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

Wednesday, 17 March 2021

8:30am

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
17 March 2021

Venue: A+ Trust Room, Clinical Education Centre, Level 5, ACH, Grafton

Time: 8.30am

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

Agenda

Please note that agenda times are estimates only

8.30am **0. KARAKIA**

1. ATTENDANCE AND APOLOGIES

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?

3. CONFIRMATION OF MINUTES -18 NOVEMBER 2020

4. ACTION POINTS

There are no outstanding actions for review.

5. DECISION REPORTS

5.1 Terms of Reference

6. INFORMATION REPORTS

6.1 Planning Funding and Outcomes Update

6.2 AAA Screening Pilot with Tongan men

6.3 Tobacco Control and Vaping Update

6.4 System Level Measures – Quarter 2 Report

7. GENERAL BUSINESS

8. EXCLUSION OF PUBLIC

Next Meeting:	Wednesday, 16 June 2021 at 8.30am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

Healthy communities | World-class healthcare | Achieved together

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
Teulia Percival (Chair)	c	c	c	c	c	c	1
Michelle Atkinson (Deputy Chair)	c	c	c	c	c	c	1
Jo Agnew	c	c	c	c	c	c	1
Zoe Brownlie	c	c	c	c	c	c	1
Tama Davis	c	c	c	c	c	c	1
Peter Davis	c	c	c	c	c	c	1
Fiona Lai	c	c	c	c	c	c	1
Bernie O'Donnell	c	c	c	c	c	c	1
Michael Quirke	c	c	c	c	c	c	1
Heather Came-Friar	c	c	c	c	c	c	1
Michael Steedman	c	c	c	c	c	c	1
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	02.12.2020
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 – Freemans Bay School 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	18.02.2021
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
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 Owner/Operator– Mokokoko Limited Senior Advisor to DCE – Oranga Tamariki	05.03.2021

	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

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Minutes
Community and Public Health Advisory Committee – Commissioning Health Equity Advisory Meeting 18 November 2020

Minutes of the Community and Public Health Advisory Committee – Commissioning Health Equity Advisory meeting held on Wednesday, 18 November 2020 in the Marion Davis Library, Building 43, Auckland City Hospital commencing at 1:30pm

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Teuila Percival (Chair)	Dr Karen Bartholomew	Director of Health Outcomes – ADHB/WDHB
Michelle Atkinson (Deputy Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Tama Davis	Meg Poutasi	Chief of Strategy, Participation and Improvement
Peter Davis	**Auckland DHB Senior Staff Present**	
Fiona Lai	Samantha Bennett	Manager Asian Migrant and Refugee Health Gain
Bernie O'Donnell	Ruth Bijl	Funding and Development Manager Women's /Child and Youth Health
Michael Quirke	Nigel Chee	Interim General Manager Māori Health
Heather Came	Meenal Dugal	Funding and Development Manager – Mental
Michael Steedman	Deepa Hughes	Youth and Oral Health Portfolio Manager
	Leani Sandford	Pacific Health Portfolio Manager
	Raj Singh	Project Manager Asian Migrant & Refugee Health Gain
	Marlene Skelton	Corporate Business Manager
	Kate Sladden	Funding and Development Manager – Health of Older People
	Shayne Wijohn	Manager Māori Health Gains
	Tim Wood	Funding and Development Manager Primary Care
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia

Tama Davis led the Karakia for the meeting.

Chairs Introduction

Dr Teuila Percival gave a brief introduction and outline of her professional background advising that she was of Samoan descent and a Consultant Paediatrician at KidzFirst Children's Hospital, at Middlemore. Dr Percival holds a number of leadership positions in the Pacific health sector and academia. She is Head of Pacific Health and Senior Lecturer at the School of Population Health at the University of Auckland, Vice-President of the Pasifika Medical Association (PMA), a trustee of TaPasefika Primary Health Organisation and serves on a number of government health advisory

groups. Dr Percival has a specific interest in Pacific people's health and a passion for the community, service and equity.

1. ATTENDANCE AND APOLOGIES *(Page 5)*

That the apologies of Peter Davis and Bernie O'Donnell (both for late arrival) be received.

The apologies of Executive Leadership Team members, Sue Waters, Chief Health Professions Officer and Dr Margaret Wilsher, Chief Medical Officer be received.

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

There were no changes to the Interest Register and no conflicts with any items on the open agenda.

3. CONFIRMATION OF MINUTES – NIL

There were no minutes to confirm.

4. ACTION POINTS -NIL

There were no action points to review.

5. INDUCTION AND OVERVIEW

Karen Bartholomew, Director of Health Outcomes – Auckland and Waitematā DHBs tabled a slide presentation providing an overview of the previous CPHAC approaches to equity and spoke to the points raised therein. [Attachment 5.1.1]

This information was provided to assist in informing where members may like to direct work from this point forward.

The following points were made during discussion of the overview presentation:

- Tama Davis commented that this overview had provided him with a good understanding of what the critical success factors might be for moving forward. He would like to know how Auckland DHB could be more involved particularly with Kōtui Hauora around the devolvement of services back to regional Iwi. It would be good to see how that has been progressed and how the DHB is looking at supporting that and how it can be provided with the necessary weight and authority. It was advised that the December meeting would provide direction for these issues.
- Dr Teuila Percival commented that it was good to see the emphasis on the use of evidence and developing evidence when it is missing. She asked that with the equity focus being on Māori and Pasifika how much time was spent looking at Māori and Pasifika research and how much of that research was utilised. It was advised that this could be addressed during discussion of items 5.1 and 5.2

5.1 Planning Funding and Outcomes: Approach to Commissioning *(Pages 9-49)*

5.2 Planning, Funding and Outcomes: Summary of community investment and areas of focus *(Pages 50-70)*

Dr Debbie Holdsworth, Director of Funding – Auckland and Waitematā DHBs asked that the reports be taken as read and considered together.

The advantage of working as a joint Auckland and Waitematā DHB team is that some scale has been able to be developed and a lot of the work undertaken informs programmes that are subsequently rolled out nationally.

The team adhere to a number of key traits, including impartiality, and apply a consistent set of principles that drive our approach. These principles are:

- Elimination of gaps in equity of outcome
- Population health focus and needs assessment
- Evidence based or developing an evidence base
- Deep understanding of the data
- Continuous quality and equity improvement
- Partnership with people with lived experience, communities and providers of services

In terms of the earlier question in relation to utilisation of Māori and Pasifika research Dr Matire Harwood sat on the joint CPHAC. The team are very much aware of her research and have utilised it within their work, also a number of key clinical and academic Māori and Pasifika leaders are involved in some of the programmes outlined.

The following points were made during discussion:

An explanation was given as to how the team engaged with Te Tiriti in a number of ways. A memorandum of understanding exists with Ngāti Whātua as manuwhenua. The Māori Health Gain team have responsibility for the relationship with our Te Tiriti partner. The Waitematā DHB also has a memorandum of understanding with Te Whānau o Waipareira Trust. Both of these MOU partners are partners on the District Alliance in Primary Care.

Shayne Wijohn advised that the MOU partners were involved in any funding decisions that were being made. The DHBs engage through them with Māori communities to understand the issues and needs of communities.

Nigel Chee added that Kōtui Hauora which is the Iwi Partnership Board is the most visible manifestation of Te Tiriti in terms of the way in which the partners work together.

It was acknowledged that there were a number of pilot programmes were clearly showing good results with the AAA programme of work being seen as an exemplar. It was asked whether these could be moved from a pilot phase and kept going. Karen Bartholomew commented that the AAA Screening was seen as a programme of work intentionally taking action on a small but important gap in life expectancy. International evidence was used to inform that but the approach was to generate local evidence. There was a view that Māori had lower coverage in screening programmes but that if you design a programme by Māori for Māori that does not have to be the case. This was demonstrated by this

programme, it had high participation and it was cost effective. The extension is now to take the same approach to Pasifika particularly around language needs. The intention is to be able to provide back to the Board an effective model for AAA screening that is focussed on addressing inequities and what that would look like for the DHB, across the region and ideally nationally.

Introduction of Planning and Funding Team

Members of the team introduced themselves.
Meenal Duggal – Mental Health Care
Tim Wood – Primary Care and Pharmacy
Ruth Bijl – Child and Women's Health
Shayne Wijohn – Māori Health Gains
Kate Sladden – Health of Older People Services
Leani Sandford – Pacific Health
Samantha Bennett – Asian Health
Raj Singh – Asian Health

The following points were made during resumption of discussion:

Tama Davis directed a question to Tim Wood in relation to understanding patient/whānau voice in terms of the PHO. How is that community voice captured? Tim Wood gave an example of the work undertaken for the Diabetes Programme where both patient and whānau are brought into the room with the GP to discuss diabetic care. This work started with the use of social media to engage with Māori and Pasifika people in the community who had poor diabetes control and did not go and see their GP in order to understand what the issues were for those people. This information was presented to the PHOs and General Practice teams and is being used to get all parties in the room together to talk about the experiences Māori have had and the barriers they have around effectively managing their diabetes care. There are whānau, cultural and social issues that need to be taken account of. It is hoped that this will raise awareness with the General Practise teams around what they can do to at their level to respond in a better way. The challenge will be replicating this across all General Practises as this is a cultural shift for them too.

Tama Davis commented that he acknowledged that a focus had to be on GPs to get intelligence and change at a grass roots level; however it was the PHOs that applied for funding to support practise members to deliver in areas the DHB requires them to deliver to. PHOs were an area that required more work to get better information so that informed decisions could be made as to what service could be devolved and where community investment should be made.

Tim Wood referred to the Kare Programme which was only able to be worked through and have a funding model applied by actually working directly with the GPs to understand how that programme would work with their business models. The problem a funder or commissioner has is that people want to talk about money before talking about service and outcomes. There is effort being made to shift conversations to deal with outcomes and service models before talking about funding models. Ailsa Claire advised that in terms

of the diabetes programme a commitment was made to identify the full expenditure, including that funding which sat within the DHB so that all of that money could be placed in one collective pot. This allowed more freedom for decisions to be made around how to do things differently. However, trying to get PHOs to identify and itemise what they were spending on diabetes was problematic.

Michelle Atkinson acknowledged that the DHB had some serious problems to deal with in terms of equity and if the DHB was looking to change outcomes then some of these small but well-designed projects mentioned in the reports, for a small investment, make a very big difference. Michelle referred to rheumatic fever and healthy homes. Investing a small sum in a healthy home now provides an immediate benefit for children not to mention the wider household and the health outcomes of that child in the future. Therefore, it was important to prioritise these small projects because they were easy to lose sight of and to be the first to be cut in the face of what might be perceived as bigger problems to fund.

Tama Davis commented that in terms of Māori Health Gains he would like to see how the networking and on-going relationship building will enable the DHB to place itself in a good position to take on implementation of Wai 2575 in a meaningful way along with supporting the entry of the Māori Health Authority into the funding arena. Advice was given that there were several local and regional networks with providers directly placed in communities. While the relationships are important, they have to provide a good understanding of what the Māori health providers needs are along with the needs of the communities that they serve for the DHB as a funder to increase its investment.

Bernie O'Donnell asked whether a discussion had ever been had with the partners around what wellbeing looked like so that something could be co-designed that speaks to the partnership and starts to provide an understanding of what is meant by "Hauora" as opposed to a merely clinical Kaupapa. Bernie also raised the issue of socialising the concept of Manu Motuhake and working on getting that to resonate with the partnerships. It was advised that there is clear good will and intent across the DHBs and that there is a structure in place in terms of Kōtui Hauora with opportunity in terms of outcome, health gain and priorities for Māori. What does not exist is the right process which has been delayed due to the challenging year that 2020 has been. Given that the planning cycle for 2021/2022 is about to begin the time is right for these conversations to be had to bring all threads together from the perspective of the partners and the Crown through the DHBs. Kōtui Hauora is the beginning of the process and it is hoped that as a result of this process an agreed plan that the Crown and Māori through Kōtui Hauora can agree to results.

Energy needs to be focussed on those things that will bring the biggest and greatest gains given that resource is constrained.

Resolution:

That the Community and Public Health Advisory Committee note:

1. **The focus of Planning, Funding and Outcomes on equity and evidence informed commissioning initiatives.**

2. **The exemplar case studies provided to illustrate the commissioning approach.**
3. **The need for continued investment in primary and community services to achieve equity and address the continuum of prevention, early detection and service needs including the impact on secondary care.**
4. **The range, value and breadth of community investment and areas of focus.**
5. **The constraints on funding and contracting arrangements, with limited discretionary funding opportunities.**

Carried

6. ASIAN, NEW MIGRANT, FORMER REFUGEE & CURRENT ASYLUM SEEKER HEALTH PLAN 2020-2023 *(Pages 71-125)*

Samantha Bennett, Manager Asian Migrant & Refugee Health Gain – Asian Health and Raj Singh – Asian Health Gain

Advising that the Plan is a collection and collation of all the effort in the Planning and Funding outcomes space across the two DHBs. It has been guided by the health needs assessment completed in 2017. This information highlighted that overall Asian populations do experience very good health outcomes and life expectancy. The recommendations from the report highlighted some nuanced disparities that some of the target population experience. It was decided as a result to create a new plan that addressed these disparities for select groups. The plan tabled today does not specifically outline everything done for all the Asian population but it specifically addresses where health gains and improved health outcomes can be made.

There are three key areas around capability and capacity building. If granularity can be obtained in data and an understanding gained of level four data for ethnicity, then a more nuanced view of the Asian population can be formulated.

Another key area is around access to health services with a focus on primary care for Asian, new migrant and former refugee and current asylum seeker groups. This opens the door for those communities in accessing language via an interpreter at primary care level in particular to access wrap-around support.

The last area is around partnerships. Work has been done with the Northern Region Health Coordination Centre during the two outbreaks of COVID 19. The learnings from these outbreaks in relation to communication and welfare support has shown that there is a need to ensure strong relationships and partnerships with ethnic and religious leaders and ethnic associations. These relationships will assist in supporting the effort required to deliver this new plan over the next three years.

There is an Asian and MELAA Governance Group who are members of the Planning and Funding Outcomes Team across the two DHBs for the portfolios that were highlighted. It Quarterly progress is monitored via a scorecard. The Governance Group feeds information through to Committee Funder Updates and CPHAC reports.

The following points were made during discussion:

Dr Percival agreed with the points made in the introduction noting that this was such a diverse group making it very important to disaggregate and collect the right data as needs are going to be so different. There are some concerning issues around diabetes in some subpopulations and asylum seekers must have mental health issues which are not being addressed.

It was asked how much of the greater Auckland population fits within the category of new Asian, migrant and former refugee and current asylum seekers. Advice was given that 70% of this population lives within the Auckland region. Auckland DHB has 35% of the Asian population and significantly what is seen with this population is a growing Filipino, south East Asian demographic. Chinese and Indian are still the biggest demographic.

The other area of focus would be the Middle Eastern group. That became obvious was seen during COVID 19 with the Botany cluster where, even though the population was within the Counties Manukau DHB area, the ripple effect from the cluster cascaded into Auckland DHB. A lot of effort went into ring fencing this cluster so that the Auckland DHB Middle Eastern communities weren't impacted.

The Asylum Seeker population typically lives within the Auckland DHB boundaries and they do so because they need to be close to the INZ Building in the central city. A lot of these communities are living in the fringe suburbs around the city or living in the Asylum Seeker Trust Hostel.

It was commented that this appeared to be a large work programme for 1a small team. In terms of what is laid out in the Plan is it thought that the actions are achievable with collective effort across the Planning and Funding and Outcomes and partner organisations. While Samantha and Raj led the Plan a lot of effort goes into influencing peer portfolio groups to assist. This Plan may be ambitious but at the core of it is a focus on Primary Care, Mental Health and Oral Health as this is where the greatest disparity lies for new Asian, migrant and former refugee and current asylum seekers.

It was asked that in terms of the network spoken of, whether schools are part of that as many have students where English is a second language. It was advised that the Child and Women's Health Team were utilised to identify, particularly former refugee students, in the school-based health network. GP access for Asians has improved due to awareness raising around the role of a GP. There are areas of improvement for Asian youth who may not understand the role of a practise nurse or primary care or seeing a nurse at school. There are issues around confidentiality as communities worry that someone else within their community may find out about their personal details. There is more work to do to understand how this fear can be addressed.

It was commented that for a number of these communities' midwifery is not part of their cultural norm. Is this something that is being addressed? It was advised that a NZ Health System video has just been developed to increase awareness to new migrants and it has been translated into Mandarin, Korean with Arabic the next translation to be provided. There is a newly crafted message to be inserted into the video around, "When you are pregnant what do you do?" While people do go to their GP it is the other things that you

are required to do like finding a midwife.

It was noted by Fiona Lai that different cultures will accept different types of health promotion and that needs to be clearly understood. Accessibility and navigating the health system are very important so data is important to know where to focus effort. Fiona asked whether the Team felt that they had tapped into all the different partners within the Asian community or more work was required in this area.

It was advised that an Asian campaign is being launched this week as a result of the recent COVID cases within the CBD with a focus on traditional Chinese language. It will be aimed at the Hongkongese, Taiwanese and other communities that prefer to read information in traditional Chinese. Nuance around language is very important. It was noted that even though Filipinos in general speak very good English they themselves had asked for material that was important to them to be provided in Tagalog.

It was advised that there are only a few key core key players within the Asian community that have the required reach into their communities. The safe guard is dealing directly with these key leaders and agencies that it is known can get the message across.

The inclusion of the statements (transferred from the Annual Plan) including reference to Article 4 [guarantee around customs and beliefs] of Te Tiriti was commented upon. It was noted that reference needs to be discussed with manuwhenua and kaurangi around what that might mean for them.

Action

It was agreed that the areas around Te Tiriti be flagged in the Plan for consideration when the Plan goes to Board for final endorsement.

Resolution: Moved Zoe Brownlie / Seconded Tama Davis

That the Community and Public Health Advisory Committee recommend to the Board that it:
Endorse the Asian, New Migrant, Former Refugee and Current Asylum Seeker Health Plan 2020-2023

Carried

7. ORAL HEALTH - UPDATE *(Pages 126-151)*

Ruth Bijl, Funding and Development Manager Women's /Child and Youth Health asked that the report be taken as read, highlighting as follows:

There are fundamental challenges to be addressed in the oral health space. The system has been in place for more than 20 years and it is time that it be reviewed and redesigned.

Dr Percival commented that it was a very concerning situation. Ailsa Claire advised that there was a programme of work being undertaken to address the waiting list however the critical action lies with the future redesign of the system. She made mention of the Regional Vulnerable Services Framework which is work being undertaken on a number services where rapid change is absolutely required. The oral health issue will become part of that framework.

It was asked whether the waiting list of 2000 were children who had been seen and were waiting for a general anaesthetic or that they simply had not been seen or a combination of both. It was advised that these were children waiting to be seen. There were some children who absolutely needed to be seen because they had congenital abnormalities as opposed to those that were well but had bad teeth requiring removal under anaesthesia.

There was a need to work through the process with those people accessing the service to fully understand what the solutions might be that work for them. There is also the school age to 18-year-old youth cohort to consider, wherein only 50% of Māori youth are being seen by a dentist under the combined dental agreement arrangement. In terms of the highest impact however Ailsa Claire advised that a significant number of the children referred to the specialist dental service are under five years of age.

It was asked how the COVID19 investment referred to would help address the backlog. It was advised that it would allow referrals to be dealt with as they came in so that no new waiting list was being built up.

It was acknowledged that the pre-school cohort was critical as preventative health education was required to halt dental disease. Part of what the Auckland Regional Dental Service (ARDS) does is visit early childhood and kōhanga reo settings to provide fluoride varnish, dental health promotion and other dental work. It is known that there are cohorts of children who are missing out on being seen. Stakeholder research has shown that people do not have a good awareness of healthy teeth messages and of the services.

There is one piece of work specific to Auckland DHB around maternal oral health which it was hoped to progress further when the evaluation of its efficacy was received.

Bernie O'Donnell commented he was not sure whether oral health had been prioritised correctly. He asked that over the next months the Committee be informed of what was being done to engage with Māori and Pasifika to reverse these statistics. He asked whether the capacity existed for the DHB to develop its own programmes or did it wait for someone else to develop something. It looks like once again the DHB is the ambulance at the bottom of the cliff which is frustrating.

Ruth Bijl acknowledged that it was a difficult situation made worse by COVID 19. A clear view had prevailed that dental procedures were a high risk and should not be performed during certain COVID alert levels which had placed providers in a situation of not being permitted to provide a service. Ailsa Claire agreed noting that a number of the dental vans had been reassigned to deal with COVID testing.

The use of the mobile units led by Māori and Pasifika during COVID 19 demonstrated that there were different ways of engaging and that in some instances you simply had to have a go and try something different rather than waiting.

It was acknowledged that while there were certain aspects during COVID 19 that prevented care being offered and which had dismantled any gains made, the situation did exist pre COVID 19. What COVID 19 had provided was seed funding which provided a platform to move forward on. The funding is sufficient to deal with the combined Auckland DHB children currently on the waiting list. There is an inclusive common goal

across all four regional DHBs to address this situation.

Advice was given that the Auckland metro region has the highest number (310) combined dental providers. In addition to that there were three mobile dental units which cover the low decile 1-5 schools. Statistics show that there are a high number of Māori and Pasifika teenagers engaging with this service. The model of taking the service to them works. The inequity is seen in the higher decile schools. There is also a cultural aspect to be aware of as some teenagers find it difficult to walk into a high-end dental practise which is very different from what they are used to in a school dental service. Work is being done with these providers to get them to understand how best to provide a service to and engage with this cohort.

Tama Davis, like Bernie O'Donnell wanted the team to provide guidance around where the service should be heading and what it should look like. It might be that divestment of some parts of the service is required and reinvestment in others. Ruth Bijl responded that something could be designed for the vast majority and they would use that service. However, it does not work for all and that is where the effort has to be made to ask those families what they require to make it work for them.

It was asked what the plan was, outside of co-creating with the community, as something has to be in place in the short term to turn this situation around. Advice was given that the key concern was around dental disease starting and progressing so preventative health education was critical.

Bernie O'Donnell suggested that a visit be paid to Takaparawhā to see what was being done in terms of working with other organisations in the area of wellbeing. They are working with these agencies in shared space and are able to stipulate what is required. This arrangement allows very good access to the people. There is a level of trust being the people are interacting with trusted voices and trusted faces. This situation requires outreach with the genuine intention to do things differently.

Concern was expressed again that money itself was not going to address these issues and Ailsa Claire was asked what political landscape existed that would allow the situation to be thoroughly reviewed. Ailsa Claire advised that the money would reduce the waiting list for people who had been referred for secondary care but not solve the core issue. The DHB needed to get itself in a position where outcomes could be determined and different things tried. The money would not need to be spent in the secondary service if the core of the problem at the pre-school level was addressed. How do we all collectively stop this issue which relies on a cultural change being made? It is largely sugar laden drinks that are causing this problem.

Working with the region specific funding has been allocated to Waitematā DHB to address the redesign of the children's school service and specific funding allocated to Auckland DHB to address the waiting list in the secondary service. That is a real opportunity to undertake a total rethink around service delivery but with the assistance of those using the services.

Assurance was provided that the waiting list was being addressed now and in terms of the service redesign under the Vulnerable Services Framework that would enter a "rapid

process" which would take six weeks to provide a pathway for what should be done next.

In reply to a question asked about what opportunities were being explored for Pasifika children Meg Poutasi advised that this why a regional approach was so very important as a large number on the list were Pasifika children based in the Counties Manukau DHB. The solutions must be designed together to be effective.

Resolution:

That the Community and Public Health Advisory Committee:

1. **Notes that oral health is a vital component of general health and that there are persistent inequities for Pacific and Māori children.**
2. **Notes that some good progress had been made against the equity focused 2017 Preschool Oral Health Action Plan, but gains have been lost due to COVID-19 outbreaks and on-going requirements placed by the Dental Council of New Zealand.**
3. **Notes that there are significant delays in time to treatment for hospital-based (secondary) dental care that have led this to be identified as a vulnerable service in the regional services plan.**
4. **Notes that Auckland DHB has used $650k of the Ministry of Health Planned Care COVID-19 catch up activity funding to fund additional secondary dental capacity to address these delays in three above.**
5. **Notes the need for urgent additional targeted approaches to improve access to oral health services for Māori and Pacific children and adolescents, cognisant of the on-going risk of COVID-19 and Dental Council of New Zealand requirements. Further work will be undertaken within the Regional Vulnerable Services Framework.**

Carried

8. ARPHS - UPDATE *(Pages 152-176)*

Dr William Rainger, Director and Jane McEntee, General Manager were in attendance to answer questions relating to the report.

The service has primarily been focused on the COVID response since late January. Following the first wave June and July was spent building capacity to deal with future community outbreaks. In particular, with the support of the DHB and the region capacity was built to respond to community outbreaks in vulnerable communities; Pasifika and Māori. In August the second wave came which disproportionately affected the Pasifika community. The service was relatively well placed to respond to that with the assistance of the DHB.

Systems, capacity and resource are again being reviewed and rebuilt to respond to future outbreaks while managing smaller outbreaks as they occur such as the Maritime Technology Worker and recently the November Quarantine outbreak. It is hoped that the combined health sector and multi-agency approach will enable cases to be identified very early on and therefore allowing a strong response to be mounted across the health sector to manage these situations.

The service does have other responsibilities and while 60%-80% of capacity is deployed to

dealing with COVID 19 it is important that other critical public health functions are continued. Particularly important is the area of communicable diseases, notable being tuberculosis as the last thing required is multi drug resistant TB emerging because of the focus on COVID.

The population health improvement work is important and some work has managed to be continued in the areas of tobacco, alcohol and "Healthy Auckland Together".

Looking forward the Government has signalled its intention to move forward with changes in how Public Health Services are configured and delivered and ARPHS is keen to work with the DHBs on a regional basis to ensure that whatever emanates from that review will work best for the Auckland population.

The following points were made during discussion:

The good work being done in the areas of drinking water, smoke-free and alcohol pre COVID 19 was acknowledged with concern being expressed that with the continuation of COVID 19 outbreaks the service might not be able to get back to full capacity in those areas. It was advised that since May a COVID 19 response unit had been built within ARPHS to not just allow a COVID response but also to ring-fence ARPHS resources allowing this other work to continue. It is impossible to say when the Service would be back to normal strength but there was a commitment to deploying as much resource as possible to other work.

Jane McEntee advised that the Service also looked to see where it might participate regionally and nationally to support some of that other work and gain a wider impact. The Service participated in the Public Health Advocacy Group which is led by the NRA and endorsed by the DHB CEOs across the country.

It was advised that the Northern Regional Health Coordination Centre is an incident management response structure that is fully regional and includes Northland which has particular work streams dedicated to primary care, for testing, Māori and Pacific health and other functions and is based in Bledisloe House in the city. ARPHS is an operating unit within that wider structure. When there is an outbreak then testing and primary care is an important part of that response. ARPHS works by linking with the NRHCC to deliver that component.

In a response situation it is ARPHS responsibility to receive the notification of that case and mount the immediate response to the case and undertake the required contact tracing. The region supports the response in terms of the testing and primary care components.

Ailsa Claire advised that ARPHS have had to flex up in a way that they have never had to previously. The only way that could occur was by DHBs offering staff. When staff were first required schools were shut so school nurses were transferred to ARPHS. Staff cannot just turn up at ARPHS and begin work they must undertake training. As there was not a long enough gap between the first and second COVID waves other groups of staff could not be trained so the same pool of people were being drawn upon during the second wave and this time schools remained open. There is now a complex plan around bringing in additional staff to ARPHS which relies on core funding and a flex group that have a shadow roster so if they are required, they can be brought in without adversely affecting the

hospitals BAU. Work is also being done to look at how new graduate nurses can be brought into the hospital releasing more qualified staff to be transferred to ARPHS.

Dr Rainger added that there was another dimension to assisting ARPHS in the way that Ailsa Claire had described and that was the national network. This is through the Ministries National Investigation and Tracing Centre with the concept being that the Ministry and Public Health Units around the country should be able to work as a distributive network and share out the work. It is complicated in terms of delegations as to who does what in a safe and effective way. That is progressing and improving. In the latest outbreak Waikato has been assisting with the management of the cases from the managed isolation facilities. The more efficient that becomes the more ARPHS will be able to protect some of its core resource to undertake core business.

Meg Poutasi commented that one of the things that the pandemic had provided was an opportunity to review and learn. ARPHS were to be congratulated on how quickly they have responded and adapted their model to be more responsive to the community. In the first stand-up the Pacific team at the NRHCC was significantly larger than it was in the second and third response because functions were able to be delegated into ARPHS as a result of their review following the first wave and the design of a Pacific model which was incorporated into ARPHS structure. The second thing they did was picking up social support and moving that into a public health response model which allowed a very smooth referral process with the Whānau Ora Commissioning Agency. One of the other benefits of this model of evolution may well be the gains made in working with Pacific providers regionally and the willingness of those providers to be involved in public health conversations going forward. For instance, messages about sugary drinks and immunisation can be pushed through that network. It will be important to preserve and maintain these relationships and networks for other public health good.

Resolution:

That the Community and Public Health Advisory Committee

Receive this update from the Auckland Regional Public Health Service (ARPHS) on key areas of work that are underway and/or have been completed between January and September 2020.

Carried

9. HPV SELF TESTING - UPDATE *(Pages 177-189)*

Dr Karen Bartholomew, Director of Health Outcomes – Auckland DHB and Waitematā DHB asked that the report be taken as read.

Acknowledgement was made of the women who had participated in the programme of work, the research team, providers across primary care and Māori, Pacific and Asian health advisors.

This programme of work was started to test the acceptability of self-testing in a New

Zealand context. Specifically to test a new technology in addressing current long standing persistent inequities in cervical screening. It was known that new technologies could make inequities worse if a specific design for process and approach is not undertaken. It was wanted to ensure that new technology could improve the participation in cervical screening and that it was done so with a focus on Māori women first.

There was a commitment to a Kaupapa Māori evaluation of that work before it was proceeded with any other population groups and that was done with partners in the WaiHealth Waipereira Research Unit. It was hoped that the Programme would have national influence which it did attain with the Ministry this year agreeing to accept self-testing as part of the national programme when it is rolled out. The challenge when it is rolled out is that a new national register will be required. That is important for a number of reasons but particularly because the cervical screening programme is governed by its own legislation.

The following points were made during discussion:

It was commented that while universal support may have been gained the programme was still in a holding pattern awaiting a rollout date, funding and the fact that a National IT system was required for the screening programme. There are good lessons to be learned from Gisborne and the Cartwright Report when things are not done right and there is a need to be mindful of those.

It was noted that it would take a big commitment from central Government to move this forward. Karen Bartholomew agreed and acknowledged her colleague Professor Beverley Lawton from Victoria University who was a champion of self-testing and promoting it widely. She had just been awarded additional funding to undertake further work for Northland. There is a drive from a Māori health perspective to ensure that self-testing stays front and centre in discussions with the National Screening Unit.

Resolution:

That the Community and Public Health Advisory Committee note:

1. **That the two equity focused human papilloma virus (HPV) Self-Testing studies are now complete with results awaiting publication.**
2. **The HPV Self-Testing research programme has demonstrated that the approach is acceptable and will improve equity of access, including for those women who are most underserved in the current screening programme. This research aligns well with similar work undertaken by research colleagues in Northland District Health Board.**
3. **The Parliamentary Review Committee in 2018 strongly recommended that HPV Self-Testing alongside primary HPV screening is implemented with urgency in the New Zealand national cervical screening programme.**
4. **On the basis of the successful local research and the clear international evidence there is increasing support in metro Auckland for local implementation of HPV self-testing in ahead of national programme implementation to address low coverage and worsening inequities. The volume of deferred screens related to COVID-19 has provided further urgency. It is likely that the national implementation of a primary HPV programme will be further delayed; noting that supportive infrastructure such a**

new national cervical screening register is not yet in place.

Carried

10. RESOURCE CENTRE *(Pages 190-213)*

10.1 System Level Measures Improvement Plan 2020/2021

[Information material to be read in conjunction with the papers in the agenda.]

The meeting closed at 3.45pm with a Karakia led by Bernie O'Donnell.

Signed as a true and correct record of the Board meeting held on Wednesday, 18 November 2020

Chair: _____ Date: _____

Teulia Percival

OVERVIEW OF PREVIOUS CPHAC APPROACHES TO EQUITY

Auckland DHB CPHAC

Dr Karen Bartholomew, Director Health Outcomes

Planning, Funding and Outcomes

November 2020

OUTLINE

- Auckland DHB Board Equity Sessions
- Broader Auckland DHB equity focus
- Waitematā DHB Equity Framework
- Equity focus in previous joint CPHAC
- CPHAC scorecard
- Auckland DHB strategy and CPHAC future focus

ADHB BOARD EQUITY SESSIONS

Session # 1: What equity means

Session # 2: Drivers of inequities

Session # 3: Governance for health equity – Choices and critical questions

ADHB BOARD SESSIONS QUESTIONS FOR DISCUSSION

- Do we have common understandings of equity?
- Do we have a shared framework for thinking about equity?
- Do we know what equity 'endgame' outcome we are trying to achieve?
- Do we feel equipped on the 'how' of equity – governance, leadership, service, individuals?
- Do we have critical questions we can ask?
- How do we measures ourselves/success?

SUMMARY SESSION #1

- Māori Health and equity
- Role of the DHB in reducing health inequities and improving Māori Health, legislation
- Equity definitions
- Equity parameters, importance of language
- Difference between health equity and healthcare equity
- Difference between equity of access and equity of outcomes
- Consideration of potential 'endgames' for equity of outcome

NZ PUBLIC HEALTH AND DISABILITY ACT

22 Objectives of DHBs

(1) Every DHB has the following objectives:

(a) to improve, promote, and protect the health of people and communities:

(b) to promote the integration of health services, especially primary and secondary health services:

(ba) to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs:

(c) to promote effective care or support for those in need of personal health services or disability support services:

(d) to promote the inclusion and participation in society and independence of people with disabilities:

(e) **to reduce health disparities by improving health outcomes for Maori** and other population groups:

(f) **to reduce, with a view to eliminating, health outcome disparities** between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:

(g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:

(h) **to foster community participation in health improvement**, and in planning for the provision of services and for significant changes to the provision of services:

(i) **to uphold the ethical and quality standards** commonly expected of providers of services and of public sector organisations:

(j) to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations:

(k) to be a good employer in accordance with section 118 of the Crown Entities Act 2004.

SUMMARY SESSION #2

- Drivers of inequity, detail and examples for each (Camara Jones/Robson & Reid):
  - Differences in the quality of care
  - Differences in access to care
  - Differences in the determinants of health, exposures, and opportunities
- What is racism; institutional racism?
- Reflection on governance role in equity as framing for session #3

BROADER AUCKLAND DHB EQUITY FOCUS

- Chair and Board, CEO, Exec, though organisation; awareness raising – equity and institutional racism
- Equity in commissioning – contracts equity audit, analysis of utilisation and cost, ongoing broad and issue-specific Health Needs Assessments and service responses
- Māori Health Plan review (underway) in relation to the Wai2575 report findings and MoH Strategy
- Māori Health Pipeline refresh and recommendations to Kōtui Hauora in Dec 2020
- Pacific Health Plan refresh align with Ola Manuia: Pacific Health and Wellbeing Action plan 2020-2025
- Asian, new migrant, former refugee and current asylum seeker health plan 2020-2023; previous International Benchmarking of Asian Health Outcomes report (2017)
- Provider arm focus in four areas – cancer, child health, women's health, mental health
- Hospital pathway assessments in the sprint work
- COVID-19 Māori health and Pacific health focused community, language, welfare and public health health support
- Post COVID-19 equity planned care focus – regional oversight group
  - Māori clinical governance and Pacific CTAG
  - Auckland DHB Navigator programme (early evaluation underway)

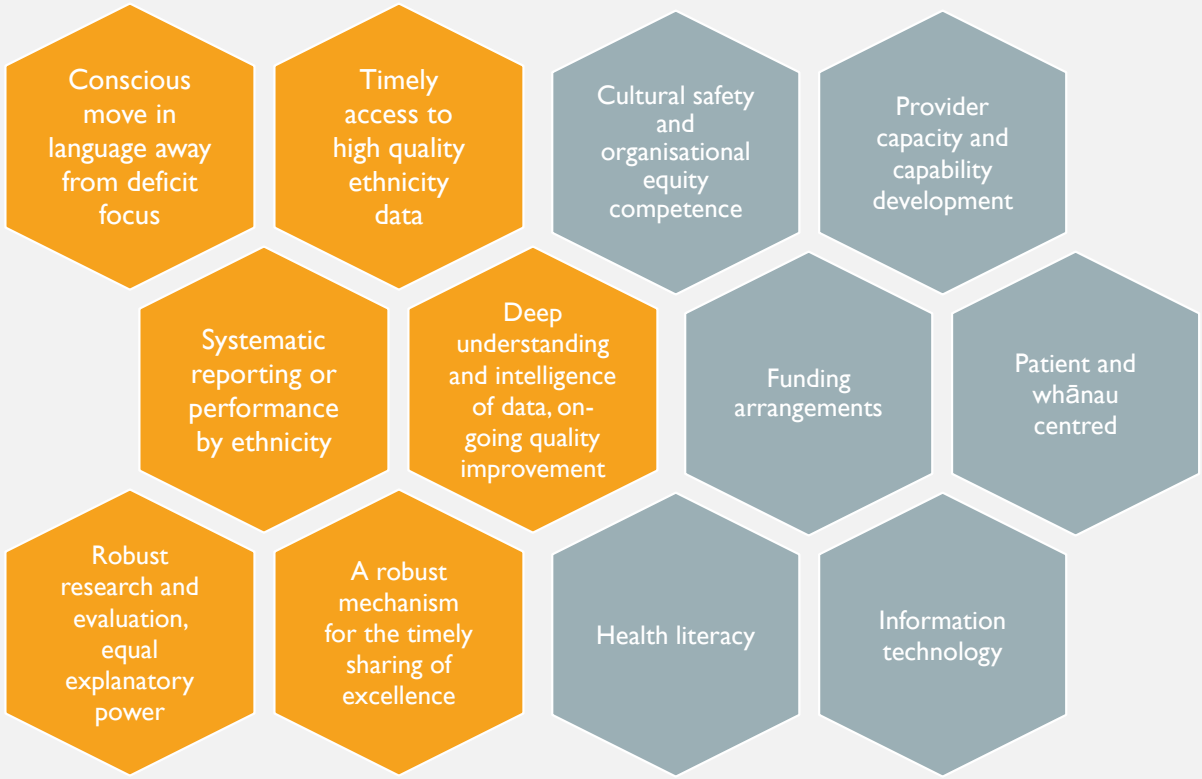
WDHB REFRESHED EQUITY FRAMEWORK BOARD APPROVED JULY 2018

- Framework of drivers of inequity of the Camara Jones/Robson & Reid: differences in quality of care, access to care and differences in determinants of health
- Referenced a number of equity and Māori health strategies, frameworks and documents – international, national, lcoal including the DHB Outcomes Framework and Nga Painga Hauora (Sir Mason Durie for the DHB)
- Improving life expectancy and reducing the life expectancy gap continue to be the primary objective
- Framework with 5 elements based on IHI model, with key enablers/building blocks
- Proposed critical governance questions developed from HEAT/Whānau Ora tools and promotion of He Pikinga Waiora evaluation planning tool

FIVE ELEMENTS OF FRAMEWORK

1. Health equity as a strategic priority
2. On-going investment in partnership approach
3. Develop structures and processes to support equity work
4. Ensure that equity is a key component of quality in delivery of care
5. Deploy specific strategies

BUILDING BLOCKS / ENABLERS

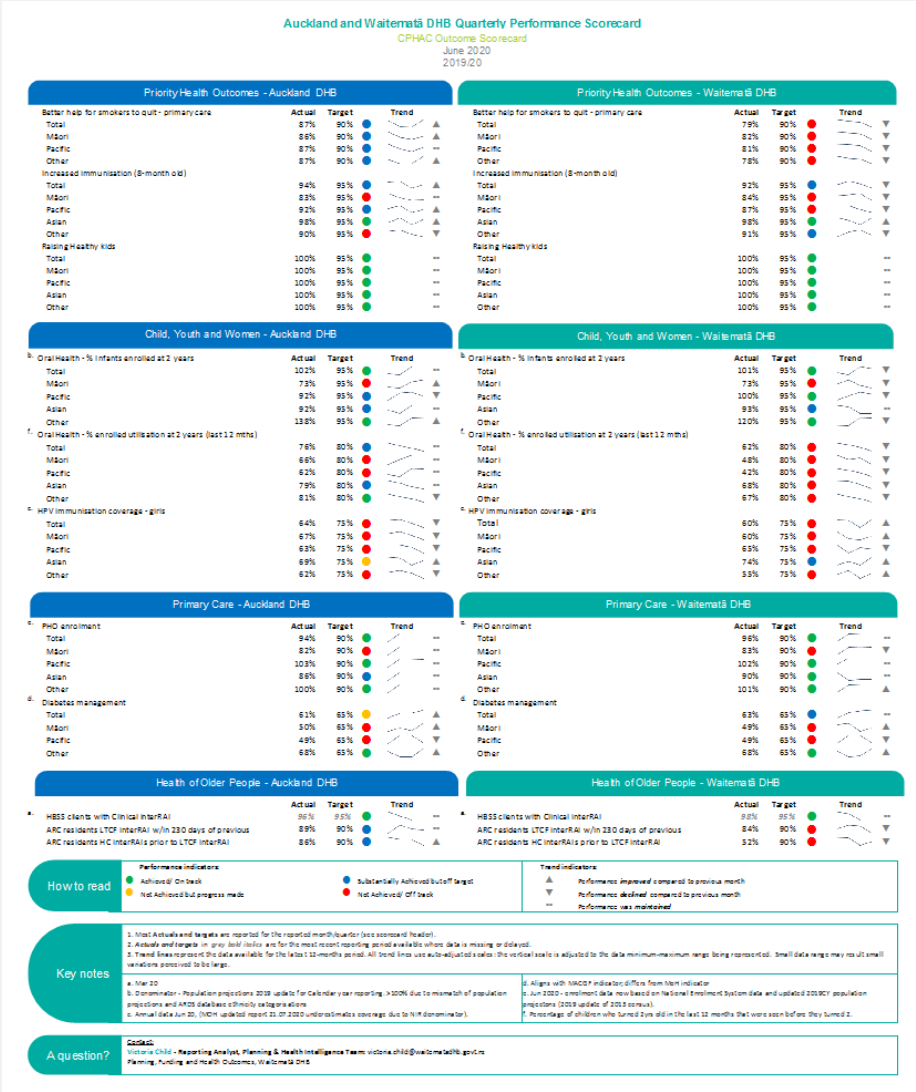


PREVIOUS JOINT CPHAC EQUITY FOCUS

- Previous deep dives with an equity focus in CPHAC; evidence, specific issues and critical success factors
  - Rheumatic fever
  - System Level Measures (SLMs) – previously the primary care performance programme developed into a quality improvement programme
  - Breast and cervical screening
  - AAA Screening
  - Cardiac rehab prototype
  - ARPHS – detail on infectious disease surveillance, HAT, policy work
  - Social investment programmes (social determinants of health)
  - Healthy housing initiative (Previously Kainga Ora, now Noho Āhuru)
- Previous areas of focus for joint CPHAC – oral health, child health, child obesity, mental health, prevention, social determinants of health, policy

CPHAC SCORECARD

- CPHAC has always received ethnic-specific indicator reporting in scorecards with associated narrative format
- Lots of 'red' because indicator areas of focus are specifically chosen as areas of importance for health outcomes and equity
  - Keeping these in focus on the scorecard has been an important way to frame the reporting



Auckland and Waitematā DHB Quarterly Performance Scorecard

CPHAC Outcome Scorecard

June 2020

2019/20

Priority Health Outcomes - Auckland DHB

	Actual	Target	Trend
Better help for smokers to quit - primary care			
Total	87%	90%	
Māori	86%	90%	
Pacific	87%	90%	
Other	87%	90%	
Increased immunisation (8-month old)			
Total	94%	95%	
Māori	83%	95%	
Pacific	92%	95%	
Asian	98%	95%	
Other	90%	95%	
Raising Healthy Kids			
Total	100%	95%	
Māori	100%	95%	
Pacific	100%	95%	
Asian	100%	95%	
Other	100%	95%	

Priority Health Outcomes - Waitematā DHB

	Actual	Target	Trend
Better help for smokers to quit - primary care			
Total	79%	90%	
Māori	82%	90%	
Pacific	81%	90%	
Other	78%	90%	
Increased immunisation (8-month old)			
Total	92%	95%	
Māori	84%	95%	
Pacific	87%	95%	
Asian	98%	95%	
Other	91%	95%	
Raising Healthy Kids			
Total	100%	95%	
Māori	100%	95%	
Pacific	100%	95%	
Asian	100%	95%	
Other	100%	95%	

Child, Youth and Women - Auckland DHB

	Actual	Target	Trend
b. Oral Health - % infants enrolled at 2 years			
Total	102%	95%	
Māori	73%	95%	
Pacific	92%	95%	
Asian	92%	95%	
Other	138%	95%	
f. Oral Health - % enrolled utilisation at 2 years (last 12 mths)			
Total	76%	80%	
Māori	66%	80%	
Pacific	62%	80%	
Asian	79%	80%	
Other	81%	80%	
c. HPV immunisation coverage - girls			
Total	64%	75%	
Māori	67%	75%	
Pacific	63%	75%	
Asian	69%	75%	
Other	62%	75%	

Child, Youth and Women - Waitematā DHB

	Actual	Target	Trend
b. Oral Health - % infants enrolled at 2 years			
Total	101%	95%	
Māori	73%	95%	
Pacific	100%	95%	
Asian	93%	95%	
Other	120%	95%	
f. Oral Health - % enrolled utilisation at 2 years (last 12 mths)			
Total	62%	80%	
Māori	48%	80%	
Pacific	42%	80%	
Asian	68%	80%	
Other	67%	80%	
c. HPV immunisation coverage - girls			
Total	60%	75%	
Māori	60%	75%	
Pacific	65%	75%	
Asian	74%	75%	
Other	33%	75%	

Primary Care - Auckland DHB

	Actual	Target	Trend
c. PHO enrolment			
Total	94%	90%	
Māori	82%	90%	
Pacific	103%	90%	
Asian	86%	90%	
Other	100%	90%	
d. Diabetes management			
Total	61%	65%	
Māori	50%	65%	
Pacific	49%	65%	
Other	68%	65%	

Primary Care - Waitematā DHB

	Actual	Target	Trend
c. PHO enrolment			
Total	96%	90%	
Māori	83%	90%	
Pacific	102%	90%	
Asian	90%	90%	
Other	101%	90%	
d. Diabetes management			
Total	63%	65%	
Māori	49%	65%	
Pacific	49%	65%	
Other	68%	65%	

Health of Older People - Auckland DHB

	Actual	Target	Trend
a. HBSS clients with Clinical InterRAI	96%	95%	
ARC residents LTCF InterRAI w/in 230 days of previous	89%	90%	
ARC residents HC InterRAIs prior to LTCF InterRAI	86%	90%	

Health of Older People - Waitematā DHB

	Actual	Target	Trend
a. HBSS clients with Clinical InterRAI	98%	95%	
ARC residents LTCF InterRAI w/in 230 days of previous	84%	90%	
ARC residents HC InterRAIs prior to LTCF InterRAI	32%	90%	

How to read

Performance indicators

- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators

- Performance improved compared to previous month
- Performance declined compared to previous month
- Performance was maintained

Key notes

1. Most Actuals and targets are reported for the reported month/quarter (see scorecard header).
2. *Actuals and targets in grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. Trend lines represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales (the vertical scale is adjusted to the data minimum-maximum range being represented). Small data range may result small variations perceived to be large.

a. Mar 20

b. Denominator - Population projections 2018 update for Calendar year reporting. >100% due to mismatch of population projections and ARMS database ethnicity categorisations

c. Annual data Jun 20, (NCH updated report 21.07.2020 underestimates coverage due to NIR denominator).

d. Aligns with NACRP indicator; differs from Nat indicator

e. Jun 2020 - enrolment data now based on National Enrolment System data and updated 2019CY population projections (2019 update of 2013 census).

f. Percentage of children who turned 2yrs old in the last 12 months that were seen before they turned 2.

A question?

Contact:
Victoria Child - Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

AUCKLAND DHB CPHAC – CONSIDERATIONS FOR FUTURE FOCUS

Our Strategic Priorities

Te Tiriti o Waitangi in action

Support a tangata whenua/ mana whenua led change to deliver mana motuhake and Māori self-determination in the design, delivery and monitoring of health care.

Develop transformation processes with a long-term view, to give effect to the Treaty principles of: partnership; active protection; equity and options.

Develop a whenua ki te whenua, life course approach, to redesign work.

Support the expression of hauora Māori models of care.

Eliminate inequity

Embed principles of equity and take action:

- Protect Māori Indigenous rights
- Build a common understanding of equity and causes
- Support Māori-led responses
- Support Pasifika -led responses
- Strengthen network of primary and community care
- Dismantle policies and drivers that cause inequity

Digital transformation

Insights and Intelligence - enhance data management and data analytics

Digital Health Services:

- Integrate care solutions – digital solutions that support integrated care
- Core clinical systems – integrated paper-lite core clinical information systems

Workforce and Business systems – enhance tools to foster organisational effectiveness

People, patients and whānau at the centre

Invest in a greater range of supports that 'stand beside' patients and whānau, and actively support self-directed care.

Connections and partnerships exist with communities, to achieve shared health service planning and delivery, focussed on areas and groups with the highest need (our localities approach).

Improve experience by partnering with people and service users in the design, in the delivery and evaluation of services (co-design).

Resilient services

Deliver safe and flexible health care with our population in the Covid-19 pandemic response.

Deliver sustainable benefits from the agile and rapid adaption programmes across the provider, focussing on step-change.

Implement agreed continuous improvement initiatives.

Deliver regional approaches in planned care, including changes to vulnerable services and gains in the equity pathways.

Deliver large scale capital investments on time and budget.

Our Organisational Pillars

People and Culture value

Strengthening our culture and building our capability.

- Strengthen our organisational culture and values – making Te Toka Tumai a great place to work and a great place for care
- Uphold Te Tiriti o Waitangi – our framework to eliminate racism, build culturally safe practice and achieve health equity
- Grow and develop ngā kaimahi Māori
- Create a healthy workplace – through Kia Ora tō Wahi Mahi
- Deliver a workforce that is fit for the future – attracting the best and growing our people
- Make it easier to work here – improving our people's experience

Quality, Safety, and Risk (QSR)

Supporting excellent patient and staff outcomes through:

- System reliability and a proactive approach to risk management
- Integrating QSR, so it becomes a core part of everyone's role
- Moving from data to intelligence to inform insights, learning and action
- Providing leadership and oversight

Commissioning services for our populations' needs

Planning, developing, sourcing and monitoring service delivery systems to achieve the best outcomes for our population.

Our Purpose

Support our population to be well and healthy

Manage within our means

Put hauora for patients and their whānau at the heart of our transformation work

Commission health and disability services across the whole system mai te whenua ki te whenua/ mō te katoa

Provide specialist healthcare services to patients and whānau from the Northern Region, across districts, and New Zealand

Our Vision

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

Healthy communities,
World-class healthcare,
Achieved together

Te Toka Tumai
Auckland District Health Board
Strategy to 2023

AUCKLAND DHB CPHAC – CONSIDERATIONS FOR FUTURE FOCUS

- Context of the Wai2575 report and the Health and Disability Sector Review
- Auckland DHB strategy – two of the five strategic priorities - *Te Tiriti in Action* and *Eliminate Inequity*
- Alignment of equity focus between Board and Board Committees (HAC and CPHAC particularly)
- Kōtui Hauora direction and development of areas of focus

KEY ELEMENTS OF THE WDHB FRAMEWORK BASED ON THE

IHI MODEL HEALTHCARE (ORGANISATIONAL) EQUITY

Figure 3. A Framework for Health Care Organizations to Achieve Health Equity

Source: IHI http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

Terms of Reference for the Community and Public Health Advisory Committee

Recommendation

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.**

Prepared by: Marlene Skelton, Corporate Business Manager
Endorsed by: Debbie Holdsworth, Director Funding

Executive Summary

Following the February 2020 Board endorsement of the committee membership, and the ability post COVID 19 to stand this committee up, it is proposed that the Terms of Reference for the Community and Public Health Advisory Committee be updated to reflect that it is a stand alone committee of the Auckland DHB and that there is a focus on Equity and Ti Tiriti o Waitangi responsiveness along with the provisions specified in the New Zealand Public Health and Disability Act 2000.

The draft terms of reference are attached for review and discussion.

AUCKLAND DISTRICT HEALTH BOARD

Community and Public Health Advisory Committees

Terms of Reference

Revised - March 2021

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1. Establishment

The Community and Public Health Advisory Committee (CPHAC) is established by the Auckland District Health Board ("Auckland DHB") under section 34 of the New Zealand Public Health and Disability Act 2000 ("Act"). The Board may amend the terms of reference for the Committee from time to time.

2. Functions of Committees

The function of CPHAC is to:

- Ensure provision for Equity and Ti Tiriti o Waitangi responsiveness
- Give the Board advice on:
  a) the needs of the resident populations of the Auckland DHB
  b) any factors that the committee believe may enhance or degrade the health status of the resident population of the Auckland DHB; and
  c) priorities for use of the health funding available to Auckland DHB
- The aim of CPHAC's advice will be to ensure that service delivery provided for the Auckland DHB population maximises the overall health gain for the population through:
  a) all service interventions Auckland DHB has provided or funded or could provide or fund for the population;
  b) all policies the DHB has adopted or could adopt for its population
- The Committees' advice must not be inconsistent with the New Zealand Health Strategy

3. Responsibilities

(a) The Committee will be responsible for review and advice to the Board on:

- ensuring that the Committee and Board have a global view of the health needs of the Auckland district population.

- recommendations from management concerning health services to be provided by Auckland DHB to its respective resident population.
- the needs of the population and developing principles on which to determine priorities for using finite health funding.
- establishing and maintaining processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.
- continuing to foster the development of Māori capacity for participating in the health and disability sector and providing for the needs of Māori.
- establishing and maintaining processes to enable Pacific people to participate in, and contribute to, strategies for Pacific health improvement.
- continuing to foster the development of Pacific capacity for participating in the health and disability sector and providing for the needs of Pacific people.
- interpreting the local implications of the nation-wide and sector-wide health goals and performance expectations.
- the prioritisation framework used by Auckland DHB to achieve an equitable and efficient funding mix between services and population groups.
- the effectiveness of the Northern Region's Health Plan and Auckland DHB's annual plan and advice to the Board on the plans' effectiveness in meeting district health needs and meeting Government health goals.
- oversight and monitoring of the contracting processes relating to service agreements with other providers of health and disability support services. This will include:
    - ensuring appropriate systems, policies and procedures are in place for auditing and monitoring the performance, capacity and sustainability of contracted providers.
    - reviewing and providing advice on associated legal, service and financial risks.
- improving collaboration and coordination of services between Auckland DHB with Waitematā DHB to effectively and efficiently provide for the needs of the wider populations served.

(b) The Committee will identify issues and opportunities in relation to the provision of health services that the Committee considers may warrant further investigation and advise the Board accordingly.

4. Relationship with Board and Management

(a) The Committee is established by and accountable to the Board. The Committees role is advisory only, and unless specifically delegated by the Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committee.

(b) The Committee shall receive all material and information for review or consideration through the Chief Executive Officer.

(c) The Committee shall provide advice and make recommendations to the Board only.

(d) The Committee is to comply with the standing orders of the Auckland DHB based on the model standard standing orders.

5. Membership

(a) The Committee shall comprise up to sixteen members in total, inclusive of Board members and external appointees, but less as deemed necessary by the Board.

(b) Any number of Board members may be appointed to the Committee by the Board.

(c) The number of externals who can be appointed (where a number is stated) is a ceiling not a fixed requirement.

(d) The Chairperson of Auckland DHB will appoint the Chairperson of the CPHAC.

(e) The Board will endeavour to appoint, as members of the Committee, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committee to carry out its functions.

(f) The Board will ensure that the Committee include representation for Māori in accordance with section 34 of the Act and for Pacific people.

(g) The Board will appoint any external appointees as members in accordance with the following process:

- The Chair and Deputy Chair with the Chief Executive Officer will evaluate potential members in accordance with the criteria determined by the Board and make recommendation to the Board as to the proposed appointments.
- The Board will make the final appointments (if any) to the Committee.

6. Meeting Procedure

(a) The Committee shall meet four times per year. Meetings shall be conducted in accordance with:
- The requirements of the Act
- The Standing Orders of Auckland DHB

(b) The Chief Executive will ensure adequate provision of management and administrative support to the CPHAC function including attendance of the CEO and Director Funding and Director Health Outcomes.

(c) The venue for the meeting will normally be at the Auckland City Hospital, Grafton site, with technology (e.g. Zoom, video or teleconferencing) aiding from remote locations where appropriate.

(d) The quorum of each meeting shall be, if the total number of members of the Committees is an even number, half that number; but if the total number of members is an odd number, a majority of the members.

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
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
B4SC		B4 School Check
CIR	-	COVID Immunisation Register
CPHAC	-	Community and Public Health Advisory Committee
CTC		Community Testing Centre
CVD	-	Cardiovascular Disease
DCNZ		Dental Council of New Zealand
DHB	-	District Health Board
FPA	-	Family Planning Association
GP	-	General Practitioner
HBHF	-	Healthy Babies Healthy Futures
HC	-	Health Coach
HCSS	-	Home and Community Support Services
HIP	-	Health Improvement Practitioner
HPV	-	Human papillomavirus
HVAZ	-	Healthy Village Action Zones
IPMHAS	-	Integrated Primary Mental Health and Addiction Services
IPS	-	Individual Placement and Support
LARC	-	Long Acting Reversible Contraception
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
NCSP	-	National Cervical Screening Programme
NGO	-	Non-Governmental Organisation
NIR	-	National Immunisation Register
NRHCC	-	Northern Region Health Coordination Centre
NSU	-	National Screening Unit
PFO	-	Planning, Funding and Outcomes
PHO	-	Primary Health Organisation
SPPGG	-	Suicide Prevention and Postvention Governance Group

UR-CHCC - Uri Ririki - Child Health Connection Centre
WCTO - Well Child Tamariki Ora

1. Purpose

This report updates the Waitematā DHB's Community and Public Health 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 presented to the Finance, Risk and Assurance Committee at their meeting on 23 February for their consideration and review. This is to be circulated to the Board for final approval prior to being submitted to the Ministry of Health (MoH) on 8 March 2021. Feedback on the first draft is expected from 9 April from the MoH. The Plan will subsequently be updated and the second draft – post Board approval – is due with the MoH by mid-June.

2.2 Annual Reports

The audit approved 2019/20 Annual Report has been finalised and printed. Following presentation to parliament, this documented will be published to the DHB's website.

Development of the timeline for 2020/21 audit and development of the 2020/21 Annual Report has commenced.

3. Primary Care

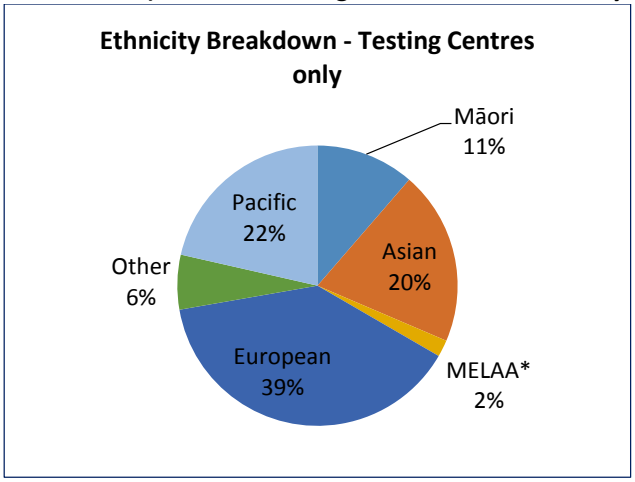
3.1 Response to COVID-19

The primary care team, with staff working within both the DHB and the Northern Region Health Coordination Centre (NRHCC), continues to support the Metro Auckland response. With the pandemic response entering a more settled phase, the team have been re-prioritised to support COVID vaccination planning.

The framework of semi-permanent fixed site Community Testing Centres (CTCs) and mobile testing units that was established in July last year is still in place. General practices and urgent care clinics also continue to support our COVID-19 testing programme. This Framework was able to adapt quickly during the recent surge in testing demand due to the three positive community cases that were confirmed in January. To meet increased demand for testing over this period two addition 'pop-up' testing sites were stood up at Victor Eaves Park (28 – 30 January) and North Harbour Stadium (27 January – 1 February). 11,284 swabs were taken during this period of heightened risk through CTCs, mobile testing units and 'pop-up's alone (28 January 2021 – 6 February 2021).

Since the August COVID-19 outbreak (between 12 August 2020 and 6 February 2021), CTCs and mobile clinics completed 330,152 swabs, while another 266,399 swabs were taken through general practice and urgent care clinics across metropolitan Auckland.

Graph 1. Proportion of tests taken at CTCs and mobile testing clinics by ethnicity (Source: e-notifications) between 12 August 2020 and 6 February 2021.



* Middle Eastern Latin American and African

COVID-19 vaccination programme

Planning for how our metro-Auckland primary care network will support the rollout of the COVID-19 vaccination programme is underway; the PFO Primary Care Team will lead this work. This is a part of a larger regional process to develop and execute a COVID-19 vaccination roll out starting with tier 1 (border staff and their whānau) and tier 2 (front line health workers), and eventually leading to the whole community vaccination roll out.

Mobile Outreach Health clinics

During COVID-19 Alert Level 4, approximately 500 rough sleepers were accommodated in motel units ("managed accommodation") across metropolitan Auckland; 41% of these people are Māori and 15% are Pacific. Auckland and Waitematā DHBs successfully implemented mobile health clinics to provide health services to those living in managed accommodation from 1 July 2020 to 30 September 2020.

The mobile health clinics are nurse-led and have access to general practitioners or nurse practitioners, and social workers. Services include comprehensive health assessments, triaging, limited range of treatments and supply of medicines, screening/prevention activities and COVID-19 testing if required. The evaluation of the services demonstrated the benefits of the Auckland/Waitematā programme to Māori and Pacific people. These services have been extended to 31 March 2021 to continue providing services to people in managed accommodation.

Your Health Summary

The 'Your Health Summary' Shared Primary Care Summary is an on-going initiative that provides clinical information to better support high quality patient care when a patient accesses care at an alternative setting to their 'medical home'. This might be because their practice has closed due to COVID-19 or they are accessing care at an Urgent Care Centre or hospital. The programme provides a secure centralised repository of summary primary care information for all patients in the Auckland region that is accessible for patient care by appropriate health practitioners in other settings. There is the ability for patients to opt off the system.

Your Health Summary is an important component of a high functioning regional health care system to enable quality continuity of care. There is a focus to achieve high coverage for Māori, Pasifika, people living in quintile 5 areas, and people 65 years and older as these population groups have on average higher healthcare needs, require healthcare more often and may be more mobile regarding where they seek healthcare.

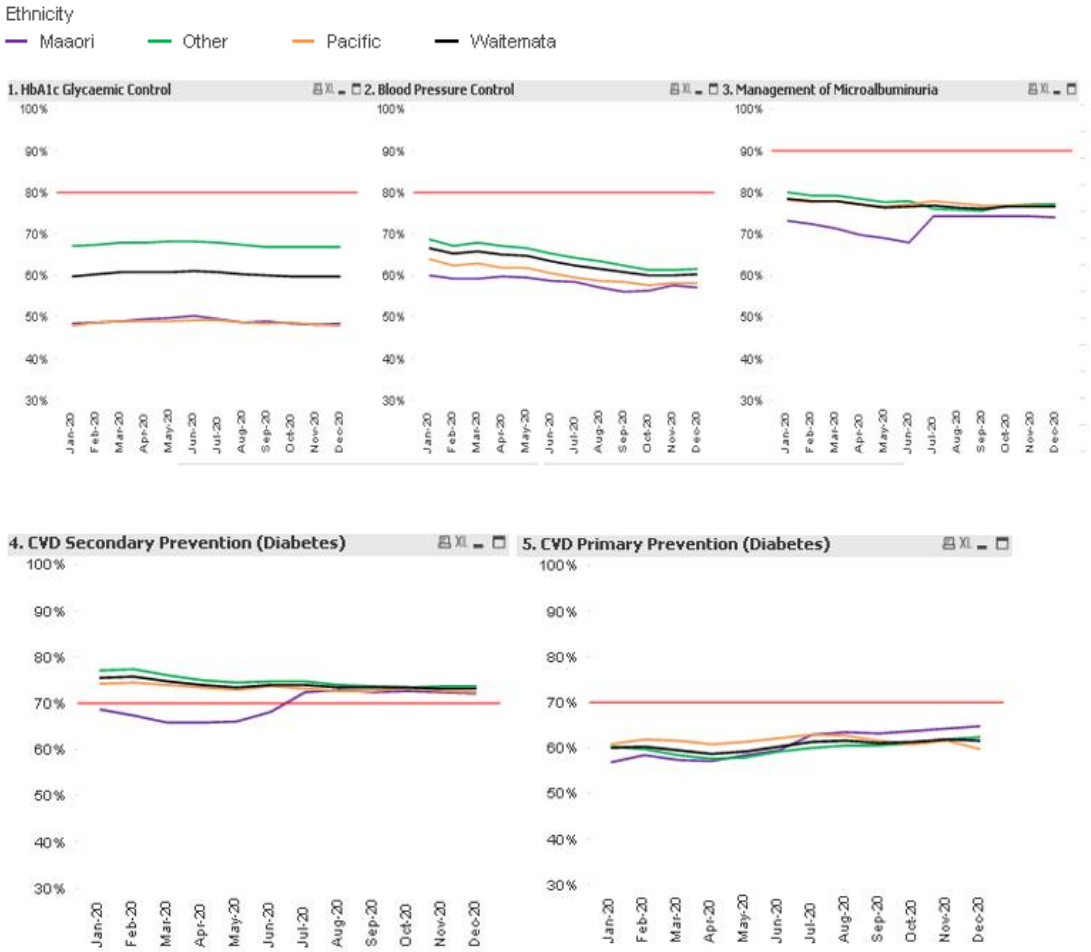
Primary Healthcare Organisations (PHOs) have agreed to make this a priority area to improve the rate of uptake.

3.2 Diabetes

The following are some key facts from the latest (December 2020) diabetes quarterly report for Auckland DHB. At the end of quarter two 2020/21 the following can be noted:

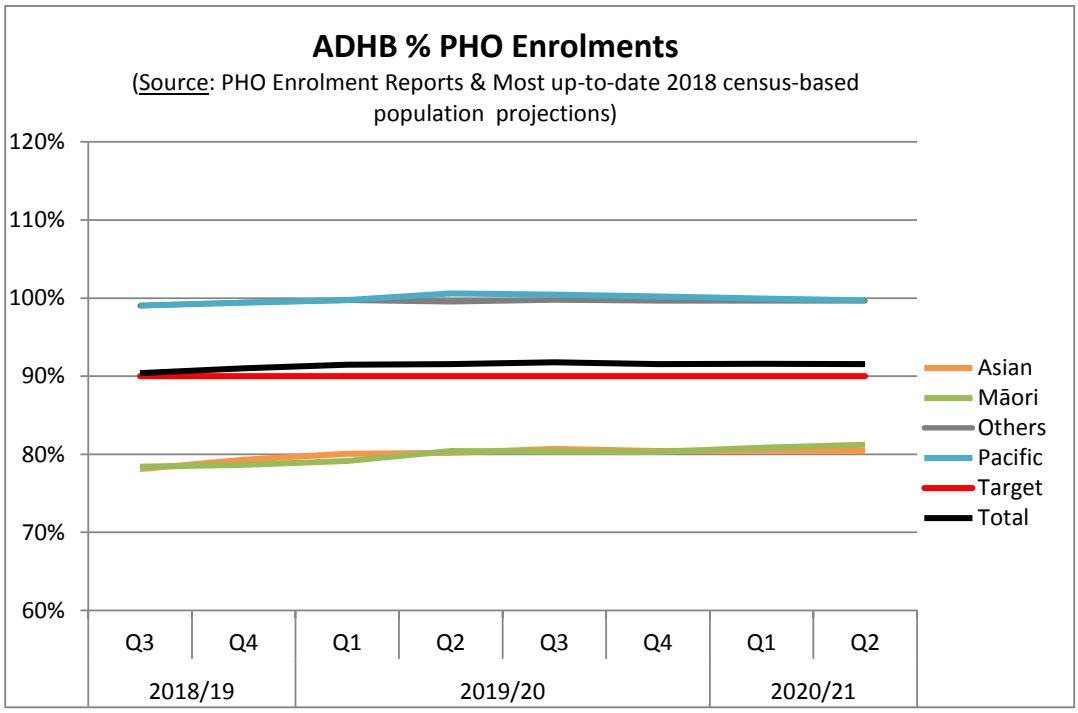
- Despite COVID-19 performance against six of the seven indicators, with the exception of blood pressure management and CVD primary prevention in Pacific people has remained within +/- 3% of their January 2020 result.
- Performance against the diabetes control (HbA1c) indicator remains consistently poor with stark inequities for HbA1c with almost 25 percentage points across ethnicities.
- Auckland DHB have the lowest percentage (11%) of patients with diabetes without an HbA1c result within the last 15 months in the region at the end of December compared to the other metro Auckland DHBs

The following graphs present the performance between January 2020 and December 2020 (NB: the target is represented by the red line).



3.3 PHO Enrolment

Below is the most recent PHO enrolment data from quarter three 2018/19 to Q2 2020/21. The data is sourced from the National Enrolment System and the most up-to-date population projections based on the 2018 census.



NB: * 2018/19 Q3 new data source (National Enrolment System) and 2020 update of 2018 census population projections

4. Health of Older People

4.1 Aged Residential Care

Planning is underway for the COVID-19 vaccination roll out to aged residential care for both residents and staff; it is in the initial stages but indicative numbers of residents and staff have been collated and all Aged Residential Care (ARC) facilities in metro Auckland have completed a survey providing relevant information to inform the process.

The COVID-19 preparedness status of ARC remains a focus. There is a Northern Region structure to oversee this work comprising the following groups:

- ARC COVID-19 Steering Group – to identify and agree the areas that require a consistent and aligned regional response to ensure effective prevention and management of a COVID-19 outbreak in an ARC facility
- ARC COVID-19 Operations Working Group – to address planning relevant to operations including logistics, PPE, vaccination planning
- ARC COVID-19 Clinical and Public Health Working Group - to provide clinical and public health recommendations to the Steering Group on specific topics e.g. principles for resident transfer decisions, infection prevention and control support/protocols, principles for staff stand downs.

4.2 Home and Community Support Services

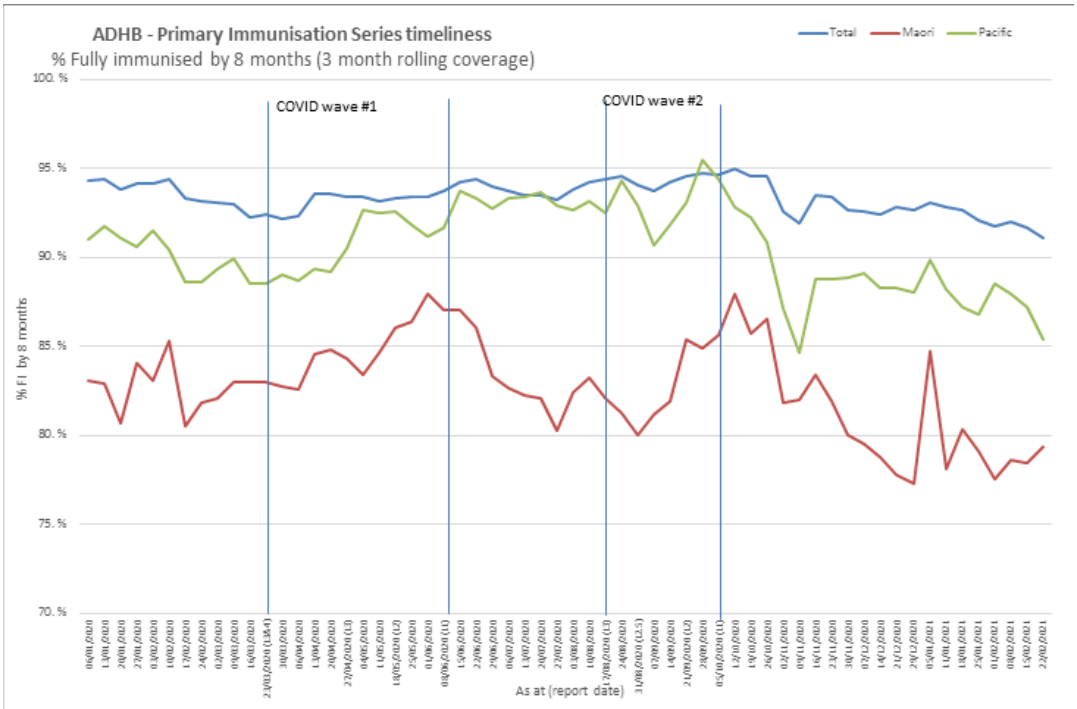
The national framework and service specification for Home and Community Support Services (HCSS) was published at the end of last year. The approach is a restorative HCSS model using a case mix methodology to group people with similar levels of assessed needs together and enables services to flex up and down to respond to real time client needs. There is a requirement for all DHBs to transition to this model by 1 July 2022. The new model is not dissimilar to the current model in place at Auckland DHB and review of key changes that would be required in order for the DHB to transition to the national service specification has been undertaken. Work is underway with the HCSS providers and DHB Community Services to determine if it is feasible to transition to the new service specification on 1 July 2021; noting that the service speciation currently being used has not been updated for several years.

5. Child, Youth and Women's Health

5.1 Immunisation

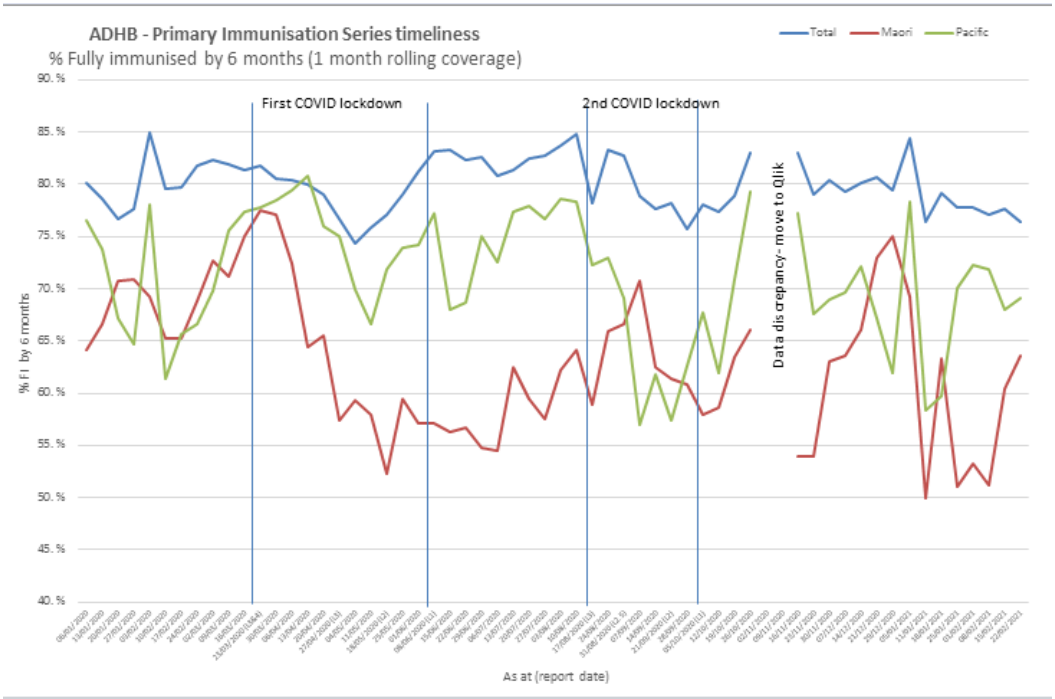
5.1.1 Childhood Immunisation Schedule Vaccinations

As previously indicated, COVID-19 will have an impact on immunisation coverage – the impact on on-time immunisation is being reflected in the coverage at 8 months. Auckland DHB is currently not achieving the 95% target, with coverage as at 22 February 2021 at 91% for the total population and 79% for tamariki Māori – at the same time last year, coverage was 93% for the total population and 81% for tamariki Māori.



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 seeing coverage improving towards pre-COVID levels for Pacific and Total, but there Māori coverage has not recovered.



We are working with our Māori Health Gain team colleagues on an analysis of the factors impacting immunisation coverage. The ethnicity insights from the Qlik platform demonstrate Māori as having more than twice the rate of opt-off and decline (8.1%) compared to non-Māori (3.4%). We are supporting the Māori Health Gains team on their initiative to engage with iwi to support positive immunisation messages. As part of this support we have re-run immunisation coverage on the Qlik platform for an insight into vaccine hesitancy by ethnicity – at the same time last year, our Māori decline/opt-off rate at 8 months is estimated to have been 8.6%, whilst the total population was 2.5%.

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. We are also working with our colleagues in Counties Manukau on hosting a hui of child health providers to identify the factors for vaccine hesitancy and delay, and strategies to address these.

We have been working with our 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.

The move to the Qlik platform for immunisation coverage has seen some data issue discrepancies, now affecting the 18-month coverage following the schedule changes in October 2020. This has been escalated to the MoH.

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.

Since the campaign was soft launched by Minister Genter in July 2020, 476 MMR doses had been recorded on the NIR for Auckland DHB 15 to 30 year olds, with 544 doses claimed for to the end of January 2921. Of these 44 were to Māori (32 claimed) and 85 to Pacific (95 claimed). The discrepancy between NIR and claims data is recognised as a challenge with not all opted onto the NIR, not all providers having access to the NIR.

Whilst the volume is lower than desired, this still represents a great achievement with the MMR catch-up competing with COVID, as well as having limited promotion. The Ministry/Health Promotion Agency resources were not available until late October/November.

Following our focus groups with rangitahi Māori and Pacific people aged 15-30; we have adapted the national communications suite based on their feedback. Posters, leaflets and campaign t-shirts have been distributed to primary care and GP practices.

The MoH has commissioned digital and audio advertising. The DHB is also commissioning washroom advertising in malls across the DHB, as well as social media postings.

The vaccine numbers will start to increase in the coming months with events scheduled in our enhanced school based health service schools and tertiary institutes (campus and halls of residents). A health promotion event the project was supporting Ngati Whatua Orakei with on Waitangi Day was cancelled due to COVID concerns. There are also discussions about health promotion events at community libraries following focus group feedback. Contracts are now in place with Family Planning Association (FPA) and the Regional Sexual Health Clinics, with negotiations progressing with private occupational health providers. An initiative is also being explored to deliver MMR to patients receiving Bicilin injections.

5.1.3 COVID vaccine

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.

The Immunisation Programme Manager and NIR team leader have been part of a subject matter expert workshop in reviewing the new COVID Immunisation Register (CIR) and how it could be used in practice for delivering the COVID vaccine, particularly in the first phase of MIQ and border workers.

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 102 Auckland babies previously missing from the NIR were identified via NCHIP and linked in with GPs or outreach for immunisation follow up in Q2 20/21. In the same quarter, the Ministry of Social Development (MSD) shared new contact details for 9/19 (47%) of 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 28 February 2021, Auckland DHB received 1,610 referrals to Noho Āhuru – Healthy Homes (NA-HH). This included 6,059 family members getting access to healthier home interventions. Of the referrals received, 566 (35.2%) were for families with a newborn baby or hapu woman.

The service has received new promotional resources, which are being promoting to referrers and community agencies over the coming months. These resources have been prepared with the services new name and imagery, and include a number of new tools such as posters and 'table talkers' alongside pamphlets similar to those that have been in use for the last couple of years. Consultation with service delivery partners was included in the design phase. Further feedback will be sought from referrers and partners in 3-4 months to inform any changes required before a further print run.

Summer students completed an audit process for Auckland DHB and Waitematā DHB whānau referred to the NA-HH service. Report of audit results is in preparation. These audits will help identify opportunities to strengthen on-referral and support in a number of domains in addition to core healthy housing interventions.

5.3 Well Child Tamariki Ora and B4 School Check

All providers have continued to provide face-to-face WCTO services under COVID-19 alert level 1. Phone screening still occurs before undertaking home visits.

Recent data as shown in the table below shows that providers have managed to catch up those tamariki that had missed their core checks during the lock downs with the exception of the Pacific population. Overall, for the period (November- December) of 2020, the Auckland DHB WCTO services delivered a total of 1,423 core checks compared to 1,407 for the same period of 2019.

WCTO Core checks November – December 2020 and November – December 2019

	Asian	European	Māori	Pacific	Other	Unknown	Total
Nov-Dec 2020	176	236	497	438	44	32	1,423
Nov-Dec 2019	192	227	423	514	46	5	1,407

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 data sharing process.

COVID alert levels have impacted B4 School Check (B4SC) services but the provider has worked hard to catch up the tamariki.

The table below shows that the B4SC coverage was on target for January 2021 for the high deprivation, Māori and Pacific tamariki. The overall coverage was slight below the target. The provider continues to prioritise tamariki who are close to their fifth birthday, Māori, Pacific and children living in areas of high deprivation (Quintile 5). It is positive to note that despite COVID lockdowns, coverage for children is on track.

B4SC Comparison Auckland DHB January 2020 and January 2021

Percentage of eligible population checked	High deprivation	Māori coverage	Pacific coverage	Overall coverage
January 2020	48.8%	53.5%	51.1%	48.6%
January 2021	54.6%	53.2%	53.8%	50.3%

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 January 2021.

5.4 Rheumatic Fever

Work is on-going 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. 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.

Over the past two-years, there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: Saturday clinics; the supportive treatment pathway; the development of a small centralised booking and scheduling team; implementing new booking practices; and focusing on the date in which the child was last seen, rather than their recall date.

However, the COVID-19 pandemic had a significant impact on service performance, as routine oral health care (as per Dental Council of New Zealand (DCNZ) guidance) was unable to be provided during Alert Levels 3 and 4. Consequently, ARDS was unable to operate for eleven weeks in 2020. In addition, the DCNZ has issued new infection control and pre-screening requirements. This has impacted on productivity and means the service is unable to operate its usual model of care (where the majority of children are seen while at school, without a parent present). The overall situation has resulted in a significant increase in the number of children in arrears. It is estimated that arrears grew approximately 0.8% each week during Alert Levels 3 and 4 when the service was unable to operate.

There is also concern that the DCNZ requirement to screen all children prior to their appointment has created barriers for accessing care and will further perpetuate oral health inequities. That is, the service has experienced challenges in reaching some families/whānau to complete the pre-screening requirement. Those children whose parents cannot be contacted are missing out on their dental examination and preventative treatments.

Improvement Plan

An improvement plan has been developed and is being implemented to focus on improving service performance, without further exacerbating oral health inequities. Specifically, the plan aims to:

- reduce the number of children with an incomplete episode of care ('under treatment')
- reduce the number of long waiting children
- reduce arrears
- improve chair utilisation
- improve attendance

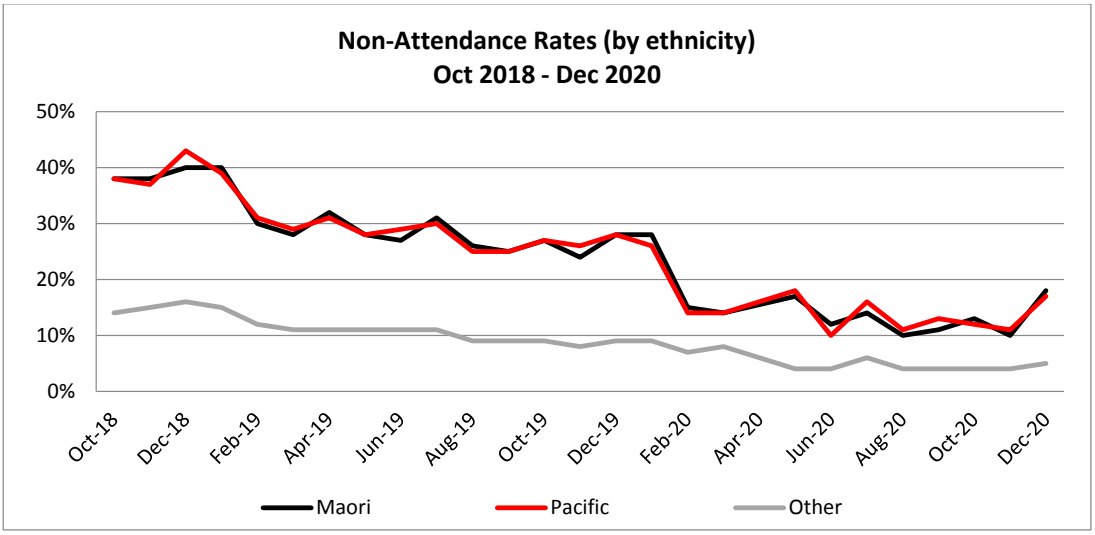
In addition to the improvement plan:

- The Northern Region Chief Executives have allocated $560k to support a redesign of Oral Health service provision for children and adolescents across the continuum.
- $195k has also been allocated from the MoH DHB led Improvement Sustainability fund to ARDS to redesign and reconfigure the service in order to optimise productivity and operational efficiency; improve oral health outcomes; and reduce oral health inequities.
- 10.50 FTE additional (over-recruited) new graduate oral health therapists have been recruited, who will commence with the service in January 2021.
- A pilot programme, using elements from the Scottish ChildSmile programme, is currently being scoped to be delivered in high-need communities in West Auckland from mid-2021. The pilot will be used to design a targeted mode of care, which, over time, will reduce oral health inequities and see sustained improvements in the oral health status of children. It will also assist in determining the cost and feasibility of extending the programme to other areas of Auckland.

Progress to Date

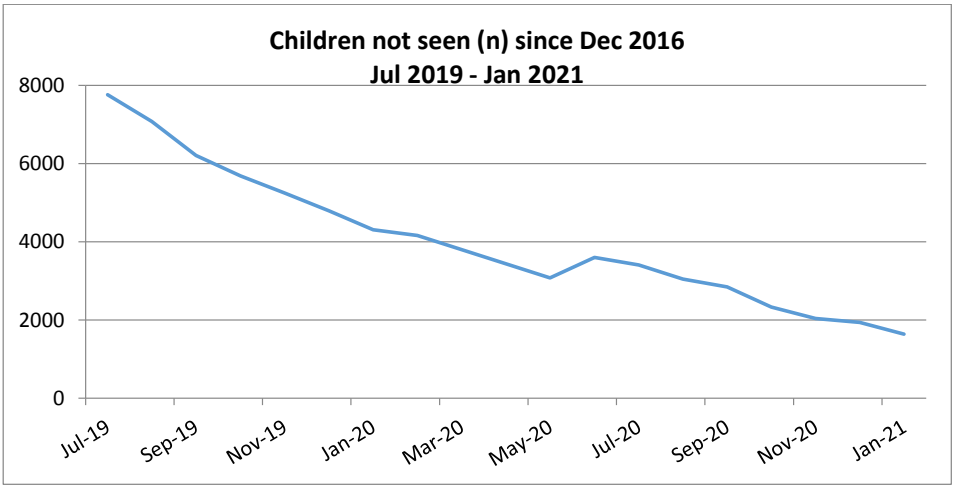
Non-attendance rate

Over the past two-years there has been a significant focus on improving the systems and processes that support equity and attendance. This has included undertaking initiatives such as: operating Saturday clinics; implementing a structure pathway to locate children and support them to attend appointments; development of a centralised booking and scheduling team; and implementing new booking practices. These initiatives have resulted in a significantly improved attendance rate. As demonstrated in the graph below, non-attendance rates have improved across all ethnicities and the gap between Māori/Pacific and other children has narrowed.



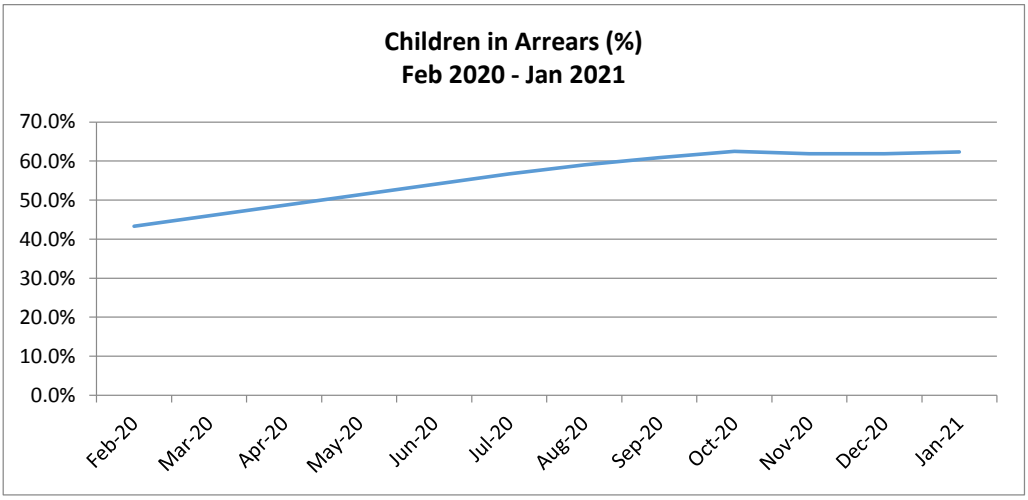
Long waiting children

As demonstrated in the graph below, there continues to be a steady reduction in the longest waiting children. The service continues to prioritise these children and progress by team is being tracked weekly. The supportive treatment pathway is being utilised to support children and whānau to access the service but COVID-19 pre-screening requirements continue to create challenges in supporting children who experience barriers to accessing care.

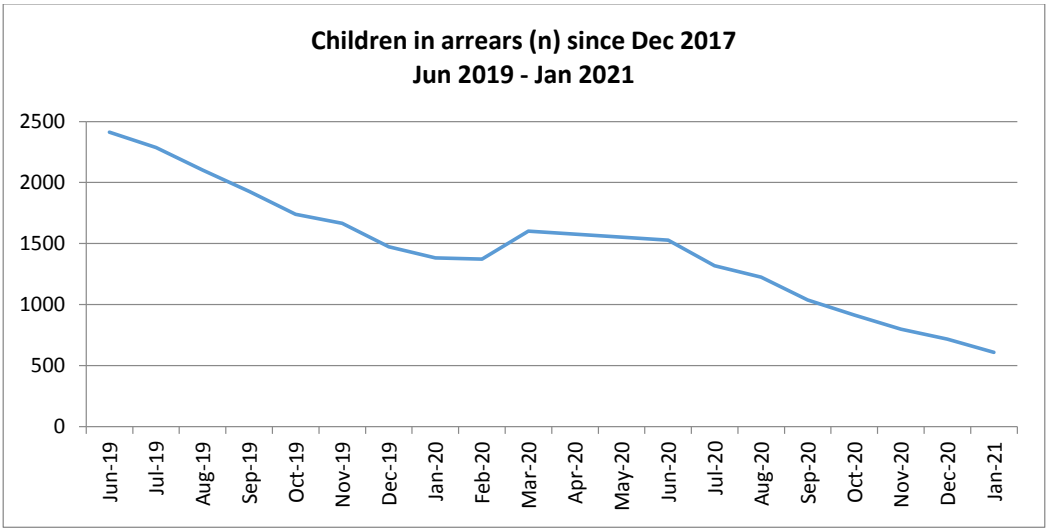


Arrears

The growth in arrears has been stabilised and the first reduction since the onset of COVID-19 was seen in November 2020. There was a slight increase in arrears in January 2021 due to planned clinic closures over the Christmas and New Year period. However, improvement is now being seen – over the first week of February 2021, arrears have reduced by 0.5%.



Of note, there has been on-going improvement in the number of children in arrears the longest. This is demonstrated in the graph below. This has been supported by the introduction of a new patient prioritisation co-ordinator role, which ensures that each clinic receives regular lists of children they need to prioritise for care and ensure that progress continues to be made.



In summary, COVID-19 has had a significant impact on community oral health service provision. The ARDS has implemented an improvement plan, which focuses on prioritising resources to children with the greatest oral health needs. Improvements have been seen across a number of domains, including attendance rates, and arrears growth has been stabilised.

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

A total 138 referrals were received by the service in 2020. Of these, eight referrals did not meet the eligibility criteria and five declined to take part in the service. Of the 125 wahine who are accepted into the service, 13% have completed their episode of care. The remaining are currently under

treatment (83) or have their initial appointment booked (26). A majority of booked appointments (66%) have been with the dentist, compared with 34% with the therapist. The length of appointments reflects the needs with an average appointment being 45 to 60 minutes long. About 34% of wahine needed longer (90 minutes) appointments. A majority of active referrals are Pacific (53%) and Māori (39%) wahine. Nearly half of wahine seen by the service are aged in their 20s and are 42% in their 30s. About 6% are in their late teenage years and 2% are in their 40s.

5.6 Contraception

We continue to monitor uptake of the Long Acting Reversible Contraception (LARC) service in primary care and promote the opportunity to providers. We are working with the provider arm to ensure that services provided within DHB services are captured accurately.

The MoH has commissioned the preparation of National Contraception Guidelines; these were published in December and are available on the MoH website. The guidance is currently being integrated into the Health Pathways platform. A training package has been released by FPA. This training, which has been commissioned by MoH, will provide some free training for health practitioners to access LARCs training. To date we are still not clear on the number of training places available. We understand that online modules have been developed and our team are coordinating requirements for the practical demonstration and assessment component of the training. Training has been a gap to date and remains an issue in achieving a robust network of providers who can offer all types of contraceptive options. We are working with Family Planning to confirm the offering for our DHB and prioritise recipients of training as well as work towards a sustainable training programme going forward. We have signalled this may include additional training, as concern remains that FPA programme will not be sufficient to meet the demand and need to significantly improve coverage of service provision and address access barriers.

5.7 Cervical Screening

Cervical Screening coverage for Auckland DHB remains significantly below the coverage target of 80%, updated coverage based on the revised population forecast shows an 8.7% increase in coverage for the total population with coverage now reported at 69.6%. The coverage rate remains inequitable for Māori, while the revised population forecast has increased coverage for Māori (now 57.8%); there is a 22% difference in coverage between Māori and 'Other' women who are meeting 80% coverage. Coverage for Pacific and Asian women also remains inequitable at 61.3% and 59.3% respectively (noting that there is currently no outcome inequity for Asian women, however this remains for both Māori women and Pacific women).

Coverage among Māori, Pacific and Asian women has declined over the last three years while coverage for Other women has increased slightly. Cervical Screening coverage has been declining over the past 3 years nationally and locally. The recent COVID restrictions 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 5 years or more. The National Screening Unit (NSU) is moving toward implementation of the HPV Primary Screening Programme, which offers some significant advantages for improving equity and coverage. One of these is the implementation of HPV self-testing which the NSU have recently confirmed will be included in the HPV Primary Screening Programme. An implementation timeline remains unclear. The HPV self-testing research continues in the Māori Health Pipeline.

A project to evaluate the effectiveness of incentives for cervical screening is being developed by the Māori Public Health Registrar, and will be implemented early in the 2021. This is based on the maternal smoking cessation incentives programme, and a range of incentives schemes across the country, however there is not currently high quality evidence evaluating their effectiveness and reach.

A number of guidelines changes have been implemented, some of which came into effect during the April-May 2020 lockdown period. There appears to be a good level of understanding of the updated guidelines in the sector following a webinar provided by the Coordination Service that has had over 200 views to date. We have worked to update the Health Pathways guidance to reflect these changes; this went live on 27 November 2020.

6. Mental Health and Addictions

6.1 Individual Placement and Support (IPS)

IPS is an internationally recognised and evidence-based integrated approach to employment support for people with mental illness and/or addiction. Meaningful employment can play a critical role in recovery and therefore, Auckland DHB has funded IPS for many years. This consists of employment consultants being co-located within several specialist mental health services. The service is currently delivered by five NGO FTE. This is very successful, however, this level of FTE is significantly below national modelling for adequate employment consultant ratios and as such, the service is not able to meet the demand for it.

MSD funded an expanded high fidelity IPS model at Waitematā DHB under Oranga Mahi, a cross-agency established in 2016 to deliver a set of cross-agency prototypes for clients living with health conditions or disabilities. The outcomes from this provided MSD the evidence for IPS and the significance of employment in enabling recovery for people with mental illness and/or addiction. The PFO team has worked with MSD in Waitematā DHB and have advocated for an expansion of the IPS service in Auckland DHB.

We now have an opportunity to work in partnership with the MSD to increase the number of employment consultants and thus expand the delivery of service. A Letter of Intent has been received from MSD. This confirms investment of up to $1M to expand the IPS service for a trial period of 12 months. Negotiations are being concluded with MSD and the plan is for Auckland DHB is to run a competitive process to identify provider/s, with delivery starting within 6 months.

6.2 Rapau te Ahuru Mowai – Homelessness Transitions Pilot

Rapau te Ahuru Mowai, the Mental Health and Addictions Homelessness Transitions Pilot (the 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 Aotearoa New Zealand Homelessness Action Plan (the Plan) sets out an overarching framework with actions to improve the wellbeing and housing outcomes of individuals and whānau who are at risk of, or experiencing, homelessness. The Plan had 18 immediate actions to be put in place in 2020. The Homelessness Transitions Pilot is one of these 18 actions. This initiative seeks to address the urgent issue of people stuck in inpatient services who no longer clinically need to be there as they 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 100 people transition from acute mental health and addictions inpatient units into the community, with housing and other wraparound support. The programme will be trialled in two sites – Auckland and Waikato. 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.

There are two parts of this procurement:

1. Wrap-around Services including Flexi-fund (Budget: $4,298,592.86 – four-year total)
2. Property Sourcing and Housing Co-ordination / Tenancy Management Services (Budget: $1,452,814.00 – four-year total).

PFO has started an open procurement process for a joint proposal for both aspects of the Pilot. In order to meet government contractual expectations, it is anticipated that contracts will be signed by early May and the service start shortly after that.

6.3 Suicide Prevention update:

Data reported from the Coroner (for the purposes of postvention work until publically released by that Office); indicate some concerning trends in suspected suicides in the Auckland DHB area. Included in this data was information about suspected suicides linked to a small rural community which has had caused great distress to the affected whānau and community at large. Various forms of support have been provided for the whānau and community through our postvention response group which includes specific suicide prevention training by Le Va, an NGO provider.

Mental Health 101 training is scheduled to be delivered within Auckland DHB. One of the training session is Lifekeepers, a specific suicide prevention programme, 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 area in March 2021.

The Suicide Prevention and Postvention Governance Group (SPPGG) continue to meet monthly with a focus on implementing the draft Suicide Prevention Action Plan 2020/23. A board paper has been developed for endorsement, however, relevant parts of this action plan have operative and reporting to the MoH has occurred through the DHB reporting process.

There is an on-going review currently in progress regarding the suicide notification pathway and postvention response. Working in collaboration at regional level has been very useful and productive during this review process.

6.4 Integrated Primary Mental Health and Addiction Services

Integrated Primary Mental Health and Addiction Services (IPMHAS) is a Ministry funded initiative based on the recommendations of He Ara Oranga. It aims to expand access to primary mental health and addiction services with a particular focus on those with mild to moderate needs. In the metro Auckland region, a range of providers (including the three DHBs, PHOs and NGOs) collaborated as the Auckland Wellbeing Collaborative in putting together a proposal for this funding. The proposal was successful and Auckland DHB became the contract holder, on behalf of the Auckland Wellbeing Collaborative for IPMHAS.

Naming of collaborative, launch and website

The collaborative acknowledges with great appreciation Robert Clark, Barry Bublitz and colleagues (Manawhenua I Tāmaki Makaurau) for the gift of the name for the Auckland Wellbeing Collaborative, Tū Whakaruruhau - To stand and Shelter. The Pohutukawa is our tree, with a strong base, and many branches coming together to stand in and shelter under. These branches can be the communities we serve; the partners and providers in the collaborative and the different services or elements to this overall programme.

Te Tumu Waiora and Awhi Ora, both come with their unique whakapapa, and sit inside the collaborative within these branches, as gifted identities within this overall programme.

An official launch for Tu Whakaruruhau is being initiated by Auckland DHB CEO and the Programme Board in liaison with Office of the Minister of Health. A date is yet to be confirmed. A wider communications process will occur around the time of the launch.

Stage 1 of the Tū Whakaruruhau website became live from Friday 26 February (for the Auckland Wellbeing Collaborative) http://www.aklwellbeingcollab.co.nz/

The website is intended to respond to several information needs within Tū Whakaruruhau:

- **People in need** – information about the new service and how to access services within primary care
- **Providers** – information about the roles and functions within the new services and about the role of the enablement team.
- **Careers** – information for people who may want to work in one of the services within the Auckland Wellbeing Collaborative.

Planning for 2021/22 contract and rollout schedule

During the 2020/21 year there was an under spend of the IPMHAS contract. On 12 February 2021, an initial meeting was held with the MoH to discuss use of the under spend. Tim Wood facilitated the discussion as Chair of Programme Leadership Board and represented, Ailsa Claire, as the contract signatory.

The MoH team agreed to the proposal tabled by the Auckland Wellbeing Collaborative for the use of underspend as follows:

1. Bring forward 11 practices into this contract year; and
2. Fully fund the initial two months of 2021/22 (July and August 2021.

The MoH team confirmed funding for existing service contract volumes into 21/22 and for the full cost of the Enablement Team and workforce support into 21/22.

Planning for new practices 21/22

The Enablement team proposed a roll out plan for 21/22 of around 51 practices by June 2022.

The MoH Team responded with indication of the level of investment/ practices being about right but for over a 2-year period rather than the 1 year period proposed by Tū Whakaruruhau. This would result in the roll slowing down significantly.

The Strategic Sponsor Governance Group, Programme Leadership Board and Auckland Primary Care Leadership Group are keen to advocate for not slowing down and a letter has been written to Dr Ashley Bloomfield and Toni Gutschlag requesting they review the proposed slowing down of implementation in Auckland given the success to date, the rising need given the impact of COVID-19 and concern over an increase in suspected suicides in the region.

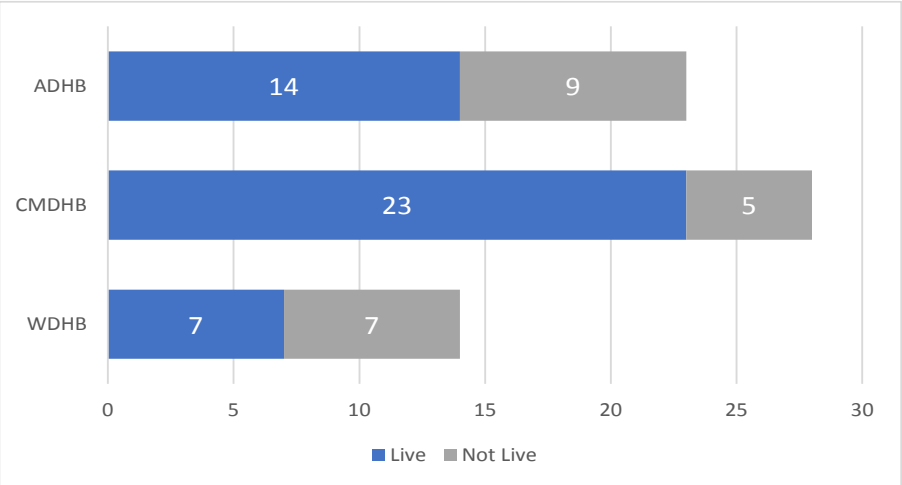
The MoH have indicated they would confirm a potential contract value and volumes in early March. The enablement team continue to work on the roll out of new practices for 21/22 using several modelling options. We are trying to take into account the best opportunity for reach to high needs communities (enrolled Māori, Pacific and Youth) along with logistics of implementation, coverage for PHOs and DHBs, and potential impact of mental health funding in future.

Implementation of IPMHAS Contract 20/21

Across metro Auckland, as of the end of January 2021, there are now 44 practices "live", 14 more than end of October report. Awhi Ora is available in more practices outside of this contract in the Auckland DHB and Waitematā DHB areas.

Auckland DHB now has a total of 24 practices being implemented to June 2021 (Fig 1). Since November 2020, Auckland DHB has had three new practices go live with several in set-up, recruitment and training phase during January and February. (see Table 1 for list of "live" practices)

Figure 1. Comparison by DHB – actual practices vs proposed number by June 2021



NB. This figure has changed from n=18 since Nov 20. The difference between previously planned 18 and now planned 24 practices includes: additional 8 practices from 11 new ones, addition of Aotea Health (yet to be added to Fig 1) and withdrawal of Tongan Health Society n=3 practices).

Table 1: List of practices now operational in Auckland DHB area as of end Jan'21-

Facility Name	PHO
Auckland University of Technology City*	Auckland PHO
Avondale Family Health Centre	AH+
Avondale Health Centre	Auckland PHO
Local Doctors Glen Innes	Total healthcare
Local Doctors Mt Roskill	Total healthcare
Orakei Health Services	National Hauora Coalition
Ostend Medical Centre	ProCare
Piritahi Hau Ora Trust	Auckland PHO
Stoddard Rd	ProCare
The Doctors Onehunga	ProCare
Three Kings Accident & Medical Clinic	National Hauora Coalition
Turuki Charitable Trust - Panmure	ProCare
University of Auckland, Student Health Centre	ProCare
Waiheke Medical Centre	Auckland PHO

We are drawing on underspend in this contract year to bring forward 11 additional practices: Eight of these are in the Auckland DHB area and three in Waitematā DHB. Funding for the 11 new practices does not start until March and April funding (Table 2).

Table 2: 11 Additional Practices added to 20/21 rollout schedule

Practice	PHO
New Al-Dawa Medical & Dental Surgery	AH+(Avondale Cluster) March
Rosebank Road Medical Services Limited	AH+ (Avondale Cluster) March
Hong Kong Surgery Limited	AH+ (Otahuhu Cluster) April
Lifeline Medical Services Limited	AH+ (Otahuhu Cluster) April
Otahuhu Family Medical Centre Limited	AH+(Otahuhu Cluster) April
Queen Street Medical Centre Limited	AH+ (Otahuhu Cluster) April
Singha Zenith Limited	AH+(Otahuhu Cluster) April
Auckland City Mission/Calder Centre	Auckland PHO April

As of the week of 22 February 2021, we are now also fast tracking into this year implementation into Aotea Health on Great Barrier Island, due to increased need. Planning started on 25th February 2021. A flexible approach will be required given the circumstances of the Island.

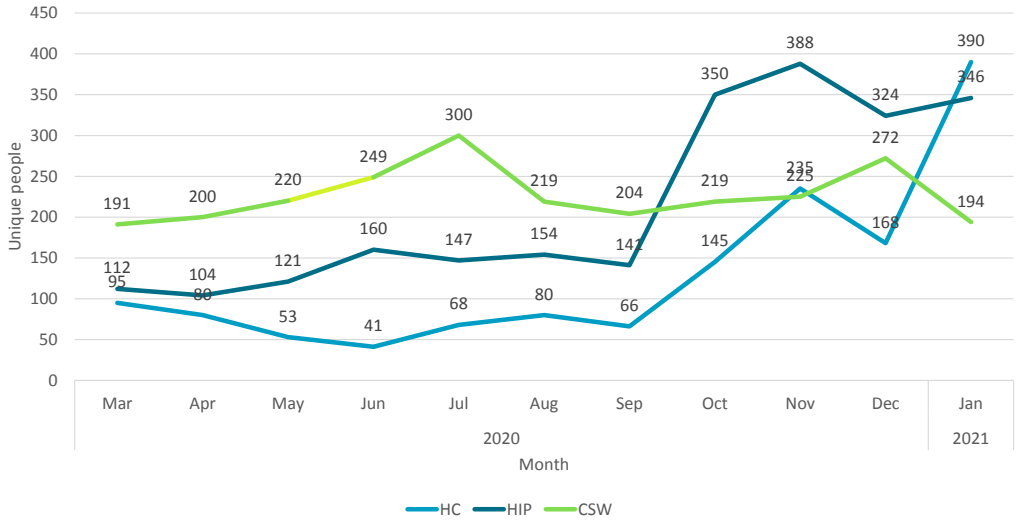
People Seen

Implementation has continued through all of the COVID19 alert level restrictions in Auckland. Across Tāmaki Makaurau, from the 1st March 2020 to the end of January 2021, 5,137 people, (unique individuals) have been seen by Health Coaches (HCs); 6,967 people by Health Improvement Practitioners (HIPs); 1,884 people by Awhi Ora support workers: and 5,071 people through Wellness support (CMDHB only).

In the Auckland DHB area this was 390 people by HC, 346 people by HIPs and 194 people by Awhi Ora. (See Fig 2.) The Christmas period and summer holidays, with leave taken had some import for

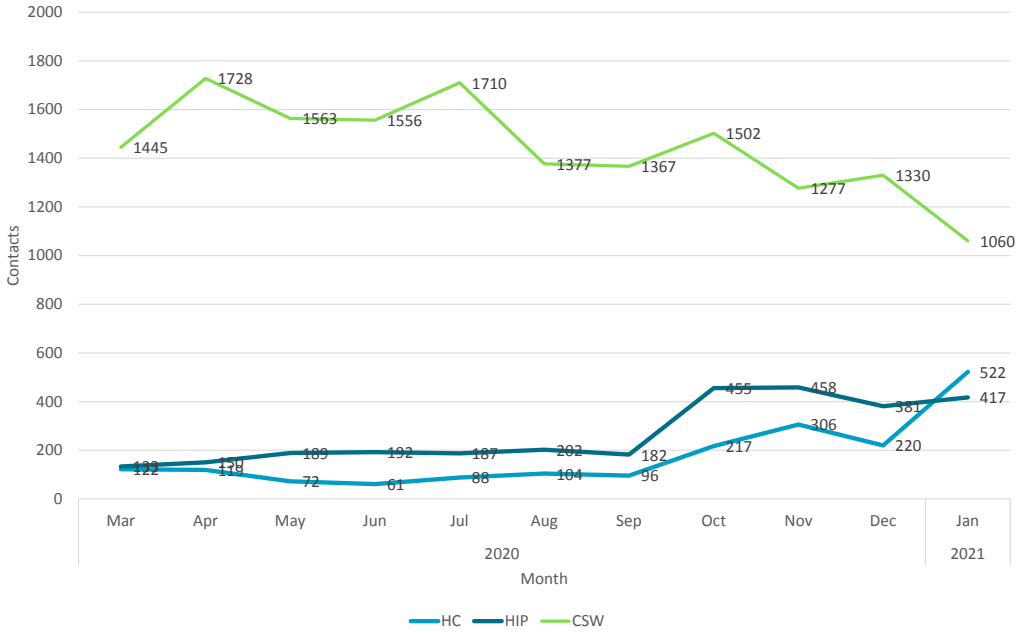
HIPs and Awhi Ora. We are looking into to understanding the big change for HCs to see what has influenced this.

Figure 2. Auckland DHB- Unique people seen by role.



Contacts for Auckland DHB area, increasing for HIPs and HCs but not for Awhi Ora (See Fig 3). There was concern shared that some Awhi Ora providers in Auckland DHB were at peak capacity and not due for an increase in allocation of hours until February. The increase was fast-tracked by the Funder to start as soon as the provider had the capacity to do more.

Figure 3 Auckland DHB – Contacts



Are we seeing the high priority populations?

For Auckland DHB, since the start of the contract start, Awhi Ora/CSWs have seen the higher percentage of Māori (18%) followed by HIPs (15%). However, in total only 13% of people seen in practices that are operating the model in the Auckland DHB area are Māori. (Table 3). This may

change over coming months with three of the Kaupapa Māori and Māori providers now providing services (Orakei Health (NHC); Piritahi Trust, Waiheke Island (Auckland PHO); and Turuki Panmure (ProCare)). The enablement team are concerned about this low figure and need to do further investigation to map this against the ratio of % Māori pop for the practices that are operating the model, then review access in those practices if this is significantly different. Work is also starting on Equity in the enablement team in terms of quality improvement initiatives related to the model and responsiveness to Māori, and in how we measure equity.

HCs have highest contact with Pacific people (47%) then Asian population; Awhi Ora currently have the highest contact % with European; HIPs currently have highest percentage contact with European then Asian (Table 3). This needs to be checked against the ratio of those populations across the practices with the model.

The reach to Māori and Pacific populations is slightly different for Metro Auckland over all (see Table 4.) The enablement team will also be looking to better understand the differences across the region.

Table 3. Ethnicity of People seen- Auckland DHB

Role	Māori	Pacific	European	Asian	MELAA	Other
Health Coach	8%	47%	11%	26%	3%	5%
Health Imp Practitioner	15%	14%	34%	29%	4%	4%
Comm Support Worker/ Awhi Ora	18%	15%	35%	17%	8%	7%
Total	**13%**	**24%**	**27%**	**27%**	**4%**	**5%**

Table 4. Overall – Metro Auckland

Role	Māori	Pacific	European	Asian	MELAA	Other
Health Coach	22%	41%	21%	12%	1%	2%
Health Imp. Practitioner	22%	25%	31%	16%	2%	2%
Comm Support Worker/Awhi Ora	16%	13%	44%	13%	5%	3%
Total	**22%**	**32%**	**28%**	**14%**	**2%**	**2%**

General practice specialist advice and support for Auckland and Waitematā DHBs

Auckland DHB and Waitematā DHB provider arm mental health and addiction services leadership have worked together to plan for the enhancement of the current support provided from secondary services, and interface with, primary care. The proposal from the two DHBs has evolved from solely an enhanced GP-Psychiatrist phone line noted in the contract to now incorporate:

- Clinical Nurse specialist to provide advice, consultation and coaching support to mental health credentialed nurses. Implementation planning work has started this month with the employment of a part-time project manager who is also supporting health pathways work. The project manager is a very experienced senior nurse and very familiar with both Waitematā DHB and Auckland DHB.
- Auckland DHB will fund 0.5FTE SMO phone line. Discussion is occurring between Auckland DHB and Waitematā DHB on this.
- Strengthening priority health pathways to support transition between primary and secondary care services.

7. Pacific Health Gain

7.1 Pacific Regional response to COVID-19

The Pacific Health Gain team continue to support the NRHCC in testing and responding to surges of COVID-19, and the rollout of the COVID-19 vaccination. We are managing our resources accordingly, and ensuring our providers are enabled to be a critical part of the region's response to COVID-19. This includes the timely flow of information between the NRHCC and the provision of Pacific led health services like Mobile Clinics (discussed below).

7.2 Pacific Mobile service

The Tongan Health Society Pacific Mobile service provides support to individuals and families that find it very difficult to access primary care services. This service is being extended to 30 June 2021 with an understanding that it will deliver further COVID-19 testing and support the COVID-19 Vaccine immunisation programme, when required.

7.3 Positive Parenting and Active Lifestyle (PPAL)

In the past 6 months, 25 PPAL programmes were delivered to 130 parents with 100 graduating over the same period. The remaining thirty parents will complete their programme by March 2021. An additional 20 parents enrolled for the one on one programmes will graduate by March 2021. In total, 150 parents have participated in PPAL programmes over the past two quarters.

7.4 Healthy Village Action Zones

44 churches in the Healthy Village Action Zones (HVAZ) Network have supported Pacific health providers as well as the NHRCC in its COVID -19 response. During the August outbreak, 16 Pacific churches agreed for their church facilities to be used for COVID-19 pop-up testing sites. This improved access for Pacific families and communities to access COVID-19 testing at sites that were local and familiar to them. Both HVAZ Parish Nurses and Coordinators were redeployed to pop-up testing sites to assist the operational aspects of the site and to help families access food parcels and other social, financial and housing support available.

7.5 MMR Vaccination plan

Samoan and Tongan community groups with extensive networks across the Auckland region have been identified and approached to support the promotion of the MMR campaign through various channels. An intergenerational approach which includes educating and promoting the MMR vaccine to parents, grandparents will be adopted as a way of encouraging and supporting those aged 15-30 years old to seek an MMR vaccination and make an informed decision.

7.6 Self-Management Education/Diabetes Self-Management Education Programmes.

Two SME/DSME programmes were completed in February 2021. Each programme consists of six week Self-Management Education workshops and two Diabetes self-management workshops. A total of 40 participants completed the programme of which 90% of the participants experience multiple long-term conditions.

7.7 Fanau ola Integrated services

Over 50% of the annual target number of new enrolments of families or households was achieved by December2020. Many Pacific families continue to struggle with unemployment, financial hardship and financially instability, living with extended family to share daily living costs, living with existing chronic conditions for example diabetes. This has been exacerbated by the COVID-19 pandemic which continues to cause some fear, confusion and anxiety affecting Pacific families and communities.

In response, the fanua ola integrated service providers actively work with each family and/or household to understand what are the pressing priorities and what would be most helpful for them. A holistic response which considers and includes the ethnic language, cultural and spiritual affiliations of the family or household is provided. Services may include but is not limited to access to social service housing and financial support, couple relationship counselling, mental health support, health education on a wide range of topics including asthma, cardiovascular disease, high blood pressure, high cholesterol, pre diabetes and diabetes.

8. Māori Heath Gain

8.1 COVID-19 specific responses and service

The Māori Health Gain Team has supported the Māori Response to COVID-19 Programme (the Programme). This Programme is broken down into five key areas that cover immediate responses to longer term system redesign. The five *pou* are:

1. Leadership and oversight
2. Engagement and communication
3. Māori health services (existing and redeployment)
4. Protecting Māori whānau and communities (testing strategy)
5. Welfare and wellbeing (welfare response and Pae Ora public health response)

For the previous quarter, our focus was on re-establishing the Māori Mobile Units that were redirected to COVID-19 testing following the August outbreak. We have maintained three mobile testing units operating across both Auckland and Waitematā DHBs.

To date the three mobiles have:

- A total of 649 contacts(with 241 through marae based clinics)
- 80 flu vaccinations
- 88 child vaccinations
- Six GP enrolments
- Over 500 wellbeing assessments and accompanying wellbeing support
- 83 strep throat swabs
- 28 referrals to other agencies and care providers

These mobiles will form a critical part of the wider COVID-19 response and management going forward. All three are capable of supporting/leading the vaccination roll out or testing strategy in high needs communities, where an outreach strategy is important to ensure access for residents.

8.2 Māori Pipeline Projects

8.2.1 Māori Health Plan Acceleration Projects

Breast Screening Data Match: A data match was undertaken between primary care enrolment and the breast screening services of the Northern Region to identify Māori women not currently enrolled in breast screening and invite them to be screened. Across the region, 730 Māori women were enrolled in the breast-screening programme. This project is now complete and a draft report is being prepared to share with stakeholders.

Cervical Screening High Grade Project: Our previous research project on HPV self-testing for cervical screening in Waitematā DHB and Auckland DHB identified a large group of women who had a history of an abnormal previous screening result (high grade; at high risk of cervical abnormality/cancer) who had not been followed up. This project sought to systematically identify these women and offer

screening via an alternative service based on Māori values. Unfortunately, the National Cervical Screening Programme (NCSP) declined to provide the required data to triage the women efficiently and offer service to those most at risk, citing legal reasons. The project has therefore had to change direction, instead creating an audit tool to be used at practice level. The audit tool has been completed and undertaken in three pilot practices by the project team, and has subsequently been trialled as a self-audit tool with approval by the College of General Practice to accredit the tool for use nationally. Lessons learned are being shared with the NCSP and locally with cervical screening stakeholders.

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, developed from participants in the previous focus groups and surveys, has met twice and supported a range of project material development. A Decision Aid tool is under development, and Health Literacy NZ have been engaged to assist with development of participant materials. A pilot with four to six general practices will get underway when the ethics approval is granted. The team are awaiting research-funding decisions for a larger trial and additional studies.

AAA Screening: The data analysis for the abdominal aortic aneurysm (AAA) risk prediction for Māori, as part of the original project, is underway. A small number of practices unable to complete the original Māori AAA project have been offered to have screening undertaken for their population. A small team is working together on invitations. The Pacific AAA screening project (under the Māori Health Pipeline as it is the same team) has completed the pilot with Tongan men, and moved on to offer screening to other Pacific ethnic groups. Kōtui Hauora agreed to consider AAA screening extension to Northland DHB; discussions are underway.

Hepatitis C: the Ministry of Health have agreed to the Northern Region leading the datamatch for the country, a proposal is currently being finalised. 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.

PHO enrolment: This was the first project in the DHB to formally undertake a Māori Data Sovereignty Assessment and act on its results (Iwi and MoU partner governance and decision making about the data). The data match with Māori providers has been closed-off although not all providers in Waitematā DHB and Auckland DHB provided their data. Counties Manukau DHB was originally involved in the project, however their providers chose not to participate. The project demonstrated a significant number of people enrolled in Māori providers were not enrolled in primary care, which means the project can progress to Phase 2, which is the development, with Māori providers of either a facilitated primary care enrolment service or an alternative offer of service.

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, and was on hold for some time as this work was completed. It has now been restarted with the support of Kapa Haka expert Annette Wehi and whānau, and physiotherapists from DHBs across metro Auckland.

8.3 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) programme is on track despite COVID-19 disruptions to educating parents in nutrition and physical activity. The programme is seeking additional funding to develop videos suitable for 15 e-Learning courses and as a video resource for live webinars and face to face workshops. The community partnership grants particularly with Kōhanga Reo and church based groups will be a main feature for educating Māori and Pasifika parents in the 2021 – 2022 year. The Asian community enjoys a large waiting list of parents ready to learn while the South Asian community have exceeded their targets also.

Table 1: HBHF Key measures July 1st 2020 - Jan 31st 2021

	TextMATCH Enrolments		Programme (6 courses) enrolments		Lifestyle reviews collected - 6 weeks post	
PROVIDER	**Actual**	**Performance**	**Actual**	**Performance**	**Actual**	**Performance**
HealthWEST - Māori	140	105%	67	84%	35	62%
FONO - Pasifika	121	91%	106	126%	53	94%
TANI – South Asian	176	132%	134	159%	91	162%
CNSST - Asian	186	139%	322	335%	102	159%
Total	623	138%	629	175%	281	141%

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 and Former Refugee Health Gain team continue to support NRHCC to provide culturally appropriate guidance for the current COVID-19 response in the Auckland region. The team continue to work and liaise with ethnic leaders and community partners in promoting and disseminating the key information and messaging from NRHCC in relation to the current outbreak. The team is supporting Office of Ethnic Communities in producing culturally appropriate short videos on the importance of following official COVID-19 instructions.

The team is in consultation with key trusted Asian and Middle Eastern, Latin American and African (MELAA) ethnic partners in collating feedback on COVID-19 vaccine hesitancy to inform culturally appropriate messaging via NRHCC.

The team is providing feedback from an Asian and MELAA perspective into the development of the COVID-19 Public Health Strategy and Operational Programme (led by MoH).

9.2 Increase access and utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a PHO to meet 90% by 30 June, 2021

The number of Asian enrolees Q1 2021 has increased by 542 for Auckland DHB, compared to last quarter. The Waitematā DHB PHO enrolment is 80%.

(The population projections '2020 Update' (based on Census 2018) is used for the analysis of Q1 2021. Earlier (e.g Q4 2020), the '2019 Update' which was based on Census 2013 was used).

The team have provided input into the Refugee Health Handbook Edition 2 and into the Migrant and Refugee section of the Health Pathways page.

We continue to work with community stakeholders and promote the updated resources and flyers, on the NZ Health and Disability System. Work is underway in producing the NZ Health and Disability System awareness raising video in Arabic.

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)

In October 2020, the New Zealand government agreed to resettle refugee and asylum seekers under emergency priority (people who need protection because they face an immediate life-threatening situation, deportation, detention or imprisonment) referred by the United Nations Refugee Agency (UNHCR).

As part of this, a variation to the existing eligibility criteria in the *Improving access to general practice services for former refugees and current asylum seekers* agreement is being made to include a new category – 'quota refugee emergency cases referred by the United Nations Refugee Agency (UNHCR)'. This is to ensure that those arriving under the emergency quota and resettling in the metropolitan Auckland region are able to access the funded services under the existing aforementioned agreement.

Earlier in February, the Government announced that New Zealand's Refugee Quota Programme will be resuming, and small groups of refugee families will start arriving for resettlement from mid-February 2021.

The team has provided feedback into Ministry of Health review, conducted by PWC on Mental Health Pathway and settlement support available for Former Refugees after they are resettled in the communities.

AAA Screening Pilot with Tongan men

Recommendation

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.**

Prepared by: Dr Karen Bartholomew (Director Health Outcomes), Anna Maxwell (Study Coordinator), Erin Chambers (Project Manager, AAA screening), Aivi Puloka (Clinical Coordinator, Tongan AAA screening); Mr Andrew Hill (ADHB Vascular Service); Mellissa Murray (AAA screening administrator); Dr Corina Grey (previous AAA screening clinical lead and advisor), Leani Sandiford (Pacific Health Gain team).
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

AAA		Abdominal aortic aneurysm
AF		Atrial fibrillation
ADHB		Auckland District Health Board
WDHB	-	Waitematā District Health Board
PHO	-	Primary Health Organisation

1. Executive summary

This paper reports on the recently completed pilot of abdominal aortic aneurysm (AAA) and atrial fibrillation (AF) screening with 150 Tongan men.

The project follows on from the success of the Māori AAA/AF screening programme and is the first part of the DHB programme assessing the feasibility, acceptability and potential benefits of AAA screening among Pacific populations, in order to inform recommendations regarding a national AAA screening programme in NZ. Auckland DHB championed the extension of the approach for Pacific, and the project was funded by an A+ Trust grant.

The project began with focus groups with Tongan men in December 2019 and screening was completed in October 2020 with a high uptake rate. Seven AAAs were identified and these participants are being followed up in a surveillance programme.

This paper notes the key lessons learned relevant for implementation from the project and outlines next steps.

2. Background

Abdominal aortic aneurysm is a disease in which the main artery in the abdomen balloons out and, if it becomes large enough, can burst, usually with fatal consequences, unless it is repaired surgically

beforehand. Studies have shown that Māori men and women and Pacific men have a particularly high risk of dying from AAA.[1] Among Māori and Pacific men who undergo surgery for AAA, most (60%) do so in an emergency, rather than elective basis, whereas the reverse is true for European men (61% undergo elective repair).[2] Mortality from AAA can be significantly reduced for men ≥64 years through once-in-a-lifetime abdominal ultrasound screening of the aorta.[3]

Atrial fibrillation is an irregular heart rhythm that is an important risk factor for stroke. It can be managed with antithrombotic therapy (mostly warfarin or dabigatran) to reduce symptoms and prevent complications. Both Māori and Pacific populations have strokes at younger ages than non-Māori, non-Pacific[4] therefore identification of AF as a stroke risk factor could potentially be important in reducing stroke inequities.

CPHAC has previously received reports on the successful WDHB/ADHB pilot projects in which 2500 Māori men and women completed screening for AAA/AF from 2016-2018. Based on the findings of these pilots, Māori men aged 65 years had a prevalence of AAA approximately double that of the men who participated in UK and Swedish AAA screening programmes. There have been no studies to date examining the prevalence of AAA in Pacific populations.

Previous NZ research into AAA mortality using national datasets indicates that AAA mortality is just as high in Pacific men as in Māori men [1], and risk factors for AAA, including smoking and a history of vascular disease, are also high in Pacific people. Aside from a lack of data about AAA prevalence, there are uncertainties regarding the impact of higher rates of obesity and diabetes in Pacific populations on the validity of abdominal ultrasound as a screening tool.

Given the significant gaps in our current knowledge about the impact of AAA screening on Pacific populations, as well as a need to ensure that Pacific health and equity remains central to health system decision making, further research to assess the benefits and harms of screening in Pacific people is needed in order to make evidence-informed recommendations regarding a national AAA screening programme in NZ.

3. DHB Programme

The Auckland DHB and Waitematā DHB AAA/AF programme consists of a series of interconnected implementation projects that aim to achieve better understanding of these conditions in NZ populations and robust testing of potential approaches focused on equity (Figure 1 below).

[1] Rossaak J, Sporle A, Birks C and van Rij A. Abdominal aortic aneurysms in the New Zealand Māori Population. Br J Surg 2003;90(11):1361-1366 and Sandiford P, Mosquera D, Bramley D. Ethnic inequalities in incidence, survival and mortality from abdominal aortic aneurysm in New Zealand. J Epidemiol Comm Health 2012;doi: 10.1136/jech-2011-20075

[2] Chiang N, Jain JK, Hulme KR, et al. Epidemiology and outcomes of abdominal aortic aneurysms in New Zealand: a 15-year experience at a regional hospital. Ann Vasc Surg 2018; 46:274-284.

[3] Takagi H, Ando T, Umemoto T : ALICE (All-Literature Investigation of Cardiovascular Evidence) Group. Abdominal aortic aneurysm screening reduces all-cause mortality: make screening great again. Angiology 2018; 69(3):205-211

[4] AM Tomlin, H. L. (2017). Atrial fibrillation in New Zealand primary care: Prevalence, risk factors for stroke and the management of thromboembolic risk. European Journal of Preventive Cardiology, 311-319.

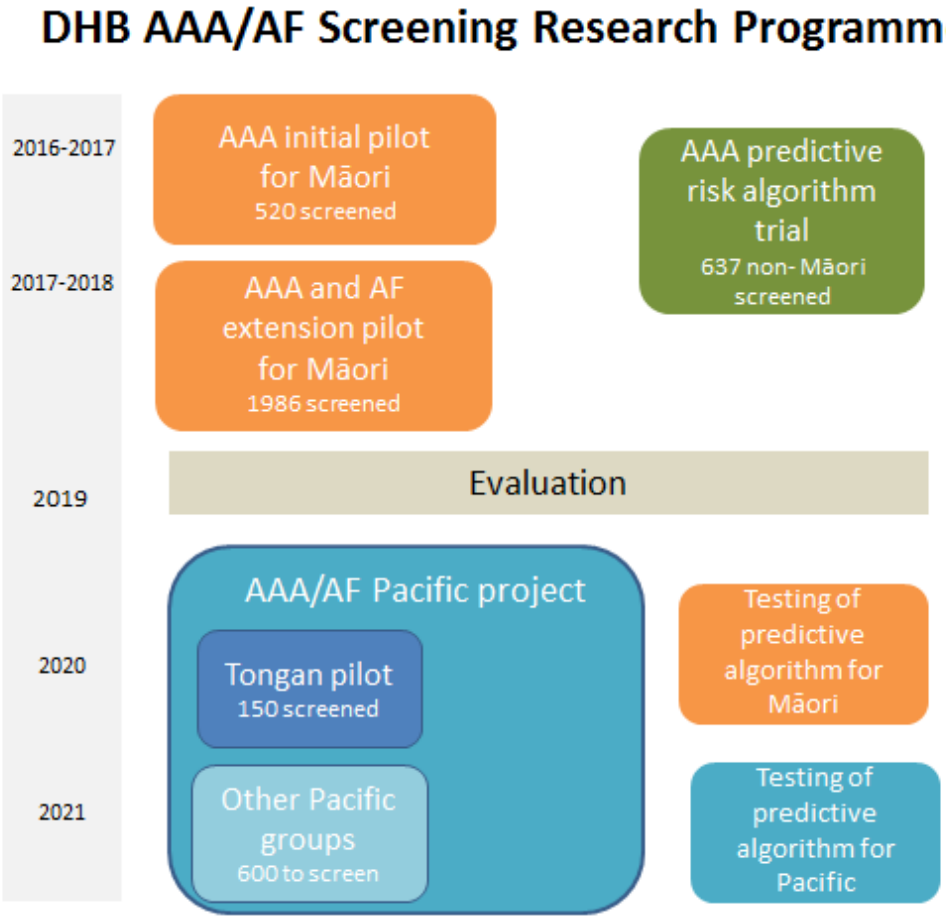


Figure 1. DHB AAA/AF Programme

The Pacific AAA/AF screening project is an observational cross-sectional study screening 750 Pacific men (60-74 years). It will provide robust data on AAA prevalence and the suitability of abdominal ultrasound as a screening tool in Pacific people. It also tests a range of parameters of importance to the development of national policy on AAA and AF screening, including the acceptability and feasibility of community screening, effective strategies for optimising invitation methods and follow-up, and the feasibility of offering other health interventions within the context of the screening session. Alongside results from the previous AAA/AF screening pilots, results from the Pacific pilot will contribute to policy options for future regional and national AAA screening programmes.

The Pacific AAA/AF screening research programme has strong clinical and academic leadership from ADHB Vascular Service and Cardiology, the University of Auckland and University of Otago. The steering group has representation from vascular service (ADHB vascular service and Lupe Taumoepeau, Pacific vascular surgeon Capital & Coast DHB), primary care, Pacific advisors within DHB Planning & Funding and the Pacific community.

The project has chosen to take a Pacific ethnic-specific approach, beginning with a pilot with Tongan men, supported by DHB Tongan staff who have close links with the Tongan community and strong language and cultural skills.

A grant for the pilot was received from ADHB A+ Trust.

4. Tongan pilot methods

Focus groups

The Tongan Pacific AAA/AF screening project began with focus groups with men likely to be eligible for screening. The groups advised on invitation methods and resources, whether the draft participant invitation material was easy to understand, the amount and content of information and how participants responded to the design of the brochure.

Feedback from the focus group participants directly informed the changes to the study materials (including written, graphic design, instructions, use of QR codes) as well as informing support pathways. Based on the findings, amendments were made to participant materials.

Book a FREE scan today

For an appointment or more information call
0800 55 75 85
Or
021 198 8568
To access Pacific translated documents visit
http://www.waitematadhb.govt.nz/healthy-living/pacific-aaa-screening-project/

'We need to look after our health for our mokopuna and be there for our family.'

Where can I get advice and support?

You can talk with your doctor to see if they believe that screening is the right thing for you or you can call us to talk about it more.

Dr Aivi Puloka
Waitematā and Auckland DHB
Aivi.puloka@waitematadhb.govt.nz

Dr Karen Bartholomew
Principal Investigator, Waitematā and Auckland DHB
Karen.Bartholomew@waitematadhb.govt.nz
Phone (09) 486 8920 ext. 45407

If you want to talk to someone who is not involved in the study, (and not your doctor), you can contact an independent health and disability advocate.

Phone – 0800 555 050

Email – advocacy@advocacy.org.nz

This study has received ethical approval from Northern B Health and Disability Ethics Committee (Ref 19/NTB/227)

For more information, you can talk to your doctor, they know that you have been invited for this scan, or you can contact the AAA team: **0800 55 75 85**

Fou's story

Last year I noticed some chest discomfort over my heart that was not there all the time and not painful but enough to make me worry about a heart attack. I went to see my GP and got an ultrasound scan.

I took the scan report back to my GP on the same day who arranged for admission to Auckland Hospital immediately and I had surgery the next morning.

What I couldn't understand was why my GP and the hospital doctors were rushing to get me to theatre because I was not sick and did not have any pains. The doctors said I had a large aneurysm that needed urgent repair to prevent bleeding.

I am a very lucky man that the aneurysm was picked up in time and I got my surgery before any complications. I have asked my brother to go for aneurysm check-up because it runs in the family and I had not heard of aneurysm before. I have stopped smoking since.

Fou Sagaga is Samoan, 69 years of age, living in West Auckland with his wife and four grown up children.

Classification number: 0180-01-088 (Date issued: July 2020

Pacific Abdominal Aortic Aneurysm Screening Project

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitematā District Health Board Best Care for Everyone

Figure 2. Brochure for Pacific invitees

Screening

Screening sessions were held either at practices or convenient community locations, drawing on our experience from previous pilots of the importance of appropriate screening venues and times. In addition to an abdominal ultrasound scan for AAA and AF screening (using a simple Kardia mobile ECG device), the screening session involved a range of other 'co-benefits'. Blood pressure was taken on all participants and smokers were given brief cessation advice and offered referral to quit smoking services. Participants were also given general health promotion advice.

Screening was supported by as far as possible by face-to-face discussions with an onsite clinician who was able to converse in Tongan. Screening results were given to participants immediately. Where participants are found to have an aortic diameter ≥30mm, a referral for further assessment and on-going surveillance was made and the GP notified. Screening and follow up were supported by routine quality assurance and failsafe processes.

Screening was completed in October 2020. Overall COVID-19 lockdowns delayed the completion of the pilot by approximately four months.

5. Results from the Tongan pilot

The pilot achieved a high rate of participation with low Did Not Attend (DNA) rates. Invitations sent to 227 Tongan men resulted in 150 men completing screening, an overall participation rate (66%) similar to the participation in the extended Māori AAA screening pilot. Two people had an informed decline to participate.

Of the 150 Tongan men screened:

- 7 AAA (≥ 30mm) were found (4.7%)
- 4 new cases of atrial fibrillation (1 of these cases was urgently referred via the project to cardiology, another to heart failure clinic at follow-up)
- 4 participants were referred back to their GP for very high blood pressure
- 4 participants were referred to smoking cessation services (39 participants were current smokers, 67 were ex-smokers).

Feedback from participants was very positive:

> *"…I am so happy to join this project. I am here today because I want to take care of my life."*
>
> *"….I really want to thank you for giving me this opportunity… I came a skeptic and I don't usually listen to health providers' advice, but today I am happy to give up smoking"*
>
> *"…the clear description and explanation you have given me is something a lot of Tongans out there need to hear. "*

6. Key implementation lessons learned from the Tongan pilot

- The positive feedback and high participation rates indicate that with careful attention to design of a person-centred and culturally appropriate programme, a one-off screen for AAA is highly acceptable to Tongan men.
- One of the key factors in the high uptake rate is likely to have been the employment of a Tongan lead with established relationships with the Tongan community, who publicised the project through Tongan radio and churches and was very active in following up invitees in their own language. While posted invitations served as a useful reference for subsequent conversations, only a few participants mentioned that they had seen and read the invitation letter.
- Close involvement of partners and family who were often active in supporting and taking responsibility for husband's health was important in achieving the outcomes for Tongan men.
- Accessible community locations for screening were important as transport was an issue for many participants.
- There were no cases of non-visualisation at screening, confirming the suitability of ultrasound to assess the abdominal aorta in this population.
- AF screening and other health checks were readily incorporated into the screening process.

7. Completion of the Pacific AAA/AF screening project

The Pacific AAA/AF screening programme continues to progress with other Pacific groups. Screening is on-going at participating PHOs for eligible Niuean and Cook Island populations (supported by Dr

Colin Tukuitonga on Niue/Cook Island radio) and screening with Samoan men is in progress. Overall the project seeks to recruit 750 people to determine AAA prevalence in Pacific men. Future extensions of the programme intend to include Pacific women.

Evaluation

Our previous interviews with participants of the Māori AAA pilots identified that some people experienced stress around attending the first specialist appointment (for example discomfort around asking questions) and a small proportion experienced anxiety relating to being diagnosed with an aneurysm.

As part of the project evaluation, follow up interviews are being conducted by a Tongan nurse with Tongan men found to have an aneurysm at screening. We are interested in their experience of the invitation process, the follow up specialist appointment at the hospital as well a how they are getting on now with their diagnosis.

Project data will be interpreted in the context of overseas programmes and recent Māori and non-Māori pilot programme.

8. Conclusion

Optimisation of the screening programme for Tongan population from the outset of project development appears to have supported a high uptake of the offer of screening and a positive screening experience. A formal evaluation is being completed; feedback to date suggests a positive experiences can contribute to increased trust in the health system. While the sample in the Tongan men in the pilot was small, seven AAAs were identified, indicating the prevalence may be similar to that in Māori men. Some participants also received a range of co-benefits.

Tobacco Control and Vaping Update

Recommendations:

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.**

Prepared by: Leanne Catchpole (Programme Manager, Primary Care), Dr Subha Rajanaidu (Public Health Physician), Dr Andrew Old (Clinical Director, Health Gain)
Endorsed by: Dr Karen Bartholomew (Director, Health Outcomes), Dr Debbie Holdsworth (Director, Funding)

Glossary

ARPHS – Auckland Regional Public Health Service
DHB – District Health Board
MOH – Ministry of Health
RSQ – Ready Steady Quit

1. Executive Summary

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. In the interim, this paper provides a brief background and update on current DHB activities.

2. Introduction & Background

In Auckland DHB 10% of the total population are regular smokers (Census 2018, usually resident population), with 23% of Māori and 20% of Pacific being regular smokers. This is a decrease from the 2013 Census when the rate of smoking was 11% for the total population, 26% for Māori and 22% for Pacific.

The DHB is contracted by the Ministry of Health (MOH) to provide leadership and coordination of tobacco control activities that facilitate an integrated tobacco control environment that supports smoking cessation, with a focus on Māori, Pacific populations and pregnant women.

Auckland DHB utilises this funding of $493,000 to fund smokefree coordination roles in secondary care and mental health and addiction services. The DHB previously funded similar roles in Primary Health Organisations (PHOs), however these agreements ended in June 2020 as they had achieved their purpose of establishing smokefree systems, training and resources. The funding is being reallocated to target investment into services for Māori and Pacific populations and we are working with Māori and Pacific NGOs to develop a community based approach to support more Māori wāhine and Pacific to quit.

In addition, the Ministry of Health contracts directly with ProCare for the delivery of stop smoking services for the Auckland and Waitematā DHB populations. ProCare delivers this service, called Ready Steady Quit (RSQ), in partnership with The Fono.

Auckland DHB also utilises baseline funding to contract for a Pregnancy incentives programme – the DHB funds incentives of up to $350 per pregnant woman and $200 per whānau member at milestones along their stop smoking journey. The service is provided by RSQ.

The Planning, Funding and Outcomes Team will continue to review and update the DHB's tobacco control plan as part of the engagement with, and aligned to, the new national Smokefree 2025 Plan. Changes are expected in the DHB's tobacco control contract with the MoH, and due to the outcome of the consultation process on the vaping regulations vaping will come under the national Smokefree 2025 action plan.

3. Next Steps

Smokefree 2025 Plan
The draft national Smokefree 2025 Plan is expected to be released for consultation in March or April. The Auckland Regional Public Health Service (ARPHS) will lead the compilation of the metro-Auckland DHBs feedback on the plan. Auckland DHB are active contributors to the development of the regional response and there will be opportunities for the DHB and our communities to contribute to the plan as it develops.

Vaping Regulations
The Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020 (the Amendment Act) commenced on 11 November 2020. The Amendment Act amended the Smoke-free Environments Act 1990 and renamed it the Smokefree Environments and Regulated Products Act 1990 (the Act).

The Act aims to strike a balance between ensuring vaping products are available for smokers who want to switch to a less harmful alternative, and ensuring these products aren't marketed or sold to young people.

Public consultation on the vaping regulations is now open. Responses can be submitted until 5.00pm on 15 March 2021. The MoH is seeking feedback on a number of regulatory proposals that will help achieve the intent of the new provisions of the Act. ARPHS is leading the compilation of the Auckland Region DHBs' submission on the regulations due to the strong compliance focus of the consultation document.

The MoH is working directly with Hāpai Te Hauora to run a series of events where Māori and Pacific communities will be able to gather and have a say on regulations that will affect our most impacted communities.

4. Conclusion

Auckland DHB continues to purchase services in line with the MoH's expectations for its tobacco control agreement. The DHB is also purchasing an additional tobacco control service from baseline funding. All services have an equity focus, with specific emphasis on reaching Māori and Pacific populations.

The MoH is currently consulting on amendments to the Smokefree Environments and Regulated Products Act 1990 that includes new regulations regarding vaping and will soon begin consultation on a national Smokefree 2025 Plan. The DHB will provide submissions to both of these opportunities and develop our local plan to reflect them once national expectations and funding intentions are finalised. There is an opportunity for local input and activities aligned with the national framework.

System Level Measures – Quarter 2 Report

Recommendation:

That the Community and Public Health Advisory Committee note the Quarter two[1] results for the fifth System Level Measures (SLM) Improvement Plan.

6.4

Prepared by: Wendy Bennett (Planning and Health Intelligence Manager)
Endorsed by: Dr Debbie Holdsworth (Community and Provider Funding and Procurement) and Karen Bartholomew (Director Health Outcomes)

Glossary

ACP	-	Advance Care Plan
ALT	-	Alliance Leadership Team
ARPHS	-	Auckland Regional Public Health Service
ASH	-	Ambulatory sensitive hospitalisations
CEO	-	Chief Executive Officer
CVD	-	Cardiovascular disease
DHB	-	District Health Board
ED	-	Emergency Department
HT	-	Health Target
HQSC	-	Health Quality and Safety Commission
PES	-	Patient Experience survey
PHC	-	Primary health care
PHO	-	Primary Health Organisation
POAC	-	Primary Options for Acute Care
SLM	-	System level measure
WCTO	-	Well Child/Tamariki Ora

1. Introduction

Please note that due to COVID-19, some data has been delayed and also activities and actions that were paused over lockdown will take time to recover performance.

The System Level Measures (SLMs) Framework was developed by the Ministry of Health with the aim of improving health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. This provides a framework for continuous quality improvement and system integration.

System Level Measures are set nationally and designed to be outcomes focused, requiring all of the health system to work together to achieve. They are focused primarily on children, youth and those parts of the population who experience poorer health outcomes than others. DHBs are able to choose from a suite of 'contributory' measures or devise their own – which they have identified as having the biggest impact on achievement of each system level measure. These in turn are connected to local clinically led quality improvement activities.

System Level Measures recognises that good health outcomes require health system partners to work together. Therefore the district alliances are responsible for implementing SLMs in their districts.

[1] Latest available data currently

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) jointly developed the 2020/21 System Level Measures Improvement Plan and are firmly committed to achieving the SLM milestones over the medium to longer term. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. Contributory measures were added where data collection processes have been developed in response to identified clinical priorities.

The steering group continues to meet in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. PHO Implementation Groups also meet to support and enable implementation of SLM improvement activities.

This paper provides quarter two results (where available) on the current (fifth) improvement plan: 2020/21. The six System Level Measures are:

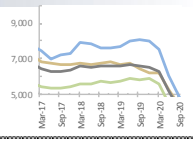
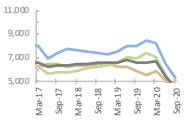
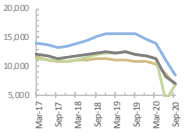
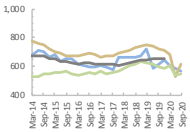
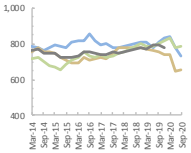
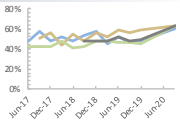
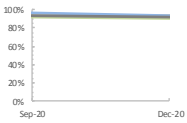
1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2020/21. The milestone must be a number that improves performance from the district baseline, reduces variation to achieve equity, or for the developmental SLMs, improves data quality. In 2020/21, the Auckland Metro Region has continued focusing on cross–system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. The work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

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

This report includes the most up-to-date data available at quarter two for each DHB for both the SLMs and contributory measures. It also outlines progress against the improvement activities identified for each SLM in the SLM Improvement Plan.

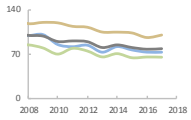
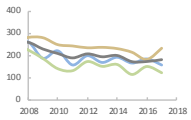
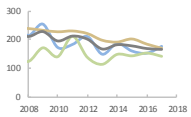
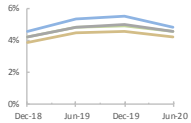
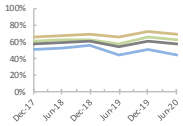
Scorecard – Part 1

		DHB / Region	Target		Performance: Actual	Data Period	Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds							
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Total Population	Auckland	7,749 (max.)	●	**4,822**	12-monthly	
		Counties Manukau	6,062	●	**4,380**	to	
Target 2020/21:	3% reduction	Waitemata	5,727	●	**3,511**	Sep-20	
		Metro Auckland	6,341	●	**4,162**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Maori	Auckland	8,155 (max.)	●	**5,294**	12-monthly	
		Counties Manukau	5,421	●	**4,539**	to	
Target 2020/21:	3% reduction	Waitemata	7,170	●	**4,095**	Sep-20	
		Metro Auckland	6,459	●	**4,518**		
Measure:	Rate per 100,000 domiciled 0-4 year-olds - Pacific	Auckland	14,391 (max.)	●	**8,505**	12-monthly	
		Counties Manukau	10,440	●	**6,721**	to	
Target 2020/21:	3% reduction	Waitemata	11,510	●	**6,904**	Sep-20	
		Metro Auckland	11,503	●	**7,138**		
2. Acute Hospital Bed Days							
Measure:	Age-standardised rate per 1,000 domiciled population - Maori	Auckland	623 (max.)	●	**566**	12-monthly	
		Counties Manukau	686	●	**610**	to	
Target 2020/21:	3% reduction	Waitemata	567	●	**542**	Sep-20	
		Metro Auckland	631	●	**577**		
Measure:	Age-standardised rate per 1,000 domiciled population - Pacific	Auckland	809 (max.)	●	**729**	12-monthly	
		Counties Manukau	718	●	**655**	to	
Target 2020/21:	3% reduction	Waitemata	791	●	**789**	Sep-20	
		Metro Auckland	753	●	**698**		
3. Patient Experience of Care							
Measure:	DHB Adult Inpatient Experience Survey - medicine side effects question	Auckland	50%	●	**66%**	Quarterly	
		Counties Manukau	62%	●	**62%**	to	
		Waitemata	47%	●	**59%**	Dec-20	
Target 2020/21:	5% improvement	Metro Auckland	52%	●	**61%**		
Target 2020/21:	Primary Care Survey - cultural needs	Auckland	98%	●	**93%**	Quarterly	
		Counties Manukau	97%	●	**91%**	to	
		Waitemata	100%	●	**93%**	Dec-20	
Target 2020/21:	Establish baseline and then 5% improvement	Metro Auckland	98%	●	**92%**		

A note about the population:

Stats New Zealand and the Ministry of Health recently released updated population estimates and projections using new methodology (and there are likely to be further updates to these figures). This had a significant impact on the population figures for Auckland DHB, with substantially fewer people living within the DHB boundaries according to these new figures compared with previous estimates and projections. This will in turn have a substantial impact on performance against those measures that use DHB population as denominator. Going forward, there may be marked changes in both current results and trend information. Note: that some of the target data has had to be reworked within this dashboard and therefore, may not match the target presented in previous SLM Plans or previous dashboards/reporting.

Scorecard – Part 2

		DHB / Region	Target		Performance: Actual	Performance: Data Period	Performance: Trend
4. Amenable Mortality							
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds.	Auckland	69 (max.)	●	**73**	12 monthly	
		Counties Manukau	98	●	**100**	to	
	6% reduction by 2021	Waitemata	62	●	**65**	Dec-17	
Target 2020/21:		Metro Auckland	75	●	**78**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Maori	Auckland	180 (max.)	●	**156**	12 monthly	
		Counties Manukau	177	●	**232**	to	
	2% reduction by June 2021	Waitemata	146	●	**121**	Dec-17	
Target 2020/21:		Metro Auckland	168	●	**180**		
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds - Pacific	Auckland	150 (max.)	●	**177**	12 monthly	
		Counties Manukau	181	●	**171**	to	
	2% reduction by June 2021	Waitemata	151	●	**142**	Dec-17	
Target 2020/21:		Metro Auckland	166	●	**166**		
5. Youth Health							
Measure:	Chlamydia testing coverage for 15-24 year-old males.	Auckland	6%	●	**4.8%**	12 monthly	
		Counties Manukau	6%	●	**4.2%**	to	
Target 2020/21:	6% coverage rate by June 2021	Waitemata	6%	●	**4.6%**	Jun-20	
		Metro Auckland	6%	●	**4.5%**		
6. Babies Living In Smokefree Households							
Measure:	Proportion of babies living in smokefree homes at 6 weeks postnatal	Auckland	68%	●	**69%**	6 monthly	
		Counties Manukau	46%	●	**44%**	to	
Target 2020/21:	2% increase on baseline	Waitemata	59%	●	**62%**	Jun-20	
		Metro Auckland	56%	●	**57%**		

Legend

- ● Target met / on track
- ● Improvement needed
- ● Significant improvement needed
- ● Data or target unavailable

- Metro Auckland Region
- Auckland DHB
- Counties Manukau DHB
- Waitematā DHB

Overall Progress Report

Overarching activities for Q2:

- Implementation of the 2020/21 SLM Improvement Plan is well established.
- Reporting is released quarterly or more frequently where available to PHOs via Citrix Sharefile or from Healthsafe, which allows safe and secure sharing of confidential information.
- The 2021/22 SLM Improvement Plan is currently under development.

3. System Level Measures Report

Keeping children out of hospital

ASH rates per 100,000 for 0–4 year olds

Improvement Milestone: 3% reduction (on Dec-19 baseline) (by ethnicity) by 30 June 2021

	Milestone Target			**Actual – 12 months to September 2020**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Total pop.	7,749	6,062	5,727	4,822	4,380	3,511
Māori	8,155	5,421	7,170	5,294	4,539	4,095
Pacific	14,391	10,440	11,510	8,505	6,721	6,904

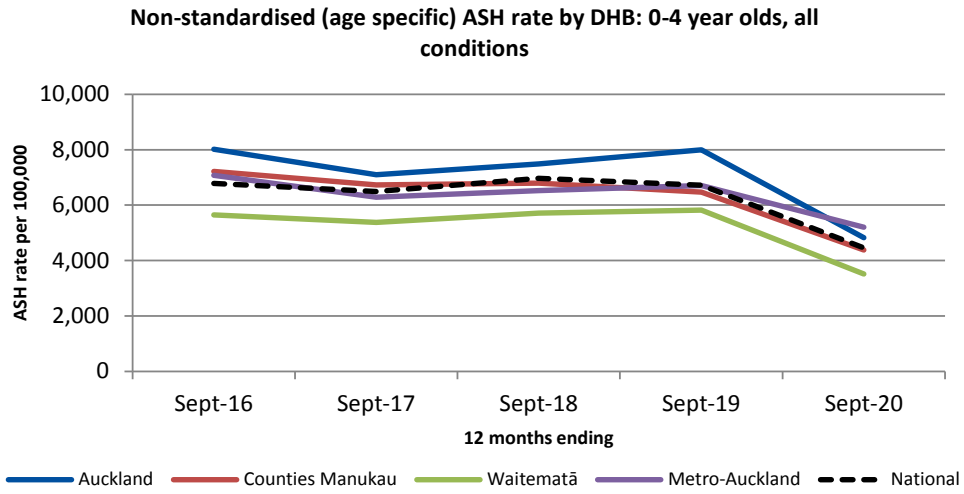
Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

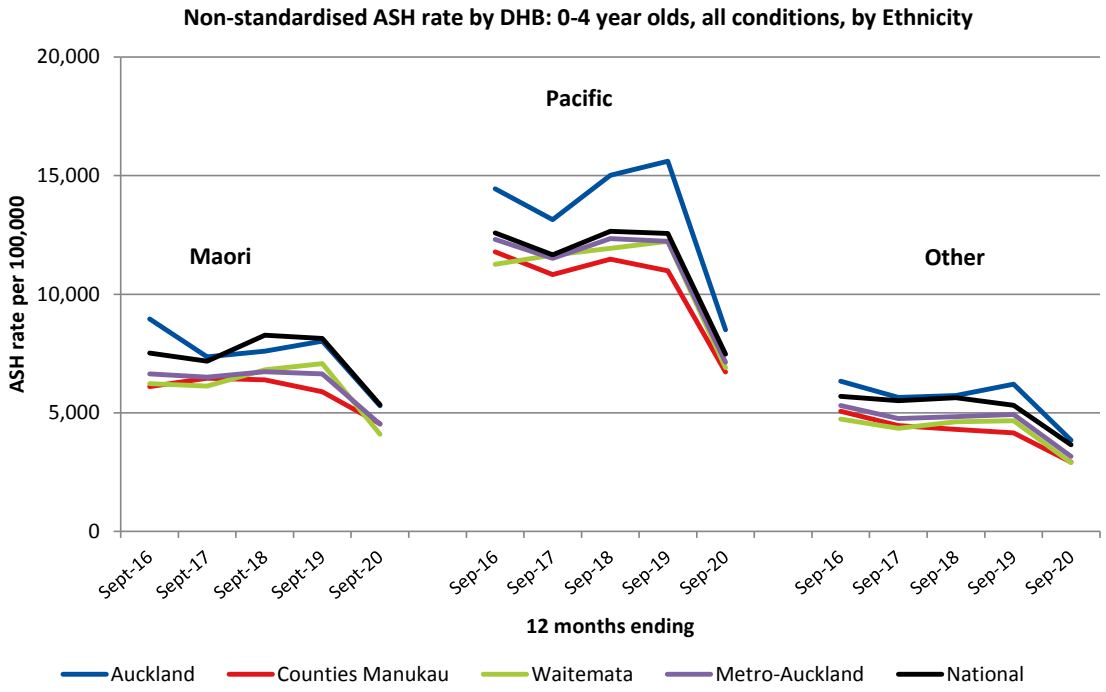
Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

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

In 2020/21, the overall improvement milestone and the milestone for both Māori and Pacific ASH rates are to achieve a reduction of 3% for 0-4 year olds by June 2021. Ethnic specific targets are important to ensure that interventions reduce, not worsen inequity. Metro Auckland's rate is 4,162 per 100,000 for the 12 months to September 2020 for the total population. This is a 36% decrease (improvement) on the results to December 2019 (baseline) of 6,537 per 100,000 population. At an ethnic-specific level, the Māori and particularly Pacific rates also improved (by 32% and 40%) from baseline.

While these results show a very significant improvement compared to baseline, it should be noted that during the COVID-19 lockdown period (Apr-May 2020), many people avoided seeking treatment at healthcare facilities, including hospitals. Therefore lower rates of acute hospital admissions were observed during this period than expected, including admissions for ambulatory sensitive conditions, appearing to improve performance when compared to the previous year. The incidence of some ASH conditions improved through the efforts to reduce the spread of COVID-19 – seasonal influenza and other respiratory infection rates dropped due to social distancing and good hygiene practices (improved vaccination rates may also have impacted influenza rates). Performance will need to be monitored over time to determine if this improvement is sustained.





While the higher (non-standardised) rates for Pacific children and particularly Auckland DHB Pacific children persist, the decline as a result of COVID-19 is significant.

While the gap between ethnicities has declined with the overall decline in ASH admissions, when compared, rates for Pacific are still around four times that of 'Other' ethnicities across metro-Auckland for cellulitis, dermatitis and eczema and around three times the rate for respiratory infections and dental conditions.

Using health resources effectively

Total acute hospital bed days

Improvement Milestone: 3% reduction (on Dec-19 baseline) for Māori and Pacific population by 30 June 2021 (standardised)

	Milestone Target			**Actual – 12 months to September 2020 (latest available)**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Māori	623	686	567	566	610	542
Pacific	809	718	791	729	655	789

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between the community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1,000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). The social determinants of health are a key driver of acute demand.

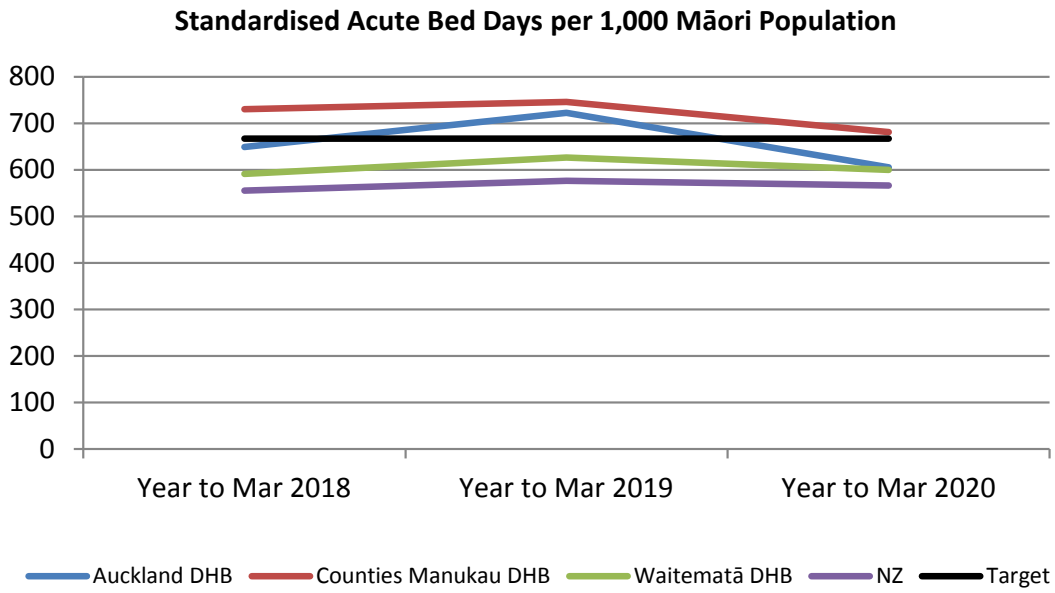
The Auckland Metro age standardised acute bed day rate per thousand population has been re-calculated and targets re-set to reduce the rate by:

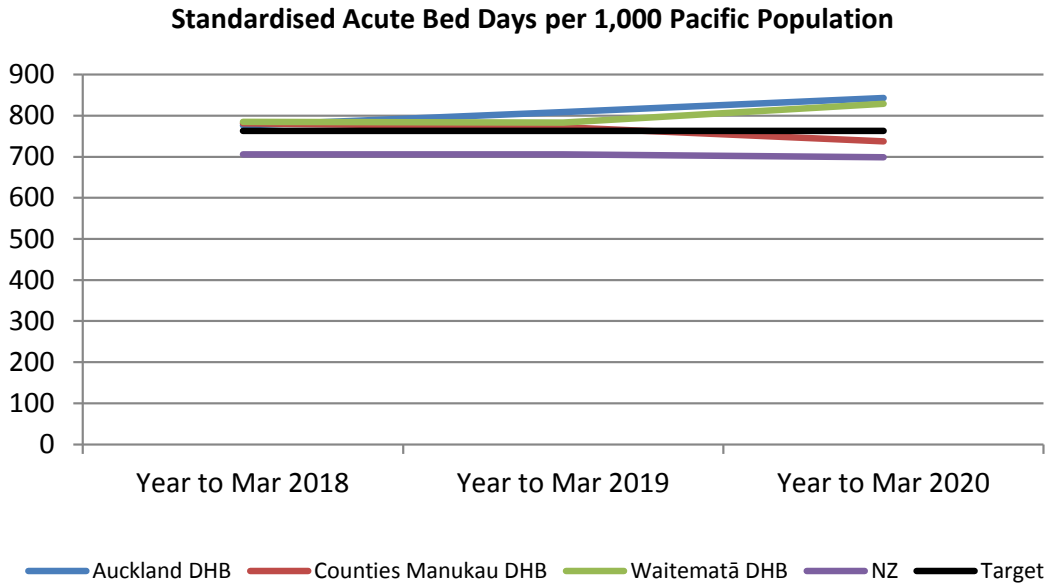
- 3% for the Māori population – target 667.0 standardised acute bed days/1000 by June 2020
- 3% for the Pacific population – target 762.6 standardised acute bed days/1000 by June 2020

It must be noted that the opening of new beds within the region will impact on this indicator.

While overall standardised rates have been generally declining over time, the metro-Auckland ethnic specific rates to March 2020 are mixed. Pacific rates are not meeting target for either Auckland or Waitematā DHBs, rates for Māori are better than target for both these DHBs. For Counties Manukau, performance is the opposite – better for Pacific and worse for Māori.

It is to be noted that only three time periods are presented in the trend graphs below, as recalculation of rates has not been done on retrospective datasets prior to this.


Standardised Acute Bed Days per 1,000 Māori Population
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target


Standardised Acute Bed Days per 1,000 Pacific Population
900
800
700
600
500
400
300
200
100
0
Year to Mar 2018
Year to Mar 2019
Year to Mar 2020
Auckland DHB
Counties Manukau DHB
Waitematā DHB
NZ
Target

Patient Experience

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

Hospital inpatient survey

The nationally applied DHB Adult Inpatient Survey was conducted quarterly from 2014. However, with the move to another reporting provider in 2020, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. The redeveloped survey was conducted for the first time in August 2020 and results are now available for the first quarter (August 2020 survey) and second quarter (November 2020) 2020/21 periods.

The monitored question has changed slightly between the previous Adult Inpatient Experience Survey and the new one:

> Previous question: Did a member of staff tell you about medication side effects to watch for when you went home?
>
> New question: Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?

The 2020/21 target is to achieve a 5% relative improvement on this inpatient survey question by 30 June 2021.

Interventions take a multidisciplinary approach, focusing on culturally appropriate patient-centred information, co-design of patient experience initiatives with a focus on Māori and Pacific, developing an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms and developing a Māori Patient Experience plan endorsed by the Māori Health Equity Committee.

Learnings are to be shared with primary care through established networks and forums. There is also a focus on improving response rates, especially for Māori and Pacific, and monitoring this through regular reporting.

Waitematā DHB convened a Consumer Council in 2019 to advise on DHB priorities, strategy, health literacy and patient experience.

Improvement milestone: 5% relative improvement on the inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?' by 30 June 2021.

Hospital Inpatient survey – percentage of respondents who answered 'yes, completely', to the inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
49.7%	61.8%	47.0%	49.4%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21**	**Q2 2020/21**	**Trend**
Auckland DHB	60.9%	66.3%	↑
Counties Manukau DHB	63.0%	61.5%	↓
Waitematā DHB	63.2%	59.0%	↓
Metro-Auckland	62.7%	61.2%	↓

With the exception of Counties Manukau DHB, the improvement target has been achieved for this measure in Q2 2020/21. However, only Auckland DHB results have improved between quarters one and two of this financial year.

Primary health care patient experience survey (PHC PES)

Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021

The PHC PES was implemented in practices over the 2017/18 year. Since then, practice participation has steadily increased. As noted above, with the move to another reporting provider, the HQSC has taken the opportunity to redevelop both the inpatient and outpatient surveys. The redeveloped survey was conducted for the first time in August 2020 and results are now available for the first quarter (August 2020 survey) and second quarter (November 2020) 2020/21 periods.

Given this is the first year to monitor this particular question, no baseline data could be derived from previous years. Thus, the August 2020 results have been used as baseline to set targets. These results were very high – resulting in the targets being very high.

Primary health care patient experience survey – percentage of respondents who answered 'yes, completely', to the survey question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
98.2%	96.6%	100%	98.1%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21 (Baseline)**	**Q2 2020/21**	**Trend**
Auckland DHB	93.5%	93.0%	↓
Counties Manukau DHB	92.0%	90.7%	↓
Waitematā DHB	95.9%	93.3%	↓
Metro-Auckland	93.5%	92.4%	↓

None of the three DHBs are meeting target in Q2 2020/21, although achievement is above 90% for all.

Preventing and detecting disease early

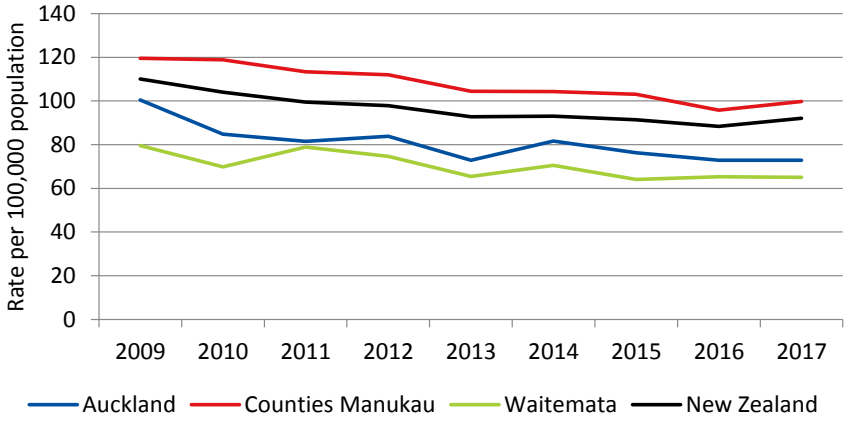
Amenable mortality

Improvement milestone 6% reduction for each DHB (on 2013 baseline) by 30 June 2021.
2% reduction for Māori and Pacific by 30 June 2021.

	Milestone Target			Actual – 2017 deaths		
	Auckland DHB	Counties Manukau DHB	Waitematā DHB	Auckland DHB	Counties Manukau DHB	Waitematā DHB
Total Pop	68.5	98.1	61.5	72.8	99.8	65.0
Māori	179.9	177.4	146.3	156.1	231.7	121.1
Pacific	150.1	180.9	150.5	177.1	170.5	142.3

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before 75 years of age. This indicator considers all deaths for those aged 0-74, in the relevant year with an underlying cause of death included in the defined list of amenable causes. It takes several years for some coronial cases to return verdicts, therefore results for this indicator are approximately 2-3 years delayed. The 2016 mortality coded mortality data has been delayed, as such we are unable to provide updated results currently.

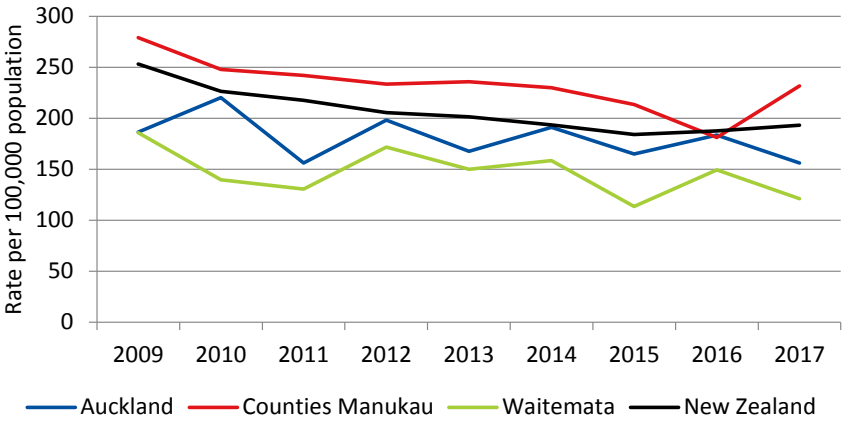
Amenable mortality age standardised rates 0-74 year olds 2009-2017



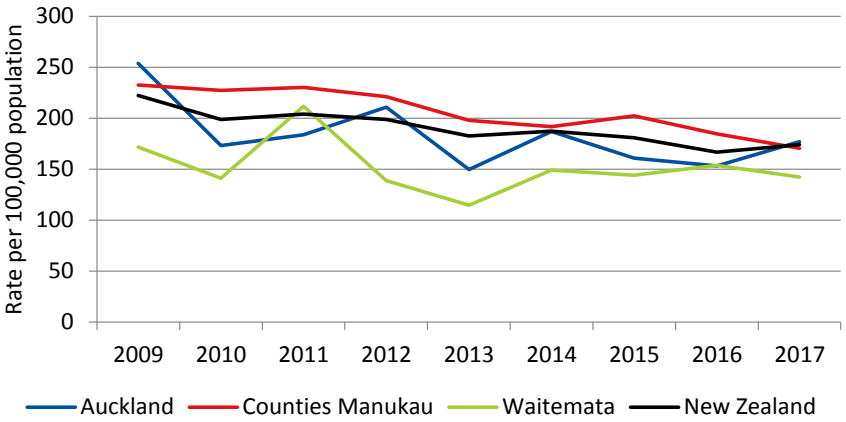
Based on trends over time, all three Metro Auckland DHBs show consistently declining rates as illustrated in the graph above, despite some fluctuation. Comparing current (2017) rates with baseline (2013) rates, there is a 2.3% decline in rates for metro-Auckland, against the targeted 6% reduction to be met by June 2021.

While rates for Māori and Pacific are also declining, the more consistent decline seen for overall rates is not evident and there has been a spike in rates for Counties Manukau DHB for Māori in the latest data.

Amenable mortality age standardised rates 0-74 year old Māori 2009-2017



Amenable mortality age standardised rates 0-74 year old Pacific 2009-2017



Youth access to and utilisation of youth-appropriate health services

Chlamydia testing coverage in 15-24 year old males

Improvement milestone: increase coverage of chlamydia testing for males to 6% for 15-24 year olds by June 2021.

Results for the six-month period to June 2020 (latest available): males only – note this is at a population level (so may include males in this age group who are un-enrolled in a PHO).

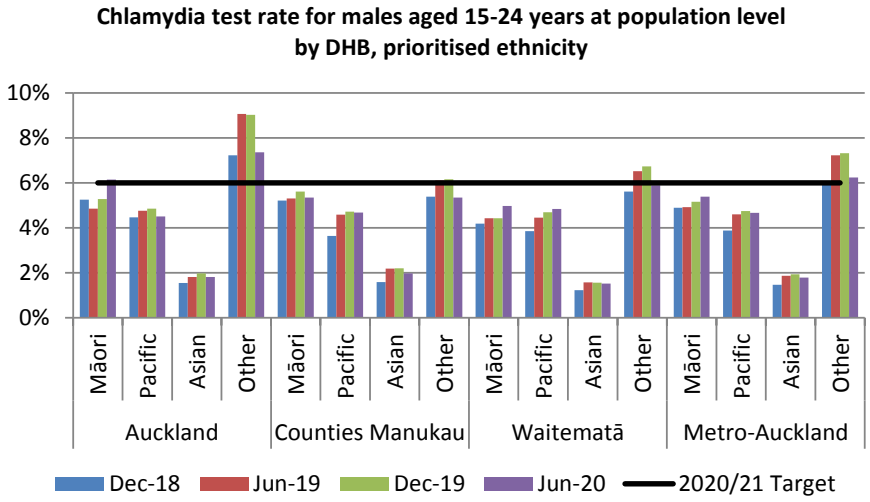
DHB	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
Auckland	Māori	233	3790	**6.1%**	**5.3%**	↑
	Pacific	232	5150	**4.5%**	**4.9%**	↓
	Asian	256	14210	**1.8%**	**2.0%**	↓
	Other	1089	14790	**7.4%**	**9.0%**	↓
Counties Manukau	Māori	461	8630	**5.3%**	**5.6%**	↓
	Pacific	566	12120	**4.7%**	**4.7%**	-
	Asian	235	11920	**2.0%**	**2.2%**	↓
	Other	570	10670	**5.3%**	**6.2%**	↓
Waitematā	Māori	296	5960	**5.0%**	**4.4%**	↑
	Pacific	208	4300	**4.8%**	**4.7%**	↑
	Asian	157	10330	**1.5%**	**1.5%**	-
	Other	1247	21170	**5.9%**	**6.7%**	↓
Metro-Auckland	Māori	990	18380	**5.4%**	**5.2%**	↑
	Pacific	1006	21570	**4.7%**	**4.7%**	-
	Asian	648	36460	**1.8%**	**1.9%**	↓
	Other	2906	46630	**6.2%**	**7.3%**	↓

* 10 with unknown gender excluded

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet can lead to increased risk of poor adult health and overall poor life outcomes.

The focus for 2020/21 is on increasing engagement with young people by working with general practices to encourage participation in the RNZCGP Maintenance of Professional Standards (MOPS) Youth Service audit, as well as increasing sexual health screening and funded sexual health consults for enrolled young people (including screening for pregnant woman).

At a population level, screening coverage rates for men declined slightly overall, when comparing the six months to June 2020 and the six months to June 2019, however, screening may well have been impacted by COVID-19. Between December 2019 and June 2020, rates for Māori improved slightly across the metro region, with the most improvement for Auckland DHB domiciled males, which was the only DHB to make target for Māori. However, the rates for all other ethnicities declined slightly. The gap between Māori and Other ethnicities (non-Māori, non-Pacific, non-Asian) appears to be declining over time and while this is also true for Pacific, it is less pronounced. Given the impacts of COVID-19 on this latest reporting period, further trend information will be required to ascertain if the gap data remains consistent.



Current results – at PHO enrolled population level:

Results at this level, although better, have generally decreased between reporting periods. Again, this is probably due to the impact of COVID-19 on primary care services as well as access behaviour, particularly over the lockdown periods.

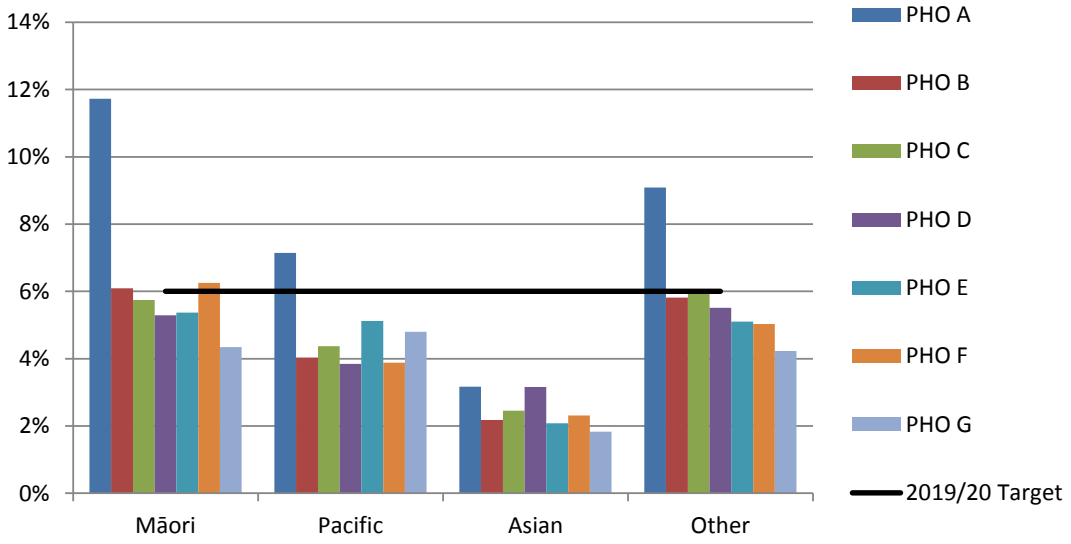
The differences between this level and population level coverage rates suggests that there is under-enrolment for this cohort of the population.

Results at June 2020 compared to December 2019 (2019/20 target 6%):

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
PHO A	Māori	34	290	11.7%	9.0%	↑
	Pacific	26	364	7.1%	9.8%	↓
	Asian	35	1,104	3.2%	3.8%	↓
	Other	112	1,232	9.1%	9.7%	↓
PHO B	Māori	86	1,411	6.1%	6.2%	↓
	Pacific	61	1,513	4.0%	3.6%	↑
	Asian	49	2,250	2.2%	2.7%	↓
	Other	109	1,875	5.8%	7.6%	↓
PHO C	Māori	402	7,004	5.7%	6.2%	↓
	Pacific	367	8,405	4.4%	4.4%	-
	Asian	240	9,765	2.5%	2.6%	↓
	Other	1,512	25,105	6.0%	6.6%	↓
PHO D	Māori	74	1,398	5.3%	5.8%	↓
	Pacific	134	3,485	3.8%	4.4%	↓
	Asian	53	1,676	3.2%	3.3%	↓
	Other	107	1,942	5.5%	6.2%	↓
PHO E	Māori	61	1,136	5.4%	6.6%	↓
	Pacific	28	547	5.1%	4.9%	↑

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
	Asian	37	1,780	2.1%	2.3%	↓
	Other	410	8,042	5.1%	5.8%	↓
PHO F	Māori	161	2,576	6.3%	6.9%	↓
	Pacific	255	6,572	3.9%	4.0%	↓
	Asian	76	3,287	2.3%	2.3%	-
	Other	71	1,412	5.0%	4.3%	↑
PHO G	Māori	14	322	4.3%	6.1%	↓
	Pacific	7	146	4.8%	4.9%	↓
	Asian	26	1,418	1.8%	1.9%	↓
	Other	137	3,240	4.2%	4.1%	↑

Chlaymdia test rate for males aged 15-24 years at PHO enrolled population level by ethnicity - 6 months to June 2020

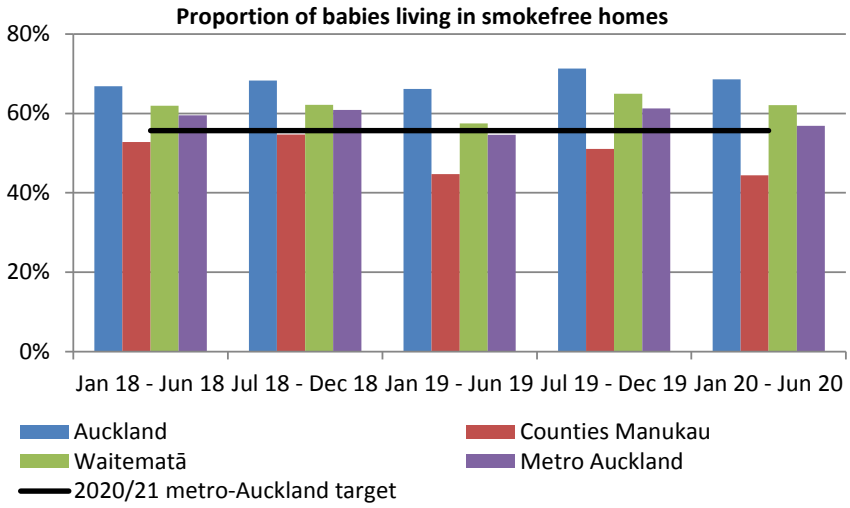


Healthy start

Proportion of babies who live in a smoke-free household at six weeks post-natal

Improvement milestone: Increase the proportion of babies living in smokefree homes by 2% (Jan 19 – Jun 19 baseline)

Reporting period	DHB of domicile			
	Metro-Auckland	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
Jul 19 – Dec 19	61.2%	71.3%	51.1%	64.9%
Jan 20 – Jun 20	56.9%	68.6%	44.4%	62.1%
2020/21 Targets	**55.7%**	**67.5%**	**45.6%**	**58.6%**

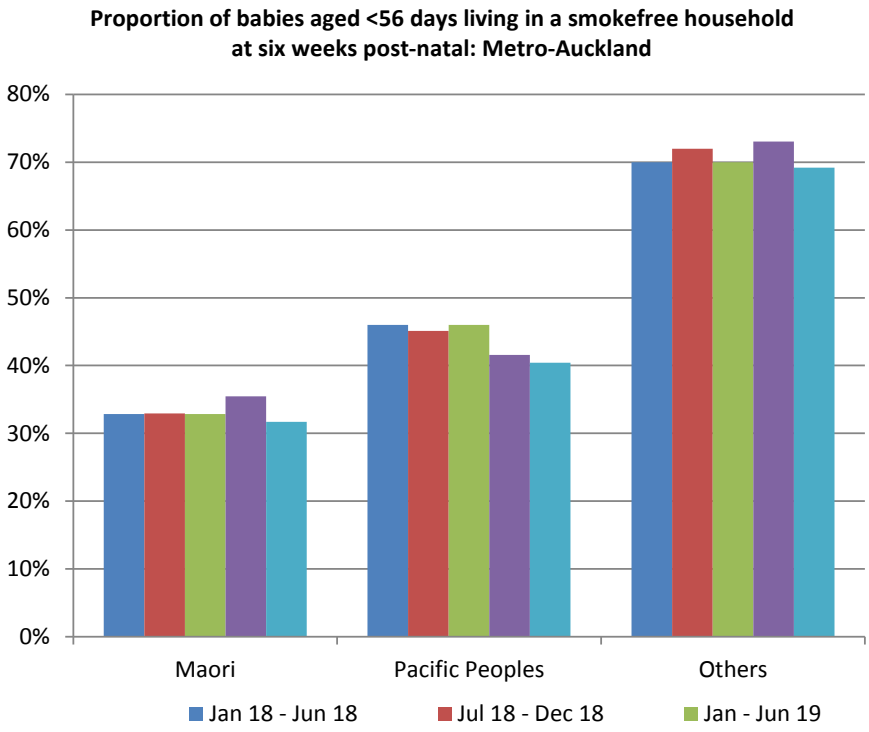


The methodology for calculating measures on previous Ministry of Health releases has been changing. The data from January 2018 uses the latest methodology. Results show that only Counties Manukau DHB is not reaching the DHB's individual target and performance has declined since the last reporting period for all DHBs.

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy to birth and the home environment within which they will initially be raised.

Data is sourced from Well Child Tamariki Ora providers and shows that around 56% of metro-Auckland babies live in a smokefree household at six weeks post-partum with a small improvement since the January - June 2019 reporting period.

The percentage of Māori babies living in smokefree homes is much lower than other ethnicities - 22% in Counties Manukau DHB, 39% in Waitematā DHB and 45% in Auckland DHB. Rates for Pacific are also lower than other ethnicities. Rates for all ethnicities have declined since the previous reporting period. While higher rates correlate with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations, there would also have been some impact from COVID-19 on this indicator.



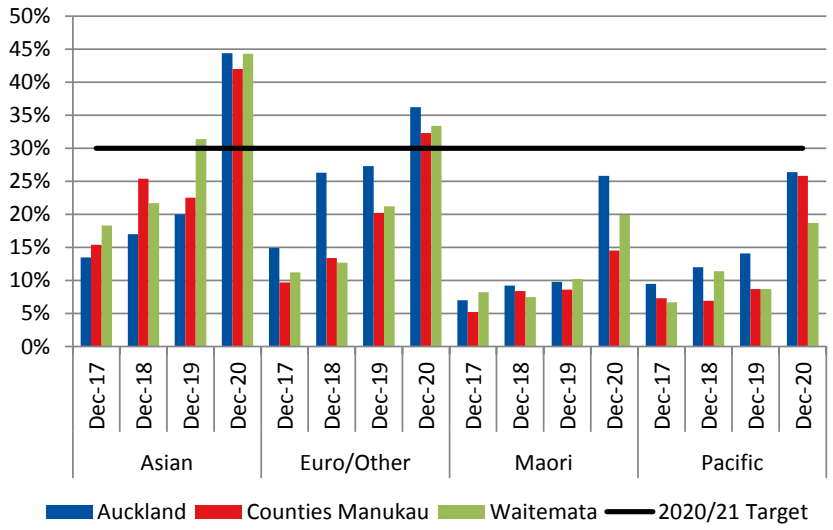
4. Improvement Activities and Contributory Measures

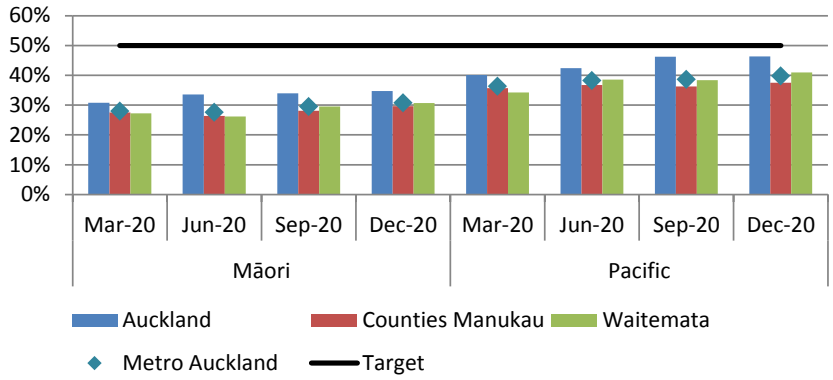
Improvement activities create change and contribute towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2020/21, Auckland Metro region focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Respiratory Admissions in 0-4 year olds

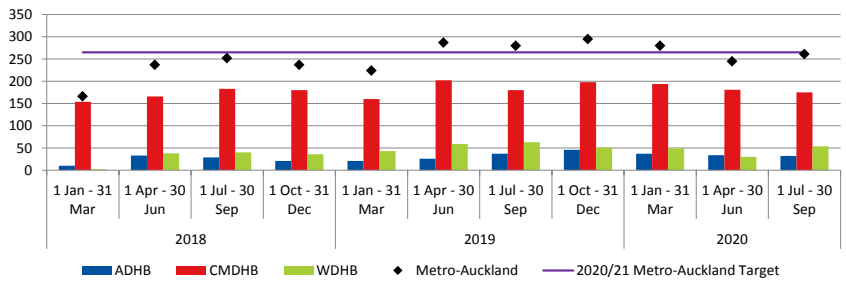
SLM Milestones impacted: Ambulatory Sensitive Hospitalisation (ASH) Rates per 100,000 for 0 – 4 Year Olds
Amenable mortality
Babies in Smokefree Homes
Acute hospital bed days

Respiratory conditions are the largest contributor to ASH rates in Metro Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants and young children, and can lead to further respiratory complications; both of these are vaccine preventable. Social factors like housing and smoking also contribute to poor respiratory health. We are working to increase referrals to healthy housing programmes and help more pregnant women quit smoking. eReferrals for smoking and healthy housing went live in early 2019, supporting a reduction in ASH admissions. We intend to work with healthAlliance to develop a process for matching e-referral data to PHO registers with a view to driving increased referrals from practices.

Indicator	Target	Results
Influenza vaccination rates for eligible Māori and Pacific children	30%	***Flu vaccination rates at December 2017, December 2018, December 2019 and December 2020 for eligible children (those hospitalised with a respiratory condition)***  **Commentary** • Overall coverage has increased from 9.7% in December 2017 to 28.8% in December 2020. Coverage rates have consistently increased since monitoring and improvement activities began. • Auckland DHB domiciled children have the highest coverage at 33.2%, followed by Waitematā at 29.7% • While a coverage rate of nearly 29% has been achieved for the total population, rates for Māori and Pacific children continue to be much lower. While these rates though are also increasing, they are still below the 30% target for all DHBs • Only two of the seven PHOs have surpassed the 30% target for their eligible Māori children, while four have surpassed this target for their Pacific children. Implementation of the special immunisation programme had wide support by PHOs, although national supply chain logistics challenges related to influenza vaccine may have adversely affected these results. The data matching process conducted by DHBs produced valuable lists for action supported by PHOs. Concerns about COVID-19 in the community and coordinated efforts to vaccinate vulnerable populations as part of winter planning likely impacted the increase in uptake in quarter 4. Further integration of processes in practice PMS and workflow will likely see greater gains. Vaccination rates should continue to improve – particularly for Māori and Pacific children – with integration into wider systems such as inpatient services – where the first vaccination is given in hospital, socialisation of the importance of flu vaccination for children can occur alongside more effective use of discharge summaries.

<table>
<tr><th>Indicator</th><th>Target</th><th>Results</th></tr>
<tr><td rowspan="2">Increase influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific women</td><td rowspan="2">50%</td><td>Influenza vaccination coverage rates for pregnant Māori and Pacific women who birthed in the previous 12 months enrolled in metro-Auckland PHOs
 
</td></tr>
<tr><td>Commentary
Antenatal influenza vaccination rates have improved markedly since June 2017, more than doubling for Waitematā DHB. Improvements for Pacific are also obvious. Despite this, coverage for both Māori and Pacific pregnant women is still well below the target of 50% and below that of ‘Other’ ethnicities.

Antenatal pertussis vaccination rates for Māori and Pacific were below 10% for all the metro-Auckland DHBs in 2016 and are now over 28% for Māori and nearly 37% for Pacific. Across 2018 and 2019 there has been a significant uplift across multiple ethnicities. To December 2020, the highest vaccination coverage rates (12 month period) are seen among women domiciled in Auckland DHB (63.0%), followed by Waitematā DHB (54.1%) and Counties Manukau DHB (42.2%).
By ethnicity, Auckland and Waitematā DHBs have the best results for Māori at 36.0% and 31.3% respectively, with Counties Manukau at 23.9%.</td></tr>
<tr><td rowspan="2">Increase referrals to maternal incentives smoking cessation programmes, for pregnant women</td><td rowspan="2">ADHB = 27
WDHB = 58
CMH = 180

= 265 per quarter</td><td>Number of referrals to the Maternity Incentive Stop-Smoking Programme
 
</td></tr>
<tr><td>Commentary
Overall performance for the region is not meeting the 2020/21 target, with only Auckland DHB meeting their specific quarterly target. Referral numbers have declined over the last two reporting periods, but have been impacted by COVID-19. Note that the differences in referral number targets between DHBs reflect the size of the programme operating at each DHB – the Counties programme being much larger than the others.

In the long term, PHOs believe that uptake and utilisation of the Best Start Pregnancy Assessment Tool will support bulk referrals. In the meantime, PHOs are considering ways they can query their own databases to match smoking status with antenatal blood tests for bulk referrals if practices agree. Progress has been made to get a Lead Maternity Carer representation on the SLM programme.</td></tr>
</table>

Alcohol Harm Reduction

SLM Milestones impacted: ***Youth access to and utilisation of youth-appropriate health services***
Acute bed days
Amenable mortality

Alcohol-related harm is recognised as an important and increasing health issue with widespread impacts across health, social, and economic sectors. The burden is not only the individual consuming alcohol, but also their whānau, friends, and the wider community. In New Zealand, rates of hazardous drinking are increasing with men, Māori, young people, and those living in more socioeconomically deprived areas at greater risk of alcohol related harm. Alcohol use is the leading risk factor for health loss for New Zealanders aged 15-49 years and is a major contributor to non-communicable disease burden e.g. cancers. It is a significant contributor to morbidity and mortality in general; for example the harmful use of alcohol is a causal factor in more than 200 diseases and injuries.

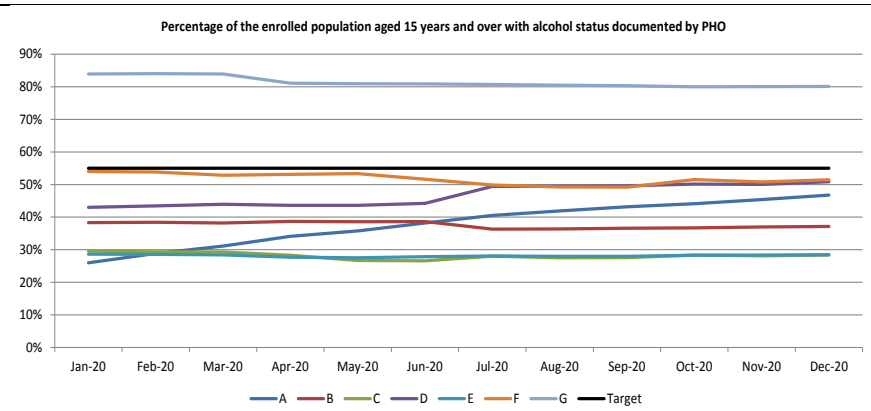
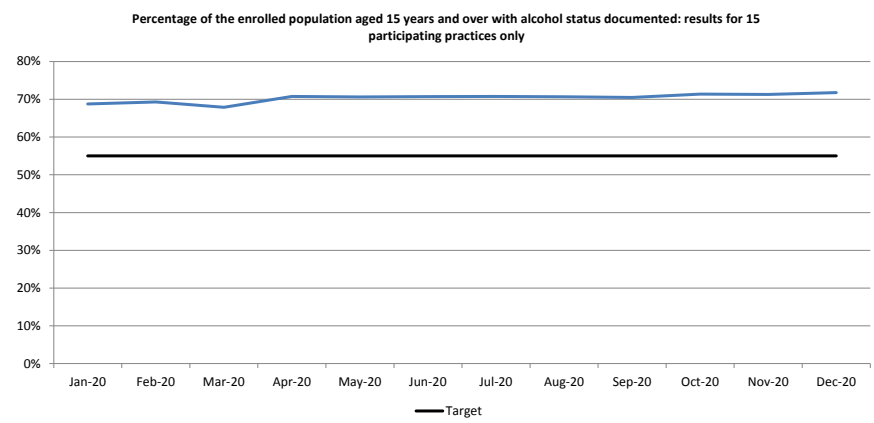
Harm reduction in alcohol, like tobacco, requires multiple health agencies and intersectoral working.

Recent work has been focused on the roll-out of a primary care based audit tool to assess patients attending clinical appointments – mainly in the Counties Manukau district. Using either the AUDIT-C or SACS (for youth) tools, patients are asked by a GP or nurse about alcohol use. Patients identified as consuming alcohol above the recommended 'low-risk drinking guidelines' can then be offered Brief Advice, including feedback about their assessment, advice and information about more appropriate levels of alcohol consumption in the context of their age and relevant health conditions/factors and, if appropriate, encouraged to access alcohol counselling.

The focus for 2020/21 is on improving the data collection and reporting on alcohol harm reduction interventions, through:

- The establishment of an alcohol ABC baseline in primary care for reporting indicators
- Providing general practices with localised resources, training and effective tools to support the systematic and equitable delivery of alcohol ABC to their enrolled population
- Improving data collection capability to multiple practice management systems.

The indicator being monitored is: the percentage of the enrolled population aged 15 years and over with alcohol status documented, with a target of **55**%. Data collection commenced during 2019. There are currently 15 Counties Manukau DHB practices formally engaged in the programme. Therefore, the results for these practices only are presented in the second graph below.

Indicator	Target	Results
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: PHOs de-identified*	55%	
Percentage of the enrolled population aged over 14 years with alcohol status documented *Note: data for participating 15 practices only*	55%	

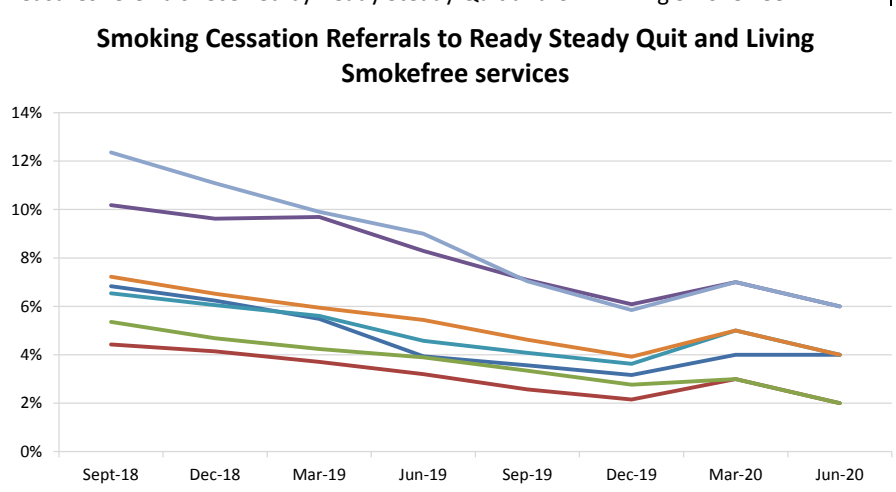
Commentary

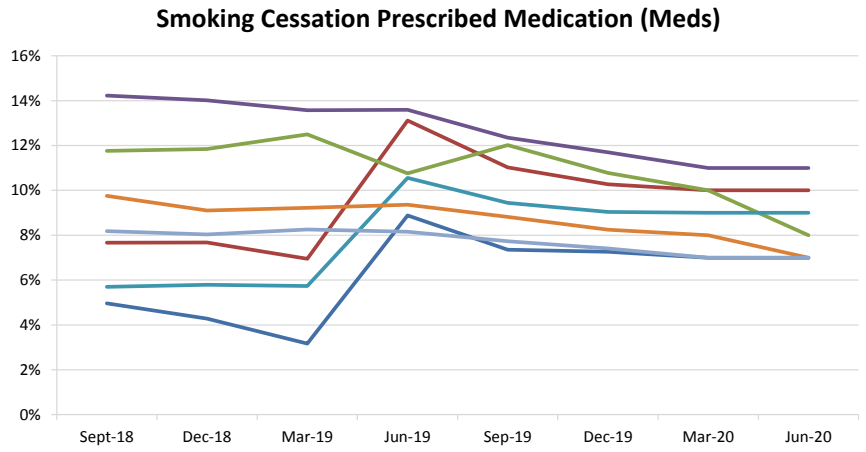
The data is only available from practices with Medtech PMS and represents 73% of the enrolled population aged over 14 years. Most PHOs are not meeting target, or only meeting it for some ethnic groups. One PHO is an exception though, reporting over 80% compliance overall and well surpassing the 55% target for all ethnic groups. We are working with PMS vendors to reduce the amount of missing data. A quality improvement approach across all DHBs is in development, but has been delayed due to the increased requirements in the sector for COVID-19 response.

Smoking Cessation

SLM Milestones impacted: ***Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds***
Acute bed days
Amenable mortality
Babies in smokefree homes

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. Using the 2018 usually resident population, 13% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (28%) and Pacific people (21%), although reduced since 2013. Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Indicator	Target	Commentary
Rate of referral to smoking cessation providers by PHO *Note: PHOs de-identified*	6%	Referral rates have previously been measured using Read codes in the practice PMS. This has been found to be inaccurate hence a new definition was developed that measures referrals received by Ready Steady Quit and CMH Living Smokefree. 

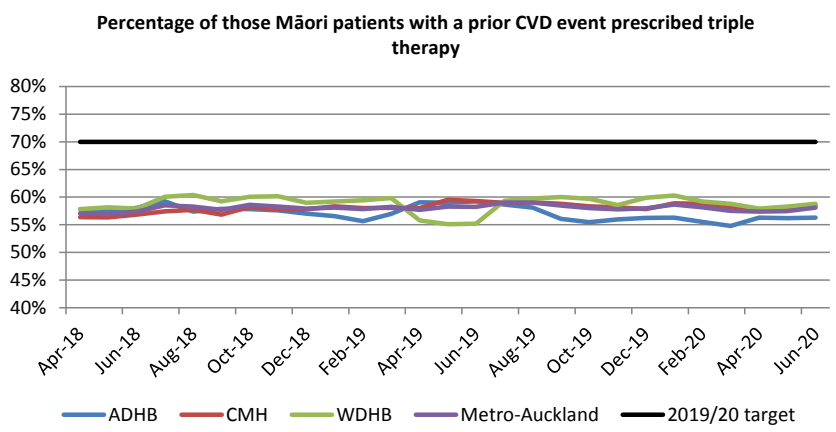
Indicator	Target	Commentary
Rate of prescribing of smoking cessation medications by PHO *Note: PHOs de-identified*	12%	Measuring prescribing rates using Read codes under reports primary care prescribing. Again, a new definition has been developed for this performance indicator that measures prescriptions supplied, sourced from PHOs' PMS systems. 

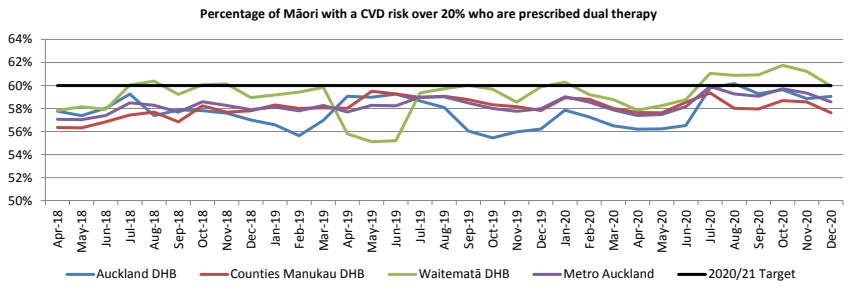
Cardiovascular Disease (CVD) Risk Assessment and Management

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

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

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

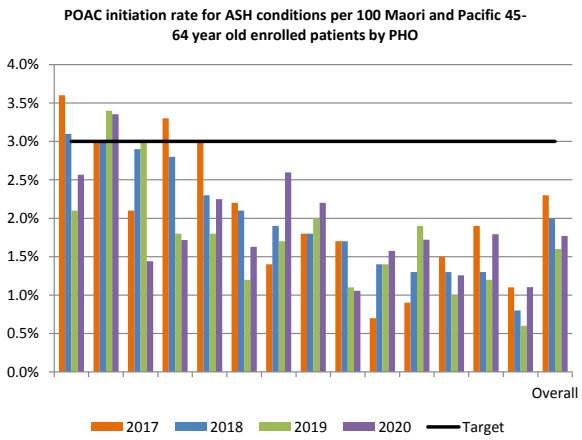
Indicator	Target	Commentary
CVD Risk Assessment (CVDRA) rates for Māori	90%	The introduction of the new CVDRA algorithms following the 2018 consensus statement has meant that primary care has needed to transition from the previous algorithm to the new one over time. The number of people eligible for risk assessment has increased as a result of the new algorithm. Considerable work has been done by PHOs to implement the new risk assessment algorithms, and the process for capturing data during the transition period is still being developed. Thus there is currently no data to report. Previous data (supplied by the Ministry of Health and based on the previous algorithm – up to December 2019) showed performance was declining over time. Various strategies have been tried by PHOs to engage with young Māori men to measure cardiovascular risk. Considerable resource has been required with minimal results, primary care enrolment and engagement is low for this age cohort. Many of these men do not engage with primary care. PHO-led initiatives at work places and at social events have encountered barriers including: • Difficulty in obtaining blood results • No clear criteria for referral and follow-up for patients at different levels of clinical acuity • Lack of processes resulting in poor flow of data between systems including practice management systems, Testsafe and risk assessment tools • Patients being enrolled in different PHOs • Cost of running initiatives Extensive discussions on approaches and results have been had at both Implementation and Steering Group level with the resulting view that a nationally driven health promotion approach is more likely to result in success.
Percentage of Māori with a previous CVD event who are prescribed triple therapy	70%	 Results remain relatively static over time for Māori, with a relatively marked difference between Pacific and Māori (and Other ethnicities) – 55% and 48% respectively for the metro-Auckland region. Results are well below the 70% target.

Indicator	Target	Commentary
Percentage of Māori with a CVD risk over 20% who are prescribed dual therapy	60%	 Results remain relatively static over time with little difference between ethnic groups. All DHBs are at or very close to the 60% target. *Also, see commentary above.*

Primary Options for Acute Care

SLM Milestones impacted: ***Acute bed days***
Amenable mortality

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

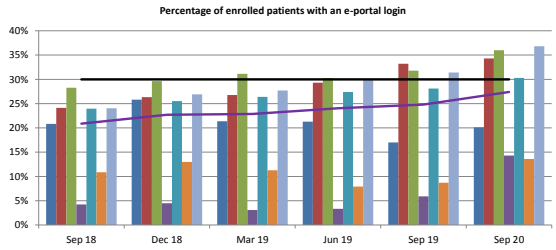
Indicator	Target	Results	Commentary
Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions	3 per 100 (3%) per PHO	 **Variation by PHO (split by DHB location) across the metro-Auckland region (PHOs not identified)**	Initiation rates vary by geographic location, even where the PHO is the same. Overall, rates have improved between this and last reporting period. NHI level data is available to PHOs.

Patient Experience

E-portals

SLM Milestones impacted: ***Patient experience of care***

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

Indicator	Target	Results	Commentary
Percentage of each PHO's enrolled population with login access to a portal	30%	 **Variation by PHO across the metro-Auckland region and change over time (PHOs not identified)**	Note: data is missing for three of the last four quarters – it was not supplied by the Ministry of Health due to the prioritisation of COVID-19 response work. The latest available data shows the target was achieved in four of the seven PHOs, but not for the Metro Auckland enrolled population. One PHO that did not achieve the target is actively piloting a new portal system.

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 - 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	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

	disadvantaged if that information was made public.	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]