COUNTIES MANUKAU HEALTH

Maaori Health Plan

2015 -16

COUNTIES MANUKAU DISTRICT HEALTH BOARD

E mihi ana kia Ranginui e tu iho nei

E mihi ana kia Papatuanuku e takato ake nei

Ki nga pou whare o nga tupuna

E mihi ana kia ratou kua mene ki te po,

Ratou te tutuunga i te puehu i te wa takatu ai ratou

Haere oti atu

Ki te Kingi a Tuheitia me te Kahui Ariki nui tonu

Tenei te mihi

Kia tatou te hunga ora, nga waihotanga o ratou ma

Tena tatou katoa

Greetings to Ranginui the sky father

Greetings to Papatuanuku the earth mother

Greetings to the ancestral houses of our forebears

We pay homage to those who have passed on

We acknowledge the Maaori King, Tuheitia and the kingship

Finally acknowledge, and greet all who remain

Counties Manukau District Health Board Maaori Health Plan 2015/16

Published July 2015.

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Foreword

Achieving 'Healthy Futures for Maaori' or Paeora is a priority for Counties Manukau Health (CM Health). To achieve this, CM Health will strive to become a centre of excellence for Maaori health and the Maaori health workforce. We aim to see Maaori living longer, healthier lives with whaanau and in their communities. This is an aspiration that our Board shares with our strategic Maaori partner Manawhenua I Tamaki Makaurau Trust Board.

To reflect our relationship with Mana Whenua I Tamaki Makaurau we have integrated their Hauora Plan, the Ministry's planning guidance and input from the Counties Manukau Primary Health Organisations (PHOs) into this plan. This plan is a reflection of our joint commitment to improve the health of Maaori living in our district. We recognise our efforts need to be joined up, targeted and regularly reviewed to ensure the desired excellence we strive for is being achieved in Maaori health. We also recognise that the role of tribal and Maaori community leadership in the CM Health district is pivotal if we are to enable and support Whaanau to achieve their aspirations in our district

To accelerate our performance in Maaori health, we will continue our endeavour to align effective Maaori led service provision in our district to a robust outcomes framework.

We will work closely with localities to further develop the localities networks and to strengthen the cohesion and collaboration required to accelerate the achievement of Whaanau Ora in our localities. Central to this will be support for the on-going implementation of the At Risk Individuals (ARI) programme across localities. This programme provides comprehensive care for many Maaori who have multiple long term conditions, and are at risk of poor health outcomes.

We will be working with Manawhenua to develop a robust Hauora Performance Monitoring Framework that will enable us to better measure and monitor our collaborative efforts to achieve Hauora, Whaanau Ora, Paeora or in short Maaori Health Excellence at CM Health.

Pivotal to this endeavour will be achieving our aspiration to become the employer of choice for Maaori health professionals (current and future). We will implement robust Maaori recruitment, development and retention actions that will increase the number and proportion of Maaori in our workforce. These strategies will extend from secondary school through to employment.

All stakeholders are pivotal to endeavours in Maaori health, especially PHOs who have a critical role to play in achieving Maaori health gain. This plan has been developed in partnership with the Counties Manukau PHOs and a formal letter of endorsement of this plan by the PHOs has been provided. We express our thanks to our PHO partners for their contribution to the actions in this Plan, and look forward to working together in this coming year.

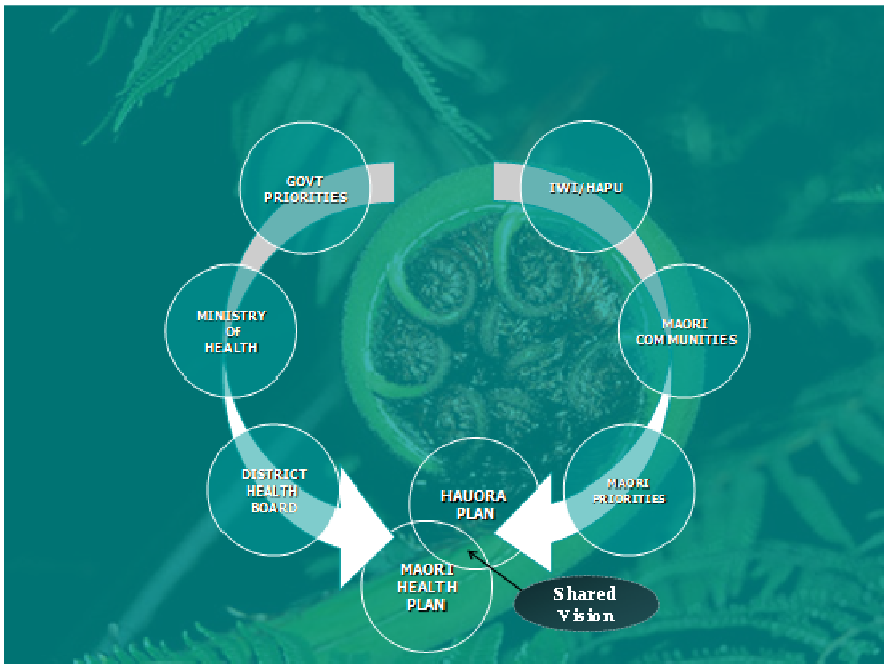
Dr Lee Mathias
Chair

Geraint A Martin
Chief Executive

1.0 Introduction

Counties Manukau Health[1] (CM Health) is committed to reducing health inequalities, accelerating Maaori health gain and progressing the principles of the Treaty of Waitangi. The opportunity and challenge of Maaori health outcome improvement is one we share with our treaty partner, Manawhenua I Tamaki Makaurau. This is an important partnership relationship for CM Health and integral to moving forward in-step with the local hapu, iwi and Maaori communities. This plan supports the relationship interests of both CM Health and Manawhenua I Tamaki Makaurau which are focussed on addressing health inequalities and accelerating the health interests of Maaori in this district (refer below and excerpt from Hauora Plan 2012–2017).

Figure 1: Maaori Health Plan and Hauora Plan Development



An integrated service planning approach within CM Health has been undertaken to develop our Maaori Health Plan. It provides a comprehensive collection of evidenced based activities with performance indicators designed to accelerate Maaori health gains and to monitor health outcomes for Maaori living in Counties Manukau. We aim to increase our ability to not only measure, but also inform Maaori communities of our progress.

Adoption of the Te Ara Whakawaiora[2] approach by CM Health means that we have identified indicator champions who will lead and facilitate a coordinated strategy with key stakeholders in each indicator area.

This year there will be increased focus on improving the collection of accurate 'self-identified' ethnicity information with the implementation of the Primary Care Ethnicity Data Audit tool (EDAT) with PHOs in the district. The implementation of the EDAT tool will increase the robustness of ethnicity data accuracy in PHOs and will enable a more informed understanding of the Maaori population. Research undertaken to identify ways to improve Maaori access and use of health services has revealed that cost and lack of transportation are barriers, as well, as the culture of health of services. This includes the employment and ongoing development of appropriate staff across all services whom are able to engage and achieve the confidence and trust of Maaori to use health services. Addressing barriers to health and disability care will help improve Maaori use of health services and achievement of individual and whaanau focused outcomes[3].

Strengthening relationships with our PHOs by meeting systematically to review performance on health indicators such as PHO enrolments for new born infants, cervical screening rates, immunisation coverage rates, smoking cessation for pregnant women, and accuracy of ethnicity data across all practices within CM Health. All are important proxy indicators related to achieving improvements in Maaori health gain.

[1] To reflect a system approach to health service planning, the collective health resources and associated infrastructures to deliver services for our resident population is referred to as Counties Manukau Health (CM Health)
[2] Tumu Whakarae Advice Paper "Accelerating A MHP Indicator Performance" to DHB CEOs.
[3] Cram F. (2014). Improving Maaori Access to Cancer Health Care: Literature Review. Auckland http://www.katoa.net.nz: Katoa Ltd

Maaori women who are eligible and are identified as high need for a cervical smear will be supported this year with the increased availability of free smears for high needs women. Similar efforts will also be made to reach and support eligible Maaori women to be screened for breast cancer and for Maaori men aged 35-44 years to be assessed for cardiovascular disease.

We are committed to efforts to reduce the Maaori SUDI rate in the CM Health region for it is unacceptable that the Maaori population has a significantly higher rate of infant mortality than other population groups. This is an area which can be changed.

Development of an integrated patient and whaanau focussed care and delivery system for health services which are safe and are outcome focussed will continue. Integral to this is will be the ongoing development of high performing providers combined with attracting, building and retaining a workforce that is competent and able to engage and provide effective services and appropriate care to Maaori patients and whaanau.

Implementing this plan will require a collaborative and integrated effort across the Counties Manukau health system and a strong commitment to shared accountability and action. It also requires us to strengthen our capability to accelerate Maaori health gain and to move beyond the equity gap.

2.0 Working with Manawhenua

2.1 Manawhenua I Tamaki Makaurau Board to Board Relationship

The oversight for monitoring progress against the Maaori Health Plan and the Hauora Plan will comprise:

- Reports against progress to CM Health Board and Manawhenua I Tamaki Makaurau Boards; and
- Twice yearly meeting of both Boards to assess progress to date

The framework for governance monitoring is shaped by the four principles set out in the Hauora Plan. Management of both organisations are responsible for implementing an annual work plan that sets out the activities under these objectives (refer Figure 2 below).

Figure 2: Hauora Plan Principles and Objectives 2015/16

Hauora Plan Principles	Objectives
Treaty Principle	Strengthen relationships at all levels to provide for shared decision making and partnering
	Establish relationships with Crown agencies and Maaori communities that impact on the social determinants of health
Matauranga Maaori	Review and monitor the training of tikanga best practice as it is applied across all departments of CM Health
	Develop and implement a robust training and development framework that is made available to all health services in the region
Service Planning	Establish a collective Maaori knowledge base to support Maaori health and hauora planning
	Regularly consult with Maaori networks to encourage information sharing to improve services planning and identify barriers to Maaori participation
	Develop mechanisms to support Maaori service users to independently identify their wellbeing aspirations-outcomes and to evaluate service responsiveness
Whaanau based quality	Ensure a inclusive health environment exists that encourages and actively supports whaanau to independently identify their hauora and health outcomes
	Agree the whaanau outcome measure for Maaori to evaluate service responsiveness for future implementation

2.2 Maaori Health Advisory Committee

The Maaori Health Advisory Committee (MHAC) as a sub-committee of the Board will provide advice, strategic direction and make robust recommendations to the CMDHB Board aimed at the acceleration of Maaori health gains to address ongoing Maaori health inequities. MHAC membership comprises of Board members, Manawhenua and Maaori health expertise from the wider community. This committee is not a substitute of the peer Board to Board relationship with Mana Whenua.

The MHAC will meet four times a year and will implement forums to facilitate community based wananga or learning environments to engage Maaori communities on issues of priority related to acceleration of Maaori health gains.

3.0 Demographic and Health Profile of Counties Manukau Maaori

3.1 Population Size, Age Distribution, and Growth

The estimated resident Maaori population in CMDHB for 2015/16 is 82,450, making up 16 percent of the Counties Manukau population and 12 percent of the New Zealand Maaori population.

In the 2013 Census, 83 percent of Maaori living in Counties Manukau identified with one or more iwi. The most common iwi affiliations were with Te Tai Tokerau or Tamaki Makaurau iwi (51 percent) and Waikato/Tainui iwi (26 percent).

Manawhenua from the Counties Manukau district comprise 8 hapu – Te Aakitai, Ngati Te Ata, Ngati Paoa, Ngai Tai, Te Kawerau A Maki, Ngati Taahinga, Ngati Amaru and Ngati Tipa.

Similar to the national Maaori population, Maaori in Counties Manukau are relatively young compared to the non-Maaori/non-Pacific population. Population estimates for 2015/16 suggest that 36 percent of the Maaori population in Counties Manukau are aged 15 years and younger, compared to 17 percent of the non-Maaori/non-Pacific population.

By 2032/33, the Maaori population in Counties Manukau is predicted to increase by 19 percent to reach just under 100,000. The non-Maaori population is predicted to increase by 28 percent, with Pacific and Asian populations predicted to increase by 36 percent and 50 percent respectively.

While population growth in the younger age groups is expected, growth in the number of people aged 65 years and older is also important. The proportion of the Maaori population aged over 65 years is projected to increase from 3,930 (5 percent) in 2015/16 to 8640 (9 percent) by 2032/33. This is a projected increase of 120 percent for the Maaori population aged 65 years and over.

3.2 Social Determinants of Health

At the time of the 2013 Census, 58 percent of the Counties Manukau Maaori population lived in areas classified as being the most socio-economically deprived (NZ Dep 9 and 10) in New Zealand, compared to 17 percent for European/Other and 76 percent for Pacific people living in Counties Manukau.

In 2013, 78 percent of Maaori adults (aged 15 years and over) in Counties Manukau did not own their own home; that figure was 58 percent for the total CM population and 41 percent for Pakeha adults. In 2013, 38 percent of Maaori tamariki aged 0-14 years were living in crowded households; that figure was 30 percent for the total CM population aged 0-14 years and 6 percent for Pakeha children.

In the 2006 Census, 27 percent of Maaori adults (aged 15 years and over so this included some rangatahi still at school) in Counties Manukau had achieved a post school qualification; the comparative figure for Pakeha adults was 43 percent.

3.3 Whaanau Wellbeing

Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013) showed that 76 percent of Maaori surveyed in Counties Manukau thought their whaanau were doing well or extremely well. A high level of connectedness with whaanau was reported and 83 percent of those surveyed said it was easy or very easy to get support from their whaanau. When asked about the importance of being engaged in Maaori culture, 71 percent of Counties Manukau respondents said it was very, quite, or somewhat important. Fifty-eight percent reported discussing or exploring their whakapapa or family history, 60 percent reported being involved in cultural practices such as singing a Maaori song, haka performance, giving mihi, taking part in Maaori performing arts and crafts, and 79 percent reported watching a Maaori television programme in the last 12 months. When asked about Te Reo Maaori, 35 percent of those surveyed were able to understand Te Reo Maaori very well, well, or fairly well; 25 percent were able to speak Te Reo Maaori very well, well, or fairly well; and 19 percent used Te Reo Maaori regularly in their home. Two-thirds of Maaori surveyed reported wairua (spirituality) being very, quite or somewhat important to their well-being.

3.4 Life Expectancy

Overall life expectancy (2011-2013 average) at birth for Maaori in Counties Manukau is 74 years. However, while Maaori life expectancy has been improving at a similar absolute rate compared with non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific is 9.5 years.

3.5 Disability

Based on the national 2013 Disability Survey, it is estimated there are approximately 20,000 Maaori people with disability[4] living in Counties Manukau, 25 percent of the total Maaori population of Counties Manukau, and 18 percent of all people in Counties Manukau living with disability. The most frequent type of impairment for Maaori adults is physical impairment, followed by sensory impairment, 'other' impairments including impaired speaking, learning and remembering, psychiatric/psychological impairment, and intellectual impairment. For Maaori children, the most frequent type of impairment is 'other' impairments (including impaired speaking, learning and development delay), followed by psychiatric/psychological, sensory, intellectual, and physical impairments. The most frequent cause of impairment for Maaori adults is disease or illness. Injury is also a frequent cause in Maaori adults aged less than 65 years. For Maaori children, the most frequent causes are conditions that existed at birth, disease or illness, and conditions that are categorised in the Survey as 'other causes' (including conditions on the autism spectrum, attention deficit hyperactivity disorder, developmental delay, dyslexia and dyspraxia).

3.6 Avoidable Mortality

Leading causes of avoidable mortality overall for Maaori in Counties Manukau (based on age-standardised rates) are ischaemic heart disease, lung cancer, diabetes, chronic obstructive pulmonary disease (COPD), and cerebrovascular disease. The top five causes by gender are listed below in Figure 3.

Figure 3: Leading causes of Avoidable Mortality for the Counties Manukau population aged 0-74 years, 2009-2011

Ethnic group	Males	Females	Total
Maaori population	Ischaemic heart disease Lung cancer Diabetes Liver cancer Suicide & self-inflicted injuries	Lung cancer Ischaemic heart disease Diabetes Breast cancer COPD	Ischaemic heart disease Lung cancer Diabetes COPD Cerebrovascular disease
Non-Maaori/Non-Pacific population	Ischaemic heart disease Lung cancer Suicide & self-inflected injuries Motor vehicle accidents Colorectal cancer	Breast cancer Lung cancer Ischaemic heart disease Colorectal cancer Cerebrovascular disease	Ischaemic heart disease Lung cancer Suicide & self-inflicted injuries Colorectal cancer Cerebrovascular disease

Reducing smoking prevalence and obesity, and improving CVD risk management, nutrition and physical activity would contribute significantly to reducing the leading causes of mortality. Encouragingly the Counties Manukau Maaori population smoking prevalence fell from 47 percent at the 2006 Census to 36 percent in the 2013 Census. However, smoking prevalence among Maaori is more than double that of the overall Counties Manukau population, and smoking prevalence among Maaori women aged 20 to 50 years is more than 40 percent.

[4] 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'

3.7 Avoidable Hospitalisations

Avoidable hospitalisation rates for Maaori in Counties Manukau are significantly higher than the non-Maaori/non-Pacific rates. The leading five causes of avoidable hospitalisation for the Counties Manukau Maaori population overall (based on age-standardised rates) are cellulitis, angina and chest pain, COPD, diabetes, and respiratory infections. The top five causes by age group are listed below in Figure 4.

Figure 4: Leading causes of Avoidable Hospitalisations for the Counties Manukau population, 2012-2014

Ethnic group	0-14 years	15-44 years	45-64 years	65+ years
Maaori population	Respiratory infections Dental conditions Asthma Cellulitis ENT infections	Cellulitis Sexually transmitted diseases Angina & chest pain Asthma Kidney/urinary infection	Angina & chest pain COPD Cellulitis Diabetes Respiratory infections	COPD Diabetes Respiratory infections Congestive heart failure Angina & chest pain
Non-Maaori/Non-Pacific population	Dental conditions ENT infections Respiratory infections Epilepsy Asthma	Angina & chest pain Cellulitis Sexually transmitted diseases Kidney/urinary infection Epilepsy	Angina & chest pain Cellulitis Diabetes Myocardial infarction Skin cancers	Angina & chest pain Skin cancers Diabetes COPD Respiratory infections

3.8 PHO enrolment

In estimating the percentage of Maaori enrolled in a PHO, it is important to be aware of the differences between ethnicity as recorded in the PHO enrolment register, ethnicity as recorded against the NHI, and ethnicity of the estimated resident population projections based on the 2013 Census. Comparisons suggest that ethnicity data derived from both PHO and NHI datasets underestimate Maaori and Asian populations while over estimating Pacific and European/Others. It seems likely that some people identified as Pacific or European/Other in the PHO register would be identified and prioritised as Maaori or Asian in Census-based population projections.

It is also important to be aware that there are different 'views' of the enrolled population. Presented here is the enrolment data for Maaori who are resident in the Counties Manukau area and who are enrolled with any PHO (some practices and PHOs are outside the Counties Manukau area). Another 'view' is that of Maaori who are enrolled with practices within the Counties Manukau area and who may live inside or outside the Counties Manukau area boundary.

Based on PHO enrolment data for Quarter 1 2015, 77,034 Maaori living in Counties Manukau are enrolled in a PHO, 94 percent of the estimated resident Maaori population for 2015[5]. Just over half the Counties Manukau Maaori population is enrolled in practices that are part of the Procare PHO. Twenty-two percent of Maaori are enrolled with Total Healthcare practices, 12 percent with Alliance Health+, 9 percent with National Hauora Coalition, and 4 percent with East Health.

Figure 5: PHO enrolment for Maaori resident in Counties Manukau[6]

PHO	Number of Maaori enrolled	Percentage of total Maaori enrolled
ProCare[7]	40,797	53%
Total Healthcare	16,871	22%
National Hauora Coalition	6,637	9%
Alliance Health+	9,050	12%
East Health	2,877	4%
Other PHOs	792	1%

[5] Denominator used for this calculation is the estimated resident population for 2015 (n=81,930), based on the 2013 Census.
[6] As at Q1 2015, sourced from PHO Register.
[7] Enrolment numbers for Procare include 473 Maaori enrolled with ETHC Otahuhu.

4.0 National Indicators

4.1.1 Data Quality

Improve the accuracy of ethnicity reporting in PHO registers

Accurate ethnicity data is a "necessary and critical step" in tackling health inequalities. Issues with misclassification of ethnicity data arise in all health data sources, including in primary care, resulting in an undercount of Maaori, Pacific and Asian ethnicities. Self-reported ethnicity data is important, not only for the accurate monitoring and reporting of programme performances, but also for appropriate targeting of individual patients and resources for certain programmes[8].

Accurate ethnicity data is important for informing the public and the health sector, identifying health need, service planning and funding, and monitoring activities. However there is currently inconsistency in the quality of health sector ethnicity data collection. In 2015/16 CM Health will implement the Primary Care Ethnicity Data Audit Toolkit (EDAT) to enable assessment and improvement of ethnicity data collection in primary health care settings.

Actions and Milestones

In partnership, CMDHB and PHOs to:

Scope implementation of EDAT in CM Health PHOs

- Q1: Undertake joint consultation and confirm the resources required to implement EDAT including the appointment of the EDAT project coordinator

Initiate implementation of EDAT in two CM Health PHOs

- Q4: Complete implementation of the three stages of EDAT to achieve 90 percent coverage of the general practices in two CM Health PHO's practices

Develop and provide EDAT training sessions for relevant CM Health DHB and PHO staff

- Q2: DHB and PHO staff complete EDAT training

Provide quarterly reports to MHAC on progress, issues and risks with mitigation strategies to address risks

- Q1-Q4: Implementation activities and milestones are achieved as per the implementation plan, and any issues are identified and addressed

	2014/15 Baseline	2015/16 Target
Percentage of general practices in 2 CM Health PHOs who have completed the 3 stages of EDAT	0%	50%

Monitoring Process

- Provide quarterly reports to the Maaori Health Advisory Committee on progress, issues and risks with mitigation strategies to address risks

4.1.2 Access to Care

Increase Maaori engagement in primary care and improve PHO enrolment rates

Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment will improve access to primary care services that enable early intervention and reduce health disparities between Maaori and non-Maaori.

Increasing Maaori new born enrolment in primary health care organisations (PHOs) is important so they can access health services, and health and social interventions to give them the best start in life[9].

		2014/15 Baseline	2015/16 Target
Percentage of Maaori enrolled in PHOs	Maaori	94.7%[10]	100%

Monitoring Process

- Quarterly monitoring of newborn enrolment rates by PHOs
- Quarterly updates to Maaori Health Gains Team and six monthly to MHAC

[8] Ministry of Health. (2013). Primary Care Ethnicity Data Audit Toolkit: A toolkit for assessing ethnicity data. Wellington: Ministry of Health http://www.health.govt.nz.
[9] Ministry of Health. (2014). Well Child Tamariki Ora Programme Delivery for 2013. Wellington: Ministry of Health.
[10] Using 2013 Census projections.

Actions and Milestones

Increase newborn enrolment rates

- Q1: In partnership with PHOs, develop an action plan to increase newborn enrolment
- Q1-Q4: Implement actions according to action plan
- Q1: Scope and investigate development of the 'High Five New Born Enrolment Initiative' (enrolment at birth with GP, National Immunisation Register, Well Child Tamariki Ora, Hearing and Vision and Community Oral Health Service)
- Q1-Q4: Ongoing monitoring of newborn enrolment rates
- Q1-Q4: 98 percent of newborns enrolled by 3 months

Implementation of the Primary Care Ethnicity Data Toolkit in 50 percent of general practices of 2 Counties Manukau PHOs - refer section 4.1.1

Reduce avoidable hospitalisations in Maaori

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting.

Age has a significant impact on admissions for some conditions, especially for newborns and children. For children (29 days–14 years) dental, otitis media/upper respiratory tract infections, asthma, gastroenteritis, pneumonia and cellulitis/skin infections are the major causes of ASH admissions. Angina, congestive heart failure, pneumonia and gastroenteritis admissions increase significantly as people age. Maaori and Pacific peoples had significantly higher admissions for asthma, congestive heart failure, epilepsy, pneumonia and cellulitis/skin infections[11].

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.

Actions and Milestones

Implementation of child and adult regional clinical pathways for cellulitis

- Q1:Development and implementation of a dynamic cellulitis clinical pathway linked with GP IT systems
- Q1-Q4: NRA to work with PHOs to support implementation of cellulitis clinical pathways including professional development for doctors and nurses

Targeted actions to reduce ASH rates for Maaori 0-4 years

- Q1-Q4: Increase newborn enrolment rates with PHOs, general practice and Well Child Tamariki Ora – refer section 4.1.2
- Q1-Q4: Increase the percentage of Maaori infants breastfed – refer section 4.1.3
- Q1-Q4: Increase immunisation rates and timeliness of immunisation for Maaori tamariki – refer section 4.1.7
- Q1-Q4: Improve enrolment with and access to oral health services for Maaori tamariki – refer section 4.1.8
- Q1-Q4: All children admitted to secondary care who meet the criteria are referred to Auckland Wide Housing Initiative (AWHI) and/or Warm Up Counties Manukau

Ambulatory Sensitive Hospitalisation rates		2014/15 Baseline	2015/16 Target
Maaori	Age 0-4	-	-
	Age 45-64	-	-
Total	Age 0-4	-	-
	Age 45-64	-	-

Note: There is currently work underway at the MOH towards developing new measures for ASH, therefore until this is confirmed the MOH do not expect DHBs to put baselines and targets in their Annual Plans.

Monitoring Process

- Quarterly reporting of ASH rates by ethnicity to MHAC, ELT and Maaori Health Gains Team
- Quarterly progress updates against each of the actions to Maaori Health Gains Team
- Implementation monitored by Northern Region Child Health Group
- Refer to section 4.1.2
- Refer to section 4.1.3
- Refer to section 4.1.7
- Refer to section 4.1.8
- Referrals are recorded and monitored monthly on the Kidz First Scorecard by the Directorate of Hospital Services

[11] Health Quality and Safety Commission. (2015). The Atlas of Healthcare Variation. Wellington: Health Quality and Safety Commission Http://wwwhqsc.govt.nz/our programmes.

▪ Q1: Investigate improved referral pathways for referrals to Auckland Wide Housing Initiative (AWHI) and/or Warm Up Counties Manukau ▪ Q1-Q4: Reduce smoking prevalence and smoking related-harm amongst Maaori – refer section 4.1.6 of this document and section 2.1.5 of the CM Health Annual Plan	▪ Refer section 4.1.6
Targeted actions to reduce ASH rates for Maaori 45-64 years Reduce smoking prevalence and smoking related-harm amongst Maaori ▪ Q1-Q4: Reduce smoking prevalence and smoking related-harm amongst Maaori – refer section 4.1.6 of this document and section 2.1.5 of the CMDHB Annual Plan ▪ Q1-Q4: Implement Year 3 of CMDHB's Smokefree 2025 initiative	▪ Refer section 4.1.6
Diabetes Management ▪ Q1-Q4 – Improve diabetes management - refer section 5.1.3	▪ Refer section 5.1.3
CVD Risk Assessment and Management ▪ Q1-Q4: Early identification, support and management of CVD amongst Maaori – refer section 4.1.4 ▪ Q1-Q4: Continue to work with the Northern Regional Cardiac Network and the MOH to establish CVD management indicators ▪ Q1-Q4: Monthly reports provided by PHOs to practices in order to monitor, understand and plan effectively for practice populations ▪ Q1-Q4: Medicine adherence (triple therapy) for secondary prevention i.e. management of > 20 percent risk	▪ Refer section 4.1.4
At Risk Individuals Programme ▪ Q1: Complete roll out of phase 1 of the At Risk Individuals (ARI) Programme, providing more planned, proactive care for patients with long term conditions, a number of which impact ASH rates for Maaori aged 45-64 years	▪ Quarterly monitoring by ARI Project Board
Note and linkages: Actions supporting immunisation, breastfeeding, B4 school checks, cardiovascular disease and smoking cessation make a significant contribution to reducing respiratory illness, ENT conditions, diabetes and cardiovascular disease. These are covered in other sections of this document.	

4.1.3 Child Health

Increase the percentage of Maaori infants breastfed

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 and recognition of traditional Maaori nurturing of tamariki and mokopuna.

Research in New Zealand indicates that for Maaori, having a breastfeeding culture in the whaanau, appropriate and accessible professional support and accurate knowledge about breastfeeding are keys to establishing and continuing breastfeeding[12].

Percentage of infants exclusively or fully breastfeed		2014/15 Baseline	2015/16 Target
Maaori	LMC discharge 4-6 weeks	52%	75%
Total		57%	
Maaori	3 months	38%	60%
Total		46%	
Percentage of infants receiving breast milk		**2014/15 Baseline**	**2015/16 Target**
Maaori	6 months	46%	65%
Total		61%	

[12] National BreastFeeding Committee of New Zealand, (2009). National Strategic Plan of Action for Breastfeeding 2008-2012. Wellington: Ministry of Health http://www.moh.govt.nz.

Actions and Milestones

Develop and deliver a workforce development and training initiative to maternity, child health, primary and secondary care health professionals working in Counties Manukau to improve health providers a) understanding and awareness of the barriers and challenges identified in the needs assessment regarding breastfeeding and the introduction of first foods; b) responsiveness and sensitivity to provide non-judgemental and culturally appropriate care; c) engagement with the wider whaanau/family when discussing breastfeeding, infant and toddler feeding and nutrition; d) understanding of health literacy

- Q1: Key project messages developed
- Q1: Initial engagement meetings with maternity, child health, primary and secondary care health professionals working in CMDHB
- Q1: Workforce training, framework, curriculum and resources developed
- Q1: Training of 100 priority 1 workforce completed
- Q1-Q2: On-going mentoring of workforce who have completed the training

In response to the need assessment findings and recommendations (which was completed in phase 1 of the project) develop and deliver a public health community initiative to support and improve breastfeeding and the introduction of first foods with a focus on Maaori, Pacific and South Asian whaanau and communities.

- Q1: Complete scoping of community models and service delivery options
- Q1: Project plan developed
- Q2-4: Activities implemented according to project plan with a focus of Maaori as one of the three target groups
- Q1-Q4: Project evaluation activities completed by external evaluator. Equitable access for to the community breastfeeding support for all three target groups will form part of the evaluation

Other actions

- Q1: Complete stocktake of community breastfeeding support and lactation services
- Q1: Work collaboratively with Well Child Tamariki Ora providers to strengthen their breastfeeding support services
- Q1: Review CM Health Breastfeeding policy
- Q1: Seek learning's from other DHB who have high breastfeeding rates
- Q1-Q4: Regular (six monthly) monitoring and review of breastfeeding data from Plunket and Turuki
- Q1-Q4: All Health professionals employed or access holders to CM Health Maternity Services undertake Baby Friendly Hospital Initiative education which has a Maaori component outlining historical and cultural barriers to breastfeeding for Maaori and how this can be remedied
- Q1-Q4: Community based organisations, self-employed and community midwives provide breastfeeding support
- Q2: Deployment of Tapuaki pregnancy and parenting programme via personal app on smartphones from TAHA to supports and influence breastfeeding
- Q4: Implement new outcomes framework
- Q1-Q4: Maintain BFHI (Baby Friendly Hospital Initiative) accreditation

Monitoring Process

- Six-monthly report on breastfeeding rates to Maaori Health Advisory Committee (MHAC) and MOH
- Quarterly report to MHAC on Infant Nutrition Project progress
- Monthly progress updates to Child & Infant Nutrition Expert Advisory Group

4.1.4 Cardiovascular Disease

Improve early detection and management of CVD amongst Maaori

Cardiovascular Disease (CVD) is the leading cause of death in CM Health. People with CVD and diabetes are associated with high level of health care costs, and have a significant impact on the health and social and economic wellbeing of Maaori individuals and whaanau. In 2008 Maaori had the highest age standardised CVD prevalence compared to other ethnic groups in the CM Health district. Focus on the prevention of cardiovascular disease, screening for CVD risk and appropriate management of CVD, including diabetes and alongside other chronic health conditions as gout is important for Maaori[13] [14].

Ensuring Maaori have equitable access to cardiovascular and diabetes risk assessments could reduce inequities in cardiovascular disease, gout and diabetes outcomes by detecting risk factors and disease at an early stage to prevent disease development, providing there is an appropriate management pathway once risk is identified.

Actions and Milestones

In partnership, CMDHB and PHOs to support general practices to increase the number of eligible Maaori who have had their cardiovascular risk assessed in the last 5 years

- Q1: Nurse led CVD risk assessment (CVDRA) clinics established in practices
- Q1: Outreach and after hours clinics established in practices
- Q3: Improvements in information technology (IT) resulting in improved and more timely data collection. This will support tracking of performance and identification of areas for improvement
- Q1-Q4: Monthly meetings between CM Health and the PHOs to review performance under all 5 IPIF indicators including CVDRA
- Q1: "Test safe" data used to complete non face-to-face CVDRA in all PHOs
- Q2: Patients who have not had a CVDRA in the last 5 years will be profiled to enable these groups to be targeted in all PHOs
- Q1: Active recall of patients who are overdue for CVDRA by text and phone calls
- Q2: Maaori and other high needs women supported with transport to attend clinics if required
- Q2: Free CVDRA are offered to some high needs patients in PHOs
- Q2: Explore opportunity of providing CVDRA in pharmacies to increase access for eligible Maaori
- Q2: Continue to explore the possibility of intersectoral and workplace screening
- Q1-Q4: CVD prevalence is higher in those who have diabetes and therefore prevention and management of diabetes is important to impact CVD outcomes

Acute Coronary Syndrome

- Q1-Q4: Continue to support ANZACS- QI nationally and collect data for the Cardiac register. This will enable CM Health to provide appropriate intervention and ACS risk stratification progress monthly
- Q1-Q4: Work within CM Health and the regional group, to improve outcomes for ACS patients using the ANZACS-QI data

Percentage of eligible population who have had their cardiovascular risk assessed in the last 5 years	2014/15 Baseline	2015/16 Target
Maaori	86.6%	90%
Total	91.2%	
Percentage of eligible Maaori tane aged 35-44 years who have had their cardiovascular risk assessed in the last 5 years	2014/15 Baseline	2015/16 Target
Maaori	70%	90%
Total	77%	
Percentage of high-risk patients who receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0')	2014/15 Baseline	2015/16 Target
Maaori	82.1%	>70%
Total	88.7%	
Percentage of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI data collection within 30 days	2014/15 Baseline	2015/16 Target
Maaori	100%	>95%
Total	96.6%	

Monitoring Process

- Monthly CVDRA data sent by the PHOs to the DHB by ethnicity
- Weekly monitoring at PHO level of practice performance
- Monthly data evaluation at DHB and PHO level
- Monthly reporting to CPHAC, ELT and Board
- Quarterly reporting to the MOH
- Monitoring of DHB performance by the Regional Cardiac Network members

[13] Chan W C, J. G. (2010). Health Care costs related to cardiovascular disease in CMDHB in 2008. Auckland: Counties Manukau District Health Board www.cmdhb.org.nz/aboutCMDHB/Planning/ Health Status/htm.

[14] Health Quality and Safety Commission. (2015). The Atlas of Healthcare Variation. Wellington: Health Quality and Safety Commission Http://wwwhqsc.govt.nz/our programmes.

- Q1-Q4: Continue to monitor wait list times to sustain current performance
- Q1-Q4: Quarterly reporting by ethnicity
- Q1-Q4: 70 percent of patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0'), reported by ethnicity
- Q1-Q4: 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days

Linkages: Further actions to support early detection and long-term condition management and to improve cardiac services are detailed in the 2015/16 CM Health Annual Plan and Northern Region Health Plan.

4.1.5 Cancer

Improve early detection and early intervention for cervical cancer in Maaori wahine

Cervical cancer is preventable, and the National Screening Unit recommends cervical screening for early identification of cervical cancer and prevention of invasive disease. Maaori have a lower coverage rate for cervical screening compared with non-Maaori. Improving cervical screening coverage rate for Maaori will support a reduction in Maaori cervical cancer mortality.

A framework has been developed to guide health practitioners, health organisations and the health system to achieve equitable health care for Maaori. The framework is endorsed by the National Screening Unit. To improve the number of eligible Maaori women who are screened for both cervical and breast cancer the following is required:

- Leadership – by championing the provision of high-quality health care that delivers equitable health outcomes
- Maaori knowledge – developing a knowledge base about ways to effectively deliver and monitor high-quality health care for Maaori
- Commitment – to providing high-quality health care that meets the health care needs and aspirations of Maaori[15].

Actions and Milestones

Promote cervical screening to Maaori wahine

- Q1: Work with the Auckland Regional Cervical Screening Coordination Service to develop a regional cervical screening awareness-raising strategy with a focus on reaching and engaging Maaori wahine aged 20-70 years in the Metro Auckland region
- Q2–Q4: Support implementation of the cervical screening awareness-raising strategy by working with community, iwi, ISP and primary care providers to promote key messages encouraging Maaori wahine aged 20-70 years to have regular cervical smears

Identify women who have not been screened or are underscreened (not screened in the past five years)

Complete a data match between the PHO Register and the National (or Regional) Cervical Screening Programme Register to enable more accurate identification of unscreened and underscreened priority/high needs women

- Q2: Data match completed with 2 PHOs
- Q3-Q4: Data match completed with remaining 3 PHOs
- Q3-Q4: Use EDAT implementation in two PHOs to improve the quality of ethnicity recording in primary care settings - refer to section 4.1.1. Data Quality

Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 36 months	2014/15 Baseline[17]	2015/16 Target
Maaori	62%	80%
Total	71.5%	

Monitoring Process

- Monthly Cervical Screening Coverage reports from the National Screening Unit
- Quarterly PHO Cervical Screening Coverage reports from DHB Shared Services
- Quarterly updates to Maaori Health Gains Team

[15] Cram F. (2014). Improving Maaori Access to Cancer Health Care: Literature Review. Auckland http://www.katoa.net.nz: Katoa Ltd.
[17] As at 31 December 2014

Support PHOs to successfully invite and recall Maaori women to cervical screening

- Q2: Deliver training/education sessions to all PHOs (that agree to undertake the training) on implementation on the 'How To Guide: Best Practice Manual for Cervical Screening'
- Q3: PHOs who have completed the data match in Q2 to generate lists of unscreened and underscreened enrolled priority/high needs women will have systems in place, particularly within their five lowest performing practices, to follow up/engage with the identified women to invite and recall them for smears
- Q3: Complete call centre activity with each PHO and their practices to action the lists of unscreened and underscreened priority women, utilising culturally competent staff to engage with enrolled women
- Q4: PHOs who have completed the data match in Q3 to generate lists of unscreened and underscreened enrolled priority/high needs women will have systems in place with practices to follow up/engage with the identified women to invite and recall them for smears
- Q4: All PHOs will have utilised their entire annual allocation of volumes for free cervical smears for priority women

Strengthen the communication skills of primary care provider staff to enable improved cervical screening health literacy and improved access to cervical screening services particularly for priority/high needs women

- Q2: Deliver a training session(s) in conjunction with the Auckland Regional Cervical Screening Coordination Service for primary care and Independent Service Provider[16] (ISP) staff and practitioners who have responsibility for engaging and communicating with women regarding cervical smears

Support collaborative working relationships between providers across the cervical screening pathway

- Q2: Improved referral pathways operating between primary care providers and ISPs will be in place enabling more targeted approaches for hard to reach priority high needs women
- Q1: 'Excellence Forum' on best practice activities to reach and engage Maaori women in the cervical screening pathway will have been delivered for primary care and community providers

Improve the experience of colposcopy for Maaori wahine

- Q1-Q4: Work with both ISPs and PHOs to actively engage and support hard to reach Maaori wahine through the cervical screening pathway including colposcopy
- Q2: Complete patient satisfaction survey to seek feedback to improve service delivery
- Q4: Review written information to patients (e.g invitation letters to attend colposcopy and leaflets explaining what colposcopy is) to ensure they reflect a patient and whaanau centred approach to care

Improve early detection and early intervention for breast cancer in Maaori wahine

Breast cancer is the second leading cause of cancer mortality for Maaori wahine. The National Screening Unit recommends breast screening to identify breast cancer early, enable earlier treatment, and reduce breast cancer morbidity and mortality. Maaori are one of the priority groups for the national BreastScreen Aotearoa programme. BreastScreen Counties Manukau (BSCM) and CMDHB are committed to increasing breast screen coverage rates among eligible Maaori wahine through BSCM and addressing barriers which impede access and uptake of breast screening[18].

Percentage of eligible women aged 50-69 years who have had a BSA mammogram in the past 24 months	2014/15 Baseline	2015/16 Target
Maaori	67.9%	70%
Total	71.1%	

Monitoring Process

[16] Independent Service Providers (ISPs) are support to screening service providers and are contracted by the MOH.
[18] Cram F. (2014). Improving Maaori Access to Cancer Health Care: Literature Review. Auckland http://www.katoa.net.nz: Katoa Ltd.

Actions and Milestones

Identify wahine who have not been screened or are under screened

Complete data matching with whare oranga, primary care practices and PHOs

- Q1: Visit and offer data matching to 26 practices
- Q2: Visit and offer data matching to an additional 26 practices
- Q2: Visit and offer data matching to an additional 26 practices
- Q4: Visit and offer data matching to the remaining practices in CMDHB (by Q4 all practices in CMDHB will have been visited and offered data matching)
- Q4: Complete data matching with 2 PHOs

Collate lists of wahine who have not responded to invitation or have not attended their screening appointments (DNR/DNA) for further follow-up, including after-hours phone calls

- Q1-Q4: Each quarter generate DNR/DNA lists for all mobile sites visited during the quarter and follow up 100 percent of Maaori wahine on the lists
- Q2 & Q4: Generate DNR/DNA lists for the fixed sites at Mangere and Manukau SuperClinic and follow up 100 percent Maaori wahine on the lists

Promote breast screening to Maaori women

- Q1-Q4: Attend events such as Poukai, Marae and Clinic based Hauora days and other events with high numbers of Maaori women attending to promote breast screening and encourage Maaori wahine to enrol and attend
- Q1-Q4: Work with Whare Oranga and Marae based clinics to promote the mobile visiting these sites

Support and encourage primary care (including PHOs) to successfully invite, enrol and recall wahine Maaori women onto to breast screening the BSA programme

During each practice visit, practices are provided with training about the BSA programme including eligibility criteria, priority groups and referral processes (including electronic referrals), provided with BSA resources and offered a data match. With the consent of the practice, BSCM will facilitate a mail out on behalf of the practice to women who are not enrolled in the programme.

- Q1-Q4: Refer above for milestones relating to practice visits
- Q2 & Q4: Breastscreen training evening/workshop delivered to practice staff

BSCM develops a regional plan in conjunction with stakeholders, primary care and ISPs, a minimum of 2 meetings per annum are held to discuss progress and to review the plan.

- Q1-Q4: BSA programme manager meets with ISPs and PHOs a minimum of twice a year
- Q1 & Q4: Regional co-ordination meetings held
- Q2 & Q4: Complete planning meetings with all PHOs and ISPs

BSCM will report on a monthly basis to CMDHB Maaori Health, and on a six monthly basis to BSA:

- Coverage - percent of women screened in the BSA programme
- Progress (number of practices visited and number of data matches carried out)
- Progress (number of Maaori women identified on DNR lists and number subsequently screened)
- Promotional activities undertaken
- Meetings held with stakeholders including ISPs and PHOs

4.1.6 Smoking

Reduce smoking prevalence and smoking related-harm amongst pregnant Maaori women

Tobacco use is the leading attributable risk factor to health loss in New Zealand. The prevalence of smoking for Maaori in Counties Manukau is 36 percent compared with 16 percent for the total population. For Maaori in the Northern region, lung cancer is a leading cause of cancer mortality and COPD is a prominent cause of hospitalisation.

Within Counties Manukau, an estimated 51 percent of Maaori women smoke at time of birth. All pregnant women should be referred to stop smoking services as soon as pregnancy is confirmed within a primary care setting or at booking with a midwife. Smoking cessation within 15 weeks gestation reduces all smoking related harm to the baby and mother. Support delivered via specialist stop smoking services is the most effective means of supporting pregnant women to quit.

Actions and Milestones

Continue to deliver Smokefree Pregnancy Incentives Pilot

- Q1-4: Continued delivery within existing localities
- Q2: Extend programme to Papakura
- Q1-4: Identify effective strategies to ensure all pregnant women in the pilot areas have access to the programme

Scope incentivising abstinence postnatally

- By Q4: Investigate whether incentivising abstinence postnatally for pilot participants reduces the relapse rate and make recommendation for implementation

Set targets for Maaori referral and engagement rates for smoking cessation, using current baseline data

- Q1: Baseline referral rates established and targets set
- Q1-4: Ongoing monitoring and targeted action to improve rates

Increase the number of referrals for Maaori wahine, ensuring that there is equal access to care via all midwives

- Q1-4: Address inconsistencies in referrals rates and promote proactive referring
- Q2: Explore Maaori specific training to upskill midwives to deliver smoking cessation messages for Maaori clients

Collaborate with Maaori Providers and marae to ensure effective interventions are provided

- Q1-4: Identify and develop referral relationships with key providers and marae who work with pregnant women, with a focus on those working with teen parents
- Q3: Scope efficacy of incentivising referrals from identified providers

Ensure providers of specialist smokefree pregnancy support are prioritising and promoting their services to Maaori communities and generating self-referrals

- Q1-4: Identify and share best practice service delivery for pregnant Maaori women across all specialist smokefree providers
- By Q2: Provide guidance to providers on expected outcome rates for both pregnant and whaanau clients
- Q1-4: With providers, identify new strategies to increase the proportion of self-referrals for pregnant women
- Q1-Q4: Increase referral rates at time of birth for all women who smoke to support postnatal abstinence

Percentage of pregnant Maaori wahine who are smokefree at 2 weeks postnatal	2014/15 Baseline	2015/16 Target
Maaori	To be established	86%
Total		

Monitoring Process

- Quarterly review of performance data from MOH and audits of systems other than MMPO (My Practice, Patrac)
- Monthly review of referral rates by ethnicity and referral source
- Monthly monitoring of incentives programme outcomes including 4 and 12 week quit outcomes as defined by National Tier One service specs
- Qualitative analysis from focus groups with clients and midwives scheduled over the quarters.
- Consulting with DHBs testing the incentivisation postnatal on a quarterly basis
- Service data from providers working with hapu wahine via monthly reports to the DHB

Showcase whaanau quitting stories

- Q1-4: Showcase whaanau quitting stories and monitor impact on self-referrals
- Q1: Introduce referral intervention at time of birth for all women who smoke and evaluate long-term quit outcomes
- Work collaboratively with Well Child Tamariki Ora (WCTO) providers to support sustainability of smoking cessation or abstinence for whaanau
- Q2: Develop an action plan in partnership with WCTO providers to support postnatal and whaanau smoking cessation or abstinence
- Q2-Q4: Implement actions as per action plan

4.1.7 Immunisation

Reduce the prevalence and impact of vaccine preventable diseases in tamariki Maaori

Vaccination can protect newborns and infants from infectious diseases and broader community protection via 'herd immunity'. To ensure that tamariki Maaori have the best start in life and are protected, barriers which impede Maaori newborns and infants having their immunisations on time will be addressed. With Maaori whaanau and communities CM Health will achieve the target that 95 percent or more Maaori infants have completed their primary course of immunisation on time by 8 months of age[19].

Maaori children have significantly lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases compared with non-Maaori children. Ensuring that vaccination coverage at eight months exceeds the national target is a critical component to enabling Maaori children to achieve the best possible state of health.

Actions and Milestones

- Q1-Q4: Continue to deliver targeted immunisation strategies to achieve 95 percent coverage for Maaori children for the 8 month and 24 month milestone targets
- Q2: Develop an immunisation action plan to ensure that 95 percent of four year olds are fully immunised
- Q1-Q4: DHB Immunisation Alliance and Steering Group is made up PHO nurse leaders, Well Child Providers, Nurse Leader Immunisation, Nurse Leader Maaori Health and Pacific Health, and representation from Maternity Services. This group will meet monthly to:
  - Continually review and update the immunisation strategies
  - Monitor and evaluate immunisation coverage at DHB, PHO and Practice level, manage identified service delivery gaps
  - Drive service changes within the sector
- Q1-Q4: Monthly monitoring and evaluation of immunisation coverage by DHB National Health Target Working Group
- Q1-Q4: CM Health representation and attendance at Regional and National immunisation forums
- Q1-Q4: Immunisation Nurse Leader to work with all practices with low Maaori and high needs coverage rates and meet individually with each practice to improve performance measured by the datamart report in the following month

Percentage of infants who have completed their primary course of immunisation on time by 8 months of age	2014/15 Baseline	2015/16 Target
Maaori	88%[20]	95%
Total	93%[20]	

Monitoring Process

- Weekly monitoring of progress by DHB Immunisation Nurse Leader
- Monthly datamart report evaluation at DHB, PHO and Practice level
- Monthly reporting to CPHAC, ELT and Board
- Quarterly reporting to MHAC and MOH
- Monthly monitoring and evaluation of immunisation coverage by DHB National Health Target Working Group

[19] Ministry of Health. (2014). Well Child Tamariki Ora Programme Delivery for 2013. Wellington: Ministry of Health.
[20] As at Quarter 2, 2014/15

- Q1-Q4: Use a collaborative approach to offer parents, whaanau and caregivers support to attend immunisation appointments and/or offer outreach in alternative venues
- Q1-Q4: Prioritisation of Maaori pepe and tamariki for immunisation outreach services
- Q1-Q4: Connecting immunisation outreach services with the WCTO Provider who has been providing WCTO services to the pepe/tamariki to enable outreach and follow up to be done by a health professional the whaanau is familiar with
- Q1-Q4: Active follow up on declines by Immunisation Nurse Leader to provide additional information to parents and whaanau on the benefits of immunisation and to address any concerns and questions
- Q1-Q4: All children presenting to Kidz First services (as inpatients or ED presentations) will have their immunisation status checked and opportunistic immunisations provided
    - Q4: Investigate expanding the checking of immunisation status and opportunistic immunisations to outpatient appointments
- Q1-Q4: Increase new born enrolment rates:
    - Continue working with maternity and primary care partners to monitor the newborn enrolment rates
    - Work with primary care to establish a process to ensure all newborn enrolments are accepted
    - Refer Access to Care section 4.1.2
- Q3-Q4: Actively promote and participate in 'Immunisation Week'
- Q1: Develop an immunisation education and event calendar jointly with primary care and NGO sectors to include various promotional activities e.g. radio talk-back interviews, Reminder Cards, PHO incentives
- Q2: Establish formal links with intersectoral providers and agencies to assist with promotional activities as well as tracking families not currently engaged with health services and timely referrals to outreach immunisation providers

Measures

- 85 percent of 6 week immunisations are completed (measured through the completed events report at 8 weeks)
- 95 percent of eight months olds are fully immunised (6 weeks, 3 months and 5 months immunisation events)
- 95 percent of two-year-olds are fully immunised
- Coverage rates for Maaori equal to non-Maaori
- 90 percent of 4 year olds are fully immunised before their 5th birthday

Reduce the prevalence and impact of seasonal influenza in vulnerable Maaori aged 65+

Influenza can have significant complications for the population aged 65 years and older, which can result in hospitalisation, significant morbidity, and mortality.

Actions and Milestones

During the flu season, review CM Health influenza vaccination coverage data at ethnicity level with each PHO and where required support PHOs to identify actions to improve Maaori coverage for kaumatua and kuia

Percentage of the eligible population 65 years and over who have had a seasonal influenza vaccination	2014/15 Baseline[21]	2015/16 Target
Maaori	66%	75%
Total	67%	

Monitoring Process

- Quarterly Influenza Vaccination Coverage reports from DHB Shared Services

[21] As at Quarter 2 2014/15

- Q1 & Q4: PHOs complete quarterly monitoring and reporting of flu vaccination coverage by ethnicity at monthly PHO / DHB forums
- Q1 & Q4: PHOs identify and complete actions to improve coverage rates for Maaori where required

Promote the benefits of flu vaccination to Maaori aged 65+ by (a) supporting PHOs to carry out promotions through their networks and media and (b) profiling local kuia/kaumatua as flu vaccination champions in community publications

- Q1: Article on influenza and photo opportunity in local paper with Kaumatua and Kuia at Papakura Marae receiving vaccinations
- Q1: Promote access for Maaori to clinics for influenza vaccinations through the immunisation working group /PHO Nurse Leaders

Q1: Promote and offer opportunistic influenza vaccination/referral to 'health care home' to Maaori 65+ who have contact with inpatient and outpatient DHB services

Support Maaori providers of primary and community health services to promote and encourage flu vaccinations for Maaori aged 65+ at community events

- Q1: Kuia/kaumatua flu vaccination champion promotional campaign completed
- Q1: Promotion and awareness-raising of the benefits of flu vaccination carried out at a minimum of four community events including the Manukau Health Expo event
- Q1: Influenza vaccination provided at Marae clinics
- Q1: Encourage Maaori patients to visit GP or Nurse for funded vaccination

- Quarterly updates to Maaori Health Gains Team

4.1.8 Rheumatic Fever

Reduce rheumatic fever rates in tamariki Maaori and whaanau

CM Health has the highest number of rheumatic fever notifications in comparison to all DHBs, and has an overall rheumatic fever rate of 13.2 per 100,000 population. There has been a large investment by CM Health in our rheumatic Fever prevention Plan with the aim to reduce the incidence of rheumatic fever among all tamariki in Counties Manukau

Actions and Milestones

Deliver activities and actions as per current CM Health Rheumatic Fever Prevention Plan. This plan can be found at:

http://www.countiesmanukau.health.nz/about-us/performance-and-planning/planning-documents/#Rheumatic_Fever_

- Review the school based throat swabbing service, in view of evaluation findings and the withdrawal of MOH funding, with the aim of developing a sustainable model within funding constraints
- Q1-Q4: Work with the National Hauora Coalition to deliver sore throat swabbing services to 61 schools in Counties Manukau until December 2015
- Q1-Q4: Work with CM localities to enhance the delivery of the school based rheumatic fever prevention programme
- Q2: Work in partnership with the Ministry of Health to agree funding for sore throat swabbing services when contracts end in 2015
- Q1: Develop and agree a sustainable pathway for the service long term
- Q1-Q4: Continue with the rapid response clinics as agreed between the MOH and the Rheumatic Fever Alliance Leadership Group

Acute rheumatic fever first hospitalisations rates per 100,000 population	2009/10-2011/12 Baseline	2015/16 Target
Maaori	-	5.9 per 100,000 (32 cases)
Total	13.2 per 100,000	

Monitoring Process

- Monthly updates to CPHAC
- Quarterly reporting to MHAC and MOH

- Work with the provider arm and primary care to develop systems to identify families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and/or Pacific) living in crowded housing with 100 percent being referred to Auckland Wide Housing Initiative (AWHI)
- Work collaboratively with primary and community service partners to develop systems that ensure that people with Group A strep have begun treatment within 7 days
- Q1-Q4: Continue to work with the provider arm to ensure that the notification of acute rheumatic fever to the Medical Officer of Health occurs within 7 days
- Q1-Q4: Secondary care clinicians will review cases of rheumatic fever to identify risk factors and system failure points
- Q1: Work with Primary Care to understand the number of people receiving prophylaxis through General Practice rather than through community nursing services

- Q1: Review and update the Rheumatic Fever Prevention Plan
- Q1-Q4: Deliver activities as per the updated Plan

4.1.9 Oral Health

Increase early detection and intervention for improved oral health among tamariki Maaori

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. Tamariki Maaori are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and better target those most in need.

The aim of the community oral health service is "every child is able to enter adulthood pain free, disease free, with functional dentition and positive dental self-esteem". Improving access and barriers to good oral health and dental care for Maaori infants will address current dental and oral health inequalities for this population and support them to have a good start in life[22,23].

Actions and Milestones

Improve access for children aged 0-4 years to Community Oral Health Services (COHS):

- Q2: Review of Preschool and Adolescent Oral Health strategy to better meet targets and improve Oral Health outcomes for Children and Young people
- Q2: Review the process for enrolment, risk assessment and signed consent of babies by WCTO providers in Community Oral Health Services (COHS) at the 9 month check to facilitate the uptake of examinations in COHS clinic by 12 months
- Q1: Scope early enrolment in COHS at 3 months for high risk, focussing on earlier enrolment of children from Maori, Pacific and high deprivation communities
- Q1-Q4: Training of 'Lift the Lip' to be offered to Primary Care / WCTO providers
- Q1-Q4: Oral Health education is provided to parents and caregivers by WCTO Providers at all core contacts, and includes advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments

Percentage of preschool children 0-4 years enrolled in the community oral health service	2014/15 Baseline	2015/16 Target
Maaori	69.6%	85% by Dec 2015 95% by June 2016
Total	76%	95% by Dec 2016

Monitoring Process

- Monthly service metrics - reported to CHAC quarterly, MOH 6 monthly including preschool enrolments as percentage of population by ethnicity and age year, utilisation ie examinations as percentage population, Arrears, DNAs, Referrals, Preventative treatments
- Annual oral health outcomes targets reported to CPHAC and MOH annually ie preschool enrolments as percentage of population by ethnicity and age year, Caries free percentage five years population, mean dmft (decayed missing, filled teeth) five years population by ethnicity, mean DMFT (Decayed Missing, Filled Teeth) of year 8 students by ethnicity, and examination Arrears

[22] RothnieJ,J, W. M. (2012). An exploratory study of pregnant women's knowledge of child oral health care in New Zealand. NZ Dent.J, 108(4) 129-33.
[23] Kilpatrick NM, G. M. (September 2008). Maternal and Child Oral Health- Systematic Review and Analysis; A report of the New Zealand Ministry of Helath. Children's research Institute.

- Q1-Q4: WCTO providers deliver 'Lift The Lip' examination at every core contact and refer any concerns to COHS
- Q1-Q4: All children to be examined in a COHS dental clinic by their 1st birthday
- Q1-Q4: Oral Health education is provided to all preschool centres, ECE, Kohanga Reo, Language nests, and Kindergartens to facilitate enrolments, referrals and liaison with COHS
- Q1-Q4: Extending hours of service at community dental hub clinics to weekday evening and Saturdays subject to localised demand and to assist in reduction of DNAs
- Q1-Q4: SMS/text message reminder systems to parents of preschool tamariki to assist in reduction DNAs
- Q2: Develop process for follow-up of persistent DNAs in preschool patient group through WCTO, PHN or community health workers

4.1.10 Mental Health

Reduce health disparity for Maaori with regards to the use of Mental Health Act: Section 29 Compulsory Treatment Orders and continue to reduce seclusion and restraint rates

There is a pressing need to address and reduce the health disparity for Maaori with regards to the use of Community Treatment Orders.

Actions and Milestones

Identify and review the factors influencing the health disparity for Maaori with regards to the higher rate of compulsory community treatment orders (CTO's) under the Mental Health Act 1992: Section 29

Review the process to monitor compliance and timeliness of MH Act reviews

Identify and review the factors influencing application for and release from the Mental Health Act 1992: Section 29

- Q2: Identify factors that contribute to the higher rate of Maaori service users under a CTO in CM Health mental health services
- Q3: 100 percent compliance of s76(3) certificate medical reviews completed within legislated timeframes for all patients with CTO's
- Q3: Propose a prioritised solution to address the higher rate of Maaori service users under a CTO in CM Health mental health services
- Q4: Pilot implementation of highest priority solution with a view to successively implementing the solution across the 6 adult teams/services (I.e. 4 CHMCs, ICT, Te Puna Waiora) thereafter

Continue to reduce seclusion and restraint rates with a particular focus on Maaori. Refine procedures to ensure there is cultural capability and capacity for appropriate Maaori engagement before, during and after admission

- Q2: Two hourly reviews of use of seclusion include a Kaumatua, Kuia or culturally trained Maaori staff member to help re-establish rapport and reduce time in seclusion
- Q3: All Maaori admitted to the acute unit have a consultation with a Kaumatua, Kuia or culturally trained Maaori staff member within 24 hours to establish whanau/iwi links
- Q4: Reduce average time spent in seclusion by 50 percent

		2014/15 Baseline	2015/16 Target
Mental Health Act: Section 29 Community Treatment Order rates per 100,000 population	Maaori	216.4[24]	-
	Total	85.7[24]	
Average time spent in seclusion	Maaori	23 hours	Reduce by 50%
	Total	14.9 hours	-
Percentage of 2-hourly reviews of use of seclusion that include Kaumatua, Kuia or culturally trained Maaori staff member	Maaori	0%	100%
Percentage of clients admitted to the acute unit who have a consultation with Kaumatua, Kuia or culturally trained Maaori staff member within 24 hours	Maaori	0%	100%

[24] July to December 2014

Monitoring Process

- Provide quarterly reports to the Maaori Health Gains team on progress, issues and risks with mitigation strategies to address risks

Input into the quarterly updates will come from:

- Monthly project meetings within Mental Health and Addiction services
- Monthly service metrics from iPMS legal tracking database and HCC database
- Weekly risk review exception reports

4.1.11 Sudden Unexpected Death in Infancy (SUDI)

Reduce SUDI rates in Maaori infants

Since 2002, the sudden unexpected death in infancy (SUDI) rate for Maaori and other ethnic groups has remained fairly stable, with persisting disparities.

Counties Manukau are one of the district health boards that have a significantly higher SUDI rate and where families were less likely to be provided SUDI information at GP/ WCTO provider core contact one.

In response to this CM Health have developed programmes to collaborate to reduce SUDI risk factors by early engagement in maternity services, smoking cessation in pregnancy, safe sleeping environment for baby, increasing breastfeeding rates and duration, earlier engagement with Well-child/Tamariki Ora providers, and earlier enrolment of babies in all key health support services. Recommendations from the Child Youth Mortality Review Committee have been included in the development of the Northern Regional Alliance (NRA) DHBs SUDI 5 year Action Plan.

A significant part of the uptake and implementation of the SUDI / Safe Sleep messaging is through the Safe Sleep / SUDI Coordinator. This role is dedicated to facilitating and progressing the SUDI Action Plan across Counties Manukau Health and maintaining strong relationships regionally, and with Whakawhetu and TAHA.

Community and intersectoral linkages are facilitated through monthly Safe Sleep Champion meetings, and quarterly Community Network hui. The Safe Sleep Coordination role facilitates education through health and community organisations, engagement with community events (e.g. Waitangi Day Manukau and Safe Sleep day), sharing resources, and facilitating access to safe sleep devices. Further engagement of community networks is progressing to action the promotion of Pregnancy and Parenting education opportunities with Maaori whanau incorporating key SUDI messages and support services.

Actions and Milestones

Workforce Knowledge and Development

- Q1-Q4: Encourage and support heath providers involved with families in the antenatal and postnatal period to access SUDI training options available
- By Q4: All CM Health child health and maternity related contracts will include SUDI training as part of workforce development programmes

Primary Care SUDI risk screening and utilisation of the Risk Assessment tool

- In collaboration with PHOs, pilot of Prof. Ed Mitchell's SUDI risk assessment tool for use in patient management systems in Primary Care

SUDI deaths per 1,000 live births		2010[25] baseline	2015/16 Target
	Maaori	2.48	0.5 deaths per 1000 live births
	Total	1	
Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1	Maaori	45%	100%
	Total	65%	

Monitoring Process

Monitoring will be based on quarterly reports that monitor progress against milestones as outlined in left-hand column. These progress updates will be monitored through the following forums at least quarterly:

- Maaori Health Gains Team
- PHAC forum
- CM Health Executive Leadership Team meetings
- Manawhenua Board meetings
- MHAC quarterly meetings
- Locality Leadership Groups
- CM Health SUDI Governance Group
- Regional SUDI Governance Group
- 6 monthly reporting to the MOH on the community engagement initiative

- Quarterly reports on # of health providers working with families in antenatal and postnatal period completed Safe Sleep / SUDI education
- Quarterly PHO report percent and number of babies identified for risk screen tool

[25] 2010 mortality data is the most recent data available due to the delay in receiving coded mortality data

- Collaborate with PHOs to ensure that every child immunised at 6 week check is screened using the screening question(1) Smoking in Pregnancy 2) bed-sharing, to identify higher risk infants; provision of SUDI risk information and PEPE messaging is documentedQ1-Q2 Northern Regional collaboration to support implementation of tool being piloted in specific PHOs
- Q3-Q4 Phased implementation with PHOs of (MEDTECH) Screening pop-up questions (1) Smoking in Pregnancy 2) bed-sharing, to identify higher risk infants who are then automatically linked to the full SUDI Risk Assessment tool

CM Health SUDI strategy is aligned to the NRA SUDI 5 year Action Plan

- Increase the number of women who register with an LMC in their first trimester of pregnancy through:
  - Q2: Implementation of GP referral pathways to encourage early referral before 10/40 to a Midwife. The referral pathway triggers either direct referral to a Self Employed Midwife for women suitable for Primary Care or to the DHB referral system
  - Q2: Regional development of GP referral pathways for pregnant women to provide a consistent approach in Primary Care to cater for women who reside in one area but choose to birth in another
  - Q1: Implementation of a marketing campaign encouraging pregnant women to engage with an LMC in the first trimester of pregnancy
- Ensure a minimum of 30 percent of Maaori pregnant women access antenatal and early parenting education
  - Q1: Develop revised curriculum with a focus on Maaori, Pacific and teen pregnant parents
  - Q2: Retender pregnancy and early parenting education services to identify and contract culturally appropriate providers to provide targeted antenatal and early parenting education to Maaori and Pacific pregnant women
  - Q2: Develop and provide alternate methods of delivery of antenatal and early parenting education suited to Maaori, Pacific and teen pregnant mothers - refer to "Whanau Hapu Waananga" section below
  - Q1-Q4: Ongoing monitoring of access rates and participation in antenatal and early parenting education
- Increase newborn enrolment rates – refer section 4.1.2
  - Q1: Scope and investigate development of the 'High Five New Born Enrolment Initiative' (enrolment at birth with GP, National Immunisation Register, Well Child Tamariki Ora, Hearing and Vision and Community Oral Health Service
  - Q2-Q4: Review referral and enrolment protocols as part of the WCTO Quality Improvement Framework
- Develop a process to ensure ongoing sustainability of safe sleep programme
- Review and develop a regional safe sleep programme model of distribution of safe sleep devices for high risk population and resource required for on-going management
- Safe Sleep policy and PEPE messaging is implemented in all maternity wards and primary units and monthly safe sleep audits completed and recorded
  - Q1-Q4: All babies in unsafe sleeping environments at risk of SUDI are identified , and referred to Safe Sleep Team for intervention of Safe Sleep programme and if required a safe sleep device
  - Q2: 100 percent compliance with safe sleep policy in all CM Health Primary and Birthing units and maternity ward

- Quarterly monitoring of access rates and participation in antenatal and early parenting education by ethnicity
- Audits reported monthly to Quality and Risk Manager Kidz 1st & Womens Health and SUDI Governance, 6 monthly to NRA

- Q3: Plan developed for regional safe sleep programme management of safe sleep devises and resource
- Q4: Process for ongoing sustainability of safe sleep programme developed

Activities to Support SUDI Risk factors ie P.E.P.E.:

PLACE baby in own baby bed, face clear of bedding

- LMC/midwife in 1st week visit assesses sleep environment and baby bed, provision of safe sleep information and PEPE messaging documented. Referral of whanau with unsafe sleeping environment to Safe Sleep team for intervention
  - Q1-2: Work programme developed by Safe Sleep Coordinator in partnership with LMC to improve service quality to ensure safe sleep environment
  - Q1-2: Development of a referral process for LMCs to assist parents in accessing safe sleep devices
  - Q2: Investigate feasibility of a safe sleep environment assessment alert at handover to WCTO/GP
- Implement and monitor provision of SUDI risk information and PEPE messaging at WCTO Core Contact 1 via WCTO Quality Improvement Framework
  - Q1-Q4 LMC and WCTO assessment of sleeping environment, provision of SUDI risk information and PEPE messaging is documented, and intervention strategy for whanau initiated where required

ELIMINATE smoking in pregnancy & protect baby with smokefree whanau, whare & waka

- Q1-Q4: All pregnant women who smoke are offered brief advice and support to quit
  - Q1-Q4: Ongoing monitoring of mandatory alert of smoking in pregnancy at midwife booking interview or admission to maternity facilities and referral to Smoking Cessation Services for follow-up
  - Q2: Develop automated referral system to smoking cessation support for all pregnant women who smoke
- Reduce smoking prevalence and smoking related-harm amongst Maaori – refer section 4.1.6 of this document and section 2.1.5 of the CMDHB Annual Plan
- Q1-Q4: Implement Smoking Cessation in Pregnancy Plan

ENCOURAGE and support Mum to breastfed

- Increase the percentage of Maaori infants breastfed – refer section 4.1.3

Community based SUDI initiative with focus on engaging with Maori in "Whānau Hapu Waananga"

- Stakeholder engagement to develop the Community based initiative to engage Maaori whanau early in pregnancy in a series of "Whānau Hapu Waananga" (comprehensive childbirth and post-natal education programme to reduce SUDI risk factors)
- Identification, development and training of the SUDI initiative with community organisations. Waananga to be held in 4 CM Health localities
- Identified community organisations support hapu Mama and whanau with an open invitation to participate in Waananga
- Waananga will provide activities and information on key SUDI messages, antenatal wellbeing & healthy eating, smoking cessation, alcohol free pregnancy, breast feeding and baby care including Safe Sleep messaging
- Opportunity for Mothers to create (weave) a safe bed for their baby whilst learning a traditional skill (weaving) in a well-supported Kaupapa Maaori framework

- Referrals to Safe Sleep team actioned, monthly reporting of reason for referral, and actions taken

- Quarterly Reporting of referrals to Smoking Cessation and utilisation of pregnancy incentive programme

Quarterly reporting:

- Number of Waananga, coverage localities and community organizations
- Number of Maaori hapu mama and whanau support participating
- 100 percent of hapu mama participants are enrolled in maternity services
- Number of participants referred to Smoking Cessation services
- 100 percent of hapu Mamas have a safe baby bed planned for their baby
- Evaluation feedback form at Waananga; participation in post-natal support
- Percent and number of Waananga participants utilise breast feeding support

- Q1: Project plan and specifications agreed for "Whānau Hapu Waananga" with stakeholders
- Q2: Identification, development, procurement and training of the SUDI initiative with community organisations
- Q2-4 to Q1 2016: Implementation of the Waananga

5.0 Local Indicators

5.1.1 Workforce Development

Maaori health workforce development, recruitment and retention are key enablers in our quest to reduce health inequalities by improving outcomes for Maaori. A highly trained and robust Maaori and non-Maaori health workforce will better enable us to meet the needs of our diverse communities and populations. At the very least the Counties Manukau Health workforce needs to better reflect the demographics of our community, patients and whaanau we serve. This is particularly the case for our Maaori workforce, who in comparison to our population is significantly underrepresented in all employment areas.

Workforce Percentage by Ethnicity

Based on population estimated, Maaori make up 16.3 percent of the population serviced by CMDHB and 7.1 percent of CMDHB employees, a variance or gap of 9.2 percent. This means that the number of Maaori employees would need to more than double to reflect the estimated population.

	Asian	European & Other	Maaori	Pacific Island
percent of Workforce (Headcount)	29.8%	53.0%	7.1%	10.2%
Counties Population Estimate	23.0%	37.6%	16.3%	23.1%
Variance	6.8%	15.4%	-9.2%	-12.9%

Actions and Milestones

- Q1: Develop and implement a robust performance monitoring system that will enable systematic and accurate monitoring of the Maaori health workforce at CMDHB
- Q1–Q4: Implement the Maaori Workforce Development Strategy
- Q1: Implement workforce strategies for the recruitment of tertiary students that are enrolled with Kia Ora Hauora that have indicated a desire to work for CM Health

Increase Maaori Nursing Workforce

The CM Health nursing workforce represents the largest regulated workforce employed across CM Health and is often the first point of contact for Maaori patients and whaanau. Increasing the Maaori workforce in this area would reflect the demographics of the population served by CM Health. The recruitment, professional development and cultural competence of this group is critical to improving health outcomes and the quality of services for Maaori patients and whaanau

- Q2: The NETP process and nursing assessment models support an increase in the number of Maaori nurses employed

Percentage of CM Health employees who are Maaori		2014/15 Baseline	2015/16 Target
	Maaori	7.1	8% (55 new Maaori employees)

Monitoring Process

Monitoring will be based on the regular reporting of the following dashboards:

- PHO level Counties Manukau Maaori Health Plan Indicator Dashboard – Quarterly

These will be monitored through the following forums at least quarterly:

- PHO CEO forums
- CM Health Executive Leadership Team meetings
- Manawhenua Board meetings
- MHAC quarterly meetings
- Locality Leadership Groups

Developing our future workforce is an essential activity if we are to achieve a health workforce that better reflects the community we serve. This will continue be a priority for CMDHB

- Q1: Implement a targeted Rangatahi programme aimed at increasing the number of Maaori into tertiary level health programmes
- Q1-Q4: 150 local Maaori students are engaged in health careers programmes, such as Kia Ora Hauora or are actively engaged in 2 or more future workforce activities
- Q2: A minimum of 20 Year 13 students have identified a chosen course and applied for foundation or tertiary study towards a health field in 2016

Having accurate workforce data is essential to planning and developing our future health workforce. A core part of this activity is to ensure our current workforce data is accurately reported by ethnicity

- Q1: Commence a project that collects accurate ethnicity of our not declared nursing workforce

Retaining our current workforce is an essential activity if we are to achieve a health workforce that better reflects the community we serve. This will continue be a priority for CMDHB

- Q1-Q4: Implement a number of activities that will strengthen and promote CMDHB as the employer of choice for Maori health professionals (current & future)

Developing the capability of our current workforce to work effectively with Maaori and to reduce Maaori health disparities/inequities is essential if we are to accelerate Maaori health gains in our district

- Q1: Implement a cultural competence programme that develops the wider workforce capability to work with Maaori with a view to addressing Maaori health inequities

5.1.2 Mental Health

Improve and preserve the mental wellbeing of rangatahi Maaori

CM Health are taking a broad strategic approach to the planning of youth health services for rangatahi Maaori, which includes meeting the objectives of the Prime Minister's Youth Mental Health project. The new Youth Health model of care will unite youth services across many different service providers and settings. Working collaboratively across the sector and with other agencies, we will develop clear inter-agency pathways between health, education and justice, in order to intervene earlier for those most at risk of developing mental health and addictions issues. There will be a strong focus on integrated youth health services including primary care, mental health and addictions services and the Centre for Youth Health.

Actions and Milestones

Youth Primary Mental Health

- Increase the number of rangatahi Maaori accessing Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions
- Q4: Increase 30 percent from established baseline (possibly around 40-50 going on current performance at Q2) to 65
- Q4: Increase 30 percent from established baseline (possibly around 130 going on current performance at Q2) to 170

Number of rangatahi accessing Alcohol Brief Interventions		2014/15 Baseline	2015/16 Target
	Maaori	12	Increase 30% from established baseline
	Total	58	

Number of rangatahi accessing Mental Health Brief Interventions		2014/15 Baseline	2015/16 Target
	Maaori	7	Increase 30% from established baseline
	Total	72	

Monitoring Process

- Quarterly Primary Mental Health reporting from PHOs
- Manawhenua Board meetings
- MHAC quarterly meetings

Improve the responsiveness of primary care to youth

- Identify gaps in responsiveness, access, service provision, clinical and financial sustainability for rangatahi Maaori and to feed into the WOS Youth Health Model of Care
- Appropriate pathways for rangatahi Maaori, aligned with the new model of care, are refined, to ensure early intervention, referral, support, advice, advocacy and mental health and addiction support
- Q2: Stocktake of youth health services undertaken to complement previous stocktake, with a focus on services for rangatahi Maaori
- Q2: Appropriate pathways are implemented to ensure rangatahi Maaori are connected to services

- Quarterly reporting to the Ministry of Health

Improve and preserve the mental wellbeing of Maaori with a focus on depression

Research from Te Rau Hingenero indicates that in Aotearoa New Zealand major depression among Maaori is higher than for non-Maaori.

At March 2015, 18 percent of those enrolled in the CM Health Chronic Care Management Depression (CCM Depression) programme were Maaori. This is appropriate given the estimated resident Maaori population is 16 percent. We know that Maaori are accessing the CCM Depression programme, however their ongoing engagement in the programme is significantly lower than for non-Maaori. We would like to explore the barriers to ongoing Maaori participation in the programme. During the 2015-16 year, CM Health will focus on analysis of both data and evidence for best practice. The results of this analysis will be used to strengthening existing approaches and/or develop new ways to engage Maaori with mental health problems, namely those with moderate to severe depression in the CCM Depression programme.

There is a strong correlation between socio-economic deprivation and mental ill health. Holistic approaches to mental health will also be explored in the context of the At Risk Individuals Programme. There will be consideration of integration of care pathways and opportunities and risks in particular with regard to Maori access and engagement.

Actions and milestones

- Q2: Complete a review of existing CCM Depression programme data, resulting in a more comprehensive view of Maaori engagement with the programme and Maaori outcomes against the programme indicators
- Q2: Complete an audit of a random sample of patients who have participated in the CCM Depression programme. Data captured in the primary care Practice Management System will be compared with data submitted through CCM Depression reporting to examine patient journeys of engagement. The audit will include an over representation of Maaori service users
- Q2: Complete a stocktake of the ethnicity and languages of health professionals providing cognitive behavioural therapy for patients enrolled in the CCM Depression programme
- Q2: Complete a review of evidence for effectiveness on best practice approaches for treatment of depression in primary care to support improved mental health outcomes for Maaori
- Q3: Carry out consultation with stakeholders to share findings from the analysis phase and to consider development of options for culturally appropriate models of care for Maaori including consideration of the holistical needs. This may include integration of mental health within the At Risk Individuals Programme.
- Q4: In partnership with PHOs and other stakeholders agree on the change initiatives to be implemented to strengthen Maaori engagement in management of their mental health, primarily through the CCM Depression programme

Measure in development

	2014/15 Baseline	2015/16 Target
Maaori	-	-
Total	-	

Monitoring Process

- Quarterly reports on progress to the CCM Depression Clinical Governance Group and the Maaori Health Gains Team
- Monthly review of CCM Depression Programme indicator data
- Quarterly primary mental health reporting from PHOs

5.1.3 Diabetes Management

Improve diabetes management

Diabetes is a long term condition that leads to increased rates of morbidity and mortality if the condition is not well managed. CM Health has the largest number of people in the country with diabetes, with over 37,000 people recorded as having diabetes in 2013. Prevalence, morbidity and mortality rates from diabetes are higher for Maaori 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. The At Risk Individuals (ARI) programme is a model of care to work collaboratively with patients and whanau to provide more planned, proactive care for complex patients. CM Health will expand the (ARI) programme in primary care to include a greater focus on diabetes, in particular for patients that have poorly controlled diabetes. We will redesign the Diabetes Care Improvement Package (DCIP) services and will use existing diabetes measures that have been agreed at the Auckland Metro Clinical Governance Forum and the Alliance Leadership Team.

Actions and Milestones

- Q1: Develop a revised model of care for diabetes including targeted interventions for Maaori patients and whaanau with diabetes. This will be progressed within the broader redesign of DCIP services through the ARI programme
- Q1: Determine the outcome measures for diabetes and any diabetes-related incentive payments within the ARI programme
- Q4: 50 percent of Maaori patients with diabetes and complex health needs will have a care plan, a self-management assessment and a named care coordinator
- Q2-Q4: Improved access to self-management support services to enhance health literacy, healthy lifestyles, adherence to medication and overall health and wellbeing for Maaori patients and whaanau with diabetes
- Q4: Pathways will be in place in 1-2 CM Health Localities to address social and holistic needs for Maaori patients with diabetes and complex health needs and who are enrolled in the ARI programme

Measure in development		2014/15 Baseline	2015/16 Target
	Maaori	-	-
	Total	-	

Monitoring Process

- Quarterly reporting to MHAC and ARI Clinical Governance Forum

Appendices

Appendix 1: Hauora Plan – 2012 to 2017

Hauora Plan – 2012 to 2017

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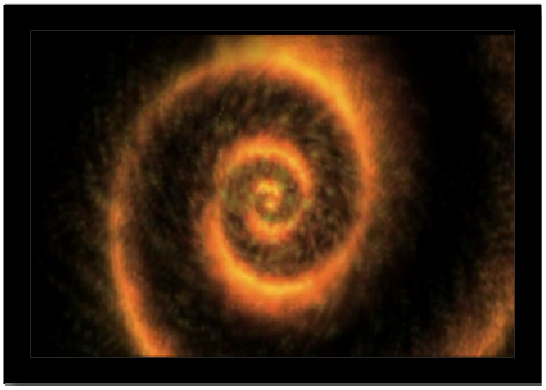
Kupu whakataki - Preface

He haerenga uaua - a difficult journey



The decision by Mana Whenua to claim a space in the health sector and improve Maori wellbeing was made 12 years ago, during the drafting of the Health and Disability Act 2000. Through the efforts of Tariana Turia, Associate Minister of Health at the time, attempts were being made to recognise the status of Te Tiriti o Waitangi and the role of Mana Whenua in the Act. Concerns about the position of Maori health and a commitment to work together provided an opportunity for local hapu to collectively form a shared governance arrangement with Counties Manukau District Health Board. Thus a Memorandum of Understanding was shaped between the parties.

The different interpretations of shared governance however became a bone of contention during the development of the MoU between Mana Whenua and CMDHB. In addition to challenges concerning the authority of both parties to enter into a relationship based on Te Tiriti o Waitangi, the journey over the last 12 years has been an arduous one. Although the Memorandum was signed in 2000, an 'understanding' had never really been reached, and as such the relationship between the two entities has been wrought with difficulties and unresolved issues.

He timatanga hou – a new beginning

The unique appearance of Matariki in 2012 signalled a significant distinction more so than in any other year according to well known astrologist Dr Rangi Mataamua. Observers have noted that for the first time, Matariki has risen right alongside Parearau (Jupiter) and Tawera (Venus) signalling an unusual alignment in Te Ao Maori. Mataamua considers that this extraordinary event signifies the presence of two major issues facing Maori at this time. Some practitioners identify those issues as Matauranga Maori and Hauora Maori while others consider Maori leadership and tikaanga as prominent matters.

However interpreted, this occurrence has emerged at a time most appropriate for Mana Whenua to review the past, assess the present and plan a future of improved Maori wellbeing.

Therefore the completion of the Hauora Plan heralds a new beginning in relationships, energies and efforts to make a significant difference in the lives of whanau.

This document is an invitation to Health authorities to re-establish a purposeful, Treaty based relationship with Mana Whenua i Tamaki Makaurau. There is an incredible amount of work to do, given that Maori in Counties Manukau are more likely to be unwell than Maori living in any other region of Aotearoa. Such a situation is simply unacceptable, and in order to transform Maori wellbeing, the collective efforts of all stakeholders have to be consolidated in a way that has never been attempted before.

Nga Mihi - Acknowledgements

There have been numerous people who have contributed to this work both purposefully and unintentionally. To all who have participated through commitment, dedication and a commonality of purpose, our members acknowledge you.

Te Roopu Waiora Trust working to ensure whanau haua are brought back into the fold of their communities, we thank for their generous gift of the adaptation to Hua Oranga, a whanau outcome measurement tool. This tool developed by the Maori studies Dept of Massey University, after numerous changes by Te Roopu Waiora to improve usability and access, has a significant place in this Hauora Plan.

We also acknowledge the Health Sponsorship Council and Ian Potter, brave enough to support the development of Mauriora, and the exceptional team led by Katerina Te Heikoko Maitaira whose life was dedicated to the wellbeing of our people. To Moana Jackson, New Amsterdam Reedy, Cathy Dewes, Tane Cassidy, Tahuna Minhinnick, Shane Bradbrook, Riripeti Haretuku, Tania Kingi and Eru Potaka Dewes our appreciation for contributing to the debate and pursuing another philosophy on wellbeing in the form of Mauriora that has guided this Hauora Plan. We also thank Tania for the immense work in putting this document together, leading the consultation hui and working with our members to bring these strategies to our communities.

We acknowledge too the development of a Treaty framework by Kere Cookson-Ua and Ngati Whatua which has been generously shared and adapted in this Hauora Plan. Also the many providers of health and wellbeing services whose work is often scrutinised but rarely honoured. In particular Te Ora o Manukau, for their continued acknowledgement of our role in this rohe and support of the Treaty framework contained within - such a crucial part of moving forward. Counties Manukau District Health Board, thank you for your contributions toward this plan both financially and in the information you have shared. We look forward to a much improved relationship in the future.

Finally our members, both past and present. It has been a daunting but rewarding journey to get us to this point and many of our founding members have since passed on. We acknowledge the incredible struggle to establish a meaningful, working relationship, the many lessons along the way, and the good will that still exists to continue this lifelong pursuit.

Nga mihi kia koutou katoa

Nganeko Minhinnick
Chair Mana Whenua i Tamaki Makaurau

Introduction

This Hauora Plan is a collective effort by the members of Mana Whenua i Tamaki Makaurau and the many contributors committed to Maori wellbeing. Its creation will assist position Mana Whenua to expand Hauora Maori and progress the various relationships needed to make the necessary improvements. The strategies contained within will further clarify the role of Mana Whenua and that of the Crown and its agencies, along with those communities and service providers that share a common purpose.

The overall goal of this plan is to ensure that the policies, resources and services delivered within this rohe are responsive, equitable and improve the wellbeing of whanau.

Overview

According to various academics, long-term goals being applied by Crown agencies are lacking a clear sense of Maori responsiveness, ownership and self determination. Analysts advance that the government's many changes of direction in recent years shows that generally 'Crown policies regarding the Treaty of Waitangi[1] and Maori responsiveness have been formulated in response to political events of the day'[2].

Most Crown agencies have conveniently sidestepped obligations to the Treaty by diminishing or deleting references in their key documents or initiating debates regarding Treaty relationships or partnerships, principles and articles, iwi or hapu, mataawaka or Mana Whenua. The impact this has on Maori was articulated in the Public Health Association's submission to the parliamentary select committee, advancing that without Treaty references 'we run the risk of returning to an era where Maori were expected to passively accept decisions made outside their communities.' [3]

Further alienation of the Treaty occurs through diluting the status of Mana Whenua to that of advisory committee or using the 'multicultural' rhetoric to 'treat all communities the same'. Maori health plans and strategies developed by health authorities are no exception. Ignoring Treaty issues prevents Mana Whenua from deciding Maori advancement at a time when 'Maori are afflicted by higher rates of disease than the non-Māori population, receive treatment later and of lower quality, and have poorer outcomes'[4]. According to the Global Report[5], New Zealand is characterized by some of

[1] The use of the term 'Treaty' in this document refers to the version written in Te Reo Maori
[2] Williams, D (2002) Honouring the Treaty of Waitangi: Are the parties measuring up?
[3] Referenced by Hon.Tariana Turia re: submissions currently being presented on the Public Health Bill – April 2008 from http://www.maoriparty.com/
[4] Downloaded from: www.thelancet.com volume 378, 12 November 2011
[5] ibid

the largest health disparities between Indigenous and non-native populations in the world.

It must be understood that because vote health funds are received by health authorities and not Mana Whenua, this plan in no way assumes the responsibility of CMDHB. Every health authority must be held accountable for the current position of Maori health. Decisions regarding resource allocations, service menus and health priorities that impact on Maori must be carefully and consistently scrutinized internally and externally; in an effort to redress the underperformance of the health sector regarding Maori health gain. There has always existed a critical role for Mana Whenua; not operationally as a service provider, but as a legitimate Treaty partner functioning at a governance level. Health authorities should recognize that properly resourced agreements with Mana Whenua to exercise a treaty partnership are fundamental to improving the health sector's performance.

Position Statements

While most Crown Agency decision makers may be unable or unwilling to understand the relationship between breaches of the Treaty of Waitangi and Maori illness and deprivation, developments by Maori authorities are almost always underpinned by the Treaty in an effort to claim the space for self determination. Mindful of this, Mana Whenua i Tamaki Makaurau have developed a Treaty-based Hauora Plan. It is a document that articulates our pathway forward, signposted by several clear position statements:

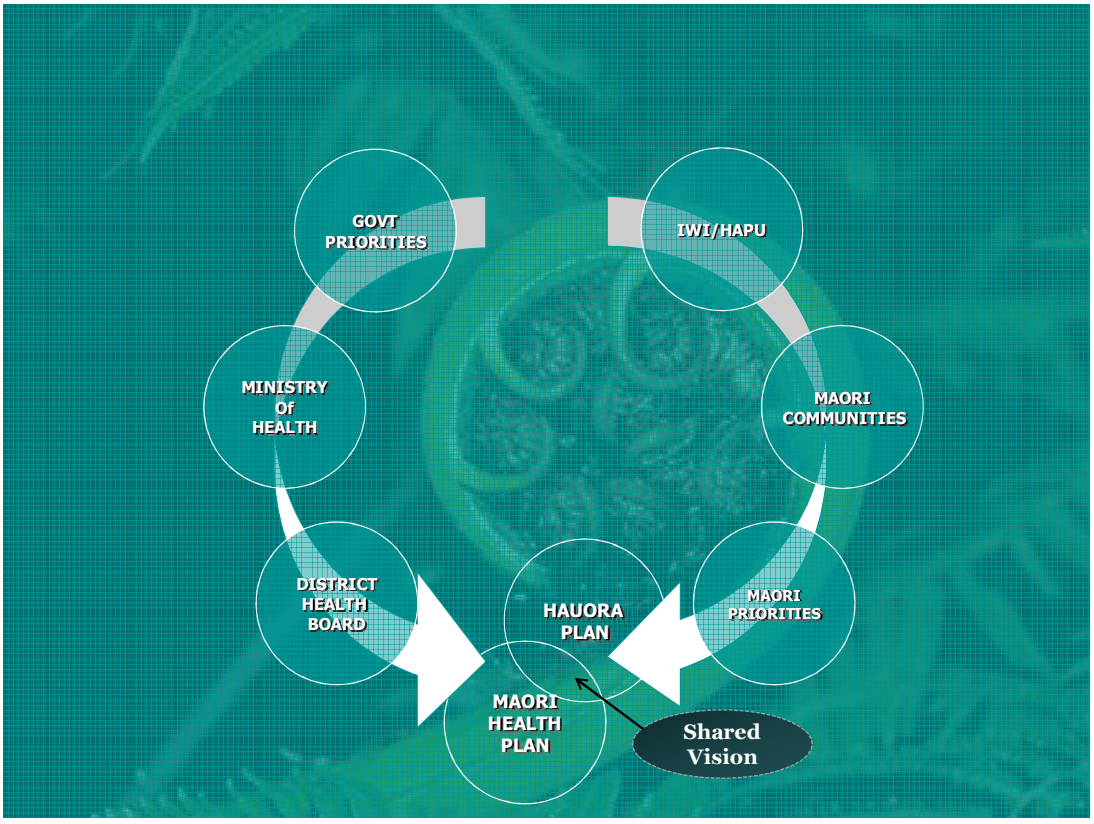
- Counties Manukau sits within the rohe of Mana Whenua i Tamaki Makaurau; the legitimate entity with which to secure a Treaty relationship with the Crown and its agencies
- True partnering with health authorities and relative Crown Agencies will support the planning and operation of competent, high quality services to Maori within this rohe
- Mana Whenua i Tamaki Makaurau as an independent authority has an important role in evaluating providers and funders resourced to improve Maori wellbeing
- In this rohe MWiTM is a key contributor to defining tikaanga Maori practice in the provision of health services to Maori.

Our Process

Over the last 12 months Mana Whenua have explored and debated these position statements within the context of hauora. A broad analysis detailed in an earlier position paper provided to Mana Whenua has informed this plan. Four key principles have been determined, each with a number of strategies. The Hauora Plan's key principles are:

Review and Sample

In August 2011, a review was undertaken by Mana Whenua of the draft Maori Health Plan from CMDHB. Presented as an Action Plan and obviously written to direct the CMDHB, the review was helpful to analyse process, priority areas and gaps related to Maori health. This confirmed for Mana Whenua the direction the Hauora Plan would take. The different pathways are best illustrated in the following diagram:



By building on a common purpose while acknowledging the different pathways the government and Mana Whenua have taken, the Hauora plan has captured a foundation for strengthening roles and future relationships.

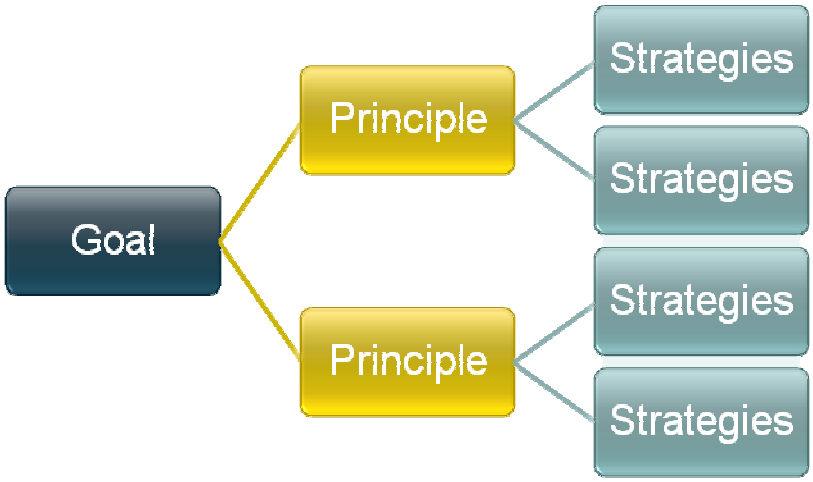
A tested whanau outcome measuring tool adapted by one of our local organisations was also trialled by Mana Whenua in October 2011 to inform the Hauora Plan. This exercise illustrated the value of a whanau centred evaluation process measuring wellbeing principles to determine service quality. The findings indicate a much needed system that will yield valuable consumer driven information. As a result, this is included as a key strategy.

To further support the development of this plan, a survey by Mana Whenua representatives was carried out targeting whanau among various hapu in December 2011. Reviewed alongside a study of whanau aspirations undertaken by a local whanau ora initiative, the findings identified priority areas among Maori communities – and more importantly, the need to ensure whanau aspirations are a major component in determining the menu and approach from health services to Maori.

Four consultation hui have been held seeking feedback from marae, hapu, whanau, government representatives, service providers and communities from March 2012 to date. We will continue to invite feedback from Maori as we implement the strategies contained within.

It is understood that this plan constitutes a first step to realise the overall goal of Mana Whenua i Tamaki Makaurau. Although there is a strong health focus, the concept adopted is far broader and more appropriate for Maori wellbeing, which for the purpose of this document; we have referred to as hauora Maori.

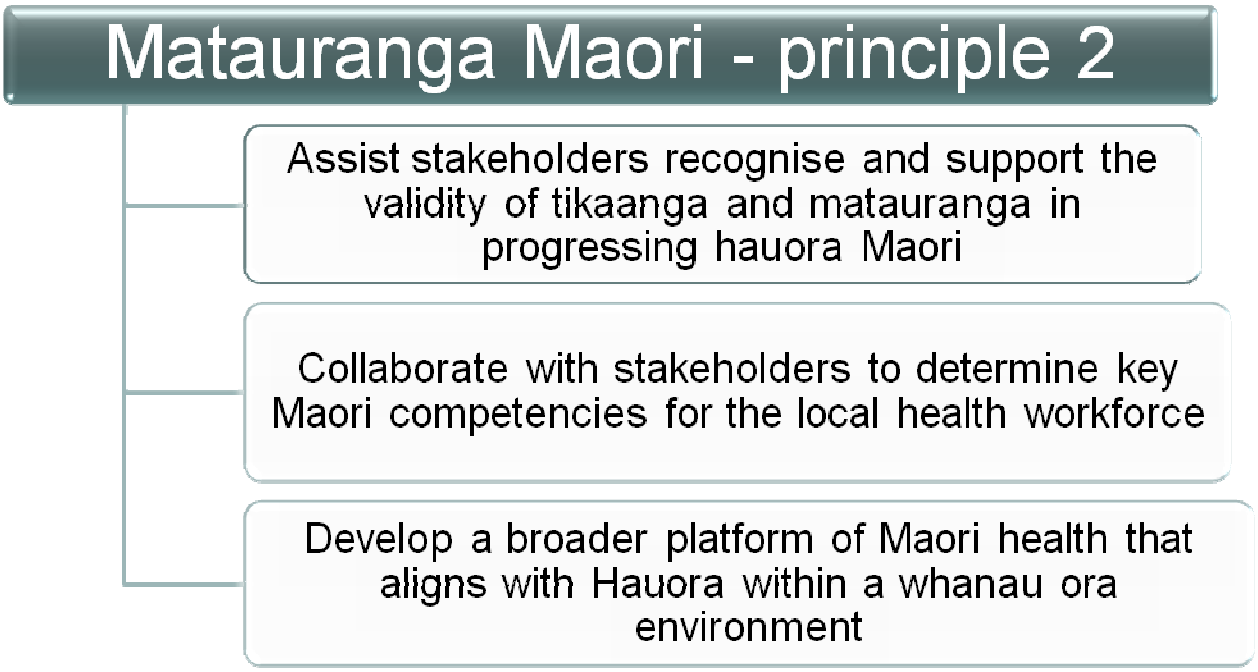
Structure of the Hauora Plan



Goal

To ensure policies, resources and services within the rohe of Mana Whenua i Tamaki Makaurau are responsive, equitable and improve the wellbeing of whanau


Treaty Partnership - principle 1
Implement the Treaty framework to progress relationships with stakeholders responsible for improving and monitoring Maori wellbeing
Develop agreements with Crown agencies that commits resources, goals and measures to progress this framework
Establish engagement protocols as the basis of all future relationships with Mana Whenua i Tamaki Makaurau


Matauranga Maori - principle 2
Assist stakeholders recognise and support the validity of tikaanga and matauranga in progressing hauora Maori
Collaborate with stakeholders to determine key Maori competencies for the local health workforce
Develop a broader platform of Maori health that aligns with Hauora within a whanau ora environment

Services Planning - principle 3

- Establish an operational division that will work with the Crown to implement the strategies of this Hauora Plan
- Source and incorporate whanau goals and aspirations in the planning of policy and service provisions
- Establish a governance partnership with CMDHB to review and plan the progress, resources and services within the Counties Manukau area

Whanau based quality - principle 4

- Secure resources to trial and implement whanau evaluation processes and Maori outcome measures
- Establish a service benchmark that supports service engagement and responsiveness to Maori
- Implement appropriate methods to involve Maori communities in decisions to improve Hauora Maori

The Treaty Partnership

> 'Because social and economic policies are so closely linked, and because avenues of active participation in decision making and policy formation are critically important, the significance of the Treaty as a force for social well-being should not be underestimated. Its cursory treatment in the past cannot be accepted as a reason for its exclusion from arenas where future planning occurs'.[6]

Mana Whenua i Tamaki Makaurau have focused on a Treaty framework that establishes meaningful working relationships from which to progress Maori wellbeing. Although a number of treaty frameworks exist; the most appropriate, not only in resolving some of our past challenges but guiding our future, was developed by Ngati Whatua[7]. It is evident when reviewing the most recent Auckland District Health Board annual plan that the Ngati Whatua/ADHB relationship has influenced the planning of Maori health. The intent of this Hauora Plan is to capitalise on existing energy to lift the planning and the performance of the health sector, stakeholders and Maori communities, through a clear understanding of roles and obligations.

It is fitting that the Treaty underpins this Hauora Plan. The Treaty has been portrayed as 'the first Maori health strategy,' describing a Maori population in sharp decline following the impact of 'unmanaged colonisation.'[8] Busby raised concerns in 1837 of the 'miserable condition of the natives' which he reported if left unchecked would result in the extinction of the Maori race. Whether this was the real motivation behind Busby's actions still remains contentious today. However his unease over the health and welfare of Maori, to which he placed some of the blame on the total European impact,'[9] was a factor in persuading the British Colonial office to propose a Treaty to Maori.

Such was the contrast to earlier references by the first immigrants that described Maori as bountiful, healthy and vibrant. The Crown offered protection of land, culture and wellbeing, resources and the continued ability of the tribes to control their interests in the form of a Treaty. Despite controversy and debate by the chiefs of the hapu regarding the intent of the Crown, 'concerns over Maori health were not insignificant in terms of both shaping and selling the Treaty to Maori.'[10]

Much has been debated concerning the history and validity of the principles as applied to the Treaty of Waitangi. This Hauora Plan advances the importance of the articles although it is acknowledged that the principles are the Crown's interpretations of a document yet to be properly honoured by successive governments. Over time specific strategies based on the articles will be developed for more detailed planning exercises.

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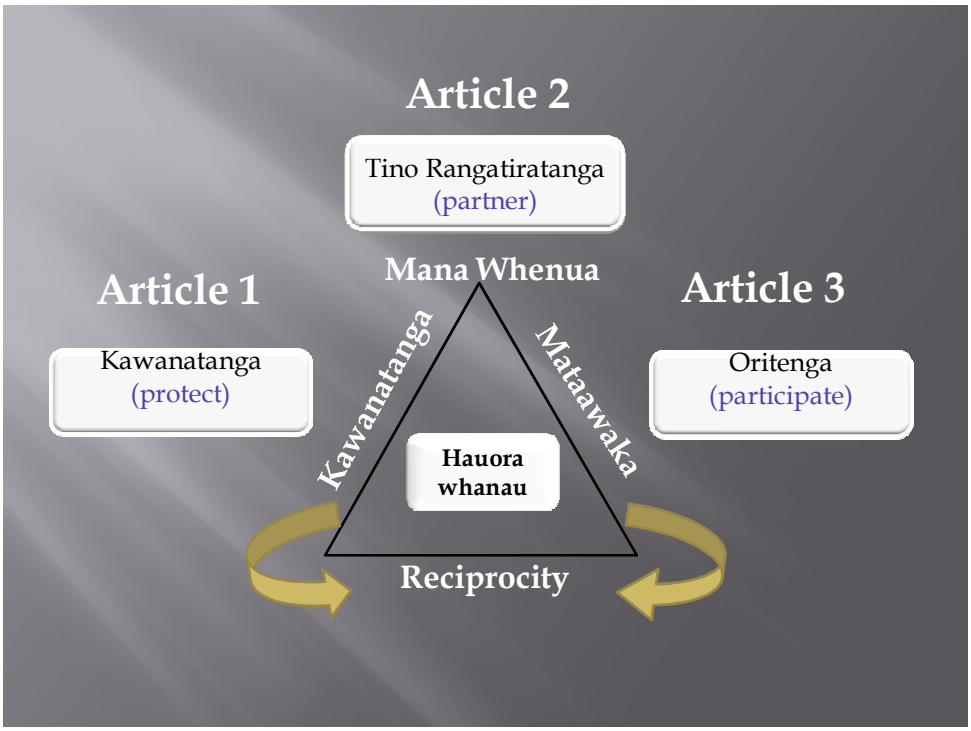
[6] Kawharu I (ed): 1994, p 287
[7] 2011 presentation by Kere Cookson Ua, CEO of Te Kahu Pokere, Te Runanga o Ngati Whatua
[8] Kingi, TKR (2006) *The Treaty of Waitangi and Maori Health.* Te Pumanawa Hauora, School of Maori Studies, Massey University, Wellington
[9] Orange, C (1987) *The Treaty of Waitangi*, p25. Allen & Unwin NZ Ltd, Wellington
[10] Kingi TR (2006). *Culture, Health and Maori Development:* A paper presented at the Te Mata o te Tau Lecture Series, Palmerston North

Treaty Framework in Action



In brief the Treaty has three main articles that in contemporary times and through NZ case law have been aligned to the three principles of protection, partnership and participation. The Hauora Plan recognises the articles and the intent of the principles within the original framework from Ngati Whatua.

Article one – Kawanatanga and the obligation to exercise protection by the Crown. The government and its agencies have a responsibility to protect the rights conferred in articles two and three.

Article two – Tino Rangatiratanga and the right of Mana Whenua to enter into partnership with the Crown. Mana Whenua maintains this responsibility, while ensuring those who reside within their geographical areas are supported to exercise their right of participation.

Article three – Oritenga in terms of equitable participation by Mataawaka - Maori and non Maori in the provision of services to improve Maori wellbeing. While Mana Whenua supports quality service provision within its rohe, in terms of reciprocity, Mataawaka participation supports Mana Whenua to exercise their right to rangatiratanga through the process of a Treaty partnership.

There should be no further misunderstanding of the position Mana Whenua holds within their rohe. Not to be confused with iwi from other areas, urban Maori communities or

service providers, the framework guides the way forward in terms of Treaty obligations and relationships with the Crown, its agencies and Mana Whenua i Tamaki Makaurau.

> *"Indigenous peoples have regrouped, learned from past experiences, and mobilized strategically around new alliances. Many indigenous communities are spaces of hope and possibilities, despite the enormous odds aligned against them…tribes and nations are in dialogue with the states which once attempted by all means possible to get rid of them."*[11]

Matauranga Maori

The New Zealand Health and Disability Sector Standards require services to identify and respond to: "cultural values and beliefs of Maori service users and their whanau, and seek to provide services that promote:

- Tikanga a iwi and hapu (the use of appropriate protocols for dealing with tribes and sub-tribes)
- Tino Rangatiratanga (sovereignty)
- Whanaungatanga (extended family wellbeing);
- Te taha tinana (physical well-being);
- Te taha wairua (spiritual well-being);
- Te taha whanau (family well-being);
- Te taha hinengaro (mental well-being);
- Te taha matauranga (learning)[12].

The values and principles listed above are by all accounts fundamental to the improvement of Maori wellbeing and are necessary elements to ensure whanau decision making and participation occurs. However much of the available resource has largely concentrated on service provision dominated by clinical practice. If such an approach yielded the same health status for Maori as it does for Pakeha, there would be no issue. But it does not; and there is little resource invested in the capacity building of whanau to determine their own health journey using Maori knowledge and practices. Furthermore, it is not a matter of one type of development in favour of another.

This Hauora Plan promotes an environment where cultural pathways warrant equal attention. Communities and organisations providing services nurtured by Maori principles must be appropriately resourced in terms of capacity; but so too must whanau be capable of selecting and utilising services, making their own choices and collectively managing their wellbeing.

Maori principles are not considered or determined in any appropriate, structured way when deciding health services to Maori. Yet they should be if we are to collectively make necessary improvements to Maori wellbeing. Through this Hauora Plan, Mana

[11] Smith, LT (1999): Decolonizing Methodologies – Research and Indigenous Peoples
[12] Standards New Zealand (2003) p21

Whenua i Tamaki Makaurau is positioned to *set and monitor* the benchmark of cultural practice as applied by stakeholders operating within this rohe. Work is already underway to not only validate Maori wellbeing through concepts of hauora, mauri ora and whanau ora, but to recognise poor attempts to culturally flavour service provisions in an effort to maintain funding levels. Hauora should for its people, encapsulate the life essence or Mauri ora from principles and practices such as:

Oranga wairua: Spiritual Wellbeing

Nga Rangituhaha (the abode of the supernatural); nga tikaanga hei whakatau i te wairua (the rituals and practices to acknowledge wairua); te wairua – Te Ira Tangata (the spirit – the life principles of mortals); nga tohu o te wairua ora (the indicators of spiritual wellbeing).

Oranga tinana: physical wellbeing

Nga tikaanga whakapiki i te ora o te tinana (the rituals and practices to raise physical wellbeing); nga tohu o te tinana ora (the indicators of physical wellbeing)

Oranga Taiao: environmental wellbeing

Te ahua o te taiao (the presence of the environment); nga tikaanga tiaki i te taiao (the rituals and practices for looking after the environment); nga tohu o te tangata manaaki i te taiao (the skills and knowledge of a person to look after the environment); ngahere ora (thriving forest); wai ora (safe, clean water)

Oranga whanau: family wellbeing

Nga whanau o mua (families of times past); nga matapono o te whanau ora (the principles of whanau wellbeing); he whanau ake (specific whanau groups); nga tohu o te whanau ora (indicators of a well and healthy whanau); oranga tangata (individual wellbeing).[13]

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Whareoranga developments are seen as important initiatives where clinical health (particularly GP based) and Matauranga Maori can be effectively combined using a Hauora framework. For this reason their maintenance and growth is a key priority for Mana Whenua.

[13] Developed by the Mauriora working group led by Katerina Te Heikoko Mataira and published in 2012

Services Planning

It is obvious with the growing demands on health services and the limited resource available that more must be done with less. Besides concerns regarding bureaucratic wastage, ballooning health costs and excessive administration; attention also must be paid to both the menu and effectiveness of service provisions – and in particular, how Maori priorities have been considered in the process of decision making. An exercise undertaken recently by a group of whanau developing their goals and aspirations for wellbeing produced a range of service needs not currently provided in Counties Manukau. A second exercise undertaken by Mana Whenua to identify priorities among whanau from a number of hapu and iwi again revealed a range of services that were similar but also different to those that exist.

What would happen if the planning of services to Maori was undertaken to deliberately and directly include whanau priorities and aspirations? We are confident that such an approach would not only improve Maori utilisation and engagement but lift the status of whanau health and wellbeing. There is amble research to evidence that this is the case, and the attempts by whanau ora initiatives to adopt this approach have been designed on this premise.

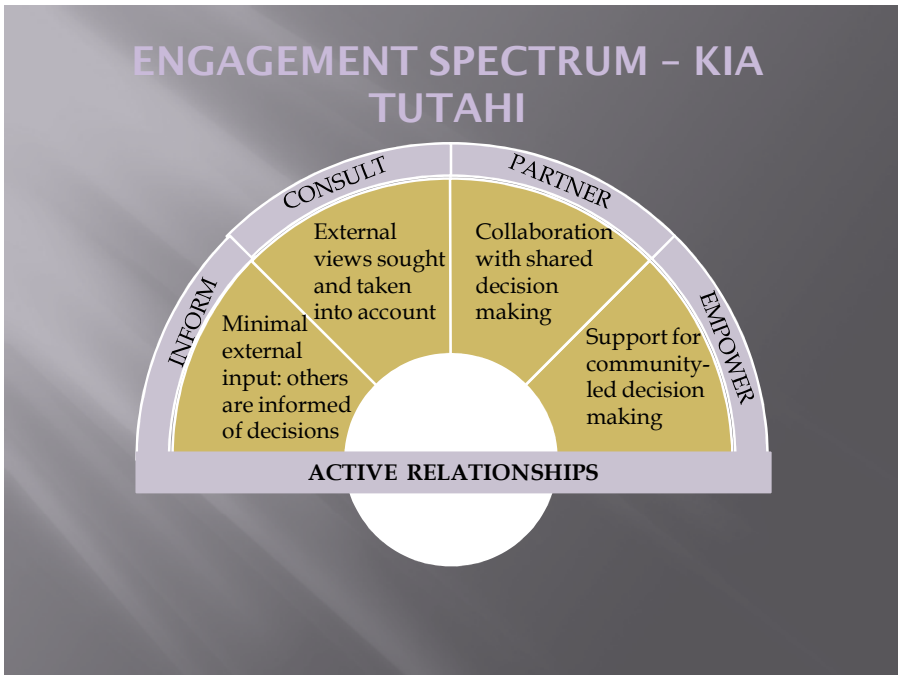
In a recent publication of the Lancet[14] the deputy director-general of Maori Health from the Ministry of Health stated that the health system has been complicit in propagating inequalities. According to Theresa Wall, the disparities especially over the last 20 years largely indicate improvements in the health of non-Maori that have not been matched by equal progress in the Maori population.

Furthermore Wall states that public health interventions designed for the general population and delivered through mainstream service providers often failed to take into account the barriers that might prevent Maori from accessing them. Such an admission offers a way forward for Mana Whenua and health authorities to work together in addressing the disparities, eliminating the barriers and ensuring those same improvements to Pakeha health are mirrored among Maori populations.

A way to ensure communities play more than a cursory role in services planning is to strengthen their presence in creating relationships of value. In August 2011, the Kia Tutahi Relationship Accord was signed by representatives on behalf of the communities of Aotearoa and the Prime Minister on behalf of government. The accord illustrates a stronger commitment by the parties to ensure improved relationships – not only between the government and the communities of Aotearoa, but also individuals and

[14] Downloaded from: www.thelancet.com volume 378, 12 November 2011

service users. The illustration below[15] provides a progressive spectrum Mana Whenua have included as a guide to strengthen the relationships to progress this Hauora Plan.



The Health Landscape

In this region identifying resource allocations for the provision of health services to Maori is a difficult exercise. Whereas the data from CMDHB to quantify services to Maori as well as funding levels to Maori organisations is available; identifying the same in relation to Pakeha organisations is an entirely different matter. There are a number of reasons why this is the case. Poor ethnicity data collection by Pakeha services is a primary concern and more must be done to ensure accurate and timely reporting. The competency levels of the health workforce responsible for ethnicity identification, data collection and reporting is also an issue as not enough importance is placed on the way in which information should be collected and recorded from Maori.

From a funding perspective; varying units and their distinct costs across providers make comparisons impossible. Bed nights, hourly rates, programme costs and bulk funding data is available but of no real use when attempting to ascertain overall resource allocations in relation to the services purchased and usage across various populations. There are over 300 CMDHB contracts currently in place for health services in this rohe and it appears to be an ongoing struggle to glean the necessary information regarding

[15] Kia Tutahi Relationship Accord – Guide produced by the Office of the Community & Voluntary Sector (2011)

costs and services to Maori. Strategies of this Hauora plan focus on working with Health authorities to identify the level of services and resources to support Maori health and determine how and what improvements can be made.

Whanau based Quality

As the service landscape shows signs of transformation towards consumer and patient centred healthcare, attention to measures of wellbeing are gaining momentum; particularly as Whanau Ora initiatives extend across the regions. Outcomes rather than outputs and inputs, as a measure of service quality have also gained wider traction, amid challenges regarding validity, credibility, suitability and accuracy.

In the health sector, universal measures relevant to all people are applied as instruments to measure Maori wellbeing, such as life expectancy, mortality data and immunisation rates. This application is based on the notion that all people have common views about being well therefore wellness can be measured in similar ways. There are however unique Maori characteristics to wellness that requires specific measurement. All too often these are misunderstood and ignored in the health sector.

Coordinating outcome measures for Maori and identifying what level indicators are most appropriate, deserves dedicated study. Winnard has identified concern that 'whanau progress was being measured against indicators that reflect economic concerns (ie. reducing hospitalisations).'[16] Similarly McPherson and others point out that 'most measures of process and outcome are based largely on Eurocentric or American perspectives.'[17] Though such approaches have a place, they fail to address issues that matter most to Maori.

A number of health authorities have adopted outcome measuring systems from off-shore due to a lack of suitable and appropriate measures being developed in New Zealand. A popular tool is the SF36 quality of life measure introduced in over 47 countries with reviews from both France[18] and Bangladesh claiming its usefulness as a measuring tool if modified for cross-cultural adaptation.[19] The appeal of the SF36 is that it is a self assessment, quality of life measure that:

- Describes functioning and wellbeing of individuals with and without medical conditions
- Provides outcome criterion for interventions

[16] Winnard, D (2007) Indicator frameworks and tools for contract monitoring and evaluating programmes for Maori health gain: A review

[17] McPherson K, Harwood M, McNaughton HK (2003): Ethnicity, equity and quality: Lessons from New Zealand. BMJ Publishing Group

[18] Legplege A (2003) The French SF-36 Health Survey Translation, Cultural Adaptation and Preliminary Psychometric Evaluation. Journal of Clinical Epidemiology , Volume 51 , Issue 11 , Pages 1013 - 1023

[19] Ahmed SM, Rana AK, Chowdhury M, Bhuyia A (2002) Measuring perceived health outcomes in non-western culture: does SF-36 have a place? Journal of health, population and nutrition Dec;20(4):334-42

- An aid for decision-making in the healthcare field[20]

The dimensional structure of the SF36[21] parallels western theories of health which place it at a distance in terms of an appropriate measure of Maori health and wellbeing. Primarily the SF36 fails to incorporate spiritualism and whanau connectedness as quality of life factors. To overlook these dimensions illustrates the notion that western principles apply to all cultures and peoples. Such a misconception should be challenged when transposed to interpret Maori health experiences. If results from measures influence the design and type of services targeting Maori and purchased by funders, then these tools must be deconstructed and assessed for cultural integrity. The lack of comparative health gain to Maori demands it.

Cunningham proposes that mainstream measures health rather than hauora. While tools applied by health authorities measure physical health, mental health and independence; Maori concerns include spiritual, whanau and environmental wellbeing. 'Hauora is not the Maori word for health. It is related but different in concept. There are collective and social elements to it.'[22]

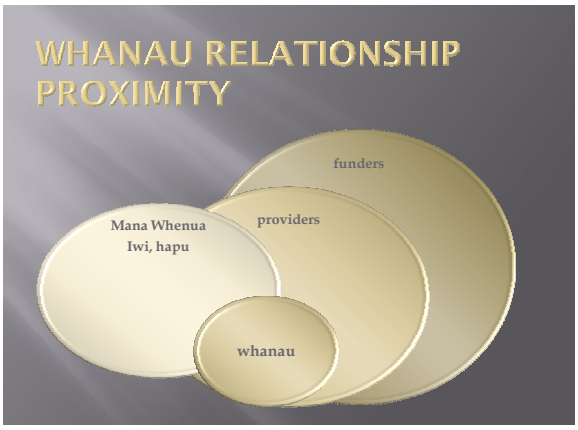
A theory behind most outcome measuring tools is that the user is a prepared participant willing to divulge intimate information useful to the process. Much depends on objectivity within a safe and trusted environment free from service influence. Furthermore the *preparedness* of Maori users to engage in these processes is often overlooked; particularly if poor experiences have occurred in the past. Some might argue that this is the point of evaluation systems, however if the evaluation in itself is a contributing factor to anxiety, results are likely to be inconclusive. The 'pre-evaluation environment' requires some effort and attention quite apart from those services being evaluated.

Recognising service quality is just as important as the process of evaluation. The idea of acknowledging Hauora Maori service excellence deserves support and consideration. Reaching the cultural practice benchmark by providers as determined by results from whanau evaluation processes should be acknowledged in a simple yet effective way – much the same as the National Heart Foundation's tick of approval.

The extent of this work is significant. The first step for Mana Whenua is to develop an operational structure that will provide a vehicle to evaluate services experienced by whanau. The trials undertaken during the formation of this plan have revealed the relationship required with whanau as well as the means to access and engage the local Maori population, develop an environment of trust and support whanau assume their natural roles of shared obligations.

[20] Bullinger M, Schmidt S: The Challenge of Cross-Cultural Quality of Life Assessment, Institute of Medical Psychology, University of Hamburg. Downloaded March 2008 from www.bath.ac.uk

[21] Short Form 36 (SF36) designed for use in clinical practice and research, considers eight aspects of health.
[22] Cunningham, C (2002) Massey University Magazine, Issue 14



Over a period of time the infrastructure planned by Mana Whenua will provide the working arm to progress the strategies contained within. Each strategy is interconnected but can be progressively built from the Treaty framework.

Mana whenua recognize not only its obligations to those within its tribal boundaries but the position to remain independent from service provision. The intent is to objectively ensure that high quality, effective services are invited and supported to operate within the rohe of Mana Whenua i Tamaki Makaurau. To do so means a different relationship with health authorities that shares decision making concerning Maori health and wellbeing. This is the space where a shared vision exists between Maori health and Hauora Maori. The Hauora Plan is a governance tool to navigate the way forward for Mana Whenua much the same as the District and Annual Plans do for the CMDHB. An opportunity now exists to ensure planning is progressed from a secure Treaty partnership in spite of a history of mistrust and misdemeanors.

Conclusion

> *No problem can be solved from the same level of consciousness that created it.*
> *Albert Einstein*

As well as the opportunities such initiatives bring, there are also many challenges to overcome to implement this Hauora Plan. Transforming and building roles and responsibilities internally is a significant undertaking but necessary to transform the external environment as described within.

Across the health sector the present systems and decision making structures have not worked for Maori, and it is unwise to continue much of the same in the hope that improvements will result while ignoring decades of systemic failure. Subsequently the future will require a kind of leadership that serves its people thereby creating a domain where whanau map their own way forward in the pursuit of Hauora Maori.

COUNTIES
MANUKAU
HEALTH