TARANAKI DISTRICT HEALTH BOARD

TE MATAKITE

MĀORI HEALTH PLAN

2016-2017

Version 8 – Final Approved

Table of Contents

OVERVIEW

This Plan describes the Taranaki District Health Board's (TDHB) priorities in Māori health for 2016-2017. The plan is, amongst other strategies and plans, the TDHB's primary approach to improving Māori health and reducing disparities as per its obligations under the New Zealand Public Health and Disability Act (2000). This Plan aligns to the TDHB's strategic framework that aims to achieve the vision of "Taranaki whānui, he rohe oranga", the wider aspirations of Pae ora – healthy futures for whanau, and Te Kawau Mārō, Taranaki Māori Health Strategy. It's format and the indicators included follow the 2016-2017 Operational Policy Framework guidelines.

In addition to the national priorities, we will continue to focus on priorities which address 1) Access to secondary services as measured by Failed Attendance rates for out-patient appointments[*] and 2) Māori Workforce Development as measured by the proportion of Māori employed by the TDHB.

We have introduced an indicator to address access to oral health services by tamariki and rangatahi, to build on the achievement by the TDHB of more than 90% of pre-schoolers enrolled in community oral health services.

In addition we have introduced priorities to emphasise the significance of public health strategies that focus on improving natural and built environments consistent with Waiora as a key element of Pae Ora – healthy futures for whanau. Three local priorities are being led by the TDHB Public Health Unit: 3) creating healthy eating environments by supporting adoption of Sugar-Sweetened Beverage-free policies, 4) increasing food security and food-borne illness by assessing the cultural and biological health of Taranaki streams/catchments/rivers, and 5) increasing health literacy of people working with pregnant women regarding Foetal Alcohol Syndrome Disorder (FASD).

The Māori Health Plan outlines a one-year subset of actions to towards achieving the targets set for national Māori Health Plan indicators. Longer term activities (2 – 5 years) are described in the 2016-2017 TDHB Annual Plan of which this Plan is part.

Performance against the indicators in this Plan will be reported quarterly and disseminated to key audiences including:

- The Māori Health Plan Steering Group consisting of senior managers from the TDHB, Pinnacle Midland Health Network PHO and Te Kawau Mārō Māori Health Alliance
- the joint meeting of the TDHB and Te Whare Punanga Korero Iwi relationship Boards
- The TDHB Board

These groups represent key governance and operational stakeholders which are directly engaged in delivery against the Plan.

We will continue to monitor / report the extent of disparities between Māori and non-Māori for those indicators which measure results by ethnicity.

Finally the DHB's Māori Health Plan performance will be presented in the DHB's Annual Report and annual Quality Report.

[*] Whānau Ora Health Needs Assessment, Māori Living in Taranaki, Dr M Ratima and B Jenkins, Taranaki DHB, 2012

1. SUMMARY OF INDICATORS

Health Issue			Indicator(s)Target	Target	Baseline TDHB	
					Māori	Non-Māori
National Priorities						
1	N1	Data Quality	Accuracy of ethnicity reporting in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit	100%	84%	
2	N2.1	Access to care	1. Percentage of Māori enrolled in PHOs	100%	84%	94%
3	N2.2		2. Ambulatory Sensitive Hospitalisations rates per 100,000 for the age groups 0-4 yrs	7,174	7,559	5,310
			45-64 yrs	5,444	7,328	3,512
4	N3.1	Child Health	1. Exclusive or fully breastfed at LMC discharge (4-6 weeks)	75%	54%	67%
5	N3.2		2. Exclusive or fully breastfed at 3 months	60%	43%	57%
6	N3.3		3. Receiving breast milk at 6 months	65%	49%	67%
7	N4.1	Cancer	1. Cervical Screening, percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25-69 years who have had a cervical screening in the past 36 months (by ethnicity)	80%	65%	83%
8	N4.2		2. Breast screening: 70 percent of eligible women, aged 50 to 69 will have a BSA mammogram every two years.	70%	61%	74%
9	N5	Tobacco	Smoking cessation: Percentage of pregnant Māori women who are smokefree at two weeks postnatal.	95%	62%	78%
10	N6.1	Immunisation	1. Percentage of infants fully immunised by eight months of age (ht)	95%	83%	91%
11	N6.2		2. Seasonal influenza immunisation coverage rates in the eligible population (65 years and over)	75%	67%	67%
12	N7	Rheumatic Fever	Number and rate of first episode rheumatic fever hospitalisations for the total population.	0.3/ 100,000	0.9 / 100,000	
13	N8	Oral Health	Percentage of Māori preschool children enrolled in the community oral health service (COHS).	95%	79%	101%
14	N9	Mental Health	Mental health (Compulsory Assessment and Treatment) Act 1992: Section 29 Community Treatment Order. Reduce the rate of Māori on the Mental Health Act: section 29 Community Treatment Orders relative to other ethnicities.	New measure	92%	63%
15	N10	SUDI	1. Most recent five year average annualised SUDI infant deaths by DHB region of domicile, Māori and total population. (Rate not supplied when number of deaths were <3.)	0.4	2.31	0.0
			2. Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1. (Using 2014 results)	100%	40.6%	61.8%
Local Priorities						
16	L1	Access to Services	Failed Appointments (DNA) rate for outpatient appointments reduced to 5% by June 2017.	5%	18%	5%
17	L2	Access to Services	Access by tamariki and rangatahi to oral health services: Proportion of tamariki and rangatahi that have annual oral healthcare plans in place.	New measure	New measure	
18	L3	Workforce Development	Percentage of Māori employed in the health and disability workforce at the Taranaki DHB	13%	8.34%	N/A
19	L4.1	Healthy Eating & Physical Activity	Organisations that have adopted healthy policies and practises as a result of PHU intervention and are 100% Sugar Sweetened Beverage-free.	2	-	
20	L4.2		Number of streams and rivers in Taranaki which are assessed using the Cultural Health Index	New measure	-	
21	L4.3	Alcohol Related Harm	Increase knowledge of people working with pregnant women regarding Foetal Alcohol Syndrome Disorder (FASD).	75%	-	

N.B. Baseline data for national indicators sourced from Trendly and BRAD, whichever has the latest information.

MĀORI POPULATION AND THEIR HEALTH NEEDS

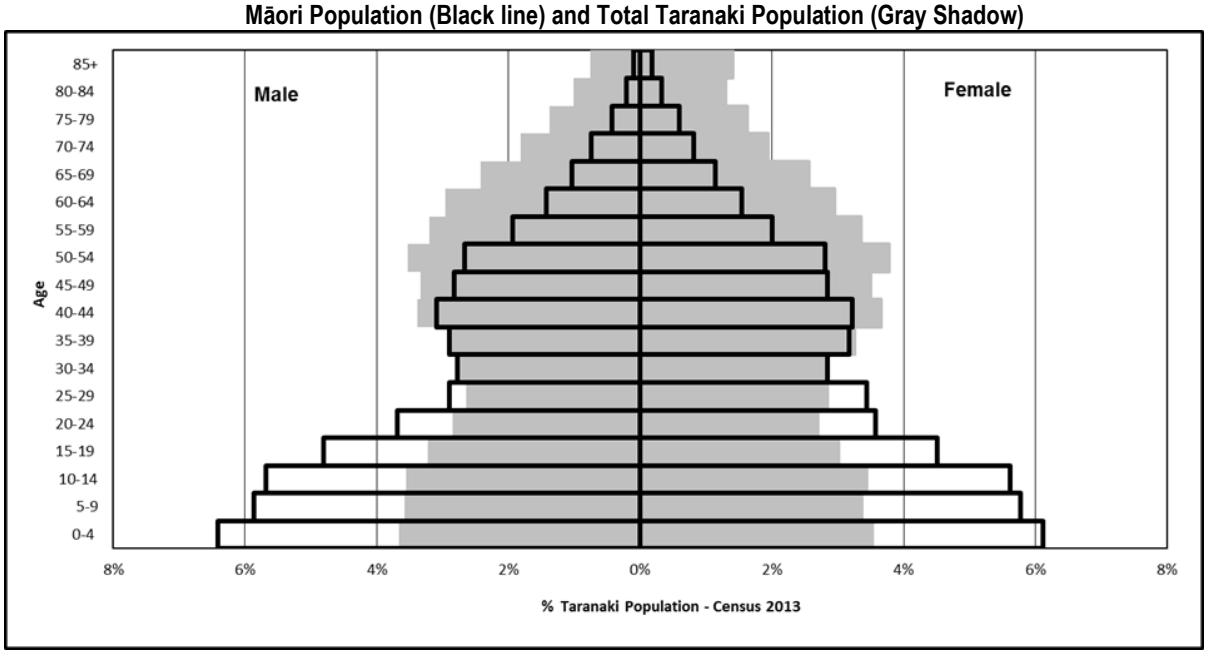
1.1. Based on the 2013 census Māori make up 16.6% or 18,150 of the total Taranaki population of 109,608 (non-Māori 91,458). This represents the 15th highest number of Māori serviced by any other DHB and a slightly higher proportion than the national average of 14.1%.

1.2. Projections for 2016/17 (based on 2013 Census) show Taranaki DHB serving a population of 118,110, with 18.9% of the population identifying their primary ethnicity as Māori.

Age Distribution

1.3. As at Census 2013, the Māori population in Taranaki is very young compared to the overall population as shown below. For Māori, 35.5% of the population resident in Taranaki is under 15 years of age compared to 21.1% for the total population. The difference is even more marked for older Māori, with 5.5% of the Māori population resident in Taranaki aged 65 years and over compared to 16.2% for the total population. This is, in part, a reflection of the lower Māori life expectancy relative to non-Māori.

Māori Population (Black line) and Total Taranaki Population (Gray Shadow)



Age Structure of Taranaki DHB, 2013

Geographic Distribution

1.4. TDHB comprises three territorial authorities. In 2013 the majority of the Māori population was based in the New Plymouth District Council catchment (11,085) while the largest proportion of Māori resided in the South Taranaki District (22.8%)

	South Taranaki District	Stratford District	New Plymouth District
Total Population	26,577	8,991	74,187
Māori	6,069	1,011	11,085
Māori (% of Total))	22.8%	11.2%	14.9%

Source: Statistics NZ, Census 2013 data tables – www.stats.govt.nz

Population Growth (based on 2016/17 projections from Census 2013 data)

1.5. While the non-Māori population of Taranaki is projected to increase to 96,020 by 2032, an increase of 0.29%, the Māori population is growing much faster with a projected population increase of 40.0%, to 31,370. By 2032 Māori are projected to make up 24.6% of the total Taranaki population.

1.6. The Māori population in the region will increase faster in the younger age groups. Based again on 2016/17 projections, by 2032 Māori are expected to account for 39.4% (30.9% in 2016/17) of those aged under 15, and 39.6% (29.3% in 2016/17) of those aged between 15 and 24.

Iwi

1.7. The 2013 census reveals the following iwi population makeup of Taranaki:

IWI	TOTAL IWI POPULATION	IWI RESIDENT IN TARANAKI	% IN TARANAKI
Ngati Tama	1,338	387	29%
Ngati Mutunga	2,514	759	30%
Te Atiawa	15,273	3,820	25%

Ngati Maru	852	291	34%
Taranaki	6,087	1,688	28%
Ngaruahinerangi	4,803	1,779	37%
Ngati Ruanui	7,260	1,827	25%
Ngaa Rauru Kiitahi	4,176	717	17%
Tangahoe	246	96	39%
Pakakohe	351	144	41%
Other – Not Defined	120	21	18%
TOTAL	**43,020**	**11,529**	**27%**
Māori: non-Taranaki iwi		**6,621**	
Total Māori Population		**18,150**	

1.8. Māori who whakapapa to iwi of Taranaki account for 63.5% of the local Māori population or 11,529 people, while 36.5% percent whakapapa to iwi outside of Taranaki. Around 26.8% of the 43,000 Taranaki uri, live in the Taranaki region.

Deprivation

1.9. 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.

Leading Causes of Avoidable Mortality†

1.10. The leading causes of avoidable mortality are ranked below:

	Avoidable Mortality		
Māori Females	CVD-IHD	Māori Males	CVD-IHD
	Lung cancer		COPD
	COPD		Lung cancer
	Breast Cancer		Diabetes
	Stroke		Accidents
			Suicide

On average there were 51 potentially avoidable Māori deaths per year, at a rate 2.1 times the non-Māori rate, or 119 more deaths per 100,000 per year.

Amenable mortality rates were more than twice as high for Māori as for non-Māori, or 87 more deaths per 100,000. On average, 37 Māori deaths per year were amenable to health care.

Potentially Avoidable Hospitalisation‡

On average 1188 Māori hospital admissions per year were potentially avoidable through population based prevention strategies. The rate of admission was 37% higher for Māori than for non-Māori, or 1476 more admissions per 100,000.

On average, there were 623 ambulatory sensitive hospitalisations per year among Māori, at a rate 58% higher than the non-Māori rate, or 1063 more admissions per 100,000.

Health Service Utilisation

1.11. Pinnacle Midlands Health Network is the only PHO in Taranaki. As at March 2016, Māori accounted for 17.2% of the network's enrolled population for Taranaki (18,802 of 109,207), with 84.0% of Taranaki Māori enrolled with the network.

1.12. A sole GP clinic located in Hawera, South Taranaki sits outside the PHO however the number and proportion of Māori enrolled there is unknown.

Health Needs Based on the Pathways of He Korowai Oranga

1.13. The health needs of Taranaki Māori and priorities for action are identified in the Taranaki DHB's Whānau Ora Health Needs Assessment (Ratima and Jenkins, 2012) as well as the TDHB Māori Health Profile 2015 (Te Ropu Rangahau Hauora a Eru Pomare). The Whanau Ora HNA identifies needs which are categorised under the pathways of He Korowai Oranga, as follows:

Te Ara Tuatahi Pathway One – 'Development of Whānau, hapu, iwi and Māori communities'
The Māori community has a limited capacity to engage with work around Whānau Ora, and in this context Māori community development at whānau, hapū, iwi levels was important. A need to engage whānau in preventative and aspirational activities was identified. At the whānau level, work is required to strengthen whānau cohesion so that whānau

† Potentially avoidable mortality, pg 31, Taranaki District Health Board, Māori Health Profile 2015, Te Ropu Rangahau Hauora a Eru Pomare
‡ Potentially avoidable hospitalisations, pg 29, Taranaki District Health Board, Māori Health Profile 2015, Te Ropu Rangahau Hauora a Eru Pomare

are better positioned to exercise the positive functions of whānau. Strengthening cultural identity as a mechanism to achieve health gain was also identified. Whānau level development as a basis for Whānau Ora is a priority area. The Taranaki DHB acknowledges that it has a supportive role in this endeavour rather than a leadership one and will look to support Marae, hapu and iwi as and when they are willing and able. The TDHB Public Health Unit supported three Māori communities - Manaia, Opunake and Patea, to undertake a health and social needs assessment to inform future planning by the communities themselves. The Unit has also worked closely with the Parihaka community to identify needs that will help inform the TDHB's contribution to improving access to health services by the Parihaka community.
Te Ara Tuarua Pathway Two – 'Māori participation in the Health and Disability Sector'
Building Māori workforce and organisational capacity and capability is a priority to ensure Māori participate in decision-making at all levels of the sector. Māori-specific organisation and workforce is expressed in the following categories: • Te Whare Punanga Korero Trust represents the eight iwi of Taranaki and is resourced by TDHB to inform and influence TDHB's strategic decision-making; • Te Kawau Maro Alliance is the preferred provider of Māori health services in Taranaki. The Alliance consists of Ngaruahine Iwi Health Services, Ruanui Health Services and Tui Ora Ltd; • The Chief Advisor Māori Health is a member of the Taranaki DHB Executive Management Team reporting to the CEO. The role provides strategic advise across the DHB to bring about improved Māori health outcomes. The role leads a small team which is largely focused on improving responsiveness of the sector to the needs of Māori. • Whakatipuranga Rima Rau is an intersectoral collaboration which drives the supply of Māori into the Taranaki health and disability workforce. Key partners in the Trust are the TDHB, Te Whare Punanga Korero Trust, and the Ministry of Social Development. The Trust's principle funders are the TSB Community Trust, the JR McKenzie Trust and the TDHB.
Te Ara Tuatoru Pathway Three – 'Effective health and disability services'
The priorities in terms of protective and risk factors and preventative care are smoking, obesity, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. All factors are reflected in the Māori Health Plan.
Priority health conditions are diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability. All conditions are included in either the Māori Health Plan of the Annual Plan including within the Whanau Ora priority.
Te Ara Tuawha Pathway Four – 'Working across sectors'
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. Addressing determinants of health through intersectoral collaboration is therefore a priority.

2. HEALTH EQUITY

The Taranaki DHB is currently developing for implementation across the organisation, a policy framework for mandatory application of health equity and quality improvement tools that support the delivery of high-quality health care that is responsive to the needs and aspirations of Māori.

It is expected that health equity tools will be applied to the priorities and indicators described in this Plan to assess and identify appropriate actions to achieve health equity for the Taranaki population. The TDHB acknowledges that this will require more intense focus in Māori communities including a wider range of interventions, for this to occur.

3. PRIORITIES AND INDICATORS

The following section of the plan presents the national and local Māori health priorities and indicators. Each indicator details the outcome we want to achieve, how we will achieve it, who will be responsible and how we will know if we have been successful.

The 'inequalities box' at the bottom right of the tables provides a snapshot of the extent of disparity that exists between Māori and non-Māori. The absolute measure of inequality provided is the 'gap' between Māori and non-Māori expressed as a percentage difference. We will also report quantitative assessment of disparities between Māori and non-Māori, using the following symbols:

Symbol	Key	Symbol	Key
☺	Gap eliminated	☑	Progressing well
Ⓟ	Some progress (Reduced over 1 quarter only)	☒	No progress or worsening (Increase over 1 quarter only, or stayed the same)
Ţ	Not yet sufficient time to judge	?	Further info or work required
↑	Increasing gap (Increase over 2 or more consecutive quarters)	↓	Decreasing gap (Decrease over 2 or more consecutive quarters)

<table>
<tr><th>National Indicator 1

Outcome we want to achieve</th><th>ETHNICITY DATA QUALITY

What we are planning to do to achieve it</th><th colspan="2">Who will be responsible: PM, Primary Care

How we will know if we have been successful</th></tr>
<tr><td rowspan="5">Improve and maintain the quality of data collected locally and supplied to national collections.

Accuracy of ethnicity reporting in PHO registers acknowledging that ethnicity is self selected by the patient.</td><td rowspan="5">Continue to work with the Midland Health Network PHO to check, improve and maintain the accuracy of ethnicity data submitted to national collections by the PHO, by

• MHN will check Age Sex Register against updated Stats NZ population data to update the status of Māori enrolments in MHN PHO

• MHN will produce a quarterly report through the ALT and where gaps are identified between enrolments and Stats NZ data, will work with General Practices to increase enrolments.

• Ethnicity data accuracy will be measured by the quarterly comparisons of PHO enrolment data with Stats NZ population data

• Monthly monitoring of performance against planned actions and use results to make improvements to service delivery (PDSA approach)</td><td colspan="2">• 100% of Māori will be enrolled in the MHN PHO (as a proxy for reporting on Ethnicity Data accuracy).
• Commentary on how the quality of ethnicity data is improving.</td></tr>
<tr><td>Māori
Non-Māori</td><td>84%</td></tr>
<tr><td>Progress</td><td>N/A</td></tr>
<tr><td>Gap (%)</td><td>N/A</td></tr>
</table>

<table>
<tr><th>National Indicator 2.1
Outcome we want to achieve</th><th>ACCESS TO CARE (PHO Enrolment)
What we are planning to do to achieve it</th><th colspan="2">Who will be responsible: PM, Primary Care
How we will know if we have been successful</th></tr>
<tr>
<td>1. Increased access by Māori to primary health care services.

2. There is a process to follow to enable an increase in enrolments. No tool currently used.

3. Increase enrolment rates through a range of methods – NCHIP being a key one for kids and new born.</td>
<td>The Midland Health Network has a NO GAPS policy. The Network approach is to achieve equal health outcomes for all patients. As the only PHO in Taranaki the Midland Health Network will actively promote enrolment in the PHO to all Māori.
• MHN will check ASR against updated Stats NZ population data to update the status of Māori enrolments in MHN PHO. The information will be submitted as part of our quarterly report to the Alliance Leadership Team.
• Where gaps are identified between enrolments and Stats NZ data, the ALT will work with General Practices, TKM alliance and TDHB to increase enrolments including:
  • Integrate Primary Option plans with development of Patient Access Centre and Single Point of Access development, by June 2016.
  • ED continue to support the re-engagement of low acuity patients back into. primary care
  • Implement Child Health Coordination Services integrated service plan including SPOA by June 2016 . The plan to include active engagement with TKM Alliance and Mama, Matua Pepi Tamariki services to identify and enrol non-enrolled children and their whanau.
• Ethnicity data accuracy will be measured by the quarterly comparisons of PHO enrolment data with Stats NZ population data
• Monthly monitoring of performances against planned actions and use results to make improvements to service delivery (PDSA approach)
• Monitor indicator performance on a quarterly basis through the MHN ALT and the Māori Health Plan Steering Group</td>
<td colspan="2">97% of Māori will be enrolled in PHOs.

Utilisation of services by Māori 1:1 or higher than non Māori.</td>
</tr>
<tr><td></td><td></td><td>Māori</td><td>84%</td></tr>
<tr><td></td><td></td><td>Non-Māori</td><td>94%</td></tr>
<tr><td></td><td></td><td>Progress</td><td>☒</td></tr>
<tr><td></td><td></td><td>Gap (%)</td><td>10%</td></tr>
</table>

National Indicator 2.2 **Outcome we want to achieve**	**ACCESS TO CARE (ASH Rates)** **What we are planning to do to achieve it**	**Who will be responsible:** PM, Primary Care and Chief Advisor Māori Health **How we will know if we have been successful**
Reduced ambulatory sensitive hospitalisation (ASH) rates among all age groups: 0-4 years 45-64 years	**0-4 years** 1. Maintain or improve B4 School Check coverage for tamariki Māori, on-going. 2. Investigate childhood asthmas as a leading cause of avoidable hospitalisation, develop interventions in partnership with the MHN and Te Kawau Maro Alliance, trial and monitor effectiveness in a continuous improvement cycles to improve results. 3. Work with the Midland Health Network to ensure tamariki under thirteen years have access to free after hours primary care, on-going. 4. Continue to work with TDHB dental, maternity and child health teams as well as primary care providers to support enrolment of all pre-school children in dental services and to support whānau engagement with dental and other pre-school service initiatives. 5. With the introduction of the Health Care Home model of care in Taranaki, PHO peer groups will be looking at the ASH rates by General Practice and address issues at a practice level. 6. Continue to promote the increased use of the Map of Medicine Pathways by General Practitioners to reduce ASH rates. 7. Monitor indicator performance on a quarterly basis through the Māori Health Plan Steering Group. 8. The MHN Network Plan 2014-2017 objectives include a. Tackling the health status inequity faced by Māori is a priority issue for the network. b. The underlying objective is NO GAPS. This means no gaps in health status between Māori and the wider population. c. All of the activities above will be reported through the ALT reporting on a quarterly basis by ethnicity to track progress to eliminating the current Gaps.	1. DHB specific targets based on current equity gap for Māori. 2. Reduction of equity gap by minimum 50% with an expectation of equitable rates for Māori within 5 years. NOTE: Targets to be confirmed/worked through with each DHB before March 2016.

45-64 years

1. Taranaki DHB and the Midland Health Network continue to work together to implement the Primary Options to Acute Care for Taranaki and the ED Overflow Clinics at Medicross Accident and Medical clinic in New Plymouth and Mountainview General Practice in South Taranaki.
2. Continue to support Midlands Health Network PHO to:
    a. People living with LTC in the community have access to services delivered by the MDT including Clinical Pharmacy, Social Work, Dietetics and Podiatry.
    b. support GP Practices to increase checks for CVD and Diabetes with the aim of meeting the 90% of the eligible population having had a CVD Risk assessment.
    c. Continue to upskill the Primary Health workforce in the care and management of Diabetic patients and Insulin Initiation.
3. Use the tracking of e-referrals to monitor any time delays between GP referral and FSA.
4. The Integration Programme will be implemented using the Pae Ora Framework [i] which will support equity of access to care for Māori and aims to reduce avoidable hospital admissions
5. Continue to fund MHN General Practices and Community Pharmacies to provide free first level medical care for under 13 year olds
6. Te Tiriti o Waitangi training for General Practice
7. Cultural Competency training for General Practice teams
8. Monthly monitoring of performance against planned actions and use results to make improvements to service delivery (PDSA approach)
9. Monitor indicator performance on a quarterly basis through the Māori Health Plan Steering Group
10. Regular analysis of the B4SC outreach register – targeting specific demographic/geographical areas with an aim to increase the number of high deprivation checks completed.

	0-4y	45-64
Māori	7,559	7,328
Non-Māori	5,310	3,512
Progress	↑	↑
Inequalities Gap	2,249	3,816

National Indicator 3 Outcome we want to achieve	CHILD HEALTH (BREASTFEEDING) What we are planning to do to achieve it	Who will be responsible *PM - Population Health; CSM - Child and Maternal Health; Health Promotion Manager – Public Health Unit* How we will know if we have been successful
Increase the numbers of exclusively, fully, and partially (6 months only) breastfed Māori babies at 6 weeks, 3 months, and 6 months of age by 30 June 2017. *TDHB are focussed on addressing the inequalities experienced in health outcomes for Māori children to improve health outcomes for mother and baby. Breastfeeding rates in Taranaki remain well below the national target and the discrepancy between Māori and non-Māori has increased over the past two years with breastfeeding rates for Māori remaining consistently low.* *Research shows that children who are exclusively breastfed for the early months are less likely to suffer the adverse effects of childhood illnesses such as respiratory tract infections, gastroenteritis, otitis media etc. Breastfeeding benefits the health of mother and baby, as well as providing a protective factor against SUDI, asthma, and childhood obesity.*	• Continue to contract Te Kawau Maro to deliver the Mama Pepe Hauora (MPH) Programme including: o Undertake 4 MPH Advisory Group meetings with Māori leadership and participation o Refine the referral and triage process for Breastfeeding Community Support prioritising Māori, high deprivation, and <6 months of age referrals o Number of Tiaki Ukaipo (Community Breastfeeding Support) referrals received including to Lactation Consultants and Peer Support Counsellors (Māori/non-Māori) o Number of Peer Support Counsellors completed refresher training (Māori/non-Māori) o 4 providers achieve BFCI (re-)accreditation (including Le Leche League, Tui Ora Limited, Plunket, and Pregnancy Help) o 12 breastfeeding group education sessions are delivered o 6 new Early Childhood Education settings in priority communities become Breastfeeding Welcome Here (BFWH) accredited o Participate on the Whangai U Breastfeeding Network • Maintain Baby Friendly Hospital Initiative (BFHI) accreditation across TDHB facilities o Number of facilities BFHI accredited • Continue to implement the Taranaki WCTO Quality Improvement Plan o Launch NCHIP o Implement WCTO and GP enrolment at birth process o Monitor 6 monthly combined breastfeeding data	• MPH Quarterly Reporting to TDHB Portfolio Manager – Population Health o 30 September 2016 o 30 June 2017 o 30 June 2017 o 30 June 2017 o 30 June 2017 o 30 June 2017 o 30 June 2017 o 30 June 2017 • Maternal Quality and Safety (MQS) Annual Report to Clinical Services Manager – Child and Maternal Health o 30 June 2017 • Child Health Service Level Alliance Team (SLAT) Monthly Report to TDHB Portfolio Manager – Population Health o 30 September 2016 o 30 September 2016 o 30 June 2017

	• Maintain the implementation of the BFWH project to create safe and supportive environments for breastfeeding, including working with Māori women and their whanau to identify priority sites o Complete audits of up to 40 accredited sites o Accredit 5 to 8 new sites	• Public Health Unit Six Monthly Report to Health Promotion Manager o 30 June 2017 o 30 June 2017

Full and Exclusive Breastfeeding Rates	**6 weeks** *(Source: National Maternity Collection 6 Monthly Data, MoH)*		**3 months** *(Source: WCTO and Plunket Combined 6 Monthly Data, MoH)*		**6 months including Partial** *(Source: WCTO and Plunket Combined 6 Monthly Data, MoH)*	
	2013/14	**2014/15**	**2013/14**	**2014/15**	**2013/14**	**2014/15**
Total	58%	64%	50%	54%	60%	63%
Māori	58%	54%	43%	43%	41%	49%
Non-Māori	58%	67%	52%	57%	65%	67%
WCTO Target	**75%**	**75%**	**60%**	**60%**	**65%**	**65%**

Progress to date

- 6 week and 3 month breastfeeding data has improved for non-Māori since the implementation of the Mama Pepe Hauora (MPH) Programme, however now the services (particularly the Breastfeeding Community Support – Tiaki Ukaipo) need to be further refined and prioritised to best meet the needs of Māori.
- Breastfeeding data collection and reporting has also improved since the Baby Friendly Community Initiative (BFCI) has been achieved and maintained by two out of three WCTO providers along 6 month reporting from the Ministry of Health on Plunket and WCTO combined data to TDHB. Prior to this data was reported inconsistently, was not timely, and did not reflect our entire population. TDHB and local stakeholders have agreed to all use the Ministry's 6 Monthly Combined Breastfeeding Data as the best source for accurate and timely reporting of breastfeeding rates consistently for the region and monitoring progress towards the target.
- The WCTO Quality Improvement Plan has been updated in 2015/16 to reflect current priorities of which breastfeeding is included. The launch of NCHIP and Child and Youth Coordination Service (CaY-C) will provide a multi-provider child-centric view of 0 – 5 year olds and ensure no child is lost to the service. The development of NCHIP has also enabled a review of processes that contribute to the child health milestones and as such a new enrolment at birth process has been developed to increase timely enrolment with General practice and WCTO providers and therefore increasing the likelihood of child health milestones being achieved on time
- TDHB's preferred Māori Health Provider, Te Kawau Maro, have been contracted to deliver the Mama Pepe Hauora Programme since 2013 when the Ministry issued a request for proposals for Maternal and Infant Physical Activity and Nutrition Initiatives. The Ministry has continued the funding through to 2016/17. To date the programme has worked with a variety of stakeholders (including the Public Health Unit, Maternity Services, Le Leche League, WCTO providers, LMCs, ECEs, CBEs) to:
  - Train and mentor 4 new Lactation Consultants
  - Train 24 Peer Support Counsellors
  - Receive in excess of 240 Peer Support Counsellor and Community Lactation Consultant referrals
  - Support and train 3 providers to achieve BFCI accreditation – Tui Ora Limited, Le Leche League, and Plunket
  - Deliver 24 breastfeeding group education sessions
  - Support 22 Early Childhood Education settings (including 4 Kohanga Reo) to achieve Breastfeeding Welcome Here (BFWH) accreditation

National Indicator 4.1 **Outcome we want to achieve**	**CANCER (CERVICAL SCREENING)** **What we are planning to do to achieve it**	**Who will be responsible:** PM, Cancer Services **How we will know if we have been successful**
Reduced cancer mortality and morbidity and reduction in inequalities in cancer mortality and morbidity	1. Work with the Taranaki Regional Screening Unit to continue to work with the National Cervical Screening Unit, PHOs and Te Kawau Maro alliance to develop and implement strategies to improve cervical screening rates for Taranaki Māori women. Deliver six monthly reporting and disseminating information gathered with regard to cervical screening rates for Māori and non-Māori in Taranaki. 2. Support for the PHO/community providers to identify women who have not been screened or under-screen is planned by the Regional Screening Unit data matching project. Report quarterly: a. referrals received, number of contacts and smears completed by outreach services 3. Improve ethnicity data quality with data-match cleansing and provide quarterly updates on progress made. 4. Health promotion activities continue to focus on Māori and include for example: • Waitangi Day Promotion • Workplace Promotion, Tegel Foods Ltd • Kapahaka Events • Pae Pae in the Park (Patea) • Kaumatua at Te Roopu Pahake O Waitara • Tui Ora Kaumatua group	80% of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25-69 will have had a cervical screen in the past 36 months. The Taranaki region has developed in conjunction with Māori Health Providers a health promotion plan with a strong focus on working collaboratively with the PHO and community providers. We continue to work closely with the PHO to increase coverage with 85% of activities being completed by the PHO.

	• Radio Campaigns, interviews – 1-2 annually 5. Review health promotion activies 2015/16 with a view to updating strategies to reach priority women. Medical Officer of Health and TKM alliance will be consulted, ensuring health promotion is effective for Māori women 6. To improve the timeliness and experience of colposcopy for Māori women. • Dashboard developed to identify women at high risk of DNA, based on their history. o Māori Health Team regularly review DNA report to identify new or high risk DNA patient/s o Kaimahi phones/contacts patient, attendance pathway followed identifying any barriers to attending o Kaimahi, nurse, booking clerk, meet to develop individualised plans for non attendees through to attendance o Pae Ora template developed and implemented o Early intervention occurs for women who DNA o Identification of barriers, planning and documentation for Māori women who have a high DNA rate to colposcopy o Improved patient information pamphlets – designed to meet the literacy needs of the patient group, provides friendly, welcoming, culturally inclusive messages o Annual open days to colposcopy clinics 7. The NCSP will continue to provide all providers with overdue reports to assist with identification of priority women.		
		Māori	65%
		Non-Māori	83%

	8. Support collaborative working relationships between providers across the cervical screening pathway. • Identify and participate in 1-2 community events which reach priority women • Deliver 1-2 media awareness campaigns annually • Bi- monthly meetings with Māori health promotion team 9. Monitor indicator performance on a quarterly basis through the Māori Health Plan Steering Group. 10. Activities continue with kaimahi making direct phone contacts for cervical screening with referrals from practice nurses for our Outreach service. All sessions are evaluated.	**Progress**	Ⓟ
		Gap (%)	18

<table>
<tr><th>National indicator 4.2

Outcome we want to achieve</th><th>CANCER (BREAST SCREENING)

What we are planning to do to achieve it</th><th colspan="2">Who will be responsible: GM Funding & Planning

How we will know if we have been successful</th></tr>
<tr><td rowspan="6">Reduced cancer mortality and morbidity

Increase BreastScreening rates for Māori and reduce inequalities in BreastScreening rates between Māori and Non-Māori</td><td rowspan="6">• To participate in the Regional Coordination Group and contribute to the development of the 2016-2018 Regional Plan
• To support BSCC to complete a Taranaki BreastScreening Health Needs Assessment (BSHNA) This assessment will inform initiatives to support an increase of Māori women to participate in breast screening.
- Project report content & timeline determined by 01 September 2016
- BSHNA completed and report finalised by 11 December 2016
- Present findings to key stakeholder by March 2017
• BSHNA to inform the DHB and BreastScreen Coast to Coast to continue working collaboratively with National, Regional and local key stakeholders to determine planning actions for the Regional Coordination Plan 2016 – 2017
- To promote breast screening
- To Increase enrolment and attendance
- To identify women who have not been screened or are under screened
- Screening, assessment and treatment to screening services to contribute to reducing equity gaps in breast screening
-
• Taranaki DHB champion to monitor indicator performance on a quarterly basis
- 6 monthly reported completed
To work with primary care (including PHO's) to ensure data matching with BreastScreen Coast to Coast</td><td colspan="2">70% of eligible women aged 50 to 69 will have a BSA mammogram every two years.

"Non Māori" data is calculated as "Total" less "Māori" and Pacific women's data – data is sourced from the National Screening Unit, Q2 2015/16 coverage data.</td></tr>
<tr><td>Māori</td><td>61%</td></tr>
<tr><td>Non-Māori</td><td>74%</td></tr>
<tr><td>Progress</td><td>☒</td></tr>
<tr><td>Gap (%)</td><td>13%</td></tr>
</table>

<table>
<tr><th>National Indicator 5

Outcome we want to achieve</th><th>TOBACCO

What we are planning to do to achieve it</th><th colspan="2">Who will be responsible:
GM Funding & Planning
How we will know if we have been successful</th></tr>
<tr><td>Taranaki DHB is committed to continue to contribute towards achieving a Smokefree Taranaki 2025 and reduction in smoking prevalence inequalities between Māori and Non Māori
• Our Tamariki and Rangatahi deserve a future where smoking is history</td><td>• Ensure all patients who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital based maternity service
• 2016-2017 Maternity Quality Safety Committee to determine and implement actions:
- To review the ABC pathway, resources and training in maternal child and health
- Increase access of Nicotine Replacement Therapy and smoking cessation medicines within hospital based maternity services
- Improve referral process and pathway for hospitalised pregnant smokers to specialist stop smoking services

• The DHB to work collaboratively with local specialist stop smoking services and key stakeholders to collectively agree activities for pregnant mothers who smoke to be included in the 2016 -17 Taranaki Tobacco Action Plan.</td><td colspan="2">95% of pregnant Māori women are smokefree at two weeks postnatal.

Results are sourced from Well Child Tamariki Ora Quality Indicator 19 for the period 1 July – 31 December 2014 (latest published results). No results available for Non Māori.</td></tr>
<tr><td></td><td></td><td>Māori</td><td>62%</td></tr>
<tr><td></td><td></td><td>Non-Māori</td><td>78%</td></tr>
<tr><td></td><td></td><td>Gap</td><td>16%</td></tr>
<tr><td></td><td></td><td>Progress</td><td></td></tr>
</table>

<table>
<tr><th>National Indicator 6.1

Outcome we want to achieve</th><th>IMMUNISATION - INFANTS

What we are planning to do to achieve it</th><th colspan="2">Who will be responsible: PM, Child & Youth

How we will know if we have been successful</th></tr>
<tr><td rowspan="6">Improved children's health</td><td rowspan="6">Maintaining a well functioning Taranaki Immunisation Steering Group (TISG) and Operational Taskforce Group to drive the activity associated with continuous improvement in systems and service delivery.
Use of the monthly Dashboard to monitor immunisation activity and gaps in service provision.
Continued implementation of NCHIP – continuous improvement of the functionality of the system.
Promote the use of General Practice pregnancy registers to ensure early enrolment.
Improve the interface between Lead Maternity Carers (LMC's) and General Practice with a focus on early enrolment and information sharing.
Enabling flexibility in OIS resource to meet the demand of referrals.
Decrease the number of OIS referrals by focused efforts of keeping families engaged or reengaged with Primary Care.
Continue to improve the interface with opportunistic vaccinations throughout the District Health Board services.
A MOU or similar is in place between relevant agencies to maximise ability to locate hard to reach families.</td><td colspan="2">95% of infants are fully immunised by eight months of age (ht)</td></tr>
<tr><td>Māori</td><td>83%</td></tr>
<tr><td>Non-Māori</td><td>91%</td></tr>
<tr><td>Progress</td><td>☒</td></tr>
<tr><td>Gap (%)</td><td>8%</td></tr>
</table>

National Indicator 6.2 **Outcome we want to achieve**	**IMMUNISATION – SEASONAL INFLUENZA** **What we are planning to do to achieve it**	**Who will be responsible:** PM, Primary Care **How we will know if we have been successful**	
Reduced communicable disease	• The DHB will maintain funding for the 2016-2017 year to provide additional outreach Influenza vaccinations through Māori Womans Welfare League health days on Marae and in the community. • MHN has deployed a range of population targeting tools across all practices within the network including the patient prompt (PP) and BPAC. • PP provides a floating traffic light dash board for each patient on the PMS system showing key milestones or core health information that is incomplete. • Linked to the Pinnacle Quality framework that funds achievement of population goals in key areas. • Regular practice visits and reports provide active feedback on performance. • Peer groups that include identifiable reports for Drs and nurses are also being rolled out to also assist with quality improvement and best practice. • The BPAC report allows any members of the practice or MHN to daily run a series of reports that highlight performance against all performance targets including national Health targets, IPIF and local clinical indicators. • Regularly monitor indicator performance to identify issues and implement on a quarterly basis through the Māori Health Plan Steering Group	75% of the eligible population (65 years and over) have their seasonal influenza immunisation	
		Māori	67%
		Non-Māori	67%
		Progress	☒
		Progress	0

<table>
<tr><th>National Indicator 7

Outcome we want to achieve</th><th>RHEUMATIC FEVER

What we are planning to do to achieve it</th><th colspan="2">Who will be responsible: Medical Officer of Health
How we will know if we have been successful</th></tr>
<tr><td rowspan="6">Reduce the incidence of Rheumatic Fever</td><td rowspan="6">The Taranaki DHB Rheumatic Fever Prevention Plan
http://www.tdhb.org.nz/misc/document_library.shtml#DLR
uses a “population health approach” and acknowledges the three main drivers of health inequalities as outlined by Camara Jones. Strategies however need to be consistent with local need because Taranaki is a “low incidence area” with an average of less than one case per year. The minimum actions as required by Ministry of Health for low incidence DHBs are:
Actions to treat Group A streptococcal throat infections quickly and effectively
• Ensuring that health professionals likely to see high risk children follow the most up-to-date sore throat management guidelines
• Ensuring that people with Group A streptococcal throat infections complete a full course of antibiotic treatment (treatment compliance)

Actions facilitating the effective follow-up of identified rheumatic fever cases
• Ensuring that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission.
• Investigate notified cases as per the 2012 MOH Communicable Disease Control guidelines, and identify and follow up known risk factors and system failure points including reviewing cases of recurrent rheumatic fever to identify reasons for recurrence (where identifiable) and take actions to improve secondary prevention where indicated.
• Ensuring that all patients notified with rheumatic fever are entered onto the Rheumatic Fever Register and patients with a past history of rheumatic fever receive monthly antibiotics not more than 5 days after their due date.
• Complete an annual audit of rheumatic fever secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years, and adults aged 25+ years.</td><td colspan="2">First episode rheumatic fever hospitalisation rate is two-thirds below baseline (3 year average rate 2009/10 – 2011/12). For Taranaki this means a target of no cases.</td></tr>
<tr><td>Māori</td><td rowspan="2">0 Total</td></tr>
<tr><td>Non-Māori</td></tr>
<tr><td>Gap (%)</td><td></td></tr>
<tr><td>Progress</td><td>☺</td></tr>
</table>

National Indicator 8 **Outcome we want to achieve**	**ORAL HEALTH** **What we are planning to do to achieve it**	**Who will be responsible:** Clinical Services Manager, Child and Maternal Health **How we will know if we have been successful**	
Improved dental health of Māori Children	• Continue to ensure that all children are enrolled at birth with the dental service. • Work alongside Māori health workers and community Māori health teams to locate enrolled children and their whanau to engage with community dental wellness strategies. • Work with the midland team to support the introduction of IT systems that will facilitate better engagement with families eg NCHIP • Monitor indicator performance on a quarterly basis through the Māori Health Plan Steering Group	95% of preschool children are enrolled with community oral health Services every quarter and at December 2016.	
		Māori	79%
		Non-Māori	101%
		Progress	☒
		Gap (%)	22%

National Indicator 9 Outcome we want to achieve	MENTAL HEALTH What we are planning to do to achieve it	Who will be responsible: Clinical Services Manager, Mental Health & Addictions How we will know if we have been successful	
Improved mental health outcomes for Māori	TDHBs Mental Health & Addiction Service (MHAS) and its Māori Provider Partner plan to: Q1 & 2 Take a whanau ora approach by interviewing the Whanau, the Tangata Whaiora and relevant Keyworkers with the following questions <u>Patient Questions</u> • What are the benefits of being under the MHA? • What would happen if you were not under the MHA? <u>Whanau/ Key Worker Question</u> • What would happen if Pt. x was not under MHA? Q3 & 4 As a result of the work carried out in Q1&2 solutions are to be discussed at the MHAS clinical governance forum and then jointly agreed for implementation.	Reduction in the number and proportion of Community Treatment Orders issued under Section 29 of the Mental health Act for Māori relative to other ethnicities.	
		Māori	92
		Non-Māori	63
		Progress	↑
		Gap	29 (Gap reduced from 39 to 29)

National Indicator 10 Outcome we want to achieve	SUDDEN UNEXPLAINED DEATH OF INFANTS SYNDROME (SUDI) What we are planning to do to achieve it	Who will be responsible: Acting Clinical Services Manager How we will know if we have been successful
Improved child health	All caregivers of Māori infants are provided with SUDI prevention information at Well child Tamariki Ora Core Contact 1. TDHB safe sleep policy is update 3yearly and all staff are expected to teach safe sleep in line with this on discharge. Our safe sleep champion co-ordinates pepi pod distribution and ensures education around this. As part of our maternity quality programme a safe sleep audit occurs annually to audit safe sleep practice and adherence to safe sleep policy. All inpatient maternity patients have included in their maternity care plan a safe sleep, assessment and education careplan. TDHB will maintain current activities to keep early enrolment rates with an LMC rates at 95+% Breastfeeding education and support is provided to all mothers with an emphasis on stopping smoking and not sharing sleeping areas. To ensure that 100% of new mothers receive information and support around safe sleeping and are offered a pepi pod if appropriate. That online SUDI prevention training for health	The current 0.4 SUDI deaths per 1000 Māori live births is reduced. This is the five year rate achieved by non-Māori (95%CI 0.34-0.52). • Success will be indicated by the gap between Māori and non Māori being reduced, that that rate for all is below 0.4 deaths per 1000. • 100% of caregivers of Māori infants are provided with SUDI information at Well Child Tamariki Ora Core Contact 1 • By December 2017 a 10% increase in the numbers of Māori first time mothers accessing antenatal classes.

professionals is made available and used by staff to support staff training.

- To ensure that LMC provide safe sleep information to patients post natally and before they are discharged from LMC care, eg 49 days. Care Plans are available on the postnatal ward.
- We will work with WCTO and Plunket on information related to safe sleep to ensure there is consistency in the training applied.
- We will have Plunket contract devolved from Waikato as of 1 July 2017.
- We will then review the services across the region with the intention of implementing the Hapu Wananga Tool currently in development.
- Once signed off we will use the Report on TDHB Maternity Quality and Safety Consumer Engagement Survey to help with identify areas of focus.
- We will be reviewing the pregnancy and parenting services

	SUDI deaths per 1,000 live births (using 2010-2014 five year annualised average rates)	**% of caregivers provided with SUDI information at WCTO Core Contact 1 (using 2014 results)**
Māori	2.31	40.6%
Non-Māori	0.0	61.8%
Total Population	0.90	56.0%
Progress		
Gap	2.31	21.2%

Local Indicator 1 **Outcome we want to achieve**	**ACCESS TO SERVICES – Failed Outpatient Appointments (DNA)** **What we are planning to do to achieve it**	**Who will be responsible:** Clinical Services Manager, Medical **How we will know if we have been successful**	
Improved access to secondary care	Investigate failed Diabetes-related and dental outpatient clinics appointments, develop and trial interventions including implementation of successful interventions from the Colposcopy DNA project. Participate in the Regional DNA Discussion Group to enable sharing of initiatives across DHBs Monitor indicator performance on a quarterly basis including through the Māori Health Plan Steering Group.	Failed appointment rates for outpatient clinics are reduced to 5% by July 2017	
		Māori	18%
		Non-Māori	5%
		Progress	☒
		Gap (%)	13%

Local Indicator 2 **Outcome we want to achieve**	**WORKFORCE DEVELOPMENT** **What we are planning to do to achieve it**	**Who will be responsible:** HR Manager, Chief Advisor Māori Health **How we will know if we have been successful**	
Taranaki has a Māori health and disability workforce proportionate to the Taranaki Māori population, predominantly engaged in clinical and frontline health worker roles.	1. Develop and implement the Position Impact Assessment support tool for TDHB recruiting managers to help identify and prioritise positions where a proactive approach to recruiting Māori is warranted. 2. Continue to expand the delivery of education and awareness training to TDHB recruiting managers to improve their awareness of the need to increase the Māori health and disability workforce, the opportunities and their responsibilities in this regard.	a) Percentage of Māori employed in the Taranaki DHB -13% by 30 June 2017	
		Māori @ June 2016	153 Māori (WRR Inc) 8.34%
		Progress	Ⓟ

<table>
<tr><th>Local Indicator 3

Outcome we want to achieve</th><th>ACCESS TO SERVICES: ORAL HEALTH - Tamariki and Rangatahi
What we are planning to do to achieve it</th><th>Who will be responsible: PM, Oral Health and the HSS Service Manager Maternal and Child Health
How we will know if we have been successful</th></tr>
<tr><td>Improved access to oral health services by tamariki and rangatahi Māori and elimination of inequality in oral health status between Māori and non-Māori</td><td>1. Taranaki DHB Hospital and Specialists services the DHB funder and Māori Health Services to jointly undertake a review of all oral health services provided by Taranaki DHB with the aim of re-prioritising services to target engagement with tamariki and rangatahi between the ages of 0-18 years.
2. Review the service model for engaging with 0-18 year olds and work with TDHB Community Oral Health service, private dentists Te Kawau Maro Alliance, Health Promotion and other interested stakeholders to develop a model that ensures all tamariki and rangatahi have annual oral healthcare plans completed and supported by the provision of timely, accessible and appropriate education and oral health treatment.
3. Develop and implement initiatives that results in:
a. children/tamariki Māori aged 0-4 have attended a dental clinic within the previous 12 months, and
b. youth/rangatahi Māori aged 12 – 18 have attended a dental clinic within the previous 12 months.</td><td>By 30 June 2017:
• 95% of all tamariki aged 0 – 4 have a completed annual oral health care plan in place
• 85% of rangatahi Māori aged 12- 18 have had all treatment under their annual oral health care plan completed.

<table><tr><th></th><th>Tamariki 0 – 4</th><th>Rangatahi 12 - 18</th></tr><tr><td>Māori</td><td>39%</td><td></td></tr><tr><td>Non-Māori</td><td>28%</td><td></td></tr><tr><td>Progress</td><td></td><td></td></tr><tr><td>Gap (%)</td><td></td><td></td></tr></table></td></tr>
</table>

Local Indicator 4 **Outcome we want to achieve**	**WAIORA – Child Obesity** **What we are planning to do to achieve it**	**Who will be responsible:** Medical Officer of Health & Manager, Health Promotion **How we will know if we have been successful**
Contribute to a reduction in child obesity in Taranaki children.	1. Support the development of healthy and sustainable policy and practices to reduce the consumption of sugar sweetened beverages (SSB) in Taranaki children. 2. Identify and work with 2 schools to implement healthy settings approaches including: a. adopt SSB free policies, and b. raise awareness of workers within the schools of the SSB policy and its implications	# / % of organisations that have adopted healthy policies and practices as a result of PHU intervention and are 100% SSB free (BC, CC, O) **How many = # (quantity of effort)** • 2 organisations supported to implement healthy settings approaches • # of schools with SSB free policies **How well = % (quality of effort)** • 50% of workers are aware of SSB policy in their organisation Inequalities Box not applicable

Local Indicator 5 **Outcome we want to achieve**	**WAIORA – Health of streams/catchments/rivers** **What we are planning to do to achieve it**	**Who will be responsible:** Medical Officer of Health & Manager, Health Promotion **How we will know if we have been successful**
Increase food security and reduce food-borne illness for Taranaki Māori.	1. Facilitate provision of training in the Cultural health Index (CHI) to iwi/hapu/whanau 2. Support iwi and hapu to implement a programme of assessing the cultural and biological health of Taranaki streams/catchments/rivers.	# of streams and rivers in Taranaki which are assessed using CHI (CC, O) **How many = # (quantity of effort)** • # of iwi/hapu/whanau trained in application of CHI **How well = % (quality of effort)** • 100% of trainings held in Māori settings Inequalities Box not applicable

Local Indicator 6 **Outcome we want to achieve**	**WAIORA – Alcohol & Drug Awareness** **What we are planning to do to achieve it**	**Who will be responsible:** Medical Officer of Health & Manager, Health Promotion **How we will know if we have been successful**
Increase knowledge of people working with pregnant women regarding FASD.	1. Develop a regional Foetal Alcohol Syndrome Disorder action plan. 2. Implement 1 project based on recommendations of the MOH FASD Action Plan that targets health literacy of those people that work with pregnant women.	75% of people working with pregnant women report knowledge consistent with content of the MOH FASD Action Plan and Kaupapa Māori research as a result of PHU intervention (SK, AO, S) **How many = # (quantity of effort)** • 1 action plan developed • 1 project delivered **How well = % (quality of effort)** Recommendations of the MOH FASD Action Plan and Kaupapa Māori research are evident in both the regional action plan and project plan. Inequalities Box not applicable

ABBREVIATIONS

ALT	Alliance Leadership Team
ASR	Age/Sex Register
ASH	Ambulatory Sensitive Hospitalisation
BFCI	Breastfeeding Friendly Community Initiative
BSA	BreastScreen Aotearoa
BSCC	BreastScreen Coast to Coast
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BSHNA	BreastScreening Health needs Assessment
CEO	Chief Executive Officer
COHS	Community Oral Health Service
COPD	Chronic Obstructive Pulmonary Disease
CSM	Clinical Services Manager
CVD	Cardiovascular disease
CVD-IHD	Cardiovascular disease – Ischaemic heart disease
DHB	District Health Board
DNA	Did not attend (used in the measurement of outpatient clinic attendance)
ED	Emergency Department
ECE	Early Childhood Education
FASD	Foetal Alcohol Syndrome Disorder
FSA	First Specialist Assessment
GP	General Practitioner
IPIF	Integrated performance and incentive framework
LMC	Lead Maternity Carers
LTC	Long Term Conditions
MDT	Multi Disciplinary Team
MHAS	Mental Health & Addiction Service
MHN	Midland Health Network
MOH	Ministry of Health
MOU	Memorandum of Understanding
MPH	Mama Pepe Hauora
NCHIP	National Child Health Information Platform
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHI	National Health Index
OIS	Outreach Immunisation Service
PDSA	Plan Do Study Act
PHO	Primary Health Organisation
PM	Portfolio Manager
PMS	Patient Management System
PP	Patient Prompt
SPOA	Single Point of Access
SSB	Sugar sweetened beverages

SUDI	Sudden Unexplained Death of an Infant
TDHB	Taranaki District Health Board
TISG	Taranaki Immunisation Steering Group
TKM	Te Kawau Maro
TSB	Taranaki Savings Bank
WCTO	Well Child Tamariki Ora