2015/16
Māori Health Plan
Auckland District Health Board

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Mihimihi

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"

Foreword

The purpose of the Māori Health Plan is to accelerate 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. The DHB is strongly committed to acclerating Māori health gain to eliminate disparities in health status by improving the health outcomes of Māori. This requires focused and dedicated collective action across the health sector, keeping the advancement of Māori health at the very fore of planning, funding and service delivery activities. A key tool to support this approach is the Minsitry of Health Equity of Health Care for Māori Framework.

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

- Health partnership with manawhenua - partnership approach to working together at both governance and operational levels
- Health equity – ensuring the appropriate resources are applied to accelerate Māori health gain
- Self-determination - supporting meaningful Māori involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence
- Indigeneity - ensuring health development and decision making is based on the aspirations of Māori
- Ngā kaupapa tuku iho – including Māori beliefs, values, protocols and knowledge to guide health service planning, quality programming and service delivery
- Whole-of-DHB-responsibility – Accelerating Māori health gain and reducing ethnic inequalities between Māori and non-Māori is a key consideration of all activities across the health system
- Evidence-based approaches – utilising scientific and other evidence to inform policy, planning, service delivery and practice to accelerate Māori health gain and reduce inequalities

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 and enjoying a better quality of life. 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.

Auckland District Health Board has Memoranda of Understanding (MoU) with partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust. Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust 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. The development of meaningful allicance models with primary care to support accelerated Māori health gain is a key area for development. For 2015/16 we have specifically documented each PHOs 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.

Contents

Introduction

The purpose of the Māori health plans is to document DHB and PHO direction for accelerating Māori health gain and reducing inequities for Māori. Waitemata and Auckland 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.

Activities in this plan to reduce Māori health inequities and accelerate Māori health gain are embedded in Waitemata and Auckland DHB's Annual Plans . Furher activities to accelerate Māori health gain are included in DHB planning documents and are aligned to the Northern Regional Health Plan.

Both DHBs are committed to accelerating Māori health gain, 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.

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.

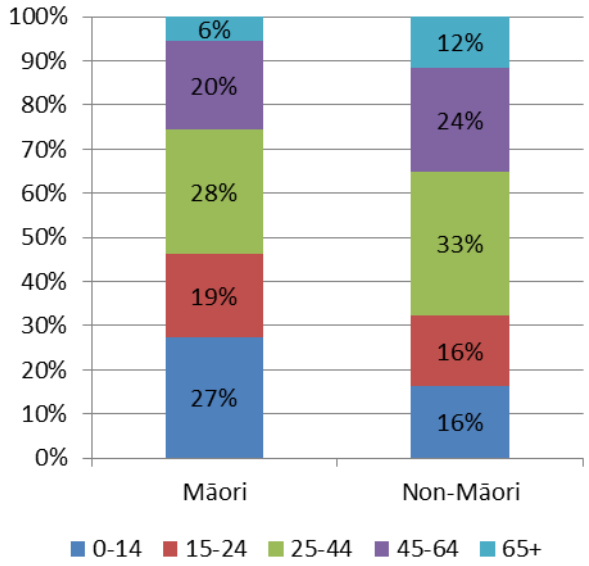
Auckland population

Profile and Health Needs

1. Population

- Auckland DHB's population is estimated to be 482,015 in 2015/16. It is an ethnically diverse area with greater proportions of Asian and Pacific peoples than in New Zealand as a whole. Māori make up 8.2% of Auckland DHB's population (40,000 people) compared with 15.5% nationally.
- Geographically, most Māori reside within the Maungakiekie -Tamaki (25% of Māori) and Albert-Eden-Mt Roskill areas (29% of Māori).
- The Auckland DHB Māori population is younger with 46% under 25 years (18,000 young people), compared with 32% of non-Māori. Conversely, 5.6% of Māori are over 65 years of age (2,300 people) compared with 11.5% of non-Māori.

Percent of Auckland DHB population in each age group, Māori and non-Māori, 2015/16

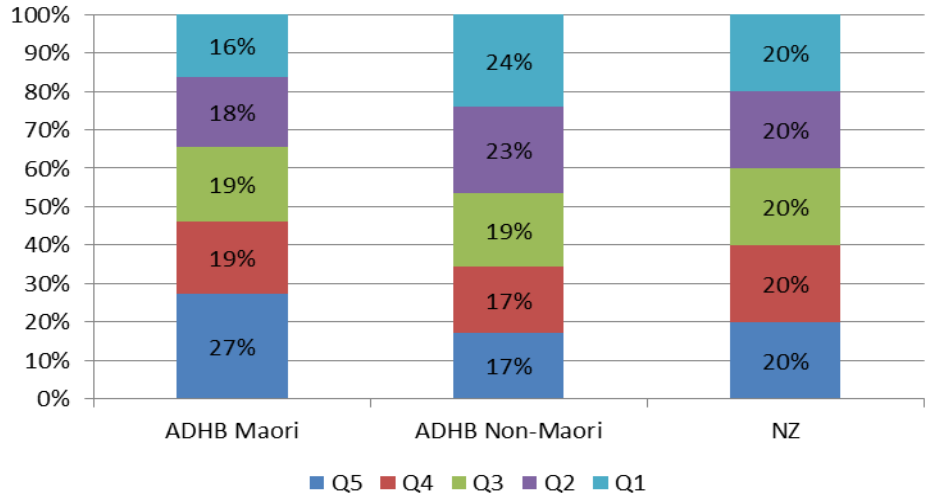


- By 2032/33, the Māori population in Auckland DHB is expected to increase by12%, compared with a projected national increase of 19.5%. The non-Māori population is expected to increase by 26% (National increase 14.7%)

2. Population Health Drivers

The NZ Deprivation index is a made up of a number of socio-economic factors collected in the census, which have a strong influence on health. The index divides the population into evenly-sized groups. Based on the 2013 Census data, 46% of Māori who usually reside in Auckland DHB live in areas of higher deprivation, compared with 40% for New Zealand as a whole, and 34% for non-Māori in Auckland DHB.

Percent of Auckland DHB Māori and Non-Māori and NZ population in each deprivation category, 2013



Q1 least deprived - Q5 most deprived

3. Modifiable Risk Factors

Smoking, obesity, lack of physical activity, high blood pressure and high cholesterol levels are key contributors to cancer, cardiovascular disease, diabetes and respiratory disease. The prevalence of smoking is lower amongst Māori in Auckland DHB than amongst Māori in the rest of New Zealand but considerably higher than for the total population. Māori adults and children in Auckland DHB have the same rates of obesity as Māori nationally, and again these rates are considerably higher than for non-Māori. Regular physical activity is reported by similar proportion of Māori in Auckland DHB and nationally and by non-Māori in Auckland DHB. A higher proportion of Māori both in Auckland DHB and in New Zealand are medicated for high blood pressure. Māori in Auckalnd DHB and Māori nationally are more likely to be medicated for high blood cholesterol than are non-Māori in Auckland DHB. This may reflect higher prevalence of these factors and/or higher detection and treatment amongst Māori.

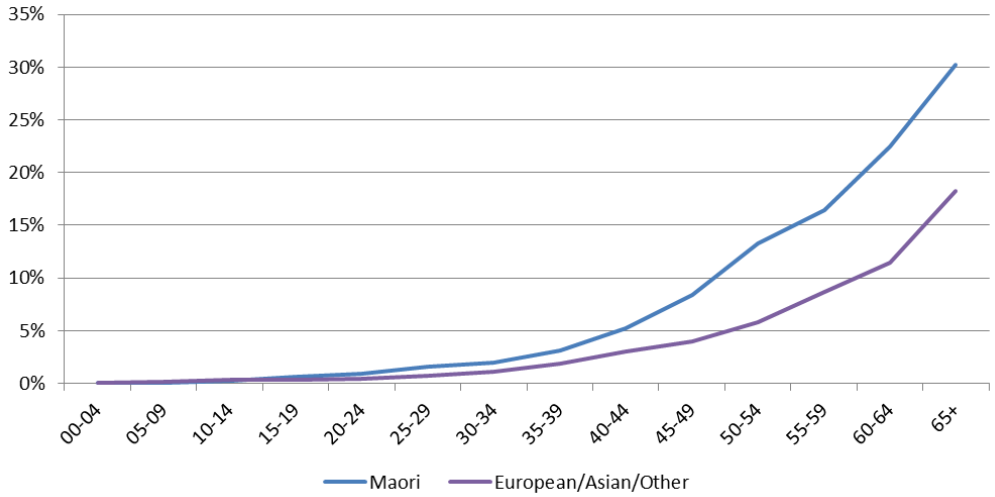
Table 3: Modifiable Risk Factors

Indicator	Prevalence Māori ADHB	Prevalence Māori NZ	Prevalence Total Population ADHB
Current smoking	26%	32%	11%
Regular physical activity	51%	52%	50%
Obese adults	46%	47%	22%
Obese children	18%	18%	10%
Medicated high blood pressure	15%	16%	10%
Medicated high blood cholesterol	11%	10%	8%

Sources: Smoking: 2013 census, Crude Prevalence; remainder: NZHS 2011/13, Age-Standardised Prevalence

The rate of diabetes among Māori in Auckland is higher in every age group than the rate for European/Asian/Other people. The overall figure is also higher (5.1% compared with 4.5%). Because the rate of diabetes increases with age, and there are relatively fewer Māori aged 65 years and over, the difference in the overall rates is not as high as the differences in each of the age bands.

Diabetes prevalence by age band in Auckland DHB, 2013

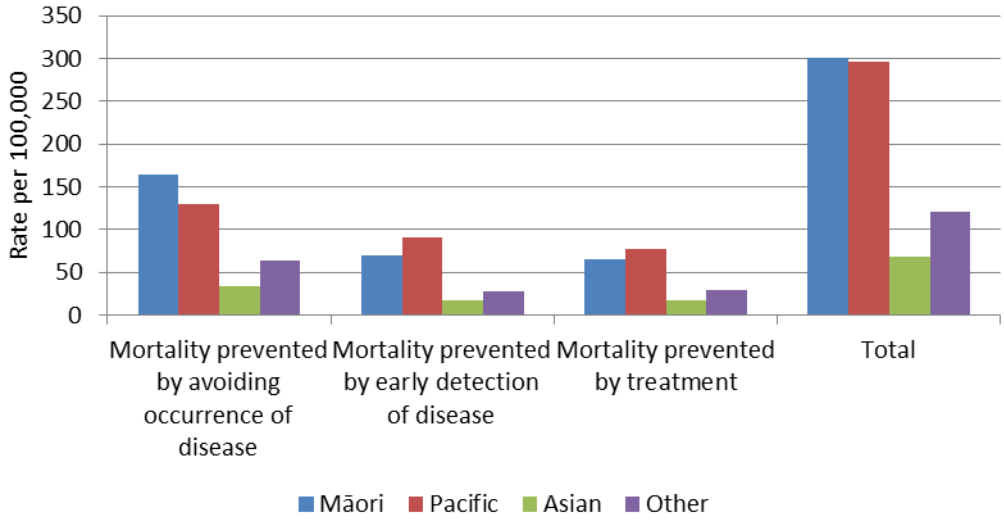


4. Leading Causes of Avoidable Mortality

Life expectancy for Māori in Auckland DHB is 79.3 years, 3.9 years shorter than for non-Māori. The age-standardised rate of avoidable mortality from all causes for Māori in Auckland DHB is 300 per 100,000 population, compared with 121 per 100,000 for the European/Other population.

The greatest potential for reducing avoidable mortality lies in preventing the development of disease; more than double the potential gains from early detection or from treatment.

Age-standardised rates of avoidable mortality in Auckland DHB by ethnicity and by method of prevention



The leading causes of avoidable mortality for Māori men in Auckland DHB are ischaemic heart disease, lung cancer, unintentional injuries, suicide and diabetes. For Māori women in Auckland DHB, the leading causes of avoidable mortality are lung cancer, chronic obstructive pulmonary disease (COPD), ischaemic heart disease, breast cancer and cerebrovascular diseases (stroke).

Table 3: Leading five causes of mortality by gender for those aged 0-74 years, 2009-2011

	Males		Females	
	ADHB	NZ	ADHB	NZ
Māori	Ischaemic heart disease	Ischaemic heart disease	Lung cancer	Lung cancer
	Lung cancer	Unintentional injuries	COPD	Ischaemic heart disease
	Unintentional injuries	Lung cancer	Ischaemic heart disease	Breast cancer
	Suicide and self inflicted injuries	Diabetes	Breast cancer	COPD
	Diabetes	Suicide and self inflicted injuries	Cerebrovasular diseases	Diabetes
Non-Māori	Ischaemic heart disease	Ischaemic heart disease	Breast cancer	Breast cancer
	Lung cancer	Lung cancer	Lung cancer	Lung cancer
	Unintentional injuries	Unintentional injuries	Ischaemic heart disease	Ischaemic heart disease
	Cerebrovascular diseases	Suicide and self-inflicted injuries	Colorectal cancer	Colorectal cancer
	Suicide and self-inflicted injuries	Colorectal cancer	Cerebrovascular diseases	COPD

5. 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 78% of the eligible Māori population and 91% of the non-Māori in December 2014)
- Contract with 5 Māori providers totalling $3.7 million
- Multiple local and national non-profit and private health and social providers.

Successes to date in Auckland District Health Board

- Māori life expectancy at birth in Auckland DHB is 79.3 years is approximately four years above the national average for New Zealand Māori (75.4 years in 2013). It has increased by 1.1 years over the last 10 years.
- Smoking prevalence has declined by 11% for Māori between the 2006 and 2013 censuses to 26%.
- Over 95% of Māori people in hospital and primary care are being offered smoking cessation advice (December 2014).
- Māori enrolment in PHOs is 78%.
- Heart and diabetes checks for Māori have increased from 58% to 88% between December 2012 and December 2014.
- 95% of Māori children were fully immunised at 8 months at the end of December 2014.
- At the two year old milestone, 96% of Māori infants are fully immunised.
- Cervical screening rates have improved from 53% to 56% since June 2012.
- Breast screening rates are 69%, just short of the target of 70%.
- The Waitemata and Auckland DHB Māori Workforce Development Strategy, which was led by Te Rūnanga o Ngāti Whātua, has been endorsed by the Board.

National priority summary

	National Health Priority Area	Indicators	Baseline Data Non-Māori[1]	Baseline Data Māori[1]	Target
1.	**Data Quality**	Accuracy of ethnicity reporting in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit.			NA
2.	**Access To Care**	Percentage of Māori enrolled in PHOs.	94%	79%	NA
2.1		Ambulatory sensitive hospitalisation rates per 100,000 for age groups: • 0-4 years • 45-64 years	 73% 103%	 102% 236%	NA
3.	**Child Health**	Exclusively or fully breastfed at LMC discharge (4-6 weeks)[2] Exclusively or fully breastfed at 3 months[3] Receiving breast milk at 6 months[3]	81% 60% 75%	81% 51% 69%	75% 60% 65%
4	**Cardio Vascular Disease**	Percentage of eligible Māori who have had a CVD risk recorded within the past five years[4]	92%	89%	90%
4.1		Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had a CVD risk recorded within the past five years			
4.2		70 percent of high-risk patients will receive an angiogram within three days of admission ('Day of Admission' being 'Day 0'[5]).	89%	83%	70%
4.3		Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACZ QI data collection within 30 days[6].	75%	83%	>95%
5	**Cancer**	Percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25–69 years who have had a	81%	56%	80%

[1] Baseline data Q2 2014/15, unless otherwise stated
[2] Well Child Tamariki Ora quality indicators, Sept 2014
[3] Plunket, 2013/14
[4] Q3 data
[5] Q3 data
[6] Q3 data

	National Health Priority Area	Indicators	Baseline Data Non-Māori[1]	Baseline Data Māori[1]	Target
		cervical screening event in the past 36 months.			
5.1		70 percent of eligible women, aged 50 to 69 will have a BSA mammogram every two years.	68%	64%	70%
6.	**Smoking**	Percentage of pregnant Māori women who are smokefree at two weeks postnatal.[2]	97% (total pop'n)	82%	95%
7	**Immunisation**	Percentage of infants fully immunised by eight months of age[7].	94%	86%	95%
7.1		Seasonal influenza immunisation rates in the eligible population 65 years and over.	67%	67%	75%
8.	**Rheumatic Fever**	Number and rate of first episode rheumatic fever hospitalisations for the total population	3.2[8]		1.4[9]
9.	**Oral Health**	Percentage of pre-school children enrolled in the community oral health service[10]	77%	62%	80[11]%
10.	**Mental Health**	Reduce the rate of Māori on the Mental Health Act: section 29 community treatment orders relative to other ethnicities.	61[8]	258	NA

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 2015/2016 the local priorities have been identified via tripartite agreement with both Māori MoU partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust.

[7] Q3 data
[8] 3.2 per 100,000 (2009/10-2011/12)
[9] 2009/10–2011/12 55% reduction on baseline baseline rate (3-year average rate)
[10] As at December 2013
[11] Interim target of 80% for Dec 15

1 Data quality

What are we trying to do?

Improve the quality of ethnicity data collected at primary care.

To achieve this we will focus on:

Develop an e-learning tool for primary care practice management and administrative staff. This tool would address a clear training gap identified through the implementation of the Primary Care Ethnicity Data Audit Toolkit (EDAT). In addition it would provide a concrete opportunity for quality improvement as an outcome of EDAT. The e-learning module is aimed at driving behaviour change in primary care, supported by relevant elements including the meaning of ethnicity, why ethnicity data collection is important, and key elements of the Ministry of Health Ethnicity Data Protocols.

Why is this a priority?

Primary care data is important for policy, planning and monitoring of many indicators important for Māori Health. There are known issues with ethnicity data quality, including in primary care data. There is evidence from EDAT and other DHB work that there are variable systems, policies, and practices related to the collection and recording of ethnicity data in primary care which results in an undercount and misclassification which impacts the ability to plan and target interventions, and to monitor progress. Waitemata DHB has implemented EDAT in general practices in the Auckland and Waitemata DHB areas, which included training components for PHOs, general practices and frontline staff. This process has clearly identified a need for on-going training for administrative staff (particularly where there is high turnover) to better collect and record ethnicity data. Universally this was requested to be online. Development of the e-learning module will utilise the expertise from EDAT implementation, national ethnicity data expertise, and end-user perspective in order to develop a tool that will have impact in primary care. The tool will be developed with the intention of being available to primary care nationally, and in association with relevant accreditation or quality improvement schemes.

	What are we going to do?	Timing	Responsibility
1.	Develop e-learning module on ethnicity	Q2	Māori Health Gain Team
2.	Pilot and evaluate e-learning	Q3	Māori Health Gain Team
3.	Implement the e-learning tool nationally in a variety of settings in collaboration with the Ministry of Health, DHBs, primary care	Q3-Q4	Māori Health Gain Team
4.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

2 Access to health care – enrolment

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?

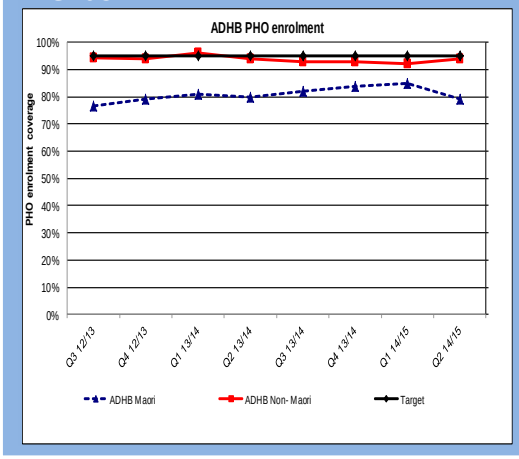
A focus on ensuring access to primary care is an initial step in addressing Māori health inequalities. Only when equitable access to primary care for Māori is achieved, can there be demonstrable improvement across all Māori health gain priorities, within the primary care setting.

Where do we want to get to?

- 95% Māori enrolment in PHOs

DHB/PHO	Non-Māori	Māori	Target
ADHB	94%	79%	NA

Trends



	What are we going to do?	Timing	Responsibility
1.	Implement the Multienrolment Project to enable referral and enrolment of new-borns into a range of services, including enrolment with a PHO	Q4	Women's, Children and Youth Team
2.	Analyse the proportion of Māori ASH admissions without a GP recorded and develop an approach to increase enrolment in this group	Q2	Māori Health Gain Team
3.	Develop, implement and evaluate a pilot initiative to support prisoners released from prison to enrol with a GP and have a free first visit.	Q4	Māori Health Gain Team
4.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

2.1 Access to health care – ambulatory sensitive hospitalisation

What are we trying to do?

Reduce Ambulatory Sensitive Hospital (ASH) admission rates in two priority age groups 0-4 years and 45-64 years.

To achieve this we will focus on:

Analysing the results of an ASH survey focused on patient experience to inform changes in current activities. We will continue to provide a variety of activities to improve pathways for high priority ASH conditions for 0-4 years and 45-64 years. This work aligns with the activity outlined in Sections 2.0, 4.1, 9 and 13.

Why is this priority?

Developing an understanding of pathways to hospital will support the development of interventions.

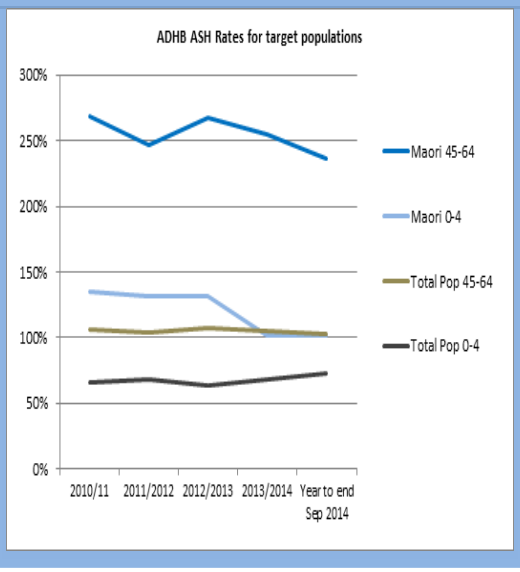
Issues and considerations

ASH data has been collected and reported in New Zealand since 2001. ASH conditions are a subset of all health conditions that are believed to be relatively amenable to out-of-hospital management, and ASH rates are undoubtedly impacted by the quality of primary care services, but also by high quality population health care, and the interfaces between population health, primary/community care, and secondary/hospital care

Where do we want to get to?

- Reduction in ASH rates across priority age groups.

DHB/PHO	Non-Māori	Māori	Target
ASH rates 0-4 years			
ADHB	73%	102%	NA
ASH rates 45-64 years			
ADHB	103%	236%	NA



	What are we going to do?	Timing	Responsibility
1.	Conduct analysis of survey results for pathways to hospital for Māori admitted with ASH conditions.	Q1	Māori Health Gain Team
2.	Identify evidence based activities to reduce ASH rates based on survey findings and examine opportunities to strengthen current pathways or develop a new initiative	Q2-Q4	Māori Health Gain Team
3.	Implement the Multienrolment Project to enable referral and enrolment of new-borns into a range of services, including enrolment with a oral health provider and	Q4	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	a General Practitioner by June 2016 (see Section 2.0, activity 1).		
4.	Establish best practice (whole of system approach, including primary care), regionally consistent Cardiac Rehabilitation Programme – by June 2016 (Section 4.1, activity 4).	Q4	Hospitals Team
5.	Measure retention rate on current cardiac rehabilitation programme to enable comparison once new programme established – by September 2015 (Section 4.1, activity 5).	Q1	Hospitals Team
6.	Define improved pathway to cardiac rehabilitation programmes and expected outcomes by June 2016 (Section 4.1, activity 6).	Q4	Hospitals Team
7.	Audit existing referral pathways to cardiac rehabilitation programmes by ethnicity – completed by December 2015 (Section 4.1, activity 7).	Q4	Hospitals Team
8.	Work with ARDS to develop and implement at least one action to increase oral health care service utilisation by infants aged less than 1 year, with a particular focus on Māori infants, by June 2016 (Section 9, activity 2).	Q4	Women's, Children and Youth Team
9.	Provide access to self-management workshops with particular focus on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016 (Section 13, activity 2).	Q4	Primary Care Team
10.	Explore ways to improve participation in these workshops, particularly high needs populations, and develop a set of recommendations by June 2016 (Section 13, activity 5).	Q4	Primary Care Team
11.	General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals with CVD risk >15% and put in place appropriate management plans – on-going (Section 13, activity 6).	Q1-Q4	Primary Care Team
12.	Work with PHOs and regional Primary Options for Acute Care (POAC) members to	Q1-Q4	Primary Care Team

	What are we going to do?	Timing	Responsibility
	continue to support the services across Auckland (including cellulitis treatment)– ongoing.		
13.	Continue to provide Long Term Conditions nurse-led clinics in community settings – ongoing.	Q1-Q4	Primary Care Team
14.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

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[12,13].

To achieve this we will focus on:

Understanding what specific factors contribute to the decline in rates of exclusive and fully breastfed Māori babies at 3 months. We will also work with the new pregnancy and parenting education providers to develop key messages and delivery mechanisms relevant for breastfeeding that are appropriate for Māori women

Where do we want to get to?

- 75% of Māori babies are fully or exclusively breastfed at 6 weeks
- 60% of Māori babies are fully or exclusively breastfed at 3 months
- 65% of Māori babies are receiving breast milk at 6 months.

DHB/PHO	Total population	Māori	Target
6 week			
ADHB	81%	81%	75%
3 month			
ADHB	60%	51%	60%
6 month			
ADHB	75%	69%	65%

Why is this priority?

Research shows that children who are exclusively breastfed for the early months are less likely to suffer adverse effects from childhood illnesses such as respiratory tract infections, gastroenteritis, otitis media, etc. Breastfeeding benefits the health of both mother and baby, as well as reducing the risk of SUDI, asthma, diabetes and obesity.

	What are we going to do?	Timing	Responsibility
1.	Run focus groups with mothers to analyse the reasons for declining breastfeeding rates for infants aged between 6 weeks and three months (particularly for Māori and Pacific infants), and present recommended actions to the Alliance for consideration by October 2015	Q2	Women's, Children and Youth Team, Māori Health Gain Team
2.	Continue to support the implementation of the Healthy Babies Healthy Futures breastfeeding key messages to Māori women through text messaging, community promotion, and support groups.	Q1-Q4	Māori Health Gain Team
3.	Support the implementation of a combined WCTO and midwifery breastfeeding education course for these	Q3	PFO child health team, midwives, LMCs, WC/TO providers

[12] Exclusively or fully breastfed at LMC discharge (4-6 weeks) - Well Child Tamariki Ora quality indicators, Sept 2014.
[13] Exclusively or fully breastfed at 3 months and receiving breast milk at 6 months[3] - Plunket, 2013/14

	What are we going to do?	Timing	Responsibility
	professionals.		
4.	Implement the new pregnancy and parenting education smartphone app to encourage all women, particularly Māori, Pacific and Asian, to breastfeed for at least the first 6 months of their baby's life by March 2014	Q3	Women's, Children and Youth Team, Māori Health Gain Team
5.	Maintain Baby Friendly Hospital Initiative (BFHI) across maternity facility.	Q1-Q4	Hospitals Team
6.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

4 Cardiovascular disease – risk assessment

What are we trying to do?

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

To achieve this we will focus on:

Maintain the percentage of eligible Māori who have had their CVD risk assessed within the last five years. We will also continue to support improved management of risk factors, prevention and treatment of cardiovascular disease where these are identified.

Why is this a priority?

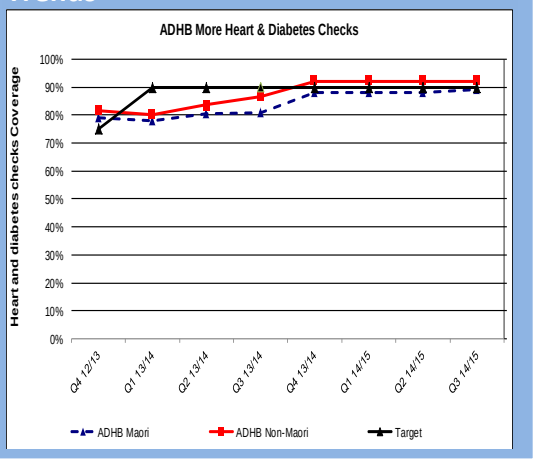
CVD is a major cause of morbidity and mortality for Māori and makes a substantial contribution to the inequalities between Māori and non-Māori in all cause life expectancy. Risk assessment is the first step in implementing evidence-based prevention and management of CVD.

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	92%	89%	90%

Trends



	What are we going to do?	Timing	Responsibility
1.	PHO and general practice service agreements and activities will reflect the requirement to ensure that 90% of the eligible population particularly at risk populations (Māori, Pacific and South Asian men between 35 and 44) have their cardiovascular and diabetes risk assessment completed every five years – on-going.	Q1-Q4	Auckland PHO, ProCare, Alliance Health Plus, National Hauora Coalition, Primary Care Team, Māori Health Gain Team
2.	General Practices will use appropriate risk assessment, patient management and monitoring IT tools to identify individuals with CVD risk >15% and put in place appropriate management plans – ongoing	Q1-Q4	Auckland PHO, ProCare, Alliance Health Plus, National Hauora Coalition, Primary Care Team, Māori Health Gain Team
3.	Commitment of budget 2013 funding for PHO practice support/liaison team who assist practices with: • identifying eligible population and provide optimal management, as appropriate, of modifiable risk factors, namely lipid profile and glycaemic	Q1-Q4	Auckland PHO, ProCare, Alliance Health Plus, National Hauora Coalition, Primary Care Team, Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
	control • providing continued professional education on the quality standards for the optimal management for patients with Diabetes and high cardiovascular risk profiles • conduct audit and running practice level reporting to demonstrate improvement in patient care - ongoing		
4.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

4.1 Cardiovascular disease – acute coronary syndrome

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:

There are a range of access and quality indicators in cardiac care that include assessment and management of acute coronary syndrome in the Emergency Department (the Accelerated Chest Pain Pathway), access to cardiac diagnostics and interventions, and access and retention in best practice cardiac rehabilitation programmes. We will continue to monitor and investigate relevant cardiac interventions and any ethnic disparities between Māori and others.

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	89%	83%	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	75%	83%	95%

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

It is acknowledged that indicators presented here are new, and that for Māori the numbers are very small (when reported quarterly this leads to some fluctuations). However early indicators are that for Acute Coronary Syndrone (ACS) the 70% target is being met and there are not significant ethnic disparities. For the completion of the registry data there is on-going work to improve systems to meet targets.

	What are we going to do?	Timing	Responsibility
1.	Review of the end-of-year data for the new ACS <3 day angiogram measure by ethnicity.	Q3	Hospitals Team, Māori Health Gain Team
2.	Continue to work on improving systems for data input and recording for cardiac registry data.	Q1	Hospitals Team
3.	Work with regional colleagues to manage the acute patient flow to minimise patient wait times and refine transfer process using the CPAC tool, to be regionally agreed to and applied by October 2015.	Q2	Hospitals Team
4.	Establish best practice (whole of system approach, including primary care), regionally consistent Cardiac Rehabilitation Programme – by June 2016.	Q4	Hospitals Team

	What are we going to do?	Timing	Responsibility
5.	Measure retention rate on current cardiac rehabilitation programme to enable comparison once new programme established – by September 2015.	Q1	Hospitals Team
6.	Define improved pathway to cardiac rehabilitation programmes and expected outcomes by June 2016.	Q4	Hospitals Team
7.	Audit existing referral pathways to cardiac rehabilitation programmes by ethnicity – completed by December 2015.	Q4	Hospitals Team
8.	Work with regional colleagues secondary and primary care to establish guidelines and protocols for heart failure management.	Q4	Hospitals Team
9.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

5 Cancer screening – cervical

What are we trying to do?

Reduce Māori cervical cancer morbidity and mortality.

To achieve this we will focus on:

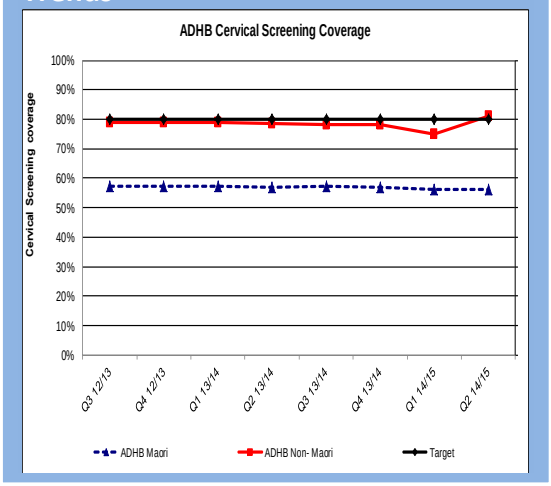
Improving cervical screening coverage rates for Māori women and reducing ethnic disparities in screening rates. While the work undertaken in the Cervical Screening Ethnicity Data Quality Improvement Project (correcting misclassification of ethnicity data in primary care) resulted in some improvement to coverage, the focus of the regional cervical screening work will be significant improvement in coverage for Māori women. The flagship data-matching project has prioritised unscreened and underscreened Māori women, the implementation of the 'How To' guide has begun supporting general practices with low coverage, and a new kaiatawhai initiative will be launched and evaluated.

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	81%	56%	80%

Trends



Why is this a priority?

Māori women continue to have significantly lower participation in the cervical screening programme.

Considerations:

The results of the Cervical Screening Ethnicity Data Quality Improvement Project (14/15) was used to inform the EDAT implementation and development of Q1 activities in Indicator 1.

	What are we going to do?	Timing	Responsibility
1.	Pilot new initiative in one large general practice to utilise data-matched lists to identify Māori women and invite participation using a kaiatawhai individual follow up approach.	Q3	Women's, Children and Youth Team
2.	Develop and implement a survey to get feedback from women on their colposcopy experience by September 2015.	Q2	Women's, Children and Youth Team
3.	Conduct ethnic specific examination of colposcopy clinic DNA rates to help inform future strategies to improve access for Māori women to colposcopy	Q2	Women's, Children and Youth Team, Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
	services by December 2015.		
4.	Continue to provide free smears for Māori women aged 30-69 years through PHOs.	Q1-Q4	Women's, Children and Youth Team, Primary Care
5.	Complete the data matching pilot with one large PHO. Pilot complete with evaluation findings available to inform ongoing datamatching by August 2015.	Q1	Women's, Children and Youth Team, Primary Care, Māori Health Gain Team
6.	Continue to support datamatching opportunities with PHOs and general practices until a regional regular PHO datamatching is process is in place. Promotion through the Operations Group and PHO forums of datamatch pilot 'best practice template' format for the lists to be returned to practices to result in practice action.	Q1-4	Women's, Children and Youth Team, Primary Care, Māori Health Gain Team
7.	Continue to support practices implementing the 'How To' guide with a focus on practices with high numbers of priority group women.	Q1-Q4	Women's, Children and Youth Team, Primary Care, Māori Health Gain Team
8.	Deliver a training programme (which has been developed in collaboration with a health literacy organisation) for frontline reception staff. This will support a new model of care for patient recall where reception staff and practice nurses work together. This activity is focused on Māori women.	Q4	Cervical Screening Region Co-ordinator, Māori Health Gain Team, Women's, Children and Youth Team
9.	Continue to coordinate the monthly Operations Group for implementing coordination service activities, and sharing success stories of PHO and Independent Service Provider (ISP) activities to improve coverage. These activities have a focus on strategies to improve Māori coverage.	Q1-Q4	Women's, Children and Youth Team
10.	Through the Operations Group develop and implement the referral pathway between PHOs and ISPs to improve coverage for priority group women, with a focus on improving Māori coverage.	Q1	Women's, Children and Youth Team
11.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

5.1 Cancer screening – breast

What are we trying to do?

Reduce Māori breast cancer morbidity and mortality[14].

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?

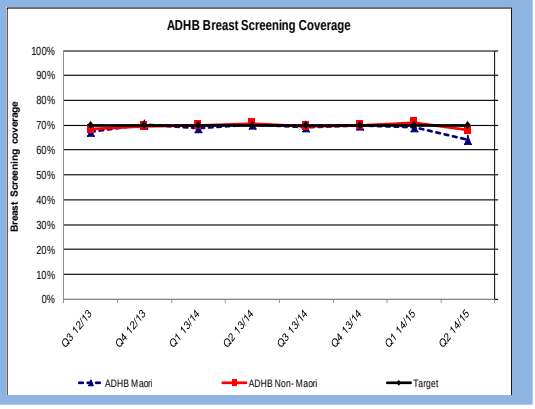
Breast screening can reduce breast cancer mortality through early detection. Māori women in ADHB have significantly higher breast cancer mortality rates than non-Māori/non-Pacific women.

Where do we want to get to?

- 70% breast screening coverage of eligible Māori women

DHB/PHO	Non-Māori	Māori	Target
ADHB	68%	64%	70%

Trends



	What are we going to do?	Timing	Responsibility
1.	Continue health promotion, primary care and Independent Service Provider (ISP) engagement and Mobile Unit Breast screening activities to facilitate BreastScreen Aotearoa enrolment in order to increase coverage rates for Māori women. Provide home visits and transport to Māori women who identify transport as a barrier to screening.	Q1-4	BreastScreen Auckland Ltd Lead Provider
2.	Continue to progress datamatching at practice level and via PHO MoUs. This is a key strategy to identify never screened and underscreened Māori women, and then invite and recall those women, through phone conversations. Through the MoUs include active feedback of results of the datamatch to general practices, including clarification of patient contact details.	Q1-Q4	BreastScreen Auckland Ltd Lead Provider, Women's, Children and Youth Team, Primary Care
3.	Support collaborative working relationships with all key stakeholders	Q1-Q4	Women's, Children and Youth Team, Māori Health Gain Team

[14] Data as at Dec 2014

	What are we going to do?	Timing	Responsibility
	across the screening pathway to improve coverage. This is achieved by attendance at 6 monthly lead provider regional meetings with ISPs and primary care.		
4.	Maintain a focus on Māori breast screening coverage through the DHB Planning and Funding Breast Screening Steering Group (Auckland DHB and Waitemata DHB). Continue to develop collaborative working relationships with the Lead Providers through this forum.	Q1-Q4	Women's, Children and Youth Team, Māori Health Gain Team
5.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

6 Smoking

What are we trying to do?

Reduce smoking related morbidity and mortality rates for Māori, and create smokefree environments for pregnant women and children. We specifically want to increase the number of women who are smokefree in pregnancy and postpartum to improve maternal and infant outcomes.

Where do we want to get to?

- 95% of Māori women are smokefree at two weeks postnatal.

DHB/PHO	Total	Māori	Target
ADHB	97%	82%	95%

To achieve this we will focus on:

Moving from the provision of brief advice to clearly understanding the referral and utilisation of cessation services by Māori, and maximising opportunities for supported quit attempts. The focus of this work is on pregnant mothers, however a range of approaches across the lifespan are in progress.

Why is this a priority?

Smoking is a key driver of the gap in life expectancy between Māori and non-Māori, contributing to lung cancer, cardiovascular disease and respiratory disease. In addition smoking in pregnancy has important risks to the baby (small for gestational age, prematurity) and contributes to Sudden Unexplained Death of an infant (SUDI), childhood respiratory infections and asthma. Becoming and staying smokefree is critical to improve the health of individuals and their whānau.

	What are we going to do?	Timing	Responsibility
1.	Implement the voucher incentive scheme targeting wāhine hapu.	Q2	Māori Health Gain Team, Healthy Lifestyles team
2.	Develop and implement a communications plan that promotes quitting to pregnant women and their whānau.	Q2	Māori Health Gain Team, Healthy Lifestyles team
3.	Build on the training provided by Innovat8 to ensure that all midwives and General Practice staff can support pregnant women to quit – on-going.	Q1-Q4	Healthy Lifestyles team
4.	Build relationships between Lead Maternity Carers, Maternity Services, Well Child Tamariki Ora providers and all locally available stop smoking services – on-going.	Q1-Q4	Healthy Lifestyles team
5.	Implement a programme with 2-3 schools (one based in Rodney, Hato Petera and Otahuhu college) to pilot youth initiated smoking prevention strategies for high risk youth. Lessons learnt from these pilot sites could be used to develop and implement a	Q2-Q3	Māori Health Gain Team, Healthy Lifestyles team

	What are we going to do?	Timing	Responsibility
	school based smoking prevention programme.		
6.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

7 Immunisation – infants

What are we trying to do?

Improve child health by improving immunisation coverage.

To achieve this we will focus on:

Increasing the percentage of Māori babies who are immunised on time, as measured at 8 months of age.

Why is this a priority?

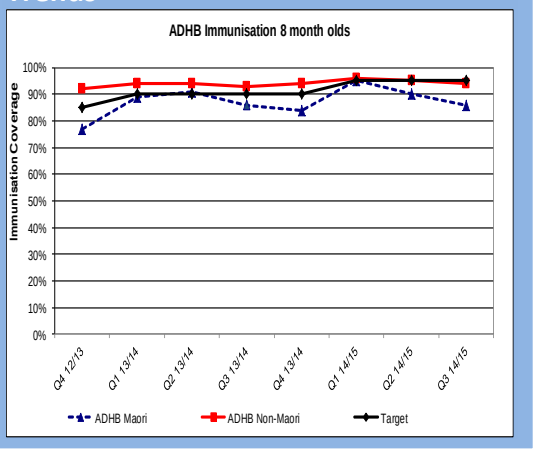
Immunisation can prevent a number of diseases and is a very cost-effective health intervention. It provides not only individual protection, but for some diseases also population-wide protection by reducing the incidence of diseases and preventing them from spreading to vulnerable people.

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	94%	86%	95%

Trends



	What are we going to do?	Timing	Responsibility
1.	Continue to work with primary care to develop strategies to improve newborn enrolment via the Multi Enrolment Project to enable timely vaccination.	Q1-Q4	Women's, Children and Youth Team, Māori Health Gain Team
2.	Liaise closely with the Auckland and Waitemata Immunisation Operations Group, PHOs and the NIR to detect early and action problem solving measures when required – on-going	Q1-Q4	Women's, Children and Youth Team
3.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

7.1 Immunisation – 65 +

What are we trying to do?

Improve the health of older Māori by improving Māori health outcomes and reducing inequalities.

To achieve this we will focus on:

Building the capacity of the Māori health workforce through increasing the number of Māori vaccinators, promoting vaccinations to eligible Māori admitted to hospital, offering vaccinations in rest homes and in residential settings and investigating the provision of an equity based programme in primary care.

Why is this a priority?

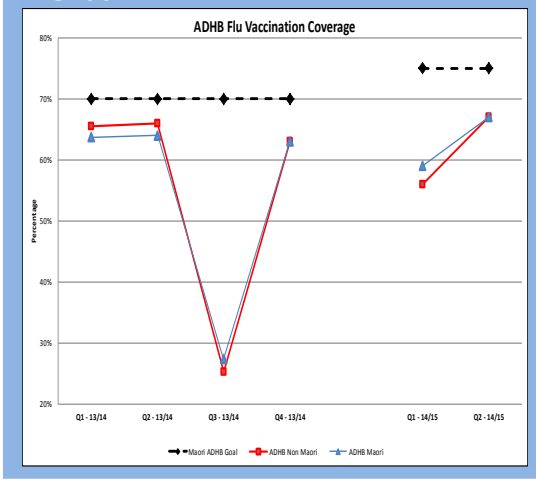
The complications of influenza in older people can be serious or life threatening.

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	67%	67%	75%

Trends



	What are we going to do?	Timing	Responsibility
1.	Work with PHOs to investigate the feasibility of developing and implementing an equity focussed incentivised Flu vaccination programme for Māori 65+ based in primary care.	Q1–Q4	Primary Care Team, Māori Health Gain Team, Alliance Health Plus, ProCARE, Auckland PHO
2.	Develop the capacity of Māori RN workforce by funding Māori nurses within Māori providers to complete vaccinator's course.	Q3	Māori Health Gain Team
3.	Promote vaccinations and record details of Kaumatua and Kuia not vaccinated who are admitted to Hospital in collaboration with He Kamaka Waiora Team.	Q3–Q4	WDHB Māori Health Provider Team, Māori Health Gain Team
4.	Offer vaccinator training to registered nurses working with rest homes and other residential settings so they can offer vaccinations to eligible people.	Q1-Q4	Health of Older People Team
5.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

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:

In 2015/16 we will review and revise the Rheumatic Fever Programme Plan and continue to support the Rheumatic Fever Rapid Response clinics established in a number of general practices and pharmacies throughout the district and evaluate their effectiveness. We will enhance our school based surveillance by maintaining our programmes in primary schools and introduce community health workers into high needs secondary schools.

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.

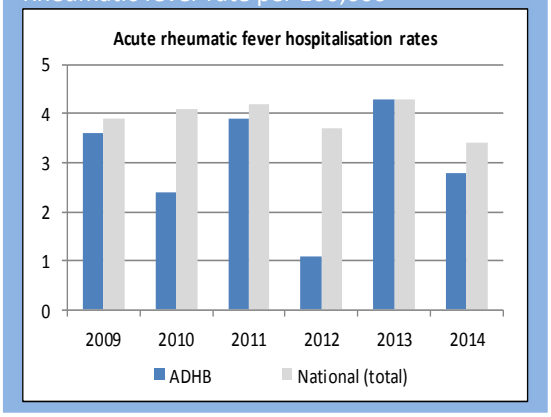
Where do we want to get to?

- 55% below 3-year average rate 2009/10–2011/12

DHB/PHO	Total population	Target
ADHB	3.2	1.4

Trends

Rheumatic fever rate per 100,000



	What are we going to do?	Timing	Responsibility
1.	Review and revise the ADHB Rheumatic Fever Programme Plan in line with Ministry expectations by September 2015.	Q1	Women's, Children and Youth Team
2.	Complete an evaluation of the effectiveness of the school based throat swabbing and management programme including health literacy by September 2015.	Q1	Women's, Children and Youth Team
3.	Introduce community health workers into 4 high-needs secondary schools to support the rapid response programme by April 2016.	Q4	Women's, Children and Youth Team
4.	Ensure all eligible referrals for housing related concerns are sent to the Auckland Wide Healthy Housing Initiative (AWHI) Hub and that systems and relationships support referrers to help keep families informed.	Q1-Q4	Women's, Children and Youth Team
5.	Working with the Māori Health Gain team and with Pacific Health Gain team, train at least 60 non-health front-line staff who	Q2	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	interface with the target group from at least three organisations about the importance of sore throats and seeking medical help by December 2015.		
6.	Maintain the intensive school based throat swabbing and management programme in five primary schools.	Q1-Q4	Women's, Children and Youth Team
7.	Monitor the effectiveness of the Rapid Response Clinics in general practice and in pharmacy.	Q4	Women's, Children and Youth Team
8.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

9 Oral health

What are we trying to do?

Ensure access to health care, to reduce inequalities in oral health status for tamariki Māori[15].

To achieve this we will focus on:

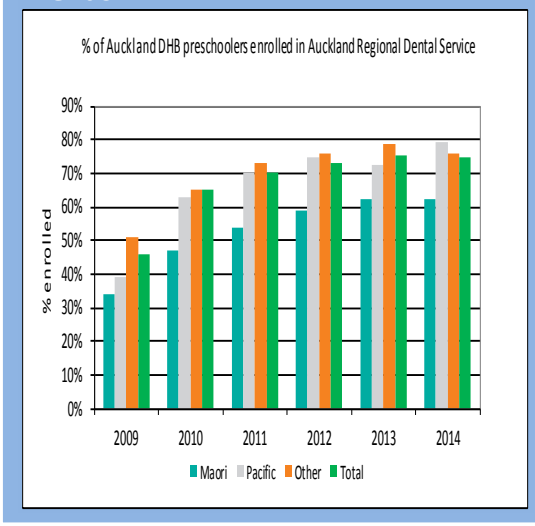
Early enrolment and utilisation of community oral health services is essential to enable proactive oral health behaviours, and provide preventative treatments, to supporting good oral health across a lifetime. We will reduce disparities in access to oral health services by increasing Māori preschool enrolments in oral health services. The focus for this work will be in early enrolment and utilisation of community oral health services within the first year of life for Māori infants.

Where do we want to get to?

- 75% Preschool Oral Health Enrolments for Māori

DHB/PHO	Non-Māori	Māori	Target
ADHB	77%	62%	80%

Trends



Why is this a priority?

Dental caries are one of the most common diseases of childhood. Oral disease can impact negatively on child growth, development and quality of life as well as being one of the top five avoidable causes of hospitalisation for Māori children. Poor oral health is almost entirely preventable.

	What are we going to do?	Timing	Responsibility
1.	Collaborate with oral health clinical leaders and service management to identify areas for further regional collaboration in approaches to oral health data collection.	Q2	Women's, Children and Youth Team
2.	Work with ARDS to develop and implement at least one action to increase oral health care service utilisation by infants aged less than 1 year, with a particular focus on Māori infants, by June 2016.	Q4	Women's, Children and Youth Team
3.	Implement the Multienrolment Project to enable referral and enrolment of new-borns into a range of services, including enrolment with a oral health provider.	Q4	Women's, Children and Youth Team
4.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

[15] Interim target of 80% for Dec 15

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 Baby and Mother Mental Health Services and strategies to reduce suicide rates in Māori.

Why is this a priority?

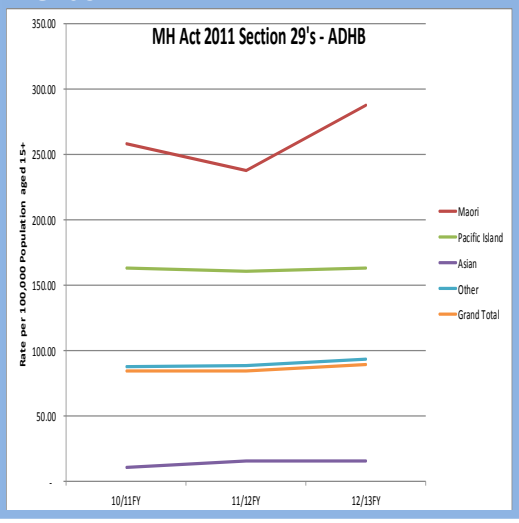
The Ministry is concerned that there are disproportionate numbers of Māori being treated under the Mental Health Act. Improving access to Perinatal and Infant Maternal Health Services and strategies to reduce suicide rates in Māori.

Where do we want to get to?

- Decreased rate of Māori treatment orders made under section 29 of the Mental Health Act.

DHB/PHO	Non-Māori	Māori	Target
ADHB	61	258	NA

Trends



	What are we going to do?	Timing	Responsibility
1.	Run focus groups with Tangata Wai I te Ora and whānau accessing mental health services to gain insights into the negative and positive effects of compulsory community treatment orders by March 2016.	Q3	Māori Health Gain Team, Whitiki Maurea Team
2.	Monitor and analyse section 29 Mental Health Act treatment orders for Māori: • Record the number of CTOs (including indefinite CTOs) by ethnicity – quarterly • Record the duration of CTO orders by ethnicity – quarterly • Record the number and average length of admission by ethnicity – quarterly.	Q1-Q4	Māori Health Gain Team, ADHB Mental Health Provider Team
3.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

11 Workforce

What are we trying to do?

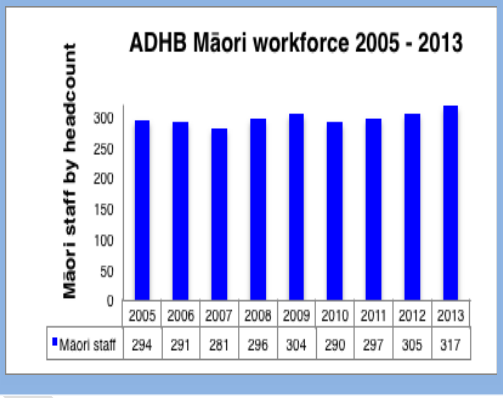
Increase the number, and improve the skills, of the Māori health and disability workforce by at least 10% everywhere by 2020.

Where do we want to get to?

- Māori workforce numbers increase by 10% everywhere by 2020

DHB/PHO	Māori	Target
ADHB	317	≥ 348

Trends



To achieve this we will focus on:

Increasing the number of Māori university graduates with qualifications in health (or particular clinical qualifications) and ensuring those graduates are employed. This will be achieved by continuing to support the Rangatahi Programme, and ensuring that Māori graduates are recruited into suitable roles. This will also entail focusing on the workforce pipeline, and developing relationships with secondary schools in the ADHB catchment area, which will ensure there is an increased flow of Māori entering university who are interested in a career in health and suitably qualified to undertake tertiary level training in a health course. Improvements in the way in which workforce ethnicity data is collected will be made to ensure workforce participation can be measured.

Why is this a priority?

Increasing Māori health workforce participation rates is fundamental to improving the quality and effectiveness of care. There is evidence that a 'pipeline' or student driven approach to workforce development and implementing evidenced-based interventions to overcome barriers to workforce participation will enhance graduate success. Barriers need to be reduced and innovative ways established to make it easier for more Māori to walk through the door and into employment in the health and disability sector.

	What are we going to do?	Timing	Responsibility
1.	Work with senior ADHB leaders to identify clinical positions that should be earmarked as 'Māori specific positions'.	Q4	Director of Human Resources
2.	Review current ADHB HR policies and procedures as they relate to recruitment and retention for Māori (new graduates, current employees, new employees).	Q4	Māori Health Gain Team
3.	Align the Kia Ora Hauora programme to the Rangatahi Programme by developing Health Science Academies targeting Year 9 & 10 students in schools.	Q4	Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
4.	Ensure workforce data is captured in a standardised data set in accordance with ANZSCO job classification system and Ethnicity Data Collection Protocols for workforce monitoring and reporting purposes.	Q4	Director of Human Resources
5.	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Māori Health Gain Team

12 Obesity

What are we trying to do?

Reduce the prevalence of obesity in Māori populations.

To achieve this we will focus on:

Population and individual strategies are required to address obesity, and we are participating in activities that address both elements. We are leading and contributing to the inter-sectorial work through Healthy Auckland Together on the development of an agreed regional obesity approach, and the Healthy Babies Healthy Futures Project. Alongside this longer term development work we will also focus on bariatric surgical services to identify and remedy barriers to Māori being accepted onto the bariatric surgery waiting list.

Why is this a priority?

Māori have higher rates of obesity than the non-Māori non-Pacific population. Excess weight is a leading contributor to a number of health conditions, including diabetes, cardiovascular diseases, some types of cancer (eg, kidney and uterus), osteoarthritis, gout, sleep apnoea, some reproductive disorders and gallstones. Bariatric surgery is an effective method of reducing and maintaining weight loss for individuals.

	What are we going to do?	Timing	Responsibility
1.	Work with the bariatric service, including surgeons, to identify and remedy barriers within the triage service which hinder acceptance of Māori and Pacific people onto the bariatric surgery waiting list – by September 2015.	Q1	Hospital Services
2.	Collate bariatric surgery figures for 2014/15 by ethnicity to assess procedure rates for Māori and Pacific patients and set baseline for 2015/16 – by July 2015.	Q1	Hospital Services
3.	Continue to support the implementation of the Healthy Babies Healthy Futures project: • Provide women with key breastfeeding messages through text messaging, community promotion, and support groups – on-going • Continue to work with our Auckland and Waitemata Collective partners to target specific ethnic groups (Māori, Pacific, Asian, Chinese, Korean and Japanese) – on-going	Q1-Q4	Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
	• Evaluate the project by June 2016.		
4.	Develop a business case for a Māori focused settings based healthy lifestyles programme.	Q4	Māori Health Gain Team
5.	Support and participate in the Healthy Auckland Together inter-sectorial group to progress regional actions to improve physical activity and nutrition – on-going.	Q1-Q4	Planning and Funding Outcomes Team
6.	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Māori Health Gain Team

13 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:

The Auckland and Waitemata DHBs have entered into an Alliance agreement with the PHOs across both districts and the two Memorandum of Understanding partners. Diabetes and cardiovascular disease have been identified by the Alliance Leadership Team as the priority areas in the Alliance Work Plan. Cardiovascular disease management includes both secondary prevention (risk factor management) and tertiary prevention (reducing the mortality and morbidity from disease). The hospital level tertiary prevention work includes a range of activities which broadly come under Section 5 and are not detailed further here. This section focuses on primary care secondary prevention activity. We have extended our focus from risk assessment (Section 4) to ensuring that eligible Māori have appropriate management of any cardiovascular risk factors identified, including diabetes.

Why is this a priority?

Cardiovascular disease remains the most significant cause of death for Māori men, and an important cause for Māori women. Māori have higher prevalence of risk factors associated with cardiovascular disease.

	What are we going to do?	Timing	Responsibility
1.	Monitor and report on key indicators (by ethnicity) for the management of diabetes and CVD as prioritised by the District Alliance at the PHO level by December 2015 and at the practice level by June 2016.	Q4	Primary Care Team
2.	Provide access to diabetes self-management workshops with particular focus on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016.	Q4	Primary Care Team
3.	Explore ways to improve participation in these workshops, particularly high needs populations, and develop a set of recommendations by June 2016.	Q4	Primary Care Team
4.	General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals with CVD risk >15% and put in place appropriate management plans – on-going.	Q1-Q4	Primary Care Team
5.	Monitor and report on key indicators (by		Primary Care Team

	What are we going to do?	Timing	Responsibility
	ethnicity) for the management of diabetes and CVD as prioritised by the District Alliance at the PHO level by December 2015 and at the practice level by June 2016		
6.	Quarterly reporting of performance and progress on activities to Manawa Ora.	Q1-Q4	Māori Health Gain Team

14 Glossary

Kawanatanga	Governance
Mana whenua	People who have authority over the land
Mihimihi	Acknowledgement
Ngā kaupapa tuku iho	Respect for distinctly Māori values, beliefs, responsibilities, protocols, and knowledge.
Oritetanga	equity
Te Tiriti o Waitangi	Treaty of Waitangi
Te Ritenga	Right to beliefs and values
Tino Rangatiratanga	Self-determination
Whānau ora	Intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing