COUNTIES MANUKAU HEALTH

Pacific Health Plan

He Pou Koorero

E soso'o le fau i le fau- Unity is strength (Samoan)

****Fau-Hibiscus tiliaceus is customary designated of all fibrous plants for a number of purposes in Samoa.***

'E soso'o le fau i le fau' is an oratory remark that refers to working and connecting together strengthens us to achieve great things.

It stems from many of the cultural and traditional practices in Samoa. The 'Fau' tree lines the shores of many of our Pacific islands. The bark is very resilient making it versatile for use.

It is stripped and dried before the different strands are brought together to bind, tie and hold together things. The strands are also used to weave the prestigious fine mat 'ie sina used in many traditional exchanges of gifts. One strand is weak but in the numbers provide strengths to hold and bind things together.

Hence 'In Unity Is Strength'.

Table of Contents

Foreword

We are incredibly proud of the diversity and value that Pacific peoples living in Counties Manukau bring to our community. By 2020, it is estimated that 21 percent of the people living in our district will identify as Pacific. That is equivalent to a 6 percent growth in total Pacific population to approximately 121,000 Pacific people. CM Health acknowledges that protecting the current and future health of our Pacific population will require strong collaborative partnerships.

While there is commonality within the Pacific cultures there are many differences among the recognised Pacific ethnicities of Samoa, Tonga, Cook Islands, Niue, Fiji, Tokelau, Tuvalu, Vanuatu and Kiribati. Language, cultural practice, traditional healing and beliefs, contribute to those differences. The Pacific population has evolved over time from one that was largely migrants to currently being New Zealand born with multiple-ethnicities. One out of every three Pacific people in New Zealand lives in Counties Manukau. The Pacific population of Counties Manukau in 2017 is youthful with an estimated 30 percent under the age of 15 years.

Immunisation coverage for Pacific people at eight months of age was 96 percent (MoH June 2016). This indicator has achieved the government target of 95 percent. We need to pause and celebrate this achievement. It is a reminder that the system can work and work consistently. That said, we also need to acknowledge that there are still challenges ahead. Thirty percent of Pacific children were identified as obese.[1] One in three Pacific children is caries free. Pacific engagement with and access to health services when they are needed remains a challenge. Therefore in 2017/18, we are targeting the health of our Pacific children with a focus on access to healthcare, childhood obesity and oral health improvements.

Counties Manukau Health cannot achieve this alone. We look forward to working in partnership with our communities, Localities, non-government organisations, government and social agencies with a strong commitment to working collaboratively across our region with Auckland and Waitemata District Health Boards.

[1] Ministry of Health (2016) Annual Update of Key Results 2015/16 – New Zealand Health Survey

1.0 Introduction

1.1 Our Partners

Protecting the current and future health of our Pacific population within CM Health will require collaborative partnerships. This means working with and alongside communities, central and local government, Non-Governmental Organisations, Primary Health Organisations, health and social service providers, Auckland and Waitemata DHBs.

Since 2017, the three DHBs across Auckland share the same Board Chair with an opportunity to further enhance regional collaboration. We are actively working with Auckland and Waitemata District Health Boards to increase our Pacific workforce through five Health Science Academies and Programme W&AT, collaboration on a regional approach to Childhood obesity and Oral Health as well as collegial contribution to the Northern Region Health Plan.

CM Health's locality approach to service development provides the foundation for community engagement as well as the platform for the Fanau Ola Pacific Nurse Case Managers and Social Workers to deliver services that are appropriate, timely and integrated. It is the people living and working in Counties Manukau that provide invaluable insights, local intelligence, inspiration and knows the approaches that works best to meet the needs of our diverse Pacific community groups.

In addition, CM Health will continue to provide Pacific Cultural Competency training for its staff, provide the consultancy required to support health development within the Pacific and provide the clinical and logistic support through the New Zealand Medical Assistance Team (NZMAT). NZMAT is the New Zealand Government's clinical response to emergencies and disasters in New Zealand and within the South West Pacific.

1.2 Te Tiriti o Waitangi

Counties Manukau Health (CM Health) 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 Maaori development, health and wellbeing by guaranteeing Maaori a leading role in health sector decision making in a national, regional, and whaanau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Maaori health advancement by requiring District Health Boards (DHBs) to establish and maintain responsiveness to Maaori while developing, planning, managing and investing in services that do and could have a beneficial impact on Maaori communicates.

Te Tiriti o Waitangi provides four domains under which Maaori health priorities for CM Health can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Maaori 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 Maaori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Maaori leadership, engagement, and participation in relation to CM Health'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 Maaori 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 Maaori patients, staff and communities across all activities.

These guiding principles are applicable to our diverse Pacific communities as they contribute to cultural safety and in particular, their contribution to positive health outcomes and experience of care. Cultural safety is underpinned by respectful communication, recognition of the diversity of world views (both within and between ethnic groups). The relevance of and respect for the importance of this framework is reflected in our integration of Te Reo terms in this Pacific Health Plan.

1.3 Our Decision Making Kaupapa

CM Health Strategic Goal and Values

Achieving "Healthy Futures for Pacific People" (Paeora) is a priority for CM Health and aligns with our Healthy Together strategic goal. This means:

- Seeing Pacific people living longer, healthier lives with whaanau and families in their own communities
- Working together to achieve health equity for Pacific communities experiencing health disparities

To achieve this, our transformational challenge is:

> *"To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality"*

We intend to progress and measure our progress over the next 5 years by:

- Advocating for healthier environments and settings that make healthy choices easier
- Better supporting people and families to live well with a diagnosed, long term condition through ways of working that honour Pacific peoples wellbeing
- Targeting service delivery to Pacific people at risk and their fanau. Ensuring Pacific peoples to get access to services earlier than they otherwise would, in planned, proactive models of integrated care.
- Providing healthcare closer to home. By orientating our service delivery to Localities, services are better connected with Pacific fanau and with other health, social and community service providers supporting their wellbeing.

There is a Maaori whakatauki (proverb) that embodies this challenge – *"Ko tou rourou, ko toku rourou ka ora ai te iwi."*

If we ask ourselves – how can we achieve health equity and how can we value everyone - we can all contribute to this goal. And there, in our quest for health equity, we can continue to narrow the health gaps for all communities living in Counties Manukau.

Our values reinforce our commitment to excellent, collaborative, compassionate and safe healthcare that we aspire to live and breathe every day.

- **Manaakitanga** (Kind)
  Care for other people's wellbeing
- **Rangatiratanga** (Excellent)
  Safe, professional, always improving
- **Whakawhanaungatanga** (Valuing Everyone)
  Make everyone feel welcome and valued
- **Kotahitanga** (Together)
  Include everyone as part of the team

2.0 The Pacific Peoples We Serve

2.1 Pacific People in the Auckland Region

Auckland is home to one of the largest Pacific populations in the world. The 2017 estimated Pacific population across the Auckland region is 211,990 or 13 percent of the total Auckland metropolitan population[2]. Approximately 67 percent of New Zealand's Pacific population resides in the Auckland region with just over half (54 percent) living in Counties Manukau[3]. Statistic New Zealand medium projections show that by 2026 (from the year 2006-2026), the Pacific population in the Auckland region is expected to increase by 30 percent.

Auckland has a very young Pacific population. In the 2013 Census there were 67,770 Pacific people under the age of 15 years. Pacific children accounted for a quarter (24.2 percent) of all children in Auckland[4].

In 2013, 76 percent of Auckland's Pacific peoples lived in areas rated 8, 9 or 10 on the New Zealand Index of Deprivation (indicating relatively poor socio-economic outcomes). This is a considerably higher proportion than was found across the other main ethnic groups.

Samoans comprise the largest single Pacific ethnic population group in the Auckland region. This is followed by Tongans and Cook Islanders. Over half of each of these populations resides in the Counties Manukau area. Pacific peoples are diverse and heterogeneous with each Pacific Island having its own set of customs, language, values, traditions and beliefs.

These factors alongside available services and community networks impact how we monitor population health, design and deliver supporting services. While the three Auckland region District Health Boards (DHBs) are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are important to local population needs.

Figure 1: Auckland Region DHB estimated Pacific Population in 2017 by age group

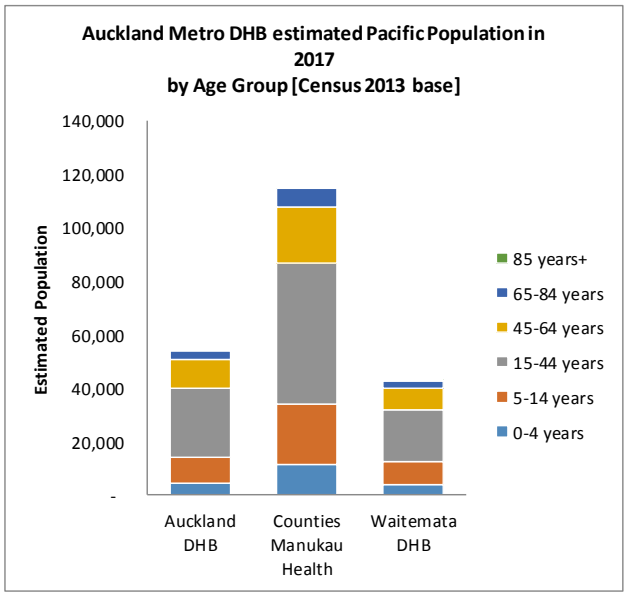
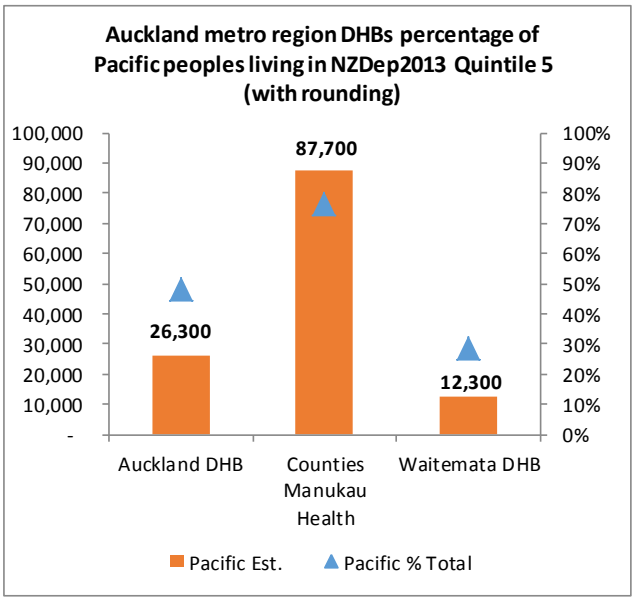


Figure 2: Auckland Region DHBs percentage of Pacific peoples living in NZDep 2013 9 &10 (Quintile 5)



[2] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections,(2013-Census Base) – October 2016 Update
[3] Health Partners Consulting Group 2012. Metro-Auckland Pacific Population Health Profile. Auckland: HPCG.
[4] http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/Documents/pacificpeoplesinaucklandrresultsfrom2013census201510.pdf

2.2 Pacific Peoples Living in Counties Manukau

2.2.1 Population size, age distribution, and growth

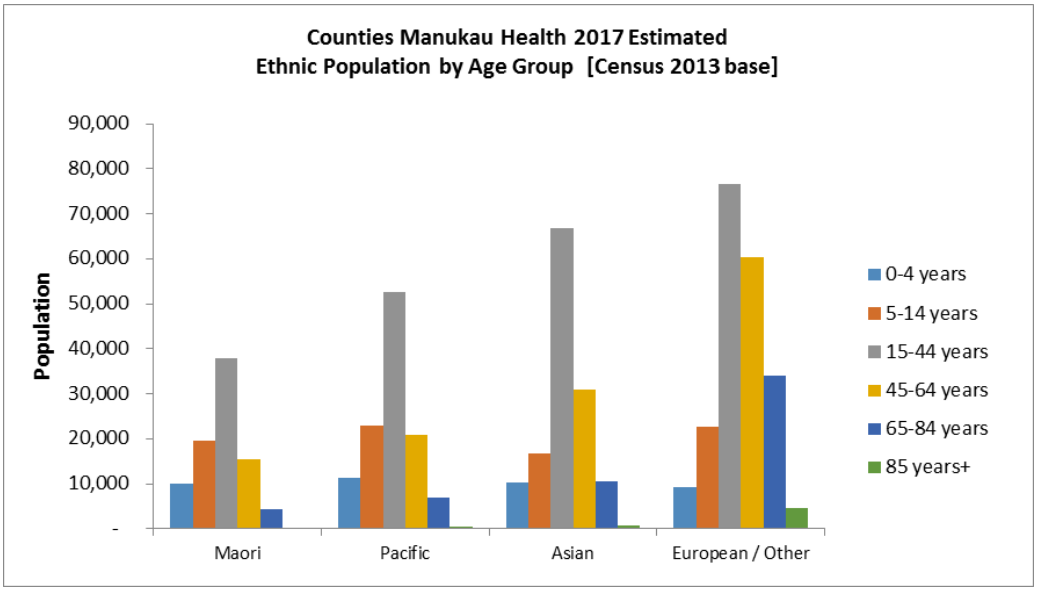
The estimated total population of Counties Manukau in 2017 is over 545,000[5]. Pacific peoples make up 115,020 people, or 21 percent of the total Counties Manukau population. Thirty seven percent of all Pasifika peoples in New Zealand live in Counties Manukau. From 2017 to 2036, the Counties Manukau Pacific population is predicted to increase by over 41,000 people (36 percent).

Over half of Pacific peoples (55.7 percent) in Counties Manukau reside in the Mangere/Otara locality, 36.9 percent in the Manukau locality and 7.4 percent are at the Franklin and Eastern locality[6]. Pacific peoples tend to have dual residency and live in both New Zealand and the Pacific Islands[7].

The Pacific population of Counties Manukau is youthful as an estimated 29 percent are under the age of 15 years of age and 26.5 percent were under 24 years of age. Young Pacific people are more likely to identify with multiple ethnicities. A third of young Pacific peoples in Counties Manukau identify with more than one ethnicity.

The 2013 Census found that amongst Pacific peoples residing in Counties Manukau, 46.2 percent (53,208) identified themselves as Samoan, 21 percent (24,450) identify as Tongan, 19 percent (22,362) as Cook Islands Maaori, 7.8 percent (8,979) as Niuean, 2.5 percent (3,369) as Fijians.

Figure 3: Ethnicity distribution within age groups of the estimated resident population of Counties Manukau in 2017



2.2.2 Social determinants of health

A high number of Pacific peoples in Counties Manukau are living in overcrowded houses (Figure 4). This equates to almost half of all Pacific peoples and 53 percent of Pacific children.

The 2013 Census indicated that 10 percent of Pacific peoples living in Counties Manukau were unemployed. This was approximately three times higher than NZ European/other groups (3.4 percent). More than 60 percent of Pacific peoples who are 15 years of age and over earn less than $30,000 a year. Low income, unemployment, limited education, and low social connectedness and cohesion impact significantly on Pacific peoples' physical, mental, and emotional health.

The impact of low income for Pacific peoples was reflected in the results from the annual update of the New Zealand Health Survey 2015/16. This report highlighted 19 percent of Pacific adults had not collected a prescription due to

[5] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections,(2013-Census Base) – October 2016 Update
[6] DHB Population projections by age, gender and priortised ethnic groups (2015) Ministry of Health Update, based on Census 2013
[7] Ethnicity distribution within localities based on the UR population counts for CM in 2013

cost. Pacific adults and children are more than three times as likely to have not collected a prescription due to cost as non-Pacific adults and children respectively, after adjusting for age and sex differences[8]

The negative impacts of economic and social determinants are entrenched in the lives of Pacific peoples and are shown in health status inequities. The New Zealand Health Survey from 2015/16 tells a story of opportunities to work with others to do better for Pacific peoples, and in particular Pacific peoples:

- 30 percent of Pacific children were obese
- 10 percent of Pacific children had been physically punished in the past four weeks
- Pacific children were 1.8 times as likely to have been physically punished as non-Pacific children
- 21 percent of children living in the most socioeconomically deprived areas were obese compared with 2.1 percent of children living in the least deprived areas. The childhood obesity rate was five times higher in children living in the most deprived areas than it was for children living in the least deprived areas. This link between obesity and neighbourhood deprivation was far stronger for children than for adults.

Figure 4: Number of Usual Residents in a household in Counties Manukau by ethnicity (Census 3013)

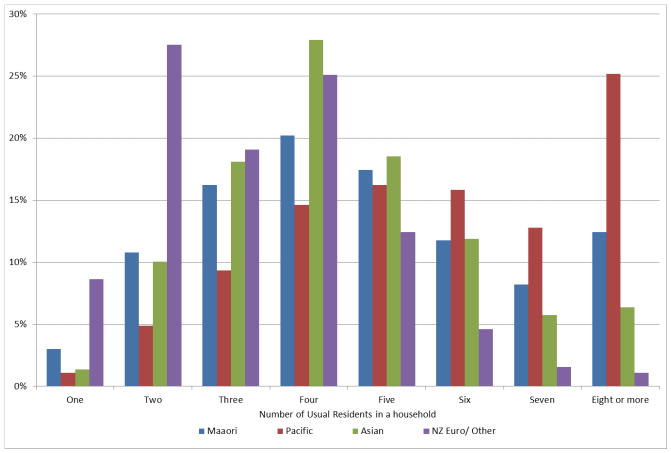
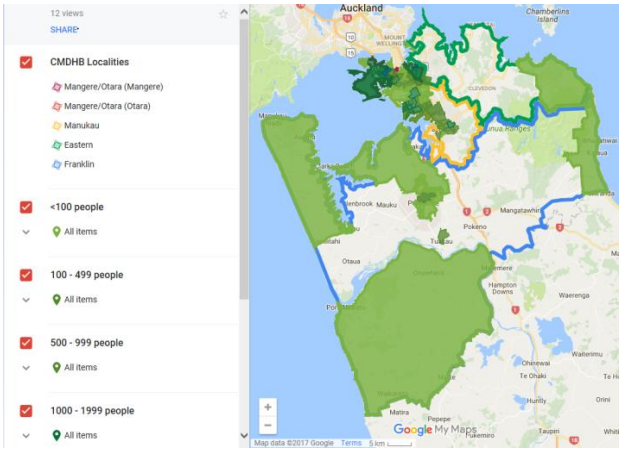


Figure 5: Counties Manukau Usually Resident Total Pacific people living in Quintile 5 areas in 2013



2.2.3 Life expectancy

In 2015, the overall life expectancy for Pacific peoples in Counties Manukau was 76.6 years. Although the life expectancy of Pacific people from 2006 to 2015 improved by 1.9 years, there is still a gap between Pacific and non-Maaori/non-Pacific of 7 years.

2.2.4 Disability

Based on the national 2013 Disability Survey[9], about 51,000 Pacific people with disability live in New Zealand. Counties Manukau, 37.4 percent of the total Pacific population. A total of 1,874 (6.0 percent) Pacific people were allocated Ministry-funded disability support services.[10] Pacific disabled people overall remain under-represented in disability support services relative to the total Pacific population, which made up 7.4percent (296,944) of the New Zealand population. Most of the Pacific disabled people allocated disability support services live in the Auckland region (74 percent), followed by the Wellington region (11 percent), the Waikato region (3 percent), the Christchurch region (3 percent), and the Manawatu / Wanganui region (2 percent). The Pacific population is the most youthful population of all ethnic groups in New Zealand with a median age of 22.1 years old. This is consistent with the ages of Pacific people using Ministry-funded disability support services, with 42 percent of the Pacific people who were

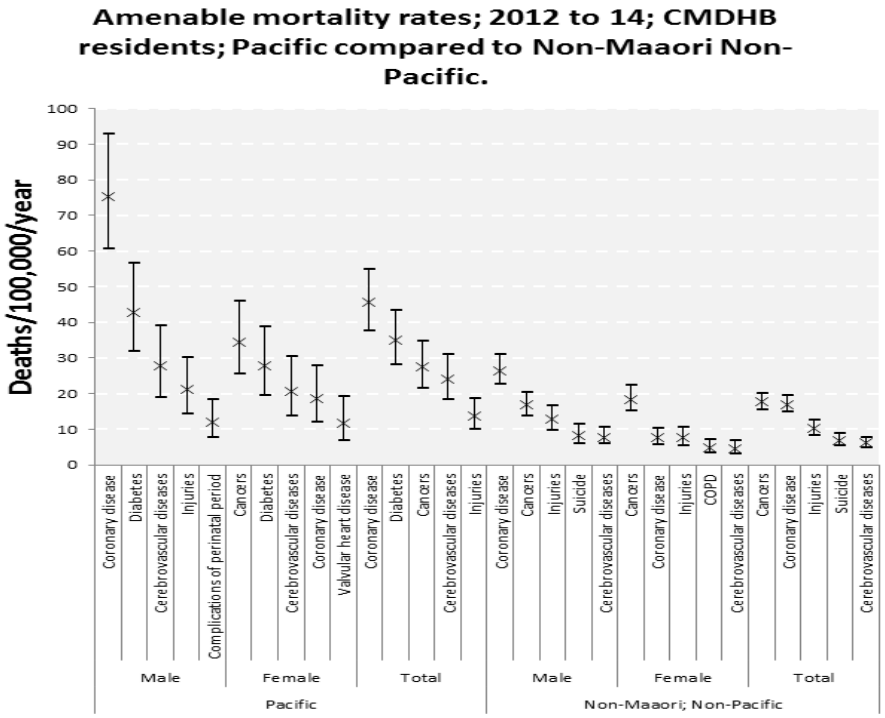
[8] Ministry of Health. 2016. Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health
[9] Disability is defined in the 2013 Disability Survey as 'an impairment that has a long-term, limiting effect on a person's ability to carry out day-to-day activities'
[10] Disability Support Services: Faiva Ora National Pasifika Disability Plan
http://www.health.govt.nz/system/files/documents/pages/faiva-ora-plan-2014-16.pdf

allocated Ministry funded disability supports being aged 19 years and below (compared with 32 percent European/other). Of these, 60 percent were male and 40 percent were female.

2.2.5 Amenable mortality

The leading causes of amenable mortality (Figure 5) for Pacific peoples in Counties Manukau are coronary disease, diabetes, cerebrovascular disease, injuries and complications of perinatal period (male). For Pacific females the leading causes are cancers, diabetes, cerebrovascular disease, coronary and valvular heart disease.

Figure 5: Five Leading causes of Avoidable Mortality[11] for the Counties Manukau population aged 0 to 74 years (age-standardised death rates), Pacific compared to non-Pacific and non-Maori people, by gender, 2012 to 2014.[12]



2.2.6 Community and primary healthcare engagement

While the majority of Pacific peoples are enrolled with Primary Health Organisations (PHOs) within Counties Manukau in 2016, 22,616 patients enrol in practices outside our district (Table 1). Many of these are of Tongan ethnicity enrolled with practices based in Otahuhu.

Table 1: Counties Manukau residents enrolled in CM Health practices, all ages combined

Primary Health Organisation	Domiciled in Counties Manukau & enrolled anywhere in New Zealand	Domiciled in Counties Manukau & enrolled in CM Health located practice	Domiciled anywhere& enrolled in CM Health located practice
Alliance Health Plus Trust	29,350	19,924	21,806
East Health Trust	2,272	2,272	2,501
National Hauora Coalition	5,519	2,829	2,987
Procare	44,068	34,281	36,517
Total Healthcare	49,815	49,815	53,570
Others	713	-	-
Grand Total	**131,737**	**109,121**	**117,381**

11 Cancers here include melanoma of the skin, stomach, rectal, bone and cartilage, breast, prostate, testis, thyroid, Hodgkin's lymphoma, acute lymphoblastic leukaemia. 'Maternal and infant' relates to complications of the perinatal period for either mother or baby. COPD: chronic obstructive pulmonary disease.
12 CM Health analysis of the 2014 Mortality Data

3.0 Key Achievements

In 2016/17 CM Health focused on health gain areas that were identified as national and local priorities. This included a mixture of actions to shore up our health systems and improvements to the way we work with Pacific peoples to make a positive difference to health outcomes.

This means working together and collectively CM Health achieved the following key outcomes in the past year.[13]

Matua, Pepe ma Tamaiti (Parents, Infants and Children)

- Immunisation coverage 96 percent (MoH June 2016) at eight months of age Government target 95 percent.
- Rheumatic fever rates have dropped nationally by 45 percent (Beehive 7th March, 2016). More than half the national reduction was in Northland and Counties Manukau DHBs. Counties Manukau Health most recent rate (2016) is 7.9 per 100,000 hospitalisations which has almost halved since it peaked at 15.5 per 100,000 back in 2013.
- Pacific extreme obese children screened at Before School Checks (B4SC) and referred to a health professional for clinical assessment has improved from a baseline of 28 percent to 67 percent in quarter 2 2016/2017
- Established a Pacific Child Health Network with 11 Pacific Childhood Education Centre and home base of which is a forum for raising awareness in regards to health issues affecting Pacific children.

Tagata matutua ma aiga (Adult and Family Group)

- 91 percent of Pacific peoples have had their cardiovascular risk assessed in the last 5 years. The Ministry of Health target is 90 percent
- 60 percent an increase from 58 percent of enrolled Pacific patients with diabetes (aged 15-74 years old) had a good/acceptable glycaemic control with HbA1c
- The number of new referrals to Pacific Fanau Ola Nurse Case Managers and Social workers has continued to increase from 64 and 25 (respectively) in the month of February 2017 to 87 and 50 (respectively), in March 2017

Itumalo aoao o Counties Manukau (District Wide)

- 60 percent of Pacific students enrolled in our regional Pacific Workforce program (Program W&AT) successfully secured a job in their respective areas in the health sector

Pacific Region

- Successful completion of contract work in the Pacific region including training of clinical health professionals from Fiji and Kiribati. Also successfully launched Tele-health with the National Health Service of Samoa.

[13] By the end of quarter 2 -31 December 2016

4.0 Performance Expectations for 2017/18

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the **true story of inequities**, i.e. what is the gap in health outcomes and scale of health gain we plan for? Our thinking is that the comparator population is not so much right or wrong but appropriate or 'fit for purpose' to the local lived realities for our community.

CM Health has chosen the New Zealand 'European/Other' population as our health equity comparator group. For this reason, our baseline measures and related trend graphs outlined in Section 5 of this plan reflects this as our 'local health equity target' in addition to the national targets reflecting government performance expectations.

Priority Area	Key Indicators	Baseline 2015/16 Total[14]	Baseline 2015/16 European/Other	Baseline 2015/16 Pacific	Target 2017/18 Result
Matua, Pepe ma Tamaiti – Parents, Infants and Children					
PHO enrolment	Proportion of newborns enrolled with a PHO by 3 months old	75%	70%[15]	63%	100%
Well Child Tamariki Ora Services	*A new measure, baseline and target will be developed in 2017/18*				
Breastfeeding	Percentage of Pacific babies fully or exclusively breastfed at 6-weeks	58%	67%	71%	75%
	Percentage of babies fully or exclusively breastfed at 3-months	45%	56%	39%	60%
	Percentage of babies fully, exclusively or *partially* breastfed at 6-months	58%	66%	59%	65%
Oral health[16]	Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services	84%	90%	85%	95%
	Percentage of population of children aged 5 years who are caries free	48%	65%	30%	52%
	Mean DMFT of year 8 school children (12/13 years)	0.96	0.62	1.42	0.90
Healthy Kids	Percentage of obese children identified in the Before School Check (B4SC) programme who are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention		*New target*		95%
Rheumatic fever	Rate of acute rheumatic fever hospitalisations at 5.9 per 100,000	5.9	-	23.2	8
Hospitalisation	Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years[17]	7,109	4,789	11,977	11,378[18]
Autalavou, Lafu, Mapu (Young People)					
Sexual and Reproductive Health	*A measure, baseline and target is being developed in 2017/18*				
Tagata Matutua ma Aiga (Adults and Family Group)					
Smoking Cessation	Percentage of Pacific people who smoke and are enrolled in General Practice are offered brief advice and cessation support	92%	92%	92%	90%
	Percentage of Pacific people who smoke and are hospitalised are offered brief advice and cessation support	96%	96%	96%	95%

[14] Total means the indicator result for the all Counties Manukau population groups as at 30 June 2016 (unless otherwise noted)
[15] Health equity comparator group is non-Maaori/non-Pacific for this measure
[16] Baseline data is based on the calendar year (to 31 December 2016). A 'non-Maaori/non-Pacific' health equity comparator group applies as disaggregated 'European/Other' other data was not available in 2016. Note 2017/18 targets reflect national expectations for the total population.
[17] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the Auckland, Waitemata and Counties Manukau Health Alliances 2017/18 Auckland Region System Level Measures Improvement Plan.
[18] 2017/18 target represents a 5% reduction from baseline per the regional 2017/18 Auckland Region System Level Measures Improvement Plan.

Priority Area	Key Indicators	Baseline 2015/16 Total[14]	Baseline 2015/16 European/Other	Baseline 2015/16 Pacific	Target 2017/18 Result
Diabetes	Percentage of eligible population with HbA1c ≤ 64mmol/mol	65%	73%	58%	69%
	Percentage of enrolled patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 months is <140 mmHg	*The baseline and target is in development as part of a regional collaboration.*			
	Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker	*The baseline and target is in development as part of a regional collaboration.*			
Cardiovascular disease	Percentage of eligible population who have had their cardio-vascular risk assessed in the last five years	72%	93%	92%	90%
	Percentage of eligible population who have a risk greater than 20 percent and are on dual therapy (dispensed)[19]	49%	44%	49%	52%[20]
	Percentage of eligible population who have had a prior CVD event who are on triple therapy (dispensed)[21]	58%	57%	62%	65%[22]
Fanau Ola	*A new measure, baseline and targets will be set during 2017/18*				
Itumalo aoao o Counties Manukau (District Wide)					
Workforce	Maaori workforce headcount for prioritised occupational groups[23]	3,195	-	239	295
Mental Health	*A new measure, baseline and target is being developed in 2017/18*				

Baseline data referenced is based on Quarter 4 2015/16 (30 June 2016) results unless otherwise stated. This baseline was chosen to align with the metropolitan Auckland District Health Board 2017/18 Annual Plan indicator baselines.

[19] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the Auckland, Waitemata and Counties Manukau Health Alliances 2017/18 System Level Measures Improvement Plan.
[20] 2017/18 target represents a 5% increase from baseline per the regional 2017/18 System Level Measures Improvement Plan.
[21] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the regional 2017/18 System Level Measures Improvement Plan.
[22] 2017/18 target represents a 5% increase from baseline per the regional 2017/18 System Level Measures Improvement Plan.
[23] Baseline data is for 30 June 2015.Counties Manukau target of 21.4% Pacific peoples workforce headcount is based on the estimated 2025 Pacific peoples working population aged 20-64 proportion of the total working population; translated to annual recruitment targets by prioritised occupational group.

5.0 Pacific Peoples Health Gain Focus for 2017/18

The indicators in this section have been grouped into four main themes: 1) universal access (Access), 2) equitable outcomes 3) continuous quality improvement (CQI) and 4) System Level Measures (SLM).

5.1 Matua, Pepe ma Tamaiti – Parents, Infants and Children

Our children are our future. Good child health is important not only for children and family now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. Child health, development and wellbeing also have broader effects on educational achievement, violence, crime and unemployment. These impacts start in pregnancy and therefore our action focus is on the home environment, good nutrition, oral health and reduction in potentially avoidable diseases. In 2017/18, our action focus for Pacific infants, children and family is on access to health care specifically Primary Health Organisations (PHOs), Well Child Tamariki Ora (WCTO), childhood obesity, oral health, breastfeeding, rheumatic fever and Ambulatory Sensitive Hospitalisation.

5.1.1 Access of Pacific newborns to General Practice

New-born enrolment with a PHO by 3 months

A CM Health Newborn Enrolment (NBE) working group was set up in 2016/2017 with the aim of addressing existing issues and to improve newborn enrolment coverage in Counties Manukau.

A CM Health NBE Action Plan was developed and agreed by the working group. The action plan reflects the issues identified by the working group and the activities required to address them. The action plan also has a set of milestones for stakeholders to complete to track progress and performance.

What are we trying to do?

To improve NBE coverage in Counties Manukau.

Why is this priority?

Increasing Pacific NBE in Primary Health Organisations (PHOs) is important so that they are supported to have the best start in life. While rates have improved over the past several months there are still a significant number of Pacific babies who are not enrolled.

What will we focus on?

We will set up a Monitoring and Evaluation system to monitor and evaluate the implementation of the NBE Action Plan. Utilise data to identify gaps, share and celebrate success and drive continuous improvement.

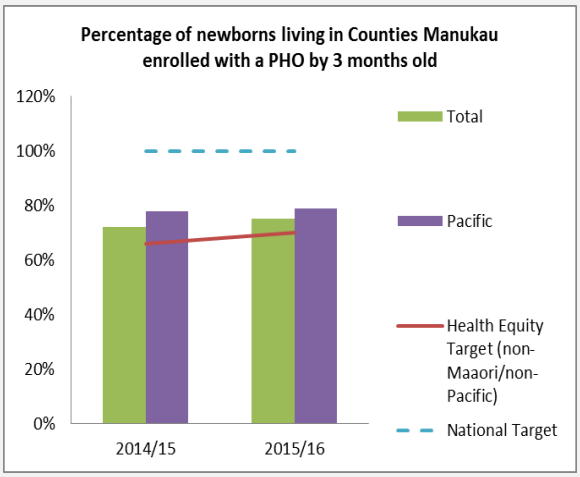
Where do we want to get to?

- 100 percent newborn pepe enrolment with a PHO by 3 months

2015/16 Total	2015/16 non-Maaori/ non-Pacific	2015/16 Pacific	2017/18 Target
Proportion of newborns enrolled with a PHO by 3 months old			
75%	70%	79%	100%

Note: data for newborn enrolment in GPs are not available. Primary Health Organisation (PHO) data has been used. This indicator is reported 6-monthly.

Where are we now?



Note:

The period that includes Christmas and New Year always show a low enrolment. In addition, this indicator is collected from PHOs. However, there are other parties involved (Lead Maternity Carers and GPs).

Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Implement CM Health Newborn Enrolment Action Plan.	Report monthly enrolment by ethnicity
	Q1-4: Support PHOs and practices in implementing the Action Plan.	
2	Q1-4: Set up Monitoring and Evaluation system to track the implementation of the NBE action plan.	
3	Q1: Clarify the current time frames for data collection and reporting.	
4	Q1-Q4: Progress to a timelier reporting timeframe e.g. monthly.	
5	Q1-Q4: Fanau Ola Nurse Case Managers help register Pacific newborns without Lead Maternity Carers or a PHOs and documenting reasons why.	Report in Q4
6	Collaboration with Auckland and Waitemata DHBs for a Regional Pacific Child Health Plan.	

5.1.2 Access of Pacific newborn to Well Child Tamariki Ora services in their first year

Infants receive all Well Child Tamariki Ora core contacts due in their first year

The Well Child Tamariki Ora (WCTO) programme is a series of health visits and support that are free to all families for children from around 6 weeks up to 5 years of age. This programme cover:

- child growth and development
- family health and wellbeing
- immunisation information
- oral health (teeth and gum) checks
- early childhood education
- vision (sight) and hearing
- health and development checks for learning well at school

What are we trying to do?

Increase the proportion of Pacific infants receiving all WCTO core contacts in their first year.

Why is this priority?

These are 5 crucial initial contacts in the first year of life. These consist of i) family health and wellbeing, ii) child growth and development, iii) PEDS, iv) oral health v) vision and hearing.

What will we focus on?

Meet with PHOs and WCTO providers to sort out the challenges.

Where do we want to get to?

Improve the current percentage of infants receiving all WCTO core contacts due in their first year.[24]

Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Implement CM Health NBE Action Plan	Improve NBE coverage for Pacific infants
	Q1-4: Support PHOs and practices in implementing the Action Plan	
2	Work with Plunket and other WCTO providers to improve coverage for Pacific infants.	Improve the current percentage of infants receiving all WCTO core contacts due in their first year

[24] Data baselines will be established in 2017/18

5.1.3 Access of Pacific new-born to Community Oral Health Services

Pacific children aged 0 – 4 years enrolled in DHB-funded Community Oral Health Services

Early Childhood Caries (ECC) or dental decay remains the most prevalent chronic and irreversible disease in the Western World. In New Zealand disparities still exist in oral health by ethnicity, deprivation level, and age group, and this is particularly evident in Counties Manukau where Maori and Pacific children have higher rates of caries.

Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

In addition we are also focussing this year on oral health of Pacific adolescents who are below the age of 18 years. There is evidence that Pacific adolescents are less likely to visit oral health care providers despite the cost being free.

What are we trying to do?

Improve access of Pacific infants aged 0 – 4 years to DHB funded Community Oral Health Services (COHS).

Why is this a priority?

The core role of this access indicator is to facilitate and support a family/fanau timely engagement with DHB funded COHS so that they are integrated into the oral health system.

What will we focus on?

Preschool children from 1 year on.

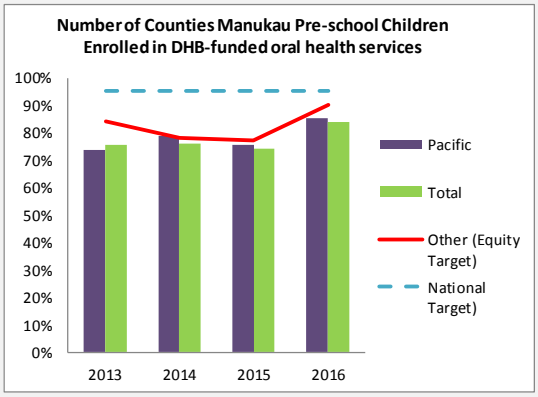
Where do we want to get to?

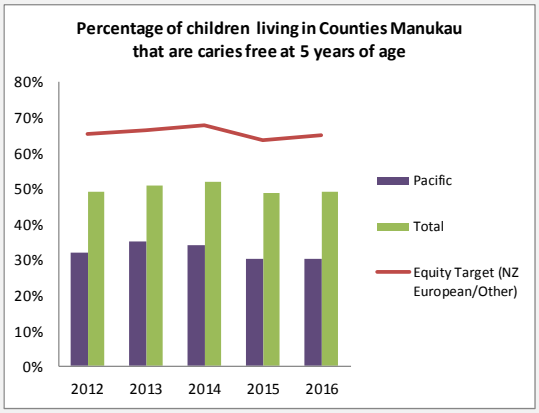
- Improve the current percentage of Pacific children aged 0 – 4 years enrolled in DHB-funded COHS

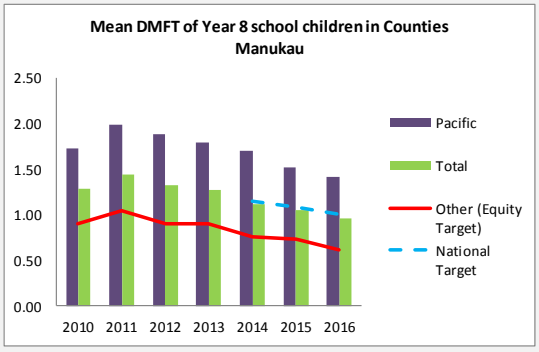
2016 Total	2016 non-Maaori/ non-Pacific	2016 Pacific	2017/18 Target
Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services (COHS)			
84%	90%	85%	95%
Percentage of population of children aged 5 years who are caries free			
48%	65%	30%	52%*
Mean DMFT of year 8 of school children (12/13 years)			
0.96	0.62	1.42	0.90*

*Data provided by Auckland Regional Dental Service as at December 2016. *Baseline data based on the calendar year (to 31 December). Note 2017/18 target results national expectations for the total population.*

Where are we now?







DMFT means decayed missing filled teeth

Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Monitor delivery of programmes and support for families through health providers. Our aim is to increase our exposure to pepi, tamariki and youth and make it easier for them and fanau to attend.	Percentage of infants and preschool children examined by dental therapist at 1 year of age.
	Q1-4: Follow-up of persistent DNAs in preschool patient group through WCTO, Public Health Nurse or community health workers	Percentage of enrolled children aged 0 to 12 years in arrears i.e. more than 30 days overdue for their scheduled annual examination. Percentage of adolescents utilising DHB funded oral health services
	Q1-4: Increase appointment capacity and reduce barriers to access by expanding service hours at Hub clinics in areas of high need for twilight weekday clinics and Saturdays	
2	Q1-4: Deliver targeted programmes of specific interventions (including tooth brushing, promoting healthy drinks, fluoride varnish application, nutrition and others) to support families to sustain their oral health. LotuMoui staff: Identify and Work with Pacific churches and Communities that have Early Childhood Education (ECE) Centres to support.	Preschool oral health education and tooth brushing programme to an additional 80 identified preschools. Number of Pacific/Communities ECE in Counties Manukau. Number of Pacific/Communities ECE in Counties that enrolled in the FVA programme.
3	Q1-4: Implementation of an early intervention Infant and Preschool strategy of Fluoride Varnish Application (FVA) and nutritional advice targeted to Maaori, infants to prevent caries in 12 month old infants (re-apply FVA every 6 months)	Reduced equity gaps for proportion of tamariki at 5 years who are caries free.
4	Q1-4: Support regional Preschool Oral Health Strategy to improve engagement of Pacific pre-schoolers through 11 Pacific ECE providers in LotuMoui.	
	Q1-4: Activities that support the 2017/18 SLM Improvement Plan include promotional focus on Pacific churches and parenting groups[25], provider upskilling in Lift the Lip assessments and referrals, and increased numbers of extended hours and Saturday dental clinics.	
5	Fanau Ola Nurse Case Managers to opportunistically lift the lip of infants and children they have come across through the current referral system. Refer them to appropriate services e.g. WCTO providers.	Q4: Report on numbers.
6	Support Otago University research on Pacific adolescents' understandings and experiences of oral health care	Q4: Report on findings.

[25] This action supports the 2017 Draft Pre-School Oral health strategy

5.1.4 Equitable Outcomes in Breast feeding

What are we trying to do?

Increase the number of exclusively or fully breastfed Pacific babies at 3 months of age.

Why is this priority?

Exclusive breastfeeding is recommended by the World Health Organisation for the first six months of an infant's life to support healthy infant growth and development. Breastfeeding has numerous benefits, supporting infant development and immune protection, protecting against sudden unexpected death in infancy (SUDI), respiratory illness and chronic otitis media, childhood, obesity, diabetes.

What will we focus on?

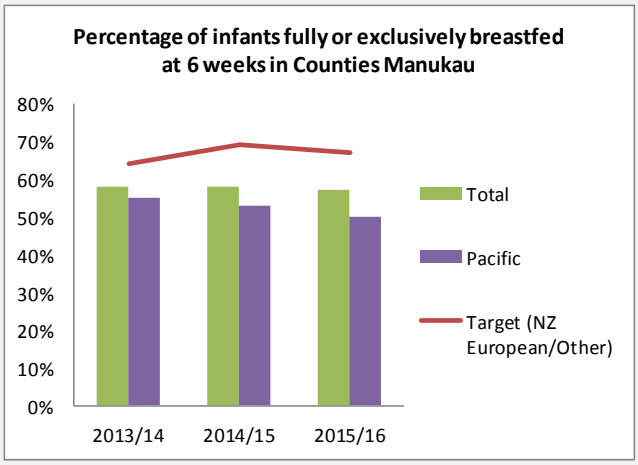
We will increase access to breastfeeding information and support for Pacific women through targeted community-based service provision. We will also look to areas where our breastfeeding offering to Pacific women can be extended.

Where do we want to get to?

- 75 percent of babies fully or exclusively breastfed at 6-weeks

2015/16 Total	2015/16 European/ Other	2015/16 Pacific	2017/18 Target
Percentage of babies fully or exclusively breastfed at 6-weeks			
57%	67%	50%	75%
Percentage of babies fully or exclusively breastfed at 3-months			
45%	56%	39%	60%
Percentage of babies fully, exclusively *or partially* breastfed at 6-months			
58%	66%	59%	65%

Where are we now?



Ref.	What are we going to do?	Measure/Milestone
1	Q1: Recruit and train additional Pacific Peer Supporters.	Q2: Report
2	Q1-Q4: Work collaboratively with South Seas, one of the new Pregnancy and Parenting Education Providers, to co-deliver the breastfeeding education module to Pacific parents and enroll women and fanau into the Te Rito Ora service.	Q4: Evaluation Report on the collaboration
3	Q1: Scope additional breastfeeding support groups in Mangere/Otara.	Q2: Report
4	Q2: Implement 'Breastfeeding Welcome Here initiative' in Manukau and Mangere/Otara.	Q4: Report
5	Q1-Q4: Support organisations in Counties Manukau who are Baby Friendly Community Initiative (BFCI) accredited or working towards BFCI to maintain/achieve their accreditation.	Q4: Report.
6	Q1-Q4: Provide breastfeeding education and training sessions to priority workforces.	Q4: Report.
7	Q1-Q2: Work collaboratively with WCTO providers to strengthen the support they provide breastfeeding mothers and fanau/aiga.	Q3: Report on the collaboration
8	Q1-Q4: Increase Lead Maternity Carer, WCTO, primary care and community awareness about services and referral processes.	Q4: Report

5.1.5 Quality Improvement: Raising Healthy Kids/Childhood Obesity

What are we trying to do?

Counties Manukau DHB has the highest prevalence of childhood obesity out of all the DHBs in the country. Just over 14 percent of 4 year olds are obese – which equates to approximately 880 children.

Why is this a priority?

As at end of Oct 2016, 55 percent of Pacific children identified as obese at their B4SC were offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention.

What will we focus on?

Developing community-based support and maturing our referral systems is our focus in 2017/18.

Where do we want to get to?

- 95 percent of Pacific children identified as obese were referred appropriately (see note below)

2015/16 Total	2015/16 European/Other	2015/16 Pacific	2017/18 Target
Percentage of obese children identified in the Before School Check (B4SC) programme who are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention			
-	-		95%

New indicator introduced in 2016/17 therefore no baseline data is available. This is a national health target that focuses on not just the referral, but that it was acknowledged, or who are already under care or the referral was declined by the parent/caregiver. (refer MOH 2017/18 DHB Health Target definitions for further information)

Ref.	What are we going to do?	Measures/Milestones
1	Involve people, fanau and families as an active part of their health team and provide information in a way that is understandable and culturally appropriate.	Q4. A Summative evaluation outlining the experiences of parents and children involved in the referrals process and interventions.
	Monitor the rate of declines and gather insights from fanau focus groups/interviews to best understand reasons for declines.	
	Provide fanau and families information to support nutrition, physical activity and lifestyle changes.	
2	Develop IT systems in Primary Care to integrate information and referral processes.	Report on the progress of IT systems development and integration of information and referral processes
	Integrate e-referral processes into Counties Manukau Health Practice Management Systems.	
	Establish dual-referral processes to Primary Care and family-based nutrition, activity and lifestyle intervention providers to support children identified as obese.	
	Standardise information collected.	
	Support the implementation of the regional growth chart solution for use in secondary care in Counties Manukau Health.	
3	Grow Counties Manukau Health workforce capability to engage and support fanau and families to make healthier lifestyle choices.	
	Deliver training to support health professionals to initiate empowering conversations about weight management.	
	Provide Be Smarter Tool and Healthy Lifestyle Packs to Counties Manukau Health workforce.	
	Provide training and site visits for General Practices to support the Healthy Weight guideline.	
4	Scoping options for monitoring outcomes over time for children identified as obese at their B4SC.	
5	Work together with Otara Health Charitable Trust with their Family Based Services to Improve Nutrition and Physical Activity.	
6	Work with Ko Awatea and Otara Health Charitable Trust in the LENS4LIFE project.	

5.1.6 Quality Improvement: Rheumatic Fever

What are we trying to do?

Reduce the incidence of acute rheumatic fever (ARF).

Why is this priority?

New Zealand has some of the highest rates of rheumatic fever of any developed country, particularly amongst Pacific. 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 will we focus on?

Improving our understanding of the progress we have made with our prevention activities and improving engagement with Pacific children.

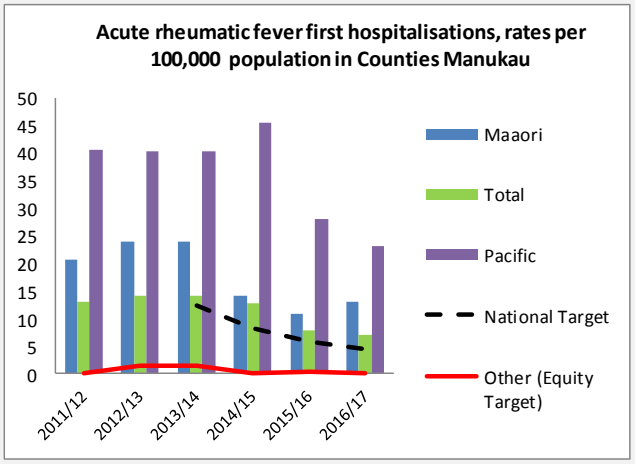
Where do we want to get to?

- ARF hospitalisations rate of 8 per 100,000 population

2015/16 Total	2015/16 European/ Other	2015/16 Pacific	2017/18 Target
Acute rheumatic fever first hospitalisation rate per 100,000 population			
5.9	NA	23.2	8

Baseline data for Quarter 1 2015/2016 unless otherwise noted.

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-Q4: Implement delivery of school and community based sore-throat programmes and support for Primary Care workforce to deliver assessments	Sore throat programmes delivered in 54 Mana Kidz schools by Q4
2	Q1-4: Grow community capability in recognising the symptoms and treatment options of Rheumatic Fever in Pacific children and youth. We will do this through hui (for engagement and feedback) and promotional campaigns.	Pacific stakeholder fono/meeting
	Q1-4: Work with the Counties Manukau communications team to grow local communication opportunities to reach Pacific. This will build on Health Promotion Agency (HPA) led communications work	
3	Q1-4: Continue to monitor and review CM Health systems that support the delivery of programmes to pepe, tamaiti, autalavou and aiga. This activity includes professional development training for providers, housing referral system improvements, case review and notification and others	Implemented Workforce Development Plan
	Q1 Establish a role to support referrals into the Housing programme to ensure families who are eligible are referred to housing programme	
	Q1-2: Develop Workforce Plan with a focus on ensuring training and professional development aligned across all providers	

5.1.7 System Level Measures – Ambulatory Sensitive Hospitalisations (ASH) for children 0-4 years

What are we trying to do?

Reduce potentially avoidable hospital admissions for Pacific children aged 0-4 years.

Why is this a priority?

Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting. 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. Reducing ASH for 0-4 year olds is a key focus of the Auckland Region System Level Measure Improvement Plan. The main conditions that contribute to high ASH rates in Pacific 0 – 4 year olds from highest to lowest are: Upper and ENT respiratory infection, asthma, pneumonia, cellulitis, gastroenteritis/dehydration and oral health.

What will we focus on?

We will continue to provide a variety of activities to improve pathways for high priority (most frequent) ASH events for pepe and Pacific children aged 0-4 years.

Where do we want to get to?

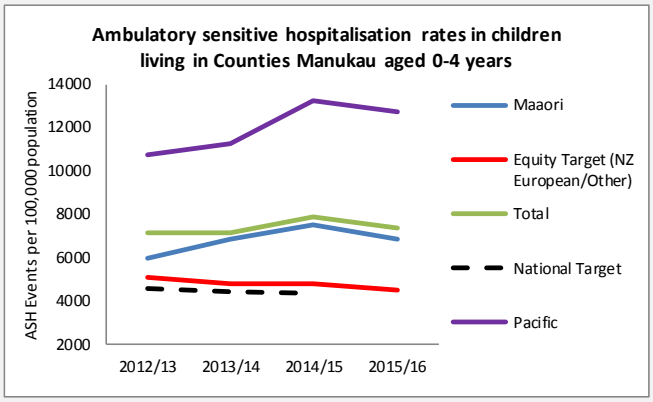
- 5 percent reduction in the ASH rate for Pacific children aged 0-4 years

2015/16 Total	2015/16 European/Other	2015/16 Pacific	2017/18 Target
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population			
7,109	4,789	11,977	11,378[26]

Baseline data for 12 months to September 2016 aligned with the regional 2017/18 Auckland Region System Level Measures Improvement Plan.

Data source: Ministry of Health SI1 Quarterly data.

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Support the increased integration of service offerings that contribute to reduced ASH rates for pepi and Pacific preschoolers aged 0-4 years. These services include newborn enrolments, immunisation, nutrition, oral health, and breastfeeding.	At least 5 preschools and 3 primary schools engaged in a water-milk policy by Q4
	Q1-4: Design and implement a 'water and milk' only policy, eliminating sugary drinks, for high deprivation preschools and primary schools in the Counties Manukau district.	
2	Q1-4: Develop CM Health system capability in providing support to fanau with pepi and Pacific pre-schoolers to improve self-management of health. Capability development will include provider training and clinical advice on skin infections and resources to support fanau self-management of respiratory conditions.	Reduction in ASH rate for pepi and Pacific pre-schoolers 0-4 years
	Q1-4: Deliver training to WCTO providers and primary care on regional clinical pathways and resources for skin infections and early identification and treatment of skin infections and key messages for families for preventing skin infections ('clean, cut, cover').	Training delivered to WCTO providers in Q1 and to primary care by Q4
	Q4: Establish a clinical nurse specialist service to provide clinical advice to WCTO providers around the management of skin conditions.	
3	Q1-4: Support Nurses in Primary Care to conduct assessments and development treatment plans for adults and children with respiratory conditions through the Clinical Pathway.	All fanau of Pacific pre-schoolers with asthma have access to self-management support/plans.
4	Q1-Q4: Fanau Ola Nurse Case Managers to be involved in Ref 1 – 3 to opportunistically provide.	Document and report on the Fanau Ola.
5	Q1-4: Activities that align to the 2017/18 SLM Improvement Plan include;	

[26] 2017/18 targets represent a 5% reduction from baseline per the regional 2017/18 System Level Measures Improvement Plan.

Ref.	What are we going to do?	Measures/Milestone
	immunisation work programmes, pregnancy immunisation promotion, resource and education package delivery of skin infection messaging to providers, development of an oral health engagement measure, awareness building of free dental service, identifying all eligible children for free influenza vaccines and Boostrix vaccines for pregnant women.	

Note and linkages: Actions supporting immunisation, breastfeeding, B4 School Checks, cardiovascular disease and smoking cessation make a significant contribution to reducing respiratory illness, Ear, Nose and Throat conditions, diabetes and cardiovascular disease. These are covered in other sections of this Plan.

5.2 Autalavou (Samoan), Lafu (Niuean, Sibling) Mapu (Cook Island) - Young People

"*Ka tupu te moko taro me aravei it vai ora: Young taro shoots will grow if they meet life giving water*". (Cook Islands)

Good health enables young people to achieve their dreams and aspirations, and to make meaningful contributions to their families and communities. In CM Health, we are committed to support Pacific young people living in Counties Manukau so that they can achieve their dreams and aspirations and live to be healthy lives. In 2017/18, our action focus for Pacific young people is on sexual & reproductive health, mental health and oral health.

5.2.1 Sexual and Reproductive Health

What are we trying to do?

We want Pacific young people access to barriers free sexual and reproductive health services.

Why is this a priority?

Sexual and reproductive health is a sensitive subject that is not discussed openly among many Pacific cultures. Christianity plays a big role in this. Embarrassment, stigma, shame and confidentiality issues are often barriers preventing Pacific young people accessing to sexual and reproductive health services. Evidence has shown Pacific youth underuse of contraception, and high termination of pregnancy among Asian students (Pacific Youth 2012, University of Auckland).

What will we focus on?

Promote free 'walk-in' sexual health service offered at GP clinics; identify training needs of school staff, development a referral pathway and to establish baseline data.

Where do we want to get to?

Improve sexual and reproductive health for Pacific young people.[27]

Ref.	Timing	What are we going to do?	Measures/Milestones
1	Q1-Q4	Develop a promotion plan to promote free 'walk-in' sexual health service offered at specific GP clinics for Pacific young people in particular the Mangere-Otara locality.	A promotion plan of free 'walk-in' sexual health service targeting Pacific young people is developed.
2	Q1-Q4	Identify youth sexual health training needs of school nurses and counsellors.	Youth sexual health training needs of school nurses and counsellors are identified.
3	Q1-Q4	Develop a free sexual health service referral pathway in Mangere-Otara Locality.	A referral pathway is developed and documented.
4	Q4	Establish 2016/17 baseline data of Pacific young people accessed free 'walk-in' sexual health service in Mangere-Otara Locality.	Baseline data established and achieved a five percentage increase of Pacific young people accessed free 'walk-in' sexual health service in Mangere-Otara Locality.
5	Q4	Establish baseline data of Pacific young people accessed to long acting reversible contraception (LARC).	Baseline data of Pacific young people accessed to LARC is established.

[27] This is a new priority for 2017/18 and baseline data will be defined and developed.

5.3 Metua (Cook Islands- adult), Kakai Lalahi (Tongan-Adult)

5.3.1 Smoking

What are we trying to do?

An estimated 17,900 people who smoke are Pacific people in the CM Health Catchment (Census, 2013). Prevalence is high in particular, Tongan Men (30.7 percent) and Cook Island Women (30 percent).

Why is this a priority?

Smoking is a key driver of the gap in life expectancy between Pacific and European/Other people. This contributes to lung cancer, cardiovascular disease and respiratory diseases. Increasing the number of Pacific people who are smoke-free is also an amenable mortality contributory measure as part of the Auckland Region System Level Measures Improvement Plan.

What will we focus on?

Our focus is to clearly understand the referral, and utilisation of, cessation services by Pacific people especially Tongan males and Cook Island females, and maximising opportunities for supported quit attempts.

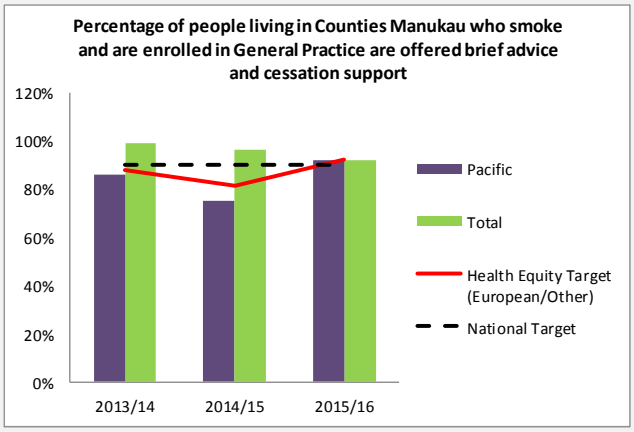
Where do we want to get to?

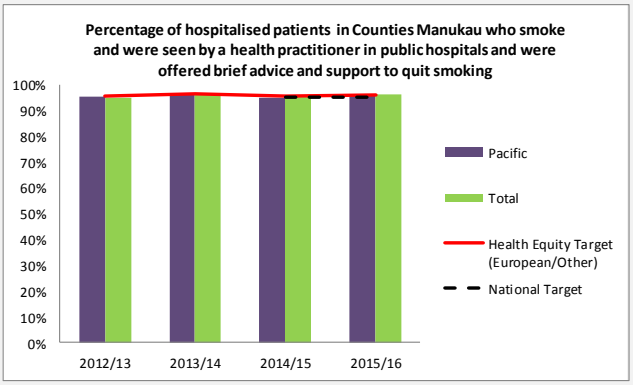
- Increased 4 week quit rates for Pacific people who smoke

2015/16 Total	2015/16 European/Other	2015/16 Pacific	2017/18 Target
Percentage of Pacific People who smoke and are enrolled in General Practice are offered brief advice and cessation support			
92%	92%	92%	90%
Percentage of Pacific People who smoke and are hospitalised are offered brief advice and cessation support			
96%	96%	96%	95%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?





Ref.	What are we going to do?	Measures/Milestones
1	Q1-Q4: All hospital and primary care smokefree best practice systems and processes are constantly reviewed using developed internal audits and continuous quality improvement to ensure maintenance of the Hospital and Primary Care Smokefree Health target equitably for Pacific.	Smokefree best practice systems and processes reviewed in hospital and primary care throughout Q1 and Q4.
2	Q2: Explore conducting a focus group of Pacific people who smoke to understand the low uptake of Smokefree support services	Hold a focus group to understand the experiences and opinions of Pacific people to better understand low acceptance and uptake of Nicotine Replacement Treatment (NRT) by Q2 Campaign /strategy designed to encourage frontline health

Ref.	What are we going to do?	Measures/Milestones
		professionals to adjust their tact in prescribing by Q4. Campaign /strategy designed to encourage Pacific people to accept an offer of NRT or referral to cessation support by Q4.
5	Q1: Continue validation of sub segmentation (persona) findings, testing 'Feta' (pacific, male, family man) and his communication and engagement preference.	Feta (pacific, male, family man) persona tested and validated by Q1.
6	Q1-Q4: Support the actions of the 2017/18 Auckland Region System Level measures Improvement Plan which relate to smoking cessation.	Monitor System Level Measure Smokefree Indicators throughout Q1 and Q4.
7	Q1-Q4: Motivational Interviewing Training is offered to Primary Health Organisations.	Motivational Interviewing Training is delivered to Primary Health Organisations throughout Q1and Q4.
8.	Q1-Q4. Development of baseline data for key Pacific populations.	Baseline data for key Pacific populations developed throughout Q1 and Q4.
9	Q1-Q4: Development of Stop Smoking Service delivery by healthcare professionals in identified localities to support Pacific people to stop smoking.	Healthcare professionals identified, trained and developed to become qualified Stop Smoking Practitioners throughout Q1and Q4. Pacific people who smoke are supported by Stop Smoking Practitioners who are health professionals in identified localities throughout Q1 and Q4.

5.3.2 Long Term Conditions – Diabetes

What are we trying to do?

Reduce Pacific morbidity and mortality via improved access to quality diabetes care.

Why is this a priority?

Prevalence, morbidity and mortality rates from diabetes are higher for Pacific than other groups, therefore targeted initiatives are required to reduce the prevalence of risk factors for the development of diabetes and to improve identification, screening and management of diabetes, particularly to achieve good glycaemic control.

What will we focus on?

We will redesign the Diabetes Care Improvement package to focus on those who have poor glycaemic control. Clinical Governance Structures will be implemented with a strong focus on data utilisation, reporting and performance.

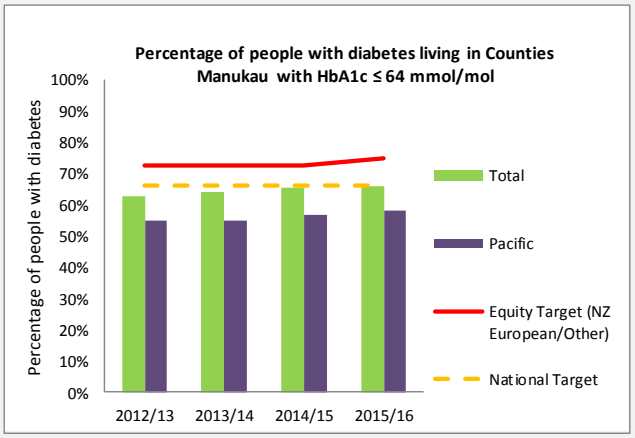
Where do we want to get to?

- 69 percent of Pacific adults with diabetes have an HbA1c less than or equal to 64 mmol/mol

2015/16 Total	2015/16 European/Other	2015/16 Pacific	2017/18 Target
Percentage of eligible population with Hb1Ac ≤ 64mmol/mol			
65%	73%	58%	69%
Percentage of enrolled Pacific patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 months is <140 mmHg			
Baseline data in development			
Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker			
Baseline data in development			

Baseline data for Quarter 4 2015/16.

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1: Continue to target those patients who have poor glycaemic control through the implementation of a planned proactive care approach and spread of the virtual review model between primary and secondary care.	Quarterly reports.
2	Q1: Build on the learnings from the diabetes collaborative and spread these to the other practices within CM Health including ways to improve patient engagement.	
3	Q1: Diabetes Nurse Specialists and Senior Medical Officers will be supporting primary care through multi-disciplinary team meetings, virtual reviews, and physical reviews with patients and structured education at the practice.	
4	Q2: Identification of insulin medication errors through ED attendances and admissions to secondary care and feedback proactively to primary care to support medication compliance, patient education and improved insulin management.	Q3 Report on the findings.
6	Q1: Clinical Governance – Pacific representative to be appointed to the Local Diabetes Team.	
7	Q1: Five diabetes indicators will be reported by ethnicity so performance can be monitored and analysed with the aim of reducing variation between practices and variation between ethnicities.	Indicators are reported by ethnicity.
8	Q1: Ensure Pacific people are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.	Percentage of Pacific people accessing podiatry, dietetics and health psychology.
9	Q1- Q4: Improved access to self-management support services, including self-management education and health coaches via a new locality based service which targets Pacific patients and family with diabetes.	Quarterly reports.
10	Q1-Q4: Practices will work to identify Pacific people who have not had a retinal screen, or who are overdue for a retinal screen and ensure they are referred to the service or follow up.	Quarterly reports.
11	Q4: Practice Nurses who work in practices with high numbers of Pacific patients with diabetes will be encouraged to attend the Manukau Institute of Technology (MIT) Diabetes Care and Management courses.	Report on the number of nurses that have attended the MIT Diabetes Care Management courses.

5.3.3 Long Term Conditions – Cardiovascular Disease

What are we trying to do?

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

Why is this priority?

Cardiovascular disease (CVD) is one of the most significant causes of death for Pacific people. Pacific people have higher prevalence of risk factors associated with cardiovascular disease. Hospital admission due to CVD is the biggest ASH contributor for Pacific people. In addition, CVD contributes to the regional amenable mortality SLM Improvement Plan.

What will we focus on?

CVD management for two different groups of people. Primary prevention targets people at risk of having a cardiovascular event through dual medication therapy and life style changes. Secondary prevention is for people with prior events to reduce the risk of ongoing mortality and morbidity through triple medication therapy and life style changes..

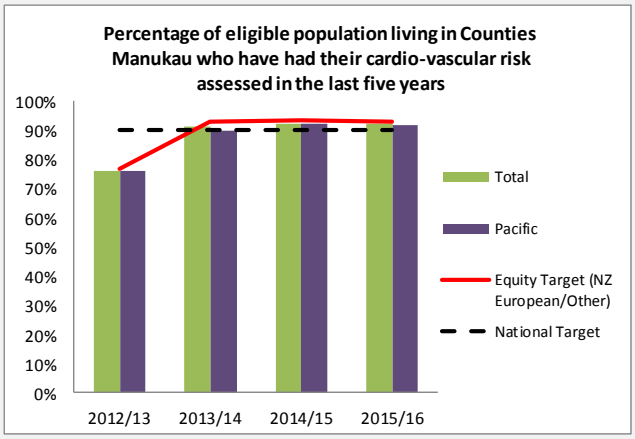
Where do we want to get to?

- 90 percent of the eligible population who has had their cardiovascular risk assessed in the last five years

2015/16 Total	2015/16 European/ Other	2015/16 Pacific	2017/18 Target
Percentage of eligible population who have had their cardio-vascular risk assessed in the last five years			
72%	93%	92%	90%
Percentage of eligible population who have a risk greater than 20 percent and are on dual therapy (dispensed)			
49%	44%	49%	52%[28]
Percentage of eligible population who have had a prior CVD event who are on triple therapy (dispensed)			
58%	57%	62%	65%[28]

Baseline data for dual and triple therapy is for the 12 months ended 30 September 2016 in order to align with the regional 2017/18 System Level Measures Improvement Plan except CVD Risk Assessment (CVDRA) which is as at Quarter 4 2015/16.

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-Q4: Continue the implementation of the updated CVDRA guidelines to ensure best practice for Pacific people, including lifestyle and exercise guidance.	Q4: A Progress report
2	Q1-Q4: Continue using data (e.g. electronic decision support etc.) to monitor and support people with identified risk factors so that their care is enhanced.	
3	Q1-Q4: Develop information sharing protocols and relationships to ensure that services offered are of greatest value to users and fanau.	
4	Q1-4: Targeted engagement with Pacific people for promotion or for proactive support. This will include community awareness projects through, active recalls to General Practice and dual therapy prescriptions for Pacific people with CVD risk of >20% or through LotuMoui and Fanau Ola Case Managers.	A community engagement/awareness raising project targeting Pacific males aged 35-44
5	Q1-4: PHD to continue working with Sports Auckland on Green Prescriptions.	Record the number of people
6	Q1-4: Activity aligning to the 2017/18 SLM improvement plans include Pacific specific interventions to improve uptake of and adherence to Triple Therapy as well as post-event medication counselling and other rehabilitation services in hospital.	

[28] 2017/18 target represents a 5% increase from baseline per the regional 2017/18 Auckland Region System Level Measures Improvement Plan.

5.4 Fanau Ola (Family/Household)

5.4.1 Fanau Ola (Family/Household)

What are we trying to do?

Utilise the Fanau Ola approach to engage with Pacific patients and families who have complex health issues and are high users of the health system.

Why is this priority?

Patients that are high users of the health system utilises up to 45 percent of the total hospital resources. Pacific patients are more likely to be readmitted to hospital compared to non-Pacific non-Maori population.

What will we focus on?

Fanau Ola team will focus on three main areas such as implementing the Fanau Ola approach (family/household centred), health promotion and also focus on being opportunistic in assessing and raising awareness within Pacific families. Focussing on these three areas should enable us to achieve what we are trying to do as mentioned previously.[29]

Ref.	What are we going to do?	Measures/Milestones
1	Fanau Ola will develop education and health promotion activities that enhance patient knowledge about presenting earlier to GP.	Work plan of activities with LotuMoui Q1-Q4 Digital media as part of our engagement Q1-4
2	Scope an e-referral process that integrates with iPMS system used by CM Health.	Report to be produced by Q2
3	Provide options for Fanau Ola staff to provide consistent care model.	Number of team building sessions held by Q4
4	Scoping a Fanau Ola database that supports collection and analysis of data to support monitoring and evaluation to inform future developments.	Establish a baseline for patient information Q4 Report on the patient/fanau reality of living Q4
5	Building relationship with Primary and Secondary care to strengthen the continuum of care for Fanau Ola patients.	Attending 6 MDT meetings Q1-Q4 Attending 6 GPs practice meetings Q1-Q4 Report outlining the use of e-shared care Q4
6	Developing a unique holistic Fanau Ola model of care and further defining the point of difference and service proposition.	Developing a business case for practical support for Fanau Ola patient Q2 Create a systematic way of responding to Pacific primary and secondary DNA Q4

[29] This is a newly redefined focus for 2017/18. Baselines and datasets will be developed over 2017/18.

5.5 Itumalo aoao o Counties Manukau - District Wide[30]

5.5.1 Mental Health and Addictions

What are we trying to do?

Improve the wellbeing of Pacific people through earlier intervention and access to specialist episodic care.

Why is this priority?

There is an equity gap for Pacific people accessing mental health care (Youth 2012 Survey, University of Auckland; 'Ala Mo'ui, June 2016 MoH). Pacific people have lower access rates to specialist mental health services compared to the total New Zealand population.

What will we focus on?

We want to ensure that the quality of clinical care offered to Pacific people accessing specialist mental health services is culturally appropriate. We will be focusing on:

- Improving engagement with Pacific people who access Mental Health Secondary Care services, through the provision of Clinical Cultural Liaison (CCL) services and Specialist Episodic Care.
- We will focus on culturally consistent practices and knowledge transition across Mental Health child, youth and adult services for Pacific people to encourage a life course approach.
- We will support the greater Mental Health workforce to be competent when working with Pacific people and their families.

Where do we want to get to?

Improved access and quality of clinical cultural care for Pacific people who use mental health and addictions services.[31]

Ref.	What are we going to do?	Measures/Milestones
1	Provide Pacific CCL services to Pacific service users and their families to support secondary care MH&A clinicians working with Pacific service users.	Establish baseline data on the number of Pacific service users referred to Mental Health services who use CCL services.
2	Review Pacific service users who Do Not Attend (DNA) clinical appointments with mental health services. Engage with service users to understand the reasons why they DNA.	Establish baseline data on number of Pacific service users referred to Mental Health services who DNA and why. Analysis of Pacific service users who use CCL services and DNA data completed. Complete a report with recommendations.
3	Ensure all Pacific service users referred to Mental Health services have a Care Plan to support specialist episodic care.	100 percent Pacific service users with a Referral open to Mental Health services have a current Care Plan.
4	Relocate the Pacific Child and Youth team to the same facility as the Pacific Adult team to support the life course approach to mental health.	Vaka Tao, Child and Youth team to relocate from Whirinaki in East Tamaki to Matariki in Otahuhu, and co-locate with the Faleola Adult team.
5	Increase Mental Health workforce cultural competencies in working with Pacific service users and their families.	80 percent MH&A staff have completed Pacific Core Cultural Training.

[30] Samoan for District of Counties Manukau) or Inati (Tokelauan, *for everyone*)
[31] A new access-focused measure and baseline will be developed in 2017/18.

5.5.2 Pacific Workforce Development

What are we trying to do?

To increase the proportion of Pacific peoples employed by CM Health to better reflect our community.

Why is this priority?

While Pacific makes up 21 percent of the people that live in Counties Manukau, only 12 percent of employees identify as Pacific ethnicity. This means that the current number of Pacific employees would need to almost double to reflect the estimated population today.

What will we focus on?

Growing the capacity and capability, and the size of our Pacific and Maaori workforce is one of the Northern Region's four priority areas for workforce development in the 2016/17 Plan. To achieve this, the region will agree differential targets for our clinical and non-clinical workforces and develop related strategies to achieve these by the end of Quarter 1. A whole of systems collaborative approach by CM Health Workforce.

Development and Human Resources will target initiatives to increase the proportion of Pacific people in our workforce. These initiatives aim to 'widen the workforce pipeline' established by CM Health's 'Grow Our Own' initiative.

Where do we want to get to?

- By 2025, 21.4 percent of the DHB workforce is Pacific
- By 30 June 2018 a net increase in number of Pacific peoples headcount employed in prioritised occupations by 55

Occupation Group	Jun 2015 Pacific Workforce	Annual Target Extra Pacific	Extra Pacific Required by 2025
Junior Medical	20	7	56
Nursing	207	39	309
Midwifery	4	4	33
Dental Therapist	NA	NA	NA
Dietitian	0	1	9
Occupational Therapist	6	2	18
Physiotherapist	2	2	19

Data source: Regional Decision Support Team. Maori and Pacific Workforce Target Mar16 Revised 20170424 ver1 3a (2).xlsx. Northern Regional Alliance Limited, April 2017).

Dental therapists are Waitemata DHB employed therefore not applicable to CM Health recruitment targets.

Recruitment targets by occupational group were set in each of the Auckland Metropolitan DHBs as part of a Northern Region workforce planning commitment.

For estimated Pacific recruitment numbers, the Northern Region agreed to a target denominator of adult working population aged 20-64 years. Annual recruitment targets are based on a 2025 estimate of 21.4 percent of the working population is Pacific and annual recruitment targets are calculated compared to the June 2015 baseline.

Ref.	What are we going to do?	Measures/Milestones
1	Q1-Q4: Implement and monitor the MOH funded Regional Pacific contract (Program W&AT).	Quarterly reports.
2	Q1-Q4: Fund and support Pacific Midwifery Students to be awarded Scholarships for Years 2-3.	
3	Q1-Q4: Fund and support Pacific oral health workforce development.	
4.	Continue funding existing Health Science Academies.	Quarterly reports.
5	Q1-Q4: Work with HR team to co-design, develop, and implement the values-based recruitment strategy organisation-wide, with ethnicity specific targets to increase Pacific workforce.	

5.5.3 LotuMoui and Community

What are we trying to do?

LotuMoui and Community is the main platform for CM Health to engage with Pacific communities in the Counties Manukau district. This platform is a key vehicle for us to enable, empower and encourage Pacific communities to take action and ownership in improving their health and wellbeing.

Why is this priority?

Pacific people experience large health inequities. In order for us to achieve equity at a population level for Pacific peoples we are to work together with Pacific communities, where they live and work and understand their realities. In doing so, we are then able to work together with Pacific communities supporting them in taking actions to improve their health.

What will we focus on?

LotuMoui and Community will focus on collaborating with Pacific communities in empowering them to take ownership of their health. This is in identifying, coordinating, implementing, and evaluating activities that will in turn improve their health and wellbeing.

Ref.	What are we going to do?	Measures/Milestones
1	Q3-Q4: Co-ordinate and carry out evaluation of activities carried out by LotuMoui in 2016/2017. ▪ Reporting on these findings and using these finding to inform ▪ Future activities amongst Pacific communities in Counties Manukau.	Produce report of findings and work plan of activities.
2	Q3-Q4: Explore community organising as an appropriate methodology to utilise in Pacific communities in Counties Manukau to empower and enable communities to take action on issues they identify to be affecting their health. This will be through testing the community organising methodology with 1-2 Pacific community.	Produce and/or publish a literature review on the concept of community organising.
3	Q2: Explore new avenues and ways to engage with Pacific youth in a meaningful and effective way that will get them to engage in their healthcare.	
4	Q1-Q4: Continue to liaise with Pacific community groups currently involved in the LotuMoui programme to support and coordinate workshops in relation to specific health issues.	

5.5.4 Supporting Health Care in the Pacific Region

What are we trying to do?

CM Health is contributing towards two of the New Zealand government's twelve objectives within NZAIDs Strategic Plan 2016-2019 to "*Improve the Health of People in the Pacific and Respond to Humanitarian Emergencies within New Zealand and the Pacific.*"

Why is this a priority?

This is a priority because we are constantly reminded of the linkage between the people of the Pacific and their families who live within the CM Health area and how Pacific families provide resource and support where there is need. We also know that disasters and emergencies are an annual event that impacts many communities and CM Health acknowledges the strong connection between its Pacific peoples and their islands.

What will we focus on?

Focus will be on fulfilling our contract agreements with our funders.

Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Successful design and delivery of contracts as agreed with MFAT and development donors in Pacific countries.	Contracts delivered

6.0 Appendices

6.1 Glossary

Term	Definition
Aiga	Extended family grouping
ARF	Acute rheumatic fever
ASH	Ambulatory sensitive hospitalisation (potentially avoidable event)
B4SC	Before school check
BFCI	Baby Friendly Community Initiative
CCL	Clinical Cultural Liaison
CTO	Community treatment order (under the Mental Health Act)
CVDRA	Cardiovascular disease risk assessment
DHB	District Health Board
DNA	Did not attend (people scheduled but did not present for a health care appointment)
EDAT	Ethnicity data audit tool
Fanau	Family group
Fanau Ola	The Fanau Ola family based health gains programme
FVA	Fluoride varnish application for teeth (in pre-school aged children)
GP	General practitioner
Hb1Ac	Measure of blood sugar levels
HPA	Health Promotion Authority
Kaupapa	Agenda or Logic Framework
LARC	Long acting reversible contraception
LotuMoui	Lotu – Church or Faith, Mo'ui – Health or Wellbeing
Matua	Parents
MH&A	Mental Health and Addictions
MHSC	Mental Health Secondary Care services
MoH	Ministry of Health
NGO	Non-government organisation
NRT	Nicotine Replacement Treatment (to support smoking cessation)
Pepe	Babies and infants
PGY1	Postgraduate year 1 (junior doctors)
PHO	Primary health organisation
Q	Reference to a financial year (1 July to 30 June) 'quarter' meaning a three month period typically for reporting purposes, e.g. Quarter 4 is the April, May and June period
SEC	Specialist Episodic Care
SLM	System level measure (national set of six health indicators)
SUDI	Sudden unexpected death in infants
Tagata Matutua	Adult
Tamaiti	Children
WCTO	Well child tamariki ora (service providers)
Whaanau	Family group

Spelling and writing Maaori in Counties Manukau Health documents

Counties Manukau Health respect and acknowledge the variation between Māori dialects in New Zealand. We seek to follow the Tainui kawa (marae) protocol spelling for CM Health published documentation and communications.

The key dialect differences relate to **double vowel spelling**, e.g. whaanau that is reflected by a macron (whānau) in other districts.

COUNTIES
MANUKAU
HEALTH