Hutt Valley District Health Board

Māori Health Action Plan

2016 – 17

Whānau Ora Ki Te Awakairangi
Towards a Healthier Hutt Valley

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HE MIHI

Ti Hei Mauriora
He honore he kororia ki te Atua
He maungarongo ki te whenua
He whakaaro pai ki te tangata

E mihi ana tenei ki a Te Atiawa otira ki nga iwi o te motu e noho mai nei i roto i te rohe o Awakairangi ara Te Upoko o te Ika.

Tenei te karanga, te wero, te whakapa atu i a tatou katoa kia horapa, kia whakakotahi o tatou kaha i te whakatikatika o tatou mauiui. He aha ai, he oranga mo te tangata.

Kei i a te Poari Hauora o Awakairangi te mana tiaki putea me ki e rua nga whainga o te Poari. Ko te whainga tuatahi ko te tohaina o te putea ki nga wahi e tika ana.

Tuarua ki a waihangatia katoa nga ratonga he painga mo te iwi.
No reira e raurangatira ma kei roto i a tatou ringaringa te korero.
No reira haere whakamua, pumau ra ki te kaupapa o te Hauora.

Tena koutou katoa.

Greetings

All honour and glory to our maker.
Let there be peace and tranquility on earth.
Goodwill to mankind.

The Hutt Valley District Health Board respectfully recognises Te Atiawa and acknowledges the community of the Hutt Valley.

This is the cry, the challenge to all concerned to collectively unite our efforts in addressing and improving the health needs of the community.

The Hutt Valley District Health Board's Māori Health Plan has specific responsibilities in providing equitable funding in the continual delivery of core services. The ultimate goal of the Hutt Valley District Health Board is the wellness of the community.

Therefore the community collectively needs to grasp with both hands the initiative to be involved and committed.

So let's move forward.

Tena koutou katoa.

Health Needs Assessment

This section provides a summarised analysis of population and health condition data. Where possible the data has been aligned to the national Māori Health Plan indicators and areas identified as local priorities.

The following analysis has been sourced from the following documents: the Health Needs Assessment for Wairarapa, Hutt Valley and Capital and Coast DHB (2015) (HNA 2015)[i], the Draft 2016 / 17 Hutt Valley DHB Annual Plan[ii] and the Hutt Valley DHB Māori Health Profile (MHP 2015)[iii], and the 3DHB Equity Report (Equity Report)[iv] and the New Zealand Child and Youth Epidemiology Service Report for the Hutt Valley (NZCYES, 2014)[v]. Data for the Māori Population pyramids has been sourced from Statistics New Zealand. Where possible we have used the latest data available. Because the MOH requires a brief report, explanatory information (eg. what a PHO is and what ASH shows) has been excluded.

In 2013, approximately 3% (23,800) of the country's total Māori population lived in the Hutt Valley District Health Board area. The total population of the DHB (142,500) made up 3% of the national population. In 2015, the Māori population is estimated to be 24,200 and the total population 144,200.

Table 1: Population by age group, Hutt Valley DHB, 2013

Age group (years)	Māori			Non-Māori		Total DHB Number
	Number	Age distribution	% of DHB	Number	Age distribution	
0–14	7,960	33%	27	22,030	19%	29,990
15–24	4,250	18%	23	14,590	12%	18,840
25–44	6,190	26%	16	31,500	27%	37,690
45–64	4,420	19%	12	32,640	28%	37,060
65+	980	4%	5	17,910	15%	18,890
Total	23,800	100%	17	118,700	100%	142,500

Source: Statistics NZ Population projections for the Ministry of Health (2013 Census base) 2014 update

In 2013, Māori residents comprised 17% of the DHB population. The Māori population is relatively young, with a median age in 2013 of 24.2 years, compared with 37.7 years for the total DHB population. Māori comprised 27% of the DHB's children aged 0–14 years and 23% of those aged 15–24 years.

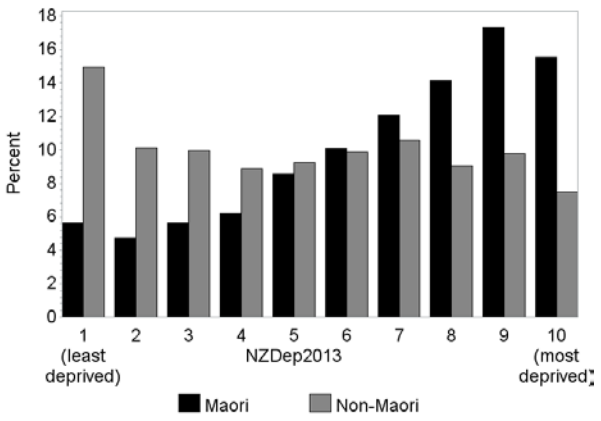
The proportion of Māori who were aged 65 years and over in 2013 was 4% but is projected to increase to 12% in 2033. Between 2013 and 2020 the number of Māori aged 65 and over will increase by 62% from 980 to 1,590. In 2013, there were 250 Māori aged 75 years and over in the Hutt Valley DHB area, with 69 living alone

Deprivation

The NZDep2013 index of deprivation reflects eight dimensions of material and social deprivation. The most deprived areas are concentrated in Lower Hutt City around areas of Taita, Naenae and Wainuiomata. Hutt Valley Māori have a more deprived small area profile than	*Fig 1: Hutt Valley population distribution across deprivation deciles, 2013 (MHP, 2015)*

Hutt Valley non-Māori.

In 2013, 59% of Māori lived in the four most deprived decile areas compared to 37% of non-Māori. Conversely, only 10% of Māori lived in the two least deprived decile areas, compared to 25% of non-Māori

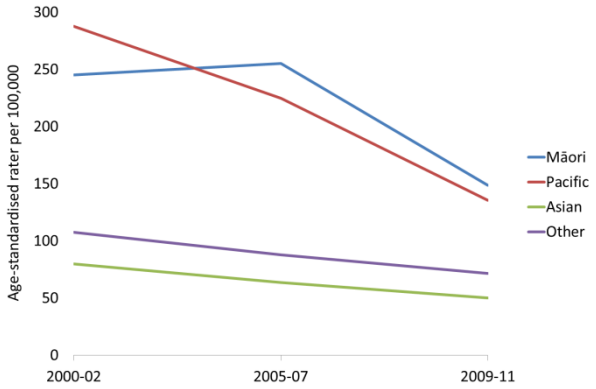


Health Status

Amenable Mortality

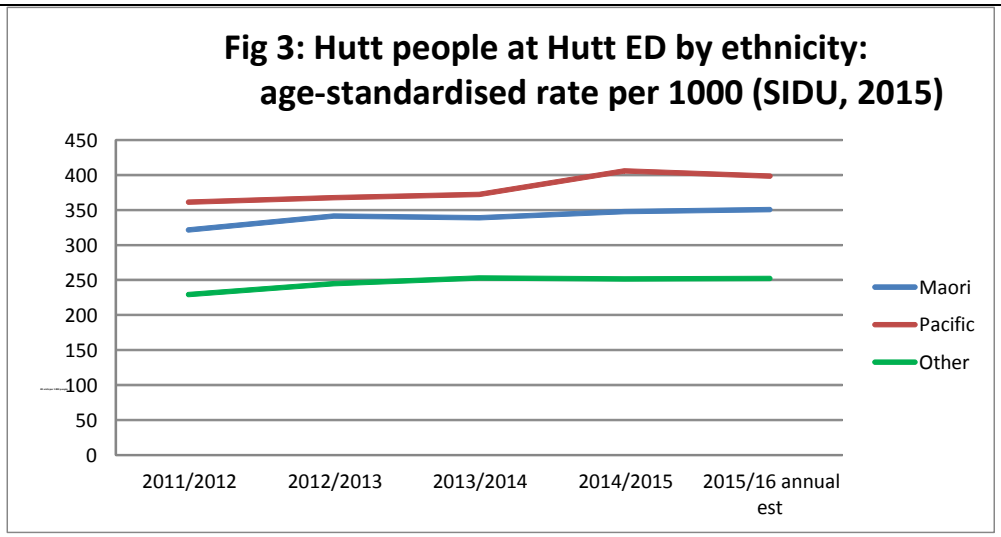
In the Hutt Valley amenable mortality for Māori has declined alongside other ethnic groups but a significant inequity remains. Māori (and Pacific people) experienced much higher amenable mortality than Asian, or people of other ethnicities (significantly higher for New Zealand).

Fig 2: Hutt Valley amenable mortality by ethnicity, 0-74 years (HNA, 2015)



ED Attendances

ED attendances were highest amongst all attendances. Māori attendances were 30% higher than Other. The graph below shows the age standardised rate of ED visits per 1000 people for Hutt residents going to Hutt ED (excluding DNW) grouped into Māori, Pacific and Other ethnic groups. Hutt Pacific people had a highest rate of visits to Hutt ED and increased in 2014/15. Hutt Māori people had the second highest rate.



National Focus:

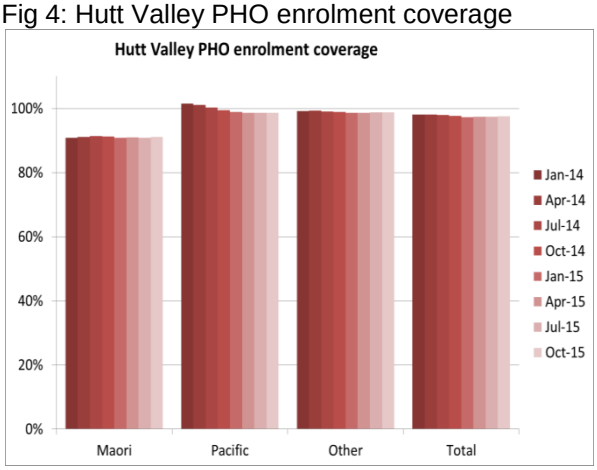
PHO Enrolment

Primary care services are delivered in the Hutt Valley through Te Awakairangi Health Network (which has 22 practices on 24 sites) and Cosine PHO (a cross-DHB PHO which has one practice in Lower Hutt and one in Wellington).

Estimates of PHO coverage shows:

98% of Hutt Valley residents were enrolled with a PHO. At 91%, Māori enrolment was lower than for Other particularly for children – 85% for under-fives and 87% for 5-14 year olds.

Fig 4: Hutt Valley PHO enrolment coverage



ASH: 0–4, 0-74 and 45–64 years.

We note that the new definition of ASH may create differences between 15/16 and previous years. ASH performance will have to take into account how the new definition affects continuity across the time series. For Hutt Valley DHB, some ASH conditions are of particular concern for Māori children and Māori adults:

Māori children (0-4 years)

1. *Upper respiratory & ENT infections*
   In the year up to September 2015, the top ASH condition for Māori children in Hutt Valley DHB was upper respiratory & ENT infections. During this period, 51 Māori children were admitted with upper respiratory & ENT infections. For the last five years, 51 Māori children are on average admitted for this condition each year. The proportion of Māori children admitted to hospital for upper respiratory & ENT infections in 2014-2015 is lower than Other children, 20% and 23% respectively. Put back in the skin infection

2. *Dental conditions*
   In the year up to September 2015, dental conditions were the second leading cause for Māori children resulting in ASH admissions. Dental conditions accounted for 17% of the total ASH admissions for Māori children in the year up to September 2015. This rate has been consistently higher than Other children; non-Māori and up to 2014 was consistently lower than Pacific children. Forty-two Māori children were admitted in 2014-2015, which is lower than the average of 50 Māori children over the last five years.

3. *Asthma*
   In the year up to September 2015, 31 Māori children were admitted as the result of asthma. These admissions comprised 12% of all Māori children's ASH admissions. Over a five year period up to September 2015, 31 Māori children were, on average, admitted each year for asthma. ASH admissions for Māori children due to asthma are almost consistently higher than Other and Pacific children. While nominally fewer Māori children were admitted for asthma in the year up to September 2015, these admissions constituted a higher proportion of ASH admissions for Māori children compared to Other and Pacific children.

4. *Skin infections*
   Among the 0-14 age group here were approximately 64 admissions per year on average for serious skin infections among Māori children. The rate was 95% higher than for non-Māori children, or 387 more admissions per 100,000 children per year.

Māori adults (45-64 years)

1. *Angina & chest pain*
   In the year up to September 2015, angina and chest pain was the leading ASH condition amongst Māori adults. During 2014-2015, 80 Māori adults were admitted for angina and chest pains, equating to 27% of total Māori adult ASH admissions. In the last five years, 69 Māori adults were, on average, admitted for angina and chest pains. In the last 5 years, ASH admissions for angina and chest pains amongst other adults have increased by 67% over the same period. However, ASH admissions for angina and chest pains amongst Māori adults increased by 42%.

2. *COPD*
   In the year up to September 2015, COPD admissions accounted for 14% of Māori adult ASH. In 2014-2015, 42 Māori adults were admitted for COPD; compared to 34 Māori adults, on average, for the last five year period. COPD

admissions for Māori adults in 2014-2015 increased by 45% from 2013-2014, and increased by 31% from 2011. Other adults COPD admissions have decreased by 6% from 2013-2014. In comparison to Other adults, Māori adults were twice as likely to be admitted due to COPD.

3. *Cellulitis*
   In the year up to September 2015, 36 Māori adults were admitted for cellulitis. This was an increase of 44% from the year ending September 2011. In the last five years, 32 Māori adults are, on average, admitted due to cellulitis each year. In 2014-2015 the proportion of Māori adults admitted due to cellulitis (12%) was equal to Other adults. This is a reduction in the proportional disparity of ASH admissions due to cellulitis between other adults and Māori adults to cellulitis in the years ending September 2012, 2013 and 2014.

Table 2 summarises Māori health status and areas of health need compared with non Māori or Other. It highlights areas for potential action under the national indicators.

Table 2: Summary of national and local priority areas

Health status, protective and risk factors	HVDHB status Māori (Ma) vs Non-Māori (NM) or Other	Comments	Data source	National and local indicators & actions
PHO enrolment	91% Ma vs 98% Other.	PHO enrolment particularly low for children – 85% for under-fives and 87% for 5-14 year olds.	Equity Report, 2015	1: Ethnicity data quality
ASH	Higher rates for Māori. Adults 2x rate of Other; Children 1.2 times rate of Other.		SIDU NSFL	2: Access to Care
Breastfeeding	Lower rates than the general population 3months Ma 36.6% vs Total 50.4%(Target 60%); 6 months Ma 49.7% vs Total 62.0 (65).		WCTO, 2014/15	3: Child Health
CVD	Higher burden of disease and complications for Māori. Ma 1.6 times NM for diseases of circulatory system; 33% higher admissions for IHD including x2 rate for Ma women vs Other women; Ma women had x2 rate of ACS than Other; Ma 4x admissions for heart failure; 75% higher admission for stroke; 5x rate admission for chronic rheumatic heart disease; COPD 3.5 times prevalence rate of Other.		MHP 2015	4: CVD + Local indicator-CVD RA followup
Cervical cancer	Lower coverage than NM. 86% screening coverage Ma vs 93% screening coverage NM.		Trendly, 2016	5. Cancer screening
Breast cancer	Lower coverage than Other - 64% Ma vs 74%NM screening coverage.			

Health status, protective and risk factors	HVDHB status Māori (Ma) vs Non-Māori (NM) or Other	Comments	Data source	National and local indicators & actions
Smoking	Between 2006 and 2013 the proportion of Māori adults who smoked cigarettes regularly decreased from 44% to 35%. However, Māori remain more than twice as likely as non-Māori to smoke regularly. This impacts on disproportionately high rates of lung cancer.		MHP, 2015	6. Smoking
Immunisation	Ma 89.3 vs NM 94.4 (95% immunised by 8 months)		Trendly, 2016	7.Immunisation
Rheumatic fever	Ma 6x rate of NM for under 15s.		MHP 2015	8. Rheumatic fever
Oral health	Number of under 5s with caries 65% higher than other; mean no DMFT 2.4 vs 1.3 NM; Year 8 students 49% (mean 1.1) Ma vs 36% NM (mean 0.7) had caries; 37% higher admissions for Ma for tooth and gum disease.		MHP, 2015	9. Oral health
Mental health	18-25 yr olds: hospitalisation for self harm 44% higher rate than NM.		MHP 2015	10. Mental Health
SUDI	Higher than for other ethnicities.		NZCYES 2014	11. Sudi
Gout	5.6% Ma prevalence vs 3.3% NM; 2.3x higher Ma hospitalisation rate vs NM.		MHP 2015	Local indicator 2
Did not attend (DNAs)	Higher than for other ethnicities.		HVDHB, 2015	Local indicator 1
Diabetes	4% Ma (lower than NM); however, 3.2 higher rate of lower limb amputation vs NM.	Crude rates not age adjusted so may be higher in some age groups	MHP 2015	Local indicator 4

NATIONAL INDICATORS

Indicator 1: Ethnicity Data Quality

Accuracy of ethnicity reporting in PHO registers

<table>
<tr><td>Outcome Sought</td><td>Greater accuracy of ethnicity data in PHO enrolment databases.</td></tr>
<tr><td>Measures</td><td>Ethnicity data accuracy will increase as measured through implementation of the General Practice self-auditing.

At the time of patient enrolment / re-enrolment, General Practice administration requires patients to confirm / re-confirm their ethnicity. Any anomalies are investigated to ensure accurate ethnicity recording.

On a regular basis, General Practices check all patient records to ensure ethnicity has been coded correctly and accurately</td></tr>
<tr><td>Notes</td><td>It is important to note that where there are commonalities of work programmes between CCDHB, HVDHB and WaiDHB; one programme of work will be developed and agreed as a combined 3DHB approach.</td></tr>
<tr><td>Current Status</td><td>In 2016/17, ethnicity data accuracy will be checked as part of the Capital National Enrolment Systems (NES) Process. Baselines will then be set.
<table>
<tr><th>Ethnicity</th><th>2016 Jan-April Trendly report (PHO register)</th><th>Target</th><th>Variance to Target</th></tr>
<tr><td>Māori</td><td>88%</td><td>100%</td><td>-12%</td></tr>
<tr><td>Other</td><td>99%</td><td>100%</td><td>-1%</td></tr>
</table>
</td></tr>
</table>

Planned Actions	Owner	Timeframe
Continue use of Ethnicity Data Protocols, EDAT tool and Statistics New Zealand Ethnicity Standard being used in general practices to improve the accuracy of ethnicity recording and ethnicity reconfirmation. This work will include increasing General Practices' understanding of the necessity to record accurate ethnicity data to identify and address the inequalities and health needs of Māori. PHOs will work closely with general practices and visit each practice within one year of NES (National Enrolment System) starting. 90% of practices will have EDAT implemented within one year of the NES implementation starting. Once the stage 1 audit checklist is complete improvements will be tied into the NES rollout based on MOH's upcoming 'NHI Best Practice' content which will accompany NES rollout.	PHOs	Q1-4 starting when NES is implemented
Monitor and report PHO Enrolment indicator performance by ethnicity including improvement in accuracy and enrolment gaps on a quarterly basis to:	DHB	Q1-4

- Hutt Valley Māori Health Services Development Group - CPHAC (Equity report) Based on Equity report, portfolio managers will work with PHOs to address how anomalies (drops/gaps) in PHO enrolments can be addressed.		

Indicator 2: Access to Care

Percentage of Māori enrolled in PHOs

(Source: Trendly, 2016)

Outcome Sought	Increased access for the Māori population to primary health care services.
Measures	100% of Māori in HVDHB will be enrolled with a PHO.
Current Status	

Ethnicity	Current Baseline	Target	Variance to Target
Māori	89%	100%	-11%
Other	100%	100%	nil

Planned Actions	Owner	Timeframe
PHO will continue to encourage people to enrol in primary care services at a wide range of community events e.g. Te Ra o te Raukura, Tumeke Taita, Christmas in da hood. This aims to increase awareness among the Māori community of the importance and advantages of enrolling, and encouragement to enrol at the time. PHOs will report on the numbers of people that they engage with at community events (e.g. those who get a Hauora WOF and/or blood pressure check) to record how many unenrolled people were encouraged to enrol at community events.	PHOs	Q2 and Q3
PHOs maintain an active list of practices outlining which ones are taking new patients on a local website.	PHO	Ongoing
Possible research in ED to ascertain from people who attend there and who are not enrolled what the barriers are to enrolment	DHB via Hutt Inc acute demand network	Q1
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC (Equity report)	DHB	Q1-4

Ambulatory sensitive hospitalisation (ASH) rates per 100,000 for the age groups of 0–4 and 45–64 years.
(Source: NSFL dataset)

<table>
<tr><td>Outcome Sought</td><td>We aim to bring down the ASH rates for the whole of the Hutt Valley and reduce disparities. While the gap is narrowing we still have a way to go in reducing inequalities. Also aiming for reduced admissions / re-admissions for respiratory conditions</td></tr>
<tr><td>Measures</td><td>Equity gap for ASH rates, 0-4 and 45-64 year olds</td></tr>
<tr><td>Current Status</td><td>
<table>
<tr><th></th><th>Ethnicity</th><th>Current Baseline Non-standardised ASH Rate</th><th>Target</th><th>Māori rate relative to National Total rate as at March 2016</th></tr>
<tr><td rowspan="4">0-4</td><td>Other</td><td>7,174</td><td rowspan="4">≤8,486</td><td></td></tr>
<tr><td>Māori</td><td>10,176</td><td>49.9%</td></tr>
<tr><td>Pacific</td><td>15,238</td><td></td></tr>
<tr><td>Total</td><td>8,908</td><td></td></tr>
</table>
<table>
<tr><th></th><th>Ethnicity</th><th>Current Baseline Standardised ASH Rate</th><th>Target</th><th>Māori rate relative to National Total rate as at March 2016</th></tr>
<tr><td rowspan="4">45-64</td><td>Other</td><td>3,256</td><td rowspan="4">≤5,041</td><td></td></tr>
<tr><td>Māori</td><td>6,525</td><td>83.3%</td></tr>
<tr><td>Pacific</td><td>7,024</td><td></td></tr>
<tr><td>Total</td><td>3,891</td><td></td></tr>
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Planned Actions	**Owner**	**Timeframe**
All ASH conditions The DHB wide quality improvement plan to meet the requirements of the System Level Indicators Project focuses on ASH and acute admissions. This will provide an overarching framework and intervention logic for tackling priority ASH conditions (discussed below) in the District. Because the planning work will occur in Q1 some of the actions below may change or may be indicative only. All actions aim to achieve the following for Māori: • Reduce acute exacerbations of LTCs by improved clinical management and self management by patients • Ensure that relevant health pathways include referrals to self management and to community providers or increased patient support • Reducing DNAs at relevant secondary outpatient clinics.	DHB PHOs	Q1
Respiratory conditions Implement recommendations from the Respiratory Patient	DHB PHOs	Q1-4

Journey Project evaluation (to be completed in June 2016) with aim of enhanced integration, better health outcomes and improving patient experience of navigating the system. Focus is on disparity reduction, particularly for Māori.		
Improving primary care access to specialist nurse and/or doctor advice as part of the Respiratory Patient Journey Project.	DHB	Q1-4
Asthma – Asthma primary care quality improvement programme includes: • tracking prescribing of preventers and relievers with aim of correct combination for all Māori asthma patients. • Focus on management of childhood asthma including inhaler prescribing and consistent management through the consistent use of asthma plans and enhanced parent education.	DHB, PHOs, Tu Kotahi	Q1-4
COPD Action in primary care to improve clinical management of COPD includes: • Risk stratification to identify patients with COPD; • Including COPD patients in LTC practice plans; • Encouraging primary care clinicians to use the relevant Health Pathways; • Educating GPs on the new LABA/LAMA inhalers. Increased self-management support for all "at risk" populations, with upskilling of whanau ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to them, for followup support for the patients and whanau. This will link to the Self Management Support Framework under the LTC Network across the 3DHBs.	DHB, PHOs	Q1-4
Skin infections Ensuring that consistent advice is given in primary care about identification of and care of skin infections. Encouraging primary care and RPH to use existing pathways and existing skin infection pack so that patients receive the same messages irrespective of where they present.	DHB, PHOs RPH	Q1-4
Increased promotion to the public of actions to prevent and get early treatment for skin infections in time for summer 2016	RPH DHB	Q2
RPH will continue to prevent, identify and treat serious skin infections in children in decile 1-6 primary schools and other vulnerable children in higher decile primary schools, via referrals to public health nurses working with primary schools. .As this is a demand driven service RPH will report on number of skin related referrals to RPH public health nurses, per annum to track patterns and schools that warrant particular intervention. This contributes to reducing 0-4, 45-64 age group ASH rates as it contributes to preventing future serious skin infections for the child and for the wider whanau (that may require hospitalisation).	RPH	ongoing
RPH will support te kohanga reo kaimahi to build healthier environments for nga mokopuna through workshops. RPH will report on the number of workshops as this is demand driven.	RPH	ongoing

Review ED attendances and admissions for cellulitis by general practice, and provide professional development for outlier practices	PHOs	ongoing
Diabetes Assess services against the 20 Diabetes quality standards Develop a service improvement plan to address gaps. This work will reference the Atlas of Healthcare Variation, the 20 quality standards and the Quality Standards for Diabetes Care Toolkit 2014. Link to DHB work to develop a diabetes working group to monitor diabetes management in primary care as part of Health Pathways for LTCs that are developed and rolled out.	DHB	Q1-2
Link to activities detailed under local priority indictor 4	All	Q1-4
Monitor and report indicator performance by ethnicity and by component of ASH (Asthma, COPD, skin infections) on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC (Equity report)	DHB	Q1-4

Indicator 3: Child Health

Breastfeeding

- **Exclusive or fully breastfed at LMC discharge (4-6 weeks)**
- **Exclusive or fully breastfed at 3 months**
- **Receiving breast milk at 6 months**

(Source: WCTO QIF Report September 2015)

<table>
<tr><td>Outcome Sought</td><td>Breast milk is considered the most complete food for babies and it gives children a healthy start in life. The lack of breastfeeding is implicated in childhood obesity, the onset of Type II Diabetes later in life, and many other negative health outcomes.

Research also shows that children who are exclusively breastfed in the early months are less likely to suffer adverse effects from common childhood illnesses like gastroenteritis, otitis media and respiratory tract infections.</td></tr>
<tr><td>Measures</td><td>75% Exclusive or fully breastfed at LMC discharge (4-6 weeks)
60% Exclusive or fully breastfed at 3 months
65% Receiving breastmilk at 6 months</td></tr>
<tr><td>Current Status</td><td>
<table>
<tr><th colspan="4">Breastfeeding: Exclusive or Fully breastfed at LMC discharge</th></tr>
<tr><td>Ethnicity</td><td>Current Baseline</td><td>Target</td><td>Variance to Target</td></tr>
<tr><td>Māori</td><td>55%</td><td>75%</td><td>20%</td></tr>
<tr><td>Pacific</td><td>68%</td><td>75%</td><td>7%</td></tr>
<tr><td>Total</td><td>62%</td><td>75%</td><td>13%</td></tr>
<tr><th colspan="4">Breastfeeding: Exclusive or Fully breastfed at 3 months</th></tr>
</table>
</td></tr>
</table>

	<table><tr><td>Ethnicity</td><td>Current Baseline</td><td>Target</td><td>Variance to Target</td></tr><tr><td>Māori</td><td>38%</td><td>60%</td><td>12%</td></tr><tr><td>Pacific</td><td>50%</td><td>60%</td><td>10%</td></tr><tr><td>Total</td><td>51%</td><td>60%</td><td>9%</td></tr><tr><td colspan="4">Breastfeeding: Exclusive, Fully or Partially breastfed at 6 months</td></tr><tr><td>Ethnicity</td><td>Current Baseline</td><td>Target</td><td>Variance to Target</td></tr><tr><td>Māori</td><td>52%</td><td>60%</td><td>8%</td></tr><tr><td>Pacific</td><td>70%</td><td>60%</td><td>10%</td></tr><tr><td>Total</td><td>64%</td><td>60%</td><td>4%</td></tr></table> Data for this indicator has been sourced from the Indicators for the Well Child/Tamariki Ora Quality Improvement Framework [1].

Planned Actions	**Owner**	**Timeframe**
HVDHB will continue to fund / support WCTO providers to deliver the Well Child schedule with a particular focus on improving Māori breastfeeding rates. Each WCTO provider is directly aligned to a PHO. They will support PHOs to implement initiatives aimed at promoting / raising the awareness of breastfeeding	DHB	Q1-4
Maintain Baby Friendly Hospital Initiative as an ongoing initiative to make breastfeeding an easy and obvious option in hospital and after discharge	DHB	1-4
DHB to redesign and develop breastfeeding coordinator role with specific focus on increasing rates at 6wk, 3 months and 6 months	DHB	
Complete a stocktake and survey of current services (Q1) to identify (Q2) and implement (Q3 on) key actions to improve Breastfeeding rates, with a focus on inequalities: • DHB to redesign and develop breastfeeding coordinator role with specific focus on increasing rates at 6wk, 3 months and 6 months	DHB	Q1-4
Health4Life programme upskilling health workers who are caring for women in pregnancy and the first year of life with messages around nutrition, physical activity, smokefree and alcohol.	PHOs	Q1 to Q4
Introduce a Marae based pregnancy and parenting programme run by Birth Ed.	DHB + providers	Q1
Support local breastfeeding networks and work with them to identify key actions to improve Maori Breastfeeding rates	DHB	Q1-4
Implement a Request for Proposal for the provision of Green Prescription (Q1-Q2). This will include the new Maternal Green Prescription (MGRx) which includes a component on improving breast feeding rates	DHB	Q1-2
Monitor (quarterly) and review (at 6 months) the efficacy of the	DHB	Q1-4

[1] http://www.health.govt.nz/publication/indicators-well-child-tamariki-ora-quality-improvement-framework-september-2015

HV community lactation consultants role to ensure targeted approaches to improve breastfeeding are effective for Maori.		
Review and strengthen breastfeeding support for Māori women in the DHB facilities to ensure seamless continuity of breastfeeding support from birthing facility into the community	DHB	Q1-4
Targeted Breastfeeding Education and Support (including Safe Sleep Messaging) for Breastfeeding Peer Counsellor Programme Administrators and Peer Counsellors.	DHB	Q1-4
Monitor and report indicator performance by ethnicity of Well Child/Tamariki Ora provider data and Plunket data (where available) on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC	DHB	Q1-4
Support local breastfeeding networks	DHB	Q1-4

Indicator 4: Cardiovascular disease

Percentage of the eligible population who have had their CVD risk assessed within the past five years

Outcome Sought	Reduced cardiovascular disease mortality and morbidity through cardiovascular risk assessment (CVDRA) and appropriate management.		
Measures	90% of the eligible Māori population will have had their cardiovascular risk assessed in the last five years.		
Current Status	More Heart and Diabetes Checks 2015/16 Q2		

Ethnicity	Current Baseline	Target	Variance to Target
Māori	84.8%	90%	-5.2%
Other	90.5%	90%	+0.5%

Planned Actions	**Owner**	**Timeframe**
Now that CVD risk assessment rates are close to the 90% target, the focus is moving to better management of the conditions identified. Long Term Conditions programme will be rolled out across primary care PHOs with better clinical management (e.g. blood pressure and lipid management) and advice re lifestyle changes (e.g. smoking cessation, reduction in alcohol misuse, nutrition and physical activity). Activity detailed below in local indicator 3.	PHOs	Q1 to Q4
Continue subsidies for CVD risk assessments for people who have not yet been reached, including Māori men aged 35-44yrs.	PHOs	Ongoing
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Hutt Valley Māori Health Services Development Group	DHB	Q1-4

- CPHAC (Equity report)		

Indicator 5: Cancer Screening

Cervical screening: percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25–69 years who have had a cervical screening event in the past 36 months.

(Source:NCSP Report – 3 years until 31 December 2013).

Outcome Sought	Lower cervical cancer morbidity and mortality among Māori women through better utilisation of the national cervical screening programme for women aged 25-69 years
Measures	Cervical screening rates for Māori women will have reached the national target of 80%.
Current Status	NCSP coverage (%) in the three years ending 31 March 2016 by ethnicity, women aged 25–69 years

Ethnicity	Current Baseline	Target	Variance to Target
Māori	63.1%	80%	-16.9% (1,305 to target)
Total	87.3%	80%	+7.3%

Planned Actions	Owner	Timeframe
Engage with primary care through the Regional Screening Coordination Group to identify women who currently don't get screened. Target promotion of screening services to these women	RSS	Q1-2
Evaluate the effectiveness of Regional Screening Services support to primary care	RSS	Q1
Ensure that Māori and Pacific women are referred to other providers e.g. Mana Wahine and Pacific Health Service for support.	RSS PHO	Q1-4
Implement a joint approach with Mana Wahine / PHOs / NGOs to increase Māori screening rates.	RSS DHB	Q1-2
Implement a Cervical Screening incentive trial programme targeting Māori.	Compass Health	Q1-2
Promote cervical screening at a minimum of four community events where priority women gather	RSS	Q1-4
Provide staff to undertake active follow up and support of colposcopy services for priority women	RSS	Q1-4
Support Primary Care through assistance with - Use the PHO Cervical Screening Data Match Report to work intensively with a minimum of 4 general practices to improve coverage in Māori women	RSS	Q1-4

- Provide staff to undertake follow up and recall of priority women	RSS	Q1-4
Support Primary Care and other relevant providers through providing - Annual colposcopy training - Two education evenings - Quarterly smear taker workshops	 RSS RSS RSS	 Q4 6 monthly Q1-4
Provide quarterly priority women breast and cervical screening days	RSS	Q1,2,3,4
All PHOs will have utilised their entire annual allocation of volumes for free cervical smears for priority women	PHOs	Q4
Improve the experience of colposcopy for Māori women: - Work with both Independent Service Providers and PHOs to actively engage and support hard to reach Māori wahine through the cervical screening pathway including colposcopy - Review written information to patients (e.g invitation letters to attend colposcopy and leaflets explaining what colposcopy is) to ensure they reflect a patient and Whānau centred approach	 RSS DHB	 Q1-4 Q2
6 monthly report of completed referrals by ethnicity, attendance, DNR, DNA, cancellations and reschedules	RSS	Q1-4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

Breast screening: 70 percent of eligible women, aged 50 to 69 will have a BSA mammogram every two years.

(Source: NSCP 2 years ending September 2015))

<table>
<tr><td>Outcome Sought</td><td>Lower breast cancer morbidity and mortality among Māori women through better utilisation of the national breast screening programme for women aged 50-69 years</td></tr>
<tr><td>Measures</td><td>Screening rates for Māori women (50-69 years) will have reached the national target of 70% by reaching the approximately 500 women in Te Awakairangi who have not been breast screened</td></tr>
<tr><td>Current Status</td><td>BSA coverage (%) in the two years ending September 2015 by ethnicity, women aged 50–69 years
<table>
<tr><td>Ethnicity</td><td>Current Baseline</td><td>Target</td><td>Variance to Target</td></tr>
<tr><td>Māori</td><td>66.5%</td><td>70%</td><td>-3.5%</td></tr>
<tr><td>Total</td><td>70.8%</td><td>70%</td><td>+0.3%</td></tr>
</table></td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
Data-matching between the BSA register and PHO registers to identify and followup with women who are unscreened or overdue	BSC PHOs	Q 1
Encourage BreastScreen Central to offer screening clinics in extended hours.	BSC DHB PHOs	Ongoing Q1 to Q4
Provide quarterly priority women breast screening days.	BSC	Q4
Reduce transaction costs by automatically notifying general practices of results for their patients, with opt-off policy	BSC	Ongoing
Increased promotion and public education by DHB Communications team, around Breast Screening month	DHB	Ongoing
Monitor and report indicator performance by ethnicity on a quarterly basis to the Hutt Valley Māori Health Services Development Group	BSC	Q1-4
Out of hours breast screening clinics will be available (e.g. Saturdays)	BSC	Q1-4 July, September, November, March and May
Promote Breastscreening at four community events where priority women gather	BSC	ongoing
One new BSC mobile site to be opened to improve access for priority women	BSC	Q4

Indicator 6: Smoking

Smoking cessation: Percentage of pregnant Māori women who are smokefree at two weeks postnatal.

Outcome Sought	The percentage of Māori women who were pregnant and were offered smoking cessation advice and support and who are smokefree at two weeks postnatal will increase over 2016/17 as a result of our efforts.		
Measures	95% of pregnant Māori women who are smokefree at two weeks postnatal.		
Current Status	Baseline to be determined from WCTO data		
Planned Actions		**Owner**	**Timeframe**
Health4Life programme upskilling health workers who are caring for women in pregnancy and the first year of life with messages around nutrition, physical activity, smokefree and alcohol.		PHOs	Q1 to Q4
Engage with Ministry of Health to identify a system for monitoring brief advice to quit smoking, acceptance of cessation support, and followup with pregnant women on smoking.		DHB	Q1
Monitor and report by ethnicity smoking cessation advice provision performance and smokefree rates at two weeks postnatal on a quarterly basis to the Hutt Valley Māori Health Services Development Group		DHB	Quarterly

Indicator 7: Immunisation

Percentage of infants fully immunised by eight months of age (ht).

(Source: Trendly Q1 2015/16)

Outcome Sought	Reduced immunisation-preventable morbidity and mortality.			
Measures	95% of infants fully immunised by eight months of age			
Current Status				

Ethnicity	**Current Baseline**	**Target**	**Variance to Target**
Māori	89.3%	95%	5.7%
Other	94.4%	95%	0.6%

Planned Actions	**Owner**	**Timeframe**
Continued collaboration across National Immunisation Register (NIR), primary care and Outreach Immunisation Service (OIS) to reach whanau and encourage immunisation on time	All	Ongoing
Sub-Regional Action Maintain an Immunisation Governance Group who are responsible for monitoring implementation and actions to deliver on the national health target on immunisation, including monitoring immunisation coverage by ethnicity.	DHB	Q1-4
Local Action Continue the 3DHB newborn triple enrolment programme	DHB PHO	Q1-4

Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date.	DHB	Q1-4
Local immunisation continue to identify areas where performance could be improved and progress opportunities to address specific areas of concern.	RPH WCTO DHB PHOs	Q1-4
Continue education opportunities provided for nurses and midwives.	NIR	Q1-4
Provide an active search for Māori tamariki and whanau in collaboration with the HVDHB Whanau Care team,Imms team, Māori Health providers and the PHO Community Health Workers to ensure tamariki are actively found, followed through and are presenting to either their GP or OIS for their required immunisations	NIR	Q1-Q4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC (Equity report)	DHB	Q1-4

Seasonal influenza immunisation rates in the eligible population (65 years and over).

(Source: Trendly, February 2016)

Outcome Sought	Reduced influenza morbidity through increased seasonal influenza vaccination rates in the eligible population (65 years and over).			
Measures	75% of the eligible population (65 years and over) completed Seasonal influenza immunisation.			
Current Status	**Ethnicity**	**Current Baseline**	**Target**	**Variance to Target**
	Māori	63%	75%	12%
	Other	65%	75%	10%
Planned Actions			**Owner**	**Timeframe**
Identify eligible patients particularly Māori; advise of influenza immunisation; and administer influenza immunisation.			PHOs	Q1-4
DHB PHO and NGO services to undertake a minimum of two promotional activities to encourage the uptake of influenza immunisation for 65+ with a particular focus on elderly Māori.			DHB, RPH PHOs NGO	Q1, Q3
Increased promotion of seasonal influenza vaccination by DHB Communications team as part of winter planning (April to June each year)			DHB	Q4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC (Equity report)			DHB	Q1-4

Indicator 8: Rheumatic fever

Number and rate of first episode rheumatic fever hospitalisations for the total population

<table>
<tr><td>Outcome Sought</td><td>In 2014 a sub-regional rheumatic fever plan was developed. The aim is to reduce the incidence of Rheumatic Fever in the region through a programme of work focussed on prevention, treatment and follow-up of rheumatic fever. The plan is part of the Government's Rheumatic Fever Prevention Programme (RFPP) which is working to improve outcomes for vulnerable children and achieve the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds to a rate of 1.6 cases per 100,000 people by June 2017.

Hutt Valley DHB, along with our sub-regional DHBs partners, are committed to achieving our DHB-specific rheumatic fever targets by delivering the actions outlined in our prevention plan. The governance of this plan will continue to be provided by the sub-regional RFPP Steering Group, who will oversee the implementation of the updated plan.

The refreshed Rheumatic Fever Prevention Plan can be accessed at http://www.ccdhb.org.nz/initiatives/FINAL%20Refreshed%20Sub-regional%20RFPP%20-%2027%20November%202015%20Updated%20Section%203.pdf</td></tr>
<tr><td>Measures</td><td>First episode rheumatic fever hospitalisation rate two-thirds below baseline (3 year average rate 2009/10-2011/12)</td></tr>
<tr><td>Current Status</td><td>Rates at baseline and target rates for rheumatic fever hospitalisations (cases/100,000 population)
<table>
<tr><th>DHB</th><th>2009/10-2011/12</th><th>2016/17</th></tr>
<tr><td></td><td>Baseline year (3 year average rate)</td><td>Target</td></tr>
<tr><td>Hutt Valley</td><td>4.9</td><td>1.6</td></tr>
</table></td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
Primary care and community pharmacies continue to provide rapid response "sore throat clinics"	PHOs /DHB	Q1, Q4
Strengthened model for effective assessment of sore throats (rapid response) across the Hutt Valley through the promotion of rapid response "sore throat clinics", with increased promotion in winter in line with the DHB's refreshed Subregional Rheumatic Fever Prevention Plan	DHB	Q1, Q4
Link all DHB level activities to the Subregional Rheumatic Fever Prevention Plan		
RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home	RPH, DHB	Ongoing

warmth and dryness. (3DHB).		
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Hutt Valley Māori Health Services Development Group - CPHAC (Equity report)	DHB PHOs	Q1-4

Indicator 9: Oral health

Percentage of pre-school children enrolled in the community oral health service (preschool enrolments, PP13a).

Outcome Sought	Improved oral health outcomes for Māori children.
Measures	Percentage of Māori pre-school children enrolled in the community oral health service
Target	98% of Māori pre-school children enrolled in the community oral health service by December 2016.
Current Status	Source: Bee Healthy Regional Dental Service April 2016)

Ethnicity	Current Baseline	Target	Variance to Target
Māori	83.7%	98%	-14.3%
Pacific	87.9%	98%	-11.1%
Other	99.4%	98%	+0.4%
HVDHB total	93.8%	98%	-4.2 %

Planned Actions	Owner	Timeframe
Analysis of coverage indicators (e.g.% seen- arrears rate) and outcome indicators (DMFT, caries-free) to meet set arrears target of 10%.	Bee Healthy	Q1-4
Early Intervention team to work with targeted high need ECE, including Kohanga Reo, to increase enrolments; deliver oral health education and support the centres with healthy food policies	Bee Healthy	Q1-4
Continue to PHO and Bee Healthy registers to identify under-fives who are not enrolled with Bee Healthy and undertake an 'opt-off' process for enrolment.	Bee Healthy, PHO	Q1-4
Participate in Health Families Lower Hutt initiatives to promote 'water only' environments and increase whanau knowledge of healthy eating and drinking.	DHB	Q1-4
Monitor and report indicator performance: - Monthly inhouse with Bee Healthy Service - Quarterly to the Hutt Valley Māori Health Services Development Group - Six monthly to CPHAC	DHB Bee Healthy	Q1-4

Indicator 10: 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.
(Source: Trendly Q4 2014/15)

<table>
<tr><td>Outcome Sought</td><td colspan="3">Appropriate rates of use of Section 29 of the Mental Health Act (community treatment order).</td></tr>
<tr><td>Measures</td><td colspan="3">No targets set for 2016/17 - reduced rate of Māori committed to compulsory treatment relative to non-Māori</td></tr>
<tr><td>Current Status</td><td colspan="3">As at March 2016
<table>
<tr><th>Ethnicity</th><th>Current Baseline[2]</th></tr>
<tr><td>Māori</td><td>249</td></tr>
<tr><td>Non-Māori</td><td>115</td></tr>
</table></td></tr>
<tr><td colspan="2">Planned Actions</td><td>Owner</td><td>Timeframe</td></tr>
<tr><td colspan="2">Analysis of Māori uptake of primary mental health services to see how many Māori are using services and whether utilisation aligns with prevalence.</td><td>DHB</td><td>Q1-4</td></tr>
<tr><td colspan="2">Jointly with the Ministry of Health, identify variance in use of Section 29 by establishing consistent data collection processes for this indicator</td><td>MoH DHB</td><td>Q1-4</td></tr>
<tr><td colspan="2">Analyse the degree of variance in use of Section 29 within the DHB by reviewing the rationale for its use</td><td>DHB</td><td>Q1-4</td></tr>
<tr><td colspan="2">Report findings of analyses to practitioners and a clinically-led multidisciplinary mental health forum.</td><td>DHB</td><td>Q1-4</td></tr>
<tr><td colspan="2">Develop guidelines and regular auditing processes to support standardised application of Section 29</td><td>DHB</td><td>Q1-4</td></tr>
<tr><td colspan="2">Monitor and report indicator performance by ethnicity on a quarterly basis to Hutt Valley Māori Health Services Development Group</td><td>DHB</td><td>Q1-4</td></tr>
</table>

Indicator 11: SUDI

Outcome Sought	Reduced SUDI mortality of Māori children.
Measures	1. Most recent five year average annualised SUDI infant deaths by DHB region of domicile, Māori and total population BASELINE 1.69 (annualised average rate 2010-2014); 5 deaths 2. Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 BASELINE 48.0%
Targets	1. 0.4 SUDI deaths per 1000 Māori live births 2. 70% of caregivers of Māori infants are provided with SUDI information at Well Child Tamariki Ora Core Contact 1.
Current Status	Whānau within the Hutt Valley DHB area have disproportionately

[2] Rate per 100,000

	experienced higher rates of SUDI since they were reported for the 2003–2007 period through to the current reporting period of 2008–2012. In 2008-2012 there were 14 SUDI deaths among Māori, and 17 deaths among the total Hutt Valley population. The rate of SUDI for 2008-2012 was 4.36 SUDI deaths per 1,000 Māori births, and 1.59 per 1,000 births in Hutt Valley. As per the MOH WCTO SUDI report 3 March 2013, the baseline percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1 in 2013 was 50% of caregivers of Māori infants and 77% of caregivers of European/Other infants. 27% of Māori infants in Hutt Valley did not receive WCTO Core Contact 1. The Hutt Valley DHB is investing in programmes to support breastfeeding, Māori antenatal education, tobacco cessation and access to maternity and well child services that support increased knowledge of safe infant care practices including safe sleep. All of these actions contribute to reducing the risk of SUDI.

Planned Actions	**Owner**	**Timeframe**
Safe sleep information discussed with women before discharge from hospital. Discussion is recorded in discharge summary.	DHB	ongoing
Continued support from DHB Sleep Safe Champion who ensures that staff are aware of and implement policy.	DHB	Ongoing
Access to pepi pods via Plunket, Kokiri and NET for mothers who wish to have one.	DHB	ongoing
Renew Baby Friendly Hospital Initiative accreditation	DHB	August 2016
Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1	DHB PHOs	ongoing
SUDI prevention information is given at six week immunisation event in primary care (linkage with Immunisation HVDHB Annual Plan 2016/17)	PHOs	ongoing
SUDI prevention information is given at community events – Te Ra etc	PHOs, community providers	ongoing
DHB Safe Sleep Champions will provide SUDI Prevention training to all new staff employed in the inpatient child health services and to the DHB core midwives in the maternity postnatal service: Targeted Breastfeeding Education and Support (including Safe Sleep Messaging) for Breastfeeding Peer Counsellor Programme Administrators and Peer Counsellors.	DHB	ongoing

The HVDHB Safe Sleep Policy will be incorporated as part of the SUDI Prevention training	DHB	ongoing
Monitor and report indicator performance: - Quarterly to the Hutt Valley Māori Health Services Development Group - Six monthly to CPHAC	DHB	Q1-4

LOCAL PRIORITIES

1. 99% Attendance at outpatient clinics

This is a local enabling activity that supports national priority areas and links to gout, diabetes and CVDRA follow-up at a local level.

Outcome Sought	Decrease in Did Not Attend (DNA) rates for Māori via increased attendance to Hospital appointments	
Planned Actions	**Owner**	**Timeframe**
Maintain a special focus on outpatient specialties that have the highest DNA rates.	DHB	Q1-4
Support all clinics to have a DNA focus on children 0-4 years	DHB	Q1-4
Monitor and report indicator performance on a quarterly basis to HVDHB Board and Hutt Valley Māori Health Services Development Group	DHB	Q1-4

2. Gout

A recent Health Quality and Safety Commission audit using the Atlas of Health[vi] found prescribing problems in medications for gout in primary care. Further, a recently published audit[vii] identified that Hutt Valley DHB secondary services are not following medication guidelines. Therefore there seem to be opportunities to influence prescribing in primary and secondary settings in addition to community based awareness raising and action to improve gout outcomes among Māori.

Outcome Sought	More consistent prescribing of gout medication; improved self management for people with gout. Reduced admissions and readmissions for gout.
Measures	Age-Standardised hospitalisation rates for Gout 25 years +
Current Status	Source: HVDHB Māori Health Profile 2015

Ethnicity	**Gender**	**Current Baseline 2011-2013**	**Target**	**Variance to Target**
Māori	Male	165.1	TBC by Hutt Inc LTC network Q1	
Māori	Female	21.8		
Other	Male	58.6		
Other	Female	6.7		

Planned Actions	Owner	Timeframe
Develop an action plan to improve management of gout, with the following elements: • Sharing specialist knowledge, prioritising activity in practices in with high Māori populations. • Develop a decision support tool to improve consistency of prescribing for gout. • Collaborative co-design of community support. This will improve health literacy and management for Māori men and postmenopausal women. • Explore links with rongoa Māori services.	PHOs, DHB, Community providers	By Q4
Monitor and report indicator performance: - Quarterly to the Hutt Valley Māori Health Services Development Group Six monthly to CPHAC	DHB	Q1-4

3. Cardiovascular disease – better management of CVD

Although CVD risk assessment is no longer a national target CVD remains a significant concern for the Māori population in the Hutt Valley, in particular the steps that occur post-assessment for better clinical and self management.

Outcome Sought	Reduction in admissions for people who have had a CVD risk assessment.
Measures	ASH
Current Status	Source (MOH: More Heart and Diabetes Checks 2015/16 Q2)

Ethnicity	Current Baseline	Target	Variance to Target
Māori	84.8%	90%	-5.2-
Other	90.5%	90%	+0.5

Planned Actions	Owner	Timeframe
Increase screening - Focus on Māori men aged 35-44 years by linking in with Health Pathways for LTCs that are developed and rolled out.	PHOs, DHBs	Q1-4
Followup from assessment: **Collaborative co-design of community pathways** to reduce admissions for CVD. This includes education, support, wraparound services and whole of whanau empowerment.	PHOs, DHBs Community providers	Q1-4
Continue professional development for general practice clinicians about regular identification and monitoring, especially blood pressure monitoring	PHOs	Ongoing
Increased self-management support for all “at risk” populations, with upskilling of whanau ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to them, for followup support for the patients and whanau. This will link to the Self Management Support	DHB PHOs Community providers	Ongoing

Framework under the LTC Network across the 3DHBs.		
Building community capacity – improving health literacy and self-management strategies for those Māori identified as high risk of CVD.		
Continued health promotion to reduce risk factors in population, including Healthy Families Lower Hutt	DHB	Ongoing
Use community events to promote and encourage uptake of CVD Risk Assessment with a particular focus on increasing the number of Māori men aged 35-44 years	PHOs	Ongoing
RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Māori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. his will reduce functional and structural overcrowding, and improve in home warmth and dryness. (3DHB).	RPH	Ongoing
RPH will continue to establish and support community based fruit and vegetable co-operatives, in areas with high Māori, Pacific and children populations and high socioeconomic deprivation.	RPH	Ongoing
Monitor and report indicator performance: - Quarterly to the Hutt Valley Māori Health Services Development Group Six monthly to CPHAC	DHB	Q1-4

4. Diabetes

Outcome Sought	Lowered diabetes prevalence. People have lower 70% of Hutt Valley Māori with Diabetes have a HbA1c of <64mmol/			
Measures	To be determined by LTC Network diabetes working group			
Current Status	Source: DHB Quarterly reporting			
	Ethnicity	**Current Baseline**	**Target**	**Variance to Target**
	Māori	65%	70%	-5
	Other	73%	70%	+3
Planned Actions			**Owner**	**Timeframe**
Better management of diabetes within the LTC programme rolled out across primary care. This links to activities under national indicator 2 (ASH).			PHO	Q1-4
Implement the LTC programme in Te Awakairangi Health Network general practices across the Hutt Valley (12 practices by Q2, 16 practices by Q4 and all by Q1 2017/18). Activities include: Diabetes and pre-diabetes identification will be undertaken as part of the Long Term Conditions programme. The DHB will assess performance against the Quality Standards			PHO	Q1-4

for Diabetes Care and recommend actions to address any gaps Diabetes working group will be established to monitor key clinical indicators across primary and secondary care and identify service improvements to improve clinical outcomes and reduce disparities. Increase and improve specialist advice across all primary health care teams. Continue to improve the integration of care for children and adults with type 1 diabetes across the Hutt Valley health system.		
Increased self-management support for all "at risk" populations, with upskilling of whanau ora navigators, community health worker and kaiawhina workforce, and connecting specific general practices to identify and followup patients and , and support them and their whanau. This will link to the Self Management Support Framework.	DHB PHOs, Community providers	TBC
Better management of diabetes, with Long Term Conditions programme rolled out across including PHOs screening for renal disease with blood pressure monitoring and increasing insulin starts where appropriate.	DHB PHOs Community providers	Ongoing
Link with Health Pathways for LTCs that are developed and rolled out.	All	
Monitor and report indicator performance: - Quarterly to the Hutt Valley Māori Health Services Development Group Six monthly to CPHAC	DHB	Q1-4

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[i] SIDU. *3 DHB Health Needs Assessment,* 2015.

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[iii] Robson B, Purdie G, Simmonds S, Waa A, Scorringe K, Rameka R. 2015*. Hutt Valley District Health Board Māori Health Profile 2015.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

[iv] SIDU. 3 DHB Equity Report, December 2015

[v] Simpson J, Oben G, Craig E, Adams J, Wicken A, Duncanson M, and Reddington A. (2014) The Determinants of Health for Children and Young People in the Hutt Valley, Capital & Coast and Wairarapa. Dunedin, NZ Child & Youth Epidemiology Service, University of Otago.

[vi] New Zealand Health Quality and Safety Commission. Gout: Atlas of Healthcare. http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/ Accessed 2 February 2016.

[vii] Kennedy, N. J., Healy, P. J. and Harrison, A. A. (2016), Inpatient management of gout in a New Zealand hospital: a retrospective audit. International Journal of Rheumatic Diseases, 19: 205–210. doi: 10.1111/1756-185X.12578) of Rheumatic Diseases, 19: 205–210. doi: 10.1111/1756-185X.12578)