Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting

Wednesday, 16 June 2021

1:00pm

A+ Trust Room
Clinical Education Centre
Auckland City Hospital
Grafton

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Agenda
Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting 16 June 2021

Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital

Time: 1:00PM

Committee Members	**Auckland DHB Executive Leadership**	
Teuila Percival (Chair)	Karen Bartholomew	Director of Health Outcomes – ADHB/WDHB
Michelle Atkinson (Deputy Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Zoe Brownlie	Meg Poutasi	Chief of Strategy, Participation and Improvement
Tama Davis	Sue Waters	Chief Health Professions Officer
Peter Davis	Dr Margaret Wilsher	Chief Medical Officer
Fiona Lai	**Auckland DHB Senior Staff**	
Bernie O'Donnell	Carly Orr	Director Communications
Michael Quirke	Marlene Skelton	Corporate Business Manager
Heather Came	Nigel Chee	Interim General Manager Māori Health
Michael Steedman	(Other staff members who attend for a particular item are named at the start of the respective minute)	
Seat at the Table Member		
Maria Ngauamo		

Agenda

Please note that agenda times are estimates only

1.00pm		**KARAKIA**
1:10pm	**1.**	**ATTENDANCE AND APOLOGIES**
		Meg Poutasi
	2.	**REGISTER OF INTEREST AND CONFLICTS OF INTEREST**
		Does any member have an interest they have not previously disclosed?
		Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
1.13pm	**3.**	**CONFIRMATION OF MINUTES 17 MARCH 2021**
1.20pm	**4.**	**ACTION POINTS - NIL**
1.20pm	**5.**	**EXECUTIVE INFORMATION REPORT**
	5.1	Planning, Funding and Outcomes Update
1.40pm	**6.**	**DECISION REPORTS**

	6.1	Joint Auckland and Waitematā DHB Suicide Prevention and Postvention Action Plan 2020 - 2023
	7.	**INFORMATION REPORTS**
2.10pm	7.1	Auckland Regional Public Health Service Briefing
	7.2	Oral Health in the Auckland Region
	7.3	Rheumatic Fever Deep Dive
3.30pm	**8.**	**GENERAL BUSINESS**
3.30pm	**9.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 15 September 2021 at 8:30am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Kia kotahi te oranga mo te iti me te rahi o te hāpori

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.

Attendance at Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meetings

Members	19 Feb. 20	22 Apr. 20	03 Jun. 20	15 July 2020	02 Sep. 20	07 Oct. 20	18 Nov 2020	17 March 2021
Teulia Percival (Chair)	c	c	c	c	c	c	1	1
Michelle Atkinson (Deputy Chair)	c	c	c	c	c	c	1	1
Jo Agnew	c	c	c	c	c	c	1	1
Zoe Brownlie	c	c	c	c	c	c	1	1
Tama Davis	c	c	c	c	c	c	1	1
Peter Davis	c	c	c	c	c	c	1	x
Fiona Lai	c	c	c	c	c	c	1	1
Bernie O'Donnell	c	c	c	c	c	c	1	x
Michael Quirke	c	c	c	c	c	c	1	1
Heather Came-Friar	c	c	c	c	c	c	1	1
Michael Steedman	c	c	c	c	c	c	1	x
Key: 1 = present, x = absent, # = leave of absence, c = cancelled								

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An "interest" can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full **nature** of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Register of Interests – Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting

Member	Interest	Latest Disclosure
Teulia PERCIVAL (Chair)	Director – Pasifika Medical Association Group Employee Clinician – Counties Manukau Health DHB Chairman – South Seas Healthcare Trust, Otara Board Member – Health Promotion Agency (Te Hiringa Hauora) Senior Lecturer Researcher – University of Auckland Director Researcher – Moana Research	24.07.2020
Michelle ATKINSON (Deputy Chair)	Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector Chargenet, Director & CEO – Partner	21.05.2020
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, majority shareholder) Member – New Zealand Nurses Organisation [NZNO] Member – Tertiary Education Union [TEU]	30.07.2019
Zoe BROWNLIE	Co-Director – AllHuman Board Member – Waitakere Health and Education Trust Partner – Team Leader, Community Action on Youth and Drugs Advisor – Wellbeing, Diversity and Inclusion at Massey University	26.05.2021
William (Tama) DAVIS	Director/Owner – Ahikaroa Enterprises Ltd Whanau Director/Board of Directors – Whai Maia Ngati Whatua Orakei Director – Comprehensive Care Limited Board Director – Comprehensive Care PHO Board Board Member – Supporting Families Auckland Board Member – District Maori Leadership Board Iwi Affiliations – Ngati Whatua, Ngati Haua and Ngati Tuwharetoa Director - - Board of New Zealand Health Partnerships Elected Member – Ngati Whatua o Orakei Trust Board	31.05.2021
Peter DAVIS	Retirement portfolio – Fisher and Paykel Retirement portfolio – Ryman Healthcare Retirement portfolio – Arvida, Metlifecare, Oceania Healthcare, Summerset, Vital Healthcare Properties Chair – The Helen Clark Foundation	22.12.2020
Fiona LAI	Member – Pharmaceutical Society NZ Casual Pharmacist – Auckland DHB Member – PSA Union Puketapapa Local Board Member – Auckland Council Member – NZ Hospital Pharmacists' Association	26.08.2020
Maria NGAUAMO	To be advised	
Bernie O'DONNELL	Chairman Manukau Urban Māori Authority(MUMA) Chairman UMA Broadcasting Limited Board Member National Urban Māori Authority (NUMA) Board Member Whānau Ora Commissioning Agency National Board-Urban Maori Representative – Te Matawai Board Member - Te Mātāwai. National Māori language Board	05.03.2021

	Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki Engagement Advisor – Ministerial Advisory Panel – Oranga Tamariki	
Michael QUIRKE	Chief Operating Officer – Mercy Radiology Group Convenor and Chairperson – Child Poverty Action Group Director of Strategic Partnerships for Healthcare Holdings Limited	27.05.2020
Heather CAME	Employed by – Auckland University of Technology Contractor – Ako Aotearoa Acting Co-President – Public Health Association of NZ Fellow – Health Promotion Forum Co-Chair – STIR: Stop Institutional Racism Member – Tamaki Tiriti Workers	27.07.2020
Michael STEEDMAN	No interests	27.08.2020

Minutes
Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting
17 March 2021

Minutes of the Community and Public Health Advisory Committee – Commissioning Health Equity Advisory meeting held on Wednesday, 17 March 2021 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital commencing at 8:30am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Teuila Percival (Committee Chair)	Dr Karen Bartholomew	Director of Health Outcomes – ADHB/WDHB
Michelle Atkinson (Deputy Chair)	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Jo Agnew	Meg Poutasi	Chief of Strategy, Participation and Improvement
Zoe Brownlie (Arrived during item 6.2)		
Heather Came	**Auckland DHB Senior Staff Present**	
Tama Davis	Ruth Bijl	Funding and Development Manager, Children, Youth and Women
Fiona Lai (arrived during item 6.3)	Leanne Catchpole	Programme Manager, Primary Care
Michael Quirke	Meenal Duggal	Funding and Development Manager, Mental Health and Addiction Services
	Carly Orr	Director Communications
	Marlene Skelton	Corporate Business Manager
	Shayne Wijohn	Acting Funding and Development Manager, Primary Care and Māori Health Gain Manager
	Invited guest	
	Aivi Puloka	Lead for the Tongan AAA project
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

0 KARAKIA

Tama Davis led the Committee in the Karakia.

1. ATTENDANCE AND APOLOGIES (Page 5)

That the apologies of committee members Peter Davis, Bernie O'Donnell and Michael Steedman be received. That the apologies of Zoe Brownlie and Fiona Lai for lateness be received.

That the apologies of Executive Leadership Team members Ailsa Claire, Chief Executive, Margaret Dotchin, Chief Nursing Officer and Dr Margaret Wilsher, Chief Medical Officer be received.

2. REGISTER AND CONFLICTS OF INTEREST (Pages 6-8)

There were no new interests to record and no conflicts with any items on the open agenda.

Heather Came advised that she wished it placed on record that she had been approached by the Auckland DHB Mental Health Unit and the Auckland Regional Public Health Service to conduct training relating racism. She also does this for Northland and the Midland DHBs. Put in context this is part of her regular business. The Committee did not see that this raised a conflict of interest.

3. CONFIRMATION OF MINUTES 18 NOVEMBER 2020 (Pages 9-40)

Resolution: Moved Jo Agnew / Seconded Tama Davis

That the minutes of the Board meeting held on 18 November 2020 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS - NIL

There were no actions to review.

5. DECISION REPORTS

5.1 Terms of Reference *(Pages 41-44)*

Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs asked that the report be taken as read, advising that with both Waitematā and Auckland DHBs making the decision to have their own Community and Public Health Advisory Committees new terms of reference had to be adopted. The Auckland DHB would have four meetings per year with the ability to still hold two joint meetings with Waitematā DHB when required.

There were no questions.

Resolution: Moved Teuila Percival / Seconded Heather Came

That the Community and Public Health Advisory Committee:

1. **Receives the draft Terms of Reference for the Community and Public Health Advisory Committee.**
2. **Recommends that the Auckland District Health Board approve the Terms of Reference.**

Carried

6. INFORMATION REPORTS

6.1 Planning Funding and Outcomes Update *(Pages 45-70)*

Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs asked that the report be taken as read, advising as follows:

A number of the team have been diverted into the area of critical planning of a COVID 19

Vaccine rollout

Debbie then called on members of the Funding and Planning team to address key issues within the report.

Mental Health

Meenal Duggal, Funding and Development Manager, Mental Health and Addiction Services addressed this section of the report.

IPS

For some time Auckland DHB has internally funded five FTE to provide employment support to clients who are experiencing mental health and addiction difficulties. This has been a very evidence based and successful programme however, this level of FTE is significantly below the level of service we would like to provide, particularly to achieve fidelity with the model for adequate employment consultant ratios.

Planning and Funding have strongly advocated with MSD on behalf of Auckland DHB and have obtained funding to increase FTE that the DHB is currently funding itself on a pilot basis for a period of 12 months. Work will continue with MSD to try to extend that.

Rapau te Ahuru Mowai – Homelessness Transitions Pilot

This transition pilot is part of the homelessness action plan taking place over four years. The Auckland DHB is seeking to fund 70 whaiora into a home with package of wraparound services enabling them to remain in the community. This is aimed at whaiora in the inpatient unit who are homeless or in insecure housing.

A decision was made to run a competitive process and to be entirely fair and transparent. It has been advertised on the national GETS platform.

The following was covered in discussion of the report to this point:

It was asked that through this process was there a strategy in place when assessing and for prioritisation of Māori providers in terms of delivering the service. Advice was given that it was an equity focused program and the whaiora disproportionately affected, shown by evidence, are Māori and that has to be a focus of the procurement process where the provider factor would be a part of the Matrix used in decision-making.

Michael Quirke commented that it was an interesting example of contract management with a focus around implementation and structuring of equity drivers.

Michael asked in relation to IPS how the additional budget was to be applied and was advised that it was hoped to apply that to obtaining further FTE.

Michelle Atkinson expressed support for what was outlined in the report and being done in the mental health and addictions space.

Meenal Duggal, Funding and Development Manager, Mental Health and Addiction Services continued her report.

Suicide Prevention

The Suicide Prevention Coordinator and Suicide Postvention role sit within Meenal Duggal's team and cover both Auckland and Waitematā DHBs. Both roles are funded by the Ministry of Health.

Mental Health 101 training is scheduled within the Auckland DHB in the near future and is being delivered by Le Va and funded by the Ministry of Health. Mana ake ake is the Māori version of Lifekeepers and these programmes aim to equip frontline community workers, community leaders in churches, marae and other relevant community hubs. There will be two training sessions for Auckland DHB and Waitematā DHB areas in March 2021.

Careful detailed mapping of the pathway for notification and how the postvention program is actually working is underway. There are two competing tensions that are being worked through. There is knowledge and a desire to share information in order to carry out postvention and prevention work because good postvention is prevention. On the other hand, there is very legitimate concern about privacy and ensuring security of information. This is a very difficult set of tensions that as a governance group and as a group working in this space are trying to navigate.

Integrated primary Mental Health Service

Drawing attention to the Integrated Primary Mental Health Service and its rollout in the Auckland. DHB area where the focus is on Auckland DHB although that is a metro Auckland collaborative initiative. Of note is a new name and the launching of a website.

Child, Youth and Women's Health

Ruth Bijl, Funding and Development Manager, Children, Youth and Women addressed issues relating to Child, Youth and Women's Health.

Ruth drew attention to the huge and competing space around vaccination with MMR catch up and COVID and competing demands on vaccinator staff. In terms of MMR initiatives the team have had a young Māori researcher undertake some focus groups with rangitahi and young Pacific people to really understand what their drivers are, what their knowledge is, what their locations are. This information will be shared with the COVID team because the same themes will be relevant to them.

Rheumatic Fever

There are some initiatives being re-launched. This is an area which is incredibly complex in terms of the family situations when you look at who gets rheumatic fever. A community paediatric physician has been leading this work with support from Māori and Pacific colleagues and researchers.

A driver behind these new initiatives is the state of housing and the conditions in which people are living. Ruth commented that she had reinforced many times the importance of housing and advocating at national level around the quality and quantity of housing available.

Breast Screening

The ministry contracts directly for breast screening services in Auckland Central. Waitemata DHB has extended its service to now cover Auckland DHB domiciled women.
A brand new mobile unit has been secured which should be ready in June and service those communities of high need.

The following was covered in discussion of the report to this point:

Jo Agnew drew attention to page 54 of the agenda in relation to oral health and asked whether every child in the Auckland region was enrolled and how those enrolments occurred and how it was known when someone was not enrolled. It was advised that there is not currently a population register, it was not a perfect system but numerous tools were employed to identify these children from birth lists, school lists through to encouraging other primary health care providers to check in with parents to ensure their children were enrolled. The harder cohort to track were those under five who were not on school lists.

Jo Agnew was advised that the Flu shot would be offered this year along side the two COVID 19 vaccination shots. Jo felt that this may be too much for people and that they may opt out and wanted to know what was being done by way of communication of the necessity to have all three shots. Debbie Holdsworth acknowledged that this was a good point and would be followed up.

Tama Davis asked that with the current data that is held around oral health was there an ability to provide a projected timeline on when inequities would be able to be addressed. Tama Davis was advised that there was work being done on a regional level in relation to a solution to the issue. Meg Poutasi, Chief of Strategy, Participation and Improvement advised that she was on that regional group and in terms of what the Provider did in terms of paediatric oral health there is a schedule plan around OR capacity and the attempt to catch up. The call on the region is to determine how to secure as much operating theatre capacity to meet that demand. There is a two year timeframe being worked to for the current wait list moving forward.

The Committee Chair, Teuila Percival added that at the last meeting it was raised as a real concern for children not enrolled and followed up and the year 8 students in terms of secondary care. Tama Davis signalled that he was supportive of putting the necessary resource into the community to address these needs more quickly as the issue will continue to build and not stay static.

Michelle Atkinson was advised that there would be a new breast screening mobile bus coming online, which will provide an improvement in capacity and equity of access. The schedule will be reviewed to build in more flexibility.

Michelle Atkinson was advised that women with symptoms are not eligible for the screening programme which was for asymptomatic women. Those women with issues got sent on a different pathway by their GP which was aimed at getting a diagnosis and treatment as quickly as possible.

Karen Bartholomew advised that there was disappointment in the High Grade pipeline project around cervical screening referred to by Michelle Atkinson, were the National Cervical Screening Programme (NCSP) had not approved the use of data to triage the large list of women in metro Auckland to appropriately tailor the service response. The project had

to be revised. A final report had been completed for the project on what had been achieved which was still important, despite dealing with a smaller number of clinics. The DHB were in the process of formally submitting back to the NCSP and reiterating the issue with access to data in order to provide service.

Michelle Atkinson was advised that the B4 School Check was part of the Well Child group of services and the Ministry of Health has undertaken a review of those services over a number of years and are close to concluding that work. The conversations had with them have been about the importance of better targeting the resources and ensuring that there are more services going to those who most need them and less services going to those who might be better at advocating for their needs, but didn't actually need the service.

There is great importance of starting these checks in pregnancy and not waiting until birth because while there is a maternity system led by midwives they cannot be expected to do nor have they been funded to do everything. The need is for a joined up system that provides a pregnant woman the support and the education she needs so she delivers the healthiest possible baby.

The evidence from the measure for the B4 School check would suggest that there is a need to start not at age 4 but with supporting women and families with the environment, with the tools and with the knowledge to actually have healthy eating activity from the outset.

The Committee Chair, Teuila Percival commented that it was obviously a very complicated area and noted that with the B4 School Check there were a number of concerns from an equity focus from a Māori and Pacific perspective. Firstly, access is poor and when you do get access the tools that are used are ineffective and not appropriate for children. Secondly in respect of the Well Child Tamariki Ora review, Māori and Pacific children do not access and do not get their visits and when they do they are often not culturally appropriate. Teuila Percival considered that there was an excessive focus on transactional activity for our children rather than building trusted relationships. The need to start at pregnancy is a very good focus.

Michael Quirke was advised that the reference made by the Minister of Health that with the borders closed there would not be the level of measles seen in the community as in past years related to the fact that measles cases are all imported to New Zealand (there is no endemic disease here). Imported cases however can lead to outbreaks, as seen in the large outbreak last year, and this risk is ongoing due to the historically under vaccinated cohort, hence the need for the current campaign to vaccinate those 15-30 years. The challenge with the MMR programme specifically, is that the age cohort who require vaccination is invariably challenging to engage.

Schools during the COVID lockdown did not want the extra burden of engaging with this problem as it was more than they could deal with to deliver an education package. The programme has restarted and that means engaging with universities, institutes and apprenticeship schemes and associated workplaces to get as broad-based approach as possible. Even with the best program there will still be young people who just cannot be engaged with as they don't see it as being an issue.

Māori Health Pipeline

Dr Karen Bartholomew, Director of Health Outcomes Auckland and Waitematā DHBs advised as follows:

Section 8.2 in the report provides more detail on some of the projects being undertaken in the refreshed programme approved by Kōtui Hauora in December. Karen drew particular attention to how Northland could be supported to join the programme. Discussions were being progressed in regard to AAA screening and lung cancer screening. While there were a lot of challenges and despite the COVID lockdowns and vaccination roll out there is still progress being made. The AAA programme has a potential to be able to reach rural communities in particular and discussions include how to build in co-benefits.

The new Hepatitis C project (within the broader Hepatitis C programme rest, managed by the NRA) provides a real opportunity to offer people with known Hepatitis C curative treatment. That piece of work will encompass the whole Northern Region. A Māori pharmacist is leading the project. A national data match will be undertaken to identify people and systematically offer them treatments and measure the outcome of the contacts.

There is also a Māori Public Health Registrar working on a cervical cancer incentives project in the community to determine whether and/or how well incentives worked. This project is with the National Hauora Coalition.

The following was covered in discussion of the report to this point:

Tama Davis drew attention to a comment made in the report around utilising community providers to build in-house intelligence and attempts to build efficiency into the service delivery with known data. He wanted to know what other aspects were being worked on in terms of building a trust factor with Community providers to be able to share that information seamlessly with the DHB? This is the action that Tama Davis wanted to see moving forward.

Karen agreed that good data sharing could not exist without trust and also having a common goal about what was to be done with the data. The report highlights some opportunities in this area. The PHO data match provides an opportunity to actually create a service from the gap that Tama Davis identified and to do that together with Māori providers and actually determine what that service might look like. The opportunities chosen must have a goal associated with this type of data and have a known benefit.

It was asked how good the DHB was at sharing the research and resource that this institution is able to gather together with other health providers themselves, so they can build and have a fuller picture of the community and also gain an understanding of how they allow the DHB to engage with them over the data that the DHB has already collected.

Karen advised that she could only speak to the pipeline projects and where the DHB did partner and share data, individualised reports were prepared for the providers that did participate. For example, with the HPV work and the High Grade work, individualised reports at an itemised level were produced. The aim was to be able to say, “can you help us learn about how we might do things better.”

Teuila Percival was advised that in terms of the AAA screening program there were specific

questions being looked at by Auckland and Northland DHBs around access to rural communities. In terms of moving from projects into a formal national screening programme including funding, the National Screening Advisory Committee had reviewed the evidence on AAA screening and had provided advice that it met the screening criteria and should be supported. There are current constraints on funding and capacity to support new programmes in the Ministry. There were also workforce issues to consider eg sonography and infrastructure such as registers. The DHB has trained a Māori sonography technician for the project, and this approach could be extended if there was support to do so. There is commitment to that in Northland where there is the desire to train an additional sonography technician alongside the programme.
Teuila Percival commented that one of the things that existed in Fiji was trained nurses to undertake the sonography for rheumatic fever screening which all they did. It was about a six month training programme. She considered that this was a way costs could be reduced and a workforce built.

There were no further questions or comment.

Resolution:

That the Community and Public Health Advisory Committee note the key activities within the Planning, Funding and Outcomes Unit.

Carried

6.2 AAA Screening Pilot with Tongan men (*Pages 71-76)*

Dr Karen Bartholomew, Director of Health Outcomes introduced Aivi Puloka, Lead , Tongan AAA screening acknowledging Aivi's leadership of the project and Dr Corina Grey who was the initiator of this broader Pacific project of which the Tongan component is the first part.

This project is intentionally building on the success of the Māori AAA project where we wanted to answer some specific questions for the Pacific community. Aivi Puloka developed with Corina Grey the questions required for this process. Acceptability and experience were key things that we wanted to look at in this broader population. Diabetes has been raised as having a potential beneficial effect in the case of AAA. The interest was in whether the same prevalence existed and what might be found. There was a specific question about body size and visualisation of the Aorta, and the specific concern that we didn't want to design a screening program that didn't serve the population in the community.

There were very positive results from the project. There was a high prevalence of 4.7 per cent; similar to the rate for Māori. The AF results were also very positive, including the ability provided by working with the cardiology clinicians directly as part of the team enabling seen rapid clinic access for assessment and management. The feedback on that has been very positive and is an important co- benefit as it is known that Māori and Pacific people have strokes at younger ages.

Aivi Puloka reflected on the project.

This was a great opportunity for me to experience what it is like working with my own people

in my mother tongue and I'm going to emphasise three key successful factors.

The first was that is was a Tongan ethnic specific approach centred on language appropriate to tools and approaches and the specific objectives included testing the participant materials and invitation method, testing the uptake and visibility, addressing issues of screening, language and cultural support and primary care support required. It was a real privilege to have been a part of this team having a clinical background, as an emerging Tongan researcher with primary care experience and cultural support in the Pacific Health and Community Services, fluent in speaking, translating and writing in Tongan.

The second successful factor was in co-designing the resources and the method of invitation. Careful attention had to be paid to the design of a person-centered and culturally appropriate program for this one off screen for AAA, looking at whether it was acceptable to Tongan men or not. From the focus group discussion their feedback was included in the production of those resources. Things that they mentioned included that posting the invitation would not be a successful way to invite people and true to their words of the 227 invitations sent out only 12 people called me to book an appointment for a scan after receiving a letter. The preference was for word to be spread via radio programs and church meetings. That content contain more graphics and less text. At the beginning of the focus group discussion they thought that AAA was something new and fatal asking whether there was a Tongan and word for it. Once the transliteration of the term AAA was provided they felt at ease and with more awareness they were happier to promote this and they all agreed to participate. They also co-designed with our GPs as the opinion from GPs was that they were too busy to participate in another study and didn't have enough staff to do it. An attempt was made to limit the workload required with the programme recruiting and booking appointments and sending invitations under the auspices of the GP and the practice.

The third successful factor three was around meaningful patient engagement. I've advocated in Pacific Health that in Primary Care the interface between the provider and the community is the missing link in attempting to address the inequity of health accessibility and poor health outcomes. In this project. I was the first to be surprised at the level of engagement embraced and it started from the time I called them over the phone and the resulting high attendance rate and low DNA's.

Despite the current Pacific health statistics Tongan people do care about their health status and want to look after their health so that they can enjoy a long life with their families. They do attend their appointments and make a lot of effort to do so and when they cannot they do make contact to inform and apologise and ask to be rescheduled. When their appointments were rescheduled they did attend and even after their appointments had been rescheduled more than once there was always a valid reason behind it. These were related to their work, casual work arrangements, transportation, family matters and physical un-wellness. This was a lightbulb moment for me; Tongan people do care to participate in health screening programs and do make a lot of effort to arrive before the appointment time.

Meaningful patient engagement does impact lifestyle, changing Tongan people by improving health literacy and promoting a healthy lifestyle. It was much appreciated by many participants to have their wife attend with them. Meaningful patient engagement also included cultural values of family and relationships and the value in that is bestowed on who you are and not what you do. Of cultural competency language and literacy; I often say, for Pacific people the heart has to be moved before the hands and feet move. This is the essence of our Pacific dance and music. We move rhythmically according to the tempo of the music

because of the warmth and the joy in our hearts and therein lies the value of trust and relationships.

Proactive calling for recruitment was very much appreciated. The value proposition of this research was about what could I get out of this from the clients point of view and not so much to complete the research as one of the complaints of Pacific people is that they have been the focus of other research programmes but to what value. AAA was a great screening program that Illustrated that the patient is more important than the health provider. The little things that we do to make the patient experience satisfactory really counted a lot.

Health Equity requires a great patient experience of the Health Service and it starts by looking Inward and not being afraid of digging deeper.

Aivi Puloka was thanked for sharing her observations. Karen Bartholomew commented that this result was obtained over two COVID 19 outbreaks and a lot of time was spent rescheduling people and that was a difficult thing to do. This project does continue to roll out with the aim of having 750 Pacific men screened. There has been an intentional ethnic-specific approach with screening completed for Nuian and Cook Island men and now moving to Samoan men.

The following points were made during discussion.

Michelle Atkinson commented that she wished everyone in the health sector, including leadership could hear, fully understand and take on board Aivi Puloka's comments. The comments that struck Michelle were; "the patient is more important than the health care provider" and "it's the little things you do" and that Tongan people do want to engage in health.

Michelle Atkinson was advised that the AAA rate for Māori men was 4% once the full cohort is known then there will be more confidence around the estimate. It was anticipated that it might be lower than that and certainly demonstrates the value of this kind of work. Conversations have been had around including Pacific woman as was done in the Māori AAA project because the incidence rates aren't high but what we suspect is that they are not really known.

Teuila Percival commented that this was a wonderful piece of work showing that working with our providers, who are part of the community, is what we need to be doing more of not just sending out pamphlets. She thanked both Karen Bartholomew and Aivi Puloka for this work and the presentation.

Resolution:

That the Community and Public Health Advisory Committee:

1. **Note that a pilot project screening 150 Tongan men aged 60-74 years for abdominal aortic aneurysm (AAA) and atrial fibrillation (AF) has been completed.**
2. **Note the project demonstrated the approach is acceptable to the Tongan community and resulted in a high uptake rate. Participant interviews are to commence shortly and will provide more information to inform future implementation.**

3. **Note that the Pacific AAA/AF screening research project continues with other Pacific ethnic groups as part of the broader research programme into AAA/AF screening.**

Carried

[**Secretarial Note:**

With the arrival of Meg Poutasi in the meeting an earlier question asked by Heather Came was put again. Heather understood that the DHB was committed to working with Māori text but on page 37 of the agenda had found another reference to the English version in the principles. Meg Poutasi advised that the drafting of this strategy came as a response to Wai 2575. At the time it was drafted the DHB were using the principles on advice from the Māori GM and do understand the shift towards recognising the Articles and the Māori version of the treaty. It is appreciated that the position is different now in terms of aligning all the pieces of the DHB strategy and language. Part of the equity review of content is to make sure the DHB does align in this respect otherwise work is being designed using different frameworks at different times which are not reflected back into the core documents. Therefore the DHB was happy to review and to make sure that language reflects the current position.

Heather Came then drew attention to page 40 of the agenda and the history of the equity approach slides from last time and the language used in the IHI framework under the heading of Institutional Racism related to buildings. Karen Bartholomew advised this was an example in the IHI framework but the main examples were policies and processes eg HR, and that the local use of the framework wasn't tied to the original IHI examples.

6.3 Tobacco Control and Vaping Update *(Pages 77-79)*

Dr Karen Bartholomew, Director of Health Outcomes introduced Leanne Catchpole, Portfolio Manager in the Primary Care Team.

The Ministry of Health have announced the development of a draft national Smokefree 2025 plan. Consultation on the new national plan is expected to begin in March or April. The DHB Tobacco Control Plan is required to reflect actions contained in the national plan. By first engaging in the national development process we will be able to bring an updated DHB plan, aligned to the national approach, back to the Board later in 2021. Similarly, we are engaged in the national consultation process on the Vaping Regulations, which will be a component of our plan.

Karen Bartholomew advised that the general view is that the new regulations are positive and that they have good restrictions. The submission made by ARPHS on behalf of the DHBs pointed out some areas for improvement.

The following points were made during discussion.

Michelle Atkinson asked where management felt the DHB would be by 2025 with Leanne advising that smoking is only high in certain populations, communities and within certain age groups. There are some communities that already under five percent. Attention needs to be focused on areas where it is still particularly high, young Māori woman in particular. Interestingly, Great Barrier Island has the highest rate of smoking for the Auckland DHB area followed by Tamaki. In terms of age groups, it's the younger age groups that have a higher rate of smoking particularly the 25 to 29 year old Māori women. Opposed to that there are communities like Orakei that has a smoking rate of 5%.

Heather Came asked whether the DHB was going to have a position on smoking taxation and was advised that there had been a lot of discussion around this in the regional group. The burden and regressive nature of taxation for Māori and Pacific communities was noted There is renewed government focus on tobacco with the new plan, and it was hoped that more funds would be applied to smoking cessation measures, particularly by Māori for Māori.

Zoe Brownlie asked about statistics in terms of the population now vaping and whether they are higher in the areas of smoking or are they completely different and was advised that there is available research on vaping statistics, but would need to bring this back. There is certainly active research in the specific area of smoking, vaping and mental health.

Resolution:

That the Community and Public Health Advisory Committee:

a) **Note the Ministry of Health announcement of a new national Smokefree 2025 action plan. Consultation on the plan is opening in March or April 2021 with the requirement for the DHB to respond.**

b) **Note that alongside the Smokefree 2025 action plan a consultation process is being conducted on the vaping regulations to be enacted of the Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020, closing mid-March 2021.**

c) **Note that in order to respond and align to the national plan and vaping regulations the timing for development of local plans has been adjusted.**

d) **Note the collaborative work to address tobacco related harm with the Auckland Regional Public Health Service continues, including collaborative responses to the consultation.**

Carried

6.4 System Level Measures – Quarter 2 Report *(Pages 80-106)*

Dr Karen Bartholomew, Director of Health Outcomes – Auckland and Waitematā DHBs asked that the report be taken as read, advising as follows:

There was limited capacity to support practice activity during COVID and there have been substantial delays in data provision by the Ministry of Health due to COVID so this is more of

a holding report. It should be noted too that the new population estimates released has seen the Auckland population numbers drop and that has impacted the data.

Karen drew attention to the ASH graphs on page 85 of the agenda and the significant reduction in ASH which is directly related to COVID lockdowns and to reduced circulating viruses. The highest reduction has been seen for the Pacific community. It highlights the huge contribution that respiratory disease has in preventable hospitalisations. Housing is also related to this measure.

On page 97 of the agenda Karen highlighted the improvement in Flu vaccination for children and in Auckland DHB in particular the antenatal vaccination. This has been a very good quality improvement gain.

The following points were made during discussion.

Heather Came commented that these good news stories needed to be written up and circulated in medical journals so that others can learn and it can be taught in classrooms. So if there are ways to share Heather would encourage that. Karen advised that university colleagues had written on some of these topics.

Resolution:

That the Community and Public Health Advisory Committee note the Quarter two results for the fifth System Level Measures (SLM) Improvement Plan.

Carried

7. GENERAL BUSINESS

Vaccinators

Jo Agnew asked what was occurring with accessing vaccinators was advised these people came from community providers and public nursing and unfortunately this is the same workforce that manages all the school and outreach programmes.

Meg Poutasi advised that there has been a call out to train more nurses to become vaccinators and that there was a view nationally that the unregulated cohorts could be considered to undertake some work so other workforces are being looked at to support with complementary work. At the end of 12 months there would be a much wider workforce able to undertake other types of vaccination work.

8. RESOLUTION TO EXCLUDE THE PUBLIC (*Pages 107-108)*

Resolution: Moved Jo Agnew / Seconded Tama Davis

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Attendance and Apologies	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Conflicts of Interest	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Minutes - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5. Assessment of equity in contracts and utilisation	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982

		[NZPH&D Act 2000]

The meeting closed at 11.15am.

Signed as a true and correct record of the Board meeting held on Wednesday, 17 March 2021

Chair: _____ Date: _____

Teulia Percival

Planning Funding and Outcomes Update

Recommendation:

That the Community and Public Health Advisory Committee notes the key activities within the Planning, Funding and Outcomes Unit.

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence), Kate Sladden (Funding and Development Manager Health of Older People), Ruth Bijl (Funding and Development Manager, Children, Youth & Women), Meenal Duggal (Funding & Development Manager, Mental Health and Addiction Services), Leani Sandford (Portfolio Manager, Pacific Health Gain), Raj Singh (Project Manager, Asian, Migrant and Former Refugee Health Gain), Shayne Wijohn (Acting Funding and Development Manager, Primary Care and Māori Health Gain Manager)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
AF	-	Atrial Fibrillation
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
B4SC		B4 School Check
CALD	-	Culturally and Linguistically Diverse
CASA	-	Clinical Advisory Services Aotearoa
CPHAC	-	Community and Public Health Advisory Committee
CTC		Community Testing Centre
DHB	-	District Health Board
DPMC	-	Department of Prime Minister and Cabinet
ESBHS	-	Enhanced School Based Health Services
HEEADSSS	-	Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
GP	-	General Practitioner
HBHF	-	Healthy Babies Healthy Futures
HCSS	-	Home and Community Support Services
HPV	-	Human papillomavirus
LARC	-	Long Acting Reversible Contraception Services
MELAA	-	Asian & Middle Eastern Latin American and African
MMR	-	Mumps, Measles and Rubella
MoH		Ministry of Health
MSD	-	Ministry of Social Development
NA-HH		Noho Āhuru – Healthy Homes
NCHIP	-	National Child Health Information Platform
NGO	-	Non-Governmental Organisation
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
RhF	-	Rheumatic Fever
UR-CHCC	-	Uri Ririki - Child Health Connection Centre
WCTO	-	Well Child Tamariki Ora

1. Purpose

This report updates the Auckland DHB's Commissioning Health Equity Advisory Committee (CPHAC) on Planning and Funding and Outcomes (PFO) activities and areas of priority.

2. Planning

2.1 Annual Plans

The first draft of the 2021/22 Annual Plan was submitted to the Ministry of Health (MoH) on 11 March 2021. Feedback on the first draft was received on 9 April from the MoH and this has mostly been addressed with key contributors and also further updates made to meet the requirements contained in the latest Planning guidance.

The second draft of the Annual Plan, incorporating these changes, was presented to the 26 May Board meeting for consideration and review. This is to be circulated to the Board for final approval prior to being submitted to the MoH on 25 June 2021.

The following sections were updated and resubmitted separately to the MoH on 7 May:

- actions to improve sustainability and information on the financial impacts of the actions identified
- information on FTE movements that were expected to be included in the service change section of the plans and also in the supporting narrative requested to be provided with summary financial templates
- financial information
- completed production plan.

Feedback on these sections was received from the MoH on 24 May and further updates are progressing in response to this feedback.

Further feedback on the second draft is expected by 16 July from the MoH. The Plan will subsequently be updated based on this feedback and resubmitted for Ministerial approval.

2.2 Annual Reports

Audit NZ performed their interim visit in early May. We are working with the auditors to complete the 2020/21 audit process and develop the first draft of the 2020/21 Annual Report.

3. Primary Care

3.1 Response to COVID-19

Our team remain heavily involved in the primary care roll-out of the COVID vaccination. The primary care approach led by the Northern Regional Health Coordination Centre (NRHCC) enlisted a small number of practices across metro Auckland that met a set of agreed criteria, and worked with these practices to start vaccinating their enrolled and neighbouring non-enrolled population as per national sequencing. This has provided the opportunity to model how operationally, safely and logistically, vaccinating will work in this sector and testing our on-boarding processes. In addition to general practice, a similar process has been undertaken with community pharmacies.

Of the selected practices for the first tranche, five are in the Auckland DHB catchment area, and cover some of our most isolated communities with selected practices on Waiheke and Great Barrier.

Following this initial tranche of practices, there is now a rolling programme of on boarding approximately 10 General Practices and 2 pharmacies per week across metro Auckland in preparation for the scheduled wider population roll out commencing later this year. It is expected that vaccinating general practice and pharmacies will account for approximately 25% of all COVID vaccinations in the region.

4. Health of Older People

4.1 Aged Residential Care

The COVID-19 vaccination rollout to aged residential care (ARC) is well underway. There are four NRHCC outreach teams operating from the Mt Wellington community vaccination centre and two large community pharmacy providers with teams visiting ARC facilities to deliver vaccination sessions to both residents and staff; staff are also able to attend community vaccination centres. The programme rollout encompasses metro Auckland and the initial ARC facilities to receive vaccinations were located in Counties Manukau DHB with the programme scaling up across the three metro Auckland DHBs over May.

4.2 Home and Community Support Services

Home and Community Support Services (HCSS) support workers are able to receive COVID-19 vaccinations at community vaccination centres and this workforce has been receiving invitations to attend a vaccination centre since the 12 April.

Work is underway to transition to the new national service specification for HCSS including adopting new service response and using a new triage tool for non-complex and complex clients.

The HCSS case mix cost model is being re-calculated to determine the daily rates for each case mix category for the 2021/22 contracts taking account of forecasted client numbers, complexity changes, and average hours per category.

PFO has been participating in the Technical Working Group to determine the pay equity uplift for 2021/22. This is the final year of current Settlement Agreement.

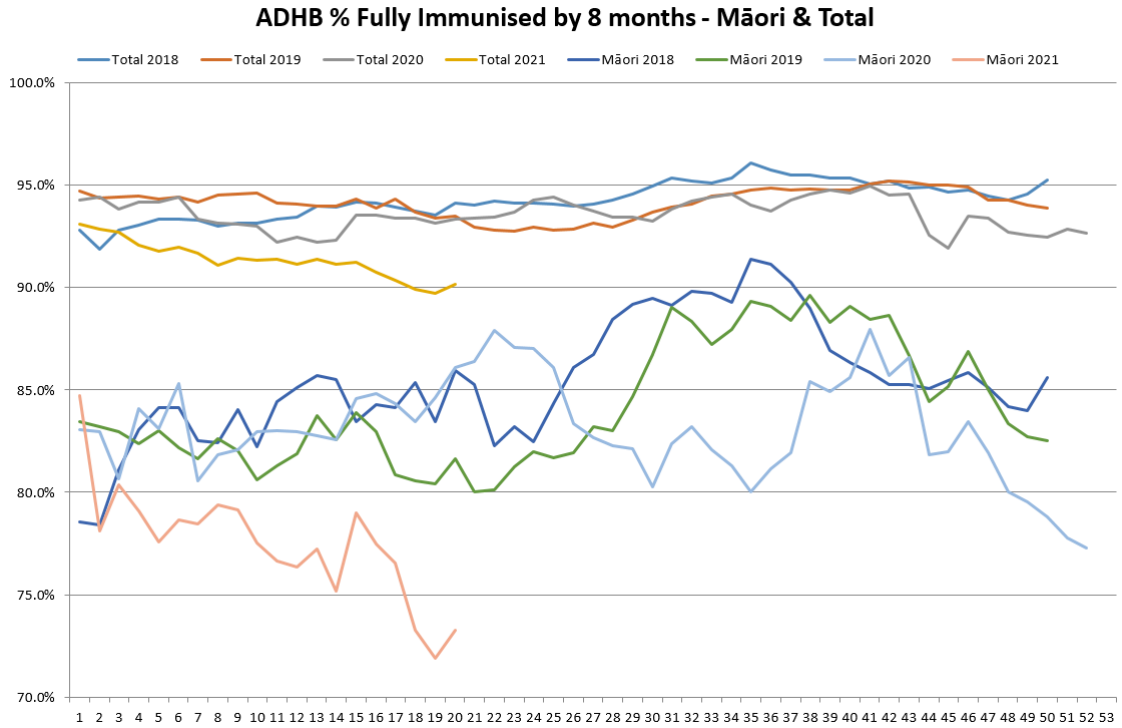
5. Child, Youth and Women's Health

5.1 Immunisation

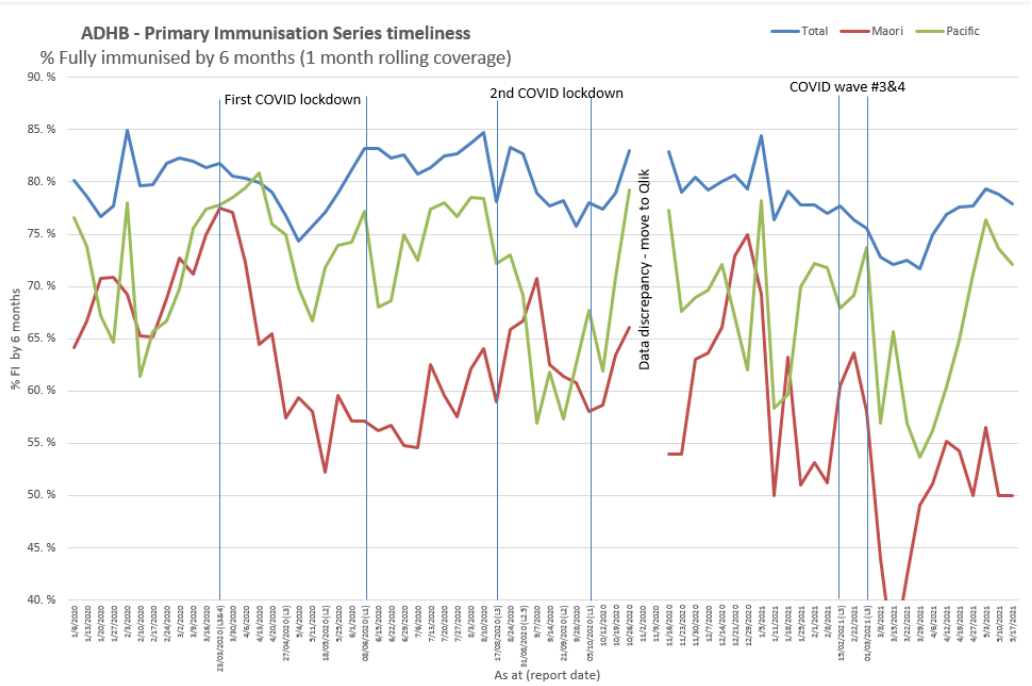
5.1.1 Childhood Immunisation Schedule Vaccinations

As previously indicated, COVID-19 has had an impact on immunisation coverage – the impact on on-time immunisation is being reflected in the coverage at 8 months. Auckland DHB did not meet the 95% target for Q3 2020/21, with 92% for the total population and 81% for tamariki Māori – at the same time last year, coverage was 94% for the total population and 84% for tamariki Māori.

As immunisation is prone to seasonal fluctuation, a comparison of the week on week changes since 2018 is shown below. The graph demonstrates the effect COVID and increased vaccine hesitancy has had on immunisation coverage, with the impact being stark for Māori tamariki.



PFO continues to monitor the impact on "on-time" immunisation as measured at 6 months of age, particularly the rolling 1-month coverage which demonstrates the "real time" coverage although is more prone to fluctuation due to smaller population size. As demonstrated by the graph below, coverage has fallen during the lockdowns, with recovery as we have moved into level 1, however the drop in coverage is more sustained for tamariki Māori. Another drop occurred around the festive season, which fit with the pattern of previous years due to competing family priorities and practices not being open, there had been recovery until we had the third COVID lockdown. When looking at the more stable 3 month coverage (not graphed), we are continuing to see a drop off in coverage for total population, some recovery for the Pacific population, however Māori coverage has not recovered.



The ethnicity insights from the Qlik platform demonstrate some improvement in vaccine hesitancy for tamariki Māori, although at 7.5% as at 17 May 21 they remain more than twice the rate of opt-off and decline compared to non-Māori (3.1%). Review of other DHBs reflects that we are not alone with high Māori decline rates, with other DHBs experiencing rates as high as 18% at 8 months (Whanganui DHB). Reports from the sector continue to reflect the impact of a viral video by a Māori social media influencer, as well as rhetoric from some church groups and political candidates against immunisation having an impact. We have requested assistance from the MoH at a National level to promote immunisation and address vaccine hesitancy. We are also working with our colleagues in Counties Manukau on hosting a hui of Māori child health providers to identify the factors for vaccine hesitancy and delay, and strategies to address these – this is being planned for mid-June.

We have been working with our Primary Health Organisation (PHO) colleagues to support them with data access with the move to the Qlik reporting platform. The next focus is ensuring all PHOs can access identifiable lists of their Māori tamariki to ensure focus is directed to this area. Unfortunately, the MoH unexpectedly made drastic changes to the Qlik platform which has meant a lot of this training and effort is now redundant. We are working with the MoH to ensure that the platform is fit for purpose and enables not just a target view, but a population view. There continues to be some data discrepancies with the move to the Qlik platform following immunisation schedule changes.

We are working with our PHO and IMAC colleagues on a fridge magnet concept, with support from Waitematā DHB comms. The concept is that the magnet will be sent out with the "welcome to NCHIP/NIR" letter to all newborns, providing a visual reminder of the upcoming immunisations.

5.1.2 Measles

Work as part of the national MMR catch-up focused on 15 to 30 year olds, particularly Māori and Pacific, continues, with the Auckland strategy to increase awareness of the need to be immunised and increasing access to the vaccine.

We have seen a positive upswing in vaccinations given in March and April 2021 as the school and tertiary institutes components of the programme are rolled out. Since the campaign was soft

launched by Minister Genter in July 2020, 1,422 MMR doses had been recorded on the NIR for Auckland DHB 15 to 30 year olds. Of these 136 were to Māori and 272 to Pacific. Family Planning and the Reginal Sexual Health clinic are now contracted to provide MMR alongside routine services.

The DHB MMR team have given 583 MMR doses across the Auckland and Waitematā settings, taking a holistic approach and offering a catch up of Boostrix (pertussis, 129 vaccines) and HPV (202 doses) in schools and meningococcal (73 doses) in tertiary residential facilities. To date, 117 Counties DHB domiciled patients will also have been immunised by the Auckland DHB/Waitematā DHB MMR project in both schools and tertiary locations. A further 40 people have been immunised by the Auckland DHB/Waitematā DHB MMR team in the tertiary setting where their records have them as domiciled outside of Metro Auckland, which is common in tertiary settings.

The MoH sent all DHB Chief Executives a letter on 30 March 2021 regarding vaccination priorities for DHBs, which are "COVID-19 and childhood immunisation including outreach and school based and BCG". However, the advice recognised some DHBs might find the competing vaccination priorities challenging and provided guidance that allowed a short term reduced focus on the National Measles Immunisation Campaign until October 2021. The advice noted that DHBs with the ability and the infrastructure in place to continue to deliver the MMR campaign over the next few months, to proceed as planned. The MoH have indicated that the programme is likely to be extended to March 2022.

Consideration of this option was undertaken and a decision was made to continue the MMR programme, with a 'protected' workforce; noting that it will be nearly impossible to 're-start' the programme should it be delayed. This decision also recognised that both Waitematā and Auckland DHBs actively championed a national campaign on the basis of the clinical risk associated with the under vaccinated population, most recently during the 2019 measles outbreak. While the borders are not fully closed, an imported case remains a possibility. When the borders re-open there will be an on-going risk of measles outbreaks occurring due to the under-vaccinated cohort. Both the World Health Organisation and UNICEF have indicated COVID-19 has created a disruption to the delivery and uptake of immunisation worldwide. The resultant drop in immunisation coverage increases the likelihood of outbreaks of vaccine preventable diseases

5.1.3 COVID vaccine

The NRHCC continues to lead the COVID vaccine roll-out across Metro Auckland. The Senior Programme Manager – Child Health has been seconded as a Project Manager. The Immunisation Programme Manager is supporting the cold chain establishment at the new vaccine clinics, as well as the conversations as primary care comes on board with clear expectations that this vaccine programme cannot disrupt the childhood immunisation events.

The MoH has confirmed the replacement for the National Immunisation Register (NIR) – the "National Immunisation Solution" will be released to support the COVID-19 vaccination information and then will be extended to include replacing the entire NIR by early 2022. We await an update on progress as continue to undertake many workarounds for the legacy NIR platform.

5.2 Uri Ririki – Child Health Connection Centre

The Uri Ririki - Child Health Connection Centre (UR-CHCC) and National Child Health Information Platform (NCHIP) is starting to deliver real and tangible results. A total of 38 Auckland babies previously missing from the NIR were identified via NCHIP and linked in with GPs or outreach for immunisation follow up in Q3 20/21. We continue to follow up children with Ministry of Social Development (MSD) for babies who were previously unable to be located by any of the child health service providers.

NCHIP data is now actively being used to investigate which babies are missing their first Well Child Tamariki Ora (WCTO) core check (4-6 weeks). Following a data quality check, priority is given to Māori, Pacific or babies living in areas of high deprivation (Quintile 5) for direct whānau contact to link them with an appropriate WCTO provider of their choice. A 6-month evaluation of this Newborn Enrolment Process project is planned for March 2021.

As at 30 April 2021, Auckland DHB received 1656 referrals to Noho Āhuru – Healthy Homes (NA-HH). This included 6293 family members getting access to healthier home interventions. Of the referrals received, 586 (35%) were for families with a newborn baby or hapu woman.

Targeted initiatives to promote referrals into the programme are being implemented. As well as presentations to referrers, new resources for referrers to share with families are being trialled. Quality improvement opportunities identified in the recent audits of the service are being reviewed with consideration of targeted training and possible system improvement plans being developed.

Training for the wider NA-HH programme teams is underway, input will be sought to develop training programme for the coming year which includes service delivery improvement and implementation of quality initiatives.

5.3 Well Child Tamariki Ora and B4 School Check

Comparison of WCTO core checks data for Q3 of 2021/21 and that of 2019/20 as shown in the table below shows that Well Child Tamariki Ora (WCTO) providers have managed to catch up those tamariki that had missed their core checks during the lock downs. Overall, for Q3 of 2020/21, the Auckland DHB WCTO services delivered 3,232 core checks compared to 2,457 for Q3 of 2019/20. Auckland DHB will be working closely with the providers to make sure that there are no outstanding core checks.

WCTO Core checks Q3 2020/21 and Q3 2019/20

	Asian	European	Māori	Pacific	Other	Unknown	Total
Q3 2020/21	383	533	1,154	1,016	110	36	3,232
Q3 2019/20	285	358	980	706	111	17	2,457

The WCTO core checks in the table above do not include Plunket data. The MoH funds Plunket directly, however, Plunket is now required to share some information with the DHBs and therefore we expect to have some monitoring data from them going forward. Auckland DHB is working with Plunket to establish a process of data sharing.

COVID-19 alert levels have impacted B4 School Check (B4SC) services but the B4SC provider has worked hard to catch up the tamariki. Auckland DHB achieved the 67.5% target for the High deprivation for Q3 of 2020/21 but did not meet the Māori, Pacific and eligible total population target. The Auckland DHB B4SC provider indicated that the target was not met largely due to COVID-19 and the lockdown periods Auckland has experienced, as well as the reduced contact numbers in alert level 2. When face to face visits are not allowed (during level 3) or when the provider needs to limit numbers to ensure they can thoroughly clean between each client (during level 2) the numbers of children they are able to see is reduced.

Furthermore, the provider indicated that some families remain reluctant to see them – especially families who were involved in the Papatoetoe cluster and the Kmart cluster. They want to protect their families and limit interactions with people outside the home. The provider also indicated that they have had an increase in staff sickness due to COVID-19 like symptoms, as well as having staff off work for 14 days after being identified as casual plus contacts in the previous Auckland outbreak.

To meet the target, the provider continues to prioritise Māori, Pacific and Q5 families and following up on families that were seen via zoom. The provider is offering clinic visits as well as home visits. They see a child in their Early Childhood Education if that is what suits the parent. They are also offering virtual visits to those families who are still concerned about face-to-face visits due to COVID-19.

The table below shows that all the B4SC targets for Q3 of 2020/21 were higher than those of Q3 2019/20. It is positive to note that despite COVID-19 lockdowns, Auckland DHB achieved the 67.5% target for the High deprivation.

B4SC Comparison Auckland DHB Q3 2020/21 and Q3 2019/20

Percentage of eligible population checked	High deprivation	Māori coverage	Pacific coverage	Overall coverage
Q3 2020/21	67.6%	66.0%	66.4%	61.7%
Q3 2019/20	58.9%	63.5%	63.8%	59.5%

Auckland DHB has continued to achieve the Health Target with 100% of obese children identified in the B4SC programme being offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions in Q3 of 2020/21.

5.4 Rheumatic Fever

Work is ongoing for the four short-term/high impact initiatives in the Auckland DHB and Waitematā DHB regions in support of managing Rheumatic Fever (RhF) as follows:

- *Identification of culturally safe ways to increase referrals to NA-HH initiative.* A procurement process has been completed to recruit both kaupapa Māori and Pacific researchers who will use guidance from families to develop resources. Planning is underway to gather insights from health workers who will be 'end users' of the resources
- *Piloting of whānau support worker programme*. Work is underway to develop a service specification for this programme alongside the nursing service which will partner with the social workers in NA-HH, as there are synergies between the two programmes.
- *Piloting dental health services for adults with Acute RhF / Rheumatic Heart Disease*. Early costings and pathways are being developed for hospital-based clinics and community based clinics.
- *Finalisation, evaluation and release of 'fight the fever' mobile app.* The app has been launched and young people on monthly bicillin injections are now being recruited to the evaluation.

The project manager is working with a Public Health Physician Registrar on opportunities for increasing awareness, which may include schools and pharmacy settings.

5.5 Oral Health

The Auckland Regional Dental Service (ARDS) is the provider of universal oral health services for pre-school and school age children across metropolitan Auckland, this service is provided by Waitematā DHB. There are approximately 280,000 children enrolled with the service. Services are delivered from 83 clinics, which are primarily located in schools. The majority of children are seen while they are at school, without a parent or caregiver present.

Enrolment

The enrolment target set by the MoH is 95%. The enrolment rate for Māori preschool children for Auckland DHB is 81%. ARDS is reviewing the automatic enrolment system to increase the enrolment of all babies including Māori.

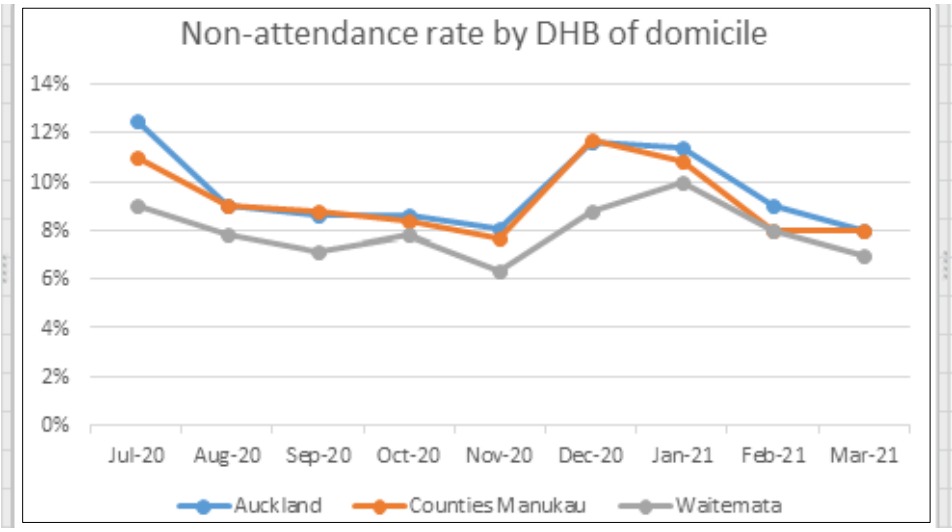
A data matching exercise with NCHIP showed ARDS current report algorithms did not identify all babies born in the three metro Auckland DHBs including some Māori babies. It was identified that this is likely because NCHIP pulls NHIs directly from the MoH's feed source, whereas ARDS' automated report pulls from the DHB birth lists. A data analyst is currently reviewing how ARDS can receive a monthly cross-match of all NCHIP enrolments to ARDS enrolments to:

a) Identify babies enrolled in NCHIP but not in ARDS;
b) Automatically enrol these babies into Titanium (ARDS' patient management system); and
c) Retrospectively do a one-off analysis of babies enrolled in NCHIP but not in ARDS and enrol them into Titanium.

In addition, when babies are automatically enrolled into ARDS from birth lists, their ethnicity reflects their mother's ethnicity only. This means if a baby's father is Māori and the mother is not, the baby will not be recorded as being Māori in ARDS. This will affect the proportion of babies identified as Māori recorded in our database. ARDS' Standard Operating Procedures now reflect the need to confirm the ethnicity of all children at the time of booking their appointment.

Non-attendance rate

Over the past two years, there has been a significant focus on improving the systems and processes that support equity and attendance. These initiatives have resulted in a significantly improved attendance rate. As demonstrated in the graph below, non-attendance rates have improved across all ethnicities though, the gap between Māori (15%), Pacific (15%) and other (4%) children is still present. The overall non-attendance rate is reduced to 7.7% for Auckland DHB.



Long waiting children

The volume of long waiting children, those who last attended ARDS prior to 2018, across metro Auckland has reduced by 13%, with 1,454 less children appearing on this list over the last month. The service continues to prioritise children who are most overdue. In addition, the Discharge Management Process is now well established in ARDS. Currently, there are 1,615 long waiting children in Auckland DHB.

Timeliness
The growth in arrears (not seen on time) has been stabilised with the service maintaining an arrears percentage of 62% in March. The service will continue to reallocate resources during the school term time to ensure children with the highest clinical needs are prioritised, of which Māori and Pacific children are over-represented. The table below outlines the percentage of children in arrears by ethnicity and DHB of domicile as of 31 March 2021.

DHB	Māori	Pacific	Asian	Other	Total
Auckland	61%	62%	59%	62%	61%
Counties Manukau	65%	64%	59%	62%	63%
Waitematā	61%	64%	60%	63%	62%
ARDS TOTAL	***62%***	***63%***	***59%***	***62%***	***62%***

5.5.1 Maternal Oral Health Project - Hapu Māmā Oranga Niho Ki Tamaki

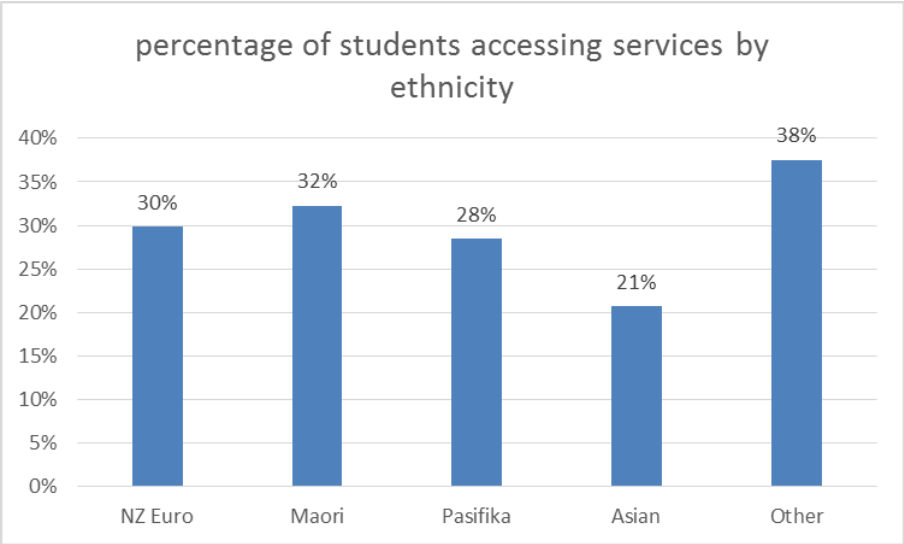
A total 184 referrals were received by the service by March 2021. Of these, nine referrals did not meet the eligibility criteria and seven declined to take part in the service. Of the 168 wāhine who are accepted into the service, 16 have completed their episode of care. The remaining are currently under treatment (109) or have their initial appointment booked (43). A majority of booked appointments (69%) have been with the dentist, compared with 31% with the therapist. The length of appointments reflects the needs with an average appointment being 45 to 60 minutes long. A majority of active referrals are Pacific (49%) and Māori (40%) wāhine. Nearly half of wāhine seen by the service are aged in their 20s and are 41% in their 30s. About 2% are in their late teenage years and 3% are in their 40s.

5.6 Youth Health – Enhanced School Based Health Services

The Enhanced School Based Health Services (ESBHS) programme is delivered in ten mainstream secondary schools, Alternative Education settings and the Teen Parent Unit. The programme provides youth friendly, confidential, and easy to access health services – the nurse is available at school every day, supported by a visiting general practitioner and clinical psychologist. Through this programme about 9,000 secondary school students have improved access to primary healthcare in Auckland DHB.

The model involves a contract between the DHB and school to fund and employ appropriately qualified nurses and set expectations, such as all Year 9 students having a bio-psychosocial HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) assessment to identify unmet health needs.

HEEADSSS completed by ethnicity
The graph below shows the percentage of completed HEEADSSS assessments in Auckland ESBHS schools in Term 1 by ethnicity.



5.7 Contraception and Abortion

We continue to promote the opportunity to provide funded Long Acting Reversible Contraception services (LARCs) in the community. Steady increase in providers is positive, with some high needs geographic locations requiring more work.

MoH is leading work to clarify training expectations for the provision of LARCs and clarify the pathway. We are participating and supporting this initiative. MoH funding for targeted provision of LARCs going forward is not yet confirmed but it has been indicated that funding will continue.

Online training modules from Family Planning Associations National Contraception Training Service are available. Contraception counselling module is now available to all health care professionals. We understand that other e-learning modules will become available more widely and we will promote their uptake. Delivery of practical training has been progressed in partnership with Auckland DHB women's health and feedback from participants has been very positive.

The contract with Auckland Medical Aid Centre is live, with women from across the region now accessing abortion services from this newly contracted provider.

5.8 Cervical Screening

Cervical Screening coverage across New Zealand including Auckland DHB continues to decline and is below the national performance target of 80%. In the Auckland DHB area, 69% of eligible women were screened in the three years ending 30 April 2021. Of critical concern, the coverage rate remains inequitable for Māori at 57.9%, over 20% below the performance target. Coverage for Pacific and Asian women also remains inequitable at 60.2% and 58.5% respectively (noting that there is currently no outcome inequity for Asian women, however this remains for both Māori women and Pacific women). A modest improvement in coverage in the most recently reported data is noted across all groups which is positive.

We welcome the Government pre-budget announcement on the funding for human papilloma virus (HPV) primary screening, including HPV self-testing. Waitematā DHB and Auckland DHB have led two trials of HPV self-testing which have contributed substantially to the evidence base for decision-making and will continue to contribute to the implementation planning.

COVID-19 restrictions have had a significant impact on completion of cervical screens which are largely provided in primary care. Of greatest concern however are the women who have never been screened or have not been screened for five years or more. To support an equitable return to cervical screening among Māori and Pacific women, the MoH has notified of two planned initiatives including additional funding to provide free and accessible cervical screening for Māori and Pacific women and a campaign to increase screening uptake. A modest additional fund will be allocated regionally based on composition of the eligible population by ethnicity, areas with the highest assessed COVID-19 impact on screening coverage and areas with the highest pre-COVID-19 equity gap. The screening campaign will be developed in collaboration with a sector advisory group and it will build on the Start to Screen campaign. Preparation for implementing some equity targeted catch up has commenced, however we are yet to receive contracts from MoH outlining the parameters to progress this.

Implementation of an 'incentives' evaluated trial which was planned for this quarter has not been progressed due to capacity issues. However, this will be progressed in the new financial year.

6. Mental Health and Addictions

6.1 Rapau te Ahuru Mowai – Homelessness Transitions Pilot

On 10 February 2021 MoH entered into a contract with Auckland DHB to deliver the Rapau te Ahuru Mowai/Homelessness Transitions Pilot. Auckland DHB Mental Health Service is one of two pilot sites to deliver this pilot nationally (Waikato DHB being the other site). This pilot is an action from the Aotearoa New Zealand Homelessness Action Plan, a central government-led and cross-agency plan that has been developed to prevent and reduce homelessness. The pilot seeks to address the urgent issue of people stuck in inpatient services who no longer clinically need to be there but are homeless and without a suitable discharge address. The central goal of the Pilot is to help strengthen and improve the responses of Mental Health Inpatient Units when discharging service users/tāngata whaiora (who have experienced or are at risk of homelessness) back into the community.

The Homelessness Transitions Pilot will take place over 4 years and help approximately at least 70 people transition from Auckland DHB acute mental health and addictions inpatient units into the community, with housing and other wraparound support.
The key components of the Pilot include:

- flexible home-based services, tailored to meet the unique needs of individuals in scope for this initiative
- provision of housing through access to the public and private market/social or supported housing
- provision of mental and physical health services
- provision of broader support services

The Pilot aims to support adults with complex mental health and addictions and other needs requiring specialist health services to gain and maintain wellbeing in a community setting. The target cohort includes adults who:

- are transitioning out of acute mental health and addictions inpatient units
- are homeless or do not have suitable accommodation
- have wider wellbeing support needs
- who are able to live in the community with support

A high proportion of tangata whaiora who have an extended stay in mental health and addictions inpatient units are Māori. The Homelessness Transitions Pilot initiative will include a focus on providing culturally appropriate support that responds to the needs of Māori.

PFO has completed an open procurement process for a joint proposal for both aspects of the Pilot (Wrap-around Services and Property Sourcing and Housing Co-ordination / Tenancy Management Services). Two providers have been selected and contract negotiations are underway, with an intended contract start date in May 2021.

6.2 Suicide Prevention update:

Many people who are thinking of suicide seek help from whānau and friends, and need whānau support to increase their wellbeing or seek further support. Whānau are able to recognise members experiencing suicidal distress and feel confident to talk to them about their situation and know how to help them access further support. We facilitate regular trainings on suicide prevention throughout the year and in the last quarter we supported two organisations to deliver relevant trainings. Le Va delivered Mana ake ake which is a Lifekeeper training focusing on building whānau capability in Maori community at Waitakere area. Blue Print delivered Mental Health 101, a programme giving people the confidence to recognise, relate and respond to people experiencing mental health challenges. This training was well attended by participants from organisations within Auckland DHB who lack mental health knowledge but are in ideal place to assist people in their community.

Clinical Advisory Services Aotearoa (CASA) was supported by Auckland DHB to deliver Aoake Te Ra, information Hui, and then followed up with one day of workshop. This workshop was attended by a number of local providers that potentially can deliver this counselling services, a free, brief therapeutic service for individuals and whānau needing specific support for bereavement by suicide.

Whānau support for those bereaved by suicide: The whānau support coordinator has now been in position for six months. Here are the main progress updates:

- Review of the notification pathway and addition to this taking on the lead role for coordination of support for whānau following a suicide, this has progressed to be trialled however this is dependent on the relationship and information sharing across the network by Victim support.
- Working through the trauma investigation process in Auckland DHB, Whānau support coordinator now a part of the investigation process within Auckland DHB and working well connecting whānau through the investigation process.
- Engaging with external stakeholders to engage better with whānau after a suicide and develop referral pathways for whānau
- Engaging with CASA regarding contagion identification and establishment and promotion around Aoake Te Ra. Also supporting the roll out of registration of professionals across the Auckland region.
- Engaging with the wider stakeholder group in response to a contagion identified across the region – stakeholder came together through a facilitated process to wrap a support package around the whānau.
- Whānau support coordinator meeting with all Governance boards across the DHB for education around the postvention roll.
- Creation of a service model of care for the Whānau support coordinator role. This position would like to lead a KIND response to the bereaved and lead with direct contact with whānau providing a Koha with a no obligation offer of support. This is currently in its final draft; this service has been gifted a name of Hapitia.
- Working alongside and in partnership Kenzie's gift (bereavement support for children) that already distribute and have prepared written whānau booklets after bereavement, these have been very useful and very receptive by the whānau and the children in the whānau.
- Over the past three months have made 29 separate visits to NGO partners across Auckland to meet and greet and inform them about the role of Whānau support.
- Whānau supported over in the last quarter are:

- 16 whānau referrals into the Whānau support coordinator
- 18 adults – supported together or 1:1
- 19 children in the whānau households
- Referrals made to Aoake Te Ra, Grief support Centre, Tu tangata Tonu, Kenzie's Gift, Asian mental health services, funeral homes and funeral directors, local peer support services.

Zero Suicide Framework:
The Zero Suicide Framework project has resumed as of the 2021 calendar year after been placed on hiatus during COVID-19 health system response. Cultural fit and equity assessment has resumed. It is expected that the review and adaptation of the framework for cultural fit will be completed by the end of 2021 calendar year. The activities this quarter include briefing leadership, project plan re-development, establishing governance group with effective contribution from lived experience / whānau group.

7. Pacific Health Gain

7.1 Pacific Regional response to COVID-19

The Pacific team is working on a range of NRHCC Pacific COVID-19 response initiatives that support access, engagement and equity of Pacific health outcomes. Two Pacific Locality Vaccination Centres have been set up in Otara and Westgate, Massey. Work to promote and support Pacific communities to access the specific Pacific centres and other vaccination sites in local areas aligned to the vaccine roll out plan is being undertaken.

Across the metro Auckland region, work is underway to engage with a diverse range of Pacific communities including church ministers and their congregations about the COVID-19 vaccine and the booking process. A team comprising a GP, nurse and member of the NRHCC booking team is visiting community groups starting with several Samoan church denominations to share information about the vaccination sites and booking process. As result of this engagement, the team received a request for group and family bookings which it suggests will improve access to the vaccine. The Samoan Congregational Christian Church Maungakiekie synod was the first group booked to receive their first COVID vaccine. This organisation consists of nine church communities across the Auckland DHB region. Media coverage of the group vaccination was reported and aired on TV1, TV3 and other media channels. Further group bookings are planned.

7.2 Pacific Mobile service

The Tongan Health Society Pacific Mobile service has engaged with the fourteen Healthy Village Action Zone churches to discuss the COVID-19 vaccine roll-out plan. Health education sessions have included information about the vaccine and the possible side effects that might be experienced after receiving the vaccine. The Tongan Health Society continues to deliver services at both church and home settings actively following up with people by phone and text messages when appointments are missed. A range of other services were delivered included flu vaccinations, 14 smoking cessation education sessions, 82 general health advice, 26 wellbeing assessments, 26 long term condition assessments, referrals to social services and mental health services. The location of service delivery spans across Auckland with majority residing in Auckland Central.

7.3 Positive Parenting and Active Lifestyle

The Positive Parenting and Active Lifestyle programme supports families to prevent and manage childhood obesity, to establish health eating routines and positive parenting strategies to help them facilitate and maintain changes in their child's eating behaviour and activity levels. From July 2020 to

March 2021, 16 programmes were delivered to individual Pacific Churches and community groups, with a further 2 to be completed prior to 30 June 2021. The team engaged and delivered programmes to 215 parents during this time, and 37 parents will be graduating by the end of this financial year. The maximum target is 150 parents for this program. However, a total 252 will complete this program. There is a current waiting list of 5 Pacific Churches and Community Organisations (50-75 parents). The programme will end June 2021.

8. Māori Heath Gain

8.1 Māori Mobile Units

From 4 January 2021 a new contract was put in place with Ngati Whatua o Orakei to provide a kaupapa Māori, nurse led mobile unit in Auckland DHB. The previous service had been put in place to focus on influenza vaccinations for kaumātua, however, due to the timing of the new contract and whānau needs from the numerous lockdowns and pandemic related complications an emphasis was also placed on the holistic wrap around services available to whānau. Services which have been offered include:

- Opportunistic vaccinations for priority groups (including children, adolescents, pregnant women, elderly, front line and disability workers)
- 'Strep throat' management (swabbing and RhF management)
- Skin infection management
- Risk assessment and swabbing for COVID-19
- Wellbeing/social assessment
- Health education -particularly around current medication use
- Smoking cessation support and advice
- Tikanga/cultural support

Since January 4 the following services have been delivered:

- Over 200 households contacted
- 315 NIR status checks to determine vaccination status
- 136 Immunisations (with a further 98 which were scheduled, but cancelled by whānau, the service continues to follow these up)
- 79 Flu vaccinations
- 29 patients who were given specific education around immunisations
- 20 MMR Vaccinations
- 5 COVID swabs

Specific education regarding vaccinations has been a particularly positive aspect of the service, with a number of whānau who have previously declined vaccinations deciding to vaccinate themselves or their tamariki following a session with the nurse. Advice given has usually centred on:

- The diseases on the National Immunisation Schedule
- How childhood immunisations work to protect us from these types of harmful diseases
- Other ingredients found in immunisations that are used to enhance the body's immune response (with nurses often pointing out whānau often consume many of these in their kai or baby products)
- The importance of immunising on time.

We are working to expand the capacity of this service, adding another provider in Auckland DHB, this is likely to be active within the next couple of months.

8.2 Māori Pipeline Projects

The Pipeline is one of the three prioritised areas of focus for Kōtui Hauora.

8.2.1 Māori Health Plan Acceleration Projects

Breast Screening Data Match: The project is complete and demonstrated a significant number of Māori women were able to be identified and contacted to offer enrolment in breast screening services. We welcome the recent Government announcement, alongside the HPV self-testing announcement, of an IT system inclusive of a full population register within the next two years. This will mean that datamatching with primary care and hospital data will no longer be required to identify Māori women missing out on services.

Cervical Screening High Grade Project: This project is complete and a project report sent to the National Cervical Screening Programme.

8.2.2 New Services

Lung Cancer Screening Project: This is a large-scale collaborative project with Otago University, Waitematā DHB and Auckland DHB, led by Professor Sue Crengle and supported by a Māori-led steering group. The Consumer Advisory Group Te Ha Kōtahi met again recently an approved the new study information sheet and programme logo, supported by Health Literacy NZ. The documents are to be submitted shortly for ethical review, and the pilot is planned to be underway in July. The research team presented and supported the inaugural Aotearoa Lung Screening Symposium, hosted by the Thoracic Society of Australia and New Zealand National. The symposium and presentations were well received and resulted in positive discussions with a range of clinicians and interested stakeholders nationally.

AAA/AF Screening: The completion of the National Hauora Coalition practices is being finalised, and the Pacific AAA/AF trial is progressing well, with more than half the anticipated 750 participants now completed. The Atrial Fibrillation (AF) component of the research was recently presented to the National Screening Advisory Committee, demonstrating a detection rate of 2% for newly diagnosed AF. Anticoagulation (stroke prevention) prescribing for those newly diagnosed with AF was lower than anticipated, and the team are following this up. Kōtui Hauora requested consideration of a AAA screening extension to Northland DHB. The team have met with Northland DHB representatives and agreed to work together on a pilot project to test rural access pathways. Grant funding applications to support this work are in preparation.

8.2.3 New Models of Care

Kapa Haka Pulmonary Rehabilitation: This project seeks to use Kapa Haka as an intervention to improve respiratory fitness and determine whether it can on its own, or augmented, be used as pulmonary rehabilitation. The project developed out of Dr Sandra Hotu's PhD studies. Staffing and venues for the prototype are being confirmed.

Hepatitis C: the MoH have agreed to the Northern Region leading the datamatch for the country, in close collaboration with the MoH. Approvals are in progress. The project will support appropriate datamatching to enable the re-offer of treatment to those with known Hepatitis C who have no record of receiving treatment. The project focuses on elimination for Māori first, with the clinical team led by a Māori pharmacist and Māori GP. The clinical pathway is currently being finalised with key stakeholders and the engagement coordinators are being recruited.

8.3 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) programme is on track educating whānau about nutrition and physical activity for their children.

Outlook: Use of funding grants and relationship building

We have supported this network of providers to apply for external funding grants to:

- Build up HBHF e-Learning courses and
- Create a video resource library for live webinars and face-to-face workshops.

Community partnership grants are a part of this programme to allow community groups to lead their own education sessions using HBHF resources and staff members. We are looking to increase these from 6 to 20 partnerships in the new contractual year. This is in line with our broader strategy to empower communities to educate themselves.

The focus for the year 2021 - 2022 of the Māori and Pacific providers is on building on-going relationships to deliver the programme through:

- The Kōhanga Reo Trust (Māori) and
- Pacific church groups.

The Asian community continues to have high engagement with their communities with large waiting lists of eager parents ready to learn. The South Asian community have exceeded their targets ahead of schedule.

Table 8: HBHF Key measures – 1st July 2020 to 31st March 2021

	TextMATCH Enrolments		Programme (6 courses) enrolments		Lifestyle reviews collected - 6 weeks post	
COMMUNITIES	**Actual**	**Performance**	**Actual**	**Performance**	**Actual**	**Performance**
Māori	192	112%	96	89%	40	55%
Pasifika	182	106%	124	115%	79	110%
South Asian	242	141%	160	148%	100	139%
Asian	246	143%	396	367%	102	142%
Total	**862**	**126%**	**776**	**179%**	**321**	**111%**

9. Asian, Migrant and Former Refugee Health Gain

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

The Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023 is now published and is available on website here.

The Asian, new migrant and former refugee health gain project manager continue to support NRHCC and Department of Prime Minister and Cabinet (DPMC) to provide culturally appropriate guidance for COVID-19 vaccination roll out plan and COVID-19 vaccine resources.

The team is working closely with NRHCC and Counties Manukau DHB Communications team to produce '*Introduction to COVID-19 vaccine*' promotion videos for the Culturally and Linguistically Diverse (CALD) communities. The videos feature health professionals (doctors) who share some basic information about the COVID-19 vaccine and encouraging their respective community members to get the vaccine.

The videos have been produced in the following languages:

- English
- Arabic
- Burmese

- Cantonese
- Hindi
- Khmer
- Korean
- Mandarin
- Punjabi
- Tagalog
- Urdu and
- Vietnamese

The videos have been well received, for instance the Tagalog video have had over 10,0000 views. (for example the English video is available here).

We have supported the translation of the *Your COVID-19 vaccination*- a quick guide booklet into multiple languages.

Important COVID-19 reminders social tiles were made available in a number of languages during the recent outbreaks including Amharic, Arabic, Bengali, Burmese, Gujarati, Hindi, Japanese, Korean, Portuguese, Punjabi, Simplified Chinese, Sinhalese, Spanish, Tagalog, Tamil, Traditional Chinese, Urdu, Vietnamese, Swahili, Somali and English.

We have provided input and linkages for NRHCC's media plan for Asian and Middle Eastern, Latin American and African (MELAA) communities.

We continue to advocate for COVID-19 vaccination related resources being made available in different languages. This is to ensure that the MELAA communities receive the information in their language from trusted sources. This will help reduce vaccine hesitancy and misinformation.

9.2 Increase access and utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 90% by 30 June, 2021

The number of Asian enrolees Q2 2021 has increased by 455 for Auckland DHB, compared to last quarter. The Auckland DHB PHO enrolment is 80%. (The population projections ('2020 Update') used for the analysis of Q2 2021 are based on Census 2018 as for Q1 2021).

2021 Flu Immunisation Campaign

Translated 'Free flu immunisation for people 65 years+' posters have been created to promote the Free flu immunisation campaign in the CALD community. The posters are available in English, Arabic, Burmese, Hindi, Japanese, Korean, Simplified Chinese, Spanish, note Punjabi and Portuguese will be uploaded soon) here

9.3 Indicator: Increase opportunities for participation of eligible former refugees enrolled in participating general practices as part of the *'Improving access to general practice services for former refugees and current asylum seekers' agreement'* (formerly known as Former Refugee Primary Care Wrap Around Service funding)

We continue to work with Refugee Health Liaison Team and CMDHB as the refugee quota programme is reinstated and small groups of refugee families start arriving for resettlement in New Zealand.

We are working with NRHCC and DPMC to produce COVID-19 vaccination resources for the former refugee community languages.

Joint Auckland and Waitematā DHB Suicide Prevention and Postvention Action Plan 2020 - 2023

Recommendations:

That the Community and Public Health Advisory Committee recommend the Board:

1. **Approves the joint Auckland and Waitematā DHB suicide prevention and postvention action plan 2020 - 2023**
2. **Note the collaborative work that has been undertaken to develop this plan**

Prepared by: Dr. Sarah Gray (Public Health Physician, Health Gain Team, Planning, Funding and Outcomes)
Endorsed by: Meenal Duggal (Funding & Development Manager, Mental Health & Addictions), Dr Karen Bartholomew (Director, Health Outcomes), Dr Debbie Holdsworth (Director Funding), ADHB Senior Leadership Team

Glossary

CASA	Clinical Advisory Services Aotearoa
DHB	District Health Board
MoH	Ministry of Health
SPPGG	Suicide Prevention and Postvention Governance Group

1. Executive Summary

This paper presents a joint Auckland and Waitematā DHB Suicide Prevention and Postvention action plan "Tārai Kore Whakamomori" for approval. The plan covers the time period July 2020 to June 2023 and replaces the previous plan which was developed in 2015. This update brings our planned actions into line with the current national strategic direction. The action plan has been informed by the Auckland and Waitematā DHB population statistics, coronial suspected suicide data, the published evidence base and local expert opinion. It should be noted that this plan is a living document which is open to review if new relevant evidence or suicide trends emerge.

The overarching aim of the joint Auckland and Waitematā DHB Suicide Prevention and Postvention Action Plan is to reduce, if not eliminate, the number of suicides that occur in our communities. The actions in this plan are designed to work towards an integrated approach to suicide prevention and postvention whereby Auckland and Waitematā DHBs work collaboratively across sectors and with communities to reduce suicide in their populations. The action plan is also consistent with the Board's vision of promoting wellness and focus on improving equity.

2. Introduction

Suicide is a significant public health issue in New Zealand. The latest annual provisional coronial suicide data, reported a national total of 654 deaths in the year to 30 June 2020, equating to a suicide rate of 13.01 per 100,000 people (Office of the Chief Coroner of New Zealand 2020). This was a drop from the previous year's total of 685 deaths, but is still unacceptably high.

While suicides occur across the lifespan, some groups are disproportionately affected. New Zealand has some of the highest youth suicide rates in the developed world, and Māori have significantly higher rates of suicide than any other ethnic group in New Zealand. The suicide rate in men is nearly three times that in women (Ministry of Health 2019a).

Despite concerted suicide prevention efforts over several decades worldwide, the evidence base for reducing suicide rates remains limited. However new approaches are emerging and the evidence base is accumulating. It is well recognised that preventing suicide at a population level is complex and that a multilevel approach across sectors and long-term commitment is required.

DHBs are required by the Ministry of Health (MoH) to have a suicide prevention and postvention action plan in place. In 2019/2020 Auckland and Waitematā District Health Boards (DHBs) developed a joint action plan "Tārai Kore Whakamomori", which describes how Auckland and Waitematā DHBs will work to reduce their suicide rates from July 2020 to June 2023. This replaces the previous plan which initially covered 2015 – 2018 and which was then rolled over for two subsequent years. This paper presents "Tārai Kore Whakamomori" for approval.

3. Background

From 1 July 2019 to 30 June 2020 there were 58 suspected suicides in the Auckland DHB population and 54 suspected suicides in the Waitematā DHB population (Office of the Chief Coroner of New Zealand 2020). Figure 1 shows the trend in rates of suspected suicides in Auckland and Waitematā DHBs and NZ as a whole, since this data was first reported in 2007/08. Rates fluctuate more widely from year to year at a local level compared with nationally due to the smaller numbers involved. However with the exception of Auckland DHB in 2017/18 the rates in both DHBs have consistently been below the national average in the time period covered.

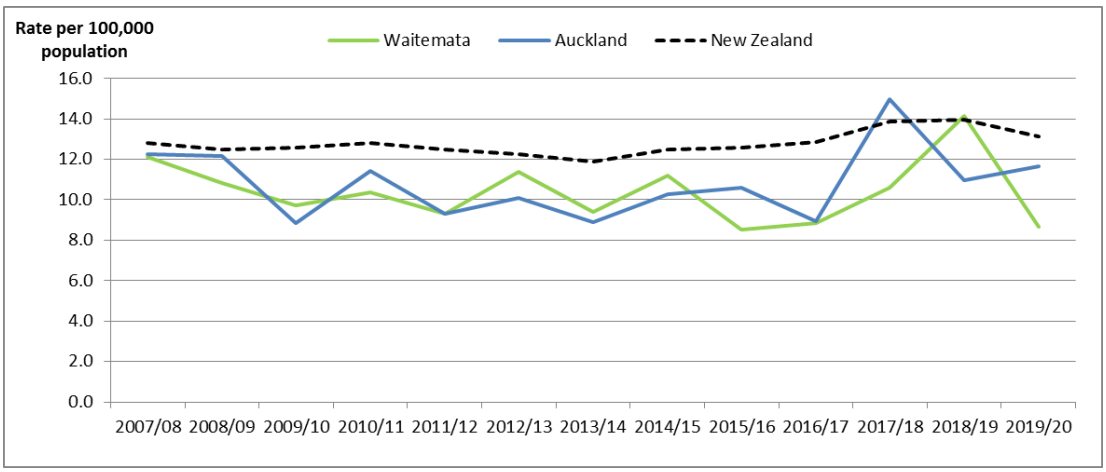


Figure 1 Rates of suspected suicide per 100,000 population in NZ, Auckland and Waitematā DHBs 2007/08 to 2019/20

Trends in rates by sex, ethnicity and life-stage group cannot be tracked reliably at a DHB level, as the absolute numbers of suicide are too small. However indications are that trends are similar to those seen nationally with rates higher in Māori and males. In terms of absolute numbers, the majority of suicides in Auckland DHB occur in non-Māori males aged 25-64 years.

The reasons for suicide are complex and although it can be precipitated by a single distressing event, an accumulation of experiences over a person's lifetime usually contribute. Suicide prevention

initiatives generally aim to promote protective factors and reduce risk factors for suicide at a population level and improve the services available for people in distress.

The evidence base for reducing suicide is limited, however, psychosocial treatments, well coordinated postvention input, gatekeeper training (improving the ability of people who have daily contact with vulnerable groups to recognise suicidal distress and know where to refer for help), health care professional training and reducing access to the means of suicide, are all initiatives that have been evaluated and shown to have an impact.

One emerging approach to suicide prevention is The Zero Suicide Framework.' Zero Suicide' applies a quality improvement and safety approach to the prevention of suicide throughout the health system. The foundational belief of Zero Suicide is that suicide deaths are preventable (Suicide Prevention Resource Centre). The Framework originated in the United States in 2012 but has since been implemented successfully in other health systems worldwide, most notably in the Gold Coast in Australia. Auckland DHB has chosen to pilot this approach in their youth mental health service in the first instance with view to rolling out to other services in due course. This approach is reflected in our action plan.

Suicide postvention refers to all the activities undertaken after a suicide to facilitate recovery for those left behind and features strongly in our action plan. It is a form of suicide prevention in that the aim is to reduce the incidence of suicidal distress and further suicide amongst those recently bereaved by suicide.

In September 2019 the Government released a new strategy and action plan "Every Life Matters" – He Tapu te Oranga o ia Tangata: National Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024. These documents provide an updated view and approach to preventing suicides in New Zealand, moving the emphasis from a largely mental health service-based response, to enabling communities, whānau, hapū and iwi to nurture and support their own family and whānau when they are experiencing suicidal distress. The vision for the new strategy is "every life matters". This vision proposes that by working together, we can achieve a future where there is no suicide in Aotearoa New Zealand (Ministry of Health 2019b).

4. The Suicide Prevention and Postvention Governance Group

A joint Auckland and Waitematā DHB Suicide Prevention and Postvention Governance Group (SPPGG) was established in 2015 followed shortly after by the formation of a separate interagency group. In mid-2019 these groups were merged, to improve efficiency and effectiveness and facilitate collaboration across sectors.

Current members of the SPPGG represent various sectors, organisations and teams including: DHB Planning, Funding and Outcomes teams (Mental health, Health gains, Primary care and Māori Health gain teams), DHB Mental Health Services (Psychiatric Liaison Services, Adult, Youth, Community Alcohol and Drugs Service), Māori , Pacific, Asian, The Rainbow community, Ministry of Education, Victim Support, Oranga Tamariki, Police, Le Vā and Clinical Advisory Services Aotearoa (CASA) and members of the Child and Youth Mortality Review Committee and Suicide Mortality Review Committee.

The main task of the SPPGG is to advise, guide and monitor the development and implementation of a comprehensive, integrated and evidence-based suicide prevention and postvention action plan for

the two DHBs. The SPPGG currently reports to the DHB Boards through the Auckland and Waitematā DHB Planning and Funding Division.

5 The Auckland and Waitematā DHB suicide prevention and postvention action plan "Tārai Kore Whakamomori"

In 2015 the Auckland and Waitematā DHB SPPGG developed an inaugural suicide prevention and postvention action plan which was implemented from 2015 - 2020. This was based on the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016. The following activities were successfully delivered:

- Suicide prevention awareness presentations were given to a wide range of audiences
- Suicide prevention resources were developed and distributed
- Suicide prevention training was provided (i.e. SafeTalk, QPR; ASIST and Lifekeepers)
- Suicide primary care pathways were developed
- Notification pathways were improved regionally
- An Interagency group was formed.

In order to develop the new plan, a three-hour workshop with key stakeholders was convened by the Suicide Prevention Programme Manager for Auckland and Waitematā DHBs to brainstorm potential activities. This enabled DHB collaboration with a wide range of community organisations including, but not limited to those with SPPGG representation. A specific Māori focussed analysis was completed by the Māori Health Gain team.

The action plan "Tārai Kore Whakamomori" describes how Auckland and Waitematā DHBs will work to reduce their suicide rates from July 2020 to June 2023. The action plan has been guided by the following national strategic documents; "Every Life Matters" – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019 – 2029 and Suicide Prevention Action Plan 2019 – 2024 for Aotearoa New Zealand" and "Turamarama ki te Ora" – Bringing Light to the Dark: National Māori Strategy for Addressing Suicide 2017 – 2022 (Durie MH et al. 2017).

The key action areas within our plan align to the national action plan and are:

- Promotion: promoting wellbeing.
- Prevention: responding to suicide distress.
- Intervention: responding to suicidal behaviour.
- Postvention: supporting people after a suicide.

Within each action area, three or four specific areas of focus have been identified. For each focus area there is one goal and one to four detailed actions.

The focus areas, goals and specific actions can be found in the full plan which is attached as an appendix (Appendix 1). The rationale for choosing each focus area is also articulated in the plan. Many areas reflect our prioritisation of improving outcomes for high risk groups such as Māori and youth, others a commitment to working with whānau, to service improvement or workforce development. Although knowledge as to how to best reduce suicide is limited, the actions in the plan strive to be as evidence and practice based as possible.

This action plan is intended to guide activities in the suicide prevention and postvention space for the next three years, but is also intended to be a living document. Therefore if circumstances dictate, actions may be modified in consultation with key stakeholders. This could, for instance, be in

response to new emerging evidence of an effective approach to suicide prevention, or a change in need, such as a steep rise in suicide rates in a particular sub group of the population. This also allows us to remain agile and respond to any additional external funding opportunities becoming available.

The plan has been designed to leverage existing local and national investment as much as possible. There are no funding implications associated with endorsing this action plan for 2020 – 2021. For the subsequent two years the extent to which a small number of activities can be implemented will depend on internal or external funding being available. Business cases will be developed for consideration of DHB investment as required.

Once approved by the Auckland and Waitematā Boards the plan will be submitted to the MoH for approval.

6 Equity

Within Auckland DHB achieving equitable outcomes is a priority. Our action plan acknowledges that there are differences in the wider determinants of health and wellbeing and in health outcomes that are not only avoidable but unfair and unjust. Our plan recognises that different individuals and groups with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

In particular Māori are overrepresented in groups of people at higher risk for suicide such as the unemployed and those under the justice system. Māori also experience a significantly higher rate of suicide than the non Māori population. Our plan takes account of the principles of Te Tiriti o Waitangi and has a clear emphasis on supporting Māori to take action on suicide throughout the plan.

The actions in the plan have been guided by the key action areas in 'Turamarama ki te Ora' – Bringing Light to the Dark: National Māori Strategy for Addressing Suicide 2017 – 2022 (Durie, et al. 2017). These are:

- Facilitate culturally and clinically safe practices through effective community/whānau development, hope-building and leadership development.
- Build safe collective networks that encourage all those with an interest in suicide prevention to participate.
- Enable and support hope-building in suicide prevention. For example, include safe practices such as story-telling whakawhitiwhiti kōrero, kōrero tahi use of pūrakau and tā moko for cultural and whakapapa reconnection and healing.
- Fostering Māori healing practices that are culturally valued and effective.

Other groups that are also prioritised in the plan include young people, men, mental health and addiction service users, Pacific Peoples, Asian, and the Rainbow community.

7 Monitoring and Evaluation

A monitoring framework for the action plan is currently being finalised. From Quarter 4 2020/21 onwards this will be used to track progress on the goals and actions outlined in the plan. The framework sets out a high level time frame by which actions should be completed. The suicide prevention programme manager will collate data and enter this into a reporting template which will be reviewed by the SPPGG on a quarterly basis. Quarterly reports are also submitted to the MoH. A

brief update on suicide prevention activities is currently provided to the Boards in the funder updates.

8 Conclusion

Many factors can contribute to a suicide and success in suicide prevention will require a multifaceted approach across a wide range of organisations and sectors. The actions in this plan are designed to work towards an integrated approach to suicide prevention and postvention whereby the DHBs work collaboratively across sectors and with their communities to address risk factors and improve services.

The overarching aim of the joint Auckland and Waitematā DHB Suicide Prevention and Postvention Action Plan is to reduce, if not eliminate, the number of suicides that occur in our communities. Thus approval of the action plan demonstrates the commitment of the Auckland DHB Board to reducing suicide in their population.

References

1. Durie MH, Lawson-Te Aho KR, Naera MH, et al. 2017. Tūramarama ki te Ora ('Bringing Light to the Dark'): National Māori Strategy for Addressing Suicide 2017- 2022. Rotorua: Te Rūnanga o Ngāti Pikiao Trust.
2. Ministry of Health. 2019a. Suicide Facts: Data Tables 1996- 2016. URL:https://www.health.govt.nz/publication/suicide-facts-data-tables-19962016 (accessed March 2021)
3. Ministry of Health. 2019b. Every Life Matters – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand. Wellington: Ministry of Health.
4. Office of the Chief Coroner of New Zealand. 2019. *Provisional suicide statistics 2018/19*. URL: https://coronialservices.justice.govt.nz/ assets/Documents/Publications/Provisional-Figures-August-2019.pdf (accessed March 2021).
5. Suicide Prevention Resource Centre. About Zero Suicide URL: https://zerosuicide.sprc.org/about (accessed November 2019)

Appendix 1

Waitematā and Auckland District Health Board
Suicide Prevention and Postvention Action Plan
2020 – 2023
"Tārai Kore Whakamomori", to fashion, chipping away the prevention

Prepared by
Manu Fotu, Suicide Prevention Programme Manager
And
Waitematā and Auckland District Health Board Suicide Prevention and Postvention Governance Group
2020

Contents

Introduction

Suicide is a global phenomenon in all regions of the world. Each year 800,000 people die from suicide and it is the second leading cause of death in 15-19 years olds (WHO, 2015). New Zealand has some of the highest youth suicide rates in the developed world, and it is also apparent that Māori continue to have significantly higher rates of suicide than any other ethnic group in New Zealand.

There is no single explanation for the unacceptable suicide rates in New Zealand. Many factors can contribute to a suicide including psychiatric illness; an impulsive response to anguish; a misguided sense of loyalty to friends who had taken their own lives; a breakdown in key relationships; and a reflection of societal inequities and injustices to name a few. We know that preventing suicide is complex and that there is no single way to achieve this goal, but it is still preventable (WHO 2015). There is some positive progress being made by current suicide prevention strategies and services locally and nationally, however the steady increase in rates nationally suggests further development of initiatives and investment is required.

This action plan "Tārai Kore Whakamomori" describes how Auckland and Waitematā DHBs aim to reduce their suicide rates and improve well-being for all, over the next 3 years. In order to achieve these aims the DHBs have worked collaboratively with their community stakeholders to develop a suite of actions they believe will result in improvements to the current services and systems. The action plan has also been guided by the advice and recommendations provided in the following national strategic documents; "Every Life Matters" – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019 – 2029 and Suicide Prevention Action Plan 2019 – 2024 for Aotearoa New Zealand" and "Turamarama ki te Ora" – Bringing Light to the Dark: National Māori Strategy for Addressing Suicide 2017 – 2022 (Durie, et al. 2017).

Within both Auckland and Waitematā DHBs achieving equitable outcomes is a priority. This action plan acknowledges that there are differences in health outcomes that are not only avoidable but unfair and unjust. It recognises that different individuals and groups with different levels of

advantage require different approaches and resources to achieve equitable health outcomes. In particular, our DHBs will need to focus on achieving equity for Māori given Māori experience disproportionately higher rates of suicide nationally and locally. This has resulted in a clear emphasis on Māori activity within this action plan. Other groups that are also prioritised in this plan include young people, men, mental health and addiction service users, pacific peoples, Asian, rural, and LGBTQ.

The release of 'Every Life Matters' and 'Turamarama ki te Ora' has provided the DHBs with the guiding principles they needed to create an updated suicide prevention and postvention action plan. Therefore, all activities in Auckland and Waitematā DHBs action plan align with the current action areas noted in 'Every Life Matters' and 'Turamarama ki te Ora'. The key action areas are:

Every Life Matters

- Promotion: promoting wellbeing.
- Prevention: responding to suicide distress.
- Intervention: responding to suicidal behaviour.
- Postvention: supporting people after a suicide.

Turamarama ki te Ora

- Facilitate culturally and clinically safe practices through effective community/whānau development, hope-building and leadership development.
- Build safe collective networks that encourage all those with an interest in suicide prevention to participate.
- Enable and support hope-building in suicide prevention. For example, include safe practices such as story-telling whakawhitiwhiti kōrero, kōrero tahi use of pūrakau and tā moko for cultural and whakapapa reconnection and healing. Fostering Māori healing practices that are culturally valued and effective.

Background

Suicide is devastating for all those personally affected. It can have a huge impact on individuals, whānau, friends, peers, colleagues, hapū, Iwi and our wider communities. In 2016, 553 people died by suicide in Aotearoa New Zealand (a rate of 11.3 per 100,000) (Ministry of Health 2019). This number has unfortunately likely been steadily increasing since 2016, according to the coroner's 2019 provisional suicide report (Coroner media release, 2019). It is clear that suicide does not discriminate and detrimentally affects all communities and populations living in New Zealand.

In 2015 Auckland and Waitematā DHB developed a suicide prevention and postvention action plan. This action plan was based on the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016. The plan was developed and implemented over the period 2015 – 2019 and the following activity was successfully delivered:

- Suicide prevention awareness campaign,
- Suicide prevention resources were development and distributed,
- Suicide prevention training provided (i.e. SafeTalk, QPR; ASIST and Lifekeepers),
- Developed suicide primary care pathways,
- Notification pathways improved regionally, and Interagency group developed and implemented.

In September 2019 the Government released their new strategy and action plan "Every Life Matters" – He Tapu te Oranga o ia Tangata: National Suicide Prevention Strategy 2019–2029 and Suicide

Prevention Action Plan 2019–2024, which replaces the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016 (Ministry of Health 2013).

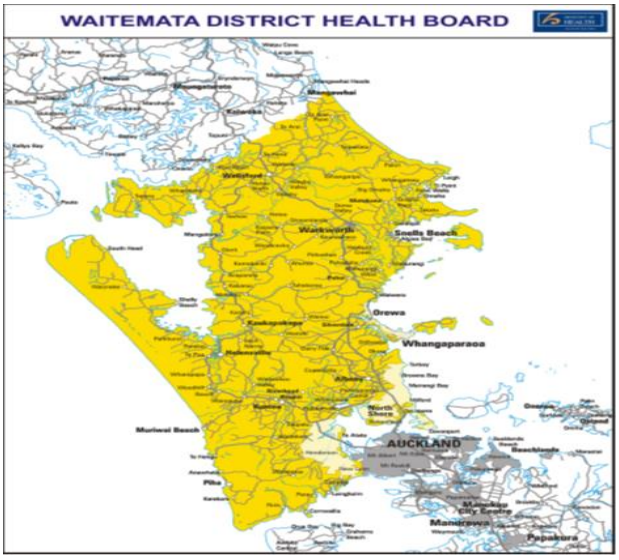
The new strategy draws from the learning's of the past strategies and plans and provides an updated view and approach to preventing suicides in New Zealand. The vision for the new strategy is "every life matters". This vision proposes that by working together, we can create a future where there is no suicide in Aotearoa New Zealand. The new strategy moves the emphasis from a largely mental health service-based response, which was recommended in the last strategy, to enabling communities, whānau, hapū and Iwi to nurture and support their own family and whānau when they are experiencing suicidal distress.

The link between mental illness and suicidal behaviour is well known with approximately 42 percent of those who died by suicide or undetermined intent (aged 10 to 64 years) being mental health service users (Ministry of Health, 2017a). However, there are other risk factors associated with suicidal behaviour including exposure to trauma, a lack of social support, poor family relationships and difficult economic circumstances. The prevention of suicide is both complex and challenging, and no single initiative or organisation can prevent suicide on its own. A comprehensive and coordinated approach is required across government and non-governmental organisations, and in partnership with the community (Ministry of Health, 2013).

Demographic Summary

***Waitematā DHB*[1]**

The Waitematā District Health Board is the largest of New Zealand's 21 Health Boards. It is estimated the population of the district is approximately 627,000.

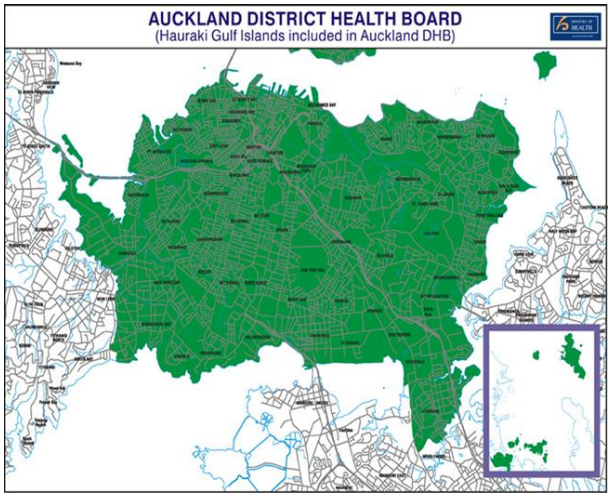


The population is ethnically diverse with nearly 10% Māori, 7% Pacific, 22% Asian and 61% European/Other. The district contains a large migrant population with over one third born overseas. The Pacific population is predominantly Samoan (52%), Tongan (17%) and Cook Island Māori (15%). The Asian population is diverse but is predominantly Chinese (40%), Indian (23%) and Korean (14%). *(Source: Statistics New Zealand, population projections based on 2013 census. updated 2018)*

The population is relatively affluent with a large proportion living in areas with low levels of socio-economic deprivation (NZDep 1-4) and the region having the fourth highest median personal income when compared with other DHBs. While the Waitematā population enjoys a high median income, home ownership is increasingly unaffordable. Over-crowding is more common than in New Zealand overall, especially for Māori and Pacific families. The Māori and Pacific populations have lower rates

[1] For a full demographic and health profile, see the WDHB Health Needs Assessment on the WDHB website http://www.Waitematādhb.govt.nz/

of educational achievement and high unemployment. The most socio-economically deprived areas are located within the Henderson-Massey, Waitakere and Whau boards with small pockets within the Rodney board.



Significant population growth is expected in the future. Waitematā population is projected to increase by 30%, reaching 818,000 by 2038/39. It will also be an older population with the number of people aged 65 years and older expected to almost double, increasing from the current 88,000 to 168,000, and making up 21% of the total, compared with 14% at present. Waitematā Māori, Pacific and Asian populations will also grow, with Māori population by 36%, Pacific by 41% and Asian population by 71%.

Auckland DHB[2]

The Auckland District Health Board is the fourth largest of New Zealand's 21 Health Boards. The estimated population of the district is approximately 542,000. The population is ethnically diverse with 8% Māori, 10% Pacific and 34% Asian and over 40% being born overseas.

The Pacific population is predominantly Samoan (44%), Tongan (31%) and Cook Island Māori (17%). The Asian population is diverse but is predominantly Chinese (41%) and Indian (33%). Auckland's population is urban with only 0.2% of the population living in rural areas (Great Barrier Island). *(Source: Statistics New Zealand, population projections based on 2013 census, updated 2018.)* The age composition of Auckland residents is somewhat different from the national picture, with 35% in the 25-44 age group, compared with 27% in this age group nationally. Auckland has 11% of its population in the 65+ age group, compared with 15% nationally.

Significant socio-economic gradients exist within the district with a large proportion (28%) living in areas with high levels of socio-economic deprivation (NZDep 8-10). When compared across ethnicities, over half (52%) of the Māori and Pacific population live in areas with high levels of socio-economic deprivation. While Auckland's population enjoys a high median income, home ownership is increasingly unaffordable. Over-crowding is more common than in New Zealand overall, especially for Māori and Pacific families. The Māori and Pacific populations have lower rates of educational achievement and high unemployment. The most socio-economically deprived areas are located within the Mangere - Otahuhu, and Waitematā boarders with small pockets within the Puketapapa board.

Similar to other areas of New Zealand, the district is projected to undergo significant population growth and demographic change over the next two decades and beyond. By 2038/39 Auckland's population is projected to increase by 156,000 people, making it 29% larger than it is now. The population will also be considerably older with the number of people aged 65 years and older expected to increase from the current 60,670 to approximately 115,000, and making up 17% of Auckland population, compared with 11% at present. The Māori and Asian populations will also

[2] For a full demographic and health profile, see the ADHB Health Needs Assessment on the ADHB website http://www.adhb.govt.nz/

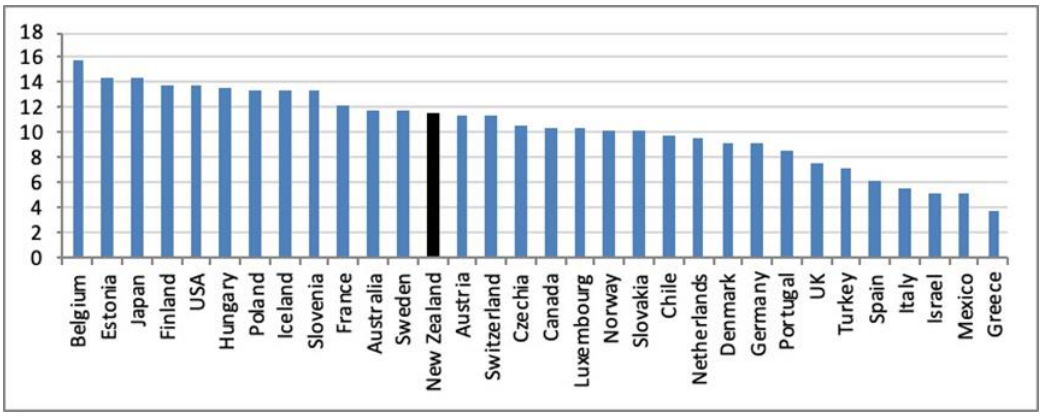
grow, with Māori population by 33% and Asian by 64%. The Pacific population is projected to grow by 21%.

Suicide Data

Two national data sources exist from which suicide data is reported. The MoH publish data annually and report on suicides up to three years before the date of publication (Ministry of Health, 2016); the second source is the coronial data released annually by the Chief Coroner (Chief Coroner NZ, 2019). The numbers of deaths from suicide recorded in the MoH publication differ from those released by the Chief Coroner. This is primarily due to the Chief Coroner's data including all deaths initially identified at the coroner's office as potentially 'intentionally self-inflicted'. Of these, only those deaths determined by the coroner following investigation to be 'intentional' will receive a final verdict of suicide and be included in the Ministry data. In addition, the Chief Coroner's data covers different time periods (years ended 30 June rather than the calendar years used in the MoH publication).

International context

Comparison of suicide rates with other countries is limited because of the different standards used to determine whether a death is a suicide. However, compared to reported data for OECD countries, New Zealand had suicide rates slightly above the median in 2016. **(Figure 1)**.



Source: World Health Organisation Mental Health Global Health Observatory database

Figure 1 Age-standardised suicide rates 2016 - OECD Countries

National Data

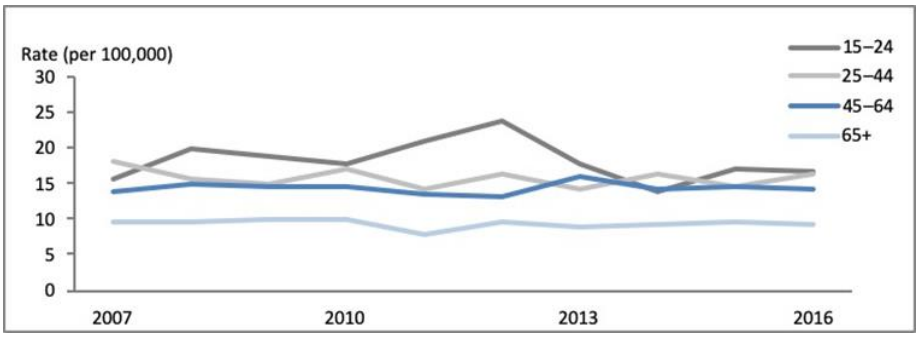
The most recent publication by the Ministry of Health is the 'Suicide Facts: 2016 data (provisional)' report, released in July 2019. At the time of publication coroner inquiries for 26 deaths from 2016 were yet to be completed. These deaths are excluded from this data although they may later be classified as suicides.

In 2016, 553 people died by suicide in New Zealand, which equates to an age-standardised rate of 11.3 per 100,000. Over the ten-year period 2007–2016, although the number of suicides has gradually increased, the rate of suicide remained relatively stable due to population growth

Provisional suicide rates reported by the Office of the Chief Coroner have however increased over the last five years from 11.73 per 100,000 in 2013/14 to 13.93 in 2018/19. In 2016 there were 412 male suicides and 141 female suicides (17.0 per 100,000 and 5.8 per 100,000 respectively). For every

female suicide there were 2.9 male suicides. From 2007–2016 inclusive, the rate for males has consistently been at least 2.5 times that for females.

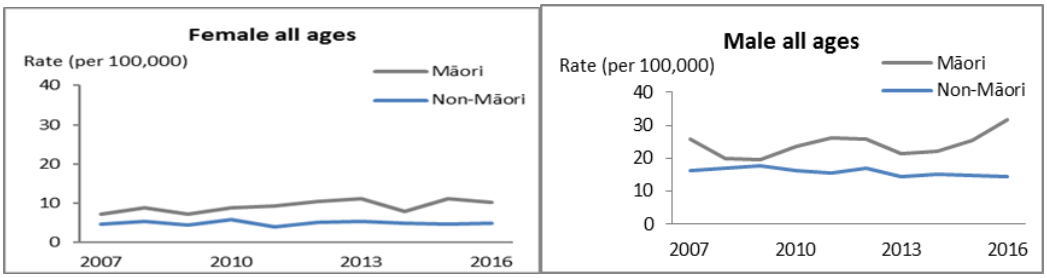
The rate of youth suicide has been variable. Prior to 2013 the youth rate was predominantly higher than the other life-stage age groups, but from 2013 – 2016 inclusive were more similar to the other life-stage groups less than 65 years. Figure 2 shows age specific suicide rates by life-stage group.



Source: MoH Suicide Facts: 2016 data(provisional)

Figure 2 Age-specific suicide rates by life-stage group 2007 - 2016

Over the ten year period shown the rate of suicide for Māori was consistently higher than the rate for non-Māori, for both males and females. The rate for Māori males increased markedly from 2013 to 2016 (21.2 per 100,000 and 31.7 per 100,000 respectively). The gap between Māori and non-Māori is due to high rates in Māori youth and the 25-44 years life stage groups. There is no difference in the older life-stage groups

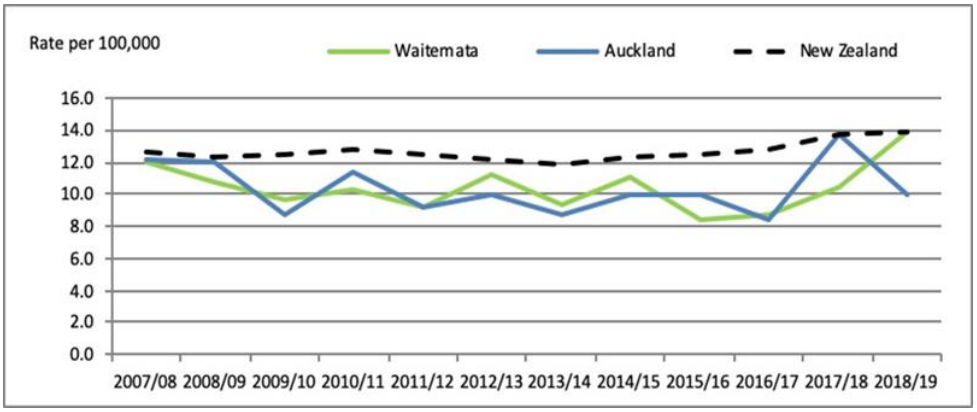


Source: MoH Suicide Facts: 2016 data(provisional)

Figure 3 Age-standardised suicide rates by Maori and non- Maori 2007 - 2016

Waitematā and Auckland DHB suicide numbers and rates

Waitematā and Auckland DHBs generally have a lower suicide rate than NZ as a whole. However in 2018/19 Waitematā rates increased to the NZ average. It is not possible to tell if this is a new long term pattern or a single aberration. It can be seen that the same pattern occurred in Auckland DHB in 2017/18 but returned to the long term lower rates in 2018/19.



Source: Coronial Provisional Suicide Statistics 2018/19

Figure 4 Crude provisional suicide rates in Auckland and Waitematā DHB compared with New Zealand

Suicide Prevention and Postvention Governance Group (SPPGG)

A joint Auckland and Waitematā DHB Suicide Prevention and Postvention Governance Group was established in 2015 along with a separate interagency group. In mid-2019 these groups were combined into one, to ensure efficiency and effectiveness and facilitate collaboration across the sector. The main task of the SPPGG, is to advise and guide the development and implementation of a comprehensive, integrated and evidence-based suicide prevention and postvention plan for the two DHBs.

Members of the Suicide Prevention and Postvention Governance Group (SPPGG) include representation from various sectors including:

- Mental Health Planning and Funding
- Mental Health Services
- Primary Care Planning and Funding
- Psychiatric Liaison Services
- CADS
- Youth Services
- Maori
- Pacific
- Asian
- Tūhono
- MOE
- Victim Support
- Oranga Tamariki
- Police
- Le Vā
- LGBTQ
- CYMRC – Child and Youth Mortality Review Committee

The joint Auckland and Waitematā DHB Suicide Prevention and Postvention Governance Group (SPPGG) will again be tasked with overseeing the overall delivery of this action plan and will play a major role in the implementation phase.

The Action Plan

An inaugural action plan was developed in 2015 and covered the three-year period 2015 – 2017 inclusive. This plan was rolled over in 2018 and 2019. Now with the release of 'Every Life Matters' work has been carried out to update the action plan for 2020 to 2023 inclusive and align actions with the national action plan focus areas.

In order to develop the new action plan, a three-hour workshop was held in October 2019 with key stakeholders to brainstorm potential actions. There was representation from a wide range of organisations and perspectives including: Le Vā, NZ Police, Ministry of Education, Lifeline, Asian Family Services, Waitematā DHB SMHAS, Auckland DHB Family Services, Oranga Tamariki, Consumer Advisors, Fresh Mind (Primary Services), Rainbow Community, DHB Youth Mental Health Services and DHB Planning and Funding (Pacific, Mental Health, Primary Care and Health Gain Team representation). A specific Māori focussed analysis was completed by the Māori Health Gain team. This has helped to inform what high impact activities are required locally to improve the current Māori suicide rates. This action plan will incorporate several actions with a specific Māori focus, aiming to achieve equity for our Māori population.

With the over representation of Māori within suicide statistics, any action plan needs to be responsive to Māori needs and ensure interventions are accessible, effective and appropriate for Māori. The involvement and participation of Māori has been embedded into each activity. We have also embedded the broad principles of Whānau Ora into our approach as we recognise the importance of family in the work of suicide prevention.

The Waitematā and Auckland DHB SPPAP 2020-2023 takes a population health and community development approach to suicide prevention, and highlights priority actions for suicide prevention and postvention in our districts. It aims to reflect current strategic directions and acknowledge the national actions being delivered, while responding to local community needs and priorities. Emphasis has been placed on ensuring outcomes are realistic within identified timeframes. The SPPAP notes specific work needing to be undertaken alongside at-risk groups in our district including Māori, Pasifika, LGBTQ community, Asian, youth, older people, migrants and the rural community.

This plan is also underpinned by the principles in the Strategy 2019-2029 so all activities should:

- be evidence based
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a coordinated multi-sectorial approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

This Suicide Prevention and Postvention Action Plan endeavours to reflect ownership by Waitematā and Auckland DHBs, along with commitment from key stakeholders for its implementation for the next three years and beyond

1. Promoting Wellbeing		Vision: Every person in our communities can access wellbeing programmes that provide connection, skills and support	
Focus Area	**Rationale and Goal**	**Key Actions**	**Project Lead and Key Partners**
1.1 Resiliency, connectedness and wellbeing in youth	**Rationale:** We know that resiliency, having friends and whānau that you can confide in and good self-esteem are protective factors for suicide. **Goal:** Youth have access to programmes and initiatives that will build skills needed to cope with distressing life events and to be able to support each other through hard times	• Identify and explore funding streams for programmes that aim to increase youth resiliency and social connectedness.	**Lead:** PFO Mental Health Team **Partners:** Ember (NGO - mental health, AOD and intellectual disability services)
1.2 Māori wellbeing	**Rationale:** The Māori suicide rate is significantly higher nationally than any other group and has continued to climb for the past ten years. It is expected that we would see an uptake of Māori wellbeing programmes if the right programmes are in place. **Goal:** Māori have access to programmes and initiatives that will build skills for wellbeing and positive relationships	• Conduct a stock take of all Māori wellbeing programmes within Auckland and Waitematā DHB catchment areas • Scope (including data analysis) with view to implementing and evaluating an Alcohol/Drug brief intervention in ED for Māori working aged men and Māori Youth if indicated • Scope (including data analysis) with view to implementing and evaluating a domestic violence brief intervention in ED for Māori working aged men – partner with NGO, West Auckland • Scope (including data analysis) with view to implementing and evaluating a Kaupapa Māori Service for Māori working age men that enriches their sense of identity, connection and inclusion	**Lead:** PFO Māori Health Gain Team **Partners:** Te Whānau o Waipareira (non-government – whānau services)
1.3 Access to wellbeing initiatives for all	**Rationale:** Wellbeing initiatives can increase resilience and wellbeing for disadvantaged	• Support promotion of existing evidence based programmes through	**Lead:** PFO Mental Health Team

vulnerable groups	and vulnerable people. **Goal:** Vulnerable groups including but not limited to older people, the Rainbow community, ethnic minority groups, children in care and people under corrections, can access programmes and initiatives that support wellbeing.	SPPGG networks • Support the development and implementation of new evidence based programmes that are designed to promote wellbeing • Link with 'Awhi Ora programme which provides timely access to support for socioeconomic issues	/ Suicide Prevention programme Manager (SPPM) **Partners:** All SPPGG members and their organisations
2. Responding to suicidal distress		**Vision: Our communities and providers are competent in responding to suicidal distress**	
Focus Area	**Rationale and Goal**	**Key Actions**	**Project Lead and Key Partners**
2.1 **Access to support in the community for Māori and Pacific working aged men**	**Rationale:** Māori and Pacific men are at high risk of death by suicide, representing a health equity issue. **Goal:** Māori and Pacific aged working men are able to access help for suicidal distress in a time of need	• Conduct a stock take of all support available currently to Māori and Pacific working aged men experiencing suicidal distress • Hold Hui to determine uptake of support and any barriers to accessing support for Māori and Pacific men and their preferred model of care • Implement and evaluate actions that aim to increase access to psychotherapeutic interventions and other support in primary care / other preferred settings for working aged Māori and Pacific men experiencing suicidal distress	**Lead:** PFO Māori Health Gain Team PFO Pacific Health Gain Team **Key partners:** Primary care Iwi Māori health Providers
2.2 **Whānau capability**	**Rationale:** Many people who are thinking of suicide seek help from whānau and friends, and need whānau support to increase their wellbeing or seek further support. **Goal:** Whānau are able to recognise members experiencing suicidal distress and feel confident to talk to them about their situation and know how to help them access further support	• Gatekeeper training to be delivered by Le Vā (Lifekeepers). • Identify and promote use of free resources i.e. Mental Health Foundation, Le Vā online Lifekeepers training and other website resources • Promote the 1737 "free call or text any time" and other appropriate resources to	**Lead:** PFO Māori Health Gain Team SPPM **Key partners:** Whānau Advisors Le Vā Mental Health

		Whānau and community	Foundation
2.3 **Education provider response to youth**	**Rationale:** Many youths who are feeling suicidal are connected with education providers – mainstream schools, Kura Kaupapa, tertiary providers and vocational training providers. **Goal:** Young people who are connected with education providers have access to staff who feel confident assessing students for suicidal risk, providing support and know when and who to refer young people onto further support.	• Explore opportunities to deliver further support and training to education provider based health and pastoral care staff (i.e. nurses, GPs, counsellors, psychologists) in order to improve their capability to undertake suicide assessment and participate in suicide prevention • Review, develop and implement clear guidance on referral pathways for education provider based health and pastoral care staff for youth experiencing suicidal thoughts and behaviours • Hold a Hui with Kura Kaupapa Staff and provide tailored training for them to undertake suicide risk assessment and participate in suicide prevention	**Lead:** PFO Mental Health Team **Key partners:** MoE PFO Child, Youth and Women's Health Team ADHB Zero Suicide Project Manager
3. Responding to suicidal behaviour		**Vision: Everyone who presents to health services with suicidal behaviour has a comprehensive risk assessment, has access to treatment that works and a safety plan involving their support people**	
Focus Area	**Rationale and Goal**	**Key Actions**	**Project Lead and Key Partners**
3.1 **Transitions of care**	**Rationale:** It is well-recognised that transitions of care are a time when people can lose contact with the health care system. **Goal:** Everyone discharged after being seen by either MHA Specialist Services or ED following a serious self-harm or suicide attempt is helped to develop a clear safety plan including follow up care with specialist services	• Audit existence and quality of safety plans on record for people discharged from ED or MHA Specialist Services after serious self-harm or suicide attempt and implement actions to improve as required • Audit provision of follow up appointments and any corrective actions and improve processes as required • Work with ADHB Mental Health and Addiction Commissioning Board to explore the role of a peer	**Lead:** SMHAS QI ED **Key partners:** PFO Health Gain Team

		support navigator to assist in ED with care transitions	
3.2 **Non-specialised services**	**Rationale:** People with suicidal behaviour often present to non-specialist services **Goal:** Non-specialized health workers have access to training in the assessment and management of suicidal behaviour	• Promote available training options. • Explore options for co-ordination of training so that there is regionally provided, consistent training provision in place.	**Lead:** SPPM **Key partners:** Le Vā AOk Blue Print Lifeline Youthline
3.3 **Suicide risk assessment and safety plans**	**Rationale:** People who have made a serious self-harm or suicide attempt are thought to be at higher risk of further self-harm or suicide attempt. Safety planning which includes reducing access to lethal means is evidence based. **Goal:** The specialist MH&A and primary health workforce feel capable and confident to undertake suicide risk assessment for people exhibiting suicidal behaviour and to develop safety plans with the person and their support people – in particular the rural workforce **Goal:** Flags are in place to identify when treatments are not working	• In ADHB: Planning and initial implementation of the Zero Suicide Framework for specialist mental health and addictions services, primary care and NGO providers. • In WDHB: Scoping, planning and implementation of evidence-based self-harm and suicide risk assessment, safety planning and supporting activities in the Waitematā DHB specialist mental health and addiction services • Explore options for regionally provided, consistent training provision. • Support provision of and promote attendance of unconscious bias training to all mental health and addictions clinical staff	**Lead:** ADHB Zero Suicide Project Manager SPPM Rural Health Alliance Service leads SMHAS **Key partners:** Le Va AOk Blue Print Lifeline Youthline
3.4 **Family and whānau capability**	**Rationale:** Family and whānau are the key natural resource for people with suicidal thoughts and behaviours **Goal:** Whānau and friends feel confident to support whānau members who have been discharged after a serious suicide or self-harm attempt as part of a co-ordinated response with services and are themselves supported	• Promote national written resources and groups for whānau which increase whānau capability • Establish local coordination of groups and programmes for whānau	**Lead:** Whānau Advisors Service Leads SMHAS **Key partners:** Whānau Advisors

4. Postvention		Vision: Those affected by a suicide are able to access the right support at the right time for them. They also have access to good information about the related processes	
Focus Area	**Rationale and Goal**	**Key Actions**	**Project Lead and Key Partners**
4.1 **Whānau access to appropriate support at the right time and right place – coordination**	**Rationale:** Grief comes in many shapes and forms. People need the opportunity to fully process their feelings of grief and loss in a culturally appropriate way at a time right for them to prevent further emotional distress. People personally affected by suicide require timely access to high quality support and information in order to remain safe themselves. **Goal:** All people including children who have lost a whānau or family member to suicide are able to access the type and level of bereavement support at the right time and place for them. Accessible, free, flexible and responsive	• Pilot of a full time Whānau Support Coordinator (Bereaved by Suicide) to provide and coordinate an appropriate level of support for each bereaved whānau across both DHB areas, with a focus on Māori whānau needs. • Review the processes in place for supporting Māori whānau after a suicide in the provider arm with view to improving processes if required • Scope new kaupapa Māori suicide prevention & postvention resources and develop and implement new postvention processes that are culturally responsive to Māori	**Lead:** SPPM Māori Health Gain Team **Key partners:** CASA (CPRS/BSRS) MoH Contracts Te Rau Ora MHF SMHAS QI Asian Family Services Rainbow Community
4.2 **Support for Health Care Professionals affected by suicide**	**Rationale:** Health care professionals can be personally and professionally impacted by the death of a client by suspected suicide including experiencing emotional distress and post-trauma symptoms. **Goal:** All health care professionals who experience the loss of a client by suspected suicide are able to access appropriate support to enable them to process the loss	• Review, scope and develop options for increasing support for specialist mental health staff impacted by suicide deaths and provide training on how to talk to and support colleagues impacted by a client suicide. • Implement relevant learning from Health Quality and Safety Commission (HQSC) Learning from Adverse Events work stream.	**Lead:** WDHB SMHAS ADHB MHAD DLT Zero Suicide Project Manager **Key partners:** EAP
4.3 **Notification Pathways**	**Rationale:** People personally affected by suicide require timely access to high quality support and information in order to remain safe and reduce distress	• Ensure through regular review and audit that notification pathways of suspected suicides result in timely, appropriate data forwarded to all relevant agencies, and lead to	**Lead:** SPPM **Key partners:** CDS (Coronial

	Goal: Reduce community distress and anxiety, and minimise risk of any further suicidal behaviour by responding to coronial information and providing timely and appropriate active outreach, support and other suicide postvention services to family, whānau, and communities bereaved by suicide.	effective postvention action • Ensure processes are in place so that vulnerable individuals are identified in the event of a contagion and the right information goes to those services in a position to provide support • Contribute to any reviews of the coronial notification pathways	Data Service) Victim Support Asian Family Services Police MoE Oranga Tamariki

Postvention Response

Suicide postvention includes all the activities undertaken after a suicide to address the traumatic after-effects for survivors of suicide, including bereavement and trauma recovery needs, as well as ensuring education and screening efforts to reduce the risk of further suicides. When the Coroners office advise a suspected suicide has occurred and contact details have been received, the postvention response can begin. The various support services are then informed, namely:

- Victim support
- Police
- Oranga Tamariki
- MoE Trauma Team
- Mental Health Services and other relevant support services
- Relevant cultural services when appropriate

There are other signs indicative of “contagion” (including concerns of self-harm) such as media sensationalisation, unsupervised gatherings of youth around the event, mass texts, face-book postings etc. about the sentinel event, heightened community anxiety or a history of suicidal clusters or contagion in the community. Information will NOT be disseminated beyond the Postvention groups and agencies that are providing postvention services, except for the purpose of minimising suicide contagion/clusters. The Suicide Postvention Group (SPG) strengthens the postvention response, by initiating postvention activity following a suicide event. The role of the SPG is not to work directly with the affected individuals, whānau and communities but to ensure a successful postvention response is provided. It also ensures a consistent and proactive community response to suicide events that alleviates the distress of affected individuals and whānau and promotes the healthy recovery of the affected community.

Development of good working relationships with the various organisations that facilitate suicide prevention activities within their community is critical to reducing the suicide rate.

Monitoring and Evaluation process

Effective implementation of the actions recorded in this Plan requires support from a number of Organisations, namely, the Organisations who have contributed to the development of this Plan, those who are represented in the SPG and those with a common interest in reducing the occurrence

of suicide and suicidal behaviour in the WDHB and ADHB areas. Prior to tasks being assigned to any particular Organisation, their express consent will be sought.

A multi-faceted approach to the monitoring of this Action Plan will be implemented to ensure relevance and success throughout. In particular, the Suicide Prevention programme manager will have an ongoing monitoring role, and will develop an appropriate monitoring and evaluation framework to utilise in the monitoring and evaluation of the plan. They will report through the planning and funding monthly reports and regularly to the SPPGG.

Where postvention groups or the Suicide Prevention Programme manager identify postvention risks that are not easily managed or have not been confronted before, support is sought from the Suicide Prevention Office (SPO) at the Ministry, Clinical Advice Services Aotearoa (CASA) and also internally from the Waitematā and Auckland DHB Mental Health Clinical Director. The Suicide Prevention Programme Manager may also identify more systemic postvention and prevention risk issues in conjunctions with the Suicide Prevention Governance Group through regular reports to Waitematā and Auckland DHB reporting processes. The Suicide Prevention Programme Manager will use this adopted Action Plan as a template for reporting against, ensuring outcomes and risk and opportunities can be identified.

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Glossary

ADHB – Auckland District Health Board
CADS - Community Alcohol and Drugs Service
CASA - Clinical Advisory Services Aotearoa
CDS – Coronial Data Service
EAP – Employee Assistance Programme
OT – Oranga Tamariki
CYMRC - Child and Youth Mortality Review Committee
DHB - District Health Board
E.D - Emergency Department
GP - General Practitioner
LGBTI - Lesbian, Gay, Bisexual, Transgender, Inter-sex
MoE – Ministry of Education
MoH - Ministry of Health
MoU - Memorandum of Understanding
MHSOA - Mental Health Services for Older Adult
MHF - Mental Health Foundation
NGO - Non-Government Organisation
NRA - Northern Regional Alliance
OECD - Organisation for Economic Co-operation and Development
PFO – Planning, Funding and Outcomes
PHO - Primary Health Organisation
SMHAS – Specialist Mental Health and Addictions Service
SPINZ - Suicide Prevention Information New Zealand
SPPAP - Waitematā and Auckland DHB Suicide Prevention and Postvention Action Plan
SPPM – Suicide Prevention Programme Manager
SPG - Suicide Postvention Group
WDHB - Waitematā District Health Board

Auckland Regional Public Health Service Briefing

Recommendation:

It is recommended that the Community and Public Health Advisory Committee receive this update from the Auckland Regional Public Health Service on key areas of work that are underway and/or have been completed since our last report in September 2020

Prepared and submitted by Dr William Rainger, Director and Jane McEntee, General Manager; Auckland Regional Public Health Service (ARPHS).
Endorsed by: Dr Margaret Wilsher (Auckland DHB Chief Medical Officer)

Glossary

AIPHG - Auckland Intersectoral Public Health Group
ARLA - Alcohol Regulatory and Licensing Authority
ARPHS - Auckland Regional Public Health Service
ASA - Advertising Standards Authority
BCG - Bacillus Calmette-Guérin
ELS - Early Learning Services
FSANZ - Food Standards Australia New Zealand Act
HAT - Healthy Auckland Together
LAP - Local Alcohol Policy
LTBI - Latent Tuberculosis Infection
MIF - Managed Isolation Facilities
MoE - Ministry of Education
MoH - Ministry of Health
NCC - National Coordination Centre
NITC - National Investigation and Tracing Centre
NRHCC - Northern Region Health Coordination Centre
NZMJ - New Zealand Medical Journal
PHUs - Public Health Units
SOPs - Standard Operating Procedures
TB - Tuberculosis
VPD - Vaccine Preventable Diseases

Purpose

The Auckland Regional Public Health Service (ARPHS) is providing this update to Waitematā CPHAC on key areas of work contributing to ARPHS long-term outcomes that are underway and/or have been completed since our last report in September 2020. This report contains the following updates:

1. People are protected from the impact of notifiable infectious diseases:
    1.1. COVID -19
    1.2. Other notifiable diseases (Tuberculosis and Vaccine Preventable Diseases)
2. People are protected from the harms associated with harmful commodities:
    2.1. Alcohol
    2.2. Smokefree
3. The environments in which people live, learn, work and play promote health and wellbeing: Healthy Auckland Together
4. People are protected from the impact of environmental hazards:
    4.1. Hazardous Substances & New Organisms

4.2. Disease Investigation
4.3. Border Health
4.4. Built Environments
4.5. Drinking Water

5. Public health leadership, workforce development and organisational sustainability.

Appendix A outlines ARPHS services it delivers to people residing in the Auckland and Waitematā District Health Boards areas and in the rohe of Counties Manukau Health.

Appendix B provides an update on surveillance of other infectious diseases.

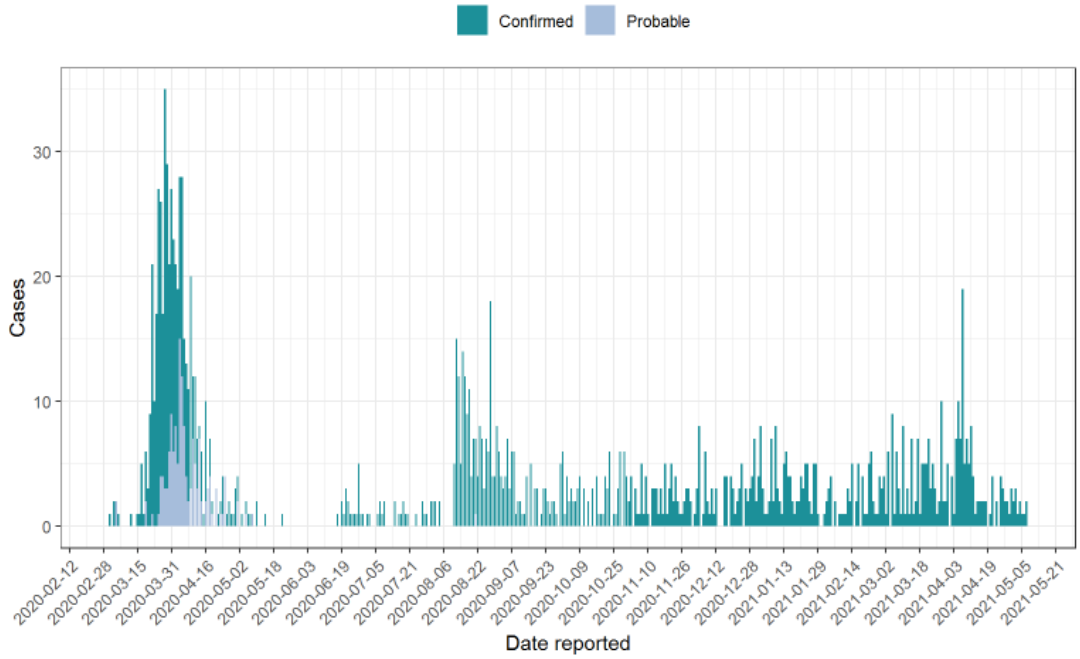
1. People are protected from the impact of notifiable infectious diseases

1.1 Novel Coronavirus (COVID – 19)

Overview – summary of case numbers since the first case was notified (28 February 2020) to 7 May 2021

ARPHS has continued responding to the COVID-19 pandemic. From the first notification received on 28 February 2020 to 7 May 2021, 1467 cases have been investigated (1321 confirmed cases and 146 probable, see Figure 1). 62% (911) of these cases occurred in people arriving from overseas, 3.5% (53) cases were related to imported cases and 34.5% (503) were acquired in the community.

Figure 1: Weekly confirmed and probable COVID-19 cases, Auckland region, 28 February 2020 to 7 May 2021



Total cases per DHB (community cases) and in Managed Isolation Facilities (MIF) for the Auckland region for the same period are included in Table 1. 73.9% of cases occurred in MIF facilities, followed by 11.3% in Waitematā DHB, 8.7% in Auckland DHB and 6.1% in CMH.

Table 1: COVID-19 confirmed and probable case distribution by DHB, Auckland region, 28 February 2020 to 7 May 2021

DHB	Auckland DHB	Counties Manukau Health	Waitematā DHB	MIF
Confirmed cases	81	69	109	1062
Probable Cases	46	20	57	23
Total	127	89	166	1085

Figure 2 shows the age distribution for cases with the highest volume in the 20-29 year age bracket. In addition, most of the cases have been reported in the New Zealand European population group (Table 2).

Figure 2. Confirmed and probable case distribution by age, Auckland region, 28 February 2020 to 7 May 2021.

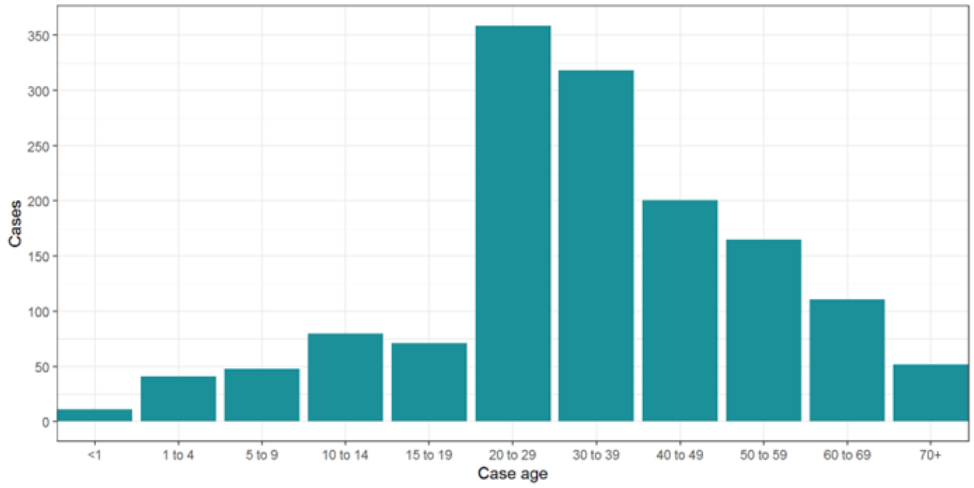


Table 2: COVID-19 confirmed and probable case distribution by ethnic group, total response ethnicity counts[1], Auckland region, 28 February 2020 to 7 May 2021.

Ethnicity	Cases[2]	Percentage
African	60	4%
Asian nfd	14	1%
Chinese	37	3%
Cook Islands Maori	30	2%
European nfd	55	4%
Fijian	2	0%
Indian	367	25%
Latin American	12	1%
Maori	108	7%
Middle Eastern	41	3%
New Zealand European	490	33%
Niuean	11	1%
Other Asian	48	3%
Other Ethnicity	2	0%
Other European	98	7%
Other Pacific Peoples	7	0%
Samoan	136	9%
Southeast Asian	74	5%
Tongan	20	1%

1.1.2 Summary of ARPHS response between October 2020 to 7 May 2021

Operational response

The core principles for a sustainable response to COVID-19 include:

- work in partnership to deliver equitable outcomes for Māori and Pacific communities
- maintain a trained workforce and management infrastructure to support rapid scale up
- early identification of, and response to, outbreaks and cases
  - rapid response with scalability within defined parameters, and
  - transfer of contacts to the national investigation and tracing centre on an agreed risk basis.

ARPHS has continued to work with the Northern Region Health Coordination Centre (NRHCC), the MoH, the National Investigation and Tracing Centre (NITC) and other Public Health Units (PHUs) in its response to COVID-19. ARPHS is looked to for its operational experience of COVID-19 case and contact management.

ARPHS manages all COVID cases in Tamaki Makaurau. Out of a total of 5149 close contacts generated by cases confirmed during the period 1 October to 7 May 2021, 538 were managed by ARPHS due to their higher risk. 109 were delegated to other PHUs and 4502 close contacts were contacted and managed by NITC.

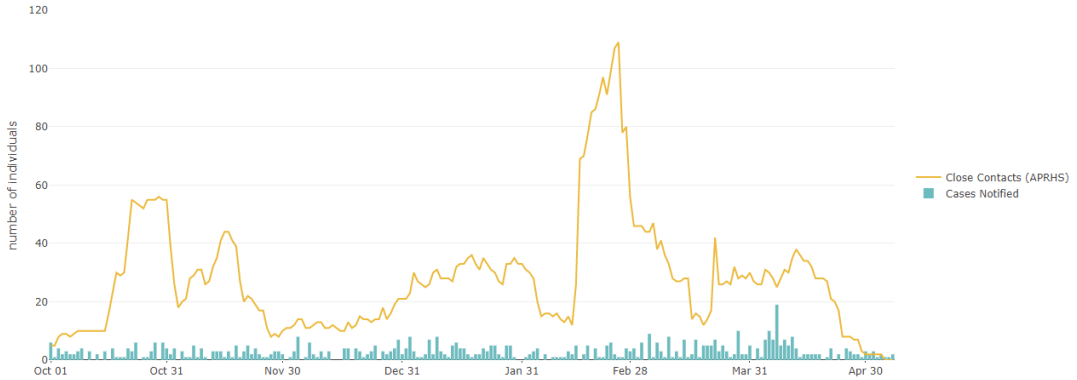
Close contact management may or may not include additional follow-up for a varying number of days. Additional follow-up occurs, for instance, when a close contact develops COVID-19 symptoms. Daily follow up of close contacts adds significantly to ARPHS volume of work. Figure 3 shows the

[1] People who reported more than one ethnic group are counted once in each group reported. This means that the total number of responses for all ethnic groups can be greater than the total number of people who stated their ethnicities.

[2] Ibid.

volume of close contacts managed and followed-up by ARPHS on any day for the period October 2020 to 7 May 2021 in comparison to confirmed cases (community, MIF and cases related to imported cases). Figure 3 includes only close contacts managed and followed-up by ARPHS, excluding contacts that did not require follow up or contacts followed up by either other PHUs or NCC.

Figure 3. Number of cases and close contacts followed-up by ARPHS on any day, Auckland region, 1 October 2020 to 7 May 2021.[3]

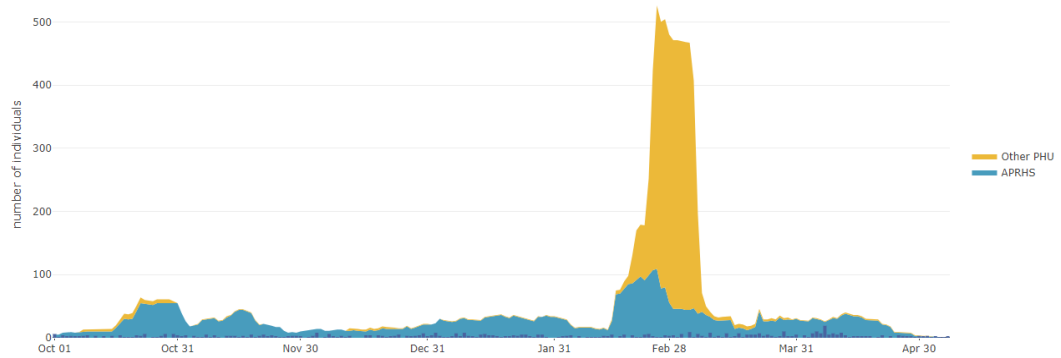


After the August 2020 resurgence, the Auckland region has mostly experienced small outbreaks. Since January 2021 clusters that had four or more cases during the reporting period are:

- January 2021 Auckland cluster, four confirmed cases
- February 2021 Auckland cluster (involving Papatoetoe High School), 15 confirmed cases
- March MIF worker cluster, four confirmed cases.

While the February 2021 Auckland cluster was a relatively small outbreak in terms of number of cases, it was characterised by multiple exposure events and required significant management of a large number of contacts. This impacted on national capacity and required support from other PHUs (Figure 4). In this instance, other PHUs managed MIF cases and overflow work while ARPHS focused on containing the outbreak. Greater coordination of national PHU resources is a model which is likely to be utilised in the future.

Figure 4. Number of cases and close contacts followed-up by ARPHS and other PHUs on any day, Auckland region, 1 October 2020 to 7 May 2021



[3] Including close contacts managed and followed-up by ARPHS, excluding contacts who did not required follow up or contacts followed up by either other PHUs or NCCS.

The February 2021 outbreak raised the challenges of requiring a large community to isolate and required a broad manaaki response which was delivered on a national level by the Ministry of Social Development (MSD) and by the NRHCC at a regional level.

Surge workforce
The surge framework was refined following the August 2020 outbreak and was repeatedly utilised to communicate workforce needs to the NRHCC for staffing requests. On-going refinements are made following each outbreak.

ARPHS' response has been supported by both, national and regional workforces including Auckland Council and Auckland metro DHBs who have provided staff to support several aspects of the response.

Continuous Quality Improvement and evolving response
The COVID-19 response has placed significant demand on ARPHS and required rapid escalation at times to support the public health response. The response has needed to manage complex cases and contact tracing, ensuring the needs are met to support isolation and quarantine requirements. ARPHS continues to refine its approach to case and contact management, as well as to its operational processes through continuous quality improvement. After each cluster there are debriefs to understand how we could do things better. A number of improvements summarised below have been made in the reporting period:

- recruited Kaiwhakahaere and Kaimanaaki roles to support the implementation of a Pae Ora (healthy futures for Māori) response model
- ongoing review and refinement of existing Standard Operating Procedures (SOPs), including response at the maritime border and for outbreak management
- working with the DHBs to support the health response part of the isolation and quarantine facilities
- review the surge framework for our response; which includes triggers and processes for an escalating response (including accessing additional staff from the DHBs)
- ongoing training to maintain competency of internal and external staff who have been involved in the response.

Quarantine Free Travel Zones
At the end of 2020, ARPHS developed an approach for managing a quarantine-free travel zone from the Cook Islands to New Zealand. This involved ARPHS supporting the DHB border team with triaging passengers with symptoms. Work was completed to support the Australian quarantine-free travel zone which started mid-April, including significant operational process alignment between the border health teams, Auckland International Airport, and NRHCC.

National Policy Development
ARPHS was successful in its proposal to lead the development of national SOPs for COVID-19 which will support the national PHU response model being led by the MoH. This is a six month contract from April 2021.

Next steps
For the next 12-15 months ARPHS will continue to deliver core COVID-19 'Stamp it Out' public health actions including:

- public health surveillance and reporting
- public health management of cases notified from MIF and cases/outbreaks due to community transmission

- contact tracing and follow up including monitoring effective isolation and quarantine of cases and contacts, assessing their welfare requirements and provision of cultural support
- outbreak identification, investigation and management
- use of statutory powers when required,
- support and advice for prevention of spread from border settings,
- public information management, including translated resources
- assessment and endorsement or otherwise of exceptional exemptions requested through Managed Isolation Facilities
- training staff to develop/maintain their case and contact management expertise
- Jet Park liaison, manaaki support, exemption and "bubble breach" functions
- support and advice for vaccination programmes, and
- provision of public health advice.

Research
The paper Transmission of Severe Acute Respiratory Syndrome Coronavirus 2 during Border Quarantine and Air Travel, New Zealand (Aotearoa), published in the Emerging Infectious Diseases journal, had an ARPHS Medical Officer of Health as lead author and has been widely cited internationally as part of the evidence base contributing to the understanding of COVID-19 as capable of airborne transmission.

The paper *SARS-CoV-2 RT-PCR Test Results Across Symptomatic COVID-19 Cases in Auckland, New Zealand, February – June 2020* written by an ARPHS Medical Officer and a medical student on placement at ARPHS, has been accepted for publication in the Communicable Diseases Intelligence journal.

Associate Minister for Health visit
Associate Minister for Health, Dr Ayesha Verrall, visited ARPHS on Friday, April 9. Dr Verrall's expressed a strong interest in all facets of ARPHS work, from Healthy Auckland Together and Smokefree, to our COVID-19 response.

1.2 Other notifiable diseases (Tuberculosis and Vaccine Preventable diseases)

ARPHS continues to manage both Tuberculosis (TB) and vaccine preventable diseases (VPDs). VPD notifications have remained low since the lockdown periods in 2020, with no measles, mumps or rubella cases confirmed. New TB notifications are tracking at the same number of cases compared to the same reporting period in the previous year with 80% of new TB cases born outside of New Zealand. The probable source countries are India, Philippines, Fiji, Samoa, and Tonga (See Appendix B).

Latent Tuberculosis Infection (LTBI) and Bacillus Calmette-Guérin (BCG) vaccine clinics resumed in November 2020 however continued to be interrupted by the two lockdown periods in 2021. A decision has been made to continue both LTBI and BCG clinics during any subsequent level 3 lockdown to prevent increases in waiting times. ARPHS completed approximately 840 BCG vaccinations in the reporting period with about 3,000 children awaiting vaccination.

2. People are protected from the harms associated with harmful commodities

2.1. Alcohol

The alcohol programme of work has been affected by the redeployment of staff to the COVID-19 response.

Alcohol regional steering group: ARPHS has created a regional steering group consisting of members from metro-Auckland DHBs, Hāpai Te Hauora, Te Hiringa Hauora, Te Hā Oranga and the National Public Health Advocacy team. The strategic priorities of the group are advocating for a review of the Sale and Supply of Alcohol Act 2012 and regulating alcohol sports sponsorship.
As part of this work:

- ARPHS Medical Officer of Health Dr Nick Eichler wrote a letter to Minister Faafoi supporting the Minister's comments that he would review the Act if it was not fit-for-purpose.
- A further 15 people wrote similar letters to Minister Faafoi including David Ratū at Kōkiri Ki Tāmakimakaurau Trust, Ōtara Māori wardens, Dr Grant Hewison at Communities Against Alcohol Harm, Dr Collin Tukuitonga and Dr Tony Farrell from Alcohol Action NZ.
- ARPHS has instigated a regional network with stakeholders to advocate to central government to regulate alcohol sponsorship of sports and other events. The first workshop was led by Dr Rob Beaglehole and Penny Arrowsmith with 14 different organisations attending.

Alcohol signage: ARPHS is writing a research letter to the New Zealand Medical Journal outlining the findings of its audit of 66 bottle-shops in South Auckland that were non-compliant with Auckland Council's by-law. The key recommendation is for central government to adopt stage three of the Law Commission 2010 recommendations on sponsorship, advertising and marketing.

Alcohol licensing: The Immediate Modification Order, which is empowered by the Epidemic Preparedness (COVID-19) 2020 Renewal Notice 2021, has extended ARPHS statutory reporting timeframes and allowed this volume to be managed. Applicants continue to apply for new unlicensed premises and novel applications not envisaged by the Act, for instance, restaurants using off-licences. Both of these types of applications generate additional work through liaison with agency partners (Auckland Council, Police) and possible hearings with the District Licensing Committees. Priorities continue to be new off licences, particularly bottle shops, in vulnerable communities. At least three of these types of application have been made in the last quarter which is higher than any time in the last two years.

Local Alcohol Policy (LAP): Due to the COVID-19 lockdowns in early 2021, the Court of Appeal hearing of the Auckland Council's appeal of the Judicial Review launched by the supermarkets was re-scheduled to 15 - 17 June 2021. ARPHS will be appearing at the hearing as an *Interested Party* in support of Auckland Council's position. Until these legal proceedings have concluded the Alcohol Regulatory and Licensing Authority (ARLA) cannot re-hear the Provisional LAP elements and therefore endorse the proposed LAP so it can come into effect. One of the main impacts of the LAP, if endorsed, will be off-licence hours reduced to a maximum of 9pm across the whole of the Auckland Council region. The continued delay of the LAP is disappointing for population health and reducing alcohol-related harm as it is envisaged a policy will likely come into effect in 2023 at the earliest; ten years after the process began.

2.2. Smokefree

Smokefree Environments and Regulated Products Regulations submission: ARPHS, in collaboration with the three Auckland metro DHBs submitted on the consultation of supporting regulations to the Smokefree Environments and Regulated Products (vaping) Amendment Act. The consultation closed on 15 March 2021.

The submission included support for:

- changing the definition of an 'internal area' and have suggested additional points which will make this definition much easier to enforce
- requiring retailers to display purchase age (R18) notices at each point-of-sale

- health warnings for vaping and smokeless tobacco products
- product notification and safety requirements
- annual reporting and fee structures.

The submission went further to recommend:
- the display of vaping products to be regulated
- plain packaging of vaping products in alignment with tobacco
- the development of approved standalone public health message statements
- the reduction of nicotine content in nicotine salts to be reduced to UK levels
- the sales threshold required to be a specialist vape retailer extend to the entire business, not just the physical premises
- that specialist vaping retailers do not have lower threshold of vaping products to meet the registration requirements
- the addition of social workers and addiction counsellors to also be deemed 'suitably qualified health workers.

Smokefree 2025 Action Plan submission: The Smokefree2025 Action Plan is being consulted on with submissions closing on 31 May 2021. An ARPHS and DHB working group has developed key messages for each of the areas of tobacco control which will guide the submission. Within this working group, Leanne Catchpole is the lead for Auckland DHB/Waitematā DHB and Sarah Sharpe for CM Health while Te Ha Oranga provides a Mana Whenua voice.
The areas addressed in the key messages are:
- Te Tiriti o Waitangi responsiveness
- Tobacco-related harm and Māori communities
- Equity
- Tobacco supply reduction
- Making tobacco products less appealing and less addictive
- Stop smoking services
- Smokefree outdoor areas
- Affordability of tobacco
- Mass media campaigns
- Industry responsibility.

Key messages were shared with the Auckland Intersectoral Public Health Group (AIPHG) on 13 April 2021. The key messages are also being shared with DHB Māori and Pacific health teams, and CM Health and Te Ha Oranga are consulting with community groups.

Tobacco Retail Reduction: ARPHS chairs Aukati Tupeka Kore, the national tobacco retail steering group. A planning day was held on 16 March which resulted in the development of an action plan for the group which aims to reduce the commercial availability of tobacco in New Zealand. The steering group consists of members from the Cancer Society, Northland DHB, Mid-Central DHB, Hapai te Hauora, Otago University, T&T Consulting Ltd and Tākiri Mai te Ata Whanau Ora Collective Regional Stop Smoking Service. Steering groups meetings are held fortnightly with sub-group meetings as required.

Tobacco Retail Reduction research: A letter to the editor of the New Zealand Medical Journal (NZMJ) has been submitted. It is advocating for mandated retailer reductions rather than voluntary reductions. The letter details key findings from ARPHS tobacco retailer research:
- There are 1800 tobacco retailers in Tāmaki Makaurau in comparison to just 425 community pharmacies

- There is one tobacco retailer for every 887 inhabitants of Tāmaki Makaurau and one for every 80 people who smoke daily
- Tobacco retailers are more likely to be located in close proximity to another tobacco retailer than pharmacies
- Seventy-five percent of tobacco retailers had another retailer within 250m compared to 50% of pharmacies
- Forty-two percent of tobacco retailers had three or more other tobacco retailers within 250m compared to 13% of pharmacies.

3. The environments in which people live, learn, work and play promote health and wellbeing

3.1. Healthy Auckland Together

Healthy Auckland Together (HAT) is a coalition of 32 partners committed to making it easier for Aucklanders to eat better, be physically active and maintain a healthy weight. HAT partners include health entities (including Auckland metro DHBs), local government, iwi-based organisations and non-governmental organisations. ARPHS is the backbone organisation for HAT, providing a coordination and administrative function as well as being a partner.

Due to the ongoing demands from the COVID-19 response, members of the HAT team continue to be re-deployed to the roles in the ARPHS COVID-19 Response Unit. This has impacted on deliverables but the programme has been able to implement the following initiatives under each action area: Collaboration and Leadership

Interagency Group Meetings: two interagency group meetings were held in the reporting period. In November 2020, there were 33 attendees from 18 partner organisations with presentations and discussions focussing on the impacts of COVID-19 on our mahi and building resilience in the sector. In March 2021, there were 31 attendees from 11 partner organisations with Professor Boyd Swinburn sharing about his win in the Whale Oil defamation case and implications for public health advocacy.

Research: The Research Platform working group has developed a database of the research grants and student placements that HAT partners can access to support their work. A public health registrar has been leading a project to re-imagine HAT in a world living with COVID-19. This involved a literature review and iterative workshops with partners. A report has been produced outlining a series of short to long-term recommendations for HAT to consider and inform the future direction of the coalition:

Short term	• Increase connectivity within the HAT network and strengthen shared work-streams • Develop a shared communication plan • Re-engage organisational leaders
Medium term	• Seek and prioritise kaupapa Māori actions • Support actions which achieve equitable outcomes
Longer term	• Realign the overarching objectives of HAT to focus on strength-based outcomes • Review shared values and principles • Develop a plan of collaborative actions • Advocate for the inclusion of health promotion in future pandemic planning • Develop relationships with local and national political figures and

encourage health advocacy.

Data collection has been completed for the analysis of food and drink marketing on convenience stores near primary schools in Auckland. Initial findings indicate opportunities for policy changes to better protect children from this type of marketing. Detailed analysis is underway and a journal publication is in draft. Preliminary findings included that:

- advertisements for non-core food were more common than core food
- sugary drinks (155 ads) were the most frequently marketed food category, followed by non-core foods (140 ads) (eg. ice-cream, cookies and meat pies) then energy drinks (64 ads)
- large signs on store windows (28.5%) and standing signs (20.8%) were the predominant marketing mediums
- the majority (70.2%) of advertisements were targeted at children and adults by displaying the brand/product
- promotions and discounts (33.0%), branded store colouring (21.5%) and text only (19%) were the most common forms of secondary marketing techniques.
- Submissions: In November 2020, ARPHS and the University of Auckland provided submissions on the scoping paper for the Review of the Food Standards Australia New Zealand Act (FSANZ) 1991. These emphasised the need for stricter regulations on front of package marketing and expanding their definition of public health beyond the current food safety focus to include the role of food in non-communicable diseases.

3.2. Food and Marketing Environments

Marketing to Children: members of the working group published a study in Frontiers, highlighting how brands leveraged COVID-19 lockdowns to market unhealthy food through social marketing campaigns. Six posts were found to potentially breach Advertising Standards Authority (ASA) Codes by promoting excessive consumption or targeting children. This publication received positive media coverage online and on radio.

HAT submitted a complaint to the ASA about the HELL Reading Challenge (Hell Pizza, NZ Book Awards Trust and Auckland Libraries). Children were incentivised with pizza, classified as an occasional food, to read books. The ASA facilitated a mediation process between all parties and an agreement was not reached so the complaint was submitted. It was not upheld by the ASA Complaints Board and is another example showing the ineffectiveness of the current self-regulatory system.

A new communications project is underway to develop a campaign to build public awareness and support for stronger regulation of food marketing, particularly to children. This included contributing to Consumer NZ research which found that 78 percent of people agreed children are exposed to too many ads for unhealthy food and drinks and the majority (67 percent) support regulation of food marketing. The group also worked with Health Coalition Aotearoa to develop a summary of relevant evidence on the impact of food and beverage marketing, with recommendations to ensure children are adequately protected from exposure to marketing. Rob Beaglehole presented this to Health Ministers in February 2021 as an effort to inform policy recommendations.

A marketing training package is available on the HAT website and was designed to enable teachers to deliver a one-hour session on how to make ASA complaints. The training package is suitable for secondary school and university students and was created to encourage young people to think more critically about food and beverage marketing.

Wai Auckland: Fifty-eight new RefillNZ Stations, places where people can refill reusable water bottles for free, have been signed up and there are now a total of 223 for the region. Wai Auckland was acknowledged in the University of Auckland's Sustainability Development Goals Report 2020 for

contributions to - 6 Clean Water and Sanitation. So far, ten students from the Faculty of Medical and Health Sciences have been involved with Wai Auckland, by developing business case proposals to inform Auckland Council policies, an evaluation plan and an infrastructure survey. As a result drinking fountain locations are now available on the AKL Paths website; previously this information was not available online.

3.3. Streets, Parks and Places

Separate transport and physical activity working groups have been established to enable better collaboration within the coalition for partners working on these issues.

3.4. Schools and Early Learning Services

Healthy Active Learning: the Nutrition Advisors have supported 15 Early Learning Services (ELS) with compliance to the MoH's new recommendations for reducing food-related choking in young children. They are also working with the Ministry of Education (MoE) to develop nutritional support by mapping and addressing topical issues.

A literature review has been completed to inform a research project with six ELS language nests - Tongan, Samoan, Niuean and Cook Island. This project will help identify how organisations can be more culturally responsive to Pacific nutrition needs. Pacific Heartbeat and ARPHS Pacific staff are partners on this project.

For schools, the team have been working in collaboration with the Heart Foundation and MoE to assist schools participating in Ka Ora, Ka Ako – the healthy school lunches programme. Schools using the internal model (self-managing lunches) have been offered support. New resources have been created by the team to support implementation of food and drink guidance for schools, including policies, allergies and halal food guidance. These have been circulated nationally for use in other regions.

4 People are protected from the impact of environmental hazards

4.1 Hazardous Substances & New Organisms (HSNO)

On 11 February 2021, ARPHS was notified of a chemical leak in Auckland Central from a resin manufacturer. Methyl methacrylate leaked from an underground storage tank, via storm water drain, into the Manukau Harbour. ARPHS' Medical of Officer of Health issued a health alert for workers in the industrial area (Penrose and Onehunga). Warnings were also placed on the SafeSwim website for members of public to avoid recreational activities within 5km of where the spill would have entered the Mangere inlet (shorelines at Māngere Bridge, Taumanu East, Taumanu Central, Taumanu West and Onehunga) Warnings were in place for a week.

Testing of the storm water showed the chemical present in water but none were detected in the soils of residential areas. As a precautionary measure, Watercare temporarily shut down the Onehunga Water Treatment Plant in order to carry out additional sampling from the bores. All samples returned below detection limits for methyl methacrylate. Sampling will continue for a year due to persistence of the chemical in the environment.

4.2 Disease Investigation

A significant increase in enteric disease outbreaks, primarily norovirus outbreaks, occurred during November - December 2020 mostly affecting childcare and primary school facilities. 57 outbreaks were notified in December 2020 alone in comparison to 5 in December 2019. This increase was thought to be due to two factors :

- Change in hand hygiene measures in response to COVID-19 from soap and water to hand gels
- Change from using hypochlorite as a disinfection agent to others marketed as more effective against COVID-19.

ARPHS worked with MoE to provide clear communication and advice to the settings involved. The Christmas break assisted to stop spread and enabled deep cleaning of Early Childhood settings and schools. See Appendix B, section B1 for more information.

4.3 Border Health:

On 11 February 2021, an exotic mosquito (Aedes aegypti) was found in a surveillance trap located close to the Auckland International Airport. ARPHS implemented a three weeks enhanced surveillance programme, which confirmed that this was contained and the mosquito had not established a population. The MoH is engaging an external auditor to review the recent response to the interception.

As part of the response, ARPHS is planning to conduct audits of imported produces in the year 2021/22 in the Ministry of Primary Industries Transitional Facilities around the region to verify that operators are meeting their biosecurity controls.

4.4 Built Environments:

Post the COVID-19 lock-down in March 2021, the number of applications for disinterments increased in the Auckland region. ARPHS usually processes two to three disinterments per year; currently during the third quarter of 2020/21 (January to March 2021), ARPHS has processed three disinterments. A likely cause is due to limitations, delays and restrictions related to the COVID-19 response.

4.5 Drinking water.

New Drinking Water Regulator: Taumata Arowai, the new national drinking water regulator became a Crown entity in March 2021. It is set to become the dedicated water services regulator for Aotearoa when the Water Services Bill passes, expected to be in the second half of 2021. ARPHS drinking water regulatory responsibilities will then transfer to Taumata Arowai.

5 Public Health Leadership, workforce development and organisational sustainability

5.1 Engagement with Mana whenua

ARPHS has re-engaged with mana whenua, hosting a hui on 30 March with representatives of Ngāti Whatua (Te Hā Oranga). The hui included presentations on ARPHS current activities across all teams, showcasing the breadth of ARPHS services. Discussions included options on future engagement and common areas of interest.

5.2 Policy submissions

ARPHS develops policy submissions to represent the public health view for the Auckland region on behalf of the three Auckland metro DHBs.

Policy capacity has been reduced with the redeployment of staff to the COVID-19 response. ARPHS completed a submission on “Bullying and harassment at work”. See key recommendations below:

Topic	Brief note
Bullying and harassment at work *31 March 2021*	Work is one of the determinants of health and wellbeing. Insecure, precarious work, workplace bullying and poor working conditions are harmful to health. Bullying and harassment at work is associated with poor mental health, self-reported ill health, and increased risk of cardiovascular events. Adverse health effects extend beyond the individual being bullied; they are also experienced by people in the workplace who observe bullying behaviours. Māori, Pacific Peoples and migrants are at increased risk of exposure to bullying and harassment at work along with women, disabled people, young people and members of the Rainbow community. The ARPHS submission made some general points and ARPHS recommended that the Ministry of Business, Innovation and Employment: • Prioritise Māori collaboration and policies designed to address bullying and harassment at work in order to contribute to reducing health inequities for tangata whenua; • Review the Health and Safety at Work Act 2015 and regulations with a view to improving its effectiveness in preventing bullying and harassment at work; • Develop systems and pathways for improved intelligence and data on workplace bullying and harassment; • Take leadership in supporting businesses to create healthy, inclusive workplaces where bullying cannot thrive.

Appendix A - Overview of ARPHS and its role

ARPHS is one of New Zealand's 12 public health units (PHUs). ARPHS provides regional public health services to people residing in the rohe of Counties Manukau Health and Waitematā and Auckland District Health Boards (DHBs) through health protection and promotion, and disease prevention. A key role for ARPHS is provision of regulatory public health services and work to improve population health outcomes for the people of Tāmaki Makaurau. ARPHS is funded via a direct contract from the MoH to Auckland DHB, who manage the contract with ARPHS on behalf of the three DHBs in the metro Auckland rohe.

ARPHS' vision is Te Ora ō Tāmaki Makaurau. ARPHS' strategic long term outcomes are:

- People are protected from the harm of notifiable infectious diseases
- People are protected from the impact of environmental hazards
- People live free from the harms associated with harmful commodities
- The environments in which people live, learn, work and play promote health and wellbeing.
- Long term outcomes are supported by the organisational enabler: Public Health leadership, sustainability and workforce development.

ARPHS strategic priorities 2017-2022 include:

1. Reduce the harm of notifiable infectious diseases, in particular:
    - Reduce the spread of Tuberculosis through TB case and contact management
    - Actively manage infectious diseases and pursue an 'up stream' approach to infectious disease prevention
2. Build healthy and resilient environments and communities, in particular:
    - Early identification and active management of enteric diseases
    - Active support and management of waters and wastes
3. Reduce obesity, improve nutrition and physical activity
4. Support Smokefree 2025
5. Enhance surveillance of communicable and non-communicable diseases and risk factors for public health action and reporting
6. Enhance and build stakeholder relationships with organisations and communities to continuously improve public health for Tāmaki Makaurau.

The work of ARPHS

ARPHS' work includes management of notifiable infectious and environmental diseases, including operational management of the regional tuberculosis control programme. ARPHS provides advice and support on actual/potential environmental hazards such as recreational water quality, air quality, border health protection, and hazardous substances. Much of ARPHS' work involves working with other agencies, including work on liquor licensing, smokefree, emergency response, physical activity and nutrition and obesity prevention activities. These other agencies include central government agencies, Auckland Council, non-government organisations and workplaces.

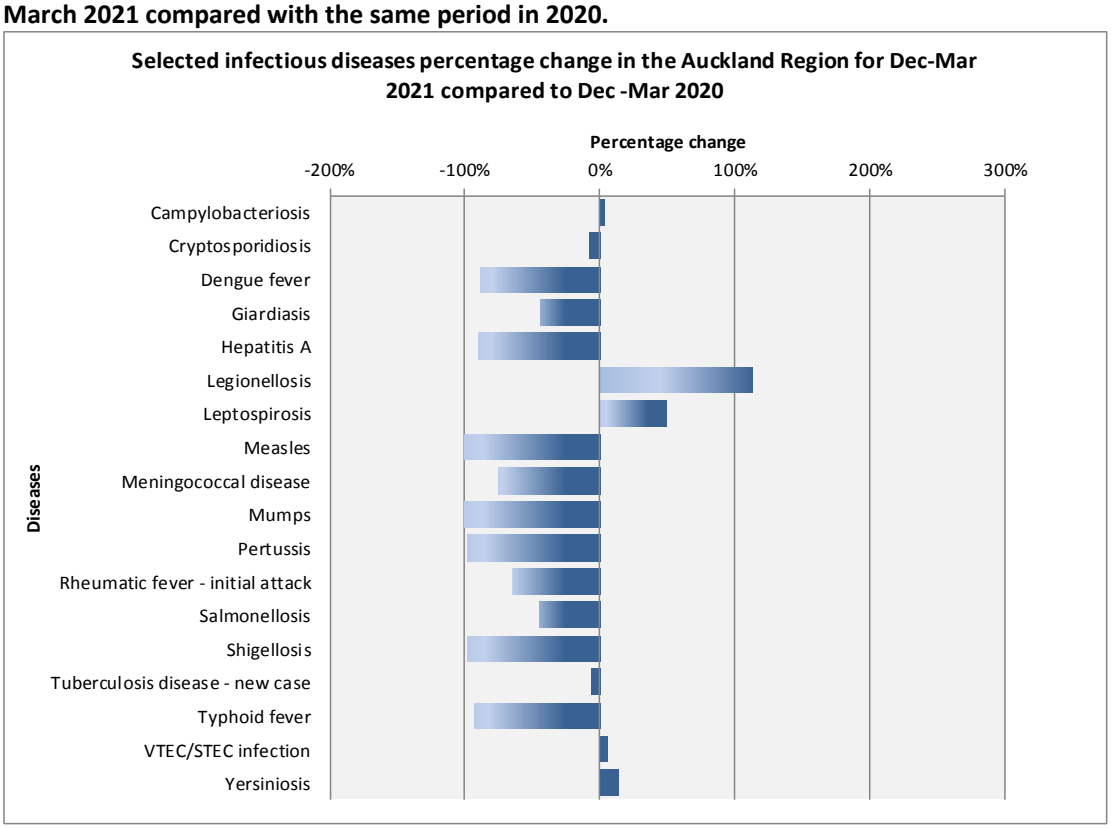
Intersections between the work of ARPHS and the three Auckland metro DHB

Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in sharing surveillance information, managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food. For example, ARPHS provides the backbone support team for the Healthy Auckland Together (HAT) coalition, of which the three DHBs are partners. The recent Coronavirus preparedness and response is an example of where strong collaboration between ARPHS and DHBs is critical.

Appendix B –Surveillance

ARPHS undertook a comparison of notifications between the six month period between December to March, 2020 and the same period in 2021 (Figure 5). Almost all infectious disease notifications (except COVID-19) have remained low after the significant drop in 2020 (post lockdown periods). This includes Vaccine Preventable Diseases (VPD); with no measles, mumps or rubella notifications received. Some enteric diseases have remained lower than normal (cryptosporidiosis, giardiasis, typhoid, paratyphoid and shigellosis), with notifications returning to normal levels for campylobacteriosis, and increasing slightly for VTEC, yersiniosis (likely due to a change in laboratory testing) and salmonellosis (which is experiencing a spike in cases currently under investigation). Legionellosis was one of the few diseases that had an increase in notifications. Acute rheumatic fever notifications are lower than in the same period in 2020 and due to border restrictions, arbovirus notifications remained low. New tuberculosis notifications are tracking at similar numbers compared to the same period of the previous year.

Figure 5. Selected infectious diseases percentage change in the Auckland region for December to March 2021 compared with the same period in 2020.



B1. Foodborne diseases:

Enteric disease notifications dropped considerably in 2020 with notifications down between 30% and 90% across various enteric diseases. In 2021, this has remained lower than normal for cryptosporidiosis, giardiasis, salmonellosis and high risk enterics (typhoid, paratyphoid, shigellosis). Notifications returned to normal levels in 2021 for campylobacteriosis, and increased slightly for VTEC and yersiniosis. The increase in yersiniosis has been contributed to by an increase in laboratory detection with a change to PCR testing.

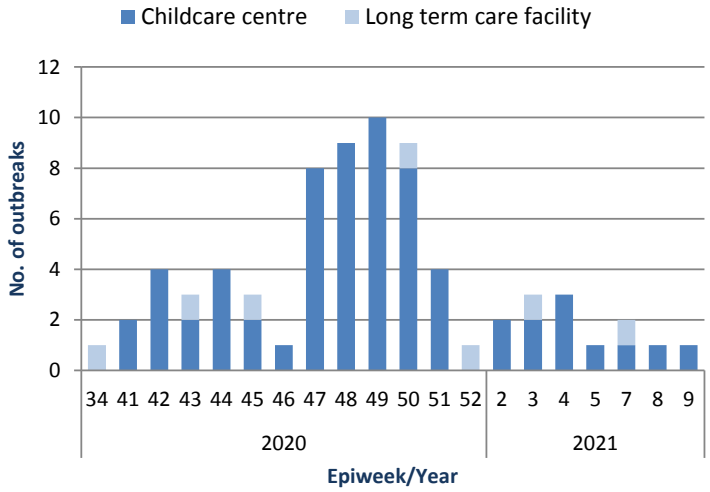
Stringent infection control precautions at aged residential care and other institutions has resulted in few gastroenteritis outbreaks at residential care settings during December 2020 to March 2021,

however, there was an unexpected increase in gastroenteritis due to norovirus reported for ELS and primary schools at the end of 2020 (Figure 6). Typically there are two to four ELS outbreaks per month but for December 2020 there were 39 outbreaks reported. This increase was thought to be due to two factors:

- Change in hand hygiene measures in response to COVID-19 from soap and water to hand gels
- Change from using hypochlorite as a disinfection agent to others marketed as more effective against COVID-19.

ARPHS worked with MoE to provide clear communication and advice to the settings involved. The Christmas break assisted to stop spread and enabled deep cleaning of ELS settings and schools.

Figure 6. Number of gastroenteritis outbreaks in Early Childcare Centres and Long-term Facilities, Auckland Region, end of 2020 epidemic weeks and beginning of epidemic weeks 2021.



- Salmonellosis notifications have generally been running at about half the expected number. However March 2021 saw an unexpected spike in salmonellosis cases half of which have required hospitalisation. Whole genome sequencing (WGS) of the Auckland cases has since identified local salmonellosis cases as a S*almonella enteriditis* (ST11) similar to a cluster of cases associated to a high end Auckland restaurant in 2019 and from which occasional cases have emerged since (not associated with the restaurant). A common source for this latest spike has not been identified and investigations are still underway.
- Yersiniosis notifications moved against the trend showed by other enteric diseases. The number of cases reported returned to normal within weeks of the end of the April 2020 lockdown and has remained normal or slightly higher than normal since that time. ARPHS estimated that 25% of the increase in yersiniosis is due to the increased detection by PCR methodology, however a change in the epidemiology has been noted with a 20% increase in cases with Asian (predominantly Chinese ethnicity) from 43 % to 60% and especially in the under 5 years and 30 to 39 year age groups.
- VTEC notifications experienced an increase in O157 infections during January 2021. Multiple risk factors were identified.
- There was one case of Hepatitis A cases notified in an elderly woman who had consumed frozen berries (food samples were negative). Another case since March 31, 2021 features an unknown Korean source and ESR serotyping identified a single serotype for 4 Korean cases over the past 18 months. Interviews have not elicited a common source or event.

- Listeriosis cases notifications were three for the period despite various MPI recalls of foods possibly contaminated with listeria. Cases were aged between 53 and 92 and all had comorbid conditions.

B2. Airborne and Environmental diseases:

- There have been no confirmed cases of measles, mumps or rubella.
- Invasive pneumococcal disease (IPD) is a seasonal disease and tends to accompany seasonal influenza however the number of notifications (34) in the last six months has been significantly down (by 37%) compared to the same period last year in 2020 (54).
- There were concerns that under lockdown conditions meningococcal cases might increase. This has not been observed and there has been only one case notified compared with four over the same period in 2020. This case was serotype B.
- New tuberculosis notifications are tracking at similar number of cases (46) compared with 49 for the same period in 2020. Of the 46 cases, 80% of new TB cases were born outside of New Zealand. The probable source countries were India (39%), Philippines (8%), Fiji (8%), Samoa (5%), and Tonga (5%).
- Acute rheumatic fever notifications for the period December 2020 to March 2021 were 12 compared with 34 for the same period in 2020. ARPHS had concerns that an increase might occur with COVID lockdown, household crowding and winter climatic conditions but fortunately this did not occur. Of the 12 cases, ten were aged 5 – 19 years (83%). Of these, five self-identified as Māori, and three were of Pacific descent. The largest burden of disease remains in CMDHB with seven of the 12 cases compared with Auckland DHB and Waitematā DHB with 2 and 3 cases respectively.
- Legionellosis was one of the few diseases that had an increase in notifications (17) compared with 2020 (8). Of the 17 confirmed cases serotyping is currently available for eight. *L. pneumophila* sero-group 1 was identified in three which is typically associated with aerosolised water and man-made warm water systems, especially cooling towers. There were five *L. longbeachae* cases over this period but this serotype typically increases during spring and summer months with increased contact with soil and landscaping products.

B3. Vectorborne diseases:

As a result of border restrictions arbovirus notifications for the period were markedly lower in 2021 (3 cases) compared with 27 for the same period in 2019. All acquired their illness in the Cook Islands.

B4. Blood borne diseases:

- There were six cases of hepatitis in 2020. There were no confirmed cases for the period December 2020 to March 2021
- There was one hepatitis C cases notified in 2020 with multiple risk factors but no cases for the reporting period
- Five cases of hepatitis NOS were notified to ARPHS in 2020. Three were cases of hepatitis E. Two were imported from India and Myanmar but the source of the third case was not found. The two delta cases were aged between 60 and 69 years and four had Māori and Pacific ethnicity. There were no cases for the reporting period.

Oral Health in the Auckland Region

Recommendation:

That the Community and Public Health Advisory Committee notes the update on Oral Health in the Auckland region since the last report in November 2020

Prepared by: Ruth Bijl (Funding & Development Manager, Child, Youth & Women's Health), Deepa Hughes (Programme Manager, Oral Health and Youth Health)
Endorsed by: Dr Debbie Holdsworth (Director Funding) and Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ARDS	-	Auckland Regional Dental Service
ARHSD	-	Auckland Regional Hospital and Specialist Dentistry
CDA	-	Combined Dental Agreement
CMH	-	Counties Manukau Health
CPHAC	-	Community and Public Health Advisory Committee
DCNZ	-	Dental Council of New Zealand
DHB	-	District Health Board
dmft	-	decayed, missing or filled teeth (a measure of severity of dental disease)
FSA	-	First Specialist Appointment
GA	-	General Anaesthesia
OR	-	Operation Room

1. Purpose

This report updates the Committee as requested after the recent Auckland District Health Board (DHB) Board discussion, and follows from the previous report 'Oral Health in the Auckland Region' submitted to the Community and Public Health Advisory Committee (CPHAC) in November 2020.

2. Introduction

Good oral health is vital to general health and wellbeing across all ages. Poor oral health affects general health by causing considerable pain and suffering, limiting what people can eat, and affecting overall quality of life and well-being. There is also a growing body of evidence linking poor oral health to specific medical conditions, including heart disease, diabetes, and pre-term and low birth-weight babies. Poor oral health can be particularly devastating for children, significantly affecting their physical, psychological and social development. Dental decay in infants and children can lead to pain and infection in teeth and gums, poor nutrition, difficulty sleeping, speech impairments and delayed language development, and low self-esteem and confidence.

Dental caries is one of the most prevalent health issues that affect both children and adults in New Zealand. There are marked ethnic inequities in the oral health of children in the Auckland region. Māori children, Pacific children and those living in most deprived areas have significantly higher levels of dental caries. Treatment alone cannot achieve good oral health in the long term. Adoption of preventive practices and early interventions are necessary from a young age to achieve good oral health over the course of life.

Oral health is a complex issue that reflects the impacts associated with the social determinants of health, with marked inequities in outcomes seen across all age group. These are most marked for Pacific peoples and for Māori. To address these known and longstanding inequities the Preschool Oral Health Action Plan was developed in 2017, focused on prevention, promotion and intervening early. The main service provider, the Auckland Regional Dental Service (ARDS), also undertook a significant change programme. Unfortunately, what progress had been made has been largely reversed by the impact on services of COVID-19 lockdowns and service disruptions.

Dental disease is one of the leading causes of potentially preventable admissions to hospital for young children, as well as a significant source of inequity for Māori and Pacific populations. These admissions also come at a significant cost. In the 2019/20 financial year, 1,609 children under the age of 15 years received dental extraction or restoration under general anaesthesia (GA) in metro Auckland.

3. Services Overview

2.1 Auckland Regional Dental Service
In New Zealand, dental services are publicly funded for children from birth until their 18th birthday. Until School Year 8, children primarily receive dental care from dental therapists and some dentists within the Community Oral Health Service. In Auckland, this service is referred to as the Auckland Regional Dental Service (ARDS).

ARDS provides screening, early detection, preventive and restorative dental services for preschool and school-aged children. Children requiring treatment outside the scope of ARDS clinicians are referred to either hospital dentists (if treatment is required by a paediatric specialist including the use of GA) or private dentists with a Combined Dental Agreement.

ARDS is managed by Waitematā DHB on behalf of all three metro Auckland DHBs. There are approximately 280,000 children enrolled with the service. Service provision extends from Wellsford to the Bombay Hills and is delivered in 83 facilities, including fixed, mobile and transportable dental units across all three DHBs with 188 patient chair capacities.

2.2 Adolescents Oral Health Service: The Combined Dental Agreement
From School Year 9 until a person's 18th birthday, dental care is provided by private dental practices contracted under the Combined Dental Agreement (CDA).

Dental care for adolescents is funded via a nationally standardised CDA. The agreement also covers special dental services for children in Year 8 and younger who have been referred from ARDS due to treatment requirements beyond the scope of a dental therapist (for example, some treatments of oral disease, the restoration of dental tissue, or extractions). There are 310 dental providers across three metro Auckland DHBs - Auckland DHB 97, CMH 92 and Waitematā DHB 121. As well as fixed dental practices in the community, three large private mobile providers take mobile dental clinics into some secondary schools to provide adolescent dental care. A small number of high-risk adolescents continue to receive services from ARDS.

A small review of the agreement occurs annually focusing on small amendments and price increases. A major review occurs every three years allowing more significant changes to the agreement. A broader national landscape review scheduled by the National Oral Health Group and the Ministry of Health is proposed to establish how well the CDA provides equitable access to dental care and recommend improvements to future contracting years.

2.3 The Auckland Regional Hospital and Specialist Dentistry
Once a person turns 18, there is a very limited range of publicly funded dental services available for adults. These services include dental treatment due to an accident or injury and specialist oral health care for people with needs that prevent them from accessing community-based private dental care.

The Auckland Regional Hospital and Specialist Dentistry (ARHSD) is the regional hospital dental service, providing secondary and tertiary oral health care services to people living in Auckland, Waitematā and Counties Manukau DHBs. It is funded by the three metro Auckland DHBs, and is managed by Auckland DHB.

ARHSD provide clinical services to a large and growing group of medically complex and special care patients, children requiring care under General Anaesthetic (GA), and patients who require dental or oral health services as an essential part of in- and out-patient hospital medical and surgical treatment. ARHSD also provide very limited emergency dental care for low-income adult's service, as do dentists in the community who hold a contract with the DHB.

2.4 Emergency Dental Services for Low income adults
Emergency dental services are services that are required for the immediate relief of pain and infections for low-income adults. Under the service coverage schedule, DHBs are required to provide emergency dental services where funding and capacity allows. Metro Auckland DHBs have historically allocated funding for emergency dental treatment. The ARHSD and a limited number of dentists in the community who hold a 'Relief of Pain' contract with the DHB provide these services. In order to access this service, adults must hold a valid Community Service Card. There is a $40 co-payment for this service. Treatment is restricted to the current problem and does not include any preventative or maintenance treatment

2.5 Maternal Oral Health Project - Hapu Māmā Oranga Niho Ki Tamaki
Auckland DHB also funds for a new oral health service for pregnant women/new mothers in the Tamaki area to receive free maternal oral health care. ARDS is responsible for the provision of this service that commenced in February 2020 and since then 210 women have been accepted into the service. This service is further extended to 12 months until June 2022 to treat additional 180 pregnant women.

4. Update on Oral Health Outcomes

A summary of latest oral health outcomes are highlighted below, with a full description provided in Appendix 1. All oral health services were significantly disrupted in 2020. Consequently, the available outcome data for 2020 may not provide an accurate picture. However, even before COVID-19, there were access issues across all oral health services with persistent inequity demonstrated across all age groups.

- In April 2021, approximately 173,123 (61%) children aged 0 to 13 years were not seen on time (are in arrears) across metro Auckland.
- In ADHB alone, 40,390 (60%) children were overdue for their scheduled examination.
- There are 9,155 children across metro Auckland who are significantly overdue (last seen before 2018).
- The 'did not attend' rate for Māori (17%) and Pacific (19%) children is higher compared to non-Māori and non-Pacific (6%) children.

- Since January 2021, 794 (15%) of Auckland DHB children aged one year have been seen by ARDS (Table 1)
- Of those one-year-old children enrolled with ARDS, 7.5% received fluoride application between Jan to May 2021 (Table 2)
- 68% of Māori and 75% of Pacific children have dental decay at age five, compared to 46% of non-Māori and non-Pacific children.
- Māori and Pacific children have more severe dental disease with an average of 3.30 to 4.20 decayed, missing or filled teeth (dmft) respectively by the age of five compared to non-Māori and non-Pacific children (2.10).
- For children aged 12 to 13, Māori and Pacific children have more severe dental disease with an average of 0.63 and 0.77 dmft respectively, compared to 0.37 dmft for non-Māori and non-Pacific children.
- The utilisation rate for adolescents in ADHB is 74% but only 43% for Māori rangatahi.
- Dental admission rates for Pacific children aged 0-4 years are highest and above the national average.
- Though a drop in admission rate for all children is seen in 2020, dental admission rates for those aged under 19 years and younger still remains highest in Pacific children followed by Māori children.
- In metro Auckland, 1362 children are on the waiting list for a first specialist appointment with a further 637 on the surgical wait list for dental treatment under a general anaesthetic, a total of 1,999 in May 2021 (down from 2,157 in July 2020).

Treatment alone cannot achieve good oral health in the long term. Adoption of preventive practices and early interventions are necessary from early years to achieve good oral health over the course of life.

The table 1 below shows the percentage of children, by ethnicity, who are one years of age and have attended an appointment with the service.

Table 1: Percentage of children under 2 years of age seen by the service

DHB	Māori	Pacific	Asian	Other	Total
Auckland	12% (79)	13% (111)	17%	15%	15% (794)
Counties Manukau	13% (134)	12% (295)	19%	13%	14% (1113)
Waitematā	10% (100)	9% (70)	21%	16%	16% (1233)
ARDS Total	9% (313)	12% (476)	14%	14%	15% (3140)

The preventative strategy, applying fluoride varnish is measured at one years of age. Of those one-year-old children who attended ARDS appointment, 51% received fluoride varnish, resulting in 7% of one-year-old children in metro Auckland receiving this application.

- Total metro Auckland population of one-year-old children(n=23,710)
- Total ARDS enrolled children of one-year-old children (n=21,275)
- Total number of one-year-old patient who attended appointments (n=3,140)
- Total number of one-year-old patient who received Fluoride treatment during their visit (n=1,589)

Table 2: Percentage of one-year-old children received fluoride varnish in 2021 (Jan to May)

DHB	Ethnicity	Of the population	Of those enrolled	Of those who attended
ADHB	Māori	3.02%	3.90%	32.91%
	Pacific	4.59%	3.38%	26.13%
CMH	Māori	2.99%	3.87%	47.01%
	Pacific	4.37%	4.26%	35.25%
WDHB	Māori	3.78%	5.27%	54.00%
	Pacific	5.29%	5.44%	64.29%
ARDS TOTAL	**ALL**	**6.70%**	**7.47%**	**50.61%**

5. Oral Health Service Improvement Initiatives

There are marked ethnic inequities in the oral health of children in the Auckland region. Māori children, Pacific children and those living in the most deprived areas experience much higher rates of dental caries and tooth extractions. As highlighted in the previous CPHAC report, services had been taking steps to improve oral health overall, and address longstanding inequities in oral health, however, the situation is now urgent needing additional, targeted approaches to improve access to oral health services particularly for Māori and Pacific children.

As a response to poor oral health outcomes and persistent inequities, three major service improvements work is taking place in Child and Adolescent oral health in Auckland region.

1. A broader and longer term End to End Service Improvement Initiative
2. ARDS Service Improvement Initiative
3. ARHSD Service Improvement Initiative

4.1 Child and Youth Oral Health End-to-End System Redesign

Across the Northern region, we have not achieved the level of oral health we would like for our children and youth. There is no evidence that the inequities seen in oral health have narrowed over the last two decades. Children with high rates of dental caries generally face a number of barriers to accessing care, including high wait times and delays in care. COVID-19 lockdowns have exacerbated wait times, with routine oral health services unable to operate. Public health prevention and health promotion efforts to stop caries developing are variable across the region. Recognising that we have the potential to deliver more comprehensive and coordinated care, an equity focused end-to-end model of care redesign is currently underway with the aim of improving oral health inequities and outcomes for Māori and Pacific tamariki and rangatahi. This work is co-led by the Executive and Equity leads for Northern Region DHBs, Dr Peter Watson (CMO, CMH) and Aroha Haggie (Director Funding and Equity, CMH). The child and youth oral health oversight group (the Group) is a key component of moving this work forward.

Considering the recently announced health sector reforms, rather than trying to redesign the whole end-to-end pathway during a time of change, the Group has proposed a two-prong approach.

1. A locality based co-(re)design of oral health services for children and youth in a high needs area (in Counties Manukau) to explore how approaches could be re-designed and scaled, particularly for Māori and Pacific. This will explore discourse, access, and barriers in partnership with a locality based community that experiences high needs. This will be paired with key evidence in wider system design, including funding and delivery models. This aligns with the locality approaches signalled in the Health and Disability System Review and reforms.

2. Ensuring ongoing improvements in current services are implemented, as well as improved integration, through strengthened regional oversight, monitoring and key metrics for children and youth with the ability to direct greater resourcing/effort where it is considered important as well as escalate risk.

Both work streams are underpinned by improving health equity and developing a seamless, integrated end-to-end model of care for children, young people and their whānau.

Appendix 2 sets out the proposed implementation schedule for this work programme. The proposed plan is being presented to the Regional Executive Forum in early June for approval.

4.2 ARHSD Service Improvement Initiative

Dental disease is one of the leading causes of potentially preventable admissions to hospital for young children, as well as a significant source of inequity for Māori and Pacific populations. These admissions also come at a significant cost. A service-planning project under the auspices of the Long Term Investment Plan (LTIP) provided by the Northern Regional Alliance was established in late 2019 but was put on hold in early 2020 due to lockdown. Following lockdown, recovery in planned care became the focus. Dental surgery was identified as a priority with worsening waiting lists for treatment under GA and was subsequently included in the Vulnerable Services programme.

Further work led to dental surgery provided by ARHSD becoming an ADHB-led project. This work won a bid under the Ministry of Health's Planned Care Recovery Fund. The Planned Care COVID-19 catch up activity funded $650k for this project to increase capacity to address the current waiting times.

Currently, there are 1,999 children on the waiting list for a first specialist appointment (FSA) or dental treatment under General Anaesthesia (GA) a reduction of 158 children (from 2,157) in July 2020. The referrals exceed current capacity and with significant arrears across ARDS the demand for treatment under GA is likely to grow further. As part of this initiative, work is underway to address immediate needs such as insufficient staffing to support service delivery, insufficient Operating Room (OR) capacity to meet demand and insufficient Clinic Room capacity to meet demand.

Progress made to date and the plan for the next 3 months includes:

- Increased FTE capacity (some still under recruitment) – Dental House Officers (3fte), Senior Dental Officers (2.2fte), Dental Assistants (3fte)
- Development of dental roster to maximise FTE capacity
- Service related changes to patient pathway and models of care
- Changes in service delivery locations for FSA clinics
- Additional weekend FSA Super clinics (April to June)
- Facilities and equipment upgrade for Starship outpatient dental room
- Mobile Surgical Unit (10 May - 2 July 2021)
- Saturday OR lists at Greenlane or Starship
- Operationalise fortnightly Saturday all day lists at Manukau Surgical Centre

Plan is also underway to contract private providers for additional OR access. One additional day per fortnight is already confirmed with Quay Park and a tender process is planned to engage other private providers. Engagement and collaborative working with Kaiārahi Nāhi and Pacific Care Navigators is also underway to ensure equity.

4.3 ARDS Service Improvement Initiative

There are several critical issues that are currently impacting the Auckland Regional Dental Service (ARDS). These include:

- Long standing ethnic inequities in oral health outcomes (for Māori and Pacific children)
- New requirements introduced as a result of the COVID-19 pandemic, including ceasing all routine oral health care during Alert levels three and four
- Geographically dispersed clinics, which over time has resulted in clinical variation and a lack of standardisation of operational processes
- National workforce shortages.

As a result, the service is reviewing its operating model in order to maximise productivity and operational efficiency, while not perpetuating oral health inequities.

Key deliverables for this project include:

- Develop more flexible facility options to ensure services can be provided most efficiently in areas with the highest need (by Aug 2021).
- Review of ARDS operating model to ensure it is fit for purpose and supports equitable oral health outcomes (by Sept 2021)
- Creation of a workforce development plan to ensure that the service has the culture, capability and capacity to operate and deliver equitable oral health outcomes (by Oct 2021)
- Develop an agreed future state and a 'road map' to transition to the new operating model (by Dec 2021)
- Develop a five year Clinical Services Plan to guide future service development and provision (by Jun 2022).

In order to produce an overall proposal for the re-design of the Auckland Regional Dental Service, four work streams have been identified (Operating Model, Work Force Development, Design and Clinical Services Plan). Under this are 18 sub-work streams each with a plan, key deliverables and performance indicators. The project has 81 key deliverables with 39 performance indicators. Four tests for operational change will also be performed to inform ARDS re-design.

As of mid-May, 17 key deliverables have been completed including one test for change. The test for change that was completed was to address the low volume of attendances of children aged 12-23 months olds, as part of the plan for fluoride varnish application of 1 year olds. Using quality improvement methodologies (PDSA cycles), the volume of attendances of 22 month olds in 5 ARDS teams increased from 20% to 74% using 1.0FTE ring-fenced administrative resource over two months. Time in motion studies demonstrated ARDS requires 4.1FTE to book all children aged 12-23 months olds, with additional resource required for non-contactable families/whanau.

A full list of performance indicators are provided in Appendix 3.

6. Conclusion

Both ARDS and ARHSD services have improvement processes underway in addition to the northern regional end-to-end system redesign. Nationally, a broader, long-term (2021-2024) oral health project supported by national DHBs Planning and Funding General Managers and Chief Executives is also being planned to identify systems and services change required to have a better and more equitable oral health outcome.

Appendix 1: Oral Health Outcomes

Oral Health Outcomes for Children

Oral health status for children is measured through two: (i) caries-free rates (i.e. the proportion of children with no evidence of dental decay) and (ii) mean number of decayed, missing or filled teeth (dmft). However, these rates are likely to underestimate the true prevalence of dental disease and the extent of inequities in our population, as they do not include children not examined by ARDS.

In 2020 (our most recent data), approximately 28% (6,717) of 5-year-old children and 32% (7,137) of school Year 8 (ages 12 – 13) were examined by ARDS in comparison to 53% (11,554) of 5-year-old children and 71% (15,073) of School Year 8 (ages 12 – 13) children examined in 2019.

Children who have been unable to access this free dental service are likely to have poorer health outcomes than those who have been examined and/or received treatment (although the numbers accessing private dentists is unknown).

Figures 1 and 2 show caries-free rates and the mean dmft at the age of five years in the Auckland region, by ethnicity from 2010-2020. There is a decline in number children who are caries-free at age five across all ethnic groups. The rates of dmft also appear to show an increase in severity of dental disease among all children.

Figure 1: Caries-free rates at age five for the Auckland Region, by ethnicity

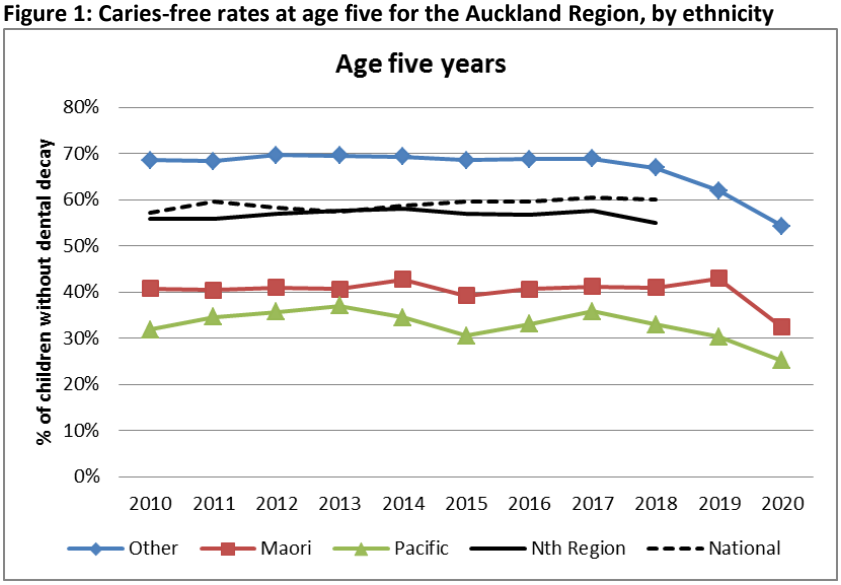
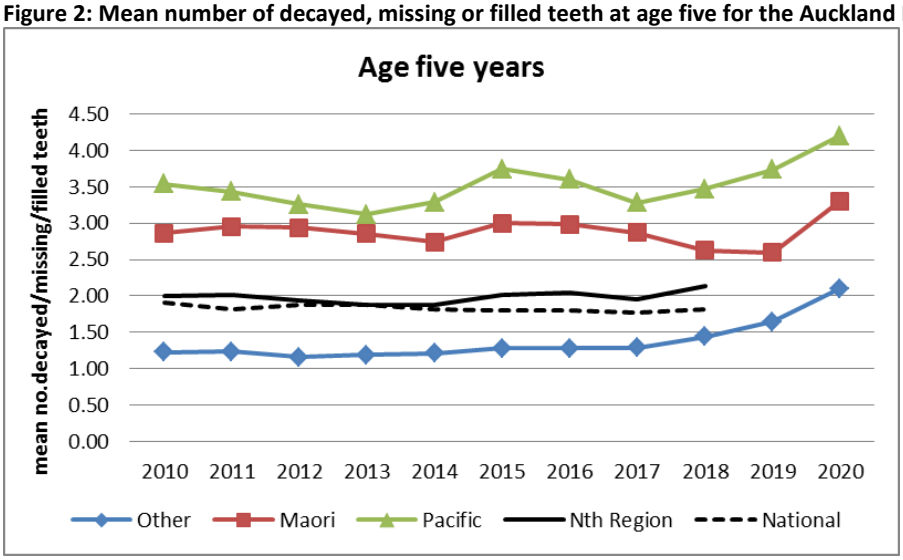


Figure 2: Mean number of decayed, missing or filled teeth at age five for the Auckland Region, by ethnicity



Figures 3 and 4 below show caries-free rates and the mean dmft at school Year 8 for children in the Auckland region by ethnicity from 2010-20209. Caries-free and mean dmft rates for children at School Year 8 continue to improve suggesting that school dental services in general have made progress in improving the oral health outcomes of school-aged children, but more work needs to be done to reduce persistent inequities seen at all ages for Māori and Pacific children.

Figure 3: Caries-free rates at age school Year 8 for the Auckland Region, by ethnicity

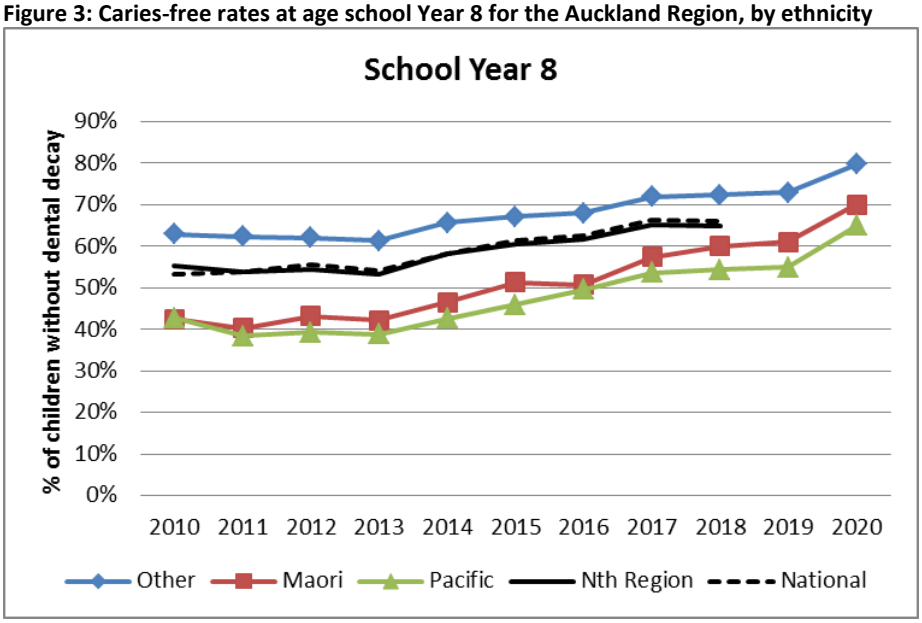
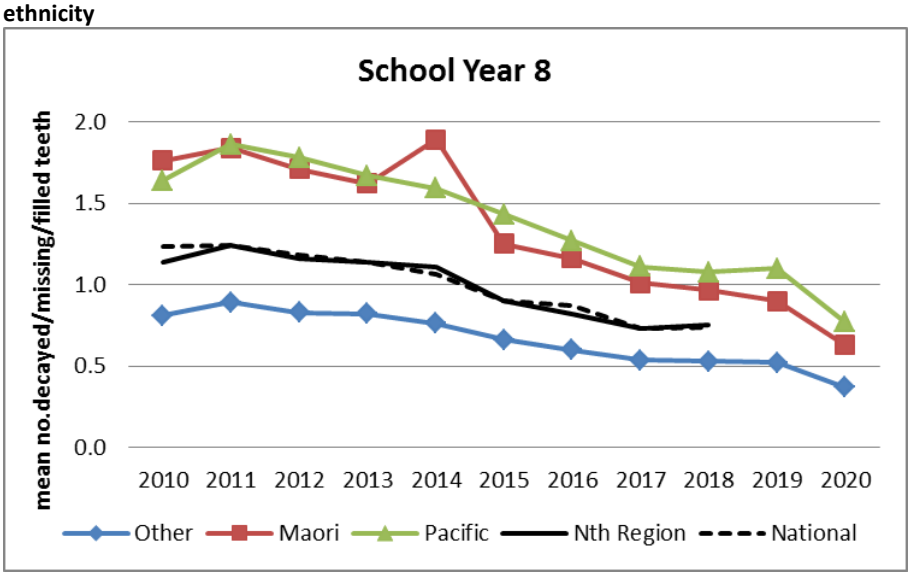
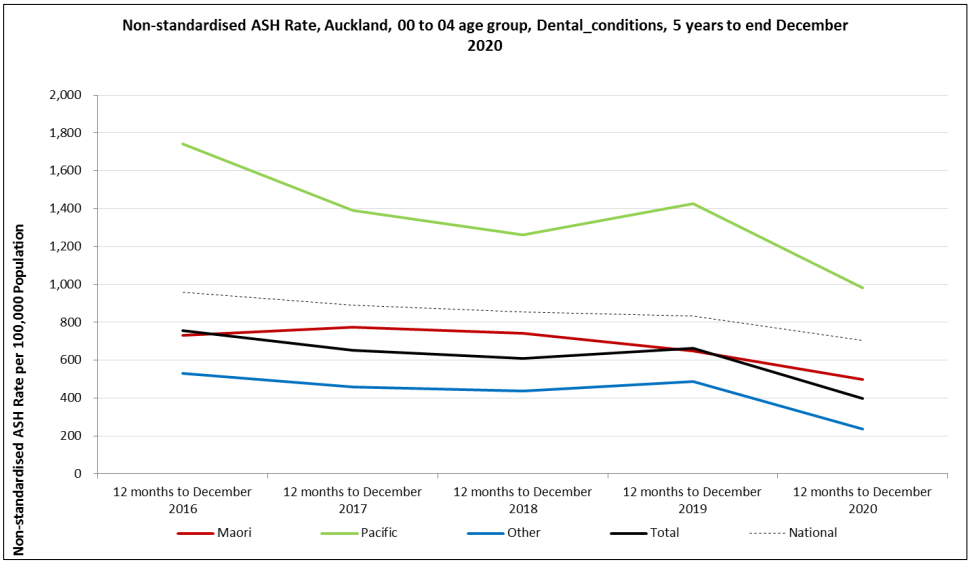


Figure 4: Mean number of decayed, missing or filled teeth at school Year 8 for the Auckland Region, by ethnicity



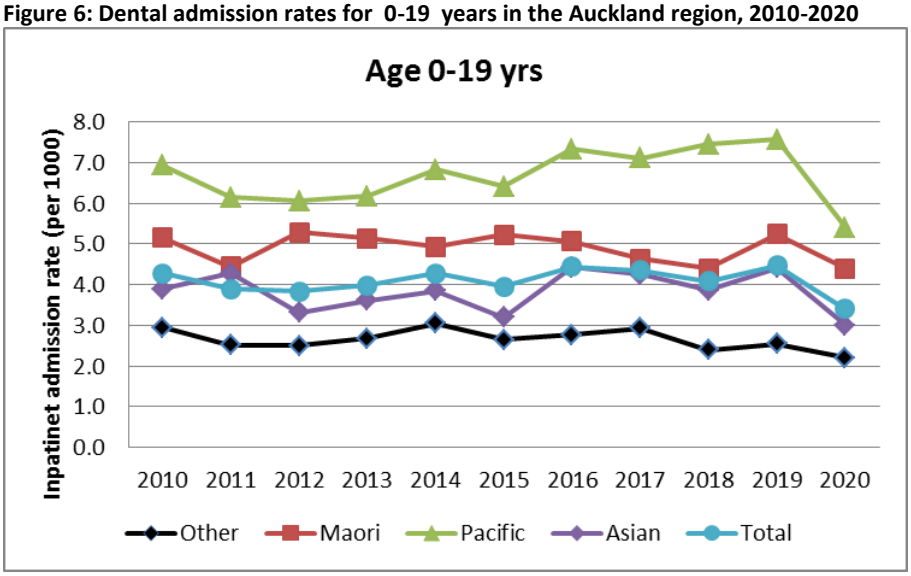
Dental admission rates for children aged 0-4 years are highest and also above the national average in Pacific children in the Auckland region. Dental admissions, mainly for dental extractions under GA are an important cause of ambulatory sensitive hospitalisations (i.e. hospitalisations considered potentially reducible through preventive or treatment strategies deliverable in a primary care setting), and the childhood dental admission rate for Pacific and Māori children though declined in 2020, it still remains higher than for other children.

Figure 5: Dental admission rates for children aged <5 years in Auckland DHB, 2016-20



Dental admission rates for those aged under 19 years and younger are also highest in Pacific children follwed by Māori children demonstrating that the inequities from childhood persist into adulthood. It is important to note that the drop in admission rate for all children could be related to COVID-19 disruptions.

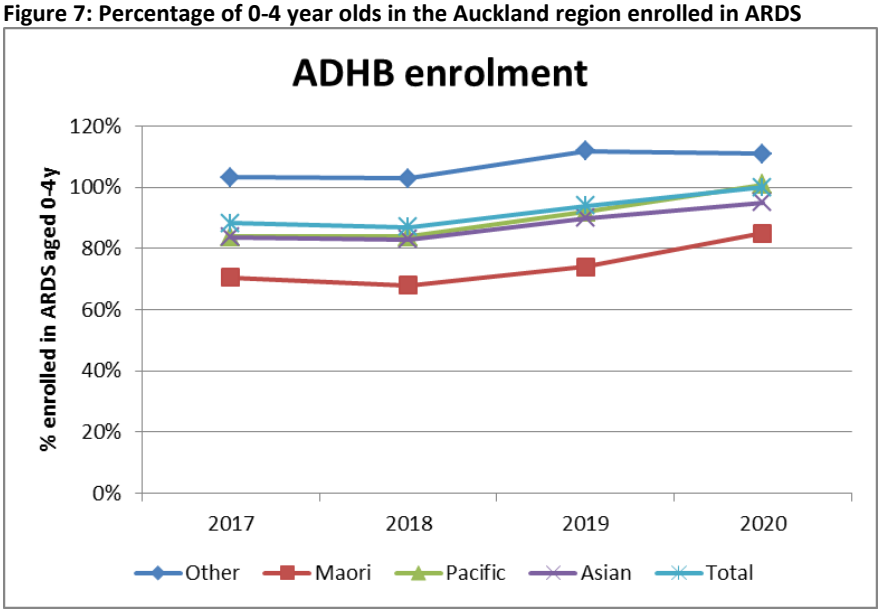
Figure 6: Dental admission rates for 0-19 years in the Auckland region, 2010-2020



Pre-school Enrolment

Ensuring that all children are enrolled in ARDS is a crucial first step in ensuring that all children are able to access the service. Figure 7 show the percentage of children in the metro Auckland region enrolled in ARDS by the age of five. Māori children enrolled with ARDS continue to improve with 15% of 0-4 year old Māori children not yet enrolled in ADHB.

Figure 7: Percentage of 0-4 year olds in the Auckland region enrolled in ARDS



Arrears

Arrears is a timeliness indicator that measures the proportion of children who are overdue for their scheduled examination. The national target is that 10% or less children are in arrears. While the national target for arrears has not been met for any ethnic group in recent years, COVID-19 has significantly increased the percentage of children in arrears across metro Auckland. The table below outlines the updated percentage of children in arrears by ethnicity and DHB of domicile as of 30 April 2021.

Table 3: Children in Arrears – April 2021 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	61% (4557)	61% (6933)	58% (11977)	61% (16923)	60% (40390)
Counties Manukau	65% (14867)	64% (20798)	58% (15272)	61% (16801)	62% (67738)
Waitematā	61% (8526)	64% (6776)	60% (16366)	63% (33327)	62% (64995)
ARDS TOTAL	**62% (27950)**	**63% (34507)**	**59% (43615)**	**62% (67051)**	**61% (173123)**

Significantly overdue

Currently there are a further 9,155 children in the Auckland region who last attended an appointment prior to 2018. ARDS Community Engagement Coordinators continue to focus on contacting the whanau/family of these children and aim to have no child who last attended ARDS before 2016 by the end of May. In addition, clinic staff continue to refer non-contactable children via the Supportive Treatment Pathway for the Centralised Booking Team to contact, which include many of our long waiting children.

The table below outlines the number of significantly overdue children (last attended prior to 2018) by ethnicity and DHB of domicile as of 30 April 2021.

Table 4: Long waiting Children – April 2021 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	178	285	404	645	1,512
Counties Manukau	1110	1373	805	1236	4,524
Waitematā	393	303	705	1718	3,119
TOTAL	**1681**	**1961**	**1914**	**3599**	**9,155**

School Year 8 Students

ARDS provides care to all children from birth to the end of School Year 8. Following this, young people are transferred to private contracting providers, where they continue to receive free dental care up until their 18th birthday under the CDA. Before transferring these children, ARDS is required to examine all Year 8 students and complete their treatment.

The table below details the percentage of school year 8 students seen by the service as at 30 April 2021.

Table 5: percentage of School Year 8 Students seen by ARDS – 2020 data

DHB	Māori	Pacific	Asian	Other	Total
Auckland	20% (144)	23% (228)	21% (270)	19% (429)	21% (1071)
Counties Manukau	17% (330)	20% (517)	23% (389)	18% (419)	20% (1655)
Waitemata	19% (214)	21% (178)	16% (244)	15% (660)	18% (1296)
TOTAL	19% (688)	21% (923)	20% (903)	17% (1508)	19% (4022)

Non-attendance rate

Work is underway to develop a strategy for Māori and Pacific children to address these inequities, as part of the Service Improvement Initiative's Access Policy work stream.

Table 6: Non-attendance rate for children seen by ARDS

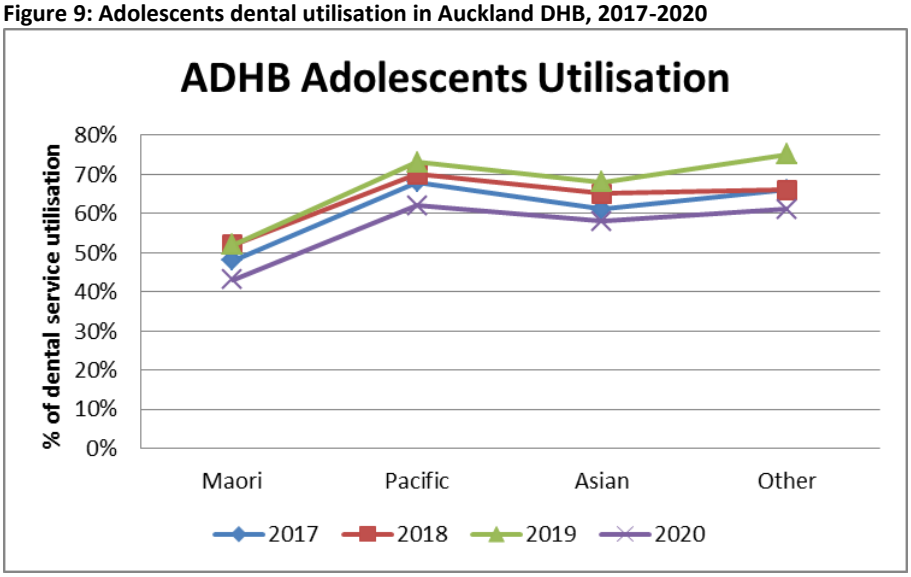
DHB	Māori	Pacific	Asian	Other	Total
Auckland	18.2% (91)	21.7% (226)	4.2% (69)	7.4% (94)	12.88% (482)
Counties Manukau	16.1% (296)	16.8% (476)	3.7% (74)	4.4% (85)	10.25% (931)
Waitemata	16.5% (161)	18.8% (130)	4.3% (88)	6.4% (217)	11.5% (596)
TOTAL	**17% (548)**	**19% (832)**	**4 % (231)**	**6% (396)**	**12% (2007)**

Oral Health Outcomes for Adolescents

Unlike children, there are no standardised outcome indicators (such as caries-free or dmft) available for adolescents. The Ministry of Health has set an utilisation target of 85% of adolescents from school year 9 – 17 years to receive annual dental care. This is measured by identifying unique individuals using the claims data from contracting dentists and adding a small number of high risk adolescents seen by seen by Community Oral Health Services (ARDS in the Auckland region).

Auckland DHB coverage for adolescents' oral health in 2020 was impacted by COVID-19. In 2020, the utilisation rate for adolescents was 58% compared to 69% in 2019. There is a significant disparity in dental coverage for Māori teenagers with only 43% coverage (52% in 2019) for Auckland DHB. While Māori teenagers' utilisation rate is slightly above the national average of 42%, more work is needed to increase the uptake of dental service by Māori teenagers in Auckland region.

Figure 9: Adolescents dental utilisation in Auckland DHB, 2017-2020



Appendix 2: Implementation schedule for co-design (DRAFT)

Outcome	Activity	Indicative timing
1. Set-up	• From existing data identify locality/localities of highest need within Counties Manukau. • Draft case for a range of approaches based on existing data and patient and whānau feedback	June-July
	Identify and convene working group members for planning hui	June
	Develop project information and data pack and shorter communications for community stakeholders, incl. online and social media	July-September
	Develop and agree wider community engagement plan	June-September
2. Service design	Working group and wider community stakeholders (where appropriate) engage with clinicians and decision makers	September-December
	Agree service model to trial, including identification of costs, workforce, location(s), equipment and resourcing	December
3. Implementation	Set up agreed service model for trial and development	January-March 2022
	Gain stakeholder, clinician, community and patient and whānau feedback	February-April
4. Review and scale	Review one or more service models trial and identity resource and localities to scale up	May onwards

Implementation schedule for oversight of ARDS & ARHDS improvement initiatives (DRAFT)

Outcome	Activity	Indicative timing
1. Agree measures	ARDS suggested measures: • Equity; improvement in service for Māori and Pacific children • Timeliness of children being seen • Application of fluoride varnish in under five-year-olds • Patient and whānau feedback about access, comfort and care – impact on everyday life • Additional rapid service improvement measures (as opp. to BAU)	June
	ARHSD suggested measures: • Audit of e.g. 400 children aged three to six who have been referred for GA extraction; detailed patient journey for this group • Patient and whānau feedback about any education and longer term oral health goals for themselves • Monitor existing measures; FSA wait list and completed,	June

Outcome	Activity	Indicative timing
	surgical wait list and completed	
2. Reporting format/ dashboard developed	• Set high level measures for delivery data, based on Faster Cancer Treatment format, test and review	June
3. Regular reporting from ARDS, ARHSD to the Group	• "One page" report at regular Oversight Group meetings	Monthly to six-weekly from June/July
4. Evaluate longer term outcomes	• Review achievements over the past year, outcomes and usefulness/practicality of measures used – update for coming year	Annually, from May/June 2022

Appendix 3: ARDS service improvement initiative performance measures

Table 1: Performance indicators for each work streams

Sub work stream	Key deliverable
Team boundaries	DMFT
	Patient experience
	Staff experience
Facilities and clinical equipment management	Chair closure days due to maintenance
	Clinical equipment replacement time
Telehealth	Volume of telehealth assessments completed <2 year olds
	DMFT
ROP and triage	Volume of triage calls that did not result in a clinic appointment
	Volume of ROP/concern appointments completed
Clinic deployment and outreach	Arrears tail
	Attendance rate
	DMFT
	Last attended tail
	Treatment tail
	DNA rates
Clinical supplies	Cost savings in clinical supplies
	Reduction in clinic supplies waste
	Consistent and appropriate use of consumables
	Product and consumables used align with DCNZ standards
	Consumables use aligns with treatment provisions and support improved patient outcomes
Booking and scheduling: Access policy	Chair utilisation
	DNA rates
	Clinical utilisation %
	Arrears %
	Arrears tail
	Last attended tail
	Year 8 attendance
	5 year old attendance
	<2 year old attendance
Booking and scheduling: Discharge management	Monthly audit
	September 2021 AEC report to demonstrate improved process than 2020
Treatment planning and risk assessment: Allocation of recall	Team compliance measures to recall
	Individual compliance measures to recall

Sub work stream	Key deliverable
	Arrears %
	Treatment volume for decayed teeth
Treatment planning and risk assessment: Fluoride varnish <2 year olds	Volume <2 year olds attended ARDS
	Of the <2 year olds who attended, % who had fluoride
Quality compliance and assurance	Variation from EAM database
	Variation from audits
Leadership and team structure	Feedback from leadership and clinic staff
	Vacancy rate %
	Turnover rate %
Cultural competency	Māori and Pacific DMF
	DNA rate Māori and Pacific
	Net promoter score FFT Māori and Pacific
Orientation and training	Environmental and clinical audits
	Turnover rate %
Facilities redesign	DNA rate
	Arrears %
	Arrears tail
	Longest waiting tail
	DMFT
Rebranding	Recognition of service
	Engagement rate
	Attendance rate

Rheumatic Fever Update

Recommendation:

That the Community and Public Health Advisory Committee:

1. **Note the history of national and local rheumatic fever activity since 2012.**
2. **Note that the Ministry of Health rheumatic fever funding has reduced over time and will cease in July 2022.**
3. **Note that school-based throat-swabbing programmes have not been effective as has been initially hoped, particularly in the Auckland DHB region with lower incidence, more dispersed cases, and low coverage of high-risk children through the school-based programme.**
4. **Note a focus on prevention for those with known ARF remains critical to preventing life-limiting Rheumatic Heart Disease consequences and improvements have been made to the DHB Bicillin programme.**
5. **Note that the recent case-control study suggests that action on other modifiable risk factors may be as effective, particularly housing interventions, which has been a focus of DHB activity for some time and which we welcome the recent budget announcement of continued investment. Note that the team continues to work to improve the Noho Āhuru Healthy Housing service, including recent expansion of the multidisciplinary team.**
6. **Note the current focus of activity is on improvements to Noho Āhuru (primordial prevention) and holistic management of Rheumatic Fever and Rheumatic Heart Disease (secondary and tertiary prevention).**

Prepared by: Ruth Bijl (Funding and Development Manager – Child, Youth and Women); Dr Alison Leversha (Community Pediatrician); Kim McRae (Project Manager); Faimafili Tupu (Pacific Health Gain); Scott Abott (Māori Health Gain); Jackson Rowe-Williams (Researcher)
Endorsed by: Dr Debbie Holdsworth (Director Funding), Dr Karen Bartholomew (Director Health Outcomes)

Glossary

ARF - Acute Rheumatic Fever
ASH - Ambulatory Sensitive Hospitalisations
B4SC - Before School Check
CHW - Community Health Worker
CPHAC - Community and Public Health Advisory Committee
GAS - Group A Streptococcus
HHI - Healthy Housing Initiative
MoH - Ministry of Health
PHN - Public Health Nurse
PHO - Primary Healthcare Organisation
RFPP - Rheumatic Fever Prevention Plan
RHD - Rheumatic Heart Disease
WCTO - Well Child Tamariki Ora

1. Executive Summary

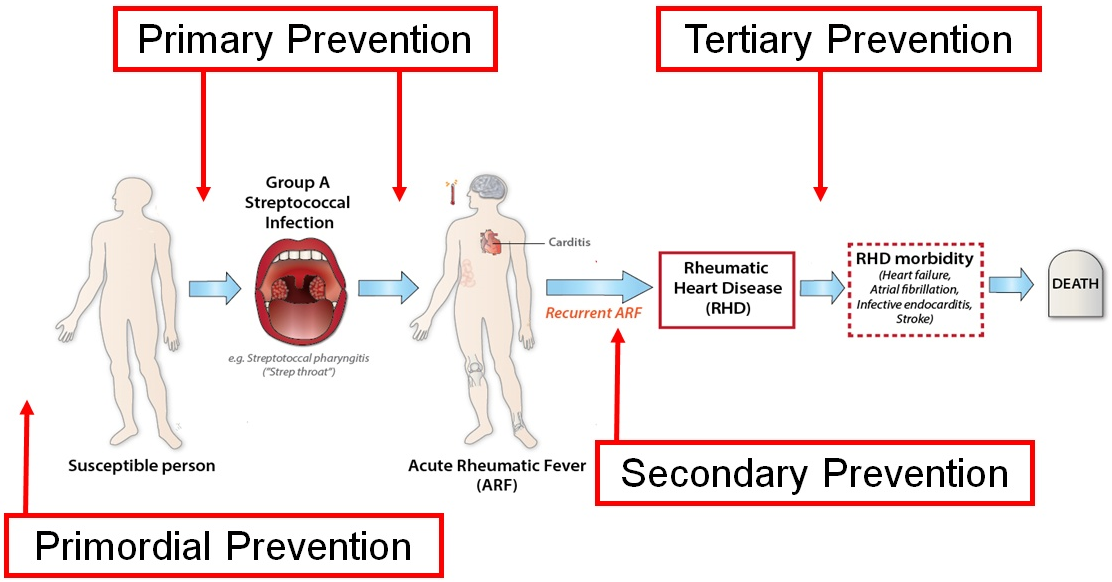
This paper outlines the history of the Rheumatic Fever Prevention Programme in Auckland District Health Board (DHB), the rationale for changes to the programme and current areas of focus.

2. Background

Acute Rheumatic Fever (ARF) is an auto-immune disease triggered by Group A Streptococcal (GAS) infection – most commonly a GAS pharyngitis (sore throat), with some suggestion that a GAS skin infection may also trigger ARF (role remains unclear in New Zealand). ARF is diagnosed on criteria rather than a diagnostic test, with some diagnostic challenges. ARF occurs mostly in children aged 5-20 years (most common in school-aged children). Approximately 80% of new cases of ARF have involvement of the heart (inflammation), which can lead to Rheumatic Heart Disease (RHD present in 60% ARF cases; 20% severe RHD[1]). Recurrent episodes of ARF increase the risk and severity of RHD. Treatment with IM penicillin monthly for at least 10 years prevents progression of RHD. ARF is strongly associated with poverty.

Prevention of ARF has been a focus internationally and in New Zealand. Approaches to prevention are outlined in Figure 1 below.

Figure 1. Prevention of ARF



Source: Dr Andrew Steer (Paediatrician, Royal Children's Hospital, Melbourne) modified by Dr Catherine Jackson.

[1] Heart valve damage which can lead to heart failure, valve infection, increased risk of stroke. May require surgical repair/replacement. Pregnancy poses a high risk for people with RHD.

ARF and RHD have all but disappeared from high-income countries. Yet here in Aotearoa New Zealand they remain an alarming and inequitable cause of preventable suffering and death for Māori and Pacific peoples. Over the 2000-2018 period, Pacific children (5–14 years of age) were 80 times more likely, and Māori children were 36 times more likely, to develop ARF compared with European/other children (based on initial ARF hospitalisations).[2] The ethnic inequity of distribution continues to drive elevated rates of RHD and contribute to premature death for Māori and Pacific peoples. On average, people with rheumatic fever die 15 years younger than their unaffected counterparts. There are approximately 140 deaths due to RHD every year in New Zealand, twice that of cervical cancer.[3]

The New Zealand Rheumatic Fever Prevention Programme (RFPP) was established in 2011 to prevent and treat strep throat infections, which can lead to rheumatic fever. The Rheumatic Fever Prevention Programme (RFPP) had three main strategies to reduce rheumatic fever rates:

- increase awareness of rheumatic fever, what causes it and how to prevent it
- reduce household crowding and therefore reduce household transmission of strep throat bacteria within households
- improve access to timely and effective treatment for strep throat infections in priority communities

The programme was expanded significantly from 2012 following the introduction of the five-year rheumatic fever Better Public Services (BPS) target. The government invested about $65 million to identify and trial new initiatives to reduce the rheumatic fever rates throughout Aotearoa New Zealand. Although the RFPP ended on 30 June 2017, rheumatic fever prevention continues to be a focus for the 11 DHBs with a high incidence of rheumatic fever. The RFPP funding to DHBs decreased significantly over the period of the programme – with funding reducing by more than $1M to Auckland DHB to the currently $240K. Ministry of Health funding for RF prevention is due to cease in June 2022.

3. School based throat swabbing – history and evidence

As noted above, a significant plank of the RFPP was investment in free assessment and treatment of sore-throats in high prevalence communities via school-based services. Approximately half of cases of ARF report a preceding sore throat, therefore it was hypothesised approximately half of cases of ARF could be prevented if reached through school-based programmes. A large trial conducted in Auckland led by Professor Diana Lennon indicated that a school-based programme would be effective in reducing ARF,[4] particularly in areas with high incidence such as Counties Manukau DHB. It was estimated that a high number (approximately 1,000) GAS positive sore throat infections would be needed to treat (NNT) to prevent one case of ARF.

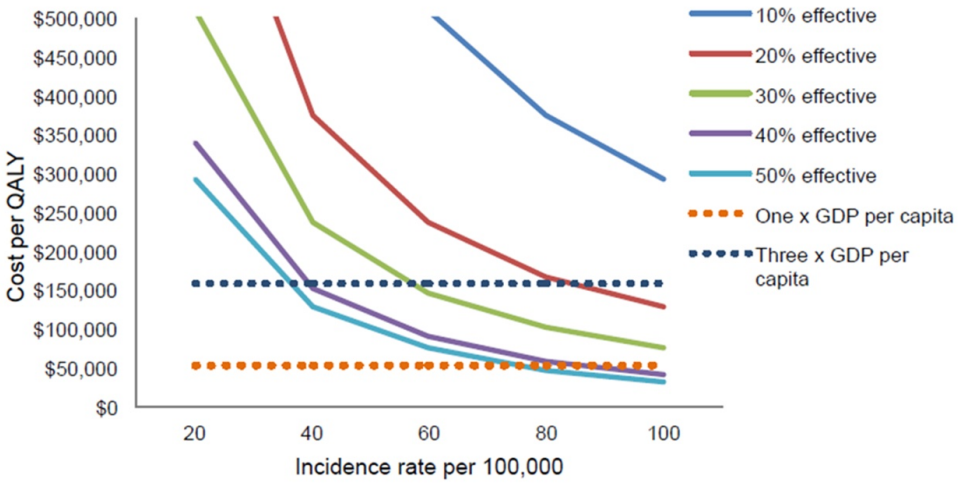
It is noted that sore throats are common, and most sore throats are not due to GAS. The role of GAS carriage is not clear: Māori and non-Māori rates of GAS carriage are similar. Evidence from the school programmes (including the Auckland DHB and Waitematā DHB programmes) demonstrate they do pick up GAS – with a February GAS positive rate of 17-20% reducing to an average of 7-8% over the

[2] Bennett J, Zhang J, Leung W, et al. Rising Ethnic Inequalities in Acute Rheumatic Fever and Rheumatic Heart Disease, New Zealand, 2000-2018. Emerg Infect Dis 2021; 27:36-46.
[3] Milne RJ, Lennon D, Stewart JM, Vander Hoorn S, Scuffham PA. Mortality and hospitalisation costs of rheumatic fever and rheumatic heart disease in New Zealand. Journal of Paediatrics & Child Health 2012;48:692-7.
[4] Lennon D, Anderson P, Kerdemelidis M, Farrell E, Mahi S.C, Percival T, Jansen D, Stewart J. First Presentation Acute Rheumatic Fever is Preventable in a Community Setting: A School Based Intervention. Pediatric Infect. Dis. J. 2017, 36, 1113–1118.

year.[5]

An evaluation of the costs and cost effectiveness of the school-based sore throat management in preventing ARF was undertaken in 2015.[6] For any given level of funding, the cost effectiveness depends on the *baseline incidence rate of ARF* and the *effectiveness* of the school-based services. This is confirmed in a recent evidence review, where school-based programmes were only recommended in very high incidence settings.[7]

Figure 2. Range of cost effectiveness estimates (cost per QALY) by varying incidence rates



The cost per quality adjusted life year (QALY) gained was estimated at $12,000-24,000 thousand for the Counties Manukau DHB primary school service, at an ARF incidence of approximately 80-90 per 100,000 children and assuming a cost per child of $150 per year and effectiveness of 40-50%. At $200 per child (more realistic price for Counties Manukau DHB original model) the cost per QALY is $40-$60,000 assuming 40-50% effectiveness. We note that this measure of cost effectiveness changes dramatically if the incidence is lower, which is the case for Auckland DHB and Waitematā DHB.

- At an incidence of 60 per 100,000 (Auckland DHB) the cost per QALY is approximately $80,000-$100,000.
- At an incidence of 40 per 100,000 (Waitematā DHB) the cost per QALY is approximately $125,000.

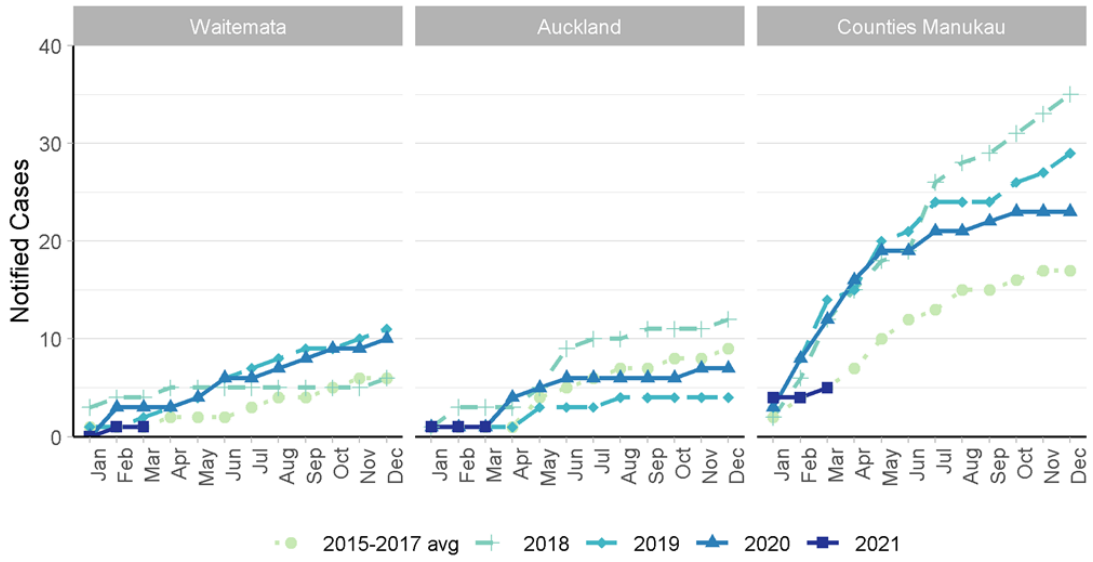
These are assuming the same parameters (40-50% effectiveness and $200 per child per year) neither of which hold for our region. For Northland DHB, with an incidence of 20-25/100,000 the cost per QALY is $250,000-$300,000.

Several reviews of sore throat programmes have been conducted since the RFPP began, noting

[5] Historical DHB school programme routine reporting.
[6] Jack SJ, Williamson DA, Galloway Y, Pierse N, Zhang J et al Primary prevention of rheumatic fever in the 21st century: evaluation of a national programme. Int J Epidemiol, 2018. 47(5): p. 1585-1593.
[7] Bennett J, Rentta N, Leung W, Anderson A, Oliver J et al. Structured review of primary interventions to reduce group A streptococcal infections, acute rheumatic fever and rheumatic heart disease. Journal of Paediatrics and Child Health. 2021 Apr 20.

limited evidence of effectiveness outside of Counties Manukau (CMDHB) and Tairawhiti DHBs.[8] Despite a drop in cases seen in 2015 in those two DHBs, and the ongoing throat-swabbing programmes across all DHBs despite reduced funding, there has not been a material impact on ARF rates. This includes Counties Manukau DHB where rates are now higher than pre-programme levels (see Figure 3). An evaluation (regression-discontinuity) undertaken by the PFO team in 2017 demonstrated no difference in ARF rates after the establishment of the programme.

Figure 3. Cumulative monthly count of ARF cases, 5 to 12 year olds by DHB and year, 2015-2021, Auckland Region



Source: Auckland Regional Public Health Service Surveillance Regional Report Q1 2021.

Due to the lower incidence of cases, Auckland DHB historical RFPP funding from the Ministry of Health was less, which meant the school programme was developed in 16 low decile schools (covering 46% of the recent ARF cases, but only 36% of 'high-risk' children). It was calculated when data was later available that this number of schools/limited coverage would never have been able to achieve the previous government target of a 2/3 reduction in cases. The calculations indicated a minimum of 34 schools to achieve impact with 51 schools to achieve similar coverage to Counties Manukau DHB (80-90% coverage with the 60 schools in the ManaKids programme).

The option to expand the number of schools was discussed with CPHAC and a business cases presented to the Auckland DHB Board in 2017 when DHB funding support to cover the Ministry reduction of funding was requested. The estimated cost of the school expansion to 34 schools was $2M (cost per case averted of approximately $667,000 per annum). The school programme expansion case was not supported by the Board due to other priorities and the evidence of effectiveness was not strong enough to warrant continuation of the existing dedicated school

[8] The Jack et al evaluation (see 6) and Walsh L, et al., School-based Streptococcal A Sore-throat Treatment Programs and Acute Rheumatic Fever Amongst Indigenous Māori: A Retrospective Cohort Study. Pediatr Infect Dis J, 2020. 39(11): p. 995-1001 and the Waitematā DHB and Auckland DHB Evaluation, Robinson T 2017.

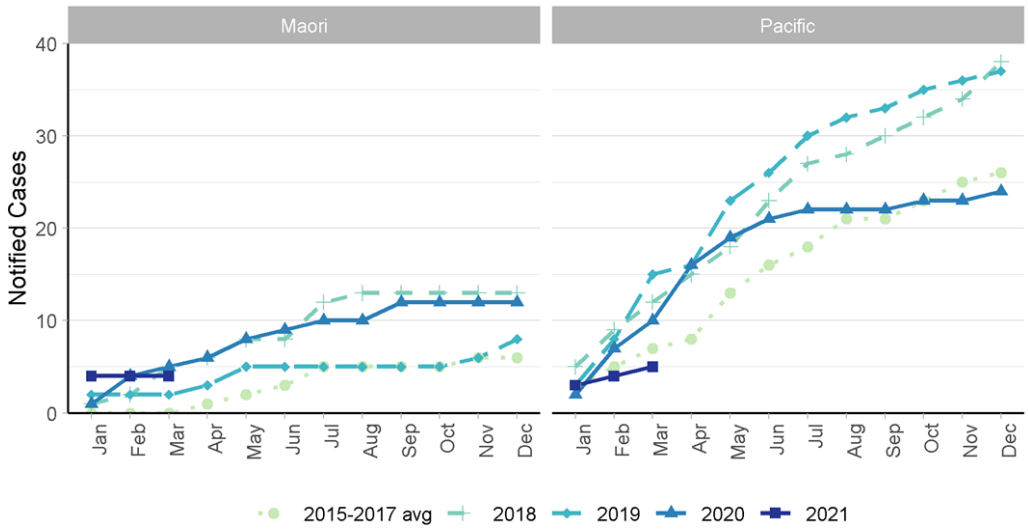
programme. Free sore throat assessment and treatment continue to be provided by as part of routine care in lower decile primary by Public Health Nurses (PHNs), and secondary schools by the DHB funded nurse-led School Based Health Services.

School-based health services provide a range of interventions and provide alternate access to primary care services. Programmes include management of skin infection due to the potential link with ARF and preventable Ambulatory Sensitive Hospitalisations (ASH), although it is noted that this also has not had a material impact on hospitalisations for skin infections.[9]

4. Rheumatic Fever for Māori and Pacific children

Auckland DHB has approximately 4-14 cases of ARF in 5-12 year olds annually, with fluctuations due to small number variation. Cases for 2020 and to date 2021 have been notably lower, likely due to public health interventions with COVID: lower circulating respiratory illness, hand hygiene, and reduction in mass gatherings reducing close contact infectious agent transmission. ARF cases are almost exclusively Pacific or Māori children. The higher numbers of cases for Pacific can be seen in Figure 4, and the different Pacific sub groups in Figure 5. The temporary drop in cases for Counties Manukau DHB in 2015 can be seen in Figure 5. Of note, the Counties Manukau DHB prevention approach has not substantially changed since 2012.

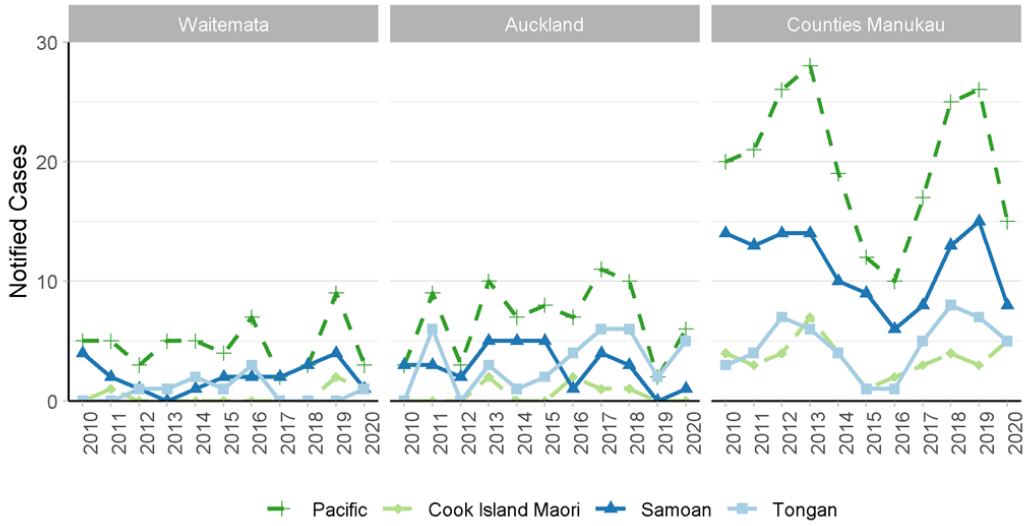
Figure 4. Cumulative monthly count of ARF cases, Māori and Pacific 5 to 12 year olds by year, 2015-2021, Auckland region



Source: Auckland Regional Public Health Service Surveillance Regional Report Q1 2021.

[9] Anderson P, King J, Moss M, Light P, McKee T et al. Nurse-led school-based clinics for rheumatic fever prevention and skin infection management: evaluation of Mana Kidz programme in Counties Manukau. NZ Med J. 2016 Jan 8;129(1428):36-45.

Figure 5. Annual count of ARF cases, Pacific 5 to 12 year olds with ethnic-sub group, by DHB and year, 2010-2021, Auckland region



Source: Auckland Regional Public Health Service Surveillance Regional Report Q1 2021

5. Evidence, the case control study, and other risk factors

A review of the Auckland DHB and Waitematā DHB programme in 2017, along with emerging evidence from New Zealand Rheumatic Fever Risk Factors Study (case-control study), suggested a change in prevention focus from solely sore throats to include other modifiable risk factors could be as effective as a school-based sore throat programme. Early evidence from the case-control study[10] demonstrated multiple housing-related factors were strongly related to ARF. Crowding was already identified as a primordial prevention intervention point in the RFPP, however, it was clear that a number of housing factors were important. These factors include:

- Crowding – one or more-bedroom deficit (CNOS). Also associated with people/house, people/room, self-assessed crowding
- 'Hot bedding' – someone else sleeps in the bed when not in use
- Housing quality – self-reported as poor or very poor
- Damp and Mould – one or more of; mould on the walls or ceilings, damp walls or ceilings in the bedrooms, damp or musty smell in bedroom or living room in the last 12 months
- Cold – one or more of; in the winter colder than you would like, in the winter do you put up with cold to save heating costs, share a room to stay warm in the last 4 weeks, so cold you shivered in the last 4 weeks?
- Limited hot water – sometimes have a cold or lukewarm bath/shower or put off having a bath/shower because there is not enough hot water.

Auckland DHB implemented a Healthy Housing Initiative (HHI): initially Kainga Ora, now called Noho Āhuru. Housing interventions provide disproportionate benefits for child and adult health[11] and the

[10] Baker MG, Gurney J, Oliver J, Moreland NJ, Williamson DA et al. Risk factors for acute rheumatic fever: literature review and protocol for a case-control study in New Zealand. International journal of environmental research and public health. 2019 Jan;16(22):4515 and Michael Baker, et al., Modifiable risk factors for ARF: results from NZ case-control study. 2019, University of Otago: Wellington.

[11] Jackson G, Thornley S, Woolston J, Papa D, Bernacchi A, Moore T. Reduced acute hospitalisation with the healthy housing programme. Journal of Epidemiology & Community Health. 2011 Jul 1;65(7):588-93 and the body of evidence from the

HHI national evaluation[12] (previously presented to CPHAC) confirmed this noting:

- For every ten children referred, in the first year after intervention there were
    - one fewer hospitalisation
    - six fewer GP visits
    - six fewer filled prescriptions
- A $30 million in health care costs averted over three years
- A return on investment is less than two years.

These results underestimate the actual benefits as they related only to health costs for the index referred child. An updated evaluation is underway, and we welcome the recent Government budget announcement of continued funding for HHI.

Evidence from the national case-control study indicated that factors such as having a family history of ARF, household crowding, mould and damp homes, limited access to hot water for washing and consumption of sugar sweetened beverages (SSBs) had significant independent relationships with risk of developing ARF.[10] There was no evidence for oral health, skin infection alone, living with a tobacco smoker, or barriers to primary healthcare being independent risk factors. The study further indicated that attending a school where throat swabbing services was available did not decrease the risk of developing ARF in children. Evidence for preceding throat infection was noted in 49% of cases, and skin infection and a sore throat in 21% cases (skin infection alone was not statistically significant).

Notably this study methodology matched cases and controls by age, ethnicity, deprivation, DHB, and time period, all of which are known risk factors for ARF. By doing this it advances the understanding or risk factors for ARF specifically in Māori and Pacific children and young people living in areas of similar deprivation and with similar rates of ARF.

The case-control study team made the following recommendations:

- A sustained holistic approach to improve housing conditions
    - prioritisation of vulnerable children for interventions to improve housing conditions
    - addressing household crowding, reducing bed sharing by children
    - improving housing quality – insulation, heating, addressing damp and mould, and introduction of housing warrant of fitness
    - reducing costs of home and water heating
- Revised population approach to GAS infection management could include
    - targeted and intensive approach based on family history of RF combined with demographic factors including age, ethnicity
    - treatment of both sore throats and skin infections including free treatment of scabies (note: already done in school-based programmes)
- Improved diet for children
    - reducing the consumption of SSBs among high risk children
    - interventions aimed at reducing overweight and obesity.

Housing and Health studies for example this review Chisholm E, Pierse N, Davies C, Howden-Chapman P. Promoting health through housing improvements, education and advocacy: Lessons from staff involved in Wellington's Healthy Housing Initiative. Health promotion journal of Australia: official journal of Australian Association of Health Promotion Professionals. 2020 Jan;31(1):7-15.

[12] https://www.health.govt.nz/publication/healthy-homes-initiative-outcomes-evaluation-service-initial-analysis-health-outcomes-interim-report

6. Auckland DHB activities

Since the introduction of the RFPP in Auckland DHB there have been a range of approaches introduced, informed by an expert advisory group. The housing component was introduced later within the programme and is not the main focus of this update. A full update was presented to CPHAC in late 2019, and results are routinely reported in the PFO update to CPHAC and the Board.

6.1.School sore throat swabbing and management programme

As noted previously, the Auckland DHB programme received comparatively less funding and implemented free assessment and treatment in 16 decile 1 primary schools. The programme had all the key components identified in the clinical trial: active identification of sore throats and skin infections by community health workers and nurses in the schools, free assessment and treatment, health promotion, and follow-up for affected whānau members. It did not have the same intensity as the Counties Manukau programme for:

- Geographic location: All schools in a suburb in CMDHB cf. targeted schools in ADHB
- Frequency of swabbing: Five days per week in CMDHB cf. three in ADHB
- Attempted reduction in GAS load: CMDHB undertook case finding 1-2 times per term (for identifying GAS pharyngitis in children who do not self-report a sore throat), cf. none in ADHB except for whole class swabbing where there were multiple children in a single class with GAS. Introduction of the school-based clinics in ADHB did reduce the overall GAS load in those schools; however, this was not followed by a reduction in ARF prevalence.

It can be seen in the geomap of ARF cases 2016-2021 in the Appendix that the geographically clustered approach is efficient in Counties Manukau DHB, but that throughout the rest of the region cases are dispersed. Given the low coverage of the Auckland DHB programme and the lack of impact on rates seen in our area or in the Counties Manukau area, it is difficult to know whether more investment into the school-based programme (reach within funded schools, or coverage of more schools) would have made a difference or not.

6.2.Health promotion and health literacy initiatives

In 2015, a large advertising campaign was launched in those communities with a high incidence of RhF to raise awareness and educate about the importance of getting sore throats checked. The 'Katoa twins' campaign generally engaged the community well and led to some behaviour change. The DHB also funded (and continues to fund) the B4SC providers to deliver health promotion for the target population. This includes messaging about the importance of getting a sore throat checked, and tips on practical healthy housing activities (such as not drying clothes inside and letting water vapour out by opening windows or turning extractor fans on in bathrooms and kitchens). An evaluation of this initiative will be undertaken this calendar year. Community nurses and community health workers continue to provide some health promotion for RhF prevention as part of their work in low decile schools.

6.3.Primary care responsiveness and role in a new model

As previously discussed with CPHAC, the traditional primary care model of health care delivery does not always meet the needs of those communities who have the most need due to access and other barriers. This was demonstrated in an 'access audit' undertaken by the DHB which showed low levels of cultural competency or understanding of the Rapid Response (RR) programme contracted for by the DHB, through PHOs. (The RR programme was delivered by selected practices that had a high proportion of younger Māori, Pacific and economically deprived enrolled patients). In addition, the expectation that people would go to a different practice from their family doctor's for sore throat management did not work in practice. Consequently, effective coverage was, in reality, poor.

Since the 'access audit', PHOs engaged their contracted practices individually to provide feedback on performance and provide examples of exemplary practice (as demonstrated by those practices that performed well in the audit). After the programme began, free care for under 13s was introduced and clinical guidelines were developed. Primary care leaders agreed that delivering appropriate (culturally and clinically) care should now be business as usual for all practices.

It was agreed with PHOs that from 1 July 2017 contracts with the PHOs for ARF would be based on a fee for service model, where a practice could invoice for a nurse-led throat swab for the target population group who are 13-19 years old (free for under 13s). Case finding was to be introduced and the option of a once only antibiotic injection (bicillin) rather than a ten-day course was funded and offered. All practices were expected to deliver services in line with the National Heart Foundation Guidelines. In practice, few claims were submitted for swabbing with almost no evidence of any bicillin injections being given, in spite of community focus groups indicating about half of the families would prefer that option as it was 'over and done with' (albeit painful).

6.4.Bicillin Secondary Prevention Programme

Some of these initiatives have continued and improvements have been made. Notably improvements were made in the delivery of the bicillin programme. It has been outlined recently[7] that if one area of investment other than housing is the focus, it should be on secondary prevention through ensuring compliance with the 28-day cycle of bicillin injections required for the ten years following the first presentation with ARF. The improvements to the bicillin programme were more pronounced in the programme delivered by the child health team, and it is suggested that these teams should stay with existing (and some new) clients for longer, due to the known risks with becoming 'lost to services' during transitions in care. Adherence to the 28-day cycle is near 100% with the Starship Community service, but closer to 80% under the service delivered by the (adult) District Nursing Service.

7. Current initiatives

Current work being undertaken or planned for in the Auckland DHB and Waitematā DHB regions in support of managing ARF are covered below:

Primordial

- Referrals to Noho Āhuru for people with RhF and at-risk of developing ARF (noting family members are at a higher risk)
- Health promotion via Well Child Tamariki Ora (WCTO) nurses during the Before School Check (B4SC).

Primary prevention

- Continued free sore throat assessment and treatment for children and young people presenting to nurses at low decile primary schools and secondary schools (through the SBHS). These rely on children/young people self-identifying or reporting to teachers .however as nurses and CHWs no longer actively search out symptomatic children.
- Continued free sore throat assessment and treatment according to National Heart Foundation guidelines for children presenting to primary health care (free for under 13s).
- Continued linkage with ThinkPlace: MoH-funded co-design initiative exploring approaches and potential interventions for communities at risk of RhF and for whanau with a family history of RhF
- Continued work with the Health Quality and Safety Commission (HQSC) to develop a primary care project regarding sentinel events and quality improvement.

Secondary prevention

- Continued rheumatic fever disease management group and associated quality improvement initiatives.
- Continued case reviews, and associated quality improvement initiatives
- Rheumatic Fever Nurse Specialist based in cardiology to coordinate care.
- Establishment of a nursing role to work alongside Noho Āhuru – Healthy Homes social workers, noting the increased risks for family members (and to provide a holistic health service looking for other unmet health need).
- Ongoing quality improvement initiatives for the Bicillin services via community nursing (PHNs and District Nurses). Current adherence rate for Starship Community is 99-100%, and for adult and long term conditions is 75-85%. A small amount secondary prevention is delivered via primary care. The absence of a national rheumatic fever Bicillin register among a mobile population makes tracking and monitoring difficult.

Tertiary prevention

- Health promotion and animations regarding ARF, RHD and self-care (available on kidshealth and soon to be in Te Reo, Tongan and Samoan)
- ARF/RHD multidisciplinary clinic: One stop clinic with adult and paediatric rheumatic fever specialists, cardiologists, ARF nurse specialist, echocardiogram, free dental care, free flu vaccine and warm handover by paediatric team to their future adult clinician
- Review of disease management and transition process from paediatrics to adults given drop off in adherence at this time. Note multiple life changes and transitions occur at this time: school to work/training, paediatric to adult community nursing bicillin administration, paediatric to adult secondary care for RHD, and increased reliance on self-care rather than parental care. Explore continuing the relationship with paediatric community nursing service over this transition time period (have typically seen the same nurse every 28 days for 4-8 years by then).
- Involvement in Pū Manawa Aotearoa: newly developed national Rheumatic Fever/RHD network of cross-sector stakeholders including consumer representatives with Māori and Pacific co-leads and aims to contribute to reducing the incidence of ARF and RHD, improving outcomes for those living with ARF/RHD, and ultimately the elimination of ARF/RHD as a health problem in Aotearoa, and to contribute new knowledge and expertise to support global efforts to reduce the health impact of ARF/RHD. Through this, we support the recommendation of a national Rheumatic Fever and RHD disease management register.
- Regional nursing collaboration to ensure efficient and consistent RhF management
- Rheumatic fever/RHD being now one of three target conditions for the cardiovascular NRA work.

8. New Initiatives 2021

New work is ongoing for the four short-term/high impact initiatives:

- *Identification of culturally safe ways to increase referrals to the Noho Āhuru - Healthy Homes initiative.* A procurement process has been completed to recruit both Kaupapa Māori and Pacific researchers who will use guidance from families to develop resources or a kete to assist health professionals asking about housing conditions, bed sharing, and household income etc. Planning is underway to gather insights from health workers who will be 'end users' of the resources.
- *Piloting of whānau support worker programme.* Work is underway to develop a service specification for this programme alongside the nursing service which will partner with the social workers in NA-HH, as there are synergies between the two programmes. This role will help address the social complexities experienced by these patients, and reflects the medical team's observations that social needs are compounding health needs.

- *Piloting dental health services for adults with Acute ARF / Rheumatic Heart Disease.* Secondary prevention activity. Community based clinics are being funded to provide free oral health care for patients with RHD (NHF guidelines recommend 6 monthly dental care). Adult RHD patients generally do not access this due to cost and are at significant risk of infective endocarditis (high mortality and high cost).
- *Finalisation, evaluation and release of 'Fight the fever' mobile app.* This app was co-designed with young people with rheumatic fever to increase self-management and encourage regular bicillin as they transition to adulthood. The app has been launched, and young people on monthly bicillin injections are now being recruited to the evaluation.

The project manager is working with a Public Health Physician Registrar on opportunities for increasing awareness specific for Pacific and for Māori communities, which may include schools and pharmacy settings.

Other mobile primary services going into communities (Māori mobile services or Pacific mobile services as seen in the COVID response) could potentially improve access, and could undertake throat swabbing and provide sore throat management.

9. External projects underway

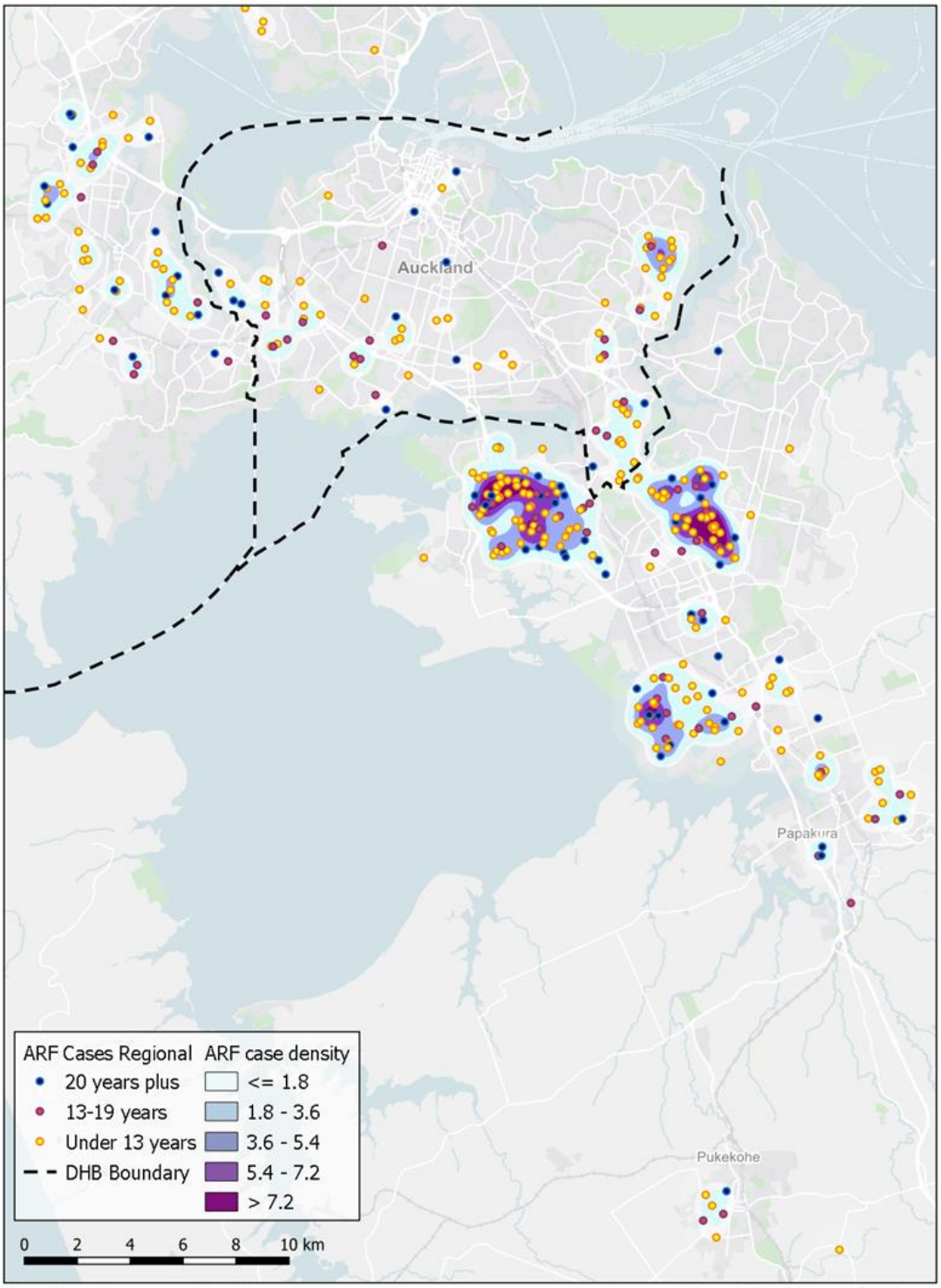
As context, nationally there are a range of activities related to ARF in progress:

- **GAS vaccine:** Research and development is ongoing nationally and internationally but is expected to be more than five-ten years away.
- **Extended evaluation of the HHIs:** Further analysis of the health gains and cost benefits of the HHI interventions on the whole whānau expected later this year.
- **MoH-funded co-design project:** Underway. Prototypes likely to be piloted next year with final results and systems change anticipated mid-2023.
- **Update of National Heart Foundation Rheumatic Fever Guidelines:** Potential co-funded project Starship Foundation and Ministry of Health to update guidelines based on recent evidence and transfer into more usable digital format.
- **Novel intervention for acute Rheumatic fever:** RCT of hydroxychloroquine commencing this year. PI Dr N Wilson, Auckland DHB. Funded by curekids.
- **Risk factor study:** Start: exploring biomarkers for ARF and RHD. Just finished recruiting from Auckland DHB and Counties Manukau DHB. Will identify timely accurate diagnostic test for ARF and identify potential new therapeutic interventions.
- **Secondary prophylaxis improvement:** Australia and NZ developing an acceptable alternative to the painful IM bicillin injections. Anticipated trial late 2021.
- **Transition project:** MoH funded Counties Manukau DHB initiative for disease management 10-25 years of age. PI P Anderson and B Farrant, A Anderson.
- **National Rheumatic Fever/RHD register:** Election promise. Potential to be based on the COVID case tracking system but currently stalled due to other priorities including COVID vaccine rollout.
- **Sibling echo screening:** Approximately 5% of siblings of new cases of RhF have previously undiagnosed RHD. Secondary prophylaxis would reduce the risk of a recurrence of ARF with resultant worsening of RHD and reduce the prevalence of adults presenting with undiagnosed severe RHD. Pilot currently being implemented in Counties Manakau DHB where nurses are trained to do screening echoes (PI R Webb, funded by HRC).

10. Conclusions and Recommendations

Rheumatic Fever disproportionately affects young Māori and Pacific people. It is associated with poverty, poor quality (cold, damp and mouldy), and over-crowded living conditions. A vaccine has not yet been developed for GAS so our strategies need to be largely either primordial (e.g. removing the conditions which foster the disease (noting these are poverty and poor housing), or ameliorative (providing a high quality bicillin programme). The services that our Starship Community and PHN staff provide in primary schools are also essential but, alone, are insufficient as outlined.

Appendix: Geomap of cases of ARF 2016-2021.



Acute Rheumatic Fever cases by age group and density (2016 - 2021)

Source: Auckland Regional Public Health Service Surveillance Regional Report Q1 2021.

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Attendance and Apologies	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Conflicts of Interest	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Minutes – 17 March 2021	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points - Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5. General Business		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]