2016/17
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 a Memorandum of Understanding (MoU) with Te Rūnanga o Ngāti Whātua. Te Rūnanga o Ngāti Whātua have strong links with Māori communities across Auckland City and represents the aspirations of these communities. Te Rūnanga o Ngāti Whātua 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. We are also committed to working in prioritsed locations to support solutions that are reflective of the communities needs and desires. Activities throughout this plan support this approach.

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 2016/17 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. Further 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. The four Articles of Te Tiriti o Waitangi provide a framework for Māori development, health and wellbeing by guaranteeing Māori a leading role in health sector decision making in a national, regional, and whānau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Māori health advancement by requiring DHBs to establish and maintain a responsiveness to Māori while developing, planning, managing and investing in services that do and could have a beneficial impact on Māori communicates.

Te Tiriti o Waitangi provides 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

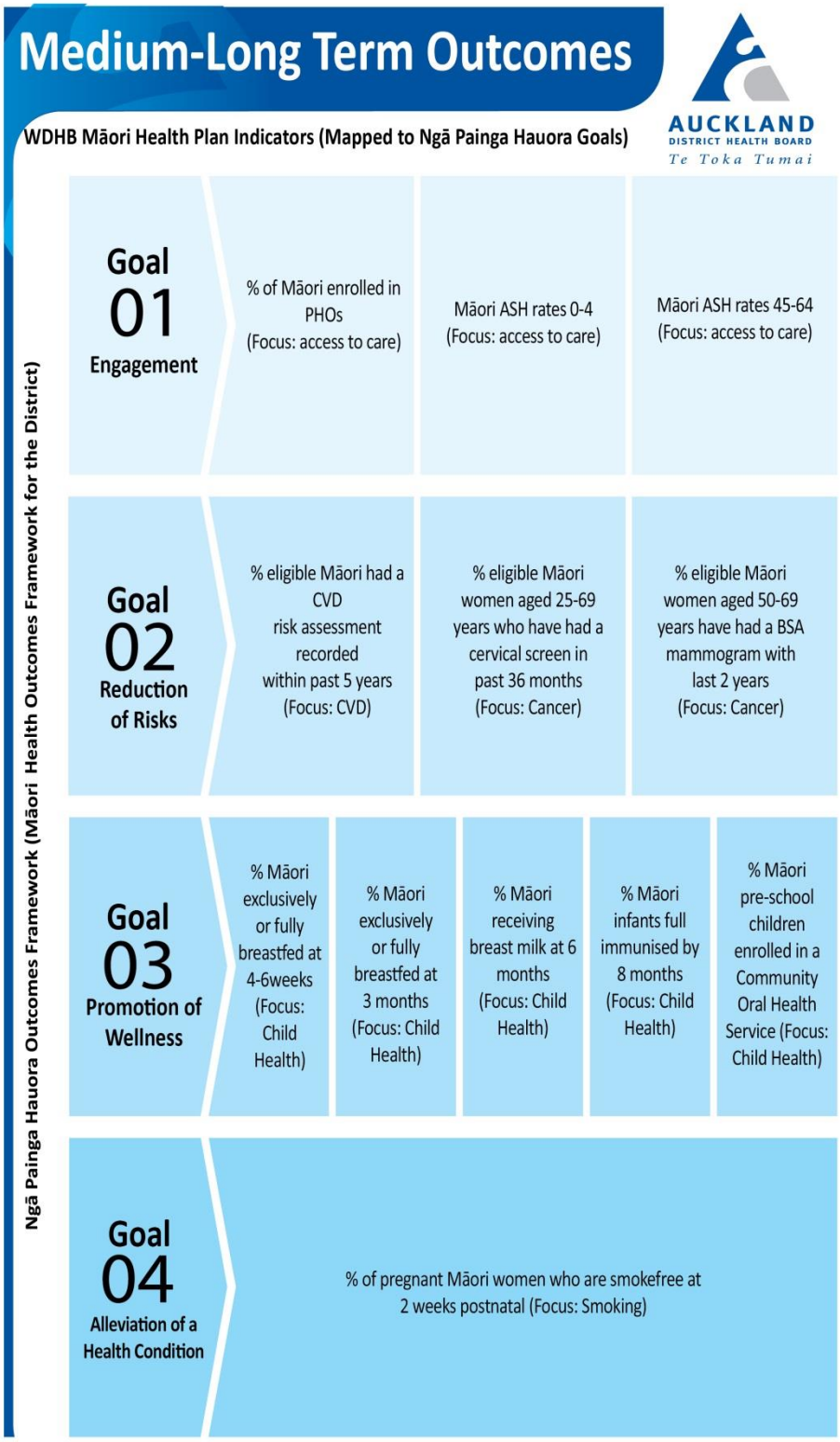
The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgement, drawing on a Māori development perspective and social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

Improving Māori health outcomes

Auckland DHB is committed to achieving demonstrable health gains and reducing inequities for Māori within our region. To this end, we are moving away from an outputs or process measure focus towards measuring the health outcomes that make timely and sustainable difference to our whānau.

Ngā Painga Hauora: Māori Health Outcomes Framework (Figure 1.0) developed in partnership between ADHB/WDHB and local Māori health providers, and led by Professor Sir Mason Durie, outlines the outcomes we are aiming for and how we measure our progress towards them. Our outcomes framework (below) aligns the high level outcomes of Waitemata DHB and aims of He Korowai Oranga – the Ministry of Health Māori Health Strategy to achieve Pae Ora (and the related domains of Mauri Ora, Whanau Ora and Wai Ora). The Framework gives four health outcome goals Engagement, Alleviation of a health condition, Reduction of Risks and Promotion of Wellness which will direct assessment of provider effectiveness and measurement of population health gain.

Figure 1.0 Ngā Painga Hauora: Māori Health Outcomes Framework



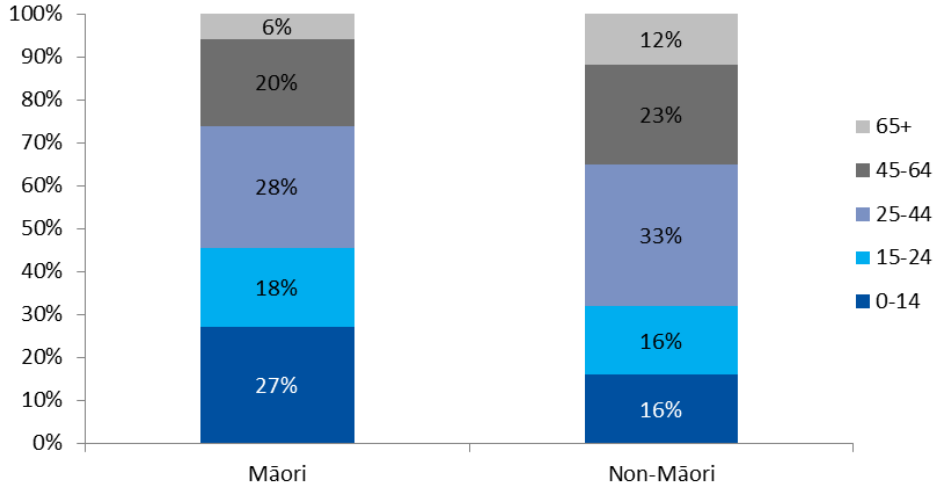
Auckland population

Profile and Health Needs

1. Population

- Auckland DHB's population is estimated to be 510,450 in 2016/17. 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 (41,700 people) compared with 15.8% 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 45% under 25 years (18,900 young people), compared with 30% of non-Māori. Conversely, 6.1% of Māori are aged 65 years or over (2,500 people) compared with 11.5% of non-Māori.

Percent of Auckland DHB population in each age group, Māori and non-Māori, 2016/17

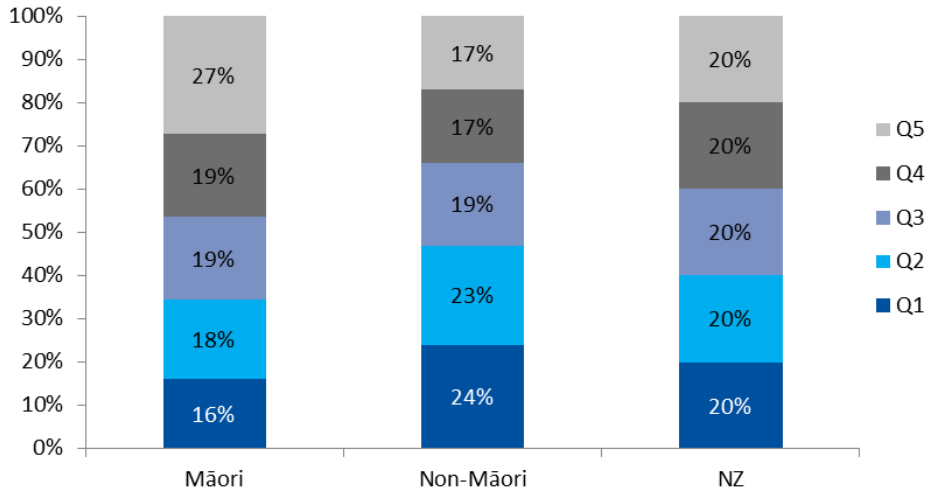


- Over the next 20 years, the Māori population in Auckland DHB is expected to increase by 43%, compared with a projected national increase of 40.8%. The non-Māori population is expected to increase by 30% (National increase 12.6%)

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 (Q4 and Q5), 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



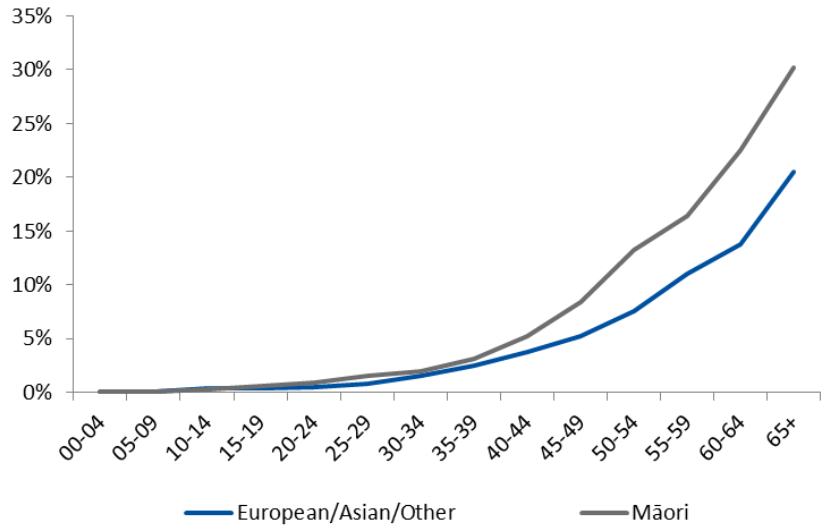
[1]Q1 least deprived quintile - Q5 most deprived quintile

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 in Auckland DHB have lower rates of obesity compared with Māori nationally. However, these rates are considerably higher than for non-Māori. Obesity in Māori child is similar in ADHB to that of Māori children nationally. Regular physical activity is reported by similar proportion of Māori in Auckland DHB and nationally and by non-Māori in Auckland DHB. A similar proportion of Māori both in Auckland DHB and in New Zealand are medicated for high blood pressure or high cholesterol. This is despite the reportedly higher rates of high blood pressure and high cholesterol in the Māori population.

The prevalence of diabetes among Māori in Auckland is higher in every age group than the rate for European/Asian/Other people. The overall prevalence is similar in Māori (5.0%) compared with European/Asian/Other people (excluding pacific) (5.2%). Because the prevalence of diabetes increases with age, and there are relatively fewer Māori aged 65 years and over, the similarity in the overall prevalence is driven by a much higher prevalence in younger Māori.

Diabetes prevalence by age band in Auckland DHB, 2013



Note: Source is VDR 2013, European/Asian/Other excludes Pacific.

Table 1: Modifiable Risk Factors

Indicator	Prevalence Māori ADHB	Prevalence Māori NZ	Prevalence Total Population ADHB
Current smoking	26%	32%	11%
Regular physical activity	53%	52%	47%
Obese adults	39%	46%	22%
Obese children	18%	17%	10%
Medicated high blood pressure	11%	14%	11%
Medicated high blood cholesterol	8%	9%	9%

Sources: Smoking: 2013 census, Crude Prevalence; remainder: NZHS 2011/14, crude prevalence

4. Leading Causes of Avoidable Mortality

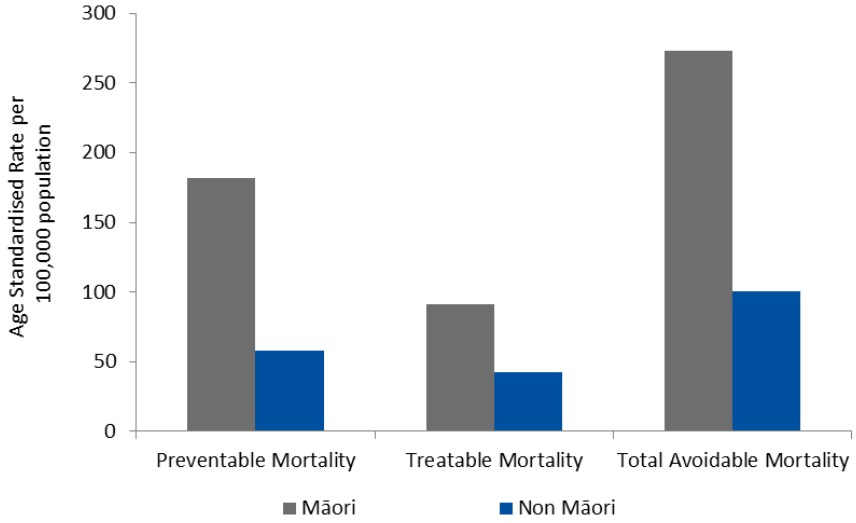
Life expectancy for Māori in Auckland DHB is 76.6 years (2014), 7 years shorter than for other ethnicities (excluding pacific). Over 3 years of this gap can be attributed to mortality at a younger age from CVD (1.6 years) and Cancer (1.7 years). A further 1.2 year of the gap can be attributed to death through external causes, such as injuries as a result of accidents, violence and self-harm. The age-standardised rate of avoidable mortality from all causes for Māori in Auckland DHB is 273 per 100,000 population aged 0-74, compared with 101 per 100,000 population aged 0-74 for the European/Other population. The rate of avoidable mortality has declined in the Auckland Māori population from a rate of 292 per 100,000 population aged 0-74 between 2002 and 2004.

Another way to look at the burden of avoidable mortality is to assess the potential years of life lost (deaths before the aged of 75) from potentially avoidable causes. For Māori in

Auckland, between 2010 and 2012, 5,840 years of life were lost from premature deaths from potentially avoidable causes. This equates to a rate of 5,431 per 100,000 population, which is over twice that of non-Māori (2182 per 100,000 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. Preventable deaths includes deaths from conditions linked to modifiable risk factors, such smoking and deaths linked to effective public health interventions for example immunisations and injuries.

Age-standardised rates of potentially avoidable mortality in Auckland DHB Māori compared with non-Māori (2010-2012)



The leading causes of avoidable mortality for Māori men in Auckland DHB between 2010 and 2012 were injuries, avoidable cancers and diseases of the circulatory system. For Māori women in Auckland DHB, the leading causes of avoidable mortality were avoidable cancers, diseases of the respiratory system) and injuries.

Table 2: Leading five causes of mortality by gender for those aged 0-74 years, 2010-2012

	Males		Females	
	ADHB	**NZ**	**ADHB**	**NZ**
Māori	Injuries	Injuries	Lung cancer	Lung cancer
	Ischaemic heart disease	Ischaemic heart disease	Injuries	Ischaemic heart disease
	Lung cancer	Lung cancer	COPD	Injuries
	COPD	Diabetes	Ischaemic heart disease	Breast cancer

	Males		Females	
	Other Heart Diseases	Other heart diseases	Stroke	COPD
Non-Māori	Ischaemic heart disease	Ischaemic heart disease	Breast Cancer	Breast cancer
	Injuries	Injuries	Lung cancer	Lung cancer
	Lung cancer	Lung cancer	Injuries	Injuries
	Diabetes	Colorectal cancer	Colorectal cancer	Ischaemic heart disease
	Stroke	Stroke	Ischaemic heart disease	Colorectal cancer

5. Health Service Providers

Key health service providers in ADHB include:

- Two public hospitals; Auckland City (including Starship Children's Hospital) and Greenlane Clinical Centre.
- Four PHOs (which had enrolled 79% of the eligible Māori population and 92% of the non-Māori in October 2015)
- 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 79.4 years, four years above the national average for New Zealand Māori (75.4 years in 2013). Life expectancy for Māori has increased 4.2 years over the past decade.
- Smoking prevalence has declined by 11% for Māori between the 2006 and 2013 censuses to 26%.
- Over 95% of Māori people in hospital are being offered smoking cessation advice (December 2015).
- 94% of Māori attending ED are admitted or discharged within the 6 hour health target (December 2015).
- Māori enrolment in PHOs is 81%.
- Heart and diabetes checks for Māori have increased from 58% to 85% between December 2012 and December 2015.
- 85% of Māori are fully immunised by 8 months of age (December 2015).
- At the two year old milestone, 96% of Māori infants are fully immunised.
- Cervical screening rates have improved from 53% to 59% since June 2012.
- Auckland DHB and Waitemata DHB were the first DHBs to complete the Ethnicity Data Audit Tool in more than 95% of General Practices. The findings from the project contributed to the Ministry of Health refreshing the ethnicity data protocols.
- Conducted local analysis of the life expectancy gap between Māori and non-Māori. The findings from this work have informed activities in the Māori Health Plan.
- Active participants in the Cervical Screening Data-Match Working Group which led to the first successful national data-match.

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 PHO[2]s.	95%	81%	100%
2.1		Ambulatory sensitive hospitalisation rates per 100,000 for age groups[3]: • 0-4 years • 45-64 years	 8265 3199	 8797 6197	 <7793 <4879
3.	**Child Health**	Exclusively or fully breastfed at LMC discharge (4-6 weeks)[4] Exclusively or fully breastfed at 3 months[5] Receiving breast milk at 6 months[6]	70% 60% 75%	67% 54% 62%	75% 60% 65%
4.	**Cancer[7]**	Percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25–69 years who have had a cervical screening event in the past 36 months.	78%	59%	80%
4.1		70 percent of eligible women, aged 50 to 69 will have a BSA mammogram every two years.	65%	60%	70%
5.	**Smoking**	Percentage of pregnant Māori women who are smokefree at two weeks postnatal[8].	96%	78%	95%
6.	**Immunisation**	Percentage of infants fully immunised by eight months of age.	95%	85%	95%
6.1		Seasonal influenza immunisation rates in the eligible population 65 years and over.	65%	63%	75%

[1] Baseline data Q2 2015/16, unless otherwise stated
[2] Baseline data Q3 2015/16
[3] Baseline data 2014/15
[4] WCTO September 2015 baseline data
[5] Baseline data January – June 2015 WCTO
[6] Ibid
[7] Baseline data Q3 2015/16
[8] Baseline data Q4 2014/15

	National Health Priority Area	Indicators	Baseline Data Non-Māori[1]	Baseline Data Māori[1]	Target
7.	**Rheumatic Fever**	Number and rate of first episode rheumatic fever hospitalisations for the total population (total population rate per 100,000).	3.2		1.1
8.	**Oral Health**	Percentage of pre-school children enrolled in the community oral health service[9].	66%	48%	95%
9.	**Mental Health**	Reduce the rate of Māori on the Mental Health Act: section 29 community treatment orders relative to other ethnicities.	132	456	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 2016/2017 the local priorities have been identified in agreement with our MOU partners, Te Rūnanga o Ngāti Whātua.

[9] Baseline data December 2015

1 Data quality

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 the Ethnicity Data Audit Tool (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 is has implemented EDAT in 98% 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 trying to do?

Improve the quality of ethnicity data collected at primary care.

To achieve this we will focus on:

Providing training for frontline administrative staff to improve ethnicity data collection and supporting low performing practices to improve their ethnicity data collection.

	What are we going to do?	Timing	Responsibility
1.	Develop and implement a primary care training tool for PHOs targeted at frontline administrative staff in practices to improve ethnicity data collection.	Q3-Q4	Māori Health Gain Team
2.	Provide direct support to 22 practices identified with poor quality ethnicity data to undertake quality improvement processes as directed by the EDAT.	Q4	Māori Health Gain Team
3.	Contribute to the Ministry of Health Working Group to refresh the ethnicity data protocols.	Q4	Māori Health Gain Team
4.	Through education and awareness raising with all PHOs support the implementation of the Ministry of Health ethnicity data protocols.	Q4	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

2 Access to health care – enrolment

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.

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:

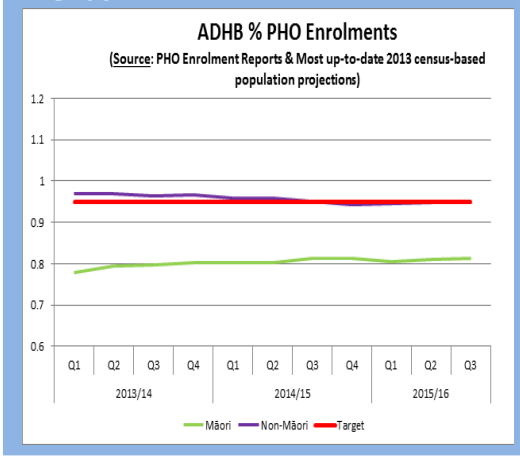
Identifying Māori who are not enrolled with a General Practitioner and offering support to enrol and implementing a project to enrol newborn Māori with a General Practitioner and other vital services.

Where do we want to get to?

- 100% Māori enrolment in PHOs

DHB/PHO	Non-Māori	Māori	Target
ADHB	95%	81%	100%

Trends



	What are we going to do?	Timing	Responsibility
1.	80 percent of all new-borns are enrolled with a GP, in NIR, WCTO, Community Oral Health and hearing screening in the first 3 months by Q4 as part of the Single Enrolment Project.		Women's, Children and Youth Team
2.	As determined in a 2014-15 audit of pregnant women there is significant under-enrolment for Māori women. Develop processes with Maternity Services at facilities booking to identify women without a GP. Work with He Kamaka Waiora to facilitate enrolment with a GP. Evaluate effectiveness of intervention and present recommendations report by June 30 2017.	Q4	Māori Health Gain Team
3.	Develop a monthly reporting template for He Kamaka Waiora staff to support timely identification and active follow up of Māori ASH patients with no GP identified at admission. Evaluate effectiveness of intervention and present recommendations report by June 30 2017.	Q4	Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
4.	Complete datamatch between Māori Providers and PHO enrolment in order to identify opportunities for service development and/or offer of service (eg PHO enrolment, screening, CVDRA, imms etc). Present findings quarterly at the Māori Provider Forum.	Q4	Māori Health Gain Team
5.	Improve ethnic specific measurement of PHO enrolment by supporting the implementation of the Ministry of Health refreshed ethnicity protocols.	Q4	Māori Health Gain 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

2.1 Access to health care – ambulatory sensitive hospitalisation

Why is this priority?

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting. By reducing risk factors and taking appropriate early intervention, many conditions can be prevented or managed without the need for hospital level care. Keeping people well and out of hospital is a key priority; not only is it better for our population, but it frees up hospital resources for people who need more complex and urgent care.

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.

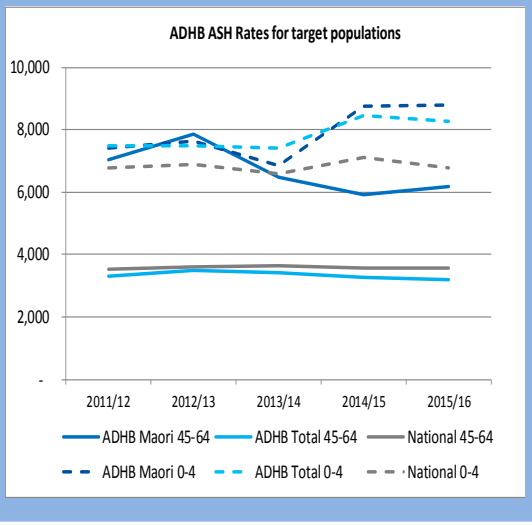
To achieve this we will focus on:

Continuing to provide a variety of activities to improve pathways for high priority ASH conditions for 0-4 years and 45-64 years.

Where do we want to get to?

- 50% reduction in the equity gap between Māori and non-Māori

DHB/PHO	Total population	Māori	Target
ASH rates 0-4 years			
ADHB	8265	8797	<7793
ASH rates 45-64 years			
ADHB	3199	6197	<4879



	What are we going to do?	Timing	Responsibility
1.	80 percent of all new-borns are enrolled with a GP, in NIR, WCTO, Community Oral Health and hearing screening in the first 3 months by Q4 as part of the Single Enrolment Project.	Q4	Women's, Children and Youth Team
2.	Complete audit of asthma action plan use in primary care and secondary care by December 2016.	Q2	Māori Health Gain Team
3.	Implement intervention(s) based on the findings of the audit by June 2017	Q4	Māori Health Gain Team
4.	Complete an audit of hospital data to identify reasons behind why urinary tract infections are so high in the ADHB Māori population.	Q4	Māori Health Gain Team
5.	Present request for pathway development for acute conditions in the top 5 causes of	Q4	Māori Health Gain Team

	What are we going to do?	Timing	Responsibility
	ASH admissions to Pathway Team by June 30 2017.		
6.	Reach target of 90% for Māori CVD risk assessment by December 2016. Monitor progress through routinely collected ethnic specific quarterly data.	Q2	Primary Care Team, PHOs
7.	Implement the recommendations of the Primary Options for Acute Care (POAC) and access to diagnostics review by March 2017.	Q3	Primary Care Team, PHOs
8.	Work with PHOs and POAC providers to increase the services across Auckland and expand services to support increased access to diagnostics and interventions locally.	Q4	Primary Care Team, PHOs
9.	Develop and pilot a mechanism to monitor if Māori children who are receiving asthma support services are presenting to ED as ASH admissions by December 2016. Evaluate effectiveness of pilot and present recommendations report by June 30 2017.	Q4	Māori Health Gain Team
10.	Implementation of activities from the Cardiovascular Disease (section 12) and Smoking (section 5) sections of the Māori Health Plan.	Q4	Māori Health Gain Team, Primary Care 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

3 Child health

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.

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	70%	67%	75%
3 month			
ADHB	60%	54%	60%
6 month			
ADHB	75%	62%	65%

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:

We will work with the pregnancy and parenting education providers to develop key messages and delivery mechanisms relevant for breastfeeding that are appropriate for Māori women. We will also work to support improved access to the Healthy Babies Healthy Futures (HBHF) programme for Māori mothers.

	What are we going to do?	Timing	Responsibility
1.	Provide culturally appropriate breastfeeding support to women and their families via increased resourcing of information via the Pregnancy and Parenting App and Website by June 2017.	Q4	Women's, Children and Youth Team
2.	Based on the high numbers of Māori mothers attending the HBHF programme delivered in partnership with kōhanga reo, deliver a maximum of 5 additional HBHF programmes with kōhanga reo across Auckland and Waitemata DHBs by 30 June 2017.	Q4	Pacific Health Team
3.	Based on learnings from a review of the HBHF programme, develop and implement a brief to support LMCs to introduce mothers to the HBHF Programme Coordinators to offer the Programme to eligible mothers.	Q4	Pacific Health Team
4.	Disseminate Mama Aroha Talk Cards resource targeted at mothers to support	Q1-Q4	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	them to breastfeed their babies by 30th June 2017.		
5.	Maintain Baby Friendly Hospital Initiative (BFHI) across maternity facilities.	Q1-Q4	BFHI Coordinator
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 Cancer screening – cervical

Why is this a priority?

Māori women continue to have significantly higher burden of disease and persistent and unacceptable lower participation in the cervical screening programme. We intend for the HPV self-sampling project to provide policy relevant evidence as the National Cervical Screening Programme transitions to a HPV primary screening programme.

What are we trying to do?

Reduce Māori cervical cancer morbidity and mortality.

To achieve this we will focus on:

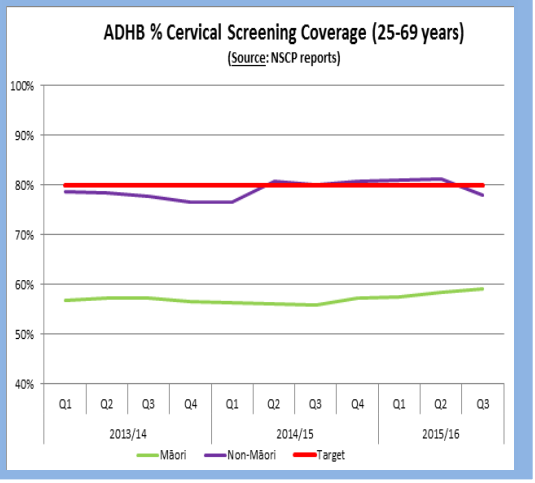
Implementing the Māori specific human papilloma virus (HPV) self-sampling feasibility project in West Auckland with our MoU partner, Women's Health and Primary Care colleagues. In addition we will continue our ongoing programme of work to improve cervical screening coverage rates for Māori women through improvements to the primary care datamatching process, implementation of the health literacy focussed non-clinical invitation and recall support package and smeartaker nurse specialist support for targeted general practices.

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	78%	59%	80%

Trends



	What are we going to do?	Timing	Responsibility
1.	Implement the health literacy focussed non-clinical support for invitation and recall package	Q4	Cervical Screening Coordination Service
2.	Implement the Māori specific HPV Self-Sampling Feasibility Project.	Q4	Women's, Children and Youth Team
3.	Deliver equity focussed systems support to selected general practices (based on the 'How To Guide' best practice and including support for utilisation of the datamatched lists).	Q1-Q4	Women's, Children and Youth Team
4.	Identify women who have not been screened or are under screened through datamatch lists with PHOs and general practices.	Q1-Q4	Women's, Children and Youth Team
5.	Support and promote PHO and general practice use and ongoing refinement of the datamatch lists, through the	Q1-Q4	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	ProCare Datamatch Pilot Working Group. This includes regional coordinator support for PHOs and practices on how to use the lists and how to prioritise invitation and recall activities for Māori women.		
6.	Ongoing promotion of overdue alert flags in primary care to support opportunistic screening (offer of screening at every healthcare contact opportunity).	Q1-Q4	Women's, Children and Youth Team
7.	Conduct a clinical audit and quality improvement cycle on the use of cervical screening exemption coding in primary care with a focus on Māori.	Q2	Women's, Children and Youth Team
8.	Conduct and support PHOs and General Practice to provide locality based 'pop up' clinics.	Q4	Women's, Children and Youth Team
9.	Support local promotion activity via the NSU Facebook page.	Q1-Q4	Women's, Children and Youth Team
10.	Determine quality improvement activities with the Women's Health Service based on the colposcopy patient experience survey and analysis of timeliness of colposcopy for Māori women.		Māori Health Gain Team
11.	Support collaborative working relationships between providers across the cervical screening pathway through the Metro Auckland Cervical Screening Governance Group and Operations Groups as well as the regional coordination function.	Q1-Q4	Women's, Children and Youth Team
12.	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 Cancer screening – breast

Why is this a priority?[10]

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.

What are we trying to do?

Reduce Māori breast cancer morbidity and mortality.

To achieve this we will focus on:

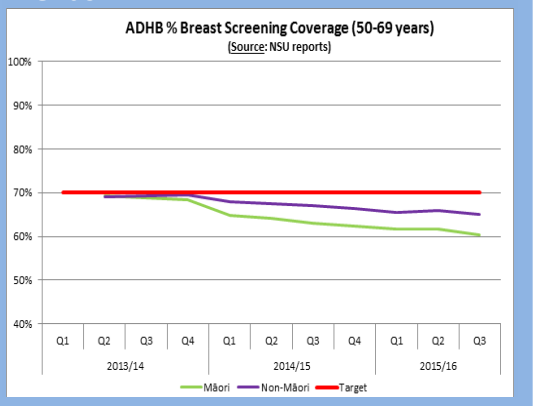
Improving breast screening coverage rates for Māori women and reducing ethnic disparities in screening rates. The focus will be on datamatching and working with primary care to identify Māori women for invitation and recall. With our focus on outcomes and patient experience we will also examine the disparities in uptake of breast cancer radiotherapy for Māori women.

Where do we want to get to?

- 70% breast screening coverage of eligible Māori women

DHB/PHO	Non-Māori	Māori	Target
ADHB	65%	60%	70%

Trends



	What are we going to do?	Timing	Responsibility
1.	Work with PHOs and Breast Screening Independent Service Providers to develop and implement a best practice datamatching process to identify, invite and recall Māori women. Measure the % of practices following best practice process.	Q2	Women's, Children and Youth Team, Alliance Health + PHO, Auckland PHO, ProCare PHO, BSAL
2.	Work collaboratively with Breast Screening Independent Service Providers and PHOs to analyse the contactability and screening outcomes from the previous datamatch activity, to inform the development of a best practice model.	Q1	Women's, Children and Youth Team, Alliance Health + PHO, Auckland PHO, ProCare PHO, BSAL
3.	Work with the Breast Screening Independent Service Providers to coordinate attendance at promotional events and support to service provision for women identified on monthly lists.	Q1-Q4	BSAL

[10] Baseline data is Q3 (1 Jan -31 Mar 2016)

	What are we going to do?	Timing	Responsibility
4.	Liaise with 2 workplaces to provide screening onsite. Evaluate the impact of workplace screening by 30 June 2017.	Q1-Q4	BSAL
5.	Support collaborative working relationships with all key stakeholders across the screening pathway to improve coverage. This is achieved by attendance at 6 monthly lead provider regional meetings with ISPs and primary care.	Q1-Q4	Women's, Children and Youth Team, Māori Health Gain Team
6.	Promote location of mobile van for the calendar year and link with community groups to identify eligible Māori women in the communities close to the mobile units. Promotion will be through ISP providers, Metro – Auckland Operations group, other community events focussing on Women's wellness. Social media possibilities will be explored.	Q1-Q4	Women's, Children and Youth Team
7.	Run a minimum of 6 Coordinated co-promotion breast and cervical screening events. For example at the cervical screening pop up clinics, the mobile breast screening services, well women church events, Matariki GP campaign.	Q1-Q4	Women's, Children and Youth Team
8.	Implement a qualitative research project to investigate the reasons and barriers to breast cancer radiotherapy for Māori women.	Q2	Women's, Children and Youth 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 Smoking

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.

Where do we want to get to?

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

DHB/PHO	Total	Māori	Target
ADHB	96%	78%	95%

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.

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.

	What are we going to do?	Timing	Responsibility
1.	Plan for implementing the new System Level Measure of 'number of PHO-enrolled babies who live in a smokefree household at the 6-week vaccination' by June 2017.	Q4	Primary Care Team
2.	Implement initiatives to increase the number of smokers that make supported quit attempts, particularly for Māori and Māori pregnant women – June 2017	Q4	Primary Care Team
3.	Set a hospital's target for the percentage of smokers that make a supported quit attempt (prescribed NRT and/or accept a referral to a Stop Smoking Service) – October 2016.	Q2	Primary Care Team
4.	Build relationships and referral pathways with the new Stop Smoking Services that the MOH contracts with in the Auckland and Waitemata DHB areas – December 2016	Q2	Primary Care Team
5.	Implement a pilot programme of youth initiated smoking prevention strategies with lessons learnt from work undertaken	Q2	Primary Care Team

	What are we going to do?	Timing	Responsibility
	with schools in 2015-16 – December 2016.		
6.	Develop a proposal for a Māori specific lung cancer screening research project by June 2017.	Q4	Māori Health Gain Team
7.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

6 Immunisation – infants

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.

What are we trying to do?

Improve child health by improving immunisation coverage.

To achieve this we will focus on:

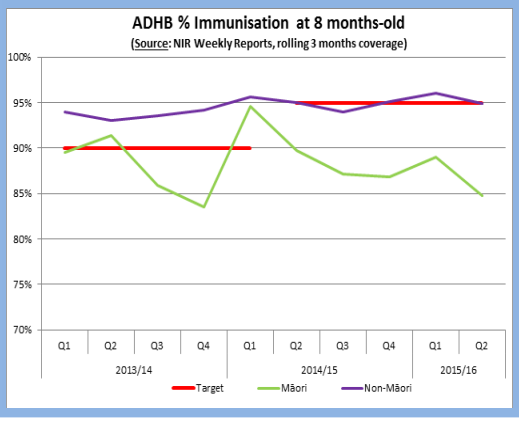
Increasing the percentage of Māori babies who are immunised on time, as measured at 8 months of age.

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	95%	85%	95%

Trends



	What are we going to do?	Timing	Responsibility
1.	Monitoring Immunisation coverage rates weekly with a focus on achieving equity for Māori babies -ongoing	Q1-Q4	Women's, Children and Youth Team
2.	With Ngāti Whātua, WCTO, PHOs, oral health and DHB partners, establish a Māori Immunisation Reference Group to share information and agree actions to support Māori whānau and babies who have overdue immunisations by June 2017	Q4	Women's, Children and Youth Team
3.	Collaborate with the Immunisation Governance Group members to utilise outcomes from the audit 'From Hospital to General Practice', to further align processes across tertiary, secondary and primary care providers regarding follow-up of children not fully immunised and those eligible for special immunisations by March 2017	Q3	Women's, Children and Youth Team
4.	Maintain the effectiveness and engagement of key stakeholders in the Joint Auckland DHB/Waitemata DHB Immunisation Steering and Operations Groups and Auckland Metro School Based	Q1-Q4	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	Immunisation Working Group – ongoing		
5.	Work with PHOs and NIR/OIS on the Shared Approached Plan to develop a pathway for early enrolment and B-code enrolment of all newborns with general practices by July 2017	Q4	Women's, Children and Youth Team
6.	Provide joint DHB/PHO education workshops for primary and secondary care providers, and school based nurses, addressing vaccine hesitancy and best practice by June 2017	Q4	Women's, Children and Youth Team
7.	Facilitate education workshops for secondary care providers to enable opportunistic immunisation in ADHB facilities including renal, ED and maternity services by June 2017	Q4	Women's, Children and Youth Team
8.	Provide two funded Midwives Immunisation Education sessions to provide an annual update re the Antenatal Immunisation programme	Q4	Women's, Children and Youth Team
9.	Work with ARPHS to develop a plan to promote Immunisation Week 2017 by February 2017.	Q3	Women's, Children and Youth Team
10.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

6.1 Immunisation – 65 +

Why is this a priority?

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

What are we trying to do?

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

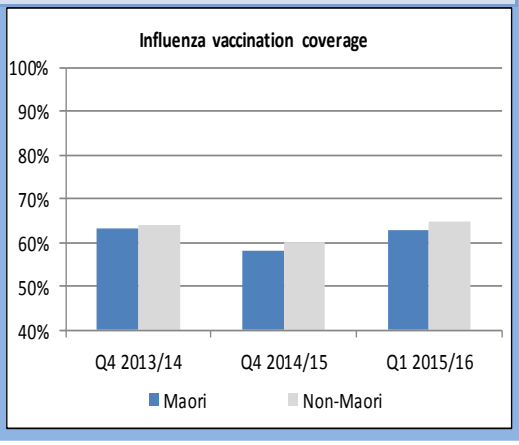
To achieve this we will focus on:

Identifying eligible Māori who have not received an influenza vaccination and offer a vaccination in a primary care or hospital settings.

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	65%	63%	75%



	What are we going to do?	Timing	Responsibility
1.	Implement a flu vaccination pilot targeted at eligible Māori to improve access to seasonal influenza vaccine with one PHO.	Q3	Māori Health Gain Team
2.	Continue to promote influenza vaccinations to eligible Māori in hospital.	Q3	Māori Health Gain Team
3.	Develop a follow-up mechanism for eligible Māori who have been advised to get an influenza vaccination to see if they have received a vaccination by March 2017.	Q3	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

7 Rheumatic fever

Why is this a priority?

New Zealand has some of the highest rates of rheumatic fever of any developed country, particularly amongst Māori and Pacific children. It is widely believed that this over representation is due to a combination of overcrowded living conditions, poverty and decreased access to treatment options. Rheumatic fever is almost entirely preventable with timely identification and treatment.

What are we trying to do?

Achieve a reduction in incidence of acute rheumatic fever.

To achieve this we will focus on:

Implementing the Rheumatic Fever Prevention 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. A copy of the the Rheumatic Fever Prevention Programme Plan can be found here.

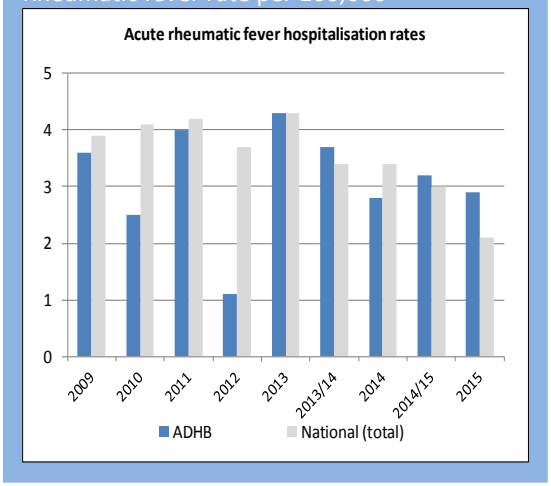
Where do we want to get to?

- 2/3 reduction below 3-year average rate 2009/10–2011/12

DHB/PHO	Total population	Target
ADHB	3.2	1.1

Trends

Rheumatic fever rate per 100,000



	What are we going to do?	Timing	Responsibility
1.	Engage PHOs to provide increased access to clinical leadership for their specific rapid response clinics - ongoing	Q1-Q4	Women's, Children and Youth Team
2.	Promote rapid response clinics through localised community consultation events.	Q1-Q4	Women's, Children and Youth Team
3.	Develop a Rheumatic Fever promotional campaign that utilises existing resources, to specifically engage Māori and Pasifika communities across Auckland DHB and Waitemata DHB by June 2017.	Q4	Women's, Children and Youth Team
4.	Support PHOs to lead targeted activity to increase health literacy and access to sore throat clinics by June 2017.	Q4	Women's, Children and Youth Team
5.	Hold the school based 'HYPE' event 2016 - a youth health priority event to promote RhF prevention and support youth RhF advocates, by September 2016.	Q1	Women's, Children and Youth Team
6.	Collaborate with Plunket/ Tamariki Ora	Q2	Women's, Children and

	What are we going to do?	Timing	Responsibility
	Well Child Providers to introduce RhF health messages within the B4School Checks by December 2016.		Youth Team
7.	Monitor and increase the effectiveness of the Rapid Response Clinics in general practice and in pharmacy through the Rheumatic Fever Programme Clinical & Operations Group.	Q1-Q4	Women's, Children and Youth Team
8.	Complete analysis and report on the cross-sectional survey of West Auckland caregivers and children at high risk of RhF by December 2016.	Q4	Women's, Children and Youth Team, Māori Health Gain 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

8 Oral health

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 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:

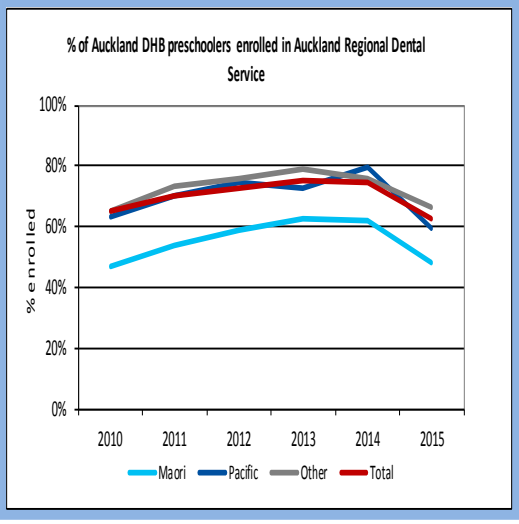
Implementing the Auckland Regional Dental Services (ARDS) Preschool Strategy to improve enrolment and utilisation of preschool Māori children. We will also implement a project to enrol newborn Māori with community oral health services and other vital services and implement a case review group to identify children not enrolled in services and offer support to enrol in community oral health services.

Where do we want to get to?

- 95% of Māori pre-school children enrolled in the COHS at December 2016

DHB/PHO	Non-Māori	Māori	Target
ADHB	66%	48%	95%

Trends



	What are we going to do?	Timing	Responsibility
1.	Finalise ARDS Preschool strategy to improve Māori pre-school children enrolment and utilisation in community oral health services.	Q1	Auckland Regional Dental Services, Women's, Children and Youth Team
2.	Implement the ARDS preschool and adolescent strategy	Q2	Auckland Regional Dental Services, Women's, Children and Youth Team
3.	80 percent of all new-borns are enrolled with a GP, in NIR, WCTO, Community Oral Health and hearing screening in the first 3 months by Q4 as part of the Single Enrolment Project.		Women's, Children and Youth Team
4.	Establish a case review group to identify children who are not enrolled in services and implement processes to support enrolment in a community oral health provider.	Q4	Women's, Children and Youth Team

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

9 Mental health

Why is this a priority?

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

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.

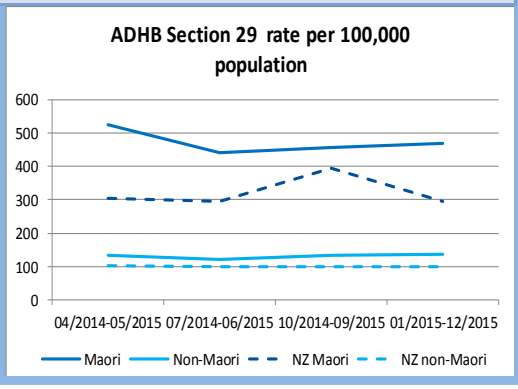
To achieve this we will focus on:

Improving our understanding of the performance of current pathways and implement activities to improve outcomes for Māori under Compulsory Treatment Orders.

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	132	456	NA



	What are we going to do?	Timing	Responsibility
1.	Audit clinical/cultural care pathway for Māori in ADHB mainstream services under compulsory community treatment orders and provide a report with recommendations on the elements of the current care pathway that need improvement by June 2017	Q4	Mental Health Provider Arm Services
2.	Evaluate cultural competency of clinical staff working with Māori and CTOs (Section 29), identify gaps in current competency levels, and give recommendations of what training is required and who needs it by June 2017	Q4	Mental Health Provider Arm Services
3.	Run Focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommend steps for improvement by June 2017	Q4	Mental Health Provider Arm Services
4.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

Local Priorities

10 Workforce

Why is this a priority?

Increasing Māori health workforce participation rates is fundamental to improving the quality and effectiveness of care.

What are we trying to do?

Increase the Māori workforce to 7.4% % of the total Waitemata DHB workforce, with a particular focus on prioritised occupations, by 2025.

To achieve this we will focus on:

Increasing and maintaining the overall proportion of the Māori health workforce in ADHB to match the working age percentage of Māori in the district population (20-64 years); supporting partners to increase the proportion of Māori who enrol in and graduate from health career related education and training; supporting, growing and strengthening Māori strategic and operational leadership across the health sector.

Where do we want to get to?

- By 2025 7.4% of the ADHB workforce is Māori.
- Increase the number of Māori across the total workforce to 694 by 2025.

Workforce	Māori Dec 15	16/17 target	2025 target
Total	325	366	694

- Increase the net number of Māori by headcount employed in prioritised occupations to 193 by 2025.

Workforce	Māori Dec 15	16/17 target	2025 target
Junior Med	11	15	42
Nursing	106	134	249
Midwifery	5	7	13
Dental Therapist	N/A	N/A	N/A
Dietitian	-	1	4
Occupational Therapist	5	6	9
Physiotherapist	5	6	8

	What are we going to do?	Timing	Responsibility
1.	Review, update and improve DHB HR recruitment and retention policy and processes – ongoing.	Q1-Q4	Human Resources Director
2.	Implement agreed processes and approaches that improve recruitment and retention – ongoing.	Q1-Q4	Human Resources Director, General Manager Māori
3.	Evaluate and if necessary refresh/align all DHB funded programmes with strategy and aims with Māori Workforce Development Strategic Plan aims including: Rangatahi Programme, Health Workforce New Zealand and Kia Ora Hauora by 31 March 2017.	Q3	General Manager Māori
4.	Update our partnership work with the education pipeline and pilot refined approaches where agreed by 30 June 2017	Q4	General Manager Māori

	What are we going to do?	Timing	Responsibility
5.	Improve Māori workforce access to and graduation from Health Workforce New Zealand funded training by 30 June 2017.	Q4	General Manager Māori
6.	Implement Regional Diversity Hui by 30 June 2017.	Q4	Human Resources Director, General Manager Māori
7.	Scope and implement new senior Māori leadership roles, initiatives and programmes by 30 September 2016.	Q1	Human Resources Director, General Manager Māori
8.	Implement agreed new leadership approaches by 30 June 2017.	Q4	Human Resources Director, General Manager Māori
9.	Insert a clause in NGO contracts to collect and report on Māori workforce data to the DHB by 30 June 2017.	Q4	Director Planning and Funding
10.	Develop and implement new Health Care Assistants programme by 31 December 2016.	Q2	Director Allied Health, General Manager Māori
11.	Invest in workforce mentoring support – ongoing.	Q1-Q4	Human Resources Director, General Manager Māori
12.	Funding primary health care/community clinical placements for Māori by 31 March 2017.	Q3	Human Resources Director, General Manager Māori
13.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

11 Obesity

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 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 the Healthy Auckland Together group, an inter-sectoral group working to improve the nutrition environment, we are also contributing to various other inter-sectoral groups with a similar goal. We are also developing pathways to support obese four year olds to have improved health outcomes. 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.

	What are we going to do?	Timing	Responsibility
1.	Further strengthen connections with maternity services and with kohanga reo to increase access to the Healthy Babies Healthy Futures (HBHF) programme by December 2016.	Q2	Māori Health Gain Team
2.	Agree a national DHB food and beverage environments policy by August 2016 and work towards compliance with the policy by June 2017.	Q4	Women's, Children and Youth Team
3.	Revise the patient selection process, including review of the referral pathway, for bariatric surgery to develop a best practice shared Multidisciplinary Team for both Auckland and Waitemata DHBs.	Q4	Māori Health Gain Team
4.	Implement the recommendations from the Whānau Health Literacy Review on patient materials.	Q4	Māori Health Gain Team
5.	Map the food environment of ECEs, schools, DHBs and other community settings around schools in collaboration with Healthy Auckland Together partners	Q4	Women's, Children and Youth Team

	What are we going to do?	Timing	Responsibility
	by June 2017.		
6.	Collaborate with Healthy Auckland Together (HAT), Kai Auckland, Healthy Families Waitakere (HFW) and Social Sector Leadership Group to engage intersectorally with social services and non-health organisations to support healthy food environments, and to extend the reach of the Aiga Challenge programme to other groups by June 2017.	Q4	Women's, Children and Youth Team
7.	Develop and pilot a brief intervention and goal setting resource with B4SC to ensure consistent health promotion messages across community, primary and secondary care, including at each oral health visit by December 2016.	Q2	Women's, Children and Youth Team
8.	Develop a quantitative indicator to monitor the effectiveness of a family-based nutrition, physical activity and parenting programme by June 2017.	Q4	Women's, Children and Youth 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

12 Cardiovascular disease

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 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. This section focuses on primary care secondary prevention activity.

	What are we going to do?	Timing	Responsibility
1.	Continue to monitor acute coronary syndrome time to treatment indicators to ensure equity between Māori and non-Māori patients is maintained.	Q1-Q4	Māori Health Gain Team
2.	Continue to fund primary care to provide More Heart and Diabetes Checks to their eligible populations.	Q1-Q4	Primary Care Team
3.	Continue to perform More Heart and Diabetes Checks on at least 90% of the eligible population	Q1-Q4	Primary Care Team
4.	Develop and implement Community Based Phase Two Cardiac Rehabilitation Programme with Māori Providers.	Q4	Māori Health Gain Team, Māori Providers
5.	Undertake a Co-design process for diabetes self-management involving patients and their family and whanau and providers to identify factors that affect access, utilisation and effectiveness by December 2016.	Q2	Primary Care Team
6.	Develop a DSME Service Delivery Model including a model specific to Māori and Pacific that will improve access and utilisation by June 2017	Q4	Primary Care Team
7.	Commence the implementation of the	Q4	Primary Care Team

	What are we going to do?	Timing	Responsibility
	Diabetes Pathway by June 2017.		
8.	Develop a consistent Care Planning template for use in the Northern region by June 2017.	Q4	Primary Care Team
9.	Develop strategies to improve secondary diabetes services DNA rates, particularly in high needs patients, as part of the Service Alliance Work Programme by June 2017.	Q4	Primary Care Team
10.	Develop standard referral criteria to optimise appropriate referrals and utilisation of specialist service by patients with diabetes by June 2017	Q4	Primary Care Team
11.	Develop a diabetes/CVD education programme for primary health care nurses based on the National Diabetes knowledge and Skills framework by June 2017.	Q4	Primary Care Team
12.	PHOs will continue to work with general practices to ensure patients, especially Māori and Pacific patients, are referred to exercise and nutrition programmes – ongoing.	Q1-Q4	Primary Care Team
13.	Report on the regionally agreed diabetes/cardiovascular disease clinical indicators and establish baseline data by June 2017	Q4	Primary Care Team
14.	Use this information to provide feedback on clinical indicator performance at practice level and support practices to improve management of CVD (particularly for high risk populations) by June 2017	Q4	Primary Care Team
15.	Progress of activities and performance against health targets will be monitored and reported to Manawa Ora quarterly.	Q1-Q4	Māori Health Gain Team

13 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