2014/15

Māori Health Plan

Auckland District Health Board

Auckland District Health Board May 2014

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

M I H I M I H I

E ngā mana, e ngā reo, e ngā kārangarangatanga tāngata
E mihi atu nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā koutou katoa
Ki wā tātou tini mate, kua tangihia, kua mihia kua ēa
Rātou, ki a rātou, haere, haere, haere
Ko tātou ēnei ngā kanohi ora ki a tātou
Ko tēnei te kaupapa, 'Oranga Tika', mo te iti me te rahi
Hei huarahi puta hei hapai tahi mō tātou katoa
Hei oranga mō te katoa
Nō reira tēnā koutou, tēnā koutou, tēnā koutou katoa

To the authority, and the voices, of all people within the communities
We send greetings to you all
We acknowledge the spirituality and wisdom of those
who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to
ensure a healthy tomorrow, greetings
This is the Plan
Embarking on a journey through a pathway that requires your
support to ensure success for all
Greetings, greetings, greetings

"Kauā e mahue tētahi atu ki waho
Te Tihi Oranga O Ngati Whatua"

F O R E W O R D

This plan for Māori health will be the catalyst for driving Māori health gain within our district. It provides Auckland District Health Board (ADHB) and our local health services with priority areas for action over the next twelve months and specifies accountabilties for the activities. One of the key functions of a DHB is to reduce disparities in health status by improving the health outcomes of Māori. This requires collective action across the health sector, keeping Māori health at the very fore of planning, funding and service delivery activities.

Whānau ora will be a key platform on which activties to improve health outcomes and reduce health inequities for Māori through quality prevention, assessment and treatment services will be based. The principles that underpin this work will be:

- Commitment to manawhenua
- Health equity
- Self-determination
- Indigeneity
- Nga kaupapa tuku iho
- Whole-of-DHB-responsibility
- Evidence-based approaches

Orienting the health sector to respond effectively to Māori health needs will require the commitment of the wider health workforce, and advanced competencies for health practitioners. Such an approach will also contribute positively to opportunities of potential that a Māori-led health focus brings. It will also inherently require a shift in practice.

By 2020 we want to see Māori in our region living longer, enjoying a better quality of life with fewer avoidable problems and hospitalisations. We want to see a system that is responsive, integrated, well resourced, and sustainable so that gains we make today can be built upon by future generations. These ambitions are certainly achievable and will be one of the key ways in which our success as a District Health Board and as health professionals will be measured in years to come.

ADHB has a Memorandum of Understanding (MoU) with partner, Te Runanga o Ngati Whatua. Te Runanga o Ngati Whatua have Contributed to the content of the Auckland District Māori Health Plan and will be key to partnering the District Health Board to engage key stakeholders for increased Māori health gain.

Primary Health Organisations (PHO) also have a critical role to play in achieving Māori health gain. For 2014/15 we have specifically documented each PHO's contribution to Māori health improvement. Progress against these activities will be actively monitored via the joint Auckland and Waitemata DHB Māori Health Board Advisory Committee – Manawa Ora.

C O N T E N T S

INTRODUCTION

The purpose of the Māori health plans is to document DHB and PHO direction for improving Māori health outcomes and reducing inequities for Māori. Auckland and Waitemata DHBs continue to work collaboratively and share a joint Māori health team for planning and funding.

The Māori health plans for both DHBs have been developed collaboratively between the two DHBs and in partnership with both MOU partners and with the PHO partners. Where possible, Māori health gain activities have been aligned across both DHBs, whilst highlighting instances where there are differences in data, current performance, focus of activities, or differing approaches to activities. As a result, the two Māori health plans contain identical activities for the majority of priority areas and the local priorities are aligned.

Activities to reduce Māori health inequities and foster Māori health gain are also found in other DHB planning documents including both DHBs Annual Plans and the Northern Region Health Plan.

Both DHBs are committed to Māori health, and all of these strategic documents should be read together in order to gain a complete understanding of the DHBs' activities to meet this commitment.

TE TIRITI O WAITANGI

ADHB recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides a framework for Māori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

Te Tiriti o Waitangi serves as a conceptual and consistent framework for Māori health gain cross the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for the ADHB can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with manawhenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

GUIDING PRINCIPLES

The following seven principles underpin this Māori Health Annual Plan, and have provided practical direction for the identification of local Māori health priority areas and associated activities and indicators.

Local Alignment

The selection of local priorities gave weight to the following principles. More importantly Iwi and Māori community need, has been taken into account. Local priorities were selected by DHBs and the Māori MoU partners, with consideration of the principles described below.

Commitment to Manawhenua

This principle is reflected in a Memorandum of Understanding between Te Rūnanga o Ngāti Whātua and ADHB, which outlines the partnership approach to working together at both governance and operational levels. This relationship will ensure the provision of effective health and disability services for Māori resident within the rohe of Ngāti Whātua.

Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing. The approach is whānau-centred and involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective.

Health equity

As a principle, health equity is concerned with eliminating avoidable, unfair and unjust systematic disparities in health between Māori and non-Māori. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key DHB contribution towards achieving health equity.

Self-determination

This principle is concerned with the right of Māori individuals and collectives to be informed and exert control over their health. This is consistent with full involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence.

Indigeneity

Indigeneity is concerned with the status and rights of Māori as indigenous peoples. The value placed on Indigeneity should be reflected in health policies and programmes that support the retention of Māori identity, the participation of Māori in decision-making, and health development based on the aspirations of Māori.

Ngā kaupapa tuku iho

As a principle, ngā kaupapa tuku iho requires acknowledgment and respect for distinctly Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning, quality programming and service delivery for Māori.

Whole-of-DHB responsibility

Achieving best health outcomes for whānau and health equity for Māori is a whole-of-system responsibility. Therefore, contributing to Māori health gain and reducing ethnic inequalities in health between Māori and non-Māori is an expectation of all health activities through the whole of the health system.

Evidence-based approaches

The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgement, drawing on a Māori development perspective and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of Māori health policy, purchasing, service delivery and practice.

AUCKLAND POPULATION

Profile and Health Needs

1. Geographic Distribution

- ADHB's population was estimated to be 472,650 in 2014. 8% of ADHB's population identified as Māori compared with 15% nationally;
- A third of the ADHB population resides in the Albert-Eden-Mt Roskill area. ADHB's population is ethnically diverse with greater proportions of Asian and Pacific peoples than in New Zealand as a whole, and a smaller proportion of Māori.
- More Māori reside within the Maungakiekie -Tamaki and Albert-Eden-Mt Roskill areas.

2. Health Service Providers

Key health service providers in ADHB include:

- Three public hospitals; Auckland City Starship Children's and Greenlane Clinical Centre.
- Four PHOs (which had enrolled 82% of the eligible Māori population and 92% of the non-Māori in March 2013/14)
- Contract with 5 Māori providers totalling $3.5 million
- Multiple local and national non-profit and private health and social providers.

3. Age Distribution of the Māori Population

- It is predicted that in 2014-15, ADHB's over-65 population will be approximately 11% of the total population; Māori over-65 will be less than half at 5%. Other age categories remain similar to the rest of the country;
- The ADHB Māori population is skewed towards younger age groups with higher proportions in the 0-14, 15-24 and 25-44 age groups, but fewer older adults and elderly:

Table 1: Age distribution of the ADHB population predicted 2013-2014

Age Group	**0-14**	**15-24**	**25-44**	**45-64**	**65+**
Māori (%)	29%	17%	30%	19%	5%
Non-Māori (%)	16%	15%	36%	23%	11%

4. Age Distribution of the Māori Population

From 2014 to 2024 ADHB's Māori population will grow but at a lesser rate (6%) than non-Māori (15%), and the national Māori population (12%).

5. Deprivation Distribution

ADHB's population is spread reasonably evenly across the NZDep categories, there is however distinct difference between Māori and Non-Māori. Non-Māori are represented evenly across all deciles, Māori representation increases with each deprivation decile (from least deprived to most deprived). Twice as many Māori (22%) are represented compared to non-Māori (11%) in Decile 10.

6. Modifiable Risk Factors

Modifiable risk factors are significant contributors to morbidity and mortality. Smoking, obesity, high blood pressure and high cholesterol levels are the most important modifiable risk factors in our population. The prevalence of these factors is shown in the following table below. The prevalence of smoking and obesity are lower amongst Māori in Auckland than amongst Māori in the rest of NZ but considerably higher than for the total population. The

reverse is true for medicated high blood pressure and medicated high blood cholesterol; this may reflect lower prevalence of these factors and/or lower detection and treatment amongst Māori.

Table 2: Modifiable Risk Factors

Indicator	Prevalence Māori ADHB	Prevalence Māori NZ	Prevalence Total Population ADHB
Current smoking (2013 census, Crude Prevalence)	26.3%	32.7%	11.2%
Regular Physical Activity (NZHS 2006/07, Age-Standardised Prevalence)	43.6%	57.7%	40.3%
Obese (NZHS 2006/07, Age-Standardised Prevalence)	33.6%	42.5%	21.3%
Medicated high blood pressure (NZHS 2006/07, Age-Standardised Prevalence)	7.5%	8.3%	10.0%
Medicated high blood cholesterol (NZHS 2006/07, Age-Standardised Prevalence)	6.1%	4.4%	9.2%

7. Leading Causes of Avoidable Mortality

The leading causes of avoidable mortality by gender are ranked in Table 3 below:

Table 3: Leading five causes of mortality by gender for those aged 0-74 years, 2007-2009

	Males		Females	
	ADHB	**NZ**	**ADHB**	**NZ**
Māori	Ischaemic Heart Disease	Ischaemic Heart Disease	Lung Cancer	Lung Cancer
	Lung Cancer	Unintentional Injury	Ischaemic Heart Disease	Ischaemic Heart Disease
	Unintentional Injury	Lung Cancer	Diabetes	COPD
	Stroke	Diabetes	COPD	Breast Cancer
	Suicide and self-harm	Suicide and self-harm	Breast Cancer	Unintentional Injury
Non-Māori	Ischaemic Heart Disease	Ischaemic Heart Disease	Breast Cancer	Breast Cancer
	Lung Cancer	Unintentional Injury	Lung Cancer	Lung Cancer
	Suicide and self-harm	Lung Cancer	Ischaemic Heart Disease	Ischaemic Heart Disease
	Colorectal Cancer	Colorectal Cancer	Stroke	Colorectal Cancer
	Stroke	Suicide and self-harm	Diabetes	COPD

SUCCESSES TO DATE IN AUCKLAND DHB

- Māori life expectancy at birth in ADHB (75 years) is 1 year above the national average for New Zealand (74 years) (between 2008 – 2012) and has increased by 6% over the last 10 years or 4.7 years over the last 10 years.
- We have increased the number of heart and diabetes checks to achieve 83.3% coverage of the population at ADHB. Coverage for Māori has improved 27% since December 2013.
- Diabetes annual checks have improved significantly by 28% between 2012-2013 and 2013/2014
- 94% of Auckland children were fully immunised at 8 months at the end of December 2013 and major progress has been made in reducing the equity gap with an increase of 14% for Māori.
- At the two year old milestone, 91% of Māori infants are fully immunised compared to 94% overall.
- A pathway has been established for rapid referral to outreach immunisation services and primary care for Māori new borns with no GP.
- Mental health access rates for Māori youth reached 5.08% and 3% all youth against a target of 3%.
- Mental health access rates for Māori adults reached 11.5% and 3.9% all adults against targets of 8.18% and 3.3% respectively.
- Mental health access rates for Māori older adults reached 3.9% and 3.6% all older adults against an overall target of 3.58%.
- Cervical screening rates have improved from 49% to 57.1% over the last three years.
- To ensure we meet the smoking health targets, we have put nine free face-to-face cessation services in place across both DHBs including Māori providers.
- A Whānau Ora assessment tool has been implemented at Auckland City Hospital and a draft Whānau Ora Policy developed.

NATIONAL PRIORITY SUMMARY

National Health Priority Area	Indicators	Baseline Data Non-Māori	Baseline Data Māori	Target
Data Quality	Ethnicity Data Accuracy: 95% Coverage of the Ethnicity data Audit Tool.	NA	NA	95%
Access To Care	Percentage of Māori enrolled in PHOs.	94%	80%	95%
	ASH Rates per 100,000 0-74 years 0-4 years 45-64 years.	 94%[1] 64%[1] 107%[1]	 203% 118% 253%	 95% 95% 102%
Child Health	Rates of fully and exclusive breastfeeding at: 6 weeks 3 months 6 months (**includes partial also*).	 82%[1] 59%[1] 74%[1]	 81% 47% 58%	 68% 54% 59%
Cardio Vascular Disease	Percentage of Māori who have had their CVD risk assessed within the last five years.	84%	80%	90%
	70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission= Day 0).	94%	100%	70%
	95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	72%	75%	95%
Cancer	Breast Screening rates: 70% of eligible women will have a mammogram every two years.	70%	69%	70%
	Cervical Screening rates: percentage of women aged 25-69 who have had a cervical screen in the past 36 months.	79%	57%	75%
Smoking	Hospitalised smokers provided with advice and help to quit.	96%	96%	95%
	Current smokers enrolled in a PHO and provided with advice and help to quit.	94%	80%	90%

National Health Priority Area	Indicators	Baseline Data Non-Māori	Baseline Data Māori	Target
Immunisation	Percentage of infants fully immunised by eight months of age.	94%	91%	90%
	Seasonal influenza immunisation rates in the eligible population 65 years and over.	66%	64%	65%
Rheumatic Fever	2014/15 rheumatic fever target 40% reduction from baseline (3 year average 2009/10-2010/11.	3.5[1]	NA	1.9
Oral Health	Preschool enrolments (0-4 years).	78.8%	62.3%	82%
Mental Health	Mental Health ACT: section 29 community treatment order indefinites comparing Māori rates with other[2].	93.36	288.16	NA

[1] Total population data

[2] Reporting to the Office of the Directors of Mental Health

National indicators are set and reviewed annually by a national advisory group and include health targets, DHB and PHO performance measures which link to the leading causes of mortality and morbidity for Māori.

DHBs and PHOs are required to document specific planned actions to address each of the national indicators. Ministry planning advice suggests that a mix of universal and targeted interventions will be required to reduce inequalities.

Local Priorities

Local priorities are informed by the health needs of the population and guided by the overarching principles contained in this plan (pages 6-7). For 2014/2015 the local priorities have been agreed by the Auckland and WDHBs and the MoU partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust.

1. DATA QUALITY

What are we trying to do?

Improve the quality of ethnicity data to ensure that accurate data is available for informing the public and the health sector, identifying health need, service planning, and monitoring activities.

To achieve this we will focus on:

Improving accuracy of ethnicity reporting in PHO registers. This will occur via implementation of the Ethnicity Data Audit Tool (EDAT) in all general practices, within the Auckland and Waitemata catchment areas. EDAT implementation will be delivered using a joint approach for Auckland and WDHBs.

Why is this a priority?

There are known issues with ethnicity data quality in New Zealand health sector. Although there is an ethnicity data protocol issued by the Ministry of Health (MoH), there is evidence of inconsistent data policies and practices and an overall undercounting of Māori in primary care. The Ministry and WDHB funded the development of the Primary Care Ethnicity Data Audit Toolkit. The Toolkit provides a resource for assessing ethnicity data collection and use in New Zealand primary health care settings and supporting quality improvement.

Issues and considerations:

Improving data accuracy in primary care will contribute to more accurate tracking of Māori Health Plans indicators across the primary care related Māori Health Plan (MHP) indicators.

Rationale:

Accurate ethnicity data will support identification of areas of focus.

	What are we going to do?	Timing	Responsibility
1.1	Implement phase 1 of EDAT to coverage of 35% of practices.	Q2	Tim Wood, Anna-Marie Ruhe
1.2	Implement phase 2 of EDAT to coverage of 70% of practices.	Q3	Tim Wood, Anna-Marie Ruhe
1.3	Implement phase 3 of EDAT to coverage of 95% of practices.	Q4	Tim Wood, Anna-Marie Ruhe
1.4	Develop and provide training sessions for relevant ADHB and WDHB primary care and PHO staff.	Q1	Tim Wood, Micol Salvetto
1.5	Develop and provide training sessions to other participating DHBs (4).	Q1	Tim Wood, Micol Salvetto
1.6	Provide lists of practices for each wave and phase of audit to EDAT coordinator.	Q1-Q4	Tim Wood, Micol Salvetto, Anna-Marie Ruhe
1.7	Facilitate EDAT communications between DHB/PHO/GPs and EDAT coordinator.	Q1-Q4	Tim Wood, Micol Salvetto, Anna-Marie Ruhe

2.1 ACCESS TO HEALTH CARE

What are we trying to do?

Ensure access to health care, to reduce inequalities in health status for Māori and improve Māori health outcomes.

To achieve this we will focus on:

Increasing the percentage of Māori enrolled in PHOs.

Why is this a priority?

Ensuring access to primary care is an initial step in addressing Māori health inequalities.
Equitable access to primary care for Māori is an important strategy for Māori health gain across all primary care related priorities.

Issues and considerations:

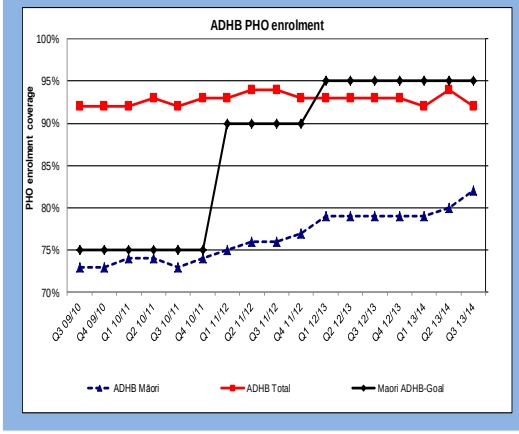
Misclassification of ethnicity on Primary Healthcare Organisation (PHO) registers is a significant problem that affects our ability to address inequalities in health outcomes.
Implementation of EDAT as stated in National Priority (NP) 1. will support more accurate monitoring of Māori health gain.
An agreed process between PHOs to target and improve Māori enrolments will contribute to improved access to primary health care.

Where do we want to get to?

- 95% Māori enrolment in PHOs

DHB/PHO	Non-Māori	Māori	Target
ADHB	92%	82%	**95%**

Trends



Rationale:

Understanding the barriers and enablers for Māori in accessing primary health care is critical for creating systems and processes that will improve access and reduce inequalities.

	What are we going to do?	Timing	Responsibility
2.1.1	Undertake a match of NHI – PHO register databases to identify cases where ethnicity data is mis-matched between the two databases.	Q2-3	APHO, AHPPHO, PCPHO, NHC and DHB analyst
2.1.2	Implement a process to confirm the correct ethnicity data and update, where necessary, PHO ethnicity data.	Q3-4	APHO, AHPPHO, PCPHO, NHC
2.1.3	Undertake an analysis of census data against enrolment to identify key target areas.	Q3-4	Anna-Marie Ruhe, MoU partner
2.1.4	As part of the Māori health needs assessment include discussion of issues impacting the Māori community's enrolment with PHOs.	Q2-3	Anna-Marie Ruhe
2.1.5	Work with PHOs to develop activities	Q1-4	APHO, AHPPHO, PCPHO, NHC

	What are we going to do?	Timing	Responsibility
	that will improve Māori enrolment rates. This may include working with Māori Health Providers to develop systems to support enrolment and identifying practices with low Māori enrolment compared with expected enrolments.		Anna-Marie Ruhe
2.1.6	Through regular monitoring identify successful activities and implement best practice sharing process.	Q1-4	Anna-Marie Ruhe
2.1.7	Quarterly monitoring of PHO ethnicity enrolment data to Manawa Ora.	Q1-4	Anna-Marie Ruhe

2.2 ACCESS TO HEALTH CARE

What are we trying to do?

Reduce Ambulatory Sensitive Hospital Admission rates in all three age groups 0-74 years, 0-4 years, 45-64 years.

To achieve this we will focus on:

Identifying the leading causes of ASH in each age group, developing an understanding of pathways to ASHs, and better understanding access to POAC services relative to health need.

Why is this a priority?

ASH rates are an indicator of, among other things, access to high quality primary care.

Issues and considerations:

The 'ideal' rates of admission for ASH conditions are unknown.

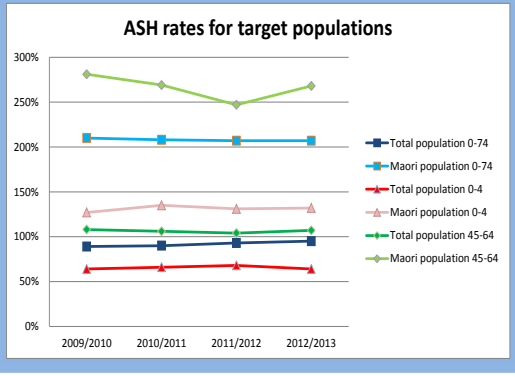
Rationale:

Understanding Māori access rates in relation to health need and the pathways for accessing care will inform the development of systems and processes that will contribute to an improvement in service delivery for Māori whanau.

Where do we want to get to?

- Reduction in ASH rates across all age groups.

DHB/PHO	Total population	Māori	Target
ASH rates 0-74 years			
ADHB	95%	203%	95%
ASH rates 0-4 years			
ADHB	64%	113%	95%
ASH rates 45-64 years			
ADHB	107%	253%	102%



	What are we going to do?	Timing	Responsibility
2.2.1	Develop and conduct survey of Māori (or caregivers of children) admitted for a top 5 ASH condition for each age group to better understand their pathway into hospital.	Q2-3	Marty Rogers, Patricia Bolton
2.2.2	Identify health literacy resources that are available for the leading ASH conditions. Disseminate these to appropriate groups and through appropriate fora.	Q1-4	Māori Health Gain Team
2.2.3	Continue to support community and whanau participation in the Tamaki ward focussing on Mental Health issues.	Q1-4	Marty Rogers, Primary Care Team
2.2.4	Participate in the review of POAC	Q1-4	Marty Rogers, Anna-Marie

	What are we going to do?	Timing	Responsibility
	contracts, including reporting, undertaken by the Primary Care Team to ensure that ethnic specific rates of POAC utilisation are calculated.		Ruhe
2.2.5	In collaboration with Primary Care Team develop a process: • for comparing ethnic specific POAC utilisation rates with hospitalisation rates for the most common POAC conditions to better understand geographical and practice-based access to POAC for each age group.	Q1-4	Marty Rogers, Anna-Marie Ruhe
2.2.6	Utilise data from POAC, survey to identify any further gaps in access, utilisation and service delivery to develop and start implementation of further strategies to reduce avoidable admissions for Māori.	Q3-4	Māori Health Gain Team, Primary Care Team
2.2.7	Quarterly reporting of ASH performance and progress on activities to Manawa Ora.	Q1-4	Marty Rogers

3. CHILD HEALTH

What are we trying to do?

Increase the numbers of exclusively/fully and partially (6 months only) breastfed Māori babies at 6 weeks, 3 months and 6 months.

To achieve this we will focus on:

Identifying specific factors that contribute to the decline in rates of exclusive and fully breastfed Māori babies at 3 months.

Why is this a priority?

Research shows that children who are exclusively breastfed for the early months are less likely to suffer the adverse effects from childhood diseases. Current rates show a significant decline in rates at 3 months.

Issues and considerations:

The 3 month decline may coincide with the end of paid parental leave. Therefore further investigation into factors which contribute to the decline in rates at 3 months is required.

Rationale:

Understanding the barriers and enablers for breast feeding is critical for creating systems and processes which support whānau to continue to breast feed for as long as possible.

Where do we want to get to?

- 68% of Māori babies are fully and exclusively breastfed at 6 weeks
- 54% of Māori babies are fully and exclusively breastfed at 3 months
- 59% of Māori babies are fully, exclusively or partially breast fed at 6 months.

DHB/PHO	Total population	Māori	Target
6 week			
ADHB	82%	81%	68%
3 month			
ADHB	59%	47%	54%
6 month			
ADHB	74%	58%	59%

	What are we going to do?	Timing	Responsibility
3.1	Monitor and analyse Māori uptake of text messaging service promoting breast feeding.	Q1-Q4	Nelson Wahanui
3.2	Support the Healthy Babies, Healthy Futures Programme develop and implement a nutrition and physical activity "train the trainer" programme for health and social services providers who provide services for rangatahi, pregnant women and their tamariki and whānau to promote breast feeding as part of a healthy lifestyle.	Q2	Nelson Wahanui
3.3	Include whanau in the review of current practices within hospital services and PHOs. Use this information in the development and implementation of strategies to increase breast feeding for Māori	Q2	Ruth Bijl

	What are we going to do?	Timing	Responsibility
	babies.		
3.4	In partnership with Waitemata DHB conduct a review of cultural appropriateness of breast feeding content of DHB funded antenatal courses. Review will include: 1. Focus groups with Māori participants 2. Analysis and recommendations for improvements Implementation of new model of delivery.	Q2	Ruth Bijl, Marty Rogers
3.5	Monitor the delivery of breastfeeding health promotion activities to Māori mothers and whānau in the Maternal and Infant Regional Nutrition Project.	Q1-Q4	Nelson Wahanui
3.6	Maintain Baby Friendly Hospital Initiative (BFHI) across all ADHB maternity facilities.	Q1-Q4	Ruth Bijl
3.7	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Tracy Walters

4.1 CARDIOVASCULAR DISEASE

What are we trying to do?

Reduce Māori morbidity and mortality via improved cardiovascular access and care.

To achieve this we will focus on:

Increasing the percentage of eligible Māori who have had their CVD risk assessed within the last five years.

Why is this a priority?

CVD is a major cause of morbidity and mortality for Māori and makes a substantial contribution to the inequalities between Māori and non-Māori in all cause life expectancy. Risk assessment is the first step in implementing evidence-based prevention and management of CVD.

Issues and considerations:

Interim PHO Performance management Programme (PPP) targets will incrementally increase to align with total population to achieve equity. This is required to address the differential ethnic targets historically set under PPP.

Rationale:

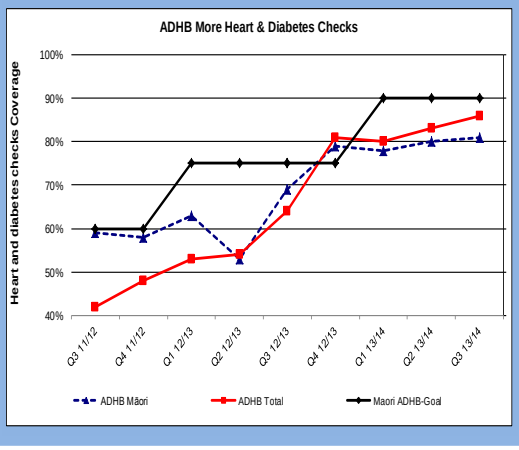
Understanding the barriers and enablers for Māori receiving a CVD risk assessment is critical for creating systems and processes that will improve access and reduce inequalities.

Where do we want to get to?

- 90% of eligible Māori will have their risk assessed within five years.

DHB/PHO	Non-Māori	Māori	Target
ADHB	86%	81%	90%

Trends



	What are we going to do?	Timing	Responsibility
4.1.1	Continue to support PHO activities to increase CVD risk assessment for Māori.	Q1-Q4	Anna-Marie Ruhe
4.1.2	Investigate opportunities to implement CVD risk assessment in other settings. For example, point of care testing, NGO providers, outreach.	Q2	Anna-Marie Ruhe
4.1.3	Monitor current activities to identify strategies that are effective in increasing access for Māori to CVD risk assessment.	Q1-Q4	Anna-Marie Ruhe
4.1.4	PHOs to review activities to identify opportunities to improve access to CVD risk assessment for Māori.		Anna-Marie Ruhe
4.1.5	Identify high performing DHBs in CVD assessment & management practices	Q1-4	Anna-Marie Ruhe

	What are we going to do?	Timing	Responsibility
	and with PHO's investigate possibility of cross fertilisation.		
4.1.6	Quarterly reporting of performance and progress on activities to Manawa Ora.		Anna-Marie Ruhe

4.2 CARDIOVASCULAR DISEASE

What are we trying to do?

Reduce Māori morbidity and mortality via improved access to quality cardiovascular care.

To achieve this we will focus on:

Monitor and investigate the rates of tertiary cardiac intervention any ethnic disparities between Māori and others.

Why is this a priority?

CVD is a major cause of morbidity and mortality for Māori and makes a substantial contribution to the inequalities between Māori and Non-Māori in all cause life expectancy.

Issues and considerations:

Performance for the angiography indicator is below target. Performance for these two indicators is, in absolute terms, equitable but may not fully reflect access relative to need.

Rationale:

Understanding the barriers and enablers for Māori receiving appropriate tertiary cardiac intervention is critical for creating systems and processes that will improve access and reduce inequalities.

Where do we want to get to?

- 70% of acute coronary syndrome patients will are accepted for coronary angiography having it within 3 days of admission.

DHB/PHO	Non-Māori	Māori	Target
ADHB	94%	100%	70%

- 95% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within one month.

DHB/PHO	Non-Māori	Māori	Target
ADHB	72%	75%	95%

	What are we going to do?	Timing	Responsibility
4.2.1	Representation at Northern Region Cardiac Network (NRCN) to identify inequities for Māori and provide recommendations for improving access to services.	Q1-Q4	Māori Clinical Lead
4.2.2	Monitor implementation of recommendations from NRCN that support improved access and utilisation for Māori.	Q1-Q2	Andrea Baker, Joanne Brown, Kerry Hiini
4.2.3	Where necessary (and as identified in activity above) require the reporting of NRCN indicators by ethnicity where this is not already being done.	Q3-Q4	Andrea Baker, Joanne Brown, Kerry Hiini
4.2.4	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Kerry Hiini

5.1 BREAST CANCER

What are we trying to do?

Reduce Māori breast cancer morbidity and mortality.

To achieve this we will focus on:

Improving breast screening coverage rates for Māori women and reducing ethnic disparities in screening rates.

Why is this a priority?

Breast screening can reduce breast cancer mortality through early detection. Māori women in ADHB have significantly higher breast cancer mortality rates than non-Māori/non-Pacific women.

Issues and considerations:

ADHB's performance is very close to meeting the target. We will continue to focus on breast screening to further improve coverage.

Rationale:

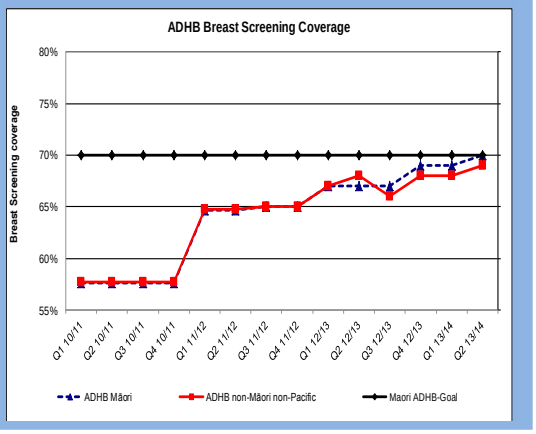
Utilisation of existing best practice models to support increased access to breast screening services by Māori is an important factor in improving Māori health outcomes.

Where do we want to get to?

- 70% breast screening coverage of eligible Māori women

DHB/PHO	Non-Māori	Māori	Target
ADHB	70%	69%	70%

Trends



	What are we going to do?	Timing	Responsibility
5.1.1	Continue to support PHOs to conduct data-matching with Breast Screening Lead Providers to identify eligible women who are enrolled with GP practices.	Q1-Q4	Pam Hewlett, Wai Vercoe
5.1.2	Breast Screening Lead Providers to share learnings through the development and implementation of a best practice model.	Q3-Q4	Pam Hewlett, Wai Vercoe
5.1.3	Support regular sharing of successful activities and strategies to improve Māori breast screening coverage at 6 monthly lead provider meetings.	Q3-Q4	Pam Hewlett, Wai Vercoe
5.1.4	Support and monitor the implementation of best practice model.	Q3-Q4	Pam Hewlett, Wai Vercoe
5.1.5	6 monthly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q2-Q4	Pam Hewlett, Wai Vercoe

5.2 CERVICAL CANCER

What are we trying to do?

Reduce Māori cervical cancer morbidity and mortality.

To achieve this we will focus on:

Improving cervical screening coverage rates for Māori women and reducing ethnic disparities in screening rates.

Why is this a priority?

Cervical cancer is one of the most preventable cancers with regular smear tests. In WDHB ethnicity data misclassification in Primary care and NCSP-R has been shown to contribute to the inaccurate reporting of Māori women's participation in the cervical screening programme. Activities to improve the quality of ethnicity data have been led by WDHB and have supported national discussions on how to optimise the recording of ethnicity data. There is clear evidence that cost is a barrier to women accessing regular smear tests, but cost is not the only barrier.

Issues and considerations:

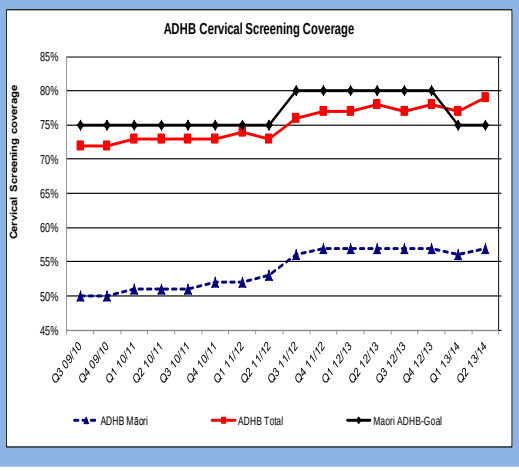
The cervical screening rate for Māori women is much lower in Auckland than for non-Māori women.

Where do we want to get to?

- 80% of eligible Māori women received a three yearly cervical screen.

DHB/PHO	Non-Māori	Māori	Target
ADHB	79%	57%	**80%**

Trends



Rationale:

Understanding the barriers and enablers for Māori receiving a cervical screening is critical for creating systems and processes that will improve access and reduce inequalities.

	What are we going to do?	Timing	Responsibility
5.2.1	Support the implementation of the "Best Practice Manual" with all providers of smear tests, including Māori specific smear taking providers.	Q1-Q4	APHO, AHPPHO, NHC, PCPHO, Sue Crengle, Karen Bartholomew
5.2.2	Identified PHO will pilot data matching program with the National Screening Unit to identify Māori women who are unscreened or under screened.	Q1-Q2	APHO, AHPPHO, NHC, PCPHO, Sue Crengle, Karen Bartholomew
5.2.3	Participate in the development and implementation of a project to increase cervical screening in the Auckland metro region. The project will include systematic support to implement a suite of Best Practice Manual strategies and kaiawhina to facilitate unscreened and	Q1-Q4	Marty Rogers, Karen Bartholomew

	What are we going to do?	Timing	Responsibility
	under-screened women's attendance for screening.		
5.2.4	Continue to support the provision of free smears to Māori women and support activities to improve uptake of free smears.	Q1-Q4	Wai Vercoe
5.2.5	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Wai Vercoe

6.1 SMOKING

What are we trying to do?

Reduce cancer morbidity and mortality, and improve respiratory health through reduced smoking rates.

To achieve this we will focus on:

Identified current Māori smokers enrolled in a PHO and provided with advice and help to quit.

Why is this a priority?

A substantial proportion of the Māori population continues to smoke. Smoking is an important issue among pregnant Māori women. A large proportion of Māori are enrolled with general practices and should receive smoking cessation advice and help to quit with general practices.

Issues and considerations:

Further work is required to ascertain the quality of advice and accessibility of help to quit.

Rationale:

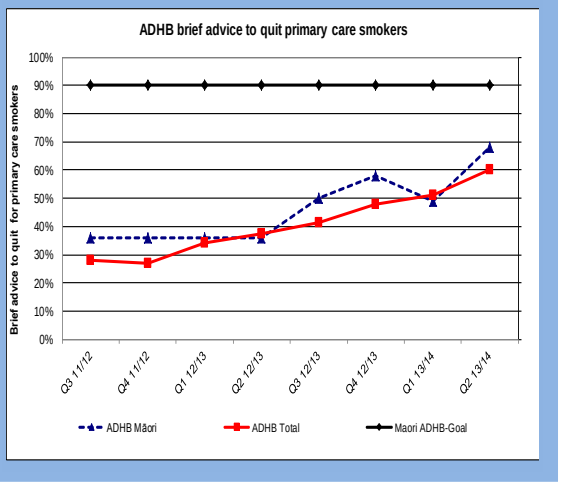
Understanding the barriers and enablers for Māori receiving advice and help to quit is critical for creating systems and processes that will increase the likelihood of becoming smoke-free and reduce inequalities.

Where do we want to get to?

- 90% of identified Māori smokers enrolled with a PHO are provided with advice and help to quit.

DHB/PHO	Non-Māori	Māori	Target
ADHB	59%	68%	90%

Trends



	What are we going to do?	Timing	Responsibility
6.1.1	Work with maternity services and PHO's to investigate effectiveness of a wraparound campaign for pregnant Māori mothers.	Q2-Q3	Leanne Catchpole, Tracy Walters
6.1.2	Identify gaps in current programmes and develop and implement strategies to improve access to and utilisation of cessation support.	Q1-Q2	Leanne Catchpole, Tracy Walters, APHO, AHPPHO, PCPHO and NHC
6.1.3	PHOs will identify poorly performing practices and implement strategies to improve performance in offering brief advice to quit and smoking cessation support.	Q1-Q4	Leanne Catchpole, Tracy Walters , APHO, AHPPHO, PCPHO and NHC
6.1.4	PHOs to work with GP practices to identify smokers who have not been provided with brief advice and	Q1-Q4	Leanne Catchpole, Tracy Walters , APHO, AHPPHO, PCPHO and NHC

	What are we going to do?	Timing	Responsibility
	support to quit and implement a process to offer cessation support.		
6.1.5	Through regular monitoring identify successful activities and implement best practice sharing process.	Q1-Q4	Leanne Catchpole, Tracy Walters
6.1.6	Support the development and implementation of systems to prompt providing advice to quit to patients.	Q1-Q4	Leanne Catchpole, Tracy Walters
6.1.7	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Tracy Walters

6.2 SMOKING

What are we trying to do?

Ensure access to health care, to reduce inequalities in health status for Māori and improve Māori health outcomes.

To achieve this we will focus on:

Hospitalised Māori smokers provided with advice and help to quit.

Why is this a priority?

The health target has been consistently achieved for hospitalised smokers offered advice and help to quit. Activity for 2014/15 will focus on the quality of the advice and help to quit.

Issues and considerations:

Further work is required to ensure quality advice is given and optimal accessibility to quit help services.

Rationale:

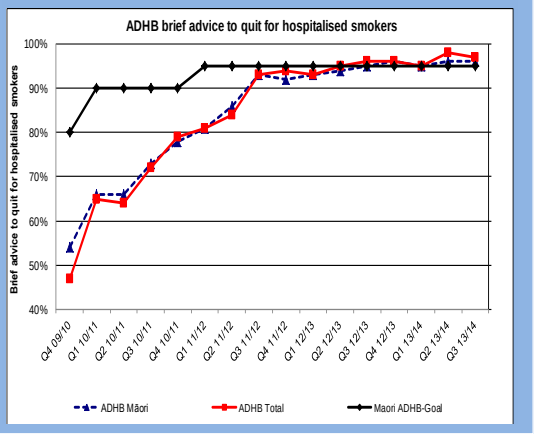
Understanding the barriers and enablers for Māori to become and stay smokefree is critical for creating systems and processes that will increase the likelihood of becoming smokefree and reduce inequalities.

Where do we want to get to?

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

DHB/PHO	Non-Māori	Māori	Target
ADHB	97%	96%	95%

Trends



	What are we going to do?	Timing	Responsibility
6.2.1	Continue to provide brief advice to quit and offer referral to smoking cessation service to all hospitalised patients.	Q2-Q3	Leanne Catchpole, Tracy Walters
6.2.2	Conduct a survey with Māori patients who requested referral to cessation services to ascertain whether contact was made by/with the cessation services, the outcome of their engagement with the service and their current smoking status.	Q1-Q2	Leanne Catchpole, Tracy Walters
6.2.3	Develop and implement a model to improve accessibility to cessation services for Māori.	Q1-Q4	Leanne Catchpole, Tracy Walters
6.2.4	Continue to support the workforce to offer brief advice and help to quit through the Smokefree Leads in each department.	Q1-Q4	Leanne Catchpole, Tracy Walters
6.2.5	Support follow up of Māori people seeking post discharge support to quit smoking to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs follow up support	Q1-Q4	Leanne Catchpole, Tracy Walters

	process in place by December 2014.		
6.2.6	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Leanne Catchpole, Tracy Walters

7.1 IMMUNISATION

What are we trying to do?

Improve child health by improving immunisation coverage.

To achieve this we will focus on:

Increasing the percentage of pepi Māori fully immunised at 8 months of age.

Why is this a priority?

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. It provides not only individual protection, but for some diseases also population-wide protection by reducing the incidence of diseases and preventing them from spreading to vulnerable people. The timeliness is the focus of the 8 month immunisation at 8 months.

Issues and considerations:

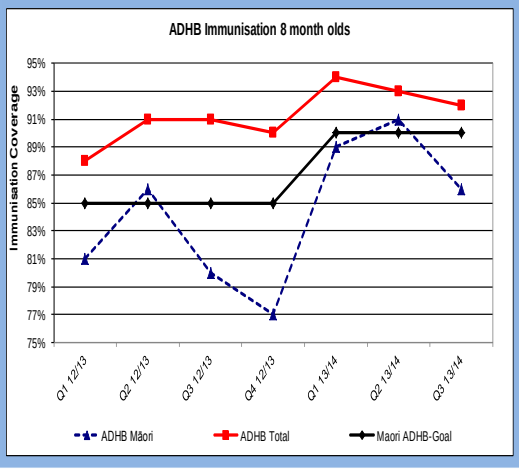
A focus on new born enrolment, including transition from LMC to GPs, PHO enrolment and oral health enrolment will be a focus for child health in 2014/15. We will continue to utilise existing local and regional mechanisms to support our activities and increase access to immunisations.

Where do we want to get to?

- 95% of Māori babies fully immunised by eight months of age.

DHB/PHO	Non-Māori	Māori	Target
ADHB	92%	86%	95%

Trends



Rationale:

Understanding the barriers and enablers for Māori accessing immunisation services is critical for creating systems and processes that will improve access and reduce inequalities.

	What are we going to do?	Timing	Responsibility
7.1.1	Continue to conduct monthly analysis of the practices to identify practices that need support to improve immunisation coverage. Support GP practices to implement targeted action plans to improve coverage.	Q1-Q4	Ruth Bijl, Tracy Walters
7.1.2	Continue to deliver outreach services to improve immunisation rates for Māori babies.	Q1-Q4	Ruth Bijl, Tracy Walters
7.1.3	Continue enhanced focus on pre-calling and re-calling to be part of normal practice.	Q1-Q4	Ruth Bijl, Tracy Walters
7.1.4	PHOs to develop and implement a model to increase Māori baby 8-month immunisation rates.	Q1-Q4	Ruth Bijl, Tracy Walters
7.1.5	Participate in the development of a new born enrolment process that focuses on GP enrolment, oral health enrolment and seamless transition between LMC, GP and	Q1-Q4	Ruth Bijl, Tracy Walters

	What are we going to do?	Timing	Responsibility
	WCTO providers.		
7.1.6	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Ruth Bijl, Tracy Walters

7.2 IMMUNISATION

What are we trying to do?

Improve the health of older Māori.

To achieve this we will focus on:

Increasing the rates of seasonal influenza vaccinations among Māori 65+ years of age.

Why is this a priority?

The complications of influenza in older people can be serious or life threatening.

Issues and considerations:

Over the previous year immunisation rates within both DHBs has improved. However there is still a lot of work to be done to achieve the immunisation target for Māori 65+. Therefore we will look to improve the current Māori rates via a concerted approach to promote Flu Vaccinations to Māori 65+, building the capacity of the Māori workforce in this area, and closer monitoring of performance. We will continue to utilise existing local and regional mechanisms to support our activities and increase access to immunisations.

Rationale:

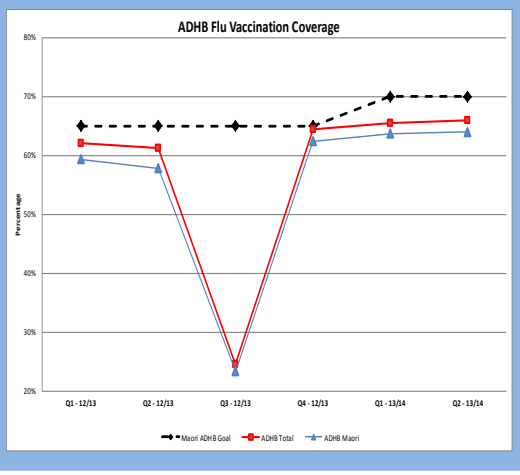
Understanding the barriers and enablers for Māori accessing immunisation services is critical for creating systems and processes that will improve access and reduce inequalities

Where do we want to get to?

- 75% Māori aged 65+ years of age will have received the seasonal influenza vaccine.

DHB/PHO	Non-Māori	Māori	Target
ADHB	66%	64%	75%

Trends



	What are we going to do?	Timing	Responsibility
7.2.1	PHOs to identify gaps in current practices and develop and implement strategies to improve access to immunisation services.	Q1-Q2	Karl Snowden, PHOs
7.2.2	PHOs to identify high performing GP practices to share learnings through the development and implementation of a best practice model.	Q2-Q3	Karl Snowden, PHOs
7.2.3	Investigate the feasibility of providing vaccinations through Māori providers.	Q3-Q4	Karl Snowden
7.2.4	Support Māori providers participate in multiple community events in high needs areas to provide opportunistic vaccinations. for kuia and kaumātua	Q3	Karl Snowden, PHOs
7.2.5	Develop capacity within the Māori RN workforce currently in aged related care services through the completion of the vaccinator's course in February 2015.	Q4	Karl Snowden, PHOs
7.2.6	Investigate the feasibility of an outreach	Q1-Q4	Karl Snowden

	What are we going to do?	Timing	Responsibility
	programme for seasonal vaccinations for kuia and kaumātua utilising existing Māori providers.		
7.2.7	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Karl Snowden

8. RHEUMATIC FEVER

What are we trying to do?

Achieve a reduction in incidence of acute rheumatic fever.

To achieve this we will focus on:

Achieve a 40% reduction in the rate of rheumatic fever from the baseline rate.

Why is this a priority?

Rheumatic Fever is a 'better public service' target. The DHB is implementing a plan to reach the targets for rheumatic fever.

Issues and considerations:

The ADHB's rheumatic fever Implementation Plan forms the basis of our work in this area. There are three work streams incorporating nine key activities in the plan.

Rationale:

Ensure that all activities are implemented with a focus on improving Māori health outcomes and reducing inequalities.

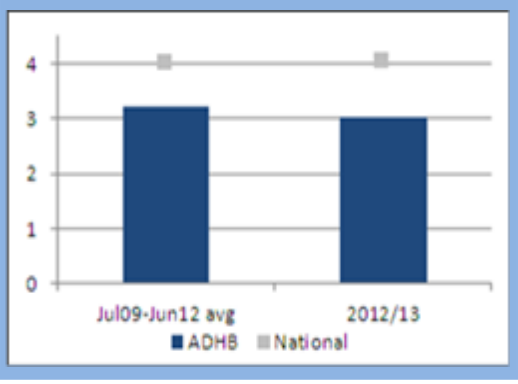
Where do we want to get to?

- The 2014 – 15 target hospitalisation rate is 1.9 per 100,000

DHB/PHO	Total population	Target
ADHB	3.2	1.9

Trends

Rheumatic fever rate per 100,000



	What are we going to do?	Timing	Responsibility
8.1	Continue implementation of all work streams within the plan.	Q1-Q4	Ruth Bijl, Sue Crengle
8.2	Continue to work closely with Service Alliance Leadership team to support implementation across the ADHB's region.	Q1-Q4	Ruth Bijl, Marty Rogers
8.3	Continue to be involved in regional and national activities that support implementation of the rheumatic fever programmes.	Q1-Q4	Ruth Bijl, Sue Crengle
8.4	Continue to support sentinel rapid response practices.	Q1-Q4	APHO, AHPPHO, PCPHO and NHC
8.5	Monitor activities and outcomes in the workstreams to determine progress, identify issues arising quickly, and implement actions to address any issues in a timely manner.	Q1-Q4	Marty Rogers, Sue Crengle

9. ORAL HEALTH

What are we trying to do?

Ensure access to health care, to reduce inequalities in oral health status for tamariki Māori.

To achieve this we will focus on:

Reducing disparities in access to oral health services by increasing Māori preschool enrolments in oral health services.

Why is this a priority?

Oral diseases are among the most common health problems and can impact on nutrition, sleeping, rest, and social roles including self-image (Kopu and Keefe). Oral diseases are relatively easy to detect with regular check-ups. The impact of untreated disease on children is substantial and disadvantaged children are disproportionately affected.

Issues and considerations:

Analysis and examination of disparities in access will be a priority for DHBs in 2014/15.

Rationale:

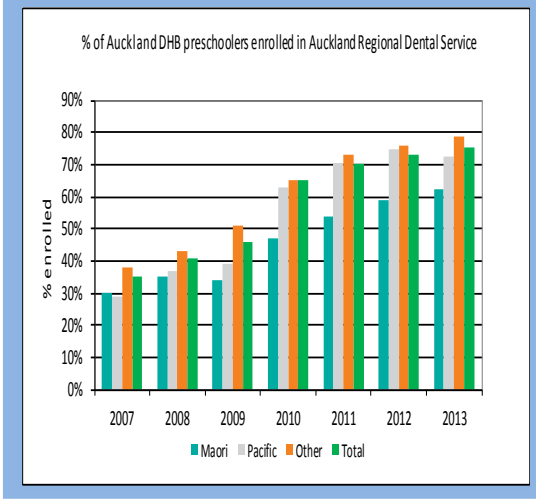
Understanding the barriers and enablers for Māori accessing oral health services is critical for creating systems and processes that will improve access and reduce inequalities.

Where do we want to get to?

- 82% Preschool Oral Health Enrolments for Māori.

DHB/PHO	Other	Māori	Target
ADHB	78%	62%	**82%**

Trends



	What are we going to do?	Timing	Responsibility
9.1	Complete consultation with PHOs, Māori providers and communities, and ARDS to review current enrolment processes and information sources.	Q1-Q2	Helene May, Tracy Walters
9.2	Develop and implement best practice approaches to increase enrolment to oral health services for Māori.	Q2-Q4	Helene May, Tracy Walters
9.3	ARDS to develop and implement strategies to increase engagement with Māori communities to improve access to oral health services.	Q2-Q4	Helene May, Tracy Walters
9.4	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Tracy Walters

10. MENTAL HEALTH

What are we trying to do?

Ensure appropriate access to and receipt of Mental Health services to support achievement and maintenance of good Mental Health.

To achieve this we will focus on:

Decreased rate of Māori treatment orders made under section 29 of the Mental Health Act. Improving access to Perinatal and Infant Maternal Health Services and strategies to reduce suicide rates in Māori.

Why is this a priority?

The Ministry is concerned that there are disproportionate numbers of Māori being treated under the Mental Health Act.

Issues and considerations:

This is a new indicator and whilst we have access to the numbers, there is little understanding of the drivers in this area.

Rationale:

To get an understanding of the potential ethnic inequities for treatment orders, made under section 29 of the Mental Health Act, access to Perinatal and Infant Maternal Health Services and suicide prevention ensure that new services and strategies maintain a key focus on reducing inequalities for Māori.

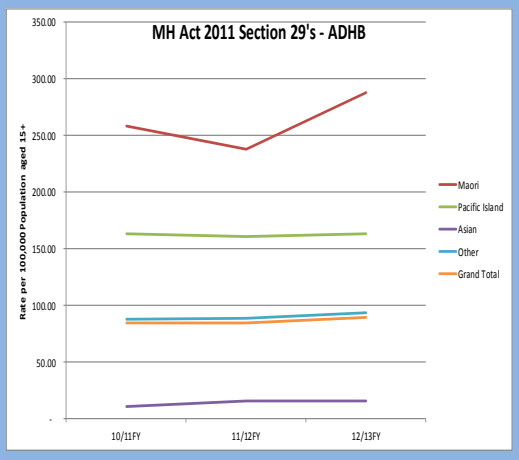
Where do we want to get to?

- Continue to reduce sections 29 treatment order rates

Baseline and targets per 100,000 (aged 15+)

DHB/PHO	Other	Māori	Target
ADHB	93.36	288.16	NA

Trends



	What are we going to do?	Timing	Responsibility
10.1	Monitoring and analysis of section 29 Mental Health Act treatment orders by: • Number by ethnicity • Number of indefinites by ethnicity • Cause.	Q1-Q4	Murray Patton, Clive Benseman Karl Snowden,
10.2	A clinical audit of Māori section 29 treatment orders under the Mental Health Act.	Q2-Q4	Murray Patton Karl Snowden, Clive Benseman
10.3	Participate in the implementation of the Mother and Baby Mental Health Service development to ensure equitable access to services.	Q1-Q4	Helen Woods, Marty Rogers
10.4	Participate in the Regional Suicide Prevention and Postvention Strategy	Q1-Q4	Marty Rogers, Karl Snowden

	What are we going to do?	Timing	Responsibility
	development and implementation to ensure approaches are culturally appropriate and that the reduction of inequalities is a priority.		
10.5	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Karl Snowden

11. YOUTH HEALTH

Local Priority 1)

What are we trying to do?

Improved health outcomes for Rangatahi Māori.

To achieve this we will focus on:

Increased access to primary care services, oral health services, sexual health, and mental health services.

Why is this a priority?

Māori youth are an under serviced group within our communities. Appropriate access is limited, high risk behaviours are common and the cost to whānau, rangatahi, and the community at large is growing.

Issues and considerations:

Data about access and utilisation across a range of services (oral, sexual, mental health and primary care) is limited.

Rationale:

Understanding the barriers and enablers for Māori youth accessing oral health services, primary mental health services and primary health care is critical for creating systems and processes that will improve access and reduce inequalities.

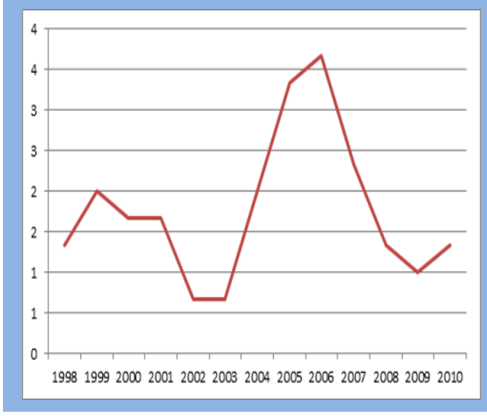
Where do we want to get to?

Decrease in youth suicides for Māori.

DHB	Non-Māori	Māori
ADHB	4	2

Trends

Māori Youth Suicide Deaths of Auckland DHB by year, 3 yearly moving average (1998-2010)



	What are we going to do?	Timing	Responsibility
11.1	Analysis of utilisation across sexual health, oral health & hospital services.	Q1	Marty Rogers, Craig Heta
11.2	Conduct survey with Rangatahi to identify enablers and barriers to accessing health services.	Q1-Q2	Marty Rogers, Craig Heta, MoU partner
11.3	Develop strategies and measures to influence Rangatahi health outcomes.	Q1-4	Marty Rogers, Craig Heta
11.4	Participate in the Regional Suicide Prevention and Postvention Strategy development and implementation to ensure approaches are culturally appropriate and that the reduction of inequalities is a priority.	Q1-Q4	Karl Snowden, MoU partner
11.5	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Craig Heta

12. KAUMĀTUA HEALTH

Local Priority 2)

What are we trying to do?

Improve the health and wellbeing of kaumātua.

To achieve this we will focus on:

Developing a Kaumātua Action Plan that focusses on the key issues affecting Kaumatua health e.g. access to Home Based Support Services (HBSS), Dementia Care, Palliative Care, Aged Residential Care, Respite Care and 65+ Influenza vaccination.

Why is this a priority?

Currently Māori make up only 4% of the aged population in Auckland and WDHB areas; however, the size of this population group will increase. The excess burden of disease experienced by the Māori population requires careful planning and service development. It is timely therefore that the Auckland and WDHBs develop an overarching action plan to meet the current and future needs of this population group.

Where do we want to get to?

Increased life expectancy for Māori and reduced impact of aged related illnesses through increased utilisation of aged related services.

Currently utilisation across a range of aged care services is very low. In some cases data is not available e.g. Dementia services.

Issues and considerations:

The Māori population, as well as the overall population, is aging. Therefore an action plan is needed so that the needs of this population group are proactively identified and addressed.

Rationale:

Ensure that all activities are implemented with a focus on improving Māori health outcomes and reducing inequalities.

	What are we going to do?	Timing	Responsibility
12.1	Complete development and begin implementation of the Kaumātua Action Plan.	Q2	Kate Sladden, Karl Snowden
12.2	Identify opportunities to grow the capacity and capability of Māori providers to provide HBSS using a Whanau Ora model of care.	Q1-Q2	Karl Snowden, Kate Sladden, MoU partner
12.3	Support Māori Providers participate in the development of the Palliative Care strategy.	Q1-Q4	Karl Snowden, MoU partner
12.4	Implement systems to collect ethnicity data for Dementia Care services.	Q2-Q4	Karl Snowden, Kate Sladden
12.5	Participate in the development of the Dementia Models of care work, to ensure cultural responsiveness.	Q1-Q4	Karl Snowden, Kate Sladden
12.6	Explore the development of an aged residential care model for Māori.	Q2-Q4	Karl Snowden, MoU partner

	What are we going to do?	Timing	Responsibility
12.7	Work with the Older Persons team to identify options that are available for Respite Care day beds.	Q1-Q3	Karl Snowden, MoU partner, Kate Sladden
12.8	Support the implementation of the CARE Project to ensure that a reduction in inequalities is a priority.	Q1-Q4	Kate Sladden, Karl Snowden
12.9	Quarterly monitoring and reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Karl Snowden

13. WORKFORCE

Local Priority 3)

What are we trying to do?

Grow the Māori workforce available to the hauora sector.

To achieve this we will focus on:

Growth and development of rangatahi Māori studying senior NCEA sciences and interested in health careers.

Identifying and addressing systematic barriers in our current recruitment and retention processes.

Why is this a priority?

Māori aged 15 – 64 years account for around 6.4% of the Auckland DHB catchment. Note this is based on total population estimates derived from the 2006 census and is not prioritised ethnic groups. As at June 2013 3.1% of the health workforce was Māori. There have been no percentage increases in the overall Māori workforce for a number of years.

Where do we want to get to?

Increase the proportion of Māori who are employed in the health workforce

Health workforce		Total population
Māori	3.1%	6.4%
Non-Māori	96.9%	93.6%

Increase the percentage of Māori in Auckland DHB's regulated workforce

DHB/PHO	Non-Māori	Māori
Regulated	69%	60.4%
Unregulated	31%	39.6%

Issues and considerations:

Barriers exist along the workforce development pipeline especially in lack of health careers awareness in Māori communities, lack of relevant quality delivery of NCEA sciences for rangatahi, and lack of value placed upon cultural competency when competing for entry into tertiary programmes or employment. Strong cross-sectoral partnerships with secondary schools and tertiary education providers are critical, and these relationships are currently ably supported by the Rangatahi Programme and the Kia Hauora programme.

Rationale:

Addressing the critical shortage of Māori health professionals is considered to be integral to overcoming the well-documented Māori: non-Māori disparities in health outcomes across life expectancy, morbidity and mortality.

	What are we going to do?	Timing	Responsibility
13.1	Complete development and start implementation of the Auckland and WDHB Māori workforce strategy.	Q2	MoU Partners, Marty Rogers
13.2	Implement the Kia Ora Hauora 14/15 Action Plan.	Q1-4	Vanessa Duthie
13.3	Support the work of the Māori Clinical Governance group.	Q1	Māori Health Gain team
13.4	Develop five Māori specific clinical roles across the services	Q1-Q4	John Paterson
13.5	Develop Māori workforce targets.	Q4	MoU Partners, Marty Rogers
13.6	Work with DoN, Service GM and HR	Q2	Vanessa Duthie

	What are we going to do?	Timing	Responsibility
	Teams to increase cultural competence.		
13.7	Report performance and progress on activities to Manawa Ora.	Q1-Q4	Vanessa Duthie, MoU Partners, Marty Rogers

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GLOSSARY

ADHB	Auckand District Health Board
APHO	Auckland Primary Health Organisation
AHPPHO	Allied Health Plus Primary Health Organisation
ARDS	Auckland Regional Dental Service
ASH	Ambulatory Hospital Sensitive Admissions
AWHI	Auckland Wide Healthy Homes Initiative
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVDRA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
EDAT	Ethnicity Data Audit Tool
ENT	Ear Nose and Throat
GP	General Practice
HR	Human Resources
LMC	Lead Maternity Carer
MoU	Memorandum of Understanding
NHC	National Hauora Coalition
PCPHO	Pro Care Primary Health Organisation
PHO	Primary Health Organisation
POAC	Primary Options for Acute Care
RN	Registered Nurse
WCTO	Well Child/Tamariki Ora
WDHB	Waitemata District Health Board