Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

4 June 2019

9(2)(a) [redacted]

[redacted]

RE Official Information Act request CDHB 10052 and WCDHB 9292

I refer to your email dated 5 March 2019 requesting the following information under the Official Information Act from Canterbury DHB and West Coast DHB regarding vaccination/immunisation. I note that this request was partially transferred to the Ministry of Health Immunisation Team on 8 March 2019 and that the Canterbury DHB and West Coast DHB are responding to the following for the past four years.

- **any copies of reports, initiatives, discussion papers, advice, plans or policies created by your DHB around vaccination rates (for example: plans for how to address declines in rates, discussion of any communities that are hotspots for anti-vaxxers, etc.) This includes complaints or alerts of any active anti-vaccination communities or individuals.**

Please refer to **Appendix 1** (attached) for information requested from Canterbury DHB for 2015- 2019. This Appendix includes Workplan planning with the Canterbury Clinical Network (CCN) Service Level Alliance.

Please refer to **Appendix 2** (attached) that contains agendas for CDHB meetings (with papers) for 2015, 2016, 2017, 2018.

Please refer to **Appendix 3** (attached) that contains agendas for WCDHB meetings (with papers) for 2015, 2016, 2017, 2018.

I trust that this satisfies your interest in this matter.

Please note that these responses, or an edited version of these responses may be published on the Canterbury DHB and West Coast DHB websites after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 16 April 2019 1:32 p.m.
To: Bridget Lester
Subject: 2015 Imms OIA information
Attachments: Immunisation System.docx; ISLA 2014 15 workplan.docx; HPV proposal 2015 to AST UPDATED.docx; Memo HPV programme.dotx

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

GET IMMUNISED

FOR AST CONSIDERATION	Canterbury Clinical Network
TITLE	HPV Outreach Programme
PREPARED BY	Bridget Lester, IPG HPV Working Group and Immunisation Service Level Alliance
DATE	9 April 2015
FINANCIAL RESOURCING	
RECOMMENDATION	That the AST reviews the paper and • Provide support for the current HPV Outreach Programme (previously known as a Mop up programme) to be moved forward two years and offered to year 8 girls, in their school setting. • General practice will continue to offer the HPV vaccination from aged 11 years. • Approves the paper to go to ALT on 20 April 2015

1. AIM

The aim of the Immunisation Service Level Alliance (ISLA) is to ensure that every eligible girl has access to the HPV vaccination programme, which is delivered in a way to suit the girl and her family's needs.

2. PURPOSE

The purpose of a school based HPV vaccination programme is to ensure that all young women in Canterbury are given the opportunity to be protected against HPV by providing a vaccination programme for girls who have not been vaccinated within a general practice setting.

The revised programme will be targeted at all year 8 girls, who attend school in Canterbury. The programme will endeavour to achieve equitable coverage across ethnicities by offering the programme at all schools across Canterbury. Specifically the programme will utilise the Whanau Ora and HEAT (Health Equity Assessment Tool) models to ensure that Maori and Pacific young women (who are most at risk of cervical cancer) are given every opportunity to receive HPV vaccination.

3. RATIONALE

3.1 BACKGROUND

Since 2009 Canterbury DHB has provided the funded national HPV vaccination programme through General Practice. This programme is available to all girls from age 9 to 20 years. The Ministry of

Health's (MoH) key target group is 12 year old girls (school year 8) and the 2015/2016 MoH target for this group is 65% of girls completing the programme.

All DHB's in New Zealand, except Canterbury, provide a school based HPV programme aimed at girls in year 8. Coverage is 59% of girls in the target group completing the programme. The Canterbury DHB coverage for the same group is only 45% for dose one, with only 35% of girls receiving all 3 does of the vaccination within the targeted year[a].

		Immunisation coverage						
DHB	Vaccination	Maori	Pacific	Asian	Other**	All	Decline	Opt off
Auckland	HPV-1 Quadrivalent	77%	91%	72%	82%	81%	657 (29.7%)	16 (0.7%)
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	HPV-3 Quadrivalent	57%	66%	57%	52%	55%	146 (4.1%)	
NZ Total	HPV-1 Quadrivalent	70%	79%	67%	59%	65%	4989 (17.7%)	52 (0.2%)
	HPV-2 Quadrivalent	68%	78%	67%	57%	63%	2399 (8.5%)	
	HPV-3 Quadrivalent	63%	72%	64%	54%	59%	2390 (8.5%)	

Figure 1 HPV Coverage 2014 year 8 girls

In 2013, in an attempt to normalise HPV and improve coverage, Canterbury general practices were encouraged to offer the HPV vaccination to girls with their 11 year old immunisation event. In Canterbury we achieve approximately an 80% uptake for the 11 year old Boostrix vaccination. As a result, HPV performance has improved slightly but still only 27% of the target group were fully vaccinated by the end of the 2014 year.

General Practice continues to offer HPV vaccine to girls from age 11 to 20 years, however as a DHB we are not meeting national expectations and although some improvements have been made over the last 7 years, we fail to meet MoH targets and coverage falls well below other comparable DHB's.

3.2 RATIONALE BEHIND VACCINATING FROM 11 YEARS OF AGE.

There are several reasons why vaccinations should be commenced from age 11 years.

- The HPV vaccination produces a better immune response in preteens than it does in older teens[1]

[a] This data relates to girls born in 2001, which is the target year for the 2013/14 year. Girls born in 2002 will be the target group for the 2015/16 year.

- All three doses of HPV vaccine need to be given to ensure optimal protection. Giving the vaccination at age 11 or 12 years allows more time to follow up girls who have not received the completed course (before they are exposed to the virus).
- Vaccinations should begin prior to the commencement of any sexual activity, in order to protect against sexual transmission of HPV. The US Centre for Disease Control (CDC) recommends the vaccine should be given at the age of 11 or 12 years, partly for this reason[2]. The US Mayo Clinic states the vaccine can be given from the age of 9 years[3] and the vaccine is licensed in New Zealand from the age of 9 years.
- For HPV vaccines to be effective, they should be given prior to exposure to HPV. New Zealand studies have found 10-30% of young people have had sex by 15 years[4] and preteens should receive all three doses of the HPV vaccine series before they begin *any* type of sexual activity and are exposed to HPV.

3.3 SECONDARY SCHOOL OUTREACH (MOP UP) PROGRAME

In 2014, Canterbury DHB piloted a school based HPV outreach programme[b], aimed at year 10 girls in Secondary schools. This programme is known as the HPV Secondary School Programme. This programme was developed to support the general practice programme. The coordination team for this service is located within Pegasus Health, as the lead PHO. The relationship with the schools and the support for vaccinating teams lies with the public health nursing service.

Year one of the HPV Secondary School Programme appeared to be a success. The programme reached year 10 girls who were subsequently either vaccinated as part of the programme, or referred back to general practice. Of the girls targeted in the programme, 63% have received dose one. This is a result of pre-programme vaccination, during programme vaccination, or the decision to go to general practice during the year to be vaccinated. This is the best uptake of HPV vaccine the Canterbury DHB has seen in any age group.

Although the programme in secondary schools has had significant success, the focus should be on vaccinating the target age group in order to achieve both the Ministry of Health expectations and to give girls the best possible protection because of key clinical reasons to vaccinate at aged 11 years.

3.4 PHARMAC CHANGES

Dr Tony Walls, member of ISLA, is also a member of the national PHARMAC Immunisation Sub Committee. Dr Walls has advised ISLA that the Sub Committee has approved a two dose HPV Programme. PHARMAC was approached regarding implementation of this, and how this might impact on a school based programme. PHARMAC indicated that there is a short term problem, as the Gardasil vaccine, used for this programme, is registered for three doses and to reduce it to two would be considered off label use requiring consent from the patient/caregiver/parent which makes the process complicated. Gardasil is now registered and given as a two dose vaccine in many other countries (including the UK). However it is understood that the supplier in NZ does not intend to change the registration status in NZ at this stage.

[b] The School based programme has been known as the "mop up" programme as it is seen to been mopping up the girls not vaccinated within general practice. However it has been decided to refer to this now was an outreach service as this language and model used for childhood immunisations. For the purpose of this paper the programme will be known as the HPV School Based Outreach Programme.

PHARMAC advised that any planning for a year 8 programme should include a three dose programme.

PHARMAC also indicated their wider concerns with the Canterbury DHB coverage and lack of year 8 school programme. We have been advised that moves towards a year 8 school programme would be "well received" by the Immunisation Sub Committee.

4. HPV SERVICE DELIVERY MODEL

General Practice will continue to be the primary provider of the HPV programme, by offering this programme to girls at aged 11. The number of girls targeted at age 11 years within the practice would remain unchanged. Based on 2014 data, around 36% of girls received dose one of HPV at general practice, with only 11% of girls completing the programme.

The new programme will be known as the HPV School Based Outreach Programme, and will continue to support the general practice programme. By moving the school programme from year 10 to year 8, the target number of girls would remain relatively static but would be in a different birth cohort (about 2300 girls per year). The main difference in this programme would be the number of schools to target.

Forty secondary schools are part of the current year 10 programme, however a move into primary schools this would see 213 schools being targeted. This is a mixture of primary, area, intermediate and secondary schools.

In total there are 206 schools in Canterbury who have year 8 girls. Of these schools the following modelling has occurred:

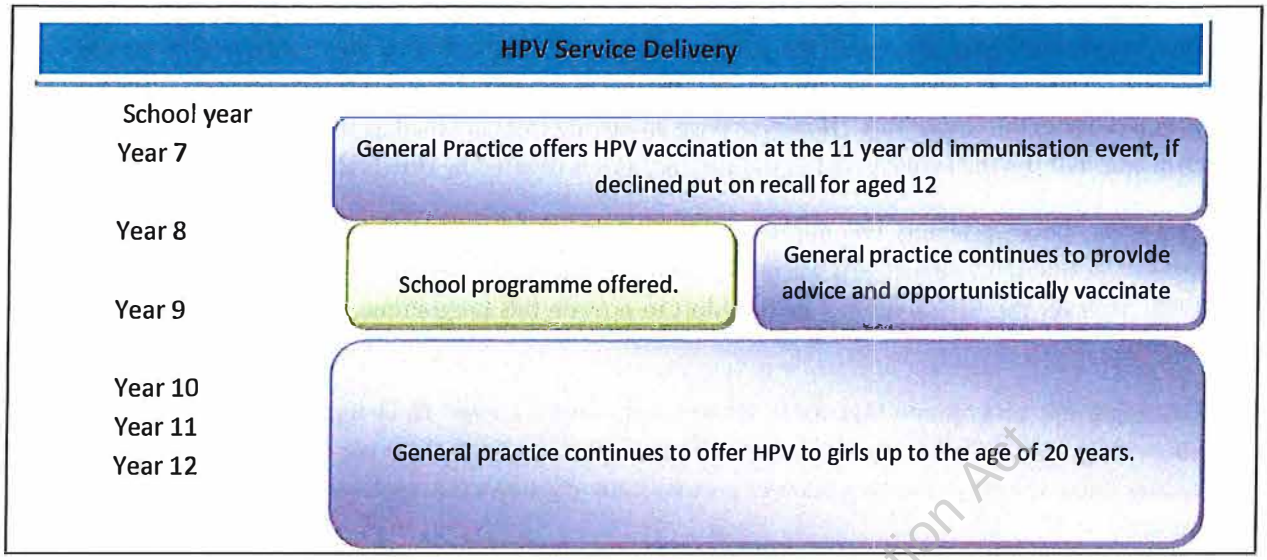
Range of girls	Number of schools	Number of sessions	Total number of sessions
No girls	7	0	0
1-10 girls	131	0.50	65.5
11-20 girls	40	1	40
21-41 girls	25	2	50
41 - 60 girls	4	3	12
61-80 girls	2	4	8
81 - 100 girls	1	5	5
100 - 150 girls	3	6	18
Total	213		133
Total vaccination days per term			**66.5**

Figure 2: Modelling for number of school sessions required.

A session is worked out as two hours of vaccinating time, with 40 girls targeted per session. This is made up of a team with a Welcomer, Checker, Vaccinator and Resource nurse. The team will flex up and down based on the size of the schools.

This modelling indicates that there would be a need for around 67 vaccinating days per school term, for three terms, in order to vaccinate the 2300 girls with 3 doses of vaccine within the programme. This would require one fulltime vaccinating team and a supplementary team when vaccinating in the bigger schools. Support will continue to be required from the public health nursing service who works in the school.

Diagram one: HPV Service Delivery Model: REVISED MODEL



5. SUMMARY OF PROGRAMME MODELS OF THE YEARS

Year	Programme	Comment
2008	12year old General Practice Programme	2.2 million, Including set up, project management and vaccine cost. This funding decreased over the year and by 2011/12 400,000 was moved into DHB baseline funding.
2013	11year old General Practice Programme	Programme moved to start at age 11 to align it with the 11year old event
2014	Introduction of the Secondary School Year 10 programme	A two year pilot with a Outreach programme supporting the General practice programme. Positive outcomes, but suggested wrong age groups being targeted
2016	Proposed Year 8 programme	As proposed model in this paper.
2017	HPV School based year 8 programme	The concern is, that if the DHB does not move to introduction the year 8 programme on our terms will be required to do so by the MoH in the near future. The recent paper developed by the MoH regarding the realisation of the HPV programme, has suggested that all DHBs will be required to provide a year 8 programme by 2017.

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6. FINANCIAL IMPLICATIONS

The cost of providing the HPV programme can be split into two areas, the administration of the vaccine, and the cost of the vaccine. General Practice order the vaccine for free and claim the administration cost back from Sector Services (MoH). The MoH will then invoice the DHB for the cost of the vaccine and the administration fee.

Canterbury DHB also has a contract with the Pegasus Health for the coordination of the HPV School Based Outreach Programme. This includes a full time coordinator and administrator. In year one of the programme, they provided HPV vaccines in schools, supported by the public health nursing service. This programme orders the vaccine though the normal vaccine ordering process, with the DHB picking up the cost of this. However since all vaccine costs are managed through PHARMAC, the DHB does not see the actually cost of the vaccine, as it is covered by DHB PHARMAC rebates.

Extending the programme, will improve the uptake of the programme, with an expectation that around an additional 40% of girls will engage in the programme. This will be an increased cost to the DHB, however the DHB is funded by the MoH to provide this programme, and reach the expected targets.

Extending this programme into more schools will require a need to change the structure of the vaccinating team, which will result in an additional cost to the DHB. However, there is an opportunity to also utilise this HPV Outreach team to provide some children's outreach services, should workload allow it.

Further work needs to occur around what the final makeup of this service would be – however there is an estimate additional cost of **$180,000** on top of the current agreement arrangements. This funding would be used to provide more administration and vaccination support to the service due to the need to go into more schools.

There however be some cost in shifting with this programme, as these girls will be picked up in a school programme and not under the current fee for service general practice programme. It is estimated that this would be around $50,000 by year 2 of the programme. Therefore the total new funding to support this programme is an estimated **$133,000**.

If approved the work would start now for the implementation of this programme for the start of the 2016 calendar year.

	Current (2015 year)	**Proposed (year one)**	**Proposed Year two**
HPV School based programme	$120,000	$200,000	$300,000
Vaccine Cost	N/A	N/A	
General Practice Subsidy	$135,000	$106,000	$85,000
Consent form printing	$2,000	000	000
Promotion of programme	$10,000	$10,000	$10,000
Total	**$262,000**	**$316,000**	**$395,000**

References:

[1] according to the CDC (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[2] (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[3] (http://www.mayoclinic.org/healthy-living/sexual-health/in-depth/cervical-cancer-vaccine/art-20047292)

[4] (references to studies and risk factors for early sexual experience in: http://www.moh.govt.nz/moh.nsf/Files/Chapter9/$file/Chapter9.pdf)

Immunisation System

Event focus	Timeframe	Acton	Target	Interventions
Before baby	2nd Trimester xxx (please note this is NOT a requirement of S88)	LMCs promote pregnancy vaccinations. Agreed to share maternity scan	40% of pregnancy women are vaccinated against pertussis Pregnancy women vaccinated against seasonal influenza	Provide LMCs with resources and education regarding vaccinations
	When women is 26 weeks	GPT recalls women for Pertussis and Seasonal influenza vaccine		Support general practice to recall systems and education around vaccinations
	3rd Trimester	childhood immunisations, National immunisation register and enrolment with a GP	95% New-borns enrolled on NIR at birth 98% of new-borns enrolled in General Practice	Education GPT on accepting New born enrolments and the B code
Childhood immunisations	At 4weeks	GPT recall babies for 6 week immunisations	95% of 8 months old fully vaccinated	Support GPT to recall children, NIR follow up on all overdue children, if 4 weeks overdue for an event children referred to MEC. If needed OIS will visit family.
	At 10 weeks	GPT recall babies for 12 week immunisation		
	At 22 weeks	GPT recall babies for 5 month immunisations		
	At 14months	GPT recall children for their 15month events	95% of 2 year olds children	
	At 4 years of age	GPT recall children for their 4 year old events	90% of 5 year olds	
Adolescent Immunisations	At 11 years of age	GPT recalls all 11year old for their 11 year old event, which includes HPV for Girls	85% of 11year olds 70% of Girls for HPV at 12	Education GPT on the key HPV messaging
	At 14 year of age (year 8)	Overdue girls offered the HPV school programme	70% of girls receive dose 3	Education and promotion to girls and their families around the programme

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	Maintain the Immunisation Service Level Alliance (SLA) with clinical leadership from across the system.	Ensure that CDHB is represented at all key national and regional immunisation forums.	On going	Canterbury DHB is represented at regional and national forums.	Everyone	
Before (and just after) Baby)	Support LMCS to promote and education pregnant women on Childhood Immunisation and the NIR Invest in free seasonal flu vaccinations pregnant women. Support LMC to provide free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children. Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Regular communication and linkages with LMCs Work with LMCs, Primary Care and Immunisation Services to develop a DHB plan for managing an monitoring new-born enrolments This piece of work is being led by CYWS	Q4	Monitor uptake of Influenza and Pertussis vaccination. 95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth. 98% of newborns are enrolled with general practice by 2 weeks. Develop relationships with services already working with children to focus on high needs, at risk children.	Planning and Funding to Lead P&F to link with CYWS to get feedback on this	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
Preschool immunisations	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Refining NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Supporting the Missed Event Coordinator and OIS to locate missing children. Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations, including offering NIR access. Continue to offer the Influenza vaccination to those under 18years of age.	Work with NIR, IC and OIS to ensure health and performance target children are monitor and referred in a timely manner Share PHO and Practice Milestone ages reports with practices. Undertake Assessment of OIS services. Providing recommendations to ISLA	Q2 on going	Quarterly performance reports circulated to PHOs, to review progress against targets. 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated Q2. 95% of all two-year-olds are fully immunised Child Health ward can check status and vaccinate overdue children. 40% of children receive the U18 Flu Vaccination	NIR, IC, OIS and P&F NIR P&F, ISLA	
Preteen immunisation	Maintain a HPV Programme in both a primary care setting and in schools by: • Continue to link 11-year-old and HPV immunisation events.	Maintain the HPV working group who will Develop an annual plan including	On going	70% of Girls have received dose 1 65% of girls have received dose 2	IPG AND HPV WORKING GROUP	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	• Continue to provide the Secondary School HPV Programme	communisations and monitor performance, and provide advice to ISLA and any service model changes.	On going	60% of girls have received dose 3		
Adult immunisation	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women.	Maintain the seasonal flu working group and develop a plan for the 2015 season.	Q2 Q4 On going	Seasonal flu plan developed 75% of people aged 65+ have a seasonal flu vaccination Q4.	IPG and Flu Working Group	
System Support	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week by: • Maintaining a Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates; • Maintaining streamlined access to immunisation awareness information; • Developing a plan for implementing Immunisation Week.	Review systems resources and ensure it is up-to-date Develop Immunisation Resources Group who will review all DHB and MoH immunisation resources and oversea the Immunisation Promotion programme	Q3 On going Q3 Q4	Annual update provided to practices Plan developed for Immunisation Week. Narrative report on interagency activities completed to promote Immunisation Week.	P&F, DHB Communisations and ICs	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Area	Action	Timeframe	Responslbity	Progress
Education	Develop an education programme for LMCs, to educate them on the importance of vaccinating during pregnancy.	February 2015	Margo to organise Tony to present	
	Regular message to LMC twice a year regarding the importance of vaccinations	February and July	Bridget	
	Link with DHB Maternity Outpatients to ensure they are advising women around vaccination	October 2014	Margo	
Information Linkages	Develop a way to link Maternity Suite Bookings back to General Practice (need to ID a way to notify practices of miscarriages). This will enable the practice to know who is pregnant and recall them at 30 weeks for vaccination. A draft letter to be developed to support this programme.	December 2014	Bridget and DHB IT	
	Develop a sticker for the Hand Held Maternity Notes books, to remind LMCs and Pregnant Women about when to vaccinate	December 2014	Bridget to develop and distribute Margo to educate LMCs	
	Update Pertussis section of Health Pathways to reflect key messages	December 2014	Margo to link with Di Bos	
Promotion	Update promotional material to include key messages	December 2014	Bridget, Margo and Mick	
Vaccination	Discussion vaccination of parents in NICU for at risk children	December 2014	Margo	

Canterbury
District Health Board
Te Poari Hauora o Waitaha

MEMO

To be Noted		For Decision	
Yes			

To Planning and Funding Leadership Team

On behalf Bridget Lester, Project Specialist

Attachment: HPV Outreach Programme Paper to ALT

Approved/Declined

Sign-off & Comments	Action	Date
Team Leader	Approved/Declined	
Information Analyst	Section 10 and 11 accurate YES ☐ NO ☐	
Financial Manager ☐ Side funding confirmed ☐ Side funding unconfirmed ☐ Ring fence money ☐ Budget updated	Is this in the Budget YES ☐ NO ☐ Cost and Budget section accurate YES ☐ NO ☐	
P & F General Manager	Approved/Declined	

Please note the attached paper that has been approved by the Immunisation Service Level Alliance to go to AST on the 9th April 2015.

HPV proposal 2015 to AST.docx

FOR AST CONSIDERATION	
TITLE	HPV Outreach Programme
PREPARED BY	Bridget Lester, IPG HPV Working Group and Immunisation Service Level Alliance
DATE	9 April 2015
RECOMMENDATION	That the AST reviews the paper and • Provide support for the current HPV Outreach Programme (previously known as a Mop up programme) to be moved forward two years and offered to year 8 girls, in their school setting. • General practice will continue to offer the HPV vaccination from aged 11 years. • Approves the paper to go to ALT on 20 April 2015

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The revised programme will be targeted at all year 8 girls, who attend school in Canterbury. The programme will endeavour to achieve equitable coverage across ethnicities by offering the programme at all schools across Canterbury. Specifically the programme will utilise the Whanau Ora and HEAT (Health Equity Assessment Tool) models to ensure that Maori and Pacific young women (who are most at risk of cervical cancer) are given every opportunity to receive HPV vaccination.

3. RATIONALE

3.1 BACKGROUND

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	HPV-2 Quadrivalent	62%	70%	59%	55%	58%	136 (3.8%)	
	HPV-3 Quadrivalent	57%	66%	57%	52%	55%	146 (4.1%)	
NZ Total	HPV-1 Quadrivalent	70%	79%	67%	59%	65%	4989 (17.7%)	52 (0.2%)
	HPV-2 Quadrivalent	68%	78%	67%	57%	63%	2399 (8.5%)	
	HPV-3 Quadrivalent	63%	72%	64%	54%	59%	2390 (8.5%)	

Figure 1 HPV Coverage 2014 year 8 girls

In 2013, in an attempt to normalise HPV and improve coverage, Canterbury general practices were encouraged to offer the HPV vaccination to girls with their 11 year old immunisation event. In Canterbury we achieve approximately an 80% uptake for the 11 year old Boostrix vaccination. As a result, HPV performance has improved slightly but still only 27% of the target group were fully vaccinated by the end of the 2014 year.

General Practice continues to offer HPV vaccine to girls from age 11 to 20 years, however as a DHB we are not meeting national expectations and although some improvements have been made over the last 7 years, we fail to meet MoH targets and coverage falls well below other comparable DHB's.

3.2 RATIONALE BEHIND VACCINATING FROM 11 YEARS OF AGE.

There are several reasons why vaccinations should be commenced from age 11 years.

- The HPV vaccination produces a better immune response in preteens than it does in older teens[1]
- All three doses of HPV vaccine need to be given to ensure optimal protection. Giving the vaccination at age 11 or 12 years allows more time to follow up girls who have not received the completed course (before they are exposed to the virus).

[a] This data relates to girls born in 2001, which is the target year for the 2013/14 year. Girls born in 2002 will be the target group for the 2015/16 year.

- Vaccinations should begin prior to the commencement of any sexual activity, in order to protect against sexual transmission of HPV. The US Centre for Disease Control (CDC) recommends the vaccine should be given at the age of 11 or 12 years, partly for this reason[2]. The US Mayo Clinic states the vaccine can be given from the age of 9 years[3] and the vaccine is licensed in New Zealand from the age of 9 years.
- For HPV vaccines to be effective, they should be given prior to exposure to HPV. New Zealand studies have found 10-30% of young people have had sex by 15 years[4] and preteens should receive all three doses of the HPV vaccine series before they begin *any* type of sexual activity and are exposed to HPV.

3.3 SECONDARY SCHOOL OUTREACH (MOP UP) PROGRAME

In 2014, Canterbury DHB piloted a school based HPV outreach programme[b], aimed at year 10 girls in Secondary schools. This programme is known as the HPV Secondary School Programme. This programme was developed to support the general practice programme. The coordination team for this service is located within Pegasus Health, as the lead PHO. The relationship with the schools and the support for vaccinating teams lies with the public health nursing service.

Year one of the HPV Secondary School Programme appeared to be a success. The programme reached year 10 girls who were subsequently either vaccinated as part of the programme, or referred back to general practice. Of the girls targeted in the programme, 63% have received dose one. This is a result of pre-programme vaccination, during programme vaccination, or the decision to go to general practice during the year to be vaccinated. This is the best uptake of HPV vaccine the Canterbury DHB has seen in any age group.

Although the programme in secondary schools has had significant success, the focus should be on vaccinating the target age group in order to achieve both the Ministry of Health expectations and to give girls the best possible protection because of key clinical reasons to vaccinate at aged 11 years.

3.4 PHARMAC CHANGES

Dr Tony Walls, member of ISLA, is also a member of the national PHARMAC Immunisation Sub Committee. Dr Walls has advised ISLA that the Sub Committee has approved a two dose HPV Programme. PHARMAC was approached regarding implementation of this, and how this might impact on a school based programme. PHARMAC indicated that there is a short term problem, as the Gardasil vaccine, used for this programme, is registered for three doses and to reduce it to two would be considered off label use requiring consent from the patient/caregiver/parent which makes the process complicated. Gardasil is now registered and given as a two dose vaccine in many other countries (including the UK). However it is understood that the supplier in NZ does not intend to change the registration status in NZ at this stage.

PHARMAC advised that any planning for a year 8 programme should include a three dose programme.

[b] The School based programme has been known as the "mop up" programme as it is seen to been mopping up the girls not vaccinated within general practice. However it has been decided to refer to this now was an outreach service as this language and model used for childhood immunisations. For the purpose of this paper the programme will be known as the HPV School Based Outreach Programme.

PHARMAC also indicated their wider concerns with the Canterbury DHB coverage and lack of year 8 school programme. We have been advised that moves towards a year 8 school programme would be "well received" by the Immunisation Sub Committee.

4. HPV SERVICE DELIVERY MODEL

General Practice will continue to be the primary provider of the HPV programme, by offering this programme to girls at aged 11. The number of girls targeted at age 11 years within the practice would remain unchanged. Based on 2014 data, around 36% of girls received dose one of HPV at general practice, with only 11% of girls completing the programme.

The new programme will be known as the HPV School Based Outreach Programme, and will continue to support the general practice programme. By moving the school programme from year 10 to year 8, the target number of girls would remain relatively static but would be in a different birth cohort (about 2300 girls per year). The main difference in this programme would be the number of schools to target.

Forty secondary schools are part of the current year 10 programme, however a move into primary schools this would see 213 schools being targeted. This is a mixture of primary, area, intermediate and secondary schools.

In total there are 206 schools in Canterbury who have year 8 girls. Of these schools the following modelling has occurred:

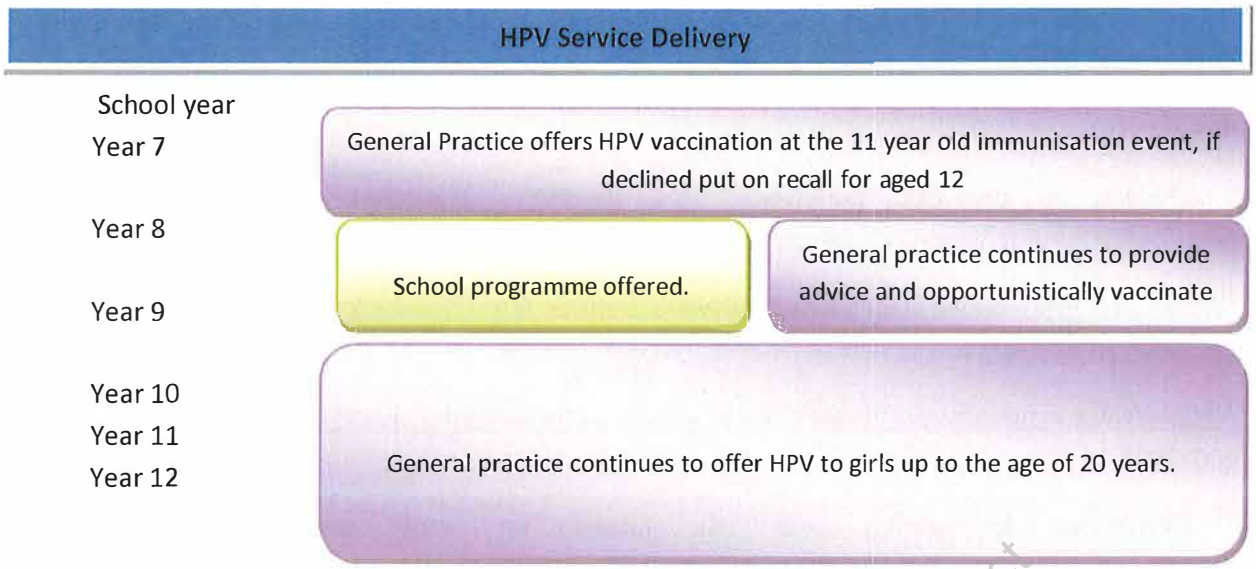
Range of g'	Number of schools	Number of sessions	Tota number of session
No girls	7	0	0
1-10 girls	131	0.50	65.5
11-20 girls	40	1	40
21-41 girls	25	2	50
41 - 60 girls	4	3	12
61-80 girls	2	4	8
81 - 100 girls	1	5	5
100 - 150 girls	3	6	18
Total	213		133
Total vaccination days per term			**66.5**

Figure 2: Modelling for number of school sessions required.

A session is worked out as two hours of vaccinating time, with 40 girls targeted per session. This is made up of a team with a Welcomer, Checker, Vaccinator and Resource nurse. The team will flex up and down based on the size of the schools.

This modelling indicates that there would be a need for around 67 vaccinating days per school term, for three terms, in order to vaccinate the 2300 girls with 3 doses of vaccine within the programme. This would require one fulltime vaccinating team and a supplementary team when vaccinating in the bigger schools. Support will continue to be required from the public health nursing service who works in the school.

Diagram one: HPV Service Delivery Model: REVISED MODEL



5. FINANCIAL IMPLICATIONS

The cost of providing the HPV programme can be split into two areas, the administration of the vaccine, and the cost of the vaccine. General Practice order the vaccine for free and claim the administration cost back from Sector Services (MoH). The MoH will then invoice the DHB for the cost of the vaccine and the administration fee.

Canterbury DHB also has a contract with the Pegasus Health for the coordination of the HPV School Based Outreach Programme. This includes a full time coordinator and administrator. In year one of the programme, they provided HPV vaccines in schools, supported by the public health nursing service. This programme orders the vaccine though the normal vaccine ordering process, with the DHB picking up the cost of this.

Extending the programme, will improve the uptake of the programme, with an expectation that around an additional 30% of girls will engage in the programme. This will be an increased cost to the DHB, however the DHB is funded by the MoH to provide this programme, and reach the expected targets.

Extending this programme into more schools will require a need to change the structure of the vaccinating team, which will result in an additional cost to the DHB. However, there is an opportunity to also utilise this HPV Outreach team to provide some children's outreach services, should work load allow it.

Further work needs to occur around what the final makeup of this service would be – however there is an estimate additional cost of **$200,000** on top of the current agreement arrangements. This funding would be used to provide more administration and vaccination support to the service due to the need to go into more schools.

There will be a cost in shifting this programme, as these girls will be picked up in a school programme and not under the current fee for service general practice programme. It is estimated that this would be around $60,000 per year. Therefore the total new funding to support this programme is an estimated **$140,000**.

If approved the work would start now for the implementation of this programme for the start of the 2016 calendar year.

References:

[1] according to the CDC (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[2] (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[3] (http://www.mayoclinic.org/healthy-living/sexual-health/in-depth/cervical-cancer-vaccine/art-20047292)

[4] (references to studies and risk factors for early sexual experience in: http://www.moh.govt.nz/moh.nsf/Files/Chapter9/$file/Chapter9.pdf)

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 16 April 2019 1:07 p.m.
To: Bridget Lester
Subject: 2016 Information OIA
Attachments: PHARMAC - Proposal to amend listings in the National Immunisation Schedule.msg.docx; PHARMAC - Proposal to amend listings in the Influenza.docx; 201617 isla workplan.docx; Preg paper.docx

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

Planning and Funding

Matthew Wolfendent
Procurement Manager
PHARMAC
PO Box 10 254
Wellington

Sent via email to: vaccines@pharmac.govt.nz

Dear Matthew

RE: Proposal to amend listings in the National Immunisation Schedule

Thank you for the opportunity to provide feedback on the proposed changes to the national immunisation schedule.

The Canterbury Immunisation Service Level Alliance has had the opportunity to review these proposal changes, and a comfortable with the direction the PHARMAC is moving in. The additional of funding Varicella vaccine to the schedule at 15months, will benefit many children's, families and prevent hospital admissions.

Changing the eligibility for HPV, and widening this to include boys will reduce the current inequalities and protect the whole population. We hope that this will also have a flow on effect to normalise the vaccine and increase over programme coverage. We are also supportive of this being offered in a school programme in year7.

Canterbury DHB has been offering HPV to girls at the 11year old event for the past 3 years, with positive uptake. We would be concerned if DHBs were directed by PHAMRAC on how to provide the programme. (i.e, that this event can only be given in a school programme, and that we need to also do the 11year old event at the same time).

Service delivery and how to reach our population is the role of the DHB. We understand that role of PHARMAC is to manage the schedule and supply, but not the delivery.

Please contact me directly if you wish to discuss this further. I am more than happy to talk about the Canterbury model of service delivery.

Yours sincerely

Dr Ramon Pink
Chair of the Immunisation Service Level Alliance

Planning and Funding

Christine Chapman
Senior Therapeutic Group Manager
PHARMAC
PO Box 10 254
Wellington 6143

Sent via email to: Christine.chapman@pharmac.govt.nz

Dear Christine

RE: Proposal for the supply of influenza vaccines

Thank you for the opportunity to provide feedback on the proposed changes to the Supply of influenza vaccine.

The Canterbury Immunisation Service Level Alliance (ISLA) and the West Coast Immunisation Advisory Group (IPG) have both had the opportunity to review these proposal changes, and a comfortable with the direction the PHARMAC is moving in in regards to the vaccine. We however would like to highlight a couple of our concerns with this proposal

Eligibility
We continue to below the funded influenza vaccine for all children under age of 5 would benefit the whole population. This group is more a likely to spread the illness or risk hospital admissions if they contract influenza and which has a wider impact on the health system. We ask that you review this criteria.

We also are concerned around the removal of clause C) Individual DHBs may fund patients over and above the over criteria. The claiming process for these additional patients should be determine between the DHB and the Contractor.

Removing this, limited DHBs to provide targeted programmes to their population. In 2011 Canterbury DHB funded the under 18 Influenza programme, as an earthquake response. We have also provide target programme to Maori and other populations, who would not attend general practice. In 2016, the West Coast PHO supported enabling community pharmacy to order Seasonal Influenza to eligibility patients, this was based on access issues with General Practice. These was decision made by our DHBs based on changes situations and specific populations. The removal of C) would prevent this from occurring. It will have a wider impact on how a DHB services their population. This change is not supported.

While we acknowledge your comments around "applications for variation on the current criteria must be sent to PHARMAC" gives the DHB an opportunity to provide targeted programmes, again do not understand why we need approval from PHARMC to provide DHB specific and funded programmes. In the past, PHARMAC have been slow to response to DHB specific request, pasted them around their internal systems, and not feedback to the initial enquire. This gives DHBs little faith in PHARMAC ability to response in a timely, and understanding manner to DHB specific request, an example of this

is PHARMAC handing of the West Coast DHB requires to enable community pharmacy to vaccinate for seasonal influenza. This programme is being funded directly by the DHB and initial feedback is that this is successful in reaching people who have not attended general practice. PHARMAC were not supportive this model, and we do not have confidence that they would support the programme in the future. The removal of clause C) would mean the DHB cannot fund this directly, how a need has been identified within our community.

Please contact me directly if you wish to discuss this further. I am more than happy to talk about the Canterbury model of service delivery.

Yours sincerely

Dr Ramon Pink
Chair Canterbury ISLA

Cheryl Brunton
Chair West Coast IPG

IMMUNISATION SERVICE LEVEL ALLIANCE 2016/17 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to educate and promote immunisation and the NIR for both mother and baby. Maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services • Support LMCs for early hand over to GPT and Well Child providers; • Support early enrolment with General practice teams, and use of B code; • Support NIR to establish timely reporting to follow up children with no nominated provider.	Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support NIR and PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Provider a school based HPV programme	Q1 – Q4	• 70% of Girls have received dose 3 (for 2016/17 it is the 2003 birth cohort measured at 30 June in 2017).	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Implement a DHB wide Immunisation Week Plan. Use the Maori Kete and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4 Q1-Q4	• Canterbury DHB is represented at regional and national forums. • Narrative report on interagency activities completed to promote Immunisation Week.	

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Continue to explore linkages withopportunities with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.

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Regular meetings achieved?

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IMMUNISATION SERVICE LEVEL ALLIANCE 2016/17 WORKPLAN Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well				
Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
	Continue to work through the Child and Youth Workstream, explore opportunities with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.		Improved Coverage of Immunisation	

FOR ISLA CONSIDERATION	Canterbury Clinical Network

TITLE	Vaccinating Pregnant Women in Secondary Care
PREPARED BY	Margaret Kyle, Jayne Thomas and Bridget Lester
DATE	29 September 2016
RECOMMENDATION	That the ISLA review the paper and approves the following: • Approach the Planning and Funding Leadership Team for funding to support a 12month pilot in Women's and Children for the vaccination of Women who are either pregnant, or with high risk children in NICU. • Funding of $20,000 per annum is sort.

1. Background

Vaccinating pregnant women for Pertussis and Seasonal Influenza for two key objectives of the Immunisation Service Level Alliance. These vaccines are free to Pregnancy women, and generally given in General Practice.

This paper focus on increasing coverage of Pertussis Vaccinations. In Canterbury we have a low uptake of this vaccines. An estimated 30% of pregnant women are vaccinated for Pertussis.

For the past 12month ISLA have been considering ways to improve coverage the Canterbury region, they are also concern about parents who due to their babies being born early, may not have had the vaccination. Preterm babies are vulnerable to disease and as a health system we need to ensure they are protected.

In the past the P&F Leadership Team has given approval to developing a programme to vaccine parents of preterm babies in NICU. Work has been underway on the development of this programme. In doing this, the focus has expanded to look at reaching women in Maternity out patients.

Currently a group of women (around 2000 per annum) attend outpatient's clinics due to high risk pregnancies. These women regularly attend clinics at Christchurch Women's. It is believed that these clinics provide an opportunity to vaccinate pregnant women against Pertussis.

2. Service Model

A number of service models have been considered, how the following is the preferred model from the Immunisation Service Level Alliance

1. LMCs and Nurses within Christchurch Women's Outpatients are provided with education and information around vaccinating Pregnant Women.
2. A regular weekly clinic is offered at Christchurch Women's, to vaccinate the current inpatients (pregnant women on bed rest) and parents with children in NICU.

3. All women between gestation periods 32-38 weeks will be offered the Pertussis vaccination when attending an outpatient's clinic. Before this time, they will also be provided with information around the vaccinations, and can choose to go to general practice to be vaccinated.
4. Opportunistic vaccinations to be offered to inpatients if possible.

To achieve this model, there is a need to change the current processes within Outpatients to have an increased focus on immunisation within this service. This service changed occurred a few year age in Child Health wards, where the immunisation of every child admitted to the ward is now checked and they are given information on immunisation and if possible vaccinated during their stay.

Canterbury Immunisation has the contract with the DHB to provide education and support to Secondary Care Services. They are willing to provide an education session to LMCs and nurses with Women's Health around the Pertussis vaccination. This will enable the staff to have the knowledge and confidence to vaccination.

To make this process happen, there is a need to resource women's health to vaccinate. When the team (Jayne Thomas, Margaret Kyle and Bridget Lester) met with Natalie King around this service, it was felt that a 0.4FTE was required. On further consideration and discussion at our previous ISLA meeting it was signalled that a 0.2FTE position could be resources. This would cover the Friday clinics and opportunistically within Outpatients.

This level of resourcing will require around $20,000 per annum to support the initial pilot. To offset the cost of doing this in general practice, 952 vaccinations would need to be given within the 12month period.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 16 April 2019 1:10 p.m.
To: Bridget Lester
Subject: 2017 OIA Information
Attachments: CCN WORK PLAN 17_18 ISLA CCN feedback updated (003).docx; HPV Report for ISLA.docx; Tdap and HPV papper to ISLA.docx; Missed Events Summary report 2016.docx

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

Immunisation Service Level Alliance WORK PLAN 2017/18

Canterbury Clinical Network

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
Increased Immunisation BPS and Health Target 	People Powered	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	1. To ensure parents are informed and vaccinated Before (and just before Baby)	1.1. Continue to support Lead Maternity Carers (LMCS) to educate and promote immunisation and the NIR for both mother and baby. • Develop an inpatient and outpatient vaccinating programme at Christchurch Women's Hospital 1.2. Maintain systems for enrolment and seamless handover between maternity, general practice and Well Child Tamariki Ora (WCTO) services • Ensure that new-borns on the NIR are allocated to a GPT. • Develop a system to work with families not enrolled in GPT. • Support early enrolment with General practice teams, and use of B code; • Support LMCs for early hand over to GPT and Well Child providers; • Support the Child Health Coordination Service, and support the use of data linkages.	Q1-Q4 Q1	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. *50% of Pregnant Women are vaccinated for Pertussis* • 98% of new-borns are enrolled with general practice by 2 weeks.	Ramon Pink	Bridget Lester

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
		olds	2. Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	2.1. Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Support National Immunisation Register (NIR) and GPTs to identify unvaccinated children and refer to the Missed Events Service. • Provide practice-level coverage reports to Primary Health Organisations (PHOs) which identify and address gaps in service delivery. • Identify immunisation status of children presenting at hospital and vaccinate if possible	Q1-Q4	• 95% of eight month olds and two year olds are fully immunised • 95% of five year olds are fully immunised.	Ramon Pink	Bridget Lester
			3. .Adolescents are fully vaccinated according to the national schedule.	3.1. Provide the 11year old event and HPV to all eligible people, in a general practice setting 3.2. Provide a school based HPV programme, for both TDap (adult tetanus and diphethia vaccine and adult acellular pertussis vaccine) and Human papillomavirus (HPV), to complement the 11year old	Q1-Q4	▪ 70% of Girls have fully vaccinated for HPV (for 2017/18 it is the 2004 birth cohort measured at 30 June in 2018). ▪ 70% of Maori, Pacific, NZ and other	Ramon Pink	Bridget Lester

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GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
				general practice programme, for both boys and girls 3.3. Promote HPV and TDap vaccine to rangatahi and pacific youth, through NGOs, Māori Community and Maori Womens Welfare League (MWWL), Etu Pacifika and other key groups		ethnicities are vaccinated		
			4. Adults are fully vaccinated	4.1. Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women. • Work with general practice to ensure all events are recorded on the NIR • Support the expand role of community pharmacy in vaccinating for influenza. 4.2 Promote Influenza vaccine to pregnant Māori and Pacific women, through MWWL, Māori LMC, Mother and Pepi Services and Etu Pacifikia.	Q1-Q4	• 75% of people aged 65+ have a seasonal flu vaccination • 75% of Maori, Pacific, NZ and other ethnicities are vaccinated	Ramon Pink	Bridget Lester
			5. The whole health system supported to promote and encourage immunisation for life.	5.1. Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups 5.2. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3	• Canterbury DHB is represented at regional and national forums. ▪ Narrative report on interagency activities	Ramon Pink	Bridget Lester

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
				5.3. Use the Māori Kete and other key tools to support improved Immunisation coverage	Q1 - Q4	completed to promote Immunisation Week. • Improved Coverage of Immunisation		

HPV Report for ISLA

Dose 1: 27/02 - 3/04

Dose 2: 28/08 -

Challenges

Pre -programme planning

Last year we sort the school role in November, and during December pulled down the NHI and immunisation status of all the girls. The Admin Coordinator decided that this was not necessary in 2017. It was believed that this could be done once the consent form are returned. However due to large number of consent returns, this has coursed issued in 2017.

Start date

- Number of consents received close to the first vaccination data
- School roles – at the end of February some schools had not forwarded the school roll which added pressure to the admin staff.
- There were only a couple of smaller schools who changed the scheduled date for vaccination which was surprising compared to the schedule changes the previous year.
- Getting information out to schools when they go back, and the starting the programme within three weeks puts strain on the schools to provide the student information we require and to get the consents out to the schools, back from parents and then schools to be processed at what is a busy time.
- We need to start early in the school year to be able to fit all the schools in and have the required 26 week gap between the first and second Gardisal dose and complete the programme before school camps and other end of year school activities come into play in the fourth term. We found in 2016 there were many changes made to the schedule when vaccinating in the fourth term.

Staffing

- The admin coordinator transferred to another department the day the programme started. This created a skill gap in regard to Medtech, NIR, spreadsheets and admin processes.
- For the nursing staff the main issue has been the number of nurses required for vaccination events at most schools. Most days there have been 4/5 nurses required to safety deliver the programme. A small number have required 8. This has had an impact on "normal" service delivery.
- All consents that have been received by the service have been checked and actioned with all those consenting to the programme being offered vaccination as appropriate.

Vaccinations completed in the school programme to date 2030, expect to do a further 220 during the next two weeks. We may have a slight change of total consented as there have been some late consents.

Summary: 2016		
Total Schools Who Committed Yes		127
Total Schools who have said NO		27
- Yes (Vaccinated)		109
- Yes (No Returns)		9
- Yes None (Returns but all NOs)		9
- Yes (Withdrew)		1
Possible Number to Reach		1898
Consented to the Program		476
Decline Programme - Going to GP		349
Decline Programme - Other		80
Decline HPV		200
Non Return		792

Summary: 2017		
Total groups of Year 8 children		7165
estimate gender split male (55%)		3940.75
estimate gender split female (45%)		3224.25
Already vaccninated	dose1	1607
	dose2	1510
	dose3	1379
Possible Number to Reach		5558
Consented to the Program		2226 (40%)
Number of boys consented		1530
Number of girls consented		696
		2206
Declined the Program - (Going to GP, Child has already been vaccinated, do not consent to the Program)		1611
Already Vaccinated		54
Completed after round 1		34
Total Schools Who Committed Yes		132
Total Schools who have said NO		27
- Yes (Vaccinated)		
- Yes (No Returns)		
- Yes None (Returns but all NOs)		
- Yes (Withdrew)		

FOR ISLA CONSIDERATION	Canterbury Clinical Network
TITLE	11 year old event (HPV and Tdap) and Year 8 School Programme
PREPARED BY	Bridget Lester
DATE	31 March 2017
RECOMMENDATION	That the ISLA review the paper and approves the following: • Support the continued offering of HPV and Tdap at 11 in a general practice programme • Extend the Year 8 HPV Programme to include a catch up programme for Tdap.

1. Purpose

The purpose of this paper is to provide background information to the South Island GM, relevant PHOs around the proposed changes to the Tdap (11 year old event) and the HPV programme.

We ask that the GM review this and work with their DHBs to make a decision on the preferred service model will be for their region.

2. Background

In mid-2016 the Ministry of Health (MoH) and PHARMAC advised of changes to the national HPV programme. These changes included

- Extending the eligibility to include boys
- Changing the vaccine from a 4 valiant to a 9 valiant
- Changing the doses from a 3 dose programme to a 2 doses programme.

At this time, the MoH wrote to all DHBs signalling the changes to the programme in 2017 and noting that there would be potential changes in 2018. The MoH encouraged DHBs to focus on the 2017 year, and the introduction of vaccine availability to boys at the Year 8 HPV School Programme.

It was also noted that planning was underway to move HPV from Year 8 to Year 7, and offer this in a school programme with the Year 7 Tdap event.

3. Current Service

Currently there is not national consistency in the delivery of the Tdap programme. In the majority of the country (the north island and NMDHB) Tdap is provided within a school programme to all year 7 children. However in what was the older Southern Reginal Health Authority region (Canterbury, South Canterbury, Southern and the West Coast) this programme is offered in a general practice setting, while HPV is offered in as a full school programme in Year 8. Canterbury is the exception: HPV is offered at the 11 year old event in general practice, with a catch up programme in Year 8, in schools.

Therefore while the proposed national changes, will not have a large impact on the North Island, they will have an impact on the South Island and there is need for consideration and possible consultation on this.

4. Rationale behind changes

The rationale behind these changes is around streamlining and 'normalising' the HPV programme vaccination programme in schools. The assumption is that there will be increased coverage and reduced administration costs to a combined primary care/school approach.

The Canterbury DHB has combined the two events since 2013 and this has proven to be successful in increasing HPV coverage in the region.

5. National Planning

A national working group has been set up to look at the implementation of this concept and proposed service models. While there are concerns in the Southern region, there are also concerns in the northern regions around what the change in doses and the schedule will mean for the workforce and programme planning.

At the national teleconference a number of alternative models was suggested, including:

- Offer HPV in term one and term 3 and Tdap separately in term 2
- Offer HPV and TDap at Year 8, and this would remove the concern around hump year (when both the programmes are running, this will be a one off).
- While option of the Year 8 programme would be better for the South Island, as we could continue to offer our 11 year old programme with the Year 8 programme, it would not leave any option for a school catch up programme.

6. Current service performance

The Canterbury DHB is still performing lower than other DHBs with HPV coverage. However we are currently sitting at 68% coverage for dose 1 and 59% coverage for dose three. The national target for HPV is 70% for girls born in 2003. While our coverage is not at the national target, there has been a marked improvement over the past two years.

The change from a three to a two dose programme and the eligibility of boys to receive the vaccine, will normalise this programme more, and see improved coverage.

Tdap coverage use to be regularly reported to P&F. However due to a change in contracting and data collection, this has not been possible. When the data was collected the CDHB coverage was 80%. While these 11 year olds are now part of the NIR birth cohort, again challenges with loading this event on the NIR and the schedule not being updated to make this simple, means that what is being given is not being counted. The NIR team and the Immunisation Coordinators have been working with MoH national team to try and determine the issues in the processing.

7. South Island Consultation

This change needs to be discussed widely to ensure there is agreement within the MoH, DHB and Primary Care around any changes to the 11year old immunisations.

What has already occurred?

- The issue was highlighted at a recent South Island GM Planning and Funding meeting

- An email has been sent to all Planning and Funding Immunisation Portfolio Managers asking their thoughts around the proposed changes.
- A discussion has occurred with the West Coast Immunisation Advisory Group and the West Coast PHO Clinical board
- A discussion has occurred with the Canterbury DHB Immunisation Service Level Alliance, and the Canterbury PHO CEO meeting.

8. Proposed Service Models

MoH Proposal - Offer HPV and Tdap in a Year 7 School Programme - this is the MoH proposed model, but it will have a major impact on general practice. This could be seen as moving the children from their current health home, and into an isolated school programme. This would require increased staffing with the school vaccinating team, and reduced funding to general practice.

However, it would see the normalisation of the event and school programmes achieve higher service coverage for Māori and Pacific populations.

Canterbury DHB Proposal - Offer HPV and Tdap at the 11year old event in general practice - This would see HPV moved forward a year to the 11 year old event and offered in general practice however this would require a catch up programme at Year 8 in the school programme. This would again normalise HPV and Tdap and consolidate the programme i.e all events are given in general practice at 11years of age, and will follow up in school at 12 years.

While this proposal is not within current national direction, it fits within the direction of our DHB with general practice being the families' health hub. The model is currently seen as effective, so why change the model we have worked so hard to get effective.

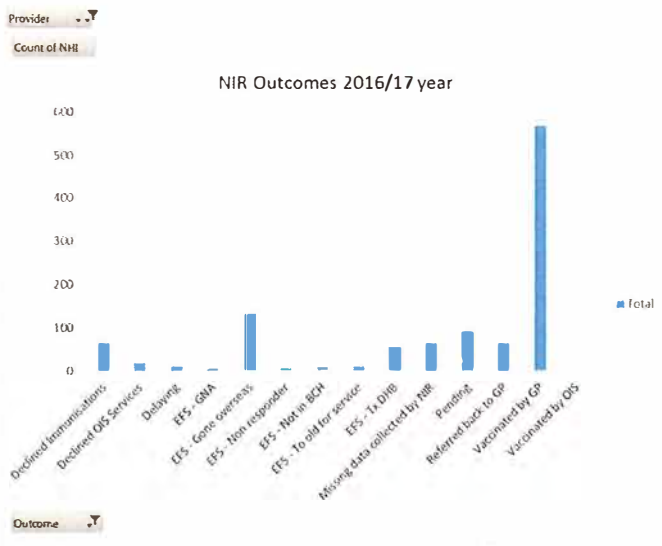
Missed Events Summary report 2016/17 year

2016/17 year by month	NIR	PTC	TPKOT	CI	WC	Grand Total
Jul	59	34	29	22		144
Aug	92	25		39	2	158
Sep	101			151		252
Oct	80			96		176
Nov	110			115		225
Dec	54			81		135
Jan	102			102		204
Feb	89			78		167
Mar	115			140		255
Apr	59			109		168
May	153			148		301
Jun	94			106		200
Grand Total	**1108**	**59**	**29**	**1187**	**2**	**2385**

In the 2016/17 year 2385 were referrals were received through the Missed Events Service. Of these 1108 (46%) were managed by the MEC, while 1275 (54%) were referred to Outreach Immunisation Services.

Table Two NIR Outcomes

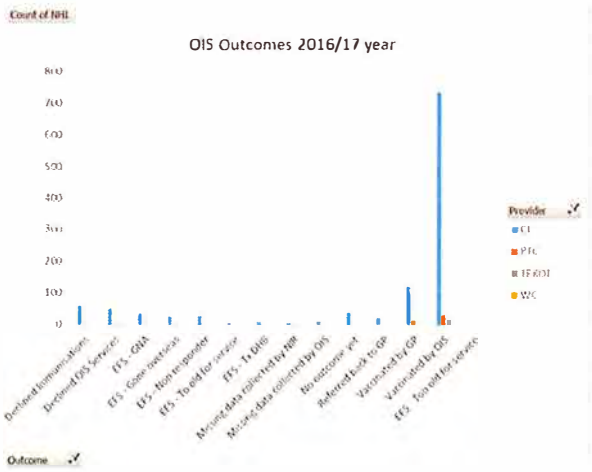
Outcomes	Grand Total
Declined Immunisations	63
Declined OIS Services	20
Delaying	12
EFS - GNA	6
EFS - Gone overseas	133
EFS - Non responder	7
EFS - Not in BCH	8
EFS - To old for service	11
EFS - Tx DHB	55
Missing data collected by NIR	65
Pending	91
Referred back to GP	67
Vaccinated by GP	567
Vaccinated by OIS	1
Grand Total	**1106**



Of the children managed by NIR 51% were vaccinated by general practice, while 17% had left the DHB. 7% of families declined OIS or Immunisation. For 6% of children missing data (normally overseas history was collected. Currently there are 91 children with a status of Pending, which means they are still being worked on by MEC, while 67 children have been referred by to GP but not yet vaccinated.

Outreach Immunisation Service Outcomes

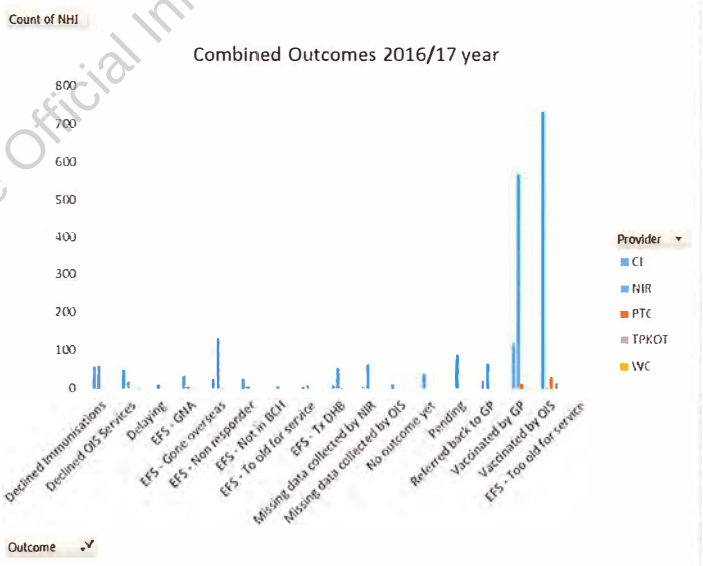
Outcomes	CI	PTC	TPKOT	WC	Grand Total
Declined Immunisations	61	2	1		64
Declined OIS Services	51	3	5		59
EFS - GNA	36	3	2		41
EFS - Gone overseas	26	2			28
EFS - Non responder	28				28
EFS - To old for service	6				6
EFS - Tx DHB	10	2			12
Missing data collected by NIR	6	1			7
Missing data collected by OIS	12	1			13
No outcome yet	40				40
Referred back to GP	23		3		26
Vaccinated by GP	121	14	2	2	139
Vaccinated by OIS	733	31	16		780
EFS - Too old for service	1				1
Grand Total	**1154**	**59**	**29**	**2**	**1244**



Of the 1244 referred sent to OIS service in 2016/17, 780 of them or 63% of them were vaccinated by OIS, 11% were vaccinated by general practice. Therefore 74% of children were vaccinated following an OIS referral. Of the 25% not vaccinated, 10% declined OIS or Immunisation, and 8% were not contactable.

Combined Outcomes

An analyst has occurred of the combined outcomes, which shows the following



- 63% of all referrals have been vaccinated, with by OIS or at general practice
  - 30% general practice
  - 33% OIS
- 9% of families declined OIS or to be vaccinated, while a further 0.5% are delaying immunisation
- 10% of children had either left the DHB or moved overseas.
- 10% of all referrals haven't had an outcome, as there they have been referred back to GP and not vaccinated, gone no address, to old of OIS services or with a no outcome/pending status

General Practice Referrals

The following providers make up the majority of referrals to MEC.

New Brighton Health Care	4.46%
Linwood Avenue Medical Cei	3.65%
Piki Te Ora	2.78%
Shirley Medical Centre	2.64%
Moorhouse Medical Centre	2.54%
Doctors On Riccarton	2.45%
Darfield Medical Centre	2.30%
Durham Health	2.16%
Eastcare Health	1.87%
ProMed Edgeware Doctors	1.78%
Helios Health Ltd	1.78%
Hei Hei Health Centre	1.44%
Allenton Medical Centre	1.34%
Village Health Lincoln Road	1.20%

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 16 April 2019 1:12 p.m.
To: Bridget Lester
Subject: 2018 information
Attachments: 2018_19 CCN Immunisation SLA Workplan Reviewed.docx; Decline project 2017.docx; cold chain resoulation pathway..docx ← file error, can't be printed.

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

CCN Immunisation Service Level Alliance WORK PLAN 2018/19

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME
				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions						
1. Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy	1.1 Support LMC to promotion Immunisation 1.1.1 Hold a focus group with LMCs to determine what they need 1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.1.3 Do a stocktake of resources to determine what the gaps are 1.2 General Practice Teams are supported to vaccinate 1.2.1 Educated around the importance of Pregnancy Vaccinations 1.2.2 Education how to load the events on the NIR 1.3 Work with the MoH to ensure regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme	On going Q1 Q3 Q1 Ongoing Q3 Q3 On going	▪ LMC focus group held in Q1 ▪ Resource stocktake completed in Q1 ▪ 50% of women are vaccinations for Pertussis during Pregnancy	Ramon Pink Helen Fraser	Bridget Lester	▪ Delayed/avoided burden of disease & long term conditions ○ Population vaccinated ○ Protective factors enhanced ○ Risk factors addressed
2. Reduce the number of declined immunisation event in our region, against the immunisation schedule	2.1 Develop a more structured general practice decline process 2.2. Work with C&PH to better understand why Maori are declining immunisation **EOA**	Q2 Q2	▪ Decrease in child hood immunisation declines – compared to 2017 year baseline/Target ▪ Reduction in the Maori decline rate baseline/Target	Ramon Pink	Bridget Lester	*Contribute to National Health and Performance Targets* ▪ Delayed/avoided burden of disease & long term conditions ○ Population vaccinated
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor						
1. Timely Childhood Immunisations	1.1. Continue to monitor all 8months, 2 year olds and 5 years olds to ensure they are fully vaccinated	Ongoing each quarter	▪ 95% of 8month olds, year olds and 5 year olds are fully vaccination.	Ramon Pink	Bridget Lester	*National Health and Performance Target*

Commented [RR1]: Melissa/Ruth Feedback Consider running a focus group with people who have declined and providers to understand the issues and co-design change strategies
Bridget – this may be part of the process, but at this stage we were not looking at specifics as a lot of work has been done nationally on this already.

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	Canterbury Health SYSTEM OUTCOME
						▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
2. ***Influenza Vaccination Programme***	2.1. Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations. 2.2. Work with DHB Occupation health to Staff influenza vaccinations loaded on the NIR (esp for staff 65 or over)	Q2, Q3	▪ 75% of those 65 of over are vaccinated.	Ramon Pink	Bridget Lester	*SLM and Performance Target* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
3. ***HPV and Tdap Programme***	3.1. Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8	On going	▪ 75% of girls born in 2006 are fully vaccinated for HPV ▪ 85% of children born in 2006 are fully vaccinated for Tdap	Ramon Pink	Bridget Lester	*Performance Target* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
4. ***General Practice New-born Enrolment***	4.1. Work with the PHOs to continue to provide education to general practice teams around the need to accept all New Born nominations and "B" code new borns SLM	On going	• 95% of New-borns are enrolled with General Practice at 3 months of age	Ramon Pink	Bridget Lester	*SLM* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated

Commented [RR2]: Melissa/Ruth Feedback Question...What are we going to that is different from previous years. Can you identify one action that will continue the improved HVP vaccination rates

Bridget - This is sitting under Monitoring, so this year we plan to continue to monitor our coverage – there has been ongoing changes with this programme over the years and we want to let this settle in the 2018/19 year. Eg 2017 intro of boys, 2018 intro of Tdap.

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)	
Data Metric Definition	Data Source
1.	
2.	
3.	
4.	

4 year old declines 2017 year

In total 294 children had their 4 year old immunisations declined, this was an increased from 250 children in the 2015/16 year. Of these 88 children had all events declined. In regards to specific immunisations, the following was identified

- PCV declines - 133 had declined all PCV, While, 205 only the 15month PCV
- MMR - 199 had 4 year old MMR declined, while 135 had declined both MMRs. 15 had declined MMR15 but had the 4 year old, this is down on the 29 children last period.
- HIB - 178 children had their HIB15 declined as well as other immunisations, such as MMR, 4 year old imms, etc, however a small group of only 24 children had the HIB15 declined, but had their MMRs.
- 4 year old immunisations - 31 children had their 4year old immunisation declined, but where fully vaccinated for all other immunisations.
- 15month immunisations - 141 children had their 15month immunisations declined however they were also declining other events.
    - Only two children had only their 15months declined.
    - 17 declined their 15m and 4 years but had the rest
- 8 month immunisations - 22 had their 6 week and 3 months immunisation, and then started to decline.

Below are a list of practices with more than 4 four year olds having declines recorded in the 2017 year. This would be a good group to approach with supporting information around declines.

Practice Name	Declined
Helios Health Limited	63
Durham Health	16
New Brighton Health Care	11
Riccarton Clinic	7
Doctors On Riccarton	6
Linwood Medical Centre	5
Barrington Medical Centre	5
Main North Road Medical Centre	5
Fendalton Medical Centre	5
Allenton Medical Centre	5
Greers Road Medical Centre	5
Pegasus Medical Centre	5
Halswell Health	5
Harewood Medical Centre	5
Woodham Road Clinic	5
Kaiapoi Medical Centre	4
Amberley Medical Centre	4
Christchurch South Health Centre	4
Rolleston Central Health	4
Lincoln University Student Health and Support	4
Marshlands Family Health Centre	4

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 16 April 2019 1:14 p.m.
To: Bridget Lester
Subject: 2019 info
Attachments: ISLA workplan 201920 yearv2 15 March.docx

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ Bridget.Lester@cdhb.health.nz
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

GET IMMUNISED

CCN Immunisation Service Level Alliance WORK PLAN 2019/20 TEMPLATE

Canterbury Clinical Network

OBJECTIVE *Succinctly what you are aiming to achieve. E.g. Improved Oral Health for 0-18year olds, Improved access to mental health services for older persons, increased sustainability rural workforce*	ACTIONS *What are the priority actions that the group can achieve in 2019-20 to address the stated objective. Indicate if these actions contribute to improved Equity of Outcomes (EOA) or System Level Measures (SLM)*		TIME FRAME *In which Q will the action be completed (Q)*	MEASURES OF PROGRESS & SUCCESS / TARGET/ MILESTONES *How will we know if we have been successful at implemented our actions. Are there milestones to measure progress against Is there a target or baseline metric to include.*	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too? What is the outcome we are trying to achieve?*
	EOA or SLM				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1.0 Improve Pregnancy Vaccinations coverage		1.1 Survey new parents around Pregnancy Vaccinations Develop Education Programmes for: 1.2 General Practitioners. 1.3 LMCs, including updating the LMC Toolkit. 1.4 Further investigate the opportunity to provide Pregnancy Vaccinations through community pharmacy	Q2 Q2 Q3	Understand why parents are not vaccinations and the messages they are given during pregnancy will be developed. General practice, LMCs and Pharmacy have the tools to talk to women around pregnancy vaccinations Increase vaccination coverage rate. Target =60%	Helen Fraser	Bridget Lester	Delayed/avoided burden of disease & long term conditions Population vaccinated. Protective factors enhanced. Risk factors addressed
2.0 Ensure timely childhood immunisation	EOA	2.1 Continue reducing declines for childhood vaccinations, by supporting general practice teams, with a focus on decreasing the Maori decline rate. 2.2 Work with National Immunisation Register and Outreach Immunisation Services to focus on	Q1	▪ Declines are reduced each quarter to an level of 3.5%	Sarah Marr Alison Wooding	Bridget Lester	Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions

OBJECTIVE *Succinctly what you are aiming to achieve.* *E.g. Improved Oral Health for 0-18year olds, Improved access to mental health services for older persons, increased sustainability rural workforce*	**ACTIONS** *What are the priority actions that the group can achieve in 2019-20 to address the stated objective.* *Indicate if these actions contribute to improved Equity of Outcomes (EOA) or System Level Measures (SLM)*		**TIME FRAME** *In which Q will the action be completed (Q)*	**MEASURES OF PROGRESS & SUCCESS / TARGET/ MILESTONES** *How will we know if we have been successful at implemented our actions.* *Are there milestones to measure progress against* *Is there a target or baseline metric to include.*	**ACCOUNTABILITY**		**Canterbury Health SYSTEM OUTCOME** *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
	EOA or SLM				**CLINICAL LEAD**	**PROJECT LEAD**	
		improved coverage at 5 years olds for all population groups.					Population vaccinated
3.0 Improve equity coverage of Adolescent Immunisations		3.1 Consult with Maori and Pasifika groups to better understand barriers to adolescent vaccinations 3.2 Continue to support general practice, to enable them to promote the co-delivery of HPV and Tdap at age 11, including development of resources 3.2 Develop a trial for an online consenting process for the school based programme	Q2 Q2 Q2	General Practice continue to be supported to offer the programme. Coverage rates of Tdap and HPV given in general practice are similar. Online consenting is offered for the 2020 School based programme	Ramon Pink	Bridget Lester	Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated
4.0 Rheumatic Fever patients receive their medication in a timely manner		4.1 Oversee delivery of the new service model implemented March 2019	Ongoing	▪ Receive regular reports on the timeliness of engagement ▪ ▪ 70% of RF patients receive their regular treatment on time	Tony Walls	Bridget Lester	Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated

SECTION TWO: Actions Towards Monitoring Progress							
5.0 Monitoring of Funded vaccines to ensure equity of coverage of these vaccines		5.1 Receive regular reports on coverage, review and monitor these 5.2 Develop plan to improve if coverage is decreasing		▪			Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated
6.0 Improve Older Person Vaccinations		Work with PHO and Pharmacy Leads to identify local strategy's to support an integrated approach to improving Ider person's vaccination (Flu and Shingles) rates with a focus on Maori. This will include: 6.1 Reviewing current performance data; 6.2 Identifying any areas of improvement; and 6.3 Develop a plan for improvement as needed	Q1 Q2 Q3	Improvement in Influenza coverage by 2% on previous year rates			Contribute to National Health and Performance Targets Delayed/avoided burden of disease & long term conditions Population vaccinated

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes, monitor performance targets etc. *(Consider whether the data is available in a way that identifies any inequity)*

Description of Metric	Data Source	Comments on access to data / metrics
1. Vaccination coverage including by ethnicity		
2. Vaccination declines by ethnicity		
3. HPV coverage by ethnicity		

Thinking about the data and what is on your work plan my thoughts would be including the following:

% Declines broken down by ethnicity – given the Maori declines are a priority

HPV broken down by ethnicity given your priority for Maori & Pacific

Shingles +65year olds?

Is there any measure of pregnancy vaccinations or is it invisible

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 30 January 2015 2:48 p.m.
To: 'Alison Wooding'; 'Anne Feld'; 'Geraldine Clemens'; Helen Barbour; 'Linda Hill'; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Agenda and papers for ISLA meeting 3 Feb
Attachments: Draft minutes 1612014 ISLA.docx; ISLA 2014 15 workplan October 2014.docx; Immunisation Service Level Alliance draft 201516 workplan.docx; Interests register 28 Oct 2014.docx; Risk Register Dec.docx; Imms Reporting Template 3 FEB ISLA.docx; 3 Feb draft agenda.docx; RE: Maori Health Action Plan

Hi all
Please find attached the agenda and papers for our meeting next week

- Agenda
- Draft minutes from Last meeting
- Data Report
- ISLA Work plan 2014/15
- Draft work plan 2015/16
- CDHB Maori Health Plan (email attachment)
- Risk Register
- Interest Register

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
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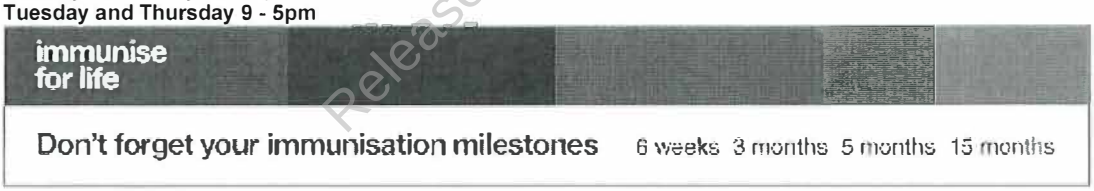


Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 16 December 2014	Time: 2-4.00pm
Present: Ramon Pink(Chair), Dr Tony Walls, , Dr Alison Wooding, Dr Sarah Marr, Bridget Lester, Anne Feld, Linda Hill, Margaret Kyle and Anne Feld	
Apologies: Anna Harwood	
In attendance: Ruth Robson, Meagan Draper, Matae Gillies and Wendy Dallas-Kaute	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes 28 Oct 2014 meeting were approved for Bridget to send to CCN.	Bridget	23 December
2.	**Previous Actions & Matters Arising**	• Bridget met with OIS providers and indicated our expectations that they would work as one service. If no change in service relationship is made, then we made need to move towards one service provider for Canterbury. • Opting off process – this has not occurred • Updated work plan – this is to be discussed later in the meeting		
3.	**He Kete Hauora Waitaha**	Matea and Wendy attended the meeting to present to ISLA the Kete developed by the CCN Māori Caucus They have identified HPV as an areas of interest and sought feedback on why our DHB is performing below expectations. They indicated that Maori Women Welfare Leagues have contracts with the MoH to promote immunisation in their region. ISLA to share with them key messaging with MMWL to ensure consistent messaging in Canterbury Discussion around how we can link with them for Immunisation Week.	Wendy to share list of MWWL contacts. Bridget to liaise with them.	
4.	**ISLA Work plan**	**Q1 data** = 93% 8month olds, 95% 2 year olds **Health Target** – we are not on track to reach 95% in Q2. **Vaccinations in Pregnancy** – process on this continues. **HPV** – Good uptake is being see from the school programme of which 68% of year 10 years have started dose one. This has occurred via a mixture of pre-vaccination, school programme or being vaccinated by the GP in 2014. The MoH has recently realised a paper around reviving the HPV programme. In this they are recommending that ALL DHBs offer a school base HPV		

	Item	Discussion/Action	Responsibility	Date due
		programme at year 7 or year 8. Discussion have occurred around how we could manage this expectations within CDHB. **Seasonal Influenza** – ALT has decided to not support the U18 programme for the 2015 year. The public health nurses have been advised, however schools have not been advised yet due to delays in the approval for the letter to go out. PHOs will be advised to let their practices know. Ramon has sent a letter to Sir John Hanson, Chair of ALT around process.		
5.	**2015/16 Workplan**	Planning package has been realised which sees increased focus on Immunisation. The HT remain at 95% of 8month old The following expectations are also included • 95% of 2 year olds fully vaccinated • 90% of 4 year olds • 75% of year 8 girls have received dose one of HPV.		16 Dec
6.	**Operational**	**Risk Register** – the risk of not achieve the 2year old target needs to be removed. We will add again, if it looks like we are not going to achieve this.	Bridget	10 Nov
7.	**Next Meeting**	4 February 2014 2-4pm at C&PH Meeting dates for 2015 • 4 February 2015 • 10 March 2015 • 28 April 2015 • 2 June 2015 • 21 July 2015 • 25 August 2015 • 29 September 2015 • 3 November 2015 • 15 December 2015		

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	Maintain the Immunisation Service Level Alliance (SLA) with clinical leadership from across the system.	Ensure that CDHB is represented at all key national and regional immunisation forums.	On going	Canterbury DHB is represented at regional and national forums.	Everyone	
Before (and just after) Baby)	Support LMCS to promote and education pregnant women on Childhood Immunisation and the NIR Invest in free seasonal flu vaccinations pregnant women. Support LMC to provide free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children. Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Regular communication and linkages with LMCs Work with LMCs, Primary Care and Immunisation Services to develop a DHB plan for managing an monitoring new-born enrolments This piece of work is being led by CYWS	Q4	Monitor uptake of Influenza and Pertussis vaccination. 95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth. 98% of newborns are enrolled with general practice by 2 weeks. Develop relationships with services already working with children to focus on high needs, at risk children.	Planning and Funding to Lead P&F to link with CYWS to get feedback on this	Plan developed – actions attached to this plan for monitoring. Data regarding Non-enrolled children is now being shared with PHOs, however this data is around the 8month target and not available for early groups.

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
Preschool immunisations	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Refining NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Supporting the Missed Event Coordinator and OIS to locate missing children.	Work with NIR, IC and OIS to ensure health and performance target children are monitor and referred in a timely manner Share PHO and Practice Milestone ages reports with practices. Undertake Assessment of OIS services. Providing recommendations to ISLA	Q2 on going	Quarterly performance reports circulated to PHOs, to review progress against targets. 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated Q2. 95% of all two-year-olds are fully immunised Child Health ward can check status and vaccinate overdue children.	NIR, IC, OIS and P&F NIR	Currently 93% of 8month and 95% of 2 year olds
	Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations, including offering NIR access. Continue to offer the Influenza vaccination to those under 18years of age.			40% of children receive the U18 Flu Vaccination	P&F, ISLA	2015 Flu programme paper to go to ALT (21 October 2014)
Preteen immunisation	Maintain a HPV Programme in both a primary care setting and in schools by: • Continue to link 11-year-old and HPV immunisation events.	Maintain the HPV working group who will Develop an annual plan including	On going	70% of Girls have received dose 1 65% of girls have received dose 2	IPG AND HPV WORKING GROUP	Progress continues, so data report for changes in uptake.

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	• Continue to provide the Secondary School HPV Programme	communisations and monitor performance, and provide advice to ISLA and any service model changes.	On going	60% of girls have received dos e3		Need work up education plan for 2015.
Adult immunisation	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women.	Maintain the seasonal flu working group and develop a plan for the 2015 season.	Q2 Q4 On going	Seasonal flu plan developed 75% of people aged 65+ have a seasonal flu vaccination Q4.	IPG and Flu Working Group	2015 Flu programme paper to go to ALT
System Support	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week by: • Maintaining a Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates; • Maintaining streamlined access to immunisation awareness information; • Developing a plan for implementing Immunisation Week.	Review systems resources and ensure it is up-to-date Develop Immunisation Resources Group who will review all DHB and MoH immunisation resources and oversea the Immunisation Promotion programme	Q3 On going Q3 Q4	Annual update provided to practices Plan developed for Immunisation Week. Narrative report on interagency activities completed to promote Immunisation Week.	P&F, DHB Communisations and ICs	Di Bos working on the updating the Toolkit.

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Area	Action	Timeframe	Responslbity	Progress
Education	Develop an education programme for LMCs, to educate them on the importance of vaccinating during pregnancy.	February 2015	Margo to organise Tony to present	
	Regular message to LMC twice a year regarding the importance of vaccinations	February and July	Bridget	
	Link with DHB Maternity Outpatients to ensure they are advising women around vaccination	October 2014	Margo	
Information Linkages	Develop a way to link Maternity Suite Bookings back to General Practice (need to ID a way to notify practices of miscarriages). This will enable the practice to know who is pregnant and recall them at 30 weeks for vaccination. A draft letter to be developed to support this programme.	December 2014	Bridget and DHB IT	Not currently possible, however contact has been made to see if we can run a report to pull the data.
	Develop a sticker for the Hand Held Maternity Notes books, to remind LMCs and Pregnant Women about when to vaccinate	December 2014	Bridget to develop and distribute Margo to educate LMCs	
	Update Pertussis section of Health Pathways to reflect key messages	December 2014	Margo to link with Di Bos	
Promotion	Update promotional material to include key messages	December 2014	Bridget, Margo and Mick	
Vaccination	Discussion vaccination of parents in NICU for at risk children	December 2014	Margo	

	IMMUNISATION SERVICE LEVEL ALLIANCE 2014/15 WORKPLAN			MEASURE OF SUCCESS		ACCOUNTABILITY	
System Level Outcome	***Activity Level Outcome***	***Objective (in the next year)***	**ACTIONS**	**TIMING**	**TARGET *or Measurable Result***	**CLINICAL LEAD**	**PROJECT LEAD**
Delayed/avoided burden of disease	***Population is vaccinated*** ***Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well***	To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Ramon Pink	Bridget Lester
		Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.		
		Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3		
		Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially for the free group for those under eighteen, as well as older people (65+) and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination		
		The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.		

OTHER CONSIDERATIONS....

Are your actions time bound?

Are your actions measurable? Can they be more specific?

Consider the Gaps in performance Do your actions address these?

If you set a measure – can you measure it - what is the current performance?

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 28 October 2014	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Linda Hill	Chair – Immunisation Providers Group Regional Advisor IMAC
Margaret Kyle	CDHB LMC liaison LMC midwife Midwifery services advisor – Clinical researcher the New Zealand Institute of Community Health Care NZCOM midwifery standards reviewer Chair Canterbury/West Coast NZCOM
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding Member of IPG

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

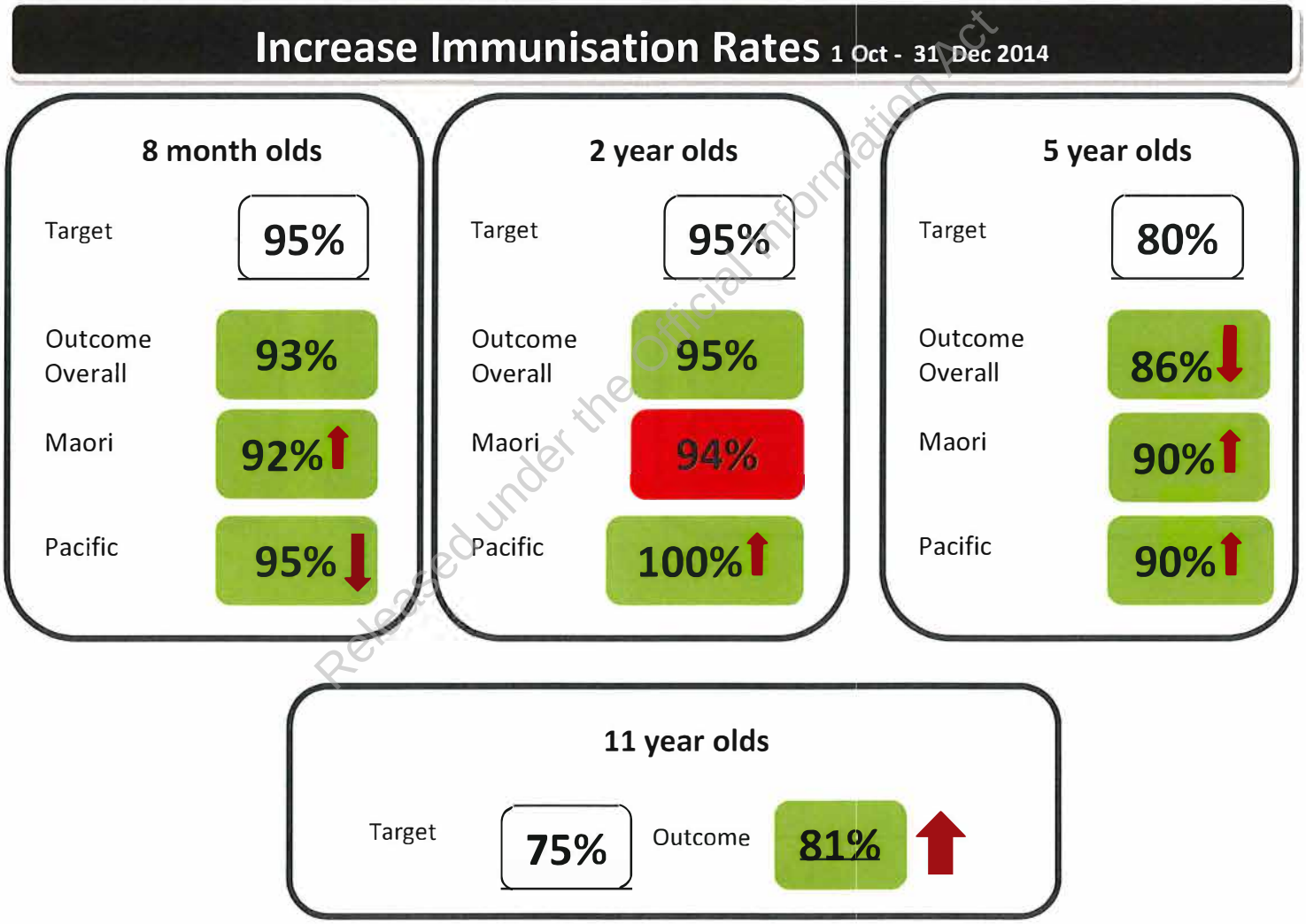
RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children"	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. The HPV School programme has been put in place to pick up the girls not reached in the general practice programme.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

our health system

Key Performance Indicators and Childhood Immunisation Reporting

January 2014



Childhood Immunisation – MoH Health Targets up until 30 Jan 2015

Fully Immunised 8 month olds – DHB LEVEL

Q1 2013/14 Actual	Q2 2014/15 Actual	Q3 2014/15 Progress including pending	Q4 2014/15 Progress including pending
93% fully	93% fully	92% fully	90% fully
% overdue	1.8% overdue	3.5% could reach	5.5% overdue

Fully Immunised Two year olds - DHB LEVEL

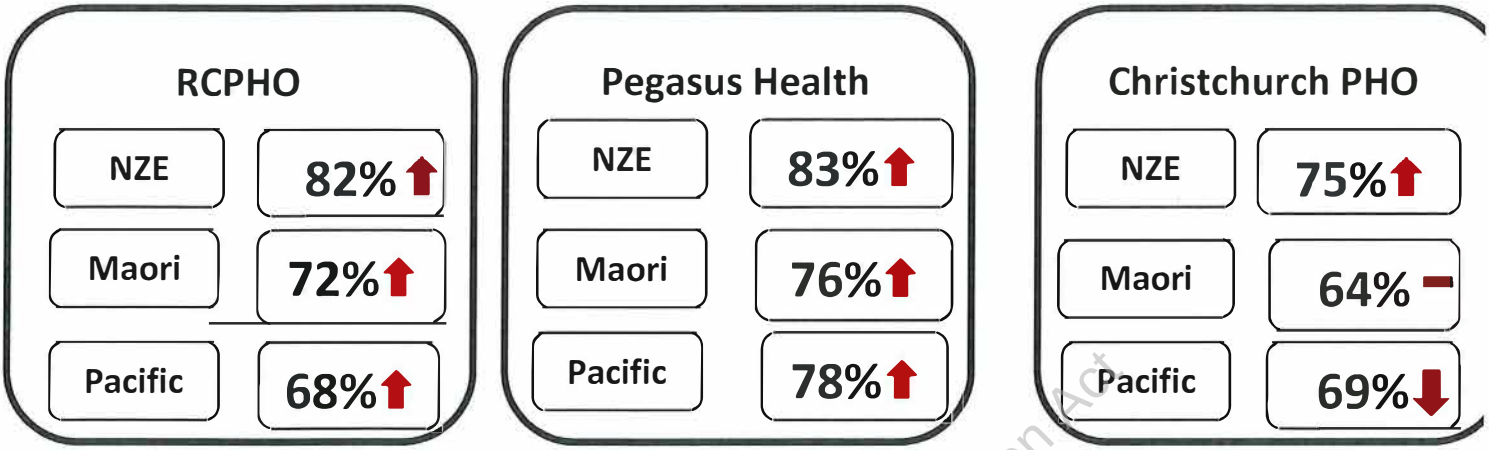
Q4 2013/14 Actual	Q1 2013/14 Actual	Q2 2014/15 Progress	Q3 2014/15 Progress
95% fully	95% fully	93.8% fully	92% fully
.5% overdue	.5% overdue	1% overdue	3% overdue

Fully Immunised 8month and two year olds - PHO LEVEL 30 Jan 2015

	8 month olds		2 year olds	
	Q1 Actual	Q2 Progress Including Pending	Q1 Actual	Q2 Progress Including Pending
RCPHO	93%	91%	94%	94%
Pegasus	94%	94%	95%	94%
Christchurch PHO	96%	96%	96%	99%

Pre teen Immunisations

11 vear old – PHO Level until 30 March 2014



HPV – Similar DHB Level All Doses Dec 13

See page below for HPV data

Immunisation Reporting Programme

The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
  - DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
  - Reporting periods
    - Q1 = 1 July – 30 September
    - Q2 = 1 October – 31 December
    - Q3 = 1 January – 31 March
    - Q4 = 1 April – 30 June
  - HPV Reporting – girls born in 1999 and 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.
  - Please email suggestions and feedback to NIRCanterbury@cdhb.govt.nz

HPV data to come

Q2 2014/15 DATA RUN 5 January 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,539	1,338	87. %	804	720	90. %	217	169	78. %	77	64	83. %	192	180	94. %	249	205	82. %	16 ()	1.0 (0.0) %	44	2.9 %
8 Month	1,492	1,395	93. %	744	705	95. %	246	227	92. %	61	59	97. %	187	182	97. %	254	222	87. %	16 (1)	1.1 (0.1) %	56	3.8 %
12 Month	1,491	1,405	94. %	755	726	96. %	233	214	92. %	74	72	97. %	189	186	98. %	240	207	86. %	20 (1)	1.3 (0.1) %	50	3.4 %
18 Month	1,490	1,313	88. %	779	706	91. %	220	176	80. %	77	63	82. %	172	157	91. %	242	211	87. %	12 (1)	0.8 (0.1) %	47	3.2 %
24 Month	1,562	1,488	95. %	832	797	96. %	220	206	94. %	76	76	100. %	185	184	99. %	249	225	90. %	16 (0)	1.0 (0.0) %	51	3.3 %
5 Year	1,754	1,514	86. %	951	843	89. %	256	231	90. %	81	73	90. %	153	129	84. %	313	238	76. %	27 ()	1.5 (0.0) %	104	5.9 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,539	1,338	87. %	360	298	83. %	356	313	88. %	370	326	88. %	253	224	89. %	200	177	89. %	0	0	-
8 Month	1,492	1,395	93. %	372	340	91. %	334	313	94. %	324	302	93. %	255	241	95. %	207	199	96. %	0	0	-
12 Month	1,491	1,405	94. %	395	360	91. %	314	300	96. %	319	302	95. %	243	235	97. %	220	208	95. %	0	0	-
18 Month	1,490	1,313	88. %	397	352	89. %	333	301	90. %	311	272	87. %	249	220	88. %	200	168	84. %	0	0	-
24 Month	1,562	1,488	95. %	418	387	93. %	300	288	96. %	342	327	96. %	271	260	96. %	231	226	98. %	0	0	-
5 Year	1,754	1,514	86. %	544	453	83. %	394	342	87. %	351	314	89. %	267	232	87. %	198	173	87. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Immunisation Service Level Alliance Agenda

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Venue: C&PH Waitaha Room	
Date: 3 February 2015	Time: 2 – 4pm
Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	Linda Hill: Apology
Anne Feld :	Margaret Kyle (Acting Chair):
Anna Harwood:	Dr Sarah Marr:
Dr Tony Walls:	Geraldine Clemens: Apology

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Margo Kyle	
2.	2.05pm	**Confirmation of minutes of last meeting**	Margo Kyle	Draft minutes 1612014 ISLA.docx
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Margo Kyle	Yes
4.	2.20pm	**Updates** **2014/15 IPG Work Plan** • **Vaccination in Pregnancy (pertussis in pregnancy programme)** • **Early enrolment in GPT** • **HPV** • **Seasonal Influenza Programme** • **Health Target progress – KPI**	Bridget Lester	Imms Reporting Template 3 FEB ISLA ISLA 2014 15 workplan October 2
	2.40pm	**HPV Model discussion**	Bridget Lester	
5.	2.50pm	**2015/16 Work plan discussion**	Margo Kyle	Immunisation Service Level Alliance
6.	3.10pm	**CDHB Maori Health Plan**	Bridget Lester	
7.	3.30pm	**Operational** • **Interest register** • **Risk Register**	Margo Kyle	Risk Register Dec.docx Interests register 28 Oct 2014.docx
8.	3.40pm	**Any other business**	Margo Kyle	

Action Register

Action	Timeframe
Wendy to share list of MWWL contacts, Bridget to liaise with them	Next meeting

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

Removed 2year old risk from Risk Register – Bridget	16 Dec
Send e-invites of 2015 meetings – Bridget	16 Dec

Next meeting: March 10th 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

Lara Williams (Administrator)

From: Matthew Reid
Sent: Friday, 30 January 2015 2:31 p.m.
To: Bridget Lester
Subject: RE: Maori Health Action Plan
Attachments: Canterbury Maori Health Action Plan 1415.pdf; Maori Health Action Plan Dashboard - July 2014.pdf

Hi Bridget,

Here's the MHAP 2014/15 and the most recent dashboard related to it – there should be a data update coming soon for Dec 2014.

AS discussed, it's not intended that we make radical departures from the workplans – things should align with what's happening in CCN SLAs and workstreams, and be agreed by them, alongside various Māori fora – including the CCN Māori Caucus.

Cheers, Matt

From: Matthew Reid
Sent: Wednesday, 28 January 2015 3:21 p.m.
To: Bridget Lester; Alison Young; Linda Wensley; Nancy Stewart; Melissa Kerdemelidis; Erin Wilmshurst; Paulina Baird; Wayne Turp
Subject: Maori Health Action Plan

Kia ora,

I'm starting work with Hector Matthews on renewing the Māori Health Action Plan for the coming year. I'd like to discuss it with you from in your specific areas – access to care, child health (breastfeeding, immunisation (child and HPV), oral health, B4SC), cardiovascular disease (risk assessment and procedures), cancer (screening), smoking.

When would be good? Some individual meetings would likely be best, and some joint ones. We are on a somewhat restricted timeline, with proposed plans needing to be worked up enough in Jan/Feb to be discussed by various fora in Canterbury in mid- to late-February, before going to the Ministry in early March.

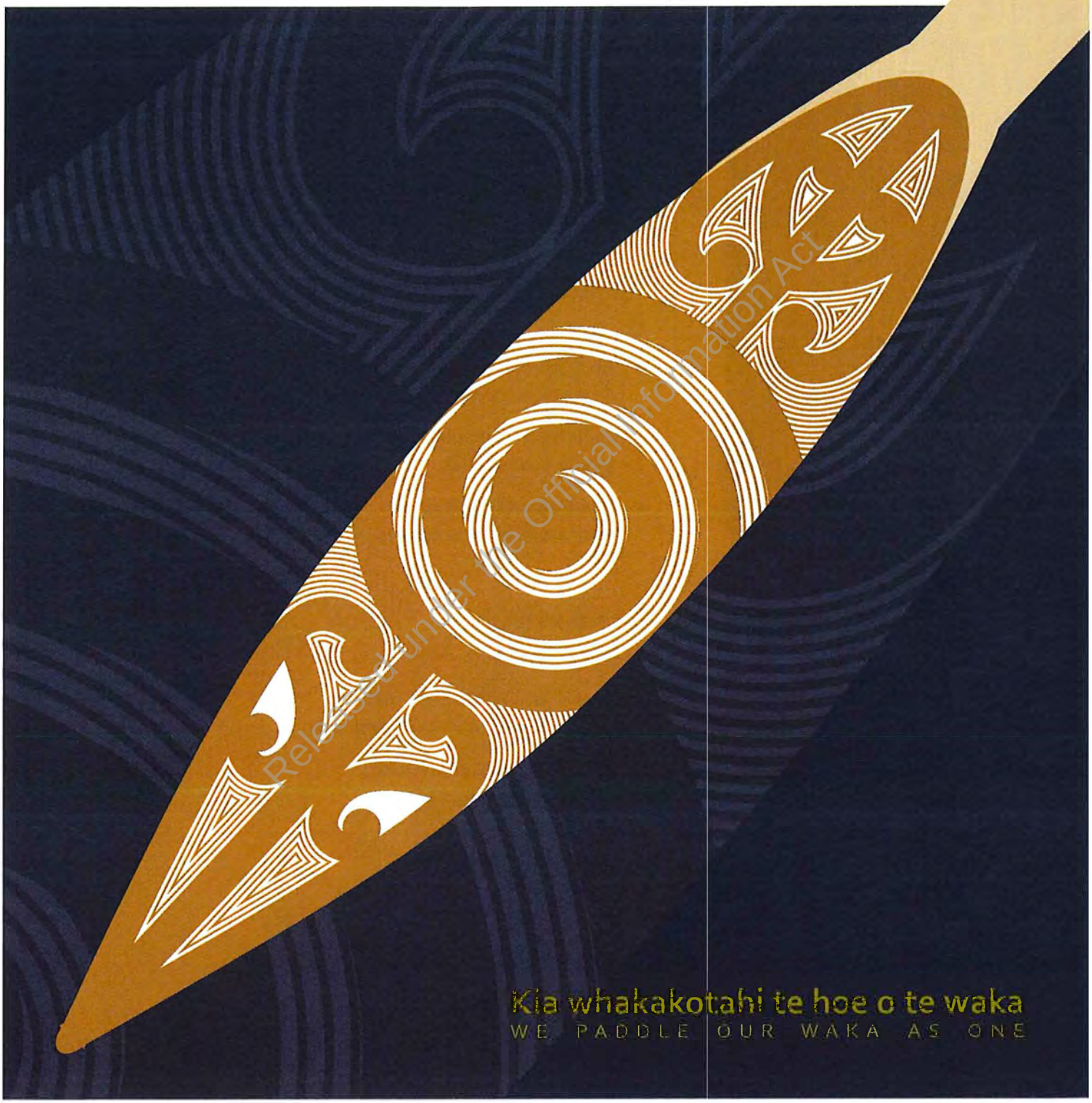
Do I have the right people? Having been away for more than two years, things will have changed a bit in my absence.

Ngā mihi, Matthew

Dr Matthew Reid
Public Health Physician
Planning and Funding
Canterbury District Health Board
matthew.reid@cdhb.health.nz | +64211370818 | www.cdhb.health.nz
Level 3, The Princess Margaret Hospital, Christchurch

Māori Health

ACTION PLAN 2014/15



Pegasus

RURAL CANTERBURY
Primary Health Organisation
Te Roopu Hauora Matua O Waitaha Tahwhenua

christchurch pho

Canterbury Clinical Network

Te Kāhui o Papaki Kā Tai

Manawhenua ki Waitaha

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Tā Mātou Matakite

OUR MISSION

Ki te whakapakari, whakamaanawa me te whakahaere i te hauora mo te orakapai o kā tākata o te rohe o Waitaha.

To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.

Ā Mātou Uara

OUR VALUES

- Manaaki me te kotua i etahi atu.
  Care and respect for others.
- Hapai i a mātou mahi katoa i ruka i te pono.
  Integrity in all we do.
- Kaiwhakarite i kā hua.
  Responsibility for outcomes.

Kā Huari Mahi

OUR WAY OF WORKING

- Arotahi atu ki kā tākata meka.
  Be people and community focused.
- Whakaatu whakaaro hihiko.
  Demonstrate innovation.
- Tu atu ki ka uru.
  Engage with stakeholders.

Contents

INSIDE THS PLAN

Introduction

On 30 June 2010, an amendment was made to the New Zealand Public Health and Disability (NZPHD) Act governing DHBs. Under the amendment, DHBs must complete Regional Health Services Plans, Annual Plans and Māori Health Plans. The NZPHD Act lays out the responsibilities that DHBs have in ensuring Māori health gain as well as Māori participation in health services and decision-making.

The Act also reiterates our responsibility to recognise and respect the principles of the Treaty of Waitangi in the health and disability support sector and our relationship with the Crown's Treaty partner, in our case, Ngāi Tahu. This Māori Health Action Plan is prepared in accordance with this legislation[1].

Overview

This is not a strategic plan, rather, it is an Action Plan highlighting the activity that will occur across our health system in the coming year in key priority areas. The majority of these are chosen nationally and are reflected in the Māori Health Action Plan of all DHBs - a few are areas chosen locally as priorities for improving the health of Māori in Canterbury.

This Māori Health Action Plan draws principles from a number of documents. Key amongst these is the national Māori Health Strategy *He Korowai Oranga*. This plan follows the key strategies in *He Korowai Oranga* while continuing our mission to facilitate and improve the wellbeing of the people of Canterbury. The aim of *He Korowai Oranga* "Whānau ora; Māori families supported to achieve their maximum health and wellbeing" is reflected in our own action plan and in activity happening right across Canterbury.

Implementing this Plan will require a collaborative effort across the Canterbury health system. Our Action Plan has a strong focus on strengthening whānau engagement with health services, empowering people to take more responsibility for their own health and wellbeing and supporting people to stay well. This approach is linked to the DHB's vision for improving the health and wellbeing of the Canterbury population and the work of the Canterbury Clinical Network (CCN) District Alliance in keeping people at the centre of everything we do.[2]

Key Canterbury Māori health organisations

Manawhenua ki Waitaha: Is a collective of the seven Ngāi Tahu Rūnanga health representatives within Canterbury that have a treaty-based relationship with the DHB. This group works in partnership with the Canterbury DHB, all three of the Primary Health Organisations (PHOs) in Canterbury and many community health providers and non-government organisations to plan and take action to improve outcomes for Māori. Manawhenua ki Waitaha also works with other iwi, Taura Here and Maata Waka groups to improve outcomes for Māori in Canterbury.

He Oranga Pounamu (HOP): This charitable trust is mandated by Te Rūnanga o Ngāi Tahu with its key focus on strengthening Māori provider development. HOP has an established affiliated local and South Island Māori provider network. They are currently leading Te Waipounamu Whānau Ora Collective implementation.

Te Kāhui o Papaki Ka Tai: Is a Canterbury-wide Māori Health Reference Group with close links with primary care, the DHB and the CCN District Alliance. The Reference Group has a focus on joint planning for improvements in health outcomes for Māori. Members include community care providers, primary care providers, the three Canterbury PHOs and the DHB.

Canterbury Māori and Pacific Health Provider Forum: The forum enables providers to engage with the DHB's Planning and Funding division as a collective group. Members are those Māori and Pacific providers that hold Canterbury DHB health contracts.

Te Tumu Whakahaere Forum: The forum is chaired by the DHB's Executive Director of Māori and Pacific Health and supports a collective approach to Māori health across the DHB. Members are senior Māori health managers from across the DHBs hospital and specialist services.

Te Herenga Hauora: The South Island Māori General Managers Group is a forum for regional engagement and supports the development of cross-DHB initiatives, such as the development of integrated pathways for whānau who must travel between DHBs for treatment. Te Herenga Hauora also provides regional oversight to Kia Ora Hauora, a national Māori health workforce development programme aimed at Māori students and current Māori health workers to promote careers in the health sector.

[1] *This Māori Health Action Plan is a companion document to the Canterbury DHB's Annual Plan which can be found on the CDHB website: www.cdhb.govt.nz.*

[2] *The CCN is an alliance of health professionals and providers from organisations across the Canterbury health system, including the DHB as a key partner. Some actions in this Māori Health Action Plan are also deliverables in the CCN work plan.*

Maori Health Providers:

The following is a current list of Māori Health Providers contracted by the Canterbury DHB to deliver health and social services in Canterbury. An extensive list of Canterbury providers is available online at www.healthinfo.co.nz. Rural Canterbury & Christchurch PHOs also have service provider directories available on their respective websites: www.rcpho.org.nz and www.chchpho.org.nz.

- He Oranga Pounamu Charitable Trust.
- He Waka Tapu Limited.
- Purapura Whetu Trust.
- Te Awa o Te Ora Trust.
- Te Kakakura Trust.
- Te Puawaitanga Ki Otautahi Trust.
- Te Runanga o Nga Maata Waka.
- Te Tai o Marokura Charitable Trust.
- Te Whatumanawa Māoritanga o Rehua.
- Mokowhiti Ltd.

Monitoring performance and achievement

A Performance Dashboard has been established to monitor performance against the Māori Health Action Plan. This will be completed six-monthly alongside the reports on the national measures provided by the Ministry of Health's Māori Health Division and Te Tumu Whakarae also produced six-monthly.

The Dashboard will be presented to the DHB Board's Community and Public Health Advisory Committee (CPHAC) by the DHB's Executive Director of Māori Health who will provide updates on progress against the plan.

The Performance Dashboard will also presented to and monitored by Manawhenua ki Waitaha, Te Kāhui o Papaki Ka Tai and the Canterbury Clinical Network (CCN) District Alliance's Māori Caucus (six-monthly).

Acknowledgement is given to the Ministry of Health's Māori Health Division and Te Tumu Whakarae for provision of a six monthly performance report against the national indicators in the Māori Health Plan which assists in local performance reporting.

An annual Māori Primary Health Care Report is also prepared and presented to the same groups to provide progress against the Māori Health Plans of the three Canterbury PHOs. This reports covers the national activity areas presented in the Māori Health Action Plan.

Performance against the national Health Targets (included in the Māori Health Action Plan) are monitored on a quarterly basis. These reports are shared with the Board and the PHOs and are available on the Canterbury DHB website: www.cdhb.govt.nz.

Baselines and Targets

All of the baseline data in this Plan (unless otherwise stated) has been calculated on either the full 2012/13 year, the Calendar 2013 year or the final quarter of the 2012/13 year, to align reporting with the Canterbury Annual Plan. Graphs provide the most recent performance data in order to give the reader context as to current performance.

Canterbury's Māori Outcomes Framework

In 2013/14 members of Te Kāhui o Papaki Ka Tai Māori Health Reference Group developed an outcomes framework with the understanding that collective action and focus will make real a difference in health outcomes for Māori.

With a much wider focus than the Māori Health Action Plan - the outcomes framework is aligned to the vision of the Canterbury health system. The goals and associated deliverables are reflected in the work plans of the three Canterbury PHOs, the Canterbury DHB and the CCN District Alliance.

The Outcomes Framework does not pre-determine what action an organisation or provider will take, but helps to highlight a number of focus areas where a positive impact may be made. This may be increased engagement or uptake of services, improved quality of service delivery, reduced waiting times or better health outcomes. A mix of impact measures have been chosen to populate the Framework.

In considering the Framework and opportunities to improve health outcomes for Māori, four priority areas were identified for 2014-2015: cervical cancer screening, delivery of B4 Schools Checks, Human Papilloma Virus (HPV) immunisations and child and youth oral health. The activity planned over the coming year is outlined against these local priorities in this Action Plan. Appendix 1 provides an overview of the Framework.

The Canterbury Māori population

Approximately 37,965 people in Canterbury identified as Māori in the 2013 Census, making up 8.2% of the whole Canterbury population and 6.3% of the New Zealand Māori population. [3]

Ngāi Tahu/Kāi Tahu are the Manawhenua in Canterbury. The most common iwi affiliations are Ngāi Tahu/Kāi Tahu (31%), Ngāpuhi (11.5%) and Ngāti Porou (8.7%), though over 120 iwi are represented in Canterbury.

As with the national Māori population, Māori in Canterbury are younger compared to non-Māori and have a higher fertility rate - meaning the growth of the Māori population is faster.

- From 2006 to 2013, there was a 14% increase in the size of the Māori population, with the proportion of people identifying as Māori in the total Canterbury population increasing from 7.4% to 8.2%.
- 33.5% of the Canterbury Māori population are under the age of 15, compared to 17.5% for non-Māori.

Overall health status and access

The Canterbury population generally has a better health status than the average New Zealand population. This is true for all ethnicities living in Canterbury. Nonetheless, there are still real disparities between Māori and non-Māori in relation to health outcomes and life expectancy.

Mortality

Māori in Canterbury have a higher rate of premature death than non-Māori, although the rate is lower than Māori nationally. The leading causes of death for Māori in Canterbury are circulatory system diseases, cancer, accidents, respiratory diseases, and endocrine, nutritional/metabolic diseases (mostly Type 2 diabetes).

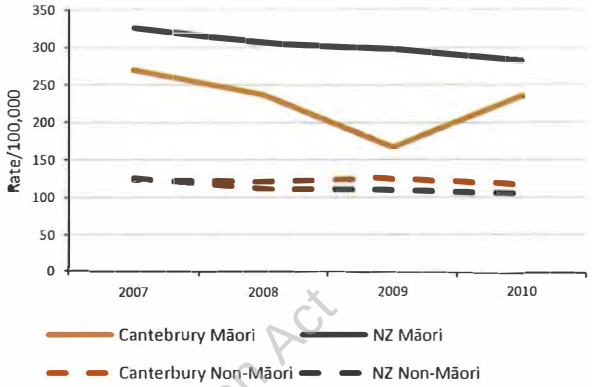
Compared to non-Māori, Māori in Canterbury are:

- More than five times as likely to die from diabetes;
- Almost twice as likely to die from accidents;
- One and a third times as likely to die from cancer;
- One and a half times as likely to die from cardiovascular or respiratory disease.

Mortality from external causes of injury is higher for Māori in Canterbury than non-Māori, particularly for deaths due to drowning, fires and accidental poisoning.

FIGURE 1: ALL-CAUSE PREMATURE MORTALITY

Canterbury Māori (<65) have a higher mortality rate than non-Māori



Source: Ministry of Health Mortality and Demographic Datasets

Health service utilisation

In terms of health service utilisation:

- PHO enrolment is lower for Māori in Canterbury than for 'Other' ethnicities. Suggesting Māori are more likely to have had an unmet need for a general practitioner.
- Spending per capita on prescriptions and laboratory testing is lower for Māori in Canterbury.
- A lower proportion of older Māori in Canterbury are living in Aged Residential Care facilities.

Hospitalisation

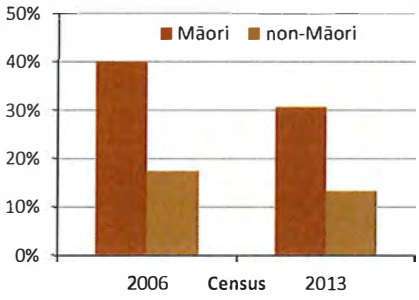
The overall rate of hospitalisation is lower for Māori than non-Māori in Canterbury, contrasting with a higher rate for Māori than non-Māori nationally. Compared to non-Māori, Canterbury Māori have:

- Higher rates of hospitalisation for pregnancy and childbirth, respiratory disease, mental and behavioural disorders and circulatory diseases.
- Lower rates of hospitalisation for injury and poisoning, and digestive system disease.

[3] Data in this section is a mix of 2013 Census data, Stats NZ data and data from the Huora Waitaha I Māori Health Profile completed in April 2010. The DHB is planning to update its Māori Health Profile in the coming year.

FIGURE 2 CURRENT REGULAR SMOKERS 2013

Smoking prevalence is higher for Māori (aged 15 years+).



Source: Statistics New Zealand 2013 Census

Disease prevention

Many of the health outcomes in which Māori in Canterbury fare worse than non-Māori are strongly associated with socio-economic status, smoking and other risk factors.

Social circumstances

In general the Canterbury population is less deprived than the overall New Zealand population. While Māori in Canterbury live in relatively less deprived areas than Māori nationally, they still live in relatively more deprived areas than non-Māori in Canterbury.

With respect to individual socio-economic indicators, Māori are more socio-economically disadvantaged. The differences in age-structure between Māori and non-Māori in Canterbury contributes to differences in socio-economic status, but Māori are also more deprived in terms of income, unemployment, educational qualifications, home ownership, household crowding and phone and motor vehicle access.

Risk factors

Māori in Canterbury have a higher prevalence of obesity and appear to have a higher prevalence of hazardous drinking and marijuana use.

While lower than the prevalence for Māori nationally, the prevalence of smoking is higher for Māori in Canterbury, especially for females and young people. Māori women in Canterbury are almost two and a half times more likely to smoke than non-Māori; two in every five Māori women are current daily smokers.

While youth smoking is decreasing over time, more than four times as many Māori Year 10 students smoke daily than non-Māori, and a higher proportion of Māori young people are exposed to smoke at home.

Child and youth health

Together, children and young people (aged 0 to 24) make up over half (53%) of the Māori population in Canterbury (compared with 31% of non-Māori).

- Childhood immunisation coverage is similar for Māori and non-Māori in Canterbury and significantly higher than for Māori nationally.
- HPV immunisation rates are low. Improving these rates is a local priority for 2014/2015.
- Māori children in Canterbury have poorer oral health status than non-Māori and Māori living in fluoridated areas of New Zealand. Improving child and youth oral health is a local priority for 2014/2015.
- The rate of hearing test failure at school entry, and the rate of grommets insertion, is higher for Māori children than 'Others' in Canterbury. Ear, Nose and Throat infections (ENT) are also a significant driver of hospital admissions for children. Improving B4 Schools Checks coverage is a local priority for 2014/2015.[4]

Maternity

The rates of preterm birth, low birthweight and infant mortality appear higher for Māori than Europeans while the rate of breastfeeding is lower.[5] This suggests a relationship between higher risk (preterm birth and low birth weight) and lower protective (breastfeeding) factors for infants, and worse outcomes in terms of mortality. The rate of teenage pregnancy is much higher for Māori than for Europeans in Canterbury.

Chronic conditions

Incidence and mortality rates for Māori in Canterbury are, in almost all areas, lower than for Māori nationally.

However, Māori in Canterbury suffer from a significant burden of long-term conditions, with four of the five leading causes of death for Māori in Canterbury associated with chronic conditions: cardiovascular disease, cancer, respiratory disease and diabetes.

[4] *The final core Well Child/ Tamariki Ora check, which children receive at age four. The free check allows health concerns to be identified and addressed early in a child's development for the best possible start for school and later life. It includes a hearing check.*

[5] *This data is based on the NZ Child and Youth Epidemiology Service 2013 report on the Health of Children with Chronic Conditions. In this report, 'European/other' ethnicity is based on the 2006 Census information of those who identified as NZ European, New Zealander and European.*

Cardiovascular disease (CVD)

Canterbury Māori have a larger burden of CVD mortality and hospitalisation:

- For ischaemic heart disease, the mortality rate is higher for Māori in Canterbury than non-Māori, but hospitalisation rates are the same, suggesting an area of unmet need for Māori.
- Canterbury Māori have a lower rate of angioplasty and a higher rate of coronary artery bypass grafting than non-Māori, which may indicate a higher level of disease severity among Māori.
- Stroke mortality and hospitalisation rates are not significantly different for Māori and non-Māori in Canterbury, but are significantly lower than for Māori nationally.

Cancer

Canterbury Māori have a larger burden of cancer than non-Māori in Canterbury. Incidence overall for Māori is lower, but the mortality for Māori is higher, Māori with cancer are overall more likely to die from those cancers than non-Māori.

- Lung cancer incidence and mortality rates are higher for Māori than non-Māori.
- Incidence of colorectal cancer is lower for Māori, and there is no difference in the mortality rate.
- Incidence of breast cancer is the same for Māori and non-Māori, but mortality is higher for Māori.
- Cervical screening coverage rates are lower for Māori than non-Māori, suggesting an area of need. Improving cervical screening coverage rates is a local priority for 2014/2015.

Respiratory disease

Respiratory disease mortality and hospitalisation rates are higher for Māori than for non-Māori in Canterbury. This includes asthma, chronic obstructive pulmonary disease and bronchiectasis. Respiratory health is an opportunity for early intervention to improve Māori outcomes.

Diabetes

Canterbury Māori experience higher hospitalisation, mortality and complications for diabetes than non-Māori. A lower proportion of Māori in Canterbury have diabetes annual reviews and retinal screening, suggesting an important unmet need for Canterbury Māori.

Mental health

The access rates for Mental Health Services are higher for Māori in Canterbury than for non-Māori.

- The rates of hospitalisation for schizophrenia, manic episodes, bipolar disorder and psychoactive substance use disorders are higher for Māori than for non-Māori in Canterbury.
- The overall rate of hospitalisation for Māori for mental health problems is higher than the national average for psychoactive substance use and depression.

The World Health Organisation predicts that depression will be the second highest cause of death and disability globally by 2020, so this is a potential area of future focus for improving Māori health.

Impact of the earthquakes

The health profile presented in this document is based on the 2013 Census and other data collected prior to the Canterbury earthquakes.

The earthquakes have had a relatively minor effect on the size of Canterbury's population. Canterbury's population has increased by 3.4% since the previous census in 2006. The population of Christchurch was the most affected, with a two percent decrease in population since 2006. However, the Māori population in Christchurch has increased by over 2,000 people during this period.

The 2013 Census does reveal some of the impact the rebuild is having on our population. There has been an increase of 2,840 males aged between 20-29 years Canterbury since 2006, of which 510 are Māori.

However, at this stage we are not able to tell how many more people have moved into the region since the census, or predict how many more will continue to arrive, what their health will be like and how long they will stay. There is a high level of uncertainty and risk in terms of unpredicted demand.

Many of the most deprived suburbs in Christchurch that were home to a higher proportion of Māori, were the hardest hit by the earthquakes. Despite the large general population loss from these areas, particularly in the east of the city, the 2013 Census shows that many Māori are still living there. Our deprived population groups, already more vulnerable and with higher health needs, have been disproportionately affected by the quakes.

Concerning signals from international research on disaster recovery indicate an increase in risk behaviours is typical in response to stressful events. People who were more vulnerable prior to a major disaster have a

significantly increased risk of poor health post-disaster[6]. Māori are one such vulnerable population group in Canterbury.

Despite it being over three years since the February 2011 earthquake, our population still faces crowded and temporary housing, damaged heating sources, disrupted transport links and social infrastructure, uncertainty about the future and increased stress – all of which is taxing their normal resilience.

The results of the 2013 Census show that eight percent of Māori households in Canterbury are overcrowded, a rate much higher than non-Māori households. Of these, the number of Māori households that are significantly overcrowded has increased since 2006.

As well as the physical health risk caused by factors such as overcrowding and cold housing, the stress of uncertainty and ongoing issues will have a significant psychological impact on our population.

Post-disaster patterns after Hurricane Katrina indicated a substantial increase in experiences of depression, with 31% of displaced people having a mood or anxiety disorder.[7]

Addressing the increased level and immediacy of both physical and mental health need across our population is a priority for the next several years.

Now more than ever, we must support increased capacity in primary and community-based settings to continue to deliver services to our vulnerable population.

[6] *Bidwell, S. 2011. 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review'*

[7] *Wang PS, Gruber MJ, Powers RE, Schoenbaum M, Speier AH, Wells KB, Kessler RC, 2007. Mental health service use among hurricane Katrina survivors in the eight months after the disaster. Psychiatry Services 58: 1403-11*

National Māori health priorities

FOR NEW ZEALAND/AOTEAROA

The following priorities and associated indicators for Māori health have been identified nationally. Identified against each are the key actions and activity Canterbury is undertaking to address the priority area and reach the targets set.

Data Quality

Objective	**Maintain the accuracy of ethnicity reporting in PHO registers.** Collecting robust, quality ethnicity data allows us to monitor trends and performance by ethnicity, enabling health planners, funders and providers to design and deliver services that better engage Māori to improve health outcomes and reduce inequalities.
Reporting Stream	Te Kāhui o Papaki Ka Tai
Data Source	PHO Enrolment Register and Ministry Population-Based Funding Formula
Key Stakeholders	Canterbury DHB; CCN Māori Health Caucus; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO

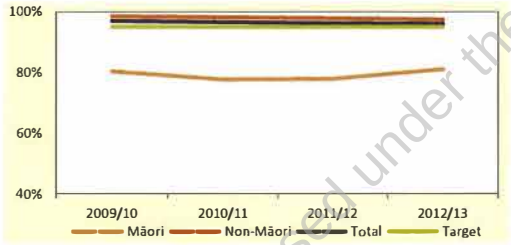
OUR PERFORMANCE STORY 2014/15

Indicator/Target

≥95% of the Māori population is enrolled with a PHO.[8]

Baseline 12/13:

Māori:	81%
Total Population :	96%
Target 14/15:	≥95%



Activity/Evidence

Both the Canterbury DHB and the PHOs are focused on ensuring complete, accurate and consistent collection and reporting of ethnicity data across the system. This is also a focus for Te Kāhui o Papaki Ka Tai and workstreams under the CCN District Alliance who are seeking to demonstrate the effectiveness of programmes.

Over the coming year we will:

- **Q1-Q4:** Quarterly review PHO ethnicity data reports and Māori enrolment data to ensure quality is maintained with regular monitoring through Te Kāhui o Papaki Ka Tai.
- **Q2:** Distribute updated Māori Census data summaries and cross-referenced analysis across the sector.
- **Q3-Q4:** Update the Hauora Waitaha I Māori Health Profile with the latest national summaries and 2013 Census Results.
- **Q1-Q2:** Support the PHOs and general practice to implement Stage 1 to 3 of the Primary Care Ethnicity Data Quality Toolkit (EDAT) to improve ethnicity data collection and quality.
- **Q3-Q4:** Complete the EDAT Audit Process and introduce regular reporting using the EDAT tool (once implemented) to highlight issues and opportunities to improve data quality.

[8] *This measure is a proxy measure and the DHB aims to replace this measure with one more reflective of the quality of the data being collected once the Ethnicity Data Quality Toolkit is implemented.*

Access to Care

Objective	**Promote early intervention through greater Māori engagement in primary care.** Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment will improve access to primary care services that enable early intervention and reduce health disparities between Māori and non-Māori.
Reporting Stream	Te Kāhui o Papaki Ka Tai, Māori & Pacific Health Provider Forum, Community and Public Health Advisory Committee (CPHAC)
Data Source	PHO Enrolment Register and Ministry Population-Based Funding Formula
Key Stakeholders	Canterbury DHB; CCN Māori Caucus; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO, Te Kāhui o Papaki Ka Tai

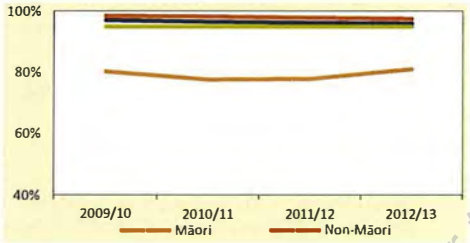
OUR PERFORMANCE STORY 2014/15

Indicator/Target

≥95% of the Māori population is enrolled with a PHO.

Baseline 12/13:

Māori	81%
Total Population:	96%
Target 14/15:	>95%



Activity/Evidence

Ensure Māori health needs and access rates are presented to CCN Workstreams and Service Level Alliances to improve consideration of Māori perspectives in the development of strategies and work plans.

Q1: Develop and provide a Kete for all CCN Workstreams and the wider health sector, to support application of the HEAT tool, Whanau Ora tool, and the Māori Health Framework in order to improve understanding of strategies to improve engagement of Māori in health services.

Q2-Q4: Support key staff to work alongside workstreams and DHB divisions to circulate the Kete and apply the tools.

Continue to support PHOs to provide cultural competency training and access to practical application tools to improve the quality of engagement and responsiveness between general practice teams and Māori patients and to lift enrolment rates.

Q1: PHOs have current Māori Health Plans in place.

Q1-Q4: Pegasus Charitable Health Ltd work with the Māori Indigenous Health Institute (MIHI) to identify ways in which the Meihana Training Model can be adopted for general practice teams and pharmacy.

Q4: Adapted Meihana programme available online.

Q4: >10 Treaty Training (and application to health) workshops provided across PHOs and community pharmacy.

Work alongside Kia Ora Hauora, He Oranga Pounamu, PHOs and the Māori Health Provider Forum to promote health as a career for Māori to improve the responsiveness of the system to the needs of Māori and increase whānau engagement with health services.

Q4: Canterbury Māori Workforce Action Plan completed.

Q1-Q4: Support the Kia Ora Hauora Programme to recruit 375 new Māori onto a health study pathway and at least 75 new Māori into first year tertiary study over the next three years.

Raise the profile of Māori Providers and improve links between primary care, mainstream and Māori services to improve the responsiveness of the system to the needs of Māori and increase whānau engagement with health services.

Q3: HealthPathways listings of Māori Health Providers expanded.

Q4: Updated directory of Māori Health Providers circulated to rural general practices and key stakeholders to increase practice staff awareness of services available.

Access to Care...

Objective	**Maintain low rates of avoidable hospitalisation for Māori of all ages.** By reducing risk factors and taking appropriate early intervention, many conditions can be prevented or managed without the need for hospital-level care. Keeping people well and out of hospital is a key priority; not only is it better for our population, but it frees up hospital resources for people who need more complex and urgent care.
Reporting Stream	Te Kāhui o Papaki Ka Tai, CPHAC, CCN Māori Health Caucus
Data Source	Ministry of Health
Key Stakeholders	Canterbury DHB; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO, Te Kāhui o Papaki Ka Tai, Child and Youth Workstream, Health of Older People Workstream, Māori and Pacific Provider Forum

OUR PERFORMANCE STORY 2014/15

Indicator/Target

A reduction in ambulatory sensitive (avoidable) hospital admissions for Māori (rate per 100,000 people).[10]

Population aged 0-74

Baseline 12/13:
Māori: 154%
Total Population: 91%
Target 14/15: <95%

Population aged 0-4

Baseline 12/13:
Māori 142%
Total Population: 114%
Target 14/15: <111%

Population aged 45-64

Baseline 12/13:
Māori: 170%
Total Population: 81%
Target 14/15: <95%

Activity/Evidence[9]

Continue to support the Māori Health Provider services to improve access rates to services in order to reduce avoidable hospital admissions across all age groups.

Q1-Q4: Promote Māori Health service information on HealthInfo.

Q1-Q4: Increase HealthPathways links to Māori providers and programmes to support increased engagement with services.[11]

Contribute to cross-sector initiatives to support vulnerable, unwell and at-risk pēpe and tamariki increase whānau engagement with health services.

Q1-Q4: Implement the WCTO Quality Improvement Framework for Quality Indicator 3, increasing the proportion of pēpi who receive all WCTO core contacts in their first year.

Contribute to cross-sector initiatives to support vulnerable, unwell and at-risk adults.

Q1: Work with He Oranga Pounamu and Active Canterbury to pilot a Kaupapa Māori workshop.

Q4: Work with Te Tairanga Kaumatua Network and the Health of Older People Workstream to strengthen community support services.

Q1-Q4: Work alongside general practice to identify the Māori population at-risk-of and with diabetes and improve access to programmes that support them to improve the management of their condition.

Q1-Q4: Increase referrals for older Māori to CREST services to support earlier discharge from hospital and reduce the likelihood of future admission or readmission. Base 34.

[9] Note: Actions supporting Immunisation, Breastfeeding, B4 School Checks, Cardiovascular Disease and Smoking Cessation make a significant contribution to reducing Respiratory Illness, ENT Conditions, Diabetes and Cardiovascular Disease (the top drivers of ASH rates in Canterbury for Māori). These are covered in other sections of this document.

[10] This measure is based on the national performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori results against this measure. The DHB is working with the Ministry to resolve this issue.

[11] HealthPathways website contains clinically developed information and resources to help Canterbury health professionals provide care for their patients, including information on referrals, specialist advice, diagnostic tools, GP-to-GP referral and GP procedure subsidies.

Child Health

Objective	**Promote breastfeeding to give tamariki a healthy start to life.** High quality maternity services provide a key foundation for ensuring healthy families and children. In particular, ensuring new mothers can establish breastfeeding and increasing confidence levels in their ability to parent provides a positive start to life for tamariki. Breastfeeding also contributes positively to infant health and wellbeing.
Reporting Stream	Canterbury Breastfeeding Steering Group, Canterbury & West Coast Maternity Clinical Governance Committee, CPHAC, Te Kāhui o Papaki Ka Tai, CCN Māori Health Caucus
Data Source	Plunket
Key Stakeholders	Canterbury DHB; Christchurch PHO; Pegasus Health; Rural Canterbury PHO, Canterbury and West Coast Maternity Clinical Governance Committee, Child and Youth Workstream

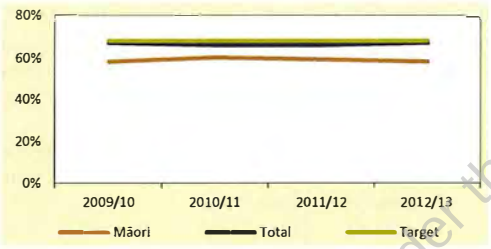
OUR PERFORMANCE STORY 2014/15

Indicator/Target

An increased percentage of tamariki are breastfed:

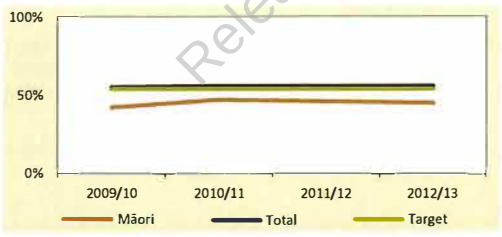
Age 6 weeks fully & exclusively breastfed

Baseline 12/13:
Māori: 58%
Total Population: 67%
Target 14/15: >68%



Age 3 months fully & exclusively breastfed

Baseline 12/13:
Māori: 45%
Total Population: 56%
Target 14/15: >54%



Age 6 months fully, exclusively and partially breastfed

Baseline 12/13:
Māori: 55%
Total Population: 66%
Target 14/15: >59%

Activity/Evidence

Through the Canterbury Breastfeeding Steering Group the DHB will strengthen stakeholder alliances, undertake joint planning and promote available services to improve breastfeeding rates amongst Māori across the whole maternity journey.

Q1: Implement internal processes to ensure every Māori mother has a breastfeeding assessment prior to hospital discharge.

Q1-Q4: Maintain Baby Friendly Hospital accreditation across all DHB facilities.

Q4: >75% of Māori babies are exclusively breastfed on hospital discharge.

Expand the variety and location of breastfeeding and parenting and pregnancy courses to better engage with high needs and at risk wāhine and improve integration of services to support breastfeeding.

Q3: Review DHB-funded pregnancy/parenting education content to better meet the needs of a wider range of wāhine Māori and younger mothers.

Q1-Q4: Continue to promote the use of Mama Aroha Talk Cards to Lead Maternity Carers.

Q1-Q4: Continue to support the Kaupapa Māori Breastfeeding Advocacy Service delivered by Te Puawaitanga.

Invest in supplementary services - including Mum-4-Mum peer support and community-based lactation services to support high-need and at-risk wāhine to breastfeed.

Q4: Increased number of Māori mothers with complex breastfeeding issues are referred to lactation consultant support. Baseline: 7 mothers.

Cardiovascular Disease (CVD)

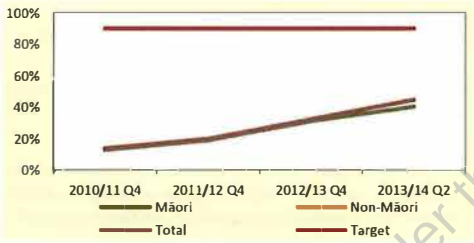
Objective	**Improve early detection and support long-term condition management amongst Māori.12** CVD includes coronary heart disease, circulation, stroke and other diseases of the heart. Māori have higher rates of CVD hospitalisations and mortality, and CVD is the leading cause of death for Canterbury Māori. CVD is strongly influenced by risk behaviours such as poor nutrition, lack of physical activity and tobacco smoking – making it a key opportunity to reduce inequalities for Māori through prevention, early intervention and condition management support.
Reporting Stream	Planning & Funding, PHOs, CPHAC, DHB Board, Ministry of Health
Data Source	PHOs, Canterbury DHB internal reporting
Key Stakeholders	Canterbury DHB; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO

OUR PERFORMANCE STORY 2014/15

Indicator/Target

Quarterly increase in the percentage of the eligible Māori population having had their CVD risk assessed within the past five years.

Baseline 12/13 Q4:
Māori: 31%
Total Population: 32%
Target 14/15: 90%



70% of high-risk patients will receive an angiogram within 3 days of admission (where the day admission is day 0). [13]

Baseline 12/13: *New*
Target 14/15: 70%

95% of patients presenting with ACS who undergo angiography have completion of registry data collection within 30 days.

Baseline 12/13: *New*
Target 14/15: 95%

Activity/Evidence

Work with the PHOs to support general practice to consistently deliver and record CVD Risk Assessments (including structured discussions) and increase the number of eligible Māori who have had a CVDRA in the past five years:

Q1-Q4: Monitor dashboard reporting on progress to targets.

Q2: Complete a 'gap' analyses of the eligible Māori population not recorded as having received a CVDRA to improve improved coding and delivery of risk assessments.

Q2-Q4: Encourage general practice to engage in the delivery of additional general practice/nurse led CVD consultations after-hours or in alternative locations to reach Māori not currently engaged.

Q3: Review successful outreach programmes for Māori in other DHBs and identify opportunities to implement this activity in Canterbury.

Implement the 'Heart Failure Initiative' to assist patients, general practice and ambulance staff to safely manage heart conditions in the community where appropriate and reduce acute hospital admissions:

Q2: Review and updated the Heart Failure Healthpathway and where appropriate include Māori health provider service links.

Q2-Q4: Work with the Māori Mobile Disease State Management Services and CardioRespiratory Integrated Specialist Service (CRISS) service in the development of the 'Red Card' plan for people with heart failure.

Q4: Implement a Common Accelerated Chest Pain Pathway to reduce unnecessary hospital admissions.

Participate in the South Island Cardiac Alliance Workstream to align cardiac activity across the South Island:

Q1-Q4: Continue to implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and appropriate transfer of ACS patients.

Q1-Q4: Continue to participate in the provision and collection of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and quality of service delivery.

[12] *The maternity journey covers pre-conception through to the first six months, and from six months onwards.*

[13] *Data will be provided and monitored for the ACS measure via the South Island Alliance Programme Office.*

Cancer

Objective	**Improve early detection and reduce the disease burden of cancer amongst Māori.** Cancer is the second leading cause of death for Māori in Canterbury and a major cause of hospitalisation. At least one third of cancers are preventable, and the impact and death rate of cancer can be reduced through early detection and treatment. Māori in Canterbury are one and a third times more likely to die from cancer, even though incidence of cancer overall is lower for Māori than non-Māori. This suggests an area of unmet need for Māori and highlights the importance of cancer screening to ensure early detection and treatment.
Reporting Stream	Canterbury & South Canterbury Cervical Screening Strategic Group, CCN Māori Health Caucus, Te Kāhui o Papaki Ka Tai, CPHAC
Data Source	BreastScreen Aotearoa Register, National Cervical Screening Programme Register
Key Stakeholders	Cervical Screening Strategic Group[14]; National Cervical Screening Programme Service; BreastScreen Aotearoa; Canterbury DHB; Christchurch PHO; Pegasus Health; Rural Canterbury PHO

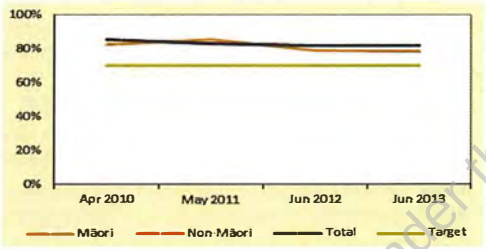
OUR PERFORMANCE STORY 2014/15

Indicator/Target

≥70% of Māori women aged 45-69 screened in the last two years under the BreastScreen Aotearoa (BSA) programme.

Baseline 12/13: Māori: 78%
Total Population: 82%

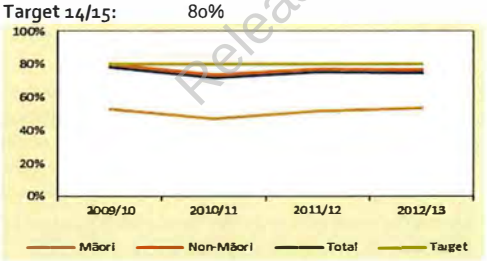
Target 14/15: >70%



80% of Māori women aged 25-69 screened in the last three years under the National Cervical Screening Programme.[15]

Baseline 12/13: Māori: 53%
Total Population: 75%

Target 14/15: 80%



Activity/Evidence

Through the Canterbury & South Canterbury Cervical Screening Strategic Group, strengthen stakeholder alliances, review pathways and encourage general practices to place special focus on screening wāhine Māori for cervical and breast cancer as a high-priority group.

Q1: Work with National Cervical Screening Programme (NCSP) and PHOs to datamatch the eligible enrolled population to gain a comprehensive list of women who are five years overdue for their cervical smear.

Q2: Identify and design actions (alongside primary care) to pro-actively contact Māori women overdue for their cervical smear.

Q1-Q4: Gather best practice information from other DHBs and share with the sector to identify opportunities to improve wāhine Māori engagement with screening programmes.

Q2-Q4: Investigate the feasibility for a mobile colposcopy clinic for high risk Māori women as a strategy to address colposcopy DNA rates for Māori women.[16]

[14] The Cervical Screening Strategy Group is an integrated group representing primary care, PHOs, regional NCSP services, colposcopy services and the Canterbury and South Canterbury DHBs.

[15] The NCSP recently changed the age group for which they report cervical screening coverage. Results prior to 2011/12 are for the 20-69 age group, while results from 2011/12 are for the 25-69 age group.

[16] An application to Health Research Council is being submitted to establish a mobile colposcopy clinic as a pilot project.

Smoking

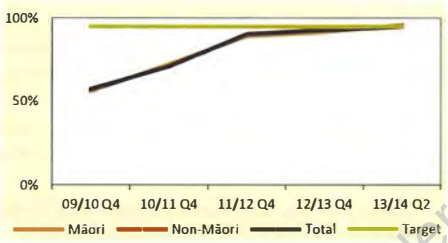
Objective	**Reduce the prevalence of smoking and smoking-related harm amongst Māori.** Tobacco smoking contributes to a number of preventable illnesses and long-term conditions, resulting in a large burden of disease. In addition to the high public cost of treating tobacco-related disease, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Tobacco control remains the foremost opportunity to rapidly reduce inequalities and improve Māori health.
Reporting Stream	Planning & Funding, PHOs, CPHAC, DHB Board, Ministry of Health
Data Source	Canterbury DHB (hospitalised smokers); PHOs (primary care smokers)
Key Stakeholders	Canterbury DHB; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO; Community and Public Health

OUR PERFORMANCE STORY 2014/15

Indicator/Target

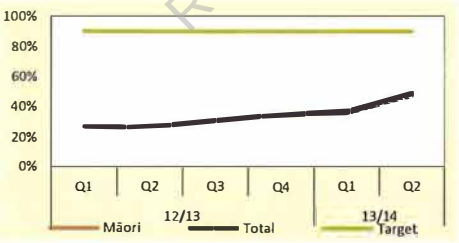
95% of hospitalised Māori smokers are provided with advice and help to quit.

Baseline 12/13 Q4:
Māori: 92%
Total Population: 93%
Target 14/15: 95%



Quarterly increased percentage of current Māori smokers enrolled in a PHO provided with advice and help to quit. [17]

Baseline 12/13 Q4:
Māori: 34%
Total Population: 35%
Target 14/15: 90%



Activity/Evidence

Contribute to the work of Smokefree Canterbury to ensure an integrated approach towards Smokefree Aotearoa by 2025.

Q1-Q4: Continue to promote Auahi Kore (Smokefree) environments to reduce exposure to second-hand smoke including Kohanga Reo, marae and workplaces.

Q2: Updated Canterbury DHB Tobacco Control Plan in place.

Support PHOs in the implementation of the ABC smoking cessation programme to increase the number of smokers offer support and advice and to reduce smoking rates. [18]

Q1-Q4: Monthly monitoring of performance against the target.

Q2: Share secondary care ABC data with the PHOs to identify Māori enrolled patients that are yet to receive Help to Quit.

Q2: Review successful outreach programmes in other DHBs and identify opportunities to implement these activities in Canterbury.

Q1-Q4: Expand the use of advanced IT tools to prompt and capture ABC activity include Text-2-Remind and appointment scanners and practice-level coaching to improve the recording of interventions.

Q3-Q4: Provide ABC and tikanga based cessation training to Māori health workers to increase the ABC interventions provided.

Q4: 3 tikanga based cessation training courses delivered.

Refine delivery of ABC programmes in hospital settings to increase the number of smokers offer support and advice and reduce smoking rates.

Q1-Q4: Maintain weekly feedback reports on performance; continue to undertake audit analysis where no intervention is recorded and follow-up with staff to improve performance and systems.

Q1-Q4: Maintain a Training Calendar for Smokefree education to staff (from the ABC team) and support e-learning modules.

Q4: >250 staff received ABC training.

Provide targeted community-based cessation support for Māori.

Q1-Q4: Work alongside Smokechange, Aukati KaiPaipa and Pacific Quit Coaches to provide targeted community based cessation support to Māori and whanau.

Q4: >240 Māori enrolments in Aukati KaiPaipa.

Q1-Q4: Work with Lead Maternity Carers to provide advice and support to Māori women to stop smoking.

Q4: 86% of mothers smokefree at two weeks post-natal.

[17] *Data is provided by the PHO Performance Programme. Results may vary slightly from the health target results.*

[18] *The ABC Strategy involves Asking whether the patient smokes, offering Brief advice to quit and referring the patient to Cessation support.*

Immunisation

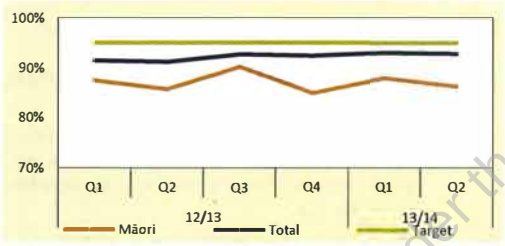
Objective	**Increase immunisation amongst vulnerable Māori population groups to reduce the prevalence and impact of vaccine-preventable diseases.** Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. While Canterbury has high immunisation rates for both Māori and non-Māori, these high rates must be maintained or improved in order to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough).
Reporting Stream	Immunisation Service Level Alliance, Te Kāhui o Papaki Ka Tai, CCN Māori Health Caucus, CPHAC
Data Source	National Immunisation Register (childhood immunisation); PPP Programme (flu vaccinations)
Key Stakeholders	Canterbury DHB; CCN ISLA; Immunisation Provider Group; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO, Te Puawaitanga, Te Tai o Marokura

OUR PERFORMANCE STORY 2014/15

Indicator/Target

95% of eight-month-olds are fully immunised.[19]

Baseline 12/13 Q4:
Māori: 85%
Total Population: 92%
Target 14/15: 95%



75% of the eligible population (aged 65+) have had a seasonal influenza vaccination.[20]

Baseline 12/13 Q2:
Māori: 70%
Total Population: 75%
Target 14/15: 75%

Activity/Evidence

Through the CCN Immunisation Service Level Alliance (ISLA) strengthen clinical leadership across the system and work toward ensure equity across the provision of Immunisation Services.

Q1-Q4: Support and maintain systems for seamless communication and handover between maternity, general practice and WCTO services and support the multiple enrolments of newborns.

Q4: >95% of newborns enrolled on the NIR at birth.

Q1-Q4: Continue to use the NIR to monitor immunisation coverage at DHB, PHO and general practice level, circulating performance reports to maintain coverage and identify unvaccinated tamariki.

Q1-Q4: Supporting the Outreach Immunisation Services and Te Puawaitanga to locate tamariki who are not up to date with their vaccinations.

Q1-Q4: Strengthen connections with the Māori Health Provider Network to promote the importance of the timeliness of vaccinations to better reach Māori populations.

Q3: Implement the DHB Immunisation Promotional Plan 'Immunise for Life' to profile the importance of immunisation at all ages.

Q1-Q4: Maintain focus on Influenza Vaccination by the Immunisation Steering Committee with monitoring of uptake and progress.

Q2-Q3: Continue to promote influenza vaccination to all Māori, with a focus on those 65 and over.

Q2-Q3: NIR Team supports general practice to record provision of influenza vaccinations on the NIR.

[19] *Data for the new eight-month-old immunisation health target is not available prior to the 2012/13 year. The Canterbury DHB result for Quarter 3 2012/13 was 90% for Māori and 93% for the total Canterbury eight-month-old population.*

[20] *Influenza data is provided via the PHO Performance Programme and baseline is for the October-December 2013 period.*

Rheumatic Fever

Objective	**Reduce rheumatic fever rates in the South Island.** In a small number of people, an untreated Group A streptococcal sore throat develops into rheumatic fever, where their heart, joints, brain and skin become inflamed and swollen. This inflammation can cause rheumatic heart disease, where there is scarring of the heart valves. This may require heart valve replacement surgery, and in some cases, premature death may result. Māori children and young people are more likely to get rheumatic fever, and raising awareness and supporting people to manage their illness can improve outcomes for Māori.
Reporting Stream	Canterbury Rheumatic Fever Network, South Island Service Level Alliance Programme Office
Data Source	Canterbury DHB
Key Stakeholders	Canterbury DHB; South Island Regional Alliance; Community and Public Health, Māori and Pacific Health Provider Network

OUR PERFORMANCE STORY 2014/15

Indicator/Target

Maintain low rates of rheumatic fever in the South Island.

Baseline 12/13: 0.7 per 100,000
Target 14/15: <0.3 per 100,000[21]

Canterbury rheumatic fever notifications (initial attack)

	2012/13	2013/14
Māori	2	0
Non-Māori	3	4
Total	5	4

Activity/Evidence

Continue to strengthen health outcomes for rheumatic fever patients in Canterbury through implementation of the Regional Rheumatic Fever Plan.

Q1-Q4: Continue to support the Canterbury Rheumatic Fever Network to monitor provision of services and support for Māori identified with rheumatic fever.[22]

Q1-Q4: Support the implementation of a South Island Regional Rheumatic Fever Prevention and Management Plan through the South Island Public Health Workstream.

Q1-Q4: Continue to review all Māori identified with rheumatic fever on an annual basis and provide a review and lessons learnt summary for any new cases identified during the year.

Q4: Meet with the Māori Health Provider Network to provide an annual update on rheumatic fever developments in Canterbury.

[21] *Because of the very low numbers of rheumatic fever cases, South Island DHBs do not have individual rheumatic fever targets. Instead, the South Island DHBs are taking a regional approach, outlined in the South Island Regional Health Services Plan.*

[22] *This network comprises of a Paediatrician, Medical Officer of Health, Rheumatic Fever Liaison Nurse, Adult Infectious Disease, Cardiologist, Community and Hospital Dental staff, Planning and Funding.*

Mental Health

Objective	**Improve health outcomes for the Māori population by assisting services to enhance service quality and responsiveness.** Canterbury is experiencing an increased demand for mental health services. Our system has been responding to meeting the needs of tangata whaiora and their whanau, who are having to cope with the additional stressors of a post-earthquake environment.
Reporting Stream	Mental Health Leadership Workstream, Te Kāhui o Papaki Ka Tai. CCN Māori Health Caucus, CPHAC
Data Source	Ministry of Health PRIMHD
Key Stakeholders	Canterbury Mental Health Leadership Workstream, Specialist Mental Health Services, PHOs, Community-based NGOs, Māori and Pacifica NGO Mental Health and Addiction Collective

OUR PERFORMANCE STORY 2014/15

Indicator/Target

Establish an understanding of the drivers behind CTO rates.[23]

Baseline 12/13: 185 per 100,000

	Number of clients under s29	Rate per 100,000 population
Māori	77	185
Non-Māori	378	81

Activity/Evidence

Through the Mental Health Leadership Workstream strengthen clinical leadership across the system to improve the mental wellbeing of Māori.

Q2: Complete a review of existing tangata whaiora HealthPathways and identify strategies to strengthen pathways and relationships.

Q3: Engage Specialist Mental Health Services in the Canterbury MāoriHealth Outcome Framework to identify strategies and initiatives to improve outcomes for Māori.

Q4: Ensure Māori health providers are listed on HealthPathways for the new mental health pathways being developed (Child & Youth and Single Point of Entry (SPOE)).

Q4: Work with Specialist Mental Health Services to better understand the differences between Māori and non-Māori Compulsory Treatment Order (CTO) rates.

[23] *PRIMHD data as provided by the Ministry of Health.*

Local Māori health priorities

FOR CANTERBURY/WAITAHA

In addition to those priorities already identified at a national level, four areas of focus were identified as collective priorities under the Māori Health Outcomes Framework. There were many areas where collective activity could lead to improvements, but these were areas where there were clear inequities in access or outcomes, where baselines existed in order to determine progress and where there was a particular focus on vulnerable children and youth. Cervical screening has already been covered (page 12). The other three priorities; B4 School Checks, HPV immunisation and oral health—are set out below. Identified under each is the key activity planned to improve performance and reach the targets set.

Oral Health

Objective	**Improve oral health for tamariki and rangatahi.** Regular dental care has lifelong health benefits. It also indicates early contact with effective health promotion and reduced risk factors, such as poor diet. Tamariki Māori are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and better target those most in need.
Reporting Stream	Oral Health Virtual Service Level Alliance, Te Kāhui o Papaki Ka Tai. CCN Māori Health Caucus, CPHAC
Data Source	Canterbury DHB School and Community Dental Services [23], Te Kāhui o Papaki Ka Tai, CCN Maori Health Caucus, Community and Public Health Advisory Committee
Key Stakeholders	Canterbury DHB; Christchurch PHO; Pegasus Health; Rural Canterbury PHO; Te Herenga Hauora

OUR PERFORMANCE STORY 2014/15

Indicator/Target

75% of preschool children (0-4) enrolled in school and community dental services: [24]

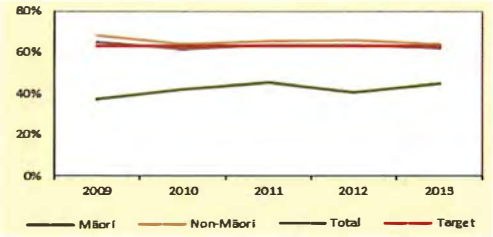
Baseline 2013: Māori 31%
Total Population: 71%

Target 2014/15: 75%

63% of children caries-free (no holes or fillings) at age 5.

Baseline 2013: Māori 31%
Total Population: 71%

Target 2014/15: 75%



Activity/Evidence

Work with Tamariki Ora providers and general practice to identify tamariki most at risk of tooth decay and support them to maintain good oral health and access preventive care:

- **Q1-Q4:** Implement the Aranui High School adolescent clinics with the aim to engage more rangatahi Māori in oral health services.
- **Q1-Q4:** Work with practice and public health nurses to ensure that tamariki with level 2 to 6 dental decay are referred to the community dental service.
- **Q4:** >86% of tamariki with level 2 to 6 dental decay are referred.
- **Q2:** Work with LMC, and Tamariki Ora providers to streamline referrals through to community dental.
- **Q4:** Purapura Whetu will explore practical and simple ways of improving children's general health, oral health and their behaviour in the school setting through the creation and promotion of a sugar-free school environment for Canterbury schools with high populations of Māori.
- **Q4:** He Oranga Pounamu in partnership with the Dental School, Otago University and Charity Hospital will host final year students in Christchurch in order to improve access by Māori to dental services.

[24] *Oral health data is collected against school year data and reported annually.*

B4 School Checks

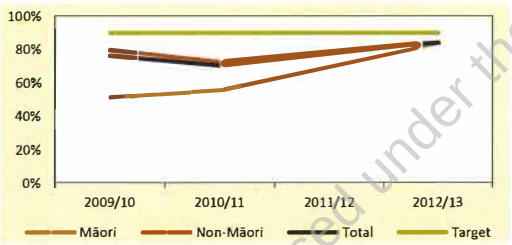
Objective	**Provide children with developmental checks that support early intervention to reduce health issues that negatively affect children's wellbeing and development.** A focus on child health is an investment in the future wellbeing of our population, as poor health in childhood can lead to poorer health into adulthood and have a significant impact on health long-term. We will work together to identify vulnerable tamariki and wrap services around them to give them the best possible start to life. The B4 School Check is the final core Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be addressed early in a child's development, giving him/her the best possible start for school and later life. B4 School Check uptake is lower amongst Māori in Canterbury, so it also presents an opportunity to reduce inequalities.
Reporting Stream	CCN Māori Health Caucus, Te Kāhui o Papaki Ka Tai, CPHAC
Data Source	Ministry of Health
Key Stakeholders	Canterbury DHB; B4 Schools Checks Clinical Advisory Group; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO, Child and Youth Workstream

OUR PERFORMANCE STORY 2014/15

Indicator/Target

90% of tamariki (aged four) are receiving B4 Schools Checks.

Baseline 12/13:
Māori: 84%
Total Population: 84%
Target 14/15: 90%



Activity/Evidence

Monitor access to referred services following B4 School Checks and implement actions to expedite service delivery.

Q4: Work with Hearing and Vision Technicians to identify tamariki who are not attending an early childhood education centre to ensure they are having their hearing and vision tested.

Q1-Q4: Work with practice and public health nurses, and ECE providers to identify and engage tamariki who have not had a B4 School Check.

HPV Immunisation

Objective	**Increase HPV immunisation rates to reduce the prevalence and impact of vaccine-preventable diseases.** Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.
Reporting Stream	Immunisation Service Level Alliance, Te Kāhui o Papaki Ka Tai, CCN Māori Health Caucus, CPHAC
Data Source	National Immunisation Register
Key Stakeholders	Canterbury DHB; CCN Immunisation Service level Alliance; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO

OUR PERFORMANCE STORY 2014/15

Indicator/Target

60% of eligible Māori girls receive dose 3 of the HPV vaccination programme.[25]

Baseline 2013:

Māori:	49%
Total Population:	43%
Target 14/15:	60%

Activity/Evidence

Through the CCN Immunisation Service Level Alliance (ISLA) strengthen clinical leadership across the system and work to ensure equity across the provision of Immunisation Services.

Q1-Q4: Monitor immunisation rates and work with Te Kāhui o Papaki Ka Tai and other key groups to identify ways to reach Māori whanau.

Q1-Q3: Maintain the HPV Programme in a primary care setting at 11 year old events and promote HPV School-based programme in year 11.

Q3: Evaluate the secondary school HPV programme to determine equity of service provision between Māori and non-Māori and provide recommendations to the ISLA to improve uptake.

[25] *The baseline is the percentage of girls born in 1996 receiving dose 3 by the end of 2012. Canterbury's programme is slightly different to others nationally as it is primary care rather than school based.*

Appendix 1

Canterbury Māori Health Framework 2013-2015

KIA WHAKAKOTAHI TE HOE O TE WAKA | *We Paddle Our Waka As One*

Background and rationale[26]

Canterbury health service providers from across the Canterbury District Health Board (CDHB), Primary Health Organisations (PHOs) and Non-Government Organisations (NGOs) aspire to achieving equitable health outcomes for Māori and support Māori families to flourish and achieve their maximum health and wellbeing. In addition, the CDHB and PHOs are required to have formal plans for improving Māori health.

Although each organisation is striving to contribute to these aspirations, there have been barriers to achieving their goals. One of these is that while we are on the same boat, there has not been a strong sense that we are all paddling in the same direction. To date, plans have not been coordinated and there has been limited collective effort to achieve shared outcomes.

Following a series of discussions between the CDHB and PHOs, a strong commitment has developed between these parties to have an overarching framework that identifies shared outcomes and priority areas, acts as a basis for organisation work plans and encourages collective efforts that make a difference for Māori and their whānau.

Purpose

The purpose of the Canterbury Māori Health Framework is to establish shared outcomes, shared priority areas, shared language and common understanding - so that we can better achieve our goal of health equity for Māori by all paddling the waka in the same direction and in unison.

Governance of the framework

Te Kāhui o Papaki Ka Tai and Manawhenua ki Waitaha.

Partners in the framework

In the first instance, the partners in this framework are those that are required by legislation to have a Māori health plan: the CDHB and its Community and Public Health division, and the Primary Health Organisations (Rural Canterbury PHO, Christchurch PHO and Pegasus Health). The intention is to be fully inclusive and to widen this partnership to include other partners.

Related plans

- Canterbury DHB Māori Health Action Plan 2013/14.
- Canterbury Clinical Network Plan 2013-2016.
- Rural Canterbury PHO, Christchurch PHO and Pegasus Health Māori Health Plans.
- Community and Public Health (CDHB) Māori Health Plan.

The framework

The framework is an outcomes framework. That is, the framework identifies the various layers of activities and strategies that contribute to our shared outcomes of equitable health outcomes and improved quality of life for Māori. The framework also identifies indicators that we can use to measure progress towards the achievement of the shared outcomes (see below for a diagram of the framework).

Priority areas

There are many areas of focus that our collective actions could contribute to. It was decided that in the first instance, the areas of focus would be those where there were differentials in access or outcomes for Māori, where indicators existed that were readily measureable in order to determine progress and a particular focus would be placed on vulnerable child and youth:

- HPV immunisation coverage;
- B4 School Check coverage;
- Cervical screening coverage; and
- Child/youth oral health.

How this framework will work

Partners in this framework will:

- Develop organisational work plans that are based on the framework and priority areas;
- Work together to achieve the improvement in shared priority areas;
- Be open to new ways of working to achieve outcomes;
- Undertake to have good communication and regularly report on progress; and
- Review the framework annually so it may be linked to the partners' plans for the following year.

[26] *The full framework can be found at www.cdhb.govt.nz.*

Canterbury Māori Health Framework

Kia whakakotahi te hoe o te waka

WE PADDLE OUR WAKA AS ONE

Appendix 2

Abbreviations

ABC	An approach to smoking cessation requiring health staff to **A**sk about smoking status, to give **B**rief advice to all smokers to stop smoking and to provide evidence based **C**essation support for those who which to stop smoking
ACS	Acute Coronary Syndrome
ASH	Ambulatory sensitive hospitalisation
CCN	Canterbury Clinical Network
CDHB	Canterbury District Health Board
CPHAC	Community and Public Health Advisory Committee
CRISS	CardioRespiratory Integrated Specialist Services
CTO	Compulsory Treatment Order
CVD	Cardiovascular disease
CVDRA	Cardiovascular disease risk assessments
DHB	District Health Board
DMFT	Decayed, missing or filled teeth
DNA	Did not attend
ECE	Early Childhood Education
EDAT	Primary Care Ethnicity Data Quality Toolkit
ISLA	Immunisation Service Level Alliance
hbA1c	Glycerated haemoglobin
HEAT	Health Equity Assessment Tool.
MIHI	Māori Indigenous Health Institute
MoH	Ministry of Health
NCSP	National Cervical Screening Programme
NIR	National Immunisation Register
PHO	Primary Health Organisation
SPOE	Single Point of Entry
WCTO	Well Child/Tamariki Ora

Māori Health Action Plan

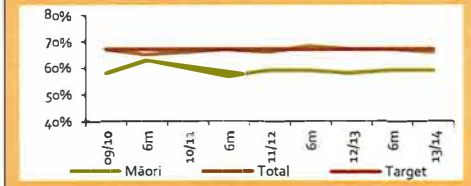
Produced July 2014

Canterbury District Health Board
PO Box 1600, Christchurch
www.cdhb.health.nz

ISSN: 2230-424X (Print)
ISSN: 2230-4258 (Online)

Tamariki Health and Wellbeing

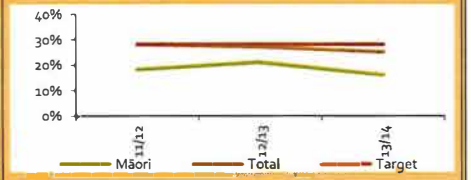
% of babies exclusively and fully breastfed at 6 weeks



Previous	Latest	Target
58%	59%	67%

Note: measure is missing data from Tamariki Ora providers

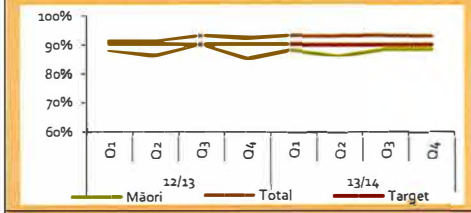
% of babies exclusively and fully breastfed at 6 months



Previous	Latest	Target
18%	17%	28%

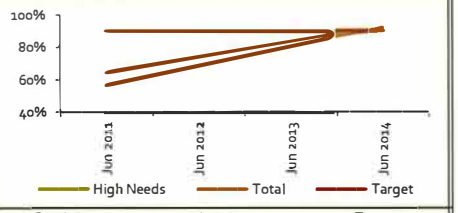
Note: measure is missing data from Tamariki Ora providers

% of 8 month olds fully vaccinated



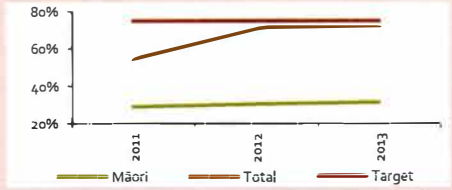
Previous	Latest	Target
86%	88%	90%

% of children who have had a B4 School check



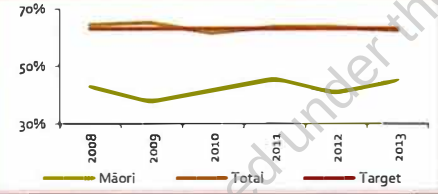
Previous	Latest	Target
51%	90%	80%

% of under 5 year-olds enrolled in DHB-funded oral health services



Previous	Latest	Target
30%	31%	75%

% of under 5 year-olds who are caries free



Previous	Latest	Target
41%	45%	65%

Ambulatory sensitive (avoidable) hospital admissions for 0-4 year-olds

This measure is currently under review by the Ministry of Health.

The definition of this measure changed for 2013/14. The measure changed from using the PBFF population estimates to PHO enrolled population. However, a different use of prioritised ethnicity significantly under-counted our Māori population. Results will be included once an updated version of this measure has been confirmed.

Previous	Latest	Target

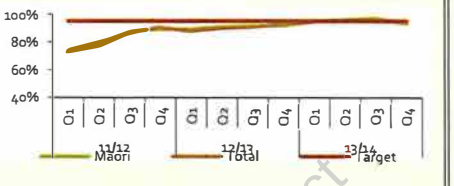
Cases of rheumatic fever

Year	Māori	Total
08/09	1	2
09/10	1	1
10/11	2	3
11/12	0	1
12/13	1	1
13/14 to date	2	5

Target
0

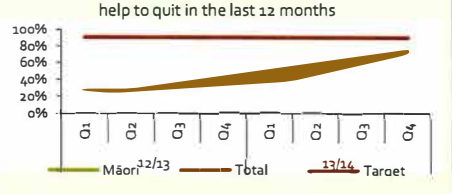
Adult Health and Wellbeing

% of hospitalised smokers given advice and help to quit



Previous	Latest	Target
92%	93%	≥95%

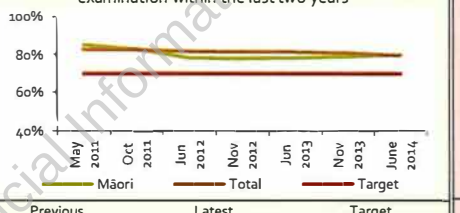
% of smokers identified in primary care receiving advice and help to quit in the last 12 months



Previous	Latest	Target
34%	62%	90%

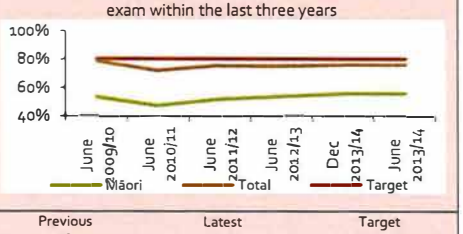
Note: data comes from PPP and may differ from health target results

% of women aged 45-69 who have had a breast screen examination within the last two years



Previous	Latest	Target
78%	80%	≥70%

% of women aged 25-69 who have had a cervical screen exam within the last three years



Previous	Latest	Target
53%	55%	80%

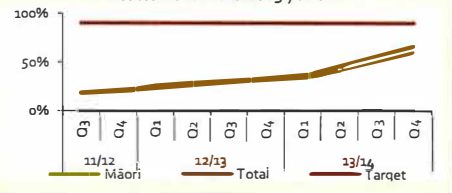
Ambulatory sensitive (avoidable) hospital admissions for 0-74 year-olds

This measure is currently under review by the Ministry of Health.

The definition of this measure changed for 2013/14. The measure changed from using the PBFF population estimates to PHO enrolled population. However, a different use of prioritised ethnicity significantly under-counted our Māori population. Results will be included once an updated version of this measure has been confirmed.

Previous	Latest	Target

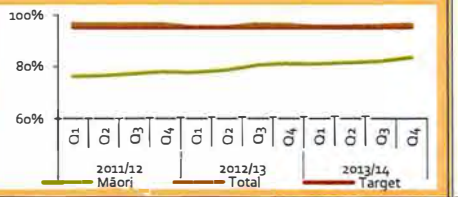
% of eligible population who have received a CVD risk assessment in the last 5 years



Previous	Latest	Target
31%	60%	90%

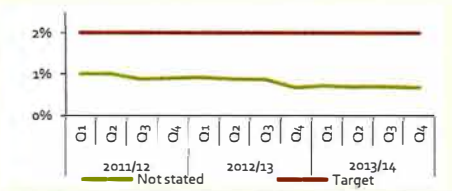
Enablers to Improving Health and Wellbeing

% of the population enrolled with a PHO



Previous	Latest	Target
81%	83%	95%

% of PHO enrolees with ethnicity 'not stated'



Previous	Latest	Target
0.67%	0.68%	≤2%

Key

Going well | Mixed progress | Requires monitoring

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 16 March 2015 2:34 p.m.
To: Alison Wooding; Anne Feld; Geraldine Clemens; Helen Barbour; 'Linda Hill'; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; Tony Walls
Subject: 17 March draft agenda
Attachments: 17 March draft agenda.docx

Hi all

Sorry I have reformatted the agenda, and I notice the old version was attached to the papers. Content is the same – but all the attachments are in here.

Please let me know if you need me to run you off copies of the papers.

Regards Bridget

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 17 March 2015, 2-4pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	Linda Hill:
Anne Feld :	Margaret Kyle (Acting Chair):
Anna Harwood:	Dr Sarah Marr:
Dr Tony Walls:	Geraldine Clemens:

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Margo Kyle	
2.	2.05pm	**Confirmation of minutes of last meeting**	Margo Kyle	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Margo Kyle	Draft minutes 030215 ISLA.docx
4.	2.20pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI**	Bridget Lester	Imms Reporting Template March ISL ISLA 2014 15 workplan.docx
5	2.40pm	**HPV Model discussion**	Bridget Lester	HPV proposal 2015.docx
6.	3.10pm	**CDHB Maori Health Plan**	Bridget Lester	Immunisation MHAP 1516.docx HPV Immunisation MHAP updated 1516
7.	3.30pm	Operational • **Terms of Reference IPG and ISLA review** • **CCN Website and ISLA section** • **Interest register** • **Risk Register**	Margo Kyle	TOR Immunisation Provider Group - Ma ISLA ToR v2 draft 121213.docx

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

	Time	Item	Who	Papers
				New CCN Website - Immunisation SLA - I Risk Register Dec.docx Interests register 28 Oct 2014.docx
8.	**3.40pm**	**Any other business**	Margo Kyle	

Action Register	Responslbity	Timeframe
MWWL Following contact	Bridget	20 Feb 2015
Change date of March meeting, ensure Geraldine is on e-list	Bridget	4 Feb 2015
Write to Pegasus regarding issues with Helios	Sarah and Alison	10 March 2015
Vaccination in Pregnancy Resources – letter etc	Bridget	28 Feb 2015
Align Pertussis with National programme, Liaise with Tony and Nicola Austin	Bridget	13 Feb 2015
U18 Letter to go to schools	Bridget	5 Feb 2015
MoH HPV Consultation feedback	Bridget	10 Feb
HPV Model change paper – paper to go to next ISLA meeting	Bridget	13 March
GP update to be draft including HPV, Seasonal Influenza and Pertussis	Bridget	13 February
Work plan, update u18 section	Bridget	5 Feb
Immunisation Week – draft Plan	Bridget	6 March
Maori Heath Plan – updated sections	Bridget	20 February

Next meeting: April 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 3 February 2015	Time: 2-4.00pm
Present: Margaret Kyle (Chair) Dr Alison Wooding, Dr Sarah Marr, Bridget Lester, Anna Harwood and Anne Feld	
Apologies: Dr Tony Walls, Ramon Pink, Linda Hill and Geraldine Clemens	
Notes cc'd to: CCN Programme Office	

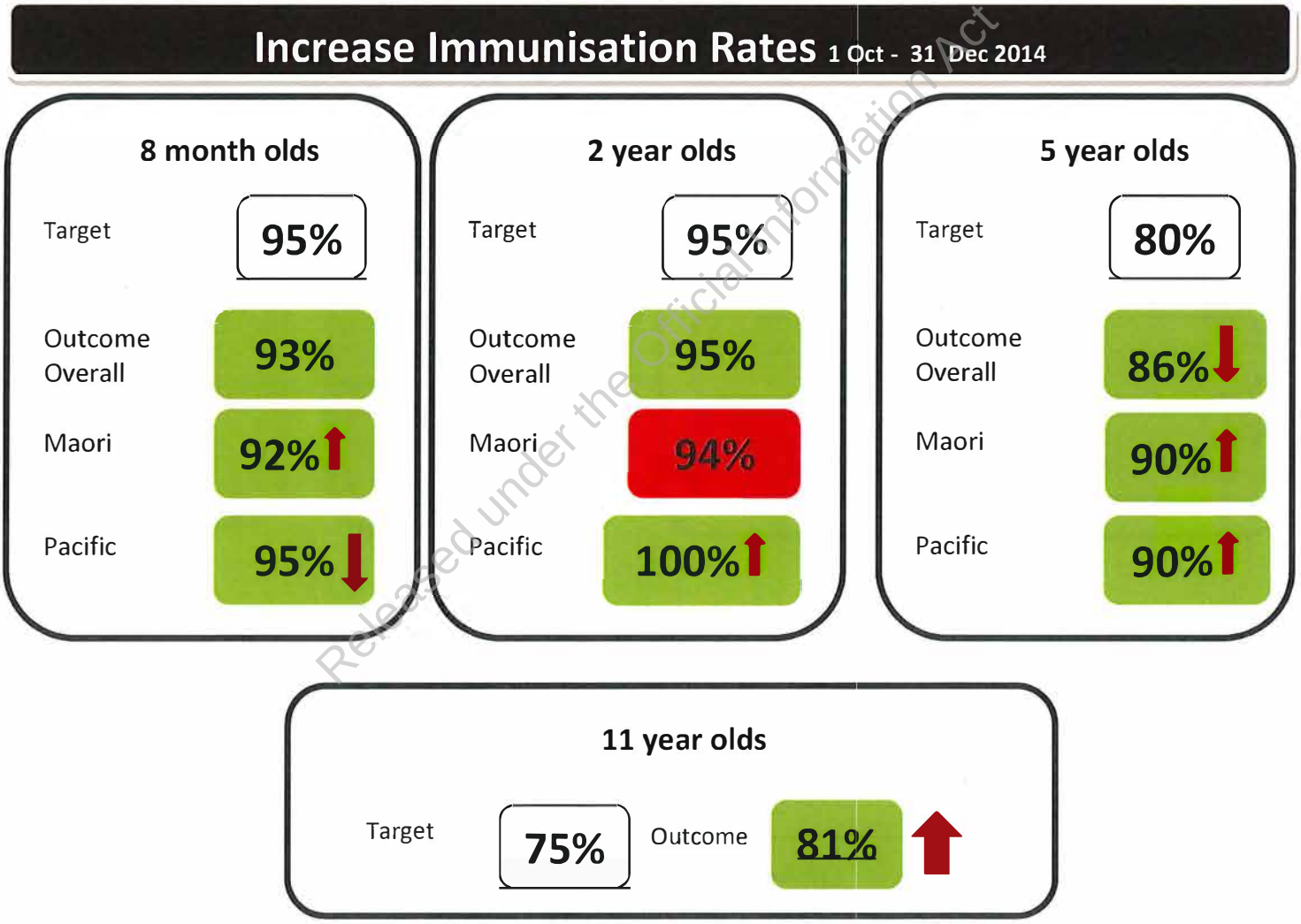
	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes 16 December 2014 meeting were approved for Bridget to send to CCN.	Bridget	5 Feb
2.	**Previous Actions & Matters Arising**	• Bridget is yet to receive the MWWL contacts from Wendy, she will follow up • 2 year old risk has been removed from Risk Register • E-invites have been sent, however agreed to move the March meeting to ensure even split before meeting.	Bridget to follow up Bridget to update	
3.	**ISLA Work plan**	**Q2 data** = 93% 8month olds, 95% 2 year olds **Health Target** – we did not reach HT this quarter. There was a combined opt-off and decline rate of 5%, which made it very difficult to reach 95% fully vaccinated. In total 24 children were missed – 10 were vaccinated after their milestone age, 4 could not be reached due to moving to NZ during the quarter and on a catch up schedule and 10 remain overdue. There is a concern around one big practice that declines a lot of immunisations, and the overall impact on the DHB and their PHO around this. Sarah and Alison to write to PHO clinical leader to highlight the risk. Bridget to put risk on the ISLA Risk register. **Vaccinations in Pregnancy** – Agree that LMC Flu (including pertussis info) packs will be sent including Q&A, brochures, stickers and posters. Letter to be drafted. Agreed to most GPT receive notification of a women's 12 week or 20 week scans – a process will be developed to advise GPT on the importance of setting up a recall for these women. IPG will develop, but run past ISLA for comment. Agreed to that we should alignthe Pertussis programme with the national programme however it will continue to be offered to parents of children in NICU until 2 weeks of age. Need to liaise to NICU to see how we can make this happen. **HPV** – A new HPV coordination's has been appointed. Process is underway for the 2015 school programme.	Sarah and Alison, Bridget to share practice data with them for letter. Bridget to update risk register Bridget to update, and pull together resources Bridget to contact Nicola and Tony Email feedback to MoH	10 March 28 February 13 February

	Item	Discussion/Action	Responsibility	Date due
		The delay in notifying schools around the U18 programme. ISLA feedback on the draft HPV programme is sitting with P&F to be sent to MoH. A paper is being worked up around the school based programme, and moving this forward a few years. Modelling is occurring around the potential service model and cost of the programme. The draft paper will go to the March ISLA meeting of approval, and this to ALT. **Seasonal Influenza** – The national comms programme has been shared, and the CDHB will build on this instead of doing our own programme in 2015. It was agreed that a GP update would be sent to all Canterbury GPs, regarding the HPV programme, Flu and pregnancy vaccinations. Bridget to draft and share with ISLA for this input. Discussion around a Maori festival occur in March. Bridget to follow up to see if Pegasus team are promotion immunisation at this event	Bridget Bridget Bridget	5 February 10 Feb 13 March 13 February
4.	**2015/16 Workplan**	Supported the approved plan, but just need to reword the flu section around the U18 programme.	Bridget	5 Feb
5.	**Immunisation Week**	Agreed to support NIR give morning tea to selected practices. Agreed to ask Pharmacy to run a window completion to win morning tea. Pull together a plan with IPG members	Bridget	6 March
6.	**Maori Health Plan**	Need to update the Immunisation section to reflect performance and new deliverables. Update the HPV section to reflect the 11year old event, and the national targets.	Bridget	20 February
7.	**Operational**	**No further updated required**		
8.	**Next Meeting**	17 March 2015 2-4pm at C&PH Meeting dates for 2015 • 28 April 2015 • 2 June 2015 • 21 July 2015 • 25 August 2015 • 29 September 2015 • 3 November 2015 • 15 December 2015		

our health system

Key Performance Indicators and Childhood Immunisation Reporting

March 2015



Childhood Immunisation – MoH Health Targets up until 28 Feb 2015

Fully Immunised 8 month olds – DHB LEVEL

Q1 2013/14 Actual	Q2 2014/15 Actual	Q3 2014/15 Progress including pending	Q4 2014/15 Progress including pending
93% fully	93% fully	94.76% fully	90.13% fully
% overdue	1.8% overdue	.58% could reach	5.61%

Fully Immunised Two year olds - DHB LEVEL

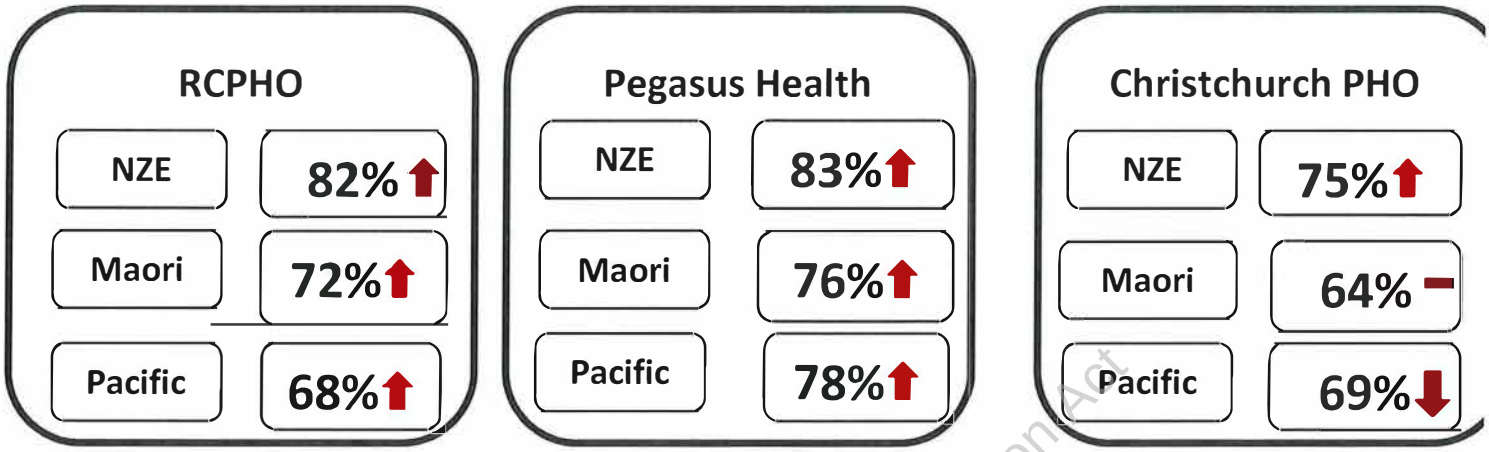
Q4 2013/14 Actual	Q1 2013/14 Actual	Q3 2014/15 Progress	Q4 2014/15 Progress
95% fully	95% fully	94.2% fully	93.64%
.5% overdue	.5% overdue	.198%	1.8% overdue

Fully Immunised 8month and two year olds - PHO LEVEL 30 Jan 2015

	8 month olds		2 year olds	
	Q2 Actual	Q3 Progress Including Pending	Q2 Actual	Q3 Progress Including Pending
RCPHO	93%	95%	94%	94%
Pegasus	94%	96%	95%	94%
Christchurch PHO	96%	100%	96%	98%

Pre teen Immunisations

11 vear old – PHO Level until 30 March 2014



HPV – Similar DHB Level All Doses Dec 13

See page below for HPV data

Immunisation Reporting Programme

The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
  - DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
  - Reporting periods
    - Q1 = 1 July – 30 September
    - Q2 = 1 October – 31 December
    - Q3 = 1 January – 31 March
    - Q4 = 1 April – 30 June
  - HPV Reporting – girls born in 1999 and 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.
  - Please email suggestions and feedback to NIRCanterbury@cdhb.govt.nz

As of 28 Feb 2015

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	214	61	138	1,323	1,736	390	110	190	2,260	2,950	55%	55%	73%	59%	59%	297 (10.1%)	0 (0.0%)
	HPV-2 Quadrivalent	199	56	134	1,257	1,646						51%	51%	71%	56%	56%	302 (10.2%)	
	HPV-3 Quadrivalent	185	51	126	1,193	1,555						47%	46%	66%	53%	53%	308 (10.4%)	
2000	HPV-1 Quadrivalent	190	46	155	1,168	1,559	420	100	200	2,230	2,940	45%	46%	78%	52%	53%	190 (6.5%)	0 (0.0%)
	HPV-2 Quadrivalent	174	41	152	1,105	1,472						41%	41%	76%	50%	50%	191 (6.5%)	
	HPV-3 Quadrivalent	146	33	142	1,006	1,327						35%	33%	71%	45%	45%	202 (6.9%)	
2001	HPV-1 Quadrivalent	157	43	99	1,066	1,365	420	110	190	2,290	3,010	37%	39%	52%	47%	45%	123 (4.1%)	0 (0.0%)
	HPV-2 Quadrivalent	134	37	92	976	1,239						32%	34%	48%	43%	41%	119 (4.0%)	
	HPV-3 Quadrivalent	105	24	76	839	1,044						25%	22%	40%	37%	35%	122 (4.1%)	
2002	HPV-1 Quadrivalent	152	35	80	933	1,200	390	100	160	2,310	2,970	39%	35%	50%	40%	40%	82 (2.8%)	1 (0.0%)
	HPV-2 Quadrivalent	123	31	74	828	1,056						32%	31%	46%	36%	36%	87 (2.9%)	
	HPV-3 Quadrivalent	84	22	63	643	812						22%	22%	39%	28%	27%	87 (2.9%)	
2003	HPV-1 Quadrivalent	130	29	61	805	1,025	390	110	180	2,150	2,830	33%	26%	34%	37%	36%	49 (1.7%)	1 (0.0%)
	HPV-2 Quadrivalent	80	18	47	600	745						21%	16%	26%	28%	26%	40 (1.4%)	
	HPV-3 Quadrivalent	27	6	22	268	323						7%	5%	12%	12%	11%	42 (1.5%)	
Total	HPV-1 Quadrivalent	843	214	533	5,295	6,885	2,010	530	920	11,240	14,700	42%	40%	286%	47%	47%	741 (5.0%)	2 (0.0%)
	HPV-2 Quadrivalent	710	183	499	4,766	6,158						35%	35%	267%	42%	42%	739 (5.0%)	
	HPV-3 Quadrivalent	547	136	429	3,949	5,061						27%	26%	229%	35%	34%	761 (5.2%)	

Q2 2014/15 DATA RUN 5 January 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,539	1,338	87. %	804	720	90. %	217	169	78. %	77	64	83. %	192	180	94. %	249	205	82. %	16 ()	1.0 (0.0) %	44	2.9 %
8 Month	1,492	1,395	93. %	744	705	95. %	246	227	92. %	61	59	97. %	187	182	97. %	254	222	87. %	16 (1)	1.1 (0.1) %	56	3.8 %
12 Month	1,491	1,405	94. %	755	726	96. %	233	214	92. %	74	72	97. %	189	186	98. %	240	207	86. %	20 (1)	1.3 (0.1) %	50	3.4 %
18 Month	1,490	1,313	88. %	779	706	91. %	220	176	80. %	77	63	82. %	172	157	91. %	242	211	87. %	12 (1)	0.8 (0.1) %	47	3.2 %
24 Month	1,562	1,488	95. %	832	797	96. %	220	206	94. %	76	76	100. %	185	184	99. %	249	225	90. %	16 (0)	1.0 (0.0) %	51	3.3 %
5 Year	1,754	1,514	86. %	951	843	89. %	256	231	90. %	81	73	90. %	153	129	84. %	313	238	76. %	27 ()	1.5 (0.0) %	104	5.9 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,539	1,338	87. %	360	298	83. %	356	313	88. %	370	326	88. %	253	224	89. %	200	177	89. %	0	0	-
8 Month	1,492	1,395	93. %	372	340	91. %	334	313	94. %	324	302	93. %	255	241	95. %	207	199	96. %	0	0	-
12 Month	1,491	1,405	94. %	395	360	91. %	314	300	96. %	319	302	95. %	243	235	97. %	220	208	95. %	0	0	-
18 Month	1,490	1,313	88. %	397	352	89. %	333	301	90. %	311	272	87. %	249	220	88. %	200	168	84. %	0	0	-
24 Month	1,562	1,488	95. %	418	387	93. %	300	288	96. %	342	327	96. %	271	260	96. %	231	226	98. %	0	0	-
5 Year	1,754	1,514	86. %	544	453	83. %	394	342	87. %	351	314	89. %	267	232	87. %	198	173	87. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	Maintain the Immunisation Service Level Alliance (SLA) with clinical leadership from across the system.	Ensure that CDHB is represented at all key national and regional immunisation forums.	On going	Canterbury DHB is represented at regional and national forums.	Everyone	
Before (and just after) Baby)	Support LMCS to promote and education pregnant women on Childhood Immunisation and the NIR Invest in free seasonal flu vaccinations pregnant women. Support LMC to provide free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children. Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Regular communication and linkages with LMCs Work with LMCs, Primary Care and Immunisation Services to develop a DHB plan for managing an monitoring new-born enrolments This piece of work is being led by CYWS	Q4	Monitor uptake of Influenza and Pertussis vaccination. 95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth. 98% of newborns are enrolled with general practice by 2 weeks. Develop relationships with services already working with children to focus on high needs, at risk children.	Planning and Funding to Lead P&F to link with CYWS to get feedback on this	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
Preschool immunisations	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Refining NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Supporting the Missed Event Coordinator and OIS to locate missing children. Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations, including offering NIR access. Continue to offer the Influenza vaccination to those under 18years of age.	Work with NIR, IC and OIS to ensure health and performance target children are monitor and referred in a timely manner Share PHO and Practice Milestone ages reports with practices. Undertake Assessment of OIS services. Providing recommendations to ISLA	Q2 on going	Quarterly performance reports circulated to PHOs, to review progress against targets. 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated Q2. 95% of all two-year-olds are fully immunised Child Health ward can check status and vaccinate overdue children. 40% of children receive the U18 Flu Vaccination	NIR, IC, OIS and P&F NIR P&F, ISLA	
Preteen immunisation	Maintain a HPV Programme in both a primary care setting and in schools by: • Continue to link 11-year-old and HPV immunisation events.	Maintain the HPV working group who will Develop an annual plan including	On going	**70%** of Girls have received dose 1 65% of girls have received dose 2	IPG AND HPV WORKING GROUP	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	• Continue to provide the Secondary School HPV Programme	communisations and monitor performance, and provide advice to ISLA and any service model changes.	On going	60% of girls have received dose 3		
Adult immunisation	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women.	Maintain the seasonal flu working group and develop a plan for the 2015 season.	Q2 Q4 On going	Seasonal flu plan developed 75% of people aged 65+ have a seasonal flu vaccination Q4.	IPG and Flu Working Group	
System Support	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week by: • Maintaining a Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates; • Maintaining streamlined access to immunisation awareness information; • Developing a plan for implementing Immunisation Week.	Review systems resources and ensure it is up-to-date Develop Immunisation Resources Group who will review all DHB and MoH immunisation resources and oversea the Immunisation Promotion programme	Q3 On going Q3 Q4	Annual update provided to practices Plan developed for Immunisation Week. Narrative report on interagency activities completed to promote Immunisation Week.	P&F, DHB Communisations and ICs	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Area	Action	Timeframe	Responslbity	Progress
Education	Develop an education programme for LMCs, to educate them on the importance of vaccinating during pregnancy.	February 2015	Margo to organise Tony to present	
	Regular message to LMC twice a year regarding the importance of vaccinations	February and July	Bridget	
	Link with DHB Maternity Outpatients to ensure they are advising women around vaccination	October 2014	Margo	
Information Linkages	Develop a way to link Maternity Suite Bookings back to General Practice (need to ID a way to notify practices of miscarriages). This will enable the practice to know who is pregnant and recall them at 30 weeks for vaccination. A draft letter to be developed to support this programme.	December 2014	Bridget and DHB IT	
	Develop a sticker for the Hand Held Maternity Notes books, to remind LMCs and Pregnant Women about when to vaccinate	December 2014	Bridget to develop and distribute Margo to educate LMCs	
	Update Pertussis section of Health Pathways to reflect key messages	December 2014	Margo to link with Di Bos	
Promotion	Update promotional material to include key messages	December 2014	Bridget, Margo and Mick	
Vaccination	Discussion vaccination of parents in NICU for at risk children	December 2014	Margo	

FOR ISLA CONSIDERATION	Canterbury Clinical Network

TITLE	HPV Outreach Programme
PREPARED BY	Bridget Lester and IPG HPV Working Group
DATE	18 March 2015
RECOMMENDATION	That the ISLA reviews the paper and • Provide support for the current HPV Outreach Programme (previously known as a Mop up programme) to be moved forward two years and offered to year 8 girls, in their school setting. • General practice will continue to offer the HPV vaccination from aged 11 years. • Approves the paper to go to AST on 9 April and ALT on 20 April 2015

1. AIM

The aim of the Immunisation Service Level Alliance (ISLA) is to ensure that every eligible girl has access to the HPV vaccination programme, which is delivered in a way to suit the girl and her family's needs.

2. PURPOSE

The purpose of a school based HPV vaccination programme is to ensure that all young women in Canterbury are given the opportunity to be protected against HPV by providing a vaccination programme for girls who have not been vaccinated within a general practice setting.

The revised programme will be targeted at all year 8 girls, who attend school in Canterbury. The programme will endeavour to achieve equitable coverage across ethnicities by offering the programme at all schools across Canterbury. Specifically the programme will utilise the Whanau Ora and HEAT (Health Equity Assessment Tool) models to ensure that Maori and Pacific young women (who are most at risk of cervical cancer) are given every opportunity to receive HPV vaccination.

3. RATIONALE

3.1 BACKGROUND

Since 2009 Canterbury DHB has provided the funded national HPV vaccination programme through General Practice. This programme is available to all girls from age 9 to 20 years. The Ministry of Health's (MoH) key target group is 12 year old girls (school year 8) and the 2015/2016 MoH target for this group is 65% of girls completing the programme.

All DHB's in New Zealand, except Canterbury, provide a school based HPV programme aimed at girls in year 8. Coverage is 59% of girls in the target group completing the programme. The Canterbury DHB coverage for the same group is only 45% for dose one, with only 35% of girls receiving all 3 does of the vaccination within the targeted year[a].

		Immunisation coverage						
DHB	Vaccination	Maori	Pacific	Asian	Other**	All	Decline	Opt off
Auckland	HPV-1 Quadrivalent	77%	91%	72%	82%	81%	657 (29.7%)	16 (0.7%)
	HPV-2 Quadrivalent	79%	92%	73%	81%	80%	603 (27.3%)	
	HPV-3 Quadrivalent	73%	88%	70%	78%	77%	603 (27.3%)	
Canterbury	HPV-1 Quadrivalent	37%	39%	52%	47%	45%	123 (4.1%)	0 (0.0%)
	HPV-2 Quadrivalent	32%	34%	48%	43%	41%	119 (4.0%)	
	HPV-3 Quadrivalent	25%	22%	40%	37%	35%	122 (4.1%)	
Capital and Coast	HPV-1 Quadrivalent	71%	71%	69%	70%	71%	450 (26.5%)	0 (0.0%)
	HPV-2 Quadrivalent	68%	69%	68%	68%	69%	389 (22.9%)	
	HPV-3 Quadrivalent	65%	68%	69%	66%	67%	389 (22.9%)	
Counties Manukau	HPV-1 Quadrivalent	73%	81%	62%	54%	68%	710 (18.1%)	0 (0.0%)
	HPV-2 Quadrivalent	71%	80%	64%	56%	68%	80 (2.0%)	
	HPV-3 Quadrivalent	59%	72%	60%	50%	61%	79 (2.0%)	
Waitemata	HPV-1 Quadrivalent	63%	72%	60%	56%	59%	760 (21.2%)	32 (0.9%)
	HPV-2 Quadrivalent	62%	70%	59%	55%	58%	136 (3.8%)	
	HPV-3 Quadrivalent	57%	66%	57%	52%	55%	146 (4.1%)	
NZ Total	HPV-1 Quadrivalent	70%	79%	67%	59%	65%	4989 (17.7%)	52 (0.2%)
	HPV-2 Quadrivalent	68%	78%	67%	57%	63%	2399 (8.5%)	
	HPV-3 Quadrivalent	63%	72%	64%	54%	59%	2390 (8.5%)	

Figure 1 HPV Coverage 2014 year 8 girls

In 2013, in an attempt to normalise HPV and improve coverage, Canterbury general practices were encouraged to offer the HPV vaccination to girls with their 11 year old immunisation event. In Canterbury we achieve approximately an 80% uptake for the 11 year old Boostrix vaccination. As a result, HPV performance has improved slightly but still only 27% of the target group were fully vaccinated by the end of the 2014 year.

General Practice continues to offer HPV vaccine to girls from age 11 to 20 years, however as a DHB we are not meeting national expectations and although some improvements have been made over the last 7 years, we fail to meet MoH targets and coverage falls well below other comparable DHB's.

3.2 RATIONALE BEHIND VACCINATING FROM 11 YEARS OF AGE.

There are several reasons why vaccinations should be commenced from age 11 years.

- The HPV vaccination produces a better immune response in preteens than it does in older teens[1]
- All three doses of HPV vaccine need to be given to ensure optimal protection. Giving the vaccination at age 11 or 12 years allows more time to follow up girls who have not received the completed course (before they are exposed to the virus).

[a] This data relates to girls born in 2001, which is the target year for the 2013/14 year. Girls born in 2002 will be the target group for the 2015/16 year.

- Vaccinations should begin prior to the commencement of any sexual activity, in order to protect against sexual transmission of HPV. The US Centre for Disease Control (CDC) recommends the vaccine should be given at the age of 11 or 12 years, partly for this reason[2]. The US Mayo Clinic states the vaccine can be given from the age of 9 years[3] and the vaccine is licensed in New Zealand from the age of 9 years.
- For HPV vaccines to be effective, they should be given prior to exposure to HPV. New Zealand studies have found 10-30% of young people have had sex by 15 years[4] and preteens should receive all three doses of the HPV vaccine series before they begin *any* type of sexual activity and are exposed to HPV.

3.3 SECONDARY SCHOOL OUTREACH (MOP UP) PROGRAME

In 2014, Canterbury DHB piloted a school based HPV outreach programme[b], aimed at year 10 girls in Secondary schools. This programme is known as the HPV Secondary School Programme. This programme was developed to support the general practice programme. The coordination team for this service is located within Pegasus Health, as the lead PHO. The relationship with the schools and the support for vaccinating teams lies with the public health nursing service.

Year one of the HPV Secondary School Programme appeared to be a success. The programme reached year 10 girls who were subsequently either vaccinated as part of the programme, or referred back to general practice. Of the girls targeted in the programme, 63% have received dose one. This is a result of pre-programme vaccination, during programme vaccination, or the decision to go to general practice during the year to be vaccinated. This is the best uptake of HPV vaccine the Canterbury DHB has seen in any age group.

Although the programme in secondary schools has had significant success, the focus should be on vaccinating the target age group in order to achieve both the Ministry of Health expectations and to give girls the best possible protection because of key clinical reasons to vaccinate at aged 11 years.

4. HPV SERVICE DELIVERY MODEL

General Practice will continue to be the primary provider of the HPV programme, by offering this programme to girls at aged 11. The number of girls targeted at age 11 years within the practice would remain unchanged. Based on 2014 data, around 36% of girls received dose one of HPV at general practice, with only 11% of girls completing the programme.

The new programme will be known as the HPV School Based Outreach Programme, and will continue to support the general practice programme. By moving the school programme from year 10 to year 8, the target number of girls would remain relatively static but would be in a different birth cohort (about 2300 girls per year). The main difference in this programme would be the number of schools to target.

Forty secondary schools are part of the current year 10 programme, however a move into primary schools this would see 213 schools being targeted. This is a mixture of primary, area, intermediate and secondary schools.

[b] The School based programme has been known as the "mop up" programme as it is seen to been mopping up the girls not vaccinated within general practice. However it has been decided to refer to this now was an outreach service as this language and model used for childhood immunisations. For the purpose of this paper the programme will be known as the HPV School Based Outreach Programme.

In total there are 206 schools in Canterbury who have year 8 girls. Of these schools the following modelling has occurred:

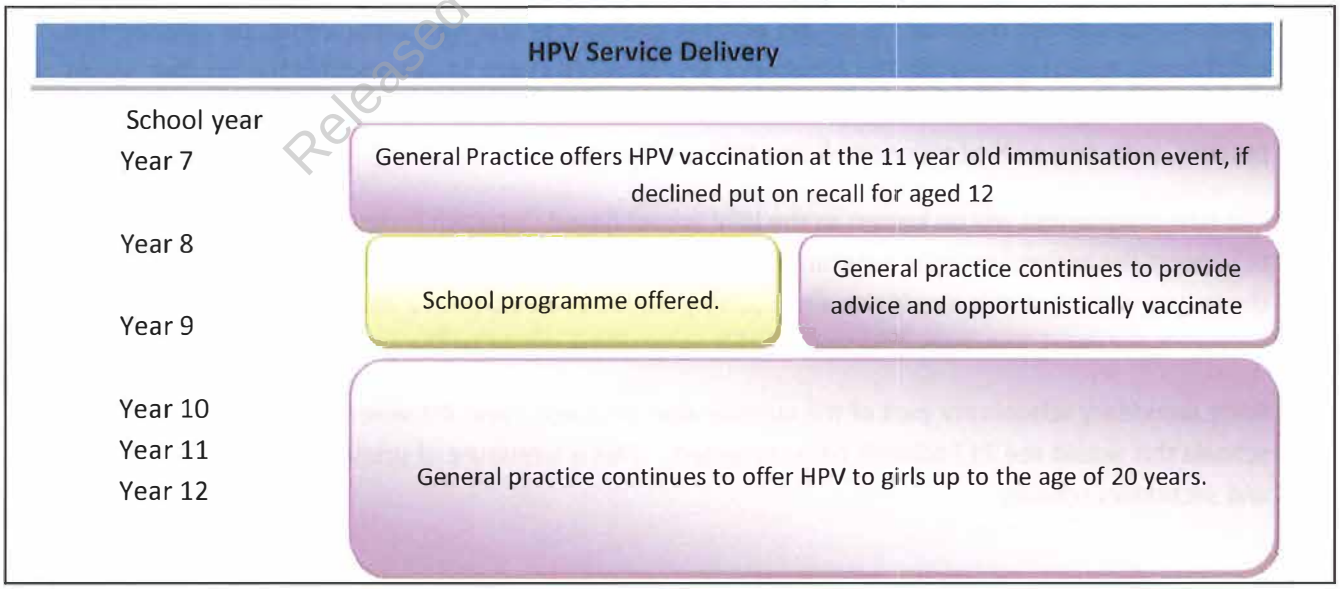
Range of girls	Number of schools	Number of sessions	Total number of session
No girls	7	0	0
1-10 girls	131	0.50	65.5
11-20 girls	40	1	40
21-41 girls	25	2	50
41 - 60 girls	4	3	12
61-80 girls	2	4	8
81 - 100 girls	1	5	5
100 - 150 girls	3	6	18
Total	213		133
Total vaccination days per term			**66.5**

Figure 2: Modelling for number of school sessions required.

A session is worked out as two hours of vaccinating time, with 40 girls targeted per session. This is made up of a team with a Welcomer, Checker, Vaccinator and Resource nurse. The team will flex up and down based on the size of the schools.

This modelling indicates that there would be a need for around 67 vaccinating days per school term, for three terms, in order to vaccinate the 2300 girls with 3 doses of vaccine within the programme. This would require one fulltime vaccinating team and a supplementary team when vaccinating in the bigger schools. Support will continue to be required from the public health nursing service who works in the school.

Diagram one: HPV Service Delivery Model: REVISED MODEL



5. FINANCIAL IMPLICATIONS

The cost of providing the HPV programme can be split into two areas, the administration of the vaccine, and the cost of the vaccine. General Practice order the vaccine for free and claim the

administration cost back from Sector Services (MoH). The MoH will then invoice the DHB for the cost of the vaccine and the administration fee.

Canterbury DHB also has a contract with the Pegasus Health for the coordination of the HPV School Based Outreach Programme. This includes a full time coordinator and administrator. In year one of the programme, they provided HPV vaccines in schools, supported by the public health nursing service. This programme orders the vaccine though the normal vaccine ordering process, with the DHB picking up the cost of this.

Extending the programme, will improve the uptake of the programme, with an expectation that around an additional 30% of girls will engage in the programme. This will be an increased cost to the DHB, however the DHB is funded by the MoH to provide this programme, and reach the expected targets.

Extending this programme into more schools will require a need to change the structure of the vaccinating team, which will result in an additional cost to the DHB. However, there is an opportunity to also utilise this HPV Outreach team to provide some children's outreach services, should work load allow it.

Further work needs to occur around what the final makeup of this service would be – however there is an estimate additional cost of **$200,000** on top of the current agreement arrangements. This funding would be used to provide more administration and vaccination support to the service due to the need to go into more schools.

There will be a cost in shifting this programme, as these girls will be picked up in a school programme and not under the current fee for service general practice programme. It is estimated that this would be around $60,000 per year. Therefore the total new funding to support this programme is an estimated **$140,000**.

If approved the work would start now for the implementation of this programme for the start of the 2016 calendar year.

References:

[1] according to the CDC (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[2] (Reference: HPV Vaccine - Questions & Answers, website: http://www.cdc.gov/vaccines/vpd-vac/hpv/vac-faqs.htm).

[3] (http://www.mayoclinic.org/healthy-living/sexual-health/in-depth/cervical-cancer-vaccine/art-20047292)

[4] (references to studies and risk factors for early sexual experience in: http://www.moh.govt.nz/moh.nsf/Files/Chapter9/$file/Chapter9.pdf)

Immunisation

Objective	**Increase immunisation amongst vulnerable Māori population groups to reduce the prevalence and impact of vaccine-preventable diseases.** Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. While Canterbury has high immunisation rates for both Māori and non-Māori, these high rates must be maintained or improved in order to prevent or reduce the impact of preventable diseases such as measles and pertussis (whooping cough).
Reporting Stream	Immunisation Service Level Alliance, Te Kāhui o Papaki Ka Tai, CCN Māori Health Caucus, CPHAC
Data Source	National Immunisation Register (childhood immunisation); NSIG (flu vaccinations), IPIF (new-born enrolment
Key Stakeholders	Canterbury DHB; CCN ISLA; Immunisation Provider Group; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO, Te Puawaitanga, Te Tai o Marokura

OUR PERFORMANCE STORY 2015/16

Indicator/Target

95% of eight-month-olds are fully immunised.[1]

Baseline 14/15 Q2:
Māori: 92%
Total Population: 93%
Target 15/16: 95%

Graph

75% of the eligible population (aged 65+) have had a seasonal influenza vaccination. [2]

Baseline 12/13 Q2:
Māori: 70%
Total Population: 75%
Target 14/15: 75%

Activity/Evidence

Through the CCN Immunisation Service Level Alliance (ISLA) strengthen clinical leadership across the system and work toward ensuring equity across the provision of Immunisation Services.

Activity **Q1-Q4:** Support and maintain systems for seamless communication and handover between maternity, general practice and WCTO services and support the multiple enrolments of newborns, to overcome the barrier to timely immunisation of late enrolment.

Evidence **Q1 – Q4:** Ensure that >99% of newborns enrolled on the NIR at birth.

Q1 – Q4: Ensure that 98% of newborns are enrolled with primary care by 2 weeks of age

Activity **Q1-Q4:** Continue to use the NIR to monitor immunisation coverage at DHB, PHO and general practice level, circulating performance reports to maintain coverage.

Q1 – Q4 Continue to use the NIR to identify unvaccinated tamariki.

Q1-Q4: Support the Outreach Immunisation Service and Te Puawaitanga to locate tamariki who are not up to date with their vaccinations.

Q1-Q4: Strengthen connections with the Māori Health Provider Network and the Immunisation Service Level Alliance to promote the importance of the timeliness of vaccinations to better reach Māori populations.

Q1-Q4: Continue to review and monitor opt offs and declines within our Maori Population, and work with practices with large number of declines.

Evidence **Q1 – Q4**: 95% of 8month olds, 95% of 2 year olds and 90% of 5 year olds are fully vaccinated

Q2-Q3: When developing the annual influenza plan, continue to promote influenza vaccination to all Māori, with a focus on those 65 and over, those with chronic health conditions and Pregnant Women.

[1] Data for the new eight-month-old immunisation health target is not available prior to the 2012/13 year. The Canterbury DHB result for Quarter 3 2012/13 was 90% for Māori and 93% for the total Canterbury eight-month-old population.
[2] Influenza data is provided via the PHO Performance Programme and baseline is for the October-December 2013 period.

Evidence Q4: 70% of Maori 65 year and older are vaccinated against Influenza	
Q1-Q4:	Continue Māori representation on the Immunisation Service Level Alliance and the Immunisation Providers Group

Deleted: What about declines and opt offs? I'll email you the draft MoH guidance – it asks for health promotion activities to reduce these if we have high rates.¶

HPV Immunisation

Objective	**Increase HPV immunisation rates to reduce the prevalence and impact of vaccine-preventable diseases.** Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups. HPV immunisation needs to be normalised. Therefore in Canterbury this will offered at aged 11 with the 11year old immunisation event.
Reporting Stream	Immunisation Service Level Alliance, Te Kāhui o Papaki Ka Tai, CCN Māori Health Caucus, CPHAC
Data Source	National Immunisation Register
Key Stakeholders	Canterbury DHB; CCN Immunisation Service level Alliance; Christchurch PHO; Pegasus Charitable Health; Rural Canterbury PHO

OUR PERFORMANCE STORY 2014/15

Indicator/Target

The 2014/15 target was 60% of eligible Māori girls born in 1996 receive dose 3 of the HPV vaccination programme.[1]

Outcomes 2014/15:
Māori: 57%
Total Population: 53%

Target 2015/16
65% of girls born in 2002 receive dose 3 of the HPV vaccination programme.
In 2015 year we are shifting our focus to match the national targeted age group. This target is girls who turn 12years old during the year. For 2015/16 the target group will be girls born in 2002.

Baseline 2014:
Girls turning 12 years who received dose 3 of the HPV vaccination programme.
Māori: 25%
Total Population: 37%

Activity/Evidence

Through the CCN Immunisation Service Level Alliance (ISLA) strengthen clinical leadership across the system and work to ensure equity in the provision of Immunisation Services.

Q1-Q4: Maintain the HPV Programme in a primary care setting at 11 year old events and promote HPV School-based programme in year 10.

Q3: Review the evaluation of the secondary school HPV programme to determine equity of service provision between Māori and non-Māori and provide support to the ISLA on future service models.

Q1-Q4: Monitor immunisation rates and work with Te Kāhui o Papaki Ka Tai and other key groups to identify ways to reach Māori whanau.

[1] The baseline is the percentage of girls born in 1996 receiving dose 3 by the end of 2012. Canterbury's programme is slightly different to others nationally as it is primary care rather than school based.

TERMS OF REFERENCE

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Immunisation Provider Group

Background	▪ The Canterbury District Health Board is working within an Alliance Framework for service development, design and contracting. ▪ The Immunisation Service Level Alliance acts as the guardians of Immunisation in Canterbury. ISLA vision is: • *To ensure protection for the Canterbury population across their life span, against vaccine preventable disease.* • *Immunisation is recognised as normal and acceptable protection against vaccine preventable diseases* ▪ The Immunisation Provider Group has been developed by ISLA to streamline Immunisation Service Meetings and was established in May 2011.
Objectives of Service Level Provider Meetings	With key deliverers of immunisation services, implement recommendations of the Immunisation Service Level Alliance by working together as follows: ▪ To provide support to each other and strengthen working relationships ▪ To share ideas and information ▪ To network, and provide links to community service areas ▪ To develop systems to achieve key performance indicators ▪ To develop methods to reduce service duplication ▪ To identify areas for improvement in immunisation services, and report these to the Immunisation Service Level Alliance
Accountability	▪ This group will report to Immunisation Service Level Alliance
Conflicts of Interest	▪ Each of us will proactively manage any potential Conflict of Interest and comply with the provisions relating to Conflicts of Interest.
Decision making	▪ All decisions will be made on a 'Best for System' basis and when making such decisions will give predominate weight to the interests of our objectives over our own self interest. ▪ Decision making will be informed by the use of best evidence, the CDHB Prioritisation tool / framework, and priorities outlined in the District Strategic and Annual Plans. ▪ Consensus decision making will be used. However if we can not reach consensus we will go with a 90% vote from the members present. ▪ Group members will support the decisions of the group
Membership	These include representation from: • PHOs • Immunisation Co-ordination • Public Health Nursing • Practice Nursing • Child Health • Well Child providers • Outreach Immunisation Providers • IMAC – South Island Regional Immunisation Advisor • National Immunisation Register • ISLA • Planning and Funding • Maori • Pacific

	• HPV Co-ordinator The provider group will make a recommendation to ISLA regarding the Chair of this group. ISLA will appoint the chair from these recommendations. Members will be opted on as required for specific projects.
Communication	▪ The group will appoint one person as key spokes person for the group. Key messages should be approved by the Chair of ISLA before distributed
Meetings	▪ Every month ▪ Quorum will be 50% of membership plus one. ▪ 60% attendance required – if unable to attend, an alternative representative from the organisation may attend
Meeting Support	▪ Administrative support will be provided by National Immunisation Register Team ▪ This will include provision of agendas and meeting minutes
Review Date	▪ ISLA will review this group in May 2012 and on an annual basis thereafter. ▪ Terms of Reference for this group will be reviewed annually

Reviewed and updated – March 2015

Next Review Date – March 2016

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

TERMS OF REFERENCE
Immunisation Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

IMMUNISATION SERVICE LEVEL ALLAINCE

1. BACKGROUND

1.1. The Immunisation Service Level Alliance (ISLA) was established in 2010 with its initial role to develop an Immunisation Service Model (see appendix one) with a focus on fully immunised 2year olds (the health target at the time). Following the development of Service Model the ISLA moved into the implementation stage, focusing on the implementation of the service model. This included the development of an Immunisation Outcomes Framework (see appendix two).

1.2. The ISLA has moved into a monitoring phase of the outcomes framework, which focused on normalising immunisation over a lifetime and reaching specific health and performance targets. The focus of Immunisation SLA has moved to all scheduled immunisation events and any necessary immunisation events to manage outbreaks.

2. PURPOSE

To be the guardians of the immunisation service across Canterbury ensuring that the service is supported to deliver reduced vaccine preventable disease & increased scheduled vaccination rates within an alliance framework. This includes working towards a variety of health and performance targets including but not limited to:

- Achieve 8month immunisation health target
- Achieve 2 year old immunisation performance target
- Achieve seasonal flu target
- Improve 4yr, HPV &11 yr old vaccination rates
- Non schedule events as part of an outbreak

To achieve this the ISLA needs to provided

- Provide strategic planning, design, prioritisation and oversee implementation of immunisation service/s across the Canterbury health system;

- Recommend how services will be funded using collective decision making and available resources from a range of sources.

3. EXPECTED OUTCOMES OF THE SLA

3.1. The ISLA has developed an immunisation outcomes framework and set key performance targets each year by the Ministry of Health.

4. MANDATE

4.1. ISLA will make recommendations to ALT when considering strategic direction for new models of service implementation or delivery. They will brief ALT on the process of this implementation and delivery.
4.2. Once an approval is made by ALT, decisions on governance and implementation of the above strategy will be made by ISLA.
4.3. Implementation of these recommendations and decisions will be made by the Immunisation Providers Group, or Planning and Funding
4.4. For all decisions which involve budgets, approval will be sought by Planning and Funding Leadership Team

5. SCOPE

5.1. In Scope
- Overseeing all immunisation programmes in Canterbury funded by health funding
- The Seasonal Influenza Programme both subsidised and non-subsidised

5.2. Out of Scope - Overseeing non-funded immunisation programmes eg no subsided immunisation events

6. MEMBERSHIP

6.1. The membership of the ISLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;
6.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the ISLA to achieve success;
6.3. The ISLA will review membership annually to ensure it remains appropriate;
6.4. Membership will include a member of the ALT;
6.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;
6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;
6.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;
6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

7.1. New or replacement members will be identified by the ISLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;
7.2. The chair and deputy chair will, in most cases, be nominated by members of the ISLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the ISLA is:

Name(s)	Perspective/Expertise
Dr Ramon Pink	Community and Public Health Background
Helen Johnson	Operational understanding of Primary Health Organisation
Margo Kyle	Lead Maternity Carer
Linda Hill	National understanding of immunisation policy
Ann Feld	Background in Child Health
Dr Tony Walls	Secondary Care, Immunisation Academic
Dr Alison Wooding	General practice
Dr Sarah Marr	General practice
Anna Harwood	Pharmacist
Currently vacant	Maori Health specialist
Bridget Lester	An operational understand of Planning & Funding / Facilitator

9. ACCOUNTABILITY

9.1. The ISLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ISLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

10.2. The ISLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held 6 weekly while the Immunisation Provider Group meetings and any relevant sub groups will be held monthly

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The ISLA will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Reports will be provided by the ISLA in a template provided by the CCN Programme Office.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ISLA chair and facilitator;

13.2. Agendas will be circulated no less than 2 days prior to the meeting, as will any material relevant to the agenda;

13.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed.

13.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

14. QUORUM

14.1. The quorum for meetings is half plus one ISLA member from the total number of members of the SLA.

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new ISLA or programme of work, conflicts of interest will be stated, recorded and available on request to the CCN programme Office. "Conflict of Interest" will be a standing item on ISLA agenda's.

16. REVIEW

16.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

RESPONSIBLITIES

17. RESPONSIBILITY OF THE SLA

17.1. Apply the delegated funding available to lead the required service/service change;
17.2. Establish new work groups to guide service design;
17.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

18. CHAIR

18.1. Lead the team to identify opportunities for service improvement and redesign;
18.2. Lead the development of the service vision and annual work plan;
18.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
18.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
18.5. Provide leadership when implementing the group's outputs;
18.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
18.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
18.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

19. CLINICAL LEADER

19.1. Provide strong clinical leadership across all SLA work activity;
19.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;
20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. PROJECT MANAGER/FACILITATOR

21.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
21.2. Provide or arrange administrative support;
21.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
21.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
21.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
21.6. Keep key stakeholders well informed;
21.7. Proactively meet reporting and planning dates;

21.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;

21.9. Identify report and manage risks associated with the SLA work activity.

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;

22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;

22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

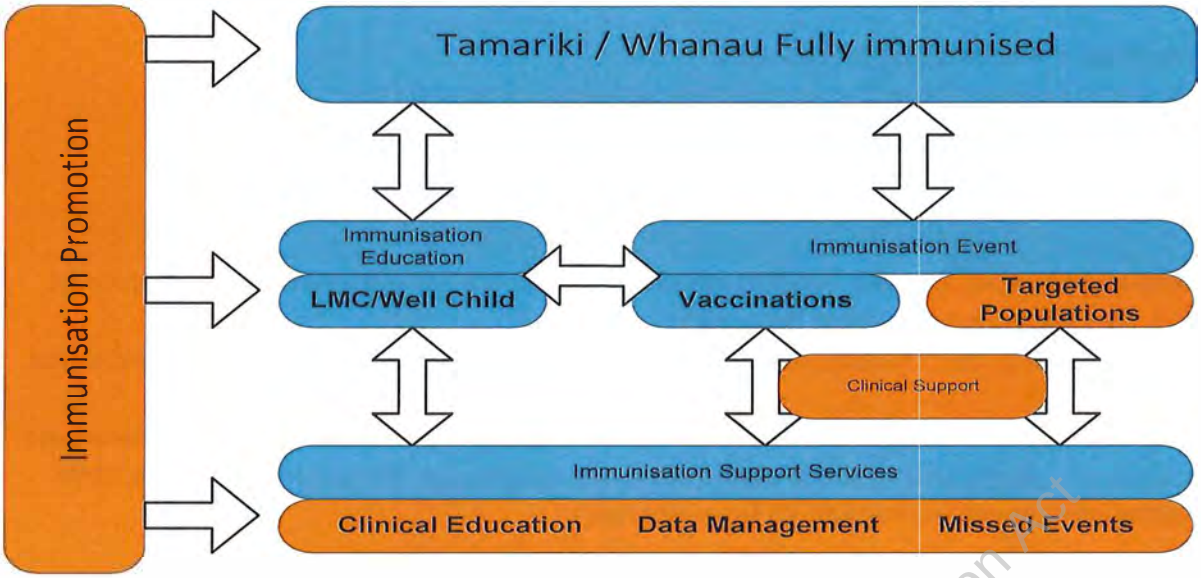
ENDORCEMENT OF MINUTES

Agreement and endorsement of these TOR should be dated and recorded in the minutes.

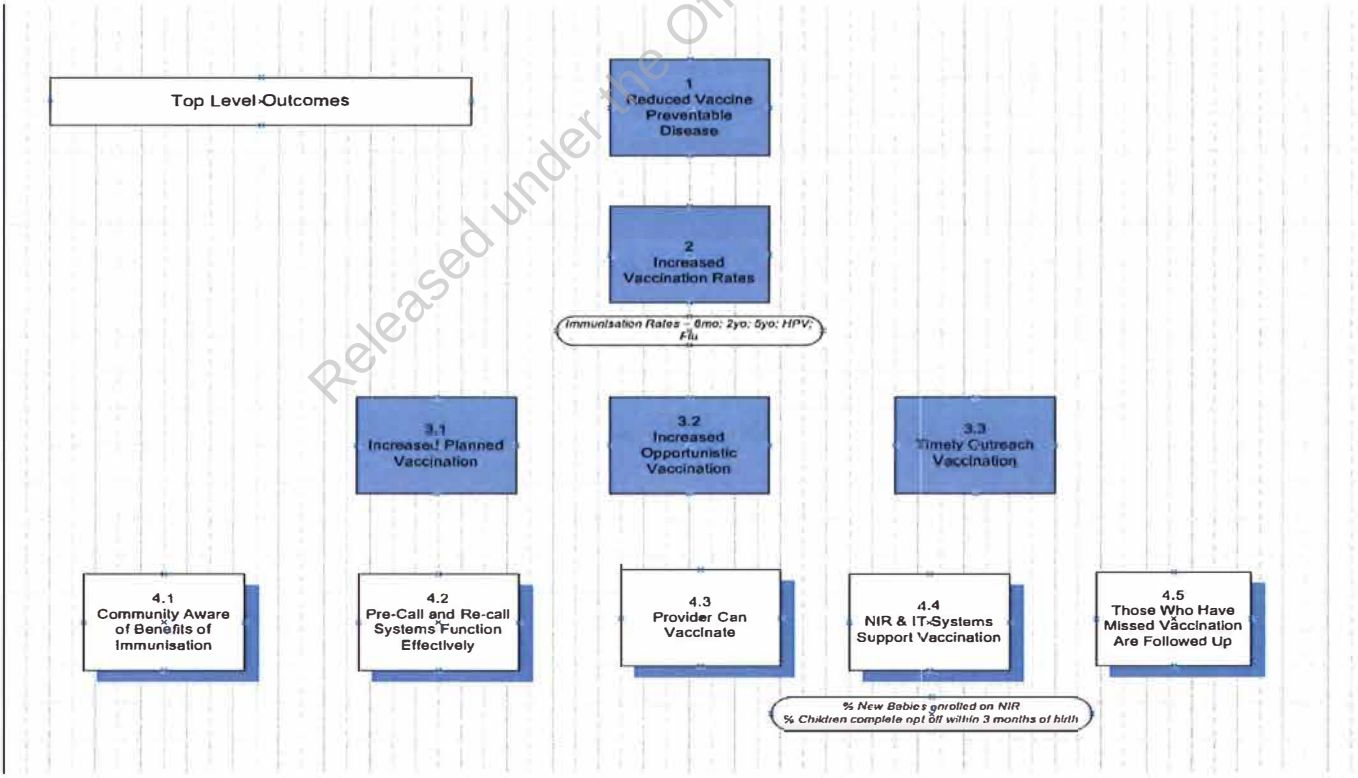
Date of agreement and finalisation by SLA members: / /2013

Date of endorsement from ALT: / /2013

Appendix One: Immunisation Service Model



Appendix Two: Immunisation Outcomes Framework



Lara Williams (Administrator)

From: Meagan Draper <Meagan.Draper@ccnweb.org.nz>
Sent: Wednesday, 4 March 2015 2:30 p.m.
To: Bridget Lester
Subject: New CCN Website - Immunisation SLA - Return by 25 March
Attachments: Immunisation SLA.docx

Hi Bridget

As you know the CCN website is undergoing a makeover. ALT has endorsed a way forward and I'm now working on gathering content. To help with this, can I please request:

1. A slot in the next ISLA agenda to show the group the vision for the new website
2. Amendments to the attached ISLA page by 25 March 2015

I'm also very happy to meet one-on-one if you'd like to see the new website prototype and discuss.

Thank you for your help.

MEAGAN DRAPER| CCN Communications and Project Coordinator | Canterbury Clinical Network
P: 021 683 728 | DDI: 03 3725127 | E: meagan.draper@ccnweb.org.nz
PO Box 741, Christchurch 8140 | 160 Bealey Avenue, Christchurch 8014
W: http://www.ccnweb.org.nz SKYPE Name: meagandraper

CCN WEBSITE – CONTENT REQUEST	Canterbury Clinical Network
TO	**IMMUNISATION SLA**
PURPOSE	The CCN Website is undergoing redevelopment and we need your help to get the content correct. Would you please read and amend the information below for inclusion on the new website. This is a rough draft designed to be a starting point for you to work from. You can track your changes or delete completely and start again. More Information To discuss this request further or provide suggestions for the new website, contact Meagan Draper, CCN Communications Coordinator by phone 021 683 728 or email Meagan.Draper@ccnweb.org.nz. Request another page Fill in this form if you think we've missed a crucial topic or information for the website. CCN Website Blank Content Request Form
RETURN TO	Return by email to Meagan.Draper@ccnweb.org.nz or give to a member of the Programme Office.
RETURN BY	**25 MARCH 2015**

Page title	**Immunisation Service Level Alliance**
About	The Immunisation Service Level Alliance (Immunisation SLA) is the guardian of the immunisation service across Canterbury, aiming to increase immunisation coverage to reduce vaccine-preventable diseases. The Immunisation SLA focuses on normalising immunisation over a lifetime and reaching specific health and performance targets. This includes: • All immunisation programmes in Canterbury funded by health funding; • The Seasonal Influenza Programme, both subsidised and non-subsidised; • Vaccination of the health workforce; and • Any necessary immunisation events to manage outbreaks. Immunisation plays an important role in the Canterbury health system's objectives to support people to take greater responsibility for their own health and stay well in their own homes and communities. Immunisation can prevent a number of diseases and is a very cost-effective health intervention. The Immunisation SLA was established in 2010 and provides strategic planning, design, prioritisation and implementation oversight of immunisation services across the Canterbury health system, including recommendations for how services will be funded. As part of this, the Immunisations SLA developed an Immunisation Outcomes Framework and is set key performance targets each year by the Ministry of Health. Implementation of endorsed recommendations and decisions is by the Immunisation Providers Group or Canterbury District Health Board Planning and Funding.
Members *As per terms of reference*	**Perspective/Expertise** — **Member** Medical Officer of Health, background in Maori Health. — Ramon Pink, Medical Office of Health General practitioners for small high needs practice and from large mixed need practice. — Dr Alison Wooding, Piko Te Ora; Sarah Marr, Halswell Health A focus on child health with an understanding of Immunisation from a health promotion perspective. — Anne Feld, Plunket Member of a community pharmacy team who offers non-subsided Immunisation events. Part of the wider picture of Immunisation service delivery. — Anna Harwood, Bishopdale Pharmacy Member of the Planning and Funding team, with an understanding of national requirements and DHB — Bridget Lester, Project Specialist

	processes.	
	A member of the Canterbury College of Midwives with linkages to LMC and an understanding of their role in the Immunisation service model.	Margaret Kyle, LMC
	A member of the IMAC team, with an understanding of national direction and clinical requirements for immunisation. Chair of the Immunisation Providers Group.	Linda Hill, SI Regional Advisor for IMAC
	A paediatrician with an interest in immunisation. Linkages to DHB Secondary Care services and educational facilities.	Dr Tony Walls, Paediatric Infectious Diseases, Senior Lecturer
	Operational understanding of Primary Health Organisation.	Geraldine Clemens
	ALT sponsor.	Vacant

Any resources you'd like to share on the page *Example: TOR, meeting minutes, newsletters*	**<u>What is it?</u>**	**<u>Private or Public?</u>**
	TOR	Public
	Immunisation Outcomes Framework	Public
Any other phrases or abbreviations people might use to find this page	**ISLA**	

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❷		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children"	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. The HPV School programme has been put in place to pick up the girls not reached in the general practice programme.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 28 October 2014	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Linda Hill	Chair – Immunisation Providers Group Regional Advisor IMAC
Margaret Kyle	CDHB LMC liaison LMC midwife Midwifery services advisor – Clinical researcher the New Zealand Institute of Community Health Care NZCOM midwifery standards reviewer Chair Canterbury/West Coast NZCOM
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding Member of IPG

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 24 April 2015 11:01 a.m.
To: Alison Wooding; Anne Feld; Geraldine Clemens; Heather Burns; 'Linda Hill'; 'Margaret Kyle'; marr.sarah@gmail.com; 'Michael McEvedy'; Michael McIlhone; pharmacists@bishopdale.co.nz; Ramon Pink; Tony Walls
Subject: Agenda and papers for Tuesday 28 ISLA meeting
Attachments: 28 April 2015 draft agenda.docx; Imms Reporting Template April ISLA.docx; ISLA 2014 15 workplan.docx; Risk Register April.docx; Interests register 17 March 2015.docx; Draft minutes 17 March ISLA meeting.docx

HI all

Please find papers etc attached.

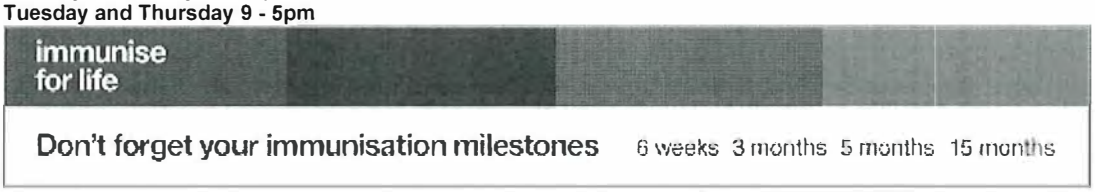
- Agenda
- Draft minutes
- ISLA workplan
- Data Report
- Risk Register
- Interest Register

I also hope to have a draft HPV project plan to you by Tuesday for discussion at our meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm



Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 28th March 2015, 2-4pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Linda Hill:
Anne Feld : Apology	Margaret Kyle:
Anna Harwood:	Dr Sarah Marr:
Dr Tony Walls:	Geraldine Clemens:
Michael McIlhone	

	Time	Item	Who	Papers
1.	2.00pm	Welcome and Introductions	Ramon Pink	
2.	2.05pm	Confirmation of minutes of last meeting	Ramon Pink	
3.	2.10pm	Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting	Ramon Pink	Draft minutes 17 March ISLA meeting.
4	2.15pm	Immunisation Promotion – Flu and Imms for Life	Vicky Hewitt	
5.	2.30pm	Updates 2014/15 IPG Work Plan Health Target progress – KPI	Bridget Lester	ISLA 2014 15 workplan.docx Imms Reporting Template April ISLA.
5	2.45pm	HPV Project Plan	Bridget Lester	
6.	3.00pm	Operational • CCN Website and ISLA section • Interest register • Risk Register	Ramon Pink	Risk Register Dec.docx Interests register 28 Oct 2014.docx
8.	3.40pm	Any other business	Ramon Pink	

Action Register	Responslbity	Timeframe
Letter to Pegasus regarding Helio	Bridget	30 March 2015
GP update and LMC package	Bridget	30 March
Update Risk Register	Bridget	16 April 2015
HPV Model – send paper to AST and then ALT	Bridget	9th April

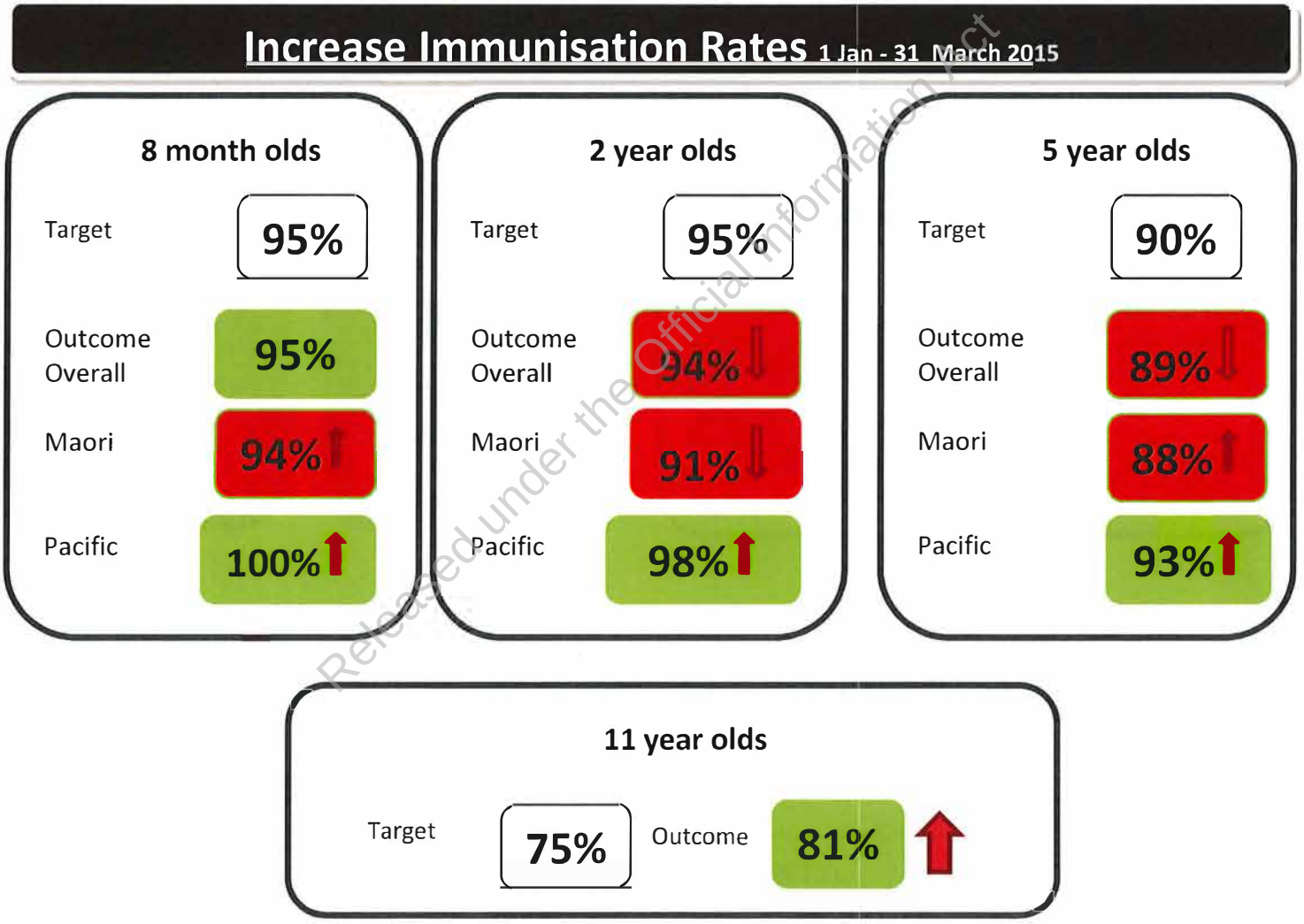
Next meeting: June 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

our health system

Key Performance Indicators and Childhood Immunisation Reporting

April 2015



Childhood Immunisation – MoH Health Targets up until 31 March 2015

Fully Immunised 8 month olds – DHB LEVEL

Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Progress including pending	Q1 2015/16 Progress including pending
93% fully	95.3% fully	92% fully	86% fully
1.8% overdue	1.2% overdue	3.7% could reach	7.5% could reach

Fully Immunised Two year olds - DHB LEVEL

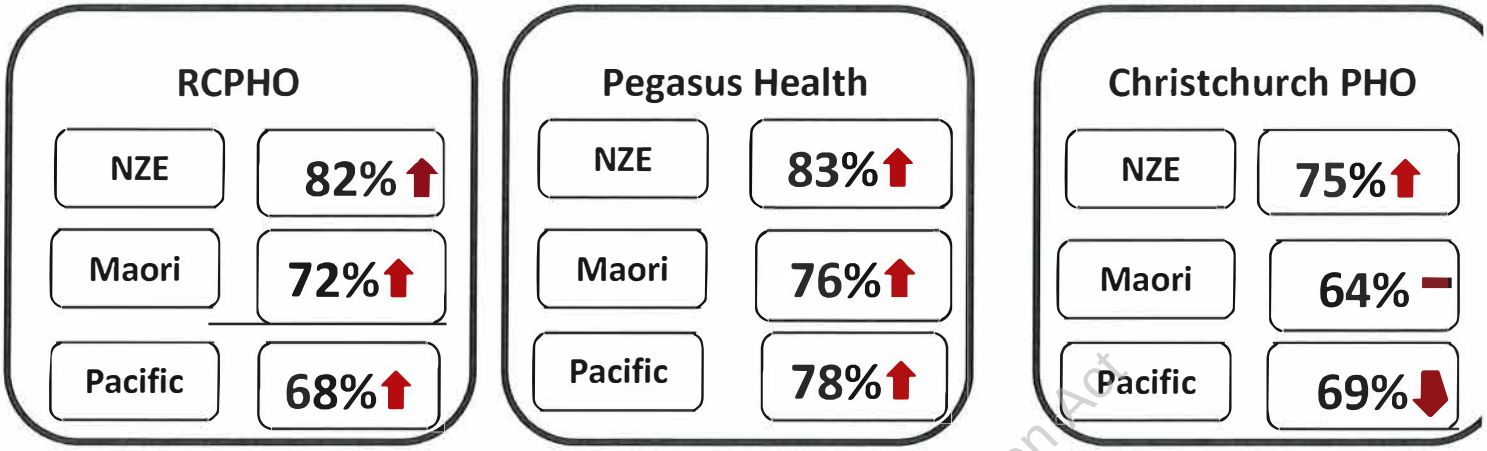
Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Progress	Q1 2015/16 Progress
95% fully	93.7% fully	94.8% fully	92.3% fully
.5% overdue	1.7% overdue	1% overdue	3.0% overdue

Fully Immunised 8month and two year olds - PHO LEVEL 30 Jan 2015

	8 month olds		2 year olds	
	Q3 Actual	Q4 Progress Including Pending	Q3 Actual	Q4 Progress Including Pending
RCPHO	94%	94%	93%	98%
Pegasus	96%	93%	94%	95%
Christchurch PHO	99%	95%	96%	97%

Pre teen Immunisations

11 vear old – PHO Level until 30 March 2014



HPV – Similar DHB Level All Doses Dec 13

See page below for HPV data

Immunisation Reporting Programme

The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
    - DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
    - Reporting periods
        - Q1 = 1 July – 30 September
        - Q2 = 1 October – 31 December
        - Q3 = 1 January – 31 March
        - Q4 = 1 April – 30 June
    - HPV Reporting – girls born in 1999 and 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.
    - Please email suggestions and feedback to NIRCanterbury@cdhb.govt.nz

As of 28 Feb 2015

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	214	61	138	1,323	1,736	390	110	190	2,260	2,950	55%	55%	73%	59%	59%	297 (10.1%)	0 (0.0%)
	HPV-2 Quadrivalent	199	56	134	1,257	1,646						51%	51%	71%	56%	56%	302 (10.2%)	
	HPV-3 Quadrivalent	185	51	126	1,193	1,555						47%	46%	66%	53%	53%	308 (10.4%)	
2000	HPV-1 Quadrivalent	190	46	155	1,168	1,559	420	100	200	2,230	2,940	45%	46%	78%	52%	53%	190 (6.5%)	0 (0.0%)
	HPV-2 Quadrivalent	174	41	152	1,105	1,472						41%	41%	76%	50%	50%	191 (6.5%)	
	HPV-3 Quadrivalent	146	33	142	1,006	1,327						35%	33%	71%	45%	45%	202 (6.9%)	
2001	HPV-1 Quadrivalent	157	43	99	1,066	1,365	420	110	190	2,290	3,010	37%	39%	52%	47%	45%	123 (4.1%)	0 (0.0%)
	HPV-2 Quadrivalent	134	37	92	976	1,239						32%	34%	48%	43%	41%	119 (4.0%)	
	HPV-3 Quadrivalent	105	24	76	839	1,044						25%	22%	40%	37%	35%	122 (4.1%)	
2002	HPV-1 Quadrivalent	152	35	80	933	1,200	390	100	160	2,310	2,970	39%	35%	50%	40%	40%	82 (2.8%)	1 (0.0%)
	HPV-2 Quadrivalent	123	31	74	828	1,056						32%	31%	46%	36%	36%	87 (2.9%)	
	HPV-3 Quadrivalent	84	22	63	643	812						22%	22%	39%	28%	27%	87 (2.9%)	
2003	HPV-1 Quadrivalent	130	29	61	805	1,025	390	110	180	2,150	2,830	33%	26%	34%	37%	36%	49 (1.7%)	1 (0.0%)
	HPV-2 Quadrivalent	80	18	47	600	745						21%	16%	26%	28%	26%	40 (1.4%)	
	HPV-3 Quadrivalent	27	6	22	268	323						7%	5%	12%	12%	11%	42 (1.5%)	
Total	HPV-1 Quadrivalent	843	214	533	5,295	6,885	2,010	530	920	11,240	14,700	42%	40%	286%	47%	47%	741 (5.0%)	2 (0.0%)
	HPV-2 Quadrivalent	710	183	499	4,766	6,158						35%	35%	267%	42%	42%	739 (5.0%)	
	HPV-3 Quadrivalent	547	136	429	3,949	5,061						27%	26%	229%	35%	34%	761 (5.2%)	

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
8 Month	1,547	1,474	95. %	807	778	96. %	222	209	94. %	75	75	100. %	201	197	98. %	242	215	89. %	17 ()	1.1 (0.0) %	36	2.3 %
12 Month	1,501	1,425	95. %	757	731	97. %	230	215	93. %	69	68	99. %	193	190	98. %	252	221	88. %	17 (2)	1.1 (0.1) %	43	2.9 %
18 Month	1,492	1,322	89. %	746	689	92. %	238	193	81. %	68	57	84. %	199	189	95. %	241	194	80. %	23 (1)	1.5 (0.1) %	48	3.2 %
24 Month	1,530	1,434	94. %	779	746	96. %	233	211	91. %	80	78	98. %	189	180	95. %	249	219	88. %	19 ()	1.2 (0.0) %	62	4.1 %
5 Year	1,654	1,470	89. %	880	813	92. %	268	235	88. %	84	78	93. %	159	138	87. %	263	206	78. %	21 (2)	1.3 (0.1) %	66	4.0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,518	1,298	86. %	379	315	83. %	309	270	87. %	329	288	88. %	274	238	87. %	227	187	82. %	0	0	-
8 Month	1,547	1,474	95. %	367	335	91. %	336	320	95. %	366	357	98. %	251	245	98. %	227	217	96. %	0	0	-
12 Month	1,501	1,425	95. %	395	366	93. %	341	327	96. %	302	288	95. %	255	243	95. %	208	201	97. %	0	0	-
18 Month	1,492	1,322	89. %	372	316	85. %	325	306	94. %	316	291	92. %	263	218	83. %	216	191	88. %	0	0	-
24 Month	1,530	1,434	94. %	402	365	91. %	339	320	94. %	343	328	96. %	237	222	94. %	209	199	95. %	0	0	-
5 Year	1,654	1,470	89. %	516	460	89. %	331	293	89. %	329	287	87. %	280	248	89. %	198	182	92. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	Maintain the Immunisation Service Level Alliance (SLA) with clinical leadership from across the system.	Ensure that CDHB is represented at all key national and regional immunisation forums.	On going	Canterbury DHB is represented at regional and national forums.	Everyone	
Before (and just after) Baby)	Support LMCS to promote and education pregnant women on Childhood Immunisation and the NIR Invest in free seasonal flu vaccinations pregnant women. Support LMC to provide free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children. Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Regular communication and linkages with LMCs Work with LMCs, Primary Care and Immunisation Services to develop a DHB plan for managing an monitoring new-born enrolments This piece of work is being led by CYWS	Q4	Monitor uptake of Influenza and Pertussis vaccination. 95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth. 98% of newborns are enrolled with general practice by 2 weeks. Develop relationships with services already working with children to focus on high needs, at risk children.	Planning and Funding to Lead P&F to link with CYWS to get feedback on this	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
Preschool immunisations	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Refining NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Supporting the Missed Event Coordinator and OIS to locate missing children. Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations, including offering NIR access. Continue to offer the Influenza vaccination to those under 18years of age.	Work with NIR, IC and OIS to ensure health and performance target children are monitor and referred in a timely manner Share PHO and Practice Milestone ages reports with practices. Undertake Assessment of OIS services. Providing recommendations to ISLA	Q2 on going	Quarterly performance reports circulated to PHOs, to review progress against targets. 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated Q2. 95% of all two-year-olds are fully immunised Child Health ward can check status and vaccinate overdue children. 40% of children receive the U18 Flu Vaccination	NIR, IC, OIS and P&F NIR P&F, ISLA	
Preteen immunisation	Maintain a HPV Programme in both a primary care setting and in schools by: • Continue to link 11-year-old and HPV immunisation events.	Maintain the HPV working group who will Develop an annual plan including	On going	70% of Girls have received dose 1 65% of girls have received dose 2	IPG AND HPV WORKING GROUP	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	• Continue to provide the Secondary School HPV Programme	communisations and monitor performance, and provide advice to ISLA and any service model changes.	On going	60% of girls have received dose 3		
Adult immunisation	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women.	Maintain the seasonal flu working group and develop a plan for the 2015 season.	Q2 Q4 On going	Seasonal flu plan developed 75% of people aged 65+ have a seasonal flu vaccination Q4.	IPG and Flu Working Group	
System Support	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week by: • Maintaining a Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates; • Maintaining streamlined access to immunisation awareness information; • Developing a plan for implementing Immunisation Week.	Review systems resources and ensure it is up-to-date Develop Immunisation Resources Group who will review all DHB and MoH immunisation resources and oversea the Immunisation Promotion programme	Q3 On going Q3 Q4	Annual update provided to practices Plan developed for Immunisation Week. Narrative report on interagency activities completed to promote Immunisation Week.	P&F, DHB Communisations and ICs	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Area	Action	Timeframe	Responslbity	Progress
Education	Develop an education programme for LMCs, to educate them on the importance of vaccinating during pregnancy.	February 2015	Margo to organise Tony to present	
	Regular message to LMC twice a year regarding the importance of vaccinations	February and July	Bridget	
	Link with DHB Maternity Outpatients to ensure they are advising women around vaccination	October 2014	Margo	
Information Linkages	Develop a way to link Maternity Suite Bookings back to General Practice (need to ID a way to notify practices of miscarriages). This will enable the practice to know who is pregnant and recall them at 30 weeks for vaccination. A draft letter to be developed to support this programme.	December 2014	Bridget and DHB IT	
	Develop a sticker for the Hand Held Maternity Notes books, to remind LMCs and Pregnant Women about when to vaccinate	December 2014	Bridget to develop and distribute Margo to educate LMCs	
	Update Pertussis section of Health Pathways to reflect key messages	December 2014	Margo to link with Di Bos	
Promotion	Update promotional material to include key messages	December 2014	Bridget, Margo and Mick	
Vaccination	Discussion vaccination of parents in NICU for at risk children	December 2014	Margo	

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora/Iwi Hauora

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❷		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children"	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. The HPV School programme has been put in place to pick up the girls not reached in the general practice programme.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Canterbury Clinical Network
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Canterbury Clinical Network - Register of Interests Current as at 28 October 2014	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Linda Hill	Chair – Immunisation Providers Group Regional Advisor IMAC
Margaret Kyle	CDHB LMC liaison LMC midwife Midwifery services advisor – Clinical researcher the New Zealand Institute of Community Health Care NZCOM midwifery standards reviewer Chair Canterbury/West Coast NZCOM
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding Member of IPG

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 17 March 2015	Time: 2-4.00pm
Present: Margaret Kyle (Chair) Dr Alison Wooding, Dr Sarah Marr, Bridget Lester, Anna Harwood, Dr Tony Walls, Linda Hill and Geraldine Clemens	
Apologies: Ramon Pink and Anne Feld	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Following some minor changes, minutes 3 Feb 2015 meeting were approved for Bridget to send to CCN.	Bridget	20 March
2.	**Previous Actions & Matters Arising**	• Bridget attempted to contact the MWWL, however with little success. Agree to not process with this any further. • Alison has drafted a letter to Pegasus, this just needs to be formatted and sent. • Vaccination in Pregnancy Resources – these have been updated, and are at the printers • Align pertussis with National programme – completed, however still need to work out NICU vaccination programme. • U18 Letter has gone to all secondary school. Only received feedback from 1 school • HPV Consultation feedback went to MoH. • GP update – this has been drafted, and just need to arrange for it to be sent. • Work plan, U18 removed for the 2015/16 plan. • Immunisation week plan has been sent to the MoH • Maori health plans – sections updated.	Bridget to format and send to Alison and Sarah Bridget to progress	20 March
3.	**ISLA Work plan**	**Q3 data** = 95% 8month olds, 94% 2 year olds. It appears we will reach health target this quarter. Need to follow up with PHOs regarding 11year old data. Also need to look at developing a process to monitor 4 year old performance. **Vaccinations in Pregnancy** – Information packages will be sent once the Flyer and Sticker are updated and printed. **HPV** – A new HPV coordination's has been appointed. Process is underway for the 2015 school programme. Good return rate for consent for this year. Working relationship with schools also seems to be a lot better. **Seasonal Influenza** – The delay in the vaccine being received will have an impact on general practice.	Sarah and Alison, Bridget to share practice data with them for letter. Bridget to update risk register	10 March

	Item	Discussion/Action	Responsibility	Date due
		However this is a national issues. Practices advised to target subsided groups and referral non-subsided group to Pharmacy. The national comms programme has been shared, and the CDHB will build on this instead of doing our own programme in 2015.		
4.	**HPV model discussion**	Paper presented to ISLA. Tony indicated that there may be changing coming to the schedule and to follow up with PHARMAC. **Acton: Approve paper to go to AST on 9th April. Approved model.** **Follow up with PHARMAC and link changes in to paper.**	Bridget	
5.	**Immunisation Week**	Going to be low key this year, with no major adverting programme. However approaching Pharmacy, The Warehouse, and General practice and DHB sites to put up displays. Winning displays will win a morning tea. Also approaching ECEs to promote the 4 year old event.	Bridget	31 March
6.	**Maori Health Plan**	Sections updated and approved by ISLA		

7.	**Operational**	• **Risk Register** - Change Risk Register as we are not going to reach the 2year old target.
		• **Interest Register** - No changes
		• **CCN Website** - Meagan presented the updated CCA Website. We need to look at ISLA section and feedback by 25th March
		• **Terms of reference**
		  o IPG updated TOR approved
		  o Updated ISLA TOR to reflect membership changes.
			Bridget	25 March

8.	**Next Meeting**	28 April 2015 2-4pm at C&PH Meeting dates for 2015 • 2 June 2015 • 21 July 2015 • 25 August 2015 • 29 September 2015 • 3 November 2015 • 15 December 2015		

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 29 May 2015 3:17 p.m.
To: 'Alison Wooding'; 'Anne Feld'; 'Geraldine Clemens'; Heather Burns; 'Linda Hill'; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'Michael McIlhone'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Agenda: ISLA meeting 2 June 2015
Attachments: 100623 CCNDA Charter FINAL.pdf; 2 June 2015 draft agenda.docx; Draft minutes 28 april ISLA meeting.docx; Imms Reporting Template June ISLA.docx; ISLA 2014 15 workplan.docx

Hi all

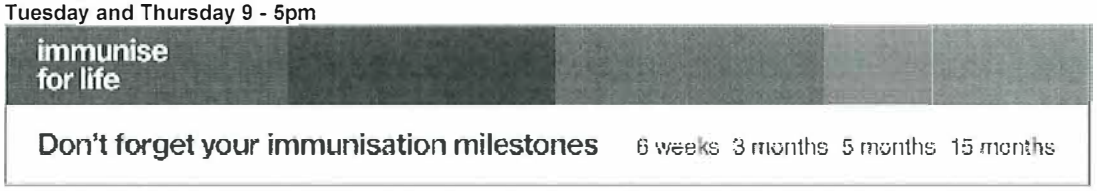
Please find attached the agenda for next Tuesdays ISLA meeting.

Papers include
Agenda
Minutes of last meeting
ISLA Work plan
Data Report
Interest Register
Risk Register
CCN Charter

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm



Canterbury Clinical Network
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ALLIANCE LEADERSHIP TEAM CHARTER

This Charter document outlines our commitments and the key principles and "rules of engagement" we will follow as members of the Canterbury Clinical Network Alliance Leadership Team, and/or Service Alliance Leadership Teams, for the Canterbury Clinical Network District Alliance.

We are members of a group of key clinical leaders, key managers from provider organisations, and the Canterbury District Health Board, who have been selected to successfully lead our Alliance to achieve its objectives. We have been selected not as representatives of specific organisations or communities of interest, but because collectively we provide the range of competencies required for our Alliance to achieve success.

While we serve at different levels within the Alliance framework, we share common objectives and commitments which are outlined in this Charter. The Charter should be read together with, and our actions and decisions must have regard to, the Canterbury Clinical Network District Alliance Agreement ("the Agreement").

PURPOSES

Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations, as outlined in the Agreement. We aim to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a 'best for patient, best for system' framework.

In the first instance, our priority is to implement the Canterbury Clinical Network Implementation Plan.

PRINCIPLES

The foundation of our Agreement is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system'. As a leadership team we will conduct ourselves and undertake our leadership role in a manner consistent with the Alliance principles, set out in the Agreement. These include:

- We will support clinical leadership, and in particular clinically-led service development;
- We will conduct ourselves with honesty and integrity, and develop a high degree of trust;
- We will promote an environment of high quality, performance and accountability, and low bureaucracy;
- We will strive to resolve disagreements co-operatively, and wherever possible achieve consensus decisions;
- We will adopt a patient-centred, whole-of-system approach and make decisions on a Best for System basis;
- We will seek to make the best use of finite resources in planning health services to achieve improved health outcomes for our populations;
- We will balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural and urban populations;
- We will adopt and foster an open and transparent approach to sharing information; and
- We will actively monitor and report on our alliance achievements, including public reporting.

We acknowledge there are some areas where the DHB may exercise a reserved power as outlined in the Agreement. We understand the DHB will exercise its reserved powers in good faith and will consult with the Alliance Leadership Team before exercising a reserved power (subject to any need for urgency).

COMMITMENTS

We will work closely and collaboratively with our team members, in an innovative and open manner, to produce outstanding results. To achieve this we make the following commitments:

- **Shared responsibility:** We will actively address all tasks and duties of our role as members of our leadership team, and will comply with the operational provisions and guidance for our team, as set out in the Agreement.
- **Shared decision-making:** We agree that our decisions will be made by consensus. We will use our best endeavours to facilitate unanimous decisions, and will not prevent a consensus being reached for trivial or frivolous reasons.
- **Shared accountability:** We agree that we will have a robust airing of views, but that once our team has reached a decision we will all abide by that decision and support it publicly. (This includes keeping confidential the views of particular individuals expressed during the discussion, but does not prevent us sharing the issues that were balanced in reaching that decision.)
- **Good faith:** We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.
- **Treaty of Waitangi:** We agree that the Treaty of Waitangi establishes the unique and special relationship between Iwi, Māori and the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.
- **Confidentiality:** To encourage the open and transparent sharing of information we agree to keep confidential matters shared on a confidential basis, to enable improved decision-making.
- **Active engagement:** We agree our members' continuous involvement in and attendance at our team meetings is critical, and will make every effort to attend and participate fully.

If a member of our team does not act in accordance with our principles and commitments, our team will discuss the situation with the member involved. If no resolution can be found, that member may be removed in accordance with the process outlined in the Agreement.

MANDATE AND FUNCTIONS

Canterbury Clinical Network Alliance Leadership Team

For members of the Canterbury Clinical Network Alliance Leadership Team, our role is set out in the Agreement. Broadly, our functions are to:

- Agree our Alliance Objectives and Key Results Areas within the scope of our Alliance Activities *(in the first instance, this will be the scope of services included in the business case),* including the systems and KPIs for assessing achievement of these;
- Agree the work, activity and services that need to be provided to meet our Alliance Objectives;

- Make recommendations on the method and form of contracting to give effect to agreed priorities and service delivery mechanisms, on a best practice basis;
- Monitor the outcomes of Alliance Activities, and use that information to inform our stakeholders (particularly our populations) and to guide further decisions on prioritisation and service change;
- Develop a process for how our alliance will annually review its scope and objectives, to keep refreshing our strategy and approach to meet our Alliance Objectives;
- Determine, run and review an agreed process for refreshing our membership;
- Discuss with the DHB any potential exercise of a reserved power.

In respect of any Service Alliances, our role is to:

- Establish service alliances and other working groups as necessary to oversee the development and delivery of services that fall within scope of our Alliance, including determining the scope and objectives and approving the membership of such service alliances, and disestablishing groups as required;
- Provide system-level oversight and monitoring of the work done by service alliances, and ensuring connectedness and a whole of system approach to alliance activities;
- Adjudicate should any disputes arise within a service alliance that are unable to be resolved at that level.

Service Alliance Leadership Team

For members of the Service Alliance Leadership Team, the scope of our activities and decision-making is as determined on establishment of our Service Alliance, by the Canterbury Clinical Network Alliance Leadership Team. Within that scope our role is broadly to review all aspects of the delivery of those health services to patients and develop new approaches to improve their effectiveness and quality. This includes deciding how such improvements would best be implemented, taking into account our fixed resources.

RELEASE OF LIABILITY

As members of a leadership team for the Canterbury Clinical Network District Alliance, we are committed to direct and lead the Alliance in accordance with this Charter and the provisions in the Agreement. It is not our intention that our actions as members of our leadership team will give rise to an action in law from alliance participants or other members of our leadership team.

COMMITMENT TO SERVE

On the basis of the above, I agree to serve as a member of a leadership team for the Canterbury Clinical Network District Alliance.

Signed: _____

Name: _____

Date: _____

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 2 June 2015, 2-4pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Linda Hill:
Anne Feld : Apology	Margaret Kyle: Apology
Anna Harwood:	Dr Sarah Marr:
Dr Tony Walls:	Geraldine Clemens:
Michael McIlhone:	

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions - Michael**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 28 april ISLA meeting.d
4	2.15pm	**Immunisation Promotion – Flu and Imms for Life**	Vicky Hewitt	
5.	2.30pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI**	Bridget Lester	ISLA 2014 15 workplan.docx Imms Reporting Template June ISLA.
5	2.45pm	**HPV Year 8 programme update**	Bridget Lester	
6.	3.00pm	**Operational** • **Interest register** • **Risk Register** • **CCN Charter**	Ramon Pink	Risk Register Dec.docx Interests register 28 Oct 2014.docx 100623 CCNDA Charter FINAL.pdf
8.	3.40pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Letter to Pegasus regarding Helios – update this	Bridget	8 May 2015
GP letter follow up	Bridget	8 May 2015
Update Risk Register – DHB staff flu vax and	Bridget	8 May 2015
HPV Model – update paper and send to ISLA via email for approval	Bridget	8 May 2015

Next meeting: 21 July 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 28 April 2015	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Dr Alison Wooding, Dr Sarah Marr, Bridget Lester, Linda Hill and Geraldine Clemens	
Apologies: Anna Harwood, Tony Walls, Michael McIlhone and Anne Feld	
Notes cc'd to: CCN Programme Office	

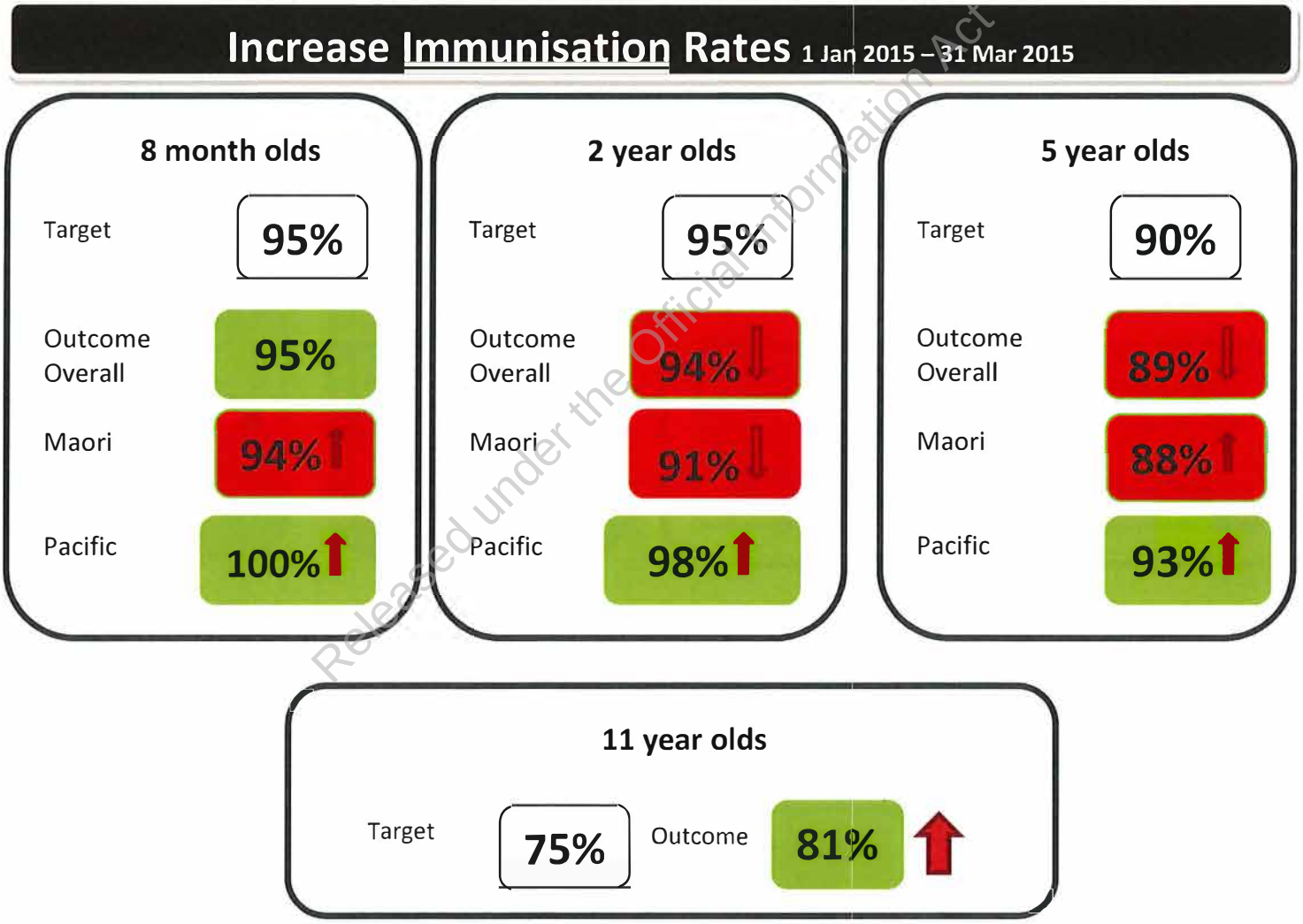
	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Following some minor changes to the, minutes 17th Match meeting and then approved for Bridget to send to CCN. • The ALT has appointed Michael Mclhone as the new ALT representative and sponsor.	Bridget	1 May
2.	**Previous Actions & Matters Arising**	• Letter needs to be reframed to capture current DHB performance. • GP update and pregnancy resources – these have been updated and gone out. There was a question around the GP letter. Bridget to follow up to see who this was sent too	Bridget Bridget	1 May
3.	**Flu and Immunisation Promotion update**	Vicky updated ISLA on the national flu promotional programme. The CDHB will be supporting this programme and might enhance it once the national commitment ends in June. The agreement with Strategy for Immunise for Life has ended and all future planning will occur in gin house.		
4.	**ISLA Work plan**	**Q3 data** = 95% 8month olds, 94% 2 year olds. DHB reached national health target. Have received 11year old data from PHO, at 81% Q4 – 8m = 92% and will be difficult to reach 95%. Work has started on 4year olds there appears to be a large number of children overdue for 4year old Immunisations Immunisation Week – this was last week. Communications went to Early Childhood, Pharmacy and The Warehouse. Flu – there is concern around access to vaccine. There is also concern around the delay in the DHB staff programme. Add this is risk register.	 Bridget	10 March
5.	**HPV year8 programme**	The shift to a year 8 outreach programme was approved by ALT. Approval was sought by ISLA to start the implementation of this programme. This will consist of the following	Bridget	

	Item	Discussion/Action	Responsibility	Date due
		• Mixed model – with a Host PHO and Vaccination team mix • Approval needs to be sought by the PHOs as to how should be the Host PHO • A DHB wide steering group to be established for the implementation. This will include PHNS, current HPV Team, Planning and Funding, PHOs, Education, Immunisation Coordinator and Maori representations. • Planning and Funding to undertake initial project management and implementation. • More clarity needs to be provided between the roles and responsible between the Coordination Team and Vaccinating team. • Links need to be developed with MoE.		
6.	**Operational**	• **Risk Register** – Update to include declines risk and DHB staff risk. • **Interest Register** – Check with Michael • **CCN Website** – Bridget still needs to complete this.	Bridget	8 May
7.	**Next Meeting**	2 June 2015 2-4pm at C&PH Meeting dates for 2015 • 21 July 2015 • 25 August 2015 • 29 September 2015 • 3 November 2015 • 15 December 2015		

our health system

Key Performance Indicators and Childhood Immunisation Reporting

June 2015



Childhood Immunisation – MoH Health Targets up until 29 May 2015

Fully Immunised 8 month olds – DHB LEVEL

Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Progress including pending	Q1 2015/16 Progress including pending
93% fully	95.3% fully	93.66% fully	85% fully
1.8% overdue	1.2% overdue	.4% could reach	11% could reach

Fully Immunised Two year olds - DHB LEVEL

Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Progress	Q1 2015/16 Progress
95% fully	93.7% fully	95% fully	86% fully
.5% overdue	1.7% overdue	.2% overdue	9.3% overdue

Fully Immunised Four year olds - DHB LEVEL

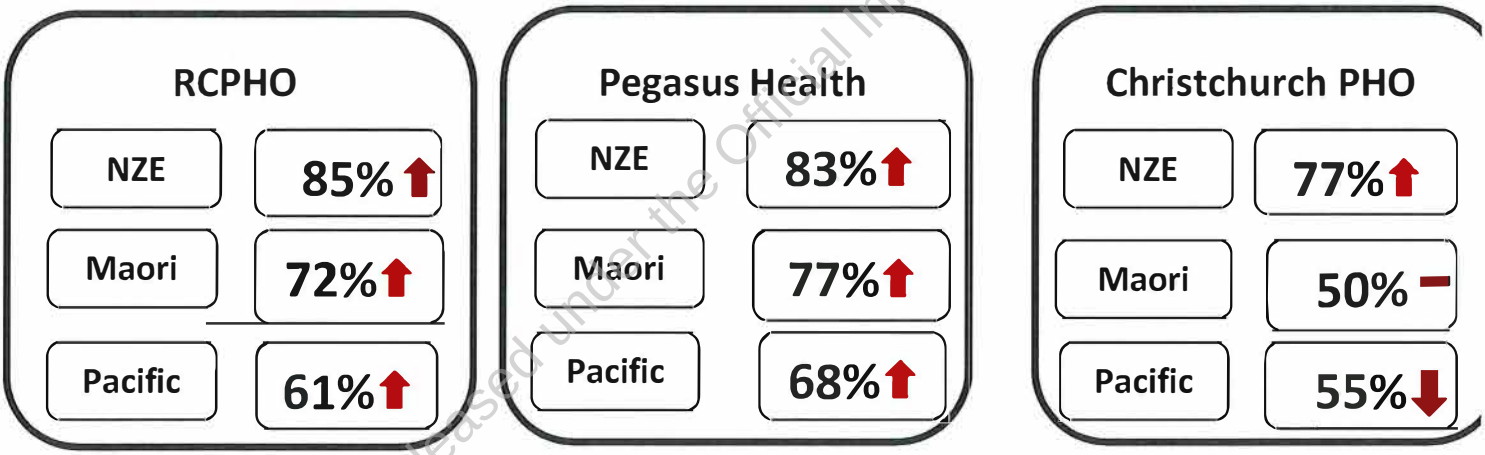
Q2 2014/15 Actual	Q3 2014/15 Actual	Q4 2014/15 Progress	Q1 2015/16 Progress
0 fully	89% fully	0% fully	92% fully
0 overdue	5.6% overdue	0% overdue	3.5% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 29 May 2015

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		4 year olds	
Christchurch PHO	99%	95%	96%	97%	88%	
Pegasus	96%	95%	94%	95%	89%	
Rural Canterbury	94%	93%	93%	98%	75%	

Pre teen Immunisations

11 year old – PHO Level until 31 December 2014



HPV – Similar DHB Level All Doses Dec 13

See page below for HPV data

Immunisation Reporting Programme

The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

- DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
- Reporting periods
    - Q1 = 1 July – 30 September
    - Q2 = 1 October – 31 December
    - Q3 = 1 January – 31 March
    - Q4 = 1 April – 30 June
- HPV Reporting – girls born in 1999 and 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.
- Please email suggestions and feedback to NIRCanterbury@cdhb.govt.nz

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	220	62	145	1,336	1,763	390	110	190	2,260	2,950	56%	56%	76%	59%	60%	299 (10.1%)	0 (0.0%)
	HPV-2 Quadrivalent	204	57	137	1,276	1,674						52%	52%	72%	56%	57%	305 (10.3%)	
	HPV-3 Quadrivalent	188	51	131	1,207	1,577						48%	46%	69%	53%	53%	312 (10.6%)	
2000	HPV-1 Quadrivalent	220	61	189	1,348	1,818	420	100	200	2,230	2,940	52%	61%	95%	60%	62%	233 (7.9%)	0 (0.0%)
	HPV-2 Quadrivalent	181	44	153	1,134	1,512						43%	44%	77%	51%	51%	233 (7.9%)	
	HPV-3 Quadrivalent	150	38	146	1,045	1,379						36%	38%	73%	47%	47%	245 (8.3%)	
2001	HPV-1 Quadrivalent	178	52	111	1,191	1,532	420	110	190	2,290	3,010	42%	47%	58%	52%	51%	142 (4.7%)	0 (0.0%)
	HPV-2 Quadrivalent	147	38	96	1,024	1,305						35%	35%	51%	45%	43%	140 (4.7%)	
	HPV-3 Quadrivalent	114	26	80	887	1,107						27%	24%	42%	39%	37%	145 (4.8%)	
2002	HPV-1 Quadrivalent	163	36	86	1,000	1,285	390	100	160	2,310	2,970	42%	36%	54%	43%	43%	88 (3.0%)	1 (0.0%)
	HPV-2 Quadrivalent	129	32	78	886	1,125						33%	32%	49%	38%	38%	93 (3.1%)	
	HPV-3 Quadrivalent	103	23	68	711	905						26%	23%	43%	31%	30%	94 (3.2%)	
2003	HPV-1 Quadrivalent	145	33	69	884	1,131	390	110	180	2,150	2,830	37%	30%	38%	41%	40%	53 (1.9%)	1 (0.0%)
	HPV-2 Quadrivalent	102	25	58	731	916						26%	23%	32%	34%	32%	47 (1.7%)	
	HPV-3 Quadrivalent	42	8	32	390	472						11%	7%	18%	18%	17%	48 (1.7%)	
Total	HPV-1 Quadrivalent	926	244	600	5,759	7,529	2,010	530	920	11,240	14,700	46%	46%	321%	51%	51%	815 (5.5%)	2 (0.0%)
	HPV-2 Quadrivalent	763	196	522	5,051	6,532						38%	37%	280%	45%	44%	818 (5.6%)	
	HPV-3 Quadrivalent	597	146	457	4,240	5,440						30%	28%	244%	38%	37%	844 (5.7%)	

As of 30/04/2015

Q3 2014/15 31 March 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
8 Month	1,547	1,474	95. %	807	778	96. %	222	209	94. %	75	75	100. %	201	197	98. %	242	215	89. %	17 ()	1.1 (0.0) %	36	2.3 %
12 Month	1,501	1,425	95. %	757	731	97. %	230	215	93. %	69	68	99. %	193	190	98. %	252	221	88. %	17 (2)	1.1 (0.1) %	43	2.9 %
18 Month	1,492	1,322	89. %	746	689	92. %	238	193	81. %	68	57	84. %	199	189	95. %	241	194	80. %	23 (1)	1.5 (0.1) %	48	3.2 %
24 Month	1,530	1,434	94. %	779	746	96. %	233	211	91. %	80	78	98. %	189	180	95. %	249	219	88. %	19 ()	1.2 (0.0) %	62	4.1 %
5 Year	1,654	1,470	89. %	880	813	92. %	268	235	88. %	84	78	93. %	159	138	87. %	263	206	78. %	21 (2)	1.3 (0.1) %	66	4.0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,518	1,298	86. %	379	315	83. %	309	270	87. %	329	288	88. %	274	238	87. %	227	187	82. %	0	0	-
8 Month	1,547	1,474	95. %	367	335	91. %	336	320	95. %	366	357	98. %	251	245	98. %	227	217	96. %	0	0	-
12 Month	1,501	1,425	95. %	395	366	93. %	341	327	96. %	302	288	95. %	255	243	95. %	208	201	97. %	0	0	-
18 Month	1,492	1,322	89. %	372	316	85. %	325	306	94. %	316	291	92. %	263	218	83. %	216	191	88. %	0	0	-
24 Month	1,530	1,434	94. %	402	365	91. %	339	320	94. %	343	328	96. %	237	222	94. %	209	199	95. %	0	0	-
5 Year	1,654	1,470	89. %	516	460	89. %	331	293	89. %	329	287	87. %	280	248	89. %	198	182	92. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	Maintain the Immunisation Service Level Alliance (SLA) with clinical leadership from across the system.	Ensure that CDHB is represented at all key national and regional immunisation forums.	On going	Canterbury DHB is represented at regional and national forums.	Everyone	
Before (and just after) Baby)	Support LMCS to promote and education pregnant women on Childhood Immunisation and the NIR Invest in free seasonal flu vaccinations pregnant women. Support LMC to provide free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children. Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Regular communication and linkages with LMCs Work with LMCs, Primary Care and Immunisation Services to develop a DHB plan for managing an monitoring new-born enrolments This piece of work is being led by CYWS	Q4	Monitor uptake of Influenza and Pertussis vaccination. 95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth. 98% of newborns are enrolled with general practice by 2 weeks. Develop relationships with services already working with children to focus on high needs, at risk children.	Planning and Funding to Lead P&F to link with CYWS to get feedback on this	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
Preschool immunisations	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Refining NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Supporting the Missed Event Coordinator and OIS to locate missing children. Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations, including offering NIR access. Continue to offer the Influenza vaccination to those under 18years of age.	Work with NIR, IC and OIS to ensure health and performance target children are monitor and referred in a timely manner Share PHO and Practice Milestone ages reports with practices. Undertake Assessment of OIS services. Providing recommendations to ISLA	Q2 on going	Quarterly performance reports circulated to PHOs, to review progress against targets. 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated Q2. 95% of all two-year-olds are fully immunised Child Health ward can check status and vaccinate overdue children. 40% of children receive the U18 Flu Vaccination	NIR, IC, OIS and P&F NIR P&F, ISLA	
Preteen immunisation	Maintain a HPV Programme in both a primary care setting and in schools by: • Continue to link 11-year-old and HPV immunisation events.	Maintain the HPV working group who will Develop an annual plan including	On going	70% of Girls have received dose 1 65% of girls have received dose 2	IPG AND HPV WORKING GROUP	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Immunise for Life	ACTIONS (What action will we take to make this happen?)	TASKS	TIMEFRAME	MEASURE OF SUCCESS (How will we demonstrate achievement/change?) TARGET	RESPONSIBILITY	PROGRESS
	• Continue to provide the Secondary School HPV Programme	communisations and monitor performance, and provide advice to ISLA and any service model changes.	On going	60% of girls have received dose 3		
Adult immunisation	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women.	Maintain the seasonal flu working group and develop a plan for the 2015 season.	Q2 Q4 On going	Seasonal flu plan developed 75% of people aged 65+ have a seasonal flu vaccination Q4.	IPG and Flu Working Group	
System Support	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week by: • Maintaining a Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates; • Maintaining streamlined access to immunisation awareness information; • Developing a plan for implementing Immunisation Week.	Review systems resources and ensure it is up-to-date Develop Immunisation Resources Group who will review all DHB and MoH immunisation resources and oversea the Immunisation Promotion programme	Q3 On going Q3 Q4	Annual update provided to practices Plan developed for Immunisation Week. Narrative report on interagency activities completed to promote Immunisation Week.	P&F, DHB Communisations and ICs	

Immunisation SLA Work plan 2014/15

Increase Immunisation Coverage: To reduce vaccine-preventable diseases and support people to stay well

Area	Action	Timeframe	Responslbity	Progress
Education	Develop an education programme for LMCs, to educate them on the importance of vaccinating during pregnancy.	February 2015	Margo to organise Tony to present	
	Regular message to LMC twice a year regarding the importance of vaccinations	February and July	Bridget	
	Link with DHB Maternity Outpatients to ensure they are advising women around vaccination	October 2014	Margo	
Information Linkages	Develop a way to link Maternity Suite Bookings back to General Practice (need to ID a way to notify practices of miscarriages). This will enable the practice to know who is pregnant and recall them at 30 weeks for vaccination. A draft letter to be developed to support this programme.	December 2014	Bridget and DHB IT	
	Develop a sticker for the Hand Held Maternity Notes books, to remind LMCs and Pregnant Women about when to vaccinate	December 2014	Bridget to develop and distribute Margo to educate LMCs	
	Update Pertussis section of Health Pathways to reflect key messages	December 2014	Margo to link with Di Bos	
Promotion	Update promotional material to include key messages	December 2014	Bridget, Margo and Mick	
Vaccination	Discussion vaccination of parents in NICU for at risk children	December 2014	Margo	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 16 July 2015 1:30 p.m.
To: 'Alison Wooding'; 'Anne Feld'; 'Geraldine Clemens'; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: 21 July 2015 ISLA Agenda
Attachments: 21 July 2015 draft agenda.docx; 201516 workplan.docx; WC Imms Reporting July 2015 Summary.docx; Draft minutes ISLA 2 June meeting.docx; Risk Register April.docx; Interests register 28 Oct 2014.docx

Hi all

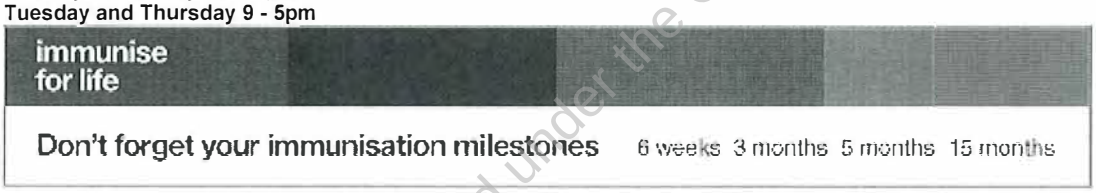
Please find attached the agenda and papers for next Tuesday ISLA meeting.

Please note this will be a shorter meeting from 2 – 3.30pm

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm



From: Bridget Lester
Sent: Tuesday, 14 July 2015 11:55 a.m.
To: Ramon Pink
Subject: 21 July 2015 draft agenda

Hi Ramon
As discussed – draft agenda for our ISLA meeting next week.

If you are ok with this, I will send out to the membership.

Regards Bridget

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 21 July 2015, 2-3.30pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld : Apology	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes ISLA 2 June meeting.doc
5.	2.30pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI**	Bridget Lester	201516 workplan.docx Imms Reporting Template July 2015
5	2.45pm	**HPV Year 8 programme update**	Bridget Lester	Discussion
6.	3.00pm	**Operational** • **Membership changes** • **IPG Chairperson** • **Meeting schedule** • **Interest register** • **Risk Register** • **CCN Charter**	Ramon Pink	Risk Register Dec.docx Interests register 28 Oct 2014.docx
8.	3.40pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Letter to Pegasus regarding Helios – update this	Bridget	17 July 2015
GP letter follow up	Bridget	17 July 2015

Next meeting: 21 July 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2014/15

	8 month olds	2 year olds	5 year olds
Target	95%	95%	80%
Outcome Overall	85% ⬇	90% ⬆	80% ⬇
Maori	80% ⬇	100% ⬆	86% ⬆
Pacific	50% ⬇	100% ⬆	100%

The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

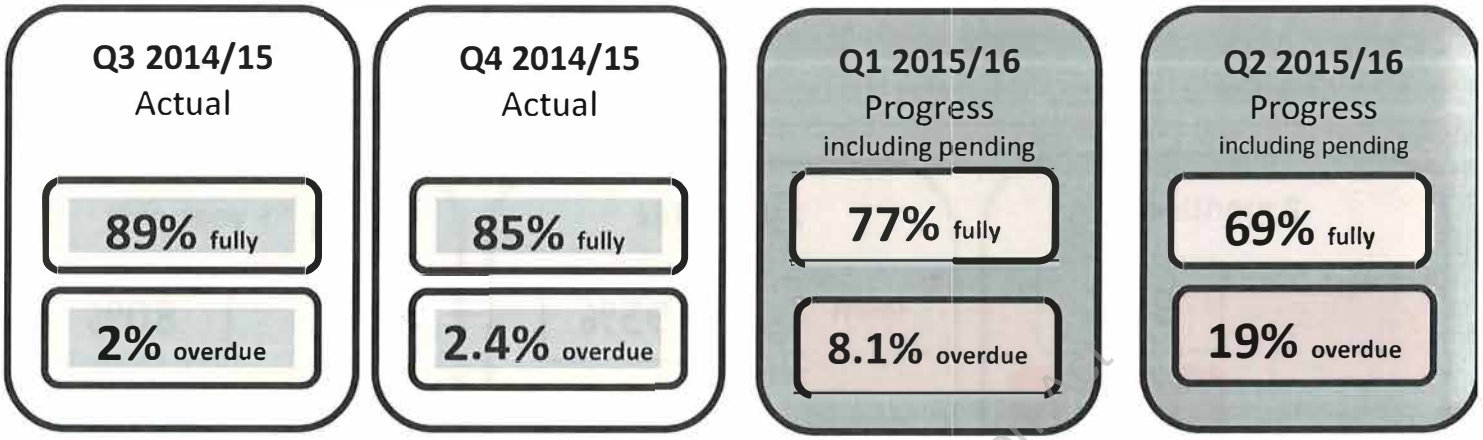
Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

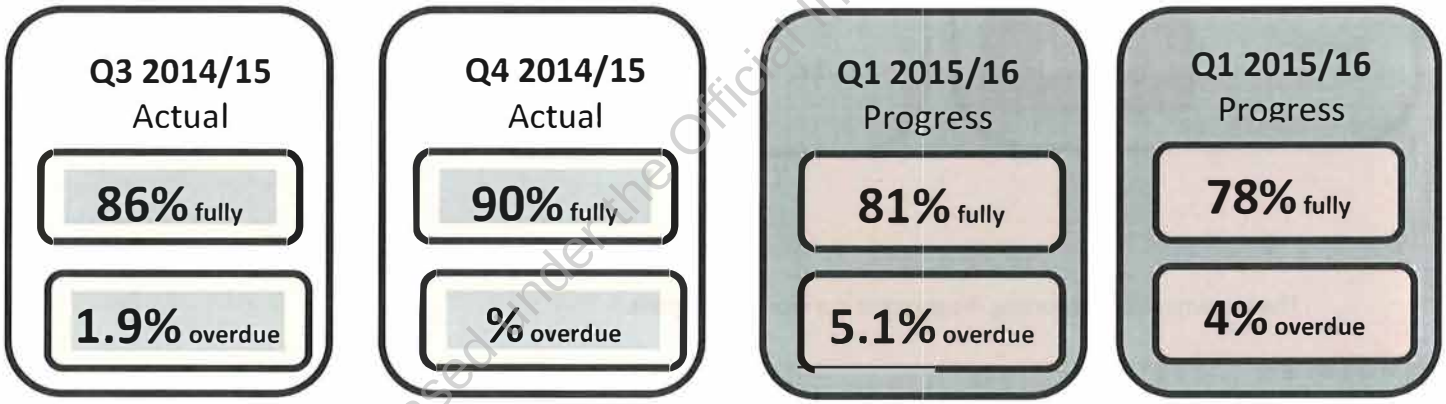
HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 10 July 5

Fully Immunised 8 month olds – DHB LEVEL



Fully Immunised Two year olds - DHB LEVEL



By practice outcomes (please note this excludes our children who have opted off the NIR)

Q4 2014/15 –Actual - 8month old

Q4 2014/2015 – Actual - 2 year olds

8 month Q1 2015/16 – In progress

2 year olds Q1 2015/16 In progress

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	82	66	80. %	45	40	89. %	23	18	78. %	1	1	100. %	5	5	100. %	8	2	25. %	6 (0)	7.3 (0.0) %	2	2.4 %
8 Month	95	81	85. %	55	52	95. %	20	16	80. %	2	1	50. %	7	7	100. %	11	5	45. %	6 (0)	6.3 (0.0) %	6	6.3 %
12 Month	91	83	91. %	54	52	96. %	18	16	89. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.4 (0.0) %	2	2.2 %
18 Month	107	81	76. %	54	47	87. %	21	18	86. %	3	3	100. %	5	5	100. %	24	8	33. %	16 (0)	15.0 (0.0) %	7	6.5 %
24 Month	90	81	90. %	44	42	95. %	25	25	100. %	4	4	100. %	5	5	100. %	12	5	42. %	7 (0)	7.8 (0.0) %	2	2.2 %
5 Year	113	90	80. %	63	58	92. %	22	19	86. %	3	3	100. %	3	3	100. %	22	7	32. %	11 ()	9.7 (0.0) %	8	7.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	82	66	80. %	6	6	100. %	17	15	88. %	21	19	90. %	18	14	78. %	20	12	60. %	0	0	-
8 Month	95	81	85. %	6	6	100. %	24	23	96. %	14	13	93. %	28	25	89. %	23	14	61. %	0	0	-
12 Month	91	83	91. %	12	12	100. %	26	26	100. %	17	17	100. %	21	20	95. %	15	8	53. %	0	0	-
18 Month	107	81	76. %	7	5	71. %	17	13	76. %	26	24	92. %	28	27	96. %	29	12	41. %	0	0	-
24 Month	90	81	90. %	12	11	92. %	21	20	95. %	7	7	100. %	25	25	100. %	25	18	72. %	0	0	-
5 Year	113	90	80. %	16	14	88. %	17	16	94. %	27	25	93. %	28	24	86. %	25	11	44. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

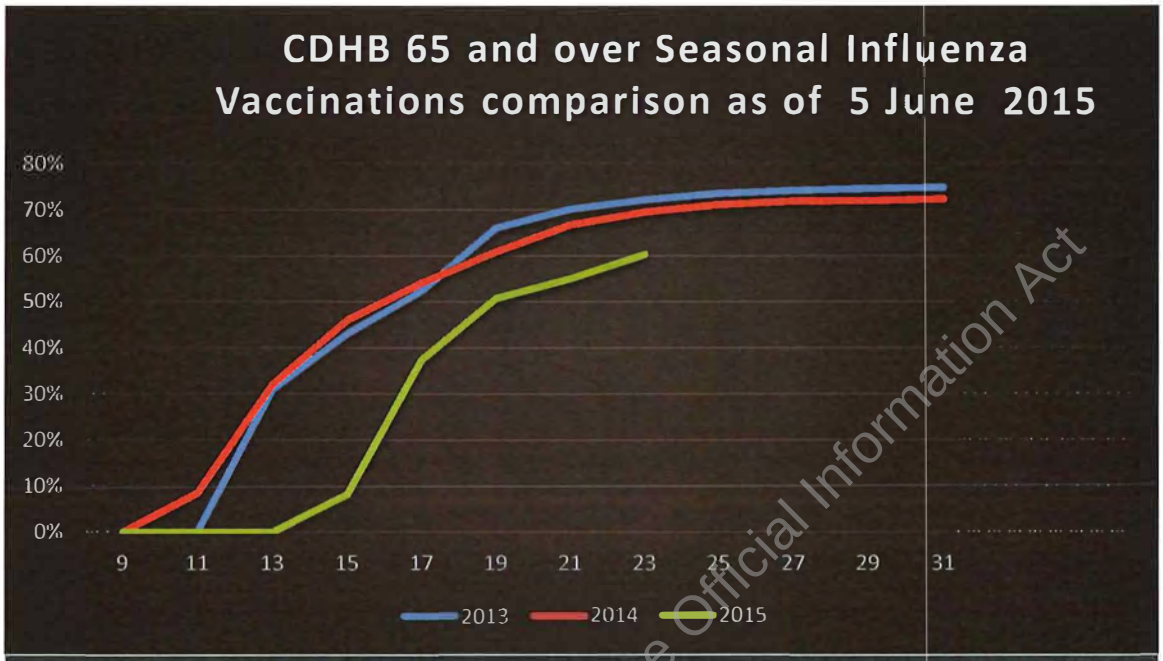
Immunisation Service Level Alliance
Action Notes/Minutes

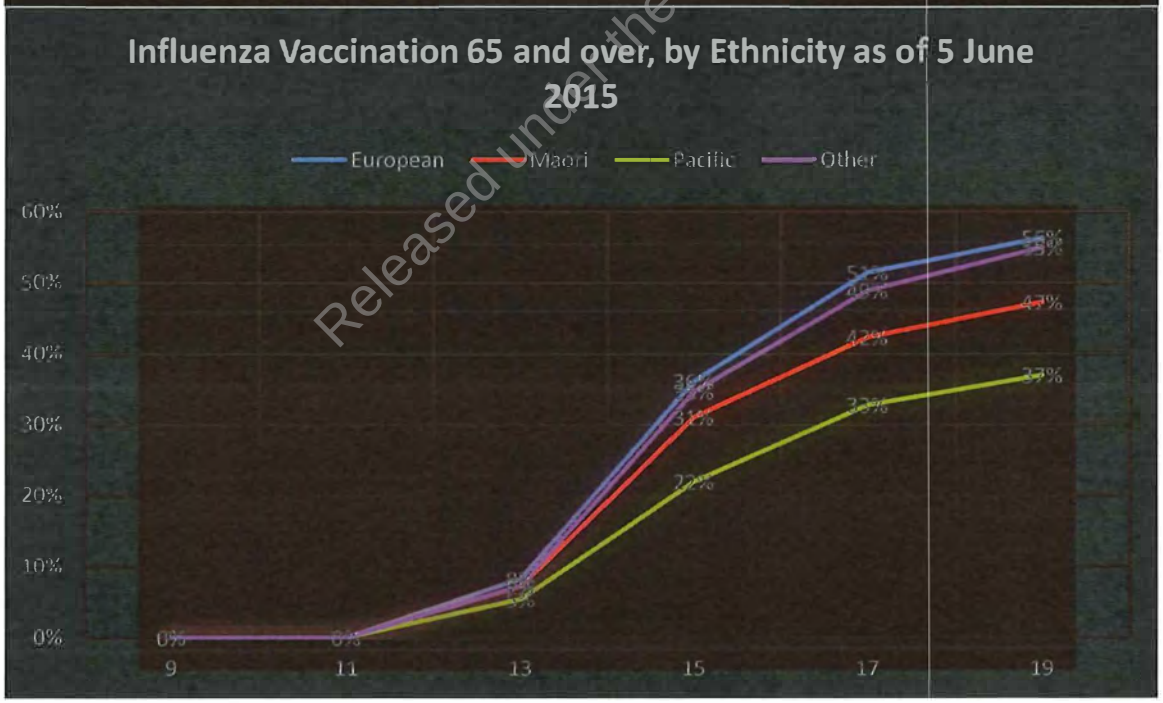
Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 2 June 2015	Time: 2-4.00pm
Present: Ramon Pink (Chair), Dr Alison Wooding, Dr Sarah Marr, Bridget Lester, Linda Hill, Anna Harwood, Tony Walls, Anne Feld and Geraldine Clemens	
Apologies: Michael McIlhone and Margaret Kyle	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 28 April were approved to go to the CCN office.	Bridget	5 June
2.	**Previous Actions & Matters Arising**	• Letter has been redraft, but agree further work needs to occur. • GP letter appears to have been sent to practices not GPs. Agree we need to update letter to include changes to HPV programme.	Bridget Bridget	19 June 30 June
3.	**ISLA Work plan**	Q4 data = progressing towards 94% 8month olds, 95% 2 year olds. Q1 = progress current sitting at 85% for 8month year old. MoH has asked DHB to focus on reaching Q1 2015/16 target. We might be able to do this with a shift in resources. This will also be the first quarter of the 5year old performance target. Current tracking see us on 92% Flu – good progress, but about 2weeks behind last year at the same time, but this is due to the late arrive of the vaccine. Please see graphs below.		
4.	**HPV year8 programme**	Discussion around the service model for the HPV programme. Agreed • PHNS to be vaccinating team, as they have the relationship with school. • Vaccinating team to be responsible for consenting process in schools and managing the cold chain.		
5.	**Operational**	• **Risk Register** – No updated required • **Interest Register** – Check with Michael • **CCN Website** – updated • **CCN Charter** – all Alliance members need to sign the CCN Charter. Tony, Anna, Anne and Sarah signed this. Bridget to scan all signed form and send to CCN office.	Bridget	12 June

	Item	Discussion/Action	Responsibility	Date due
6.	**Next Meeting**	21 July 2015 2-4pm at C&PH Meeting dates for 2015 • 25 August 2015 • 29 September 2015 • 3 November 2015 • 15 December 2015		





CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children"	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. The HPV School programme has been put in place to pick up the girls not reached in the general practice programme.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 28 October 2014	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Linda Hill	Chair – Immunisation Providers Group Regional Advisor IMAC
Margaret Kyle	CDHB LMC liaison LMC midwife Midwifery services advisor – Clinical researcher the New Zealand Institute of Community Health Care NZCOM midwifery standards reviewer Chair Canterbury/West Coast NZCOM
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding Member of IPG

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 20 August 2015 11:33 a.m.
To: 'donna.maclean@barringtonmc.co.nz'; 'Alison Wooding'; 'Anne Feld'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Agenda and Papers for Tuesdays ISLA meeting
Attachments: Draft minutes 21 July meeting.docx; 201516 workplan.docx; Imms Reporting Template August ISLA.docx; 25 August 2015 final Agenda.docx; Risk Register AUGUST.docx

HI all

Please find attached the papers for Tuesdays ISLA meeting

- Agenda
- Draft minutes
- Imms Reporting Summary
- Risk Register

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 21 July 2015	Time: 2-3.30pm
Present: Ramon Pink (Chair), Margaret Kyle, , Dr Sarah Marr, Bridget Lester, Tony Walls and Geraldine Clemens	
Apologies: Anne Feld, Dr Alison Wooding and Anna Harwood	
Notes cc'd to: CCN Programme Office	

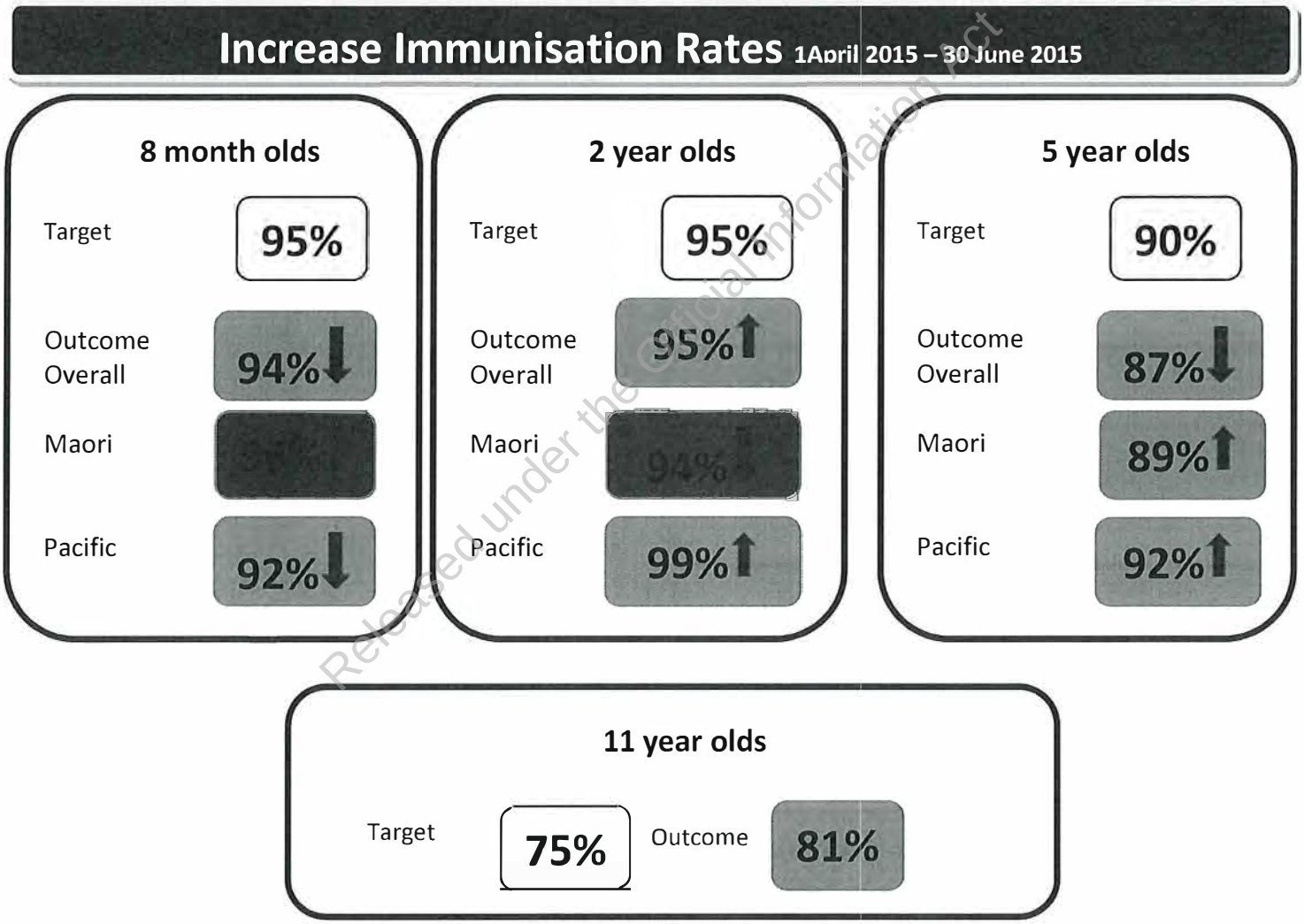
	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 2 June 2015 were approved to go to the CCN office.	Bridget	24 July
2.	**Previous Actions & Matters Arising**	• Letter has been redraft, but agree further work needs to occur. • Letter has been drafted and with Ramon, Sarah and Alison for feedback	Ramon Ramon	31 July 31 July
3.	**ISLA Work plan**	Q4 data = Achieved 94.48% 8month olds, 95% 2 year olds. Q1 = progress towards 94% again, and 95% of 2 year olds. Fully vaccinated 5 year old are now a target, we are sitting on 90% at present. Flu – good progress at last count were 70% - but are can no longer get Pegasus data, so are not able to monitoring PHO uptake **Action: Work with PHOs to see how data can be collected for 2016 year.**	Bridget and IPG	
4.	**HPV year10 programme evaluation**	• Kristy Calder presented the executive summary of the evaluation key. Recommendations are o HPV continue to be offered in primary care and school o Offered in schools at year 7 or 8 o CDHB Communications plan to be developed *Key finding and advice were* o Consider basing the programme coordinators with the CDHB PHNS o Clearly define roles of staff at a planning level and community these role to programme staff o School value their relationship with the PNHS, as they are there key health contact for their schools.		
5.	**Year 8 Programme update**	• **Discussion around the proposed Year 8 programme** • **ISLA supported the following** o Service sitting with the PHNS		

	Item	Discussion/Action	Responsibility	Date due
		○ Clinical leader role sitting within a PHO or with an IC service		
6.	**Operational**	• **Risk Register** – No update required • **Interest Register** – no update required • **Membership changes** – ○ Ramon is now Maori Rep on ALT, so will also be ISLA ALT sponsor ○ Michael will step down from and support child and youth work stream ○ Linda Hill has resigned to take up new role in Plunket. At this stage Linda will not be replaced. ○ Advertised for Practice Nurse, and had one nomination. ISLA endorsed this nomination, and will write to memo to ALT. • IPG Chair – since Linda has resigned, there is a need to appoint a new chair to IPG. Was agreed that we would thank Linda for support, but do not expect her to continue as IPG Chair. One nomination was received, how concerned that this person was key contributor and need to ensure the balance at the meeting. Ramon to follow up on proposed chair	Bridget Ramon	31 July 31 July
7.	**Next Meeting**	Agreed to change meeting dates for 2015. Next meeting 25 August 2015 2-4pm at C&PH • Oct 13th 2015 • December 8th 2015		

our health system

Key Performance Indicators and Childhood Immunisation Reporting

August 2015



Childhood Immunisation – MoH Health Targets up until 18 August 2015

Fully Immunised 8 month olds – DHB LEVEL

Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress including pending	Q2 2015/16 Progress including pending
95.3% fully	94% fully	94.4% fully	92.21% fully
1.2% overdue	1.5% overdue	1.2% could	4.5% could reach

Fully Immunised Two year olds - DHB LEVEL

Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress	Q2 2015/16 Progress
93.7% fully	95.4% fully	94.4% fully	93.7% fully
1.7% overdue	.9% overdue	.5% overdue	1% overdue

Fully Immunised Four year olds - DHB LEVEL

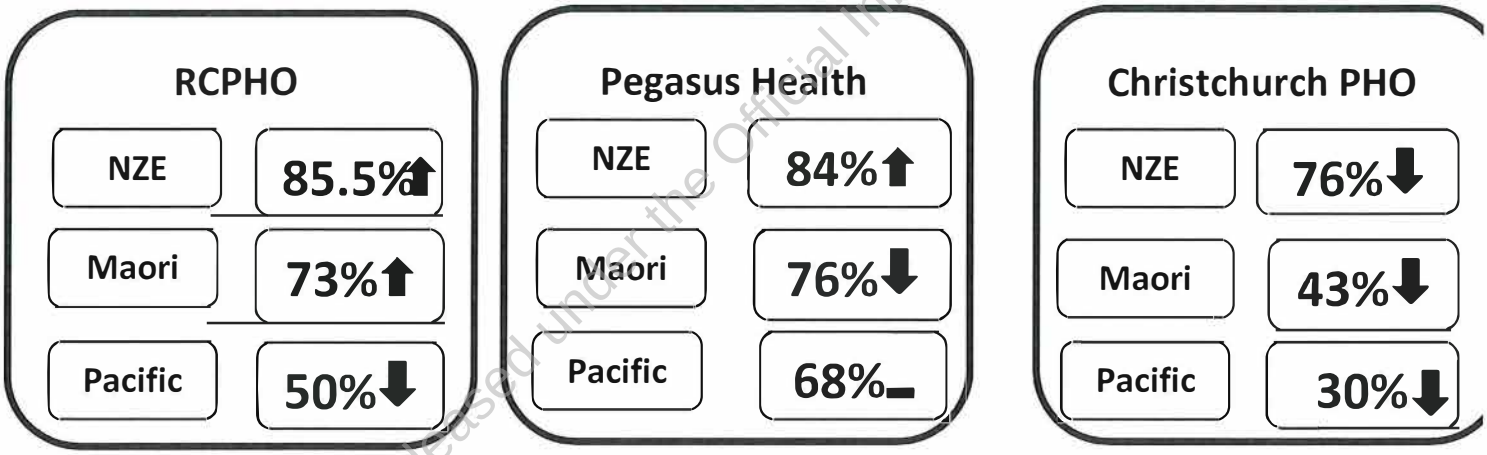
Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress	Q2 2015/16 Progress
89% fully	87% fully	92% fully	92% fully
5.6% overdue	5% overdue	1% overdue	3% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 18 August 2015

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		4 year olds	
Christchurch PHO	96%	99%	97%	96.5%	90%	97%
Pegasus	96%	95%	96%	95.5%	90%	94%
Rural Canterbury	92%	96%	97%	95%	86%	94%

Pre teen Immunisations

11 vear old – PHO Level until 30 June 2015



HPV – Similar DHB Level All Doses Jun 15

See page below for HPV data

Immunisation Reporting Programme

The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

- DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
- Reporting periods
    - Q1 = 1 July – 30 September
    - Q2 = 1 October – 31 December
    - Q3 = 1 January – 31 March
    - Q4 = 1 April – 30 June
- HPV Reporting – girls born in 1999 and 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.
- Please email suggestions and feedback to NIRCanterbury@cdhb.govt.nz

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	227	64	150	1,355	1,796	390	110	190	2,260	2,950	58%	58%	79%	60%	61%	302 (10.2%)	0 (0.0%)
	HPV-2 Quadrivalent	212	58	145	1,307	1,722						54%	53%	76%	58%	58%	311 (10.5%)	
	HPV-3 Quadrivalent	196	53	135	1,234	1,618						50%	48%	71%	55%	55%	318 (10.8%)	
2000	HPV-1 Quadrivalent	228	63	193	1,389	1,873	420	100	200	2,230	2,940	54%	63%	97%	62%	64%	306 (10.4%)	0 (0.0%)
	HPV-2 Quadrivalent	212	55	189	1,329	1,785						50%	55%	95%	60%	61%	301 (10.2%)	
	HPV-3 Quadrivalent	160	38	150	1,083	1,431						38%	38%	75%	49%	49%	316 (10.7%)	
2001	HPV-1 Quadrivalent	189	51	118	1,249	1,607	420	110	190	2,290	3,010	45%	46%	62%	55%	53%	181 (6.0%)	0 (0.0%)
	HPV-2 Quadrivalent	173	47	111	1,179	1,510						41%	43%	58%	51%	50%	187 (6.2%)	
	HPV-3 Quadrivalent	121	31	89	940	1,181						29%	28%	47%	41%	39%	195 (6.5%)	
2002	HPV-1 Quadrivalent	173	39	95	1,063	1,370	390	100	160	2,310	2,970	44%	39%	59%	46%	46%	95 (3.2%)	1 (0.0%)
	HPV-2 Quadrivalent	142	34	88	972	1,236						36%	34%	55%	42%	42%	104 (3.5%)	
	HPV-3 Quadrivalent	113	27	72	789	1,001						29%	27%	45%	34%	34%	104 (3.5%)	
2003	HPV-1 Quadrivalent	163	37	89	978	1,267	390	110	180	2,150	2,830	42%	34%	49%	45%	45%	62 (2.2%)	1 (0.0%)
	HPV-2 Quadrivalent	130	27	73	865	1,095						33%	25%	41%	40%	39%	60 (2.1%)	
	HPV-3 Quadrivalent	71	13	49	585	718						18%	12%	27%	27%	25%	61 (2.2%)	
Total	HPV-1 Quadrivalent	980	254	645	6,034	7,913	2,010	530	920	11,240	14,700	49%	48%	346%	54%	54%	946 (6.4%)	2 (0.0%)
	HPV-2 Quadrivalent	869	221	606	5,652	7,348						43%	42%	325%	50%	50%	963 (6.6%)	
	HPV-3 Quadrivalent	661	162	495	4,631	5,949						33%	31%	265%	41%	40%	994 (6.8%)	

As of 30/06/2015 - Q4 2014/15 30 June 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,493	1,323	89. %	746	671	90. %	209	169	81. %	74	64	86. %	219	205	94. %	245	214	87. %	7 ()	0.5 (0.0) %	41	2.7 %
8 Month	1,536	1,451	94. %	762	720	94. %	244	234	96. %	73	67	92. %	205	200	98. %	252	230	91. %	13 ()	0.8 (0.0) %	47	3.1 %
12 Month	1,570	1,493	95. %	808	778	96. %	223	210	94. %	80	78	98. %	205	198	97. %	254	229	90. %	16 ()	1.0 (0.0) %	49	3.1 %
18 Month	1,485	1,314	88. %	741	680	92. %	233	197	85. %	81	69	85. %	188	177	94. %	242	191	79. %	19 ()	1.3 (0.0) %	59	4.0 %
24 Month	1,495	1,426	95. %	780	750	96. %	221	207	94. %	77	76	99. %	176	172	98. %	241	221	92. %	12 ()	0.8 (0.0) %	45	3.0 %
5 Year	1,653	1,446	87. %	839	766	91. %	233	207	89. %	91	84	92. %	157	137	87. %	333	252	76. %	35 (1)	2.1 (0.1) %	89	5.4 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,493	1,323	89. %	365	325	89. %	321	281	88. %	354	310	88. %	252	234	93. %	201	173	86. %	0	0	-
8 Month	1,536	1,451	94. %	390	353	91. %	326	316	97. %	341	325	95. %	281	266	95. %	198	191	96. %	0	0	-
12 Month	1,570	1,493	95. %	370	337	91. %	357	342	96. %	380	362	95. %	250	244	98. %	209	204	98. %	4	4	100. %
18 Month	1,485	1,314	88. %	416	356	86. %	308	284	92. %	326	289	89. %	234	207	88. %	199	177	89. %	2	1	50. %
24 Month	1,495	1,426	95. %	412	389	94. %	339	323	95. %	305	295	97. %	243	230	95. %	195	188	96. %	1	1	100. %
5 Year	1,653	1,446	87. %	511	432	85. %	356	312	88. %	327	285	87. %	245	218	89. %	213	198	93. %	1	1	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 25 August 2015, 2- 400pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions** **Welcome to Donna**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 21 July meeting.docx
4.	2.20pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI** **Immunisation Conference**	Bridget Lester	201516 workplan.docx Imms Reporting Template August IS
5.	2.40pm	**New NIR Workshops**	Bridget Lester	Discussion
6.	2.50pm	**HPV Year 8 programme update**	Bridget Lester	Discussion
7	3.00pm	**Immunise for Life future**	ISLA	Discussion
8.	3.30pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Risk Register Dec.docx
9.	3.2pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Letter to Pegasus regarding Helios – update this	Ramon	21 August 2015
GP letter follow up	Bridget	21 August 2015
Membership change paper to ALT	Bridget	30 July 2015
IPG Chair	Ramon	21 August 2015

Next meeting: 13 October 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium			
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children"	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. The HPV School programme has been put in place to pick up the girls not reached in the general practice programme.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 6 October 2015 2:37 p.m.
To: Alison Wooding; Anne Feld; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers for Tuesday ISLA meeting
Attachments: 13 October 2015 Agenda.docx; 201516 workplan IAG - updated.docx; Imms Reporting Template October ISLA.docx; Draft minutes 25 August meeting.docx; Updated Risk Register.docx

Hi all

Please find attached the papers for Tuesday 13 October ISLA meeting.

Papers include

- Agenda
- Minutes of August meeting
- ISLA work plan
- ISLA Immunisation Reporting
- Risk Register

I have also invited Anna Wall the now IMAC South Island Regional advisor to the meeting, but I am waiting to hear back from her.

As Q1 has recently been completed, we have the final reporting for this period. We achieved 95% for 8month olds and 94% for two year olds, as there was a large number of opts offs this quarter.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 13 October 2015, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 25 August meeting.doc
4.	2.20pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI** **Immunisation Conference**	Bridget Lester	201516 workplan.docx Imms Reporting Template October I
6.	2.50pm	**HPV Year 8 programme update**	Bridget Lester	Discussion
7	3.00pm	**Immunise for Life update**	ISLA	Discussion
8.	3.30pm	**Operational** • **IPG Chairperson** • **Interest register** • **Risk Register**	Ramon Pink	Updated Risk Register.docx
9.	3.2pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
GP letter follow up	Bridget	17 July 2015
IPG Chair	Ramon	21 August
Immunise for Life	Bridget	13 October
OIS – Bridget and Ramon to arrange a meeting with TPWT to progress discussion	Bridget	13 October

Next meeting: 8 December 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Year 8 year old HPV School Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

our health system

Key Performance Indicators and Childhood Immunisation Reporting

October 2015

Immunisation Reporting Programme

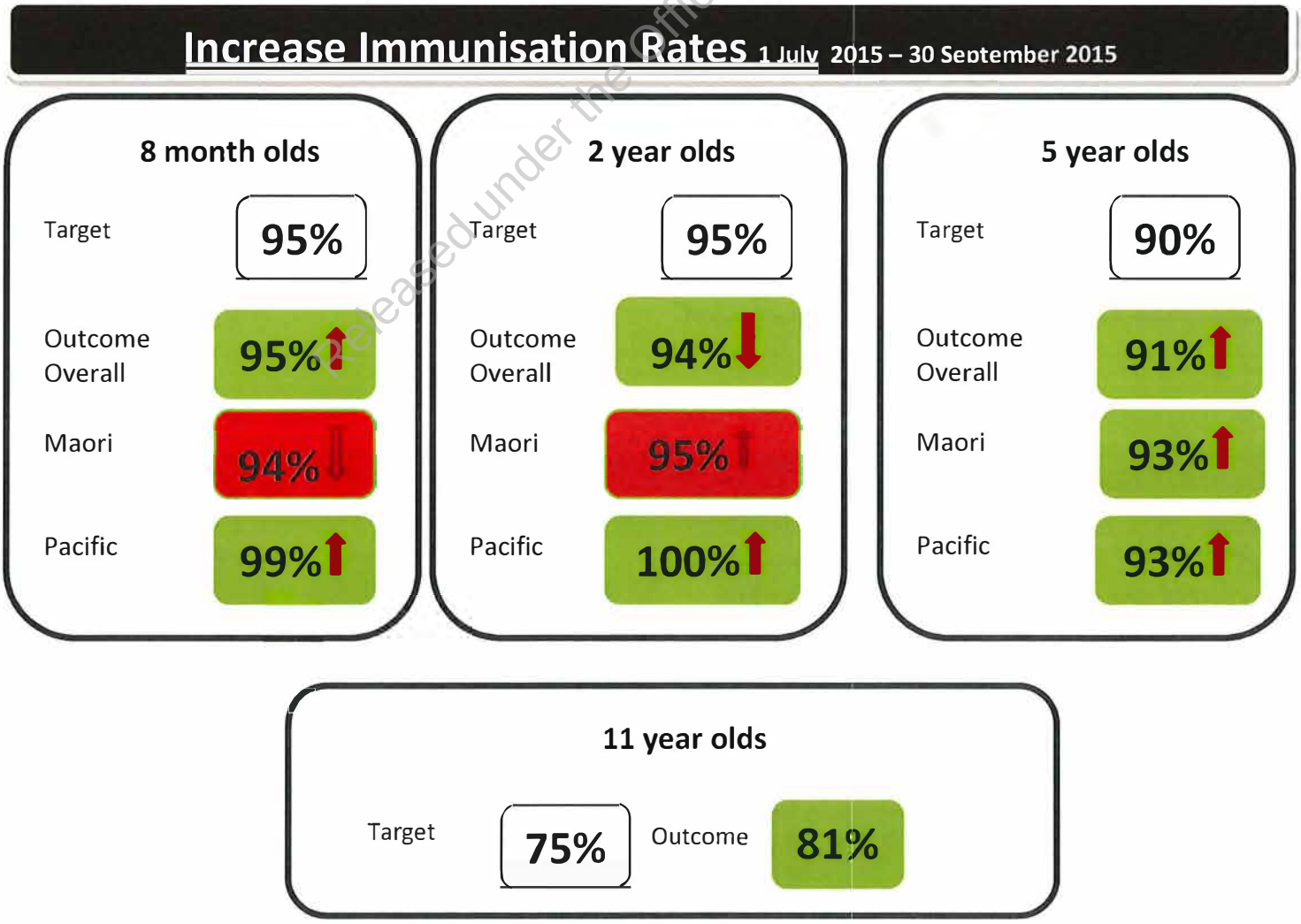
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 30 September 2015

Fully Immunised 8 month olds – DHB LEVEL

Q4 2014/15 Actual	Q1 201/16 Actual	Q2 2015/16 Progress including pending	Q3 2015/16 Progress including pending
94% fully	95% fully	89% fully	91% fully
1.5% overdue	1.5% overdue	6% could reach	6% could reach

Fully Immunised Two year olds - DHB LEVEL

Q4 2014/15 Actual	Q1 2015/16 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress
95.4% fully	94% fully	94.2% fully	93% fully
.9% overdue	1.2%	.4% overdue	2% overdue

Fully Immunised Four year olds - DHB LEVEL

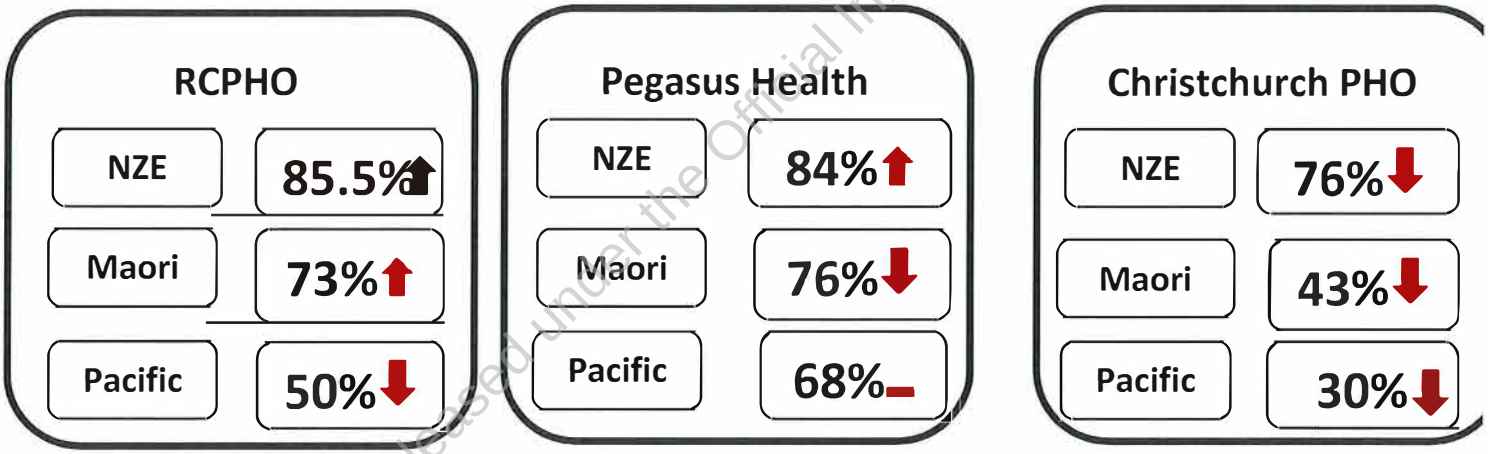
Q4 2014/15 Actual	Q1 2014/15 Actual	Q1 2015/16 Progress	Q2 2015/16 Progress
87% fully	91% fully	93% fully	93% fully
5% overdue	2.6%	3% overdue	2.5% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 September 2015

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		4 year olds	
Christchurch PHO	96%	94%	97%	96%	90%	94%
Pegasus	96%	90%	96%	94%	90%	94%
Rural Canterbury	92%	87%	97%	94%	86%	94%

Pre teen Immunisations

11 year old – PHO Level until 30 June 2015



As at 30 September 2015

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	230	64	153	1,364	1,811	390	110	190	2,260	2,950	59%	58%	81%	60%	61%	304 (10.3%)	0 (0.0%)
	HPV-2 Quadrivalent	215	60	148	1,313	1,736						55%	55%	78%	58%	59%	316 (10.7%)	
	HPV-3 Quadrivalent	202	54	142	1,255	1,653						52%	49%	75%	56%	56%	323 (10.9%)	
2000	HPV-1 Quadrivalent	228	65	195	1,401	1,889	420	100	200	2,230	2,940	54%	65%	98%	63%	64%	315 (10.7%)	0 (0.0%)
	HPV-2 Quadrivalent	215	56	191	1,352	1,814						51%	56%	96%	61%	62%	310 (10.5%)	
	HPV-3 Quadrivalent	176	44	174	1,185	1,579						42%	44%	87%	53%	54%	327 (11.1%)	
2001	HPV-1 Quadrivalent	195	51	120	1,273	1,639	420	110	190	2,290	3,010	46%	46%	63%	56%	54%	188 (6.2%)	0 (0.0%)
	HPV-2 Quadrivalent	176	48	113	1,213	1,550						42%	44%	59%	53%	51%	193 (6.4%)	
	HPV-3 Quadrivalent	132	36	97	1,014	1,279						31%	33%	51%	44%	42%	202 (6.7%)	
2002	HPV-1 Quadrivalent	175	41	100	1,097	1,413	390	100	160	2,310	2,970	45%	41%	63%	47%	48%	100 (3.4%)	1 (0.0%)
	HPV-2 Quadrivalent	149	36	93	1,000	1,278						38%	36%	58%	43%	43%	108 (3.6%)	
	HPV-3 Quadrivalent	115	28	78	841	1,062						29%	28%	49%	36%	36%	109 (3.7%)	
2003	HPV-1 Quadrivalent	170	40	96	1,022	1,328	390	110	180	2,150	2,830	44%	36%	53%	48%	47%	67 (2.4%)	1 (0.0%)
	HPV-2 Quadrivalent	136	31	81	926	1,174						35%	28%	45%	43%	41%	68 (2.4%)	
	HPV-3 Quadrivalent	85	20	57	690	852						22%	18%	32%	32%	30%	70 (2.5%)	
2004	HPV-1 Quadrivalent	83	20	49	527	679	430	130	210	2,210	2,980	19%	15%	23%	24%	23%	31 (1.0%)	0 (0.0%)
	HPV-2 Quadrivalent	48	9	35	366	458						11%	7%	17%	17%	15%	29 (1.0%)	
	HPV-3 Quadrivalent	6	0	8	71	85						1%	0%	4%	3%	3%	29 (1.0%)	
Total	HPV-1 Quadrivalent	1,081	281	713	6,684	8,759	2,440	660	1,130	13,450	17,680	44%	43%	380%	50%	50%	1005 (5.7%)	2 (0.0%)
	HPV-2 Quadrivalent	939	240	661	6,170	8,010						38%	36%	353%	46%	45%	1024 (5.8%)	
	HPV-3 Quadrivalent	716	182	556	5,056	6,510						29%	28%	297%	38%	37%	1060 (6.0%)	

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,534	1,351	88. %	781	710	91. %	228	176	77. %	89	77	87. %	200	187	94. %	236	201	85. %	8 (0)	0.5 (0.0) %	39	2.5 %
8 Month	**1,532**	**1,462**	**95. %**	**783**	**748**	**96. %**	**217**	**203**	**94. %**	**83**	**82**	**99. %**	**208**	**205**	**99. %**	**241**	**224**	**93. %**	**7 (0)**	**0.5 (0.0) %**	**46**	**3.0 %**
12 Month	1,532	1,457	95. %	773	739	96. %	240	232	97. %	70	68	97. %	198	191	96. %	251	227	90. %	18 (0)	1.2 (0.0) %	46	3.0 %
18 Month	1,502	1,350	90. %	745	689	92. %	243	204	84. %	73	69	95. %	197	187	95. %	244	201	82. %	17 (0)	1.1 (0.0) %	50	3.3 %
24 Month	1,515	1,423	94. %	754	721	96. %	240	227	95. %	68	68	100. %	207	201	97. %	246	206	84. %	24 (0)	1.6 (0.0) %	49	3.2 %
5 Year	1,637	1,488	91. %	882	821	93. %	248	231	93. %	71	66	93. %	157	142	90. %	279	228	82. %	22 (1)	1.3 (0.1) %	83	5.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,534	1,351	88. %	336	297	88. %	308	282	92. %	285	247	87. %	263	226	86. %	196	170	87. %	146	129	88. %
8 Month	1,532	1,462	95. %	364	347	95. %	341	324	95. %	336	314	93. %	259	251	97. %	206	201	98. %	26	25	96. %
12 Month	1,532	1,457	95. %	376	342	91. %	310	299	96. %	326	318	98. %	275	262	95. %	230	222	97. %	15	14	93. %
18 Month	1,502	1,350	90. %	391	349	89. %	333	310	93. %	298	272	91. %	244	214	88. %	182	161	88. %	54	44	81. %
24 Month	1,515	1,423	94. %	379	338	89. %	322	311	97. %	319	309	97. %	270	251	93. %	210	201	96. %	15	13	87. %
5 Year	1,637	1,488	91. %	504	458	91. %	336	305	91. %	321	297	93. %	256	228	89. %	202	189	94. %	18	11	61. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 25 August 2015	Time: 2-4.00pmpm
Present: Ramon Pink (Chair), Margaret Kyle, Donna MacLean, Bridget Lester, Tony Walls, Geraldine Clemens, Dr Alison Wooding and Anna Harwood	
Apologies: Anne Feld and Dr Sarah Marr	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 21 July were approved to go to the CCN office.	Bridget	28 August
2.	**Previous Actions & Matters Arising**	• Ramon has spoken to Simon Wynn-Thomas and he is going to raise the issues with the practice directly. Bridget to supply performance data. • Bridget to resend letter with updated information.	Bridget Bridget	31 July 31 July
3.	**ISLA Work plan**	Q1 data = on track to achieve 95% for both 8month olds and 2 year olds. Progress continues to be made on the other aspects of the work plan.	Bridget and IPG	
4.	**HPV Year 8 programme update**	An update was provided on the status of the project implementation • Service has been agreed to be placed with the PNHS. • Due to funding constraints the Clinical Leader Position will not be recruited during 2015/16 year. IC are confident they are able to continue to support the service. • Awaiting updated for DHB IT around using MedTech for this programme. • A majority of schools have signed up to the programme. Suggested that a process to engage with schools who decline the programme is necessary. Tony, Ramon and Alison have agreed to support these discussion.		
5.	**Operational**	• **Risk Register** – Updated to reflect current performance • **Interest Register** – need to include Donna • **Membership changes** – Practice Nurse Nomination was endorsed by ALT. Donna MacLean has joined ISLA today. • IPG Chair – Ramon has followed up on this and is still awaiting feedback	Bridget Bridget Ramon	28 August 28 August
6.	**Immunise for Life**	Agreed that ISLA want to retain this brand, but thought it would be good to have a refresh.		

	Item	Discussion/Action	Responsibility	Date due
		• Pertussis Posters to be updated, based on Flyer information and distributed to practices and LMCs. • Bridget to liaise with Vicky from Comms around getting new faces for the fliers – but keeping with the same information. • Need to consider future of what we do with website as hosting cost is quite high.		
7.	**OIS Discussion**	It has been 6months since the Evaluation of OIS was completed and we requested providers to work closer together. There is still a concern that providers are not working like this. Providers appear to be working in a whānau ora way – but is this what we want and need for immunisation. How can we support them to work smarter? Overall is OIS just under funded? Ramon and Bridget to arrange to meet with TPWT OIS.		
8.	**Next Meeting**	Next meeting 13 October 2015 2-4pm at C&PH • December 8th 2015		

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

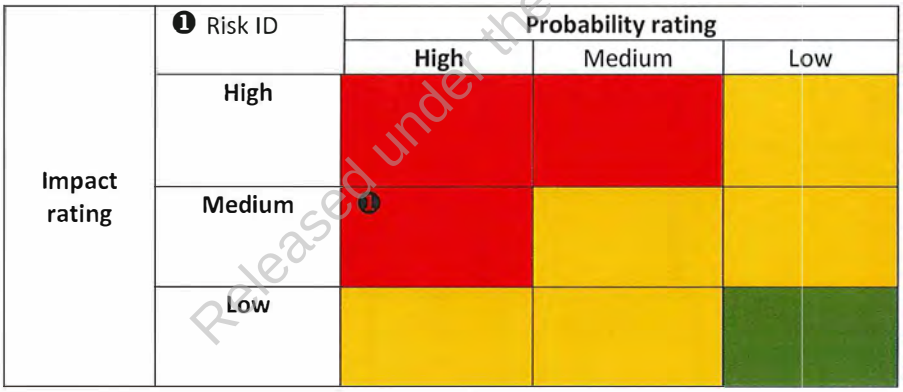
1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.



Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. Good progress has been made in 2015 toward this target. It was achieved in Q3 and very close in Q4. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2015 toward this target. It was achieved in Q4 and very close in Q3. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. Planning is underway for the Year 8 HPV programme, this should assist us in moving closer towards the national targets.	Updated narrative
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora Ki Waitaha

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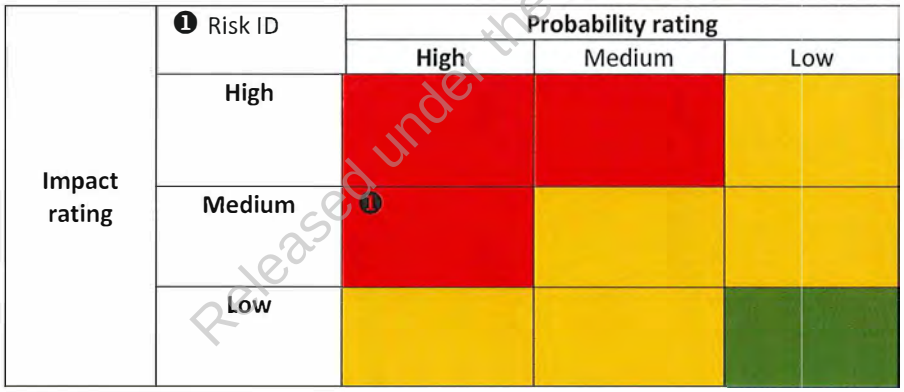

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	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 7 December 2015 11:49 a.m.
To: Alison Wooding; Anne Feld; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Paper for 8th December Immunisation Service Level Alliance Meeting
Attachments: Imms Reporting Template December ISLA.docx; 8 December 2015 Agenda.docx; Draft minutes 13 Oct ISLA meeting.docx; Risk Register October.docx

HI all

Please find attached the agenda and papers for tomorrow meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

Key Performance Indicators and Childhood Immunisation Reporting

December 2015

Immunisation Reporting Programme

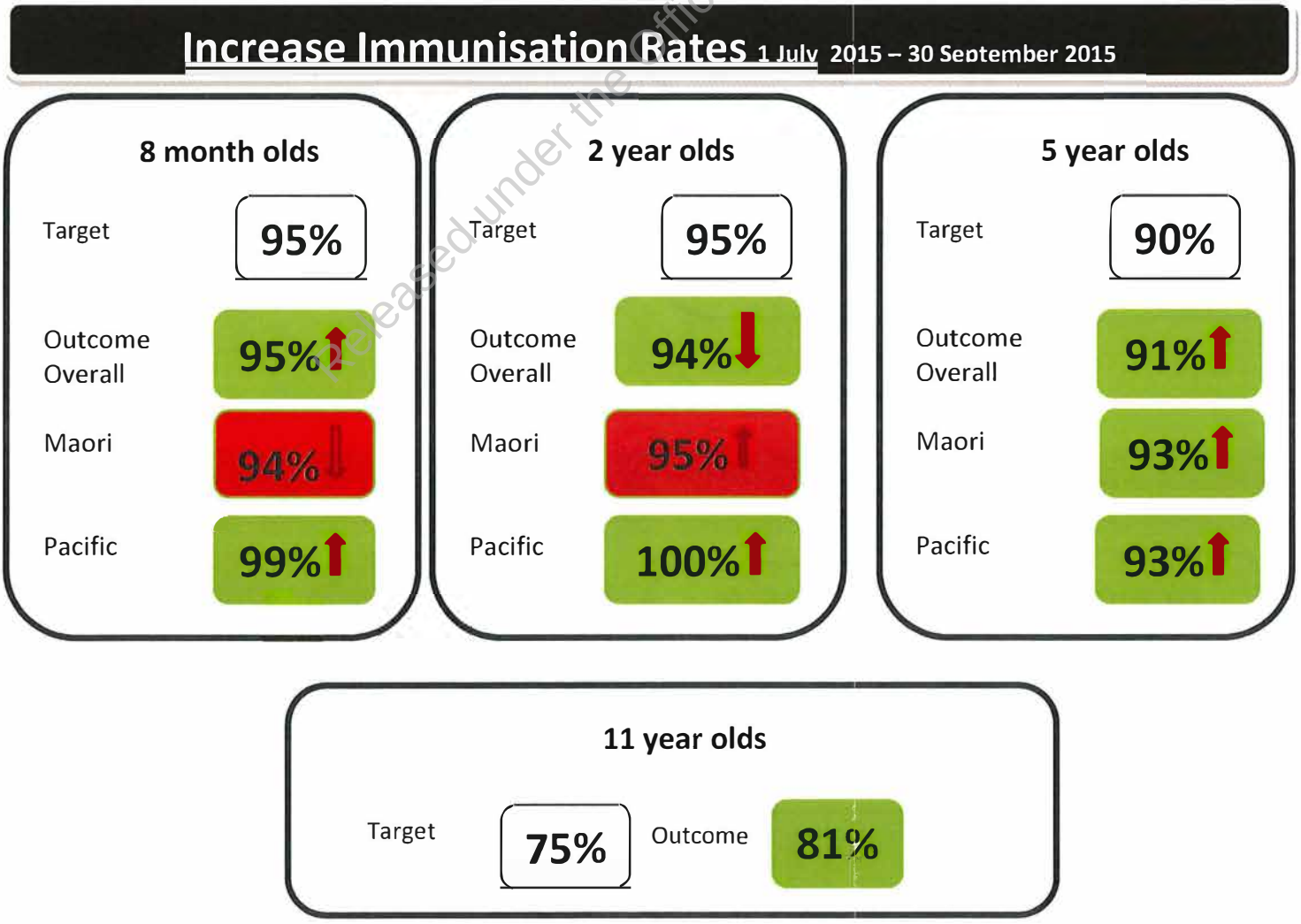
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 7 December 2015

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress Including Pending	Q3 2015/16 Progress including pending	Q4 2015/16 Progress including pending
95.4% fully	95.6% fully	87% fully	88% fully
1% overdue	.0% overdue	8.3% could	7% could reach

Fully Immunised Two year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
94.1% fully	93.9% fully	93.5	88% fully
1.12%	% overdue	3.5% overdue	7.8% overdue

Fully Immunised Four year olds - DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
92.2% fully	93% fully	89% fully	0% fully
.6% overdue	1.2%	3% overdue	0% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 September 2015

		Actual	Progress	Actual	Progress	Actual	Progress
		8month olds		2 year olds		4 year olds	
Christchurch PHO		96%	98%	97%	98.8%	90%	97%
Pegasus		96%	97%	96%	94.9%	90%	94%
Rural Canterbury		92%	96%	97%	93.6%	86%	95%

Pre teen Immunisations

11 year old – PHO Level until 30 June 2015

RCPHO

NZE	85.5% ↑
Maori	73% ↑
Pacific	50% ↓

Pegasus Health

NZE	84% ↑
Maori	76% ↓
Pacific	68% –

Christchurch PHO

NZE	76% ↓
Maori	43% ↓
Pacific	30% ↓

As at 30 September 2015

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	230	64	153	1,364	1,811	390	110	190	2,260	2,950	59%	58%	81%	60%	61%	304 (10.3%)	0 (0.0%)
	HPV-2 Quadrivalent	215	60	148	1,313	1,736						55%	55%	78%	58%	59%	316 (10.7%)	
	HPV-3 Quadrivalent	202	54	142	1,255	1,653						52%	49%	75%	56%	56%	323 (10.9%)	
2000	HPV-1 Quadrivalent	228	65	195	1,401	1,889	420	100	200	2,230	2,940	54%	65%	98%	63%	64%	315 (10.7%)	0 (0.0%)
	HPV-2 Quadrivalent	215	56	191	1,352	1,814						51%	56%	96%	61%	62%	310 (10.5%)	
	HPV-3 Quadrivalent	176	44	174	1,185	1,579						42%	44%	87%	53%	54%	327 (11.1%)	
2001	HPV-1 Quadrivalent	195	51	120	1,273	1,639	420	110	190	2,290	3,010	46%	46%	63%	56%	54%	188 (6.2%)	0 (0.0%)
	HPV-2 Quadrivalent	176	48	113	1,213	1,550						42%	44%	59%	53%	51%	193 (6.4%)	
	HPV-3 Quadrivalent	132	36	97	1,014	1,279						31%	33%	51%	44%	42%	202 (6.7%)	
2002	HPV-1 Quadrivalent	175	41	100	1,097	1,413	390	100	160	2,310	2,970	45%	41%	63%	47%	48%	100 (3.4%)	1 (0.0%)
	HPV-2 Quadrivalent	149	36	93	1,000	1,278						38%	36%	58%	43%	43%	108 (3.6%)	
	HPV-3 Quadrivalent	115	28	78	841	1,062						29%	28%	49%	36%	36%	109 (3.7%)	
2003	HPV-1 Quadrivalent	170	40	96	1,022	1,328	390	110	180	2,150	2,830	44%	36%	53%	48%	47%	67 (2.4%)	1 (0.0%)
	HPV-2 Quadrivalent	136	31	81	926	1,174						35%	28%	45%	43%	41%	68 (2.4%)	
	HPV-3 Quadrivalent	85	20	57	690	852						22%	18%	32%	32%	30%	70 (2.5%)	
2004	HPV-1 Quadrivalent	83	20	49	527	679	430	130	210	2,210	2,980	19%	15%	23%	24%	23%	31 (1.0%)	0 (0.0%)
	HPV-2 Quadrivalent	48	9	35	366	458						11%	7%	17%	17%	15%	29 (1.0%)	
	HPV-3 Quadrivalent	6	0	8	71	85						1%	0%	4%	3%	3%	29 (1.0%)	
Total	HPV-1 Quadrivalent	1,081	281	713	6,684	8,759	2,440	660	1,130	13,450	17,680	44%	43%	380%	50%	50%	1005 (5.7%)	2 (0.0%)
	HPV-2 Quadrivalent	939	240	661	6,170	8,010						38%	36%	353%	46%	45%	1024 (5.8%)	
	HPV-3 Quadrivalent	716	182	556	5,056	6,510						29%	28%	297%	38%	37%	1060 (6.0%)	

As of 30 Nov 2015

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	235	64	155	1,382	1,836	390	110	190	2,260	2,950	60%	58%	82%	61%	62%	305 (10.3%)	0 (0.0%)
	HPV-2 Quadrivalent	219	60	148	1,321	1,748						56%	55%	78%	58%	59%	318 (10.8%)	
	HPV-3 Quadrivalent	204	54	144	1,274	1,676						52%	49%	76%	56%	57%	325 (11.0%)	
2000	HPV-1 Quadrivalent	233	66	198	1,413	1,910	420	100	200	2,230	2,940	55%	66%	99%	63%	65%	320 (10.9%)	0 (0.0%)
	HPV-2 Quadrivalent	219	56	194	1,369	1,838						52%	56%	97%	61%	63%	314 (10.7%)	
	HPV-3 Quadrivalent	197	49	190	1,276	1,712						47%	49%	95%	57%	58%	332 (11.3%)	
2001	HPV-1 Quadrivalent	201	52	121	1,294	1,668	420	110	190	2,290	3,010	48%	47%	64%	57%	55%	194 (6.4%)	0 (0.0%)
	HPV-2 Quadrivalent	180	49	116	1,232	1,577						43%	45%	61%	54%	52%	199 (6.6%)	
	HPV-3 Quadrivalent	147	42	107	1,099	1,395						35%	38%	56%	48%	46%	208 (6.9%)	
2002	HPV-1 Quadrivalent	180	44	104	1,125	1,453	390	100	160	2,310	2,970	46%	44%	65%	49%	49%	103 (3.5%)	1 (0.0%)
	HPV-2 Quadrivalent	155	36	97	1,036	1,324						40%	36%	61%	45%	45%	112 (3.8%)	
	HPV-3 Quadrivalent	118	29	83	893	1,123						30%	29%	52%	39%	38%	114 (3.8%)	
2003	HPV-1 Quadrivalent	181	45	104	1,069	1,399	390	110	180	2,150	2,830	46%	41%	58%	50%	49%	72 (2.5%)	1 (0.0%)
	HPV-2 Quadrivalent	145	34	87	970	1,236						37%	31%	48%	45%	44%	73 (2.6%)	
	HPV-3 Quadrivalent	101	23	61	777	962						26%	21%	34%	36%	34%	75 (2.7%)	
Total	HPV-1 Quadrivalent	1,030	271	682	6,283	8,266	2,010	530	920	11,240	14,700	51%	51%	367%	56%	56%	994 (6.8%)	2 (0.0%)
	HPV-2 Quadrivalent	918	235	642	5,928	7,723						46%	44%	345%	53%	53%	1016 (6.9%)	
	HPV-3 Quadrivalent	767	197	585	5,319	6,868						38%	37%	313%	47%	47%	1054 (7.2%)	

Q1 2015/16 30 September 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,534	1,351	88. %	781	710	91. %	228	176	77. %	89	77	87. %	200	187	94. %	236	201	85. %	8 (0)	0.5 (0.0) %	39	2.5 %
8 Month	**1,532**	**1,462**	**95. %**	**783**	**748**	**96. %**	**217**	**203**	**94. %**	**83**	**82**	**99. %**	**208**	**205**	**99. %**	**241**	**224**	**93. %**	**7 (0)**	**0.5 (0.0) %**	**46**	**3.0 %**
12 Month	1,532	1,457	95. %	773	739	96. %	240	232	97. %	70	68	97. %	198	191	96. %	251	227	90. %	18 (0)	1.2 (0.0) %	46	3.0 %
18 Month	1,502	1,350	90. %	745	689	92. %	243	204	84. %	73	69	95. %	197	187	95. %	244	201	82. %	17 (0)	1.1 (0.0) %	50	3.3 %
24 Month	1,515	1,423	94. %	754	721	96. %	240	227	95. %	68	68	100. %	207	201	97. %	246	206	84. %	24 (0)	1.6 (0.0) %	49	3.2 %
5 Year	1,637	1,488	91. %	882	821	93. %	248	231	93. %	71	66	93. %	157	142	90. %	279	228	82. %	22 (1)	1.3 (0.1) %	83	5.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0		0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,534	1,351	88. %	336	297	88. %	308	282	92. %	285	247	87. %	263	226	86. %	196	170	87. %	146	129	88. %
8 Month	1,532	1,462	95. %	364	347	95. %	341	324	95. %	336	314	93. %	259	251	97. %	206	201	98. %	26	25	96. %
12 Month	1,532	1,457	95. %	376	342	91. %	310	299	96. %	326	318	98. %	275	262	95. %	230	222	97. %	15	14	93. %
18 Month	1,502	1,350	90. %	391	349	89. %	333	310	93. %	298	272	91. %	244	214	88. %	182	161	88. %	54	44	81. %
24 Month	1,515	1,423	94. %	379	338	89. %	322	311	97. %	319	309	97. %	270	251	93. %	210	201	96. %	15	13	87. %
5 Year	1,637	1,488	91. %	504	458	91. %	336	305	91. %	321	297	93. %	256	228	89. %	202	189	94. %	18	11	61. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 8 December 2015, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 13 Oct ISLA meeting.do
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.20pm	**Updates** **2014/15 IPG Work Plan** **Health Target progress – KPI** **Immunisation Conference**	Bridget Lester	201516 workplan.docx Imms Reporting Template December
6.	2.50pm	**HPV Year 8 programme update**	Bridget Lester	Discussion
7	3.00pm	**Outreach Immunisation**	ISLA	Discussion (paper to come)
8.	3.30pm	**Operational** • **IPG Chairperson** • **Interest register** • **Risk Register** • **Dates for 2016 meetings**	Ramon Pink	Updated Risk Register.docx
9.	3.2pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
GP letter follow up	Bridget	30 October 2015
IPG Chair	Ramon	30 October
Improving ACCESS TO Medicines and devises in primary care	Bridget	30 October
Immunise for Life	Bridget	13 October
OIS – Bridget and Ramon to arrange a meeting with TPWT to progress discussion	Bridget	30 October

Next meeting: 8 December 2015

Is there anything on today's agenda that requires a Rural, Maori, Pacific or Migrant lens?

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Venue: C&PH Waitaha Room	
Date: 25 August 2015	Time: 2-4.00pmpm
Present: Ramon Pink (Chair), Margaret Kyle, Donna MacLean, Bridget Lester, Tony Walls, Geraldine Clemens, Dr Alison Wooding, Dr Sarah Marr and Anna Harwood. Anna Walls new IMAC Regional Coordinator attended.	
Apologies: Anne Feld	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 25 August meeting were approved to go to the CCN office.	Bridget	30 October
2.	**Previous Actions & Matters Arising**	• Awaiting feedback from Ramon on GP Letter – we need to include HPV and Pertussis vaccination in this letter. • Ramon and Bridget to meet with TPWT to discuss OIS agreement.	Ramon Bridget	30 October 30 October
3.	**ISLA Work plan**	Q1 data = 8 month olds 95% achieved, we missed 96% by two children. 2 year olds, 94% achieved, there was a high number of opt offs this quarter. Progress continues to be made on the other aspects of the work plan.		
4.	**HPV Year 8 programme update**	An update was provided on the status of the project implementation • 122 schools around 80% of Canterbury schools have agreed to the programme • JD have been drafted for the 1.5 FTE Administration and 1.6 FTE Vaccinators to support the programme. • Some CDHB specific resources are being developed • MedTech has been approved just waiting confirmation on funding this. • Some funding issues need to be sorted to ensure the programme can roll out in 2016.		
5.	**Improving Access to Medicines and devices in primary care**	• PHARMAC paper was discussed. • Members to feedback to Bridget by 28 October to ensure a submission occurs by 2 November.	ISLA membership	28 October
6.	**Operational**	• **Risk Register** – Updated to reflect current performance • **Interest Register** – need to include Donna • **Membership changes** • **IPG Chair** – Ramon has followed up on this and is still awaiting feedback	Bridget Bridget Ramon	30 October 30 October

	Item	Discussion/Action	Responsibility	Date due
7.	**Next Meeting**	Next meeting 8th December 2015 2-4pm at C&PH		

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Wherever One Is Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

Impact rating	❶ Risk ID	Probability rating: High	Probability rating: Medium	Probability rating: Low
	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	High	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk if not achieved. We continue to monitor the uptake and support practices identify and reach overdue children.	
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		High	Low		This is seen as a low risk to the wider community due to our current high. We continue to monitor the uptake and support practices identify and reach overdue children. The OIS assessment is designed to look at ways to improve OIS responsiveness to reach the "missing children" performance.	
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated.	Planning is underway on the implementation of the Year8 School Based HPV programme to be implemented in 2016.
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	

	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	The OIS assessment focused on OIS services working closer together. Feedback is that this is not occurring, and consideration needs to be given to how to move forward with these eservices.

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 1 February 2016 2:50 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers and Agenda from tomorrows ISLA meeting
Attachments: ISLA 8 December 2015 WP.docx; 201516 workplan.docx; Imms Reporting Template fEB 2016 ISLA.docx; 2016 Flu Vax Plan.docx; Draft minutes 8 Dec meeting.docx; RISK REGISTER 2016.docx; 2 Febuary 2016 Agenda.docx; FW: Imms Feedback and Opportunity to Comment

Hi all

Please find attached the papers for our meeting tomorrow.

I have also attached an email from the MoH with feedback on our Q2 Health Target.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

IMMUNISATION SERVICE LEVEL ALLIANCE 2016/17 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to educate and promote immunisation and the NIR for both mother and baby. Maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services • Support LMCs for early hand over to GPT and Well Child providers; • Support early enrolment with General practice teams, and use of B code; • Support NIR to establish timely reporting to follow up children with no nominated provider. Continue to work through the Child and Youth Workstream, explore opportunities with CYF, MSD, ~~Justice and other social service agencies to raise awareness of the importance~~ of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks. *Measure*	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support NIR and PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Provider a school based HPV programme	Q1 – Q4	• 70% of Girls have received dose 3 (for 2016/17 it is the 2003 birth cohort measured at 30 June in 2017).	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Narrative report on interagency activities completed to promote Immunisation Week.	

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Commented [RR1]: Narrative report on Opportunities achieved? or
Regular meetings achieved?

Deleted: linkages with

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

our health system

Key Performance Indicators and Childhood Immunisation Reporting

February 2016

Immunisation Reporting Programme

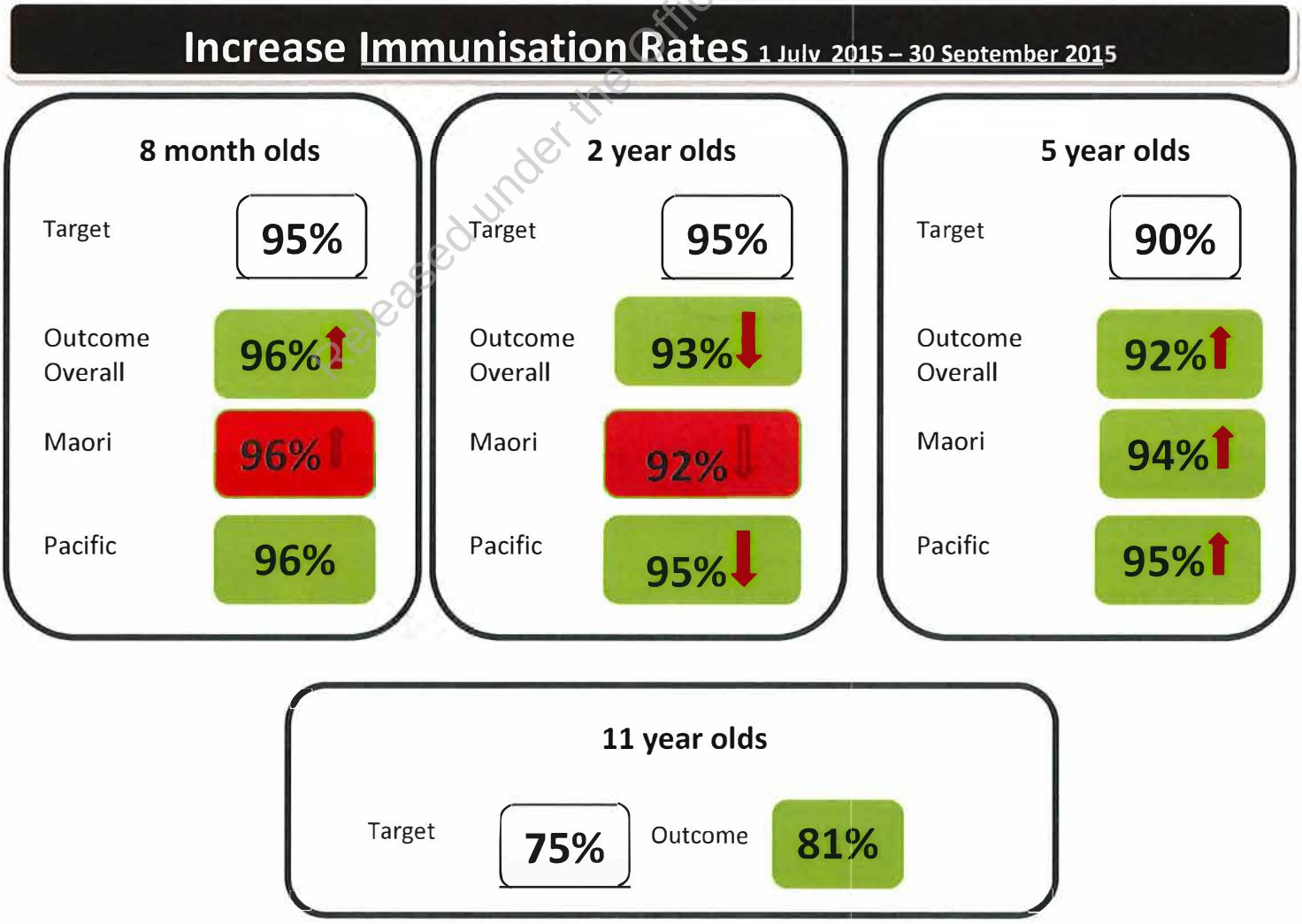
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 Febuary 2016

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress Including Pending	Q3 2015/16 Progress including pending	Q4 2015/16 Progress including pending
95.4% fully	95.6% fully	93.5% fully	88% fully
1% overdue	.0% overdue	.8% could reach	7.5% could

Fully Immunised Two year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
94.1% fully	93.9% fully	94.4%	92.8% fully
1.12%	% overdue	3.5% overdue	1.6% overdue

Fully Immunised Four year olds - DHB LEVEL

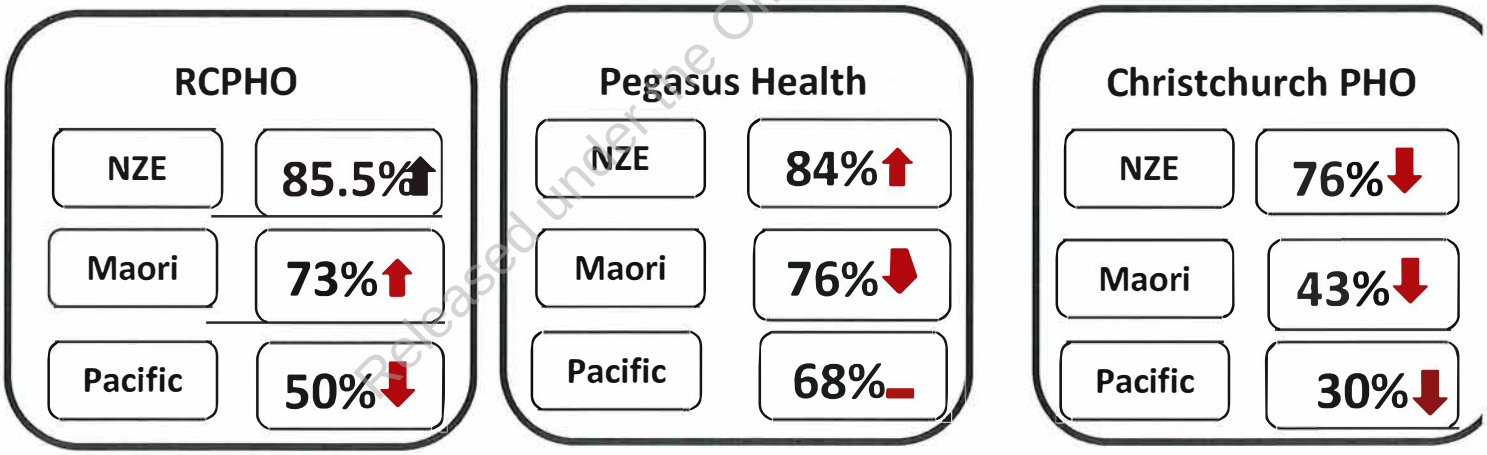
Q1 2015/16 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
92.2% fully	93% fully	91% fully	88% fully
.6% overdue	1.2%	1.5% overdue	6.5% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 September 2015

		Actual	Progress	Actual	Progress	Actual	Progress
		8month olds		2 year olds		4 year olds	
Christchurch PHO		96%	98%	97%	98.8%	90%	97%
Pegasus		96%	97%	96%	94.9%	90%	94%
Rural Canterbury		92%	96%	97%	93.6%	86%	95%

Pre teen Immunisations

11 year old – PHO Level until 30 June 2015



As of 31 Dec 2015

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,584	1,397	88. %	783	705	90. %	268	219	82. %	76	66	87. %	226	212	94. %	231	195	84. %	12 (2)	0.8 (0.1) %	35	2.2 %
8 Month	1,559	1,491	96. %	769	743	97. %	250	240	96. %	83	80	96. %	208	203	98. %	249	225	90. %	11 (0)	0.7 (0.0) %	42	2.7 %
12 Month	1,514	1,451	96. %	753	717	95. %	212	205	97. %	76	75	99. %	224	221	99. %	249	233	94. %	7 (0)	0.5 (0.0) %	47	3.1 %
18 Month	1,567	1,401	89. %	794	721	91. %	226	194	86. %	81	75	93. %	211	193	91. %	255	218	85. %	16 (0)	1.0 (0.0) %	52	3.3 %
24 Month	1,508	1,408	93. %	750	716	95. %	242	223	92. %	79	75	95. %	193	188	97. %	244	206	84. %	19 ()	1.3 (0.0) %	62	4.1 %
5 Year	1,705	1,565	92. %	870	817	94. %	277	259	94. %	74	70	95. %	171	155	91. %	313	264	84. %	20 ()	1.2 (0.0) %	74	4.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,584	1,397	88. %	318	273	86. %	292	261	89. %	314	280	89. %	260	227	87. %	203	178	88. %	197	178	90. %
8 Month	1,559	1,491	96. %	312	292	94. %	296	285	96. %	300	283	94. %	262	251	96. %	196	188	96. %	193	192	99. %
12 Month	1,514	1,451	96. %	371	350	94. %	320	308	96. %	355	335	94. %	255	252	99. %	200	194	97. %	13	12	92. %
18 Month	1,567	1,401	89. %	331	289	87. %	336	300	89. %	324	287	89. %	212	191	90. %	188	168	89. %	176	166	94. %
24 Month	1,508	1,408	93. %	419	381	91. %	316	301	95. %	325	306	94. %	229	215	94. %	200	192	96. %	19	13	68. %
5 Year	1,705	1,565	92. %	512	469	92. %	335	313	93. %	339	313	92. %	260	234	90. %	226	210	93. %	33	26	79. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Seasonal Influenza Plan 2016 year

1.0 BACKGROUND

The Seasonal Influenza vaccination programme is an annual event occurring between March and July each year. This is the biggest immunisation programs within NZ, with around 1million people being vaccinated within the 5month period. In Canterbury a large focus is given to providing this programme and ensure that our eligibility population is vacationed. Following the 2011 earthquakes, the CDHB extended the seasonal Influenza programme to include people under the age of 18 years old. This programme was pulled in 2015.

In 2016 the trivalent vaccine is subsidised by the Ministry of Health, and is the only vaccine that can be used for the national programme. A quadivalant vaccine is available, but this is for private payers only.

Trivalent - This vaccine consist of H1H2 California, H3N2 Hong Kong and B – Brisbane (Victoria).
The quadivalant vaccine consists of all of the below as well as the B – Phuket (Yangata).

2.0 PURPOSE

The purpose of this plan is to identify the key steps and decision required to ensure the smooth running of the 2016 season.

3.0 DISCUSSION

The National Influenza Group oversee a national vaccination programme. However from 2012 – 2014 Canterbury DHB has ran its own Flu messaging programmes due to the U18 programme. In 2015 the DHB resorted back to only using the National programme, with some minor supplementary programmes in Canterbury, utilising the national branding.

The national programme will focus on the subsided group of

Priority One: Parents of Children under the age of 5 with Respiratory conditions, People with Chronic Health Conditions, Pregnant Women and people 65 and older.

Canterbury other Priority groups - Canterbury DHB is also keen to focus on the non-subsided age groups, included Maori and healthy people.

Maori coverage is required to be at the same level of non-Maori, however historically coverage has been around 5-10% lower. The national campaign does not have a strong focus on Maori, so the CDHB need to develop some strategies to reach this population group. In the past there has been a reliance on promotion the event though Maori Health Providers and then direct recalling through general practice.

Healthily People – the vaccinating of the healthy workforce e.g. people aged between 18 and 65, without chronic health condition has benefits. It will reduces the spread of disease, remove pressure on general practice services, reduce pressure on workplaces if staff are sick and ultimately remove family stresses. This is where work with the CDHB staff programme and the Canterbury Chamber of Commerce regarding sharing messages with employees to support workplace vaccination.

Action	Timeframe	Responsibility
Develop the 2016 Flu Vaccination Communication Plan	End of January	DHB Communications
Messages to general practice team regarding the 2016 programme	Mid February	Immunisation Coordinators
Messages to LMCS, Pharmacy, Older Persons health services and Maori / Pacific Providers Regarding the 2016 programme	Late February	Planning and Funding
Level 1 promotion – posters and briefs to GPT, Pharmacy, Schools, Community Services	Late Feb	P&F, and C&PH
Level 2 Promotions – radio, internet, newspapers, magazines, billboards, busses	Middle of April – end of June	National

CPRG Questions

1. ***Locations of vaccination***

Subsided vaccination are provided within a general practice setting. However alternative locations have been discussed

Vaccinating in ED: The concept of vaccinating for Influenza in ED has been suggested. The general concusses is that ED is very busy during this period, and that it is not the core work of ED to vaccinate. If an at risk child is admitted, then this child can be vaccinated within the child health ward – however this does not occur within the general wards.

This concept was discussed at IPG and while vaccinating in ED is not support, there is scope to investigate how people with CDHB facilities for rehabilitation are covered with the vaccine.

Vaccinating within Maree settings: The update of Maori for the Influenza vaccine is around 5% lower than the total population of those 65 and over. Therefore a focus needs to be given on how we reach this population. One suggestion was vaccinating within a Maree setting. There are resource complexities around doing this, and concerns that we are missing an opportunity for them to attend general practice.

2. ***Promotion of the non-subsided vaccine***

CPRG has asked whether Canterbury intended to promote the non-subsided quadivalant vaccine. There is a sense that within general practice there is limited awareness of this vaccine and that private payers should be given the opportunity to be vaccinated with it over the trivalant vaccine. Community Pharmacy uses the quadivalant vaccine.

3. ***HealthCare Workforce Programme:*** The MoH continues to seek improved coverage with our health workforce. Currently this information is not recorded on the NIR. At this stage, the NIR does not have capacity to load these events, on since data cannot be pulled out of the NIR, then there is little value adding them to the NIR for the 2016 year.

4. ***Data Management*** – CPRG has indicated they would like more information around Influenza Vaccine uptake, and contact has been made with all three PHOs around what level of data they can provide us with. While Pegasus health have capacity to access different levels of data

– Christchurch PHO and Rural Canterbury are restricted. Both PHOs have indicated that extra data will cost them to access.

Data requested by CPRG:

- Number of vaccinations given for those 65 and over broken down by Pacific, Maori and other
- Number of vaccinations given for those under 5 again broken down by Pacific, Maori and other
- Number of vaccinations given to pregnant women, broken down by Pacific, Maori and other
- It would be great to collect total events given also – with would include the chronic conditions and non-subsided population.

PHOs have indicated that they can provide over 65 date, by ethnicity. They will also try and access under 5 funded vaccines but are unsure if this is possible.

Contact has also been made with the MoH around data reports form the NIR. If data can be pulled from the NIR then, we may not require information from PHOs.

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 8 December 2015	Time: 2-4.00pm
Present: Margaret Kyle (Acting Chair), Donna MacLean, Bridget Lester, Tony Walls, Anne Feld, Dr Alison Wooding, Dr Sarah Marr and Anna Harwood. Ruth Robson from CCN office attended.	
Apologies: Ramon Pink Geraldine Clemens	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 13 October meeting approved to go to the CCN office.	Bridget	11 December
2.	**Previous Actions & Matters Arising**	• GP letter has been sent to CPH for distribution • IPG Chair – Anne Morgan has been appointed IPG Chair • Ramon and Bridget have been with TPWT to discuss OIS agreement. • Improving Access to Medicines and Devices in primary care Proposals – no feedback received so no submission made. • Immunise for Life – will be looked at in 2016, however agree some direct communication needs to be made to LMCs.		
3.	**ISLA Work plan**	Q2 data = 8 month olds tracking towards 95%. 2 year olds - tracking towards 94% achieved 5 year olds – tracking towards 93% Positive again made in Dose 1 HPV at 11year old event Progress continues to be made on the other aspects of the work plan. Need to communicate to LMCs around NIR1 forms for homebirths. **Action: Draft something for Margo to share**	Bridget	14 December
4.	**2016/17 Work plan**	The MoH draft has some minor changes from the 2015/16 plan. Awaiting next lot of feedback from MoH. **Action: Will update plan and circulate with suggested ISLA changes.**	Bridget	14 December
5.	**HPV Year 8 programme update**	An update was provided on the status of the project implementation • 122 schools around 80% of Canterbury schools have agreed to the programme • HPV Team positions have been advised. • Progress is being made on MedTech development • School rolls are being received and immunisation status of girls checked to assist in planning		

	Item	Discussion/Action	Responsibility	Date due
		• 2016 Schedule has been drafted, and will go to schools in the next week. • DHB Resources have been developed and are the printers. Discussion around large % of girls who have received dose 1 and how this work will. Advice if for dose two to the girls how are due this when we are giving dose one. Then give all girls the dose three in Sept/Oct.		
6.	**OIS Services**	• Concerns around OIS services and the need for one service continue. Agreed to support the development of one OIS service for the Canterbury region.	Bridget	31 Jan 2016
7.	**Operational**	• **Risk Register** – No changes made • **Dates for 2016 meetings.** Agreed 1 Tuesday of the month, every second month. Feb, April, June, Aug, Oct, Dec. **Action: Bridget to send meeting requests.**	Bridget	
8.	**Next Meeting**	Next meeting 2 Feb 2016 2-4pm at C&PH		

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora Ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
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- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. Good progress has been made in 2015 toward this target. It was achieved in Q3 and very close in Q4. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2015 toward this target. It was achieved in Q4 and very close in Q3. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. Planning is underway for the Year 8 HPV programme, this should assist us in moving closer towards the national targets.	Updated narrative
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 2 February 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens: Apology
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 8 Dec meeting.docx
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.20pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	201516 workplan.docx Imms Reporting Template fEB 2016
7	2.40pm	**Outreach Immunisation RPF Progress**	Bridget Lester	Discussion
8.	2.50pm	**2016 Influenza Vaccination Plan**	Bridget Lester	2016 Flu Vax Plan.docx
9.	3.10pm	**Vaccinating Pregnant Women 2016 Plan**	Bridget Lester	
	3.30pm	**2016/17 Work Plan**	Bridget Lester	ISLA 8 December 2015 WP.docx
10	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Updated Risk Register.docx
9.	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Communications to LMC around NIR1 from	Bridget	14 December
ISLA Work plan – update and circulate	Bridget	14 December
OIS Service, RFP	Bridget	31 January 16
Immunise for Life	Bridget	13 October

Next meeting: 5 April 2016, 7 June 2016, 2 August 2016, 4 October 2016, 6 December 2016

Lara Williams (Administrator)

From: Jessica Wise
Sent: Monday, 1 February 2016 9:37 a.m.
To: Bridget Lester
Subject: FW: Imms Feedback and Opportunity to Comment

Hi Bridget,

As briefly discussed,

HT – Immunisations - ACHIEVED
Congratulations on again achieving the 95% target both overall and for your Māori and Pacific populations. This is an outstanding achievement and we would like to thank you for all your hard work.

We look forward to your participation in the national immunisation workshop in March, where sharing your successful strategies will be valuable in guiding national processes and strategies.

Health Target Ratings Clarification

Please note that a final rating of "Achieved" at the end of the 2015/16 year (30 June 2016) will require both the 95% target to be reached overall and significant progress to have been made for the Mâori and (where applicable) Pacific population groups. To provide greater clarity around the term "significant progress", we are proposing that the minimum acceptable level for Mâori coverage be equivalent to the highest national quarterly result for Mâori that has been achieved (91.6% Dec 2014), and there should also be evidence of coverage for Māori improving over the year. An "Outstanding" rating will be awarded where the target is met both overall and for Māori and Pacific population groups.

The definition for Partially Achieved is that the DHB's immunisation coverage has improved from the coverage at the start of the year and has made significant progress towards the target for the year. To provide greater clarity around the term "significant progress towards the target" we are proposing that the "Partially Achieved" rating be awarded where coverage has improved over the year and the overall result is above the highest national quarterly result that has been achieved (93.7% Dec 2015) but below 95% (rounded). There should also be evidence of coverage for Māori improving over the year.

We welcome feedback on these proposals.

PP21 – Immunisation Coverage – PARTIALLY ACHIEVED

Congratulations on achieving the target coverage for immunisation for 5 years of age. Coverage for age 24 months was below target at 93%, resulting in a partially achieved rating overall for the PP21 performance measure.

Jessica Wise
Accountability Coordinator | Planning and Funding
Canterbury District Health Board
☎ External: (03) 364 4114 | Internal: 62114

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 4 April 2016 11:50 a.m.
To: 'Alison Wooding'; 'Anne Feld'; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Cc: Vicky Heward
Subject: Papers for 5 April 2016 Immunisation SLA meeting
Attachments: 5 Apeil 2016 Agenda.docx; 2 Feb Minutes - draft.docx; RISK REGISTER 2016.docx; Pregnancy Vaccinations Plan 2016.docx; 201516 workplan.docx

Hi all

Please find attached the agenda and papers for tomorrow ISLA meeting. So this is late, I was off last week with Matt (he ended up with a Hernia and needed emergency surgery on Saturday night).

I will bring the data report with me on tomorrow, the data set is being refreshed today so hopefully I can bring the Q3 Outcomes.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 5 April 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	2 Feb Minutes - draft.docx
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4	2.15pm	**Communications Updated** • **Flu Programme** • **Imms for Life** • **Immunisation Week**	Vicky Heward	
5.	2.30pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	201516 workplan.docx ADD REPORT
6.	2.40pm	**Outreach Immunisation RPF Progress**	Bridget Lester	Update
7.	3.10pm	**Vaccinating Pregnant Women 2016 Plan**	Bridget Lester	Pregnancy Vaccinations Plan 2(
8.	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Updated Risk Register.docx
9	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Imms for life update – bring to next meeting	Bridget	5 April 2016
Development of Pregnancy Plan 2016	Bridget	5 April 2016

Next meeting: 7 June 2016, 2 August 2016, 4 October 2016, 6 December 2016

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 2 February 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Donna MacLean, Bridget Lester, Tony Walls, Anne Feld, Dr Alison Wooding, Dr Sarah Marr and Anna Harwood.	
Apologies: Geraldine Clemens	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 8 December 2015 meeting approved to go to the CCN office.	Bridget	5 Feb 2016
2.	**Previous Actions & Matters Arising**	• Communications with LMCs around NIR1 form, yet to be completed. • ISLA 2016/17 work plan – to be updated and circulate • OIS Service RFP – approval has been given to progress this, and letters have been sent to all providers around this. RFP will be issued late Feb with new service in place by 1 September 2016. • Immunise for Life – this has not been progressed. However a piece of work will occur to look at the MoH Resources and what CDHB specific resources we need to retain.	Bridget and Margo Bridget Bridget	13 Feb 2016 Next meeting
3.	**ISLA Work plan**	Q2 data = 8 month olds tracking towards 96%. And achieved for Maori, Pacific and NZE! Awesome effort. 2 year olds - tracking towards 93% achieved. 5.4% opt offs and declines 5 year olds – tracking towards 92% Progress continues to be made on the other aspects of the work plan. **Pregnancy Vaccinations** – need to develop a 2016 Plan. In 2015 a number of innovates were implemented – we need to determine if these were successful. Need to look education to GPs around the importance of pregnancy information – and the suggested general practice systems. Action • Develop 2016 Plan • Approach Sector Service to find 2015 uptake data. Influenza Plan 2016	Bridget	29th February

	Item	Discussion/Action	Responsibility	Date due
		• Canterbury will again be providing the programme in line with the national eligibly criteria and using the NSIG resources. • Some specific questions were asks of ISLA from the CPRG. o **Vaccinating in ED** – not supported, as not key role of ED and difficulties around eligibility criteria. Action: Education to ED around who is eligibility and what to promote. o **Data Management** – CPRG has requested the more information around vaccine uptake is shared including all eligible groups and the non-subsided group. PHOs have been contacted and they are only able to provide 65 and over data, by ethnicity – however this will only be provide monthly during the programme. Any additional reporting would come at substantial cost. Contact has been made with the MoH around what information will be available from the NIR. o **Tri vs Quadivalant** – CPRG is questions if both these vaccines could be promoted. This was not supported. Discussion occurred around why do we have two different vaccines, and is not better than the other. There was a concern that people may opt to pay for the Quadivalent, thinking it is a better vaccine which will impact on the DHB 65 and over coverage. **HPV Year 8 programme update -** the HPV Team is now in place and good progress is being made with schools. MedTech is progressing. The first vaccinations will start on the 29th February 2016.		
4.	**OIS RFP Process**	Documentation is currently being drafted. Working on the development of the Panel members. Need to ensure there no conflict of interest.	Bridget	
5.	**2016/17 Work plan**	• **Minor changes suggested. To be updated and sent to Ruth**	Bridget	
6.	**Operational**	• **Risk Register** – add risk of the Tri Vs Quadivalent	Bridget	
7.	**Next Meeting**	Next meeting 5 April 2016 2-4pm at C&PH		

CCN Risk Policy

1 PURPOSE AND SCOPE

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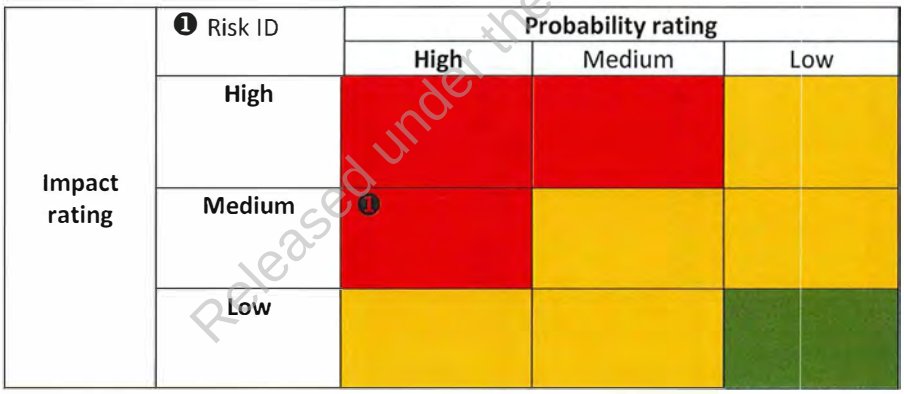

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	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. Planning is underway for the Year 8 HPV programme, this should assist us in moving closer towards the national targets.	Updated narrative
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Pregnancy Vaccinations Plan 2016

1. Background

Pregnancy Women are eligible for free Pertussis and Seasonal Influence vaccinations. Vaccinating pregnant women is reasonable new practice, but one that is seen to be very effective in protect both mother and baby. The Canterbury Health System, though the Immunisation Service Level Alliance wants to increase the uptake of these vaccinations.

Since vaccinating pregnant women is reasonable new, there are a number of challenges in getting sector wide support.

1. A number of LMCs don't support immunisation, therefore do not promote the events to Pregnant Women.
2. LMCs don't vaccinate, therefore women need to attend their general practice to be vaccinated.
3. Pregnancy vaccinations are not included in the handheld maternity notes, so there is not a reminder for the LMCs to advice work on these events.
4. Immunisations are not are large part of the curriculum when a person is training to be an LMCs and attempt to present / education this group have not been successful.
5. General Practice doesn't always know women are pregnant therefore cannot set up the normal recall process for these immunisation.
6. General Practitioners may not fully understand the need for pregnancy vaccination, and therefore do not encourage women to have them. Recent research shows that often when a women presents at her GP to be vaccinated this events is not supported her general practitioner, and therefore does not occur.
7. Women are not always aware that the vaccinations are available to them and the benefits to the women and her child.

In 2015 Canterbury DHB developed a number of process for both general practice and LMCs in an attempt to increase uptake of the vaccinations

1. A sticker was developed for LMCs to put in the women's handheld notes to remind them about pregnancy vaccinations and sharing of the ultra-scan results.
2. GP were advices to set up recalls for
    a. When a women presents to confirm there pregnancy
    b. When they receive notification of a pregnancy ultra-scan.
3. Update of the CDHB resources promotion both Pertussis and Flu vaccinations.

However, do to events not being recorded on the national immunisation register, there is no way to monitor current uptake of the events.

2. Actions for 2016

There are three key groups of people to reach

- LMCS – to provide education to women around the events
- General Practice – to provide the event, and recall women
- Women and their whanau – to understand what is available and be proactive in receiving this.

2.1Reaching LMCs

- **Education of new LMCs -** Information Sessions - There are new LMCs within the DHB each year. Each LMC needs to be set up with as an authorised user to the NIR. We are keen to use this as a way to better engage with them, and hold an Information session around the NIR and Immunisation (both pregnancy and for baby). This will include the NIR and Immunisation Coordinators.
- **Update Information Package** – an information package was developed back in 2013 to support new LMCs. This resource is due to be review and updated.
- **Communications with LMC** - ISLA has started sending regular letters to LMCs in 2015. These will continue in 2016 with the aim of having two letters per year. These need to be keep fresh and new. Other tools to be used are Facebook and Communicative

2.2 Reaching General Practice Teams

- **Information sessions to General Practice Team** – there is a need to better education general practice teams, not only the GP but also the administration and practice nurses on the importance of pregnancy vaccinating and possible practice systems to recall women. While this does occur though letters and HotShot, some verbal messages would also be effective.
- **Promotional Resources** – ensure that general practice teams have the most up to date Pregnancy resources.

2.3 Reaching Women and their Whanau

- **Resources** - Canterbury DHB has developed some key promotional resources, a poster to be placed around the DHB and flyer to promote the event. The Ministry of Health has also recently developed some resources, which we need to ensure LMC receive. **Action: Disturbed CDHB flyer to well child, blood collection centres, ultra scan services, general practice and Christchurch Women and Outpatient services.**
- **Linking with key health service –** ISLA is keen to link closer with Community pharmacy to promote the vaccinations. Pregnant women often attend Pharmacy for their folic acid and pregnancy vitamins, so this is another place information can be shared. **Action: Distribute include in Pharmacy update and distribute copy of Poster to every Pharmacy.**
- **Performance Data** - As indicated above a number of initiatives were actioned in 2016, however we are unsure of the current coverage and if these initiatives have resulted in change in practice / coverage. To be able to determine if the initiatives implemented have results in changes, work needs to occur to source this data. **Action: put a request to the MoH for a data abstract and then work with DHB Analyst to determine coverage by year in 2014 and 2015.**

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 2 June 2016 4:18 p.m.
To: 'Alison Wooding'; 'Anne Feld'; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Agenda and Papers for Tuesday ISLA meeting
Attachments: 7 June 2016 agenda.docx; Letter to SBIP leads following PHARMAC consultation ; PHARMAC - Proposal to amend listings in the National Immunisation Schedule; Draft minutes 5 April meeting.docx; Imms Reporting Template June 2016.docx

Hl all

Please find attached the papers and agenda for our meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 7 June 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 5 April meeting.docx
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
5.	2.30pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	201516 workplan.docx Imms Reporting Template June 2016
6.	2.40pm	**Outreach Immunisation RPF Progress**	Bridget Lester	Update
7.	3.10pm	**Vaccinating Pregnant Women 2016 Plan**	Bridget Lester	Pregnancy Vaccinations Plan 2(
		Immunisation Schedule Changes	Bridget Lester	PHARMAC - Proposal to amend I Letter to SBIP leads following PHARMAC
8.	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Updated Risk Register.docx
9	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Imms for life update – bring to next meeting	Bridget	5 April 2016
Development of Pregnancy Plan 2016	Bridget	5 April 2016

Lara Williams (Administrator)

From: Caitlin_Leonard@moh.govt.nz
Sent: Wednesday, 1 June 2016 2:31 p.m.
To: Immunisation_DHB_leaders_including_school_programmes@moh.govt.nz
Subject: Letter to SBIP leads following PHARMAC consultation
Attachments: Proposed changes in delivery of the HPV Programme in 2017.pdf

Hello all,

As you will know by now, PHARMAC have released their consultation paper, outlining their proposed National Immunisation Schedule changes for vaccines in 2017.

The Ministry has prepared a letter advising on the proposed changes in delivery of the HPV Programme (see attached).

FYI- The Ministry has circulated a similar letter to all DHB Planning and Funding Managers earlier today.

Kind Regards,

Caitlin Leonard
Advisor Immunisation
Service Commissioning
Ministry of Health
DDI: 04 8164461

http://www.health.govt.nz
mailto:Caitlin_Leonard@moh.govt.nz

immunise
our best protection

MINISTRY OF HEALTH
MANATŪ HAUORA

No.1 The Terrace
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

1 June 2016

Dear School Based Immunisation Programme leads

Proposed changes in delivery of the Human Papillomavirus (HPV) Programme in 2017

PHARMAC have released a consultation paper this week on their proposed vaccine schedule changes for vaccines in 2017. We are very excited about one of these changes to replace the current quadrivalent Gardasil vaccine with the Gardasil 9 vaccine that protects individuals against the most common strains of HPV that cause cervical, genital, and anal cancers and genital warts.

A Changed Medicine Notification has been lodged with Medsafe to change the regimen from three doses to two doses for children aged 14 years and under.

PHARMAC are recommending, following approval from Medsafe, that the Gardasil 9 vaccine be approved as both a two dose and a three dose HPV vaccine schedule.

From 1 January 2017, we anticipate Gardasil 9 will be available on the funded schedule as a two dose regimen for both males and females under the age of 15 years. For males and females aged 15 to 26 years, the three dose schedule is recommended and funded and available through general practice.

These changes will affect the delivery of your School Based Immunisation Programmes. Overtime, we expect the Programme to be broadly fiscally neutral. While the Ministry is unsure of the cost implications and the uptake anticipated by expanding the Programme to include boys, the cost may be offset by the reduction in number of doses offered to each student.

The current School Based Immunisation Programme

The current HPV Programme delivers a three dose quadrivalent HPV vaccine schedule for females under the age of 20. Currently, Public Health Nurses (PHNs) are visiting schools up to four times a year to vaccinate students. This does not include additional planned catch-up visits.

Girls in school Year 8 receive three visits for their HPV vaccines, while boys and girls in Year 7 receive one visit for their single dose of tetanus, diphtheria and pertussis (Tdap) vaccine (see Table 1).

Table 1: Current School Based Immunisation Programme delivery

	Eligibility	Vaccine	Number of school visits
School Year 7	boys and girls	Tdap	x1
School Year 8	girls	HPV (dose 1-3)	x3

What is changing for the School Based Immunisation Programme?
It is proposed that the School Based Immunisation Programme will deliver a two dose HPV schedule for both boys and girls.

Benefits
These delivery changes provide several efficiency gains for the School Based Immunisation Programme, including reductions in school visits, improved use of resources, streamlined services and opportunities for increasing HPV immunisation coverage.

Planning for change
The Ministry recognises there is an opportunity for moving the School Based Immunisation Programme to Year 7. For 2017 only, HPV vaccinations will be given to boys and girls in Year 8 to ensure a smooth implementation to the new schedule changes (see Table 2).

Table 2: 2017 Consolidation of boys into existing School Based Immunisation Programme

2017	Eligibility	Vaccine	Number of school visits
School Year 7	boys and girls	Tdap	x1
School Year 8	boys and girls	HPV (dose 1) HPV (dose 2) minimum 6 months later	x2

The Ministry is keen to work with DHBs during the remainder of 2016 and early 2017, to develop a nationwide solution and ensure a smooth transition to the new schedule changes. From 2018, the School Based Immunisation Programme will either offer one HPV vaccine annually in each of school Years 7 and 8, or two HPV vaccines six months apart in one school year. (Final decision will be made by PHARMAC post consultation).

The Ministry's Immunisation Team will host regional teleconferences in June to discuss and agree on the details with School Based Immunisation Programme leads on the most efficient way to deliver this Programme nationally.

The Ministry's preferred position is to offer the Tdap vaccine and the first HPV dose together in school Year 7 and offer the second HPV dose 12 months later, in Year 8 to ensure a more efficient workflow for PHNs. This schedule is recommended by the supplier as it achieves a higher seroconversion (more information on the two dose trial work can be found at www.clinicaltrials.gov). The Ministry continues to work closely with PHARMAC, who will inform us of general feedback.

Communication resources
Shifting the School Based Immunisation Programme to Year 7 enables opportunities to combine information and resources (ie, consent forms). Planning is currently underway to identify what resources will require updating (see Table 3).

Table 3: Resources requiring updates to reflect schedule changes

What	Requires update?	Status
Consent forms	Yes	The Ministry has started updating consent forms to include boys. At this stage, changes are minor. There are likely to be future changes for 2018 onwards.
Y7 and 8 video	Yes	Pre-recorded voiceover for two dose will replace the current video. We are looking at including both boys and girls.
Ministry of Health FAQs	Yes	Currently being produced and will be updated when Medsafe approve Gardasil9 as a two dose regimen.
Other communications materials	Yes	Planning for communication materials to include boys is currently underway.
Professional Standards for School Based Service Delivery	Yes	Schedule changes will be incorporated in the current up-to-date draft. Final draft expected to be complete in July 2017.
Immunisation Handbook	Yes	Should be ready in time for 1 July 2017 schedule change, however the HPV chapter may be ready earlier.
Notice to SIMPL	Yes	Ministry to advise of schedule change.
Ministry of Education notification	Yes	Ministry has met with Education to advise of schedule changes. There will be opportunities later this year to inform school bodies of the changes through their networks.
NIR changes	Yes	Requirements being developed
Service coverage requirements	Yes	To do

Considerations for planning

Boys' school

While reducing to a two dose schedule is likely to decrease PHN workloads under the current School Based Immunisation Programmes, offering the vaccine to boys' schools will now need to be considered as part of the DHB planning.

School Based Vaccination System

DHBs who use the School Based Vaccination System (SBVS) will need to work with their SBVS providers to ensure these systems are updated to comply with the new HPV Programme delivery changes. The Ministry will provide recommended IT changes to the supplier of SBVS.

Likely increase in coverage and greater catch-up opportunity between doses

Uptake in New Zealand of the HPV vaccine has been modest. At present coverage for girls aged 12-years is approximately 64 percent for dose three.

Offering both HPV and Tdap vaccines in Year 7 allows more opportunities for boys and girls to complete their HPV vaccines before they are 15 years of age. This encourages early vaccination while immune response is high and before exposure to HPV infection, and allows for possible planned catch-up clinics for any child who may have missed their vaccination at school.

Note: There is no change to the HPV target.

Going forward
The Ministry sees this change as an exciting opportunity to work together to ensure timely and effective planning for the new schedule changes in preparation for the 2017 school year.

We know you will have several questions for us and we look forward to discussing details at the teleconferences this month.

Yours sincerely

Rayoni Keith
Manager, Immunisation
Service Commissioning
Ministry of Health

Lara Williams (Administrator)

From: Bonnie_Jones@moh.govt.nz
Sent: Monday, 30 May 2016 4:14 p.m.
Cc: Bonnie_Jones@moh.govt.nz
Subject: PHARMAC - Proposal to amend listings in the National Immunisation Schedule
Attachments: 2016-05-30 Consultation on Immunisation Schedule changes.pdf

Good afternoon,

PHARMAC is seeking feedback on proposals for the supply of vaccines for the New Zealand National Immunisation Schedule. Details are available in the attachment below and on the PHARMAC website at
https://www.pharmac.govt.nz/news/media-2016-05-30-vaccines-consultations/
https://www.pharmac.govt.nz/news/consultation-2016-05-30-immunisation-schedule/

In summary, these proposals would result in the following access, brand and dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.
- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.
- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.
- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.
- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**

  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).
- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

Details of how to provide feedback are available at the PHARMAC website.

Kind regards,

Bonnie Jones
Senior Advisor Stakeholder Engagement
Immunisation
Community Health
Service Commissioning
Ministry of Health
DDI: 04 816 4434
Mobile: 021 806 021

http://www.health.govt.nz
mailto:Bonnie_Jones@moh.govt.nz

CONSULTATION

PHARMAC
Pharmaceutical Management Agency

30 May 2016

Proposal to amend listings in the National Immunisation Schedule

Following a Request for Proposals (RFP) for the supply of various vaccines, issued on 15 February 2016, PHARMAC is now seeking feedback on proposals, relating to provisional agreements with a number of suppliers, for the supply of vaccines for the New Zealand National Immunisation Schedule. In summary, these proposals would result in the following access, brand & dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.

- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.

- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.

- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.

- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**
  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).

- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

All contracted vaccines would have Sole Supply Status from 1 July 2017 until 30 June 2020, making them the only vaccines listed for use in both the community and DHB hospitals.

At this time PHARMAC has not finalised provisional agreements for the following:

- Bacillus Calmette-Guerin vaccine (BCG);
- meningococcal C conjugate vaccine;
- hepatitis A vaccine;
- hepatitis B recombinant vaccine;
- pneumococcal polyvalent vaccine;
- poliomyelitis vaccine;
- pneumococcal (PCV13) vaccine (for high risk patients);
- meningococcal A, C , Y and W135 vaccine; and
- tuberculin PPD (Mantoux) test (Tubersol).

We anticipate a consultation on proposals relating to the above products will be issued within the next three months.

Feedback sought

PHARMAC welcomes feedback on this proposal. To provide feedback, please submit it in writing by **5 pm Monday, 20 June 2016** to:

Matthew Wolfenden	Email: vaccines@pharmac.govt.nz
Procurement Manager	Fax: 04 460 4995
PHARMAC	Post: PO Box 10 254, Wellington 6143

All feedback received before the closing date will be considered by PHARMAC's Board (or its delegate) prior to making a decision on this proposal.

Feedback we receive is subject to the Official Information Act 1982 (OIA) and we will consider any request to have information withheld in accordance with our obligations under the OIA. Anyone providing feedback, whether on their own account or on behalf of an organisation, and whether in a personal or professional capacity, should be aware that the content of their feedback and their identity may need to be disclosed in response to an OIA request.

We are not able to treat any part of your feedback as confidential unless you specifically request that we do, and then only to the extent permissible under the OIA and other relevant laws and requirements. If you would like us to withhold any commercially sensitive, confidential proprietary, or personal information included in your submission, please clearly state this in your submission and identify the relevant sections of your submission that you would like it withheld. PHARMAC will give due consideration to any such request

Background

PHARMAC began managing the National Immunisation Schedule from 1 July 2012.

PHARMAC first issued an RFP for the supply of vaccines in June 2013, which resulted in agreements with five suppliers. Sole Supply Status for vaccines covered by those agreements expires on 30 June 2017.

In preparation for running an RFP, PHARMAC requested that suppliers submit applications to PHARMAC for:

- funding of any new or alternative brands of vaccines they may have available for supply from July 2017; and
- any proposed changes to the funding eligibility criteria for current listings and/or the National Immunisation Schedule.

PHARMAC subsequently sought clinical advice from the Immunisation Subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC) on:

- the suitability of new vaccines recently registered by Medsafe or planned to be registered in time for 2017 supply;
- interchangeability of alternative brands; and
- possible funding eligibility criteria changes.

The complete Immunisation Subcommittee minutes are available on our website at:

www.pharmac.health.nz/about/committees/ptac/ptac-subcommittees/

On 15 February 2016 PHARMAC released an RFP for the supply of various vaccines, which can be found at the following link:

www.pharmac.govt.nz/news/rfp-2016-02-16-supply-of-various-vaccines/

The proposed listings and amendments to the National Immunisation Schedule are as a result of this RFP process.

Distribution of Vaccines unchanged

Vaccines are distributed differently to most other pharmaceuticals. The method for ordering vaccines by vaccinators would remain the same as a result of this proposal.

The vaccines would be listed "Xpharm" with a $0.00 subsidy. An Xpharm listing means that pharmacies cannot claim subsidy because PHARMAC has made alternative distribution arrangements.

Details of the proposals

Gardasil 9 would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 January 2017. All the other vaccines set out in this proposal would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017.

PHARMAC would use its reasonable endeavours to ensure the funded Pharmaceuticals are the only brand of the Pharmaceuticals distributed by the Service Provider on or after 1 July 2017.

Confidential net prices would apply to all vaccines listed as a result of this RFP.

The current funding criteria applying to all vaccines can be found in **Section I** and **Section H** of the Pharmaceutical Schedule and would be amended to implement any changes to eligibility and/or the number of doses, should these proposals be accepted.

The current funding criteria and the proposed amendments are collated in **Annex A** of this document.

The Ministry of Health's Immunisation Handbook would continue to provide information to vaccinators on the recommended timing of dosing for particular vaccines and catch up programmes.

Further details about each of the vaccines and proposed changes are set out below as follows:

Human papilloma virus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the human papilloma virus (HPV) vaccine, as a result of a provisional agreement with Seqirus.

This proposal would result in a change of HPV vaccine from Gardasil which contains 4 HPV antigens (types 6, 11, 16, 18) to Gardasil 9 which contains 9 HPV antigens (types 6, 11, 16, 18, 31, 33, 45, 52 and 58).

Gardasil 9 is currently registered for use under a three-dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen from three doses to two doses for children aged 14 years and under.

Details of the proposal

PHARMAC proposes that from 1 January 2017 Gardasil 9 would be listed on the National Immunisation Schedule. Gardasil would be delisted from 1 July 2017.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
human papilloma virus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	Injection 270 mcg in 0.5 ml	Gardasil 9	10	$0.00	$1,415.00
Human papilloma virus (6,11,16 and 18)	Injection 120 mcg in 0.5 ml	Gardasil	10	$0.00	$1,285.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 January 2017 the funding restrictions applying to HPV vaccines in Section H (the Hospital Medicines List) and Section I (National Immunisation Schedule) would be deleted and replaced with the following:

1. Maximum of two doses for males and females aged 14 years and under; or
2. Maximum of three doses for patients meeting any of the following criteria:
    i. Male and female patients aged 26 years and under; or
    ii. For use in transplant (including stem cell) patients: or
    iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose regimen prior to 1 January 2017. Progression would be subject to Medsafe approval of the two-dose regimen.

Gardasil 9 would have Sole Supply Status in both the community and DHB hospital settings for HPV vaccine from 1 July 2017 until 30 June 2020.

Background

The human papillomavirus virus (HPV) causes a number of cancers with cervical cancer being the most prevalent. Approximately 70% of cervical cancers are caused by HPV types 16 and 18 (covered by the four antigen Gardasil, "Gardasil") while a further 20% are caused by 31, 33, 45, 52 and 58 (covered by the antigens contained in Gardasil 9). HPV vaccination also protects against a number of other cancers including anal, penile, vulval, vaginal, and some forms of oropharyngeal cancers.

In response to the RFP issued in February 2016, Seqirus has proposed supply of the 9 antigen Gardasil 9 which is registered for use under a 3 dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen for 3 doses to two doses for those children aged 14 years and under.

Clinical trials have reported Gardasil 9 to be non-inferior to Gardasil in relation to the four antigens they have in common (6, 11, 16 and 18). While results from the two dose studies have reported that doses given at both 0 and 6 months (girls and boys) and 0 and 12 months (girls and boys) achieve good seroconversion, the 0 and 12 month schedule is recommended by the supplier as it achieves a higher seroconversion (access to two dose trial work can be found at www.clinicaltrials.gov).

Both the Immunisation Subcommittee (March 2013) and PTAC itself (August 2013) have reviewed an application from the supplier for funded access to be widened to young males aged 12 years and older to match the current National Immunisation Schedule funded access for girls. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Both the Subcommittee and PTAC made the following recommendations:

- that the age of female vaccination be amended to allow the first dose at age 11 with a medium priority, and allow the school based program to be initiated in year seven rather than year eight.
- widening access to HPV vaccine to include males between the ages of 11 and 25 inclusive who identify as MSM with a high priority.
- widening access to HPV vaccine to include all males between the ages of 11 and 18 with a low priority.

Two dose vaccination schedule

In February 2015, the Immunisation Subcommittee reviewed a PHARMAC-generated proposal to fund a two dose regimen for Gardasil (the 4 antigen preparation). Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-02-18.pdf

- The Subcommittee recommended funding two-dose HPV vaccination for girls up to 15 years of age, with a high priority noting that the three-dose HPV vaccination would remain funded for girls over 15 years of age.

This recommendation would have been difficult to implement as, at that time, Gardasil was not registered for a two dose regimen and the supplier did not have an appropriate registration dossier.

If the changed medicine notification to change the registration for Gardasil 9 is approved, this proposal would enable the introduction of a two-dose regimen to year 8 girls and boys in the 2017 school year with the possibility of moving to Year 7 boys and girls at a timing determined by the Ministry of Health, which is responsible for the in-school programme. If the move to year 7 was made, year 8 boys and girls would also need to be vaccinated in the same year.

Varicella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to varicella vaccine (varicella) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in the Varilrix being the only listed varicella vaccine. Funding restrictions would be widened to include:

- Primary vaccination in children, one dose, at 15 months; and
- A catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox; and
- Funded access for patients considered to be at high risk of infection (as currently defined in the Pharmaceutical Schedule) would continue.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Varilrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	1	$0.00	$50.00
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	10	$0.00	$500.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Varilrix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amendments to restrictions shown in bold:

1. **One dose for primary vaccination for:**
   - i. **Children at 15 months; or**
   - ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**
2. Maximum of two doses for any of the following:
   - **i.** For non-immune patients:
     - (a) with chronic liver disease who may in future be candidates for transplantation; or
     - (b) with deteriorating renal function before transplantation; or
     - (c) prior to solid organ transplant; or
     - (d) prior to any elective immunosuppression*.
   - **ii.** For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

* immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Varilrix would have Sole Supply Status in both the community and DHB hospital settings for varicella vaccine from 1 July 2017 until 30 June 2020.

Background

Varilrix has been listed and funded for patients at high risk of infection since 1 July 2014. Usage under the current funding criteria is less than 1000 doses per year.

This proposal is to introduce varicella vaccination into the National Immunisation Schedule initially with one dose being given at 15 months. A catch-up dose in general practice at 11 or 12 years would be funded for patients who have not had chickenpox previously and who have not been vaccinated against chickenpox.

Chickenpox is perceived as being a mild disease and most often is. However, complications such as secondary bacterial infection, pneumonitis and encephalitis occur in about 1% of cases, more typically in young adults, and usually lead to hospitalisation.

A study by Wen et al (Prospective surveillance of hospitalisations associated with varicella in New Zealand: J. Paediatr. Child Health 2015 doi:10.1111/jpc.12937) reported an annual incidence in New Zealand of varicella-related hospitalisations of 8.3/100,000 children (95% confidence interval 7.0-9.8/100,000) between 1 November 2011 and 31 October 2013. Complications included infection (75%), respiratory (11%), electrolyte disturbance (6%) and haemorrhagic varicella (4%) and 19% had ongoing problems at discharge. Māori and Pacific Island children accounted for 74% of the hospitalisations.

A ten year (2001-2011) review by Wen et al of varicella admissions to the Paediatric Intensive Care Unit at Starship Hospital (J. Paediatr. Child Health 2014;50(4):280-5) identified 34 cases, of which 26 patients were included in the review. Of these patients admission reasons were neurological (38.5%), secondary bacterial sepsis or shock (26.9%), respiratory (15.4%), disseminated varicella (11.5%), or other causes (7.7%). Four children died, three of whom, were immunocompromised and 31% had ongoing disability after discharge.

The Immunisation Subcommittee reviewed varicella vaccine at its March 2013 meeting and PTAC reviewed varicella vaccine at its August 2013 meeting. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Most recently, PTAC reviewed varicella vaccine at its February 2015 meeting and recommended:

- Varicella vaccine be funded with a high priority as a part of a universal childhood immunisation.
- The Committee noted that varicella vaccine could be given in combination with the HiB, MMR and pneumococcal vaccine at 15 months.
- While some members of the Committee considered that introducing a fourth injectable vaccine at 15 months could be problematic the majority of the Committee considered that it is acceptable to give four injections at that time.
- The Committee noted that for vaccination against varicella to be effective, patients would eventually require two doses, as wild-type varicella incidence in the paediatric population decreases.
- The Committee recommended Varicella vaccine be listed on the Pharmaceutical Schedule funded for one infant dose at age 15 months and one catch up dose at 11 or 12 years of age, with a high priority. One member abstained from voting.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-02-18.pdf

Pneumococcal conjugate vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating for pneumococcal conjugate vaccine (PCV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in:

- Synflorix, pneumococcal 10-valent protein conjugate vaccine (PCV10), being listed and replacing Prevenar 13 (PCV13) under the following criteria:
    - the primary course of immunisation for previously unvaccinated individuals up to the age of 59 months;
    - individuals under the age of 59 months who have not completed a four dose primary course of immunisation of PCV13; and
    - testing for primary immunodeficiency diseases.

An agreement for Prevenar 13, pneumococcal 13-valent protein conjugate vaccine (PCV13), for high risk patients only, has not been finalised.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Synflorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Pneumococcal (PVC10) conjugate vaccine	Inj 1mcg of pneumococcal polysaccharide serotypes 1, 5, 6B, 7F, 9V, 14 and 23F; 3mcg of pneumococcal polysaccharide serotypes 4, 18C and 19F in 0.5ml prefilled syringe	Synflorix	10	$0.00	$1,400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Synflorix, pneumococcal (PCV10) vaccine, would be the only pneumococcal vaccine listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 for funding under the following restrictions:

Any of the following:

1) A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or

2) Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or

3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Synflorix would have Sole Supply Status in both the community and DHB hospital settings for pneumococcal conjugate vaccine from 1 July 2017 until 30 June 2020.

Background

The Immunisation Subcommittee reviewed pneumococcal conjugate vaccines at its October 2015 meeting and **noted** the following:

> The Subcommittee considered that both PCV10 (GSK's Synflorix) and PCV13 (Pfizer's Prevenar 13) are suitable for inclusion on the National Immunisation Schedule but that if PCV10 were listed for universal vaccination it may be necessary to continue to list PCV13 for vaccination of high risk groups.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-10.pdf

Since the October 2015 meeting, GlaxoSmithKline has gained approval from Medsafe for an indication for active immunisation against disease caused by cross-reactive serotype 19A. At its' May 2016 meeting, the Immunisation Subcommittee recommended that PHARMAC monitor the incidence of 19A related invasive pneumococcal disease as reported in the ESR quarterly surveillance reports.

Rotavirus vaccine

PHARMAC is seeking feedback on a proposal to list an alternative brand of rotavirus, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Rotarix being the only listed rotavirus vaccine, RotaTeq being delisted and the current three-dose regimen being replaced with a two-dose regimen.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Rotarix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Rotavirus vaccine	Pre-filled oral applicator, live attenuated human rotavirus 1,000,000 $CCID_{50}$ per dose	Rotarix	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Rotarix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amended funding restrictions (deletions in strike through, insertions in bold):

Maximum of ~~three~~ **two** doses for patients meeting the following:

1. first dose to be administered in infants aged under ~~15~~ **14** weeks of age; and
2. no vaccination being administered to children aged ~~8 months~~ **24 weeks** or over.

Rotarix would have Sole Supply Status in both the community and DHB hospital settings for rotavirus vaccine from 1 July 2017 until 30 June 2020.

Background

Rotavirus vaccine has been listed and funded for primary vaccination in children since 1 July 2014. The Immunisation Subcommittee reviewed rotavirus vaccines at its March 2013 meeting and recommended:

- Funding rotavirus vaccination with a high priority.
- The Subcommittee considered that the two commercially available vaccines (Rotarix and RotaTeq) were of equal efficacy and PHARMAC could consider the Subcommittee's considerations as applying equally to both vaccines. Members considered that the two vaccines had a same or similar clinical efficacy. Members considered that the evidence for RotaTeq did not support any improved clinical outcomes as a result of the G2 strain inclusion. Members considered that there was cross-protection between strains from vaccine or illness, but that it was not complete.
- The Subcommittee noted that both vaccines were oral and can be given as part of the existing vaccine schedule. Members considered that the approved dosing frequency, either 2 or 3 doses, of each vaccine would be appropriate for the New Zealand setting.

Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

Measles, mumps and rubella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the measles, mumps, and rubella (MMR) vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Priorix being the only listed MMR vaccine and M-M-R II being delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Priorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Measles, mumps and rubella vaccine	Injection, measles virus 1,000 $CCID_{50}$, mumps virus 5,012 $CCID_{50}$, Rubella virus 1,000 $CCID_{50}$; prefilled syringe/ampoule of diluent 0.5 ml	Priorix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 the MMR vaccine would continue to be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Priorix would have Sole Supply Status in both the community and DHB hospital settings for MMR from 1 July 2017 until 30 June 2020.

Haemophilus influenzae type B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the *Haemophilus influenzae* type B vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Hiberix being the only listed *haemophilus influenzae* type B vaccine; Act-HIB would be delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Hiberix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Haemophilus influenzae type B vaccine	Haemophilus Influenzae type b polysaccharide 10 mcg conjugated to tetanus toxoid as carrier protein 20-40 mcg; pre-filled syringe plus vial 0.5 ml	Hiberix	10	$0.00	$200.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

From 1 July 2017 the *Haemophilus influenzae* type B vaccine would be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Hiberix would have Sole Supply Status in both the community and DHB hospital settings for *Haemophilus influenzae* type B vaccine from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus and acellular pertussis vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type tetanus, diphtheria, and acellular pertussis vaccine (Tdap) virus vaccine live as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Boostrix remaining as the only listed Tdap vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Boostrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	1	$0.00	$25.00
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 adult type tetanus, diphtheria, and acellular pertussis vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Boostrix would have Sole Supply Status in both the community and DHB hospital settings for Tdap from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (DTaP-IPV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix IPV remaining as the only listed DTaP-IPV vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix IPV would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis and polio vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin and 80 D-antigen units poliomyelitis virus in 0.5 ml pre-filled syringe	Infanrix IPV	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed change

From 1 July 2017 diphtheria, tetanus, acellular pertussis and inactivated polio vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix IPV would have Sole Supply Status in both the community and DHB hospital settings for DTaP-IPV from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine virus vaccine live (hexavalent vaccine) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix-Hexa remaining as the only listed hexavalent vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix-Hexa would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin, 80 D-antigen units poliomyelitis virus, 10 mcg hepatitis B surface antigen in 0.5 ml syringe (1) and 10 mcg haemophilus influenza type B vaccine in 0.5 ml pre-filled syringe	Infanrix Hexa	10	$0.00	$1,300.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 the hexavalent vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix-Hexa would have Sole Supply Status in both the community and DHB hospital settings for the hexavalent vaccine from 1 July 2017 until 30 June 2020.

Adult diphtheria and tetanus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult diphtheria and tetanus (Td) vaccine as a result of a provisional agreement with Seqirus.

This proposal would result in ADT Booster remaining as the only listed Td vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 ADT Booster would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Adult diphtheria and tetanus	Injection 2 IU diphtheria toxoid with 20 IU tetanus toxoid in 0.5 ml	ADT Booster	5	$0.00	$84.85

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 adult diphtheria and tetanus vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

ADT Booster would have Sole Supply Status in both the community and DHB hospital settings for Td vaccine from 1 July 2017 until 30 June 2020.

Annex A – Current and Proposed Funding Criteria

The following funding criteria would apply (amendments/additions are shown in bold and deletions in strike through):

Adult diphtheria and tetanus vaccine – ADT Booster

Any of the following:

1. For vaccination of patients aged 45 and 65 years old; or
2. For vaccination of previously unimmunised or partially immunised patients; or
3. For revaccination following immunosuppression; or
4. For boosting of patients with tetanus-prone wounds; or
5. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus and acellular pertussis vaccine – Boostrix

Funded for any of the following criteria:

1. A single vaccine for pregnant woman between gestational weeks 28 and 38; or
2. A course of up to four vaccines is funded for children from age 7 up to the age of 18 years inclusive to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens.

Notes: Tdap is not registered for patients aged less than 10 years. Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine – Infanrix IPV

Funded for any of the following:

1. A single dose for children up to the age of 7 who have completed primary immunisation; or
2. A course of four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
4. Five doses will be funded for children requiring solid organ transplantation.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine – Infanrix Hexa

Funded for patients meeting any of the following criteria:

1. Up to four doses for children up to and under the age of 10 for primary immunisation; or

2. An additional four doses (as appropriate) are funded for (re-)immunisation for children up to and under the age of 10 who are patients post haematopoietic stem cell transplantation, or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or

3. Up to five doses for children up to and under the age of 10 receiving solid organ transplantation

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

Haemophilus influenzae type B vaccine – Hiberix

One dose for patients meeting any of the following:

1. For primary vaccination in children; or

2. An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens; or

3. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Human papillomavirus vaccine – Gardasil 9

1. **Maximum of two doses for males and females aged 14 years and under; or**

2. Maximum of three doses for patients meeting any of the following criteria:

    i. **Male and** female~~s~~ **patients** ~~aged under 20 years old~~ **26 years and under**; or

    ~~Patients aged under 26 years old with confirmed HIV infection; or~~

    ii. For use in transplant (including stem cell) patients; or

    iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose schedule prior to listing on the Pharmaceutical Schedule.

Measles, mumps and rubella vaccine – Priorix

A maximum of two doses for any patient meeting the following criteria:

1. For primary vaccination in children; or

2. For revaccination following immunosuppression; or

3. For any individual susceptible to measles, mumps or rubella; or

4. A maximum of three doses for children who have had their first dose prior to 12 months.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Pneumococcal (PCV10) vaccine – Synflorix

Any of the following:

1. **A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or**

2. **Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or**

3. **For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.**

Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

Rotavirus vaccine – Rotarix

Maximum of three two doses for patients meeting the following:

1. First dose to be administered in infants aged under ~~15~~ **14** weeks of age; and

2. no vaccination being administered to children aged ~~8 months~~ **24 weeks** or over.

Varicella vaccine – Varilrix

1. **One dose for primary vaccination for:**

   i. **Children at 15 months; or**

   ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**

2. Maximum of two doses for any of the following:

   i. For non-immune patients:

      (a) with chronic liver disease who may in future be candidates for transplantation; or
      (b) with deteriorating renal function before transplantation; or
      (c) prior to solid organ transplant; or
      (d) prior to any elective immunosuppression*.

   ii. For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

   iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

   iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

   v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

   vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

   vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

      * immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Lara Williams (Administrator)

From: Bonnie_Jones@moh.govt.nz
Sent: Monday, 30 May 2016 4:14 p.m.
Cc: Bonnie_Jones@moh.govt.nz
Subject: PHARMAC - Proposal to amend listings in the National Immunisation Schedule
Attachments: 2016-05-30 Consultation on Immunisation Schedule changes.pdf

Good afternoon,

PHARMAC is seeking feedback on proposals for the supply of vaccines for the New Zealand National Immunisation Schedule. Details are available in the attachment below and on the PHARMAC website at
https://www.pharmac.govt.nz/news/media-2016-05-30-vaccines-consultations/
https://www.pharmac.govt.nz/news/consultation-2016-05-30-immunisation-schedule/

In summary, these proposals would result in the following access, brand and dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.
- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.
- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.
- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.
- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**

  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).
- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

Details of how to provide feedback are available at the PHARMAC website.

Kind regards,

Bonnie Jones
Senior Advisor Stakeholder Engagement
Immunisation
Community Health
Service Commissioning
Ministry of Health
DDI: 04 816 4434
Mobile: 021 806 021

http://www.health.govt.nz
mailto:Bonnie_Jones@moh.govt.nz

CONSULTATION

PHARMAC
Pharmaceutical Management Agency

30 May 2016

Proposal to amend listings in the National Immunisation Schedule

Following a Request for Proposals (RFP) for the supply of various vaccines, issued on 15 February 2016, PHARMAC is now seeking feedback on proposals, relating to provisional agreements with a number of suppliers, for the supply of vaccines for the New Zealand National Immunisation Schedule. In summary, these proposals would result in the following access, brand & dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.

- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.

- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.

- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.

- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**
  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).

- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

All contracted vaccines would have Sole Supply Status from 1 July 2017 until 30 June 2020, making them the only vaccines listed for use in both the community and DHB hospitals.

At this time PHARMAC has not finalised provisional agreements for the following:

- Bacillus Calmette-Guerin vaccine (BCG);
- meningococcal C conjugate vaccine;
- hepatitis A vaccine;
- hepatitis B recombinant vaccine;
- pneumococcal polyvalent vaccine;
- poliomyelitis vaccine;
- pneumococcal (PCV13) vaccine (for high risk patients);
- meningococcal A, C , Y and W135 vaccine; and
- tuberculin PPD (Mantoux) test (Tubersol).

We anticipate a consultation on proposals relating to the above products will be issued within the next three months.

Feedback sought

PHARMAC welcomes feedback on this proposal. To provide feedback, please submit it in writing by **5 pm Monday, 20 June 2016** to:

Matthew Wolfenden	Email: vaccines@pharmac.govt.nz
Procurement Manager	Fax: 04 460 4995
PHARMAC	Post: PO Box 10 254, Wellington 6143

All feedback received before the closing date will be considered by PHARMAC's Board (or its delegate) prior to making a decision on this proposal.

Feedback we receive is subject to the Official Information Act 1982 (OIA) and we will consider any request to have information withheld in accordance with our obligations under the OIA. Anyone providing feedback, whether on their own account or on behalf of an organisation, and whether in a personal or professional capacity, should be aware that the content of their feedback and their identity may need to be disclosed in response to an OIA request.

We are not able to treat any part of your feedback as confidential unless you specifically request that we do, and then only to the extent permissible under the OIA and other relevant laws and requirements. If you would like us to withhold any commercially sensitive, confidential proprietary, or personal information included in your submission, please clearly state this in your submission and identify the relevant sections of your submission that you would like it withheld. PHARMAC will give due consideration to any such request

Background

PHARMAC began managing the National Immunisation Schedule from 1 July 2012.

PHARMAC first issued an RFP for the supply of vaccines in June 2013, which resulted in agreements with five suppliers. Sole Supply Status for vaccines covered by those agreements expires on 30 June 2017.

In preparation for running an RFP, PHARMAC requested that suppliers submit applications to PHARMAC for:

- funding of any new or alternative brands of vaccines they may have available for supply from July 2017; and
- any proposed changes to the funding eligibility criteria for current listings and/or the National Immunisation Schedule.

PHARMAC subsequently sought clinical advice from the Immunisation Subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC) on:

- the suitability of new vaccines recently registered by Medsafe or planned to be registered in time for 2017 supply;
- interchangeability of alternative brands; and
- possible funding eligibility criteria changes.

The complete Immunisation Subcommittee minutes are available on our website at:

www.pharmac.health.nz/about/committees/ptac/ptac-subcommittees/

On 15 February 2016 PHARMAC released an RFP for the supply of various vaccines, which can be found at the following link:

www.pharmac.govt.nz/news/rfp-2016-02-16-supply-of-various-vaccines/

The proposed listings and amendments to the National Immunisation Schedule are as a result of this RFP process.

Distribution of Vaccines unchanged

Vaccines are distributed differently to most other pharmaceuticals. The method for ordering vaccines by vaccinators would remain the same as a result of this proposal.

The vaccines would be listed "Xpharm" with a $0.00 subsidy. An Xpharm listing means that pharmacies cannot claim subsidy because PHARMAC has made alternative distribution arrangements.

Details of the proposals

Gardasil 9 would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 January 2017. All the other vaccines set out in this proposal would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017.

PHARMAC would use its reasonable endeavours to ensure the funded Pharmaceuticals are the only brand of the Pharmaceuticals distributed by the Service Provider on or after 1 July 2017.

Confidential net prices would apply to all vaccines listed as a result of this RFP.

The current funding criteria applying to all vaccines can be found in **Section I** and **Section H** of the Pharmaceutical Schedule and would be amended to implement any changes to eligibility and/or the number of doses, should these proposals be accepted.

The current funding criteria and the proposed amendments are collated in **Annex A** of this document.

The Ministry of Health's Immunisation Handbook would continue to provide information to vaccinators on the recommended timing of dosing for particular vaccines and catch up programmes.

Further details about each of the vaccines and proposed changes are set out below as follows:

Human papilloma virus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the human papilloma virus (HPV) vaccine, as a result of a provisional agreement with Seqirus.

This proposal would result in a change of HPV vaccine from Gardasil which contains 4 HPV antigens (types 6, 11, 16, 18) to Gardasil 9 which contains 9 HPV antigens (types 6, 11, 16, 18, 31, 33, 45, 52 and 58).

Gardasil 9 is currently registered for use under a three-dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen from three doses to two doses for children aged 14 years and under.

Details of the proposal

PHARMAC proposes that from 1 January 2017 Gardasil 9 would be listed on the National Immunisation Schedule. Gardasil would be delisted from 1 July 2017.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
human papilloma virus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	Injection 270 mcg in 0.5 ml	Gardasil 9	10	$0.00	$1,415.00
Human papilloma virus (6,11,16 and 18)	Injection 120 mcg in 0.5 ml	Gardasil	10	$0.00	$1,285.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 January 2017 the funding restrictions applying to HPV vaccines in Section H (the Hospital Medicines List) and Section I (National Immunisation Schedule) would be deleted and replaced with the following:

1. Maximum of two doses for males and females aged 14 years and under; or
2. Maximum of three doses for patients meeting any of the following criteria:
    i. Male and female patients aged 26 years and under; or
    ii. For use in transplant (including stem cell) patients: or
    iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose regimen prior to 1 January 2017. Progression would be subject to Medsafe approval of the two-dose regimen.

Gardasil 9 would have Sole Supply Status in both the community and DHB hospital settings for HPV vaccine from 1 July 2017 until 30 June 2020.

Background

The human papillomavirus virus (HPV) causes a number of cancers with cervical cancer being the most prevalent. Approximately 70% of cervical cancers are caused by HPV types 16 and 18 (covered by the four antigen Gardasil, "Gardasil") while a further 20% are caused by 31, 33, 45, 52 and 58 (covered by the antigens contained in Gardasil 9). HPV vaccination also protects against a number of other cancers including anal, penile, vulval, vaginal, and some forms of oropharyngeal cancers.

In response to the RFP issued in February 2016, Seqirus has proposed supply of the 9 antigen Gardasil 9 which is registered for use under a 3 dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen for 3 doses to two doses for those children aged 14 years and under.

Clinical trials have reported Gardasil 9 to be non-inferior to Gardasil in relation to the four antigens they have in common (6, 11, 16 and 18). While results from the two dose studies have reported that doses given at both 0 and 6 months (girls and boys) and 0 and 12 months (girls and boys) achieve good seroconversion, the 0 and 12 month schedule is recommended by the supplier as it achieves a higher seroconversion (access to two dose trial work can be found at www.clinicaltrials.gov).

Both the Immunisation Subcommittee (March 2013) and PTAC itself (August 2013) have reviewed an application from the supplier for funded access to be widened to young males aged 12 years and older to match the current National Immunisation Schedule funded access for girls. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Both the Subcommittee and PTAC made the following recommendations:

- that the age of female vaccination be amended to allow the first dose at age 11 with a medium priority, and allow the school based program to be initiated in year seven rather than year eight.
- widening access to HPV vaccine to include males between the ages of 11 and 25 inclusive who identify as MSM with a high priority.
- widening access to HPV vaccine to include all males between the ages of 11 and 18 with a low priority.

Two dose vaccination schedule

In February 2015, the Immunisation Subcommittee reviewed a PHARMAC-generated proposal to fund a two dose regimen for Gardasil (the 4 antigen preparation). Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-02-18.pdf

- The Subcommittee recommended funding two-dose HPV vaccination for girls up to 15 years of age, with a high priority noting that the three-dose HPV vaccination would remain funded for girls over 15 years of age.

This recommendation would have been difficult to implement as, at that time, Gardasil was not registered for a two dose regimen and the supplier did not have an appropriate registration dossier.

If the changed medicine notification to change the registration for Gardasil 9 is approved, this proposal would enable the introduction of a two-dose regimen to year 8 girls and boys in the 2017 school year with the possibility of moving to Year 7 boys and girls at a timing determined by the Ministry of Health, which is responsible for the in-school programme. If the move to year 7 was made, year 8 boys and girls would also need to be vaccinated in the same year.

Varicella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to varicella vaccine (varicella) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in the Varilrix being the only listed varicella vaccine. Funding restrictions would be widened to include:

- Primary vaccination in children, one dose, at 15 months; and
- A catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox; and
- Funded access for patients considered to be at high risk of infection (as currently defined in the Pharmaceutical Schedule) would continue.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Varilrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	1	$0.00	$50.00
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	10	$0.00	$500.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Varilrix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amendments to restrictions shown in bold:

1. **One dose for primary vaccination for:**
   - i. **Children at 15 months; or**
   - ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**
2. Maximum of two doses for any of the following:
   - **i.** For non-immune patients:
     - (a) with chronic liver disease who may in future be candidates for transplantation; or
     - (b) with deteriorating renal function before transplantation; or
     - (c) prior to solid organ transplant; or
     - (d) prior to any elective immunosuppression*.
   - **ii.** For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

* immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Varilrix would have Sole Supply Status in both the community and DHB hospital settings for varicella vaccine from 1 July 2017 until 30 June 2020.

Background

Varilrix has been listed and funded for patients at high risk of infection since 1 July 2014. Usage under the current funding criteria is less than 1000 doses per year.

This proposal is to introduce varicella vaccination into the National Immunisation Schedule initially with one dose being given at 15 months. A catch-up dose in general practice at 11 or 12 years would be funded for patients who have not had chickenpox previously and who have not been vaccinated against chickenpox.

Chickenpox is perceived as being a mild disease and most often is. However, complications such as secondary bacterial infection, pneumonitis and encephalitis occur in about 1% of cases, more typically in young adults, and usually lead to hospitalisation.

A study by Wen et al (Prospective surveillance of hospitalisations associated with varicella in New Zealand: J. Paediatr. Child Health 2015 doi:10.1111/jpc.12937) reported an annual incidence in New Zealand of varicella-related hospitalisations of 8.3/100,000 children (95% confidence interval 7.0-9.8/100,000) between 1 November 2011 and 31 October 2013. Complications included infection (75%), respiratory (11%), electrolyte disturbance (6%) and haemorrhagic varicella (4%) and 19% had ongoing problems at discharge. Māori and Pacific Island children accounted for 74% of the hospitalisations.

A ten year (2001-2011) review by Wen et al of varicella admissions to the Paediatric Intensive Care Unit at Starship Hospital (J. Paediatr. Child Health 2014;50(4):280-5) identified 34 cases, of which 26 patients were included in the review. Of these patients admission reasons were neurological (38.5%), secondary bacterial sepsis or shock (26.9%), respiratory (15.4%), disseminated varicella (11.5%), or other causes (7.7%). Four children died, three of whom, were immunocompromised and 31% had ongoing disability after discharge.

The Immunisation Subcommittee reviewed varicella vaccine at its March 2013 meeting and PTAC reviewed varicella vaccine at its August 2013 meeting. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Most recently, PTAC reviewed varicella vaccine at its February 2015 meeting and recommended:

- Varicella vaccine be funded with a high priority as a part of a universal childhood immunisation.
- The Committee noted that varicella vaccine could be given in combination with the HiB, MMR and pneumococcal vaccine at 15 months.
- While some members of the Committee considered that introducing a fourth injectable vaccine at 15 months could be problematic the majority of the Committee considered that it is acceptable to give four injections at that time.
- The Committee noted that for vaccination against varicella to be effective, patients would eventually require two doses, as wild-type varicella incidence in the paediatric population decreases.
- The Committee recommended Varicella vaccine be listed on the Pharmaceutical Schedule funded for one infant dose at age 15 months and one catch up dose at 11 or 12 years of age, with a high priority. One member abstained from voting.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-02-18.pdf

Pneumococcal conjugate vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating for pneumococcal conjugate vaccine (PCV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in:

- Synflorix, pneumococcal 10-valent protein conjugate vaccine (PCV10), being listed and replacing Prevenar 13 (PCV13) under the following criteria:
    - the primary course of immunisation for previously unvaccinated individuals up to the age of 59 months;
    - individuals under the age of 59 months who have not completed a four dose primary course of immunisation of PCV13; and
    - testing for primary immunodeficiency diseases.

An agreement for Prevenar 13, pneumococcal 13-valent protein conjugate vaccine (PCV13), for high risk patients only, has not been finalised.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Synflorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Pneumococcal (PVC10) conjugate vaccine	Inj 1mcg of pneumococcal polysaccharide serotypes 1, 5, 6B, 7F, 9V, 14 and 23F; 3mcg of pneumococcal polysaccharide serotypes 4, 18C and 19F in 0.5ml prefilled syringe	Synflorix	10	$0.00	$1,400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Synflorix, pneumococcal (PCV10) vaccine, would be the only pneumococcal vaccine listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 for funding under the following restrictions:

Any of the following:

1) A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or

2) Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or

3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Synflorix would have Sole Supply Status in both the community and DHB hospital settings for pneumococcal conjugate vaccine from 1 July 2017 until 30 June 2020.

Background

The Immunisation Subcommittee reviewed pneumococcal conjugate vaccines at its October 2015 meeting and **noted** the following:

> The Subcommittee considered that both PCV10 (GSK's Synflorix) and PCV13 (Pfizer's Prevenar 13) are suitable for inclusion on the National Immunisation Schedule but that if PCV10 were listed for universal vaccination it may be necessary to continue to list PCV13 for vaccination of high risk groups.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-10.pdf

Since the October 2015 meeting, GlaxoSmithKline has gained approval from Medsafe for an indication for active immunisation against disease caused by cross-reactive serotype 19A. At its' May 2016 meeting, the Immunisation Subcommittee recommended that PHARMAC monitor the incidence of 19A related invasive pneumococcal disease as reported in the ESR quarterly surveillance reports.

Rotavirus vaccine

PHARMAC is seeking feedback on a proposal to list an alternative brand of rotavirus, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Rotarix being the only listed rotavirus vaccine, RotaTeq being delisted and the current three-dose regimen being replaced with a two-dose regimen.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Rotarix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Rotavirus vaccine	Pre-filled oral applicator, live attenuated human rotavirus 1,000,000 $CCID_{50}$ per dose	Rotarix	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Rotarix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amended funding restrictions (deletions in strike through, insertions in bold):

Maximum of ~~three~~ **two** doses for patients meeting the following:

1. first dose to be administered in infants aged under ~~15~~ **14** weeks of age; and
2. no vaccination being administered to children aged ~~8 months~~ **24 weeks** or over.

Rotarix would have Sole Supply Status in both the community and DHB hospital settings for rotavirus vaccine from 1 July 2017 until 30 June 2020.

Background

Rotavirus vaccine has been listed and funded for primary vaccination in children since 1 July 2014. The Immunisation Subcommittee reviewed rotavirus vaccines at its March 2013 meeting and recommended:

- Funding rotavirus vaccination with a high priority.
- The Subcommittee considered that the two commercially available vaccines (Rotarix and RotaTeq) were of equal efficacy and PHARMAC could consider the Subcommittee's considerations as applying equally to both vaccines. Members considered that the two vaccines had a same or similar clinical efficacy. Members considered that the evidence for RotaTeq did not support any improved clinical outcomes as a result of the G2 strain inclusion. Members considered that there was cross-protection between strains from vaccine or illness, but that it was not complete.
- The Subcommittee noted that both vaccines were oral and can be given as part of the existing vaccine schedule. Members considered that the approved dosing frequency, either 2 or 3 doses, of each vaccine would be appropriate for the New Zealand setting.

Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

Measles, mumps and rubella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the measles, mumps, and rubella (MMR) vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Priorix being the only listed MMR vaccine and M-M-R II being delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Priorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Measles, mumps and rubella vaccine	Injection, measles virus 1,000 $CCID_{50}$, mumps virus 5,012 $CCID_{50}$, Rubella virus 1,000 $CCID_{50}$; prefilled syringe/ampoule of diluent 0.5 ml	Priorix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 the MMR vaccine would continue to be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Priorix would have Sole Supply Status in both the community and DHB hospital settings for MMR from 1 July 2017 until 30 June 2020.

Haemophilus influenzae type B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the *Haemophilus influenzae* type B vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Hiberix being the only listed *haemophilus influenzae* type B vaccine; Act-HIB would be delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Hiberix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Haemophilus influenzae type B vaccine	Haemophilus Influenzae type b polysaccharide 10 mcg conjugated to tetanus toxoid as carrier protein 20-40 mcg; pre-filled syringe plus vial 0.5 ml	Hiberix	10	$0.00	$200.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

From 1 July 2017 the *Haemophilus influenzae* type B vaccine would be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Hiberix would have Sole Supply Status in both the community and DHB hospital settings for *Haemophilus influenzae* type B vaccine from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus and acellular pertussis vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type tetanus, diphtheria, and acellular pertussis vaccine (Tdap) virus vaccine live as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Boostrix remaining as the only listed Tdap vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Boostrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	1	$0.00	$25.00
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 adult type tetanus, diphtheria, and acellular pertussis vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Boostrix would have Sole Supply Status in both the community and DHB hospital settings for Tdap from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (DTaP-IPV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix IPV remaining as the only listed DTaP-IPV vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix IPV would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis and polio vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin and 80 D-antigen units poliomyelitis virus in 0.5 ml pre-filled syringe	Infanrix IPV	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed change

From 1 July 2017 diphtheria, tetanus, acellular pertussis and inactivated polio vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix IPV would have Sole Supply Status in both the community and DHB hospital settings for DTaP-IPV from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine virus vaccine live (hexavalent vaccine) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix-Hexa remaining as the only listed hexavalent vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix-Hexa would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin, 80 D-antigen units poliomyelitis virus, 10 mcg hepatitis B surface antigen in 0.5 ml syringe (1) and 10 mcg haemophilus influenza type B vaccine in 0.5 ml pre-filled syringe	Infanrix Hexa	10	$0.00	$1,300.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 the hexavalent vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix-Hexa would have Sole Supply Status in both the community and DHB hospital settings for the hexavalent vaccine from 1 July 2017 until 30 June 2020.

Adult diphtheria and tetanus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult diphtheria and tetanus (Td) vaccine as a result of a provisional agreement with Seqirus.

This proposal would result in ADT Booster remaining as the only listed Td vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 ADT Booster would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Adult diphtheria and tetanus	Injection 2 IU diphtheria toxoid with 20 IU tetanus toxoid in 0.5 ml	ADT Booster	5	$0.00	$84.85

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 adult diphtheria and tetanus vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

ADT Booster would have Sole Supply Status in both the community and DHB hospital settings for Td vaccine from 1 July 2017 until 30 June 2020.

Annex A – Current and Proposed Funding Criteria

The following funding criteria would apply (amendments/additions are shown in bold and deletions in strike through):

Adult diphtheria and tetanus vaccine – ADT Booster

Any of the following:

1. For vaccination of patients aged 45 and 65 years old; or
2. For vaccination of previously unimmunised or partially immunised patients; or
3. For revaccination following immunosuppression; or
4. For boosting of patients with tetanus-prone wounds; or
5. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus and acellular pertussis vaccine – Boostrix

Funded for any of the following criteria:

1. A single vaccine for pregnant woman between gestational weeks 28 and 38; or
2. A course of up to four vaccines is funded for children from age 7 up to the age of 18 years inclusive to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens.

Notes: Tdap is not registered for patients aged less than 10 years. Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine – Infanrix IPV

Funded for any of the following:

1. A single dose for children up to the age of 7 who have completed primary immunisation; or
2. A course of four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
4. Five doses will be funded for children requiring solid organ transplantation.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine – Infanrix Hexa

Funded for patients meeting any of the following criteria:

1. Up to four doses for children up to and under the age of 10 for primary immunisation; or
2. An additional four doses (as appropriate) are funded for (re-)immunisation for children up to and under the age of 10 who are patients post haematopoietic stem cell transplantation, or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
3. Up to five doses for children up to and under the age of 10 receiving solid organ transplantation

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

Haemophilus influenzae type B vaccine – Hiberix

One dose for patients meeting any of the following:

1. For primary vaccination in children; or
2. An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens; or
3. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Human papillomavirus vaccine – Gardasil 9

1. **Maximum of two doses for males and females aged 14 years and under; or**
2. Maximum of three doses for patient**s** meeting any of the following criteria:
   i. **Male and** female**s patients** ~~aged under 20 years old~~ **26 years and under**; or

   ~~Patients aged under 26 years old with confirmed HIV infection; or~~

   ii. For use in transplant (including stem cell) patients; or
   iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose schedule prior to listing on the Pharmaceutical Schedule.

Measles, mumps and rubella vaccine – Priorix

A maximum of two doses for any patient meeting the following criteria:

1. For primary vaccination in children; or
2. For revaccination following immunosuppression; or
3. For any individual susceptible to measles, mumps or rubella; or
4. A maximum of three doses for children who have had their first dose prior to 12 months.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Pneumococcal (PCV10) vaccine – Synflorix

Any of the following:

1. **A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or**

2. **Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or**

3. **For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.**

Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

Rotavirus vaccine – Rotarix

Maximum of three two doses for patients meeting the following:

1. First dose to be administered in infants aged under ~~15~~ **14** weeks of age; and

2. no vaccination being administered to children aged ~~**8 months**~~ **24 weeks** or over.

Varicella vaccine – Varilrix

1. **One dose for primary vaccination for:**

   i. **Children at 15 months; or**

   ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**

2. Maximum of two doses for any of the following:

   i. For non-immune patients:

      (a) with chronic liver disease who may in future be candidates for transplantation; or
      (b) with deteriorating renal function before transplantation; or
      (c) prior to solid organ transplant; or
      (d) prior to any elective immunosuppression*.

   ii. For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

   iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

   iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

   v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

   vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

   vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

      * immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 2 February 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Donna MacLean, Bridget Lester, Tony Walls, Anne Feld, Dr Alison Wooding, Dr Sarah Marr and Anna Harwood.	
Apologies: Geraldine Clemens	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 8 December 2015 meeting approved to go to the CCN office.	Bridget	5 Feb 2016
2.	**Previous Actions & Matters Arising**	• Communications with LMCs around NIR1 form, yet to be completed. • ISLA 2016/17 work plan – to be updated and circulate • OIS Service RFP – approval has been given to progress this, and letters have been sent to all providers around this. RFP will be issued late Feb with new service in place by 1 September 2016. • Immunise for Life – this has not been progressed. However a piece of work will occur to look at the MoH Resources and what CDHB specific resources we need to retain.	Bridget and Margo Bridget Bridget	13 Feb 2016 Next meeting
3.	**ISLA Work plan**	Q2 data = 8 month olds tracking towards 96%. And achieved for Maori, Pacific and NZE! Awesome effort. 2 year olds - tracking towards 93% achieved. 5.4% opt offs and declines 5 year olds – tracking towards 92% Progress continues to be made on the other aspects of the work plan. **Pregnancy Vaccinations** – need to develop a 2016 Plan. In 2015 a number of innovates were implemented – we need to determine if these were successful. Need to look education to GPs around the importance of pregnancy information – and the suggested general practice systems. Action • Develop 2016 Plan • Approach Sector Service to find 2015 uptake data. Influenza Plan 2016	Bridget	29th February

	Item	Discussion/Action	Responsibility	Date due
		• Canterbury will again be providing the programme in line with the national eligibly criteria and using the NSIG resources. • Some specific questions were asks of ISLA from the CPRG. o **Vaccinating in ED –** not supported, as not key role of ED and difficulties around eligibility criteria. Action: Education to ED around who is eligibility and what to promote. o **Data Management** – CPRG has requested the more information around vaccine uptake is shared including all eligible groups and the non-subsided group. PHOs have been contacted and they are only able to provide 65 and over data, by ethnicity – however this will only be provide monthly during the programme. Any additional reporting would come at substantial cost. Contact has been made with the MoH around what information will be available from the NIR. o **Tri vs Quadivalant** – CPRG is questions if both these vaccines could be promoted. This was not supported. Discussion occurred around why do we have two different vaccines, and is not better than the other. There was a concern that people may opt to pay for the Quadivalent, thinking it is a better vaccine which will impact on the DHB 65 and over coverage. **HPV Year 8 programme update -** the HPV Team is now in place and good progress is being made with schools. MedTech is progressing. The first vaccinations will start on the 29th February 2016.		
4.	**OIS RFP Process**	Documentation is currently being drafted. Working on the development of the Panel members. Need to ensure there no conflict of interest.	Bridget	
5.	**2016/17 Work plan**	• **Minor changes suggested. To be updated and sent to Ruth**	Bridget	
6.	**Operational**	• **Risk Register** – add risk of the Tri Vs Quadivalent	Bridget	
7.	**Next Meeting**	Next meeting 5 April 2016 2-4pm at C&PH		

our health system

Key Performance Indicators and Childhood Immunisation Reporting

June 2016

Immunisation Reporting Programme

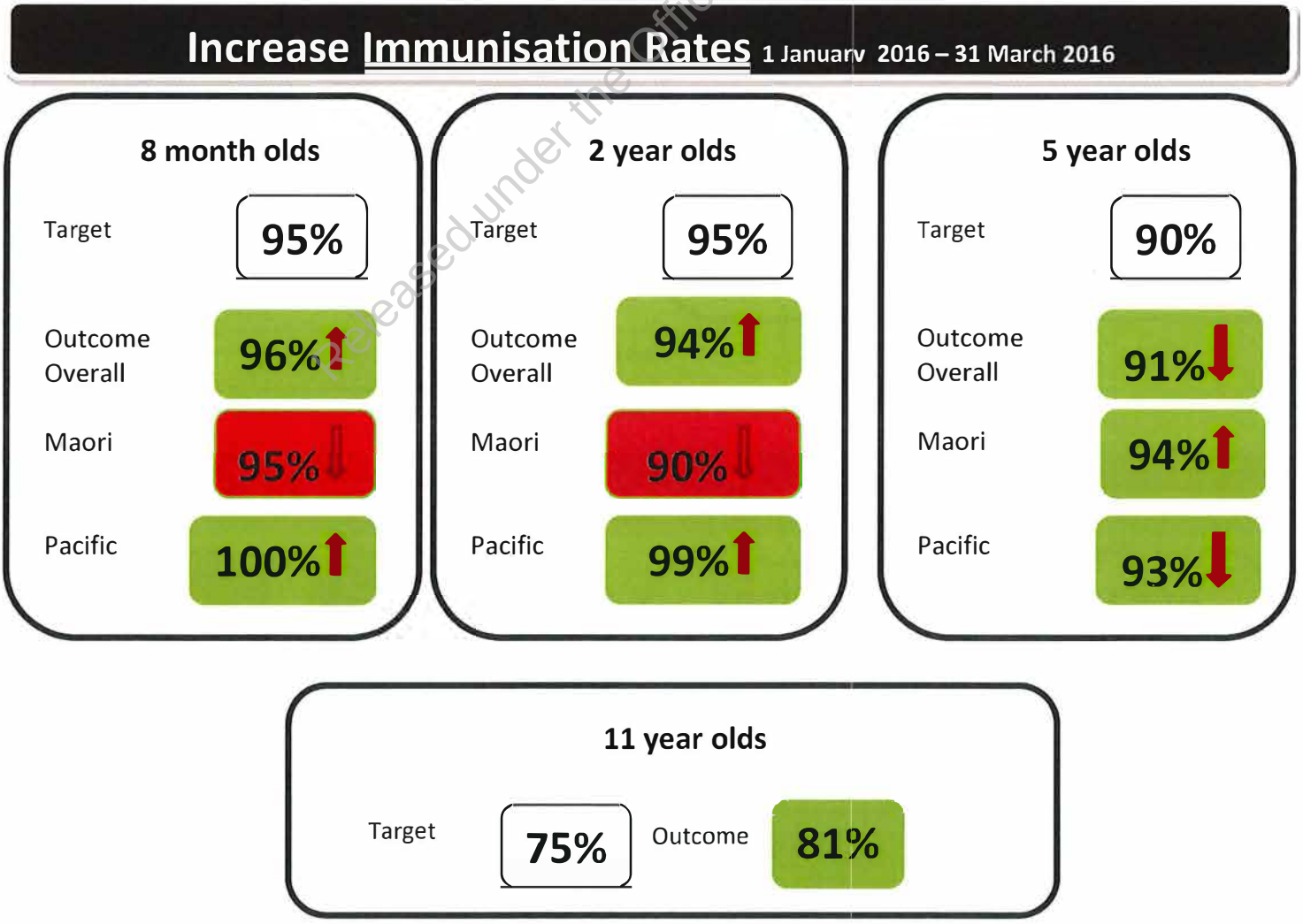
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 April 2016

Fully Immunised 8 month olds – DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Progress Including Pending	Q4 2015/16 Progress including pending	Q1 2016/17 Progress including pending
95.6% fully	96% fully	95.5% fully	90% fully
0% overdue	.0% overdue	.5% could reach	7% overdue

Fully Immunised Two year olds - DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Progress	Q4 2015/16 Progress	Q1 2017/17 Progress
93.4% fully	94% fully	94.4%	94%% fully
0% overdue	% overdue	.19%overdue	1% overdue

There we 1% opt offs and 3.5% declines.
Therefore 4.5% of children could not be reached.

Fully Immunised Four year olds - DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Progress	Q4 2015/16 Progress	Q4 2016/17 Progress
92% fully	91% fully	92% fully	88% fully
overdue	overdue	1% overdue	5% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 September 2015

		Actual	Progress	Actual	Progress	Actual	Progress
		8month olds		2 year olds		4 year olds	
Christchurch PHO		98%	98%	97%	98.8%	93%	97%
Pegasus		96%	97%	94%	94.9%	92%	94%
Rural Canterbury		97%	96%	95%	93.6%	92%	95%

Pre teen Immunisations

11 year old – PHO Level until 30 June 2015

RCPHO

NZE	85.5% ↑
Maori	73% ↑
Pacific	50% ↓

Pegasus Health

NZE	84% ↑
Maori	76% ↓
Pacific	68% –

Christchurch PHO

NZE	76% ↓
Maori	43% ↓
Pacific	30% ↓

As of 31 March 2016

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,599	1,392	87. %	749	674	90. %	295	229	78. %	96	79	82. %	223	212	95. %	236	198	84. %	10 (2)	0.6 (0.1) %	35	2.2 %
8 Month	1,540	1,479	96. %	757	735	97. %	259	247	95. %	81	81	100. %	221	215	97. %	222	201	91. %	11 (3)	0.7 (0.2) %	30	1.9 %
12 Month	1,545	1,490	96. %	778	754	97. %	230	220	96. %	91	88	97. %	208	206	99. %	238	222	93. %	8 (0)	0.5 (0.0) %	41	2.7 %
18 Month	1,556	1,376	88. %	770	691	90. %	249	209	84. %	70	65	93. %	201	191	95. %	266	220	83. %	18 (0)	1.2 (0.0) %	50	3.2 %
24 Month	1,508	1,424	94. %	739	718	97. %	246	222	90. %	70	69	99. %	204	200	98. %	249	215	86. %	17 ()	1.1 (0.0) %	56	3.7 %
5 Year	1,665	1,511	91. %	837	771	92. %	267	250	94. %	104	97	93. %	175	156	89. %	282	237	84. %	23 ()	1.4 (0.0) %	77	4.6 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,599	1,392	87. %	324	277	85. %	303	263	87. %	314	282	90. %	259	214	83. %	227	192	85. %	172	164	95. %
8 Month	1,540	1,479	96. %	318	296	93. %	286	278	97. %	298	286	96. %	243	231	95. %	213	209	98. %	182	179	98. %
12 Month	1,545	1,490	96. %	334	319	96. %	310	300	97. %	288	275	95. %	263	253	96. %	196	191	97. %	154	152	99. %
18 Month	1,556	1,376	88. %	344	292	85. %	317	289	91. %	277	246	89. %	255	227	89. %	207	182	88. %	156	140	90. %
24 Month	1,508	1,424	94. %	391	358	92. %	344	326	95. %	297	286	96. %	233	220	94. %	186	179	96. %	57	55	96. %
5 Year	1,665	1,511	91. %	481	428	89. %	341	314	92. %	340	316	93. %	258	234	91. %	201	189	94. %	44	30	68. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 1 August 2016 11:40 a.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: ISLA Agenda Tuesday 2 August
Attachments: 2 August 2016 agenda.docx; Draft minutes 7 June 2016.docx; Reporting Template July 2016.docx; Workplan July.docx; RISK REGISTER 2016.docx

Hi all

Please find attached the agenda for our meeting tomorrow.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 2 August 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 7 June 2016.docx
5.	2.30pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	Workplan July.docx Reporting Template July 2016.docx
	3.00pm	**HPV 2017 Planning**	Bridget Lester	To complete
7.	3.20pm	**Vaccinating Pregnant Women 2016 Plan** **Update for proposed Outpatients programme**	Bridget Lester	To complete
8.	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Updated Risk Register.docx
9	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Need to work out if Tdap is being loaded onto the NIR	Bridget	30 June 2016
Progress Pregnancy Vaccinations at Christchurch Women's	Bridget and Margo	30 June 2016
Draft Response to PHARMAC around schedule changes	Bridget and Ramon	20 June 2016
Rotavirus – NICU project	Bridget	On going
Immunisation Symposium	Bridget	30 June 2016

Next meeting: 4 October 2016, 6 December 2016

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 7 June 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Donna MacLean, Bridget Lester, Tony Walls, Geraldine Clemens, Anne Feld, Dr Alison Wooding, Dr Sarah Marr and Anna Harwood.	
Apologies: No	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 5 April meeting have gone missing…	Bridget	5 Feb 2016
2.	**Previous Actions & Matters Arising**	• ???	Bridget and Margo Bridget Bridget	13 Feb 2016 Next meeting
3.	**ISLA Work plan**	Q4 = 8 month olds tracking towards 96 2 year olds - tracking towards 94% 5 year olds – tracking towards 92% HPV currently sitting at 65% of girls have received Dose One. Updated work plan, attached. **Action:** Add new-born enrolled to reporting template.		
4.	**OIS RFP Process**	Ramon noted some of the challenges with this process. The Agreement was awarded to Canterbury Immunisation		
5.	**Vaccinating Pregnant Women**	Plan has been updated, and good progress is being made on the actions. Still need to get the baseline data so we know the % of women being vaccinated. Need to work out if Tdap is being loaded on the NIR. NIR to link with Donna to see if this is occurring **Action:** Need to progress Pregnancy Vaccinations and arrange meeting with Service Manager from Christchurch Women's. Bridget to approach MoH around data again.	Donna Bridget	End of June End of June

	Item	Discussion/Action	Responsibility	Date due
6.	**Immunisation Schedule Changes**	PHARMAC have released a consultation document around proposed changes to the Immunisation Schedule. This includes a two dose HPV programme, and widening the eligibility to boys. This can be offered at year7. This will result in some changes to how the DHB provides their programme. Overall ISLA supported the proposed schedule changes. **Action:** Ramon and Bridget to draft a response to PHARMAC from ISLA.	Bridget and Ramon	17 June 2016
7.	**Measles Update**	MoE has sent messages to all schools regarding Measles. Currently there are no confirmed cases in Canterbury. Currently we are not making any changes to the schedule in Canterbury. **Action:** Ramon to keep us updated.	Ramon	As required
8.	**Other Items**	**Rotavirus –** there is a concern that this is not being given in NICU and that vulnerable children are missing out on this programme. A small review of this is going to occur tracking children who are vaccinated at NICU and to see if they complete the schedule. **Immunisation Symposium** – the HPV working group have floated the idea of an Immunisation Symposium for GPT and LMCs. The aim is to have speakers on Timeliness, Decliners, Pregnancy Vaccinations and HPV. ISLA supported this idea, and suggested linking with the Canterbury Initiative around setting this up.	Bridget Bridget	On going End of June
9.	**Operational**	No changes to Interest or Risk Register	Bridget	
10	**Next Meeting**	Next meeting 2 August 2016 2-4pm at C&PH		

Key Performance Indicators and Childhood Immunisation Reporting

July 2016

Immunisation Reporting Programme

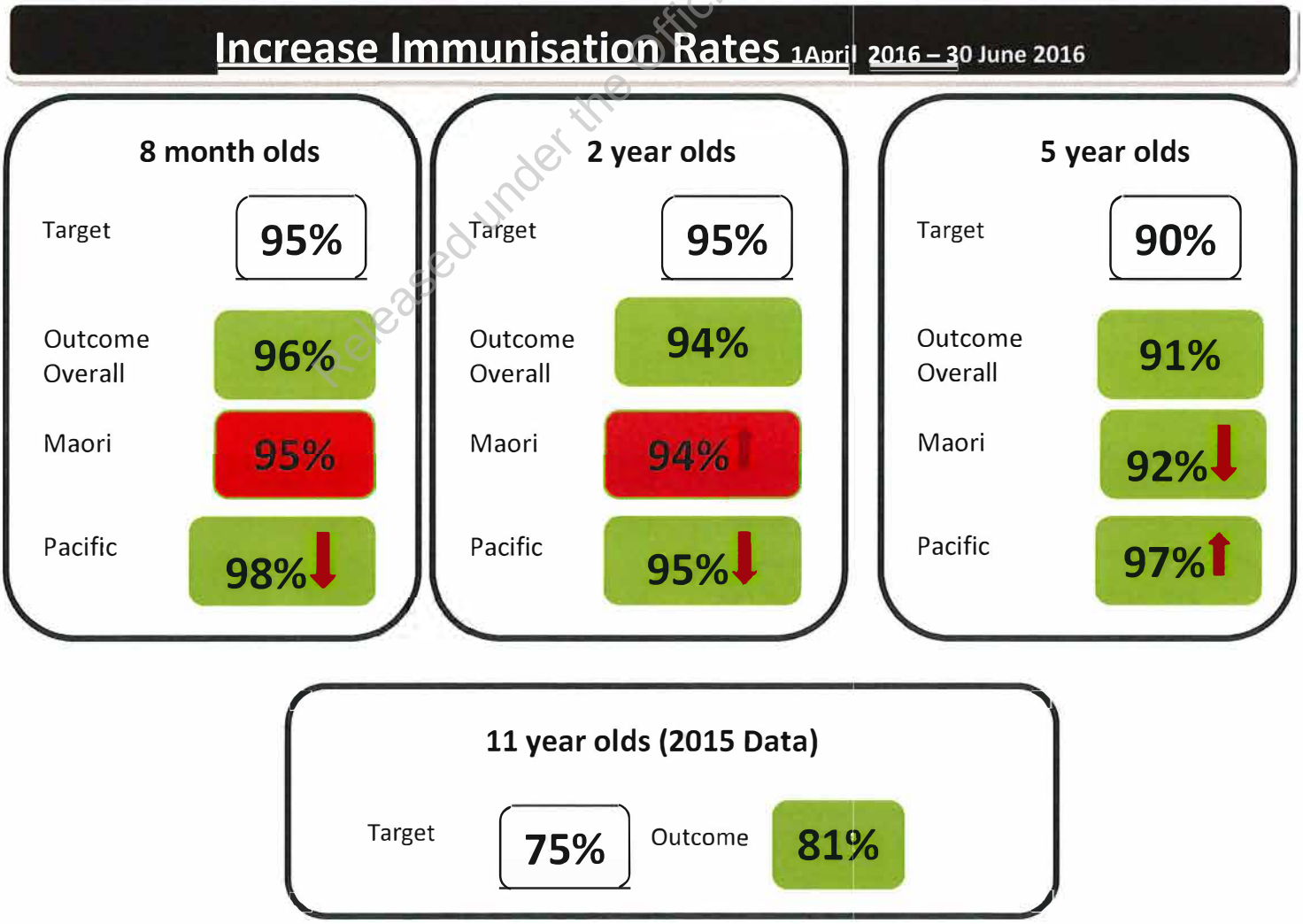
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 8 July 2016

Fully Immunised 8 month olds – DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress including pending	Q2 2016/17 Progress including pending
96% fully	96% fully	95.5% fully	90% fully
0% overdue	.0% overdue	1.35% could	7% overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
93.4% fully	94% fully	94.09%	91.5% fully
0% overdue	% overdue	1%overdue	3.8%

There we 1.1% opt offs and 3.8% declines.
Therefore 4.9% of children could not be reached.

Fully Immunised Four year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
91% fully	92% fully	89% fully	88% fully
overdue	overdue	4% overdue	5% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 March 2016

		Actual	Progress	Actual	Progress	Actual	Progress
		8month olds		2 year olds		4 year olds	
Christchurch PHO		98%	98%	97%	98.8%	93%	97%
Pegasus		96%	97%	94%	94.9%	92%	94%
Rural Canterbury		97%	96%	95%	93.6%	92%	95%

Pre teen Immunisations

HPV as of 30 June 2016

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2002	HPV-1 Quadrivalent	192	51	116	1,200	1,559	390	100	160	2,310	2,970	49%	51%	73%	52%	52%	119 (4.0%)	1 (0.0%)
	HPV-2 Quadrivalent	170	42	109	1,123	1,444						44%	42%	68%	49%	49%	135 (4.5%)	
	HPV-3 Quadrivalent	138	35	99	1,004	1,276						35%	35%	62%	43%	43%	138 (4.6%)	
2003	HPV-1 Quadrivalent	248	68	147	1,380	1,843	390	110	180	2,150	2,830	64%	62%	82%	64%	65%	90 (3.2%)	1 (0.0%)
	HPV-2 Quadrivalent	211	60	139	1,305	1,715						54%	55%	77%	61%	61%	94 (3.3%)	
	HPV-3 Quadrivalent	138	35	92	971	1,236						35%	32%	51%	45%	44%	102 (3.6%)	
2004	HPV-1 Quadrivalent	184	49	110	1,045	1,388	430	130	210	2,210	2,980	43%	38%	52%	47%	47%	83 (2.8%)	0 (0.0%)
	HPV-2 Quadrivalent	152	33	103	946	1,234						35%	25%	49%	43%	41%	93 (3.1%)	
	HPV-3 Quadrivalent	77	15	58	580	730						18%	12%	28%	26%	24%	97 (3.3%)	
Total	HPV-1 Quadrivalent	624	168	373	3,625	4,790	1,210	340	550	6,670	8,780	52%	49%	207%	54%	55%	292 (3.3%)	2 (0.0%)
	HPV-2 Quadrivalent	533	135	351	3,374	4,393						44%	40%	194%	51%	50%	322 (3.7%)	
	HPV-3 Quadrivalent	353	85	249	2,555	3,242						29%	25%	141%	38%	37%	337 (3.8%)	

As of 30 June 2016 (draft data)

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,526	1,354	89. %	731	663	91. %	230	192	83. %	91	81	89. %	221	210	95. %	253	208	82. %	8 (6)	0.5 (0.4) %	31	2.0 %
8 Month	1,625	1,557	96. %	755	733	97. %	300	285	95. %	94	92	98. %	219	212	97. %	257	235	91. %	8 (1)	0.5 (0.1) %	32	2.0 %
12 Month	1,598	1,535	96. %	778	753	97. %	272	261	96. %	77	76	99. %	232	229	99. %	239	216	90. %	12 (3)	0.8 (0.2) %	34	2.1 %
18 Month	1,547	1,388	90. %	745	684	92. %	235	192	82. %	78	72	92. %	234	216	92. %	255	224	88. %	6 (1)	0.4 (0.1) %	46	3.0 %
24 Month	1,571	1,484	94. %	789	753	95. %	230	217	94. %	81	77	95. %	214	208	97. %	257	229	89. %	16 (1)	1.0 (0.1) %	60	3.8 %
5 Year	1,587	1,450	91. %	773	722	93. %	259	238	92. %	91	88	97. %	182	164	90. %	282	238	84. %	15 (1)	0.9 (0.1) %	72	4.5 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,526	1,354	89. %	308	269	87. %	275	249	91. %	306	264	86. %	254	233	92. %	206	181	88. %	177	158	89. %
8 Month	1,625	1,557	96. %	332	313	94. %	287	274	95. %	328	317	97. %	267	258	97. %	233	222	95. %	178	173	97. %
12 Month	1,598	1,535	96. %	321	301	94. %	295	282	96. %	318	306	96. %	254	245	96. %	208	202	97. %	202	199	99. %
18 Month	1,547	1,388	90. %	325	291	90. %	303	272	90. %	311	268	86. %	256	238	93. %	183	159	87. %	169	160	95. %
24 Month	1,571	1,484	94. %	336	301	90. %	331	315	95. %	324	306	94. %	209	203	97. %	183	180	98. %	188	179	95. %
5 Year	1,587	1,450	91. %	409	361	88. %	322	296	92. %	304	287	94. %	250	233	93. %	187	171	91. %	115	102	89. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Flu Coverage – Canterbury DHB by age bands

Age Group	Total			Maori			Pacific			Asian			Other		
0-4years	32,040	2,971	9. %	5,600	288	5. %	1,530	65	4. %	4,330	519	12. %	20,580	489	2. %
5-19years	102,730	10,839	11. %	14,940	933	6. %	3,780	229	6. %	9,920	999	10. %	74,090	2,134	3. %
20-64years	319,930	36,431	11. %	25,530	2,028	8. %	7,190	599	8. %	32,340	2,441	8. %	254,870	4,655	2. %
65+years	84,090	52,110	62. %	2,760	1,176	43. %	670	363	54. %	2,940	1,285	44. %	77,720	5,041	6. %
all age bands	538,790	102,351	19. %	48,830	4,425	9. %	13,170	1,256	10. %	49,530	5,244	11. %	427,260	12,319	3. %

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - July 2016

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women.	Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth.	Around 98% of babies are enrolled at birth. NIR have discussed an issue with the fax numbers on the NIR1 form, which means they have been missing babies. – *no update from June meeting*
	Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider.	Q1-Q4	• 98% of new-borns are enrolled with general practice by 2 weeks.	80% of new-borns are enrolled with general practice in Q3, while 97% of new-borns have a nominated provider on the NIR. *No update from June meeting*
	Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4		Final draft of Toolkit shared, currently with Margo for review.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q3 = 96% 8month olds, 94% 2year olds and 91% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	• 70% of Girls have received dose 3	65% of D1 60% D2 2003 40% D1 2014 girls
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	See date report for coverage.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. • Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❷		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. Good progress has been made in 2015 toward this target. It was achieved in Q3 and very close in Q4. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2015 toward this target. It was achieved in Q4 and very close in Q3. We are also on track to achieve it again in Q1 2015/16.	Change probability from High to Medium
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		High	Medium		This is seen as a high risk, due to such low numbers being vaccinated. Planning is underway for the Year 8 HPV programme, this should assist us in moving closer towards the national targets.	Updated narrative
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		High	low		This is seen as a low risk to the community. The OIS assessment is expected to assist on this one.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 3 October 2016 12:42 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers for Tuesday Immunisation Service Level Alliance Meeting
Attachments: 4 October 2016 agenda.docx; Preg paper.docx; Reporting Template Oct 2016.docx; Workplan October 2016.docx; RISK REGISTER 2016 update August.docx; Draft minutes 2 August 2016.docx

HI all

Please find attached the papers for tomorrow's meeting.

Please let me know if you cannot make the meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ Bridget.Lester@cdhb.health.nz
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 4 October 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld : Apolgoy	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 2 August 2016.docx
5.	2.30pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	Workplan October 2016.docx Reporting Template Oct 2016.docx
6	3.00pm	**Health Pathways and Health Info update**	Bridget Lester	
		OIS Update	Bridget Lester	
7.	3.20pm	**Vaccinating Pregnant Women 2016 Plan** **Update for proposed Outpatients programme**	Bridget Lester	Preg paper.docx
8.	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	RISK REGISTER 2016 update August.docx
9	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Need to work out if Tdap is being loaded onto the NIR	Bridget	4 October 2016
HPV 2017 Planning	Bridget	4 October 2016
Progress Pregnancy Vaccinations at Christchurch Women's	Bridget and Margo	30 August 2016
Rotavirus – NICU project	Tony	4 October 2016
Immunisation Symposium	Bridget	On hold
Update Risk Register	Bridget	10 August 2016

Next meeting: 4 October 2016, 6 December 2016

FOR ISLA CONSIDERATION	Canterbury Clinical Network

TITLE	Vaccinating Pregnant Women in Secondary Care
PREPARED BY	Margaret Kyle, Jayne Thomas and Bridget Lester
DATE	29 September 2016
RECOMMENDATION	That the ISLA review the paper and approves the following: • Approach the Planning and Funding Leadership Team for funding to support a 12month pilot in Women's and Children for the vaccination of Women who are either pregnant, or with high risk children in NICU. • Funding of $20,000 per annum is sort.

1. Background

Vaccinating pregnant women for Pertussis and Seasonal Influenza for two key objectives of the Immunisation Service Level Alliance. These vaccines are free to Pregnancy women, and generally given in General Practice.

This paper focus on increasing coverage of Pertussis Vaccinations. In Canterbury we have a low uptake of this vaccines. An estimated 30% of pregnant women are vaccinated for Pertussis.

For the past 12month ISLA have been considering ways to improve coverage the Canterbury region, they are also concern about parents who due to their babies being born early, may not have had the vaccination. Preterm babies are vulnerable to disease and as a health system we need to ensure they are protected.

In the past the P&F Leadership Team has given approval to developing a programme to vaccine parents of preterm babies in NICU. Work has been underway on the development of this programme. In doing this, the focus has expanded to look at reaching women in Maternity out patients.

Currently a group of women (around 2000 per annum) attend outpatient's clinics due to high risk pregnancies. These women regularly attend clinics at Christchurch Women's. It is believed that these clinics provide an opportunity to vaccinate pregnant women against Pertussis.

2. Service Model

A number of service models have been considered, how the following is the preferred model from the Immunisation Service Level Alliance

1. LMCs and Nurses within Christchurch Women's Outpatients are provided with education and information around vaccinating Pregnant Women.
2. A regular weekly clinic is offered at Christchurch Women's, to vaccinate the current inpatients (pregnant women on bed rest) and parents with children in NICU.

3. All women between gestation periods 32-38 weeks will be offered the Pertussis vaccination when attending an outpatient's clinic. Before this time, they will also be provided with information around the vaccinations, and can choose to go to general practice to be vaccinated.
4. Opportunistic vaccinations to be offered to inpatients if possible.

To achieve this model, there is a need to change the current processes within Outpatients to have an increased focus on immunisation within this service. This service changed occurred a few year age in Child Health wards, where the immunisation of every child admitted to the ward is now checked and they are given information on immunisation and if possible vaccinated during their stay.

Canterbury Immunisation has the contract with the DHB to provide education and support to Secondary Care Services. They are willing to provide an education session to LMCs and nurses with Women's Health around the Pertussis vaccination. This will enable the staff to have the knowledge and confidence to vaccination.

To make this process happen, there is a need to resource women's health to vaccinate. When the team (Jayne Thomas, Margaret Kyle and Bridget Lester) met with Natalie King around this service, it was felt that a 0.4FTE was required. On further consideration and discussion at our previous ISLA meeting it was signalled that a 0.2FTE position could be resources. This would cover the Friday clinics and opportunistically within Outpatients.

This level of resourcing will require around $20,000 per annum to support the initial pilot. To offset the cost of doing this in general practice, 952 vaccinations would need to be given within the 12month period.

our health system

Key Performance Indicators and Childhood Immunisation Reporting

October 2016

Immunisation Reporting Programme

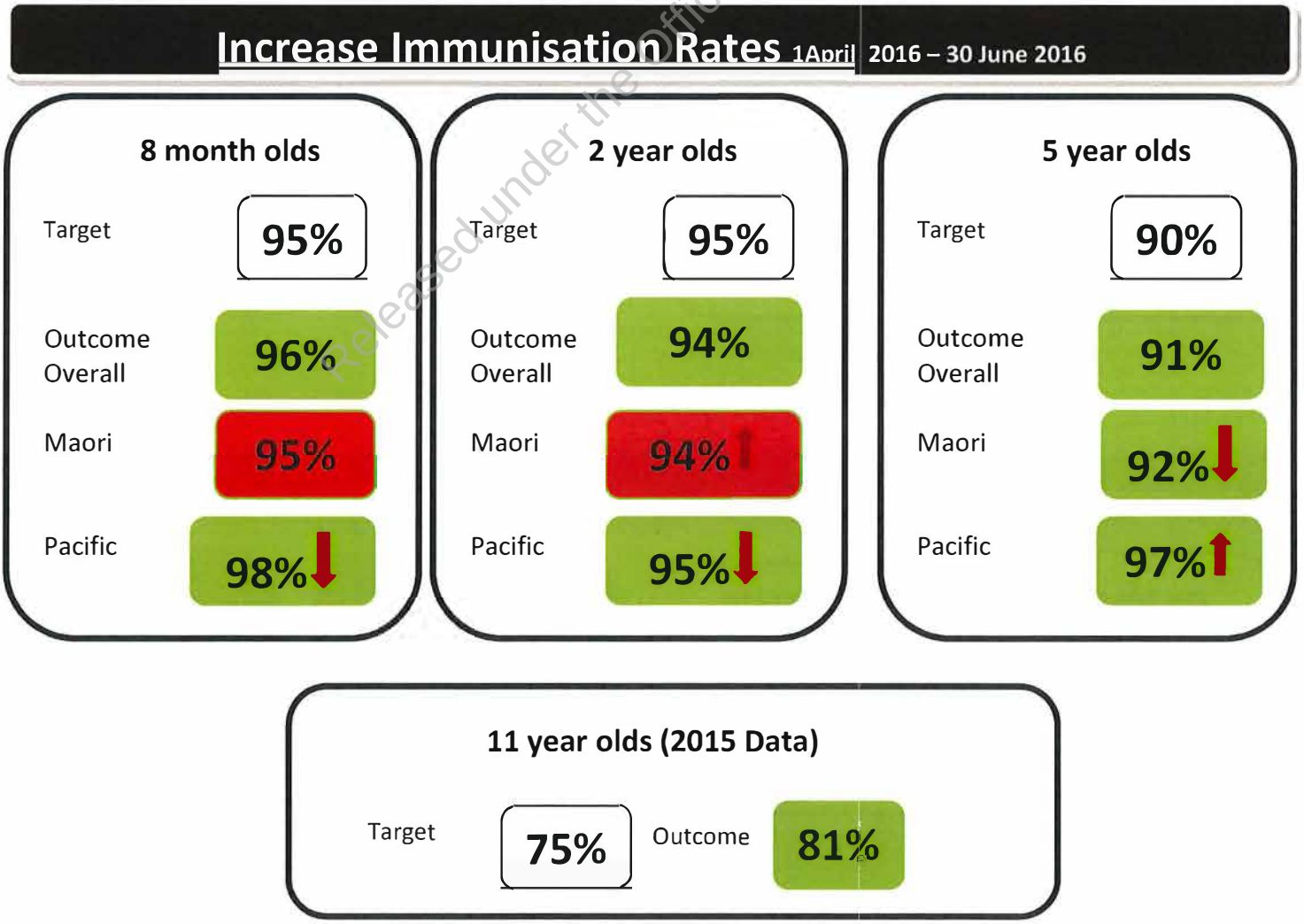
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 30 Sept 2016

Fully Immunised 8 month olds – DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress including pending	Q2 2016/17 Progress including pending
96% fully	96% fully	94% fully	87% fully
0% overdue	.0% overdue	2.4% could	8% overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
93.4% fully	94% fully	94.76%	94% fully
0% overdue	% overdue	0%overdue	1%

There we 1.1% opt offs and 3.8% declines.
Therefore 4.9% of children could not be reached.

Fully Immunised Four year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
91% fully	92% fully	92% fully	91% fully
overdue	overdue	2% overdue	3.6% overdue

There are 1.5% opt offs and 4.5% declines.
Therefore 6% of children could not be reached.

Fully Immunised 8month, two and five year - PHO LEVEL 30 Sept 2016

		Actual	Progress	Actual	Progress	Actual	Progress
		8month olds		2 year olds		4 year olds	
Christchurch PHO		98%	99%	97%	99%	93%	96%
Pegasus		96%	97%	94%	96%	92%	93%
Rural Canterbury		97%	95%	95%	96%	92%	94%

Pre teen Immunisations

HPV as of 30 September 2016

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2002	HPV-1 Quadrivalent	195	52	121	1,210	1,578	390	100	160	2,310	2,970	50%	52%	76%	52%	53%	123 (4.1%)	1 (0.0%)
	HPV-2 Quadrivalent	173	44	115	1,148	1,480						44%	44%	72%	50%	50%	140 (4.7%)	
	HPV-3 Quadrivalent	145	36	106	1,031	1,318						37%	36%	66%	45%	44%	146 (4.9%)	
2003	HPV-1 Quadrivalent	249	70	153	1,387	1,859	390	110	180	2,150	2,830	64%	64%	85%	65%	66%	93 (3.3%)	1 (0.0%)
	HPV-2 Quadrivalent	218	64	145	1,337	1,764						56%	58%	81%	62%	62%	99 (3.5%)	
	HPV-3 Quadrivalent	167	46	116	1,098	1,427						43%	42%	64%	51%	50%	107 (3.8%)	
2004	HPV-1 Quadrivalent	191	53	121	1,085	1,450	430	130	210	2,210	2,980	44%	41%	58%	49%	49%	95 (3.2%)	0 (0.0%)
	HPV-2 Quadrivalent	160	38	107	1,004	1,309						37%	29%	51%	45%	44%	108 (3.6%)	
	HPV-3 Quadrivalent	104	23	77	735	939						24%	18%	37%	33%	32%	112 (3.8%)	
Total	HPV-1 Quadrivalent	635	175	395	3,682	4,887	1,210	340	550	6,670	8,780	52%	51%	218%	55%	56%	311 (3.5%)	2 (0.0%)
	HPV-2 Quadrivalent	551	146	367	3,489	4,553						46%	43%	203%	52%	52%	347 (4.0%)	
	HPV-3 Quadrivalent	416	105	299	2,864	3,684						34%	31%	167%	43%	42%	365 (4.2%)	

As of 30 June 2016

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,526	1,354	89. %	731	663	91. %	230	192	83. %	91	81	89. %	221	210	95. %	253	208	82. %	8 (6)	0.5 (0.4) %	31	2.0 %
8 Month	1,625	1,557	96. %	755	733	97. %	300	285	95. %	94	92	98. %	219	212	97. %	257	235	91. %	8 (1)	0.5 (0.1) %	32	2.0 %
12 Month	1,598	1,535	96. %	778	753	97. %	272	261	96. %	77	76	99. %	232	229	99. %	239	216	90. %	12 (3)	0.8 (0.2) %	34	2.1 %
18 Month	1,547	1,388	90. %	745	684	92. %	235	192	82. %	78	72	92. %	234	216	92. %	255	224	88. %	6 (1)	0.4 (0.1) %	46	3.0 %
24 Month	1,571	1,484	94. %	789	753	95. %	230	217	94. %	81	77	95. %	214	208	97. %	257	229	89. %	16 (1)	1.0 (0.1) %	60	3.8 %
5 Year	1,587	1,450	91. %	773	722	93. %	259	238	92. %	91	88	97. %	182	164	90. %	282	238	84. %	15 (1)	0.9 (0.1) %	72	4.5 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,526	1,354	89. %	308	269	87. %	275	249	91. %	306	264	86. %	254	233	92. %	206	181	88. %	177	158	89. %
8 Month	1,625	1,557	96. %	332	313	94. %	287	274	95. %	328	317	97. %	267	258	97. %	233	222	95. %	178	173	97. %
12 Month	1,598	1,535	96. %	321	301	94. %	295	282	96. %	318	306	96. %	254	245	96. %	208	202	97. %	202	199	99. %
18 Month	1,547	1,388	90. %	325	291	90. %	303	272	90. %	311	268	86. %	256	238	93. %	183	159	87. %	169	160	95. %
24 Month	1,571	1,484	94. %	336	301	90. %	331	315	95. %	324	306	94. %	209	203	97. %	183	180	98. %	188	179	95. %
5 Year	1,587	1,450	91. %	409	361	88. %	322	296	92. %	304	287	94. %	250	233	93. %	187	171	91. %	115	102	89. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Flu Coverage – Canterbury DHB by age bands

Age Group	Total			Maori			Pacific			Asian			Other		
0-4years	32,040	2,971	9. %	5,600	288	5. %	1,530	65	4. %	4,330	519	12. %	20,580	489	2. %
5-19years	102,730	10,839	11. %	14,940	933	6. %	3,780	229	6. %	9,920	999	10. %	74,090	2,134	3. %
20-64years	319,930	36,431	11. %	25,530	2,028	8. %	7,190	599	8. %	32,340	2,441	8. %	254,870	4,655	2. %
65+years	84,090	52,110	62. %	2,760	1,176	43. %	670	363	54. %	2,940	1,285	44. %	77,720	5,041	6. %
all age bands	538,790	102,351	19. %	48,830	4,425	9. %	13,170	1,256	10. %	49,530	5,244	11. %	427,260	12,319	3. %

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter Four 2015/16
Newborns Born in the Following Period: 20 February 2016 to 19 May 2016
As at Quarter Three 2016 (July 2016)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	205	1,005	1,369	73%	17
Bay of Plenty	116	530	708	75%	15
Canterbury	346	1,213	1,483	82%	5
Capital and Coast	184	667	839	79%	7
Counties Manukau	333	1,479	1,967	75%	14
Hawkes Bay	132	448	533	84%	4
Hutt	118	410	487	84%	2
Lakes	25	283	363	78%	11
MidCentral	88	365	500	73%	19
Nelson Marlborough	66	322	373	86%	1
Northland	143	462	572	81%	6
South Canterbury	23	112	151	74%	16
Southern	147	644	822	78%	9
Tairawhiti	44	142	195	73%	20
Taranaki	74	281	370	76%	13
Waikato	231	955	1,221	78%	10
Wairarapa	34	95	120	79%	8
Waitemata	260	1,296	1,767	73%	18
West Coast	26	60	78	77%	12
Whanganui	51	169	201	84%	3
Overseas or Unknown	0	0	22	0%	
Total	**2,646**	**10,938**	**14,141**	**77%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter Four 2015/16
Newborns Born in the Following Period: 20 February 2016 to 19 May 2016

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	104	1,369	92%	14
Bay of Plenty	67	708	91%	18
Canterbury	61	1,483	96%	6
Capital and Coast	38	839	95%	8
Counties Manukau	127	1,967	94%	12
Hawkes Bay	46	533	91%	17
Hutt	38	487	92%	15
Lakes	16	363	96%	7
MidCentral	11	500	98%	4
Nelson Marlborough	4	373	99%	1
Northland	29	572	95%	9
South Canterbury	3	151	98%	3
Southern	45	822	95%	11
Tairawhiti	7	195	96%	5
Taranaki	20	370	95%	10
Waikato	83	1,221	93%	13
Wairarapa	2	120	98%	2
Waitemata	142	1,767	92%	16
West Coast	11	78	86%	20
Whanganui	21	201	90%	19
Unknown	3	22	86%	
Total	**878**	**14,141**	**94%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter Four 2015/16
Newborns Born in the Following Period: 20 February 2016 to 19 May 2016
As at Quarter Three 2016 (July 2016)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	309	390	79.2%	26
Auckland PHO Limited	123	163	75.5%	32
Central Primary Health Organisation	360	483	74.5%	34
Christchurch PHO Limited	98	100	98.0%	1
Compass Health - Capital and Coast	515	638	80.7%	21
Compass Health - Wairarapa	96	125	76.8%	30
Cosine Primary Care Network Trust	111	116	95.7%	4
East Health Trust	204	247	82.6%	17
Eastern Bay Primary Health Alliance	132	147	89.8%	9
Hauraki PHO	356	412	86.4%	12
Health Hawke's Bay Limited	449	495	90.7%	8
Kimi Hauora Wairau (Marlborough PHO Trust)	84	111	75.7%	31
Manaia Health PHO Limited	298	341	87.4%	11
Midlands Health Network - Lakes	90	98	91.8%	7
Midlands Health Network - Tairawhiti	92	116	79.3%	25
Midlands Health Network - Taranaki	276	349	79.1%	28
Midlands Health Network - Waikato	563	705	79.9%	22
National Hauora Coalition	257	298	86.2%	13
Nelson Bays Primary Health	238	256	93.0%	6
Nga Mataapuna Oranga Limited	33	50	66.0%	35
Ngati Porou Hauora Charitable Trust	43	55	78.2%	29
Ora Toa PHO Limited	67	72	93.1%	5
Pegasus Health (Charitable) Limited	977	1,163	84.0%	15
Procare Networks Limited	2,042	2,562	79.7%	23
Rotorua Area Primary Health Services Limited	207	254	81.5%	19
Rural Canterbury PHO	137	163	84.0%	14
South Canterbury Primary and Community	112	149	75.2%	33
Te Awakairangi Health Network	348	362	96.1%	3
Te Tai Tokerau PHO Ltd	146	179	81.6%	18
Total Healthcare Charitable Trust	382	480	79.6%	24
Waitemata PHO Limited	529	668	79.2%	27
Well Health Trust	36	63	57.1%	36
WellSouth Primary Health Network	644	776	83.0%	16
West Coast PHO	60	67	89.6%	10
Western Bay of Plenty PHO Limited	347	427	81.3%	20
Whanganui Regional PHO	177	183	96.7%	2
Unknown or Blank	0	878	0.0%	
Total	**10,938**	**14,141**	**77.3%**	

Number of Newborns Enrolled Within Three Months by DHB of Domicile and Ethnicity - Quarter Four 2015/16
Newborns Born in the Following Period: 20 February 2016 to 19 May 2016
As at Quarter Three 2016 (July 2016)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Auckland	70	137	51%	155	220	70%	780	1,012	77%
Bay of Plenty	197	251	78%	NA	NA	NA	333	457	73%
Canterbury	135	158	85%	70	73	96%	1,008	1,252	81%
Capital and Coast	104	108	96%	55	75	73%	508	656	77%
Counties Manukau	313	373	84%	442	562	79%	724	1,032	70%
Hawkes Bay	191	232	82%	28	38	74%	229	263	87%
Hutt	111	123	90%	40	43	93%	259	321	81%
Lakes	142	153	93%	NA	NA	NA	141	210	67%
MidCentral	102	156	65%	NA	NA	NA	263	344	76%
Nelson Marlborough	55	70	79%	NA	NA	NA	267	303	88%
Northland	228	295	77%	NA	NA	NA	234	277	84%
South Canterbury	16	20	80%	NA	NA	NA	96	131	73%
Southern	95	90	106%	NA	NA	NA	549	732	75%
Tairawhiti	96	138	70%	NA	NA	NA	46	57	81%
Taranaki	88	101	87%	NA	NA	NA	193	269	72%
Waikato	313	374	84%	40	49	82%	602	798	75%
Wairarapa	30	35	86%	NA	NA	NA	65	85	76%
Waitemata	165	235	70%	130	166	78%	1,001	1,366	73%
West Coast	7	9	78%	NA	NA	NA	53	69	77%
Whanganui	64	73	88%	NA	NA	NA	105	128	82%
Overseas or Unknown	0	3	0%	NA	NA	NA	0	19	0%
Total	**2,522**	**3,134**	**80%**	**960**	**1,226**	**78%**	**7,456**	**9,781**	**76%**

Number of Newborns Enrolled Within Three Months by PHO and Ethnicity - Quarter Four 2015/16
Newborns Born in the Following Period: 20 February 2016 to 19 May 2016
As at Quarter Three 2016 (July 2016)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Alliance Health Plus Trust	59	66	89%	95	128	74%	155	196	79%
Auckland PHO Limited	11	14	79%	NA	NA	NA	112	149	75%
Central Primary Health Organisation	103	151	68%	NA	NA	NA	257	332	77%
Christchurch PHO Limited	8	10	80%	NA	NA	NA	90	90	100%
Compass Health - Capital and Coast	58	61	95%	NA	NA	NA	457	577	79%
Compass Health - Wairarapa	29	35	83%	NA	NA	NA	67	90	74%
Cosine Primary Care Network Trust	12	8	150%	NA	NA	NA	99	108	92%
East Health Trust	11	7	157%	NA	NA	NA	193	240	80%
Eastern Bay Primary Health Alliance	93	93	100%	NA	NA	NA	39	54	72%
Hauraki PHO	146	179	82%	NA	NA	NA	210	233	90%
Health Hawke's Bay Limited	191	215	89%	NA	NA	NA	258	280	92%
Kimi Hauora Wairau (Marlborough PHO Trust)	16	23	70%	NA	NA	NA	68	88	77%
Manaia Health PHO Limited	126	146	86%	NA	NA	NA	172	195	88%
Midlands Health Network - Lakes	35	42	83%	NA	NA	NA	55	56	98%
Midlands Health Network - Tairawhiti	55	70	79%	NA	NA	NA	37	46	80%
Midlands Health Network - Taranaki	88	95	93%	NA	NA	NA	188	254	74%
Midlands Health Network - Waikato	150	148	101%	NA	NA	NA	413	557	74%
National Hauora Coalition	54	61	89%	NA	NA	NA	203	237	86%
Nelson Bays Primary Health	38	45	84%	NA	NA	NA	200	211	95%
Nga Mataapuna Oranga Limited	28	38	74%	NA	NA	NA	5	12	42%
Ngati Porou Hauora Charitable Trust	38	51	75%	NA	NA	NA	5	4	125%
Ora Toa PHO Limited	35	33	106%	NA	NA	NA	32	39	82%
Pegasus Health (Charitable) Limited	107	120	89%	NA	NA	NA	870	1,043	83%
Procare Networks Limited	307	394	78%	NA	NA	NA	1,735	2,168	80%
Rotorua Area Primary Health Services Limited	116	110	105%	NA	NA	NA	91	144	63%
Rural Canterbury PHO	20	18	111%	NA	NA	NA	117	145	81%
South Canterbury Primary and Community	15	20	75%	NA	NA	NA	97	129	75%
Te Awakairangi Health Network	107	98	109%	NA	NA	NA	241	264	91%
Te Tai Tokerau PHO Ltd	98	125	78%	NA	NA	NA	48	54	89%
Total Healthcare Charitable Trust	88	107	82%	NA	NA	NA	294	373	79%
Waitemata PHO Limited	43	61	70%	NA	NA	NA	486	607	80%
Well Health Trust	3	7	43%	NA	NA	NA	33	56	59%
WellSouth Primary Health Network	96	83	116%	NA	NA	NA	548	693	79%
West Coast PHO	7	9	78%	NA	NA	NA	53	58	91%
Western Bay of Plenty PHO Limited	67	76	88%	NA	NA	NA	280	351	80%
Whanganui Regional PHO	64	68	94%	NA	NA	NA	113	115	98%
Unknown or Blank	0	247	0%	NA	NA	NA	0	631	0%
Total	**2,522**	**3,134**	**80%**	**95**	**128**	**74%**	**8,321**	**10,879**	**76%**

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - October update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. An issue was identified with children born at St Georges, that there was a delay in receiving the NIR1 form. Work has occurred around a more timely process in getting these now. Q4 data shows CDHB at 82%, rank 5th. Feedback has been received around the LMC Toolkit. More work needs to occur on this. The Information Session held in May was successful, a regular slot has been offered to present to the Trainee Midwives in November.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q3 = 96% 8month olds, 94% 2year olds and 91% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	65% of Dose one of girls born in 2003. Need to consider the 2017 programme with the proposed schedule changes.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	There is now a report on Datamart for this group. Currently 64% of those 65 and over have received the seasonal influenza vaccination.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❷		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Low	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. Good progress has been made in 2015 toward this target. It was achieved in Q3 and very close in Q4. We are also on track to achieve it again in Q1 2015/16.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2015 toward this target. It was achieved in Q4 and very close in Q3. We are also on track to achieve it again in Q1 2015/16.	Risk still active
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Medium		This is seen as a high risk, due to such low numbers being vaccinated. Planning is underway for the Year 8 HPV programme, this should assist us in moving closer towards the national targets.	The School Based Programme has started, which is having an positive impact on our coverage.
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	low		This is seen as a low risk to the community.	A new OIS provider has been appointed effective 1 September 2016.

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 2 August 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, , Bridget Lester, Tony Walls, Geraldine Clemens, Anne Feld, and Anna Harwood.	
Apologies: Donna MacLean, Dr Alison Wooding and Dr Sarah Marr	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 5 June meeting where approved to be sent to the CCN office	Bridget	12 August 2016
2.	**Previous Actions & Matters Arising**	• Tdap – work continues on this. • Pregnancy vaccinations to be discussed later in meeting • PHARMAC – feedback provided • Rotavirus – project continues, but Tony is concerned as to why NICU is not vaccinating. Tony to follow up with new Clinical Director of NICU • Immunisation Symposium – still to be consider but looking at 2017.	Bridget Margo Completed Tony On hold	
3.	**ISLA Work plan**	Q4 8month olds achieved96% 2 year olds achieved 94%, high opt offs and declines 5 year olds achieved 91% HPV currently sitting at 65% of girls have received Dose One and 61% doses 2. Updated work plan, attached. Continue to be concerned about new-born enrolments. Flu is tracking ok – would be interesting to compete with distribution data. **Action:** Add new-born enrolled to reporting template.		
4.	**HPV 2017**	PHARMAC has announced the changes in this programme, including the extension of the service to boys. Agree that Canterbury will extend their current programme to include the new eligibility as follow • Offer HPV to boys at the 11year old immunisation event • Offer HPV to boys as part of the Year8 school programme. • Inform GPT that boys can be vaccinated between the ages of 13-26 in general practice.	Bridget	

	Item	Discussion/Action	Responsibility	Date due
		Discussion around the 11year old varicella vaccine. Agree to encourage GPT to give this at the 2nd event in 2017 as this will be due after the 1 July 2017. Agree to discuss with PHNS around ensuring 100% return rate of the HPV consent form for non-fully vaccinated girls and boys. CCN needs to be briefed on changes.		
5.	**Vaccinating Pregnant Women**	Bridget and Margo met with Nat King, Service Manager Maternity around vaccinating in NICU for Pertussis. This was supported, as was vaccinating pregnant women who visits outpatients and women who are in hospital on bed rest. However due to volumes and extra work an additional 0.4FTE was requested to support this programme. It was also agreed that Canterbury Immunisation will provide some training to the nursing staff. Using Pharmacy to provide information remains on ISLA agenda. Need to get resources to community pharmacy to do this. ISLA are supportive of the concept and agreed that this should be funded as a pilot – however 0.2FTE was more reasonable. This would cover itself if around 400 vaccinations were provided. **Action:** Bridget to draft B/C to Planning and Funding.	Bridget	End of August
6.	**Measles Update**	Ramon provided ISLA with an update on measles events in NZ. Currently there have been 89 confirmed cases. **Action:** Ramon to keep us updated.	Ramon	As required
7.	**Other Items**	**Rotavirus** – there is a concern that this is not being given in NICU and that vulnerable children are missing out on this programme. A small review of this is going to occur tracking children who are vaccinated at NICU and to see if they complete the schedule. **Immunisation Symposium** – the HPV working group have floated the idea of an Immunisation Symposium for GPT and LMCs. The aim is to have speakers on Timeliness, Decliners, Pregnancy Vaccinations and HPV. ISLA supported this idea, and suggested linking with the Canterbury Initiative around setting this up.	Bridget Bridget	On going End of June
8.	**Operational**	Risk Register was updated for CCN.	Bridget	
9.	**Next Meeting**	Next meeting 4 October 2016 2-4pm at C&PH		

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 2 December 2016 12:51 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Cc: 'Ruth Robson'; Miles Hartshorne; Patricia Connell
Subject: Papers for Immunisation Service Level Alliance Meeting - Tuesday 6 December 2016
Attachments: Draft minutes 4 October ISLA.docx; WorkplanOctober 2016.docx; Draft agenda Dec meeting.docx; Reporting Template dec 2016.docx

HI all

Please find attached the papers for Tuesdays meeting. Sorry I haven't had time to update the work plan, so I will do this and bring to the meeting on Tuesday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care, Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 4 October 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Bridget Lester, Geraldine Clemens, Anne Feld, Sarah Marr and Alison Wooding.	
Apologies: Donna MacLean, Anna Harwood and Tony Walls	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 2 August meeting where approved to be sent to the CCN office	Bridget	12 Oct 16
2.	**Previous Actions & Matters Arising**	• Pregnancy vaccinations to be discussed later in meeting • Rotavirus – project continues, Tony was not a meeting, so feedback not provided. • Immunisation Symposium – still to be consider but looking at 2017.	Bridget/Margo Tony On hold	
3.	**ISLA Work plan**	Q 201617 – draft result • 8month olds achieved95% 2 year olds achieved 95%, high opt offs and declines • 5 year olds achieved 91%. The target for this has now moved to 95% so some further works needs to occur on reaching this. HPV currently sitting at 66% of girls have received Dose One and 61% doses 2. Work is underway in the implementation of the schedule changes for Jan 2017. There is a concern that general practice will continue to offer Gardasil 4 until the stock is used up. Need to seek some further confirmation from the MoH around this. The school programme will start with Gardasil 9. Updated work plan, attached. Continue to be concerned about new-born enrolments. Action: Arrange meeting with PHO leads to look at new-born enrolment and what support NIR can offer	Bridget	28 Oct 16
4.	**HealthPathways and Health Info**	The Immunisation Section of Health Info requires updating. While we have though this was linked to Imms for Life, this appears not be the case. A discussion has occurred around taking the content from Imms for Life, and putting this directly on to HealthInfo. This was supported by ISLA. ISLA is keen to review HealthInfo and HealthPathways, as the clinical leads for Immunisation in Canterbury – they need to approve these sites.		

	Item	Discussion/Action	Responsibility	Date due
		Action: Review current Imms for Life content (linking with IPG) and then run final version past ISLA. Talk to HealthInfo about linking better with ISLA for site updates.	Bridget	28 Oct 16
5.	**OIS update**	The new OIS service started on the 1 September 2016, under Canterbury Immunisation. Both vaccinators from PTC to TWPT have moved to Canterbury Immunisation. In their first month they vaccinated 70 children which is a good outcome. There is concern around the high number of referrals coming from General Practice to Missed Events Service. In September there were around 250 referrals. **Action:** Continue to track referrals and see if there are any patterns with practices.	Bridget	Next ISLA meeting
6.	**Vaccinating Pregnant Women**	A paper was presented to ISLA around the proposed Pilot for Outpatients services. This was approved to go to the P&F Leadership Team, with some minor changes. **Action:** Margo to update paper Bridget to draft B/C to Planning and Funding.	Margo Bridget	28 Oct 16 4 Nov 16
7.	**Other Items**	Child Health Coordination Service – work is underway to develop a new-born enrolment process for the DHB. This use data given at birth to population NIR, NBHS and the Oral Health database. It will also enable the services to work together to identify children who have missed out on service, and try to locate them. This direction as supported by ISLA.		
8.	**Operational**	No updated required	Bridget	
9.	**Next Meeting**	Next meeting 6 December 2016 2-4pm at C&PH		

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - October update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. An issue was identified with children born at St Georges, that there was a delay in receiving the NIR1 form. Work has occurred around a more timely process in getting these now. Q4 data shows CDHB at 82%, rank 5th. Feedback has been received around the LMC Toolkit. More work needs to occur on this. The Information Session held in May was successful, a regular slot has been offered to present to the Trainee Midwives in November.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q3 = 96% 8month olds, 94% 2year olds and 91% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	65% of Dose one of girls born in 2003. Need to consider the 2017 programme with the proposed schedule changes.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	There is now a report on Datamart for this group. Currently 64% of those 65 and over have received the seasonal influenza vaccination.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 6 December 2016, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Margaret Kyle:
Anne Feld :	Dr Sarah Marr:
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean
Guests: Patricia Connell, Miles Hartshorne, Ruth Robson	

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.05pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.10pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
5.	2.30pm	**Updates** **2015/16 IPG Work Plan, including HPV update** **Health Target progress – KPI**	Bridget Lester	
6		**2017 Influenza Programme Planning, including special populations**	Bridget Lester	
7	2.50pm	**HPV Programme – 2016 update and planning for 2017**	Bridget Lester Patricia Connell Miles Hartshorne	
8	3.15pm	**2017/18 Work plan discussion**	Ramon Pink	
9	3.40pm	**Operational** • **Interest register** • **Risk Register** • **2017 Meeting dates**	Ramon Pink	RISK REGISTER 2016 update August.docx
10	3.50pm	**Any other business**	Ramon Pink	

Action Register	Responslbity	Timeframe
Need to work out if Tdap is being loaded onto the NIR	Bridget	4 October 2016
HPV 2017 Planning – use of Gardasil 4 in general practice	Bridget	2 December 2016
Imms for Life to Health Info	Bridget	28 Oct 2016
Rotavirus – NICU project	Tony	4 October 2016
MES / OIS referrals	Bridget	2 December 2016
Immunisation Symposium	Bridget	On hold
Vaccinating Pregnant women – paper update and then present to P&F Leadership Team	Bridget and Margo	1 November 2016

Next meeting: TBA

our health system

Key Performance Indicators and Childhood Immunisation Reporting

October 2016

Immunisation Reporting Programme

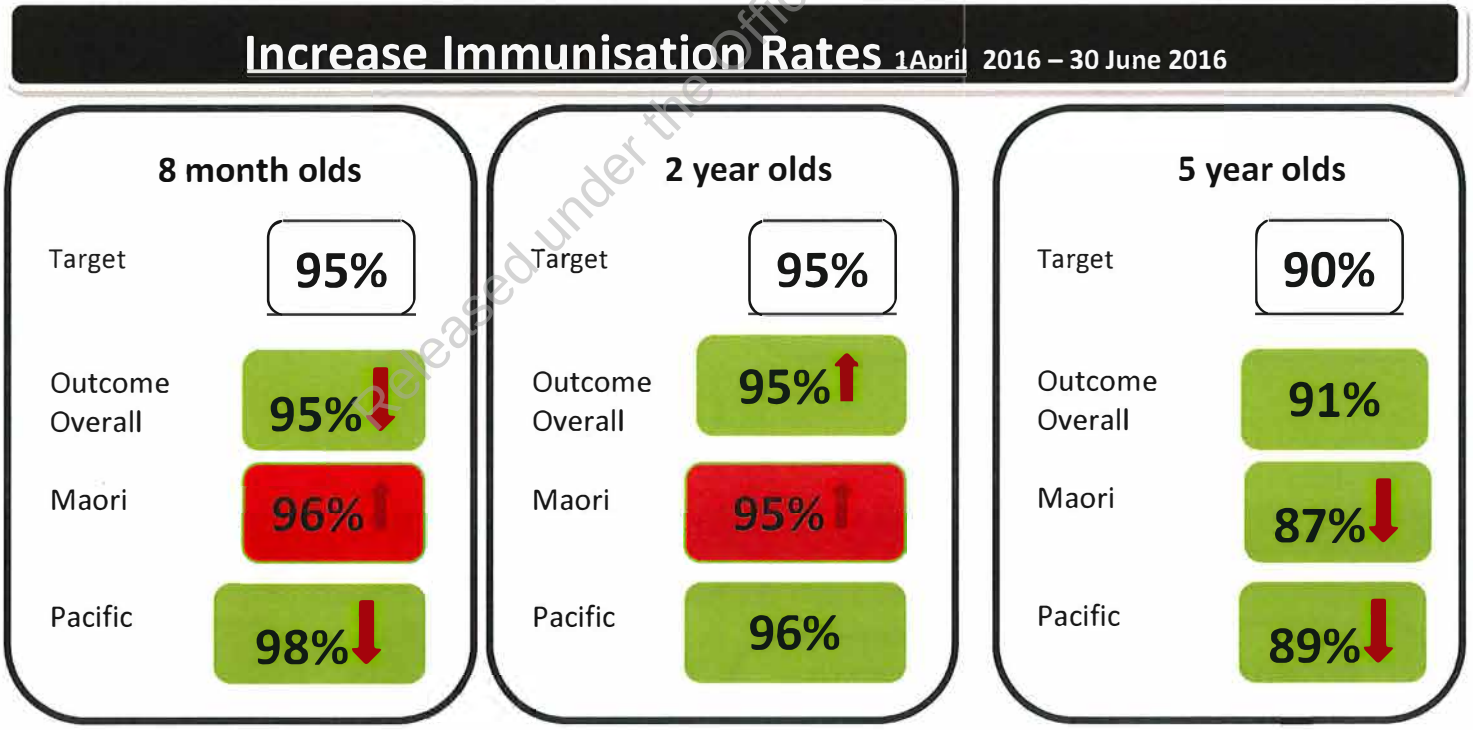
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 Dec 2016

Fully Immunised 8 month olds – DHB LEVEL

Q4 2015/16 Actual	Q1 2016/17 Actual	Q2 2016/17 Progress including pending	Q2 2016/17 Progress including pending
96% fully	95% fully	94.45%	84% fully
0% overdue	.0% overdue	0.9% could	12%

Fully Immunised Two year olds - DHB LEVEL

Q4 2015/16 Actual	Q1 2016/17 Actual	Q2 2016/17 Progress	Q3 2016/17 Progress
93.4% fully	95% fully	95%	94.6% fully
0% overdue	% overdue	0.1% overdue	1% overdue

Fully Immunised Four year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
91% fully	92% fully	93% fully	90% fully
overdue	overdue	1.5% overdue	2.8% overdue

There are 1.5% opt offs and 4.5% declines.
Therefore 6% of children could not be reached.

Fully Immunised 8month, two and five year - PHO LEVEL 30 Sept 2016

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		4 year olds	
Christchurch PHO	99%	99%	99%	99%	95%	96%
Pegasus	96%	97%	95%	96%	92%	93%
Rural Canterbury	95%	95%	93%	96%	92%	94%

Pre teen Immunisations

HPV as of 30 September 2016

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2002	HPV-1 Quadrivalent	197	52	124	1,228	1,601	390	100	160	2,310	2,970	51%	52%	78%	53%	54%	125 (4.2%)	1 (0.0%)
	HPV-2 Quadrivalent	175	44	119	1,164	1,502						45%	44%	74%	50%	51%	143 (4.8%)	
	HPV-3 Quadrivalent	148	37	106	1,064	1,355						38%	37%	66%	46%	46%	150 (5.1%)	
2003	HPV-1 Quadrivalent	249	70	157	1,394	1,870	390	110	180	2,150	2,830	64%	64%	87%	65%	66%	98 (3.5%)	1 (0.0%)
	HPV-2 Quadrivalent	220	65	154	1,348	1,787						56%	59%	86%	63%	63%	104 (3.7%)	
	HPV-3 Quadrivalent	189	55	129	1,229	1,602						48%	50%	72%	57%	57%	113 (4.0%)	
2004	HPV-1 Quadrivalent	193	56	125	1,116	1,490	430	130	210	2,210	2,980	45%	43%	60%	50%	50%	100 (3.4%)	0 (0.0%)
	HPV-2 Quadrivalent	163	41	117	1,044	1,365						38%	32%	56%	47%	46%	113 (3.8%)	
	HPV-3 Quadrivalent	125	26	91	869	1,111						29%	20%	43%	39%	37%	119 (4.0%)	
Total	HPV-1 Quadrivalent	639	178	406	3,738	4,961	1,210	340	550	6,670	8,780	53%	52%	224%	56%	57%	323 (3.7%)	2 (0.0%)
	HPV-2 Quadrivalent	558	150	390	3,556	4,654						46%	44%	216%	53%	53%	360 (4.1%)	
	HPV-3 Quadrivalent	462	118	326	3,162	4,068						38%	35%	181%	47%	46%	382 (4.4%)	

As of 30 September 2016

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
8 Month	1,490	1,419	95. %	723	693	96. %	234	224	96. %	83	81	98. %	223	217	97. %	227	204	90. %	10 (8)	0.7 (0.5) %	32	2.1 %
12 Month	1,638	1,566	96. %	762	742	97. %	309	289	94. %	95	92	97. %	233	227	97. %	239	216	90. %	11 (1)	0.7 (0.1) %	36	2.2 %
18 Month	1,542	1,402	91. %	767	709	92. %	235	208	89. %	95	84	88. %	211	197	93. %	234	204	87. %	8 (2)	0.5 (0.1) %	45	2.9 %
24 Month	1,564	1,482	95. %	773	739	96. %	252	240	95. %	72	69	96. %	202	199	99. %	265	235	89. %	18 ()	1.2 (0.0) %	54	3.5 %
5 Year	1,643	1,490	91. %	804	750	93. %	246	213	87. %	85	76	89. %	195	185	95. %	313	266	85. %	25 (2)	1.5 (0.1) %	85	5.2 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,584	1,367	86. %	347	296	85. %	326	281	86. %	306	266	87. %	227	197	87. %	201	166	83. %	177	161	91. %
8 Month	1,490	1,419	95. %	302	286	95. %	286	268	94. %	286	270	94. %	234	224	96. %	200	197	99. %	182	174	96. %
12 Month	1,638	1,566	96. %	335	314	94. %	314	301	96. %	319	309	97. %	257	247	96. %	237	227	96. %	176	168	95. %
18 Month	1,542	1,402	91. %	321	296	92. %	316	291	92. %	280	251	90. %	243	215	88. %	189	174	92. %	193	175	91. %
24 Month	1,564	1,482	95. %	348	314	90. %	320	312	98. %	277	270	97. %	255	240	94. %	205	196	96. %	159	150	94. %
5 Year	1,643	1,490	91. %	409	357	87. %	338	306	91. %	292	268	92. %	241	217	90. %	155	141	91. %	208	201	97. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter One 2016/17					
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016					
As at Quarter Four 2016 (October 2016)					
	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	243	1,113	1,414	79%	14
Bay of Plenty	97	568	715	79%	12
Canterbury	369	1,322	1,635	81%	9
Capital and Coast	176	588	841	70%	19
Counties Manukau	344	1,643	2,069	79%	13
Hawkes Bay	119	428	485	88%	2
Hutt	110	427	497	86%	4
Lakes	15	282	365	77%	16
MidCentral	100	341	562	61%	20
Nelson Marlborough	55	300	377	80%	11
Northland	152	485	562	86%	3
South Canterbury	39	137	167	82%	6
Southern	166	629	820	77%	17
Tairawhiti	58	140	179	78%	15
Taranaki	63	269	320	84%	5
Waikato	276	1,068	1,340	80%	10
Wairarapa	28	81	99	82%	7
Waitemata	266	1,407	1,981	71%	18
West Coast	41	82	92	89%	1
Whanganui	60	185	227	81%	8
Overseas or Unknown	0	0	14	0%	
Total	**2,777**	**11,495**	**14,761**	**78%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter One 2016/17				
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016				
	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	90	1,414	94%	14
Bay of Plenty	63	715	91%	17
Canterbury	57	1,635	97%	7
Capital and Coast	94	841	89%	20
Counties Manukau	114	2,069	94%	11
Hawkes Bay	30	485	94%	13
Hutt	26	497	95%	9
Lakes	8	365	98%	2
MidCentral	13	562	98%	3
Nelson Marlborough	9	377	98%	4
Northland	30	562	95%	10
South Canterbury	1	167	99%	1
Southern	21	820	97%	6
Tairawhiti	16	179	91%	18
Taranaki	8	320	98%	5
Waikato	140	1,340	90%	19
Wairarapa	5	99	95%	8
Waitemata	157	1,981	92%	16
West Coast	6	92	93%	15
Whanganui	14	227	94%	12
Unknown	2	14	86%	
Total	**904**	**14,761**	**94%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016
As at Quarter Four 2016 (October 2016)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	291	362	80.4%	23
Auckland PHO Limited	163	208	78.4%	30
Central Primary Health Organisation	334	538	62.1%	36
Christchurch PHO Limited	94	103	91.3%	11
Compass Health - Capital and Coast	463	650	71.2%	35
Compass Health - Wairarapa	82	103	79.6%	28
Cosine Primary Care Network Trust	108	109	99.1%	3
East Health Trust	270	303	89.1%	14
Eastern Bay Primary Health Alliance	129	154	83.8%	21
Hauraki PHO	433	480	90.2%	13
Health Hawke's Bay Limited	429	456	94.1%	6
Kimi Hauora Wairau (Marlborough PHO Trust)	87	122	71.3%	34
Manaia Health PHO Limited	268	310	86.5%	17
Midlands Health Network - Lakes	91	122	74.6%	32
Midlands Health Network - Tairawhiti	95	105	90.5%	12
Midlands Health Network - Taranaki	266	309	86.1%	18
Midlands Health Network - Waikato	625	720	86.8%	16
National Hauora Coalition	313	332	94.3%	5
Nelson Bays Primary Health	212	247	85.8%	19
Nga Mataapuna Oranga Limited	42	45	93.3%	7
Ngati Porou Hauora Charitable Trust	33	45	73.3%	33
Ora Toa PHO Limited	64	57	112.3%	1
Pegasus Health (Charitable) Limited	1,048	1,254	83.6%	22
Procare Networks Limited	2,153	2,713	79.4%	29
Rotorua Area Primary Health Services Limited	204	255	80.0%	25
Rural Canterbury PHO	177	221	80.1%	24
South Canterbury Primary and Community	135	161	83.9%	20
Te Awakairangi Health Network	341	366	93.2%	9
Te Tai Tokerau PHO Ltd	196	201	97.5%	4
Total Healthcare Charitable Trust	466	510	91.4%	10
Waitemata PHO Limited	588	736	79.9%	27
Well Health Trust	42	40	105.0%	2
WellSouth Primary Health Network	634	811	78.2%	31
West Coast PHO	82	88	93.2%	8
Western Bay of Plenty PHO Limited	378	427	88.5%	15
Whanganui Regional PHO	159	199	79.9%	26
Unknown or Blank	0	899	0.0%	
Total	**11,495**	**14,761**	**77.9%**	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 3 February 2017 2:10 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Margaret Kyle'; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers and Agenda for Tuesday ISLA meeting
Attachments: Agenda Feb ISLA 2017 meeting.docx; CCN WORK PLAN 17_18 ISLA CCN feedback.docx; InterimReport100316 (2).doc; Reporting Template Feb 2017.docx; Workplan Feb 2017.docx; Draft minutes 2 December ISLA.docx

Hi all

Please find attached the papers for our meeting on Tuesday.

Ramon is unable to attend the meeting, and Sarah has agreed to set in as deputy chair, and chair this times meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 7 February 2017, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	LMC Position: Vacant
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens: Apology
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Sarah Marr	
2.	2.10pm	**Confirmation of minutes of last meeting**	Sarah Marr	
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Sarah Marr	Draft minutes 2 December ISLA.docx
4.	2.30pm	**Updates** **2015/16 IPG Work Plan, including** • **HPV update** • **Tdap programme changes** • **Vaccinating Pregnant Women** • **Health Target progress – KPI** • **Influenza Programme 2017**	Bridget Lester	Reporting Template Feb 2017.docx Workplan Feb 2017.docx InterimReport100316 (2).doc
5.	3.00pm	**2017/18 Work plan Discussion – draft**	Bridget Lester	CCN WORK PLAN 17_18 ISLA CCN fee
6.	3.20pm	**Operational** • **Interest register** • **Risk Register** • **2017 Meeting dates**	Sarah Marr	RISK REGISTER 2016 update August.docx
7.	3.30pm	**Any other business**	Sarah Marr	

Action Register	Responsibility	Timeframe
New-born Enrolment Project • NIR Clinic to be advised • LMC education around GP enrolment • NIR reports to PHO	Bridget	7 Feb update
Draft 2017/18 Work plan	Bridget/Ramon	23 Dec
Vaccinating Pregnant Women project	Bridget	7 Feb - update
HPV CHANGES	Bridget	7 Feb update

• Consent form return encouragement to schools • Tony / Ramon talk to schools who require further support • Schools sharing data, Trisha to follow up with MoE		352
Schedule next meeting dates		

Next meeting: 4 April 217

Immunisation Service Level Alliance WORK PLAN 2017/18

Canterbury Clinical Network

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
Increased Immunisation BPS and Health Target 		Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	1. To ensure parents are informed and vaccinated Before (and just before Baby)	1.1. Continue to support Lead Maternity Carers (LMCS) to educate and promote immunisation and the NIR for both mother and baby. • Develop an inpatient and outpatient vaccinating programme at Christchurch Women's Hospital • Work with LMCs and General Practice Team (GPT) to improve systems to identify pregnant women to better enable the offering of Boostrix and influenza vaccine. 1.2. Maintain systems for enrolment and seamless handover between maternity, general practice and Well Child Tamariki Ora (WCTO) services • Ensure that new-borns on the NIR are allocated to a GPT. • Develop a system to work with families not enrolled in GPT. • Support early enrolment with General practice teams, and use of B code;	Q1-Q4 Q? Q?	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Ramon Pink	Bridget Lester

Commented [RR1]: Need specific milestone

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
				• Support LMCs for early hand over to GPT and Well Child providers; • Support the Child Health Coordination Service, and support the use of data linkages.				
		olds	2. Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	2.1. Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Support National Immunisation Register (NIR) and GPTs to identify unvaccinated children and refer to the Missed Events Service. • Provide practice-level coverage reports to Primary Health Organisations (PHOs) which identify and address gaps in service delivery. • Identify immunisation status of children presenting at hospital and vaccinate if possible	Q1-Q4	• 95% of eight month olds and two year olds are fully immunised • 95% of five year olds are fully immunised.	Ramon Pink	Bridget Lester

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
			3. .Adolescents are fully vaccinated according to the national schedule.	3.1. Provide the 11year old event and HPV to all eligible people, in a general practice setting 3.2. Provide a school based HPV programme, for both TDap and HPV, to complement the 11year old general practice programme.	Q1-Q4	▪ 70% of Girls have fully vaccinated for HPV (for 2017/18 it is the 2004 birth cohort measured at 30 June in 2018).	Ramon Pink	Bridget Lester
			4. Adults are fully vaccinated	4.1. Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women. • Work with general practice to ensure all events are recorded on the NIR • Support the expand role of community pharmacy in vaccinating for influenza.	Q1-Q4 Q?	• 75% of people aged 65+ have a seasonal flu vaccination	Ramon Pink	Bridget Lester
			5. The whole health system supported to promote and encourage immunisation for life. 6	5.1. Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups 5.2. Implement a DHB wide Immunisation Week Plan. 5.3. Use the Māori Kete and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q1 - Q4	• Canterbury DHB is represented at regional and national forums. ▪ Narrative report on interagency activities completed to promote Immunisation Week. • Improved Coverage of Immunisation	Ramon Pink	Bridget Lester
			6. Māori access timely vaccination and reach coverage targets	6.1 EOA - Monitor and evaluate immunisation coverage at DHB, PHO and general practice	Q1-Q4	•	Ramon Pink	Bridget Lester

Commented [RR2]: Can you write in full please

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5.4. Continue to work through the Child and Youth Workstream, explore opportunities with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.

Commented [RR4]: Should these actions extend to Pacific as well or have some specific actions for Pacific?

GOVERNMENT OR LOCAL PLANNING PRIORITY AREA	NZ HEALTH STRATEGY THEMES	Canterbury Health SYSTEM OUTCOME	OBJECTIVES	ACTIONS	Q	MEASURE OF SUCCESS	ACCOUNTABILITY	
							CLINICAL LEAD	PROJECT LEAD
				level managing identified service delivery gaps by: • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing tamariki • Support NIR and GPTs to identify unvaccinated tamariki Māori and refer to the Missed Events Service/Outreach Immunisation Service • Identify immunisation status of tamariki Māori presenting at hospital and vaccinate if possible 6.2 Promote HPV vaccine to rangatahi, through NGOs, Māori Community and Maori Womens Welfare League (MWWL) 6.3 Promote dTap and influenza vaccine to pregnant Māori women, through MWWL and Māori LMC collective				

Enablers and barriers for influenza vaccination for Māori aged 65 and over

Interim report

Background

In New Zealand, influenza vaccination became available free of charge to people aged 65 years and over in 1997. The Ministry of Health's national coverage target (75% for those aged 65 and over) has not yet been met.

Influenza continues to cause a significant burden of illness in New Zealand. Influenza-associated primary care consultations and hospitalisations show contrasting sociodemographic patterns and the rates of influenza-associated GP consultation and hospitalisation vary markedly with age. Influenza-associated hospitalisation rates were highest in the very young (0–4 years) and those aged 65 years and over. Influenza-associated GP consultation rates, however, showed the opposite pattern, with higher rates in pre-schoolers, school-aged children and adults, but a lower rate in infants (<1 year) and those in the 65 and over age group (Lopez, Wood, & Huang, 2014).

In addition, a preliminary analysis of influenza rates by ethnicity found that Māori and Pacific peoples experienced the highest rates of influenza-associated hospitalisations but the lowest rates of influenza-associated GP consultations. The most deprived populations (NZDep 9–10) were found to have the highest rates of influenza-associated hospitalisations but the lowest rates of influenza-associated GP consultations (Lopez, Wood, & Huang, 2014). Estimated influenza hospitalisation rates were also markedly higher in Pacific (83.3 per 100,000) and Māori (80.0 per 100,000) compared with European/Others (58.1 per 100,000) (Trang et al., 2015).

Mueller et al (2012) investigated disparities in immunisation uptake in New Zealand using the National Immunisation Register of children aged 12 months old. Substantial variations in uptake by District Health Board and ethnicity were evident and Māori children were at risk of low immunisation uptake. While Māori children are at risk of low immunisation uptake little is known about how older Māori perceive vaccination, and influenza vaccination in particular.

Evaluation methods

The objectives of the evaluation were primarily focused on exploring enablers and barriers for uptake of the influenza vaccination for Māori and Pacific populations, aged 65 and over. This interim report presents the key findings about enablers and barriers for influenza vaccination for Māori aged 65 and over. The key findings for older Pacific people will be available in the full report.

A literature review was undertaken and qualitative data were collected through focus groups with local kaumātua, aged 65 and over. Two focus groups were held at Rehua Marae on 28 October 2015. All focus group participants were Māori aged 65 or over who lived in Canterbury (n=18).

Key results

Barriers to influenza vaccination uptake

Most of the barriers to influenza vaccination uptake identified by Māori kaumātua in Canterbury, were very similar to what was found in a previous national study of adults aged 65 and over. (Brunton, Weir, & Jennings, 2005). These include beliefs that influenza vaccine gives you the flu/doesn't really protect you, influenza is not a serious disease, that healthy people don't get the flu/need the vaccine and fatalism.

Influenza vaccination gives you the flu/doesn't protect you
Some kaumātua believed that the influenza vaccination could give you the flu. Others were concerned that the flu injection didn't contain the correct strains of the flu that would protect them in that particular season.

Influenza is not a serious disease
Some commented that although they had had the flu, they didn't get the flu injection because of a perception that the flu wasn't that serious and that they could *"just work it off".* It was noted that men were particularly inclined to this point of view.

Healthy people don't get the flu/don't need the vaccine
A number of kaumātua perceived that if you are healthy then you are less likely to choose to have the influenza vaccination, "*It's like, if you car's running good, it may be old but why change it… if it's not broken don't fix it.* Some believed that they were not vulnerable to the flu, "*I'm from the Wairapapa, I don't recall our family ever having the flu. We have other diseases of course, but never the flu. I've never suffered the flu in my whole working life.*"

Fatalism
One participant expressed a fatalistic point of view, stating that *"bloody mindedness"* stopped her from getting vaccinated, "*It is a cynical point of view. If I get the flu and slip off my perch well, the heck, I have had a good life.*"

However, focus group participants also identified a quite different barrier to uptake of the vaccine which was not found in the national study.

Lack of trust or belief in Pākehā medication
Some kaumātua said that they would prefer to use rongoā if they did get unwell, "*I think it comes down to a matter of choices and people respecting other people's rights to make a choice... if we are missing out on something [vaccination], so be it but I also feel that if things went a bit pear-shaped further down the line, I would probably seek something that our people use, rongoā.*"

As well as beliefs about influenza vaccination that acted as barriers to vaccine uptake, kaumātua also identified other barriers to access. These included cost, as some were not aware that the vaccination was free. Not having access to vaccination at their marae was also perceived as a barrier. *"So maybe one of the barriers thinking that our kaumātua needing to go to a doctor or to a clinic for the flu injection rather than the flu injection being available out here at Rehua Marae, and we would have a vaccination day where it is more accessible."* Some identified irregular communication from their general practice about the influenza vaccination as a barrier.

Enablers of influenza vaccination uptake

As with barriers to uptake, most of the enablers identified by kaurnātua were consistent with what was identified in the literature and some of these are mirror opposites of the barriers. These include beliefs that the flu is a serious disease and that they are at risk of getting it. However, there were also some important differences in beliefs/perceptions found amongst older Māori focus group participants.

Māori may be more vulnerable to influenza
Some kaumātua expressed the belief that influenza vaccination is more important for Māori than non-Māori because cultural differences make them more at risk of the flu, "*The thing is that because we are Māori we come out to the marae and we do all the hongi and the mihi and here we are looking after ourselves but we don't know if they have been looking after themselves.*"

Importance of mokopuna
Kaumātua emphasised the importance of taking steps to protect their own health and that of their mokopuna (grandchildren):

- Stay healthy for mokopuna. "*…mine has changed from being macho to listening to the doctor… so I am taking on board everything from that because I'm looking at the future of being with my mokopuna and to be able to pass on down my knowledge so I need to be around to do this… so I'm accepting the Pākehā medication..*"
- Don't give the flu to mokopuna. "*Well if you're sick, you don't go and give it to your mokopunas.*"
- Be a role model to mokopuna. This included that the correct information about the injection needs to be provided by someone who has had the injection.

Access to vaccination
Other enablers discussed by participants related to access to vaccination. The majority of participants believed that providing vaccination at their marae would increase vaccination uptake, however, some were satisfied with current delivery of vaccination in primary care. For those that understood that the flu vaccination was free, this was seen as an enabler of uptake of flu vaccination. A number of participants who had had the flu vaccination commented that being reminded to have the flu vaccination by their practice nurse had encouraged them to have the vaccination. The participants who went to their general practice every three months for their regular medications appeared more likely to get their flu vaccination, as the doctor recommended it opportunistically.

Promotion of influenza vaccination to Māori
When participants were asked how they would promote the flu vaccination to Māori, some responded that the obvious way was to "*kōrero to our people*" or "*pānui about to other marae to say that we are having a flu vaccination day at the marae*". It was suggested that kaumātua promote the influenza vaccination to Māori. A strong message received from participants was that they wanted ordinary local people on promotional material, because "*what is wrong with ordinary people… because someone somewhere will say, I know him and then they maybe strike a chord… he is just another face promoting an injection.*"

Recommendations

The key messages of the national and local influenza campaigns are still appropriate to older Māori, however, they could be better targeted to this group, for example through:

- Clear targeted communication that the flu injection is free for everyone aged 65 and over and that influenza is a serious disease for Māori.
- Portraying local kaumātua on promotional materials .
- Encouraging kaumātua to promote vaccination themselves (local champions).
- Incorporating messages such as keeping healthy for mokopuna and keeping mokopuna healthy into promotional materials.

When primary care staff promote influenza vaccination well, including using personal vaccination reminders and face to face recommendations, this can work well for Māori. However, there would be value in considering partnering with a Māori health provider to provide the option of marae-based influenza vaccination clinics.

References

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our health system

Key Performance Indicators and Childhood Immunisation Reporting

February 2017

Immunisation Reporting Programme

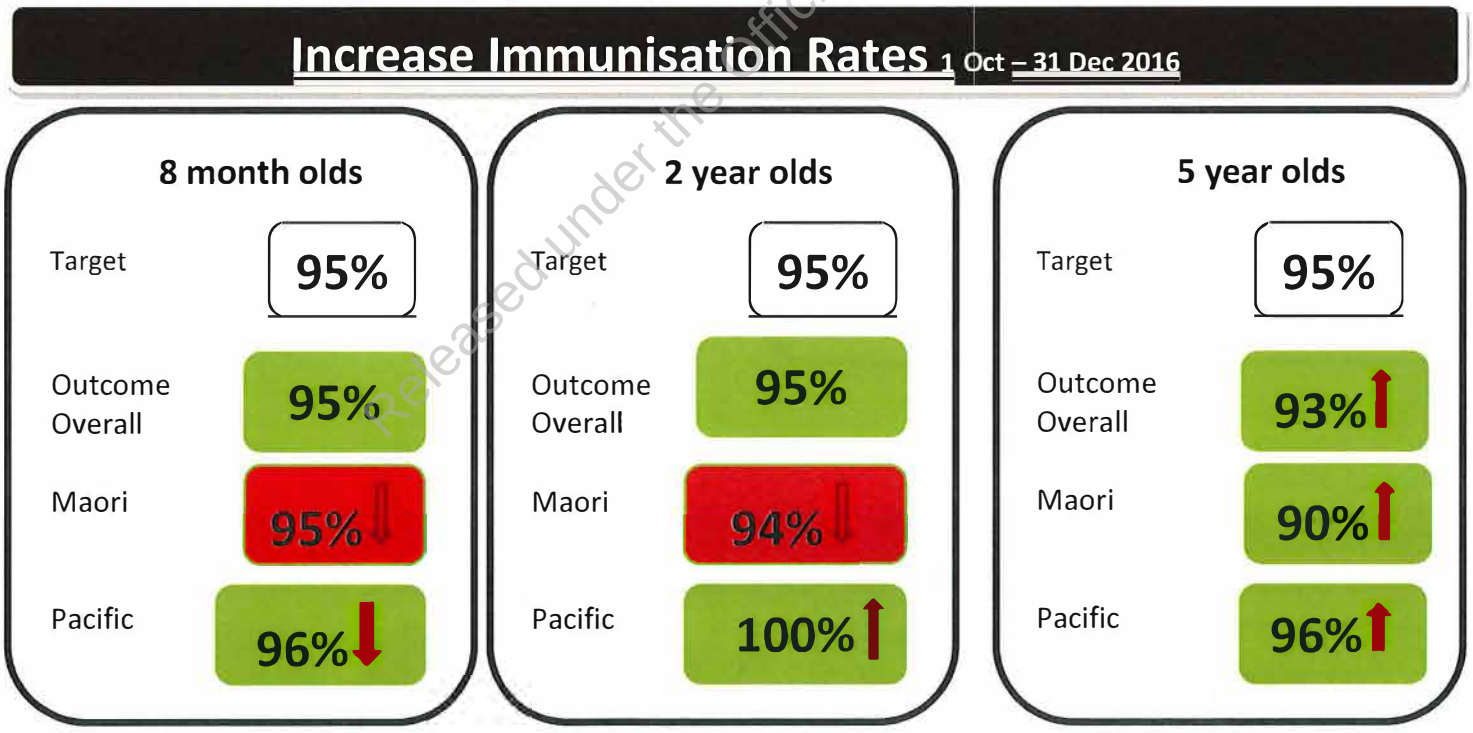
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 Febuary 2017

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress including pending	Q4 2016/17 Progress including pending
95% fully	95% fully	93.15%	88% fully
% overdue	1% overdue	1.5% could	8.3% could

Fully Immunised Two year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress	Q4 2016/17 Progress
95% fully	95% fully	95.4%	93.2% fully
0% overdue	0.8% overdue	0.7%overdue	3% overdue

Fully Immunised Four year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress	Q4 2016/17 Progress
91% fully	93% fully	91.7% fully	89.5% fully
overdue	2.4% overdue	1% overdue	5.9% overdue

Fully Immunised 8month, two and five year - PHO LEVEL 30 Sept 2016

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		4 year olds	
Christchurch PHO	95%	95%	100%	99%	92%	92%
Pegasus	96%	95%	95%	95%	93%	95%
Rural Canterbury	93%	94%	95%	96%	97%	93%

Pre teen Immunisations

HPV as of 31 December 2016

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2003	HPV-1 Quadrivalent	250	70	156	1,396	1,872	390	110	180	2,150	2,830	64%	64%	87%	65%	66%	101 (3.6%)	1 (0.0%)
	HPV-2 Quadrivalent	221	66	154	1,354	1,795						57%	60%	86%	63%	63%	107 (3.8%)	
	HPV-3 Quadrivalent	192	56	132	1,244	1,624						49%	51%	73%	58%	57%	116 (4.1%)	
2004	HPV-1 Quadrivalent	195	58	129	1,123	1,505	430	130	210	2,210	2,980	45%	45%	61%	51%	51%	103 (3.5%)	0 (0.0%)
	HPV-2 Quadrivalent	167	43	118	1,056	1,384						39%	33%	56%	48%	46%	117 (39%)	
	HPV-3 Quadrivalent	131	27	94	900	1,152						30%	21%	45%	41%	39%	124 (4.2%)	
Total	HPV-1 Quadrivalent	445	128	285	2,519	3,377	820	240	390	4,360	5,810	54%	53%	148%	58%	58%	204 (3.5%)	1 (0.0%)
	HPV-2 Quadrivalent	388	109	272	2,410	3,179						47%	45%	142%	55%	55%	224 (3.9%)	
	HPV-3 Quadrivalent	323	83	226	2,144	2,776						39%	35%	118%	49%	48%	240 (4.1%)	

As of 31 December 2016

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,539	1,346	87. %	730	650	89. %	231	190	82. %	84	75	89. %	256	233	91. %	238	198	83. %	14 (1)	0.9 (0.1) %	39	2.5 %
8 Month	1,581	1,498	95. %	720	685	95. %	252	240	95. %	82	79	96. %	257	250	97. %	270	244	90. %	13 (1)	0.8 (0.1) %	53	3.4 %
12 Month	1,536	1,482	96. %	736	714	97. %	231	226	98. %	90	90	100. %	225	221	98. %	254	231	91. %	9 (1)	0.6 (0.1) %	31	2.0 %
18 Month	1,622	1,445	89. %	779	717	92. %	282	237	84. %	81	70	86. %	236	222	94. %	244	199	82. %	12 (1)	0.7 (0.1) %	43	2.7 %
24 Month	1,562	1,487	95. %	751	713	95. %	236	223	94. %	78	78	100. %	237	235	99. %	260	238	92. %	6 (1)	0.4 (0.1) %	55	3.5 %
5 Year	1,661	1,545	93. %	829	795	96. %	280	251	90. %	68	65	96. %	193	181	94. %	291	253	87. %	14 ()	0.8 (0.0) %	62	3.7 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,539	1,346	87. %	329	281	85. %	278	245	88. %	309	278	90. %	260	227	87. %	178	150	84. %	185	165	89. %
8 Month	1,581	1,498	95. %	336	308	92. %	330	314	95. %	312	296	95. %	241	228	95. %	187	177	95. %	175	175	100. %
12 Month	1,536	1,482	96. %	316	297	94. %	281	268	95. %	306	292	95. %	251	248	99. %	205	203	99. %	177	174	98. %
18 Month	1,622	1,445	89. %	346	305	88. %	311	276	89. %	301	273	91. %	252	227	90. %	207	176	85. %	205	188	92. %
24 Month	1,562	1,487	95. %	325	304	94. %	310	295	95. %	313	293	94. %	262	254	97. %	176	172	98. %	176	169	96. %
5 Year	1,661	1,545	93. %	393	363	92. %	357	336	94. %	301	281	93. %	221	200	90. %	185	170	92. %	204	195	96. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016
As at Quarter Four 2016 (October 2016)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	243	1,113	1,414	79%	14
Bay of Plenty	97	568	715	79%	12
Canterbury	369	1,322	1,635	81%	9
Capital and Coast	176	588	841	70%	19
Counties Manukau	344	1,643	2,069	79%	13
Hawkes Bay	119	428	485	88%	2
Hutt	110	427	497	86%	4
Lakes	15	282	365	77%	16
MidCentral	100	341	562	61%	20
Nelson Marlborough	55	300	377	80%	11
Northland	152	485	562	86%	3
South Canterbury	39	137	167	82%	6
Southern	166	629	820	77%	17
Tairawhiti	58	140	179	78%	15
Taranaki	63	269	320	84%	5
Waikato	276	1,068	1,340	80%	10
Wairarapa	28	81	99	82%	7
Waitemata	266	1,407	1,981	71%	18
West Coast	41	82	92	89%	1
Whanganui	60	185	227	81%	8
Overseas or Unknown	0	0	14	0%	
Total	**2,777**	**11,495**	**14,761**	**78%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	90	1,414	94%	14
Bay of Plenty	63	715	91%	17
Canterbury	57	1,635	97%	7
Capital and Coast	94	841	89%	20
Counties Manukau	114	2,069	94%	11
Hawkes Bay	30	485	94%	13
Hutt	26	497	95%	9
Lakes	8	365	98%	2
MidCentral	13	562	98%	3
Nelson Marlborough	9	377	98%	4
Northland	30	562	95%	10
South Canterbury	1	167	99%	1
Southern	21	820	97%	6
Tairawhiti	16	179	91%	18
Taranaki	8	320	98%	5
Waikato	140	1,340	90%	19
Wairarapa	5	99	95%	8
Waitemata	157	1,981	92%	16
West Coast	6	92	93%	15
Whanganui	14	227	94%	12
Unknown	2	14	86%	
Total	**904**	**14,761**	**94%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016
As at Quarter Four 2016 (October 2016)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	291	362	80.4%	23
Auckland PHO Limited	163	208	78.4%	30
Central Primary Health Organisation	334	538	62.1%	36
Christchurch PHO Limited	94	103	91.3%	11
Compass Health - Capital and Coast	463	650	71.2%	35
Compass Health - Wairarapa	82	103	79.6%	28
Cosine Primary Care Network Trust	108	109	99.1%	3
East Health Trust	270	303	89.1%	14
Eastern Bay Primary Health Alliance	129	154	83.8%	21
Hauraki PHO	433	480	90.2%	13
Health Hawke's Bay Limited	429	456	94.1%	6
Kimi Hauora Wairau (Marlborough PHO Trust)	87	122	71.3%	34
Manaia Health PHO Limited	268	310	86.5%	17
Midlands Health Network - Lakes	91	122	74.6%	32
Midlands Health Network - Tairawhiti	95	105	90.5%	12
Midlands Health Network - Taranaki	266	309	86.1%	18
Midlands Health Network - Waikato	625	720	86.8%	16
National Hauora Coalition	313	332	94.3%	5
Nelson Bays Primary Health	212	247	85.8%	19
Nga Mataapuna Oranga Limited	42	45	93.3%	7
Ngati Porou Hauora Charitable Trust	33	45	73.3%	33
Ora Toa PHO Limited	64	57	112.3%	1
Pegasus Health (Charitable) Limited	1,048	1,254	83.6%	22
Procare Networks Limited	2,153	2,713	79.4%	29
Rotorua Area Primary Health Services Limited	204	255	80.0%	25
Rural Canterbury PHO	177	221	80.1%	24
South Canterbury Primary and Community	135	161	83.9%	20
Te Awakairangi Health Network	341	366	93.2%	9
Te Tai Tokerau PHO Ltd	196	201	97.5%	4
Total Healthcare Charitable Trust	466	510	91.4%	10
Waitemata PHO Limited	588	736	79.9%	27
Well Health Trust	42	40	105.0%	2
WellSouth Primary Health Network	634	811	78.2%	31
West Coast PHO	82	88	93.2%	8
Western Bay of Plenty PHO Limited	378	427	88.5%	15
Whanganui Regional PHO	159	199	79.9%	26
Unknown or Blank	0	899	0.0%	
Total	**11,495**	**14,761**	**77.9%**	

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - Feb 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. Q2 data shows CDHB at has dropped to 62%, but all DHBs have dropped this quarter. Rank 12h. Work continues on the LMC toolkit
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q2 = 95% 8month olds, 95% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	67% of Dose one of girls born in 2003. Work is underway on the Year 8 school programme and General Practice 11year old event programme.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	2017 Planning underway
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 6 December 2016	Time: 2-4.00pm
Present: Ramon Pink (Chair), Margaret Kyle, Bridget Lester, Geraldine Clemens, Sarah Marr, Donna MacLean, Anna Harwood and Alison Wooding.	
Apologies: Tony Walls and Anne Feld	
Visitors: Ruth Robson, Patricia Connell and Miles Hartshone	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 4 October meeting where approved to be sent to the CCN office	Bridget	16 Dec
2.	**Previous Actions & Matters Arising**	• Loading of Tdap – this continues o be worked though, considering the recent MedTech changes. This cohort is now included on the NIR, so this might make loading the data easier • Gardisal 4 – discussion has occurred with MoH and IMAC and this will not change. It is standard practice to use up old vaccine before the new stock. There is some concern that this is seen as discriminating against the CDHB General Practice HPV programme, however the vaccine is still a good vaccine and will provide coverage. It is expected that notification will be received soon around moving this from a three dose to two dose programme. • Imms for life updated and shift to HealthInfo – this is being reviews by the Pegasus Health Immunisation Coordinating Team. • MEC / OIS referrals – to be discussed later in the meeting • Vaccinating Pregnant women – to be discussed later in the meeting		
3.	**ISLA Work plan**	Q2 201617 – progress result • 8month olds – very tight hopefully will achieve 95% 2 year olds – progressing to achieved 95 • 5 year olds achieved 93%. This will be an increase in 2% on last quarter. The target for this has now moved to 95% so some further works needs to occur on reaching this. HPV currently sitting at 66% of girls have received Dose One and 57% doses 3. New-born Enrolment – Q1 81% enrolled in general practice. As this is now a Systems Level Measure, an increased focus is not put on this. There is overall concern around the data being used, and if this target can be reached. **Action:** • **Work with NIR to reduce Clinic to be advised** • **Educate LMCs on the need to have a GP** • **Relook at NIR reports to see what can be shared with PHOs around NIR nominations.**	Bridget	31 January 17
4.	**2017/18 Work plan Discussion**	Ruth attended to talk about the 2017/18 work plan. ISLA need to consider the SLM – New-born enrolled with General Practice		

	Item	Discussion/Action	Responsibility	Date due
		and Smoke Free homes at 6 weeks, in their planning for 2017/18. There was concern around what impact Immunisation could have on Smoking, but happy to consider as wider measure. ISLA work plan is largely driven by the expectations on the MoH, and then we will look at what we can do to achieve these. As the 2017/18 planning package has not yet been released, we are not able to progress the development of this plan. Ruth has asked for the first draft in mid-January 2017 **Action: Attempt to draft plan – however really need to wait for Planning Package.**		
5.	**Vaccinating Pregnant Women**	Following our previous meeting a paper was approved by the P&F leadership team around the pilot project. A meeting has occurred with the service manager, Women's to discuss the implementation. This will focus on two areas • Business as usual – vaccinating antenatal and post-natal inpatients, which fit the criteria. • Pilot – vaccinating outpatients though maternity outpatient clinics. Funding of $20,000 is allocated to this. A more details implementation is currently being worked through. **Action:** Keep ISLA update on progress, and any issues.	Bridget	
6.	HPV School programme update	Patricia and Miles attended the meeting to update ISLA on the 2016 programme. Miles presented uptake data (attached). There were a number of schools who pulled out of the programme at the last minute. There was overall concern around the low consent return rate. This needs to be considered for the 2017 year. Planning is underway for the 2017 year. Letters have been sent to all schools around the programme. 128 yes, 22 no, 9 still waiting reply. This year we have not sort the class roll from the schools, based on DHB legal advice. However, following discussions with the MoH and review of school enrolment forms, the sense is we can use this information. Patricia to follow up to seek further confirmation. ISLA supported the need to encourage the return of consent forms in schools. **Action:** • **Consideration given to how we can encourage the return of consent forms.** • **Ramon / Tony to talk to schools who need some more information.** • **Trisha to follow up use of school data with MoE.**		
7.	**2017 Influenza Programme Planning,**	We have been approached again to consider if ISLA supports the offering the Seasonal Influenza vaccinate to close contacts of oncology patients. To do this ISLA would need to put a special application to Pharmac.		

	Item	Discussion/Action	Responsibility	Date due
	including special populations	**Action: Approach Tony around what the need is for this, and if there is any data supporting this.**		
8.	**Operational**	Margo has resigned from her role in ISLA. She has been on ISLA for over 6 years and is no longer working in clinical practice. This will be her last meeting. The membership used this is a opportunity to thank Margo for all her work, and the progress which has been made in both childhood and pregnancy vaccinations with her support and direction.	Bridget	
9.	**Next Meeting**	Meeting schedule for 2017 7 February 2017 2-4pm at C&PH 4 April 2017 2-4pm at C&PH 6 June 2017 2-4pm at C&PH 8 August 2-4pm at C&PH 3 October 2-4pm at C&PH 5 December 2-4pm at C&PH		

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 31 March 2017 1:33 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers for Tuesdays ISLA meeting
Attachments: Draft agenda April 2017 meeting.docx; Tdap and HPV papper to ISLA.docx; Workplan.docx; Draft minutes 7 Feb ISLA.docx

Hi all

Please find attached the papers for Tuesday ISLA meeting.

Please let me know if you can't attend.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 4 April, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	LMC Position: Vacant
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens: Apology
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 7 Feb ISLA.docx
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.30pm	**Updates** **2015/16 IPG Work Plan, including** • **HPV update** • **Vaccinating Pregnant Women** • **Health Target progress – KPI** • **Influenza Programme 2017**	Bridget Lester	Workplan.docx To be shared at meeting with most recent data
5.	3.00pm	• **Tdap programme changes**	Bridget Lester	Tdap and HPV papper to ISLA.docx
6.	3.20pm	**HPV Programme Update**	Bridget	Paper to come
7.	3.30pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	RISK REGISTER 2016 update August.docx
8.	3.40pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
Loading HPV 4	Bridget and Donna	17 Feb 2017
2017/18 Work plan update	Bridget	17 Feb 2017
LMC representative	Bridget	End Feb
2017 Influenza – Special populations • Alison to discuss resource with her team • Bridget to check with C&HP to see if this resources can be circulated • Link with MWWL to see if there are any opportunities with Maree	Bridget	End of Feb

Next meeting: 6 April 217

FOR ISLA CONSIDERATION	Canterbury Clinical Network Transforming Health Care Whakau Oranga Whānau
TITLE	11 year old event (HPV and Tdap) and Year 8 School Programme
PREPARED BY	Bridget Lester
DATE	31 March 2017
RECOMMENDATION	That the ISLA review the paper and approves the following: • Support the continued offering of HPV and Tdap at 11 in a general practice programme • Extend the Year 8 HPV Programme to include a catch up programme for Tdap.

1. Purpose

The purpose of this paper is to provide background information to the South Island GM, relevant PHOs around the proposed changes to the Tdap (11 year old event) and the HPV programme.

We ask that the GM review this and work with their DHBs to make a decision on the preferred service model will be for their region.

2. Background

In mid-2016 the Ministry of Health (MoH) and PHARMAC advised of changes to the national HPV programme. These changes included

- Extending the eligibility to include boys
- Changing the vaccine from a 4 valiant to a 9 valiant
- Changing the doses from a 3 dose programme to a 2 doses programme.

At this time, the MoH wrote to all DHBs signalling the changes to the programme in 2017 and noting that there would be potential changes in 2018. The MoH encouraged DHBs to focus on the 2017 year, and the introduction of vaccine availability to boys at the Year 8 HPV School Programme.

It was also noted that planning was underway to move HPV from Year 8 to Year 7, and offer this in a school programme with the Year 7 Tdap event.

3. Current Service

Currently there is not national consistency in the delivery of the Tdap programme. In the majority of the country (the north island and NMDHB) Tdap is provided within a school programme to all year 7 children. However in what was the older Southern Reginal Health Authority region (Canterbury, South Canterbury, Southern and the West Coast) this programme is offered in a general practice setting, while HPV is offered in as a full school programme in Year 8. Canterbury is the exception: HPV is offered at the 11 year old event in general practice, with a catch up programme in Year 8, in schools.

Therefore while the proposed national changes, will not have a large impact on the North Island, they will have an impact on the South Island and there is need for consideration and possible consultation on this.

4. Rationale behind changes

The rationale behind these changes is around streamlining and 'normalising' the HPV programme vaccination programme in schools. The assumption is that there will be increased coverage and reduced administration costs to a combined primary care/school approach.

The Canterbury DHB has combined the two events since 2013 and this has proven to be successful in increasing HPV coverage in the region.

5. National Planning

A national working group has been set up to look at the implementation of this concept and proposed service models. While there are concerns in the Southern region, there are also concerns in the northern regions around what the change in doses and the schedule will mean for the workforce and programme planning.

At the national teleconference a number of alternative models was suggested, including:

- Offer HPV in term one and term 3 and Tdap separately in term 2
- Offer HPV and TDap at Year 8, and this would remove the concern around hump year (when both the programmes are running, this will be a one off).
- While option of the Year 8 programme would be better for the South Island, as we could continue to offer our 11 year old programme with the Year 8 programme, it would not leave any option for a school catch up programme.

6. Current service performance

The Canterbury DHB is still performing lower than other DHBs with HPV coverage. However we are currently sitting at 68% coverage for dose 1 and 59% coverage for dose three. The national target for HPV is 70% for girls born in 2003. While our coverage is not at the national target, there has been a marked improvement over the past two years.

The change from a three to a two dose programme and the eligibility of boys to receive the vaccine, will normalise this programme more, and see improved coverage.

Tdap coverage use to be regularly reported to P&F. However due to a change in contracting and data collection, this has not been possible. When the data was collected the CDHB coverage was 80%. While these 11 year olds are now part of the NIR birth cohort, again challenges with loading this event on the NIR and the schedule not being updated to make this simple, means that what is being given is not being counted. The NIR team and the Immunisation Coordinators have been working with MoH national team to try and determine the issues in the processing.

7. South Island Consultation

This change needs to be discussed widely to ensure there is agreement within the MoH, DHB and Primary Care around any changes to the 11year old immunisations.

What has already occurred?

- The issue was highlighted at a recent South Island GM Planning and Funding meeting

- An email has been sent to all Planning and Funding Immunisation Portfolio Managers asking their thoughts around the proposed changes.
- A discussion has occurred with the West Coast Immunisation Advisory Group and the West Coast PHO Clinical board
- A discussion has occurred with the Canterbury DHB Immunisation Service Level Alliance, and the Canterbury PHO CEO meeting.

8. Proposed Service Models

MoH Proposal - Offer HPV and Tdap in a Year 7 School Programme - this is the MoH proposed model, but it will have a major impact on general practice. This could be seen as moving the children from their current health home, and into an isolated school programme. This would require increased staffing with the school vaccinating team, and reduced funding to general practice.

However, it would see the normalisation of the event and school programmes achieve higher service coverage for Māori and Pacific populations.

Canterbury DHB Proposal - Offer HPV and Tdap at the 11year old event in general practice - This would see HPV moved forward a year to the 11 year old event and offered in general practice however this would require a catch up programme at Year 8 in the school programme. This would again normalise HPV and Tdap and consolidate the programme i.e all events are given in general practice at 11years of age, and will follow up in school at 12 years.

While this proposal is not within current national direction, it fits within the direction of our DHB with general practice being the families' health hub. The model is currently seen as effective, so why change the model we have worked so hard to get effective.

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - Feb 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. Work continues on the LMC toolkit
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q2 = 95% 8month olds, 95% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	69% of Dose one of girls born in 2003. Data to come
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	2017 Planning underway - looking to see if we can run a clinic at the kamatua day.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 7 February 2017	Time: 2-4.00pm
Present: Sarah Marr (Deputy Chair), Bridget Lester, Anne Feld, Donna MacLean, and Alison Wooding.	
Apologies: Tony Walls, Geraldine Clemens, Ramon Pink and Anna Harwood	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
1.	**Confirmation of Minutes**	• Minutes of the 4 October meeting where approved to be sent to the CCN office	Bridget	16 Dec
2.	**Previous Actions & Matters Arising**	• New born enrolment Project – work continues with NIR to identify possible reports to assist in monitoring this measure. • Draft work plan for 17/18 to be discussed later in meeting • Vaccinating Pregnant Women – implementation plan being drafted. • HPV Changes – discussed later in meeting		
3.	**ISLA Work plan**	Q2 201617 – progress result • 8month olds – Q2 results – 95%, however very tight for Q3 2017. 2 year olds – Q2 result 95% and it appears we have already achieved this for Q3 • 5 year olds – Q2 result, 93%, this was due to a decreased in declines and opt-offs. However, we are sitting on 91% FOR q3. NIR has been doing a project looking at decliners. Bridget to review this and provide updated to ISLA. HPV currently sitting at 66% of girls have received. Dose One and 57% doses 3. **Action: Send ISLA members National data, so we can see where CDHB is sitting.** **New-born Enrolment** – Q2 68% enrolled in general practice. This is a reduction in last quarter, but often occurs at this time of the year as the registered need to be submitted early. There is a concern around the accuracy of this data, so some further analyst needs to occur. Work to continue with PHOs to identify ways to improve coverage. **HPV** – The 11 year old event programme has started offering this to boys, resources have been developed to support this programme, which should be distributed to general practice in the next few weeks. School Programme – the consent forms have been distributed, and posters are having to be ordered. Funding has been made available to support the return of consent forms. • Total Schools – 160 • Total **Yes** to-date – 131 • Total **No** to-date – 20	Bridget	Attached to minutes

	Item	Discussion/Action	Responsibility	Date due
		• Total **Awaiting** – 5 *(Cheviot Area School, Hapuku School, Kaikoura High School, Lemon Grove School , TKKM o Te Whanau Tahi)* • Total **No Year 8** to-date - 2 *Question - how do we load HPV 4, as this has moved from a three to a two dose programme? Need to ensure consistency so that our data is accurate.*	Bridget / Donna	End of Feb
4.	**2017/18 Work plan Discussion**	Draft plan was presented to ISLA. They agreed with the feedback to incorporate Maori and Pacific outcomes into each action. Action: Bridget to update and circulate to Ramon and Sarah for approval. **Action: Attempt to draft plan – however really need to wait for Planning Package.**	Bridget	17 February 2017
5.	**2017 Influenza Programme Planning, including special populations**	Discussion around 2017 Programme. At this stage the promotion will be in line with the national campaign. The programme has been extended to go from 1 March 2017 – 31 December 2017. We is underway to enable Community Pharmacy to vaccinated the over 65s and pregnant women. While improving access to the vaccine was fully supported by ISLA, there is a concern that the general practice and Pharmacy systems are not yet link up, and this will result in increased workload and duplication for both groups. Introducing this new group will also increase the workload for NIR and Immunisation Coordinators. ISLA to draft feedback to the PHARMAC proposal. There is also a need to improve Maori Coverage. Ramon had shared the C&PH work around why Maori are not vaccinated for Influenza. A meeting to being planned with PHO Maori Health Managers to see brainstorm whys to improve coverage. **Actions** • **Alison to discuss with her team around how this can be used in a general practice setting.** • **Bridget to check with C&PH to see if this can be circulated to GPT.** • **Link with MWWL to see if there are any health promotion opportunities into Maree.**		
6.	**Operational**	LMC Representative – agreed that we need someone with both a strategic and operational understanding. Linkages with both community and Hospital Midwives is also important. **Action: Bridget to draft a JD to share with Sarah / Anne before progressing to CCN.** Risk Register – No changes to Risk Register required	Bridget	17 Feb 2017
7.	**Next Meeting**	Meeting schedule for 2017 Agreed to change October meeting, as this was scheduled in the school holidays. Meeting request to be updated. 4 April 2017 2-4pm at C&PH	Bridget	8 Feb 2017

	Item	Discussion/Action	Responsibility	Date due
		6 June 2017 2-4pm at C&PH 8 August 2-4pm at C&PH 10 October 2-4pm at C&PH 5 December 2-4pm at C&PH		

8month old, national summary data

DHB Area	Total			Opt-off*		Declined		Combined opt-off/ declined		Missed children	
	No. Eligible	Fully Immunised for Age	%	Total	%	Total	%	Total	%	Total	%
Auckland	1,362	1,299	95.4%	2	0.1%	19	1.4%	21	1.5%	42	3.1%
Bay of Plenty	758	654	86.3%	10	1.3%	57	7.5%	67	8.8%	37	4.9%
Canterbury	1,582	1,498	94.7%	14	0.9%	53	3.4%	67	4.2%	17	1.1%
Capital and Coast	891	848	95.2%	2	0.2%	24	2.7%	26	2.9%	17	1.9%
Counties Manukau	2,028	1,915	94.4%	3	0.1%	39	1.9%	42	2.1%	71	3.5%
Hawkes Bay	536	511	95.3%	2	0.4%	18	3.4%	20	3.7%	5	0.9%
Hutt Valley	468	454	97.0%	3	0.6%	8	1.7%	11	2.4%	3	0.6%
Lakes	368	346	94.0%	0	0.0%	11	3.0%	11	3.0%	11	3.0%
MidCentral	499	474	95.0%	1	0.2%	17	3.4%	18	3.6%	7	1.4%
Nelson Marlborough	403	368	91.3%	3	0.7%	25	6.2%	28	6.9%	7	1.7%
Northland	552	493	89.3%	2	0.4%	46	8.3%	48	8.7%	11	2.0%
South Canterbury	153	141	92.2%	2	1.3%	8	5.2%	10	6.5%	2	1.3%
Southern	854	803	94.0%	1	0.1%	36	4.2%	37	4.3%	14	1.6%
Tairawhiti	182	164	90.1%	1	0.5%	5	2.7%	6	3.3%	12	6.6%
Taranaki	377	349	92.6%	1	0.3%	14	3.7%	15	4.0%	13	3.4%
Waikato	1,336	1,226	91.8%	10	0.7%	57	4.3%	67	5.0%	43	3.2%
Wairarapa	126	120	95.2%	0	0.0%	4	3.2%	4	3.2%	2	1.6%
Waitemata	1,863	1,723	92.5%	10	0.5%	74	4.0%	84	4.5%	56	3.0%
West Coast	86	69	80.2%	11	12.8%	3	3.5%	14	16.3%	3	3.5%
Whanganui	204	189	92.6%	3	1.5%	10	4.9%	13	6.4%	2	1.0%
National	**14,628**	**13,644**	**93.3%**	**81**	**0.6%**	**528**	**3.6%**	**609**	**4.2%**	**375**	**2.6%**

2year old national summary data

DHB Area	Total			Opt-off*		Declined		Combined opt-off/ declined		Missed children	
	No. Eligible	Fully Immunised for Age	%	Total	%	Total	%	Total	%	Total	%
Auckland	1,593	1,499	94.1%	5	0.3%	42	2.6%	47	3.0%	47	3.0%
Bay of Plenty	761	671	88.2%	8	1.1%	58	7.6%	66	8.7%	24	3.2%
Canterbury	1,562	1,487	95.2%	7	0.4%	55	3.5%	62	4.0%	13	0.8%
Capital and Coast	907	857	94.5%	3	0.3%	24	2.6%	27	3.0%	23	2.5%
Counties Manukau	2,180	2,055	94.3%	4	0.2%	61	2.8%	65	3.0%	60	2.8%
Hawkes Bay	549	520	94.7%	1	0.2%	23	4.2%	24	4.4%	5	0.9%
Hutt Valley	523	500	95.6%	0	0.0%	18	3.4%	18	3.4%	5	1.0%
Lakes	396	350	88.4%	4	1.0%	21	5.3%	25	6.3%	21	5.3%
MidCentral	546	516	94.5%	3	0.5%	21	3.8%	24	4.4%	6	1.1%
Nelson Marlborough	409	370	90.5%	3	0.7%	33	8.1%	36	8.8%	3	0.7%

Northland	569	499	87.7%	3	0.5%	56	9.8%	59	10.4%	11	1.9%
South Canterbury	156	145	92.9%	1	0.6%	8	5.1%	9	5.8%	2	1.3%
Southern	860	812	94.4%	5	0.6%	34	4.0%	39	4.5%	9	1.0%
Tairawhiti	194	182	93.8%	0	0.0%	10	5.2%	10	5.2%	2	1.0%
Taranaki	397	369	92.9%	1	0.3%	24	6.0%	25	6.3%	3	0.8%
Waikato	1,408	1,288	91.5%	5	0.4%	87	6.2%	92	6.5%	28	2.0%
Wairarapa	135	130	96.3%	0	0.0%	3	2.2%	3	2.2%	2	1.5%
Waitemata	2,122	1,968	92.7%	15	0.7%	88	4.1%	103	4.9%	51	2.4%
West Coast	72	63	87.5%	6	8.3%	3	4.2%	9	12.5%	0	0.0%
Whanganui	225	206	91.6%	2	0.9%	14	6.2%	16	7.1%	3	1.3%
National	**15,564**	**14,487**	**93.1%**	**76**	**0.5%**	**683**	**4.4%**	**759**	**4.9%**	**318**	**2.0%**

*** Includes actual and provisional opt-off**

5 year old, national summary data

DHB Area	Total			Opt-off*		Declined		Combined opt-off/ declined		Missed children	
	No. Eligible	Fully Immunised for Age	%	Total	%	Total	%	Total	%	Total	%
Auckland	1,473	1,264	85.8%	5	0.3%	39	2.6%	44	3.0%	165	11.2%
Bay of Plenty	747	614	82.2%	4	0.5%	55	7.4%	59	7.9%	74	9.9%
Canterbury	1,661	1,545	93.0%	14	0.8%	62	3.7%	76	4.6%	40	2.4%
Capital and Coast	950	878	92.4%	4	0.4%	34	3.6%	38	4.0%	34	3.6%
Counties Manukau	2,152	1,952	90.7%	1	0.0%	49	2.3%	50	2.3%	150	7.0%
Hawkes Bay	589	551	93.5%	2	0.3%	28	4.8%	30	5.1%	8	1.4%
Hutt Valley	515	464	90.1%	0	0.0%	22	4.3%	22	4.3%	29	5.6%
Lakes	410	353	86.1%	3	0.7%	19	4.6%	22	5.4%	35	8.5%
MidCentral	564	517	91.7%	0	0.0%	35	6.2%	35	6.2%	12	2.1%
Nelson Marlborough	408	360	88.2%	2	0.5%	38	9.3%	40	9.8%	8	2.0%
Northland	651	520	79.9%	6	0.9%	64	9.8%	70	10.8%	61	9.4%
South Canterbury	169	156	92.3%	1	0.6%	10	5.9%	11	6.5%	2	1.2%
Southern	956	885	92.6%	6	0.6%	49	5.1%	55	5.8%	16	1.7%
Tairawhiti	180	151	83.9%	4	2.2%	10	5.6%	14	7.8%	15	8.3%
Taranaki	390	354	90.8%	2	0.5%	21	5.4%	23	5.9%	13	3.3%
Waikato	1,454	1,264	86.9%	6	0.4%	100	6.9%	106	7.3%	84	5.8%
Wairarapa	139	124	89.2%	0	0.0%	9	6.5%	9	6.5%	6	4.3%
Waitemata	2,110	1,809	85.7%	16	0.8%	85	4.0%	101	4.8%	200	9.5%
West Coast	85	69	81.2%	8	9.4%	5	5.9%	13	15.3%	3	3.5%
Whanganui	203	177	87.2%	0	0.0%	20	9.9%	20	9.9%	6	3.0%
National	**15,806**	**14,007**	**88.6%**	**84**	**0.5%**	**754**	**4.8%**	**838**	**5.3%**	**961**	**6.1%**

HPV Dose Three Data

DHB	Vaccination	Maori	Pacific	Asian	Other	All	Declin	Rank
Wairarapa	HPV-3 Quadrivalent	74%	70%	100%	85%	80%	58 (24.2%)	1
Auckland	HPV-3 Quadrivalent	79%	88%	71%	82%	80%	179 (8.0%)	2
Capital and Coast	HPV-3 Quadrivalent	67%	90%	86%	75%	76%	338 (20.2%)	3
Hutt Valley	HPV-3 Quadrivalent	83%	53%	71%	74%	73%	142 (16.5%)	4
Tairawhiti	HPV-3 Quadrivalent	90%	53%	140%	46%	73%	83 (24.4%)	5
Whanganui	HPV-3 Quadrivalent	86%	60%	47%	66%	73%	114 (30.0%)	6
MidCentral	HPV-3 Quadrivalent	88%	93%	104%	60%	71%	61 (6.0%)	7
Northland	HPV-3 Quadrivalent	84%	80%	110%	51%	68%	29 (2.8%)	8
Southerb	HPV-3 Quadrivalent	72%	62%	174%	62%	67%	42 (2.6%)	9
Waikato	HPV-3 Quadrivalent	73%	76%	94%	60%	66%	24 (1.0%)	10
Taranaki	HPV-3 Quadrivalent	49%	100%	45%	71%	65%	25 (3.9%)	11
Hawkes Bay	HPV-3 Quadrivalent	74%	68%	73%	55%	63%	375 (35.7%)	12
Bay of Plenty	HPV-3 Quadrivalent	68%	83%	125%	55%	63%	52 (3.9%)	13
Lakes	HPV-3 Quadrivalent	69%	75%	63%	53%	62%	1 (0.1%)	14
Counties Manukau	HPV-3 Quadrivalent	62%	71%	58%	50%	61%	30 (0.8%)	15
Waitemata	HPV-3 Quadrivalent	66%	71%	62%	53%	59%	347 (9.7%)	16
Canterbury	HPV-3 Quadrivalent	50%	51%	76%	59%	58%	120 (4.2%)	17
Nelson Marlborough	HPV-3 Quadrivalent	62%	40%	105%	51%	53%	40 (4.7%)	18
South Canterbury	HPV-3 Quadrivalent	67%	100%	200%	45%	49%	55 (16.7%)	19
West Coast	HPV-3 Quadrivalent	23%	-%	60%	42%	40%	1 (0.6%)	20

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 2 June 2017 3:45 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: ISLA agenda - Tuesday 6 June
Attachments: Draft agenda June 2017 meeting.docx

Hi all

Please find attached the paper for our meeting on Tuesday.

Please email or text me on 021 0259 3806 if you are unable to attend

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 5 June, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	LMC Position: Vacant
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens: Apology
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes 7 April ISLA.docx
4.	2.30pm	**Updates** **2015/16 IPG Work Plan, including** • **HPV update** • **Vaccinating Pregnant Women** • **Health Target progress – KPI** • **Influenza Programme 2017**	Bridget Lester	Workplan June 2017.docx Data report June data report.docx
5.	3.00pm	**Immunisation Coverage challenges**	Bridget Lester	
6.	3.20pm	**CCN Presentation - focus**	Bridget Lester	
7.	3.30pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report.docx
8.	3.40pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
U18 Flu – Hurunui Kaikoura – draft proposal to pharmac	Bridget and Ramon	asap
Tdap Paper to CCN – update and forward to CCN	Bridget	30 April
LMC Representative update	Bridget	30 April

Next meeting: 1 August 2017

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH Waitaha Room	
Date: 4 April 2017	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Sarah Marr, Bridget Lester, Anne Feld, Donna MacLean, Tony Walls, Anna Harwood, Geraldine Clemens and Alison Wooding.	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
	Confirmation of Minutes	• Minutes of the 7 March meeting where approved to be sent to the CCN office	Bridget	7 April
	Previous Actions & Matters Arising	• **Loading HPV 4** – this was sorted. HPV 4 is now all used up and general practice is using HPV9 • This was updated and shared with CCN • A blurb has been drafted, need to determine process. • 2017 Influenza – Alison shared this with her team. • **Action:** Ramon to check with C&PH around sharing the resources. • Discussion has occurred around vaccinating at Kaumatua Day – do not have the capacity to do this. • **Action:** Ramon to discuss with Ngaire, speaking at next Kaumatua Hui, and encouraging getting vaccine at GP	Ramon Ramon	
	ISLA Work plan	Q2 201617 – progress result • 8month olds – Q2 results – 95%, however very tight for Q3 2017. 2 year olds – Q2 result 95% and it appears we have already achieved this for Q3 • 5 year olds – Q2 result, 93%, this was due to a decreased in declines and opt-offs. However, we are sitting on 92% for Q3. NIR have completed the Decliner Project – a summary of this is attached. **New-born Enrolment** – No further update on this **HPV** – Discussed later in meeting		
	Tdap and HPV Change in 2018	A paper was presented to ISLA around the changes to the Tdap and HPV programme in 2017. ISLA supported the direction of this paper to go to ALT. This was • Continue to provide a general practice HPV and Tdap programme in 2018. • Continue to provide the HPV mop up programme in 2018, during the school programme – also introduce Tdap as a mop up. • Extend the current pilot of the Year 8 school programme for a further 2 years.	Bridget to update paper and share with CCN.	
	HPV School Programme update	A paper was presented regarding the current coverage of the HPV programme. ISLA wanted to thank the PHNs for this great work in the HPV programme this year	HPV Report for ISLA.docx	
	Influenza 2017	The vaccine is available and the programme has started. Uptake is looking at around 10% for over 65s. Internal approval has been given to provide free influenza for those under the age of 18, in the earthquake affected Hurunui		

	Item	Discussion/Action	Responsibility	Date due
		Kaikoura area. This has been made public, however – approval has not been sought from PHARMAC. **Action:** Ramon and Bridget to contact PHARMAC	Ramon and Bridget to work together regarding approval.	ASAP
	Operational	No changes		
	Next Meeting	**Meeting schedule for 2017** Agreed to change October meeting, as this was scheduled in the school holidays. Meeting request to be updated. • 6th June 2017 2-4pm at C&PH • 8th August 2-4pm at C&PH • 10th October 2-4pm at C&PH • 5th December 2-4pm at C&PH		

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - June 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women.	Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth.	Around 98% of babies are enrolled at birth.
	Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider.	Q1-Q4 Q1-Q4	• 98% of new-borns are enrolled with general practice by 2 weeks.	Data not yet available The LinKIDS service has gone live 1 May, this will improve data sharing and enrolments between these services. LMC toolkit is on hold – while work is being considered around a better way to engage with LMCs.
	Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.			
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q3 = 94% 8month olds, 95% 2year olds and 91% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	69% of Dose one of girls born in 2003.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Childhood Immunisation – MoH Health Targets up until 1 June 2017

Fully Immunised 8 month olds – DHB LEVEL

Q2 2015/16 Actual	Q3 2016/17 Actual	Q4 2016/17 Progress including pending	Q1 2017/18 Progress including pending
95% fully	94% fully	94.03%	86% fully
1% overdue	1% overdue	.87% could	10% could
		5.0% can't	4% can't reach

Fully Immunised Two year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2016/17 Actual	Q4 2016/17 Progress	Q1 2017/18 Progress
95% fully	95% fully	95.0%	92.9% fully
0% overdue	0.8% overdue	0.3% overdue	2.7% overdue

Fully Immunised Four year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2016/17 Actual	Q4 2016/17 Progress	Q1 2017/18 Progress
91% fully	93% fully	93% fully	91% fully
overdue	2.4% overdue	0.6% overdue	2.9% overdue
		6.2% off - dec	4.1% off- dec

our health system

Key Performance Indicators and Childhood Immunisation Reporting

June 2017

Immunisation Reporting Programme

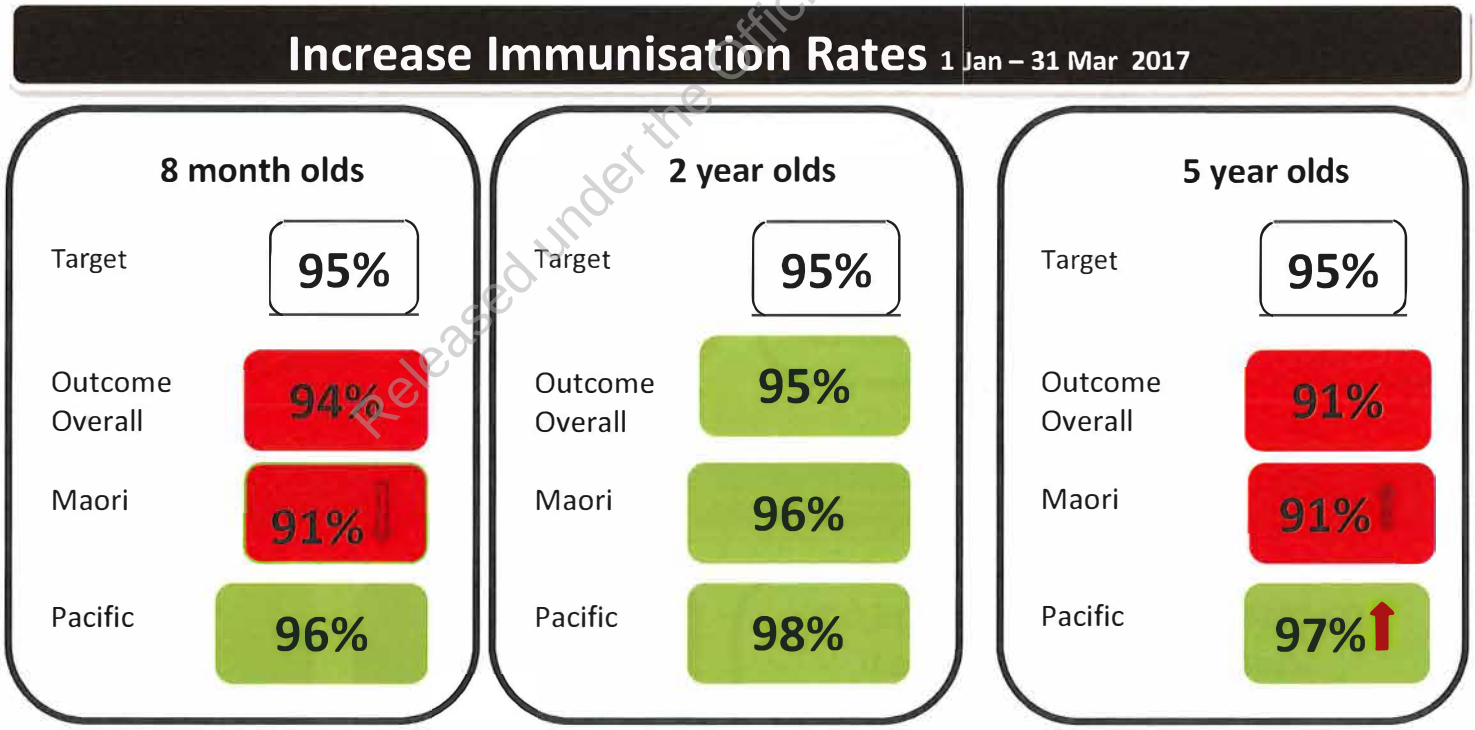
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Fully Immunised 8month, two and five year - PHO LEVEL 31 March 2017

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	97%	94%	98%	98%	88%	90%
Pegasus	96%	94%	96%	96%	93%	93%
Rural Canterbury	96%	93%	97%	93%	93%	96%

Pre teen Immunisations

HPV - 1 April 2017

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2003	HPV-1 Quadrivalent	260	72	164	1,415	1,911	390	110	180	2,150	2,830	67%	65%	91%	66%	68%	108 (3.8%)	1 (0.0%)
	HPV-2 Quadrivalent	222	68	154	1,362	1,806						57%	62%	86%	63%	64%	114 (4.0%)	
	HPV-3 Quadrivalent	199	58	141	1,265	1,663						51%	53%	78%	59%	59%	122 (4.3%)	
2004	HPV-1 Quadrivalent	270	87	193	1,420	1,970	430	130	210	2,210	2,980	63%	67%	92%	64%	66%	106 (3.6%)	0 (0.0%)
	HPV-2 Quadrivalent	183	49	132	1,076	1,440						43%	38%	63%	49%	48%	126 (4.2%)	
	HPV-3 Quadrivalent	145	35	108	951	1,239						34%	27%	51%	43%	42%	134 (4.5%)	
2005	HPV-1 Quadrivalent	162	44	149	938	1,293	440	120	230	2,040	2,830	37%	37%	65%	46%	46%	72 (2.5%)	1 (0.0%)
	HPV-2 Quadrivalent	78	29	71	502	680						18%	24%	31%	25%	24%	62 (2.2%)	
	HPV-3 Quadrivalent	45	15	54	335	449						10%	13%	23%	16%	16%	59 (2.1%)	
Total	HPV-1 Quadrivalent	692	203	506	3,773	5,174	1,260	360	620	6,400	8,640	55%	56%	248%	59%	60%	286 (3.3%)	2 (0.0%)
	HPV-2 Quadrivalent	483	146	357	2,940	3,926						38%	41%	179%	46%	45%	302 (3.5%)	
	HPV-3 Quadrivalent	389	108	303	2,551	3,351						31%	30%	153%	40%	39%	315 (3.6%)	

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,671	1,453	87. %	746	672	90. %	274	219	80. %	80	57	71. %	296	273	92. %	275	232	84. %	13 ()	0.8 (0.0) %	48	2.9 %
8 Month	1,602	1,513	94. %	766	737	96. %	242	221	91. %	68	65	96. %	279	273	98. %	247	217	88. %	20 (2)	1.2 (0.1) %	47	2.9 %
12 Month	1,605	1,516	94. %	742	712	96. %	270	255	94. %	70	65	93. %	250	241	96. %	273	243	89. %	16 ()	1.0 (0.0) %	54	3.4 %
18 Month	1,651	1,466	89. %	762	697	91. %	314	255	81. %	96	86	90. %	236	223	94. %	243	205	84. %	11 ()	0.7 (0.0) %	49	3.0 %
24 Month	1,568	1,496	95. %	770	744	97. %	239	229	96. %	95	93	98. %	221	212	96. %	243	218	90. %	8 (0)	0.5 (0.0) %	47	3.0 %
5 Year	1,634	1,495	91. %	799	751	94. %	254	232	91. %	88	85	97. %	193	172	89. %	300	255	85. %	19 ()	1.2 (0.0) %	80	4.9 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,671	1,453	87. %	344	299	87. %	370	333	90. %	310	265	85. %	254	225	89. %	198	159	80. %	195	172	88. %
8 Month	1,602	1,513	94. %	356	327	92. %	315	302	96. %	303	288	95. %	271	260	96. %	173	159	92. %	184	177	96. %
12 Month	1,605	1,516	94. %	358	326	91. %	325	311	96. %	312	296	95. %	229	213	93. %	201	194	97. %	180	176	98. %
18 Month	1,651	1,466	89. %	365	325	89. %	340	307	90. %	309	280	91. %	245	212	87. %	223	192	86. %	169	150	89. %
24 Month	1,568	1,496	95. %	334	317	95. %	319	310	97. %	281	269	96. %	242	222	92. %	194	188	97. %	198	190	96. %
5 Year	1,634	1,495	91. %	396	351	89. %	339	315	93. %	304	270	89. %	221	205	93. %	175	165	94. %	199	189	95. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

Impact rating	❶ Risk ID	Probability rating: High	Probability rating: Medium	Probability rating: Low
	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, June 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Medium		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	low		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 28 July 2017 3:09 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers for Tuesday ISLA meeting
Attachments: Missed Events Summary report 2016.docx; Draft agenda August 2017 meeting.docx; Draft minutes June 2017 meeting.docx; Risk Report.docx; Workplan June 2017.docx

Hi all

Please find attached the papers and agenda for our meeting on Tuesday.

As normal, please let me know if you can't make it.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
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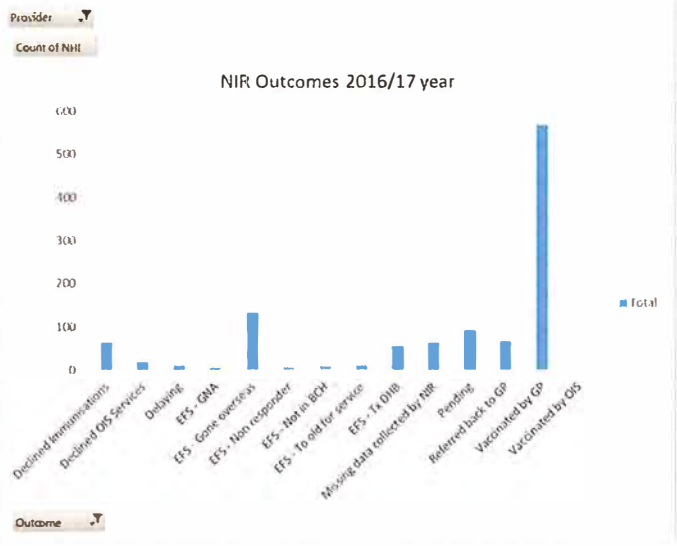
Missed Events Summary report 2016/17 year

2016/17 year by month	NIR	PTC	TPKOT	CI	WC	Grand Total
Jul	59	34	29	22		144
Aug	92	25		39	2	158
Sep	101			151		252
Oct	80			96		176
Nov	110			115		225
Dec	54			81		135
Jan	102			102		204
Feb	89			78		167
Mar	115			140		255
Apr	59			109		168
May	153			148		301
Jun	94			106		200
Grand Total	**1108**	**59**	**29**	**1187**	**2**	**2385**

In the 2016/17 year 2385 were referrals were received through the Missed Events Service. Of these 1108 (46%) were managed by the MEC, while 1275 (54%) were referred to Outreach Immunisation Services.

Table Two NIR Outcomes

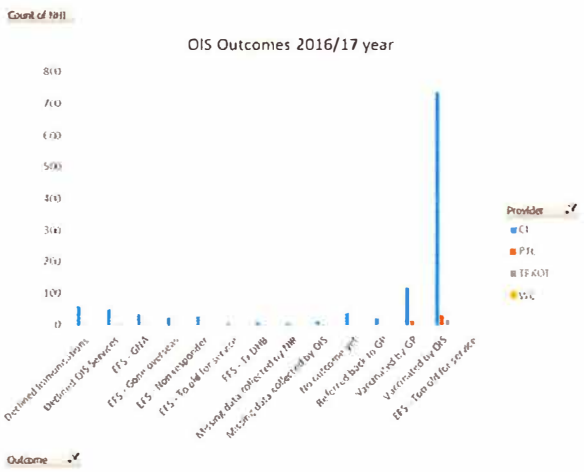
Outcomes	Grand Total
Declined Immunisations	63
Declined OIS Services	20
Delaying	12
EFS - GNA	6
EFS - Gone overseas	133
EFS - Non responder	7
EFS - Not in BCH	8
EFS - To old for service	11
EFS - Tx DHB	55
Missing data collected by NIR	65
Pending	91
Referred back to GP	67
Vaccinated by GP	567
Vaccinated by OIS	1
Grand Total	**1106**



Of the children managed by NIR 51% were vaccinated by general practice, while 17% had left the DHB. 7% of families declined OIS or Immunisation. For 6% of children missing data (normally overseas history was collected. Currently there are 91 children with a status of Pending, which means they are still being worked on by MEC, while 67 children have been referred by to GP but not yet vaccinated.

Outreach Immunisation Service Outcomes

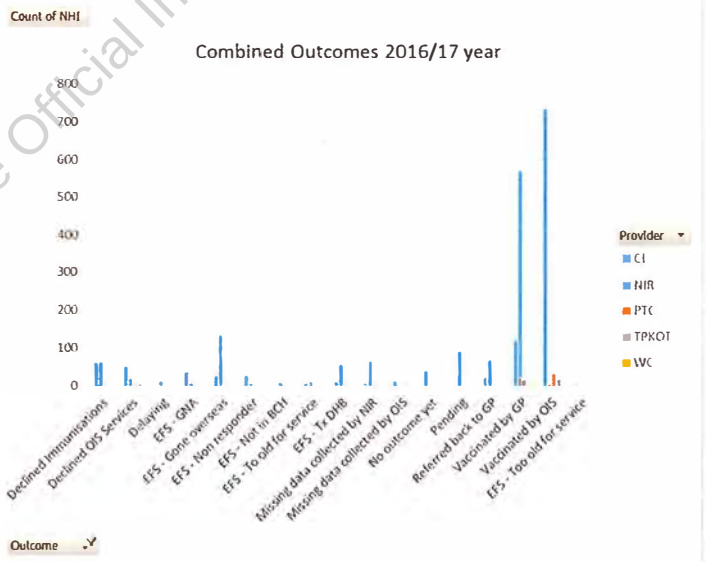
Outcomes	CI	PTC	TPKOT	WC	Grand Total
Declined Immunisations	61	2	1		64
Declined OIS Services	51	3	5		59
EFS - GNA	36	3	2		41
EFS - Gone overseas	26	2			28
EFS - Non responder	28				28
EFS - To old for service	6				6
EFS - Tx DHB	10	2			12
Missing data collected by NIR	6	1			7
Missing data collected by OIS	12	1			13
No outcome yet	40				40
Referred back to GP	23		3		26
Vaccinated by GP	121	14	2	2	139
Vaccinated by OIS	733	31	16		780
EFS - Too old for service	1				1
Grand Total	**1154**	**59**	**29**	**2**	**1244**



Of the 1244 referred sent to OIS service in 2016/17, 780 of them or 63% of them were vaccinated by OIS, 11% were vaccinated by general practice. Therefore 74% of children were vaccinated following an OIS referral. Of the 25% not vaccinated, 10% declined OIS or Immunisation, and 8% were not contactable.

Combined Outcomes

An analyst has occurred of the combined outcomes, which shows the following



- 63% of all referrals have been vaccinated, with by OIS or at general practice
  - 30% general practice
  - 33% OIS
- 9% of families declined OIS or to be vaccinated, while a further 0.5% are delaying immunisation
- 10% of children had either left the DHB or moved overseas.
- 10% of all referrals haven't had an outcome, as there they have been referred back to GP and not vaccinated, gone no address, to old of OIS services or with a no outcome/pending status

General Practice Referrals

The following providers make up the majority of referrals to MEC.

New Brighton Health Care	4.46%
Linwood Avenue Medical Cei	3.65%
Piki Te Ora	2.78%
Shirley Medical Centre	2.64%
Moorhouse Medical Centre	2.54%
Doctors On Riccarton	2.45%
Darfield Medical Centre	2.30%
Durham Health	2.16%
Eastcare Health	1.87%
ProMed Edgeware Doctors	1.78%
Helios Health Ltd	1.78%
Hei Hei Health Centre	1.44%
Allenton Medical Centre	1.34%
Village Health Lincoln Road	1.20%

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 1 August, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	LMC Position: Vacant
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens: Apology
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	Draft minutes June 2017 meeting.docx
4.	2.30pm	**Updates** **2015/16 IPG Work Plan, including** • **HPV update** • **Vaccinating Pregnant Women** • **Health Target progress – KPI** • **Influenza Programme 2017**	Bridget Lester	Workplan.docx To be shared at meeting with most recent data
	3.00pm	**Missed Events and OIS update 2016/17**	Sally Wright	Missed Events Summary report 201
7.	3.30pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	RISK REGISTER 2016 update August.docx
8.	3.40pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
U18 Kaikoura – paper for October meeting	Bridget	October
LMC Representative – contact College and seek membership	Bridget	Asap
Tdap Paper update and circulate to ALT	Bridget and Ramon	10 June 2017
ALT Presentation	Bridget and Ramon	15 June 2017
Imms conference abstracts	Bridget	15 June 2017

Next meeting: 10 October 217

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH T Room	
Date: 1 July 2017	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Sarah Marr, Bridget Lester, Anne Feld, Donna MacLean, Tony Walls, Geraldine Clemens and Alison Wooding.	
Apology: Anna Harwood	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
	Confirmation of Minutes	• Minutes of the 4 May meeting where approved to be sent to the CCN office	Bridget	9 June 2017l
	Previous Actions & Matters Arising	• **U18 Flu Hurunui Kaikoura (HK) areas –** Ramon and Bridget developed a proposal for Pharmac, which was submitted and approved. This meant that from 1 May 2017, those aged 17 and under would receive subsidised influenza vaccine, if they live in the HK area and vaccinated by an HK practice. Some non-HK practices challenged this, but the CDHB has decided to continue with its original decision. A discussion regarding offering this subsidised vaccine in 2018 and longer. It was agreed that we need to apply the same principles as the Christchurch Earthquake of which the Free U18 programme was offered for 3 years. A proposal will be prepared for PHARMAC in October. In Sept we will ask the PHOs to pull the data for the HK practices to get an understanding of the utilisation of the programme. • **LMC Member –** Bridget was approached by the Canterbury branch of the College of Midwives regarding a replacement for Margo on ISLA. A brief description of what ISLA require was sent, and this needs to be followed up. An individual was considered by ISLA; Bridget will approach to see if she is would consider the vacant position on ISLA. • **Tdap and HPV paper to CCN ALT –** this has not progressed due to the MoH releasing their consultation document. The paper will be used to reflect the CDHB submission to the MoH	Bridget to draft proposal for the Oct ISLA meeting Bridget to follow up with Collage and contact suggested member Bridget to update.	10 October 2017 16 June 2017 10 June 2017
	ISLA Work plan	Q2 201617 – progress result • 8month olds – Q3 result – 94.4% this indicates that the Health Target not met. We are also 'very tight' for the Q4 2017. 2 year olds – Q3 result 95% and on track to reach this again in Q4 • 5 year olds – Q2 result, 91%, currently on track to reach 93% in Q4. **New-born Enrolment** – No further update. **HPV** – Coverage continues to increase. For the current performance period which ends 30 June 2017 (girls born in 2003), will achieve 59% of girls. This group of girls were offered the Year8 programme in 2016. For the next performance period, girls born in 2004 we have already reached 42% for dose three. However we are unsure if the MoH will monitor dose 2 or 3. Dose 1 is currently on 66%;		

	Item	Discussion/Action	Responsibility	Date due
		this is the group being vaccinated this year in the school programme. Our group of children being vaccinated at 11 years of age, as part of the general practice programme is already at 46% having received dose 1. **Influenza coverage:** DHB coverage is around 57% which is low for this time of the year. It is not clear why this is, although some anecdotal reasons were discussed. **Pregnancy vaccinations –** Planning continues for the outpatients programme, however there is an issue around the need for a vaccine fridge. There was also a discussion around Tdap coverage in pregnant women and the need to have some data to determine what is actually happening in Canterbury. **Action**: *Donna and Geraldine are going to talk to their practices to see what data can be pulled. Bridget is going to approach the MoH again for this data.*		
	Tdap and HPV Change in 2018	As indicated above the MoH has received a consultation paper around the co-delivery of the Tdap and HPV programme in Year 7 at school. A submission was drafted which was circulated to ISLA for feedback. This was then submitted to the MoH on the 2 June 2017. A copy of this is attached.	Attached paper	
	Immunisation Challenges	There is a concern around the reaching of health targets: • Increase in referrals to OIS and MES • General Practice Teams tending to refer children to OIS/MES, as they are too busy to chase this cohort • Also a concern that some practices are not referring children, when they are more than 6months overdue. Analysis of OIS coverage since the change in contract shows vaccination numbers by OIS continue to be high. Significant increase in referrals to MES, from 200 in January to 350 for May. Challenging the service in prioritisation. Discussion around the 'stretched' capacity of general practice compounded by the Influenza seasons. Work is underway to try and reduce the workload of NIR and Immunisation Coordination to ensure they have the capacity to prioritise timeliness and support to general practice. Part of this includes the changing of the overseas event processing. There as a concern that due to capacity issues at Pegasus general practice teams are not feeling as supported. Bridget to follow up with Pegasus.		
	CCN ALT Presentation	ISLA are due to do a presentation to ALT on the 19th June 2017. The following will be covered in this presentation • Pregnancy vaccinations, why this is important and our challenges • Health Target, processes of the quarters, and current challenges (more targets, work pressures, communication) • HPV – 11year old and school programme update – the success of this mixed model of service delivery (need to change language from mop up to co-delivery).	Bridget and Ramon	15 June 2017
	IMAC Conference 2017	Two abstracts have been drafted **LinKIDS services** – how the learning for the NIR have been developed to support wider Child Health Coordination	Bridget	15 June 2017

	Item	Discussion/Action	Responsibility	Date due
		HPV Programme development – the enrolment of the CDHB programme over the years. Bridget to share these both with Ramon and Anne Feld before submitting them.		
	Operational	Risk report has been updated to reflect current issues.		
	Next Meeting	**Meeting schedule for 2017** Agreed to change October meeting, as this was scheduled in the school holidays. Meeting request to be updated. • 8th August 2-4pm at C&PH • 10th October 2-4pm at C&PH • 5th December 2-4pm at C&PH		

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, June 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Medium		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	low		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - June 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. Data not yet available The LinKIDS service has gone live 1 May, this will improve data sharing and enrolments between these services. LMC toolkit is on hold – while work is being considered around a better way to engage with LMCs.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q3 = 94% 8month olds, 95% 2year olds and 91% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	• 70% of Girls have received dose 3	69% of Dose one of girls born in 2003.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. • Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 1 August 2017 11:58 a.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Data report August data report
Attachments: Data report August data report.docx

HI all

Please find attached the data report for today's meeting – sorry it took me a bit longer to run this month!

Regards Bridget

our health system

Key Performance Indicators and Childhood Immunisation Reporting

August 2017

Immunisation Reporting Programme

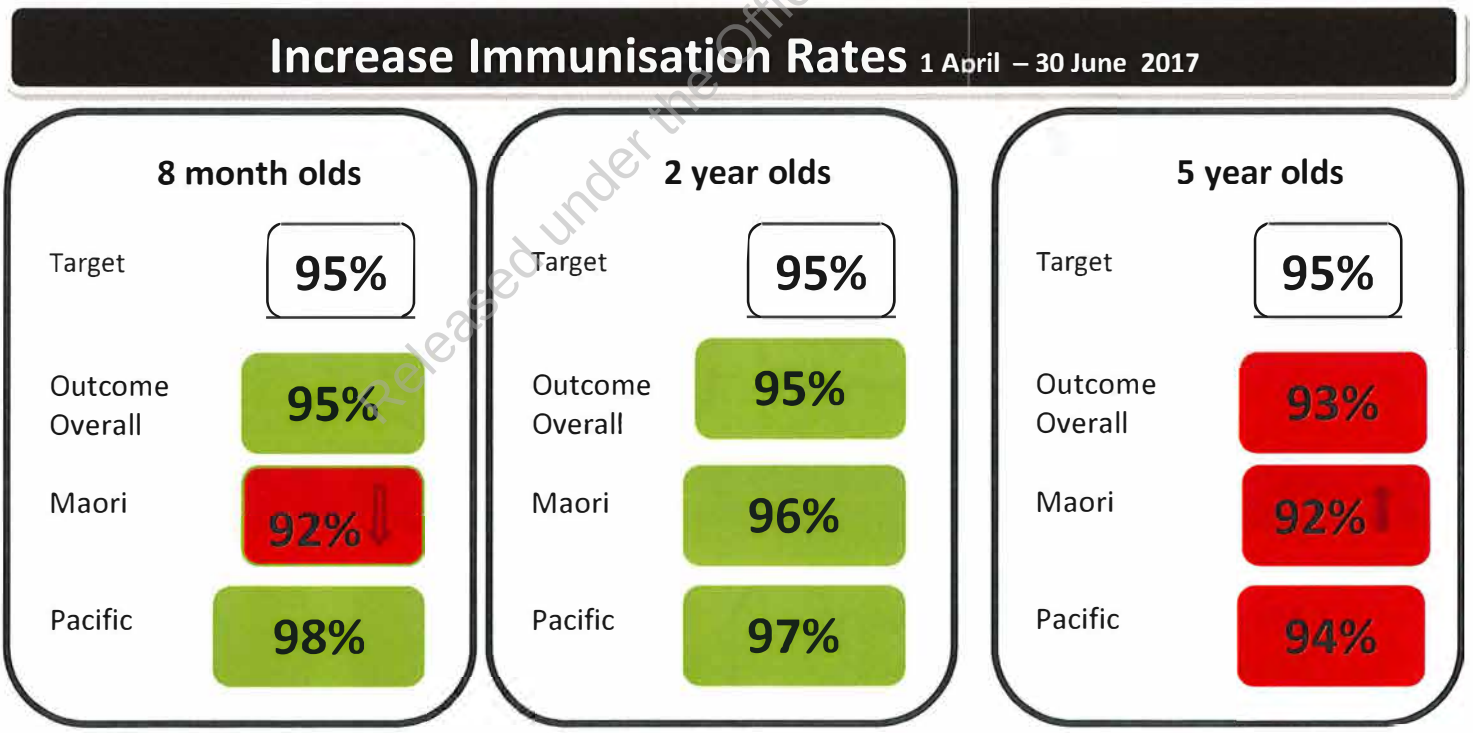
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 August 2017

Fully Immunised 8 month olds – DHB LEVEL

Q3 2015/16
Actual
- 94% fully
- 1% overdue

Q4 2016/17
Actual
- 95% fully
- 1% overdue

Q1 2016/17
Progress
including pending
- 92.63%
- 2.6% could
- 4.0% can't

Q2 2017/18
Progress
including pending
- 82% fully
- 14% could
- 3.8% can't

Fully Immunised Two year olds - DHB LEVEL

Q3 2016/17
Actual
- 95% fully
- 0.8% overdue

Q3 2016/17
Actual
- 95% fully
- 1% overdue

Q1 2016/17
Progress
- 94.46%
- 0.5%verdue
- 4.6% can't

Q2 2017/18
Progress
- 93.5% fully
- 3.2% overdue
- 3.3% can't

Fully Immunised Four year olds - DHB LEVEL

Q2 2016/17
Actual
- 93% fully
- 2.4%

Q3 2016/17
Actual
- 93% fully
- 1% overdue

Q1 2016/17
Progress
- 94.7% fully
- 1.6% overdue
- 3.5% off - dec

Q2 2017/18
Progress
- 89% fully
- 5.7% overdue
- 4.1% off- dec

Fully Immunised 8month, two and five year - PHO LEVEL 30 June 2017

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	99%	94%	98%	98%	81%	90%
Pegasus	95%	94%	96%	96%	94%	93%
Rural Canterbury	95%	93%	93%	93%	93%	96%

Pre teen Immunisations

HPV - 30 June 2017

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2003	HPV-1 Quadrivalent	267	72	170	1,444	1,953	390	110	180	2,150	2,830	68%	65%	94%	67%	69%	111 (3.9%)	1 (0.0%)
	HPV-2 Quadrivalent	226	68	156	1,366	1,816						58%	62%	87%	64%	64%	118 (4.2%)	
	HPV-3 Quadrivalent	199	59	143	1,277	1,678						51%	54%	79%	59%	59%	126 (4.5%)	
Total	HPV-1 Quadrivalent	267	72	170	1,444	1,953	390	110	180	2,150	2,830	68%	65%	94%	67%	69%	111 (3.9%)	1 (0.0%)
	HPV-2 Quadrivalent	226	68	156	1,366	1,816						58%	62%	87%	64%	64%	118 (4.2%)	
	HPV-3 Quadrivalent	199	59	143	1,277	1,678						51%	54%	79%	59%	59%	126 (4.5%)	

HPV 1 August 2017

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	276	90	200	1,454	2,020	430	130	210	2,210	2,980	64%	69%	95%	66%	68%	111 (3.7%)	0 (0.0%)
	HPV-2 Quadrivalent	183	51	133	1,087	1,454						43%	39%	63%	49%	49%	132 (4.4%)	
	HPV-3 Quadrivalent	148	36	114	974	1,272						34%	28%	54%	44%	43%	138 (4.6%)	
Total	HPV-1 Quadrivalent	276	90	200	1,454	2,020	430	130	210	2,210	2,980	64%	69%	95%	66%	68%	111 (3.7%)	0 (0.0%)
	HPV-2 Quadrivalent	183	51	133	1,087	1,454						43%	39%	63%	49%	49%	132 (4.4%)	
	HPV-3 Quadrivalent	148	36	114	974	1,272						34%	28%	54%	44%	43%	138 (4.6%)	

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,576	1,354	86. %	757	674	89. %	255	186	73. %	84	73	87. %	260	242	93. %	220	179	81. %	16 (3)	1.0 (0.2) %	51	3.2 %
8 Month	1,646	1,354	95. %	736	705	96. %	268	247	92. %	81	79	98. %	303	295	97. %	258	233	90. %	13 (0)	0.8 (0.0) %	53	3.2 %
12 Month	1,556	1,485	95. %	740	711	96. %	235	221	94. %	84	83	99. %	257	251	98. %	240	219	91. %	15 (0)	1.0 (0.0) %	45	2.9 %
18 Month	1,552	1,399	90. %	731	682	93. %	245	205	84. %	96	85	89. %	227	217	96. %	253	210	83. %	11 ()	0.7 (0.0) %	41	2.6 %
24 Month	1,625	1,549	95. %	785	754	96. %	275	265	96. %	79	77	97. %	234	231	99. %	252	222	88. %	14 (1)	0.9 (0.1) %	45	2.8 %
5 Year	1,612	1,503	93. %	766	731	95. %	264	242	92. %	88	83	94. %	207	192	93. %	287	255	89. %	17 ()	1.1 (0.0) %	63	3.9 %
12 Year	4	0	-	1	0	-	2	0	-	1	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,576	1,354	86. %	337	281	83. %	308	272	88. %	268	231	86. %	264	231	88. %	212	172	81. %	187	167	89. %
8 Month	1,646	1,559	95. %	354	321	91. %	343	334	97. %	296	278	94. %	239	228	95. %	220	213	97. %	194	185	95. %
12 Month	1,556	1,485	95. %	341	316	93. %	281	272	97. %	305	296	97. %	257	244	95. %	177	169	95. %	195	188	96. %
18 Month	1,552	1,399	90. %	344	309	90. %	281	255	91. %	314	278	89. %	226	205	91. %	212	185	87. %	175	167	95. %
24 Month	1,625	1,549	95. %	351	321	91. %	312	299	96. %	304	293	96. %	251	240	96. %	200	194	97. %	207	202	98. %
5 Year	1,612	1,503	93. %	414	379	92. %	319	306	96. %	293	268	91. %	227	215	95. %	171	157	92. %	188	178	95. %
12 Year	4	0	-	0	0	-	0	0	-	0	0	-	1	0	-	2	0	-	1	0	-

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 25 October 2017 11:02 a.m.
To: bridgetandclayton@xtra.co.nz
Subject: FW: Tuesdays Immunisation Service Level Alliance Meeting
Attachments: Draft agenda October 2017 meeting 24 October meeting.docx

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From: Bridget Lester
Sent: Friday, 20 October 2017 2:51 p.m.
To: 'Helen Fraser'; Matthew Reid; Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; Geraldine Clemens; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; Tony Walls
Cc: 'Marie Mitchell'
Subject: Tuesdays Immunisation Service Level Alliance Meeting

Hi all

Please find attached the updated agenda for our ISLA meeting on Tuesday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 24 October, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair): Apology	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Anne Feld : Apology	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean
In attendance: Dr Matt Reid	

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	3.10pm	**2018 Work plan Discussion**		
2.	2.40pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 1 August 2017 meetin
3.	2.50pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	3.00pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2017** • **Immunisations Conference**	Bridget Lester	Workplan Oct 2017.docx To be shared at meeting with most recent data
5.	3.20pm	**2018 Influenza Programme Discussion**		Diana Murfitt MOH 170815.pdf
7.	3.30pm	**Terms of Reference Review**		ISLA Updated ToR v3 draft 171213.doc
7.	3.40pm	**Operational** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
U18 Kaikoura – paper for October meeting	Bridget	October

Next meeting: 5 December 2017

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Venue: C&PH T Room	
Date: 1 August 2017	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Sarah Marr, Bridget Lester, Anne Feld, Anna Harwood and Tony Walls	
Apology: Donna MacLean, Geraldine Clemens and Alison Wooding. Guest: Sally Wright, CDHB Missed Events Coordinator	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
	Confirmation of Minutes	• Minutes of the 6 June 2017 meeting where approved to be sent to the CCN office	Bridget	9 August 2017
	Previous Actions & Matters Arising	• **U18 Flu Hurunui Kaikoura (HK) areas –** it was agreed at our last meeting a paper would be developed for the October meeting around the continuation of the U18 programme for 2018 and 2019 year. Discussion around the need for a universal influenza programme for children as a number of DHBs are applying to PHARMAC for **season by season programme due to emergency needs.** • **LMC Member –** This has not been progressed. . • **Tdap and HPV paper to CCN ALT –** this was approved by ALT for implementation in 2018. A paper seeking funding and contracting support is now being developed for the CDHB P&F Team Leaders. The same model has also been approved by the WC Immunisation Advisory Group. • **Presentation to CCN ALT –** Bridget and Ramon gave this presentation in June with positive feedback on the outcomes and stability of the Immunisation SLA. • **IMAC Conference** – abstracts were submitted but no feedback has been received yet. Both Ramon and Tony will be attending the conference. Bridget will only attend if the abstracts are accepted.	Bridget to draft proposal for the Oct ISLA meeting Bridget to follow up with Collage and contact suggested member	10 October 2017 16 August 2017
	ISLA Work plan	Q4 201617 – progress result • 8month olds – Q4 result – 95% fully vaccinated so the Health Target was achieved however only 92% of Māori children were reached. Again this quarter looks tight. 2 year olds – Q4 result 95%, with 96% of Māori children being reached. On track for 95% in Q1 • 5 year olds – Q4 93% with 93% of Māori children. Currently on track to reach 95% in Q1 201718. **New-born Enrolment** – An update has been received, but was not included in this report. (see attached tables below • Canterbury coverage at 81% with the following breakdown by PHO o CHCH PHO – 98% o Pegasus – 85% o RCPHO – 74% **HPV** – The end of the HPV reporting period for girls born in 2003 has finished with 59% of girls receiving dose 3 Positive coverage is also being seen for girls born in 2004, with 49% of them receiving dose2.		

	Item	Discussion/Action	Responsibility	Date due
		Influenza coverage: An updated Flu report has not been run – a final report for the 31 July 2017 report will be run at the start of next week. **Pregnancy vaccinations –** Geraldine sent some utilisation data from one of her general practice (44%) however the general practice has identified ways to target more women. Significant issue is that LMC systems don't talk to General Practice systems, and it appears some LMCs are not talking to women about pregnancy immunisations. As the LMC agreement is a national agreement, we need support nationally to drive this change. A discussion around how can we reach more women, and what the role of the LMC is. • *Look at current CDHB resources and communication and update and recirculate to LMCs* • *Develop a detailed plan for practices with around recalling and vaccinating pregnant women.*		
	Missed Events Service	Sally Wright from the CDHB Missed Events Service attended the meeting to provide an update on the service and the 2016/17 year outcomes. In general positive outcomes have been received, including 60% of all referrals being vaccinated; 19% have left CDHB. A further 10% have declined to be vaccinated. General Discussion around increasing referrals, and practices who refer outside the timeframes. There was a concern that the increased referrals need to be managed and a plan needs to be developed e.g. do we start declining, send children back, invest less time in them or look at increasing staff. We need look at what support can be given to high referring practices, for some of these they are also the high declining – is it a population or a system issue at the practice. **Action: Agreed very helpful to have Sally attend, and agreed to add her to the ISLA schedule for the Feb meeting.**		
	Immunisation Providers Group	The Immunisation Providers Group has been the 'operational group' for ISLA. However due to changes in ISLA membership and Immunisation staff, the last two IPG meetings have been cancelled due to not having a quorum. This may reflect that IPG structure is no longer required. While there it is important for key immunisation groups to meet regularly (NIR, IC and IMAC), another less formal forum could suffice, reducing administration etc. incurred by IPG. **Agreed that IPG members will be approached around the purpose and future of IPG. A proposal will be presented at the next ISLA meeting; we will also review the ISLA terms of reference at that meeting.**		
	Operational	Risk report has been updated to reflect current issues. Need to add the MES and OIS demand to the Risk Report		
	Next Meeting	**Meeting schedule for 2017** • 10th October 2-4pm at C&PH • 5th December 2-4pm at C&PH		

	Item	Discussion/Action	Responsibility	Date due

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter Three 2016/17
Newborns Born in the Following Period: 20 November 2016 to 19 February 2017

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	144	1,398	90%	15
Bay of Plenty	50	682	93%	8
Canterbury	68	1,510	95%	4
Capital and Coast	76	799	90%	14
Counties Manukau	143	1,896	92%	9
Hawkes Bay	53	442	88%	18
Hutt	46	433	89%	17
Lakes	15	324	95%	5
MidCentral	29	494	94%	6
Nelson Marlborough	30	332	91%	11
Northland	30	442	93%	7
South Canterbury	2	166	99%	2
Southern	21	789	97%	3
Tairawhiti	17	118	86%	19
Taranaki	32	310	90%	16
Waikato	108	1,345	92%	10
Wairarapa	1	123	99%	1
Waitemata	164	1,814	91%	12
West Coast	11	71	85%	20
Whanganui	18	190	91%	13
Unknown	0	7	100%	
Total	**1,058**	**13,685**	**92%**	

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter Three 2016/17
Newborns Born in the Following Period: 20 November 2016 to 19 February 2017
As at Quarter Two 2017 (April 2017)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	230	1,016	1,398	73%	18
Bay of Plenty	122	497	682	73%	17
Canterbury	386	1,218	1,510	81%	9
Capital and Coast	166	647	799	81%	8
Counties Manukau	279	1,415	1,896	75%	16
Hawkes Bay	164	428	442	97%	3
Hutt	124	409	433	94%	4
Lakes	13	271	324	84%	7
MidCentral	110	341	494	69%	20
Nelson Marlborough	62	292	332	88%	6
Northland	146	453	442	102%	2
South Canterbury	45	128	166	77%	13
Southern	163	591	789	75%	15
Tairawhiti	48	139	118	118%	1
Taranaki	92	282	310	91%	5
Waikato	297	1,017	1,345	76%	14
Wairarapa	29	96	123	78%	12
Waitemata	268	1,310	1,814	72%	19
West Coast	26	57	71	80%	10
Whanganui	54	151	190	79%	11
Overseas or Unknown	0	0	7	0%	
Total	**2,824**	**10,758**	**13,685**	**79%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter Three 2016/17
Newborns Born in the Following Period: 20 November 2016 to 19 February 2017
As at Quarter Two 2017 (April 2017)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	260	371		
Auckland PHO Limited	141	188		
Central Primary Health Organisation	331	458		
Christchurch PHO Limited	96	98	98%	11
Compass Health - Capital and Coast	544	639	85%	19
Compass Health - Wairarapa	100	129	78%	29
Cosine Primary Care Network Trust	79	79	100%	9
East Health Trust	233	284	82%	23
Eastern Bay Primary Health Alliance	116	154	75%	31
Hauraki PHO	370	452	82%	24
Health Hawke's Bay Limited	426	387	110%	5
Kimi Hauora Wairau (Marlborough PHO Trust)	85	93	91%	15
Manaia Health PHO Limited	270	246	110%	6
Midlands Health Network - Lakes	71	83	86%	18
Midlands Health Network - Tairawhiti	100	69	145%	
Midlands Health Network - Taranaki	276	274	101%	8
Midlands Health Network - Waikato	612	761	80%	27
National Hauora Coalition	268	322	83%	22
Nelson Bays Primary Health	207	209	99%	10
Nga Mataapuna Oranga Limited	25	35	71%	
Ngati Porou Hauora Charitable Trust	30	21	143%	
Ora Toa PHO Limited	47	39	121%	
Pegasus Health (Charitable) Limited	975	1,151	85%	20
Procare Networks Limited	1,968	2,446	80%	26
Rotorua Area Primary Health Services Limited	217	248	88%	16
Rural Canterbury PHO	147	198	74%	33
South Canterbury Primary and Community	129	163	79%	28
Te Awakairangi Health Network	339	306	111%	4
Te Tai Tokerau PHO Ltd	165	155	106%	7
Total Healthcare Charitable Trust	379	434	87%	17
Waitemata PHO Limited	569	678	84%	21
Well Health Trust	47	49	96%	12
WellSouth Primary Health Network	590	769	77%	30
West Coast PHO	57	60	95%	13
Western Bay of Plenty PHO Limited	343	425	81%	25
Whanganui Regional PHO	146	154	95%	14
Unknown or Blank	0	1,058	0%	
Total	**10,758**	**13,685**	**79%**	

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - October 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q1 = 95% 8month olds, 95% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	59% of Dose three of girls born in 2003.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	64% vaccinated
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

15 August 2017

Dr Philip Schroeder
Chairperson Canterbury Primary Response Group and CIG
C/- Pegasus Health
PO Box 741
CHRISTCHURCH

Dear Dr Schroeder

National influenza vaccination programme and the elderly

Thank you for your letter dated 3 May 2017 regarding influenza vaccine effectiveness in the elderly and your suggested vaccination strategy options and references to reduce morbidity and mortality in this age group. Please accept my apologies for the delay in responding to you.

The Ministry and PHARMAC regularly review the influenza vaccine strategy. Just recently, as you will be aware, the Influenza Immunisation Programme (the Programme) was adjusted to enable pharmacist vaccinators to provide influenza vaccine to those aged 65 years and over and pregnant women. The refreshed Better Public Services 3 also has a focus on respiratory conditions. We are currently reviewing the Programme's policy effective from 2018 onwards and your recommendations will be considered as part of this review.

PHARMAC are responsible for the procurement of funded vaccines (including influenza) and for setting the criteria for access to these vaccines by listing them on the New Zealand Pharmaceutical Schedule. I have discussed your letter with PHARMAC, who have advised that applications are considered by the Pharmaceutical Therapeutics Advisory Committee (PTAC) and the Immunisation PTAC subcommittee. If you are interested in placing a submission PHARMAC have asked if you could please complete the application form for pharmaceutical funding and either email the form to applications@pharmac.govt.nz or post it to PO Box 10254, The Terrace, Wellington 6143. The application form can be found on the PHARMAC website at https://www.pharmac.govt.nz/medicines/how-medicines-are-funded/new-funding-applications/

Healthcare workers, by virtue of their occupation, are at increased risk of contracting influenza and may transmit the infection to susceptible individuals with the potential for serious outcomes. All district health boards (DHBs) offer free influenza immunisation to their employed staff and since 2010 the Ministry of Health has been reporting on DHB healthcare worker influenza immunisation coverage. Coverage for DHB healthcare workers nationwide has increased from 45 percent in 2010 to 65 percent in 2016. The annual influenza promotional campaign includes promotion of influenza vaccination to healthcare workers and this continues to be a focus. There is wide variation between DHB healthcare workers' vaccination rates, and while Canterbury's is above average at 68 percent, it appears to have fallen since 2014. You may wish to canvas your colleagues around the country who are achieving high coverage to investigate other options for your area. More information about DHB healthcare worker influenza immunisation is published on the Ministry website at http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/influenza .

I would like to thank you for your ongoing support of the Influenza Immunisation Programme and for considering options to improve health outcomes for our older population.

Yours sincerely

Diana Murfitt
Senior Advisor
Service Commissioning

cc Lindsay Ancelet, Therapeutic Group Manager, PHARMAC

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

TERMS OF REFERENCE
Immunisation Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

The Immunisation SLA will acknowledge and support the principles of the Treaty of Waitangi.

IMMUNISATION SERVICE LEVEL ALLAINCE

1. BACKGROUND

1.1. The Immunisation Service Level Alliance (ISLA) was established in 2010 with its initial role to develop an Immunisation Service Model (see appendix one) with a focus on fully immunised 2year olds (the health target at the time). Following the development of Service Model the ISLA moved into the implementation stage, focusing on the implementation of the service model. This included the development of an Immunisation Outcomes Framework (see appendix two).

1.2. The ISLA has moved into a monitoring phase of the outcomes framework, which focused on normalising immunisation over a lifetime and reaching specific health and performance targets. The focus of Immunisation SLA has moved to all scheduled immunisation events and any necessary immunisation events to manage outbreaks.

2. PURPOSE

2.1. To be the guardians of the immunisation service across Canterbury ensuring that the service is supportecl to deliver reduced vaccine preventable disease & increased scheduled vaccination rates within an alliance framework. This includes working towards a variety of health and performance targets including but not limited to:

2.1.1. Achieve 8 month immunisation health target;

2.1.2. Achieve 2 year old immunisation performance target;

2.1.3. Achieve seasonal flu target;

2.1.4. Improve 4 year, Human Papilloma Virus (HPV) & 11 year old vaccination rates.

2.2. The Immunisation SLA also has a focus on non scheduled immunisation events as part of an outbreak and the vaccination of the Health Workforce. To achieve this the ISLA needs to provide:

2.2.1. Strategic planning, design, prioritisation and oversee implementation of immunisation service/s across the Canterbury health system;

2.2.2. Recommend how services will be funded using collective decision making and available resources from a range of sources.

3. EXPECTED OUTCOMES OF THE SLA

3.1. The ISLA has developed an immunisation outcomes framework and set key performance targets each year by the Ministry of Health.

4. MANDATE

4.1. ISLA will make recommendations to ALT when considering strategic direction for new models of service implementation or delivery. They will brief ALT on the process of this implementation and delivery.

4.2. Once an approval is made by ALT, decisions on governance and implementation of the above strategy will be made by ISLA.

4.3. Implementation of these recommendations and decisions will be made by the Immunisation Providers Group, or Planning and Funding

4.4. For all ISLA recommendations which involve budgets, advice will be sought from the Planning and Funding Leadership Team prior to the recommendation being submitted to ALT.

Deleted: decisions

Deleted: approval

Deleted: by

5. SCOPE

5.1. In Scope:

5.1.1. Overseeing all immunisation programmes in Canterbury funded by health funding

5.1.2. The Seasonal Influenza Programme both subsidised and non-subsidised

5.1.3. Vaccination of the Health Workforce

5.2. Out of Scope:

5.2.1. Overseeing non-funded immunisation programmes e.g. non subsided immunisation events

6. MEMBERSHIP

6.1. The membership of the ISLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

6.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the ISLA to achieve success;

6.3. The ISLA will review membership annually to ensure it remains appropriate;

6.4. Membership will include a member of the ALT;

6.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;

6.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

7.1. New or replacement members will be identified by the ISLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;

7.2. The chair and deputy chair will, in most cases, be nominated by members of the ISLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the ISLA is:

Name(s)	Perspective/Expertise
Dr Ramon Pink	Community and Public Health Background Maori Health Specialist
Helen Johnson	Operational understanding of Primary Health Organisation
Margo Kyle	Lead Maternity Carer
Linda Hill	National understanding of immunisation policy
Ann Feld	Background in Child Health
Dr Tony Walls	Secondary Care, Immunisation Academic
Dr Alison Wooding	General practice
Dr Sarah Marr	General practice
Anna Harwood	Pharmacist
Bridget Lester	An operational understand of Planning & Funding / Facilitator

9. ACCOUNTABILITY

9.1. The ISLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ISLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

10.2. The ISLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held 6 weekly while the Immunisation Provider Group meetings and any relevant sub groups will be held monthly;

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The SLA/WS will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Where there is a risk, exception or variance to the SLA/WS work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

12.3. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme Office.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ISLA chair and facilitator;

13.2. Agendas will be circulated no less than 2 days prior to the meeting, as will any material relevant to the agenda;

13.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed;
13.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

14. QUORUM

14.1. The quorum for meetings is half plus one ISLA member from the total number of members of the SLA.

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;
15.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
15.3. The Interests Register will be a standing item on SLA agenda's and be available to the Programme Office on request.

16. REVIEW

16.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

RESPONSIBLITIES

17. RESPONSIBILITY OF THE SLA

17.1. Apply the delegated funding available to lead the required service/service change;
17.2. Establish new work groups to guide service design;
17.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

18. CHAIR

18.1. Lead the team to identify opportunities for service improvement and redesign;
18.2. Lead the development of the service vision and annual work plan;
18.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
18.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
18.5. Provide leadership when implementing the group's outputs;
18.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
18.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
18.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

19. CLINICAL LEADER

19.1. Provide strong clinical leadership across all SLA work activity;
19.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;

20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. PROJECT MANAGER/FACILITATOR

21.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
21.2. Provide or arrange administrative support;
21.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
21.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
21.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
21.6. Keep key stakeholders well informed;
21.7. Proactively meet reporting and planning dates;
21.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
21.9. Identify report and manage risks associated with the SLA work activity.

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;
22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

23. ALT MEMBER

23.1 Act as a communication interface between ALT and the SLA;
23.2 Participate in the development and writing of papers that are submitted to ALT;
23.3 Act as Sponsor of papers to ALT so papers are best represented at the ALT table

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.

- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

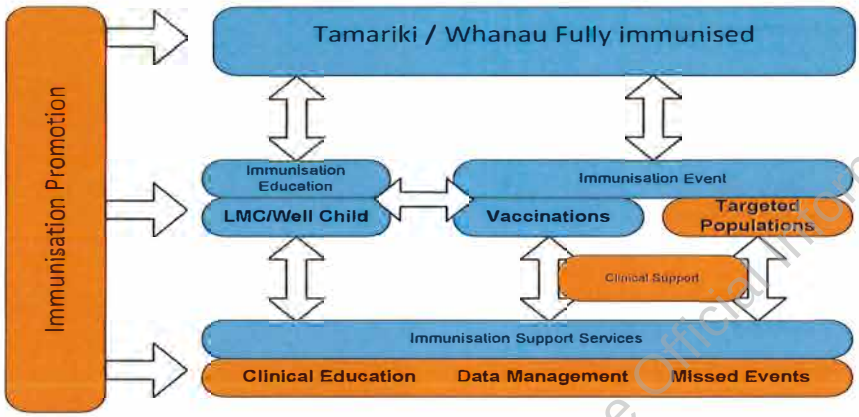
ENDORSEMENT

Date of agreement and finalisation by SLA members: 17 / 12 /2013

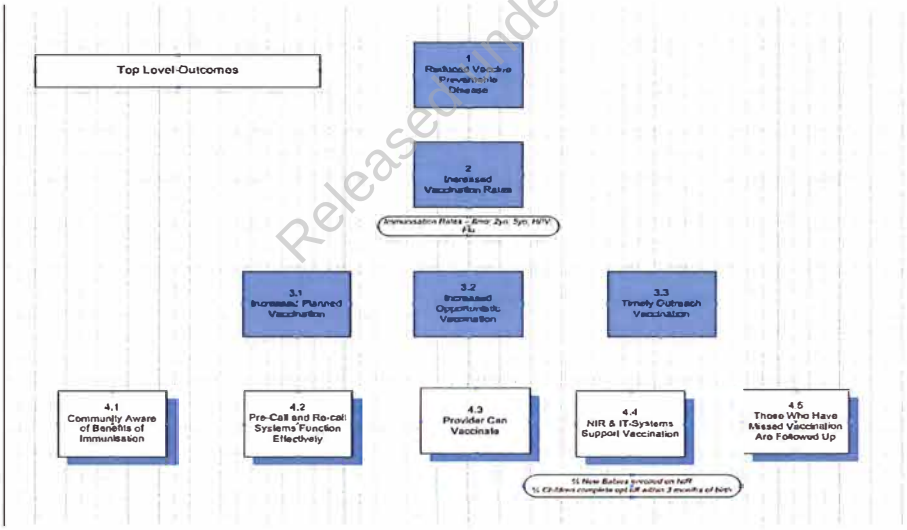
Date of endorsement from ALT: 21 / 1 /2014

Date of Review: November 2014

Appendix One: Immunisation Service Model



Appendix Two: Immunisation Outcomes Framework



CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

Impact rating	❶ Risk ID	Probability rating		
		High	Medium	Low
	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, June 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Medium		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	low		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 4 December 2017 1:33 p.m.
To: Alison Wooding; Anne Feld; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Papers for ISLA meeting 5 December
Attachments: Data report December data report.docx; Workplan Dec 2017.docx; CCN WORK PLAN template 18_19.docx; Agenda Dec 5 ISLA.docx; TOR Updated Nov 2017.docx; Risk Report.docx

HI all

Please find attached the papers for tomorrows ISLA meeting.

I have attached

- Agenda
- Draft minutes
- Updated work plan
- Updated data report
- Update TOR
- 2018/19 Workplan
- Risk Register
- Interest Register

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ Bridget.Lester@cdhb.health.nz
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

Key Performance Indicators and Childhood Immunisation Reporting

October 2017

Immunisation Reporting Programme

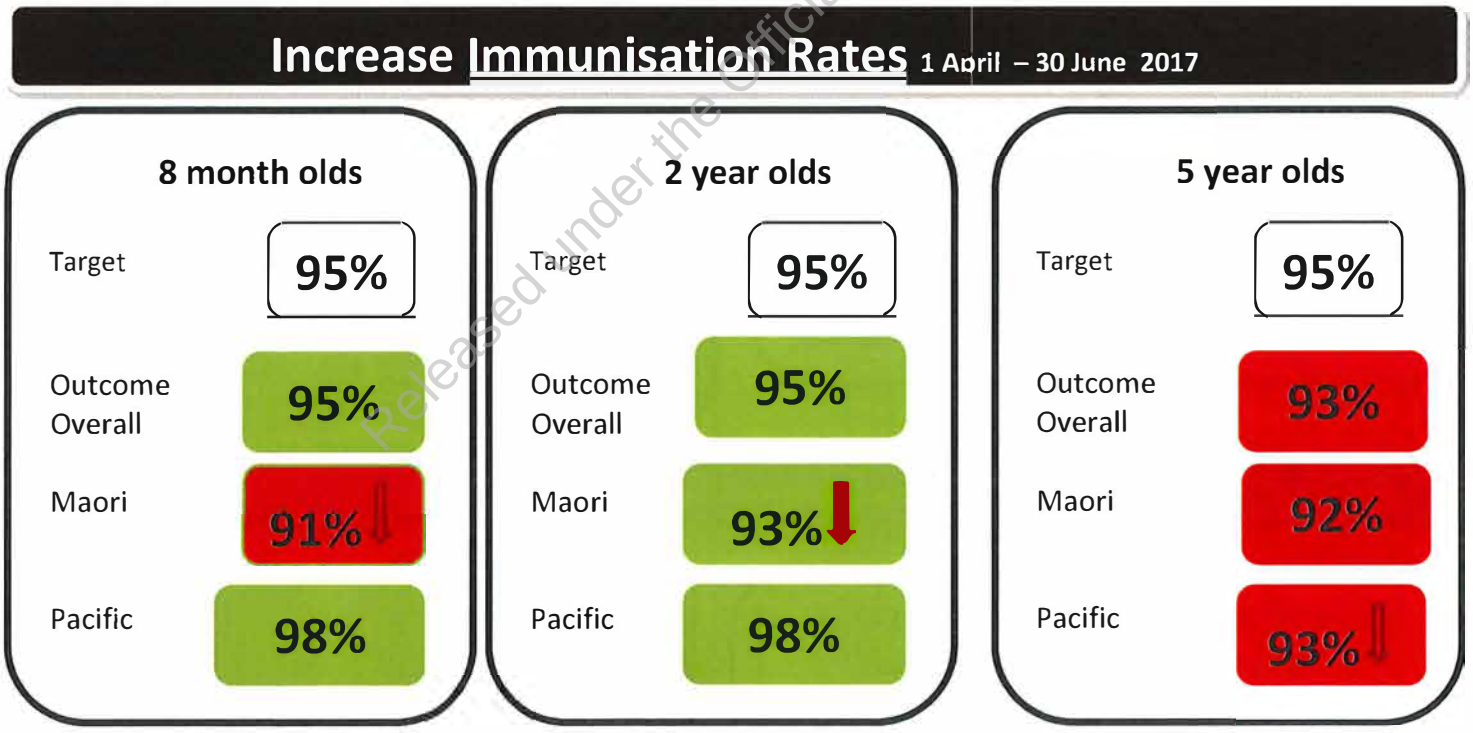
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 4 Dec 2017

Fully Immunised 8 month olds – DHB LEVEL

Q4 2016/17
Actual
- 95% fully
- 1% overdue

Q1 2016/17
Actual
- 95% fully
- 1% overdue

Q2 2016/17
Progress including pending
- 94.1%
- .75% could
- 5.1% can't

Q3 2017/18
Progress including pending
- 86% fully
- 11% could
- 2% can't reach

Fully Immunised Two year olds - DHB LEVEL

Q4 2016/17
Actual
- 95% fully
- 1% overdue

Q1 2017/18
Actual
- 95% fully
- 1.1% overdue

Q2 2017/18
Progress
- 95.4%
- .12%Overdue
- 4.44% can't

Q3 2017/18
Progress
- 94.9% fully
- 2.6% overdue
- 2.5% can't

Fully Immunised Four year olds - DHB LEVEL

Q4 2016/17
Actual
- 93% fully
- 1% overdue

Q1 2017/18
Actual
- 93% fully
- 1.8% overdue

Q2 2017/18
Progress
- 93.2% fully
- 1.3% overdue
- 5.3% can't

Q3 2017/18
Progress
- 92% fully
- 3.7% overdue
- 4.2% can't

Fully Immunised 8month, two and five year - PHO LEVEL 25 Oct 2017

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	97%	%	95%	%	95%	%
Pegasus	95%	%	95%	%	94%	%
Rural Canterbury	95%	%	95%	%	92%	%

Pre teen Immunisations

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	285	90	205	1,470	2,050	430	130	210	2,210	2,980	66%	69%	98%	67%	69%	116 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	237	70	182	1,289	1,778						55%	54%	87%	58%	60%	137 (4.6%)	
	HPV-3 Quadrivalent	151	37	117	995	1,300						35%	28%	56%	45%	44%	144 (4.8%)	
Total	HPV-1 Quadrivalent	285	90	205	1,470	2,050	430	130	210	2,210	2,980	66%	69%	98%	67%	69%	116 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	237	70	182	1,289	1,778						55%	54%	87%	58%	60%	137 (4.6%)	
	HPV-3 Quadrivalent	151	37	117	995	1,300						35%	28%	56%	45%	44%	144 (4.8%)	

DOB (All)

Count of NHI	Column Labels										
	2004					2005					Grand Total
Row Labels	Female	Male	NULL	#N/A	(blank)	Female	Male	NULL	#N/A	(blank)	
HPV Quadrivalent	**240**	**153**	**6**	**4**	**153**	**764**	**192**	**23**	**23**	**346**	**1904**
Closed					1					14	15
Completed	240	153	6	4		764	192	23	23		1405
Declined					37					67	104
Rescheduled					115					265	380
HPV9_Dose1	**431**	**1252**	**40**	**50**	**46**	**457**	**633**	**35**	**18**	**49**	**3011**
Closed					34					19	53
Completed	431	1252	40	50		457	633	35	18		2916
Declined					12					26	38
Rescheduled										4	4
HPV9_Dose2	**370**	**1011**	**28**	**44**	**24**	**304**	**417**	**26**	**16**	**42**	**2282**
Closed					14					7	21
Completed	370	1011	28	44		304	417	26	16		2216
Declined					8					18	26
Rescheduled					2					17	19
HPV9_Dose3	**29**	**3**		**3**	**10**	**37**	**2**	**1**	**1**	**25**	**111**
Completed	29	3		3		37	2	1	1		76
Declined					6					10	16
Rescheduled					4					15	19
Grand Total	**1070**	**2419**	**74**	**101**	**233**	**1562**	**1244**	**85**	**58**	**462**	**7308**

Pregnancy Vaccinations

Number of deliveries by DHB region of domicile and delivery outcome, 2016										
Source: National Maternity Collection (extracted on 28/02/2017)										
Note: these numbers are provisional and subject to change										
Note: pregnancies resulting in multiple births are counted as 1 delivery										
DHB code	DHB name	Single live birth	Single stillbirth	Twins (liveborn)	Twins (live and stillborn)	Twins (stillborn)	Other multiple births (liveborn)	Not stated	(blank)	Total
111	West Coast	304	5	3					2	314
121	Canterbury	6,166	45	77	3		1		8	6,300
National Total		57,928	451	773	23	7	6	1	381	59,570

New Born Enrolment Data Q1

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter One 2017/18
Newborns Born in the Following Period: 20 May 2017 to 19 August 2017

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	93	1,377	93%	16
Bay of Plenty	69	820	92%	19
Canterbury	47	1,586	97%	6
Capital and Coast	12	850	99%	2
Counties Manukau	120	2,086	94%	11
Hawkes Bay	32	528	94%	12
Hutt	18	494	96%	8
Lakes	22	393	94%	10
MidCentral	19	523	96%	7
Nelson Marlborough	8	358	98%	5
Northland	25	556	96%	9
South Canterbury	3	164	98%	4
Southern	14	852	98%	3
Tairawhiti	15	189	92%	18
Taranaki	26	347	93%	17
Waikato	85	1,368	94%	13
Wairarapa	1	122	99%	1
Waitemata	124	1,903	93%	14
West Coast	6	91	93%	15
Whanganui	19	220	91%	20
Overseas or Unknown	1	6	83%	
Total	**759**	**14,833**	**95%**	

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter One 2017/18
Newborns Born in the Following Period: 20 May 2017 to 19 August 2017
As at Quarter Four 2017 (October 2017)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage
Auckland	210	1,005	1,377	73%
Bay of Plenty	136	619	820	75%
Canterbury	346	1,275	1,586	80%
Capital and Coast	170	693	850	82%
Counties Manukau	375	1,648	2,086	79%
Hawkes Bay	143	417	528	79%
Hutt	117	432	494	87%
Lakes	39	330	393	84%
MidCentral	104	346	523	66%
Nelson Marlborough	55	267	358	75%
Northland	141	481	556	87%
South Canterbury	49	137	164	84%
Southern	142	670	852	79%
Tairawhiti	38	136	189	72%
Taranaki	82	263	347	76%
Waikato	296	1,054	1,368	77%
Wairarapa	26	84	122	69%
Waitemata	283	1,362	1,903	72%
West Coast	22	78	91	86%
Whanganui	52	188	220	85%
Overseas or Unknown			6	0%
Total	**2,826**	**11,485**	**14,833**	**77%**

Number of Newborns Enrolled Within Three Months by DHB of Domicile and Ethnicity - Quarter One 2017/18
Newborns Born in the Following Period: 20 May 2017 to 19 August 2017
As at Quarter Four 2017 (October 2017)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Auckland	92	130	71%	169	223	76%	744	1,024	73%
Bay of Plenty	233	290	80%	N/A	N/A	N/A	386	530	73%
Canterbury	156	206	76%	63	84	75%	1,056	1,296	81%
Capital and Coast	101	108	94%	56	75	75%	536	667	80%
Counties Manukau	349	397	88%	487	608	80%	812	1,081	75%
Hawkes Bay	174	224	78%	32	33	97%	211	271	78%
Hutt	106	132	80%	32	40	80%	294	322	91%
Lakes	189	186	102%	N/A	N/A	N/A	141	207	68%
MidCentral	79	144	55%	N/A	N/A	N/A	267	379	70%
Nelson Marlborough	59	77	77%	N/A	N/A	N/A	208	281	74%
Northland	259	292	89%	N/A	N/A	N/A	222	264	84%
South Canterbury	23	26	88%	N/A	N/A	N/A	114	138	83%
Southern	102	114	89%	N/A	N/A	N/A	568	738	77%
Tairawhiti	96	127	76%	N/A	N/A	N/A	40	62	65%
Taranaki	79	101	78%	N/A	N/A	N/A	184	246	75%
Waikato	376	439	86%	40	61	66%	638	868	74%
Wairarapa	23	38	61%	N/A	N/A	N/A	61	84	73%
Waitemata	203	257	79%	130	199	65%	1,029	1,447	71%
West Coast	20	21	95%	N/A	N/A	N/A	58	70	83%
Whanganui	88	90	98%	N/A	N/A	N/A	100	130	77%
Overseas or Unknown		1	0%	N/A	N/A	N/A		5	0%
Total	**2,807**	**3,400**	**83%**	**1,009**	**1,323**	**76%**	**7,669**	**10,110**	**76%**

Number of Newborns Enrolled Within Three Months by PHO - Quarter One 2017/18
Newborns Born in the Following Period: 20 May 2017 to 19 August 2017
As at Quarter Four 2017 (October 2017)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	330	420	79%	26
Auckland PHO Limited	136	184	74%	31
Central Primary Health Organisation	336	496	68%	34
Christchurch PHO Limited	88	95	93%	6
Compass Health - Capital and Coast	637	791	81%	22
Compass Health - Wairarapa	86	119	72%	32
Cosine Primary Care Network Trust	95	101	94%	2
East Health Trust	257	288	89%	9
Eastern Bay Primary Health Alliance	125	160	78%	27
Hauraki PHO	418	489	85%	13
Health Hawke's Bay Limited	414	496	83%	16
Kimi Hauora Wairau (Marlborough PHO Trust)	82	107	77%	29
Manaia Health PHO Limited	314	352	89%	10
Midlands Health Network - Lakes	111	112	99%	1
Midlands Health Network - Tairawhiti	114	139	82%	21
Midlands Health Network - Taranaki	257	311	83%	20
Midlands Health Network - Waikato	611	761	80%	23
National Hauora Coalition Limited	275	326	84%	15
Nelson Bays Primary Health	185	243	76%	30
Nga Mataapuna Oranga Limited	57	62	92%	7
Ngati Porou Hauora Charitable Trust	24	36	67%	35
Ora Toa PHO Limited	45	54	83%	18
Pegasus Health (Charitable) Limited	1,030	1,220	84%	14
Procare Networks Limited	2,017	2,596	78%	28
Rotorua Area Primary Health Services Limited	242	292	83%	19
Rural Canterbury PHO	158	231	68%	33
South Canterbury Primary and Community	136	156	87%	12
Te Awakairangi Health Network	353	378	93%	3
Te Tai Tokerau PHO Ltd	144	164	88%	11
Total Healthcare Charitable Trust	444	496	90%	8
Waitemata PHO Limited	622	785	79%	25
WellSouth Primary Health Network	669	840	80%	24
West Coast PHO	78	84	93%	5
Western Bay of Plenty PHO Limited	412	494	83%	17
Whanganui Regional PHO	183	196	93%	4
Unknown or Blank		759	0%	
Total	**11,485**	**14,833**	**77%**	

Q1 21718 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,570	1,355	86. %	722	640	89. %	236	186	79. %	92	71	77. %	269	249	93. %	251	209	83. %	15 (1)	1.0 (0.1) %	44	2.8 %
8 Month	1,583	1,499	95. %	747	720	96. %	255	232	91. %	95	93	98. %	247	242	98. %	239	212	89. %	13 (3)	0.8 (0.2) %	48	3.0 %
12 Month	1,697	1,616	95. %	749	723	97. %	282	262	93. %	81	78	96. %	307	299	97. %	278	254	91. %	14 (0)	0.8 (0.0) %	47	2.8 %
18 Month	1,619	1,413	87. %	742	667	90. %	276	228	83. %	72	61	85. %	253	236	93. %	276	221	80. %	17 (0)	1.1 (0.0) %	64	4.0 %
24 Month	1,646	1,559	95. %	760	727	96. %	311	288	93. %	100	98	98. %	236	232	98. %	239	214	90. %	11 (0)	0.7 (0.0) %	53	3.2 %
5 Year	1,704	1,583	93. %	819	777	95. %	289	267	92. %	72	67	93. %	261	244	93. %	263	228	87. %	11 (0)	0.6 (0.0) %	79	4.6 %
12 Year	17	0	-	8	0	-	4	0	-	0	0	-	1	0	-	4	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,570	1,355	86. %	362	318	88. %	324	280	86. %	294	262	89. %	229	195	85. %	195	158	81. %	166	142	86. %
8 Month	1,583	1,499	95. %	331	307	93. %	340	320	94. %	266	253	95. %	275	265	96. %	192	184	96. %	179	170	95. %
12 Month	1,697	1,616	95. %	358	324	91. %	375	364	97. %	309	293	95. %	254	244	96. %	199	192	96. %	202	199	99. %
18 Month	1,619	1,413	87. %	365	316	87. %	335	302	90. %	308	260	84. %	235	205	87. %	196	167	85. %	180	163	91. %
24 Month	1,646	1,559	95. %	373	344	92. %	332	320	96. %	305	293	96. %	242	228	94. %	224	214	96. %	170	160	94. %
5 Year	1,704	1,583	93. %	428	392	92. %	343	321	94. %	305	286	94. %	244	223	91. %	192	174	91. %	192	187	97. %
12 Year	17	0	-	4	0	-	4	0	-	4	0	-	1	0	-	4	0	-	0	0	-

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - December 2017 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. 80% of new-borns in Q1 were enrolled with general practice. • Data shows that 40% of women were vaccinated during pregnancy in 2016. • Fridge has been approved for order • Need to work out education and staffing • LinKIDS is working on a CTBA programme with PHOs.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Data not available Q1 = 95% 8month olds, 95% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	2005 – 53% have had D1 and 39% D2 2004 – 69% D1 an 60% D2.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	64% vaccinated
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Facilitator: First Consider/Brainstorm the following with your group:

Section One: What are our **Priority Actions toward Transformational Change and/or Impact towards improved System Outcomes?**

- What are the issues/challenges for our Population/Service that we want to influence/change/improve?
- What is the data telling us that requires action?
- What specific actions will we undertake to influence improved access/equity (Equity Outcome Actions (EOA)?
- Which National Targets are **we not doing well in** and what actions are we going to put in place to influence change and contribute to improved performance/outcomes?
- What actions are we leading in relation to System Level Measures (SLMs)?

Section Two: Actions towards other National Targets or Actions towards things we want to monitor:

- What actions will we take to support National targets **where we are doing ok?**
- What activity do we need to/ want to monitor to monitor change/impact for our population (WS) or performance indicators for our Service (SLA)?

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)

- What data based measures do we want to monitor to measure our System contribution or impact?
- Are there National targets that we are doing well with that we want to keep an eye on?

Please Code Actions that have an Equity or Access Focus with - EOA

Please Code Actions that relate to the System Level Measure Improvement Plan with - SLM

CCN Immunisation Service Level Alliance WORK PLAN 2018/19

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
					CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions toward Transformational Change and/or Impact towards improved System Outcomes including National Targets requiring action							
1. ***To ensure parents are informed and vaccinated before baby is born***	1.1 Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy 1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.2.1 Hold a focus group with LMCs to determine what they need	On going	▪		Ramon Pink Helen Leary	Bridget Lester	

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
	1.2.2 Do a stocktake of reproduces to determine what the gaps are 1.3 GP are informed that a women is pregnant to enable them to contact the women to discussion pregnancy vaccinations 1.4 Regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme						
2. Encourage caregivers to ensure all preschools are fully vaccinated	2.1. Continue to monitor all 8months, 2 year olds and 4 years olds to ensure they are fully vaccinated 2.2. Develop a more structured general practice decline process 2.3. Work with C&PH to better understand why Maori are declining immunisation.		▪				
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor							
1. Influenza Vaccination Programme	1.1. Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations.		▪				
2. HPV and Tdap Programme	2.1 Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8		▪				

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
3. General Practice New-born Enrolment	3.1 Continue to provide eudcaton to general practice teams around the need to accept all New Born nomiations and "B" code new borns. Promote		▪				

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)	
Data Metric Definition	**Data Source**
1.	
2.	
3.	
4.	

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 5 December, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Anna Harwood:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.40pm	**Confirmation of minutes of last meeting**	Ramon Pink	draft minutes 24 October ISLA meetin
3.	2.50pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	3.00pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2017** • **Immunisations Conference**	Bridget Lester	Data report December data repo Workplan Dec 2017.docx
7.	3.20pm	**2018/19 Work plan**	Bridget Lester	CCN WORK PLAN template 18_19.docx
	3.30pm	**Mumps and Whooping Cough update dates**	Ramon	
7.	3.40pm	**Operational** • **Interest register** • **Risk Register** • **Terms of Reference Update** • **Meeting Schedule for 2018**	Ramon Pink	Interests register 17 March 2015.docx Data report August data report.docx TOR Updated Nov 2017.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
U18 Kaikoura – paper for October meeting	Bridget	October
Flu Group discussion – feedback to Phil S	Ramon	November

Canterbury Clinical Network
Transforming Health Care, Wherever You Live In Waitaha

TERMS OF REFERENCE
Immunisation Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

The Immunisation SLA will acknowledge and support the principles of the Treaty of Waitangi.

IMMUNISATION SERVICE LEVEL ALLAINCE

1. BACKGROUND

1.1. The Immunisation Service Level Alliance (ISLA) was established in 2010 with its initial role to develop an Immunisation Service Model (see appendix one) with a focus on fully immunised 2year olds (the health target at the time). Following the development of Service Model the ISLA moved into the implementation stage, focusing on the implementation of the service model. This included the development of an Immunisation Outcomes Framework (see appendix two).

1.2. The ISLA has moved into a monitoring phase of the outcomes framework, which focused on normalising immunisation over a lifetime and reaching specific health and performance targets. The focus of Immunisation SLA has moved to all scheduled immunisation events and any necessary immunisation events to manage outbreaks.

2. PURPOSE

2.1. To be the guardians of the immunisation service across Canterbury ensuring that the service is supported to deliver reduced vaccine preventable disease & increased scheduled vaccination rates within an alliance framework. This includes working towards a variety of health and performance targets including but not limited to:

2.1.1. Achieve 8 month immunisation health target;

2.1.2. Achieve 2 year old and 4 year old immunisation performance target;

2.1.3. Achieve seasonal flu target;

2.1.4. Improve Human Papilloma Virus (HPV) & 11 year old vaccination rates.

2.2. The Immunisation SLA also has a focus on non scheduled immunisation events as part of an outbreak and the vaccination of the Health Workforce. To achieve this the ISLA needs to provide:

2.2.1. Strategic planning, design, prioritisation and oversee implementation of immunisation service/s across the Canterbury health system;

2.2.2. Recommend how services will be funded using collective decision making and available resources from a range of sources.

3. EXPECTED OUTCOMES OF THE SLA

3.1. The ISLA has developed an immunisation outcomes framework and set key performance targets each year by the Ministry of Health.

4. MANDATE

4.1. ISLA will make recommendations to ALT when considering strategic direction for new models of service implementation or delivery. They will brief ALT on the process of this implementation and delivery.

4.2. Once an approval is made by ALT, decisions on governance and implementation of the above strategy will be made by ISLA.

4.3. Implementation of these recommendations and decisions will be made by the Immunisation Providers Group, or Planning and Funding

4.4. For all ISLA recommendations which involve budgets, advice will be sought from the Planning and Funding Leadership Team prior to the recommendation being submitted to ALT.

Deleted: decisions

Deleted: approval

Deleted: by

5. SCOPE

5.1. In Scope:

5.1.1. Overseeing all immunisation programmes in Canterbury funded by health funding

5.1.2. The Seasonal Influenza Programme both subsidised and non-subsidised

5.1.3. Vaccination of the Health Workforce

5.2. Out of Scope:

5.2.1. Overseeing non-funded immunisation programmes e.g. no subsided immunisation events

6. MEMBERSHIP

6.1. The membership of the ISLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

6.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the ISLA to achieve success;

6.3. The ISLA will review membership annually to ensure it remains appropriate;

6.4. Membership will include a member of the ALT;

6.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;

6.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

7.1. New or replacement members will be identified by the ISLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;

7.2. The chair and deputy chair will, in most cases, be nominated by members of the ISLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the ISLA is:

Name(s)	Perspective/Expertise
Dr Ramon Pink (Chair)	Community and Public Health Background Maori Health Specialist
Geraldine Clemens	Operational understanding of Primary Health Organisation
Helen Fraser	Lead Maternity Carer
Anne Feld	Background in Child Health
Dr Tony Walls	Secondary Care, Immunisation Academic
Dr Alison Wooding	General practice
Dr Sarah Marr (Deputy Chair)	General practice
Anna Harwood	Pharmacist
Donna MacLean	Practice Nursing
Bridget Lester	An operational understand of Planning & Funding / Facilitator

9. ACCOUNTABILITY

9.1. The ISLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ISLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

10.2. The ISLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held 6 weekly while the Immunisation Provider Group meetings and any relevant sub groups will be held monthly;

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The SLA/WS will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Where there is a risk, exception or variance to the SLA/WS work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

12.3. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme Office.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ISLA chair and facilitator;

13.2. Agendas will be circulated no less than 2 days prior to the meeting, as will any material relevant to the agenda;

13.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed;
13.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

14. QUORUM

14.1. The quorum for meetings is half plus one ISLA member from the total number of members of the SLA.

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;
15.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
15.3. The Interests Register will be a standing item on SLA agenda's and be available to the Programme Office on request.

16. REVIEW

16.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

RESPONSIBLITIES

17. RESPONSIBILITY OF THE SLA

17.1. Apply the delegated funding available to lead the required service/service change;
17.2. Establish new work groups to guide service design;
17.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

18. CHAIR

18.1. Lead the team to identify opportunities for service improvement and redesign;
18.2. Lead the development of the service vision and annual work plan;
18.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
18.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
18.5. Provide leadership when implementing the group's outputs;
18.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
18.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
18.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

19. CLINICAL LEADER

19.1. Provide strong clinical leadership across all SLA work activity;
19.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;

20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. PROJECT MANAGER/FACILITATOR

21.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
21.2. Provide or arrange administrative support;
21.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
21.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
21.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
21.6. Keep key stakeholders well informed;
21.7. Proactively meet reporting and planning dates;
21.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
21.9. Identify report and manage risks associated with the SLA work activity.

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;
22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

23. ALT MEMBER

23.1 Act as a communication interface between ALT and the SLA;
23.2 Participate in the development and writing of papers that are submitted to ALT;
23.3 Act as Sponsor of papers to ALT so papers are best represented at the ALT table

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.

- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

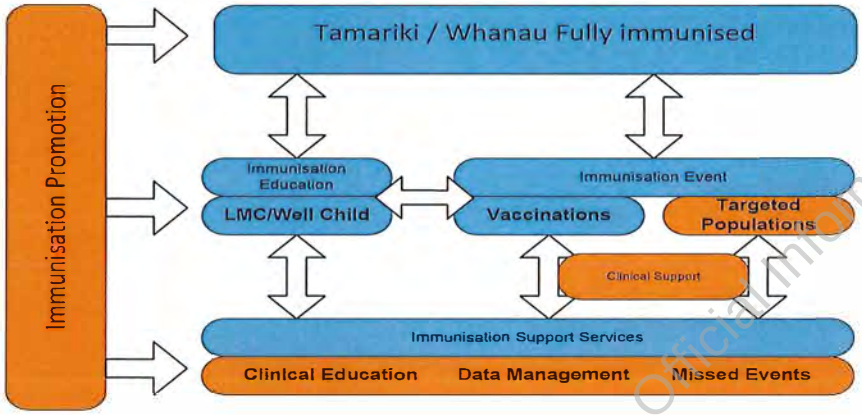
ENDORSEMENT

Date of agreement and finalisation by SLA members: 4 / 12 /2017

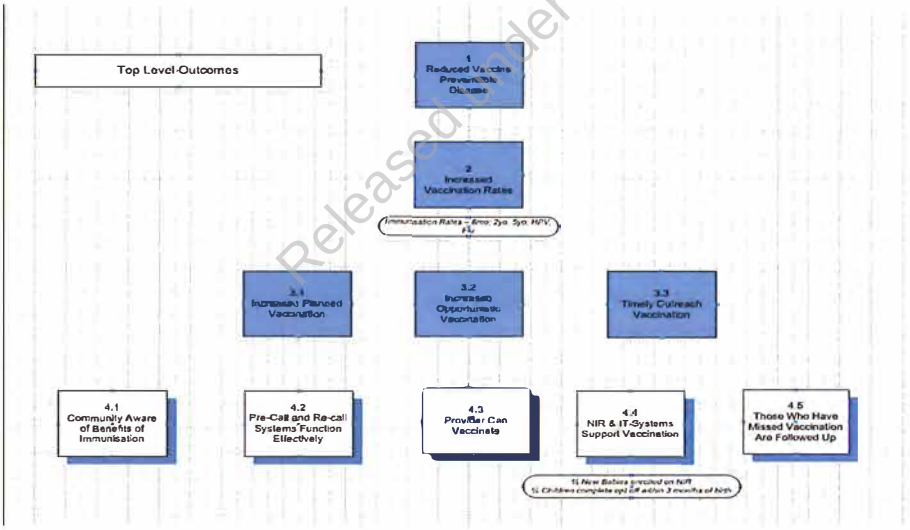
Date of endorsement from ALT

Date of Review: November 2018

Appendix One: Immunisation Service Model



Appendix Two: Immunisation Outcomes Framework



CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium			
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, June 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 65% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Medium		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event.	
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	low		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 25 January 2018 1:40 p.m.
To: 'Alison Wooding'; 'Anne Feld'; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'; 'Helen Fraser'
Subject: Jan 30th Immunisation Service Level Alliance Meeting
Attachments: Agenda 30 Jan ISLA.docx; Data report Jan 2018.docx; Draft Minutes 5.12.17 ISLA meeting.docx; Interests register 5.12.17.docx; Risk Report 5.12.17.docx; Updated TOR ISLA 5.12.17.docx; Workplan Jan 2018.docx

Hi all

Please find attached the agenda and papers for next week's meeting.

Please let me know if you want anything else added? Ramon is currently on leave – so hasn't provided any feedback yet.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 30 January, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Anne Feld :	Dr Sarah Marr (Deputy Chair):
Stuart Walker:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.40pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft Minutes 5.12.17 ISLA meeting
3.	2.50pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	3.00pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2017** • **Immunisations Conference**	Bridget Lester	Data report Jan 2018.docx Workplan Jan 2018.docx
7.	3.20pm	**2018/19 Work plan**	Bridget Lester	CCN WORK PLAN template 18_19.docx
	3.30pm	**Mumps and Whooping Cough update dates**	Ramon	
7.	3.40pm	**Operational** • **Interest register** • **Risk Register** • **Terms of Reference Update** • **Meeting Schedule for 2018**	Ramon Pink	Interests register 5.12.17.docx Risk Report 5.12.17.docx Updated TOR ISLA 5.12.17.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
U18 Kaikoura – paper for October meeting	Bridget	October

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha.

Venue: C&PH	
Date: 5 December 2017	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Sarah Marr, Bridget Lester, Helen Fraser, Anna Harwood, Donna MacLean, Geraldine Clemens and Alison Wooding.	
Apology: Anne Feld and Tony Walls	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**			
•	**Confirmation of Minutes**	• Minutes of 24 October 2017 meeting where approved to be sent to the CCN office		Friday 8 December
•	**Previous Actions & Matters Arising**	• **U18 Flu Hurunui Kaikoura (HK) areas –** this paper has yet to be completed. o Bridget has approached other DHBs, who at this stage don't intend to extend the programme in 2018. o Bridget followed up with Megan, and yes there is an interest in extending the programme. o We need to understand more around the vaccine uptake, and the issues within the community – will the flu vaccine have any benefit to them? o Action: ▪ Ramon to approach CCN to see if they have an appetite for the extension (yet to occur) ▪ Bridget to approach PHOs to see if they can pull any coverage data for 2017.	Bridget and Ramon	20 December
•	**ISLA Work plan**	Q2 201718 – progress result • 8month olds – Q2 coverage is looking low, we still need to vaccinate 5 children to reach target. Maori coverage is looking around 91% again. • 2 year olds – Q2 tracking to 95%, • 5 year olds – Q2 on track to achieve - 93%. • HPV – currently sitting at 62% of girls born in 2004 how have received dose 2 of HPV. Current target is 70% • Flu – end of season result – 64% vaccinated. • Pertussis data – the MoH provided us with some data which shows that in 2016, 40% of pregnant women were vaccinated for Pertussis. **New-born Enrolment** – Q1 New-borns enrolment data has CDHB sitting on 80% of new-borns enrolled. There is some concern around the RCPHO data – further investigation will occur into this. **HPV** – the PHNS is busy working through the implementation of the 2018 School Programme. The following is occurring • Development of dual consent form • Development of Tdap resources for both general practice and the school programme Some NIR processing issues have been identified around the Tdap loading, as this group is currently not on the NIR.		

	Item	Discussion/Action	Responsibility	Date due
		Data – some draft HPV 2004 / 2005 coverage data has been pulled – looking at gender. This is the first cut but shows that around 30% of boys born in 2004 have completed the programme in 2017 and around 13% of boys born in 2005 are fully vaccinated. **Influenza coverage:** The main focus on this season has finished, Planning for 2018 will start in early January. For the 2018 season we need to consider: • Loading of those 65 and over working in the DHB • More messaging to GPT around opting people on the NIR. • Do we have any Pharmacy vs General Practice data • Compare vaccine supply rates with coverage data • There is a survey around the currently Influenza resources – send like to ISLA members. **Pregnancy vaccinations** – Approval has been given for the purchase of a Fridge to support this Outpatient programme. Need to work on staffing and education – aim to have programme running by Feb 2018.		
•	**2018/19 Work plan discussion**	The draft work plan was shared - some minor wording changes are required, and then forward to CCN for review.	Bridget CCN WORK PLAN template 18_19.docx	20 March
•	**Mumps Whooping Cough**	Mumps - There is currently an increase in Mumps cases in Canterbury – 14 this year. There is a need to increase some of the messaging to families around this. o Suggested developing a poster for general practice to prompt opportunistic vaccinations. o Need to put a message on to HealthPathways. Whooping Cough – need to get some messages out to LMCs around the need to protect women. o Suggest that we make LMC specific HotShots to get out ASAP. o Including information around CDHB Occ Health vaccination clinics – as these are free.	Bridget Ramon Bridget Helen	ASAP
•	**Cold Chain**	o DHBs need to have a Cold Chain plan by 1 February 2018. Need some more information from the MoH around the expectations of this. There is a need to develop a DHB wide process around what will happen if a practice / pharmacy is not compliant. Agree that ISLA will oversee that development of this. There are specific requirements of the PHO agreement that a GP need to follow.	Bridget Ramon Geraldine	30 January
•	**Operational**	o Risk Register – needs uptake to reflect change in risk with HPV and OIS Capacity o Interest Register – this has been sent to the ISLA member of updating. Please update and send back by 20 December 2017. o Terms of Reference, Need to add Pregnancy Vaccinations to our ToR priority areas	Bridget Updated TOR ISLA 5.12.17.docx Interests register 5.12.17.docx Risk Report 5.12.17.docx	20 December

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•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 30th January • Tuesday 3 April • Tuesday 5 June • Tuesday 7 August • Tuesday 2 October (tentative - in the school holidays) • Tuesday 4 December		

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Venue: C&PH	
Date: 5 December 2017	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Sarah Marr, Bridget Lester, Helen Fraser, Anna Harwood, Donna MacLean, Geraldine Clemens and Alison Wooding.	
Apology: Anne Feld and Tony Walls	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**			
•	**Confirmation of Minutes**	• Minutes of 24 October 2017 meeting where approved to be sent to the CCN office		Friday 8 December
•	**Previous Actions & Matters Arising**	• **U18 Flu Hurunui Kaikoura (HK) areas** – this paper has yet to be completed. o Bridget has approached other DHBs, who at this stage don't intend to extend the programme in 2018. o Bridget followed up with Megan, and yes there is an interest in extending the programme. o We need to understand more around the vaccine uptake, and the issues within the community – will the flu vaccine have any benefit to them? o Action: ▪ Ramon to approach CCN to see if they have an appetite for the extension (yet to occur) ▪ Bridget to approach PHOs to see if they can pull any coverage data for 2017.	Bridget and Ramon	20 December
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•	**Cold Chain**	o DHBs need to have a Cold Chain plan by 1 February 2018. Need some more information from the MoH around the expectations of this. There is a need to develop a DHB wide process around what will happen if a practice / pharmacy is not compliant. Agree that ISLA will oversee that development of this. There are specific requirements of the PHO agreement that a GP need to follow.	Bridget Ramon Geraldine	30 January
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Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 5 December 2017	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Helen Fraser	
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium			
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:** Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

our health system

Key Performance Indicators and Childhood Immunisation Reporting

January 2018

Immunisation Reporting Programme

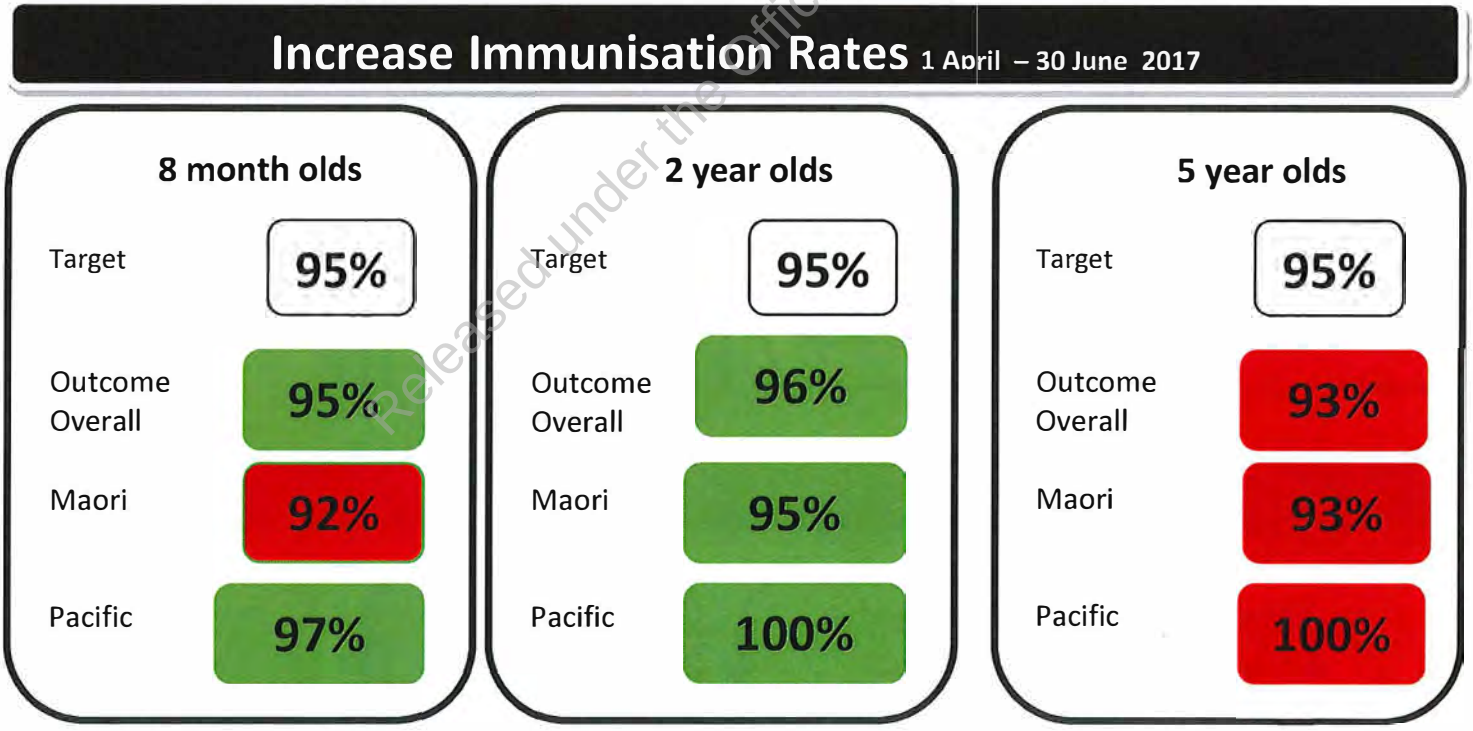
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 26 Jan 2018

Fully Immunised 8 month olds – DHB LEVEL

Q1 2017/18 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress including pending	Q4 2017/18 Progress including pending
95% fully	95% fully	91.5%	% fully
1% overdue	1% overdue	4 .7% could	% could
		3.6% can't	% can't reach reach

Fully Immunised Two year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
95% fully	95% fully	95.9%	88% fully
1.1% overdue	1% overdue	.23%o verdue	8% overdue
		3.2% can't	3.4% can't

Fully Immunised Four year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
93% fully	93% fully	93.3% fully	87% fully
1.8%	1.7% overdue	2% overdue	8.8% overdue
		4.6% can't	3.7% can't

Fully Immunised 8month, two and five year - PHO LEVEL 25 Oct 2017

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	97%	%	95%	%	95%	%
Pegasus	95%	%	95%	%	94%	%
Rural Canterbury	95%	%	95%	%	92%	%

Pre teen Immunisations

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	252	92	193	1,524	2,061	430	130	210	2,210	2,980	59%	71%	92%	69%	69%	117 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	215	73	177	1,419	1,884						50%	56%	84%	64%	63%	138 (4.6%)	
	HPV-3 Quadrivalent	136	37	113	1,021	1,307						32%	28%	54%	46%	44%	144 (4.8%)	
2005	HPV-1 Quadrivalent	157	50	167	1,127	1,501	440	120	230	2,040	2,830	36%	42%	73%	55%	53%	81 (2.9%)	1 (0.0%)
	HPV-2 Quadrivalent	112	42	137	852	1,143						25%	35%	60%	42%	40%	71 (2.5%)	
	HPV-3 Quadrivalent	61	21	64	484	630						14%	18%	28%	24%	22%	68 (2.4%)	
Total	HPV-1 Quadrivalent	409	142	360	2,651	3,562	870	250	440	4,250	5,810	47%	57%	165%	62%	61%	198 (3.4%)	1 (0.0%)
	HPV-2 Quadrivalent	327	115	314	2,271	3,027						38%	46%	144%	53%	52%	209 (3.6%)	
	HPV-3 Quadrivalent	197	58	177	1,505	1,937						23%	23%	82%	35%	33%	212 (3.6%)	

Pregnancy Vaccinations

Number of deliveries by DHB region of domicile and delivery outcome, 2016
Source: National Maternity Collection (extracted on 28/02/2017)
Note: these numbers are provisional and subject to change
Note: pregnancies resulting in multiple births are counted as 1 delivery

DHB code	DHB name	Single live birth	Single stillbirth	Twins (liveborn)	Twins (live and stillborn)	Twins (stillborn)	Other multiple births (liveborn)	Not stated	(blank)	Total
111	West Coast	304	5	3					2	314
121	Canterbury	6,166	45	77	3		1		8	6,300
National Total		57,928	451	773	23	7	6	1	381	59,570

Q2 21718 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,603	1,382	86. %	842	756	90. %	255	192	75. %	65	53	82. %	270	252	93. %	171	129	75. %	21 (1)	1.3 (0.1) %	37	2.3 %
8 Month	1,593	1,508	95. %	865	829	96. %	232	214	92. %	65	63	97. %	268	263	98. %	163	139	85. %	19 (0)	1.2 (0.0) %	45	2.8 %
12 Month	1,597	1,501	94. %	883	843	95. %	230	212	92. %	80	79	99. %	261	252	97. %	143	115	80. %	17 ()	1.1 (0.0) %	53	3.3 %
18 Month	1,551	1,348	87. %	884	791	89. %	203	163	80. %	71	58	82. %	262	238	91. %	131	98	75. %	15 ()	1.0 (0.0) %	53	3.4 %
24 Month	1,579	1,511	96. %	893	860	96. %	222	212	95. %	83	83	100. %	227	224	99. %	154	132	86. %	11 ()	0.7 (0.0) %	43	2.7 %
5 Year	1,718	1,598	93. %	997	939	94. %	217	201	93. %	69	69	100. %	250	233	93. %	185	156	84. %	16 (0)	0.9 (0.0) %	74	4.3 %
12 Year	747	475	64. %	473	323	68. %	95	61	64. %	24	15	63. %	58	28	48. %	97	48	49. %	16 (0)	2.1 (0.0) %	40	5.4 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,603	1,382	86. %	332	279	84. %	338	294	87. %	283	244	86. %	260	223	86. %	200	173	87. %	190	169	89. %
8 Month	1,593	1,508	95. %	365	333	91. %	310	301	97. %	300	290	97. %	236	223	94. %	197	181	92. %	185	180	97. %
12 Month	1,597	1,501	94. %	343	311	91. %	318	300	94. %	269	252	94. %	266	255	96. %	212	204	96. %	189	179	95. %
18 Month	1,551	1,348	87. %	358	304	85. %	306	270	88. %	289	253	88. %	237	202	85. %	173	147	85. %	188	172	91. %
24 Month	1,579	1,511	96. %	350	330	94. %	288	274	95. %	318	302	95. %	226	221	98. %	220	212	96. %	177	172	97. %
5 Year	1,718	1,598	93. %	415	372	90. %	347	330	95. %	313	289	92. %	230	215	93. %	198	188	95. %	215	204	95. %
12 Year	747	475	64. %	246	147	60. %	160	110	69. %	126	87	69. %	91	47	52. %	54	28	52. %	70	56	80. %

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - Jan 2018 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women.	Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth.	Around 98% of babies are enrolled at birth.
	Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider.	Q1-Q4 Q1-Q4	• 98% of new-borns are enrolled with general practice by 2 weeks.	No updated data available No updated data available
	Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.			However there has been a new proposed Bill in Parliament around enrolling new-borns in GP at birth.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Q1 = 95% 8month olds, 96% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	In data report – but issue identified with Maori Coverage and changing data set.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Not currently reported
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Progression Yes

Facilitator: First Consider/Brainstorm the following with your group:

Section One: What are our **Priority Actions toward Transformational Change and/or Impact towards improved System Outcomes?**

- What are the issues/challenges for our Population/Service that we want to influence/change/improve?
- What is the data telling us that requires action?
- What specific actions will we undertake to influence improved access/equity (Equity Outcome Actions (EOA)?
- Which National Targets are **we not doing well in** and what actions are we going to put in place to influence change and contribute to improved performance/outcomes?
- What actions are we leading in relation to System Level Measures (SLMs)?

Section Two: Actions towards other National Targets or Actions towards things we want to monitor:

- What actions will we take to support National targets **where we are doing ok?**
- What activity do we need to/ want to monitor to monitor change/impact for our population (WS) or performance indicators for our Service (SLA)?

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)

- What data based measures do we want to monitor to measure our System contribution or impact?
- Are there National targets that we are doing well with that we want to keep an eye on?

Please Code Actions that have an Equity or Access Focus with - EOA

Please Code Actions that relate to the System Level Measure Improvement Plan with - SLM

CCN Immunisation Service Level Alliance WORK PLAN 2018/19

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
					CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions toward Transformational Change and/or Impact towards improved System Outcomes including National Targets requiring action							
1. To ensure parents are informed and vaccinated before baby is born	1.1 Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy 1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.2.1 Hold a focus group with LMCs to determine what they need	On going	▪		Ramon Pink Helen Leary	Bridget Lester	

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY CLINICAL LEAD	 PROJECT LEAD	Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
	1.2.2 Do a stocktake of reproduces to determine what the gaps are 1.3 GP are informed that a women is pregnant to enable them to contact the women to discussion pregnancy vaccinations 1.4 Regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme						
2. Encourage caregivers to ensure all preschools are fully vaccinated	2.1. Continue to monitor all 8months, 2 year olds and 4 years olds to ensure they are fully vaccinated 2.2. Develop a more structured general practice decline process 2.3. Work with C&PH to better understand why Maori are declining immunisation.		▪				
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor							
1. Influenza Vaccination Programme	1.1. Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations.		▪				
2. HPV and Tdap Programme	2.1 Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8		▪				

OBJECTIVE *Succinct description of what you ore aiming to achieve e.g. Integrated Systems or Rurol Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we hove been successful? How will we measure our success in terms of improved outcomes/doto metric? What is the benchmark/Torget*	MILESTONE *Where we can't apply o metric, how will we know the oction has been completed*	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
					CLINICAL LEAD	PROJECT LEAD	
3. General Practice New-born Enrolment	3.1 Continue to provide eudcaton to general practice teams around the need to accept all New Born nomiations and "B" code new borns. Promote		▪				

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)	
Data Metric Definition	**Data Source**
1.	
2.	
3.	
4.	

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 5 December 2017	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Helen Fraser	
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

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TERMS OF REFERENCE
Immunisation Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

The Immunisation SLA will acknowledge and support the principles of the Treaty of Waitangi.

IMMUNISATION SERVICE LEVEL ALLAINCE

1. BACKGROUND

1.1. The Immunisation Service Level Alliance (ISLA) was established in 2010 with its initial role to develop an Immunisation Service Model (see appendix one) with a focus on fully immunised 2year olds (the health target at the time). Following the development of Service Model the ISLA moved into the implementation stage, focusing on the implementation of the service model. This included the development of an Immunisation Outcomes Framework (see appendix two).

1.2. The ISLA has moved into a monitoring phase of the outcomes framework, which focused on normalising immunisation over a lifetime and reaching specific health and performance targets. The focus of Immunisation SLA has moved to all scheduled immunisation events and any necessary immunisation events to manage outbreaks.

2. PURPOSE

2.1. To be the guardians of the immunisation service across Canterbury ensuring that the service is supported to deliver reduced vaccine preventable disease & increased scheduled vaccination rates within an alliance framework. This includes working towards a variety of health and performance targets including but not limited to:

2.1.1. Achieve 8 month immunisation health target;

2.1.2. Achieve 2 year old and 4 year old immunisation performance target;

2.1.3. Achieve seasonal flu target;

2.1.4. Improve Human Papilloma Virus (HPV) & 11 year old vaccination rates.

2.1.5. Improve Pregnancy Vaccination rates for Pertussis and Influenza

2.2. The Immunisation SLA also has a focus on non scheduled immunisation events as part of an outbreak and the vaccination of the Health Workforce. To achieve this the ISLA needs to provide:

2.2.1. Strategic planning, design, prioritisation and oversee implementation of immunisation service/s across the Canterbury health system;

2.2.2. Recommend how services will be funded using collective decision making and available resources from a range of sources.

3. EXPECTED OUTCOMES OF THE SLA

3.1. The ISLA has developed an immunisation outcomes framework and set key performance targets each year by the Ministry of Health.

4. MANDATE

4.1. ISLA will make recommendations to ALT when considering strategic direction for new models of service implementation or delivery. They will brief ALT on the process of this implementation and delivery.

4.2. Once an approval is made by ALT, decisions on governance and implementation of the above strategy will be made by ISLA.

4.3. Implementation of these recommendations and decisions will be made by the Immunisation Providers Group, or Planning and Funding

4.4. For all ISLA recommendations which involve budgets, advice will be sought from the Planning and Funding Leadership Team prior to the recommendation being submitted to ALT.

5. SCOPE

5.1. In Scope:

5.1.1. Overseeing all immunisation programmes in Canterbury funded by health funding

5.1.2. The Seasonal Influenza Programme both subsidised and non-subsidised

5.1.3. Vaccination of the Health Workforce

5.2. Out of Scope:

5.2.1. Overseeing non-funded immunisation programmes e.g. no subsided immunisation events

6. MEMBERSHIP

6.1. The membership of the ISLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

6.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the ISLA to achieve success;

6.3. The ISLA will review membership annually to ensure it remains appropriate;

6.4. Membership will include a member of the ALT;

6.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;

6.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

7.1. New or replacement members will be identified by the ISLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;

7.2. The chair and deputy chair will, in most cases, be nominated by members of the ISLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the ISLA is:

Name(s)	Perspective/Expertise
Dr Ramon Pink (Chair)	Community and Public Health Background Maori Health Specialist
Geraldine Clemens	Operational understanding of Primary Health Organisation
Helen Fraser	Lead Maternity Carer
Anne Feld	Background in Child Health
Dr Tony Walls	Secondary Care, Immunisation Academic
Dr Alison Wooding	General practice
Dr Sarah Marr (Deputy Chair)	General practice
Anna Harwood	Pharmacist
Donna MacLean	Practice Nursing
Bridget Lester	An operational understand of Planning & Funding / Facilitator

9. ACCOUNTABILITY

9.1. The ISLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ISLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

10.2. The ISLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held 6 weekly while the Immunisation Provider Group meetings and any relevant sub groups will be held monthly;

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The SLA/WS will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Where there is a risk, exception or variance to the SLA/WS work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

12.3. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme Office.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ISLA chair and facilitator;

13.2. Agendas will be circulated no less than 2 days prior to the meeting, as will any material relevant to the agenda;
13.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed;
13.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

14. QUORUM

14.1. The quorum for meetings is half plus one ISLA member from the total number of members of the SLA.

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;
15.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
15.3. The Interests Register will be a standing item on SLA agenda's and be available to the Programme Office on request.

16. REVIEW

16.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

RESPONSIBLITIES

17. RESPONSIBILITY OF THE SLA

17.1. Apply the delegated funding available to lead the required service/service change;
17.2. Establish new work groups to guide service design;
17.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

18. CHAIR

18.1. Lead the team to identify opportunities for service improvement and redesign;
18.2. Lead the development of the service vision and annual work plan;
18.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
18.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
18.5. Provide leadership when implementing the group's outputs;
18.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
18.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
18.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

19. CLINICAL LEADER

19.1. Provide strong clinical leadership across all SLA work activity;
19.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;
20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. PROJECT MANAGER/FACILITATOR

21.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
21.2. Provide or arrange administrative support;
21.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
21.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
21.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
21.6. Keep key stakeholders well informed;
21.7. Proactively meet reporting and planning dates;
21.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
21.9. Identify report and manage risks associated with the SLA work activity.

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;
22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

23. ALT MEMBER

23.1 Act as a communication interface between ALT and the SLA;
23.2 Participate in the development and writing of papers that are submitted to ALT;
23.3 Act as Sponsor of papers to ALT so papers are best represented at the ALT table

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.

- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

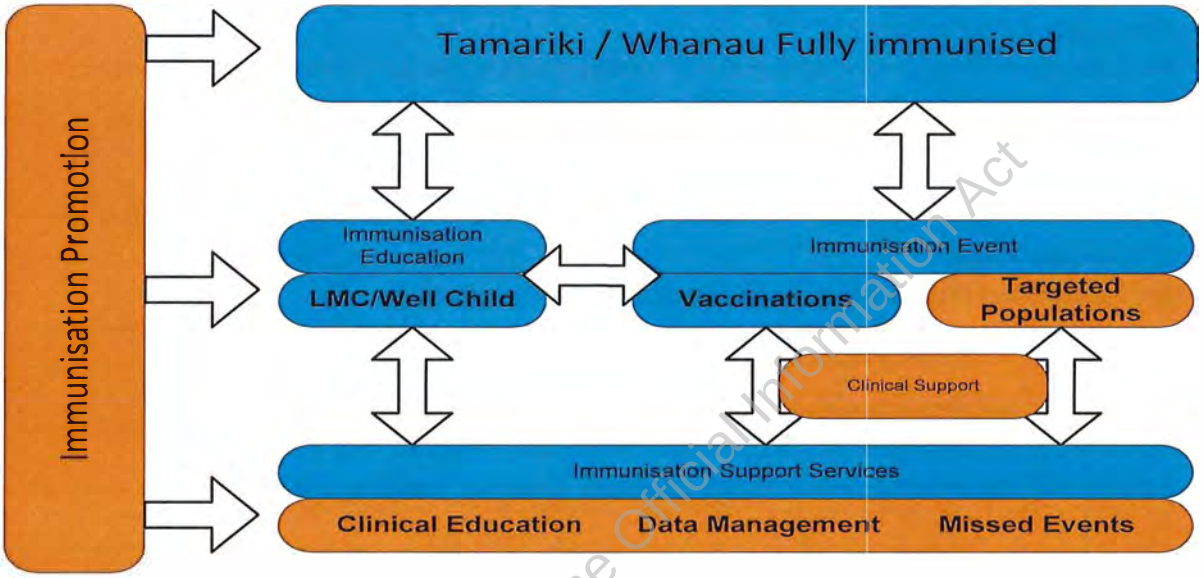
ENDORSEMENT

Date of agreement and finalisation by SLA members: 4 / 12 /2017

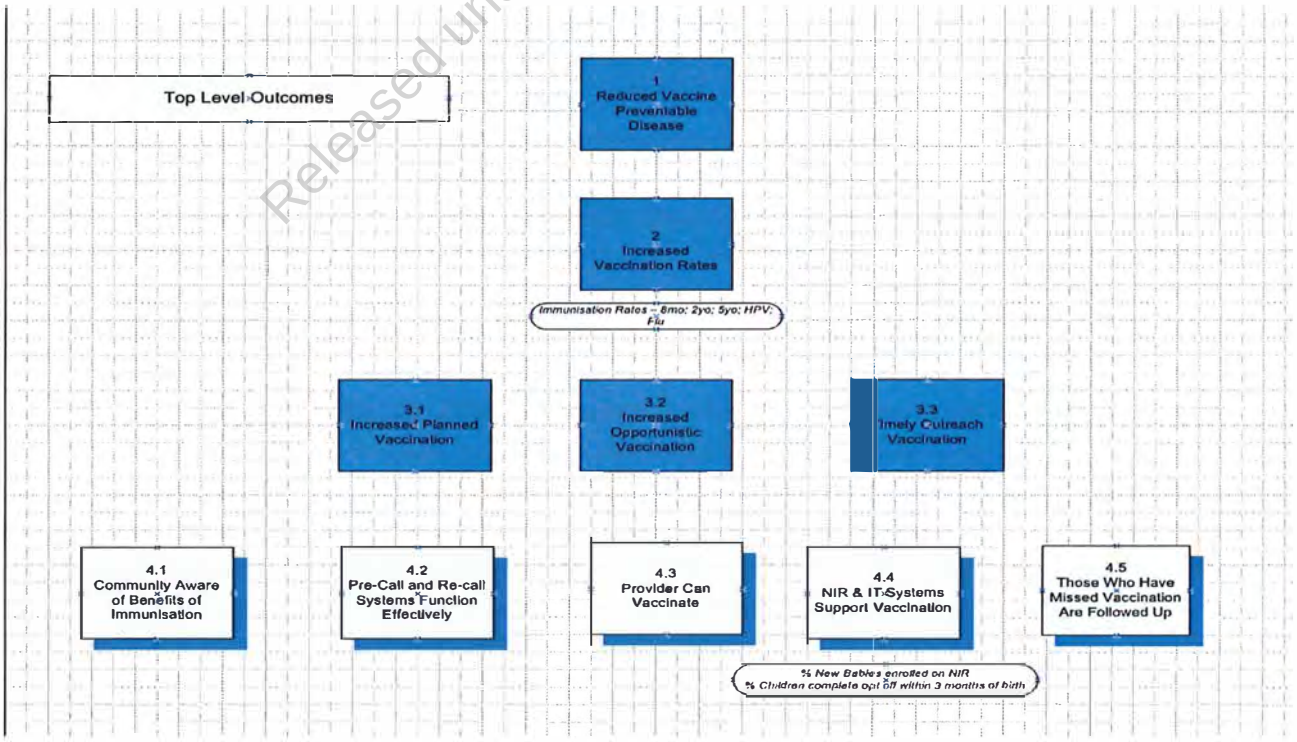
Date of endorsement from ALT

Date of Review: November 2018

Appendix One: Immunisation Service Model



Appendix Two: Immunisation Outcomes Framework



Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 3 April 2018 1:08 p.m.
To: Alison Wooding; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; Helen Fraser; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: FW: Draft ISLA agenda
Attachments: Agenda 3 April ISLA.docx

Importance: High

Hi all

Sorry just noticed that I hadn't got all the papers out to you for today's meeting.

I will run off copies for everyone.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

From: Bridget Lester
Sent: Tuesday, 27 March 2018 12:39 p.m.
To: Ramon Pink <Ramon.Pink@cdhb.health.nz>
Subject: Draft ISLA agenda

Hi Ramon

Please find attached the draft agenda for our ISLA meeting next Tuesday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ Bridget.Lester@cdhb.health.nz
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 3 April, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
	Dr Sarah Marr (Deputy Chair):
Stuart Walker:	Geraldine Clemens:
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.40pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft Minutes 30.1.18 ISLA meetinç
3.	2.50pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	3.00pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2017**	Bridget Lester	Workplan Jan 2018.docx Data report April 2018.docx Decline project 2017.docx
5.	3.30pm	**Cold Chain Escalation Process**	Ramon Pink	Cold Chain Management Resolı
6.	3.40pm	**Operational** • **Interest register** • **Risk Register** • **Terms of Reference Update** • **Meeting Schedule for 2018**	Ramon Pink	Interests register 5.12.17.docx Risk Report 5.12.17.docx Updated TOR ISLA 5.12.17.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
Draft Cold Chain Esscalation Process	**Bridget and Ramon**	**20 fEB**
Draft paper to PHARMAC around the Flu etc		
Share updated TOR with CCN office, and inform them around our declsion not to replace Anne F at present		
Update workplan and send to CCN office		

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH	
Date: 30 January 2018	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Tony Walls, Bridget Lester, Donna MacLean, and Alison Wooding.	
Apology: Anne Feld, Geraldine Clemens, Sarah Marr, Helen Fraser and Stuart Walker	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**			
•	**Confirmation of Minutes**	• Minutes of 5 December 2017 meeting were approved to be sent to the CCN office		Friday 2 February
•	**Previous Actions & Matters Arising**	• **U18 Flu Hurunui Kaikoura (HK) areas –** this paper has yet to be completed. o RCPHO were unable to pull any coverage data. o Agreed to draft a paper and submit to PHARMAC ▪ **Action:** Bridget to draft paper for PHARMAC • Terms of reference were updated and approved to go to the CCN office • Cold Chain – Geraldine pulled the information from the PHO contract would which supports and highlights the need for PHOs to take a lead on supporting their practices who are not Cold Chain compliant. Ramon indicated that the DHB requires a Cold Chain plan to be submitted to the MoH by the 2 February – this is yet to be developed. o **Action – Bridget to see if there is a national template, and draft the DHB plan for this ASAP.**	Bridget and Ramon	20 February 2 February 20 February
•	**ISLA Work plan**	Q2 201718 – progress result • 8month olds – Q2 – achieved at 95%, with a slight increase in Maori to 92%. • 2 year olds – Q2 achieved at 95%, • 5 year olds – Q2 - 93% achieved, with the same coverage for Maori. • HPV – currently sitting at 63% of girls born in 2004 have received dose 2 of HPV. Current target is 70%. There has been some interesting		
•	**2018/19 Work plan discussion**	Further discussion occurred on the 2018/19 CCN Workplan. Updated version attached. **Action: update this and send to CCN office**	Bridget 201819 ISLA workplan.docx	2 Feb
•	**Whooping Cough**	o CDHB has been approached by Plunket as to if we would fund the Pertussis vaccine for their staff, like we do DHB staff and LMCs. o Discussion around the importance of clinical staff working with small children to be vaccinated, and yes this should include all staff in the DHB region not only those who work for the DHB. o **Action - paper to go to PHARMAC to request this, and also to P&F leadership team to see if they will fund this.**	Bridget Ramon Bridget	ASAP

	Item	Discussion/Action	Responsibility	Date due
•	**Operational**	○ Risk Register – No update required ○ Interest Register – updates provided	Bridget	
•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 3 April • Tuesday 5 June • Tuesday 7 August • Tuesday 16 October **note changes in date** • Tuesday 4 December		

December 2 Data

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	285	90	205	1,470	2,050	430	130	210	2,210	2,980	66%	69%	98%	67%	69%	116 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	237	70	182	1,289	1,778						55%	54%	87%	58%	60%	137 (4.6%)	
	HPV-3 Quadrivalent	151	37	117	995	1,300						35%	28%	56%	45%	44%	144 (4.8%)	
Total	HPV-1 Quadrivalent	285	90	205	1,470	2,050	430	130	210	2,210	2,980	66%	69%	98%	67%	69%	116 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	237	70	182	1,289	1,778						55%	54%	87%	58%	60%	137 (4.6%)	
	HPV-3 Quadrivalenl	151	37	117	995	1,300						35%	28%	56%	45%	44%	144 (4.8%)	

January 9 Data

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	252	92	193	1,524	2,061	430	130	210	2,210	2,980	59%	71%	92%	69%	69%	117 (3.9%)	0 (0.0%)
	HPV-2 Quadrivalent	215	73	177	1,419	1,884						50%	56%	84%	64%	63%	138 (4.6%)	
	HPV-3 Quadrivalent	136	37	113	1,021	1,307						32%	28%	54%	46%	44%	144 (4.8%)	
2005	HPV-1 Quadrivalent	157	50	167	1,127	1,501	440	120	230	2,040	2,830	36%	42%	73%	55%	53%	81 (2.9%)	1 (0.0%)
	HPV-2 Quadrivalent	112	42	137	852	1,143						25%	35%	60%	42%	40%	71 (2.5%)	
	HPV-3 Quadrivalent	61	21	64	484	630						14%	18%	28%	24%	22%	68 (2.4%)	
Total	HPV-1 Quadrivalent	409	142	360	2,651	3,562	870	250	440	4,250	5,810	47%	57%	165%	62%	61%	198 (3.4%)	1 (0.0%)
	HPV-2 Quadrivalent	327	115	314	2,271	3,027						38%	46%	144%	53%	52%	209 (3.6%)	
	HPV-3 Quadrivalent	197	58	177	1,505	1,937						23%	23%	82%	35%	33%	212 (3.6%)	

Maori number vaccinated dropped from 285 to 252 in the month for dose 1 and 237 to 215 for dose 2. Not sure why the number have changed, either the child's ethnicity may have been updated or they may have left the DHB?????

CCN Immunisation Service Level Alliance WORK PLAN 2018/19

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY CLINICAL LEAD	 PROJECT LEAD	Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we are trying to achieve?*
SECTION ONE: Priority Actions toward Transformational Change and/or Impact towards improved System Outcomes including National Targets requiring action							
1. Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy	1.1 Support LMC to promotion Immunisation 1.1.1 Hold a focus group with LMCs to determine what they need 1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.1.3 Do a stocktake of resources to determine what the gaps are 1.2 General Practice Teams are supported to vaccinate 1.2.1 Educated around the importance of Pregnancy Vaccinations 1.2.2 Education how to load the events on the NIR 1.3 Work with the MoH to ensure regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme	On going Q1 Q3 Q1 Ongoing Q3 Q3 On going	▪ 50% of women are vaccinations for Pertussis during Pregnancy		Ramon Pink Helen Fraser	Bridget Lester	Canterbury System Outcome
1. Reduce the number of declined immunisation event in our region, against the immunisation schedule	1.1. Develop a more structured general practice decline process	Q2	Decrease in child hood immunisation declines – compared to 2017 year		Ramon Pink	Bridget Lester	*Contribute to National Health and Performance Targets*

OBJECTIVE *Succinct description of what you are aiming to achieve e.g. Integrated Systems or Rural Sustainability or Targeted Workforce Development or Improved Oral Health for 0-18 etc.*	ACTIONS *What succinct, measurable Actions will we put in place to address the stated Objective THIS YEAR...* *Code Equity/Access Actions with EOA* *Code System Level Measure Actions with SLM*	Q *When will the action be completed*	MEASURE OF SUCCESS/TARGET/ BENCHMARK *How will we know we have been successful? How will we measure our success in terms of improved outcomes/data metric? What is the benchmark/Target*	MILESTONE *Where we can't apply a metric, how will we know the action has been completed*	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	Canterbury Health SYSTEM OUTCOME *What Canterbury System Outcome are we contributing too?* *What is the outcome we ore trying to achieve?*
	1.2. Work with C&PH to better understand why Maori are declining immunisation.	Q2	Reduction in the Maori decline rate				*EOA*
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor							
1. ***Timely Childhood Immunisations***	Continue to monitor all 8months, 2 year olds and 5 years olds to ensure they are fully vaccinated	Ongoing each quarter	▪ 95% of 8month olds, year olds and 5 year olds are fully vaccination.		Ramon Pink	Bridget Lester	*National Health and Performance Target*
2. ***Influenza Vaccination Programme***	3. Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations. 4. Work with DHB Occupation health to Staff influenza vaccinations loaded on the NIR (esp for staff 65 or over)	Q2, Q3	▪ 75% of those 65 of over are vaccinated.		Ramon Pink	Bridget Lester	*SLM and Performance Target*
5. ***HPV and Tdap Programme***	2.1 Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8	On going	▪ 75% of girls born in 2006 are fully vaccinated for HPV ▪ 85% of children born in 2006 are fully vaccinated for Tdap		Ramon Pink	Bridget Lester	*Performance Target*
6. ***General Practice New-born Enrolment***	3.1 Work with the PHOs to continue to provide education to general practice teams around the need to accept all New Born nominations and "B" code new borns. Promote	On going	▪ 95% of New-borns are enrolled with General Practice at 3 months of age		Ramon Pink	Bridget Lester	*SLM*

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)

Data Metric Definition	Data Source
1.	
2.	
3.	
4.	

IMMUNISATION SERVICE LEVEL ALLIANCE 2015/16 WORKPLAN - April 2018 update

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	Around 98% of babies are enrolled at birth. Data update included in data report Data update included in data report Q2
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	95% 8month olds, 96% 2year olds and 93% 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Secondary School HPV Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	In data report – Maori issues clarified – there has been some incorrectly coding nationally which was sorted out – but reduce the overall Maori coverage. Reports on Boys now available – in data report
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Vaccine not yet in country – looking at how to load DHB over 65s in NIR.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Service Level Alliance and Immunisation Providers Groups Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan. Use the Maori Keke and other key tools to support improved Immunisation coverage	Q1-Q4 Q3 Q4	• Canterbury DHB is represented at regional and national forums. • Annual update of Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Not currently reported Yes Progression Yes

our health system

Key Performance Indicators and Childhood Immunisation Reporting

January 2018

Immunisation Reporting Programme

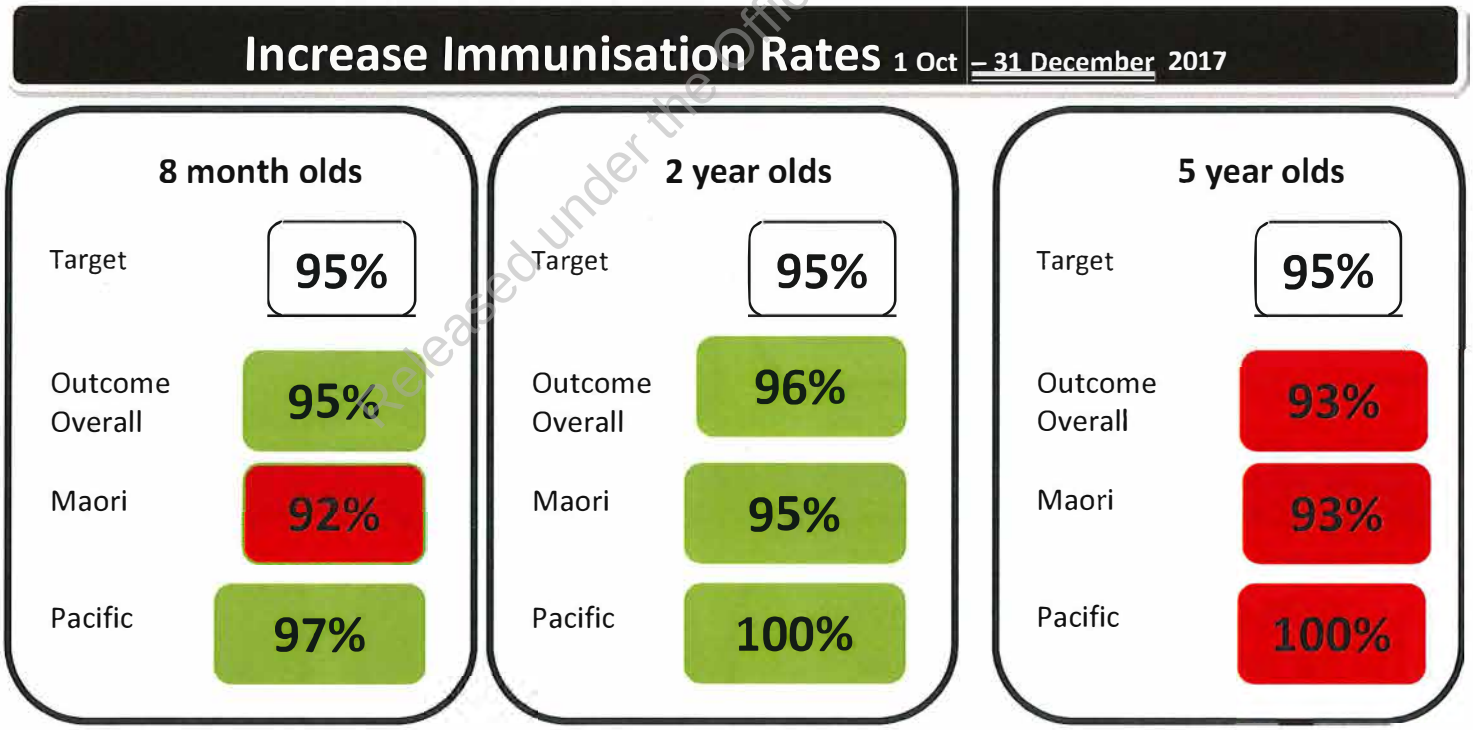
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting. "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 27 March 2018

Fully Immunised 8 month olds – DHB LEVEL

Q1 2017/18 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress including pending	Q4 2017/18 Progress including pending
95% fully	95% fully	94.9%	86% fully
1% overdue	1% overdue	.19% could reach	9.5% could
		4.9% can't	3.7% can't

Fully Immunised Two year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
95% fully	95% fully	93%	93.7% fully
1.1% overdue	1% overdue		1.5% overdue
		6.5% can't	4.7% can't

Fully Immunised Four year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
93% fully	93% fully	92.7% fully	91% fully
1.8%	1.7% overdue	.3% overdue	3.7% overdue
		5.5% can't	4.6% can't

Fully Immunised 8month, two and five year - PHO LEVEL 31 December 2017

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	95%	96.5%	98%	93.6%	91%	97%
Pegasus	95%	96.5%	96%	94.4%	94%	94%
Rural Canterbury	94%	94.3%	95%	93.5%	93%	92%

Pre teen Immunisations

DHB: Canterbury		Number of females received HPV dose (numerator)					Estimated eligible population -female* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2005	HPV-1	181	56	194	1,269	1,700	440	120	230	2,040	2,830	41%	47%	84%	62%	60%	83 (2.9%)	1 (0.0%)
	HPV-final	101	35	126	821	1,083						23%	29%	55%	40%	38%	61 (2.2%)	
2006	HPV-1	188	63	172	1,064	1,487	470	130	250	2,110	2,970	40%	48%	69%	50%	50%	67 (2.3%)	1 (0.0%)
	HPV-final	60	19	57	363	499						13%	15%	23%	17%	17%	42 (1.4%)	
2007	HPV-1	25	7	29	144	205	560	130	300	2,100	3,080	4%	5%	10%	7%	7%	12 (0.4%)	0 (0.0%)
	HPV-final	0	1	3	6	10						0%	1%	1%	0%	0%	5 (0.2%)	
Total	HPV-1	394	126	395	2,477	3,392	1,470	380	780	6,250	8,880	27%	33%	163%	40%	38%	162 (1.8%)	2 (0.0%)
	HPV-final	161	55	186	1,190	1,592						11%	14%	79%	19%	18%	108 (1.2%)	

DHB: Canterbury		Number of males received HPV dose (numerator)					Estimated eligible population -male* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2005	HPV-1	140	49	133	875	1,197	430	120	220	2,210	2,970	33%	41%	60%	40%	40%	28 (0.9%)	()
	HPV-final	71	27	69	437	604						17%	23%	31%	20%	20%	10 (0.3%)	
2006	HPV-1	172	63	159	1,112	1,506	500	140	250	2,210	3,110	34%	45%	64%	50%	48%	67 (2.2%)	1 (0.0%)
	HPV-final	49	20	54	334	457						10%	14%	22%	15%	15%	37 (1.2%)	
2007	HPV-1	27	7	35	161	230	590	140	310	2,220	3,250	5%	5%	11%	7%	7%	12 (0.4%)	0 (0.0%)
	HPV-final	1	0	4	5	10						0%	0%	1%	0%	0%	4 (0.1%)	
Total	HPV-1	339	119	327	2,148	2,933	1,520	400	780	6,640	9,330	22%	30%	135%	32%	31%	107 (1.1%)	1 (0.0%)
	HPV-final	121	47	127	776	1,071						8%	12%	54%	12%	11%	51 (0.5%)	

DHB: Canterbury		Total Number received HPV dose (numerator)					Estimated eligible population -total * (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2005	HPV-1	321	105	327	2,144	2,897	860	240	450	4,250	5,800	37%	44%	73%	50%	50%	111 (1.9%)	1 (0.0%)
	HPV-final	172	62	195	1,258	1,687						20%	26%	43%	30%	29%	71 (1.2%)	
2006	HPV-1	360	126	331	2,176	2,993	970	280	500	4,330	6,070	37%	45%	66%	50%	49%	134 (2.2%)	2 (0.0%)
	HPV-final	109	39	111	697	956						11%	14%	22%	16%	16%	79 (1.3%)	
2007	HPV-1	52	14	64	305	435	1,140	270	610	4,310	6,340	5%	5%	10%	7%	7%	24 (0.4%)	0 (0.0%)
	HPV-final	1	1	7	11	20						0%	0%	1%	0%	0%	9 (0.1%)	
Total	HPV-1	733	245	722	4,625	6,325	2,970	790	1,560	12,890	18,210	25%	31%	149%	36%	35%	269 (1.5%)	3 (0.0%)
	HPV-final	282	102	313	1,966	2,663						9%	13%	67%	15%	15%	159 (0.9%)	

Pregnancy Vaccinations

Year	Deliveries	Tdap in Pregnancy given	Percentage
2017	5792	3094	53%

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter Two 2017/18
Newborns Born in the Following Period: 20 August 2017 to 19 November 2017
As at Quarter One 2018 (January 2018)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	271	931	1,468	63%	18
Bay of Plenty	164	567	792	72%	8
Canterbury	426	1,245	1,655	75%	4
Capital and Coast	180	632	930	68%	12
Counties Manukau	357	1,401	2,095	67%	14
Hawkes Bay	164	373	522	71%	9
Hutt	115	384	503	76%	2
Lakes	27	239	372	64%	16
MidCentral	168	390	556	70%	10
Nelson Marlborough	69	254	396	64%	17
Northland	173	400	606	66%	15
South Canterbury	35	116	162	72%	7
Southern	165	644	949	68%	13
Tairawhiti	50	112	160	70%	11
Taranaki	103	279	375	74%	5
Waikato	275	911	1,449	63%	19
Wairarapa	39	105	143	73%	6
Waitemata	346	1,222	1,978	62%	20
West Coast	27	72	94	77%	1
Whanganui	51	151	199	76%	3
Overseas or Unknown			7	0%	
Total	**3,205**	**10,428**	**15,411**	**68%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter Two 2017/18
Newborns Born in the Following Period: 20 August 2017 to 19 November 2017

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	112	1,468	92%	19
Bay of Plenty	37	792	95%	11
Canterbury	45	1,655	97%	8
Capital and Coast	19	930	98%	5
Counties Manukau	123	2,095	94%	13
Hawkes Bay	14	522	97%	7
Hutt	22	503	96%	10
Lakes	18	372	95%	12
MidCentral	7	556	99%	2
Nelson Marlborough	7	396	98%	4
Northland	24	606	96%	9
South Canterbury	4	162	98%	6
Southern	13	949	99%	3
Tairawhiti	10	160	94%	15
Taranaki	26	375	93%	16
Waikato	104	1,449	93%	17
Wairarapa	0	143	100%	1
Waitemata	148	1,978	93%	18
West Coast	10	94	89%	20
Whanganui	12	199	94%	14
Overseas or Unknown	2	7	71%	
Total	**757**	**15,411**	**95%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter Two 2017/18
Newborns Born in the Following Period: 20 August 2017 to 19 November 2017
As at Quarter One 2018 (January 2018)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	279	410	68%	25
Auckland PHO Limited	117	176	66%	27
Central Primary Health Organisation	380	523	73%	18
Christchurch PHO Limited	85	97	88%	3
Compass Health - Capital and Coast	555	847	66%	28
Compass Health - Wairarapa	109	148	74%	15
Comprehensive Care Ltd (Waitemata)	587	819	72%	20
Cosine Primary Care Network Trust	82	95	86%	4
East Health Trust	227	278	82%	7
Eastern Bay Primary Health Alliance	138	161	86%	5
Hauraki PHO	371	567	65%	29
Health Hawke's Bay Limited	374	514	73%	17
Kimi Hauora Wairau (Marlborough PHO Trust)	94	135	70%	22
Manaia Health PHO Limited	257	340	76%	14
National Hauora Coalition Limited	238	326	73%	16
Nelson Bays Primary Health	159	250	64%	32
Nga Mataapuna Oranga Limited	40	47	85%	6
Ngati Porou Hauora Charitable Trust	23	41	56%	35
Ora Toa PHO Limited	62	63	98%	1
Pegasus Health (Charitable) Limited	1,027	1,285	80%	11
Pinnacle Midlands Health Network - Lakes	86	127	68%	26
Pinnacle Midlands Health Network - Tairawhiti	89	110	81%	8
Pinnacle Midlands Health Network - Taranaki	274	340	81%	9
Pinnacle Midlands Health Network - Waikato	525	754	70%	23
Procare Networks Limited	1,755	2,698	65%	30
Rotorua Area Primary Health Services Limited	161	252	64%	31
Rural Canterbury PHO	132	227	58%	34
South Canterbury Primary and Community	117	163	72%	19
Te Awakairangi Health Network	320	400	80%	10
Te Tai Tokerau PHO Ltd	129	217	59%	33
Total Healthcare Charitable Trust	400	521	77%	13
WellSouth Primary Health Network	645	934	69%	24
West Coast PHO	72	81	89%	2
Western Bay of Plenty Primary Health Organisati	375	525	71%	21
Whanganui Regional PHO	144	183	79%	12
Unknown or Blank		757	0%	
Total	**10,428**	**15,411**	**68%**	

Number of Newborns Enrolled Within Three Months by DHB of Domicile and Ethnicity - Quarter Two 2017/18
Newborns Born in the Following Period: 20 August 2017 to 19 November 2017
As at Quarter One 2018 (January 2018)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Auckland	101	171	59%	153	268	57%	677	1,029	66%
Bay of Plenty	206	301	68%	N/A	N/A	N/A	361	491	74%
Canterbury	172	248	69%	51	83	61%	1,022	1,324	77%
Capital and Coast	89	154	58%	60	91	66%	483	685	71%
Counties Manukau	280	417	67%	400	624	64%	721	1,054	68%
Hawkes Bay	130	203	64%	35	45	78%	208	274	76%
Hutt	87	137	64%	42	57	74%	255	309	83%
Lakes	130	191	68%	N/A	N/A	N/A	109	181	60%
MidCentral	106	188	56%	N/A	N/A	N/A	284	368	77%
Nelson Marlborough	38	93	41%	N/A	N/A	N/A	216	303	71%
Northland	194	327	59%	N/A	N/A	N/A	206	279	74%
South Canterbury	22	37	59%	N/A	N/A	N/A	94	125	75%
Southern	107	157	68%	N/A	N/A	N/A	537	792	68%
Tairawhiti	76	115	66%	N/A	N/A	N/A	36	45	80%
Taranaki	72	115	63%	N/A	N/A	N/A	207	260	80%
Waikato	299	501	60%	29	47	62%	583	901	65%
Wairarapa	28	45	62%	N/A	N/A	N/A	77	98	79%
Waitemata	169	320	53%	120	215	56%	933	1,443	65%
West Coast	14	22	64%	N/A	N/A	N/A	58	72	81%
Whanganui	76	91	84%	N/A	N/A	N/A	75	108	69%
Overseas or Unknown		4	0%	N/A	N/A	N/A		3	0%
Total	**2,396**	**3,837**	**62%**	**890**	**1,430**	**62%**	**7,142**	**10,144**	**70%**

Number of Newborns Enrolled Within Three Months by PHO and Ethnicity - Quarter Two 2017/18
Newborns Born in the Following Period: 20 August 2017 to 19 November 2017
As at Quarter One 2018 (January 2018)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newboms from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Alliance Health Plus Trust	55	72	76%	90	157	57%	134	181	74%
Auckland PHO Limited	12	15	80%	N/A	N/A	N/A	105	161	65%
Central Primary Health Organisation	101	175	58%	N/A	N/A	N/A	279	348	80%
Christchurch PHO Limited	15	19	79%	N/A	N/A	N/A	70	78	90%
Compass Health - Capital and Coast	63	124	51%	N/A	N/A	N/A	492	723	68%
Compass Health - Wairarapa	30	46	65%	N/A	N/A	N/A	79	102	77%
Comprehensive Care Ltd (Waitemata)	53	95	56%	N/A	N/A	N/A	534	724	74%
Cosine Primary Care Network Trust	11	14	79%	N/A	N/A	N/A	71	81	88%
East Health Trust	16	19	84%	N/A	N/A	N/A	211	259	81%
Eastern Bay Primary Health Alliance	84	102	82%	N/A	N/A	N/A	54	59	92%
Hauraki PHO	153	252	61%	N/A	N/A	N/A	218	315	69%
Health Hawke's Bay Limited	130	203	64%	N/A	N/A	N/A	244	311	78%
Kimi Hauora Wairau (Marlborough PHO Trust)	17	38	45%	N/A	N/A	N/A	77	97	79%
Manaia Health PHO Limited	100	155	65%	N/A	N/A	N/A	157	185	85%
National Hauora Coalition Limited	53	73	73%	N/A	N/A	N/A	185	253	73%
Nelson Bays Primary Health	20	50	40%	N/A	N/A	N/A	139	200	70%
Nga Mataapuna Oranga Limited	32	34	94%	N/A	N/A	N/A	8	13	62%
Ngati Porou Hauora Charitable Trust	20	34	59%	N/A	N/A	N/A	3	7	43%
Ora Toa PHO Limited	26	34	76%	N/A	N/A	N/A	36	29	124%
Pegasus Health (Charitable) Limited	142	191	74%	N/A	N/A	N/A	885	1,094	81%
Pinnacle Midlands Health Network - Lakes	40	55	73%	N/A	N/A	N/A	46	72	64%
Pinnacle Midlands Health Network - Tairawhiti	56	74	76%	N/A	N/A	N/A	33	36	92%
Pinnacle Midlands Health Network - Taranaki	69	103	67%	N/A	N/A	N/A	205	237	86%
Pinnacle Midlands Health Network - Waikato	139	192	72%	N/A	N/A	N/A	386	562	69%
Procare Networks Limited	300	467	64%	N/A	N/A	N/A	1,455	2,231	65%
Rotorua Area Primary Health Services Limited	97	151	64%	N/A	N/A	N/A	64	101	63%
Rural Canterbury PHO	15	24	63%	N/A	N/A	N/A	117	203	58%
South Canterbury Primary and Community	22	36	61%	N/A	N/A	N/A	95	127	75%
Te Awakairangi Health Network	76	119	64%	N/A	N/A	N/A	244	281	87%
Te Tai Tokerau PHO Ltd	92	158	58%	N/A	N/A	N/A	37	59	63%
Total Healthcare Charitable Trust	80	96	83%	N/A	N/A	N/A	320	425	75%
WellSouth Primary Health Network	108	153	71%	N/A	N/A	N/A	537	781	69%
West Coast PHO	14	21	67%	N/A	N/A	N/A	58	60	97%
Western Bay of Plenty Primary Health Organisat	81	128	63%	N/A	N/A	N/A	294	397	74%
Whanganui Regional PHO	74	88	84%	N/A	N/A	N/A	70	95	74%
Unknown or Blank		227	0%	N/A	N/A	N/A		530	0%
Total	**2,396**	**3,837**	**62%**	**90**	**157**	**57%**	**7,942**	**11,417**	**70%**

201718 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,603	1,382	86. %	842	756	90. %	255	192	75. %	65	53	82. %	270	252	93. %	171	129	75. %	21 (1)	1.3 (0.1) %	37	2.3 %
8 Month	1,593	1,508	95. %	865	829	96. %	232	214	92. %	65	63	97. %	268	263	98. %	163	139	85. %	19 (0)	1.2 (0.0) %	45	2.8 %
12 Month	1,597	1,501	94. %	883	843	95. %	230	212	92. %	80	79	99. %	261	252	97. %	143	115	80. %	17 ()	1.1 (0.0) %	53	3.3 %
18 Month	1,551	1,348	87. %	884	791	89. %	203	163	80. %	71	58	82. %	262	238	91. %	131	98	75. %	15 ()	1.0 (0.0) %	53	3.4 %
24 Month	1,579	1,511	96. %	893	860	96. %	222	212	95. %	83	83	100. %	227	224	99. %	154	132	86. %	11 ()	0.7 (0.0) %	43	2.7 %
5 Year	1,718	1,598	93. %	997	939	94. %	217	201	93. %	69	69	100. %	250	233	93. %	185	156	84. %	16 (0)	0.9 (0.0) %	74	4.3 %
12 Year	747	475	64. %	473	323	68. %	95	61	64. %	24	15	63. %	58	28	48. %	97	48	49. %	16 (0)	2.1 (0.0) %	40	5.4 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,603	1,382	86. %	332	279	84. %	338	294	87. %	283	244	86. %	260	223	86. %	200	173	87. %	190	169	89. %
8 Month	1,593	1,508	95. %	365	333	91. %	310	301	97. %	300	290	97. %	236	223	94. %	197	181	92. %	185	180	97. %
12 Month	1,597	1,501	94. %	343	311	91. %	318	300	94. %	269	252	94. %	266	255	96. %	212	204	96. %	189	179	95. %
18 Month	1,551	1,348	87. %	358	304	85. %	306	270	88. %	289	253	88. %	237	202	85. %	173	147	85. %	188	172	91. %
24 Month	1,579	1,511	96. %	350	330	94. %	288	274	95. %	318	302	95. %	226	221	98. %	220	212	96. %	177	172	97. %
5 Year	1,718	1,598	93. %	415	372	90. %	347	330	95. %	313	289	92. %	230	215	93. %	198	188	95. %	215	204	95. %
12 Year	747	475	64. %	246	147	60. %	160	110	69. %	126	87	69. %	91	47	52. %	54	28	52. %	70	56	80. %

4 year old declines 2017 year

In total 294 children had their 4 year old immunisations declined, this was an increased from 250 children in the 2015/16 year. Of these 88 children had all events declined. In regards to specific immunisations, the following was identified

- PCV declines - 133 had declined all PCV, While, 205 only the 15month PCV
- MMR - 199 had 4 year old MMR declined, while 135 had declined both MMRs. 15 had declined MMR15 but had the 4 year old, this is down on the 29 children last period.
- HIB - 178 children had their HIB15 declined as well as other immunisations, such as MMR, 4 year old imms, etc, however a small group of only 24 children had the HIB15 declined, but had their MMRs.
- 4 year old immunisations - 31 children had their 4year old immunisation declined, but where fully vaccinated for all other immunisations.
- 15month immunisations - 141 children had their 15month immunisations declined however they were also declining other events.
    - Only two children had only their 15months declined.
    - 17 declined their 15m and 4 years but had the rest
- 8 month immunisations - 22 had their 6 week and 3 months immunisation, and then started to decline.

Below are a list of practices with more than 4 four year olds having declines recorded in the 2017 year. This would be a good group to approach with supporting information around declines.

Practice Name	Declined
Helios Health Limited	63
Durham Health	16
New Brighton Health Care	11
Riccarton Clinic	7
Doctors On Riccarton	6
Linwood Medical Centre	5
Barrington Medical Centre	5
Main North Road Medical Centre	5
Fendalton Medical Centre	5
Allenton Medical Centre	5
Greers Road Medical Centre	5
Pegasus Medical Centre	5
Halswell Health	5
Harewood Medical Centre	5
Woodham Road Clinic	5
Kaiapoi Medical Centre	4
Amberley Medical Centre	4
Christchurch South Health Centre	4
Rolleston Central Health	4
Lincoln University Student Health and Support	4
Marshlands Family Health Centre	4

Canterbury and West Coast DHB

Cold Chain Management Resolution Pathway

1. Background

Cold Chain Accreditation (CCA) is an audit tool used to assess the cold chain management practices and processes of immunisation providers to ensure they meet the standards for safe vaccine storage and transportation before offering an immunisation programme. To achieve CCA, the provider first conducts a self-assessment and then an approved CCA reviewer conducts a review.

All immunisation providers who store vaccines all year round must have current CCA. This includes but is not limited to general practices, outreach immunisation services, public health units, community pharmacies, corrections facilities, travel clinics, emergency medical services, public and private hospital wards and departments/pharmacies, and occupational health services.

The CCA reviewer will assess the provider's past performance and current cold chain knowledge. Those findings help to determine the length of time CCA is awarded for; other considerations are the stability of the provider's workforce, the age of the equipment and the provider's cold chain history. It can be awarded for up to three years.

If a provider is compliant with all CCA Audit requirements – CCA can be issued for up to 3 years, with the expiry date reflective of the age of the fridge.

If a provider fails to meet the CCA/CCC requirements, the CCA reviewer will work with the provider to develop a remedial plan for the provider to achieve the requirements. The provider may administer vaccines while the remedial plan is in place, if the required temperature range of +2°C to +8°C can be maintained at all times and the provider works within the agreed timeframes outlined in the plan.

The maximum recommended timeframe for completing the remedial plan is three months.

For any new or short-term providers, Cold Chain Compliance (CCC) can be issued for a maximum of 9 months. Providers must comply with all requirements of Cold Chain Accreditation, with the expectation of providing 3 months temperature records. If a provider is unable to meet these requirements, a remedial plan will be agreed on, however no immunisation scan be provided until the requirements are met.

If the provider is not willing to work on a remedial plan, or does not keep to the agreed timeframe, the CCA reviewer must notify the PHO, DHB, and medical officer or Medicines Control (in the case of a pharmacy).

2. Purpose

The purpose of this plan is to document the steps required if a practice is does not achieve CCA.

3. Escalation Process

If a CCA reviewer identifies a provider who is non-complaint with CCA the following steps will be followed

Step One: The CCA reviewer and the provider will agree on a **remedial plan**, to be completed within 3 months of the non-compliance being identified. At the end of the 3 months the provider will be re-audited and

- If compliant, CCA will be awarded *for XXX years*, with the expiry date reflective of the age of the fridge.

- If the provider remains non-compliant, the CCA Reviewer informs the *DHB Immunisation Programme Manager and Medical Officer of Health,* with a recommendation about the likely resolution.

Step Two: Resolution is Imminent – the DHB will write to the provider confirming the extended remedial period and consequence of further non-compliance. The provider will be re-audited at the end of the remedial period.

Step Three: Where there is a **Lack of Progress or engagement** the Escalation Process will be activated. This will included the:

- DHB will write to the Provider to inform them of
  - Their referral to the *Escalation Panel (Should this be ISLA?)*
  - The requirement to demonstrate compliance and the consequences of the final remedial period
  - The provider will be provided with a due date for making a response to the panel.
  - The provider will be informed that during this period they must
    - Send weekly data logger reports to the Cold Chain Accreditation Reviewer for assessment
    - Hold no more than 2 weeks stock of vaccines.
- DHB will write to the supply chain informing of the supply restrictions
- The Escalation Panel will meet before the end of the remedial period to consider the evidence provider and make a recommendation to the DHB as per table one: Escalation Panel Recommendations below. An extension will be given if the panel meeting is delayed.

Step Four: The recommendation will be referred to the Ministry of Health for confirmation before the DHB's final decision.

Table One: Escalation Panel Recommendations

Step	Outcome
Re-audit	Response satisfactory – the provider is referred back to the CCA Review for re-audit
Endorsed Remedial	Where the provider requires an extension to the remedial period due to circumstances beyond their control, this will be endorsed by the DHB and the provider will be referred back to the CCA Reviewer for re-adult at the end of the extension remedial period. The outcome will be monitored by the Escalation panel.
Limited CCA	DHB writes to the provider confirming a limited CCA: • Reduce vaccine supply and/or withheld flu vaccine supply • 3 months CCA remedial period and re-audit, the outcome will be monitored by the Escalation panel • Supply chain informed
Revoke CCA	• PHO develops a plan for immunising children • DHB writes to provider informing them of revoked CCA • Cold Chain Reviewer / Imms Coordinator works with the provider to removed vaccines • Supply chain informed.

Canterbury and West Coast DHB
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Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 5 December 2017	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Chair TKOP Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anne Feld	Board Member for Early Start , Christchurch Member of Christchurch Brainwave Trust Member of the Professional Conduct Committee for NZ Nursing Council. Associate Member of the South Island Nurse Executives. Member of the Paediatric Society of NZ. Part of the Parent Education and Nursing Special Interest Groups. Member of the Nurses for Children and Young People Aotearoa Member of Child and Youth Committee, part of Canterbury Clinical Network
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Helen Fraser	
Geraldine Clemens	Primary Health Care Manager RCPHO MOH listed Health Quality Auditor Member of FFP SLA and Enhanced Capitation working group(regional) Member IPG (regional) Member of IPIF Audit Working Group (National) Private Co. Director (non health related)
Bridget Lester	Employee of CDHB, Planning and Funding

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

TERMS OF REFERENCE
Immunisation Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

The Immunisation SLA will acknowledge and support the principles of the Treaty of Waitangi.

IMMUNISATION SERVICE LEVEL ALLAINCE

1. BACKGROUND

1.1. The Immunisation Service Level Alliance (ISLA) was established in 2010 with its initial role to develop an Immunisation Service Model (see appendix one) with a focus on fully immunised 2year olds (the health target at the time). Following the development of Service Model the ISLA moved into the implementation stage, focusing on the implementation of the service model. This included the development of an Immunisation Outcomes Framework (see appendix two).

1.2. The ISLA has moved into a monitoring phase of the outcomes framework, which focused on normalising immunisation over a lifetime and reaching specific health and performance targets. The focus of Immunisation SLA has moved to all scheduled immunisation events and any necessary immunisation events to manage outbreaks.

2. PURPOSE

2.1. To be the guardians of the immunisation service across Canterbury ensuring that the service is supported to deliver reduced vaccine preventable disease & increased scheduled vaccination rates within an alliance framework. This includes working towards a variety of health and performance targets including but not limited to:

2.1.1. Achieve 8 month immunisation health target;

2.1.2. Achieve 2 year old and 4 year old immunisation performance target;

2.1.3. Achieve seasonal flu target;

2.1.4. Improve Human Papilloma Virus (HPV) & 11 year old vaccination rates.

2.1.5. Improve Pregnancy Vaccination rates for Pertussis and Influenza

2.2. The Immunisation SLA also has a focus on non scheduled immunisation events as part of an outbreak and the vaccination of the Health Workforce. To achieve this the ISLA needs to provide:

2.2.1. Strategic planning, design, prioritisation and oversee implementation of immunisation service/s across the Canterbury health system;

2.2.2. Recommend how services will be funded using collective decision making and available resources from a range of sources.

3. EXPECTED OUTCOMES OF THE SLA

3.1. The ISLA has developed an immunisation outcomes framework and set key performance targets each year by the Ministry of Health.

4. MANDATE

4.1. ISLA will make recommendations to ALT when considering strategic direction for new models of service implementation or delivery. They will brief ALT on the process of this implementation and delivery.

4.2. Once an approval is made by ALT, decisions on governance and implementation of the above strategy will be made by ISLA.

4.3. Implementation of these recommendations and decisions will be made by the Immunisation Providers Group, or Planning and Funding

4.4. For all ISLA recommendations which involve budgets, advice will be sought from the Planning and Funding Leadership Team prior to the recommendation being submitted to ALT.

5. SCOPE

5.1. In Scope:

5.1.1. Overseeing all immunisation programmes in Canterbury funded by health funding

5.1.2. The Seasonal Influenza Programme both subsidised and non-subsidised

5.1.3. Vaccination of the Health Workforce

5.2. Out of Scope:

5.2.1. Overseeing non-funded immunisation programmes e.g. no subsided immunisation events

6. MEMBERSHIP

6.1. The membership of the ISLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

6.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the ISLA to achieve success;

6.3. The ISLA will review membership annually to ensure it remains appropriate;

6.4. Membership will include a member of the ALT;

6.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;

6.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

7.1. New or replacement members will be identified by the ISLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;

7.2. The chair and deputy chair will, in most cases, be nominated by members of the ISLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the ISLA is:

Name(s)	Perspective/Expertise
Dr Ramon Pink (Chair)	Community and Public Health Background Maori Health Specialist
Geraldine Clemens	Operational understanding of Primary Health Organisation
Helen Fraser	Lead Maternity Carer
Anne Feld	Background in Child Health
Dr Tony Walls	Secondary Care, Immunisation Academic
Dr Alison Wooding	General practice
Dr Sarah Marr (Deputy Chair)	General practice
Anna Harwood	Pharmacist
Donna MacLean	Practice Nursing
Bridget Lester	An operational understand of Planning & Funding / Facilitator

9. ACCOUNTABILITY

9.1. The ISLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ISLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

10.2. The ISLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held 6 weekly while the Immunisation Provider Group meetings and any relevant sub groups will be held monthly;

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The SLA/WS will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Where there is a risk, exception or variance to the SLA/WS work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

12.3. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme Office.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ISLA chair and facilitator;

13.2. Agendas will be circulated no less than 2 days prior to the meeting, as will any material relevant to the agenda;
13.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed;
13.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

14. QUORUM

14.1. The quorum for meetings is half plus one ISLA member from the total number of members of the SLA.

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;
15.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
15.3. The Interests Register will be a standing item on SLA agenda's and be available to the Programme Office on request.

16. REVIEW

16.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

RESPONSIBLITIES

17. RESPONSIBILITY OF THE SLA

17.1. Apply the delegated funding available to lead the required service/service change;
17.2. Establish new work groups to guide service design;
17.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

18. CHAIR

18.1. Lead the team to identify opportunities for service improvement and redesign;
18.2. Lead the development of the service vision and annual work plan;
18.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
18.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
18.5. Provide leadership when implementing the group's outputs;
18.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
18.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
18.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

19. CLINICAL LEADER

19.1. Provide strong clinical leadership across all SLA work activity;
19.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;
20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. PROJECT MANAGER/FACILITATOR

21.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
21.2. Provide or arrange administrative support;
21.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
21.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
21.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
21.6. Keep key stakeholders well informed;
21.7. Proactively meet reporting and planning dates;
21.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
21.9. Identify report and manage risks associated with the SLA work activity.

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;
22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

23. ALT MEMBER

23.1 Act as a communication interface between ALT and the SLA;
23.2 Participate in the development and writing of papers that are submitted to ALT;
23.3 Act as Sponsor of papers to ALT so papers are best represented at the ALT table

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.

- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

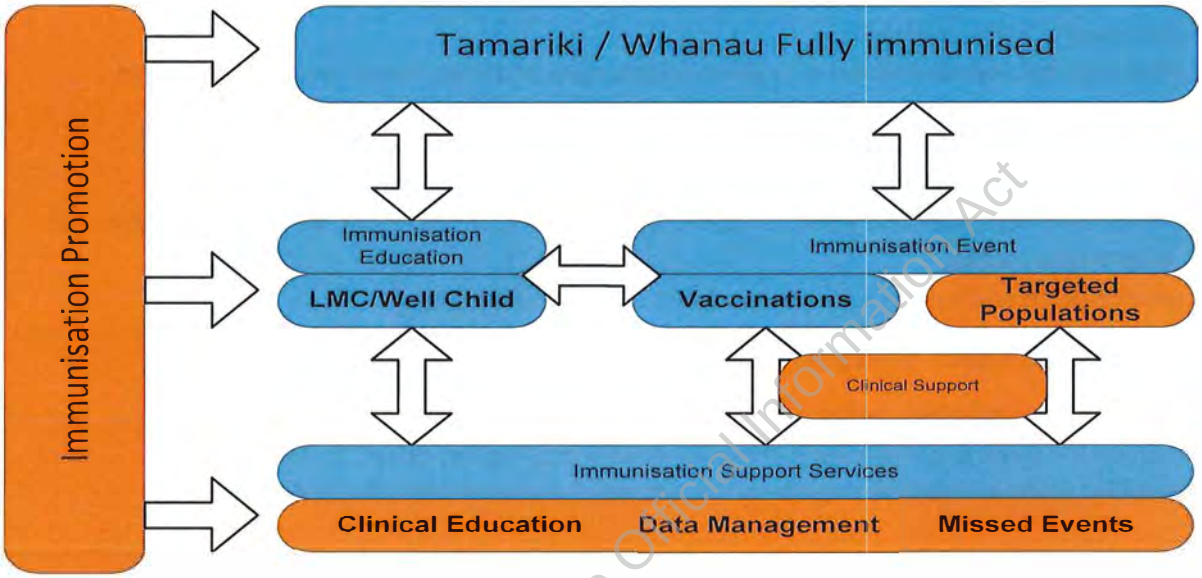
ENDORSEMENT

Date of agreement and finalisation by SLA members: 4 / 12 /2017

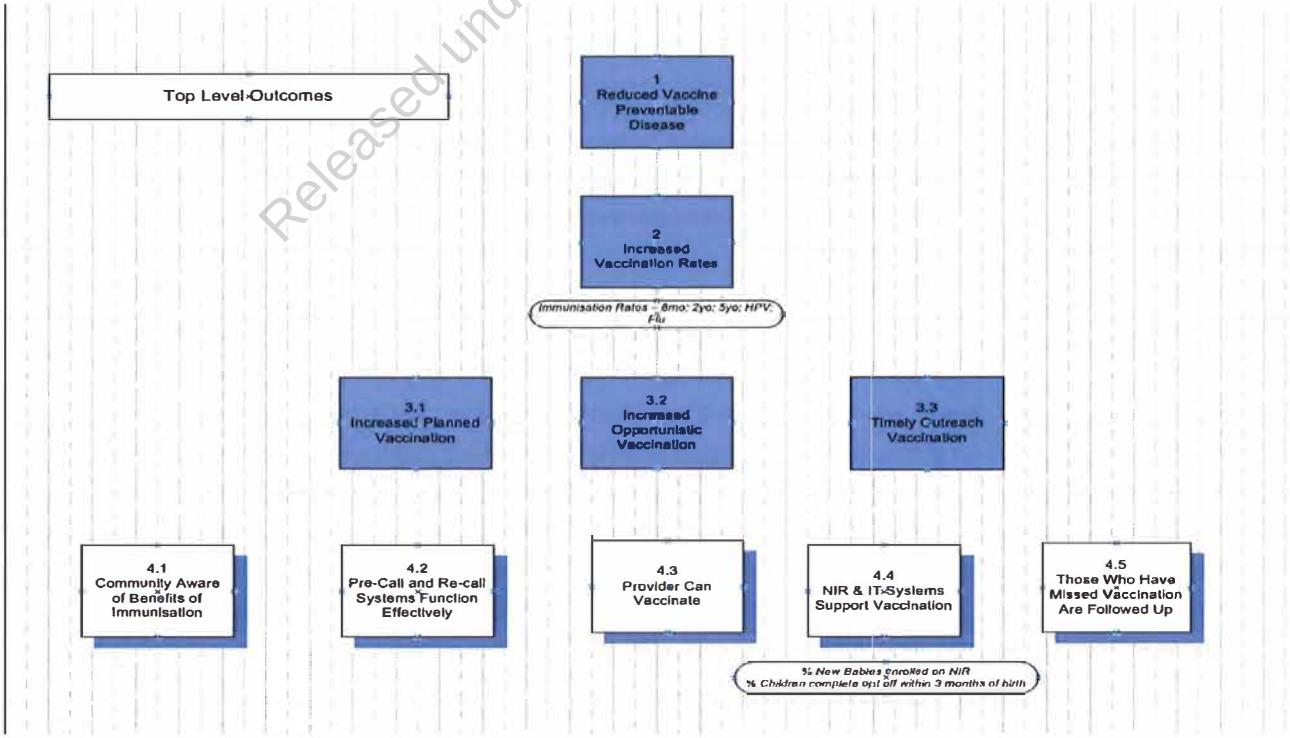
Date of endorsement from ALT

Date of Review: November 2018

Appendix One: Immunisation Service Model



Appendix Two: Immunisation Outcomes Framework



Lara Williams (Administrator)

From: Bridget Lester
Sent: Friday, 1 June 2018 2:55 p.m.
To: Alison Wooding; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; Helen Fraser; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: FW: Agenda 5 June ISLA
Attachments: Agenda 5 June ISLA.docx

Hi all

Please find attached the draft agenda for Tuesday ISLA meeting.

Sorry the Work plan and data report are not include, as I have been side tracked with other pieces of work today. I will try and get them to you earlier on Tuesday, but will also bring copies directly to our meeting

Regards Bridget

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 5 June, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Stuart Walker:	Dr Sarah Marr (Deputy Chair):
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.40pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft Minutes April ISLA meeting.docx
3.	2.50pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	3.00pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2018**	Bridget Lester	
5.	3.30pm	**Influenza Communications**	Renee Parson	
6.	3.40pm	**Operational** • **Membership** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report 5.12.17.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
HIB decline 2017 – further review	**Bridget**	**Next meeting**
New –born enrolment coverage meeting	**Bridget**	**Next Meeting**
DHB Communications follow up	**Ramon**	**6 April**
Outbreak management meeting	**Ramon**	**Next meeting**

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha

Venue: C&PH	
Date: 3 April 2018	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Tony Walls, Bridget Lester and Stuart Walker	
Apology: Donna MacLean, Alison Wooding, Geraldine Clemens, Sarah Marr and Helen Fraser	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**			
•	**Confirmation of Minutes**	• Minutes of 30 January 2018 meeting were approved to be sent to the CCN office		Friday 6 April
•	**Previous Actions & Matters Arising**	• **U18 Flu Hurunui Kaikoura (HK) areas – PHARMAC has included this in their notice for the 2018 season.** • Escalation Policy drafted – in papers later in the meeting • ISLA 2018/19 work plan was updated and sent to the CCN. Draft attached.	2018_19 CCN Immunisation SLA W	
•	**ISLA Work plan**	Q3 201718 – the quarter has just finished but the draft outcomes are • 8month olds – achieved at 95%. • 2 year olds – did not achieve at 93%, very high opt off and declines this quarter at 5.5% • 5 year olds – did not achieve at 93% achieved. Information around the declines for 2017 was tabled – which shows that the majority of declines at 4 years old are for MMR and PCV. Bridget to have a further look at the HIB declines. • HPV – new data reports show difference in the coverage. Bridget confirmed with the MoH that the 2017/18 target age is girls born in 2004. Updated data below • New-born enrolments in general practice. Coverage continues to be low at 75%. Bridget to facilitate a meeting of key stakeholders to discuss this and work out a DHB wide plan. **2018 Influenza Programme** – the vaccine is now available in general practice. However there is some concern around the introduction of Zostervax on the 1 April and what the impact this will have on over 65 flu coverage. Recommendation is to give Flu first and then following up Zostervax later. DHB Communications is working on the Comms Plan for 2018, ISLA is keen to get a better understanding of what they are proposing and to be linked into this. They would like to review the plan to ensure the information is clinically correct.	Bridget Bridget to progress Ramon to follow up with KDV	Next meeting Friday 6 April

	Item	Discussion/Action	Responsibility	Date due
•	**Cold Chain Escalation Process**	Canterbury DHB is required to develop a process for the Escalation of Cold Chain issues. A draft has been developed and shared with the Immunisation Coordinators who in general supported this. Some clarification was also sort around where to Escalate the providers who will not engage with the Immunisation Coordinators. It was agreed that a subgroup of ISLA would do this - made up of Bridget, Ramon and a GP.		
•	**Outbreak Management**	○ There was a recent outbreak of Measles in Canterbury which required a systems wide response. Some issues have been highlighted around this process, and can be used of key learnings for C&PH who managed this process. ○ A meeting will be facilitated with NIR, Immunisation Coordinators and PHOs to talk through this process.	Ramon	
•	**Operational**	○ Risk Register – No update required ○ Interest Register – Stuart to send his update to Bridget	Bridget	
•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 5 June • Tuesday 7 August • Tuesday 16 October **note changes in date** • Tuesday 4 December		

DHB: Canterbury		Number of females received HPV dose (numerator)					Estimated eligible population -female* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	241	89	196	1,514	2,040	430	130	210	2,210	2,980	56%	68%	93%	69%	68%	118 (4.0%)	0 (0.0%)
	HPV-final	189	67	166	1,304	1,726						44%	52%	79%	59%	58%	98 (3.3%)	
2005	HPV-1	189	58	203	1,317	1,767	440	120	230	2,040	2,830	43%	48%	88%	65%	62%	84 (3.0%)	1 (0.0%)
	HPV-final	103	36	127	835	1,101						23%	30%	55%	41%	39%	61 (2.2%)	
2006	HPV-1	191	66	174	1,086	1,517	470	130	250	2,110	2,970	41%	51%	70%	51%	51%	67 (2.3%)	1 (0.0%)
	HPV-final	67	21	60	369	517						14%	16%	24%	17%	17%	42 (1.4%)	
Total	HPV-1	621	213	573	3,917	5,324	1,340	380	690	6,360	8,780	46%	56%	251%	62%	61%	269 (3.1%)	2 (0.0%)
	HPV-final	359	124	353	2,508	3,344						27%	33%	158%	39%	38%	201 (2.3%)	

DHB: West Coast		Number of females received HPV dose (numerator)					Estimated eligible population -female* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	9	0	4	55	68	30	0	0	130	160	30%	-%	-%	42%	43%	3 (1.9%)	0 (0.0%)
	HPV-final	9	0	3	46	58						30%	-%	-%	35%	36%	2 (1.3%)	
2005	HPV-1	4	1	1	18	24	20	0	5	140	170	20%	-%	20%	13%	14%	0 (0.0%)	0 (0.0%)
	HPV-final	2	0	1	13	16						10%	-%	20%	9%	9%	0 (0.0%)	
2006	HPV-1	2	1	0	17	20	40	5	5	150	190	5%	20%	0%	11%	11%	1 (0.5%)	0 (0.0%)
	HPV-final	0	0	0	2	2						0%	0%	0%	1%	1%	()	
Total	HPV-1	15	2	5	90	112	90	5	10	420	520	17%	40%	-%	21%	22%	4 (0.8%)	0 (0.0%)
	HPV-final	11	0	4	61	76						12%	0%	-%	15%	15%	2 (0.4%)	

2004 = current target age of 2017/18 year
2005 = current group targeted as part of school programme
2006 = current age targeted in general practice programme.

CCN Immunisation Service Level Alliance WORK PLAN 2018/19

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY		Canterbury Health SYSTEM OUTCOME
				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions						
1. *Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy*	1.1 Support LMC to promotion Immunisation 1.1.1 Hold a focus group with LMCs to determine what they need 1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.1.3 Do a stocktake of resources to determine what the gaps are 1.2 General Practice Teams are supported to vaccinate 1.2.1 Educated around the importance of Pregnancy Vaccinations 1.2.2 Education how to load the events on the NIR 1.3 Work with the MoH to ensure regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme	On going Q1 Q3 Q1 Ongoing Q3 Q3 On going	▪ LMC focus group held in Q1 ▪ Resource stocktake completed in Q1 ▪ 50% of women are vaccinations for Pertussis during Pregnancy	Ramon Pink Helen Fraser	Bridget Lester	▪ Delayed/avoided burden of disease & long term conditions ○ Population vaccinated ○ Protective factors enhanced ○ Risk factors addressed
2. *Reduce the number of declined immunisation event in our region, against the immunisation schedule*	2.1 Develop a more structured general practice decline process 2.2. Work with C&PH to better understand why Maori are declining immunisation EOA	Q2 Q2	▪ Decrease in child hood immunisation declines – compared to 2017 year baseline/Target ▪ Reduction in the Maori decline rate baseline/Target	Ramon Pink	Bridget Lester	*Contribute to National Health and Performance Targets* ▪ Delayed/avoided burden of disease & long term conditions ○ Population vaccinated
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor						
1. *Timely Childhood Immunisations*	1.1. Continue to monitor all 8months, 2 year olds and 5 years olds to ensure they are fully vaccinated	Ongoing each quarter	▪ 95% of 8month olds, year olds and 5 year olds are fully vaccination.	Ramon Pink	Bridget Lester	*National Health and Performance Target*

Commented [RR1]: Melissa/Ruth Feedback Consider running a focus group with people who have declined and providers to understand the issues and co-design change strategies
Bridget – this may be part of the process, but at this stage we were not looking at specifics as a lot of work has been done nationally on this already.

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY CLINICAL LEAD	ACCOUNTABILITY PROJECT LEAD	Canterbury Health SYSTEM OUTCOME
						▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
2. *Influenza Vaccination Programme*	2.1. Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations. 2.2. Work with DHB Occupation health to Staff influenza vaccinations loaded on the NIR (esp for staff 65 or over)	Q2, Q3	▪ 75% of those 65 of over are vaccinated.	Ramon Pink	Bridget Lester	*SLM and Performance Target* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
3. *HPV and Tdap Programme*	3.1. Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8	On going	▪ 75% of girls born in 2006 are fully vaccinated for HPV ▪ 85% of children born in 2006 are fully vaccinated for Tdap	Ramon Pink	Bridget Lester	*Performance Target* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated
4. *General Practice New-born Enrolment*	4.1. Work with the PHOs to continue to provide education to general practice teams around the need to accept all New Born nominations and "B" code new borns SLM	On going	• 95% of New-borns are enrolled with General Practice at 3 months of age	Ramon Pink	Bridget Lester	*SLM* ▪ Delayed/avoided burden of disease & long term conditions o Population vaccinated

Commented [RR2]: [redacted]ssa/Ruth Feedback Question...What are we going to that is different from previous years. Can you identify one action that will continue the improved HVP vaccination rates

Bridget - This is sitting under Monitoring, so this year we plan to continue to monitor our coverage – there has been ongoing changes with this programme over the years and we want to let this settle in the 2018/19 year. Eg 2017 intro of boys, 2018 intro of Tdap.

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)	
Data Metric Definition	Data Source
1.	
2.	
3.	
4.	

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

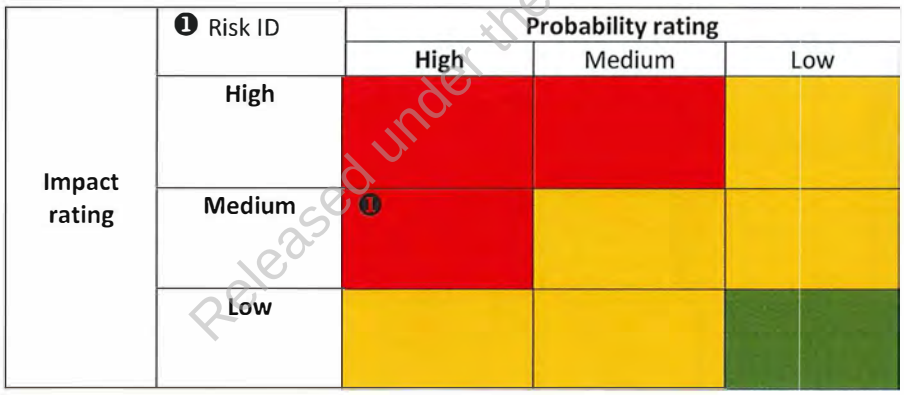
1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.



Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. . Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 30 July 2018 9:36 a.m.
To: 'Alison Wooding'; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; 'Helen Fraser'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Agenda 31 July ISLA 31 July
Attachments: Agenda ~~5 June~~ ISLA.docx; Data report July 2018.docx; Draft minutes 5 June ISLA meeting (003).docx; Interests register 5.12.17.docx

Hi all

Please find attached the agenda for tomorrow's meeting. I am pulling together the ISLA workplan and CDHD DAP – and will get a detailed implementation plan.

Regards Bridget

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday ~~5 June~~ 31 July, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Stuart Walker:	Dr Sarah Marr (Deputy Chair):
Dr Tony Walls:	Donna Maclean

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 5 June ISLA meeting (003).do
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.30pm	**Updates** **2016/17 IPG Work Plan, including** • **Health Target progress – KPI** • **HPV update** • **Vaccinating Pregnant Women** • **Influenza Programme 2018**	Bridget Lester	Data report July 2018.docx
5.	3.00pm	**Declines and Delayer Project**	Bridget Lester	
6.	3.20pm	**2018/19 DAP**	Bridget Lester	
7.	3.30pm	**BCG**	Vicky Brewer	
8.	3.40pm	**Operational** • **Membership** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report 5.12.17.docx
9.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
HIB decline 2017 – further review	**Bridget**	**Next meeting**
Interest Register Update		
Outbreak management meeting	**Ramon**	**Next meeting**

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH	
Date: 5 June 2018	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Tony Walls, Bridget Lester, Donna MacLean, Alison Wooding, Sarah Marr and Helen Fraser	
Apology: Stuart Walker	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**	Since our last meeting Geraldine has resigned from her position at RCPHO and therefore the ISLA. The ISLA membership wanted to thank Geraldine for her contribution over the past 3 years.		
•	**Confirmation of Minutes**	• Minutes of 3 April 2018 meeting were approved to be sent to the CCN office		Friday 8 June
•	**Previous Actions & Matters Arising**	• **New-born Enrolment** – a meeting was held with the PHO new-born enrolment champions to identify issues around enrolling new-borns in general practice. It appears that when the NIR nomination is accepted not all children are being "B" coded. The sense was that this might be the children being accepted by the GP. ***Action*** *– the NIR process chart is being updated and will include more clear detail to GPT around "B" coding. Linkages to be made to PHO Practice managers to discuss internal practice systems. Current New-born enrolment data has 99% of new-borns with a GP on the NIR but only 83% are enrolled with a general practice. This means that 16% of children are not being correctly coded.* • **Discussions with Communications around Flu Programme** – Communications is attending this meeting • **Outbreak meeting** – not progressed		
•	**ISLA Work plan**	Q4 201718 – currently in this quarter • 8month olds – Should meet target this quarter • 2 year olds – target will not be met this quarter – while we have some children outstanding, these are difficult to reach. • 5 year olds – Again we are tracking toward 93% coverage • The larger number of overseas children and catch up schedules continue to be an issue for reaching both the 2 year and 5 year old targets. • HPV – overall coverage is looking good with 71% of girls born in 2003 starting the programme, and 62% being fully vaccinated. There is currently no vaccine available for the general practice programme until September, so our rates will not improve. • There has been an increase in both the NIR registrations and new-born enrolments. This demonstrates the positive work being undertaken by the NIR and General Practice Teams. **2018 Influenza Programme** – Positive uptake has occurred with this year's programme with currently 55% of 65 years and over being vaccinated. General practice and pharmacy are both		

	Item	Discussion/Action	Responsibility	Date due
		experiencing increased demand. There is a concern that not all influenza is being loaded on the NIR – and that due to time constraints general practice is not selecting the opt on function. Analysis of Pegasus Health coverage reflects variances of around 10% based on what PH practice indicate they have given to what is loaded on the NIR. Discussion has taken place, regarding offering of the vaccine at Outpatient's clinics. Challenges include limited space, not enough vaccinators and cold chain requirements. Consideration was given to extending the number of the Pharmacies offering the vaccine. However, this requires an authorised vaccinator on the Pharmacy staff. Challenging, as no training is scheduled for Canterbury until August.		
•	**Flu Communications**	○ Renee from DHB Communications attended and shared the CDHB Influenza Communications programme with ISLA. ○ Communications have decided to run a separate programme this year from the National programme including developing new images and a web page. ○ ISLA has suggested that at the end of the year in October ISLA and DHB Communications work together on the development of the 2019 programme. ISLA would like to have had more input into the campaign, as this is part of ISLA's remit. ○ **Actions:** Communications to be invited to the Oct meeting.	Bridget to send KDV meeting request for Oct meeting	
•	**Operational**	○ Risk Register – need to add section on vaccine supply issues and the impact this has on programmes including BCG, HPV, Flu Vax ○ Interest Register – This needs to be updated. All members review and send to Bridget	Bridget All members	
•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 7 August • Tuesday 16 October **note changes in date** • Tuesday 4 December		

our health system

Key Performance Indicators and Childhood Immunisation Reporting

July 2018

Immunisation Reporting Programme

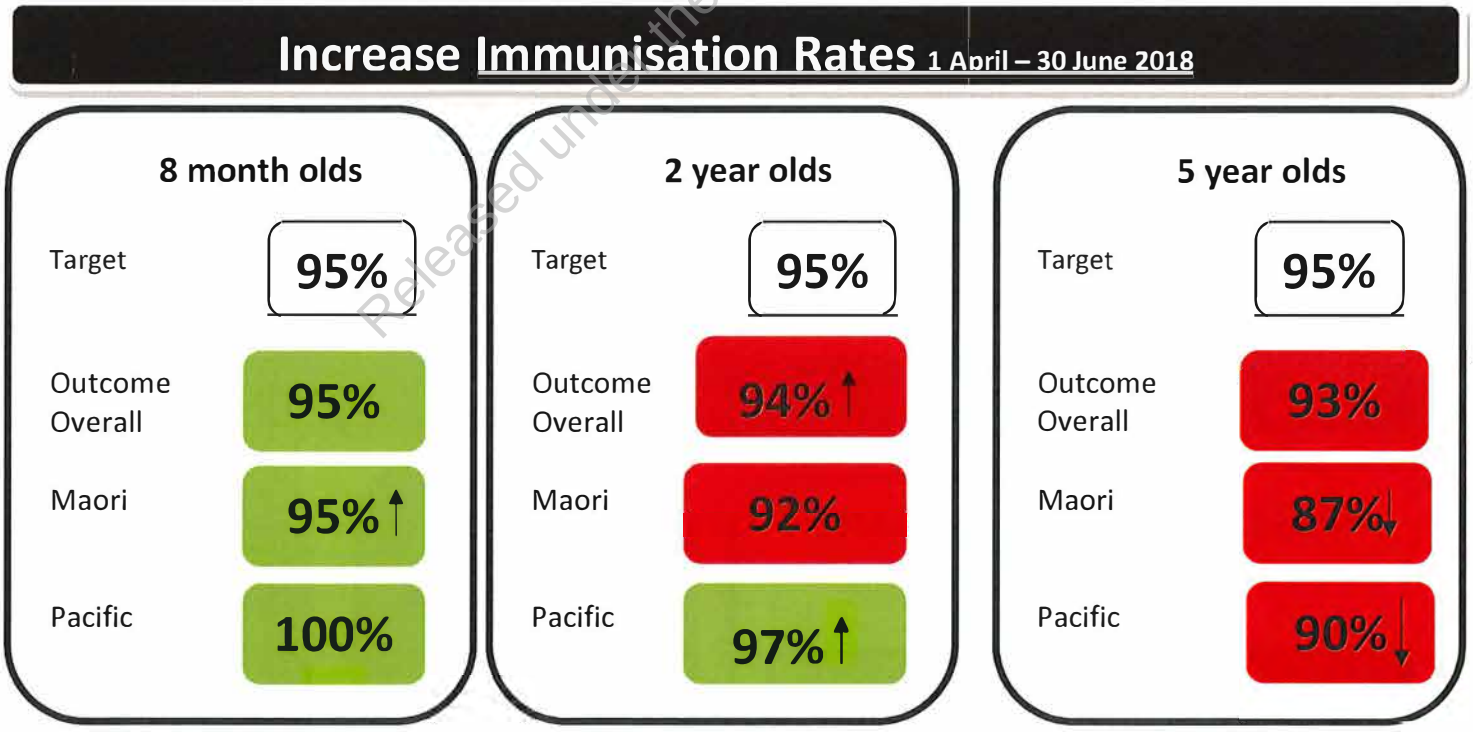
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 27 July 2018

Fully Immunised 8 month olds – DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q1 2018/19 Progress including pending	Q2 2018/19 Progress including pending
95% fully	95% fully	94.9%	87% fully
1% overdue	1% missed	.181% could	8.6% could
		4.8% can't	3.88% can't

Fully Immunised Two year olds - DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q1 2018/19 Progress	Q2 2018/19 Progress
93% fully	94% fully	91%	90.7% fully
1% overdue	1% missed	4.5% overdue	3.9% overdue
		4.3% can't	5.2% can't

Fully Immunised Four year olds - DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q1 2018/19 Progress	Q2 2018/19 Progress
92% fully	93% fully	92% fully	88% fully
1% overdue	2.2% overdue	2% overdue	5.5% overdue
		5.1% can't	6.3% can't

Fully Immunised 8month, two and five year - PHO LEVEL 1 June 2018

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	100%	100%	96%	100%	93%	93%
Pegasus	96%	96%	94%	95%	93%	94%
Rural Canterbury	94%	94%	92%	94%	95%	97%

Influenza Coverage 27 July 2018

CDHB	Total	Maori	Pacific	Asian	Other
0 - 4 year olds	9%	4%	4%	13%	10%
5 - 19 year olds	12. %	5%	6. %	12. %	13. %
20-64 year olds	13. %	9%	9. %	10. %	14. %
65 plus	60. %	37%	49. %	41. %	62. %

Age Band	PHO	Total	Maori	Pacific	Asian	NZE	Other
0-4 year olds	Christchurch PHO Limited	7. %	4. %	2. %	9. %	6. %	9. %
	Pegasus Health (Charitable) Limited	10. %	5. %	5. %	14. %	10. %	9. %
	Rural Canterbury PHO	7. %	3. %	2. %	8. %	8. %	6. %
	National	4. %	2. %	2. %	6. %	4. %	4. %
5 -19 years	Christchurch PHO Limited	11. %	6. %	5. %	11. %	9. %	30. %
	Pegasus Health (Charitable) Limited	13. %	7. %	6. %	14. %	15. %	12. %
	Rural Canterbury PHO	9. %	5. %	5. %	8. %	10. %	9. %
	National	5. %	2. %	3. %	7. %	8. %	6. %
20 - 64 years	Christchurch PHO Limited	10. %	7. %	6. %	8. %	9. %	19. %
	Pegasus Health (Charitable) Limited	14. %	10. %	8. %	11. %	15. %	14. %
	Rural Canterbury PHO	13. %	9. %	6. %	8. %	14. %	14. %
	National	10. %	8. %	9. %	9. %	11. %	11. %
65 plus	Christchurch PHO Limited	53. %	45. %	45. %	44. %	55. %	56. %
	Pegasus Health (Charitable) Limited	65. %	59. %	57. %	53. %	65. %	64. %
	Rural Canterbury PHO	67. %	57. %	41. %	49. %	68. %	62. %
	National	56. %	49. %	54. %	51. %	66. %	62. %

Pre teen Immunisations 30 June 2018

DHB: Canterbury		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	256	98	207	1,545	2,106	430	130	210	2,210	2,980	60%	75%	99%	70%	71%	119 (4.0%)	0 (0.0%)
	HPV-2 Quadrivalent	221	79	190	1,436	1,926						51%	61%	90%	65%	65%	140 (4.7%)	
	HPV-3 Quadrivalent	136	37	116	1,021	1,310						32%	28%	55%	46%	44%	146 (4.9%)	
2005	HPV-1 Quadrivalent	223	66	225	1,488	2,002	440	120	230	2,040	2,830	51%	55%	98%	73%	71%	84 (3.0%)	1 (0.0%)
	HPV-2 Quadrivalent	130	45	150	962	1,287						30%	38%	65%	47%	45%	73 (2.6%)	
	HPV-3 Quadrivalent	61	23	65	498	647						14%	19%	28%	24%	23%	69 (2.4%)	
2006	HPV-1 Quadrivalent	212	71	184	1,184	1,651	470	130	250	2,110	2,970	45%	55%	74%	56%	56%	73 (2.5%)	2 (0.1%)
	HPV-2 Quadrivalent	89	29	74	515	707						19%	22%	30%	24%	24%	63 (2.1%)	
	HPV-3 Quadrivalent	6	1	2	52	61						1%	1%	1%	2%	2%	51 (1.7%)	
Total	HPV-1 Quadrivalent	691	235	616	4,217	5,759	1,340	380	690	6,360	8,760	52%	62%	270%	66%	66%	276 (3.1%)	3 (0.0%)
	HPV-2 Quadrivalent	440	153	414	2,913	3,920						33%	40%	185%	46%	45%	276 (3.1%)	
	HPV-3 Quadrivalent	203	61	183	1,571	2,018						15%	16%	84%	25%	23%	266 (3.0%)	

Q4 201718 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,646	1,405	85. %	900	791	88. %	262	189	72. %	86	76	88. %	267	247	93. %	131	102	78. %	12 ()	0.7 (0.0) %	49	3.0 %
8 Month	1,654	1,571	95. %	911	872	96. %	273	258	95. %	83	83	100. %	241	238	99. %	146	120	82. %	15 ()	0.9 (0.0) %	49	3.0 %
12 Month	1,619	1,541	95. %	839	812	97. %	260	247	95. %	70	68	97. %	278	271	97. %	172	143	83. %	21 (1)	1.3 (0.1) %	38	2.3 %
18 Month	1,606	1,389	86. %	886	790	89. %	228	180	79. %	77	66	86. %	270	247	91. %	145	106	73. %	17 (0)	1.1 (0.0) %	65	4.0 %
24 Month	1,560	1,463	94. %	886	841	95. %	205	188	92. %	71	69	97. %	261	253	97. %	137	112	82. %	15 ()	1.0 (0.0) %	65	4.2 %
5 Year	1,577	1,462	93. %	936	902	96. %	201	175	87. %	70	63	90. %	216	204	94. %	154	118	77. %	14 (1)	0.9 (0.1) %	64	4.1 %
12 Year	1,619	1,104	68. %	1,016	759	75. %	192	127	66. %	81	47	58. %	144	69	48. %	186	102	55. %	19 ()	1.2 (0.0) %	85	5.3 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,646	1,405	85. %	339	280	83. %	345	307	89. %	317	279	88. %	255	220	86. %	193	149	77. %	197	170	86. %
8 Month	1,654	1,571	95. %	358	327	91. %	346	335	97. %	306	287	94. %	260	254	98. %	189	180	95. %	195	188	96. %
12 Month	1,619	1,541	95. %	340	307	90. %	332	319	96. %	290	279	96. %	256	250	98. %	208	197	95. %	193	189	98. %
18 Month	1,606	1,389	86. %	364	309	85. %	312	280	90. %	283	242	86. %	245	218	89. %	201	166	83. %	201	174	87. %
24 Month	1,560	1,463	94. %	365	332	91. %	307	287	93. %	296	283	96. %	236	221	94. %	166	159	96. %	190	181	95. %
5 Year	1,577	1,462	93. %	399	361	90. %	321	298	93. %	273	253	93. %	235	217	92. %	150	138	92. %	199	195	98. %
12 Year	1,619	1,104	68. %	441	306	69. %	356	259	73. %	276	175	63. %	210	127	60. %	153	89	58. %	183	148	81. %

Christchurch PHO Limited

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	100	91	91. %	25	22	88. %	13	11	85. %	5	5	100. %	47	44	94. %	10	9	90. %	0 (0)	0.0 (0.0) %	2	2.0 %
8 Month	91	91	100. %	28	28	100. %	14	14	100. %	6	6	100. %	37	37	100. %	6	6	100. %	0 (0)	0.0 (0.0) %	0	0 %
12 Month	89	85	96. %	26	25	96. %	7	7	100. %	5	5	100. %	42	41	98. %	9	7	78. %	0 (0)	0.0 (0.0) %	3	3.4 %
18 Month	126	108	86. %	47	42	89. %	9	6	67. %	8	7	88. %	50	43	86. %	12	10	83. %	0 (0)	0.0 (0.0) %	3	2.4 %
24 Month	93	89	96. %	25	25	100. %	5	5	100. %	2	2	100. %	53	49	92. %	8	8	100. %	0 (0)	0.0 (0.0) %	1	1.1 %
5 Year	86	80	93. %	34	33	97. %	13	12	92. %	3	3	100. %	33	30	91. %	3	2	67. %	0 (0)	0.0 (0.0) %	4	4.7 %
12 Year	63	23	37. %	29	13	45. %	5	2	40. %	3	1	33. %	21	6	29. %	5	1	20. %	0 (0)	0.0 (0.0) %	7	11.1 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	100	91	91. %	18	17	94. %	18	16	89. %	20	19	95. %	22	22	100. %	13	9	69. %	9	8	89. %
8 Month	91	91	100. %	12	12	100. %	17	17	100. %	15	15	100. %	15	23	100. %	13	13	100. %	11	11	100. %
12 Month	89	85	96. %	12	11	92. %	14	14	100. %	18	18	100. %	17	16	94. %	14	13	93. %	14	13	93. %
18 Month	126	108	86. %	16	13	81. %	17	15	88. %	18	15	83. %	26	24	92. %	27	21	78. %	22	20	91. %
24 Month	93	89	96. %	14	14	100. %	10	9	90. %	23	21	91. %	20	19	95. %	13	13	100. %	13	13	100. %
5 Year	86	80	93. %	15	15	100. %	9	9	100. %	20	19	95. %	17	16	94. %	17	14	82. %	8	7	88. %
12 Year	63	23	37. %	11	5	45. %	14	6	43. %	10	3	30. %	14	6	43. %	10	1	10. %	4	2	50. %

Rural Canterbury PHO

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	163	137	84. %	108	93	86. %	20	14	70. %	12	11	92. %	13	13	100. %	10	6	60. %	0 (0)	0.0 (0.0) %	10	6.1 %
8 Month	188	177	94. %	113	108	96. %	28	25	89. %	14	14	100. %	15	15	100. %	18	15	83. %	0 (0)	0.0 (0.0) %	9	4.8 %
12 Month	167	160	96. %	100	95	95. %	33	31	94. %	9	9	100. %	16	16	100. %	9	9	100. %	0 (0)	0.0 (0.0) %	6	3.6 %
18 Month	141	121	86. %	92	84	91. %	28	20	71. %	12	9	75. %	6	5	83. %	3	3	100. %	0 (0)	0.0 (0.0) %	6	4.3 %
24 Month	143	131	92. %	101	95	94. %	17	13	76. %	7	7	100. %	10	10	100. %	8	6	75. %	0 (0)	0.0 (0.0) %	10	7.0 %
5 Year	157	149	95. %	117	112	96. %	16	14	88. %	6	6	100. %	9	9	100. %	9	8	89. %	0 (0)	0.0 (0.0) %	5	3.2 %
12 Year	177	126	71. %	134	93	69. %	21	19	90. %	5	4	80. %	3	1	33. %	14	9	64. %	0 (0)	0.0 (0.0) %	9	5.1 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	163	137	84. %	42	32	76. %	54	47	87. %	23	20	87. %	29	25	86. %	3	2	67. %	12	11	92. %
8 Month	188	177	94. %	56	51	91. %	57	56	98. %	29	26	90. %	29	32	97. %	5	4	80. %	8	8	100. %
12 Month	167	160	96. %	42	41	98. %	44	42	95. %	33	30	91. %	32	31	97. %	8	8	100. %	8	8	100. %
18 Month	141	121	86. %	33	33	100. %	39	32	82. %	28	22	79. %	28	23	82. %	4	3	75. %	9	8	89. %
24 Month	143	131	92. %	40	36	90. %	45	41	91. %	21	21	100. %	27	24	89. %	0	0	-	10	9	90. %
5 Year	157	149	95. %	52	48	92. %	52	48	92. %	17	17	100. %	23	23	100. %	5	5	100. %	8	8	100. %
12 Year	177	126	71. %	62	42	68. %	46	36	78. %	27	16	59. %	25	16	64. %	5	5	100. %	12	11	92. %

Partnership Health (Canterbury)

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,363	1,174	86. %	762	671	88. %	225	164	73. %	69	60	87. %	207	191	92. %	100	88	88. %	0 ()	0.0 (0.0) %	37	2.7 %
8 Month	1,363	1,306	96. %	774	739	95. %	229	218	95. %	62	62	100. %	190	186	98. %	108	101	94. %	0 ()	0.0 (0.0) %	41	3.0 %
12 Month	1,338	1,295	97. %	716	696	97. %	219	210	96. %	54	52	96. %	220	214	97. %	129	123	95. %	0 (1)	0.0 (0.1) %	28	2.1 %
18 Month	1,335	1,189	89. %	756	680	90. %	188	156	83. %	60	53	88. %	217	204	94. %	114	96	84. %	0 (0)	0.0 (0.0) %	54	4.0 %
24 Month	1,321	1,246	94. %	763	724	95. %	185	171	92. %	62	59	95. %	205	195	95. %	106	97	92. %	0 (0)	0.0 (0.0) %	54	4.1 %
5 Year	1,347	1,259	93. %	800	769	96. %	177	155	88. %	65	58	89. %	177	168	95. %	128	109	85. %	0 (1)	0.0 (0.1) %	54	4.0 %
12 Year	1,316	928	71. %	837	637	76. %	157	101	64. %	65	39	60. %	118	63	53. %	139	88	63. %	0 (0)	0.0 (0.0) %	70	5.3 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1,363	1,174	86. %	265	230	87. %	271	242	89. %	269	238	88. %	204	173	85. %	178	139	78. %	176	152	86. %
8 Month	1,363	1,306	96. %	276	264	96. %	273	263	96. %	262	247	94. %	262	198	97. %	172	165	96. %	176	169	96. %
12 Month	1,338	1,295	97. %	266	256	96. %	280	268	96. %	237	231	97. %	206	202	98. %	179	171	96. %	170	167	98. %
18 Month	1,335	1,189	89. %	302	267	88. %	259	240	93. %	231	209	90. %	196	176	90. %	173	145	84. %	174	152	87. %
24 Month	1,321	1,246	94. %	300	282	94. %	254	238	94. %	253	241	95. %	192	181	94. %	152	144	95. %	170	160	94. %
5 Year	1,347	1,259	93. %	321	300	93. %	266	246	92. %	243	225	93. %	199	182	91. %	130	121	93. %	188	185	98. %
12 Year	1,316	928	71. %	344	249	72. %	290	217	75. %	233	152	65. %	161	98	61. %	130	82	63. %	158	130	82. %

CCN Risk Policy

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

	❶ Risk ID	Probability rating		
		High	Medium	Low
Impact rating	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Canterbury Clinical Network - Register of Interests Current as at 5 December 2017	
IMMUNSATION SERVICE LEVEL ALLIANCE	
Dr Ramon Pink	Public Health Physician, employee of CDHB Member, Clinical Advisory Group, Pegasus Member, Realign Alliance Leadership Team Member, Public Health Clinical Network Member, South Island Public Health Parternship
Dr Sarah Marr	GP Halswell Health Canterbury Initiative – Child Health, ENT, Allied Health Working Groups Clinical Reference Group Pegasus Health
Dr Tony Walls	*Private Practice Preparation* *PHARMAC Immunisation Subcommittee* *MoH Immunisation Handbook Writing Group* *Vaccine Research – funded by GSK* *Employee of CDHB* *Employee of Otago School of Medicine*
Dr Alison Wooding	GP – Union and Community Health Centre Member of Pegasus Health GP at Nurse Maude Hospice
Anna Harwood	Dispensary Manager (Pharmacist) Unichem Bishipdale MTA workgroup
Helen Fraser	
Bridget Lester	Employee of CDHB, Planning and Funding

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 11 October 2018 4:58 p.m.
To: Alison Wooding; 'donna.maclean@barringtonmc.co.nz'; 'Geraldine Clemens'; Heather Burns; Helen Fraser; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Draft agenda for Tuesdays ISLA meeting
Attachments: Agenda 16 October meeting.docx

Hi all

Ramon is away so I am send the draft agenda to you all.

Sorry, due to data only arriving on Monday, I haven't had time to do the data report, but I will get this done on Monday and out to you all.

Please let me know if you can't attend.

Regards Bridget

Bridget Lester
Portfolio Manager, Child and Youth

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 16 October, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Stuart Walker:	Dr Sarah Marr (Deputy Chair):
Dr Tony Walls: apology	Donna Maclean:

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	Draft minutes 31 July ISLA meeting (003).do
3.	2.20pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.30pm	**Updates** **2018/19 ISLA Work Plan, including** • **Health Target progress – KPI** • **Vaccinating Pregnant Women** • **Declines and Delayers** • **New Reporting Template** • **Interest from other DHBs in our programmes**	Bridget Lester	
5.	3.00pm	**Rheumatic Fever**	Bridget Lester	
	3.30	**Flu Communications**		
8.	3.50pm	**Operational** • **Membership** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report 5.12.17.docx
9.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
HIB decline 2017 – further review	**Bridget**	**Next meeting**
Interest Register Update		
Outbreak management meeting	**Ramon**	**Next meeting**

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH	
Date: 31 July 2018	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Stuart Walker , Bridget Lester, and Sarah Marr	
Apology: Tony Walls, Donna MacLean, Alison Wooding and Helen Fraser	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**	It was noted that due members being away, we did not have a quorum – however agreed to continue meeting, as there were a number of key topic to be discussed. Absent members will be contacted to ensure they support the decisions made		
•	**Confirmation of Minutes**	• Minutes of 5 June 2018 meeting were approved to be sent to the CCN office		Friday 3 August
•	**Previous Actions & Matters Arising**	• **HIB Declines**, this has moved into the wider decline project – to be discussed latter in the meeting • **Interest register** – updated and meeting, and to be shared with CCN Programme office • **Outbreak meeting** – Ramon has discussed this internally and there is a gap in the process around when the NIR and IC are linked in. Further discussions to be held around this		
•	**ISLA Work plan**	Q4 201718 – currently in this quarter • 8month olds – This target was met for the DHB and all ethnicity groups. CDHB was on the only DHB nationally to reach this target. • 2 year olds – target has not reached, achieving 94% with high declines and opt offs. • 5 year olds – this target was not reached with 93% being achieved with high declines and opt offs • HPV – overall coverage for girls born in 2004 was 65%, while this was 10% away from the national target, it was an improvement for CDHB. **2018 Influenza Programme** – Positive uptake has occurred with this year's programme with currently 60% of 65 years and over being vaccinated. There continues to be a concern around Flu not be loaded correctly on the NIR. ISLA has recommended more work occurs to determine who is not being loaded correctly on the NIR.		
•	**MoH Flu start date discussion document**	o ISLA reviewed this and supported the 1 April start date. Cheryl Brunton to be approached to see if she can add this to her WC submission.		
•	2018/19 Workplan	o As there are a number of Immunisation Targets and deliverables across the DHB, Bridget has incorporated these into the 2018/19 operational work plan for ISLA to oversee the implementation and delivery. o The main focus of this plan are o Pregnancy vaccinations, and engagement with LMCs o Reducing decliners and delayers o Loading CDHB staff influenza on to the NIR.		

	Item	Discussion/Action	Responsibility	Date due
		○ As part of this process, ISLA supported the further investigation of an education programme to support general practice around having the difficult conversation with families around declines and delayers – and supported the application to the P&F Leadership Team for some funding to be made available to enable Canterbury Immunisation to developed this programme. ○ As part of this work, the practise with the majority of declines will be targeted in the first instance. ○ Action: Bridget to pull this plan into a more detailed implementation plan and draft a proposal for the P&F leadership team around Decliners		
•		○ Frances Ryan and Vicky Brewer from the PHNS attended to talk about BCG. We have recently been advised that the BGC vaccine is now available in NZ. There are some concern around eligibility and who to manage any catch up programme. ○ The clear direction from ISLA – which the PHNS need to focus on their core work and identify their capacity for BCG. ○ Bridget, Ramon, Tony, Vicky and Frances to meet next week to determine the eligibility criteria, prioritisation framework and implementation. ○ Clear messages will be developed for LMCs and GPT.		
•	**Rheumatic Fever**	○ ISLA has been asked to consider if they should oversee the CDHB Rheumatic Fever plan. ○ This will be tabled at our next meeting		
•	**Operational**	○ Interest Register – This was updated.	Bridget All members	
•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 16 October **note changes in date** • Tuesday 4 December		

CCN Risk Policy

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	High			
	Medium	❶		
	Low			

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Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 15 October 2018 2:21 p.m.
To: 'Alison Wooding'; 'donna.maclean@barringtonmc.co.nz'; Heather Burns; 'Helen Fraser'; 'marr.sarah@gmail.com'; 'pharmacists@bishopdale.co.nz'; Ramon Pink; 'Tony Walls'
Subject: Additional Papers for Tuesdays ISLA meeting
Attachments: Data report Oct 2018.docx; Immunisation Service Level Alliance Combined DAP and ALT workplan - October 2018.docx

Hi all

Please find attached the October data report and the updated work plan.

Regards Bridget

Bridget Lester
Portfolio Manager, Child and Youth

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
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our health system

Key Performance Indicators and Childhood Immunisation Reporting

October 2018

Immunisation Reporting Programme

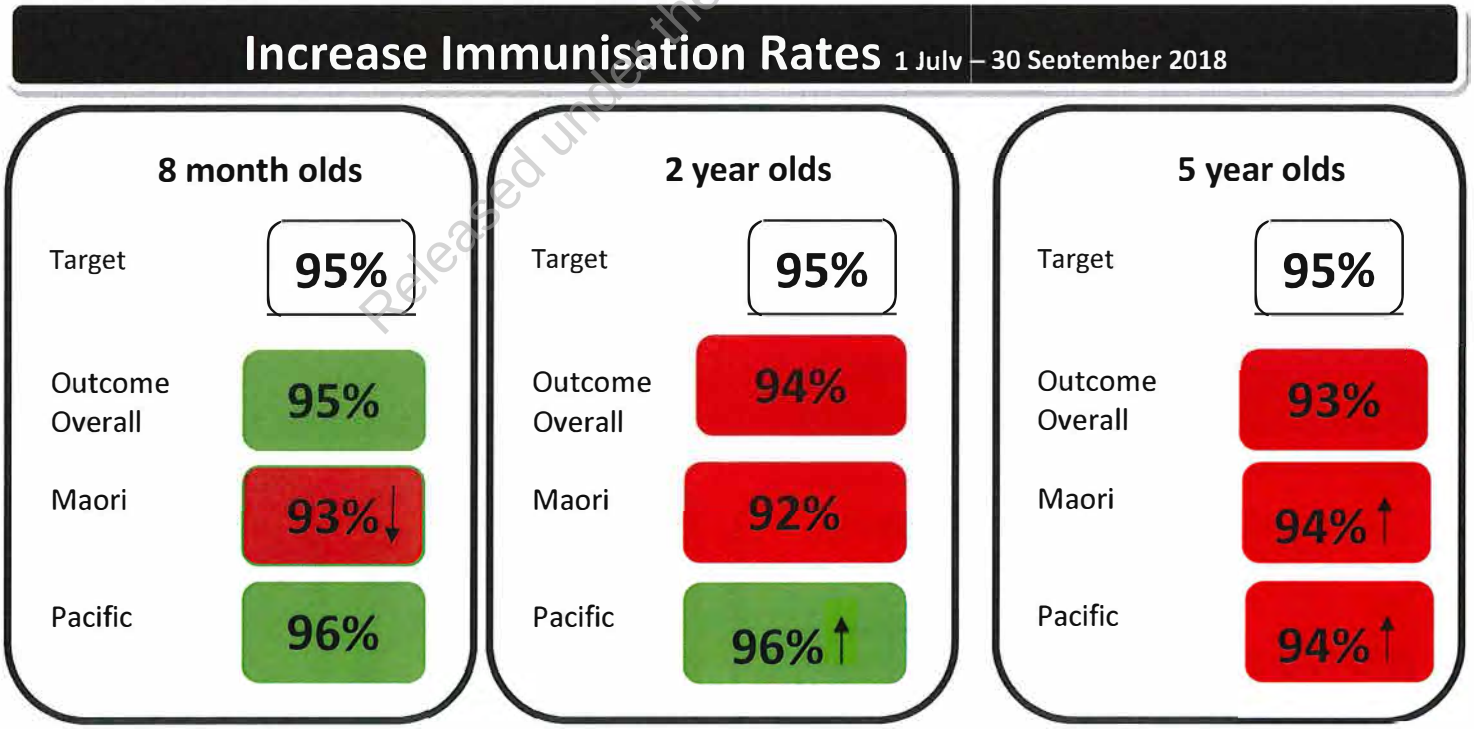
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 October 2018

Fully Immunised 8 month olds – DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress including pending	Q3 2018/19 Progress including pending
95% fully	94.6% fully	89%	89% fully
1% overdue	1.6% missed	6.5% could reach	7.8% could
	3.8% Opt/Dec	4.5% can't	3.6% can't

Fully Immunised Two year olds - DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress	Q3 2018/19 Progress
94% fully	94% fully	93.5% fully	89% fully
1% overdue	1.1% missed	1.2% overdue	5.8% overdue
	4.8% Opt/Dec	5.2% Opt/Dec	4.7% opt/dec

Fully Immunised Four year olds - DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress	Q3 2018/19 Progress
93% fully	93% fully	91% fully	86% fully
2.2%	2% overdue	2.4% overdue	7.1% overdue
	5.1% Opt/Dec	6% can't	6.5% can't

Fully Immunised 8month, two and five year - PHO LEVEL 1 October 2018

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	99%	90%	98%	94%	96%	89%
Pegasus	96%	89%	95%	94%	95%	93%
Rural Canterbury	91%%	95%	97%	95%	92%	93%

Influenza Coverage 30 Sept 2018

	PHO	Total	Maori	Pacific	Asian	NZE	Other
0-4 year olds	Christchurch PHO	7%	5%	2%	9%	6%	9%
	Pegasus Health	10%	5%	5%	15%	1%	10%
	Rural Canterbury	7%	4%	2%	8%	7%	8%
	Canterbury	10%	5%	4%	14%		11%
5-19 years	Christchurch PHO	12%	5%	5%	12%	9%	34%
	Pegasus Health	14%	8%	7%	14%	16%	13%
	Rural Canterbury	8%	4%	5%	8%	9%	7%
	Canterbury	12%	6%	6%	12%		14%
20-64 years	Christchurch PHO	10%	7%	7%	8%	9%	20%
	Pegasus Health	15%	11%	10%	12%	16%	15%
	Rural Canterbury	12%	9%	6%	8%	13%	11%
	Canterbury	14%	9%	10%	11%		15%
65 plus	Christchurch PHO	57%	55%	50%	48%	58%	59%
	Pegasus Health	69%	62%	60%	58%	70%	68%
	Rural Canterbury	61%	54%	36%	49%	62%	49%
	Canterbury	62%	40%	52%	44%		64%

Pre teen Immunisations 30 Sept 2018

HPV coverage

DHB: Canterbury		Number of females received HPV dose (numerator)					Estimated eligible population -female* (denominatpr)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	245	94	199	1,528	2,066	430	130	210	2,210	2,980	57%	72%	95%	69%	69%	120 (4.0%)	0 (0.0%)
	HPV-final	198	71	170	1,330	1,769						46%	55%	81%	60%	59%	100 (3.4%)	
2005	HPV-1	220	65	218	1,480	1,983	440	120	230	2,040	2,830	50%	54%	95%	73%	70%	91 (3.2%)	1 (0.0%)
	HPV-final	137	43	160	1,000	1,340						31%	36%	70%	49%	47%	62 (2.2%)	
2006	HPV-1	212	77	189	1,207	1,685	470	130	250	2,110	2,970	45%	59%	76%	57%	57%	82 (2.8%)	1 (0.0%)
	HPV-final	102	33	91	555	781						22%	25%	36%	26%	26%	54 (1.8%)	
Total	HPV-1	677	236	606	4,215	5,734	1,340	380	690	6,360	8,780	51%	62%	265%	66%	65%	293 (3.3%)	2 (0.0%)
	HPV-final	437	147	421	2,885	3,890						33%	39%	187%	45%	44%	216 (2.5%)	

11 year old T-dap coverage

	Total	NZE	Maori	Pacific	Asian	Other	Opt Off	Declined
RCPHO	62%	72%	53%	50%	11%	33%	0%	4.30%
CCPHO	60%	82%	57%	-	41%	67%	0%	3.80%
Pegasus	69%	75%	71%	49%	49%	54%	0%	5.5%
Canterbury Total	67%	75%	65%	45%	45%	49%	9%	5.30%

Q1 201819 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,594	1,354	85. %	821	720	88. %	264	204	77. %	94	74	79. %	263	247	94. %	152	109	72. %	19 (1)	1.2 (0.1) %	46	2.9 %
8 Month	1,643	1,556	95. %	858	822	96. %	276	256	93. %	84	81	96. %	284	280	99. %	141	117	83. %	14 ()	0.9 (0.0) %	47	2.9 %
12 Month	1,618	1,546	96. %	900	864	96. %	259	244	94. %	74	73	99. %	249	245	98. %	136	120	88. %	11 ()	0.7 (0.0) %	42	2.6 %
18 Month	1,602	1,394	87. %	838	761	91. %	239	192	80. %	85	62	73. %	280	252	90. %	160	127	79. %	16 (1)	1.0 (0.1) %	62	3.9 %
24 Month	1,701	1,602	94. %	911	863	95. %	247	228	92. %	79	76	96. %	301	296	98. %	163	139	85. %	15 (0)	0.9 (0.0) %	66	3.9 %
5 Year	1,626	1,510	93. %	888	847	95. %	246	231	94. %	71	67	94. %	258	242	94. %	163	123	75. %	23 ()	1.4 (0.0) %	60	3.7 %
12 Year	1,778	1,184	67. %	1,122	838	75. %	224	146	65. %	87	39	45. %	178	80	45. %	167	81	49. %	16 ()	0.9 (0.0) %	95	5.3 %

Immunisation Service Level Alliance

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY		Implementation
				CLINICAL LEAD	PROJECT LEAD	
SECTION ONE: Priority Actions						
1. Pregnant women in Canterbury are all offered the opportunity to be vaccinated during pregnancy	1.1 Support LMC to promotion Immunisation 1.1.1 Hold a focus group with LMCs to determine what they need 1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations 1.1.3 Do a stocktake of resources to determine what the gaps are 1.1.4 Continue to invest in the outpatients' vaccination programme to reach women and children who are not vaccinated 1.2 General Practice Teams are supported to vaccinate 1.2.1 Educated around the importance of Pregnancy Vaccinations 1.2.2 Education how to load the events on the NIR 1.3 Work with the MoH to ensure regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme	On going Q1 Q3 Q1 Ongoing Q3 Q3 On going	▪ LMC focus group held in Q1 ▪ Resource stocktake completed in Q1 ▪ 50% of women are vaccinations for Pertussis during Pregnancy	Ramon Pink Helen Fraser	Bridget Lester	The proposed focus group planed for Q1 are yet to be held. The aim will be to hold these in the next two months. The stocktake will be part of the focus groups questions. Support continues of this outpatient clinic.
2. Reduce the number of declined immunisation event in our region, against the immunisation schedule	2.1 Develop a more structured general practice decline process 2.2 Work with C&PH to better understand why Maori are declining immunisation **EOA** **2.3** Continue to support practices with catch up schedules and overseas vaccination history for children new to living in Canterbury	Q2 Q2 Q2 Q3	▪ Decrease in child hood immunisation declines – compared to 2017 year baseline/Target ▪ Reduction in the Maori decline rate baseline/Target ▪ Quarterly review of immunisation and decline rates by ethnicity. ▪ Refreshed process chart issued to general practice. ▪ Options for difficult conversation training for practice nurses explored. ▪ Q4: Opportunities to reduce decline rates captured.	Ramon Pink	Bridget Lester	This price of work is ongoing, with the process chart updated and currently at the printers. The decline programme is currently on hold while the new IMAC resources are produced.

OBJECTIVE	ACTIONS	Q	MEASURE OF SUCCESS/TARGET/ BENCHMARK MILESTONE	ACCOUNTABILITY		Implementation
				CLINICAL LEAD	PROJECT LEAD	
SECTION TWO: Actions towards other National Targets or Actions towards things we want to monitor						
3. Timely Childhood Immunisations	3.1 Continue to monitor all 8months, 2 year olds and 5 years olds to ensure they are fully vaccinated	Ongoing each quarter	▪ 95% of 8month olds, year olds and 5 year olds are fully vaccination.	Ramon Pink	Bridget Lester	As per data report
4. Influenza Vaccination Programme	4.1 Continue to offer the national Influenza programme and support general practice and community pharmacy to vaccinate their populations. 4.2 Work with DHB Occupation health to Staff influenza vaccinations loaded on the NIR (esp for staff 65 or over)	Q2, Q3	▪ 75% of those 65 of over are vaccinated.	Ramon Pink	Bridget Lester	Ongoing
5. HPV and Tdap Programme	5.1 Maintain the co-delivery model of HPV and Tdap, both in general practice at age 11 and in School at Year 8	On going	▪ 75% of girls born in 2006 are fully vaccinated for HPV ▪ 85% of children born in 2006 are fully vaccinated for Tdap	Ramon Pink	Bridget Lester	Updated as per data report
6. General Practice New-born Enrolment	6.1 Work with the PHOs to continue to provide education to general practice teams around the need to accept all newborn nominations and "B" code newborns **SLM**	On going	• 95% of newborns are enrolled with General Practice at 3 months of age	Ramon Pink	Bridget Lester	This is included the decline process chart, but there is a need for some further practice level information

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 3 December 2018 9:37 a.m.
To: Alison Wooding; 'donna.maclean@barringtonmc.co.nz'; Helen Fraser; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: FW: Agenda 4 December meeting
Attachments: Agenda 4 December meeting.docx

Hi all

Please find attached the agenda for tomorrows ISLA meeting.

Sorry I haven't managed to do the data report yet – will try and get that done today and out to you all.

Regards Bridget

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

From: Bridget Lester
Sent: Thursday, 29 November 2018 2:29 p.m.
To: Ramon Pink <Ramon.Pink@cdhb.health.nz>
Subject: Agenda 4 December meeting

Kia ora Dr Pink

Please find attached the draft agenda for Tuesday ISLA meeting.

I will send out on Friday – if it is all good with you.

Regards Bridget

Canterbury Clinical Network | IMMUNISATION SERVICE LEVEL ALLIANCE

Agenda

Community and Public Health, Waitaha Room
Tuesday 4 December, 2-4.00pm

Membership:	
Dr Ramon Pink (Chair):	Bridget Lester:
Dr Alison Wooding:	Helen Fraser:
Stuart Walker:	Dr Sarah Marr:
Dr Tony Walls: apology	Donna Maclean:

	Time	Item	Who	Papers
1.	2.00pm	**Welcome and Introductions**	Ramon Pink	
2.	2.10pm	**Confirmation of minutes of last meeting**	Ramon Pink	ISLA minutes 16 Oct 2018.docx
3.	2.15pm	**Previous actions & matters arising from last meeting (see action register below) – not already covered in meeting**	Ramon Pink	
4.	2.20pm	**Updates** **2018/19 ISLA Work Plan, including** • **Health Target progress – KPI** • **Vaccinating Pregnant Women** • **LMC Focus Group**	Bridget Lester	
5.	2.45pm	**2019 Flu Programme – CPHAC expectations**	Bridget Lester	
	3.00pm	**Rheumatic Fever discussion**	Ramon Pink	3. Business Case - Canterbury (July 2016) RF Pathway.docx
6.	3.20pm	**Annual Plan for 2019/20**	Ramon Pink	Annual Plan timeline 2019-20.docx CCN WORK PLAN template 2019_20.doc
7.	3.40pm	**Operational** • **Membership** • **Interest register** • **Risk Register**	Ramon Pink	Risk Report 5.12.17.docx
8.	3.45pm	**Any other business**	Ramon Pink	

Action Register	Responsibility	Timeframe
Send RF paper and process chart to ISLA members	**Bridget**	

Immunisation Service Level Alliance
Action Notes/Minutes

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Venue: C&PH	
Date: 16 October 2018	**Time:** 2-4.00pm
Present: Ramon Pink (Chair), Tony Walls, Donna MacLean, Alison Wooding, Helen Fraser, Bridget Lester and Sarah Marr Linda Wensley (CCN Coordinator)	
Apology: Stuart Walker	
Notes cc'd to: CCN Programme Office	

	Item	Discussion/Action	Responsibility	Date due
•	**Welcome**	Linda Wensley CCN programme manager and Jeanie Watson CDHB Communication Team attended the meeting.		
•	**Confirmation of Minutes**	• Minutes of 31 July 2018 meeting were approved to be sent to the CCN office	Bridget	Friday 19 October
•	**Previous Actions & Matters Arising**	• BCG – follow up meeting held around BCG programme. Agreed to focus on infants born after 1 June 2018. There will currently be no catch up programme. In 2019 we will look at vaccinating the siblings of those infants vaccinated after June 1st 2018. There is a demand from people who are going back to countries where TB is endemic – but currently we are not vaccinating these children due to capacity issues. • Start date of Flu programme 2019. Canterbury was included in the WC submission.		
•	**ISLA Work plan**	Q1 201819 – currently in this quarter • 8month olds – This target was met for the DHB but not for Maori children. • 2 year olds: achievied 94% coverage with high declines and opts off • 5 year olds –93% being achieved with high declines and opts off. Improved coverage was seen this quarter for Maori children **Declines and Delayers Project –** work has progressed looking at the Declines and Delayers Project. However the funding for this has yet to be approved by the P&F leadership team. We are now aware that IMAC is also in the process for developing some resources to support this issue. Currently we have placed this piece of work on hold until the IMAC resources are available. **New Reporting Template** – CCN has developed a new reporting template, which will look at how we are progressing against our work plan. To support this there is also a desire to have **some tracking of key targets.** **Interest from other DHBs –** other DHBs have been contacting P&F and the Missed Events Service to better understand our system and processes. It is encouraging to see that other DHBs want to learn from our model, and a credit to the hard work that has gone into developing and implementing our model.	Copy of Immunisation SLA 201	
•	**Rheumatic Fever**	o Currently we have 47 rheumatic fever patients on the Canterbury register. There is funding for general practice to support these patients and provide monthly penicllin injections for free. However, we only have around 30% compliance.	Bridget to send RF paper and process chart to ISLA members and a more detailed	

	Item	Discussion/Action	Responsibility	Date due
		○ CDHB Missed Events Service has taken over the tracking and follow up of those cases that are not getting timely secondary prophylaxis. ○ 24% of new rheumatic fever cases discovered during antenatal care ie are pregnant women. Need to work on providing education around this, to LMCs – What are the referral pathways? ○ Discussion around what value there would be for including RF in scope of the Immunisation SLA, to give strategic overview to RF in Canterbury. Discussion. ○ It was agreed that ISLA would take an initial oversight of the strategic work occurring for RF and see how this progresses. ISLA focus is on providing a systems wide strategic view, different from the operational functions provided by the multidisciplinary clinical group.	overview to occur at our December meeting Ramon to let people working on RF know about the strategic change.	
•	**Flu Communications**	○ Jeanie from the DHB Communications Team attended the meeting. DHB Communication intend to use the same branding and messaging from 2018 for the 2019 programme. There was some concern around the messages and the graphics. Communications are yet to undertake an evaluation of the programme to determine its impact. This should occur in partnership with ISLA as they have access to the coverage data.		
•	**Operational**	○ Interest Register – This was updated.	Bridget All members	
•	**Next Meeting**	**Meeting schedule for 2018, 2-4pm at C&PH** • Tuesday 4 December		

Canterbury Clinical Network

Immunisation SLA

20-Sep-18

Highlights and additional comments:

Objective	Health System Outcomes	Actions	Short hand actions	Timeframe for Completion	Measures Of Success / Target / Milestones	Clinical Lead(s)	Project Lead(s)	Action: % Completed	On Track?	Challenges: Why the action is off track	If off track what is being done. Update on SLM & EOA
1. Pregnant women in Canterbury are all offered the opportunityto be vaccinated during pregnancy	• Delayed/avoided burden of disease & long term conditions • Population vaccinated • Protective factors enhanced • Risk factors addressed	1.1 Support LMC to promotion immunisation	*Support LMC to promote imms*	Ongoing	• LMC focus group held in Q1 • Resource stocktake completed in Q1 • 50% of women are vaccinated for Pertussis during Pregnancy	Ramon Pink Helen Fraser	Bridget Lester	10%	Y		
		1.1.1 Hold a focus group with LMCs to determinewhat they need	*Complete a focus group to determine theneeds of LMCs*	Q1				10%	Y	Initialcontact had been mad e with College and the LMC Liaise aroundthese gorups and a pathway forward has been developed. Theplan will hopefully be to hold thefocus groups in early December.	
		1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations	*LMCs provided with tools to assist their vaccination conversations with pregnant women*	Q3				0%	Y		
		1.1.3 Doa stocktake of resourcesto determinewhat the gaps are	*Stocktake of resources*	Q1				0%	Y	It was decided to not progressthis until the Focus Groups had been held.	
		1.2 General Practice Teams are supported to vaccinate	*Support General Practice to vaccinate pregnant women*	Q4				0%	Y		
		1.2.1 Educated around the importance of Pregnancy Vaccinations	*Education on the importance of pregnancy vaccination is provided*	Q3				0%	Y		
		1.2.2 Education how to load the events on the NIR	*Education provided on loading NIR events*	Q3				0%	Y		
		1.3 Work with the MoH to ensure regular data is providedto the DHB around the uptake of the Pregnancy Vaccination programme	*Regular data on uptake of pregnancy vaccination sourced from the MOH*	Q4				0%	Y		
2. Reduce the number of declined immunisation event in our region, against the immunisation schedule	• Contribute to National Health and Performance Targets • Delayed/avoided burdenof disease & lonf term conditions • Populationvaccinated	2.1 Develop a more structure d general practicedecline process	*Develop a structured process for general practice immunisation declines*	Q2	• Decrease in child hood immunisation declines – compared to 2017 Year baseline/Target • Reduction in the Maori decline rate baseline/Target	Ramon Pink	Bridget Lester	90%	Y		
		2.2 Work with C&PH to better understand why Maori are declining immunisation EOA	*With C&PH increase understanding of declining Maori immunisation rate*	Q2				0%	Y		

Exceptions report

Filters workplans to show at risk actions only. Note: This is published in the final report, along with the 'Highlights and additional comments' box on your workplan

Immunisation SLA

20-Sep-18

Actions	Timeframe Completed	Action: % Completed	On Track?	Challenges: Why the action is off track	If off track what is being done. Update on SLM & EOA
1.1 Support LMC to promotion Immunisation	Ongoing	10%	Y	0	0
1.1.1 Hold a focus group with LMCs to determine what they need	Q1	10%	Y	Initial contact had been	0
1.1.2 LMCs are given the tools to support them have to have conversation with Pregnant women around vaccinations	Q3	0%	y	0	0
1.1.3 Do a stocktake of resources to determine what the gaps are	Q1	0%	Y	It was decided to not	0
1.2 General Practice Teams are supported to vaccinate	Q4	0%	Y	0	0
1.2.1 Educated around the importance of Pregnancy Vaccinations	Q3	0%	Y	0	0
1.2.2 Education how to load the events on the NIR	Q3	0%	Y	0	0
1.3 Work with the MoH to ensure regular data is provided to the DHB around the uptake of the Pregnancy Vaccination programme	Q4	0%	Y	0	0
2.1 Develop a more structured general practice decline process	Q2	90%	Y	0	0
2.2 Work with C&PH to better understand why Maori are declining immunisation EOA	Q2	0%	Y	0	0

Data Dashboard (Goal: each CCN group works toward their own data monitoring dashboard)

Data Metric Definition
95% of 8month olds, year olds and 5 year olds are fully vaccination.
75% of those 65 of over are vaccinated.
75% of girls born in 2006 are fully vaccinated for HPV
85% of children born in 2006 are fully vaccinated for Tdap
95% of New-borns are enrolled with General Practice at 3 months of age

	Data Source
	MoH
	MoH
	MoH
	MoH
	MoH

Risk Report

Immunisation SLA

20 September 2018

Risk ID	Risk area	Stakeholder(s) affected	Probability *(Low, Medium, High)*	Impact *(Low, Medium, High)*

Risk Rating *(Low, Medium, High)*	Risk Response - planned mitigation strategies / controls *(Accept, Avoid, Transfer and/or Reduce)*	Comment

Date of risk review
(Month Year)

BUSINESS CASE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Provider Name:	Christchurch PHO Rural Canterbury PHO Pegasus Health Canterbury Immunisation
Service Name:	Support Services for Rheumatic Fever Patients
Service Description:	A programme to provide regular Penicillin injections to Rheumatic Fever patients, either in their nominated general practice or via an Outreach Nursing Service

Provider Number:	Click here to enter number.	**Contract Number:**	Click here to enter number.

Prepared by: Bridget Lester **Date:** 19/07/2018

Attachments: Click here to list any attachments.

Sign-off & Comments	Action	Date
Service Development Manager	**Service Performance Review:** YES ☐ NO ☐ **Comments**	
Team Leader	Approved/Declined	
Financial Manager	**Checked Sections 1, 7 and 8 YES** ☐ **NO** ☐	
Leadership Team Recommendations	Approved/Declined/Deferred	
P & F General Manager	Approved/Declined	
CEO Canterbury DHB	Approved/Declined	

1. Proposed Service

That Canterbury DHB move from the current general practice lead programme, with an adhoc nursing service programme to a more formalised outreach nursing service.

Proposed Service

Start Date	End Date	Duration (months)	PU & Description	Volume	Price	Contract Total
1/9/18	**31/12/2018**	3	Outreach Nursing	1	$25,000	$25,000 per annum
1/1/19	**31/8/2020**	21	Outreach Nursing	1	25,000	$25,000 per annum
1/09/2018	**31/08/2020**	24 months	PHOG0003 Follow up Primary Care for patients with Rheumatic fever	48 individuals per year	To be worked through	Up to $25,200 per annum
				Contract Total		$100,400
				Annual Total		$50,200

❑ **Performance Based Funding (Milestone Payments)**

❑ **Fee for Service**

2. Recommendations

That the Team Leaders review the business case and approve the following

1. The extension of the current agreement with the 3 Canterbury PHOs for the provision of Rheumatic Fever services to their patients
2. That Canterbury DHB offer an agreement to Canterbury Immunisation for the provision of an specialised Outreach Nursing service for Rheumatic Fever patients
3. That the DHB Missed Events / LinKIDS service take the lead on the coordination of referrals to the Outreach Nursing Service
4. That work occurs with Community and Public to ensure they provide the clinical support to the MES / LinKIDS service
5. That work occurs to provide supportive resources, including education sessions to general practice teams and that a resources is developed for patients, around they care and treatment needs for Rheumatic Fever.

6. Purpose of the Brief

Background

In 2013 Planning and Funding undertook a piece of work looking at Rheumatic Fever. At the time there were around 14 Rheumatic Fever patients residing within our DHB.

A number of innovates were set up to support these patients, these included

- Funding be made available to general practice to see the patient 4 times a year
- Oral Health services available through hospital dental

- Funding so the patient could have 3 monthly GP visits, funding for $5 per items to fill prescriptions and funding for monthly nurse visits to give injection for most patients.
- The time contracts were put in place with PHOs to funds these services to the value of $6,720.
- A Rheumatic Fever Health Pathways was also developed.

Current Situation

There are currently 48 people in Canterbury with Rheumatic Fever, they range in ages from 5 – 39 year old, of which 18 are aged between 18-25 years old. When looking at where they live, 8 Patients live in Ashburton and 38 in the Christchurch region. 1 is at Burnham Camp and 1 at Waimari Beach. Of this there have been 8 new cases identified in 2018.

In 2017, the need to look at Rheumatic Fever, and improve our pathways was determined. There was concern that the current group of patients were not being treated. It was agreed that the Planning and Funding Missed Events Service (MES) would undertake a project to look the service and determine how best to engage the patients.

Due to a number of capacity constraints MES did not start this piece of work under April 2018. However, during the past 2 months the following concerns have been raised

- General Practice needs to be better supported with Rheumatic Fever. While Penicillin injections are due every 28 days, a number of practice have their patients on monthly recalls.
- General Practice have indicated that they find it difficult to navigate the current health pathway including what process should be followed if a patient is not engaging with general practice.
- There is currently no comprehensive Canterbury DHB database that can be used across the system to track and monitor the status of patients.

The patients, of the 48 patents, they are at 31 different practices, however Moore Street, New Brighton Health Care, Piko Te Ora and Greers Road have three or more patients. There are 19 practices with only 1 patient.

A recent audit has occurred of practices (these happen every 6 months). This audit has shown of that of the 48 patients, 39 of them are overdue their penicillin injections.

There is concern that the current model of service delivery is not meeting the needs of the patients, and work is urgently required to develop a model to suit the patients. It is common knowledge that Rheumatic Fever patients tend to have complex lives, and that the normal expectation attending general practice my not work for this group of patients.

Proposed Service intervention

Having a relationship with General Practice and presenting there every 28 days is the best practice model of care for these patients, however this is not occurring. The current model enables general practice teams to arrange for acute nursing to attend at the patient's home, if they don't present. However, to do this the patient must be overdue. The process for enabling this service is complex, and not easy to action. The Health Pathway is not clear, and the service provider is not fully aware of the expectations around this. There is also confusion from Community and Public Health around their role in managing patients with Rheumatic Fever.

Proposed new service model

It is proposed that we continue to offer General Practice as the patients first point of care, but have one outreach nursing service available to provide injection if they are unable to attend general practice. This should be a specific contract to provide this service and a block basis. It is believed that the Canterbury Immunisation, Outreach Nursing Team is best suited to provide this service.

Why Outreach Immunisation instead of other Nursing Services? Outreach Immunisation has close linkages with the Missed Events Services and LinKIDS who are coordinating the Rheumatic Fever. OIS have experience in working with complex families and visiting in multiple locations. To make sure Rheumatic Fever patients are receiving their Penicillin, there is a need for close monitoring and close working relationships between the coordination focusing and the nursing service – this relationship and processes are already in placed with OIS service.

The DHB MES will monitor and coordinate referral to this service on notification of general practice if the patient misses an appointment, or if the patient indicates that they would prefer the Outreach Nursing model of that of the general practice model.

Current Agreement with PHOs

The agreement with PHOs was extended on September 2017. While at the time there were 30 RF patients, the financial modelling occurred on 25 patients.

PHO were funded at rate of $42per patient per month. Within the monthly package patients could be seen by a GP 4 times a year, and by a practice nurse 13 times a year for their Penicillin injections.

Consideration will need to be given to the best funding method for general practice, as the current block funding method for patients would see practices being funded for patients they may not see. Discussion will need to occur with the PHOs on this model.

7. Context

Rheumatic Fever is cause by sore throats that have not been treated and have resulted in a autoimmune reaction and damaged the heart valves (called rheumatic fever). Once this occurs a person require prophylactic penicillin injections every 4 weeks for a minimum of ten years, sometimes for life (if cardiac damage is severe). Historically it was thought that this was mostly children, but this age group is changing.

Canterbury DHB implemented a service model 5 years ago for the 14 patients we know of who had rheumatic fever, within our DHB due to the increased volume of patients, and the different demographic we need to consider doing something differently.

Currently our model is impacting on equity and access for service for our most vulnerable population, and while there is an expectation that this group should attend general practice – we know this is not occurring. The Missed Events Service has engaged with a group of these patients of the past 3 months – and the overall sense is that they don't want to or can't attend general practice and are putting up barriers.

Effectiveness penicillin injections are effective in reducing RF relapse.

Equity Maori and Pacific children, who are the majority of RF patients, see barriers with the current service model .

Value for Money. Prevention of RF relapse and of endocarditis are cost effective, compared to hospitalisation and valve replacement. This model shift will not cost the DHB a lot of money, but it could prevent expensive health care in the future of these patients (a heart valve replacement for a child can only occur at Starship at a rate of around $25,000)

Acceptability - this process builds on current arrangements, in Canterbury patients are accessing penicillin via their general practices. There is buy-in from local clinicians and the Medical Officer of Health.

Ability to Implement. This should be possible as it builds on current arrangements. Discussion have not yet occurred with the 4 contract holders

8. Implementation

General Practice Services - Conversations will need to occur with the 3 PHOs around the change in service model. There agreement will be rolled at the same price – with funding for 4 GP visits, 13 Practice Nurse visits. As indicated above consideration will need to be given to who this service is funded, as the current price per patient will not fix this changed model.

Outreach Nursing - Engagement is also required with Canterbury Immunisation, around picking up this service. It is proposed this this agreement will be for a 3 month period, block funded as we work though the actual demand for the service. Current modelling indicates that to provide penicillin injections to 30 patients a year, at 13 injections per patient would be around 390 hours work which is around a 0.2 FTE, or a day a week. This should be funded at around $25,000 per annum, to account for the travel costs and regular visits to rural locations. The aim is to have the agreement in place by the 1 October at the latest, but ASAP - to be negotiation with the provider.

Coordination and Education – a plan will be developed between LinKIDS and C&PH, by the end of September around the development of a database, clinical support, education to general practice and information for patients. The expectation is that Education Session and resource will be completed by end of December.

Access to Penicillin – a piece of work is required to determine who best to ensure the supply of Penicillin to the Outreach Nursing Service. This should be a cost-natural process – but the logics need to be worked through.

9. Collaboration

This proposed model change has occurred in discussion with Dr Ramon Pink, Medical officer of health and developed following the attendance at a recent Rheumatic Fever workshop and visits to the Waikato DHB – which highlight the concern around the current service model.

Item	Risk	Mitigation
1	Canterbury Immunisation is not keen to provide this service	Conversations need to stat asap, and the funding needs to be reasonable for them to agree to take the service on. Block funding over Fee For Service is proposed, as this will show a level of trust in them as a provider. It will be clear, that if they are not fully utilising the RF resource, this can be used to support their current Outreach Immunisation Service contract.
2	Patients still don't make themselves available for the Outreach Nursing service	The current MES are great at engaging parents for childhood vaccinations. This same team will be used to engage patients for this service, hopefully improving the uptake of the service. However, this will be monitored to determine if the DNA continues. The patient resource, is hoped to improve their understanding of their condition and the timeframes around injections.

10. Revenue

N/ A

- ❑ **Side Funding (Supporting Evidence Attached)**
- ❑ **Reimbursements from other DHB/Provider Arm/ACC/Other**

11. Cost and Budget

Contract Spend				2017/18	2018/19year	2019/2020
Current Contract	**Proposed Contract**	**Variation Amount**	**Cost**	14,283	Up to 50,200	Up to 50,200
12,600	50,200	$37,600	**Budget**	12,600	12,600	50,200
			Variation	1,683	37,600	000

Explanation for Variance

Please note that the budget for the 2017/18 was not set at level for all patients to receive their 4 GP visits and 13 Practice Nurse Penicillin injections. In 2018/18 there were 30 patients, but the budget also had only been done on 25 patients.

Intended Payment Mechanism (Please select one)

- ❑ **Sector Services (invoice to MoH)**
- ❑ **Accounts Payable (invoice to P&F)**
- ❑ **Journal (for Provider Arm)**
- ❑ **Other – Please explain**

NOTE: You will require approval from the Finance Team if you choose a payment mechanism that is not Sector Services.

12. Current Performance and Opportunities

Canterbury Immunisation is a high performing providers who have over the past 2 year assisted the DHB in reaching the Immunisation Health target, 7 quarters out of 8.

They have a great relationship with Missed Events / LinKIDS.

13. Reporting

Standard Sector Services Monitoring	YES
Additional Reporting	YES

All Agreements must include reporting

Please add reporting template (if required) as an appendix to this brief.

Explanation for Identified Reporting

A regular practice audit needs to occur to determine if they are engaging with their patients, and a monthly spreadsheet will need to be completed by Outreach Nursing. Both reports need to go directly to the LinKIDS services for monitoring purposes.

14. Specifications

The service specification for the General Practice service will be reviewed to make sure if fits with the updated service model, and has the need for regular auditing included.

A new service specification will need to be drafted for the Outreach Nursing Service

15. Strategic Alignment

Rheumatic Fever had been a key focus on the Better Public Service targets. These however have now been removed, but this does not reduce the importance of supporting these patients.

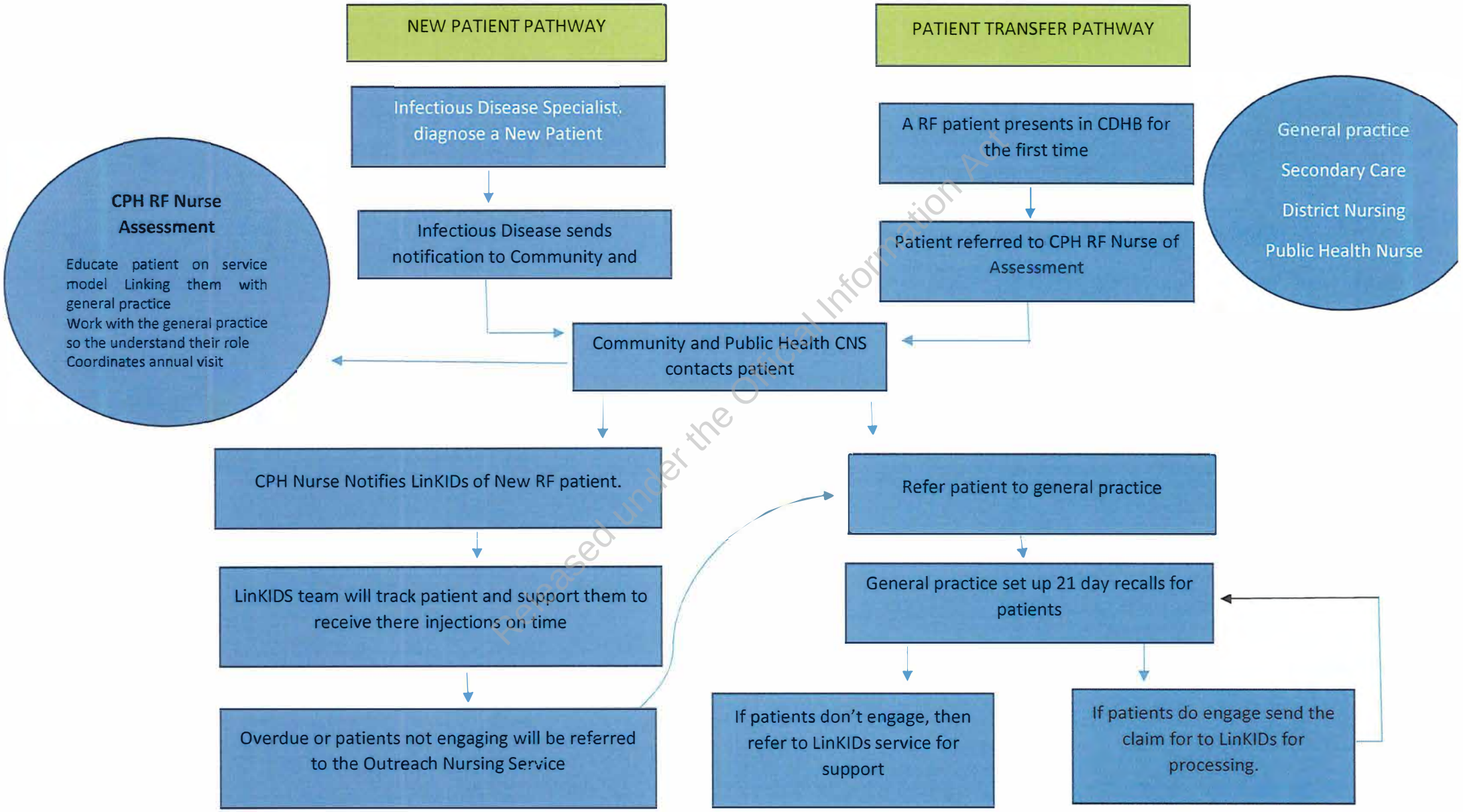
Strategic Goal	Service Link	Service Design Principle
1 – Services that support people / whanau to take increased responsibility for their health. Click to choose from drop-down list.	Yes – this will enable them to have improved access to services	*New services reflect this and a change of approach within existing services.*

2 – Development of primary health care and community services to support people / whanau in a community based setting and provide a point of ongoing continuity which for most people will be general practice. Click to choose from drop-down list.	Yes – this will be a mixed model of service, aimed at keeping people well in the community	*Primary and secondary services are delivered in community-based settings and provide a point of continuity in ongoing care.*
3 – Release secondary care based specialist resources to be responsive to episodic events and provision of support to primary care. Click to choose from drop-down list.	Yes –if we get the model right, then there will be less engagement with secondary care services	*Free up secondary care services and specialist resources to deliver episodic events and complex cases alongside support and advice to primary and community services.*

16. Evaluation

Consistent service monitoring will occur with a shift to 3 monthly service audits for general practice teams and monthly reporting for Outreach Nursing Services.

Rheumatic Fever Pathway



Work Plan progress	Timeframe
Review progress on your current work plan Step through CCN Work Plan guide and with your alliance group develop a drat work plan	November 2018 – January / February 2019
Meet with the analyst to guide with the development of measures for your data dashboard	January 2019
Draft work plan to be submitted	11th February 2019
CCN Programme Office, DHB Accountability Team, System level Measures Facilitator, Maori Caucus and Pacific Reference Group review work plans and provide feedback	12th – 25th February
Feedback provided to facilitators	25th February 2019
Final work plan to be submitted	15th March
First Draft of the DHB Annual Plan and SLM Improvement Plan submitted to the Ministry	March 2019
DHB Annual Plan circulated to PHOs and AST for feedback	April 2019
CCN Work Plan submitted to ALT for their endorsement	April 2019
DHB Annual Plan submitted to ALT for their endorsement	May 2019
DHB Annual Plan submitted to the Ministry of Health	May 2019

CCN (Your group's name) WORK PLAN 2019/20 TEMPLATE

Alliance groups are asked to develop work plans in the following three sections:

Section 1: Specific Achievable Priority Actions

*This section is the focus of your efforts in 2019-20. The aim is have a **limited number of targeted priority actions** that are **achievable** and will **achieve the best value possible.***
These actions should seek transformational change, improved health system outcomes and/or enhanced integration.

Section 2: Actions to Monitor Progress

***Actions that the group wants to monitor**, rather than focus efforts on changing; for example Canterbury's results on a national performance target, or the ongoing delivery of a local service.*

Section 3: Data Dashboard:

Identify key measures that indicate:

- *Progress on delivery of your work plan priorities;*
- *Any short to medium term impact of these; and or*
- *Any health targets of SLMs you are monitoring*

Provide a brief comment on your choice of measures.

OBJECTIVE *Succinctly what you are aiming to achieve. E.g. Improved Oral Health for 0-18year olds, Improved access to mental health services for older persons, increased sustainability rural workforce*	**ACTIONS** *What are the priority actions that the group can achieve in 2019-20 to address the stated objective. Indicate if these actions contribute to improved Equity of Outcomes (EOA) or System Level Measures (SLM)*		**TIME FRAME** *In which Q will the action be completed (Q)*	**MEASURES OF PROGRESS & SUCCESS / TARGET/ MILESTONES** *How will we know if we have been successful at implemented our actions. Are there milestones to measure progress against Is there a target or baseline metric to include.*	**ACCOUNTABILITY**		**Canterbury Health SYSTEM OUTCOME** *What Canterbury System Outcome are we contributing too? What is the outcome we are trying to achieve?*
	EOA or SLM				**CLINICAL LEAD**	**PROJECT LEAD**	
SECTION ONE: Priority Actions Towards Transformational Change, Improved System Outcomes and/or Enhanced Integration							
1.		1.1.		▪			
2.		2.1		▪			
3.		3.1.		▪			

OBJECTIVE *Succinctly what you are aiming to achieve. E.g. Improved Oral Health for 0-18year olds, Improved access to mental health services for older persons, increased sustainability rural workforce*	**ACTIONS** *What are the priority actions that the group can achieve in 2019-20 to address the stated objective. Indicate if these actions contribute to improved Equity of Outcomes (EOA) or System Level Measures (SLM)*		**TIME FRAME** *In which Q will the action be completed (Q)*	**MEASURES OF PROGRESS & SUCCESS / TARGET/ MILESTONES** *How will we know if we have been successful at implemented our actions. Are there milestones to measure progress against Is there a target or baseline metric to include.*	**ACCOUNTABILITY**		**Canterbury Health SYSTEM OUTCOME** *What Canterbury System Outcome are we contributing too? What is the outcome we are trying to achieve?*
	EOA or SLM				**CLINICAL LEAD**	**PROJECT LEAD**	
4.		4.1.		▪			
5.		5.1.		▪			
SECTION TWO: Actions Towards Monitoring Progress							
6.		6.1.		▪			
7.		7.1.		▪			
8.		8.1.		▪			
9.		9.1.		▪			
10.		10.1.		▪			

SECTION THREE: Key metrics the group will use to indicate; progress with delivering work plan actions, impact of actions on health outcomes, monitor performance targets etc. *(Consider whether the data is available in a way that identifies any inequity)*

Description of Metric	**Data Source**	**Comments on access to data / metrics**
1.		
2.		
3.		
4.		

CCN Risk Policy

Canterbury Clinical Network
Transforming Health Care Whanau Ora Ki Waitaha

1 PURPOSE AND SCOPE

The purpose of this document is to provide a framework for the management of risk relating to the Canterbury Clinical Network (CCN) Alliance Leadership Team (ALT), Alliance Support Team (AST), Programme Office, workstream activity and service level alliance activities.

The various organisations associated with CCN remain responsible for managing risk relating to their various services assets and infrastructures.

1.1 CCN Risk Management

In order to effectively manage risks across the CCNs work programme, a centralised risk register will be held by the CCN Programme Office with risk response plans to support it.

1.2 Responsibilities

Each SLA/workstream is required to conduct a regular risk assessment of their work programme and forward their risk register to the CCN Programme office. They are also responsible for documenting and implementing risk responses.

The AST and ALT via the CCN Programme Office will review and endorse the risk register and proposed risk response plans proposed by the CCN workstreams and services level alliances.

1.3 Structure of Risk Evaluation

Risks will be evaluated against probability and impact axes with each aspect being rated as either low, medium or high. The ratings are then combined to develop a final risk rating using following matrix.

Impact rating	❶ Risk ID	Probability rating: High	Medium	Low
	High			
	Medium	❶		
	Low			

Risks above the agreed threshold (i.e. red of any other risk of concern) will be reported as per the CCN Reporting Framework in an exceptions report (template available from the CCN Programme Office).

Following initial scoring, a risk response category will be identified and a plan developed for responding to the risk. Typical types of **risk responses categories** include:

- **Accept** the risk with no active management as the impact and probability are low;
- **Avoid** the risk i.e. typically involves changing some aspect of the project/service or initiative so that the threat can no longer occur;
- **Transfer** the risk i.e. a third party takes responsibility for some or all of the expected impact;
- **Reduce** the risk i.e. taking action to reduce the potential impact and/or probability of the risk.

Once the risk register has been finalised, the identified risks will then be reviewed as a standing item on the workstream/SLA meeting agenda.

The following templates will be used: Appendix A: Risk register

RISK REGISTER – Immunisation SLA, Dec 2017

Canterbury Clinical Network
Transforming Health Care Whanau Ora ki Waitaha

Risk ID	Risk area	Stakeholder(s) affected	Probability	Impact	Risk rating	Risk Response Category (i.e. Accept, Avoid, Transfer and/or Reduce) and planned response	Change since last report/comments
❶	*EXAMPLE: Clinicians lose confidence in the transformation process due to delays, barriers or non-delivery.*	*Primary, secondary and community based clinicians*	*Medium*	*High*		***Reduce:*** *Maintain open communication with providers. Balance promises against the ability of the networks to deliver.*	*New*
	Revised Health target of 95% of 8month olds are fully vaccinated is not achieved	Primary clinicians	Medium	Low		This is seen as a low risk to the wider community due to our current high performance, however could be seen as a high political risk. This target has been reached for the past few quarters, however missed this quarter. There has been issues with timeliness and increased referrals to MES and OIS.	Risk still active
	Performance Target of 95% of 2 year old are fully vaccinated is not achieved		Medium	Low		This is seen as a low risk to the wider community due to our current high. Good progress has been made in 2017 toward this target. It was achieved in Q3 and very close in Q4.	Risk still active
	Performance Target of 70% of 12year old girls are fully vaccinated for HPV is not achieved		Medium	Low		This is seen as a medium risk. The co-delivery model with the 11 year old event and the Year 8 School programme has seen an increase is coverage. The introduction of boys in 2017 has been another step to normalise this event. Coverage is sitting at around 62%, so 8% off target	Risk still active by reduced from Medium to Low
	Performance Target of 98% of new-borns are not enrolled with general practice by 2 weeks		High	Low		This is seen as a low risk to the community. Data on this is difficult to monitor, however we are now analysing the enrolment status of health target children and notifying PHOs if the children are not enrolled.	
	OIS does not have the capacity to support general practice to reach the revised health target		Medium	Medium		This is seen as a low risk to the community. However as indicated above, there has been a shift in referrals to MES and OIS which is putting pressure on the system.	Moved to Medium, as there are capacity issues with both MEC and OIS

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 3 December 2018 1:20 p.m.
To: Alison Wooding; 'donna.maclean@barringtonmc.co.nz'; Helen Fraser; marr.sarah@gmail.com; pharmacists@bishopdale.co.nz; Ramon Pink; 'Tony Walls'
Subject: Data report Dec 2018
Attachments: Data report Dec 2018.docx

Hi all

Please find attached the draft report for our meeting tomorrow

Regards Bridget

our health system

Key Performance Indicators and Childhood Immunisation Reporting

December 2018

Immunisation Reporting Programme

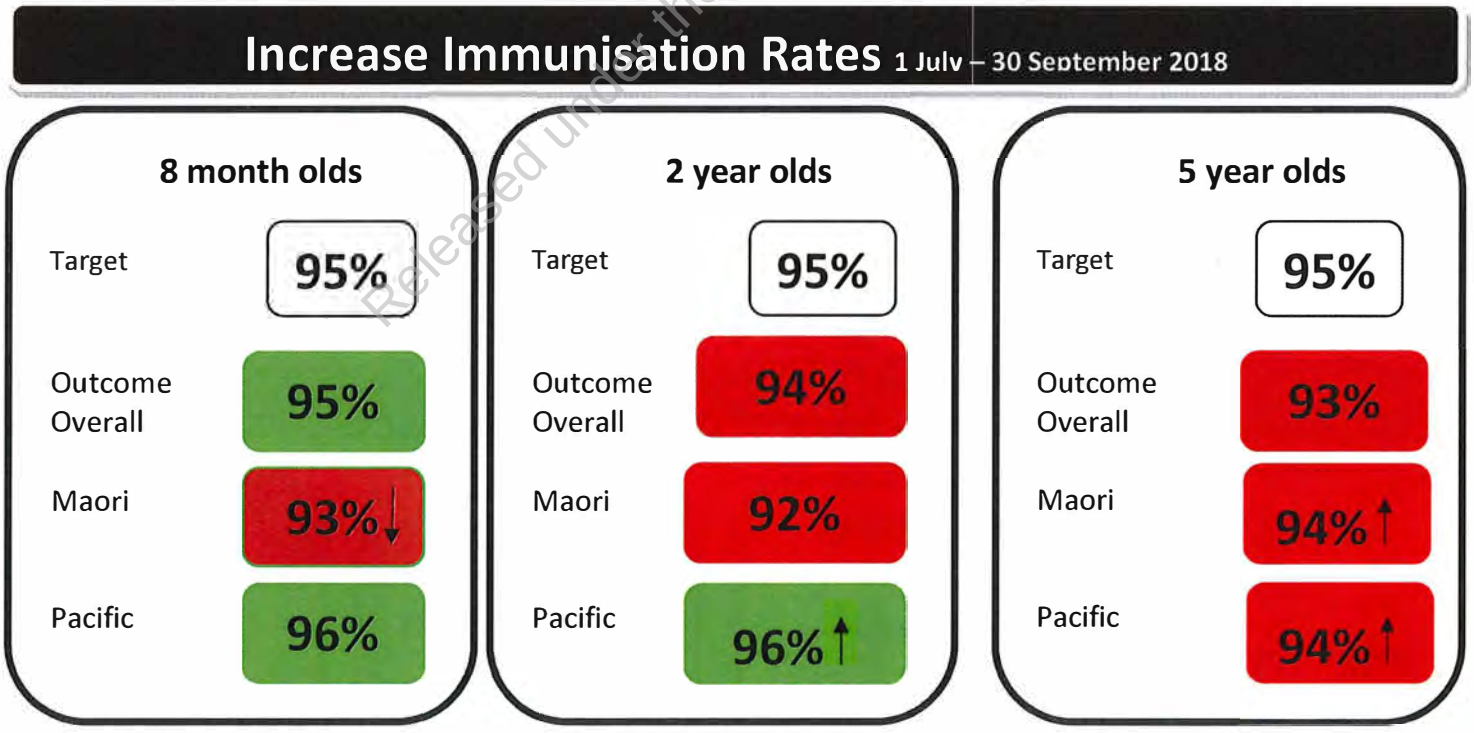
The Immunisation Reporting Programme is a work in progress.

Its goals are:

- to provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
- to identify how the health system is progressing line with MoH Heath Targets

Data sources

- Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.



Childhood Immunisation – MoH Health Targets up until 1 October 2018

Fully Immunised 8 month olds – DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress including pending	Q3 2018/19 Progress including pending
95% fully	94.6% fully	94%	85% fully
1% overdue	1.6% missed	.4% could reach	10.8%
	3.8% Opt/Dec	6% can't reach	4% can't reach

Fully Immunised Two year olds - DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress	Q3 2018/19 Progress
94% fully	94% fully	94% fully	92% fully
1% overdue	1.1% missed	.37% overdue	2.7% overdue
	4.8% Opt/Dec	5.52%	5% opt/dec

Fully Immunised Four year olds - DHB LEVEL

Q4 2017/18 Actual	Q1 2018/19 Actual	Q2 2018/19 Progress	Q3 2018/19 Progress
93% fully	93% fully	92% fully	90% fully
2.2%	2% overdue	.6% overdue	3.3% overdue
	5.1% Opt/Dec	7.1% can't	6.7% can't

Fully Immunised 8month, two and five year - PHO LEVEL 1 December 2018

	Actual	Progress	Actual	Progress	Actual	Progress
	8month olds		2 year olds		5 year olds	
Christchurch PHO	99%	99%	98%	96.8%	96%	90.5%
Pegasus	96%	95%	95%	95%	95%	93.6%
Rural Canterbury	91%%	94%	97%	95.4%	92%	94.5%

Influenza Coverage 30 Sept 2018

	PHO	Total	Maori	Pacific	Asian	NZE	Other
0-4 year olds	Christchurch PHO	7%	5%	2%	9%	6%	9%
	Pegasus Health	10%	5%	5%	15%	1%	10%
	Rural Canterbury	7%	4%	2%	8%	7%	8%
	Canterbury	10%	4%	4%	14%		11%
5-19 years	Christchurch PHO	12%	5%	5%	12%	9%	34%
	Pegasus Health	14%	8%	7%	14%	16%	13%
	Rural Canterbury	8%	4%	5%	8%	9%	7%
	Canterbury	12%	6%	6%	12%		14%
20-64 years	Christchurch PHO	10%	7%	7%	8%	9%	20%
	Pegasus Health	15%	11%	10%	12%	16%	15%
	Rural Canterbury	12%	9%	6%	8%	13%	11%
	Canterbury	14%	9%	10%	11%		15%
65 plus	Christchurch PHO	57%	55%	50%	48%	58%	59%
	Pegasus Health	69%	62%	60%	58%	70%	68%
	Rural Canterbury	61%	54%	36%	49%	62%	49%
	Canterbury	62%	40%	52%	44%		64%

Pre teen Immunisations 30 Sept 2018

HPV coverage

DHB: Canterbury		Number of males received HPV dose (numerator)					Estimated eligible population -male* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	154	37	162	1,158	1,511	450	120	220	2,250	3,040	34%	31%	74%	51%	50%	12 (0.4%)	0 (0.0%)
	HPV-final	129	34	142	1,018	1,323						29%	28%	65%	45%	44%	2 (0.1%)	
2005	HPV-1	207	68	174	1,289	1,738	430	120	220	2,210	2,970	48%	57%	79%	58%	59%	31 (1.0%)	()
	HPV-final	166	48	148	1,071	1,433						39%	40%	67%	48%	48%	12 (0.4%)	
2006	HPV-1	200	71	195	1,292	1,758	500	140	250	2,210	3,110	40%	51%	78%	58%	57%	89 (2.9%)	1 (0.0%)
	HPV-final	111	38	119	763	1,031						22%	27%	48%	35%	33%	51 (1.6%)	
2007	HPV-1	91	29	126	670	916	590	140	310	2,220	3,250	15%	21%	41%	30%	28%	51 (1.6%)	1 (0.0%)
	HPV-final	9	6	27	91	133						2%	4%	9%	4%	4%	25 (0.8%)	
Total	HPV-1	652	205	657	4,409	5,923	1,970	520	1,000	8,890	12,370	33%	39%	271%	50%	48%	183 (1.5%)	2 (0.0%)
	HPV-final	415	126	436	2,943	3,920						21%	24%	188%	33%	32%	90 (0.7%)	

DHB: Canterbury		Number of females received HPV dose (numerator)					Estimated eligible population -female^ (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other^^	All	Maori	Pacific	Asian	Other^^	All	Maori	Pacific	Asian	Other^^	All	Decline	Opt off
2004	HPV-1	246	93	203	1,536	2,078	430	130	210	2,210	2,980	57%	72%	97%	70%	70%	121 (4.1%)	0 (0.0%)
	HPV-final	199	72	171	1,340	1,782						46%	55%	81%	61%	60%	101 (3.4%)	
2005	HPV-1	222	66	222	1,503	2,013	440	120	230	2,040	2,830	50%	55%	97%	74%	71%	91 (3.2%)	1 (0.0%)
	HPV-final	169	50	184	1,200	1,603						38%	42%	80%	59%	57%	62 (2.2%)	
2006	HPV-1	217	81	197	1,239	1,734	470	130	250	2,110	2,970	46%	62%	79%	59%	58%	86 (2.9%)	1 (0.0%)
	HPV-final	125	42	119	718	1,004						27%	32%	48%	34%	34%	55 (1.9%)	
2007	HPV-1	112	35	128	624	899	560	130	300	2,100	3,080	20%	27%	43%	30%	29%	62 (2.0%)	1 (0.0%)
	HPV-final	10	1	21	97	129						2%	1%	7%	5%	4%	25 (0.8%)	
Total	HPV-1	797	275	750	4,902	6,724	1,900	510	990	8,460	11,860	42%	54%	315%	58%	57%	360 (3.0%)	3 (0.0%)
	HPV-final	503	165	495	3,355	4,518						26%	32%	216%	40%	38%	243 (2.0%)	

11 year old T-dap coverage

	Total	NZE	Maori	Pacific	Asian	Other	Opt Off	Declined
RCPHO	62%	72%	53%	50%	11%	33%	0%	4.30%
CCPHO	60%	82%	57%	-	41%	67%	0%	3.80%
Pegasus	69%	75%	71%	49%	49%	54%	0%	5.5%
Canterbury Total	67%	75%	65%	45%	45%	49%	9%	5.30%

Q1 201819 Milestone Ages Report

Canterbury

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1,594	1,354	85. %	821	720	88. %	264	204	77. %	94	74	79. %	263	247	94. %	152	109	72. %	19 (1)	1.2 (0.1) %	46	2.9 %
8 Month	1,643	1,556	95. %	858	822	96. %	276	256	93. %	84	81	96. %	284	280	99. %	141	117	83. %	14 ()	0.9 (0.0) %	47	2.9 %
12 Month	1,618	1,546	96. %	900	864	96. %	259	244	94. %	74	73	99. %	249	245	98. %	136	120	88. %	11 ()	0.7 (0.0) %	42	2.6 %
18 Month	1,602	1,394	87. %	838	761	91. %	239	192	80. %	85	62	73. %	280	252	90. %	160	127	79. %	16 (1)	1.0 (0.1) %	62	3.9 %
24 Month	1,701	1,602	94. %	911	863	95. %	247	228	92. %	79	76	96. %	301	296	98. %	163	139	85. %	15 (0)	0.9 (0.0) %	66	3.9 %
5 Year	1,626	1,510	93. %	888	847	95. %	246	231	94. %	71	67	94. %	258	242	94. %	163	123	75. %	23 ()	1.4 (0.0) %	60	3.7 %
12 Year	1,778	1,184	67. %	1,122	838	75. %	224	146	65. %	87	39	45. %	178	80	45. %	167	81	49. %	16 ()	0.9 (0.0) %	95	5.3 %

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 27 January 2015 12:18 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; Catherine Crichton (catherine.crichton@westcoastdhb.health.nz); Cheryl Brunton; Christina Houston; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; Lee Harris; Linda Hill; 'Lorraine Williams'; 'Nikki Mason'; 'Pauline Ansley'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers for Immunisation Advisory Group meeting Thursday 29th Jan, 2-3.30pm
Attachments: WC Imms Reporting Jan Summary.docx; 2015 Flu plan.docx; Feedback on the HPV Paper (2).docx; Draft Agenda - IAG 29 1 2015.docx; West Coastd Practice systems review status 2014 combined.docx; Immunsation Workplan - West Coast DHB.doc; IAG Minutes 28 Nov 2013.doc; FW: Latest NISG media release; Draft paper " National HPV Immunisation Programme: How to progress and revitalise" . Comments due by 23 Jan 2015

Hi all

Please find attached the agenda and papers for our meeting on Thursday. Please note new start time for 2pm. Please also note that I have embedded some papers into the agenda. This is useful so you know what goes with what part. I have also attached all papers just in case you can't print them.

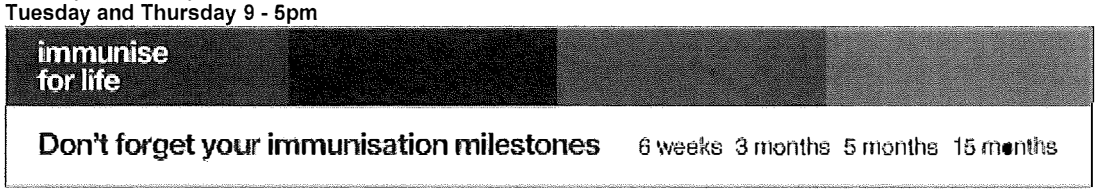
Papers include:
Agenda
Minutes from our last meeting
Immunisation Reporting
Current 2014/15 years work plan
Draft Flu Plan for 2015
Draft response to MoH HPV paper (I have attached email from the MoH regarding the paper
Draft work plan for 2015/16
West Coast Immunisation Tool Kit – for discussion – you don't have to print and review if you are not interested!
NISG media release FYI

Please let me know if you are unable to make it.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm



our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2014/15

	8 month olds	2 year olds	5 year olds
Target	90%	95%	80%
Outcome Overall	82%⇧	93%⇧	79%
Maori	95%⇧	88%⇩	73%⇩
Pacific	100%	100%	75%

The Immunisation Reporting Programme is a work in progress.

Its goals are:
To provide DHB, PHOs and Service Providers with a better understanding of their performance inline with similar providers
To identify how the health system is progressing line with MoH Heath Targets
Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources
Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

2 year olds

Row Labels	Fully	Declined	Catch up schedule	Overdue at milestone age	Grand Total
Buller Medical Centre	20	1			21
Franz Joseph Clinic	4				4
Greymouth Medical Centre	18	1	1		20
High Street Medical Centre (2005) Ltd	15	1			16
Karamea Medical Centre	1				1
Reefton Medical Centre	2				2
Rural Academic General Practice	8			1	9
Westland Medical Centre	23	1			24
Whataroa Rural Clinic	2				2
Moana Rural Clinic	2				2
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd	4				4
Kaiapoi Medical Centre	1				1
Greymonth Medical Centre	1				1
Grand Total	**102**	**4**	**1**	**1**	**108**

8month Q3 2014/15 – In progress

Row Labels	fully	Declined	on hold - with OIS	overdue with GP	Grand Total
Buller Medical Centre	17	2		3	22
Franz Joseph Clinic	1			1	2
Greymouth Medical Centre	15		1		16
HariHari Rural Clinic	2	1			3
High Street Medical Centre (2005) Ltd	7	2			9
Reefton Medical Centre	5			1	6
Rural Academic General Practice	3				3
Westland Medical Centre	17	2		1	20
Whataroa Rural Clinic	1			1	2
Moana Rural Clinic	3				3
Coast Medical Consultancy Ltd	2				2
South Westland - Haast	2				2
Grand Total	**75**	**7**	**1**	**7**	**90**

2 year olds Q3 2014/15 In progress

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2000	HPV-1 Quadrivalent	17	3	1	85	106	40	0	0	130	170	43%	-%	-%	65%	62%	20 (11.8%)	0 (0.0%)
	HPV-2 Quadrivalent	17	2	1	84	104						43%	-%	-%	65%	61%	13 (7.6%)	
	HPV-3 Quadrivalent	17	2	1	84	104						43%	-%	-%	65%	61%	13 (7.6%)	
2001	HPV-1 Quadrivalent	11	0	4	100	115	40	5	5	160	210	28%	0%	80%	63%	55%	10 (4.8%)	0 (0.0%)
	HPV-2 Quadrivalent	11	0	4	99	114						28%	0%	80%	62%	54%	10 (4.8%)	
	HPV-3 Quadrivalent	9	0	3	94	106						23%	0%	60%	59%	50%	10 (4.8%)	
2002	HPV-1 Quadrivalent	4	2		24	30	30	0	0	150	190	13%	-%	-%	16%	16%	1 (0.5%)	0 (0.0%)
	HPV-2 Quadrivalent	4	2	0	24	30						13%	-%	-%	16%	16%	0 (0.0%)	
	HPV-3 Quadrivalent	3	2	0	22	27						10%	-%	-%	15%	14%	0 (0.0%)	
2003	HPV-1 Quadrivalent	0	0		1	1	30	0	5	140	180	0%	-%	0%	1%	1%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	32	5	5	210	252	140	5	10	580	750	23%	100%	-%	36%	34%	31 (4.1%)	0 (0.0%)
	HPV-2 Quadrivalent	32	4	5	207	248						23%	80%	-%	36%	33%	23 (3.1%)	
	HPV-3 Quadrivalent	29	4	4	200	237						21%	80%	-%	34%	32%	23 (3.1%)	

Seasonal Influenza Plan 2015 year

1.0 BACKGROUND

The Seasonal Influenza vaccination programme is an annual event occurring between March and July each year. This is the biggest immunisation programs within NZ, with a target of 1.2million people being vaccinated within the 5month period. On the West Coast a large focus is given to providing this programme and ensuring that our eligible population is vacationed.

2.0 PURPOSE

The purpose of this plan is to identify the key steps and decision required to ensure the smooth running of the 2015 season.

3.0 DISCUSSION

There are a number of key decision that need to be made to ensure the smooth running of the 2015 season. These include agreement on strategy, agreement on communications branding, messaging and channels and timeframe.

Immunisation on the West Coast is governed by the Immunisation Advisory Group, however we also need to include the thinking of NSIG, the national influenza strategy group who set the national direction, when developing our plan.

Key decisions

The key decision that are required to be made for the 2015 season are:

- What level of support does Primary Care need in 2015
- What level of support does NIR need in 2015
- What level of support does secondary care service need in 2015

To ensure that any communications and decision around strategy are communicated with the sector in a reasonable timeframe, there are key times that these decisions need to be made. The following table is a guide around these timeframe and responsibility for these decisions.

2015 Communication Programme

Feedback from the 2014 programme has been that the Communication Programme was rolled out too late and that better planning and timeliness is required for the 2015 year. There are two tiers for the promotional programme.

Tier One – the national programme developed by NSIG which may include posters, newspaper advertising and radio / TV promotion. For the 2015 year NISG is develop a reviewed communication programme. This is yet to be shared with DHB. Due to the size of the West Coast some of national innovates do not get delivered such as radio, bus backs and mall advertising.

Tier Two – DHB Direct messaging to providers to support the programme. In 2014 this included letters to Maori providers, rest homes, pharmacy and LMCs.

Target Group:

2015 Actions required

Action	Timeframe	Responsibility
West Coast Communisations Strategy	IAG 29th Jan	Lee Harris – DHB Comms
Education to general practice teams regarding the 2015 programme and linkages with the NIR (suggest with use the resources developed by Pegasus Health) Face to face meetings with each general practice	Early February	Immunisation Coordinator
National Resources distributed to practices	Mid February	NSIG
Letter to LMCs around the 2015 programme and key messages	Early February	Letter drafted by P&F, Signed by Cheryl and sent by P&F
Direct contact with each LMC regarding the 2015 programme	Early March 2015	Immunisation Coordinator
Other stakeholders – key messages to be distributed	Early March 2015	Planning and Funding

Feedback on the HPV Paper – West Coast Immunisation Advisory Group

The focus on this paper is on how to revitalise the HPV programme, and should not be about directing DHB services models. Our attention should be on targets, and ensuring that the system we have in place is supported to achieve what need to be achieved.

Targets

Firstly however we need to ensure we have a good system to capture performance. Currently the NIE only has birth cohort children born from 2005. These children will not be 12 until 2017. At the national workshop, while there was a support for HPV targeted, it was clearly communicated that these should not be put in place until this

a) Cohort year was included on the NIR Birth Cohort. This would be for the 2016/17 year. Until then all girls given the HPV event, will need to be opted on to the NIR and set up as a new users and/or
b) The current issues with the NIR are sorted. While we understand that an NIR rebuild is occurring, there continues to be number of issues with loading non-birth cohort events on the NIR. These include, but are not limited to
    - If the user selects the single syringe icon to add a new immunisation and selects and completes a HPV quadrivalent immunisation, the user will NOT receive any prompts to opt on to the NIR nor will a message be generated.
    - Even if the patient has their NIR status set to Opt On in the More (4) tab on the Patient Register screen, adding and completing a HPV immunisation independent of the HPV schedule (i.e. via the single syringe) will not generate a message to the NIR.

Until this issues are sorted, the data will not be accurate, and monitoring DHB performance on inaccurate information is not reasonable.

Delivery Model

A DHBs focus should protecting our population. We acknowledge at a specific coverage is required to ensure protection. The MoH is tasks with setting this target and supporting DHBs to achieve this. There is a large concern that this paper is requiring all DHBs to provide a specific service model (a year 7 or 8 School based HPV programmes). This is directing individual on how to run their business. As Canterbury DHB is only DHB not providing a school base programme aimed at year 8 (the Canterbury DHB programme is aimed at year 10) this recommendation is clearly directed at them.

How do we revitalise the programme

- Develop a Communication programme around the HPV programme, around why it is important, and at what age is key to the success of this programme. Normalise the programme within the national immunisation schedule.
- Support General Practice teams to promote the programme, regardless of the setting it is delivered, will also ensure increased coverage. This vaccine widely questioned via social media and on the internet. Nurses need to be confident in the messages they are giving out around HPV, and encourage parents to vaccine, if the tough questions are asked. Currently there are limited resources available to them.

AGENDA

West Coast Immunisation Advisory Group

Thursday 29 January 2015, 2.00 – 3.30pm, Community & Public Health
Dial in pin: 083033 68454#

Item	Description	Discussion Leader	Papers
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (27 November 2014)	Cheryl Brunton	Draft IAG Minutes 27 Nov 2014.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting o Seasonal Influenza – 2015 Plan o HPV programme update o Pregnancy vaccinations	Bridget Bridget, Betty and Pauline Janet Bridget	WC Imms Reporting Jan Summary.docx IAG 2015 WORKPLAN DRAFT.c Yes Yes
5	2015 Work plan	Cheryl Brunton	Immunsation Workplan - West Co
6	Immunisation Week Planning	Cheryl Brunton	
7	Immunisation Tool Kit	Bridget Lester	West Coastd Practice systems revi
8	Any other business	Open	

Matters arising from last meeting

Issue	Action	Due date
Seasonal Influenza 2015	Plan to IAG by 27th November for 2015 Season	5 December
Seasonal Influenza	Distribute notes of MoH workshop	20 December
HPV promotion	Update poster as discussion	20 December

Area	Review needed	Review by	Feedback
Maintaining the Cold Chain and Cold Chain Accreditation	Handbook references need to be changed	Done	Cold Chain System and Cold Chain Acc
National Immunisation Register (NIR)	Check page content still ok	Done	NIR Practice systems review status 2014 c
Processing the new notification messages	Check page content still ok	Done	Processing the New (Birth) Notification I
Fully vaccinated by Children	Check page content still ok	Done	updated targets and process charts.c
Precall and recall	? Something about changing the auto recall	Done	updated recall section.docx
Example of Precall letters	Welcome letter needs a new Imms schedule 3 month, 5 month 15 month letters need to be changed to reflect new schedule	Done	updated letters.docx
Status Query	Check page content still ok	Done	Status Query.docx
Opt on/ Opt off	Check page content still ok	Done	Opt On Opt Off system.docx
How to enter a vaccination of a Non NIR Cohort person	New Page Please review	Bridget	Entering Non birth cohort events on NI
Rescheduling Immunisation	Add in something about changing the recall for catch ups	Tracey	Not completed

HPV	change the overview to include at risk boy information, Add in Process for at risk boys Change eligibility to include new groups	Done	HPV Section updated.docx
Authorised Vaccinators	Check page content still ok	Done	Authorised Vaccinator Informati
Declining Immunisations	New page please review	Bridget	Declining Immunisations 2015
Referral to Outreach Services	Check page content still ok	Done	updated OIS process.docx

Maintaining the Cold Chain and Cold Chain Accreditation

Overview

The success of an immunisation programme depends on maintaining vaccine potency (Immunisation Handbook 2014, Appendix 6; Page 595)

The cold chain accreditation process is a Ministry of Health regulation. It involves the practice completing a self assessment, followed by a review by an immunisation co-ordinator. For CCA to be achieved the practice must meet the essential requirements. It is valid for a period of one year. Completing this process will enable immunisation providers to meet the cold chain indicator of the Royal NZ of General Practitioners (RNZCGP) Cornerstone Programme.

- What is the cold chain?

The cold chain is the system of transporting and storing vaccine at 2 to 8 degrees celsius from the place of manufacture to the point of vaccination.
The success of an immunisation programme depends on maintaining vaccine potency.
Practices have a responsibility to have robust cold chain management systems in place.

- How is the Cold Chain maintained?

Within your practice there will be two people designated to maintain the cold chain for your surgery, however all medical staff should have a working knowledge of how to do this in the event of a fridge failure.
Maintaining the cold chain involves daily min/max recordings from your vaccine fridge door (recording graphs can be downloaded from the IMAC website –www.immune.org.nz) and a monthly download of your datalogger hanging in your fridge. These recordings must be kept for 10 years.

- Cold Chain Folder

All practice staff should be familiar with the contents and whereabouts of the cold chain folder. It holds information on all aspects of the vaccine fridge including how to download the datalogger each month including what to do in the event of an emergency that may harm your vaccines.

- What happens when the cold chain accreditation expires?

Your Immunisation Co-ordinator will provide the following documents to be completed by the designated staff responsible for the cold chain management in your surgery.

Practice/Provider Cold Chain Policy
Dose and Volume requirements
Cold Chain Accreditation Practice/Provider Assessment.

At a mutually agreed time your Immunisation Coordinator will visit and complete the cold chain accreditation process for a further period of time.

National Immunisation Register (NIR)

Overview:

The NIR is designed to retain a record of all immunisations given to individuals on the current childhood immunisation schedule (for eligible patients). The information will be retained through the lifespan of that individual and up to 10 years after their death.

The NIR provides immunisation status information to approved health providers, to assist with recall and follow up of individuals by sending immunisation updates and overdue notices as applicable to providers. Following a Status Query request (see Status Query section) the information held at the NIR enhances the ease of opportunistic vaccination.

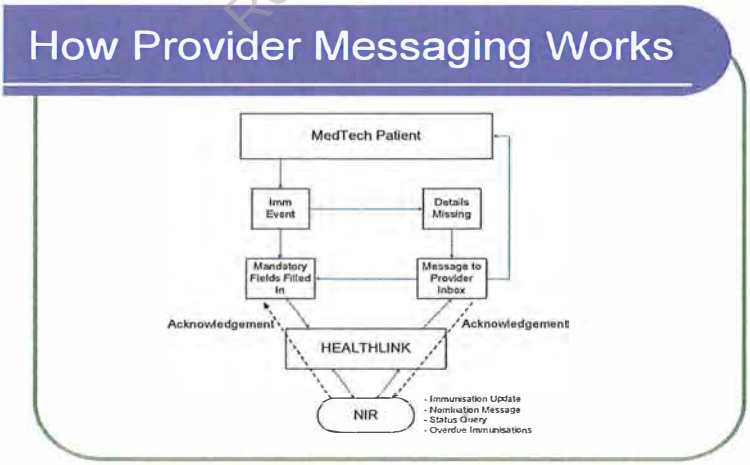
The NIR went live in Canterbury on 21st November 2005. All children receiving the National Schedule subsidised vaccinations will have these recorded together with the MeNZB programme, BCG vaccinations and Hepatitis B vaccinations given at birth to babies of Hepatitis B positive mothers. As this was a staged rollout throughout New Zealand children born before 21/11/2005 in other regions of New Zealand may have their immunisations recorded in advance of this date.

Other vaccinations now recorded on the NIR are as follows:

- 11yr dTap and young ladies receiving HPV
- Influenza started being recorded on NIR in 2014
- From 1 July 2014 the following vaccines are recorded on NIR for both children and adults who meet the eligibility criteria:
  - Rotavirus (RV5), Meningococcal C(MenCCV), Varicella (VV), MMR, Hepatitis A, Tdap (dTap) - pregnant woman, HepatitisB, and Meningococcal A, C, Y and W135 (MCV4-D).

To establish what is recorded on the NIR see Opt On, Opt Off section page 1.

How a message is sent from MedTech to the NIR



- On the machine with Healthlink on it there should be the Directory Monitoring icon "cog".

This should not be on any other machine and is most likely on an Administrators computer. To start this go to the Menu Utilities / NIR / Directory Monitoring Utility, click OK.

- *If this is on your machine and you do not have Healthlink, right-click and choose Shutdown*

Your Practice Management System is not messaging

- To see if Healthlink messaging is working you can look in the HMS Event Log and check for errors, plus see the dates and times of loads.

  Any errors call Healthlink on 0800 288 887 or your PMS technician

- Check the Schedular is going. This tells Medtech what times you want messages sent. It will appear on the taskbar at the bottom right hand side of the screen of the Healthlink computer.

  If it has switched off, go to *Utilities/Schedular/Start Schedule* then close.

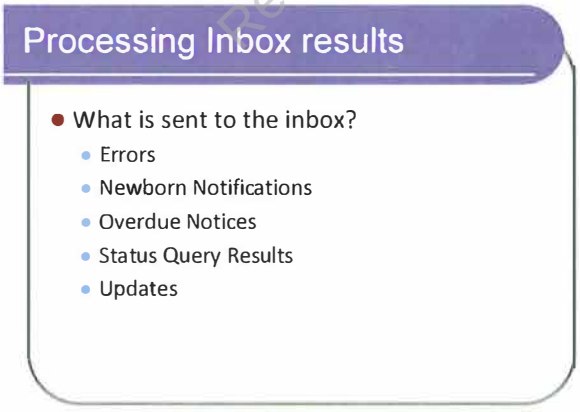
Other things to consider are whether:

- A technician has worked on your system or upgraded it.

  This could have changed the setting on your computer so that your system is not looking in the right places for the files. In this case contact your technician.

- The internet provider or Healthlink are having problems. If the NIR is having problems it will affect a status query but regular messages will still go but will be parked at the NIR.

What the NIR sends to the Provider Inbox



Filtering the Provider Inbox

See Status Query section Page 3.

NIR New Patient Notification Message

At birth, the caregiver completes NIR information onto the Newborn Enrolment Service Referral form which includes nominating the following 5 services GP, Wellchild, NIR, Oral Health, Breastfeeding support. This information is sent by the LMC to the Newborn Enrolment Service coordinator, who then forwards onto each service.

The NIR messages this information to the nominated Provider in the form of a New Patient Notification message.

It is recommended you accept the birth nomination immediately or call the NIR if you have any concerns as to the validity of the nomination. Note "B" code funding details below.

The rationale for accepting all birth nominations is to avoid babies having no provider, having delayed vaccinations and being lost.

If the baby has been born in hospital you may have already received the Post Natal Discharge Summary. This is further evidence you are the baby's provider for health services.

- What do I do when I receive a birth notification - see Processing the Birth Notification section

Code B for newborns

A pre-enrolment registration code B for newborns has been introduced. GP's/Practices who accept the NIR notification may enter the newborn baby in their PMS (with a new patient status code of "B") and submit that newborn baby "B" enrolment for funding in the next quarterly download.

Full enrolment (signed enrolment form) must be completed and the patient status changed to "E" before the download for the second quarter funding. There will be no claw back in the first funding quarter.

We do not recommend you wait until the baby presents at your surgery to accept the nomination.

On acceptance of the new patient nomination the National Childhood Immunisation Schedule is then assigned to the patient with the associated recalls. The patient is automatically set to Opt On (see Opt On/Opt off section page 1).

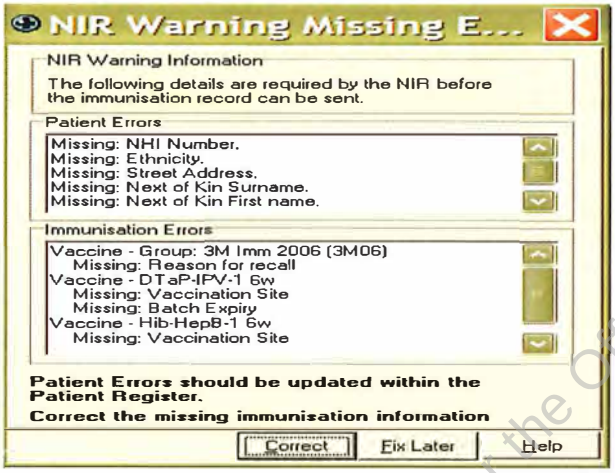
When the baby is 2 weeks of age it is recommended the practice send out a welcome letter, a sample of which is in the Precall Letter section, together with immunisation information which ideally should include an enrolment form.

Following immunisation, messaging to the NIR will now commence electronically unless Parent/Caregiver chooses the Opt Off option.

Details required to message to the NIR:
Unless the following details are correct immunisation details will not be recorded on the NIR and errors will appear in the Provider Inbox

- Patient's details are correctly entered **including next of kin details, ethnicity and NHI number** in addition to the vaccination details.
- MMR must have the diluent batch number recorded.

If you get this error correct it otherwise you will get a message in your Provider Inbox



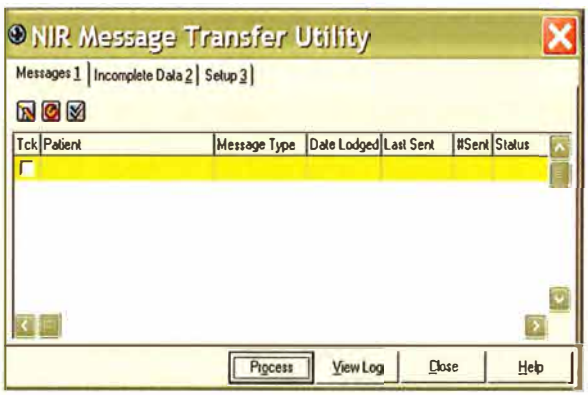
How to check the vaccination event has messaged to the NIR

NIR Message Transfer Utility

This can be viewed under Utilities/ NIR/NIR Message Transfer

There are 3 status types

- Sent - this does not mean it has been received by the NIR
- **Acknowledged – this means the NIR has received the message**
- Failed



Failed Messages

Try a dot (.) in the note field and resend (See above PMS is not messaging)

Medtech tries 3 times to send a message. You will then get a Maximum Retry Count message in the Provider Inbox. These will need to be reset by highlighting the failed message and clicking on the  icon.

You can hit the process button to re-send otherwise this will go automatically in time

When you decline a new patient notification in error

Ring the NIR and they will resend the notification.

When the Parent/Caregiver chooses a different provider

This happens occasionally and the practice finds they don't see the child for whom they have accepted the nomination and cannot contact the family. Contact the NIR who may have immunisations recorded elsewhere and can alter the Provider details.

Patients transferring

Practice staff should perform the usual procedure of making the patient inactive – this will bring up a screen asking if you would like all recalls removed- choose yes. Contact the NIR and advise them where the patient has transferred to.

Adverse events

Should an adverse event occur the outcome report from the Centre of Adverse Reactions Monitoring (CARM) should be made available to the NIR to complete the child's vaccination history

Immunisations given overseas

Do not try to enter vaccines given overseas onto the child's immunisation screen.

Fax/Send a copy of the original to the NIR . They will enter the vaccines. 10 days later send a Status Query and press the update button. The vaccines will then be entered on the child's immunisation screen as **given elsewhere**. **Please change given elsewhere to given overseas**.

If the immunisation status of a child is uncertain or unknown, plan the catch-up schedule assuming the vaccine has not been given (Page 547 Immunisation Handbook 2014)

For catch up vaccinations check the Immunisation Handbook or call your local Immunisation Co-ordinator

100% of children with missed events are known to the practice

Practices receive overdue reports each quarter. These reflect children overdue their immunisations and are based on the vaccination events the NIR has recorded. It may be the

vaccines have been given but have not messaged to the NIR (see how to check vaccination event has messaged to the NIR).

Practice Administration Responsibilities

Practices need to ensure that all relevant staff involved in the NIR have completed an NIR Authorised User Agreement (AUA) for the location the vaccination is taking place (available from NIR). This may require several user agreement forms being filled out if the vaccinator works from multiple locations. This includes both Practice Nurses and General Practitioners.

All nurses that will be delivering vaccinations must have the following in their staff setup:

- Select from the Main Menu **Setup/Staff/Members**
- Open the correct nurses record by double clicking
- On the Main Tab ensure that the nurse is ticked as a Provider

On the Provider Tab ensure:

- Affiliation has been selected as NZNC (New Zealand Nursing Council)
- Nurse Registration Number has been entered

It is recommended this be completed when the nurse is provided with the practice documentation ie IRD form.

NIR Contact details

Although the names may change it is anticipated these contact phone numbers will remain in operation.

Sharyn Kenning Phone: 03 769 7531

Francess Zampese Phone: 03 769 7464

FAX :03 769 7460

High Street

P O Box 387,

Greymouth

Processing the New (Birth) Notification Message

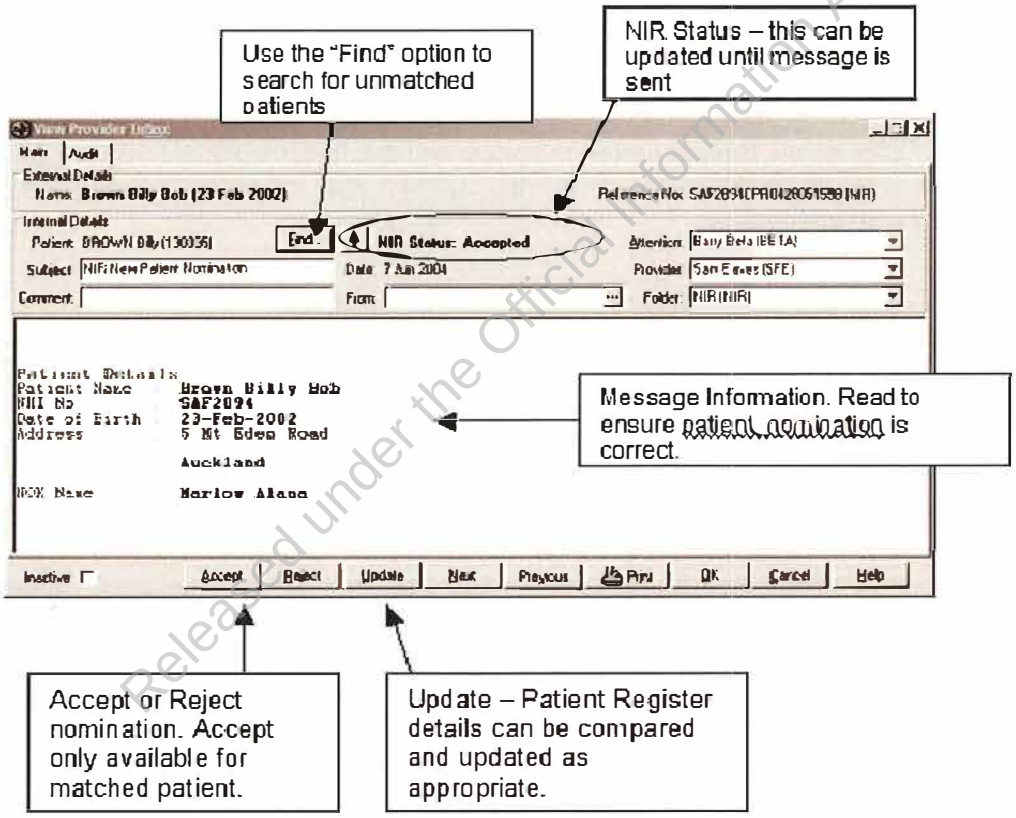
Overview

At birth, the baby's caregiver selects a Provider whom they wish to be responsible for their immunisations. A form is completed by the caregiver and sent to NIR.

NIR then sends a "**New Notification Message**" to the nominated provider for them to accept or reject the nomination.

The "**Status**" of an NIR Message is displayed to the right of the "**Find**" button. This status can be updated up until the actual message is sent to NIR.

Nomination Message:



Step 1: **Provider Inbox**

Click on the **Provider Inbox** icon  . All messages are delivered into the patient's Provider In Box. When the provider cannot be matched, the message will go into the default providers inbox.

Step 2: **View Message**

Highlight the record you wish to view and double click on it to open up.
The View Provider Inbox screen will open and display the details of the selected record.

Step 3: **Read Message**

Check the "**Patient Information**" within the text of the message to decide if you wish to accept or reject the nomination.

A: **If the patient is matched:**

Click on the **Update** button to update any details in the Patient Register window. You will need to confirm DOB, Title, Address, NHI, Next of Kin first name, last name and relationship.

B: **If the patient is not matched or incorrectly matched:**

Use the **Find** option to select the correct patient. It will display the *Search Patient* screen.

Once the required patient is selected, it is necessary to acknowledge the "*Change Patient*" prompt. Select the **Yes** option to update the message with the selected patient.

Click on the **Update** button to update any details in the Patient Register window. You will need to confirm DOB, Title, Address, NHI, Next of Kin first name, last name and relationship.

C: **If the patient is not matched and not setup already:**

Use the **Find** option to select the correct patient. It will display the *Search Patient* screen.

Click on the **Add** button. When selecting the **Add** option, the details contained within the Patient Details Section of the NIR message, will be displayed by default within the New Patient Screen.
Information includes the patient's Surname, First Names, Title, Street, Suburb, City, Date of Birth, NHI, Ethnicity and Next Of Kin.

Step 4: **Accept or Reject Record** *(see instructions below)*

Accept Record:

a) The **Accept** option is only available if the message is matched.

b) Confirm the acceptance of responsibility for the baby's immunisations by clicking onto the **Accept** option.

The NIR Status within the message is set to Accepted, and the "Attention" field is blanked out so that the record will not appear in the Providers In Box once it is closed. The next inbox record in the Provider's list will be displayed automatically.

Reject Record:

a) The Reject message is visible for matched and unmatched messages. When checking the patient's details, if the provider decides to decline the responsibility for the baby's immunisations then a rejection message should be sent to NIR by clicking on the **Reject** button.

Selecting the "**Reject**" option for an unmatched patient, will automatically link the notification to the "NIR Unmatched" account holder and a rejection message will be sent to NIR.

The NIR Status within the message will be set to Rejected and the "Attention" field is blanked out so that the record will not appear in the Providers In Box once it is closed. The next inbox record in the Provider's list will be displayed automatically.

Fully vaccinated children

Ministry of Health Immunisation Health Target is that 95% of eight months olds will be fully vaccinated by 30 December2014.

They have also sent a number of performance targets for DHBs

- 95% of 2 year old are fully vaccinated
- 90% of 5 year olds are fully vaccinated

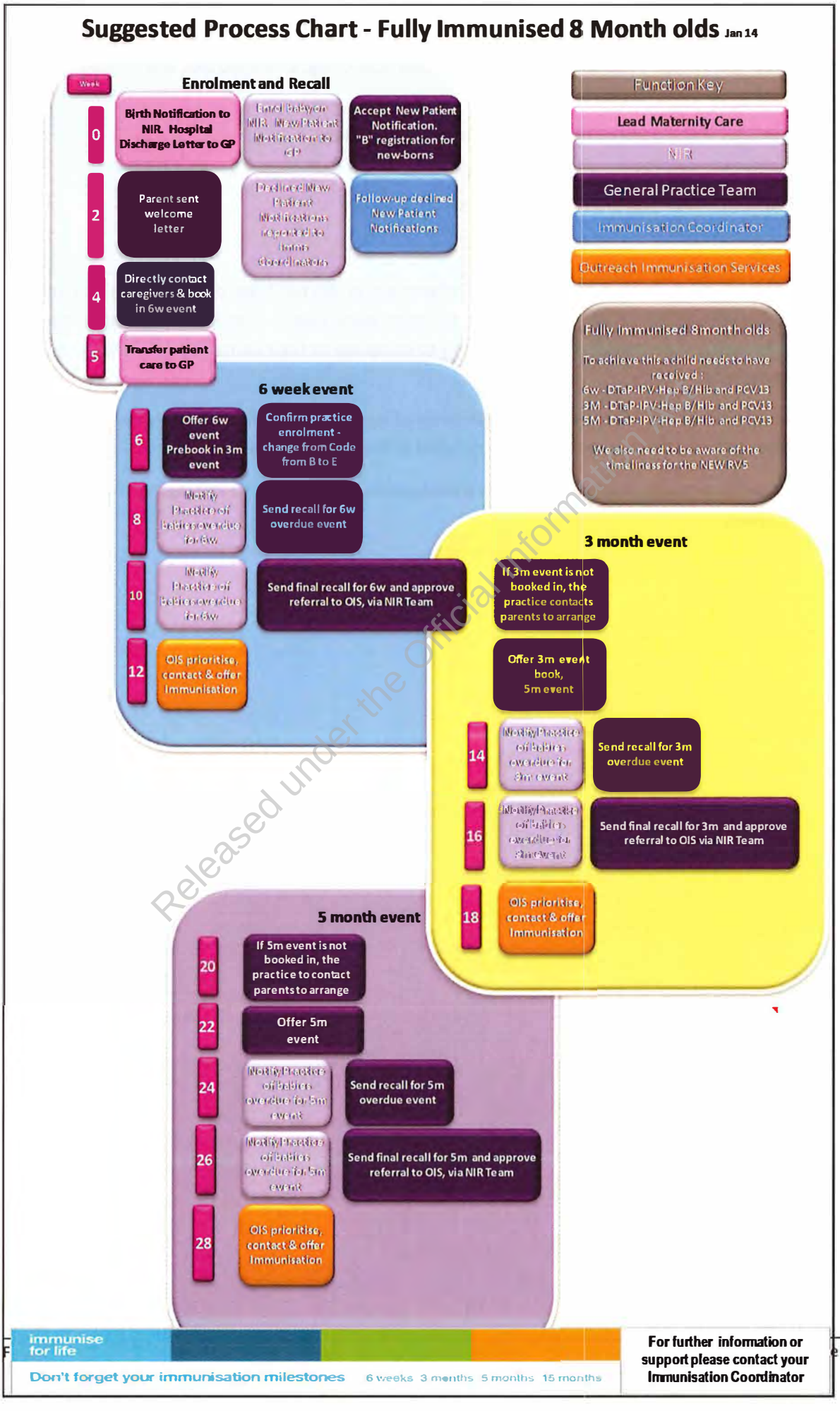
Overview:

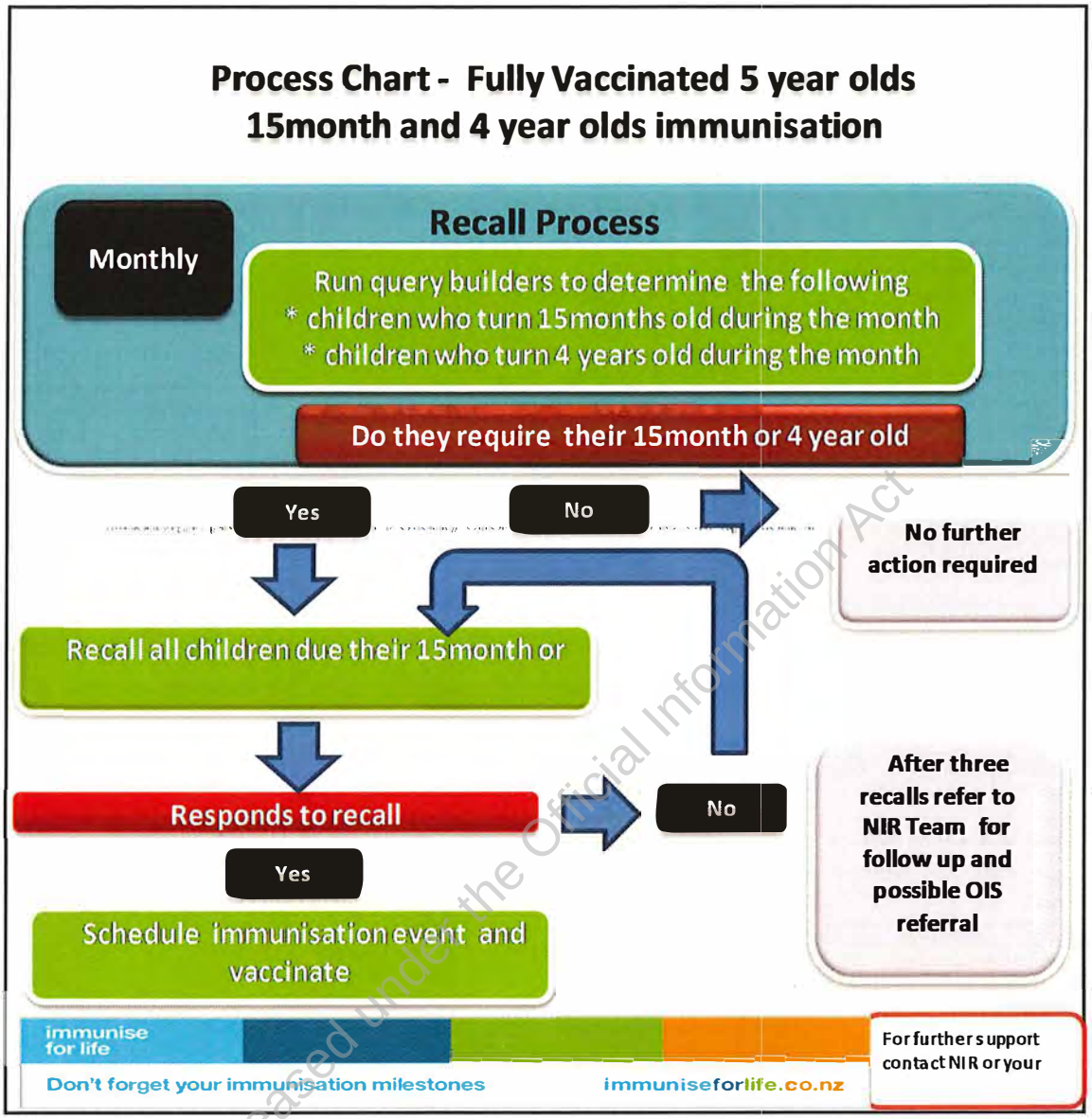
Timely immunisation is important to ensure infants are protected from diseases such as Pertussis, Measles and Pneumococcal disease. Children are most vulnerable to these diseases from birth to six months. Research shows children are more likely to complete all their immunisations if they begin the schedule early.

A suggested process chart for all departments involved in achieving the 8 month fully vaccinated target has been distributed to all surgeries and is included at the end of this section.

The following process charts have been developed to assist you in achieving these targets are attached.

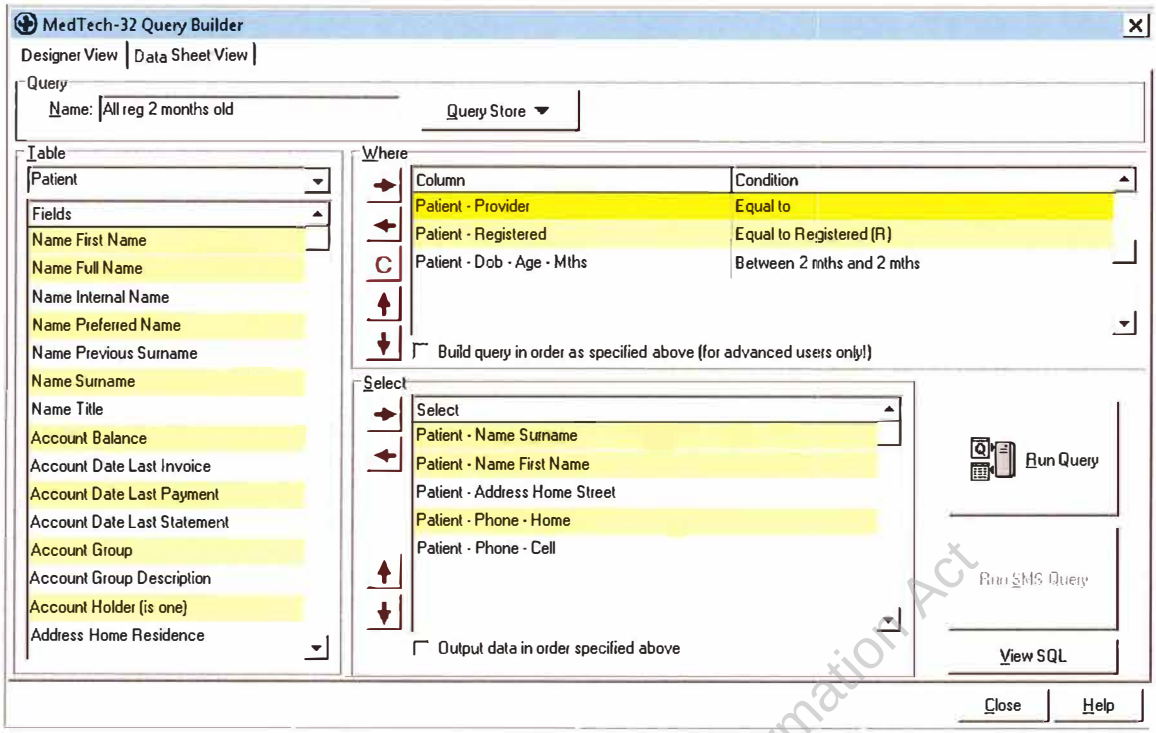
Suggested Process Chart - Fully Immunised 8 Month olds Jan 14



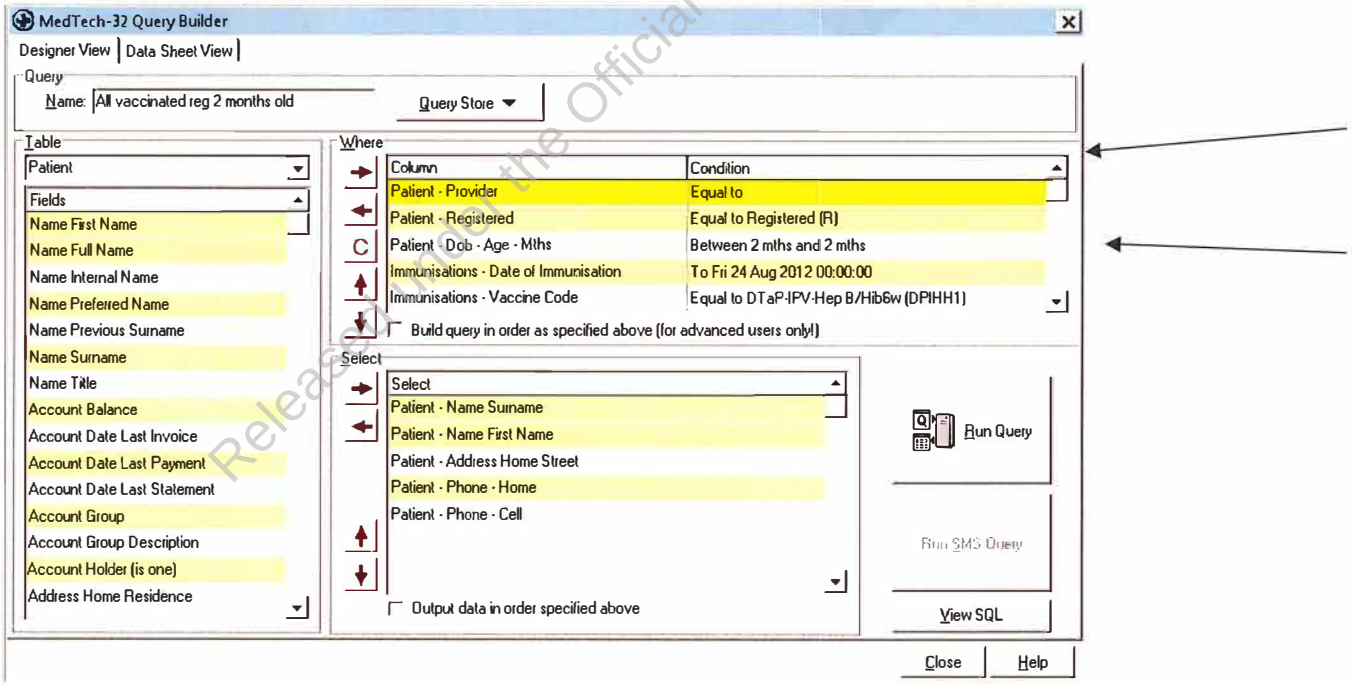


Query Builds to identify children in your practice who are over-due their 6 week, 3 month and 5 month vaccinations

Below will identify all your babies who are 2 months old

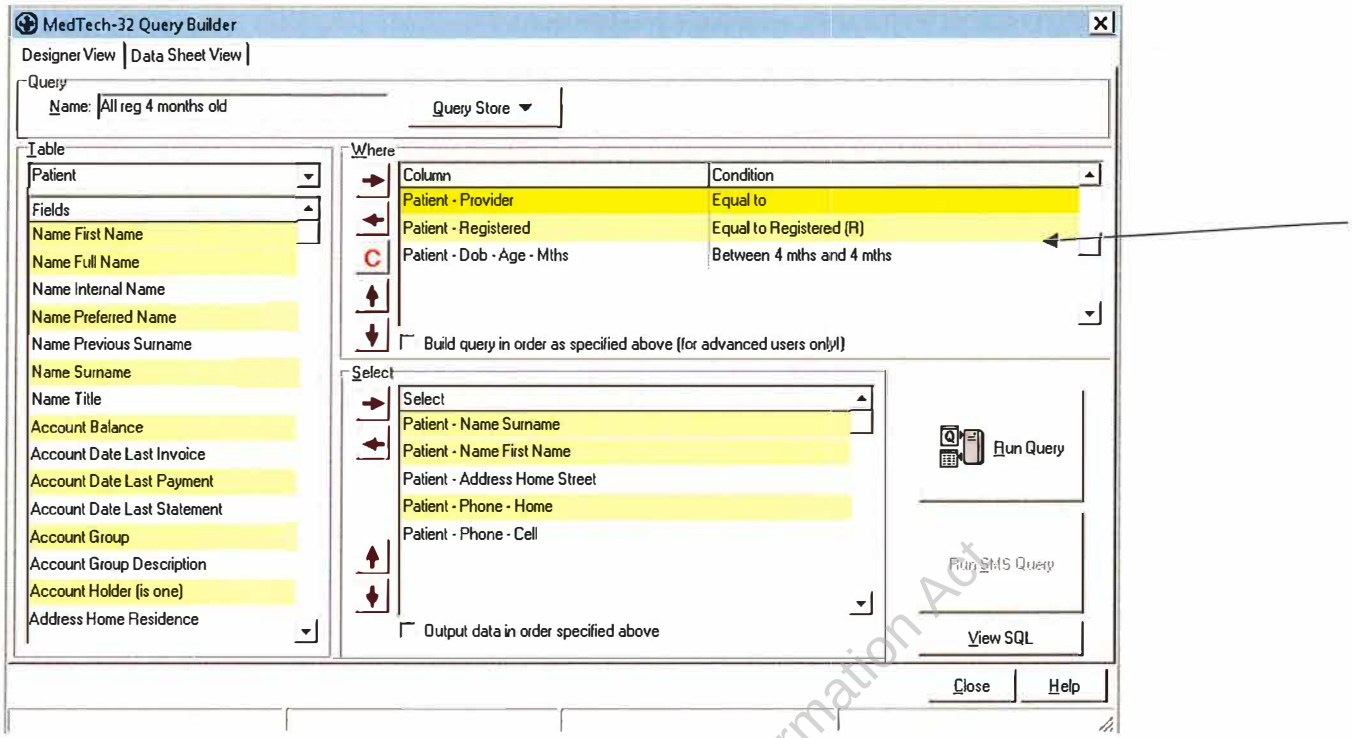


Below will identify all your babies who are 2 months old **and have been vaccinated** with their 6 week vaccinations

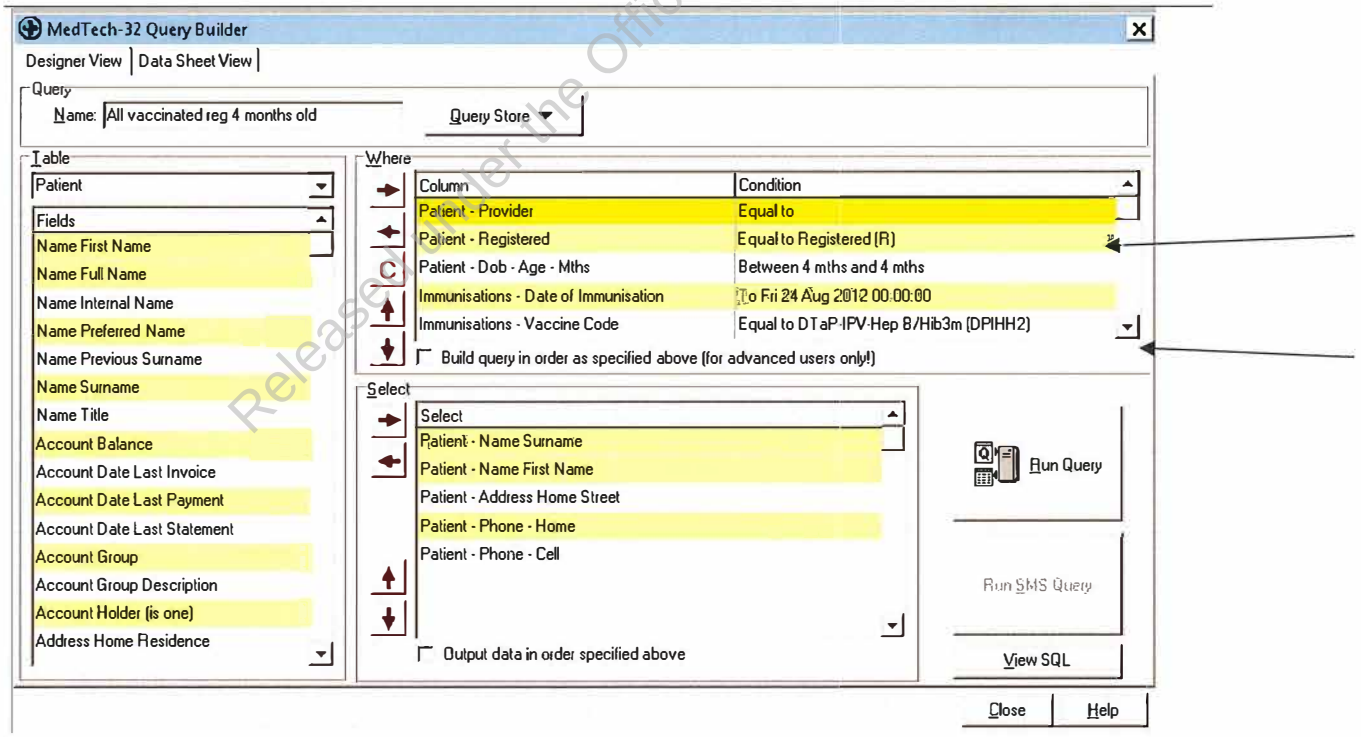


Check off the patients on this list against the patients from the previous query build to find your 2 month olds who have not been vaccinated

Below will identify all your babies who are 4 months old

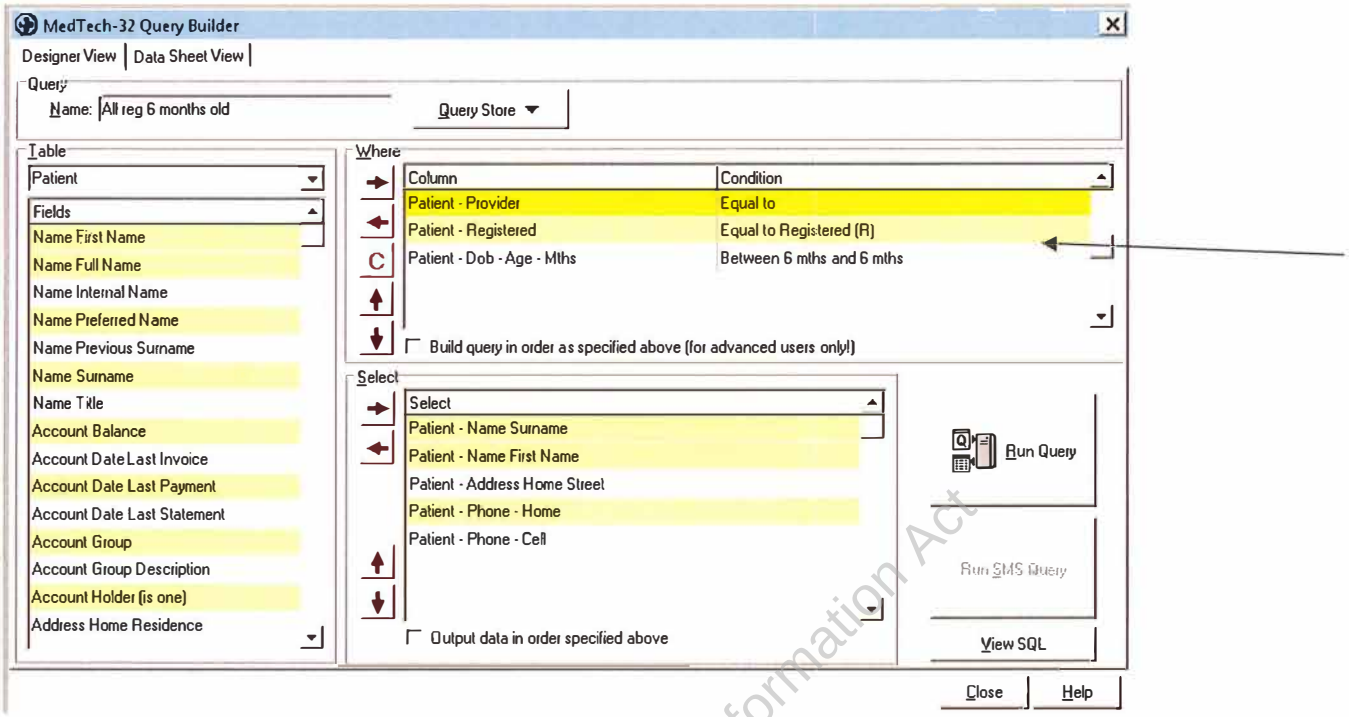


Below will identify all your babies who are 4 months old **and have been vaccinated** with their 3 month vaccinations

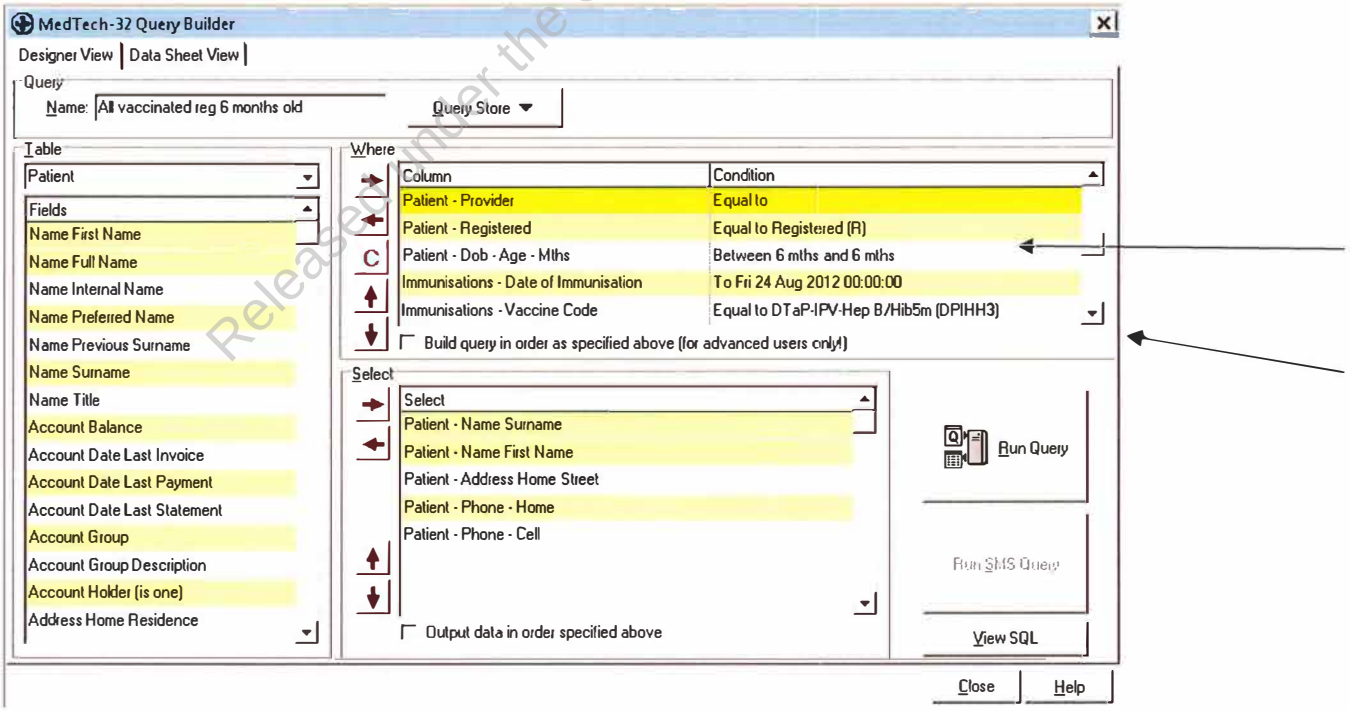


Check off the patients on this list against the patients from the previous query build to find your 4 month olds who have not been vaccinated

Below will identify all your babies who are 6 months old



Below will identify all your babies who are 6 months old **and have been vaccinated** with their 5 month vaccinations



Check off the patients on this list against the patients from the previous query build to find your 4 month olds who have not been vaccinated

Pre call and Recall

Overview:

What is Precall?

Precall is the preferred method of reminding parents/caregivers the child's vaccinations are imminent. It is sent **prior** to the vaccination, ideally 2 weeks before vaccination is due.

Around 60-70% of children receive immunisation with a simple precall system and organised process, the other 20-30% require extra time and effort in tracking and recalling. (Nikki Turner IMAC)

- Why is Pre call preferred? Can a few weeks really make a difference?

On time delivery of the 6 week vaccination is a keystone to successful immunisation. Delay in receipt of the first vaccine is one of the strongest and most consistent predictors of subsequent incomplete immunisation.

During the 1995-97 pertussis epidemic, delay in the receipt of any of the three infant doses of pertussis vaccine was associated with a four-fold increased risk of hospitalisation with pertussis. (BMJ 2003)

Precall

Accepting the birth nomination at the earliest opportunity establishes a provider and the National Childhood Immunisation Schedule is then assigned to the patient. Vaccinations will automatically be on recall for all vaccination events.

- How early can I give a scheduled vaccine?

Routinely, no earlier than 4 days before the due date unless advised by the Medical Officer of Health there is a disease outbreak requiring early immunisation. There may be circumstances where early vaccination be considered, in these circumstances contact your Immunisation Co-ordinator to discuss on a case-by-case basis.

Or

The child is overdue the primary course (6 weeks, 3 months and 5 months) vaccinations. The minimum space for these catch up vaccinations is 4 weeks. These vaccinations should be completed as soon as possible and at least by 8 months of age to provide the best protection for this vulnerable age group.

- When do I do a Pre call in Med Tech?

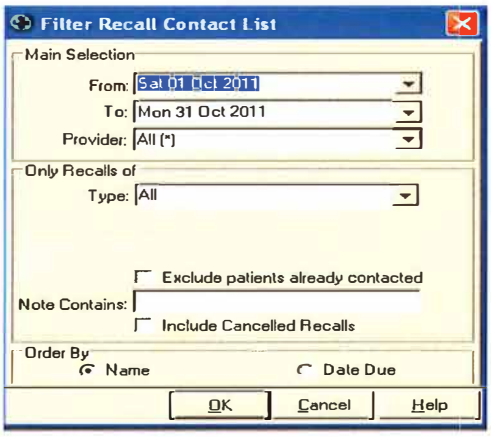
2 weeks before the immunisation is due

- How do I do a precall?

Identify children who are due for their immunisations.

Go into **Module Icon**
Go into **Recall Screening**

Click on **Recall Contact List – select appropriate dates for precall (2 weeks before immunisation is due)**



Once all the fields are filled in click OK to generate a pre call list.
Pre call letters, often the preferred option as immunisation information can be included if this hasn't been sent previously at the time of acceptance of the birth nomination, Txt 2 Remind/or phone calls. A phone call is ideal as an appointment can be made at the same time. TxT 2 Remind has also proven to be an effective communication and is fully funded.

Recall

- **What is Recall?**

A recall is a reminder sent **after** the vaccination is due therefore the vaccination is already overdue

- How do I do a Recall in Med Tech

Use your Practice Management System to systematically identify children who are overdue for their immunisations by filtering the Recall Contact List for previous weeks.
Children who haven't had their vaccinations will still feature on it
or
Do a Query Build for overdue vaccination groups.

See Query Build section (page?) or your Immunisation Co-ordinator will help you develop Query Builds and once stored will be available for future use.

Contact the parent/caregivers by phone, Txt 2 Remind, or by letter.

- Alerts

These pop up when the patient is placed on the pallet and are useful reminders that vaccinations are overdue. In MedTech to place an alert use Shift F6.

No response from parent/caregiver

- Referral to OIS

If there is no response after 3 attempts to contact the parent/caregiver, a referral for outreach services should be actioned.

The referral should not be later than 6 weeks after the due date of the immunisation. The referral is an outbox document already loaded into your PMS and is emailed or faxed to the NIR.

Further details on OIS processes are detailed under Outreach Immunisation Services

Welcome letter

Date

To the Parent or Guardian of:
.....
.....
West Coast

Dear ……..

Congratulations on the birth of your baby. The team at ..... are available for all of your child's immunisation and health needs.

Please find attached the schedule for your child's immunisations.

We encourage you to make an appointment, with your doctor, before your baby is 6 weeks old. At this appointment you can discuss your child's health care needs and any questions that you have about immunisation. An appointment can then be made with the nurses for the immunisations.

We look forward to getting to know you and your baby and being part of your family's health care team. You will receive reminders, by phone call, text or letter, when your child's immunisations are due.

We look forward to seeing you and your baby for the 6 week health check and immunisations.

Kind regards

.....

Immunisation schedule

Age Due	Infanrix-hexa	Prevenar 13	RotaTeq	Act Hib	MMR	Infanrix IPV	Boostrix	Gardasil
6 weeks	✓	✓	✓					
3 months	✓	✓	✓					
5 months	✓	✓	✓					
15 months		✓		✓	✓			
4 years					✓	✓		
11 years							✓	
11 Years girls only								✓ ✓ ✓

Infanrix-hexa – Diphtheria, Tetanus, Pertussis, Polio, Hepatitis B, Haemophillus influenza type b.

Prevenar 13 – Pneumococcal

RotaTeq – Rotavirus (given by mouth)

Act-HIB – Haemophilus influenza type b

MMR – Measles, Mumps, Rubella

Infanrix-IPV – Diphtheria, Tetanus, Pertussis, Polio vaccine

Boostrix - Diphtheria, Tetanus, Pertussis

Gardasil – Human Papillomavirus

3 month event

Date

To the Parent or Guardian of:
.....
.....
West Coast

Dear Parent or Guardian,

Our records show that ..... is due for the 3 month immunisations.

At this visit ..... will receive three immunisations:
1. Infanrix-hexa – Diphtheria, Tetanus, Pertussis, Polio, Hepatitis B, Haemophillus influenza type b.
2. Prevenar 13 – Pneumococcal
3. RotaTeq oral - Rotavirus

These are repeats of the immunisations given at the 6 week visit.

Please contact the surgery to make an appointment. I am happy to answer any questions relating to this immunisation.

You will need to wait for twenty minutes after the vaccine has been given.

Kind regards

Practice Nurse

5 month event

Date

To the Parent or Guardian of:
.....
.....
West Coast

Dear Parent or Guardian,

Our records show that ..... is due for the 5 month immunisations.

At this visit ..... will receive three immunisations:
1. Infanrix-hexa – Diphtheria, Tetanus, Pertussis, Polio, Hepatitis B, Haemophillus influenza type b.
2. Prevenar 13 – Pneumococcal
3. RotaTeq oral – Rotavirus

These are repeats of the immunisations given at the 3 month visit.

Please contact the surgery to make an appointment. I am happy to answer any questions relating to this immunisation.

You will need to wait for twenty minutes after the vaccine has been given.

Kind regards

Practice Nurse

15m event

Date

To the Parent or Guardian of:
.....
.....
.....
West Coast

Dear Parent or Guardian,

Our records show that ..... is due for the 15 month immunisations.

At this visit ..... will receive three immunisations:
1. MMR – Measles, Mumps and Rubella
2. Act-HIB -Haemophilus influenzae (Hib) – the a booster of the doses given at 6 weeks, 3 months and 5 months
3. Prevenar 13 (Pneumococcal) - a booster of the doses given at 6 weeks, 3 months and 5 months

Please contact the surgery to make an appointment. I am happy to answer any questions relating to this immunisation.

You will need to wait for twenty minutes after the vaccine has been given.

Kind regards

Practice Nurse

4 year event

Date

To the Parent or Guardian of:
.....
.....
.....
West Coast

Dear Parent/Guardian,

Our records show that ..... is 4 years old and is now due for 4 year old immunisations and a FREE B4 School Check.

The four year old immunisations include a booster of
1. Infanrix-IPV – Diphtheria, Tetanus, Pertussis (whooping cough) and Polio.
2. A second dose of MMR – Measles, Mumps and Rubella

The B4 School Check helps to make sure ..... is healthy and can learn well at school.

Please phone us to make an appointment/s with the practice nurse (allow 30 minutes for the immunisation visit and 45 minutes for the B4 School check). We will send you a parental questionnaire as well a questionnaire to be completed by your child's kindergarten or preschool teacher. We have enclosed an information pamphlet about what the B4 School Check involves.

Kind regards

Practice Nurse

11 year event

Date.....

To the Parent or Guardian of:
.....
.....
West Coast

Dear Parent or Guardian,

Our records show that ..... is due for their 11 year old immunisations.

At this visit ..... will be given Boostrix vaccine - a booster of Diphtheria, Tetanus and Pertussis (whooping cough)

Please contact the surgery to make an appointment. I am happy to answer any questions relating to this immunisation.

You will need to wait for twenty minutes after the vaccine has been given.

Kind regards

Practice Nurse

Status Query

Overview

A Status Query is a message to the NIR to establish:

- If the vaccination has been given elsewhere
- to check if they are up to date with their vaccinations

Why is it good practice to run a Status Query?

Unless the caregiver has opted the child off, the NIR will have an accurate record of vaccinations as follows:

- Childhood immunisations and BCG given to children within the birth cohort (Go Live date in Canterbury is **21st November 2005)**
- Patients who have had MeNZB
- 11yr dTap and young ladies receiving HPV
- Influenza started being recorded on NIR in 2014
- From 1 July 2014 the following vaccines are recorded on NIR for both children and adults who meet the eligibility criteria:
  - Rotavirus (RV5), Meningococcal C(MenCCV), Varicella (VV), MMR, Hepatitis A, Tdap (dTap) - pregnant woman, HepatitisB, and Meningococcal A, C, Y and W135 (MCV4-D).

By having this information the patient's records can be accurately updated, overdue vaccinations offered and duplication avoided. If there is no documented record of vaccinations age appropriate vaccines they should be repeated. (Page 547 Immunisation Handbook 2014)

When should I run a Status Query?

Before you give any immunisations. Ideally at the beginning of the day and again at lunchtime if there are immunisations booked. If the Status Query has not appeared in the Provider Inbox before vaccination, contact the NIR for a faxed copy.

NIR Status Query

The NIR will have a record of all immunisations provided the message has been sent from the surgery where the immunisation has been given. To check your message has been sent see **Events messaging to the NIR section.**

How do I know what immunisations my patient has had?

All eligible patients will have their National Schedule vaccinations recorded unless Opt Off has been chosen.

How do I run a Status Query?

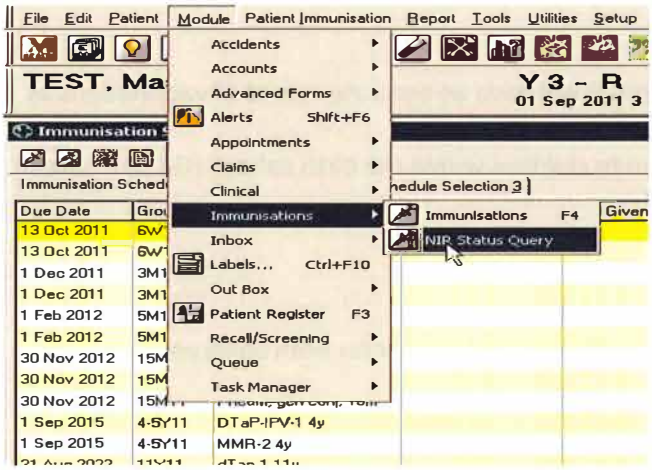
Make sure you have the patient on the palette.

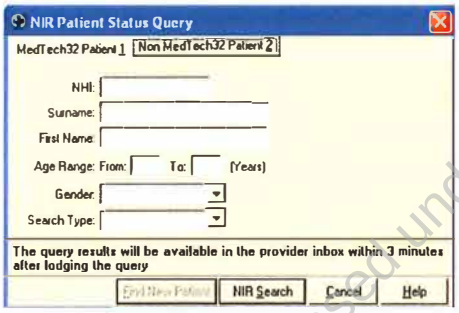
Click on the **NIR Status Query** icon on the toolbar - looks like a syringe with a ?

How do I put an icon on the tool bar?

Go to Window - Tool Bar – Set up and arrow the appropriate icon from left to right side

Or go into Module/Immunisations/NIR Status Query





This will automatically be pre-populated with the patient's details that appear on the palette.

Search type = Exact match. Click on **NIR search**.

The NIR Search button will generate a request message to NIR for pts immunisation

NIR Messages – Provider Inbox *Module / Inbox / Providers Inbox*

It is important that someone is responsible for the daily management of the Provider Inbox

All NIR messages are delivered into the patient's Provider Inbox including Status Queries. When the provider cannot be matched, the messages will display within the NIR default providers inbox.

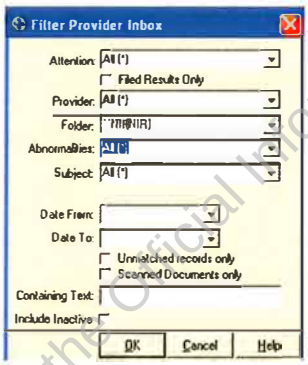
To find the NIR default provider click on Utilities / NIR / NIR Message Transfer.

If you don't have the Provider's Inbox icon on your toolbar do the same as you did for Status Query (as above)

1. When you click on this icon, it will open a window, and will show Inbox records for the person who is logged into Medtech on that machine.

2. To check for **all** NIR messages to **all** providers, click on the filter icon (2nd icon from left).

This will open the **Filter Provider Inbox** window.



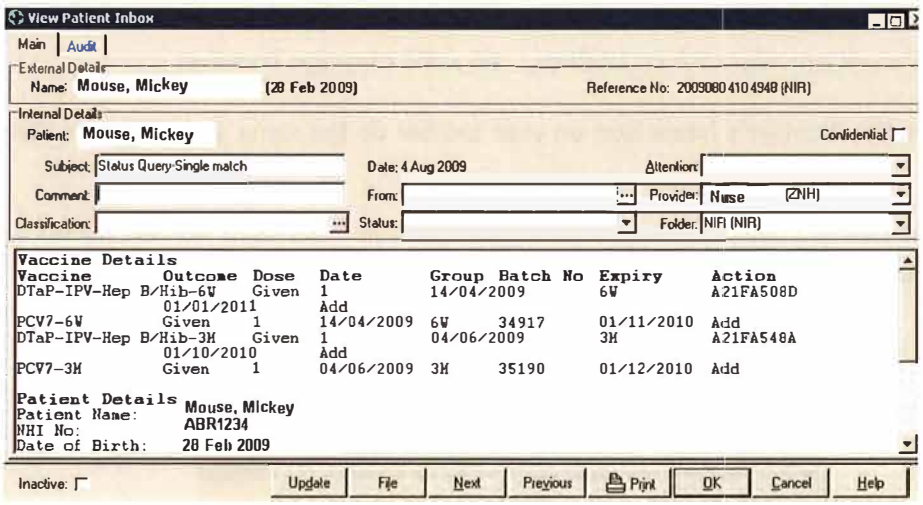
3. In the **Attention** field, select "**ALL**" from the down arrow.

4. In the **Folder** field, select "**NIR**" from the down arrow.

5. Click on **OK**.

When the status query comes back it will look like this. (If the Status Query has not arrived in the Provider Inbox when you need the information contact the NIR and ask for it to be faxed to you). By pressing Update the vaccinations will be transferred to the patients Immunisation screen.

Should the information indicate given elsewhere and you have documented evidence they were given overseas, elsewhere should be changed to overseas.



If you have documented vaccinations for a child that are not recorded on the NIR please advise the NIR team.

Opt On/Opt Off

Overview

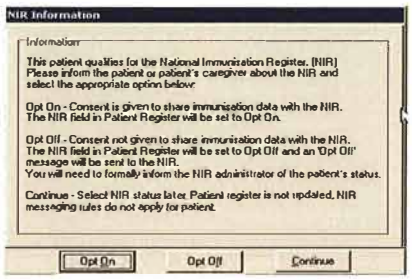
When a nomination message is accepted the patient is automatically set to Opt On

By leaving Opt On in place the NIR is able to record immunisation events accurately and can identify children at risk in situations of disease outbreak or when immunisation history is unavailable or incomplete.

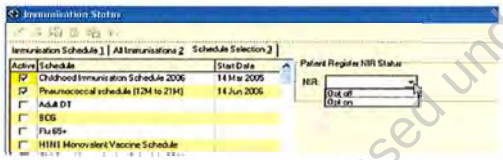
How do I Opt On / Opt Off in Med Tech

As part of the informed consent process confirm Opt On/Opt Off status with parent/caregiver.

After recording the first immunisation this screen will automatically pop up



Never select Continue. Messaging does not go to the NIR if this option is chosen



Unless the Opt On status is changed, all future immunisations will be recorded by the NIR electronically at the time the immunisation details are recorded

Opt On – Patient consents to share and allow the recording of the following information with NIR:

- NHI, Name, Date of birth, Gender, Provider, Vaccinator, Ethnicity, Midwife and Next of Kin
- Immunisation event including date, vaccine type and number in the series, batch number and expiry date, injection site.
- Recall date where applicable
- It is particularly important all immunisation history is accurately recorded on the NIR. Should disease outbreaks occur the NIR can identify children who have some protection having been immunised with the specific antigen.

Deleted: Opt On Opt Off system

- Advise the vaccination will be recorded on the NIR – this should be part of the consent process at every event where a National Schedule Vaccine is given.

Prior to any vaccination of a child a Status Query should be sent to the NIR to avoid duplication.

Opt Off –Opting Off the NIR means there will be no record of the immunisation being given. Give sufficient information to enable parent to make an informed decision.

Opt Off Process:

- Parent/caregiver is required to fill out NIR2 form at the practice.
- Practice to fax and post original to NIR as soon as possible
- Contact NIR Administrator with decision to Opt Off
- If Opt Off chosen NIR records only the NHI and date of birth of the patient.
- **Opt Off is not declining the vaccination**

Opting off the NIR is a decision made by caregivers not have vaccination information recorded on the NIR only.

Declining immunisations should be an informed decision made by parents/caregivers to decline their child receiving immunisations and should be recorded as declined on your Practice Management System. This will message to the NIR. The child should still be recorded as Opt On even if they decline the vaccination. Do not decline all events just the one due at the time. This offers the opportunity to tactfully revisit the parental decision when the next event comes up for recall.

- **Declining HPV. W**hat should I do when a parent declines when the child is 12.
  Enter as decline but reschedule for a year later to discuss it further.

Deleted: Opt On Opt Off system

How to enter event for people who are not currently on the NIR

The Ministry of Health requires that all people who received scheduled or funded vaccinations have their information recorded on this NIR. This means that events given to people who are not part of the NIR Cohort (people born before 21 November 2005) will need to have their events recorded.

As these people are not part of the NIR Cohort and therefore there information was not recorded at birth, they will need to be set up as a new person on the NIR. This requires a bit of work on your behalf.

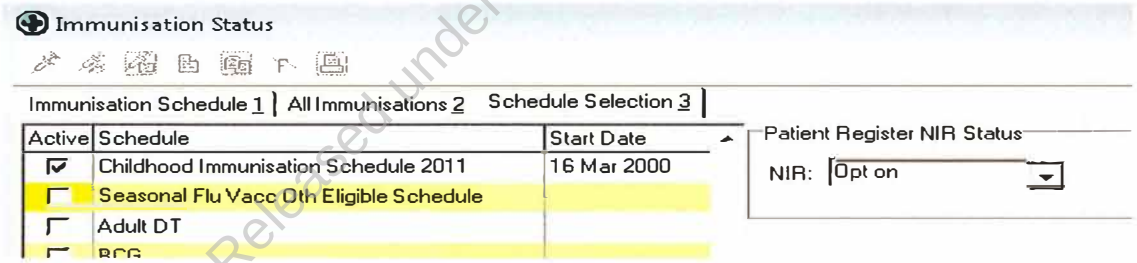
The events that need to be loaded on to the NIR include

- Year 11 event
- HPV
- Boostrix for Pregnant Women
- MMR for adults
- Seasonal Influenza

The following information gives you instructions on how to load these events on the NIR.

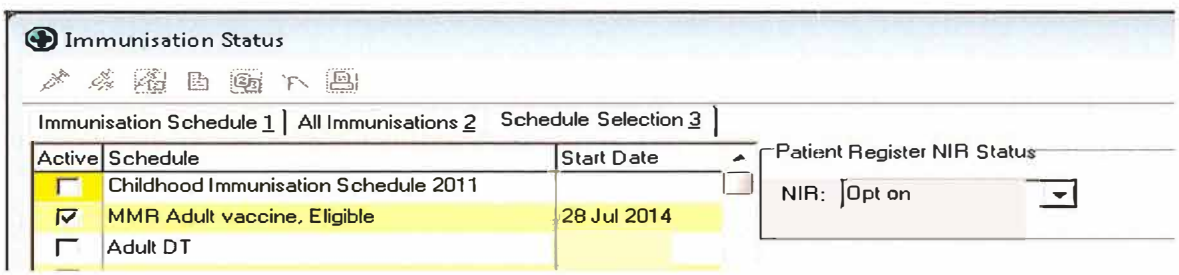
How to enter Boostrix when given at Year 11 event:

1) Select Schedule 3
2) Place tick next to Schedule 2011
3) Ensure patient is opted on to NIR (if not showing, then expand screen)
4) Go to Schedule 1 and proceed as usual



How to enter MMR for adults:

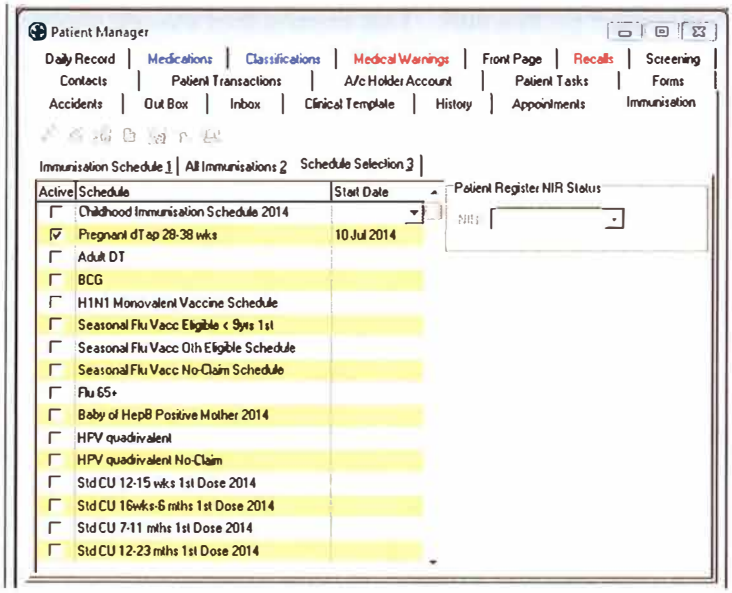
1) Select Schedule 3
2) Place tick next to MMR Adult as below
3) Ensure patient is opted on to NIR (if not showing, then expand screen)
4) Enter Schedule 1 and proceed as usual



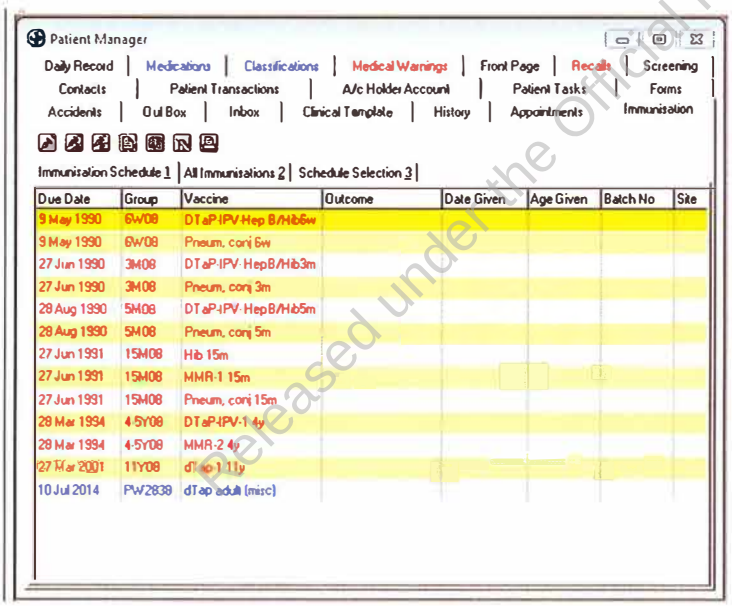
Adding Boostrix during Pregnancy.

Click on Schedule 3

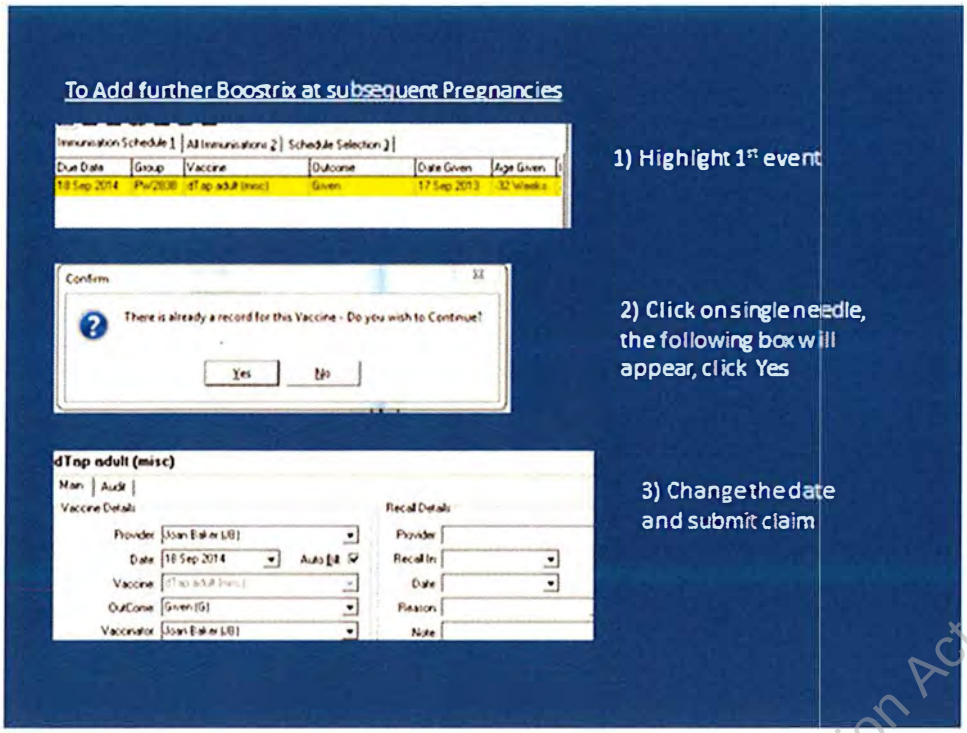
Locate Pregnant dTap 28-38weeks and tick



Go into schedule 1



Locate PW2838 – double click and add details, ensure auto bill is ticked



How to enter Influzna on the NIR

Patient age	Criteria	Process for entering on Medtech
>65	Aged over 65 years Subsidised	1. Go to Schedule selection 3 2. Select **Flu 65+** if not already selected 3. Go to Immunisation Schedule 1 4. High light **FLU 65+** 5. Click on two needle icon 6. Enter vaccine details
	Pregnant Women Subsidised	1. Go to Schedule Selection 3 2. Select **Seasonal Flu Vacc Other Eligible Schedule** 3. Go to Immunisation Schedule 1 4. High light **Flu other eligible** 5. Click on two needle icon 6. Enter vaccine details
< 65	Chronic conditions Subsidised	1. Go to All Immunisations 2 2. Click on single needle icon **3.** Select Flu vaccine from drop down list eg. **Flu Cardiovascular** **Flu Chronic Renal** **Flu Diabetes** **Flu Respiratory** **Flu Malignancy** **Flu other eligible** 4. Enter vaccine details 5. Make sure **Auto bill** is ticked
< 65	Well population Not subsidised	1. Go to Schedule selection 3 2. Select **Seasonal Flu Vacc No-claim Schedule** 3. Go to Immunisation Schedule 1 4. High light **Flu other No-claim** 5. Click on two needle icon 6. Enter vaccine details
<18	Chronic condition Subsidised	1. Go to All Immunisations 2 2. Click on single needle icon **3.** Select Flu vaccine from drop down list e.g. **Flu Cardiovascular** **Flu Chronic Renal**

		Flu Diabetes **Flu Respiratory** **Flu Malignancy** **Flu other eligible** 4. Enter vaccine details 5. Make sure **Auto bill** is ticked 6. Repeat procedure if second vaccine required
< 18	Well population Subsidised	1. Go to Schedule Selection 3 2. Select **Seasonal Flu Vacc Oth Eligible Schedule** if not already selected 3. Go to Immunisation Schedule 1 4. High light **Flu other eligible** 5. Click on two needle icon 6. **Select Continue** if Opt On Opt Off window is displayed 7. Enter vaccine details 8. Repeat procedure if second vaccine required

HPV (Human Papillomavirus)

Overview

160 NZ women a year are diagnosed with cervical cancer and 60 per year die. Maori are almost twice as likely to get cervical cancer and almost 3 times as likely to die. (Immunisation Advisory Centre, Cervical Cancer prevention & Human Papillomavirus (HPV) factsheet, June 2010).

HPV vaccine (Gardasil®) protects against the 4 most common types of HPV that cause the majority of disease (i.e. cervical pre-cancer, cancer and genital warts).

Gardasil® is fully funded and on the NZ National Immunisation Schedule for girls up to the age of 20 however it is not set up as an automatic recall on the PMS systems as other vaccines on the national schedule are.

The Ministry of Health monitors the number of girls receiving Gardasil® at age 12 for the current year and the preceding year.

On the West Coast a mixed model is provided with a schools and general practice providing the programme

- The school programme is delivered to year 8 girls. These are girls aged between 11 to 13years of age. This is delivered in schools in Greymonth, Hokitika, Westport, Granity, Reefton and Harihari.
- For all other areas a General Practice programme should be offered to girls at age 12.
- After 14 all practices should do recall on non-vaccinated girls and re-offer the programme.

Recommended Immunisation Schedule

The recommended Ministry of Health HPV vaccination course consists of three injections

Dose 1	–	0 months
Dose 2	--	2 months
Dose 3	--	4 months after Dose 2

- There is an accelerated schedule where the 2nd vaccination may be given 1 month after the first dose and the 3rd vaccination at least 3 months after dose 2.

- Where HPV dose 2 and/or 3 are given outside of the recommended or accelerated schedule time line e.g. Longer than 12 months, then a total of 3 doses should still be given. A 4th dose is not necessary.

- It is not recommended that a course of HPV immunisation be repeated where the schedule timeline has been extended. (Ministry of Health policy document October 2009)

Process

Successful delivery of HPV vaccinations can be challenging and is dependent on good communication with caregivers/parents and girls. To support in you this the following processes are recommended. The below process chart has also been developed to assist you in reaching these girls:

1. Education parents regarding the HPV programme at the 11 year event immunisation event.
2. Girls will as asked to be part of the school base programme in term 1 each year

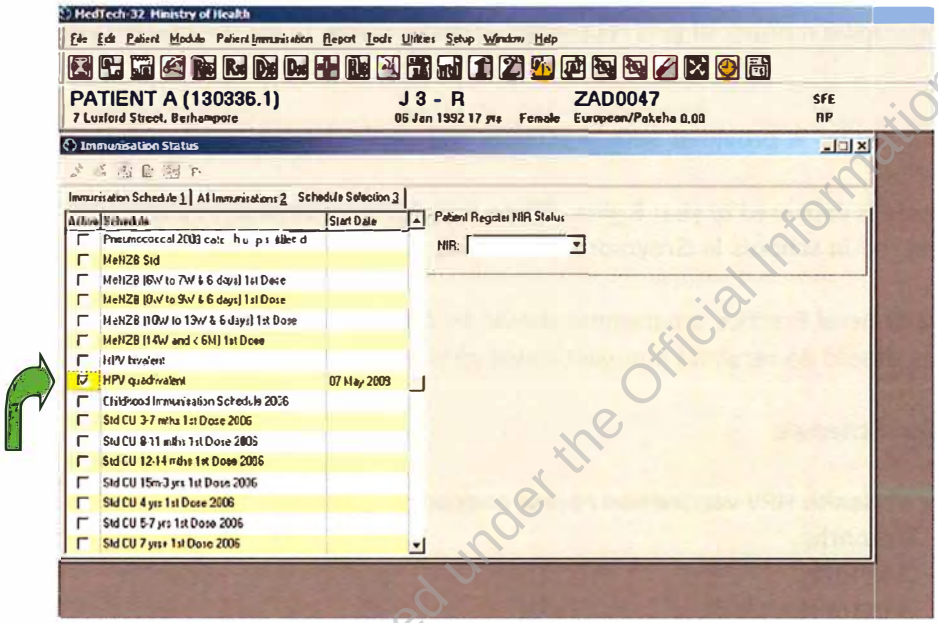
3. Recall girls not vaccinated at 14 years of age

4. Opportunistic vaccination

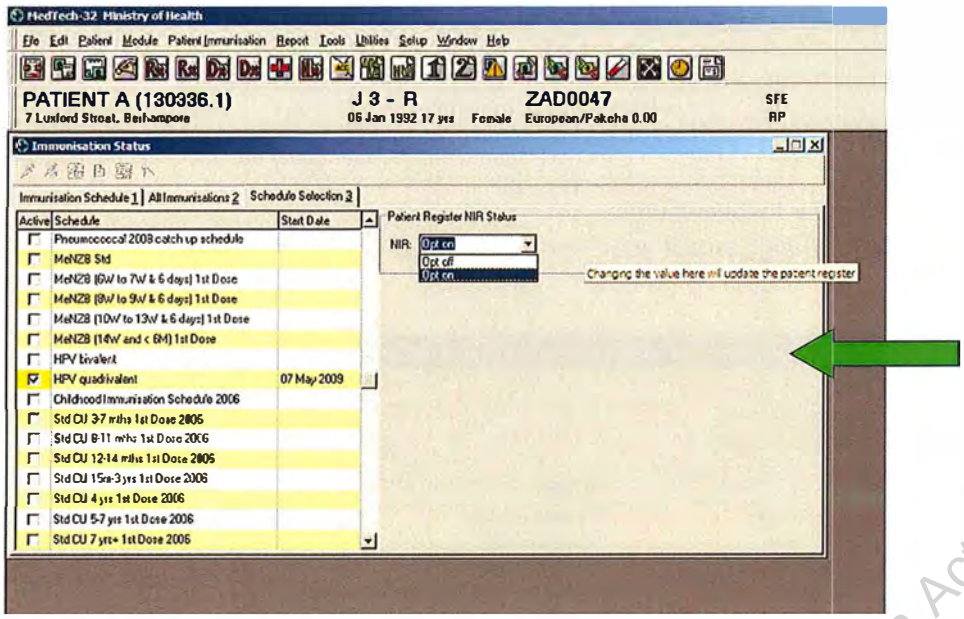
Check the daily appointment book for any young girls who might be eligible and offer if appropriate at the time.

Entering the first vaccination on the PMS

To give an immunisation, click on F4 and select the Schedule Selection (3) tab. Add a tick to the HPV quadrivalent schedule.



Select Opt On/ off from the Patient Register NIR Status drop down box.



Note: It is important the HPV vaccines are added as part of a schedule rather than as an individual vaccine.

The opt on/opt off prompt will not display when a HPV immunisation is given independent of the HPV quadrivalent schedule and the vaccine details will not message to the NIR.

Go to Immunisation Schedule 1 and enter as usual.

Placing a recall for HPV where patient has not yet started the course

Do not directly contact the 12/13 year old girls as this can cause an adverse response from the parent.

Run a query build at the start of the calendar year to identify eligible girls turning twelve.

Contact the caregiver either by:

- mail with additional HPV vaccination information if this was not supplied at the 11 year event.
- Phone or TXT2 Remind

Parents/caregivers do respond more positively if they have additional information and a positive approach from their health provider.

Contact for installation for TXT2 Remind:
Kelleigh Embers email: kembers@vensahealth.com

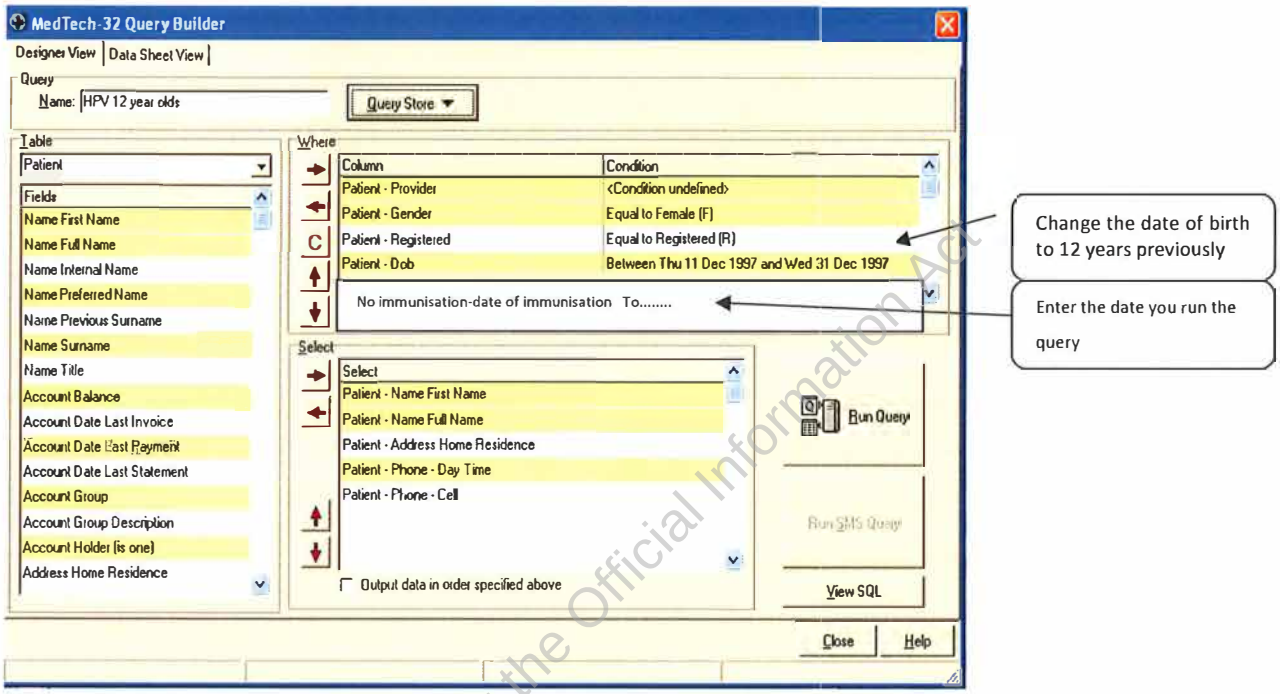
Readily available information:
Caregivers may require further information before making a decision. Please have appropriate pamphlets available at your surgery. These may be obtained from the Community Health Information Centre (CHICS)

The Ministry of Health has information for health care professionals and the general public about HPV vaccine and the HPV programme. This can be accessed on www.health.govt.nz

Information about the Canterbury HPV Programme can be found on www.immuniseforlife.co.nz

How to find a stored query build or load a new one in MedTech:

- Tools
- Query Builder
- Click on Query Store
- Check for saved query.
- If no saved query load the following one
- For further information/help contact your Immunisation Co-ordinator or Med Tech contact

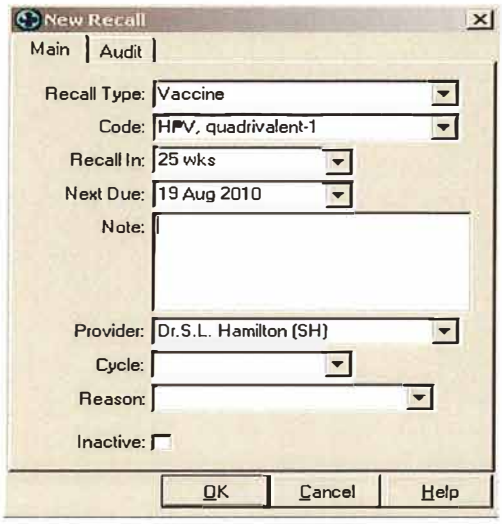


Following the first reminder you may chose to attach an **alert** to each patient that asks you to discuss this vaccination event at the next visit in case there is a delayed response. Reschedule if not a definite decline

Recall setup

Once the first vaccine has been given and entered as above recalls for further doses will happen automatically. For patients who haven't had any HPV vaccines proceed as follows:

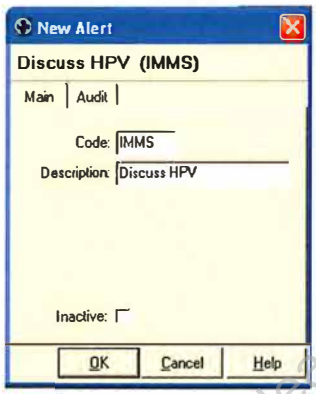
With the patient on the palette, and the Practice Manager screen up, go to recalls, click on the add a new recall icon and fill out the new recall screen as below.



When the patient comes in for the vaccine, you select the HPV quadrivalent schedule, give them their first dose, which then removes the recall you loaded way back.

How to setup an alert

With the patient on the palette go to Setup, Patient Register, click on Alerts and fill in the fields as below



We strongly suggest you **run a Status Query before any vaccinations are given.**

Further recalls

We suggest you rerun the Query Build every 3 months to identify and again recall girls who have turned 12 but not had their 1st HPV.
To do this recall change the date on the Query Build above to previous months.

Information Management Systems

Most practices will have a system that manages information on their patients such as Dashboard, Dr Info etc. These systems provide information on a patient's status regarding a variety of interventions. HPV status can be found in this information and is useful for opportunistic vaccination of girls and young women who may not appear on your recalls.

HPV Key Points to Remember.

Cervical cancer is caused by the Human Papillomavirus (HPV).HPV is very common and most sexually active people will become infected with it during their lifetime.

The HPV vaccine used in New Zealand is Gardasil®. It protects against the 4 most common types of HPV 6, 11, 16 and 18. 2 types (16 and 18) which cause 70% of cervical cancers and 2 types (6 and 11) that cause 90% of genital warts.

Gardasil® is free for girls and young women who receive their 1st vaccination before they turn 20.It is also now free for some boys (see Immunisation Handbook 2014, p for details on eligibility).

The HPV vaccine is best given at 11 because the immune response in girls aged 9-15 years is greater than in older girls and women. For better protection girls need to be vaccinated before they are exposed to HPV; which means before they start having any sexual contact. However girls who are sexually active may not have been infected with the types of HPV covered by the vaccine and may still benefit from vaccination.

Gardasil® has been tested in over 20,000 women in 30 countries and has a well-established safety profile. Over 55 million doses of Gardasil® have been given worldwide

Immunogenicity. In studies over 99% of participants developed antibody immunity responses to all 4 vaccine HPV types. These responses were higher than those seen after natural infection. After 5 years these antibody levels remained high and when a fourth dose was given a strong booster response was observed demonstrating excellent immune memory. Protection is likely to be long lasting. Younger girls aged 9-15 as well as boys show strong responses to the vaccine.

Gardasil® vaccination consists of 3 injections in the upper arm over 6 months

Early HPV vaccination, combined with regular smears from the age of 20, offers the best prevention strategy against cervical pre-cancers, cancer and genital warts (if every been sexually active).

Risks from HPV Infection	Risks from CIN 2-3	Risks from Gardasil® vaccine
• Infection of partner • Development of persistent infection (2%) • Cervical dysplasia • Cervical cancer • Other anogenital and pharyngeal cancers (rare) • Genital warts • Recurrent respiratory papillomatosis (rare)	• Invasive treatment for precancerous lesions • Some treatments significantly increase risk of premature birth in subsequent pregnancies • Cervical cancer	• Mild-moderate local pain and inflammation at the injection site (most vaccinees) • Severe pain and inflammation at the injection site (3%) • Mild-moderate fever (<1%) • Anaphylaxis estimated at 3.2 per million

Reference: IMAC Fact Sheet (HPV-HP-0609)

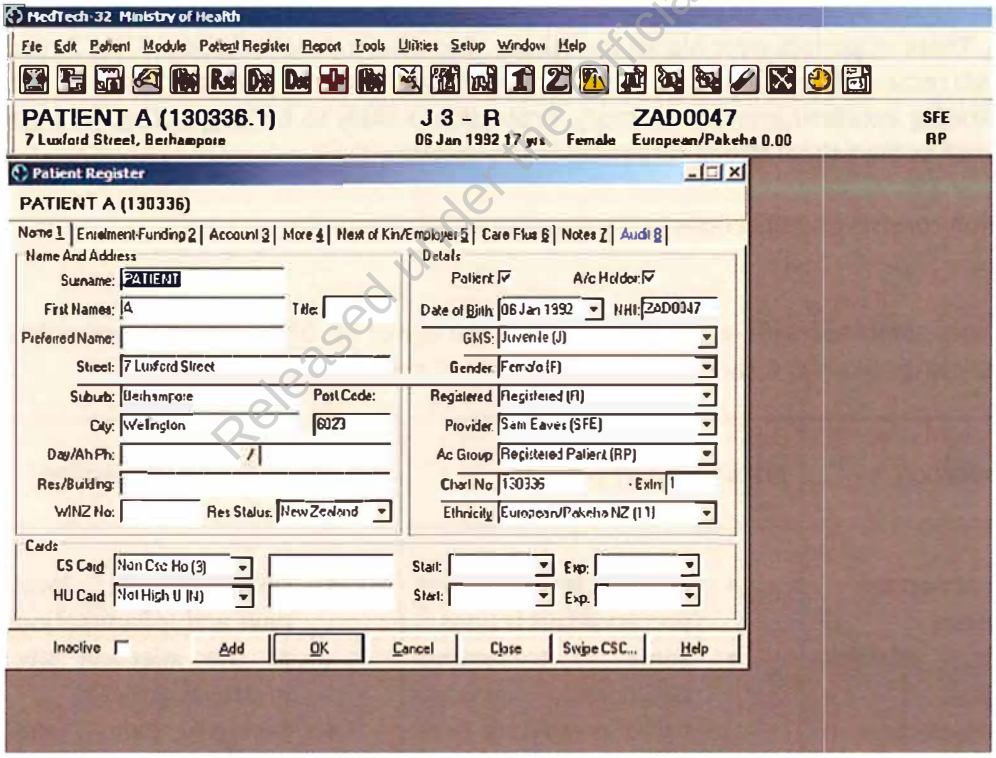
Tips for messaging HPV vaccines to the NIR using MedTech

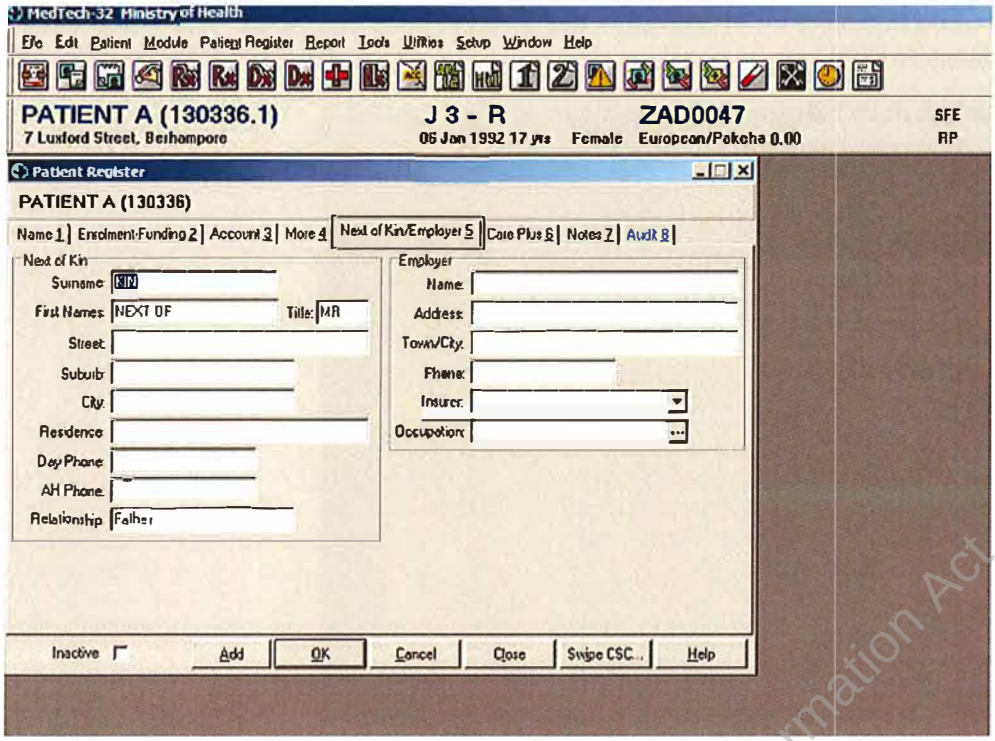
Sometimes messages recording HPV immunisation events do not reach the NIR. This is largely due to the single syringe being selected during data entry.

This tip guide shows the steps to take to ensure that all HPV records reach the NIR and how to rectify mistakes should you identify HPV events that have not reached the NIR (Version shown: V17.2, Build 2225).

Process to follow to ensure messages are sent to the NIR

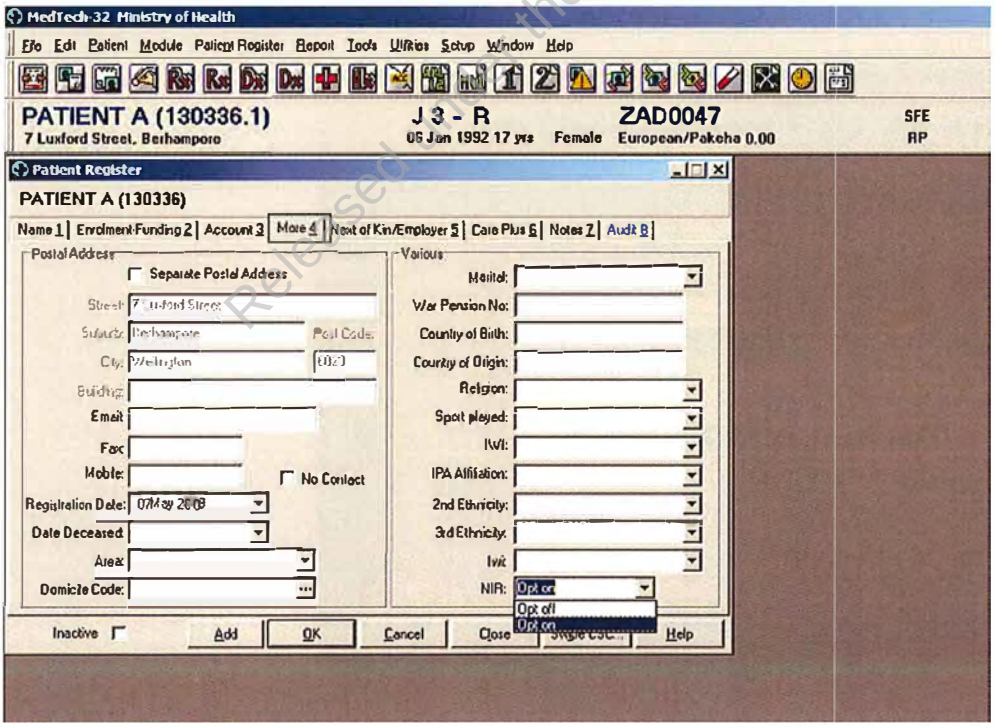
1) Ensure the patient has values in all mandatory fields required for NIR messaging, i.e. name, address, NHI, gender, ethnicity, next of kin (if under 16)



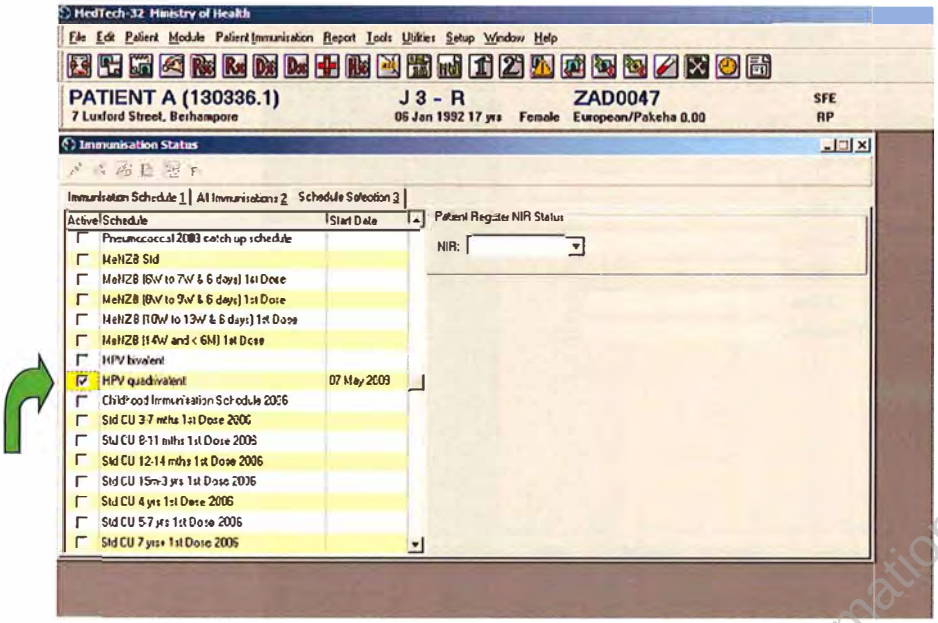


2) When an individual is added, there is the option to enrol them on the NIR through the Patient Register screen.

In the More (4) tab, select Opt On for the NIR field.

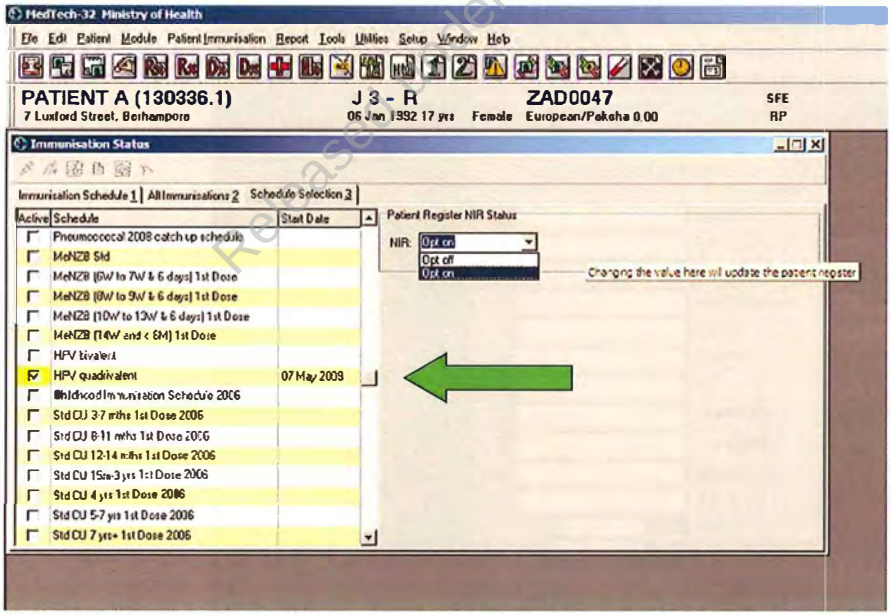


3) To give an immunisation, click on F4 and select the Schedule Selection (3) tab. Add a tick to the HPV quadrivalent schedule.



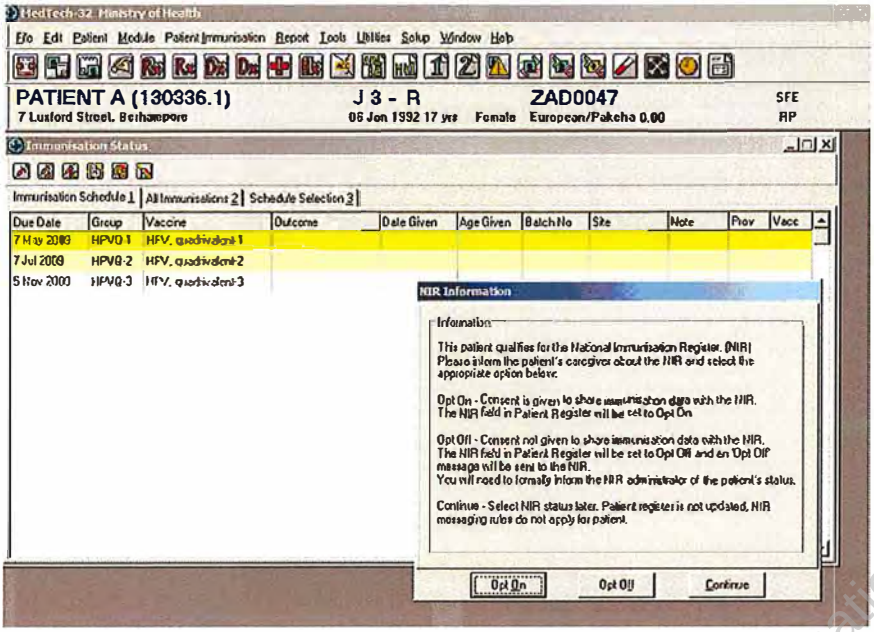
Note: It is important the HPV vaccines are added as part of a schedule rather than as an individual vaccine.
The opt on/opt off prompt will not display when a HPV immunisation is given independent of the HPV quadrivalent schedule.

5. Select Opt On from the Patient Register NIR Status drop down box.



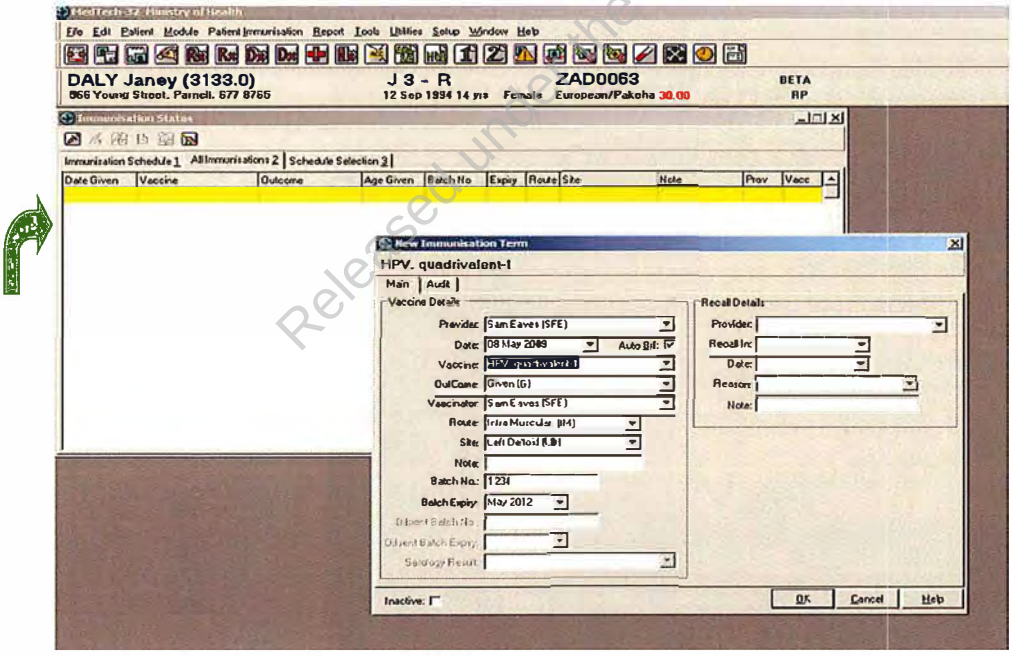
Note: If the user does not select the Patient Register NIR Status when they select the schedule, they will be presented with a prompt to do so when they select a HPV immunisation, so long as it is part of the HPV schedule.

6. Select Opt On to enable messaging of the immunisation information to the NIR for the patient.

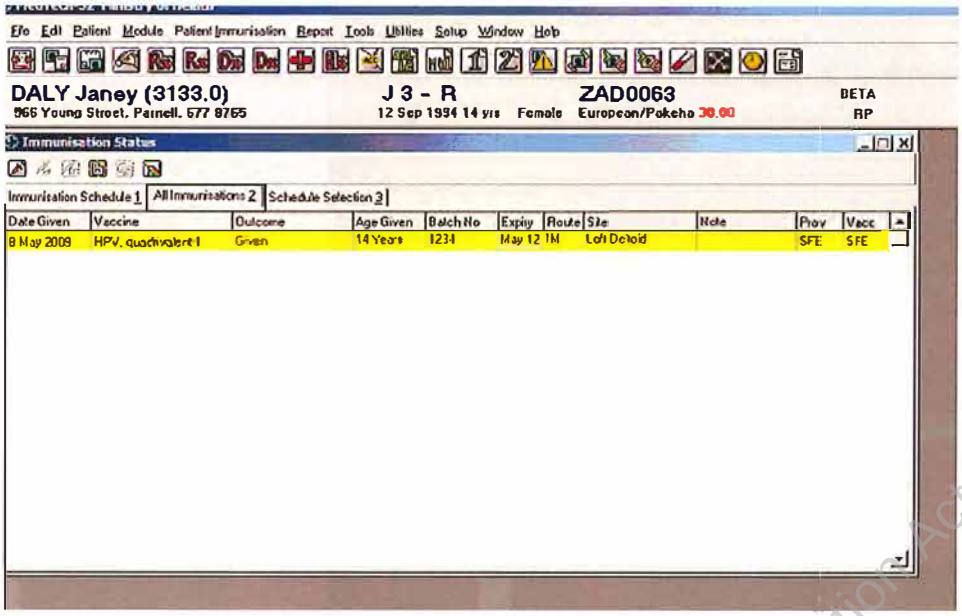


Do not enter HPV vaccination like this

If the user selects the single syringe icon to add a new immunisation and selects and completes a HPV quadrivalent immunisation, the user will NOT receive any prompts to opt on to the NIR nor will a message be generated

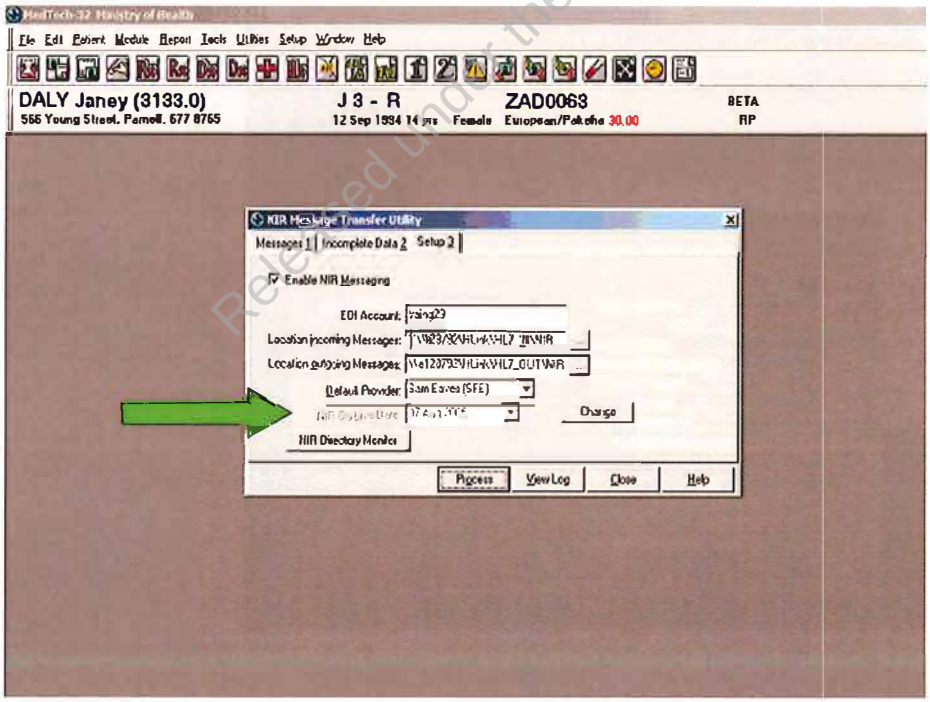


If the screen looks like this it has not messaged to the NIR



Even if the patient has their NIR status set to Opt On in the More (4) tab on the Patient Register screen, adding and completing a HPV immunisation independent of the HPV schedule (i.e. via the single syringe) will not generate a message to the NIR.

NOTE: *Do not change the NIR Go Live Date. You may be asked for this information if you have this messaging issue so the following screen shot is shown for reference only.*



Authorised Vaccinators in the Canterbury, South Canterbury & West Coast Region
(Reference: Appendices 3 & 4, Immunisation Handbook MoH, 2014)

1. Who can vaccinate?

Vaccines are prescription medicines. They can only be administered by:

- A medical practitioner
- A designated prescriber (includes nurses who meet prescribing criteria, i.e. Nurse Practitioner)
- A person authorised to administer the medicine in accordance with a standing order

AND

- An Authorised Vaccinator

2. Can an RN who has completed the Vaccinator Training Course & Written Test give vaccines on the National Schedule?

- Only with a written medical practitioner's prescription

OR

- Under a Standing Order

3. What is an Authorised Vaccinator?

Under the Medicines Regulations 1984, a Medical Officer of Health can authorise a person to administer vaccinations from an Approved Immunisation Programme, without the need for a medical prescription or standing order, or the presence of a Medical Practitioner. This usually applies to registered nurses.

4. What is an Approved Immunisation Programme?

An Approved Immunisation Programme means:

- any vaccines from the New Zealand National Immunisation Schedule (see http://immunisation.book.health.govt.nz/), and/or
- any other vaccines from a Medical Officer of Health Approved Immunisation Programme (e.g. influenza or Hepatitis B vaccination of workplace staff).

This *does not* include travel vaccines – these must be prescribed by a doctor.
An individual programme approval is required for any situation where vaccinations are to be given off site (i.e. away from a Medical Practice). Only Authorised Vaccinators can give vaccines under an off-site programme. See paragraph 16 for further information about this.

Authorised Vaccinators

5. What is expected of an Authorised Vaccinator?

By accepting your authorisation you agree to follow the Immunisation Standards (Appendix 3 Immunisation Handbook 2014) and work within your scope of practice as determined and monitored by the Nursing Council, i.e. competencies for the 'Registered Nurse' scope of practice require that all nurses have appropriate competencies for their practice and can access and use emergency equipment. Vaccinators should hold professional indemnity insurance. Members of the NZNO are covered. Employers may provide cover, but this should be checked by applicants.

6. What should I do in the event of anaphylaxis?

Anaphylaxis is a severe adverse event of rapid onset, characterised by circulatory collapse. Vaccinators must be able to recognise the signs and symptoms of anaphylaxis. Early administration of adrenaline is essential, and appropriate emergency equipment must be immediately on hand whenever immunisations are given. It is expected, as an authorised vaccinator, that you will manage anaphylaxis through the appropriate administration of adrenaline and oxygen as outlined in the New Zealand Immunisation Handbook 2011 (refer p83), and your authorisation permits you to do this.

7. How do I apply to be an Authorised Vaccinator and what information do I need to supply?

You need to apply to the local Medical Officer of Health responsible for the area(s) you practice in. For the Canterbury, South Canterbury and West Coast regions you should complete the application form and provide the following documentation. Please allow up to four weeks for processing of your application.

Initial Authorisation (first application only)

Current Nursing Council of NZ Practising Certificate
Current CPR Certificate (<2 years)
Completion of Vaccinator Training Course Certificate
Assessment of Clinical Practice for Vaccinators (IMAC Form)

Authorisation is valid for a period of 2 years from Vaccinator Training Course or last Vaccinator Update Course.

8. What will I receive after application?

Once the Medical Officer of Health has reviewed your application and is satisfied you meet the requirements for authorisation, you will receive an authorisation letter. Where applicable, this will state the route of administration you are authorised for (i.e. those who are vaccinating adults only, and are assessed for this, will be authorised to administer "deltoid vaccinations only")

9. What happens if my authorisation expires?

You can only give vaccines on the National Immunisation Schedule with a doctor's written prescription or under standing orders until you are re-authorised.

10. How do I renew my Authorisation?

You will receive a reminder letter close to the expiry date to apply for re-authorisation. You will need to complete the application form ("for further approval") and provide the following documentation. Please allow up to four weeks for processing of your application

---

Re-Authorisation (application every 2 years)

Current Nursing Council of NZ Practising Certificate
Current CPR Certificate (<2 years)
Peer Review Clinical Competency Assessment completed by **another authorised vaccinator** (Appendix 1)
Completion of Vaccinator Update Course Certificate and other vaccine specific education (minimum 4 hours)

11. What is the Peer Review Clinical Competency?

As part of your re-authorisation process you are expected to organise a peer review of your immunisation practice. Appendix 1 has the assessment form used for this process. Note – the peer reviewer must be an Authorised Vaccinator (i.e. be on the Community & Public Health list of current Authorised Vaccinators or provide proof of their authorisation if authorised in another DHB).

12. What if I have not renewed a previous authorisation?

Your authorisation automatically lapses if no paperwork (or communication regarding why paperwork might be delayed) has been received at the end of the 2 year authorisation period.
Requirements for re-authorisation depend on the length of time elapsed since last authorised:

- If less than 6mths has expired since your authorisation lapsed, applying for re-authorisation is all that is necessary.
- If less than 5 years but more than 6mths has elapsed, you will need to attend the first available Vaccinator Update Course and provide evidence that you have attended specific vaccination education sessions of minimum 4 hours duration each 2 years. Clinical assessment may be required at the discretion of the Medical Officer of Health.

If more than 5 years has elapsed since completion of initial Vaccinator Training Course then the Vaccinator Training Course must be repeated i.e. apply as for an initial authorisation.

13. What if I have completed the vaccinator training but never applied to become an Authorised Vaccinator?

Your authorisation is at the discretion of the Medical Officer of Health and dependent on Vaccinator Update Courses attended, number of vaccinations given, and clinical assessment. If more than 5 years has elapsed since completion of initial Vaccinator Training Course, then the Vaccinator Training Course must be repeated i.e. apply as for an initial authorisation.

14. What if I am currently authorised in another DHB region?

Apply to the new Medical Officer of Health (MOH) with details of proposed work in the region, and copy of authorisation from previous MOH

(duplicate)

15. What if I change jobs during the 2 year authorisation period or wish to administer vaccines I am not currently authorised for?

You will need to contact Community and Public Health and notify us of the changes so we can amend your authorisation. If additional vaccines are requested then you should discuss with your Immunisation Coordinator as a further clinical assessment may be required.

16. When do I need to apply for a programme authorisation?

The Medical Officer of Health can designate a specific immunisation programme as an "Approved Immunisation Programme". Approval is required for all situations where a vaccine is to be given off-site, i.e. away from a medical practice. Only Authorised Vaccinators can give vaccines under an off-site programme. The person intending to manage the programme is required to submit an application form to the Medical Officer of Health that includes:

- the vaccine(s) to be given
- location(s) where they will be given,
- documentation that will be used
- equipment that will be carried and
- a list of authorised vaccinators who will be giving the vaccines.

Programmes are approved for a 12 month period so, for ongoing programmes, applications need to be re-submitted annually.

Where programmes include influenza vaccination to healthy adults, programme managers are required to submit data to the Medical Officer of Health regarding the number of influenza vaccinations given to this population group at the end of their annual programme.

APPENDIX 1: PEER REVIEW OF CLINICAL PRACTICE FOR AUTHORISED VACCINATORS

For authorised vaccinators who have previously undertaken an independent clinical assessment and are now seeking further approval from the Medical Officer of Health.

Peer reviewer must be a currently authorised independent vaccinator

Vaccinator Name:	Peer Reviewer:
Vaccination Venue:	Date:

Prerequisites		YES	NO
	Vaccinator:		
	Has completed an appropriate update programme (4 Hours),		
	Has current CPR certificate, practising certificate, indemnity insurance		
Comments:			
	Emergency Equipment:		
	Checks oxygen & masks (adult & paediatric)		
	Checks adrenaline & expiry date		
	Checks emergency equipment- airways(all sizes), ambubag, needles, syringes, etc.		
	Aware of emergency policy		
	Vaccinator able to deal with anaphylaxis and other reactions (i.e. contingency plan for emergency assistance)		
Comments:			
	Venue:		
	Allows for safe management and delivery of immunisation		
	Privacy		
	Resting/waiting area		
	Safety – sharps container/spillages		
Comments:			
	Cold Chain:		
	Daily fridge monitoring/readings and documentation		
	Vaccines stored correctly		
	Demonstrates familiarity with practice's cold chain policy and Annual Cold Chain Management Guide and can explain what to do in the event of a cold chain failure.		
Comments:			
	Pre-vaccination	**YES**	**NO**
	Meet/greet patient or parent/caregiver and child		
	Checks vaccinations to be given/ nil recently received		
	Checks history, contraindications, current health status, receiving any treatment, medical precautions, well child check and weight for child/baby		
	Explains what vaccines are to be given		
	Advises what the expected responses are likely to be		
	Discusses risk versus benefit and allows time for questions		
	Gives post immunisation advice in writing and contact numbers for aftercare		
	Informs re need to wait for 20 minutes post vaccination		
	Informed consent obtained and documented		

	Administration		
	Washes hands		
	Checks correct vaccine, expiry date and appearance		
	Checks expiry date and appearance of diluent if applicable		
	Reconstitutes correctly if applicable		
	Draws up vaccine using aseptic technique		
	Changes needles		
	Uses correct needle size and length		
	Correct identification and exposure of the site		
	For a child: Held securely		
	Administers the vaccine at the appropriate site/technique		
	Disposes of the needles and syringes in sharps container		
	Washes hands again		
	Post vaccination		
	Completes all documentation on files and/or computer		
	Puts on recall for next vaccinations		
	For child, completes well child book and immunisation certificate if appropriate		
	Informs patient/caregiver of next vaccination date		
	Repeats aftercare advice		
	Keeps vaccinee in clinic for 20 minutes and inspects site before leaving		
	If not usual provider- policy exists regarding notifying usual provider of vaccination(s) administered		

Peer Reviewer's Comments

Signature:
Contact Details:

Vaccinator's Comments

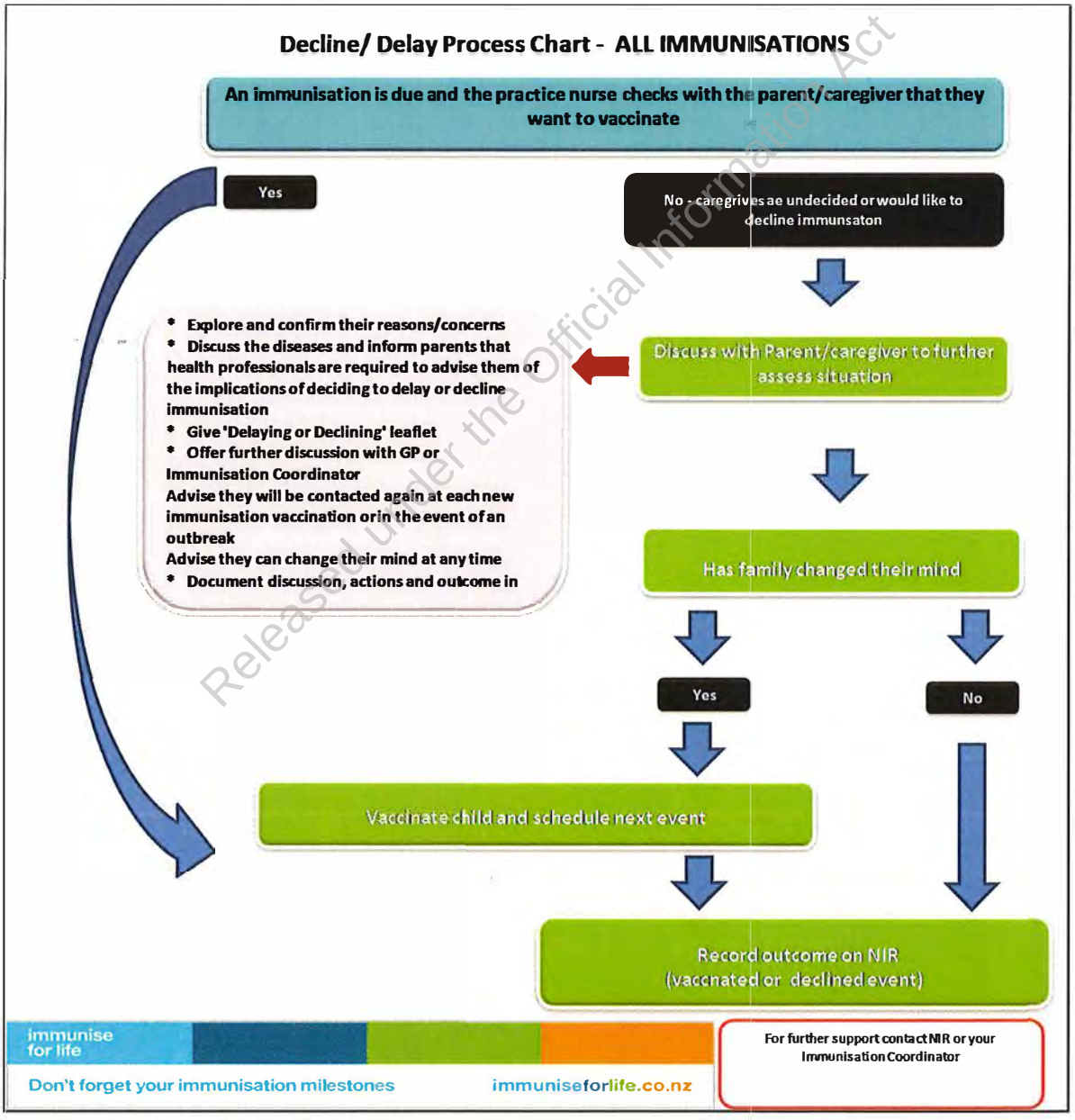
Signature:
Contact Details:

Declining Immunisations

Immunisation is not compulsory, so people have the choice to decline one or a series of immunisation events. All Declines need to be recorded on the NIR. This so we know who is not fully vaccinated and who will need to be exceed for education services in the event of an outbreak. It also assists you knowing who you have worked with, to ensure they are not contacted over and over again.

People who decline immunisation do so for a variety of reason, however it is your role as their health care professional to ensure there decision is fully informed and that they are aware of consequences of their decisions.

The following process chart has been developed to support you if a patient is thinking of declining an immunisation event.



Loading a declined event on to the NIR

When loading a Declined event on to the NIR, we ask that you only load the single event e.g. the 6w event, and then revisit the decision at each due event. People do change their minds.

We also ask that you consider the difference between delaying and declining immunisation, and set a recall up for children whose parents are delaying the event, so they can be called back in.

Referral to Outreach Services

Overview

Ideally 90% of children up to the age of 7, overdue for an immunisation event are referred to OIS before they are 6 weeks overdue.

- Outreach Services are not available for children over the age of 7
- Outreach Services cannot vaccinate if there is a history of an adverse event to a previous vaccination

Note: Do not enter any outcome for overdue immunisation events on the Immunisation screen as this will generate incorrect information on the Outreach referral form.

- Referrals from general practice are emailed or faxed to the NIR using Outreach Immunisation Referral form. (add copy of referral form)

The success of the outreach service is dependent on the quality of information provided.

Opportunistic vaccination at General Practice is encouraged regardless of an OIS referral having been generated. General practice should notify the NIR ASAP if this occurs

- There is one Outreach services on the West Coast.
- On receipt of a referral the OIS Administrator establishes the contact details are correct by attempting to contact the family. At that time she will gain for the OIS Vaccinator to administer the overdue vaccinations. If the family prefer to visit their General Practice instead she indicates they have a month to do this before the child is referred to Outreach.
- If the OIS Administrator is unsuccessful in contacting the family, the child is still referred to Outreach to see if they are able to locate the family, often by cold calling at the address provided.
- A child is with an OIS service for a variable amount of time, usually 4-6 months but sometimes longer. Should the next scheduled vaccination be within a month OIS may keep the child and complete it before discharging back to the general practice.
- Ideally 80% of children referred to OIS are vaccinated within 4 months.
- Should an adverse event happen OIS will discharge back to the general practice and notify both the Provider and the caregiver of what action has been taken.

On discharge from the outreach service detailed vaccination information is supplied to the general practice team.

Should you have any enquiries as to what the current situation is for a patient you have referred to the OIS please ring contact them **on add phone number**

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Outreach Immunisation Referral Form

Date Of Referral: _____ NHI No: _____

Child's Name: _____ DOB: _____

Gender: Male ☐ Female ☐

Last Known Address: _____ Ethnicity: 1. _____

_____ 2. _____

Phone: _____ Cellphone: _____ Email: _____

1st Contact Person _____ *2nd Contact Person* _____

Parent/Guardian: _____ Family Tree Member: _____

Contact Phone: *(if different from above)* _____ Contact Phone: *(if different from above)* _____

Referral Made By: _____ GP Practice: _____

Medical Problems / Allergies / Contraindications to previous immunisations : _____

CARM Report attached: Yes ☐ No ☐

Safety Concerns for Nurses to Visit: _____

Contact Attempts by Practice: Phone ☐ Letter ☐ Other _____

Overdue For: _____

Immunisation History (*enter dates of previous given events*)

6 Weeks	3 Months	5 Months	15 Months	4 Years	11 Years
PCV 13	**PCV 13**	**PCV 13**	**PCV 13**		
Rota Teq	**Rota Teq**	**RotaTeq**			

Please complete and return form to: ***Francess Zampese, OIS Service, C/- Community Services Dept, Grey Base Hospital, High Street (PO Box 387), GREYMOUTH***
Contact details - Ph: 03 769 7464; Fax 03 769 7460; Email francess.zampese@westcoastdhb.health.nz

Office Use Only:

OIS Contact Attempts: Phone ☐ Letter ☐ Home Visit ☐

Point of Contact: Facilitate Immunisation Primary Care ☐ Date: _____

Informed Parent/Guardian ☐ CC/Home Visit ☐ Date:

OIS Notes: _____

Exit Date from WCDHB OIS: _____

Reason for Exit:
- ☐ Complete _____
- ☐ Decline
- ☐ Refer to GP
- ☐ Moved Overseas
- ☐ Moved out of Region
- ☐ Contraindicated
- ☐ Ineligible

Signed: _____

Designation: _____

IMMUNISATON WORK PLAN 2015/16

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

OBJECTIVE *(What is our aim?)*	ACTIONS *(What action will we take in 2014/15 to make this happen?)*	TIMEFRAME	MEASURE OF SUCCESS *(How will we demonstrate achievement/change?)*	ACCOUNTABILITY *(Who will deliver?)*	
			TARGET	CLINICAL LEAD	PROJECT LEAD
	Maintain the West Coast Immunisation Advisory Group with clinical leadership across the system to provide oversight of immunisation service delivery and performance.	*6 weekly meetings*	West Coast is represented at national and regional forums	*Cheryl Brunton*	*Bridget Lester*
	Support the New-born Enrolment process which ensure seamless handover between maternity, general practice and WCTO services to support timely and multiple enrolments of new-borns with health services: ▪ Enrolment with General practice teams, and use of B codes; ▪ Timely NIR reporting to follow up un-enrolled children. Work alongside Child Youth and Family, Ministry of Social Development and other relevant social service agencies and with the Canterbury Immunisation Service Level Alliance.		98% of new-borns enrolled with a GP by 3months of age.		
	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level and circulate performance reports to maintain coverage and identify unvaccinated children. Work with Outreach Immunisation Services to locate missing children and provide advice and immunisation. Maintain internal processes whereby the immunisation status of children presenting at hospital is identified and 'missed' children referred to general practice or outreach services.	*Quarterly* *Ongoing* *Ongoing*	85% of six weeks immunisations are completed (measured through the completed events at eight weeks). 95% of eight month olds and two year olds are fully vaccinated 90% of four year olds are fully immunised by June 2016.		
	Implement the DHB-wide Immunisation Promotional Plan and use the 'Immunise for Life' programme to support Immunisation Week and profile the importance of immunisation and interagency activity.	Q4	Narrative report on interagency activities for Immunisation Week. Immunisation information is widely available across the DHB		
	Maintain an HPV Programme in a school setting and promote HPV vaccinations for eligible young women. Use on-line learning tool to promote knowledge benefits of the programme	Q2 2015/16 year	70% of girls have received HPV dose 3.		

IMMUNISATON WORK PLAN 2015/16

	Promote and provide free seasonal flu vaccinations for people aged over 65, pregnant women and people with chronic health conditions. Promote and provide (and monitor) free pertussis (whopping cough) vaccinations for pregnant women and their whānau.		75% of people aged 65+ and DHB staff have a seasonal flu vaccination Quarterly monitoring of Pertussis vaccinations.		

Minutes of the West Coast Immunisation Advisory Group Meeting

Thursday 28 November 3-4pm

Community & Public Health Meeting Room

Attendees:	Cheryl Brunton - C&PH/Medical Officer of Health (Chair) Bridget Lester – Project Specialist, Planning and Funding (teleconference) Betty Gilsenan - Immunisation Service Coordinator and Outreach Immunisation Services Janet Hogan – Sexual Health Coordinator Jan Weaver – PHN Hokitika Sharyn Kenning – NIR Administrator Fergus Bryant - Poutini Waiora	
Apologies:	Nicky Mason, Jacky Groot, Joanne Shaw, Anne Knipe, Pauline Ansley	
Agenda Items:	**Discussion**	**Action**
1 Introductions/Apologies	Welcome by Chair	
2 Minutes of last meeting (22 August 2013)	Approved - Betty, Fergus	
3. Matters Arising	None	
4. Report on KPIs (October)	Good progress continue to be made, however reaching the new 90% target is very difficult for the WCDHB.	
5 Immunisation Action Plan Progress Check 5.1 Communications Strategy	Updated Action Plan attached. Bridget has been in contact with Communications who have advised that Mick O'Donnell will work with us on Immunisation communication for the WC region. Mick has worked closely with CDHB on the *Immunise for Life* brand and has a good understanding of immunisation. Cheryl and Bridget have met with Mick, and discussed with him the needs of the WC.	Cheryl to send Bridget contact details for Corrections local person. Mick will dial into future IAG meetings.
5 Seasonal Influenza Vaccination – planning for 2014	Betty, Pauline and Bridget met with people from Canterbury DHB to do some joint DHB planning. The outcomes of this were a draft paper was presented to IPG around 2014 Flu Planning. Recommendation included:	Minor changes to the paper, and then approved by IAG.

	• Information to General practice, include road shows to general practice. • Information to LMCs • DHB Communication Programme • Work place communication. Discussion around offer the vaccination to all under 5. Due to Pharmac processes it is now complicated for DHB to change vaccine eligibility.	
6. Pertussis Update	Despite the rates of pertussis declining to pre-outbreak levels on the WC, in recent months there has been a small upsurge of cases of in the community and this is likely to continue while the disease is active elsewhere in NZ. While initial plan was to cease funding the West Coast targeted pertussis booster vaccination programme, due to this upsurge in cases it is recommended that the programme continues, at least into the New Year.	Review WCDHB targeted pertussis vaccination programme in New Year. Betty to send updated version of database to Cheryl. Cheryl will make a request for an updated report from CPH Information Team once updated data received.
7 HPV programme update	Good progress on reaching all consented girls within the school based programme. However a discussion on the overall low proportion of girls/parents consenting and what can be done to improve on this. Canterbury "Thank you" programme was shared as something that we might be able to use on the WC. Discussion about Hokitika High School and the provision of HPV at the school. The BoT have again decided to not allow this programme in their school. Jan is frustrated by this process and will arrange for Cheryl and Janet to attend a BoT meeting in the New Year	Jan to arrange for Janet and Cheryl to meet BoT in New Year
9 Immunisation Position Paper – Implementation Plan	The WC Immunisation Position Paper was approved by ALT on the 10th October. Bridget has now pulled the recommendations into an implementation plan. A copy of this plan was discussed the meeting. General feedback was that all the matters outlined in the paper were covered. Work has now begun on the Seasonal Flu, OIS and	

	Communications Planning.	IAG will monitor progress on implementation
10 Meeting dates	The following dates were agreed for 2014 year 13 February 20 March 1 May 12 June 24 July 11 September 23 October 27 November	

Lara Williams (Administrator)

From: Cheryl Brunton
Sent: Tuesday, 27 January 2015 10:04 a.m.
To: Bridget Lester
Subject: FW: Latest NISG media release
Attachments: 0127 NZ Doctor influenza immunisation release.docx

Hi Bridget

Could you please include this with the IAG papers when you send them out?

Cheers, Cheryl

From: Brenda Saunders [mailto:brenda@triocommunications.co.nz]
Sent: Tuesday, 27 January 2015 9:35 a.m.
To: Bonnie_Jones@moh.govt.nz; Cheryl Brunton; diana_murfitt@moh.govt.nz; Dr Jenny Visser; Erin Gillette; Georgina Gymer; Kate.e.Mclellan@gsk.com; Lance Jennings; Loretta Roberts; michelle kapinga; Peter Canagasingham; Renee Newman
Subject: Latest NISG media release

Hello all,
Just FYI. We're sending this release to NZ Doctor and Pharmacy today this morning.
Erin, you can upload this to the website instead of the Dompost article as it's more accurate.
Kind regards

BRENDA SAUNDERS
Communications
National Influenza Specialist Group (NISG)
Auckland New Zealand
ph: 09 536 6753
m +64 21 777 171
w: www.influenza.org.nz
w: www.fightflu.co.nz

NISG
National Influenza Specialist Group

TVNZ NZ MARKETING AWARDS
HEALTHCARE CATEGORY WINNER 2014
Flu Immunisation campaign

NISG
National Influenza Specialist Group

MEDIA RELEASE NZ DOCTOR

www.influenza.org.nz

January 27, 2015

New influenza vaccine for 2015

Two new strains in the influenza vaccines for 2015 may offer better protection for New Zealanders this winter, advises the Immunisation Advisory Centre's National Influenza Specialist Group (NISG)[1].

The influenza vaccine for 2015 Southern Hemisphere influenza season includes two new strains based upon recommendations from the World Health Organization (WHO) on the strains most likely to spread and cause illness in people this season.

The strains for the 2015 Southern Hemisphere influenza vaccine are:

- A/Californian/7/2009 (H1N1) – like virus
- A/Switzerland/9715293/2013 (H3N2) – like virus
- B/Phuket/3073/2013 – like virus.

The A/Switzerland and B/Phuket are new strains for 2015.

NISG spokesperson and virologist, Dr Lance Jennings says the bad flu season developing in the United States and possibly in Europe, was caused by an influenza A (H3N2) strain which had 'drifted' or changed and was, therefore, not included in the Northern Hemisphere flu vaccine.

"We had this strain in New Zealand at the end of our winter last year, so some people have already been exposed to it. We believe the vaccine currently being formulated for New Zealand should offer good protection against the circulating H3N2 strain."

Preparation is underway already for the 2015 programme, even though influenza season is months away.

The Flu Kit is expected to arrive in surgeries early February and will be available online at www.influenza.org.nz prior to delivery of the hard copy. The new vaccine order form is already available for download from the website. The funded seasonal influenza vaccines for 2015 are Influvac® (Abbott) and Fluarix® (GlaxoSmithKline). Either vaccine may be given to children.

Delivery of the funded influenza vaccines will be later in 2015 than in previous years due to the change in strains and the complex manufacturing process which will take longer than usual. However, Dr Jennings says the impact of the delay should be minimal.

"It is important we have a continuous supply of vaccine before we start the programme."

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[1] National Influenza Specialist Group (NISG).
NISG was formed in 2000 by the Ministry of Health to increase public awareness of influenza, its seriousness and the importance of immunisation to prevent the disease. NISG is part of the Immunisation Advisory Centre (IMAC) and manages the National Annual Influenza Awareness Campaign. NISG is a not-for-profit group of expert Kiwi doctors and nurses, whose aim is to promote the benefits of immunisation for those most in need.

Continuous supply of vaccine is expected to be available by April. Further updates on vaccine supply will be available online at www.influenza.org.nz.

"Surgeries do need to wait, however, until vaccine is in their fridge before arranging clinics."

The Flu Kit has been reviewed and updated to include a number of new resources including a new surgery poster, a new after-immunisation pad, a new tent card a new youth poster and patient brochure. Resources specifically focusing on healthcare workers and occupational health workers will be provided to both public and private hospitals in February.

Influenza vaccinations given in general practice will be recorded on the National Immunisation Register (NIR). The Ministry of Health uses the NIR to help assess the protection against influenza, monitor vaccine coverage and to plan future programmes. For more information please refer to the Flu Kit.

NISG will support health professionals with a fresh television advertisement (launching April 2015) that urges eligible people to be immunised and avoid catching or spreading influenza this season.

"The TV ad graphically shows that the influenza virus can be anywhere and is easily spread. It is a compelling image."

Protecting younger people, especially those with ongoing medical conditions, will be a special focus of this year's seasonal influenza immunisation programme.

"We know that younger people who have an ongoing medical condition such as diabetes or asthma, are often unaware that they are at risk from influenza. They possibly believe they are fit and healthy and therefore, not in need of influenza vaccination. Unfortunately, this group is particularly vulnerable to the complications of influenza because of their underlying condition and are more likely to be admitted to hospital when suffering from influenza than the general population," explains Dr Jennings.

"People 65 years and over are still a priority but we need to get higher uptake among those with ongoing medical conditions, pregnant women and eligible children."

Around 1.2 million doses of influenza vaccine were used in NZ in the 2014 season. The highest uptake was among people 65 and over.

Research has shown that healthy, pregnant women are up to 18 times more likely to be admitted to hospital when suffering from influenza than non-pregnant women.[2] There are also a range of influenza-related complications that can affect the unborn infant, and can even cause premature birth or miscarriage. Immunisation in pregnancy also offers protection to the newborn infant during the first few months of life.

Alison Eddy, professional projects advisor for the NZ College of Midwives says that midwives recognise the importance of offering information about the flu vaccine to pregnant women.

"The College of Midwives looks forward to working with NISG to ensure midwives have the most up to date material to share with women to facilitate them accessing the vaccine," says Ms Eddy.

Dr Jennings says research suggests that reminders and recommendations from a GP, nurse or midwife are the most powerful motivators in the seasonal influenza immunisation campaign.

"Immunisation is still the best form of protection from influenza and healthcare professionals play an essential role in ensuring high uptake."

Dr Jennings says it will be a challenge to improve vaccine uptake again in 2015, especially as 2013 and 2014 were relatively mild influenza seasons and people may have become complacent about the threat of influenza.

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[2] Schanzer DL, Langley JM, Tam TWS. Influenza-attributed hospitalization rates among pregnant women in Canada 1994-2000. Journal of Obstetrics and Gynaecology. 2007;29(8):622.

Influenza immunisation is free as soon as vaccine is available (from April this year) for New Zealanders at high risk of complications – pregnant women, people aged 65 and over, and anyone under 65 years of age with ongoing medical conditions such as heart disease, stroke, diabetes, respiratory disease (including asthma), kidney disease and most cancers, as well as children under five who have been hospitalised for respiratory illness or have a history of significant respiratory illness.

The subsidised season will end on July 31, 2015.

The Ministry of Health strongly encourages healthcare workers to be vaccinated - to protect their patients, but also themselves, their families and friends. In 2014, 61 percent (range 44-76 percent) of DHB healthcare workers were vaccinated, according to figures supplied to the Ministry of Health by DHBs. This figure was an improvement on the previous year (total 58 percent).

For further information go to www.influenza.org.nz or www.moh.govt.nz or call 0800 IMMUNE 0800 466 863.

Ends

Media contact: Brenda Saunders 021 777 171 or 09 536 6753.

Lara Williams (Administrator)

From: Chris_Millar@moh.govt.nz
Sent: Thursday, 4 December 2014 10:55 a.m.
To: Chris_Millar@moh.govt.nz
Subject: Draft paper " National HPV Immunisation Programme: How to progress and revitalise" . Comments due by 23 Jan 2015
Attachments: 2014 HPV Imms prog Revitalisation - Final Draft_3Dec.docx

Hello Everyone

Attached is the Draft of the " National HPV Immunisation Programme: How to progress and revitalise". This draft is a result of the contributions from all workshop attendees and subsequent discussions and input from many of you over the last few months.

I believe the draft plan provides a way forward and with your support will enable change in the future as needed so together we can achieve our aim of increasing the HPV coverage and protecting young women against HPV infections and cervical cancer.

The Minister, in his address to the Association of Salaried Medical Specialists last week, identified clinical engagement as "the key to delivering better integration across primary, secondary and tertiary care, better services within hospitals and more efficient combinations of service delivery between DHBs" and also the need for "a focus on integrated healthcare". The draft HPV programme plan identifies the importance of engagement and the integration of services and encompasses the Ministers priorities.

Please send any comments and suggestions that you may have to:

immunisation@moh.govt.nz by COB Friday 23 January 2015.

Regards Chris

Chris Millar
Advisor
Sector Capability and Implementation
Ministry of Health

DDI: 04 816 2090

http://www.health.govt.nz
mailto:Chris_Millar@moh.govt.nz

National HPV Immunisation Programme:

How to progress and revitalise

Prepared by Ministry of Health
and collective district health boards

CONTENTS

Introduction

The aim of this document is to outline a plan for progressing and revitalising the Human Papillomavirus (HPV) immunisation programme for 12 year old girls to achieve community (herd) immunity at a level which reduces the spread of the HPV infections that lead to cervical cancer and other cancers caused by HPV infections.

HPV is responsible for a substantial burden of disease in New Zealand women, the most important of which, is cervical cancer. HPV is highly transmissible and affects the majority of women and men at some stage in their life. In most cases the infection will clear spontaneously after some time, however for a small number of people persistent HPV infection may progress to changes in the cells with subsequent development of cervical cancer and cancers of the throat, neck and anal-genital region.

In September 2008 the Ministry of Health (the Ministry) launched an HPV immunisation programme. The purpose of the programme was to reduce the incidence of HPV infection and the subsequent development of cervical cancer and to reduce inequities in cervical cancer. Māori and Pacific women have a higher incidence of HPV related cancers compared to European women. From its outset, Māori and Pacific coverage has been a priority for the New Zealand programme whilst remaining focused on achieving a high coverage for all girls.

The HPV immunisation is part of the funded National Immunisation Schedule (the Schedule) and is a three dose course offered to all 12 year old girls. Since 2010 HPV immunisation coverage has remained in the mid 50 percent range. In order to provide herd immunity coverage needs to be approximately 75 to 80 percent. The national coverage target for all other primary childhood immunisations listed on the Schedule is 95 percent. The HPV programme as part of the Schedule, should achieve similar coverage as other childhood immunisations.

It is timely to reconsider the current HPV programme and look at options for revitalising the programme to achieve a coverage which would provide herd immunity, protecting not only those who are immunised, but also those who are not.

History

Internationally HPV immunisation programmes are primarily offered through school-based programmes. Since 2009 the New Zealand HPV immunisation programme has been offered to girls in school year 8 which is delivered by public health nursing school-based services. Alternatively girls could go to their GP or practice nurse, youth health or other health clinics (such as Family Planning) for the vaccine.

At the same time girls in school years 9–13 were offered the HPV vaccine as a catch-up programme which could be accessed through school-based delivery or through general practice clinics, youth health and other health clinics. In 2010 the school-delivery component of the catch-up programme ceased and the programme continued as part of the Schedule for 12 year olds.

Initial coverage targets for the ongoing vaccination cohort (i.e. girls receiving the vaccine at school in year 8 and girls aged 12 years who receive the vaccine in other primary care settings) were to be achieved by 31 December of the year in which girls

became eligible for the HPV vaccine. These were initially set at 90% for dose three for all 12 year old girls. However DHBs considered the target to be unachievable for the start of a new programme and the targets were revised.

The current targets for 12 year old girls are:

- Dose one—70 percent
- Dose two—65 percent
- Dose three—60 percent.

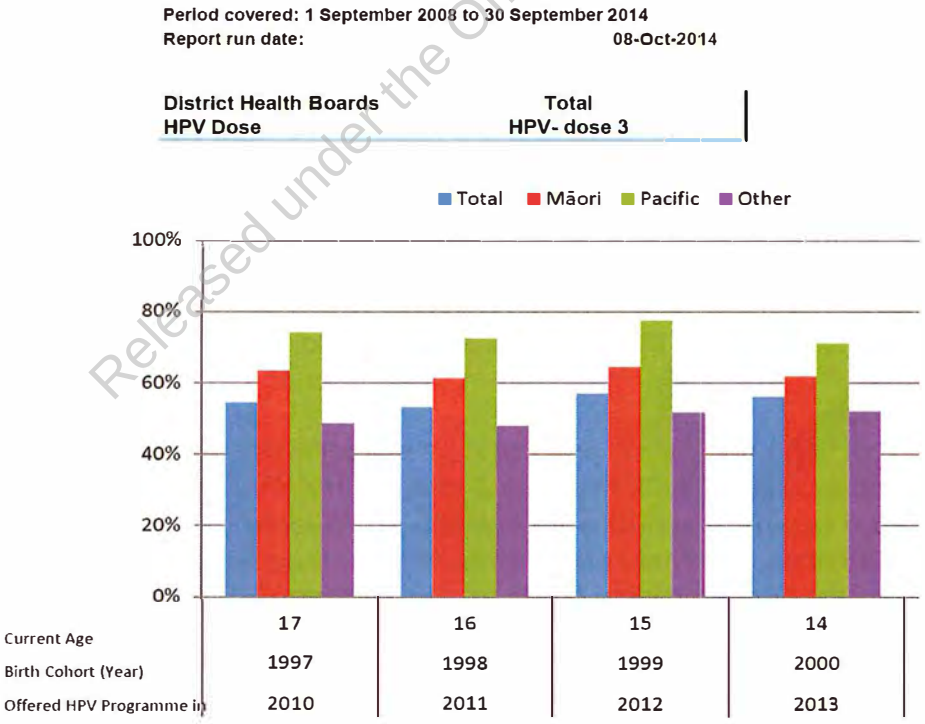
Currently the programme is predominantly offered through the school-based programme for Year 8 girls (which may include girls aged from 11–13 years); however girls can choose to have the vaccine through general practice.

In Canterbury the vaccine is offered only to 11 and 12 year old girls through general practice. However, in 2014 Canterbury DHB implemented a two year trial school-based programme to school year 10 girls (aged 13–14 years).

Coverage to date

Figure 1 below shows the National HPV immunisation, dose three coverage, from 2010 to 2013 (i.e. birth cohorts 1997 to 2000). Since 2010 to 2013, coverage for Māori (red column) and Pacific Peoples (green column) has been achieved and has exceeded the 60 percent target however coverage for the other ethnicities (purple column) and national coverage has remained below the 60 percent target.

Figure 1: HPV Immunisation Coverage by Ethnicity, Vaccination and Eligible Birth Cohort.



WHO Global Vaccine Action Plan

The Ministry's Immunisation team has adapted the six core World Health Organization (WHO) Global Action Vaccine Plan objectives (ownership, shared responsibility and partners, equity, integration, sustainability and innovation) to align

to the New Zealand context. This New Zealand adapted action plan provides a platform for all immunisation programmes (refer Appendix A).

Applying the WHO strategic objectives to the HPV Programme

The Ministry recommends applying the New Zealand adapted immunisation action plan objectives to the HPV immunisation programme. The table below outlines how these objectives apply to the HPV programme.

Ownership	Recognise the importance of and own the HPV immunisation programme (as defined by the National Immunisation Schedule) and work collectively to achieve the agreed target.
Shared Responsibility and Partnership	The Ministry, National Screening Unit and District Health Boards (DHBs), as partners and customers, respect our stakeholders (primary health care and the community) and actively look for opportunities to improve the delivery of the HPV immunisation programme.
Equity	The HPV immunisation programme deliverables need to be fair and just, in particular for Māori, Pacific and low income groups, who have the most need of primary health care services and experience the highest level of unmet need resulting from chronic HPV infection.
Integration	Integrating and coordinating the HPV immunisation programme with other programmes on the National Immunisation Schedule has the potential to lead to better outcomes for young women and improve efficiency of the school based immunisation programme delivery.
Sustainability	The HPV immunisation programme continues to have sustainable access to vaccine and funding, and remains a priority programme of the Government.
Innovation	Improve HPV immunisation programme efficiencies increasing coverage and impact through quality improvements.

Using the modified WHO Global Action Plan, the Ministry of Health Immunisation team continues to work with the National Screening Unit and DHBs to improve the HPV immunisation coverage.

i. Ownership—committing to the HPV immunisation programme

In August 2014 the Ministry held a workshop for DHB Funding and Planning Managers who had immunisation services as part of their portfolio and the HPV Immunisation Programme Managers. The purpose of the workshop was to develop strategies for revitalising the programme and working together to come up with options for increasing coverage so all 12 year old girls could be fully immunised (within the next 3 years).

Attendees considered the current New Zealand coverage, cost effectiveness of the programme, and international approaches to HPV immunisation programmes. The following questions were considered:

a) How do we de-stigmatise/normalise the HPV programme?
b) Should we transition the HPV programme to year 7 and, if so, how?
c) What are the key requirements to transitioning from a 3-dose HPV schedule to a 2-dose schedule?
d) Should the current 60 percent dose 3 HPV target be incrementally increased to reach the recommended 75 percent coverage?

There was agreement by the workshop participants that that one of the keys to increasing the HPV coverage was to incrementally increase the dose three HPV coverage target to achieve 75 percent coverage by 31 December 2017.

ii. Shared Responsibility—re-engaging with Primary Care

Currently there is disconnect between the school-based programme and general practice delivery of HPV vaccine. Although the HPV programme is delivered mainly through the school programme, best practice is that delivery would be shared by both the school programme and general practice, with the latter offering the vaccine after the school based immunisation programmes had finished.

General practice has not been given clear guidelines for the optimal time for them to recall girls who have not had the vaccination at school. Anecdotal evidence also suggests that many practices do not routinely stock the HPV vaccine in their refrigerators. There is an opportunity to work with general practice leads to re-establish best practice guidelines for HPV delivery in general practice following the school based programmes.

iii. Equity

The initial focus for the programme was on reducing inequalities. Ethnic inequalities in cancer result from multiple influences including differences in:

- underlying determinants of health
- exposure to risk and protective factors
- access to screening
- access to timely, high quality treatment (Cormack, Purdie et al 2007)[1]

Māori and Pacific Peoples are at increased risk of developing cervical cancer and dying of the disease compared to European people. Since the start of the programme the coverage for Māori and Pacific has been higher than 'other' ethnicities (this group includes European and Asian ethnicities) and has achieved the agreed dose three coverage target (i.e. 60 percent).

Where coverage is high, it is important that no slippage occurs. We need to focus on how to reengage with communities with low coverage to provide assurance about the vaccine and understand their concerns. One strategy that has worked effectively in the childhood immunisation programme is the use of community immunisation champions who are willing to front local campaigns.

iv. Integration

The HPV immunisation programme may benefit from better integration with other childhood programmes on the Schedule. Possible options for improving the integration of the programme include:

- Moving the HPV programme to Year 7, to align with Tetanus, diphtheria and acellular pertussis (Tdap).
- Re-branding the HPV programme to de-emphasise the vaccine's link with sexual activity and emphasise skin-on-skin contact as the mode of transmission.

[1] Cormack, D., Purdie, G. and Robson, B. 2007. Cancer. In: Robson, B. and Harris, R. (eds). Hauora Māori Standards of Health IV: A study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

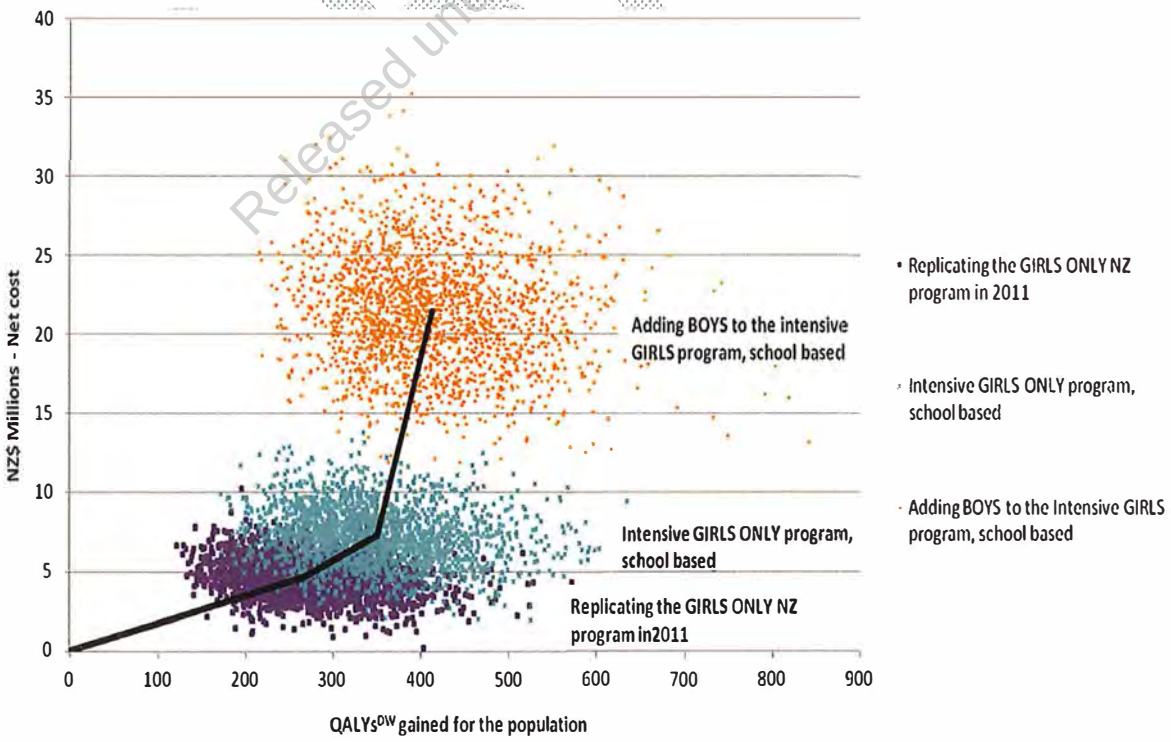
- Highlighting the vaccine's importance in preventing a variety of cancers.
- Establishing and maintaining closer working relationships on the HPV programme with primary care, public health, school programmes, Māori and Pacific immunisation leads and local cervical screening programmes.

v. Sustainability

In New Zealand the school-based programme is only offered to girls in school year 8 (11–13 year olds). The Australian HPV immunisation programme was first offered free to girls aged 12–13 years in 2007 and in 2013 the programme was extended to include both boys and girls aged 12–13 years. The inclusion of boys in the New Zealand immunisation programme was an option discussed at the August HPV workshop.

A New Zealand study conducted by Otago University concluded that the current HPV immunisation programme for girls was good value for money, but adding HPV vaccination for school-aged boys to the programme is unlikely to be a cost-effective option. The graph in Figure 2 below shows the projected impact of adding boys to the programme as well as continuing vaccinating the girls. The graph shows that at current costs adding boys to the programme will not significantly increase the coverage but would increase the programmes costs. In order for vaccination of school-aged boys to become cost-effective in New Zealand the vaccine would need to be supplied at very low prices and administration costs would need to be minimised. Figure 2 compares the NZ HPV programme total cost (which includes vaccine costs, benefit costs, programme implementation and maintenance costs for the 3 dose Gardasil vaccine as of 31/12/2012).

Figure 2: Cost-effectiveness plane for three dose HPV vaccination programme compared to no HPV vaccination (bold black lines join average values).



To reduce the prevalence of HPV infection, and subsequent cancers associated with the infection, experts estimate coverage of 75 percent is required.

The workshop agreed that for New Zealand girls to be protected against HPV infections and cervical cancer it is important that national HPV immunisation coverage of 75 percent is reached and maintained.

The following developments and initiatives may help to sustain New Zealand's programme:

- implementing a two-dose programme could help increase coverage across New Zealand. (In April 2014 the WHO Strategic Advisory Group of Experts (SAGE) on Immunisation recommended a 2-dose schedule for girls if vaccination is initiated prior to 15 years of age.)
- including boys in the HPV immunisation programme (assuming it could be delivered in a more cost effective manner than is currently projected).

The Pharmaceutical Management Agency (PHARMAC) is the New Zealand Crown agency that decides, on behalf of DHBs, which medicines (including vaccines) and related products are subsidised for use in the community and public hospitals. Any changes to the funding and eligibility criteria for vaccines will go through PHARMAC's assessment, prioritisation and approval processes before amendments to the Schedule can occur.

vi. Innovation—some ideas/questions for consideration

DHBs are experts and know how to get the best out of their local communities, health partners and IT tools. Upgrades to national (National Immunisation Register) and local (patient management) systems must be taken into account.

How do we limit interruptions to electronic messages?

Should we consider offering HPV vaccine in Year 7 along with the Tdap immunisations? This could allow a catch up Year 8 programme for those who missed the year 7 programme.

Should **additional school visits** be supported to enable catch-ups in schools? (For example a five visits schedule would allow two catchup sessions per year)

Communication is an integral part of any new approach and innovations for the HPV immunisation programme. How can we better disseminate local and national messages?

Should we consider how school-based nurses can be **better engaged** with primary health organisations/teams to support HPV vaccines that happen in the general practice?

Should we consider using **text reminder** messages of appointments/school clinics?

A summary of the breakout workshop feedback is attached in Appendix A. Appendix B lists the results of a July 2014 public health nurse survey conducted by the Immunisation Advisory Centre (IMAC).

Increasing full HPV coverage

Underlying Action Plan Principles

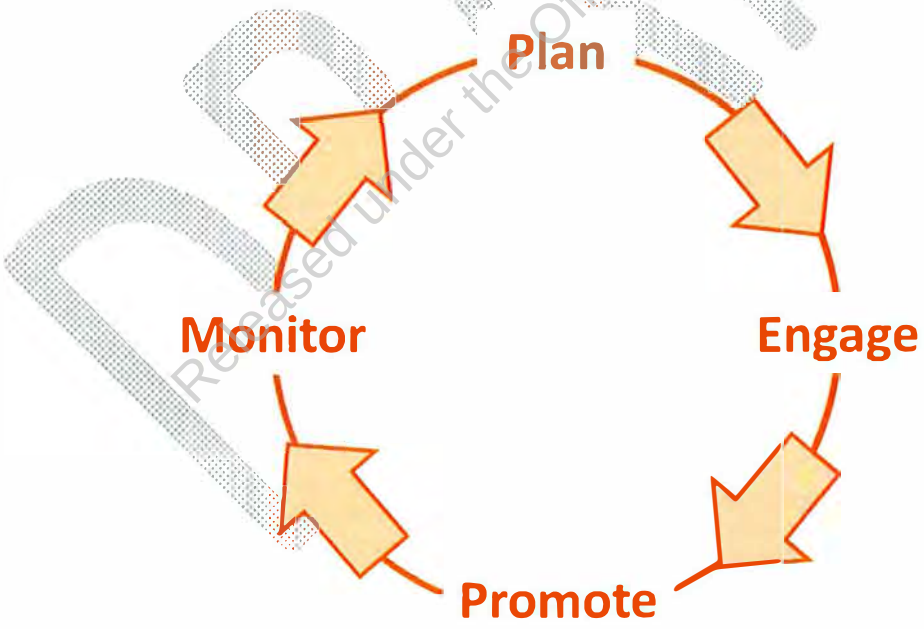
- Build on developing trusting relationships with parents
- Develop functional relationships with general practices—integrate with school programmes.
- Apply quality processes (Plan, Do, Check, Act [PDCA] cycle). Improving immunisation coverage is primarily about improving quality.
- Recognise that like raising a child, it takes a community to immunise our children.

Building on Action Plan Foundations

The HPV Immunisation programme is underpinned by effective monitoring by the programme and NIR administrators. School-based programmes which are the primary means for offering the HPV immunisation could enable better liaison between public health school programmes, primary care and a network of immunisation coordinators.

Four Point Action Plan

The Ministry has developed a four point action plan; *Plan, Engage, Promote and Monitor* to assist with the 8-month health target. The Ministry is keen to apply these learnings to the HPV Immunisation Programme to progress, revitalise and achieve a new HPV target of 75 percent coverage of girls fully immunised aged 12 years by 31 December 2017.



Intervention logic supporting activity

Principle	Activity	Intervention Logic
ACTION 1: Plan **WHO strategic objectives 1, 2, 3, 4 and 5 apply**	All DHBs plan to offer an HPV school–based programme for girls in either school year 7 or 8 by 1 February 2017.	International evidence shows school programmes are predominantly the most effective means of offering the programme to the target age group.
	School-based nurses develop methods to better engage with primary health organisations/general practice teams to support HPV vaccines that happen in the general practice.	General practice as key health providers are a vital partner in success of the HPV programme
	General practice teams work with nurse leads to develop a follow-up process and provide catch-up of incomplete or unimmunised girls (i.e. a recall at 14 years)	
	Yearly incremental milestone targets to be set for all DHBs i.e.: 2015–65%; 2016–70%; and 2017–75% across all ethnicities	Having incremental increases for the dose-3 target enables DHBs to work with their communities and providers to achieve the 75 percent coverage target by December 2017.
ACTION 2: Engage (Do) **WHO strategic objectives 2, 4, and 5 apply**	Encourage local health professionals and community leaders to become immunisation champions.	Communities respond well to local leaders driving health programmes.
	Nurse leads are encouraged to notify the child's nominated GP when the parent (or legal guardian) indicates they wish their child to be vaccinated in general practice. When GPs receive this notification the practice can recall these girls at 12 years.	Early notification of parental choice by school programmes enables the GP to engage promptly with the child's family ensuring the HPV vaccination is commenced and completed on time.
	Encourage general practice teams to recall all eligible girls in their 14th year who have not received all doses of the HPV vaccine.	Pro-active recall by primary care in the child's 14th year allows for the school programme to be completed but reduces delay for the child being vaccinated before they are exposed to the virus.
	Consider opportunistic immunisation at each contact with health system for all eligible girls 14 years and older.	Timely immunisations are important for protection because children have a stronger immune response to the vaccine and should be protected before they are exposed to the virus.

ACTION 3: Monitor (Check) families may need additional support, education and or resources. **WHO strategic objectives 2, 3, 4 and 5 apply**	Nurse leads and general practice team's work together to remedy parents and girls concerns and access barriers for 14 year old girls who do not respond within 3 months to the 14th year recall.	Build on developing trusting relationships – with parents and local health providers to assist with sharing and addressing the real issues.
	The Ministry will develop a 14 year milestone report and share DHB level coverage information with steering groups (from 2017 identifiable practice, PHO and DHB information will be included in the reports). The Ministry will measure and report to WHO on coverage for girls aged 15 years.	Immunisation reports are very helpful for DHBs. Coverage is high where DHBs apply quality processes to monitoring.
	Coverage will be reported by ethnicity (from 2017 socio-economic status will also be included).	Children in birth cohort 2005 become eligible for the HPV vaccine in 2017 and this information for this cohort and subsequent birth cohort will already be contained on the NIR.
	The Ministry, DHBs and PHOs work together to address NIR/PMS interface issues.	Changes to the interface with the current stand-alone HPV programme and the NIR/ PMS will need to be addressed prior to 2016/2017
ACTION 4: Promote (Act) **WHO strategic objectives 1, 2, and 4 apply**	Creation of a promotion plan specifically tailored for local population groups.	Different approaches are needed for different groups in the community. A promotion plan needs to coordinate activities so the key messages align.
	Promotion of immunisation through school newsletters, primary care, national screening units (e.g., mothers/grandparents presenting for cervical smears and/or primary HPV screening), youth services.	Behaviours, decision-making processes, attitudes and barriers faced by those who are delaying immunising their girls need to be understood.
	Promote immunisation with local media and parent groups—use good news stories. Provision of pro-immunisation HPV resources to schools and locations where 11–13 year olds go e.g., recreation centres, libraries, pharmacies etc.	Use targeted messages, individual stories, and the sharing of personal experiences in communications.
	Rebuttal of anti-immunisation information when appropriate.	Prepared key points and statements available for DHB to use
	Support of GPs and nurses with good resources and training.	Training programme to revisit role of immunisation, be confident informing parents about vaccine preventable diseases, managing parental anxiety.

Benefits of the four point action plan

The key actions will result in better timeliness for HPV immunisations, more transparent and consistent delivery of immunisation services, on-going integration of services as a result of local monitoring and better engagement for health professionals as they work together to develop local plans.

Other ways to improve Immunisation Coverage

The HPV programme will link in with local Māori Women's Welfare League and the Pacific Allied (Women's) Council branch offices. Māori Women's Welfare League links with DHB and primary providers can:

- assist in reaching communities with low immunisation rates
- meaningfully communicate the importance of immunisation to whānau and kaiga to increase their immunisation coverage rates.

Māori Women's Welfare League - http://www.mwwl.org.nz/

Pacific Allied (Women's) Council - http://www.pacifica.org.nz/?page_id=2

Appendix D details the Rauemi Atawhai guide to developing Health Education Resources in New Zealand, which could be useful especially at a local level.

Timelines:

Action	How	Who	When	Support
Consultation	Workshop –	DHB immunisation funding and planning & school programme managers	Held August 2014	Evidence based research studies, expert speakers, break-out discussion groups
Briefing	PSAAP	PHOs	Dec 2014	Draft plan outline provided
Consultation and put into draft plan	PHO teleconference discussion & draft plan circulated for input and comment	PHOs & General Practices	Jan-March 2015	Plan circulated Dec 2014 teleconference, sign off by DHBs & PHOs
2015	• 12 year old HPV target coverage 65% • Recall 14 year olds not fully HPV immunised	School programmes General practices	From Feb 2015 From April/May 2015	Monitoring, quarterly data provided in user friendly formats, regional teleconference
2016	• 12 year old HPV target coverage 70% • Recall 14 year olds not fully HPV immunised	School programmes General practices	From Feb 2016 From Jan 2016	Monitoring, quarterly data provided in user friendly formats, regional teleconference

2017	• 12 year old HPV target coverage 75% • Recall 14 year olds not fully immunised • All DHBs to offer HPV school–based programme for girls in to year 7 or 8.	School programmes General practices	From Feb 2017 From Jan 2017	Monitoring, quarterly data provided in user friendly formats, regional teleconference

Appendix A: WHO Global Action Plan Objectives (adapted for NZ context)

Ownership

The New Zealand Government has primary ownership and responsibility for establishing good governance and for ensuring effective, timely and quality immunisation services for all.

Shared responsibility and partnership

Immunisation against vaccine preventable diseases is a shared responsibility between individuals, families, communities, primary health care services, district health boards and nationally.

Equity

Equitable access to immunisation is a core component of health care.

Integration

Strong immunisation systems are part of the broader health system and are closely coordinated with other primary health care delivery programmes through the Better Public Service initiative

Sustainability

Informed decisions and implementation strategies, annual planning, appropriate levels of financial investment, and improved financial management and oversight are critical to ensuring the sustainability of New Zealand's immunisation programme.

Innovation

The full potential of immunisation can only be realised through learning, continuous improvement and innovation in research and development as well as innovation and quality improvement across all aspects of immunisation.

Appendix B: Workshop outcomes Summaries

Workshop 1: How do we de-stigmatise/normalise the HPV programme?

<table>
<tr><th colspan="2">What strategies could be used to de-stigmatise the HPV vaccine?</th></tr>
<tr><td>Education
With endorsement from Ministry of Education
In schools for both parents and students
Educate the teachers so they support the programme
Conversations start the year before vaccination
Include in NZ PE/Health curriculum
More emphasis on Immunisation certificates and registers at school
Multiple levels of information—different resources for children, parents, teachers
Publicity
Overall publicity needs to be ramped up—schools, school board of trustees etc
Framing of message to normalise HPV vaccine alongside the other vaccines</td><td>Technology
Update HPV video—show it at school and upload to YouTube so the parents can see exactly what the children do
Utilise school communication systems by sending emails to parents etc warning of consent forms etc coming home
Champions
Well known people to front a campaign – potentially on effect cervical cancer has had on family
Widening the message
HPV effects everyone (may be pushback because boys are not immunised)
Pregnancy outcomes
Push ‘cancer vaccine’ message—link it with cervical screening. Focus on Mums.</td></tr>
<tr><th colspan="2">Should this include the consent form, school DVD, media advertising?</th></tr>
<tr><td colspan="2">Consent form
Overseas forms often include other vaccinations so HPV is much more normalised
Keep consent forms very simple but accompanied with a more detailed information pamphlet</td></tr>
<tr><th colspan="2">Would offering the vaccine to boys help de-stigmatise the vaccine?</th></tr>
<tr><td colspan="2">Yes</td></tr>
<tr><th colspan="2">Why are Pacific and Maori parents more accepting of the vaccine?</th></tr>
<tr><td colspan="2">Māori and Pacific parents are more accepting of the vaccine and appear to have a greater acceptance of their children becoming sexually active than the “other” ethnicities. There is a need to understand the higher uptake for Māori and Pacific.</td></tr>
</table>

Workshop 2: Should we transition the HPV programme to year 7, and if so, how?

In general, the groups were supportive of moving HPV vaccine to year 7 to be given at the same time as Tetanus, diphtheria and acellular pertussis Tdap vaccine

Advantages	
Normalisation of vaccine • Use one consent form for HPV and Tdap • Opportunity to rebrand—less focus on sex • Opportunity to develop 'adolescent programme' including the following vaccines: Measles, mumps and rubella (MMR); Human papillomavirus (HPV); Tetanus, diphtheris, and acellular pertussis (Tdap); travel vaccinations, Meningococcal B (MenzB). Link to the NIR. *Better for schools* • Less disruption • Potential for orientation of school Year 7 immunisation to occur in school Year 6	*Engagement* • Parents more likely to attend school Year 6 transition activities • Parents more engaged at school Year 7 • Link to memories of Rubella programme (previously given to girls only to limit to the risk to giving birth to a baby with congenital rubella syndrome) *Logistics* • More efficient use of resources, which could lead to cost savings • More catch-up opportunities
Barriers	
Two Vaccines (HPV and Tdap) • Could create confusion should one result in an Adverse Events Following Immunisation (AEFI) • Means 2 different consent forms—how to manage partial decliners • Potential vaccinator errors (giving a boy HPV etc) • Different education for 2 different vaccines	• Could lead to a decline in Tdap coverage if they are linked together • Further criticism over young age at which girls are given HPV vaccine *Logistics* • Only for girls • Different number of doses for each vaccine • Increased volume of work—2 jobs in one day • Confusion if GPs are offering vaccine as well

Parental concerns	
• Girls being given a 'sex' vaccine at an even earlier age • Longevity of the vaccine—if it doesn't last a lifetime, is it smart to give it earlier? • Research behind safety and effectiveness of being given vaccine at an earlier age	• Trust and conversations very hard in school programmes • Fear of needles in younger girls • Making changes, yet why not boys? Ethics around decision • Overwhelming the immune system
Additional resourcing needed	
Communication • Strategy needs to be national and consistent • Use wider social media • Update DVD and get it online • Broaden the message—link to cervical screening, genital warts and other cancers • New education resources	*Logistics* • Capacity of cold chain—50% more vaccines • Linking declines to GPs • New consent forms • Workforce training *Champions?*
Would HPV immunisation provided only through the school programme improve coverage?	
• Could present challenges in declining schools • Parallels with MenzB • Would it be a national decision or could each DHB decide? Transition of families favours a national standard and helps timeliness • International evidence suggests that coverage a school based • Canterbury have a predominantly Primary Care based programme and their Tdap coverage is 83% at 11 years old • Would definitely need Primary Care engagement and back up to assist with undecided parents	

Workshop 3: What are the key requirements to transitioning from 3-dose HPV schedule to a 2-dose schedule?

Advantages	
Schools • Less school visits, less disruption • Easier to timetable/schedule • More flexibility with programme—could do booster after 1 year • Better buy in	*Increased coverage* • Better for those with needle phobia • More opportunity for catch up • Definite date for girls to have the 2 dose vaccine (2 doses would need to be administered by age 15) • Cost effective – less vaccine and less resource needed
Disadvantages	
• Has to be given before 15 years • Potentially a booster needed at 60 months • May lose transient children—transferring DHBs etc (different school cycles)	• Lack of evidence for 2 dose variant • Public can be suspicious of change—pushback • Concern that those who started on 3 dose strain would then think they only needed 2
How to make this happen?	
Communication • MOST IMPORTANT • Needed at a variety of levels • Detailed communication plan/strategy • Link with enrolment education/resources	• Prioritise catch-ups • Normalise the vaccine • Great systems and IT—NIR capability? • Logistical planning at national level • Adopt lessons learnt from original programme; national consistency, limit options etc
Impact on National Cervical Screening Programme	
• Keep linking programmes together; the more vaccinations, the less regular smears need to be • Link screening to NIR?	

Additional Question: Should HPV be made a target?

(NB: This question was asked at all three breakout workshops)

Should HPV be made a target?
YES • Benefit of herd immunity and personal protection from high HPV coverage • Staff are motivated by targets • It could assist with the buy in from the education sector • Perception that 60% does not sound very good • Link to NIR in order to get accurate figures • Could strengthen national strategy *BUT* • It would need to be increased incrementally—75% is a huge increase and could be quite demoralising • It would need buy in from Primary Care • Could we also have a target for Boostrix (Tdap)? Bring focus to school aged immunisation programme • Target would need to be evidence based

Appendix C: Public Health Nurse Survey conducted by IMAC

Key Points from School Based Immunisation Programme (SBIP) – Public Health Nurse Survey July 2014.

Challenges to delivering the SBIP

Logistics and Operations

Issues/Concerns:

- size of region—main centres via SBIP; rural areas via GP/local clinic & less priority on programme
- access to cars—planning
- no nationally consistent guidelines/standard operating procedures
- competing school priorities—i.e. vaccination clinics vs ski trips, sports trips, class trips, teacher only days etc. Programme not a priority for schools
- competing work priorities i.e. rheumatic fever (RF) throat swabbing programme (3 year programme started mid 2013)—with no additional funding so staff have been taken away from Immunising to fulfil RF programme. Seen as higher priority than immunisation.

Suggestions for Improvement:

- large DHBs share their strategies for dealing with the large volumes to assist with planning for next year
- work together on how to manage the non-consenting schools.

Consent Processes

- Public Health Nurse's (PHN) getting access to schools to deliver consent forms and pick them up
- barriers from schools obtaining school year 7 and 8 rolls
- teachers reluctant to follow up on consent form non-returns
- some schools have parents post consent form returns directly to the Public Health Nurse so school staff are not handling the consents at all.

Information and Promotion

Issues/Concerns:

- unable to engage with parents—lack of parental attendance at education sessions offered when the consent forms are given out
- providing up to date information (e.g. that the vaccination provides 10 years of immunity if not lifelong immunity). Finding suitable time for school and PHN to show DVD to school Year 8 students
- limited access to the teachers so can't talk through their issues and concerns regarding the HPV vaccine
- teachers' personal views of HPV immunisation influencing student and parental decision making
- HPV 3-dose schedule sometimes difficult to plan—would work better if time could be shortened between doses
- parents opt to take daughter to GP but do not do so.

Fact sheets for:

- Key information the health professional needs to inform the girls, get across to parents and teachers.
- Information for questions from parents/girls on:
  - why it's important to have the HPV vaccine at a younger age.
  - if vaccine will ever be offered to boys in NZ
  - if there is recent evidence that fewer doses of HPV or shortening the dosing schedule provide sufficient immunity?
  - evidence that supports vaccinating at school year 8 as the best time for sero-conversion. This might help change parental perceptions and acceptance of this vaccine being given prior to sexual activity.

Ideas/thoughts as to why parents/girls decline the HPV vaccine?

2014 decline section of form—examples of comments received included:

- taking daughter to GP
- will get vaccination when older
- not enough reliable testing or information available
- references to invalidated magazine articles on the danger of HPV vaccinations
- parents wanting HPV offered later in school when girl is older; going to the GP means time off work for them.

Suspicion about the vaccine—not been around long enough, safety profile etc.

- need evidenced based information in appropriate formats for parents.
- it's important to get the message that the Gardasil vaccination is for outcomes of HPV related infections including cervical cancer
- a lot of declines are due to parents thinking the vaccine is going to wear off too early, due to an earlier message that it was only guaranteed for 5 years. If there was more promotion around the longevity of this vaccine, parents may have their daughter vaccinated earlier.

Perceptions:

- Sex factor—parents' perception is that their child is not yet sexually active and therefore too young for the vaccine (most common parent comment and an attitude more prevalent in higher decile schools)
- Special—vaccine is not seen as normal part of the schedule; seen as "special" programme similar to MeNZB

The Sector:

- Not enough current advertising taking place—social media, magazines, radio, TV etc
- Need a consistent/clear message from the Ministry

DHB Logistics and Operations

- Information from schools needed in January to inform the PHN service of any school activities during vaccination weeks in March, May and September that need to be avoided
- For some schools starting in term 2 would be better, however the push by the Ministry of Health is to start in term 1

- A champion HPV school staff member (e.g. school counsellor) may be beneficial. They would need some basic training and resources but could be the go-to person in the school for further information
- Regional school programme meetings—focus on issues and get feedback on ideas; see what has worked and not worked elsewhere
- Standard operating procedures (SOPs) for such things as oxygen transportation etc.
- Expected obligation for SBIP to transfer care to new district when student's move—does the consent form get forwarded etc.
- It would be good to have the resource and ability to carry out catch up programmes in the school holidays, located at community houses or hubs
- Agreed 'bottom lines' with DHB management regarding student numbers and staff number ratios so that programme can be delivered effectively and safely
- Look to include in the PHN contract to catch-up those girls found in year 9 school based nursing heads assessments who have not been vaccinated in school year 8, and who have not, and would not access their primary provider.

National Logistic and Operations:

- Templates that can be adapted locally e.g. cover letter for consent form, cold chain recording etc.
- Better tracking of movement of students between schools and districts.
    - A national list of school based vaccination providers and their fax numbers would make it easy to transfer information and consent forms between districts.
    - Access to the schools "enrol" database would be a big advantage.
- Ministry of Education and schools to make the programme a priority with teachers supporting the programme
- Funding for Pacific/Māori community health workers—outreach into the community, ability to home visit, provide education and promote immunisation at a local community level
- Parents opt to take their child to the GP to be vaccinated; however, there is no capacity to follow these up. How many do actually go to GP for HPV vaccine? Currently there is no recall system.
- PHNs work in both primary and secondary school settings to be well situated to capture those who have been missed. Numbers would be small, but may increase uptake and cover of the HPV vaccine in all age groups.
    - Increase funding to resource additional healthcare assistants to chase missing forms as currently level 3 and 4 nurses are spending a lot of time doing this.
    - Amend reporting dates so there is less pressure on staff especially within the larger DHBs.
    - Consider a 2 dose programme when research supports this, easier to deliver across school year.

Information and Promotion

- Key messages for school newsletters promoting HPV programme.
- Small gift for student—currently we utilise a different coloured silicone wrist band for each of the three vaccinations so the young person will end up with three in total.
- Make sure the information advises that three doses are required for protection from the HPV virus.
    - Clear consent form—particularly Tdap, as parents often don't realise which vaccine it is and provide consent, then kids say they have already had it and so checking with GPs or parents is needed (the kids are often right).
    - Offer HPV vaccine to boys as well.
    - Update HPV and Boostrix DVDs.
    - Ministry of Health immunisation promotion for SBIP via TV, radio and IT applications such as Facebook, when students return to school at the beginning of the school year.
    - Health professional training on parents' information needs, anxieties, and concerns; and how to have conversations around these.
    - Promoting/Publicising local relevant people who will 'Champion' and promote Immunisation at local community level.
- Girls are more concerned about vaginal warts, and can easily conceptualise these as being "yuck/gross/disgusting" etc. It may be worth stressing the wart virus aspects of protection rather than the cancer at this age group.
- Promote website provided on the consent form so families can easily sit and watch the same video that is shown at school in their own home and time frame. Some parents have low literacy levels and a movie provides them the information they need to make informed consent on the vaccination of their daughter.
- Mass media provided on TV etc started earlier in the year to coincide with the consent forms going out. Currently they start as soon as schools go back in the new year; perhaps the media campaigns should start informing parents early January?
- Specifically designed pamphlet to go home at the end of the school year 7 to inform parents of the year 8 HPV program. Possibly emphasis the wart virus aspects even more, and why girls are being offered this at school year 8, even though they are not sexually active.
- Consider training for staff such as Vision and Hearing Technicians /Social Workers so that they can promote the importance of immunisation.
- Media coverage on the importance of immunisations throughout the year not just once at the beginning of the year.
- Before consent forms go home with students, parents should be informed that their daughter will bring a consent form home soon and now would be a good time to look into the vaccination. Preferable that the drive starts end of this year and pops up over school holiday /Christmas time, as HPV teams are ready to go first week back at school with education sessions and consent forms going out.

Appendix D: Rauemi Atawhai – A guide to developing health education resources in New Zealand

- Assists health professionals to produce resources that meet the needs of the intended audience.
- Ensures resources are easy to understand.
- Supports improved health literacy.

Rauemi Atawhai contains three sections. Section 1 has background information with guiding principles for developing a health education resource and matters to consider in that process – such as health literacy, cultural relevance, resource type and accessibility as well as consumer and expert input.

The website address for Rauemi Atawhai is:
http://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand

Rauemi Atawhai Guiding principles:

- be prepared
- be clear on your audience and your key messages
- be open
- be relationship focused
- be accountable
- test, test and test again with your audience and stakeholders.

Section 2 contains a flow diagram and bullet point notes detailing eight stages in the development of a resource.

Eight stages are involved in producing a health education resource:

1. **need**—research the need for a resource, identify similar existing resource, define the audience
2. **audience**— talk with the audience about what they need, like, want
3. **health literacy**—identify the health literacy demands of the audience
4. **resource scope**—finalise the purpose, form and success factors of the resource to be developed
5. **draft and test**—get experts and the audience involved in drafting and giving feedback on the resource until it's right
6. **publish and distribute**
7. **evaluate**—assess the resource's effectiveness with the audience
8. **learn**—what to do next time.

Section 3 has appendices, the first of which is a checklist of the language, design and illustration components involved in the resource production.

Effective health education resources may contribute to patient safety, improving health outcomes, and empowering individuals and whānau to improve their health and wellbeing through increasing health literacy levels. A person with a good level of health literacy is able to find, understand and evaluate health information and services easily in order to make effective health decisions.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 9 March 2015 11:53 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; Catherine Crichton (catherine.crichton@westcoastdhb.health.nz); Cheryl Brunton; Christina Houston; Hilary Ford; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; Lee Harris; Linda Hill; 'Nikki Mason'; 'Pauline Ansley'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda and papers for IAG 12 3 2015
Attachments: Agenda - IAG 12 3 2015.docx; Workplan updated.docx; Draft IAG Minutes 29 Jan 2015CB.docx; Draft IAG Minutes 27 Nov 2014.docx

Hi all

Please find attached the agenda and papers for our meeting on Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

From: Bridget Lester
Sent: Thursday, 5 March 2015 9:45 a.m.
To: Cheryl Brunton
Subject: Draft agenda IAG 12 3 2015

Hi Cheryl

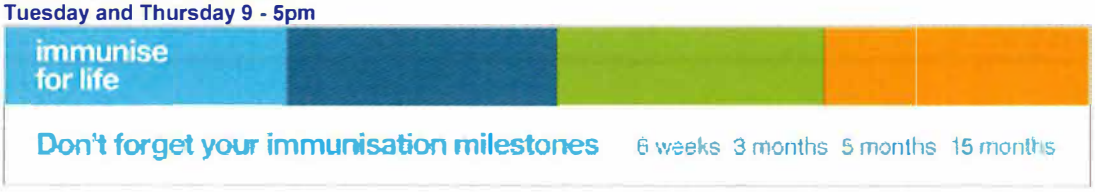
Please find attached the draft agenda for IAG for your review.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**

Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm



IAG 2014/15 Work plan

Objective: *Increase Immunisation Coverage:* To reduce vaccine-preventable diseases and support people to stay well.

March2015

ACTION	TASK	EVIDENCE	RESPONIABLITY	COMMENT
Maintain the Immunisation Advisory Group that includes all relevant stakeholders for the DHB's Immunisation Services including the Public Health Units and that participates in Regional and National forms	6 weekly IAG meetings Attend regional and national meetings when available	98% of newborns are enrolled with a General practice by three months of age.	Chair and Planning and Funding	Yes – achieved
Support and maintain systems for seamless handover between maternity, general practice and WCTO services and support enrolment of newborns with general practice.	Continue to support LMCs for early hand over to GPT and Well Child providers Ensure early enrolment with General practice teams, and use of B code Continue to support NIR to establish timely reporting to follow up children		Planning and Funding and NIR Planning and Funding, PHO and Immunisation Coordinator NIR and Planning and Funding	A WC and CDHB approach is occurring with this. Need of champion to be identified Occurring
Continue to work with Primary Care to monitor and increase newborn enrolments. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Explore linkages with CYF, MSD, Justice and other relevant social service agencies.		Child and Youth Work stream	Occurring as part of Child and Youth Work steam
Development of a DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week.	Develop and circulate the Systems Resource 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates Maintain streamlined access to immunisation awareness information. Plan developed for Immunisation Week	Narrative report on interagency activities to promote Immunisation Week Q4.	Planning and Funding and Immunisation Coordinator Planning and Funding and DHB Communications	Review has occurred, but awaiting CDHB changes to occur. Will occur in the new year
Monitor and evaluate immunisation coverage at DHB, PHO and practice level managing identified service delivery gaps • Refine NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. • Expand reporting to include practice-level coverage reports to identify and address gaps in service delivery. • Support the OIS to locate missing children.	Report to PHOs and General practice on Health Target progress and outcomes. Develop relationships with services already working with children to focus on high needs, at risk children. Continue to work with OIS service on children identified as support. Offer necessary support to Child Health Division for training and educating for opportunistic vaccinations	85% of all six-week-olds are fully immunised Q4. (measure through the completed events report at 8 weeks) 95% of all eight-month-olds are fully vaccinated by Q2. 95% of all two-year-olds are fully immunised	NIR Planning and Funding OIS and IAG Planning and Funding and Immunisation Coordination	Data not currently available 77% achieved for Q1 90% achieved for Q1

Continue to support the Child Health Division to identify the immunisation status of children presenting at hospital and provide missing or overdue immunisations.				
Continue a focus HPV Programme to increase uptake and reduce declines for the service	Continue to provide the School Based HPV Programme Continue to support general practice to vaccinate children for the 11year old event and HPV programme	60% of girls born in 2000 receive HPV dose 3 Q2.	HPV Coordinator and Planning and Funding	Discussion to occur before meeting
Provide free pertussis vaccinations for pregnant women and their Whanau.	Continue to support LMCs and general practice to promote Pertussis to Pregnant Women.		Planning and Funding, PHOs, Maternity Services	Part of wider CDHB and WC Plan

Key project areas for 2014/15 year

- Seasonal Influenza – develop project plan and implementation timeframes, including communication
- HPV – develop project plan and implementation timeframes, including increasing GPT uptake
- 11year old event – continue to collect data and monitor coverage
- Childhood immunisation – continue to support general practice and OIS to reach health and performance targets
- 4 year old event – develop resources to support general practice and promotional information to give Public Health Nurses
- LMC and GP linkages – work closer with LMCs to promote seasonal influenza and develop a process for notification by LMCs of pregnant women to ensure recall for Pertussis in Pregnancy vaccine.

Minutes of the West Coast Immunisation Advisory Group Meeting

Thursday 29 January 2.00-3.30pm

Community & Public Health Meeting Room

Attendees:	Cheryl Brunton, Janet Hogan, Bridget Lester, Ann Knipe, Pauline Ansley, Janet Hogan, Catherine Andrew Catherine Crichton Sharyn Kenning, Kylie Parkin, Lee Harris, Betty Gilsenan, Hilary Ford and Joanne Shaw.	
Apologies:	Sarah Harvey and Linda Hill	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting (27 Nov 2014)	Wrong minutes were attached, will review at next meeting	
3. Matters Arising	• These matters were discussed later in the meeting	
4. Standing Items	**Report on KPIs** • 8 months – Achieved 82% for Q2, with this quarter. With 16.6% opt off and declines. One child was missed this quarter. • 2 year old – Achieved 93% this quarter, with opt off and declines being 5.1%. We missed 2 children this quarter. • 5 year old – Achieved 79% for Q2 with 8.2% opting off and 10.9% declining. We missed 2 children this quarter. **Seasonal Influenza** • Draft 2015 Flu Plan was distributed. Discussion around pregnant women and sending all LMCs a Flu package. The vaccination season will start late this year due to the late arrival of the vaccine. • Betty and Pauline are working together on supporting general practice. • All flu vaccinations given in general practice will go on the NIR this year, not just funded vaccinations. Hopefully last year's teething issues will be sorted. • *Please note – flu vaccination given under an occupational health programme can currently NOT message to the NIR* • Letters to be sent to Residential Care providers, District Nursing Services and Maori Health provider regarding the 2015 programme. **HPV** • There is currently an issue around funding the printing of the promotional material. Cheryl to see if CPH will cover the cost of this. • Lee to have a look at letter and provide feedback. • Agreed that the programme will start in T2 this year due to the shorter T1 and a large number of schools and PHNs dates conflict in T1. •	Bridget to draft letters and share with Cheryl for approval Order resources for LMC packs Cheryl to talk to her manager around funding resources

	• Discussed WC IAG submission on Ministry draft paper on revitalising HPV programme. Agreed that group supports general intent of paper but would encourage flexibility in local delivery, moves to a two dose regimen and including boys in the programme. **Pregnancy vaccinations** • There continues to be some challenges around getting general practice to recall Pregnancy women for vaccinations. o LMC are not linking GPT into antenatal bloods or scans, therefore GPT don't know women are pregnant o If a practice does know, there is no simple way to set up a recall for Flu or Pertussis. • We need to work out how to set up the recalls at general practice and how to ensure that the LMC informs general practice that a women is pregnancy. • A sticker to put on the Maternity Notes has been drafted, and will be distributed to LMCs are part of the flu packs.	Lee to review letter Cheryl to edit draft submission with Bridget for submission tomorrow. Bridget to link with Betty and Pauline around this programme
5. 2015 Work Plan	• A copy of this was shared with IAG. It was supported to be actioned	
6. Immunisation Week	• On the WC we make this immunisation month for April, rather than just the week. • Discussion around updating the WC Immunisation poster, to make it a life event including all age groups. – Lee to look into this. • Looking for articles around pregnant women.	Bridget, Lee, Betty, Pauline and Cheryl to meet to pull the plan together.
7. Immunisation Tool Kit	• The draft tool kit was shared with IAG. Betty to have a look at the new sections and provide feedback. • Suggested that Pauline might want to have a look also from a practice perspective.	Feedback by 13 February.
8. General Business	**Health Targets** The MoH has written to all DHBs thanking them for their work in achieving 94% coverage for Q2 2014/15. They have suggested to assist in improving the 6month coverage rate road shows or a national workshop might be useful. The West Coast group supported road shows as the MoH might get an understanding of the issues on the WC if they visited us.	
Next Meeting	Thursday 12 March 2015 2.00 – 3.30pm, Community and Public Health Offices	

Minutes of the West Coast Immunisation Advisory Group Meeting

Thursday 27 November 2.30-4.00pm

Community & Public Health Meeting Room

Attendees:	Cheryl Brunton, Janet Hogan, Bridget Lester, Ann Knipe, Christine Houston, Janet Hogan, Catherine Andrew and Joanne Shaw.	
Apologies:	Kylie Parkin, Sarah Harvey, Lee Harris, Betty Gilsenan Harvey, Lee Harris, Pauline Ansley, Lorraine Williams and Catherine Crichton Sharyn Kenning Lesley Holmwood and Linda Hill	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting (11 Sept 2014)	Approved – by Cheryl and Ann	
3. Matters Arising	• These matters were discussed later in the meeting	
4. Standing Items	**Report on KPIs** • 8 months – Processing towards 80% for this quarter. Will be a long way off the MoH target of 95%. • 2 year old – processing towards around 85-90% again for this quarter • 5 year old – no update on data for this group **Seasonal Influenza** • Bridget is still working on this plan. She will get it out to the group by the 5 December. • There has been a delay in the national campaign being developed, this has delayed the West Coast planning. • Need to focus on Pregnant Women in 2015. • The workshop that Janet and Bridget attended in Auckland was valuable. Note of workshop attached. **Pertussis update** • Michael presented the data for the extended programme. • It was agreed that we would cease this programme and promote the national programme and ensure that pregnant women are vaccinated by 38 weeks. • CDHB offer a programme to women in neonatal who have had their babies early. This will also be offered to West Coast women. **HPV** • Draft 2015 plan circulated. Some minor changes to be made to the poster • Janet to run letter past Lee. • Public Health Nurses looking at providing girls health days at secondary school to promote HPV to girls who have not been vaccinated	2015 Plan to IAG – 5 December Distribute note of workshop Update posters.
5. 4 year old data	• This has been some wider discussion within the WCDHB around offering immunisations at the B4 School check.	

	• IAG agreed that the currently model of service delivery by general practice was the preferred model. Any change in service model would need to go from IAG to Planning and Funding Leadership Team. • The current rates for the West Coast are positive, so there is no real need to change the service model.	
6. Resuscitation skills for Vaccinators	• All vaccinators need have undergone training in resuscitation. The current course for this is a two day course. Discussion around how we could make this simpler. • Bridget ask what CDHB is currently doing.	Bridget to follow up.
7. Immunisation Week	• The 2015 focus is Whooping Cough and vaccination during pregnancy. Suggest we focus on Pregnancy with it being during the flu season. Week will be 20-16 April. •	
8. General Business	• Opt off children Pauline raised a concern around children opted off the NIR, and suggested that Betty contact families to see if they are a true opt off. Bridget to link with Sharyn around the current process for Opt offs on the West Coast It was agreed that we should (if we already don't) start collecting a list to ID if they are all Gloriaville opt offs, or other members of the community. • In 2015/16 year HPV and 4year old immunisation will become Performance Targets for DHBs. • Meeting dates for 2015 o 29 Jan o 12 March o 23 April o 4 June o 23 July o 10 September o 22 Oct o 3 Dec Meeting time will be 2-3.30pm *Cheryl thanked everyone and wished them all a happy Christmas season.*	Bridget to link with Sharyn and pull together a draft opt off process.
Next Meeting	Thursday 29 Jan 2015 2.00 – 3.30pm, Community and Public Health Offices	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 2 June 2015 1:21 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Christina Houston; Hilary Ford; Janet Hogan; 'Joanne Shaw'; Joelle DeDanann (Joelle.DeDannann@westcoastdhb.health.nz); 'Kylie Parkin'; Lee Harris; Linda Hill; 'Nikki Mason'; 'Pauline Ansley'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda - IAG 4 June 2015
Attachments: Agenda - IAG 4 June 2015.docx; WC Imms Reporting June 2015 Summary.docx; Draft IAG Minutes 12March 2015.docx

Hi all

Please find attached the agenda and papers for IAG on the 4th June.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM – supporting you to be well

AGENDA

Thursday 4 June 2015, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 68454#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (12 March 2015)	Cheryl Brunton	Draft IAG Minutes 12March 2015.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting ○ Seasonal Influenza – 2015 Plan ○ HPV programme update ○ Pregnancy vaccinations ○ Immunisation Week	Bridget Bridget, Betty and Pauline Janet Bridget	Workplan updated.docx WC Imms Reporting June 2015 Summary.
5	Pertussis Booster Study	Cheryl	
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Action	Due date
Seasonal Influenza 2015	Bridget to draft letters and share with Cheryl for approval	28 Feb
Seasonal Influenza	Bridget to order resources for LMC pack	30 Jan
HPV	Need to sort funding for posters Lee to review letter to parents	30 Jan
Vaccinating Pregnant Women	Bridget to link with Betty and Pauline around this	6 Feb
Immunisation Week	Bridget, Lee, Pauline, Betty and Cheryl to meet to discussion plan	10 Feb

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth

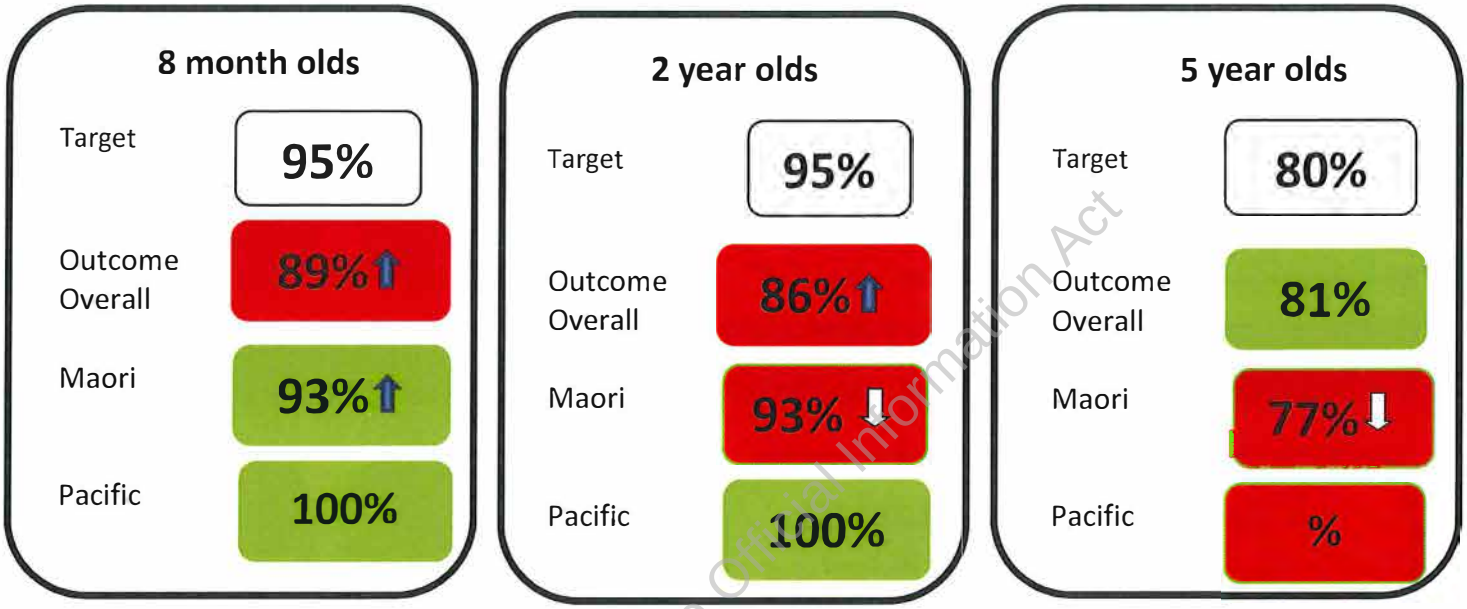
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hoki
Catherine Crichton	PHNS Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Linda Hill	IMAC Southern Regional Advisor

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q3 2014/15



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

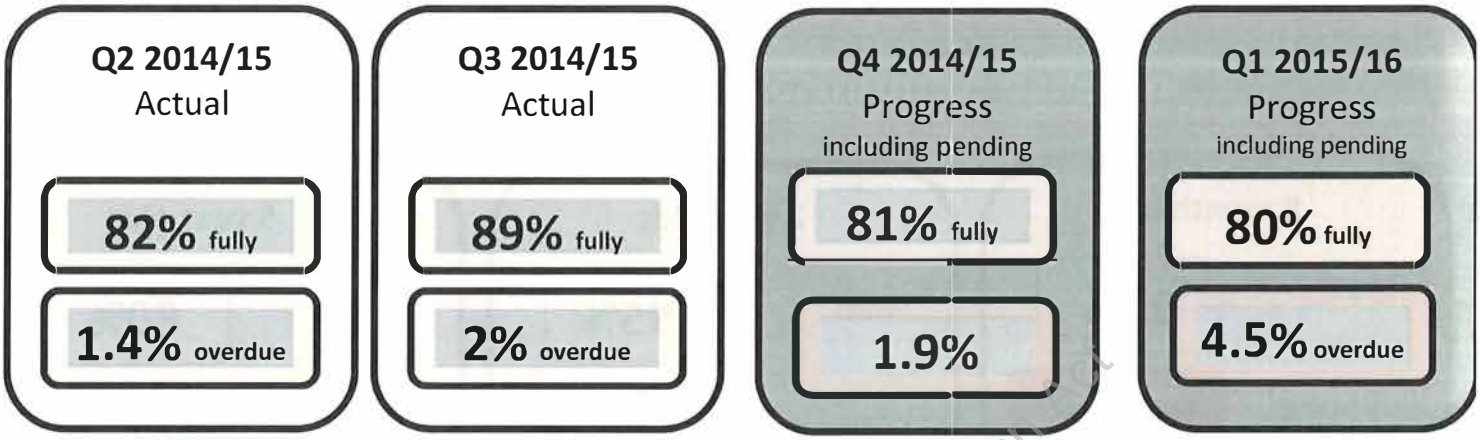
Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

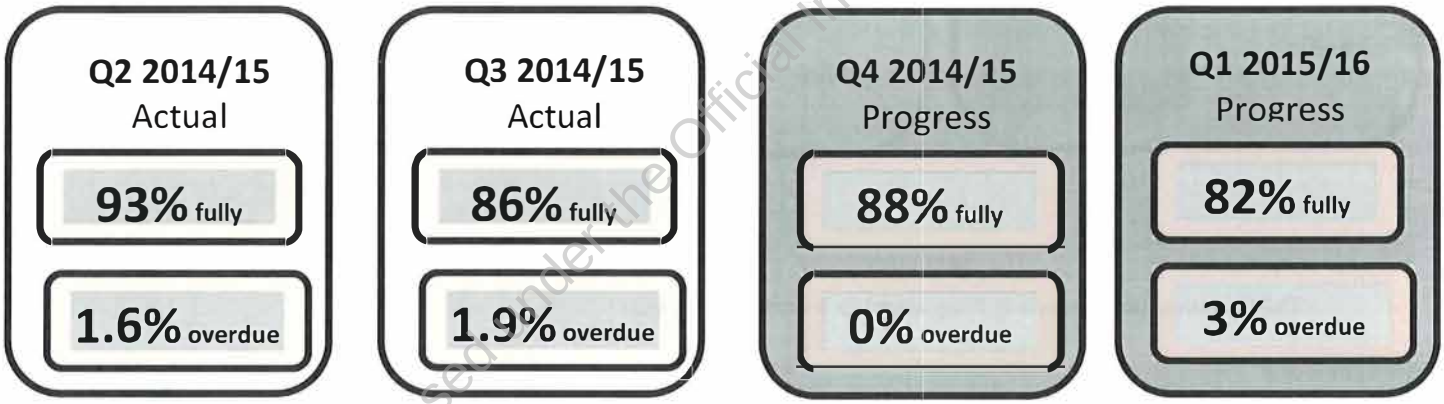
HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 May April 15

Fully Immunised 8 month olds – DHB LEVEL



Fully Immunised Two year olds - DHB LEVEL



By practice outcomes (please note this excludes our children who have opted off the NIR)

Q3 2014/15 –Actual - 8month old

Row Labels	fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	20	2		22
Franz Joseph Clinic	2			2
Greymouth Medical Centre	17			17
HariHari Rural Clinic	2	1		3
High Street Medical Centre (2005) Ltd	8	1	1	10
Reefton Medical Centre	5		1	6
Rural Academic General Practice	4			4
Westland Medical Centre	20			20
Whataroa Rural Clinic	2			2
Moana Rural Clinic	3			3
Coast Medical Consultancy Ltd	2			2
South Westland - Haast	2			2
Grand Total	**87**	**4**	**2**	**93**

Q3 2014/2015 – Actual - 2 year olds

Row Labels	Fully	Declined	awaiting overseas information	Overdue at Milestone age	Grand Total
Buller Medical Centre	20	1	1		22
Greymouth Medical Centre	24	1			25
HariHari Rural Clinic	1	1			2
High Street Medical Centre (2005) Ltd	9	2			11
Reefton Medical Centre	6				6
Rural Academic General Practice	5	1			6
Westland Medical Centre	13				13
Whataroa Rural Clinic	2				2
Moana Rural Clinic	3				3
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd	3			1	4
Linwood Avenue Medical Centre	1				1
Redcliffs Medical Centre	1				1
Grand Total	**89**	**6**	**1**	**1**	**97**

8 month Q4 2014/15 – In progress

Row Labels	FULLY	Declined	On hold - with OIS	Overdue with GP	pending	LEFT CDHB	Gone no address	Grand Total
Buller Medical Centre	17	2			1			20
Franz Joseph Clinic	3							3
Greymouth Medical Centre	14	2						16
HariHari Rural Clinic	1			1			1	3
High Street Medical Centre (2005) Ltd	6	1		1		1		9
Karamea Medical Centre	2							2
No General Practice Data								
Reefton Medical Centre	4							4
Rural Academic General Practice	8	1			1			10
Westland Medical Centre	13		1	2				16
Moana Rural Clinic	2							2
Fox Glacier Clinic	3							3
Coast Medical Consultancy Ltd	3							3
Waihopai Health Services						1		1
Grand Total	**76**	**6**	**1**	**4**	**2**	**2**	**1**	**92**

2 year olds Q4 2014/15 In progress

Row Labels	(blank)	Fully	on hold overseas	Deceased	Declined	Grand Total
Buller Medical Centre		20	1		1	22
Franz Joseph Clinic		1				1
Greymouth Medical Centre		16				16
High Street Medical Centre (2005) Ltd		12				12
Karamea Medical Centre		1	1			2
No General Practice Data				1		1
Reefton Medical Centre		5				5
Rural Academic General Practice		6				6
Westland Medical Centre		16				16
Whataroa Rural Clinic		1				1
Moana Rural Clinic		3				3
Fox Glacier Clinic		1				1
Centennial Health		1				1
Grand Total		**83**	**2**	**1**	**1**	**87**

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	99	76	77. %	60	51	85. %	15	12	80. %	3	1	33. %	5	4	80. %	16	8	50. %	7 ()	7.1 (0.0) %	9	9.1 %
8 Month	100	89	89. %	65	61	94. %	14	13	93. %	2	2	100. %	2	2	100. %	17	11	65. %	6 ()	6.0 (0.0) %	4	4.0 %
12 Month	97	78	80. %	51	49	96. %	21	20	95. %	1	1	100. %	4	4	100. %	20	4	20. %	15 (1)	15.5 (1.0) %	1	1.0 %
18 Month	99	78	79. %	59	53	90. %	19	14	74. %	2	2	100. %	2	2	100. %	17	7	41. %	10 (0)	10.1 (0.0) %	3	3.0 %
24 Month	104	89	86. %	57	53	93. %	28	26	93. %	2	2	100. %	1	1	100. %	16	7	44. %	7 (0)	6.7 (0.0) %	6	5.8 %
5 Year	118	96	81. %	78	68	87. %	22	17	77. %	0	0	-	4	3	75. %	14	8	57. %	4 (1)	3.4 (0.8) %	11	9.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	99	76	77. %	8	8	100. %	19	17	89. %	10	9	90. %	38	29	76. %	24	13	54. %	0	0	-
8 Month	100	89	89. %	16	16	100. %	15	15	100. %	16	16	100. %	35	31	89. %	18	11	61. %	0	0	-
12 Month	97	78	80. %	5	5	100. %	17	16	94. %	20	20	100. %	25	23	92. %	30	14	47. %	0	0	-
18 Month	99	78	79. %	12	12	100. %	12	11	92. %	24	23	96. %	26	20	77. %	25	12	48. %	0	0	-
24 Month	104	89	86. %	11	11	100. %	17	15	88. %	14	13	93. %	37	32	86. %	25	18	72. %	0	0	-
5 Year	118	96	81. %	11	10	91. %	16	12	75. %	25	22	88. %	45	38	84. %	21	14	67. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

MINUTES - THURSDAY 12 MARCH 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Janet Hogan, Bridget Lester, Sharyn Kenning, , Lee Harris, Betty Gilsenan, Joanne Shaw and Linda Hill	
Apologies:	Sarah Harvey Ann Knipe, Pauline Ansley, Catherine Andrew, Kylie Parkin and Catherine Crichton	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting (27 Nov 2014)	Minutes of both the 27th November and 29th January meetings were approved. **Betty / Sharyn**	
3. Matters Arising	• These matters were discussed later in the meeting	
4. Standing Items	**Report on KPIs** • 8 months – progressing towards 83% of fully vaccinated. Missed this quarter. • 2 year old – progressing towards 85%. • 5 year old – Achieved 79% for Q2 with 8.2% opting off and 10.9% declining. We missed 2 children this quarter. Planning and Funding is now providing regular reports to the PHO on Immunisation coverage by practice. This is to support the PHO to reach their IPHF targets. **Seasonal Influenza** • The delay in the vaccine being available is causing some concern. The private vax will be available from 16 March 2015. • DHB Communications plan has been developed. Cheryl to provide final approval on letters to go to a variety of providers. • Resources have been order for LMC packages. These to go out end of March. • Promotional ideas around spreading flu dust in supermarkets. • There is a concern that the WCDHB Occ Health nurse might leave during the vaccination programme. A target has been set of 70% of DHB vaccinated. **HPV** • Posters have been printed and distributed to schools. • Programme will start in term two. • Good article in next Nursing Logic magazine around HPV *(do I have this correct?)*	Cheryl to review and feedback letters Bridget to pull LMC packs together Lee to liaise with Pauline around PHO capacity to assist.

	Pregnancy vaccinations • Discussed in Flu section above.	
5. Immunisation Week Planning	• DHB Plan has been submitted to the MoH. At this stage we are focusing on Immunisation on Time, however this may change to be seasonal influenza depending on when the Flu Vax is available.	
8. General Business	**Four year olds**. • The DHB has been approached regarding immunisation at the B4 School check. We have again reinforced our message that immunisation occurs at general practice. Last quarterly only 2 children were overdue for their 4 year old event, at 5. Both these children have been with OIS services. **Membership** • Agreed to invite the new B4 School check Coordinator to join IAG. **Gloriaville leavers** • Agreed that people who leave Gloriaville should not be targeted to be vaccinated. Bridget to email MoH asking them to give some clear national messages around these families.	Bridget to approach xx to join group Bridget to email MoH
Next Meeting	• Thursday 23 April 2015 2.00 – 3.30pm, Community and Public Health Offices	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 21 July 2015 1:06 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; Joelle DeDanann; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda of Thursdays IAG Meeting
Attachments: WC Imms Reporting July 2015 Summary.docx; Draft IAG Minutes 5June meeting 2015CB.docx; Agenda - IAG 23 July 2015.docx; 201516 workplan IAG.docx

Hi all

Please find attached the agenda and papers of Thursday IAG meeting.

Please note, I will be dialling from Christchurch on Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

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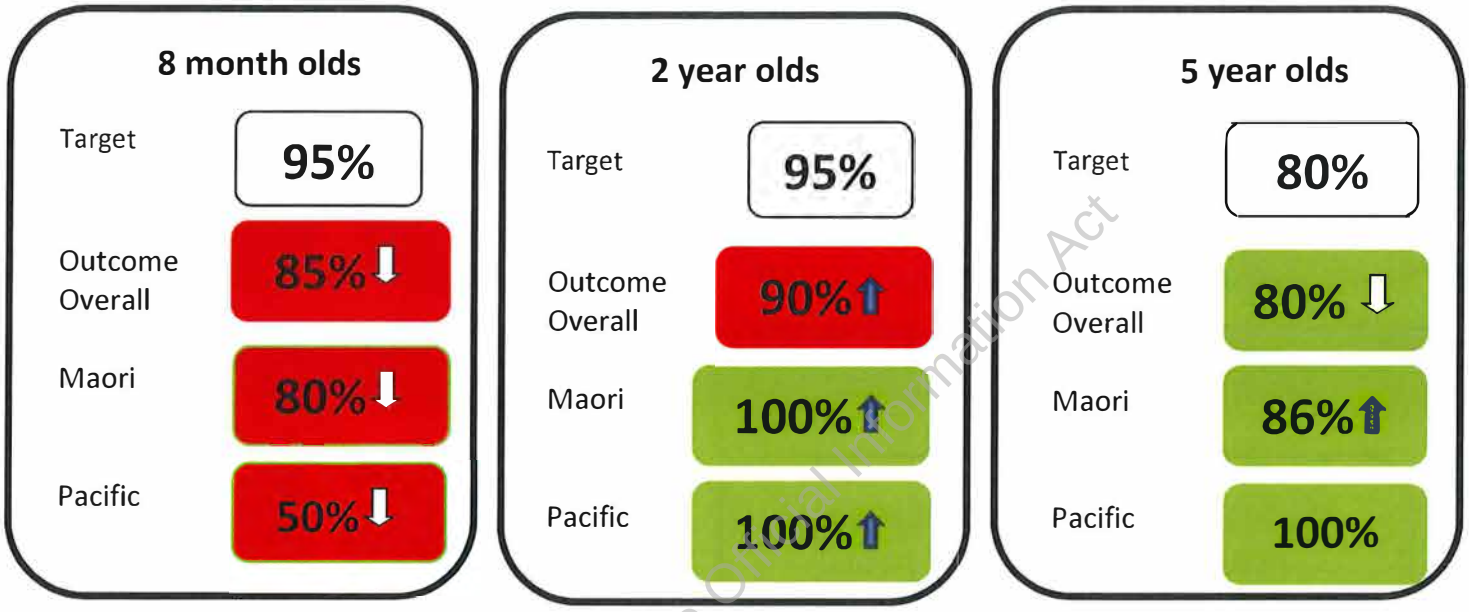

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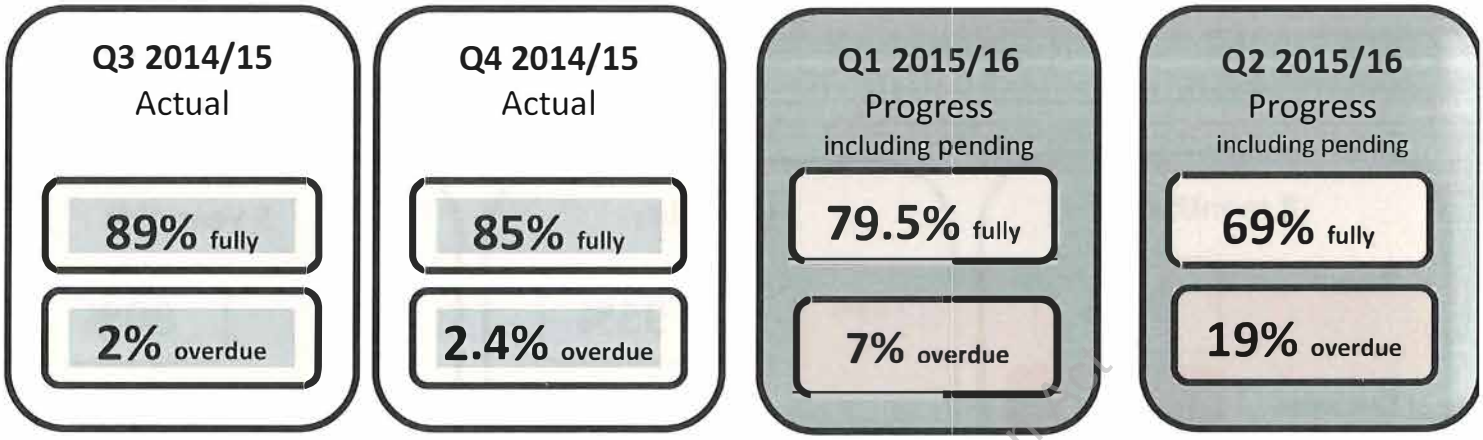
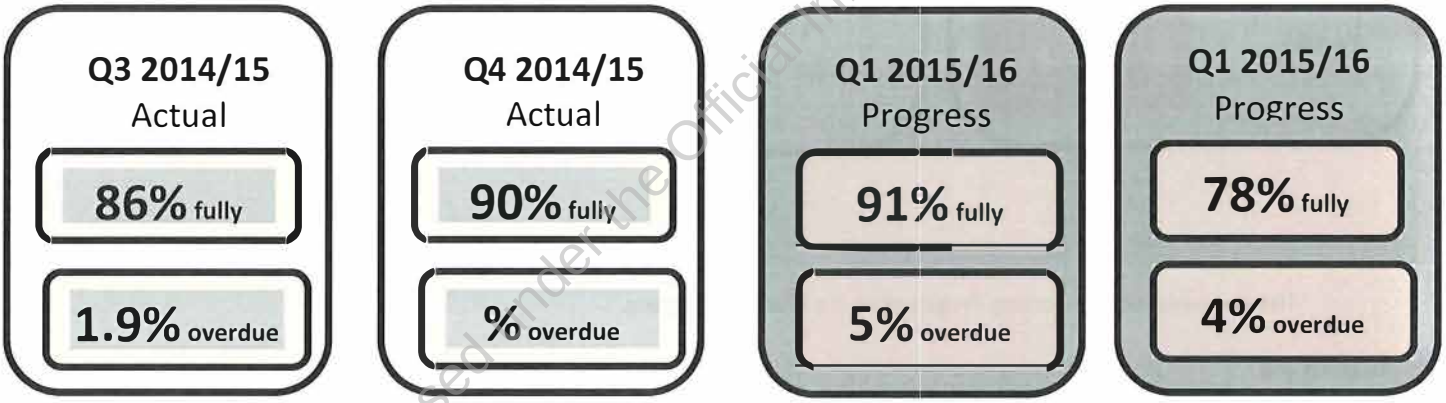
Childhood Immunisation – MoH Health Targets as of 20 July 15

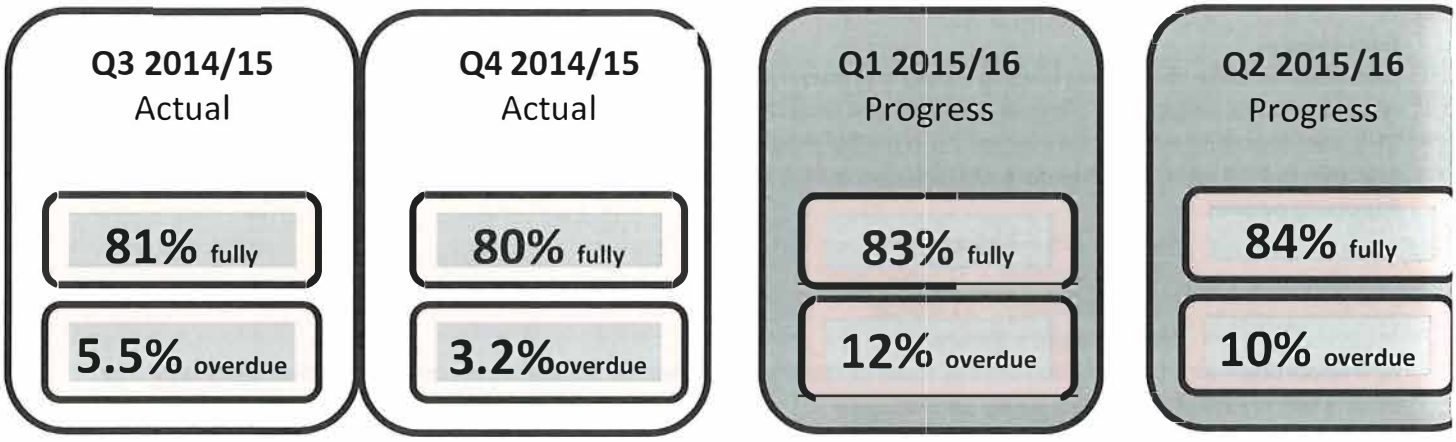
Fully Immunised 8 month olds – DHB LEVEL



Fully Immunised Two year olds - DHB LEVEL



Fully Immunised Five year olds - DHB LEVEL



Q4 8 month 2014/15 – Actual

Row Labels	FULLY	Declined	Overdue with GP	pending	Gone no address	Grand Total
Buller Medical Centre	18	2				20
Franz Joseph Clinic	3					3
Greymouth Medical Centre	15	2				17
HariHari Rural Clinic	2				1	3
High Street Medical Centre (2005) Ltd	7	1				8
Karamea Medical Centre	2					2
Reefton Medical Centre	4					4
Rural Academic General Practice	9	1				10
Westland Medical Centre	14		1	1		16
Moana Rural Clinic	2					2
Fox Glacier Clinic	3					3
Coast Medical Consultancy Ltd	3					3
Grand Total	**82**	**6**	**1**	**1**	**1**	**91**

Q4 2 years 2014/15 – Actual

Row Labels	Fully	Declined	Grand Total
Buller Medical Centre	20	1	21
Franz Joseph Clinic	1		1
Greymouth Medical Centre	16		16
High Street Medical Centre (2005) Ltd	12		12
Karamea Medical Centre	1		1
Reefton Medical Centre	5		5
Rural Academic General Practice	6		6
Westland Medical Centre	16		16
Whataroa Rural Clinic	1		1
Moana Rural Clinic	2		2
Fox Glacier Clinic	1		1
Centennial Health	1		1
Grand Total	**82**	**1**	**83**

Q1 8months 2015/16 – In progress

Practice Names	Fully	Declined	Overdue with GP	Catch up schedule	Grand Total
Buller Medical Centre	12				12
Franz Joseph Clinic	2				2
Greymouth Medical Centre	15			1	16
HariHari Rural Clinic	1				1
High Street Medical Centre (2005) Ltd	8		2		10
Reefton Medical Centre	3				3
Rural Academic General Practice	7		1		8
Westland Medical Centre	12	1	2	1	16
Moana Rural Clinic	2		1		3
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd	1				1
South Westland - Haast	1				1
Waltham Medical Centre	1				1
Grand Total	**66**	**1**	**6**	**2**	**75**

Q1 2 years 2015/2016 – In progress

Row Labels	check	Fully	Declined	On hold - with OIS	Overdue with GP	gone no address	Grand Total
Buller Medical Centre		18			1		19
Greymouth Medical Centre		19					19
High Street Medical Centre (2005) Ltd		7	1				8
Karamea Medical Centre						1	1
Reefton Medical Centre		4					4
Rural Academic General Practice	1	10	1	1			13
Westland Medical Centre		17	1		1		19
Whataroa Rural Clinic		2					2
Moana Rural Clinic		2					2
Coast Medical Consultancy Ltd		1					1
Grand Total	**1**	**80**	**3**	**1**	**2**	**1**	**88**

Q1 4years 2015/2016

Row Labels	Overdue with GP	On hold - with OIS	Declined	Catch up schedule	Fully	Grand Total
Coast Medical Consultancy Ltd		1			2	3
Westland Medical Centre			2		17	19
Buller Medical Centre	1		1	1	16	19
Whataroa Rural Clinic	1					1
Rural Academic General Practice		2	2		8	12
Greymouth Medical Centre	3				15	18
High Street Medical Centre (2005) Ltd	1				10	11
Karamea Medical Centre					1	1
Fox Glacier Clinic					1	1
Franz Joseph Clinic	1				1	2
HariHari Rural Clinic					2	2
Reefton Medical Centre					4	4
Waihopai Health Services					1	1
Central Family Health					1	1
Grand Total	**7**	**3**	**5**	**1**	**79**	**95**

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	82	66	80. %	45	40	89. %	23	18	78. %	1	1	100. %	5	5	100. %	8	2	25. %	6 (0)	7.3 (0.0) %	2	2.4 %
8 Month	95	81	85. %	55	52	95. %	20	16	80. %	2	1	50. %	7	7	100. %	11	5	45. %	6 (0)	6.3 (0.0) %	6	6.3 %
12 Month	91	83	91. %	54	52	96. %	18	16	89. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.4 (0.0) %	2	2.2 %
18 Month	107	81	76. %	54	47	87. %	21	18	86. %	3	3	100. %	5	5	100. %	24	8	33. %	16 (0)	15.0 (0.0) %	7	6.5 %
24 Month	90	81	90. %	44	42	95. %	25	25	100. %	4	4	100. %	5	5	100. %	12	5	42. %	7 (0)	7.8 (0.0) %	2	2.2 %
5 Year	113	90	80. %	63	58	92. %	22	19	86. %	3	3	100. %	3	3	100. %	22	7	32. %	11 ()	9.7 (0.0) %	8	7.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	82	66	80. %	6	6	100. %	17	15	88. %	21	19	90. %	18	14	78. %	20	12	60. %	0	0	-
8 Month	95	81	85. %	6	6	100. %	24	23	96. %	14	13	93. %	28	25	89. %	23	14	61. %	0	0	-
12 Month	91	83	91. %	12	12	100. %	26	26	100. %	17	17	100. %	21	20	95. %	15	8	53. %	0	0	-
18 Month	107	81	76. %	7	5	71. %	17	13	76. %	26	24	92. %	28	27	96. %	29	12	41. %	0	0	-
24 Month	90	81	90. %	12	11	92. %	21	20	95. %	7	7	100. %	25	25	100. %	25	18	72. %	0	0	-
5 Year	113	90	80. %	16	14	88. %	17	16	94. %	27	25	93. %	28	24	86. %	25	11	44. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES - THURSDAY 04 JUNE 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Janet Hogan, Bridget Lester, Betty Gilsenan, Joanne Shaw, Ann Knipe, Pauline Ansley, Catherine Andrew and Catherine Crichton	
Apologies:	Sarah Harvey, Kylie Parkin, Sharyn Kenning, Lee Harris and Linda Hill	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting (27 Nov 2014)	Minutes of both the 12 March meetings were approved.	
3. Matters Arising	• These matters were discussed later in the meeting	
4. Standing Items	**Report on KPIs** • 8 months – progressing towards 81% of fully vaccinated. • 2 year old – progressing towards 88%.	
	Seasonal Influenza • Season progressing well. Concern about DHB Staff not being supported to retain their Independent Vaccinator Status. • There is need to get some vaccination uptake data so we can monitor DHB performance	• Cheryl to write to EMT around importance of Independent Vaccinators • Bridget to forward WCDHB vaccine distribution data. • Pauline to check with practices around uptake.
	HPV • 70 girls have consented to this programme this year, out of 109 consents returned, and a pool of 145 girls. The MoH have indicated there are 180 girls, but the remaining 35 cannot be identified. • A discussion took place around how to increase the consent uptake, as the main issue does not appear to be around consent returns • Ideas included -- Providing more information to parents for the consent form is distributed, including an email from schools with links to useful sites and you-tube clips.	We need to develop a more detailed plan (suggest some focused brainstorming at our Sept meeting)

	– Information to be distributed to the year11 immunisation around HPV – PHNS provide education into schools around HPV and try to get into the classes or provide parent evenings – Utilise school Facebook pages around consenting **Pregnancy** • Resources were sent out to LMCs. • The Pertussis flyer has not yet been updated. • There was a discussion around children who opt off the NIR and may not have received evidence based Immunisation Information.	Bridget to send some stickers to Betty Organise to update Pertussis flyer Agree that Betty will contact these parents, and arrange a meeting with Chris and relevant LMCs
5. Immunisation Week Planning	• Occurred	
8. General Business	**MedTech HPV Messaging** – MedTech have identified an issue where some girls are messaging as boys. Sharyn will continue to monitor this issue. **Pertussis Study** – WCDHB has been approached to provide some information for a national Pertussis study, however we don't have access to this information.	Cheryl to contact researcher to indicated we can't supply data.
Next Meeting	• Thursday 23 April 2015 2.00 – 3.30pm, Community and Public Health Offices	

Discussion following meeting, which is important to note.

Five year olds. • From Q1 2015/16 this will become a Performance Target. The NIR (CDHB) will run a report and id children aged 4.6months. These children will be contacted, and if overdue at 4.8months, they will be referred to OIS.	Bridget to update data report to include 5year old data.

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 23 July 2015, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 68454#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (4 June 2015)	Cheryl Brunton	Draft IAG Minutes 5June meeting 2015
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting o Seasonal Influenza – outdate o HPV programme update o Pregnancy vaccinations	Bridget Pauline Janet Bridget	WC Imms Reporting July 2015 Summary.c 201516 workplan IAG.docx
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Action	Due date
Seasonal Influenza	• Cheryl to write to EMT around importance of Independent Vaccinators • Bridget to forward WCDHB vaccine distribution data. • Pauline to check with practices around uptake.	
HPV	• We need to develop a more detailed plan (suggest some focused brainstorming at our Sept meeting)	
Pregnancy Vaccinations	• Bridget to send some stickers to Betty • Organise to update Pertussis flyer • Agree that Betty will contact these parents, and arrange a meeting with Chris and relevant LMCs	
Pertussis Study	• Cheryl to contact researcher to indicated we can't supply data.	
Five year old target	• Bridget to update data report to include 5year old data.	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hoki
Catherine Crichton	PHNS Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Year 12 HPV School Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 8 September 2015 12:26 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; Joelle DeDanann; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Paper of Thursday IAG meeting
Attachments: Agenda - IAG 10 Sept 2015.docx; WC Imms Reporting September 2015 Summary.docx; Work plan updated.docx; Pertussis-Immunisation-A3-2015 _WCDHB.pdf

Hi all

Please find attached a copy of the papers for our meeting on Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 10 September2015, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (4 June 2015)	Cheryl Brunton	Minutes 23 July 2015.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Bridget Pauline/Cheryl Janet Bridget	201516 workplan IAG.docx WC Imms Reporting September 2015 Sur
5	HPV Planning	Open	
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Action	Due date
Seasonal Influenza	• **Lee to get article in CEO report around Reefton**	
HPV	• **List of children enrolled in Gloriavale school**	
Pregnancy Vaccinations	• **Bridget to send some stickers to Betty** • **Organise to update Pertussis flyer**	

Membership:

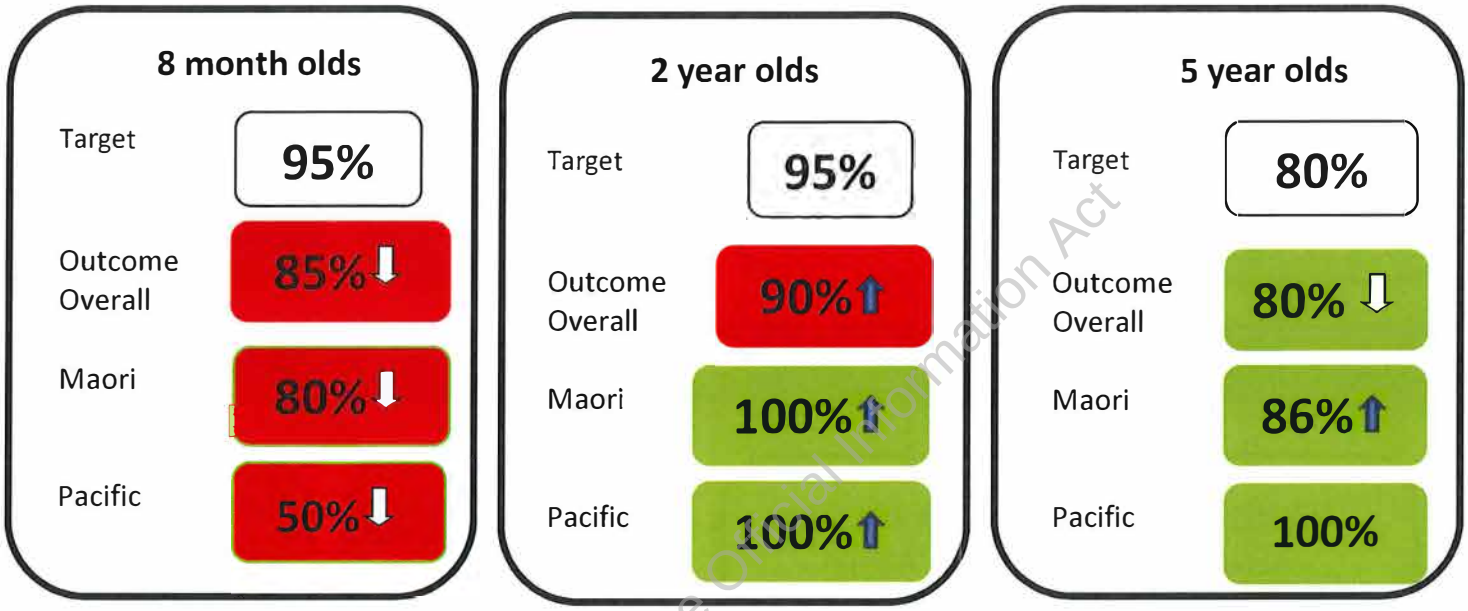
Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2014/15



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 7 Sept15

Fully Immunised 8 month olds – DHB LEVEL

Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress including pending	Q2 2015/16 Progress including pending
89% fully	85% fully	81% fully	81% fully
2% overdue	2.4% overdue	4.5% overdue	2.9%

Fully Immunised Two year olds - DHB LEVEL

Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress	Q2 2015/16 Progress
86% fully	90% fully	83% fully	83% fully
1.9% overdue	% overdue	1% overdue	0% overdue

Fully Immunised Five year olds - DHB LEVEL

Q3 2014/15 Actual	Q4 2014/15 Actual	Q1 2015/16 Progress	Q2 2015/16 Progress
81% fully	80% fully	87% fully	91% fully
5.5% overdue	3.2%overdue	6.5% overdue	0% overdue

Q4 8 month 2014/15 – Actual

Row Labels	FULLY	Declined	Overdue with GP	Gone no address	Overdue at Milestone age	Grand Total
Buller Medical Centre	18	2				20
Franz Joseph Clinic	3					3
Greymouth Medical Centre	15	2				17
HariHari Rural Clinic	2			1		3
High Street Medical Centre (2005) Ltd	7	1				8
Karamea Medical Centre	2					2
Reefton Medical Centre	4					4
Rural Academic General Practice	9	1				10
Westland Medical Centre	14		1		1	16
Moana Rural Clinic	2					2
Fox Glacier Clinic	3					3
Coast Medical Consultancy Ltd	3					3
Grand Total	**82**	**6**	**1**	**1**	**1**	**91**

Q4 2 years 2014/15 – Actual

Row Labels	Fully	Declined	Grand Total
Buller Medical Centre	20	1	21
Franz Joseph Clinic	1		1
Greymouth Medical Centre	16		16
High Street Medical Centre (2005) Ltd	12		12
Karamea Medical Centre	1		1
Reefton Medical Centre	5		5
Rural Academic General Practice	6		6
Westland Medical Centre	16		16
Whataroa Rural Clinic	1		1
Moana Rural Clinic	2		2
Fox Glacier Clinic	1		1
Centennial Health	1		1
Grand Total	**82**	**1**	**83**

Q1 8months 2015/16 – In progress

Practice Names	Fully	Declined	Catch up schedule	Overdue at Milestone age	Grand Total	Percentage fully vaccinated
Buller Medical Centre	12				12	**100%**
Franz Joseph Clinic	2				2	**100%**
Greymouth Medical Centre	16				16	**100%**
HariHari Rural Clinic	1				1	**100%**
High Street Medical Centre (2005) Ltd	11				11	**100%**
Reefton Medical Centre	3				3	**100%**
Rural Academic General Practice	8				8	**100%**
Westland Medical Centre	15	1		1	17	**88%**
Clinic TBA West Coast			1		1	**0%**
Moana Rural Clinic	2				2	**100%**
Fox Glacier Clinic	1				1	**100%**
Coast Medical Consultancy Ltd	1				1	**100%**
South Westland - Haast	1				1	**100%**
Waltham Medical Centre	1				1	**100%**
Grand Total	**74**	**1**	**1**	**1**	**77**	**96%**

Q1 2 years 2015/2016 – In progress

Row Labels	check	Fully	Declined	On hold - with OIS	Gone no address	Overdue at Milestone age	Grand Total	Percentage fully vaccinated
Buller Medical Centre		18			1		19	**95%**
Greymouth Medical Centre		19					19	**100%**
High Street Medical Centre (2005) Ltd		7	1				8	**88%**
Reefton Medical Centre		4					4	**100%**
Rural Academic General Practice	1	9	1	1			12	**75%**
Westland Medical Centre		17	1			1	19	**89%**
Whataroa Rural Clinic		2					2	**100%**
Moana Rural Clinic		2					2	**100%**
Coast Medical Consultancy Ltd		1					1	**100%**
Grand Total	**1**	**79**	**3**	**1**	**1**	**1**	**86**	**92%**

Q1 4years 2015/2016

Practice Names	Overdue with GP	On hold - with OIS	Declined	Fully	overdue after milestone age	Grand Total	Percentage fully vaccinated
Coast Medical Consultancy Ltd				3		3	**100%**
Westland Medical Centre			2	17		19	**89%**
Buller Medical Centre				15	1	16	**94%**
Rural Academic General Practice			2	9	1	12	**75%**
Greymouth Medical Centre	1	1	1	15	1	19	**79%**
High Street Medical Centre (2005) Ltd				11		11	**100%**
Fox Glacier Clinic				1		1	**100%**
Franz Joseph Clinic				1	1	2	**50%**
HariHari Rural Clinic				2		2	**100%**
Reefton Medical Centre				4		4	**100%**
Waihopai Health Services				1		1	**100%**
Central Family Health				1		1	**100%**
Grand Total	**1**	**1**	**5**	**80**	**4**	**91**	**88%**

Q2 2015/2016 8month old

Practice Names	Fully	Declined	On hold - with OIS	overdue with GP	pending	Grand Total	% fully vaccinated
Buller Medical Centre	8			1	4	13	**62%**
Franz Joseph Clinic	2				1	3	**67%**
Greymouth Medical Centre	7	1		1	6	15	**47%**
HariHari Rural Clinic	2					2	**100%**
High Street Medical Centre (2005) Ltd	4				7	11	**36%**
Reefton Medical Centre	7				1	8	**88%**
Rural Academic General Practice	6	1			1	8	**75%**
Westland Medical Centre	5	1	1		7	14	**36%**
Whataroa Rural Clinic				1		1	**0%**
Clinic TBA West Coast					1	1	**0%**
Moana Rural Clinic				1	1	2	**0%**
Coast Medical Consultancy Ltd	1					1	**100%**
Grand Total	**42**	**3**	**1**	**4**	**29**	**79**	**53%**

Q2 2015/2016 2 years progress

Row Labels	Fully	declined	Grand Total	% fully vaccinated
Buller Medical Centre	22	1	23	**96%**
Franz Joseph Clinic	4		4	**100%**
Greymouth Medical Centre	12	3	15	**80%**
HariHari Rural Clinic	2		2	**100%**
High Street Medical Centre (2005) Ltd	8		8	**100%**
Karamea Medical Centre	1		1	**100%**
Reefton Medical Centre	4	1	5	**80%**
Rural Academic General Practice	11	1	12	**92%**
Westland Medical Centre	13	1	14	**93%**
Whataroa Rural Clinic	3		3	**100%**
Moana Rural Clinic	2		2	**100%**
Coast Medical Consultancy Ltd	1		1	**100%**
Grand Total	**83**	**7**	**90**	**92%**

Q2 2015/2016 4 years progress

Row Labels	declined	Catch up schedule	fully	Grand Total	% fully vaccinated
West Coast PHO	**8**	**1**	**88**	**97**	**91%**
Westland Medical Centre	3		17	20	**85%**
Buller Medical Centre	1		27	28	**96%**
High Street Medical Centre (2005) Ltd	2		10	12	**83%**
Greymouth Medical Centre	1	1	18	20	**90%**
Reefton Medical Centre	1		10	11	**91%**
Rural Academic General Practice			3	3	**100%**
Karamea Medical Centre			1	1	**100%**
Maitai Medical Ltd			1	1	**100%**
Franz Joseph Clinic			1	1	**100%**
Grand Total	**8**	**1**	**88**	**97**	**91%**

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	82	66	80. %	45	40	89. %	23	18	78. %	1	1	100. %	5	5	100. %	8	2	25. %	6 (0)	7.3 (0.0) %	2	2.4 %
8 Month	95	81	85. %	55	52	95. %	20	16	80. %	2	1	50. %	7	7	100. %	11	5	45. %	6 (0)	6.3 (0.0) %	6	6.3 %
12 Month	91	83	91. %	54	52	96. %	18	16	89. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.4 (0.0) %	2	2.2 %
18 Month	107	81	76. %	54	47	87. %	21	18	86. %	3	3	100. %	5	5	100. %	24	8	33. %	16 (0)	15.0 (0.0) %	7	6.5 %
24 Month	90	81	90. %	44	42	95. %	25	25	100. %	4	4	100. %	5	5	100. %	12	5	42. %	7 (0)	7.8 (0.0) %	2	2.2 %
5 Year	113	90	80. %	63	58	92. %	22	19	86. %	3	3	100. %	3	3	100. %	22	7	32. %	11 ()	9.7 (0.0) %	8	7.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	82	66	80. %	6	6	100. %	17	15	88. %	21	19	90. %	18	14	78. %	20	12	60. %	0	0	-
8 Month	95	81	85. %	6	6	100. %	24	23	96. %	14	13	93. %	28	25	89. %	23	14	61. %	0	0	-
12 Month	91	83	91. %	12	12	100. %	26	26	100. %	17	17	100. %	21	20	95. %	15	8	53. %	0	0	-
18 Month	107	81	76. %	7	5	71. %	17	13	76. %	26	24	92. %	28	27	96. %	29	12	41. %	0	0	-
24 Month	90	81	90. %	12	11	92. %	21	20	95. %	7	7	100. %	25	25	100. %	25	18	72. %	0	0	-
5 Year	113	90	80. %	16	14	88. %	17	16	94. %	27	25	93. %	28	24	86. %	25	11	44. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	15	0	1	61	77	30	0	0	140	170	50%	-%	-%	44%	45%	18 (10.6%)	0 (0.0%)
	HPV-2 Quadrivalent	15	0	1	58	74						50%	-%	-%	41%	44%	11 (6.5%)	
	HPV-3 Quadrivalent	15	0	1	56	72						50%	-%	-%	40%	42%	12 (7.1%)	
2000	HPV-1 Quadrivalent	20	3	1	88	112	40	0	0	130	170	50%	-%	-%	68%	66%	19 (11.2%)	0 (0.0%)
	HPV-2 Quadrivalent	18	2	1	87	108						45%	-%	-%	67%	64%	13 (7.6%)	
	HPV-3 Quadrivalent	17	2	1	85	105						43%	-%	-%	65%	62%	13 (7.6%)	
2001	HPV-1 Quadrivalent	11	0	4	100	115	40	5	5	160	210	28%	0%	80%	63%	55%	12 (5.7%)	0 (0.0%)
	HPV-2 Quadrivalent	11	0	4	99	114						28%	0%	80%	62%	54%	11 (5.2%)	
	HPV-3 Quadrivalent	11	0	3	97	111						28%	0%	60%	61%	53%	11 (5.2%)	
2002	HPV-1 Quadrivalent	19	3		66	88	30	0	0	150	190	63%	-%	-%	44%	46%	2 (1.1%)	0 (0.0%)
	HPV-2 Quadrivalent	17	3	0	60	80						57%	-%	-%	40%	42%	1 (0.5%)	
	HPV-3 Quadrivalent	5	2	0	24	31						17%	-%	-%	16%	16%	1 (0.5%)	
2003	HPV-1 Quadrivalent	5	0		20	25	30	0	5	140	180	17%	-%	0%	14%	14%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	17	22						17%	-%	0%	12%	12%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	70	6	6	335	417	170	5	10	720	920	41%	120%	-%	47%	45%	51 (5.5%)	0 (0.0%)
	HPV-2 Quadrivalent	66	5	6	321	398						39%	100%	-%	45%	43%	36 (3.9%)	
	HPV-3 Quadrivalent	48	4	5	262	319						28%	80%	-%	36%	35%	37 (4.0%)	

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

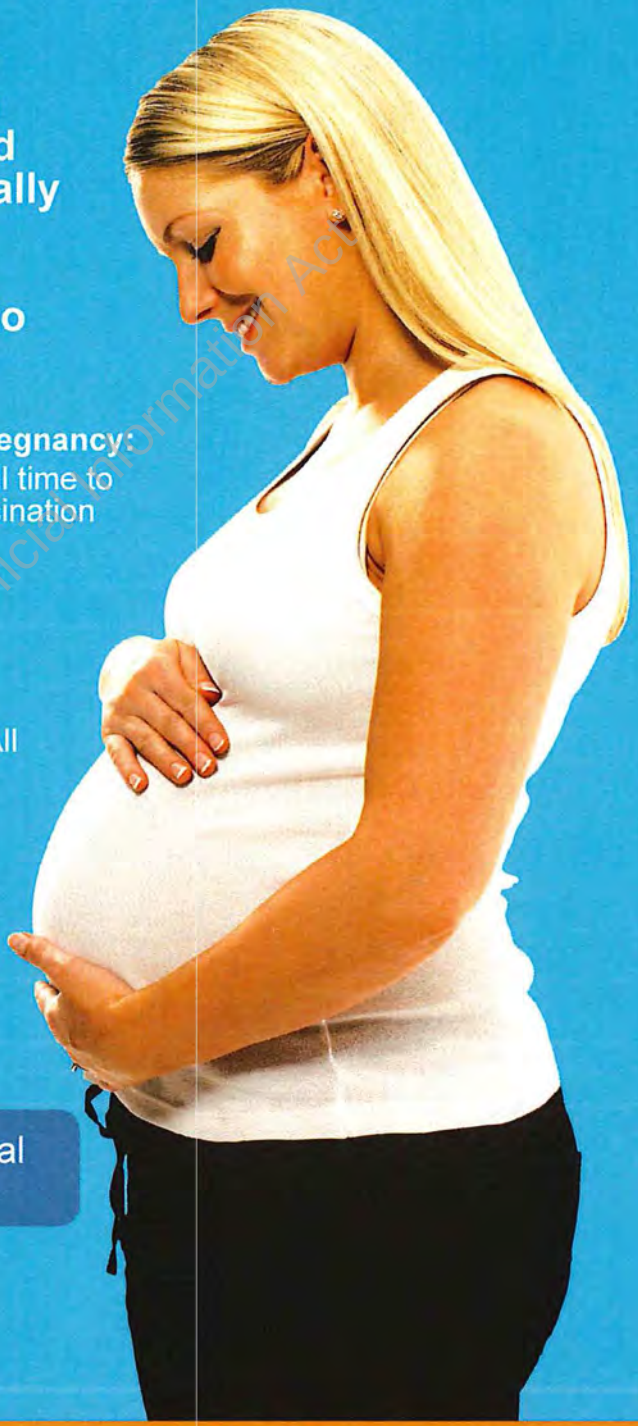
Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide a Missed Event and Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event and HPV to all eligible people, in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

immunise
for life

Protection from whooping cough starts with mum

Whooping cough is a highly contagious disease that can seriously harm unvaccinated infants and children, especially newborn babies.



Here are three things you can do to protect yourself and your child:

1. **Immunise yourself in pregnancy, every pregnancy:**
   Between 31 & 33 weeks' pregnant is the ideal time to pass protection on to your unborn baby. Vaccination is free from 28 - 38 weeks of pregnancy.

2. **Immunise your baby on time:**
   Get your baby vaccinated against whooping cough at 6 weeks, 3 months and 5 months. All three vaccinations are needed for the best possible protection for your child.

3. **Breastfeed your baby:**
   If you breastfeed your baby, you will pass on additional protection through your milk.

Ask your Lead Maternity Carer or General Practice team for more information.

immuniseforlife.co.nz

Please also remember to immunise yourself against seasonal influenza, the vaccine is available between March-July each year, and recommended at any stage in pregnancy (the earlier the better to ensure protection).

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

2015 update

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 20 October 2015 12:17 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; 'Fiona Croft'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Joelle DeDanann'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; 'riasouth@imac.org.nz'; Sarah Harvey (CPH); Sharyn Kenning
Subject: October Immunisation Advisory Group meeting Papers
Attachments: 22 October 2015 Agenda.docx; Data Report Oct 2015.docx; Updated Action Plan.docx; West Coast HPV discussion.docx; Draft minutes 10 Sept IAG meeting.docx

HI all

Please find attached the paper for our meeting on Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 22 October 2015, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (10 September 2015)	Cheryl Brunton	Draft minutes 10 Sept IAG meeting.dc
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting ○ Seasonal Influenza – update ○ HPV programme update ○ Pregnancy vaccinations	Bridget Pauline/Cheryl Janet Bridget	DATA REPORT Oct 2015.docx Updated Action Plan.docx
5	HPV Planning Update	Open	West Coast HPV discussion.docx
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Action	Due date
Seasonal Influenza	• **Lee to get article in CEO report around Reefton**	
Pregnancy Vaccinations	• **Organise to update Pertussis flyer**	
HPV Planning	• **Janet to arrange a meeting**	

Membership:

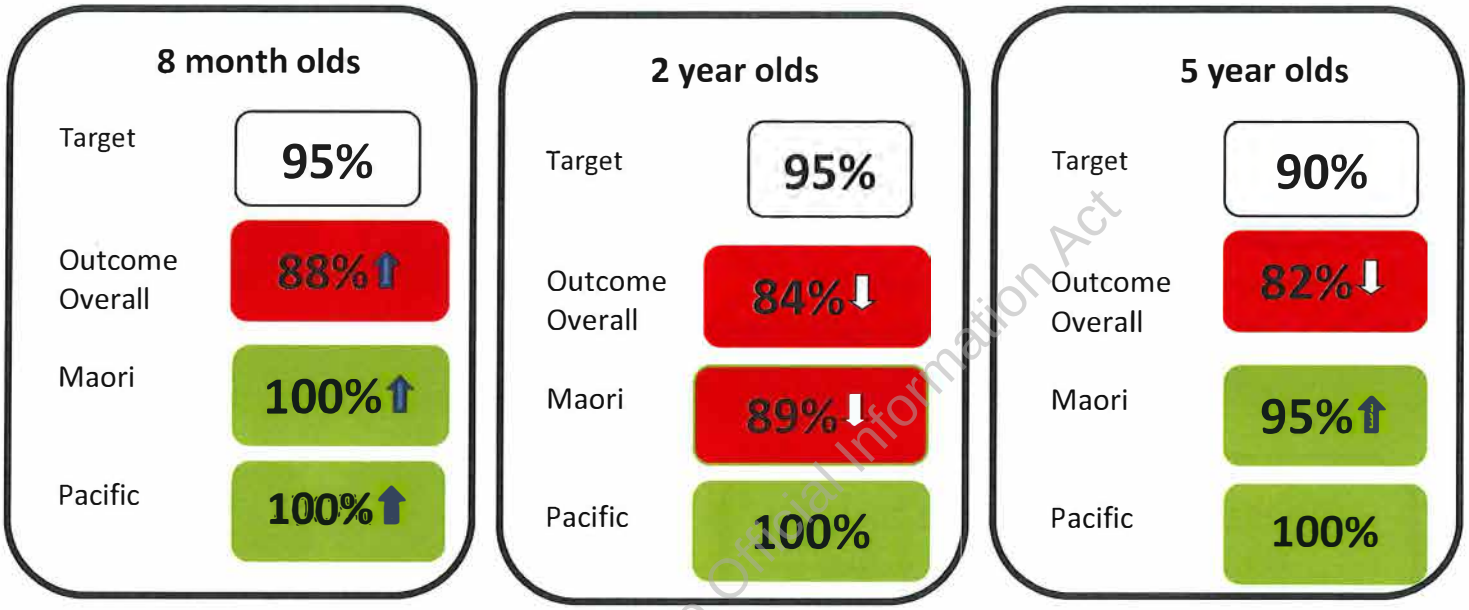
Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 19 Oct15

Fully Immunised 8 month olds – DHB LEVEL

Q4 2014/15 Actual	Q1 2015/16 Actual	Q2 2015/16 Progress including pending	Q3 2015/16 Progress including pending
85% fully	88% fully	75% fully	73% fully
2.4% overdue	overdue	10% overdue	14% overdue

Fully Immunised Two year olds - DHB LEVEL

Q4 2014/15 Actual	Q1 2015/16 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress
90% fully	84% fully	75% fully	80% fully
0% overdue	2% overdue	6.8% overdue	6.3% overdue

Fully Immunised Five year olds - DHB LEVEL

Q4 2014/15 Actual	Q1 2015/16 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress
80% fully	82% fully	82% fully	0% fully
3.2% overdue	2%overdue	0% overdue	0% overdue

Q1 8 month 2014/15 – Actual

Practice Names	Fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	12			12
Franz Joseph Clinic	2			2
Greymouth Medical Centre	16			16
HariHari Rural Clinic	1			1
High Street Medical Centre (2005) Ltd	11			11
Reefton Medical Centre	3			3
Rural Academic General Practice	8			8
Westland Medical Centre	15	1	1	17
Clinic TBA West Coast	1			1
Moana Rural Clinic	3			3
Fox Glacier Clinic	1			1
Coast Medical Consultancy Ltd	1			1
South Westland - Haast	1			1
Waltham Medical Centre	1			1
Grand Total	**76**	**1**	**1**	**78**

Q1 2 years 2014/15 – Actual

Row Labels	Fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	18			18
Greymouth Medical Centre	19			19
High Street Medical Centre (2005) Ltd	7	1		8
Reefton Medical Centre	4			4
Rural Academic General Practice	10	1	1	12
Westland Medical Centre	16	1	1	18
Whataroa Rural Clinic	2			2
Moana Rural Clinic	2			2
Coast Medical Consultancy Ltd	1			1
Grand Total	**79**	**3**	**2**	**84**

Q2 8months 2015/16 – In progress

Row Labels	Fully	Declined	On hold - with OIS	Overdue with GP	Overdue at Milestone age	Grand Total
Buller Medical Centre	13					13
Franz Joseph Clinic	2			1		3
Greymouth Medical Centre	13	1	1	1		16
HariHari Rural Clinic	2			1		3
High Street Medical Centre (2005) Ltd	10			1		11
Reefton Medical Centre	7					7
Rural Academic General Practice	7	1				8
Westland Medical Centre	10	1	1	1		13
Whataroa Rural Clinic					1	1
Moana Rural Clinic	1			1		2
Coast Medical Consultancy Ltd	1					1
Grand Total	**66**	**3**	**2**	**6**	**1**	**78**

Q2 2 years 2015/2016 – In progress

Row Labels	Fully	declined	Grand Total
Buller Medical Centre	22		22
Franz Joseph Clinic	4		4
Greymouth Medical Centre	12	3	15
HariHari Rural Clinic	2		2
High Street Medical Centre (2005) Ltd	8		8
Karamea Medical Centre	1		1
Reefton Medical Centre	3	1	4
Rural Academic General Practice	11	1	12
Westland Medical Centre	13		13
Whataroa Rural Clinic	3		3
Moana Rural Clinic	2		2
Coast Medical Consultancy Ltd	1		1
Grand Total	**82**	**5**	**87**

Q1 4years 2015/2016 – Actual

Row Labels	Declined	Fully	overdue after milestone age	Grand Total
Coast Medical Consultancy Ltd		3		3
Westland Medical Centre	2	17		19
Buller Medical Centre	1	15		16
Rural Academic General Practice	3	9		12
Greymouth Medical Centre	1	16	1	18
High Street Medical Centre (2005) Ltd		11		11
Fox Glacier Clinic		1		1
Franz Joseph Clinic		1	1	2
HariHari Rural Clinic		2		2
Reefton Medical Centre		4		4
Waihopai Health Services		1		1
Central Family Health		1		1
Grand Total	**7**	**81**	**2**	**90**

Q2 4years 2015/2016 – Actual

Row Labels	declined	Catch up schedule	fully	Grand Total
Westland Medical Centre	3		17	20
Buller Medical Centre	1		26	27
High Street Medical Centre (2005) Ltd	2		10	12
Greymouth Medical Centre	1	1	18	20
Reefton Medical Centre	1		9	10
Rural Academic General Practice			3	3
Karamea Medical Centre			1	1
Maitai Medical Ltd			1	1
Franz Joseph Clinic			1	1
Grand Total	**8**	**1**	**86**	**95**

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	91	66	73. %	48	43	90. %	20	15	75. %	4	3	75. %	3	3	100. %	16	2	13. %	14 (0)	15.4 (0.0) %	2	2.2 %
8 Month	86	76	88. %	49	47	96. %	20	20	100. %	3	3	100. %	3	3	100. %	11	3	27. %	8 (0)	9.3 (0.0) %	1	1.2 %
12 Month	95	80	84. %	57	52	91. %	14	12	86. %	3	2	67. %	5	5	100. %	16	9	56. %	7 (0)	7.4 (0.0) %	8	8.4 %
18 Month	100	73	73. %	50	46	92. %	23	17	74. %	1	1	100. %	5	5	100. %	21	4	19. %	15 (0)	15.0 (0.0) %	3	3.0 %
24 Month	94	79	84. %	56	53	95. %	19	17	89. %	2	2	100. %	2	2	100. %	15	5	33. %	10 (0)	10.6 (0.0) %	3	3.2 %
5 Year	96	79	82. %	52	44	85. %	21	20	95. %	3	3	100. %	5	5	100. %	15	7	47. %	6 ()	6.3 (0.0) %	7	7.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	91	66	73. %	5	5	100. %	12	10	83. %	14	13	93. %	29	22	76. %	29	15	52. %	2	1	50. %
8 Month	86	76	88. %	5	5	100. %	12	12	100. %	19	18	95. %	24	23	96. %	25	17	68. %	1	1	100. %
12 Month	95	80	84. %	8	8	100. %	18	17	94. %	9	9	100. %	38	33	87. %	22	13	59. %	0	0	-
18 Month	100	73	73. %	7	7	100. %	18	16	89. %	21	20	95. %	28	22	79. %	26	8	31. %	0	0	-
24 Month	94	79	84. %	11	11	100. %	11	11	100. %	23	22	96. %	25	21	84. %	24	14	58. %	0	0	-
5 Year	96	79	82. %	11	11	100. %	16	15	94. %	17	11	65. %	31	27	87. %	21	15	71. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	15	0	1	61	77	30	0	0	140	170	50%	-%	-%	44%	45%	18 (10.6%)	0 (0.0%)
	HPV-2 Quadrivalent	15	0	1	59	75						50%	-%	-%	42%	44%	11 (6.5%)	
	HPV-3 Quadrivalent	15	0	1	56	72						50%	-%	-%	40%	42%	12 (7.1%)	
2000	HPV-1 Quadrivalent	20	3	1	89	113	40	0	0	130	170	50%	-%	-%	68%	66%	19 (11.2%)	0 (0.0%)
	HPV-2 Quadrivalent	18	2	1	88	109						45%	-%	-%	68%	64%	13 (7.6%)	
	HPV-3 Quadrivalent	17	2	1	86	106						43%	-%	-%	66%	62%	13 (7.6%)	
2001	HPV-1 Quadrivalent	11	0	4	100	115	40	5	5	160	210	28%	0%	80%	63%	55%	12 (5.7%)	0 (0.0%)
	HPV-2 Quadrivalent	11	0	4	99	114						28%	0%	80%	62%	54%	11 (5.2%)	
	HPV-3 Quadrivalent	11	0	3	97	111						28%	0%	60%	61%	53%	11 (5.2%)	
2002	HPV-1 Quadrivalent	18	3		66	87	30	0	0	150	190	60%	-%	-%	44%	46%	4 (2.1%)	0 (0.0%)
	HPV-2 Quadrivalent	16	3	0	61	80						53%	-%	-%	41%	42%	3 (1.6%)	
	HPV-3 Quadrivalent	5	2	0	25	32						17%	-%	-%	17%	17%	3 (1.6%)	
2003	HPV-1 Quadrivalent	5	0		20	25	30	0	5	140	180	17%	-%	0%	14%	14%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	17	22						17%	-%	0%	12%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	1 (0.6%)	
2004	HPV-1 Quadrivalent	0	0		0	0	30	0	0	130	160	0%	-%	-%	0%	0%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	69	6	6	336	417	200	5	10	850	1,080	35%	120%	-%	40%	39%	55 (5.1%)	0 (0.0%)
	HPV-2 Quadrivalent	65	5	6	324	400						33%	100%	-%	38%	37%	39 (3.6%)	
	HPV-3 Quadrivalent	48	4	5	264	321						24%	80%	-%	31%	30%	40 (3.7%)	

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

West Coast HPV discussion, Sept 29th 2015

A meeting was held between Janet, Anne Knipe, Betty and Bridget to discuss the challenges around the West Coast HPV programme.

It was agreed that we need to focus on the following

Group	Issue	Actions	Responslbity	Current draft resources
Primary Practice Teams	There was a concern that since the HPV programme is provided within a school based programme, Primary Practice Teams have little to do with the programme, and therefore the teams are not exporters in this programme.	• Offer an education session on HPV • Work with CDHB to update the Pegasus HPV Bulletin and distribute to Practice Nurses on the West Coast • Develop some key points to give to practices nurses, so they can this conversations with parents at the 11year old event • Develop resources to be displayed within the primary practice around the programme	Pauline Bridget Betty and Janet Bridget and Lee	Education bulletin Final HPV bulletin with refs 13.06.13.p The old flyer is also being updated to support this programme.
Public Health Nurses	There a need to support PNHS so they can have the challenges conversations with parents and schools around the programme	• Offer an education session on HPV • Share the available key points with the PHNS • Work with the PNHS to ensure a consistent approach is applied to work with to schools. Agreements around what is best practice for this programme.	Pauline / Janet Janet Anne to take lead / Janet	HPV Poster.pdf HPV Postcard.pdf
Schools	There is a need to better support schools and to use school networks to implement this programme and get communication messages out	• Develop a communication programme linking in school using their Facebook and e-newsletter services		

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - Supporting you to be well

MINUTES - THURSDAY 10 September 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees: Cheryl Brunton, Janet Hogan, Bridget Lester, Betty Gilsenan, Ann Knipe, Pauline Ansley, Catherine Andrew , Catherine Crichton and Sharyn Kenning

Apologies: Joanne Shaw, Jolene D, Lee Harris

Agenda Items:

Discussion	Action
1. Intro/Apologies Welcome by Chair	
2. Minutes of last meeting (27 Nov 2014) Minutes of 23 July meeting were approved.	

3. Matters Arising

Issue	Action	Due date
Seasonal Influenza	• Lee to write article for CEO's report around Reefton	Not completed
HPV	• List of children enrolled in Gloriavale school	Completed
Pregnancy Vaccinations	• Bridget to send some stickers to Betty • Organize to update Pertussis flyer ○ Updated and tabled at meeting. Approved to be printed, need to confirm funding.	Completed Progressing

4. Standing Items

Report on KPIs

- 8 months – tracking towards 85% of fully vaccinated.
- 2 year old – tracking towards 83%.
- 4 year olds processing to 87% for this quarter.

Workplan

- New-born enrolment – discussion around where WCDHB is currently sitting on this. We don't have any data at present. (please note data were received after the meeting and are attached to these minutes)
- Practice level milestone ages reports are not currently being sent to the PHO. This will be reinstated from the end of Q1 201516.
- Seasonal Influenza
  - Progress appears to be better than 2015, which is great considering the late start to the programme.
  - Need to ensure that in 2016 all DHB staff vaccinations for over 65s are loaded onto the NIR.
- **HPV**
  - The MoH paper around the Revitalisation of the HPV programme has recently been distributed.

	– It was agreed that a small group of IAG members would get together to look at this report and see what we can do to improve HPV coverage on the WC. • Pertussis in Pregnancy – At recent national immunisation conference this was referred to as the first event in a four event series ("baby's first vaccination"). – IAG approved the draft poster to be printed as a poster and flyer. – Need to consider how we can engage better with LMCs to encourage them to educate women around the importance of the pertussis vaccination during pregnancy.	Janet to arrange meeting
Next Meeting	Thursday 22 October 2.00 – 3.30pm, Community and Public Health Offices	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 2 December 2015 10:13 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; Fiona Croft; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; Joelle DeDanann; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda and Papers for tomorrows Immunisation Advisory Group meeting
Attachments: 3 December meeting Agenda.docx; Data Report Dec 2015.docx; Draft minutes 22 October meeting.docx; Updated Action Plan.docx

Hi all

Please find attached the agenda and papers for tomorrow's meeting.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 3 December 2015, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (22 October 2015)	Cheryl Brunton	Draft minutes 22 October meeting.dc
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2014/15 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Bridget Pauline/Cheryl Janet Bridget	Add data report Data Report Dec 2015.docx Updated Action Plan.docx
5	Draft dates for 2016 • 28 January • 10 March • 28 April • 9 June • 28 July • 8 September • 27 October • 1 December	Cheryl	
6	Any other business	Open	

Actions Items from Previous Meeting

There were not matters arising from the minutes.

Membership:

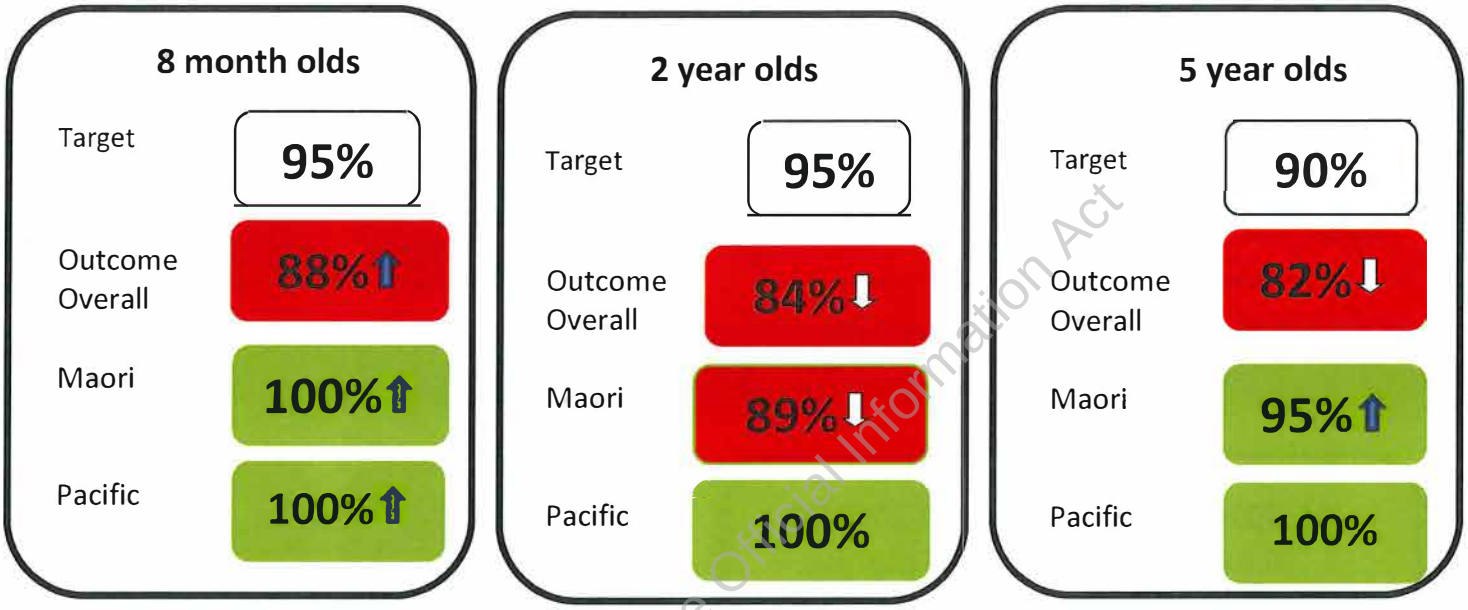
Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:
To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
To identify how the health system is progressing line with MoH Heath Targets
Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources
Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 19 Oct15

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress including pending	Q3 2015/16 Progress including pending	Q4 2015/16 Progress including pending
87% fully	83.9% fully	82.9% fully	73% fully
2% overdue	4.5% overdue	4.8% overdue	14% overdue

Fully Immunised Two year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
90% fully	84.3% fully	84.7% fully	% fully
1% overdue	0% overdue	1% overdue	% overdue

Fully Immunised Five year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
87% fully	83.5% fully	77.8% fully	0% fully
6.5% overdue	2.8%overdue	5.2% overdue	0% overdue

Q1 8 month 2015/16 – Actual

Practice Names	Fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	12			12
Franz Joseph Clinic	2			2
Greymouth Medical Centre	16			16
HariHari Rural Clinic	1			1
High Street Medical Centre (2005) Ltd	11			11
Reefton Medical Centre	3			3
Rural Academic General Practice	8			8
Westland Medical Centre	15	1	1	17
Clinic TBA West Coast	1			1
Moana Rural Clinic	3			3
Fox Glacier Clinic	1			1
Coast Medical Consultancy Ltd	1			1
South Westland - Haast	1			1
Waltham Medical Centre	1			1
Grand Total	**76**	**1**	**1**	**78**

Q1 2 years 201/16 – Actual

Row Labels	Fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	18			18
Greymouth Medical Centre	19			19
High Street Medical Centre (2005) Ltd	7	1		8
Reefton Medical Centre	4			4
Rural Academic General Practice	10	1	1	12
Westland Medical Centre	16	1	1	18
Whataroa Rural Clinic	2			2
Moana Rural Clinic	2			2
Coast Medical Consultancy Ltd	1			1
Grand Total	**79**	**3**	**2**	**84**

Q1 4years 2015/2016 – Actual

Row Labels	Declined	Fully	overdue after milestone age	Grand Total
Coast Medical Consultancy Ltd		3		3
Westland Medical Centre	2	17		19
Buller Medical Centre	1	15		16
Rural Academic General Practice	3	9		12
Greymouth Medical Centre	1	16	1	18
High Street Medical Centre (2005) Ltd		11		11
Fox Glacier Clinic		1		1
Franz Joseph Clinic		1	1	2
HariHari Rural Clinic		2		2
Reefton Medical Centre		4		4
Waihopai Health Services		1		1
Central Family Health		1		1
Grand Total	**7**	**81**	**2**	**90**

Q2 8months 2015/16 – In progress

Row Labels	Fully	Declined	On hold - with OIS	Vaccinated after milestone age	Grand Total
Buller Medical Centre	13				13
Franz Joseph Clinic	2				2
Greymouth Medical Centre	15	1			16
HariHari Rural Clinic	3				3
High Street Medical Centre (2005) Ltd	11				11
Reefton Medical Centre	8				8
Rural Academic General Practice	7	1			8
Westland Medical Centre	11	1			12
Whataroa Rural Clinic				1	1
Moana Rural Clinic	1		1		2
Coast Medical Consultancy Ltd	1				1
Woolston Medical Rooms	1				1
Grand Total	**73**	**3**	**1**	**1**	**78**

Q2 2 years 2015/2016 – In progress

Row Labels	Fully	declined	Grand Total
Buller Medical Centre	21		21
Franz Joseph Clinic	4		4
Greymouth Medical Centre	12	3	15
HariHari Rural Clinic	2		2
High Street Medical Centre (2005) Ltd	8		8
Karamea Medical Centre	1		1
Reefton Medical Centre	3	1	4
Rural Academic General Practice	11	1	12
Westland Medical Centre	13		13
Whataroa Rural Clinic	3		3
Moana Rural Clinic	2		2
Coast Medical Consultancy Ltd	1		1
Grand Total	**81**	**5**	**86**

Q2 4years 2015/2016 – Progress

Row Labels	declined	Catch up schedule	fully	Grand Total
Westland Medical Centre	3		17	20
Buller Medical Centre	1		26	27
High Street Medical Centre (2005) Ltd	2		10	12
Greymouth Medical Centre	1	1	18	20
Reefton Medical Centre	1		9	10
Rural Academic General Practice			3	3
Karamea Medical Centre			1	1
Maitai Medical Ltd			1	1
Franz Joseph Clinic			1	1
Grand Total	**8**	**1**	**86**	**95**

Q3 8 months 2015/2016 - In Progress

Practice Names	fully	On hold - with OIS	overdue with GP	pending	Grand Total
Buller Medical Centre	7	1		10	18
Franz Joseph Clinic	1	1			2
Greymouth Medical Centre	5			8	13
HariHari Rural Clinic	1				1
High Street Medical Centre (2005) Ltd	3			2	5
Reefton Medical Centre	1			2	3
Rural Academic General Practice	3		1	4	8
Westland Medical Centre	8		1	5	14
Whataroa Rural Clinic				1	1
Clinic TBA West Coast				1	1
Moana Rural Clinic				1	1
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd				2	2
South Westland - Haast				2	2
Grand Total	**30**	**2**	**2**	**38**	**72**

Q3 2 years 2015/2016 - In Progress

Row Labels	FULLY	Declined	On hold - with OIS	Grand Total
Buller Medical Centre	13	1		14
Franz Joseph Clinic	2			2
Greymouth Medical Centre	12	2		14
HariHari Rural Clinic	2			2
High Street Medical Centre (2005) Ltd	10			10
Reefton Medical Centre	2			2
Rural Academic General Practice	12			12
Westland Medical Centre	15		1	16
Moana Rural Clinic	2			2
Fox Glacier Clinic	1			1
Coast Medical Consultancy Ltd	4			4
South Westland - Haast	2			2
The Christchurch Doctors	1			1
Grand Total	**78**	**3**	**1**	**82**

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	91	66	73. %	48	43	90. %	20	15	75. %	4	3	75. %	3	3	100. %	16	2	13. %	14 (0)	15.4 (0.0) %	2	2.2 %
8 Month	86	76	88. %	49	47	96. %	20	20	100. %	3	3	100. %	3	3	100. %	11	3	27. %	8 (0)	9.3 (0.0) %	1	1.2 %
12 Month	95	80	84. %	57	52	91. %	14	12	86. %	3	2	67. %	5	5	100. %	16	9	56. %	7 (0)	7.4 (0.0) %	8	8.4 %
18 Month	100	73	73. %	50	46	92. %	23	17	74. %	1	1	100. %	5	5	100. %	21	4	19. %	15 (0)	15.0 (0.0) %	3	3.0 %
24 Month	94	79	84. %	56	53	95. %	19	17	89. %	2	2	100. %	2	2	100. %	15	5	33. %	10 (0)	10.6 (0.0) %	3	3.2 %
5 Year	96	79	82. %	52	44	85. %	21	20	95. %	3	3	100. %	5	5	100. %	15	7	47. %	6 ()	6.3 (0.0) %	7	7.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	91	66	73. %	5	5	100. %	12	10	83. %	14	13	93. %	29	22	76. %	29	15	52. %	2	1	50. %
8 Month	86	76	88. %	5	5	100. %	12	12	100. %	19	18	95. %	24	23	96. %	25	17	68. %	1	1	100. %
12 Month	95	80	84. %	8	8	100. %	18	17	94. %	9	9	100. %	38	33	87. %	22	13	59. %	0	0	-
18 Month	100	73	73. %	7	7	100. %	18	16	89. %	21	20	95. %	28	22	79. %	26	8	31. %	0	0	-
24 Month	94	79	84. %	11	11	100. %	11	11	100. %	23	22	96. %	25	21	84. %	24	14	58. %	0	0	-
5 Year	96	79	82. %	11	11	100. %	16	15	94. %	17	11	65. %	31	27	87. %	21	15	71. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
1999	HPV-1 Quadrivalent	15	0	1	61	77	30	0	0	140	170	50%	-%	-%	44%	45%	18 (10.6%)	0 (0.0%)
	HPV-2 Quadrivalent	15	0	1	59	75						50%	-%	-%	42%	44%	11 (6.5%)	
	HPV-3 Quadrivalent	15	0	1	56	72						50%	-%	-%	40%	42%	12 (7.1%)	
2000	HPV-1 Quadrivalent	20	3	1	89	113	40	0	0	130	170	50%	-%	-%	68%	66%	19 (11.2%)	0 (0.0%)
	HPV-2 Quadrivalent	18	2	1	88	109						45%	-%	-%	68%	64%	13 (7.6%)	
	HPV-3 Quadrivalent	17	2	1	86	106						43%	-%	-%	66%	62%	13 (7.6%)	
2001	HPV-1 Quadrivalent	11	0	4	100	115	40	5	5	160	210	28%	0%	80%	63%	55%	12 (5.7%)	0 (0.0%)
	HPV-2 Quadrivalent	11	0	4	99	114						28%	0%	80%	62%	54%	11 (5.2%)	
	HPV-3 Quadrivalent	11	0	3	97	111						28%	0%	60%	61%	53%	11 (5.2%)	
2002	HPV-1 Quadrivalent	18	3		66	87	30	0	0	150	190	60%	-%	-%	44%	46%	4 (2.1%)	0 (0.0%)
	HPV-2 Quadrivalent	16	3	0	61	80						53%	-%	-%	41%	42%	3 (1.6%)	
	HPV-3 Quadrivalent	5	2	0	25	32						17%	-%	-%	17%	17%	3 (1.6%)	
2003	HPV-1 Quadrivalent	5	0		20	25	30	0	5	140	180	17%	-%	0%	14%	14%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	17	22						17%	-%	0%	12%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	1 (0.6%)	
2004	HPV-1 Quadrivalent	0	0		0	0	30	0	0	130	160	0%	-%	-%	0%	0%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	69	6	6	336	417	200	5	10	850	1,080	35%	120%	-%	40%	39%	55 (5.1%)	0 (0.0%)
	HPV-2 Quadrivalent	65	5	6	324	400						33%	100%	-%	38%	37%	39 (3.6%)	
	HPV-3 Quadrivalent	48	4	5	264	321						24%	80%	-%	31%	30%	40 (3.7%)	

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES - THURSDAY 22 October 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Janet Hogan, Bridget Lester, Betty Gilsenan, Ann Knipe, Joanne Shaw, Nikki Mason, and Sharyn Kenning. Julianna Lees (in attendance)	
Apologies:	Lee Harris, Pauline Ansley, Catherine Andrew, Catherine Crichton, and Helen Reriti	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting (27 Nov 2014)	Minutes of 10 September meeting were approved.	
3. Matters Arising	See table below	
4. Standing Items	**Report on KPIs** • 8 months – 88% fully vaccinated, increase by 3% on last quarter. • 2 year old – 84% fully vaccinated, decrease on last quarter. • 4 year olds - 82% fully vaccinated, decrease on last quarter **Work plan** • **Seasonal Influenza -** Need to ensure that in 2016 all DHB staff vaccinations for 65 and over are loaded onto the NIR. • **HPV** Working Group met and discussed number of options around HPV. These need to be further worked up. • **Pertussis in Pregnancy** - Cheryl's registrar, Julianna Lees, shared information around the groups and numbers vaccinated within the DHB programme. Numbers were low. • **NIR Resources –** a discussion around which resources the NIR team should send out with the welcome letters. Agreed that three brochures were enough – the summary of national schedule, one on Rotavirus (and one other???), The A5 brochure is handed out by LMC, GP and Well Child providers.	
Next Meeting	Thursday 3 December 2.00 – 3.30pm, Community and Public Health Offices	

Issue	Action	Due date
Seasonal Influenza	• Lee to write article for CEO's report around Reefton	Not completed
Pregnancy Vaccinations	• Organize to update Pertussis flyer – approval to be printed has been given.	Progressing
HPV	• Janet to arrange a meeting – meeting occurred and summary of this will be discussed later in the meeting.	Progressing

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 26 January 2016 12:13 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; Fiona Croft; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; Joelle DeDanann; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers and Agenda for Thursday 28 IAG meeting
Attachments: Reporting doc.docx; 28 Jan meeting 16.docx; WC Imms Work plan.docm; Draft minutes 3rd December 2015 meeting.docx

Hi all

I hope you all had a great xmas break.

Please find attached the papers and agenda for Thursdays IAG meeting.

Regards Bridget

Bridget Lester
Project Specialist

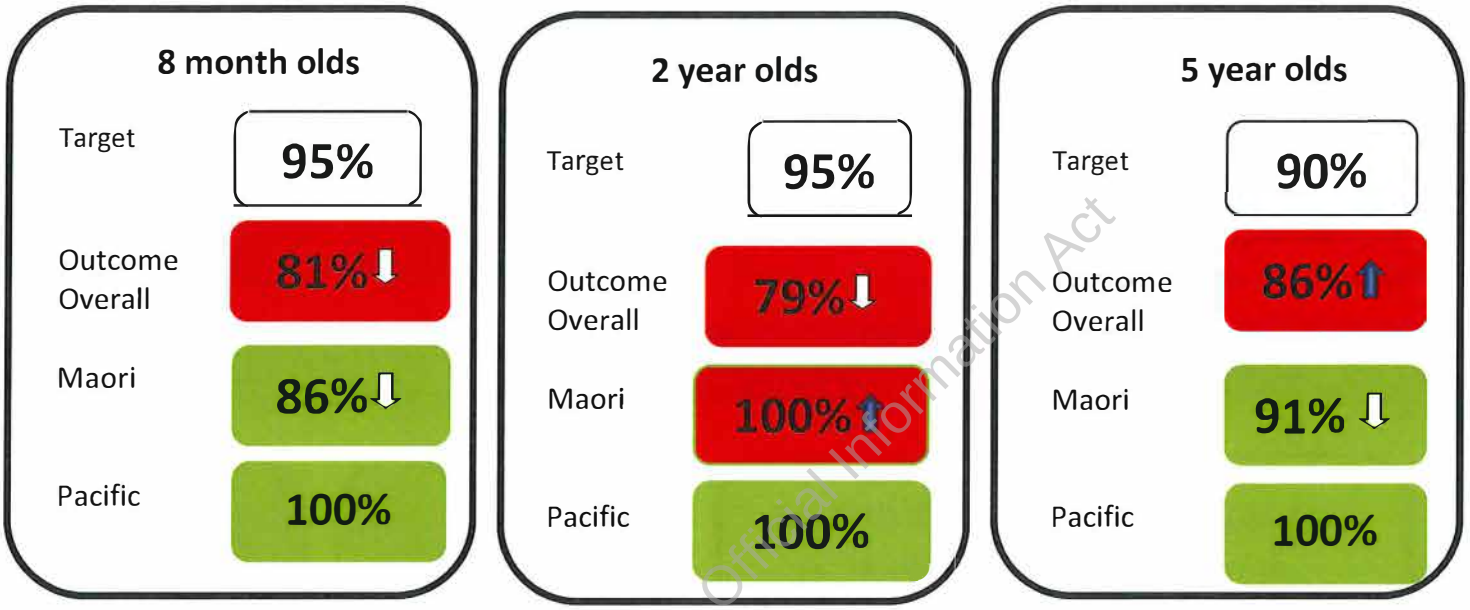
Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q2 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 19 Oct15

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress including pending	Q3 2015/16 Progress including pending	Q4 2015/16 Progress including pending
87% fully	81% fully	80% fully	71% fully
2% overdue	1 % overdue	7.5% overdue	13% overdue

Fully Immunised Two year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
90% fully	79% fully	84.7% fully	85% fully
1% overdue	0% overdue	1% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
87% fully	83.5% fully	79% fully	0% fully
6.5% overdue	2.8%overdue	3% overdue	0% overdue

Q2 8 month 2015/16 – Actual

Row Labels	Fully	Declined	Vaccinated after milestone age	Grand Total
Buller Medical Centre	13			13
Franz Joseph Clinic	2			2
Greymouth Medical Centre	15	1		16
HariHari Rural Clinic	3			3
High Street Medical Centre (2005) Ltd	11			11
Reefton Medical Centre	8			8
Rural Academic General Practice	7	1		8
Westland Medical Centre	11	1		12
Whataroa Rural Clinic			1	1
Moana Rural Clinic	2			2
Coast Medical Consultancy Ltd	1			1
Woolston Medical Rooms	1			1
Grand Total	**74**	**3**	**1**	**78**

Q2 2 years 201/16 – Actual

Row Labels	Fully	declined	Grand Total
Buller Medical Centre	21		21
Franz Joseph Clinic	4		4
Greymouth Medical Centre	12	3	15
HariHari Rural Clinic	2		2
High Street Medical Centre (2005) Ltd	8		8
Karamea Medical Centre	1		1
Reefton Medical Centre	3	1	4
Rural Academic General Practice	11	1	12
Westland Medical Centre	13		13
Whataroa Rural Clinic	3		3
Moana Rural Clinic	2		2
Coast Medical Consultancy Ltd	1		1
Grand Total	**81**	**5**	**86**

Q2 4years 2015/2016 – Actual

Row Labels	declined	fully	Grand Total
Westland Medical Centre	3	17	20
Buller Medical Centre	1	26	27
High Street Medical Centre (2005) Ltd	2	10	12
Greymouth Medical Centre	1	19	20
Reefton Medical Centre	1	9	10
Rural Academic General Practice		3	3
Karamea Medical Centre		1	1
Maitai Medical Ltd		1	1
Franz Joseph Clinic		1	1
Grand Total	**8**	**87**	**95**

Q3 8months 2015/16 – In progress

Practice Names	fully	On hold - with OIS	Overdue with GP	Grand Total
Buller Medical Centre	15		3	18
Franz Joseph Clinic	1	1		2
Greymouth Medical Centre	12			12
HariHari Rural Clinic	1			1
High Street Medical Centre (2005) Ltd	5			5
Reefton Medical Centre	3			3
Rural Academic General Practice	7		1	8
Westland Medical Centre	14	1		15
Whataroa Rural Clinic	1			1
Moana Rural Clinic	1			1
Fox Glacier Clinic	1			1
Coast Medical Consultancy Ltd	2			2
South Westland - Haast	1			1
Grand Total	**64**	**2**	**4**	**70**

Q3 2 years 2015/2016 – In progress

Row Labels	FULLY	Declined	On hold - with OIS	Grand Total
Buller Medical Centre	13	1		14
Franz Joseph Clinic	2			2
Greymouth Medical Centre	12	2		14
HariHari Rural Clinic	2			2
High Street Medical Centre (2005) Ltd	10			10
Reefton Medical Centre	2			2
Rural Academic General Practice	12			12
Westland Medical Centre	15		1	16
Moana Rural Clinic	2			2
Fox Glacier Clinic	1			1
Coast Medical Consultancy Ltd	4			4
South Westland - Haast	2			2
The Christchurch Doctors	1			1
Grand Total	**78**	**3**	**1**	**82**

Q3 4years

Row Labels	overdue with GP	On hold - with OIS	Declined	Fully	Grand Total
West Coast PHO	**2**	**1**	**7**	**76**	**86**
Coast Medical Consultancy Ltd				3	3
Westland Medical Centre				11	11
Buller Medical Centre		1	2	16	19
Central Medical Centre Alexandra				1	1
Whataroa Rural Clinic				3	3
High Street Medical Centre (2005) Ltd	1			3	4
Greymouth Medical Centre	1		3	21	25
Reefton Medical Centre				3	3
Rural Academic General Practice				9	9
Karamea Medical Centre			2	2	4
Fox Glacier Clinic				2	2
Ngakawau Clinic				1	1
Moana Rural Clinic				1	1
Grand Total	**2**	**1**	**7**	**76**	**86**

Q2 2015/16

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	80	59	74. %	47	38	81. %	16	13	81. %	2	2	100. %	5	4	80. %	10	2	20. %	7 (0)	8.8 (0.0) %	1	1.3 %
8 Month	89	72	81. %	45	44	98. %	22	19	86. %	4	4	100. %	4	4	100. %	14	1	7. %	13 (0)	14.6 (0.0) %	3	3.4 %
12 Month	82	73	89. %	46	45	98. %	22	20	91. %	1	1	100. %	5	5	100. %	8	2	25. %	6 (0)	7.3 (0.0) %	2	2.4 %
18 Month	89	79	89. %	50	47	94. %	20	17	85. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.5 (0.0) %	3	3.4 %
24 Month	102	81	79. %	51	46	90. %	19	19	100. %	3	3	100. %	5	5	100. %	24	8	33. %	16 (0)	15.7 (0.0) %	5	4.9 %
5 Year	99	85	86. %	55	48	87. %	23	21	91. %	2	2	100. %	2	2	100. %	17	12	71. %	5 ()	5.1 (0.0) %	9	9.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	80	59	74. %	12	10	83. %	15	14	93. %	7	6	86. %	22	16	73. %	20	9	45. %	4	4	100. %
8 Month	89	72	81. %	10	10	100. %	14	13	93. %	12	11	92. %	26	25	96. %	26	12	46. %	1	1	100. %
12 Month	82	73	89. %	5	5	100. %	16	16	100. %	22	21	95. %	19	18	95. %	20	13	65. %	0	0	-
18 Month	89	79	89. %	9	9	100. %	22	22	100. %	20	19	95. %	22	19	86. %	12	6	50. %	4	4	100. %
24 Month	102	81	79. %	6	5	83. %	16	14	88. %	25	24	96. %	28	28	100. %	27	10	37. %	0	0	-
5 Year	99	85	86. %	12	10	83. %	12	9	75. %	15	15	100. %	38	35	92. %	22	16	73. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM – supporting you to be well

AGENDA

Thursday 28 January 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (22 October 2015)	Cheryl Brunton	Draft minutes 3rd December 2015 mee
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Bridget Pauline/Cheryl Janet Bridget	Reporting doc.docx Updated Action Plan.docx
5	2016/17 Immunisation Work plan	Bridget	WC Imms Work plan.docm
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Seasonal Influenza • **Investigate if Pharmacy are able to provide subsided Flu vaccinations to increase uptake** • **Promotion sought between Flu and Colds -**	**Bridget** **Lee**	28 Jan 16
HPV • **Janet requested that a letter come from Cheryl to parents regarding the HPV School programme.**	**Janet to draft for Cheryl to sign.**	
Pregnancy Vaccinations • **Posters and Flyer update**	**Bridget**	
11 year old event resources – can the CDHB resources be used?	**Bridget**	
Meeting schedule for 2016 – send outlook requests	**Bridget**	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

BETTER PUBLIC HEALTH SERVICES

6.13 Increasing immunisation rates

Improved immunisation coverage leads to reduce rates of vaccine preventable disease and better health and independence for children, who will be enrolled with primary care and visiting their primary care provider on the regular basis. West Coast has a clinically-led cross sector Immunisation Advisory Group whose members provide collective oversight of service deliver and identity opportunities to improve immunisation rates.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase immunisation rates to reduce vaccine preventable disease and improve health and wellbeing.[1]	▪ Maintain the West Coast Immunisation Advisory Group with clinical leadership across the system to provide oversight of immunisation service delivery and performance. ▪ Work alongside Child Youth and Family, Ministry of Social Development and other relevant social service agencies and with the Canterbury Immunisation Service Level Alliance.	✓ West Coast is represented at national and regional forums. ✓ Immunisation information is widely available across the DHB.
	▪ Continue to support the New-Born-Enrolment process which promotes seamless handover between maternity, general practice and WCTO services and supports timely and multiple enrolments of new-borns with health services. ▪ Continue to support the National Immunisation Register (NIR) team to delivery timely reporting to follow up children with no nominated provider (unenrolled children).	✓ Quarterly immunisation performance reporting. ✓ 95% of all new-borns enrolled on the NIR at birth. ✓ 98% of all new-borns enrolled with a GP by 3months of age.
	▪ Continue to monitor and evaluate immunisation coverage at DHB, PHO and general practice level and circulate performance reports to maintain coverage and identify unvaccinated children. ▪ Work with Outreach Immunisation Services to locate missing children and provide advice and immunisation. ▪ Maintain internal processes whereby the immunisation status of children presenting at hospital is identified and 'missed' children referred to general practice or outreach services.	✓ 95% of eight month olds are fully immunised. ✓ 95% of two year olds are fully immunised. ✓ 90% of four year olds are fully immunised Q4.
	▪ Support Immunisation Week by profiling the importance of immunisation and interagency activity.	✓ Narrative report on interagency activities for Immunisation Week.
	▪ Maintain a Human Papillomavirus (HPV) Programme in a school setting and promote HPV vaccinations for eligible young women. ▪ Link with general practice to promote HPV to girls who did not complete the programme in year 8. ▪ Work to implement and promote new national online learning tools to support the HPV programme as they are developed.	✓ 70% of girls have received HPV dose 3, for 2016/17 this is girls born in 2003.
	▪ Promote and provide free seasonal flu vaccinations for people aged over 65, pregnant women and people with chronic health conditions. ▪ Continue to work with LMCs, Antenatal providers and general practice to promote, provide and monitor free pertussis (whooping cough) vaccinations for pregnant women.	✓ 75% of people aged 65+ have a seasonal flu vaccination. ✓ Quarterly monitoring of Pertussis vaccinations.

[1] *The West Coast DHB has higher than average 'opt-off' and 'decline' rates for immunisation. Around half of those opting off have strongly held religious views on this issue, which are unlikely to change. Nonetheless, we will use our best endeavours to reach the national target and continue to focus on immunising 100% of all those children whose parents consent to immunisation.*

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 3rd DECEMBER 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Joanne Shaw Sue Neilson (minutes)	
Apologies:	Bridget Lester, Lee Harris, Pauline Ansley, Janet Hogan, Nikki Mason, Catherine Crichton, Catherine Andrew, Sharyn Kenning. and Helen Reriti	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting	Minutes of 22nd October meeting were approved.	
3. Matters Arising	See below	
4. Standing Items	**Report on KPIs** • Noted progress on targets with increased coverage at 8 months, including 100% for Māori and pacific infants. • 2 year old and 5 year old coverage down slightly. • Very small percentage overdue for this quarter and these are in active follow up. **Work plan** • **Seasonal Influenza** – Flu Kits should be available shortly on-line. Ministry may decide to have programme pushed out to end of July rather than extend after the fact as has been done in recent years. No delay of vaccine anticipated this year. NISG will use same Blue Dust ad campaign as last year with a more concentrated effort on pregnant women as there was not a high uptake in this group. Discussion about ideas raised at WCPHO Clinical Governance Committee regarding pharmacists being permitted to offer funded vaccine to help increase uptake. WCPHO also keen to see promotion of difference between flu and colds as well as promotion of vaccine. PHNs keen to include this in school newsletters. • **HPV** – Janet has asked Cheryl to write a letter to parents of eligible girls about the vaccine. • **Pregnancy immunisation**- Betty has been to McBrearty Ward and talked to the midwives. There were also two from Gloriavale present which was very positive. They are keen to do the training and this will be looked at in the New Year. Cost $600	Bridget to check if this is possible Lee Cheryl to request Janet drafts letter for her to sign

	• **NIR Resources –** discussion about resources on 11 year olds immunisation event. Nurses would like to have this to share at schools as well as in practices	Cheryl to check with Bridget whether CDHB resource could be adapted and used
Next Meeting	Thursday 28th January 2016 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 10 March 9 June 28 July 8 September 27 October 1 December	Bridget to send Outlook appointments

- discussion about resources on Immunisation for 11 year olds. Action Cheryl to check with Bridgette on these resources.
- Anne suggested we could distribute to schools and GP's
- . Seasonal Influenza Adult Kits-should be on the way by Christmas and will be electronic also again this year. Season to end July or beginning of August. No delay for the Vaccine. NISG meeting Cheryl was unable to attend. Ad campaign will be Blue Dust as last year with a pore concentrated effort on Pregnant women as there was not a strong uptake. Action Work with Lee Harris to get it out into the community.
- Discussion around NIR for 65 plus working within the DHB. Was mentioned some Pharmacy staff can offer this but it is at a cost. PHO to follow up this.
- Occupational Flu program needs to feed back to Practices when their staff are vaccinated through the DHB
-
- Pregnant mums can be vaccinated at 28-38 weeks and 2 weeks after the birth.
- Action Cheryl to follow up

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 8 March 2016 12:23 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; 'Fiona Croft'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Joelle DeDanann'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda and Papers for Thursdays 10 march meeting
Attachments: 10 march agenda.docx

Hi all

Please find attached the agenda for our meeting on Thursday.

Regards Bridget

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

AGENDA

Thursday 10 March 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (28 January 2016)	Cheryl Brunton	Draft minutes 28 Jan meeting.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting ○ Seasonal Influenza – update ○ HPV programme update ○ Pregnancy vaccinations	Bridget Pauline/Cheryl/Betty Janet Bridget	Reporting March 2016.docx Updated Action Plan.docx
5	Immunisation Week	Cheryl Brunton	
6	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Seasonal Influenza **Investigate if Pharmacy are able to provide subsided Flu vaccinations to increase uptake**	**Bridget**	15 Feb
2016/17 Work Plan – make minor changes and send to P&F	**Bridget**	30 Jan
Immunisation Week – update WC plan and send to MoH	**Bridget**	6 Feb

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 28 January 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Joanne Shaw, Bridget Lester, Lee Harris, Pauline Ansley, Janet Hogan, Nikki Mason, Fiona and Sharyn Kenning	
Apologies:	Catherine Crichton, Catherine Andrew	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair. Welcome to Fiona from Plunket.	
2. Minutes of last meeting	Minutes of 2 December meeting were approved.	
3. Matters Arising	Pharmacy vaccinating – yet to be completed discuss further in meeting Code verse Flu – yet to occur Letter to parents of year 7 girls – Completed 11year old event resources – yes they can be shared 2016 meetings – outlook requests - completed	
4. Standing Items	**Report on KPIs** • Q2 = 81% 8 Month olds and 79% 2 year olds. These were both down on last quarter. Good progress for 5 year olds at 86%. • There are a number of children overdue this quarter, which is a concern. **Work plan** • **Seasonal Influenza** – Bridget and Betty held first planning meeting. Need to link up with Pauline. o Focus on recalling Maori 65 and older o Need regular data from PHO on progress o Will be using national programme with some direct messaging's to General practice, LMCs, Pharmacy, Maori and Rest homes. o CDHB developing some badgers to give out, will share on the WC. o Staff programme – needs to be more organised – seek list of staff and check off when someone has been vaccine. Dropbox for questions with responses in the CEOs update. o Can we pilot Pharmacy vaccinating subsided groups will need to ensure ▪ Data to NIR ▪ Not vaccinating these already done ▪ Can only use trivalent vaccine ▪ Need to be authorised by Immunisation Coordinator ▪ Need to develop process to ensure they can be paid.	Bridget to check if this is possible

	WCPHO also keen to see promotion of difference between flu and colds as well as promotion of vaccine. PHNs keen to include this in school newsletters. • **HPV –** Letter has gone to Parents for year 8 girls around HPV programme. • **Pregnancy** immunisation- New posters and flyers have been printed and will be distributed.	
2016/17 Work plan	Some minor changes made but happy to go to P&F. Final version attached.	Bridget to completed
Immunisation Week	Plan due next week. Will look at doing some targeted promotion around Pregnancy Vaccinations – and seek a high profile local mum to be.	Bridget to complete and share
Next Meeting	Thursday 10 March 2016 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 9 June 28 July 8 September 27 October 1 December	

- discussion about resources on Immunisation for 11 year olds. Action Cheryl to check with Bridgette on these resources.
- Anne suggested we could distribute to schools and GP's
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- Occupational Flu program needs to feed back to Practices when their staff are vaccinated through the DHB
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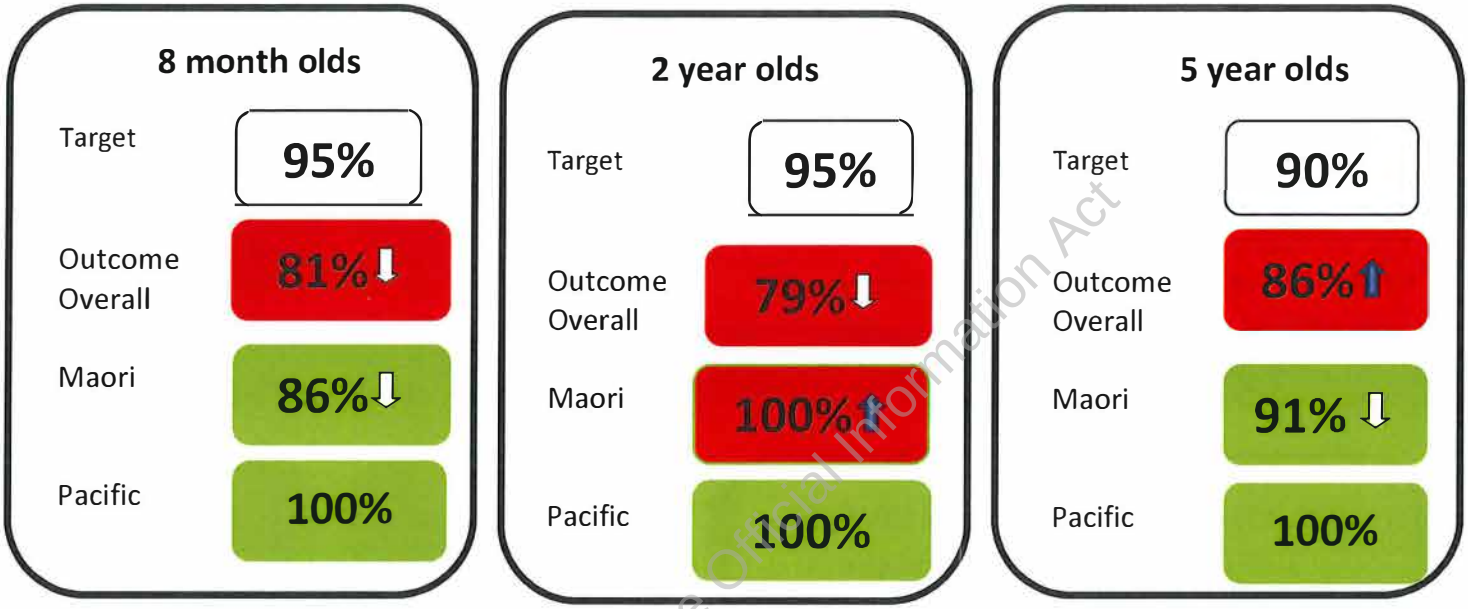
- Pregnant mums can be vaccinated at 28-38 weeks and 2 weeks after the birth.
- Action Cheryl to follow up

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q2 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 7 March 16

Fully Immunised 8 month olds – DHB LEVEL

Q1 2015/16 Actual	Q2 2015/16 Progress including pending	Q3 2015/16 Progress including pending	Q4 2015/16 Progress including pending
87% fully	81% fully	85% fully	75% fully
2% overdue	1 % overdue	1.3% overdue	7.2%

Fully Immunised Two year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
90% fully	79% fully	84.7% fully	85% fully
1% overdue	0% overdue	1% overdue	0% overdue

Fully Immunised Five year olds - DHB LEVEL

Q1 2014/15 Actual	Q2 2015/16 Progress	Q3 2015/16 Progress	Q4 2015/16 Progress
87% fully	83.5% fully	80% fully	77% fully
6.5% overdue	2.8%overdue	2% overdue	6.2% overdue

Q2 2015/16

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	80	59	74. %	47	38	81. %	16	13	81. %	2	2	100. %	5	4	80. %	10	2	20. %	7 (0)	8.8 (0.0) %	1	1.3 %
8 Month	89	72	81. %	45	44	98. %	22	19	86. %	4	4	100. %	4	4	100. %	14	1	7. %	13 (0)	14.6 (0.0) %	3	3.4 %
12 Month	82	73	89. %	46	45	98. %	22	20	91. %	1	1	100. %	5	5	100. %	8	2	25. %	6 (0)	7.3 (0.0) %	2	2.4 %
18 Month	89	79	89. %	50	47	94. %	20	17	85. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.5 (0.0) %	3	3.4 %
24 Month	102	81	79. %	51	46	90. %	19	19	100. %	3	3	100. %	5	5	100. %	24	8	33. %	16 (0)	15.7 (0.0) %	5	4.9 %
5 Year	99	85	86. %	55	48	87. %	23	21	91. %	2	2	100. %	2	2	100. %	17	12	71. %	5 ()	5.1 (0.0) %	9	9.1 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	80	59	74. %	12	10	83. %	15	14	93. %	7	6	86. %	22	16	73. %	20	9	45. %	4	4	100. %
8 Month	89	72	81. %	10	10	100. %	14	13	93. %	12	11	92. %	26	25	96. %	26	12	46. %	1	1	100. %
12 Month	82	73	89. %	5	5	100. %	16	16	100. %	22	21	95. %	19	18	95. %	20	13	65. %	0	0	-
18 Month	89	79	89. %	9	9	100. %	22	22	100. %	20	19	95. %	22	19	86. %	12	6	50. %	4	4	100. %
24 Month	102	81	79. %	6	5	83. %	16	14	88. %	25	24	96. %	28	28	100. %	27	10	37. %	0	0	-
5 Year	99	85	86. %	12	10	83. %	12	9	75. %	15	15	100. %	38	35	92. %	22	16	73. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 7 June 2016 1:00 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; 'Christina Houston'; 'Fiona Croft'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Joelle DeDanann'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda and papers for Thursday IAG meeting
Attachments: 9 June 2016 IAG draft agenda.docx; PHARMAC - Proposal to amend listings in the National Immunisation Schedule; Reporting June 2016.docx; Draft minutes March 10th IAG meeting.docx; WC Imms Work plan.docm

Hi all

Please find attached the agenda and papers for our meeting on Thursday. Please let me know if you are unable to make it.

I am dialling in from Christchurch for the meeting, but speak to you all on Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 9 June 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (10 March 2016)	Cheryl Brunton	Draft minutes March 10th IAG mee
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Bridget Pauline/Cheryl/Betty Janet Bridget	Reporting June 2016.docx Updated Action Plan.docx
5	Proposed Schedule Changes (Pharmac consultation)	Cheryl/Bridget	PHARMAC - Proposal to amend I
6	Measles update	Cheryl	
7	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Immunisation Week – update	Bridget	9 June 16

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Maori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator
Anna Wall	South Island Regional Immunisation Advisor IMAC

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 28 January 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Joanne Shaw, Bridget Lester, Lee Harris, Pauline Ansley, Janet Hogan, Nikki Mason, Fiona and Sharyn Kenning	
Apologies:	Catherine Crichton, Catherine Andrew	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair. Welcome to Fiona from Plunket.	
2. Minutes of last meeting	Minutes of 2 December meeting were approved.	
3. Matters Arising	Pharmacy vaccinating – yet to be completed discuss further in meeting Code verse Flu – yet to occur Letter to parents of year 7 girls – Completed 11year old event resources – yes they can be shared 2016 meetings – outlook requests - completed	
4. Standing Items	**Report on KPIs** • Q2 = 81% 8 Month olds and 79% 2 year olds. These were both down on last quarter. Good progress for 5 year olds at 86%. • There are a number of children overdue this quarter, which is a concern. **Work plan** • **Seasonal Influenza –** Bridget and Betty held first planning meeting. Need to link up with Pauline. o Focus on recalling Maori 65 and older o Need regular data from PHO on progress o Will be using national programme with some direct messaging's to General practice, LMCs, Pharmacy, Maori and Rest homes. o CDHB developing some badgers to give out, will share on the WC. o Staff programme – needs to be more organised – seek list of staff and check off when someone has been vaccine. Dropbox for questions with responses in the CEOs update. o Can we pilot Pharmacy vaccinating subsided groups will need to ensure ▪ Data to NIR ▪ Not vaccinating these already done ▪ Can only use trivalent vaccine ▪ Need to be authorised by Immunisation Coordinator ▪ Need to develop process to ensure they can be paid.	Bridget to check if this is possible

	WCPHO also keen to see promotion of difference between flu and colds as well as promotion of vaccine. PHNs keen to include this in school newsletters. • **HPV –** Letter has gone to Parents for year 8 girls around HPV programme. • **Pregnancy** immunisation- New posters and flyers have been printed and will be distributed.	
2016/17 Work plan	Some minor changes made but happy to go to P&F. Final version attached.	Bridget to completed
Immunisation Week	Plan due next week. Will look at doing some targeted promotion around Pregnancy Vaccinations – and seek a high profile local mum to be.	Bridget to complete and share
Next Meeting	Thursday 10 March 2016 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 9 June 28 July 8 September 27 October 1 December	

- discussion about resources on Immunisation for 11 year olds. Action Cheryl to check with Bridgette on these resources.
- Anne suggested we could distribute to schools and GP's
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- Pregnant mums can be vaccinated at 28-38 weeks and 2 weeks after the birth.
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Performance in line with Key Performance Indicators

Increase Immunisation Rates Q3 2015/16

8 month olds	
Target	95%
Outcome Overall	89% ⬆
Maori	100% ⬆
Pacific	0%

2 year olds	
Target	95%
Outcome Overall	81% ⬆
Maori	100%
Pacific	100%

5 year olds	
Target	90%
Outcome Overall	84% ⬇
Maori	90% ⇩
Pacific	100%

The Immunisation Reporting Programme is a work in progress.

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HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 7 March 16

Fully Immunised 8 month olds – DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Actual	Q4 2015/16 Progress including pending	Q1 2016/17 Progress including pending
81% fully	89% fully	87% fully	70% fully
2% overdue	0 % overdue	0% overdue	10%

Fully Immunised Two year olds - DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Progress	Q4 2015/16 Progress	Q1 2016/17 Progress
79% fully	79% fully	81% fully	fully
0% overdue	0% overdue	1% overdue	overdue

Fully Immunised Five year olds - DHB LEVEL

Q2 2015/16 Actual	Q3 2015/16 Actual	Q4 2015/16 Progress	Q1 2016/17 Progress
86% fully	% fully	80% fully	82% fully
0% overdue	%overdue	0% overdue	5% overdue

Q3 2015/16

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	89	69	78 %	47	43	91 %	21	16	76 %	1	1	100 %	4	4	100 %	16	5	31 %	11 (0)	12.4 (0.0) %	4	4.5 %
8 Month	75	67	89 %	46	45	98 %	16	16	100 %	0	0	-	2	1	50 %	11	5	45 %	6 (0)	8.0 (0.0) %	0	0 %
12 Month	93	76	82 %	49	49	100 %	20	18	90 %	4	4	100 %	3	2	67 %	17	3	18 %	14 (0)	15.1 (0.0) %	2	2.2 %
18 Month	99	79	80 %	60	52	87 %	13	12	92 %	2	2	100 %	6	4	67 %	18	9	50 %	7 (0)	7.1 (0.0) %	7	7.1 %
24 Month	97	79	81 %	49	46	94 %	23	23	100 %	1	1	100 %	4	4	100 %	20	5	25 %	15 (0)	15.5 (0.0) %	3	3.1 %
5 Year	93	78	84 %	57	52	91 %	21	19	90 %	2	2	100 %	1	1	100 %	12	4	33 %	7 (0)	7.5 (0.0) %	7	7.5 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%	No Eligible	Fully immunised for Age	%
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12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

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Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	

Lara Williams (Administrator)

From: Bonnie_Jones@moh.govt.nz
Sent: Monday, 30 May 2016 4:14 p.m.
Cc: Bonnie_Jones@moh.govt.nz
Subject: PHARMAC - Proposal to amend listings in the National Immunisation Schedule
Attachments: 2016-05-30 Consultation on Immunisation Schedule changes.pdf

Good afternoon,

PHARMAC is seeking feedback on proposals for the supply of vaccines for the New Zealand National Immunisation Schedule. Details are available in the attachment below and on the PHARMAC website at
https://www.pharmac.govt.nz/news/media-2016-05-30-vaccines-consultations/
https://www.pharmac.govt.nz/news/consultation-2016-05-30-immunisation-schedule/

In summary, these proposals would result in the following access, brand and dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.
- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.
- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.
- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.
- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**

  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).
- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

Details of how to provide feedback are available at the PHARMAC website.

Kind regards,

Bonnie Jones
Senior Advisor Stakeholder Engagement
Immunisation
Community Health
Service Commissioning
Ministry of Health
DDI: 04 816 4434
Mobile: 021 806 021

http://www.health.govt.nz
mailto:Bonnie_Jones@moh.govt.nz

CONSULTATION

PHARMAC
Pharmaceutical Management Agency

30 May 2016

Proposal to amend listings in the National Immunisation Schedule

Following a Request for Proposals (RFP) for the supply of various vaccines, issued on 15 February 2016, PHARMAC is now seeking feedback on proposals, relating to provisional agreements with a number of suppliers, for the supply of vaccines for the New Zealand National Immunisation Schedule. In summary, these proposals would result in the following access, brand & dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.

- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.

- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.

- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.

- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**
  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).

- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

All contracted vaccines would have Sole Supply Status from 1 July 2017 until 30 June 2020, making them the only vaccines listed for use in both the community and DHB hospitals.

At this time PHARMAC has not finalised provisional agreements for the following:

- Bacillus Calmette-Guerin vaccine (BCG);
- meningococcal C conjugate vaccine;
- hepatitis A vaccine;
- hepatitis B recombinant vaccine;
- pneumococcal polyvalent vaccine;
- poliomyelitis vaccine;
- pneumococcal (PCV13) vaccine (for high risk patients);
- meningococcal A, C , Y and W135 vaccine; and
- tuberculin PPD (Mantoux) test (Tubersol).

We anticipate a consultation on proposals relating to the above products will be issued within the next three months.

Feedback sought

PHARMAC welcomes feedback on this proposal. To provide feedback, please submit it in writing by **5 pm Monday, 20 June 2016** to:

Matthew Wolfenden	Email: vaccines@pharmac.govt.nz
Procurement Manager	Fax: 04 460 4995
PHARMAC	Post: PO Box 10 254, Wellington 6143

All feedback received before the closing date will be considered by PHARMAC's Board (or its delegate) prior to making a decision on this proposal.

Feedback we receive is subject to the Official Information Act 1982 (OIA) and we will consider any request to have information withheld in accordance with our obligations under the OIA. Anyone providing feedback, whether on their own account or on behalf of an organisation, and whether in a personal or professional capacity, should be aware that the content of their feedback and their identity may need to be disclosed in response to an OIA request.

We are not able to treat any part of your feedback as confidential unless you specifically request that we do, and then only to the extent permissible under the OIA and other relevant laws and requirements. If you would like us to withhold any commercially sensitive, confidential proprietary, or personal information included in your submission, please clearly state this in your submission and identify the relevant sections of your submission that you would like it withheld. PHARMAC will give due consideration to any such request

Background

PHARMAC began managing the National Immunisation Schedule from 1 July 2012.

PHARMAC first issued an RFP for the supply of vaccines in June 2013, which resulted in agreements with five suppliers. Sole Supply Status for vaccines covered by those agreements expires on 30 June 2017.

In preparation for running an RFP, PHARMAC requested that suppliers submit applications to PHARMAC for:

- funding of any new or alternative brands of vaccines they may have available for supply from July 2017; and
- any proposed changes to the funding eligibility criteria for current listings and/or the National Immunisation Schedule.

PHARMAC subsequently sought clinical advice from the Immunisation Subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC) on:

- the suitability of new vaccines recently registered by Medsafe or planned to be registered in time for 2017 supply;
- interchangeability of alternative brands; and
- possible funding eligibility criteria changes.

The complete Immunisation Subcommittee minutes are available on our website at:

www.pharmac.health.nz/about/committees/ptac/ptac-subcommittees/

On 15 February 2016 PHARMAC released an RFP for the supply of various vaccines, which can be found at the following link:

www.pharmac.govt.nz/news/rfp-2016-02-16-supply-of-various-vaccines/

The proposed listings and amendments to the National Immunisation Schedule are as a result of this RFP process.

Distribution of Vaccines unchanged

Vaccines are distributed differently to most other pharmaceuticals. The method for ordering vaccines by vaccinators would remain the same as a result of this proposal.

The vaccines would be listed "Xpharm" with a $0.00 subsidy. An Xpharm listing means that pharmacies cannot claim subsidy because PHARMAC has made alternative distribution arrangements.

Details of the proposals

Gardasil 9 would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 January 2017. All the other vaccines set out in this proposal would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017.

PHARMAC would use its reasonable endeavours to ensure the funded Pharmaceuticals are the only brand of the Pharmaceuticals distributed by the Service Provider on or after 1 July 2017.

Confidential net prices would apply to all vaccines listed as a result of this RFP.

The current funding criteria applying to all vaccines can be found in **Section I** and **Section H** of the Pharmaceutical Schedule and would be amended to implement any changes to eligibility and/or the number of doses, should these proposals be accepted.

The current funding criteria and the proposed amendments are collated in **Annex A** of this document.

The Ministry of Health's Immunisation Handbook would continue to provide information to vaccinators on the recommended timing of dosing for particular vaccines and catch up programmes.

Further details about each of the vaccines and proposed changes are set out below as follows:

Human papilloma virus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the human papilloma virus (HPV) vaccine, as a result of a provisional agreement with Seqirus.

This proposal would result in a change of HPV vaccine from Gardasil which contains 4 HPV antigens (types 6, 11, 16, 18) to Gardasil 9 which contains 9 HPV antigens (types 6, 11, 16, 18, 31, 33, 45, 52 and 58).

Gardasil 9 is currently registered for use under a three-dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen from three doses to two doses for children aged 14 years and under.

Details of the proposal

PHARMAC proposes that from 1 January 2017 Gardasil 9 would be listed on the National Immunisation Schedule. Gardasil would be delisted from 1 July 2017.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
human papilloma virus (6, 11, 16, 18, 31, 33, 45, 52 and 58)	Injection 270 mcg in 0.5 ml	Gardasil 9	10	$0.00	$1,415.00
Human papilloma virus (6,11,16 and 18)	Injection 120 mcg in 0.5 ml	Gardasil	10	$0.00	$1,285.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 January 2017 the funding restrictions applying to HPV vaccines in Section H (the Hospital Medicines List) and Section I (National Immunisation Schedule) would be deleted and replaced with the following:

1. Maximum of two doses for males and females aged 14 years and under; or
2. Maximum of three doses for patients meeting any of the following criteria:
    i. Male and female patients aged 26 years and under; or
    ii. For use in transplant (including stem cell) patients: or
    iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose regimen prior to 1 January 2017. Progression would be subject to Medsafe approval of the two-dose regimen.

Gardasil 9 would have Sole Supply Status in both the community and DHB hospital settings for HPV vaccine from 1 July 2017 until 30 June 2020.

Background

The human papillomavirus virus (HPV) causes a number of cancers with cervical cancer being the most prevalent. Approximately 70% of cervical cancers are caused by HPV types 16 and 18 (covered by the four antigen Gardasil, "Gardasil") while a further 20% are caused by 31, 33, 45, 52 and 58 (covered by the antigens contained in Gardasil 9). HPV vaccination also protects against a number of other cancers including anal, penile, vulval, vaginal, and some forms of oropharyngeal cancers.

In response to the RFP issued in February 2016, Seqirus has proposed supply of the 9 antigen Gardasil 9 which is registered for use under a 3 dose regimen, the same as Gardasil. A Changed Medicine Notification has been lodged with Medsafe to change the regimen for 3 doses to two doses for those children aged 14 years and under.

Clinical trials have reported Gardasil 9 to be non-inferior to Gardasil in relation to the four antigens they have in common (6, 11, 16 and 18). While results from the two dose studies have reported that doses given at both 0 and 6 months (girls and boys) and 0 and 12 months (girls and boys) achieve good seroconversion, the 0 and 12 month schedule is recommended by the supplier as it achieves a higher seroconversion (access to two dose trial work can be found at www.clinicaltrials.gov).

Both the Immunisation Subcommittee (March 2013) and PTAC itself (August 2013) have reviewed an application from the supplier for funded access to be widened to young males aged 12 years and older to match the current National Immunisation Schedule funded access for girls. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Both the Subcommittee and PTAC made the following recommendations:

- that the age of female vaccination be amended to allow the first dose at age 11 with a medium priority, and allow the school based program to be initiated in year seven rather than year eight.
- widening access to HPV vaccine to include males between the ages of 11 and 25 inclusive who identify as MSM with a high priority.
- widening access to HPV vaccine to include all males between the ages of 11 and 18 with a low priority.

Two dose vaccination schedule

In February 2015, the Immunisation Subcommittee reviewed a PHARMAC-generated proposal to fund a two dose regimen for Gardasil (the 4 antigen preparation). Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-rninutes-2015-02-18.pdf

- The Subcommittee recommended funding two-dose HPV vaccination for girls up to 15 years of age, with a high priority noting that the three-dose HPV vaccination would remain funded for girls over 15 years of age.

This recommendation would have been difficult to implement as, at that time, Gardasil was not registered for a two dose regimen and the supplier did not have an appropriate registration dossier.

If the changed medicine notification to change the registration for Gardasil 9 is approved, this proposal would enable the introduction of a two-dose regimen to year 8 girls and boys in the 2017 school year with the possibility of moving to Year 7 boys and girls at a timing determined by the Ministry of Health, which is responsible for the in-school programme. If the move to year 7 was made, year 8 boys and girls would also need to be vaccinated in the same year.

Varicella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to varicella vaccine (varicella) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in the Varilrix being the only listed varicella vaccine. Funding restrictions would be widened to include:

- Primary vaccination in children, one dose, at 15 months; and
- A catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox; and
- Funded access for patients considered to be at high risk of infection (as currently defined in the Pharmaceutical Schedule) would continue.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Varilrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	1	$0.00	$50.00
Varicella vaccine	Inj 2000 PFU pre-filled syringe plus vial	Varilrix	10	$0.00	$500.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Varilrix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amendments to restrictions shown in bold:

1. **One dose for primary vaccination for:**
   - i. **Children at 15 months; or**
   - ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**
2. Maximum of two doses for any of the following:
   - **i.** For non-immune patients:
     - (a) with chronic liver disease who may in future be candidates for transplantation; or
     - (b) with deteriorating renal function before transplantation; or
     - (c) prior to solid organ transplant; or
     - (d) prior to any elective immunosuppression*.
   - **ii.** For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

* immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Varilrix would have Sole Supply Status in both the community and DHB hospital settings for varicella vaccine from 1 July 2017 until 30 June 2020.

Background

Varilrix has been listed and funded for patients at high risk of infection since 1 July 2014. Usage under the current funding criteria is less than 1000 doses per year.

This proposal is to introduce varicella vaccination into the National Immunisation Schedule initially with one dose being given at 15 months. A catch-up dose in general practice at 11 or 12 years would be funded for patients who have not had chickenpox previously and who have not been vaccinated against chickenpox.

Chickenpox is perceived as being a mild disease and most often is. However, complications such as secondary bacterial infection, pneumonitis and encephalitis occur in about 1% of cases, more typically in young adults, and usually lead to hospitalisation.

A study by Wen et al (Prospective surveillance of hospitalisations associated with varicella in New Zealand: J. Paediatr. Child Health 2015 doi:10.1111/jpc.12937) reported an annual incidence in New Zealand of varicella-related hospitalisations of 8.3/100,000 children (95% confidence interval 7.0-9.8/100,000) between 1 November 2011 and 31 October 2013. Complications included infection (75%), respiratory (11%), electrolyte disturbance (6%) and haemorrhagic varicella (4%) and 19% had ongoing problems at discharge. Māori and Pacific Island children accounted for 74% of the hospitalisations.

A ten year (2001-2011) review by Wen et al of varicella admissions to the Paediatric Intensive Care Unit at Starship Hospital (J. Paediatr. Child Health 2014;50(4):280-5) identified 34 cases, of which 26 patients were included in the review. Of these patients admission reasons were neurological (38.5%), secondary bacterial sepsis or shock (26.9%), respiratory (15.4%), disseminated varicella (11.5%), or other causes (7.7%). Four children died, three of whom, were immunocompromised and 31% had ongoing disability after discharge.

The Immunisation Subcommittee reviewed varicella vaccine at its March 2013 meeting and PTAC reviewed varicella vaccine at its August 2013 meeting. Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

www.pharmac.govt.nz/assets/ptac-minutes-2013-08.pdf

Most recently, PTAC reviewed varicella vaccine at its February 2015 meeting and recommended:

- Varicella vaccine be funded with a high priority as a part of a universal childhood immunisation.
- The Committee noted that varicella vaccine could be given in combination with the HiB, MMR and pneumococcal vaccine at 15 months.
- While some members of the Committee considered that introducing a fourth injectable vaccine at 15 months could be problematic the majority of the Committee considered that it is acceptable to give four injections at that time.
- The Committee noted that for vaccination against varicella to be effective, patients would eventually require two doses, as wild-type varicella incidence in the paediatric population decreases.
- The Committee recommended Varicella vaccine be listed on the Pharmaceutical Schedule funded for one infant dose at age 15 months and one catch up dose at 11 or 12 years of age, with a high priority. One member abstained from voting.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-02-18.pdf

Pneumococcal conjugate vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating for pneumococcal conjugate vaccine (PCV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in:

- Synflorix, pneumococcal 10-valent protein conjugate vaccine (PCV10), being listed and replacing Prevenar 13 (PCV13) under the following criteria:
    - the primary course of immunisation for previously unvaccinated individuals up to the age of 59 months;
    - individuals under the age of 59 months who have not completed a four dose primary course of immunisation of PCV13; and
    - testing for primary immunodeficiency diseases.

An agreement for Prevenar 13, pneumococcal 13-valent protein conjugate vaccine (PCV13), for high risk patients only, has not been finalised.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Synflorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Pneumococcal (PVC10) conjugate vaccine	Inj 1mcg of pneumococcal polysaccharide serotypes 1, 5, 6B, 7F, 9V, 14 and 23F; 3mcg of pneumococcal polysaccharide serotypes 4, 18C and 19F in 0.5ml prefilled syringe	Synflorix	10	$0.00	$1,400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

Synflorix, pneumococcal (PCV10) vaccine, would be the only pneumococcal vaccine listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 for funding under the following restrictions:

Any of the following:

1) A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or

2) Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or

3) For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Synflorix would have Sole Supply Status in both the community and DHB hospital settings for pneumococcal conjugate vaccine from 1 July 2017 until 30 June 2020.

Background

The Immunisation Subcommittee reviewed pneumococcal conjugate vaccines at its October 2015 meeting and **noted** the following:

> The Subcommittee considered that both PCV10 (GSK's Synflorix) and PCV13 (Pfizer's Prevenar 13) are suitable for inclusion on the National Immunisation Schedule but that if PCV10 were listed for universal vaccination it may be necessary to continue to list PCV13 for vaccination of high risk groups.

Full minutes of the meeting can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2015-10.pdf

Since the October 2015 meeting, GlaxoSmithKline has gained approval from Medsafe for an indication for active immunisation against disease caused by cross-reactive serotype 19A. At its' May 2016 meeting, the Immunisation Subcommittee recommended that PHARMAC monitor the incidence of 19A related invasive pneumococcal disease as reported in the ESR quarterly surveillance reports.

Rotavirus vaccine

PHARMAC is seeking feedback on a proposal to list an alternative brand of rotavirus, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Rotarix being the only listed rotavirus vaccine, RotaTeq being delisted and the current three-dose regimen being replaced with a two-dose regimen.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Rotarix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Rotavirus vaccine	Pre-filled oral applicator, live attenuated human rotavirus 1,000,000 $CCID_{50}$ per dose	Rotarix	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Rotarix would be listed in Section I and Part II of Section H of the Pharmaceutical Schedule from 1 July 2017 with the following amended funding restrictions (deletions in strike through, insertions in bold):

Maximum of ~~three~~ **two** doses for patients meeting the following:

1. first dose to be administered in infants aged under ~~15~~ **14** weeks of age; and
2. no vaccination being administered to children aged ~~8 months~~ **24 weeks** or over.

Rotarix would have Sole Supply Status in both the community and DHB hospital settings for rotavirus vaccine from 1 July 2017 until 30 June 2020.

Background

Rotavirus vaccine has been listed and funded for primary vaccination in children since 1 July 2014. The Immunisation Subcommittee reviewed rotavirus vaccines at its March 2013 meeting and recommended:

- Funding rotavirus vaccination with a high priority.
- The Subcommittee considered that the two commercially available vaccines (Rotarix and RotaTeq) were of equal efficacy and PHARMAC could consider the Subcommittee's considerations as applying equally to both vaccines. Members considered that the two vaccines had a same or similar clinical efficacy. Members considered that the evidence for RotaTeq did not support any improved clinical outcomes as a result of the G2 strain inclusion. Members considered that there was cross-protection between strains from vaccine or illness, but that it was not complete.
- The Subcommittee noted that both vaccines were oral and can be given as part of the existing vaccine schedule. Members considered that the approved dosing frequency, either 2 or 3 doses, of each vaccine would be appropriate for the New Zealand setting.

Full minutes of these meetings can be found at:

www.pharmac.govt.nz/assets/ptac-immunisation-subcommittee-minutes-2013-03-06.pdf

Measles, mumps and rubella vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the measles, mumps, and rubella (MMR) vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Priorix being the only listed MMR vaccine and M-M-R II being delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Priorix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Measles, mumps and rubella vaccine	Injection, measles virus 1,000 $CCID_{50}$, mumps virus 5,012 $CCID_{50}$, Rubella virus 1,000 $CCID_{50}$; prefilled syringe/ampoule of diluent 0.5 ml	Priorix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 the MMR vaccine would continue to be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Priorix would have Sole Supply Status in both the community and DHB hospital settings for MMR from 1 July 2017 until 30 June 2020.

Haemophilus influenzae type B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the *Haemophilus influenzae* type B vaccine, as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Hiberix being the only listed *haemophilus influenzae* type B vaccine; Act-HIB would be delisted.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Hiberix would be listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Haemophilus influenzae type B vaccine	Haemophilus Influenzae type b polysaccharide 10 mcg conjugated to tetanus toxoid as carrier protein 20-40 mcg; pre-filled syringe plus vial 0.5 ml	Hiberix	10	$0.00	$200.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes

From 1 July 2017 the *Haemophilus influenzae* type B vaccine would be listed, with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Hiberix would have Sole Supply Status in both the community and DHB hospital settings for *Haemophilus influenzae* type B vaccine from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus and acellular pertussis vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type tetanus, diphtheria, and acellular pertussis vaccine (Tdap) virus vaccine live as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Boostrix remaining as the only listed Tdap vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Boostrix would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	1	$0.00	$25.00
Diphtheria, tetanus and acellular pertussis vaccine	Inj 2 IU diphtheria toxoid with 20 IU tetanus toxoid, 8 mcg pertussis toxoid, 8 mcg pertussis filamentous haemagluttinin and 2.5 mcg pertactin in 0.5 ml pre-filled syringe	Boostrix	10	$0.00	$250.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 adult type tetanus, diphtheria, and acellular pertussis vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Boostrix would have Sole Supply Status in both the community and DHB hospital settings for Tdap from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (DTaP-IPV) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix IPV remaining as the only listed DTaP-IPV vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix IPV would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis and polio vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin and 80 D-antigen units poliomyelitis virus in 0.5 ml pre-filled syringe	Infanrix IPV	10	$0.00	$400.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed change

From 1 July 2017 diphtheria, tetanus, acellular pertussis and inactivated polio vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix IPV would have Sole Supply Status in both the community and DHB hospital settings for DTaP-IPV from 1 July 2017 until 30 June 2020.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult type diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine virus vaccine live (hexavalent vaccine) as a result of a provisional agreement with GlaxoSmithKline.

This proposal would result in Infanrix-Hexa remaining as the only listed hexavalent vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 Infanrix-Hexa would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacture's price (ex GST)
Diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine	Inj 30 IU diphtheria toxoid with 40 IU tetanus toxoid, 25 mcg pertussis toxoid, 25 mcg pertussis filamentous haemagluttinin, 8 mcg pertactin, 80 D-antigen units poliomyelitis virus, 10 mcg hepatitis B surface antigen in 0.5 ml syringe (1) and 10 mcg haemophilus influenza type B vaccine in 0.5 ml pre-filled syringe	Infanrix Hexa	10	$0.00	$1,300.00

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed changes:

From 1 July 2017 the hexavalent vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

Infanrix-Hexa would have Sole Supply Status in both the community and DHB hospital settings for the hexavalent vaccine from 1 July 2017 until 30 June 2020.

Adult diphtheria and tetanus vaccine

PHARMAC is seeking feedback on a proposal to amend the listing relating to the adult diphtheria and tetanus (Td) vaccine as a result of a provisional agreement with Seqirus.

This proposal would result in ADT Booster remaining as the only listed Td vaccine.

Details of the proposal

PHARMAC proposes that from 1 July 2017 ADT Booster would remain listed on the National Immunisation Schedule.

Chemical	Presentation	Brand	Pack size	Subsidy	Manufacturer's price (ex GST)
Adult diphtheria and tetanus	Injection 2 IU diphtheria toxoid with 20 IU tetanus toxoid in 0.5 ml	ADT Booster	5	$0.00	$84.85

A confidential discount would apply, reducing the net price of the product to the Funder.

Proposed Changes

From 1 July 2017 adult diphtheria and tetanus vaccine would be listed with no change to the current funding restrictions in Section I or Part II Section H of the Pharmaceutical Schedule.

ADT Booster would have Sole Supply Status in both the community and DHB hospital settings for Td vaccine from 1 July 2017 until 30 June 2020.

Annex A – Current and Proposed Funding Criteria

The following funding criteria would apply (amendments/additions are shown in bold and deletions in strike through):

Adult diphtheria and tetanus vaccine – ADT Booster

Any of the following:

1. For vaccination of patients aged 45 and 65 years old; or
2. For vaccination of previously unimmunised or partially immunised patients; or
3. For revaccination following immunosuppression; or
4. For boosting of patients with tetanus-prone wounds; or
5. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus and acellular pertussis vaccine – Boostrix

Funded for any of the following criteria:

1. A single vaccine for pregnant woman between gestational weeks 28 and 38; or
2. A course of up to four vaccines is funded for children from age 7 up to the age of 18 years inclusive to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post haematopoietic stem cell transplantation or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens.

Notes: Tdap is not registered for patients aged less than 10 years. Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis and inactivated polio vaccine – Infanrix IPV

Funded for any of the following:

1. A single dose for children up to the age of 7 who have completed primary immunisation; or
2. A course of four vaccines is funded for catch up programmes for children (to the age of 10 years) to complete full primary immunisation; or
3. An additional four doses (as appropriate) are funded for (re-)immunisation for patients post HSCT, or chemotherapy; pre- or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or
4. Five doses will be funded for children requiring solid organ transplantation.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Diphtheria, tetanus, acellular pertussis, inactivated polio, *Haemophilus influenzae* type B and hepatitis B vaccine – Infanrix Hexa

Funded for patients meeting any of the following criteria:

1. Up to four doses for children up to and under the age of 10 for primary immunisation; or

2. An additional four doses (as appropriate) are funded for (re-)immunisation for children up to and under the age of 10 who are patients post haematopoietic stem cell transplantation, or chemotherapy; pre or post splenectomy; pre- or post solid organ transplant, renal dialysis and other severely immunosuppressive regimens; or

3. Up to five doses for children up to and under the age of 10 receiving solid organ transplantation

Note: A course of up-to four vaccines is funded for catch up programmes for children (up to and under the age of 10 years) to complete full primary immunisation. Please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes.

Haemophilus influenzae type B vaccine – Hiberix

One dose for patients meeting any of the following:

1. For primary vaccination in children; or

2. An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens; or

3. For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.

Human papillomavirus vaccine – Gardasil 9

1. **Maximum of two doses for males and females aged 14 years and under; or**

2. Maximum of three doses for patient**s** meeting any of the following criteria:

    i. **Male and** female**s patients** ~~aged under 20 years old~~ **26 years and under**; or

    ~~Patients aged under 26 years old with confirmed HIV infection; or~~

    ii. For use in transplant (including stem cell) patients; or

    iii. An additional dose for patients under 26 years of age post chemotherapy.

The criteria proposed above assume market approval of the Gardasil 9 two dose schedule prior to listing on the Pharmaceutical Schedule.

Measles, mumps and rubella vaccine – Priorix

A maximum of two doses for any patient meeting the following criteria:

1. For primary vaccination in children; or

2. For revaccination following immunosuppression; or

3. For any individual susceptible to measles, mumps or rubella; or

4. A maximum of three doses for children who have had their first dose prior to 12 months.

Note: Please refer to the Immunisation Handbook for appropriate schedule for catch up programmes.

Pneumococcal (PCV10) vaccine – Synflorix

Any of the following:

1. **A primary course of four doses for previously unvaccinated individuals up to the age of 59 months inclusive; or**

2. **Up to three doses as appropriate to complete the primary course of immunisation for individuals under the age of 59 months who have received one to three doses of PCV13; or**

3. **For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician.**

Note: please refer to the Immunisation Handbook for the appropriate schedule for catch up programmes

Rotavirus vaccine – Rotarix

Maximum of three two doses for patients meeting the following:

1. First dose to be administered in infants aged under ~~15~~ **14** weeks of age; and

2. no vaccination being administered to children aged ~~8 months~~ **24 weeks** or over.

Varicella vaccine – Varilrix

1. **One dose for primary vaccination for:**

   i. **Children at 15 months; or**

   ii. **For previously unvaccinated children at 11 years old, who have not previously had a varicella infection (chickenpox).**

2. Maximum of two doses for any of the following:

   i. For non-immune patients:

      (a) with chronic liver disease who may in future be candidates for transplantation; or
      (b) with deteriorating renal function before transplantation; or
      (c) prior to solid organ transplant; or
      (d) prior to any elective immunosuppression*.

   ii. For patients at least 2 years after bone marrow transplantation, on advice of their specialist.

   iii. For patients at least 6 months after completion of chemotherapy, on advice of their specialist.

   iv. For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist.

   v. For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella.

   vi. For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

   vii. For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella.

      * immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 26 July 2016 3:01 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; Cody Frewin (cody.frewin@poutiniwaiora.co.nz); 'Fiona Croft'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers and Agenda for Thursdays IAG meeting
Attachments: 28 July 2016 IAG draft agenda.docx; July data report.docx; July Workplan update.docx; 9 June 2016 IAG draft agenda.docx; 10March2016IAGMinutes.docx

Hi all

Please find attached the papers for our meeting on Thursday. Please let me know if you are unable to attend.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 28 July 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (9 June and 10 March 2016)	Cheryl Brunton	Draft MinutesJune2016 IA 10March2016IAGMinutes.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Bridget Pauline/Cheryl/Betty Janet Bridget	July Workplan update.docx July data report.docx
6	Measles update	Cheryl	
7	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Share regular Flu Coverage Data with IAG	Bridget	On going
DHB Staff Clinic messages	Cheryl to follow up with Mark	
Measles message – Cheryl to follow up if nothing comes out nationally	Cheryl	
Proposed Immunisation Schedule changes – draft response to PHARMAC	Bridget and Cheryl	20 June 2016

HPV Planning 2017 – form working group	Bridget, Janet, Cheryl H and Pauline	260
Planning for wider Immunisation Schedule changes – form working group	Bridget, Janet, Pauline, Betty	

Membership:

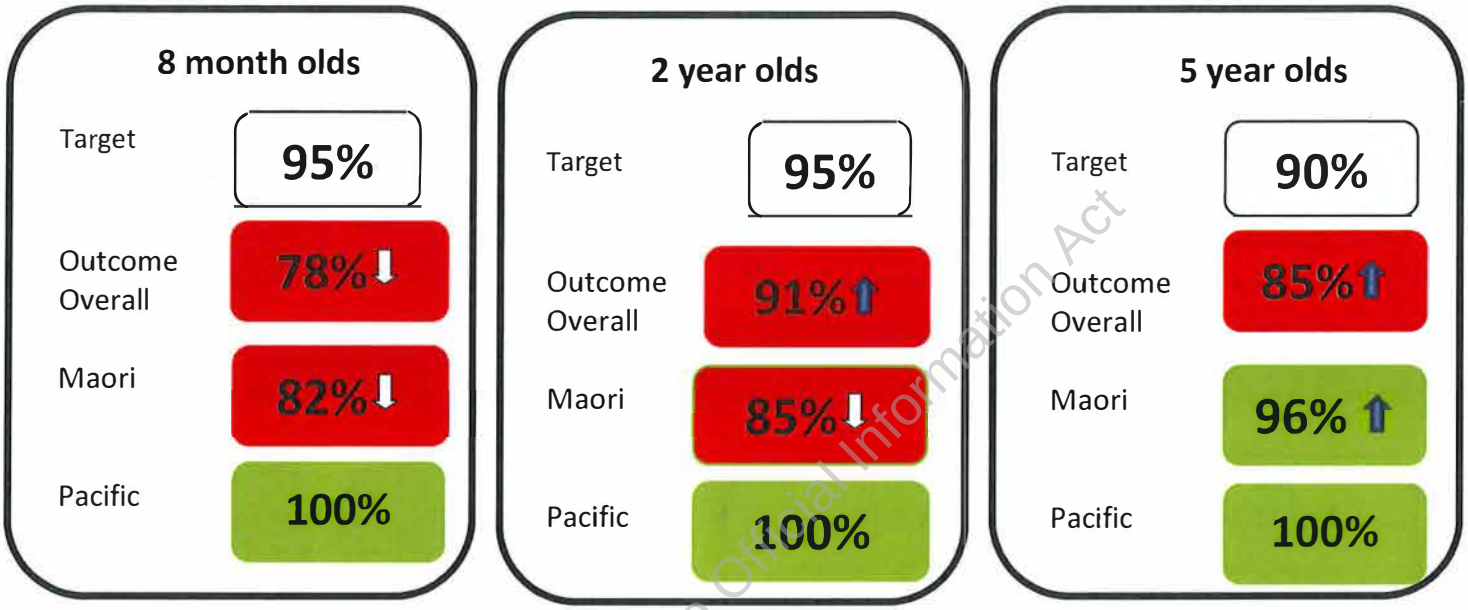
Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Cody Frewin	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 22 July 16

Fully Immunised 8 month olds – DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress including pending	Q2 2016/17 Progress including pending
89% fully	78% fully	74% fully	72%% fully
0% overdue	0 % overdue	4% overdue	13% overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Progress	Q1 2016/17 Progress	Q2 2016/17 Progress
79% fully	91% fully	90% fully	91% fully
0% overdue	0% overdue	0% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
86% fully	85% fully	84% fully	84% fully
0% overdue	%overdue	2% overdue	1% overdue

Q4 2015/16

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	97	67	69. %	54	46	85. %	19	14	74. %	1	1	100. %	4	3	75. %	19	3	16. %	15 (0)	15.5 (0.0) %	7	7.2 %
8 Month	101	79	78. %	53	51	96. %	17	14	82. %	1	1	100. %	7	7	100. %	23	6	26. %	16 (0)	15.8 (0.0) %	6	5.9 %
12 Month	80	73	91. %	48	48	100. %	15	15	100. %	2	2	100. %	4	4	100. %	11	4	36. %	7 (0)	8.8 (0.0) %	0	0 %
18 Month	71	60	85. %	39	38	97. %	21	17	81. %	1	1	100. %	2	2	100. %	8	2	25. %	6 (0)	8.5 (0.0) %	2	2.8 %
24 Month	89	81	91. %	50	49	98. %	20	17	85. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.5 (0.0) %	4	4.5 %
5 Year	93	79	85. %	47	43	91. %	23	22	96. %	1	1	100. %	4	4	100. %	18	9	50. %	9 (0)	9.7 (0.0) %	5	5.4 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	97	67	69. %	2	2	100. %	22	18	82. %	19	14	74. %	19	15	79. %	31	14	45. %	4	4	100. %
8 Month	101	79	78. %	5	5	100. %	17	15	88. %	15	13	87. %	21	19	90. %	36	20	56. %	7	7	100. %
12 Month	80	73	91. %	13	13	100. %	13	13	100. %	9	9	100. %	24	24	100. %	17	10	59. %	4	4	100. %
18 Month	71	60	85. %	6	6	100. %	12	11	92. %	16	16	100. %	22	19	86. %	13	6	46. %	2	2	100. %
24 Month	89	81	91. %	9	9	100. %	22	22	100. %	19	19	100. %	22	20	91. %	14	8	57. %	3	3	100. %
5 Year	93	79	85. %	7	7	100. %	17	14	82. %	15	13	87. %	26	26	100. %	26	17	65. %	2	2	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2002	HPV-1 Quadrivalent	19	3		68	90	30	0	0	150	190	63%	-%	-%	45%	47%	4 (2.1%)	0 (0.0%)
	HPV-2 Quadrivalent	18	3	0	66	87						60%	-%	-%	44%	46%	3 (1.6%)	
	HPV-3 Quadrivalent	14	3	0	64	81						47%	-%	-%	43%	43%	3 (1.6%)	
2003	HPV-1 Quadrivalent	9	3	3	61	76	30	0	5	140	180	30%	-%	60%	44%	42%	2 (1.1%)	0 (0.0%)
	HPV-2 Quadrivalent	6	0	0	26	32						20%	-%	0%	19%	18%	1 (0.6%)	
	HPV-3 Quadrivalent	3	0	0	17	20						10%	-%	0%	12%	11%	1 (0.6%)	
2004	HPV-1 Quadrivalent	5	0		13	18	30	0	0	130	160	17%	-%	-%	10%	11%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	2	0	0	3	5						7%	-%	-%	2%	3%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	33	6	3	142	184	90	0	5	420	530	37%	-%	-%	34%	35%	7 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	26	3	0	95	124						29%	-%	-%	23%	23%	4 (0.8%)	
	HPV-3 Quadrivalent	17	3	0	81	101						19%	-%	-%	19%	19%	4 (0.8%)	

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	For all new-borns an Enrolment Form is completed and sent to NIR. There is a QIP underway which is looking at how to improve linkages with children born in Christchurch Women's to ensure that there information is shared with WC NIR. Q3 data shows that 93.2% of new-borns were enrolled. Q4 data is not yet available
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Coverage was 78% of 8month olds 91% of 2 year olds and 85% of 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	• 70% of Girls have received dose 3	Currently sitting on 42% for Dose 1.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Currently tracking at 54% for 65s and over. This figure has not been updated.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. • Narrative report on interagency activities completed to promote Immunisation Week.	Yes Not yet completed Yes.

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

MINUTES – THURSDAY 10 March 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Bridget Lester, Janet Hogan, Catherine Andrews, Anna Wall and Sharyn Kenning	
Apologies:	Catherine Crichton, Lee Harris, Pauline Ansley, Joanne Shaw	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair.	
2. Minutes of last meeting	Minutes of 28 January meeting were approved.	
3. Matters Arising	Pharmacy vaccinating – this has been approved to progress. 2016/17 Workplan – updated and sent to P&F Immunisation Week Plan – completed and sent to MoH.	
4. Standing Items	**Report on KPIs** • No further updated from last month. **Work plan** **Seasonal Influenza** • Vaccine is now available. Letters are to be drafted to GPT, Pharmacy, LMC and Older Person Health services to be distributed. Some badges have been developed which will be distrusted into the community and given to staff when vaccinated. • Betty is going to be vaccinating to AgFest. This programme is being funded by the WCPHO and has been approved. • Work is underway with the two community pharmacies which will be offering the subsidised vaccine. We need to liaise with Lee around how to promote this. **HPV –** Programme to start in T2. Information has been included in school newsletters. **Pregnancy immunisation**- Resources have been distributed. A LMC specific Toolkit is also being developed, with key messages around Opting off and Declines. **Well Child App** – discussion around this and how it could be used on the West Coast. Members to download app and have a look.	
Immunisation Week	Need to keep this on our radar, and arrange a meeting to progress maters.	Bridget to complete and share
Next Meeting	Thursday 9 June 2016 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 28 July, 8 September, 27 October, 1 December	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Monday, 29 August 2016 1:09 p.m.
To: Cheryl Brunton
Cc: Betty Gilsenan
Subject: 8th Sept IAG
Attachments: 8 Sept 2016 IAG draft agenda.docx

Hi Cheryl

I am on leave from Friday for two weeks, not back until the 19th September, so I will not be attending the 8th Sept IAG. I will get the draft agenda and papers to you by tomorrow though.

Betty and Anna are also not able to attend as they will be at the IMAC Imms Workshop.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Princess Margaret Hospital
Cashmere Road
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION
ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 8 August 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (9 June and 10 March 2016)	Cheryl Brunton	Draft Minutes 28 July IAG.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Cheryl Pauline Janet	Sept Workplan update.docx Sept data report.docx
7	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV Workplan, 2017 schedule changes	Janet and Bridget	On going

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Cody Frewin	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

MINUTES – THURSDAY 28 July 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Joanne Shaw, Bridget Lester, Pauline Ansley, Janet Hogan, Anna Wall and Hilary	
Apologies:	Catherine Crichton, , Catherine Andrew, Lee Harris, Nikki Mason, Cody Frewin and Sharyn Kenning	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting	Minutes of March and June meetings were approved.	
3. Matters Arising	No matters were arising from the last meeting. Sharing of Regular Flu Coverage Reports – ongoing DHB Staff Clinic – Cheryl followed up with Mark Measles – information to be shared later in the meeting PHARMAC proposed schedule changes, response – completed.	
4. Standing Items	**Report on KPIs and Action Plan** • Q4 = 78% 8 Month olds and 91% 2 year olds. 5 year olds at 85%. However we had reached all possible 8month and 2year olds. • There appears to be some Maori Children in the Opt off group. July Workplan update.docx Updated work plan attached.	
Seasonal Influenza	**Primary Care** -This shows WC at 54% for 65 and overs. This currently is the national average. **DHB Staff coverage** – there is positive increases in staff coverage, but there is a concern that messages around clinics are not getting out within the DHB system. We need the key message round "it's now available at"	

Staff	2015	2016
Nurses	43%	67%
Doctors	76%	95%
LMC	56%	67%
Allied Health	38%	65%

	Others 71% 88% **Rates -** Very low national rates of Influenza cases. Not much activity yet. There appears to be a breakthrough in the H3 strain in Canterbury. This year surveillance is being led by SHIVERS. There is concerns around lack of engagement tin this national programme and therefore this is resulting in under reporting.	
Pregnancy Vaccinations	Pertussis continues to be active in the community. We need to get our messaging right between normal vs outbreak. There is a concern around high levels of testing and screening. There is a lot of children with coughs around at present.	
Measles	**89** confirmed in NZ, two new ones last week.	
HPV	PHARMAC have announced the change in the HPV for 2017. Eligibility extended to include boys, change in vaccine to 9 strain and a move to two doses, 6 months apart. This will include in the school programme – with the need to now target boys, and the reduction on number of visits to schools. WC plan • Offer to boys in Year 8 at the same time as girls. • There is no need to link with new schools. • Get GPT to promote the change at the 11year old events and then get GPT to recall boys ages 13 – 26 for catch-up. • Need to draft letter to parents for boys to go out in Oct/Nov.	*Janet and Bridget*
Schedule Changes	These have been approved by PHARMAC. Need to start looking at what needs to occur to implement these from 1 July 2017.	
Next Meeting	Thursday 8 September 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 27 October 1 December	

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

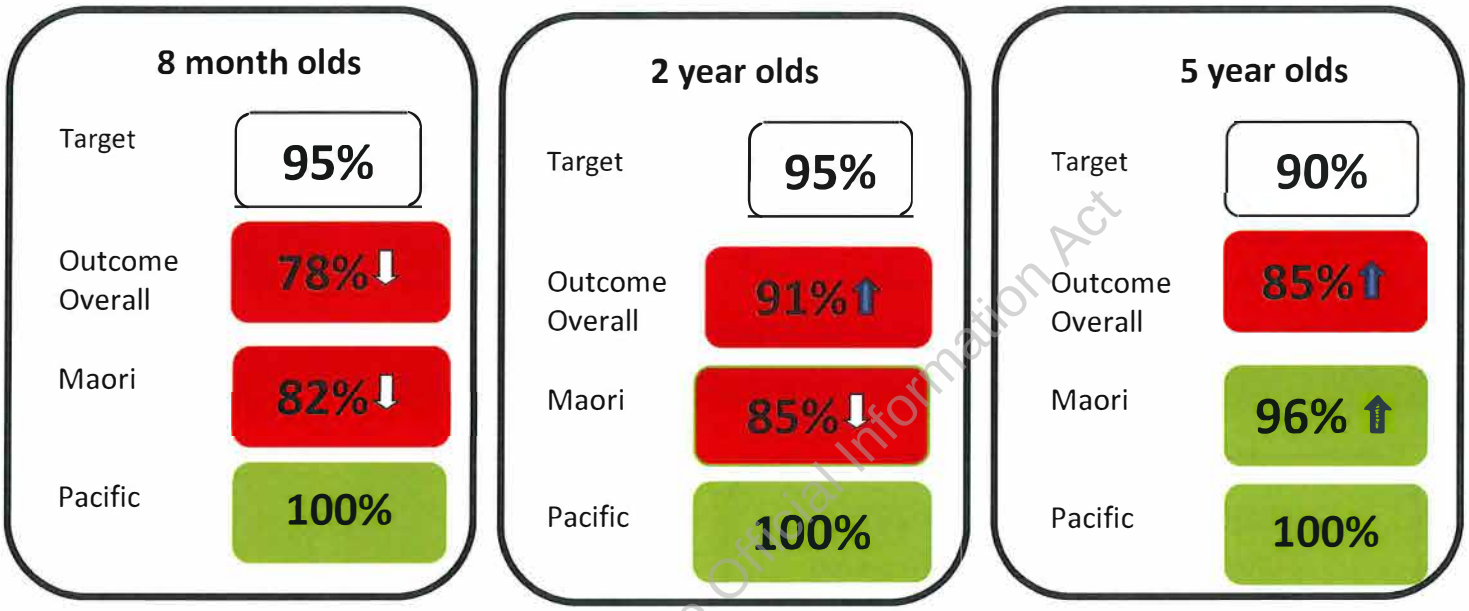
Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	For all new-borns an Enrolment Form is completed and sent to NIR. There is a QIP underway which is looking at how to improve linkages with children born in Christchurch Women's to ensure that there information is shared with WC NIR. Q3 data shows that 93.2% of new-borns were enrolled. Q4 data is not yet available
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Coverage was 78% of 8month olds 91% of 2 year olds and 85% of 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	Currently sitting on 42% for Dose 1.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Currently tracking at 54% for 65s and over. This figure has not been updated.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Not yet completed Yes.

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2015/16



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 August 16

Fully Immunised 8 month olds – DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress including pending	Q2 2016/17 Progress including pending
89% fully	78% fully	76% fully	79% fully
0% overdue	0 % overdue	1.2% overdue	6% overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Progress	Q1 2016/17 Progress	Q2 2016/17 Progress
79% fully	91% fully	90% fully	91% fully
0% overdue	0% overdue	0% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q3 2015/16 Actual	Q4 2015/16 Actual	Q1 2016/17 Progress	Q2 2016/17 Progress
86% fully	85% fully	84% fully	84% fully
0% overdue	%overdue	2% overdue	1% overdue

Q1 8months tracking by practice

Practice Name	Fully	Declined	On hold - with OIS	Overdue at Milestone age	vaccinated after milestone age	Grand Total
Buller Medical Centre	12	1				13
Greymouth Medical Centre	14	3				17
HariHari Rural Clinic	2					2
High Street Medical Centre (2005) Ltd	3					3
Reefton Medical Centre	2	1				3
Rural Academic General Practice	4					4
Westland Medical Centre	17	1		1	1	20
Whataroa Rural Clinic	2		1			3
Moana Rural Clinic	1					1
Fox Glacier Clinic	1					1
Coast Medical Consultancy Ltd	2					2
Grand Total	**60**	**6**	**1**	**1**	**1**	**69**

Q1 2year olds, tracking by practice

practice Name	Fully	Declined	Grand Total
Buller Medical Centre	21		21
Franz Joseph Clinic	5		5
Greymouth Medical Centre	18	1	19
High Street Medical Centre (2005) Ltd	9	1	10
Karamea Medical Centre	1		1
Reefton Medical Centre	4		4
Rural Academic General Practice	5		5
Westland Medical Centre	17		17
Whataroa Rural Clinic	1		1
Fox Glacier Clinic	2		2
Coast Medical Consultancy Ltd	4		4
South Westland - Haast	1		1
Redcliffs Medical Centre	1		1
Grand Total	**89**	**2**	**91**

Q2 8 month olds, tracking

Practice Name	fully	Declined	on hold - with OIS	overdue with GP	pending	Gone No address	Grand Total
Buller Medical Centre	9			1	8		18
Franz Joseph Clinic	1	1					2
Greymouth Medical Centre	8				4		12
High Street Medical Centre (2005) Ltd	6				3		9
Reefton Medical Centre	1		1	1	1	1	5
Rural Academic General Practice	1				3		4
Westland Medical Centre	7	1		2	5		15
Whataroa Rural Clinic					1		1
Moana Rural Clinic				1	1		2
Fox Glacier Clinic	1						1
Coast Medical Consultancy Ltd					3		3
South Westland - Haast	1						1
Aotea Health					1		1
Grand Total	**35**	**2**	**1**	**5**	**30**	**1**	**74**

Q2 2 year olds, tracking

Practice Name	Fully	Declined	overdue with GP	Grand Total
Buller Medical Centre	16			16
Franz Joseph Clinic	3			3
Greymouth Medical Centre	20			20
HariHari Rural Clinic	2			2
High Street Medical Centre (2005) Ltd	4			4
Reefton Medical Centre	4			4
Rural Academic General Practice	9		1	10
Westland Medical Centre	21	1		22
Moana Rural Clinic	1			1
Fox Glacier Clinic	1			1
Murchison Hospital & Health Centre	1			1
Coast Medical Consultancy Ltd	2			2
Mataura Medical Centre	1			1
Grand Total	**85**	**1**	**1**	**87**

Q4 2015/16

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	97	67	69. %	54	46	85. %	19	14	74. %	1	1	100. %	4	3	75. %	19	3	16. %	15 (0)	15.5 (0.0) %	7	7.2 %
8 Month	101	79	78. %	53	51	96. %	17	14	82. %	1	1	100. %	7	7	100. %	23	6	26. %	16 (0)	15.8 (0.0) %	6	5.9 %
12 Month	80	73	91. %	48	48	100. %	15	15	100. %	2	2	100. %	4	4	100. %	11	4	36. %	7 (0)	8.8 (0.0) %	0	0 %
18 Month	71	60	85. %	39	38	97. %	21	17	81. %	1	1	100. %	2	2	100. %	8	2	25. %	6 (0)	8.5 (0.0) %	2	2.8 %
24 Month	89	81	91. %	50	49	98. %	20	17	85. %	2	2	100. %	2	2	100. %	15	11	73. %	4 (0)	4.5 (0.0) %	4	4.5 %
5 Year	93	79	85. %	47	43	91. %	23	22	96. %	1	1	100. %	4	4	100. %	18	9	50. %	9 (0)	9.7 (0.0) %	5	5.4 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	97	67	69. %	2	2	100. %	22	18	82. %	19	14	74. %	19	15	79. %	31	14	45. %	4	4	100. %
8 Month	101	79	78. %	5	5	100. %	17	15	88. %	15	13	87. %	21	19	90. %	36	20	56. %	7	7	100. %
12 Month	80	73	91. %	13	13	100. %	13	13	100. %	9	9	100. %	24	24	100. %	17	10	59. %	4	4	100. %
18 Month	71	60	85. %	6	6	100. %	12	11	92. %	16	16	100. %	22	19	86. %	13	6	46. %	2	2	100. %
24 Month	89	81	91. %	9	9	100. %	22	22	100. %	19	19	100. %	22	20	91. %	14	8	57. %	3	3	100. %
5 Year	93	79	85. %	7	7	100. %	17	14	82. %	15	13	87. %	26	26	100. %	26	17	65. %	2	2	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2002	HPV-1 Quadrivalent	19	3		68	90	30	0	0	150	190	63%	-%	-%	45%	47%	4 (2.1%)	0 (0.0%)
	HPV-2 Quadrivalent	18	3	0	66	87						60%	-%	-%	44%	46%	3 (1.6%)	
	HPV-3 Quadrivalent	14	3	0	64	81						47%	-%	-%	43%	43%	3 (1.6%)	
2003	HPV-1 Quadrivalent	9	3	3	61	76	30	0	5	140	180	30%	-%	60%	44%	42%	2 (1.1%)	0 (0.0%)
	HPV-2 Quadrivalent	6	0	0	26	32						20%	-%	0%	19%	18%	1 (0.6%)	
	HPV-3 Quadrivalent	3	0	0	17	20						10%	-%	0%	12%	11%	1 (0.6%)	
2004	HPV-1 Quadrivalent	5	0		13	18	30	0	0	130	160	17%	-%	-%	10%	11%	1 (0.6%)	0 (0.0%)
	HPV-2 Quadrivalent	2	0	0	3	5						7%	-%	-%	2%	3%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	-%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	33	6	3	142	184	90	0	5	420	530	37%	-%	-%	34%	35%	7 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	26	3	0	95	124						29%	-%	-%	23%	23%	4 (0.8%)	
	HPV-3 Quadrivalent	17	3	0	81	101						19%	-%	-%	19%	19%	4 (0.8%)	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 25 October 2016 3:10 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; Cody Frewin (cody.frewin@poutiniwaiora.co.nz); 'Fiona Croft'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Thursdays Immunisation Advisory Group meeting
Attachments: 27 Oct 2016 IAG draft agenda.docx; Coverage Trend Graphs_9 Oct 2016_Final.xls; OCT data report.docx; oct Workplan update.docx; Draft Minutes 28 July IAG.docx

Hi all

Please find attached the papers for our meeting on Thursday. Please let me know if you can't attend.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM – Supporting you to be well

AGENDA

Thursday 27 October 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (28th July 2016)	Cheryl Brunton	Draft Minutes 28 July IAG.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting o Seasonal Influenza – update o HPV programme update o Pregnancy vaccinations	Cheryl Pauline Janet	OCT data report.docx oct Workplan update.docx Coverage Trend Graphs_9 Oct 2016_I
7	Any other business	Open	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV Work plan, 2017 schedule changes	Janet and Bridget	On going

Membership:

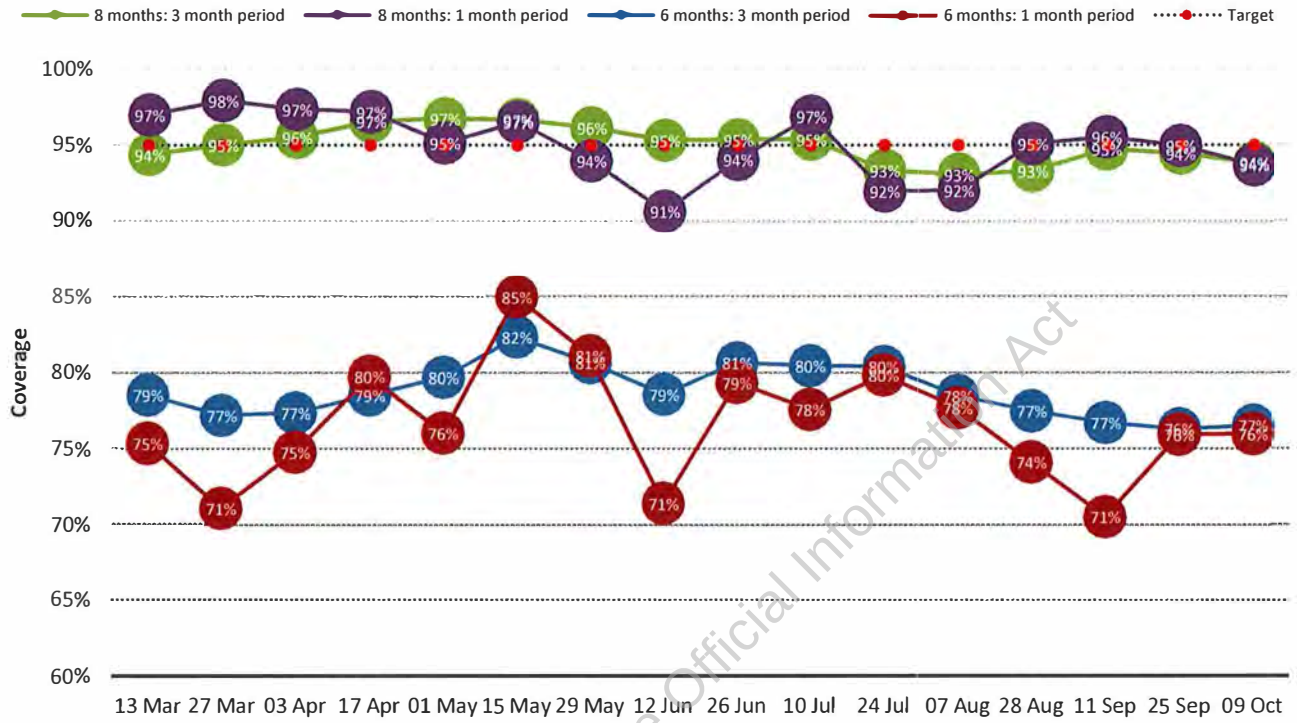
Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

Immunisation coverage of children at 6 months and 8 months - fortnightly update

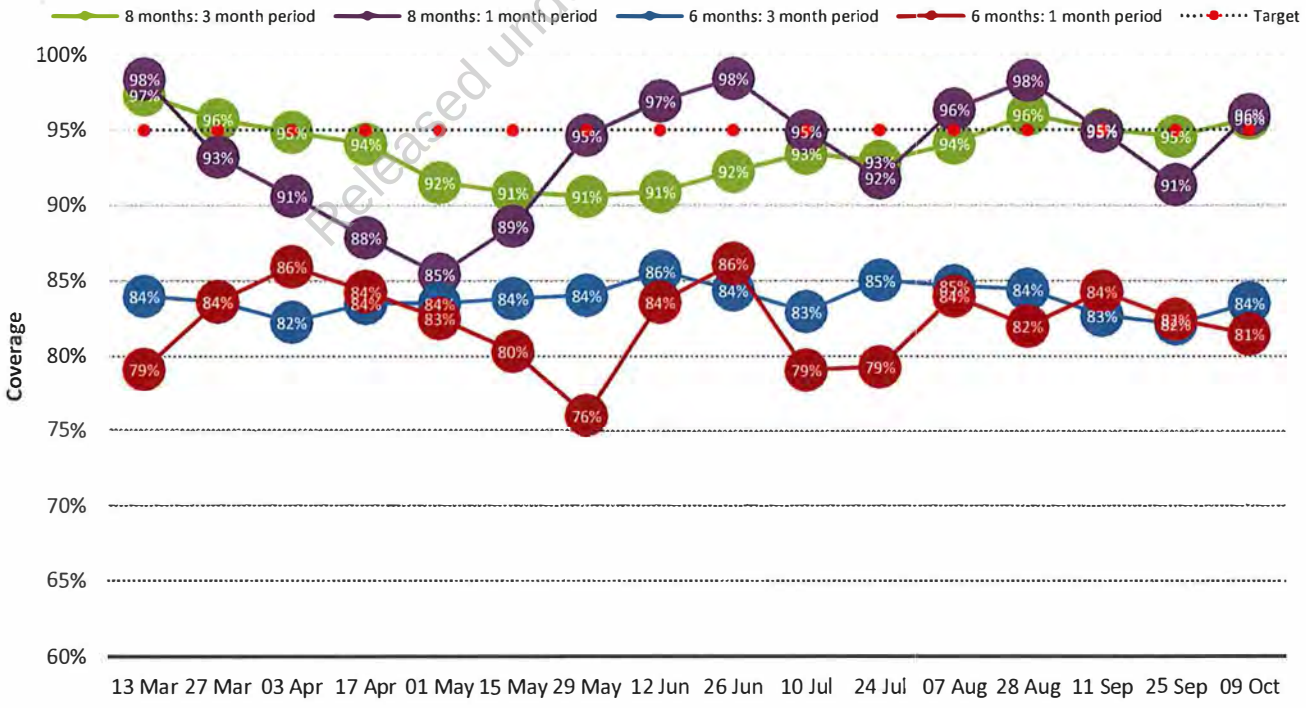
Source: National Immunisation Register Datamart coverage based on latest quarterly PHO enrolment register update

Alliance Health Plus Trust

Report run date: 12 October 2016

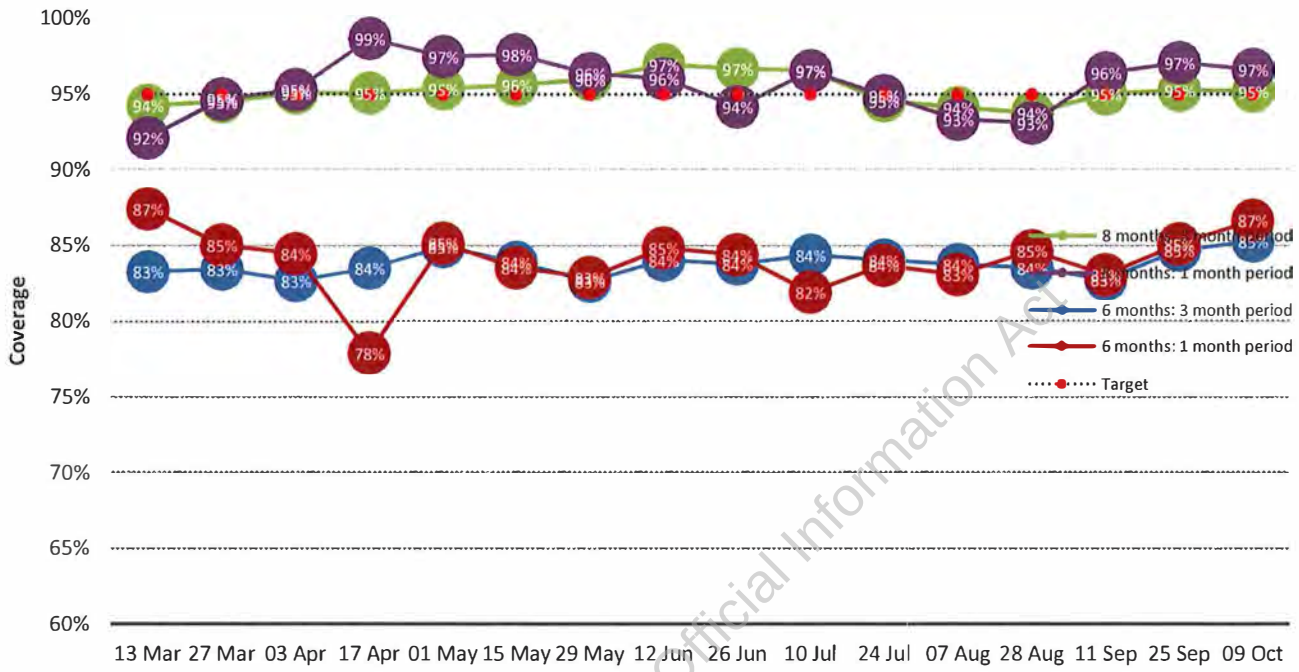


Auckland PHO Limited

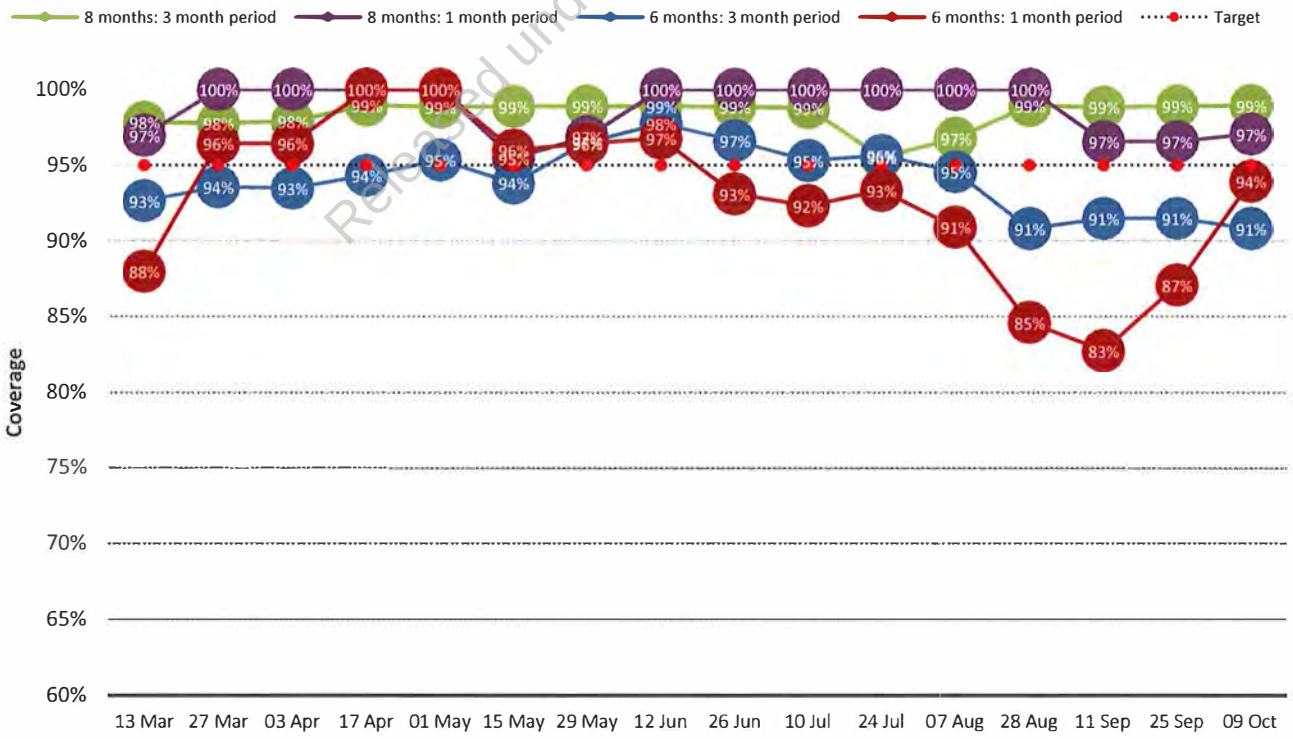


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Central Primary Health Organisation

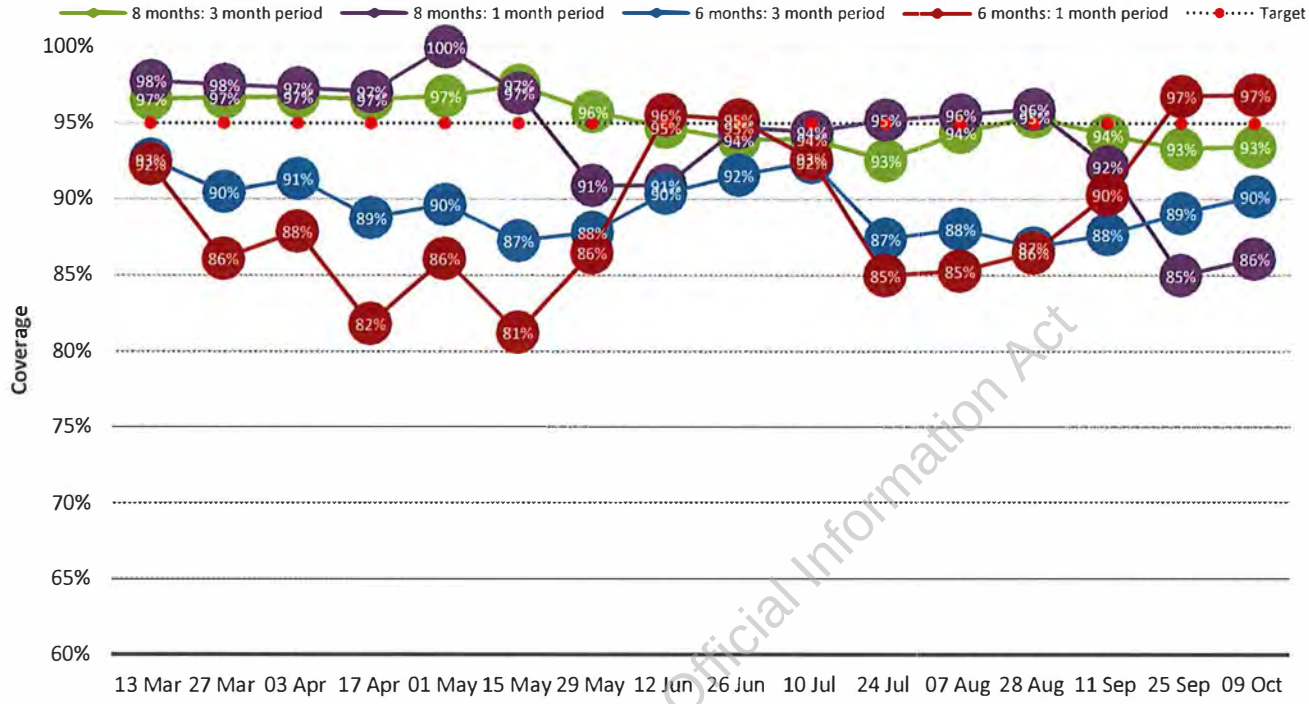


Christchurch PHO Limited

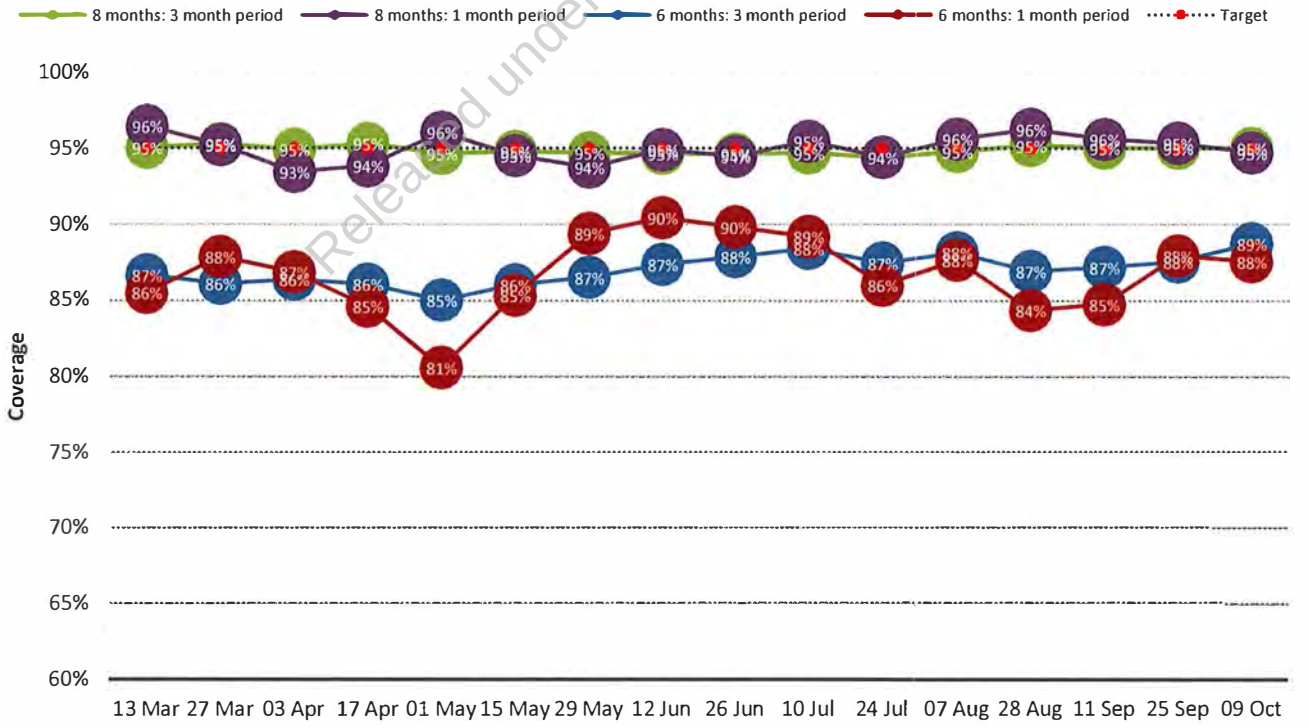


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Compass Health

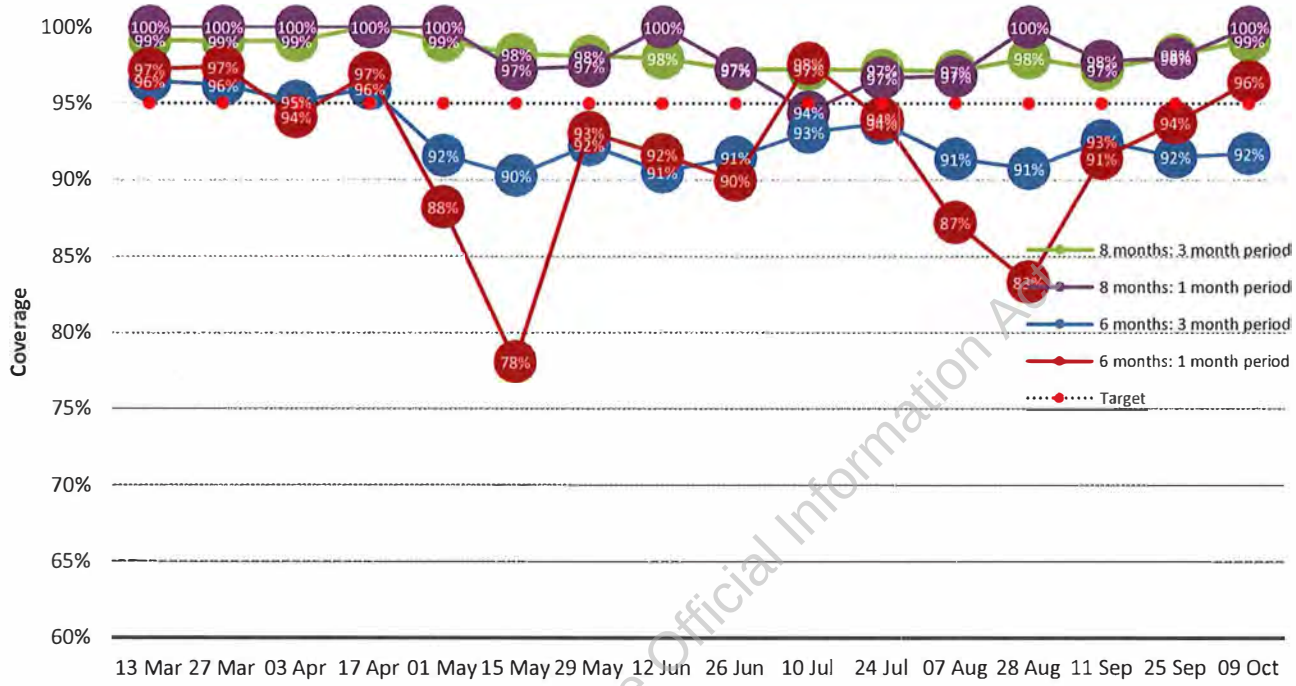


Compass Health - Capital and Coast

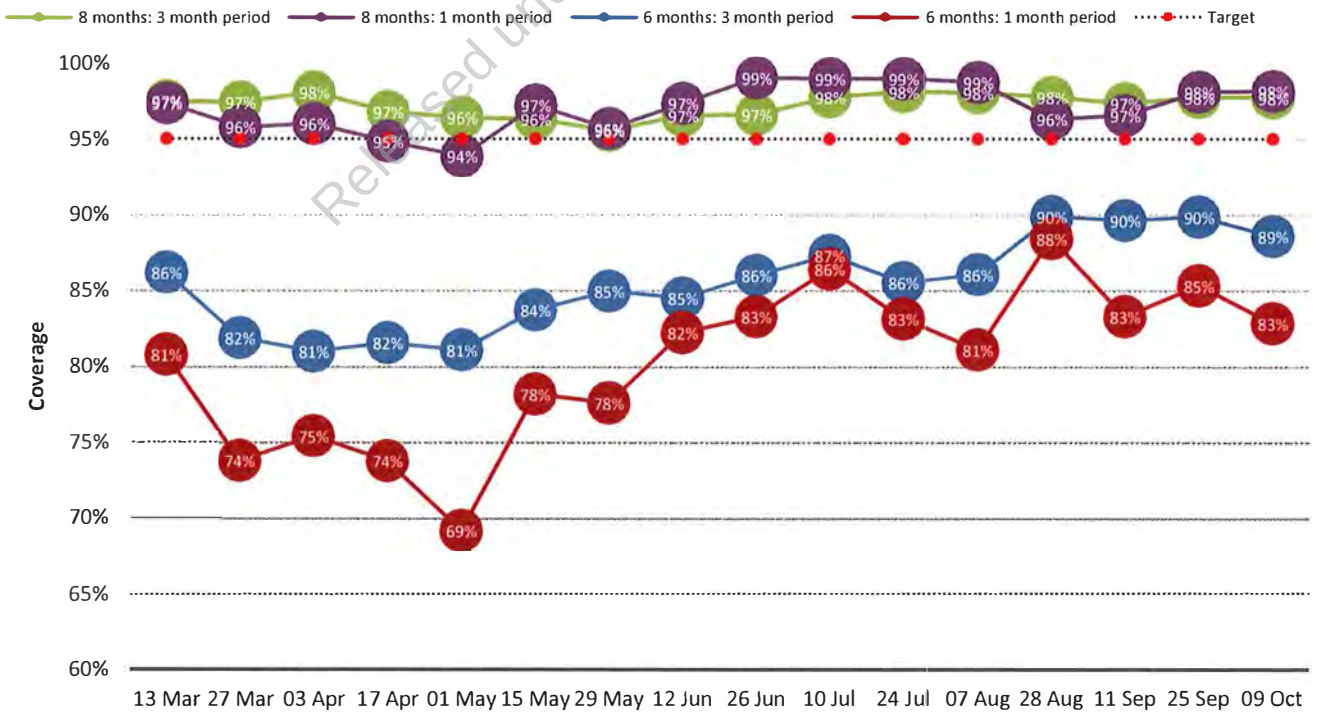


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Cosine Primary Care Network Trust

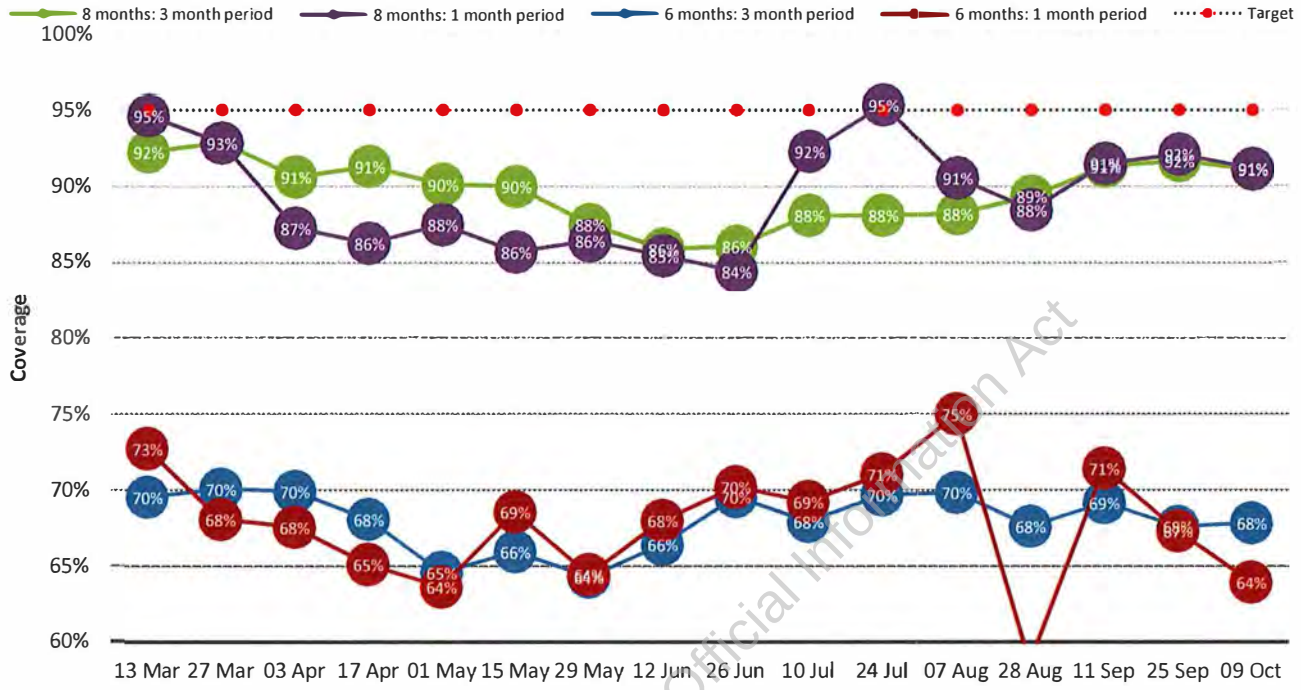


East Health Trust

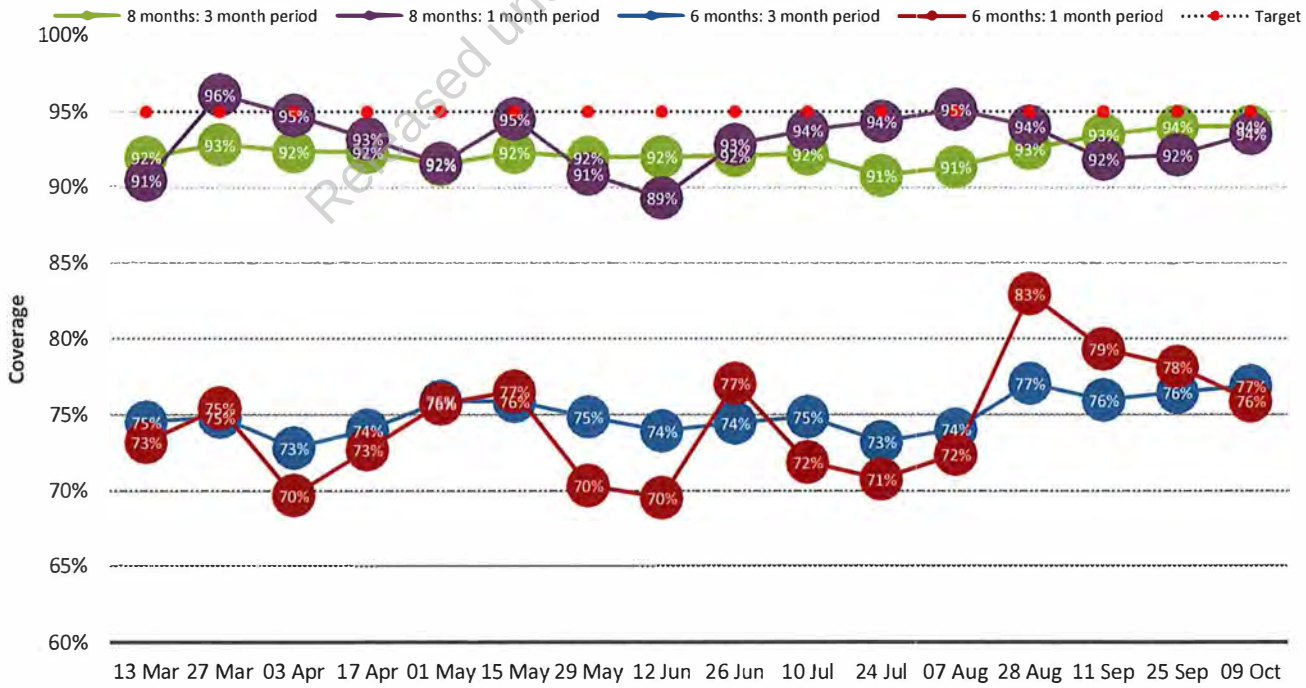


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Eastern Bay Primary Health Alliance

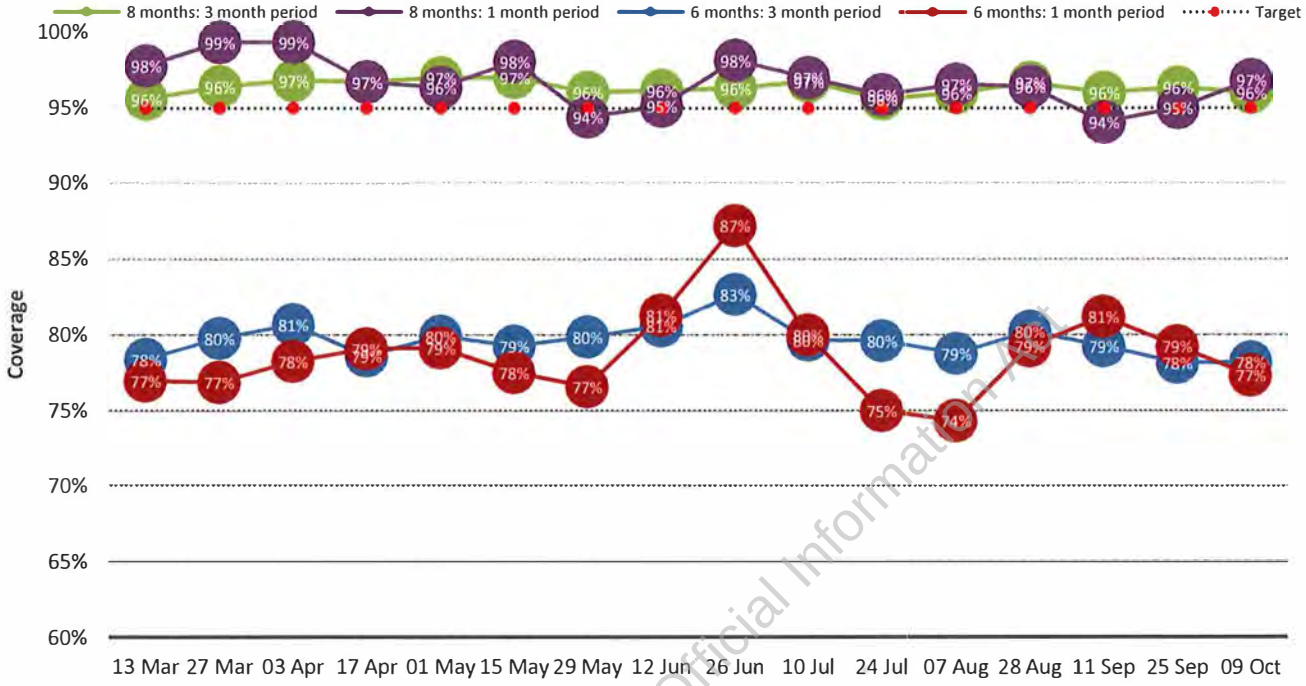


Hauraki PHO

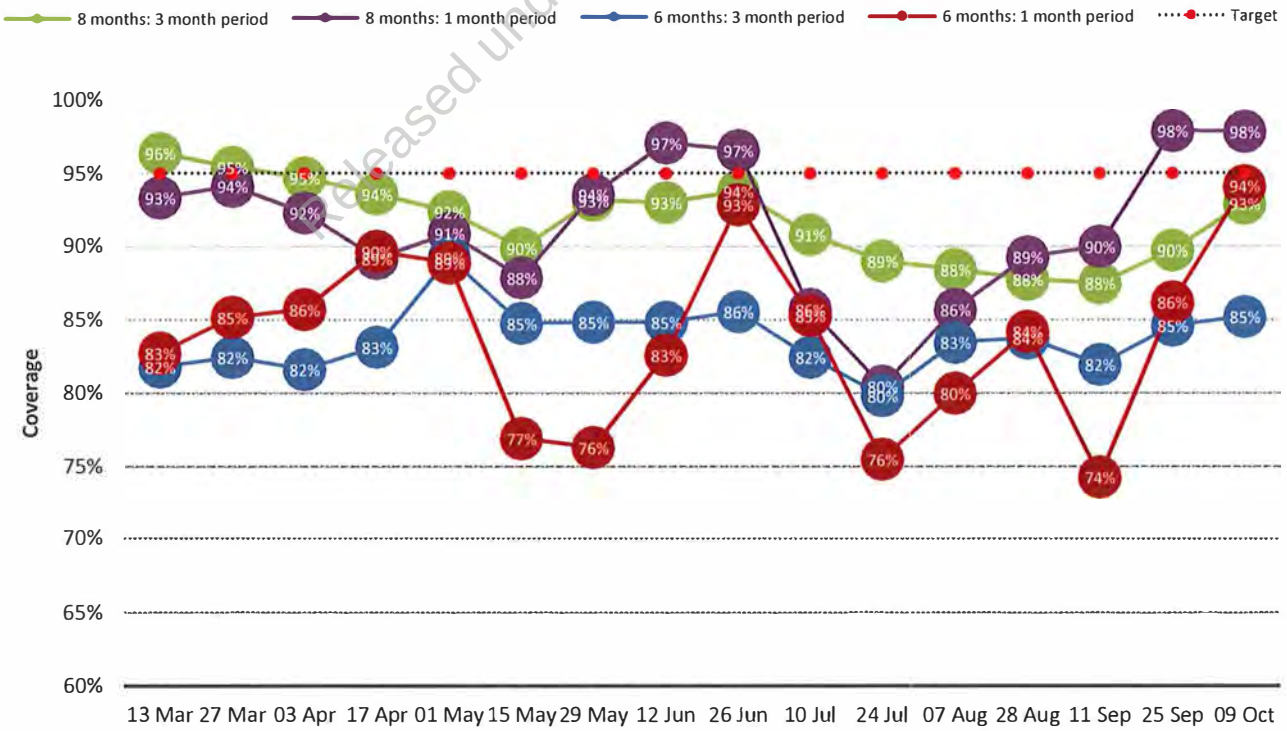


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Health Hawke's Bay Limited

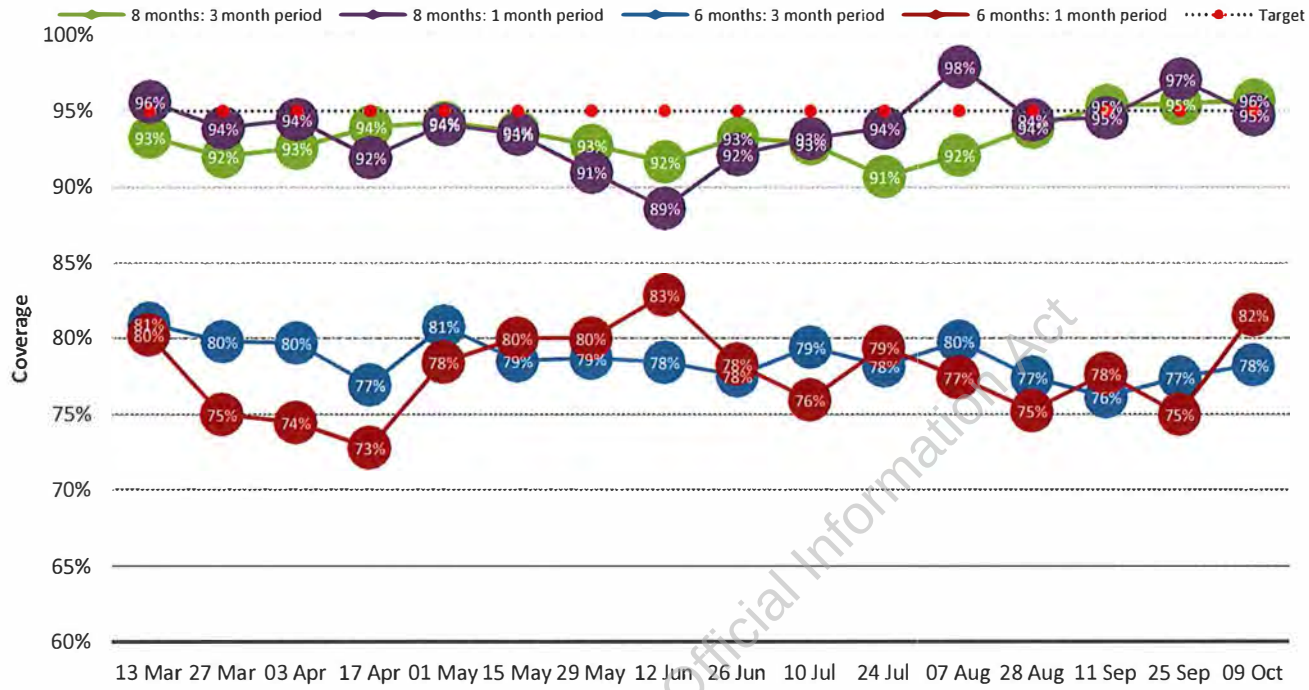


Kimi Hauora Wairau (Marlborough PHO Trust)

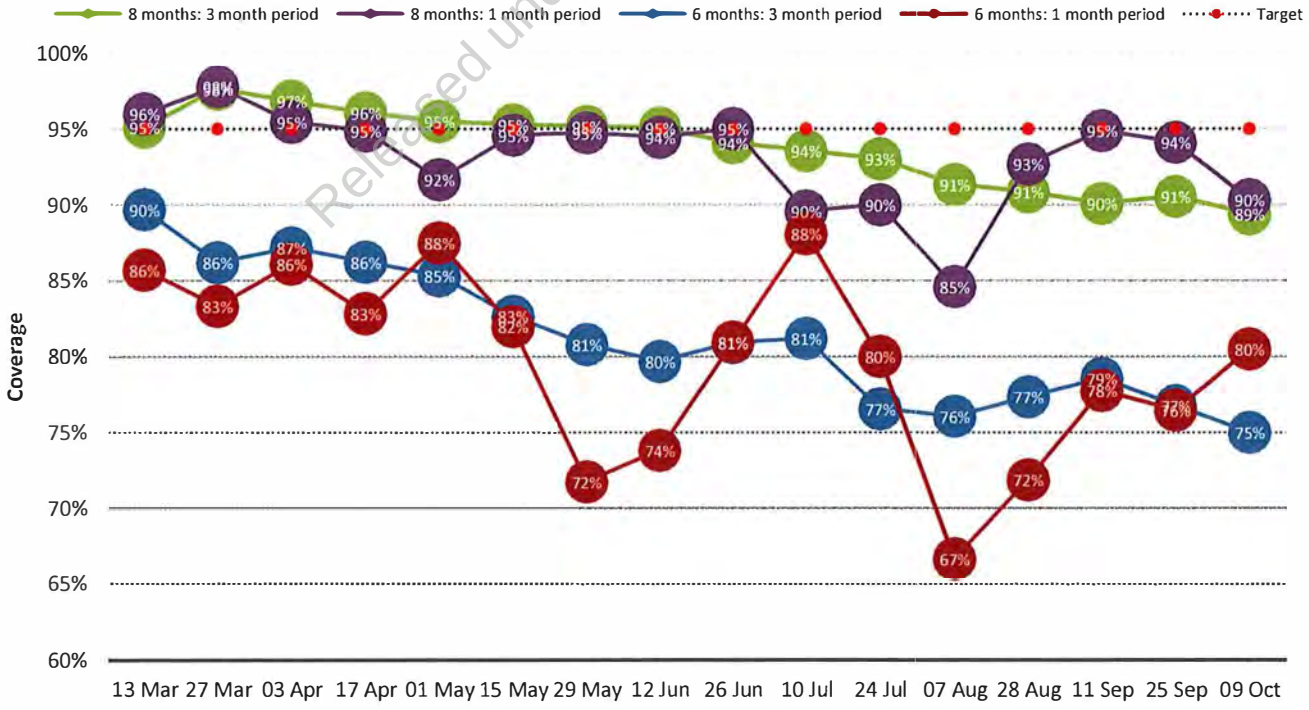


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Manaia Health PHO Limited

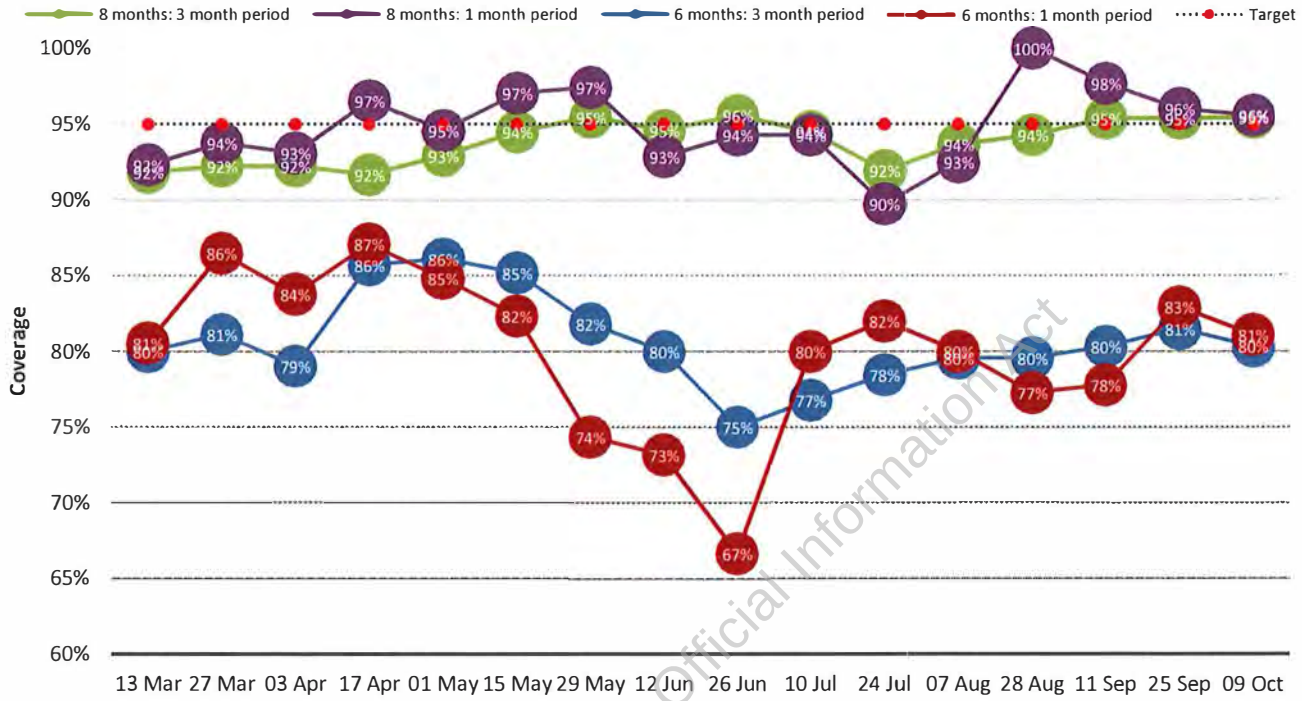


Midlands Health Network - Lakes



Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Midlands Health Network - Tairawhiti



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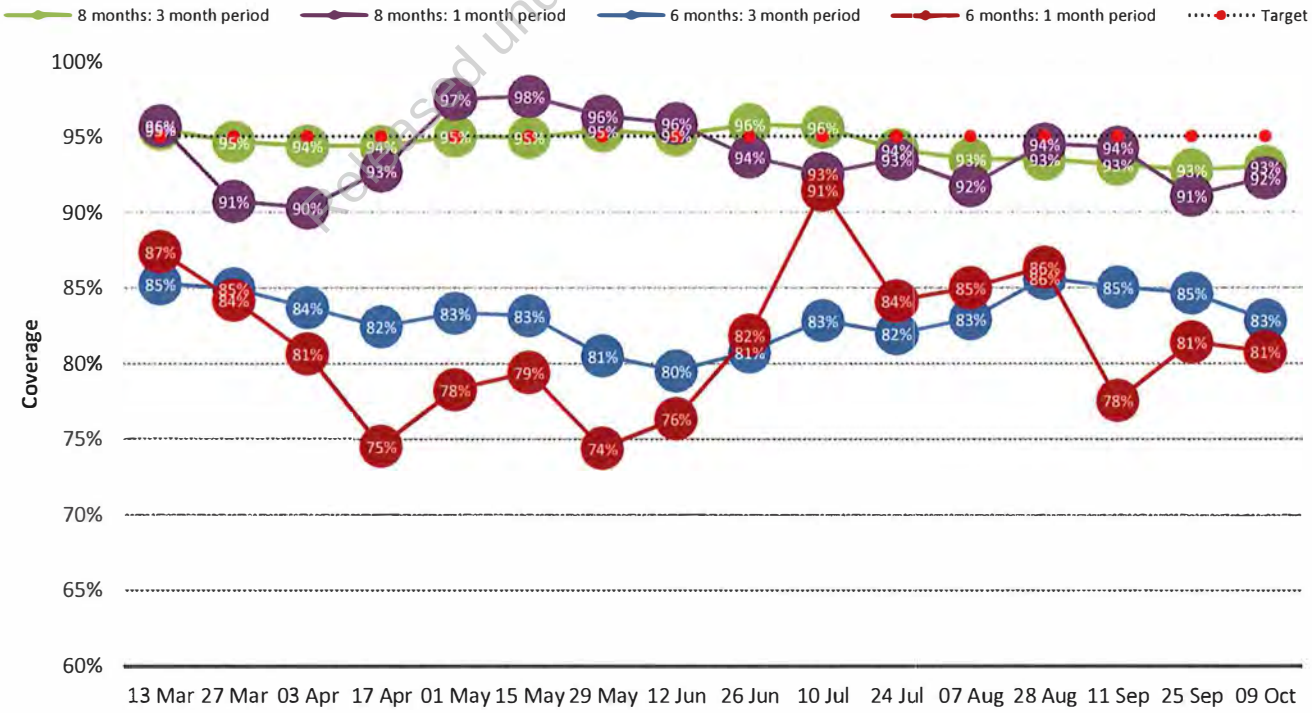
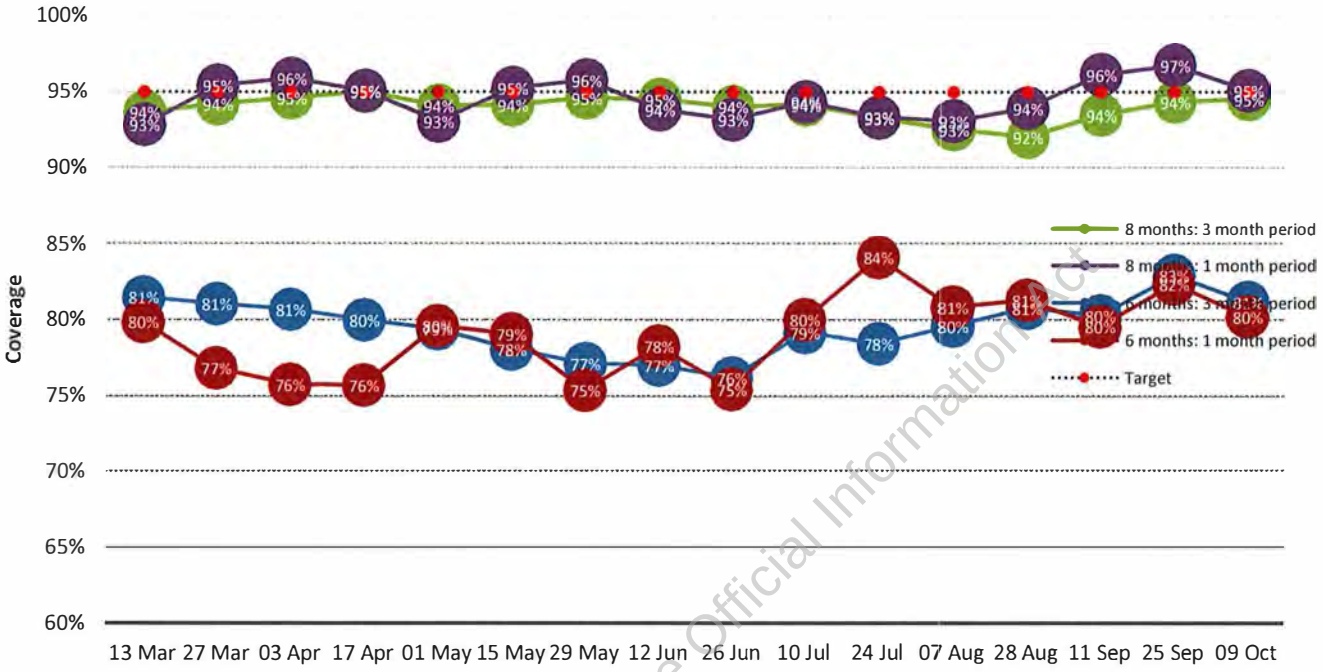
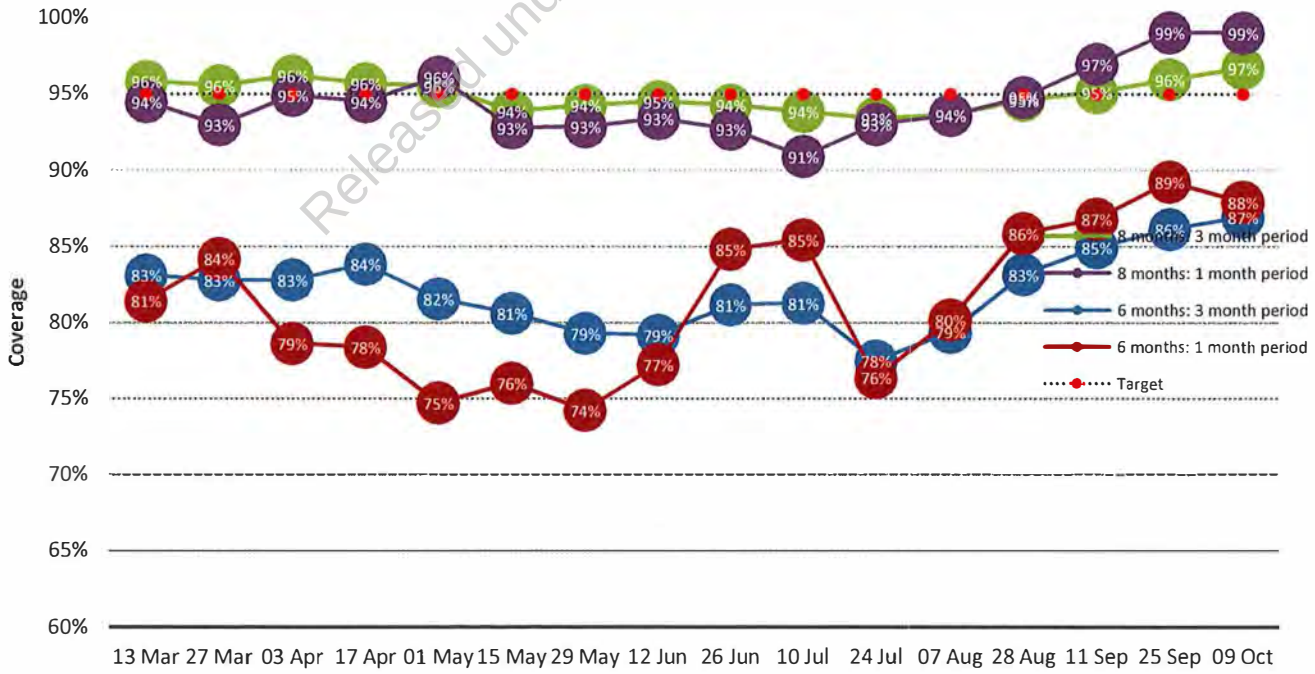


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Midlands Health Network - Waikato

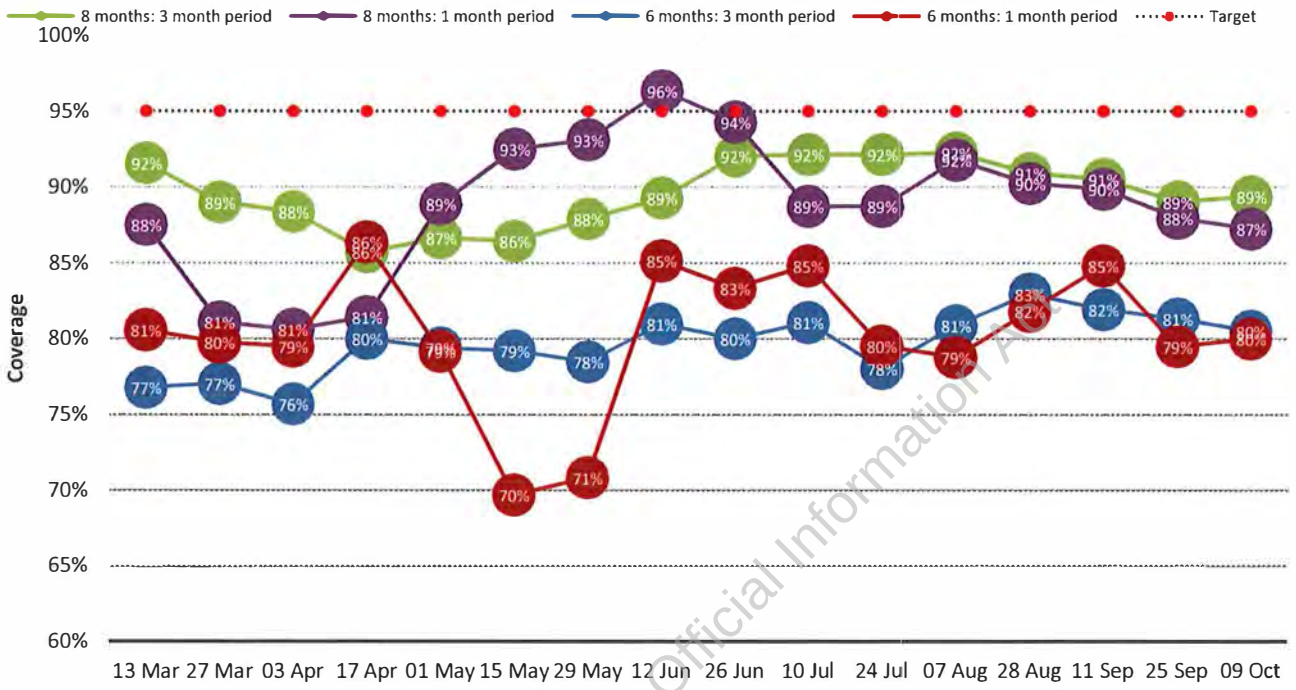


National Hauora Coalition Incorporated

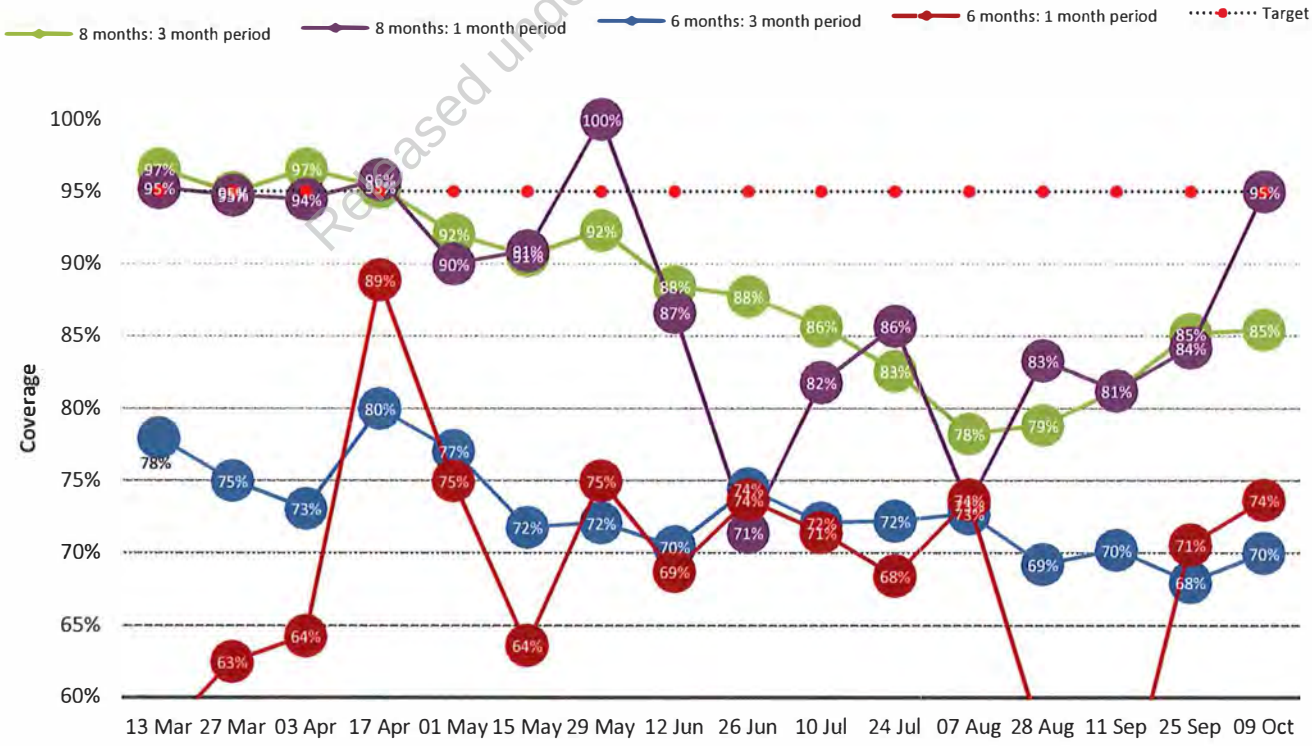


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Nelson Bays Primary Health

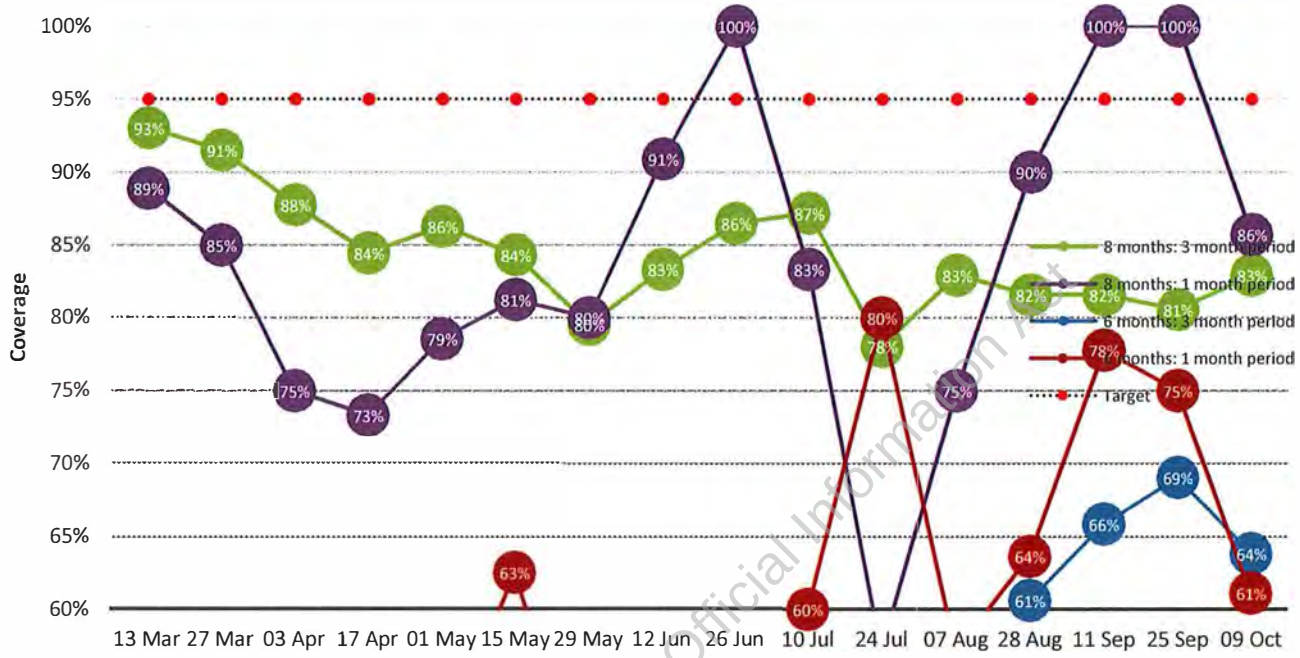


Nga Mataapuna Oranga Limited

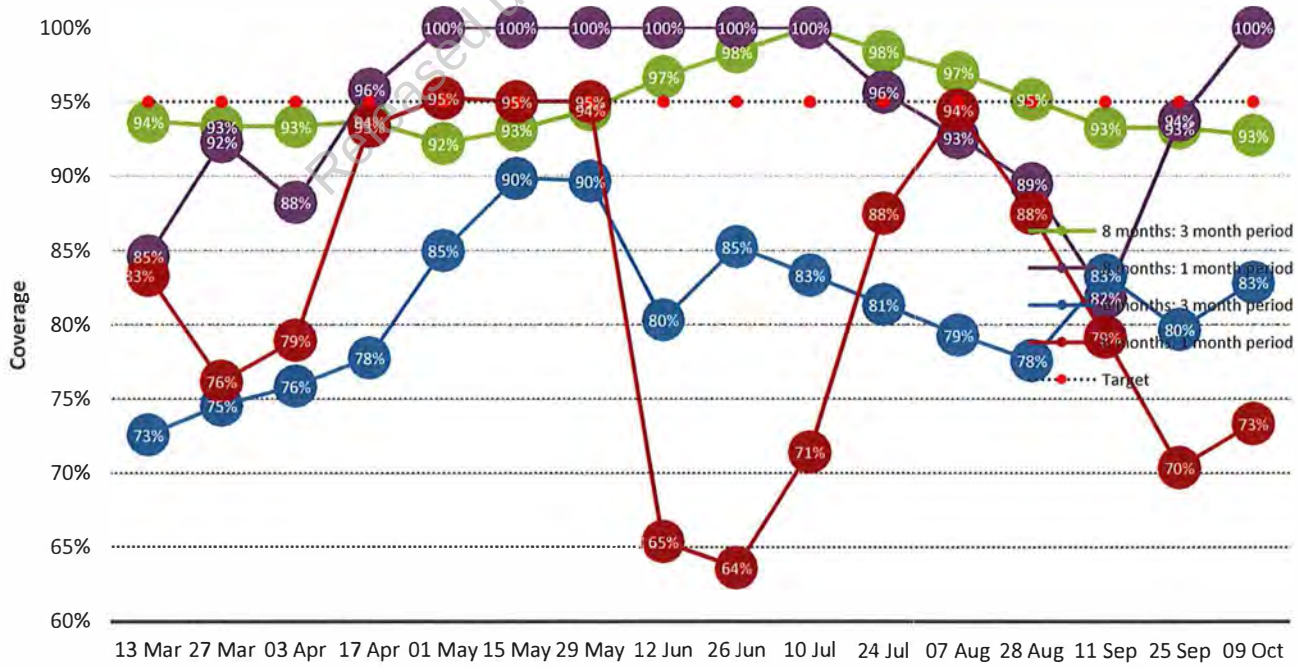


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Ngati Porou Hauora Charitable Trust

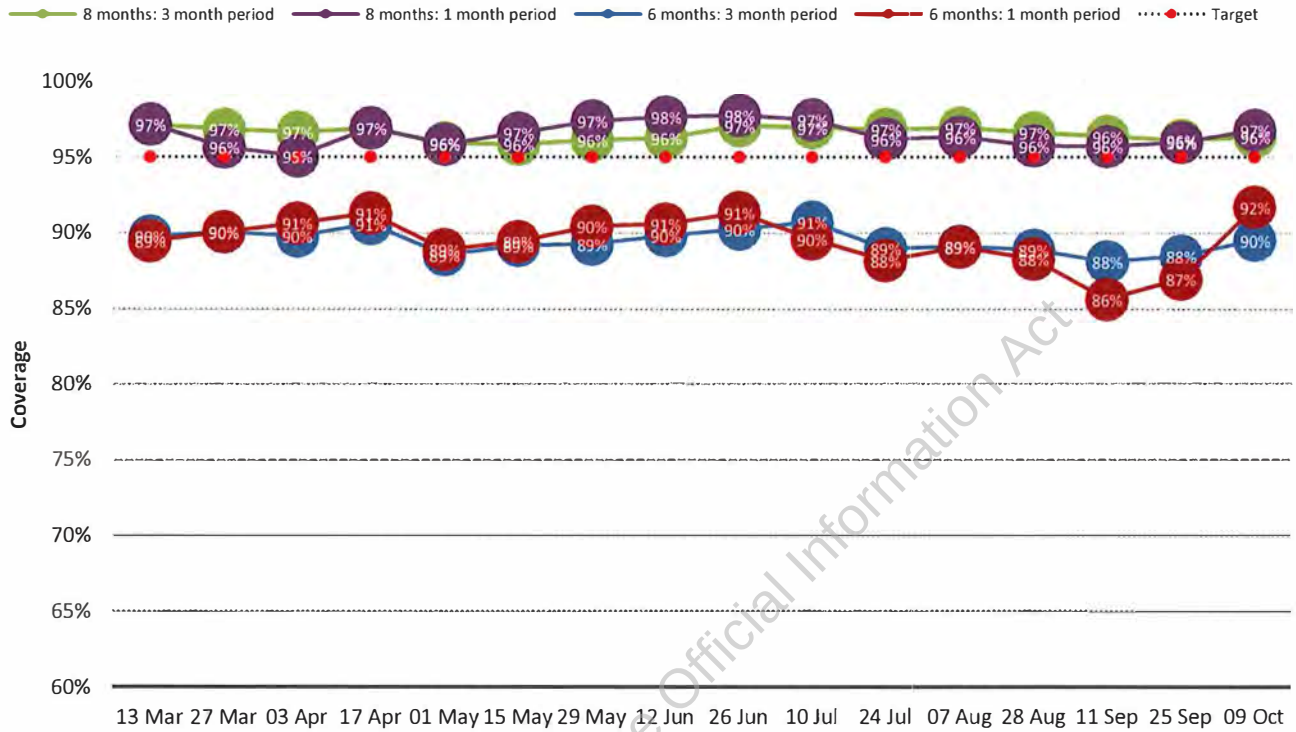


Ora Toa PHO Limited

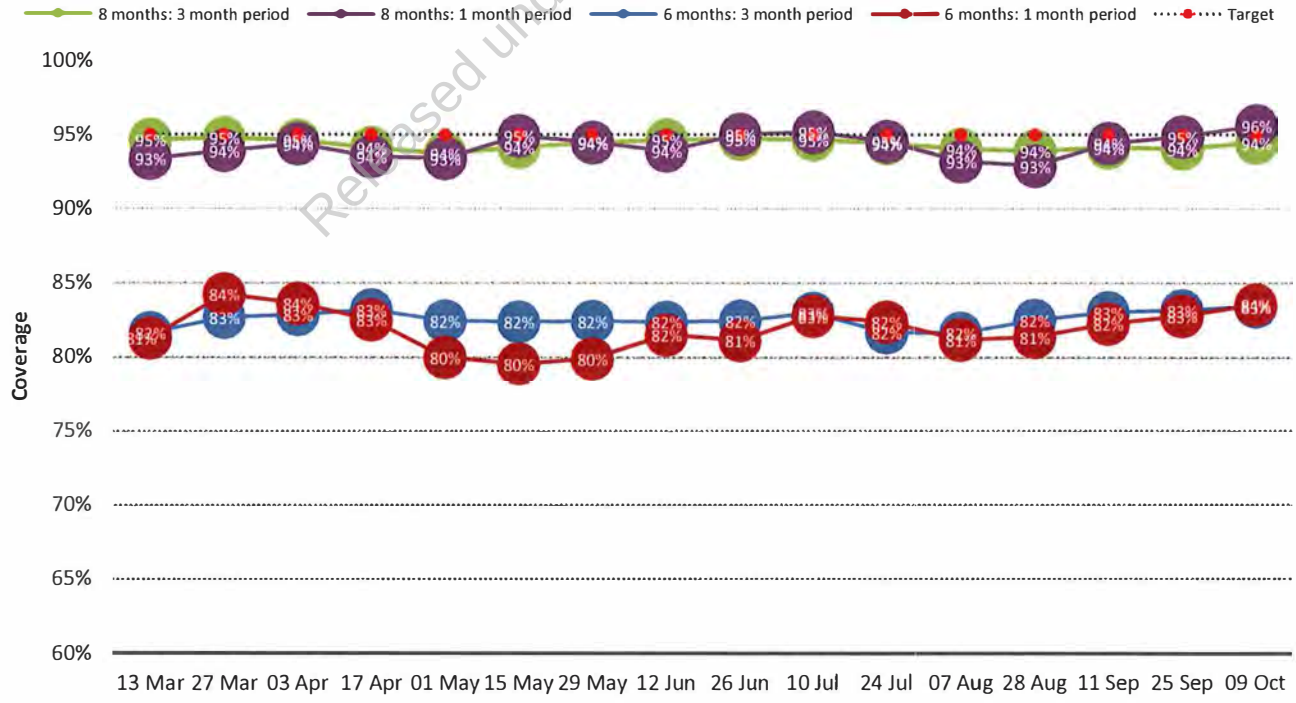


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Pegasus Health (Charitable) Limited

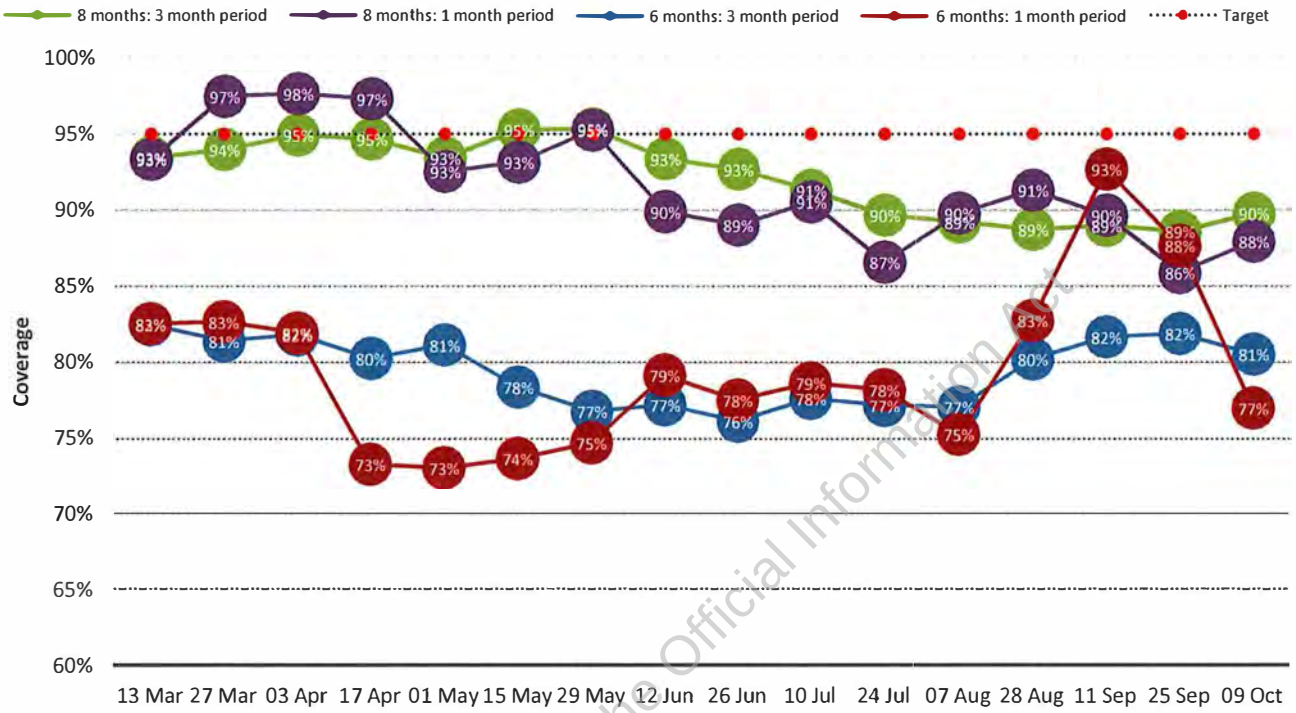


Procare Networks Limited

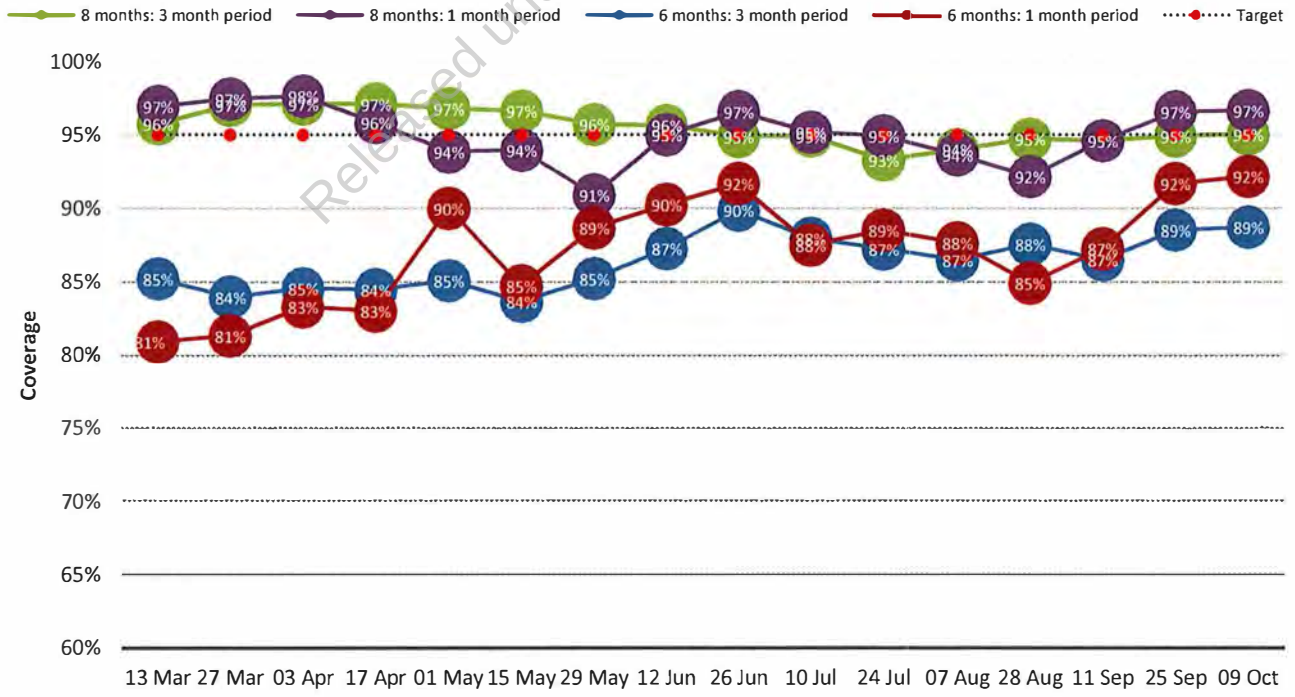


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Rotorua Area Primary Health Services Limited

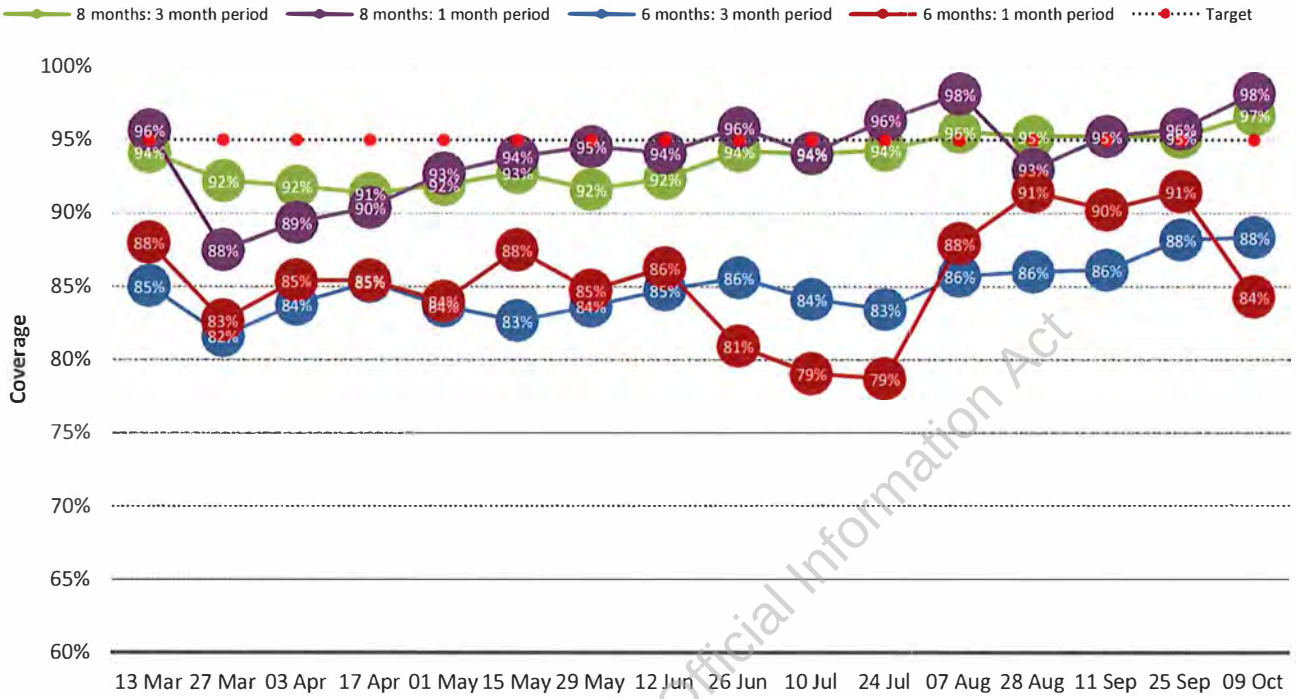


Rural Canterbury PHO

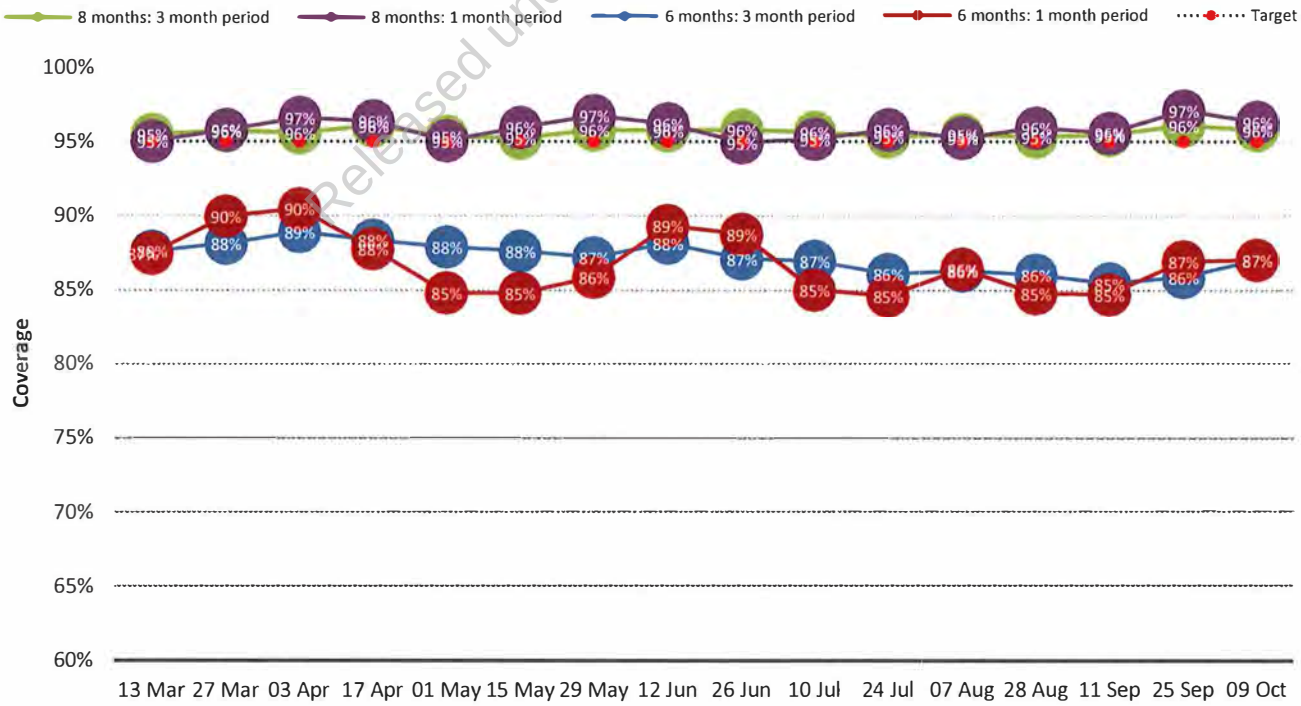


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

South Canterbury DHB

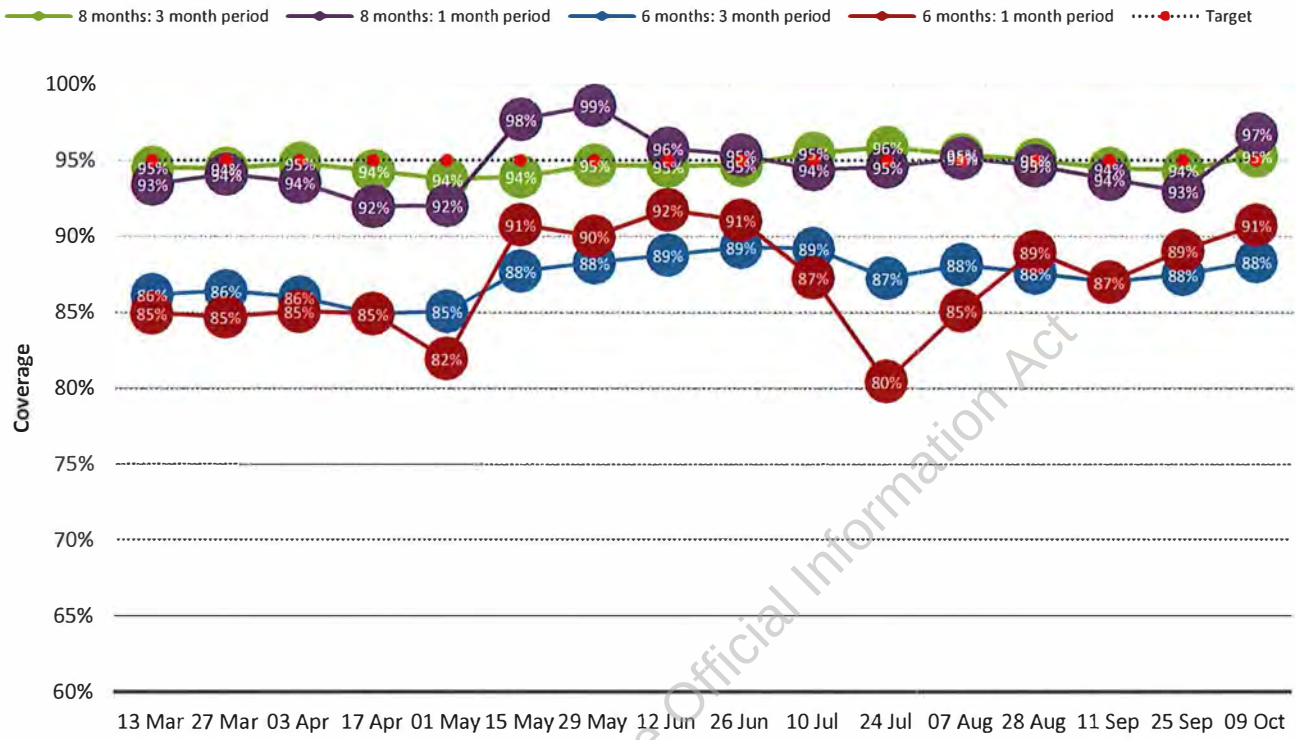


WellSouth

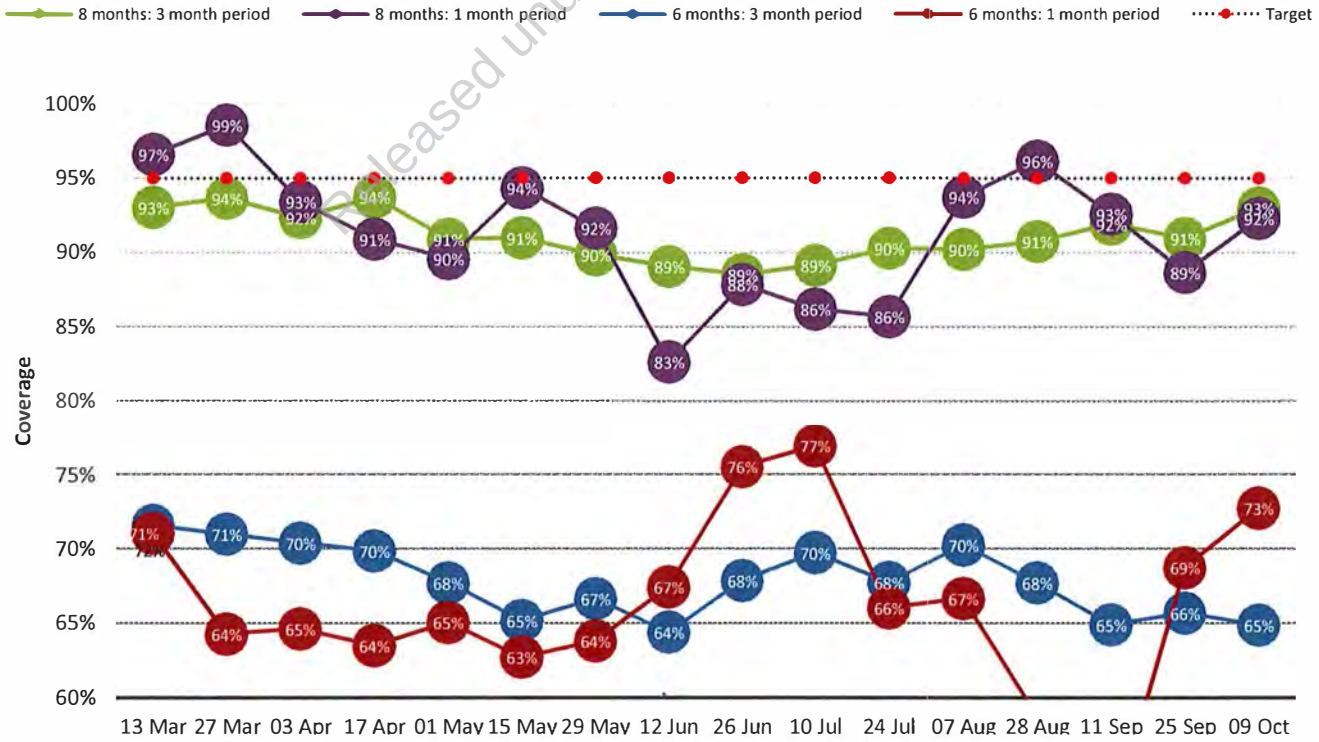


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Te Awakairangi Health Network

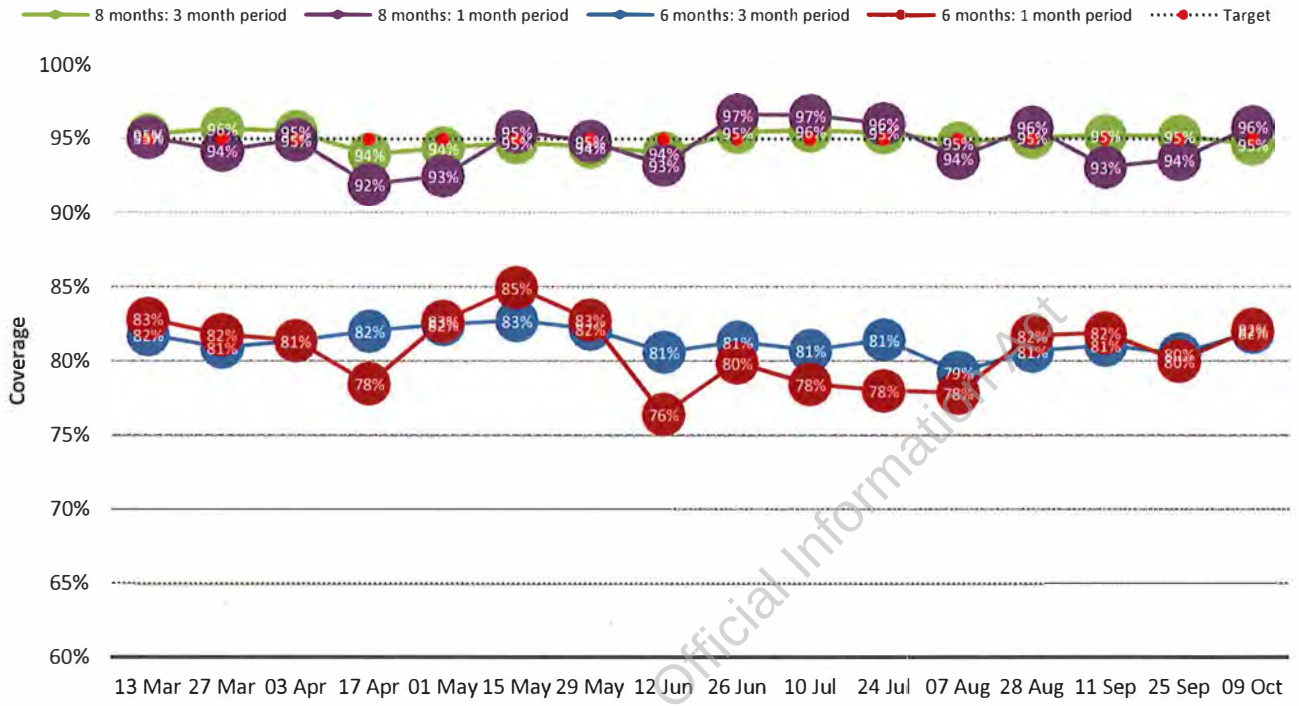


Te Tai Tokerau PHO Ltd

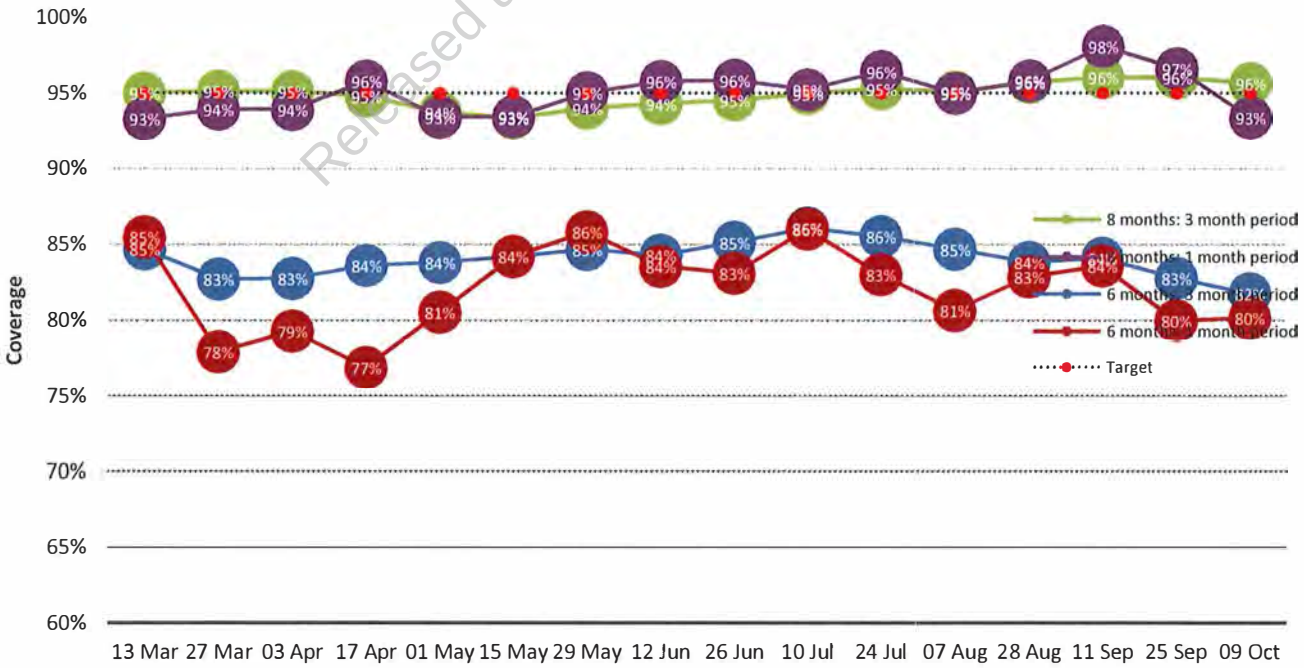


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Total Healthcare Charitable Trust

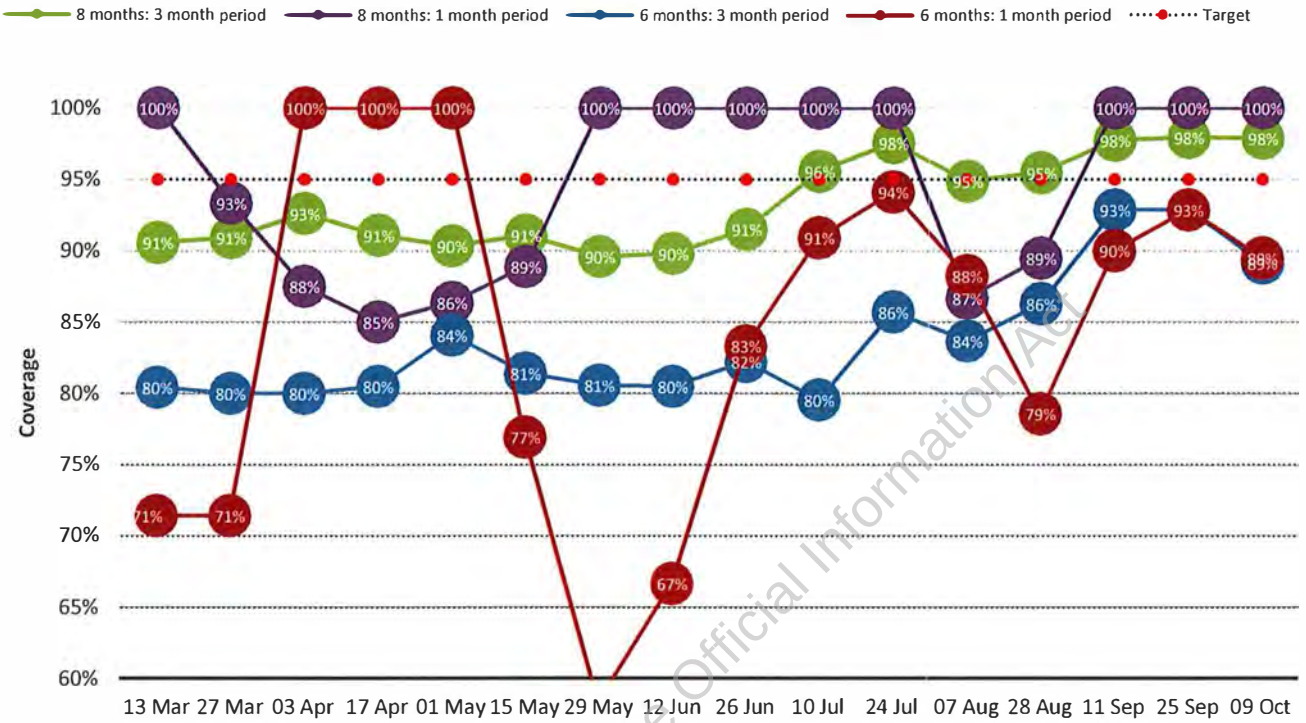


Waitemata PHO Limited

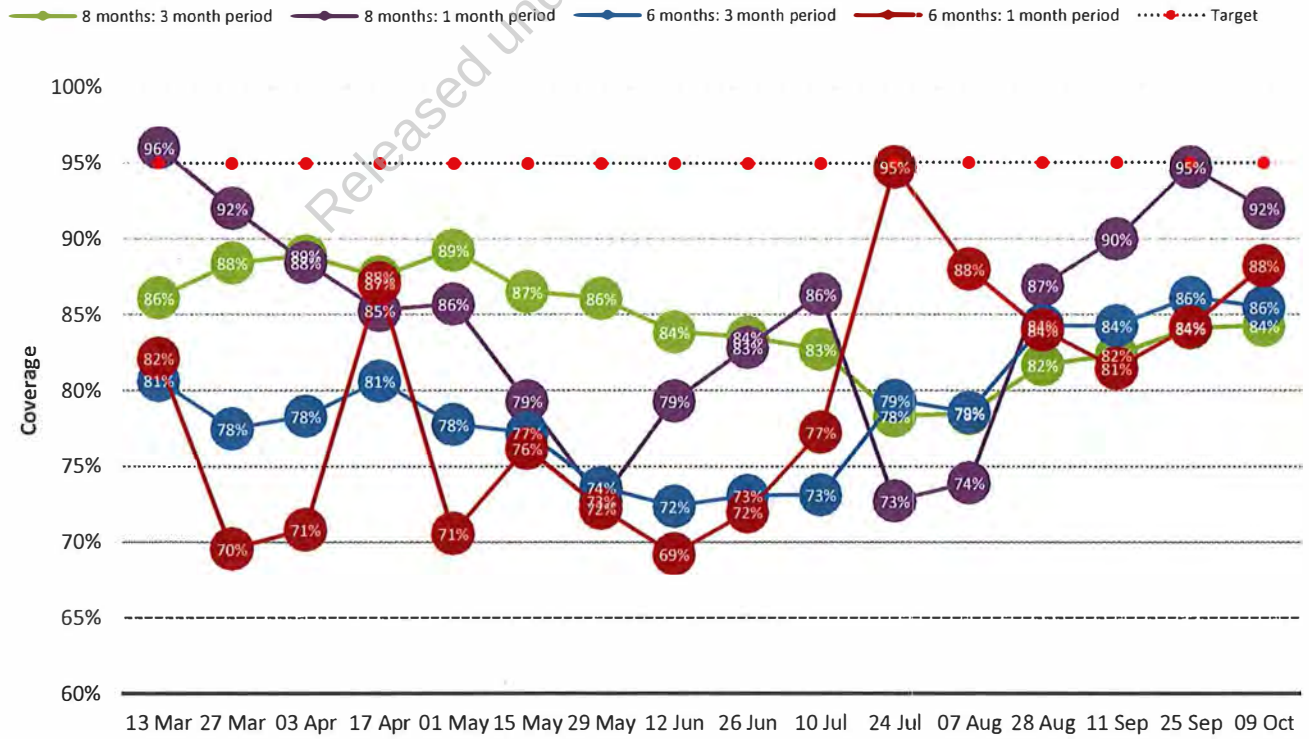


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Well Health Trust

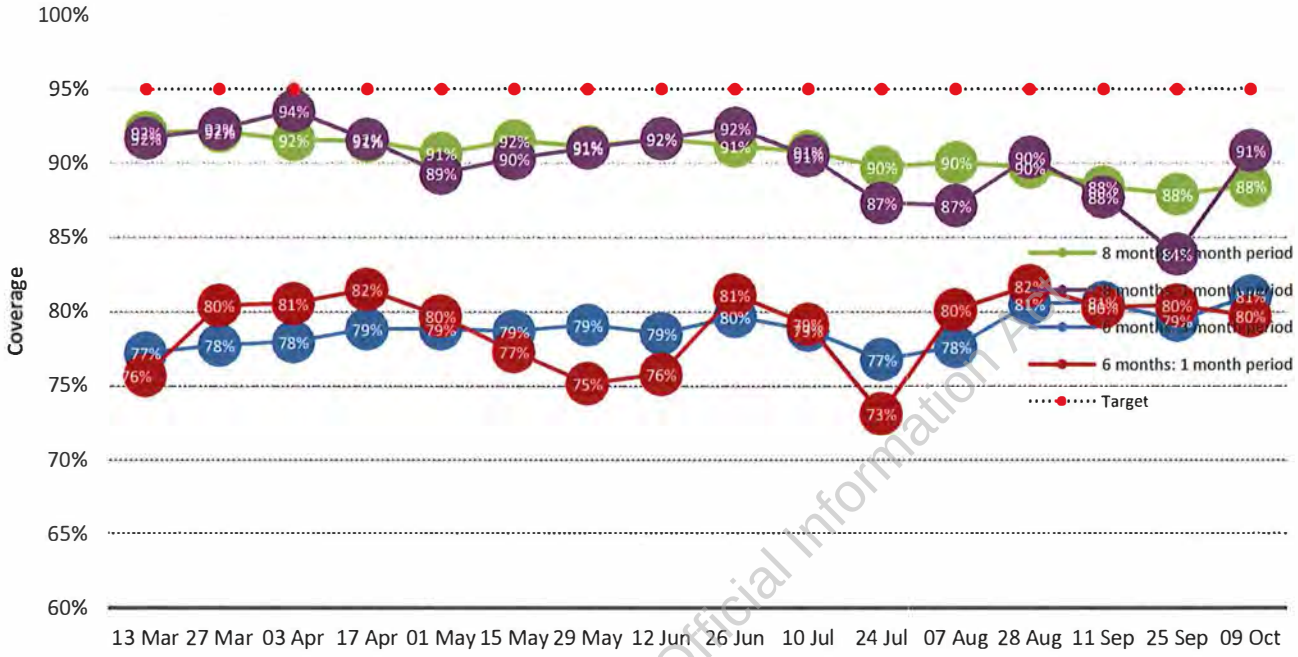


West Coast PHO

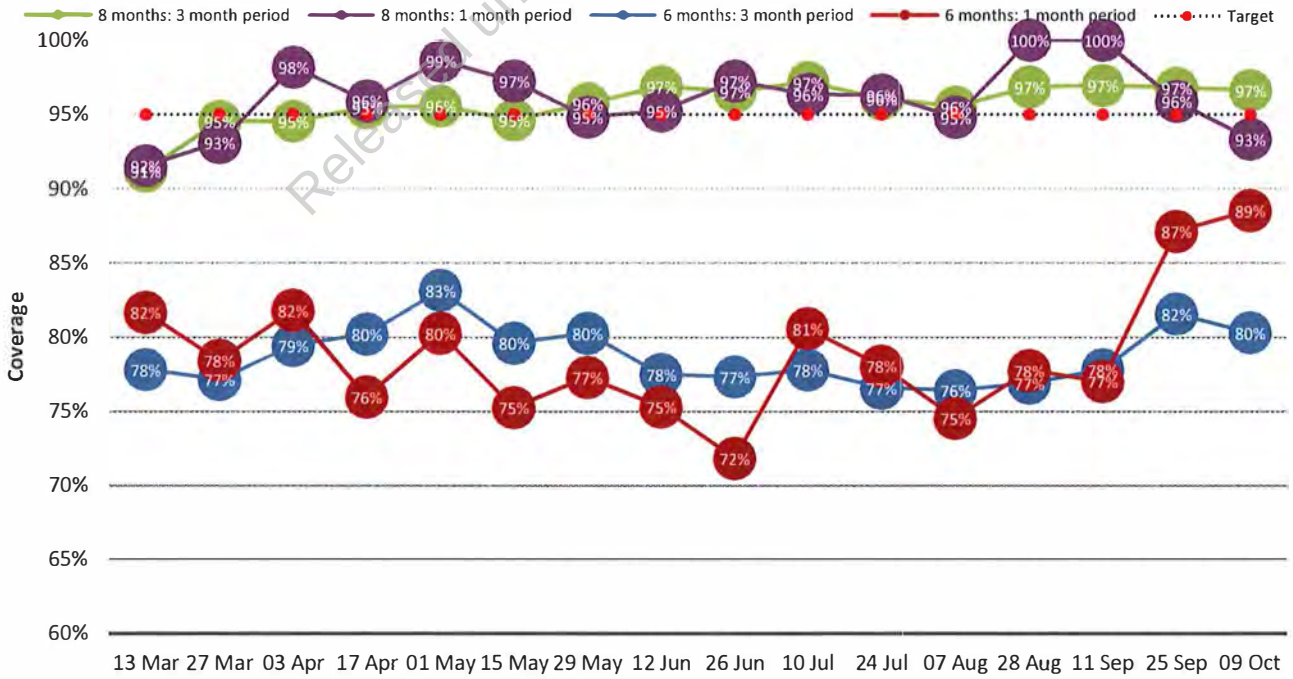


Immunisation Coverage of children at 6 months and 8 months - fortnightly update

Western Bay of Plenty Primary Health Organisation Limited

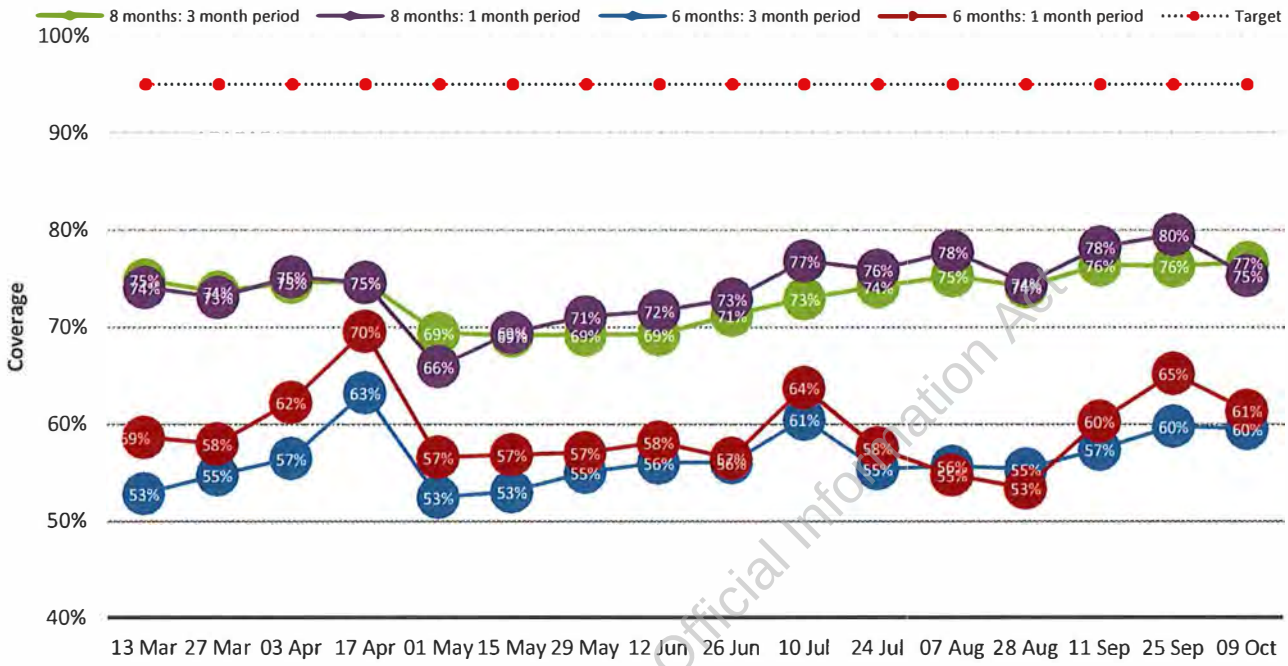


Whanganui Regional PHO



Immunisation Coverage of children at 6 months and 8 months - fortnightly update

All children not enrolled with PHO

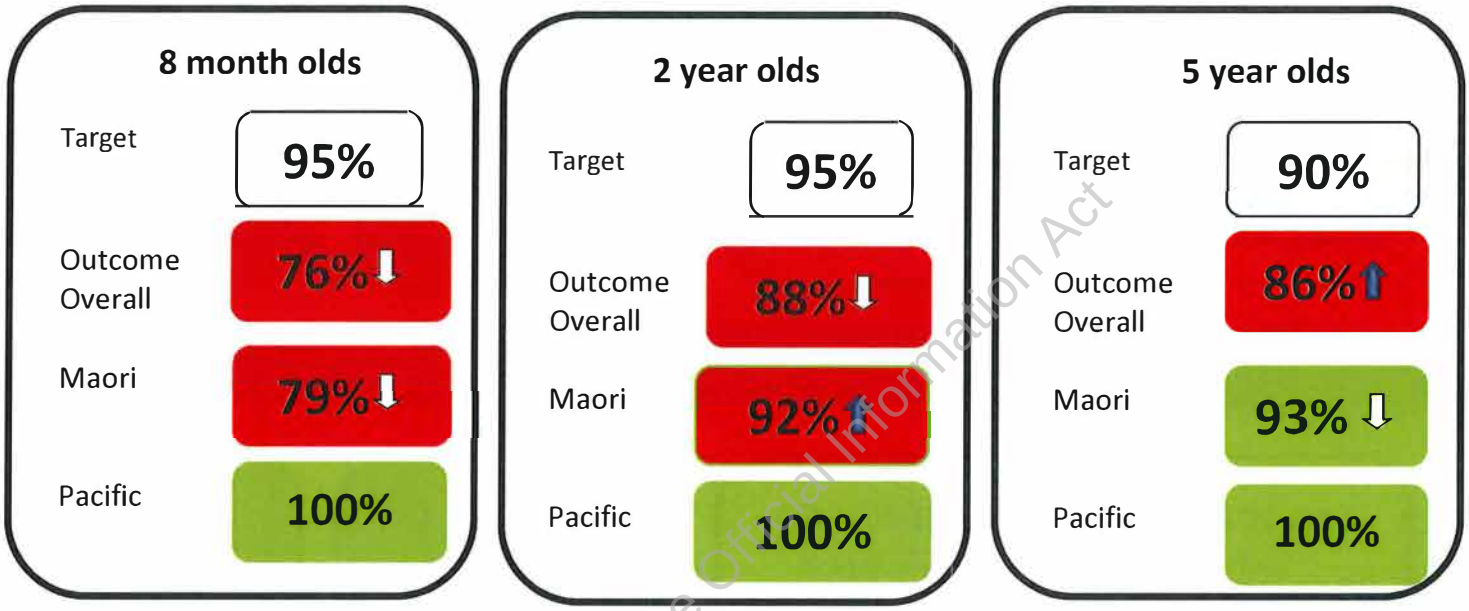


our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2016/17



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 25 October 16

Fully Immunised 8 month olds – DHB LEVEL

Q4 2015/16 Actual	Q1 2016/17 Actual	Q2 2016/17 Progress including pending	Q3 2016/17 Progress including pending
78% fully	76% fully	81% fully	87% fully
0% overdue	4% overdue	3.5% overdue	4% overdue

Fully Immunised Two year olds - DHB LEVEL

Q4 2015/16 Actual	Q1 2015/16 Progress	Q2 2016/17 Progress	Q3 2016/17 Progress
91% fully	88% fully	91% fully	78% fully
0% overdue	0% overdue	0% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q4 2015/16 Actual	Q1 2015/16 Actual	Q2 2016/17 Progress	Q3 2016/17 Progress
85% fully	86% fully	85% fully	79% fully
0% overdue	2% overdue	0% overdue	5.5% overdue

8month olds

Practice Name	Fully	Declined	Overdue at Milestone age	vaccinated after milestone age	Grand Total
Buller Medical Centre	12	1			13
Greymouth Medical Centre	14	3			17
HariHari Rural Clinic	2				2
High Street Medical Centre (2005) Ltd	3				3
Reefton Medical Centre	2	1			3
Rural Academic General Practice	4				4
Westland Medical Centre	17	1	1	1	20
Whataroa Rural Clinic	2				2
Moana Rural Clinic	1				1
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd	2				2
Grand Total	**60**	**6**	**1**	**1**	**68**

2year olds

practice Name	Fully	Declined	Grand Total
Buller Medical Centre	21		21
Franz Joseph Clinic	5		5
Greymouth Medical Centre	18	1	19
High Street Medical Centre (2005) Ltd	9	1	10
Karamea Medical Centre	1		1
Reefton Medical Centre	4		4
Rural Academic General Practice	5		5
Westland Medical Centre	17		17
Whataroa Rural Clinic	1		1
Fox Glacier Clinic	2		2
Coast Medical Consultancy Ltd	4		4
South Westland - Haast	1		1
Redcliffs Medical Centre	1		1
Grand Total	**89**	**2**	**91**

5 year olds

Practice Name	Declined	Fully	Gone no address	Vaccinated after milestone age	Grand Total
Westland Medical Centre		23			23
Buller Medical Centre	4	23			27
Whataroa Rural Clinic		1			1
Stoke Medical Centre		1			1
Rural Academic General Practice		10			10
Greymouth Medical Centre		24	1		25
High Street Medical Centre (2005) Ltd		13		1	14
Karamea Medical Centre	2				2
Fox Glacier Clinic		1			1
Franz Joseph Clinic		2			2
HariHari Rural Clinic		2			2
Reefton Medical Centre	2	4			6
Coast Medical Consultancy		1			1
Moana Rural Clinic		1			1
Grand Total	**8**	**106**	**1**	**1**	**116**

Q2 2016/17 Tracking Data
8 month olds

Practice Name	fully	Declined	overdue with GP	vaccinated after milestone age	Grand Total
Buller Medical Centre	17		2		19
Franz Joseph Clinic	1	1			2
Greymouth Medical Centre	12				12
High Street Medical Centre (2005) Ltd	9				9
Reefton Medical Centre	4			1	5
Rural Academic General Practice	3		1		4
Westland Medical Centre	14	2			16
Whataroa Rural Clinic	1				1
Moana Rural Clinic	2				2
Fox Glacier Clinic	1				1
Coast Medical Consultancy Ltd	3				3
South Westland - Haast	1				1
Grand Total	**68**	**3**	**3**	**1**	**75**

2 year olds

Practice Name	Fully	Declined	Overdue at Milestone age	Grand Total
Buller Medical Centre	16			16
Franz Joseph Clinic	3			3
Greymouth Medical Centre	20			20
HariHari Rural Clinic	2			2
High Street Medical Centre (2005) Ltd	4			4
Reefton Medical Centre	4			4
Rural Academic General Practice	9		1	10
Westland Medical Centre	21	1		22
Moana Rural Clinic	1			1
Fox Glacier Clinic	1			1
Murchison Hospital & Health Centre	1			1
Coast Medical Consultancy Ltd	2			2
Mataura Medical Centre	1			1
Grand Total	**85**	**1**	**1**	**87**

5 year olds

Practice Name	Declined	Fully	Grand Total
Coast Medical Consultancy Ltd	2	3	5
Westland Medical Centre	1	13	14
Buller Medical Centre	1	16	17
Whataroa Rural Clinic		1	1
Rural Academic General Practice		7	7
Greymouth Medical Centre		17	17
High Street Medical Centre (2005) Ltd		6	6
Karamea Medical Centre		2	2
Franz Joseph Clinic		2	2
Reefton Medical Centre		1	1
Murchison Hospital & Health Centre		1	1
Grand Total	**4**	**69**	**73**

Q1 2016/17

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	83	61	73. %	55	46	84. %	11	9	82. %	0	0	-	2	2	100. %	15	4	27. %	11 (0)	13.3 (0.0) %	4	4.8 %
8 Month	85	65	76. %	47	43	91. %	19	15	79. %	1	1	100. %	4	4	100. %	14	2	14. %	11 (0)	12.9 (0.0) %	6	7.1 %
12 Month	90	74	82. %	45	44	98. %	21	18	86. %	1	1	100. %	5	5	100. %	18	6	33. %	11 (0)	12.2 (0.0) %	4	4.4 %
18 Month	89	69	78. %	44	42	95. %	21	17	81. %	4	4	100. %	4	4	100. %	16	2	13. %	14 (0)	15.7 (0.0) %	4	4.5 %
24 Month	97	85	88. %	60	56	93. %	12	11	92. %	2	2	100. %	5	5	100. %	18	11	61. %	7 (0)	7.2 (0.0) %	5	5.2 %
5 Year	120	103	86. %	61	55	90. %	29	27	93. %	2	2	100. %	5	5	100. %	23	14	61. %	7 (0)	5.8 (0.0) %	8	6.7 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	83	61	73. %	5	5	100. %	13	12	92. %	8	6	75. %	25	22	88. %	29	14	48. %	3	2	67. %
8 Month	85	65	76. %	6	6	100. %	20	19	95. %	17	16	94. %	18	14	78. %	23	10	43. %	1	0	-
12 Month	90	74	82. %	7	7	100. %	16	15	94. %	17	15	88. %	20	18	90. %	27	16	59. %	3	3	100. %
18 Month	89	69	78. %	6	6	100. %	11	11	100. %	12	10	83. %	26	23	88. %	31	16	52. %	3	3	100. %
24 Month	97	85	88. %	9	9	100. %	19	19	100. %	12	12	100. %	31	28	90. %	23	14	61. %	3	3	100. %
5 Year	120	103	86. %	11	11	100. %	25	24	96. %	19	16	84. %	32	29	91. %	30	20	67. %	3	3	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	For all new-borns an Enrolment Form is completed and sent to NIR. There is a QIP underway which is looking at how to improve linkages with children born in Christchurch Women's to ensure that there information is shared with WC NIR. Q3 data shows that 93.2% of new-borns were enrolled. Q4 data is not yet available
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Coverage was 78% of 8month olds 91% of 2 year olds and 85% of 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	• 70% of Girls have received dose 3	Currently sitting on 42% for Dose 1.
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Currently tracking at 54% for 65s and over. This figure has not been updated.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. • Narrative report on interagency activities completed to promote Immunisation Week.	Yes Not yet completed Yes.

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 28 July 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Joanne Shaw, Bridget Lester, Pauline Ansley, Janet Hogan, Anna Wall and Hilary	
Apologies:	Catherine Crichton, , Catherine Andrew, Lee Harris, Nikki Mason, Cody Frewin and Sharyn Kenning	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting	Minutes of March and June meetings were approved.	
3. Matters Arising	No matters were arising from the last meeting. Sharing of Regular Flu Coverage Reports – ongoing DHB Staff Clinic – Cheryl followed up with Mark Measles – information to be shared later in the meeting PHARMAC proposed schedule changes, response – completed.	
4. Standing Items	**Report on KPIs and Action Plan** • Q4 = 78% 8 Month olds and 91% 2 year olds. 5 year olds at 85%. However we had reached all possible 8month and 2year olds. • There appears to be some Maori Children in the Opt off group. July Workplan update.docx Updated work plan attached.	
Seasonal Influenza	**Primary Care** -This shows WC at 54% for 65 and overs. This currently is the national average. **DHB Staff coverage –** there is positive increases in staff coverage, but there is a concern that messages around clinics are not getting out within the DHB system. We need the key message round "it's now available at"	

Staff	2015	2016
Nurses	43%	67%
Doctors	76%	95%
LMC	56%	67%
Allied Health	38%	65%

	Others 71% 88% **Rates -** Very low national rates of Influenza cases. Not much activity yet. There appears to be a breakthrough in the H3 strain in Canterbury. This year surveillance is being led by SHIVERS. There is concerns around lack of engagement tin this national programme and therefore this is resulting in under reporting.	
Pregnancy Vaccinations	Pertussis continues to be active in the community. We need to get our messaging right between normal vs outbreak. There is a concern around high levels of testing and screening. There is a lot of children with coughs around at present.	
Measles	**89** confirmed in NZ, two new ones last week.	
HPV	PHARMAC have announced the change in the HPV for 2017. Eligibility extended to include boys, change in vaccine to 9 strain and a move to two doses, 6 months apart. This will include in the school programme – with the need to now target boys, and the reduction on number of visits to schools. WC plan • Offer to boys in Year 8 at the same time as girls. • There is no need to link with new schools. • Get GPT to promote the change at the 11year old events and then get GPT to recall boys ages 13 – 26 for catch-up. • Need to draft letter to parents for boys to go out in Oct/Nov.	*Janet and Bridget*
Schedule Changes	These have been approved by PHARMAC. Need to start looking at what needs to occur to implement these from 1 July 2017.	
Next Meeting	Thursday 8 September 2.00 – 3.00pm, Community and Public Health Offices Other meeting dates for next year: 27 October 1 December	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 30 November 2016 1:09 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; 'riasouth@imac.org.nz'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers for Thursday IAG
Attachments: 1 December IAG draft agenda.docx; Dec Workplan update.docx; Dec data report.docx

Hi all

Please find attached the papers for tomorrow IAG meeting.

Please let me know if you are not able to attend. So far I have Sarah down as an apology.

I am dialling in from Christchurch, so speak to you all at 2pm.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 1 December 2016, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (13 October 2016)	Cheryl Brunton	Draft minutes 27 October 2016.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2015/16 Progress to be updated at meeting ○ HPV programme update ○ Influenza 2017	Bridget Janet Cheryl	Dec Workplan update.docx Dec data report.docx
5	11 year old Tdap programme	Cheryl Brunton	

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Immunisation Toolkit	Bridget and Betty	On going

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	For all new-borns an Enrolment Form is completed and sent to NIR. There is a QIP underway which is looking at how to improve linkages with children born in Christchurch Women's to ensure that there information is shared with WC NIR. West Coast are at 89% for Q1. Rank 1 in country Toolkit is in draft stages, and relooking at LMC resources.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Coverage was • 76% of 8month olds • 88% of 2 year olds • 86% of 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Currently sitting on 42% for Dose 1.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Currently tracking at 54% for 65s and over. This figure has not been updated. Yes Not yet completed Yes.

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

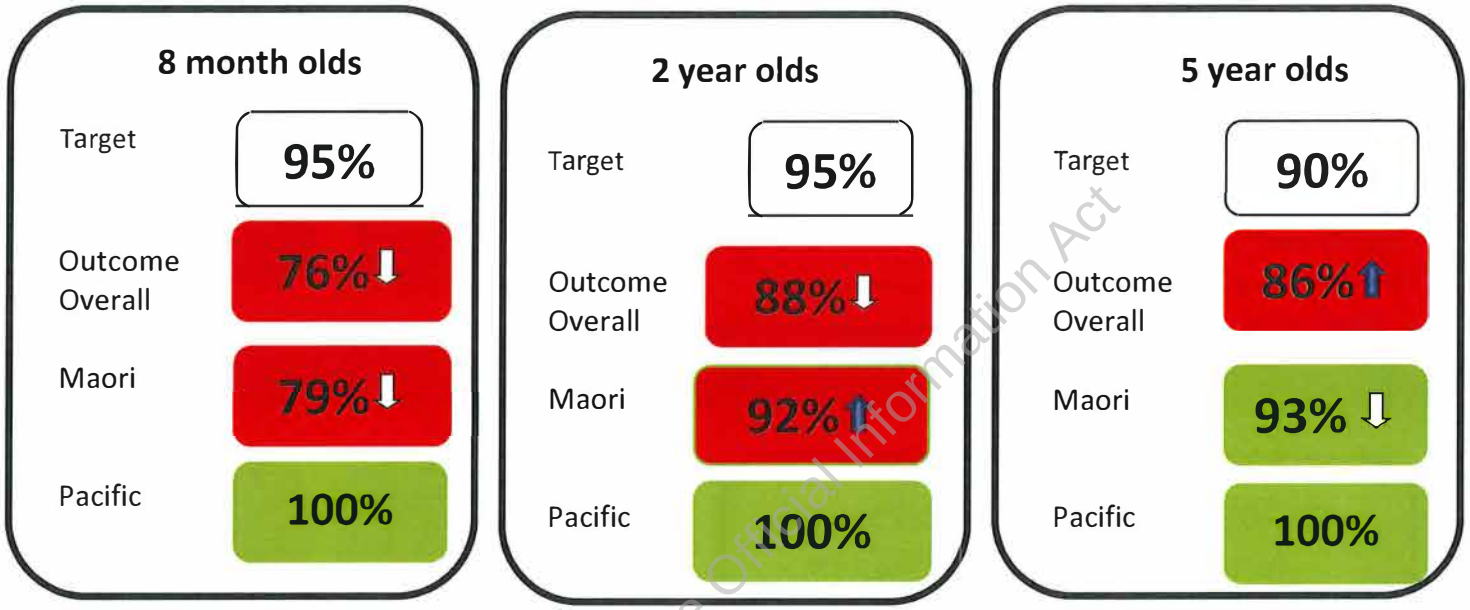
Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2016/17



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 November 16

Fully Immunised 8 month olds – DHB LEVEL

Q4 2015/16 Actual	Q1 2016/17 Actual	Q2 2016/17 Progress including pending	Q3 2016/17 Progress including pending
78% fully	76% fully	82% fully	76% fully
0% overdue	4% overdue	2.3% overdue	15% overdue

Fully Immunised Two year olds - DHB LEVEL

Q4 2015/16 Actual	Q1 2015/16 Progress	Q2 2016/17 Progress	Q3 2016/17 Progress
91% fully	88% fully	91% fully	78% fully
0% overdue	0% overdue	0% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q4 2015/16 Actual	Q1 2015/16 Actual	Q2 2016/17 Progress	Q3 2016/17 Progress
85% fully	86% fully	85% fully	80% fully
0% overdue	2% overdue	0% overdue	4.5% overdue

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016
As at Quarter Four 2016 (October 2016)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	243	1,113	1,414	79%	14
Bay of Plenty	97	568	715	79%	12
Canterbury	369	1,322	1,635	81%	9
Capital and Coast	176	588	841	70%	19
Counties Manukau	344	1,643	2,069	79%	13
Hawkes Bay	119	428	485	88%	2
Hutt	110	427	497	86%	4
Lakes	15	282	365	77%	16
MidCentral	100	341	562	61%	20
Nelson Marlborough	55	300	377	80%	11
Northland	152	485	562	86%	3
South Canterbury	39	137	167	82%	6
Southern	166	629	820	77%	17
Tairawhiti	58	140	179	78%	15
Taranaki	63	269	320	84%	5
Waikato	276	1,068	1,340	80%	10
Wairarapa	28	81	99	82%	7
Waitemata	266	1,407	1,981	71%	18
West Coast	41	82	92	89%	1
Whanganui	60	185	227	81%	8
Overseas or Unknown	0	0	14	0%	
Total	**2,777**	**11,495**	**14,761**	**78%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	90	1,414	94%	14
Bay of Plenty	63	715	91%	17
Canterbury	57	1,635	97%	7
Capital and Coast	94	841	89%	20
Counties Manukau	114	2,069	94%	11
Hawkes Bay	30	485	94%	13
Hutt	26	497	95%	9
Lakes	8	365	98%	2
MidCentral	13	562	98%	3
Nelson Marlborough	9	377	98%	4
Northland	30	562	95%	10
South Canterbury	1	167	99%	1
Southern	21	820	97%	6
Tairawhiti	16	179	91%	18
Taranaki	8	320	98%	5
Waikato	140	1,340	90%	19
Wairarapa	5	99	95%	8
Waitemata	157	1,981	92%	16
West Coast	6	92	93%	15
Whanganui	14	227	94%	12
Unknown	2	14	86%	
Total	**904**	**14,761**	**94%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter One 2016/17
Newborns Born in the Following Period: 20 May 2016 to 19 August 2016
As at Quarter Four 2016 (October 2016)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	291	362	80.4%	23
Auckland PHO Limited	163	208	78.4%	30
Central Primary Health Organisation	334	538	62.1%	36
Christchurch PHO Limited	94	103	91.3%	11
Compass Health - Capital and Coast	463	650	71.2%	35
Compass Health - Wairarapa	82	103	79.6%	28
Cosine Primary Care Network Trust	108	109	99.1%	3
East Health Trust	270	303	89.1%	14
Eastern Bay Primary Health Alliance	129	154	83.8%	21
Hauraki PHO	433	480	90.2%	13
Health Hawke's Bay Limited	429	456	94.1%	6
Kimi Hauora Wairau (Marlborough PHO Trust)	87	122	71.3%	34
Manaia Health PHO Limited	268	310	86.5%	17
Midlands Health Network - Lakes	91	122	74.6%	32
Midlands Health Network - Tairawhiti	95	105	90.5%	12
Midlands Health Network - Taranaki	266	309	86.1%	18
Midlands Health Network - Waikato	625	720	86.8%	16
National Hauora Coalition	313	332	94.3%	5
Nelson Bays Primary Health	212	247	85.8%	19
Nga Mataapuna Oranga Limited	42	45	93.3%	7
Ngati Porou Hauora Charitable Trust	33	45	73.3%	33
Ora Toa PHO Limited	64	57	112.3%	1
Pegasus Health (Charitable) Limited	1,048	1,254	83.6%	22
Procare Networks Limited	2,153	2,713	79.4%	29
Rotorua Area Primary Health Services Limited	204	255	80.0%	25
Rural Canterbury PHO	177	221	80.1%	24
South Canterbury Primary and Community	135	161	83.9%	20
Te Awakairangi Health Network	341	366	93.2%	9
Te Tai Tokerau PHO Ltd	196	201	97.5%	4
Total Healthcare Charitable Trust	466	510	91.4%	10
Waitemata PHO Limited	588	736	79.9%	27
Well Health Trust	42	40	105.0%	2
WellSouth Primary Health Network	634	811	78.2%	31
West Coast PHO	82	88	93.2%	8
Western Bay of Plenty PHO Limited	378	427	88.5%	15
Whanganui Regional PHO	159	199	79.9%	26
Unknown or Blank	0	899	0.0%	
Total	**11,495**	**14,761**	**77.9%**	

Q1 2016/17

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	83	61	73. %	55	46	84. %	11	9	82. %	0	0	-	2	2	100. %	15	4	27. %	11 (0)	13.3 (0.0) %	4	4.8 %
8 Month	85	65	76. %	47	43	91. %	19	15	79. %	1	1	100. %	4	4	100. %	14	2	14. %	11 (0)	12.9 (0.0) %	6	7.1 %
12 Month	90	74	82. %	45	44	98. %	21	18	86. %	1	1	100. %	5	5	100. %	18	6	33. %	11 (0)	12.2 (0.0) %	4	4.4 %
18 Month	89	69	78. %	44	42	95. %	21	17	81. %	4	4	100. %	4	4	100. %	16	2	13. %	14 (0)	15.7 (0.0) %	4	4.5 %
24 Month	97	85	88. %	60	56	93. %	12	11	92. %	2	2	100. %	5	5	100. %	18	11	61. %	7 (0)	7.2 (0.0) %	5	5.2 %
5 Year	120	103	86. %	61	55	90. %	29	27	93. %	2	2	100. %	5	5	100. %	23	14	61. %	7 (0)	5.8 (0.0) %	8	6.7 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	83	61	73. %	5	5	100. %	13	12	92. %	8	6	75. %	25	22	88. %	29	14	48. %	3	2	67. %
8 Month	85	65	76. %	6	6	100. %	20	19	95. %	17	16	94. %	18	14	78. %	23	10	43. %	1	0	-
12 Month	90	74	82. %	7	7	100. %	16	15	94. %	17	15	88. %	20	18	90. %	27	16	59. %	3	3	100. %
18 Month	89	69	78. %	6	6	100. %	11	11	100. %	12	10	83. %	26	23	88. %	31	16	52. %	3	3	100. %
24 Month	97	85	88. %	9	9	100. %	19	19	100. %	12	12	100. %	31	28	90. %	23	14	61. %	3	3	100. %
5 Year	120	103	86. %	11	11	100. %	25	24	96. %	19	16	84. %	32	29	91. %	30	20	67. %	3	3	100. %
12 Year	0	0	-	0	0	-	0	0		0	0	-	0	0	-	0	0	-	0	0	-

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 7 March 2017 9:21 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers and Agenda for IAG meeting: PLEASE NOTE CHANGE IN MEETING TIME - 2.30 START
Attachments: 9 March IAG draft agenda.docx; March Workplan update.docx; March data report.docx; Draft workplan 2017.docx

Hi everyone

Its seems so long since we last met!

Please find attached the agenda and papers for IAG on Thursday.

We have had issues with room bookings so we are going to need to start IAG half an hour later on Thursday at 2.30pm. Please email me or text me on 021 0259 3806 if you can't make it.

See you all then.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION
ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

AGENDA

Thursday 9 March 2017, 2.30 – 4.00pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (1 December 2017)	Cheryl Brunton	draft minutes 1 Dec 2016_CB.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Cheryl	March data report.docx March Workplan update.docx
5	Schedule Changes	Betty	
6	Immunisation Week 2017	Bridget	
7	11 year old Tdap programme	Cheryl Brunton	
8	Other Business • Meeting date 2017		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Immunisation Toolkit	Bridget and Betty	On going

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

IMMUNISATION ADVISORY GROUP 2015/16 WORKPLAN

Increased Immunisation Coverage: Reduces vaccine-preventable diseases and support people to stay well

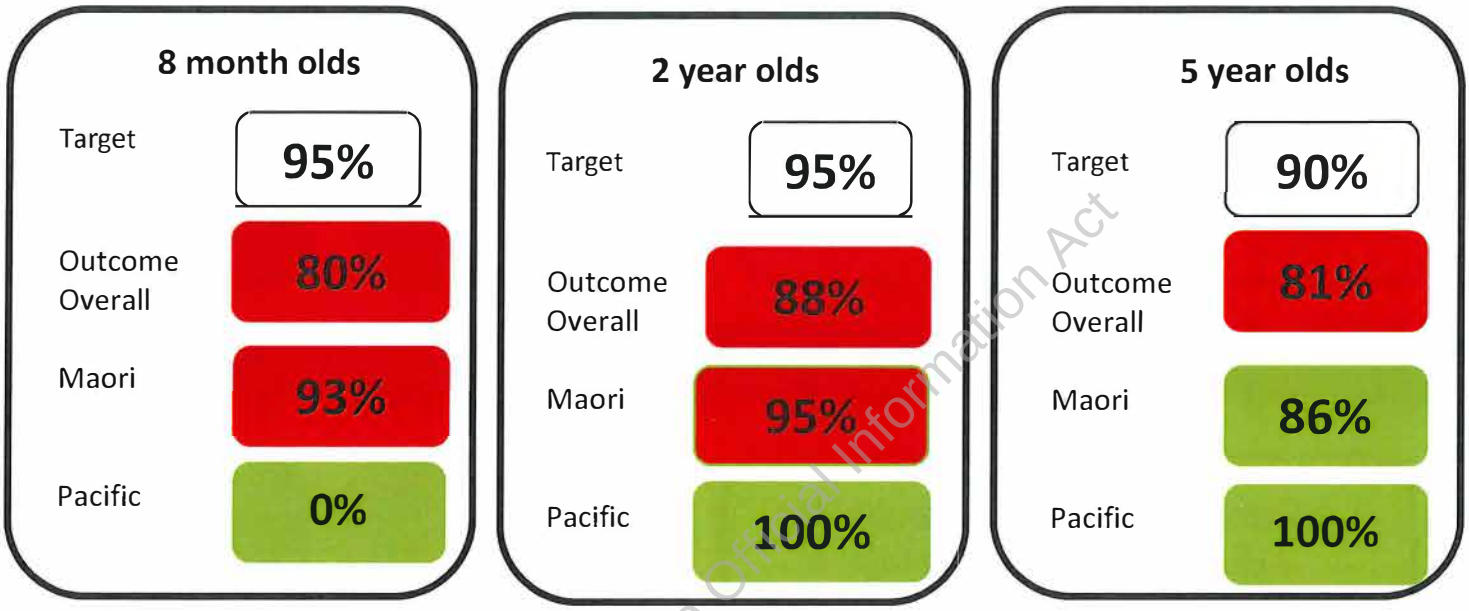
Objective (in the next year)	ACTIONS	TIMING	TARGET *or Measurable Result*	Progress
To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice by: • Continuing to support LMCs for early hand over to GPT and Well Child providers; • Ensuring early enrolment with General practice teams, and use of B code; • Continuing to support NIR to establish timely reporting to follow up children with no nominated provider. Continue to explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of vaccination.	Q1-Q4 Q1-Q4 Q1-Q4	• 95% of all new-born babies are enrolled on the National Immunisation Register at birth. • 98% of new-borns are enrolled with general practice by 2 weeks.	For all new-borns an Enrolment Form is completed and sent to NIR. There is a QIP underway which is looking at how to improve linkages with children born in Christchurch Women's to ensure that there information is shared with WC NIR. West Coast are at 70% for Q2. Rank 7 in country Toolkit is in draft stages, and relooking at LMC resources.
Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. • Provide practice-level coverage reports to PHOs which identify and address gaps in service delivery. • Provide an Outreach Immunisation service to locate and vaccinate missing children. • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date		• 85% of six week immunisations are completed • 95% of eight month olds and two year olds are fully immunised • 90% of four year olds are fully immunised by June 2016.	Coverage was • 80% of 8month olds • 88% of 2 year olds • 81% of 5 year olds.
Adolescents are fully vaccinated according to the national schedule.	Provide the 11year old event in a general practice setting at age 11. Maintain the Year 8 HPV School Programme. Support General practice to vaccinate for HPV. Use an on-line learning tool to promote knowledge benefits of the programme	Q1 – Q4	▪ 70% of Girls have received dose 3	
Adult are fully vaccinated	Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.		• 75% of people aged 65+ have a seasonal flu vaccination	Vaccine has arrived.
The whole health system supported to promote, courage and engage in immunisation.	Maintain an Immunisation Advisory Group Develop an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. Maintain streamlined access to immunisation awareness information. Implement a DHB wide Immunisation Week Plan.	Q1-Q4 Q3 Q4	• West Coast DHB is represented at regional and national forums. • Immunisation Toolkit provided to practices. ▪ Narrative report on interagency activities completed to promote Immunisation Week.	Yes Not yet completed Yes.

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q2 2016/17



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 November 16

Fully Immunised 8 month olds – DHB LEVEL

Q1 2016/17 Actual	Q2 2016/17 Actual	Q3 2016/17 Progress including pending	Q4 2016/17 Progress including pending
76% fully	80% fully	90% fully	% fully
4% overdue	3.5% overdue	0% overdue	% overdue

Fully Immunised Two year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2016/17 Progress	Q3 2016/17 Progress	Q4 2016/17 Progress
88% fully	88% fully	78% fully	90% fully
0% overdue	0% overdue	1.1% overdue	% overdue

Fully Immunised Five year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2016/17 Actual	Q2 2016/17 Progress	Q3 2016/17 Progress
86% fully	81% fully	81% fully	77.5% fully
2% overdue	3.5%overdue	1.8% overdue	5% overdue

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter Two 2016/17
Newborns Born in the Following Period: 20 August 2016 to 19 November 2016
As at Quarter One 2017 (January 2017)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	210	944	1,498	63%	17
Bay of Plenty	114	440	726	61%	20
Canterbury	351	1,120	1,640	68%	12
Capital and Coast	181	615	875	70%	6
Counties Manukau	288	1,384	2,105	66%	15
Hawkes Bay	126	352	508	69%	8
Hutt	109	361	502	72%	4
Lakes	18	298	439	68%	13
MidCentral	104	317	512	62%	18
Nelson Marlborough	47	271	373	73%	3
Northland	160	454	618	73%	1
South Canterbury	38	117	171	68%	11
Southern	128	564	831	68%	14
Tairawhiti	45	128	182	70%	5
Taranaki	80	271	392	69%	9
Waikato	274	875	1,362	64%	16
Wairarapa	39	79	115	69%	10
Waitemata	279	1,245	2,041	61%	19
West Coast	24	52	74	70%	7
Whanganui	55	138	189	73%	2
Overseas or Unknown	0	0	8	0%	
Total	**2,670**	**10,025**	**15,161**	**66.1%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter Two 2016/17
Newborns Born in the Following Period: 20 August 2016 to 19 November 2016

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	108	1,498	93%	13
Bay of Plenty	63	726	91%	17
Canterbury	53	1,640	97%	7
Capital and Coast	19	875	98%	3
Counties Manukau	156	2,105	93%	14
Hawkes Bay	43	508	92%	16
Hutt	27	502	95%	9
Lakes	23	439	95%	8
MidCentral	14	512	97%	6
Nelson Marlborough	9	373	98%	4
Northland	39	618	94%	11
South Canterbury	2	171	99%	1
Southern	21	831	97%	5
Tairawhiti	20	182	89%	20
Taranaki	25	392	94%	12
Waikato	133	1,362	90%	18
Wairarapa	2	115	98%	2
Waitemata	115	2,041	94%	10
West Coast	8	74	89%	19
Whanganui	15	189	92%	15
Unknown	0	8	100%	
Total	**895**	**15,161**	**94%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter Two 2016/17
Newborns Born in the Following Period: 20 August 2016 to 19 November 2016
As at Quarter One 2017 (January 2017)

	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Alliance Health Plus Trust	260	397	65.5%	30
Auckland PHO Limited	118	211	55.9%	36
Central Primary Health Organisation	311	491	63.3%	32
Christchurch PHO Limited	119	130	91.5%	1
Compass Health - Capital and Coast	517	742	69.7%	23
Compass Health - Wairarapa	81	116	69.8%	22
Cosine Primary Care Network Trust	74	85	87.1%	2
East Health Trust	233	335	69.6%	24
Eastern Bay Primary Health Alliance	93	149	62.4%	33
Hauraki PHO	321	476	67.4%	28
Health Hawke's Bay Limited	351	461	76.1%	11
Kimi Hauora Wairau (Marlborough PHO Trust)	84	118	71.2%	20
Manaia Health PHO Limited	267	341	78.3%	7
Midlands Health Network - Lakes	76	122	62.3%	34
Midlands Health Network - Tairawhiti	95	117	81.2%	3
Midlands Health Network - Taranaki	268	365	73.4%	17
Midlands Health Network - Waikato	527	735	71.7%	19
National Hauora Coalition	250	330	75.8%	12
Nelson Bays Primary Health	187	251	74.5%	16
Nga Mataapuna Oranga Limited	26	44	59.1%	35
Ngati Porou Hauora Charitable Trust	28	37	75.7%	13
Ora Toa PHO Limited	49	67	73.1%	18
Pegasus Health (Charitable) Limited	831	1,240	67.0%	29
Procare Networks Limited	1,925	2,814	68.4%	26
Rotorua Area Primary Health Services Limited	226	301	75.1%	15
Rural Canterbury PHO	165	207	79.7%	4
South Canterbury Primary and Community	121	170	71.2%	21
Te Awakairangi Health Network	302	395	76.5%	10
Te Tai Tokerau PHO Ltd	170	216	78.7%	6
Total Healthcare Charitable Trust	359	478	75.1%	14
Waitemata PHO Limited	496	778	63.8%	31
Well Health Trust	38	48	79.2%	5
WellSouth Primary Health Network	565	815	69.3%	25
West Coast PHO	52	67	77.6%	9
Western Bay of Plenty PHO Limited	316	462	68.4%	27
Whanganui Regional PHO	124	159	78.0%	8
Unknown or Blank	0	891	0.0%	
Total	**10,025**	**15,161**	**66.1%**	

Number of Newborns Enrolled Within Three Months by DHB of Domicile and Ethnicity - Quarter Two 2016/17
Newborns Born in the Following Period: 20 August 2016 to 19 November 2016
As at Quarter One 2017 (January 2017)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Auckland	94	169	56%	142	219	65%	708	1,110	64%
Bay of Plenty	173	265	65%	NA	NA	NA	267	461	58%
Canterbury	148	179	83%	59	76	78%	913	1,385	66%
Capital and Coast	98	127	77%	57	83	69%	460	665	69%
Counties Manukau	279	375	74%	395	570	69%	710	1,160	61%
Hawkes Bay	159	230	69%	21	23	91%	172	255	67%
Hutt	76	125	61%	48	51	94%	237	326	73%
Lakes	141	177	80%	NA	NA	NA	157	262	60%
MidCentral	101	159	64%	NA	NA	NA	216	353	61%
Nelson Marlborough	48	68	71%	NA	NA	NA	223	305	73%
Northland	233	346	67%	NA	NA	NA	221	272	81%
South Canterbury	18	26	69%	NA	NA	NA	99	145	68%
Southern	94	113	83%	NA	NA	NA	470	718	65%
Tairawhiti	91	115	79%	NA	NA	NA	37	67	55%
Taranaki	80	100	80%	NA	NA	NA	191	292	65%
Waikato	264	397	66%	29	52	56%	582	913	64%
Wairarapa	26	43	60%	NA	NA	NA	53	72	74%
Waitemata	161	259	62%	96	154	62%	988	1,628	61%
West Coast	11	13	85%	NA	NA	NA	41	61	67%
Whanganui	60	84	71%	NA	NA	NA	78	105	74%
Overseas or Unknown	0	2	0%	NA	NA	NA	0	6	0%
Total	**2,355**	**3,372**	**70%**	**847**	**1,228**	**69%**	**6,823**	**10,561**	**65%**

Number of Newborns Enrolled Within Three Months by PHO and Ethnicity - Quarter Two 2016/17
Newborns Born in the Following Period: 20 August 2016 to 19 November 2016
As at Quarter One 2017 (January 2017)

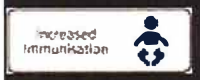
	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Alliance Health Plus Trust	51	61	84%	94	130	72%	115	206	56%
Auckland PHO Limited	15	22	68%	NA	NA	NA	103	189	54%
Central Primary Health Organisation	99	151	66%	NA	NA	NA	212	340	62%
Christchurch PHO Limited	15	7	214%	NA	NA	NA	104	123	85%
Compass Health - Capital and Coast	69	90	77%	NA	NA	NA	448	652	69%
Compass Health - Wairarapa	27	46	59%	NA	NA	NA	54	70	77%
Cosine Primary Care Network Trust	4	4	100%	NA	NA	NA	70	81	86%
East Health Trust	15	13	115%	NA	NA	NA	218	322	68%
Eastern Bay Primary Health Alliance	58	91	64%	NA	NA	NA	35	58	60%
Hauraki PHO	120	179	67%	NA	NA	NA	201	297	68%
Health Hawke's Bay Limited	159	209	76%	NA	NA	NA	192	252	76%
Kimi Hauora Wairau (Marlborough PHO Trust)	15	23	65%	NA	NA	NA	69	95	73%
Manaia Health PHO Limited	116	170	68%	NA	NA	NA	151	171	88%
Midlands Health Network - Lakes	36	48	75%	NA	NA	NA	40	74	54%
Midlands Health Network - Tairawhiti	58	63	92%	NA	NA	NA	37	54	69%
Midlands Health Network - Taranaki	78	91	86%	NA	NA	NA	190	274	69%
Midlands Health Network - Waikato	131	162	81%	NA	NA	NA	396	573	69%
National Hauora Coalition	64	78	82%	NA	NA	NA	186	252	74%
Nelson Bays Primary Health	33	43	77%	NA	NA	NA	154	208	74%
Nga Mataapuna Oranga Limited	22	34	65%	NA	NA	NA	4	10	40%
Ngati Porou Hauora Charitable Trust	28	35	80%	NA	NA	NA	0	2	0%
Ora Toa PHO Limited	24	24	100%	NA	NA	NA	25	43	58%
Pegasus Health (Charitable) Limited	106	130	82%	NA	NA	NA	725	1,110	65%
Procare Networks Limited	296	417	71%	NA	NA	NA	1,629	2,397	68%
Rotorua Area Primary Health Services Limited	109	130	84%	NA	NA	NA	117	171	68%
Rural Canterbury PHO	26	27	96%	NA	NA	NA	139	180	77%
South Canterbury Primary and Community	18	27	67%	NA	NA	NA	103	143	72%
Te Awakairangi Health Network	70	105	67%	NA	NA	NA	232	290	80%
Te Tai Tokerau PHO Ltd	112	150	75%	NA	NA	NA	58	66	88%
Total Healthcare Charitable Trust	71	96	74%	NA	NA	NA	288	382	75%
Waitemata PHO Limited	55	71	77%	NA	NA	NA	441	707	62%
Well Health Trust	7	11	64%	NA	NA	NA	31	37	84%
WellSouth Primary Health Network	95	109	87%	NA	NA	NA	470	706	67%
West Coast PHO	11	11	100%	NA	NA	NA	41	56	73%
Western Bay of Plenty PHO Limited	86	94	91%	NA	NA	NA	230	368	63%
Whanganui Regional PHO	56	74	76%	NA	NA	NA	68	85	80%
Unknown or Blank	0	276	0%	NA	NA	NA	0	615	0%
Total	**2,355**	**3,372**	**70%**	**94**	**130**	**72%**	**7,576**	**11,659**	**65%**

Q2 2016/17

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	88	73	83. %	59	54	92. %	16	13	81. %	0	0	-	3	3	100. %	10	3	30. %	5 ()	5.7 (0.0) %	1	1.1 %
8 Month	86	69	80. %	51	47	92. %	14	13	93. %	0	0	-	4	3	75. %	17	6	35. %	10 (1)	11.6 (1.2) %	3	3.5 %
12 Month	100	75	75. %	52	47	90. %	21	18	86. %	1	1	100. %	4	4	100. %	22	5	23. %	15 (0)	15.0 (0.0) %	7	7.0 %
18 Month	80	71	89. %	49	48	98. %	17	16	94. %	1	1	100. %	4	4	100. %	9	2	22. %	7 (0)	8.8 (0.0) %	0	0 %
24 Month	72	63	88. %	39	37	95. %	21	20	95. %	2	2	100. %	2	2	100. %	8	2	25. %	6 (0)	8.3 (0.0) %	3	4.2 %
5 Year	85	69	81. %	40	37	93. %	22	19	86. %	1	1	100. %	4	4	100. %	18	8	44. %	8 (0)	9.4 (0.0) %	5	5.9 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	88	73	83. %	11	11	100. %	13	13	100. %	22	19	86. %	20	14	70. %	21	15	71. %	1	1	100. %
8 Month	86	69	80. %	4	4	100. %	15	12	80. %	11	10	91. %	25	24	96. %	28	17	61. %	3	2	67. %
12 Month	100	75	75. %	2	2	100. %	22	21	95. %	20	18	90. %	19	16	84. %	30	13	43. %	7	5	71. %
18 Month	80	71	89. %	11	11	100. %	16	16	100. %	12	12	100. %	22	20	91. %	15	8	53. %	4	4	100. %
24 Month	72	63	88. %	6	6	100. %	11	11	100. %	14	14	100. %	23	22	96. %	16	8	50. %	2	2	100. %
5 Year	85	69	81. %	7	6	86. %	11	11	100. %	10	10	100. %	26	22	85. %	27	17	63. %	4	3	75. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Increased Immunisation BPS and Health Target 	Continue current activity, in accordance with national immunisation strategies and service specifications, to immunise all available children.	**Value and high performance**	1. To ensure parents are informed and vaccinated Before (and just after) Baby)	Continue to support LMCS to promote and educate pregnant women on Childhood Immunisation and the NIR including • Free seasonal flu vaccinations pregnant women. • Free pertussis vaccinations for pregnant women. Support and maintain systems for enrolment and seamless handover between maternity, general practice and WCTO services and support enrolment of new-borns with general practice	*98% of new-borns are enrolled with general practice at 3months of age*
			2. Encourage caregivers to ensure all pre-schoolers to be fully vaccinated	Monitor and evaluate immunisation coverage at DHB, PHO and general practice level managing identified service delivery gaps by: • Support PHOs by identify unvaccinated children by general practice. Provide an Outreach Immunisation service to locate and vaccinate missing children.	*95% of eight-month-olds are fully immunised.* *95% of two year olds are fully immunised.* *95% of four year olds are fully immunised.*
			3. Adolescents are fully vaccinated according to the national schedule.	Maintain the Year 8 HPV School Programme for both Boys and Girl. Support General practice to vaccinate for HPV, from age 9 – 26, including developing support systems to recall children at 14 years of age. Promote the seasonal influenza vaccine, especially those with chronic health conditions, those 65 and older and pregnant women.	*70% of girls are fully immunised for HPV.*
			4. Adult are fully vaccinated		*75% of 65 are fully vaccinated for Influenza*

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 6 June 2017 12:33 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers IAG meeting 8 June 2017
Attachments: 8 June IAG draft agenda.docx; Consultation Proposed School Based Immunisation Delivery Changes from 2018.pdf; HPV and Tdap paper WCIAG June 2017.docx; June data report.docx; WestCoast IAGSubmissionCo-deliveryTdapHPVinSchoolYear7.docx; Draft minutes March 9 Meeting.docx

Hi all

Please find attached the paper for our IAG meeting on the 8th June. Please note start time of 2pm.

I will be dialling in for Christchurch, please let me know if you can't make it.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 8th June 2017, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (9 March 2017)	Cheryl Brunton	9 March IAGDraftMinutes.do
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Cheryl	March Workplan update.docx June data report.docx
5	Ministry proposal for co-delivery of Tdap and HPV vaccines in school Year 7 • West Coast alternative proposal	Cheryl Brunton	HPV and Tdap paper WCIAG June 2 WestCoast IAGSubmissionCo-d Consultation Proposed School Ba
6	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Newborn Enrollment – Bridget to run report and send to Pauline and Sharyn	Bridget	
Immunisation Toolkit – Bridget to finalize this and run past Janet and Betty	Bridget	

HPV Vaccination at West Coast Fishing School – Janet to follow up with Lynley and Buller GP. Pauline to assist as needed	Janet	
Flu vaccinations to staff at Buller High – • Catherine C to feedback to Buller High and encourage them to link with their local general practice to obtain this services • Pauline to link with the GP to update them on the discussion	Catherine C Pauline	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

MINISTRY OF HEALTH
MANATŪ HAUORA

Co-delivery of Tdap and HPV vaccines in school year 7

April 2017

What we are proposing

We propose operational changes to the National Immunisation Programme, to co-deliver the Tetanus, Diphtheria and Pertussis (Tdap) and Human papillomavirus (HPV) vaccines in School Year 7 through the school based immunisation programme (SBIP).

What would the effect be?

From 2018 district health boards (DHBs) would be able to co-deliver the two vaccines in school Year 7 using the option outlined in Table 1 below.

Table 1: Co-delivery 2018 and 2019

School Year	Vaccination Event/s	
	1	2 (6 months later)
2018 (transition year)		
Year 7	Tdap + HPV	HPV
Year 8	HPV	HPV
2019		
Year 7	Tdap + HPV	HPV
Year 8	-	-

We recommend that all DHBs offer a school Year 7 Tdap programme. We see this programme change as an opportunity to review policies and co-deliver the HPV and Tdap vaccination events within your SBIP.

Who we think will be interested in this proposal

DHB planners and funders of school based immunisation programmes, public health units, nurses, vaccinators, doctors in general practice, schools offering year 7 and 8 programmes, parents of school year 7 and 8 students, organisations with an interest in vaccination.

Why we're proposing this

Since 2010 the expert Immunisation Advisory Groups to the Ministry and PHARMAC have recommended the school Year 7 and 8 vaccination events be co-delivered in Year 7. Administration of the HPV and Tdap vaccines on the same day is considered to be safe and effective from a clinical perspective and this supports co-delivery of these two vaccines. The Ministry supports this clinical advice and anticipates it will provide a more co-ordinated and efficient service to students, parents, schools, vaccinators and DHBs. Countries such as the United Kingdom and Australia are providing multiple vaccines given on the same day in their SBIPs.

Details about our proposal

This document describes our recommendation of proposed changes to the timing of the delivery of vaccines covered through the SBIP from 2018 and seeks your feedback on this recommendation.

We would appreciate your feedback on our recommendation by 2 June 2017. Please email your response to immunisation@moh.govt.nz

Once we have reviewed the feedback we will finalise this decision and provide recommendations to you and work on implementation.

Background

Currently there are two separate components to the School Based Immunisation Programme (SBIP); the Tetanus, Diphtheria and Pertussis (Tdap) booster, given in Year 7 and the Human Papillomavirus (HPV) vaccination in Year 8 (See Table 2: Current Programme Delivery 2017).

Since 1 July 2011 all SBIPs have been funded through district health board (DHB) base line funding. PHARMAC have procured the vaccines on behalf of DHBs since 1 July 2012, when the management of vaccines transferred from the Ministry to PHARMAC.

While the Ministry acknowledges that South Island DHBs except Nelson Marlborough DHB do not currently have a school Year 7 Tdap programme in place, we view this as an opportune time for these DHBs to consider implementing a Tdap programme in addition to their HPV programme.

School-based vaccination delivery remains the Ministry's preferred mode of delivery for routine administration of National Immunisation Schedule vaccines to older children, as these programmes consistently deliver equitable coverage for Māori and Pacific students. Equity remains a priority for the immunisation programme and ensures healthy futures for all New Zealanders.

The HPV vaccine coverage rates in SBIP shows that equitable coverage is occurring. We have not been able to measure coverage or equity for the Tdap programme, but from 2017 we expect to report on coverage for the 2005 National Immunisation Register (NIR) birth cohort, who are now aged 11 year.

Since 2010 the expert Immunisation Advisory Groups to the Ministry and PHARMAC have recommended the school Year 7 and 8 vaccination events be co-delivered in Year 7. Administration of the HPV and Tdap vaccines on the same day is considered to be safe and effective from a clinical perspective and this supports co-delivery of these two vaccines. The Ministry supports this clinical advice and anticipates it will provide a more co-ordinated and efficient service to students, parents, schools, vaccinators and DHBs.

Countries such as the United Kingdom and Australia are providing multiple vaccines given on the same day in their SBIPs.

To allow for co-delivering these vaccines in Year 7, a transition year is recommended in 2018 with both Year 7 and Year 8 programmes being delivered. Programme delivery costs will increase for one year only. It is anticipated that combining the two programmes into one school year will ultimately reduce the ongoing costs of service delivery.

Table 2: Current Programme Delivery 2017

School Year	Vaccination Event/s	
	1	2 (6 months later)
2017		
Year 7	Tdap	
Year 8	HPV	HPV

Note:

- Three school visits are required to vaccinate Year 7 and 8 students
- A six month gap between HPV vaccination events, minimises the chance of student movement to other schools or areas between the doses
- If Tdap is delivered on a separate day this allows for a catch up for HPV doses missed
- Disruption is across two school years on vaccination days
- If Tdap delivery is timed between the two HPV doses, this spreads the workload will be spread across the school year.

Work undertaken to date

The Ministry worked with a small group of DHB funding and planning managers to develop options for SBIP delivery. See Appendix One for membership of this Working Group. The group considered the vaccine co-delivery options, timeframes and looked at the benefits and potential challenges of co-delivery.

Benefits of co-delivery

In the short term, there may be inconvenience and increased costs associated with changing programme delivery and transitioning to Year 7. In the long term, the expected benefits of combining the vaccination events may include:

- reduced visits to schools, resulting in less disruption for students and teachers and potential cost savings for DHBs
- reduced administration and follow up time for SBIP teams and schools
- more convenient for parents with reduced information requests and only one consent form to complete
- greater acceptance of the HPV vaccine as part of the National Immunisation Schedule
- reduced anxiety inducing events for students.

Work streams

1. Informing the sector

- Work with DHBs to support the transition year in 2018.
- Develop a combined Tdap and HPV consent form that meets the Health and Disability Commissioner Act 1994 (the Act) and the Code of Health and Disability Services Consumers' Rights (the Code) right six – the right to be fully informed.

    - This consent form would be developed by the Ministry in conjunction with the Health Promotion Agency and in consultation with clinical leads and programme delivery experts for example Public Health Nurses.

- Inform parents in a way that gives them confidence that co-delivery of these vaccines on the same day is proven to be safe and effective.

    - The Ministry has commissioned research on parental responses towards multiple vaccine deliveries in the SBIP setting, a summary is supplied in Appendix Two.

- Work with the Ministry of Education, Home Schooling, and school Boards of Trustees on logistics for the delivery of two vaccines on the same day.
- Inform general practices/Primary Healthcare Organisations (PHOs) and others about co-delivery of these programmes and provide recommendations to support them in the delivery of these National Immunisation Schedule vaccines ie, update the *GP HPV Action Plan*.
- Development of key messages for health education resources for example a consent DVD (including a Te Reo version) and pamphlets that supports the co-delivery.

2. Vaccinator Training

- Providing support and resources for vaccinators to ensure they can confidently and safely provide the programme.

    - Work with the Immunisation Advisory Centre to update the Public Health Nurse Vaccinators update course.
    - Information on co-delivery models was sought from Australia where some states have recently transitioned to running a SBIP in school Year 7 only. A summary of this information is in Appendix Three.

3. IT changes

- Making changes to the IT systems to support co-delivery.

    - Updating recording and reporting via the Practice Management Systems (including School Based Vaccination Service) and NIR.

Recommendation

The Ministry recommends DHBs work towards co-delivery of the SBIP in school Year 7 using the option outlined in Table 1.

Assumptions for Year 7 programme delivery in 2018:

1. an individual student would receive both Tdap and HPV vaccines during School Year 7
2. a student will get HPV (dose 1) and Tdap vaccines on the first visit
3. a minimum of 26 weeks/6 months later, HPV dose 2 will be delivered
4. all students in a school year would be vaccinated ideally on one day (excluding non-consents and those absent) in each school
5. there will be a single consent form for both HPV and Tdap
6. consent for both vaccines would be sought at the beginning of the school year
7. a student's consent form is still valid if the student transfers to a different school and/or a public health district
8. HPV vaccine will need to be provided to Year 8 students in 2018.

The Ministry recommends that those DHBs who do not currently offer a school Year 7 Tdap programme, consider this as an opportunity to review their policy and combine this vaccination event with the HPV vaccine they already deliver.

Note: 2018 Transition year

- Four school visits may be required if the service is unable to vaccinate Year 7 and 8 on the same day.

2019 onwards

- There will be a reduction from the current three visits to two if Tdap and HPV are co-delivered.
- Utilisation of the six month gap between HPV doses, minimises the chance of student movement to other schools or districts between doses.
- As there is not a third visit scheduled for HPV there may not be a natural opportunity to provide catch up doses, however SBIP could provide HPV dose 1 and Tdap at the second school visit for those who missed out earlier in the year.
- There is disruption to only one school year.

If the co-delivery of HPV and Tdap at visit 1 is not manageable for a DHB then option 2: Delivery in Year 7 (see Table 3 in Appendix Four) may be considered.

Appendix One: Working group membership

Service Manager, School Based & Community Clinical Service, Northland DHB.

Senior Programme Manager, Child Health, Planning and Funding, Auckland & Waitemata DHB.

Senior Portfolio Manager, Children, Youth & Intersectoral Partnerships, Strategy, Planning & Performance, MidCentral DHB.

Project Specialist, Planning and Funding, Canterbury and West Coast DHB.

Portfolio Manager, Lakes DHB.

Manager, Immunisation, Servicing Commissioning, Ministry of Health.

Advisor, Immunisation, Service Commissioning, Ministry of Health.

Appendix Two: Summary research to test reactions to proposed changes to a school-based immunisation approach

22 February 2017

The Ministry of Health is inquiring about combining the Year 7 Tdap vaccination into a single vaccination event with the initial HPV vaccination. The safety and effectiveness of this approach is well documented. The Ministry commissioned Standard of Proof (Proof) to establish whether or not parents would support both vaccinations being administered at the same time at school.

Proof interviewed parents of Year 7 entrants who were planning to have their child vaccinated in line with the current schedule. Semi-structured interviews were held with 17 families to identify this group's possible different reactions to the specified approach. The research found that the change would either have a neutral or positive effect on immunisation rates, as long as the information and options provided by the Ministry address any concerns they might have.

Proof identified three parental groupings:

1. Families that would likely benefit from the combined approach (ie making it easier to immunise their children).

These families require information on the vaccines and their importance; evidence of Ministry approval; information on the safety of this approach; and confirmation that the vaccination will be administered by a registered nurse.

2. Families that would not experience any additional benefit (ie, the status quo remains)

These families require evidence of Ministry approval and confirmation that the vaccination will be administered by a registered nurse.

3. Families that would need further information in order to confidently consent to the new approach

These families require clear information on the vaccines, their importance, safety and the process involved; confirmation that the vaccines are recommended by health professionals; an opportunity to engage with health professionals; further information online and/or via the phone; an opportunity to engage with parents' experiences; and a choice of where the vaccination is administered.

The Ministry recommends moving to deliver both vaccines in a single event from 2018. Information will be developed to support parents in making informed decisions and supporting health professionals to engage with parents.

Appendix Three: Australian School Based Immunisation Programme co-delivery

Queensland - Email communication:

- QLD transitioned dTpa [Diphtheria, Tetanus and Pertussis] from Year 10 to Year 8 (our first year of high school at that time) in 2014, co-administered with HPV [vaccine] in the same school year. This was done as the uptake of dTpa in Year 10 was low and our research identified that the consent form may be more likely to get home and be returned and children turn up for vaccination in the younger years.

Was there an increase in children refusing vaccination on the day?

- We don't believe there was. In fact our service providers reported that they think the children in the first year of high school (now Year 7 in Queensland) are more compliant.

Do you use a combined consent form?

- This year we have redesigned our consent form to one combined form and it is available at https://publications.qld.gov.au/dataset/school-based-vaccination-program The redesign aims to improve parent completion and return of the consent.
- Prior to 2017, we had separate consent forms for each vaccine.

Do parents have the choice of choosing just one vaccine?

- Yes, they also have the option to say no to vaccination.

What was the response from the vaccinators regarding giving two injections to an older child?

- As stated above, the vaccinators believe the Year 7 students are mostly more compliant as they are new to the high school.

Other materials for our School Immunisation Program are available at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/schools

Victoria - Summary of conversation:

Historically the SBIP has been spread over school years 7, 8, 9 and 10. In 2015 a mass catch up was done, to allow transition of HPV, Tdap and Varicella vaccination to school Year 7.

2016 was the first year with a combined consent form, prior to this they had been separate.

Combining the programme and forms has improved consent form return rate.

Year 7 students are less likely to lose/hide the consent form. No noted problems with students refusing the second injection (Programme- visit 1: HPV & Tdap, visit 2: HPV & Varicella; visit 3: HPV). Parents tend to be more involved in their children's school life in Year 7.

The feeling is that combining HPV vaccine with other schedule vaccines has helped normalise it, along with including boys in the programme. Their website http://immunehero.health.vic.gov.au has been developed mostly for schools to use to help support the school based program. There are resources including games, videos, and resources for teachers to use in the classroom.

Appendix Four: Other programme options considered by the Working Group

The following options were discussed by the Working Group and while each has benefits, the general agreement was that they were less workable than the recommended option in Table 1. The option outlined in Table 3 (below) is recommended by the Ministry for those DHBs who do not feel that co-delivery will be workable.

Table 3: Delivery in Year 7

School Year	Vaccination Event/s		
	1	2	3
2018			
Year 7	HPV	Tdap	HPV
Year 8	HPV		HPV
2019			
Year 7	HPV	Tdap	HPV
Year 8	-	-	-

Notes:

This option is not co-delivery but it does move the programme to Year 7.

2018

Five school visits will be required if the service is unable to vaccinate Year 7 and 8 on the same day.

2019 onwards

Three school visits will be required if the service is unable to vaccinate Year 7 and 8 on the same day, this is the same as the current 2017 programme delivery.

Utilisation of the six month gap between HPV, should minimise the chance of student movement to other schools or districts between doses.

HPV vaccine could be provided to students at the Tdap visit if they were away at anearlier school visit.

If a student moves schools between the HPV and Tdap visits, they may miss Tdap vaccination at their new school, depending on the SBIP at the new school.

There will be disruption to only one school year.

The Working Group did not view this as a workable option for the SBIP either.

Table 4: HPV programme with 12 month gap

School Year	Vaccination Event/s	
	1	2 (6 months later)
2018		
Year 7	Tdap + HPV	
Year 8	HPV	HPV
2019		
Year 7	Tdap + HPV	
Year 8	HPV	

Notes:

2018

Three school visits will be required if the service is unable to vaccinate Year 7 and 8 on the same day. This is the same number of visits as for the current 2017 programme delivery.

2019 onwards

This assumes that all Year 7 students would have had Tdap, although it is possible to offer catch up in Year 8.

Two school visits will be required if the service is unable to vaccinate Year 7 and 8 on the same day

The 12 month gap between HPV vaccine doses increases the chance of student movement between schools and districts between vaccination visits. *(The Working Group felt that if this option was used, students would need to re-consent at the beginning of Year 8, due to student movement across schools and districts.)*

The 12 month gap between HPV vaccine doses produces a larger antibody response. The clinical relevance of this is unknown.

There would be disruption across two school years.

School visits would be planned at the beginning of the year, which may give opportunities for use of dedicated immunisation staff in other areas (eg influenza or allow for catch up school clinics). This may allow for the relocation of permanent staff with the use of causal or public health nurses during the high volume times. For those DHBs who use PHN staff to deliver the SBIP there would be less disruption to their regular work in the second part of the year.

The Working Group, felt that this option would not work as FTE would be moved off the programme during the second part of the year and it would be difficult to reallocate staff at the beginning of the fully year when workload would be high.

FOR	West Coast Immunisation Advisory Group
TITLE	PPV and Tdap: 11 year old vaccination event and Year 8 school-based vaccination programme
PREPARED BY	Dr Chery Brunton, Chair West Coast Immunisation Advisory Group Bridget Lester, Planning and Funding
DATE	2 June 2017
RECOMMENDATION	That the Immunisation Advisory Group reviews this paper and endorse the following: • Support the combining of HPV and Tdap at age 11 in a primary care based programme from January 2018. • Continue to offer a Year 8 school-based catch up programme for both HPV (and Tdap).

1. Purpose

The purpose of this paper is to provide background information to the West Coast Immunisation Advisory Group, around the proposed changes to the administration of the Tdap (tetanus-diptheria-pertussis) vaccine given at 11 years old and the HPV (Human Papilloma Virus) vaccination programme.

2. Background

In mid-2016 the Ministry of Health and PHARMAC advised changes to the national HPV programme. These changes included

- Extending the eligibility criteria to include boys
- Changing from a quadrivalent vaccine (protecting against four HPV strains) to a nine valent vaccine (protecting against nine HPV strains)
- Changing from a three dose programme to a two dose programme

At this time, the Ministry wrote to all DHBs signalling the changes to the programme in 2017 and foreshadowing that there would also be potential changes in 2018. They also indicated that DHBs should focus their efforts on the inclusion of boys in the Year 8 HPV School Programme in 2017.

On the 8th May 2017, the Ministry circulated a proposal to move HPV vaccination from Year 8 to Year 7, to continue to offer HPV vaccination in a school-based programme and also to offer the Tdap vaccination given at 11 years within the school-based programme (Year 7).

3. Current Service

There is currently no national consistency in the delivery of the Tdap to 11 year olds. In the majority of the country (the North Island and Nelson Marlborough DHB) Tdap vaccination is provided through a school-based programme to all year 7 children. However, in what was the older Southern Regional Health Authority region (Canterbury, South Canterbury, West Coast and Southern DHBs) this

vaccination is offered in a primary care setting, while HPV vaccination is offered in a school-based programme in Year 8 (except for Canterbury were HPV is offered at the 11 year old event in general practice, with a catch up programme in schools in Year 8).

Therefore while the proposed national changes will not have a large impact on the North Island, they will have an impact on the South Island and there is a need to consider whether the changes being proposed by the Ministry should be implemented by the WCDHB on the West Coast.

4. Rationale behind changes

The national rationale behind these changes is around normalising the HPV programme as part of the National Immunisation Schedule and streamlining school-based vaccination programmes. The assumption is that there will be overall increases in coverage and reduced administration costs if what is now done in Year 7 and Year 8 school-based programmes is combined.

5. National Planning

A national working group was set up to look at the implementation of this concept and proposed service models. While there are concerns in the Southern region, there are also concerns in the northern regions around what the change in the number of doses and schedule will mean for workforce and programme planning.

At a recent national teleconference a number of alternative models were suggested:

- Offer HPV in Term one and Term 3 and offer Tdap separately in Term 2
- Offer HPV and TDap at Year 8, as this would remove the concern around a one-off hump year when both the programmes are running contemporaneously.
- While option of the Year 8 programme would be better for the South Island, as we could continue to offer our 11 year old vaccinations with the Year 8 programme, it would not leave any room for a school-based catch up programme.

6. Current service performance

On the West Coast HPV coverage is low compared to other DHBs at 40-43% (for the 2003 cohort). The national target for HPV is 70% for girls born in 2003. Our coverage is affected by the dominator which is based on census data, and not actual WCPHO register data. While 100% of girls who consent to the school programme are vaccinated, there is still a large group that chooses not to vaccinate. In addition the West Coast school-based programme did not achieve equity of coverage for Māori girls born in 2003 (coverage was 27-33%).

By comparison, Tdap vaccination coverage at 11 years is very good. A review of the data undertaken by the WCPHO indicated that over 90% of eligible children were fully vaccinated and only a small number were overdue for a short period. There was no apparent inequity in Tdap coverage.

None of the above data include children from Gloriavale.

7. Consultation

Following the December West Coast Immunisation Advisory Group meeting, the WCPHO Clinical Governance Committee (CGC) was approached for comment regarding their view on the proposed national changes. Following a discussion around service model, data and challenges, the WCPHO CGC suggested moving HPV vaccination into the 11year old general practice programme, and then offering it as a mop up programme in schools with Tdap at Year 8.

This recommendation was then taken to the March West Coast Immunisation Advisory Group meeting, who supported the idea in principle. A paper requesting formal endorsement of the recommendation will be considered at the WCPHO CGC meeting on the 7th June.

8. South Island Consultation

This change needs to be discussed widely to ensure there is agreement within the MoH, DHB and Primary Care around any changes to the 11year old immunisations.

What has already occurred?

- The issue was highlighted at a recent South Island GM Planning and Funding meeting.
- An email has been sent to all Planning and Funding Immunisation Portfolio Managers asking their thoughts around the proposed changes.
- A discussion has occurred with the West Coast Immunisation Advisory Group and the West Coast PHO Clinical Governance Committee.
- A discussion has occurred with the Canterbury DHB Immunisation Service Level Alliance, and the Canterbury PHO CEO meeting.
- The Ministry has invited submissions on its proposal (these submissions closed on 2nd June 2017)

9. Proposed Service Models

MoH Proposal - Offer HPV and Tdap in a Year 7 School Programme

This is the Ministry's proposed model, but will have a major impact on primary care. This could be seen as moving children from their current healthcare home (where they currently receive their Tdap), and into a stand-alone school-based programme. This would require increased staffing within the school-based programme vaccination team, and result in reduced funding to general practice.

However, there is evidence that school-based vaccination programmes can achieve better equity of coverage, particularly for Māori and Pacific populations. Delivery of both HPV and Tdap vaccines in a school-based programme would also serve to help normalise HPV vaccine as part of the normal childhood schedule (i.e. it would no longer be standalone programme).

West Coast DHB Proposal - Offer HPV and Tdap at the 11year old event in general practice and a school-based catch up programme in Year 8

This would see HPV vaccination moved forward a year to the 11 year old event and offered in primary care, with a catch up school-based programme at Year 8. This would also normalise HPV as part of the National Immunisation Schedule and consolidate childhood vaccine delivery i.e. all vaccination events given in primary care at 11years of age, with follow up in school at 12 years.

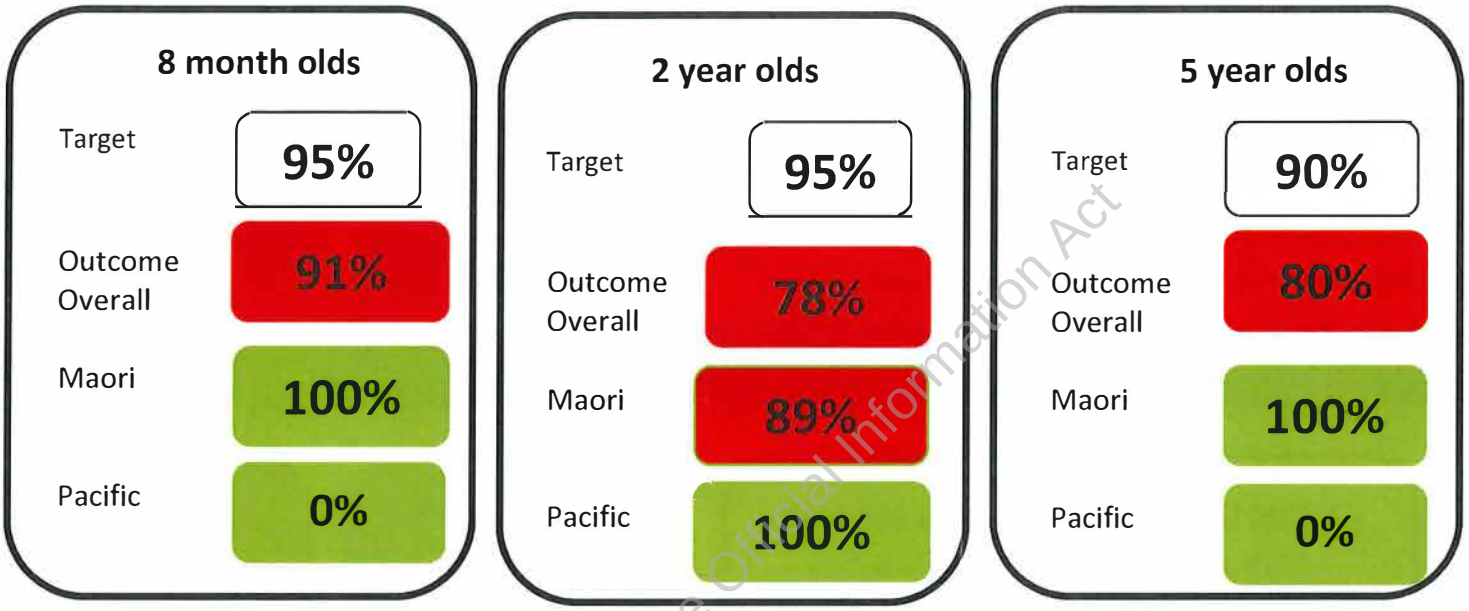
While this proposal is not within current national direction, it fits within the direction of our DHB with primary care being the main provider of healthcare for families. Existing Tdap coverage is excellent (with no evidence of inequity of delivery) and the current school-based programme coverage is suboptimal and also inequitable.

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q3 2016/17



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 November 16

Fully Immunised 8 month olds – DHB LEVEL

Q2 2016/17 Actual	Q3 2016/17 Actual	Q4 2016/17 Progress including pending	Q1 2017/18 Progress including pending
80% fully	91% fully	80% fully	73% fully
3.5% overdue	1.6% overdue	1.2% overdue	15% overdue

Fully Immunised Two year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2016/17 Progress	Q4 2016/17 Progress	Q1 2017/18 Progress
88% fully	78% fully	90% fully	81% fully
0% overdue	2% overdue	0% overdue	1% overdue

Fully Immunised Five year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2016/17 Actual	Q4 2016/17 Progress	Q1 2017/18 Progress
81% fully	80% fully	79%% fully	86% fully
3.5% overdue	3% overdue	2.5% overdue	2% overdue

Q3 2016/17

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	83	61	73. %	44	38	86. %	21	15	71. %	0	0	-	7	6	86. %	11	2	18. %	9 (0)	10.8 (0.0) %	3	3.6 %
8 Month	81	74	91. %	55	53	96. %	15	15	100. %	0	0	-	3	3	100. %	8	3	38. %	5 (0)	6.2 (0.0) %	1	1.2 %
12 Month	85	68	80. %	54	50	93. %	12	12	100. %	0	0	-	3	2	67. %	16	4	25. %	11 (0)	12.9 (0.0) %	4	4.7 %
18 Month	88	69	78. %	45	43	96. %	19	16	84. %	2	1	50. %	4	4	100. %	18	5	28. %	11 (0)	12.5 (0.0) %	4	4.5 %
24 Month	88	69	78. %	44	43	98. %	18	16	89. %	4	4	100. %	4	4	100. %	18	2	11. %	14 (0)	15.9 (0.0) %	4	4.5 %
5 Year	107	86	80. %	64	58	91. %	17	17	100. %	0	0	-	5	5	100. %	21	6	29. %	15 (0)	14.0 (0.0) %	4	3.7 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	83	61	73. %	8	5	63. %	12	10	83. %	10	10	100. %	29	24	83. %	22	10	45. %	2	2	100. %
8 Month	81	74	91. %	10	10	100. %	13	13	100. %	14	14	100. %	22	21	95. %	22	16	73. %	0	0	-
12 Month	85	68	80. %	5	5	100. %	16	14	88. %	8	7	88. %	27	25	93. %	26	15	58. %	3	2	67. %
18 Month	88	69	78. %	6	6	100. %	16	15	94. %	18	16	89. %	19	16	84. %	26	13	50. %	3	3	100. %
24 Month	88	69	78. %	6	5	83. %	11	11	100. %	12	11	92. %	25	23	92. %	32	17	53. %	2	2	100. %
5 Year	107	86	80. %	12	11	92. %	15	15	100. %	17	17	100. %	30	27	90. %	32	15	47. %	1	1	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 27 October 2.00-3.30PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Bridget Lester, Pauline Ansley, Janet Hogan, Lee Harris, Joanne Shaw and Anna Wall	
Apologies:	Catherine Andrews, Hillary Ford, Sarah Harvey, Cheryl Hutchison	
Agenda Items:	**Discussion**	**Action**
1. Intro/Apologies	Welcome by Chair	
2. Minutes of last meeting	Minutes of October meetings were approved.	
3. Matters Arising	No matters were arising from the last meeting not already on agenda	
4. Standing Items	**Report on KPIs and Action Plan** • Q1 = 76% 8 Month olds and 88% 2 year olds. These were both a decrease on last quarter. 2 8month olds were missed this quarter. 5 year olds increased to 86%. The work plan was discussed. • New-born Enrolment data shows WC ranked 1. Well done team! • The Immunisation Toolkit has been updated to reflect WC immunisation systems. Betty and Cheryl will review this. The HPV section needs to be updated to reflect the changes for 2017 • Outreach has not been at full capacity due to Betty being on sick leave. • Betty will be back to full time in the near future, so this issue should be sorted soon. • PHO has offered Health Navigator to bring families in. this could help Betty • Some family have wanted to wait until Betty gets back so she can vaccinate their children.	
HPV	**2016 programme** 80 girls consented to programme. 76 fully vaccinated. 1 left DHB, 1 not due yet, 1 done by OIS and other to be done on Monday. Thank you letters have gone to all schools. **2017 Programme** Two health scholarship students have been really useful updating contact details. Letter due to go to schools next week as well as advert to schools.	*Lee to write something for CEO update.*

	Concern around resource management if high interest in programme. Starting in second term, as per previous years. Phillip Wheble current acting GM of Grey/Westland Services. He understands the issue. HPV – Community Health Services contributing articles for Ask a Professional series in the Messenger. Would be good to have an article about HPV to go out in Feb / March. Janet would be keen to have a little pack of information to have hand out to parents around the changes in the programme. Need to look at using available national and IMAC resources are to support this. Consent forms are yet to be printed.	*Janet to write this.*
Influenza	Betty and Cheryl attended the Influenza Symposium in Wellington in November. This was a useful meeting. The extension of the National Programme (65 and over and pregnant women) to include community pharmacy is yet to be confirmed. Should know by end of year if this will happen, otherwise the WCDHB will have to put a proposal to Pharmac for this to happen on West Coast. Strong possibility that overall programme will be extended to August as has occurred incrementally in last few years. Nationally they are also looking at extending the programme for high risk pregnant women until 31 December. Loading every staff member on the NIR. Can OSH nurse do this themselves using MedTech? Or can we at least get the over 65s loaded.	*Bridget to talk to Phil around who to make this work and get the data*
11year old Imms	Discussed issue with Ministry's preference for combining Tdap and HPV in school-based programme for 2018. Need to work together and find the best model for the West Coast. Will probably always need to have a mixed model of service delivery, especially with our rural children. Current school HPV programme gaining consent takes the most of the time. This could increase with combined consent form for school programme. Tdap currently delivered in primary care and contributes income for practices Will doing a school-based programme actually improve the uptake of HPV and Tdap? Could we look at a joint general practice/school programme? How are we doing for 11 year old coverage now?	*Pauline to do query with practices to ascertain this.*

	As well as consulting IAG, need to discuss pros and cons at WCPHO Clinical Governance Committee. Important that primary care consulted and on bioa Bring back for further discussion at first meeting of IAG in February	*Pauline to invite discussion at next week's WCPHO CGC*
Next Meeting	Meeting Dates: Day and timeslot are OK - need to check with Kay Jenkins around 2017 dates for CPHAC/DSAC to align these. We need find a replacement for Nicky Mason, Betty has suggested Christine Neylon – from Reefton Practice.	*Bridget to email*

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 26 July 2017 2:31 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Cc: Robert Raeder
Subject: Papers: Immunisation Advisory Group meeting
Attachments: 27 July IAG draft agenda.docx

Hi all

Please find attached the paper for our meeting tomorrow.

I will be dialling in from Christchurch.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ Bridget.Lester@cdhb.health.nz
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

AGENDA

Thursday 27th July 2017, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
1	Introductions/Apologies	Cheryl Brunton	
	Fridges and Cold Chain	Robert Raeder	Aerscout Vaccine Refrigerator Replace
2	Minutes of last meeting (9 March 2017)	Cheryl Brunton	Minutes IAG June 2017 - draft.docx 9 March IAGDraftMinutes.do
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Cheryl	July data report.docx
6	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
11 year old event reporting breakdown – bridget to send to Pauline	Bridget	
HPV changes, dicuss with Child and Youth Workstream	Cheryl	
Cold Chain	Robert	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Kenning	NIR Coordinator

West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

Grey Base Hospital
High Street, Greymouth 7805

Telephone 03 769-7400
Fax 03 769-7790

25th July 2017

Dr Cheryl Brunton
Medical Officer of Health
Community and Public Health
3 Tarapuhi Street
Greymouth/

Dear Dr Brunton

Vaccine Refrigerator's

The WCDHB currently operates 16 dedicated Vaccine Refrigerators throughout its West Coast facilities, 14 of these units have now been operational for 12 yrs.

To comply with the MOH National Standards for Vaccine Storage the WCDHB has implemented a program whereby the refrigerators will be replaced at a rate of 4 per annum.

Any refrigerator that develops a fault to the extent that it requires servicing by a refrigeration company will be replaced.

Prior to the replacement program commencing the WCDHB will, within the next 12 months, implement Aeroscout, a real-time monitoring system that in the event of any failure will provide off site notification to the appropriate personal. The staged replacement of our vaccine refrigerators will commence during the 2018-2019 financial yr.

CDHB currently monitors 650 temperature controlled devices including those operated by NZ Blood Service via the Aeroscout system.

A full technical brief of the temperature monitoring system can be found via this link.

https://www.stanleyhealthcare.com/solutions/health-systems/environmental-monitoring/temperature-monitoring

Regards

Robert Raeder
Biomedical Engineer
WCDHB

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - Supporting you to be well

MINUTES – THURSDAY 9 March 2.30- 4.00PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Ann Knipe, Bridget Lester, Hillary Ford, Pauline Ansley and Anna Wall	
Apologies:	Cheryl Hutchison, Lee Harris, Joanne Shaw, Catherine Andrews, Betty Gilsenan and Janet Hogan	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of last meeting were not available. To review and approve at next meeting	
Matters Arising	No matters were arising from the last meeting not already on agenda	
Standing Items	**Report on KPIs and Action Plan** • Q3 = 90% 8 Month olds and 78% 2 year olds. These were both an increase on last quarter. 5 year olds decreased to 80%. The work plan was discussed. • Data not currently available	
HPV	141 consented for the School Based Programme (of these 64 are girls & 77 boys), this is up from 65 girls last year **To celebrate** • Grey District: 60% consented (with a 88.5% return) • Lake Brunner School came on board with year, great to have the RNS support **However, on the negative side** • Westland District: 23% consented (with a 38% return – a huge drop from past years). We had 20 girls last year at Westland High, only 1 this year and 5 boys. • Awaiting to hear if our advertising in Hokitika has made a difference and late consent forms have come in? • Buller District: 40% consented (with a 61% return), when Reefton is removed 31% consent for Westport (with a 53% return) • Still have Reefton Schools to complete and a handful of catch-ups in Buller Primary practices are being provided with their patient details, both consented and declined	
Influenza	Strong focus on the high needs patients. Pauline has a strong focus on reaching the SLM for this. Many practices have either achieved target or are close. • Coast Med need 4,	

	• SW have achieved, • Grey Medi = 44. • Haven't heard back from High Street and Westland Medical around their coverage.	
HPV Changes	A submission was sent to the Ministry of Health regarding their recommendation for co-delivery of HPV and Tdap programme in schools. The West Coast supports this co-delivery; however, we proposed that this is given in a general practice setting for 11 year olds with a catch up school programme in Year 8. This model was also proposed to the WCPHO Clinical Advisory Group which agreed to this direction, however, they questioned how this would be monitored and whether OIS criteria be widened to assist. The IAG agree to this model of care. The wider concern is that primary practices are already providing good coverage for Tdap at 11 years but the school HPV programme is not reaching a large group of children. If Tdap is taken from primary practice, will this potentially affect our overall Tdap coverage adversely. Send this age breakdown data to Pauline for her to work with Karo – to see if they can develop a report pulling the data from the practice level. Ask the MoH if they can pull a PHO level or Practice Level HPV reports like they do for childhood imms. Karo can run reports of us to give us what we need. Cheryl to take this to the Child and Youth workstream, for their feedback. Southern are keen to move towards a school-based programme, but we are not aware of what is happening for South Canterbury DHB. The MoH paper was silent on varicella vaccine, which should be provided in a general practice programme. There are opportunities around other Health Promotion measure considering there will be two visits for 11 year olds in general practice if our model of care being adopted.	*Pauline* *Cheryl*
Cold Chain	There is a issue around Vaccine Fridges being older than 10 years old. Rob Raeder is to develop a paper and attend the next meeting.	*Rob Raeder*
Next Meeting	27 July 2017	

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 9 March 2.30- 4.00PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Bridget Lester, Catherine Andrews, Hillary Ford, Sarah Harvey, Catherine Creighton, Pauline Ansley, Janet Hogan and Anna Wall	
Apologies:	Cheryl Hutchison, Lee Harris, Joanne Shaw	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of December meetings were approved.	
Matters Arising	No matters were arising from the last meeting not already on agenda	
Standing Items	**Report on KPIs and Action Plan** • Q2 = 80% 8 Month olds and 88% 2 year olds. These were both an increase on last quarter. 5 year olds decreased to 81%. The work plan was discussed. • New-born enrolment data show a decrease nationally, due to the timing of the report. WC is on 70% ranked 7. Bridget has located a new report, which will help identify the children missed, and therefore help with working with practices for tiding up records. • The Immunisation Toolkit has been updated to reflect WC immunisation systems. Betty and Bridget have received this for the final time, some minor changes are required, as well as an update on the HPV section. Influenza – coverage of high needs patients is a System Level Measure for West Coast PHO, so there will be an increased focused on reaching this population in 2017.	*Bridget to run report and share with Sharyn and Pauline.* *Bridget to finalise these and run past Betty and Janet*
HPV	The **School Programme** is due to start vaccinating in term two. The consent forms are nearly ready to go to all schools. There will be a bigger demand for this programme with the introduction of boys. Moana School has signed up to the programme this year. **Westport Fishing School Students** – there is interest in providing HPV vaccination for Fishing School students. This will be outside the school programme. Due to Pharmac changes with programme delivery, there was concern that this programme will need to be managed to fit within these new expectations. Suggestion was that these vaccinations could be offered by the nearest general practice, as an outreach programme. Would be able to give two doses within the six weeks students are at the school and give these students a referral back to their own GP for dose 3.	*Janet to follow up with Lynley and Buller GP practice. Pauline to assist as needed.*

	Westland Medical has sent recall letters for the older group. This is a positive move. **South Westland** – there is a concern that there is a group of kids who are not going to general practice to be vaccinated. Janet indicated that she has spoken to Dr Ramon Pink (MOH who does programme approvals), who said that a special programme approval is not required if they want to vaccinate these students in a Year 11-12 school programme. Further work will need to be done before this occurs, and agreement will need to be reached about whether or not this is the correct model. **Tdap and HPV changes in 2018 –** the MoH has proposed the moving of the HPV programme to Year 7, to align with the Year 7 Tdap programme. However, on the West Coast this programme is provided in General Practice. Following the last IAG meeting, a discussion was held with the PHO Clinical Governance Group. At this meeting the following points were presented: • Current Tdap coverage in the West Coast is around 90%. Those not vaccinated are either not due, or just overdue. This does exclude the Gloriavale population. • Current HPV coverage in the school programme is around 50%. It was acknowledged that the school programme reaches every child who has consented, but there is a concern around those who don't consent. It was also acknowledged that the coverage data is based on census population – and it is difficult to locate all the children. The PHO Clinical Governance Croup was concerned at the potential removal of 11 year old immunisation event from general practice. They are focused on general practice being the patient's health home. Current data do not suggest that there is any problem with coverage. The PHO Clinical Governance Group recommended the following approach for 2018. • General Practice to offer both Tdap and HPV at 11 years old. • A school programme will continue to be offered as a catch up programme in year 8 for both HPV and Tdap. This model was discussed and supported by IAG. Consultation will occur with the Child and Youth Workstream, Planning and Funding, and other relevant groups.	
Influenza	The vaccine is now available and in general practice. PHO is going to pay for some WC specific advertising. There have been changes in this programme in 2017: • Vaccine will be available until 31 December 2017 • Pharmacies will be able to provide the subsided vaccine for pregnant women and those 65 and older. A data portal has been set up to transfer the data to the NIR.	

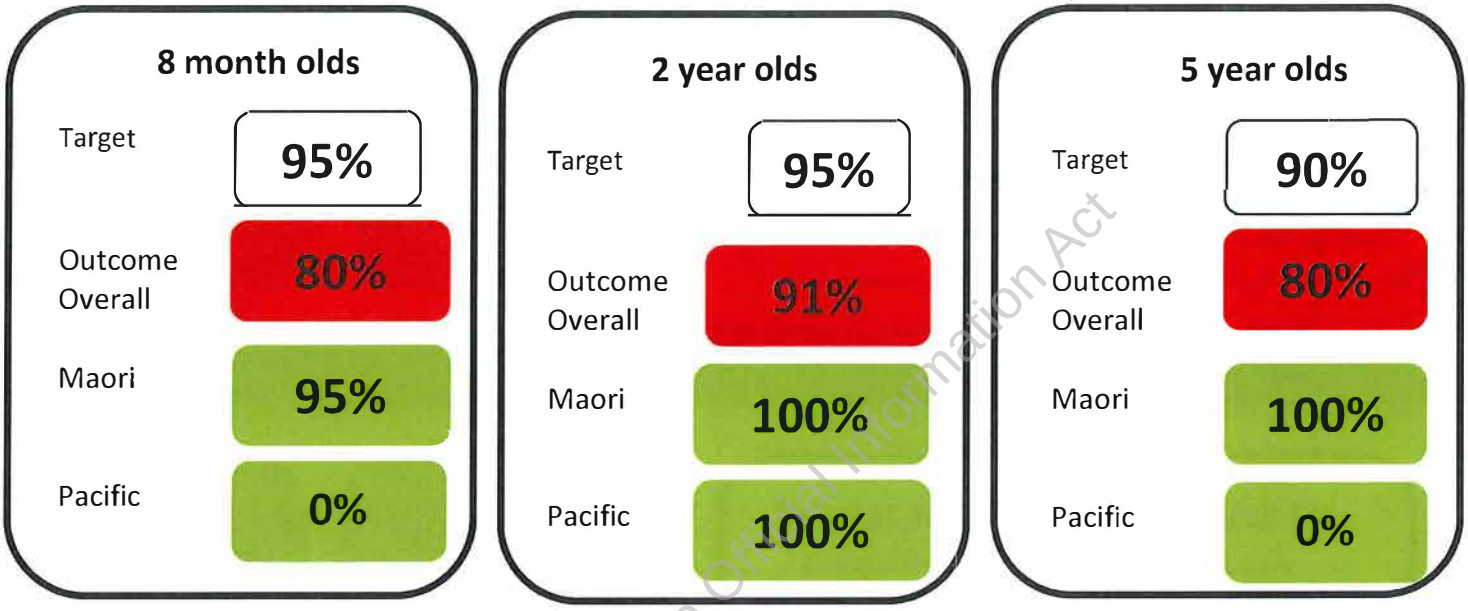
	The SLMF target is 65% of high needs populations (Māori, Pacific and Q5) by 30 June 2017. Poutini Waiora team are supportive of the general practice programme. The focus for performance improvement will be on to Buller Medical and Grey Medi, as they had the lowest coverage in 2016. Buller High – in 2016 teachers at Buller High were vaccinated with support from the PHNS. They have requested this again. There was a concern at IAG that this programme will need to be funded by the School and not provided free. There was also a concern around using PHN staff and the DHB OIS service to do this, as teachers are not a priority target group for the programme. The recommendation of IAG was that the school approach the local medical centre to see if they can provide the vaccination as an Occupational Health Programme. Betty will be supporting Poutini Waiora and others, including Westland Medical Centre in an education and information programme at the Arahura marae.	*Catherine C to feed back to Buller High, and encourage them to link with their local general practice to obtain this service.* *Pauline to link with the general practice to update them on the discussion.*
Next Meeting	Meeting Dates: Change November meeting date. 27 April 2017.	*Bridget to send updated email request*

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2016/17



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 November 16

Fully Immunised 8 month olds – DHB LEVEL

Q3 2016/17 Actual	Q4 2016/17 Actual	Q1 2017/18 Progress including pending	Q2 2017/18 Progress including pending
91% fully	80% fully	77% fully	71% fully
1.6% overdue	2.5% overdue	9% overdue	15% overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2016/17 Actual	Q4 2016/17 Progress	Q1 2017/18 Progress	Q2 2017/18 Progress
78% fully	91% fully	81% fully	% fully
2% overdue	0% overdue	1.1%	% overdue

Fully Immunised Five year olds - DHB LEVEL

Q3 2016/17 Actual	Q4 2016/17 Actual	Q1 2017/18 Progress	Q2 2017/18 Progress
80% fully	80% fully	86% fully	80% fully
3% overdue	3.8%	2% overdue	8% overdue

Q4 2016/17

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	64	51	80. %	39	34	87. %	14	14	100. %	1	1	100. %	2	2	100. %	8	0	-	8 (0)	12.5 (0.0) %	2	3.1 %
8 Month	80	64	80. %	44	38	86. %	21	20	95. %	0	0	-	5	4	80. %	10	2	20. %	8 (0)	10.0 (0.0) %	4	5.0 %
12 Month	83	75	90. %	56	54	96. %	14	13	93. %	0	0	-	2	2	100. %	11	6	55. %	5 (0)	6.0 (0.0) %	1	1.2 %
18 Month	96	68	71. %	51	45	88. %	18	12	67. %	1	1	100. %	4	4	100. %	22	6	27. %	15 (0)	15.6 (0.0) %	9	9.4 %
24 Month	77	70	91. %	49	49	100. %	14	14	100. %	1	1	100. %	4	4	100. %	9	2	22. %	7 (0)	9.1 (0.0) %	0	0 %
5 Year	79	63	80. %	44	40	91. %	19	19	100. %	1	0	-	2	2	100. %	13	2	15. %	10 (0)	12.7 (0.0) %	3	3.8 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	64	51	80. %	4	4	100. %	7	5	71. %	6	4	67. %	19	19	100. %	22	13	59. %	6	6	100. %
8 Month	80	64	80. %	6	5	83. %	13	11	85. %	10	9	90. %	29	27	93. %	20	10	50. %	2	2	100. %
12 Month	83	75	90. %	10	10	100. %	13	13	100. %	22	21	95. %	18	17	94. %	20	14	70. %	0	0	-
18 Month	96	68	71. %	3	3	100. %	18	15	83. %	19	18	95. %	20	16	80. %	29	11	38. %	7	5	71. %
24 Month	77	70	91. %	11	11	100. %	13	13	100. %	12	12	100. %	21	21	100. %	16	9	56. %	4	4	100. %
5 Year	79	63	80. %	4	3	75. %	15	14	93. %	12	12	100. %	27	24	89. %	21	10	48. %	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2003	HPV-1 Quadrivalent	10	3	1	63	77	30	0	5	140	180	33%	-%	20%	45%	43%	3 (1.7%)	0 (0.0%)
	HPV-2 Quadrivalent	9	3	1	60	73						30%	-%	20%	43%	41%	1 (0.6%)	
	HPV-3 Quadrivalent	8	3	1	59	71						27%	-%	20%	42%	39%	1 (0.6%)	
Total	HPV-1 Quadrivalent	10	3	1	63	77	30	0	5	140	180	33%	-%	20%	45%	43%	3 (1.7%)	0 (0.0%)
	HPV-2 Quadrivalent	9	3	1	60	73						30%	-%	20%	43%	41%	1 (0.6%)	
	HPV-3 Quadrivalent	8	3	1	59	71						27%	-%	20%	42%	39%	1 (0.6%)	

  - adult diphtheria and tetanus vaccine (ADT Booster); and
  - human papillomavirus vaccine (Gardasil 9).
- **GlaxoSmithKline NZ Limited (GlaxoSmithKline)**
  - diphtheria, tetanus and acellular pertussis vaccine (Boostrix);
  - diphtheria, tetanus, acellular pertussis and inactivated polio vaccine (Infanrix IPV);
  - diphtheria, tetanus, pertussis, polio, hepatitis B and haemophilus influenzae type B vaccine (Infanrix Hexa);
  - varicella-zoster vaccine (Varilrix);
  - pneumococcal (PCV10) vaccine (Synflorix);
  - measles, mumps and rubella vaccine (Priorix);
  - haemophilus influenzae type B vaccine (Hiberix); and
  - rotavirus vaccine (Rotarix).

Details of how to provide feedback are available at the PHARMAC website.

Kind regards,

Bonnie Jones
Senior Advisor Stakeholder Engagement
Immunisation
Community Health
Service Commissioning
Ministry of Health
DDI: 04 816 4434
Mobile: 021 806 021

http://www.health.govt.nz
mailto:Bonnie_Jones@moh.govt.nz

Lara Williams (Administrator)

From: Bonnie_Jones@moh.govt.nz
Sent: Monday, 30 May 2016 4:14 p.m.
Cc: Bonnie_Jones@moh.govt.nz
Subject: PHARMAC - Proposal to amend listings in the National Immunisation Schedule
Attachments: 2016-05-30 Consultation on Immunisation Schedule changes.pdf

Good afternoon,

PHARMAC is seeking feedback on proposals for the supply of vaccines for the New Zealand National Immunisation Schedule. Details are available in the attachment below and on the PHARMAC website at
https://www.pharmac.govt.nz/news/media-2016-05-30-vaccines-consultations/
https://www.pharmac.govt.nz/news/consultation-2016-05-30-immunisation-schedule/

In summary, these proposals would result in the following access, brand and dose changes:

From 1 January 2017:

- **Human papillomavirus (HPV) vaccine**
  - Funded access would be widened to include males and females aged 26 years old and under.
  - A two-dose regimen would be funded rather than a three-dose regimen for those males and females aged 14 and under. This would be subject to Medsafe approval of the two-dose regimen.
  - A three-dose schedule for males and females aged 15-26 years.
  - The 4 valent (Gardasil) HPV vaccine would be replaced with the 9 valent (Gardasil 9) vaccine.
  - Females who have started a three-dose regimen of Gardasil would be able to complete their remaining doses in 2017.

From 1 July 2017:

- **Varicella vaccine**
  - Funded access would be widened to include one dose for primary vaccination in children at 15 months old and a catch up in general practice of one dose for unvaccinated children aged 11 years, who have not previously been vaccinated against varicella or contracted chickenpox.
  - Funding criteria for high risk patients would remain unchanged.
- **Pneumococcal conjugated vaccine (PCV)**
  - The 13 valent (Prevenar 13) pneumococcal vaccine would be replaced with the 10 valent (Synflorix) PCV10 vaccine on the National Immunisation Schedule.
  - Prevenar 13 would remain available for high risk patients only.
- **Rotavirus vaccine**
  - The currently listed RotaTeq brand would be replaced with the Rotarix brand.
  - The current three-dose regimen would be replaced with a two-dose regimen.
- **Measles, mumps and rubella vaccine**
  - The currently listed MMR-II brand would be replaced with the Priorix brand.
- ***Haemophilus influenzae* type B (Hib) vaccine**
  - The currently listed Act-Hib brand would be replaced with the Hiberix brand.

Provisional agreements have been reached with the following suppliers:

- **Seqirus (NZ) Limited (Seqirus)**

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 26 October 2017 12:43 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; Catherine Crichton (catherine.crichton@westcoastdhb.health.nz); Cheryl Brunton; Cheryl Hutchison; Christina Houston; Hilary Ford; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: RE: Agenda - IAG 2514
Attachments: Oct data report.docx

Hi all

Immunisation Data report for today's IPG.

regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

From: Bridget Lester
Sent: Wednesday, 25 October 2017 11:11 a.m.
To: 'Ann Knipe' <ann.knipe@westcoastdhb.health.nz>; Betty Gilsenan <betty.gilsenan@westcoastdhb.health.nz>; 'Catherine Andrew' <catherine.andrew@westcoastdhb.health.nz>; Catherine Crichton (catherine.crichton@westcoastdhb.health.nz) <catherine.crichton@westcoastdhb.health.nz>; Cheryl Brunton <Cheryl.Brunton@cdhb.health.nz>; Cheryl Hutchison (cheryl.hutchison@westcoastdhb.health.nz) <cheryl.hutchison@westcoastdhb.health.nz>; Christina Houston <christina.houston@westcoastdhb.health.nz>; Hilary Ford <hilary.ford@westcoastdhb.health.nz>; Janet Hogan <janet.hogan@westcoastdhb.health.nz>; 'Joanne Shaw' <joanneshaw@westlandmed.co.nz>; 'Kylie Parkin' <kylie.parkin@westcoastdhb.health.nz>; Lee Harris <Lee.Harris@westcoastdhb.health.nz>; 'Nikki Mason' <nikki.mason@westcoastdhb.health.nz>; 'Pauline Ansley' <Pauline.Ansley@westcoastpho.org.nz>; riasouth@imac.org.nz; Sarah Harvey (CPH) <Sarah.Harvey@cdhb.health.nz>; 'Sharyn Kenning' <sharyn.kenning@westcoastdhb.health.nz>
Subject: FW: Agenda - IAG 2514

Hi all

Please find attached the agenda for tomorrows IAG meeting. I have done the data report, but I am working from home today and can't seem to attach it – so will send separately tomorrow.

Please let me know if you can't make it. I am again will be dialling in from Christchurch, my Dad had some health issues last week – so I have decided to stay close to home for a while.

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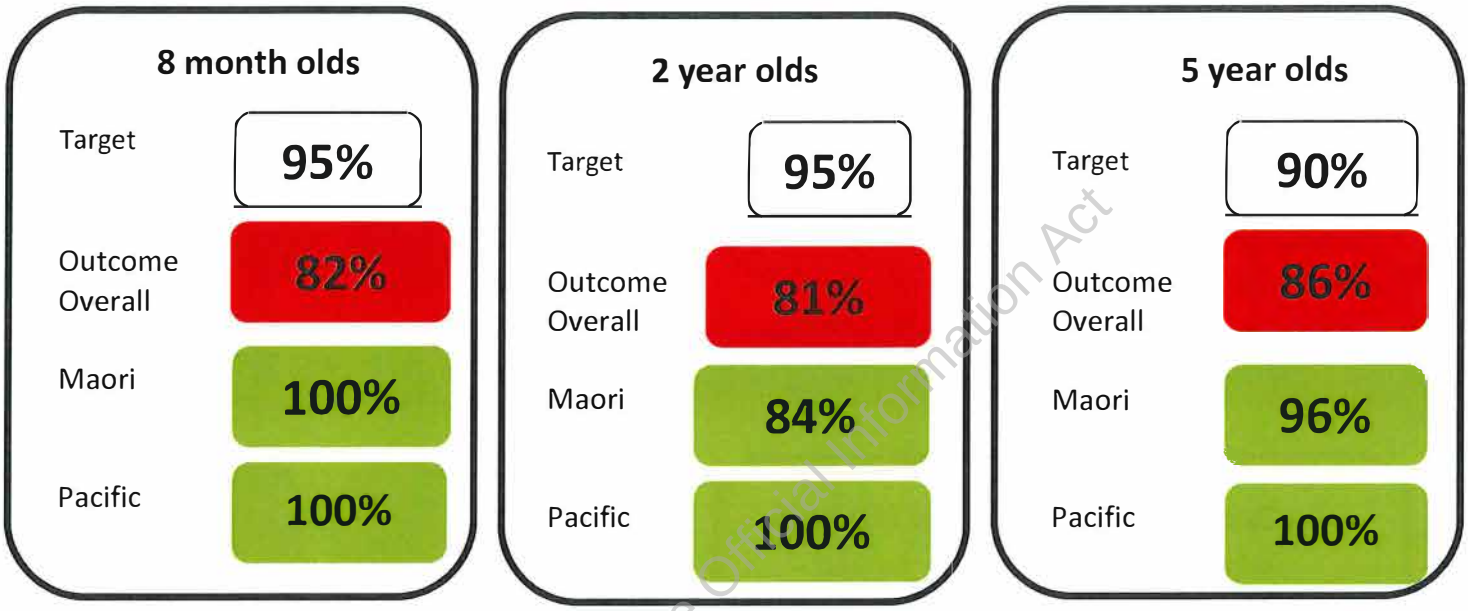
Regards Bridget

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2017/18



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 24 Oct17

Fully Immunised 8 month olds – DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress including pending	Q3 2017/18 Progress including pending
80% fully	82% fully	79% fully	% fully
2.5% overdue	% overdue	7% overdue	% overdue

Fully Immunised Two year olds - DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress	Q2 2017/18 Progress
91% fully	81% fully	76% fully	% fully
0% overdue	2.3% overdue	1%	% overdue

Fully Immunised Five year olds - DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress	Q3 2017/18 Progress
80% fully	86% fully	83% fully	% fully
3.8% overdue	2.4%	3.8% overdue	% overdue

Q1 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	90	65	72. %	53	45	85. %	17	12	71. %	0	0	-	3	2	67. %	17	6	35. %	9 (0)	10.0 (0.0) %	3	3.3 %
8 Month	77	63	82. %	49	44	90. %	12	12	100. %	1	1	100. %	3	3	100. %	12	3	25. %	8 (0)	10.4 (0.0) %	2	2.6 %
12 Month	81	67	83. %	42	38	90. %	20	19	95. %	0	0	-	7	7	100. %	12	3	25. %	9 (0)	11.1 (0.0) %	3	3.7 %
18 Month	84	65	77. %	51	46	90. %	12	12	100. %	0	0	-	5	4	80. %	16	3	19. %	12 (0)	14.3 (0.0) %	4	4.8 %
24 Month	84	68	81. %	44	44	100. %	19	16	84. %	1	1	100. %	3	3	100. %	17	4	24. %	11 (0)	13.1 (0.0) %	3	3.6 %
5 Year	95	82	86. %	53	46	87. %	24	23	96. %	1	1	100. %	7	7	100. %	10	5	50. %	5 (0)	5.3 (0.0) %	6	6.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	90	65	72. %	11	9	82. %	11	8	73. %	17	15	88. %	31	25	81. %	20	8	40. %	0	0	-
8 Month	77	63	82. %	8	8	100. %	7	7	100. %	10	10	100. %	26	21	81. %	20	11	55. %	6	6	100. %
12 Month	81	67	83. %	6	5	83. %	11	11	100. %	9	9	100. %	31	29	94. %	22	11	50. %	2	2	100. %
18 Month	84	65	77. %	4	4	100. %	18	17	94. %	10	9	90. %	27	23	85. %	23	11	48. %	2	1	50. %
24 Month	84	68	81. %	6	6	100. %	16	15	94. %	15	13	87. %	18	17	94. %	26	14	54. %	3	3	100. %
5 Year	95	82	86. %	7	6	86. %	11	11	100. %	22	20	91. %	30	28	93. %	19	11	58. %	6	6	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Q1 2017-18

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	8	0	4	56	68	30	0	0	130	160	27%	-%	-%	43%	43%	2 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	14	19						17%	-%	-%	11%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	13	18						17%	-%	-%	10%	11%	1 (0.6%)	
Total	HPV-1 Quadrivalent	8	0	4	56	68	30	0	0	130	160	27%	-%	-%	43%	43%	2 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	14	19						17%	-%	-%	11%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	13	18						17%	-%	-%	10%	11%	1 (0.6%)	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 13 September 2017 9:32 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; 'riasouth@imac.org.nz'; Sarah Harvey (CPH); Sharyn Kenning
Subject: Agenda for IAG tomorrow
Attachments: Draft Agenda - IAG 2514.docx

Hi all

Please find attached the agenda for IAG tomorrow.

I will be dialling in for CHCH again – speak to you all at 2pm.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 26th October 2017, 2.00 – 3.30pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa *For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (27 July 2017)	Cheryl Brunton	july 27 IAG minutes.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	 Bridget Janet Cheryl	
5	HPV and Tdap Changes, Implementation Plan	Bridget	
6	Update on mumps and pertussis	Cheryl	
7	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Pertussis – booster can be offered to DHB staff – Lee to include this in CEOs update	Lee	
Cold Chain and Fridges – Robert to check with IS to see if Aeroscout can be offered to all vaccine fridges on the West Coast	Robert	
Cold Chain – Fridge Replacement – Anna to check with MoH around timeframes	Anna Wall	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Newcombe	NIR Coordinator

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 27 July 2.00- 3.00PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Joanna Shaw, Lee Harris, Betty Gilsenan, Ann Knipe, Bridget Lester, Pauline Ansley and Anna Wall	
Apologies:	Cheryl Hutchison, Catherine Crighton, Catherine Andrews, Hillary Ford, Sharyn, and Janet Hogan	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of 9th March and 8 June reports were approved.	
Matters Arising	Tdap reporting template – data sent to Pauline HPV Changes – paper was shared with Jenni Stephenson facilitator of the Child and Youth Workstream. This paper was endorsed by the Workstream.	
Standing Items	**Report on KPIs and Action Plan** • Q4 o 80% 8 Month olds o 91% 2 year olds. o 5 year olds to 80%. o HPV end of girls born in 2003 group coverage 48% Pertussis – there is a creep in rates of pertussis in Southern and Nelson Marlborough DHBs, so we need to keep an eye on this. Therefore we need to remember and promote our key messages around this: • *Importance of on time immunisation for babies under one year old* • *Pertussis vaccination for pregnant women in every pregnancy* • *Health professional working with children under the age of one year, should check their pertussis vaccination status and have a booster every 5 years* Occupational Health will vaccinate WDCHB staff who require a booster. Some at the meeting asked if we could offer to vaccinate WCPHO staff or other non-WCDHB health professionals working with children under the age of one year old. This was done during the last pertussis epidemic, as was vaccination of ECC workers but this is not currently funded. Can still promote booster vaccination to these groups in the meantime. Put something into the CE update around this.	*Action: Lee to include key messages in CEO Update*
HPV	Following endorsement of the proposed WC model from C&Y Workstream, a paper is being drafted for the Planning and	

	Funding leadership team. This will hopefully be presented 31 July and if approved – aim for implementation in 2018	
Influenza	**No update provided**	
Cold Chain	Robert attended to talk to his paper around replacement of vaccine refrigerators. WCDHB is unable to afford to replace all its vaccine refrigerators at once (though almost all are at least 10 years old). The proposal instead is to: 1. Roll out a data monitoring system within the 2017/18 year. Aeroscout is a real-time monitoring system that in the event of any failure will provide off site notification to the appropriate personnel. This will result in better monitoring of current fridges 2. A staged replacement programme for the current DHB fridges, replacing four a year from 2018/19 year. There was discussion about whether or not the fridges at the private practices could be included in the rollout of Aeroscout (WMC already has it), so that there could be oversight of monitoring of all vaccine fridges on the Coast. There was concern that the MoH Cold Chain Accreditation guidelines require replacement of fridges every 10 years, and that this proposal will not fit within the MoH guidelines. By the time that this staged upgrade is complete some fridges will be around 15 years old. However, the new logging system should ensure that any issues with the fridges are identified, and if faulty they will be replaced not repaired. As a DHB we need to be careful of any precedent we set.	*Action: Robert to check with IS to see if this is possible* *Action: Anna to check with Ministry national direction on this.*
Next Meeting	14 September 2017 2-3.30pm	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 25 October 2017 11:11 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; Catherine Crichton (catherine.crichton@westcoastdhb.health.nz); Cheryl Brunton; Cheryl Hutchison; Christina Houston; Hilary Ford; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; Lee Harris; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: FW: Agenda - IAG 2514
Attachments: Draft Agenda - IAG 2514.docx; Mumps update letter and annexes.pdf

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MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

19 October 2017

Dear All Medical Officers of Health

Mumps update to Medical Officers of Health

Over the course of 2017 an increasing number of cases of mumps have been reported predominantly in Auckland region but also across New Zealand. This letter explains updated recommendations for the management of cases and contacts. A brief update regarding the current epidemiology of the disease in New Zealand is provided in Annex 1. The updated chapter for the CDC Manual is provided in Annex 2.

Globally, mumps outbreaks continue to occur, especially in teenagers and young adults. These outbreaks seem to be facilitated by mumps vaccine effectiveness (lower than for measles and rubella), waning vaccine-induced immunity and populations in settings more conducive to outbreaks (e.g. schools, universities).

The significant changes in mumps guidance provided in the Communicable Disease Control Manual are the following:

- **Prioritise MMR immunisation as public health response**

The most effective single action we can take is against mumps to vaccinate those with no or partial history of vaccination.

All susceptible individuals born after 1981 are eligible for two free doses of MMR vaccine, regardless of their citizenship or residency. While there are some concerns regarding a slightly lower efficacy for the mumps component of the MMR vaccine (as compared to measles or rubella) it is still recognised as very safe and effective. Vaccination of all those eligible is the most effective way of stopping the current outbreak, and should be the first course of action taken by providers.

Given the difficulties with contact tracing (see below), public health response in mumps outbreaks should focus on increasing MMR immunity, in order to avoid further cases of mumps and to provide protection against future importations of measles or rubella.

Though active immunisation with MMR vaccine is not considered effective against incubating mumps infection, MMR should be offered to susceptible contacts for protection against future exposure, which is likely to occur in significant outbreaks.

All vaccinations given should be recorded on the National Immunisation Register via the Practice Management Systems or by completing the NIR3 immunisation event form and sending this to the District Health Board NIR Administrator.

In settings other than health care, to support vaccine uptake, susceptible contacts who are excluded can be readmitted immediately after they have received the first MMR dose. This allows them to avoid an often long exclusion period if they get the vaccine. Those who have a history of one dose of MMR vaccination should be offered their second vaccine dose and should not be excluded.

In health care settings however, full exclusion of susceptible contacts will apply if they receive the first or second MMR dose after exposure to mumps. In general, full documented immunisation with two MMR doses should be required in these settings.

- **Limit contact tracing to particular settings**

Given that mumps can be paucisymptomatic or asymptomatic, more likely occurs in fully immunised people than measles or rubella, and has a long incubation period, contact tracing can be difficult and resource-consuming and may not be very effective.

Therefore contact tracing should be limited to settings where people are likely to be highly vulnerable, in particular health care settings given the potential presence of immunocompromised people, or where further transmission is likely to occur. Secondary and tertiary education institutions are more likely to experience outbreaks given the lower immunity in this population (those born after the introduction of MMR (1990) and before the introduction of the National Immunisation Register in 2005) and high population density with high contact rates that facilitate transmission.

As mentioned above, the response to mumps should give priority to immunisation of those who are likely not immunised (i.e. have no documentation of two doses of MMR).

- **Avoid serological screening where possible**

Serological screening to identify susceptible contacts is not recommended. The presence of mumps-specific IgG does not necessarily predict protection from mumps disease despite it being considered as evidence of mumps immunity.

It is recommended to rely on documentation of MMR immunisation (or previous mumps disease), and offer MMR vaccine to all those who cannot produce this documentation.

- **Case definition: fever is no longer required to meet the case definition.**

Please feel free to contact the Ministry of Health Communicable Diseases Team if further questions develop.

Yours sincerely

Dr Caroline McElnay
Director Public Health
Protection, Regulation and Assurance

MINISTRY OF HEALTH
MANATŪ HAUORA

Annex 1

Brief update on mumps epidemiology

During the period from 01/09/2016 to 22/09/2017 there were 581 confirmed or probable cases of mumps reported to ESR across 16 DHBs on both the North and South Islands. Auckland Regional Public Health Service had reported 434 confirmed or probable cases, i.e. 75% of the national total. The epidemiological curve is shown on figure 1.

Figure 1: number of confirmed and probable mumps cases by week and date of onset, 1 September 2016 to 22 September 2017

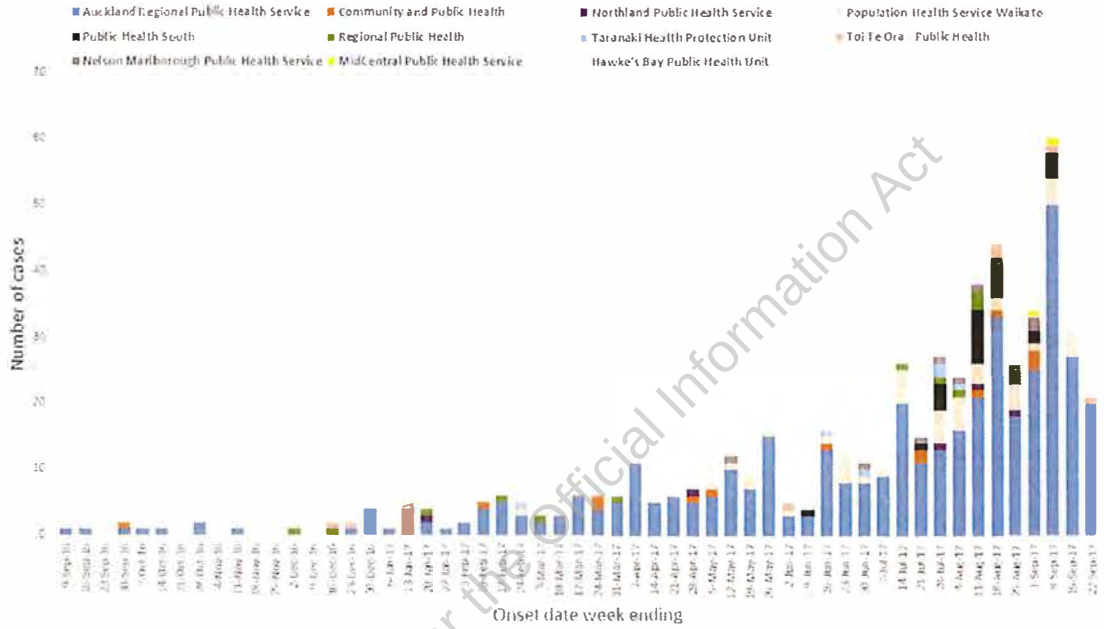


Table 1 shows the number of cases and the proportion of total cases by age group. Seventy percent of the cases are between 10 and 29 years of age.

Table 1: Number of confirmed and probable mumps cases and proportion of total cases by age group, 1 September 2016 to 22 September 2017

Age Group	Number of cases	Proportion of cases
<1	5	1%
1 to 4	28	5%
5 to 9	57	10%
10 to 14	83	14%
15 to 19	163	28%
20 to 29	159	27%
30 to 39	44	8%
40 to 49	25	4%
50 to 59	13	2%
60 to 69	4	1%
Grand Total	**581**	**100%**

Sex is evenly distributed among cases. Of the 462 cases which occurred in individuals 5 to 29 years of age, and thus those in the age group expected to be fully vaccinated, 266 (58%) reported no vaccination, 4 (1%) had been vaccinated in the past 14 days, 53 (11%) had received one dose of mumps-containing vaccine, and 139 (30%) reported having received the full schedule of two doses of MMR vaccine.

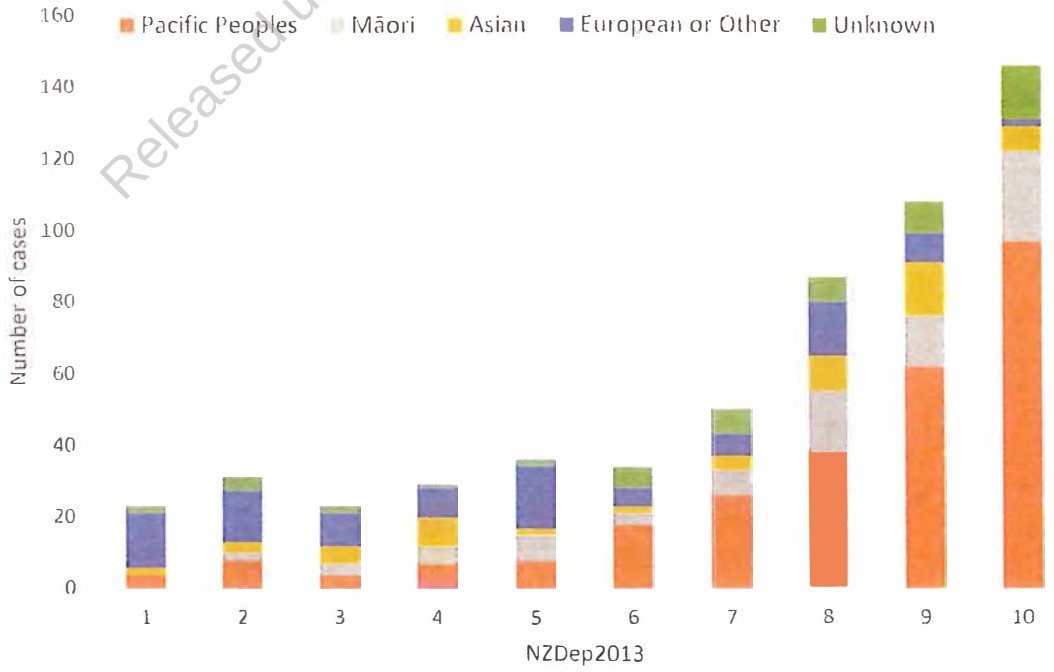
The following table shows the proportion of cases by ethnicity in New Zealand. The Pacific Island ethnic group is greatly over-represented among the cases, whereas those in the European and Other ethnic group are under-represented.

Table 2: proportion of confirmed and probable mumps cases by prioritised ethnicity for which ethnicity is known compared to the proportion of the same ethnic groups in the NZ population, 1 September 2016 to 22 September 2017

Prioritised ethnicity	Percentage of total number cases (number of cases)	Proportion of the NZ population (2016-2017)
Maori	16% (84)	15%
Pacific Peoples	53% (275)	7%
Asian	11% (59)	13%
European or Other	20% (105)	65%

Cases are more likely to be from most deprived areas, particularly for Pacific Island and Māori ethnicities (Figure 2).

Figure 2: number of confirmed and probable mumps cases by Deprivation 2013 Index and prioritised ethnicity, 1 September 2016 to 22 September 2017



Sixty-six cases (11%) were overseas during the incubation period. Of these, 52 cases (79%) have been in a Pacific Island: 27 cases (41%) had travelled to Fiji, 20 cases (30%) had been in Tonga. Cases have also come Tuvalu and Kiribati (2 cases each) and Samoa (1 case).

Genotyping of mumps viruses from eighteen cases from Auckland region has found the genotype G.

Population immunity against mumps

Mumps is a vaccine-preventable disease, however rates of vaccination with the measles, mumps, and rubella (MMR) vaccine were below optimal levels in New Zealand before the introduction of the National Immunisation Register. Those born in 1981 or before are considered as immune given the period mumps outbreaks before the introduction of the MMR vaccine. Also, many countries in the Pacific do not currently vaccinate for mumps, using a measles and rubella (MR) vaccine instead. Fiji, Kiribati, Nauru, Papua New Guinea, Solomon Islands, Tonga, Tuvalu and Vanuatu fall into this category. Thus there is a potential population of mumps-naïve individuals in the region, and likely in New Zealand, that is fuelling the current outbreak.

In summary, in the current outbreak there have been multiple importations from Pacific Islands. Significant risk factors for a case include an age between 10 and 29 years, living in a deprived area and being of Pacific ethnicity. The latter may be due to most importations being from Pacific Islands, overcrowding as it is combined with deprivation for this population, and a smaller proportion of people immune to mumps in this population. While vaccination is significantly protective, a large proportion of cases are found to be fully vaccinated.

Mumps (Updated chapter in CDC Manual)

Epidemiology in New Zealand

The incidence of mumps in New Zealand has been stable in recent years. Mumps epidemics in New Zealand occurred in 1989 and 1994 while the most recent began at the end of 2016 (mainly in Auckland region). Before the introduction of the measles–mumps–rubella (MMR) vaccine in 1990, mumps epidemics occurred every 3–5 years.

Detailed epidemiological information is available on the Institute of Environmental Science and Research (ESR) surveillance website in the annual notifiable disease reports at https://surv.esr.cri.nz/surveillance/annual_surveillance.php.

Globally, mumps outbreaks continue to occur, especially in teenagers and young adults. These outbreaks are facilitated by mumps vaccine effectiveness (lower than for measles and rubella), waning vaccine-induced immunity and populations in settings more conducive to outbreaks (e.g. schools, universities).

Given that mumps cases may only be mildly symptomatic, and that about a third of infections may be asymptomatic, infected (and possibly contagious) individuals may not consult health services. Therefore, identifying chains of transmission in an outbreak situation may be difficult.

Case definition

Clinical description

An acute illness with unilateral or bilateral tenderness and swelling of the parotid or other salivary gland/s, lasting more than 2 days, with or without fever and without other apparent cause. Other symptoms may uncommonly include orchitis, mastitis, oophoritis, meningitis, encephalitis, pancreatitis, and hearing loss.

Laboratory tests for diagnosis

Laboratory definitive evidence for a confirmed case requires at least one of the following:

- detection of mumps virus nucleic acid (PCR) (recommended)
- detection of IgM antibody specific to the virus.
- IgG seroconversion or a significant rise (four-fold or greater) in antibody level for the virus between paired sera tested in parallel where the convalescent serum was collected 10 to 14 days after the acute serum
- isolation of mumps virus by culture.

If the case received a vaccine containing the mumps virus in the 6 weeks prior to symptom onset then laboratory definitive evidence requires also:

- evidence of infection with a wild-type virus strain obtained through genetic characterisation.

If necessary, consult a microbiologist to discuss testing.

Case classification

- **Under investigation:** A case that has been notified, but information is not yet available to classify it as probable or confirmed.
- **Probable:** A clinically compatible illness.
- **Confirmed:** A clinically compatible illness that is laboratory confirmed or epidemiologically linked to a confirmed case.
- **Not a case:** A case that has been investigated and subsequently found not to meet the case definition.

Spread of infection

Incubation period

About 16–18 days, ranging from 12–25 days.

Mode of transmission

By droplet spread or by direct contact with saliva or fomites from an infected person.

Period of communicability

People with mumps are most infectious from 2 days before to 5 days after the onset of parotitis. However, mumps virus has been isolated in saliva from 7 days before to 9 days after the onset of parotitis. Asymptomatic cases also can be infectious.

Notification procedure

Attending medical practitioners or laboratories must immediately notify the local Medical Officer of Health of suspected cases. Notification should not await confirmation.

Management of case

Investigation

Ascertain whether there is a history of vaccination and travel and identify any possible contacts, including travellers from overseas.

Ensure laboratory confirmation by viral nucleic acid detection from a buccal swab taken ideally within 3 days, up to 7 days of parotitis onset. The buccal area to swab is the space near the upper rear molars between the cheek and gum (if unilateral parotitis, swab the affected side).

Restriction

In a health care facility, implement droplet (in addition to standard) precautions for 5 days after the onset of glandular swelling.

Exclude cases from school, university, sports, early childhood services, health care employment or other work, and from close contact with other susceptible people for 5 days from onset of glandular swelling.

Counselling

Advise the case and their caregivers of the nature of the infection and its mode of transmission. In particular, advise good hand hygiene, cough/sneeze etiquette, avoiding sharing food/drink/utensils, and social distancing.

Management of contacts

Definition

Any person with close contact[1] (for example, through household, early childhood services, school, workplace, camp, cultural or sports-related activities, transportation or social mixing) with the case during the period of communicability.

Susceptible contact

Anyone born after 1981 who has not had mumps infection or has not been fully vaccinated for their age.[2]

Investigation

In an outbreak, obtain a history of previous immunisation or natural illness with mumps to identify susceptible contacts.

Serological screening to identify susceptible contacts is not recommended. The presence of mumps-specific IgG does not necessarily predict protection from mumps disease despite it being considered as evidence of mumps immunity.

Restriction

Advise exclusion of susceptible contacts in health care settings and for those working or living with immune-compromised people from 12 days after the first exposure to 25 days after last exposure to the infectious case. Documented full immunisation with two MMR doses should be required in these situations.

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[1] For practical reasons close contact may be defined as face-to-face contact within 1 metre.

[2] Mumps vaccine was first offered in the 1990 schedule as MMR at 15 months and a second dose was introduced in 1992 at 11 years. However, any person born between 1969 and 1981 who has not received two documented doses of MMR vaccine should be offered the vaccine to protect them against measles and rubella. People born between 1991 and 1996 may have only had 1 dose of MMR as the second dose was offered as part of a school catch up programme at this time.

In general, **consider** advising exclusion of susceptible contacts with zero MMR doses from tertiary education, school or early childhood services or work from 12 days after the first exposure to 25 days after last exposure to the infectious case, if there is a high risk of mumps transmission.

Exclusion is more important in secondary and tertiary education settings as these settings are more conducive to outbreaks.

All excluded contacts in settings other than healthcare or with immunocompromised people can be readmitted immediately after they have received the first MMR dose. Those who have a history of one dose of MMR vaccination should be offered their second vaccine dose and be allowed to remain in school.

These measures will increase overall immunity in these populations and limit the spread of mumps (as well as protecting against measles and rubella), but also minimise the disruption due to exclusion.

All vaccinations given should be recorded on the National Immunisation Register via the Practice Management Systems or by completing the NIR3 immunisation event form and sending this to the District Health Board NIR Administrator.

Prophylaxis

Passive immunisation is not effective. Active immunisation with MMR vaccine is not considered effective against incubating infection, but MMR should be offered to susceptible contacts for protection against future exposure.

Counselling

Advise good hand hygiene, cough/sneeze etiquette, avoiding sharing food/drink/utensils, and social distancing. Advise all contacts of the incubation period and typical symptoms of mumps. Encourage them to seek early medical attention and avoid contact with others if symptoms develop.

Other control measures

Prevention

Make sure that all those born after 1969 and who are susceptible are offered MMR vaccine, with priority given to those borne after 1981.

Identification of source

Check for other cases in the community.

Disinfection

Clean and disinfect surfaces and articles soiled with saliva or urine. For more details, refer to Appendix 1: Disinfection.

Health education

Encourage complete childhood vaccination with the MMR vaccine. This currently involves two doses, the first at 12–15 months of age and the second at 4 years of age, before school entry.

Encourage early childhood services to keep up-to-date immunisation records.

Outbreak response

The focus of the Public Health response should be:

- to increase population immunity against measles, mumps and rubella
- to limit outbreaks in settings where transmissions may be more intense and prompt public health intervention may be effective (especially secondary and tertiary education)
- to stop any spread in health care settings, and protect immune-compromised people.

Immunisation response should be prioritised.

Reporting

Ensure complete case information is entered into EpiSurv.

If a cluster of cases occurs, inform the Ministry of Health Communicable Diseases Team and outbreak liaison staff at ESR, and complete the Outbreak Report Form.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 29 November 2017 11:04 a.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Harvey (CPH); Sharyn Kenning
Subject: Papers and Agenda for Tomorrows meeting
Attachments: 2017_workforce_influenza_coverage_by_dhb.docx; Draft Agenda - IAG 301117.docx; iag minutes 26 oct 2017.docx; nOV data report.docx

Hi all
Please find attached the minutes from our last meeting, agenda and papers.

Remember the meeting is on at 9.30am tomorrow at C&PH.

I will be dialing in.

Please let me know if you can't attend.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

2017 DHB Health Care Worker Influenza Immunisation Coverage

Background

Health care workers, by virtue of their occupation, are at increased risk of contracting influenza and may transmit the infection to susceptible contacts, with the potential for serious outcomes.

All district health boards (DHBs) offer free influenza immunisation to their employed staff. Since 2010, the Ministry of Health has been reporting on DHB health care worker influenza immunisation coverage.

Occupational groups

The following occupational groups are included by DHBs for the collection and comparison of their influenza immunisation coverage rates:

Nurses	Includes registered and enrolled nurses.
Doctors	Includes registered doctors.
Midwives	Includes registered midwives.
Allied staff	Includes but not limited to physiotherapists, laboratory technicians, occupational therapists, dieticians, social workers, pharmacists, radiologists and speech language therapists etc.
Other employees	May include but not limited to health care assistants, cleaners, orderlies, administrators and management etc.

Non-employed individuals

DHBs also offer free influenza immunisation to individuals not employed by the DHB but working in their facilities such as contractors, registered midwives and health care students etc. The numbers of vaccines given to this group are collected by DHBs but it is not possible to calculate the immunisation coverage as there is no set denominator for this group.

DHB staff vaccinated elsewhere

DHB employed staff who have had their influenza immunisation elsewhere (e.g. own general practitioner) are not included in these DHB coverage rates. However, some DHBs collect this information and staff are requested to inform the DHB if they have been vaccinated elsewhere.

Total DHB Health Care Worker Coverage 2010 - 2017

Figure 1. Total DHB Health Care Worker Influenza Immunisation Coverage 2010 -2017

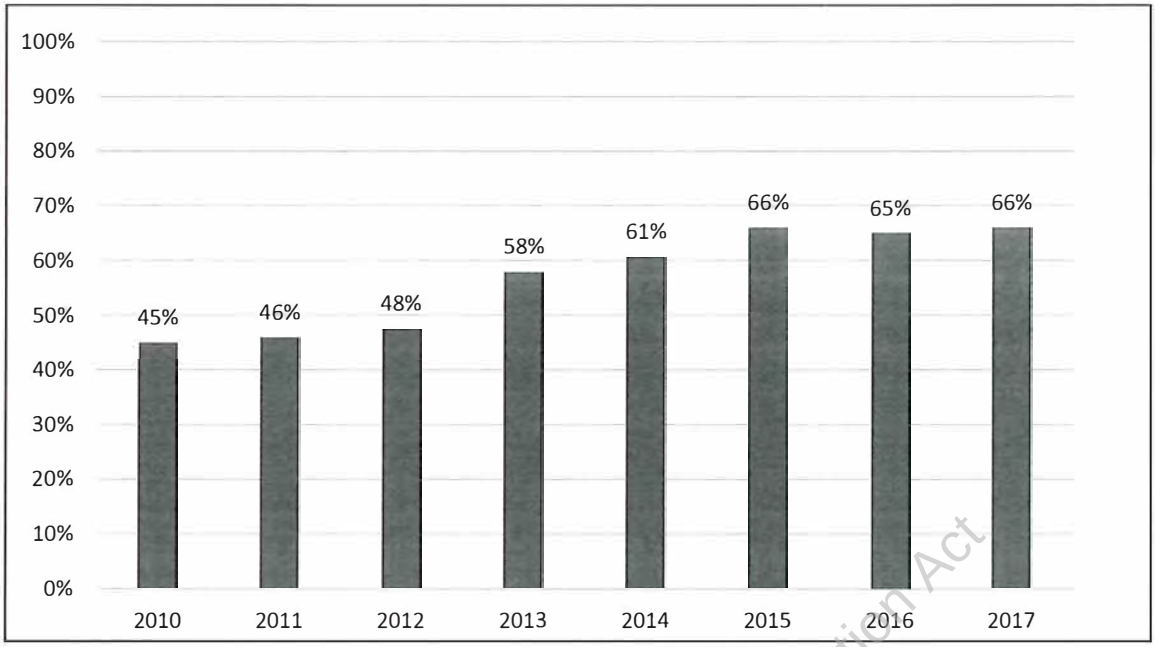


Figure 1: Total DHB health care worker influenza immunisation coverage rates have steadily increased since 2010 and have remained around 65 – 66 percent for the last few years.

Comparison of DHB Health Care Worker Coverage by DHB 2014 - 2017

Figure 2. DHB Health Care Worker Influenza Immunisation Coverage by DHB 2014 - 2017

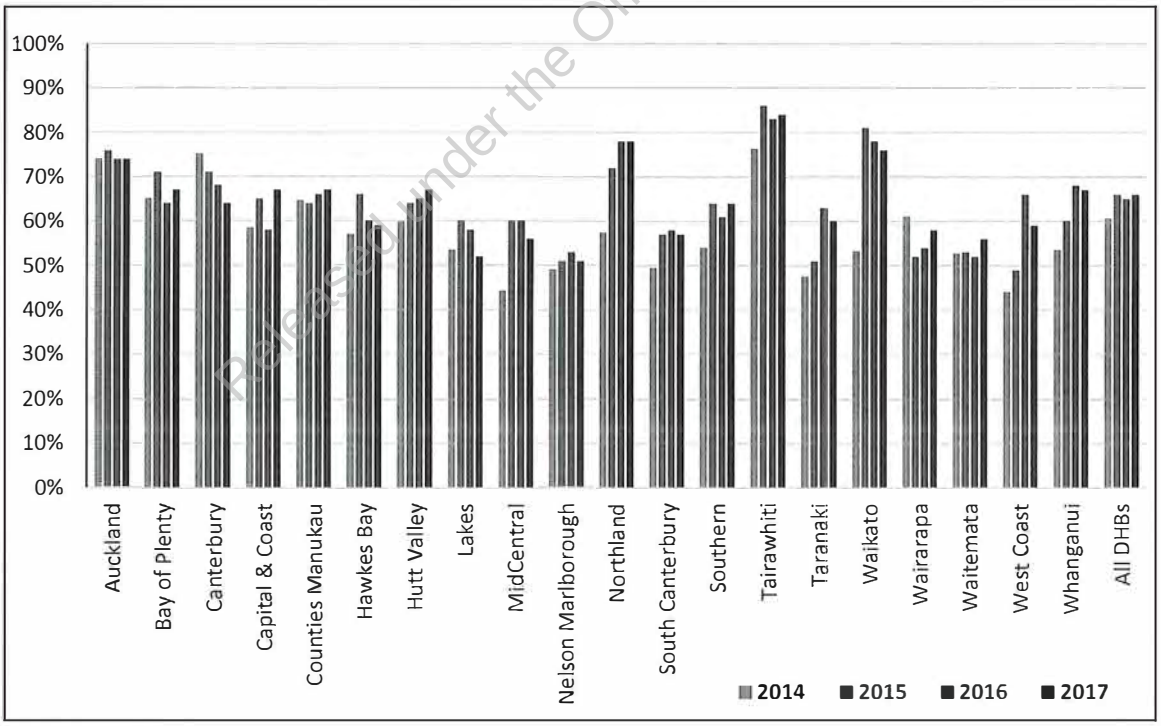


Figure 2: DHB health care worker influenza immunisation coverage rates in 2017 varied, with an average of 66 percent across all DHBs. Four DHBs sustained coverage over 70 percent and Capital & Coast DHB made significant increases in coverage in 2017 compared to 2016. Nelson Marlborough DHB coverage continues to sit at about 50 percent.

Comparison of DHB Health Care Worker Coverage by Occupation 2014 - 2017

Figure 3. DHB Health Care Worker Influenza Immunisation Coverage by Occupation 2014 -2017

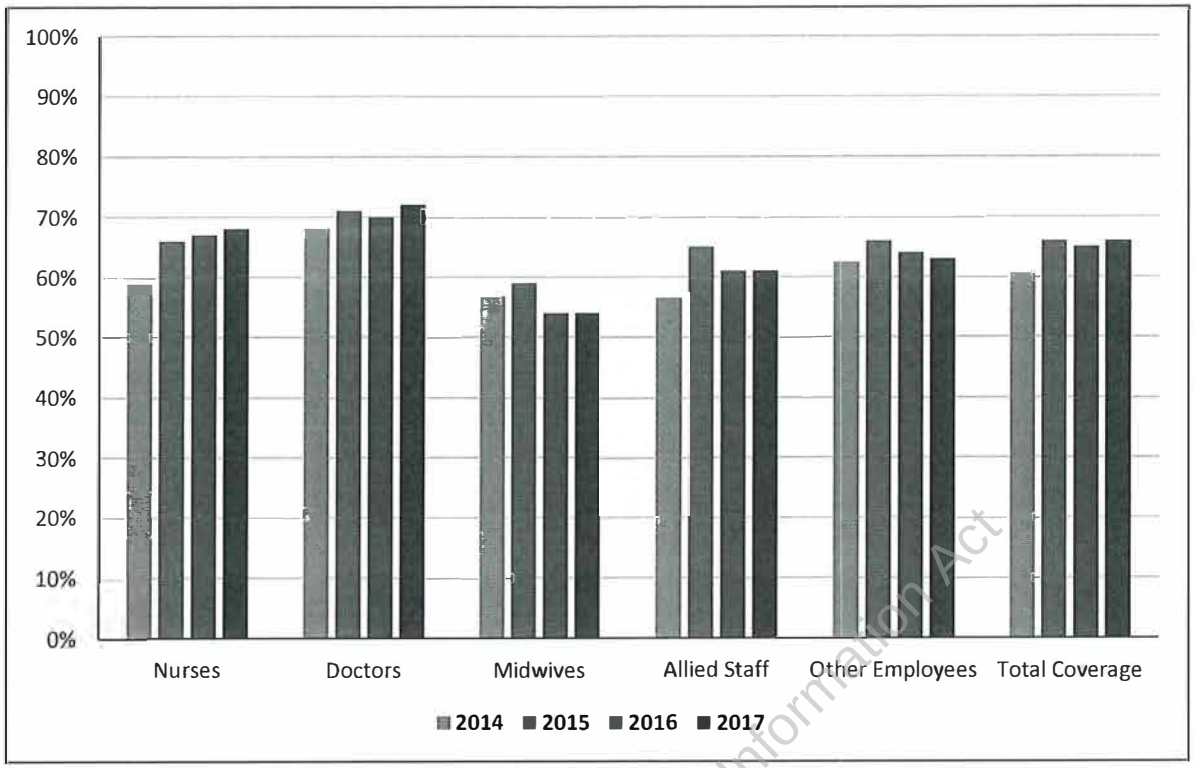


Figure 3: DHB health care worker influenza immunisation coverage by occupation has remained steady across all occupational groups in 2017, averaging 66 percent. There was a slight upward trend for doctors and nurses, while midwife coverage remained at 54 percent.

Figure 4. Nurses Influenza Immunisation Coverage by DHB 2014 – 2017

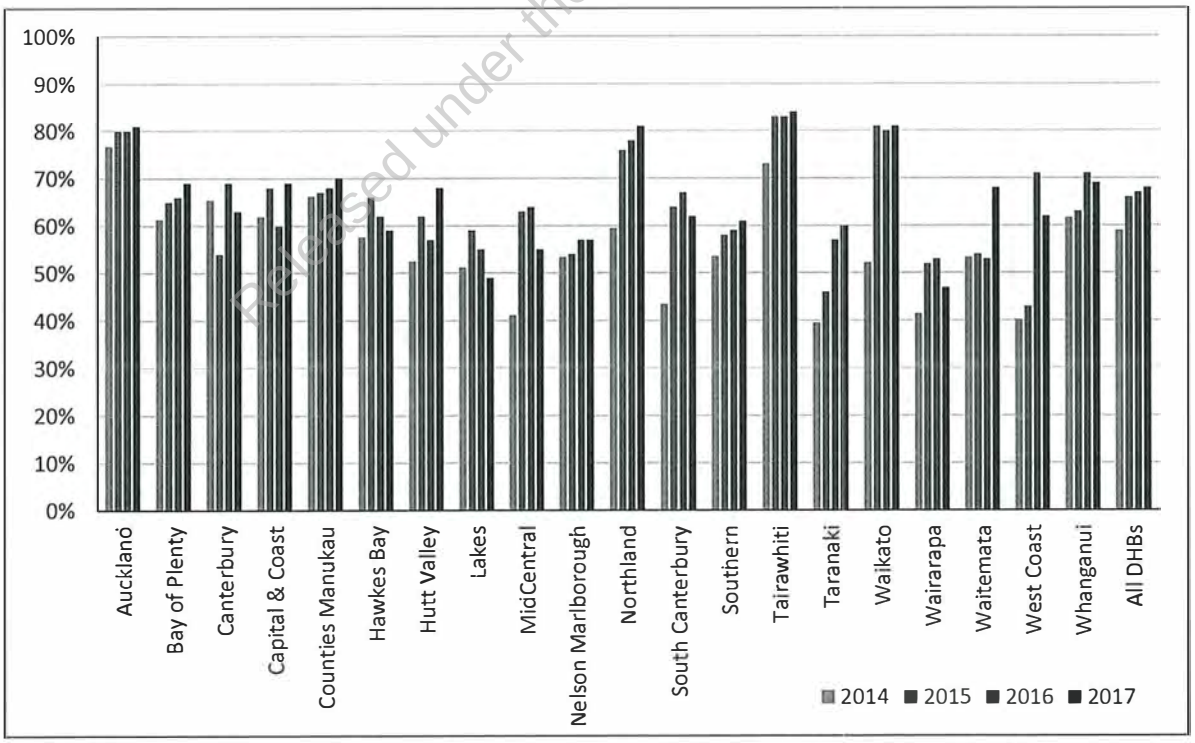


Figure 4: The 2017 total influenza immunisation coverage rate for DHB nurses averaged 68 percent, an increase on 2016 coverage. 13 DHBs maintained or increased coverage of their nursing staff, while Capital & Coast, Hutt Valley and Waitemata DHBs had a significant increase in coverage for nurses, compared to 2016.

Figure 5. Doctors Influenza Immunisation Coverage by DHB 2014 – 2017

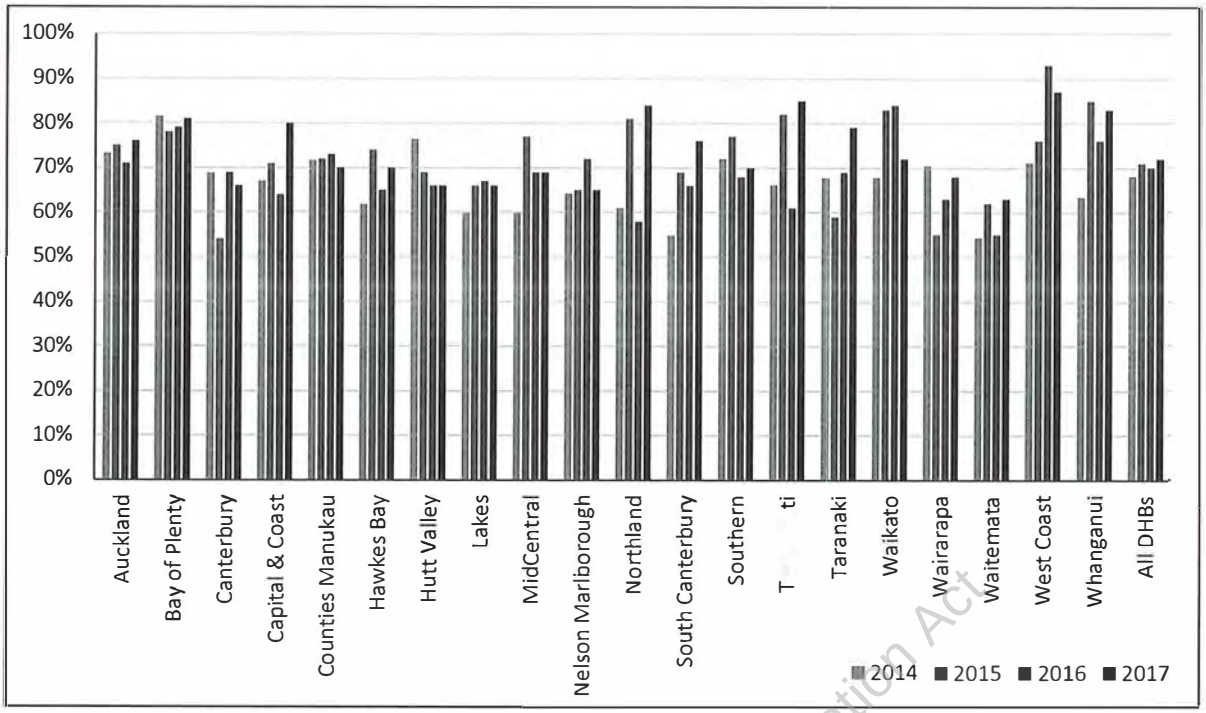


Figure 5: The 2017 influenza immunisation coverage rate for DHB doctors averaged 72 percent. Capital & Coast, Hawkes Bay, Northland, South Canterbury, Tairawhiti, Taranaki, Waitemata and Whanganui DHBs had a significant increase in coverage for doctors compared to 2016. Similar to nurse coverage, doctor coverage increased in 2017, compared to 2016.

Figure 6. Midwives Influenza Immunisation Coverage by DHB 2014 – 2017

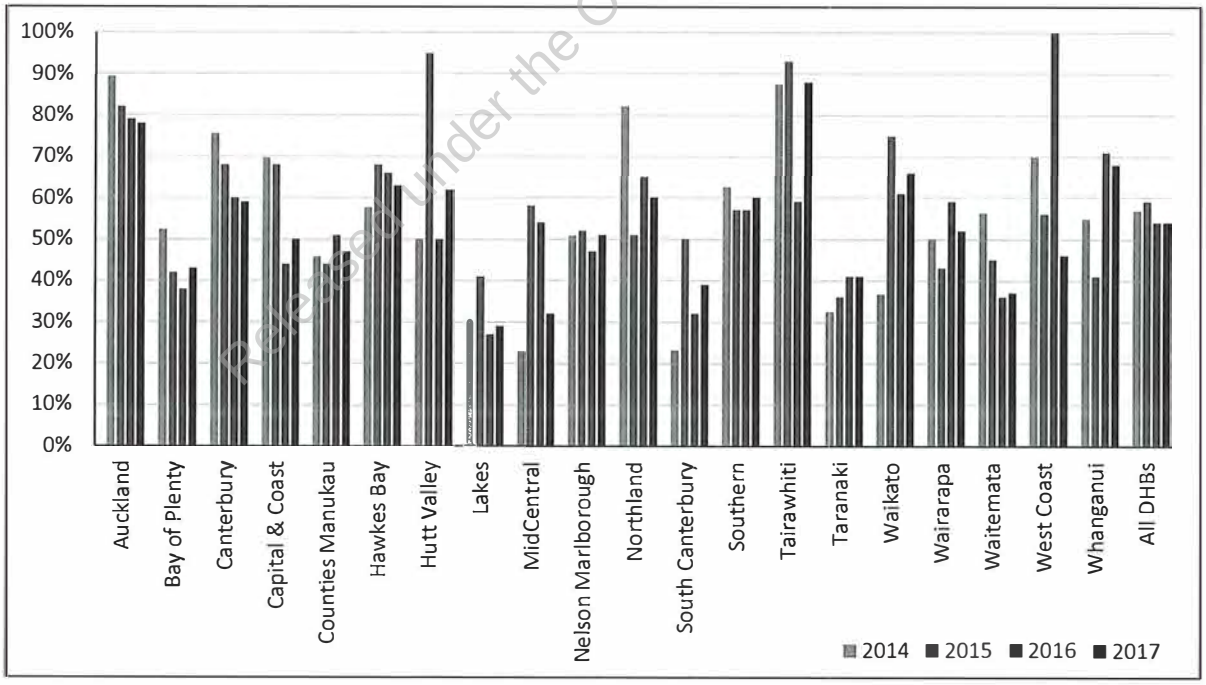


Figure 6: The 2017 influenza immunisation coverage rate for DHB midwives averaged 54 percent. While coverage varied across DHBs, Auckland DHB has consistently maintained coverage over 70 percent for the last four years.

Figure 7. Allied Staff Influenza Immunisation Coverage by DHB 2014 - 2017

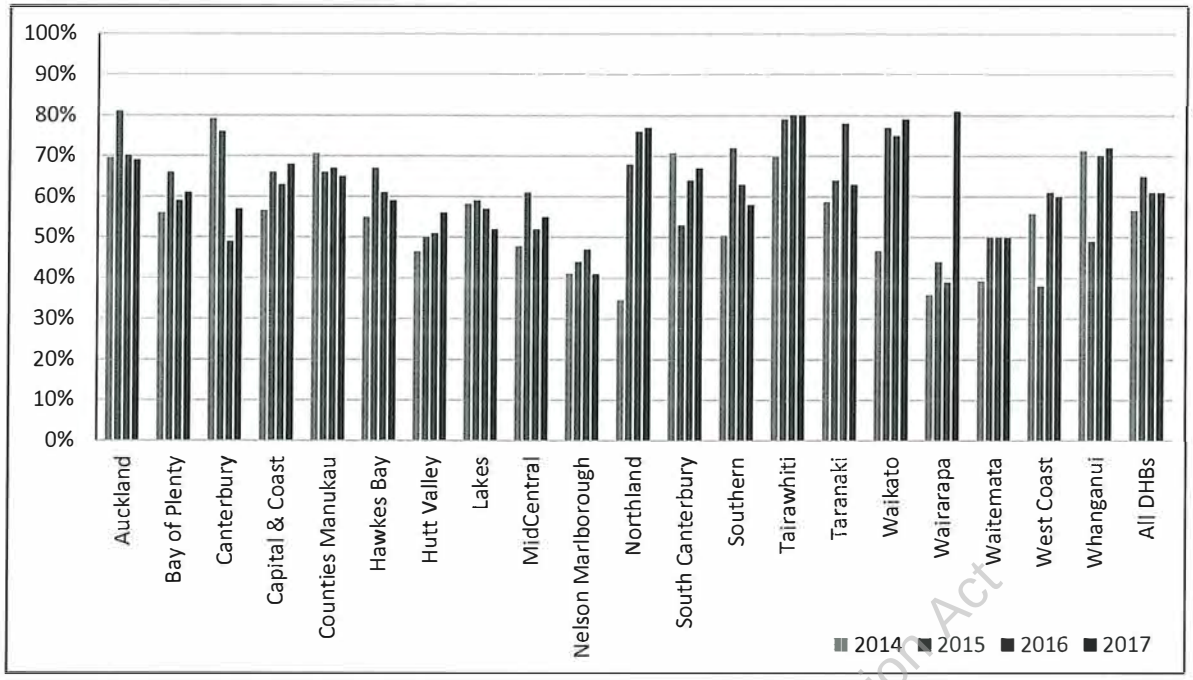


Figure 7: The 2017 influenza immunisation coverage rate for DHB allied staff remained the same as 2016, averaging 61 percent. Canterbury, Capital & Coast, Hutt Valley and Wairarapa DHBs had a significant increase in coverage for allied staff, compared to 2016.

Figure 8. Other Employees Influenza Immunisation Coverage by DHB 2014 – 2017

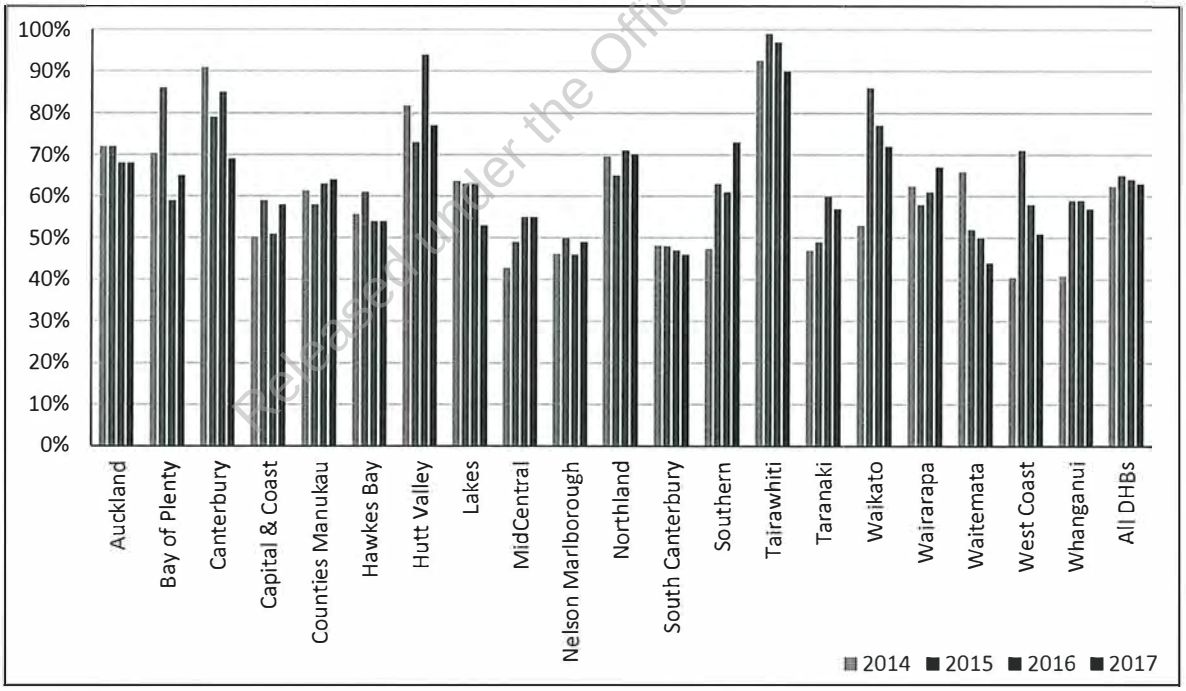


Figure 8: The 2017 total influenza immunisation coverage rate for other DHB employees had an average of 63 percent. Bay of Plenty, Capital & Coast, Southern and Wairarapa DHBs had significant increases in coverage compared to 2016. Over half of the DHBs experienced a drop in coverage (11 in total).

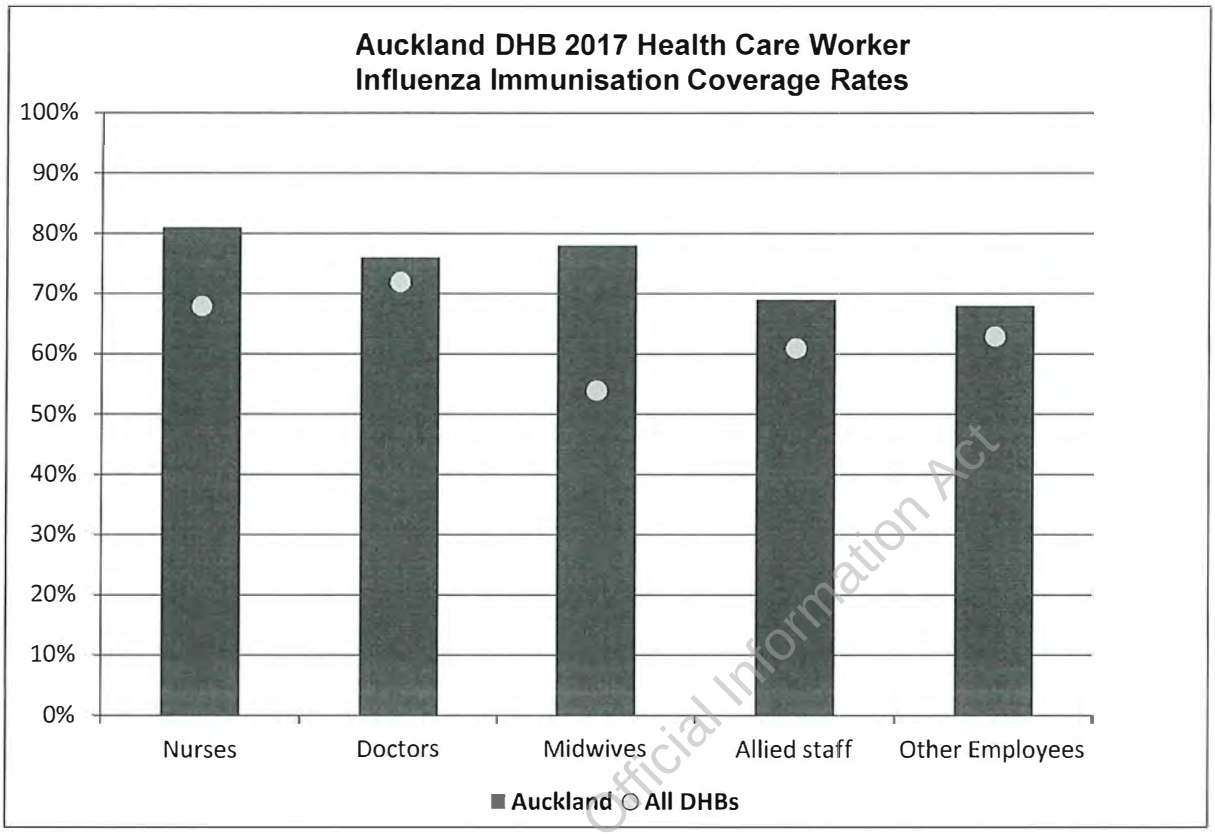
Appendix One

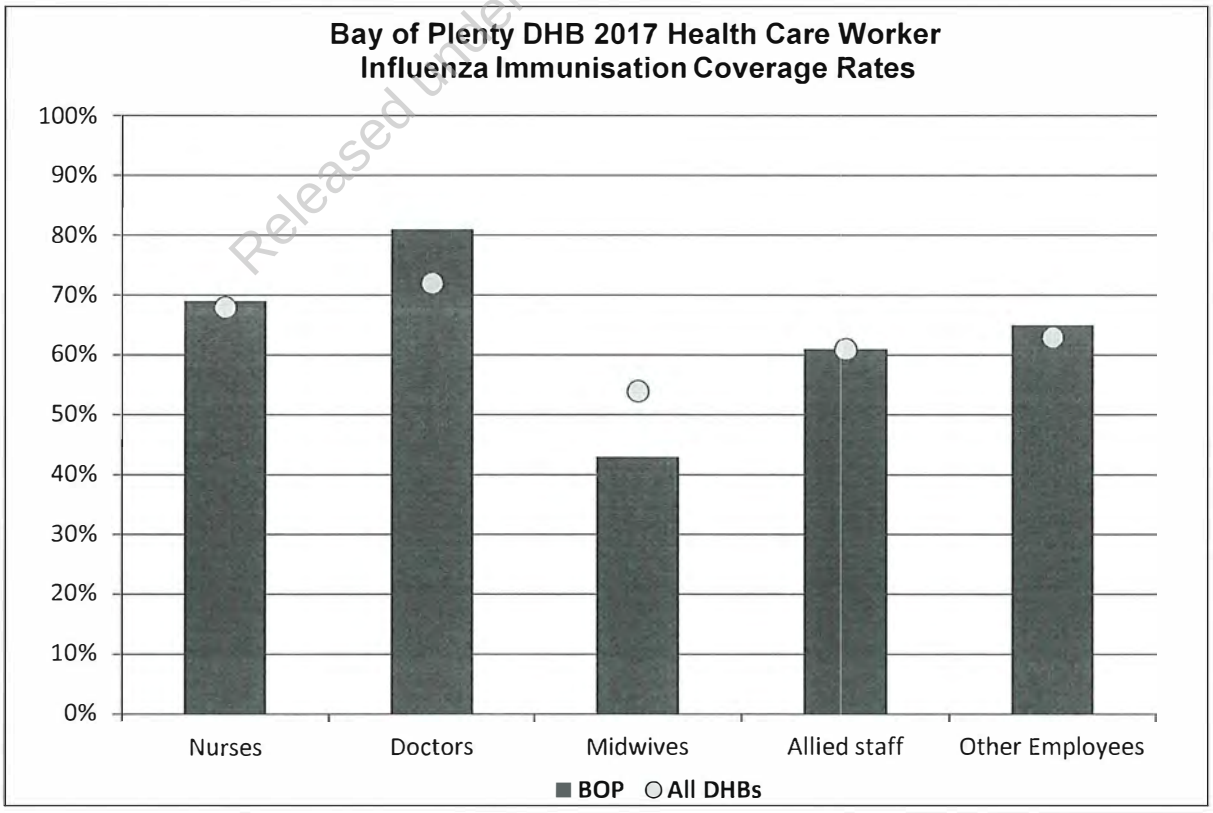
DHB Health Care Worker Influenza Immunisation Coverage rates 2014 – 2017

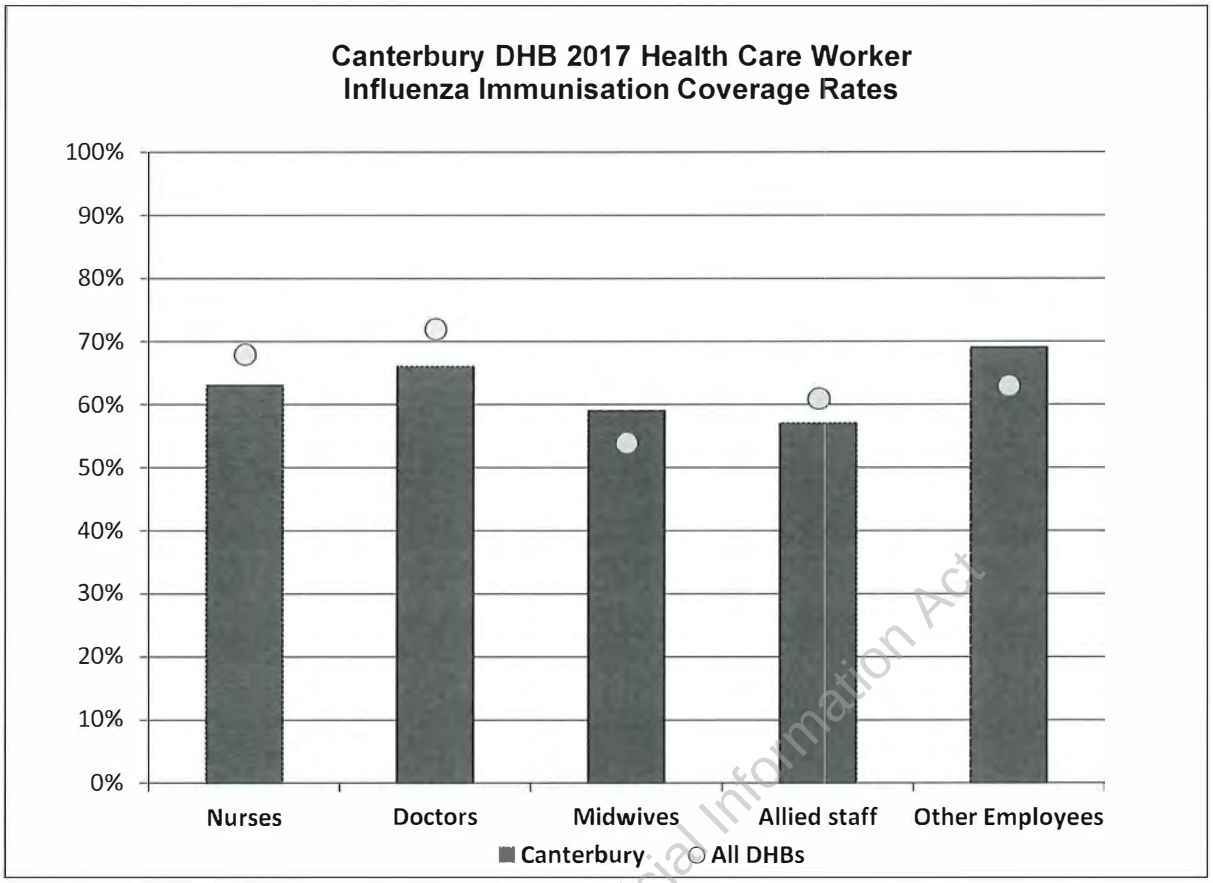
	Nurses				Doctors				Midwives				Allied staff				Other employees				Total coverage			
District Health Boards	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Auckland	77%	80%	80%	81%	73%	75%	71%	76%	89%	82%	79%	78%	70%	81%	70%	69%	72%	72%	68%	68%	74%	76%	74%	74%
Bay of Plenty	61%	65%	66%	69%	82%	78%	79%	81%	52%	42%	38%	43%	56%	66%	59%	61%	70%	86%	59%	65%	65%	71%	64%	67%
Canterbury	65%	54%	69%	63%	69%	54%	69%	66%	76%	68%	60%	59%	79%	76%	49%	57%	91%	79%	85%	69%	75%	71%	68%	64%
Capital & Coast	62%	68%	60%	69%	67%	71%	64%	80%	70%	68%	44%	50%	57%	66%	63%	68%	50%	59%	51%	58%	58%	65%	58%	67%
Counties Manukau	66%	67%	68%	70%	72%	72%	73%	70%	46%	44%	51%	47%	71%	66%	67%	65%	61%	58%	63%	64%	65%	64%	66%	67%
Hawkes Bay	58%	66%	62%	59%	62%	74%	65%	70%	58%	68%	66%	63%	55%	67%	61%	59%	56%	61%	54%	54%	57%	66%	60%	59%
Hutt Valley	52%	62%	57%	68%	76%	69%	66%	66%	50%	95%	50%	62%	46%	50%	51%	56%	82%	73%	94%	77%	60%	64%	65%	67%
Lakes	51%	59%	55%	49%	60%	66%	67%	66%	31%	41%	27%	29%	58%	59%	57%	52%	64%	63%	63%	53%	54%	60%	58%	52%
Midcentral	41%	63%	64%	55%	60%	77%	69%	69%	23%	58%	54%	32%	48%	61%	52%	55%	43%	49%	55%	55%	44%	60%	60%	56%
Nelson Marlborough	53%	54%	57%	57%	64%	65%	72%	65%	51%	52%	47%	51%	41%	44%	47%	41%	46%	50%	46%	49%	49%	51%	53%	51%
Northland	60%	76%	78%	81%	61%	81%	58%	84%	82%	51%	65%	60%	35%	68%	76%	77%	70%	65%	71%	70%	57%	72%	78%	78%
South Canterbury	44%	64%	67%	62%	55%	69%	66%	76%	23%	50%	32%	39%	71%	53%	64%	67%	48%	48%	47%	46%	50%	57%	58%	57%
Southern	54%	58%	59%	61%	72%	77%	68%	70%	63%	57%	57%	60%	50%	72%	63%	58%	47%	63%	61%	73%	54%	64%	61%	64%
Tairawhiti	73%	83%	83%	84%	66%	82%	61%	85%	88%	93%	59%	88%	70%	79%	80%	80%	93%	99%	97%	90%	76%	86%	83%	84%
Taranaki	39%	46%	57%	60%	68%	59%	69%	79%	32%	36%	41%	41%	59%	64%	78%	63%	47%	49%	60%	57%	48%	51%	63%	60%
Waikato	52%	81%	80%	81%	68%	83%	84%	72%	37%	75%	61%	66%	47%	77%	75%	79%	53%	86%	77%	72%	53%	81%	78%	76%
Wairarapa	41%	52%	53%	47%	70%	55%	63%	68%	50%	43%	59%	52%	36%	44%	39%	81%	63%	58%	61%	67%	61%	52%	54%	58%
Waitemata	53%	54%	53%	68%	54%	62%	55%	63%	56%	45%	36%	37%	39%	50%	50%	50%	66%	52%	50%	44%	53%	53%	52%	56%
West Coast	40%	43%	71%	62%	71%	76%	93%	87%	70%	56%	100%	46%	56%	38%	61%	60%	40%	71%	58%	51%	44%	49%	66%	59%
Whanganui	62%	63%	71%	69%	63%	85%	76%	83%	55%	41%	71%	68%	71%	49%	70%	72%	41%	59%	59%	57%	54%	60%	68%	67%
All DHBs	59%	66%	67%	68%	68%	71%	70%	72%	57%	59%	54%	54%	57%	65%	61%	61%	62%	66%	64%	63%	61%	66%	65%	66%

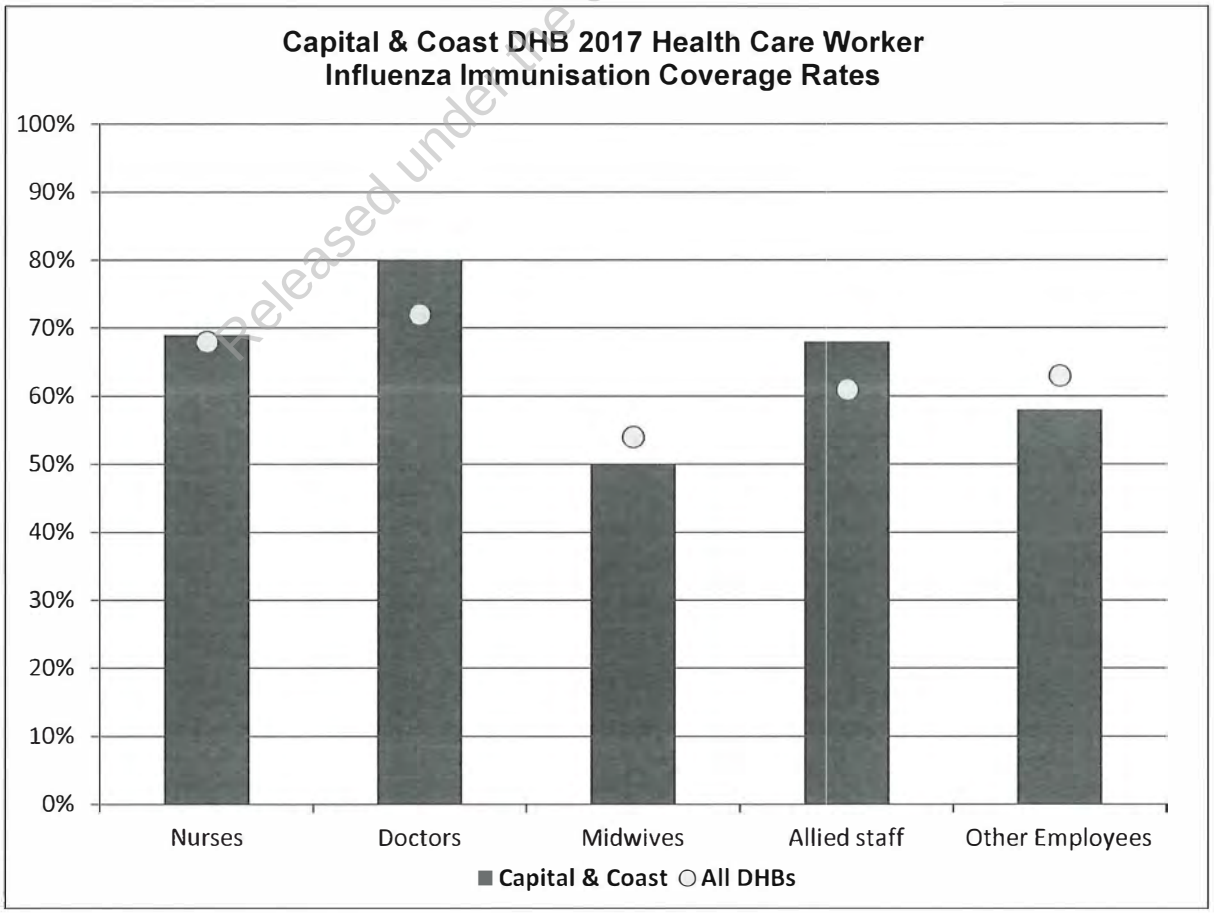
Appendix Two

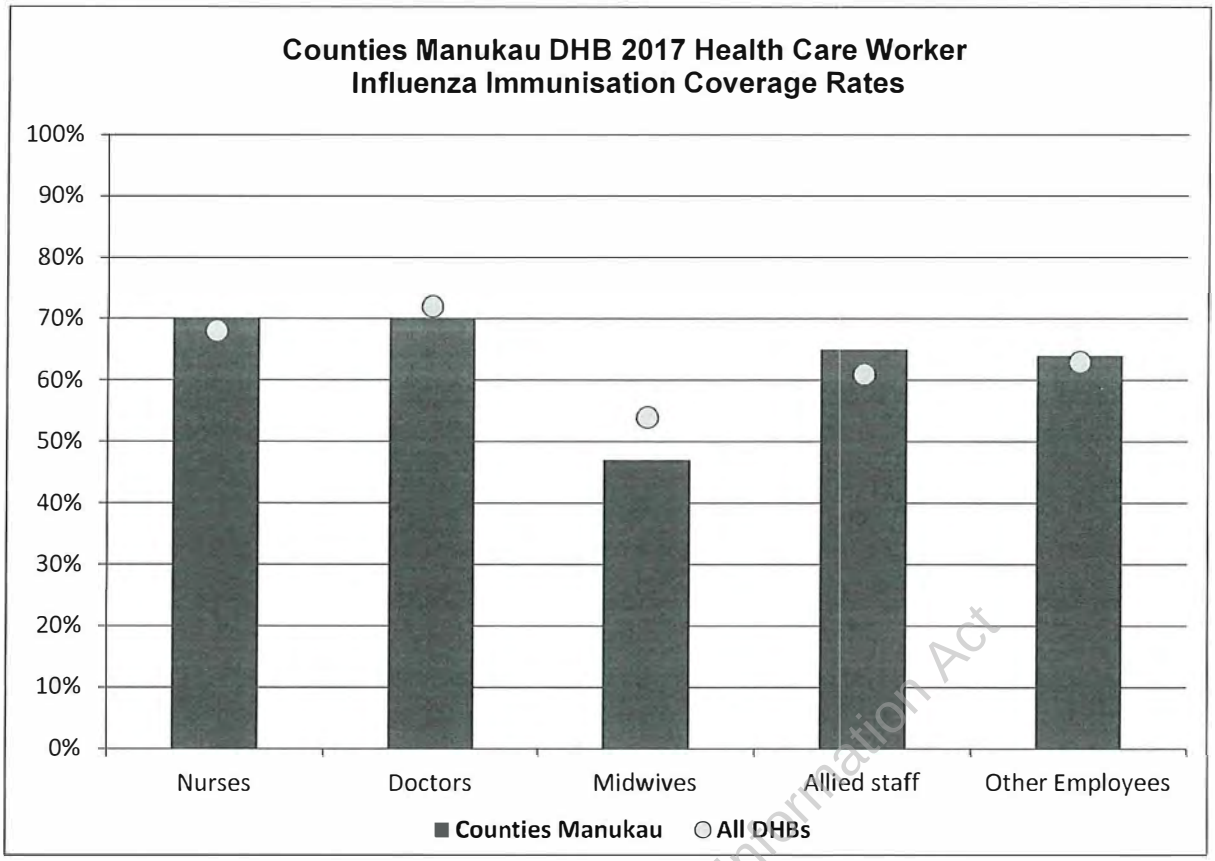
2017 DHB Health Care Worker Influenza Immunisation Coverage by Occupation (in alphabetical order)

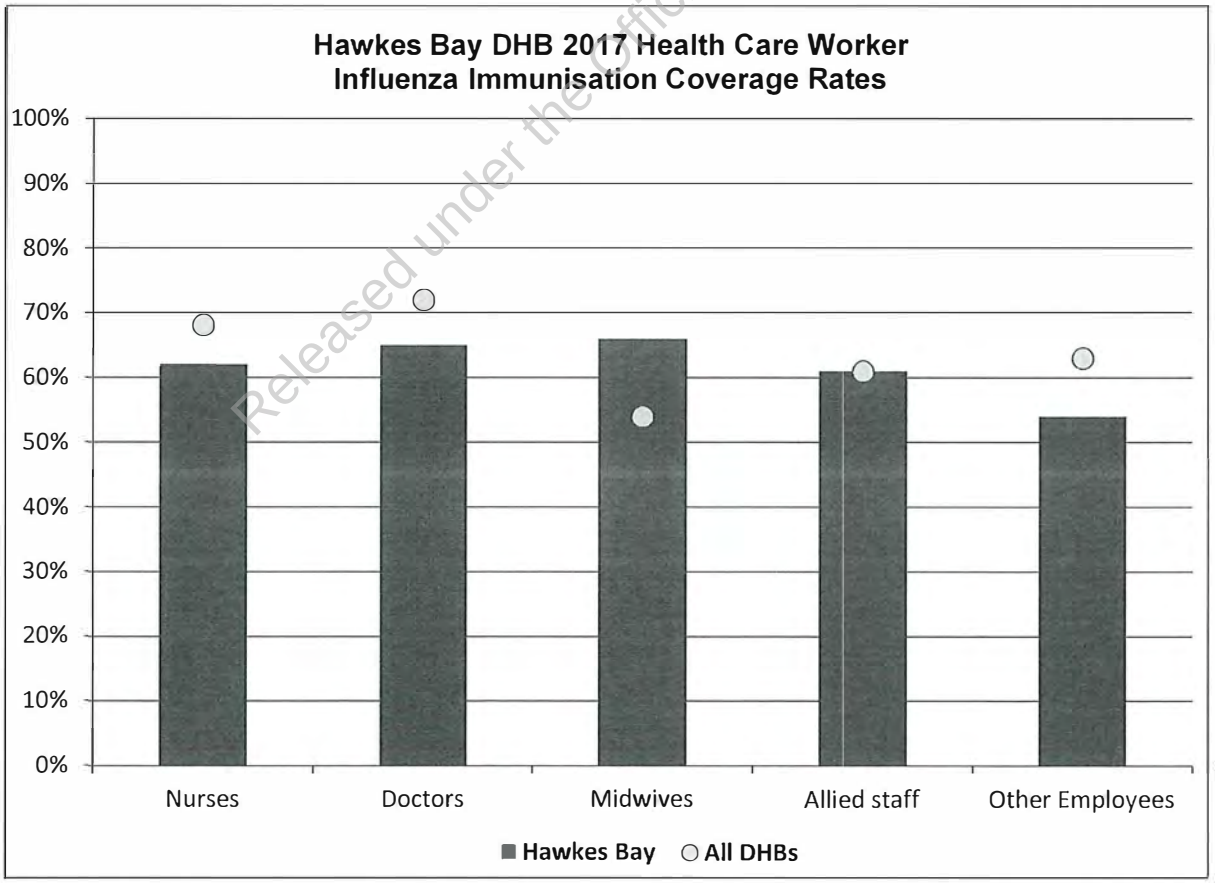


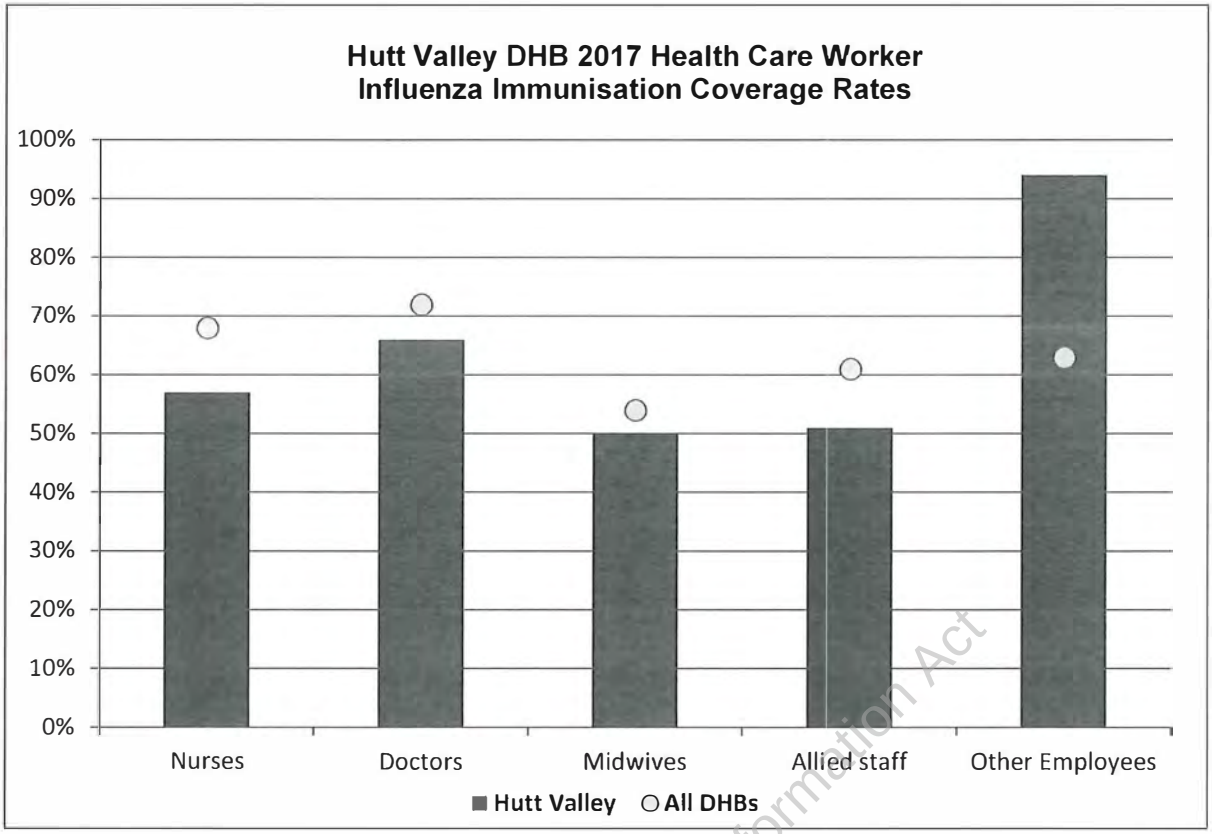


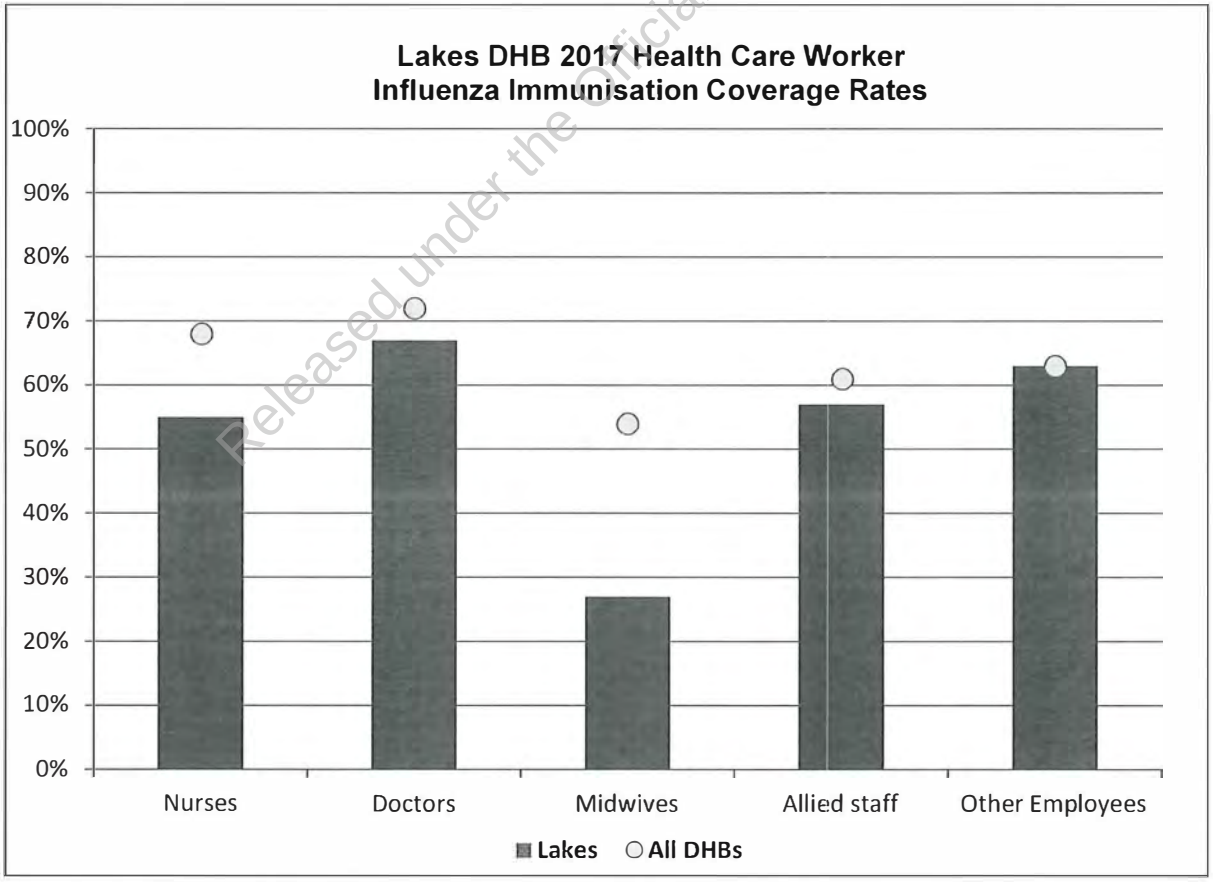


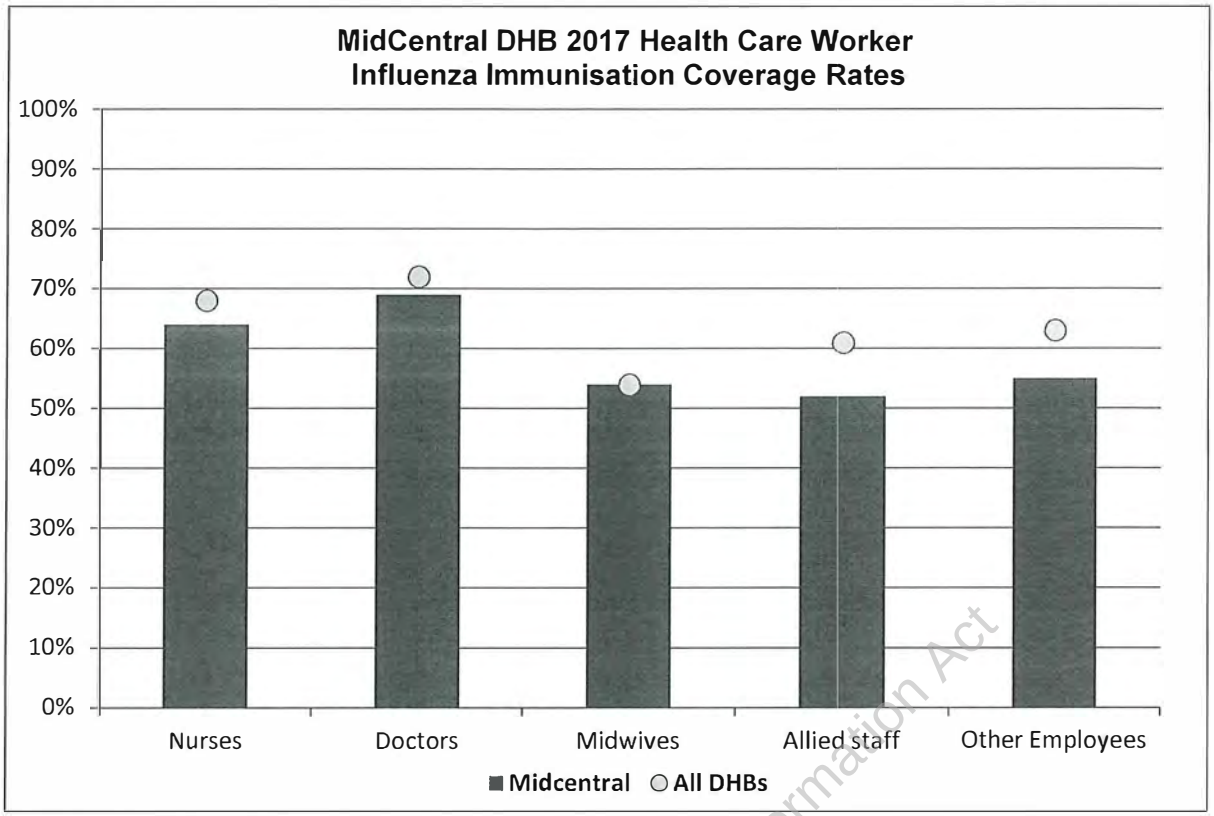


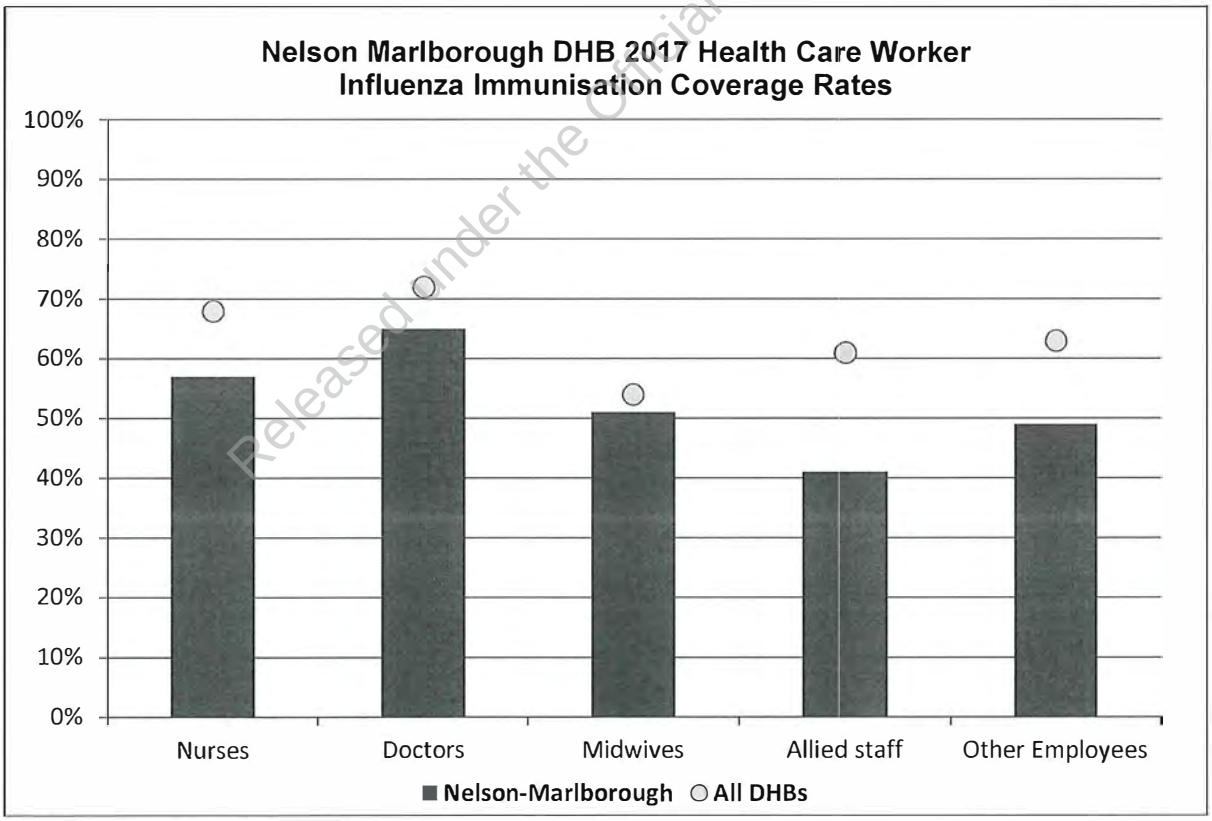


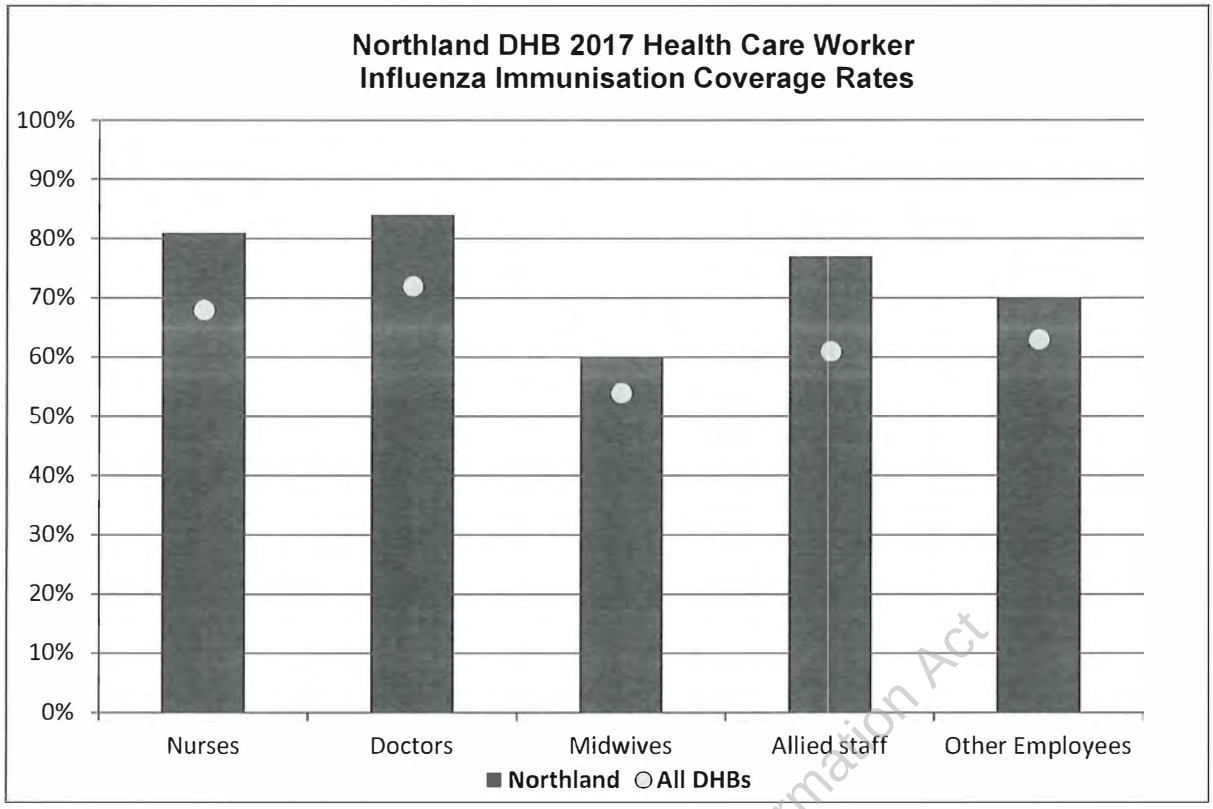


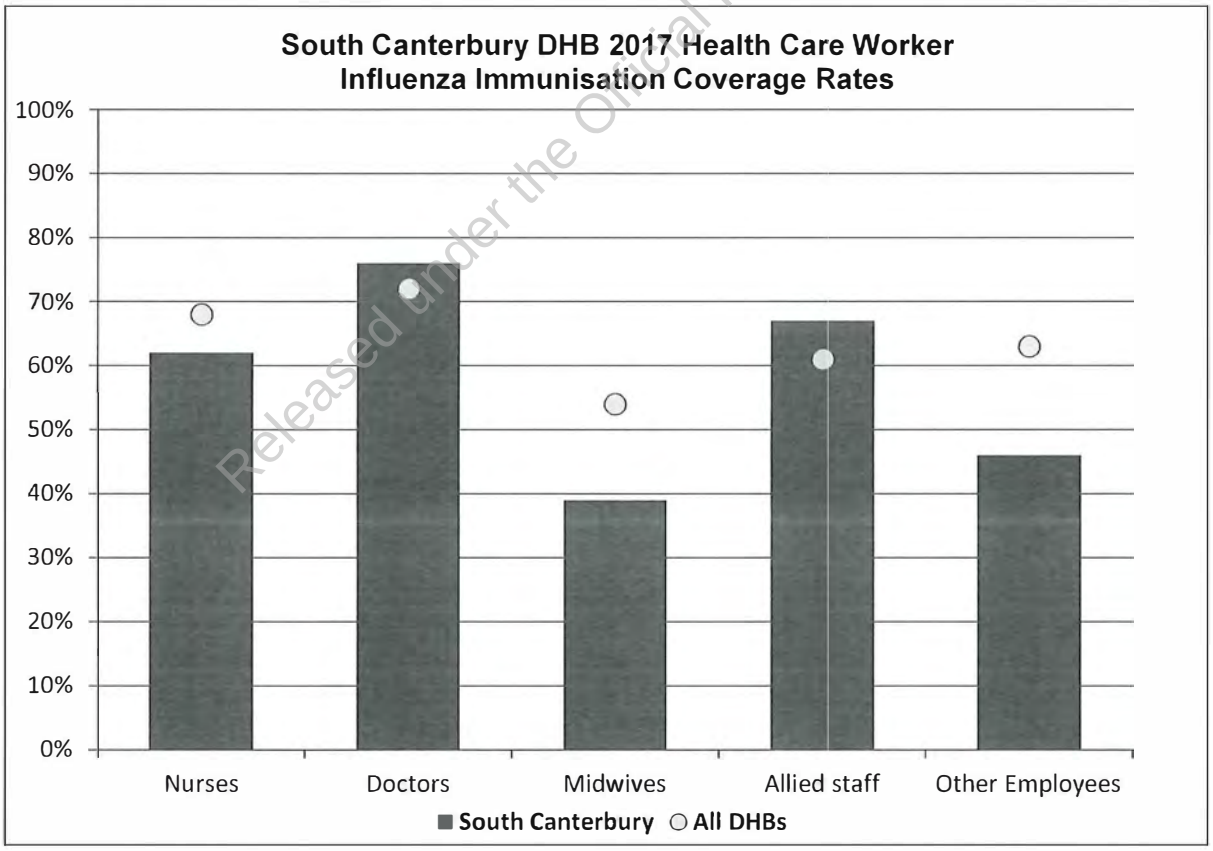


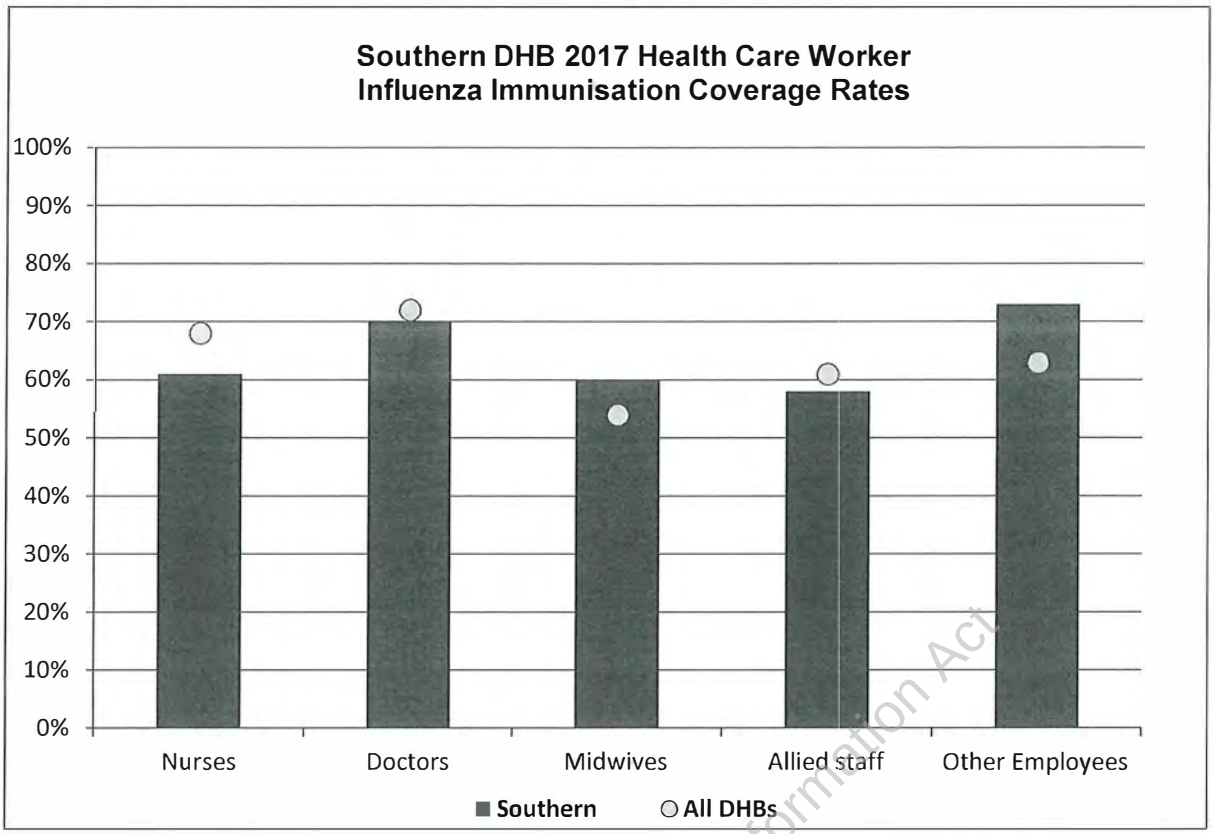


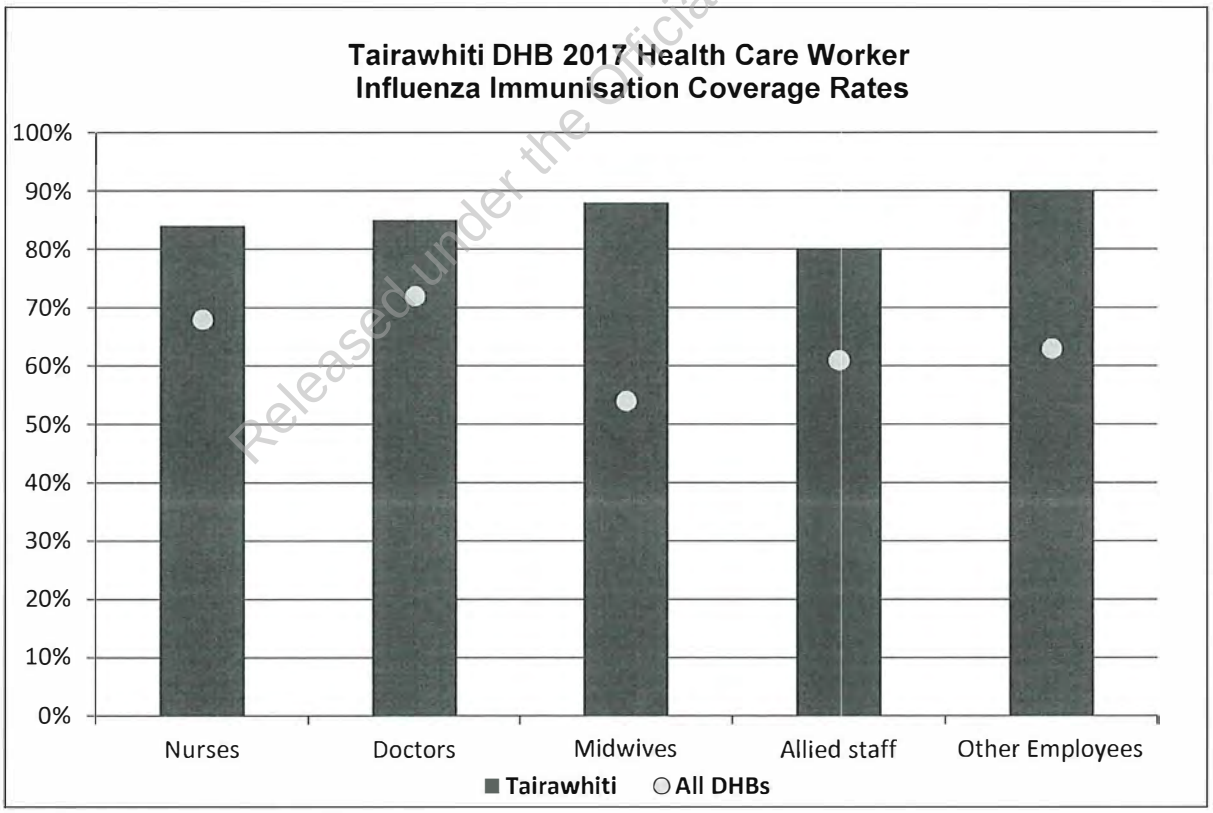


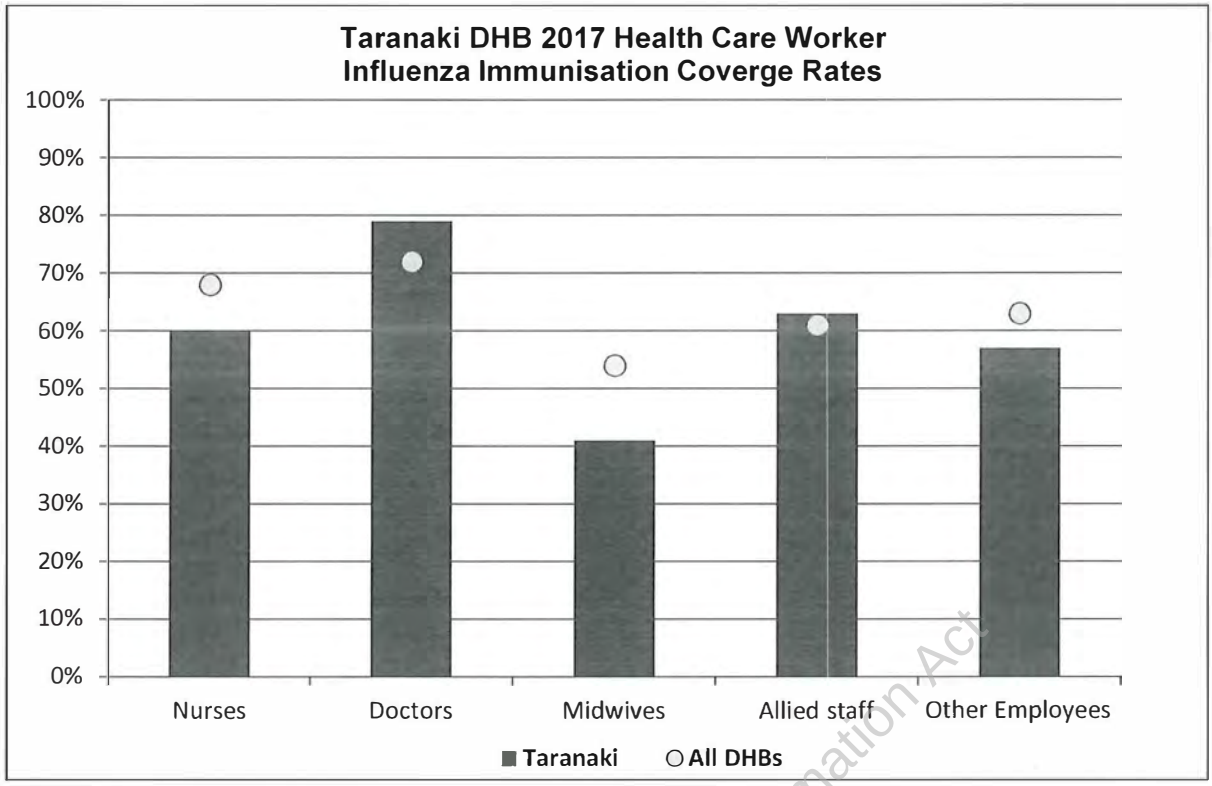


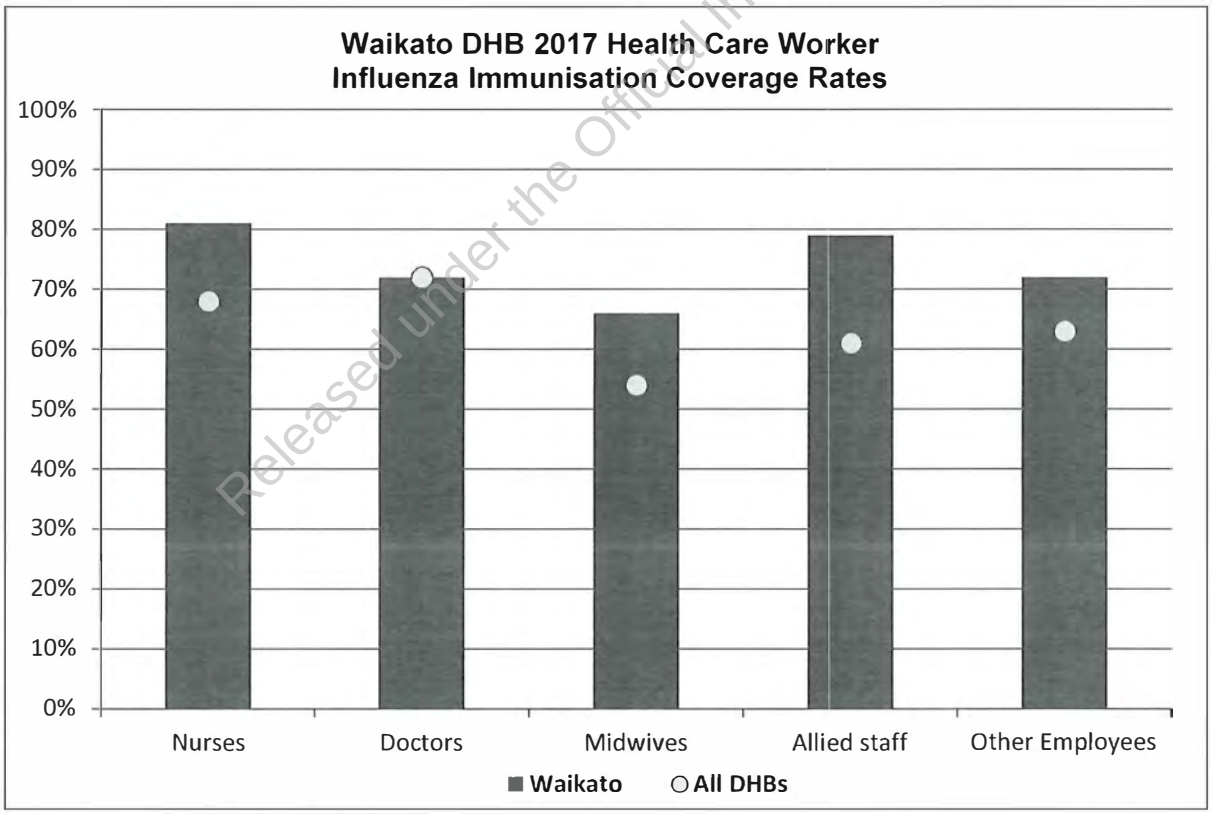


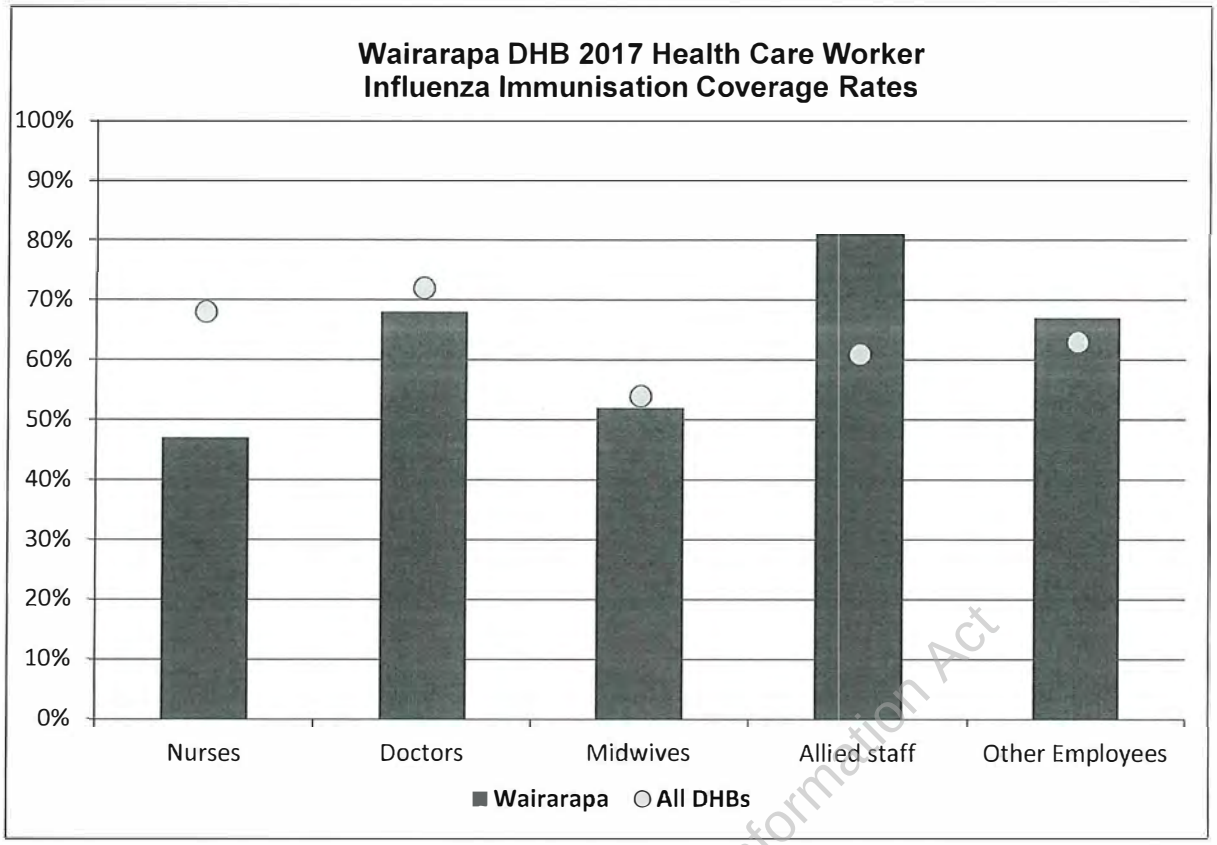


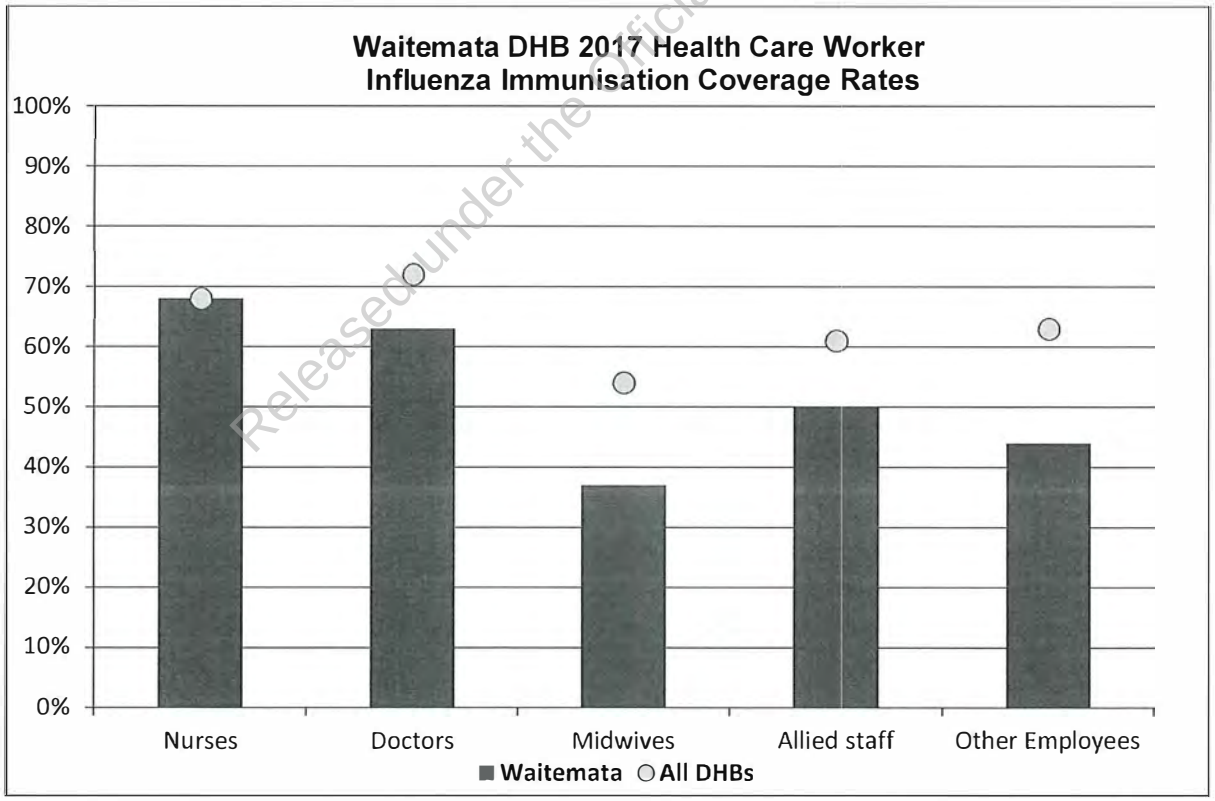


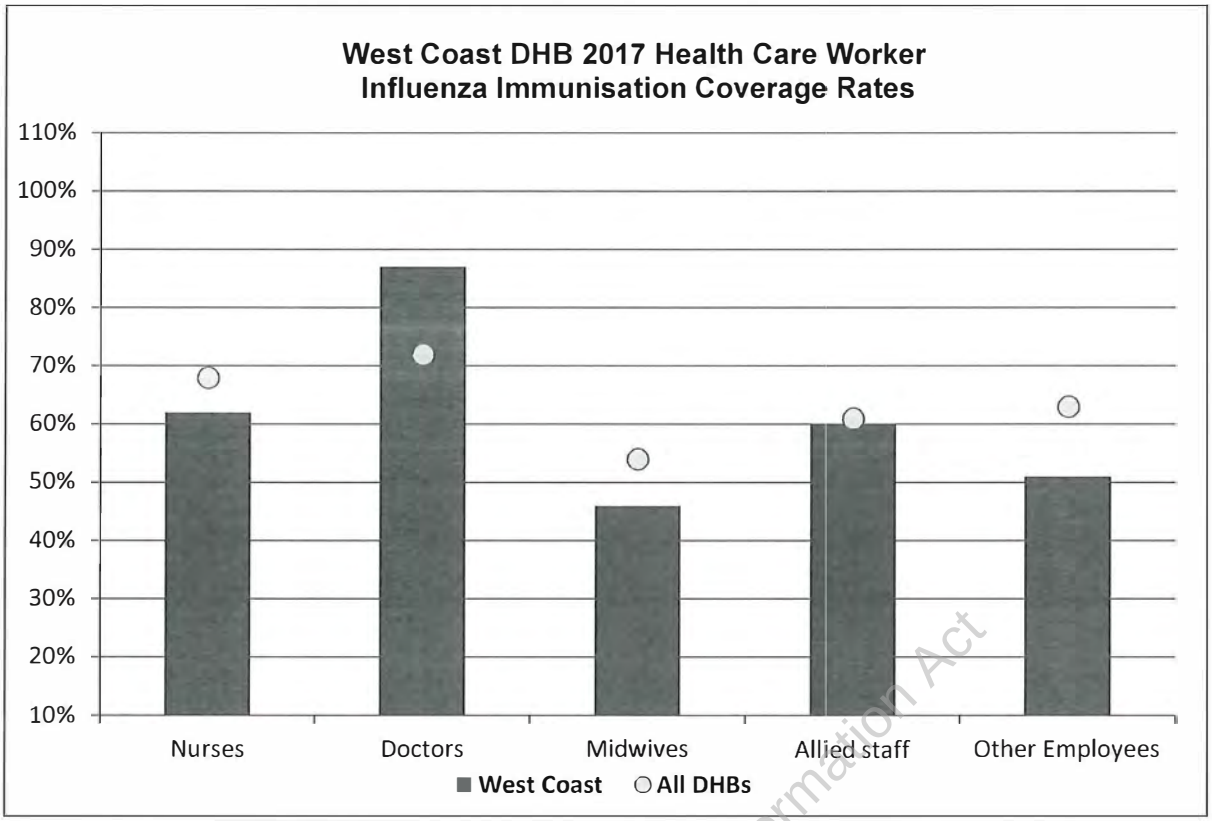


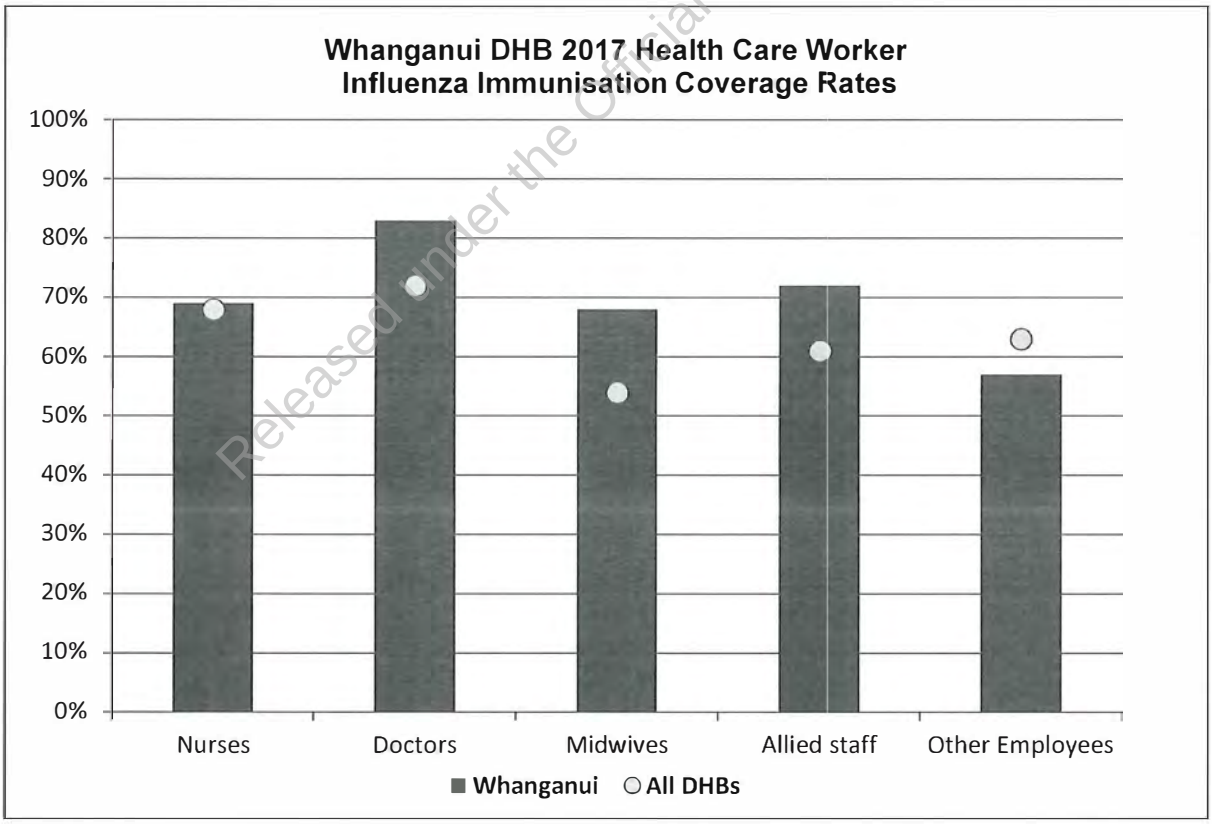












WEST COAST IMMUNISATION
ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 30th November 2017, 9.30-11.00am
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa *For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (26 October)	Cheryl Brunton	iag minutes 26 oct 2017.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Betty/Pauline	nOV data report.docx
5	HPV and Tdap Changes, Implementation Plan	Bridget	
6	Update on mumps and pertussis	Cheryl	
7	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV and Tdap progress implementation	Bridget, Betty, Janet, Pauline	
Cold Chain – clarify what Fridges are required and work on business case to fund these	Bridget and Betty	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sarah Harvey	Health Promoter, Community and Public Health
Sharyn Newcombe	NIR Coordinator

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 26 October 2.00- 3.00PM
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, , Betty Gilsenan, Pauline Ansley, Sharyn Newcombe and Bridget Lester	
Apologies:	Joanna Shaw, Lee Harris, Cheryl Hutchison, Ann Knipe Catherine Crighton, Anna Wall Catherine Andrews, Hillary Ford, and Janet Hogan	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of 31 July were approved.	
Matters Arising	• Lee has put an item in the CEO update around Staff vaccination. • Cold Chain – Aeroscout – Fridge replacement = discussed below	
Standing Items	**Report on KPIs and Action Plan**	
HPV	Progress continues on the co-delivery of Tdap and HPV in general practice at 11years of age and Year 8 at school. A number of resources need to be developed these include • An HPV brochure for both GP and School Programme • A Tdap brochure for both GP and School Programme • Posters of GP • A letter and supporting information to general practice • A co-delivery consent form. The MoH has shared their draft consent form with us, and a group from the CDHB programme is reviewing these. These will also be shared with Janet and Betty. A discussion needs to also occur between Betty and Pauline around the best way to provide education and support to general practices.	*Bridget, Betty, Janet and Pauline*
Influenza	**No update provided**	
Cold Chain	• **Vaccine fridge** – Robert Raeder is questioning the type of vaccine fridge. In labs and blood service they use different fridges which Robert believes would be suitable for storing vaccines. He is challenging the Ministry guidance on this. Recommendation is that he talk directly to the MoH. Betty also advised him to talk to Anna about this in relation to accreditation requirements. • **Cornerstone Accreditation** – this is important for general practice and the PHO, and Cold Chain Accreditation is required to achieve Cornerstone.	

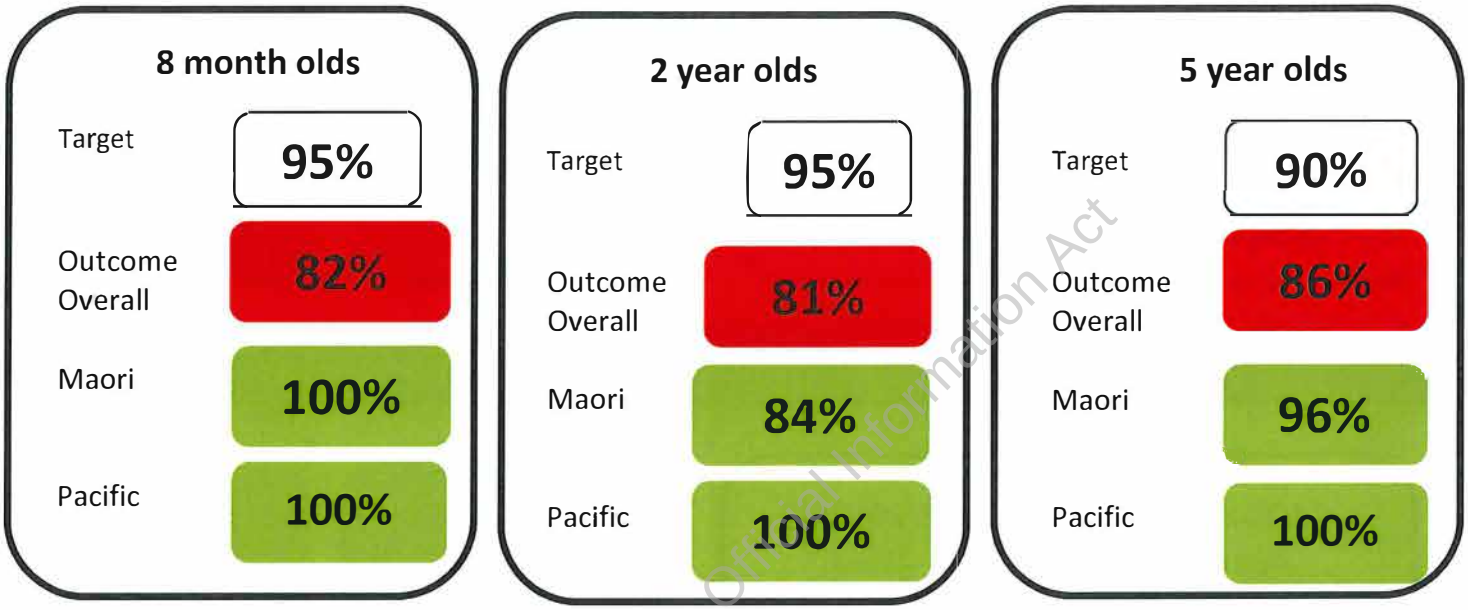
	• **Fridge –** these need to be replaced after 10 years. Bridget has followed up with the MoH who have indicated that a process needs to be developed to achieve this. • **Type of Fridge –** brief discussion on whether or not we need to get a different type of fridge due to the potentially extreme environmental temperatures in parts of the West Coast? Betty has checked out what we need for the WC. o **9 small and 3 large fridges. What is the total cost of this?** **Action: Once the type of fridge(s) required is/are identified, a proposal needs to go to EMT around this. Bridget to check with Phil W around the correct process**	
Next Meeting	30 November 2017 2-3.30pm However we will look at a morning meeting as Bridget has a workshop to attend in the afternoon.	

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2017/18



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 29 Nov 17

Fully Immunised 8 month olds – DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress including pending	Q3 2017/18 Progress including pending
80% fully	82% fully	82.7% fully	% fully
2.5% overdue	% overdue	0% overdue	% overdue

Fully Immunised Two year olds - DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress	Q2 2017/18 Progress
91% fully	81% fully	76% fully	% fully
0% overdue	2.3% overdue	1%	% overdue

Fully Immunised Five year olds - DHB LEVEL

Q4 2016/17 Actual	Q1 2017/18 Actual	Q2 2017/18 Progress	Q3 2017/18 Progress
80% fully	86% fully	82.6% fully	% fully
3.8% overdue	2.4%	.9% overdue	% overdue

Q1 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	90	65	72. %	53	45	85. %	17	12	71. %	0	0	-	3	2	67. %	17	6	35. %	9 (0)	10.0 (0.0) %	3	3.3 %
8 Month	77	63	82. %	49	44	90. %	12	12	100. %	1	1	100. %	3	3	100. %	12	3	25. %	8 (0)	10.4 (0.0) %	2	2.6 %
12 Month	81	67	83. %	42	38	90. %	20	19	95. %	0	0	-	7	7	100. %	12	3	25. %	9 (0)	11.1 (0.0) %	3	3.7 %
18 Month	84	65	77. %	51	46	90. %	12	12	100. %	0	0	-	5	4	80. %	16	3	19. %	12 (0)	14.3 (0.0) %	4	4.8 %
24 Month	84	68	81. %	44	44	100. %	19	16	84. %	1	1	100. %	3	3	100. %	17	4	24. %	11 (0)	13.1 (0.0) %	3	3.6 %
5 Year	95	82	86. %	53	46	87. %	24	23	96. %	1	1	100. %	7	7	100. %	10	5	50. %	5 (0)	5.3 (0.0) %	6	6.3 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	(0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	90	65	72. %	11	9	82. %	11	8	73. %	17	15	88. %	31	25	81. %	20	8	40. %	0	0	-
8 Month	77	63	82. %	8	8	100. %	7	7	100. %	10	10	100. %	26	21	81. %	20	11	55. %	6	6	100. %
12 Month	81	67	83. %	6	5	83. %	11	11	100. %	9	9	100. %	31	29	94. %	22	11	50. %	2	2	100. %
18 Month	84	65	77. %	4	4	100. %	18	17	94. %	10	9	90. %	27	23	85. %	23	11	48. %	2	1	50. %
24 Month	84	68	81. %	6	6	100. %	16	15	94. %	15	13	87. %	18	17	94. %	26	14	54. %	3	3	100. %
5 Year	95	82	86. %	7	6	86. %	11	11	100. %	22	20	91. %	30	28	93. %	19	11	58. %	6	6	100. %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

Q1 2017-18

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	8	0	4	56	68	30	0	0	130	160	27%	-%	-%	43%	43%	2 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	14	19						17%	-%	-%	11%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	13	18						17%	-%	-%	10%	11%	1 (0.6%)	
Total	HPV-1 Quadrivalent	8	0	4	56	68	30	0	0	130	160	27%	-%	-%	43%	43%	2 (1.3%)	0 (0.0%)
	HPV-2 Quadrivalent	5	0	0	14	19						17%	-%	-%	11%	12%	1 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	13	18						17%	-%	-%	10%	11%	1 (0.6%)	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 6 March 2018 3:41 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Lee Harris'; 'Nikki Mason'; 'Pauline Ansley'; 'riasouth@imac.org.nz'; Sharyn Kenning
Subject: Papers for Thursdays IAG meeting 1-2pm
Attachments: Data Report March 2018.docx; Draft Agenda - IAG 8318.docx; HPV-Tdap-and-Varicella-Immunise-brochure-22-2-2018.pdf

Hi all

Please find attached the papers for Thursdays IAG meeting.

Talk to you all then.

Regards Bridget

Bridget Lester
Project Specialist

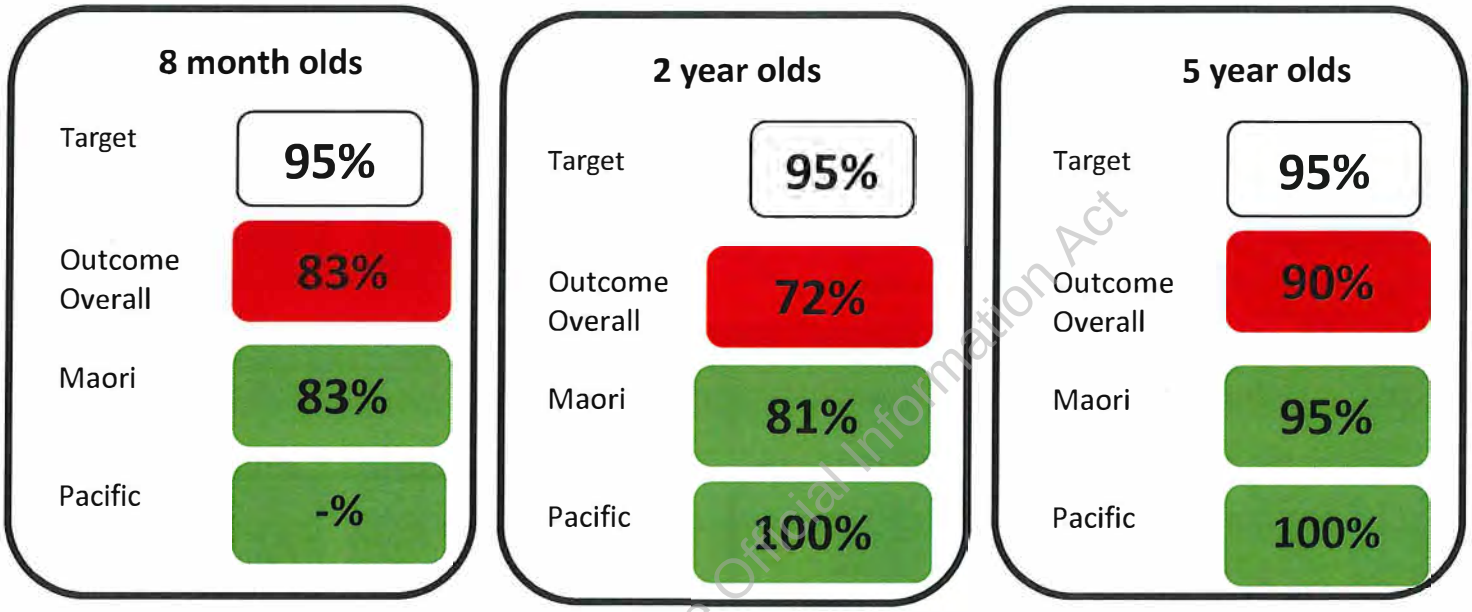
Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q2 2017/18



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Childhood Immunisation – MoH Health Targets as of 29 Nov 17

Fully Immunised 8 month olds – DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress including pending	Q4 2017/18 Progress including pending
82% fully	89% fully	80% fully	81% fully
0% overdue	4.4% overdue	5% overdue	6% overdue

Fully Immunised Two year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
81% fully	89% fully	79% fully	90% fully
2.3% overdue	4.4% overdue	1.25%	4% overdue

Fully Immunised Five year olds - DHB LEVEL

Q1 2016/17 Actual	Q2 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
86% fully	90% fully	83% fully	% fully
2.4% overdue	3.2%	1% overdue	% overdue

Q2 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	102	74	73. %	52	46	88. %	26	20	77. %	3	2	67. %	6	5	83. %	15	1	7. %	12 (0)	11.8 (0.0) %	2	2.0 %
8 Month	89	74	83. %	53	52	98. %	18	15	83. %	1	0	-	4	4	100. %	13	3	23. %	10 (0)	11.2 (0.0) %	1	1.1 %
12 Month	66	56	85. %	41	39	95. %	14	14	100. %	0	0	-	3	3	100. %	8	0	-	8 (0)	12.1 (0.0) %	2	3.0 %
18 Month	82	73	89. %	62	59	95. %	11	10	91. %	0	0	-	1	1	100. %	8	3	38. %	5 (0)	6.1 (0.0) %	1	1.2 %
24 Month	94	68	72. %	54	46	85. %	16	13	81. %	2	2	100. %	4	4	100. %	18	3	17. %	15 (0)	16.0 (0.0) %	10	10.6 %
5 Year	92	83	90. %	61	56	92. %	19	18	95. %	1	1	100. %	5	4	80. %	6	4	67. %	2 (0)	2.2 (0.0) %	4	4.3 %
12 Year	49	29	59. %	30	18	60. %	10	9	90. %	0	0	-	1	1	100. %	8	1	13. %	4 (0)	8.2 (0.0) %	4	8.2 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	102	74	73. %	5	5	100. %	23	19	83. %	16	13	81. %	30	23	77. %	27	14	52. %	1	0	-
8 Month	89	74	83. %	6	6	100. %	14	11	79. %	17	16	94. %	28	27	96. %	23	13	57. %	1	1	100. %
12 Month	66	56	85. %	4	4	100. %	9	9	100. %	6	5	83. %	18	18	100. %	23	14	61. %	6	6	100. %
18 Month	82	73	89. %	10	10	100. %	14	14	100. %	19	17	89. %	18	16	89. %	20	15	75. %	1	1	100. %
24 Month	94	68	72. %	3	3	100. %	15	14	93. %	19	18	95. %	22	17	77. %	28	10	36. %	7	6	86. %
5 Year	92	83	90. %	9	8	89. %	18	17	94. %	17	16	94. %	30	28	93. %	16	12	75. %	2	2	100. %
12 Year	49	29	59. %	6	6	100. %	10	7	70. %	5	3	60. %	11	4	36. %	15	7	47. %	2	2	100. %

Q2 2017-18

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
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	HPV-2 Quadrivalent	9	0	3	49	61						30%	-%	-%	38%	38%	2 (1.3%)	
	HPV-3 Quadrivalent	5	0	0	16	21						17%	-%	-%	12%	13%	2 (1.3%)	
2005	HPV-1 Quadrivalent	2	1	1	17	21	20	0	5	140	170	10%	-%	20%	12%	12%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	2	0	1	12	15						10%	-%	20%	9%	9%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	11	1	5	73	90	50	0	5	270	330	22%	-%	-%	27%	27%	4 (1.2%)	0 (0.0%)
	HPV-2 Quadrivalent	11	0	4	61	76						22%	-%	-%	23%	23%	2 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	16	21						10%	-%	-%	6%	6%	2 (0.6%)	

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

AGENDA

Thursday 8th March 2018, 1 – 2pm
Community & Public Health
Dial in pin: 083033 684544#

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa *For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (30 November)	Cheryl Brunton	draft Minutes.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Betty/Pauline	Data Report March 2018.docx
5	HPV and Tdap Changes, Implementation Plan	Bridget	HPV-Tdap-and-Varicella-Immunise-broc
6	Update on mumps and pertussis	Cheryl	
	Cold Chain update	Betty / Bridget	
7	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV and Tdap progress implementation	Bridget, Betty, Janet, Pauline	
Cold Chain – clarify what Fridges are required and work on business case to fund these	Bridget and Betty	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sharyn Newcombe	NIR Coordinator

How safe are the vaccines?

All vaccines have excellent safety records supported by studies in hundreds of thousands of vaccinated people. The best evidence to date shows no increase in reactions over any other childhood vaccine.

For more information on each vaccine's safety, see the summary Consumer Medicine Information section of this form, visit www.health.govt.nz/hpv or call 0800 IMMUNE (0800 466 863).

Who should be vaccinated?

All children from the age of 11 should be given these vaccines.

Who shouldn't be vaccinated?

There are very few children who should not be immunised. If your child has had a serious reaction to a vaccine, you should talk to your doctor, specialist or nurse before vaccination. Children with asthma, allergies or who are recovering from an illness such as the common cold can still be immunised.

How are the vaccinations given?

Boostrix, HPV and Varilix are safe to be given on the same day. The second dose of HPV is given at least six months after the first. The injections are given in the upper arm.

What are the alternatives to having the immunisations at general practice?

HPV and Tdap are available in a school programme in Year 8, in participating schools.

Chicken Pox vaccine can only be given at a GP practice.

Common reactions

As with all vaccinations, your child may have a sore arm and get redness, pain or swelling at the injection site.

Other reactions that can occur, usually within one or two days, include:

- a fever (feeling hot)
- nausea (feeling sick)
- vomiting
- fainting, dizziness (light-headedness)
- headache
- feeling unwell, aches and pains
- skin reaction (rash).

Your child will be observed for 20 minutes after vaccination. This is standard practice following any vaccination. The nurse will also give them post-vaccination advice and a form stating where (left or right arm) and when each vaccination was given.

Where can I get more information?

- Speak to your general practice doctor, nurse or public health nurse.
- Visit www.health.govt.nz/your-health/healthy-living/immunisation/immunisation-older-children
- Freephone 0800 IMMUNE (0800 466 863)

immunise for life

THANKS for thinking about our future

Canterbury District Health Board
Te Poari Hauora ō Waitaha

immuniseforlife.co.nz

Immunisations for 11-year-olds

In Canterbury and the West Coast, general practice offer a range of Immunisations to 11 year olds. These are designed to protect against tetanus, diphtheria, whooping cough (pertussis) human papillomavirus (HPV) and chicken pox (varicella).

What are the diseases?

Tetanus

This disease can enter the body through a cut or a graze. It causes muscles to stiffen and spasm. It may affect the breathing muscles.

Diphtheria

This disease affects the throat, making it hard to breathe and swallow. It may also affect the nerves, muscles, heart and skin.

Whooping cough (pertussis)

This disease damages the breathing tubes. Affected children may vomit and find it difficult to breathe when they cough.

Chicken Pox

This is a highly infectious disease caused by the varicella-zoster virus and is most commonly seen in children. The virus can spread from person to person through droplets in the air from coughing, sneezing or laughing.

Human papillomavirus (HPV)

This common virus spreads through intimate skin to skin contact. Without immunisation, most people will have an HPV infection at some point in their lives. Most HPV infections get better on their own, but some HPV infections don't get better, and can lead to cancer or warts, if they aren't detected and treated first. These affect both men and women.

HPV related cancers can impact on various parts of the body, particularly the genital area, throat or mouth. The most common is cervical cancer, which is cancer of the lower part of the uterus or womb. Each year in New Zealand, around 160 women are diagnosed with cervical cancer and around 50 women die from it.

What are the vaccines and how do they work?

Tetanus/Diphtheria/Whooping Cough (Tdap)

The vaccine that protects against tetanus, diphtheria and whooping cough is called Boostrix.

In New Zealand, babies (at six weeks, three and five months old) and young children (four year old) are given these vaccines. As children get older, this protection wears off, so from 11, children need the Boostrix vaccine to boost their protection against the three diseases.

HPV

The HPV vaccine is called Gardasil9®. It protects against nine types of HPV – seven that are most likely to cause cancer and two that cause most genital warts. The vaccine cannot cause the HPV infection or cancer.

Chicken Pox

The vaccine that protects against Chicken Pox is call Varilrix.

The vaccines cause the body's immune system to produce its own protection against the diseases. They cannot cause the diseases themselves.

How effective are the vaccines?

Tetanus/Diphtheria/Whooping Cough

After the booster dose, more than 97 percent of people are protected against tetanus and diphtheria, and around 84 percent against whooping cough.

Protection against tetanus and diphtheria is expected to last for at least 20 years. Protection against whooping cough is expected to last up to 10 years. However protection may start to reduce after five years.

HPV

The HPV vaccine is very effective in preventing infection from the nine types of HPV responsible for around 90 percent of cancers caused by HPV. Protection is expected to be long lasting.

The number of HPV infections and diseases has fallen significantly among young people in countries offering HPV vaccination, including New Zealand.

For this vaccine to be most effective people should be immunised before they are exposed to HPV, which means well before they start having any sexual contact.

People also need to have all the recommended number of vaccine doses for their age. Those aged 14 or younger need fewer doses (two instead of three) of the vaccine to be protected because they respond better to the vaccine than older people.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 24 April 2018 12:50 p.m.
To: 'Christina Houston'; Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Nikki Mason'; 'Pauline Ansley'; riasouth@imac.org.nz; Sharyn Kenning
Subject: Agenda - IAG 26418
Attachments: Draft Agenda - IAG 26418.docx; Data Report April 2018.docx; IAG March 8 2018 minutes.docx; Cold Chain Management Resolution Pathway.docx; HPV-Tdap-and-Varicella-Immunise-brochure-20-4-18.pdf

Hi all

Agenda and papers attached.

See you all Thursday.

Regards Bridget

Bridget Lester
Project Specialist

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

From: Bridget Lester
Sent: Tuesday, 24 April 2018 11:51 a.m.
To: Cheryl Brunton <Cheryl.Brunton@cdhb.health.nz>
Subject: Draft Agenda - IAG 26418

HI Cheryl

Draft agenda for Thursdays IAG meeting.

I am heading home soon, so will also email this out to the wider group.

Regards Bridget

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - Supporting you to be well

AGENDA

Thursday 26 April 2018, 1 – 2pm
Community & Public Health
Dial in pin: 083038 6307786389#
Leader Pin (Host) 0881

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa *For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
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6	Update on mumps and pertussis	Cheryl	

7	Cold Chain update	Betty / Bridget	Cold Chain Management Resolu
8	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV and Tdap progress implementation Feedback to be provided on 11 year old immunisation brochure	Betty and Cheryl	
Cold Chain report to be completed and sent to Phil Wheble	Bridget	
Cold Chain Escalation Policy – Cheryl to talk to Ramon Pink about this	Cheryl	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
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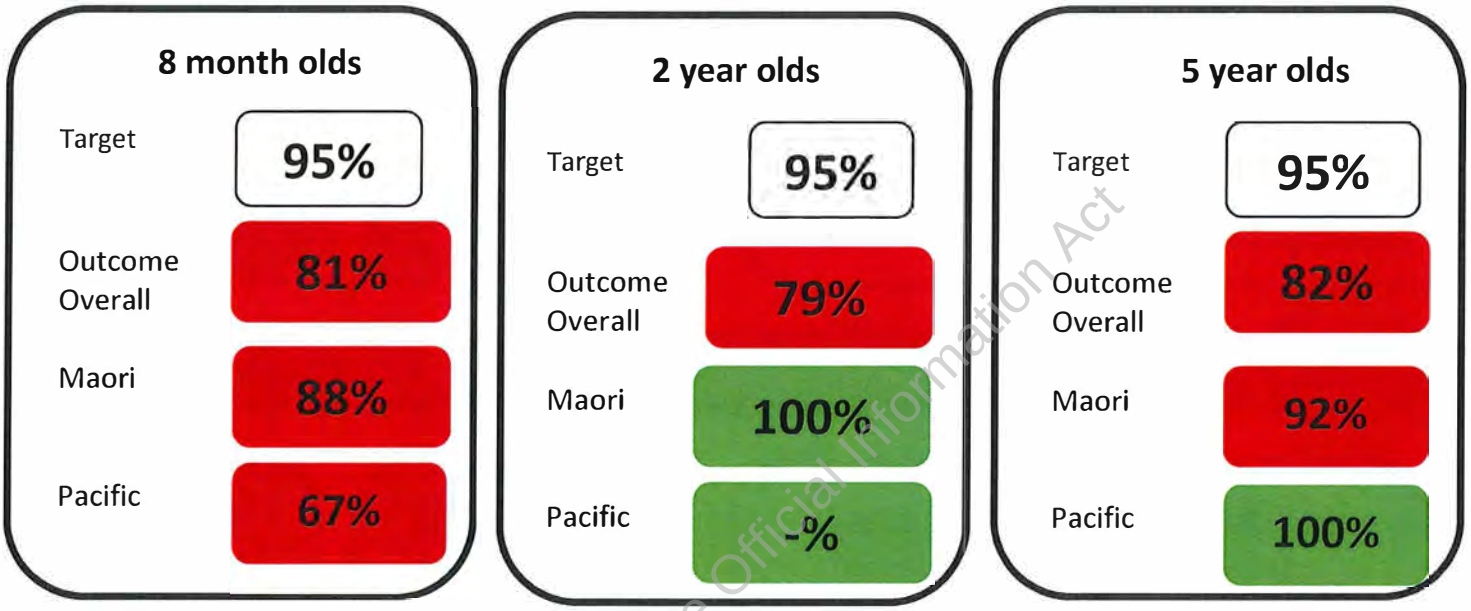
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Lee Harris	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sharyn Newcombe	NIR Coordinator

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q3 2017/18



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 23 April 18

Fully Immunised 8 month olds – DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q4 2017/18 Progress including pending	Q1 2017/18 Progress including pending
89% fully	81% fully	80% fully	fully
4.4% overdue	5% overdue	5% overdue	overdue

Fully Immunised Two year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
89% fully	79% fully	92% fully	
4.4% overdue	1% overdue	2% overdue	

Fully Immunised Five year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q4 2017/18 Progress	Q4 2017/18 Progress
90% fully	82% fully	86% fully	% fully
3.2% overdue	4%	1.6% overdue	% overdue

Q3 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	82	62	76. %	50	39	78. %	19	16	84. %	1	0	-	4	4	100. %	8	3	38. %	5 (1)	6.1 (1.2) %	4	4.9 %
8 Month	98	79	81. %	52	47	90. %	25	22	88. %	3	2	67. %	5	5	100. %	13	3	23. %	10 (1)	10.2 (1.0) %	3	3.1 %
12 Month	90	74	82. %	57	54	95. %	14	13	93. %	0	0	-	3	3	100. %	16	4	25. %	9 (0)	10.0 (0.0) %	2	2.2 %
18 Month	80	60	75. %	44	36	82. %	18	15	83. %	1	1	100. %	6	6	100. %	11	2	18. %	9 (0)	11.3 (0.0) %	4	5.0 %
24 Month	80	63	79. %	52	47	90. %	10	10	100. %	0	0	-	4	4	100. %	14	2	14. %	12 (0)	15.0 (0.0) %	4	5.0 %
5 Year	102	84	82. %	62	57	92. %	21	16	76. %	4	4	100. %	2	2	100. %	13	5	38. %	7 (0)	6.9 (0.0) %	7	6.9 %
12 Year	101	69	68. %	61	45	74. %	21	16	76. %	2	1	50. %	4	3	75. %	13	4	31. %	5 (0)	5.0 (0.0) %	9	8.9 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	82	62	76. %	6	6	100. %	27	23	85. %	12	9	75. %	17	12	71. %	15	8	53. %	5	4	80. %
8 Month	98	79	81. %	5	5	100. %	28	25	89. %	12	11	92. %	30	25	83. %	21	11	52. %	2	2	100. %
12 Month	90	74	82. %	13	11	85. %	12	11	92. %	14	14	100. %	33	29	88. %	18	9	50. %	0	0	-
18 Month	80	60	75. %	8	5	63. %	15	14	93. %	9	7	78. %	24	23	96. %	23	10	43. %	1	1	100. %
24 Month	80	63	79. %	4	4	100. %	16	15	94. %	9	9	100. %	26	23	88. %	23	11	48. %	2	1	50. %
5 Year	102	84	82. %	4	3	75. %	20	19	95. %	18	17	94. %	33	25	76. %	24	17	71. %	3	3	100. %
12 Year	101	69	68. %	7	6	86. %	24	20	83. %	18	14	78. %	29	19	66. %	19	6	32. %	4	4	100. %

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	9	0	4	55	68	30	0	0	130	160	30%	-%	-%	42%	43%	4 (2.5%)	0 (0.0%)
	HPV-2 Quadrivalent	9	0	4	49	62						30%	-%	-%	38%	39%	2 (1.3%)	
	HPV-3 Quadrivalent	5	0	0	16	21						17%	-%	-%	12%	13%	2 (1.3%)	
2005	HPV-1 Quadrivalent	4	1	1	18	24	20	0	5	140	170	20%	-%	20%	13%	14%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	3	0	1	13	17						15%	-%	20%	9%	10%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
2006	HPV-1 Quadrivalent	2	1		17	20	40	5	5	150	190	5%	20%	0%	11%	11%	1 (0.5%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	2	2						0%	0%	0%	1%	1%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	0%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	15	2	5	90	112	90	5	10	420	520	17%	40%	-%	21%	22%	5 (1.0%)	0 (0.0%)
	HPV-2 Quadrivalent	12	0	5	64	81						13%	0%	-%	15%	16%	2 (0.4%)	
	HPV-3 Quadrivalent	5	0	0	16	21						6%	0%	-%	4%	4%	2 (0.4%)	

Q3 data by practice

West Coast PHO - Buller Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	7	6	86. %	4	3	75. %	3	3	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	13	11	85. %	8	7	88. %	5	4	80. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	7.7 %
12 Month	17	16	94. %	13	12	92. %	3	3	100. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	5.9 %
18 Month	12	9	75. %	7	4	57. %	4	4	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	2	16.7 %
24 Month	10	10	100. %	9	9	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	18	15	83. %	12	11	92. %	4	3	75. %	0	0	-	0	0	-	2	1	50. %	0 (0)	0.0 (0.0) %	2	11.1 %
12 Year	24	13	54. %	17	10	59. %	2	1	50. %	2	1	50. %	1	1	100. %	2	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Coast Medical Consultancy Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	2	1	50. %	2	1	50. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	3	3	100. %	2	2	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	5	5	100. %	4	4	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
5 Year	5	3	60. %	3	3	100. %	2	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	6	4	67. %	5	3	60. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	1	16.7 %

West Coast PHO - Fox Glacier Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	2	100. %	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	2	2	100. %	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Franz Joseph Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	6	3	50. %	3	0	-	0	0	-	0	0	-	1	1	100. %	2	2	100. %	0 (0)	0.0 (0.0) %	0	0 %
8 Month	4	4	100. %	4	4	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	0	-	1	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	100.0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Greymouth Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	30	26	87. %	23	21	91. %	5	3	60. %	0	0	-	2	2	100. %	0	0	-	0 (1)	0.0 (3.3) %	2	6.7 %
8 Month	32	29	91. %	17	15	88. %	13	12	92. %	0	0	-	2	2	100. %	0	0	-	0 (1)	0.0 (3.1) %	2	6.3 %
12 Month	23	19	83. %	17	16	94. %	1	1	100. %	0	0	-	1	1	100. %	4	1	25. %	0 (0)	0.0 (0.0) %	0	0 %
18 Month	25	22	88. %	15	14	93. %	7	5	71. %	1	1	100. %	2	2	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	18	17	94. %	12	11	92. %	3	3	100. %	0	0	-	2	2	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	5.6 %
5 Year	35	33	94. %	24	22	92. %	6	6	100. %	2	2	100. %	2	2	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	2	5.7 %
12 Year	28	20	71. %	18	13	72. %	7	5	71. %	0	0	-	0	0	-	3	2	67. %	0 (1)	0.0 (3.6) %	4	14.3 %

West Coast PHO - HariHari Rural Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	3	3	100. %	2	2	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	2	1	50. %	1	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	50.0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - High Street Medical Centre (2005) Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	5	4	80. %	5	4	80. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	5	4	80. %	5	4	80. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	14	13	93. %	12	11	92. %	0	0	-	0	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
18 Month	8	5	63. %	6	4	67. %	2	1	50. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	12.5 %
24 Month	8	8	100. %	8	8	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	11	9	82. %	7	6	86. %	3	2	67. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	1	9.1 %
12 Year	10	9	90. %	6	5	83. %	2	2	100. %	1	1	100. %	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	10.0 %

West Coast PHO - Karamea Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	2	1	50. %	2	1	50. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	3	2	67. %	2	2	100. %	0	0	-	0	0	-	1	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Moana Rural Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	2	100. %	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0		-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Reefton Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	4	3	75. %	3	2	67. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	25.0 %
8 Month	4	4	100. %	4	4	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	2	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
18 Month	7	7	100. %	6	6	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	6	6	100. %	4	4	100. %	0	0	-	1	1	100. %	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
12 Year	5	2	40. %	3	1	33. %	2	1	50. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	20.0 %

West Coast PHO - Whataroa Rural Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

West Coast PHO - Westland Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	21	18	86. %	11	8	73. %	8	8	100. %	0	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	4.8 %
8 Month	20	20	100. %	8	8	100. %	5	5	100. %	2	2	100. %	2	2	100. %	3	3	100. %	0 (0)	0.0 (0.0) %	0	0 %
12 Month	17	16	94. %	9	9	100. %	8	7	88. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	5.9 %
18 Month	14	13	93. %	6	5	83. %	3	3	100. %	0	0	-	4	4	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	7.1 %
24 Month	19	17	89. %	12	10	83. %	5	5	100. %	0	0	-	2	2	100. %	0	0	-	0 (0)	0.0 (0.0) %	2	10.5 %
5 Year	14	13	93. %	8	8	100. %	5	4	80. %	1	1	100. %	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	7.1 %
12 Year	13	11	85. %	8	7	88. %	3	3	100. %	0	0	-	1	1	100. %	1	0	-	0 (0)	0.0 (0.0) %	2	15.4 %

West Coast PHO - South Westland - Haast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

MINUTES – THURSDAY 8 March 2018 1-2pm
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Hillary Ford, , Bridget Lester, Joanna Shaw , Catherine Andrews and Janet Hogan	
Apologies:	Anna Wall, Lee Harris. Christina Houston, Pauline Ansley, Sharyn Newcombe and Cath Whaley	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of 30 November are approved	
Matters Arising	• Cold Chain - $36,000 plus lost in vaccines from recent cold chain failures - Cold Chain Escalation Policy – is required by the MoH. A version has been drafted and shared with the IC. Feedback is sought on this. Bridget to follow up with Ramon Pink • Still working on the type of fridges we need, once confirmed – a paper will go the Leadership Team and discussions required with Phil W to process funding. Bridget to send to Betty and Cheryl for feedback.	
Standing Items	**Report on KPIs and Action Plan** - Data are looking positive - Bridget to share overdue children with Janet and Frances - HPV – Feedback is that general practice are doing HPV with Tdap - Bridget to pull data around o 11 year olds o HPV boys o Tdap in Pregnancy	
HPV / Tdap	**2018 HPV / Tdap programme** **General Practice** • There appears to be a positive uptake of HPV in general practice • Canterbury DHB has developed a resource, that they are happy to print and share with the West Coast – Cheryl and Betty to provide comment to Bridget **School Programme** • Consent forms will have a one week turn around • Tdap loading issue on NIR – Bridget and Janet to T/C around this, but it looks like NIR will need to ring general practice to confirm once a parent consents. • Aiming to start in May.	*Bridget, Betty, Janet and Pauline*

Influenza	- Can LMCs give the Influenza and Pertussis? Yes - Vaccine is a bit late this year, this is due to some last minute changes in the composition of the quadrivalent vaccine to cover strains which caused problem late in northern hemisphere season. - Discussed vaccination healthcare workers and DHB policy regarding those who choose not to be vaccinated. Should staff who are not vaccinated, be "rostered" to areas with less vulnerable patients? - Need to give message around o Please don't over order o Load on the NIR o DHB staff load on the NIR. Especially vaccinations given to staff aged 65 years and older.	*Betty to confirm time frame that these reports are being sent*
Outbreaks	Pertussis - West Coast currently at 7th highest in country – rates are increasing. - Not always being diagnosed or notified in a timely manner - Some women/babies getting it who have not been offered vaccination in pregnancy - Concern that LMCs are promoting it, but practices are not prioritising. - Issue with LMCs not having their Boostrix. Has been 7 years since last pertussis outbreak on the Coast when Boostrix was offered to midwives and should be offered again now. Cheryl and Lee working on some public comms around this We also need to get some messaging to LMCs around the importance of offering vaccine to pregnant women and having a booster themselves Mumps -A notification has been received.	
Staff changes	Betty is focusing more on IC role, and Christina has been contracted 1 day a week to do outreach. Lee has resigned from WCDHB	
Next Meeting	26 April 2018	

Canterbury and West Coast DHB
Cold Chain Management Resolution Pathway

1. Background

Cold Chain Accreditation (CCA) is an audit tool used to assess the cold chain management practices and processes of immunisation providers to ensure they meet the standards for safe vaccine storage and transportation before offering an immunisation programme. To achieve CCA, the provider first conducts a self-assessment and then an approved CCA reviewer conducts a review.

All immunisation providers who store vaccines all year round must have current CCA. This includes but is not limited to general practices, outreach immunisation services, public health units, community pharmacies, corrections facilities, travel clinics, emergency medical services, public and private hospital wards and departments/pharmacies, and occupational health services.

The CCA reviewer will assess the provider's past performance and current cold chain knowledge. Those findings help to determine the length of time CCA is awarded for; other considerations are the stability of the provider's workforce, the age of the equipment and the provider's cold chain history. It can be awarded for up to three years.

If a provider is compliant with all CCA Audit requirements – CCA can be issued for up to 3 years, with the expiry date reflective of the age of the fridge.

If a provider fails to meet the CCA/CCC requirements, the CCA reviewer will work with the provider to develop a remedial plan for the provider to achieve the requirements. The provider may administer vaccines while the remedial plan is in place, if the required temperature range of +2°C to +8°C can be maintained at all times and the provider works within the agreed timeframes outlined in the plan.

The maximum recommended timeframe for completing the remedial plan is three months.

For any new or short-term providers, Cold Chain Compliance (CCC) can be issued for a maximum of 9 months. Providers must comply with all requirements of Cold Chain Accreditation, with the expectation of providing 3 months temperature records. If a provider is unable to meet these requirements, a remedial plan will be agreed on, however no immunisation scan be provided until the requirements are met.

If the provider is not willing to work on a remedial plan, or does not keep to the agreed timeframe, the CCA reviewer must notify the PHO, DHB, and medical officer or Medicines Control (in the case of a pharmacy).

2. Purpose

The purpose of this plan is to document the steps required if a practice is does not achieve CCA.

3. Escalation Process

If a CCA reviewer identifies a provider who is non-complaint with CCA the following steps will be followed

Step One: The CCA reviewer and the provider will agree on a **remedial plan**, to be completed within 3 months of the non-compliance being identified. At the end of the 3 months the provider will be re-audited and

- If compliant, CCA will be awarded *for XXX years*, with the expiry date reflective of the age of the fridge.

- If the provider remains non-compliant, the CCA Reviewer informs the *DHB Immunisation Programme Manager and Medical Officer of Health,* with a recommendation about the likely resolution.

Step Two: Resolution is Imminent – the DHB will write to the provider confirming the extended remedial period and consequence of further non-compliance. The provider will be re-audited at the end of the remedial period.

Step Three: Where there is a **Lack of Progress or engagement** the Escalation Process will be activated. This will included the:

- DHB will write to the Provider to inform them of
  - Their referral to the *Escalation Panel (Should this be ISLA?)*
  - The requirement to demonstrate compliance and the consequences of the final remedial period
  - The provider will be provided with a due date for making a response to the panel.
  - The provider will be informed that during this period they must
    - Send weekly data logger reports to the Cold Chain Accreditation Reviewer for assessment
    - Hold no more than 2 weeks stock of vaccines.
- DHB will write to the supply chain informing of the supply restrictions
- The Escalation Panel will meet before the end of the remedial period to consider the evidence provider and make a recommendation to the DHB as per table one: Escalation Panel Recommendations below. An extension will be given if the panel meeting is delayed.

Step Four: The recommendation will be referred to the Ministry of Health for confirmation before the DHB's final decision.

Table One: Escalation Panel Recommendations

Step	Outcome
Re-audit	Response satisfactory – the provider is referred back to the CCA Review for re-audit
Endorsed Remedial	Where the provider requires an extension to the remedial period due to circumstances beyond their control, this will be endorsed by the DHB and the provider will be referred back to the CCA Reviewer for re-adult at the end of the extension remedial period. The outcome will be monitored by the Escalation panel.
Limited CCA	DHB writes to the provider confirming a limited CCA: • Reduce vaccine supply and/or withheld flu vaccine supply • 3 months CCA remedial period and re-audit, the outcome will be monitored by the Escalation panel • Supply chain informed
Revoke CCA	• PHO develops a plan for immunising children • DHB writes to provider informing them of revoked CCA • Cold Chain Reviewer / Imms Coordinator works with the provider to removed vaccines • Supply chain informed.

For more information on each vaccine's safety, see the summary Consumer Medicine Information section of this form, visit www.health.govt.nz/hpv or call 0800 IMMUNE (0800 466 863).

Who should be vaccinated?

All children from the age of 11 should be given these vaccines.

Who shouldn't be vaccinated?

There are very few children who should not be immunised. If your child has had a serious reaction to a vaccine, you should talk to your doctor, nurse or specialist before vaccination. Children with asthma, allergies or who are recovering from an illness such as the common cold can still be immunised.

How are the vaccinations given?

Boostrix, HPV and Varilix are safe to be given on the same day. The second dose of HPV is given at least six months after the first. The injections are given in the upper arm.

What are the alternatives to having the immunisations at a general practice?

HPV and Tdap are available in a school programme in Year 8, in participating schools.

Chickenpox vaccine can only be given at a GP practice.

Common reactions

As with all vaccinations, your child may have a sore arm and get redness, pain or swelling at the injection site.

Other reactions that can occur, usually within one or two days, include:

- a fever (feeling hot)
- nausea (feeling sick)
- vomiting
- fainting, dizziness (light-headedness)
- headache
- feeling unwell, aches and pains
- skin reaction (rash).

Your child will be observed for 20 minutes after vaccination. This is standard practice following any vaccination. The nurse will also give them post-vaccination advice and a form stating where (left or right arm) and when each vaccination was given.

Where can I get more information?

- Speak to your general practice doctor, nurse or public health nurse.
- Visit www.health.govt.nz/your-health/healthy-living/immunisation/immunisation-older-children
- Freephone 0800 IMMUNE (0800 466 863)

immunise for life

THANKS for thinking about our future

Immunisations for 11-year-olds

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Immunisations for 11-year-olds

In Canterbury and the West Coast, general practices offer a range of immunisations to 11 year olds. These are desiged to protect against tetanus, diphtheria, whooping cough (pertussis) human papillomavirus (HPV) and chickenpox (varicella).

What are the diseases?

Tetanus can enter the body through a cut or a graze. It causes muscles to stiffen and spasm. It may affect the breathing muscles.

Diphtheria affects the throat, making it hard to breathe and swallow. It may also affect the nerves, muscles, heart and skin.

Whooping cough (pertussis) damages the breathing tubes. Affected children may vomit and find it difficult to breathe when they cough.

Chickenpox is a highly infectious disease caused by the varicella-zoster virus and is most commonly seen in children. The virus can spread from person to person through droplets in the air from coughing, sneezing or laughing.

Human papillomavirus (HPV) is a common virus which spreads through intimate skin to skin contact. Without immunisation, most people will have an HPV infection at some point in their lives. Most HPV infections get better on their own, but some HPV infections don't get better, and can lead to cancer or warts, if they aren't detected and treated first. These affect both men and women.

HPV-related cancers can affect various parts of the body, particularly the genital area, throat or mouth. The most common is cervical cancer, which is cancer of the lower part of the uterus or womb. Each year in New Zealand, around 160 women are diagnosed with cervical cancer and around 50 women die from it.

What are the vaccines and how do they work?

Tetanus/Diphtheria/Whooping Cough (Tdap)

The vaccine that protects against tetanus, diphtheria and whooping cough is called Boostrix.

In New Zealand, babies (at six weeks, three and five months old) and young children (four years old) are given these vaccines. As children get older, this protection wears off, so from 11, children need the Boostrix vaccine to boost their protection against the three diseases.

HPV

The HPV vaccine is called Gardasil9®. It protects against nine types of HPV – seven that are most likely to cause cancer and two that cause most genital warts. The vaccine cannot cause HPV infection or cancer.

Chickenpox

The vaccine that protects against Chickenpox is called Varilrix.

The vaccines cause the body's immune system to produce its own protection against the diseases. They cannot cause the diseases themselves.

How effective are the vaccines?

Tetanus/Diphtheria/ Whooping Cough

After the booster dose, more than 97 percent of people are protected against tetanus and diphtheria, and around 84 percent against whooping cough.

Protection against tetanus and diphtheria is expected to last for at least 20 years. Protection against whooping cough is expected to last up to 10 years. However protection may start to reduce after five years.

HPV

The HPV vaccine is very effective in preventing infection from the nine types of HPV responsible for around 90 percent of cancers caused by HPV. Protection is expected to be long lasting.

The number of HPV infections and diseases has fallen significantly among young people in countries offering HPV vaccination, including New Zealand.

For this vaccine to be most effective people should be immunised before they are exposed to HPV, which means well before they start having any sexual contact.

People also need to have all the recommended number of vaccine doses for their age. Those aged 14 or younger need fewer doses (two instead of three) of the vaccine to be protected because they respond better to the vaccine than older people.

Chickenpox

In children aged from 9 months to under 13 years, a single dose of vaccine will protect around eight in 10 children. Up to two in 10 may still get chickenpox, but are usually protected against moderate to severe disease

How safe are the vaccines?

All vaccines have excellent safety records supported by studies in hundreds of thousands of vaccinated people. The best evidence to date shows no increase in reactions over any other childhood vaccine.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 24 July 2018 12:11 p.m.
To: 'Tracy Sollitt'; Sarah Gilsenan; Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Pauline Ansley'; riasouth@imac.org.nz; Sharyn Kenning
Subject: Papers for IAG Thursday 26 July 2018 1-2pm
Attachments: Discussion document.pdf; Draft Agenda - IAG 26718.docx; Immunisation DAP.docx; update combined with declines a3.pdf; IAGMinutesJune2018.docx

Hi all

Please find attached the papers for IAG on Thursday.

Sorry I am yet to complete the data report, or the updated escalation policy but will have these both to you tomorrow.

Please let me know if you cannot attend. I will be dialling in for Christchurch.

Regards Bridget

MINISTRY OF HEALTH
MANATŪ HAUORA

Discussion document for consideration on the best time to start the Annual Influenza Immunisation Programme

Summary

This discussion paper considers options and provides a recommendation on the best time to start the Annual Influenza Immunisation Programme (the Programme). The paper discusses recent research on the decline of influenza vaccine effectiveness (VE), influenza surveillance, the international context and considers the implications of a change in the timing of the Programme on service delivery.

The options for consideration are:

- **Status Quo**: maintain the status quo and start the Programme as soon as the vaccine becomes available in early to mid-March each year
- **Preferred Option**: move the timing of the Programme to start from 1 April each year.

What we need from you?

- We are seeking your feedback on the best time to start the Programme.
- Take the time to consider the discussion below and answer the questions provided at the end.
- Please email your responses to immunisation@moh.govt.nz by **10 August 2018**.

Background

Influenza can cause severe illness and secondary complications can lead to hospitalisation and death in high risk groups, including young children, older people, pregnant women and those with a range of underlying medical conditions.[1, 2] However, sometimes even healthy children and adults can also be at risk of serious illness following influenza infection. Māori and Pacific people and those from lower income groups experience a higher burden of disease from influenza.[3, 4] On average, approximately 400 deaths are attributed to influenza and its complications annually.[2]

Each year, seasonal influenza impacts on population health and the health system, causing increased demand for health services, including general practice visits and hospitalisations, especially for those at greater risk from the complications from influenza.[1]

The impact of influenza in New Zealand is substantial on the health of the population and health sector.[3] The highest burden of disease is in the very young, older people, pregnant women, those with underlying medical conditions, people from low income groups, and Māori and Pacific peoples.[3, 4]

The influenza vaccination is the most effective preventative measure to protect those at risk from influenza and its complications.[1] Influenza vaccination prevents the spread of

disease, reducing the chance of passing on the influenza virus to those in high risk groups.[1,2,5]

Factors that impact on vaccine effectiveness (VE)

VE is affected by the influenza vaccine's match to circulating influenza virus strains, vaccine characteristics, and other host factors such as the individual's age, underlying medical conditions and time since vaccination.[5,8] During seasons where the vaccine strains closely matches the circulating strains, VE can be as high as 80 to 90 percent in healthy adults. [5-9] The World Health Organization (WHO) annually selects the vaccine strains for the Northern and Southern Hemisphere influenza seasons to match the most recent circulating strains.[6]

International research on vaccine effectiveness

New research shows that protection begins to decline after vaccination.[5] Maximum protection is observed shortly after vaccination and starts to decline by about 7 percent every month. [6-8] Studies from the United Kingdom (UK), Canada and Australia show that VE against influenza strains A and B declines significantly after 6 months.[9-12] VE decline is more prominent and rapid in those aged 65 and older and the very young in comparison to healthy adults.[5-7]

Optimal time to vaccinate against influenza

An understanding of VE and the duration of protection helps to determine the optimal time to vaccinate, as vaccinating too early ahead of the influenza season may substantially reduce protection during the peak of the influenza activity. [5-9] This decline in VE may cause increases in overall incidence of influenza and associated outbreaks (particularly in aged care residential facilities) as well as increase hospitalisations and deaths.

Delaying vaccination might result in greater immunity later in the season, but such deferral might also result in missed opportunities to vaccinate, as well as increasing the pressure on service providers to vaccinate the population in a shorter time period before winter hits.

Community vaccination programmes should balance maximizing vaccine-induced protection through the season with avoiding missed vaccination opportunities, undue pressure on vaccinators, or vaccinating after onset of influenza circulation occurs.[11,12]

Asymptomatic carriers

The majority of influenza infections are asymptomatic, with most symptomatic cases self-managing without seeing their general practitioner. Results from the 2015 Southern Hemisphere Influenza and Vaccine Effectiveness, Research and Surveillance (SHIVERS) serosurvey showed that around 26 percent of people in New Zealand had contracted influenza over the 2015 season.[13]

Approximately 80 percent of infected people (4 in 5 infected) were asymptomatic, with only 2.5 percent (1 in 40) of those infected visiting their GP and 0.2 percent (1 in 560 infected) hospitalised.[13] Asymptomatic carriers are still infectious and can spread the virus among their family, co-workers, classmates and patients without realising it.[13]

Impact of influenza on high risk groups and government priorities

Achieving equity and delivering equitable health outcomes is a government priority. It is imperative that preventative measures such as high vaccination coverage reach New Zealanders who are most at risk and experience inequitable health outcomes.

Health inequities exist in the burden of influenza. The groups with highest influenza mortality and hospitalisations are people aged 65 and older, children under one year and Māori and Pacific peoples.

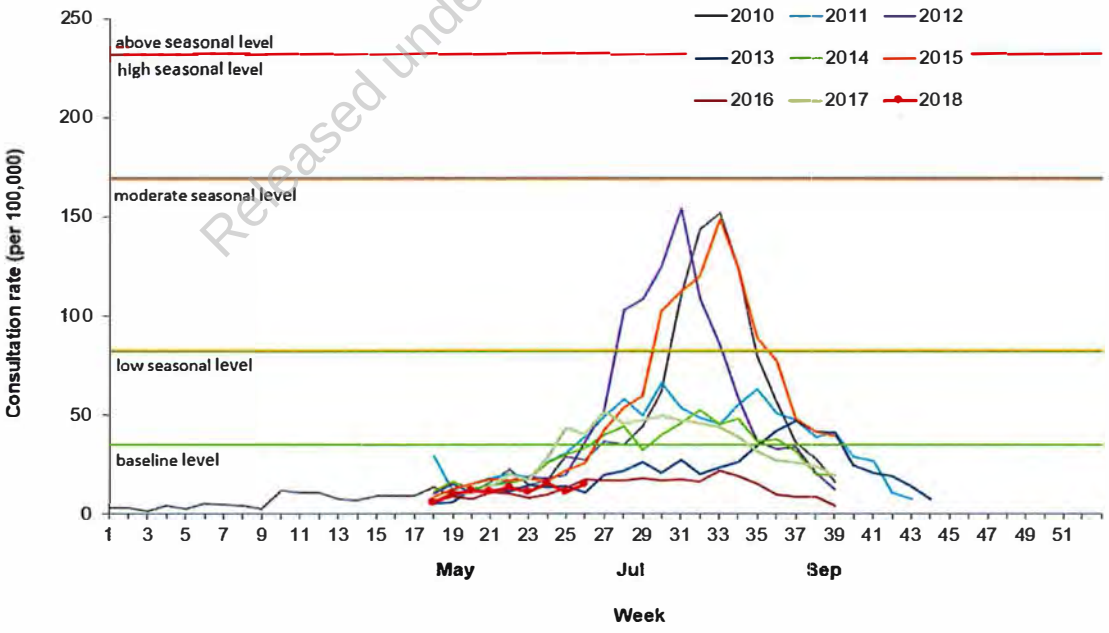
New Zealand's Annual Influenza Immunisation Programme

Influenza seasons vary in timing and duration.[1] Surveillance data shows that the New Zealand influenza season typically runs from May to September and peaks around July (refer to Figure 1).[4] However, in recent years the peak has moved to August, which was the rationale for extending the end of the funded Programme until 31 December each year.

Based on current surveillance data, the shift in peak influenza activity and the decline in VE support a change to the timing of the start of the Programme, for example to early April.

Influenza programmes need to start before the onset of the influenza season, and the vaccine takes up to two weeks to become effective. Any change to the Programme's start date will need to be considered alongside the implications for service delivery.

Figure 1. Weekly general practice consultation rates for influenza like illnesses



Source: ESR

Status Quo

The Programme traditionally started in late February/early March and continued to 31 July. In recent years the Programme has been extended due to the influenza peak not being reached until late July/August. From 2017 onwards, the Programme end date was moved to 31 December to ensure high risk groups, especially pregnant women or those who were not vaccinated earlier in the year, continue to have access to protection against influenza even as activity decreases.

There have been years where the Programme has started late due to a delay in vaccine manufacture associated with a strain change. In 2018, the Programme did not start until early April and in 2015, the Programme started 26 March. Delays in vaccine manufacture associated with a strain change cannot be predicted.

International Influenza Immunisation Programmes

Influenza activity is not usually significant in the United Kingdom (UK) before the middle of November. They recommend vaccination take place between September and early November and completed by the end of November.[14] In the UK, protection afforded by the vaccine is thought to last for at least one influenza season, however annual revaccination is recommended.[14]

The Canadian influenza season usually occurs between November and April.[15] Most adults (75 percent) are vaccinated during October or November. Based on the information sourced on the UK and Canadian programmes they do not appear at this stage to have considered the impact of declining VE on the best time to start influenza vaccination.

Since 2017, Australia has chosen not to start their influenza programme until early April to accommodate the timing of their influenza season, April to October.[16] The period of peak influenza circulation is typically June to September for most parts of Australia. The Australian Technical Advisory Group on Immunisation (ATAGI) Influenza Position Statement notes that where vaccine protection is generally expected to last for the whole season, optimal protection against influenza occurs within the first 3 to 4 months following vaccination.[16]

Analysis of options

Options	Pros	Cons	Implications on service delivery
Status quo	Programme starts when vaccine is available approximately February/March. Approximately three months prior to the influenza peaks during July-August. Allows more time for primary care to vaccinate their at risk populations prior to the start of the season.	If individuals are vaccinated in February/March they may not have optimal protection against influenza during the July-August seasonal peaks. Those most at risk from the complications of influenza (ie very young and older people) are most affected by a decline in VE.	No change to current programme. Could still promote that the best time to be vaccinated to ensure individuals are protected during the peak of the influenza season (ie, 3-4 months before July-August).

	General practice patients, especially the older population are used to being vaccinated early enabling practices to plan their vaccine recall once the bulk of patients have already been vaccinated. Aligns with the commencement of the private sector occupational health influenza immunisation programmes, which tend to start as soon as the private vaccines are made available (usually just prior to the funded vaccine).	No certainty with regards to start date can be given to general practices and vaccinating pharmacies to enable them to better plan their influenza immunisation programmes.	
1 April *Preferred Option*	Starting the influenza programme on or around 1 April would allow for optimal VE during the peak of the influenza season, especially for those at greater risk from influenza (ie, older people). Supported by evidence of VE decline with time since vaccination. Certainty can be given to general practices and vaccinating pharmacies that the vaccine will be available on this date enabling them to better plan their influenza immunisation programmes. Aligns with the delivery of most DHB healthcare worker influenza immunisation programmes – which do not routinely start until April. This change in start date will enable more time for training and preparation of vaccinators and immunisation coordinators will be able to build vaccinator capacity. This is turn will relieve immunisation services of any undue pressures.	One less month for general practices to vaccinate their at risk populations before the peak of the influenza season in July-August.	Consultation is required with the key stakeholders to identify the implications or any unintended consequences of moving to a later start date. Communication strategy providing the rationale for this change will need to be circulated as soon as practicable before the end of the year to enable general practices time to plan their programmes and inform their patients.

Questions for your feedback:

1. Please comment or provide your views on your preferred start date for the Influenza Immunisation Programme
2. Do you agree with the Ministry's preferred option to start the Influenza Immunisation Programme on 1 April, if not, why not?
3. What implications do you think commencing on 1 April will or may have?
4. Do you have any other comments on the discussion paper?

Please email your responses to immunisation@moh.govt.nz by 10 August 2018.

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WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - Supporting you to be well

AGENDA

Thursday 26 July, 1pm – 2.00pm
Community & Public Health
Dial in pin: 083038 6307786389#
Leader Pin (Host) 0881

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa		*For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (7 June)	Cheryl Brunton	IAGMinutesJune2018.docx
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Betty/Pauline	
5	MoH Influenza Notice	Cheryl	Discussion document.pdf
6	Cold Chain update	Betty/Bridget	
7	Pertussis update	Cheryl	
9	2018/19 Work plan • Engagement with Maori • Engagement with LMCs	Bridget	Immunisation DAP.docx
10	Updated Immunisation Process Chart for General Practice	Bridget/Pauline	update combined with declines a3.pdf
11	Membership review	Cheryl/Bridget	

12	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Tdap loading issues – Janet is working on a report about this	Janet	End of August
Cold Chain Escalation Paper	Bridget and feedback from all	End of June
Cold Chain – Fridge confirmation	Betty	End of June
Membership • Sarah Gilsenan to Membership list • Approach Maternity for representative	Bridget Betty	End of June

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
Tracy Solitt	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation, WCDHB
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
	WCDHB Communications
Sarah Gilsenan	WCDHB Occupation Health Representative
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sharyn Newcombe	NIR Coordinator

		e Team	
MoH Expectations	Actions to Improve Performance	Milestones	Measure of Success
Identify actions that demonstrate how you will work as one team, across all immunisation providers within your region and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood.[1]	Continue to monitor and evaluate immunisation coverage at DHB, PHO and general practice level to maintain coverage and identify unvaccinated children. Fill the vacant Maori provider role on the cross-system Immunisation Advisory Group to ensure a strong focus on Maori as a priority group. (EOA) Continue with a focus on pregnancy vaccination, supporting LMCs to have the conversation with pregnant women. Shared refreshed immunisation process charts and include tips and prompts for having difficult immunisation conversations. Support general practice to promote the co-delivery model for HPV and Tdap.	Q1: Quarterly review of vaccination and decline rates by ethnicity. Q1: Maori representative on the Immunisaton Advisory Group. Q2: LMC engagement to identify barriers to promoting immunisation. Q2: Refreshed process chart issued to general practice. Q2: HPV and Tdap Information and education resources issued to general practice. Q4: Options for difficult conversation training for practice nurses explored.	PP21: Delivery of Annual Plan actions. 50% of pregnant women vaccinated for Pertussis. 95% of eight-month-olds fully immunised. 95% of two-year olds fully immunised. 95% of five-year olds fully immunised.

[1] *West Coast's immunisation results are impacted by higher than average 'opt off' and decline rates. Around half of the people opting off have strongly held religious views on this issue, which are unlikely to change. The DHB continues to use best endeavours to reach the national target and challenges its team to ensure we are immunising 100% of those children whose parents consent to immunisation on time.*

Enrolment Process

At birth the LMC confirms the babies' general practice with caregiver. This information is loaded into the "system" and messages to the nominated practice via the NIR Nominated Provider Process

At birth a NIR Nomination is sent to general practice

- Accept New Patient Notification. "B" registration for new-borns
- If unsure and you send to GP for acceptance, ensure they send back to reception for B coding
- Practices declines New Patient Notifications - advise NIR why this is declined
  - Practice sends "welcome to practice" letter, including Immunisation information
  - NIR will follow-up declined New Patient Notifications, and refer to LinKIDS if necessary

"Opt Offs

Parents can opt their children off at birth, or at general practice. If parents want to opt their child off the NIR, do the following:

- Discuss with the parents what opt off means, e.g. difference between opt off and declining Immunisations
- The family must complete the NIR 2 Opt off form
- Send the form to the NIR, and the NIR team will update the child's status.

Pre-call and re-call Process

Send a Precall to all children 2 weeks before event is due

- Parents non-responsive to recalls
  - Send two further recalls, one being by phone for overdue event
  - Complete referral to Missed Events Service when child is 4 weeks overdue their event.
  - Missed events service contacts family
    - Cannot reach family
    - Reach family, but unable to attend practice
      - Referrer to OIS
        - OIS can't reach family
        - OIS declined
        - Child referred back to GP to reach opportunistically
    - Reach family and facilitates them back to general practice
      - OIS reach family and they agree to be vaccinated
- Caregiver contact GP and arrange appointment time
  - Family DNA appointment
  - Family present at practice for imms
  - Vaccinate for scheduled event, and if under 5 months old pre-book next event.
- Caregiver interested in delaying / declining immunisation

Discuss the following

Decline / Delay Process

Explore and confirm their reasons/ concerns

- Discuss the diseases and inform parents that health professionals are required to advise them of the implications of deciding to delay or decline immunisation
- Give 'Delaying or Declining' leaflet
- Offer further discussion with GP or Immunisation Coordinator
- Advise they will be contacted again at each new Immunisation vaccination or in the event of an outbreak
- Advise they can change their mind at any time
- Document discussion, actions and outcome in the child's clinical notes.
- Load the declines on the NIR
- Delayers – get a date from the family around how long they are delaying

- Caregiver changes their mind and decides to vaccinate
- Caregiver delayers / declines to vaccinate
  - Family cancel appointment as child is sick/unable to attend
  - Load declines on the NIR.
  - Schedule a new appointment for 1 weeks' time

KEY

- NIR/MES Team
- Reception
- Practice Nurse
- Caregivers
- Outreach Imms

Canterbury District Health Board
Te Poari Hauora ō Waitaha

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

MINUTES – THURSDAY 7 June 2018 11-12pm
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Anna Wall, Bridget Lester, and Janet Hogan	
Apologies:	Ann Knipe, Joanna Shaw, Catherine Andrews, Hillary Ford, Christina Houston, Sharyn Newcombe, Pauline Ansley and Cath Whaley	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of 26 April accepted	
Matters Arising	HPV – Tdap concerns – the practice information sheet was developed and circulated to all practices. This included information around loading HPV and Tdap on the NIR. Positive feedback has been received from practices around this, as this information was not known to them.	
Standing Items	**Report on KPIs and Action Plan** - Data are looking positive - PHO Clinical governance group raised some concerns around the increase in "missed" children. This is often due to families who don't want to vaccinate on time or are new to our DHB. When Carolyn Cox for CDHB NIR was over in April, she provided OIS with some information around timeframes and support to referral child to OIS if the GPT doesn't want to. - There are some concerns that due to the changes in OIS, that the service might not be as accessible to families. **Action: OIS will be asked to keep a record of families they can't reach due to hours**	
HPV / Tdap	**2018 HPV/Tdap programme** **General Practice –** there is currently limited stock on the WC, but it should be enough to get the Private Practices though until September. Betty has some single doses of the vaccine. **School Programme –** positive uptake with around 140 doses given. Included in this was 5 people who missed completing the programme last year. 20 people also received Tdap in the school programme. The issues with general practice loading and recording of information has impacted the school programme. Janet and Christine are keeping a record of this.	*Bridget and Betty* *Janet*
Influenza	• Over 50% of staff have been vaccinated • 48% of those over 65 year old in the DHB have been vaccinated. Positive coverage for Maori and Pacific through the PHOs. • WCDHB and CDHB have changed their Flu messaging this year	

	• Cheryl is linked in with both newspapers Health reporters. We also need to link Chery in with Renee from DHB communications.	
Outbreaks	**Measles -** It has been 2 incubation periods since the last case of Measles. All cases were linked back to the same initial contact case – from Queenstown. **Pertussis** – this continues to be an issue on the West Coast and there appear to be 2 families who are not vaccinated how are being tested. These are in Reefton and Buller. Discussion around health professional such as LMCs who are not vaccinated for Pertussis, and what the action should be around these people as they are coming into contact with vulnerable populations.	
Cold Chain Escalation Policy	Cheryl has discussed this with Ramon Pink from CDHB. It has been agreed that a similar policy will be actioned across both DHBs jus with different escalation groups. West Coast to include Cheryl, Pauline, Anna and Bridget. Feedback on paper to be sent to Bridget by Friday 15 June. Bridget will then send final version to Chery for approval and then to the MoH.	*All*
Fridge	The paper around the Fridges was sent to Phil Webbie. Feedback was that this was supported. $10,000 donation has been received by the DHB and this will be used to purchase some fridges in 2018 year. Confirmation is still to be received as to if the other fridges will be funded. Action: Betty to confirm which fridges will be purchased using the $10,000. Bridget to follow up around the other fridges for the 2018/19 year Capex.	*Betty* *Bridget*
Membership	Request to add Sarah Gilsenan to the membership list, she is the WCDHB Occ Health Rep Cheryl to approach the new Maternity manager around her availability to attend IAG.	*Bridget* *Cheryl*
Next Meeting	26 July 2018	

PHO	Total			Maori			Pacific			Asian			NZE			Other		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age		No. Eligible	Fully Immunised for Age	%
West Coast PHO	5,876	2,816	48. %	233	124	53. %	8	5	63. %	29	14	48. %	5,317	2,549	48. %	289	124	43. %

DHB NAME	Total			Maori			Pacific			Asian			Other		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
West Coast	6,195	2,871	46. %	300	128	43. %	40	5	13. %	105	14	13. %	5,750	2,724	47. %

Lara Williams (Administrator)

From: Bridget Lester
Sent: Thursday, 26 July 2018 10:20 a.m.
To: 'Tracy Sollitt'; Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Gilsenan; Sharyn Kenning
Subject: Additional Papers - IAG
Attachments: Data Report July 2018.docx; Cold Chain Esculation Policy.odt.docx

Please find attached the Data Report and updated Cold Chain Escalation policy for today's IAG meeting.

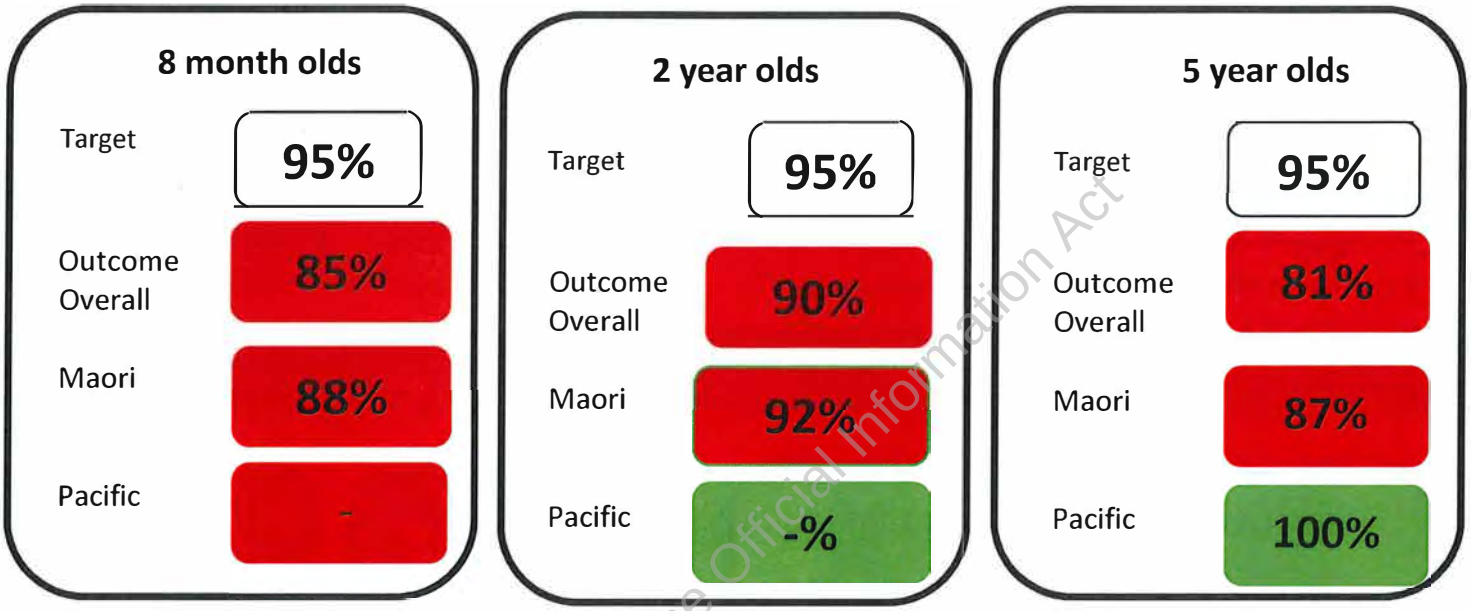
Regards Bridget

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q4 2017/18



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 26 July 18

Fully Immunised 8 month olds – DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q1 2018/19 Progress including pending	Q2 2018/19 Progress including pending
81% fully	85% fully	fully	fully
5% overdue	3.8% overdue	overdue	overdue

Fully Immunised Two year olds - DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q1 2018/19 Progress	Q2 2018/19 Progress
79% fully	90% fully	81% fully	
1% overdue	3.8% overdue	1.2%	

Fully Immunised Five year olds - DHB LEVEL

Q3 2017/18 Actual	Q4 2017/18 Actual	Q4 2018/19 Progress	Q1 2018/19 Progress
82% fully	81% fully	87% fully	% fully
4% overdue	4.4%	1.6% overdue	% overdue

Q4 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	97	69	71. %	64	50	78. %	22	16	73. %	0	0	-	3	3	100. %	8	0	-	8 (1)	8.2 (1.0) %	6	6.2 %
8 Month	96	82	85. %	57	53	93. %	24	21	88. %	0	0	-	6	6	100. %	9	2	22. %	7 (1)	7.3 (1.0) %	4	4.2 %
12 Month	102	85	83. %	52	50	96. %	25	24	96. %	4	2	50. %	6	6	100. %	15	3	20. %	12 (0)	11.8 (0.0) %	3	2.9 %
18 Month	74	59	80. %	45	40	89. %	15	14	93. %	0	0	-	4	4	100. %	10	1	10. %	8 (0)	10.8 (0.0) %	2	2.7 %
24 Month	81	73	90. %	59	57	97. %	13	12	92. %	0	0	-	0	0	-	9	4	44. %	5 (0)	6.2 (0.0) %	0	0 %
5 Year	89	72	81. %	47	41	87. %	23	20	87. %	3	3	100. %	6	6	100. %	10	2	20. %	7 (0)	7.9 (0.0) %	6	6.7 %
12 Year	94	66	70. %	62	52	84. %	13	11	85. %	0	0	-	4	1	25. %	15	2	13. %	8 (0)	8.5 (0.0) %	3	3.2 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	97	69	71. %	8	6	75. %	18	15	83. %	15	12	80. %	37	28	76. %	19	8	42. %	0	0	-
8 Month	96	82	85. %	9	8	89. %	20	19	95. %	15	14	93. %	27	23	85. %	22	15	68. %	3	3	100. %
12 Month	102	85	83. %	5	5	100. %	23	21	91. %	15	14	93. %	31	29	94. %	27	15	56. %	1	1	100. %
18 Month	74	59	80. %	6	6	100. %	12	11	92. %	12	11	92. %	18	16	89. %	19	8	42. %	7	7	100. %
24 Month	81	73	90. %	10	10	100. %	14	13	93. %	19	17	89. %	17	17	100. %	20	15	75. %	1	1	100. %
5 Year	89	72	81. %	9	8	89. %	14	11	79. %	15	12	80. %	23	21	91. %	23	15	65. %	5	5	100. %
12 Year	94	66	70. %	10	7	70. %	10	9	90. %	14	9	64. %	32	26	81. %	26	13	50. %	2	2	100. %

Newborn Enrolment Data Q3 2017/18

Number of Newborns Enrolled Within Three Months by DHB of Domicile - Quarter Three 2017/18
Newborns Born in the Following Period: 19 Nov 2017 to 19 Feb 2018
As at Quarter Two 2018 (April 2018)

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	237	966	1,338	72%	17
Bay of Plenty	140	569	697	82%	4
Canterbury	489	1,377	1,656	83%	3
Capital and Coast	180	630	838	75%	13
Counties Manukau	350	1,476	2,006	74%	16
Hawkes Bay	151	429	533	80%	6
Hutt	140	417	493	85%	1
Lakes	30	265	359	74%	15
MidCentral	112	358	531	67%	20
Nelson Marlborough	68	273	354	77%	10
Northland	158	436	573	76%	11
South Canterbury	43	121	150	81%	5
Southern	141	586	776	76%	12
Tairawhiti	35	133	179	74%	14
Taranaki	96	281	358	78%	9
Waikato	308	970	1,362	71%	18
Wairarapa	45	118	149	79%	8
Waitemata	305	1,325	1,879	71%	19
West Coast	30	76	95	80%	7
Whanganui	54	189	227	83%	2
Overseas or Unknown			4	0%	
Total	**3,112**	**10,995**	**14,557**	**76%**	

Number of Newborns Without a Nominated Provider by DHB of Domicile - Quarter Three 2017/18
Newborns Born in the Following Period: 19 Nov 2017 to 19 Feb 2018

	Newborns with Unknown Nominated Provider	No. of Newborns from NIR	% with Nominated Provider	Rank
Auckland	83	1,338	94%	11
Bay of Plenty	47	697	93%	14
Canterbury	24	1,656	99%	1
Capital and Coast	104	838	88%	20
Counties Manukau	103	2,006	95%	9
Hawkes Bay	46	533	91%	18
Hutt	14	493	97%	6
Lakes	15	359	96%	8
MidCentral	21	531	96%	7
Nelson Marlborough	10	354	97%	5
Northland	38	573	93%	13
South Canterbury	4	150	97%	4
Southern	17	776	98%	3
Tairawhiti	15	179	92%	17
Taranaki	20	358	94%	10
Waikato	102	1,362	93%	15
Wairarapa	3	149	98%	2
Waitemata	141	1,879	92%	16
West Coast	11	95	88%	19
Whanganui	15	227	93%	12
Overseas or Unknown		4	100%	
Total	**833**	**14,557**	**94%**	

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	9	0	4	53	66	30	0	0	130	160	30%	-%	-%	41%	41%	5 (3.1%)	0 (0.0%)
	HPV-2 Quadrivalent	9	0	4	49	62						30%	-%	-%	38%	39%	2 (1.3%)	
	HPV-3 Quadrivalent	5	0	0	16	21						17%	-%	-%	12%	13%	2 (1.3%)	
2005	HPV-1 Quadrivalent	10	3	4	53	70	20	0	5	140	170	50%	-%	80%	38%	41%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	3	0	1	16	20						15%	-%	20%	11%	12%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
2006	HPV-1 Quadrivalent	3	3		31	37	40	5	5	150	190	8%	60%	0%	21%	19%	1 (0.5%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	5	5						0%	0%	0%	3%	3%	1 (0.5%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	0%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	22	6	8	137	173	90	5	10	420	520	24%	120%	-%	33%	33%	6 (1.2%)	0 (0.0%)
	HPV-2 Quadrivalent	12	0	5	70	87						13%	0%	-%	17%	17%	3 (0.6%)	
	HPV-3 Quadrivalent	5	0	0	16	21						6%	0%	-%	4%	4%	2 (0.4%)	

Practice Level data for
Q1 2018/19

Practice Name	Fully	Declined	On hold - with OIS	overdue with GP	Gone No address	Overdue at Milestone age	Grand Total
Buller Medical Centre	17	1		1			19
Greymouth Medical Centre	24	2	1	1	1	1	30
High Street Medical Centre (2005) Ltd	8						8
Karamea Medical Centre		1					1
Reefton Medical Centre	3	2					5
Westland Medical Centre	14		2				16
Moana Rural Clinic				1			1
Fox Glacier Clinic	1						1
Coast Medical Consultancy Ltd	1	1					2
Grand Total	**68**	**7**	**3**	**3**	**1**	**1**	**83**

Q1 2018/19 2 year old data by practice

Practice Name	Fully	Declined	overdue with GP	Gone no address	Grand Total
Buller Medical Centre	11	1			12
Greymouth Medical Centre	24			1	25
High Street Medical Centre (2005) Ltd	6	1	1		8
Reefton Medical Centre	6	1			7
Westland Medical Centre	14	1			15
Murchison Hospital & Health Centre	1				1
Coast Medical Consultancy Ltd	4				4
Tokoroa Family Health	1				1
Grand Total	**67**	**4**	**1**	**1**	**73**

5 years olds with Practices

Practice Name	Fully	Declined	On hold - with OIS	overdue with Gp	gone no address	overdue at milestone age	awaiting overseas information	Grand Total
Buller Medical Centre	19	1						20
Franz Joseph Clinic	1						1	2
Greymouth Medical Centre	23	2	1	1		2		29
High Street Medical Centre (2005) Ltd	6	1						7
Karamea Medical Centre					1			1
Reefton Medical Centre	3	1						4
Westland Medical Centre	13							13
Coast Medical Consultancy Ltd	1							1
Tahunanui Medical Centre	1							1
Kaiapoi Family Doctors	1							1
Grand Total	**68**	**5**	**1**	**1**	**1**	**2**	**1**	**79**

West Coast PHO - Coast Medical Consultancy Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	3	2	67. %	2	1	50. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	33.3 %
8 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	3	2	67. %	3	2	67. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	33.3 %
18 Month	12	11	92. %	10	9	90. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	8	7	88. %	5	5	100. %	3	2	67. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	4	3	75. %	3	2	67. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	3	2	67. %	0	0	-	0	0	-	0	0	-	3	2	67. %	0	0	-	0	0	-
8 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-
12 Month	3	2	67. %	0	0	-	0	0	-	0	0	-	2	1	50. %	1	1	100. %	0	0	-
18 Month	12	11	92. %	0	0	-	3	3	100. %	1	1	100. %	5	5	100. %	3	2	67. %	0	0	-
24 Month	8	7	88. %	1	1	100. %	2	1	50. %	2	2	100. %	0	0	-	2	2	100. %	1	1	100. %
5 Year	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Year	4	3	75. %	0	0	-	0	0	-	0	0	-	3	2	67. %	1	1	100. %	0	0	-

West Coast PHO - Fox Glacier Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	1	50. %	0	0	-	0	0	-	1	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	4	3	75. %	0	0	-	0	0	-	1	1	100. %	2	2	100. %	1	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Month	2	1	50. %	0	0	-	1	1	100. %	1	0	-	0	0	-	0	0	-	0	0	-
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
24 Month	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-
5 Year	4	3	75. %	0	0	-	1	1	100. %	3	2	67. %	0	0	-	0	0	-	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

West Coast PHO - Franz Joseph Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	2	2	100. %	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	5	5	100. %	1	1	100. %	0	0	-	0	0	-	2	2	100. %	2	2	100. %	0 (0)	0.0 (0.0) %	0	0 %
12 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
5 Year	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	1	0	-	1	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	2	2	100. %	0	0	-	0	0	-	1	1	100. %	1	1	100. %	0	0	-	0	0	-
8 Month	5	5	100. %	0	0	-	0	0	-	2	2	100. %	1	1	100. %	0	0	-	2	2	100. %
12 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-
18 Month	2	2	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	1	1	100. %
24 Month	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-
5 Year	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	1	1	100. %
12 Year	1	0	-	0	0	-	0	0	-	0	0	-	0	0	-	1	0	-	0	0	-

West Coast PHO - Greymouth Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	31	23	74. %	25	18	72. %	6	5	83. %	0	0	-	0	0	-	0	0	-	0 (1)	0.0 (3.2) %	1	3.2 %
8 Month	27	25	93. %	21	19	90. %	5	5	100. %	0	0	-	1	1	100. %	0	0	-	0 (1)	0.0 (3.7) %	1	3.7 %
12 Month	27	26	96. %	13	12	92. %	13	13	100. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	3.7 %
18 Month	14	11	79. %	8	6	75. %	3	3	100. %	0	0	-	2	2	100. %	1	0	-	0 (0)	0.0 (0.0) %	1	7.1 %
24 Month	20	19	95. %	16	15	94. %	3	3	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
5 Year	28	24	86. %	18	16	89. %	5	3	60. %	2	2	100. %	2	2	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	4	14.3 %
12 Year	26	20	77. %	18	15	83. %	5	4	80. %	0	0	-	1	0	-	2	1	50. %	0 ()	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	31	23	74. %	2	2	100. %	7	5	71. %	6	4	67. %	13	9	69. %	3	3	100. %	0	0	-
8 Month	27	25	93. %	5	5	100. %	7	6	86. %	6	6	100. %	7	6	86. %	2	2	100. %	0	0	-
12 Month	27	26	96. %	2	2	100. %	4	3	75. %	5	5	100. %	10	10	100. %	6	6	100. %	0	0	-
18 Month	14	11	79. %	2	2	100. %	2	1	50. %	2	2	100. %	5	4	80. %	3	2	67. %	0	0	-
24 Month	20	19	95. %	4	4	100. %	1	1	100. %	7	6	86. %	6	6	100. %	2	2	100. %	0	0	-
5 Year	28	24	86. %	2	2	100. %	6	4	67. %	4	3	75. %	11	10	91. %	5	5	100. %	0	0	-
12 Year	26	20	77. %	1	1	100. %	3	3	100. %	4	3	75. %	10	8	80. %	7	4	57. %	1	1	100. %

West Coast PHO - HariHari Rural Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	4	3	75. %	3	3	100. %	0	0	-	1	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Month	4	3	75. %	0	0	-	2	1	50. %	0	0	-	2	2	100. %	0	0	-	0	0	-
18 Month	2	2	100. %	0	0	-	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-
24 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

West Coast PHO - High Street Medical Centre (2005) Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	10	10	100. %	9	9	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	9	9	100. %	9	9	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	7	7	100. %	7	7	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	9	9	100. %	8	8	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	5	4	80. %	5	4	80. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	11	9	82. %	8	6	75. %	2	2	100. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	9.1 %
12 Year	16	13	81. %	12	10	83. %	1	1	100. %	0	0	-	2	1	50. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	6.3 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	10	10	100. %	3	3	100. %	1	1	100. %	1	1	100. %	5	5	100. %	0	0	-	0	0	-
8 Month	9	9	100. %	3	3	100. %	1	1	100. %	2	2	100. %	2	2	100. %	1	1	100. %	0	0	-
12 Month	7	7	100. %	2	2	100. %	1	1	100. %	0	0	-	3	3	100. %	0	0	-	1	1	100. %
18 Month	9	9	100. %	2	2	100. %	1	1	100. %	1	1	100. %	4	4	100. %	1	1	100. %	0	0	-
24 Month	5	4	80. %	4	4	100. %	0	0	-	1	0	-	0	0	-	0	0	-	0	0	-
5 Year	11	9	82. %	2	2	100. %	1	0	-	2	2	100. %	4	3	75. %	2	2	100. %	0	0	-
12 Year	16	13	81. %	4	3	75. %	1	1	100. %	2	1	50. %	5	4	80. %	2	2	100. %	2	2	100. %

West Coast PHO - Karamea Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1	0	-	0	0	-	1	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	100.0 %
8 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1	0	-	0	0	-	0	0	-	1	0		0	0	-	0	0	-	0	0	-
8 Month	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-
12 Month	2	2	100. %	0	0	-	0	0	-	1	1	100. %	1	1	100. %	0	0	-	0	0	-
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
24 Month	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-
5 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

West Coast PHO - Moana Rural Clinic

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	1	0	-	0	0	-	1	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	2	2	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	1	0	-	0	0	-	0	0	-	0	0	-	0	0	-	1	0	-	0	0	-
8 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
12 Month	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-
18 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
24 Month	2	2	100. %	0	0	-	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-
5 Year	1	1	100. %	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-
12 Year	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-

West Coast PHO - Reefton Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	8	6	75. %	7	5	71. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	2	25.0 %
8 Month	8	7	88. %	6	5	83. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	12.5 %
12 Month	8	8	100. %	7	7	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	5	5	100. %	5	5	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	9	8	89. %	6	5	83. %	3	3	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	11.1 %
12 Year	4	4	100. %	2	2	100. %	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	8	6	75. %	0	0	-	1	1	100. %	1	1	100. %	3	2	67. %	3	2	67. %	0	0	-
8 Month	8	7	88. %	0	0	-	1	1	100. %	0	0	-	2	1	50. %	5	5	100. %	0	0	-
12 Month	8	8	100. %	0	0	-	1	1	100. %	0	0	-	4	4	100. %	3	3	100. %	0	0	-
18 Month	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-	0	0	-
24 Month	5	5	100. %	0	0	-	1	1	100. %	1	1	100. %	2	2	100. %	1	1	100. %	0	0	-
5 Year	9	8	89. %	0	0	-	3	3	100. %	2	1	50. %	2	2	100. %	2	2	100. %	0	0	-
12 Year	4	4	100. %	0	0	-	0	0	-	0	0	-	3	3	100. %	1	1	100. %	0	0	-

West Coast PHO - Westland Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	18	14	78. %	10	8	80. %	8	6	75. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	19	17	89. %	8	8	100. %	10	8	80. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	5.3 %
12 Month	19	19	100. %	6	6	100. %	5	5	100. %	2	2	100. %	3	3	100. %	3	3	100. %	0 (0)	0.0 (0.0) %	0	0 %
18 Month	13	11	85. %	5	4	80. %	7	6	86. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	7.7 %
24 Month	15	15	100. %	9	9	100. %	6	6	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	9	8	89. %	5	5	100. %	4	3	75. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	20	16	80. %	13	11	85. %	4	4	100. %	0	0	-	2	1	50. %	1	0	-	0 (0)	0.0 (0.0) %	1	5.0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	18	14	78. %	2	1	50. %	9	8	89. %	3	3	100. %	3	1	33. %	1	1	100. %	0	0	-
8 Month	19	17	89. %	0	0	-	10	10	100. %	2	1	50. %	4	3	75. %	2	2	100. %	1	1	100. %
12 Month	19	19	100. %	0	0	-	10	10	100. %	4	4	100. %	3	3	100. %	2	2	100. %	0	0	-
18 Month	13	11	85. %	0	0	-	5	5	100. %	2	1	50. %	4	3	75. %	0	0	-	2	2	100. %
24 Month	15	15	100. %	0	0	-	7	7	100. %	2	2	100. %	2	2	100. %	4	4	100. %	0	0	-
5 Year	9	8	89. %	3	2	67. %	2	2	100. %	2	2	100. %	1	1	100. %	1	1	100. %	0	0	-
12 Year	20	16	80. %	2	2	100. %	4	3	75. %	3	2	67. %	8	6	75. %	3	3	100. %	0	0	-

West Coast PHO - Buller Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	14	12	86. %	9	8	89. %	4	3	75. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	7.1 %
8 Month	17	15	88. %	9	8	89. %	7	6	86. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	5.9 %
12 Month	15	14	93. %	9	9	100. %	6	5	83. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	6.7 %
18 Month	9	9	100. %	7	7	100. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	15	14	93. %	13	12	92. %	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	1	6.7 %
5 Year	18	17	94. %	10	9	90. %	7	7	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
12 Year	21	16	76. %	15	14	93. %	3	2	67. %	0	0	-	0	0	-	3	0	-	0 (0)	0.0 (0.0) %	1	4.8 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	14	12	86. %	1	0	-	0	0	-	2	2	100. %	9	8	89. %	2	2	100. %	0	0	-
8 Month	17	15	88. %	1	0	-	0	0	-	2	2	100. %	10	9	90. %	4	4	100. %	0	0	-
12 Month	15	14	93. %	1	1	100. %	3	3	100. %	2	2	100. %	6	5	83. %	3	3	100. %	0	0	-
18 Month	9	9	100. %	1	1	100. %	0	0	-	2	2	100. %	0	0	-	2	2	100. %	4	4	100. %
24 Month	15	14	93. %	1	1	100. %	1	1	100. %	0	0	-	6	5	83. %	7	7	100. %	0	0	-
5 Year	18	17	94. %	1	1	100. %	0	0	-	3	3	100. %	4	4	100. %	7	6	86. %	3	3	100. %
12 Year	21	16	76. %	4	2	50. %	1	1	100. %	7	5	71. %	6	6	100. %	3	2	67. %	0	0	-

Canterbury and West Coast DHB
Cold Chain Management Resolution Pathway

1. Background

Cold Chain Accreditation (CCA) is an audit tool used to assess the cold chain management practices and processes of immunisation providers to ensure they meet the standards for safe vaccine storage and transportation before offering an immunisation programme. To achieve CCA, the provider first conducts a self-assessment and then an approved CCA reviewer conducts a review.

All immunisation providers who store vaccines all year round must have current CCA. This includes but is not limited to general practices, outreach immunisation services, public health units, community pharmacies, corrections facilities, travel clinics, emergency medical services, public and private hospital wards and departments/pharmacies, and occupational health services.

The CCA reviewer will assess the provider's past performance and current cold chain knowledge. Those findings help to determine the length of time CCA is awarded for; other considerations are the stability of the provider's workforce, the age of the equipment and the provider's cold chain history. It can be awarded for up to three years.

If a provider is compliant with all CCA Audit requirements – CCA can be issued for up to 3 years, with the expiry date reflective of the age of the fridge.

If a provider fails to meet the CCA/CCC requirements, the CCA reviewer will work with the provider to develop a remedial plan for the provider to achieve the requirements. The provider may administer vaccines while the remedial plan is in place, if the required temperature range of +2°C to +8°C can be maintained at all times and the provider works within the agreed timeframes outlined in the plan.

The maximum recommended timeframe for completing the remedial plan is three months.

For any new or short-term providers, Cold Chain Compliance (CCC) can be issued for a maximum of 9 months. Providers must comply with all requirements of Cold Chain Accreditation, with the expectation of providing 3 months temperature records. If a provider is unable to meet these requirements, a remedial plan will be agreed on, however no immunisation scan be provided until the requirements are met.

If the provider is not willing to work on a remedial plan, or does not keep to the agreed timeframe, the CCA reviewer must notify the PHO, DHB, and medical officer or Medicines Control (in the case of a pharmacy).

2. Purpose

The purpose of this plan is to document the steps required if a practice is does not achieve CCA.

3. Escalation Process

If a CCA reviewer identifies a provider who is non-complaint with CCA the following steps will be followed

Step One: The CCA reviewer and the provider will agree on a **remedial plan**, to be completed within 3 months of the non-compliance being identified. At the end of the 3 months the provider will be re-audited and

- If compliant, CCA will be awarded *for XXX years*, with the expiry date reflective of the age of the fridge.

- If the provider remains non-compliant, the CCA Reviewer informs the *DHB Immunisation Programme Manager and Medical Officer of Health,* with a recommendation about the likely resolution.

Step Two: Resolution is Imminent – the DHB Immunisation Programme Manager will write to the provider confirming the extended remedial period and consequence of further non-compliance. The provider will be re-audited at the end of the remedial period.

Step Three: Where there is a **Lack of Progress or engagement** the Escalation Process will be activated. This will included the:

- DHB Immunisation Programme Manager will write to the Provider to inform them of
  - Their referral to the *Escalation Panel (A subgroup of the Immunisation Advisory Group, made up of Immunisation Programme Manager, IMAC, PHO Clinical Leader and Medical Officer of Health)*
  - The requirement to demonstrate compliance and the consequences of the final remedial period
  - The provider will be provided with a due date for making a response to the panel.
  - The provider will be informed that during this period they must
    - Send weekly data logger reports to the Cold Chain Accreditation Reviewer for assessment
    - Hold no more than 2 weeks stock of vaccines.
- DHB will write to the supply chain informing of the supply restrictions
- The Escalation Panel will meet before the end of the remedial period to consider the evidence provider and make a recommendation to the DHB as per table one: Escalation Panel Recommendations below. An extension will be given if the panel meeting is delayed.

Step Four: The recommendation will be referred to the Ministry of Health for confirmation before the DHB's final decision.

Table One: Escalation Panel Recommendations

Step	Outcome
Re-audit	Response satisfactory – the provider is referred back to the CCA Review for re-audit
Endorsed Remedial	Where the provider requires an extension to the remedial period due to circumstances beyond their control, this will be endorsed by the DHB and the provider will be referred back to the CCA Reviewer for re-adult at the end of the extension remedial period. The outcome will be monitored by the Escalation panel.
Limited CCA	DHB writes to the provider confirming a limited CCA: • Reduce vaccine supply and/or withheld flu vaccine supply • 3 months CCA remedial period and re-audit, the outcome will be monitored by the Escalation panel • Supply chain informed
Revoke CCA	• PHO develops a plan for immunising children • DHB writes to provider informing them of revoked CCA • Cold Chain Reviewer / Imms Coordinator works with the provider to removed vaccines • Supply chain informed.

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 23 October 2018 5:11 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Gilsenan; Sharyn Kenning; 'Tracy Sollitt'
Subject: Papers for Immunisation Advisory Group meeting on Thursday
Attachments: Data Report Oct 2018.docx; Draft Agenda - IAG 251018.docx; draft minutes 26718.docx

Hi all

Please find papers attached. Cheryl is on leave, so Betty will be chairing the meeting.

I will be dialling in from Christchurch. Please let me know if you are not able to attend.

Regards Bridget

Bridget Lester
Portfolio Manager, Child and Youth

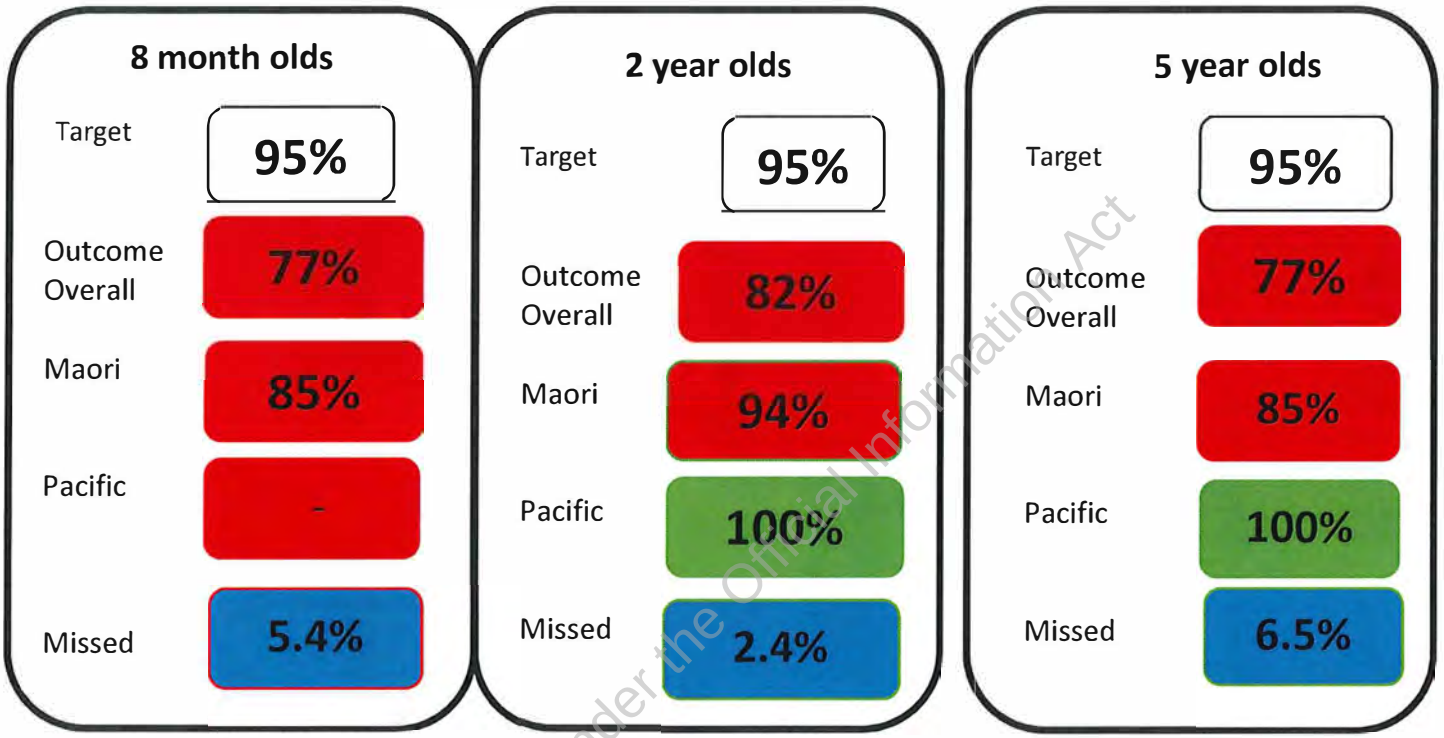
Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q1 2018/19



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers
To identify how the health system is progressing line with MoH Heath Targets
Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.
DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.
Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Newborn Enrolment – MoH Targets 85% Q1 2018 data

	B Codes	PHO Enrolment (including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Rank
Auckland	204	1,112	1,403	79%	15
Bay of Plenty	159	610	747	82%	10
Canterbury	449	1,318	1,580	83%	7
Capital and Coast	202	645	843	77%	18
Counties Manukau	343	1,591	2,042	78%	16
Hawkes Bay	168	442	517	85%	5
Hutt	123	430	474	91%	2
Lakes	31	273	378	72%	20
MidCentral	145	416	559	74%	19
Nelson Marlborough	72	293	366	80%	13
Northland	134	457	565	81%	11
South Canterbury	31	120	149	81%	12
Southern	163	677	776	87%	3
Tairawhiti	28	144	171	84%	6
Taranaki	103	336	407	83%	9
Waikato	318	1,052	1,324	79%	14
Wairarapa	41	99	119	83%	8
Waitemata	284	1,351	1,757	77%	17
West Coast	31	85	91	93%	1
Whanganui	51	178	208	86%	4
Overseas or Unknown			3	0%	
Total	**3,080**	**11,629**	**14,479**	**80%**	

Number of Newborns Enrolled Within Three Months by PHO - Quarter One 2018/19
Newborns Born in the Following Period: 19 May 2018 to 19 Aug 2018
As at Quarter Four 2018 (Oct 2018)

	PHO Enrolment (Including B Codes)	No. of Newborns from NIR	Newborn Enrolment Coverage	Coverage Change from Previous Quarter	Rank
Alliance Health Plus Trust	302	375	81%	▲ 5.5%	26
Auckland PHO Limited	147	185	79%	▼ -0.5%	30
Central Primary Health Organisation	403	536	75%	▲ 1.9%	32
Christchurch PHO Limited	98	110	89%	▼ -7.0%	12
Comprehensive Care Ltd (Waitemata)	569	702	81%	▲ 3.5%	25
Cosine Primary Care Network Trust	77	83	93%	▼ -2.7%	7
East Health Trust	196	233	84%	▲ 5.3%	20
Eastern Bay Primary Health Alliance	87	93	94%	▲ 22.5%	6
Hauraki PHO	481	550	87%	▲ 2.8%	15
Health Hawke's Bay Limited	440	462	95%	▼ -1.5%	5
Kimi Hauora Wairau (Marlborough PHO Trust)	97	121	80%	▲ 4.8%	27
Manaia Health PHO Limited	259	302	86%	▲ 7.8%	19
Pinnacle Midlands Health Network - Lakes	103	119	87%	▲ 22.6%	17
Pinnacle Midlands Health Network - Tairawhiti	108	123	88%	▲ 1.9%	13
Pinnacle Midlands Health Network - Taranaki	330	368	90%	▼ -1.3%	10
Pinnacle Midlands Health Network - Waikato	553	693	80%	▼ -0.4%	29
National Hauora Coalition Limited	239	273	88%	▲ 2.8%	14
Nelson Bays Primary Health	198	237	84%	▲ 2.1%	22
Nga Mataapuna Oranga Limited	38	52	73%	▼ -22.9%	33
Ngati Porou Hauora Charitable Trust	35	29	121%	▲ 24.1%	1
Ora Toa PHO Limited	59	61	97%	▼ -13.1%	4
Pegasus Health (Charitable) Limited	1,130	1,307	86%	▲ 1.9%	18
Procare Networks Limited	2,185	2,637	83%	▲ 2.3%	23
Rotorua Area Primary Health Services Limited	184	261	70%	▼ -9.5%	34
Rural Canterbury PHO	84	121	69%	▼ -4.4%	35
South Canterbury Primary and Community	119	145	82%	▼ -4.5%	24
Te Awakairangi Health Network	362	371	98%	▲ 5.0%	3
Te Tai Tokerau PHO Ltd	176	220	80%	▼ -3.8%	28
Total Healthcare Charitable Trust	476	532	89%	▼ -4.1%	11
Tu Ora Compass Health Capital and Coast	585	773	76%	▲ 4.2%	31
Tu Ora Compass Health Wairarapa	100	119	84%	▲ 6.3%	21
WellSouth Primary Health Network	682	759	90%	▲ 8.9%	9
West Coast PHO	85	83	102%	▲ 3.8%	2
Western Bay of Plenty Primary Health Organisation Limited	471	544	87%	▲ 1.4%	16
Whanganui Regional PHO	171	188	91%	▼ -0.2%	8
Unknown or Blank		712	0%		
Total	**11,629**	**14,479**	**80%**		

Number of Newborns Enrolled Within Three Months by DHB of Domicile and Ethnicity - Quarter One 2018/19
Newborns Born in the Following Period: 19 May 2018 to 19 Aug 2018
As at Quarter Four 2018 (Oct 2018)

	Maori			Pacific			Other		
	PHO Enrolment (including B Codes)	No. of Maori Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Pacific Newborns from NIR	Newborn Enrolment Coverage	PHO Enrolment (including B Codes)	No. of Other Newborns from NIR	Newborn Enrolment Coverage
Auckland	104	153	68%	161	210	77%	847	1,040	81%
Bay of Plenty	225	275	82%			N/A	385	472	82%
Canterbury	194	207	94%	66	88	75%	1,058	1,285	82%
Capital and Coast	98	129	76%	55	67	82%	492	647	76%
Counties Manukau	316	377	84%	511	625	82%	764	1,040	73%
Hawkes Bay	175	203	86%	28	37	76%	239	277	86%
Hutt	104	135	77%	41	39	105%	285	300	95%
Lakes	138	188	73%			N/A	135	190	71%
MidCentral	119	171	70%			N/A	297	388	77%
Nelson Marlborough	57	71	80%			N/A	236	295	80%
Northland	236	307	77%			N/A	221	258	86%
South Canterbury	23	30	77%			N/A	97	119	82%
Southern	85	94	90%			N/A	592	682	87%
Tairawhiti	85	97	88%			N/A	59	74	80%
Taranaki	101	113	89%			N/A	235	294	80%
Waikato	336	406	83%	38	51	75%	678	867	78%
Wairarapa	33	40	83%			N/A	66	79	84%
Waitemata	183	232	79%	133	195	68%	1,035	1,330	78%
West Coast	22	20	110%			N/A	63	71	89%
Whanganui	79	86	92%			N/A	99	122	81%
Overseas or Unknown						N/A		3	0%
Total	**2,713**	**3,334**	**81%**	**1,033**	**1,312**	**79%**	**7,883**	**9,833**	**80%**

Influenza Vaccine Coverage - target 75% 65 plus

Age Group	PHO vs DHB	Total	Maori	Pacific	Asian	NZE	Other
0-4 years	WCPHO	1%	2%		5%	1%	0%
	WCDHB	1%	2%		4%		1%
5-19years	WCPHO	3%	3%	3%	4%	3%	1%
	WCDHB	2%	2%	3%	2%		2%
20-64years	WCPHO	10%	8%	8%	9%	10%	10%
	WCDHB	9%	8%	4%	5%		9%
65 +	WCPHO	56%	60%	45%	57%	56%	49%
	WCDHB	54%	48%	17%	20%		55%

Childhood Immunsation Coverage - target 95%

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	85	63	74. %	53	46	87. %	11	7	64. %	1	1	100. %	8	8	100. %	12	1	8. %	11 ()	12.9 (0.0) %	3	3.5 %
8 Month	94	72	77. %	59	50	85. %	20	17	85. %	0	0	-	5	5	100. %	10	0	-	10 ()	10.6 (0.0) %	7	7.4 %
12 Month	81	71	88. %	48	45	94. %	20	18	90. %	1	1	100. %	4	4	100. %	8	3	38. %	5 (1)	6.2 (1.2) %	4	4.9 %
18 Month	94	74	79. %	65	57	88. %	12	9	75. %	0	0	-	6	6	100. %	11	2	18. %	9 (0)	9.6 (0.0) %	4	4.3 %
24 Month	83	68	82. %	46	41	89. %	18	17	94. %	1	1	100. %	7	7	100. %	11	2	18. %	9 (0)	10.8 (0.0) %	4	4.8 %
5 Year	91	70	77. %	61	55	90. %	13	11	85. %	2	2	100. %	3	1	33. %	12	1	8. %	10 (0)	11.0 (0.0) %	5	5.5 %
12 Year	94	64	68. %	67	50	75. %	9	6	67. %	3	1	33. %	5	4	80. %	10	3	30. %	5 (0)	5.3 (0.0) %	5	5.3 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	85	63	74. %	6	6	100. %	19	18	95. %	14	12	86. %	24	20	83. %	21	7	33. %	1	0	-
8 Month	94	72	77. %	7	7	100. %	17	16	94. %	16	14	88. %	34	29	85. %	20	6	30. %	0	0	-
12 Month	81	71	88. %	5	5	100. %	26	25	96. %	13	11	85. %	17	15	88. %	15	10	67. %	5	5	100. %
18 Month	94	74	79. %	11	11	100. %	15	13	87. %	13	11	85. %	33	27	82. %	20	10	50. %	2	2	100. %
24 Month	83	68	82. %	9	6	67. %	16	16	100. %	10	9	90. %	24	23	96. %	23	13	57. %	1	1	100. %
5 Year	91	70	77. %	6	6	100. %	12	10	83. %	18	16	89. %	28	23	82. %	25	14	56. %	2	1	50. %
12 Year	94	64	68. %	11	8	73. %	20	14	70. %	13	7	54. %	29	21	72. %	16	9	56. %	5	5	100. %

West Coast PHO - Buller Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	16	14	88. %	11	10	91. %	4	3	75. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	6.3 %
8 Month	16	14	88. %	11	10	91. %	4	3	75. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	1	6.3 %
12 Month	7	7	100. %	4	4	100. %	3	3	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	19	17	89. %	15	13	87. %	3	3	100. %	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	2	10.5 %
24 Month	12	11	92. %	7	6	86. %	4	4	100. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	1	8.3 %
5 Year	19	18	95. %	14	13	93. %	5	5	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	5.3 %
12 Year	21	13	62. %	19	12	63. %	1	1	100. %	0	0	-	0	0	-	1	0	-	0 (0)	0.0 (0.0) %	2	9.5 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	16	14	88. %	0	0	-	3	3	100. %	4	4	100. %	6	5	83. %	3	2	67. %	0	0	-
8 Month	16	14	88. %	0	0	-	1	1	100. %	4	4	100. %	7	6	86. %	4	3	75. %	0	0	-
12 Month	7	7	100. %	0	0	-	0	0	-	1	1	100. %	3	3	100. %	3	3	100. %	0	0	-
18 Month	19	17	89. %	2	2	100. %	1	1	100. %	3	3	100. %	8	6	75. %	5	5	100. %	0	0	-
24 Month	12	11	92. %	3	2	67. %	2	2	100. %	0	0	-	4	4	100. %	2	2	100. %	1	1	100. %
5 Year	19	18	95. %	0	0	-	2	2	100. %	6	6	100. %	4	4	100. %	7	6	86. %	0	0	-
12 Year	21	13	62. %	1	1	100. %	4	2	50. %	3	1	33. %	7	3	43. %	3	3	100. %	3	3	100. %

West Coast PHO - Coast Medical Consultancy Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	5	4	80. %	5	4	80. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	3	2	67. %	3	2	67. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	33.3 %
12 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	4	4	100. %	3	3	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	2	1	50. %	1	1	100. %	1	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	5	4	80. %	0	0	-	0	0	-	0	0	-	2	2	100. %	2	2	100. %	1	0	-
8 Month	3	2	67. %	0	0	-	0	0	-	0	0	-	3	2	67. %	0	0	-	0	0	-
12 Month	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
18 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
24 Month	4	4	100. %	0	0	-	0	0	-	0	0	-	3	3	100. %	1	1	100. %	0	0	-
5 Year	2	1	50. %	0	0	-	0	0	-	0	0	-	1	1	100. %	1	0	-	0	0	-
12 Year	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-	1	1	100. %

West Coast PHO - Greymouth Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	23	20	87. %	14	12	86. %	3	2	67. %	1	1	100. %	5	5	100. %	0	0	-	0 ()	0.0 (0.0) %	1	4.3 %
8 Month	31	26	84. %	22	17	77. %	6	6	100. %	0	0	-	3	3	100. %	0	0	-	0 ()	0.0 (0.0) %	2	6.5 %
12 Month	30	27	90. %	23	21	91. %	5	4	80. %	0	0	-	2	2	100. %	0	0	-	0 (1)	0.0 (3.3) %	2	6.7 %
18 Month	25	22	88. %	21	18	86. %	2	2	100. %	0	0	-	2	2	100. %	0	0	-	0 (0)	0.0 (0.0) %	2	8.0 %
24 Month	25	24	96. %	15	15	100. %	7	6	86. %	1	1	100. %	2	2	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
5 Year	33	27	82. %	24	21	88. %	4	3	75. %	1	1	100. %	3	1	33. %	1	1	100. %	0 (0)	0.0 (0.0) %	3	9.1 %
12 Year	26	16	62. %	19	12	63. %	6	3	50. %	1	1	100. %	0	0	-	0	0	-	0 ()	0.0 (0.0) %	3	11.5 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	23	20	87. %	4	4	100. %	6	6	100. %	3	3	100. %	7	6	86. %	3	1	33. %	0	0	-
8 Month	31	26	84. %	3	3	100. %	6	5	83. %	5	4	80. %	14	12	86. %	3	2	67. %	0	0	-
12 Month	30	27	90. %	4	4	100. %	8	7	88. %	6	5	83. %	10	9	90. %	2	2	100. %	0	0	-
18 Month	25	22	88. %	4	4	100. %	4	3	75. %	3	3	100. %	10	9	90. %	3	2	67. %	1	1	100. %
24 Month	25	24	96. %	5	4	80. %	6	6	100. %	3	3	100. %	7	7	100. %	4	4	100. %	0	0	-
5 Year	33	27	82. %	4	4	100. %	7	5	71. %	2	1	50. %	14	11	79. %	5	5	100. %	1	1	100. %
12 Year	26	16	62. %	6	3	50. %	2	1	50. %	5	2	40. %	8	7	88. %	5	3	60. %	0	0	-

West Coast PHO - Westland Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	10	8	80. %	6	5	83. %	3	2	67. %	0	0	-	0	0	-	1	1	100. %	0 (0)	0.0 (0.0) %	1	10.0 %
8 Month	15	15	100. %	8	8	100. %	7	7	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	22	21	95. %	10	10	100. %	10	9	90. %	0	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	4.5 %
18 Month	18	15	83. %	10	10	100. %	6	3	50. %	0	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
24 Month	14	13	93. %	6	5	83. %	2	2	100. %	0	0	-	5	5	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	7.1 %
5 Year	13	13	100. %	9	9	100. %	3	3	100. %	1	1	100. %	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Year	16	14	88. %	11	10	91. %	2	1	50. %	0	0	-	2	2	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	1	6.3 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	10	8	80. %	0	0	-	5	5	100. %	2	1	50. %	2	1	50. %	1	1	100. %	0	0	-
8 Month	15	15	100. %	2	2	100. %	8	8	100. %	3	3	100. %	2	2	100. %	0	0	-	0	0	-
12 Month	22	21	95. %	0	0	-	14	14	100. %	2	1	50. %	3	3	100. %	2	2	100. %	1	1	100. %
18 Month	18	15	83. %	2	2	100. %	4	3	75. %	4	3	75. %	7	6	86. %	1	1	100. %	0	0	-
24 Month	14	13	93. %	0	0	-	5	5	100. %	1	1	100. %	4	4	100. %	4	3	75. %	0	0	-
5 Year	13	13	100. %	1	1	100. %	2	2	100. %	5	5	100. %	3	3	100. %	2	2	100. %	0	0	-
12 Year	16	14	88. %	1	1	100. %	7	7	100. %	4	4	100. %	4	2	50. %	0	0	-	0	0	-

West Coast PHO - Reefton Medical Centre

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	3	2	67. %	2	2	100. %	1	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	5	3	60. %	5	3	60. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	2	40.0 %
12 Month	4	3	75. %	3	2	67. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	25.0 %
18 Month	1	1	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
24 Month	9	8	89. %	7	6	86. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	11.1 %
5 Year	4	3	75. %	4	3	75. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	25.0 %
12 Year	2	2	100. %	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	3	2	67. %	0	0	-	0	0	-	2	1	50. %	0	0	-	1	1	100. %	0	0	-
8 Month	5	3	60. %	0	0	-	0	0	-	1	1	100. %	2	1	50. %	2	1	50. %	0	0	-
12 Month	4	3	75. %	0	0	-	0	0	-	0	0	-	1	0	-	3	3	100. %	0	0	-
18 Month	1	1	100. %	0	0	-	0	0	-	0	0	-	0	0	-	1	1	100. %	0	0	-
24 Month	9	8	89. %	0	0	-	2	2	100. %	4	3	75. %	2	2	100. %	1	1	100. %	0	0	-
5 Year	4	3	75. %	0	0	-	0	0	-	2	1	50. %	1	1	100. %	1	1	100. %	0	0	-
12 Year	2	2	100. %	1	1	100. %	0	0	-	0	0	-	1	1	100. %	0	0	-	0	0	-

West Coast PHO - High Street Medical Centre (2005) Ltd

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	11	11	100. %	9	9	100. %	0	0	-	0	0	-	2	2	100. %	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
8 Month	8	8	100. %	7	7	100. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
12 Month	5	5	100. %	5	5	100. %	0	0	-	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	0	0 %
18 Month	13	12	92. %	11	10	91. %	0	0	-	0	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %
24 Month	8	6	75. %	6	4	67. %	2	2	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	12.5 %
5 Year	7	6	86. %	6	5	83. %	1	1	100. %	0	0	-	0	0	-	0	0	-	0 (0)	0.0 (0.0) %	1	14.3 %
12 Year	15	14	93. %	12	12	100. %	0	0	-	1	0	-	1	1	100. %	1	1	100. %	0 (0)	0.0 (0.0) %	0	0 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	11	11	100. %	2	2	100. %	2	2	100. %	3	3	100. %	4	4	100. %	0	0	-	0	0	-
8 Month	8	8	100. %	2	2	100. %	1	1	100. %	1	1	100. %	4	4	100. %	0	0	-	0	0	-
12 Month	5	5	100. %	1	1	100. %	1	1	100. %	1	1	100. %	1	1	100. %	1	1	100. %	0	0	-
18 Month	13	12	92. %	2	2	100. %	3	3	100. %	1	1	100. %	6	5	83. %	1	1	100. %	0	0	-
24 Month	8	6	75. %	1	0	-	0	0	-	1	1	100. %	4	3	75. %	2	2	100. %	0	0	-
5 Year	7	6	86. %	1	1	100. %	0	0	-	2	2	100. %	4	3	75. %	0	0	-	0	0	-
12 Year	15	14	93. %	3	3	100. %	4	4	100. %	1	0	-	6	6	100. %	1	1	100. %	0	0	-

HPV Coverage - target 80%

DHB: West Coast		Number of males received HPV dose (numerator)					Estimated eligible population -male* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	9	3	2	56	70	40	5	0	180	220	23%	60%	-%	31%	32%	1 (0.5%)	0 (0.0%)
	HPV-final	9	3	2	50	64						23%	60%	-%	28%	29%	()	
2005	HPV-1	15	2	3	53	73	40	0	5	160	210	38%	-%	60%	33%	35%	0 (0.0%)	0 (0.0%)
	HPV-final	2	1	1	16	20						5%	-%	20%	10%	10%	0 (0.0%)	
2006	HPV-1	8	0	1	35	44	30	5	0	180	220	27%	0%	-%	19%	20%	3 (1.4%)	0 (0.0%)
	HPV-final	0	0	0	6	6						0%	0%	-%	3%	3%	2 (0.9%)	
2007	HPV-1	3	0	2	18	23	20	0	5	170	200	15%	-%	40%	11%	12%	2 (1.0%)	()
	HPV-final	0	0	0	0	0						0%	-%	0%	0%	0%	1 (0.5%)	
Total	HPV-1	35	5	8	162	210	130	10	10	690	850	27%	50%	-%	23%	25%	6 (0.7%)	0 (0.0%)
	HPV-final	11	4	3	72	90						8%	40%	-%	10%	11%	3 (0.4%)	

DHB: West Coast		Number of females received HPV dose (numerator)					Estimated eligible population -female* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	10	0	4	54	68	30	0	0	130	160	33%	-%	-%	42%	43%	4 (2.5%)	0 (0.0%)
	HPV-final	9	0	3	49	61						30%	-%	-%	38%	38%	2 (1.3%)	
2005	HPV-1	9	3	4	54	70	20	0	5	140	170	45%	-%	80%	39%	41%	0 (0.0%)	0 (0.0%)
	HPV-final	2	0	1	17	20						10%	-%	20%	12%	12%	0 (0.0%)	
2006	HPV-1	4	3	0	31	38	40	5	5	150	190	10%	60%	0%	21%	20%	1 (0.5%)	0 (0.0%)
	HPV-final	2	0	0	7	9						5%	0%	0%	5%	5%	1 (0.5%)	
2007	HPV-1	6	1	1	16	24	20	0	5	160	190	30%	-%	20%	10%	13%	7 (3.7%)	0
	HPV-final	0	0	0	1	1						0%	-%	0%	1%	1%	2 (1.1%)	
Total	HPV-1	29	7	9	155	200	110	5	15	580	710	26%	140%	0%	27%	28%	12 (1.7%)	0 (0.0%)
	HPV-final	13	0	4	74	91						12%	0%	-%	13%	13%	5 (0.7%)	

DHB: West Coast		Total Number received HPV dose (numerator)					Estimated eligible population -total * (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1	19	3	6	110	138	60	5	5	300	380	32%	60%	120%	37%	36%	5 (1.3%)	0 (0.0%)
	HPV-final	18	3	5	99	125						30%	60%	100%	33%	33%	2 (0.5%)	
2005	HPV-1	24	5	7	107	143	60	0	10	300	370	40%	-%	70%	36%	39%	0 (0.0%)	0 (0.0%)
	HPV-final	4	1	2	33	40						7%	-%	20%	11%	11%	0 (0.0%)	
2006	HPV-1	12	3	1	66	82	70	5	5	330	410	17%	60%	20%	20%	20%	4 (1.0%)	0 (0.0%)
	HPV-final	2	0	0	13	15						3%	0%	0%	4%	4%	3 (0.7%)	
2007	HPV-1	9	1	3	34	47	50	5	10	330	380	18%	20%	30%	10%	12%	10 (2.6%)	1 (0.3%)
	HPV-final	0	0	0	1	1						0%	0%	0%	0%	0%	3 (0.8%)	
Total	HPV-1	64	12	17	317	410	240	15	30	1,260	1,540	27%	80%	240%	25%	27%	19 (1.2%)	1 (0.1%)
	HPV-final	24	4	7	146	181						10%	27%	120%	12%	12%	8 (0.5%)	

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

AGENDA

Thursday 25 October, 1pm – 2.00pm
Community & Public Health
Dial in pin: 083038 6307786389#
Leader Pin (Host) 0881

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa		*For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*
1	Introductions/Apologies	Cheryl	
2	Minutes of last meeting (7 June)	Cheryl	draft minutes 26718.docx
3	Matters arising (see list below) 3.1 Feedback to Ministry of Health re: start date for influenza programme	Cheryl	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2017/18 Progress to be updated at meeting o HPV programme update o Influenza 2018	Bridget Janet Betty/Pauline	Data Report Oct 2018.docx Immunisation DAP.docx
5	Cold Chain update	Betty/Bridget	
6	BCG vaccine availability	Betty/Cheryl	
7	Pertussis update 7.1 Current outbreak 7.2 Safety of TDap vaccination in pregnancy	Cheryl	

8	Other Business		522

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Updated Immunisation Process Chart – Feedback	All	Friday 10 August
Cold Chain Escalation Policy Feedback -	All	Friday 3 August
Influenza Programme Start Date - feedback	All	Friday 3August
OIS concerns	Bridget	Next meeting
Catarina Morais – CNM Midwifery – add to group and meeting requests	Bridget	3 August

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	B4SC
Catherine Waly	Public Health Nurse - Buller
Tracy Solitt	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation, WCDHB
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
Imogen Squires	WCDHB Communications
Sarah Gilsenan	WCDHB Occupational Health Representative
Pauline Ansley	Clinical Manager WCPHO
Catarina Morais	WCDHB Clinical Nurse Manager - Maternity
Sharyn Newcombe	NIR Coordinator
Christina Houston	OIS and HPV support

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- supporting you to be well

MINUTES – THURSDAY 27 July 2018 1-2pm
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, Ann Knipe, Sharyn Newcombe, Hillary Ford, Tracy Solitt, Bridget Lester, and Janet Hogan	
Apologies:	Joanna Shaw, Catherine Andrews, Christina Houston, Pauline Ansley, Kas Whaley and Sarah Gilsenan	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Tracy Solitt (Poutini Waiora Tamariki Ora Nurse) was welcomed to the meeting. The group noted that Caterina Morais (CNM Midwifery) had indicated she would be willing to join the group	*Bridget to send details of next meeting to Caterina*
Minutes of last meeting	Minutes of 3 June approved	
Matters Arising	**Action Item: OIS will be asked to keep a record of families they can't reach due to hours** Sharyn and Betty commented that there did not seem to be an issue with hours of OIS availability preventing access. To be discussed at next meeting with OIS co-ordinator	*Bridget to seek response from OIS*
Standing Items	**Report on KPIs and Action Plan** - Discussion around data, new 11 year old data – question for Ministry around what they are counting (they should have data dictionary) - New born enrolment processes. Sharyn piloting a new process – arrange meeting with Pauline to talk about this a bit more	
HPV/Tdap	**2018 HPV/Tdap programme** - HPV coverage is at 38% girls fully vaccinated. Currently only a small group of girls have started the programme in general practice.	
Influenza	- Over 71% of staff have been vaccinated - 59% of those 65 years old and over in the DHB have been vaccinated. Positive improvement in coverage for Māori and Pacific through the PHO. - Need to remind general practice that the vaccine programme goes until 31 December 2018. - Also need to ensure that all primary care teams are loading the flu correctly and opting patients on to the NIR. - NIR and Westland Medical Centre do regular practice audits to ensure that patients are messaging. - Influenza surveillance shows only low level activity at present	
MoH Influenza Notice	What's the best time to start the influenza vaccination programme each year? Ministry consulting on two options: - Status quo (programme starts when vaccine available	*All – DUE DATE Friday 3 August*

	- Fixed date of 1 April for start each year Those present agreed that fixed date would aid planning but there would need to be good communication about this as many patients already present early for vaccination. Send any comments to Cheryl – by Friday 3 August.	*Cheryl to compile submission by 10 August*
Pertussis	There is still a national outbreak though numbers are declining. Still seeing a higher rate of pertussis on the Coast in all districts, though Buller still has largest number of cases. Cheryl will be sending an update to primary care in the next few weeks	
Cold Chain Escalation Policy	Changes made to reflect the roles within the WCDHB who would carry out each function. Further clarification has been provided. Amended paper approved in principle. Feedback needs to be provided to Bridget and Cheryl by next Friday if any other changes are required. Otherwise this will be forwarded to the Ministry	*ALL – DUE DATE Friday 3 August*
2018/18 Work plan	This was shared and the increased focus on Māori immunisation was supported. There is a need to develop a plan for vaccination in pregnancy and to improve engagement with maternity services and midwives. The draft plan was approved.	
Updated Immunisation Process Chart	Shared with group – feedback to Bridget sought by 10 August	*All Due Friday 10 August*
Next Meetings	13 September 25 October 6 December	

Lara Williams (Administrator)

From: Bridget Lester
Sent: Wednesday, 5 December 2018 12:11 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Pauline Ansley'; riasouth@imac.org.nz; Sarah Gilsenan; Sharyn Kenning; 'Tracy Sollitt'
Subject: FW: Papers for Thursday IAG
Attachments: 201810.pdf; Draft Agenda - IAG 4121018.docx

Hi all

Please find attached the agenda and papers for our IAG meeting tomorrow.

Please let me know if you cannot make it.

Regards Bridget

Bridget Lester
Portfolio Manager, Child,Youth and Family Health

Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Thursday 9-2.30pm
Tuesday and Fridays 9– 5.00pm

C&PH Pertussis Monthly Report

5 November 2018

To 31 October 2018

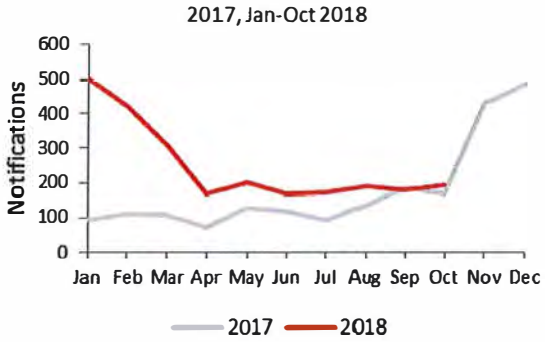
Canterbury, South Canterbury and West Coast District Health Board Areas

KEY POINTS

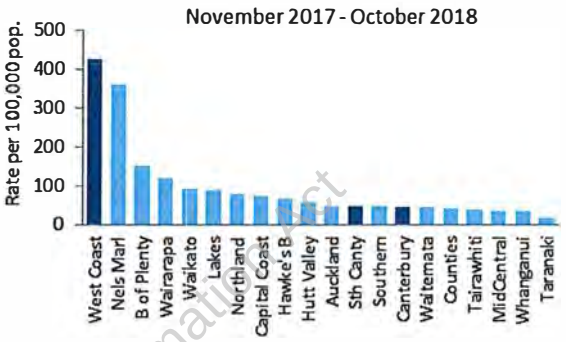
- Pertussis notifications remain slightly increased in Canterbury.
- Nationally, notification rates are similar to 2017.
- In C&PH DHBs, 12 months rates remain highest among those aged <1 year, with 71% (12/17) requiring hospitalisation .

NEW ZEALAND

Notifications

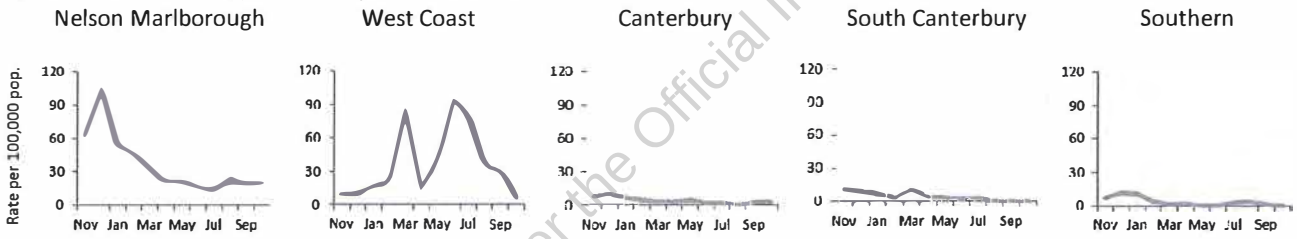


Rates by DHB—past 12 months



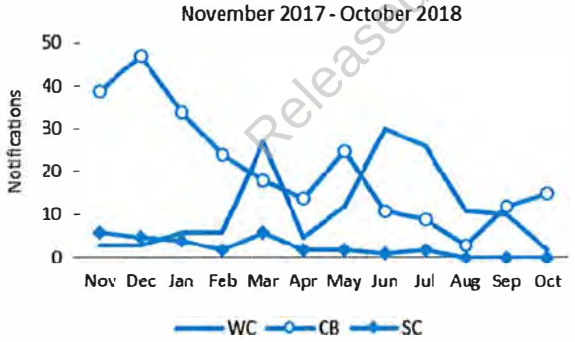
SOUTH ISLAND

Notification rates by month—past 12 months

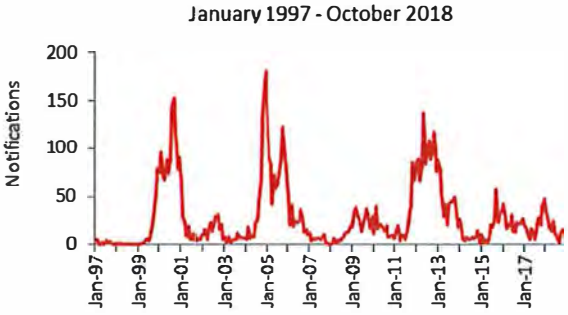


C&PH DHBs

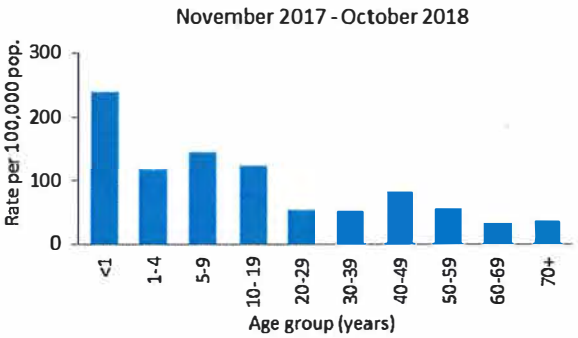
Notifications—past 12 months



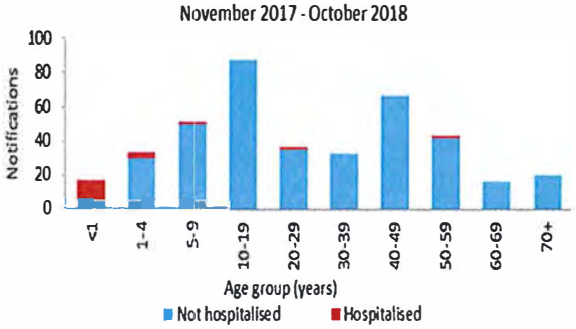
Canterbury notifications 1997— 2018



Age rates—past 12 months



Hospitalisations by age—past 12 months

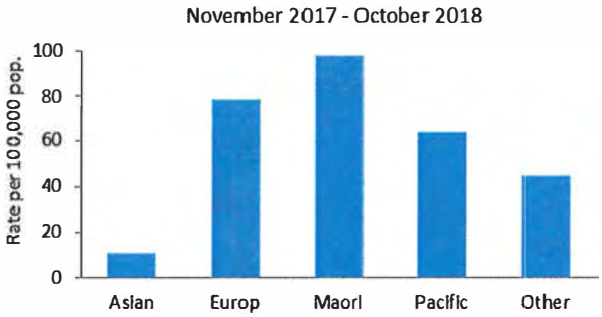


Surveillance Unit
Community and Public Health
Canterbury District Health Board

P.O Box 1475 Christchurch
Ph (03) 364 1777, Fax (03) 3796484
Internet: http://www.cph.co.nz

C&PH DHBs continued

Ethnicity Rates—past 12 months



DETAILS OF C&PH DHB NOTIFICATIONS

12 months, November 2017 – October 2018

Case Status	Canterbury	South Canterbury	West Coast
Confirmed	139	8	99
Probable	93	16	40
Suspect	16	5	0
Total	248	29	139
Sex			
Male	117	12	63
Female	134	17	76
Male: Female ratio	1: 1..1	1:1.4	1: 1.2
Age			
Average age	32.4 yrs	34.4 yrs	21.8 yrs
Age range	27 d — 81 yrs	25 d — 96 yrs	20 d — 87 yrs
Aged < 12 months	13	1	3
Aged < 3 months	5	1	2
Immunisations			
Vaccinated (any doses)	30 %	36 %	48 %
Unvaccinated	15 %	7 %	30 %
Unknown	56 %	57 %	22 %
Deaths	None reported	None reported	None reported

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

AGENDA

Thursday 4 December, 1pm – 2.00pm
Community & Public Health
Dial in pin: 083038 6307786389#
Leader Pin (Host) 0881

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa		
	For this meeting *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
1	Introductions/Apologies	Cheryl	
2	Minutes of last meeting (7 June)	Cheryl	draft minutes 251018.docx
3	Matters arising (see list below)	Cheryl	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2017/18 Progress to be updated at meeting o HPV programme update o Influenza 2018	Bridget Janet Betty/Pauline	Imm Dap progress Oct.docx
5	Infectious Disease update 5.1 Current pertussis outbreak 5.2 Safety of TDap vaccination in pregnancy	Cheryl	
6	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
Pregnancy Vaccinations • Betty to link with LMCs • Bridget to talk to Norma Campbell	Betty and Bridget	Next meeting
OIS concerns	Bridget	Next meeting

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	B4SC
Catherine Waly	Public Health Nurse - Buller
Tracy Solitt	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation, WCDHB
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Sarah Gilsenan	WCDHB Occupational Health Representative
Pauline Ansley	Clinical Manager WCPHO
Catarina Morais	WCDHB Clinical Nurse Manager - Maternity
Sharyn Newcombe	NIR Coordinator
Christina Houston	OIS and HPV support

Lara Williams (Administrator)

From: Bridget Lester
Sent: Tuesday, 5 June 2018 1:23 p.m.
To: Ann Knipe; Betty Gilsenan; Catherine Andrew; 'Catherine Crichton (catherine.crichton@westcoastdhb.health.nz)'; Cheryl Brunton; Cheryl Hutchison; 'Christina Houston'; 'Hilary Ford'; Janet Hogan; 'Joanne Shaw'; 'Kylie Parkin'; 'Nikki Mason'; 'Pauline Ansley'; 'riasouth@imac.org.nz'; Sharyn Kenning
Subject: Paper for Thursdays IAG meeting 11 - 12pm
Attachments: Data Report June 2018.docx; Draft Agenda - IAG 7618.docx; IAGMinutesFinalApril2018.docx

Hi all

Please find attached the papers for Thursdays IAG meeting.

Please note early start time of 11am.

Regards Bridget

Bridget Lester
Project Specialist

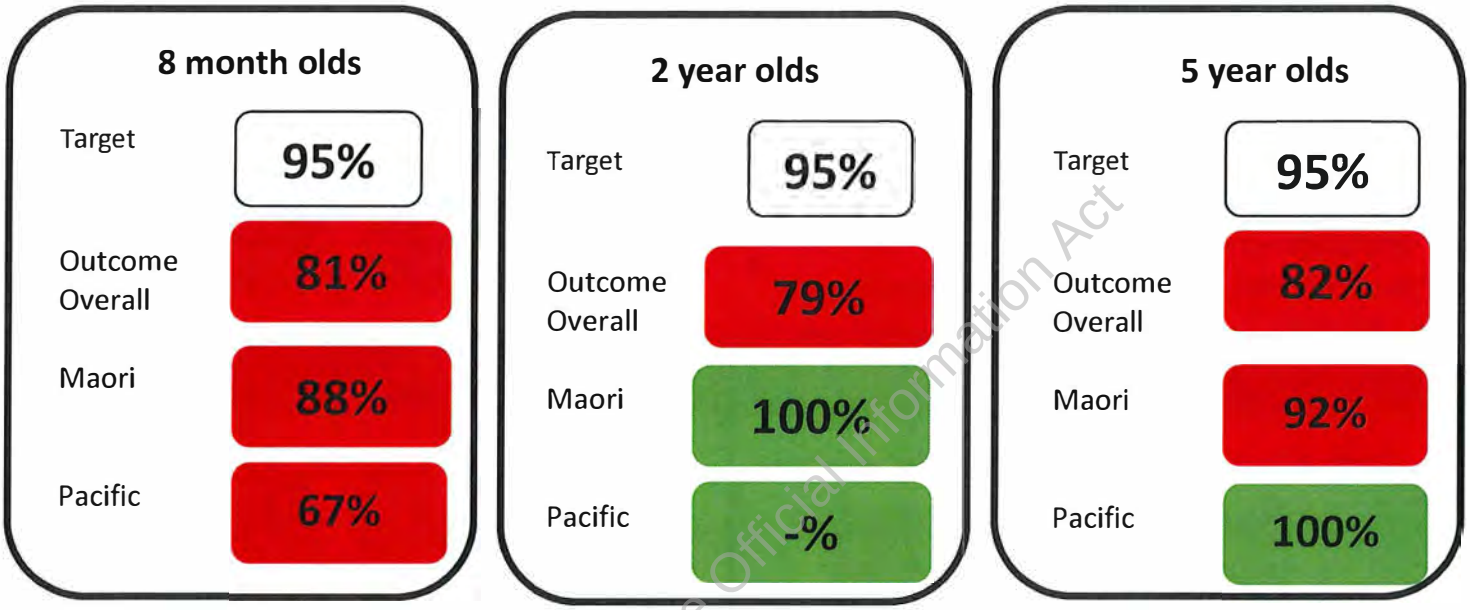
Canterbury and West Coast District Health Board
Planning and Funding
Level 2, 32 Oxford Terrace
PO Box 1600
Christchurch 8140
☎:DDI 03 364 4109 | 🖷: 03 364 4165 | ✉ **Bridget.Lester@cdhb.health.nz**
Monday and Friday 9-2.30pm
Tuesday and Thursday 9 - 5pm

our health system

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Performance in line with Key Performance Indicators

Increase Immunisation Rates Q3 2017/18



The Immunisation Reporting Programme is a work in progress.

Its goals are:

To provide DHB, PHOs and Service Providers with a better understanding of their performance in line with similar providers

To identify how the health system is progressing line with MoH Heath Targets

Share scheduled Immunisation data for Childhood Immunisation and School Aged Immunisation. Seasonal Flu information will be provided yearly during the October reporting period.

Data sources

Two different data sources are used to collect this data. Data recorded as "Actual" is from Ministry of Health Datamart reporting. Data recorded as "Progress" is from NIR level reporting, "Progress" figures are shaded in gray.

DHB level reporting includes on average 2% opt offs (children who are not recorded on the NIR). This information is not available to PHO level, and therefore not included in PHO level reporting.

Reporting periods

Q1 = 1 July – 30 September
Q2 = 1 October – 31 December
Q3 = 1 January – 31 March
Q4 = 1 April – 30 June

HPV Reporting – girls born in 2000 are the focus of the MoH this year, so we will report this information separately. For other years we will provide a summary percentage.

Childhood Immunisation – MoH Health Targets as of 6 June 18

Fully Immunised 8 month olds – DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q4 2017/18 Progress including pending	Q1 2017/18 Progress including pending
89% fully	81% fully	85% fully	fully
4.4% overdue	5% overdue	2% overdue	overdue

Fully Immunised Two year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q3 2017/18 Progress	Q4 2017/18 Progress
89% fully	79% fully	92% fully	
4.4% overdue	1% overdue	2% overdue	

Fully Immunised Five year olds - DHB LEVEL

Q2 2016/17 Actual	Q3 2017/18 Actual	Q4 2017/18 Progress	Q4 2017/18 Progress
90% fully	82% fully	87% fully	% fully
3.2% overdue	4%	1.6% overdue	% overdue

Q3 2017/18

West Coast

Milestone Age	Total			NZE			Maori			Pacific			Asian			Other			Opt Off		Declined	
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	Actual (Provisional)	%	Total	%
6 Month	82	62	76. %	50	39	78. %	19	16	84. %	1	0	-	4	4	100. %	8	3	38. %	5 (1)	6.1 (1.2) %	4	4.9 %
8 Month	98	79	81. %	52	47	90. %	25	22	88. %	3	2	67. %	5	5	100. %	13	3	23. %	10 (1)	10.2 (1.0) %	3	3.1 %
12 Month	90	74	82. %	57	54	95. %	14	13	93. %	0	0	-	3	3	100. %	16	4	25. %	9 (0)	10.0 (0.0) %	2	2.2 %
18 Month	80	60	75. %	44	36	82. %	18	15	83. %	1	1	100. %	6	6	100. %	11	2	18. %	9 (0)	11.3 (0.0) %	4	5.0 %
24 Month	80	63	79. %	52	47	90. %	10	10	100. %	0	0	-	4	4	100. %	14	2	14. %	12 (0)	15.0 (0.0) %	4	5.0 %
5 Year	102	84	82. %	62	57	92. %	21	16	76. %	4	4	100. %	2	2	100. %	13	5	38. %	7 (0)	6.9 (0.0) %	7	6.9 %
12 Year	101	69	68. %	61	45	74. %	21	16	76. %	2	1	50. %	4	3	75. %	13	4	31. %	5 (0)	5.0 (0.0) %	9	8.9 %

Milestone Age	Total			Dep 1-2			Dep 3-4			Dep 5-6			Dep 7-8			Dep 9-10			Dep Unavailable		
	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%	No. Eligible	Fully Immunised for Age	%
6 Month	82	62	76. %	6	6	100. %	27	23	85. %	12	9	75. %	17	12	71. %	15	8	53. %	5	4	80. %
8 Month	98	79	81. %	5	5	100. %	28	25	89. %	12	11	92. %	30	25	83. %	21	11	52. %	2	2	100. %
12 Month	90	74	82. %	13	11	85. %	12	11	92. %	14	14	100. %	33	29	88. %	18	9	50. %	0	0	-
18 Month	80	60	75. %	8	5	63. %	15	14	93. %	9	7	78. %	24	23	96. %	23	10	43. %	1	1	100. %
24 Month	80	63	79. %	4	4	100. %	16	15	94. %	9	9	100. %	26	23	88. %	23	11	48. %	2	1	50. %
5 Year	102	84	82. %	4	3	75. %	20	19	95. %	18	17	94. %	33	25	76. %	24	17	71. %	3	3	100. %
12 Year	101	69	68. %	7	6	86. %	24	20	83. %	18	14	78. %	29	19	66. %	19	6	32. %	4	4	100. %

DHB: West Coast		Number of HPV doses given (numerator)					Estimated eligible population* (denominator)					Immunisation coverage						
Cohort	Vaccination	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Maori	Pacific	Asian	Other**	All	Decline	Opt off
2004	HPV-1 Quadrivalent	9	0	4	55	68	30	0	0	130	160	30%	-%	-%	42%	43%	4 (2.5%)	0 (0.0%)
	HPV-2 Quadrivalent	9	0	4	49	62						30%	-%	-%	38%	39%	2 (1.3%)	
	HPV-3 Quadrivalent	5	0	0	16	21						17%	-%	-%	12%	13%	2 (1.3%)	
2005	HPV-1 Quadrivalent	4	1	1	18	24	20	0	5	140	170	20%	-%	20%	13%	14%	0 (0.0%)	0 (0.0%)
	HPV-2 Quadrivalent	3	0	1	13	17						15%	-%	20%	9%	10%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	-%	0%	0%	0%	0 (0.0%)	
2006	HPV-1 Quadrivalent	2	1		17	20	40	5	5	150	190	5%	20%	0%	11%	11%	1 (0.5%)	0 (0.0%)
	HPV-2 Quadrivalent	0	0	0	2	2						0%	0%	0%	1%	1%	0 (0.0%)	
	HPV-3 Quadrivalent	0	0	0	0	0						0%	0%	0%	0%	0%	0 (0.0%)	
Total	HPV-1 Quadrivalent	15	2	5	90	112	90	5	10	420	520	17%	40%	-%	21%	22%	5 (1.0%)	0 (0.0%)
	HPV-2 Quadrivalent	12	0	5	64	81						13%	0%	-%	15%	16%	2 (0.4%)	
	HPV-3 Quadrivalent	5	0	0	16	21						6%	0%	-%	4%	4%	2 (0.4%)	

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM
- Supporting you to be well

AGENDA

Thursday 7 June 2018, 11am – 12.00pm
Community & Public Health
Dial in pin: 083038 6307786389#
Leader Pin (Host) 0881

ITEM	AGENDA ITEM	DISCUSSION LEADER	PAPERS
	Karakia E te hui Whāia te mātauranga kia marama Kia whai tāke ngā māhī katoa Tū maia, tū kaha Aroha atu, aroha mai Tātou i a tātou katoa *For this meeting* *Seek knowledge for understanding* *Have purpose in all that you do* *Stand tall, be strong* *Let us all show respect for each other*		
1	Introductions/Apologies	Cheryl Brunton	
2	Minutes of last meeting (26 April)	Cheryl Brunton	
3	Matters arising (see list below)	Cheryl Brunton	
4	Standing Items • Report on KPIs • Immunisation Action Plan 2016/17 Progress to be updated at meeting o HPV programme update o Influenza 2017	Bridget Janet Betty/Pauline	
5	Update on measles and pertussis	Cheryl	
6	Cold Chain update	Betty/Bridget	Cold Chain Management Resolı
7	Other Business		

Actions Items from Previous Meeting

Issue	Responsibility	Due date
HPV and Tdap loading concerns	Betty and Bridget	

Membership:

Cheryl Brunton (Chair)	Medical Officer of Health
Ann Knipe	Public Health Nurse - Greymouth
Anna Wall	South Island Regional Immunisation Advisor IMAC
Betty Gilsenan	Immunisation Coordinator and OIS Vaccinator
Bridget Lester (Coordinator)	Planning and Funding
Catherine Andrew	Public Health Nurse – Hokitika
Catherine Crichton	Public Health Nurse - Buller
	Tamariki Ora Nurse – Poutini Waiora
Fiona	Plunket
Janet Hogan	Clinical Manager, Immunisation
Joanne Shaw	Administrator, Westland Medical Centre
Kylie Parkin	Māori Health Portfolio Manager
	WCDHB Communications
Nikki Mason	Rural Nurse Specialist
Pauline Ansley	Clinical Manager WCPHO
Sharyn Newcombe	NIR Coordinator

WEST COAST IMMUNISATION ADVISORY GROUP

THE WEST COAST HEALTH SYSTEM - supporting you to be well

MINUTES – THURSDAY 26 April 2018 1-2pm
COMMUNITY & PUBLIC HEALTH MEETING ROOM

Attendees:	Cheryl Brunton, Betty Gilsenan, , Bridget Lester, Joanna Shaw , Catherine Andrews and Janet Hogan Sharyn Newcombe	
Apologies:	Ann Knipe, Hillary Ford, Anna Wall, Christina Houston, Pauline Ansley, and Cath Whaley	
Agenda Items:	**Discussion**	**Action**
Intro/Apologies	Welcome by Chair	
Minutes of last meeting	Minutes of 8 March meeting are approved	

Matters Arising	• Cold Chain
	  • Paper has been circulated and feedback received. It was then forwarded to Phil Wheble. Bridget has since followed up with Phil and this paper is being used to support the purchase of the necessary fridges.
	  • Cold Chain Escalation Policy – still awaiting feedback on this.
	• 11 year old resource – there is a spelling mistake in the last page. Bridget to get updated	

Standing Items	**Report on KPIs and Action Plan** - Data are looking positive - HPV – Feedback is that general practice are doing HPV with Tdap.	

HPV / Tdap	**2018 HPV/Tdap programme**
	
	General Practice
	• There is concern around how these data are being loaded at general practice, as the HPV and Tdap don't appear to be messaging currently to the NIR. This has animpact on the school programme.
	• Bridget and Betty, with support from Carolyn Cox (CDHB NIR) will pull together an information sheet for general practice which will include
	  o The current vaccine shortage means that only Dose 1 for 11 year olds can be given in general practice
	  o Information on how to load Tdap and HPV correctly.
	
	School Programme
	• Consent forms have gone out, but due to the loading issues indicated above there is a concern that parents are consenting to Tdap when their child has already been vaccinated – but this is not being caught by NIR as it hasn't' been loaded correctly. There are around 11
		Bridget and Betty
		
		Janet

	children that have consented. Janet/Christina will contact the general practice directly to confirm the child's immunisation status. • There is also a concern that parents think that if they don't consent to the School programme for HPV they can take their child to general practice. This is not the case. Janet to work up a message to go to schools	
Influenza	• Vaccination programme underway in both general practice and secondary care. • The vaccine for 6-35month olds is not yet available on the WC.	
Outbreaks	Measles - There is currently a South Island Measles outbreak. The majority are in Canterbury but no confirmed cases on the WC. - Need to remember key messages around vaccination on time, and the catch up for adults who have not have two doses of the MMR.	
Next Meeting	7 June 2018	