## COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING (CPHAC)

**Wednesday, 10 April 2019**

### Venue: Ko Awatea, Room 101, Middlemore Hospital, Otahuhu, Auckland

**Time:** 9.00am

### Committee Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Colleen Brown</td>
<td>Committee Chair &amp; CMDHB Board Member</td>
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<td>Dr Ashraf Choudhary</td>
<td>CMDHB Board Member</td>
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<td>Dianne Glenn</td>
<td>CMDHB Board Member</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
<td>CMDHB Board Member</td>
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<td>Dr Lyn Murphy</td>
<td>CMDHB Board Member</td>
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<td>Apulu Reece Autagavaia</td>
<td>CMDHB Board Member</td>
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<td>John Wong</td>
<td>Community Representative</td>
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### CMDHB Management

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<th>Name</th>
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<tr>
<td>Ms Margie Apa</td>
<td>Chief Executive</td>
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<tr>
<td>Jenny Parr</td>
<td>Chief Nurse and Director of Patient &amp; Whaanau Experience</td>
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<tr>
<td>Dr Gary Jackson</td>
<td>Director, Population Health</td>
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<tr>
<td>Elizabeth Powell</td>
<td>GM Pacific Health Development</td>
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<tr>
<td>Dr Kate Yang</td>
<td>Business Manager</td>
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<td>Vicky Tafau</td>
<td>Secretariat</td>
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### AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>9.00am</td>
<td>1. AGENDA ORDER AND TIMING</td>
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<td>2. GOVERNANCE</td>
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<td>2.1 Apologies</td>
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<td></td>
<td>2.2 Register of Interests</td>
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<td>2.2.1 Does any member have an interest they have not previously disclosed?</td>
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<td>2.2.2 Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?</td>
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<tr>
<td>9.05am</td>
<td>2.3 Confirmation of Public Minutes of the Community &amp; Public Health Advisory Committee Meeting – 27 February 2019</td>
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<tr>
<td>9.10am</td>
<td>2.4 Action Items Register</td>
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<td>2.5 CPHAC Workplan 2019</td>
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<td>3. PRESENTATION</td>
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<tr>
<td>9.15am</td>
<td>3.1 Long Term Conditions Model of Care – Co-design Discovery Phase Report (Lucy Hall, Service Development Manager, Primary Care)</td>
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<tr>
<td></td>
<td>3.1.1 The CM Health Co-Design Discovery Phase Report</td>
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<td>3.1.2 CM Health Co-Design Approach Presentation</td>
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<td>4. BRIEFING PAPER</td>
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<td>10.10am</td>
<td>4.1 Metro-Auckland Healthy Weight Action Plan for Children Progress Report (Carmel Ellis, General Manager Integrated Child, Youth &amp; Maternity, Primary Care)</td>
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<td>5. INFORMATION PAPERS (information only, no discussion)</td>
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<td></td>
<td>5.1 Stop Gout Brochure</td>
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<td>5.2 Health Resources Available to the Asian Community</td>
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<td>5.3 Notes: CPHAC Special Meeting; Hearing from the South Asian Community (27.3.19)</td>
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<td>5.4 Community Hubs Update (27.02.2019) Presentation</td>
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<td>6. RESOLUTION TO EXCLUDE THE PUBLIC</td>
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<td>7. Move to Room 106 - MORNING TEA – 10.30am to 10.45am (Outside Room 106)</td>
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## BOARD MEMBER ATTENDANCE SCHEDULE 2019 – CPHAC

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>27 Feb</th>
<th>Mar</th>
<th>10 Apr</th>
<th>22 May</th>
<th>June</th>
<th>3 Jul</th>
<th>14 Aug</th>
<th>25 Set</th>
<th>Oct</th>
<th>6 Nov</th>
<th>18 Dec</th>
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<tr>
<td>Colleen Brown (Chair)</td>
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<td>No Meeting</td>
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<td>Ashraf Choudhary (Deputy Chair)</td>
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<td>Dianne Glenn</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
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<td>Apulu Reece Autagavaia</td>
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<tr>
<td>Dr Lyn Murphy</td>
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<td>John Wong - External Appointee</td>
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appointed 13/9/17
# CPHAC MEMBERS
## DISCLOSURE OF INTERESTS
### 10 April 2019

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

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 27 February 2019

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apulu Reece Autagavaia</td>
<td>Item 4.1 on the CPHAC agenda – New Government’s health Policies &amp; Priorities</td>
<td>Mr Autagavia is a member of the District Licensing Committee of Auckland Council</td>
<td>21 February 2018</td>
<td>That Apulu Reece Autagavaia’s specific interest is noted and the Committee agreed that he may remain in the room and participate in any deliberations of the Committee but is not permitted to participate in any decision making, if applicable.</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 27 February 2019 at 9.00am – 12.30pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dianne Glenn
John Wong
Katrina Bungard
Dr Lyn Murphy
Apulu Reece Autagavaia

ALSO PRESENT

Margie Apa (Chief Executive)
Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Gary Jackson (Director, Population Health)
Dr Kate Yang (Business Manager, Primary Care)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

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

APOLOGIES

Apologies were received from Ashraf Choudhary, and George Ngatai.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

There amendments to the Disclosures of Interest were noted by Ms Tafau.
There were no amendments to the Disclosure of Specific Interests.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 5 December 2018.**

   **Resolution** (Moved: Colleen Brown /Seconded: Dianne Glenn)

   Minutes: piece of work pg 8

   That the minutes of the Community and Public Health Advisory Committee meeting held on 5 December 2018 be approved.

   Carried

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

   Action Items were noted as being on track.

   Women in Prisons: an update paper was provided by Ms Glenn in the Information Paper section of this agenda.

   During the work plan discussion, later in the session, the items on the current Action Item register will be discussed for their relevance.

   Add to the Action Item Register that Julia Burgess-Shaw is to present on what Youth activities CM Health are assisting in the community.

3. **BUSINESS CASE**

3.1 **Owning My Gout (Trevor Lloyd, Portfolio Manager – Pharmacy Service, Primary Care)**

   Mr Lloyd gave an overview of the Business Case. The aim is to encourage Gout sufferers to go to the Pharmacy rather than the GP. Regular testing allows GPs to see when adherence to taking medication isn’t happening. The programme is assisting people as young as 19 to be able to manage their medication ongoing for the rest of their lives.

   Business case has yet to be presented to ELT.

   This programme is tailored to work easily for GPs and Nurses, but also for Pharmacists.

   Capitation funding isn’t set up to cover a monthly GP visit. Also, many gout sufferers don’t only suffer from gout. A GP will focus on more serious issues before they get to gout and gout may be missed off the list.

   Funding is available for funding new services. This is a good place for OMG to get funding.

   The Stop Gout booklet is an easy to understand guide on how to manage symptoms. There is a gene that makes certain families susceptible to gout. The same gene also makes you more resistant to malaria.
Action
A copy of the Stop Gout booklet will be provided for the Committee.

Mr Lloyd is currently speaking with the MoH in regard to removing the co-payment for those on a Community Services card. The committee raised the difficulty of applying for a community services card as an issue.

Capital Coast DHB is undertaking a study where they are making the co-payment. It is showing that adherence to taking medication improves when the medication is fully funded.

The pharmacy model is one that the DHB will look to explore further. Smaller pharmacies are struggling to cope as people are travelling to bigger pharmacies to get free prescriptions.

The business case is still being updated and will go through ELT for endorsement.

4. BRIEFING PAPER

4.1 Quarter 1 2018/19 Non-Financial Summary Report Alanna Soupen, Planning & Reporting Advisor)

Performance against mental health targets: transition planning and employment measure has improved in Q2. AOD 0-18 yr olds: waiting lists are long across the country. Staff retention is a problem in this area.

The discharge plan target was low. The committee was advised that this is a new target and there is high expectation that these figures will continue to increase.

Raising Healthy Kids Target: identification is good, but where is the data to show treatment? Programme is currently be evaluated and is due to be completed at the end of April 2019.

In regard to Immunisations, we do need to refresh our promotional messaging in regard to imms as the issues change for each generation.

Report on Q2 – will provide more insight from Health Kids team and more narrative on Mental Health, in particular AOD. Reiterate the focus on Maaori Immunisations. Focus on Maaori Imms.

Resolution

The Community & Public Health Advisory Committee:

Noted that this Quarter 1 2018/19 Summary Report was approved for forwarding to the Community and Public Health Advisory Committee by ELT on 11 December 2018.

Noted the results for Quarter 1 progress against draft planned 2018/19 actions and performance expectations, including commentary on challenges and resolution plans for those measures where performance was low.

Noted that due to Ministry of Health quarterly reporting delays, ELT received the Quarter 1 2018/19 Summary Report toward the end of Quarter 2. As Quarter 2 has now concluded, indicative Quarter 2 updates have been added to this Quarter 1 2018/19 Summary Report. Quarter 2 data has been added with additional commentary provided for those measures where performance continued to be low or dropped in Quarter 2, where this information is currently available. Information for some measures is not yet available and full Quarter 2
performance information will be provided in the Quarter 2 2018/19 Summary Report, after the completion of the Quarter 2 reporting cycle in February.

Noted that as the 2018/19 Annual Plan has yet to be approved by the Ministry of Health, for Quarter 1 the Ministry did not rate DHBs’ achievement against Annual Plan targets. For Quarter 1 descriptive assessments have instead been assigned by the Ministry, of either Satisfactory (S) or Not enough information/performance concerns (N). Performance against targets has therefore been provided by the Planning team for reference only and do not represent Ministry ratings of performance.

Reviewed the identified issues and associated actions for Quarter 1 2018/19.

Noted the appended Northern Region Health Plan Quarter 1 2018/19 summary report provided by the Northern Regional Alliance (Appendix 2).

**Moved:** Ms Colleen Brown/ **Seconded:** Ms Dianne Glenn/ **Passed:** Unanimously

5. **UPDATE**

5.1 **Community Hubs – Current State** (Alan Greenslade, Service Development Manager, Mangere/Otara Locality)

A broader piece of work is currently being undertaken – Primary and Community Care in a broader context, looking at what have we learnt in regard to place-based care that has been implemented over the last two years. What does it mean in terms of where we want to go? Looking at our priorities and also looking to eliminate inequities. Mr Hannant will return to CPHAC in the next few months to provider a further update.

Ms Tafau to include presentation with minutes.

Original vision slide
Strengths/Opportunities
Risks/Issues – not always about need, but opportunity
Place-based structures in tension with PHOs – more than one PHO operating in communities

Disability Services are not available in communities. CPHAC felt this was an opportunity for the DHB. There is the potential for finding space within the Community Hubs to set these types of support up.

The Northern Regional Long Term Investment Plan talks to the role of Community Hubs playing a part as we move forward.

Community Hubs graphic: Mr Greenslade will look to update to include disability services.

We have a lot of co-location but not enough integration. This is part of the next phase.

Opportunities & Issues
CPHAC raised Clendon/Rata Vine/Randwick Park as places with very few or no GP services. However Community Houses in those areas could be used to provide GP and other health services.

DNA rate is 18 to 20% lower at the Mangere Community Hub. One of the things the hub is investigating is an extension of hours of operation.
Otara Community Hub is a smaller property so does not have the same range of services as Mangere.

Botany Hub provides multiple services in a co-location. The DHB only owns a third of the title and has a good working relationship with East Health and integration is a work in progress.

New Hub opportunities slide

Next steps
CMDHB working with Waikato DHB and will set up a team to work together around planning for a new hospital, if this is agreed upon by the Government.

Resolution

The CPHAC Committee recommended an investigation into the disability services we currently have and how we could utilise community hub to expand these services.

Moved: Ms Colleen Brown/Seconded: Ms Katrina Bungard/Passed: Unanimously

Mr Greenslade advised that thought has been put into using community hubs to partner with education organisations. Work is currently be undertaken with ADHB stroke research in Otara/Botany, speech & language therapy students have been included. There is work with Botany hub to have a shared workforce. Additional investigation has been undertaken looking at Primary Care facilities being able to provide services in hard to reach communities.

Advertising of services in the community hubs is still a work in progress. There are forums in place where we have providers meet and share.

The committee thanked Mr Greenslade for his update.

6. DISCUSSION

6.1 2019 CPHAC Workplan (Kate Yang/Colleen Brown)

A strategic deep dive should marry up with HAC’s focus.
Operational Deep Dive – a look at business cases that will be going up to the Board.
Site Visits

Equity is to be at the forefront/Maaori Health/Pacific Health/Service Risks (Oral Health) – collate information from teams as a regular update to CPHAC.

Deep Dives: focus on Equity
Youth – inequities for Maaori & Pacific. The difficulty in capturing data for immigrants was noted.
Disabled youth.
Need to focus on what lies within the DHB’s remit.

Older people: include information on how the DHB can disseminate information to the Asian community who are not aware of how to navigate our Health System.

The committee thanked Kate Yang for the work she has put in to forming this work plan.

Add Pacific Health to the December meeting.
The committee was advised that in other Committees (outside the DHB) Maaori Impact statements are part of every report/paper. Kate Yang will liaise with Aroha Haggie, GM Maaori Health, as to how the DHB could look to implement this initiative.

7. INFORMATION PAPERS

7.1 Long Term Conditions Model of Care Update

The paper was taken as read and noted.

7.2 Screening Female Prisoners
7.2.1 Women in Prison: Provision of Alternatives to Detention

The papers were taken as read and noted.

7.3 CPHAC Committee Visit to Papatoetoe High School 31.1.2019: Brief

The paper was taken as read and noted.

The meeting concluded at 11.30am.


Colleen Brown
Committee Chair
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

**Community & Public Health Advisory Committee Meeting – Action Items/Resolution Register – 27 February 2019**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<td><strong>Standing Items</strong></td>
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<td>Locality Updates: Provide updates for Locality Hubs in general until established enough to provide individual deep dives.</td>
<td>22 May (to discuss alongside EPC business case)</td>
<td>Alan Greenslade, Matt Hannant and Penny Magud</td>
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<td>ARPHS – six-monthly update.</td>
<td>3 July</td>
<td>Doone Winnard</td>
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<td>Quarterly Non-Financial Summary Report</td>
<td>3 July</td>
<td>Alanna Soupe</td>
<td>Q3</td>
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<td>17/18 Metro Auckland SLM Improvement Plan – quarterly report.</td>
<td>25 September</td>
<td>Kate Dowson</td>
<td>As per the Workplan.</td>
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<tr>
<td>29.11.2017</td>
<td>3.1</td>
<td><strong>Every $ Counts</strong> – Project team to present an update on this project.</td>
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<td>Sarah Sharpe</td>
<td>To be removed from the register as this piece of work is currently on hold. Population Health will keep CPHAC apprised when work resumes.</td>
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<td>18.10.2017</td>
<td>3.4</td>
<td>Healthy Weight Action Plan for Children: Update</td>
<td>10 April</td>
<td>Carmel Ellis</td>
<td>See item 4.1 on this agenda.</td>
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<td>6.9.2017</td>
<td>3.1</td>
<td><strong>Owning my Gout</strong> – the project team were asked to return in 6 months’ time to update the Committee on their progress, particularly how they have got on working with A/WDHB as they have the balance of the 31,000 Gout sufferers.</td>
<td>27 February</td>
<td>Trevor Lloyd</td>
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<td>21.2.2018</td>
<td>3.1</td>
<td><strong>Green Prescriptions in Counties Manukau - Green Prescription</strong> is currently undergoing a re-procurement process and will update once this process has concluded.</td>
<td>3 July</td>
<td>Ryan Stangroom and Matt Hannant</td>
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<td>23.5.18</td>
<td>3.1</td>
<td><strong>Mental Health &amp; Addictions Update:</strong> with regard to homelessness for MH&amp;A whaanui, Housing First to be invited to present to CPHAC.</td>
<td>TBC</td>
<td>Kate Yang</td>
<td>Waiting to hear back from Julie Nelson re presenting in August as per the Workplan.</td>
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<td>4.7.2018</td>
<td>3.1</td>
<td><strong>Youth Services</strong>: Provide basic information/data around the youth in this community and what services they</td>
<td>22 May</td>
<td>Julia Burgess Shaw and Carmel Ellis</td>
<td>To be discussed in context with Youth Deep Dive</td>
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</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

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</thead>
<tbody>
<tr>
<td>4.7.2018</td>
<td>5.1</td>
<td>Mangere/Otara Community Hubs:</td>
<td>27 February</td>
<td>Kate Yang</td>
<td>Done Winnard will notify Ms Tafau when there is updated information to report to the committee.</td>
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<tr>
<td>19.9.2018</td>
<td>Board</td>
<td>MoH Letter – Strengthening the DHB Healthy Food &amp; Drink Policy - Doone Winnard and Stella Welsh are looking at what the DHB is currently doing and what this letter means and will report back via HAC and CPHAC.</td>
<td>TBC</td>
<td>Doone Winnard</td>
<td>Doone Winnard will notify Ms Tafau when there is updated information to report to the committee.</td>
</tr>
<tr>
<td>26.9.2018</td>
<td>3.1</td>
<td>Healthy Families New Zealand: Update to CPHAC in 6 months’ time.</td>
<td>3 July</td>
<td>Amy Carter and Carmel Ellis</td>
<td></td>
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<tr>
<td>26.9.2018</td>
<td>5.1</td>
<td>Maaori Immunisations: The paper that has been submitted to ELT to be made available to CPHAC.</td>
<td>TBC</td>
<td>Colleen Brown</td>
<td>Yet to be confirmed if this paper can be presented to CPHAC.</td>
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<tr>
<td>7.11.2018</td>
<td>2.4</td>
<td>Women in Prisons: Report back on health services that are provided to all Prisons in South Auckland – breast screening, cervical, prostate, bowel, vision &amp; hearing.</td>
<td>22 May</td>
<td>Dianne Glenn and Kate Dowson</td>
<td>Ms Yang will put together a memo of providers.</td>
</tr>
<tr>
<td>7.11.2018</td>
<td>4.3</td>
<td>Asian Health: A report to be brought back to the committee on what resources are already out there, is it factually correct and how we can disseminate this information on a larger scale to the Asian communities.</td>
<td>10 April</td>
<td>Kate Yang/Kitty Ko</td>
<td>See Item 5.2 on this agenda.</td>
</tr>
<tr>
<td>5.12.2018</td>
<td>3.1</td>
<td>Southern Corridor Planning with a focus on Primary &amp; Community Developments: provide update to CPHAC in 2019 when there is updated information.</td>
<td>18 December</td>
<td>Kate Yang</td>
<td></td>
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<tr>
<td>5.12.2018</td>
<td>5.1</td>
<td>SUDI Workplan Briefing: The Sudi Sleep Calculator tool will swing into action in the New Year, mid-January. Come back to the Committee with a preliminary report on the findings (3 July), including some more information on why the rates for Pacific women</td>
<td>6 November</td>
<td>Christine McIntosh &amp; Tina Higgens</td>
<td></td>
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</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tbody>
<tr>
<td>27.02.2019</td>
<td>3.1</td>
<td><strong>Owning My Gout Update:</strong> a copy of the STOP My Gout booklet is to be provided to the committee for their information.</td>
<td>10 April</td>
<td>Trevor Lloyd</td>
<td>Provided and located in the information section of the current agenda.</td>
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increased in the 1990’s.
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Strategic Deep Dive</th>
<th>Operational Deep dive</th>
<th>Site Visit (not necessarily on same day)</th>
<th>External/Regional presentations</th>
<th>Public Excluded</th>
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<tbody>
<tr>
<td>26 February</td>
<td>Owning My Gout business case Locality hubs</td>
<td></td>
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<tr>
<td>10 April</td>
<td>None. Need to make time for MH Workshop</td>
<td>Update on Long Term Conditions Co-design ((Matt Hannant) LTC Discovery Phase Report</td>
<td>South Asian Community Papatoetoe (March)</td>
<td>None. Need to make time for MH Workshop</td>
<td>Workshop to discuss Mental Health NGO Procurement (2 hours)</td>
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<tr>
<td>22 May</td>
<td>Youth (Carmel Ellis, Julia Burgess Shaw)</td>
<td>EPC business case Hospital in the Home (Penny Magud, Yvette Hallam)</td>
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<td>Pharmacy ALT update</td>
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<tr>
<td>3 July</td>
<td>People Living with Disability (Sanjoy Nand)</td>
<td>Primary Care Deep Dive Auckland Regional Public Health Service</td>
<td>Totara Hospice</td>
<td>Healthy Families New Zealand Update</td>
<td>Primary Care Procurement Pipeline (Matt Hannant)</td>
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<tr>
<td>14 August</td>
<td>Older People (Dana Ralph-Smith)</td>
<td>ARC / home based care Rest home TBD</td>
<td></td>
<td>Housing First (Julie Nelson)</td>
<td></td>
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<tr>
<td>25 September</td>
<td>Women’s Health, including Reproductive Health (Carmel Ellis, Nettie Knetsch)</td>
<td>The Falls and Fracture Prevention Steering Group (Matt Hannant, Ryan Stangroom)</td>
<td>Botany Primary Birthing Unit</td>
<td>SLM presentation (MoH report)</td>
<td></td>
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<td>6 November</td>
<td>Maaori Health (Aroha Haggie)</td>
<td>SUDI Workplan Update Papakura Marae</td>
<td></td>
<td>School Based Services</td>
<td>Equity in Procurement</td>
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<tr>
<td>18 December</td>
<td>Pacific Health (Elizabeth Powell)</td>
<td>Auckland Regional Public Health Service</td>
<td>TBD</td>
<td>Southern Corridor Planning with a focus on Primary &amp; Community Developments</td>
<td>School based services</td>
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Counties Manukau District Health Board
Community & Public Health Advisory Committee
Long Term Conditions Model of Care – Co-design Discovery Phase Report

Recommendation

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

Receive the attached Long Term Conditions DRAFT Discovery Phase Report which describes the ‘engage and capture’ phase of the co-design process.

Note the report is still in draft pending final feedback from Pacific community and Maaori Whaanau engagement sessions occurring in early April 2019.

Note that the report has been presented to the Counties Manukau Health Executive Leadership Team and is on the Counties Manukau Board Agenda 9th April 2019.

Prepared and submitted by: Matt Hannant General Manager Primary Care, Funding and Development and Lucy Hall Service Development Manager Primary Care on behalf of Dr Campbell Brebner Chief Medical Advisor, Primary Care.

Purpose

This cover paper is to provide background context to the accompanying Long Term Conditions Co-design Discovery Phase Report.

Background

Since mid-2018, the Primary Care team have been coordinating the engage and capture phase of a co-design approach considering new models of care for people with long term conditions. This Discovery Phase report describes the work completed to date and provides visibility of key feedback in themed responses from consumers/whaanau and providers (including secondary care colleagues).

The feedback from this consultation phase will be included as one of the key data sets that will be informing a business case for models of care to support people/whaanau with long term conditions in July 2019.

Co-design Update

The engage and capture phase (see Figure 1) of the co design process has been instrumental in providing the necessary insights of the experiences of health service delivery for our population with long term conditions and from the providers that support them.
The accompanying Co-design Discovery Phase Report provides a summary of the methodology, what was heard and the key themes from the different perspectives of stakeholders engaged throughout this phase. A draft version of this report has been shared with community and provider groups that have contributed to the content for comment. Copy of the raw data content gained from the different consumer and provider engagement sessions is in the Diligent Resource Centre.

It is important to note that the Primary Care Team are still engaging with key consumer groups including:

- Tongan community focus group – in partnership with the CM Health Fanau Ola team 28 March 2019
- Samoan community focus group – in partnership with the CM Health Fanau Ola team 31 March 2019
- Mixed Pacific peoples focus group – in partnership with the CM Health Fanau Ola team 3 April 2019
- Maaori Whaanau Hui with Pakeke males aged 25 -40 years old – in partnership with Mana Whenua i Tamaki Makaurau and the CM Health Maaori Health Gain team in early April 2019.

Feedback from these final sessions will be added to the current data set and captured in the Report. This final version of the Report will be provided in print and electronic copy to all who have been involved in the process as a public facing document.

**Discussion**

Advice and feedback regarding the key themes and content presented in the paper is sought.
Supporting people and whaanau/families living with long term conditions

The Counties Manukau Health Co-Design Discovery Phase Report
Introduction

In mid-2018, the Counties Manukau Health Board requested a proposal which describes the design and implementation plan for enhanced models of care that support people and their whaanau living with long term conditions. In consideration of the Counties Manukau Health (CM Health) community this work needed to reflect its population and equity.

In order to design new models of care we utilised a co-design approach. To date we have gathered key perspectives from the community and sector partners about their current experiences of delivering and receiving care and ideas they have to inform future models.

In this context the definition of co-design is as follows: co-design is an important part of a collaborative process to identify challenges or opportunities, engage people; consumers, whaanau and staff, capture their experiences and ideas, organise the learning that it brings to create new understanding and insight from the perspective of the care journey and emotional journey, continue together in partnership to review learning and ideas, plan and implement improvements then finally; review what difference that has made.

This Discovery Phase report summarises the engage and capture phases of the co-design process and illustrates the early stages of organising the learning through the development of key themes drawn from interviews and Hui.
Methodology

Co-design brings service users, their whaanau and health professionals together to understand and improve healthcare experiences, systems and processes. It acknowledges that lived experience is a valuable form of expert knowledge that forms an essential part of the design or redesign of health and care processes and services.

Co-design utilises a Delphi technique\(^1\) as a method of achieving a level of consensus of opinion around a specific topic by engaging people with expertise, which in the case of this programme of work is those with lived experience of delivering or receiving models of care for long term conditions.

The co-design process has been underpinned by the following principles, see Principles of Co-design and been guided through the expertise of Lynne Maher and supported by her Ko Awatea colleagues. These expert colleagues have expressed confidence in our process especially regarding the depth and reach of the engagement that has been achieved in this stage of the co-design.

Principles of Co-design

Also see Appendix 1 for a full description of co-design principles.

Everyone who has participated has been provided with information about the purpose of the project, how their experiences will help inform the work and how their feedback will be used. Any comments that any people provided were completely non identifiable.

Consumers have also signed consent forms relating to their participation and permitting photographs to be taken.

Consumer participants and their whaanau have also been provided with contact details that they can use if they have and questions following their participation and have all been provided with a koha as per the CM Health Policy.\(^2\)

The CM Health Executive Leadership Team has provided governance and oversight of the process and the CM Health Board has been updated regularly as to the progress of the project.

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1. [https://www.students4bestevidence.net/the-delphi-technique/](https://www.students4bestevidence.net/the-delphi-technique/)
2. CM Health Policy: Recognising Community Participation v 4.0
A co-design process such as this one that the Primary Care team embarked on can only include information that is as rich as the people that come along to local feedback events and share their experiences. The people who have participated in this journey have left the team with a gift of their stories, expertise and knowledge, and we wish to acknowledge everyone that has taken time to attend the co-design Hui’s since we began this journey in August 2018.

An integral part of this co-design process has been to understand as many of the experiences from the perspectives of the culturally diverse community that CM Health serves.

In order to achieve this in a meaningful way, the CM Health Primary Care team has partnered with Mana Whenua i Tamaki Makaurau and been supported by the Maaori Health Gain Team. The CM Health Asian Health Gain Advisor and the CM Health Pacific Health team including Fanau Ola management have also consulted and guided the team during this co-design journey.

In addition, the Primary Care team have benefited from the insight and connections provided by the CM Health Consumer Council lead by Rosalie Glynn and special thanks to members of Asian communities – Debbie Siau and Zhengxiu Xie who connected us with their networks; as well as Tevita Havea who has offered to support the upcoming Church based Tongan community engagement.

The Primary Care team wish to acknowledge all this support, guidance and leadership and are confident that CM Health’s journey to understand the needs of whaanau will continue as part of ongoing service design and delivery.

Acknowledgements

The information that is included in this report has been compiled from the following activities:

**Maaori whaanau feedback Hui**
- **12** Number of Hui
- **26** whaanau to date*
- Approx. numbers participating

**Pacific Peoples Talanoa**
- **2** Number of Hui
- **50** to date**
- Approx. numbers participating

**Asian communities listening workshops**
- **4** Number of Hui
- **45** Approx. numbers participating
- Including: Mandarin, Cantonese and Indian speaking consumers

**Counties Manukau Health Consumer Council**
- **3** Number of Hui
- **30** Approx. numbers participating

**Primary care provider feedback forums**
- **18** Number of Hui
- **150** Approx. numbers participating

**Secondary care specialty services and cultural support teams**
- **12** Number of Hui
- **50** Approx. numbers participating

* there is another Hui planned in early April 2019 aiming to engage Pakeke male whaanau
** there are another x 2 Church based Talanoa scheduled in the last week of March and first week of April 2019
What we learnt
Key insights from both consumers and providers during our engage and capture phase process

From both our consumer and provider feedback sessions we heard the importance of a “People centred care” model encompassing whaanau/family in care delivery.

Emerging from the collective data set, we have been able to group the feedback from both consumers and providers into the following 4 domains:

- **People centred care partnership**
  - Acknowledging our language, our story and our journey

- **People centred people in need**
  - Reaching people who need support the most

- **People centred collaborative care teams**
  - With a workforce ready and equipped with the right tools

- **People centred settings of care**
  - The importance of place and the one stop shop idea
Key insights from consumers

In November 2019, the Counties Manukau Health Board agreed that the priority populations for receiving extra support with the funding available should be Māori, Pacific and People living in Quintile 5 living with two or more long term conditions – of which indicative numbers are approximately 13,000 people.

With these key populations in mind this co-design phase has deliberately sought to engage with people/whānau representative of these cultures.

The next section highlights the key findings from the different consumer groups but common to all ethnicities are the following 3 themes:

• The importance of a trusting relationship, which begins with valuing me/us through a process of genuine and compassionate engagement and understanding of what I/we need as a person/whānau.

MAORI WHAANAU THEMES

The following themes were synthesized from 14 ideas generated from Māori Whānau that attended a Hui at Te Awamarahi Marae in Port Waikato.

The majority of Whānau that attended this initial Hui were Kaumatua and Kuia. These themes will be added to on completion of the next Hui during which we are seeking to hear the experiences of Pakeke males. Values that work for whānau were also identified and have been used as headings but with a “what works for whānau focus”.

These values are:

• Whanaungatanga
• Manaakitanga
• Tikanga
• Kaitiakitanga
• Rangatiratanga

WHANAUNGATANGA

• Trust – relationship/engagement
Māori Whānau stressed the importance of taking time to get to know whānau and appreciate their unique needs, abilities and challenges. Only by establishing this relationship will a trusting partnership develop. “Here’s this doctor that doesn’t know me and who I am and how I am feeling – can’t do that in 13 minutes. Will only dish out meds.”

NOTE: Whanaungatanga also includes engagement and communication.

• Help us to understand
Many identified the need for more time with their health care providers which would allow education delivered in a way that they can understand. This would enable whānau to know more about their conditions and realise the importance of the prescribed treatments. “But how does he know that I have diabetes? He didn’t explain it to me and I am not going to take the tablets he gave me” and “He doesn’t know what he is taking it for – he just trusts the doctors”.

WISHING TREE
• **Access**
  This theme encompasses many different aspects of access including location of services, setting and affordability. “Many Maaori can’t go to the doctor, don’t feel welcome, expensive” and “We need to prioritise food over medicine”. We heard many whaanau request that health care for their Kaumatua should be cheaper “I was thinking that any Kaumatua shouldn’t have to pay the same price”. In addition whaanau stated that they would like to have more access to health care in a setting of their choice. “Would be better if we had more local doctors.”

**MANAAKITANGA**

• **Being done with rather than done to**
  Whaanau stressed the importance of being meaningfully involved in care planning and care decisions “I was told, not consulted or included.”

This theme demonstrates the value of Whakamana = to empower vs Whakama = embarrass or made to feel dumb. A partnership approach would ensure that whaanau feel valued, cared for, and nurtured through understanding what works for whaanau and is meaningful for them.

**TIKAANGA**

• **Understand us – importance of TIKAANGA – A-WHAANAU**
  Doing what works for whaanau, listening to whaanau voice and responding to whaanau needs.

An understanding and respect for cultures, world views and traditional ways enables trust. Maaori whaanau told us that “If you want our trust then you need to listen to our people’s story” and “The doctor just shut it down – they didn’t understand what it was”.

**KAITIAKITANGA**

Protection for whaanau that includes whaanau choice of services and shared decisions regarding their pathway plan.

• Keeping whaanau safe and supporting them to make informed decision on the wellness.
• Whaanau expressed their choice and preference in also choosing traditional Maaori knowledge, rongoa, mirimiri and kaupapa Maaori services. “We get too far away from our natural meds, why can’t our people use it, should be included.”

**RANGATIRATANGA**

Enabling whaanau to lead their wellness including whaanau self-assessment, what works for their whaanau to lead their plan and then to be able to measuring whaanau progress and success.

• **Whaanau based**
  Recognition of the significance of whaanau in people’s lives, health and wellbeing. “My whaanau is my care team” and “We need to speak up if we are going to change it for future generations”.

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**WHAAANAU FROM TE AWAMARAH MARAE HUI**

[Image of a group of people in a health care setting]
PACIFIC PEOPLE’S THEMES

The themes captured below originated from two sessions with the Pacific People’s Health Advisory Group. The group provided feedback in an initial session and then agreed and prioritised the following themes in a subsequent engagement session.

Further engagement with up to 90 Pacific families is planned over the next two weeks with a Tongan Group on 28th March, a Samoan group on 31st March and a Mixed Pacific Group on 3rd April. All of these events have been organised through the Church communities of our Counties Manukau Health Fanau Ola colleagues.

• **Care for the family, not the individual**
  It is important to Pacific people that health professionals ensure that all the family are considered in the support and care of the Pacific person with long term health conditions. “No privacy in the Pasifika, it is the whole families business.”

• **One stop shop**
  Pacific people were keen to have all their supporting health services in one easy to access location. They felt that this would be a good option to try and reach some of their community that are not currently supported. “Coordinated, supportive with lots of parking.”

• **Help to get in and around health and social services**
  It was highlighted that our health system is very difficult to navigate, especially for people who have English as a second language. The Pacific people’s feedback saw value in establishing more supporting roles to help their people get the support they need. “Need connectors to reach families that aren’t connected.”

• **Teach people to own their health**
  Pacific people that we spoke to are aware that there is a need to support their people to take control of their own health and accept some responsibility in the choices they make. They see an important role for the younger members of their communities to assist in supporting this change in mind-set “self-responsibility, teach the family, cultural shift” and “start the messages young, think about prevention in schools”.

• **Access to health services**
  Recognition of the importance for Pacific people to have access to culturally supportive health services that are “acceptable, affordable and in my language”.

PARTICIPANTS IN THE PACIFIC PEOPLES HEALTH ADVISORY GROUP SESSION
ASIAN PEOPLE’S THEMES

The themes identified below came from the feedback sessions during which we captured the experiences of our diverse Asian communities.

There were sessions organised for Mandarin and Cantonese speaking Asian groups as well as two more focus groups for South Asian community groups. All of these sessions had appropriate interpreters to support information sharing.

- **Language and understanding**
  Language is perceived by Asian communities as a barrier. Asian people will go out of their way to find a suitable Doctor. For example they may choose to wait for long hours or travel great distances to see a GP who speaks their language and can help them understand. “At times, I paid double to allow myself to have enough time to address all my health issues and ask my own GP questions regarding the multiple health concerns that I have.”

- **Managing ourselves**
  It is important to the Asian communities that they stay as well as they can in order to support and look after the rest of their extended family. “*My children and grandchildren are helping, but they are also busy and working long hours. Sometimes I get worried about them more than myself.*”

- **Value of good health**
  Asian people prioritise their health and wellbeing and seek support to remain well. “*My health is my own responsibility. I always write down on a piece of paper what I want to ask my GP before seeing him. I measure my own blood pressure and record down the readings, and I let my GP know if I take notice of anything with my body. I try to work with my GP.*”

- **Health and wellbeing through social connectedness**
  Community based health opportunities “*tell our groups, our communities what is going on and where, support our group and organisation as they will tell us and make arrangements for us*.”

- **Understand our differences** (differences of Mandarin, Cantonese and South Asian peoples)
  “*Every time I have been asked to change my diet, I ask ‘What? But how? How can I do that? I don’t like to hear you’ please listen and then talk to me is what I want to hear my way? our group in my Indian way*”
CONSUMER COUNCIL THEMES

The CM Health Consumer Council has been providing support and guidance to the team throughout this phase of the co-design process and the following section was their feedback from a deep dive workshop in November 2018.

• Patient and whaanau expectation
  The Council members provided their insight as to the way in which patient and whaanau understanding and expectation could be managed better. “Design a stepped approach and explain to patients that there is support available if people choose to work in partnership with their care team.”

• Understanding
  The Council described many examples where patient and whaanau education and understanding of long term condition could be improved. “Many people living with long term conditions normalise their symptoms and we need to challenge this” and “It doesn’t have to be this way, you don’t need to live in pain (e.g. Gout)”. They also reflected that normalisation is affected by different cultural perspectives. “Tongan people will be polite and say yes they are fine, when maybe they are not.”

• Variation in delivery of care
  There was strong feedback from Council members that the application of the current model of care supporting people with long term conditions was extremely variable and this variability was not just provider to provider, but also between practitioner to practitioner within providers. The advocated for consistency in model of care delivery. “Some people are put in the too hard basket and don’t even get offered support.”

• Community focus
  All of the Council members present agreed that this work needs a whole of community approach with health messaging delivered through many different forums and taken to areas of greatest need. “Use people with Mana to deliver messages in local churches and community settings.”

• Supporting youth
  An area identified by the Council members that needs particular attention is the transition of support from child/youth speciality services to adult services. They provided experience and insight that this is an opportunity for primary care providers to support people/whaanau with and act as key navigators. “Use the funding to support the coordination and follow up required.”
Key insights from providers perspectives

From August 2018 to March 2019, the team have engaged with a broad range of provider stakeholders through a variety of channels.

These have included providers, clinicians, governance groups, subject matter experts, Primary Health Organisations, and District Health Board Speciality teams; as well as Locality hosted forums and individual innovative provider ‘deep dives’ regarding their models of care.

The objective of this initial engagement was to gain insights and understand possibilities, share stories, and collect information on:

I. What’s working;
II. What’s not working, and
III. Opportunities for the future.

The following is a summary of the key perspectives from providers.

• Flexibility and addressing wellness and the social determinants
  There was consistent feedback from providers regarding the need to tailor the intervention package to what people/whaanau need, and that this may not be the traditional Doctor consultation. Examples given include use of funding to provide medicines and transport.
  “We need to have the ability to direct funding towards people with the greatest need and/or where it would have the greatest impact” and “we currently have an environment that is lacking in capacity, rigid, fragmented, frequently changing and not well aligned to patient/family needs”, whilst a secondary care team acknowledged the “Complexity of socio determinants means that patients find health service navigation impossible”.

• Engagement and relationship building
  There was conflicting feedback from providers regarding patient and whaanau engagement in the current model. Engagement approaches that were stated as working included making a dedicated workforce available, offering patients more time and a single point of contact and continuity of care.
  “Reach people wherever they are, only when we have engaged successfully can we co-plan” and “Anecdotal feedback is very positive, patients all appreciated having continuity of care providers – one single point of contact to enable trust and action”.

Conversely, other providers described patient engagement as problematic, citing complexity of the system, lack of time, restrictive inclusion/exclusion criteria as intervening issues.

“Lack of time with the patients as we have to spend too much time on claiming versus actual patient care.”

And secondary care teams’ reflections include “there was a lot of good out of PPC – but it wasn’t reaching the right people”.

• Assessment and planning
  There was strong agreement from providers that using a person centred approach is something that is working in the current model especially to understand a person’s aspirations and their whaanau needs.
  “A person centred strengths based approach is working in long term conditions management” and “whaanau based assessment is a priority”.

However, there was also a significant amount of feedback that the current assessment and care planning tools were not working well.

“The Partners in Health tool and the shared care plan are what we have to use, and they take so much time and they are mostly not suitable for the people/whaanau that we are supporting.”

• Team based care
  There was a significant amount of feedback from providers regarding the benefits of team based care and the need to work collaboratively across primary, secondary care and community services with expanded workforce roles.
  “Integrated and comprehensive team based support with more navigator type roles such as health coaching, peer support and kaiawhina.”

Secondary Care teams provided feedback supporting working as one team.

“The biggest opportunity is for us to work together with respiratory patients – 5 minute intervention by practice nurse + referral on to respiratory nurse clinic to continue the journey.”

“Our Fanau Ola nurses have the time and we can relate and home visiting with the GP or nurse would be ideal.”

“Multidisciplinary team meetings in the localities have meant that all of the various teams included in the care of our patients have got to meet each other and to discuss how best to go forward in some of the challenges that people face.”
• **Culturally safe models of care**

Providers state that there is availability of a culturally and linguistically diverse workforce to work with Māori and Pacific people.

“There is a need to consider the culture of practitioners to deliver culturally safe services that are non-judgemental and will do whatever it will takes.”

• **Coordination and continuity**

Care coordination by nurses was stated as something that is working well, benefits that were mentioned include better access for patients to their nurses who were able to proactively follow up.

“This is an area where we are seeing that nurses are best placed to be actively monitoring and central point of contact for patients.”

There were some concerns noted by providers about the challenges of coordinating care including a lack of information about community services for care coordinators to be able to access readily. There was recurrent feedback from secondary care teams regarding the current electronic shared care platform that was not seen to be working in terms of providing visibility of who was involved in patient care and being able to communicate in an asynchronous manner.

“Best idea for the future would be to be able to communicate better amongst the care team – both ways.”

• **Accountability**

Feedback from providers is that Counties Manukau Health needs to decide what outcome they desire from the investment and then ensure that there is a robust outcome and evaluation framework built into the new models.

“The DHB needs to be clear on priorities and not chop and change.”

Accountability is also something that providers acknowledged could be improved across all parties in terms of the patient perspective.

“Sometimes I wonder where “we” as the health system/service has been in some of our families’ lives.”

• **Workforce capacity and capability**

More time is required when working with people/whaana living with complex needs from provider’s point of view. Many providers felt that they had limited capacity due to staffing insufficiencies, administrative burden and funding which came at the cost of patient care and workforce training/capability building.

“More time spent in claiming/IT compared to face to face patient time.”

Secondary care team insights included;

“Practice nurses don’t need or want study days, they want to know who we are and how they can contact us and how we can work together on cases.”

“Secondary supporting resources need to focus on support for primary care. Do not take over case management for 3 months and then drop patients back for general practices to try and manage.”

“There is a need to get real and resource diabetes management appropriately.”

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**INFORMATION CAPTURED FROM A PROVIDERS CO-DESIGN FEEDBACK SESSION**
Where to next in the long term conditions co-design process?

This report has summarised a significant amount of information that has been generated out of the ‘engage and capture’ phase of the co-design process.

In order to continue in the principled manner in which this process has been conducted and to ‘be true’ to the whole journey, the next steps in the long term are to compare what we have learnt from our engagement process with recommended best practice and validated local models of care.

It is then our intention to apply ongoing co-design methodology to develop local models of care/interventions proposals that will ultimately lead to improvement in the way people living with long term conditions are supported to live well and stay well within their own communities.
Appendix 1

CO-DESIGN PRINCIPLES – SOURCE: LYNNE MAHER, KO AWATEA

1. True partnership – enable the active involvement and participation of people who are impacted by the design of health and care processes and systems. This includes consumers, carers, families and whaanau and health workers.

2. Respect – the expertise of all involved, ensure that all have an equal voice and practise shared ownership.

3. Teamwork – work together on a shared goal, trust the process and learn together.

4. Safety – is paramount for all involved. Maintain an environment which feels safe and brings confidence for everyone.

5. Value – the lived experience of delivering and receiving care.

6. Be true – to the process, the means is as important as the end.
Discovery Phase report written by Lucy Hall, supported by colleagues from Primary Care and Ko Awatea, Counties Manukau Health.
Supporting people and whaanau/families living with long term conditions

Counties Manukau Health Co-design Approach

Community & Public Health Advisory Committee Presentation
The journey began:

Principles of Co-design:
- True Partnership
- Be true
- Respect
- Value
- Teamwork
- Safety
## Phases of co-design

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Emerging Themes:

- People centred care partnership
  Acknowledging our language, our story and our journey

- People centred settings of care
  The importance of place and the one stop shop idea

- People centred people in need
  Reaching people who need support the most

- People centred collaborative care teams
  With a workforce ready and equipped with the right tools
What we have learnt: Maaori Whaanau perspective

- **Trust - relationship/engagement - WHANAUNGATANGA** - Taking time to know a person and appreciate their unique needs, abilities and challenges; facilitates effective relationships. “You don’t know me – you all need to KNOW me”

- **Help us to understand** – Many identified the need for more time with clinicians and more education so that they can really understand their conditions and prescribed treatments. “he doesn’t know what he is taking it for – he just trusts the doctors”

- **Access** – Location, setting and affordability have been identified as enablers in terms of access to care. “Would be better if we had more local doctors”

- **Being done with rather than done to - MANAAKI** – People stressed the importance of being meaningfully involved in care planning and care decisions. “I was told, not consulted or included”

- **Understand us – importance of TIKAANGA** – An understanding and respect for cultures, world views and traditional ways enables trust. “If you want our trust then you need to listen to our people’s story”

- **Whaanau based** – Recognition of the significance of whaanau in peoples lives, health and wellbeing. “we need to speak up if we are going to change it for future generations”
What we have learnt: Pacific People’s perspectives

- **Care for the family, not the individual** – It is important to Pacific people that health professionals ensure that all the family are considered in the support and care of the Pacific person with long term health conditions “*No privacy in the Pasifika, it is the whole families business*”

- **One stop shop** – Pacific people were keen to have all their supporting health services in one easy to access location “*coordinated, supportive with lots of parking*”

- **Help to get in and around health and social services** – It was highlighted that our health system is very difficult to navigate, especially for people who have English as a second language. The Pacific people’s feedback saw value in establishing more supporting roles to help their people get the support they need. “*need connectors to reach families that aren’t connected*”

- **Teach people to own their health** - Pacific people that we spoke to are aware that there is a need to support their people to take control of their own health and accept some responsibility in the choices they make. “*self-responsibility, teach the family, cultural shift*” and “*start the messages young, think about prevention in schools*”

- **Access to health services** - Recognition of the importance for Pacific people to have access to culturally supportive health services that are “*acceptable, affordable and in my language*”
What we have learnt:
Asian people’s perspectives

- **Language and understanding** – language is perceived by Asian communities as a barrier. Asian people will go out of their way to find a suitable Doctor. For example they may choose to wait for long hours or travel great distances to see a GP who speaks their language and can help them understand “At times, I paid double to allow myself to have enough time to address all my health issues and ask my own GP questions regarding the multiple health concerns that I have.”

- **Managing ourselves** - it is important to the Asian communities that they stay as well as they can in order to support and look after the rest of their extended family “My children and grandchildren are helping, but they are also busy and working long hours. Sometimes I get worried about them more than myself”.

- **Value of good health** - Asian people prioritise their health and wellbeing and seek support to remain well “My health is my own responsibility. I always write down on a piece of paper what I want to ask my GP before seeing him. I measure my own blood pressure and record down the readings, and I let my GP know if I take notice of anything with my body. I try to work with my GP.”

- **Health and wellbeing through social connectedness** – Asian people like connecting through community based health opportunities “Tell our groups, our communities what is going on and where, support our group and organisation as they will tell us and make arrangements for us”.

- **Understand our differences** - through these feedback sessions we have learnt that the different sub cultures within the collective umbrella of Asian communities have very different preferences and views – *e.g.* the Mandarin community are keen to embrace technology and virtual ways of receiving support, whereas the Cantonese people that we talked to were not keen on this.
Wishing Trees – “if only we could”
What we have learnt: The provider perspective

- Flexibility and addressing wellness and the social determinants – “we need to have the ability to direct funding towards people with the greatest need and/or where it would have the greatest impact”

- Engagement and relationship building – “reach people wherever they are, only when we have engaged successfully can we co-plan

- Assessment and planning – “whaanau based assessment is a priority”

- Team based care – “integrated and comprehensive team based support with more navigator type roles such as health coaching, peer support and kaiawhina”
What we have learnt: The provider perspective

- Culturally safe models of care – “there is a need to consider the culture of practitioners to deliver culturally safe service, that are non judgemental and will do whatever it will takes”

- Coordination and continuity – “to support team based care we need an improved shared care record that promotes access to relevant information”

- Accountability – “the DHB needs to be clear on priorities and not chop and change” and “we need to reduce the administrative and compliance burden of the current planned proactive care model”
Acknowledgements:

- Counties Manukau Health consumers
- Counties Manukau Health providers
- Mana Whenua i Tamaki Makaurau
- Ko Awatea – Lynne Maher
- Counties Manukau Health colleagues
  - Maaori Health Gain Team
  - Pacific Health Gain Team
  - Asian Health Gain Advisor
  - Consumer Council
Next steps in the journey:

• We will compare what we have learnt from our engagement process with recommended best practice and local innovative models of care

THEN:

• We will apply ongoing co-design methodology to support the development of local models of care that will ultimately lead to improvement in the way people living with long terms conditions are supported to "live well and stay well within their own communities"
Thank you – any questions?
Recommendation

It is recommended that CPHAC:


**Prepared and submitted by:** Basil Fernandes (Portfolio Manager, Smokefree) and Sarah Sharpe (Public Health Physician, Population Health), Summer Hawke (Manager, Population Health Programmes) on behalf of Gary Jackson (Director, Population Health).

Glossary

CM - Counties Manukau  
NZHS - New Zealand Health Survey  
TFG - Tobacco Free Generation

Purpose

The purpose of this paper is to present the CM Health Living Smokefree Service Action Plan to the Committee, including an update on the proposed approach to supporting people who choose to use vaping (i.e. e-cigarettes) to quit smoking.

Executive Summary

Smokefree work continues to be a key population health priority for CM Health. Although smoking prevalence is reducing, stark ethnic inequities remain, and current actions are not enough to achieve the Smokefree 2025 goal (5% or less smoking prevalence across all groups), which current estimations predict will be missed by a large margin for Maaori and Pacific Peoples.

This paper presents an overview of the refreshed CM Health Living Smokefree Service Action Plan 2018-2020, which retains a strong equity focus and prioritises reducing smoking prevalence for Maaori and Pacific communities. Alongside strengthening of core business (including increasing reach and referral numbers), the Service will focus on developing a TFG approach and undertake activities to support clients who choose to use vaping (e-cigarettes) for smoking cessation and tobacco harm reduction. The Action Plan has been approved by the CM Health Executive Leadership Team.

Background

Smoking is the second highest preventable risk factor for premature death and morbidity in New Zealand, with Maaori and Pacific Peoples disproportionately affected.\(^1\) Large contributions to the life expectancy gap in CM (9.3 years and 7 years between Maaori and Pacific Peoples, respectively, and New Zealand European/Other) are from the potentially preventable long-term health conditions cardiovascular disease, diabetes, respiratory disease and cancers. Smoking cessation (alongside reducing obesity, poor nutrition, and alcohol use, and improving physical activity) is critically important for prevention of these diseases and reducing the life expectancy gap, as well as other important conditions and inequities (e.g. pregnancy outcomes, infant and child health). Therefore, in CM Health, smokefree work is a key population health priority and an important contributor towards achieving the

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\(^1\) Institute for Health Metrics and Evaluation. GBD Compare, 2016. Available from: [https://vizhub.healthdata.org/ebd-compare/](https://vizhub.healthdata.org/ebd-compare/)
In 2011, the NZ Government committed to the Smokefree Aotearoa New Zealand goal of becoming smokefree by 2025, defined as 5% or less smoking prevalence across all groups, with interim goals to be achieved by 2018 (daily smoking <10% overall and Maaori and Pacific prevalence halved to no more than 19% for Maaori and 12% for Pacific people). In CM, work to date has been guided by CM Health’s ‘Smokefree 2025 Initiative’ five year plan (2013-2018). There has been a sustained focus on reaching priority groups, including Maaori, Pacific people, pregnant women, people with mental illness and/or additions and/or chronic conditions, younger age groups, and people living in the localities of Manurewa, Papakura, Maangere, and Otara.

CM Health Living Smokefree Service is currently funded by the Ministry of Health until June 2019 through two revenue streams for Core Tobacco Control activities ($679,920 per annum) and Stop Smoking Service provision ($1,134,125 per annum). (Further detail is provided in the appended Action Plan, section 3).

Proposal

A refreshed Action Plan 2018-2020 has been developed, which builds on the previous five year plan and the high quality work already well-established within the Living Smokefree Service. CM Health remains committed to achieving the Smokefree 2025 goal and, in order to do so, needs to develop new effective approaches alongside strengthening existing smoking cessation support.

The Action Plan has three key Objectives:
1. Explore and develop a TFG approach in CM, which will involve:
   - Refocusing existing work and prioritising key population groups;
   - Trialing new initiatives that contribute to TFG;
   - Building a TFG ‘movement’ in CM.
2. Champion innovative approaches for smoking cessation and harm reduction, including supporting people who choose to use vaping products.
3. Strengthen smoking cessation support in primary, secondary, maternity, mental health, and community settings, including:
   - Supporting health care practitioners to provide Smokefree ABC;
   - Increasing the number of referrals to stop smoking services;
   - Increasing access, and reducing inequities in access, to smoking cessation medications.

Workstreams are outlined in detail in the appended Action Plan, section 6 pages 26-36. In summary, the CM Health Living Smokefree Service will continue its strong equity focus and prioritise reducing smoking prevalence for Maaori and Pacific communities. Core business will be strengthened, including increasing reach and referral numbers. The Service currently receives approximately 5000 referrals per annum and the goal is to double this to 10,000 per annum. In addition, innovative approaches beyond ‘business as usual’ will be tested and implemented, including supporting clients who choose to use e-cigarettes for smoking cessation and tobacco harm reduction. Also, a TFG approach will be explored and developed, including opportunities for championing the concept of TFG across CM communities. Monitoring and evaluation of activities will continue to be an important focus for the Smokefree Service and will contribute to informing programme development.

In the Action Plan, there is a revised intermediate goal for 2020, i.e.: reduction in population smoking prevalence from 14% (current estimated prevalence based on New Zealand Health Survey (NZHS) data) to 11% in 2020. As the plan prioritises smoking cessation among Maaori and Pacific populations and creating a TFG, the intermediate goal includes targets for smoking prevalence among Maaori, Pacific, and younger age groups, i.e.:
- reduction in smoking prevalence in the CM Maaori population from 38% (current estimated prevalence based on NZHS data) to 28% in 2020;
- reduction in smoking prevalence in the CM Pacific population from 21% (current estimation) to 16% in 2020;
• reduction in smoking prevalence in the CM 15-24 year old population from 11% (current estimation) to 9.5% in 2020;
• reduction in smoking prevalence in the CM 25-44 year old population from 19% (current estimation) to 15% in 2020.

Discussion

Although CM Health remains committed to achieving the Smokefree 2025 goal, evidence suggests that the 2025 goal of minimal smoking prevalence is likely to be missed nationally, with large inequities remaining for Māori and Pacific people.\(^2\) The interim goal for the previous Smokefree Service plan (2013-2018) was to reduce smoking prevalence in the CM adult population to 12% or less by 2018, with halving of prevalence to 18% for Māori and 12% for Pacific people. Estimations indicate current smoking prevalence in the CM adult population is approximately 13-14%, with smoking prevalence in Māori much higher (Census-based projection 29%; NZHS estimation 38%) and smoking prevalence in Pacific also higher (Census-based projection 18%; NZHS estimation 21%) than other ethnic groups.

In other words, current actions are not enough in order to reduce inequities and achieve the Smokefree 2025 goal. There are no current government strategies or plans to address this (although this may change). We have reviewed the literature, including the ‘Achieving Smokefree Aotearoa by 2025’ plan (2017) created by then ASPIRE2025 expert group,\(^3\) and recommend that there are actions we can take locally in CM that could have large impacts on smoking prevalence and inequities. These are briefly outlined next.

**Explore and develop a TFG approach in CM**

TFG is a proposed tobacco endgame strategy which involves a legislated ban on the provision of tobacco to those born from a set date onwards, i.e. there would be an annual increase in the minimum age of purchase each year. This strategy is included as a recommended key action (Objective 2, Action 2.3) in the action plan ‘Achieving Smokefree Aotearoa by 2025’. NZ modelling studies suggest such a policy would result in a large reduction in smoking prevalence, particularly for Māori aged <45 years. A TFG law would help restrict availability of tobacco and reduce smoking initiation among young people. It would send a clear message that tobacco is unsafe at any age and avoid the ‘coming of age’ implication of a fixed minimum age law, which implies that smoking becomes acceptable at the age of 18.

The TFG concept is also being used as a ‘social movement’ or ‘approach’. For example, in Singapore “Tobacco Free Generation” www.tobaccofreegen.com is a not-for-profit organisation describing itself as “a social movement that seeks to re-balance the landscape of teenage smoking,” and involving doctors, medical students, teachers, and others, who go into schools and promote the concept and build support for it. There has also been support for the concept in Tasmania. ASH Scotland has published ‘Scotland’s Charter for a Tobacco-Free Generation’, which organisations can sign up to and pledge actions that the organisation will take to support the goal of creating a TFG. A TFG ‘approach’ has been incorporated into England’s tobacco control plan. This plan is titled ‘Towards a Smokefree Generation’ and states the vision “to create a smokefree generation” and a range of actions (i.e. smoking cessation and initiation reduction, not TFG legislation) to achieve this ambition.

Given the current absence of TFG legislation in NZ, the CM Health Living Smokefree Service plans to take a TFG approach which will involve strengthening/re-focusing of existing work, trialling new projects, and promoting/championing the concept of TFG in CM. A TFG approach is aligned with CM Health’s focus on children and young people having the best start in life. Key areas of action will be strengthening existing Smokefree pregnancy and homes/whaanau work. To develop a TFG approach we will focus on the following key areas:

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\(^2\) Van der Deen FS, Wilson N, Cleghorn CL, et al. Impact of five tobacco endgame strategies on future smoking prevalence, population health and health system costs: two modelling studies to inform the tobacco endgame. Tobacco Control 2017; doi:10.1136/tobaccocontrol-2016-053585

\(^3\) https://aspire2025.org.nz/hot-topics/smokefree-action-plan/
1. Smokefree pregnancies;
2. Babies live in smokefree homes/whaanau;
3. Young people are supported to be smokefree (i.e. to never start smoking);
4. Young people who smoke are supported to quit;
5. Promote cross-generational smokefree change.

Support people who choose to use vaping products

The use of vaping products by people who smoke is growing at a rapid rate and provides a potential opportunity to dramatically reduce smoking prevalence rates and reduce inequities. The Ministry of Health position statement on vaping products states: “The Ministry of Health believes vaping products have the potential to make a contribution to the Smokefree 2025 goal and could disrupt the significant inequities that are present.” Emerging evidence and expert opinion suggest that vaping products are significantly less harmful than smoking tobacco but are not completely harmless. Information on e-cigarette use by clients of the Living Smokefree Service (Jan 2017-June 2018) shows that 11% of clients were reported as using e-cigarettes; there were no differences by ethnicity. The Service reports higher quit rates among those who vape (77% quit rate) compared with those who do not vape (62% quit rate).

The current regulatory framework does not fully cover all vaping products. The Government is currently considering how best to apply risk-proportionate regulation across all tobacco products including smoked tobacco, smokeless tobacco and vaping products. Changes to the Smokefree Environments Act 1990 are proposed which may see the Act amended to regulate all nicotine and nicotine-free vaping liquids/products/devices including aspects such as advertising, promotion, and sales to minors, prohibit vaping in legislated smokefree areas (e.g. indoor workplaces, early childhood centres, and schools), and specific product safety requirements.

Meanwhile, the Ministry of Health has provided guidance to Smoking Cessation Services stating that services should: become ‘vaping friendly’, provide accurate information to people about vaping, and support people who choose to use a vaping product to stop smoking. Advice from the Ministry of Health states that “smokefree policies should be updated to include vaping and other products that are not smoked (e.g. heat not burn). Updated smokefree policies should reflect that there are no legal restrictions on vaping in smokefree areas and that, whilst vaping in indoor spaces may be inappropriate, DHBs could allow vaping in outdoor spaces if they so choose.”

The Living Smokefree Service plans to focus on the following key initiatives:
1. Policy: Review and update existing Living Smokefree Service and CM Health policy to include vaping and other products that are not smoked (e.g. ‘heat not burn’ products), and to allow for designated outside vaping areas within Middlemore Hospital grounds.
2. Staff knowledge and skills: Upskill Living Smokefree Service staff and other healthcare professionals to provide appropriate advice and support to clients/patients regarding use of e-cigarettes (and including concurrent use of smoking cessation medications and vaping, and combining smoking and vaping).
3. Support for clients/patients: Develop information for clients and provide support including group-based therapy for people who use e-cigarettes.
4. Vape vendors: Engage with responsible vape vendors, share Living Smokefree Service information and encourage referrals for stop smoking support, and train vendors to have smokefree brief conversations and refer.
5. Data on vaping: Explore data sources for describing e-cigarette use in the CM population and strengthen the Living Smokefree Service data capture of e-cigarette use by clients.


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Counties Manukau Health Living Smokefree Service

Action Plan 2018-2020
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List of abbreviations

ABC  Assessment, Brief advice, and Cessation
CO  Carbon Monoxide
CM  Counties Manukau
DHB  District Health Board
FTE  Full Time Equivalent
HCC  HealthCare Community (the shared electronic health record for mental health and addictions services across the Auckland region)
MOH  Ministry of Health
NGO  Non-Governmental Organisation
NHI  National Health Index
NRT  Nicotine Replacement Therapy
NZHS  New Zealand Health Survey
PHO  Primary Health Organisation
SLM  System Level Measure
SUDI  Sudden Unexplained Death of an Infant
TFG  Tobacco Free Generation

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1 Introduction

1.1 Background

Smoking is the second highest preventable risk factor for premature death and morbidity in New Zealand, with Māori and Pacific people disproportionately affected. In 2011, the NZ Government committed to the Smokefree Aotearoa New Zealand goal of becoming smokefree by 2025, defined as 5% or less smoking prevalence across all groups, with interim goals to be achieved by 2018 (daily smoking <10% overall and Māori and Pacific prevalence halved to no more than 19% for Māori and 12% for Pacific people).

In CM Health, smokefree work is a key population health priority and an important contributor towards achieving the organisation’s ‘Healthy Together’ strategic goal. This action plan describes the approach and actions the CM Health Living Smokefree Service intends to take for the next two years. It builds on the previous five year plan (2013-2018) and the high quality work underway within the Service. There has been a sustained focus on reaching priority groups, including Māori, Pacific people, pregnant women, people with mental illness and/or additions and/or chronic conditions, younger age groups, and people living in the localities of Manurewa, Papakura, Maangere, and Ootara.

CM Health is committed to achieving the smokefree 2025 goal, however evidence suggests that the 2025 goal of minimal smoking prevalence is likely to be missed nationally, with large inequities remaining for Māori and Pacific people. The interim goal for the previous CM Health five year smokefree plan was to reduce smoking prevalence in the CM adult population to 12% or less by 2018, with halving of prevalence to 18% for Māori and 12% for Pacific people. Estimations indicate current smoking prevalence in the CM adult population is approximately 13-14% (see section 1.2.1), with smoking prevalence in Māori much higher (Census-based projection 29%; NZ Health Survey estimation 38%) and smoking prevalence in Pacific also higher (Census-based projection 18%; NZ Health survey estimation 21%) than other ethnic groups.

Therefore, the CM Health Living Smokefree Service intends to continue its strong equity focus and prioritise reducing smoking prevalence for Māori and Pacific communities. Core business will be strengthened, including increasing reach and referral numbers. The Service currently receives approximately 5000 referrals per annum and the goal is to double this to 10,000 per annum. Innovative approaches beyond ‘business as usual’ will be tested and implemented, including supporting clients who choose to use e-cigarettes for smoking cessation and tobacco harm reduction. A Tobacco Free Generation (TFG) approach will be explored and developed, including opportunities for championing the concept of TFG across CM communities. Monitoring and evaluation of activities will continue to be an important focus for the Service and will contribute to informing programme development.

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1.2 Information to Support Smokefree Planning: The Population who Smoke in Counties Manukau

There are two data sources available from which the prevalence of smoking in the CM resident population can be estimated: NZ Census and NZ Health Survey (NZHS). NZ Census is a self-completion questionnaire (2006, 2013, 2018) and includes the question “Do you smoke cigarettes regularly (that is, one or more a day)?” with response options being: Yes and No. The NZHS is administered face-to-face by trained interviewers (conducted as a rolling study since 2011/12, reported annually) and includes the questions “Have you ever smoked cigarettes or tobacco at all, even just a few puffs?” and “How often do you now smoke?” with response options being: You don’t smoke now, At least once a day, At least once a week, At least once a month, Less often than once a month. The Census definition of ‘regular smoking’ is approximately comparable to the NZHS definition of ‘daily smoking’.³

Estimations of the number of CM residents who smoke, from the two sources (i.e. modelling based on NZ Census and NZHS - see below for more detail) are similar: approximately 55,600 people in 2018 from the Census-based model and 55,000 people from 2014-2017 NZHS data. Total population prevalence estimations are also similar (13% from Census-based model, 13.6% from NZHS data). However, there are large differences in estimations of prevalence by ethnic groups, with the Census-based model painting a more encouraging picture for Maaori and Pacific smoking prevalences than the NZHS estimations (Census-based model: Maaori 29%, Pacific 18%; NZHS: Maaori 38%, Pacific 21%).

1.2.1 Smoking Prevalence Estimation from NZ Census

Census data from 2006 and 2013 demonstrated a significant reduction in smoking prevalence in the CM resident population overall (2006: 22%; 2013: 16%), and for Maaori (2006: 47%; 2013: 36%) and Pacific Peoples (2006: 30%; 2013: 23%), who have the highest smoking prevalence of all ethnic groups in the region. Smoking prevalence in 2013 was higher in CM compared with NZ (NZ Census 2013: overall 15%, Maaori 33%, Pacific Peoples 23%). Detailed demographic analysis of the CM population who smoke based on Census 2013 data has been undertaken and is available elsewhere.⁴ Of note, smoking prevalence for Maaori was three times, and Pacific nearly twice, that of European/Other groups. Gender and age patterns were distinctive, with prevalence for Maaori women (38%) being higher than that of Maaori men (34%), and approximately 60% of Maaori and Pacific people who smoked being aged under 40 years compared with approximately 40% for European/Other groups and approximately 50% for Asian groups.

As results from Census 2018 are not yet available (expected early/mid 2019), estimation of current prevalence is from a linear forecast model based on Census 2006 and 2013 smoking prevalence and extrapolated into the future (Figure 1). Estimated smoking prevalence is applied to Stats NZ Estimated Resident Population projections for CM to estimate the number of people who smoke (Table 1). In 2018, the prevalence of ‘regular smoking’ in CM is estimated to be 13%, approximately 55,600 CM residents. There are large inequities by ethnic group, with prevalence of smoking among Maaori estimated to be 29% and among Pacific Peoples estimated to be 18%. The estimated number of Maaori residents who smoke regularly is approximately 17,100, representing 31% of all CM residents who smoke. The estimated number of Pacific people who smoke regularly is approximately 15,500, representing 28% of all CM residents who smoke regularly.

Figure 1. Linear forecast model of prevalence of regular smoking in CM Health area, by ethnicity

![Linear forecast model of prevalence of regular smoking in CM Health area, by ethnicity](image)

Source: CM Health analysis, based on NZ Census data.

Table 1. Modelling based on Census 2006 and 2013 ‘regular smoking’ prevalence and Estimated Resident Population forecast (2017 update for 2018 year)

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>Maori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence</td>
<td></td>
<td>29%</td>
<td>18%</td>
<td>5%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Estimated number of people who smoke</td>
<td>17,100</td>
<td>15,500</td>
<td>6,200</td>
<td>16,800</td>
<td>55,600</td>
<td></td>
</tr>
<tr>
<td>% of total CM population who smoke</td>
<td>31%</td>
<td>28%</td>
<td>11%</td>
<td>30%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Source: CM Health modelling, based on NZ Census and ERP data.

Note: Percentages are rounded to nearest ‘1’ percent; numbers are rounded to nearest ‘100’.
1.2.2 Smoking Prevalence Estimation from NZ Health Survey

For the time period 2014-2017, ‘daily smoking’ prevalence is estimated to be 13.6%, approximately 55,000 CM residents. There are large inequities by age group, ethnic group, and deprivation quintile. Of note, people aged 25-44 year, Maaori and Pacific groups, and people living in Quintile 5 areas have very high smoking prevalence. Maaori women have the highest prevalence of any subgroup, estimated to be 44%.

Table 2. ‘Daily smoking’ prevalence estimation from NZ Health Survey, 2014-2017

<table>
<thead>
<tr>
<th>Population group</th>
<th>Total (%)</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Estimated number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>13.6</td>
<td>13.8</td>
<td>13.5</td>
<td>55,000</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>10.8</td>
<td>9.1</td>
<td>12.3</td>
<td>10,000</td>
</tr>
<tr>
<td>25-44</td>
<td>19</td>
<td>19.6</td>
<td>18.4</td>
<td>25,000</td>
</tr>
<tr>
<td>45-64</td>
<td>13.3</td>
<td>14.2</td>
<td>12.5</td>
<td>16,000</td>
</tr>
<tr>
<td>65+</td>
<td>6.8</td>
<td>7.5</td>
<td>6.1</td>
<td>4,000</td>
</tr>
<tr>
<td>Ethnic group (total response)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maaori</td>
<td>38</td>
<td>31.4</td>
<td>43.6</td>
<td>19,000</td>
</tr>
<tr>
<td>Pacific</td>
<td>20.6</td>
<td>22.1</td>
<td>19.5</td>
<td>18,000</td>
</tr>
<tr>
<td>Asian</td>
<td>4.2</td>
<td>7.2</td>
<td>1</td>
<td>5,000</td>
</tr>
<tr>
<td>Neighbourhood deprivation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quintile 1</td>
<td>7.4</td>
<td>8.6</td>
<td>6.2</td>
<td>5,000</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>8.2</td>
<td>9.2</td>
<td>7.3</td>
<td>7,000</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>7.9</td>
<td>7.9</td>
<td>7.9</td>
<td>4,000</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>15</td>
<td>15</td>
<td>14.9</td>
<td>9,000</td>
</tr>
<tr>
<td>Quintile 5</td>
<td>21.6</td>
<td>21.4</td>
<td>21.9</td>
<td>30,000</td>
</tr>
</tbody>
</table>

Note: The Regional Data Explorer does not currently provide data for the ‘European/Other’ ethnic groups.

1.2.3 Smoking Prevalence Estimation from General Practice Data

Smoking prevalence in the population enrolled in general practices is estimated from quarterly data from the ‘Better Help for Smokers to Quit’ health target, sourced from reporting submitted by PHOs. The population described are PHO enrolled patients aged 15-74 years of age. Number of people who smoke and ‘current smoking’ prevalence for CM Health captures data about people who are enrolled in general practices located in the CM Health area and therefore is a different population to the CM resident population used in smoking prevalence estimations from the Census and NZ Health Survey. See Appendix One for more detail.

1.2.4 Summary

The prevalence of smoking in the CM population is estimated to be 13-14% (13% from Census-based model, 13.6% from NZHS data. The number of CM residents who smoke is estimated to be approximately 55,000-56,000 people (55,600 people in 2018 from the Census-based model and 55,000 people from 2014-2017 NZHS data). There are large inequities in smoking prevalence within

5 The most recent NZ Health Survey data available is for the year 2016/17 (estimated ‘daily smoking’ prevalence 13% and number 60,000), however estimations by ethnicity, age group and deprivation quintile are available only for 3-year pooled data, as shown in Table 2.
CM, with Maaori and Pacific people having much higher smoking prevalences than other ethnic groups. Hence this plan prioritises reducing smoking prevalence for Maaori and Pacific communities.

1.3 Information to Support Smokefree Planning: Estimation of Smoking Cessation Medication Utilisation

There are three commonly used smoking cessation medications in New Zealand: nicotine replacement therapy (NRT), bupropion (Zyban), and varenicline (Champix). Use of these medications greatly increases the likelihood of a successful quit attempt. Analysis of smoking cessation medication utilisation, based on data from the Ministry of Health Pharmaceutical Collection, is described in tables 3 and 4 below. As the Pharmaceutical Collection data for NRT has missing NHI data on large percentages of prescriptions (6.7% missing NHI in 2017), estimations of the number and percentage of CM residents who received NRT in 2017 have also been calculated (see section 1.3.2).

1.3.1 Smoking Cessation Medication Utilisation by the CM Health Population

In 2017, approximately 6,300 CM residents aged 15 years or more were dispensed NRT at least once (11% of the CM population who smoke), approximately 2,300 were dispensed varenclene at least once (4% of the CM population who smoke), and approximately 1,000 were dispensed bupropion at least once (1.8% of the CM population who smoke). The numbers and percentages of people dispensed smoking cessation medications have declined over recent years (see Table 3). Uptake of e-cigarettes may have contributed to the decline, however there are no data available on e-cigarette utilisation in the CM population (see section 1.3.3 for data from the Living Smokefree Service).

Table 4 shows that there are inequities by ethnicity in the percentages of smoking cessation medications dispensed. For example, in 2017 NRT was dispensed to 15% of the estimated population of Asian people who smoke and 15% of people of ‘Other’ ethnicities who smoke, but only 8% of Pacific and 9% of Maaori people who smoke.

Table 3. Number and percentage of CM Health residents aged 15+ who received smoking cessation medications

<table>
<thead>
<tr>
<th>Year</th>
<th>Bupropion</th>
<th>Nicotine Replacement</th>
<th>Varenicline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% of CM health contact pop</td>
<td>% of est pop who smoke</td>
</tr>
<tr>
<td>2013</td>
<td>1679</td>
<td>0.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2014</td>
<td>1395</td>
<td>0.4%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2015</td>
<td>1271</td>
<td>0.3%</td>
<td>2.2%</td>
</tr>
<tr>
<td>2016</td>
<td>1196</td>
<td>0.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>2017</td>
<td>1028</td>
<td>0.2%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Source: Pharmaceutical Collection, CM Health analysis

Table 4. CM Health residents aged 15+ who received smoking cessation medications, by ethnicity (number and percentage of total number of people who smoke in each ethnic group)
### 1.3.2 Estimate of Number of CM Residents who Received NRT in 2017

It is estimated that 10,000 CM residents received NRT in 2017 (note this is an approximate ‘ball-park’ estimate), based on Pharmaceutical Collection data on NRT dispensed (6329 individuals), NRT supplied by the Smokefree Service (1163 individuals) and NRT dispensed to inpatients (approximately 2453 individuals). This equates to 2.4% of the CM population aged 15 years or more who had ‘contact’ with the health system (n=422,950) and 17.6% of the estimated total number of CM residents who smoke.\(^6\)

We have quit status for people who receive support through Smokefree services but not for others using NRT. However, if a 10% quit success rate\(^7\) is applied, this suggests that in 2017 approximately 1,000 people would have achieved quit status supported by use of at least some NRT.

### 1.3.3 E-cigarette Use by Clients of the Living Smokefree Service

For the 18-month period Jan 2017- June 2018, 11% (n=211) of people who enrolled with the Living Smokefree Service were documented as using e-cigarettes. There were no differences by ethnicity, i.e. 11% of Maori, 11% of Pacific people, and 11% of Other ethnic groups who enrolled used e-cigarettes. Among pregnant clients who enrolled with the service, 4% overall used vaping products (3% of Maori, 2% of Pacific women, and 5% of Other ethnic groups). The Service reports higher quit rates among those who vape (77% quit rate) compared with those who do not vape (62% quit rate).

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\(^6\) Estimation of the percentage of people who smoke uses a denominator of 56,500 people, which is from the Census-based model as described in section 1.1, but for the year 2017

\(^7\) Ministry of Health estimate
1.3.4 Summary
Use of smoking cessation medications and/or vaping increase the likelihood of successful quit attempts. In 2017, bupropion was dispensed to approximately 1,000 people (2% of estimated population who smoke), varenicline was dispensed to approximately 2,300 people (4% of estimated population who smoke), and NRT was received by an estimated 10,000 CM residents (approximately 18% of the estimated total number of CM residents who smoke). Inequities in smoking cessation medications dispensed are evident, with Māori and Pacific people who smoke being dispensed a lower percentage of medications than other ethnic groups. Data on e-cigarette use by clients of the Living Smokefree Service shows that 11% of clients were reported as using e-cigarettes; there were no differences by ethnicity. This plan includes actions to increase access and reduce inequities in access to smoking cessation medications, and improve supports for clients who choose to use e-cigarettes for smoking cessation and tobacco harm reduction.
2 Overview of Plan

2.1 Goal
The Living Smokefree Service will work with others to reduce smoking prevalence to less than 5% for all population groups by December 2025.

2.2 Objectives
1. Explore and develop a Tobacco Free Generation (TFG) approach in CM, which will involve:
   • Refocussing existing work and prioritising key population groups;
   • Trialling new initiatives that contribute to TFG;
   • Building a TFG ‘movement’ in CM.
2. Champion innovative approaches for smoking cessation and harm reduction, including supporting people who choose to use vaping products.
3. Strengthen smoking cessation support in primary, secondary, maternity, mental health, and community settings, including:
   • Supporting health care practitioners to provide Smokefree ABC;
   • Increasing the number of referrals to stop smoking services;
   • Increasing access, and reducing inequities in access, to smoking cessation medications.

2.3 Guiding Principles
The following principles underpin the work of the CM Living Smokefree Service:
• A strong equity focus: CM Health will prioritise reducing smoking prevalence for Maaori and Pacific communities;
• A dual focus on strengthening our core activity, whilst also moving beyond a ‘business as usual’ approach, thinking differently, and testing and trialling innovative approaches;
• Increase consumer involvement and co-design approaches at a programme and individual project level;
• Collaborate with key stakeholders to inform service planning and implementation (including health and non-health stakeholders, regional stakeholders, and CM Health communities);
• Demonstrate organisational leadership towards Smokefree Aotearoa 2025;
• Continual evaluation and monitoring to inform programme development.

2.4 Priority Populations
Smoking disproportionately affects certain groups in Counties Manukau, and on this basis the following priority groups have been identified:
• Maaori;
• Pacific People;
• Pregnant women and their families/whaanau;
• People with mental illness and/or addictions;
• People with chronic conditions;
• Younger age groups (15-49 year olds overall, and 20-34 year olds specifically);
• Manurewa, Papakura and Maangere/Ootara localities.
The priority groups identified above are not discrete groups, and there will be much overlap between them. This means there is considerable potential to reach people who belong to more than one of the identified priority groups (e.g. young pregnant Maaori women and their whaanau who live in Papakura or Pacific families who live in Maangere and have a range of health needs). This means we need to develop smart strategies that can cater to multiple groups at once. It also means that we need to work closely with our partners in the health system and with other stakeholders who already work with these groups.

It is likely that high proportions of people with long-term (physical health) conditions, particularly smoking-related conditions, smoke or are recent ex-smokers. This group will be important influencers for their family members, who may already smoke or be susceptible to starting. It will be important to reach this group in addition to the younger age groups identified above, both in order to achieve the Smokefree 2025 vision, and to contribute to both short and long-term impacts in the health system.

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8 Geography distribution based on Census 2013 data
2.5 Logic Model

The Living Smokefree Service Logic Model aligns with the Smokefree Aotearoa 2025 Road Map (see Appendix Two). In 2011, the NZ Government committed to the Smokefree Aotearoa New Zealand goal of becoming smokefree by 2025, defined as 5% or less smoking prevalence across all groups, with intermediate goals to be achieved by 2018 (daily smoking <10% overall and Maaori and Pacific prevalence halved to no more than 19% for Maaori and 12% for Pacific people).

In this plan, the Living Smokefree Service Logic Model has a revised intermediate goal for 2020, i.e.:

- reduction in population smoking prevalence from 14% (current estimated prevalence based on NZHS data) to 11% in 2020.

As the plan prioritises smoking cessation among Maaori and Pacific populations and creating a Tobacco Free Generation, the intermediate goal includes targets for smoking prevalence among Maaori, Pacific, and younger age groups, i.e.:

- reduction in smoking prevalence in the CM Maaori population from 38% (current estimated prevalence based on NZHS data) to 28% in 2020;
- reduction in smoking prevalence in the CM Pacific population from 21% (current estimation) to 16% in 2020;
- reduction in smoking prevalence in the CM 15-24 year old population from 11% (current estimation) to 9.5% in 2020;
- reduction in smoking prevalence in the CM 25-44 year old population from 19% (current estimation) to 15% in 2020.
SMOKEFREE COUNTIES MANUKAU 2025
5% smoking prevalence or less across all groups

2020 INTERMEDIATE GOAL
11% smoking prevalence overall
Reduce smoking prevalence to 28% for Māori, 16% for Pacific, 9.5% for age group 15-24 years, 15% for age group 25-44 years

INCREASE SUCCESSFUL QUITTING
People who smoke are motivated and enabled to quit and stay smokefree.

REDUCE INITIATION
No-one, especially children and young people, starts smoking.

WORKSTREAM ONE:
TOBACCO FREE GENERATION (TFG)
Explore and develop a Tobacco Free Generation (TFG) approach in CM, which will involve:
- Refocussing existing work and prioritising key population groups;
- Trialling new initiatives that contribute to TFG;
- Building a TFG ‘movement’ in CM.

WORKSTREAM TWO:
INNOVATIONS
Champion innovative approaches for smoking cessation and harm reduction, including supporting people choosing to use vaping products.

WORKSTREAM THREE:
CORE BUSINESS
Strengthen smoking cessation support in primary, secondary, maternity, mental health, and community settings, including:
- Supporting health care practitioners to provide Smokefree ABC;
- Increasing the number of referrals to stop smoking services;
- Increasing access, and reducing inequities in access, to smoking cessation medications.

WORKSTREAM FOUR: EVALUATION AND MONITORING
Effectively monitor the impact of both the wider Smokefree programme and individual projects (with a focus on increased successful quitting)
- Evaluate and monitor innovation trials to determine impact and add to the knowledge base for what works
- Share learnings within the programme and across the sector to inform future activity
3 Current Services

Current Services: Tobacco Control Leadership, Health Targets, Smoking Cessation Services and Health Promotion Services (Counts Manukau Health)

CM Health is currently funded by the Ministry of Health for a range of core tobacco control activities, as set out in Table 5 below. This funding is currently in place until June 2019. CM Health also receives Ministry of Health Stop Smoking Services funding for provision of stop smoking services in Counties Manukau District, as set out in Table 6.

Table 5. CM Health funding for Core Tobacco Control Activity

<table>
<thead>
<tr>
<th>Revenue Stream</th>
<th>Required Activity</th>
<th>Current Activity</th>
</tr>
</thead>
</table>
| Tobacco Control | Tobacco Control Leadership | • Develop, implement and review progress against a DHB tobacco control plan  
• Provide leadership and coordination related to tobacco control in CMDHB catchment area (or region, where a regional approach is taken)  
• Support the Government’s Health Targets  
• Monitor, plan, coordinate and develop local smoking cessation activity  
• Keep our tobacco control gap/needs analysis up to date  
• Monitor and analyse referrals and service uptake for priority populations  
• Support and/or lead local health | • CM Health currently employs a core team of 8 FTE (the core tobacco control service) who collectively provide tobacco control leadership, planning and strategy, analysis, support to achieve health targets, delivery of a triage service, health promotion, and national service development work.  
• This team is comprised of:  
1FTE Portfolio Manager  
1 FTE Team Leader (team management and smokefree maternity care advisor functions)  
1FTE Senior Smokefree Specialist (Stop Smoking Service coordination)  
0.5 FTE Smokefree Primary Care Advisor  
1FTE Smokefree Secondary Care Advisor  
1FTE Smokefree Mental Health and Community Health Advisor  
1 FTE Smokefree Referrals Coordinator  
1FTE Smokefree Inpatient Advisor  
• The Target Advisor roles continue to align with MOH priorities to work across the health system, and have a specific focus on improving cessation support within target activity.  
• The Target Advisors each carry a small caseload of clients requiring specialist support.  
• The Inpatient Advisor provides a dedicated specialist smoking cessation service to inpatients in Middlemore Hospital and satellite sites.  
• The Primary Care Advisor works alongside a CM Health Primary Care Programme Manager to focus on enabling and building capacity to achieve and sustain the Smokefree health target, and on improving the rate of cessation support in line with primary care Smokefree plans and the Smokefree 2025 vision of Counties Manukau Health. |
<table>
<thead>
<tr>
<th>Promotion activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop/support smokefree policies</td>
</tr>
<tr>
<td>• Systematically ensure that tobacco control is included as a key activity in all DHB health documents, plans and policies</td>
</tr>
<tr>
<td>• Participate in national service development work and adhere to national specifications and guidelines</td>
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<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Revenue Stream</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
</tbody>
</table>
| Stop Smoking Service $1,134,125 p.a. to June 2019 | Plan and deliver evidence-based stop smoking interventions which include multi-session face-to-face behavioural support, and help for people to access and use the full range of stop-smoking medicines (NRT, bupropion, nortriptyline, varenicline). | • Lead Stop Smoking Service Provider – CM Health (Living Smokefree Service)  
• Stop Smoking Service Partners – Working with health system frontline community and primary care partners and localities to support identified priority population.  
• Expected outcomes include:  
  Enrolling at least 5% (3,403) of regular smokers within the Counties Manukau DHB catchment area (agreed volume) per annum.  
  Achieving carbon monoxide (CO) validated quit rates of at least 50% (at four weeks)  
• Services include:  
  Local community stop smoking service  
  Smokefree Pregnancy incentives  
  Mobile Service  
  Social media communications  
  Frontline health professionals (primary care, well child tamariki ora providers (WCTO), midwives, Whaanau Ora, Fanau Ola, Mental health etc) in each locality providing brief advice and cessation support and refer.  
• Support options include:  
  Face to face  
  Home visits/ phone contact  
  Group programmes  
  Drop-in clinics  
  Free NRT, advice on other stop smoking medicines  
  Delivered in an individual, whaanau/ family or group setting  
• Support health promotion, prevention of uptake and awareness-raising activities.  
• Quality improvements made to the Stop Smoking Service as a result of reflective practice. |
4 Summary of Achievements 2016-2018

4.1 Organisational Commitment to Smokefree as a Major Population Health Priority
In 2012 the CM Health Executive Leadership Team and Board endorsed Smokefree as a key population health priority area and endorsed the strategic approach to achieve a Smokefree Counties Manukau by 2025 (defined as 5% smoking prevalence or less across all groups). From the 2016 review of Smokefree policy and initiatives there continues to be strong support for Smokefree activity at the Executive Leadership level and across many areas of the organisation which ensures that it retains a high profile. CM Health is committed to preparing responses on behalf of the organisation to tobacco control issues that have an impact on our whole population, such as Plain Packaging, the Auckland Council Smokefree Policy, and implementation of the Smokefree policy by Local Boards.

4.2 Needs Analysis and Market Research
Counties Manukau Health has undertaken an extensive needs analysis process which has included in-depth analysis of demographic data about our smoking population, attempting to quantify the number of people required to quit in order to achieve the Smokefree 2025 goal, ongoing community consultation, and reviews of current service provision. This process continually informs our planning at both project and whole of programme level. Most recently, we have completed market research and design thinking to gain deeper insights into the Māori and Pacific smoking population and continue to design and implement initiatives based on the findings from previous campaigns e.g., Snapped Out, Hang Tuff Don’t Puff, Smokefree Notes.

4.3 ‘One Stop Shop’ for Support to Stop Smoking: Connected Cessation Services
Smoking cessation services in Counties Manukau are well connected to each other, with a good degree of cooperation and communication between services. This is supported by a well-established Provider Network that meets monthly and is open to all stop smoking services and other services involved in Smokefree activity in the district. CM Health also provides a Clinical Supervision Network that is open to all stop smoking practitioners in the district.

Since 2016, the CM Health Stop Smoking Service became the lead provider of Stop Smoking Services within CM District and is promoted as a ‘one stop shop’ for anyone who wants support to stop smoking. A key to this approach is a centralised triage service, which has been in place at the Counties Manukau Health Smokefree Service since March 2013. It provides a first phone assessment for all referrals and connects them to the most appropriate locality-based stop smoking support option. It is staffed by a dedicated Referrals Coordinator and currently handles in excess of 4800 client referrals per year, with the referrals from primary care, secondary care, other health professionals such as midwives, community and from other sources such as workplaces and self-referrals. Over half of these clients who have been referred engaged with the service.
4.4  Improving the Reach, Volumes and Performance of Stop Smoking Services

4.4.1 Realignment of CM Health Resource Across the Health System and Community

CM Health’s needs analysis process has clearly indicated that stop smoking services must support significantly more people to stop smoking than service targets allowed for in the previous plan. CM Health has implemented a new programme structure that provides targeted support across primary, secondary and maternity care, as well as within the community. This has resulted in a significant increase in referrals and engagement with 4822 referrals in Financial Year 2017/18 (2016/17 – 4361, 2015/16 – 3969, 2014/15 – 2785, 2013/14 – 2204, 2012/13 – 1145). This does not take into account the referrals to Quitline and community providers.

4.4.2 Design and Deliver Services for Younger Age Groups

Smoking prevalence data are clear that our priority age group is 20-34 years, and more broadly the age group 15-49 years. Social media and community-based services appear to be reaching younger age groups overall.

Stop smoking services and activities are designed with younger age groups in mind, and overall there has been a shift from the traditional service delivery approach to a Smokefree social change approach through youth initiatives such as “Snapped Out” social media campaign, health promotion in schools, Hang Tuff 2015 Facebook page and engagement with youth provider to deliver stop smoking services.

As noted previously, it is still important that alongside this priority for young people, we continue to work with older smokers as they influence the behaviour of those around them, and quitting will improve their own well-being and contribute to achieving the 2025 goal.

4.4.3 Successful Innovations

CM Health has trialled a range of initiatives to increase the reach of the service. After being selected as the lead stop smoking service provider we were able to build the Smokefree Pregnancy Incentives programme and Quit Bus initiatives, both commenced as innovation projects, into business as usual. To achieve the Smokefree 2025 goal, CM Health is continuing to demonstrate further innovative approaches to supporting greater numbers of people who smoke to quit by piloting initiatives which have proven to be successful such as “Hang Tuff Don’t Puff Challenge” and locality-based stop smoking programmes. These programmes have resulted in equitable access to stop smoking support and outcomes for our priority population with Maaori and Pacific people accounting for 7 out of 10 people who stop smoking.

Smokefree Pregnancy Incentives:

The Incentives based programme is now into its 6th year and is attracting referrals for just over half the estimated population of pregnant women who smoke. A quarter of those who have enrolled have referred one or more whaanau members. It has doubled the throughput and tripled the 4-week success rate compared to the pre-existing non-incentives Smokefree support programme. Since its evaluation, the programme has been replicated in many other Smokefree services across New Zealand and has attracted international interest with its inclusion in International Conferences.
**The Quit Bus:**
The Quit Bus has reached significant numbers of people who smoke from priority populations, particularly Maori, and younger age groups. During its first two years and nine months of service provision, the Counties Manukau Quit Bus engaged 1266 people for one-off support to quit, an additional 1504 for intensive support, and had a brief conversation with 11,119 people (total reach 13,889).

**Hang Tuff Don’t Puff Stop Smoking Challenge:**
“Hang Tuff Don’t Puff Stop Smoking Challenge” initiative (co-designed with community with a strong equity focus) encourages people who smoke to attend their local stop smoking drop-in clinic to receive intensive evidence-based stop smoking support. People who successfully stop smoking (Carbon monoxide validated) at the end of the four-week challenge receive a $100 voucher as an incentive. Results for July 2017 to March 2018 indicate that there was a 69% increase in number of 4-week quitters (309 to 521), 47% for Maori and 41% for Pacific compared to the previous period.

**Locality-Based Stop Smoking Programmes:**
To increase access to stop smoking support in the community CM Health delivers an average of 30 health promotion/service utilisation initiatives, 27 weekly drop-in clinics and 7 Group Based programmes a month throughout the district (schools, tertiary education providers, workplaces, marae setting, community houses, libraries, town centres, GP practices and mental health settings) with a particular focus on priority populations.

4.4.4 Support for People with Mental Illness and Other Addictions
We have identified a considerable gap in activity to support people with mental illness and other addictions who smoke, and responded as follows:

- Providing training to increase DHB mental health services staff capability and confidence to provide consistent Smokefree assessment, brief advice and support to people using mental health services.
- All service users’ tobacco use is routinely assessed and documented as part of their full mental health and wellbeing assessment which has provided a smoking prevalence of 57% among people using DHB mental health services.
- A dedicated Smokefree Advisor, Mental Health coordinates face to face stop smoking support to people using mental health services via home visits, drop-in clinics and Quit Bus visits.
- The dedicated Smokefree Advisor, Mental Health also supports Mental Health NGOs with stop smoking resources and support options, development of service specific Smokefree plans, Smokefree Best Practice implementation and Smokefree champion development.

4.4.5 Increased Access to Nicotine Replacement Therapy (NRT)
Free Nicotine Replacement Therapy is available to all service users as well as users of partnering services (i.e. DHB Pacific & Maori Health Teams and Mental health NGOs) through trained champions. Subsidised NRT is also available through pharmacies as of 1st October 2017.

4.4.6 Cost per Successful Quit
An analysis of the cost per quitter for existing smoking cessation services in Counties Manukau, for the year 2017, indicated cost per quitter (4 weeks after a quit date) of $1209 (CO validated). This is less than the expected national cost per quitter measurement of $1500.
4.5 Consistent Achievement of “Better Help For Smokers To Quit” Targets
The secondary care target has consistently and equitably been achieved since Quarter 4 2011/12, and the primary care target since Quarter 4 2013/14. This means that a large proportion of the currently smoking population are receiving brief advice and support to stop smoking through the health system. The maternity target has also been achieved since Quarter 1 2014/15 except the first two quarters of 2016/17 due to data collection issues with the database that CM Health started piloting for the Ministry of Health.

4.6 Workforce Development
Tailored training related to Smokefree ABC, information on recent Smokefree developments and research, Smokefree Best Practice, support related to Smokefree health targets, Motivational Interviewing training and Group Based Treatment (GBT) training opportunities are provided to enhance delivery of ABC in clinical practice and other settings.

In addition to training and development for clinical/ non clinical staff in Primary, Secondary, Maternity, Mental Health and Community setting, CMH Living Smokefree service staff and Smokefree practitioners of the district are supported through: stop smoking foundation training, GBT training, Smokefree Best Practice (practical training) for new staff members, supervision from senior experienced stop smoking practitioners, motivational Interviewing training, monthly smokefree provider network meetings, monthly team supervision, stop smoking practitioner buddy support, opportunities to attend Smokefree symposiums, conferences, and related workshops and to complete the Stop Smoking Practitioner Qualification through National Training Service.

CM Health Primary, Secondary, Maternity and Mental Health Smokefree advisors have the respective Smokefree Best Practice Training packages endorsed by National Training Service (NTS) to become accredited trainers and educators.

4.7 Collaboration
CM Health is involved in the Smokefree Auckland Tupeka Kore Tamaki Makaurau strategy that focuses on strengthening connections between Smokefree Auckland-Tupeka Kore organisations/whānau, sharing organisational plans and actions towards our bold goals, supporting effective aligned action, discussing challenges and options for addressing and agreeing mechanisms for communicating our aligned action and staying connected.

As part of the CM Health Smokefree Intersectoral initiative, the staff of three Auckland Council Recreation Centres (Manurewa, Ootara and Papatoetoe) have been trained in Smokefree Best Practice to enable them to conduct smokefree brief conversations with their clients and refer to CM Health Living Smokefree Service for support to stop smoking. This initiative will be extended to other centres in 2018. This work has been done in conjunction with Taamaki Healthy Families NZ.
5 Key Opportunities for Smoking Cessation Activities

This section summarises the key opportunities and aspects requiring strengthening in relation to current smoking cessation activities for the priority populations identified in this plan. The priority populations are:

- Māori,
- Pacific peoples,
- Younger age groups (20-34 year olds in particular, and 15-49 year olds overall),
- Pregnant women and their families/whānau,
- People with mental illness and addictions,
- People with chronic health conditions,
- The Locality populations of Manurewa, Papakura and Maangere/Ootara/Papatoetoe.

5.1 Improving the Reach of the Living Smokefree Service

CM Health Living Smokefree Service currently receives approximately 5,000 referrals per annum and at the current rate of enrolment into the Stop Smoking programme we require approximately 10,000 referrals to work towards achieving the 2025 goal of <5% smoking prevalence. This requires a significant increase in the number of referrals (i.e. double) from Primary Care, Secondary Care, Maternity Care, Mental Health, Pharmacies, other Health and Non-Health agencies, workplaces and self-referrals.

5.1.1 Māori, Pacific Peoples, and People in Younger Age Groups

Currently, CM Health Stop Smoking Services enrol and support a higher proportion of Māori and Pacific people (70% of total enrolments and 73% CO validated quitting). However, the number of people quitting needs to increase significantly (i.e. double) to reach the overall goal of achieving <5% smoking prevalence across all groups.

CM Health has undertaken market research to inform the planning and prioritisation of new initiatives, the adaptation of existing activity and the design of effective communications, engagement and marketing approaches. An important objective of this work is to gain in-depth insights to help the Living Smokefree Service improve its reach to Māori and Pacific people who smoke.

A three stage approach was undertaken in 2014-16. Stage one included a research review and the gathering of qualitative insights from smoking cessation practitioners, in order to gain deeper insights into CM Māori and Pacific smoking populations. In stage two, the key insights were explored in depth with consumers to gain understanding of communication preferences, influences in their life, and life course intervention points for older and younger Māori and Pacific men and women. The smoking population was ‘segmented’ into four types of smokers, presented as personas (Moses, Moana, Feta and Dorothy).

Stage three tested young people’s communication preference with a social media campaign ‘Snapped Out’ – Snap out of it, smoking is not cool! using Facebook and Snap Chat. The six week campaign was successful in attracting 1100 followers on Snapchat with an average 54% engagement rate (those who watched the Snapchat story). Over 100,000 Snapchat impressions were received and 540 artworks contributed – 3,400 people followed the campaign on Facebook. At the conclusion of the campaign, 200 Snaps were exhibited at the Maangere Arts Centre. Following the ‘Snapped
Out’ Campaign, there was a doubling of quit dates set by young people receiving stop smoking support from the Quit Bus.

There is an opportunity for planning and implementing campaigns around each of the identified personas which will allow Counties Manukau Health to reach these priority groups in an effective, personal way with a clear focus on increased quit outcomes.

5.1.2 Pregnant Women and Their Families/Whaanau

The Pregnancy Incentives Service has demonstrated a highly effective approach to supporting pregnant women to stop smoking during pregnancy. The Pregnancy cessation service has a strong focus on Māori and Pacific women within CM Health. Estimates indicate there were approximately 1,700 pregnant women who smoked in CM Health prior to 2016 with just under 1,200 smoking per year from 2016. The prevalence rate has been calculated as 22% for the total population with Māori rates sitting at 36% and Pacific rates at 14%. This equates to ~620 Māori women and ~390 Pacific women.9

Currently the service receives referrals for just over half of the estimated smoking in pregnancy population (56%). With only 40% of these setting a quit date, a higher number of referrals (remaining 44% to be targeted) are required to achieve a significant impact to address smoking in pregnancy. An analysis of the 2017 data showed that midwives refer only 40% of their smoking case load with a potential 60% not referred (although referrals are also received from primary care and community sources).

The number of midwives undergoing smokefree training has decreased over time due to the lack of training opportunities, although a face to face education session is provided to all new DHB midwives and graduate midwives on orientation. Therefore, innovative training packages are required to help increase the number of midwives referring (currently 100% of DHB midwives refer but only 50% of self-employed midwives refer).

The postnatal period has also been identified as a high risk time in terms of the effects of second hand smoke, with a known relapse rate for those that have achieved a Smokefree pregnancy (anywhere from 50 – 80%). The service has historically received a low number of referrals from birthing units and postnatal midwives with client’s loss of motivation to be Smokefree often provided as a barrier to referring. Of those that are referred postnatal, there have been minimal quit outcomes. Since the introduction of the Smokefree households for 6 week old babies System Level Measure (SLM), there has been renewed emphasis on increasing referrals in the postnatal period and therefore the pregnancy incentives programme was replicated for postnatal women and their whaanau in June 2017 to gauge its impact.

Since June there has been a significant increase in the number of referrals but more importantly the number of engagements and successful outcomes. In the 6 months prior to the introduction of the incentive programme, the service received 36 referrals for postnatal women resulting in zero quitters. The following 6 months resulted in 60 referrals and 12 women successfully Smokefree at 4 weeks. There was a knock on affect with whaanau numbers engaging with referrals doubling and quitters trebling.

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9 Data source: Maternity Clinical Information System
5.1.3 People with Mental Illness, Addictions, and/or Chronic Health Conditions

People with mental illness and/or addictions other than smoking comprise a significant proportion of our total smoking population. Mental health HealthCare Community (HCC) Smokefree Assessment Form Completion analysis completed in June 2018 indicates that 55% people using DHB mental health services smoke. There has been an absence of dedicated support for this priority group until recently and relatively poor data available for monitoring service provision for this group.

CM Health Smokefree initiatives with DHB and NGO mental health services have made significant progress from the year 2016 onwards in relation to Smokefree policy, systems, training, champion development and stop smoking support. However, this is priority population requiring increased engagement and quitting.

There is limited information about the number of people who have a chronic physical condition (e.g. gout, diabetes, cardiovascular disease, chronic obstructive pulmonary disease and coronary heart failure) who smoke, however it may be reasonable to assume that a higher proportion of this cohort smoke or are a recent ex-smoker than the overall population, due to the presence of what may be a smoking-related condition. CM Health is well placed to engage with this group through both secondary and primary care target activity, and other health system initiatives.

There is likely to be significant overlap between these two priority groups. CM Health analysis indicates that people who had received care for mental health unwellness had a higher prevalence of long-term conditions, and 12-18% of people with long term conditions are likely to have a severe mental health condition and/or addiction.

Community Health CM Health Smokefree initiatives with DHB and NGO mental health services have made significant progress from the year 2016 onwards in relation to Smokefree policy, systems, training, champion development and stop smoking support. However, this is priority population requiring increased engagement and quitting.

5.1.4 CM Health Living Smokefree Service Profile

There is a need for consistent communications activity to stakeholders in relation to profiling of CM Health Living Smokefree Service and what it offers. This would increase awareness among stakeholders of treatments, available services, and their effectiveness.

5.1.5 Cross Sector Smokefree Initiatives

The service has engaged with a wide range of non-health sector settings to equip them to address smoking amongst staff, clients and within their settings. Agencies included Community Probation Services, Work and Income, Alternative Education, Auckland council leisure centres, other social services, NGOs, tertiary providers, and workplaces. Increased buy-in and engagement is required to support staff of these organisations to understand Smokefree and its relevance to themselves and the people they work with, incorporating Smokefree discussions into their everyday business. This will help to address the gap in stop smoking service utilisation from these settings.
5.2 Increase Use of Smoking Cessation Medications and Support for E-cigarettes

There is a significant opportunity to increase access for people who smoke, and reduce inequities in access by ethnicity, to stop smoking medications. This is a very important area of action for primary and secondary care health target activities, and aligns with the smoking contributory measure in the amenable mortality SLM where the emphasis needs to be strongly on the ‘C’ of ABC. Our analysis of the NRT data indicates that once people have tried NRT, they are more likely to try it again. Understanding barriers to initial use of NRT and supporting people to overcome those barriers are key activities.

In recent years, electronic cigarettes have become popular among people who smoke as a means to help quit smoking or to reduce cigarette use. Eleven percent of people who enrol with the CM Health Living Smokefree Service are documented as using e-cigarettes and the quit rate is higher among those who vape. Currently the CM Health Stop Smoking Service does not have a formal policy on use of e-cigarettes for tobacco harm reduction. Use of e-cigarettes is a significant opportunity requiring further consideration and attention by the service.

5.3 IT Enablers

5.3.1 Community Referral Pathway
The CM Health Smokefree Triage Service is well established to receive referrals from referrers across the health system but not from community referrers. There is a need for a web based referral pathway.

5.3.2 Client Information Management System
Increasing volumes of clients being seen and managed by the CM Health Living Smokefree Service has increased the demand on this existing database, and this is expected to continue to increase within the context of CM Health’s Smokefree 2025 population health initiative. Consequently, there is an increasing need for a specific database that is built to manage larger volumes and automation of reporting.

5.4 Coordinated Regional Approach to Achieve Smokefree 2025
The recent Regional Tobacco Integration Network (Regional-TIN) governance groups, Primary Care Continuing Medical Education (CME), Counties Manukau Smokefree Provider Network groups and SLM initiatives have highlighted the need to take a more coordinated approach between key stakeholders towards achieving Smokefree 2025. This means working in a more coordinated manner with other DHBs (particularly Auckland and Waitemata), with the Auckland Regional Public Health Service, and with Ministry of Health in relating to planning and funding decisions. A strategic approach towards achieving Smokefree 2025 for the Auckland region would provide focus, direction and efficiencies in achieving our shared vision. There will be some tensions in this for CM Health, given we do not want our local impetus to be diluted as a consequence of collaborative efforts.
6 High Level Actions 2018-2020

6.1 Workstream One: Tobacco-Free Generation

The focus of this workstream is to:
- Explore and develop a Tobacco-Free Generation (TFG) approach for the Living Smokefree Service.
- Strengthen/re-focus existing work and trial new projects that contribute to a TFG approach.
- Promote the concept of TFG in CM.

TFG concept
TFG is a proposed tobacco endgame strategy which involves a legislated ban on the provision of tobacco to those born from a set date onwards, i.e. there would be an annual increase in the minimum age of purchase each year. This strategy is included as a recommended key action (Objective 2, Action 2.3) in the action plan ‘Achieving Smokefree Aotearoa by 2025’. NZ modelling studies suggest such a policy would result in a large reduction in smoking prevalence, particularly for Maori aged <45 years. A TFG law would help restrict availability of tobacco and reduce smoking initiation among young people. It would send a clear message that tobacco is unsafe at any age and avoid the ‘coming of age’ implication of a fixed minimum age law, which implies that smoking becomes acceptable at the age of 18.

The TFG concept is also being used as a ‘social movement’ or ‘approach’. For example, in Singapore “Tobacco Free Generation” is a not-for-profit organisation describing itself as “a social movement that seeks to re-balance the landscape of teenage smoking,” and involving doctors, medical students, teachers, and others, who go into schools and promote the concept and build support for it. There has also been support for the concept in Tasmania. ASH Scotland has published ‘Scotland’s Charter for a Tobacco-Free Generation’, which organisations can sign up to and pledge actions that the organisation will take to support the goal of creating a TFG. A TFG ‘approach’ has been incorporated into England’s tobacco control plan. This plan is titled

13 ASH Scotland. Scotland’s Charter for a Tobacco-free Generation. Available at: https://www.ashscotland.org.uk/what-you-can-do/scotlands-charter-for-a-tobacco-free-generation/
Towards a Smokefree Generation’ and states the vision “to create a smokefree generation” and a range of actions (i.e. smoking cessation and initiation reduction, not TFG legislation) to achieve this ambition.\textsuperscript{14}

Given the current absence of TFG legislation in NZ, the CM Health Living Smokefree Service proposes taking a TFG approach which will involve strengthening/re-focusing of existing work, trialling new projects, and promoting/championing the concept of TFG in CM. A TFG approach is aligned with CM Health’s focus on children and young people having the best start in life. Key areas of action will be strengthening existing Smokefree pregnancy and homes/whaanau work. To develop a TFG approach we will focus on the following key areas:

<table>
<thead>
<tr>
<th>Smokefree pregnancies</th>
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<tbody>
<tr>
<td>- Improve reach and increase referrals to Living Smokefree Service.</td>
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<tr>
<td>- Enhance pregnancy incentives programme.</td>
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<tr>
<td>- Support pregnant women who choose to use e-cigarettes.</td>
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<table>
<thead>
<tr>
<th>Babies live in smokefree homes/whaanau</th>
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<tr>
<td>- Develop and implement a whaanau/fanau incentives programme to engage and support</td>
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<tr>
<td>whaanau/fanau/family/household groups to become smokefree. This work will prioritise</td>
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<tr>
<td>whaanau/fanau with babies/children aged 0-4 years and whaanau/fanau/households of</td>
<td></td>
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<tr>
<td>women involved with the smokefree pregnancies programme.</td>
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<tr>
<td>- Capture stop smoking whaanau/fanau stories to inspire other whaanau/fanau to become smokefree.</td>
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<thead>
<tr>
<th>Young people are supported to be smokefree (i.e. to never start smoking)</th>
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<tr>
<td>- Develop and support three youth-led projects (one in a primary school, one in a</td>
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<tr>
<td>secondary school, and one in a tertiary institution) to promote the concept of TFG</td>
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<td>in homes, schools, and neighbourhoods.</td>
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<tr>
<td>- Engage with school youth health councils, alternative education providers,</td>
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<tr>
<td>tertiary education institutes to champion TFG concept/movement.</td>
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<tr>
<td>- Develop and support interschool competitions to generate content and spread TFG</td>
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<tr>
<td>messages.</td>
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<tr>
<td>- Engage with sports and entertainment event organisers (e.g. Manurewa Weetbix</td>
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<tr>
<td>Tryathlon) to promote Smokefree events and branding.</td>
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<tr>
<td>- Implement ‘Snapped out’ campaign in schools.</td>
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<table>
<thead>
<tr>
<th>Young people who smoke are supported to quit</th>
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<tbody>
<tr>
<td>- Improve reach and increase referrals to Living Smokefree Service.</td>
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<tr>
<td>- Enhance and spread smokefree messaging and stop smoking support in schools (including Quitbus visits to schools).</td>
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<tr>
<td>- Train and support school oral health service staff and community dentists to provide smokefree ABC.</td>
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<tr>
<th>Promote cross-generational smokefree change</th>
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<tr>
<td>- Build TFG movement via a social media campaign.</td>
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<tr>
<td>- Explore building a youth-led TFG movement (see education settings projects above).</td>
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<tr>
<td>- Work with Mana Whenua, Maaori Women’s Welfare League, Church and community initiatives to promote TFG as a movement.</td>
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6.2 Workstream Two: Innovations

The focus of this workstream is to:
- Trial and evaluate innovation initiatives (small and large scale)
- Adapt or adopt successful models into core business
- Continually monitor initiatives to ensure reach to priority groups, adapting where required
- Champion innovation initiatives led by others, ensuring a focus on CM Health priority groups.

To achieve this we will focus on the following key initiatives:

| Smoking cessation and tobacco harm reduction through supporting use of e-cigarettes | Policy: Review and update existing Living Smokefree Service and CM Health policy on vaping and other products that are not smoked (e.g. ‘heat not burn’ products). |
| --- | - Staff knowledge and skills: Upskill Living Smokefree Service staff and other healthcare professionals to provide appropriate advice and support to clients/patients regarding use of e-cigarettes (and including concurrent use of smoking cessation medications and e-cigarettes, and combining smoking and vaping). |
| Alcohol ABC Approach integration project | - Support for clients/patients: Develop information for clients and provide support including group-based therapy for people who use e-cigarettes. |
|  | - Vape vendors: Engage with responsible vape vendors, share Living Smokefree Service information and encourage referrals for stop smoking support, and train vendors to have smokefree brief conversations and refer. |
|  | - Data on vaping: Explore data sources for describing e-cigarette use in the CM population and strengthen the Living Smokefree Service data capture of e-cigarette use by clients. |
| Pharmacy | - Explore feasibility of increased referrals from community Pharmacies. |
|  | - Trial and test provision of stop smoking services by selected pharmacies in priority localities. |
| Social media campaign | - Continue the sub segmentation, or ‘Persona’, work to more effectively target Smokefree services to specific population groups, particularly for Maaori and Pacific. |
|  | - Test and validate ‘Dorothy’ persona, and campaign using her opinion leaders and influence. |
|  | - Test and validate Feta’ (Pacific, male, family man) persona. |
- Re run “Snapped Out” Campaign with a clear focus on increased quit outcomes for youth.
  - Facilitate focus groups of those that meet the ‘Dorothy’ and ‘Moana’ personas to uncover barriers around accessing the service and new ways to attract and deliver treatment to these target audiences.

**IT enablers**
- Develop an online referral pathway for referrers and self-referrers to enable easier access to the CM Health Living Smokefree service.
- Develop a client information management system for the Living Smokefree Service.

### 6.3 Workstream Three: Core Business

The focus of this workstream is to:
- Improve the focus on cessation (the ‘C’ of ABC), and specifically on increasing access and use of stop smoking medications, within the health system (including DHB funded and contracted services),
- Expand the reach of smoking cessation support in other settings,
- Ensure core activity is targeted to priority groups, and that these groups receive consistent messaging and access to support,
- Demonstrate Smokefree leadership within and across the organisation,
- Improve the reach and quality of DHB funded and delivered smoking cessation services with a focus on testing new and innovative models,
- Actively support key initiatives delivered by others in our district.

To achieve this we will focus on the following key areas:

<table>
<thead>
<tr>
<th><strong>Secondary Care</strong></th>
<th><strong>Health Target:</strong></th>
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<tr>
<td>Continue to employ a dedicated Secondary Care Advisor to support sustained achievement of the secondary care target and a continual improvement in the proportion of patients receiving smoking cessation support.</td>
<td>- Provide, and/or resource Nurse Educators, Smokefree Champions and other clinical staff to provide ongoing best practice training, orientation training and refreshers.</td>
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<tr>
<td><strong>Overall target</strong></td>
<td>- Formalise the Smokefree Champions programme and ensure there is an identified Champion in all secondary care services.</td>
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<tr>
<td>95 percent of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking.</td>
<td>- Support and resource Smokefree Champions to promote commitment to Smokefree Best Practice</td>
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<tr>
<td><strong>Local target</strong></td>
<td>- Ensure there is an identified Smokefree lead in all secondary care services.</td>
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<td>A minimum of one-third of inpatients, and one-third of</td>
<td>- Audit and feedback processes including monthly target and referrals reporting and coordination about missed interventions.</td>
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<td>- Acknowledge top referrer of the month across secondary care services.</td>
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<td>- Continue to provide the three Annual Awards acknowledging Smokefree Best Practice.</td>
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<tr>
<td></td>
<td>- Continue to support Manukau Super Clinic modules and other satellite sites to implement Smokefree Best Practice.</td>
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</table>
other hospital services referrals will be for Māori, and one-third for Pacific.

| Support Charge Nurse Managers, Smokefree Champions and ward staff to develop and implement plans during the busy or winter months when occupancy rate is high to avoid increase in missed interventions. |
|Smokefree environments: |
| Review Smokefree hospital initiatives and update existing CM Health Smokefree policy to include vaping and other products that are not smoked (e.g. ‘heat not burn’ products). |
| Initiatives: |
| Adopt successfully trialled text triage system to engage with more people who smoke using a digital platform into BAU. |
| Utilise the evitals (patient track software used by wards and units in CM Health) as another referral pathway for inpatients. |
| Promote and strengthen the Smokefree support pathway for elective surgery patients. |
| Trial new initiatives in secondary services aimed at increasing access to Smokefree support for patients and whānau, visitors and staff. |

### Primary Care

Support PHO’s to sustain achievement of the target and continue to employ a dedicated Primary Care Advisor to support a continual improvement in the proportion of patients receiving smoking cessation support.

**Overall target**

90 percent of PHO enrolled patients who smoke have been offered help to quit smoking within the past 15 months.

SLM target: 10% increase in cessation activity in primary care.

| Focus on sustaining equitable target performance: |
| Meet with PHO partners monthly to support the PHOs to achieve MOH and SLM targets by assessing performance and sharing best practice ideas including issues with other PHOs through SLM meetings. |
| Disseminate best practice advice from MOH better help for smokers to quit Clinical Champion around target activity. |
| Using insights from the regionally conducted self-assessment forms completed by practice staff, develop training packages according to need focusing on utilisation of nurses and healthcare assistants, doctors and reception staff. |
| Continue to promote MOH smoking cessation e-module training. |
| Ensure that patient dashboards and prompts are used when patients attend practice visits. |
| Support practices to produce reports and undertake audits to help them track progress against MOH targets. |
| Provide support to practices with regular staff visits to discuss progress to date, share best practice with other practices, advise on cessation options and promote Smokefree services. |

**Focus on improving the rate of cessation support:**

- Dedicated Smokefree Advisor (Primary Care) is employed by CM Health to support PHO’s to improve the rate of cessation support, with a focus on Māori and Pacific. Activities include:
- Produce monthly reports regarding referrals to the local Smokefree service. Providing PHOs context on how many received and from which practices to help identify areas which may need further promotion.
- Through SLM reporting analyse PHO/practice performance in relation to cessation support and...
pharmacotherapy prescription rates to inform the provision of tailored support to prioritised practices.
- Work with PHO’s and visit practices to build referral relationships with local smoking cessation services.
- Through training and audit tools support practices to actively outreach to high priority groups e.g. pregnancy, post-natal, those prescribed cessation medication and offer a full range of support encouraging referrals to cessation support services.
- Based on the needs analysis deliver and/or coordinate regional Smokefree Best Practice training as approved by National Training service and any other relevant education opportunities e.g. CME sessions.
- Coordinate agreed pilot projects to increase access to cessation support.
- Continue to embed Smokefree support in clients’ primary care homes e.g. drop-in clinics or group based therapy in practice.
- Support Smokefree initiatives in general practice such as World Smokefree Day.
- Coordinate with other screening activity to deliver Smokefree messages (e.g. CVD risk assessments, cervical screening).
- Motivational Interviewing Training is offered to Primary Health Organisations.

**System Level Measures Improvement Plan Activities:**

Patient outcomes related to harm from smoking will be improved by:
- Continuing to focus on brief advice in primary care.
- An increase in referrals to cessation support.
- Support for the delivery of medication therapy in primary care.

The importance of smoking cessation as an intervention will be promoted by:
- Continued working with Cessation Providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services.
- Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS.
- Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation.

**Contributory measure:**
- An increase in cessation support received by enrolled patients who are current smokers by 10%.
- Metro Auckland Smoking Indicators (in development).
- Establish a baseline with a view to an increase in the proportion of smokers who receive medicines to support their cessation.
Maternity
Achieve and sustain the maternity target, with a focus on improving access to cessation support in pregnancy, particularly for Māori women.

Overall targets
90% of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.

95% of Māori wāhine are Smokefree at 2 weeks postnatal.

Development of contributory measures for System Level Measure of Smokefree Households for babies 6 weeks old.

Local target
75% of pregnant women who smoke are referred to cessation services (and 60% of Māori women).

Smokefree pregnancy strategy is integrated into wider SUDI prevention strategy alongside safe sleep programme and breastfeeding to support the following actions:

Health target:
- Continue to promote proactive referrals by Midwives to specialist Smokefree services.
- Review strategies and resources implemented in 2017/18 that increased referrals and continue those that were effective.
- Support training opportunities for Midwives and monitor training uptake (inhouse and e-learning tool).
- Take a targeted approach to addressing low referral rates within existing DHB and community services.
- Routinely receive and review list of missing NHIs for internal audits and reviews.
- Implement actions as decided by the Smokefree Households SLM working group and work with DHB system to obtain accurate data collection in 2018/19.

Partnerships:
- Work with DHB Maternity services manager to further integrate wellness services and develop streamlined holistic care for women—one care package offered including Smokefree, green prescription, antenatal classes, nutrition in order to connect all service supporting whānau.
- Collaborate with providers and community settings with high reach to pregnant women to increase delivery of Smokefree messages and referrals to specialist services.
- Work collaboratively with Well Child Tamariki Ora and other providers to deliver Smokefree interventions with whānau.
- Continue to work with health promoter to target promotional opportunities and dedicate more time to looking for pregnant women in the community, presenting to Māori organisations and workplaces.
- Collaborate with Māori providers to deliver Smokefree messages and increase referrals to specialist services. Ensure specialist smoking cessation services actively promote to Māori communities and generate self-referrals.

Communication:
- Promote the importance of reducing smoking prevalence in pregnancy, particularly for Māori, via newsletters, monthly meetings with self-employed midwives, seminars and internal communications.
- Showcase successful quitting stories with a focus on Māori and Pacific.

Initiatives:
- Continue to trial opt out system with one PHO and offer to other PHOs for pregnant women in priority localities.
- Trial opt out system with community midwives to increase referrals and engagement for pregnant women.
- Continue to implement recommendations of market research activity completed in mid-2015 in relation to pregnant women and whanau.
- Monitor provision and efficacy of Quickmist or any other new non-subsidised products for pregnant and postnatal women referred from primary birthing units and birthing ward at Middlemore hospital.
- Continue to run drop in clinics, trialling new times and locations to access as many Maaori waahine as possible.
- Continue delivering Pregnancy Incentives programme to the whole of Counties Manukau testing strategies to increase uptake of the programme including implementing an attendance incentive for the first assessment at a drop-in clinic and trialling increased incentive amount.
- Expand incentives programme to postnatal women, working with birthing units and postnatal midwives to reduce relapse rate to smoking post delivery.

<table>
<thead>
<tr>
<th>Community Health and Mental Health and Addictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support community health and mental health and addictions services to consistently address Smokefree so that service users receive consistent Smokefree messaging and consistent Smokefree care.</td>
</tr>
</tbody>
</table>
| - Continue to fund the dedicated local Smokefree community health and mental health resource with a focus on DHB and NGO mental health and addictions services and community health. **Key activities to include:**  
  - Support DHB and NGO mental health and community health services with development of service specific Smokefree plans that includes policy, systems, training, support options and champion development.  
  - Work with services to provide and document consistent Smokefree brief interventions.  
  - Provide Smokefree Best Practice and refresher training for staff, champions, and peer support specialists.  
  - Coordinate Smokefree activity across inpatient, community and NGO services.  
  - Improve access to local stop smoking services for service users, whaanau and staff via drop-in clinics, GBTs, Quit Bus visits etc.  
  - Develop resources to assist in the implementation of Smokefree activity.  
  - Implement key initiatives including incentives aimed at promoting quitting amongst service users/staff.  
- Monitor performance of the new stop smoking support initiatives, of which people with mental illness and/or addictions are an identified priority group.  
- Facilitate access to appropriate mental health and addictions and smoking cessation training for smoking cessation practitioners in the CM district.  
- Produce monthly reports regarding referrals to the local Smokefree service. Providing services context on how many received and from which services to help identify areas which may need further promotion. |
<table>
<thead>
<tr>
<th>Funding and Delivering Smoking Cessation Services</th>
<th>Deliver Stop Smoking Services that include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Māori and Pacific intensive stop smoking services, with a focus on improved reach, quality and effectiveness.</td>
<td></td>
</tr>
<tr>
<td>- Continue to deliver the DHB Triage and Specialist Smoking Cessation Service with a continued focus on improving the number of referrals and enrolments.</td>
<td></td>
</tr>
<tr>
<td>- Trial new promotional strategies to increase self-referrals to the DHB Triage Service including social media and social marketing avenues.</td>
<td></td>
</tr>
<tr>
<td>- Lead and coordinate the district-wide clinical supervision network for intensive stop smoking practitioners.</td>
<td></td>
</tr>
<tr>
<td>- Implement the key opportunities for smoking cessation activities identified in this plan.</td>
<td></td>
</tr>
<tr>
<td>- Refresh Master Record (Smokefree patient information system) to streamline referrals triage system and patient information.</td>
<td></td>
</tr>
<tr>
<td>- Increase number of staff completing Motivational Interviewing training to have effective Smokefree conversation to motivate clients to stop smoking.</td>
<td></td>
</tr>
<tr>
<td>- Set up Smokefree drop-in clinics in all CM Health localities.</td>
<td></td>
</tr>
<tr>
<td>- Develop baseline data for key Pacific and Asian populations.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smokefree Leadership</th>
<th>Health target:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Continue to lead Smokefree Best Practice through dedicated Smokefree Advisors for Primary, Secondary, Maternity and Mental Health/ Community Health Care.</td>
<td></td>
</tr>
<tr>
<td>- Constantly review all hospital and primary care Smokefree Best Practice systems and processes using developed internal audits and CQI to ensure maintenance of the Smokefree Health targets equitably for Māori and Pacific.</td>
<td></td>
</tr>
<tr>
<td>- Monitor the impact of incorporation of Smokefree requirements within the service specification for Māori Health Integrated Service agreements and introduce into other health service agreements.</td>
<td></td>
</tr>
<tr>
<td>- Develop an enhanced Smokefree clause for inclusion in all DHB contracts.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Workforce development:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Work with HR, Recruitment and Occupational Health to develop a project aimed at supporting a Smokefree workforce. Investigate feasibility of regional initiative.</td>
</tr>
<tr>
<td>- Become accredited NTS approved trainers of ABC Smokefree Best Practice.</td>
</tr>
<tr>
<td>- Increase the number of Smokefree champions within community to have brief conversations with people and refer them to CM Health stop smoking service.</td>
</tr>
<tr>
<td>- Coach and mentor students in relation to Smokefree 2025 through student placements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiatives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Improve coordination with existing DHB programmes and services to extend the reach of Smokefree support.</td>
</tr>
</tbody>
</table>
- Continue to support a strong Smokefree focus within key organisational initiatives.
- Explore engagement and referral pathways with Council and leisure centres.
- Continue to identify and trial new initiatives aimed at enabling more CM Health staff and their families to become Smokefree.

**Partnerships:**
- Support the implementation of Auckland Council’s Smokefree Policy and initiatives.
- Increase reach by leveraging off cross-functional relationships (Healthy Families, Cancer Society, ARPHS, HPA, Auckland City Council, Hapai).
- Establish linkage with Green Prescription team to cross promote free face-to-face Stop Smoking services.
- Engage with large employers that are located within the CM Health catchment area -aim for 12 employers to be approached.
- Actively participate in Regional Tobacco Integration Network (Regional-TIN) governance group.
- Collaborate with Māori and Pacific health teams to improve access to stop smoking support for whānau/ fanau.

**Young people**
- Replicate youth initiatives implemented previously with clear focus on tangible quit outcomes.
- Collaborate with Māori and Pacific workforce development initiatives and community providers to grow young Smokefree champions and identify smoking cessation training opportunities.
- Promote Smokefree at schools to target youth smoking.
### 6.4 Workstream Four: Evaluation and Monitoring

The focus of this workstream is to:
- Effectively monitor the impact of both the wider Smokefree programme and individual projects (with a focus on increased successful quitting)
- Evaluate and monitor innovation trials to determine impact and add to the knowledge base for what works
- Share learnings within the programme and across the sector to inform future activity.

We will focus on the following key areas:

| Evaluation and Monitoring | - Evaluate and monitor relevant key performance indicators for access to smoking cessation support across the district.
|                          | - Monitor relevant systems to enable capture of this data.
|                          | - Continue to invest time and resource where necessary in ensuring we can measure the impact of actions in this plan (e.g. collecting data about vaping)
|                          | - Evaluate the impact of new innovation trials using improvement methodology. |
Appendix One: Prevalence of Smoking in the Population Enrolled in Counties Manukau General Practices

Based on 2017/18 Q3 health target data, the estimated number of people who are recorded within the last 15 months in general practice as being ‘current smokers’ is 66,762. Of people who are enrolled in CM general practices and who smoke, one third are Maaori, 31% Pacific Peoples, and 36% are European, Asian and Other ethnic groups. Using the PHO enrolled population aged 15-74 as the denominator, the estimated prevalence of smoking is 19% overall. There are large inequities, with prevalence of smoking among Maaori estimated to be 41.5%, approximately four times the prevalence of ‘Other’ ethnic groups. Prevalence of smoking in people of Pacific ethnicities is estimated to be 25%.

Table 7. ‘Current smoking’ prevalence estimation from ‘Better Help for Smokers to Quit (Primary Care)’ health target, 2017/18 Quarter 3

<table>
<thead>
<tr>
<th>Q3 2017/18</th>
<th>Maaori</th>
<th>Pacific</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people recorded as smoking</td>
<td>21,935</td>
<td>20,608</td>
<td>24,219</td>
<td>66,762</td>
</tr>
<tr>
<td>Enrolled population aged 15-74 years</td>
<td>52,827</td>
<td>81,805</td>
<td>221,266</td>
<td>355,898</td>
</tr>
<tr>
<td>Estimated prevalence</td>
<td>41.5%</td>
<td>25.2%</td>
<td>10.9%</td>
<td>18.8%</td>
</tr>
<tr>
<td>% of enrolled population aged 15-74 years who smoke</td>
<td>33%</td>
<td>31%</td>
<td>36%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Sources: a) ‘Number of people who smoke’ is from ‘Better Help for Smokers to Quit (Primary Care) Health Target, 2017/18 Q3, denominator of Indicator 3: Brief Advice (denominator definition: “the number of PHO enrolled patients aged 15-74 years old who are current smokers (within the last 15 months)”, from Ministry of Health, based on reports submitted by PHOs and PHO enrolment dataset; b) ‘Enrolled population aged 15-74 years’ is from Q3 PHO enrolment dataset; c) Estimated prevalence is calculated from ‘Number of people who smoke’ (numerator) and ‘Enrolled population aged 15-74 years’ (denominator).
Appendix Two: Road Map – Smokefree Aotearoa 2025

**Government Goal**

**Healthier New Zealanders**
Fewer deaths and harm from tobacco use with focus on maximizing benefit for Māori and Pacific people

**Objectives**

- More Support for Quitting
  - All current smokers to quit

- Effective Policy
  - Control of tobacco supply, price and availability

- Reduced Initiation
  - No one, especially children, become addicted to smoking

**Outcomes**

- Increase in Quitting
  - Current smokers are motivated and enabled to quit and remain smokefree.

- Demand & Supply Reduction
  - Tobacco is difficult to supply and to purchase.

- Protection of Children
  - Children and young people are not exposed to smoking or to tobacco marketing.

**Impacts of Tobacco Control Sector Activities**

**Cessation**
- Increased tobacco control mass media.
- Comprehensive cessation services tailored to community needs
- Best cessation technologies and services used
- Policy response to electronic nicotine delivery systems

**Legislation & Regulation**
- Plain packaging
- Increase price of tobacco products
- Effective product warnings
- Restrict and reduce tobacco supply
- Control tobacco product content
- Full FCTC implementation

**Public Support**
- Expansion of smokefree settings, including smokefree cars
- New Zealanders know about and support 2025 goal
- Smokefree support increases
- New Zealanders completely mistrust the tobacco industry

**Research and Evaluation**
- Monitoring of tobacco use
- Monitoring of quitting behaviours and attitudes
- Evaluation of interventions
- Monitoring of industry
- Academic research

**Monitoring and Enforcement**
- Monitoring of retail outlets
- Enforcement of smokefree laws and regulations
- Monitoring of tobacco industry practices, incl. marketing

**Policy**
- Engage national decision makers
- Engage national influencers
- Review relevant existing and overseas laws
- Advise and inform policy processes

**Community Engagement**
- Local activities to make communities smokefree and protect children from exposure to tobacco
- Engagement with decision makers and media
- Raise local awareness of Smokefree 2025 goal

**Marketing**
- Unpaid Media/PR
- Paid Media
- Communications
- Signage
- Branding
- Events

**Working Together**

**Cessation**
- Interventions in primary, secondary and public health care
- All services evidence based
- Existing and emerging effective treatments funded
- Whānau ora
- Services to priority populations
- Innovative cessation methods are encouraged

**RESEARCH AND EVIDENCE**
Comprehensive research and evaluation to underpin policy, advocacy and programme development.
CM Health Living Smokefree Service Action Plan

Presentation to Community & Public Health Advisory Committee
10\textsuperscript{th} April 2019
Basil Fernandes & Sarah Sharpe
Smokefree work is a priority

• Smoking is one of the most significant preventable risk factors for premature death and morbidity.

• Key driver of inequities for Maaori and Pacific people.

• Smoking prevalence is reducing, but we are not on track to reach the Smokefree 2025 goal and stark inequities remain.
## Smoking prevalence

### ‘Daily smoking’ prevalence estimation from NZ Health Survey, 2014-2017

<table>
<thead>
<tr>
<th>Population group</th>
<th>Total (%)</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Estimated number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>13.6</td>
<td>13.8</td>
<td>13.5</td>
<td>55,000</td>
</tr>
<tr>
<td><strong>Age group (years)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-24</td>
<td>10.8</td>
<td>9.1</td>
<td>12.3</td>
<td>10,000</td>
</tr>
<tr>
<td>25-44</td>
<td>19</td>
<td>19.6</td>
<td>18.4</td>
<td>25,000</td>
</tr>
<tr>
<td>45-64</td>
<td>13.3</td>
<td>14.2</td>
<td>12.5</td>
<td>16,000</td>
</tr>
<tr>
<td>65+</td>
<td>6.8</td>
<td>7.5</td>
<td>6.1</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Ethnic group (total response)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>38</td>
<td>31.4</td>
<td>43.6</td>
<td>19,000</td>
</tr>
<tr>
<td>Pacific</td>
<td>20.6</td>
<td>22.1</td>
<td>19.5</td>
<td>18,000</td>
</tr>
<tr>
<td>Asian</td>
<td>4.2</td>
<td>7.2</td>
<td>1</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Neighbourhood deprivation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quintile 1</td>
<td>7.4</td>
<td>8.6</td>
<td>6.2</td>
<td>5,000</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>8.2</td>
<td>9.2</td>
<td>7.3</td>
<td>7,000</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>7.9</td>
<td>7.9</td>
<td>7.9</td>
<td>4,000</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>15</td>
<td>15</td>
<td>14.9</td>
<td>9,000</td>
</tr>
<tr>
<td>Quintile 5</td>
<td>21.6</td>
<td>21.4</td>
<td>21.9</td>
<td>30,000</td>
</tr>
</tbody>
</table>

Note: The Regional Data Explorer does not currently provide data for the ‘European/Other’ethnic groups.
Current Services
Achievements

- Organisational Commitment to Smokefree as a Major Population Health Priority
- Needs Analysis and Market Research
- One Stop Shop’ for Support to Stop Smoking: Connected Cessation Services
- Improving the Reach, Volumes and Performance of Stop Smoking Services
- Consistent Achievement of “Better Help For Smokers To Quit” Targets
- Workforce Development
- Collaboration
Living Smokefree Service Action Plan

**Goal:** The Living Smokefree Service will work with others to reduce smoking prevalence to less than 5% for all population groups by December 2025.

**Objectives:**

1. Explore and develop a Tobacco Free Generation (TFG) approach in CM.

2. Champion innovative approaches for smoking cessation and harm reduction, including supporting people who choose to use vaping products.

3. Strengthen smoking cessation support in primary, secondary, maternity, mental health, and community settings.
Tobacco-Free Generation (TFG)

- TFG is a proposed tobacco endgame strategy involving a legislated ban on provision of tobacco to those born from a set date onwards.
- Also used as a concept or approach.
- We are developing TFG approach in CM; key areas are:
  1. Smokefree pregnancies;
  2. Babies live in smokefree homes/whaanau;
  3. Young people are supported to be smokefree (i.e. to never start smoking);
  4. Young people who smoke are supported to quit;
  5. Promote cross-generational smokefree change.
Innovations, including vaping initiatives

• Use of vaping by people who smoke is growing at a rapid rate.
• Ministry of Health believes vaping has potential to contribute to Smokefree 2025 goal and could disrupt the significant inequities that are currently present.
• Vaping is significantly less harmful than smoking tobacco but is not completely harmless.
• We will be supporting people who choose to use vaping products for smoking cessation and harm reduction.
Innovations, including vaping initiatives

Key initiatives planned:

1. Review and update CM Health policy to allow for designated outside vaping areas within Middlemore Hospital grounds.
2. Upskill Living Smokefree Service staff and others to support clients/patients who choose to vape to quit.
3. Develop information for clients and provide support including group-based therapy for people who use e-cigarettes.
4. Engage with responsible vape vendors, share Living Smokefree Service information and encourage referrals for stop smoking support.
5. Explore and strengthen data sources for describing e-cigarette use in CM.
Strengthening core business

- We have a high performing and innovative team....however we all need to do more to reach the Smokefree 2025 goal.
- We are aiming to:
  - Double the number of referrals to our service.
  - Provide more support for health care practitioners to provide Smokefree ABC.
  - Increase access to smoking cessation medications.
Questions & discussion....

• Do you have thoughts and feedback about the TFG concept?
• Do you have thoughts and feedback about how we can support patients who choose to vape to quit?
• What are community perceptions of vaping?
Counties Manukau District Health Board
Community & Public Health Advisory Committee
Metro-Auckland Healthy Weight Action Plan for Children Progress Report

Recommendation

It is recommended that the CPHAC:

Receive this update report on the progress CM Health has made against the Metro-Auckland Healthy Weight Action Plan for Children

Note that this plan sits alongside the Healthy Auckland Together (HAT) Plan 2015 – 2020

Prepared and submitted by Amy Carter, Child Health Service Development Manager on behalf of Carmel Ellis, General Manager Integrated Child, Youth & Maternity and Margie Apa, CEO

Glossary

ARPHS - Auckland Regional Public Health Service
BMI - Body Mass Index
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
ESBHS - Enhanced School Based Health Services
GPs - General Practitioner
HAT - Healthy Auckland Together

Executive Summary

The Metro-Auckland DHB Healthy Weight Action Plan for Children was developed in accordance with our vision that “All Tamariki in the Auckland Region of New Zealand are of a healthy weight”. Health sector led actions were established in the plan, to contribute to the cross-sectoral response required to address childhood weight management. This update report informs progress made in the implementation of the plan for the period 1 July – 31 December 2018. Actions and indicators are presented by DHB and target population: women of childbearing age, pregnant women, infancy and pre-school/school aged children and adolescents.

Purpose

The purpose of the this report is to provide an update on progress CM Health has made against the Metro-Auckland DHB Healthy Weight Action Plan for Children during the period 1 July – 31 December 2018.

Background

This is the second update report on progress against the Metro-Auckland DHB Healthy Weight Action Plan for Children. The first report, documenting delivery against outcomes, was presented to CPHAC in August 2018. This follow on report details progress made in the period 1 July – 31 December 2018. Monitoring and reporting on the Healthy Weight Action Plan for Children will continue to occur at regular intervals, or as requested by CPHAC. For indicators that are already reported on elsewhere, information on progress toward meeting the indicator(s) is provided. For some individual programmes instituted as part of the plan, more rigorous monitoring and evaluation plans have been developed. For the next round of reporting the indicators will be reviewed and updated to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. The Action Plan will be
updated annually. In addition, annual monitoring of the current and future health of Aucklanders continues to be undertaken by HAT.

**Progress Update**

A summary of progress during Q1 and Q2 2018/19 is provided below. The full report is provided in Appendix 1.

**Highlights**

The following highlights have emerged during this reporting period. Note: the reporting cycle for this period is six months, compared with the reporting which covered a 12-month period.

- The National Healthy Food and Drink Policy is being successfully implemented across the three metro-Auckland DHBs; the implementation plan is on track. All ‘red’ items are due to be removed by April 2019.
- Green Prescription equity targets for enrolments for Māori and Pacific continue to be met.
- Culturally appropriate antenatal education is available which supports and promotes breastfeeding and healthy eating during pregnancy. Prioritisation of delivery to Māori, Pacific and Quintile 5 groups has resulted in 89% of participants in Pregnancy and Parenting Education being priority population.
- Three randomised controlled trials (TARGET, GEMS and HUMBA studies\(^1\)) related to healthy eating during pregnancy, including women with Gestational Diabetes Mellitus, are progressing well and are still on track.
- GPs, primary care and public health nurses, and healthcare workers have been trained across the region on having conversations about healthy weight with families with overweight children; Between pre- and post-training, the overall percentage of health professionals who were quite or very confident increased from 82% to 97%, with 55% of health professionals reporting increased levels of confidence. Importantly, health professionals who were least confident pre-training were the most likely to report increased confidence.
- We continue to exceed the health target, with 100% of children identified as obese at their B4 School Check being referred to a health professional.
- Te Rito Ora Breastfeeding Support Service continues to successfully engage with priority populations to provide intensive support to women to establish and continue breastfeeding. 231 women were supported by the Service during the reporting period and 846 home visits were provided.
- A regional growth chart solution for use in secondary care (Sysmex) has been implemented across the three DHBs and is receiving positive feedback.
- A health professional’s guide for oral health and healthy weight messages has been developed and is ready for publishing. Plans are in place to disseminate the guide.

**Risks and Issues**

The following risks and issues have emerged during this reporting period. Note: the reporting cycle for this period is six months, compared with the reporting which covered a 12-month period.

- There has been no progress since the last reporting cycle on the implementation of the National Healthy Food and Drink Policy for organisations in the community. This work is being led by ARPHS and Healthy Families NZ through Healthy Auckland Together (HAT).
- Referrals/enrolment of pregnant women into Green Prescription continues to be low. The current Provider’s contract is due to end in June 2019 and we are currently undertaking a procurement process to contract for this service going forward.

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\(^1\) GEMS: Gestational Diabetes Mellitus Study of Diagnostic Thresholds; Liggins Institute, the University of Auckland. Funder: HRC
TARGET: Optimal Glycaemic Targets for Gestational Diabetes: the randomised trial – TARGET; Liggins Institute, The University of Auckland. Funder: HRC
HUMBA: Healthy Mums and Babies Trial; Department of Obstetrics and Gynaecology, the University of Auckland. Funders: Counties Manukau Health, Cure Kids, Lottery Health Research, RANZCOG Mercia Barnes Trust, Gravida National Centre for Growth and Development, and the University of Auckland Faculty Development Research Fund and Reinvestment Fund.
- There has been an increase in the number family/whaanau of Maaori children, identified at their B4SC as being an unhealthy weight, declining a referral to primary care for clinical assessment. We continue to provide training opportunities for health professionals on having conversations about healthy weight with families with overweight children.
- There has been a small decrease in the number of children being referred through to whaanau focused physical activity and nutrition programme to support healthy weight. The provider continues to actively promote the service to WCTO providers and primary care, and undertake community outreach/engagement.

This second Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children presents an overview of activity during Q1&2. The Action Plan indicators have been developed collaboratively across the region, with consistency in data collection and reporting, where appropriate. The indicators will be reviewed and updated before the next round of reporting; updates will occur annually to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. Regular updates to CPHAC will continue. While many actions remain on track, it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole towards a healthy weight.
### APPENDIX 1 - Healthy Weight Action Plan for Children Reporting: Q1 and Q2 at January 2019

#### Women of Childbearing Age

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate access barriers to bariatric surgery for Māori and Pacific women of childbearing age</td>
</tr>
<tr>
<td>Time-frame</td>
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<tr>
<td>Jun-18</td>
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<tr>
<td>Pacific</td>
</tr>
<tr>
<td>Scope what an Adult Obesity Service (intensive lifestyle intervention Tier2-3 service) might look like as part of the bariatric pathway</td>
</tr>
<tr>
<td>Dec-17</td>
</tr>
<tr>
<td>Promote Green Prescription to primary care and identify and address barriers to primary care referrals</td>
</tr>
<tr>
<td>Jul-18, Jul-19, Jul-20</td>
</tr>
<tr>
<td>Pacific</td>
</tr>
<tr>
<td>Implement the National Healthy Food and Drink Policy in DHB-owned sites</td>
</tr>
<tr>
<td>Baseline audit Follow-up audits</td>
</tr>
<tr>
<td>Jul-18, Jul-19</td>
</tr>
<tr>
<td>Work with ARPHS and Healthy Families NZ through Healthy Auckland Together (HAT) to implement the National Healthy Food and Drink Policy for Organisations in the community.</td>
</tr>
<tr>
<td>Dec-18</td>
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<tr>
<td>Work with DHB contracted providers to support implementation of aligned healthy food and drink policies</td>
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<tr>
<td>Dec-18</td>
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## Pregnant Women

<table>
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<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority Popn</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure culturally appropriate antenatal education available to promote and support breastfeeding</td>
<td>On-going</td>
<td>Deliver contracted volumes of breastfeeding related programmes with 80% of services delivered to the priority populations (Māori, Pacific and Quintile 5)</td>
<td>Māori</td>
<td>On Track</td>
<td>On Track</td>
<td>Achieved/Complete</td>
<td>ADHB/WDHB: Culturally appropriate antenatal education is available which supports and promotes breastfeeding. Prioritisation of delivery to these identified groups is on-going. Healthy Babies, Healthy Futures groups also continue to provide this support to targeted groups postnatally. CM Health: 89% of participants at Pregnancy and Parenting Education were priority populations. 80% of women enrolled with Te Rito Ora Breastfeeding Support were priority populations. Between Jul-Dec ‘18, 231 women received in-home antenatal breastfeeding education.</td>
</tr>
<tr>
<td>Providing women and their families with key breastfeeding messages through textMATCH messaging, community promotion, and teaching practical skills for better nutrition and increased physical activity</td>
<td>On-going</td>
<td>% of 6-monthly target (450) and of people receiving textMATCH service</td>
<td></td>
<td>Jul-Dec ‘18: 114% (n=512) 2017-18: 93.6%</td>
<td></td>
<td></td>
<td>Data not reported per DHB. HBHF is looking into this in 2019. Note: 6 month reporting period this reporting cycle compared to 12 month reporting previous cycle.</td>
</tr>
<tr>
<td>Working with partners to engage with specific vulnerable community groups (Māori, Pacific, Asian, and South Asian)</td>
<td>Jun-18</td>
<td>% of 6-monthly target (400) and of mothers engaged in healthy conversations</td>
<td>Māori</td>
<td>Jul-Dec ‘18: 114% 2017-18: 102%</td>
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<td></td>
<td>Pacific</td>
<td>Jul-Dec ‘18: 113% 2017-18: 136%</td>
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<td></td>
<td>Asian</td>
<td>Jul-Dec ‘18: 203% 2017-18: 104%</td>
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<td></td>
<td>South Asian</td>
<td>Jul-Dec ‘18: 120% 2017-18: 104%</td>
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<tr>
<td>Further strengthen HBHF connections with maternity services, Kohanga reo, Churches and ECEs to increase access to the HBHF programme</td>
<td>Dec-17</td>
<td># of Community Learning Programme (CLP) groups held within community settings (6-monthly target: 24)</td>
<td></td>
<td>Jul-Dec ‘18: 35 2017-18: 13</td>
<td></td>
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<tr>
<td>Promoting HBHF to pregnant mothers at the earliest possible stage when engaging with DHB services</td>
<td>Dec-17</td>
<td>% of 6-monthly target (600) and of mothers given the opportunity to engage with a HBHF provider</td>
<td>Jul-Dec ’18: 172% (1034) 2017-18: 98%</td>
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<tr>
<td>Continue the development of Te Rito Ora service and B4 baby services which engage with women in antenatal period to support breastfeeding</td>
<td>Jun-18</td>
<td>70% women accessing the service will be fully/exclusive breastfeeding at 6 weeks (aligned to the WCTO indicator targets)</td>
<td>Achieved</td>
<td>67% breastfeeding rate at 6 weeks for women enrolled in Te Rito Ora antenatally</td>
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<tr>
<td>Incorporate referrals to Green Prescription and healthy weight gain in pregnancy conversations into existing Auckland Regional Health Pathways</td>
<td>Dec-18</td>
<td>Health Pathways updated to include referral options for pregnant women, e.g. Green Prescription (Y/N)</td>
<td>Partially achieved</td>
<td>Partially achieved</td>
<td>Partially achieved</td>
<td>The first iteration of changes has been made with the healthy weight changes in pregnancy resources now live on the Health Pathways website. Further changes regarding Green Prescription referral has been submitted to Clinical Editors for consideration</td>
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</tr>
<tr>
<td>Establish a baseline(1) and increase(2) referrals of pregnant women into Green Prescription for healthy weight management</td>
<td>Dec-18</td>
<td># pregnant women enrolled in Green Prescription</td>
<td>Jul-Dec ’18: 11 2017-18: n=52 Baseline (’16-’17) n=24</td>
<td>Jul-Dec ’18: 5 2017-18: n=13 Baseline (’16-’17) n=3</td>
<td>Partially achieved</td>
<td>CM Health: 9 referrals, however these are referrals with GDM only. We will continue to work with the provider to improve reporting. This has been led with implementation of a new reporting template for Q2. Note: 6 month reporting period this reporting cycle compared to 12 month reporting previous cycle.</td>
<td></td>
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<tr>
<td>Develop Pathway for management of pregnant women with high BMI</td>
<td>Dec-18</td>
<td>Pathway developed and implemented (Y/N)</td>
<td>Achieved</td>
<td>As per previous update, a guideline for the management of obesity in place. This guideline is currently being reviewed and updated. At this point it is not on Auckland Regional Health Pathways, however is being integrated into MCIS</td>
<td></td>
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<tr>
<td>Undertake research (RCTs) related to healthy eating during pregnancy and Gestational Diabetes Mellitus</td>
<td>Dec-20</td>
<td>Feedback from study Principle Investigator of the progress of the 3 studies:</td>
<td>See notes</td>
<td>See notes</td>
<td>See notes</td>
<td>TARGET: data collection complete. Data currently being analysed. GEMS: recruitment targets are being met. HUMBA: recruitment complete; results analysed; follow-up studies on-going.</td>
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</tbody>
</table>
**TARGET** (study on how GDM should be treated) Recruit women for multisite study

**GEMS** is a multi-site randomised controlled trial investigating how GDM should be diagnosed

**HUMBA** is a trial of dietary education and probiotics in overweight in South Auckland with the aim of reducing pregnancy weight gain

<table>
<thead>
<tr>
<th>Infancy</th>
<th>Time-frame</th>
<th>Measures</th>
<th>Priority Popn</th>
<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance the pregnancy and parenting education smartphone app and website to encourage all women, particularly Māori, Pacific and Asian, to breastfeed for at least the first 6 months of their baby’s life</td>
<td>Jun-18</td>
<td>% of Māori and Pacific women who breastfeed at 3 months (Target of 70% of babies are exclusively or fully breastfed at 3 months)</td>
<td>Māori</td>
<td>On Track</td>
<td>On Track</td>
<td>PP37. Note: website and app available, good feedback regarding utilisation from target groups for website. However, content and promotion of resource due for review.</td>
<td></td>
</tr>
<tr>
<td>Postnatal support through Titifaitama and Wahakura Wananga including peer support and breastfeeding support groups</td>
<td></td>
<td># who attend support groups</td>
<td>Māori</td>
<td>Achieved</td>
<td>Achieved</td>
<td>PP37.</td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>Achieved</td>
<td>Achieved</td>
<td>PP37. Healthy Babies, Healthy Futures provides Pacific support group postnatally. This includes health nutrition and breastfeeding.</td>
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<tr>
<td>Intensive post-natal support through Te Rito Ora service including peer support and home visits</td>
<td>Jun-18, Dec-18, 6-monthly report</td>
<td># of visits in 6 month period (Target - Kaitipu Ora Workers will engage with clients a minimum of 3x in Week 1 postnatally, and then weekly until Week 12)</td>
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<tr>
<td>Evaluate effectiveness of Auckland DHB breastfeeding community clinic and home visiting approach and integrate learnings into future efforts.</td>
<td>Mar-18</td>
<td>Build findings from evaluation into contract for the 17/18 financial year (Y/N)</td>
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<tr>
<td>Description</td>
<td>Status</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Ongoing Description</td>
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<tr>
<td>Community cooking courses to support pregnant woman and parents and whānau of 0-2 year olds to make healthy, affordable and culturally appropriate meals which meet the nutrition needs of pregnant women and infants and toddlers</td>
<td>Ongoing</td>
<td></td>
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<td>26 women completed the full course and of these 92% were priority populations</td>
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<tr>
<td>Enhance the training plan for GPs, nurses and other relevant health professionals to increase their confidence in having culturally appropriate conversations about child weight and healthy lifestyles with families.</td>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
<td>26 women completed the full course and of these 92% were priority populations</td>
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<tr>
<td></td>
<td>Achieved</td>
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<td></td>
<td>ADHB/WDHB: 98% of participants (up from 95% at last reporting) identified an increase in confidence with having conversations about healthy weight following the Raising Healthy Kids training sessions. Feedback from health professionals indicated that the most useful aspects of the training were the resources, BMI calculator, tips on how to start the conversation and goal setting. CM Health: Between pre- and post-training, the overall % of health professionals who were quite or very confident increased from 82% to 97%, with 55% of health professionals reporting increased levels of confidence. Importantly, health professionals who were least confident pre-training were the most likely to report increased confidence.</td>
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</table>

**ADHB/WDHB**: Auckland District Health Board/Waitakere District Health Board

**CM Health**: Counties Manukau Health
<table>
<thead>
<tr>
<th>Actions</th>
<th>Time-frame</th>
<th>Measures</th>
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<th>ADHB</th>
<th>WDHB</th>
<th>CMDHB</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen support for schools to implement healthy food and beverage policies by achieving an 80% adherence</td>
<td>Dec-19</td>
<td>WDHB/ADHB: 80% of contracted schools have a healthy food and drink policy. CM Health: Introduce a healthy food and drink policy in Mana Kids schools</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
<td>ADHB: WDHB: 83% of Enhanced School Based Health Services (ESBHS) schools have healthy food and beverage policies in place. The Nurse Educator is working with the remaining school to ensure an appropriate policy is put into place this year. ADHB: 50% of ESBHS schools have healthy food and beverage policies in place. The Nurse Educator and Youth Health Programme Manager are working with the remaining five schools to ensure appropriate policies are put into place this year. Next steps: review all school food / beverage policies, where possible, to ensure quality / adherence to MoH guidelines, including schools new to the Programme in 2019. CM Health: Planning is underway to introduce healthy food and drink policies across all schools by Dec '19.</td>
<td></td>
</tr>
<tr>
<td>In collaboration with HAT and Healthy Families NZ, engage intersectorally to support a gap analysis of healthy food environments in and around Kohanga reo, Pacific Language nests and ECEs to determine areas for future DHB support</td>
<td>Jun-18</td>
<td>Gap analysis complete</td>
<td>Achieved/ Complete</td>
<td>Achieved/ Complete</td>
<td>Achieved/ Complete</td>
<td>ADHB/WDHB: A dietitian has now been contracted to work on some of the recommended improvements identified in the gap analysis. CM Health: Continuing to work to establish relationship with Healthy Families.</td>
<td></td>
</tr>
<tr>
<td>Utilise INFORMAS survey results, along with information from the Heart Foundation, ARPHS and Healthy Families NZ sites to engage with high-priority ECEs and schools to support development and implementation of food policies and healthy food environments.</td>
<td>Jun-19</td>
<td># of ECEs and schools prioritised for support; # of ECEs and schools supported</td>
<td>7-8 ECEs</td>
<td>7-8 ECEs</td>
<td>On track</td>
<td>ADHB/WDHB: Approx 15 ECEs will receive initial support. Currently scoping out a separate programme for Kohanga Reo. CM Health: Healthy food and drink education incorporated into school health plans across Mana Kidz network. Analysis of available information to prioritise school engagement to commence in early '19.</td>
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</tr>
<tr>
<td>Contract a provider to deliver a whānau-focused physical activity, nutrition and parenting programme for pre-school children identified as being ≥98th centile, including a psychological component and development of specific approaches for Māori and Pacific populations</td>
<td>WDHB/ADHB</td>
<td># of children enrolled; # of Māori and Pacific children enrolled (baseline)</td>
<td>Māori</td>
<td>Achieved/Complete</td>
<td>Achieved/Complete</td>
<td>Achieved/Complete</td>
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<tr>
<td>ADHB/WDHB: The Positive Parenting and Lifestyle (PPAL) Programme was launched in July-18. Both providers are experiencing limited engagement of families attending the programme. A community/engagement plan has been developed and both DHBs are implementing a quality improvement approach. CM Health: Otara Health Charitable Trust deliver Active Futures to priority population groups - 75% of children engaged in the programme are Māori or Pacific.</td>
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<tr>
<td>ADHB/WDHB: # referred provided as opposed to # enrolled. CM Health: Total number of referrals (all ethnicities) = 92. Of this total, 41 children were enrolled (45%). Note: 6 month reporting period this reporting cycle compared to 12 month reporting previous cycle</td>
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<tr>
<td>Undertake communication activities to promote and familiarise primary care / WCTO partners with target</td>
<td>On-going</td>
<td>By December 2017, 95% of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions</td>
<td>Achieved</td>
<td>Achieved</td>
<td>Achieved</td>
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<td>ADHB/WDHB: Both DHBs have been exceeding the health target with 100% of children identified as obese being referred to a health professional. The bottom indicator of this section &quot;develop consistent health promotion messages...&quot; will be part of communication activities for primary care and WCTO partners. CM Health: Since Sept '16 100% of obese children identified in the B4SC programme have been referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions</td>
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<tr>
<td>Ensure referral process for referrals from B4 school provider to primary care for children with BMI&gt;98th centile is in place and all obese children are referred to primary care and that referral is acknowledged (electronic referral process in CM Health, paper based in ADHB/WDHB).</td>
<td>On-going</td>
<td>Percentage of declined referrals to primary care programmes</td>
<td>Māori</td>
<td>19%</td>
<td>17%</td>
<td>38%</td>
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</tr>
<tr>
<td>Pacific</td>
<td>8%</td>
<td>7%</td>
<td>19%</td>
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</tbody>
</table>

| Provide community, primary and secondary care training by dietitian on use of Be Smarter brief intervention and goal setting healthy lifestyles tool and other resources so health professionals are confident to initiate conversations with families and talk about healthy weight to enable families to be as healthy as they can be | On-going | # of training sessions delivered | Jul-18 to Dec-18: 85 people trained. Jan-18 to Jul-18: 31 people trained. Jul-16 to Jul-18: 83/138 GP practices received training | Jul-18 to Dec-18: 148 people trained. Jan-18 to Jul-18: 42 people trained. Jul-16 to Jul-18: 74/107 GP practices received training | 1 Jul 18 - 31 Dec 18: 60 people trained. 1 Jul-17 to 31 Jun-18: 369 people trained | Staff trained include: GPs, primary care nurses, Well Child Tamariki Ora staff, healthcare workers, Starship community staff (public health nurses), practice managers, Active Futures coordinators and clinical assistants. Note: 6 month reporting period this reporting cycle compared to 12 month reporting cycle previous cycle |
| ADHB/WDHB: Feedback from participants indicated training was a helpful starting point for childhood obesity management in primary care. In addition to this work more support is being provided to practices, including: regular updates on new resources, tools, information and MoH updates. There will also be regular engagement with all practices 1-year post training, offering further training/support (particularly practices with high numbers of children referred from the B4SC). |

<p>| Design and implement an evaluation of families and health professional engagement with Raising Healthy Kids referral pathway. | Dec-18 | Evaluation plan complete with recommendations (Y/N) | On Track | On Track | On Track | ADHB/WDHB: An evaluation framework was developed in collaboration with the Pacific and Māori Health Gain Teams. Framework includes both a... |</p>
<table>
<thead>
<tr>
<th>Task Description</th>
<th>Start Date</th>
<th>Details</th>
<th>Status 1</th>
<th>Status 2</th>
<th>Status 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the implementation of the regional growth chart solution for use in</td>
<td>Dec-18</td>
<td>An electronic growth chart is implemented in the metro Auckland DHBs</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
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<td>secondary care in metro Auckland DHBs</td>
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<td>Sysmex is now live and receiving good feedback. Good for regional visibility. Some idiosyncrasies due to different reference ranges, but this will be fixed in time.</td>
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<tr>
<td>Work with ARDS and the Northern Region DHBs to develop consistent health</td>
<td>Jun-18</td>
<td>Message alignment complete with 5 key messages agreed upon. Priority languages identified and translation services costed.</td>
<td>On Track</td>
<td>On Track</td>
<td>On Track</td>
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<td>promotion messages using the common risk factor approach for obesity and oral</td>
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<td>health</td>
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<td>Investigate translation into priority languages</td>
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<td>A health professional’s guide for Oral Health and Healthy Weight messages has been developed based on the Northland DHB guide. The final draft is currently being edited following feedback from the Northern Region Child Health Steering Group and will be ready for publishing by the end of Jan-19.</td>
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</tbody>
</table>
Scope the feasibility for a pilot to assess measuring weight and height at the year eight dental check. The aim is to facilitate collection of data for population level monitoring of trends and to feedback to parents information on their child’s weight and growth. This pilot could potentially assess:
- Consenting of children
- Impacts on clinic flow and staffing
- Scalability
- Data collection requirements and utility
- Communication of outcomes to parents
- Staff and consumer perspectives
- Identification of any adverse or unexpected outcomes
This would inform the assessment of whether this could be implemented across the region and the trade-off of costs compared to the potential impact of the information gained for children, their families and the sector as a whole.

<table>
<thead>
<tr>
<th>Dec-18</th>
<th>Pilot complete</th>
<th>At Risk</th>
</tr>
</thead>
</table>

Pilot has not been scoped due to other issues being worked through with ARDS and prioritisation of other pieces of work this reporting period.
To **STOP GOUT**

you need to bring your uric acid levels down.
Why do I get gout?

You might think that gout is caused by drinking too much beer and fizzy drinks and eating too much meat and shellfish. In fact, gout is caused by having too much of a chemical called uric acid in your blood.

Your body makes uric acid when you eat food. It is normal and healthy to have some uric acid in your body. Most people get rid of uric acid through their urine.

However, if you eat food, such as meat, seafood, beer, fizzy drinks and orange juice, your body can make too much uric acid.

How does gout affect you?

Gout can be a sign you could get diabetes, heart disease and kidney problems.

Gout can be very painful and can stop you doing all the things you enjoy. Gout can stop you playing sport and spending time with your family or whānau.

Gout can stop you feeling good about yourself and your life.
What causes your gout attacks?

If there is too much uric acid in your blood, the acid turns into crystals in your joints especially your toes, knees, elbows, wrists and fingers.

The crystals are very sharp, like needles, and your joint gets very sore and painful. This is called a gout attack.

Crystals can cause damage to your joints.

The crystals cause lumps which are called tophi (you say toe-fy). If tophi get too big they can make it hard for you to wear shoes, use a knife and fork, write and walk easily.
What causes high uric acid in your body?

80% of high uric acid is caused by your body not getting rid of uric acid properly. This could be because of:
- your genes
- your weight
- kidney problems

20% of high uric acid is caused by what you eat and drink.
How can you get rid of uric acid in your body?

You can get rid of 80% of uric acid by taking uric acid medicines everyday.

You can get rid of 20% of uric acid by:
- eating less seafood and meat
- not drinking beer, fizzy drinks and orange juice
- drinking water
- being active – walk, swim, go to the gym
- losing weight if you need to
Most people get rid of uric acid through their urine

Some people, including many Māori and Pacific people, get rid of some of their uric acid, and the rest stays in their blood.
Some uric acid medicines stop your body making too much uric acid

Some uric acid medicines help your body get rid of uric acid through your urine

How uric acid medicines help you

- Food
- Allopurinol
- Uric acid
- No uric acid crystals

- Food
- Probenecid
- Uric acid
- No uric acid crystals
# Medicines for gout

There are two types of medicines for gout:

## 1. Uric acid medicine

<table>
<thead>
<tr>
<th>Uric acid medicines bring your uric acid levels down. You need to take them every day.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common uric acid medicines are allopurinol and probenecid. There are other uric acid medicines as well.</td>
</tr>
<tr>
<td>You need to take uric acid medicine every day, even if you are having a gout attack. When you start taking uric acid medicines, you might get a gout attack. So make sure your doctor also gives you medicine to treat the pain from a gout attack.</td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
</tr>
<tr>
<td>Make sure you ask your doctor, nurse or pharmacist what the side effects of uric acid medicine could be and what you should do if you get side effects.</td>
</tr>
</tbody>
</table>

## 2. Gout attack medicines

<table>
<thead>
<tr>
<th>Gout attack medicines treat gout attacks. You take these medicines when you feel a gout attack coming on or if you are in pain.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common gout attack medicines are colchicine, prednisone, naproxen, diclofenac (Voltaren®) and ibuprofen.</td>
</tr>
<tr>
<td>Gout attack medicines only treat pain and swelling. Gout attack medicines do not stop gout because they do not bring your uric acid levels down.</td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
</tr>
<tr>
<td>Most gout attack medicines should not be taken for a long time. People with tophi may need to take colchicine for a long time.</td>
</tr>
<tr>
<td>Taking gout attack medicines all the time can cause side effects such as stomach problems.</td>
</tr>
<tr>
<td><strong>Always ask your doctor, nurse or pharmacist how long you should take your gout attack medicine for.</strong></td>
</tr>
</tbody>
</table>
Starting on uric acid medicine

Your doctor should start you on a low dose and slowly build up to a stronger dose. When you start on uric acid medicine you also need to take gout attack medicine. You will be taking two medicines.

1st medicine

Your uric acid medicine is called ____________________________

You take:

______ mg a day for _________________

______ mg a day for _________________

______ mg a day for _________________

______ mg a day for _________________

Remember, keep taking your uric acid medicine every day even if you get an attack. Tell your doctor or nurse if you get an attack. Stop taking uric acid medicine immediately if you get a bad skin rash. Tell your doctor or nurse immediately if you get a bad skin rash.

Take your uric acid medicine every day even if you get a gout attack.

2nd medicine

Your gout attack medicine is ____________________________

You take:

______ mg a day for _________________

______ mg a day for _________________

______ mg a day for _________________

______ mg a day for _________________

Remember, you shouldn’t take most gout attack medicines for a long time as they can cause stomach problems.
When you take uric acid medicine your target is to get your uric acid levels down to 0.36. You need to get your uric acid level checked regularly. You might need to take a stronger dose of your uric acid medicine if your levels don’t come down. If you have tophi you might need to get your uric acid levels down to 0.30 to get rid of your tophi.
Choosing the right shoe

If you get gout in your foot, try not to wear:

sandals  jandals  slippers  old shoes

These shoes don't support your feet properly when you are walking or standing. This can affect your balance and make your pain worse.

People with gout in their feet need to wear shoes that:

1. are comfortable (not too tight), so there is room if your foot swells up
2. have a wide toe to leave room for your sore toe
3. have laces or velcro so you can tighten or loosen your shoe
4. have a cushioned insole that supports your foot
5. have a deep heel so your foot fits into your shoe properly
6. have a small heel because high heels can cause problems with your feet, knees and legs
7. have a firm sole that is not worn.

You need to buy a good quality shoe but your shoes don’t have to be expensive.

If you are not sure about what shoes to buy, take this list with you and talk to the salesperson in the shop.
Ask your doctor, nurse or pharmacist

What is my uric acid level?

What else can I do to bring my uric acid levels down?

When do I need to get my uric acid level checked again?

This medicine doesn’t seem to be working for me – I am still getting gout attacks and my uric acid level isn’t going down. Can you talk to a rheumatologist or specialist nurse and ask them what else we can do?

Should I stop taking this medicine if I get side effects?

Do I need to get my heart and diabetes checked as well?

What can I say to my family so they don’t get gout?

What are the possible side effects from this new medicine?

When do I need to call you if I have any side effects?

Do I need to take more uric acid medicine to get my uric acid level down?

Want to know more about gout:

Health Navigator:
www.healthnavigator.org.nz/health-topics/gout/

Arthritis NZ: Phone: 0800 66 34 63 (freephone for cell phones and landlines)
www.arthritis.org.nz

This booklet was developed by Workbase Education Trust as part of a research project funded by the Ministry of Health. Workbase would like to thank the Māori Gout Action Group, Dr Peter Jones, Leanne Te Karu, Arthritis New Zealand and PHARMAC for feedback on this resource.
Counties Manukau District Health Board
Community and Public Health Advisory Committee
Resources Available to the Asian Community

Recommendation

It is recommended that the Executive Leadership Team:

Note the range of health resources available to the Asian Community.

Prepared and submitted by: Kitty Ko, Asian Health Advisor and Kate Yang, Executive Advisor Chief Executive’s Office on behalf of Gary Jackson, Director of Population Health

Purpose

Following a meeting with members of the Asian community, CPHAC requested an audit of health literacy resources available to the Asian community to be brought back to the committee, as well as an assessment on whether these resources are factually correct.

Summary

There are many resources for health literacy available online in languages utilized by the Asian communities of Counties Manukau Health. Appendix 1 lists key resources referring to local services, available publicly. These resources contain factually accurate information, although some contact information is outdated and some programmes have ceased.

Anecdotally, many members of the Asian community also refer to health literature from their home countries as well as those from other immigrant communities e.g., Canada and Australia. Further, chat forums using social media platforms such as We Chat (Simplified Chinese) and Kakao Talk (Korean) are common ways to obtain information about medical conditions and healthcare.

Appendix 1 lists the key resources available to the Asian communities of CM Health, their contents, and if the website is available to be viewed in other languages.
## Appendix 1. Table of health resources available to the Asian Community

<table>
<thead>
<tr>
<th>Source</th>
<th>Link</th>
<th>Non-English Languages Served</th>
<th>Type of resource</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Point</td>
<td><a href="https://www.healthpoint.co.nz/">https://www.healthpoint.co.nz/</a></td>
<td>Chinese, Korean, Vietnamese</td>
<td>Directory</td>
<td>Mental Health, Heart Disease, Medication Safety</td>
</tr>
<tr>
<td>WDHB Asian Health Services</td>
<td><a href="http://www.asianhealthservices.co.nz/Resources/Brochures-Publications">http://www.asianhealthservices.co.nz/Resources/Brochures-Publications</a></td>
<td>Chinese, Korean</td>
<td>Provider site</td>
<td>Brochures around healthcare services</td>
</tr>
<tr>
<td>Asian Quit Smoking Support</td>
<td><a href="http://www.comprehensivecare.co.nz">www.comprehensivecare.co.nz</a></td>
<td>Chinese and Korean</td>
<td>Provider site</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td>Kidney NZ</td>
<td><a href="http://www.kidneys.co.nz">www.kidneys.co.nz</a></td>
<td>Chinese</td>
<td>Information</td>
<td>Renal disease</td>
</tr>
<tr>
<td>Mental Health Foundation</td>
<td><a href="https://allright.org.nz/resources/">https://allright.org.nz/resources/</a></td>
<td>Chinese, Korean, Hindi, Nepali, Farsi</td>
<td>Information</td>
<td>Mental health</td>
</tr>
<tr>
<td>Asian Family Services</td>
<td><a href="http://www.asianfamilyservices.nz">www.asianfamilyservices.nz</a></td>
<td>Chinese, Korean, Hindi</td>
<td>Provider site</td>
<td>Resources on suicide prevention and anti-discrimination towards people with mental illness</td>
</tr>
<tr>
<td>Chinese New Settler’s Trust</td>
<td><a href="http://www.cnstt.org.nz/">http://www.cnstt.org.nz/</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>Able to arrange health workshop in Asian languages</td>
</tr>
<tr>
<td>Shanti Niwas Charitable Trust</td>
<td><a href="http://www.shantiniwas.org.nz">http://www.shantiniwas.org.nz</a></td>
<td>Hindi</td>
<td>Provider site</td>
<td>Able to arrange health workshop in South Asian languages</td>
</tr>
<tr>
<td>Korean Positive Ageing Trust</td>
<td><a href="https://sites.google.com/site/positiveagingcm/members/korean-positive-ageing">https://sites.google.com/site/positiveagingcm/members/korean-positive-ageing</a></td>
<td>Korean</td>
<td>Provider site</td>
<td>Social services, health promotion, activity for Korean elderly. Able to arrange health workshops in Korean language</td>
</tr>
<tr>
<td>Age Concern (Auckland &amp; CM)</td>
<td><a href="https://www.ageconcernauckland.org.nz/">https://www.ageconcernauckland.org.nz/</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>Service leaflets</td>
</tr>
<tr>
<td>Age Concern (National Office)</td>
<td><a href="https://www.ageconcern.org.nz">https://www.ageconcern.org.nz</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>EPOA leaflet</td>
</tr>
<tr>
<td>Disability Connect</td>
<td><a href="http://disabilityconnect.org.nz/resources/">http://disabilityconnect.org.nz/resources/</a></td>
<td>Chinese, Korean</td>
<td>Provider site</td>
<td>Lots of translated information available e.g. booklets, videos and service leaflets</td>
</tr>
<tr>
<td>Independent Living Services</td>
<td><a href="https://ilsnz.org/">https://ilsnz.org/</a></td>
<td>Chinese, Korean</td>
<td>Provider site</td>
<td>Service description video is available in Mandarin; although no translated material available online</td>
</tr>
<tr>
<td>Framework Trust</td>
<td><a href="http://www.framework.org.nz/">http://www.framework.org.nz/</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>Programme leaflets and some referrals forms were translated into Chinese (not available on line, need to ask)</td>
</tr>
<tr>
<td>Sae Woom Tor</td>
<td><a href="http://www.saewoomtor.org.nz/">http://www.saewoomtor.org.nz/</a></td>
<td>Korean</td>
<td>Information</td>
<td>MH info translated in Korean by Korean MH health</td>
</tr>
<tr>
<td>Source</td>
<td>Link</td>
<td>Languages Served</td>
<td>Type of resource</td>
<td>Content</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-----------------</td>
<td>------------------</td>
<td>---------</td>
</tr>
<tr>
<td>St John</td>
<td><a href="https://www.stjohn.org.nz/What-we-do/Community-programmes/Caring-Caller/">https://www.stjohn.org.nz/What-we-do/Community-programmes/Caring-Caller/</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>Asian Caring Caller Services has translated its leaflet into Chinese (not available online, need to ask)</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td><a href="https://www.youtube.com/results?search_query=Waitemata+District+Health+Board+Hindi">https://www.youtube.com/results?search_query=Waitemata+District+Health+Board+Hindi</a></td>
<td>Chinese, Hindi</td>
<td>Provider site</td>
<td>Videos are also available in Mandarin and English on how to access health services</td>
</tr>
<tr>
<td>Plunket</td>
<td><a href="http://www.plunket.org.nz">www.plunket.org.nz</a></td>
<td>Chinese</td>
<td>Information</td>
<td>Service leaflets in Chinese as well as information about Child &amp; Youth health</td>
</tr>
<tr>
<td>East Health Trust</td>
<td><a href="https://www.easthealth.co.nz/practices">https://www.easthealth.co.nz/practices</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>It lists the cost of all GP practices under East Health Trust; patients can make informed choices of which practice is cheapest. Also offers programme in Chinese and other Asian languages</td>
</tr>
<tr>
<td>East Auckland Chinese Network</td>
<td>WeChat platform</td>
<td>Chinese, Korean, Hindi, Japanese, Burmese, Gujarati, Punjabi, Thai, Vietnamese</td>
<td>Information</td>
<td>Health information relevant to Counties Manukau rohe</td>
</tr>
<tr>
<td>Arthritis NZ</td>
<td><a href="https://www.arthritis.org.nz/resources-and-information-pamphlets/">https://www.arthritis.org.nz/resources-and-information-pamphlets/</a></td>
<td>Chinese, Hindi</td>
<td>Information</td>
<td>Arthritis info e.g. diet and pain management</td>
</tr>
<tr>
<td>Vagus Centre (Chinese MH Consultation Services Trust)</td>
<td><a href="http://www.cmh.org.nz/Event.aspx">http://www.cmh.org.nz/Event.aspx</a></td>
<td>Chinese</td>
<td>Provider site</td>
<td>Counselling and Circle of Security programme</td>
</tr>
<tr>
<td>Totara Hospice</td>
<td><a href="http://www.hospice.co.nz/">http://www.hospice.co.nz/</a></td>
<td>Chinese, Hindi</td>
<td>Information</td>
<td>What Happens As We Are Dying leaflet is available in Chinese and Hindi (not available online, need to ask)</td>
</tr>
</tbody>
</table>
Notes from CPHAC Special Meeting: Hearing from the South Asian Community

Date: 27th March 2018 1.30pm-3.35pm
Venue: Saanjh Community Trust, 129 Kolmar Rd, Papatoetoe, Auckland 2013

What was said during the community meeting:

Older People’s Health

- A lot of older people won’t want to be admitted into hospital – is there an option to stay at home and be treated instead?
- Some people have had good experiences with Western medicine / hospitals in their home countries, but others have been traumatised. Can’t expect everybody to immediately trust doctors and hospitals.
- Bad experiences even in NZ with language barriers, miscommunication with staff and culturally inappropriate food been given. There are religious considerations and when food is brought from home, people are being told this food is not appropriate and food is rejected.
- Language barriers make people afraid of going into hospital e.g., what if they need to go to the bathroom and can’t explain this to the nurse? Language barriers while in the hospital with no family or interpreter available.
- If they absolutely must be admitted into hospitals, can they have a support person stay with them overnight? Usually the entire family is responsible for caring for the sick.
- Unintended consequences of busy clinicians trying their best, especially when there are language barriers.
- High blood pressure and diabetes are major issues with the elderly, who come from environments where they could burn off the calories from the high-fat, high-sugar diet to the relative sedentary lifestyle of New Zealand.
- Was professional and independent back home, but now dependent on younger children. Unable to get around by themselves as can’t drive or can’t speak English, and sometimes feel trapped at home.
- Home assessment takes too long. Elderly Indian people also work e.g., caring for grandchildren, doing housework, cooking and cleaning. So not being able to do this impacts on the whole family

Women’s Health

- South Asian women are shy and won’t present with complaints, especially if they think it may reflect badly on them e.g., domestic violence, children are being disobedient, husband is drinking
- Empowering women takes a lot of effort. DHBs need to educate, empower and find community champions
- Having female providers of similar ethnic origin often backfires e.g., when going for screening, Indian nurse asked her “would you feel more comfortable with somebody else” as she knew that there was a fear of gossip among Indian community
Diabetes and nutritionist services

- Are you planning on extending the number of dieticians in the community? Waiting too long on the waiting list, people getting anxious about what they can and can’t eat.
- What about dieticians from the same backgrounds as the people they serve? Told not to eat rice or roti so decided to just ignore the advice, as their diet is predominantly based on rice and roti and it’s too hard to change.
- Culturally considerate when recommending changes to diet e.g., in Indian culture, using less oil is considered being stingy.
- Younger people are unable to tell older members of the family what they can and can’t eat, as would be considered rude. They need support from clinicians backed by scientific evidence.

Alcohol and Other Drugs

- Alcohol is a big problem which affects our communities. Many people own liquor stores or bars where alcohol is easily available
- Alcohol has long term effects and can remain hidden for a long time. Need to raise awareness of the dangers of alcoholism.
- Alcohol abuse is also a driver of domestic violence and a lot of people won’t come forward as there are stigmas associated with it.

Other

- People want to try ancient remedies before going to Western alternatives, so by the time they come to the GP it may be quite late. Can doctors be more accommodating of wanting to try alternative therapies so that people can be honest and upfront, and perhaps get Western and ancient treatment at the same time?
- Need to bring across learnings from older settlements in the diaspora e.g., Canada, Surrey
- “Brown” people are treated differently in ED. Feel like being spoken in a different way. Nurses make assumptions
- Need to support more self-management as Asian people care about their health and are wanting to improve it
- Need culturally appropriate staffing and food in rest homes, where elderly Asians find it difficult to adjust
- If Airlines can give specific meals e.g., Jain, Hindi, etc. why can’t the Hospital? Can they work with external providers to ensure the food given is culturally and religiously appropriate for the patient?
- “Waiting times for elective surgery is... we will be in Heaven by then.”
- Optometry and dental care are too expensive.
- Customer service is lacking in the Hospital. Daughter-in-law won’t have another child due to the traumatic experience of dealing with a nurse in the Hospital with first born.
Community Hubs Update for CPHAC
February 2019

- Locality overview and opportunities
- Locality/Community Hub Developments and priorities including Southern corridor greenfield site(s)
Summary of Slides

1. Recap on original philosophy/vision for the localities
2. Strengths/Opportunities and Issues/Risks across all the Localities
3. Key Issues in each Locality
4. Purpose of the Locality-Community Hubs – how do they fit with NRLTIP?
5. Strengths/Opportunities and Issues/Risks for each Locality hub
6. Opportunity for the greenfield southern corridor
7. Next Steps
The original vision for localities was to integrate care across the system

Organising primary care, secondary care, and other health providers around the same local populations, and linking with other local social care providers

- Planning and coordinating services around a number of primary care practices in a geographical area enables primary care practitioners with specialist interests/skills to provide care for a larger population.

- Localities are a **logical and efficient** means to deliver a wider range of services closer to where people live and work, by shifting services to primary/community-based settings.

- Locality-based planning enables interaction with NGOs, health promotion services, local government and other community services that can support the improvement of health outcomes in that locality.

- There is potential for **sharing members of a scarce workforce** across a number of practices without decreasing efficiency.

- There is potential to **improve equity** by adapting services to take local issues into account.

Community model of care developments and complex case management of LTC’s is an integral part of Locality thinking and developments.
Convenient care close to home

Development of local communities to ground our work in place and help us to understand the local needs.

Otara & Mangere Locality

Of the 100,000 plus people living in this locality in 2013, almost 59,000 are Pacific and 17,500 Māori. Nearly 30% of residents are aged under 15 years. About 77% of people are living in areas of high socio economic hardship.

Franklin Locality

Our most rural locality with over 67,000 residents in 2013. Approximately 13% of people are aged 65 years and over, with a significant Māori population, making up about 17% of the residents living in Franklin.

Eastern Locality

Our second largest locality with over 146,000 residents in 2013. This includes more than 51,000 people of Asian ethnicities and over 18,000 people aged 65 years and over.

Manukau Locality

Our largest locality of over 181,000 residents in 2013. This includes almost 40,000 Pacific people, 42,000 Māori people and 41,000 people of Asian ethnicities. A quarter of the population are aged under 15 years. About 50% of people are living in areas of high socioeconomic hardship.

2013 population data
Different populations in our Localities

Based on ER population 2013, after the 2013 Census

Mangere/Otara ER Pop 2013 by ethnicity

Eastern ER Pop 2013 by ethnicity

Manukau ER Pop 2013 by ethnicity

Franklin ER Pop 2013 by ethnicity
<table>
<thead>
<tr>
<th>Opportunities/Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision:</strong> Localities are the ‘loci’ for shifting the emphasis from hospital provision to services delivered in the locality, preferably at home and with primary care support.</td>
</tr>
<tr>
<td>The overall model of care – cluster MDTs, place based pop health, proactive care, community hubs etc.</td>
</tr>
<tr>
<td>Flexibility to allow each Locality’s wider-stakeholder group develop at own pace</td>
</tr>
<tr>
<td>Each locality identifies its key priorities and establishes working groups e.g. Manukau (Manurewa) Alcohol Harm Minimization in collaboration with Family Success Matters, Franklin – children</td>
</tr>
<tr>
<td>ILOC teams in all Localities covering approx. 36 GP Practices (50% enrolled pop), 10 secondary schools, 20 ARC facilities, 2 Marae</td>
</tr>
<tr>
<td>Greater potential to contract with NGO and other providers for wider range of services and model of care provision</td>
</tr>
<tr>
<td>Utilising locality hubs/ facilities as enablers for integration</td>
</tr>
<tr>
<td>Potential to streamline operational management of DHB community teams and strengthen clinical leadership</td>
</tr>
<tr>
<td>DHB FTE allocated for individual Locality Nurse and Medical Leads - review roles</td>
</tr>
<tr>
<td>Regional Collaborative Community Care IT platform – potential to share record across providers and scheduling functionality for teams (Community Central) etc.</td>
</tr>
</tbody>
</table>
Strengths/Opportunities and Issues/Risks across the Localities

Issues/Risks

• Each Locality at a different stage in integration evolution and level of ‘self determination’ results in different opportunities presenting. No ‘one size fits all’

• Health Equity issues particularly around access to services – potential ‘post code lottery’ of service provision within DHB teams requires consistency of standards of care

• Lack of funding and resources devolved to the locality level mean co-designed initiatives are challenging to implement

• Need to align community based staff with our GP Practice clusters – needs to be more flexible than locality boundaries

• Evaluation and measuring the impact of the locality groups & the additional investment/attribution of benefits

• Place-based structures in tension with PHOs
Locality/Community Hubs
Original plan for networked models and hubs

- Plans to develop network of **6 Community Hubs** over next 10 years

- To provide necessary infrastructure and resources to support delivery of a **greater range of services in the community** - focus on services that are outside the typical scope of general practice or require centralised volume to be viable in a community-setting.

- Each Hub will link to clusters of general practices in the surrounding geographical area.

- Provide setting to support the interaction between health, social and disability providers
Community hubs as part of the health service delivery network

Drivers:

• Growing and ageing population in all localities
• Reduce demand on ED, Manukau Super Clinic and Middlemore Hospital (bend the demand curve)
• Support from the community
• Leveraging Locality capability that already exists in Community Hub sites e.g. urgent care clinics, radiology, pharmacy, Labs, therapies, private specialists and PHO services

Opportunities:

• Create a model which focuses on reducing inequities in health outcomes
• Put patient experience at the centre - improve patient experience
• Provide holistic care across primary, secondary and social continuum
• Provide a one-stop shop for community to access the care and support they need
• Deliver services closer to home/improving access to local health and social services (youth health, elder services, etc.)
• Leverage off new technologies in delivering care closer to home
• Improve integration and collaboration across primary - community, secondary and social service providers
• Focus is strategic - planning and funding new models of care rather than annual contracting, monitoring and reporting
• Capacity – land and buildings available for expansion and reconfiguration to support integration and maximise utilisation.
NRLTIP’s delivery model describes delivering care through an integrated, collaborative network of primary, community and hospital based healthcare settings where the patient is put at the centre of our wider healthcare system.


Emphasis is on places, populations and systems rather than organisation. Intention to develop new models of care across professional and organisational boundaries.

Hub strategy will be different in each Locality based on local population need, pre-existing local service models, service mobility needs, operating models, existing ownership models of facilities/buildings and optimal service location.

Different potential ownership models: DHB be a tenant within a hub, DHB own the land and buildings, or public private JV.

Southern corridor provides opportunity for green field development of new hub(s) dependent on future site of South Auckland Hospital.

Will require development of a community radiology/diagnostics plan to support hubs.
Community Hubs and their Interface with Secondary Services

Question
What determines which services should go into a hub and which should go into Manukau Health Park

Community Hubs X 6

Manukau Health Park
(Ambulatory Elective Centre)

Middlemore Hospital

ADHB - Green Lane
Community hubs as part of the health service delivery network

High level schematic to illustrate potential model

- **Primary Care**
  - General Practice
  - Community Pharmacy
  - Dental
  - Primary Mental Health services
  - Radiology
  - Laboratory Services
  - Community nursing

- **Social Care**
  - Work and Income (WINZ)
  - Ministry of Social Development (MSD)
  - Citizens advice Bureau

- **Secondary Care**
  - Specialist Paediatrics
  - Well child services
  - Sexual Health
  - Diabetes care
  - Mental Health

Individual services operate as teams within the hub rather than individual providers within a building.
### Specific Existing Hub Opportunities and Issues

**Manukau Locality**

<table>
<thead>
<tr>
<th>Strengths/Opportunities</th>
<th>Issues/Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>'blank piece of paper’</td>
<td>Site(s) remain unconfirmed/unidentified</td>
</tr>
<tr>
<td>Explore opportunity to work with NZ Housing Development entities to develop new hub on</td>
<td>Clusters: Manukau/Papatoetoe, Manurewa/Clendon, Papakura/Takanini but could</td>
</tr>
<tr>
<td>‘brown field’ site similar to Tamaki Redevelopment Company and ADHB plans</td>
<td>include Manukau Health Park</td>
</tr>
<tr>
<td></td>
<td>Need confirmation of South Auckland new hospital location as may affect Papakura</td>
</tr>
<tr>
<td></td>
<td>requirements</td>
</tr>
</tbody>
</table>
Mangere Community Hub

- 7 clinic rooms (planning for 10)
- 900 patient consultations/month. 20% FSA
- 94% occupancy. 16% DNAs
- Diabetes - SMO, NP, CNS and Health Psychology
- Renal - SMO, NP, CNS and Dietician
- Rheumatology – SMO & NP
- Neurology SMO
- Respiratory – SMO and NP Sleep clinic
- Gastro – SMO & NP
- Cardiology - NP
- Stroke clinic - SMO
- Podiatry – Secondary & Locality
- Long acting removable contraception (LARC) clinics
- Retinal Screening
- CMH Midwives
- Cervical screening
Otara Community Hub

112 Bairds Road, Otara. Owned by Ngati Tamaoho Trust

- 6 clinic rooms, 80% occupancy
- 370 patient consults/month
- 25% FSA. 15% DNAs
- Diabetes - NP, CNS and Health Psychology
- Renal - CNS and Dietician
- Rheumatology - CNS
- Dermatology (infectious diseases) – CNS
- Respiratory – CNS and NP
- Sleep clinic
- District Nurse Clinic (full time)
- Public Health Nurse (Ear clinic)
- Podiatry – Secondary & Locality
- Retinal Screening
- CMH Midwives
- Cervical screening
- No SMO clinics
- No after-hours clinics
### Mangere - Otara Locality

**Strengths/Opportunities**
- Popular location for services – currently oversubscribed for the space available (Mangere & Otara)
- Well situated to support the focus on equity (Mangere & Otara)
- Other providers moving into vicinity – e.g. birthing unit (Mangere)
- Availability of facility infrastructure (Mangere)
- Health facilities landlord willing to develop infrastructure for CM Health (Mangere)
- Local transport improvements planned
- A long-term replacement for the Otara Hub may be procured in collaboration with the Ngati Tamaoho Trust (current Landlord) who is looking at a new build option in 10-15 years (Otara)

**Issues/Constraints**
- Currently operating as a co-location model. Potential not being fully realised. Not managing care collectively regardless of organisational boundaries.
- 1 building (6 Waddon Place) require renovation in long-term – old building (Mangere)
- Urgent replacement radiology equipment required (Mangere)
- Facility constraints (Otara)
East Locality – Botany Super Clinic

Botany Services

• Botany Super Clinic Specialist services
• Mercy Radiology
• Lab Tests
• Audiology
• Dental (private)
• Handworks & Fracture Clinic
• Physiotherapy
• Pharmacy
• East Care Urgent Care Centre 24/7
• CMH Community Health
• Specialist wound management
• Specialist ostomy & continence
• Maternity
• Private specialists incl. Auckland Eye
• Starship outpatients
## Specific Hub Opportunities and Issues

### East Locality

#### Strengths/Opportunities

- DHB owns **some** of the land and buildings – potential for facility infrastructure development
- Local providers keen to develop infrastructure in collaboration with CM Health
- Fast developing hub – integrated planning with PHO & Urgent care provider
- Botany Super Clinic has outpatient ambulatory care services as well as Urgent Care, PHO, MH, Community Health, radiology Labtests, maternity services + specialist private services
- Room to develop site further

#### Issues/Constraints

- Complex ownership model (Botany Super Clinic)
- DHB facilities not fit for purpose
## Franklin Locality

### Strengths/Opportunities
- DHB owns land and buildings, Pukekohe Hospital – but may not be in the right place
- Waikato DHB keen to work with CMDHB on new model of care
- Local private provider development in Pukekohe – opportunity for JV and re-think of hub model

### Issues/Constraints
- Space constraints and clinical model at Pukekohe unsustainable for 8-10 years until South Auckland Hospital commissioned
- Current inpatient palliative care model not sustainable in long-term
- Need clarity over hub model if South Auckland Hospital ‘10 minutes’ down the road
New hub opportunities in South Corridor working with Waikato DHB

- Potential green field site for hub development – but need to know where South Auckland hospital to be located

- Need to develop hub specification – difficult when unsure of what the population characteristics will be

- Primary Care Provider Policy development required which is designed to encourage individual providers to join the integrated hub as the population grows to meet the demand rather than establishing small services in the vicinity which potentially will be in competition. ADHB/WDHB keen to work with us on joint policy approach

- ADHB taking a RoI approach (asking primary care provider) to co-design health hub. Could we do something similar?
Next steps

• Take paper to Board to re-affirm the Community Hub strategy and place in wider development of MMH and Manukau Health Park

• Prioritise community hub development – which sites?

• Link directly with work on planning Manukau Health Park

• Work with ADHB on Primary Care Policy to ensure provision and location of primary/community care services (GP/pharmacy/radiology etc.) to a scale required and in the right place

• Work up detailed plans for priority Community Hubs (Mangere has some immediate needs)

• Need to plan service provision in new greenfield site and existing southern hubs agnostic of DHB boundaries (Waikato DHB & CMDHB)

• Identify resources within DHB for work identified above
6.0 Resolution to Exclude the Public

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Mental Health & Addictions NGO Workshop | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)] |