Community and Public Health Advisory Committees Meeting

Wednesday, 29th April 2015
2.00pm

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

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

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

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

---

**Creator and Spirit of life**

To the ancient realms of the Creator

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

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

Well Being to All.
AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES (CPHAC) MEETING
29th April 2015

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna

COMMITTEE MEMBERS
Gwen Tepania-Palmer – Committee Chair (WDHB and ADHB Board member)
Lester Levy - ADHB and WDHB Board Chair
Max Abbott - WDHB Deputy Chair
Jo Agnew - ADHB Board member
Peter Atkin - ADHB Board member
Judith Bassett – ADHB Board member
Pat Booth - WDHB Board member
Chris Chambers - ADHB Board member
Sandra Coney - WDHB Board member
Warren Flasunty - Committee Deputy Chair (WDHB Board member)
Lee Mathis - ADHB Deputy Chair
Robyn Northey - ADHB Board member
Christine Rankin - WDHB Board member
Allison Roe - WDHB Board member
Elsie Ho - Co-opted member
Rev Featunai Liuaana – Co-opted member
Tim Jelleyman - Co-opted member

MANAGEMENT
Dale Bramley - WDHB, Chief Executive
Ailsa Claire - ADHB, Chief Executive
Debbie Holdsworth - ADHB and WDHB, Director Funding
Simon Bowen - ADHB and WDHB, Director Health Outcomes
Naida Glavish - ADHB and WDHB Chief Advisor, Tikanga
Paul Garbett - WDHB, Board Secretary

Apologies: Debbie Holdsworth
Leave of Absence: Pat Booth

AGENDA

KARAKIA

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

PART 1 - Items to be considered in public meeting

2.00pm  (please note agenda item times are estimates only)

1 AGENDA ORDER AND TIMING

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Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 29/04/15
Auckland and Waitemata District Health Boards  
Community and Public Health Committees  
Member Attendance Schedule 2015

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* absent  
* attended part of the meeting only  
^ leave of absence  
# absent on Board business  
+ ex-officio member
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<tr>
<th>Committee Member</th>
<th>Involvements with other organisations</th>
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| Lester Levy      | Chair - Auckland District Health Board  
|                  | Chairman - Auckland Transport  
|                  | Independent Chairman - Tonkin & Taylor  
|                  | Chief Executive - New Zealand Leadership Institute  
|                  | Professor of Leadership - University of Auckland Business School  
|                  | Trustee - Well Foundation (ex-officio member)  
|                  | Director - Orion Health Ltd (includes Director – Orion Corporate Trustee Ltd)  
|                  | Member – State Services Commission’s Performance Improvement Framework Review Panel  
|                  | Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology  
|                  | Patron - Raeburn House  
|                  | Advisor - Health Workforce New Zealand  
|                  | Board Member - AUT Millennium Ownership Trust  
|                  | Chair - Social Services Online Trust  
|                  | Board Member - The Rotary National Science and Technology Trust  
| Max Abbott       | Jo Agnew  
|                  | Professional Teaching Fellow - School of Nursing, Auckland University  
|                  | Trustee Starship Foundation  
|                  | Casual Staff Nurse - ADHB  
| Peter Aitken     | Pharmacist  
|                  | Shareholder/Director, Consultant - Pharmacy Care Systems Ltd  
|                  | Shareholder/Director - Pharmacy New Lynn Medical Centre  
| Judith Bassett   | Nil  
| Pat Booth        | Consulting Editor – Fairfax Suburban Papers in Auckland  
| Chris Chambers   | Employee - Auckland District Health Board (wife employed by Starship Trauma Service)  
|                  | Clinical Senior Lecturer- Anaesthesia Auckland Clinical School  
|                  | Associate - Epsom Anaesthetic Group  
|                  | Member - ASMS  
|                  | Shareholder - Ormiston Surgical  
| Sandra Coney     | Elected Member - Chair: Waitakere Ranges Local Board, Auckland Council  
| Warren Flaunty   | Member - Henderson - Massey and Rodney Local Boards, Auckland Council  
|                  | Trustee (Vice President) - Waitakere Licensing Trust  
|                  | Shareholder - EBOS Group  
|                  | Shareholder - Green Cross Health  
|                  | Director - Westgate Pharmacy Ltd  
|                  | Chair - Three Harbours Health Foundation  
|                  | Director - Trusts Community Foundation Ltd  
| Lee Mathias      | Chair - Counties Manukau District Health Board  
|                  | Chair – Unitec  
|                  | Director – Health Innovation Hub  
|                  | Director – healthAlliance  
|                  | Director – healthAlliance FPSC  
|                  | Managing Director - Lee Mathias Ltd  
|                  | Trustee - Lee Mathias Family Trust  
|                  | Trustee - Awamoana Family Trust  
|                  | Director - Pictor Ltd  
|                  | Director - John Seabrook Holdings Ltd  
|                  | Chair - Health Promotion Agency  
|                  | Director - IAC IP Ltd  
|                  | Advisory Chair - Company of Women Ltd  
|      |  
|  
| Robyn Northey    | Project management, service review, planning etc - Self-employed Contractor  
|                  | Board member - Hope Foundation Northern Region  
|                  | Trustee - A+ Charitable Trust  

Auckland and Waitemata DHBs’ Community and Public Health Advisory Committees Meeting 29/04/15
### Register of Interests continued...

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<tr>
<th>Name</th>
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<tr>
<td><strong>Christine Rankin</strong></td>
<td>Member - Upper Harbour Local Board, Auckland Council</td>
<td>17/05/13</td>
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<td>Director - The Transformational Leadership Company</td>
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<td>CEO - Conservative Party</td>
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<td><strong>Allison Roe</strong></td>
<td>Member - Devonport-Takapuna Local Board, Auckland Council</td>
<td>02/07/14</td>
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<td>Chairperson - Matakana Coast Trail Trust</td>
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<td><strong>Gwen Tepania-Palmer</strong></td>
<td>Chairperson - Ngatihine Health Trust, Bay of Islands</td>
<td>10/04/13</td>
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<td>Life Member - National Council Maori Nurses</td>
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<td>Alumni - Massey University MBA</td>
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<td>Director - Manaia Health PHO, Whangarei</td>
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<td>Committee Member - Lottery Northland Community Committee</td>
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<td><strong>Elsie Ho</strong></td>
<td>Associate Professor - School of Population Health, University of Auckland</td>
<td>03/09/14</td>
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<td>Member - Waitemata DHB Asian Mental Health and Addiction Governance Group</td>
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<td>Member - Problem Gambling Foundation of New Zealand Advisory Board</td>
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<td>Trustee – New Zealand Chinese Youth Trust</td>
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<td><strong>Rev Featunai Liuaana</strong></td>
<td>To be advised.</td>
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<td><strong>Dr Tim Jelleyman</strong></td>
<td>Member - Active Clinic Network for Greater Auckland Integrated Health Network</td>
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<td>Chair - Child Health Network, Northern Regional Health Plan</td>
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<td>Honorary Clinical Lecturer - Faculty Medicine and Health Sciences, University of Auckland</td>
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<td>Member-Board of Kaipara Medical Centre</td>
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2.1 Confirmation of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 18\textsuperscript{th} March 2015

Recommendation:

That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 18\textsuperscript{th} March 2015 be approved.
Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 18 March 2015

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 2.02 p.m.

COMMITTEE MEMBERS PRESENT:

Gwen Tepania-Palmer (Committee Chair) (ADHB and WDHB Board member)
Max Abbott (WDHB Board member)
Jo Agnew (ADHB Board member)
Peter Aitken (ADHB Board member)
Judith Bassett (ADHB Board member)
Chris Chambers (ADHB Board member)
Sandra Coney (WDHB Board member)
Warren Flaunty (Committee Deputy Chair) (WDHB Board member)
Robyn Northey (ADHB Board member)
Elsie Ho (Co-opted member)
Rev Featunai Liuaana (Co-opted member)
Tim Jelleyman (Co-opted member)

ALSO PRESENT:

Dale Bramley (WDHB, Chief Executive) (present until 3.30p.m.)
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Simon Bowen (ADHB and WDHB, Director Health Outcomes)
Stuart Jenkins (ADHB and WDHB, Clinical Director, Primary Care)
Andrew Old (ADHB, Chief of Strategy/Participation & Improvement)
Paul Garbett (WDHB, Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Lynda Williams, Auckland Womens Health Council
Tracy McIntyre, Waitakere Health Link
Tanja Binzegger, Health Link North
Wiki Shepherd-Sinclair, Health Link North
Kate Moodabe, Total Healthcare PHO
Anna Mrkusic, New Zealand Nutrition Foundation

APOLOGIES:

Resolution (Moved Jo Agnew/ Seconded Robyn Northey)

That the apologies from Lester Levy, Pat Booth, Lee Mathias, Christine Rankin Allison Roe, Ailsa Claire and Tim Wood be received and accepted.

Carried
PRAYER: Rev Liuaana led the meeting in prayer, including for the people of Vanuatu, suffering from Cyclone Pam.

DISCLOSURE OF INTERESTS
There were no additions or amendments to the Interests Register.
There were no declarations of interests relating to the open agenda.

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 Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 04th February 2015 (agenda pages 7-16)
Resolution (Moved Tim Jelleyman/Seconded Robyn Northey)
That the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 04th February 2015 be approved.
Carried

Resolution (Moved Jo Agnew/Seconded Judith Bassett)
That the Public Excluded Section of the Minutes of the Auckland and Waitemata District Health Boards’ Community and Public Health Advisory Committees Meeting held on 04th February 2015 be approved.
Carried

Matters Arising (agenda page 17)
No issues were raised.

3 DECISION ITEMS
3.1 Alliance Diabetes and Cardiovascular Disease Clinical Indicators and Measures (agenda pages 18-28)
Jagpal Benipal (Senior Programme Manager – Primary Care, Auckland and Waitemata DHBs), Dr Catherine McNamara (Diabetologist/Physician, Waitemata DHB) and Dr Stuart Jenkins (Clinical Director, Primary Care, Auckland and Waitemata DHBs) presented this item.
The Committee Chair commented on the excellent results being achieved in primary care for cardiovascular and diabetes targets.

Jagpal Benipal introduced the report, including noting that 22 indicators had been selected for the intervention logic model, but priority is to be given to five of them, as described in the report. The aim is to monitor diabetes treatment performance across the health sector and optimise progress in improving the health of people with diabetes and CVD and in reducing the prevalence of these conditions in the population. The report had been endorsed by the Alliance Leadership Team.

In response to a request made at the meeting, the intervention logic model used will be shared with Tim Jelleyman (and any other Committee members requesting it).

Catherine McNamara advised that she was pleased with the decision to prioritise and move ahead on the five indicators. Proactive screening and quality information around those indicators can reduce a lot of the complications that cause problems for people with diabetes.

Matters covered in discussion and response to questions included:

- An explanation was supplied of the term “triple therapy” (combined medication of aspirin, a statin and a blood pressure lowering agent given on discharge from hospital to CVD patients, with recommendation for continued use).
- In answer to a question, Catherine McNamara advised that Indicator 13 is in line with the current Ministry of Health guidelines.
- Debbie Holdsworth commented that this is an extremely significant and vital piece of work which has been embraced regionally and has the full support of all the PHOs in the region. She acknowledged all the work that had gone into it.
- With regard to Indicator 10 referring to attendance at DSME courses, the question was raised of how this relates to the SME courses based on the Stanford model and used by Procare. Some patients who had attended the SME course thought that they did not need to attend a DSME course. Catherine McNamara confirmed that it is recommended that patients attend the DSME course which is a diabetes specific programme that they are trying to match to the requirements of the population being served.
- Sandra Coney raised the issue that a certain amount of research indicated that medication used to reduce CVD risk may have different effects and side effects for women and men. In response Catherine McNamara commented that gender is a factor in initial risk assessment, with CVD often occurring at an earlier age in men than in women. However people with diabetes are at three times the risk of cardiovascular disease than the general population and because of that high risk, women with diabetes are treated much like men in terms of medication for CVD risk.
- With regard to triple therapy for CVD for people who do not have diabetes, Catherine McNamara advised that the Ministry of Health is looking at the question of adverse effects from statins. The current position is that if someone has a five year CVD risk of over 15%, this is considered high risk and the benefits of being on statins are considered to outweigh the risks of side effects. Dale Bramley confirmed that there has been evidence of increased risk of diabetes (for men as well as women) from use of statins and the FDA had put out a comment on that. At the same time they had commented on benefits outweighing that risk.
- With regard to high risk feet, Catherine McNamara advised that a risk assessment tool determines what the risk for feet is. Every diabetes patient should have an...
annual check for this. It is a work in progress to achieve this. Above a certain risk level, patients qualify for referral for free podiatry treatment.

- Warren Flaunty raised a concern from his experience as a pharmacist. Triple therapy involves aspirin of 100mg which has the possibility of causing gastric bleeds. Lower dose aspirin is available but unfortunately is not funded and therefore not prescribed. A lot of people had experienced gastric bleeds and are paying for 75mg aspirin themselves. The Committee asked that Catherine McNamara look at that issue.

The Committee Chair acknowledged and thanked those involved in this project and in ongoing work on diabetes and CVD, including the NGOs, health links and Maori, Pacific and Asian consumer input. She encouraged them to keep up the good work with this “work in progress”.

**Resolution (Moved Peter Aitken/Seconded Jo Agnew)**

That the Community and Public Health Advisory Committee:

a) Receives the report.

b) Notes that the diabetes and cardiovascular disease clinical indicators and measures have been endorsed by the Waitemata and Auckland District Alliance Leadership Team and Metro Auckland Clinical Governance Forum.

c) Endorses the proposed 22 diabetes and cardiovascular disease clinical indicators and measures.

d) Notes the focus on five prioritised indicators.

**Carried**

### 3.2 Waitemata and Auckland DHB Suicide Prevention and Postvention Action Plan 2015-2017

(agenda pages 29-47)

Manu Fotu (Programme Manager Suicide Prevention - Mental Health and Addictions, Waitemata and Auckland DHBs), Mike Butcher (Allied Health Director, Mental Health and Addictions, Auckland DHB), Murray Patton (Clinical Director Mental Health Services, Waitemata DHB), Jean-Marie Bush (Mental Health and Addictions Portfolio Manager, Auckland and Waitemata DHBs), Anna-Marie Frost (Committee Co-ordinator Child Youth Mortality Review, Auckland and Waitemata DHBs), Karl Snowden (Profile Manager, Maori Health Gain, Auckland and Waitemata DHBs) and Theresa Rongonui (Youth Health Programme Manager, Auckland and Waitemata DHBs) were present for this item.

Manu Fotu introduced the report, including noting:

- The expectations from the Ministry of Health.
- The New Zealand Suicide Prevention Action Plan’s emphasis on co-ordination with other agencies.
- Representation from both DHBs on this project, and acknowledgement of Simon Bowen for chairing meetings and providing leadership.
- The key role of the Advisory Committee, with its representation from many sectors (shown on page 35 of the agenda) in putting this plan together.
Murray Patton spoke about the Plan, commenting that it had a very broad set of actions. A key issue is that the factors driving suicide rates are many, including issues not classically seen as health issues, for example employment, financial problems, bullying at school. The approach needed was a very broad one, involving multi-agency contributions. The role of the DHB was in facilitating this process and helping build capacity. The Plan spans a number of years and many aspects will take a long period of time to achieve. Outcomes may be medium term rather than short term.

Jean-Marie Bush commented that there is existing data, but they want to get much better data collected and analysed, particularly for understanding trends. It is clear that there are some high risk groups such as young Maori and the aging population, but there is more to be learned.

Anna-Marie Frost noted that New Zealand has the second highest suicide rate among OECD countries for both males and females in the 15-24 age group. In researching these deaths it is often found that a family member or a cousin has previously committed suicide. Postvention is very important.

Matters covered in discussion and response to questions included:

- The coroner defines whether a death is a suicide or not. There are cases where the most likely cause of death is suicide but where that is not certain.
- Anna-Marie Frost advised that in about 20% of cases of self-harm, that person goes on to commit suicide. Murray Patton commented that certainly they are interested in rates of self-harm as part of the appraisal of suicide risk; those people who repeatedly self-harm are definitely of greater risk. There are also a number of accidental deaths as a result of self-harming.
- With regard to the two sets of data: coronial data and Ministry data, Murray Patton advised that the coronial data is more timely but includes deaths that look like they were the result of suicide and many of these cases the coroners don’t ultimately confirm as suicide. The official data provided in the Ministry of Health reports is provided annually but is five year aggregated data to smooth out year by year fluctuations. This data is of course less sensitive to change as well.
- Tim Jelleyman commented that it was great to see this work coming together and made a plea for explicit linkage with the Children’s Action Plan. He noted the linkage with early risk factors, particularly relating to the social development of the child.
- There is a focus group in the Advisory Group which is discussing evaluation process.
- Max Abbott spoke from experience over many years of the importance of commitment and a lot of energy if initiatives like this are to succeed.
- Simon Bowen acknowledged the contribution Manu Fotu had made in just three months with the DHB. He had brought a lot of expertise, energy and vigour to this area in such a short space of time.
- The importance of involvement in the greater social context was discussed, for example the issue of music videos encouraging suicide. In discussion it was suggested that some measures could be approached via inter agency collaboration, however others required Government support and possibly legislation. It was noted that the DHBs have pursued some national issues previously, for example the legal highs issue. Any underlying issues that the Suicide Prevention Advisory Committee considers it will be useful for the DHBs to take action on, including possibly at a national level, are to be brought back to CPHAC for consideration.
- Dale Bramley commented that he was really pleased to see this paper arrive; a hundred people across the two DHBs take their lives every year and the devastation
left behind is enormous. Necessarily the actions proposed are very broad; the evidence base is not strong.

- In answer to a question, Murray Patton advised that because of how suicide and self-harm are reported, it is difficult to know for sure how many deaths of people who have been engaged with Mental Health Services are due to suicide. His rough estimate would be that probably up to half of suicides have been engaged with Mental Health Services.

- The issue of certain locations (such as particular bridges, reserves, train tracks) being popular sites for suicide was raised. Murray Patton confirmed that there is evidence that making such spots more difficult for suicide attempts can make some difference, for example the history with the Grafton Gully Bridge. It was agreed as an action that information be collated on where suicides are occurring and any clusters identified and that an approach then be made to the Council about what could be done by it to minimise the likelihood of suicide attempts in those places.

- Mike Butcher advised that a significant amount of work had been done at Auckland DHB to provide information, support and training about suicide to school guidance counsellors, including providing strategies for discussion with students. He also commented that there is an epidemic of self-harm, with many young people using this as a way of expressing their feelings. The school setting is the primary place for addressing that.

- Rev Featunai Liuaana commented that he would have liked to see more tables in the report pertaining to the two DHBs and including breakdown by ethnicity, so that the situation can be related back to the Action Plan.

- It was suggested that some GPs do play an important role in the prevention of suicide. Elsie Ho noted that for some Asian communities there is a stigma attached to revealing that you have been thinking about suicide. A GP who is sensitive to picking up signals can play an important role.

- Robyn Northey spoke of the importance of postvention; a suicide in the family has a huge impact on other members. Murray Patton noted that there are two elements in postvention; helping reduce the risk of contagion and helping relieve the suffering of family members.

The Committee Chair concluded the discussion by providing some key messages, including:

- The important of listening to groups of younger people on this issue and getting their views on how the issue should be managed and responded to.
- Her experience with a group of young people in Northland who are making a positive difference by conveying the message that suicide should not be a first step, come and talk.
- Particular locations do attract suicide attempts and that issue needs to be looked at.
- There is the impact of the digital age; messages (including negative videos, music etc.) are coming to young people continuously, everywhere. That needs to be taken into account.
- Technology cannot be under-estimated. It would be worthwhile seeing what could be done in partnership with major technology players such as Microsoft and Vodafone. She would like to see that suggestion looked at and brought back to the Committee.
- As Max Abbott had pointed out, a great deal of drive and energy will be needed if progress is to be made. A courageous approach needs to be taken. There may be a need for a reallocation of resources and development of new partnerships.
Resolution (Moved Jo Agnew /Seconded Robyn Northey)

That the Community and Public Health Advisory Committee:

a) Note the Ministry of Health requirement that the Auckland and Waitemata DHBs submit to it a draft district suicide prevention and postvention plan by 20 April 2015.

b) Endorse the draft district suicide prevention and postvention plan attached as Appendix 1 to this paper.

c) Subject to any suggested amendments from the Community and Public Health Advisory Committee, agree that the draft district suicide prevention and postvention plan attached to this paper as Appendix 1 be submitted to the Ministry of Health on or before 20 April 2015.

Carried

It was noted that the above decision was unanimous.

4. INFORMATION ITEMS

4.1 Mental Health and Addictions Quarter 2 Update on 2014/15 Actions (agenda pages 48-58)

Jean-Marie Bush (Mental Health and Addictions, Portfolio Manager), Lee Reygate (Mental Health and Addictions, Portfolio Manager) and Manu Fotu (Programme Manager, Suicide Prevention – Mental Health and Addictions) were present for this item. An apology was conveyed from Cate Wallace.

Jean-Marie Bush introduced the report, noting that improved reporting was a highlight of it.

Lee Reygate outlined the current review of support hour models with NGOs (pages 49-51 of the agenda). The concern from the NGOs is that the support hours approach may focus too much on the hours delivered rather than quality.

Lee Reygate also referred to the reporting on employment and housing indicators included in the report. The report from the Auckland and Waitemata DHBs’ Mental Health Employment Project will hopefully be available in early April and is attracting a lot of interest from the Ministry of Health.

Matters covered in discussion and response to questions included:

- With regard to the calculation of face to face time for support hours, it was confirmed that face to face time does include travel time to and from the appointments. Part of the concern about quality expressed by the NGOs is that there does need to be time to prepare for interviews.
- Work is underway to improve Mental Health reporting alignment with the Provider Arm.
- With the Ranui Social Sector Trial it was difficult to get an accurate picture of progress because of differences in data that the Police, social services and the DHB collect. Anecdotally, people there are seeing support services more often and more positive activity is taking place.

3.30p.m – Dale Bramley retired from the meeting.
Further matters discussed included:

- There was a discussion about the need for reliable data to evaluate programmes. Simon Bowen confirmed that for any programme put in place they want a good robust mechanism to evaluate how it is doing. This needs to be balanced with the cost of collecting data – a proportionate response is needed. Where something is being done with less certainty as to what it will achieve, there needs to be clear evidence of the outcome. Debbie Holdsworth confirmed that a strong evaluative philosophy operates. Lee Reygate noted that the Ranui trial has some unique features including data being kept by a number of parties. This made it more difficult to evaluate than normal.

- Max Abbott advised that the latest national health survey contained some good news: a huge reduction in smoking; a reduction in use of alcohol amongst young people; and a significant reduction in problem gambling.

The Committee Chair thanked the team involved in producing this report.

Resolution (Moved Jo Agnew/Seconded Chris Chambers)

That the report be received.

Carried

5. STANDARD REPORTS

5.1 Primary Care Update Quarter 2, 2014/15 (agenda pages 59-78)

Jagpal Benipal (Senior Programme Manager Primary Care, Auckland and Waitemata DHBs) and Dr Stuart Jenkins (Clinical Director Primary Care, Auckland and Waitemata DHBs) were present for this item.

Jagpal Benipal introduced the report. Matters that he highlighted included:

- Results against the national health targets (pages 60-65 of the agenda). For the better help for smokers to quit target for Primary Care, Waitemata DHB was the top performing DHB in the country and Auckland DHB the second. Other targets are also being met.

- With the Integrated Performance Incentive Framework data (pages 65-68 of the agenda), in future DHB Shared Services will provide a quarterly report by DHB and by ethnicity.

- With the Annual Plan deliverables (pages 69-75 of the agenda) the Alliance Leadership Team is meeting monthly to deliver on a number of these issues.

Stuart Jenkins referred to progress with the Locality Projects (pages 73-75 of the agenda).

Matters covered in discussion and response to questions included:

- Warren Flaunty advised that over 200 pharmacists had met the previous evening to discuss the Community Pharmacy Services Agreement and they are very discontented with what is happening.

- The issue of the low number of POAC referrals for Auckland and Counties-Manukau DHBs (page 71 of the agenda) was raised. Stuart Jenkins advised that there was a significant variation between practices in the utilisation of POAC. Debbie Holdsworth
noted that they are trying to get better data related to the utilisation of POAC. They intended to review and report back. She would come back with a time frame for that.

- The Cervical Screening rates (pages 66-67 of the agenda) were raised. Sandra Coney noted that targets had been in place for 25 years, but were still not being completely met. She suggested that this really required greater scrutiny. Karen Bartholomew advised that there are two viewpoints: from the PHO perspective as presented here and from the DHB viewpoint. She will provide tables in the Child, Women and Family quarterly report to the next CPHAC meeting. There had been an upward trend and improved results since 2002. A wide range of measures are in place to support this. From the DHB perspective there are women not enrolled in primary care and there had been a lot of work with independent providers.

The Committee Chair thanked the Primary Care team for the report.

Resolution (Moved Sandra Coney/Seconded Max Abbott)

That the Community and Public Health Advisory Committee receive the report.

Carried

5.2 Planning, Funding and Outcomes Update (agenda pages 79-88)

Simon Bowen (Director Health Outcomes) and Debbie Holdsworth (Director Funding) presented this report. Aroha Haggie (Acting Manager Maori Health Gain), Craig Heta (Portfolio Manager, Maori Health) and Karen Bartholomew (Public Health Physician) also participated.

Matters that were highlighted or updated included:

- The Health Needs Assessments had been well received by the two Boards.
- Both DHBs’ Annual Plans were submitted to the Ministry of Health on 13 March. They are awaiting feedback from the Ministry, which will be reported to a future CPHAC meeting.
- A new section on Auckland Regional Public Health service activity had been included in the report (pages 86-88 of the agenda).
- Good progress with implementing the Ethnicity Data Audit Tool (page 83 of the agenda) with 66% of general practices having implemented to date. However this is not the only area that needs to be focused on in addressing the broader target of enrolment of Maori in primary care.
- The Healthy Babies Healthy Futures programme is progressing well (page 83 of the agenda). Providers are working to slightly different models which respond to the needs of Maori, Pacific and Asian communities.
- Progress with Pacific Health Gain (pages 84-86 of the agenda).

The Committee Chair thanked the authors of the report, acknowledged the work being done in Maori Health, and also asked that an acknowledgement from the Committee of the work being done in Pacific Health be passed on to that team by the Managers.

A request was made for a broader understanding of the context of the issues that ARPHS is submitting on (page 86 of the agenda). Simon Bowen will arrange for brief summary
information on what the context is and the issue submitted on for future Planning, Funding and Outcomes update reports.

Resolution (Moved Max Abbott/Seconded Jo Agnew)

That the Community and Public Health Advisory Committee receive the report.

Carried

6. General Business

There was no general business.

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

The meeting concluded at 4.00p.m.
## Actions Arising and Carried Forward from Meetings of the Community and Public Health Advisory Committees as at 20th April 2015

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPHAC 05/02/14</td>
<td>3.1</td>
<td>Healthy Eating and Physical Activity – request to ARPHS to bring back a report to CPHAC on opportunities for interventions in the promotion of products that influence levels of obesity.</td>
<td>William Rainger</td>
<td>CPHAC 29/04/15</td>
<td>Report 4.1 on this agenda.</td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.1</td>
<td>Rheumatic Fever Programme Evaluation/Public Nurse Role in Schools – that the regional evaluation results for the rheumatic fever programme be reported back to the Community and Public Health Advisory Committee when available and that the public/community health nurse role in schools and the appropriate model of care related to that then be reviewed by the Committee.</td>
<td>Ruth Bijl</td>
<td>CPHAC 10/06/15</td>
<td>Will provide an interim evaluation report with options for further evaluation at the June meeting.</td>
</tr>
<tr>
<td>CPHAC 04/02/15</td>
<td>4.2</td>
<td>Child, Youth and Women’s Health Scorecard – Breast feeding rates at six months to be put back in the Scorecard.</td>
<td>Ruth Bijl</td>
<td>CPHAC 29/04/15</td>
<td>Included in report 4.2 on this agenda.</td>
</tr>
<tr>
<td>CPHAC 18/03/15</td>
<td>3.1</td>
<td>Alliance Diabetes and Cardiovascular Disease Clinical Indicators and Measures - Intervention Logic Model to be shared with Tim Jelleyman (and any other members requesting it). - Issue with triple therapy of aspirin of 100mg being funded but not 75mg to be looked at.</td>
<td>Jagpal Benipal</td>
<td>CPHAC 10/06/15</td>
<td>Actioned – forwarded to Tim Jelleyman</td>
</tr>
<tr>
<td>CPHAC 18/03/15</td>
<td>3.2</td>
<td>Suicide Prevention and Postvention Action Plan - Any underlying issues that the Suicide Prevention Advisory Committee considers it will be useful for the DHBs to take action on, including possibly at a national level, to be brought back to CPHAC for consideration. - Information to be collated on where clusters of suicides are occurring and an approach to then be made to the Auckland Council about what it could do to minimise the likelihood of suicide attempts in those places. - To consider the role of technology as part of the Suicide Prevention Plan and the possibility of partnerships with major technology players.</td>
<td>Manu Fotu</td>
<td></td>
<td>See note below.</td>
</tr>
<tr>
<td>CPHAC 18/03/15</td>
<td>5.1</td>
<td>Primary Care Update – more information on the issue of under-utilisation of POAC to be brought to CPHAC. Time frame for doing this to be advised.</td>
<td>Debbie Holdsworth</td>
<td>CPHAC 10/06/15</td>
<td>Analysis has been initiated.</td>
</tr>
</tbody>
</table>
Planning, Funding and Outcomes Update
– with ARPHS section of the report to include in future reports a brief summary of context of submissions and issues submitted on.

<table>
<thead>
<tr>
<th>CPHAC 18/03/15</th>
<th>5.2</th>
<th>Simon Bowen</th>
<th>Actioned – included from April report.</th>
</tr>
</thead>
</table>

Note: Suicide Prevention and Postvention Action Plan (from Manu Fotu)

Draft plan submitted to the Ministry in April. These issues raised by CPHAC will be given ongoing consideration until the Plan is finalised and implemented from July.

The Suicide Prevention Advisory Committee is proposing that the following priority areas will be the focus for the next two years:

- Development of the Suicide Prevention and Postvention Inter-agency Working Group
- Development of a centralised suicide and self-harm data collection process for the two DHBs
- Workforce development including primary care focusing on at risks clients and postvention support.
3.1 Draft Tobacco Control Plan 2015-18

Recommendation

That the Community and Public Health Advisory Committee:

a) Note the Ministry of Health requirement that the Auckland and Waitemata DHBs produce a Tobacco Control Plan for 2015-18, based on national guidelines.

b) Approve the draft Tobacco Control Plan attached as Appendix 1 to this paper, which the Funder submitted to the Ministry of Health on 31 March 2015 for feedback.

c) Subject to any suggested amendments the Community and Public Health Advisory Committee may have, agree that the draft Tobacco Control Plan be finalised on the basis of Ministry of Health feedback, and re-submitted to the Ministry of Health on or before 31 May 2015.

Prepared by: Leanne Catchpole (Programme Manager - Primary Care Team), Patricia Bolton (Public Health Physician), Sarah Gray (Public Health Physician), Sally Hughes (Project Manager - Primary Care Team), Maria Lafaele (Project Manager - Primary Care Team), Tracy Walters (Business Analyst - Māori Health Gain Team) and Lifeng Zhou (Epidemiologist, Health Outcomes Team)

Endorsed by: Tim Wood (Deputy Director Funding), Aroha Haggie (Manager Māori Health Gain), Dr Debbie Holdsworth (Director Funding) and Simon Bowen (Director Health Outcomes)

Glossary

CPHAC    -  Community and Public Health Advisory Committee
DHB      -  District Health Board
MOH      -  Ministry of Health
NGO      -  Non-Government Organisation

1. Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on progress against the draft Tobacco Control Plan for 2015-18 for Auckland and Waitemata District Health Boards (DHBs). The draft Plan is attached to this report as Appendix 1.

The Funder has completed a thorough needs analysis, review of evidence and stakeholder engagement process to develop the draft Plan. The content of the draft Plan has been completed in accordance with Ministry of Health’s (MOH) guidance. The draft Plan has been submitted to the MOH for feedback, and the Funder is required to submit a final copy of the plan to the MOH by 31 May 2015.

The Committee is asked to approve the draft Plan, subject to any amendments it proposes be made.

Auckland Waitemata DHBs Community and Public Health Advisory Committees Meeting 29/04/15
2. Background

Smoking is the single most modifiable risk factor causing disease and death in our community. This is particularly so for our Māori and Pacific populations, resulting in a significant reduction of quality of life and years of life. Māori and Pacific women also have high rates of smoking in pregnancy. Reducing these rates will lead to improved maternal and neonatal outcomes.

The Government has set a goal of ‘Smokefree Aotearoa 2025’. The measure of achievement for this goal is that the rate of smoking in New Zealand is 5% (or less) of the population by 2025. To progress towards SmokeFree Aotearoa 2025, an interim goal of 9% smoking by 2018 has also been set. District Health Boards (DHBs) have a key role in supporting the achievement of these goals and the overarching SmokeFree vision. Waitemata and Auckland DHB will not meet these goals for Māori and Pacific populations with a business as usual approach. Therefore, the Plan proposes that a number of additional actions be undertaken to support the realisation of these goals for priority population groups. Priority population groups identified through the planning process include:

- Māori
- Pacific
- Pregnant women
- Mental health and addiction clients

The MOH has contracts with both Auckland and Waitemata DHBs for tobacco control activity and some quit smoking support services. Through the tobacco control contracts, DHBs have been resourced to lead, coordinate and develop tobacco control activities and meet the ‘better help for smokers to quit’ health targets. The DHB tobacco control contracts therefore also allow for the strengthening of relationships and for finding better ways of working between communities, primary and secondary care.

The MOH requires all DHBs to have Tobacco Control Plans for 2015-18, and has specified guidelines on the content. Draft plans were submitted to the MOH on 31 March. The MOH will feedback to DHBs on their plans. DHBs are required to submit the final version of their plans to the MOH by 31 May 2015. The MOH has advised DHBs to focus the content of their plans on the 2015-16 year and to review and update each plan by July 2016 for the following year.

3. Activity / progress

Auckland and Waitemata DHBs started planning for the Tobacco Control Plan in July 2014 with the completion of a population needs analysis. A series of three stakeholder workshops were held between August and November 2014. The workshops were attended by approximately 60 representatives from the DHBs, PHO and NGO representatives. The workshops covered the following topics:

Workshop One

- Presentation of demographic and high level service information
- Identification of service issues and gaps
- Presentations from other providers / DHBs on successful innovative initiatives
- Presentation from researchers on recent evidence
Workshop Two

- Presentations from researchers and providers on innovative approaches
- Discussion by sector area on potential actions to include in the tobacco control plan
- Development of logic model and vision statements

Workshop Three

- Further refinement of the proposed actions, logic model and vision statements

The development of Auckland and Waitemata DHBs’ Plan has been overseen by a Steering Group that has reviewed and prioritised the actions to include in the plan. Many of the actions that were proposed in the workshops and have not made it into the plan will be completed as operational activities during ‘business as usual’. Some of the proposed actions would be better undertaken by other organisations such as the Health Promotion Agency, and the DHB will follow-up on these with the appropriate agencies.

The plan prioritises the DHB’s actions over the next year to:

- Ensure action towards, and current achievement of the health targets are sustainable by further embedding advice and support to quit as a clinical intervention that is part of ‘usual care’ by health professionals
- Increase the number of smokers that are offered support to quit and referrals to quit smoking services, particularly those within priority population groups
- Develop new approaches to reach populations that are not high users of health services, through working with other agencies.

Subject to any amendments CPHAC has, the Funder intends to revise the Plan on the basis of the feedback it receives from the MOH, and submit a final version of the Plan to the MOH on 31 May 2015.

4. Conclusion

The Funder has completed a comprehensive analysis and stakeholder engagement process to develop a draft Tobacco Control Plan for the period 2015-18, that will support progress towards SmokeFree Aotearoa 2025.

The draft Plan was submitted to the MOH for comment on 31 March 2015.

The Funder now seeks CPHAC’s agreement to the Plan, and subject to any suggested amendments, will finalise the Plan, based on feedback it receives from the MOH, before re-submitting a final version on or before 31 May 2015.
DRAFT
Tobacco Control Plan
2015 - 2018
Mihi

E aha te mea nui o tenei AO, he Tangata, he Tangata, he Tangata; Kahore e kai paipa ana, Kia kore ai e ngaro te whakapapa Tangata, Teheiwa mauri ora, teheiwa mauri mate, ki te hunga kai paipa, maumau tangata ki te po, Ratou te hunga mate ki a ratou, ko tatou te hunga whakapakiri tinana, mauri ora.

Foreword

Auckland DHB and Waitemata DHB have developed this Tobacco Control Plan for 2015-18 to provide leadership, coordination in support of ongoing work for all tobacco control work undertaken by the many services in seeking a Smokefree Aotearoa 2025.

We believe that the actions and initiatives outlined within this Tobacco Control Plan will significantly contribute towards the goal of a ‘Smokefree Aotearoa 2025’ through the strengthening of relationships and for innovative solutions that target Māori and other at risk populations in using services based in primary and secondary care.

Further, this plan will contribute to a reduction in smoking prevalence in Auckland and Waitemata districts in particular the priority populations Māori, Pacific people, pregnant women and mental health and addiction service users by providing a framework and tools for best practice.

Finally, we acknowledge the all of the work and guidance provided by all who attended the various hui we held across Auckland and Waitemata DHB’s.

Vision

Our vision for Auckland DHB and Waitemata DHB’s tobacco control work.

Aotearoa Free of Tobacco
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Background

Smoking is the single most modifiable risk factor causing disease and death in our community. This is particularly so for our Māori and Pacific populations, resulting in a significant reduction of quality of life and years of life. New Zealand also has relatively high rates of smoking in pregnancy, particularly for Māori women; reducing these rates will result in better maternity and neonatal outcomes.

The Government has set a goal of ‘Smokefree Aotearoa 2025’. The measure of achievement for this goal is that the rate of smoking in New Zealand is 5% (or less) of the population by 2025. DHBs have a key role in supporting the achievement of this vision.

The Ministry of Health (MOH) has contracts with both Auckland District Health Board (Auckland DHB) and Waitemata District Health Board (Waitemata DHB) for tobacco control activity and some quit smoking support services. Through the tobacco control contracts, DHBs have been resourced to lead, coordinate and develop tobacco control activities and meet the ‘better help for smokers to quit’ health targets. The DHB tobacco control contracts therefore also allow for the strengthening of relationships and for finding better ways of working between communities, primary and secondary care.

In 2009 the Government introduced the ‘better help for smokers’ to quit health target. The target requires 95% of patients who smoke and are seen by a health practitioner in a public hospital, 90% of patients who smoke and are seen by a health practitioner in a primary care setting and 90% of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC)) to be offered brief advice and support to stop smoking. More specifically, the target is designed to prompt health providers to (1) ask about and document every person’s smoking status, (2) give brief advice to stop smoking to every person who smokes, and (3) strongly encourage every person who smokes to use support to quit smoking (a combination of behavioural support and stop-smoking medicine works best) and offer to help them access it. This process is commonly known as ABC.
There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. An offer of treatment is even more likely to prompt a quit attempt than brief advice alone. Reducing the number of people who smoke and the harm from tobacco products is one of the government’s health targets, referred to as ‘better help for smokers to quit’. Activity to meet the targets is the focus of tobacco control work in secondary and primary care.

Overview

This plan describes Auckland and Waitemata DHB’s intentions for their tobacco control activities for 2015 to 2018. It focuses on the continuation of the implementation of the Ask, Brief intervention and cessation (ABC) approach in both the primary and secondary sector with a particular emphasis on the link between referral to stop smoking services and uptake. Interventions within the wider community to reduce smoking prevalence and mortality will be expanded.

It is consistent with the Ministry of Health’s current plan for tobacco control (Clearing the Smoke), the 2014 Better Help for Smokers to Quit Guidelines and the Government’s current Health targets for providing ‘help and support’ to quit both in hospital settings and the wider community.

Development of Plan

Waitemata DHB had a three-year Tobacco Control Plan that ended in November 2013, and Auckland DHB has a two year Tobacco Control Plan that ended in December 2014.

The Planning, Funding and Outcomes Unit started developing a combined tobacco control plan for 2015-18 for both DHBs in June 2014. A Steering Group was formed to guide the development and subsequent implementation of the plan.

A series of meetings and consultation workshops informed the development of the new Tobacco Control Plan. Each workshop built on the information gathered from the previous group and helped to further refine the priorities for action in the new Tobacco Control Plan.

The first workshop brought together sector representatives and provided the opportunity for updates on the current status of tobacco control work in the Auckland Region. Issues and challenges that needed addressing to achieve progress over the next three years were explored and recorded.

The second workshop focussed on generating new directions, strategies and vision for the 2015-2018 Plan. To provide context and inspiration for the work an update on the latest research and a session on innovations was also provided. The third workshop refined the vision and actions for the plan.
Goals and Objectives

The overarching aims of the combined Auckland and Waitemata DHB’s Tobacco Control Plan are to reduce tobacco related morbidity and mortality, and decrease tobacco-related disparity.

Māori and Pacific people are priority groups for Waitemata DHB and Auckland DHB due to the high smoking prevalence experienced in these populations. Due to the serious impacts of smoking during pregnancy and the harmful impacts of second hand smoke, pregnant women who smoke along with whanau/households where a child lives with one or more people who smoke are also priority populations for Waitemata DHB and Auckland DHB. Mental health and addiction service users are a further high priority group for both DHBs.

Progress Towards 2025

Key Goals and Objectives of the Tobacco Control Plan are:

Goals

- To maintain current Ministry of Health targets to provide ‘better help for smokers to quit’:
  - 95% of hospitalised smokers will be provided with advice and help to quit.
  - 90% of current smokers enrolled within primary care settings will receive advice and help to quit.

Within the target a specialised identified group will include progress towards 90 percent of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer) are offered advice and support to quit.

Outcome: Reduce overall prevalence of smoking.

Target: 9% by 2018 (half of 2011 levels)

- Reduce health inequalities, particularly as they affect Māori and Pacific people.

Outcome: Reduce inequalities in ethnic specific smoking prevalence.

In addition a new indictor has been added to Māori Health Plan reporting requirements:

- 95% of pregnant Māori women who smoke are smoke free at two weeks post natal

Objectives

- Reduce smoking prevalence in priority populations: pregnant women, people who live in households with children, mental health and addiction service users.
- Reduce harm from smoking and second hand smoke
- Reduce hospitalisations and mortality rate of smokers
- Increase the number of smokers that are offered support to quit and referrals to quit smoking services.
- Increase the quality of Stop Smoking Services
- Increase the number, quality and timeliness of referrals to Stop Smoking Services
• Reduce rates of smoking initiation
• Change the culture around smoking

Approach

The overall approach of the new ADHB/WDHB Tobacco Control Plan will be to work with the sector to increase the number of people making quit attempts. Reducing initiation may emerge as a component of a youth co-designed approach.

To reduce the current inequities in smoking statistics the plan needs to ensure that priority populations (Māori, Pacific, pregnant women, and mental health and addiction service users) receive consistent information and support to quit smoking from all sectors of the health system they engage with e.g. primary care, secondary care and other providers.

Strategies to reach populations that do not regularly use health services i.e. Māori, Pacific and youth will need to be developed ensuring that they are appropriate for each population.

Collaborative relationships across all organisations that work in tobacco control will be built in order to strengthen our combined effectiveness in reducing smoking.

This plan focuses on the 2015/16 year and will be reviewed in 12 months. To facilitate this review the DHB will lead a stakeholder workshop in November 2015 to inform the 2016/17 plan.
Section One: Health Needs Analysis

Demographics of smoking population

Waitemata DHB and Auckland DHB have differences in their respective resident populations. Waitemata DHB serves a population of 574,495 people, and Auckland DHB serves a population of 475,765 people (2014/15 estimates). In comparison with the national average Waitemata DHB's total population has a high proportion of people in the least deprived sections of the population, and tends to be slightly younger, and to have a lower proportion of Māori and a similar proportion of Pacific people. In comparison with the national average Auckland DHB’s total population has similar levels of deprivation, but tends to be younger, and to have a lower proportion of Māori and a higher proportion of Pacific people. Figure 1 provides an overview of the resident population by age, and shows different distribution of age groups between the two DHBs, particularly between the ages of approximately 20-34, where Auckland DHB has a higher number of young adult residents in comparison with Waitemata DHB.

![Figure 1: Resident population by age group, Waitemata and Auckland DHBs, 2013](image)

1 Smoking rates are based on Census 2013. The smoking rate is calculated as a percentage of 'regular smokers'. Census 2013 smoking definitions include:

- Regular smoker – Someone who actively smokes one or more manufactured or hand-rolled tobacco cigarettes per day.
- Never smoked – Someone who never actively smoked manufactured or hand rolled tobacco cigarettes at all or never actively smoked one or more per day.
- Ex-smoker – Someone who is not a regular smoker now but had been a regular smoker of one or more cigarettes in the past.

'Not Elsewhere Included' is excluded from the analysis as inclusion of this part could lead to potential under-estimate of the smoking rate.

The population from which the smoking rates are extracted is based on the concept of 'census usually residents', which is different from the estimated population (ER) used for planning and funding purposes. The census usually resident population (UR) has not yet taken into account census under-count or people who were temporarily overseas on census night. For this reason, the gender-age-ethnic specific smoking rate has to be applied to the projected resident population. In the present analysis, the projected population is sourced from the MoH based on 2013 data series.
The total number of smokers within the DHBs in 2013 was 98,106, with 54,002 in Waitemata DHB, and 44,104 in Auckland DHB (Table 1). Across both DHBs, individuals of Other ethnicity have the highest number of smokers: 52,117 compared with Māori (16,552), Asian (15,996) and Pacific (13,441).

Table 1: Summary table of numbers of smokers by DHB and ethnicity in 2013

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>Total</th>
<th>Total Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata DHB</td>
<td>9667</td>
<td>5528</td>
<td>6794</td>
<td>32013</td>
<td>54002</td>
<td>559,960</td>
</tr>
<tr>
<td>Auckland DHB</td>
<td>6885</td>
<td>7913</td>
<td>9202</td>
<td>20104</td>
<td>44104</td>
<td>466,520</td>
</tr>
<tr>
<td>Grand total</td>
<td>16552</td>
<td>13441</td>
<td>15996</td>
<td>52117</td>
<td>98106</td>
<td>1,026,480</td>
</tr>
</tbody>
</table>

* all ages

Māori and Pacific populations have smoking rates that are at least twice those of Asian and Other populations (Figure 2). Ethnic-specific rates show that Māori females have the highest smoking rates within both DHBs, followed by Māori and Pacific males, Pacific females, Asian and Other males, Other females and the lowest smoking rates are in Asian females.

Figure 2: Crude smoking rate of regular smokers by gender and ethnicity for Waitemata and Auckland DHBs, Census 2013

The age groups with highest number of individuals who smoke differ between the two DHBs. Within Waitemata DHB, the highest number of individuals who smoke are aged 20-29 years (Figure 3); a large number of those who smoke are also aged 30-43, and 40-59. Within Auckland DHB, the highest number of individuals who smoke are aged 25-29 years with closely followed by 20-24 and 30-34 age groups (Figure 4).
Smoking rates differ by age, gender and ethnicity (Figures 5-8). Māori women have particularly high smoking rates across all age groups, followed by Pacific women, while rates for Asian women are very low. Smoking rates for males within both DHBs are highest for Māori and Pacific men; Asian rates are similar to those of Other ethnicity. Within both DHBs, and all ethnic groups smoking rates increase substantially between the 15-19 years age group to the 20-24 age group. The pattern thereafter differs by gender and ethnicity, but generally shows a steep decline from 55 years onwards. Specific rates by age, gender and ethnicity are provided in the appendices.
Figure 5: Waitemata DHB regular smokers for females, Census 2013

Figure 6: Waitemata DHB regular smokers for males, Census 2013
Figure 7: Auckland DHB regular smokers for females, Census 2013

Figure 8: Auckland DHB regular smokers for males, Census 2013

Smoking rates differ by geographic location. Local Board Areas with higher smoking rates (>15%) overall include: Mangere-Otahuhu, Great Barrier, Henderson-Massey, Waiheke and Maungakiekie-Tamaki. Māori rates of smoking are high in all Local Board Areas, but are particularly high (>30%) in: Mangere-Otahuhu, Whau, Maungakiekie-Tamaki and Henderson-Massey.
Table 2: Smoking rate of regular smokers by local board for Waitemata and Auckland DHBs, Census 2013

<table>
<thead>
<tr>
<th>DHB</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auckland</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albert-Eden Local Board Area</td>
<td>26.3%</td>
<td>21.5%</td>
<td>7.4%</td>
<td>9.6%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Great Barrier Local Board Area</td>
<td>21.2%</td>
<td>20.2%</td>
<td>6.7%</td>
<td>9.1%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Mangere-Otahuhu Local Board Area</td>
<td>39.6%</td>
<td>25.3%</td>
<td>8.5%</td>
<td>19.8%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Maungakiekie-Tamaki Local Board Area</td>
<td>33.7%</td>
<td>22.2%</td>
<td>7.1%</td>
<td>12.3%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Orakei Local Board Area</td>
<td>16.3%</td>
<td>17.5%</td>
<td>5.1%</td>
<td>5.9%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Puketapapa Local Board Area</td>
<td>28.8%</td>
<td>20.5%</td>
<td>6.6%</td>
<td>11.0%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Wahineke Local Board Area</td>
<td>29.7%</td>
<td>21.1%</td>
<td>5.7%</td>
<td>14.8%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Waitemata Local Board Area</td>
<td>22.0%</td>
<td>20.9%</td>
<td>10.5%</td>
<td>10.5%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Whau Local Board Area</td>
<td>27.5%</td>
<td>20.0%</td>
<td>7.0%</td>
<td>11.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td><strong>Waitemata</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devonport-Takapuna Local Board Area</td>
<td>16.9%</td>
<td>13.5%</td>
<td>7.1%</td>
<td>6.5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Henderson-Massey Local Board Area</td>
<td>32.2%</td>
<td>20.6%</td>
<td>7.6%</td>
<td>15.0%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Hibiscus and Bays Local Board Area</td>
<td>20.5%</td>
<td>13.9%</td>
<td>7.5%</td>
<td>9.1%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Kaipatiki Local Board Area</td>
<td>24.1%</td>
<td>19.9%</td>
<td>8.0%</td>
<td>11.2%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Rodney Local Board Area</td>
<td>26.8%</td>
<td>18.4%</td>
<td>5.3%</td>
<td>10.9%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Upper Harbour Local Board Area</td>
<td>15.7%</td>
<td>18.6%</td>
<td>8.6%</td>
<td>8.3%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Waitakere Ranges Local Board Area</td>
<td>26.4%</td>
<td>21.3%</td>
<td>6.6%</td>
<td>12.3%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Whau Local Board Area</td>
<td>37.1%</td>
<td>19.9%</td>
<td>7.4%</td>
<td>13.5%</td>
<td>14.5%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>26.8%</td>
<td>20.9%</td>
<td>7.5%</td>
<td>10.3%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

Smoking in pregnancy

Section 88 of the Public Health and Disability Act requires the Lead Maternity Carer to document a women’s smoking status at registration and two weeks post-natally, and during the first trimester to provide women with health information on smoking in pregnancy. For women who choose to deliver in hospital, smoking status is documented on the DHB booking form for registering to birth in hospital. Smoking status is also documented at birth for women who deliver in hospital. DHB staff are required to provide brief advice and support to quit when a women presents to a DHB facility.

In Waitemata DHB, NMDS data showed that there were 1039 smokers who birthed at Waitemata DHB facilities in 2013: 351 Māori (50.8%), 151 Pacific (20.8%) and 537 Other (51.7%) (Table 3). Overall, Māori women comprised 33.8 percent of all pregnant smokers.

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2 The TCDR data does not provide smoking rates by ethnic groups. For this reason, the smoking rate by prioritised ethnicity (level 1) at Census Area Unit level was aggregated to local boards. Some area units are shared by more than one local board; in this case, they are forced to be within a single local board. Census area units are completely within boundaries of a DHB: no area units are shared by DHBs.

Waitemata DHB and Auckland DHB shares Whau local board. The minor variation of DHB level smoking rate by ethnicity between the table below and the data provided in previous figures is due to data rounding and confidentiality. The Mangere-Otahuhu local board is shared with Counties Manukau DHB, their population has been removed from the data, so that it is for the Auckland DHB population only.
Table 3: Waitemata DHB smoking status for women birthing at Waitemata DHB facilities in 2013 by prioritised ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total Bookings</th>
<th>Smoking at birth Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>691</td>
<td>351</td>
<td>50.8%</td>
</tr>
<tr>
<td>Pacific</td>
<td>727</td>
<td>151</td>
<td>20.8%</td>
</tr>
<tr>
<td>Asian</td>
<td>1995</td>
<td>48</td>
<td>2.4%</td>
</tr>
<tr>
<td>NZ European</td>
<td>3956</td>
<td>474</td>
<td>12.0%</td>
</tr>
<tr>
<td>Other</td>
<td>257</td>
<td>15</td>
<td>5.8%</td>
</tr>
<tr>
<td>Total</td>
<td>7626</td>
<td>1039</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

In Auckland DHB, Healthcare data showed that there were 415 smokers who booked with National Women’s Hospital in 2013: 172 Māori (41.4% of pregnant smokers - all ethnicities), 120 Pacific (28.9%) and 123 Other (30%) (Table 4).

Table 4: Auckland DHB smoking status at booking by prioritised ethnicity for 2013 for women birthing at the Auckland DHB facility

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total Bookings</th>
<th>Smoking at booking Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>532</td>
<td>172</td>
<td>32.3%</td>
</tr>
<tr>
<td>Pacific</td>
<td>904</td>
<td>120</td>
<td>13.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>2196</td>
<td>15</td>
<td>0.7%</td>
</tr>
<tr>
<td>NZ European</td>
<td>2548</td>
<td>93</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1043</td>
<td>15</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total</td>
<td>7,223</td>
<td>415</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Smoking in mental health and addiction service users

Limited data is available from secondary care and non-government organisation contracted providers on the smoking status of people with a mental health and addictions diagnosis. Currently, no information is available from primary care, as primary care smoking status data is not analysed by diagnosis.

Secondary care documents the smoking status of all inpatients, however inpatients comprise a very small subset of the mental health and addictions population. In Waitemata DHB, secondary care community services record the smoking status of approximately 60 percent of their clients; approximately one third of this 60 percent are documented as current smokers. In Auckland DHB, very few clients have smoking status documented. Both DHBs are planning to do a smoking status ‘census’ in April 2015 where the smoking status of all clients will be captured.

The most comprehensive data that provides a population view of smoking status among mental health and addiction service users is for clients that receive support from a mental health and addiction non-government organisation. The Northern Regional Alliance undertook a convenience sampling survey of the smoking rate of clients of the 76 contracted providers in the Northern region, which includes Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB. Of the 41 providers that responded (54% response rate)
3,950 clients were documented as current smokers, which equates to 44 percent of clients with these providers. This data is not able to be broken down to DHB level.

Due to the high rate of smoking by mental health and addiction service users, the DHBs are undertaking projects to promote smokefree lifestyles within mental health and addiction services. The Waitemata DHB smokefree project started in 2009 and the Auckland DHB mental health and addiction services started a smokefree project in November 2014.

The DHBs are also supporting a regional project led by the Northern Regional Alliance (NRA) that is working with all mental health and addiction non-government organisations (NGOs). A comprehensive smokefree policy clause has been added to NGO contracts and the NRA is providing training and support to the NGO providers.

**Stop Smoking Services and service coverage**

In addition to the support to quit smoking available from primary care, there are ten quit smoking services available in Waitemata DHB area and three in the Auckland DHB area that provide face-to-face support to help people to quit smoking (Table 5). Many of the services had a significant increase in referrals during April to June 2014, as a result of the proactive work by primary care to reach the health target.
<table>
<thead>
<tr>
<th>Service and coverage</th>
<th>Provider</th>
<th>Funder</th>
<th>Service description</th>
<th>2013-14 enrolments /targets per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitline (national)</td>
<td>The Quit Group</td>
<td>MOH</td>
<td>Phone, text, blog, NRT</td>
<td>Enrolments 2013/14: 3,227 (Auckland DHB); 3,226 (Waitemata DHB)</td>
</tr>
<tr>
<td>Aukati Kai Paipa (Auckland and Waitemata DHBs)</td>
<td>Ngati Whatua O Orakei and Te Ha O Te Oranga O Ngati Whatua</td>
<td>MOH</td>
<td>Face-to-face, text and NRT targeted to Māori</td>
<td>Clients: 626 Target: 640</td>
</tr>
<tr>
<td>Pacific Quit Service (Auckland and Waitemata DHBs)</td>
<td>Auckland Regional Public Health Service</td>
<td>MOH contract with both DHBs</td>
<td>Face-to-face, text and NRT by Pacific language speakers</td>
<td>Clients: 283 Target: 360</td>
</tr>
<tr>
<td>Elect Service (Waitemata DHB only)</td>
<td>Waitemata DHB</td>
<td>MOH contract with Waitemata DHB</td>
<td>All smokers referred to Elective Surgical Services are provided with advice and support to quit prior to surgery, including face-to-face, text, NRT</td>
<td>Clients: 132 Target: 75 (in addition to one-off advice and referral to other services)</td>
</tr>
<tr>
<td>Hospital Outpatient Services (Waitemata DHB only)</td>
<td>Waitemata DHB</td>
<td>Waitemata DHB baseline</td>
<td>Face-to-face or group counselling and NRT, targeted to patients that have a smoking related illness</td>
<td>Clients: 262 Target: 300</td>
</tr>
<tr>
<td>Whanau Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>MOH contract with Waitemata DHB</td>
<td>Face-to-face, phone, text, NRT targeted to families with children</td>
<td>Clients: 448 Target: 300</td>
</tr>
<tr>
<td>Asian Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>Waitemata DHB baseline</td>
<td>Face-to-face, text and email by Asian language speakers</td>
<td>Clients: 393 Target: 420</td>
</tr>
<tr>
<td>Community Pharmacy (Waitemata DHB only)</td>
<td>16 community pharmacies</td>
<td>MOH contract with Waitemata DHB</td>
<td>Face-to-face support and NRT provided by pharmacy staff</td>
<td>Clients: 242 Target: 550</td>
</tr>
<tr>
<td>Pregnancy Smokefree Communities (Waitemata DHB only)</td>
<td>Waitemata PHO</td>
<td>MOH</td>
<td>Face-to-face, text, email targeted to pregnant women and their partners</td>
<td>Clients: 266 Targets: 420</td>
</tr>
<tr>
<td>Pregnancy Smokefree Communities (Auckland DHB only)</td>
<td>Auckland DHB</td>
<td>MOH</td>
<td>Face-to-face, text, email targeted to pregnant women and their partners</td>
<td>Clients: 206 Target: 360</td>
</tr>
</tbody>
</table>

The total target enrolments for smoking cessation providers are 4,080 within the Auckland DHB region, and 5,805 in Waitemata DHB (Table 6). The figure for Quitline is not a true
target, instead it is the number of people that they treated in 2013/14. Quitline has capacity to increase this number.

Table 6: Total stop smoking service targets for Auckland DHB and Waitemata DHB populations in 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Auckland DHB</th>
<th>Waitemata DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitline</td>
<td>3,200</td>
<td>3,200</td>
</tr>
<tr>
<td>Face-to-Face providers</td>
<td>880</td>
<td>2,605</td>
</tr>
<tr>
<td>Total targets per year</td>
<td>4,080</td>
<td>5,805</td>
</tr>
</tbody>
</table>

In addition to the services listed in Table 5, support to quit smoking is also available from the following services.

- General Practice and hospital based interventions
- WERO, Quit bus, Waipareira programme, Breakfree (mental health NGO service)
- Other quit card providers

Note that some people will manage to quit cold turkey, or via other self-help measures such as: purchasing Nicotine Replacement Therapy (NRT) over the counter, using apps or other online support. Others will enrol in more than one programme at time i.e. use Quitline and compete in WERO challenge.

**Primary Care**

The ‘Better Help for Smokers to Quit’ Health Target has resulted in improved rates of documenting smoking status in primary care and providing smokers with advice and support to quit. In Waitemata DHB 94 percent of enrolled patients have their smoking status recorded, with 44,235 recorded as current smokers. In Auckland DHB 94 percent of enrolled patients have their smoking status recorded, with 46,937 recorded as current smokers. This data is according to General Practice location rather than patient DHB of residence.

Both Auckland and Waitemata DHBs have maintained achievement of the primary care ‘better help for smokers to quit’ health target since quarter four, 2013/14 (Table 7). In quarter two 2014/15 44,124 current smokers and recent ex-smokers were provided with advice and support to quit in the Auckland DHB area, and 44,235 in the Waitemata DHB area.
Of the current smokers provided with advice to quit, some also receive support to quit, i.e. smoking cessation medication prescribed, referral to a stop smoking service or behavioural support from the General Practice. In quarter two 2014/15 12,500 people (22.5% of current smokers) received support to quit in Auckland DHB area and 13,820 people (25.5% of current smokers) in Waitemata DHB.

Secondary Care

Waitemata DHB has consistently achieved the ‘Better help for smokers to quit’ target since September 2011. For the 2013-14 year, North Shore and Waitakere Hospitals had combined admissions of 94,143. Of these, 13,667 (15%) were identified as currently smoking and 13,278 (97%) were given brief advice and support to quit smoking. For Māori, the total number of admissions was 7,746 of which 2,956 (38%) smoke and 2,873 (97%) were given brief advice and support to quit smoking, and for Pacific, the totals were 7,003 of which 1,261 (18%) smoke and 1,233 (98%) were given brief advice and support to quit smoking.

Auckland DHB has consistently achieved the ‘Better help for smokers to quit’ target since December 2012. For the 2013-14 year, there have been 97,536 discharges over this period with 94,154 coded at the time of writing. Within these coded figures 12,095 current smokers were identified (12.8% smoking rate). Brief advice to stop smoking and an offer of support to quit was given to 11,612 (96%) of the smoking population. For Māori, there were 8,836 coded discharges, of which 2,821 smoke (31.9%) and 2,713 (96.2%) were given brief advice and an offer of support to quit. For Pacific peoples there were 11,926 coded discharges, of which 1,848 (15.5%) smoke and 1,785 (96.6%) were given brief advice and an offer of support to quit smoking.

Within, Waitemata DHB and Auckland DHB, Smokefree Leads within each service area are trained, resourced and supported by the Smokefree Team to support colleagues and peers in providing brief advice and support.
Each month, Waitemata and Auckland DHBs each see approximately 1,000-1,200 patients who smoke, and refer approximately 50 (Waitemata DHB) and 70 (Auckland DHB) patients to smoking cessation services, equating to a referral rate of approximately 4-7 percent. Both DHBs now have a triage service to support referral to smoking cessation services on discharge. Targets have also been developed for monthly referral rates of 80 in Waitemata DHB and 100 in Auckland DHB in 2015/16. Both DHBs are also developing a process for Māori and Pacific patients who would like support to quit smoking to be proactively followed-up post-referral to ensure that they have had every opportunity to engage with a quit smoking service.

The Smokefree Services teams also maintain a general awareness of the target such as being present on Welcome Day for all new employees (Auckland DHB) and holding World Smokefree Day activities in May.

**Public Health Unit**

The Auckland Regional Public Health Service (ARPHS) undertakes a number of tobacco control responsibilities for the entire Auckland region. ARPHS aims to prevent harm from tobacco by the promotion of social, physical and environmental strategies to improve and protect the public’s health. Core to ARPHS role is support and leadership for regional and national advocacy, and environmental and system change initiatives across supply, demand reduction and reducing opportunities to consume tobacco. The mix of health promotion, policy and compliance responsibilities means that ARPHS is uniquely positioned to support DHB aspirations for reduced tobacco sales and consumption, the prevention of initiation, protection of children from exposure to smoking and increased Smokefree spaces across the District Health Board area in the Auckland region.

ARPHS is the only organisation in the Auckland region that has regulatory responsibilities under the Smokefree Environments Act. ARPHS Smokefree enforcement officers are granted special powers under legislation to support them in carrying out their duties. These regulatory responsibilities are important components of the national action plan to a Smokefree Aotearoa. As part of enforcement activities, ARPHS processes complaints and undertakes an average of 250 proactive Controlled Purchase Operations (CPO) per year.

ARPHS health promotion and policy functions aim to strengthen strategic alliances and networks, increase the adoption of policies which support the reduction of tobacco related harm and support high need populations to be Smokefree. Activities include formal submissions and advocacy, leading regional stakeholder coordination for World Smokefree Day, and supporting public venues, events and workplaces to commit to being smokefree.

**Referral Pathways and mechanisms**

All DHB and MoH funded local stop smoking services accept self-referrals and referrals from health professionals, these can be made by phone call, email, fax, letter and from some services by using an electronic form.

General Practices have two or three options for making referrals, depending on which PHO they belong to. For Quitline the easiest referral mechanism is an electronic referral link via Medtech. For referring to local services an electronic referral via the e-referral mechanism
called CareConnect is available. These referrals are then triaged by the DHB Smokefree Teams and referred on to the most appropriate service. Some PHOs also have their own electronic referral mechanism and manual options for referring.

Both Auckland and Waitemata DHB Smokefree Teams operate a stop smoking referral service. The service aims to make it easy for primary and secondary care services to make referrals for support to stop smoking, and ensure that patients are referred to the most appropriate service for them.

All admitted patients across both hospitals are asked if they smoke tobacco. After identifying a current smoker, brief advice to stop smoking is given by a health professional and documented in the patient file. Brief advice is reinforced via advice/support options contained in the electronic discharge summary for those identified as current smokers. To maintain the focus on documentation, weekly auditing is carried out by the Smokefree Services team of the notes of smokers that have not been given advice and support to quit. The Smokefree Service teams provide targeted training when an audit shows an area is not performing well. Every week the health target results are calculated for each inpatient ward/service. These results are then displayed showing the reporting service percentage, alongside the overall percentage result, and distributed via email by the CEO. For those services where the 95% target is not met, the respective Charge Nurses are contacted and strategies requested to minimise a reoccurrence.

Ministry of Health Innovation Fund

There are five projects occurring in the Auckland and Waitemata DHB areas that are funded by the Ministry of Health (MOH) Pathway to 2025 Innovation Fund. These projects are trialing new and innovative ways to reduce smoking in our communities. These projects include the:

- Breakfree Smokefree Programme, stop smoking support for mental health and addictions service users
- Intersectoral project, that is working with government e.g. WINZ and non-government organisations e.g. Budgeting to promote stopping smoking through their services
- Quit Bus, a mobile stop smoking service
- Te Whanau O Waipareira Trust culturally tailored support to quit smoking programme
- Waitemata DHB NRT Survival Packs (this project was stopped early due to the DHB’s medication protocols preventing its implementation)

Reaching the Smokefree Aotearoa 2025 goal

In comparison with 2006 smoking rates, 2013 rates show considerable decline within both DHBs, and for all ethnicities (Table 8). Percentage decline has been most considerable for Māori (10.3 WDHB; 10.7% ADHB) and Pacific (6.5% WDHB; 6.7% ADHB) populations. This decline in smoking can also be seen in Year 10 student (14-15 years) survey results (Figure 9).3

3 Action on Smoking and Health New Zealand Data
Table 7: Comparison of 2006 and 2013 smoking rates, Waitemata and Auckland DHBs

<table>
<thead>
<tr>
<th>DHB</th>
<th>Ethnicity</th>
<th>Census</th>
<th>2006</th>
<th>2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata</td>
<td>Māori</td>
<td></td>
<td>37.4%</td>
<td>27.1%</td>
<td>10.3%</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td></td>
<td>26.5%</td>
<td>20.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td></td>
<td>10.7%</td>
<td>7.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td>16.0%</td>
<td>10.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>17.4%</td>
<td>12.0%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Auckland</td>
<td>Māori</td>
<td></td>
<td>37.0%</td>
<td>26.3%</td>
<td>10.7%</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td></td>
<td>28.2%</td>
<td>21.5%</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td></td>
<td>10.8%</td>
<td>7.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td>14.5%</td>
<td>9.6%</td>
<td>4.9%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>16.5%</td>
<td>11.2%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Figure 10: Proportion of Year 10 students who are regular smokers, by year and DHB

If the slope of the decline between 2006 and 2013 was to continue at the same rate for the next 10 years, both DHBs would reach the Smokefree Aotearoa 2025 goals. In comparison with other DHBs nationally, both Waitemata and Auckland DHBs are on track to achieve Smokefree Aotearoa 2025 for the total population. However, ethnic-specific rates for Māori and Pacific are likely to be significantly higher than the goal. Recent national projections suggest that intensive effort is required to ensure that Māori smoking rates decline at almost twice the degree of Non-Māori smoking rates for Māori to achieve Smokefree Aotearoa 2025. This research suggests that to reach Smokefree Aotearoa 2025, a ten percent annual cessation rate for Non-Māori and a 20 percent cessation rate for Māori is required. To achieve these cessation rates, cessation needs to increase 2-4 fold for Non-Māori, double this again (5-8 fold) for Māori. Using 2013 current smoker data, these percentage decreases

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would equate to 1,933 (WDHB) and 1,377 (ADHB) Māori, and 4,434 (WDHB) and 3,722 (ADHB) Non-Māori stopping smoking in that year, or for the total population: 6,367 (WDHB) and 5,099 (ADHB).

Given that Waitemata DHB and Auckland DHB have lower current smoking rates compared with national figures, the figure required to reach the Smokefree Aotearoa goal will be lower than this, but are still significant. An approximate calculation suggests that we need to reduce the overall pool of current smokers (Figure 11) by an average of approximately 3,000 per year in Auckland and 3,500 in Waitemata. These figures are a rough approximation, and assume that young people will take up smoking at the same rates as currently, and that new migrants to the DHB regions have the same smoking rates as the current population. Population growth and ageing has been allowed for as per Statistics NZ estimated population projections. Using the 2013 current smoker information as an example, a reduction of 3,000 smokers in Auckland DHB and 3,500 in Waitemata DHB equates to a needed smoking cessation rate of 6-7 percent per year for each DHB.

![Figure 91: Simple schematic of smoking migration](image)

### Gaps and issues for reaching the goal

While recognising the need for further intensive smokefree action, the smokefree workforce can be proud of what has been achieved to date; targets set within the DHB’s previous Tobacco Control Plans have been achieved.

In order to achieve the necessary further reductions in smoking rates within each DHB, a number of gaps and issues in current services need to be addressed. It must be noted however that DHB leadership in reaching the 2018 and 2025 Smokefree Aotearoa goals can only reach so far; further national leadership in the form of for example: increased taxation, smokefree cars, plain packaging and innovative actions is required. An overriding issue is ensuring that inequities in smoking initiation and stopping smoking are not perpetuated or increased through strategies to prevent initiation, limit harm or increase stopping smoking. Inequities must be addressed in order for the Smokefree Aotearoa 2025 goal to be achieved for each ethnic group within the DHB’s populations.

Gaps and issues that need to be addressed have been identified during the process of developing the 2015-2018 plan. During September - November 2014, Waitemata DHB and Auckland DHB held a series of stakeholder workshops from that were well attended by the tobacco control and health sectors. The workshops reviewed strategies that have been in place in recent years, and outcomes achieved. This collaborative process identified a number of gaps and issues of importance to achieving the 2025 Smokefree Aotearoa goal that have
informed development of this plan. In addition, the Waitemata Youth Advisory Group has provided a youth perspective to Smokefree Aotearoa 2025 planning through participation in a focus group session. Feedback from youth involved indicated that things that would have the greatest impact on encouraging youth smoking cessation include: showing youth what they are missing out on socially by smoking, showing them alternative ways to manage stress, empowering them to know they can quit, encouraging youth to keep trying to quit, and highlighting that a good friend is someone who supports friends to quit. The group suggested that strategies to prevent initiation should include changing the social perspective of smoking by showing youth that being responsible and mature does not include smoking, and showing adults that their smoking behaviours have a generational impact on children and youth acceptance of smoking as a norm, and subsequent smoking initiation.

From the collaborative workshops and youth focus group, key gaps and issues for reaching Smokefree Aotearoa 2018 and 2025 were identified:

- Brief advice is being actioned and the A (ask about smoking status) and B (brief advice) carried out, but the C (support to stop smoking) is often missing. There needs to be a focus on the link between advice and ensuring there is action to quit.
- There needs to be more connectivity between parts of the system, for example between general practice, pharmacies and secondary care. Better linkages in the sector will achieve more.
- The new plan needs to extend out into other sections of the health sector and into social services, particularly to reach young people, and those experiencing socioeconomic disadvantage.
- The current approach to smoking in pregnancy is not working. Something new must be tried.
- There are issues with Stop Smoking Services that need addressing especially the low number of referrals and improvement to systems and data.
- The environments that surround smokers must be addressed and the attitudes of whanau and communities that sometimes make it hard for people to quit need to change.
- The work undertaken to date has focussed on the health sector and is successful with people who engage with sector. However this work fails to reach those people and groups who do not engage with the sector, for example youth.

**Logic Model**

A logic model outlining DHB activities, impacts of activities and short, medium and long-term outcomes is provided on the following page.
Goal: To equitably achieve Smokefree Aotearoa by 2025

**DHB led Activities**

**Impacts**

**Short-term outcomes**

**Medium-term and long-term outcomes**

**Glossary:**
- ARPHS - Auckland Regional Public Health Service
- NGOs - Non-Government Organisations
- NRT - Nicotine Replacement Therapy
- SSS - Stop Smoking Services
- SUDI - Sudden Unexplained Death in Infants
- Supported Quit Attempts = Prescribing NRT or referral to a SSS

* see detailed National and ARPHS tobacco control plans
Section Two: Tobacco Control Implementation
Plan 2015-2018

Action Areas

Seven areas have been identified for action. Much of the work in these areas will be a continuation of strategies undertaken in previous plans. However improvements and enhancements will be introduced as a result of feedback and experience. New initiatives and ways of working will be introduced to meet unmet needs.

The areas are:
- Primary care
- Secondary care
- Maternity
- Mental health and addictions
- Non-government health organisations (NGOs) and community
- Stop Smoking Services
- Youth and emerging approaches

The consultation process used in the development of this plan identified many possible actions that could be undertaken in this plan. This plan has included the more strategic actions. Many of the operational actions that were identified and have not made it into the plan will be carried out through existing services workplans.
Spheres of Influence

To reach the Smokefree 2025 goal the DHBs will expand their activities into wider spheres of influence and make links with an increased number of services in the community. The priority populations of Māori, Pacific, mental health and addiction clients and pregnant women apply across all spheres.
Evidence Statement

Intervention areas outlined in the following pages align with evidence of effectiveness regarding brief advice, counselling delivery approaches, incentivisation and youth and community approaches.5

- A considerable body of evidence of effectiveness exists for brief advice as a smoking cessation tool when compared with minimal or no intervention, particularly when provided by health professionals including: general practitioners, hospital doctors, nurses, lead maternity carers and dentists.
- Intensive individual counselling and/or individual motivational interviewing are more effective in supporting cessation than brief advice alone.
- Individual counselling and pharmacotherapy are more effective in supporting cessation than counselling on its own.
- Group based therapy is as effective as individual counselling at the same intensity in supporting cessation, and is more effective than self-help, however it may only provide minimal additional benefit when added to brief advice and NRT. NRT pharmacotherapy is more effective than placebo or no NRT, and use of two types of NRT is more effective than use of a single type of NRT alone in supporting cessation.
- For youth, there is some evidence of effectiveness for behavioural change interventions compared with usual care. There is limited evidence of effectiveness of community interventions that aim to address youth initiation prevention and smoking cessation as socially acceptable choices compared with no intervention, single interventions or school-based interventions. There is evidence of effectiveness for school-based interventions that are based on social competence (improving life skills and self-esteem) training, or a combination of this and social influence (understanding social influences that encourage or perpetuate smoking) training, compared with no intervention, or social influence interventions alone.
- Workplace interventions that target individuals using behavioural or pharmacology approaches are as effective at supporting cessation as individual approaches in other settings.
- Telephone counselling provides additional benefit to self-help or pharmacotherapy interventions alone.
- There is some evidence that internet interventions are more effective than self-help or no intervention in supporting smoking cessation, but only if they are tailored to the individual and are interactive.
- There is some evidence of effectiveness in supporting smoking cessation for video and/or text messaging that provides motivational support or quit advice.
- Self-help material provides some effect in enabling smoking cessation compared with no intervention, particularly if materials are tailored to the user.
- For pregnant women, counselling is effective in supporting smoking cessation when compared with ‘usual’ care, however incentives are highly effective in enabling smoking cessation.

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Primary Care

Primary care provides an ideal setting for brief advice and support to quit smoking. The Ministry of Health ‘better help for smokers to quit’ target for primary care reflects this: 90% of enrolled patients, who smoke and are seen in General Practice, will be provided with advice and help to quit.

PHOs in the Waitemata and Auckland DHB regions have achieved this target. A key factor in this success is the leadership that has been shown by PHOs. For instance, all PHOs prioritised smoking cessation brief advice, and put additional resources into project teams that supported General Practices to achieve the target. This level of activity and support is however not sustainable in the long term. PHOs have identified that what is needed to continue to reach the target, and beyond, is for advice and support to quit to become embedded as a clinical intervention as part of ‘usual/standard’ General Practice care. As part of this embedding process a next step is to move the focus from brief advice to be on support to quit, and quit attempts/outcomes – refreshing ABC training will enable a shift of focus.

Barriers to providing support to quit include inherent General Practice time pressures, however other barriers need to be identified. Innovative ways to address barriers to referrals for support to quit should be explored, for example through actions such as improved collaboration between general practice and pharmacies, and the use of apps and other resources as support to quit tools.

For approximately two-thirds of women, a general practitioner is the first health professional they see in the first trimester of pregnancy. Ensuring that processes are in place to support smoking cessation in the early stages of pregnancy is a critical role that general practice can play in improving maternal and child health.

To enable continued focus on brief advice, and a strong focus on support to quit, the DHB will contract with each PHO to lead and coordinate support to General Practices including setting key performance indicators, regular feedback on performance, IT tools and providing clinical support. Where possible work will be undertaken as projects with all PHOs and with other relevant agencies such as the Heart Foundation.

### Actions for Improvement

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine barriers to low referral rates to stop smoking services and implement a project to address issues identified</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Refresh the ABC training provided to General Practice to improve the quality of support to quit and increase the number of supported quit attempts, particularly to Māori and Pacific patients</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Develop a targeted approach for pregnant women that smoke and are seen in General Practice to ensure they are proactively supported to quit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Develop an outcomes focused target by year to maintain momentum towards meeting the Smokefree Aotearoa goal</td>
<td>✓ ✓ ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify existing apps and social media resources to promote quitting that can be promoted by PHOs</td>
<td>✓ ✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Secondary Care

Engagement with secondary care presents a critical point where the provision of brief advice and support to quit has particular effect. The Ministry of Health secondary care target ensures health professionals provide ‘better help for smokers to quit’ within secondary care: “95 per cent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking”.

Strategies undertaken during the previous Tobacco Control Plan have resulted in the target being achieved consistently since September 2011 for Waitemata DHB and December 2012 for Auckland. Successful strategies contributing to this achievement will be continued and enhanced.

Both hospitals have a Smokefree Services team that supports the achievement of the target through systems, training and auditing.

In addition, new strategies have been identified to extend the reach to all patients that use secondary care and to focus more attention on priority groups such as Māori, Pacific, mental health and maternity.

While emphasis on the provision of brief advice needs to continue, increased emphasis needs to be placed on supporting people to quit. Refreshing training with an emphasis on the cessation (C) component is necessary to keep brief advice momentum going and to shift the focus onto referrals and support to quit. Optimising and extending current monitoring systems will ensure feedback on referral rates and review and improvement of ABC provision. Extending the reach of ABC advice to include relatives and visitors aligns with a focus on smokefree home environments on discharge. Patient resources need to be clear concise and appropriate to support quit attempts. Currently, follow-up of outcomes after provision of NRT is not possible – a process to enable follow-up will support collaboration on smoking cessation between primary and secondary care.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refresh the ABC training provided to health professionals to increase the number of patients that make supported quit attempts, particularly to Māori and Pacific patients</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop and monitor systems that support health care professionals working in provider-arm services, including community and outpatient services to know and routinely use the ABC approach with all patients</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Implement the ABC approach with the parents of paediatric patients</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Review and revise the information provided to patients on smoking and support to quit</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a process to follow-up on people prescribed NRT in hospital</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Maternity

Smoking in pregnancy has a negative health effect on both the mother and foetus. Foetal, infant, and child growth and development are negatively impacted by maternal smoke exposure. Smoking cessation in the first trimester reduces maternal and infant risks of adverse health outcomes from smoking considerably.

To enable smoking cessation in the earliest stage of pregnancy, the Ministry of Health requires action and reporting on a maternity ‘better help for smokers to quit’ Health Target: Progress towards 90 percent of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC)) are offered advice and support to quit. In addition, post-natal smoking status has been included as a Māori Health Plan indicator: 95% of pregnant Māori women are smoke free at two weeks post natal.

The consultation process for the development of the plan made it clear that current approaches to pregnant women are not working and new strategies need to be developed. Key challenges to be addressed include delivering smoking cessation interventions in a manner that builds stronger relationships between midwives and pregnant women, and optimises opportunistic engagement with other sectors, such as pharmacies. A wrap around approach has been recommended that involves the whanau and community and ensures that pregnant women are in supportive environments. Work in tobacco control will link to other work being done in the maternity sector. The approach for working with pregnant women trials a number of new initiatives that have been shown to be effective internationally and in some DHBs in New Zealand.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement an incentive scheme to motive pregnant women, their whanau and pregnant friends that smoke to quit</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement a pilot of providing midwives with carbon monoxide monitors to use with pregnant women as a motivational tool to promote quit attempts</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Evaluate the midwife incentive scheme that is being piloted by Waitemata PHO and if successful continue to implement (funding permitting)</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Develop and implement a communications plan that promotes quitting to pregnant women and their whanau</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Work with pharmacy sector to identify and support pregnant women to quit in the early stages of pregnancy</td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>
Mental Health and Addictions

Mental health and addiction service users have one of the highest rates of smoking in the population. Smoking rates are also particularly high among staff. The consultation process in the development of the plan showed that good progress had been made in addressing the culture of smoking in mental health and addiction services in Waitemata DHB and NGO services. It also identified that work needs to continue to ensure that asking and recording smoking status and supporting service users to quit becomes a routine part of care. Mental health services users need consistent messages regarding the harms of tobacco use from all healthcare settings. In addition, many mental health and addiction service users use other substances of abuse, in addition to tobacco, which requires different/additional advice to be provided within ABC approaches.

The Waitemata DHB District Mental Health and Addiction Services have been undertaking a project across all of their adult services (including addiction services) for the past five years to reduce the high rates of smoking in service users and mental health staff. Auckland DHB has introduced a new similar project in 2014.

The approach for this sector is to continue to fund coordinators in both DHB areas and with the NGO sector through the Northern Regional Alliance. The aim is to ensure this population is equally supported by other parts of the sector.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a smokefree strategy for the mental health and addictions sector</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide training to smokefree practitioners so they are able to support mental health and addiction service users to quit smoking</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Smoking cessation to be part of the care plan of every consumer who smokes and continue when consumers transition to, from and through other services</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Ensure all mental health and addictions clinical staff know and routinely use the Ask, Brief advice and Cessation support approach</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address smoking as part of a healthy lifestyle approach within mental health and addiction settings i.e. include in coordinated care plan along with other behaviour change</td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>
Non-Governmental (NGO) and Community Services

To date DHB Tobacco Control Plans have focused on the health sector. This new plan recognises the important work done by NGOs and community services to reach smokers in non-health settings. This is particularly important for youth, who engage with the health sector less frequently than other age groups.

In order to reach populations that are not using health services, initiatives will be developed to reach those populations. This approach will focus on working with organisations already engaging with the community, such as Council, Auckland Regional Public Health Service, Early Childhood Education, DHB community development programmes, and community groups. There are many settings in the social service sector that have a broad client base, many of who are smokers. This could provide many opportunities to offer brief advice and a referral to a stop smoking service. Processes and training methods that have been developed for primary care can be adapted for use with social service agencies. Other health services, such as dentists and sonographers, may represent further opportunities to enhance the reach of ABC brief advice into the community.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extend the Intersectoral project being undertaken by ARPHs to train and support more social services agencies to promote stopping smoking, and provide access to stop smoking services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Link into and build on existing DHB programmes and services to promote and support stopping smoking e.g. Enua Ola / Healthy Village Action Zone, school based health services, workplace health programmes, Marae based programmes etc.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Strengthen Early Childhood Education activities to support smokefree cars, homes and Early Childhood Education workforce</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Connect with community groups e.g. sports clubs, to support them to implement smokefree policies and promote stopping smoking to their members (support Auckland Council smokefree environments policy)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ensure that community based health professionals e.g. dentists and sonographers are trained in the ABC approach and know how to refer to stop smoking services (regional approach)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Continue to work with Council and Council owned enterprises (i.e. ATEED) to support public venues, events and workforces are smokefree</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Build on work with prioritised non public (i.e. not Council) venue owners and event organisers (including Sports clubs as appropriate) to develop policies and approaches that support smokefree events and membership</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Stop Smoking Services

Quit attempts are more successful when stop smoking services are used. Under current capacity there are not enough stop smoking services to meet the 2025 goal, particularly in Auckland DHB. An issue that must be addressed is that stop smoking services are currently required to spend time acquiring referrals when that time would be better utilised delivering stop smoking services. A review is required to ascertain if there is the correct mix of services to deliver quality and effectiveness, particularly for priority populations, and for other populations without tailored services, for example Asian populations. There are also process issues that need to be addressed to ensure stop smoking services receive referrals, and that service responses occur quickly following referral.

In addition to the support to quit smoking available from primary care, there are a number of publicly funded options available across both DHBs. The utilisation and quit rates of these services were analysed to inform the development of this Tobacco Control Plan.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete a service review of contracted Stop Smoking Services in the district to determine if services are being delivered effectively, efficiently and reaching priority populations</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure contracted services have the knowledge and skills to meet the needs of groups with a high incidence of smoking including; mental health and addiction service users; Māori and Pacific people; and lesbian, gay, bisexual and transgender community</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Support local participation in incentive funding schemes such as WERO and investigate other options for incentivising specific target populations</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Investigate implementing the Elect service delivered by Waitemata DHB (stop smoking support prior to elective surgery) in Auckland DHB (will require additional funding from the DHB)</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Evaluate the Waitemata DHB pharmacy stop smoking services delivered in the Waitemata DHB area and implement recommendations from the evaluation</td>
<td></td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Investigate implementing a service that targets the Asian population in Auckland DHB (will require additional funding from the DHB)</td>
<td></td>
<td></td>
<td>√</td>
</tr>
</tbody>
</table>
Youth and Emerging Approaches

Previous DHB Tobacco Control Plans have not focused on youth, as youth tend to use health services less frequently than other age groups. Action to reduce youth tobacco use was identified as a gap during consultation with stakeholders.

Consultation resulted in a number of innovative approaches being suggested for inclusion in the plan. Many of these aimed to address identified gaps and groups that are currently not being reached with smokefree services. However, consultation recognised that any approach to working with youth should be developed through a co-design approach with youth. Approaches will also need to work within settings used/frequented by youth.

Scoping will initially be carried out to determine if these new approaches are feasible and can be funded.

<table>
<thead>
<tr>
<th>Actions for Improvement</th>
<th>2015 to 2016</th>
<th>2016 to 2017</th>
<th>2017 to 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Youthline Youth Advisory group – DHB Funded group. Already an existing group – connect with them for their input</td>
<td>✓</td>
<td></td>
<td></td>
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Monitoring and Evaluation

A number of monitoring systems are currently in place, and will be utilised to ensure progress is continuously being made towards Smokefree Aotearoa 2018 and 2025 goals. Monitoring systems currently sit within primary care and secondary care to deliver regular reporting on health target indicators, including brief advice and referrals. Other systems include data collection and reporting of brief advice, referrals and quit rates via the contracted Stop Smoking Services, mental health NGOs, Quitline and the National Maternity Database (MAT), which includes reporting on the Māori Health Plan post-natal indicator.

This plan recognises the need to improve data collection and reporting for monitoring and evaluation purposes, particularly data on quit rates, mental health and addiction secondary care services and the maternity sector. Work is currently occurring to improve mental health and addiction data collection and reporting. An audit of maternity databases will be undertaken in 2015 to determine the quality of data collection, and enhance data accuracy to support evaluation of progress with the pregnancy interventions outlined in the plan.

This plan also recognises the importance of evaluation of new approaches to inform and improve the content, delivery and direction of approaches. Evaluation of pilot programmes and interventions will be built into programme/intervention development from the scoping phase – for example the pregnancy incentives project, and the carbon monoxide pilot. Opportunities to audit existing interventions, processes and data collection systems will be optimised.

The logic model presented in ‘Section One: Health Needs Analysis’ outlines key indicators for short, medium and long-term outcomes. These outcomes must be monitored using ethnic-specific data, with the aim of reducing and ultimately eliminating inequities in access to care, care received and outcomes for high priority groups.

**Short-medium term outcome indicators:**
- Health target brief advice increased (particularly from Lead Maternity Carers (LMC); maintain high levels in primary and secondary care);
- Increased referrals to Stop Smoking Services (Health Target support to quit: primary and secondary care referral rates, LMC referral rates);
- Increased enrolment with Stop Smoking Services (measure of quality of brief advice and referral process).

**Medium-term outcome indicators:**
- Stop Smoking Service quit rates increased (by referral source);
- Current smoker rates reduced;
- Reduced smoking- and second-hand smoke exposure-related hospitalisation rates; mortality rates and adverse maternal/infant complication rates.

**Long-term outcome indicators:**
- Overall smoking prevalence reduced to nine percent by 2018;
- Smoking prevalence reduced for priority populations: Māori, Pacific, Pregnant women, households with children, mental health and addiction clients;
- Eliminate inequities in ethnic-specific smoking prevalence.
Appendix 1: Estimated number of regular smokers by gender, age group and ethnicity (prioritised level 1), Waitemata DHB, 2013

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DRAFT Auckland DHB and Waitemata DHB Tobacco Control Plan 2015-18
4.1 Overview - Food Environments Paper to Healthy Auckland Together

Recommendation:

That the report be received.

Prepared by: Dr Julia Peters (Clinical Director - ARPHS) and Dr Michael Hale (Public Health Medicine Specialist - ARPHS)
Reviewed by: Simon Bowen (Director Health Outcomes - Waitemata and Auckland DHBs)

Glossary

Auckland DHB - Auckland District Health Board
ARPHS - Auckland Regional Public Health Service
CPHAC - Auckland and Waitemata DHBs’ Community and Public Health Advisory Committee
DHB - District Health Board
Waitemata DHB - Waitemata District Health Board

1. Purpose

This report provides an overview of the paper on Food Environments (attached as Appendix 1) that was considered by Healthy Auckland Together\(^1\) at its 19 February 2015 meeting.

2. Background

In February 2014, the Waitemata and Auckland DHBs’ Community and Public Health Advisory Committee (CPHAC) requested the Auckland Regional Public Health Service (ARPHS) to bring back a report on opportunities for interventions in the promotion of products that influence levels of obesity. That paper was deferred in response to ARPHS establishing a new regional inter-sectoral group – Healthy Auckland Together - that aims to reduce obesity, increase physical activity and improve nutrition.

3. Context

Tackling the obesity problem requires concerted effort across layers of governance, involving many stakeholders. Some of the most effective levers require a national commitment and legislative change, as outlined in the recent WHO\(^2\) report. For example, legislative measures to increase the price of energy dense food and measures to prevent energy dense food being marketed to children.

\(^1\) Healthy Auckland Together is a new regional inter-sectoral group, led by ARPHS, that aims to reduce rates of obesity, increase physical activity and improve nutrition.

\(^2\) World Health Organisation, Population Based Approaches to Childhood Obesity Prevention, [http://apps.who.int/iris/bitstream/10665/80149/1/9789241504782_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/80149/1/9789241504782_eng.pdf?ua=1)
While there is renewed interest by central government to tackle obesity, current signals are that legislative measures will not be considered.\footnote{A recent Select Committee report on improving child health outcomes, the government accepted 55 of the 62 recommendations with the following recommendations relating to food environments not accepted: regulating the marketing of unhealthy food to children and taxing high-sugar beverages. Report of the Health Select Committee, \textit{Briefing on matters relating to the Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age} (April 2014).}

Given the national policy environment, Healthy Auckland Together is developing a strategic and innovative region-wide approach that involves better co-ordination and strengthening existing programmes as well as collaboration amongst partner organisations. Healthy Auckland Together’s main focus is on those activities that can be achieved at the regional level and is in the direct control of partner agencies, while using its collective voice to influence policy settings at the national level.

To date Healthy Auckland Together has met five times, with high level engagement from ARPHS, DHBs, Auckland Council, Auckland Transport, Mana Whenua, Aktive Auckland, Ministry of Health, Health Promotion Agency, Auckland University, NGOs working in the sector such as the Heart Foundation and Pacific, Asian and Disability interests.

The Government has recently invested in a new Healthy Families initiative that shares similar goals as Healthy Auckland Together. Healthy Families similarly focus on nutrition and physical activity taking a systems approach to change at a community level. In the Auckland region, Healthy Families will be implemented within one site in West Auckland and two sites in South Auckland. Healthy Families are members of Healthy Auckland Together, which provides opportunities for the benefits of Healthy Families investment to be realised across the region.

4. Healthy Auckland Together meeting on Food Environments

On 19 February 2015, Healthy Auckland Together considered options to intervene in the food environment. The Food Environments report to Healthy Auckland Together is attached for your information. The group has also considered topics on physical activity, children and young people’s settings and Healthy Families NZ.

At the meeting, a number of actions outlined in the attached Food Environments paper were supported. These actions will be refined for potential inclusion into a Healthy Auckland Together Plan, subject to budget and resource considerations. The Healthy Auckland Together Plan will be drafted by June 2015.

Below is an outline of the broad areas for intervention, with some draft actions agreed by Healthy Auckland Together:

- \textit{Actions within Healthy Auckland Together workplaces} – Healthy Auckland Together partner organisations employ over 40,000 Aucklanders: strengthening and implementing health and wellbeing policies within partner organisations can have a positive collective impact on Auckland’s food environment as well as providing a role model for other employers. Draft actions include:
  - complete the implementation of the recently endorsed healthy food policies within the Auckland metro DHBs
  - create best practice toolkits for developing food policies as part of workplace wellbeing.
• **Actions that require working with other organisations and sectors** – some important healthy food environment settings, particularly schools and ECE services, are outside the direct control of member agencies and require Healthy Auckland Together to work and support work done by others. Draft actions include:
  o support large employing organisations to implement workplace wellbeing programmes
  o support schools and early childhood education services to develop and implement healthy food policies.

• **Actions that support or advocate for wider environmental change** – environmental change takes time and involves multiple stakeholders. The paper identifies actions to support and work towards wider change.
  o use a collective voice to promote changes to food environment, e.g. collectively raise the profile of issues related to the obesogenic food environment and submit on government policy documents
  o work with food suppliers, such as supermarkets, to improve healthy food choices.

5. **Next steps**

Now that preliminary meetings are complete, Healthy Auckland Together will develop a Healthy Auckland Together Plan by June 2015. The Plan will set out how the agencies will work together to halt or reverse the rising rates of obesity, improve nutrition and increase physical activity. The Plan will include lead actions to be pursued by partner organisations, with support by other members. The Action Plan will also include implementation timeframes and indicators against which to measure progress.

ARPHS will provide a final Healthy Auckland Together Plan to CPHAC for its information.
To: Healthy Auckland Together
From: Michael Hale
Date: 19 February 2015

Topic: Healthy food environments

Purpose
1. This paper reviews current evidence to identify possible interventions in the food environment to improve nutrition and halt or reverse the rising rate of obesity in Auckland.

Executive summary
2. Multiple factors influence the rising rate of obesity, with obesogenic food environments playing an important role. Our environments (eg our neighbourhoods, towns and workplaces) are saturated with energy dense food that is widely available and comparatively inexpensive. Often energy-dense, low-nutrient foods are the only or main option available. Making changes to the food environment has a great potential to halt or reverse the rising rates of obesity and improve nutrition. By changing the food environment, the healthy choice can become the easy choice.

3. Healthy Auckland Together has opportunities to influence the food environment in a number of ways. By making changes within member organisations, developing joint programmes, influencing other agencies, championing good practice, advocating for change, researching and facilitating regional dialogue.

4. The following prioritisation principles were used to identify possible interventions in the food environment: strength of evidence, size of impact, capacity to act and potential to reduce inequalities.

Recommendations

Actions within Healthy Auckland Together workplaces
5. Healthy Auckland Together member organisations employ over 40,000 Aucklanders. We therefore have a direct opportunity to change the food environment within our own organisations, and collectively this can have a significant impact on Auckland’s food environment as well as providing a role model for other employers. To do this, Healthy Auckland Together can:

a) develop or strengthen healthy workplace food policies in our own organisations.

b) require and provide guidance to subsidiary or contracted organisations to adopt healthy food policies and require healthy food policies within vendor agreements

c) share successful policies, tools, implementation strategies with other agencies

d) showcase examples of healthy food environments

e) model and showcase a specific high profile food issue to raise awareness of the issue eg removal of sugar sweetened beverages from an organisation
f) promote the implementation of front of pack labelling through promotion and purchase specifications

g) adopt healthy food advertising policies for own organisations assets

**Actions that require working with other organisations and sectors**

6. Other organisations and sectors are important food environment settings for change, particularly schools and ECECs, but are outside the direct control of member agencies. To promote changes within these environments Healthy Auckland Together can:

h) assess the number of schools with healthy food policies in the Auckland region. This will help understand the nature and scale of the problem. The assessment will form a benchmark to measure the success of interventions or changes over time

i) identify opportunities to co-ordinate and collaborate with services that work with schools and are represented on Healthy Auckland Together

j) publicise key examples of innovation, showing what can happen through committed leadership. Strengths and models for adoption in other schools or centres can be drawn from these examples.

k) assess the uptake of League for Life healthy modules and evaluate whether support can be provided to improve uptake among rugby league clubs/ extend model to other sports organisations

l) identify opportunities to work with sports venues to encourage or require healthy options in their vendor catering contracts

m) keep informed of the establishment of the Food Policy Council and endorse aligned actions that improve nutrition and food security

n) support the local food initiatives of Kai Auckland where possible, such as the collective buying clubs that are being established in Massey

**Actions that support or advocate for wider environmental change**

7. Some interventions require long term resourcing or legislative change. Direct delivery of these interventions may be outside the scope of Healthy Auckland Together however the group is very well positioned to undertake advocacy, promotion or targeted interventions to achieve change. Healthy Auckland Together can:

o) establish relationships with supermarkets/supermarket companies and work towards developing a healthy supermarket accord

p) work with supermarkets/supermarket companies to create at least one checkout aisle free of energy dense food or similar action like behaviour change prompts within a supermarket

q) use Auckland Regional Public Health’s mapping tool that measures density and location of fast food premises for further analysis and support and inform change in the local food environment

r) investigate opportunities to submit on the Resource Management Act review to provide councils with the ability to zone for fast food outlets

s) investigate opportunities to support submissions to the Unitary Plan that aim to protect elite and prime fertile land in the face of pressure to relax the rural urban boundary and rezone land for residential housing
t) showcase examples of localised actions that limit what dairies sell to children, young people and their families
u) undertake small scale research or analysis to understand the nature and scale of dairies selling energy dense foods to children.
v) promote and advocate changes to legislation to make healthy food more affordable and make unhealthy food more expensive
w) advocate for changes to reduce television advertising of energy dense food to children by amending legislation, enforcing or evaluating the voluntary code or promoting the ability to make complaints under the code.

Background

8. New Zealand’s already high obesity rate is increasing, while in other OECD countries the rate is flattening or reversing. The burden of obesity is not equally shared, with Maori, Pacific and those living in low socio-economic neighbourhoods more likely to be obese. The rising rate of obesity among children is a particular concern.

9. Multiple factors contribute to rising obesity, but our food environments play a significant role. New Zealand’s food environment has become saturated with energy dense food, which is widely available and comparatively inexpensive. Advertising, promotion, and marketing are major influences on food choices and eating habits.

10. Making unhealthy food decisions is not due to individual choices alone, but are reflective of a combination of environmental factors. As such, environmental approaches have the greatest potential to reduce the problem and are less likely to exacerbate health inequalities. Changes can be made to the food environment in two ways: decreasing the over-abundance of unhealthy food, and increasing the affordability and access to healthy food.

11. Obesity can also be associated with food security, which is the ability to buy nutritious food for a healthy life. Reasons for this are complex, but the prevalence of cheap foods that are energy dense and high in fat and sugar contribute to the trend. People with limited resources often select foods that are more energy dense to satisfy hunger and energy needs, while foods high in energy can be low in nutrients. In developed countries the risk of obesity is 20-40 percent higher in women who experience food insecurity compared with the rest of the population. This was found in America, Europe and Australia.

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1 Statistics New Zealand, New Zealand Health Survey.
2 Food environments are defined as the collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people’s food and beverage choices and nutritional status. Swinburn, B., Dominick, C.H and Vandevijvere, S Benchmarking Food Environments: Experts’ Assessments of Policy Gaps and Priorities for the New Zealand Government. University of Auckland 2014.
3 Foods that are energy dense have a high concentration of calories per bite. Energy dense foods are often processed foods.
4 Report of the Health Select Committee, Inquiry into Obesity and Type 2 Diabetes in New Zealand. (2007)
5 Report of the Health Select Committee, Inquiry into Obesity and Type 2 Diabetes in New Zealand. (2007)
8 Burns, Elizabehth, A review of the literature describing the link between poverty, food insecurity and obesity with specific reference to Australia, Melbourne, Vic Health.
12. Again, Māori, Pacific and those families living in most deprived neighbourhoods are more likely to experience food insecurity.\textsuperscript{9}

13. This paper proposes 19 actions across three areas: actions that can be addressed within current resources, actions that require additional resourcing and actions that contribute to longer term change.

14. In looking at possible actions, the following \textit{prioritisation principles} were used:
   - Strength of evidence
   - Size of impact:
     - direct impact (interventions we can implement ourselves)
     - semi-direct impact (eg influencing or advocating for policies or practices)
     - indirect impact (eg interventions which might have high impact as a catalyst for awareness/profile raising or influencing decision makers).
   - Capacity to act (is our group positioned/resourced to act in this area?\textsuperscript{10}) and add value
   - Potential to reduce inequalities.

\textbf{Actions within Healthy Auckland Together workplaces}

15. Healthy Auckland Together agencies represent about 40,000 employees across Auckland. As well as being able to control the food environment within our own organisation, members can provide healthy food environments for visitors, guests or at functions. We can influence the broader environment by leading by example, influencing and negotiating.

\textbf{Healthy policies for workplaces}

16. On average, adults spend about a third of their working life at the workplace.\textsuperscript{11} For those who work full-time at least one meal per day is consumed at work.

17. A healthy workforce is linked to higher productivity, better staff retention and a happier, more resilient workforce. On the other hand, poor employee health can cost organisations through: absenteeism and long term sick pay, loss of production, poor staff retention; as well as contributing to low morale, high stress levels and decreased job satisfaction.\textsuperscript{12}

18. Workplaces can support good employee health by promoting healthy eating and providing nutritious appropriately apportioned foods in the organisations cafeteria, in the vending machines and at workplace functions.

\textsuperscript{9} Ministry of Health (2012), \textit{Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2-18 years): A background paper.}

\textsuperscript{10} Note: As Healthy Auckland Together evolves the group may wish to also explore more ambitious interventions requiring new resources or partnerships to implement.

\textsuperscript{11} World Health Organisation, \textit{Global strategy on occupational health for all: The way to health at work,}

\textsuperscript{12} World Health Organisation, \textit{Workplace Health Promotion}
http://www.who.int/occupational_health/topics/workplace/en/index1.html
19. Organisations adopting healthy food policies can show leadership in the sector and the community, and can develop frameworks that can be used by other agencies and companies.

20. For example, Auckland, Waitemata and Counties Manukau DHB are implementing a policy on suitable food and drink to be served in DHB owned and operated staff cafes and vending machines. Across the three DHBs, this can have some impact. For example, 570,000 retail transactions were made in the Waitemata DHBs last year alone. Many of these purchases will be coffees, while others account for three course meals.

21. The Nelson City Council, Nelson/Marlborough DHB and Northland DHB recently implemented a sugar free beverages policy for all organisation owned buildings and events. The Nelson City Council is now working through how this policy would apply to all its activities, for example vendors at council events, volunteer groups selling sugary drinks to fundraise at council facilities or events, and leaseholders of council-owned properties who sell the beverages as part of their businesses.13

22. Organisations are both providers of food environments and influencers of food environments. As providers the organisations can adopt and implement healthy food policy and healthy food procurement strategies. This can be extended to services that are contracted into the community. For example, a Wellington study surveyed food provided in 16 council owned swimming pools and libraries, including cafes and vending machines: 73 percent of the food and drink options available were unhealthy.14 Making changes to subsidiary or contracted out services can further deepen interventions and improve effectiveness.

23. Large organisations have economic power to negotiate clauses in contracts. As influencers, there is a range of action that can be taken to improve food environments.

- Implement healthy food policy in own organisation
- Implement healthy food policies within subsidiary organisations
- Mobilise and encourage healthy food policies in other organisations
- Require healthy food policies within all vendor contracts.

24. **Action**: Healthy Auckland Together can develop or strengthen workplace food policies in our own organisations.

25. **Action**: Healthy Auckland Together can require or provide guidance to subsidiary or contract organisations to adopt healthy food policies and require healthy food policies within vendor agreements

26. **Action**: Healthy Auckland Together can share policies, tools and implementation strategies with other agencies.

27. **Action**: Healthy Auckland Together can showcase examples of healthy food environments.

28. **Action**: Healthy Auckland Together can model and showcase a specific high profile food issue to raise awareness of the issue eg removal of sugar sweetened beverages

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13 [http://www.stuff.co.nz/nelson-mail/news/10345659/City-council-not-sugar-police](http://www.stuff.co.nz/nelson-mail/news/10345659/City-council-not-sugar-police)

Front of pack labelling

29. Front of pack labelling provides interpretive information on the healthiness of food in a non-numerical graphical form. The front of pack labelling can have two positive health outcomes. Labelling can help consumers make more informed choices by providing a simple comparative tool by which to assess food products. Secondly, labelling can encourage companies to reformulate products to achieve a healthier and better rating.

30. A new Health Star Food Rating is currently in development and due to be rolled out this year. The Health Star Food Rating uses a five star rating, from ½ to five stars to indicate the nutritional value of the product. See image below.

31. The Health Star Food Rating will be voluntary and therefore will only be successful if there is widespread adoption by companies, and if consumers use them in making their food choices.

32. Action: Healthy Auckland Together can contribute to the implementation of front of pack labelling, by:

   • advocating and promoting front of pack labelling to increase prominence and promote adoption - the Health Promotion Agency will be doing a national campaign and Healthy Auckland Together may choose to support this campaign
   • prioritising those products with higher star ratings in agency purchasing
   • applying the label to food prepared in agency cafeterias
   • working with other organisations to adopt a similar purchasing model
   • encouraging companies to adopt the labelling
   • advocating for labelling to become mandatory if there is not widespread adoption in two years.

Food reformulation

33. Food reformulation aims to reduce unhealthy components often found in mass food production. Reformulation of low cost, high volume foods can have significant impact by removing large amounts of sodium, sugar and saturated fat from our food chain and improving the nutritional profile of the basic foods on which low income families depend.

34. The Heart Foundation has worked with parts of the food industry to reformulate recipes and reduce sodium from bread, processed meats and breakfast cereals. For example, over 80 percent of the bread market has now reduced its sodium content of bread to meet the agreed target of <450mg/100g.\(^\text{15}\)

\(^\text{15}\) Swinburn et al, (2014).
35. The Heart Foundation is now setting targets for cooking sauces and savoury snacks. The industry is also looking at reducing the sodium content of bread to meet a new lower target.

36. No further action is suggested for this area.

**Advertising in physical environments**

37. Our environments are filled with food messages that infiltrate lives in a variety of ways: from television, internet, sports clubs, sponsored products, billboards, stores, buses and bus shelters.

38. A Wellington study found an average of 87 food advertisements within a 1km radius of ten secondary schools. Seventy percent of those products advertised were considered unhealthy.\(^\text{16}\) Note that Auckland Council does not allow commercial advertising and promotions in their recreational facilities and libraries. The recreational facilities are also implementing healthy vending machine guidelines.

39. **Action:** Healthy Auckland Together can:
   - review advertising policies on own agency’s assets
   - assess opportunities to adopt a healthy choices advertising policy that allows only products that meet the nutritional guidelines to be advertised on the organisation’s assets. Or attempt to balance the advertising between unhealthy foods with healthy foods or other products.

**Actions that require working with other organisations and sectors**

40. The food environments in other settings, such as schools and sports clubs, are important settings for change. These settings however, are outside the control of member agencies and such changes would require additional resources.

**Healthy food policies for schools and early childhood education centres\(^\text{17}\)**

41. School and early childhood education environments are considered important places to promote healthy eating.\(^\text{18}\) Most children or young people attend a care or school setting, which provides opportunities for change within a receptive setting. Children and young people spend a significant part of their day within school or care settings. They have opportunities to undertake physical exercise, learn about the world and often eat one or two meals per day.

42. In New Zealand, early childcare centres and schools are provided only high level guidelines, with no compliance requirements, on what food can be served and eaten.

43. Since 2008, early childcare education licensing guidelines require that food meet the nutritional needs of the child, and that the centre encourages healthy eating when

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\(^\text{17}\) Note that the school environment was discussed in the previous paper to Healthy Auckland Together (see children and young person’s settings paper 29/11/2014), however given the importance of schools and early childhood education centres, it is also covered in this paper.

food is prepared by parents. Childcare centres vary in the implementation of these licensing guidelines, both in their food preparation and their ability to influence parent choices. Compliance to the guidelines is monitored through a self-review process.

44. For schools, National Administration Guidelines recommend that Boards of Trustees promote healthy food and nutrition for all students, however there is no measure or monitoring to show schools are meeting this guideline.

45. Many schools have a canteen or school tuckshop. Research studies found that most foods sold in school tuckshops were high in fat, sugar and/or salt.

46. While recognising that schools are an effective setting for intervention, schools are faced with multiple curricular obligations and limited financial and staff resources. In the absence of central government policy imperatives, it depends on the commitment of the senior leadership within schools to prioritise nutrition and physical activity.

47. Some schools take a very proactive approach to their food environment. For example, Rhode Street School in Hamilton has a kitchen garden complete with chickens and a wood-fired pizza oven, a commercial teaching kitchen, tunnel house and hydroponics centre, an organic orchard, and the Kai Time student cafe. The school takes a whole school and community approach to nutrition, which is integrated through the curriculum, covers sponsorship and food sold in canteens.

48. Two research project underway will provide further information on food and nutrition in ECECs and schools.
   - Kai time in ECECs links survey data with the Growing Up in New Zealand longitudinal study to examine how different ECE environments are influencing the diet and growth patterns of pre-school children.
   - INFORMAS research into healthy and unhealthy food provision in schools.

49. Action: Healthy Auckland Together can assess the number of schools with healthy food policies in the Auckland region. This will help understand the nature and scale of the problem. The assessment will form a benchmark to measure success of interventions or changes over time. The assessment will also enable any later programmes and interventions to be targeted and help reduce inequalities. Estimated costs of assessment would be $60-$80,000 additional or in kind resources.

50. Action: Healthy Auckland Together can assess opportunities to co-ordinate and collaborate on services in organisations that work with schools, and are represented on Healthy Auckland Together (note that similar networks for early childhood education centres have already been established)

51. Action: showcase key examples of innovation, showing what can happen through committed leadership. Strengths and models for adoption in other schools or centres can be drawn from these examples.

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19 HS19 # Food is served at appropriate times to meet the nutritional needs of each child while they are attending. Where food is provided by the service, it is of sufficient variety, quantity, and quality to meet these needs. Where food is provided by parents, the service encourages and promotes healthy eating guidelines. Licensing Criteria for Early Childhood Education and Care Centres 2008: Early Childhood Education Curriculum Framework, July 2011.

20 Note that a 2008 guideline that schools only provide healthy food options within school canteens was removed in 2009.

Sports venues and children’s sports clubs

52. Sport is an integral part of children’s lives in New Zealand. Up to two-thirds of children belong to a sports club or a school sports team. Sports clubs particularly touch and rugby league\textsuperscript{22}, are important settings for reaching Maori and Pacific youth and adults who are over-represented in negative health statistics.

53. Sports clubs have multiple food associations – in sponsorship, catering, food available in sports grounds, cafes and vending machines, for prizes (such as player of the day vouchers), half time and nutrition and dietary advice for players.

54. Research has shown that energy-dense, nutrient-poor foods and beverages dominated the types of food and beverages available at sports games.\textsuperscript{23} Most venues sold more unhealthy than healthy foods and beverages. Simultaneously, often food and drink associated with sports, especially sports drinks, are unhealthy.\textsuperscript{24}

55. New Zealand Rugby League is implementing the League for Life programme. As part of League for Life, league clubs complete modules to become accredited League for Life member. The modules include information on nutrition and effects of sugar sweetened beverages, implementing healthy vending machines and healthy options fundraising.

56. Action: Assess the uptake of League for Life healthy modules and evaluate whether improvements can be made or support given to improve uptake among rugby league clubs.

57. Action: Evaluate whether the League for Life model could be extended to other sports organisations.

58. Action: review opportunities to work with sports venues to encourage or require healthy options in their vendor catering contracts.

Support and promote the Food Policy Council and Kai Auckland

59. Some cities across Australia, Canada, USA and UK have established a food policy council which brings together stakeholders from diverse food-related sectors to examine how the food system is operating and to develop recommendations on how to improve it. Recommendations may include establishing community gardens, food co-ops, bulk buying groups, creating a charter and running eat local/seasonal campaigns.

60. Auckland Council is establishing a Food Policy Council with key stakeholders in the sector. This is in its early days, and the structure and strategy of the council is still being formed.

61. Auckland Council is also facilitating a people’s food movement - Kai Auckland.\textsuperscript{25} Kai Auckland offers a cohesive and integrated approach to creating connection and nourishment through food. Kai Auckland has five mobilising initiatives to facilitate, enable and organise knowing, growing and sharing across Auckland by 2016:


\textsuperscript{23} Smith, Moira, Consuming calories and creating cavities: Beverages NZ children associate with sport, Appetite, June 2014.

\textsuperscript{25} See www.kaiauckland.org.nz
• Virtual hub – create a dynamic clearinghouse for the movement for local communities to learn, share and inspire each other to grow and enjoy good food.

• Physical Food Hubs - enable physical food hubs where members of the community can connect, learn and work together to buy, grow and share food.

• Community Gardens - support community gardens to evolve into knowledge gardens where community members can learn new skills, grow food and cook together.

• Schools and Education - work within existing environmental programmes, such as Enviro Schools, to grow a food movement at the heart of the food system, in schools.

• Fruit Trees - work with administrators of public and private land and residents to facilitate the purposeful planting of trees on school routes and in common areas.

62. **Action**: Healthy Auckland Together can keep informed of the establishment of the Food Policy Council and endorse aligned actions that improve nutrition and food security.

63. **Action**: Healthy Auckland Together can support the local initiatives of Kai Auckland where possible, such as the collective buying clubs that are being established in Massey, targeting segments of the population that are over-represented in negative statistics and thereby reducing inequalities.

### Actions that support or advocate for wider environmental change

64. Some effective interventions require changes to the legislative environment, or long term partnering, particularly with the private sector to alter practice. The actions identified below identify a first step towards larger changes in the food environment. These actions involve gathering intelligence to inform the decision makers, promoting and showcasing innovative approaches and advocating, and researching effective policies.

#### Supermarkets

65. Supermarkets are a key component in the food environment as most families make the majority of their food choices in supermarkets. The way supermarkets promote, price, place and stock their products has an impact on the food choices that people make.

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26 Note that menu board labelling (providing the nutrient profile of food) for fast food outlets with standardised can be another intervention. But given that there is mixed evidence of the intervention and voluntary moves by industry to provide menu board labelling, it is not included as an action in this paper.

27 New Zealanders buy 70 percent of their food at the supermarket. Ministry of Health, Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 years): A background paper,
Checkouts free of energy dense foods and placement of products

66. Research has shown that foods displayed at supermarket checkout counters are predominantly energy dense and are often promoted or displayed in a way that targets children and encourages adults to impulse buy. 28

67. Similarly, changes in product placement or ‘aisle management’ can change consumer behaviour. For example, recent research found greater sales of more healthful foods when those foods were placed in more prominent locations, such as eye level and at the end of the aisle. 29

68. Straight forward placement strategies that promote healthier options of certain products have been found to make a difference in consumer purchasing. 30 However, supermarkets design stores and layout according to what sells best, with suppliers paying for prime spots on supermarket shelves. Significant consumer research underpins the layout and the placement of stock. This places limitations on what changes supermarkets are willing to make that were not cost neutral or enhanced the profile of the supermarket.

Food supplied in supermarkets

69. Supermarkets decide what products to stock within their branch and thereby supermarkets determine the options available to consumers. Not all supermarkets stock the same products. This is important when it limits healthy choices for consumers. For example, in Manukau the DHB found that the local supermarket only stocked full fat milk. The DHB worked with the supermarket to encourage them to stock reduced fat milk as well.

Supermarket promotions and pricing

70. Sale promotions are a common form of food marketing for unhealthy foods and drinks, for example, price reductions and multi-buys. Promotions can increase sales volumes by 200 percent and are likely to also increase consumption of that particular product. 31 Generally, promotions favour less healthy foods, 32 which has public health concerns when high volumes of unhealthy foods are purchased at the expense of healthy foods.

71. Supermarkets at times advertise loss leaders, where products are advertised at a loss to attract customers, while supermarkets recoup profits on other products.

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31 Ministry of Health, Food and Nutrition Guidelines for Healthy Children and Young People (aged 2-18 years): a background paper. 2012.

32 Sharron Bowers, Kristie Carter, Delvina Gorton, Craig Heta, Tolotea Lanumata, Ralph Maddison, Christina McKerchar, Clona Ni Mhurchu, Des O’Dea, Jamie Pearce, Louise Signal, Mathew Walton Enhancing Food Security and Physical Activity for Maori, Pacific and Low Income Peoples, Clinical Trials Research Unit, University of Auckland; GeoHealth Laboratory, University of Canterbury; Health Promotion and Policy Research Unit, University of Otago; Te Hotu Manawa Maori. July 2009.
72. Evaluation of the Fresh for Less campaign in Manukau shows how supermarkets can play a role in promoting healthier choices. Fresh for Less was a 7 week intervention where fruit and vegetables were significantly discounted, resulting in a corresponding increase in purchases.33

73. Some supermarkets have introduced initiatives to promote healthy eating. Tesco, the largest supermarket in the United Kingdom, launched a long term programme to help children have a better relationship with food through field trips, live video chats and hands-on cooking. The project is estimated to cost NZ$30m in the first year.34

74. A Morrison supermarket in UK introduced ‘Let’s Shop Healthier’ signs in the fruit and vegetable department, as well as life size cut outs of local health professionals prompting healthier choices. This simple behaviour change prompt (akin to stair climbing campaigns), resulted in a 20 percent increase in fresh fruit sales.35 Compellingly, such a campaign does not affect established relationships that supermarkets have for placement and promotions with suppliers.

75. Working with supermarkets for broad changes, such as the healthier supermarkets strategies in Australia, would require ongoing resources. For example to undertake research or analysis on the cost impact of changes to placement, pricing or promotion. However, another option is to do a single defined action with supermarkets.

76. Action: Healthy Auckland Together can advocate for supermarkets to have at least one aisle free of energy dense food or similar action. While this action is likely to have small health benefits, it starts a relationship for ongoing work.

77. Action: Healthy Auckland Together can investigate behaviour change prompts within a supermarket or chain of supermarkets.

78. Action: Healthy Auckland Together can establish relationships with supermarkets/supermarket companies and work towards developing a healthy supermarket accord.

Local government zoning to limit fast food outlets and/or convenience stores

79. Multiple studies, both national and international, have found a relationship between an abundance of unhealthy food outlets in low socio-economic areas and limited choice of fresh food in those same areas36,37. Research, including New Zealand research, has also found a proliferation of unhealthy food outlets near schools that target children, particularly around secondary schools and low decile schools.38

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34 Or £30m. See http://www.eathappyproject.com/home/

35 http://www.healthierchoicespilot.com/#about


37 Pearce, Jamie PhD. Tony Blakely, PhD, Karen Witten, PhD, Phil Bartie, MSc, *Neighborhood Deprivation and Access to Fast-Food Retailing: A National Study,* Day, Peter and Jamie Pearce, Obesity-Promoting Food Environments and the Spatial Clustering of Food Outlets Around Schools, American Journal of Preventive Medicine, V40, Issue 2, 113–121, February 2011.

38 New Zealand research found that fast food and convenience outlets are five times more likely to be near schools than other areas. In addition, the most socially deprived quintile of schools had three times the number and proportion of food outlets compared to the least-deprived quintile. Day, Peter and Jamie Pearce, Obesity-Promoting Food Environments and the Spatial Clustering of Food Outlets Around Schools, American Journal of Preventive Medicine, V40, Issue 2, 113–121, February 2011.
80. Overseas, some jurisdictions have limited the number of fast food outlets through their planning rules. In the UK, the Town and Planning Act enables local authorities to plan location of new hot food takeaways. No council in New Zealand has tried to limit fast food outlets through their planning and zoning rules as it is unclear whether this is possible under the Resource Management Act. Similarly, being able to pursue such provisions through a bylaw is unclear. Enabling council’s to plan for the density and proximity of fast food outlets would require legislative change to provide certainty to territorial authorities, similar to changes made to liquor licensing laws.

81. The recent announcement on a review of the Resource Management Act can provide some opportunities to advocate for councils to be able to limit fast food outlets and convenience stores.

82. In 2009, Regional Public Health (Wellington) funded research to examine the food environments in Eastern Porirua. The research found limited healthy food options in the area and an abundance (‘swamp’) of unhealthy food choices. The research was used to raise awareness and discuss potential solutions with the local council.

83. Auckland Regional Public Health is mapping licensed fast food premises and geographic access by residential demographic populations modelled (eg. % of population with five or more fast food premises reachable within 10min travel time). A second standardised measure of neighbourhood ‘excess’ is also being developed which will identify areas and populations with a surplus of fast food premises relative to other general food premises. INFORMAS research will also be developed that looks at the density and proximity of healthy and unhealthy food outlets in communities in relation to schools.

84. Action: Healthy Auckland Together can use ARPHS mapping tool, which measures density and location of fast food premises, for further analysis and support and inform change in the local food environment. Focus will also be on areas of deprivation.

85. Action: investigate opportunities to submit on the Resource Management Act review to provide councils with the ability to zone for fast food outlets.

Local government zoning to protect elite arable land

86. Almost 10 percent of the best quality (elite) land in Auckland has been converted from food producing land to urban development from 1972 to 2012. Additionally, most of the land lodged for future greenfield developments is on high class land, converting an extra 4.8 percent of elite and prime land away from food production use.

87. Planning and zoning changes are made through the Unitary Plan planning process. When zoning land, Auckland Council is faced with a trade off between housing a fast growing population, improving housing affordability and preserving or managing land important to food security and economic development. Making these trade offs is not easy.

39 In Detroit a zoning code prohibits the building of fast food restaurants within 500ft of all schools.
40 In 2008, Los Angeles city council placed a 1-year moratorium on the opening of new fast food outlets in several south Los Angeles neighbourhoods with high fast food density and high obesity rates.
42 Curran-Cournane, Mealanie Vaughan, Ali memon, Craig Fredrickson, Trade-offs between high class land and development: Recent and future pressures on Auckland’s valuable soil resources, Land Use Policy, 2014.
88. **Action:** investigate opportunities to support submissions to the Unitary Plan that aim to protect elite and prime fertile land in the face of pressure to relax the rural urban boundary and rezone land for residential housing.

**Limit what dairies sell to children**

89. Dairies contribute to obesity promoting environments, with food sold in dairies often being energy dense and targeted to children and young people. New Zealand research found that the proximity of convenience stores are highest around secondary schools, low decile schools and those in densely populated and commercial areas. A median of two convenience stores were located within 5-10 minutes’ walk of schools. The most deprived schools had almost three times more convenience stores than least deprived neighbourhoods.

90. Schools may attempt to provide healthy food environments, but efforts are frustrated by dairies selling cheap energy dense food to students outside school gates. Some schools recognise dairies as a problem, with principals calling for restrictions to what dairies are able to sell between school hours.

91. Responding to this problem at a population level is difficult outside of changes to regulation and zoning. Dairies do not have an umbrella organisation that can be approached, so any intervention would be on a localised level. However, examples of interventions can provide starting points to see what works and what can be duplicated.

92. **Action:** showcase examples of what can be done drawing information from schools. For example, Rhode Street School in Hamilton took a student’s voice approach in identifying and responding to this problem. The students identified the dairies as a problem in their food environment. The students approached, and signed five out of seven local dairies in their vicinity to an agreement to not sell SSBs or energy dense food to children in Rhodes school uniforms before or after school. The result has been a marked improved in the food that children bring to school.

93. **Action:** undertake small scale research or analysis to understand the nature and scale of dairies selling energy dense foods to children. Focus will be in areas of deprivation.

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43 Note that commercial areas are often low decile, which would contribute to the correlation.
44 Convenience stores are defined as dairy, small food market, or petrol station. Note that commercial areas are often low decile, which would contribute to the correlation. Day, L. *Day, Peter and Jamie Pearce, Obesity-Promoting Food Environments and the Spatial Clustering of Food Outlets Around Schools, American Journal of Preventive Medicine, V40, Issue 2, 113–121, February 2011.*
45 [Call to Restrict Junk Food Sale near Schools, The Press, 25/01/2011](http://www.stuff.co.nz/national/health/4575807/Call-to-restrict-junk-food-sale-near-schools)
46 [Dairy deal keeps pupils off lollies](http://www.stuff.co.nz/national/health/4575807/Call-to-restrict-junk-food-sale-near-schools), the student council of Rhode Street School in Hamilton approached neighbouring dairies to sign agreement to not sell lollies and sugary drinks to students in uniform. 14 November 2014.
Limit television advertising of energy dense food to children

94. Advertising, promotion, and marketing are major influences on food preferences and eating habits, especially in children. Advertising helps to form food preferences in children and can normalize unhealthy food.47

95. Television remains the main vehicle through which marketing reaches children.48 New Zealand has a very high proportion of adverts for energy dense food. These ads promote unhealthy food that is high in fat and high in sugar, with 70 per cent of food ads counter to improved nutrition.49 Children, particularly those under ten, are more susceptible to marketing and have less ability to assess critically the marketing tactics used in advertising.50 While some other jurisdictions51 have placed limits on the time and type of advertising that can be targeted at children at certain hours, New Zealand does not have similar legislation. This is despite a majority of parents and grandparents wanting advertising of food and drink to children on television to be reduced.52

96. The New Zealand Advertising Standards Authority, an industry body, self regulates compliance with a voluntary code of advertising food to children.53 The New Zealand Medical Association contends that self-regulation does not adequately protect children’s rights to health. Primarily because restrictions do not apply during children’s peak viewing times and the system is reactive and dependent on complaints being made.54

97. Actions: Healthy Auckland Together can:
   - advocate for legislative change to limit some food advertising to children55
   - advocate for the voluntary code to be reviewed for effectiveness
   - engage with the Advertising Standards Authority to improve enforcement of the code
   - make parents, NGOs and other agencies that work with children, aware of their right to make a complaint to the Advertising Standards Authority when provisions under the Children’s Code are breached.

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49 See http://www.otago.ac.nz/profiles/environmentalobesity.html
50 New Zealand Medical Association, Tackling Obesity, may 2014.
51 For example, Norway, Sweden and Quebec. Jurisdictions covers Countries, states or territories with legislation making powers.
52 76% of parents and grandparents wanted more restrictions. Phoenix Research, Survey of Public Opinions about Advertising Food to Children, 2007.
53 The Children’s Code includes the following food guidelines: 2 (k) Advertisements should not undermine the role of parents in educating children to be healthy and socially responsible individuals. 2 (l) Persons, characters or groups who have achieved particular celebrity status with children shall not be used in advertisements to promote food or drink in such a way so as to undermine a healthy diet, taking into account the Ministry of Health’s “Food and Nutrition Guidelines” for children: http://www.asa.co.nz/code_children_2006.php
54 New Zealand Medical Association, 2014.
55 Note that the Government has signalled that legislative change that places limits on advertising to children is currently off the agenda.
National pricing strategies

98. Legislative measures can influence the food environment by increasing the price of energy dense food, or decreasing the price of healthy food like fruit and vegetables.

99. Following a recent health select committee report on improving child health outcomes however, the Government signalled that legislative changes to the pricing or advertising would not be considered.\(^{56}\)

**Increase the price of unhealthy food**

100. Making foods, particularly those with a known risk to health more expensive through taxes is one way of reducing consumption. Placing taxes on tobacco and alcohol is an accepted strategy to discourage consumption and channel the revenue into population health benefits. Similar strategies for sugar sweetened beverages (SSB) are being implemented in other jurisdictions.\(^{57}\)

101. SSB consumption is linked to unhealthy weight gain and dental caries. SSBs are mainly targeted at children and young people, with young people aged 15 to 18 deriving 27 to 29 per cent of their “total sugars” intake from non-alcoholic beverages.\(^{58}\) Similar taxes can also be placed on other energy dense food, such as saturated fat.

102. Hungary, Mexico and France, have implemented a SSB tax. Rigorous evaluations of the impact of the tax are yet to be published. Preliminary results, however of the first three months after a tax on SSBs was introduced in Mexico in 2014 found that purchases had declined by 10 percent compared to the same time period last year. Meanwhile purchases of milk and bottled water went up 7 and 13 percent respectively.\(^{59}\)

**Reduce price of healthy food**

103. Household food choices are sensitive to price changes. Food prices can have an influence on the food choices of low income families. Two nutrition surveys found\(^{60}\) nearly half of Pacific and 40 percent of Māori households with children felt stressed because they did not have enough money for food.

104. Several studies have found that reducing the price of healthful foods, in particular fruit and vegetables, increases the purchase of those foods.\(^{61,62}\) A recent trial involving

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\(^{56}\) In a recent Select Committee report on improving child health outcomes, the Government accepted 55 of the 62 recommendations with the following recommendations relating to food environments not accepted: regulating the marketing of unhealthy food to children and taxing high-sugar beverages. Report of the Health Select Committee, *Briefing on matters relating to the Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age* (April 2014).

\(^{57}\) Countries, states or territories with legislation making powers.


\(^{60}\) The National Nutrition Survey 1997 and Children’s Nutrition Survey 2002


\(^{62}\) French, Simone, *Pricing Effects on Food Choices*, The Journal of Nutrition, [http://jn.nutrition.org/content/133/3/841S.long](http://jn.nutrition.org/content/133/3/841S.long)
New Zealand supermarkets found that price discounts on healthy foods significantly increased purchases of those foods.63

105. Other countries have made healthy food more affordable. For example, Australia has a GST exemption for basic foods including fruit and vegetables. Pricing strategies are the most cost effective interventions to improve population health.64 While there is no national imperative for legislative change, Healthy Auckland Together can undertake other actions to reduce the cost of healthy food, as outlined in this paper.

106. Action: Healthy Auckland Together can stay informed of international developments that provide evidence of the effectiveness of pricing strategies and promote discussion for change.

Targets and Measures

107. Monitoring and tracking progress helps to define and articulate the obesity, physical activity and nutrition problems. Below is a table with a set of possible indicators for group discussion.

108. Additional indicators will also be developed that will look at measuring progress for priority populations, Maori and Pacific people, children, and lower socio-economic groups. In addition, when programmes or interventions are developed we will be looking at reaching those groups that are over-represented in the obesity, poor nutrition and physical inactivity statistics to reduce rather than widen inequalities.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Aucklanders live, learn and work in settings that are supportive of healthy food choices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome indicators</td>
<td>% reduction of children drinking fizzy drinks 3+ per week (NZ Health Survey)</td>
</tr>
<tr>
<td>Focus Areas</td>
<td>Influencing Auckland workplaces to implement healthy food policies</td>
</tr>
<tr>
<td>Focus area targets (what we can measure together)</td>
<td>Member Organisations with implemented comprehensive healthy food policies or Number of staff of member organisations working in venues with healthy food policies</td>
</tr>
</tbody>
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4.2 Child, Youth and Women’s Health Scorecard

Recommendation:

That the Community and Public Health Advisory Committee note results against key child, youth and women’s health indicators, with accompanying commentary.

Prepared by: Ruth Bijl (Funding and Development Manager - Child, Youth and Women’s Health), Natalie Desmond (Senior Programme Manager - Child Health), Pam Hewlett (Programme Manager - Women’s Health), Dr Karen Bartholomew (Public Health Physician) and Dr Alison Leversha (Community Paediatrician)

Endorsed by: Simon Bowen (Director Health Outcomes)

Glossary

ARDS - Auckland Regional Dental Service
BPS - Better Public Service
CHIP - Child Health Improvement Plan
CPHAC - Community and Public Health Advisory Committee
CYF - Child, Youth and Family
DHB - District Health Board
EEG - Early Engagement in Pregnancy Care Group
HEEADSSS - Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety
HPV - Human Papilloma Virus
IPIF - Integrated Performance Incentive Framework
ISP - Independent Service Providers for cervical and breast screening
LMC - Lead Maternity Carer
MACSAG - Metropolitan Auckland Cervical Screening Advisory Group
MQSP - Maternity Quality and Safety Programme
NIR - National Immunisation Register
NMMG - National Maternity Monitoring Group
NSU - National Screening Unit
OIS - Outreach Immunisation Service
PHO - Primary Health Organisation
PMS - Practice Management System
RhF - Rheumatic Fever
SBHS - School Based Health Service
WCTO - Well Child Tamariki Ora

1. Summary

This report presents information on significant health outcomes for children, youth and women. The report is in the form of a scorecard (see Appendix 1 and 2) and is being presented for the second time. The indicators cover the life-course of maternity, child and youth health, as well as women’s health. All indicators are presented as a Total with breakdowns by Maori, Pacific and Asian ethnicity (with two exceptions where this information is still being sourced).
2. Introduction

At its meeting in February 2015, the Community and Public Health Advisory Committee was presented for the first time with a Child, Youth and Women’s scorecard. The scorecard provided with this paper provides updated data against items presented previously and makes a small number of amendments.

The indicators in the scorecard are:

(a) Child Health Indicators (Appendix 1)
   i. Immunisation health target – 8 months (Health Target)
   ii. Rheumatic fever (Better Public Service Target)
   iii. Two years and five years of age immunisation coverage

(b) Maternity Indicators (Appendix 1)

(c) Baby and Early Childhood (Appendix 1)

(d) Youth Health Indicators (Appendix 2)

(e) Women’s Health Indicators (Appendix 2)

Amendments to the indicators since the February report include:

(a) Breast-feeding at 6 weeks has been amended to breast-feeding at discharge from lead maternity carer (LMC) to align with reporting in other areas. Discharge from LMC occurs between 4-6 weeks.

(b) The addition of breast-feeding at 6 months, as requested by CPHAC.

(c) The addition of oral health utilisation by one year of age, as requested by the Pregnancy and First Year of Life Service Alliance.

(d) A change to the Human Papilloma Virus vaccination (HPV) target from 70% at dose 1 to 65% at dose 3, to align with Ministry of Health target amendments.

3. How to read the Child, Youth and Women’s Health Scorecard

The scorecard is a standardised performance scorecard. It aligns to the overall organisation scorecard. The scorecard shows how each District Health Board (DHB) is tracking against the range of indicators. For each measure, the green bar reflects how well each DHB is doing against the target for the period presented.

The bar will begin to show green when the target has been partially achieved. For most indicators, this is once 60 per cent of the target has been met. If performance is achieving or better than target, the bar will display as a solid green line. Where the bar is blank, this reflects very poor performance against the target, or that no data is available, or no target has been set.
4. **Data Sources**

Data for the scorecard comes from a number of sources and timeframes vary between indicators due to data reporting availability, for example:

(a) All immunisation data including HPV comes from the National Immunisation Register (NIR) and is considered robust and timely

(b) Data for Rheumatic Fever (RhF) is for hospital admissions and is provided by the Ministry of Health

(c) Early engagement with a LMC data is based on 2013 information and was provided to DHBs by the Ministry of Health in 2015 for the second time

(d) Smoke-free data is from hospital maternity data

(e) Breast-feeding data is sourced from two sources: Ministry of Health for information at discharge from LMC and from Plunket, which provides services to more than 95% of the DHBs’ population. Data from other Well Child Tamariki Ora (WCTO) providers is not yet of sufficient quality to use for reporting purposes

(f) Primary Health Organisation (PHO) newborn enrolment data is provided by the Ministry of Health

(g) Oral health data is obtained from Auckland Regional Dental Service

(h) Before School Check (B4SC) data is provided by the Ministry of Health in the form of monthly reports

(i) Youth Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) data is collated from School Based Health Services (SBHS) quarterly monitoring reports

(j) Cervical and breast screening data comes from the Ministry of Health databases for the national programmes and population estimates are used for the denominators. As indicated to CPHAC in February 2015, there has been a change in the data as a result of updated census data.

5. **Performance against targets - Children**

5.1 **Fully immunised by 8 months (Appendix 1)**

The 8 months immunisation health target (to complete three immunisations due at six weeks, three months and five months to protect against diphtheria, tetanus, pertussis, polio, hepatitis B, haemophilus and pneumococcal diseases) is 95%.

The target is reported on at each three-monthly period, against all infants who turn 8 months in that quarter as recorded by the NIR.
As of 21 March 2015, Auckland DHB achieved 94% (no change) and Waitemata DHB achieved 93%, a
decrease of 1%.

Provisional data indicates that of the 1485 (Auckland DHB) and 1907 (Waitemata DHB) infants who
turned 8 months in the January to March 2015 quarter:

- 88 (Auckland DHB) and 65 (Waitemata DHB) infants were not fully immunised
- 27 (1.8%) (Auckland DHB), and 66 (3.5%) (Waitemata DHB) declined immunisation
- 3 (0.2%) (Auckland DHB) and 12 (0.6) (Waitemata DHB) infants opted off the NIR.

(Both the decliners and the opt-off groups remain in the population denominator and have had
contact with the primary care health system.)

The outreach immunisation service (OIS) aims to find all children who are overdue for immunisation
and vaccinate them during an outreach visit to their home or other venue and encourage them back
to their own or a new general practice. At the end of February, one (Waitemata DHB) infant could
not be contacted by the outreach service. This infant may have left the country but until such time
as the Ministry of Health develops an information sharing agreement with Immigration, the Funder
cannot be certain about the status of this infant. One infant from Auckland DHB and two infants
from Waitemata DHB were not fully vaccinated but turned 8 months before they moved into the
DHB. The DHB had no ability to affect the vaccination outcome for these infants.

The period around the traditional summer holiday season has consistently shown a drop in
immunisation rates. This year the drop off appears slightly shallower than previous years but
presents an ongoing challenge for providers and families.

The joint Auckland DHB/Waitemata DHB Immunisation Governance Group continues to scrutinise
coverage and activity. The Group is well supported by both primary and secondary care. One
observation from the last meeting was that there is a notable difference in the number of events
provided by the OIS service in Auckland and Waitemata (over double). This and other matters
affecting the ability of Waitemata DHB to achieve the target are being considered by external
evaluators led by Dr Nicky Turner. Other strategies that have been implemented in the last quarter
include:

- Education for practice nurses regarding how to communicate with patients/families that are
  undecided or considering delaying or declining immunisation. This has been well received.
- Appointment of immunisation coordinators in Waitemata DHB (these roles have been
  embedded in Auckland DHB for around 5 years).
- Shift to ‘whole of system’ approach in Waitemata DHB – with hospital services stepping up in
  relation to checking immunisation status and encouraging immunisation.

To date, the ‘whole of system’ approach in WDHB includes the following actions.

1. A data analysis of ‘missed opportunities’ (children presenting who were overdue for
   immunisation);
2. The Children’s Emergency Department (CED) receiving training updates on talking with families
   about immunisation.
3. The Emergency Department clerical team at Waitakere Hospital being allocated access log-ins in
   order to view and print out the child’s immunisation status as recorded on the National
   Immunisation Register (NIR).
Finally, as part of the joint Immunisation Governance Group, Dr Liz Wilson, Infectious Diseases Consultant, Starship Children’s Hospital, provides a regular update on vaccine preventable disease. In this last quarter there have been hospitalisations of infants with whooping cough and with meningitis. These are very serious diseases and our best wishes go out to the families affected by these tragic illnesses, and to the staff dedicated to caring for them.

5.2 Fully immunised at 2 years and 5 years (Appendix 1)

There are no notable changes to the report regarding the 2 years and 5 years immunisation results.

As previously reported, following the first three vaccination episodes covered under the eight month target (6 weeks, 3 months and 5 months of age), there is a fourth vaccination scheduled at 15 months, then another at four years of age, with the milestones measured at two years and five years of age respectively. The significant difference in coverage between these two milestones demonstrates the effect of the sustained efforts associated with achieving the health target.

The 2 years immunisation result demonstrates the sustained activity since the advent of the first health target. Perhaps of greatest significance is the result for Māori infants where the Funder sees little, if any, equity gap. Immunisation rates at 2 years for Maori children in Auckland DHB are extremely pleasing.

For both Māori and Pacific infants there is a timeliness issue that the Funder is working to address through activities such as early new-born enrolment with primary care.

A continued focus on timeliness and an increased focus on the five year milestone will be required to achieve consistently high immunisation rates and the level of herd immunity required to protect the very vulnerable children and infants who are too young to be or are not able to be immunised. The Ministry of Health has signalled the 5 year milestone will be a monitored indicator from 1 July 2015.

5.3 Rheumatic Fever (Appendix 1)

The Better Public Service (BPS) target for Rheumatic Fever (RhF) measures people of any age at first hospitalisation for acute RhF. As the number of people in any given year is small, the measure is a rate per 100,000 with a target for Auckland DHB of seven cases and for Waitemata DHB of six cases. At this time, indications are that Auckland DHB is on track to achieve the target. Waitemata DHB numbers (four to end March 2015) have not yet shown the expected drop, but variation in small numbers makes this early interpretation difficult.

Young Māori, Pacific and people living in very deprived communities are much more likely to be at risk of RhF. As a result, the RhF programme targets Māori, Pacific and Quintile 5 of the deprivation index (the 20% most deprived) only.

As previously reported, poverty and housing are two of the key determinants to contracting this disease. The health response is to:
1. refer at risk people for housing assessments and improvements (with 341 referred from ADHB to end January 2015 and 115 from WDHB);
2. to increase health literacy regarding the disease and also sleeping habits (proximity);
3. to undertake primary prevention by managing streptococcal throat infections – through the school swabbing programme and rapid response clinics; and,
4. to provide secondary prevention through the use of a prophylactic antibiotic (bicillin) programme.
In relation to the school based swabbing programme for the 2014 calendar year, across the 16 schools in ADHB and 5 schools in WDHB:

- 4,600 children were consented; 7,079 swabs were taken with an average GAS positive rate of 11% in ADHB schools.
- 963 children were consented; 7,073 swabs were taken with an average GAS positive rate of 9% in WDHB schools.

Both the Ministry of Health (MoH) and the DHBs are conducting evaluations on the school swabbing service with the previously signalled reduction in MoH funding from 30 June 2015. It should be noted that the length of time the school swabbing programme has been running makes it difficult to draw meaningful conclusions as to its efficacy in reducing rheumatic fever. Consequently the MoH has indicated that they may engage in a discussion regarding funding the primary school-based sore throat swabbing and management programme over the 2015 winter period and potentially until June 2016. Preliminary analysis of Group A Strep load (GAS, the necessary precursor of RhF) in a subsample of schools with school-based health clinics has identified a significant reduction in both GAS load and skin infections. The RhF team is working with Dr Tom Robinson on an initial evaluation.

In 2015, the MoH has also placed greater emphasis on integrating components of the RhF strategy including the sore throat and rapid response programmes with Pacific and youth engagement and housing initiatives.

As previously reported, case reviews are done of each patient. The patient journey across the health system is being tracked and areas of mismatch are being actively improved. The Auckland DHB disease management team were successful in obtaining a grant from the Green Lane Research and Education Fund for a research assistant to examine the issues across the whole health system to identify issues and areas for improvement and redesign. Work continues on the Rheumatic Fever register. The RhF team won a Healthcare Hackathon for their work on an app that assists self-management for young people with RhF. Discussions are underway with Curekids regarding funding for further development.

5.4 Maternity indicators (Appendix 1)

Indicators to reflect a healthy start to life include early access to pregnancy related care and smoke-free pregnancy.

Early Pregnancy Care Engagement

Early engagement in pregnancy care is important for maternal and infant health because it means women receive health information, screening and early interventions as appropriate.

The early pregnancy care indicator is the percentage of women who register (‘book’)1 with a LMC in their first trimester of pregnancy. Since 2013 DHBs have been directed to include this indicator in their Annual Plans, along with activities to improve engagement with an LMC in the first trimester, with a target of 80% being set. There has been little improvement nationally in the percentage of

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1 Registration in this context refers to the process of officially ‘booking’ a woman; completing the registration paperwork. This registration form (LMC claim) is processed by the Ministry of Health under section 88 (a centrally managed funding mechanism between LMCs and the Ministry of Health, DHBs are not involved in LMC claims). It should be noted that a LMC may see (or have phone/other contact with) a woman one or more times before this formal registration form is completed. She may also have received care from a general practitioner (GP) or other health professional before seeing her LMC. From the perspective of the woman she may consider herself ‘booked’ with a LMC on the first contact (or the acceptance of her care verbally/in person) by the LMC which may or may not involve the registration process. The ‘measure’ of early engagement is the receipt of a registration form from the LMC.
women registering with a LMC in their first trimester (approximately 63%), however the annual indicator is not reported in a timely manner (the 2013 provisional data has only just been released) and therefore it is difficult to know if recent DHB activity has made an impact. The data also currently only reflects care provided by self-employed LMCs and not hospital provided care (approximately 10% for Waitemata DHB and 20% for Auckland DHB). The Funder understands this will be included in the measure from mid-2015.

A new Integrated Performance Incentive Framework (IPIF) measure for early engagement is being considered from July 2015. This measure is proposed to provide quarterly data on the timeliness of registration with an LMC for women enrolled with a general practice. The intention of this measure is to promote the role of general practices/general practitioners (GPs) in helping women to find and register with a LMC in the first trimester of pregnancy.

DHB work toward improving the number of women registering with a LMC in the first trimester was initially undertaken through the Maternity Quality and Safety Programme (MQSP) coordinators. In mid-2014 a regional group was established to focus and align activities. The Early Engagement in Pregnancy Care Group (EEG) is a working group reporting up to the Auckland DHB and Waitemata DHB Pregnancy and First Year of Life Service Alliance. The focus of EEG has been the experience of early pregnancy care for women and the timing and quality of the services provided. This is much broader than just LMC registration and acknowledges that 70% of women see a GP first in pregnancy. Pre-existing work in each of the DHBs, including survey results, GPs and LMC perspectives, was utilised to shape the work of the group. Of note the survey findings indicate that most women know pregnancy care is important, but not that early care in the first trimester is important.

EEG has prioritised the following activities, all with a focus on priority group women:

(a) Advertising campaign promoting early engagement key messages to women and their whanau.
(b) Progression of the first trimester clinical pathway once primary care funding has been clarified with the Ministry of Health.
(c) Survey of GP current practice (service delivery, models of care and funding) for first trimester care.
(d) The development of narratives demonstrating examples of successful GP/LMC relationships, referral pathways and models of care.

A range of further work streams building on the current activity have also been identified, with a focus on provider education, community education, information sharing and strengthening relationships.

Maternal Smokefree
The smokefree literature shows poorer birth and long term health outcomes associated with maternal smoking in pregnancy. The focus of activity is on strategies for Māori women (as noted in the scorecard the percentage of Māori women smoke free at delivery is much lower than the target of 86% - 64% smoke free Auckland DHB, and 75% smoke free Waitemata DHB). The smoke free coordinator has moved to the Māori Health Gain Team with an initial focus on a project incentivising pregnant women to quit. This incentive programme will start in July 2015. The Funder is also undertaking a maternal smoking audit to investigate issues with the capture and transfer of data, as well as auditing the provision of brief advice and referral pathways through cessation services for pregnant women. The audit will also identify the numbers of women who decline smoke free services.
**Breastfeeding**

Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. Breastfeeding rates on discharge from hospital are positive but there is a significant decline following this. To ensure breastfeeding rates are monitored for the duration of breastfeeding and not just initiation this report now includes the 6 month breastfeeding rates. This includes any breast milk given at 6 months as at this stage in their development it is also appropriate that infants have complementary foods introduced.

Whilst the overall rate is 71% for Waitemata DHB and 75% for Auckland DHB there are differences by ethnicity with 57% of Maori infants receiving any breast milk in Waitemata DHB (below target) and 69% in Auckland DHB. Rates for Pacific are just above the MoH set target at 61% in Auckland DHB and 62% in Waitemata DHB. Asian rates remain high, 76% in Waitemata DHB and 79% in Auckland DHB.

The 6 week breastfeeding data is now in line with the Well Child/Tamariki Ora Quality Improvement Framework and is collected from LMC discharge data as opposed to Plunket data. This change ensures more babies are captured (90% vs approximately 70%). This data reports fully and exclusive breastfeeding rates.

Our goal is to reduce the inequities that exist and to understand what support our community needs to increase breastfeeding rates up to and beyond 6 months. This will be achieved by providing evidence based information through the revised pregnancy and parenting programme. This will include providing information using modern technology such as Apps.; informing the community on what free breastfeeding support services are available, and; developing combined LMC/ Well Child Tamariki Ora (WCTO) breastfeeding education.

5.5 Baby and early childhood (Appendix 1)

Connecting infants with healthcare providers is a focus for a number of areas, though the Funder reports in this scorecard on enrolment with PHOs and community oral health only. The Funder has established a multi-enrolment project until such time as electronic linkages can be put in place. Following advice from the Privacy and Security Committee, planning is underway to develop communications with LMCs and women regarding sharing contact information only (not health information) with PHOs/General Practice, WCTO and Auckland Regional Dental Service (ARDS).

The rates of enrolment with ARDS for infants in the first year of life vary significantly by DHB and ethnicity. The Total enrolled for ADHB is 22% with 53% in WDHB. Ethnicity breakdowns are:

- Maori 20% ADHB; 34% WDHB
- Pacific 20% ADHB; 38% WDHB
- Asian 19% ADHB; 50% WDHB.

The service has recently begun to focus on enrolments by one year of age, rather than ‘pre-school’ enrolment. Planning has begun to implement the Pregnancy and First Year of Life Alliance Group recommendation to offer enrolment on the post-natal wards in Auckland DHB as is already occurring in Waitemata DHB until such time as the multi-enrolment project is functioning effectively. Further analysis will be undertaken to determine why the rates are significantly lower than desired in both DHBs but particularly in Auckland DHB.
The B4 School Check Programme has improved dramatically over time and with Plunket as the provider for both Auckland DHB and Waitemata DHB. The programme is tracking to achieve the 90% coverage target including for the most deprived communities. The positive shift for Auckland has been noted nationally by the Ministry of Health.

6. Performance against targets - Youth

6.1 HPV Immunisation Coverage (Appendix 2)

As previously noted the HPV immunisation indicator has changed to 65% at Dose 3. End of year results from 2014 show Auckland DHB on 76% is already exceeding the target but Waitemata DHB on 54% is tracking below target. Current activities to improve uptake at Waitemata DHB include:

- Establishing a dedicated Immunisation Coordinator position in Child and Family Services, WDHB
- Introducing the School-based vaccination system (SBVS) database to enhance information management and provide timely information for primary care providers.

6.2 HEEADSSS coverage in DHB funded schools health services (Appendix 2)

The data in this report is the same as that provided in February. As previously noted, new contracts were put in place in Waitemata DHB for School Based Health Services (SBHS) during 2014 and it is expected to take some time before the Waitemata DHB services are delivering against expectations.

In relation to youth services delivered through primary care, this is a focus for 2015 directed through the Youth Services Alliance Leadership Team (YSALT). Each of the PHOs is represented on this group which started in Auckland DHB. This year, Waitemata PHO joined the YSALT and collectively will be considering how to increase the responsiveness of primary care to young people.

An evaluation of the Prime Minister’s Youth Mental Health Initiative has been commissioned centrally by the Ministries of Health, Social Development and Education. One locality being explored through this evaluation is Henderson. The evaluation will help identify what works and provide guidance for future youth mental health initiatives.

In addition to this evaluation, Waitemata DHB has commissioned an evaluation of youth health services in the district.

7. Performance against targets – Women

7.1 Cervical screening rate (25-69 years: 3 year coverage) (Appendix 2)

Cervical screening coverage in December 2014 showed an increase for Auckland DHB to 78.9%, with no change for Waitemata DHB at 76.1%.

Table 1. Cervical screening coverage trend

<table>
<thead>
<tr>
<th></th>
<th>Jun-13</th>
<th>Sep-13</th>
<th>Dec-13</th>
<th>Mar-14</th>
<th>Jun-14</th>
<th>Sep-14</th>
<th>Dec-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>77%</td>
<td>77%</td>
<td>77.0%</td>
<td>77.0%</td>
<td>76.6%</td>
<td>76.5%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Auckland</td>
<td>77%</td>
<td>77%</td>
<td>76.9%</td>
<td>76.2%</td>
<td>75.3%</td>
<td>75.2%</td>
<td>78.9%</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>69%</td>
<td>70%</td>
<td>69.8%</td>
<td>70.0%</td>
<td>69.8%</td>
<td>69.6%</td>
<td>71.5%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>76%</td>
<td>76%</td>
<td>76.2%</td>
<td>76.4%</td>
<td>76.3%</td>
<td>76.5%</td>
<td>76.1%</td>
</tr>
</tbody>
</table>
The December figures use the new census denominators, and although the number of women screened in both DHBs rose by approximately 1,000 women over the quarter (1,254 in Waitemata DHB and 1,060 in Auckland DHB), the changes to the denominator meant that this was not reflected in the Waitemata DHB coverage rate (because the population was larger than previously projected) and the increase was magnified for Auckland DHB (because the population was smaller than projected).

Table 2. Impact of new census data on cervical screening

<table>
<thead>
<tr>
<th></th>
<th>Women eligible for screening (hysterectomy adjusted population)</th>
<th>Women screened in last 3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB</td>
<td>Auckland</td>
<td>Waitemata</td>
</tr>
<tr>
<td>Q1</td>
<td>134,550</td>
<td>147,555</td>
</tr>
<tr>
<td>Q2</td>
<td>129,596</td>
<td>149,812</td>
</tr>
<tr>
<td>Difference</td>
<td>-4,954</td>
<td>2,257</td>
</tr>
</tbody>
</table>

In the PHO Performance Programme (PPP) the target for cervical screening was changed from 75% to 80% in January 2014. Since June 2014 cervical screening has been one of the five IPIF indicators, with interim targets set to achieve programme IPIF coverage target of 80% by June 2015. These changes have resulted in motivation for improving practice level cervical screening coverage. There have been improvements in cervical screening coverage in IPIF since early 2014 for both DHBs as shown in the figures below.
As recommended by the review of the Metropolitan Auckland Cervical Screening Advisory Group (MACSAG) in 2014, MACSAG has moved to providing high level strategic advice on the screening pathway and coverage improvement. Under MACSAG the Operations Group involves PHOs and Independent Service Providers (ISPs) to implement MACSAG’s two platform activities to support IPIF: data matching and, through the Coordination Service, implementation of the ‘How To’ Guide at a practice level. The MACSAG strategic plan is due for review by June 2015, and this is being revised with a singular focus on priority group women.

The Operations Group and the Coordination Service are also supporting and assisting PHO-led initiatives such as Saturday clinics, vouchers/raffles/draws, best practice invitation and recall systems support, nurse smear taker training, reception/administrative staff training to assist invitation and recall, and building opportunistic alerts into Practice Management Systems (PMS).

The large data matching pilot has now been completed and the repeat match is nearly due for release to practices. The data match evaluation is underway. Early learnings from the pilot have informed the presentation of lists of women over-due for a smear to practices in a way to be maximally useful and result in practice action. The lists are prioritised by clinical risk, length of time overdue and ethnicity. The pilot has developed a ‘best practice’ approach to data matching. The National Screening Unit (NSU) is now working with us in a small working group to see if this approach can be scaled up to provide monthly data matched lists to all PHOs nationally through the secure PHO portal. This is a significant step forward, and will provide the most efficient and systematic solution.

### 7.2 Breast screening (50-69 years: 2 year coverage) (Appendix 2)

The new census denominator was introduced for breast screening in Quarter 2. This has resulted in reductions in coverage particularly for Māori and for Pacific women. The breast screening coverage overall dropped 2% to 67% in Auckland DHB and remained unchanged at 68% in Waitemata DHB; both just below the coverage target of 70%. Māori coverage dropped nearly 4% in both DHBs.
Previous coverage has indicated that Lead Providers were on track for achieving Māori coverage of 70% (particularly in Auckland DHB at 68%). There is now more of a step to reach target as measured by the new census data – 190 more women for Auckland DHB and 411 more women for Waitemata DHB need to be screened to reach the coverage target for Māori women (see Table 3).

Table 3. Number of Māori women required to reach coverage target for breast screening (at Dec 2014)

<table>
<thead>
<tr>
<th></th>
<th>Eligible women</th>
<th>2 year coverage 50-69 yrs %</th>
<th>2 year actual number of women</th>
<th>Numbers of women needed to reach 70% target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB – Māori</td>
<td>3,220</td>
<td>64.1%</td>
<td>2,064</td>
<td>190</td>
</tr>
<tr>
<td>Waitemata DHB - Māori</td>
<td>4,140</td>
<td>60.1%</td>
<td>2,487</td>
<td>411</td>
</tr>
</tbody>
</table>

Source: NSU

Pacific coverage dropped 3% in Waitemata DHB and 10% in Auckland DHB although Pacific coverage remains above target in both DHBs. Asian rates are not available from the NSU data, although this data has been requested and the NSU are working through reporting Asian coverage routinely.

The Lead Providers for breast screening are actively working on data matching with PHOs as a key strategy to identify, and invite or recall eligible women. A memorandum of understanding (MOU) has been agreed to enable this to happen. This data matching will enable higher numbers of Māori women to be identified and screened in a timelier manner. Staff will follow up invite letters with phone calls if women have not responded by two weeks.

8. Indicators under development

The Funder is still considering an indicator to reflect the Better Public Service (BPS) target Reducing Assaults on Children, tied in with the Vulnerable Children Act and expectations of the Children’s Action Plan. Specifically, the Funder is establishing whether it is feasible to report family violence screening for all pregnant women who interface with secondary/tertiary health services. Pregnant women are a key group to target for identification and intervention. Pregnant women are particularly at risk of family violence and both mother and baby are put at significant risk by family violence. If achievable, the Funder would anticipate reporting on whether women are screened, no matter which part of the system they connect with, such as the emergency department, mental health or traditional maternity services. This indicator is likely to be in addition to notifications by DHB staff to Child Youth and Family (CYF).

9. Conclusion

The scorecard provides an overview of progress in key areas for children, youth and women with a focus on priority groups. The Funder is pleased with progress in a number of areas but recognise there is still much work to do to achieve and maintain the immunisation health target, the rheumatic fever Better Public Service target and also notably in the areas of oral health and both cervical and breast screening. There is a wide range of work underway, managed by the team to achieve targets and, particularly, to achieve equity.
## Appendix 1

### Auckland and Waitemata DHBs Community and Public Health Advisory Committees Meeting 29/04/15

#### Priority 1: Health Targets - Auckland DHB

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully immunised by 8 months</td>
<td>94%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
</tbody>
</table>

#### Priority 2: Better Public Service Target - Auckland DHB

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
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</thead>
<tbody>
<tr>
<td>Rheumatic Fever rate*</td>
<td>2.30</td>
<td>1.90</td>
<td>CY 2014</td>
</tr>
</tbody>
</table>

*Acute cases per 100,000 population.

#### Priority 3: Other Targets - Auckland DHB

### Children

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully immunised by 8 months</td>
<td>94%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Meeni</td>
<td>88%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Pacific</td>
<td>92%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Asian</td>
<td>90%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Other</td>
<td>93%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
</tbody>
</table>

#### Priority 4: Other Targets - Waitemata DHB

<table>
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<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
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</thead>
<tbody>
<tr>
<td>Fully immunised by 8 months</td>
<td>93%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
</tbody>
</table>

#### Priority 2: Better Public Service Target - Waitemata DHB

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
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<tbody>
<tr>
<td>Rheumatic Fever rate*</td>
<td>2.70</td>
<td>1.40</td>
<td>CY 2014</td>
</tr>
</tbody>
</table>

*Acute cases per 100,000 population.

#### Priority 3: Other Targets - Waitemata DHB

### Children

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully immunised by 8 months</td>
<td>94%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Meeni</td>
<td>88%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Pacific</td>
<td>92%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Asian</td>
<td>90%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Other</td>
<td>93%</td>
<td>95%</td>
<td>21/04/14</td>
</tr>
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</table>

### Before School Check coverage rates

<table>
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<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>63%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Meeni</td>
<td>60%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Pacific</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Asian</td>
<td>63%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>78%</td>
<td>90%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Meeni</td>
<td>75%</td>
<td>90%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Pacific</td>
<td>77%</td>
<td>90%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Asian</td>
<td>85%</td>
<td>90%</td>
<td>21/04/14</td>
</tr>
<tr>
<td>Other</td>
<td>72%</td>
<td>90%</td>
<td>21/04/14</td>
</tr>
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### % of women booking with a LMC before 12 weeks

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>64%</td>
<td>80%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Meeni</td>
<td>64%</td>
<td>80%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Pacific</td>
<td>86%</td>
<td>80%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Asian</td>
<td>63%</td>
<td>80%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Other</td>
<td>89%</td>
<td>80%</td>
<td>CY 2013</td>
</tr>
</tbody>
</table>

### % of women smokefree at delivery

<table>
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<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>99%</td>
<td>86%</td>
<td>03</td>
</tr>
<tr>
<td>Meeni</td>
<td>95%</td>
<td>86%</td>
<td>03</td>
</tr>
<tr>
<td>Pacific</td>
<td>86%</td>
<td>86%</td>
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<td>Asian</td>
<td>63%</td>
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<td>03</td>
</tr>
<tr>
<td>Other</td>
<td>99%</td>
<td>86%</td>
<td>03</td>
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### % of women smokefree at 12 weeks

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>75%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Meeni</td>
<td>66%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Pacific</td>
<td>62%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Asian</td>
<td>71%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Other</td>
<td>78%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
</tbody>
</table>

### % of women breastfed at discharge from LMC

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>82%</td>
<td>68%</td>
<td>Jun-Oct 13</td>
</tr>
<tr>
<td>Meeni</td>
<td>82%</td>
<td>68%</td>
<td>Jun-Oct 13</td>
</tr>
<tr>
<td>Pacific</td>
<td>85%</td>
<td>68%</td>
<td>Jun-Oct 13</td>
</tr>
</tbody>
</table>

### % of women breastfeeding at 6 months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>60%</td>
<td>54%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Meeni</td>
<td>52%</td>
<td>54%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Pacific</td>
<td>44%</td>
<td>54%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Asian</td>
<td>60%</td>
<td>54%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Other</td>
<td>66%</td>
<td>54%</td>
<td>CY 2013</td>
</tr>
</tbody>
</table>

### % of women breastfeeding at 3 months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>75%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Meeni</td>
<td>66%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Pacific</td>
<td>62%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Asian</td>
<td>71%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Other</td>
<td>78%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
</tbody>
</table>

### % of women receiving breast milk at 6 months

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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<td>Meeni</td>
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<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Pacific</td>
<td>62%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Asian</td>
<td>71%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
<tr>
<td>Other</td>
<td>78%</td>
<td>59%</td>
<td>CY 2013</td>
</tr>
</tbody>
</table>

### % of babies enrolled with a PHO by 3 months

<table>
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<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>72%</td>
<td>98%</td>
<td>Sep 14</td>
</tr>
</tbody>
</table>
| Oral health - % infants enrolled in dental service by 1 year

### Oral health - % of infants enrolled in dental service by 1 year

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>22%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Meeni</td>
<td>20%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Pacific</td>
<td>20%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Asian</td>
<td>19%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Other</td>
<td>28%</td>
<td>98%</td>
<td>Mar-15</td>
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</table>

### Oral health - % utilisation by 1 year

<table>
<thead>
<tr>
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<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>8%</td>
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<td>Feb 14</td>
</tr>
<tr>
<td>Meeni</td>
<td>7%</td>
<td>100%</td>
<td>Jan 00</td>
</tr>
<tr>
<td>Pacific</td>
<td>7%</td>
<td>100%</td>
<td>Jan 00</td>
</tr>
<tr>
<td>Asian</td>
<td>7%</td>
<td>100%</td>
<td>Jan 00</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td>100%</td>
<td>Jan 00</td>
</tr>
</tbody>
</table>

### Oral health - % utilisation by 1 year

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>72%</td>
<td>98%</td>
<td>Sep 14</td>
</tr>
</tbody>
</table>
| Oral health - % of infants enrolled in dental service by 1 year

### Oral health - % of infants enrolled in dental service by 1 year

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>53%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Meeni</td>
<td>53%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Pacific</td>
<td>38%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Asian</td>
<td>50%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Other</td>
<td>65%</td>
<td>98%</td>
<td>Jan 00</td>
</tr>
</tbody>
</table>

### Oral health - % utilisation by 1 year

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual</th>
<th>Target</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Meeni</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Pacific</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Asian</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Other</td>
<td>62%</td>
<td>60%</td>
<td>Mar-15</td>
</tr>
</tbody>
</table>
### Appendix 2

#### Youth

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Total Coverage</th>
<th>Target Coverage</th>
<th>Improvement against previous result</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV immunisation coverage (dose 3)</td>
<td>76%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>74%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>88%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>70%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>76%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td>HEEADSS coverage in DHB-funded school health services</td>
<td>95%</td>
<td>95%</td>
<td>95% Dec-14</td>
</tr>
</tbody>
</table>

#### Women

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Total Coverage</th>
<th>Target Coverage</th>
<th>Improvement against previous result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical screening rate (25-69 years; 3 year coverage)</td>
<td>79%</td>
<td>80%</td>
<td>80% Dec-14</td>
</tr>
<tr>
<td></td>
<td>56%</td>
<td>80%</td>
<td>80% Dec-14</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>80%</td>
<td>80% Dec-14</td>
</tr>
<tr>
<td></td>
<td>66%</td>
<td>80%</td>
<td>80% Dec-14</td>
</tr>
</tbody>
</table>

#### Breast screening rate (50-69 years; 2 year coverage)

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Total Coverage</th>
<th>Target Coverage</th>
<th>Improvement against previous result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>64%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>77%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>70%</td>
<td>70% Dec-14</td>
</tr>
</tbody>
</table>

---

**How to Read Graphs**

- **Actual DHB Performance**: Displays the actual performance of the DHB against the target.
- **Target**: The target performance is set for each indicator.
- **Improvement against previous result**: Displays the improvement in performance compared to the previous year.
5.1 Planning, Funding and Outcomes Update

Recommendation:

That the Community and Public Health Advisory Committee receive the report.

Prepared by: Aroha Haggie (Manager - Maori Health Gain), Lita Foliaki (Manager - Pacific Health Gain), Samantha Bennett (Manager - Asian, Migrant & Refugee Health Gain), Jane McEntee (General Manager - Auckland Regional Public Health Service)

Endorsed by: Simon Bowen (Director Health Outcomes)

Glossary

AMRHGT - Asian, Migrant and Refugee Health Gain Team
ARPHS - Auckland Regional Public Health Service
ASH - Ambulatory Sensitive Hospital
CPHAC - Community and Public Health Advisory Committee
DHB - District Health Board
MHGT - Maori Health Gain Team
MBIE - Ministry of Business, Innovation and Employment
MOU - Memorandum of Understanding
PCN - Parish Community Nurses
PHAP - Pacific Health Action Plan
PHO - Primary Healthcare Organisation

Summary

This report updates the Community and Public Health Advisory Committee (CPHAC) on Auckland and Waitemata DHBs’ planning and funding activities not reported on elsewhere in the agenda.

1. Maori Health Gain

1.1 Planning

The first draft of the 2015/16 Waitemata Maori Health Plan was endorsed by the Waitemata DHB Board and the Auckland DHB Audit and Finance Committee and submitted to the National Health Board on 13 March 2015 with the Annual Plan. The Maori Health Gain Team (MHGT) is expecting feedback from the Maori Health Business Unit (MHBU) in late April. The MHGT will continue to engage with its Memorandum of Understanding (MOU) partners, Primary Healthcare Organisations (PHO), Māori providers and key internal stakeholders to refine the Maori Health Plan in conjunction with MHBU feedback.

1.2 Maori Health Outcomes Framework

The MHGT is working with Mason Durie to develop a Maori Health Outcomes Framework. The aim of the Framework is to measure the contribution the health system is making to improving health outcomes for Māori. Two workshops have been held with Māori providers to inform the development of the Framework. The feedback received will support the development of the
Framework which is expected to be finalised shortly. The Framework will support the development of multi-year integrated contracts for Maori providers and support more flexible service delivery.

1.3 Ethnicity Data Audit Tool

Implementation of the Ethnicity Data Audit Tool (EDAT) Project is progressing well. All of the DHB led training requirements have been delivered. To date, EDAT has been implemented in 159 general practices. This represents an implementation rate of 70%. The Funder is confident that it will reach 95% implementation rate by the end of the project (June 2015), as is stipulated in the contract with the Ministry of Health.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of EDAT</td>
<td>70%</td>
<td>95% of General Practitioner Practices have implemented EDAT</td>
</tr>
</tbody>
</table>

1.4 Ambulatory Sensitive Hospital Survey

Reducing Ambulatory Sensitive Hospital (ASH) admission rates is one of the priority areas of the Maori Health Plan. To support this goal the MHGT is conducting a survey with Maori patients who have been admitted to hospital with an ASH related condition to get a better understanding of their pathway. This information will be used to support the development of interventions to improve access to primary and community care. The survey will be completed by June 2015 with possible interventions identified by September once analysis is complete.

2. Asian, Migrant and Refugee Health Gain

2.1 Asian and Middle Eastern, Latin American and African (MELAA) Health Governance Group and Auckland Regional Asian and MELAA Primary Care Working Group

The Asian, Migrant and Refugee Health Gain Team (AMRHGT) continues to lead the Asian and Middle Eastern, Latin American and African (MELAA) Health Governance Group for Auckland and Waitemata DHBs; and the Auckland Regional Asian and MELAA Primary Care Working Group to guide implementation of their respective 2014/15 Action Plans, and development of the 2015/16 Action Plans.

Actions specific to increasing PHO enrolments of Asians as part of the Auckland Regional Asian and MELAA Primary Care Working Group include agreement on targets across the two DHBs at 80% (Auckland DHB) and 83% (Waitemata DHB). Interventions to increase awareness of the need to enrol with a PHO (and benefits), and the role of primary care, include presentations at orientation sessions at the Auckland Regional Migrant Services (ARMS) and Citizen’s Advice Bureau (CAB) face-face sessions, collateral development of the Your Local Doctor materials and e-poster to be disseminated to key partners and Asian communities across the Asian and mainstream sectors.

AMRHGT also has active involvement in the Auckland Regional Public Health Service’s planning of a regional Asian approach to public health and cross-links to health services for Asian communities.

2.2 Refugees

The Funder is planning three Auckland Regional Refugee Health Network forums in 2015 to primary health professionals to increase their awareness of emerging refugee priority health areas.
The Refugee Primary Care Wrap-Around Service contracts with PHOs are rolling out with identified general practices participating in the programme to offer subsidised culturally appropriate services to enrolled refugees within the practices. The Programme Manager - Asian, Migrant and Refugee (WDHB-ADHB) will provide onsite support to practices where necessary to address barriers to uptake of services experienced by the refugee populations or primary health workforce. An Operational Group for participating PHOs has been established to provide support and act as a platform for shared learnings and group discussion. Two receptionists are training frontline staff in March and May 2015 to up skill staff on the soft skills and cultural competencies required to support refugee families at the practice level.

2.3 Paper to the Auckland DHB Board

AMRHG is developing a paper to the Auckland DHB Board on current health services gaps for Asian populations.

3. Pacific Health Gain

The Pacific Health Action Plan 2013-2016 (PHAP) has six priorities and an update on the progress of its implementation follows.

3.1 PHAP - Priority 1

In relation to the first priority that children are safe and well and that families are free of violence the initial work is to participate in existing forums addressing family violence. The first Incredible Years parenting programme is in its 8th week and the second one, which is being run in a Samoan church on the North Shore, is in its 3rd week. The Funder is on track to deliver at least two parenting support programs by the end of the current financial year as required by DAP 2014/15 and further develop the family violence prevention programme.

3.2 PHAP - Priority 2

The second priority of the Plan is that Pacific people are smoke free. The WERO group quit smoke competition has started. One Tongan church from West Auckland is part of the competition and participants are being supported by a Tongan quit coach from the Pacific Quit Smoke Service (ARPHS) and one of the parish community nurses who is Tongan.

3.3 PHAP - Priority 3

The third priority is that Pacific people eat healthy and stay active. Weekly physical activities and nutrition training is continuing. The parish community nurses (PCNs), two in West Auckland and one on the North Shore are currently working with Enua Ola churches / groups to systematically take individuals’ blood pressure and glucose levels in the community. There is enthusiastic support from the church and community groups for the nurses’ work and the challenge is to manage and to align the expectations’ of the community with the capacity of the nurses.

3.4 PHAP Priority 4

The fourth priority is that we seek help early. A key function of the PCNs is to improve the health literacy of Pacific communities / individuals.

The PCN Working Group has been established and as well as focusing on the development of indicators and measures of effectiveness, it will also focus on establishing the scope and
competencies required and work towards formal recognition of community parish nursing by the NZ Nursing Council.

3.5 PHAP Priority 5

The fifth priority is that Pacific people use hospital services when needed. The General Manager for Pacific Hospital Services reports on this priority.

3.6 PHAP Priority 6

The sixth priority is that Pacific families live in warm healthy houses that are not overcrowded. The Ministry of Business, Innovation and Employment (MBIE) held a meeting on 13th March with interested Pacific people to discuss different options for addressing the housing needs of Pacific people, specifically in Auckland. This was followed by another meeting hosted by MBIE as well as the Ministry of Social Development and the Ministry of Pacific Affairs. Details of the government’s social housing policy were explained. A number of Pacific health providers, community leaders involved with the health sector as well as Pacific DHB staff attended. The conclusion of many people who attended both meetings is that Pacific community groups and churches are not in the position to become providers of social housing because of insufficient capital and expertise. There is a possibility of Pacific community organisations working in partnership with other entities, but this also appears to be a major challenge.

General Comments

It is a year from when the current PHAP was launched. The Funder is intending to organise meetings with the community to report back on the progress of the Plan’s implementation in June 2015. The Funder will take the opportunity to further converse with the community as to what they think could be done through the PHAP to address housing needs.

4. Auckland Regional Public Health Service

4.1 March and April 2015 submissions

The Auckland Regional Public Health Service (ARPHS) has completed eight submissions during March and April 2015.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland Council (Notified Consent) City Rail Link Britomart to Wyndham St Section</td>
<td>Issues with contaminated land - provided public health advice on the draft Risk Management Plan.</td>
</tr>
<tr>
<td>Auckland Council’s Long Term Plan (also known as the 10yr Budget)</td>
<td>Provided advice around prioritising initiatives that can assist and improve health such as encouraging prioritisation of active transport, reducing impact on communities by rates increases and encouraged further collaboration.</td>
</tr>
<tr>
<td>Auckland Transport’s Draft Long Term Regional Transport Plan</td>
<td>Provided advice on the usefulness of further research into and impact of the transport options proposed in particular the unintended consequences of introducing tolls, rates increases or regional fuel taxes. We encouraged and sought further collaboration and partnership with Council and Auckland Transport.</td>
</tr>
<tr>
<td>Application for discharge consent on wastewater overflows in the Waikato Region Area</td>
<td>Provided general advice and guidance to Watercare regarding discharging of water. This was generated by the Watercare Project team who sought feedback and advice from ARPHS through early engagement during RMA processes.</td>
</tr>
<tr>
<td>Topic</td>
<td>Brief note</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>KiwiSport Consultation 2015-2018</td>
<td>Provided general advice around funding allocations to encourage further research on how government intervention can encourage and best target areas of public good, evaluation processes, and Fundamental Movement Skills as prerequisite for future participation in sport.</td>
</tr>
<tr>
<td>Feedback sought on regulatory proposals under the Food Act 2014 (Ministry of Primary Industries)</td>
<td>The proposals represent a significant move in support of decreasing the incidence of food related illnesses. ARPHS provided general advice and feedback on the proposals and encouraged the Ministry of Primary Industries to continue to collaborate with other agencies including the Ministry of Education regarding food safety for early childhood centres. We also encouraged food notices to require consideration of public health impacts.</td>
</tr>
<tr>
<td>Application for discharge of contaminants into the air and operation of an existing aggregate processing facility (Waikato Regional Council)</td>
<td>Issues were around the discharge to sensitive receivers (schools, neighbours, childcare centres). There are potential risks of accidental and fugitive discharges of matter less than 10um in diameter – having more of an impact on children.</td>
</tr>
<tr>
<td>Clear Heads – options to reduce the risks of alcohol and drug related impairment across Aviation, Marine and Rail industries (Ministry of Transport)</td>
<td>Significant issues surrounding public health and public safety in regard to reducing risk of impairment from drugs and alcohol. We have provided specific advice across the proposed options for further regulation across industries, acknowledging the differences in application between commercial and recreational operators of vehicles. We have encouraged a regime similar to commercial operators to be created for recreational maritime operators, as this appears to be a significant gap in current legislative tools.</td>
</tr>
</tbody>
</table>

### 4.2 Anticipated submissions for May 2015

<table>
<thead>
<tr>
<th>Topic</th>
<th>Brief note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guide to the management of reverse sensitivity effects on the state highway network</td>
<td></td>
</tr>
<tr>
<td>Consultation on the need for any change to current limits used for Campylobacter performance targets by New Zealand poultry processors of broiler chicken</td>
<td></td>
</tr>
<tr>
<td>Food Safety Law Reform Bill (Ministry of Primary Industries)</td>
<td></td>
</tr>
<tr>
<td>Property and Nuisance By-Law</td>
<td>This bylaw will have public health implications in addressing legionnaire’s disease and fouling by animals</td>
</tr>
</tbody>
</table>

Please note there may be more submissions identified for May through ARPHS’s screening process.

### 4.3 Unitary Plan

ARPHS continues to be engaged in the Unitary Plan process. ARPHS’s full submission on the Proposed Auckland Unitary Plan is in three parts and available here (http://www.arphs.govt.nz/about/submissions).
During the March – April period ARPHS has been in mediations regarding the following topic areas:

- Contaminated Land
- Hazardous Substances
- Infrastructure
- Transport Objectives, Polices, Rules and Other
- SEA and Vegetation Management
- Trees.

ARPHS has also been in Hearings in the following topic areas:

- Regional Policy Statements General Notification
- Natural Hazards and Flooding
- Artworks, Signs and Temporary Activities.

5. Conclusion

This report does not include an update to CPHAC on Auckland and Waitemata DHBs’ Primary Care, Mental Health and Addictions or Health of Older People work areas, as these were reported on substantively to the meeting of 18 March 2015. It is anticipated that a full update on activities in these work areas will be reported on again at the meeting of 10 June 2015.

Auckland and Waitemata DHBs’ Planning and Children, Youth and Women’s work areas are reported on elsewhere in the agenda.
7. Resolution to Exclude the Public

Recommendation:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following item, 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>
<tbody>
<tr>
<td>1. Review of 2015/16 Annual Plan and Statement of Intent for Auckland and Waitemata DHBs</td>
<td>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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]</td>
</tr>
</tbody>
</table>