



# **TE MATAKITE MĀORI HEALTH PLAN 2012-2013**



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## **INTRODUCTION**

This Plan documents the direction for planning, funding, and delivery of services in Taranaki during 2012/13, that focus on improving Māori health and reducing Māori health inequalities. It sits within a framework of DHB planning that aims to achieve the vision of “Taranaki Whanui, He rohe oranga” and the wider aspirations of Whānau ora as described in He Korowai Oranga, national Māori Health Strategy and Te Kawau Mārō, Taranaki Māori Health Strategy 2009 - 2029.

The draft plan consists of the following sections:

- Section One – Profile of the Taranaki DHB population

- Section Two – Health Needs Profile

- Section Three – Summary of Planned Actions

- Section Four – Monitoring Framework Description

- Section Five - National Priorities and Actions

- Section Six - Regional Priorities and Actions

- Section Seven - Local Priorities and Actions

Sections Five, Six and Seven identify the actions the Taranaki DHB will carry out over the next 12 months to address the priorities that have been identified, provides the rationale for their prioritisation and includes the indicators that will be used to measure progress.

## 1. SECTION ONE: TARANAKI MĀORI POPULATION

- 1.1. Taranaki DHB serves 2.8% of the Māori population of New Zealand. At the 2006 Census, 15,816 Māori were resident in Taranaki; this represents the 14<sup>th</sup> highest number of Māori serviced by any of the DHB's. However Māori make up 15.2% of the total Taranaki DHB population which is slightly higher than the national of 14%.
- 1.2. In the regional context Taranaki DHB has the lowest number and lowest proportion of Māori living in its service area of all the Midland DHB's. The highest number and proportion of Māori live in the Midland region.

### Age Distribution

- 1.3. The Māori population has a younger age structure than the non-Māori population, with 35.9% of Māori aged under 15 years, compared to 21.8% for non-Māori. Just under half (47%) of Taranaki Māori are under the age of 20 years while over 60% of Māori living in Taranaki are under the age of 30 compared to 36% of non-Māori. The median age of Taranaki Māori (half are younger, and half older) is 22.3 years while the median age of the total Taranaki population is 38.0 years.
- 1.4. At the 2006 census 14.8% of the total Taranaki population was over the age of 65 compared to only 4.8% of the Māori population.

### Iwi

- 1.5. There are eight iwi in Taranaki:

IWI	TOTAL IWI POPULATION	IWI POPULATION RESIDENT IN TARANAKI	% IN TARANAKI
Ngati Tama	1,167	306	26.2%
Ngati Mutunga	2,094	516	24.6%
Te Atiawa	12,852	2,721	21.1%
Ngati Maru	735	192	26.1%
Taranaki	5,352	1,473	27.5%
Ngaruahinerangi	3,726	1,449	38.8%
Ngati Ruanui	7,035	1,614	22.9%
Ngaa Rauru Kiihahi	4,047	726	17.9%
<b>TOTAL</b>	<b>37,008</b>	<b>8,997</b>	<b>24.3%</b>
<b>Māori: non-Taranaki iwi</b>		<b>6,801</b>	
<b>Total Māori Population</b>		<b>15,798</b>	

### Geographic distribution

- 1.6. TDHB comprises three territorial authorities. In 2006 the majority of the population were based in the New Plymouth District Council catchment (9369) while the largest proportion were based in the South Taranaki District (20.6%).

	South Taranaki District	Stratford District	New Plymouth District
<b>Total Population</b>	26,484	8,892	68,898
<b>Māori (%)</b>	20.7%	10.9%	13.6%

### Population Growth

- 1.7. The Māori population in Taranaki is growing much faster than the non-Māori population, which is projected to decline. The Taranaki population is projected to increase from 104,280 in 2006 to 109,975 by 2026, an increase of 5.5%. However, the Māori population is expected to increase to 22,800 over the same period, an increase of 44%. This means that, by 2026, Māori are expected to account for around 20.7% of the region's population compared to 15.2% in 2006.

- 1.8. The Māori population in the region will increase faster in the younger age groups. By 2026, Māori are expected to account for 36.7% (27.3% in 2008) of those aged under 15, and 33.6% (23.9% in 2008) of those aged between 15 and 24.
- 1.9. Māori who whakapapa to Taranaki iwi account for 57 percent of the local Māori population or around 9,000 people, while almost 43 percent whakapapa to iwi outside of Taranaki. Around one quarter of the 37,000 Taranaki uri live in the Taranaki region.

#### **Deprivation**

- 1.10. Taranaki had a higher proportion of people living in deciles 6 to 10. Māori make up a significantly higher proportion of Taranaki residents in deprivation deciles 8 and 9 and a much higher proportion of Māori in decile 10. Conversely in deciles 1 to 4, the proportion of non-Māori is much higher.

## **2. SECTION TWO: HEALTH NEEDS PROFILE**

The health needs of Taranaki Māori and priorities for action, based on the four pathways of He Korowai Oranga, are identified in the Taranaki DHB's Whānau Ora Health Needs Assessment 2012\* and are summarised as follows:

- a. **Te Ara Tuatahi Pathway One – 'Development of Whānau, hapu, iwi and Māori communities'**  
Whānau, hapū, iwi and Māori community development as a basis for Whānau Ora is a priority area. The challenge for funders and providers is to identify ways in which they may facilitate this development without taking leadership and therefore risking engendering dependency.
- b. **Te Ara Tuarua Pathway Two – 'Māori participation in the Health and Disability Sector'**  
Building the capacity and capability of Māori providers and the Māori health workforce are identified priorities. Key providers of health services for Māori in the TDHB region currently include:
  - Te Kawau Mārō strategic alliance between Tui Ora Ltd and the National Hauora Coalition and their respective affiliated providers. The alliance is the preferred provider of Māori-specific primary health care services in Taranaki;
  - Two PHOs: The *National Hauora Coalition PHO* incorporates the General Practices of Ruanui Health Services in Hawera with 57% or 3354 of its enrolled population being Māori, Te Atiawa Medical Services in New Plymouth with 1918 or 66% of its enrolled population being Māori and Te Waipuna Medical Clinic in Waverley with 41% or 744 Māori enrolled. The *Midlands Health Network* has 13% or 99,653 of its enrolled population across the Midland region identifying as Māori;
  - Two public hospitals - Taranaki Base Hospital in New Plymouth with 179 inpatient, 25 inpatient mental health, 21 emergency department and 18 maternity beds and Hawera Hospital with 20 inpatient, 7 emergency department and 4 maternity beds.

In terms of the Māori health and disability workforce, there is a lack of reliable information available to assess this currently. The Taranaki DHB regularly collects information on its workforce though accuracy of the data is limited, while there is no mechanism for gathering NGO workforce data.

Whakatipuranga Rima Rau Trust (WRR) is a joint venture between Te Whare Punanga Korero Trust, Ministry of Social Development and the Taranaki DHB. Supported by the TSB Community Trust and Te Puni Kokiri, WRR aims to get 500 Māori into jobs in the Taranaki health and disability sector over ten years.

As at June 2012, 6.67% of Taranaki DHB staff or 113 from a total of 1,695 identified as being of Māori ethnicity.

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\* Whanau Ora Health Needs Assessment, Māori living in Taranaki, Mihi Ratima and Becky Jenkins, Taranaki DHB, February 2012

**c. Te Ara Tuatoru Pathway Three – ‘Effective health and disability services’**

Increased access to health services at all levels, and particularly at the primary health care level are priorities and include geographically equitable access to quality health care across the Taranaki Region and the implementation of Whānau Ora oriented service provision.

The priorities in terms of protective and risk factors and preventative care are smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening.

Priority health conditions identified are diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

**d. Te Ara Tuawha Pathway Four – ‘Working across sectors’;**

There is clear evidence that Māori living in Taranaki have poor access to socio-economic determinants of health, and this is reflected in high relative levels of deprivation, compared to non-Māori. It is also reflected in barriers to health care and related needs (e.g. ability to pay for service provision and access to transport) identified through community engagement. Addressing determinants of health through intersectoral collaboration is a priority area.

**3. SECTION THREE: SUMMARY OF PLANNED ACTIONS**

The action plans that follow describe the activities the Taranaki DHB will undertake during 2012/13. The actions, reflective of the financial constraints faced by the TDHB, are presented in tables that summarise:

- What we are trying to do
- What we will focus on to do this
- The outcome we desire
- Who will be responsible
- What we are going to do and why
- Where we are at now
- Where we want to get to in the next year
- Key Issues
- The inequalities status between Māori and non-Māori

The action plans relate to the following national, regional and local priorities:

National Priorities and Indicators		
1	N1-Data Quality	Ethnicity data accuracy in PHO registers
2	N2-Access to Care	Percentage of Māori enrolled in PHOs
3		Ambulatory sensitive hospitalisation (ASH) rate 0-4 yrs 45-64 yrs 0-74 yrs Age Standardise Rate per 100,000
4		N3-Maternal Health
5	N4-Cardiovascular Disease	Number of tertiary cardiac interventions
6		The proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five years
7	N6-Cancer	Breast screening rate among the eligible population
8		Cervical screening rate among the eligible population
9	N7-Smoking	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit
10		Percentage of smokers in primary care who are provided with advice and help to quit

11	N8-Immunisation	Percentage of 8 month olds fully immunised
12		Seasonal influenza immunisation rates for Māori aged 65 years and over
<b>Regional Priorities and Indicators</b>		
13	R1- Māori Health Investment and Māori Provider Capacity Development	Investment in Māori-specific services including Māori provider service contracts, Māori-specific services in mainstream organisation, Māori PHO's (non-capitated funding) and Māori health and disability workforce development
14	R2 Māori health workforce	Increase the recruitment and retention of Māori into the Taranaki DHB workforce
	R3-Action plans for the following regional priorities are provided in He Raranga-A-Tira Regional Services Plan, Midland Māori Health Accountability Framework, Section Two, Midland Regional Services Māori Health Action Plan. The priorities and indicators are summarised below:	
15	Active participation of Māori in decision-making / Promoting and Monitoring Māori health gain	Integrate a robust Māori Health component into the Midland Regional Services Plan (RSP)
16		Integrate Māori Health Plan priorities and monitoring framework into the Midland RSP
17	Build Māori health workforce capacity within Midland region	Kia Ora Hauora projects in secondary schools, tertiary institutes and Māori community completed
18		Annual report on Midland DHB's Māori health workforce by professional group (R2)
19		Renal and cancer work-streams establish one day training for Midland Māori non-regulated workforce
20		Midland Tumu Whakarae represented on Midland Training Network Leadership Group
21	Mechanisms in place to audit and monitor cultural responsiveness of NGO and Midland DHB's	He Ritenga cultural audit done in one regional service area in all Midland DHB's
22		Midland staff have access to Bicultural education
<b>Local Priorities and Indicators</b>		
23	L1-Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments
24	L2-Oral Health	Percentage of 5 year olds in Taranaki carries-free
25		DMFT scores at year 8 in Taranaki
26	L3-Respiratory Health	Asthma hospitalisation rate 0-14 years ASR per 100,000
27	L4-Sudden Unexplained Death of Infants Syndrome	SUDI mortality rate per 1,000 live births of Māori infants
28	L5-Māori Health Workforce	Report on the total number of Māori recruited to the Incubator programme

29	L6-Whanau Ora	Te Kawau Mārō strategic alliance integrated outcomes-based contract
30		Support the implementation of Taranaki Ora provider collective business plan
31		Framework for intersectoral planning to address health and socio-economic determinants
32	L7-Diabetes	Percentage of diabetics who have attended a Diabetes Management Programme;
33		Percentage of diabetics who have participated in a Diabetes Management Programme and are HbA1c < 64 mmol/mol

#### 4. SECTION FOUR: MONITORING FRAMEWORK

4.1. A performance monitoring framework is being developed to monitor sector performance to improve Māori health and reduce Māori health inequalities. It incorporates the following elements:

- a. A quarterly dashboard showing progress over time, against quantitative targets. National indicators will be presented as a Midland dashboard comparing progress of the five Midland DHB's over time;
- b. Quarterly review of progress against individual National, Regional and Local priorities;
- c. Annual dashboard summary of achievement against all targets. The dashboard will also present the absolute disparities gaps between Māori and non-Māori in relation to each indicator, and will also provide an indication of progress over time made in addressing inequalities;

4.2. Taranaki DHB will participate in regional seminars in which the experiences of high-performing DHB's will be shared to improve outcomes in areas where targets are not being met.

4.3. Responsibility for development, implementation and accountability for each priority is allocated to the relevant TDHB manager. They will report to a joint TDHB and Te Whare Punanga Korero Iwi relationship Board forum convened to monitor progress to improve Māori health and reduce Māori health inequalities.

4.4. Māori Health Plan monitoring reports will be disseminated to the following stakeholders for information and follow up relevant to each stakeholder group:

- a. Te Whare Punanga Korero (Taranaki Iwi representative body)
- b. Taranaki DHB Board and Advisory Committees
- c. Taranaki DHB Executive Management Team
- d. Taranaki DHB Clinical Governance Board
- e. Taranaki DHB Planning, Funding and Population Health portfolio management team
- f. Taranaki DHB Hospital and Specialist Services management team
- g. Midland Health Network PHO
- h. National Hauora Coalition PHO
- i. Te Kawau Mārō strategic alliance
- j. Midland GM's Māori
- k. Midland Region Iwi Relationship board
- l. Ministry of Health
- m. Other stakeholders as required.

4.5. Quarterly, six-monthly and/or annual (as relevant to each indicator) quantitative assessment of disparities between Māori and non-Māori, where relevant, will be reported. The following symbols will be used to report progress on inequalities indicators:

- Progressing well     
 - Some progress     
 - No progress or worsening  
 - Not yet sufficient time to judge     
 - Further info or work required  
 - Increasing gap     
 - Decreasing gap

Monitoring reports will be used to constantly check progress, identify areas for adjustment and inform subsequent actions to improve Māori health



## 5. SECTION FIVE: NATIONAL PRIORITIES AND INDICATORS ACTION PLAN

<b>Health Priority N1 DATA QUALITY</b>	<b>What are we trying to do?</b> – Improving the accuracy of ethnicity data in PHO registers	<b>To achieve this we will focus on:</b> Achieving high levels of accuracy of ethnicity data in PHO registers	<b>Outcome we desire:</b> Accurate population health information to inform planning and service delivery	<b>Who will be responsible:</b> Portfolio Manager, Primary Care
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
December 2012	1. Engage with PHOs to carry out ethnicity data audits	<ul style="list-style-type: none"> <li>The accuracy of ethnicity data in PHO and TDHB databases is unknown</li> <li>Accurate ethnicity data is essential for tracking progress in Māori health outcomes</li> </ul>	<p>There is currently no known baseline of the accuracy of ethnicity data captured by PHOs or TDHB</p> <p>The MOH is developing an ethnicity data audit tool to audit ethnicity data accuracy.</p>	<ul style="list-style-type: none"> <li>Audits completed or scheduled for completion in each Taranaki PHO</li> <li>Data accuracy baseline is determined and performance targets set for PHO registers</li> </ul>
March 2013	2. Work with PHO's to set ethnicity data accuracy performance targets for PHO databases and schedule subsequent ethnicity data accuracy audits			
June 2013	3. Work with PHO's to improve collection, quality, availability and sharing of population health data across the DHB and PHO's.			
Annually, quarter 4	4. Complete reporting control schedule at required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Accurate ethnicity data is essential for tracking progress in Māori health outcomes. The accuracy of ethnicity data in PHO databases is unknown			Māori	Unknown
			Non-Māori	Unknown
			Progress	
			Gap	

<b>Health Priority N2.1 ACCESS TO CARE</b>	<b>What are we trying to do? – Increase PHO Māori enrolment rates</b>	<b>To achieve this we will focus on:</b> Percentage of Māori enrolled in PHOs	<b>Outcome we desire:</b> Increased access to primary care	<b>Who will be responsible:</b> Portfolio Manager, Primary Care
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
30 September 2012	1. Assess the current rate of PHO enrolment for Māori and non-Māori in Taranaki	<ul style="list-style-type: none"> <li>PHO enrolment rates vary throughout the country</li> <li>PHO enrolment facilitates easier access to preventative health care and early condition management</li> </ul>	Māori enrolled with PHOs is 86% as at December 2011	96%
December 2012	2. Establish a reporting system which provides six monthly PHO enrolment rates for Māori and non-Māori			
December 2012	3. Engage with PHO's to raise awareness regarding enrolment rates for Māori compared to that of non-Māori and work with PHO's to establish PHO enrolment targets			
Half-yearly	4. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> PHO enrolment facilitates easier access to preventative health care and early condition management			Māori	86% enrolled
			Non-Māori	96% enrolled
			Progress	†
			Gap	10%

<b>Health Priority N2.2 ACCESS TO CARE</b>	<b>What are we trying to do? – Reduce the ambulatory sensitive hospitalisation (ASH) rate</b>	<b>To achieve this we will focus on:</b> Ambulatory sensitive hospitalisation (ASH) rate (0-4y, 45-64, 0-74y) ASR per 100,000	<b>Outcome we desire:</b> Improved access to primary care	<b>Who will be responsible:</b> Portfolio Manager, Primary Care
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
December 2012	1. Profile ASH presentations by diagnosis, age, location and other variables	<ul style="list-style-type: none"> <li>ASH rates for Māori are almost double those of non-Māori</li> <li>Effective primary care can reduce ASH rates</li> </ul>	83% 0-4 years, 86% 45-64 years, 81% 0-74 years	<95% 0-4 years, <95% 45-64 years, <95% 0-74 years
January 2013	2. Identify interventions to address the leading causes of ASH			
January 2013	3. Work with primary care to identify systems and strategies which will reduce ASH			
February 2013	4. Establish a reporting system which provides quarterly information on agreed indicators and includes referral for oversight of the Clinical Governance Board			
Quarterly	5. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> ASH rates for Māori are almost double those of non-Māori Effective primary care can reduce ASH rates				
				0-4 yrs 45-64 0-74
			Māori	83% 86% 81%
			Non-Māori	65% 65% 77%
			Progress	‡ ‡ ‡
			Gap	18% 21% 4%

<b>Health Priority N3 MATERNAL HEALTH</b>	<b>What are we trying to do? -</b> Percentage of infants exclusively breastfed at 6 months	<b>To achieve this we will focus on:</b> Improving Māori breast feeding rates	<b>Outcome we desire:</b> Increase in breast feeding rates for Māori and reduce inequalities in breastfeeding rates between Māori and non-Māori	<b>Who will be responsible:</b> Portfolio Manager, Population Health; Service Manager, Child and Maternal Health								
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>								
October 2012	1. Support the implementation of the Breastfeeding Friendly Community Initiative and breastfeeding peer support services	There are benefits to baby if breastfed exclusively (not having any solid food) until six months old, and continuing to breastfeed once baby has started solid food, until at least 1 year of age (Plunket New Zealand).	6 months Māori 13%	6 months Māori 26% by 30 June 2013								
January 2013 and six-monthly	2. Monitor data collection and reporting processes for breastfeeding statistics resulting from the Breastfeeding Friendly Community Initiative											
Half-yearly	3. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)											
<p><b>Key Issues:</b> Breastfeeding contributes significantly to infant, maternal, and whanau health in both the short and long term. In the short term, breastfeeding reduces the risk of infectious diseases and respiratory diseases. It also reduces the risk of sudden Unexplained Death of an Infant (SUDI) and lowers the risk of hospitalisation in the first year of life. The long-term benefits include reductions in the risks of chronic conditions such as obesity, type 2 diabetes, asthma, and cardiovascular disease. Breastfeeding benefits for the mother include a reduction in the risk of post-partum haemorrhage, type 2 diabetes and breast ovarian cancers (Ip et al 2007, Horta et al 2007, Leon-Cava et al 2002).</p>			<table border="1"> <tr> <td>Māori</td> <td>13%</td> </tr> <tr> <td>Non-Māori</td> <td>22%</td> </tr> <tr> <td>Progress</td> <td>†</td> </tr> <tr> <td>Gap</td> <td>9%</td> </tr> </table>		Māori	13%	Non-Māori	22%	Progress	†	Gap	9%
Māori	13%											
Non-Māori	22%											
Progress	†											
Gap	9%											

<b>Health Priority N4.1 CARDIOVASCULAR DISEASE</b>	<b>What are we trying to do? – Monitoring the number of tertiary cardiac interventions for Māori and non-Māori in TDHB</b>	<b>To achieve this we will focus on: Number of tertiary cardiac interventions</b>	<b>Outcome we desire: Reduced mortality through improved cardiovascular health</b>	<b>Who will be responsible: Clinical Services Manager, Medical</b>
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
August 2012	1. Determine the number of tertiary cardiac interventions for TDHB Māori for the 2011/12 year	A Midland Regional Services Plan was developed in 2011; reducing inequalities in cardiovascular outcomes and improving access to CVD management are priorities for the Midland Māori population.	Baseline not yet established. Data will be collected as part of the national indicator set.	A Midland target will be established proportionate to both CVD burden and local and national tertiary cardiac intervention rates.
September 2012	2. Compare TDHB intervention rates with other regional and national benchmarks			
September 2012	3. Set up a reporting system which provides monthly tertiary cardiac intervention rates			
Half-yearly	4. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> The rate of cardiovascular disease hospitalisation and mortality are higher for Māori than non-Māori in Taranaki and the extent of disparities is greater for mortality.			Māori	TBA
			Non-Māori	TBA
			Progress	?
			Gap	TBA

<b>Health Priority N4.2 CARDIOVASCULAR DISEASE</b>	<b>What are we trying to do? –</b> Increasing the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population	<b>To achieve this we will focus on:</b> Proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five year	<b>Outcome we desire:</b> Reduced mortality through improved cardiovascular health	<b>Who will be responsible:</b> Portfolio Manager, Primary Care
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
October 2012	1. Work with PHO's to establish a monitoring system which provides agreed indicator data	<ul style="list-style-type: none"> <li>Cardiovascular disease is a leading cause of mortality for Māori, with rates 2.5 times those of non-Māori</li> <li>Māori hospitalisation rates are almost double those of non-Māori</li> <li>CVD is substantially preventable with lifestyle advice and treatment</li> </ul>	49.7% of eligible population have had their CVD risk assessed in the last 5 years	By 30 June 2013 75% of the eligible population will have had their CVD risk assessed in the last 5 years
March 2013	2. Work with primary care providers and PHO's to identify and implement successful interventions to improve CVD risk assessment rates			
June 2013	3. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Given the extent of the burden of cardiovascular disease for Māori and wide ethnic inequalities in cardiovascular health outcomes, access to risk assessment is important as a starting point for discussion with health professionals. Cardiovascular disease risk assessment involves measurement of cardiovascular risk factors including blood pressure, lipid profiles (ie cholesterol check), fasting serum glucose, height and body mass.			Māori	49.7%
			Non-Māori	TBA
			Progress	?
			Gap	TBA

Health Priority N6.1 CANCER	What are we trying to do? – Improve breast screening rates among the eligible population	To achieve this we will focus on: Improving breast screening rates	Outcome we desire: Reduced cancer mortality and morbidity	Who will be responsible: Portfolio Manager, Population Health
By these dates:	What are we going to do?	Why carry out these activities?	Where are we at now?	Where do we want to get to in a year?
August 2012	1. Explore with BreastScreen Aotearoa opportunities to strengthen local reporting of breast screening rates by DHB and ethnicity	<ul style="list-style-type: none"> <li>Māori female breast cancer registrations are 1.3 times that of non-Māori</li> <li>Breast cancer mortality is 1.8 times that of non-Māori</li> <li>For older women, breast screening using mammography (breast x-rays) followed by appropriate treatment is the best way of reducing the chance of dying from breast cancer</li> </ul>	Breast screening coverage rates for Māori women aged 50 to 69 years screening for the 24 months to 30 June 2011: 55.2%	Increase Breast screening coverage rates for Māori women aged 50 to 69 years to >55%
October 2012	2. Identify and implement with BreastScreen Aotearoa any effective interventions tailored toward populations with low screening rates in Taranaki			
Half-yearly	3. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> The purpose of Breast Screening is to detect breast cancer at an early stage, in order to reduce breast cancer morbidity and mortality. In Taranaki, the screening coverage rate among Māori women is lower than for other ethnicities. Achieving high rates of breast screening coverage for Māori women is important, given that according to national data, Māori women are more likely to be diagnosed at a later stage of breast cancer spread than non-Māori and that for many cancers at each stage Māori-specific mortality rates post diagnosis are higher.			Māori	55.2%
			Non-Māori	TBA
			Progress	?
			Gap	TBA

<b>Health Priority N6.2 CANCER</b>	<b>What are we trying to do? – Improved cervical screening rates</b>	<b>To achieve this we will focus on:</b> Cervical screening rate among the eligible population	<b>Outcome we desire:</b> Reduced cancer mortality and morbidity	<b>Who will be responsible:</b> Portfolio Manger, Population Health								
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>								
December 2013	1. Work with the National Cervical Screening Unit to establish and deliver six monthly reporting on rates for Māori and non-Māori in Taranaki	<ul style="list-style-type: none"> <li>• Māori cervical cancer registrations are two times those of non-Māori</li> <li>• Cervical cancer mortality is 3.6 times that of non-Māori</li> <li>• Cervical cancer is one of the most preventable of all cancers and having a cervical smear test every three years can prevent cervical cancer (National Screening Unit).</li> </ul>	Cervical screening coverage rates for Māori women aged 20 to 69 years increased from 57.6% in June 2006 to 67% in March 2012.	Increase the % of Māori women aged 25 to 69 who have had a cervical smear in the past 3, to >66.3 %								
June 2013	2. Identify and implement interventions tailored toward populations with low screening rates											
Half-yearly	3. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)											
<b>Key Issues:</b> Although cervical screening coverage for both Māori and non-Māori in the Taranaki Region is higher than the national figures, the cervical screening coverage for Māori women in Taranaki (67%) is far lower than for non-Māori (88%). This is particularly concerning given that cervical cancer is largely preventable through regular three yearly cervical smear tests which can reduce a women’s risk of developing cervical cancer by 90%.			<table border="1"> <tr> <td>Māori</td> <td>67%</td> </tr> <tr> <td>Non-Māori</td> <td>88%</td> </tr> <tr> <td>Progress</td> <td>†</td> </tr> <tr> <td>Gap</td> <td>21%</td> </tr> </table>	Māori	67%	Non-Māori	88%	Progress	†	Gap	21%	
Māori	67%											
Non-Māori	88%											
Progress	†											
Gap	21%											



<b>Health Priority N7.1 SMOKING (HOSPITAL)</b>	<b>What are we trying to do? –</b> Increasing the proportion of hospitalised smokers who are offered cessation advice and support to quit	<b>To achieve this we will focus on:</b> Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit	<b>Outcome we desire:</b> Less people smoking	<b>Who will be responsible:</b> Portfolio Manager, Population Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
June 2013	1. Review and strengthen TDHB Smokefree/Auahi Kore Policy	Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.	91% of Māori hospitalised smokers were provided with advice and help to quit in the quarter ended 30 June 2012	95% of Māori patients who smoke are seen by a health practitioner in Public Hospitals, are offered brief advice and support to quit smoking.
March 2013	2. Provide training and education that equips staff with the skills to engage appropriately with Māori patients to provide advice and help to quit			
June 2013	3. Strengthen smoking cessation support for pregnant women and their whanau			
December 2012	4. Develop referral systems between the Quit Group and Smoking Cessation providers - Strengthen linkages between primary and secondary care			
Quarterly	5. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Smoking is a significant risk factor for Māori in the Taranaki Region. Māori have a higher prevalence of smoking than other New Zealanders. Some 47% of Taranaki Māori females and 38% of Māori males are regular smokers, compared to around 21% of New Zealand Europeans. The prevalence of regular smoking in Taranaki Māori females is also higher than the national average.			Māori	91%
			Non-Māori	90%
			Progress	<input checked="" type="checkbox"/>
			Gap	+1%

<b>Health Priority N7.2 SMOKING (PRIMARY CARE)</b>	<b>What are we trying to do? –</b> Increasing the proportion of smokers who are seen by a health practitioner in Primary Care who are offered cessation advice	<b>To achieve this we will focus on:</b> Percentage of smokers in primary care who are provided with advice and help to quit	<b>Outcome we desire:</b> New Zealanders living longer, healthier and more independent lives	<b>Who will be responsible:</b> Portfolio Manager, Population Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
December 2012	1. Explore options for strengthening and supporting Māori leadership of Tupeka Kore programs in Taranaki communities	Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.	35% of Taranaki patients who smoke aged 15 years and over and are seen by a health practitioner in last 12 months in Primary care are offered brief advice and support to quit smoking	90% of Māori patients who smoke aged 15 years and over and are seen by a health practitioner in last 12 months in Primary care are offered brief advice and support to quit smoking
March 2013	2. Strengthen and support the Implementation of NZ smoking cessation guidelines in General Practice and Primary Care Teams			
March 2013	3. Support progress on the implementation of Taranaki Tobacco Action Plan			
December 2012	4. Develop referral systems between the Quit Group and Smoking Cessations providers - strengthen linkages between primary and secondary care			
Quarterly	5. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.			Māori	35%
			Non-Māori	34%
			Progress	†
			Gap	1%

<b>Health Priority N8.1 IMMUNISATION</b>	<b>What are we trying to do? –</b> Increasing the proportion of 8 month old Māori children who have completed their vaccinations	<b>To achieve this we will focus on:</b> Percentage of 8 month old Māori children complete their scheduled vaccinations	<b>Outcome we desire:</b> Improved children's health	<b>Who will be responsible:</b> Portfolio Manager, Population Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
March 2013	1. Profile patterns of immunisation uptake in Taranaki by Māori and location	<ul style="list-style-type: none"> <li>Immunisation is linked to primary care access and management</li> <li>Immunisation can prevent a number of diseases and is a cost-effective health intervention.</li> </ul>	<ul style="list-style-type: none"> <li>The percentage of children at eight months who have completed their primary course of immunisations (6 weeks, 3 months and 5 months) is a new measure for 2012/13</li> <li>81.9% of children aged 8 months have completed their primary course of immunisations</li> </ul>	85% of eight month old Māori Children have completed their primary course of immunisations (6 weeks, 3 months and 5 months) by 30 June 2013
March 2013	2. Work with the Ministry of Health Immunisation Team to prioritise and implement interventions to address low immunisation rates for Māori through the Taranaki Immunisation Steering Group and the Taranaki Immunisation Strategic Plan			
Quarterly	3. Complete reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<ul style="list-style-type: none"> <li><b>Key Issues:</b> Immunisation is linked to primary care access and management Immunisation can prevent a number of diseases and is a cost-effective health intervention.</li> </ul>			Māori	81.9%
			Non-Māori	TBA
			Progress	?
			Gap	TBA%

<b>Health Priority N8.2 IMMUNISATION</b>	<b>What are we trying to do? –</b> Increasing the proportion of eligible Māori who have received the seasonal influenza vaccine	<b>To achieve this we will focus on:</b> Seasonal influenza immunisation rates for Māori aged 65 years and over	<b>Outcome we desire:</b> Reduced communicable disease	<b>Who will be responsible:</b> Portfolio Manager, Primary Care
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
March 2013	1. Explore with PHO's a means of assessing influenza immunisation rates for Māori and non- Māori aged 65 years and over, identify and implement interventions to address low immunisation rates for Māori	The complications of influenza (more commonly known as 'flu') in elderly can be serious or life threatening. As a result, the Government funds the cost of influenza vaccinations and their administration for people aged 65 and over and people of any age with certain chronic conditions.	Seasonal influenza immunisation rates for Māori aged 65 years and over 66.4%	Increase percentage of Māori aged 65 years and over immunised for influenza to 70%
Annual	2. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> The complications of influenza (more commonly known as 'flu') in elderly can be serious or life threatening. As a result, the Government funds the cost of influenza vaccinations and their administration for people aged 65 and over and people of any age with certain chronic conditions.			Māori	66.4%
			Non-Māori	TBA
			Progress	?
			Gap	TBA

## 6. SECTION SIX – REGIONAL PRIORITIES AND INDICATORS ACTION PLAN

The following regional priority is in addition to the regional non-clinical indicators which sit within the Midland Māori Health Accountability Framework, Section Two (see Appendix A attached)

Health Priority <b>R1 MĀORI HEALTH INVESTMENT AND PROVIDER CAPACITY DEVELOPMENT</b>	What are we trying to do? – Build Māori capacity and capability to enable Māori participation at all levels of decision-making to support a kaupapa Māori focus on wellness, early intervention and case management in the community within the context of whānau	To achieve this we will focus on: Protect investment in Māori provider funding across Midland DHB's to at least the same level as existed in 2011-2012; Protect the investment in other Māori-specific services to at least the same level as in 2011	Outcome we desire: Improved access to services by Māori and other high needs populations and continued provision of 'for Māori, by Māori' services	Who will be responsible: GM, Planning, Funding and Population Health And Chief Advisor Māori Health
By these dates:	What are we going to do?	Why carry out these activities?	Where are we at now?	Where do we want to get to in a year?
July 2012 and on-going	1. Maintain funding levels to Māori-specific services to at least the same level as in 2011-2012	<ul style="list-style-type: none"> <li>Māori Provider capacity supports a Kaupapa Māori focus on wellness, early intervention and case management in the community within the context of whanau</li> <li>Māori participation at all levels of the sector contributes to responsiveness to Māori health needs</li> </ul>	2011/12 Māori Health Spend <ul style="list-style-type: none"> <li>Māori providers \$8.6M</li> <li>Māori-specific services in mainstream \$0.735M;</li> <li>Māori PHOs \$1.020M</li> <li>Māori workforce development \$0.051M</li> <li>Total \$10.406M</li> </ul>	<ul style="list-style-type: none"> <li>No less than \$8.6M investment in service contracts with Māori providers</li> <li>No less than \$1.806M investment in other Māori-specific services</li> </ul>
December 2012	2. Prioritise Kaupapa Māori service delivery as the preferred vehicle for delivery of services in areas where significant Māori health inequalities are identified			
Annual	3. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Current Māori capacity and capability dedicated to Māori-specific services has been developed over the last 15 to 20 years and represents only approximately 2% to 3% of Midland DHB's funding allocations. Building of Māori capacity further will aid the achievement of further Māori health gains and reduction of inequalities.			Māori 2011/12	\$10.406
			Māori 2012/13	
			Decrease / Increase	

<b>Health Priority R2 MĀORI HEALTH WORKFORCE</b>	<b>What are we trying to do?</b> – Increase the recruitment and retention of Māori into the Taranaki DHB workforce	<b>To achieve this we will focus on:</b> The total number and percentage of Māori employed within Midland DHB's reported and improving trend evidenced	<b>Outcome we desire:</b> Increased Māori participation in the health and disability workforce People receive better health and disability services	<b>Who will be responsible:</b> General Manager, HR;  Chief Advisor Māori Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
September 2012	1. Establish annual TDHB workforce targets to 30 June 2016	<ul style="list-style-type: none"> <li>The aim of Māori workforce development is to build a professionally competent workforce which is reflective of and responsive to the community it services</li> <li>Increases across the board are required to improve sector responsiveness to Māori health needs.</li> </ul>	<p>As at 30 June 2012 Māori accounted for 6.67% of the total TDHB workforce made up of the following workforce proportions:</p> <ul style="list-style-type: none"> <li>6.71% clinical</li> <li>8.61% allied health</li> <li>11.43% non-health support</li> <li>7.93% administration</li> <li>5.71% management</li> </ul> <p>There is currently a large number and proportion of staff who have incomplete ethnicity recorded</p>	<p>By 30 June 2013 Māori will make up 8% of the TDHB workforce.</p> <p>Improved completeness of workforce data by ethnicity</p>
January 2013	2. Collaborate and partner with the TDHB recruitment team to develop and deliver an education package targeting TDHB recruiting managers inclusive of the need to drive implementation of Māori recruitment strategies			
December 2012	3. Improve the completeness of ethnicity data collection from all existing staff			
Half-yearly at the end of Q2 and Q4	4. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4) dissemination to relevant stakeholders			
<b>Key Issues:</b> It is nationally and internationally recognised that workforce shortages now and into the future is a key strategic issue facing the health sector; The aim of Māori workforce development is to build a professionally competent workforce which is reflective of and responsive to the community it services. Increases across the board are required to improve sector responsiveness to Māori health needs.			Māori 2011-12	6.67%
			Māori 2012-13	
			Progress	
			Gap	N/A

<b>HEALTH PRIORITY R3 HE RARANGA- A-TIRA MIDLAND REGIONAL SERVICES MĀORI HEALTH ACTION PLAN</b>	<b>What are we trying to do? –</b> Improve the environment for enabling Māori responsiveness approaches;	<b>To achieve this we will focus on:</b> <ul style="list-style-type: none"> <li>• Active participation of Māori in decision-making / Promoting and Monitoring Māori health gain</li> <li>• Build Māori health workforce capacity within Midland region</li> <li>• Ensure mechanisms are in place to audit and monitor cultural responsiveness of NGOs and Midland DHB's</li> </ul>	<b>Outcome we desire:</b> Improved Māori health and reducing Māori health inequalities	<b>Who will be responsible:</b> Various responsibilities, as per He Raranga-A-Tira
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
As Per He Raranga-A-Tira Midland Regional Services Māori Health Action Plan				

## 7. SECTION SEVEN - LOCAL PRIORITIES AND INDICATORS ACTION PLAN

Health Priority L1 ACCESS TO SERVICES	What are we trying to do? – Did-Not-Attend (DNA) rate for outpatient appointments	To achieve this we will focus on: Reducing the Did-Not-Attend (DNA) rate at outpatient appointments	Outcome we desire: Improved access to secondary care	Who will be responsible: Clinical Services Manager, Medical
By these dates:	What are we going to do?	Why carry out these activities?	Where are we at now?	Where do we want to get to in a year?
September 2012	1. Complete a profile report of DNA's in relation to cardiovascular, diabetes, dental, colposcopy and respiratory-related clinics	<ul style="list-style-type: none"> <li>Higher disease burden coupled with higher DNA rates will result in ongoing unmet health need;</li> <li>If the DNA rate for Māori was equivalent to that of non-Māori there would be more than 900 fewer missed appointments per year which equates to significant unmet need;</li> </ul>	Overall outpatient DNA rates for Māori as at June 2012 was 16.92%;	<11% by 30 June 2013
December 2012	2. Develop and implement an action plan and targets based on the results of the DNA profile and literature reviews to reduce DNA rates in the identified specialty areas			
March 2013	3. Develop a mechanism to monitor and report DNA rates at quarterly intervals			
October 2012 and quarterly on-going	4. Complete the reporting control schedule at required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> An analysis of hospital outpatient appointment DNA rates for the three year period 2008/09 to 2010/11 shows that Māori have double the DNA rate for first specialist outpatient appointment compared to "Other" ethnic groups in Taranaki and around three times the DNA rate for follow-up specialist outpatient appointments. While DNA rates for the Taranaki DHB population are consistently lower than the national figures they have been increasing over the three year period and the extent of ethnic inequalities between Māori and non-Māori is similar.			Māori	16.92%
			Non-Māori	5.74%
			Progress	†
			Gap	11.18%



<b>Health Priority L2 – ORAL HEALTH</b>	<b>What are we trying to do? –</b> Percentage of 5-year olds in Taranaki caries free - DMFT scores at year 8 in Taranaki	<b>To achieve this we will focus on:</b> Percentage of 5 year olds carries-free; DMFT scores at year 8	<b>Outcome we desire:</b> Improved oral health among Māori children	<b>Who will be responsible:</b>  Service Manager, Child and Maternal Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
October 2012	1. Audit the current levels of 5 year olds carries-free and DMFT scores at year 8 in TDHB region by age, ethnicity, domicile, NZDep and other variables	<ul style="list-style-type: none"> <li>All ethnic groups have an increasing number of decayed, missing, and filled primary teeth (dmf) at age five, but the dmf is worse for Māori</li> <li>Māori five-year-olds have a significantly higher dmf than other five-year olds</li> <li>Some reduction in disparity by school year 8 is evident although Māori children still had a higher dmf than non-Māori and were less likely to be caries-free</li> </ul>	<ul style="list-style-type: none"> <li>The percentage of Māori children who were caries free at age 5 in 2012 was 29.87% compared to 61.39% for non-Māori</li> <li>The mean number of decayed, missing, or filled teeth (DMFT) for Māori children in Year 8 in TDHB in 2012 was 1.09 compared to the non-Māori rate of 0.78;</li> </ul>	<ul style="list-style-type: none"> <li>The percentage of 5 year olds caries free to be 60% by 2012</li> <li>and 68% by 2013</li> <li>The mean number of DMFT in Year 8 to be 1.01 by 2013</li> </ul>
December 2012	2. Process map the 5 and 8 year olds attendance pathway to identify gaps in service access and delivery			
March 2013	3. Develop an action plan and targets based on the audit and process mapping results			
March 2013	4. Establish a data collection and reporting system which provides monthly dental clinic attendance rates			
Annual	5. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Māori have higher average counts of decayed, missing and filled deciduous (dmft) and permanent (DMFT) teeth than non-Māori.				
				% 5 yr olds
			Māori	29.87%
			Non-Māori	61.39%
			Progress	†
			Gap	31.52%
				DMFT yr 8
				1.09
				0.78
				?
				0.31

<b>Health Priority L3 – RESPIRATORY HEALTH</b>	<b>What are we trying to do? – Asthma hospitalisation rate 0-14 years ASR per 100,000</b>	<b>To achieve this we will focus on:</b> Reducing the asthma hospitalisation rate for those 0- 14 years of age	<b>Outcome we desire:</b> Improved respiratory health	<b>Who will be responsible:</b> Service Manager, Child and Maternal Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
September 2012	1. Profile those presenting to hospital, and those going on to admission by age, ethnicity, domicile, NZDep, and other variables	<ul style="list-style-type: none"> <li>Poor asthma management in children has significant economic and social costs for individuals, families, and society due to absence from school or work, and medical management costs.</li> <li>If the hospitalisation rate for Māori in TDHB was equivalent to that of non-Māori there would be around 250 fewer hospitalisations per year.</li> </ul>	<ul style="list-style-type: none"> <li>The hospitalisation rate (ASR per 100,000) for 0-14 years females was twice that of non-Māori (509.6 vs. 260.8/100,000);</li> </ul>	<ul style="list-style-type: none"> <li>5% reduction in the hospitalisation rate</li> </ul>
January 2013	2. Complete an action plan with intermediate and annual performance targets			
From January 2013	3. Develop relationships with relevant stakeholders and prioritise collaborative interventions			
Half-yearly	4. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Poor asthma management in children has significant economic and social costs for individuals, families, and society due to absence from school or work, and medical management costs.			Māori	509.6/100,000
			Non-Māori	260.8/100,000
			Progress	†
			Gap	248.8/100,000

Health Priority L4 SUDDEN UNEXPLAINED DEATH OF INFANTS SYNDROME	What are we trying to do? – Reducing the rate of SUDI	To achieve this we will focus on: SUDI mortality rate per 1,000 live births of Māori infants	Outcome we desire: Improved child health	Who will be responsible: Clinical Services Manager – Child and Maternal Health
By these dates:	What are we going to do?	Why carry out these activities?	Where are we at now?	Where do we want to get to in a year?
June 2013	1. Identify and review relevant TDHB policies to introduce and drive 'Safer Sleeping Environment' messages as a key approach to reducing SUDI	<ul style="list-style-type: none"> <li>Taranaki has one of the highest rates of SUDI for Māori in New Zealand</li> </ul>	SUDI rate of 1.16 per 1,000 live births (9 deaths recorded for the 5 year period 2005-2009);	0.75 SUDI deaths per 1,000 live births of Māori infants by 2015
June 2013	2. Develop and implement an action plan to promote safer sleeping environments			
Half-yearly	3. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Taranaki has one of the highest rates of SUDI for Māori in New Zealand			Māori Non-Māori Progress Gap	1.16/1,000 TBA/1,000% TBA%

<b>Health Priority L5 -MĀORI HEALTH WORKFORCE</b>	<b>What are we trying to do? – Increasing recruitment to the Incubator programme</b>	<b>To achieve this we will focus on:</b> Report on the total number of Māori recruited to the Incubator programme	<b>Outcome we desire:</b> An increased and professionally competent workforce reflective of and responsive to the community it services	<b>Who will be responsible:</b> Chief Advisor Māori Health
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
December 2012	a. Deliver the Incubator Programme to 160 Taranaki secondary students	<ul style="list-style-type: none"> <li>It is nationally and internationally recognised that workforce shortages now and into the future is a key strategic issue facing the health sector;</li> <li>Incubator is a workforce development initiative targeted at Year 12 and 13 students. The Incubator approach is to 'grow your own workforce' via an innovative programme aligned to increasing workforce supply.</li> </ul>	111 secondary school students from 6 Taranaki secondary schools were enrolled in the Incubator programme in 2011	Participation of 160 students in the Incubator programme
Quarterly	b. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> It is nationally and internationally recognised that workforce shortages now and into the future is a key strategic issue facing the health sector;			Māori 2011	111
			Māori 2012	
			Progress	<input checked="" type="checkbox"/>
			Gap	N/A

<b>Health Priority L6 - WHANAU ORA DEVELOPMENT AND IMPLEMENTATION</b>	<b>What are we trying to do? –</b> Support the development and implementation of initiatives in Taranaki to achieve the ultimate goal of Te Kawau Mārō Taranaki Māori Health Strategy – Whanau Ora.	<b>To achieve this we will focus on:</b> Supporting existing Whanau Ora initiatives while also exploring opportunities for inter-agency collaboration to develop and implement initiatives to address socio-economic determinants of health.	<b>Outcome we desire:</b> People receive better health and disability services from a system that is whanau-centred, seamless and high-performing; Good health and independence are protected and promoted; Improving value for money;	<b>Who will be responsible:</b> Chief Advisor Māori Health; GM Planning and Funding and team; General Manager, Hospital and Specialist Services and team
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>
By December 2012	1. Work with Te Kawau Mārō Strategic Alliance to agree a Results Based Accountability Result Card to underpin an integrated service contract for delivery of health services for Māori and other high needs communities	Whanau Ora is a significant policy and action-oriented platform to advance the health and well-being of whanau. The Whanau Ora space is relatively new and evolving and shared learnings can reduce duplication of effort and enable more coordinated and effective interventions to achieve Whanau Ora outcomes.	Te Kawau Mārō Strategic Alliance is the TDHB preferred provider of health services for Māori and is the TDHB’s primary vehicle for delivery of services for Whanau. The alliance and TDHB are in the process of developing a Results Based Accountability framework to underpin an integrated outcomes-based contract for all TDHB funded Māori health services;	Te Kawau Mārō Strategic Alliance integrated outcomes-based contract successfully developed and in place by 30 June 2013;
By December 2012	2. Support Te Kawau Mārō alliance partners in the change management processes of achieving Māori provider network consolidation	Use of tools such as integrated and/or high trust contracting, use of Whanau Ora HIA and RBA frameworks are mechanisms enabling of the achievement of Whanau Ora outcomes.	Taranaki Ora collective is the TPK-led Whanau Ora provider for Taranaki and is in the process of developing its business case for implementation.	Support the implementation of Taranaki Ora Provider collective business plan commenced by 30 June 2013
July 2012 and on-going	3. Continue to engage with Te Tai Hauauro RLG to support the Taranaki Ora Provider initiative			

July 2012 and on-going	4. TDHB will continue to inform MOH assessments of Taranaki Ora business plans and intended implementation			
December 2012	5. Prioritise funding for additional Kaiawhina and Whanau Ora services in high needs communities			
On-going	6. Develop relationships with other agencies to cultivate opportunities to jointly plan initiatives that focus on supporting whanau development as a basis for Whanau Ora	Whanau Ora Health Needs Assessment 2012 (Ratima and Jenkins) identifies that there is clear evidence that Māori living in Taranaki have poor access to socio-economic determinants of health. It is also reflected in barriers to health care and related needs (e.g. ability to pay for service provision and access to transport). Addressing determinants of health through intersectoral collaboration is required.	The report “Whanau Ora Health Needs Assessment, Māori Living in Taranaki” identifies the potential for TDHB to actively participate in, or lead intersectoral activities that contribute to Whanau Ora. TDHB engages with many agencies in relation to many different projects. There is no overall framework within which this activity occurs.	An agreed framework for intersectoral planning to address the health and socio-economic needs of Taranaki communities
March 2013	7. Undertake a stock-take of intersectoral initiatives the TDHB is involved with and develop a coordinated approach to intersectoral participation and activities.			
Quarterly	8. Complete the reporting control schedule at the required intervals for monitoring purposes (as per Section 4)			
<b>Key Issues:</b> Whanau Ora is a significant policy and action-oriented platform to advance the health and well-being of whanau. The Whanau Ora space is relatively new and evolving and shared learnings can reduce duplication of effort and enable more coordinated and effective interventions to achieve Whanau Ora outcomes.			Māori	N/A
			Progress	N/A
			Gap	N/A
				N/A

<b>Health Priority L7 DIABETES</b>	<b>What are we trying to do? –</b> Percentage of diabetics who have attended a diabetes management programmes have a HbA1c ≤64 mmol/mol	<b>To achieve this we will focus on:</b> Maintaining attendance at the diabetes management programme in primary care	<b>Outcome we desire:</b> Reduced mortality and morbidity due to diabetes through improved diabetes care	<b>Who will be responsible:</b> Portfolio Manager, Primary Care	
<b>By these dates:</b>	<b>What are we going to do?</b>	<b>Why carry out these activities?</b>	<b>Where are we at now?</b>	<b>Where do we want to get to in a year?</b>	
October 2012	1. Work with PHO's to establish a reporting system which provides relevant indicator data, quarterly	Diabetes is a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of health services for people in most need. The indicator monitors access to quality improvement programs in primary care.	77% of the eligible population have had a Diabetic Annual Review (note discontinuation of DARs)  68% of the diabetics who have had an annual review have a HbA1c ≤64 mmol/mol	95% of the eligible population have participated in a diabetic management programme by 30 June 2013  83% of the diabetics who have participated in a diabetic management programme have a HbA1c ≤64 mmol/mol by 30 June 2013	
March 2013	2. Work with primary care providers and PHOs to identify and implement successful interventions				
Quarterly	3. Provide quarterly reporting to CAMH for dissemination to relevant stakeholders				
<b>Key Issues:</b> Access to regular diabetes checks is essential for effective diabetes management and to reduce disparities in the burden of complications that disproportionately impact Māori.				% DMP	HbA1c ≤64 mmol/mol
			Māori	77%	68%
			Non-Māori	70%	80%
			Progress	‡	‡
			Gap	7%%	12%