kit e Tonga District Maori Committee</td>
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| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed Disability Sports  
• Member of NZ National Party |
| Apulu Reece Autagavaia | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board  
• Member, District Licensing Committee of Auckland Council  
• Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation |
| John Wong  
(remaining updates) | • Board member, Asian Family Services (a subsidiary of Problem Gambling Foundation of NZ).  
• Chair and Trustee, Chinese Positive Ageing Charitable Trust.  
• Founding member and council member, Asian Network Incorporation (TANI).  
• Board member, Auckland District Police Asian Advisory Board.  
• Board member, Chinese Mental Health Consultation Service Trust. |
## COMMUNITY and PUBLIC HEALTH ADVISORY COMMITTEE MEMBERS’
REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 26 September 2018

<table>
<thead>
<tr>
<th>Director having interest</th>
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<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tr>
<td>Ms Margie Apa</td>
<td>Item 3.1 on the CPHAC agenda – Aged Related Residential Care Overview</td>
<td>Ms Apa is Chair of Presbyterian North who provide older people services.</td>
<td>3 May 2017</td>
<td>That Ms Apa’s specific interest is noted and the Committee agreed that she may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
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<td>Mr Reece Autagavaia</td>
<td>Item 4.1 on the CPHAC agenda – New Government’s health Policies &amp; Priorities</td>
<td>Mr Autagava is a member of the District Licensing Committee of Auckland Council</td>
<td>21 February 2018</td>
<td>That Mr Autagavaia’s specific interest is noted and the Committee agreed that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
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Board Members Present

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

Also Present

Margie Apa (Chief Executive)
Benedict Hefford (Director Primary, Community and Integrated Care)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

Public and Media Representatives Present

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

Apologies

There were no apologies to note.

Welcome

The meeting was opening with a prayer from Aupulu Reece Autagavaia. Ms Kate Yang, Primary Care Business Manager, was introduced to the committee.

Disclosure of Interest/Specific Interests

The Disclosures of Interest amendments were noted, including a change for Mr Ngatai. There were no amendments to the Disclosure of Specific Interests.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 15 August 2018.**

   A change to the name of South Seas Trust was noted and will be amended.

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

   That the minutes of the Community and Public Health Advisory Committee meeting held on 15 August 2018 be approved.

   **Carried**

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

   The RSA has been sold. Ms Brown has asked a local real estate agent to keep their eyes open for any new suitable properties.

   All other items noted as being on track.

   **NOTE:** A change in the order of the agenda was required due to Dr Pete Watson having another meeting to attend across town and the delay in Dr Pat Tuohy’s flight from Wellington to Auckland.

   As such a preparation discussion was held prior to the conversation later in the agenda with Dr Tuohy’s visit.

   The difficulty of navigating the B4SC system was noted as being one of the drivers for wanting to meet with Dr Tuohy.

   Access to data, in particular data that shows that assistance has been offered and taken up by whaanau, continues to be an issue for the DHB.

   The Southern Initiative (TSI) will be undertaking some research and have advised that they will be using the B4SC data as a base for the study. Apulu Reece advised the committee that he had notified TSI of the limitations with the data.

   A major concern for this committee is the missing link where whaanau have been referred, which is recorded, but there is not data collection that shows whether or not that referral has been followed up on.

   The DHB would like to ask Dr Tuohy if he is open to a flexible approach in terms of CM Health being able to test some different methods of assessment, also looking for a more holistic approach.

   A provisional date of 5 November 2018 has been identified for an additional CPHAC meeting with the Asian Community. The committee will hear from 6 different groups based on 2 criteria, current health care needs and the biggest bang for buck. The meeting will comprise patients, whaanau and providers discussing being Asian in South Auckland and accessing healthcare.
It was suggested a separate meeting for South Asian/Indian which is doable if agreed to. Potentially a meeting for those that have been in NZ for many years and a different meeting for those that are new to NZ. Will hold the initial big picture meeting and then drill down to meeting with small, more specific groups.

3. BRIEFING PAPER

3.1 Healthy Families New Zealand (Rachael Enosa, Chief Executive & Annie Ualesi, Partnership & Engagement Manager, et al)

An introduction to Healthy Families NZ was provided by Ms Enosa. She advised that 275,000 community are covered by this mahi looking at the social determinants and the primary causes of health issues for the community. They are currently focussed on on a set of risk factors: movement, nutrition, smoking, alcohol. The intention is to gather intelligence through lived experiences and data, applying a systems thinking lens to determine what parts of the system are having the impact and what are the inter-relationships. Currently working with communities in regard to a leverage point. Move to co-design with communities and stakeholders to look at solutions.

Democratise the voice of community to influence equitable investment. South Auckland is a national priority and requires a system to be responsive to the aspirations of this community. A collective impact approach will be used. A working group has been established: walking/cycling. Key messages are around equitable provision and earlier investment. This has been up and running since January 2018. Input has been given into the submission process, influencing where funding will go.

Safe Healthy Streets Working Group is working with community, supporting CLM, etc. The cycle lane alongside the motorway in South Auckland, these are seen out west but nothing in South Auckland. This is a shame that with all the work that is being undertaken along the motorway, there are no cycle lanes. The working groups are aware of this and continue to make noise in regard to this at various forums.

The committee asked if CM Health and CPHAC can help and agreed to an open door with HFNZ to enable them to alert the DHB/CPHAC when there are issues that the DHB can lend their support to.

Maaori Responsiveness Strategy
70 reasons were given as to why Maaori cannot achieve health equity in South Auckland. This information was whittled down to 8 key themes.

Maaori in South Auckland: need to address historical trauma/mental health – wairua centred approach, challenging western ideologies. For example, Hayman Park, looking to activate this space. Clean up the waterway has been a need identified from the community. This is the next agenda for the Council.

Creating connectivity for certain communities to the land that is currently available but not accessible. Focus on the environment and maximise the benefits that fall out of that.

Mr Ngatai raised the Treaty obligation of healthy lifestyles for their Treaty partner. The Committee advised that they were enthused by the work that is being undertaken by HFNZ. The committee are aware of the complexities of all the different organisations that need to be worked with in order to facilitate change for the areas such as Puhinui Stream and Hayman Park.
HFNZ meet regularly with the Manukau Locality Project Manager. CM Health would like to encourage more influential activities between the two. Engage with Doone Winnard and Marianne Scott as Population Health & Planning leads.

HFNZ invited CPHAC to an open home, where they can see firsthand the work that is being undertaken in the lab. This will provide an opportunity to meet the people and have an interactive experience.

**Action**

HFNZ to return in 6 months’ time to determine what progress has been made.

The conversation continued around 0-5 years in ECEs. There is more to the issues than nutrition and physical activity.

Key themes noted were health and wellbeing in multicultural environments don’t include nutrition and physical activity.

ECE teachers are struggling to see what the role of an ECE would be for families in vulnerable situations.

HFNZ are using design thinking to shift the mindsets. Have co-designed and early years design challenge. There were some interesting findings. The greatest impact was from ECEs that operated within a cultural framework, greater buy in from whaanau. They were taught value of replacing sugary drinks, taught science of water. If it is a non-cultural framework, there is slower buy in, less buy in.

Excellent benefits was seen from peer learnings. Currently deep-diving into the cultural frameworks, in particular for Pacific Islanders. Wellbeing of ECE teaching staff is a consideration. There is a lack of investment of ECE professional development in regard to complex whaanau situations. Need to get investment for tailored professional development.

Professional development for ECE centres is being asked for along with workplace wellbeing and is deeply exploring the impact of cultural frameworks.

The Committee thanked HFNZ for the work that they are undertaking and look forward to working together more collaboratively. Analysis of data would be most beneficial to CPHAC. Story telling is paramount, changing the narrative: tell the good stories of change.

HFNZ is also looking forward to working together.

4. **PRESENTATION**

4.1 **Otago Dental School – Joint Venture with CM Health** (Peter Cathro, Senior Lecturer, Joint Associate Dean (Clinical Services), and Head of Discipline of General Practice Dentistry)

Otago is looking to work collaboratively with CM Health.

Student preparation for dealing with communities of different cultures is required and there is an expectation that students will be aware. Otago is happy to build this early into the curriculum and Dr Cathro is keen to work collaboratively.

Students are currently growing in Maori numbers, a lot of Asian coming through, however trends show low Pacific numbers.
Otago is looking to work in a supplementary way with clinics in South Auckland. Mobile units are preferred in South Auckland, however, the logistics of transportation etc, will be worked through.

Accommodation for students will be a factor. This has not currently been addressed to date and is a risk, but investigation is underway into suitable properties within the area. It was suggested that a meeting with Auckland Council would be beneficial to gain information around transport routes, facilities in the area, etc.

The committee advised that community have asked if it is safe to be treated by students and Dr Cathro said these students are year 5, in their final year of study and will be under supervision. Established referral pathways will be in effect.

CPHAC is looking forward to this project coming to fruition.

11.10am: Ms Parr and Miss Apa left to attend/present at the Staff Forum.

5. BRIEFING PAPER

5.1 Quarter 4 2017/2018 Population Health Performance Report (Ms Marianne Scott, Master Planner & Ms Alanna Soupen, Planning & Reporting Advisor)

The Report was taken as read.

2018/19 reporting: consolidate population health plan reports into the annual plan reports. The Annual Plan report has stratified performances targets by ethnicity. Each population group will have a ‘road map’.

Ms Scott advised that Q4 is a good reflection of the year. Standouts to note are ASH rates for skin infections which have seen a 6% reduction for Maaori 0-4 and 7% reduction for Pacific 0-4.

The focus will shift to respiratory for 18/19 and similar methods will be used in working with vulnerable communities.

Action
SLM Improvement Plan to be made available to CPHAC. Marianne Scott

Pacific breastscreening rates have remained high for South Auckland.

Maaori Immunisations: a paper is to be taken to ELT in regard to how we can improve these numbers.

Action
Ms Tafau to investigate if this paper can be made available to CPHAC.

CPHAC talked to the possibility of the implementation of a Maaori Strategy put forward to address this issue. If we are to continue supporting the current methods, the numbers may well not change.

The issue of the East Asian and South Asians was raised again and the need for the separation of the data collected.

Action
Cervical Screening with home kits – CPHAC would like to know where this has got to.
Mortality data to be presented to CPHAC – prevalence of cervical cancers in women. Pacific, Maaori, South Asian, East Asian.
It was brought to the attention of the committee that due to the Government not requiring Asian data, this data is not provided to the DHBs. Also to note is that the MoH holds a lot of these contracts, not the DHB, but the DHB are the ones responsible for the performance of these contracts.

Equity Targets: rest of the country is Maaori/Non-Maaori and this is not helpful for CM Health. CM Health chose to put up NZ European as the comparator as this better reflects the true equity gap. If we chose the National Equity targets, our results would be much better. From 18/19 it will revert to the National Target.

The committee is interested to know how do we address the poor picture that is presented for Maaori? How can we influence the support and invest into these challenges? The Chair advised that when our need meets with the focus of the Government and we can secure targeted funding, this is when changes can be seen. For example Mana Kids, Rheumatic Fever, this model of care tailored for our communities.

Next report should be on 5 December 2018.

CPHAC noted their deep concern for the challenges facing Maaori/Pacific/Asian in our communities. Of particular note is the lack of data for Asian health and further the lack of definition for East Asian and South Asian.

6. RESOLUTION TO EXCLUDE THE PUBLIC

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

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

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

<table>
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<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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| 2.1 Minutes of the CPHAC meeting (Public Excluded) held on 15 August 2018. | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | 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 Postvention Suicide Brief | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)] |

Carried
7. DISCUSSION

7.1 Child & Youth Health Priorities (Dr Pat Tuohy, Chief Advisor Child & Youth Health, MoH)

Notes from the Discussion

The Well Child Framework ends with B4SC. Dr Tuohy was asked if this a well-being check or a health check for 0-5? Dr Tuohy responded as with all services, they have a history, this is what shapes them. He is aware that the Well Child programme is intended to be more holistic than just health, helping parents to assist their children to thrive. The B4SC part has advanced the most in this area as it looks a broad sub-set of a child’s well-being, linking closely to ECE, forming a seamless hold. It has been variable in its implementation and the potential has not been realised in many places.

The Well child programme is in need of reconfiguring. Literacy and oracy are critical. The intention is for them not to be in the WCP as they would be in other forums. This is not always the case.

The programme as a whole: clear that as well as B4SC needing to lift its game, the system as a whole needs to lift its game. It will take a whole of government approach to address the multiple issues for vulnerable whaanau.

This committee talks about numbers that are vast. Entire extended whaanau all living in deprivation. This committee is struggling with the ineffectiveness of B4SC, where it could be so effective.

Any approach will need to be a whole of system across agencies. New changes to information sharing are coming up. A consultation document is currently being prepared.

The Child wellbeing strategy is being prepared for consultation within the next month or so. The intention is to start with more vulnerable whaanau.

Within the DHBs we have to move away from children coming through the front door, work more in the communities. Working around Family violence and child protection: get providers on board with the Alert System. Dr Tuohy has some funding that will enable health professionals to have visibility of these alerts. It is a critical intervention point. Expectation from Dr Tuohy is that an MDT is undertaken, looking at family, child and extended family.

The statutory threshold is higher in CM than the rest of the country. We are not able to access the services that are required to help the vulnerable whaanau. Counties Manukau has a huge volume to contend with as well. It is a Board decision at CM Health to decide where funding for services go, not the MoH. The issue for the DHB is that it has no influence over the contracts that are delivering services in our communities.

Ministry are testing whether or not new born hearing testing can also be used in 3 year olds. There is no doubt that the delivery of services in Counties Manukau should be different than in other DHBs. Vision and oral testing, etc is still important. Other factors are also critical to look at in Counties Manukau including family violence, housing.

We need to keep a universal service: bump up the middle level (community level). The MoH should be trying to find the money to do this. On top of the Well Child programmes issues is the issue of challenges for Maaori children. In order to change statistics for Maaori children, CM Health need to be able to opt out in order to fund Maaori providers as they have the wrap around services.
For Māori by Māori and for Pacific by Pacific. This committee believes this is a key factor. Dr Tuohy advised that there should not be a default provider of choice. Money should follow the parents. The choice of provider shouldn’t make a difference to the outcome for the patient, but MOH knows that it can.

B4SC nurses are not social workers and often not able to address the issues vulnerable families are facing. CM Health queries if this needs to be looked at, and a change made. Capability of workforce and validity of tests also need to be looked at. Evidence shows that children at 5 or 6 are presenting with issues that should have been picked up much earlier. Dr Tuohy feels that it’s a delivery issue not a tools issue.

PEDS questions should be asked at every contact with the nurse providing the checks. It is apparent that we cannot identify families just through the B4SC. Outreach immunisation, whilst expensive, is proven to work. Making a difference for whānau in Counties Manukau will be expensive and intensive and as such we need to cease funding services that are proven not work.

The Plunket ratios of 1:150 is not working, not effective. Needs to be adjusted to 1:15 and this will be expensive. There does need to be a fundamental shift in thinking and an upskilling of the current workforce. Dr Tuohy agreed that a refresh is required. Unfortunately there has been no increase over the last 5 years in funding to the WCP.

Need a service that can flex up to the needs of the community/whānau and can flex down when things are going well. Dr Tuohy is keen to bring Family Start in but is also aware that their kaupapa is not suitable for everyone.

Provision of health services in ECEs was raised. Dr Tuohy said there was nothing outside School Based Health Services. There is no formal relationship between ECE and MoH. If WCP and ECE worked closely, then Plunket and Oranga Tamariki could link in.

The committee advised Dr Tuohy the would like to see a significant change for children in Counties Manukau.

Ms Brown asked Dr Tuohy to return to CPHAC to continue this conversation. Dr Tuohy agreed a change was necessary and that services needed to reflect the requirements of whānau in the community and this will vary from DHB to DHB.

The committee thanked Dr Tuohy for his attendance.

Meeting concluded at 13.11pm.


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 – 26 September 2018

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<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<td><strong>Standing Items</strong></td>
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<tr>
<td>19.8.15</td>
<td>Locality Updates: Franklin Eastern</td>
<td>7 November 5 December</td>
<td>Penny Magud Penny Magud</td>
<td>Refer Item 4.1.</td>
<td></td>
</tr>
<tr>
<td>14.6.17</td>
<td>ARPHS – six-monthly update.</td>
<td>5 December</td>
<td>Doone Winnard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.11.2017</td>
<td>Population Health Plans (Asian, Pacific &amp; Maori) – quarterly update including a local picture as well as national data on the Healthy Mums &amp; Babies target.</td>
<td>27 February 2019</td>
<td>Marianne Scott/ Alanna Soupen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.11.2017</td>
<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
<td>5 December</td>
<td>Kate Dowson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.11.2017</td>
<td>3.1</td>
<td>Every $ Counts – Project team to present an update on this project.</td>
<td>22 May 2019</td>
<td>Sarah Sharpe</td>
<td>Deferred in agreement with the Chair (Colleen Brown)</td>
</tr>
<tr>
<td>6.9.2017</td>
<td>3.1</td>
<td>Owning my Gout – the project team were asked to return in 6 months’ time to update the Committee on their progress, particularly how they have got on working with A/WDHB as they have the balance of the 31,000 Gout sufferers.</td>
<td>TBA</td>
<td>Trevor Lloyd</td>
<td>Will come to CPHAC when the Business Case has been finalised.</td>
</tr>
<tr>
<td>21.2.2018</td>
<td>3.1</td>
<td>Green Prescriptions in Counties Manukau - The CPHAC committee would like Ms van Paauwe to return in the latter half of year to provide an update on progress.</td>
<td>5 December</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>23.5.18</td>
<td>3.1</td>
<td>Mental Health &amp; Addictions Update: with regard to homelessness for MH&amp;A whaanau, Housing First to be invited to present to CPHAC.</td>
<td>5 December</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>4.7.2018</td>
<td>3.1</td>
<td>Youth One Stop Shop: Provide basic information/data around the youth in this community and what services they are accessing and how they are accessing them. Oranga Tamariki – provide information around how many youth are in vulnerable situations that may lead to them being adults that are unaware around how to navigate health services.</td>
<td>5 December</td>
<td>TBC</td>
<td></td>
</tr>
</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7.2018</td>
<td>5.1</td>
<td><strong>Community Meeting - Youth:</strong> Invite youth from the Youth Councils across Manukau to participate in a meeting and ask for feedback around their concerns and their needs.</td>
<td>5 December</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.7.2018</td>
<td>5.1</td>
<td><strong>Mangere/Otara Community Hubs:</strong> Karyn Sangster to make some investigations into the area of vaccinating in community hubs and report back to CPHAC. Mr Greenslade to return to CPHAC with a community hub update.</td>
<td>7 November</td>
<td>Karyn Sangster</td>
<td>Action item response attached as an appendix to this Register.</td>
</tr>
<tr>
<td>4.7.2018</td>
<td>5.1</td>
<td><strong>Mangere/Otara Community Hubs:</strong> Karyn Sangster to make some investigations into the area of vaccinating in community hubs and report back to CPHAC. Mr Greenslade to return to CPHAC with a community hub update.</td>
<td>Early 2019</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>19.9.2018</td>
<td>Board</td>
<td><strong>MoH Letter – Strengthening the DHB Healthy Food &amp; Drink Policy:</strong> Doone Winnard and Stella Welsh are looking at what the DHB is currently doing and what this letter means and will report back via HAC and CPHAC.</td>
<td>5 December</td>
<td>Doone Winnard/ Stella Welsh</td>
<td></td>
</tr>
<tr>
<td>26.9.2018</td>
<td>3.1</td>
<td><strong>Healthy Families New Zealand:</strong> Update to CPHAC in 6 months’ time.</td>
<td>10 April 2019</td>
<td>Carmel Ellis</td>
<td></td>
</tr>
<tr>
<td>26.9.2018</td>
<td>5.1</td>
<td><strong>Auckland Metro SLM Improvement Plan:</strong> Plan to be made available to CPHAC for their information.</td>
<td>7 November</td>
<td>Marianne Scott</td>
<td>Refer Item 6.1.</td>
</tr>
<tr>
<td>26.9.2018</td>
<td>5.1</td>
<td><strong>Maori Immunisations:</strong> The paper that has been submitted to ELT to be made available to CPHAC.</td>
<td>7 November</td>
<td>Vicky Tafau</td>
<td>CPHAC to confirm with Ms Apa at the meeting on 7 November if this paper is ready for release to Board Sub-committees.</td>
</tr>
</tbody>
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Counties Manukau District Health Board  
Community and Public Health Advisory Committee  
Follow up from July CPHAC questions on vaccination in community clinics

**Recommendation**

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

- **Receive** follow up information from question on availability of using Community Health team clinics to provide immunisation programme
- **Note** that the information has been submitted by Operations Manager Otara/Mangere Locality
- **Recommended** that the report be received.

Prepared and submitted by Karyn Sangster on behalf of Penny Magud GM Localities / Jenny Parr Chief Nurse and Director of Patient/Whanaau Experience

**Executive Summary**

There has been exploration of options to provide routine vaccinations within the Mangere/Otara community clinics. The preferred option is to refer to primary care for routine vaccinations where the vaccine and administration are funded and the workforce is available to provide this service.

**Purpose**

To provide additional information to CPHAC on the ability of community health teams to provide additional services such as a one stop shop to increase vaccination rates in our vulnerable populations.

**Background**

In July CPHAC received a presentation on the clinics provided in the Otara and Mangere Locality. CPHAC were impressed with the clinic model and asked for further information regarding delivery of routine vaccinations to be provided at the clinics.

The following questions were asked:
- What are the demographics and attendance rates at the clinics?
- Can we utilise PHN to vaccinate other adults and children?
- Can we offer flu and boostrix to pregnant women at midwifery clinics?
- Do we know the vaccination status of the people attending the clinics?
- Do we routinely ask people their vaccination status?
- How can we provide flexible responsive services to our clinic attenders?

Response to questions raised the Operations Manager in the Otara Mangere Community Health Team was asked to provide answers to the questions raised. These have been compiled with additional information.
Mangere Hub
In Mangere the following clinics are provided:
- Cardiology
- Diabetes
- Gastroenterology
- Neurology \ Diabetic Ophtalmology
- Cervical screening outreach
- Psychological medicine
- Renal Medicine
- Respiratory Medicine
- Rheumatology
- Stroke

The total volume of patients per month is 750-890 individuals all who are adults. There are up to 120-185 people who do not attend their appointments. The demographics of the population have not been captured in the data collected. The clinics are both medical and nursing led along with some allied health roles such as physiologists, dieticians, podiatrists and retinal screeners. The clinics are mostly outreach clinics usually provided at Manukau Super Clinic and under the clinical care of CM Health Medical or Surgical Services. There are also two patient care assistants and one nurse coordinator for all the clinics held at Mangere.

The midwifery clinics are held at 6 Waddon place along with public health nurse clinics. The volumes at these clinics are not captured as they are provided independently within their own services.

Otara
The clinics are located near the town centre with four general practices within walking distance.
At Otara the following clinics are hosted as well as a district nurse clinic. Again only adult patients are seen in this location and there is no dedicated resource for a clinic nurse. The outreach clinics are self-sufficient and complete administrative tasks to support patient flow. The District Nurses provide a clinic for district nurse clients who prefer to visit clinic than have a home visit there is a patient care assistant who helps with administration and non-clinical tasks.
- Cardiology
- Maternity
- Diabetes
- Dietary
- Ophthalmology diabetes
- Psychological Medicine
- Respiratory Medicine
- Rheumatology

At Otara 310-370 patients are seen monthly plus the district nurse clinic (these numbers are not included). There are approximately between 50-93 patients not attending planned appointments per month. The clinic is located on the edge of the Otara town centre and there are three general practices in walking distance.

Discussion
The operations manager has looked into the opportunity to provide opportunistic vaccinations. There are medication fridges at both locations these would need to be assessed if they have the correct specifications to hold vaccinations and meet the national standards for cold chain accreditation.

Vaccinators
Vaccines are prescription medicines that can only be administered by a nurse practitioner, a medical practitioner, a registered midwife, a designated prescriber, a person authorised to administer the medicine in accordance with a prescription or standing order. Or a person authorised by the Director
General of Health or a medical officer of health under Regulation 44A of the Medicines Regulations 1984 this includes authorised nurse and pharmacist vaccinators.

To become an authorised vaccinator the registered nurses is required to complete an immunisation course. This is a two day training course at a cost of $160.00. The nurse then requires a clinical assessment to be completed by an accredited assessor.

Public Health Nurses
Public health nurses are authorised vaccinators and provide scheduled vaccinations to children at school they are not able to vaccinate young children or adults. They provide school based programmes to immunise our primary and intermediate school aged children. They are our go to workforce if there is a public health emergency or pandemic response requiring mass vaccination. As a workforce they are fully utilised with their current work and would not have additional capacity or the authorisation to vaccinate young children or adults.

Midwives
Midwives can become vaccinators for babies and mothers on completion of a one day course. CM Health has been encouraging midwives to vaccinate pregnant women for flu and boostrix. They refer women back to their primary care practice for vaccination. We do have low rates of vaccination during pregnancy. The cold chain national standards requirements for storing of vaccines requires approved fridges and daily monitoring of fridge temperatures. For our midwives working in the community they find this to be a barrier. They are also not eligible for the administration of vaccine payment that primary care receives.

Vaccination Status
All patients would need to have their vaccination status checked on the immunisation register adult vaccinations are not easily accessible as they are not often recorded on the data base but in the primary care practice management system. Therefore the primary care provider would need to be phoned to check the vaccination status. On admission to community health service patients are asked their vaccination status and it is recorded in their clinical record. During influenza season we advise eligible children and adults to see their primary practice for vaccination. Within our outpatient clinics flu vaccination is actively promoted when patients attend their appointments and they are encouraged to have their annual vaccine at their primary care practice. On discharge summaries we advise medical practitioners that their patients meet criteria for annual flu vaccination or other funded vaccines.

Vaccine supply
As these clinics are not registered primary care practices they would not be eligible to order or administer funded vaccines. The vaccines have a short shelf life and need to be kept at consistent temperatures in an approved fridge as per national standards. If there is a breach in temperature all vaccines in the fridge must be disposed of.

PHARMAC
PHARMAC criteria require administration of vaccines only to eligible populations outside of health care worker immunisations. In a letter from PHARMAC CEO Sarah Fitt received on 21st March 2018 she reminds DHB’s of notification in 2016 that we can no longer run local immunisation programmes without PHARMAC authorisation. This is related to expansion of funded access would have on both product and service cost that would need to be prioritised against competing priorities.

There is a potential opportunity with the Mangere location where there is a dedicated clinic nurse who could undertake the training for adult vaccinations. The vaccines would not be subsidised so would need to be purchased directly from the supplier and a costs would need to be budgeted. The clinician providing care at the clinic would need to notify the nurse that the patient needed a vaccination. The primary care provider would need to be notified to check the vaccination status and
to record the administration into their records to ensure that a duplicate dose was not given at the primary care practice. There would be additional costs for cold chain accreditation to be met. A vaccine fridge would need to be purchased and maintained. We would be able to provide vaccinations only to those who meet the eligibility criteria as outlined in the PHARMAC schedule. As there are a number of general practices in walking distance it would be more cost effective to refer people there for vaccinations where they would be provided with funded vaccines and the practices can claim the immunisation subsidy. The district nurses do not have capacity to provide additional nursing tasks they currently do not have capacity to deliver care to meet current demand. The recent care capacity demand management assessment showed that they require additional an estimated 6.5 FTE. Midwives are also a workforce where they struggle to meet the care demands required within current staffing levels.

Therefore costs of staff and ensuring cold chain management are a barrier at present we need to ensure people are connected to their primary care teams for provision of routine vaccinations.
21 March 2018

DHB Chief Executives
DHB Chief Operating Officers
DHB Chief Medical Officers
DHB GMs Planning and Funding
DHB Chief Pharmacists

Dear Colleagues

2018 Influenza Season

We have recently received several enquiries from DHBs about the possibility of widening the access criteria for influenza vaccine to include a mass childhood influenza vaccination programme. This letter sets out PHARMAC’s position in relation to potentially expanding funded access to influenza vaccine, and some other matters related to the 2018 influenza season.

Widening of funded access

We recognise that there is a high level of concern amongst DHBs about potential impacts of influenza in 2018, stemming from the impact of influenza during the Northern Hemisphere winter. With our focus on best health outcomes, we share those concerns. Our focus continues to be on working with the Ministry of Health to improve uptake of vaccines within current funded access criteria. We are aware many eligible people are not accessing treatment.

A mass childhood vaccination programme is not planned in 2018, for two primary reasons:

- Firstly, a mass childhood vaccination programme, or widened access to other large population groups, would require a significant increase in vaccine stocks. This has not been forecast for the 2018 season and stocks have already been ordered, for New Zealand and other countries.

- Secondly, any expansion of funded access would have both product and service costs, and PHARMAC would need to prioritise this investment against other competing priorities. Applications for widening of funded access for influenza vaccine need to be considered through the normal PHARMAC evaluation and decision process that applies to all treatments. We have already held preliminary discussions with our clinical advisers about expanding funded access to the influenza vaccine to include children aged under 5 in future years, and our Immunisation Subcommittee will be considering this further when they meet in May 2018.

We note that the UK is the only jurisdiction that has, so far, implemented a mass vaccination programme for children, and this was using an intranasal formulation. There are currently no Medsafe approved intranasal products available in NZ.

We also note, for the avoidance of doubt, DHBs can no longer run local immunisation programmes without PHARMAC authorisation. We notified DHBs of this change in 2016.
**Strain coverage**

WHO sets the strain coverage for each season, based on the circulating strains globally. The 2017/18 US circulating strains have been H1N1pdm09, H3N2/Hong Kong, B/Brisbane and B/Phuket) ([http://gis.cdc.gov/grasp/fluview/fluportaldashboard.html](http://gis.cdc.gov/grasp/fluview/fluportaldashboard.html)).

The funded vaccine for the NZ 2018 season is, for children under 3 years, Fluarix Tetra and, for adult patients, Influvac Tetra (both are quadrivalent vaccines). Both have a different H3N2 strain (Singapore), which is expected to provide better protection against the circulating strains.

**DHB staff vaccinations**

We have received several enquiries from DHBs seeking information about occupational health & safety (OHS) programmes they are running which include staff influenza vaccinations, asking whether the funded vaccine can be used for staff and how the pricing compares to private market vaccines.

PHARMAC has negotiated national pricing for Influvac Tetra and Fluarix Tetra; however neither brands are subject to Hospital Supply Status, which means that DHB Hospitals can choose to purchase other brands if they wish.

Some DHBs have informed PHARMAC of the purchase price of other brands of influenza vaccine they have been offered, which are lower than the listed price of Influvac Tetra and Fluarix Tetra listed in the Schedule ($9 per unit). Please note that the funded vaccine price is subject to confidential rebate and we can confirm that the net price of the funded vaccines are substantially lower than the prices of other brands which DHBs have been offered that have been disclosed to us.

**Funded treatments for Influenza**

Another matter that has been raised with us is the possibility of making funded oseltamivir (Tamiflu) antiviral stocks available for dispensing in the community. PHARMAC considered the funding of neuramidase inhibitors (NIs), which include oseltamivir, for the prevention and treatment of seasonal influenza in 2013 and our clinical advisors recommended their use be restricted to inpatients only.

Our advisers considered that the benefits of NIs were limited, and that there is currently insufficient evidence of benefit (beyond a reduction of time to alleviation of symptoms) to recommend wider funding. Oseltamivir is listed in Part II of Section H of the Pharmaceutical Schedule for use by DHB Hospitals and is restricted to inpatient use only and it cannot be dispensed for discharge.

I hope this information sets out PHARMAC’s views clearly. We would welcome feedback from DHBs on these topic or any other matters.

Yours sincerely

Sarah Fitt
Chief Executive

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Counties Manukau Health
Community & Public Health Advisory Committee
Community Water Fluoridation Position Statement

Recommendation

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

Recommend to the CM Health Board that they endorse the position on Community Water Fluoridation in Appendix 1.

Prepared by: Auckland Regional Public Health Service: Julia Peters (Clinical Director), David Sinclair (Medical Officer of Health), Delvina Gorton (Senior Policy Analyst); Auckland Regional Dental Service: Sathananthan Kanagaratnam (Clinical Director), Dr Helen Tane (Professional Leader); Auckland Regional Dental and Oral Health: Hugh Trengrove (Service Clinical Director); Counties Manukau Health: Doone Winnard (Clinical Director Population Health), Philippa Anderson (Public Health Physician), Carmel Ellis (General Manager Integrated Child, Youth & Maternity), Aroha Haggie (General Manager Māori Health Development); Auckland & Waitematā DHBs: Karen Bartholomew (Director Health Outcomes), Ruth Bijl (Funding & Development Manager Womens/Child & Youth Health), Stacey Strang (Programme Manager Child & Maternity), Riki Nia Nia (General Manager Māori Health), Shayne Wijnohn (Māori Portfolio Manager)

Endorsed by: Margie Apa (Chief Executive), Doone Winnard (Clinical Director Population Health), Philippa Anderson (Public Health Physician), Carmel Ellis (General Manager, Integrated Child, Youth and Maternity), Aroha Haggie (General Manager, Māori Health Development)

Glossary

RSNZ/OPMCSA: Royal Society of New Zealand and the Office of the Prime Minister’s Chief Science Advisor

Purpose

The Health (Fluoridation of Drinking Water) Amendment Bill proposes a transfer of decision-making on community water fluoridation from Territorial Authorities to District Health Boards (DHBs). The Select Committee Report was presented to Parliament in May 2017 and the Bill is waiting for its second reading.

A joint Auckland region DHB position will confirm that oral health is a key priority for equity and will provide transparency on the DHB’s position on community water fluoridation prior to any Board decision on fluoridation.

This is an issue of public health significance. There are substantial inequities in oral health outcomes. Community water fluoridation is equally available to all people in our communities on reticulated water supplies, and has the most benefit for people experiencing higher rates of tooth decay. It is therefore a pro-equity strategy to improve oral health.
Executive Summary

Fluoride is a trace element widely present in soil, food and water.¹ Community water fluoridation adjusts the level of naturally-occurring fluoride in drinking water to an optimal level for protection against tooth decay.

The New Zealand Oral Health Survey shows that New Zealanders living in areas with community water fluoridation have significantly less lifetime risk of tooth decay than those in non-fluoridated areas.² This is supported by numerous reviews of international data.

Community water fluoridation is an effective, safe, equitable, and highly cost-saving strategy for improving dental health. It has been safely implemented in New Zealand, and around the world, for over sixty years. A review by the Royal Society of New Zealand and the Office of the Prime Minister’s Chief Science Advisor (RSNZ/OPMCSA) concluded that community water fluoridation creates no health risks and provides protection against tooth decay at the concentration recommended by the New Zealand Ministry of Health.³ The courts have established the legality of community water fluoridation and that it is not medication.

DHBs role in reducing the burden of tooth decay

The Health and Disability Act 2000 requires District Health Boards (DHBs) to improve, promote, and protect the health of communities. Tooth decay is the most prevalent chronic and irreversible disease in New Zealand,⁴ responsible for one per cent of all health loss.⁵

DHBs are also required to improve Māori health and reduce inequities in health status. Children and adults from lower socio-economic areas, in which Māori and Pacific peoples are over-represented, have higher rates of tooth decay and untreated tooth decay. Community water fluoridation is socially equitable. It reaches all households on fluoridated community water supplies regardless of income, ethnicity, or age. Thus, the greatest benefits are likely to be for children from lower socio-economic communities.⁶

Children bear a significant burden from tooth decay. Direct effects include pain, infection, disfigurement, loss of sleep, altered behaviour, and missed school. Longer term it can adversely affect growth, development and general health.⁷ Tooth decay is a leading cause of avoidable hospital admissions for children. Over 7% of hospital admissions for children aged up to 14 years are for dental conditions.⁸ ⁹ Children aged 3-4 years have significantly higher rates of admission to hospital than any other age group.¹⁰

While the greatest benefits in oral health may be for children, the benefits of community water fluoridation continue throughout the lifespan. For older adults, drinking fluoridated water is associated with less root decay and greater retention of natural teeth into old age.\textsuperscript{11}

**Community water fluoridation in the northern region (Auckland and Northland)**

Three out of five New Zealanders receive fluoridated drinking water.\textsuperscript{12} In the three Auckland DHB regions, approximately 85\% of the population are on Watercare’s reticulated (piped) water supply. The remaining 15\% have individual rainwater supplies, or small bore or surface water supplies.

Nearly all Aucklanders on a reticulated water supply receive fluoridated water. The non-fluoridated areas are typically the satellite towns, such as Warkworth and Helensville, and Onehunga (for historic reasons). Pokeno and Tuakau (in the Counties Manukau DHB but Waikato District Council area) receive Watercare’s fluoridated water supply.\textsuperscript{13}

In the Northland DHB region, half the population is on reticulated community water supplies and none are fluoridated. Fluoridation of community water supplies was trialled in Kaikohe and Kaitaia in 2007-2009. Despite leading to improved dental outcomes for children over that time frame, the community voted against its continuation.\textsuperscript{14} This is in contrast to Auckland, where 88\% of those surveyed in 2014 either supported or were neutral about adjusting levels of fluoride in drinking water.\textsuperscript{15}

Rural communities who are not on reticulated supplies rely on fluoridated toothpaste, fluoride varnishes and/or fluoride supplements. Māori are more likely than non-Māori to live in non-fluoridated areas.\textsuperscript{16}

**Community water fluoridation delivers population health benefits**

Fluoride is a nutrient essential to human health.\textsuperscript{17} New Zealand has lower levels of fluoride than other parts of the world.\textsuperscript{18} It is naturally present in water and food, with common food sources being...
When teeth are developing, fluoride acts systemically through incorporation into tooth enamel. For permanent teeth, it acts topically when fluoridated water and saliva pass around the teeth.

International and New Zealand data shows that community water fluoridation is associated with fewer decayed, missing and filled teeth; and fewer children with tooth decay. The New Zealand Oral Health Survey found a 40% reduction in risk of tooth decay in fluoridated compared to non-fluoridated areas.

Community water fluoridation is safe

The safety of community water fluoridation has been studied extensively over many years. The review by RSNZ/OPMCSA found:

"From a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in the communities where it is used".

They also found that:

"... no effects on brain development, cancer risk or cardiovascular or metabolic risk have been substantiated, and the safety margins are such that no subset of the population is at risk because of fluoridation".

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The only substantiated potential adverse effect of fluoride at levels used in New Zealand is dental fluorosis. This is a mild cosmetic issue causing white flecks on the teeth. The Oral Health Survey found a low prevalence of mild to moderate fluorosis, often difficult to see, and no cases of severe fluorosis. The level of fluoridation set in New Zealand’s Drinking Water Standards 2005 is well below the threshold where severe fluorosis would occur.

The RSNZ/OPMCSA report concludes that it is safe to use fluoridated water with infant formula. A low level of mild fluorosis has been found in both areas with fluoridated and non-fluoridated water supplies, indicating fluoridated toothpaste as a contributing source. The consensus expert opinion is that the benefit of fluoride in formula-fed children exceeds the small risk of minor fluorosis that may occur.

The Health (Fluoridation of Drinking Water) Amendment Bill would transfer decision-making on fluoridation to DHBs.

Public Health Units are currently required by their service specifications to “engage with councils to promote water fluoridation as a safe, effective mechanism to reduce the burden of dental decay.” Public Health Units provide public health services for DHBs. The Health (Fluoridation of Drinking Water) Amendment Bill, if passed, will transfer decision-making on adjusting levels of fluoride in community water supplies from territorial authorities to DHBs. The aim of the Bill is for more consistency in fluoridation decisions across New Zealand and to extend community water fluoridation coverage.

The Bill would authorise DHBs to direct local authorities whether or not to fluoridate water supplies owned by the local authority. For water supplies which are already fluoridated, the Bill would require water fluoridation to continue unless directed otherwise by the DHB. Where a water supply crosses DHB boundaries, as with most of Auckland’s metropolitan water supply, any change in fluoridation must be approved by all affected DHBs.

The legality and ethics of community water fluoridation have been well considered not only by the courts but by organisations such as the UK Nuffield Council on Bioethics. The courts in New Zealand have ruled that community water fluoridation is lawful, and it is not medication. The Nuffield ethics review found that community water fluoridation contributed to the central goals of public health stewardship by reducing inequities, reducing disease through environmental measures, and benefiting child health. Nevertheless, the review recommended the ethics and effects of both fluoridating and not fluoridating community water supplies be considered when local decisions are made, in a similar way to decisions about water chlorination.
This paper is not seeking a decision on whether or not community water fluoridation is extended in Auckland. The purpose of the position statement is to confirm oral health as a key equity priority, to provide transparency on the DHB’s position, and support the Ministry of Health’s position on community water fluoridation. Manawhenua have provided support for the DHBs’ community water fluoridation position statement. Any consideration of changes to community water fluoridation would only occur if the Bill is passed, and should be undertaken through collaboration with iwi and Māori health providers.

**Conclusion**

- Adjusting levels of fluoride in community water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years
- Fluoridation of community water supplies delivers better health and saves money. It is particularly beneficial for low-income families for whom there are disparities in dental health
- The courts have supported the legality of fluoridating community water supplies and ruled that it is not medication
- Adjusting levels of fluoride in drinking water to recommended fluoride levels is an effective and safe measure to improve the oral health of everyone in our communities.

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APPENDIX 1: Community Water Fluoridation Position Statement

Community water fluoridation is a safe and effective way to reduce tooth decay for everyone in our communities. The District Health Board (DHB) supports fluoridating community water supplies to the level recommended by the Ministry of Health.

Position statement

1. The DHB acknowledges that tooth decay is an important population health issue that causes significant avoidable harm and health inequities

2. The DHB supports the Ministry of Health’s position that community water fluoridation is an important, safe and effective component of a population health approach to protect against tooth decay

3. The DHB supports fluoridating community water supplies to the level recommended by the Ministry of Health

4. The DHB notes these recommendations are based on scientific evidence that community water fluoridation:
   - Is established best practice both in New Zealand and internationally
   - Is effective at reducing tooth decay
   - Is safe at recommended levels of fluoridation
   - Is cost saving in community water supplies for more than 1000 people
   - Has an important role in reducing inequities in tooth decay as it reaches all groups in a community equally
   - Has been found by the Courts to be legal and not a medication.

Rationale for the DHB’s position

Fluoride is a trace element naturally present in food and water. It plays an important role in preventing tooth decay. New Zealand’s natural fluoride levels are lower than in other parts of the world.

Tooth decay is the most prevalent chronic and irreversible disease in New Zealand, responsible for one per cent of all health loss. Community water fluoridation adjusts the natural content of fluoride in water to a level that helps prevent tooth decay. It does this by:
- making tooth enamel more resistant to decay
- interfering with the growth of bacteria that cause cavities
- repairing the early stages of tooth decay.

Community water fluoridation is an effective, safe, and highly cost-saving strategy for improving oral health. It has been used to varying degrees in New Zealand since 1954. Children and young people in areas with fluoridated water have a 40 per cent reduction in risk of dental decay. The scientific consensus is clear that community water fluoridation at recommended levels benefits dental health and is safe. The Ministry of Health recommends 0.7 to 1ppm fluoride in drinking water as a level that improves oral health and is well below thresholds where severe fluorosis could occur.

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49 Office of the Prime Minister’s Chief Science Advisor and Royal Society of New Zealand. (2014 [updated 2015]) Health effects of water fluoridation: A review of the scientific evidence. Auckland; Available from:
There are substantial inequities in oral health outcomes; oral health is a key equity priority for the DHB. This is demonstrated in rates of tooth extraction due to decay, infection or disease, which are one-and-a-half to two times higher for Māori and Pacific adults, and for people living in the most socio-economically deprived areas. Inequities in rates of tooth extraction are even greater for Māori and Pacific children. Admissions to hospital for dental care show similar inequities. The greatest benefits of community water fluoridation are for lower socio-economic communities who have higher rates of tooth decay.

Community water fluoridation is international best-practice. It is recommended by the World Health Organization and many other organisations around the world as one of the most effective public health measures for prevention of dental decay. There is no health risk from community water fluoridation at the concentration recommended by the New Zealand Ministry of Health.

Most of Auckland’s reticulated water has been fluoridated for many years, covering 85% of the region’s water supply. No water supplies in Northland are fluoridated.

Legal rulings support community water fluoridation

The High Court, Court of Appeal, and Supreme Court in New Zealand have made judgments on community water fluoridation in recent court cases. Together, these judgments have established that:

- Local authorities have the statutory authority to fluoridate water supplies
- Community water fluoridation is legal and permitted by Part 2A of the Health Act 1956
- Community water fluoridation is not medical treatment for the purposes of section 11 of the New Zealand Bill of Rights Act 1990, and even if it were, community water fluoridation is justified under section 5 of the Bill of Rights
- Fluoride added to community water supplies at recommended levels are not medicines in terms of the Medicines Act 1981


Community water fluoridation is consistent with Māori values

Te Aō Marama, the NZ Māori Dental Association, supports fluoridation of reticulated water supplies. It states that fluoridation does not “diminish the mauri of water, because it improves health and wellbeing for all.”\textsuperscript{57} The DHB’s position statement has the support of manawhenua.

Community water fluoridation is cost-effective

Community water fluoridation is highly cost-effective for water supplies serving more than 1,000 people. On average, each dollar invested in fluoridation in New Zealand saves nine dollars. Thus, fluoridation provides health gains and a net return to society.\textsuperscript{58,59}

Community water fluoridation is one component of dental health

Community water fluoridation is one important component of good dental health. Ideally it is combined with twice-daily teeth brushing with fluoridated toothpaste, regular dental checks, and healthy eating with reduced consumption of sugars.\textsuperscript{60}

Conclusion

- Adjusting levels of fluoride in drinking water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years
- The Courts have supported the legality of adjusting levels of fluoride in community water supplies
- Fluoridation of community water supplies delivers better health and saves money
- It is particularly beneficial for low-income families and individuals for whom there are disparities in oral health.

\textsuperscript{59} Moore D et al. (2017). The costs and benefits of water fluoridation in NZ. BMC Oral Health 17:134
Locality Services

Franklin Locality
Franklin 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 Māori. 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 Māori population, making up about 17% of the residents living in Franklin.

**Manukau Locality**

Our largest locality of over 183,000 residents in 2013. This includes almost 40,000 Pacific people, 42,000 Māori 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**

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.
Franklin Locality Demographics

52,910 people are enrolled with one of the 7 general practices within the Franklin Locality.

30% of the resident population is expected to increase by 2033.

34% of Franklin Locality are under 25 yrs.

15% of Franklin Locality are over 65 yrs.

This is expected to double in the next 20 yrs.

Franklin Locality comprises 14% of Counties Manukau Health Population.

Resident Population

76,100
Locality Leadership

- Locality Champion General Manager Role
- Locality Leadership Group – review of Terms of reference, frequency of meeting & membership
- Franklin Locality Wellness Group
- ‘Principles’ meeting - review of Terms of reference, frequency of meeting & membership
Community Health Service Referrals

Number of Referrals by Triage Category

- **Urgent Response within 48 Hours**
- **Routine Response within 2-5 days**
- **Low Risk Response within 6-15 days**

Community Health Team Referrals Locality

- Eastern CHT: 22%
- Franklin CHT: 32%
- Mangere/Otara CHT: 17%
- Manukau CHT: 29%
Triaged Priorities
Franklin Community Health Team

Franklin Referrals by Triage Category

- 29.14% Routine / Low Risk 6-15 working days
- 19.70% Routine / Medium Risk 2-5 working days
- 51.17% Urgent 2-48 hours
Pukekohe Hospital Outpatient Services

- Antenatal CMDHB
- Audiology - New-born Hearing
- Cancer Support
- Cardiac Rehabilitation Education Class
- Cardiac Risk
- Centre for Youth Health (CFYH)
- Child Development Service
- Community Alcohol and Drugs Service (CADS)
- Community Health Team-District Nurse
- Counsellor- Private
- Dementia Auckland
- Dietitian
- Franklin Acupuncture & Well Being Clinic (FAWC)

- Franklin Parents Centre
- General Medicine
- General Medicine Prep Clinic
- Gynaecology- Maternity
- Contraception Hand Therapy
- Health Psychology for Diabetes/Renal
- Horizon Radiology
- La Leche
- Maternal Mental Health
- Mental Health- Awhinatia
- Mental Health- ILOC
- Mental Health Older Person
- Mental Health- Whirinaki / Whirinaki Te Rito
- Midwifes Private
Pukekohe Hospital Outpatient Services

- Mobile Bus- Recovery Rooms
- Occupational Therapist
- Older Person - Parkinson
- Older Person- General Medicine Clinic
- Ophthalmology- Diabetes
- Oxygen Therapy Paediatric Dietitian
- Paediatric Diabetes
- Paediatric- Kids First (Various Clinics)
- Pain Clinic- Chronic Pain
- Pharmacist
- Physiotherapy- General
- Physiotherapy- Woman's Health
- Psychologist- Private
- Public Health Nurse- HVT Immunisation Clinic
- Public Health Nurse General Clinic
- Public Health Nurse-Hearing and Vision Clinic
- Renal
- Respiratory
- Rheumatology
- Social Work
- Speech Language Therapy
- Staff Training/ Staff Meeting
- Stoma Nurse
- Youth Diabetes Clinic
- Paediatric General Medicine
- Wheelchair Services (ADHB)
Any Questions
CPHAC Special Meeting
Asian Health
16 October 2018
Although Asian populations appear to have good health outcomes on the surface...

1. What does it mean to be Asian?
2. Why focus on Asian health?
3. Why intervene now?
4. How to intervene? Engaging with communities
CMDHB’s definition of Asian is broad...

They have been in NZ for differing periods of time and have varying healthcare needs.
Although Asian populations appear to have good health outcomes on the surface...

Life expectancy at birth

Data source: Mortality Collection, Ministry of Health; Estimated populations by DHB (2015 version), Statistics New Zealand
...subgroups of Asian population have pressing health needs for which we need data to be reported.

Age-adjusted incidence rate of nasopharyngeal cancer in selected Asian countries, 1988–1992

There is opportunity for CMDHB to invest now to prepare for population growth...

CMDHB already has the highest proportion of Asians in our catchment population of Auckland DHBs

This proportion is projected to continue to grow

Statistics NZ ethnic projections for Auckland region 2017
Some Asian communities are still reluctant to engage with government, this is a reflection of the stage of their integration journey…

Model of local citizen inclusion and government engagement\(^1\) over time

![Model of local citizen inclusion and government engagement](image)

Opportunity to engage with the community today...

+ What can we do to get better visibility of key issues?
+ What areas can we look at for the greatest impact?
+ How can we plan for the future?
+ How can we engage in a sustainable way?
Hello, Kia Ora, Talofa Lava, Namaste, Nǐ hǎo, Pagbati, An-young-ha-se-yo, Jom reab suar, Xin Chao

Asian Health Overview

Kitty Ko
Asian Health Gain Advisor
Directorate of Population Health
Asian population in Counties Manukau & Who are Asian people?

Are vibrant and diverse

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Born overseas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16%</td>
<td>21%</td>
<td>25%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Counties Manukau is home to

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of Māori</th>
<th>% of Pacific</th>
<th>% of Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12%</td>
<td>37%</td>
<td>20%</td>
</tr>
</tbody>
</table>

By 2025

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>European/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17%</td>
<td>21%</td>
<td>28%</td>
<td>34%</td>
</tr>
</tbody>
</table>

The New Zealand health and disability sector classifies ethnicity data according to the Ministry of Health protocols. The term ‘Asian’ used in the New Zealand Census and related data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the USA.
Which are the largest Asian ethnic subgroups?

The largest Asian ethnic subgroups in Counties Manukau, based on Census 2013 total response ethnicity, consist of Indian and Chinese people. Indian people comprise almost half (47 percent) and Chinese a third (34 percent) of the total Counties Manukau Asian population (refer to Figure 2).

Figure 2: Distribution of Asian peoples living in Counties Manukau

- Indian: 46.5%
- Chinese: 34.0%
- Filipino: 5.5%
- Korean: 3.4%
- Cambodian: 2.5%
- Sri Lankan: 1.3%
- Thai: 1.0%
- Japanese: 0.9%
- Other Asian: 6.1%
Where do Asian people live?

Figure 3: Distribution of Asian ethnic groups living in Counties Manukau by geographic Locality in 2013

Indian communities are the largest in Papatoetoe, Ormiston and surrounding suburbs and Mangere South. Our Eastern Locality is home to the largest Asian population (estimated at 48,660 based on health service utilisation population in 2013) per local board or territorial authority in New Zealand. Chinese communities live more commonly in the Eastern suburbs such as Ormiston, Millhouse, Meadowland, Highland Park and Murvale. From a health service point of view, how these groups engage with health services will make a significant difference to population health overall.
Health issues among Asian population & Barriers to health services

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

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

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

**Note** that this Q4 Summary Report was approved by ELT on 11 September 2018.

**Note** the results for Q4 progress against planned 2017/18 actions and performance expectations.

**Review** the identified issues and associated actions.

**Note** the appended Northern Region Health Plan Quarter 4 summary report provided by the Northern Regional Alliance (Appendix 1).

Prepared and submitted by Alanna Soupen, Planning and Reporting Advisor on behalf of Margie Apa, Chief Executive Officer

Glossary

B4SC  B4 School Check  
CT  Computed Tomography  
CVDR A Cardiovascular Risk Assessment  
DMFT  Decayed, Missing and Filled Teeth (index)  
ED  Emergency Department  
FCT  Faster Cancer Treatment  
MRI  Magnetic Resonance Imaging  
NCHIP  National Child Health Information Platform  
NIR  National Immunisation Register  
OIS  Outreach Immunisation Service  
PHO  Primary Health Organisation  
Q  Quarter (3 month period)  
WCTO  Well Child Tamariki Ora

Purpose

To provide a summary picture of how we are progressing against our planned commitments outlined in the 2017/18 CM Health Annual Plan.

Significant Achievements

Overall, we have performed well in meeting our commitments outlined in our 2017/18 Annual Plan for Q4. In summary:

- **Better Help for Smokers to Quit targets achieved for all ethnic groups:** The brief advice and support for smokers to quit primary care 90% target was achieved for our Maaori, Pacific and Asian patients. We also provided 94% of Maaori pregnant women who identify as smokers advice and support to quit smoking, contributing toward a better start in life for pepe Maaori.

- **Raising Healthy Kids target achieved for all ethnic groups:** 100% of our Maaori, Pacific and Asian tamariki identified as obese during the Before School Check were offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

- **Electives target achieved for 2017/18:** There were 20,841 elective surgical discharges over 2017/18, slightly exceeding the target of 20,535. Approaches to achieve this target included additional volumes...
outsourced to private providers, increased anaesthetist availability, ongoing efforts to recover electives volumes and good performance in May due to fewer staff on leave.

Key Issues
Not all targets have been met due to differing factors:

- **Immunisation Health Target** – the Immunisation at 8 Month Health Target has not been met with a Q4 result of 93% for the total population. Māori coverage has dropped to from 89% in Quarter 1 to 84% in Quarter 4. Quarter 4 has been a period of focused collaboration between the National Immunisation Register (NIR) team, Outreach Immunisation Services (OIS) and the general practice teams to reach the immunisation target of 95%. A new outreach service was introduced in the last month of Q4, with home visits on a Saturday to connect with families who we are not reaching through the current OIS service. Māori and Pacific families are prioritised and this is working well for some families. In 2018/19 CM Health will continue to build on this work to proactively improve Māori immunisation coverage, including through facilitating early enrolment of pepe in primary care and extension of the outreach immunisation service to weekends and home visits. CM Health is also planning to pilot a contract with the Māori Women’s Welfare League (MWWL) to work alongside OIS (funding dependent) to support Māori engagement.

- **Emergency Department (ED) 6 hour Health Target** – the ED health target was not met in Q4 (March – June 2018) due to patient volume and bed demand, with performance at 91% (target 95%). This is due to a variety of factors, including high consistent surge presentation rates and consistent high hospital occupancy. As reported in previous quarters, a range of initiatives are underway or planned for 2018/19 to address underlying system challenges and manage demand including: preparation of a business case to establish additional bed capacity in winter, increasing acute inpatient beds to ensure short stay beds are used appropriately and revisiting ED capacity and hospital wide response for overcrowding, surge and acuity.

- **Breast and cervical screening targets for Māori and Asian women**: In Q4 CM Health did not meet the 70% breast screening target for Māori women and did not meet the 80% cervical screening target for any ethnic group, with performance lowest for Māori and Asian women. Several initiatives are underway to improve cancer screening performance, including offering late night and weekend breast screening clinics and an increase in the number of Support to Screening community clinics.

### CM Health 2017/18 Quarter 4 Health Target Snapshot

<table>
<thead>
<tr>
<th>Counties Manukau Health</th>
<th>Shorter stays in Emergency Departments</th>
<th>Improved access to Elective Surgery</th>
<th>Shorter wait for Cancer Treatment</th>
<th>Increased Immunisation</th>
<th>Better help for Smokers to Quit Primary</th>
<th>Better help for Smokers to Quit Maternity</th>
<th>Raising Healthy Kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1, 2017/18</td>
<td>88%</td>
<td>99.6%</td>
<td>94%</td>
<td>94%</td>
<td>90%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2, 2017/18</td>
<td>90%</td>
<td>92.9%</td>
<td>94%</td>
<td>93%</td>
<td>89%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 3, 2017/18</td>
<td>90%</td>
<td>98.7%</td>
<td>95%</td>
<td>93%</td>
<td>90%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4, 2017/18</td>
<td>91%</td>
<td>101.5%</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>92%</td>
<td>100%</td>
</tr>
<tr>
<td>Achieved</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>National target</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>95%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Appendices
1. CM Health 2017/18 Quarter 4 Non-Financial Summary Progress Report
2. Northern Regional Health Plan Quarter 4 Summary Report (detailed report available on request)
## Dashboard Key
- **Yellow** = Outstanding
- **Green** = Target Achieved
- **Orange** = Partially Achieved
- **Red** = Not Achieved

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Māori Pacific Other Asian</td>
<td></td>
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<tr>
<td><strong>National Health Targets</strong></td>
<td></td>
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<tr>
<td>Cancer</td>
<td>Percentage of patients receiving their first cancer treatment (or other management within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks)</td>
<td>Quarterly</td>
<td>90%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Elective Surgery</td>
<td>Volume of elective surgery will increase by at least 4000 discharges per year</td>
<td>Quarterly</td>
<td>Increase of 4,000 discharges per year – targeted number 20,535</td>
<td>101.5% (20,841 discharges)</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Care</td>
<td>Percentage of patients admitted, discharged, or transferred from an ED within six hours</td>
<td>Quarterly</td>
<td>95%</td>
<td>91%</td>
<td>The ED health target was not met in Q4 (April – June 2018). Patient volume and bed demand mean the hospital has been unable to reach the six hour target, in Quarter 4. This is due to a variety of factors, including high consistent surge presentation rates and consistent high hospital occupancy. Steps we are taking to improve our performance include preparation of a business case to establish additional bed capacity in winter. Work planned to support achievement of the target next quarter includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Awaiting decision to increase staffing to ensure safe staffing of critical areas and “TBS” times can be met.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Increase acute inpatient beds to ensure short stay beds are used appropriately with a model of care review in acute medicine.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Review of medical assessment unit function and implementation of findings.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Revisiting ED capacity and hospital wide response for overcrowding, surge and acuity.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Police strategy with mental health to ensure appropriate 109 presentations to ED.</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Performance – 2017/18 Quarter 3</td>
<td>Commentary / Interpretation</td>
</tr>
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<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td>Percentage of eight months olds who have had their primary course of immunisation on time</td>
<td>Quarterly</td>
<td>95%</td>
<td>Total: 93%, Maori: 84%, Pacific: 94%, Other: 93%, Asian: 98%</td>
<td>Total coverage for this target is the same as for Q3 (93%). The definition of the eight month immunisation health target requires that 95% of all eligible children aged eight months are immunised and that significant progress for the Maori population group. The coverage target was not met for Maori (84%) and is lower than the Q3 result (86%). In Quarter 4 147 more babies needed to be immunised to meet the target. Maori coverage has decreased by 2% from Q3, with 67 babies having missed the target age for immunisation (51 babies remain unimmunised as 16 babies were immunised late). Quarter 4 has been a period of focused collaboration between the NIR team, Outreach Immunisation Services (OIS) and the general practice teams to reach the immunisation target of 95%. Achieving equity for Maori at 8 months, 24 months and 5 years milestone ages is still a work in progress. A new outreach service was introduced in the last month of Quarter 4, with home visits on a Saturday to connect with families who we are not reaching through the current OIS service. Maori and Pacific families are prioritised and this is working well for some families.</td>
</tr>
<tr>
<td>Smoking (primary)</td>
<td>Percentage of enrolled patients who smoke and are seen by a health practitioner in general practice and were offered brief advice and support to quit smoking</td>
<td>Quarterly</td>
<td>90%</td>
<td>Total: 92%, Maori: 91%, Pacific: 92%, Other: 93%, Asian: 92%</td>
<td>We are pleased to note that the target has been met for our Maori, Pacific and total patient populations. This is a significant achievement in support of our Healthy Together equity goal.</td>
</tr>
<tr>
<td>Smoking (maternity)</td>
<td>Percentage of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice and support to quit smoking</td>
<td>Quarterly</td>
<td>90%</td>
<td>Total: 92%, Maori: 94%</td>
<td>In Quarter 4 CM Health achieved the Maternity smokefree target for pregnant Maori women (94%) and pregnant women in total (91%). The target was achieved for all quarters in 2017/18, reflecting the success of our Smokefree pregnancy incentives programme, health professional training in Smokefree best practice and networking activities of our Smokefree Advisor – maternity and health promoter.</td>
</tr>
<tr>
<td>Raising healthy kids</td>
<td>Percentage of obese children identified in the Before School Check (B4 School Check) programme who will be referred to a health professional for a clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017</td>
<td>Quarterly</td>
<td>95%</td>
<td>Total: 100%, Maori: 100%, Pacific: 100%, Other: 100%</td>
<td>We have achieved the health target and have the systems in place to maintain achievement of the target going forward. We continue to closely monitor the decline rate and have strategies in place to support a reduction in declines. The overall rate of referrals being declined rate in Counties Manukau this quarter is down slightly to 27% (national average is 22%), the decline rate for Maori is 30% (national average 23%) and for</td>
</tr>
</tbody>
</table>
### Policy priorities

**PP7: Improving mental health services using transition (discharge) planning and employment – overall rating from the Ministry of Health across discharged clients and audited files**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% of clients discharged will have a quality transition or wellness plan</td>
<td>Quarterly</td>
<td>95%</td>
<td>Provider arm: 99%</td>
<td>Pacific 23% (national average 17%). We will need to examine the factors surrounding the Māori and Pacific decline rate and reconsider our approaches/efforts to address this. Evaluation around Child Healthy Weight Activities under the RHK target has begun in Q4 and includes a short survey of whānau who attend a B4SC.</td>
</tr>
<tr>
<td>95% of audited files meet accepted good practice</td>
<td>Quarterly</td>
<td>N/A</td>
<td>Provider arm: 45% (20 files audited)</td>
<td>NGOs: 30% (20 files audited)</td>
</tr>
</tbody>
</table>

**PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds – overall rating from the Ministry of Health across provider and NGO arms**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td>
<td>Quarterly</td>
<td>80%</td>
<td>71%</td>
<td>Though the 0-19 age group (71.2%) is below target, it is higher than the national percentage (69.4%). Also, it is worthy of note that the corresponding percentage for the 12-19 age group is above the target at 83.6%. Further, the number of unique CMDHB domiciled clients aged 0-19 seen during the year ended 31 March 2018 was 6664, an increase from the 6335 unique clients seen in the corresponding period last year. This</td>
</tr>
<tr>
<td>PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td>
<td>Quarterly</td>
<td>95%</td>
<td>95%</td>
<td>N/A</td>
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<tr>
<th>Priority</th>
<th>Indicator</th>
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<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
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<td>Current Target</td>
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<td>Māori</td>
<td>Pacific</td>
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<td></td>
<td>Total</td>
<td>Māori</td>
<td>Pacific</td>
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Counts: 057
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<tr>
<td>PP8:</td>
<td>Shorter</td>
<td>Quarterly</td>
<td>80%</td>
<td>97%</td>
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<tr>
<td></td>
<td>waits for non-urgent mental health and addiction services for 0-19 year olds</td>
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<td></td>
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<tr>
<td></td>
<td>Addiction (NGOs)</td>
<td>&lt;3 weeks</td>
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<td></td>
<td></td>
<td>&lt;8 weeks</td>
<td>95%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Oral Health</td>
<td>PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years</td>
<td></td>
<td>85%</td>
<td></td>
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</tr>
<tr>
<td>Long Term</td>
<td>PP20:</td>
<td>Quarterly</td>
<td>90%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular (CVD) health (CVD Risk Assessment – previous health target)</td>
<td>Total eligible population</td>
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<td></td>
<td>Total eligible population</td>
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<tr>
<td></td>
<td>Eligible Maaori men aged 35-44 years</td>
<td>Quarterly</td>
<td>90%</td>
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Counts Manukau District Health Board – Community & Public Health Advisory Committee 7 November 2018

058
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<thead>
<tr>
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<td>Total</td>
<td>Maaori</td>
</tr>
<tr>
<td>PP20: Living Well With Diabetes – Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c &lt; 64mmol/mol)</td>
<td>Metro Auckland Primary Care Data – HealthSafe Database</td>
<td>Six-monthly</td>
<td>69%</td>
<td>55%</td>
<td>49%</td>
</tr>
<tr>
<td>PP20</td>
<td>Acute Coronary Syndrome - Percentage of high-risk patients who receive an angiogram within 3 days of admission (‘day of admission’ being ‘Day 0’)</td>
<td>Quarterly</td>
<td>70%</td>
<td>81%</td>
<td>77%</td>
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</tbody>
</table>

measures for metro Auckland.
• 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.
<table>
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</table>
| PP20     | Acute Coronary Syndrome - Percentage of patients presenting with ACS who  | Quarterly              | 95%            | Total: 96% | Maori: 94% | Pacific: 86% | Other: 98% | Asian: 99% | The 95% immunisation target was not met for the two-year old age group in Quarter 4. Total coverage remains consistent for Quarter 4 at 93%. Māori coverage has decreased by 1% and is now at 87% which equates to 57 toddlers missing the milestone age immunisation. 9 were immunised late through the OIS and 3 with their family doctor resulting in 48 Māori toddlers requiring further follow up with general practice. Outreach Immunisation services received 298 referrals for quarter 4:  
• Māori pepe-111  
• Pacific pepe-108  
• Other-79 |
|          | undergo coronary angiography who have completion of ANZACS Q1 ACS and Cath/PCI registry data collection within 30 days |                        |                |                                 |                            |
| PP20: Stroke – overall Ministry of Health rating |                                                                      |                        |                |                                 |                            |
| PP20: Stroke - Percentage of potentially eligible stroke patients thrombolysed (result reported one quarter in arrears – Q3 result presented) | Quarterly              | 8%               | 16%            |                                 |                            |
| PP20: Stroke - Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway (result reported one quarter in arrears – Q2 result presented) | Quarterly              | 80%              | 89%            |                                 |                            |
| PP20: Stroke – Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report % of acute stroke patients transferred to inpatient rehab) (result reported one quarter in arrears – Q3 result presented) | Quarterly              | 80%              | 65%            |                                 |                            |
| Immunisation | PP21: Percentage of two-year olds who are fully immunised | Quarterly              | 95%            | 93% | 87% | 94% | 93% | 98% | The 95% immunisation target was not met for the two-year old age group in Quarter 4. Total coverage remains consistent for Quarter 4 at 93%. Māori coverage has decreased by 1% and is now at 87% which equates to 57 toddlers missing the milestone age immunisation. 9 were immunised late through the OIS and 3 with their family doctor resulting in 48 Māori toddlers requiring further follow up with general practice. Outreach Immunisation services received 298 referrals for quarter 4:  
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• Pacific pepe-108  
• Other-79 |
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| PP21:   | Percentage of five-year olds who are fully immunised | Quarterly | 95% | 90% | 85% | 92% | 90% | 94% | From the 298 referrals the outcomes were as follows:  
- Immunisations achieved 169  
- Moved Overseas or out of area 39  
- No response to contact 58  
- Declined OIS 19  
- Declined Immunisations 13  
All families were contacted either directly or through extended family if they were not available. Some went on to visit their family doctor and some have not engaged a health provider as yet.  
Barriers to achieving the 2-year target included:  
- The hesitation around four injections seems to have settled and is been well received by families and the nursing teams  
- Toddlers been unwell and families not wanting to vaccinate during that time has been a factor this quarter  
- Parents wanting to be present at the vaccination but having work commitments has led to more referrals being sent to the Saturday clinic and general practice however parents are not always following through with these appointments.  
Initiatives to improve performance:  
- The Saturday home visiting trial also covers this age group as well as having vaccinators at the Saturday B4School clinic, which provides other venues to access immunisations for families.  
The 5-year immunization target was not met in Quarter 4 with the total decreasing by 1%.  
We have missed 67 Maaori pre-schoolers of which 10 have immunised late, after the milestone age target date. The pre-schoolers that have missed this immunisation will be supported on school entry by the New Entrant Catch-up program by the Counties Public Health School team. The Outreach Immunisation team is engaging this group earlier than at five years old by linking in the OIS team when home visiting the Quintile 5 pre-schoolers for their B4School checks.  
Equity for Maaori has not been achieved and is work in progress, as we are engaging families, informing them about available opportunities to access health care according to their needs and as yet for some this has
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<td>Total</td>
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<td><strong>75%</strong></td>
<td><strong>71%</strong></td>
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<td><strong>75%</strong></td>
<td><strong>71%</strong></td>
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<td><strong>Māori</strong></td>
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<td><strong>Māori</strong></td>
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<td><strong>Total</strong></td>
<td><strong>Māori</strong></td>
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Letters did go out to all parents of children that missed the completion of the programme to attend their GP with a letter also going to their GP to recall them.

- We have had a further increase on children receiving their first dose of HPV opportunistically at the GP when they went for the Boostrix immunisation, then receiving a further one at the school based programme which has led to an increase in resource and workload, and with the student then requiring a third dose because they have not a six month gap between the first and second dose.

### System integration

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<tr>
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<tbody>
<tr>
<td></td>
<td>PP22: Improving system integration</td>
<td>Quarterly</td>
<td></td>
<td>Total Maori Pacific Other Asian</td>
<td></td>
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<tr>
<td></td>
<td>PP22: SLMs</td>
<td>Quarterly</td>
<td></td>
<td>Total Maori Pacific Other Asian</td>
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### Health of Older People

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<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
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<th>Current Target</th>
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<tbody>
<tr>
<td></td>
<td>PP23: Implementing the Healthy Ageing Strategy</td>
<td>Quarterly</td>
<td></td>
<td>Total Maori Pacific Other Asian</td>
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### Mental Health

- PP25: Prime Minister’s Youth Mental Health Project
- PP26: The Mental Health and Addiction Service Development Plan

### Child Health

- PP27: Supporting vulnerable children

### Rheumatic Fever

<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
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<tbody>
<tr>
<td></td>
<td>PP28: Reducing rheumatic fever</td>
<td>Quarterly</td>
<td>4.5 per 100,000 (Total)</td>
<td>Data not yet available</td>
<td></td>
</tr>
</tbody>
</table>

The official number of incident cases for ARF in CM Health for the calendar year 2017 was 55. This gives a rate of 10.1/100,000 for Counties Manukau Health.

We are waiting for an update from the MoH for the official numbers for the 2017_2018 financial year. From the information we have available from local sources and Auckland regional public health service (ARPHS) the numbers of RF cases are higher than they were for the same time last year with 21 cases for the three months Jan-March 2018 compared to 12 cases for the same period in the previous year.

Key activities in Quarter 4 included:

**Stakeholder management:**
- The key engagement forum with local stakeholders continues to be the Child Health Alliance Forum. Meetings include updates from organisations involved with AWHI, secondary
### Priority

### Indicator

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<td>Total</td>
<td>Maaori</td>
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#### Improving waiting times for diagnostic services

- **PP29a: Coronary angiography – within 3 months (90 days)**
  - Monthly
  - Current Target: 95%
  - Performance: 100%
  - We have been experiencing ongoing capacity challenges that have affected our performance in 2017/18:
    - The MRI unit that will open this year was planned and anticipated for implementation in 2017, the delay in getting the third scanner into use has created an impact on our ability to increase the number of scans we do.
    - Increased demand- we have had a 28% increase in volumes over the last 3 years.

- **PP29b: CT –within than 6 weeks (42 days)**
  - Monthly
  - Current Target: 95%
  - Performance: 90%

- **PP29c: MRI – within 6 weeks (42 days)**
  - Monthly
  - Current Target: 85%
  - Performance: 35%

- **Sore throat management:**
  - A letter was sent to all PHOs Clinical directors to provide them with an update of rheumatic fever activities and remind them of the importance of following the sore throat guidelines this quarter. This letter also provided information about how PHOs could claim, on behalf of their practices, for throat swabs for family members of an index case with Group A strep positive sore throat.
  - There continues to be contact with PHOs and GPs as a result of the case review process when particular issues are identified which provides an opportunity for raising the profile of sore throat management.

- **Awareness raising:**
  - For Mana Kidz each provider is required to undertake school specific health promotion activities each school term.
  - AWHI providers attended the Hikoi Bilingual Walk Event on April 14th, 2018 in Manurewa, the Matariki Community Day in Manurewa and the Pacific Lawyers Association Community Support Expo on Saturday 19th May 2018 at the Otara Recreation Centre.
  - Activities from the ‘Awareness raising activities for sore throat management in CMH across primary care and school programmes, 2018’ are underway and we will report progress in the next report.
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<td>Total</td>
<td>Māori</td>
<td>Pacific</td>
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<tr>
<td>PP29d:</td>
<td>Urgent diagnostic colonoscopy – within two weeks (14 days)</td>
<td>Monthly</td>
<td>75%</td>
<td>95%</td>
<td></td>
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<tr>
<td>PP29e:</td>
<td>Diagnostic colonoscopy – within six weeks (42 days)</td>
<td>Monthly</td>
<td>65%</td>
<td>72%</td>
<td></td>
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<tr>
<td>PP29f:</td>
<td>Surveillance colonoscopy - within twelve weeks (84 days) beyond the planned date</td>
<td>Monthly</td>
<td>65%</td>
<td>70%</td>
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<tr>
<td>Faster Cancer Treatment</td>
<td>PP30: FCT - Length of time taken for patients to receive their first treatment (or other management) for cancer from date to decision-to-treat (31 day indicator)</td>
<td>Quarterly</td>
<td>85%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Better help for smokers to quit (previous health target)</td>
<td>PP31: Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking</td>
<td>Quarterly</td>
<td>95%</td>
<td>96% 95% 95% 93%</td>
<td>We estimate that 92.2% of the district’s Māori population are enrolled with primary care (above the 90% target). We continue to work with stakeholders to ensure that general practices are linked in with Whanau Ora and other providers to encourage whaanau to enrol with a PHO. We are working on improving engagement between these providers and will be holding a hui in the next quarter. PHOs continue to work with practice teams to ensure practice and reception staff are aware of the benefits of enrolment with a PHO and are highlighting the benefits along with patient choice of provider to patients who attend for casual visits. We have a number of activities in this area planned for the coming year under the Metro Auckland Regional System Level Measures Improvement Plan, which was developed with tangata whenua and local Māori health providers.</td>
</tr>
<tr>
<td>Quality of ethnicity data collection</td>
<td>PP32: Improving the quality of ethnicity data collection (EDAT)</td>
<td>Six monthly</td>
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<tr>
<td>Improving Māori enrolment in PHOs</td>
<td>PP33: Percentage of Māori enrolled in PHOs</td>
<td>Six monthly</td>
<td>90%</td>
<td>92%</td>
<td>We estimate that 92.2% of the district’s Māori population are enrolled with primary care (above the 90% target). We continue to work with stakeholders to ensure that general practices are linked in with Whanau Ora and other providers to encourage whaanau to enrol with a PHO. We are working on improving engagement between these providers and will be holding a hui in the next quarter. PHOs continue to work with practice teams to ensure practice and reception staff are aware of the benefits of enrolment with a PHO and are highlighting the benefits along with patient choice of provider to patients who attend for casual visits. We have a number of activities in this area planned for the coming year under the Metro Auckland Regional System Level Measures Improvement Plan, which was developed with tangata whenua and local Māori health providers.</td>
</tr>
<tr>
<td>Community Treatment Orders (CTOs)</td>
<td>PP36: Rate of Māori under the Mental Health Act: section 29 community treatment orders per 100,000</td>
<td>Quarterly</td>
<td></td>
<td>96/100,000 395/10,000</td>
<td>During 2017-2018 there has been a small increase (12) in the number of Māori under section 29 of the Mental Health Act. The rate of Māori on a CTO rose from 381 to 395 per 100,000 of the Māori population over the 12 months, while the rate of Non-Māori under section 29 remains steady at 96 per 100,000 non-Māori population. The Māori Mental Health team is being reconfigured into a district-wide kaupapa Māori team to provide clinical and cultural care and treatment across the Counties.</td>
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<tr>
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<tr>
<td>Delivery of Government Planning Priorities</td>
<td>PP38: Delivery of response actions and milestones agreed in the annual plan for each Government planning priority</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td>Manukau Māori population. The new team will be responsible for developing the kaupapa Māori integrated model of care. It is envisaged that the kaupapa Māori integrated model of care will continually improve and drive sustainable long-term solutions for the actions that Mental Health and Addictions are committed to completing as part of the Māori Health Plan.</td>
</tr>
<tr>
<td>Ambulatory sensitive hospitalisations</td>
<td>S11: Ambulatory Sensitive Hospitalisations (ASH) – overall Ministry of Health rating</td>
<td></td>
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<td>Staff EOIs were completed in Q4 and will be finalised by the end of July 2018; after which the new reconfigured Māori Mental Health team will relocate to the Awhinatia site in Papakura. Members of the existing Māori Mental Health team, including the new Clinical Lead – Māori Mental Health have been integrally involved in the concept design for the refit of the Awhinatia Community Mental Health Centre to ensure the premises are welcoming and conducive to a kaupapa Māori centre of cultural excellence. It is envisaged that when the reconfigured Māori Mental Health team works in the community with Primary Care, including on the Marae, utilising the kaupapa Māori integrated model of care, the rate of Māori requiring a CTO will be lowered through culturally appropriate earlier interventions.</td>
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<tr>
<td></td>
<td>S11: Ambulatory Sensitive Hospitalisations (ASH) – results by ethnicity</td>
<td>Six monthly</td>
<td>0-4 years: rate per 100,000 population</td>
<td>Manukau 7,094 6,819 11,873 4,555 Included in Other</td>
<td>While the 0-4 year old ASH rate for Māori and Pacific children in Counties Manukau has been declining since March 2015 there are still persistent inequities when compared to the 0-4 ASH rate for Europeans/Others. As at March 2018, the 0-4 ASH rate for Pacific children in Counties Manukau continues to be the highest across all ethnic groups, while the Māori ASH rate is still higher than the ASH rate for Europeans/Others. The 2017/18 Metro Auckland System Level Measures Improvement (SLM) Plan set a target of reducing the 0-4 year old total, Māori and Pacific ASH rates by 5% by June 2018. March 2018 results indicate CM Health will not have achieved this target for our Māori and Pacific children or overall, once June 2018 results are released. The 2018/19 SLM Plan will target reduced ASH rates through focusing on respiratory admissions, the largest contributor to 0-4 ASH rates across the three Auckland DHBs. Through both local and regional work, CM Health</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Performance – 2017/18 Quarter 3</td>
<td>Commentary / Interpretation</td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>Maaori</td>
</tr>
<tr>
<td>Ensuring service coverage</td>
<td>S13: Ensuring Service Coverage</td>
<td>Six monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard intervention rates</td>
<td>S14: Standardised intervention rates (SIRs) per 100,000 – overall Ministry of Health rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S14: Standardised intervention rates (SIRs) per 100,000</td>
<td>Angiography</td>
<td>Quarterly</td>
<td>34.70</td>
<td>28.08</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Angioplasty</td>
<td></td>
<td>12.50</td>
<td>12.29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiac Surgery</td>
<td></td>
<td>6.50</td>
<td>5.67</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major Joints</td>
<td></td>
<td>21.00</td>
<td>22.12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cataracts</td>
<td></td>
<td>27.00</td>
<td>38.01</td>
<td></td>
</tr>
<tr>
<td>Whaanau Ora</td>
<td>S15: Delivery of Whaanau Ora</td>
<td>Six monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>S110: Improved cervical screening coverage – overall Ministry of Health rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S110: Improved cervical screening coverage – results by ethnicity</td>
<td>Six monthly</td>
<td></td>
<td>80%</td>
<td>71%</td>
<td>66%</td>
</tr>
</tbody>
</table>
## Priority

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>Maaori</td>
</tr>
<tr>
<td>SI11: Improved breast screening rates – overall Ministry of Health rating</td>
<td>Six monthly</td>
<td>70%</td>
<td>71%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Note: DHBs asked to report to the Ministry of Health one quarter in arrears. The Quarter 4 rating and report is therefore based on Quarter 3 data.

The target was achieved in total and for Pacific and Other women. Eighty percent of eligible Pacific women in Counties Manukau were screened for breast cancer, exceeding the national target of 70%. CM Health met or exceeded this target for Pacific women in all quarters.

The target was not met for Maaori women. BreastScreen Counties Manukau (BSCM) has experienced a shortage of Medical Radiation Technologists which has impacted on screening volumes and coverage levels. The service is now fully staffed and the increased capacity has seen an increase in coverage. Specific strategies to increase Maaori coverage include:

0.7% since December 2017. This is in context of the National Cervical Screening Programme completing their annual data adjustment, following provision of updated population projections from Statistics New Zealand. In addition, this year the denominator was also updated with the recently reviewed hysterectomy adjustor. This resulted in CMDHB seeing an increase in Maaori coverage of 0.8%

The Support to Screening service is now providing increased community clinics in 2018, including in Otara and Mangere to ensure Maaori women can access opportunistic screening. Further engagement and training will occur with Maaori contracted providers who support the Whanau Ora approach. A second smear taker nurse has now been recruited to increase community opportunistic screening opportunities.

The coverage rate for Asian women has declined by 1.8%. This is largely due to the National Cervical Screening Programme data adjustment as detailed above, which resulted in a 1.6% drop in Asian screening rates. Additionally while the percentage coverage has decreased, CMDHB has seen an increase in the number of Asian women screened in this reporting period (577 additional women).

The Asian Community Health worker continues to invite and recall Asian women and community screening clinics have been held in the Eastern Locality to support Asian women to access funded screening. The clinics have been coordinated in collaboration with East Health PHO and have been well received by the community.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>Maori</td>
</tr>
</tbody>
</table>
| Inpatient length of stay | OS3: Inpatient length of stay | Elective LOS | Quarterly | 1.47 days | 1.66 days | A number of factors have combined to affect the level of 17/18 elective and acute ALOS at CMH. These include:  
CM Health continues to experience high acute volumes causing delays in getting to surgery, this is prolonging LOS  
Although large frequent spikes in acute volumes have flattened out, acute volumes still remain high and impact on electives. The cancellation of elective theatre lists to accommodate acutes adds time to pre op and overall LOS for elective cases  
Increase in long complex cases has impacted on both acute and elective capacity and extended LOS. This is due to the acuity and comorbidities of the patients.  
Increased complexity and comorbidities of all patients in both medicine and surgery has contributed to increased LOS.  
A shortage of anaesthetists is still impacting on both elective and acute LOS due to short notice cancellations.  
Actions to address:  
Outsourcing elective cases to private. (However because these cases are often the less complex cases, this can impact on the LOS of the patients operated in house).  
We have established a Theatre Operations Group (TOG) to improve management of theatre operations. |
<table>
<thead>
<tr>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2017/18 Quarter 3</th>
<th>Commentary / Interpretation</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Total</td>
<td>Maaori</td>
</tr>
<tr>
<td>Data Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OS10: Focus area 1 - NHI</td>
<td></td>
<td>Quarterly</td>
<td></td>
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<tr>
<td>OS10: Focus area 2 – National Collections</td>
<td></td>
<td>Quarterly</td>
<td></td>
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<tr>
<td>OS10: Focus area 3 - PRIMHD</td>
<td></td>
<td>Quarterly</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mental Health</td>
<td>OP1: Mental health output delivery against plan</td>
<td>Quarterly</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patient Experience</td>
<td>DV4: Improving patient experience - Proportion of patients who have rated CMH overall experience of care and treatment as ‘Very Good’ or ‘Excellent’</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>B4 School Check Funding</td>
<td>Quarterly</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CFA</td>
<td>Disability Support Service Funding Increase</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>Well Child Tamariki Ora Services</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>Appoint Cancer Nurse Coordinators</td>
<td>Six-monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>Appoint cancer psychological and social support workers</td>
<td>Six-monthly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>Electives Initiative and Ambulatory Initiative Variation</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS</td>
<td>Supporting delivery of the NZ Health Strategy</td>
<td>Quarterly</td>
<td></td>
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</tr>
</tbody>
</table>
1. Summary of Key Achievements

- **Cancer** – The Inaugural Northern Region Integrated Cancer Service Programme Board meeting held and implementation of Cancer Deep Dive recommendations, particularly in regard to Head and Neck Cancer in progress. The Region achieved the FCT targets and the breast and cervical cancer screening data was provided by ethnicity.

- **CVD** - The region has exceeded the 3 day ACS target, with all four DHBs exceeding target. Northland DHB showed significant improvement upon the previous quarter, following the Regional Cath Lab review. The network instigated the launch of GoodSAM at DHB level in conjunction with St John Ambulance, along with increasing awareness and access to AEDs.

- **Diabetes** – The Diabetes Network and DSLATs are focusing on the first 12 quality standards of ‘Living well with Diabetes’, while the remaining 8 should be areas of focus for secondary care services. The Network is also focusing on addressing equity issues. The network is supportive of the Health/Peer Coach Model that Counties has adopted as part of Planned Proactive Care. Other DHBs are also adopting a Health Coach approach (ADHB/WDHB Prototyping model).

- **Health of Older People** – The NRA organised and held a One Day Regional Healthy Aging Seminar that was attended by 150 Primary Care Doctors and Nurses. 15 Clinicians presented on a range of topics including Dementia, Māori Dementia, Health Equity, Frailty, Falls Prevention, Delirium, Depression, Stroke and Palliative Care. Attendees received 4.3 Education points from the College of GP’s and evaluations of the day were highly positive.

- **Hepatitis C** – Northland laboratory look back project identified 121 patients that are HCV positive. Letters were sent by Northland Pathlab in collaboration with Manaia PHO to Northland General Practitioners for 76 patients, identifying the patients current workup (Genotype, Fibroscan status) and outlining next steps in the management of their hepatitis C condition.

- **Mental Health & Addictions** – Access to perinatal / maternal mental health services has increased both in terms of numbers accessing the service, but also intensity of contact. Processes have also been put in place to collect data on barriers to discharge from inpatient units across the Acute Adult Inpatient Units and Forensic Services.

- **Stroke** – Stroke services maintained the thrombolysis count at 58 stroke patients. This equates to a thrombolysis rate of 11.6%. The Northern Region continues to exceed the (Top 10) KPI target of “80% patients are admitted to a dedicated stroke bed”.

- **Youth** – The network has engaged with Lance O’Sullivan and opportunity exists to work with his team to better align iMoko programmes with existing programmes and avoid duplication. NDHB is undertaking a significant piece of work on Chlamydia screening which should positively impact the region as a whole.

- **Trauma** – The Q2 interhospital transfer result is 30.8%. The 30-day target to upload data to NZ-MTR measured for Q3; Northland 76%, Waitemata 33%, Auckland 52%, Counties Manukau 9%. The region is on track to get their data uploaded to the NZ-MTR within the next month.

- **Workforce** – The DHBs continue to make good progress in increasing their Māori workforce across their prioritised occupations. There have been increases in the Māori workforce in six of the seven priority occupations this quarter: junior doctors, nurses, midwives, dental therapist, occupational therapists and physiotherapists. The two year pilot ‘AP Medical Laboratory Technician (MLT) Training Programme’ has finished and the final evaluation was positive and endorsed by the Regional Laboratories Joint Advisory Group.

- **Information Systems** – The Information System Strategic Plan V2 draft has been completed and is currently under review. The amendments of the V2 ISSP includes alignment with the MoH Digital Health Strategy, LTIP, the ISSP Regional Roadmap, and includes updates to accommodate the delivery approach and arrangements.

- **Capital & Assets** – The Northern Region Long Term Investment Plan has been endorsed by the Region’s DHB Boards. Work has commenced on progressing initiatives identified as part of the NRLTIP Portfolio of work. The region presented a funding request based on the analysis conducted as part of the NRLTIP to the Capital Investment Committee in June.

- **Electives** – During Q4 the region has continued to focus on meeting its ESP and service volume targets. Key recommendations from the ‘Northern Region Long Term Investment Plan: Electives Deep Dive’ are informing implementation of future regional elective services.
### NZ Health Strategy – Regional highlights for the quarter

<table>
<thead>
<tr>
<th>People powered</th>
<th>A hepatitis champion role has been established within the Auckland Opioid Substitution service to liaise with clients and key workers as a first point of contact in the absence of the CNS led clinic service, providing greater visibility, support and awareness amongst patients and staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closer to home</td>
<td>The Northern Region Neonatal Units have developed the Vision and Principles for a Northern Region System Improvement Action Plan. A focus is to ensure mothers and babies remain in the northern region.</td>
</tr>
<tr>
<td>Value and high performance</td>
<td>The NRA developed Dementia E-Learning Education hosted on Goodfellow Learning was accessed by 124 users during Q3 Jan to Mar including 21 Doctors, 76 Nurses and 27 other health professionals</td>
</tr>
<tr>
<td>One team</td>
<td>The Northern Region is working with other regions and the ambulance services by supporting the launch of the Good Sam ap as part of the process for increasing access and equity to CPR within the community</td>
</tr>
<tr>
<td></td>
<td>Close collaboration between the DHBs and central stakeholders resulted in a coordinated regional CIC funding request</td>
</tr>
<tr>
<td>Smart system</td>
<td>The National Child Health Information Platform (NCHIP) project aims to ensure that every child is enrolled at birth and that their access to the range of 28 universal health services is tracked and supported through their early childhood years, aligned with the goal of ‘Knowing Every Child’.</td>
</tr>
<tr>
<td></td>
<td>The e-Referrals (inter and intra hospital referrals programme) will improve the quality, efficiency and safety of inter-specialty referrals across the region</td>
</tr>
</tbody>
</table>


### 2. Progress for the Top 10 Commitments

The table below shows progress against the top 10 commitments

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Achieve and maintain the National Health Targets</td>
<td><img src="image" alt="on track" /></td>
<td>National targets were achieved with regard to ‘Improved access to elective surgery’, ‘Raising healthy kids’ and ‘Faster cancer treatment’, ‘Better help for smokers to quit—primary’, ‘Better help for smokers to quit—maternity’ National targets were substantially achieved with regard to: • ‘Shorter stays in ED (92% on target of 95%)’ • ‘Increased Immunisation’ (achieved 92% against a target of 95%)</td>
</tr>
<tr>
<td><strong>2</strong> Child Health continue to reduce SUDI deaths to &lt; 0.4 SUDI Deaths per 1,000 Maori live births</td>
<td><img src="image" alt="some concerns regarding progress to target" /></td>
<td>The Northern Region SUDI project is transitioning to DHBs now that funding has been distributed nationally to implement a Safe Sleep Programme.</td>
</tr>
<tr>
<td><strong>3</strong> 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months</td>
<td><img src="image" alt="on track" /></td>
<td>75.8% of LT HBSS clients have received an interRAI clinical assessment within the previous 24 months (as of 18 March 2018)</td>
</tr>
<tr>
<td><strong>4</strong> 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat</td>
<td><img src="image" alt="on track" /></td>
<td>88.5% achieved Note: 1 quarter data lag (Oct-March 2018)</td>
</tr>
<tr>
<td><strong>5</strong> Reduce the percentage of trauma patients transferred to more than one hospital for definitive care from the 2016/17 baseline of 25.4%</td>
<td><img src="image" alt="some concerns regarding progress to target" /></td>
<td>The 2017/18 Q2 results show 30.8% of patients were transferred more than once, an increase of over 5% from the base line. Further review of the date is required to measure how an appropriate transfer is determined versus a transfer that would have been better to be avoided.</td>
</tr>
<tr>
<td><strong>6</strong> 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes</td>
<td><img src="image" alt="on track" /></td>
<td>The Northern Region as a whole exceeded the target. Three out of 4 DHB’s met the target. (NDHB 50.0%, WDHB, 84.1%, ADHB 88.6% and CMH 80.0%) Northern Region 82.5%.</td>
</tr>
<tr>
<td><strong>7</strong> 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c&lt;64)</td>
<td><img src="image" alt="some concerns regarding progress to target" /></td>
<td>The latest report from January 2018 indicated 69.8% of patients have good or acceptable glycaemic control, which is a slight decrease from the previous 6 months</td>
</tr>
<tr>
<td><strong>8</strong> 80% of discharges from adult mental health services receive post discharge community care (within 7 days)</td>
<td><img src="image" alt="some concerns regarding progress to target" /></td>
<td>The discharge follow-up rate has decreased to 72%. This still compares favourably with the national rate of 66%</td>
</tr>
<tr>
<td><strong>9</strong> 80% of patients who have a stroke are treated in a stroke unit</td>
<td><img src="image" alt="on track" /></td>
<td>The Northern Region achieved 85% of stroke patients treated in a dedicated stroke unit for the period Jan – March 2018.</td>
</tr>
<tr>
<td><strong>10</strong> Reduce unintended teen pregnancies</td>
<td><img src="image" alt="not achieved or declining performance" /></td>
<td>The Youth Health KPIs continue to show a reduction in both youth pregnancy and termination of pregnancy over the last 5 years.</td>
</tr>
</tbody>
</table>

**NOTE:** The more detailed report is available on request.

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¹ There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.
System Level Measures Improvement Plan

Auckland, Waitemata & Counties Manukau Health Alliances

2018
2019
FINANCIAL YEAR
We have come too far to not go further and we have done too much to not do more.

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions
1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2018/19 System Level Measures Improvement Plan.

Continuing with the one team theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system. Building on the work outlined in previous System Level Measures Improvement Plans, in 2018/19, improvement milestones and interrelated contributory measures for each of the system level measures (SLMs) have been prioritised and focused, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Alliances are firmly committed to including additional well-aligned contributory measures over the medium to longer term, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

The district health boards (DHBs) included in this improvement plan are:
- Auckland DHB;
- Waitemata DHB, and
- Counties Manukau DHB.

The primary health organisations (PHOs) included in this improvement plan are:
- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the relationship between milestones and key activity areas chosen for this improvement plan, and the stage of life they represent. In 2018/19 improvement activities and contributory measures were chosen for their application to multiple milestones where possible. Overarching priorities for 2018/19 are a prevention approach, improvements in equity of outcome or access, activities which support intervention in high risk populations, and collective impact. Population focus has been developed to include consultation with patients, family and whānau, and community in our planning and activities.
2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT
3. PURPOSE

This document outlines how the 2018/19 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the high-level activities that will be fundamental to this improvement. Please note that, as further discussed in section 4.1, implementation planning is developed annually to sit under this document to provide a higher level of detail.

4. BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand’s health system over 10 years to 2026, to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is ‘value and high performance’ ‘te whāinga hua me te tika o ngā mahi’. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a suite of SLMs that provide a system-wide view of performance. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following:

a) Four SLMs, which were implemented from 1 July 2016:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds;
   - total acute hospital bed days per capita;
   - patient experience of care, and
   - amenable mortality rates.

b) Two further SLMs, which were implemented from 1 July 2017:
   - youth access to and utilisation of youth-appropriate health services, and
   - babies living in smokefree homes.

c) For each SLM, an improvement milestone to be achieved in 2018/19. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.

d) A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.

e) Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enables the alliance to measure local progress against the SLM activities.

f) Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

4.1 Process

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2018/19, SLMs will transition to a business-as-usual state. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibilities of the working groups will transition, with primary responsibility for implementation resting with the newly established PHO Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The PHO Implementation Group will meet to further develop key actions (particularly at a local level) and inform implementations planning, monitor data, facilitate systems partnerships, and will collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams. This group contributes to regional and organisational implementation plans, which sit under the Improvement Plan.
We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other systems partners, broadening from pharmacy and maternity to a raft of flexible working alliances with various partners named in the ‘enablers to capacity and capability’ diagram in Section 5.

Reporting processes, both at a local and regional level have been embedded over the 2017/18 year. DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the PHO Implementation Group.

4.2 Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan has been shared with the Māori, Pacific and Asian health teams at Auckland, Counties Manukau and Waitemata DHBs and their feedback has been incorporated. Consultation with the relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan has been designed to align with DHB Māori Health Plan(s). There is ongoing engagement and dialog with Māori and Pacific providers with a view to improving service integration.

4.3 Regional Working

As in previous years, a single improvement plan has been developed in 2018/19 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4.4 2018/19 Priorities for System Level Measures

In 2018/19, the Auckland Metro Region has focused on cross–system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. This is demonstrated in the ‘interrelated activity for collective impact’ diagram in Section 2. This year we also recognise those activities which enable achievement of the SLM activities and milestones. This essential work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2018/19 are a prevention approach, improvements in equity of outcome or access, activities which support intervention in high risk populations, and collective impact. We have developed our population focus to include specific consultation with patients, family and whānau, and community in our planning and activities.
5. ENABLERS TO CAPACITY AND CAPABILITY

<table>
<thead>
<tr>
<th>ENABLERS TO CAPACITY AND CAPABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRAINING AND EDUCATION</strong></td>
</tr>
<tr>
<td>- SLM related Continuing Medical Education/ Continuing Nursing Education is filmed and shared regionally</td>
</tr>
<tr>
<td>- Health literacy improvement</td>
</tr>
<tr>
<td>- Auckland Regional HealthPathways</td>
</tr>
<tr>
<td>- Resources and key messages on various SLM work streams</td>
</tr>
<tr>
<td>- Planned communications of key messages at regular intervals.</td>
</tr>
<tr>
<td><strong>DATA AND INFORMATION MANAGEMENT</strong></td>
</tr>
<tr>
<td>- SLM data definitions, sourcing, analysis and reporting</td>
</tr>
<tr>
<td>- Ongoing use of the Metro Auckland Data Sharing Framework</td>
</tr>
<tr>
<td>- Increased use of data to inform implementation and improvement activities</td>
</tr>
<tr>
<td>- National Child Health Information Platform being rolled out in A/WDHB and Northland. Offers similar functionality to Kidzlink in CMH</td>
</tr>
<tr>
<td>- Advanced forms for improved data collection</td>
</tr>
<tr>
<td>- Commitment to equity view in data analysis and reporting, identifying areas for Māori and Pacific health gain.</td>
</tr>
<tr>
<td><strong>SYSTEMS PARTNERSHIP</strong></td>
</tr>
<tr>
<td>- Lead Maternity Carer (LMC)</td>
</tr>
<tr>
<td>- Well Child Tamariki Ora (WCTO)</td>
</tr>
<tr>
<td>- Auckland Regional Dental Services (ARD-S)</td>
</tr>
<tr>
<td>- Immunisation Advisory Center (IMAC)</td>
</tr>
<tr>
<td>- Association with Auckland Regional Public Health Service (ARPHS)</td>
</tr>
<tr>
<td>- Pharmacy support</td>
</tr>
<tr>
<td>- Community laboratories</td>
</tr>
<tr>
<td>- Primary Care teams</td>
</tr>
<tr>
<td>- Secondary Care services</td>
</tr>
<tr>
<td>- Māori and Pacific providers</td>
</tr>
<tr>
<td>- Health navigators and health coaches</td>
</tr>
<tr>
<td>- School based health services</td>
</tr>
<tr>
<td><strong>QI SUPPORT</strong></td>
</tr>
<tr>
<td>- Use of improvement methodologies underlying improvement activities</td>
</tr>
<tr>
<td>- Supported integration of cross-sectorial improvement activities.</td>
</tr>
<tr>
<td><strong>CLINICAL LEADERSHIP</strong></td>
</tr>
<tr>
<td>- Liaison with Metro Auckland Clinical Governance Forum</td>
</tr>
<tr>
<td>- Population health clinical leadership in planning and implementation.</td>
</tr>
<tr>
<td><strong>CULTURAL LEADERSHIP</strong></td>
</tr>
<tr>
<td>- Stepwise consultation and feedback hui with Māori and Pacific providers</td>
</tr>
<tr>
<td>- Support from Mana Whenua.</td>
</tr>
</tbody>
</table>
### 6. SYSTEM LEVEL MEASURES 2018/19 MILESTONES

<table>
<thead>
<tr>
<th>System Level Outcome</th>
<th>Improvement Milestone</th>
</tr>
</thead>
</table>
| Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds | Keeping children out of hospital  
3% reduction for total population by 30 June 2019.  
3% reduction for Māori populations by 30 June 2019.  
3% reduction for Pacific populations by 30 June 2019. |
| Total Acute Hospital Bed Days | Using health resources effectively  
3% reduction for Māori populations by 30 June 2019.  
3% reduction for Pacific populations by 30 June 2019. |
| Patient Experience of Care | Ensuring patient centred care  
Hospital inpatient survey: Baseline response rate by ethnicity by 30 June 2019.  
Primary care survey: Increase response rate for completed surveys by 2% from baseline for Māori and Pacific by 30 June 2019. |
| Amenable Mortality | Preventing and detecting disease early  
6% reduction for each DHB (on 2013 baseline) by 30 June 2021.  
2% reduction for Māori and Pacific by 30 June 2019. |
| Youth Access to and Utilisation of Youth-appropriate Health Services | Young people manage their sexual and reproductive health safely and receive youth friendly care  
Increase coverage of chlamydia testing to 15% by 30 June 2019.  
Reduce ‘unknown’ alcohol related ED presentation status to less than 10% by 30 June 2019. |
| Babies in Smokefree Homes | Healthy start  
Increase the proportion of babies living in a smokefree homes by 2% by 30 June 2019. |
7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan for the six SLMs for 2018/19. Improvement activities create change and work towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2018/19, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

### 7.1 Respiratory Admissions in 0-4 year olds

<table>
<thead>
<tr>
<th>Activities</th>
<th>Contributory Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increase uptake of children’s influenza vaccination to prevent respiratory admissions by: &lt;br&gt;  o Reporting newly eligible children to primary care at the beginning of influenza season. &lt;br&gt;  o Following up reporting of vaccination uptake provided throughout the season.  &lt;br&gt;  o Prioritised vaccination of eligible Māori and Pacific children. &lt;br&gt;  o Exploring other options for delivering influenza vaccination in the community.</td>
<td>Increase influenza vaccination coverage for children aged 0-4 years old, who are hospitalised for respiratory illness to at least 15% (absolute) by ethnicity.</td>
</tr>
<tr>
<td>- Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: &lt;br&gt;  o Increasing the use of pregnancy registers in primary care. &lt;br&gt;  o Identifying pregnant women through booking and set immunisation recalls in primary care. &lt;br&gt;  o Opportunistic immunisation at antenatal clinics.  &lt;br&gt;  o Promotion of pregnancy immunisation especially to Māori and Pacific women, through the use of vouchers, in primary care, pharmacy, LMC, and in other pregnancy service providers.</td>
<td>Increase influenza and pertussis vaccine coverage rates for pregnant women to 50% by ethnic group.</td>
</tr>
<tr>
<td>- Support a decrease in respiratory admissions with social determinants by: &lt;br&gt;  o Supporting the development and implementation of e-referrals from primary care to healthy housing programmes.  &lt;br&gt;  o Increasing healthy housing referrals during pregnancy for low income Māori and Pacific women. &lt;br&gt;  o Supporting mothers and whānau of babies to live in smokefree homes by increased referrals from LMCs, primary care, healthy housing programmes, pharmacies and other referrers, to pregnancy smokefree services. &lt;br&gt;  o Referral of pregnant women who smoke for support to stop smoking when they visit General Practice to confirm their pregnancy.</td>
<td>Increase referrals to maternal incentives smoking cessation programmes, for pregnant women referred each quarter, to at least 46 for ADHB and 83 for WDHB, and 180 for CMH.</td>
</tr>
<tr>
<td>- Improve the quality of data collected on post-natal smoking, as an indicator of smoking in pregnancy, by: &lt;br&gt;  o Active support for Well Child Tamariki Ora providers to improve the quality of smoking status data, through feedback, education and reporting.</td>
<td></td>
</tr>
<tr>
<td>- Support population groups who have inequitable child health outcomes by: &lt;br&gt;  o Identifying Māori children (and their parents and whānau) who are not enrolled in primary care and supporting enrolment with their choice of primary care provider. &lt;br&gt;  o Supporting a regional Pacific Providers forum to support equitable outcomes for Pacific children by improving communication and linkages. &lt;br&gt;  o Promotion of enrolment with WCTO providers opportunistically in primary care, particularly for Māori and Pacific children.</td>
<td></td>
</tr>
</tbody>
</table>

**Milestones:** The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.
### 7.2 Oral Health

**Activities**

- Primary care will share information and work collaboratively with systems partners to promote improved patient outcomes by:
  - Matching data from primary care to identify children enrolled, who are not enrolled in the Auckland Regional Dental Service (ARDS).
  - Providing data to ARDS on children identified as not enrolled in their service, for contact, and enrolment in pre-school oral health services.
  - Supporting the Preschool Oral Health Strategy by ongoing work with ARDS to promote and implement their lift the lip training in primary care practices.
- Facilitation of ARDS lift the lip programme for Māori and Pacific Well Child Tamariki Ora providers.

**Contributory Measure**

- 95% enrolment in DHB funded oral health services for 0-4 year olds.

**Milestones:** The Ambulatory Sensitive Hospitalisations for 0-4 years and Total Acute Hospital Bed Days milestones will be improved by these activities.

### 7.3 Youth Sexual and Reproductive Health

**Activities**

- Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by:
  - Increased sexual health screening for young people in a variety of youth appropriate settings.
  - Increased engagement of young males in a variety of youth appropriate settings.
  - Reporting the rate of chlamydia testing coverage across all youth health specific services, with a view to those with outstanding performance championing best practice in youth healthcare, and services with low testing coverage rates increasing their testing rates.
  - Implementing chlamydia prevalence reporting to relevant stakeholders, with an expectation that this prevalence will increase as testing improves.
- Youth utilisation of and access to sexual health services is increased by:
  - Development of clear and consistent regional criteria for flexible funding pool (FFP) or SIA funded youth sexual health visits for under 22 years of age.
  - Continuing to work towards consistent regional criteria for free-to-youth sexual health consultations in primary care.

**Contributory Measure**

- Increase coverage of chlamydia testing to 15% (reported by gender and ethnicity) for 15-24 year olds.

**Milestones:** The Youth milestone will be improved by these activities.
### 7.4 Alcohol Harm Reduction

**Activities**
- Improve data collection and reporting on alcohol harm reduction interventions through the following activities:
  - Development and agreement of a data standard for primary care that defines: alcohol ABC indicators, data to be collected, and standard terms and codes for data recording and extract.
  - Establishment of an alcohol ABC baseline in primary care for reporting indicators.
  - Quality improvement activities focused on data collection for alcohol-related ED presentations, including youth.
- Take an integrated approach to alcohol harm reduction by working with other systems partners:
  - Work with ambulance services and urgent/after-hours services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting.
  - Work with student and other youth health services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting.

**Contributory Measures**
- Baseline measurement of delivery of alcohol ABC in general practice.
- Establish a baseline for alcohol-related ED presentations.
- Reduce ‘unknown’ alcohol related ED presentation status to less than 10% by 30 June 2019.

**Milestones:** The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

### 7.5 Smoking Cessation for Māori and Pacific

**Activities**
- Patient outcomes related to harm from smoking will be improved by:
  - Continuing to focus on brief advice in primary care.
  - An increase in referrals to cessation support.
  - Support for the delivery of medication therapy in primary care.
- The importance of smoking cessation as an intervention will be promoted by:
  - Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services.
  - Further development of smoking indicators from PMS data to inform primary care interventions.
  - Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation.

**Contributory Measure**
- An increase in cessation support received by enrolled patients who are current smokers by 10%.
- Metro Auckland smoking indicators (in development).
- Establish a baseline with a view to an increase in the proportion of smokers who receive medicines to support their cessation.

**Milestones:** The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.
7.6 Cardiovascular Disease (CVD) Risk Assessment and Management

**Activities**

- Primary care and systems partners work together to support equitable CVD RA for Māori by:
  - Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first.
  - Referral of highest risk Māori to culturally appropriate providers for self-management and wellness support.
- Identification of and support to enrol Māori patients who are seen by Māori providers and are not enrolled in primary care.
- In the absence of a tool to fully implement the National Consensus Statement for Assessment and Management of CVD in Primary Care, a staged process will be designed to facilitate uptake and use of the tool when it becomes available.
- Continued reporting of the indicator ‘prescribed dual therapy for those with CVD RA greater than 20%’, with a view to emphasis of the importance of this intervention, throughout change created by the implementation of the National Consensus Statement for Assessment and Management of CVD in Primary Care.
- Where the equity gap for Māori and Pacific has closed, PHOs are to identify other populations with unequitable access and facilitate interventions for those groups.
- Reporting and improvement of clinical management through prescribing is facilitated through:
  - Continued development of NHI level reporting in secondary prevention.
  - Comparing dispensing data to prescribing data and identifying any opportunities for improvements.
- Improved outcomes for patients with a high risk of CVD event are sought by:
  - Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination.
  - Interventions to improve uptake of triple therapy for Māori and Pacific people.
  - Development and implementation of processes for identification of patients with serious mental illness (SMI) in primary care to support an annual CVD risk management review.
- Opportunities to improve data collection and quality are advanced through:
  - Development and baselines for a set of quality indicators to support the implementation of CVD consensus statement (with a focus on coding specified conditions e.g. IHD, AF, CKD, diabetes, SMI).
  - Development of an indicator and establishment of baselines for influenza vaccination coverage in patients with a prior CVD event under 75 years of age.
  - Extension of the current CVD data extract to include a domicile field for DHB level reporting.

**Milestones:** The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

**Contributory Measure**

- 90% CVD RA for Māori.
- 5% increase (relative) in prescribed triple therapy for those Māori and Pacific with a prior CVD event.
- Develop an indicator and establish baseline for influenza vaccination coverage for patients with a prior CVD event under 75 years of age.
### 7.7 Complex Conditions

<table>
<thead>
<tr>
<th>Activities</th>
<th>Contributory Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chronic obstructive pulmonary disorder (COPD) and coronary heart failure (CHF) patients are supported to best access appropriate health services through:</td>
<td>2% reduction in ASH rates for COPD and CHF for adults aged 45-64 years old.</td>
</tr>
<tr>
<td>o Refinement of the end to end patient journey for CHF and COPD.</td>
<td>2% reduction in the overall ASH rate for both Māori and Pacific adults aged 45-64 years old.</td>
</tr>
<tr>
<td>o Improvements in coding in primary care for specified long term and complex conditions (e.g. COPD and CHF).</td>
<td></td>
</tr>
<tr>
<td>o Quality improvement activities which support transfer of care</td>
<td></td>
</tr>
<tr>
<td>o Testing of appropriate primary care based bundles of care for COPD and CHF patients.</td>
<td></td>
</tr>
<tr>
<td>• Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support:</td>
<td></td>
</tr>
<tr>
<td>o Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination.</td>
<td></td>
</tr>
<tr>
<td>o Māori and Pacific patients who present in primary care with ASH conditions, or comorbidities which contribute to ASH conditions, are referred to appropriate self-management or wellness support services.</td>
<td></td>
</tr>
<tr>
<td>o Primary care collaborates with Māori providers to identify the Māori primary care population with long term conditions with a view to additional support.</td>
<td></td>
</tr>
<tr>
<td>• Patients who have SMI have their general health and wellness reviewed annually.</td>
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</tr>
</tbody>
</table>

**Milestones:** The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

### 7.8 Primary Options for Acute Care (POAC)

<table>
<thead>
<tr>
<th>Activities</th>
<th>Contributory Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PHOs will work together with the POAC team to support practices to utilise POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by:</td>
<td>Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions to 3 per 100 for each PHO.</td>
</tr>
<tr>
<td>o Increasing utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64, through promotion by PHOs.</td>
<td></td>
</tr>
<tr>
<td>o Increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis.</td>
<td></td>
</tr>
<tr>
<td>o Linking with ambulance services to increase POAC utilisation where patients are able to be best managed in the community, if transport or social requirements are met.</td>
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</tr>
<tr>
<td>o Investigation of options for supportive, early discharge from hospital, such as usage of POAC, interim care, or early discharge services managed by primary, community or secondary care providers.</td>
<td></td>
</tr>
</tbody>
</table>

**Milestones:** The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.
### 7.9 E-portals

**Activities**
- Increase practices offering prescription orders, lab results and/or consultation notes, initially by increased visibility of practices providing this service, through e-portals, followed by investigation of benefits and promotion of value to early adopters.
- Continued support for patient enrolment (logon) to e-portals by practices.
- PHO actively support practices to improve in patient uptake (logon) by distribution of resources and information.

**Contributory Measure**
- Baseline and increase in practices offering prescriptions, laboratory results, and view of consultation notes.
- Increase to 20% of each PHO’s enrolled population with login access to a portal.

**Milestones:** The Patient Experience of Care milestone will be improved by these activities.

### 7.10 Patient Experience Surveys in Primary and Secondary Care

**Activities**
- Primary care will improve patient experience by:
  - Implementing a programme of responsive improvement activity following survey results, including:
    - Practices supported to participate in ‘You said, we did’ (PES to PDSA) PHC PES feedback quality improvement initiative, quarterly.
  - Work with the HQSC to improve the PHC PES to better engage Māori, Pacific and Asian respondents, including implementation of new culturally specific resources supplied by the HQSC.
  - Improved recording of cell phone numbers and email addresses in practice management systems, to enable sending of PHC PES invitations.
- Secondary care will improve patient experience by:
  - Ongoing work in DHB settings focusing on culturally appropriate, patient-centered communication.
  - Sharing learnings with primary care through established networks and forums.
  - Improve visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness.
  - Activity to support community pharmacy teach-back method to improve patient medicines knowledge.
- Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.

**Contributory Measure**
- 50% of each PHOs practices participating in PHC PES to PDSA ‘You said, we did’ quality improvement initiative at least once in the financial year.
- Increase response rate for completed surveys by 2% for Māori and Pacific from baseline by 30 June 2019.
- Maintain or increase practice participation in the PHC PES as at end June 2018.
- Baseline response rate by ethnicity in the secondary care in-patient survey.

**Milestones:** The Patient Experience of Care milestone will be improved by these activities.
8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

<table>
<thead>
<tr>
<th>System Level Outcome</th>
<th>Improvement Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping children out of hospital</td>
<td>3% reduction for total population by 30 June 2019.</td>
</tr>
<tr>
<td></td>
<td>3% reduction for Māori populations by 30 June 2019.</td>
</tr>
<tr>
<td></td>
<td>3% reduction for Pacific populations by 30 June 2019.</td>
</tr>
</tbody>
</table>

Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches.

In addition to immunisation, smoking cessation and improving the housing environment are important for improving this milestone; this year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs. In addition we are working to improve enrolment in the dental service.

We plan to connect this work with the increased immunisation for eight-month olds indicator which will support improved outcomes.

This year we aim to maintain our improvement in total rate and focus on an equity related improvement for Māori and Pacific rates.

![Graph showing Ambulatory Sensitive Hospitalisation Rates per 100,000 of Ambulatory Sensitive Hospitalisations (ASH) in children aged 0-4 years.](Image)
Rate per 100,000 of Ambulatory Sensitive Hospitalisations (ASH) in children aged 0-4 years for Māori and Pacific.

<table>
<thead>
<tr>
<th>Year</th>
<th>Māori</th>
<th>Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>6,851</td>
<td>13,187</td>
</tr>
<tr>
<td>2014</td>
<td>6,583</td>
<td>11,189</td>
</tr>
<tr>
<td>2015</td>
<td>6,021</td>
<td>10,756</td>
</tr>
<tr>
<td>2016</td>
<td>5,821</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>5,683</td>
<td></td>
</tr>
</tbody>
</table>

ADHB  CMH  WDHB
8.2 Total Acute Hospital Bed Days

<table>
<thead>
<tr>
<th>System Level Outcome</th>
<th>Using health resources effectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Milestone</td>
<td>3% reduction for Māori population by 30 June 2019.</td>
</tr>
<tr>
<td></td>
<td>3% reduction for Pacific population by 30 June 2019.</td>
</tr>
</tbody>
</table>

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Conditions identified as highest priority include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and cellulitis. Total acute hospital bed days for 2017/18 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will also focus on patients from this population in addition to the prioritised conditions.
Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient’s experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

**Hospital Inpatient PES:** This has been in place since 2014. The milestone for 2018/19 has been selected to begin work on an increase in responses from Māori and Pacific patients. Ethnicity data is available at a local level but will require some work to collate before a baseline is available. This will be supported by continued work on improved communication in hospital, with a stronger focus on culturally appropriate communication and health literacy.

**Primary Health Care PES:** The PHC PES was developed more recently and has been implemented in practices over the 2017/18 year. Completed surveys for Māori and Pacific invitees are lower than for European. As such, the focus this year is on increasing the response rate for Māori and Pacific invitees, to work towards equitable response rates. This will be supported by work towards utilization of the PHC PES data by practices, for PDSA improvement cycles.

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**8.3 Patient Experience of Care**

<table>
<thead>
<tr>
<th>System Level Outcome</th>
<th>Ensuring patient centred care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Milestone</td>
<td>Hospital inpatient survey: Baseline response rate by ethnicity by 30 June 2019.</td>
</tr>
<tr>
<td></td>
<td>Primary care survey: Increase response rate for completed surveys by 2% from baseline for Māori and Pacific by 30 June 2019.</td>
</tr>
</tbody>
</table>

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![PHC PES response rate for Māori invitees](chart.png)
8.4 Amenable Mortality

System level outcome
Preventing and detecting disease early

Improvement milestone
6% reduction for each DHB (on 2013 baseline) by 30 June 2020.
2% reduction for Māori and Pacific by 30 June 2019.

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation. In 2018/19 we aim to build on the work already underway in this area and embed the new Consensus Statement for Assessment and Management of CVD. We plan to achieve a 2% reduction in our milestone for each DHB to contribute to our 2021 target. We note we have transitioned to regionally agreed Metro Auckland Clinical Governance indicators in the CVD contributory measure this year.

CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

We plan to connect this work with the Better Help for Smokers to Quit indicator which will support improved outcomes.

Amenable mortality rates per 100,000. Rates are age standardised to WHO world standard population.

[Graph showing amenable mortality rates per 100,000 for ADHB, CMH, and WDHB from 2000 to 2015, with specific rates noted for each year.]
Amenable mortality rates per 100,000 by ethnicity. Rates are age standardised to WHO world standard population.
### 8.5 Youth Access to and Utilisation of Youth-appropriate Health Services

<table>
<thead>
<tr>
<th>System level outcome</th>
<th>Improvement milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people manage their sexual and reproductive health safely and receive youth friendly care.</td>
<td>Increase coverage of chlamydia testing rate to 15% by 30 June 2019. Reduce ‘unknown’ alcohol related ED presentation status to less than 10% by 30 June 2019.</td>
</tr>
<tr>
<td>Young people experience less alcohol and drug related harm and receive appropriate support.</td>
<td></td>
</tr>
</tbody>
</table>

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviours, in terms of drug and alcohol abuse and criminal activities.

**Chlamydia testing coverage:** This is an indicator of young people’s access to confidential youth appropriate comprehensive healthcare. For those young people 15 years and older who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender.

#### Sexual and Reproductive Health - Chlamydia test rate of youth aged 15-24 years

<table>
<thead>
<tr>
<th></th>
<th>Q2 2017</th>
<th>Q4 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>10.8</td>
<td>12.1</td>
</tr>
<tr>
<td>CMH</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>WDHB</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>
Alcohol-related ED presentations: Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm, populations and communities most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry is not complete or is more recent than 1 July 2017. The mandatory question is “Is alcohol associated with this event?” Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality is still poor, with significant missing data in some areas, therefore the 2018/19 plan will focus on quality improvement for alcohol data collection across primary care, youth services, and emergency departments.

<table>
<thead>
<tr>
<th>Alcohol-related ED presentations – Percentage of total ED attendances with ‘unknown’ alcohol relationship status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
</tr>
<tr>
<td>1.6%</td>
</tr>
<tr>
<td>Year to March 2018</td>
</tr>
</tbody>
</table>
8.6 Babies in Smokefree Homes

System level outcome
Healthy start

Improvement milestone
Increase the proportion of babies living in smokefree homes by 2%

The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific.

Data from Well Child Tamariki Ora providers now suggests that around 75-85% of babies live in a smokefree household at 6 weeks post-partum. Data reported for the 2017/18 plan indicated that data quality was an issue, and an improvement programme was put in place at a national level throughout 2017/18. Data supplied in June 2018 was of sufficient quality to move from a measure of data quality to a quality improvement focus. There is still some work to be done, as data does not reflect live births. This may be improved by an increase in the proportion of births enrolled with WCTO providers. This work should support both smoking intervention in pregnancy and the post-natal period, and continued quality data collection in the Well Child Tamariki Ora space.

![Proportion of Babies Living in a Smokefree Homes at 6 weeks post natal](image-url)
### 9. GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Assessment, Brief Advice, and Cessation Support</td>
</tr>
<tr>
<td>ADHB</td>
<td>Auckland District Health Board</td>
</tr>
<tr>
<td>AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>ARPHS</td>
<td>Auckland Regional Public Health Service</td>
</tr>
<tr>
<td>ASH</td>
<td>Ambulatory Sensitive Hospitalisations</td>
</tr>
<tr>
<td>A/WDHB</td>
<td>Auckland Waitemata District Health Boards</td>
</tr>
<tr>
<td>CHF</td>
<td>Coronary Heart Failure</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>CME/CNE</td>
<td>Continuing Medical Education/Continuing Nursing Education</td>
</tr>
<tr>
<td>CMH</td>
<td>Counties Manukau Health (referring to Counties Manukau District Health Board)</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disorder</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>CVD RA</td>
<td>Cardiovascular Disease Risk Assessment</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>GP</td>
<td>General Practice/General Practitioner</td>
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<tr>
<td>HQSC</td>
<td>Health Quality Safety Commission</td>
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<tr>
<td>IHD</td>
<td>Ischaemic Heart Disease</td>
</tr>
<tr>
<td>IMAC</td>
<td>Immunisation Advisory Center</td>
</tr>
<tr>
<td>LMC</td>
<td>Lead Maternity Carer</td>
</tr>
<tr>
<td>MACGF</td>
<td>Metro Auckland Clinical Governance Forum</td>
</tr>
<tr>
<td>MADSF</td>
<td>Metro Auckland Data Sharing Framework</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
</tr>
<tr>
<td>PES</td>
<td>Patient Experience Survey</td>
</tr>
<tr>
<td>PHC PES</td>
<td>Primary Healthcare Patient Experience Survey</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Healthcare Organisation</td>
</tr>
<tr>
<td>PMS</td>
<td>Practice Management Systems</td>
</tr>
<tr>
<td>POAC</td>
<td>Primary Options for Acute Care</td>
</tr>
<tr>
<td>SLM</td>
<td>System Level Measure</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>WDHB</td>
<td>Waitemata District Health Board</td>
</tr>
<tr>
<td>WCTO</td>
<td>Well Child Tamariki Ora</td>
</tr>
</tbody>
</table>
**Counties Manukau District Health Board**

### 7.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Minutes of Public Excluded Meeting, 26 September 2018 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)] |
| 3.1 Postvention Suicide Brief (copy of presentation) | 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Privacy  
The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)] |