Community and Public Health Advisory Committees Meeting

Wednesday 12 October 2016

2.00pm

Venue

Waitemata District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
12 October 2016

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 2.00pm**

COMMITTEE MEMBERS	MANAGEMENT
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member) Lester Levy - ADHB and WDHB Board Chair Max Abbott - WDHB Board member Jo Agnew - ADHB Board member Peter Aitken - ADHB Board member Judith Bassett – ADHB Board member Chris Chambers - ADHB Board member Sandra Coney - WDHB Board member Warren Flaunty - Committee Deputy Chair (WDHB Board member) Lee Mathias - ADHB Deputy Chair Robyn Northey - ADHB Board member Christine Rankin - WDHB Board member Allison Roe - WDHB Board member Elsie Ho - Co-opted member Rev Featunai Liuaana – Co-opted member Tim Jelleyman - Co-opted member	Dale Bramley - WDHB, Chief Executive Ailsa Claire - ADHB, Chief Executive Debbie Holdsworth - ADHB and WDHB, Director Funding Simon Bowen - ADHB and WDHB, Director Health Outcomes Naida Glavish - ADHB and WDHB Chief Advisor, Tikanga Peta Molloy - WDHB, Board Secretary

Apologies: Lester Levy and Ailsa Claire

AGENDA

KARAKIA

DISCLOSURE OF INTERESTS

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

Items to be considered in public meeting

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
2.05pm	2.1	Confirmation of Minutes of the meeting held on 31/08/2016 Actions Arising from previous meetings
	3.	**INFORMATION PAPERS**
2.10pm	3.1	Waitemata DHB and Auckland DHB Suicide Prevention and Postvention Action Plan 2015-17 Update
2.25pm	3.2	Child, Youth and Women's Health
	4.	**STANDARD REPORTS**
2.40pm	4.1	Planning, Funding and Outcomes Update
3.00pm	**4.**	**GENERAL BUSINESS**

Auckland and Waitemata District Health Boards

Community and Public Health Committees

Member Attendance Schedule 2016

NAME	FEB	MAR	APRIL	JUNE	JULY	AUG	OCT	NOV
Gwen Tepania-Palmer (ADHB / WDHB combined CPHAC Committees Chair)	✓	✓	✓	✓	✓	✓		
Warren Flaunty (ADHB / WDHB combined CPHAC Committees Deputy Chair)	✓	✓	✓	✓	✓	✓		
Dr Lester Levy (ADHB and WDHB Chair)	+	+	+	+	+	+		
Max Abbott	✓	✓	✘	✓	✓	✓		
Jo Agnew	✓	✓	✓	✓	✓	✓		
Peter Aitken	✓	✓	✘	✓	✓	✓		
Judith Bassett	✓	✓	✓	✓	✓	✓		
Chris Chambers	✓	✓	✓	✓	✓	✘		
Sandra Coney	✓	✓	✓	✓	✘	✓		
Lee Mathias (ADHB Deputy Chair)	✓	✓	✓	✘	✓	✓		
Robyn Northey	✓	✓	✓	✓	✓	✓		
Christine Rankin	✘	✘	✓	✓	✓	✓		
Allison Roe	✓	✓	✘	✓	✓	✓		
Co-opted members								
Elsie Ho	✓	✓	✘	✓	✓	✓		
Rev. Featunai Liuaana	✘	✓	✓	✘	✓	✘		
Dr Tim Jelleyman	✓	✓	✓	✓	✓	✓		

✓ attended
✘ absent
** attended part of the meeting only*
^ leave of absence
 # absent on Board business
+ ex-officio member

REGISTER OF INTERESTS

Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Chair – Auckland District Health Board Chairman – Auckland Transport Chairman – Health Research Council Independent Chairman – Tonkin + Taylor Chief Executive – New Zealand Leadership Institute Professor of Leadership – University of Auckland Business School Trustee - Well Foundation (ex-officio member) Lead Reviewer - State Services Commission, Performance Improvement Framework	03/02/16
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board Member - The Rotary National Science and Technology Trust	19/03/14
Jo Agnew	Professional Teaching Fellow - School of Nursing, Auckland University Trustee Starship Foundation Casual Staff Nurse - ADHB	01/03/14
Peter Aitken	Pharmacist Shareholder/Director, Consultant - Pharmacy Care Systems Ltd Shareholder/Director - Pharmacy New Lynn Medical Centre	15/05/13
Judith Bassett	Nil	09/12/10
Chris Chambers	Employee - Auckland District Health Board (wife employed by Starship Trauma Service) Clinical Senior Lecturer- Anaesthesia Auckland Clinical School Associate - Epsom Anaesthetic Group Member - ASMS Shareholder - Ormiston Surgical	20/04/11
Sandra Coney	Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council	12/12/13
Warren Flaunty	Member - Henderson - Massey and Rodney Local Boards, Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Owner – Life Pharmacy North West Director - Westgate Pharmacy Ltd Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd	25/11/15
Lee Mathias	Chair - Counties Manukau District Health Board Chair – Unitec Director – Health Innovation Hub Director – healthAlliance Director – New Zealand Health Partnerships Managing Director - Lee Mathias Ltd Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Director - Pictor Ltd Director - John Seabrook Holdings Ltd Chair - Health Promotion Agency	03/02/16
Robyn Northey	Project management, service review, planning etc - Self-employed Contractor Board member - Hope Foundation Northern Region Trustee - A+ Charitable Trust	18/07/12

Register of Interests continued…

Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director - The Transformational Leadership Company	15/07/15
Allison Roe	Member - Devonport-Takapuna Local Board, Auckland Council Chairperson - Matakana Coast Trail Trust	02/07/14
Gwen Tepania-Palmer	Chairperson - Ngatihine Health Trust, Bay of Islands Life Member - National Council Maori Nurses Alumni - Massey University MBA Director - Manaia Health PHO, Whangarei Board Member - Auckland District Health Board Committee Member - Lottery Northland Community Committee	10/04/13

Co-opted Members

Elsie Ho	Associate Professor - School of Population Health, University of Auckland Member - Waitemata DHB Asian Mental Health and Addiction Governance Group Member - Problem Gambling Foundation of New Zealand Advisory Board Trustee – New Zealand Chinese Youth Trust	03/09/14
Rev Featunai Liuaana	Chairperson – Congregational Christian Church Samoa Sandringham Trust Board Trustee – Congregational Christian Church Samoa Trust Chairperson – Mothers and Daughters Health – HVAZ and Alliance Health Plus Committee Member – Working Group for Pacific Health Action Plan (ADHB and WDHB) Deputy Chairperson – Working Group Pacific Family Violence (ADHB and WDHB) Member – MIT Pasifika Students Forum Secretary - Negotiation Committee – EFKSNZ Trust Secretary – EFKSNZ Trust	29/04/15
Dr Tim Jelleyman	Clinical Chair - Child Health Network, Northern Regional Health Plan Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland President elect – Paediatric Society of New Zealand Member-Board of Kaipara Medical Centre Community Paediatrician, Waitakere Hospital Member – ASMS	18/01/16

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 31 August 2016

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 31 August 2016 be approved.

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 31 August 2016

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.00pm

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member) (present from 2.07pm, item 3.1)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)
Christine Rankin (WDHB Board member)
Allison Roe (WDHB Board member) (from 2.07pm, item 3.1)
Elsie Ho (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Andrew Old (ADHB, Chief of Strategy/Participation and Improvement)
Peta Molloy (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Tracy McIntyre, Waitakere Health Link
Wiki Shepherd-Sinclair, Health Link North
Elizabeth Buswell, Waitemata PHO

WELCOME:

The Committee Chair gave a warm welcome to all those present. She extended personal thanks to all of the DHB staff noting that she had had a very busy week supporting family at North Shore Hospital in Wards 9 and 14. The week provided a good insight about not only the high standard of care but also the consistency of care for patients. To start the Committee meeting, the Committee Chair gave blessings to all the staff for their hard work.

APOLOGIES:

Resolution (Moved Warren Flaunty/Seconded Christine Rankin)

That apologies be received and accepted from Chris Chambers and Rev Featunai Liuaana and for late arrival from Allison Roe. Apologies were also received from Ailsa Claire (Chief Executive, Auckland DHB) and Simon Bowen (Director, Health Outcomes).

Carried

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

There were no declarations of interests relating to the agenda.

1. AGENDA ORDER AND TIMING

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 20 July 2016 (pages 7-14)

Resolution (Moved Tim Jelleyman/Seconded Robyn Northey)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 20th July 2016 be approved.

Carried

Matters Arising (page 15)

There were no further updates related to the matters arising.

3. STANDARD REPORTS

3.1 Primary Care Update (agenda pages 16-33)

Lee Reygate (Portfolio Manager, Mental Health and Addictions), Stuart Jenkins (Clinical Director, Primary Care) and Sonia Varma (Programme Manager Quality Use of Medicines and Pharmacy) were present for this time.

Debbie Holdsworth (Director Funding) introduced the item and gave apologies from Tim Wood (Deputy Director and Funding and Development Manager, Primary Care) who was on annual leave.

Sonia Varma noted that the new Community Pharmacy Waste Management Service was successfully implemented, the service is being provided by International Waste Limited. The following matters relating to the service were highlighted:

- That it will reduce incident of accidental poisoning, accidental needle stick injuries and environmental harm by disposal of medicines and household waste.
- That the service is free and has been successfully implemented with no disruption to the public. Pharmacists have been supportive.
- That the DHB provided collection bins to support pharmacies.
- The next steps for the service is a campaign to increase awareness and implementation of DUMP (dispose of unused medicines properly) and encourage the community to dispose of unused waste or backlog.

Later in the meeting Warren Flaunty noted that pharmacies were paying for this service. Debbie Holdsworth clarified the DHBs were previously contracting with individual pharmacies for the disposal of waste however this was not well managed in the past and in some cases was simply going to pharmacies bottom line. The DHBs have taken back this money from pharmacies and entered into a single contract with International Waste Limited and a much improved service is in place at a lower cost to DHBs.

Debbie Holdsworth highlighted the following matters:

- That the Auckland Waitemata Alliance had agreed to joint PHO/DHB funding of the clinical pathways work programme.
- That nationally Auckland DHB is third and Waitemata DHB fourth for the national 'Better Help for Smokers to Quit' health target. Warren Flaunty noted that the contract between the Ministry of Health and Waitemata DHB had concluded and that people that seek help to quit smoking from a pharmacy want assistance immediately. He hoped that Waitemata DHB would continue to advocate the Ministry of Health to establish a new contract.
- That Auckland DHB is first and Waitemata DHB sixth nationally for the national 'More Heart and Diabetes Checks' national health target. The Auckland DHB and Waitemata DHB are working with the PHOs to obtain ethnicity reporting.

<u>Diabetes Service Level Alliance Update</u>

Stuart Jenkins introduced this section of the report.

Lee Mathias noted that the Auckland DHB Board had received a presentation from an outgoing diabetologist who indicated that the number of newly confirmed diagnosis for type 2 diabetes had plateaued for all but one age group. In response Debbie Holdsworth advised that the purpose of the diabetes service level agreement is to ensure the numbers do not increase. Stuart Jenkins further advised that the Alliance group is undertaking a substantial piece of work focussing on diabetes and diabetes management.

In response to a question from Elsie Ho regarding high risk groups such as Pacific and Maori and whether the South East Asian group will also be looked at, Stuart noted that within the service level agreement all high risk groups will be included. The population from the Indian sub-continent is a group that will be focussed on. Debbie Holdsworth noted that work is also being undertaken with particular groups, like the

Auckland Taxi Association, to assist in improving participation rates and allowing easy access to screening in the first instance.

Other matters highlighted in discussion of the diabetes service level agreement included:

- That the 'Good Diabetes Management' graphs for both Auckland DHB and Waitemata DHB (pages 23 and 24 of the agenda) do not show improvements. Debbie Holdsworth noted that it was a specifically funded target; however, it is now an outcome indicator for the Alliance. It was noted that if a programme is no longer specifically funded it should become business as usual and PHOs should be held accountable to ensure targets are still met.
- That advertising on public network buses is considered as an option to raise awareness of health matters.
- Sarmila Gray noted that the accuracy of data received from practices is reliant on what is entered into the system.

Dale Bramley noted that a presentation could be arranged for the Committee from regional public health looking at broader determinants.

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

That the Committee requests a presentation regarding diabetes and diabetes management.

Carried

3.2 Planning, Funding and Outcomes Update

Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager Child, Youth and Women's Health), Aroha Haggie (Manager Maori Health Gain) and Lee Reygate (Portfolio Manager, Mental Health and Addictions) were present for this time.

Debbie Holdsworth introduced the report.

Health of Older People

Kate Sladden presented this section of the report. Matters highlighted or covered in discussion included:

- That the Auckland DHB was selected to be part of a pilot trialling a form of guaranteed hours for the home and community support service workforce. Auckland DHB was selected as it has bulk funding for the case mix.
- That the draft Health of Older People Strategy has been released for consultation, closing on 7th September. There has been feedback on the scrutiny of actions where it seems like there is limitation on the development of new models of care. There needs to be age appropriate care for a person who ages and has a disability or mental health condition.
- That the falls prevention programme is underway and a Business Case has been submitted to the Board. It was noted that the 'Otago' falls prevention programme whilst not financially viable can reduce falls by up to 50 per cent. A

more sustainable model is being investigated with cost benefits being part of that.

Child, Youth and Women's Health

Ruth Bijl presented this section of the report. Matters highlighted or covered in discussion included:

- That the Rheumatic fever target was not met; dialogue continues with the Ministry of Health on how to improve the target result. Areas of improvement include extending the programme to other groups within the community (particularly pregnant women or women with new babies), continuing to work with primary care whilst increasing community awareness about the programme.
- That good progress is being made in the childhood obesity area.

Mental Health and Addictions

Lee Reygate presented this section of the report. He noted the Waitemata DHB Stakeholder Network Mental Health and Addiction Strategic Plan 2015-2020.He also noted the Look Up Event, which is focussed on youth wellbeing around alcohol and other drugs; an evaluation of the event is being processed and it is anticipated a presentation will be given to the Committee at its meeting scheduled in October.

Maori Health Gain

Aroha Haggie (Manager Maori Health Gain) presented this section of the report. She noted that the Auckland DHB and Waitemata DHB joint DNA Strategy had been endorsed by both Boards.

In response to a comment about moving away from the term DNA to a more positive framing of 'improving attendance', Karen Bartholomew noted that changing the narrative had been an area of focus when preparing the strategy.

Pacific Health Gain

Apologies were received from the Lita Foliaki (Manager Pacific Health Gain). Debbie Holdsworth introduced the report noting that the consultation for the renewing the Pacific Health Action Plan closed on 31 August.

Asian, Migrant and Refugee Health Gain

Debbie Holdsworth noted that Asian International Benchmarking report will be presented to the Committee at its meeting scheduled in October.

Auckland Regional Public Health Service

Dr Simon Baker (Medical Officer of Health, Auckland Regional Public Health Service) and Andrew Philips (Policy Analyst – Environmental Health, Auckland Regional Public Health Service) were present for this section of the report. Apologies were received from Jane McEntee and Julia Peters (Auckland Regional Public Health Service).

Matters highlighted or covered in discussion included:

- That the Auckland Council has agreed to progress a review of its Smokefree policy.

- That in response to a question about the impact of the Government introducing legislation to transfer the decision-making for community water fluoridation from territorial local authorities to District Health Boards and the impact, it was noted that a cost benefit study was undertaken and there is significant positive impacts in introducing fluoridation (it was likened to spending 50 cents for a return value of $5). Further discussion points around the topic of fluoridation included:
  - That approximately 96 per cent of the Auckland area is fluoridated.
  - That following the water issues recently experience in the Hawkes Bay area, metro-Auckland DHBs are undertaking a review of water. A report will be presented to the Boards detailing each DHBs status and lessons learnt from Hawkes Bay.
  - That in response to a question about fluoride not being medication it was noted that the High Court concluded that fluoridation does not constitute medical treatment, on the basis that medical treatment involves direct interference with the body or state of mind of an individual, and does not extend to public health interventions delivered to the inhabitants of a particular locality or the population at large. That the Committee will be provided with information via email on costs associated with fluoridating the Auckland region.
  - That there is robust evidence on the benefits of fluoridation.
- That the monitoring of dust emissions from unsealed roads was very detailed and took into account when measuring effect of how far back people lived, wind, type of vehicle and the like.

Resolution (Moved Warren Flaunty/Seconded Jo Agnew)

That the report be received.

Carried

4. GENERAL BUSINESS

There were no items of general business.

The Committee Chair thanked those present for their participation in the meeting.

The meeting concluded at 3.24pm.

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 31 AUGUST 2016

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 03 October 2016

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
CPHAC 16/03/16	5.1	Regional After Hours Services – the Boards to be kept informed on what approach the PHOs support, when that is known.	Tim Wood		Noted. The model for the metro-Auckland after hours services is progressing, a full report will be presented to the Audit and Finance Committees detailing a proposed pathway forward. The CPHAC Committee will be informed of the approached supported by the PHOs when known.
CPHAC 31/08/16	3.1	Diabetes Service - a presentation to the Committee from regional public health looking at broader determinants.	Tim Wood		Date to be set for presentation.
CPHAC 31/08/16	3.2	Mental Health and Addictions – evaluation of the Look Up Event to be presented to the Committee.	Lee Reygate		To be presented to the Committee when available.
CPHAC 31/08/16	3.2	Asian International Benchmarking report	Samantha Bennett		The benchmarking report has now been completed and an internal review process underway before being presented to the ADHB and WDHB Board meetings scheduled in December 2016.
CPHAC 31/08/16	3.2	Community water fluoridation – provide further update on whether fluoride added to the water supply is pharmaceutical grade and on the cost/benefit analysis of fluoridating water.	Dr Simon Baker and Andrew Philips (ARPHS)	06/10/16	See agenda item 4.1 (section 8).

3.1 Update on Waitemata DHB and Auckland DHB Suicide Prevention and Postvention Action Plan 2015/17

Recommendation:

That the report be received.

Prepared by: Manu Fotu (Portfolio Manager Suicide Prevention, Mental Health and Addictions), Trish Palmer (Development Manager, Mental Health and Addictions) and Sheryl Jury (Public Health Physician, Health Gain)
Endorsed by: Murray Patton (Clinical Director, Mental Health and Addictions) and Simon Bowen (Director of Health Outcomes)

Glossary

ASIST	-	Applied Suicide Intervention Skills Training
DHB	-	District Health Board
GP	-	General Practitioner
MHSG	-	Mental Health Services Group
MoE	-	Ministry of Education
MoH	-	Ministry of Health
NGO	-	Non-Government Organisation
PHO	-	Primary Health Organisation
QPR	-	Question; Persuade; Refer
QPRNZ	-	Question; Persuade; Refer New Zealand
safeTALK	-	suicide alertness for everyone Tell, Ask, Listen and Keepsafe
SPPAG	-	Suicide Prevention and Postvention Advisory Group
SPPAP	-	Suicide Prevention and Postvention Action Plan
TPK	-	Te Puni Kokiri

1. Executive Summary

The Ministry of Health (MoH) has tasked District Health Boards (DHBs) with implementing the government's New-Zealand Suicide Prevention Strategy (2006-2016) and the Suicide Action Plan (2013-2016). DHBs are required to co-ordinate suicide prevention activities; implement a district wide plan; facilitate cross agency collaboration; and where necessary implement suicide postvention activities. In July 2015, the Ministry of Health endorsed the joint Auckland and Waitemata DHBs' Suicide Prevention and Postvention Action Plan (SPPAP) for implementation.

This report provides an update to the Community and Public Health and Advisory Committee on the key achievements against the SPPAP for Auckland and Waitemata DHBs since implementation (refer to Table 1: Suicide Prevention Postvention Action Plan Progress Summary below).
The Suicide Prevention and Postvention Advisory Group (SPPAG) identified their work programme based around the four strategic (high level) objectives from the Plan to determine the group's priorities and strategic directions underpinning the actions for the 2015/16 and 2016/17 financial years. These objectives are:

1. Support families, whānau, hapū, iwi and communities to prevent suicide
2. Support families, whānau, hapū, iwi and communities AFTER a suicide
3. Improve services and support for people at high risk of suicide who are receiving health services
4. Strengthen the infrastructure for suicide prevention

Members of the SPPAG joined one of the four focus groups to progress the implementation phase of the SPPAP. Each group focused their activities and expertise to ensure the desired outcomes were achieved. These objectives also align with the National Suicide Prevention Action Plan (2013/16).

Significant progress has been made to achieve and complete the agreed actions within the SPPP. Most of the key activities were achieved and on track as planned during the first year of implementation with a few activities not achieved but with significant progress made. The outstanding actions have proved to be more complex and will realistically take more time than previously identified; completion of these items will be the focus in the upcoming six months. There are no items not achieved or off track.

Table 1: Suicide Prevention Postvention Action Plan Progress Report

FOCUS GROUP 1: Support families, whānau, hapū, iwi and communities to prevent suicide				
Action Areas	**Key Activities**	**Outcomes**	**Progress**	**Refer**
1. Train community health and social support service staff, families, whānau, hapū, iwi and community members to identify and support individuals at risk and refer them to agencies that can help. 2. Build the capacity of families, whānau and communities to prevent suicide	Deliver suicide prevention training programmes designed for health workers and community stakeholders using SafeTALK, QPR and QPR on line training programmes	400 QPR licences allocated to Waitemata DHB and Auckland DHB. 95% registered; 22% completion; 51% partially completion SafeTalk Trainings: • 4 rural workshops; 71 attendees • 4 additional workshops delivered; 147 attendees		1.1 1.2
	Develop positive and proactive relationships with family whānau and community groups to grow community capacity in suicide prevention	Working partnerships with: • Mental Health Foundation • Le Va • Te Rau Matatini • Te Puni Kokiri • Health Link North		4.4
	To have a stocktake of all providers that provide resources in the community related to suicide prevention and postvention.	Focus Group 1 near completion of this stocktake	By Dec 2017	
	Support PHO and Primary workforce development plans to include recognising and managing common mental health issues, including depression, anxiety and substance abuse.	Aligns and links to: 1. 24 graduates from Primary Care Nurse (PCN) Credentialing Metro DHB programme. 2. Funding extension PCN Credentialing Programme 2016/17 3. Our Health in Mind – Business Case 1: Improving support to primary care for better outcomes being implemented in 2016/17.	By June 2017	

FOCUS GROUP 2: Support families, whānau, hapū, iwi and communities AFTER a suicide				
Action Areas	**Key Activities**	**Outcomes**	**Progress**	**Refer**
Develop referral pathway for those "survivors" of suicide.	Facilitated Waves Training programme	• 8 frontline workers trained. • Referral pathway to access those trained as Wave facilitators drafted • 1 WAVES programme session commenced	By June 2017	2.2
Develop a regionally coordinated community response to suicide prevention and postvention.	Establish inter-agency working group – develop suicide notification pathway	• Suicide Notification Pathway drafted and ready for sign off. • Pathway implemented twice and further details are being added based upon this work.		2.1 4.2
Training and education for Clinicians after a Client Suicide so they provide support.	Ensure training and adequate formal supervision and support to health professionals after a client suicide	• Guidelines for Clinical workforce who have lost a client to suicide drafted	By June 2017	
Communities are supported to respond to the needs of family, whānau, friends and others following a suicide and reduce suicide contagion.	Develop a Communication network that provides communities, agencies and first responders with suicide prevention and postvention information and that enables the community to strengthen help seeking behaviours.	• Work in collaboration with NGO partners to distribute resources to communities. Suicide Prevention resources from Mental Health Foundation (MHF) and Clinical Advise Service Aotearoa (CASA) • Suicide bereavement support group guidelines from MHF distributed to networks	By June 2017	1.2 2.1 4.3

FOCUS Group 3: Improve services and support for people at high risk of suicide who are receiving health services				
Action Areas	**Key Activities**	**Outcomes**	**Progress**	**Refer**
Improve services and support of people experiencing mental health problems and alcohol and other drug problems.	Conduct a stocktake of current pathway processes for people who attempt suicide or are at risk of suicide and on transition from primary to secondary services and to identify any gaps.	• Plan drafted to improve the clinical pathways between the Emergency Department (ED) and Primary Care.	By June 2017	3
	Support any development of service pathway processes to enhance transition from primary to secondary care mental health and addiction services and back to primary care.	• Audit of Risk assessments in mental health services completed. • Engage family/whanau advisor in development of service pathway mapping.	By June 2017	
FOCUS GROUP 4: Strengthen the infrastructure for suicide prevention				
Action Areas	**Key Activities**	**Outcomes**	**Progress**	**Refer**
Reducing the suicide rate for service users	Data matching and serious incident review process (reported to HAC)	One day Risk Assessment and Safety Planning training programme has been refreshed and offered to all clinicians who have not previously attended or who would benefit from refresher training during 2016.		4.2
Make better use of data related to suicide deaths and self-harm incidents	To develop a local database for data collation of completed and or suspected suicides and self-harm	• First report on suicides and self-harm data for WDHB and ADHB completed. • Public Health Physician appointed to assist with data analysis.		4.3

Achieved and on track/Achieved and ongoing	
Progress made, not yet due	
Not achieved/Off Track	

2. Support families, whānau, hapū, iwi and communities to prevent suicide

There is strong evidence that training programmes can change the knowledge, attitudes and actions among people who are in a position to help those at risk of suicide. Members of this focus group along with the Suicide Prevention Programme Manager worked with experts and their communities to identify target groups, appropriate training programmes and to facilitate delivery of programmes. A number of training programmes were facilitated for community support services staff, families,

whānau and community members to identify and support individuals at risk of suicide and refer them to agencies that can help.

2.1 Question; Persuade; Refer (QPR) on line Training

The MoH undertook a pilot of an on-line training tool for screening of people at risk of suicide. QPR Online is a foundation level, multi-media adult learning programme that aims to equip trainees with the skills to:

1) recognise that a person may be contemplating suicide,
2) ask them appropriately about suicide risk and
3) refer them to appropriate services, using the 'Question/Persuade/Refer' model.

In partnership with QPRNZ, the MoH allocated 400 licences for community health workers across Waitemata and Auckland DHBs. These licences were pro-actively promoted through networks to target health service groups across the two districts. A significant number of frontline community workers were encouraged to engage in this education programme with wide representation from: Pacific, Maori, and Asian cultural support services, clinical services, school nurses and frontline support workers from youth, adult and older adult services.

The MoH completed an evaluation of the QPR on line training programme nationally and identified problems related to recruitment, commencement, and completion of the programme.

Within our region there were no problems with recruitment or commencement as identified by the national evaluation report. However, there were a number of people who did not complete. The MoH evaluation report identified the need for a system to follow up non-starters and recommended establishing dedicated supervisors to provide additional support to participants. Waitemata DHB and Auckland DHB will continue to engage with the Ministry in any future suicide prevention funded training programmes.

2.2 SafeTALK Training

SafeTALK, an American Programme adapted by Lifeline, is a suicide alertness training programme that prepares participants to identify people with thoughts of suicide and connect them with appropriate help. The workshop emphasizes the importance of recognizing the signs, communicating with the person at risk and getting help or resources for the person at risk.

- **SafeTALK to Rural Area**
  In response to the impact on the mental wellbeing of rural communities through ongoing climate and economic pressures, the Ministry of Health and Rural Health Alliance Aotearoa delivered 40 training workshops across rural New Zealand. These workshops aimed at up-skilling health and social service professionals in suicide risk assessment and prevention strategies, for this at risk group.

  During the month of March 2016, four SafeTALK workshops were delivered in Kumeu, Warkworth, Wellsford and Great Barrier Island. These workshops were directly supported by the Rural Alliance's Secretariat, the DHBs' Programme Manager for Suicide Prevention and the Maori Health Gain Team. The four workshops attracted a total of 71 attendees with a good mix of primary care staff, allied services and support personnel.

  Following the workshops people identified the need for additional training programmes and more advanced workforce development especially for primary care nurses. Applied Suicide Intervention Skills Training (ASIST) would be more useful for this cohort of clinicians because it is also aligned to clinical intervention and advancement on SafeTALK. ASIST is a facilitated two-

day workshop programme and is an effective approach to intervening with people considered by other/s to be at risk of suicide.

- **SafeTALK to family and whānau**
  Further to the delivery of the SafeTALK workshops to the rural community, a further five workshops were planned for delivery to family and whānau throughout the Waitemata and Auckland DHB areas, targeting identified vulnerable community groups. Four workshops have been facilitated by Lifeline and delivered at: Helensville (Māori community), Glenn Innes (Pacific Community), Grafton (general public) and Newmarket (Asian community).

  A total of 147 people attended the four workshops, and an evaluation was conducted at the end of all workshops.

These workshops align with the SPPAP with regards to a systematic approach of targeting specific ethnic and high risk groups and reflect not only the needs, but diversity within our population. There are plans to fund further suicide prevention education and workforce development programmes for the next 12 months, with changes made based upon evaluation and feedback received. There will be a focus on strategies to increase uptake in Maori communities and matching skill levels to the programmes delivered/provided.

3. Support families, whānau, hapū, iwi and communities AFTER a suicide

The Suicide Prevention and Postvention Inter-Agency Working Group is well established and works as a central agent in ensuring that there is a commitment from key agencies to act to support families, whānau and communities AFTER a suicide.

3.1 Postvention Support – Notification Pathway

Suicide postvention includes all the activities undertaken after a suspected suicide to address the traumatic after-effects for the survivors of suicide, including bereavement and trauma recovery, as well as ensuring education and screening efforts to reduce the risk of further suicides. A postvention notification pathway has been developed, in consultation with both the Advisory Group and the Inter-Agency Group. The coroner's office advises the Suicide Prevention Programme Manager of any suspected suicides. The Postvention group is advised of the notification and agree an action plan which includes allocating tasks and ensuring that actions to follow-up with appropriate schools and support services are completed. Any identified risks and needs for that community are planned for and addressed.

There has been evidence of better outcomes achieved through this coordination and responsiveness in supporting schools and whanau, as a result of increased awareness and collaboration between agencies through following the notification pathway. This coordinated effort has been activated on numerous occasions already, especially with young people who are still at school and under significant stress due to either completed suicide or suicidal behaviour of close associates. For example when a young person completed suicide the relevant agencies agreed to actions and completion in a timely way with the MoE Traumatic Incident team providing the immediate support to the principal and staff of the affected school. The Victim Support agency provided support for the family and whanau, while Youth Mental Health Services provided support for identified vulnerable young people closely associated with the victim.

In another case, the Inter-Agency Group met to formulate a safety plan in response to a request from Orewa College seeking support for a number of students who displayed suicidal behaviour .The

school counsellor was unable to cope with the demand. The safety plan involved short term measures where Youthline and Youth Mental Health Services (Marinoto and Health West Youth Hub) played pivotal roles. The MoE and Child Youth and Family Services contributed to the medium and long term parts of the action plan. This coordinated process achieved the desired outcomes of not only reducing the risk of suicide but also reducing the stress level for the school and the families.

3.2 Postvention Support – WAVES Programme

The primary focus of the WAVES programme is to provide people bereaved by suicide with the opportunity to participate in a psycho-educational programme that offers an experience of healing by connecting them with other people who have been bereaved by suicide. The purpose of WAVES in this context is to help adults learn more about grief and suicide, find meaning in their experiences, learn to manage emotions, reduce stigmatisation and feelings of isolation and assist them to move forward.

Skylight (a national organisation supporting people impacted by change, loss, trauma and grief) worked cooperatively with both Waitemata and Auckland DHBs to train facilitators of the WAVES programme. Eight frontline community workers from both clinical and NGO services were trained as facilitators. One session of the WAVES Programme has been commenced, which runs for eight weeks with eight people attending, with further two sessions planned before the end of this year. This pool of facilitators meets on a quarterly basis to provide peer support, share information and to engage in recruitment planning and continue development of referral pathway. These facilitators are growing the number of support groups as planned.

4. Improve services and support for people at high risk of suicide who are receiving health services

Mental Health Services and emergency departments are the two critical intervention points in the health system that can reach people with mental health problems and/or self-harm behaviour who are at risk of suicide. The focus group working on this objective is developing a draft plan to improve the clinical pathways between the Emergency Department (ED) and Primary Care and ED and secondary mental health services for people who attempt suicide or are at risk of suicide. This plan is based on four key areas:

1. Risk assessment and formulation must follow best practice and national guidelines in relation to suicide prevention
2. Pathways to safety should be identified at first contact
3. Collaboration and sharing with whanau/family, GP's, NGOs and other health professionals across teams/DHB.
4. Pathways of care – guidelines regarding information sharing with NGOs, ensuring quality of referrals with adequate risk information and clear early warning signs.

The Quality and Improvement Mental Health Service team is taking a lead role in this focus group and will draft the clinical pathway in consultation with ED, Primary Care and Secondary care.

5. Strengthen the infrastructure for suicide prevention

5.1 Suicide Prevention Advisory Group

Auckland DHB and Waitemata DHB Suicide Prevention and Postvention Advisory Group (SPPAG) is the backbone to the infrastructure supporting the implementation of the SPPAP and is responsible for advising and guiding the Inter Agency Working Group and the Suicide Prevention Programme Manager to continue to develop and implement a comprehensive, integrated and evidence-based SPPAP for the Waitemata and Auckland DHBs. Members of the SPPAG are drawn from various sectors including: DHB Funding and Planning; Community Mental Health and Addiction Services, Primary Care, PHOs, Psychiatric Liaison Services, CADS, Youth Services, Ethnic based Community Groups (including Maori, Pacific and Asian); Child and Youth Mortality Review Committee, Mental Health Services for Older Adults, Consumer Consultants and Family Advisors.

5.2 Reducing the suicide rate in service users

Waitemata DHB MHSG remains committed to focusing on reducing the suicide rate for service users. Provisional suicide data released by the Chief Coroner for the Waitemata DHB region is compared to known Waitemata DHB MHSG suicide data and for service users who were either under the care of services[1] or had been discharged within the four weeks prior to their death. The MHSG suicide data is collected from a number of sources, including Riskpro, Serious Incident Reports, HCC and the Quality Team Records. For the period 2011 to 2016 there have been a total of 85 suicide deaths for MHSG (and nine deaths where the cause of death is unknown at this time).

Each serious incident in MHSG is reviewed. Often these reviews will include recommendations for service improvement to lower the risk of a similar incident occurring in the future. Of the 85 suicide deaths (excluding nine suspected suicide) for Waitemata DHB MHSG between July 2011 and June 2016, 59% of reviews of suicide deaths contained recommendations which are grouped into the themes of “Clinical” (35%), “Process/policy” (25%), “Communication” (23%) and “Risk” (12%).

It has been identified that each of these areas will be mostly addressed through paying greater attention to training. Consequently the one day Risk Assessment and Safety Planning training programme has been refreshed and offered to all clinicians who have not previously attended or who would benefit from refresher training during 2016. This is an internal training programme, developed from MoH evidence and advice. The training covers orientation to policy and procedures, clinical assessment and development, documentation and communication of safety plans.

5.3 Make better use of data related to suicide deaths and self-harm incidents

There are a number of activities that relate to making better use of the data that the government already collects on suicide deaths and self-harm incidents to improve understanding of how best to address suicide. There are two main sources of national suicide data; the Coronial data and the Ministry of Health data.
The Coronial data on deaths due to “suspected” suicide is available nationally by financial year with an approximate six month delay. The annual suicide rates are calculated using this data and sometimes report slightly higher rates than those calculated by the Ministry of Health as they include deaths provisionally classified as suicide that may later be determined to have an alternative cause of death. In addition, at a local level, details of suspected suicides in Auckland DHB or Waitemata DHB are provided by the Coroner to the Suicide Prevention Programme Manager as soon

[1] The services included are: Adult Mental Health Services, Regional Forensic Psychiatry Services (RFPS), Community Alcohol and Drug Services (CADS), Child and Youth Mental Health, Whitiki Maurea Maori Mental Health Service, and Takanga a Fohe Pacific Mental Health Service. Excluded are service users under the care of Mental Health Services for Older People as this service is not part of the Mental Health Services Group.

as the information becomes available. This information is then disseminated to the inter-agency group as part of the notification pathway.

The Ministry of Health produces a report titled "Suicide Facts", annually by calendar year based upon data from more than two or three years ago. This data is the most accurate official information available on suicide deaths and self-harm incidents. Overview data from "Suicide Facts 2013" is included at the end of this report.

The focus group was tasked to provide a detailed analysis of emerging trends from both data sources, which allow the SPPAG to identify targeted responses and solutions. This has taken the form of a report clarifying the strengths and limitations of the available data sources to enable a shared understanding of the possible data interpretation. It also informs the discussion as to the indicators that have the most utility to monitor progress on reduction of suicide and self-harm in both Auckland and Waitemata DHBs. This comprehensive picture of the trends in our population will be updated yearly supported by a data working group.

5.4 Working in Partnership

It is vital that good relationships are formed with relevant partners who provide support services for people who are at risk of suicide within the suicide prevention landscape. Making suicide prevention "everyone's business" is a message that needs to be shared with the public and it is important to link up with relevant organisations and community groups such as; Mental Health Foundation and Waka Hourua (Te Rau Matatini and Le Va) to share resources and to ensure information and support reaches the wider community. The Suicide Prevention Programme Manager regularly attends and participates in community events and meetings to maximise the opportunities to spread this message and to raise suicide prevention awareness. Some examples are listed below:

- Attendance at the second Youth Health Expo at Rodney College and Mahurangi College, held to target high schools within our district provided opportunity for raising awareness of the health services that are available for youth in the upper Rodney region and also to directly address some of the concerns of our youth. In a question and answer panel where students were able to ask specific questions anonymously through a text line, students were well engaged and issues relating to cyber bulling, stress and suicidal behaviours were common features of questions asked by students.
- "LookUp" is a youth run and led event that inspires innovative ways to wellbeing. The LookUp 2016 theme explores wellbeing around alcohol and other drugs and encourages young people to look at how a sense of self can build resilience and inspire thinking about how they look out for their mates.
- During the Pacific celebration week for Waitemata and Auckland DHB, a number of events were organised to promote and show case Pacific health services. The Suicide Prevention Programme Manger facilitated a men's group session to discuss mental health and the challenges Pacific men encounter when seeking help for mental health issues. Sharing stories of their journey was an effective vehicle to identify learning and to share information.
- Te Puni Kokiri (TPK) have engaged with six providers to deliver projects to reduce suicide within Rangatahi (Māori youth) with a particular focus on cyber bullying and takatapui (Lesbian, Gay, Bisexual, Transvestite) matters. The Suicide Prevention Programme Manager participated in the Hui to design an outcomes framework for these projects. Through service linkage and developing a working relationship with TPK in the area of suicide prevention especially for Rangatahi (given the high risk status of this population) the reach of support and making suicide prevention everyone's business is acted upon.

6. Review and Refresh of the Plan

The current SPPAP is due to be revised at the end of the 2017 financial year. Constructive and effective engagement with community stakeholders is critical for both the revision process and effective implementation of the revised Plan. These stakeholders will include but not be limited to the: Child and Youth Implementation Governance Group, Waitemata Stakeholder Network, Provider Executive Group, Navigate Forum, Innovate and PHO Forums.

Excerpts from Suicide and Intentional Self-Harm Data Report - February 2016. Dr Sarah Gray

Suicides

Ministry of Health Suicide Data New Zealand (Suicide Facts 2013)

The annual Ministry of Health Suicide Facts publications find that suicide rates per 100,000 population are slightly lower in both ADHB and WDHB than the national average (table 3).

Table 3: Numbers and rates (per 100,000) of suicide in ADHB, WDHB and NZ as per Ministry of Health Suicide Facts, 2011 - 2013

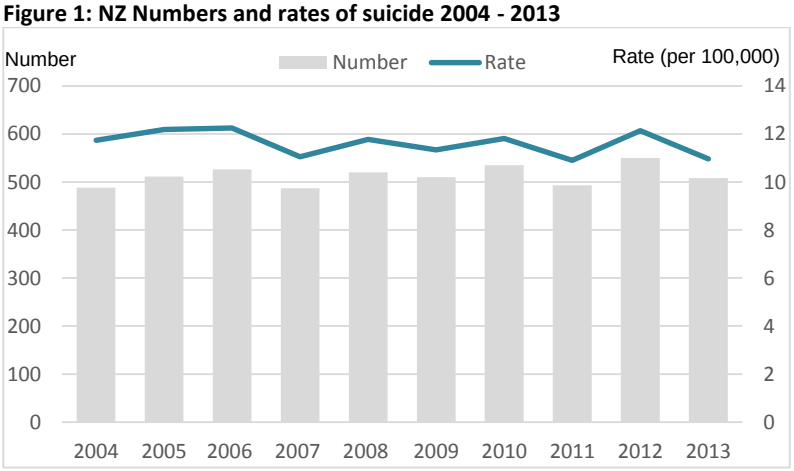
	2011 Number	Rate per 100,000 (2007 – 2011)	2012 Number	Rate per 100,000 (2008 – 2012)	2013 Number	Rate per 100,000 (2009 – 2013)
ADHB	-	8.5	-	8.9	-	awaited
WDHB	-	9.3	-	9.4	-	awaited
NZ	493	10.9*	550	12.1*	508	11.0*

** = rate for that individual year*
Source: Ministry of Health Suicide Facts

Figures 1-4 show the numbers and rates of suicide for NZ 2004 – 2013 in total, and by gender, life style age group and for Maori and non-Maori.

The national suicide rate has remained fairly steady from 2004 to 2015 fluctuating between 12.2 and 10.9 per 100,000 (Figure 1).

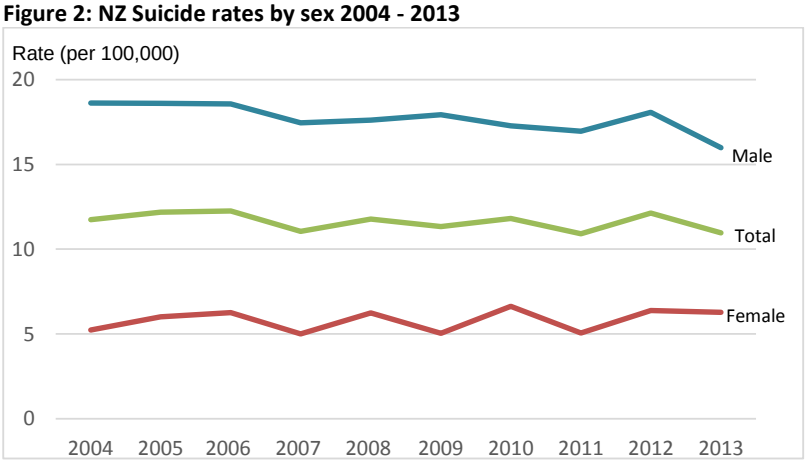
Figure 1: NZ Numbers and rates of suicide 2004 - 2013



Source: Ministry of Health Suicide Facts 2013

The rates are consistently higher for males compared to females (Figure 2) with the male rate reaching as high as 18.6 (2004 – 2006) and the female rate as low as 5.0 (2007 and 2009).

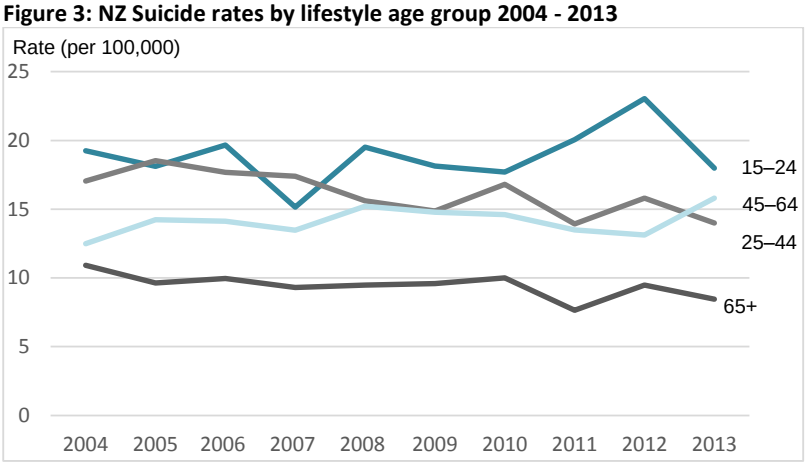
Figure 2: NZ Suicide rates by sex 2004 - 2013



Source: Ministry of Health Suicide Facts 2013

NZ suicide rates vary by lifestyle age group with rates highest in youth and lowest in the over 65 age group (Figure 3).

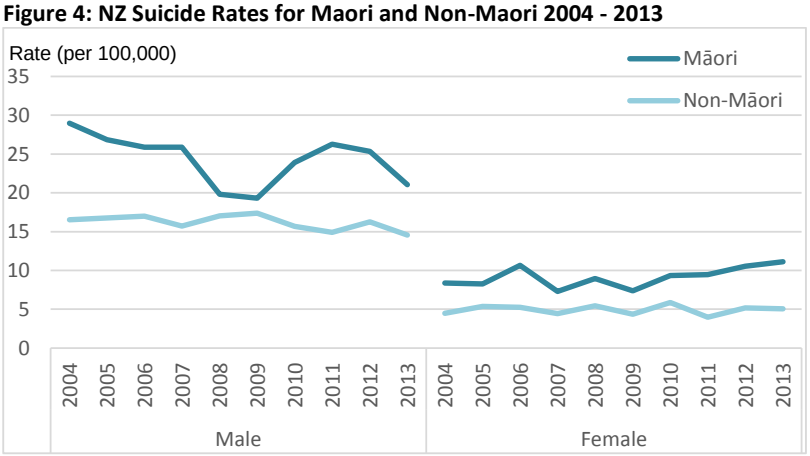
Figure 3: NZ Suicide rates by lifestyle age group 2004 - 2013



Source: Ministry of Health Suicide Facts 2013

Nationally rates are also consistently higher for Maori compared to Non-Maori (Figure 4) for both males and females.

Figure 4: NZ Suicide Rates for Maori and Non-Maori 2004 - 2013



Source: Ministry of Health Suicide Facts 2013

Intentional self-harm hospitalisations

Table 10 gives the rates of intentional self-harm hospitalisations for Auckland and Waitemata DHBs as extracted from the annual Ministry of Health (MoH) Suicide facts reports as well as the national rate. The DHB rates are averaged by the MoH over 3 years to reduce variation caused by small numbers. The DHB rates are much lower than also available decision support data; because the MoH excludes short-stay emergency department hospitalisations (less than one day) and admissions within two days of a previous intentional self-harm hospitalisation. Data is not available at DHB level by ethnic group in these reports. The 2013 data is not yet available.

Table 10: Rates of intentional self-harm hospitalisations for ADHB, WDHB and NZ

	2008 - 2010	2009 - 2011	2010 - 2012	2011 - 2013
Auckland				
Male	32.3	27.8	30.0	awaited
Female	33.8	33.3	36.8	awaited
ADHB Total	**32.8**	**30.5**	**33.3**	**awaited**
Waitemata				
Male	46.2	47.2	48.5	awaited
Female	70.3	71.2	85.6	awaited
WDHB Total	58.3	59.2	67.0	awaited
NZ Total	**61.4**	**62.2**	**66.0**	**awaited**

Source: Ministry of Health Suicide Facts reports
Rates standarised to WHO population

3.2 Child, Youth and Women's Health

Recommendation

That the report be received.

Prepared by: Ruth Bijl (Funding and Development Manager - Child, Youth and Women's Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Senior Programme Manager - Women's Health), Dr Tim Jelleyman (WDHB Community Paediatrician), Dr Alison Leversha (ADHB Community Paediatrician) and Dr Karen Bartholomew (Public Health Physician).
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

DHB	-	District Health Board
HHI	-	Healthy Housing Initiative
HPV	-	Human Papilloma Virus
ISP	-	Independent Service Providers for cervical and breast screening
LMC	-	Lead Maternity Carer
MoH	-	Ministry of Health
NHI	-	National Health Index
NSU	-	National Screening Unit
PHO	-	Primary Health Organisation
RhF	-	Rheumatic Fever

1. Summary

This report presents information on significant health outcomes for children, youth and women. The report is in the form of a scorecard. The indicators cover the life-course of maternity, child and youth health, as well as women's health. All indicators are presented as a total with separation by Māori, Pacific and Asian ethnicity. The narrative presents highlights, key issues and discussion in relation to items that are not on track.

2. Highlights and key issues for Child, Youth and Women's and Scorecard

Health and Better Public Service Targets

- The immunisation health target continues to be a challenge. The 95% coverage target will not be achieved this quarter though some progress has been made since last quarter.
- Extremely good progress is being made against the new 'raising healthy kids' process target. Waitemata, closely followed by Auckland, lead the country.
- The Committee was informed verbally at its July meeting that the Rheumatic Fever target was not achieved in either Auckland or Waitemata. Consequently the Ministry has required us to prepare a resolution plan. The draft plan proposes strengthening a number of key areas including:
    - Engaging Pacific leadership across the programme
    - Increasing community awareness
    - Improving the consistency of messages delivered by health professionals
    - Decreasing variation in primary care against the guidelines
    - Extending activities in relation to healthy homes.

Child

- A patient information sheet has been launched to inform new parents about free health services. The intent is to increase early enrolment in primary care, Well Child Tamariki Ora, oral health and other services.

Youth

- The Waitemata procurement process for integrated youth primary health services is progressing with proposals received. A recommendation from the panel will be provided to the Waitemata DHB Board in November.

Maternity

- The Obesity Plan identified increasing breastfeeding rates as a priority. To achieve this, Plunket have been contracted to pilot a Breastfeeding Peer Support programme in Glen Innes, Panmure and Ranui. The aim is to increase breastfeeding rates at three months and beyond.

- To support implementation of the Gestational Diabetes Guidelines, education regarding HbA1C testing is being provided to Primary Care at a Women's Health seminar run by the Goodfellow Institute. GPs are expected to support women with appropriate lifestyle interventions early in pregnancy, including advice on appropriate weight gain in pregnancy and eating for a healthy pregnancy. This may also refer to a Green Prescription provider. To ensure Green Prescription providers support pregnant women appropriately, a training workshop is being provided by a multidisciplinary team.

Auckland and Waitemata DHBs Child, Youth and Women's Health Scorecard

October 2016

Auckland DHB

	Actual	Target	Period
Children			
Fully immunised by 8 months			
Total	94%	95%	Sep-16
Maori	97%	95%	Sep-16
Pacific	94%	95%	Sep-16
Asian	96%	95%	Sep-16
Other	89%	95%	Sep-16
Fully immunised at 2 years			
Total	94%	95%	Sep-16
Maori	88%	95%	Sep-16
Pacific	97%	95%	Sep-16
Asian	96%	95%	Sep-16
Other	87%	95%	Sep-16
Fully immunised at 5 years			
Total	87%	90%	Sep-16
Maori	80%	90%	Sep-16
Pacific	86%	90%	Sep-16
Asian	88%	90%	Sep-16
Other	85%	90%	Sep-16
Obese children referred (and referral acknowledged)			
Total	66%	95%	Jul-16
Maori	76%	95%	Jul-16
Pacific	68%	95%	Jul-16
Other	62%	95%	Jul-16
Rheumatic Fever rate*	3.90	1.50	2015/16
* acute cases per 100,00 population			
% of women booking with a LMC before 12 weeks (community midwives)			
Total	69%	80%	CY2015
Maori	51%	80%	CY2015
Pacific	44%	80%	CY2015
Asian	71%	80%	CY2015
Other	79%	80%	CY2015
% of women smokefree at delivery			
Total	96%	86%	2015/16
Maori	62%	86%	2015/16
Pacific	91%	86%	2015/16
Asian	97%	86%	2015/16
Other	98%	86%	2015/16
Breastfeeding - % exclusive or fully breastfeeding at 3 months			
Total	61%	54%	Jul-Dec 15
Maori	47%	54%	Jul-Dec 15
Pacific	48%	54%	Jul-Dec 15
Asian	64%	54%	Jul-Dec 15
Other	66%	54%	Jul-Dec 15
Breastfeeding - % receiving breast milk at 6 months			
Total	76%	59%	Jul-Dec 15
Maori	63%	59%	Jul-Dec 15
Pacific	60%	59%	Jul-Dec 15
Asian	83%	59%	Jul-Dec 15
Other	79%	59%	Jul-Dec 15
% babies enrolled with a PHO by 3 months			
Total	73%	98%	Q4 2015/16
Maori	51%	98%	Q4 2015/16
Pacific	70%	98%	Q4 2015/16
Oral health - % infants enrolled in dental service by 1 year			
Total	49%	98%	Sep-16
Maori	24%	98%	Dec-15
Pacific	28%	98%	Dec-15
Asian	26%	98%	Dec-15
Other	36%	98%	Dec-15
Oral health - % utilisation by 1 year			
Total	7%	100%	2015/16
Maori	5%	100%	2015/16
Pacific	5%	100%	2015/16
Asian	6%	100%	2015/16
Other	8%	100%	2015/16
Before School Check coverage rates			
Total	16%	15%	Sep-16
Maori	17%	15%	Sep-16
Pacific	16%	15%	Sep-16
Other	16%	15%	Sep-16
Youth			
HPV immunisation coverage (dose 3)			
Total	83%	70%	Jun-16
Maori	91%	70%	Jun-16
Pacific	85%	70%	Jun-16
Asian	79%	70%	Jun-16
Other	82%	70%	Jun-16
Oral health: Adolescent utilisation rates			
Total	79%	80%	CY 2015
Women			
Cervical screening rate (25-69 years: 3 year coverage)			
Total	73%	80%	Jun-16
Maori	56%	80%	Jun-16
Pacific	75%	80%	Jun-16
Asian	62%	80%	Jun-16
Other	83%	80%	Jun-16
Breast screening rate (50-69 years: 2 year coverage)			
Total	65%	70%	Jun-16
Maori	60%	70%	Jun-16
Pacific	74%	70%	Jun-16
Other	64%	70%	Jun-16

Waitemata DHB

	Actual	Target	Period
Children			
Fully immunised by 8 months			
Total	94%	95%	Sep-16
Maori	88%	95%	Sep-16
Pacific	97%	95%	Sep-16
Asian	99%	95%	Sep-16
Other	90%	95%	Sep-16
Fully immunised at 2 years			
Total	92%	95%	Sep-16
Maori	94%	95%	Sep-16
Pacific	93%	95%	Sep-16
Asian	97%	95%	Sep-16
Other	85%	95%	Sep-16
Fully immunised at 5 years			
Total	83%	90%	Sep-16
Maori	83%	90%	Sep-16
Pacific	83%	90%	Sep-16
Asian	88%	90%	Sep-16
Other	80%	90%	Sep-16
Obese children referred (and referral acknowledged)			
Total	68%	95%	Jul-16
Maori	66%	95%	Jul-16
Pacific	72%	95%	Jul-16
Other	67%	95%	Jul-16
Rheumatic Fever rate*	2.10	1.00	2015/16
* acute cases per 100,00 population			
% of women booking with a LMC before 12 weeks (community midwives)			
Total	73%	80%	CY2015
Maori	57%	80%	CY2015
Pacific	48%	80%	CY2015
Asian	74%	80%	CY2015
Other	82%	80%	CY2015
% of women smokefree at delivery			
Total	93%	86%	2015/16
Maori	70%	86%	2015/16
Pacific	90%	86%	2015/16
Asian	100%	86%	2015/16
Other	96%	86%	2015/16
Breastfeeding - % fully breastfeeding at 3 months			
Total	59%	54%	Jul-Dec 15
Maori	53%	54%	Jul-Dec 15
Pacific	51%	54%	Jul-Dec 15
Asian	57%	54%	Jul-Dec 15
Other	63%	54%	Jul-Dec 15
Breastfeeding - % receiving breast milk at 6 months			
Total	72%	59%	Jul-Dec 15
Maori	60%	59%	Jul-Dec 15
Pacific	60%	59%	Jul-Dec 15
Asian	77%	59%	Jul-Dec 15
Other	75%	59%	Jul-Dec 15
% babies enrolled with a PHO by 3 months			
Total	73%	98%	Q4 2015/16
Maori	70%	98%	Q4 2015/16
Pacific	78%	98%	Q4 2015/16
Oral health - % infants enrolled in dental service by 1 year			
Total	51%	98%	Sep-16
Maori	41%	98%	Dec-15
Pacific	40%	98%	Dec-15
Asian	45%	98%	Dec-15
Other	62%	98%	Dec-15
Oral health - % utilisation by 1 year			
Total	15%	100%	2015/16
Maori	9%	100%	2015/16
Pacific	8%	100%	2015/16
Asian	15%	100%	2015/16
Other	20%	100%	2015/16
Before School Check coverage rates			
Total	16%	15%	Sep-16
Maori	17%	15%	Sep-16
Pacific	16%	15%	Sep-16
Other	15%	15%	Sep-16
Youth			
HPV immunisation coverage (dose 3)			
Total	60%	70%	Jun-16
Maori	66%	70%	Jun-16
Pacific	67%	70%	Jun-16
Asian	63%	70%	Jun-16
Other	56%	70%	Jun-16
Oral health: Adolescent utilisation rates			
Total	67%	80%	CY 2015
Women			
Cervical screening rate (25-69 years: 3 year coverage)			
Total	76%	80%	Jun-16
Maori	59%	80%	Jun-16
Pacific	76%	80%	Jun-16
Asian	65%	80%	Jun-16
Other	82%	80%	Jun-16
Breast screening rate (50-69 years: 2 year coverage)			
Total	67%	70%	Jun-16
Maori	64%	70%	Jun-16
Pacific	77%	70%	Jun-16
Other	67%	70%	Jun-16

How to read

Indicator Title — 85% (Actual) — Performance — 100% (Target)

Performance compared to previous result

DHB performance achieving at or above the target will display as a solid green line.

For most indicators, 70% achievement is required to trigger the green bar (80% for HTs)

"Other" represents all ethnicities not otherwise specified. Generally this means NZE and all non Maori, Pacific and Asian ethnicities (depending on level of data available).

3. Activity in detail

3.1 Health and Better Public Service Targets

3.1.1 Immunisation

As of 10 September 2016, both Auckland and Waitemata achieved 94%. This represents 1% improvement for both DHBs compared with the previous quarter (Q4 2015/16). However, neither DHB is likely to achieve the Immunisation Health Target of 95% of 8 month old infants fully immunised in Q1 2016/17. High coverage rates have been maintained in both Pacific and Asian communities (94% - 99%) although equity gaps remain for Māori infants with only 87% - 88% fully immunised by 8 months of age. Our evidence suggests delays and declines remain a significant challenge for Māori, particularly at this time of year as families manage winter illnesses.

In terms of numbers of children, the following table sets out the breakdown of those immunised (on time) compared with those not immunised, declined or opted off the register. (Both the decliners and the opt-off groups remain in the population denominator and have had contact with the primary care health system and outreach immunisation service.) (Note the slight difference in numbers between is that table 1 uses the known cohort turning 8 months between July-Sept 2016 whereas the scorecard uses the data for the 3 months ending 10 September 2016.) Final quarter data will be provided verbally to the Committee at its meeting.

Table 1: Immunisation status of children turning 8 months July-September 2016

Cohort and immunisation status	Auckland DHB	Waitemata DHB
Number of infants turning 8 months in the quarter (July-Sept 2016)	1,400	1,844
Immunised on time	1,310 (93.6%)	1,719 (93.8%)
Declined	26 (1.9%)	57 (3.1%)
Opt off	5 (0.4%)	9 (0.5%)
'Missed'	38 (2.7%)	32 (1.7%)

The 1% improvement in coverage suggests the new action plan with a focus on connecting earlier is achieving some traction. We aim to engage during pregnancy so women have time to consider immunisation earlier and to help predict decliners/hesitant families earlier.

A promotional campaign called 'Protecting Baby Starts in Pregnancy' is underway. Results from this promotional campaign are very positive. The 'Protecting Baby Starts in Pregnancy' campaign ran throughout June and July 2016 via radio and social media particularly in West Auckland, where the decline rate is most significant. Overall, the Facebook advertisements were presented over 2 million times, reached almost 24,000 people and generated 1,943 visits to the Ministry of Health (MoH) Immunisation webpage. The click-through rate achieved was 0.10% - double the NZ average of 0.05% for Facebook advertising. The radio advertising was heard by 60% of the core target audience (mums in Waitemata DHB area) and 45% of the Auckland-wide 'mum' audience. Sustained promotional effort will be required to reach newly pregnant women and their families.

Joint DHB/PHO education sessions are underway for primary care practice staff and lead maternity careers (LMCs) across the Auckland region and we are working with PHOs to support practices in localities with high decline rates.

This multi-pronged approach has seen a marked improvement in vaccine hesitancy in Waitemata DHB from a peak of 6.4% in March/April to 3.9% currently for babies turning 2 years old.

Specifically for Māori infants, the Māori Health Gain Team will develop and support the implementation of an action plan to eliminate the inequity gap between Māori and non-Māori 8-month immunisation coverage. This involves conducting barriers and solutions workshop with key stakeholders which are scheduled for October. The outcomes will be used to identify appropriate strategies going forward to support the achievement of the National 8-month immunisation target for Māori of 95%.

3.1.2 Childhood Obesity

The B4 School Check is a health assessment completed on four year old children in the year prior to them starting school. One of the primary purposes of the check is to make sure children have no impediments to learning and have appropriate supports from their first day at school. The 'Raising Healthy Kids' target requires the B4 School Check Nurses to establish whether a child is over the 98th BMI percentile, refer the child/family to the GP and receive acknowledgement of the referral within 30 days.

The August results released earlier this month from the Ministry of Health indicate Waitemata DHB (Figure 1) and Auckland DHB (Figure 2) are the highest and second highest performing DHBs nationally for this target at 65% and 63% respectively. Currently in Waitemata DHB, 68% of children have had their referral acknowledged by their General Practice which is an increase from 41% in our last report. In Auckland DHB, 66% of children have had their referral acknowledged this is up from 38% in the last report. This steady improvement can be seen clearly and will continue to climb as we move closer to the entire cohort being measured having been part of the intervention (Figure 3).

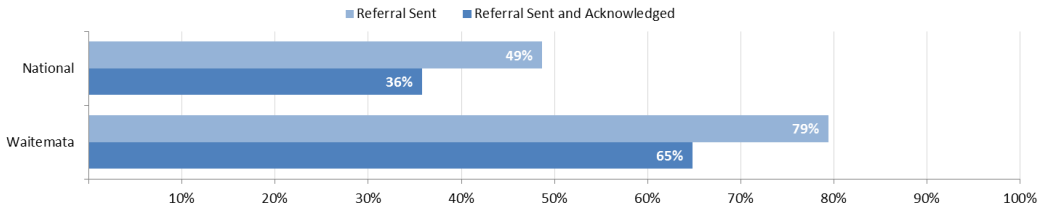


Figure 1 - Waitemata DHB Referral acknowledged compared with national average

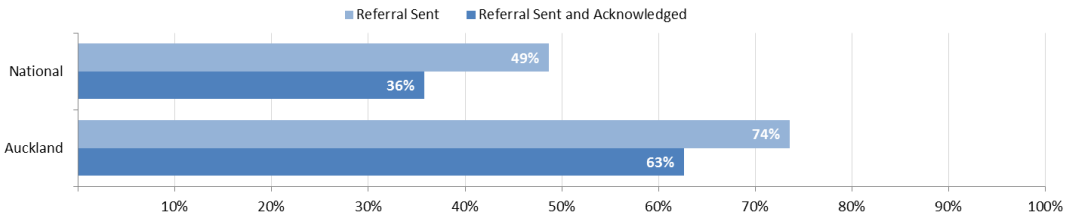


Figure 2 - Auckland DHB Referral acknowledged compared with national average.

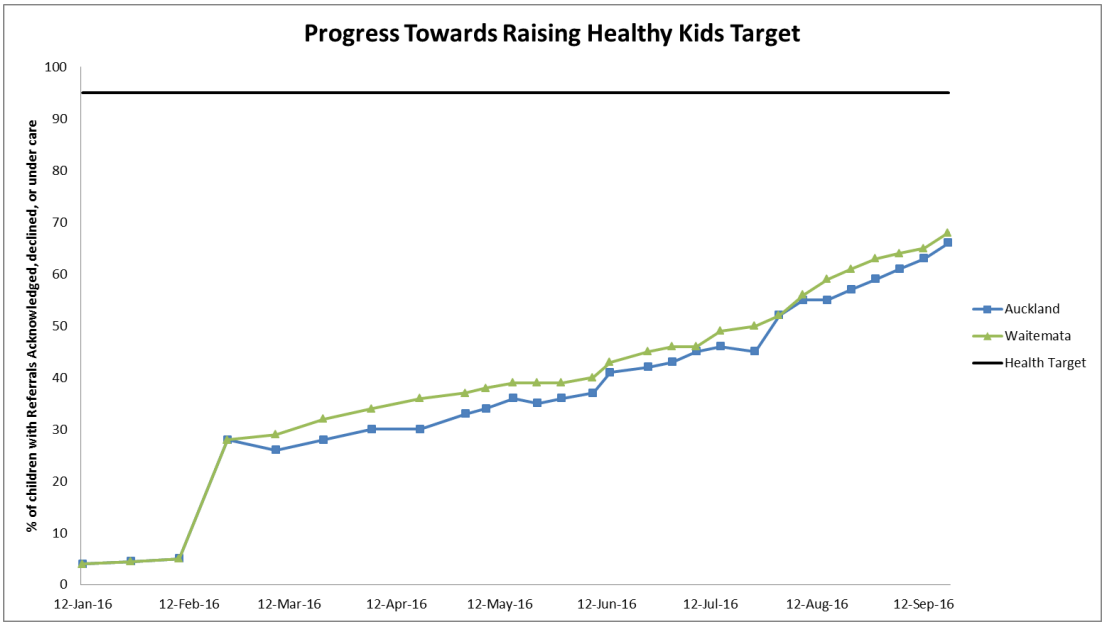


Figure 3 - Auckland and Waitemata DHB – Raising Healthy Kids

A Northern Regional Pathway has been drafted and is progressing through the approval process. The 'BeSmarter' resource (developed in Waikato) is now being used as part of our Plunket's health worker's brief intervention for children identified as over the 98th percentile. For consistency of message, general practices are also being trained in the use of the 'BeSmarter' resources. The Dietetics Departments in Auckland and Waitemata DHBs have been contracted to provide Raising Health Kids training to General Practitioners and Practice Nurses, along with general information on healthy weight in children. The Primary Health Organisations have each identified a Raising Healthy Kids Target champion.

Work has begun on designing a service model for the family-based community programme which is due to be implemented from 2017/18 financial year. This includes regular and ongoing collaboration from diverse interest groups within the DHBs. As previously signalled, the DHB will under-take a procurement process in 2016/17.

Solid progress is being made against this important new health target and progress will continue to be reported routinely to the Committee through this scorecard.

3.1.3 Rheumatic Fever

At its last meeting the Committee were advised that the Rheumatic Fever target was not achieved. Results for 2015/16 were provided by the Ministry shortly before the last Committee meeting. For 2015/16 these were:

- Auckland had 19 cases (a rate of 3.9 per 100,000)
- Waitemata 12 cases (2.1 per 100,000)

The Ministry stated that "case numbers in Auckland have remained virtually unchanged since the beginning of the Rheumatic Fever Prevention Programme: 20 cases in 2013, 17 in 2013/14, 13 cases in 2014; 15 cases in 2014/15; 14 cases in 2015; 19 cases in 2015/16. In Waitemata, there was some downward movement since 2014 but a non-significant increase in 2015/16: 9 cases in 2013, 13 in 2013/14, 15 cases in 2014; 9 cases in 2014/15; 7 cases in 2015; 12 cases in 2015/16."

Overview of target and current position

In June 2012, the MoH set Rheumatic Fever targets of:

- Auckland DHB incidence of 1.1 new RhF cases per 100,000 total population by 2016/17.
- Waitemata DHB incidence of 0.8 new RhF cases per 100,000 total population by 2016/17.

As at end 2015/16 neither Auckland DHB or Waitemata DHB had achieved the Better Public Service Target as shown in tables 1-4.

Table 1: ADHB Rheumatic Fever Better Public Service Target for rate of new cases of RhF

	2009/10–2011/12 Baseline rate	**2012/13** Remain at baseline	**2013/14** 10% reduction	**2014/15** 40% reduction	**2015 /16** 55% reduction	**2016/17** 2/3 reduction
Target rate	3.2	3.2	2.9	2.0	1.4	1.1
Actual rate	2.8	2.8	3.7	3.2	3.9	

Table 2: ADHB Rheumatic Fever Better Public Service Target for numbers of new cases RhF

# of cases	**2009/10–2011/12** Baseline	**2012/13** Remain at baseline	**2013/14** 10% reduction from baseline	**2014/15** 40% reduction from baseline	**2015 /16** 55% reduction from baseline	**2016/17** 2/3 reduction from baseline
Target	15	15	14	9	7	5
Actual	15	17	17	15	19	

Table 3: WDHB Rheumatic Fever Better Public Service Target for rate of new cases of RhF

Baseline rates	**2009/10–11/12** Baseline rate (3-year mean rate/100,000)	**2012** Remain at baseline	**2013** Remain at baseline	**2013/14** 10% reduction	**2014/15** 40% reduction	**2015 /16** 55% reduction	**2016/17** 2/3 reduction
Target	2.2	2.2	2.2	2.0	1.6	1.0	0.7
Actual	1.8	1.8	1.6	2.3	1.6	2.1	

Table 4: WDHB Rheumatic Fever Better Public Service Target for numbers of new cases RhF

# of cases	**2009/10–2011/12** Baseline	**2013** Remain at baseline	**2013/14** 10% reduction from baseline	**2014/15** 40% reduction from baseline	**2015 /16** 55% reduction from baseline	**2016/17** 2/3 reduction from baseline
Target	12	12	11	8	6	4
Actual	10	9	13	9	12	

For comparative purposes, equivalent data for Counties Manukau DHB is also provided, with thanks to Counties Manukau DHB.

Table 5: Counties Manukau DHB Rheumatic Fever Better Public Service Target for rate of new cases of RhF
(Source: Rheumatic fever prevention plans: Guiding information for District Health Boards with a high incidence of acute rheumatic fever hospitalisations. MoH 2013.)

Baseline rates	**2009/10–11/12** Baseline rate	**2012/13** Remain at baseline	**2013/14** 10% reduction	**2014/15** 40% reduction	**2015 /16** 55% reduction	**2016/17** 2/3 reduction
Target	13.6	13.6	12.2	8.2	6.1	4.5
Actual	13.6	14.5	12.7	8.0	7.0	

Table 6: Counties Manukau DHB Rheumatic Fever Better Public Service Target for numbers of new cases RhF (Source: Rheumatic fever prevention plans: Guiding information for District Health Boards with a high incidence of acute rheumatic fever hospitalisations. MoH 2013.)

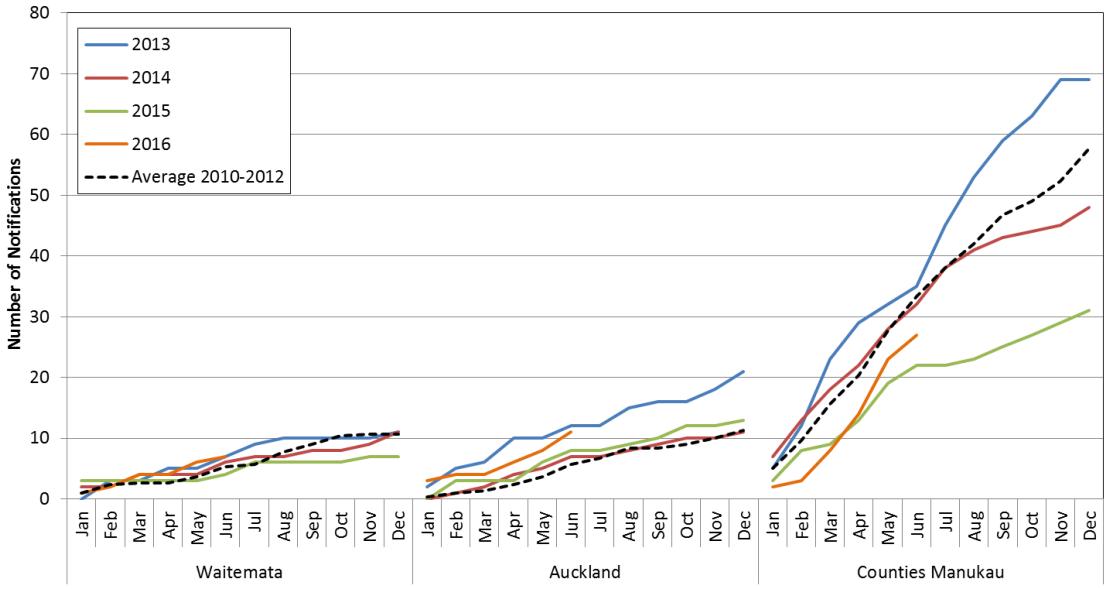
# of cases	**2009/10–2011/12** Baseline	**2012/13** Remain at baseline	**2013/14** 10% reduction from baseline	**2014/15** 40% reduction from baseline	**2015 /16** 55% reduction from baseline	**2016/17** 2/3 reduction from baseline
Target	66	66	62	42	32	24
Actual	66	72	66	41	37	

The comparative rates for the three metro Auckland DHBs for 2015/16 were:

Waitemata	2.1/100,000
Auckland	3.9/100,000
Counties Manukau	7.0/100,000

Figure 1 shows the same information regarding number of notifications over time, including results for Counties Manukau. It is important to note that, unlike Counties Manukau DHB, Auckland DHB and Waitemata DHB have limited population coverage through the primary school programme. Counties Manukau DHB has sufficient population coverage (over 80%) through the school programme to target the vast majority of the at risk community.

Figure 1: ARF Initial Attack Total Notifications by DHB and Admission Month, 2010-2016 Auckland Region prepared by Dr Catherine Jackson (ARPHS)



The actions we have taken to date in Auckland DHB and Waitemata DHB include:

- Establishing a Steering Group which was re-shaped for 2016 to include membership from across Auckland and Waitemata DHBs.
- Developing initial and Annual Plans for approval by MoH.
- Identifying DHB Champions.
- Entering an Alliance Agreement in Auckland DHB with PHOs and DHB.
- A Pacific Engagement Strategy delivered by Alliance Health Plus (through a MoH contract).
- The Auckland Wide Healthy Housing Initiative (AWHI) led by the Ola Coalition (Alliance Health Plus and the National Hauora Coalition) (through a MoH contract).
- Raising community awareness through a variety of means such as the HYPE event, school community RhF awareness raising and localised events (e.g. the Pomaria School Health Day).
- Implementing a RhF Community and Sector Engagement Team to work with frontline staff across the DHB.
- Recently, adding targeted face to face messaging to the B4SC for Māori, Pacific and Q5 about the importance of getting sore throats checked, antibiotic compliance and tips for a warmer, drier, healthier house.
- The school-based throat swabbing and treatment programme which was implemented in 16 (Auckland DHB) and 5 (Waitemata DHB) primary schools (with high incidence of RhF).
- Contracting with Te Whanau o Waipareira for community swabbing in Waitemata DHB.
- Trialling a Community Health Worker in secondary schools where we have DHB funded services.
- Providing education on RhF guidelines to secondary school-based nurses.
- Establishment through primary care of Rapid Response clinics in practices with a high proportion of Māori, Pacific and Q5. This included the addition of pharmacy in locations where practices were not engaged.
- Reviewing the Bicillin programme and implementing systems improvements to ensure compliance with 28 day antibiotic requirement.
- A major review of the adult community nursing service re Bicillin administration.
- Development of a Fight the Fever App to assist with getting Bicillin on time.

- Working actively on improving disease management including setting up a primary care group to examine coding, recall systems etc. for RhF management.
- Case finding in paediatric wards for referral to Healthy Housing Initiative (HHI).
- Case review – all cases systematically reviewed and feedback to providers.
- Establishing a process for primary care review of new RhF cases.

Some of the learnings, planned actions and new initiatives underway are summarised below:

- RhF is strongly associated with the social determinants of health. Having discussed with Ministry staff and based on self-reflection, we consider that there is still have work to do particularly in relation to housing, primary care and community awareness. We consider that the primary school programme is unlikely to have delivered significant benefits to reducing disease due to issues of 'reach' or coverage (though there are other benefits). However, the programme may have curbed an increase in disease. In fact, we would suggest that, given the increase in housing related poverty over the last five years, static (rather than increasing) levels of disease is indeed a positive outcome that has been delivered through health-driven interventions.
- We are in discussion with the MoH regarding the expanded HHI (see below). A draft plan has been prepared. The Plan aims to leverage off existing workforces (DHB social work) as well as housing/social NGOs. We met with Te Puni Kokori (TPK) to discuss engagement and feedback loops with Whanau Ora providers.
- Community awareness – the recent change to the B4SC looks worth maintaining. We consider we need to increase community awareness and improve linkages across community awareness raising activites. We met with the Chief Pacific Advisor at MoH to explore what we can do differently. The Community Engagement plan will be reviewed.
- Primary care – information regarding achievement against target was shared with the Governance Group. An extraordinary meeting was held to discuss the target and specifically what needs to be done in primary care and across the system. This information has been used to inform the draft resolution plan. PHOs have identified a named medical and nursing lead for RF in each PHO.

Further information regarding the Ministry's response to the draft resolution plan will be provided at the Committee meeting.

Healthy Homes Initiative Expansion
As previously reported, the MoH has expanded the HHI, broadening the original objective of preventing rheumatic fever by reducing household crowding to focus more broadly on warm, dry, healthy housing for 0 to 5 year old children and pregnant women.

The HHI service will systematically identify and refer eligible families/whānau to the HHI Service. Actions include:

- Engaging with eligible families/whānau.
- Coordinating interventions to deliver warmer, drier and healthier homes.
- Building and facilitating the supply of interventions (such as curtaining).
- Ensuring greater understanding among families/whānau about the relationship between living in cold, damp and unhealthy homes and preventable illness, such as infectious respiratory conditions, rheumatic fever or meningitis.
- Providing targeted tips for a warmer, drier and healthier home.

A HHI plan has been presented to and accepted by the MoH. The plan is a whānau centred approach, with health social work taking a lead and tailoring support as appropriate to meet

individual whānau needs, alongside the Māori and Pacific Teams. Referrals to Whānau Orā providers and Non-Government Organisations (NGOs) may be made as appropriate.

To date there have been positive discussions with the health social work leads across both DHBs and with Te Puni Kōkiri (Whānau Orā). The next steps in the HHI expansion include formulating a service level agreement with the provider arm (Health Social Work across child and women services) and asking for expressions of interest of the NGO sector to deliver components of the HHI service. As part of the MoH contract there are significant reporting requirements. A robust reporting system is being developed to capture all the data and show outcomes for whānau. The aim is to begin accepting referrals to the new service in December this year after promoting the new eligibility criteria and referral pathway.

Auckland DHB and Waitemata DHB have been working with the Southern Initiative (Auckland Council) to address the supply of interventions for the Health Homes Initiative through a co-design process. Findings indicate community willingness to engage and availability of a range of supplies, however, coordinating these around families/whanau could be improved.

3.2 Children

Newborn Enrolment 'Free Health Services for Your Baby' flyer launched
The Annual Plan and Manawa Ora Plan require Auckland and Waitemata DHBs to develop a multi enrolment/notification process for newborn infants. This project sits under the Pregnancy and First Year of Life Alliance – Auckland and Waitemata DHBs.

The aim is for every child to be offered the full universal package of care from 0 to 5 years of age. Currently many children miss out or are late for essential health services, sometimes due to parents not being aware of these opportunities or from delayed communication between health care providers. The multiple new-born enrolment/notification project will help bridge some of those gaps.

The Privacy and Security groups of both DHBs have been advising the project team. The advice was to develop a method to inform parents about what was planned, why and develop business processes.

A collaborative working group across Auckland and Waitemata DHBs included representatives from Maternity Services, Newborn Hearing Screening, Primary Care Organisations (PHOs), Oral Health (Auckland Regional Dental Service), National Immunisation Register, Plunket, Well Child Tamariki Ora providers, Auckland Regional Public Health Service (ARPHS) and the Māori and Pacific Health Gains Teams. The group developed the attached flyer for parents and obtained extensive feedback over a 12 month period including two rounds of consumer testing with young Māori and Pacific mothers. The final feedback was strongly positive. *'These mums love the poster and the information provided. The language poster will be very useful for most of our pacific mums.'*

Free Health Services for Your Baby - Information for parents

Due to the urgent need to improve oral health enrolments for infants the local project to start sharing patient's contact information has been accelerated. The first phase of the project to inform parents and launch the information sheet went live across Waitemata DHB on 1 August 2016 and Auckland is scheduled for October 2016. The intention of this work is not to divulge any clinical information but to share patient contact details with the relevant services. Mothers can choose to opt off.

Lead maternity carers (LMCs) will continue to provide information to mothers about choices of well child providers in the antenatal period. They will be provided with funded posters of these free baby health services to give to women ante-natally. LMCs will still refer mothers and babies to well child providers and GPs at 4-6 weeks postpartum. The next phase is to engage with Primary birthing units to make the pamphlet available through them.

3.3 Youth

As noted in the highlights, the Waitemata procurement process for integrated youth primary health services is progressing with a number of proposals received by the closing date. A recommendation from the panel will be provided to the Board in November. The Ministry of Business, Innovation and Employment is providing procurement advice across the process which includes providing an independent chair for the panel.

HPV vaccine
Planning is well advanced for the 1 January 2017 implementation of the 2-dose HPV vaccine programme. Offering the funded vaccine for males is a welcome opportunity to re-dress the previous gender bias in access to this highly effective vaccine.

In 2015/16 the target requires 65% of 12 year old girls fully immunised with 3-doses. The Ministry of Heath has signalled incremental increases in the target for all ethnicities to reach 70% in 2016/17, and 75% in 2017/18. HPV immunisation coverage results are measured once annually on 30 June due to the cycle of the school year. The results are presented here.

Nationally, 65% of 12 year old girls have received three doses of HPV vaccine. In this region both DHBs are showing strong gains in performance. Auckland is the top ranked DHB in the country this year with 83% of girls fully vaccinated. All ethnicities are exceeding target with Māori the highest at 91%, Pacific 86%, Asian 80% and Other 82%.

Waitemata DHB continues to improve with gains for the third consecutive year. Now achieving 60% overall which is a gain of 4% over the 2014/15 result. Most pleasing, this is the first year target was achieved for Māori and Pacific at 66%. Asian is 62% and further work is required for Other at 57%.

3.4 Women

3.4.1 Maternity

Breastfeeding
The draft Obesity Plan has identified increasing breastfeeding rates as a key priority. To support this, Plunket have been contracted to provide a pilot Breastfeeding Peer Support programme across Auckland DHB and Waitemata DHB. The localities for this pilot will be Glen Innes, Panmure and Ranui. Peer support counsellors have received training through the completion of a La Leche peer support training programme. Women will be supported to access the service through their LMC or Well Child Provider. The aim of the programme is to increase breastfeeding rates at three months and beyond.

Implementation of the National Gestational Diabetes Guidelines
The MoH has required all DHBs to implement the new Gestational Diabetes Guidelines by June 2016. Reports from both DHBs have been submitted to the MoH to outline progress on implementation. Education regarding HbA1C testing is being provided to Primary Care at a Women's Health seminar run by the Goodfellow Institute.

The Auckland DHB and Waitemata DHB Annual Plans require pregnant women at risk of, or with gestational diabetes to be referred to a Green Prescription provider for support with exercise and healthy eating in pregnancy. To ensure Green Prescription providers support pregnant women appropriately and are familiar with techniques to engage priority pregnant women, a training workshop is being organised. The workshop will be provided by a multidisciplinary team to the three metro-Auckland Green Prescription providers. Following the workshop, active promotion of the Green Prescription service will be provided to LMCs.

Pregnancy and Parenting Information and Education

The independent evaluation of the Auckland DHB and Waitemata DHB Pregnancy and Parenting Services has begun. Synergia have been commissioned to complete this evaluation and have been meeting with key stakeholders to inform the development of the evaluation framework. The evaluation will run for 12 months and will focus on the implementation of the Auckland DHB Service and the reach and effectiveness of the Auckland DHB and Waitemata DHB services. Both services are continuing to identify strategies to engage priority women and Synergia will provide regular feedback from the formative evaluation to ensure key findings are implemented in a timely manner.

A key focus of the new Auckland DHB service is the emphasis on supporting Māori women and their whanau to access the Pregnancy and Parenting Service. Ngati Whatua are now contracted to provide this Service, alongside their Well Child Tamariki Ora and Midwifery services. Their programme provides women with different options; women can attend four, four hour classes or attend a two day waananga (optional overnight) class. The courses incorporate the key pregnancy and parenting messages from the Mokopuna Ora curriculum and in parallel explore Te Ao Māori in relation to pregnancy. Including information on the status of waahine hapuu (pregnant women), whakapapa, ancestral stories, traditional birthing and parenting practices, karakia, waiata and kupu Māori (Māori language/words) in relation to pregnancy and parenting. Participants also make their own ipu whenua (a container for the afterbirth) and learn the significance of the afterbirth.

An example of the success the Ngati Whatua programme has experienced is detailed in the following case story:

> A wahine Māori was having her first baby. She was referred for pregnancy and parenting services by an ADHB Māori social worker. She suffered depression and anxiety and had no transport, there were financial issues and she had been homeless with her partner for a period of time but had recently secured accommodation. Growing up she had little contact with her father, and her mother experienced addiction issues and has since passed away.
>
> The ADHB Māori child birth educator visited her at home. The wahine was very anxious and their budget was stretched (they had been living off noodles for some time). The educator invited her to the Ngati Whatua classes and waananga. The wahine was reluctant to attend the waananga. She felt ill equipped in the Māori world and commented "I'm not a real Māori." The educator explained the majority of the waananga would be in English and te reo Māori would be used mainly for the powhiri, karakia, waiata and as part of general conversation and discussion. She also explained that it would be a good opportunity to meet other mothers and learn about pregnancy and birthing and traditional birthing practises. There would also be activities she could participate in (she made her own ipu whenua and took it home), and there would be lovely kai. The educator picked her up Friday evening to attend the first part of the waananga. The wahine thoroughly enjoyed the programme and especially commented on the whanaungatanga, the manaakitanga and aroha extended to her. It was a special experience for this wahine and she closed the evening with karakia. The next morning the educator went to pick her up to find that she and her partner had attended the waananga and had stayed overnight for the full day. Again, a rich experience for them both. They have now engaged with ongoing health care through Ngati Whatua and are connected to other support services to meet their needs.

3.4.2 Cervical screening

There has been a decline in coverage across all ethnicities for Auckland DHB in Q4. Māori coverage has dropped by 2.7% (59.1% to 56.4%), Pacific by 2.4% (77.7% to 75.3%) and Asian by 4.3% (66.1% to 61.8%). European coverage remains above the 80% target at 82.9%.

Waitemata DHB coverage has remained largely stable, with a slight decrease in Māori and Pacific coverage which are both down by 0.5%. Asian coverage has decreased by 1.4%. European coverage remains above target at 81.8%.

Auckland and Waitemata DHB have been waiting for the outcome of the National Screening Unit (NSU) review of the Independent Service Providers (ISP). During this period of uncertainty (from April 2016) it has been difficult for the DHBs to engage with ISP providers to drive initiatives to increase coverage rates for priority group women. We have recently been informed that Well Women and Family Trust will be the ISP for Auckland and Waitemata DHB regions. The DHBs have a strong working relationship with this provider and will now pursue strategies to develop a comprehensive cervical screening outreach service, whilst also working in collaboration with primary care. The new contract comes in to affect from 1 November 2016.

The Auckland and Waitemata Coordination service has continued to focus on supporting PHOs to interpret the monthly NSU data match lists and to translate them in to easily interpretable lists for practices. This activity is essential for ensuring invitation and recall is prioritised by clinical need. The invitation and recall letters that practices use to send women from their Patient Management System, have been reviewed and translated in to 11 different languages. These can be accessed by practices along with all other resources developed by the Coordination service, from the metro-Auckland Cervical Screening website: http://nationalwomenshealth.adhb.govt.nz/health-professionals/auckland-regional-cervical-screening-project. Opportunistic screening also remains a key focus and cervical screening is regularly offered in conjunction with the Breast Screen mobile vans.

Table 7: Three year cervical screening coverage

Ethnicity	Auckland DHB	Additional women to screen to reach 80%
Māori	56.4%	2,373
Pacific	75.3%	598
Asian	61.8%	8,288
European/Other	82.9%	
Total	73.4%	

Source: National Screening Unit (NSU) June 2016

Ethnicity	Waitemata DHB	Additional women to screen to reach 80%
Māori	59.2%	2,673
Pacific	75.7%	407
Asian	65.2%	5409
European/Other	81.8%	
Total	75.7%	

Source: National Screening Unit (NSU) June 2016

3.4.3 Breast screening (50-69 years: 2 year coverage)

The Auckland coverage has largely remained stable for Māori women and other ethnicities, with only a slight drop in Q4 compared to Q3 data, 0.4% and 0.3% respectively. Pacific coverage has dropped by 1.5% but still remains above target at 74.4%.

Waitemata coverage has improved across all ethnicities, Māori by 5.7%, Pacific by 2% and other by 1.6%. Pacific is the only ethnicity to reach above target at 76.7%.

Of note from June 2016, the NSU began reporting using the latest 2013 domicile codes and a daily data loading process, compared to previous reports which used a monthly data loading process and based reporting on 2006 domicile codes. This has resulted in variances with coverage reports that are unrelated to actual screening activity.

The identification of unscreened and under screened women through a national NHI data matching process remains the key strategy to increase coverage. To support this activity and the associated increase in coverage it has been proposed that breast screening be recognised as a contributory measure under the new System Level Measure of amenable mortality. This will support renewed focus and activity on breast screening by Primary Care.

Collaborative activity to provide joint health promotion for cervical and breast screening has also been pursued, this activity has also incorporated smoking cessation messaging and Green Prescription activity.

Table 8: Two year breast screening coverage

	Ethnic Group	Eligible women	2 year coverage 50-69 years %	2 year coverage actual number of women	Number of women needed to reach 70% target
Auckland	Māori	3400	59.9%	2,035	345
	Pacific	4,520	74.4%	3,365	
	Other	42,710	63.8%	27,270	2,627
Waitemata	Māori	4,380	64.2%	2,813	253
	Pacific	3,130	76.7%	2,540	
	Other	60,220	66.9%	40,287	1867

Source: National Screening Unit (NSU) June 2016 Quarterly Report. BreastScreen Aotearoa only report coverage by Māori, Pacific and Other (including New Zealand European).

4.1 Planning, Funding and Outcomes Update

Recommendation

That the report be received.

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Endorsed by: Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ARPHS	-	Auckland Regional Public Health Service
CPHAC	-	Community and Public Health Advisory Committee
CWF	-	Community water fluoridation
DHB	-	District Health Board
EC	-	E-cigarettes
ED	-	Emergency Department
HAT	-	Healthy Auckland Together
HCSS	-	Home and Community Support Services
MAV	-	Maximum Acceptable Value
MHA	-	Mental Health and Addictions
MoH	-	Ministry of Health
MSD	-	Ministry of Social Development
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
QALY	-	Quality adjusted life years
SACAT	-	Substance Addiction Compulsory Assessment and Treatment
WWTP	-	Wastewater Treatment Plant

1. Executive Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata District Health Boards' (DHB) planning and funding activities and areas of priority, since its last meeting on 31 August 2016. It is limited to matters not already dealt with by other Board committees or elsewhere on this meeting's agenda.

2. Planning

2.1 Annual Plans

Both Annual Plans have recently been resubmitted to Ministry of Health and we are awaiting Ministerial sign off.

2.2 Annual Reports

Final drafts of the Auckland and Waitemata DHBs' 2015/16 Annual Reports have been prepared and are in the process of being presented to Board and Audit and Finance for review and sign off.

3. Health of Older People

3.1 Home and Community Support Services (HCSS)

Part B of the Inbetween Travel Settlement Agreement focuses on achieving a regularised HCSS workforce, which incorporates guaranteed support worker hours, staff training and safe staffing ratios. Auckland DHB and Taranaki DHB have been identified as the sites for the regularised workforce pilot. A working group with representatives from the Unions, Providers, Ministry of Health (MoH) and the two DHBs has been set up to progress these pilots. Currently weekly meetings are being held and the plan is to implement virtual pilots in October, which will inform a budget bid the Ministry is preparing for funding starting 1 July 2017.

Auckland DHB's HCSS providers and NASC are collaborating with the Maori Health Gain team to develop a project aimed at making the HCSS pathway more responsive to Maori. An initial workshop scheduled mid-October to include Maori Health Services, NASC and HCSS representation will discuss a project outline to streamline transition and discharge planning from the Provider arm for Maori who are to receive HCSS. The project plan is likely to include the development of joint training across NASC/HCSS Providers. A project on responsiveness to Maori is also intended for Waitemata DHB HCSS providers with initial discussions to start in October.

3.2 Aged residential Care

The annual review of the Aged Residential Care Agreements for 2017/18 is starting earlier than in previous years. DHBs are required to identify issues they wish to have considered and submit these through their regional HOP Forum by 30 September 2016. An area of concern we will raise is how the supply of standard rooms will be maintained with many new builds focusing on premium rooms and associated premium charges.

3.2 Falls Prevention

Work is progressing according to plan on the Falls Prevention Programme under the guidance of the joint Auckland DHB, Waitemata DHB and ACC Community Falls Prevention Steering Group. The Programme aims to reduce injury falls and fragility fractures in people aged 65 years and over living in Auckland DHB, specifically to reduce hospitalisations and ACC injury claims.

The programme will deliver across four key areas:

- extending the Fracture Liaison Service.
- establishing an in-home strength and balance exercise programme for highest risk people, including traditional delivery and a trial using HCSS providers.
- facilitating further development of community group strength and balance sessions (this component will be led by ACC).
- developing a clinical pathway.

4. Mental Health and Addictions

4.1 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

There have been two sector-wide workshops to develop the map of services across the Northern DHBs including NGO services. A technical advisory group has been established to review current Managed Withdrawal (including detoxification) service provision in Northern Region DHBs and develop a regional response based upon this. Ministry of Health are expecting the development of a proposed Northern Regional continuum of care in response to SACAT impact. Workshop 1 (held 15 September 2016) identified that under the current service configuration, Northern Region DHBs do not have all the service(s) and/or structures in place to provide an effective SACAT response. Workshop 2 (held 29 September 2016) worked on the development of a draft service delivery model aligned to SACAT processes.

MoH initially estimated that 200-300 people annually will come under the new legislation nationally; 154 of these people will be in the Northern Region and 10% (15) will require on-going support either in the home or in recovery housing. Feedback to MoH from Workshop Participants based upon New South Wales (Australia) experience with a similar Act and regional experience estimated the demand to be significantly higher with unmet need sitting behind MoH original estimates, resulting in a revised estimate from the MoH (refer to table 1 Estimate of Demand in NR for meeting SACAT criteria and need for services).

Table 1: Estimate of demand in Northern Region Workshop 2

Assessment	Meet SACAT criteria	Need home support (post SACAT)	Need recovery housing (post SACAT)
580 people	270 people	45 people (17%)	35 people (13%)

The workshops highlighted that this group may require different services to those currently available under existing AOD (alcohol and other drugs) contracts. Many of these people will have cycled in and out of various treatment services, residential rehabilitation, detox facilities, homelessness services and prison repeatedly with little or no change or change that is not enduring. The treatment services currently available have not worked for this group and it is predicted that the range, intensity and therapeutic models may need to change in order to effect long lasting change in patterns of consumption. In addition, it is likely that some people placed under compulsory treatment orders may have developed cognitive related brain damage from which they may not recover sufficiently to be able to live independently. Therefore it is likely that they may need to be placed under the Protection of Personal Property Rights Act with longer term supported accommodation provided for their care. In some cases despite the significant health and social impacts of their drug and alcohol use, some people once they regain competence may choose to continue to use substances at harmful rates. There may therefore need to be additional investment in services that provide safe and secure accommodation which allows people to continue to use substances in a controlled way while their health and other essential needs are met. The intent of these services would be to reduce harm rather than achieving abstinence.

A further workshop is required to develop the model of care in sufficient detail to identify resourcing. The third workshop will have an emphasis on specifying the requirements of the detoxification service and the range of therapeutic interventions required to support people both while they are under compulsion and in the development of suitable aftercare options.

4.2 Perinatal Infant Mental Health Contract Service Review Project Update

The project is progressing well to review the perinatal and infant mental health services for mothers with babies and/or infants who are at risk. Extensive stakeholder feedback has been received from consumers, NGOs, community and also the DHB provider services and other services accessing the maternal mental health services and the acute perinatal continuum of care. A first draft of the review along with the qualitative report has been sent to the Governance Group for comment. The intention is for this report to be finalised by the Governance Group by the end of October.

4.3 MoH Project – Fit for The Future: a systems approach to primary and community mental health and addiction (MHA) services

Ministry of Health is leading a project called "Fit For the Future – A systems approach to primary and community MHA services." Fit For the Future aims to better understand how to improve outcomes for those who are not easily managed in primary care but do not meet the threshold for specialist services. The Ministry held two workshops (31 August and 21 September 2016) where over 60 representatives started to co-develop appropriate responses to better address the needs of this group. Waitemata DHB and Auckland DHB were well represented within the group discussion with representatives from DHB Service Provider, Funding and Planning, NGOs and PHOs members, Family/Whanau and Consumer Advisors. As part of this programme of work the Minister of Health asked the Ministry to set aside $5 million for investment into primary and community MHA services. The Ministry wishes to invest this money into existing initiatives in the sector to build an evidence base about integrated models that work well to improve outcomes for this group. Evidence gathered will inform both "Fit Fort the Future – A Systems Approach" and the longer term strategic plan to reshape the health system to focus on outcomes. MoH invited DHBs to submit a Registration of Interest (ROI) for consideration in MoH allocation of a $5 million investment into primary and community mental health services. Both DHBs responded individually to a MoH Registration of Interest (ROI): Existing Initiatives for Investment in Building an Evidence Base (People with moderate mental health issues. This was demanding process with invitations sent to CEOs on 6 September 2016 and ROI completed by 23 September 2016, with a-17 day turnaround of the application. The Ministry expects to be ready to enter into discussions with preferred providers in October 2016.

4.4 Auckland DHB's Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third GP practice. A review of this pilot developed seven principles of practice to guide future integration:

1. Be in, and of, the place where you are working
2. Be highly connected
3. Establish shared understanding and language
4. Give people choice including cultural choice in the services required
5. This will take time and need a network of people
6. This is a 'point in life'
7. An outcome focus: Moving from existing to thriving

Please refer to 'Awhi Ora – Supporting Wellbeing' for further information.

The pilot working group is currently focused on the development of primary care/NGO integration in further Auckland DHB localities. A further four NGO support hours providers and ten GP practices have agreed to be involved in the next phase. This includes practices from Auckland PHO, Alliance

Health Plus and National Hauora Coalition. On the 19th September an information evening was held to present the principles of practice and begin linking NGOs with practices. This meeting was well attended and the feedback was very positive. The working group is currently finalising the pairings and discussing the prioritisation of NGO support hours for this expansion.

5. Maori Health Gain

Abdominal Aortic Aneurysm

Given the potential impact of Abdominal Aortic Aneurysm (AAA) screening on Māori health outcomes, Waitemata DHB embarked upon a pilot of AAA screening in Māori men aged 55-74 and Māori women age 60-74 following approval by the Board in February 2015. The aim of the pilot was to determine several parameters to inform consideration of an AAA screening programme. The parameters of particular interest were the participation rate (uptake), the prevalence of AAA disease in the target groups, and the cost of screening. The pilot was undertaken with three general practices, Coast to Coast Wellsford, Waitakere Union and Te Puna Hauora.

The following preliminary results are available and they refer to the two practices where screening has completed. These are Coast to Coast Wellsford and Waitakere Union. Screening has also recently completed in Te Puna Hauora, with an uptake of the services of 73%, but their results are not yet finalised so they are not presented here.

Table 1 Participation in Waitemata AAA Screening Pilot (preliminary results from two practices)

Patient Status	No.	%
Eligible for AAA screening	483	-
Declined screening	37	8%
Did Not Attend	14	3%
Screened / participation rate	380	79%
Screen positive	14	3%

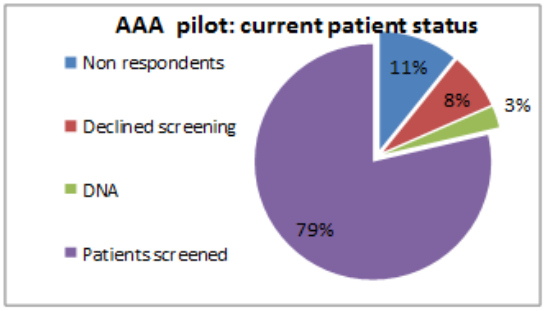

Table 2 Prevalence of aneurysms (AAA) and enlarged aorta (ectasis) in Waitemata AAA Screening Pilot (preliminary results)

Patient Group	AAA (≥ 30mm ø)			Ectasis (26-29mm ø)		
	No.	%	95% C.I.[a]	No.	%	95% C.I.[a]
Men 55-74	4/217	1.8%	0.9-4.6%	7/217	3.2%	0.9-5.6%
Men 60-74	4/142	2.8%	1.4-7.0%	7/142	4.9%	1.4-8.5%
Men 65-74	3/87	3.4%	1.1-9.2%	5/87	5.7%	2.3-12.6%
Women 60-74	1/162	0.6%	0.0-1.2%	2/162	1.2%	0.0-2.5%
Women 65-74	0/81	0.0%	-	2/81	2.5%	0.0-4.9%

[a]/Bias-corrected accelerated bootstrap 95% confidence intervals from 10,000 replications

The pilot results and analyses have demonstrated (in summary):

- This is an acceptable screening test for Māori with high participation rates: 79% of people invited have so far been screened;

- Prevalence was high among Māori men aged 60-74. Of 142 men screened in this age group four had AAA;
- Collaborative work with Otago University has permitted the cost-effectiveness of AAA in Māori men to be assessed. Screening the proposed target group of Māori men aged 60-74 would prevent 4-5 AAA related deaths and generate approximately 20 quality adjusted life years (QALYs) at an estimated cost of $9700/QALY. In NZ, interventions that cost less than $45,000/QALY are considered to be cost-effective. This means that the intervention in this group is considered to be highly cost-effective (discussed further below).
- Reducing the 7-9 year gap in life expectancy between Māori and non-Māori men is a national, regional and local health sector priority. Ethnic inequalities in AAA mortality contribute to that life expectancy gap and screening will make a small but significant contribution to reducing it.

The pilot has brought a number of additional health benefits for participants: Cardiovascular Disease-risk assessment was carried out as a requirement for screening eligible patients and all people who smoke were given high quality smoking cessation advice at the screening visit. The outcome of the pilot will be considered by the Auckland and Waitemata DHB Boards as well as the Auckland DHB and Waitemata DHB Maori Health Gain Advisory Committee, Manawa Ora with a decision to be made for a full roll-out.

Cancer evaluation Māori and Pacific Faster Cancer Treatment pilot Auckland DHB 2014/15

The Māori health team are working with the Auckland Cancer and blood service to evaluate the Māori and Pacific Faster Cancer Treatment pilot undertaken in 2014/15. The pilot was funded through Ministry of Health Faster Cancer Treatment project funding via the Northern Regional Alliance Cancer Network. The intent of the pilot was to deliver a Māori and Pacific Cancer Navigation based service to improve timeliness and ease of access, reduce DNA's and improve health literacy. The evaluation seeks to understand the effectiveness of the implementation and operationalisation of the pilot and whether it was able to improve performance against faster cancer treatment indicators and reduce DNAs. It is expected that we will be able to take these learnings and inform future practice, service improvements and investment. The report has been completed and will be presented to the North Cancer Network in October and a paper will be presented with the findings from the evaluation to the Māori Health Gain Advisory Committee in January.

6. Pacific Health Gain

6.1 Renewing Pacific Health Action Plan (PHAP)

Consultation meetings both face to face and online regarding the refresh of the Pacific Health Action Plan were completed on 31st August. A total of 290 responses were received. More attended the meetings, but not all completed and submitted the questionnaires that were given out at the meetings. The six priorities of the current plan were confirmed with over 70% supporting an additional focus on oral health and childhood obesity as part of the first priority which is children being safe and well and families being free of violence. Two new priorities were suggested by the PHAP Working Group and they are a focus on health of older people, supported by 87% and mental health promotion, supported by 89% of respondents. The renewed plan is currently being developed and will be submitted to CPHAC at its November meeting.

The implementation of Pacific Health Action Plan 2013 - 2016 (PHAP) is on target for Priorities 1 – 5.

6.2 PHAP Priority 1 – Children are safe and well and families are free of violence

This priority was strongly supported by the recent consultations undertaken with additional support for work on oral health and childhood obesity.

The consultation that we undertook with Ministry of Social Development (MSD) and ACC made it clear to us that those agencies are not funding any programmes similar to those that we are delivering in the community and churches. MSD has a focus on training practitioners and community leaders but they do not have a focus yet on delivering programmes in the community.

ACC is currently working with a Pacific provider to develop a programme with a focus on violence prevention amongst youth.

We had envisaged MSD and ACC funding or co-funding the current programmes that Auckland and Waitemata DHBs are currently funding, but that is not likely to happen in the current financial year.

6.3 PHAP Priority 2 –Pacific People are smoke-free

Waitemata DHB and West Fono have been completed consultation with Tongan men using the kava drinking forums that Tongan men participate in. The information that has been collected is rich and is currently being collated. The men that took part in the conversations expressed gratitude that the DHB and West Fono *took note of* us *and came to talk with us*. They encouraged the health workers to *not give up on us* and the strongest suggestion they made is to approach smokers as a group. They said that a commitment to a group provides stronger motivation to stop smoking than individual commitment. The intention is to invite the men who took part in the consultation to work with West Fono to design a group approach to addressing their attempts to stop smoking. The experience and knowledge gained from the WERO programme will be utilised.

6.4 Priority 3 – Pacific people are active and eat healthy

The 4th Aiga Challenge (annual 8 week weight loss competition) is currently being implemented. Workshops with Dr Fizz were held for Enua Ola and HVAZ co-ordinators as well as parish community nurses with the purpose of adding a component on preventing intake of fizzy drinks by young people (and adults) and reducing sugar intake in general as a focus of this Aiga Challenge. We will also have a stronger focus on analysing data for the four year period at the end of the Challenge.

6.5 PHAP Priority 4–People seek medical and other help early

The *Fanau Ola* Integrated Services contract with Alliance Health + has had a focus on validating data collected by front-lines workers in the periods Q4 2015/16 and Q1 2016/17. This is progressing well and the result based on initial data is that the number of families confirmed as receiving the service is not as high as initially thought. Now that the data is reliable, we are focusing on outcomes of the services delivered. The current contract was renewed till 31 December 2016. We are confident that we will be better informed about input/volumes, amount of work delivered, outcomes and funding levels, when we renew the contract from January 2017.

6.6 PHAP Priority 5 - Pacific people use hospital services when needed

The Pacific GM for Hospital Services reports on this priority.

6.7 PHAP Priority 6 – That Pacific people live in houses that are warm and are not over crowded

The recent consultation undertaken for renewing PHAP strongly supported the need to continue to focus on housing. This was priority number 6 in the last plan, but it became priority number 4 in the consultation. This is perhaps no surprise in the current housing crisis in Auckland.

7. Asian, Migrant and Refugee Health Gain

7.1 Increase the DHBs' capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations

The Final draft of the Asian International Benchmarking Report has now been completed and is currently going through internal review processes before final sign off with the two Boards.

7.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 75% (Auckland DHB) and 85% (Waitemata DHB) targets by 30 June, 2017 (current rates 73% (Auckland DHB) and 83% (Waitemata DHB) as at Q3 2016)

Indicator: Reducing acute flow to Auckland City Hospital's Emergency Department (ED)

- The 'Healthcare- where should you go?' campaign was aimed at promoting culturally appropriate messaging about enrolling with a family doctor and the benefits of it to students and new migrants living in the Auckland City Centre and inner city suburbs. The campaign ran for 8 weeks and ended 31 August. Evaluation on the effectiveness of the campaign is almost complete and will guide planning of a broader campaign roll-out to new migrants and students across the Auckland DHB as phase 2 in Q3 2016-17.
- Inputs have been added to the development of a draft New Zealand International Student Wellbeing Strategy with a key focus on: 1) increasing awareness of the NZ health & disability system, and 2) access to, and utilisation of health services. As well as a Critical Response Workflow as part of membership with the Auckland Agency Group led by the Ministry of Education.
- A small working group led by Ailsa Claire (Chief Executive, Auckland DHB) has been established with membership by key DHBs across the country and MBIE is tasked to explore issues related to utilisation of health services by migrant communities.

Indicator: Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding

The Refugee Primary Care Wrap Around Service Agreements continue to roll out for 2016/17. Professional development opportunities for primary health and the frontline workforce to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level include:

- Receptionists cross-cultural training to frontline primary health staff, planned for 19 October.
- A refugee health network forum to primary health professionals on 'former refugee child mental health' on 9 November

A 1-year pilot oral health service to adult former refugees with the Oral Health Department and Clinic at the Auckland University of Technology's (AUT) North campus (Northcote) in the Waitemata DHB catchment area will roll out by December 2016. It will aim to deliver routine dental service only,

excluding pain relief. A research component has been included in the pilot to measure the efficacy of the pilot and generalisability to scale up the service to include other vulnerable groups as phase 2.

8. Auckland Regional Public Health Service (ARPHS)

National Civil Defence Exercise

On 31 August ARPHS participated in 'Day 1' of the National Civil Defence Exercise Tangaroa 2016. ARPHS fully activated its Emergency Operations Centre, with two shifts of staff role-playing a public health emergency response to a tsunami. Seven Maori and Pacific liaison staff also came to ARPHS as observers of the exercise, from the three Auckland DHBs and key health providers. ARPHS is also participating in the smaller regional table top workshops at Civil Defence for Day 2 (14th September) and Day 3 (28th September) of Exercise Tangaroa.

Community water fluoridation (CWF) update

At the last Committee meeting more information was sought from committee members on the following matters:

- Whether the fluoride added to the water supply is pharmaceutical grade i.e. what is the purity of fluoride used by Watercare.
- More information on the cost/benefit analysis of CWF.

The Ministry of Health recommends that the fluoride content for drinking-water in New Zealand be in the range of 0.7 – 1.0 mg/L. The Maximum Acceptable Value (MAV) for fluoride is 1.5mg/L. The majority of the reticulated water in the Auckland region is already fluoridated. Watercare operates its dosing systems to achieve a treated water concentration of 0.7 mg/L.[1] The amount of fluoride added is determined at each water treatment plant and accounts for the naturally occurring level of fluoride in source water. ARPHS has contacted Watercare for further information on the nature of the fluoride it uses, but has yet to receive a response. ARPHS will update CPHAC once we have this information.

CWF is considered one of the greatest public health interventions of the 20th Century by the US Centre for Disease Control. Findings from the 2009 New Zealand Oral Health Survey noted that children and adults living in fluoridated areas had 40 percent lower incidence of dental decay than those in non-fluoridated areas.

Economic evaluations have repeatedly shown CWF to be cost-saving. That is, rather than costing the people of New Zealand to purchase health, it delivers better health *and* saves money at the same time. The most recent economic evaluation of CWF suggests that CWF is cost-saving when the drinking water supply has a population of 500 or more, and is likely to be cost-saving even below that size of supply. It demonstrated that each dollar invested returns nine New Zealand dollars, the returns being greater as the supply size increases.[2] It costs approximately $1.00 per person per year to provide water fluoridation to water treatment plants supplying a population over 50,000.

Dr Julia Peters, Clinical Director at ARPHS, has been confirmed as a participant on the Ministry of Health convened DHB fluoride working group.

[1] Perera, P. (2016). *Auckland Water Supply fluoridation – January 2016,* Watercare Services Limited. (sourced from Auckland Council's Regional and Policy Committee open agenda – 3 March 2016)
[2] David Moore and Matt Poynton, Sapere Research Group. Review of the benefits and costs of water fluoridation in New Zealand. September 2015.

Communicable diseases

Two confirmed cases of meningococcal disease were reported to ARPHS. A likely link was identified as both cases were the same strain of Group B and attended the same church in South Auckland over a short period of time. There have been no further linked cases identified. A media release was disseminated on 15 September 2016 to inform anyone who attended the church (but were not identifiable) about key public health messages. A public health clinic was held on Saturday 17 September at the church – chemoprophylaxis was dispensed to 74 individuals from the church congregation. Only one family of five did not receive antibiotics despite further efforts to follow-up, though they did receive health information.

Recently two mumps cases were notified to ARPHS. Mumps is rare in Auckland because of generally high levels of vaccination and in this instance both cases were acquired overseas. One of the cases was a student of Mt Albert Grammar. ARPHS ensured the school was informed and provided health advice, including advice that children who are not immunised should not attend school for 25 days after the infected student's last school day.

Healthy Auckland Together (HAT) update

HAT continues to engage with a range of stakeholders. HAT presented to 78 individuals representing various organisations at the Manukau East Council of Social Services Community Safety Breakfast meeting. The presentation on 25 August was well received and provided an opportunity for HAT to engage with the Howick community. Attendees were asked to endorse the HAT Plan 2015-2020 and consider some of the projects HAT are doing in the six action areas of the Plan, and how Howick could support these.

Submissions

ARPHS completed and submitted three submissions during August to mid-September 2016.

Date	Topic	Brief note
22 August	***Watercare Services Limited (Watercare) – Proposed new Wastewater Treatment Plant at Snells Beach/Algies Bay (resource consents lodged with Auckland Council)***	Watercare propose to construct a new wastewater treatment plant (WWTP) to provide ongoing service to the communities of Warkworth, Snells Beach, Algies Bay and Martins Bay. ARPHS supported the proposal as it will cater for the expected population growth in the Warkworth and Snells Beach areas, and eventually result in the complete removal of treated wastewater discharges from the upper Mahurangi Harbour once the Warkworth WWTP is decommissioned. This will have a long term positive impact on the commercial oyster farms in Mahurangi Harbour. Despite this, ARPHS did request that the hearings panel give careful consideration to what is the optimal location of the new outfall off Martins Bay, and whether monitoring of *E.coli* in treated wastewater discharge samples should apply to all wastewater treatment plants involved.
9 September	***Ethnicity Data Protocols for the Health and Disability Sector (Ministry of Health)***	The Ministry sought feedback on the draft refresh of the Ethnicity Data Protocols for the Health and Disability Sector. ARPHS recommended: that there be a standardised process for updating the NHI should user of health services indicate their recorded ethnicity is incorrect, any ethnicity data shared should be at level 4 (level 4 means any person can

		have up to 6 ethnicities from a list of 239 ethnic codes), and to develop a statistical method to handle multiple ethnicities instead of using prioritised ethnicity. ARPHS also noted that implementation will require IT modifications and training.
9 September	***Policy Options for the Regulation of Electronic Cigarettes: A consultation document (Ministry of Health)***	The Ministry of Health consulted on policy options for the regulation of e-cigarettes (EC), including possible amendments to the Smoke-free Environments Act. ARPHS's submission aimed to balance the harm reduction benefits of EC against the potential role EC play in the normalisation of tobacco consumption. It recommended that EC are legalised in New Zealand for the purpose of smoking cessation and tobacco harm minimisation, but in considering evidence which indicates EC could play a role in the normalisation of tobacco consumption (particularly for young people), also recommended that the EC and e-liquid packaging be standardised to acknowledge the unknown long-term health effects, and help buffer against future (somewhat unknown) unintended consequences.