COUNTIES MANUKAU HEALTH

Maaori Health Plan

2017/18

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Nga mihi nui

E Rau rangatira ma, me ngaa karangaranga maha o teenei rohe o Manukau, teena koutou katoa. Tuatahi, kei te mihi ki te Atua moo oona manaakitanga. Tuarua, ka mihi ki ngaa mate kua huri ki tua o paemaumahara, moe mai koutou ki roto i ngaa ringa o te Atua, moe mai e. Tuatoru, kei te mihi ki too taatau Kiingi, a Kiingi Tuheitia me toona whare Kaahui Ariki nui tonu, Paimaarire. Ngaa mihi nui, ki a taatau katoa.

Welcome to Counties Manukau District. Firstly let us take time to acknowledge our Creator our God. We farewell those who have passed on and we also pay tribute to King Tuheitia and the Royal family.

Paimaarire. Greetings to all.

He Pou Koorero

Ko te tumanako a teenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana-taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

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Foreword

Counties Manukau is home to 87,200 Maaori that represent 16 percent of the Counties Manukau total population and 12 percent of the New Zealand Maaori population. Advancing our Healthy Together health equity strategic goal will only be possible if we achieve health gain in selected priority areas for Maaori.

Health gain priorities for Maaori living in Counties Manukau in 2017/18 continue to focus on good child and whaanau (maatua, pepi me tamariki) health with activities to increase smokefree households, good nutrition, oral health and reduction in potentially avoidable childhood diseases. Support for rangatahi Maaori aims to improve access to mental health assessment and integrated care pathways. Our 2016/17 health equity achievements in the smokefree targets highlights the value of gathering insights from Maaori clients and their whaanau, rapid testing and service models that reach rangatahi. We will progress this in 2017/18 through developing coordinated and whaanau-centred services that enable whaanau to take increased responsibility to sustain their wellbeing.

Our commitment to working regionally on health gain areas of shared priority will be progressed 2017. With support and advice of Mana Whenua i Tamaki Makaurau and our Maaori Health Advisory Committee, we aim to leverage the region's collective knowledge, relationships and resources to complement local priorities. These activities will be supported by broader consultation to develop and implement a three year Auckland Metropolitan Region Maaori Health Gain Plan in early 2018.

There is a role of the health system to work with, and influence others, to achieve significant Maaori health gain by improving the ***way the healthcare system itself*** can make it easier for Maaori to reach help when they need it. We want to build a healthcare system that ***enhances the mana*** of Maaori who come into contact with care professionals, not take away their mana with a deficit mindset. Whaanau ora approaches or working with Maaori and their support systems is critical to this – we hope you see that this plan builds on that approach at a local level.

This 2017/18 Maaori Health Plan supports the relationship and common interests of both Counties Manukau Health and Mana Whenua i Tamaki Makaurau in addressing health inequities and accelerating health gain for Maaori in this rohe.

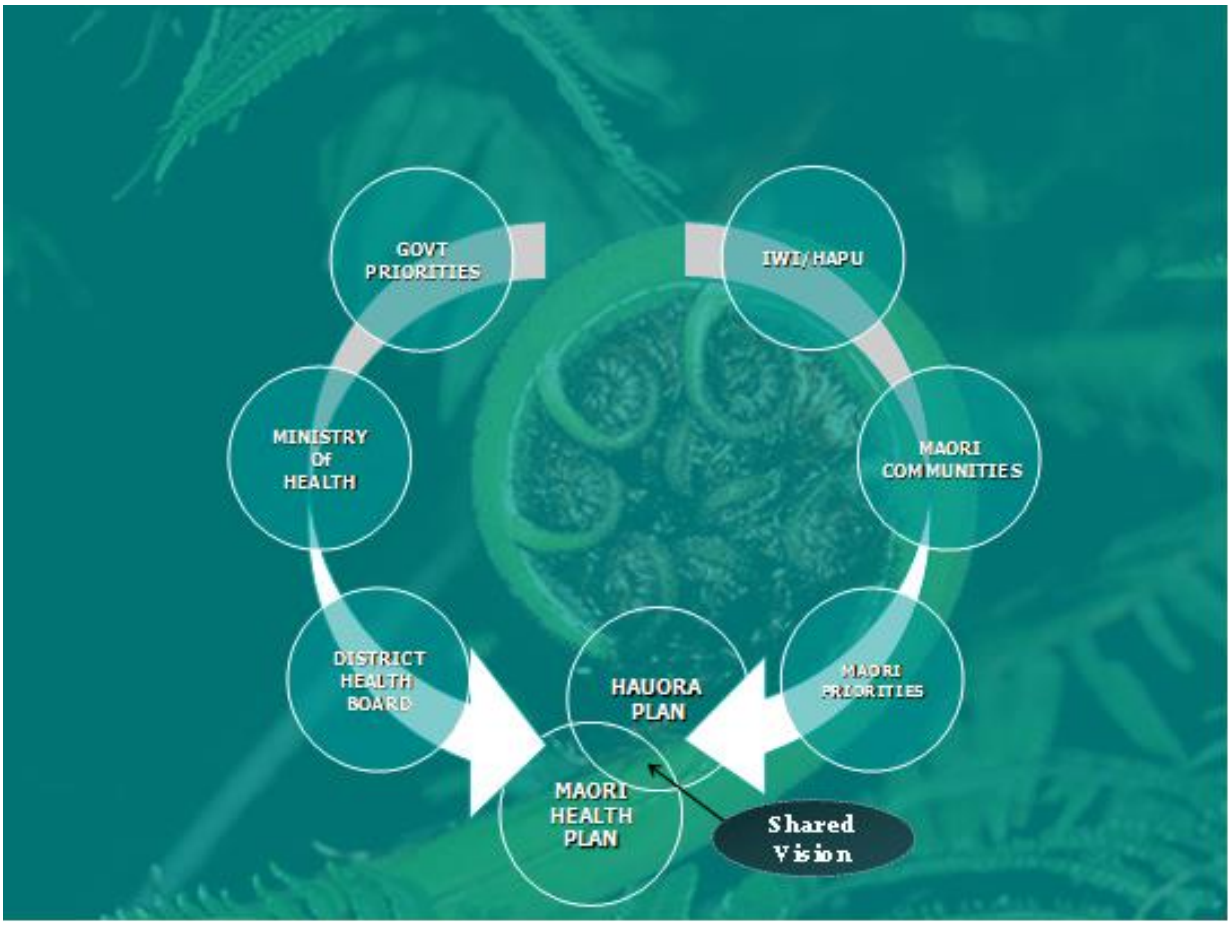
1.0 Introduction

1.1 Our Partners

Counties Manukau Health (CM Health) is committed to accelerating Maaori health gain and achieving Maaori health equity. We aim to see Maaori living longer, healthier lives with whaanau and in their communities. The opportunity and challenge of achieving Maaori health equity is one we share with our treaty partner, Mana Whenua i Tamaki Makaurau and the Counties Manukau Primary Health Organisations (PHOs). Our relationship with Mana Whenua i Tamaki Makaurau is an important partnership for CM Health and is integral to moving forward in-step with the local hapu, iwi and Maaori communities.

To reflect our relationship with Mana Whenua i Tamaki Makaurau we have integrated their Hauora Plan (section 6.2) into this Plan.

Figure 1: Maaori Health Plan and Hauora Plan Development



The 2017/18 Maaori Health Plan was developed by applying a health equity lens to prioritise our planned actions. These actions informed CM Health's 2017/18 Annual Plan 'Equitable Outcomes Actions' and related performance measures.

Mana Whenua i Tamaki Makaurau Board to Board Relationship

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

- Reports against progress to the Counties Manukau District Health Board through the Maaori Health Advisory Committee (MHAC); and
- meeting of District Health and Manawhenua i Tamaki Makaurau Boards to assess progress to date.

The framework for governance monitoring is shaped by the four principles set out in the Hauora Plan (section 6.2). Management of both organisations is responsible for implementing an annual work plan that sets out the activities under these objectives (refer Table 1 below).

Table 1: Hauora Plan Principles and Objectives

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 tikanga 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 and outcomes; and ▪ to evaluate whether or not services are responding to them.
Whaanau based quality	Ensure a conducive health environment exists that encourages whaanau to independently identify hauora and health outcomes
	Implement the whaanau outcome measure for Maaori to evaluate service responsiveness

Maaori Health Advisory Committee

The Maaori Health Advisory Committee is a committee of the Counties Manukau District Health Board. In 2017/18 the Maaori Health Advisory Committee will continue to provide advice, strategic direction and make robust recommendations to the Counties Manukau District Health Board aimed at the acceleration of Maaori health gains and addressing Maaori health inequities. Maaori Health Advisory Committee membership comprises Counties Manukau District Health Board members, Mana Whenua 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 Maaori Health Advisory Committee will meet four times a year and intends to develop a forum to facilitate community based wananga or learning environments to engage Maaori communities on issues of priority to Maaori health improvement.

Metropolitan Auckland District Health Board collaboration

Each District Health Board (DHB) in the metropolitan Auckland region has strengths and areas for development in achieving performance improvement for Maaori health gain. The 2017/18 year will see greater collaboration with metropolitan Auckland DHBs to share work programmes, insights and learnings to ensure those benefits are shared across the region. Areas to be explored include leadership, capability building in Maaori provider organisations and Maaori workforce development collaboration. In some areas this may mean joining up or merging work programmes. In others it may mean greater transparency in performance metrics and requiring DHBs or services to reflect on their existing practices or service delivery approaches if they are not showing the same improvement as others. Areas that will be explored for joined up regional leadership include focused capability building in Maaori health in workforce development.

1.2 Te Tiriti o Waitangi

CM Health recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. Te Tiriti o Waitangi establishes obligations for Maaori development, health and wellbeing by guaranteeing Maaori a leading role in health sector decision making in a national, regional, and whaanau/individual context. The New Zealand Public Health and Disability Act 2000 establishes requirements of DHBs with respect to Crown treaty obligations. This furthers commitment to Maaori health gain by requiring DHBs to establish and maintain responsiveness to Maaori while developing, planning, managing and investing in services that do and could have a beneficial impact on Maaori communities.

Te Tiriti o Waitangi provides four domains under which Maaori health priorities for CM Health can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Maaori.

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

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

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

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

1.3 Our Decision Making Kaupapa

CM Health strategic goal and values

Achieving 'Healthy Futures for Maaori' (Paeora) is a priority for CM Health and aligns with our Healthy Together strategic goal. That goal is *"Together, the Counties Manukau Health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020".* This means:

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

To achieve this, our transformational challenge is:

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

To achieve health equity for Maaori, we need to challenge, understand and address existing health gain barriers causing inequities that are unjust and amenable to resolution.

We intend to progress and measure our progress by:

- Advocating for healthier environments and settings that make healthy choices easier

- Better supporting people, whaanau and families to live well with diagnosed, long term conditions through ways of working that honours Maaori wellbeing
- Targeting service delivery to people at risk. Ensuring Maaori get access to services and resources earlier than they otherwise would, in planned, proactive models of integrated care
- Providing healthcare closer to home. By orientating our service delivery to Localities, services are better connected with whaanau and families and with other health, social and community service providers supporting their wellbeing.

There is a whakatauki (proverb) that embodies this challenge – *"Ko tou rourou, ko toku rourou ka ora ai te iwi."* If we ask ourselves – how can we achieve health equity and how can we value everyone - we can all contribute to this goal. And there, in our quest for health equity, we can continue to narrow the health gaps for all communities living in Counties Manukau.

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

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

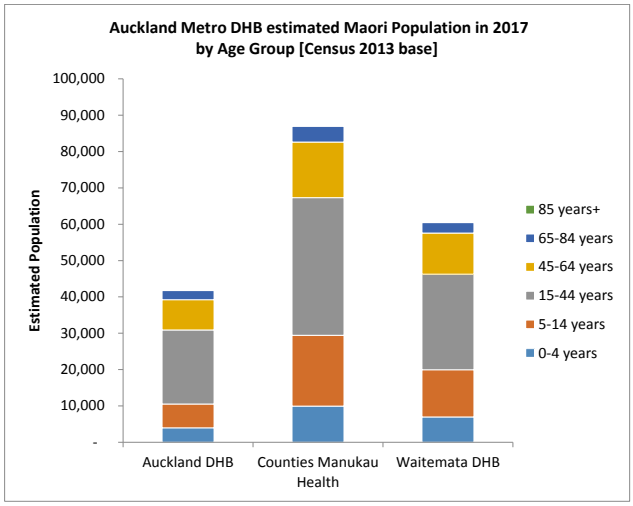
2.0 The People We Serve

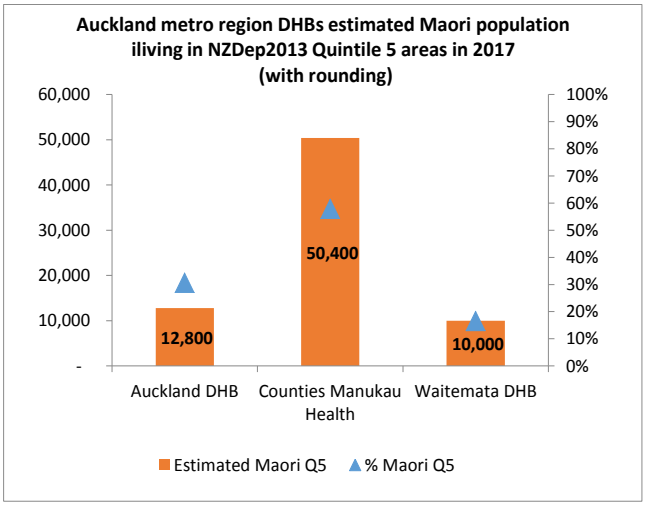
2.1 Auckland Region

There are 189,800 Maaori people in the metropolitan Auckland region (Auckland, Waitemata and Counties Manukau DHB districts) in 2017, which equates to 11 percent of the total Auckland region population[1]. Counties Manukau is home to 46 percent of the regional Maaori population. The proportion of Maaori people, as a percentage of the total Auckland region population is projected to be 13 percent by 2036. This equates to 84,890 more Maaori between 2017 and 2036. It is important to note that the people grouped under the generic label of Maaori are very diverse in health status, health beliefs and practices, housing, geographical distribution, iwi affiliation, use of languages and socio-economic status.

Socio-demographic and health status information tells us that life in New Zealand is changing for these communities. Thirty nine percent of all Maaori in the metropolitan Auckland region live in areas classified as Quintile 5 (highest socioeconomic deprivation) on the Socioeconomic Deprivation Index.[2] Figure 1 below contrasts the age and socioeconomic deprivation profile across the Auckland region Maaori populations. Counties Manukau is home to almost half of the region's tamariki Maaori (aged 0-14 years) of which 60 percent are estimated to be living in areas of high socioeconomic deprivation.

Figure 1: Summary 2017 Maaori population demography across the three Auckland region District Health Boards[3]





The factors of population growth and socioeconomic status, alongside available services and community networks, impact how we monitor population health and design and deliver supporting services. While the three metropolitan Auckland DHBs are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are important to local population health gain needs.

2.2 Iwi Maaori Living in Counties Manukau

2.2.1 Population size, age distribution, and growth

The estimated resident Maaori population in Counties Manukau for 2017 is 87,200 and makes up 16 percent of the Counties Manukau total population and 12 percent of the New Zealand Maaori population.

In the 2013 Census, 84 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 (24

[1] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections,(2013-Census Base) – October 2016 Update
[2] Source: University of Otago, Wellington (2014) NZDep2013 Area Concordance File; analysed by CM Health
[3] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections,(2013-Census Base) – October 2016 Update

percent). Mana whenua, Maaori with tribal links to the Counties Manukau district, comprise eight hapu – Te Aakitai, Ngati Te Ata, Ngati Paoa, Ngai Tai, Te Kawerau a Maki, Ngati Taahinga, Ngati Amaru and Ngati Tipa.

Geographically, many Maaori in Counties Manukau live in Manurewa, Papakura, Otara-Papatoetoe and Mangere suburbs. Similar to the national Maaori population, Maaori who live in Counties Manukau are relatively young compared to 'European/Other' people. Population estimates for 2017 indicate that 34 percent of the Maaori population Counties Manukau are aged less than 15 years, compared to 15 percent of European/Other people.

From 2017 to 2036, the Maaori population in Counties Manukau is predicted to increase by 44 percent to reach just over 125,000. The Pacific and Asian populations will increase by 36 percent and 50 percent respectively over the same period. 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 by 7,400 (162 percent increase) from 2017 to 2036.

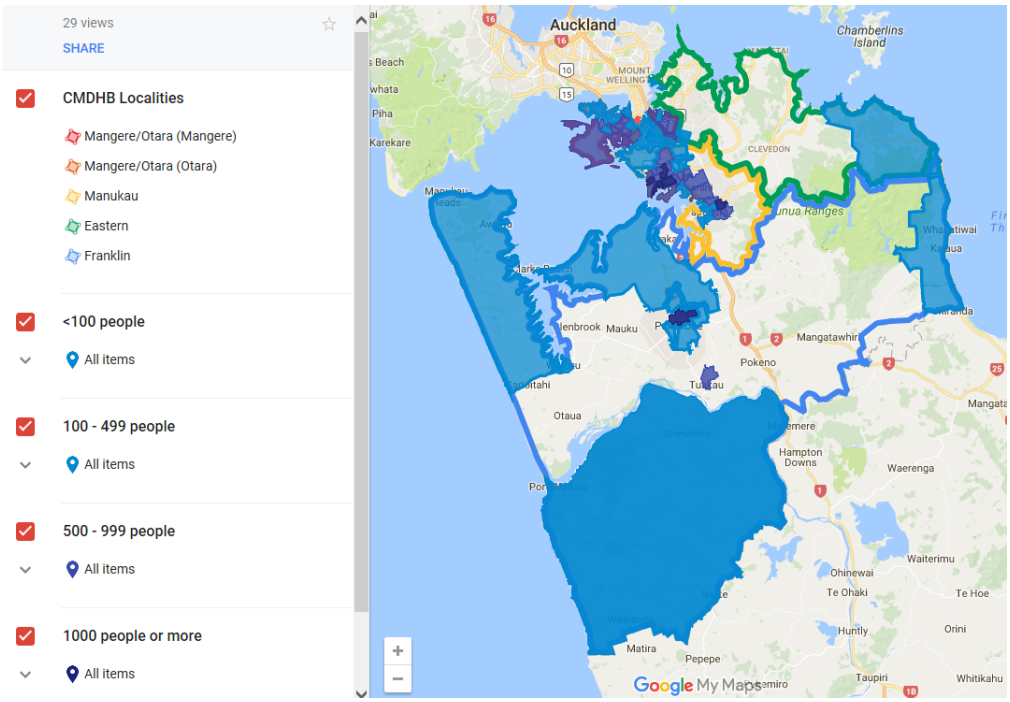
2.2.2 Social determinants of health

At the time of the 2013 Census, 58 percent of the total Counties Manukau Maaori population lived in areas considered the most socio-economically deprived (Quintile 5) in New Zealand, compared to 17 percent for European and Other living in Counties Manukau.[4] These socioeconomically deprived areas represent the suburbs of Manurewa, Papakura, Otara-Papatoetoe and Mangere (Figure 2).

In 2013, 78 percent of Maaori adults (aged 15 years and over) in Counties Manukau did not own their own home[5]; that figure was 58 percent for the total Counties Manukau population and 83 percent for Pacific 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 Counties Manukau population aged 0-14 years and 13 percent for the New Zealand European children.

In the 2013 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 Paakehaa adults was 43 percent.

Figure 2: Usually Resident Total Maaori living in Quintile 5 areas in 2013 (Counties Manukau by census area)



[4] Source: University of Otago, Wellington (2014) NZDep2013 Area Concordance File; analysed by CM Health
[5] This includes older children 15 or over living with parents who own the home.

2.2.3 Maaori Wellbeing

Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013) highlighted a number of strengths in our local Maaori residents. Of the Maaori surveyed in Counties Manukau:

- 76 percent thought their whaanau were doing 'well' or 'extremely well'
- A high level of connectedness with whaanau was reported and 83 percent 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 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 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 at home
- Two-thirds reported wairua (spirituality) being 'very', 'quite' or 'somewhat' important to their well-being

2.2.4 Life expectancy

Overall life expectancy (2013 to 2015 average) at birth for Maaori in Counties Manukau is 74.8 years. The life expectancy gap between Maaori and non-Maaori/non-Pacific peoples is 9 years.[6]

2.2.5 Amenable mortality

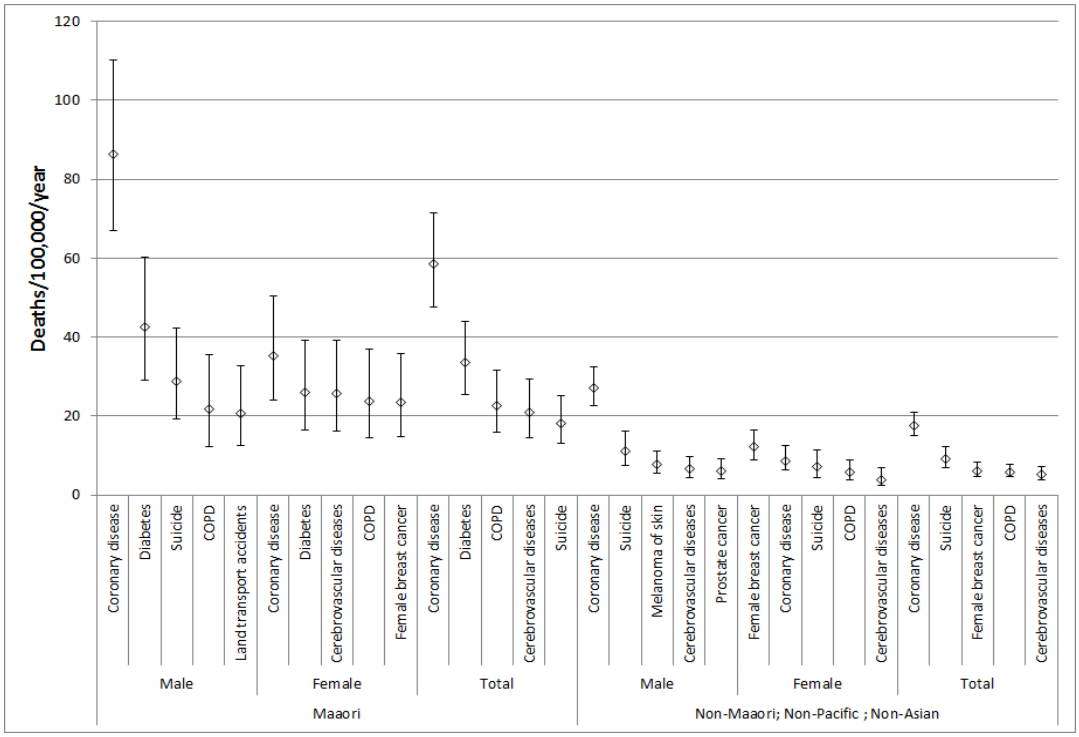
Leading causes of amenable mortality[7] for Maaori in Counties Manukau are ischaemic heart disease, diabetes, chronic obstructive pulmonary disease, cerebrovascular diseases, suicide and breast cancer (females). Those with the top five rates are age standardised to the World Health Organisation population in 10 year age groups. The top five causes of amenable mortality within each gender category are contrasted for Maaori and non-Maaori/non-Pacific peoples (Figure 3).

Age standardised rates of mortality are much higher for Maaori compared to non-Maaori/non-Pacific counterparts in the Counties Manukau district. Cardiovascular disease is the most common cause of preventable death for Maaori and non-Maaori, but it is Maaori who carry the greatest relative burden of the disease in the district. Suicide ranks higher as a preventable cause of death for Maaori men, compared to their non-Maaori/non-Pacific counterparts. Deaths attributable to diabetes are more common among Maaori than for non-Maaori/non-Pacific.

[6] Chan WC, Papa D, Winnard D (2016) Life expectancy, leading causes of death and amendable mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.

[7] Avoidable mortality includes deaths occurring among people less than 75 years of age that could potentially have been avoided through population-based interventions or through preventive and curative interventions at an individual level. Leading causes are determined by absolute numbers, rather than rates, to reflect the burden of disease for our community and health system.

Figure 3: Five Leading causes of avoidable mortality[8] for the Counties Manukau population aged 0 to 74 years (age-standardised death rates), Maaori compared to non-Maaori and non-Pacific people, by gender, 2012 to 2014.[9]



Reduced smoking and obesity prevalence, and good cardiovascular disease risk management, nutrition and physical activity contribute significantly to reducing the leading causes of mortality. 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. Encouragingly, the total Counties Manukau Maaori population smoking prevalence fell from 47 percent at the time of the 2006 Census to 36 percent in 2013.

2.2.6 Disability

Extrapolating from the national results from the New Zealand 2013 Disability Survey[10], about 20,000 Maaori people with disability live in Counties Manukau, 25 percent of the total Maaori population. This number comprises 18 percent of all people in Counties Manukau living with disability. The most frequent impairment for Maaori adults was related to mobility, hearing and agility, followed by psychiatric or psychological, intellectual and 'other' including difficulty with speaking, learning and remembering.

For tamariki Maaori, the most frequent type of impairment was classified as 'other': including impaired speaking, learning and development delay. For tamariki Maaori, the most frequent causes were 'conditions that existed at birth', 'disease or illness', and conditions that were categorised as 'other causes' (including autism spectrum, attention deficit hyperactivity disorder, developmental delay, dyslexia and dyspraxia). The next most frequent categories included: psychiatric/psychological, sensory, intellectual, and physical impairments.

The most frequent reported cause of impairment for Maaori adults was 'disease or illness'. A significant proportion of this is related to long term health conditions and disease risk factors, e.g. smoking, that are potentially avoidable. The multiple challenges many Maaori face in accessing services – living with disability, in poverty, facing institutional bias in access – is a lived reality for many in our district. Our services are ill-equipped to impact on outcomes for Maaori

[8] Cancers here include melanoma of the skin, stomach, rectal, bone and cartilage, breast, prostate, testis, thyroid, Hodgkin's lymphoma, acute lymphoblastic leukaemia. 'Maternal and infant' relates to complications of the perinatal period for either mother or baby. COPD: chronic obstructive pulmonary disease.
[9] CM Health analysis of the 2014 Mortality Data
[10] 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'

who face multiple challenges if they fail to integrate and recognise the need for a holistic approach for those populations.

2.2.7 Potentially avoidable hospitalisations

Potentially avoidable hospitalisation[11] rates for Maaori in Counties Manukau are consistently higher than for the European/Other rates across the age spectrum. The top five causes by age group and ethnicity are listed in Table 2 below. The leading five causes[12] of avoidable hospitalisation for the Counties Manukau Maaori population aged 45 to 64 years are angina and chest pain, cellulitis, chronic obstructive pulmonary disease (COPD), pneumonia, and congestive heart failure. Asthma is a more common cause of hospital admission for tamariki Maaori, compared to the European / Other group. Hospitalisation for dental treatment is common for Maaori and European/Other children aged under 15 years, both ranked second in causes of avoidable hospitalisations. Cellulitis features more prominently as a cause of hospitalisation in the younger ages for Maaori, compared to the European/Other group. When looking at where and how we can achieve health equity for Maaori, we have considered the health conditions above and the opportunities to prevent avoidable ill-health and related hospitalisation.

Table 2: Five leading causes of ambulatory sensitive hospitalisations in rank order (vertically – highest on top), Maaori compared to European/Other people, by age category 2014 to 2016.

Ethnic group	0 to 14 years	15 to 44 years	45 to 64 years	65 years or more
Maaori	Asthma Dental conditions Cellulitis Gastroenteritis Upper and ENT respiratory infections	Cellulitis Angina & chest pain Kidney and urinary infections Gastroenteritis Asthma	Angina & chest pain Cellulitis COPD Pneumonia Congestive heart failure	Pneumonia COPD Congestive Heart Failure Angina and chest pain Cellulitis
European/Other	Gastroenteritis Dental conditions Upper and ENT respiratory infections Asthma Cellulitis	Gastroenteritis Angina and chest pain Cellulitis Kidney and urinary infections Upper and ENT respiratory infections	Angina and chest pain Cellulitis Gastroenteritis Myocardial infarction Pneumonia	Angina and chest pain Pneumonia Congestive heart failure COPD Kidney and urinary infection

COPD: chronic obstructive pulmonary disease. ENT: Ear nose and throat.

2.2.8 Primary health organisation enrolment

When planning preventive services for Maaori, considering the proportions of Maaori enrolled with primary health organisations (PHOs) is worthwhile. In estimating the percentage of Maaori enrolled in a PHO, it is important to consider differences between ethnicity recorded from different sources.

Comparisons suggest that ethnicity data derived from both PHO and National Health Index (NHI) datasets underestimate Maaori and Asian populations while over estimating people who identify as Pacific and European/Others. Some people identified as Pacific or European/Other in the PHO register would be more correctly identified as Maaori or Asian in Census projections. It is also important to be aware that there are different 'views' of the enrolled population.

Based on 2017 quarter 1 PHO enrolment data, 80,024 Maaori living in Counties Manukau are enrolled in a PHO (Table 3). This reflects enrolment data for Maaori who are resident in Counties Manukau and who *are enrolled with any PHO* (some practices and PHOs are outside the Counties Manukau district) .However, 5,980 (7.4 percent) of the Maaori

[11] Avoidable hospitalisations includes hospitalisations of people aged under 75 years of age that could have been avoided through population based measures or through prevention, early detection and treatment of conditions.
[12] Leading causes are determined by absolute numbers, rather than rates, to reflect the burden of disease for our community and health system.

people domicile in Counties Manukau were enrolled outside of Counties Manukau PHO practice locality. Maaori health gain is therefore impacted by practices not covered by CM Health initiatives.

Table 3: Primary health organisation enrolment for Maaori resident in the Counties Manukau district[13]

Primary Health Organisation	Number of Maaori Enrolled	Percentage of Total Maaori Enrolled
ProCare	39,358	49%
Total Healthcare	17,719	22%
Alliance Health+	12,207	15%
National Hauora Coalition	6,482	8%
East Health	3,502	4%
Other PHOs	756	1%

[13] Data for the period October - December 2016, sourced from PHO Register. Includes residents living in Counties Manukau enrolled with any PHO and general practice, including those outside Counties Manukau

3.0 Key Achievements

In 2016/17 CM Health focused on health gain areas that were identified as national and local priorities. This included actions to shore up our health systems and improvements to the way we work with whaanau to make a positive difference to health outcomes. In most National Health Targets we improved equity for Maaori while still short of target by a very small number of people.

We are pleased to report achievement of equity for Maaori in all three Smokefree Health Targets across three health care settings – primary care, secondary and maternity. At the heart of our Smokefree success is gathering insights from Maaori clients and their whaanau, rapid testing and trying of service models that reach. The Smokefree experience has also continued to work with the healthcare system as a whole across all settings with the assumption that any contact where Maaori 'touch' the health system is a smokefree opportunity. These learnings can be replicated in many other settings.

This means working together differently across the district. Collectively CM Health reported achieving the following key outcomes in the past year.[14]

Maatua, pepi me tamariki (parents, infants and children)

- Ambulatory sensitive (potentially avoidable) hospitalisations in 0-4 year old tamariki Maaori have reduced by 5 percent
- Immunisation coverage for 8 month old pepi Maaori has increased 3 percent to 89 percent; with more improvements planned
- Proportion of obese tamariki Maaori referred in the Before School Check (B4SC) has more than doubled over the last year – 75 percent of obese tamariki Maaori seen in the B4SC had a referral sent and acknowledged by service provider
- Proportion of Maaori caregivers given SUDI (sudden unexpected death in infants) prevention information has increased from 58 percent to 73 percent

Rangatahi (young people)

- Achieved our target of 0.5 percent of rangatahi Maaori accessing Alcohol Brief Interventions

Pakeke me whaanau (adults and family group)

- By 30 June 2016, CM Health *achieved health equity for Maaori in all three of the 'better help for smokers to quit' targets,* i.e. of the pakeke accessing health services and offered brief advice and support to quit smoking – this was achieved for 95 percent of hospitalised pakeke, kaumatua and kuia; 90 percent of those seen in general practice and 90 percent of pregnant women at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer
- Ambulatory sensitive (potentially avoidable) hospitalisations for pakeke, kaumatua, kuia has reduced from a peak of 9,081 per 100,000 population in June 2015 to 8,161 in June 2016
- Modest reduction in the health equity gap for good diabetes management in Maaori adults

[14] By the end of quarter 2 (31 December 2016)

4.0 Performance Expectations for 2017/18

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the **true story of inequities**, i.e. what is the gap in health outcomes and scale of health gain we plan for?

Our thinking is that the comparator population is not so much right or wrong but appropriate or 'fit for purpose' to the local lived realities for our community. CM Health has chosen the New Zealand 'European/Other' population as our health equity comparator group.

For this reason, our baseline measures and related trend graphs outlined in Section 5 of this plan reflects this as our 'local health equity target' in addition to the national targets reflecting government performance expectations of the health sector.

Priority Area	Key Indicators	Baseline 2015/16 Total[15]	Baseline 2015/16 European/Other	Baseline 2015/16 Maaori	Target 2017/18 Result
Maatua, Pepi me Tamariki (Parents, Infants and Children)					
Breastfeeding	Percentage of babies fully or exclusively breastfed at 6-weeks	58%	67%	52%	75%
	Percentage of infants fully or exclusively breastfed at 3-months	46%	56%	37%	60%
	Percentage of infants fully, exclusively *or partially* breastfed at 6-months	58%	66%	45%	65%
Immunisation	Proportion of babies, infants and children fully immunised on time at:				
	▪ 8 months old	95%	94%	90%	95%
	▪ 2 year olds	95%	91%	92%	95%
	▪ 5 year olds	88%	88%	83%	95%
Babies exposed to smoking	Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with LMC who are offered brief advice and support to quit smoking	100%	NA	97%	95%
Oral health[16]	Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services	84%	90%	74%	95%
	Percentage of population of children aged 5 years who are caries free	48%	65%	38%	60%
	Mean DMFT of year 8 school children (12/13 years)	0.96	0.62	1.29	0.81
Rheumatic fever	Acute rheumatic fever first hospitalisations rates per 100,000 population	7.0[17]	NA	13.1	4.5
Hospitalisation	Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years[18]	7,109	4,789	6,264	5,951[19]
Death in infants	Sudden unexpected deaths in infants per 1,000 live births	0.96	0.52[20]	2.13	0.4
PHO enrolment	Proportion of newborns enrolled with a PHO by 3 months old	75%	70%[21]	84%	100%
Healthy Kids	Percent of obese children identified in the Before School Check (B4SC) programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		*New target*		95%

[15] Total means the indicator result for the all Counties Manukau population groups as at 30 June 2016 (unless otherwise noted)
[16] Baseline data is based on the calendar year (to 31 December 2016). A 'non-Maaori/non-Pacific' health equity comparator group applies as disaggregated 'European/Other' other data was not available in 2016. Note 2017/18 targets reflect national expectations for the total population.
[17] Baseline data Q1 2016/17
[18] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the Auckland, Waitemata and Counties Manukau Health Alliances 2017/18 System Level Measures Improvement Plan.
[19] The 2017/18 target represents a 5% reduction from baseline per the regional 2017/18 System Level Measures Improvement Plan.
[20] Non-Maaori equity comparator for this indicator
[21] Health equity comparator group is non-Maaori/non-Pacific for this measure

Priority Area	Key Indicators	Baseline 2015/16 Total[15]	Baseline 2015/16 European/Other	Baseline 2015/16 Maaori	Target 2017/18 Result
Rangatahi (Young People)					
Mental Health	Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)	0.42%	0.6	0.44%	0.5%
	Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)	0.06%	NA	0.11%	0.4%
Pakeke me Whaanau (Adults and Family Group)					
Hospitalisation [22]	Ambulatory sensitive hospitalisations in adults aged 45-64 years per 100,000 population	4,562	2,867	8,161	7,753
Cardiovascular disease	Percentage of eligible population receiving cardio-vascular risk assessment in the last five years	92%	93%	89%	90%
	Percentage of eligible Maaori men aged 35-44 years who have had their cardio-vascular risk assessed in the last five years	NA	NA	73%	90%
	Percentage of eligible population who have a risk greater than 20% and are on dual therapy (dispensed)[23]	49%	44%	48%	51%[24]
	Percentage of eligible population who have had a prior CVD event who are on triple therapy (dispensed)[25]	58%	57%	55%	58%[26]
Diabetes	Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)	65%	73%	61%	69%
	Percentage of enrolled patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 months is <140 mmHg	*The baseline and target is in development as part of a regional collaboration.*			
	Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker	*The baseline and target is in development as part of a regional collaboration.*			
Cancer screening	Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	69%	68%	65%	70%
	Proportion of women aged 20 - 69 years who have had a cervical smear in the last three years	75%	79%	69%	80%
Mental Health	Mental Health Act: Section 29 Indefinite Community Treatment Orders rates per 100,000 population	33.7	NA	131	↓ 10%
Te Roopu Whaanui o Counties Manukau (District Wide)					
Whaanau ora	Total packages[27] of care per annum delivered through Whaanau Ora Integrated Services	-	-	-	1224
Ethnicity data	Number of 54/61 'Other' codes in a practice's enrolment register	NA	NA	NA	<2%
Workforce	Maaori workforce headcount for prioritised occupational groups[28]	3,195	-	111	157
Primary care	Percentage of the population enrolled in a PHO	98%	96%	93%	98%

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

[22] Baseline data is for the 12 months ended 30 September 2016. The 2017/18 target represent a 5 percent decrease from baseline to align with ASH rate targets for 0-4 year olds in the regional 2017/18 Metro Auckland System Level Measures Improvement Plan

[23] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland System Level Measures Improvement Plan.

[24] The 2017/18 targets represent a 5% increase from baseline per the regional 2017/18 Metro Auckland System Level Measures Improvement Plan.

[25] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the regional 2017/18 System Level Measures Improvement Plan.

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

[27] There are five categories of care packages covering the whaanau life course from pepi through to kaumatua and kuia. Refer section 5.4.1 for further detail.

[28] Baseline data is for 30 June 2015.Counties Manukau target of 14.9 percent Maori workforce headcount is based on the estimated 2025 Maaori working population aged 20-64 proportion of the total working population; translated to annual recruitment targets by prioritised groups.

5.0 Maaori Health Gain Focus for 2017/18

5.1 Maatua, Pepi me Tamariki - Parents, Infants and Children

Good child health is important not only for tamariki and whaanau now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. Child health, development and wellbeing also have broader effects on educational achievement, violence, crime and unemployment. These impacts start in pregnancy and therefore our action focus is on the home environment, good nutrition, oral health and reduction in potentially avoidable diseases.

5.1.1 Breastfeeding

What are we trying to do?

Increase the number of Maaori babies and infants that are exclusively or fully breastfed.

Why is this a priority?

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

What will we focus on?

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

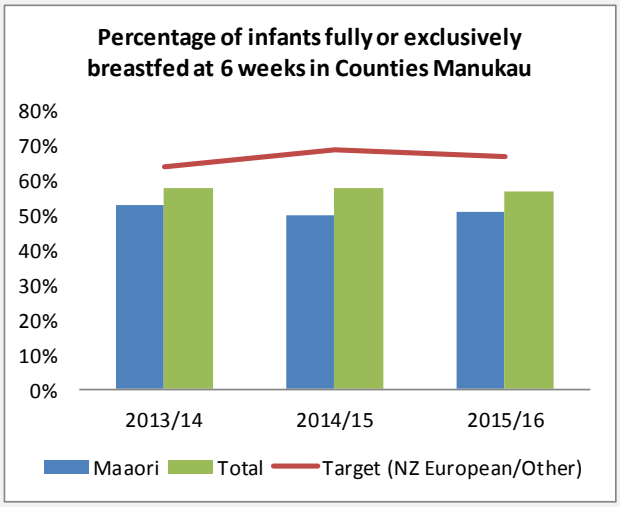
Where do we want to get to?

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

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of babies fully or exclusively breastfed at 6-weeks			
57%	67%	51%	75%
Percentage of infants fully or exclusively breastfed at 3-months			
46%	56%	37%	60%
Percentage of infants fully, exclusively *or partially* breastfed at 6-months			
58%	66%	45%	65%

Baseline data for Quarter 2 2015/16. Note trend data below is at 31 December for each financial year; data source Plunket for 2013/14 & Well Child Tamariki Ora (WCTO) providers thereafter.

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-Q4: Delivery of Te Rito Ora community based breastfeeding services including in home antenatal education, intensive postnatal support and peer support programme	
2	Q1: Recruit and train additional Maaori Peer Supporters	
3	Q1-Q4: Work collaboratively with Turuki Healthcare, one of the new Pregnancy and Parenting Education Providers, to co-deliver the breastfeeding education module to parents and enrol women and whaanau into the Te Rito Ora service	Q4: Evaluation Report on the collaboration

Ref.	What are we going to do?	Measures/Milestones
4	Q2: Implement 'Breastfeeding Welcome Here initiative' in Manukau and Mangere/Otara	Q4: Report
5	Q1-Q4: Support organisations in Counties Manukau who are Baby Friendly Community Initiative (BFCI) accredited or working towards BFCI to maintain/achieve their accreditation	Q4: Report
6	Q1-Q4: Provide breastfeeding education and training sessions to priority workforces	Q4: Report
7	Q1-Q2: Work collaboratively with Well Child Tamariki Ora (WCTO) providers to strengthen the support they provide breastfeeding maama and whaanau	Q3: Report on the collaboration
8	Q1-Q4: Increase Lead Maternity Carer, WCTO, primary care and community awareness about services and referral processes	Q4: Report

5.1.2 Immunisation

What are we trying to do?

Improve tamariki Maaori health by improving immunisation coverage.

Why is this a priority?

Tamariki Maaori have significantly lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases compared with European and other 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 and avoid potentially avoidable hospitalisations.

What will we focus on?

Achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and 2 and 5 years.

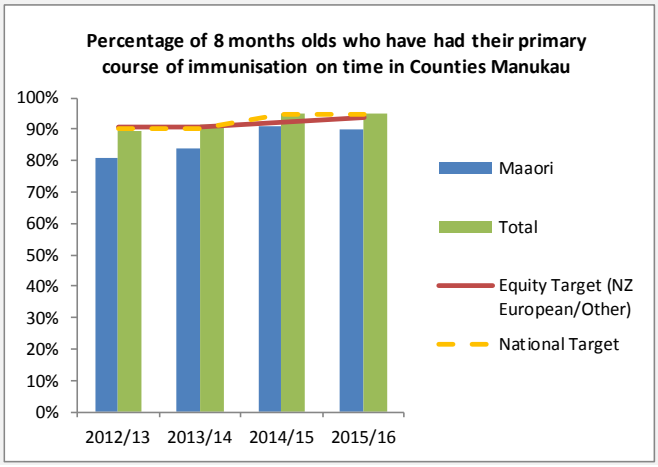
Where do we want to get to?

- 95 percent of Maaori babies are fully immunised at 8 months

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of 8 months olds who have had their primary course of immunisation on time[29]			
95%	94%	90%	95%
Percentage of 2 year olds fully immunised			
95%	91%	92%	95%
Percentage of 5 year olds fully immunised			
88%	88%	83%	95%

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

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Raise awareness about targeted immunisation programmes that drive increased engagement for tamariki Maaori and their whaanau	Implement joint communication plan with primary care and NGOs
	Q1-4: Deliver co-ordinated communications and promotional activity including media, events, on-site displays, and promotion through Well Child Tamariki Ora (WCTO) providers	
	Q1-4: Promote immunisation displays and engagement with Maaori in midwifery clinics and postnatal wards	
2	Q1-4: Gather intelligence about the experiences of tamariki Maaori and	Monthly monitoring and

[29] Primary immunisation includes 3 immunisation events at 6 weeks, 3 months and 5 months of age

Ref.	What are we going to do?	Measures/Milestones
	whaanau to support the development of programmes and interventions that grow increased engagement.	evaluation of immunisation coverage by Immunisation Working Group Performance improvement indicator – monthly DataMart report.
	Q1-4:Monitoring of GP enrolments, appointment declines, coverage gaps to improve service experience	
	Q1-4:Direct liaison between Immunisation Nurse Leader and General Practices with coverage support needs	
3	Q1-4: Deliver targeted immunisation strategies with service providers to support parents to maintain immunisation schedules for Tamariki Maaori. Programmes and interventions include the 'Awhi Mai' strategy, milestone immunisation alerts and prioritised outreach services	
4	Q1-4: Work with the Ministry of Health around newborn enrolment rate data discrepancies	Improved data accuracy

5.1.3 Babies exposed to smoking at home

What are we trying to do?

Pregnant Maaori women have significantly higher smoking prevalence than European/other people. Approximately 1,200-1,600 pregnant women smoke per year. We aim to support whaanau to become and stay smokefree to improve their health.

Why is this a priority?

Smoking is a key driver of the gap in life expectancy between Maaori and European/Other people. This contributes to lung cancer, cardiovascular disease and respiratory diseases. In addition, smoking in pregnancy has important risks to the baby (small for gestational age, prematurity) and contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. Increasing the number of Maaori who are smokefree is also an amenable mortality contributory measure as part of the regional System Level Measures Improvement Plan.

What will we focus on?

Our focus is to clearly understand the referral, and utilisation of, cessation services by Maaori, and maximising opportunities for supported quit attempts. The focus of this work is on pregnant mothers, however a range of approaches across the lifespan are in progress across Counties Manukau.

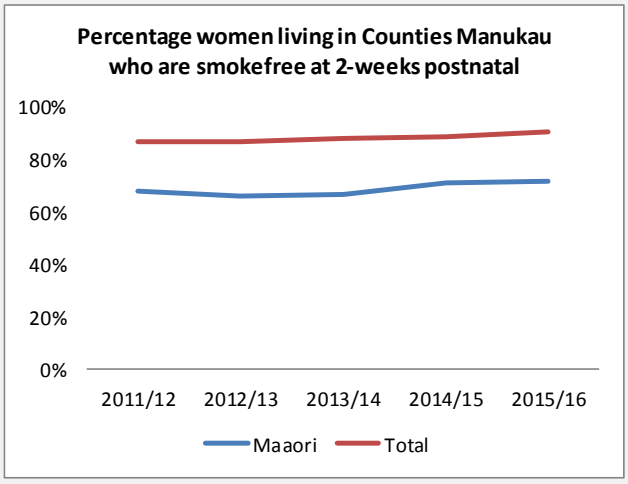
Where do we want to get to?

- 95 percent of women smokefree at 2 weeks postnatal

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with LMC who are offered brief advice and support to quit smoking			
100%	-	97%	95%
Proportion of babies who live in a smoke-free household at two weeks post natal			
91%	-	72%	86%

Baseline data for Quarter 2 2015/16 unless otherwise noted. The Smokefree household measure is six weeks postnatal and will replace the two week measure in 2018/19

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Develop and grow system capability to sustain an offering that is supportive of Maaori mothers who smoke and their whaanau to stop smoking. We will continuously monitor systems, resourcing levels and data quality.	Increased engagement by whaanau with the Smoking Cessation Service through the Hang Tough Don't Puff programme and the Health Equity Campaign

Ref.	What are we going to do?	Measures/Milestones
2	Q1-4: Monitor and review delivery of the Incentives programme to an increased number of young Maaori women, including a locality-based approach with a view to business casing further expansion	Evaluation of incentives programme in Q2 Dedicated Maternity Smokefree Advisor appointed
	Q1: Trial extending incentives programme in one locality to include the two week post natal time frame	
	Q1-4: Monitor provision and efficacy of Quickmist or any other new non-subsidised products for pregnant and postnatal women referred from primary birthing units and birthing	
3	Q1-4: Actions that align to the 2017/18 Metro Auckland SLM improvement Plan which relate to: ▪ Pregnant Smokers Referred to Cessation Support their Lead Maternity Carers and Referrals of Pregnant women who smoke to Stop Smoking Services ▪ exploring opportunities to offer smoking cessation support to new Maaori audiences (including inpatients and whaanau, parents and whaanau in home settings), increasing data analysis and insights gathering.[30]	
4	Development of Stop Smoking service delivery by healthcare professionals in identified localities to support Maaori whaanau to stop smoking	Healthcare professionals identified, trained and developed to become qualified Stop Smoking Practitioners. Maaori whaanau members who smoke are supported by Stop Smoking Practitioners who are health professionals in identified localities.

5.1.4 Oral health

What are we trying to do?

We want tamariki Maaori to be dental pain and disease free, with functional dentition (development of teeth and their arrangement in the mouth) from an early age. The means a full set of baby teeth to enable eating, and speech development, plus a positive dental self-esteem.

Why is this a priority?

Early childhood caries or dental decay remains the most prevalent chronic and irreversible disease in the western world. In New Zealand disparities still exist in oral health by ethnicity, deprivation level, and age group. This is particularly evident in Counties Manukau where Maaori children have higher rates of caries. Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being

Where do we want to get to?

- 60 percent of tamariki Maaori aged 5 years are caries free

2016 Total	2016 non-Maaori/ non-Pacific	2016 Maaori	2017/18 Target
Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services			
84%	90%	74%	95%
Percentage of population of children aged 5 years who are caries free			
48%	65%	38%	60%
Mean DMFT of year 8 of school children (12/13 years)			
0.96	0.62	1.29	0.81

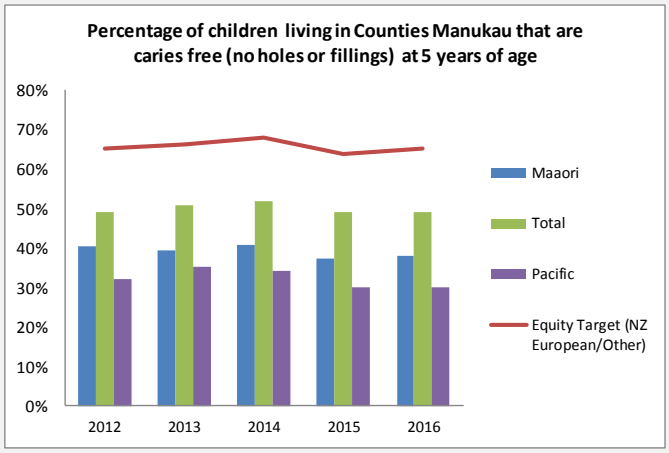
Baseline and trend graph data based on the calendar year (to 31 December). Note the 2017/18 target results above reflect the national targets for CM Health and are different to Auckland and Waitemata DHBs.

[30] Detailed actions can be found in the 2017/18 Metro Auckland System Level Measures (SLM) Improvement Plan

What will we focus on?

We want to reduce lifetime oral health inequities by preventing caries in preschool tamariki Maaori and maximise use of our funding for children's community oral health services, programmes and nutritional advice.

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Monitor delivery of programmes and support for families through health providers. Our aim is to increase our exposure to pepi, tamariki and rangatahi and make it easier for them and whaanau to attend.	Percentage of infants and preschool children examined by dental therapist at 1 year of age
	Q1-4: Follow-up of persistent Did Not Attends (DNAs) in preschool patient group through WCTO, Public Health Nurse or community health workers	Percentage of enrolled children aged 0 to 12 years in arrears i.e. more than 30 days overdue for their scheduled annual examination Percentage of adolescents utilising DHB funded oral health services
	Q1-4: Increase appointment capacity and reduce barriers to access by expanding service hours at Hub clinics in areas of high need for twilight weekday clinics and Saturdays	
2	Q1-4: Deliver targeted programmes of specific interventions (including tooth brushing, promoting healthy drinks, fluoride varnish application, nutrition and others) to support families to sustain their oral health.	Preschool oral health education and tooth brushing programme to an additional 80 identified preschools
3	Q1-4: Implementation of an early intervention Infant and Preschool strategy of Fluoride Varnish Application (FVA) and nutritional advice targeted to Maaori, infants to prevent caries in 12 month old infants (re-apply FVA every 6 months)	Reduced equity gaps for proportion of tamariki at 5 years who are caries free
4	Q1-4: Support regional Preschool Oral Health Strategy to improve engagement of tamariki Maaori	
5	Q1-4: Actions that support the 2017/18 Metro Auckland SLM Improvement Plan include; development of an engagement measure, awareness raising of free dental services and increased numbers of extended hours and Saturday dental clinics[31]	

[31] Detailed actions can be found in the 2017/18 Metro Auckland System Level Measures (SLM) Improvement Plan

5.1.5 Rheumatic fever

What are we trying to do?

Achieve a reduction in incidence of acute rheumatic fever (ARF).

Why is this a priority?

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

What will we focus on?

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

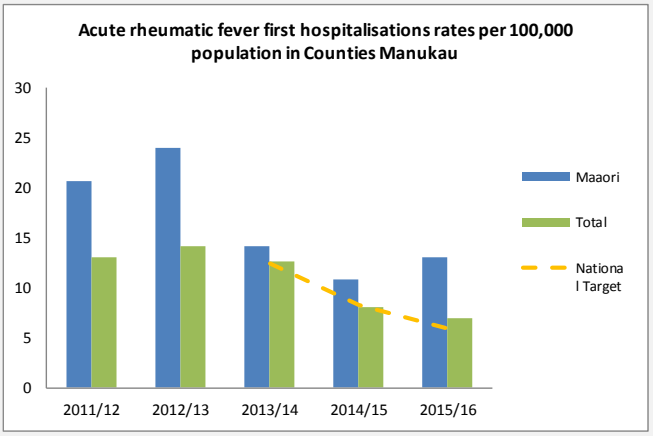
Where do we want to get to?

- Rate of ARF hospitalisations 4.5 per 100,000 population

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Acute rheumatic fever first hospitalisations rates per 100,000 population			
7.0	NA	13.1	4.5

Baseline data for Quarter 1 2016/17.

Where are we now?



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

5.1.6 Ambulatory sensitive hospitalisation (ASH) for tamariki aged 0-4 years

What are we trying to do?

Reduce potentially avoidable hospital admissions (ASH event) for tamariki Maaori aged 0-4 years.

Why is this a priority?

Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting. Keeping people well and out of hospital is a key priority; not only is it better for our population, but it frees up hospital resources for people who need more complex and urgent care. Reducing ASH for 0-4 year olds is a key focus of the regional System Level Measure Improvement Plan.

What will we focus on?

We will continue to provide a variety of activities to improve pathways for high priority (most frequent) ASH conditions for pepi and tamariki Maaori aged 0-4 years.

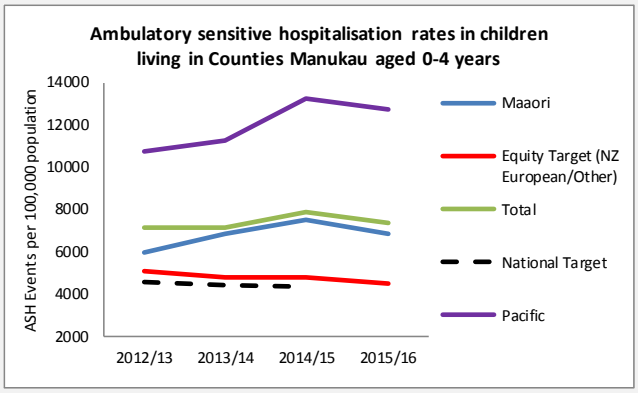
Where do we want to get to?

- 5 percent reduction in the ASH rate for tamariki Maaori aged 0-4 years

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years			
7,109	4,789	6,264	5,951[32]

Baseline data for 12 months to September 2016 aligned with the regional 2017/18 System Level Measures Improvement Plan. Data source: Ministry of Health SI1 Quarterly data.

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Support the increased integration of service offerings that contribute to reduced ASH rates for pepi and tamariki Maaori aged 0-4 years. Services include newborn enrolments, immunisation, nutrition, oral health and breastfeeding	At least 5 preschools and 3 primary schools engaged in a water-milk policy by Q4
	Q1-4: Design and implement a 'water and milk' only policy, eliminating sugary drinks, for high deprivation preschools & primary schools in Counties Manukau	
2	Q1-4: Develop CM Health system capability in providing support to whaanau with pepi and tamariki to improve self-management of health. Developments include provider training and clinical advice on skin infections and resources to support whaanau self-management of respiratory conditions	Reduction in ASH rate for pepi and tamariki Maaori 0-4 years
	Q1-4: Deliver training to WCTO providers and primary care on regional clinical pathways and resources for skin infections and early identification and treatment of skin infections and key messages for families for preventing skin infections ('clean, cut, cover')	Training delivered to WCTO providers in Q1 and to primary care by Q4
	Q4: Establish a clinical nurse specialist service to provide clinical advice to WCTO providers around the management of skin conditions	
3	Q1-4: Support Nurses in Primary Care to conduct assessments and development treatment plans for adults and children with respiratory conditions through the Clinical Pathway	All whaanau of tamariki with asthma have access to self-management support/plans
4	Q1-4: Actions that support the 2017/18 Metro Auckland SLM Improvement plan focus on; immunisation by 8 months of age, skin infections, oral health and respiratory conditions prevented by special immunisations[33]	

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

[32] 2017/18 targets represent a 5 percent reduction from baseline per the regional 2017/18 System Level Measures (SLM) Improvement Plan.
[33] Detailed actions can be found in the 2017/18 Metro Auckland SLM Improvement Plan

5.1.7 Sudden unexplained death in infants (SUDI)

What are we trying to do?

Reduce the number of SUDI deaths per 1,000 live births

Why is this a priority?

Sudden Unexpected Death in Infancy (SUDI) is the leading cause of preventable post-neonatal death in infancy. Maaori infants are 5 times more likely to die than non-Maaori infants in New Zealand. The current rate of SUDI per 1,000 live births for Maaori equates to approximately 6 Maaori babies per year.

What will we focus on?

We will focus on safe sleep environments for all pepi Maaori either in the home or in CM Health facilities. We will also provide resources and education to parents.

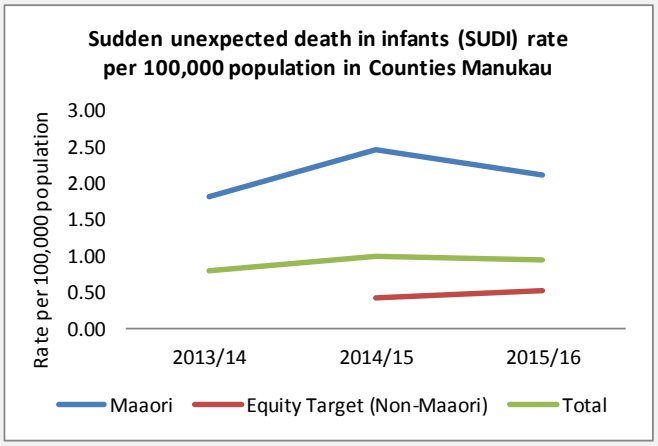
Where do we want to get to?

- 0.4 SUDI deaths of pepi Maaori per 1,000 live births

2015/16 Total	2015/16 Non-Maaori	2015/16 Maaori	2017/18 Target
SUDI deaths per 1,000 live births			
0.96	0.52	2.13	0.4
Percentage of caregivers of pepi Maaori provided with SUDI information at Well Child Tamariki Ora Core Contact 1			
80%	NA	73%	100%

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

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Develop the capability of the CM Health system through: maintaining the safe sleep policies and guidelines, workforce training and tools and evaluation of whaanau experiences.	SUDI Risk Assessment Tool available Lead Maternity Carers or Counties Manukau Midwives by Q2
	Q1-4: Review and improve use of assessment information to signpost support requirements to General Practice, service providers and CM Health workforce	
2	Q1-4: Grow the ability of whaanau to sustain safe sleep environments for their pepi. We will do this through in-home assessments, information to caregivers at WCTO core contacts, resources and awareness campaigns.	Development of a range of baby bed options for infants at high risk of SUDI. Implementation of distribution options for Lead Maternity Carers or Counties Manukau Midwives to access pepi-pod/wahakura for immediate provision as required.
	Q2 and Q4: Maternal and child health promotion of Safe Sleep at Matariki, and Safe Sleep Day through CM Health facilities, health providers and community sector	
3	Q1-4: Support the increased integration of services that have a positive impact in reducing the incidence of SUDI for pepi Maaori. Contributing services include breastfeeding and smoking cessation.	

Note and linkages: Actions supporting breastfeeding and smoking cessation make a significant contribution to reducing SUDI. Contributory actions in these areas are covered in other sections of this Plan.

5.1.8 Enrolment of newborn pepi with PHO providers

What are we trying to do?

To improve newborn enrolment coverage in Counties Manukau.

Why is this a priority?

Increasing the number of pepi enrolled with a PHO will enable better access to health services for pepi and opportunity to engage whaanau. Rates are already better than non-Maaori but still room to improve.

What will we focus on?

CM Health's Newborn Enrolment action plan outlines the newborn pepi enrolment issues and actions to address these. These actions will contribute to ASH for 0-4 year olds measure in the Auckland Region System Level Measure (SLM) Improvement Plan.

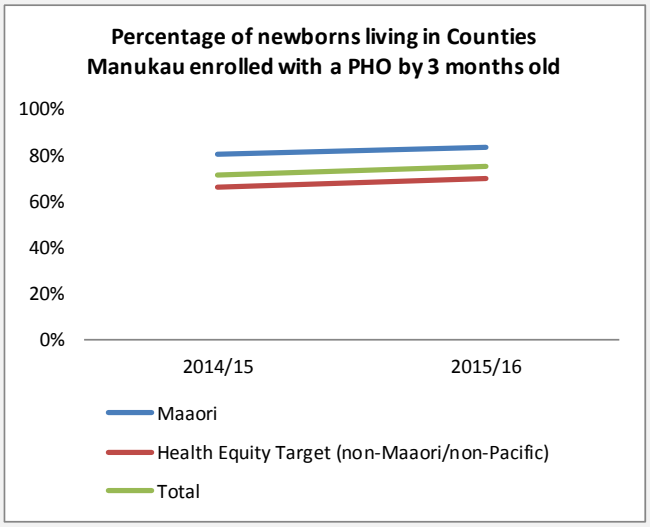
Where do we want to get to?

- 100 percent newborn pepi enrolment with a PHO

2015/16 Total	2015/16 non-Maaori/ non-Pacific	2015/16 Maaori	2017/18 Target
Proportion of newborns enrolled with a PHO by 3 months old			
75%	70%	84%	100%

Baseline data as at Q4 2015/16

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Implement CM Health Newborn Enrolment Action Plan Q1-4: Support PHOs and practices in implementing the Action Plan	Improve newborn pepi enrolments coverage
2	Support 0-4 year old ASH rates SLM working stream to reach the Counties Manukau target	Achieve ASH target in the Metro Auckland SLM 0-4 plan

5.1.9 Raising healthy kids – childhood obesity

What are we trying to do?

Increase the percentage of tamariki referred for support services arising from the Before School Check (B4SC) programme.

Why is this a priority?

Counties Manukau has the highest prevalence of childhood obesity in the country. Just over 14 percent of our 4 year olds are obese – which equates to approximately 880 children. Of all tamariki Maaori aged less than 15 years, almost 1 in 3 are obese or overweight.

What will we focus on?

Developing community-based support and maturing our referral services.

Where do we want to get to?

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

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

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

Ref.	What are we going to do?	Milestones

1	Involve people, whaanau and families as an active part of their health team and provide information in a way that is understandable and culturally appropriate	Q4. A Summative evaluation outlining the experiences of parents and children involved in the referrals process and interventions
	Monitor the rate of declines and gather insights from whaanau focus groups/interviews to best understand reasons for declines	
	Provide whaanau and families information to support nutrition, physical activity and lifestyle changes	
2	Develop IT systems in Primary Care to integrate information and referral processes	Report on the progress of IT systems development and integration of information and referral processes
	Integrate e-referral processes into Counties Manukau Health Practice Management Systems and standardise information	
	Establish dual-referral processes to Primary Care and family-based nutrition, activity and lifestyle intervention providers to support children identified as obese	
	Support the implementation of the regional growth chart solution for use in secondary care in Counties Manukau Health	
3	Grow Counties Manukau Health workforce capability to engage and support whaanau and families to make healthier lifestyle choices	
	Deliver training to support health professionals to initiate mana-enhancing conservations about weight management.	
	Provide Be Smarter Tool and Healthy Lifestyle Packs to Counties Manukau Health workforce	
	Provide training and site visits for General Practices to support the Healthy Weight guideline	
4	Scoping options for monitoring outcomes over time for children identified as obese at their B4SC	

5.2 Rangatahi - Young People

Good health enables rangatahi and young people opportunities to make meaningful contributions to their families and communities. Some risk factors for adult diseases, including diabetes, heart disease and also some mental health conditions are present for rangatahi.

5.2.1 Rangatahi mental health

What are we trying to do?

Improve access to mental health assessment and integrated care pathways.

Why is this a priority?

Maaori youth have higher rates of mental health disorders, present later for treatment and suffer worse health outcomes than non-Maaori.

What will we focus on?

Ensuring school-based health services are widely available to all eligible rangatahi Maaori

Improving access to primary mental health and alcohol brief intervention services in general practice, as well as a focus on 'youth friendly' primary care. This approach uses the primary care-based Chronic Care Management (CCM) Depression programme as a platform for 2017/18.

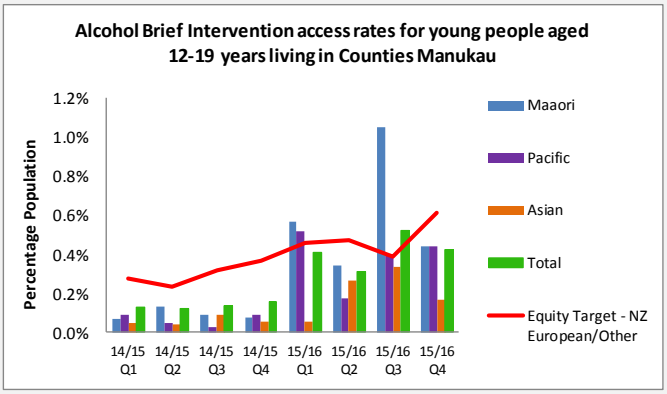
Where do we want to get to?

- 0.5 percent of rangatahi accessing Alcohol Brief Interventions
- 0.4 percent of rangatahi accessing Mental Health Brief Interventions

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)			
0.42%	NA	0.44%	0.5%
Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)			
0.06%	NA	0.11%	0.4%

Baseline data for Quarter 4 2015/16.

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Improve the responsiveness of primary care to youth (PP25 Initiative 5)	
2	Q1-4: The aim for mental health in primary care for 2017/18 is to reduce the disparity between Maaori and non-Maaori in the Chronic Care Management (CCM) Depression programme. Following information gathering and discussion with stakeholders including primary and secondary care, the following actions be implemented in 2017/18.	Implementation and socialisation of findings from Primary Care Youth Health Quality Improvement Project
	Q1-4: Partnering with Maaori providers including Te Ara WhiriWhiri (Maaori mental health collective)	
	Q1-4: Monitoring on a monthly basis with KPIs reported by ethnicity with a particular focus on patient engagement KPIs	
	Q1-4: Working to deliver group based Cognitive Based Therapy with potential for a rangatahi Maaori-tailored group	

5.3 Pakeke me Whaanau - Adult and Family Group

5.3.1 Ambulatory sensitive hospitalisations (ASH) for pakeke, kaumatua and kuia aged 45-64 years

What are we trying to do?

Reduce potentially avoidable hospital admissions for pakeke, kaumatua and kuia Maaori aged 45-64 years.

Why is this a priority?

Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through prophylactic or therapeutic interventions deliverable in a primary care setting. Keeping people well and out of hospital is a key priority; not only is it better for our population, but it frees up hospital resources for people who need more complex and urgent care.

What will we focus on?

We will continue to provide a variety of activities to improve pathways for high priority ASH conditions for pakeke, kaumatua and kuia Maaori aged 45-64 years.

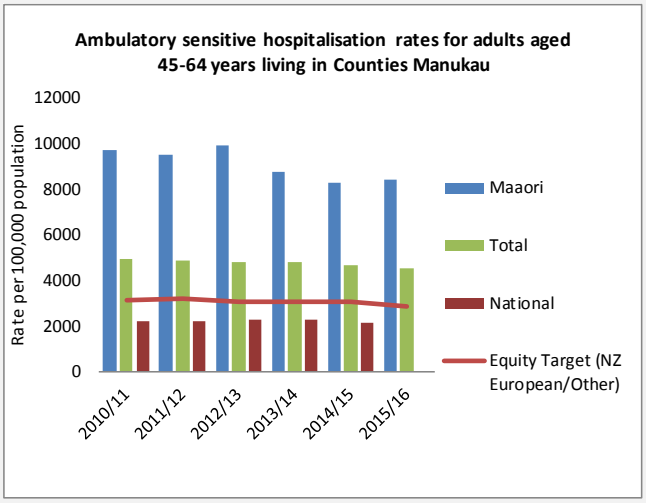
Where do we want to get to?

- 5 percent reduction in the ASH rate for Maaori aged 45-64 years 100,000 population

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Ambulatory sensitive hospitalisations per 100,000 population			
4,562	2,867	8,161	7,753

Baseline data is for the 12 months ended 30 September 2016. The 2017/18 target represents a 5 percent reduction from baseline. This target aligns with the ASH rate in children aged 0-4 in the 2017/18 Metro Auckland SLM Improvement Plan.

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Roll out network of registered nurse prescribers in Primary/Secondary schools and Primary Care to prescribe treatments for skin and throat infections.	
2	Q1-4: Support development of Primary Care Nurses in assessment, treatment planning through clinical pathway and specialist nursing advice.	
3	Q4: A minimum of 2 nurse-led clinics for skin conditions are established across CM Health to: ▪ Identify Maaori patients with complex needs for skin condition related treatment; and ▪ Provide care through a range of services and options including Planned Proactive Care, e-shared care and clinical pathways.	
4	Q1-4: Support the increased integration of services that have a positive influence in reducing the ASH rate for pakeke, kaumatua and kuia Maaori. These services include; Smoking cessation, Diabetes Management and Cardiovascular Disease (CVD) Risk Assessment & Management	Development of a supportive model of care with clinical nurse specialists and primary care nursing. Reporting on dispensing rates for Maaori and Non-Maaori patients

5.3.2 Long term conditions – cardiovascular disease

What are we trying to do?

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

Why is this a priority?

Cardiovascular disease is one of the most significant causes of death for Maaori men and an important cause of death for Maaori women. Maaori have higher prevalence of risk factors associated with cardiovascular disease. Increasing the number of eligible Maaori who receive a Cardiovascular disease Risk Assessment and improving management for Maaori with cardiovascular disease is a priority for CM Health. This contributes to the regional amenable mortality Metro Auckland SLM Improvement Plan.

What will we focus on?

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

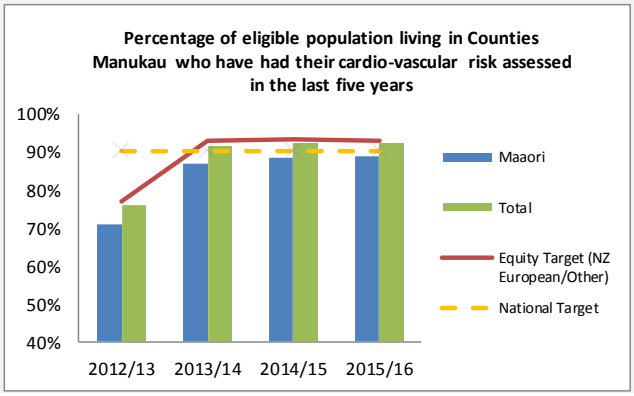
Where do we want to get to?

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

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of eligible population receiving cardio-vascular risk assessment in the last five years			
92%	93%	89%	90%
Percentage of eligible Maaori men aged 35-44 years who have had their cardio-vascular risk assessed in the last five years			
NA	NA	73%	90%
Percentage of eligible population who have a risk greater than 20% and are on dual therapy			
49%	44%	48%	51%[34]
Percentage of eligible population who have had a prior CVD event who are on triple therapy			
58%	57%	55%	68%[35]

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

Where are we now?



Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: Implement and review information gathering and processing protocols to continue enhancing care offerings to people with identified risk factors. This will include best practice guidelines on advice, data monitoring and electronic decision support.	
2	Q1-4: Develop information sharing protocols and relationships to ensure that services offered are of greatest value to users and whaanau. This will include support for Maaori health providers offering packages of care, Te Reo Maaori language resources and multi-disciplinary clinical teams	Development of a Te Reo Maaori resource, such as 'Know your numbers' and the Healthy Heart food guide
3	Q1-4: Targeted engagement with Maaori for promotion or for proactive support. This will include community awareness projects, active recalls to General Practice and dual therapy prescriptions for Maaori with CVD risk of >20%	A community engagement/awareness raising project targeting taane Maaori aged 35-44
4	Q1-4: Total population and specific interventions for Maaori to improve uptake and adherence to triple therapy (and including lifestyle intervention on nutrition, physical activity and stopping smoking).	

[34] 2017/18 target represents a 5% increase from baseline per the regional 2017/18 System Level Measures Improvement Plan.
[35] 2017/18 target represents a 5% increase from baseline per the regional 2017/18 System Level Measures Improvement Plan.

Ref.	What are we going to do?	Measures/Milestone
5	Q1-4: Actions that support the 2017/18 Metro Auckland SLM Improvement plan include; Maaori specific interventions to increase uptake and adherence of secondary and tertiary prevention medications[36]	

5.3.3 Long term conditions - diabetes

What are we trying to do?

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

Why is this a priority?

Prevalence, morbidity and mortality rates from diabetes are higher for 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.

What will we focus on?

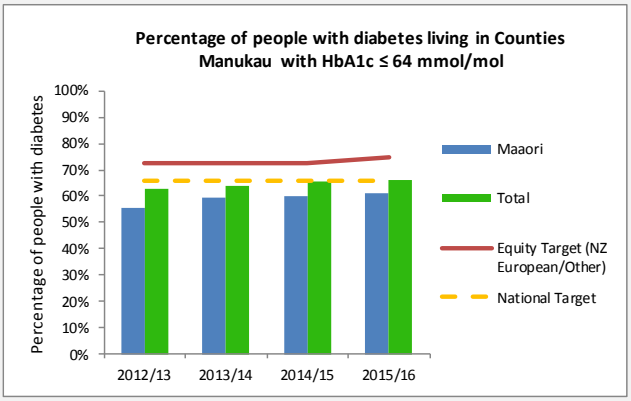
We will redesign the Diabetes Care Improvement package to focus on those who have poor glycaemic control. Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance.[37]

Where do we want to get to?

- 69 percent of Maaori adults with diabetes have satisfactory or better diabetes management

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)			
65%	73%	61%	69%
Percentage of enrolled Maaori patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 mths is <140 mmHg			
Baseline data in development			
Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker			
Baseline data in development			

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Continue to deliver targeted support and interventions to pakeke, kaumatua, kuia and their whaanau that enable more timely access to treatment. This includes increasing the number of programmes offered in community settings, increased General Practice referrals for screening, increased access to self-management resources and access to psychological assessment where necessary	Evaluation of the outcomes of trialling group based diabetes nutrition education for Maaori and their Whaanau. Updated messaging distributed to Primary Care providers outlining the benefits of early referral of pregnant women with diabetes for retinal screening Ethnic-group reporting of five Diabetes indicators to enable performance monitoring
2	Q1-4: Develop information gathering, analysis and sharing practices and protocols to sustain the cultural integrity of the care offering and support delivery across the system. This includes patient management information sharing, case review, medication compliance data and patient experience evaluations.	

[36] Further specific actions can be found in the 2017/18 Metro Auckland System Level Measures Improvement Plan

[37] Baseline data for Quarter 4 2015/16. The two diabetes management measures are in development as part of a regional collaboration Baseline data is pending (as at June 2017.

5.3.4 Cervical and breast cancer screening

What are we trying to do?

Reduce Maaori breast and cervical cancer morbidity and mortality.

Why is this a priority?

Maaori women continue to have significantly higher burden of disease and persistent and unacceptable lower participation in the cervical screening programme. Breast screening can reduce breast cancer mortality through early detection.

Where do we want to get to?

- Equity in cervical and breast screening for wahine Maaori

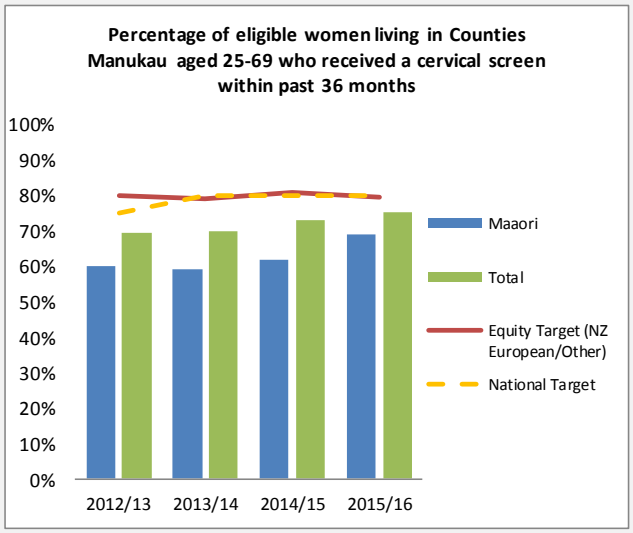
2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of eligible women aged 50-69 who received a breast screen within past 24 months			
69%	68%	65%	70%
Percentage of eligible women aged 25-69 who received a cervical screen within past 36 months			
75%	79%	69%	80%

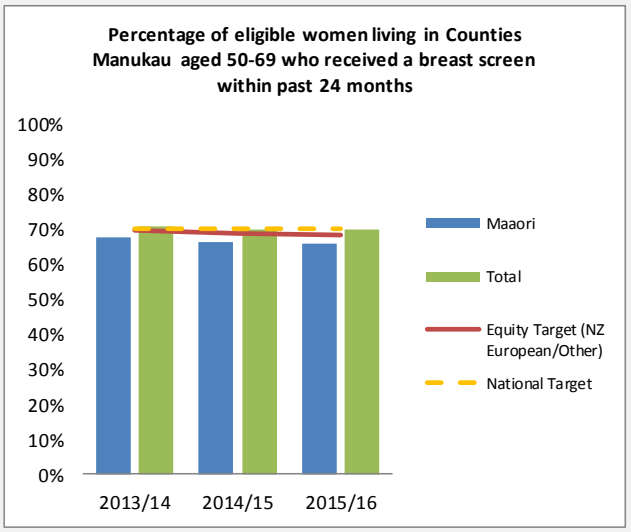
Baseline data for Quarter 4 2015/16 unless otherwise noted.

What will we focus on?

More equitable and improved breast screening coverage rates for Maaori women. We will also focus on implementing activities to improve Maaori women's access to cervical screening services.

Where are we now?





Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: CM Health and PHOs in the district will work together to update the district-wide and PHO level cervical screening action plans. The plans will focus on improving screening coverage for Maaori and other Priority Group Women, particularly those who are unscreened and under screened.	Each PHO has a dedicated cervical screening coordinator and PHOs work with their general practices to support the establishment of a cervical screening champion role by Q4 100 percent of practices offered BSCM data matching
2	Q1-4: Continue developing the capability of the CM Health system to deliver targeted and responsive screening services to wahine Maaori as an identified priority group. System developments include; data matching to support women overdue for screening, staff training, quality improvement programmes and system improvements in General Practice	
3	Q1-4: Implement and deliver targeted programmes and interventions that support equitable update of cervical and breast screening by eligible wahine Maaori. This includes contracting for free screening, extended hours, expansion into community settings, direct follow-ups of women overdue for screening, social media campaigns and follow-up by clinicians	Contracts with each PHO for free smears for Priority Maaori women continue
4	Q1-4: CM Health, Breast Screen Counties Manukau, PHOs and other stakeholders in the district will work together to update the BreastScreen Regional Co-ordination Plan. The plans will focus on improving screening	

Ref.	What are we going to do?	Measures/Milestones
	coverage for Maaori and other Priority Group Women, particularly those who are unscreened and under screened	
5	Q1-4: The Support to Screening Service will develop its opportunities to collaborate with Primary Care, Health service providers and General Practice to ensure increased access to communities under served by screening services	

5.3.5 Mental Health and Addictions

What are we trying to do?

Improve the wellbeing of Maaori through better access to Mental Health and Addictions services.

Why is this a priority?

Counties Manukau has a disproportionate numbers of Maaori being treated under the Mental Health Act s29 Community Treatment Orders (CTOs).

What will we focus on?

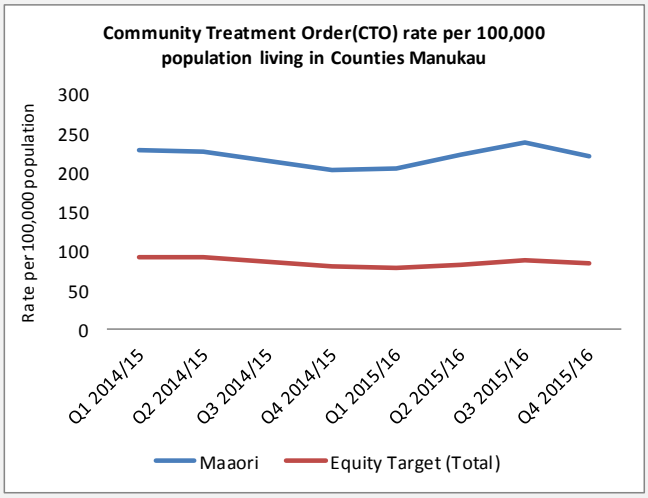
We are focusing on improved engagement with whaanau as well as improved data collection and analysis systems.

Where do we want to get to?

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Whaanau Engagement Action Plan milestones implemented			
To be confirmed during 2017/18			
Mental Health Act: Section 29 Indefinite Community Treatment Orders (CTO) rates per 100,000 population			
33.7	-	131	↓ 10%

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

Where are we now?



Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Implement the Action Plan to improve consultation/engagement with whaanau to enhance service user recovery and ability to be release from a CTO	Consultation with whaanau increased to 60%
2	Q1-4: Automate clinical reporting for Mental Health Act reviews and Data feeds into the Director Area Mental Health Services Dashboard	100 percent Monthly s.76A Report automated
3	Q1-4: Mental Health Workforce are competent in working with Maaori service users and their whaanau	50 percent of MH&A Workforce completes 'Engaging Effectively with Maaori' course

5.4 Te Roopu Whaanui o Counties Manukau - District Wide

There are health systems that are potential barriers to health gain for Maaori in our district, e.g. better health services information that helps us to understand where we can make improvements. Other actions are those that impact whaanau across Counties Manukau and our key focus is people, our current and future workforce.

5.4.1 Working better with whaanau

What are we trying to do?

To develop co-ordinated, whaanau centred service that enable whaanau to take responsibility to sustain their health and social wellbeing. CM Health Whaanau ora Integrated services are designed to measure and evidence its contribution to improving outcomes for whaanau and communities.

The following outcome statements are derived from quality of conditions to target 5 specific areas of high need aligned with specific packages of care and measureable outcomes:

a. **All children have the best start in life** (Mama Pepi Tamariki)

b. **All rangatahi realize their potential** (Rangatahi Oranga)

c. **All whaanau have control of their quality of life** (Whanau oranga)

d. **Living well with a long term condition** (Oranga ki Tua)

e. **Kaumatua and Kuia are living healthy** (Kaumatua Kuia Oranga)

Why is this a priority?

There are an estimated 87,200 Maaori residing in Counties Manukau; 16 percent of the total Counties Manukau population. Fifty percent of people are living in areas of high socioeconomic hardship. Currently patients experience disjoins in the care experience between secondary and primary services.

What will we focus on?

Growing capability of service providers and workforces to deliver high quality and integrated packages of care. By working differently, we will concurrently support whaanau to take the lead in whaanau wellness.

Ref.	What are we going to do?	Measures/Milestones
1	Deliver an integrated Whaanau ora outcomes based on packages of care for complex whaanau aimed at providing flexibility for providers to meet the specific needs of Maaori clients and their families.	
	Q1-4: To deliver *Integrated Matua Pepi Tamariki services* to pepi and tamariki (from 0-5 years), expectant mothers and their whaanau.	A total of 200 packages of care per annum.
	Q1-4: To deliver *Integrated Rangatahi Oranga* services to youth, rangatahi (from 15 to 24 years) and their whaanau.	A total of 64 packages of care per annum.
	Q1-4 To deliver *Integrated Whanau Oranga* services to high needs whaanau (from 25 to 64 years) and their whaanau.	A total of 500 packages of care per annum.
	Q1-4: To deliver *Integrated Oranga ki Tua* to whanau who are effected by long term conditions (all ages) and their whaanau.	A total of 380 packages of care per annum.
	Q1-4 To deliver *Integrated Kaumatua Kuia Oranga* services to the elderly (from 64 years+) and their whaanau.	A total of 80 packages of care per annum.
2	Q1-4: To support fit for performance providers in delivering whaanau ora outcomes based services to high need populations.	Enabling Provider capability and capacity
3	To develop, support and increase the professional Whaanau ora workforce. Includes the professional pathway of Whaanau ora navigators, Whaanau Ora Case Management Practitioners and Clinical Whaanau ora practitioner	Increased workforce capability

Ref.	What are we going to do?	Measures/Milestones
	Q1-2: Identify National based qualifications and training programmes that support professional whaanau ora workforce	Qualification alignments identified
	Q2-4: Support Maaori Health providers to develop and implement professional Whaanau ora practitioner portfolio	Whaanau ora practitioner portfolio implemented
4	To implement and deliver Whaanau ora case management and competency training to Health providers delivering Whaanau ora based services to Maaori and their whaanau	Proportion of providers competency trained
	Q1: To support Maaori Health providers to implement competency based training and upskilling to all staff that work with whaanau	
	Q2-4: To promote national Whaanau ora qualifications from level 3-5	
5	Q1-4: Supporting Whaanau capability and capacity - *Tikanga a Whaanau* - To support and mentor whaanau champions to enable whaanau to lead their whaanau wellness	Whaanau champions identified and supported to lead their whaanau wellness
	Q1-2: Identify and support key whaanau champions in empowerment and enabling whaanau leadership	
	Q1-4: Identify and acknowledge current whaanau capacity and employment opportunities	
	Q2-4: Support Whaanau champions in training that increases whaanau capability and capacity	

5.4.2 Data quality

What are we trying to do?

Ethnicity Data Audit Tool (EDAT) was implemented in 2015/16. In the year following implementation, a series of actions were introduced for each PHO to address the EDAT findings, in particular to improve ethnicity data quality.

Where do we want to get to?

Greater accuracy of ethnicity coding of Maaori enrolled in general practice. This means less than 2 percent 54/61 'Other' codes in a practice's enrolment register.

Why is this a priority?

With the introduction of the National Enrolment Service (NES) and a refresh of the Ethnicity Data Protocols, a number of data issues related to recording and collection that previously existed have now been removed.

What will we focus on?

The focus will now be on embedding and maintaining a high level of ethnicity data quality. This will be achieved by monitoring the operational processes in ethnicity data recording and collection and implementing continuous quality improvement processes.

Ref.	What are we going to do?	Milestone
1	Q1-4: PHOs to run 54/61 'Other' queries in all practice enrolment registers and to provide annual results to the DHB.	Action plan to outline quality improvement activities where use of 54/61 codes is above the recommended level
2	Q1-4: PHOs to develop an action plan to outline quality improvement activities where use of 54/61 codes in a practice is above 2 percent of the practice enrolment register. The plan is to be submitted annually to the DHB	Regular PHO reporting against achievement or progress

5.4.3 Workforce development

What are we trying to do?

Increase Maaori participation and achievement in health education through to the employed workforce in the Counties Manukau district. We want more senior and junior Maaori health professional working in our rohe across primary/community health and hospital services.

Why is this a priority?

There are a significant smaller proportion of Maaori employed staff compared to the proportion of Maaori accessing services and living in our rohe. Increasing Maaori and Pacific secondary school student participation and attainment rates for NCEA level sciences will improve the supply of future workforces and economic support for whaanau.

What will we focus on?

We will take a "lifecycle" approach to increase not only the pipeline of Maaori and Pacific students pursuing a Health Career, but better support recruitment, retention and leadership development approaches that will enhance workforce diversity. This will be successful by working locally and regionally to share expertise and learn what works for Maaori.

Where do we want to get to?

- By 2025, 14.9 percent of the DHB workforce is Maaori
- By 30 June 2018 a net increase in number of Maaori headcount employed in prioritised occupations by 46

Occupation Group	Jun 2015 Maaori Workforce	Jun 2018 Extra Maaori Workforce	Jun 2025 Extra Maaori Workforce
Junior Medical	10	5	43
Nursing	86	34	274
Midwifery	11	2	15
Dental Therapist	NA	NA	NA
Dietitian	1	1	5
Occupational Therapist	3	2	14
Physiotherapist	0	2	15

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

Recruitment targets by occupational group were set in each of the Auckland Metropolitan DHBs as part of a 2016/17 regional workforce planning commitment. Note that Dental therapists are Waitemata DHB employed therefore not applicable to CM Health recruitment targets.

For estimated Maaori recruitment numbers, the Northern Region agreed to a target denominator of adult working population aged 20-64 years. Annual recruitment targets are based on a 2025 estimate of 14.9 percent of the working population are Maaori and annual recruitment targets are calculated compared to the 2015 baseline.

Ref.	What are we going to do?	Measures/Milestones
1	Q1-4: Develop, Implement, Promote and/or Monitor programmes that support Rangatahi Maaori to consider, study for, train for and apply for jobs in the Counties Manukau Health Workforce. Programmes include: Kia Ora Hauora, Health Science Academies, COACH, MASH, REACH, Te Oohanga Mataora Paetahi Placement Programme, Cadet and Internship Programmes	End of year summary outlining engagement and achievement rates of workforce pipeline development programmes. The establishment of Youth Pledge aligned mentoring and support programmes as part of the Equity Campaign
2	Advance the *Whakamana Takuta Maaori* Health Equity Campaign project to grow the Maaori medical workforce in Counties Manukau.	
	Q1-2: Learn from the 2016/17 Workforce Hui outcomes to establish a Maaori doctors group (junior and senior hospital and primary health care doctors) to better support current and future Maaori staff	Existing Maaori medical workforce engaged in a supportive group
	Q2-3: Identify and survey existing Maaori doctors in Counties Manukau to assess how "Maaori friendly " Counties Manukau is as a workplace and opportunities to improve	Completed survey and recommendations for on-going development
	Q2-4: Work to attract and recruit more PGY1 junior doctors in the November 2017 intake	25 percent more Maaori PGY1 junior doctors by Dec 2017
3	Q2-4: Grow Maaori nurse participation in primary health care services	DHB sponsorship of 10 Maaori nurse graduates
4	Q1-4: Develop practices and policies that actively support the recruitment and retention of talented Maaori candidates	Increased number of Maaori candidates successfully

Ref.	What are we going to do?	Measures/Milestones
		obtaining interviews for positions applied for.
	Q1-4: Improve the completeness of our ethnicity data to reflect ≥ 95 percent of our workforce – starting with the DHB employed workforce and agreed commitment to gathering primary health workforce data	DHB workforce ethnicity data 95 percent complete Primary health workforce data collection commitment
	Q1-4: Build on the established recruitment process to define and embed recruitment criteria that recognises and values Maaori and Pacific workforces capabilities	Regional collaboration on Maaori workforce recruitment and retention approaches
5	Q1-4: Develop and implement programmes and practices that develop the leadership potential of Maaori staff in CM Health	Defined Maaori leadership development pathway and support structures

5.4.4 Primary care enrolment

What are we trying to do?

Ensure access to health care, to reduce inequities in health status for Maaori and improve Maaori health outcomes.

Why is this a priority?

PHO enrolment is considered an important indicator of good access to primary health care services.

What will we focus on?

Identifying Maaori who are not enrolled with a General Practitioner and other vital services, offering support to enrol. Refer to section 5.1.8 for newborn enrolment actions.

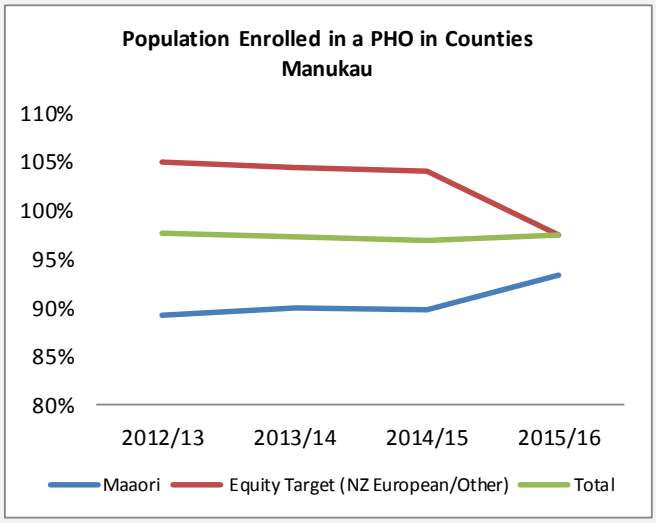
Where do we want to get to?

- 98 percent of Maaori are enrolled in a PHO

2015/16 Total	2015/16 European/Other	2015/16 Maaori	2017/18 Target
Percentage of the population enrolled in a PHO			
98%	96%	93%	98%

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

Where are we now?



Source: PHO database and population projections (Census 2013 base 2015/16 onwards)

Ref.	What are we going to do?	Measures/Milestone
1	Q1-4: We will continue to encourage un-enrolled whaanau to enrol in a PHO. We will utilise our networks through Whanau Ora providers, the Kaahui Ora hospital-based service, social media and maternity services	Percentage Maaori enrolled
2	Q1-4: PHOs will work with practice teams to ensure practice and reception staff are aware of the benefits of enrolment with a PHO and are highlighting the benefits along with patient choice of provider to patients who attend for casual visits	

5.4.5 Regional Maaori health gain planning

What are we trying to do?

The Auckland Region DHBs have a common goal to accelerate health gain in their respective Maaori populations. Together, we aim to review and learn from our health gain activities, insights and outcomes so we can benefit from our collective knowledge, leadership and guidance from relationships with Mana Whenua, iwi and health leaders.

Why is this a priority?

There are enduring inequities for Maaori that will need different approaches to make a positive change in health outcomes. Where it is helpful to do so, we need to work together to achieve best value from available resources, experience and skills in the Auckland region.

What will we focus on?

We will focus on priorities alignment and joining up conversations and expertise where appropriate. We will share available Maaori health status data; leverage respective Maaori health oversight and governance forums.

Where do we want to get to?

We will translate our korero (conversation) and learning to develop a three year Auckland Regional Maaori Health Gain Plan and ongoing health gain reporting.

Ref.	What are we going to do?	Measures/Milestones
1	Q1: Develop an Auckland Region[38] Auckland Maaori health equity scorecard for DHB respective Maaori health advisory and governance forum review and development	Auckland Regional Maaori Health Equity Scorecard
2	Q1-2: Explore opportunities for regional Maaori health governance forum linkages	Respective Chair discussions
3	Q3: Conduct a 2016/17 Maaori Health Gain Hui to identify health gain priorities that would benefit most from regional collaboration	Hui completed by Nov 2017
4	Q3-4: Develop a Metropolitan Auckland Maaori Health Gain Plan 2018-2020	Draft plan to respective Boards by May 2018

[38] This includes Auckland, Waitemata and Counties Manukau DHB districts

6.0 Appendices

6.1 Glossary

Term	Definition
ASH	Ambulatory sensitive hospitalisation (potentially avoidable)
B4SC	Before school check
BFCI	Baby Friendly Community Initiative
CTO	Community treatment order (under the Mental Health Act)
DHB	District Health Board
DMFT	Decayed Missing Filled Teeth
DNA	Did not attend (people scheduled but did not present for a health care appointment)
EDAT	Ethnicity data audit tool
FVA	Fluoride varnish application for teeth (in pre-school aged children)
HbA1c	Measure of blood sugar levels
HPA	Health Promotion Organisation
Kaumatua & Kuia	Older people
Maatua	Parents (plural)
NGO	Non-government organisation
Pakeke	Adults
Pepi	Infants
PGY1	Postgraduate year 1 (junior doctors)
PHO	Primary health organisation
Rangatahi	Young people
SLM	System level measure (national set of six health indicators)
SUDI	Sudden unexpected death in infants
Tamariki	Children
WCTO	Well child tamariki ora (service providers)
Whaanau	Family group

Spelling and writing Maaori in Counties Manukau Health documents

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

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

6.2 Mana Whenua i Tamaki Makaurau Hauora Plan 2012 to 2017

MANA WHENUA
i Tamaki Makaurau

Hauora Plan – 2012 to 2017

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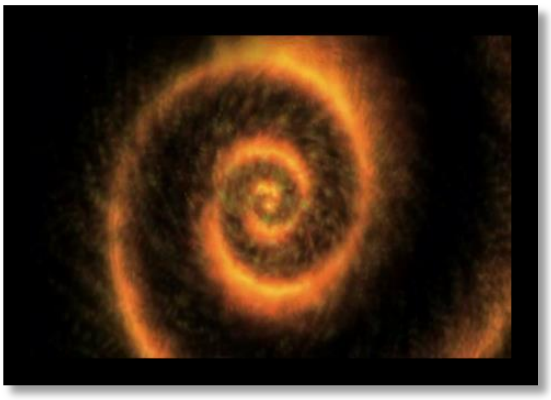
Kupu whakataki - Preface

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

[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

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:

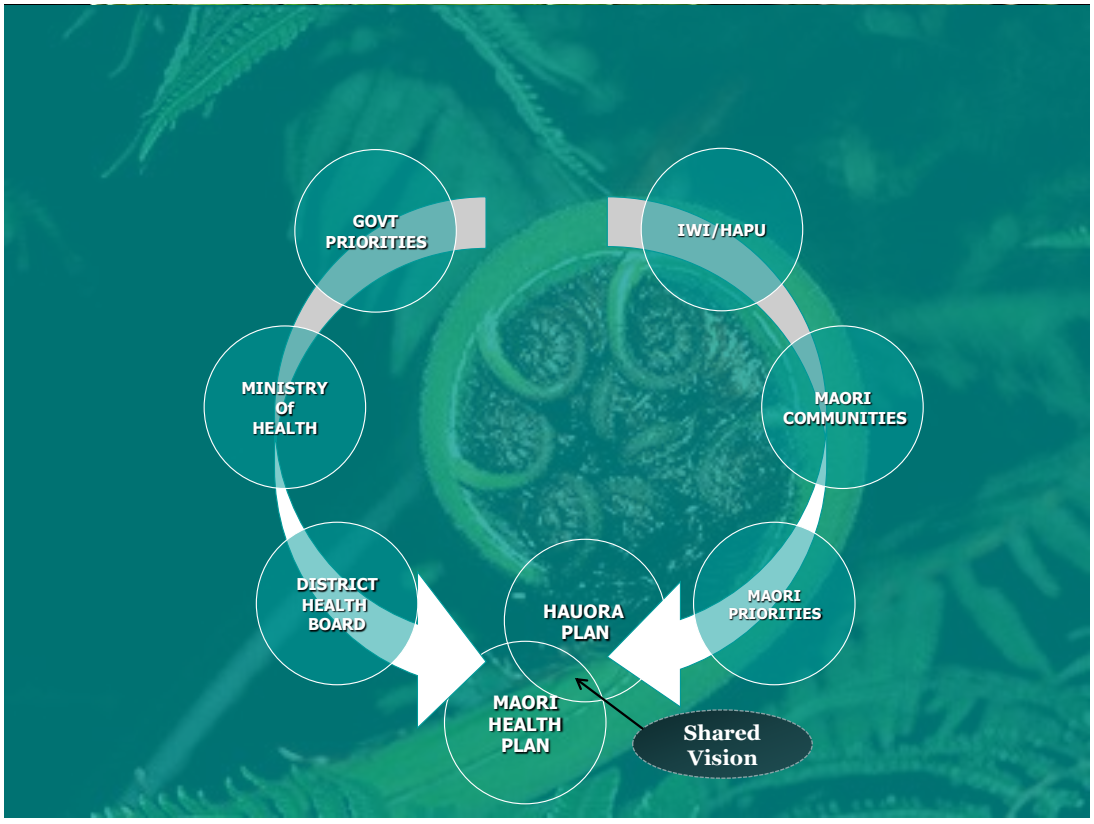
- Counties Manukau sits within the rohe of Mana Whenua i Tamaki Makaurau; the legitimate entity with which to secure a Treaty relationship with the Crown and its agencies
- True partnering with health authorities and relative Crown Agencies will support the planning and operation of competent, high quality 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.

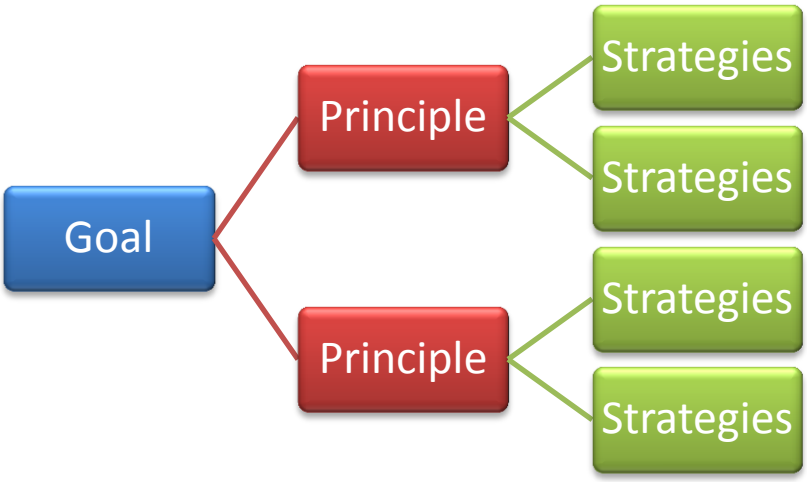
A tested whanau outcome measuring tool adapted by one of our local organisations was also trialled by Mana Whenua in October 2011 to inform the Hauora Plan. This exercise illustrated the value of a whanau centred evaluation process measuring wellbeing principles to determine service quality. The findings 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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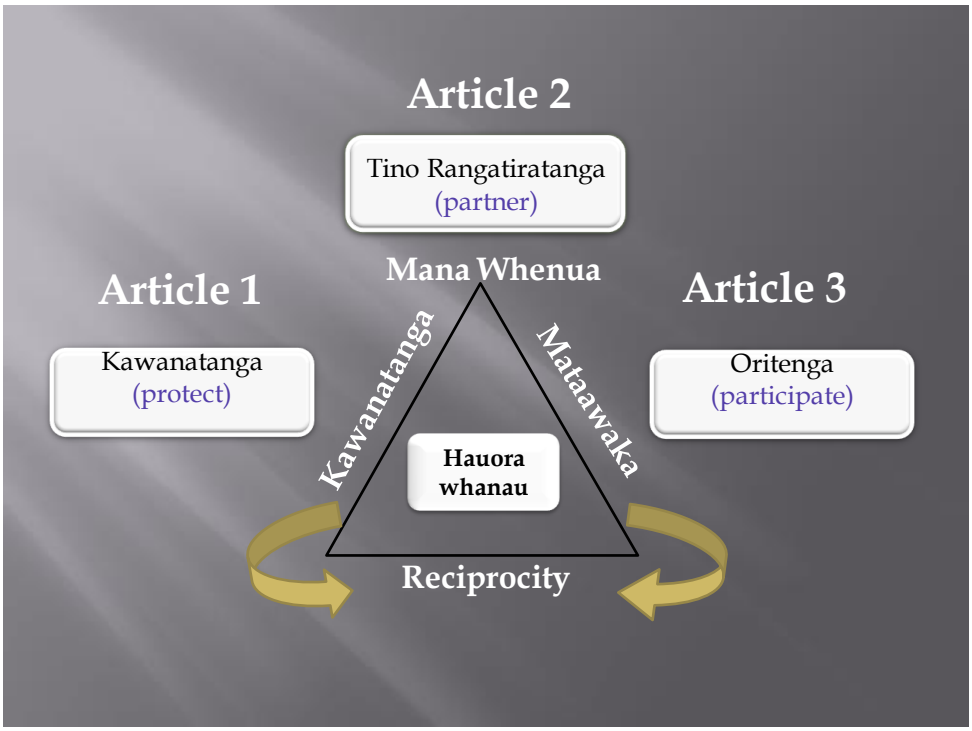
[6] Kawharu I (ed): 1994, p 287
[7] 2011 presentation by Kere Cookson Ua, CEO of Te Kahu Pokere, Te Runanga o Ngati Whatua
[8] Kingi, TKR (2006) *The Treaty of Waitangi and Maori Health.* Te Pumanawa Hauora, School of Maori Studies, Massey University, Wellington
[9] Orange, C (1987) *The Treaty of Waitangi*, 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]

******

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.

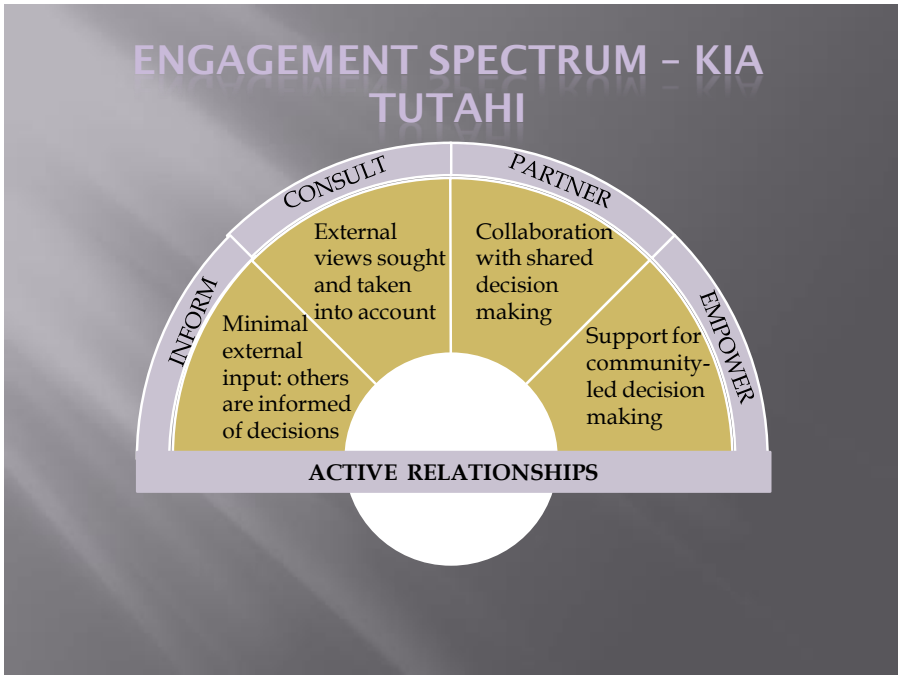
What would happen if the planning of services to Maori was undertaken to deliberately and directly include whanau priorities and aspirations? We are confident that such an approach would not only improve Maori utilisation and engagement but lift the status of whanau health and wellbeing. There is amble 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 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.

[14] Downloaded from: www.thelancet.com volume 378, 12 November 2011
[15] Kia Tutahi Relationship Accord – Guide produced by the Office of the Community & Voluntary Sector (2011)



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 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
- 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.

[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

[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.

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.

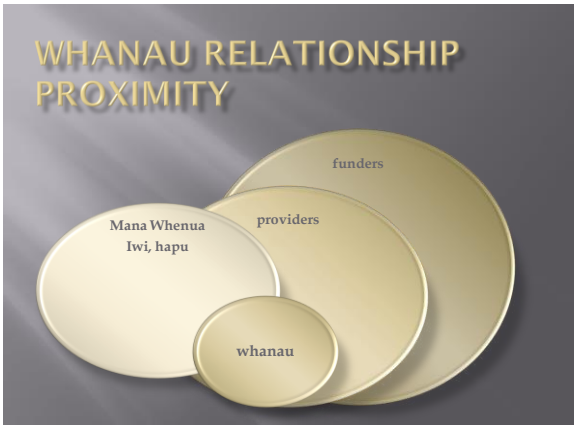
Cunningham proposes that mainstream measures health rather than hauora. While tools applied by health authorities measure physical health, mental health and independence; Maori concerns include spiritual, whanau and environmental wellbeing. 'Hauora is not the Maori word for health. It is related but 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.

[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.

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