TARANAKI DISTRICT HEALTH BOARD

TE MATAKITE

MĀORI HEALTH PLAN

2014-2015

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OVERVIEW

This Plan describes the Taranaki District Health Board's (TDHB) priorities in Māori health for 2014-2015. The plan represents the TDHB's main response to its obligations under the New Zealand Public Health and Disability Act (2000) which requires DHB's to reduce disparities and improve Māori health outcomes. It aligns to the TDHB's strategic framework that aims to achieve the vision of "Taranaki whanui, he rohe oranga" as well as the wider aspirations of Whānau ora as described in He Korowai Oranga, national Māori Health Strategy and Te Kawau Mārō, Taranaki Māori Health Strategy. The format of this plan and the indicators included follow the 2014-2015 Operational Policy Framework guidelines.

In 2014-15, in addition to the national priorities, we will continue to focus on two local priorities identified in the TDHB's 2012 Whānau Ora Health Needs Assessment of Māori living in Taranaki*, namely DNA rate for outpatient appointments and access by taiohi Māori to primary mental health services. The Sudden Unexplained Death of Infants (SUDI) priority made mandatory by the Ministry of Health in previous years, is no longer mandatory and is therefore excluded this year. The focus in previous years on children's oral health has now become a national priority and will continue to be progressed as such, the relevant indicator being pre-school dental enrolments.

The Māori Health Plan gives a one-year subset of actions and aspirational targets related to Māori health priorities and indicators. Longer term activities (2 – 5 years) to improve health for Māori and non-Māori are described in the 2014-2015 TDHB Annual Plan with which this Plan aligns.

Four national Māori Health Plan indicators identified in this Plan are prioritised in the Midland Regional Services Plan to bring about regional focus on addressing these priority issues – Cancer screening, Breast feeding, Immunisation at 8 months and Cardiovascular Risk Assessments.

Quarterly performance results for the Māori Health Plan indicators will be disseminated to key audiences. First, results will be submitted to a joint meeting of the TDHB and Te Whare Punanga Korero Iwi relationship Boards along with senior managers, to monitor progress against the Plan. Second, quarterly performance reports will be disseminated for review by the Midland Health Network as well as the Māori Health Services alliance Te Kawau Mārō Alliance Leadership Teams. These groups represent key governance and operational audiences which are directly engaged in delivery against the Plan. Finally the DHB's Māori Health Plan performance will be presented in the DHB's Annual 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	Audit tool to be implemented or PHO enrolments as proxy		
2	N2.1	Access to care	1. Percentage of Māori enrolled in PHOs	98%	85.3%	97.3%
3	N2.2		2. Ambulatory Sensitive Hospitalisations rates per 100,000 for the age groups 0-4 yrs	95%	117% 5,300	56% 2,555
			45-64 yrs	95%	168% 3,835	73% 1,677
			0-74 yrs	95%	156% 3,110	73% 1,458
4	N3.1	Child Health	Exclusive breastfeeding at 6 weeks	68%	56%	68%
5	N3.2		3 months	54%	34%	54%
6	N3.3		6 months	59%	9%	23%
7	N4.1	Cardiovascular disease	1. Percentage of the eligible population who have had their CVD risk assessed within the past five years (ht)	90%	73%	83%
8	N4.2		2. 70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	70%	25%	50%
9	N4.3		3. Over 95 percent of patients presenting with ACS who undergo coronary angiography have completed ANZACS QI ACS and Cath/PCI registry data collection within 30 days	95%	100%	94%
10	N5.1	Cancer	1. Breast Screening, 70% of eligible women will have a BSA mammogram every two years	70%	65%	79%
11	N5.2		2. Cervical Screening, percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25-69 who have had a cervical screen in the past 36 months (by ethnicity)	80%	73%	89%
12	N6.1	Smoking	1. Hospitalised smokers provided with advice and help to quit (ht)	95%	98%	96%
13	N6.2		2. Current smokers enrolled in a PHO and provided with advice and help to quit	90%	71%	72%
14	N7.1	Immunisation	1 Percentage of infants fully immunised by eight months of age (ht)	95%	89%	89%
15	N7.2		2 Seasonal influenza immunisation rates in the eligible population (65 years and over)	75%	67% High needs	70% Total
16	N8	Rheumatic Fever	2014/2015 rheumatic fever target is 0.5 per 100,000 and a 40% reduction from baseline (3 year average 2009/10 – 2010/11)	0.5/100,000	0.9	
17	N9	Oral Health	Preschool Enrolments	85%	59%	82%
18	N10	Mental Health	Mental health Act: Section 29 Community Treatment Order indefinites comparing Māori rates with other (as per reporting to the Office of the Director of Mental Health)	Improve on baseline	102/100,000	54/100,00
Local Priorities						
19	L1	Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments	5%	19%	7%
20	L2	Primary Mental Health	Access by Taiohi Māori to packages of primary mental health Care	Improve on baseline	17%	49%

ABBREVIATIONS

ABC	An approach to smoking cessation requiring health staff to ask, give brief advice, and facilitate cessation support.
ALT	Alliance Leadership Team
ASH	Ambulatory Sensitive Hospitalisation
BFCI	Breastfeeding Friendly Community Initiative
BOPDHB	Bay of Plenty District Health Board
COL	Colposcopy
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
CVD-IHD	Cardiovascular disease – Ischaemic heart disease
DEN	Dental
DHB	District Health Board
DIA	Diabetes
dmf	Decayed, missing, or filled primary teeth
DMFT	Decayed, Missing, or Filled Teeth (permanent)
dmft	Decayed, missing, or filled teeth (deciduous)
DNA	Did not attend (used in the measurement of outpatient clinic attendance)
ENT	Ear, Nose and Throat
KARO	Knowledge, Actions, Results, Opportunity – reporting database through MOH
MHN	Midland Health Network
MOH	Ministry of Health
MSD	Ministry of Social Development
NGO	Non-Government Organisation
NHC	National Hauora Coalition
PHO	Primary Health Organisation
PM	Portfolio Manager
PHN	Public Health Nurse
PMHI	Primary Mental Health Indicator
RFP	Request for Proposal
RS	Respiratory
SUDI	Sudden Unexplained Death of Infants
TDHB	Taranaki District Health Board
TLA	Territorial Local Authority

POPULATION PROFILE

1.1. Taranaki DHB serves 3.03% of the Māori population of New Zealand. At the 2013 Census, 18,165 Māori were resident in Taranaki; this represents the 15th highest number of Māori serviced by any of the DHB's. However Māori make up 16.6% of the total Taranaki DHB population which is slightly higher than the national of 14.1%.

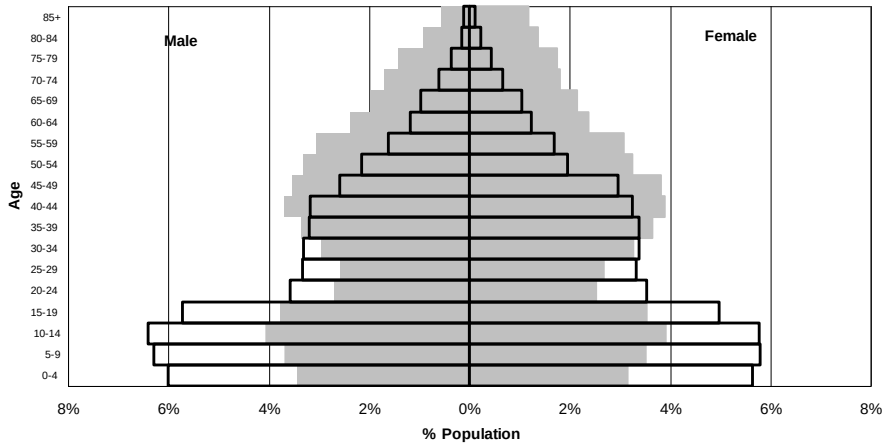
1.2. In the regional context Taranaki DHB has the lowest number and lowest proportion of Māori living in its service area of all the Midland DHB's. The highest proportion of Māori live in the Midland region.

Age Distribution

1.3. The Māori population in Taranaki is very young compared to the overall population as shown in Figure 4 below. For Māori, 35.9% of the population resident in Taranaki is under 15 years of age compared to 21.8% for the total population. The difference is even more marked for older Māori, with 4.7% of the Māori population resident in Taranaki aged over 65 years compared to 14.8% for the total population. This is, in part, a reflection of the lower Māori life expectancy relative to non-Māori.

Figure 4 Age Structure of Taranaki DHB, 2010

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



Source: Statistics NZ, Estimated Territorial Local Authority Population of TLA population June 2010.

Iwi

1.4. As at the 2013 Census the following was the population makeup of the iwi of Taranaki:

IWI	TOTAL IWI POPULATION	IWI POPULATION RESIDENT IN TARANAKI	% IN TARANAKI
Ngati Tama	1,338	387	28.92%
Ngati Mutunga	2,514	759	30.19%
Te Atiawa	15,273	3,828	25.06%
Ngati Maru	852	291	34.15%
Taranaki	6,087	1,689	27.75%
Ngaruahinerangi	4,803	1,779	37.04%
Ngati Ruanui	7,260	1,827	25.17%
Ngaa Rauru Kiitahi	4,176	717	17.17%
Tangahoe	246	96	39.02%
Pakakohe	351	144	41.03%
Other – Not Defined	120	21	17.50%
TOTAL	**43,020**	**11,538**	**26.82%**
Māori: non-Taranaki iwi		**6,627**	
Total Māori Population		**18,165**	

Geographic Distribution

1.5. TDHB comprises three territorial authorities. In 2013 the majority of the population was based in the New Plymouth District Council catchment (9369) while the largest proportion was based in the South Taranaki District (22.6%).

	South Taranaki District	Stratford District	New Plymouth District
Total Population	26,580	8,991	74,184
Māori (%)	22.8%	11.2%	14.9%

Population Growth

1.6. 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 109,608 in 2013 to 111,400 by 2031, an increase of 1.6%.

1.7. At the time of writing this Plan, Māori population projections based on the 2013 census were not available. However based on the 2006 census the Māori population is expected to increase to 22,800 by 2026, 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. The Māori population in the region will increase faster in the younger age groups. Based again on 2006 projections 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.

1.8. Māori who whakapapa to Taranaki iwi account for 63.5% of the local Māori population or 11,538 people, while almost 36.5% percent whakapapa to iwi outside of Taranaki. Around 26% 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.

2. MĀORI HEALTH NEEDS ASSESSMENT

Leading Causes of Avoidable Mortality and Hospitalisation

The leading causes of avoidable death and hospitalisation are ranked below. Similar issues ranked highly for Māori and non-Māori locally and nationally:

	Avoidable Mortality		Avoidable Hospitalisation	
	TDHB	**NZ**	**TDHB**	**NZ**
Māori	CVD-IHD	CVD-IHD	Angina and chest pain	Respiratory infections
	Lung cancer	Lung cancer	Asthma	Cellulitis
	Diabetes	Diabetes	Dental conditions	Angina
	COPD	COPD	Respiratory infections	COPD
	Cerebrovascular diseases	Road Traffic injuries	COPD	Asthma
Other	CVD-IHD	CVD-IHD	Angina and chest pain	Angina
	Cerebrovascular diseases	Lung cancer	Dental conditions	Respiratory infections
	COPD	Colorectal cancer	Cellulitis	Cellulitis
	Lung cancer	Suicide & self harm	Skin cancers	Road traffic injuries
	Colorectal cancer	Road traffic injuries	COPD	ENT infections

Health Needs Assessment

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) and are summarised below:

a. 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 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 challenge for funders and providers is to identify ways in which they may facilitate this development without taking leadership and risking engendering dependency.

b. Māori Participation and Leadership - Te Ara Tuarua Pathway Two – 'Māori participation in the Health and Disability Sector'

Building the capacity and capability of the Māori sector is a priority. The sector currently consists of the following components:

- Te Whare Punanga Korero Trust represents the eight iwi of Taranaki** and has a formal relationship with the Taranaki DHB to jointly work at a strategic level to improve Māori health outcomes;

** Ngati Tama, Ngati Mutunga, Te Atiawa, Ngati Maru, Taranaki, Ngaruahinerangi, Ngati Ruanui, Nga Rauru Kiitahi. Pakakohe and Tangahoe were represented by Ngati Ruanui on original set up of the Trust.

- Te Kawau Mārō Alliance between Tui Ora Limited, Ngati Ruanui Tahua and Ngaruahine Iwi Health Service. The alliance is the preferred provider of Māori-specific primary health care services in Taranaki;
- There is one PHO in Taranaki. Māori account for 15.57% of the Midlands Health Network PHO enrolled population for Taranaki, or 16,419 of 105,437 as at February 2014;
- Two public hospitals - Taranaki Base Hospital in New Plymouth with 152 inpatient, 23 inpatient mental health, 21 emergency department, 18 maternity beds and 8 neonatal inpatient cots, and Hawera Hospital with 10 inpatient, 6 emergency department beds and 4 maternity beds;
- Whakatipuranga Rima Rau Trust is a joint venture project between Te Whare Punanga Korero Trust, Ministry of Social Development (WINZ) and Taranaki DHB to increase the Māori health and disability workforce over ten years. A staff of three under the leadership of a General Manager, develops and delivers a range of programmes aimed at increasing the health and disability workforce supply;
- Te Roopu Paharakeke Hauora is the Māori Health directorate of the Taranaki DHB. The unit is headed by the Chief Advisor Māori Health, a member of the Taranaki DHB Executive Management Team, and along with a small team, is responsible for influencing decision-making across the funder and provider arms of the DHB to achieve improved outcomes for Māori.

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 currently no mechanism exists for gathering NGO workforce data. As at January 2014, 7.7% of Taranaki DHB staff or 132 from a total of 1,713 identified as being of Māori ethnicity.

c. Health System Performance and - 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. Social Determinants and - Te Ara Tuawha Pathway Four – 'Working across sectors'

It is well documented that there are systematic inequalities in access to social and economic determinants of health for Māori and that socio-economic status is a key factor contributing to health outcome disparity between Māori and non-Māori. 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 therefore a priority area.

3. IMPROVEMENTS UNDER WAY

Good progress is being made in reducing health inequalities for Māori in Taranaki DHB in the areas of CVD risk assessment, breast screening, help for smokers to quit in the hospital setting, and immunisations at 8 months old.

The system for addressing and monitoring Māori health improvement in Taranaki has been substantially strengthened with the implementation of Te Ara Whakawaiora, framework for accelerating Māori health improvement developed by Te Tumu Whakarae national DHB Māori Managers forum. Endorsed by the national CEO's forum, the system makes the whole DHB responsible and accountable for Māori Health improvement, through implementation, monitoring and sharing of best practice models that address the priorities and indicators within the Māori Health Plan. Monitoring of progress by the Iwi Relationship Board Te Whare Punanga Korero jointly with the Taranaki DHB Board and senior DHB and PHO managers brings significant rigor to the focus on reducing Māori health inequalities.

In terms of Health Sector Performance good progress has been to consolidate the Māori health sector. The TDHB preferred provider 'Te Kawau Mārō' alliance, a collective of Tui Ora and iwi providers evolved from an RFP process seeking a single provider of services for Māori. An outcomes-based contract which commenced on 1 July 2013,

merges 35 primary care contracts and $8.3M per annum, into a single 5-year contract. The formation of the alliance and the move to outcomes-based contracting is expected to result in;

- Reduction in operational overheads to release more funding to front line services for whānau
- Greater scope and flexibility for the alliance to deploy resources in more innovative ways to achieve better outcomes for whānau
- The burden of reporting being significantly reduced
- Clinical and cultural safety significantly strengthened
- The partners have committed to developing a common Whānau Ora system for Taranaki

4. PRIORITIES AND INDICATORS

The following section of the plan presents Māori health priorities and indicators that have been selected as national and local priorities. The national indicators are determined by the Ministry of Health and are priorities for all DHB's. These priorities are based on the leading causes of morbidity and mortality for Māori nationally and indeed reflect the priorities for Taranaki. Local priorities are determined by the Taranaki DHB Whānau Ora Health Needs Assessment (Ratima and Jenkins, 2012).

The national and local priorities are presented in tables in the following sections that summarise:

- The outcome we want to achieve
- What we are planning to do to achieve it
- Who will be responsible
- How we will know if we have been successful
- Why this outcome is important
- Where Māori are at now relative to non-Māori and the extent of the inequalities gap
- Where we want to get to in the next year

The 'inequalities box' at the bottom right of the tables provides a snapshot of the extent of disparities between Māori and non-Māori. The absolute measure of inequality provided is the 'gap' between Māori and non-Māori such as a percentage difference. As well, the 'inequalities box' provides an indication of progress made in addressing inequalities for Māori over time. Where data is available (data used to determine progress will be described in a footnote), the progress measure will report on trends over a number of years using the following symbols already used by TDHB in reporting progress on ethnic inequalities indicators.

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:

Symbol	Key
☑	Progressing well
Ⓟ	Some progress
☒	No progress or worsening
T̲	Not yet sufficient time to judge
?	Further info or work required
↑	Increasing gap
↓	Decreasing gap

5. SECTION FIVE: NATIONAL PRIORITIES AND INDICATORS ACTION PLAN

<table>
<tr><th>National Indicator 1
Outcome we want to achieve</th><th>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>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>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
• The MHN Alliance will review quarterly enrolment coverage versus census 2013 population data, via the MHN Health Intelligence reports, by March 2014
• Providing guidance on ethnicity data quality improvement activities (ongoing)
Where gaps are identified the MHN and TDHB through the Taranaki ALT will identify the appropriate mechanisms to work to support higher enrolment and accuracy.</td><td colspan="2">• 98% of Māori will be enrolled in PHOs as a proxy for reporting on Ethnicity Data accuracy.
• Commentary on how the quality of ethnicity data is improving.</td></tr>
<tr><td colspan="2" rowspan="2">Why is this outcome important:</td><td></td><td>Midland Health Network PHO Enrolments</td></tr>
<tr><td rowspan="4">Accurate ethnicity data is essential for tracking progress in Māori health outcomes. The accuracy of ethnicity data in PHO databases is unknown at present.</td><td>Māori</td><td>85.3%</td></tr>
<tr><td>Non-Māori</td><td>97.3%</td></tr>
<tr><td>Progress</td><td>☒</td></tr>
<tr><td>Gap (%)</td><td>12%</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>Increased access by Māori to primary health care services</td><td>Working within the Alliance TDHB and MHN will review quarterly access reports via the MHN Health Intelligence reports.

Where gaps are identified and where capacity exists all parties will work to support equity of access.</td><td colspan="2">98% of Māori will be enrolled in PHOs.

Utilisation of services by Māori 1:1 or higher than non Māori.</td></tr>
<tr><td colspan="2" rowspan="2">Why is this outcome important:</td><td>Māori</td><td>85.3%</td></tr>
<tr><td>Non-Māori</td><td>97.3%</td></tr>
<tr><td colspan="2" rowspan="2">PHO enrolment facilitates easier access to preventative health care and early condition management.
PHO enrolment rates vary throughout the country.</td><td>Progress</td><td>☒</td></tr>
<tr><td>Gap (%)</td><td>12%</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 0-74 years	1. Audit the most recent ASH data to identify the current leading causes of ASH for Māori in the 0-4, 45-64, and 0-74 year age groups by condition, domicile, NZDep, and hospital location. DHB and MHN action by December 2014. 2. Develop evidence based interventions targeted at Māori, in collaboration with all local stakeholders including MHN PHO, by June 2015. 3. Develop performance indicators for new interventions for agreement by the MHN Alliance and other interested stakeholders and monitor quarterly. Report findings to the joint TWPK/TDHB monitoring group and discuss successful and new interventions with the MHN and TKM Alliance. **0-4 years** 4. Maintain or improve B4 School Check coverage for tamariki Māori, on-going to June 2015. 5. Work with the Midland Health Network Taranaki Alliance Leadership Team to ensure tamariki under six years have access to free after hours primary care, on-going to June 2015. 6. Continue to work with TDHB dental, maternity and child health teams as well as primary care providers to support the Menemene Mai project to enrol pre-school children in dental services and to support whānau engagement with dental and other pre-school service initiatives. **45-64 years** 7. Taranaki DHB and the Midland Health Network continue to work together to implement the Primary Options to Acute Care for Taranaki and the GP/ED Overflow Clinic at Medicross Accident and Medical. 8. Continue to support Midlands Health Network PHO to: a. implement Diabetes Improvement packages of care in Clinical Pharmacy, Social Work, Dietetics and Podiatry. b. support GP Practices to increase checks for CVD and	ASH rates in all age groups will demonstrate movement towards the national rate for the total population in that age group. Over the 2014-15 year, ASH rates for Māori will approach the targets derived from the Ministry of Health ASH target formula as follows: 0-4 years: 95% 45-64 years: 95% 0-74 years: 95%

	Diabetes with the aim of meeting the 90% of the eligible population having had a CVD Risk assessment. c. upskill the Primary Health workforce in the care and management of Diabetic patients and Insulin Initiation. **0-74 years** 9. Continue to support the Taranaki Map of Medicine Clinical Pathways Steering Group to localise the prioritised clinical pathways. This piece of work will support Primary Options which is being launched on 14 June 2014. 10. Continue to support implementation of outreach influenza vaccination clinics to achieve increase access for the eligible population.				
Why is this outcome important:			**0-4y**	**45-64**	**0-74**
		Māori – TDHB	117% 5,300	168% 3,835	156% 3,110
		Non-Maori – TDHB	56% 2,555	73% 1,677	73% 1,458
		All – National	100% 4,532	100% 2,287	100% 1,988
Effective primary care can reduce ASH rates and ethnic inequalities in ASH rates. ASH rates are a proxy measure for access to primary care services, preventative management, and the quality of care delivered. Ambulatory sensitive hospital admissions are preventable with the appropriate quantity and quality of primary care.		**Progress**	↓	↑	↓
		Inequalities Gap – TDHB	61% 2,745	95% 2,158	83% 1,652

National Indicator 3	**CHILD HEALTH (BREASTFEEDING)**	**Who will be responsible:** PM, Population Health; Service Manager, Child and Maternal Health
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**
Increase in breastfeeding rates for Māori and reduce inequalities in breastfeeding rates between Māori and non-Māori	• Maintenance of BFHI status with 3 providers including TDHB, TKM alliance partners. • Work with the TDHB Provider Arm, Māori health and Public health teams, MHN PHO and TKM Alliance to review the breastfeeding information given to Māori women, and support associated education around breastfeeding. • Distribution of Mama Aroha Talk cards to LMC's, WCTO providers and PHO's to support education antenatally and in the community. • Audit Māori women coming through our service to establish why more are not breastfeeding, audit to be completed by Dec 2014. Service Manager – TDHB Provider • Support the Mama and Pepi Hauora project delivered by TKM to develop and deliver a toolkit to 5 priority communities to improve skills, knowledge, behaviour and attitudes with respect to nutrition, physical activity, and breastfeeding for mothers and infants including Breastfeeding Welcome Here accreditation and Active Movement training. • Link with existing Breastfeeding Peer Support and Community Lactation Services to strengthen collaborative approaches • Support 4 Scholarship Recipients to successfully register as Lactation Consultants by November 2014. • Monitor of breastfeeding data will take place quarterly by the joint TWPK/TDHB monitoring group. Successful and new interventions will be discussed with the provider arm, public health and Māori health teams of the TDHB as well as the MHN and TKM alliance.	Report on exclusive breastfeeding at 6 weeks, 3 months, and 6 months. Service Manager – Provider Māori infants will have attained breastfeeding rates consistent with the age-related targets from the Well Child Tamariki Ora Quality Improvement Framework of: Exclusive and fully breastfed at 6 weeks 68% Exclusive and fully breastfed at 3 months 54% Exclusive, fully and partially breastfed at 6 months 59%

Why is this outcome important:		**6 wks**	**3 mths**	**6 mths**
	Māori	56%	34%	9%
	Non-Māori	68%	54%	23%
Breastfeeding contributes significantly to infant, maternal, and whānau health in both the short and long term. The benefits of breastfeeding are unequivocal. In recent years breastfeeding rates in Taranaki have been declining, the Breastfeeding Community Support Service is implementing strategies to improve rates of breastfeeding particularly for Māori.	**Target**	68%	54%	59%
	Progress (inequality)	☒	☒	☒
	Inequalities Gap (%)	12%	20%	14%

National Indicator 4.1	CARDIOVASCULAR DISEASE (Risk Assessment)	Who will be responsible: PM, Primary Care
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**
Reduced mortality through improved cardiovascular health	Working within the Alliance TDHB and MHN will review six monthly performance against the agreed clinical targets. Where gaps are identified and where capacity exists the MHN PHO, TKM alliance and TDHB will work to analyse and identify gaps, develop and implement workable solutions support higher enrolment and accuracy. 1. Using NGO resource, identify and target missed opportunities by implementing systems to capture activity undertaken outside of the general practice environment 2. Fully integrate catch up and coordination services for key health targets including the utilisation of telephone catch up services 3. Increased use of MDT for diabetes & CVD 4. Enhance the electronic tools/resources available to general practice to include self-management 5. Workforce education and training in the delivery of LTCMP 6. Enhancement of existing funding strategy to further encourage general practices to deliver quality care and management and to best target resources	Primary care will achieve agreed clinical targets 90% of the eligible population have had their CVD risk assessed within the past five years (ht)

Why is this outcome important:		
	Māori	73%
	Non-Māori	83%
CVD is the leading cause of death and the leading cause of avoidable hospitalisation for Taranaki Māori. Given the extent of the burden of CVD and wide ethnic inequalities in cardiovascular health outcomes, access to risk assessment and effective condition management are important interventions to improve outcomes. CVD is substantially preventable with early identification, lifestyle advice and treatment.	**Progress**	**?**
	Gap (%)	10%

National Indicator 4.2	CARDIOVASCULAR DISEASE	Who will be responsible: Clinical Services Manager, Medical	
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**	
Reduced mortality through improved cardiovascular health	1. The Cardiac ANZACS-QI register enables reporting measures of ACS risk stratification and time to appropriate intervention 2. The data recorded in this registry enables patients level information to be reviewed by ethnicity	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	
Why is this outcome important:		**Māori**	25%
CVD is the leading cause of death and the leading cause of avoidable hospitalisation for Taranaki Māori. Given the extent of the burden of CVD and wide ethnic inequalities in cardiovascular health outcomes, access to risk assessment and effective condition management are important interventions to improve outcomes. CVD is substantially preventable with early identification, lifestyle advice and treatment.		**Non-Māori**	50%
		Progress	?
		Gap (%)	25%

National Indicator 4.3	CARDIOVASCULAR DISEASE	Who will be responsible: Clinical Services Manager, Medical	
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**	
Reduced mortality through improved cardiovascular health	On-going monitoring of existing procedures to maintain performance on this indicator	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	
Why is this outcome important:		**Māori**	100%
CVD is the leading cause of death and the leading cause of avoidable hospitalisation for Taranaki Māori. Given the extent of the burden of CVD and wide ethnic inequalities in cardiovascular health outcomes, recording and monitoring the key data associated with these events will help ensure services are clinically appropriate and equitable services are delivered to meet the needs of Taranaki Māori		**Non-Māori**	94%
		Progress	☑
		Gap (%)	-6%

<table>
<tr><th>National Indicator 5.1

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: PM, Cancer Services

How we will know if we have been successful</th></tr>
<tr><td rowspan="2">Reduced cancer mortality and morbidity</td><td>Continue to work with BreastScreen Aotearoa, PHOs and providers to strengthen local reporting of breast screening rates by DHB and ethnicity.</td><td colspan="2" rowspan="2">70% of eligible women will have a BSA mammogram every two years.</td></tr>
<tr><td>Continue to work with BreastScreen Aotearoa, PHOs and Te Kawau Mārō alliance to identify and implement effective interventions tailored toward Taranaki Māori women.
Activities include:
• Continue to support the Māori Health subgroup of the Local Cancer Network, with a focus on increasing screening rates of Māori women across Taranaki
• Working with BreastScreen Coast to Coast to influence the location of the mobile screening bus in 2014/15 to target areas with a high Māori population
• Continue to identify opportunities for BSA to work with Te Kawau Mārō alliance to expand delivery of the screening outreach programme across Taranaki
• Monitor delivery against planned actions as well as six-monthly monitoring of the overall coverage target</td></tr>
<tr><td colspan="2" rowspan="2">Why is this outcome important:</td><td>Māori</td><td>65%</td></tr>
<tr><td>Non-Māori</td><td>79%</td></tr>
<tr><td colspan="2" rowspan="2">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.</td><td>Progress</td><td>Ⓟ</td></tr>
<tr><td>Gap (%)</td><td>14%</td></tr>
</table>

National Indicator 5.2	**CANCER (CERVICAL SCREENING)**	**Who will be responsible:** PM, Cancer Services
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**
Reduced cancer mortality and morbidity	Continue to work with the National Cervical Screening Unit, PHOs and Te Kawau Mārō alliance to establish and deliver six monthly reporting on rates for Māori and non-Māori in Taranaki.	80% Cervical Screening percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25-69 who have had a cervical screen in the past 36 months The Taranaki region has a three year plan (July 2011 – June 2014) with a strong focus on PHO/community involvement. The next three year plan is currently being rewritten collaboratively by the PHO and the Regional Screening Unit. We have no evidence to gauge if recent initiatives are working as there have been no Cervical Screening statistics from the NSU since Dec 2013. We continue to work closely with the PHO to increase coverage with 85% of activities being completed by the PHO. We also take advantage of any unplanned opportunities that arise during the year.
	Work with the Taranaki Regional Screening Unit to continue to work with the National Cervical Screening Unit, PHOs and providers to develop and implement strategies to improve cervical screening rates for Taranaki Māori women	
	Health promotion activities continue to focus on Māori and include for example ♦ WINZ youth service programme ♦ Pae Pae in the Park (Patea) ♦ Kaumatua at Te Roopu Pahake O Waitara ♦ Tui Ora Kaumatua group	
	Activities continue with kaimahi making direct phone contacts for cervical screening with referrals from practice nurses for our Outreach service. All sessions are evaluated.	

Why is this outcome important:		
The cervical screening coverage for Māori women in Taranaki is lower than for non-Māori. The focus is on increasing coverage for Māori women. Cancer is a leading cause of mortality for Māori in Taranaki. 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%.	**Māori**	73%
	Non-Māori	89%
	Progress	Ⓟ
	Gap (%)	16%

National Indicator 6.1 **Outcome we want to achieve**	**SMOKING (HOSPITAL)** **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**
Less people smoking National Vision and Government Goal: Smokefree Aotearoa 2025 ▪ Our Tamariki and Rangatahi deserve a future where smoking is history	Continue to work with TDHB provider arm to apply a focus on Māori patients and their whānau to: ▪ Current unit procedures support ongoing process to ensure all Māori 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 and maternity services ▪ To promote and monitor the use and access of Pharmacotherapy medicine for hospitalised Māori Smokers o Determine a baseline by 31 September 2014 ▪ To improve and monitor the number of referrals for hospitalised Māori smokers to Quitline and specialised smoking cessation services ▪ Maternity services to monitor the use and access of Nicotine Replacement Therapy for hospitalised Māori pregnant smokers o Determine a baseline by 31 September 2014 ▪ Maternity services to establish a referral process and pathway for hospitalised Māori pregnant women smokers to Mana Wahine Hapu and other specialist smoking cessation services o Determine a baseline by 31 September 2014 ▪ To implement the recommendations from the National Smokefree mental health project within the hospital	95% of hospitalised Māori patients who smoke and are seen by a health practitioner are provided with brief advice and support to quit smoking Progress towards 90% of Māori pregnant women who identify as smokers at the time of confirmation of pregnancy in General Practice or booking with Lead Maternity Carer are offered advice and support to quit ▪ Increase percentage of Māori hospitalised smokers receiving pharmacotherapy medicine by June 2025 ▪ Increase of Māori direct referrals numbers to Quitline and specialist smoking cessation services by June 2015 ▪ Increase percentage of hospitalised pregnant smokers receiving Pharmacotherapy medicine by June 2015 ▪ Increase of direct referral numbers to Mana Wahine Hapu and specialist smoking cessation providers by June 2015 Implementation of National Smokefree Mental Health guidelines and resources within the hospital by June 2015

Why is this outcome important:		
	Māori	98%
	Non-Māori	96%
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. Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.	**Progress**	☑
	Gap (%)	2%

National Indicator 6.2 **Outcome we want to achieve**	**SMOKING - PRIMARY CARE** **What we are planning to do to achieve it**	**Who will be responsible:** PM, Population Health **How we will know if we have been successful**
New Zealanders living longer, healthier and more independent lives National Vision and Government Goal – Smokefree Aotearoa 2025 ▪ Our Tamariki and Rangatahi deserve a future where smoking is history	▪ PHO to ensure all Māori patients who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support o MHN Network Liaison Team to provide quarterly reports to all practices on their performance against the Annual Quality Plan targets o To provide a MHN centralised practice support approach for identified practices that require support for Māori smokers not contacted in 12 months o Explore options for a range of dedicated smoking cessation support in the Primary Care Setting ▪ Smokefree Pregnancy o Professional Mana Wahine Hapu community champions to deliver promotional sessions to health and community professionals o 5 Mana Wahine Hapu Whānau champion trainers to recruit and provide training support packages o Whānau champions to deliver Smokefree pregnancy conversations o Mana Wahine Hapu service to provide smoking cessation/behavioural support group interventions to pregnant women and their partners/whānau ▪ Taranaki representation on the Smokefree Midlands Māori Caucus Group	▪ 90% of Māori patients who smoke aged 15 years and over and are seen in General Practice by a health practitioner are offered brief advice and support to quit smoking ▪ Make progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnant in general practice are offered advice and support to quit ▪ Agree with MRHN a evidence based model to best support General Practice by 30 September 2014 ▪ To deliver Mana Wahine Hapu promotional sessions reaching 250 health and community professionals by 31 March 2015 ▪ 40 whānau champions recruited and trained by 31 March 2015 ▪ 400 smokefree pregnancy conversations recorded by 31 March 2015 ▪ 125 women received three facilitated group support sessions (partners included based on ratio 85% women 15% partners) by 31 March 2015 ▪ 100 pregnant women enrolled in Innov8 Smokefree telephone support by 31 March 2015 ▪ Ongoing attendance at Regional meetings

Why is this outcome important:	**Māori**	71%
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. Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector	**Non-Māori**	72%
	Progress	**?**
	Gap (%)	1%

National Indicator 7.1	**IMMUNISATION**	**Who will be responsible:** PM, Child & Youth
Outcome we want to achieve	**What we are planning to do to achieve it**	**How we will know if we have been successful**
Improved children's health	• Maintain an immunisation alliance steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit; and that participates in regional and national forums • Work with primary care partners to monitor and increase new born enrolment rates to 100% • Monitor and evaluate immunisation coverage at DHB, PHO and practice level, manage identified service delivery gaps • Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date • In collaboration with primary care stakeholders develop systems for seamless handover of mother and child as they move from maternity care services to general practice and WCTO services • In collaboration with NGOs and government agencies, describe how the DHB is working across agencies to increase immunisation coverage	95% of infants are fully immunised by eight months of age (ht)

Why is this outcome important:		
	Māori	89%
	Non-Māori	89%
• Immunisation is linked to primary care access and management • Immunisation can prevent a number of diseases and is a cost-effective health intervention.	**Progress**	☑
	Gap (%)	0%

<table>
<tr><th>National Indicator 7.2
Outcome we want to achieve</th><th>IMMUNISATION
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>Reduced communicable disease</td><td>Continue to support the NGO sector through the DHB Immunisation coordinator and the Taranaki Immunisation Steering Group to provide opportunistic immunisations at health promotion days on Marae and in the community.</td><td colspan="2">Achieving the target for seasonal influenza immunisation rates in the eligible population (65 years and over) (by ethnicity)</td></tr>
<tr><td colspan="2" rowspan="2">Why is this outcome important:</td><td>Māori</td><td>67% (High needs)</td></tr>
<tr><td>Non-Māori</td><td></td></tr>
<tr><td colspan="2" rowspan="4">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</td><td>Total</td><td>70%</td></tr>
<tr><td>Progress</td><td>Ⓟ</td></tr>
<tr><td>Gap (%)</td><td>3%</td></tr>
<tr><td></td><td></td></tr>
</table>

National Indicator 8 **Outcome we want to achieve**	**RHEUMATIC FEVER** **What we are planning to do to achieve it**	**Who will be responsible:** PM, Population Health **How we will know if we have been successful**
Reduce the incidence of Rheumatic Fever	Implement the TDHB Rheumatic Fever Prevention Plan by: ○ Ensuring that primary care providers and other health professionals likely to see high risk children follow the National Heart Foundation Sore Throat Management Guidelines ○ Ensuring people with Group A streptococcal infections are treated appropriately within 7 days of developing symptoms ○ Ensuring that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission ○ Reviewing all cases of rheumatic fever to identify any identifiable risk factors and system failure points ○ Ensuring patients with a past history of rheumatic fever receive monthly antibiotics not more than 5 days after due date	Rheumatic fever number and rate reductions are 40% below the 3-year average (2009/10 – 2010/11), towards a target of 0.5/100,000 (by ethnicity)

Why is this outcome important:		
Rheumatic Fever left untreated can damage the heart leading to life long heart problems. Working to reduce and eliminate rheumatic fever can reduce the incidence of heart disease and/or related complications.	**Māori** **Non-Māori**	0.9 Total
	Progress	Ⓟ
	Gap (%)	NA

National Indicator 9 Outcome we want to achieve	ORAL HEALTH What we are planning to do to achieve it	Who will be responsible: Service Manager, Child and Maternal Health How we will know if we have been successful
Improved dental health of Māori Children	• Work with maternity services to ensure all children are enrolled at birth with the dental service • Work with providers such as Tamariki Ora, Plunket and PHO's to ensure all pre-school children are enrolled with the dental service.	• 75% of preschool children are enrolled with Dental Services. Audited quarterly with target achieved by June 2015. • Children enrolled and 'on our books' earlier enable us to track and trace them to ensure/support oral health checks and treatment. • Working alongside Māori health workers and community Māori health teams to locate children and families easier if the child is enrolled already.

Why is this outcome important:		
	Māori	59%
	Non-Māori	82%
There is disparity between Māori children and non-Māori children's oral heath in Taranaki, this needs to be addressed to aim for equal oral health outcomes for all children. Oral health reflects and impacts on general health and well being. Having healthy teeth as a child leads to healthy adult teeth and less associated co-morbidities and health risks.	**Progress**	**?**
	Gap (%)	23%

National Indicator 10 Outcome we want to achieve	MENTAL HEALTH What we are planning to do to achieve it	Who will be responsible: How we will know if we have been successful
Improved mental health outcomes for Māori	• Establish a baseline through data reporting • Identify emerging trends. • Develop a plan to address	Reduction in the number and proportion of Community Treatment Orders issued under Section 29 of the Mental health Act for Māori.

Why is this outcome important:		
	Māori	102 per 100,000 of pop
Identify and address the disparity between Māori /Non Māori in relation to MHA/CTO rates. • Establish baseline- as of July 2014/2015 this data will be part of the MH&A PRIMD data set to facilitate better reporting. • Monitor this data monthly via the MH&A business unit. Variations will be reported to the Service Manager. Negative variations are to form part of the agenda for discussion at the Monthly Clinical Governance Forum – with a view to establishing a plan for improvement.	**Non-Māori**	54 per 100,000 of pop
	Progress	**?**
	Gap	52 per 100,000 of pop (equivalent of 9 clients for TDHB population)

LOCAL PRIORITIES AND INDICATORS ACTION PLANS

Local Indicator 1 **Outcome we want to achieve**	**ACCESS TO SERVICES – DNA'S** **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	Complete the profile of Māori DNA FSA's and follow up appointments for CVD clinics Review patient pathways including whānau feedback to identify issues that need to be addressed Drawing on successful experiences of other DHB's, develop and implement the action plan to reduce DNA rates in the particular specialties examined Establish a review process to regularly monitor progress towards reducing DNA's and make adjustments in approach where needed Look at implementing successful interventions across other DNA specialties.	DNA rate for Outpatient appointments reduced to <9% by July 2015	
Why is this outcome important:		**Māori**	19%
Māori have double the DNA rate for first specialist outpatient appointments compared to "Other" ethnic groups in Taranaki and around three times the DNA rate for follow-up 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. Higher disease burden coupled with higher DNA rates will result in ongoing unmet health need.		**Non-Māori**	7%
		Progress	↑
		Gap (%)	12%

Local Indicator 2 **Outcome we want to achieve**	**PRIMARY MENTAL HEALTH** **What we are planning to do to achieve it**	**Who will be responsible:** Portfolio Manager, Mental Health & Addictions **How we will know if we have been successful**
Taiohi are emotionally and mentally well and are achieving their best possible educational outcomes	Increase the uptake of counselling vouchers for Māori Taiohi – through schools and PHNs	>=25% of vouchers for access to counselling are available for Māori Taiohi under the Primary Mental Health Initiative. Number of referrals from mini HEADSSS and HEADSSS assessments by PHN's and School Counsellors for Māori Taiohi. (access indicator) The number of Māori youth accessing Social Sector Trial interventions from base line of 0 in March 2014 to >=25% of total contacts for Māori Taiohi by 30 June 2015
	Improve pathways for earlier intervention of young people identified with mild to moderate mental health and addictions issues.	
	Work with the social sector trial and increase the interventions available to Youth.	

Why is this outcome important:		
At least 20% of young people experience emotional and mental health issues during the course of their adolescent years. There are a number of risk factors which impact on a young person being able to maintain good mental health including, family/whānau, cultural identity, peers and friendships, activities they are involved in, boredom and being engaged with the education system. Utilisation of primary mental health interventions can significantly reduce Young Māori are over represented in a range of statistics, including teenage birth rates being double the national average at 92.0 per 1000 population. Māori are also more likely to present to hospital for self related harm. In 2011/12 38% of admissions for taiohi were for Māori. School completion and educational attainment rates are 57% for Māori compared to 71% for non-Māori.	**Māori**	17%
	Non-Māori	49%
	Progress	**?**
	Gap (%)	32%

REFERENCES

1. Whānau Ora Health Needs Assessment, Māori Living in Taranaki, Ratima and Jenkins, Taranaki District Health Board, February 2012
2. TDHB Māori Health Plan 2013-2014
3. Te Kawau Mārō, Taranaki Māori Health Strategy 2009 – 2029
4. Ministry of Health, 2014/15 Operational Policy Framework
5. Statistics NZ, District Health Board Area summary tables, Statistics NZ 2013