Hutt Valley
District Health Board

Māori Health Action Plan

2014 – 15

Whānau Ora Ki Te Awakairangi
Towards a Healthier Hutt Valley

1. 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.

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2. Background and Context

The Hutt Valley DHB (HVDHB) recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, acknowledging the special relationship between the Crown and Tangata Whenua under the Treaty of Waitangi. The HVDHB Māori Health Plan also recognises the Ministry of Health's Māori Health Strategy (2002): He Korowai Oranga which sets the direction for the health and disability sector in relation to Māori accompanied by Whakataataka, the separate action plan.

The realisation of the Whānau Ora policy alongside the Māori Health Strategy provides the opportunity to build on the developments and gains made within the health and other government sectors to progress and improve Māori health outcomes.

'Whānau Ora is an integrated and intersectoral approach to whānau wellbeing which is aimed at reducing adverse whānau incidents and increasing positive whānau achievements'

Given the inequitable rates of morbidity and mortality between the health of Māori and non-Māori, reducing disparities continues to be a key aim across the health sector with the intention of improving health outcomes for Māori and other vulnerable population groups.

As such reducing the disparities that exist for Māori in the Hutt Valley district, through the achievement of better Māori health outcomes, needs to be the highest priority in order to achieve the vision of Whānau Ora, being vibrant healthy families.

Section 6 of the 2014/15 Operational Policy Framework requires District Health Boards to develop and submit a 2014/15 Māori Health Plan (MHP) using the template provided by the Ministry to document how the DHB will improve Māori health and reduce Māori health outcome disparities.

The Hutt Valley DHB Māori Health Plan (MHP) aligns with the 2014/2015 Hutt Valley Annual Plan priorities and intentions. The MHP provides the context and mechanism by which the DHB will monitor and measure their performance and effectiveness to improve Māori Health outcomes and to reduce inequalities and disparities between Māori and non-Māori. .

Established long-term relationships, partnerships and understandings exist across a wide range of health and social sector services and groups, including Māori providers, and Iwi Māori – Mana Whenua and Taurahere alike. Several interagency services and non-government networks are also important for the DHB. These networks provide opportunities to address the social determinants of health for Māori and others.

Population health outcome: Improving Equity

Improving equity is a key desired population health outcome. In choosing improved health equity as one of our outcome areas, the DHBs see improving the accessibility and responsiveness of services integral to the patient experience and to patients being empowered to take responsibility for their own health. If we positively impact on improving health equity we will achieve health gains for all groups in our population and ensure equity of access across the three DHBs and all population groups.

To demonstrate change in improving equity, there is a quarterly equity report that is presented to the Community and Public Health Advisory Committee (CPHAC). The set of equity indicators were selected based on the following criteria: priority area – for both the

Government and Boards; coverage across the life-course; ready availability of data; measures of both the process of health care delivery and health outcomes; and consistency with the existing Maori Health indicators set.

There are three “headline indicators”, for which aspirational targets are set to drive improvement in equity in key areas. The headline indicators of the report are preschool enrolment in dental services, cardiovascular risk assessments in primary care (health target), and the rate of did not attend (DNA) hospital outpatient appointments. The headline indicator areas represent some of the major contributors to avoidable morbidity in both children and adults. They have been chosen because there are documented disparities relating to either the indicator itself or downstream outcomes (for example, with respect to CVD inequities in cardiac surgical interventions and mortality rates). They are key measures of effective access to community-based, primary and secondary healthcare services and are amenable to intervention by DHBs and PHOs.

DHB Strategic & Māori Alliances

Hutt Valley DHB participates at both a sub-regional, regional and national level with other DHB Māori health colleagues through the Central Region Māori Managers fora and Tumu Whakarae the national body of DHB Māori managers. The national work programme identifies specific priorities for DHBs which strive to exceed the national priorities and targets for Māori. In 2013/14 several national projects informed Māori health across DHBs, such as the Consolidated National Māori Health Plan Indicator Report, Draft Central Regional DHB Whānau Ora framework, and the Māori Health Workforce Development Plan.

Sub-Regional Activity

In late 2012 Wairarapa, Hutt Valley and Capital & Coast DHBs combined their Planning and Funding functions into a single unit that is jointly directed by the two CEOs of the three DHBs but is operationally managed by Capital and Coast DHB. It is now known as the Service Integration and Development Unit (SIDU) and its role is to provide a mix of strategic leadership and change management across the region. With this change challenges and opportunities are expected. A key commitment to focus on reducing health disparities by improving health outcomes for Māori and other vulnerable population groups is an integral part of this change.

3. Hutt Valley DHB's Mâori population and their health needs

This section describes the Hutt Valley DHB region's population and population health needs comparable for Māori and non-Māori.

If Māori are to achieve the same level of health as other New Zealanders, their health status should be understood in the context of the broader determinants of health, particularly social, cultural and economic status. Strategies to improve Māori health should be effective at improving access to quality health care services for Māori. The Hutt Valley DHB Health Needs Assessment identifies a range of conditions where significant disparities exist for Māori. These include:

3.1. Demographics

Hutt Valley DHB is home to 3 percent of the national population. Geographically it is an urban DHB, covering two territorial authorities: Hutt City and Upper Hutt City. Our neighbouring DHBs are Wairarapa and Capital & Coast DHBs. All of which sit within the broader Central Region inclusive of Whanganui, MidCentral and Hawkes Bay DHBs.

Key features of our population include:

- Our population is approximately 145,835[1] in the 2014/15 year, projected to increase to around 149,115 by 2026
- Population distribution (age, gender, and ethnicity) is similar to the New Zealand population, but with a slightly higher proportion of Maori (18%) and Pacific (8%) when compared with the national averages (15% and 7% respectively).
- The population of the Hutt Valley is changing and over time there will be more people who are older and more Maori, Pacific and Asian. Between 2013 and 2026 the Asian population is expected to grow by 40%, Pacific by 18% and Maori by 13%.
- Our population is currently slightly younger than the national average; with Maori and Pacific populations being generally younger than the rest
- The proportion of people residing in urban areas (98.1%) which is higher than the national rate (86%).
- 70% of the population of the Hutt Valley reside in Lower Hutt
- There is variation in the level of deprivation across the Hutt Valley, with 25% of Lower Hutt within Quintile 5, compared with 11% within Upper Hutt.
- Maori and Pacific people are over-represented in the most deprived areas. Areas of relatively high deprivation within the Hutt Valley district include Naenae, Taita, Moera, Timberlea, and parts of Petone, Stokes Valley, Wainuiomata, Waiwhetu and central Upper Hutt.

3.2. Māori Population

Māori, at 25,955 people, make up 18% of the population in the Hutt Valley. Our Māori population is generally younger than the rest of the population, and experiences higher levels of deprivation than non-Māori.

3.3. Age Structure

The proportion of people identifying themselves as Māori in Hutt Valley DHB is more than that of New Zealand as a whole, (18% compared to 14.6%). This represents 3.7 percent of the New Zealand Māori population (2006 Census).

[1] 2013 Statistics New Zealand Population Projections

The Hutt Valley Māori population is younger than both the non-Māori and total Hutt Valley populations. The Māori population is dominated by young people (peak population 0-4 years). By comparison the non-Māori population is dominated by those of working age, with a peak population at 35-39 years.

3.4. Population Growth

Over the period 2006-2026, the Māori population will increase across all age categories. By comparison the non-Māori population is expected to decline in both the 0-14 and 15-65 age categories. Whilst the Māori population is expected to increase overall by 28.8 percent, there is an expected overall decline in the non-Māori population of 0.1 percent

4. Social Determinants of Health – Indicators

4.1. Deprivation

The Hutt Valley DHB population distribution shows no particular trend across the NZDep06 deprivation deciles. However there is a very visible difference between Māori and non-Māori.

Whilst non-Māori are represented more in deciles one and two, Māori representation increases towards the higher deprivation deciles. The pattern for Māori is very similar to that seen nationally.

4.2. Education

The population of Hutt Valley DHB has a similar proportion of university graduates (degree level and above) (13.7%), compared to the New Zealand population (14.2%). It also has a similar proportion of people with no qualifications (22.8% compared to 22.4% for New Zealand).

4.3. Income

The Hutt Valley DHB has a higher proportion of the population earning over $30,000 in personal income; 41.8 percent compared to 37.3 percent for New Zealand. This represents a higher proportion of people earning around or above the average annual personal income in New Zealand, which stood at $33,189 in 2006/07 (Statistics New Zealand, 2012).

4.4. Employment

The employment rate for the Hutt Valley DHB population is similar to that for New Zealand (94.5% compared to 94.9%). In terms of type of employment, there is a slightly lower proportion of professionals and managers in the Hutt Valley (34.3% compared to 36.0% nationally) but also a lower proportion of labourers (7.7% compared to 11.0% nationally).

5. Health Service Provision

5.1. Public health services

The Ministry of Health provides funding for subregional public health services, via HVDHB, provided by Regional Public Health (RPH).

RPH is a sub-regional public health service, serving the populations of Wairarapa, Hutt Valley, and Capital & Coast DHBs. The services include health prevention, health promotion, preventive interventions, health assessment and surveillance, and public health capacity development. Because many of the strongest influences on health and wellbeing come from outside the health sector, RPH provides services that are coordinated with other sectors such as social, housing, education, and local government sectors, as well as coordinating

with other health sector providers. The complete RPH plan is available on the RPH website, www.rph.org.nz.

5.2. Hospital Based Services

HVDHB provides a complex mix of secondary and tertiary services via its Hospital and Health Services (HHS) provider arm which is located in Lower Hutt.

Hutt Valley provides a smaller number of regional services, with the specialist plastics and rheumatology services located at its Hutt facility.[2]

5.3. Community Based Services

HVDHB has service agreements with a range of providers for the delivery of primary health services, well child services, oral health services, Māori and Pacific health services, community mental health services, community pharmacy and laboratory services, community diagnostic imaging services, aged residential care services, home based support services, palliative care services.[3]

5.4. Primary Health Organisations

HVDHB provides funding to one PHO:

- Te Awakairangi Health Network 23 practices (25 sites)
- Cosine PHO 1 practice

Note: Cosine is a cross boundary PHO managed by CCDHB including Ropata Medical Centre in Hutt Valley DHB and Karori Medical Centre in CCDHB

PHO Enrolment coverage: As at January 2014[4]
The following table details the spread of PHO practice enrolment:

	Te Awakairangi Health Network	Cosine	Total
Maori	19,946	1,162	21,108
Pacific	10,346	516	10,862
Other	86,291	17,319	103,610
Total	116,583	18,997	135,580

6. Health Status

6.1. Health Needs[5]

The groups identified below are expected to be higher users of health and disability services, and in 2014/15 the DHBs are continuing to focus on:

- Ageing population and older people: The proportion of older people in the population (including Māori) is increasing, resulting in escalating pressure on services for the elderly. This is set to continue over the next twenty years.

[2] HVDHB Annual Plan 2013/14
[3] HVDHB Annual Plan 2012/13
[4] PHO enrolment is calculated by DHB of domicile
[5] Draft 2014 / 15 HVDHB Annual Plan

- Disparities in Health Outcomes: There are noted disparities in health outcomes for certain population groups, including Māori, Pacific Peoples, people living in high deprivation areas, and people who have a disability. These groups have poorer health outcomes, and for certain conditions have a higher burden of disease. To ensure people receive services when they need them, services must be accessible and acceptable. This addresses things such as cultural competency, physical access and cost and other barriers.
- Māori health: Many health conditions are more common for Māori adults than for other adults. These include ischaemic heart disease, stroke, diabetes, medicated high blood pressure, chronic pain and arthritis.[6] Māori have poor health outcomes across most indicators although differences are reducing for some areas such as immunisations and oral health. The leading causes of death for Māori adults between the ages of 25-44 were due to external causes such as car accidents and intentional self-harm (suicide). The leading causes of death for Māori adults aged over 65 were due to circulatory system disease or cancer, with ischemic heart disease being the leading circulatory system disease. Each DHB has developed a Māori Health Plan (MHP), which sets out our intentions toward improving the health of Māori and their whānau, and reducing health inequalities for Māori.
- Lifestyle factors affecting health: Lifestyle choices such as physical activity, healthy eating and not smoking can improve the health profile of individuals and the community as a whole. Māori have a lower prevalence of adequate fruit and vegetable intake, and Māori women have the highest percentage of smokers. Residents of the sub-region have lower levels of obesity than their New Zealand counterparts, however rates of physical activity have declined between 2006/07 and 2011/12 and are lower than the national average. In the sub-region there is a higher prevalence of hazardous drinking than our New Zealand counterparts[7].
- Long term chronic conditions: The burden of long term conditions continues to increase. Diabetes prevalence is increasing, with rates for Wairarapa at 5.1%, Hutt Valley 4.6% and Capital & Coast 3.8% as compared to a national prevalence of 4.9%[8]. Heart disease continues to be the leading cause of acute hospital admissions, and with increasing rates of obesity and physical activity further growth in diabetes and heart disease is expected. Respiratory conditions such as Asthma and Chronic Obstructive Pulmonary Disorder (COPD) also place a burden on patients. Management of these conditions is a focus of the DHB's work, particularly in the community. With an ageing population, the number of patients with multiple long term conditions will increase and these patients' health needs will become more complex.
- Children and Young People: While generally improving, health statistics for children in the sub-region are below national averages in some key areas. Children are more likely than adults to live in areas of high deprivation, they have high rates of hospitalisation and there are high and increasing child abuse notifications in the Wairarapa. Typically, children living in the most deprived areas have the poorest health status.

[6] *The Health of Maori Adults and Children*, Ministry of Health, March 2013.
[7] Sub-regional data sourced from the New Zealand Public Health Survey 2011/12.
[8] *Virtual Diabetes Register,* Ministry of Health, 2011.

– In the Hutt Valley during 2005-2009, SUDI rates were significantly higher than the New Zealand rate. During this period on average 3.6 [1.68 per 1000] babies died of SUDI each year in the Hutt Valley.[9]

6.2. Health Needs Assessment [10]

The Hutt Valley DHB's health profile is gained through a comprehensive Health Needs Assessment (HNA)[11] that describes our population and their health status. A clear understanding of our population's health status and the conditions and illnesses prevalent in our district helps us focus on the right priorities to meet the needs of our population. The following information is drawn from the 2008 HNA. Key features include:

6.3. Health behaviours and risk factors

Our population's rates for health risk factors are broadly similar to the national rates, i.e. for smoking prevalence, physical activity, hazardous drinking, obesity, high cholesterol, and high blood pressure. Worse or significantly worse rates, when compared with national figures, occur for:

- Consumption of fruit and vegetables
- Breastfeeding.

6.4. Health status

When compared with national figures, our population experiences:

- Higher population rates of chronic conditions; diabetes prevalence, asthma prevalence, chronic obstructive pulmonary disease prevalence, and chronic mental health disorder prevalence
- Similar leading causes of mortality, with the addition of stroke.

6.5. Health service utilisation

When compared with national figures, our population has:

- Similar leading causes of hospitalisation, with the exception that asthma is a leading cause of hospitalisation for Māori, Pacific and Asian children aged 0 to 4 years, and diabetes is a leading cause of hospitalisation for Māori and Pacific people 65 years and over
- Significantly higher rates of avoidable hospitalisation, in particular for diabetes, cardiovascular disease – especially ischaemic heart disease, and asthma
- Significantly higher rates for prescriptions in the last 12 months
- Significantly higher rates for emergency department attendances
- Lower number of GPs per 10,000 population.

7. Māori Health

If Māori are to achieve the same level of health as other New Zealanders their health status should be understood in the context of the broader determinants of health, particularly social and economic status. Strategies to improve Māori health should be effective at improving access to quality health care services for Māori. The Hutt Valley DHB HNA identifies a range of factors where significant disparities exist for Māori. These include:

7.1. Health behaviours and risk factors:

When compared with non-Māori in the district, Māori experience:

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[9] The Determinants of Health for Children and Young People in the Hutt Valley and Capital and Coast DHBs. NZ Child and Youth Epidemiology Service. 2012

[10] MoH Maori HNA 2009/2010

[11] Ministry of Health Public Health Intelligence, September 2008 and Central Technical Advisory Services, June 2008 as published on our website www.huttvalleydhb.org.nz

- Higher prevalence of smoking
- Lower consumption of vegetables and fruit
- Lower rates of breastfeeding
- Higher rates of hazardous drinking
- Higher prevalence of obesity.

7.2. Health status

When compared with non-Māori in the region, Māori experience:

- Higher rates of death from cancer (especially lung), cardiovascular disease, stroke, and suicide
- Higher prevalence of asthma, diabetes, and depression
- Poorer oral health.

7.3. Health service utilisation

When compared with non-Māori in the region, Māori experience:

1. Higher rates of avoidable hospital admissions
2. Higher rates of hospitalisation of children for dental conditions and asthma
3. Greater unmet need for a GP.

These factors indicate that our existing activities in the following areas need to continue and increase in emphasis:

- Continuing our positive engagement with our community providers, including through the cluster of Whānau Ora providers, with a focus on education, prevention and outreach services particularly amongst Māori, Pacific and low-income people, and
- Working more closely with primary care to address: long term conditions, avoidable hospitalisation, and to reinforce education and prevention, particularly amongst people with higher needs

7.4. Avoidable Mortality[12]

There were no statistically significant differences in the rates of avoidable mortality and hospitalisation between Māori and non-Māori in the Hutt Valley DHB.

Three of the top five leading causes of avoidable mortality were the same for Māori and non-Māori. These included ischaemic heart disease, lung cancer, and diabetes.

Table 3:2: Leading causes of avoidable mortality, ethnicity, 0-74 years, 2006-08

	Hutt Valley DHB		New Zealand	
	Condition	Rank	Condition	Rank
Māori	Ischaemic heart disease	1	Ischaemic heart disease	1
	Diabetes	2	Lung cancer	2
	Lung cancer	3	Diabetes	3
	COPD	4	Motor vehicle accidents	4
	Breast cancer (female only)	5	Suicide and self-inflicted injuries	5
non-Māori	Ischaemic heart disease	1	Ischaemic heart disease	1
	Suicide and self-inflicted injuries	2	Suicide and self-inflicted injuries	2
	Lung cancer	3	Lung cancer	3
	Diabetes	4	Motor vehicle accidents	4
	Birth defects	5	Colorectal cancer	5

Note: COPD=chronic obstructive pulmonary disease

[12] Centre for Public Health Research. 2012. Health Needs Assessment Hutt Valley District Health Board For the Ministry of Health

7.5. Avoidable Hospitalisation[13]

- Four of the top five leading causes of hospitalisations for both Māori and non-Māori children 5-14 years old were the same: dental conditions, respiratory infections, ENT infections, and injuries to the elbow and forearm.
- The rate of unintentional injury hospitalisation for the Hutt Valley DHB was significantly lower than the national rate, the exception being significantly higher for Māori youth 15-24 years compared to non-Māori youth.
- For older people ethnic differences were present among older persons. Congestive heart failure, diabetes, and COPD were leading causes for older Māori while ischaemic heart disease, other forms of heart disease, and skin cancers were leading causes for older non-Māori.

Table 3:5: Leading causes of avoidable hospitalisations, ethnicity, 0-74 years, 2007-09

	Hutt Valley DHB		New Zealand	
	Condition	Rank	Condition	Rank
Māori	Respiratory infections	1	Respiratory infections	1
	Dental conditions	2	Dental conditions	2
	ENT infections	3	Asthma	3
	Asthma	4	ENT infections	4
	Gastroenteritis	5	Angina	5
non-Māori	Respiratory infections	1	Respiratory infections	1
	Gastroenteritis	2	Gastroenteritis	2
	Dental conditions	3	ENT infections	3
	ENT infections	4	Dental conditions	4
	Asthma	5	Angina	5

Note: ENT infections= ear, nose and throat infections

[13] Centre for Public Health Research. 2012. Health Needs Assessment Hutt Valley District Health Board For the Ministry of Health

8. Whānau Ora

WHĀNAU ORA FOR ALL

- A 'whole of system' approach that supports and maintains 'whole of whānau/family'.
- The recent transformation of HVDHB Whānau Care Services has positioned the organisation to support community-based Whānau Ora Provider Collectives by implementing prevention intervention logic.
- Ensuring the whānau journey through our inpatient system and discharge processes back to home are supported and appropriate packages of care, including health and social supports are in place and that referrals to the support agencies/people are made and followed up.
- The intervention logic provides opportunity for community, primary and secondary services and other NGO social and Government services to work collaboratively and in a way that support whānau determined pathways

The following actions identified within this plan will be undertaken utilising the transformed model outlined previously as a basis provides a whole of whānau approach throughout all stages of **whānau** lifetime.

Whānau Ora For All

Whānau Ora provider initiatives of *Te Runanga O Taranaki Whanui* and *Takiri Mai Te Ata (Kokiri Seaview)* continues to move forward. As expected these initiatives will impact positively on the DHB's delivery of health services for all whānau. Whānau Ora Programmes of Action (POAs) have been developed and signed off by the national Whānau Ora governance group; both POAs were provided to the DHB. Over 2013/14 they will be identifying and fine tuning their infrastructural and capacity needs to ensure they are able of deliver to their own high expectations. The DHB plays a crucial role in working with these collectives across a wide range of services and initiatives for all families.

Whānau Ora - Transformational Change

If we agree with the view, that opportunity exists within Hutt Valley DHB to bring the clinical strengths of the services together with the community cultural strengths we can provide for improved wellbeing and outcomes that **Whānau** themselves will determine.

By applying a lens through the eyes of the Whānau, it becomes a journey through the "whole of system" by the "whole of Whānau" and the potential to develop a model that benefits the "whole of community" becomes more realistic.

Better, Sooner and More Convenient Health Services in relation to Whānau Ora means supporting inter-connectedness

A health system that functions well for Whānau Ora is one that:

- Supports opportunities to improve community wide collective service delivery, and
- Requires the health sector to work in a more seamless way with other parts of the social sector and expects improved outcomes and results for New Zealand families

Hospital and Health Services Transformation

Our previous Maori inpatient model, limited our inpatient interactions to <u>after</u> admissions occured, whether they were acute or planned admissions. Our engagement with other "pieces" of the system was restricted to our own organisation, the community based health workers, agencies and NGOs and GP practices <u>after</u> the inpatient event has occurred.

By implementing an Intervention Logic utilising our patient 'trend' information effectively (i.e. data sets, booking systems, red-alert systems etc) are now able to operate from a 'strengths and evidenced' based model of care that provides an early intervention collaborative approach to support whānau through their health journey.

- Family Support delivered from a Community "Place" through the Service and back to community.
- View each organisation as "Windows" to the wider Health and Social Service Community – 'Any window is the right window"
- Reduced DNA's for elective surgery and outpatient clinics and improved community packages of care to reduce ASH rates and improve social/health wellbeing.
- Reduced repeated and unnecessary admissions and Length of stay
- Improved Whānau health literacy.

9. Delivering On Priorities & Targets

The Whanau Ora intervention logic model demonstrates that to achieve the outcome of healthy whanau we need to adapt the way we operate in the 2014/15 year.

The Hutt Valley DHB Maori Health Unit are well placed as knowledgable in whanau ora, and connected to the DHB and the multiple providers of healthcare and social services, and the community itself.

In the coming year we need to consider how we use these relationships and knowledge to advance whanau ora. This will include hearing from whanau about their needs, as well as understanding, mapping, using and promoting the use of whanau ora approaches (eg, support from a community 'place', 'any window is the right window'). With this information we will then be able to use our existing relationships with the sector to influence change towards whanau ora approaches through feeding back to providers, and engaging in collaborative planning and resourcing.

Further development of Intervention Logic Frameworks for each priority is underway. The process of development will ensure providers of health and social services as well as government agencies have input and ownership of each intervention Logic and a collaborative approach is paramount. The Rheumatic Fever Intervention Logic is appended to this plan.

The tables below describe the activities to be undertaken by HVDHB during 2014/15 aimed at reducing the disparities experienced by Māori and at improving Māori health outcome. The activities have been directly aligned with the HVDHB's 2014/15 Annual Plan.

9.1. National Priorities

PRIORITY ONE	**Data Quality**				
Indicator	**2014/15 Target**			**Action**	**Indicators of success**
1. Accuracy of ethnicity reporting in PHO registers as measured by Primary		Baseline	2014/15 Target	Support PHOs to maintain current enrolment audit processes to ensure accurate collection and reporting of ethnicity.	Ethnicity data by service area is visible and reported on quarterly Ethnicity data accuracy targets at NASC and
	M	22,045	25,955		
	Total	140,367	145,835		

PRIORITY ONE	Data Quality		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
Care Ethnicity Data Audit Toolkit.	*Note: This is the enrolment target for the Hutt Valley domiciled population, not a measure of accuracy of ethnicity reporting*	Support PHOs to use Primary Care Ethnicity Data Audit Toolkit. Support PHOs to set ethnicity data accuracy performance targets for PHO registers for 2014/15. Support hospital projects, programmes and services to improve quality of ethnicity data collection. Review ethnicity data collection protocols in selected services and ensure ethnicity reporting by provider arm service area and included in the quarterly Maori Health Indicators reporting framework. Regular reporting on the implementation of the primary care ethnicity data tool, issues identified and strategies to address these	Care coordination services Ethnicity data accuracy targets at PHO level

<table>
<tr><th>PRIORITY TWO</th><th colspan="3">Access to Care</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Percentage of Māori enrolled in PHOs[14]</td>
<td><table>
<tr><th></th><th>Baseline 12/13</th><th>Target 14/15</th><th>%</th></tr>
<tr><td>M</td><td>85%</td><td>90%</td><td>5%</td></tr>
<tr><td>Total</td><td>96%</td><td>97%</td><td>1%</td></tr>
</table></td>
<td>HVDHB will work with the MoH and PHOs to agree PHO minimum requirements specifically in relation to roles, functions and results

Work with primary care partners to implement newborn enrolment policy and monitor newborn enrolment rates.

Work with primary care partners e.g.LMCs and hospital provider arm to encourage every pregnant woman to enrol with a PHO and register with a GP.

Support the implementation of the 3DHB triple enrolment programme</td>
<td>100% of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake)

Increased PHO enrolment

▪ Increase PHO enrolment by 1% total and

▪ 5% for the Maori population with the aim to achieve equity of enrolment</td>
</tr>
<tr>
<td>2. Ambulatory Sensitive Hospitalisations rates per 100,000 for the 0-74, 0-4, and 45-64 age groups</td>
<td><table>
<tr><th>Maori</th><th>Baseline 12/13</th><th>Target 14/15</th></tr>
<tr><td>Age 0-74</td><td>204%</td><td>117%</td></tr>
<tr><td>Age 0-4</td><td>231%</td><td>143%</td></tr>
<tr><td>Age 45-64</td><td>231%</td><td>108%</td></tr>
</table></td>
<td>Across the sub-region a whole of system approach is being taken to address ambulatory sensitive hospital presentations and acute demand and enable the achievement of the Shorter stays in ED Health Target. This will support quality clinical outcomes for patients such as decreased mortality and reduced lengths of</td>
<td>Baseline Yr to June 13
<table>
<tr><td>Age 0-74</td><td>Māori</td><td>4032</td></tr>
<tr><td></td><td>Pacific</td><td>4149</td></tr>
<tr><td></td><td>Total</td><td>2437</td></tr>
<tr><td>Age 0-4</td><td>Māori</td><td>10526</td></tr>
<tr><td></td><td>Pacific</td><td>10479</td></tr>
<tr><td></td><td>Total</td><td>7216</td></tr>
<tr><td>Age 45-64</td><td>Māori</td><td>5268</td></tr>
</table></td>
</tr>
</table>

[14] PHO Enrolments targets are set using 2013 Statistics New Zealand Populations for 2014/15

PRIORITY TWO	Access to Care		
Indicator	2014/15 Target	Action	Indicators of success
		aligned with and includes the initiatives under the governance of the respective integrated Alliance leadership teams in each DHB. It includes: • Preventative and proactive care in primary and community care settings to avoid the necessity for ED presentation or acute admission eg clinical management of frail elderly in the community, diabetes care improvement plans, medication management • Alternatives settings for management of patients eg clinical pathways for the management of selected conditions in primary care eg cellulitis, DVT and gastroenteritis. • Alternative access to diagnostics eg access to radiology in the community • Discharge processes. eg ensuring community support services that respond rapidly (within 12 hours) for patients not requiring hospital admission or to enable discharge at the appropriate time **Acute demand** Improving and embedding the pathways for primary care access to specialist nurse and/or doctor advice for three high-demand services	(blank) | Pacific | 4780 (blank) | Total | 2530 Indicators of Success • Bed Days • Reduction in Length of Stay • Maintain or reduce ED Presentations • Maintain or reduce Hospital Admissions

PRIORITY TWO	Access to Care		
Indicator	2014/15 Target	Action	Indicators of success
		○ Implementation of dementia pathway ○ Implementation of advanced care planning ○ Align frail elderly pathways and implement across primary care and community services **Primary Options for Acute Care (POAC)** Establish key links with services involved in treatment of Cellulitis and DVT. Confirm radiology pathways for DVT. POAC launched with established Co-ordination role and Provider CME & training Process established for ED & MAPU to refer cases Identification of additional POAC service At least 5 sites active and managing cases. Monitoring of activities due to capacity constraints in Primary Care Further 3 sites across the Hutt Valley active and managing cases. **Child Oral Health** • Children with an LTL score of 2-6 at the	

PRIORITY TWO	Access to Care		
Indicator	2014/15 Target	Action	Indicators of success
		B4SC are referred to oral health services. ○ Oral Health will lead the WCTO QIF for QUALITY B4SC Lift-the-lip programme specifically working with WCTO and other key stakeholders. Training to be provided to WCTO and B4SC staff; prompt tool developed and piloted	≥86% of children in the sub-region with an LTL score of 2-6 are referred to oral health services by December 2014.

<table>
<tr><th>PRIORITY THREE</th><th colspan="5">Child health</th></tr>
<tr><th>Indicator</th><th colspan="3">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td rowspan="9">1. Exclusive breastfeeding</td><td colspan="3">Infants exclusively, fully breastfed at 6 weeks</td><td rowspan="9">Continue to support Well Child/Tamariki Ora providers to improve breastfeeding rates with their enrolled population
• Maintain BFHI accreditation
• Maintain breastfeeding support (hospital delivered to age 6 weeks of age)
• Monitor Maori participation in newborn enrolment to publically funded services, which will include early alert to WCTO providers to foster early connection to WCTO support and planned handover and support for breastfeeding</td><td rowspan="9">Increased utilisation of breastfeeding /specialist lactation services.
BFHI accreditation
Pathway developed to receive early referrals from LMC to WCTO providers
Exclusive breastfeeding at time of initial discharge from hospital: baseline (2012 calendar year) Maori – 80.8% , target (for 2014 calendar year) >75%
The rationale for the target is that 75% is required for the BFHI.</td></tr>
<tr><td></td><td>B Line</td><td>Target</td></tr>
<tr><td>Māori</td><td>48%</td><td>68%</td></tr>
<tr><td colspan="3">Infants exclusively, fully breastfed at 3 months</td></tr>
<tr><td></td><td>B Line</td><td>Target</td></tr>
<tr><td>Māori</td><td>41%</td><td>54%</td></tr>
<tr><td colspan="3">Infants exclusively, fully or partially breastfed at 6 months</td></tr>
<tr><td></td><td>B Line</td><td>Target</td></tr>
<tr><td>Māori</td><td>53%</td><td>59%</td></tr>
</table>

PRIORITY THREE	Child health		
Indicator	2014/15 Target	Action	Indicators of success
		• Monitor Maori participation in newborn enrolment to publically funded services, which will include the participation in pre-school Oral Health Services • Participate in the Hutt Breastfeeding Network • Establishment of a Vulnerable Pregnant Women's service Pathway sub-regionally, which will include the support to women during pregnancy to consider breastfeeding their infant • Regular review of the Vulnerable Pregnant Women's teams data on Maori risk compared to others and acceptability of support offered/ provided • Encourage NGO providers and PHOs to continue their breastfeed support/ encouragement for pregnant women/ new mothers • Maintain PHO participation in delivering on QIF Indicators (note the sub-region inclusion of 2/52 post-partum smoke-free indicator, which will build relationships with LMC and WCTO and early 'additional visit').	

PRIORITY THREE	Child health		
Indicator	2014/15 Target	Action	Indicators of success
		Note that the chosen QIF Indicators will act as an entry point for smoke-free, support of breastfeeding, SUDI prevention etc. Monitor Quarterly. • Work with Maternity Governance Groups to ensure the inclusion of breastfeeding support within the maternity sector and the continuum to primary care as an important clinical focus • Maintain WCTO and Pepi agreements who reach Maori to deliver targeted support • Review sub-regional purchase of antenatal/ parenting programmes funding allocation with a focus on improving value and better outcomes during the 2014/15 year.	

<table>
<tr><th>PRIORITY FOUR</th><th colspan="3">Cardiovascular disease</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Percentage of the eligible population who have had their CVD risk assessed within the past five years</td>
<td><table>
<tr><th></th><th>Baseline</th><th>Target 14/15</th></tr>
<tr><td>Maori</td><td>68.6%</td><td rowspan="4">90%</td></tr>
<tr><td>Pacific</td><td>73.3%</td></tr>
<tr><td>Other</td><td>86%</td></tr>
<tr><td>Total</td><td>84.5%</td></tr>
</table></td>
<td>Primary Care will:
Implement practice-specific actions to increase the number of CVDRA, including an extended funding model that enables practices to provide free checks to a targeted population
Invest in further Decision Support and Reporting Tools for both practices and other service providers within the Primary Care network. Further roll out of BPAC decision tools which will enable preparation of monthly lists of patients requiring checks, and inter-practice comparison reports
Continue promotion activities that encourage people from the target populations to seek a Heart and Diabetes Check.
To maintain performance, the PHOs will continue their current approach which includes:
Working with each individual practice on implementing a business plan
Point of care testing</td>
<td>90% of the eligible population have had their CVD risk assessed within the past five years</td>
</tr>
</table>

PRIORITY FOUR	Cardiovascular disease		
Indicator	2014/15 Target	Action	Indicators of success
		• Text to remind tool installed • Publicity and promotion activities An integrated provider approach, e.g. with pharmacies, Kokiri and Pacific Health workers, will be investigated and implemented if effective. We will: • Utilise the funding increase in 2013 to enable ongoing support for primary care to deliver on the health target and ensure its sustainability 2014/15 • Ensure the expertise, training and tools needed are available to successfully complete the CVD risk assessment and management to meet clinical guidelines • Ensure that IT systems that have patient prompts, decision support and audit tools exist, are used and fully report performance. • Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care health targets More Heart and Diabetes checks and Better help for smokers to quit.	

<table>
<tr><th>PRIORITY FOUR</th><th colspan="3">Cardiovascular disease</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td></td><td></td><td>• Support Health Promotion Agency in its work on CVD awareness and publicity campaigns</td><td></td></tr>
<tr><td>2. 70% of high-risk ACS patients accepted for coronary angiography will receive this within 3 days of admission. (‘Day of Admission’ being ‘Day 0’)</td><td><table><tr><th></th><th>Baseline</th><th>Target 14/15</th></tr><tr><td>Maori</td><td></td><td>70%</td></tr></table></td><td rowspan="2">1. Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention
2. Develop processes, protocols and systems to enable local risk stratification and transfer of appropriate high risk ACS patients
3. Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for high risk ACS patients.
4. Work in collaboration with the Central Cardiac Network to implement the Acute Chest Pain Pathway (as advice on this is developed).
o Review and modification of existing pathways
o Implementation ofnew or revised pathways and guidelines
o Staff education</td><td rowspan="2">• 70% of high-risk patients will receive an angiogram within 3 days of admission. (‘Day of Admission’ being ‘Day 0’)
• Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
• Agreement to a minimum of 96 total cardiac surgery discharges for Hutt Valley population in 2014/15 (delivered by regional service)</td></tr>
<tr><td>3. 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.</td><td><table><tr><th></th><th>Baseline</th><th>Target 14/15</th></tr><tr><td>Maori</td><td>85%</td><td>95%</td></tr></table></td></tr>
</table>

PRIORITY FOUR	Cardiovascular disease		
Indicator	2014/15 Target	Action	Indicators of success
		Protocols are already in place to enable local risk stratification and transfer of high risk ACS patients, e.g. • Protocol in place with Wellington Free Ambulance to transfer high risk ACS cases directly to Capital and Coast DHB. • Recording GRACE scores for ACS patients who are transferred to Capital and Coast DHB. • Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention: • The Trend Care work flow acuity tool will be utilised to capture better information regarding ACS patients to improve patient flow.	

PRIORITY FIVE	Cancer		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
1. Breast Screening 70% of eligible women will have a BSA mammogram every two years.	Eligible women (50-69 yrs) having breast screening in the last 24 months (blank) | 2 yrs to June 13 | Target Māori | 58.5% | 70% Pacific | 59.9% | 70% Total | 67.1% | 70% (one 70% target spans the three rows)	Continue to support BreastScreen Central to provide breast cancer screening for women aged 45 to 69 years from fixed and mobile sites throughout the Hutt Valley DHB, Wairarapa DHB and Capital & Coast DHB regions. Work with Regional Screening Services to develop and implement a monitoring and reporting framework to support accelerated change in Māori breast screening rates Continue to support current Mana Wahine providers, within HVDHB region, to provide assistance complimentary other contracted services Identify a screening 'Champion' by building a strong interface with Primary Care and other stakeholders Quarterly meetings with Primary Care and other stakeholders Regular priority screening days at BSC and Kenepuru	Increased cancer screening rates. Screening 'Champion' identified Monitoring and reporting framework developed and implemented Systematic reports received
2. Cervical Screening Percentage of women (Statistics NZ Census	Eligible women having cervical screening in the last 36 months (blank) | 3 yrs to Jun | Target	Continue to support providers, including primary and community care providers, to deliver National Cervical Screening Programme coordination services.	Increased cancer screening rates Screening 'Champion' identified

PRIORITY FIVE	Cancer		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
projection adjusted for prevalence of hysterectomies) aged 25-69 who have had a cervical screen in the past 36 months	13 Māori 64% *Pacific* *63%* *Total* *80%* 80%	Continue to support current Mana Wahine providers to provide assistance Identify a screening ‘Champion’ by building a strong interface with Primary Care and other stakeholders Quarterly meetings with Primary Care and other stakeholders to ensure ease of access to screening and increase in the number of smears. Data match with Primary Care to identify women unscreened/underscreened. Develop agreed processes with Primary Care to engage women into screening in a sensitive and appropriate manner. Monitor colposcopy DNAs and support the Colposcopy services with initiatives aimed at reducing DNAs	6 Monthly report of completed referrals by ethnicity, attendance, DNR, DNA, cancellations and reschedules. Reduced DNA to Colposcopy services

PRIORITY SIX	Smoking

<table>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>• Hospitalised smokers are provided with advice and help to quit</td>
<td>95 percent of hospitalised smokers will be provided with brief advice and support to quit by July 2015

<table>
<tr><th></th><th>Baseline 12/13</th><th>Target 14/15</th></tr>
<tr><td>Maori</td><td>97%</td><td>95%</td></tr>
</table></td>
<td>The provider arm will
• promote ABC smoking cessation and NRT competency training for all health professionals to ensure they are competent to:
- ask their patients about their smoking status
- give identified smokers brief advice to quit,
- prescribe suitable pharmacotherapy, and
- make a strong recommendation to use support in addition to medication
- refer patients to smoking cessation support services
- document smoking status and support offered to patient
• provide regular feedback to wards and departments on their individual progress toward the target.
• ensure wards have appropriate documentation for smoking status and know how to capture it.
• devolve feedback and audit processes to CNMs and nurse educators.
• ensure smokefree champions are located within each health service</td>
<td>• 95% of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking

<table>
<tr><th>2013-14 Q3</th><th>Smoking rate</th><th>% of people who smoke given advice /support</th><th>Last quarter's result</th></tr>
<tr><td>ALL</td><td>16.4%</td><td>95.89%</td><td>96.7%</td></tr>
<tr><td>Māori</td><td>35.7%</td><td>94.53%</td><td>95.9%</td></tr>
<tr><td>Pacific</td><td>18.8%</td><td>94.05%</td><td>91.3%</td></tr>
</table></td>
</tr>
</table>

PRIORITY SIX	Smoking		
Indicator	2014/15 Target	Action	Indicators of success
		SIDU will: • provide cessation referral processes through the 3DHB Health Pathways	
• Current smokers enrolled in a PHO and provided with advice and help to quit	90 percent of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit smoking. (Table) Baseline / Target 14/15: Maori: 46% / 90%	SIDU will: • Promote ABC smoking cessation training for all health professionals to ensure they are competent to: - ask their patients about their smoking status - give identified smokers brief advice to quit, - prescribe suitable pharmacotherapy, - make a strong recommendation to use support in addition to medication - refer patients to smoking cessation support services. - document smoking status and support offered to patient • Promote the identification of smokefree champions within each health service • Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen	• 90% of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking

	Baseline	Target 14/15
Maori	46%	90%

PRIORITY SIX	Smoking		
Indicator	2014/15 Target	Action	Indicators of success
		current networks and focus on the primary care health targets Better Help for Smokers to Quit and More Heart and Diabetes Checks. PHOs will continue to provide support and resources to practices to assist the achievement of the health targets	
	Progress towards 90 percent of 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	Pregnant women We will: • Work with our maternity services, general practitioners and Well Child/ Tamariki Ora providers to raise awareness of the smoking in pregnancy issue and promote ABC or EBI training. • Establish a link between maternity services and the Quitline so that midwives are able to text patient details immediately to the Quitline pregnancy service • Help to develop local networks between LMCs, maternity services, and smoking cessation providers • Provide ABC smoking cessation training, to 100% of in-house hospital midwives • Provide the Quitline "Quitting Smoking for	• 90% of pregnant women who identify as smokers at confirmation of pregnancy in general practice or booking with a Lead Maternity Carer will be offered advice and support to quit smoking **2013-14 Q3** **Overall Results** Events – 328 Smokers – 78 Number offered brief advice – 70 Number offered cessation support – 46 Number accepted cessation support – 3 Smokers' gestation at registration (weeks) – 15.6 Percentage of smokers offered brief advice – 89.7% Percentage of smokers offered cessation support – 59.0% Percentage of smokers who accepted cessation support – 3.8%

PRIORITY SIX	Smoking		
Indicator	2014/15 Target	Action	Indicators of success
		Baby" resource • Provide all midwives and general practitioners and Well Child/ Tamariki Ora providers with ABC training that is specific to pregnant women	Smoking Prevalence – 23.8% **Māori Results** Events – 91 Smokers – 59 Number offered brief advice – 56 Number offered cessation support – 34 Number accepted cessation support – 2 Smokers' gestation at registration (weeks) – 16.4 Percentage of smokers offered brief advice – 94.9% Percentage of smokers offered cessation support – 57.6% Percentage of smokers who accepted cessation support – 3.4% Smoking Prevalence – 64.8% Note: The source of this data represents around 80 percent of all pregnancies nationally.

PRIORITY SEVEN	Immunisation		
Indicator	2014/15 Target	Action	Indicators of success
1. Percentage of infants fully immunised by eight months of age	95% of eight month olds fully vaccinated (Baseline as at Mar 2014 / Target 14/15) Maori: 91% / 95%	Actions to support increasing infant immunisation rates (six weeks, three months and five months immunisation events) from 90 per cent of eight-month-olds to 95 percent by December 2014: • maintain an immunisation 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% • 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 A project to design a sub-regional system of enrolment to publically funded infant services is occurring in 2013/14. Recommendations for a sub-regional newborn enrolment system will be delivered June 2014, with implementation to follow as is feasible.	• 95% of eight month olds fully vaccinated by 31 December 2014. • 98% of newborns are enrolled with general practice by three months • 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) • Narrative report on DHB and interagency activities to promote immunisation week

Nested table in the 2014/15 Target cell:

	Baseline as at Mar 2014	Target 14/15
Maori	91%	95%

PRIORITY SEVEN	Immunisation		
Indicator	2014/15 Target	Action	Indicators of success
		Enrolment is targeted to B-enrol, NIR, WCTO, Oral health, BCG, and NBHS.	
		• In 2013/14 HVDHB and CCDHB PHOs discussed devolving NIR administration and governance to primary care and made a joint decision to review NIR administration and immunisation related services in 2014/15. • A sub-regional review will be undertaken of all immunisation related services to ensure the configuration of services continues to contribute to increasing immunisation rates.	Decision on location of NIR administration for sub -region
2. Seasonal influenza immunisation rates in the eligible population (65 years and over)	<table><tr><td></td><td>Baseline 12/13</td><td>Target 14/15</td></tr><tr><td>Maori</td><td>64%</td><td>75%</td></tr></table>	• The DHB will continue its work with primary health care providers to reduce the burden of preventable hospitalisations and increase immunisation. • Support HHS, 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 Maori	% of 65+ eligible total population receive annual flu vaccination % of 65+ Maori population receive annual flu vaccination A minimum of two promotional activities to encourage the uptake of influenza immunisation for 65+ during Q2/3

<table>
<tr><th>PRIORITY EIGHT</th><th colspan="3">Rheumatic Fever (also refer to Appendix One: 13.2)</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>• Reduce incidence of rheumatic fever

2014/2015 rheumatic fever target - number and rate reductions, 40% below 3-year average</td>
<td>Rates at baseline and target rates for rheumatic fever hospitalisations (cases/100,00 population) for HVDHB

<table>
<tr><th></th><th>Baseline</th><th>Target</th></tr>
<tr><td>DHB</td><td>2009/10-2011/12</td><td>14/15</td></tr>
<tr><td>Hutt</td><td>4.9</td><td>2.9</td></tr>
</table>

Number of acute rheumatic fever initial hospitalisations ≤ 4</td>
<td>The aim of the sub-regional rheumatic fever prevention plan 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 1.4 case per 100,000 people by June 2017.

• To prevent the transmission of Group A streptococcal throat infections in the Wairarapa, Hutt Valley and Capital and Coast DHB region. This will be achieved through:

1. The development and implementation of a pathway to identify and refer high risk children to comprehensive housing, health assessment and referrals services, in 2014/15.

2. The development of the Housing and Health Capability Building Programme and implementation</td>
<td>In 2014/15 a 40 % reduction from baseline in rates of rheumatic fever hospitalisations (cases/100,000 population) is the target.</td>
</tr>
</table>

PRIORITY EIGHT	Rheumatic Fever (also refer to Appendix One: 13.2)		
Indicator	2014/15 Target	Action	Indicators of success
		of insulation referral process for high-risk patients, in 2014/15. 3. Raising community awareness, in 2014/15 and ongoing. • Actions to treat Group A streptococcal infections quickly and effectively. This will be achieved through: 1. The provision of training and information for primary care providers, in 2014/15 and ongoing. 2. Development of an audit tool for the treatment of sore throats in primary care 3. Ongoing sore throat swabbing in schools (Porirua), this will also include review of the model in 2014/15. 4. Ongoing Rapid Response Clinics in Porirua, with ongoing review and refinement of the services as required. 5. Establishment of Rapid Response Clinics in the Hutt Valley. 6. The development and wider use of standing orders for primary	

PRIORITY EIGHT	Rheumatic Fever (also refer to Appendix One: 13.2)		
Indicator	2014/15 Target	Action	Indicators of success
		care (high risk practices). • Actions to facilitate effective follow-up of identified rheumatic fever cases. This will be achieved through: 1. The tracking of the timeliness of antibiotics through the rheumatic fever register with annual audit and stakeholder meetings. 2. Appropriate mechanisms for annual training of medical staff to be explored and implemented in 2014/15. 3. The implementation of an annual audit process to follow up on cases of rheumatic fever (root cause analysis process undertaken). This will include reporting on the lessons learned and actions taken. 4. The development and implementation of a clinical pathway from diagnosis through to the end of bicillin course.	

PRIORITY NINE	Oral Health			
Indicator	2014/15 Target		Action	Indicators of success
• Preschool Enrolments	Baseline	Target	Newborn Enrolment Project implements a single system that enables enrolment of newborns in to child oral health. Oral health services to work with Primary Care to identify initiatives that support increased enrolment	Increase in enrolments
	36%	85%		

PRIORITY TEN	Mental Health		
Indicator	2014/15 Target	Action	Indicators of success
• Mental health Act: section 29 community treatment order comparing Maori rates with other.	205 per 100,000 - Maori	Reduce the need for the use of CTO through early detection and interventions Develop a monthly report to monitor, review and identify areas of concern.	a. The impact of mental health illness and addictions on the tangata whaiora, their whanau and their community is reduced b. Monthly reports developed and monitored

PRIORITY ELEVEN	SUDI		
Indicator	2014/15 Target	Action	Indicators of success
• Rate of SUDI deaths per 1000 live births	0.5 SUDI deaths per 1000 live births (Baseline: 0.5 SUDI deaths per 1000 live births)	Implementation of SUDI 'Mokopuna Ora' Plan including; Policy Development and implementation of the: • HVDHB HHS Maternity Quality Service policy by Q2 • Generic Maternity Quality Service policy for community based health services working directly with Maori and whanau, Q1-4 Training, Education & Communications • Work with national SUDI expertise to deliver 'Safe Sleep' (Whakawhetu), 'Through the Tubes training (HHS). • Professional Development for HHS and LMC staff: – Promote the uptake of E-learning Safe Sleep training modules for clinicians, – Support/promote the attendance to National and Regional fora promoting SUDI • Utilise nationally developed resources using consistent key messages for safe sleep	Internal SUDI Policy DHB approved and implemented across all services relevant to child and maternal health Annual monitoring of all SUDI Reference and Stakeholder group services implementation of a generic SUDI policy within their service and organisation. Annual monitoring of all SUDI Reference and Stakeholder groups access to SUDI information, resources and education/training. A minimum of 2 training modules delivered by Q3

PRIORITY ELEVEN	SUDI		
Indicator	2014/15 Target	Action	Indicators of success
		• Monitor and report Child Mortality and Morbidity to health professionals against CYMRC reporting. • Raise awareness of SUDI through local events, media and national campaign days **Service Delivery** • By Q4, in association with PHOs/NGOs implement a minimum of 3 Māori Wananga targeting: – Young & 1st time mum's – Young Māori and Pacific – Vulnerable pregnant women focused on: – Māori ante-natal engagement – SUDI – Breastfeeding – Smoking cessation	6 monthly reporting of SUDI rates monitored against localised CYMRC and child health service reporting A minimum of 3 marae based MAKE (Māori Ante-natal & Kai raranga Education) Wananga

10. Regional Priorities

10.1. Regional Māori Health Plan [15]

In collaboration with Technical Advisory Services (TAS), the development of a draft Regional Māori Health Plan, Tū Ora, has been completed for the Central Region. Tū Ora aspires to guide an ongoing improvement in Māori health and Māori health outcome.

10.2. Change Enablers

To enable change, Tū Ora identifies four focus areas as key areas of action:

- Māori Workforce Development
- Quality Service Provision
- Collaborative Action
- Sharing and Measuring Information

It is envisaged that the targeted actions underlying these focus areas will support improvement and sustainability over time by optimising the planning, funding and delivery of health provision for Māori within the Central Region.

PRIORITY ONE	Māori Workforce Development	
Area	Action	Indicators of success
Increased Māori Capacity.	Continue to roll out 'Kia Ora Hauora' Māori workforce development programme.	Recruit 125 new Māori onto a health study pathway. Recruit at least 25 new Māori into 1st year tertiary study (including foundation programmes).
	Support current scholarship initiatives targeting Māori uptake of	A minimum of 20 scholarships per annum

[15] Technical Advisory Services. (2010). *Central Region Māori Health Plan: Tū Ora.*

PRIORITY ONE	Māori Workforce Development	
Area	Action	Indicators of success
	Health related study pathways.	
	Support CTAS to increase its Māori / Inequalities capacity & capability and advance regional inequalities work.	Quarterly meetings
Improved Māori Capability.	Provide regional support of the implementation of Ngā Manukura ō Āpōpō Emerging and Advanced Leaders in Māori nursing and midwifery Clinical Leadership Training.	A minimum of three places filled by Central Region Māori nurses annually
	Pilot the implementation of the Regional Capability Development Framework / Training programme.	Number of staff enrolled (Maximum 40 regionally). 90% of staff achievement. Report on Regional implementation.
	Implement a bi-annual Central Region DHB Maori health development conference: Tu Kaha.	Conference implemented

PRIORITY TWO	Collaborative Action	
Objective	Action	Indicators of success
Improved relationships	Support Māori relationship boards to implement at least one joint Central Region DHB leadership hui per annum to create an opportunity for regional engagement.	Annual joint Board hui implemented.

11. Sub-Regional Priorities

11.1. Sub-Regional Strategy Overview

The sub-regional strategy of the 3DHBs is presented in a clear way for our communities, patients, staff and partners in healthcare delivery is:

Table 1: Sub-regional Strategy

Sub-regional Vision	Strategic Areas of Focus	Through a system that	Enabled by
Healthy People, Families and Communities • preventative health and empowered self-care; • provision of relevant services close to home; • quality hospital care and complex care for those who need it	1. Acute demand management, 2. Older people's health and well-being, 3. Health promotion and prevention, 4. Long term conditions management, 5. Improved health equity.	1. Is configured to provide the right mix of services to our populations and where possible closer to their homes; 2. Is both clinically and financially sustainable; 3. Adopts unified models of best practice that serve our populations well; 4. Has developed a unified culture of working; 5. Adopts a continuous improvement approach to our service delivery.	1. An active purchasing approach to service coverage and population health 2. An organisational development approach that creates the best working and operating environment 3. A system development approach that maximises efficiencies and minimises waste 4. A quality and safety approach that improves patient outcomes and eliminates risk 5. A governance and management approach that encourages innovation and enables positive change
Underpinned by Collective Values			

PRIORITY ONE	Sub-Regional Collaboration	
Objective	Action	Indicators of success
Greater Sub-Regional collaboration	Sub-regional Māori Partnership Board discussions are concluded	Local and sub-regional MPB processes are in place and functioning.
Child Health DNA	Undertake a Health Literacy project to support a decrease of DNA rates in Child Health.	Number of Māori children DNA episodes. Number of Māori children DNA follow up events completed. Decrease in DNA rates for Māori children.

12. Local Priorities – Hutt Valley DHB

PRIORITY	Whānau Ora	
Area	Action	Indicators of success
Support the implementation of Whānau Ora	• Continue the development and implementation of a Te Awakairangi Whanau Ora - Hauora Framework that enables agreed actions and intentions of the DHB, associated health sector partners and the Whanau Ora Collectives (Te Runanganui O Taranaki Whanui led "Te Awakairangi Whanau Ora" and Kokiri Hauora & Social Services "Takiri Mai Te Ata" Programmes of Action),to contribute to the collective impact of realising the vision of "Whanau Ora for all", across all levels of the DHB, Primary care and Public/Population health programmes i.e. Governance, Strategic and Operational levels • Develop and implement effective contracting and reporting processes which enable 'Whanau Ora Outcomes' to be achieved, improving on and expanding the current Integrated Contracts in place and potential opportunities for joint funding with PHO – primary care. • Identify workforce capability and capacity needs across WO Collectives, DHB/SIDU and Primary care services and workforce to utilise Results / Outcomes Based Accountability tools and resources in conjunction with Health Quality & Safety Commission (HQSC) Triple Aim quality improvement across all health services • Build on Maori Health Services Development Group and specific Maori Health Services Management (inclusive of WO Collective Programme Managers) 6mthly forum to identify health workforce priorities across services,	1. A re-established and strengthened Maori Relationship Board at a Governance level between HVDHB, Manawhenua -Te Atiawa and Taurahere Maori and Whanau Ora Collectives 2. Continued support for the Maori Health Service development Group to provide operational level advice and guidance to planning, funding and hospital/community level services. 3. RBA and MBIE strategies and actions implemented across all service development and contracts with Whanau Ora Collective services, and others 4. Continue to support Manu Tipuranga Scholarship programmes and Hauora Maori opportunities to grow local Te Awakairangi Maori health workforce through tertiary study and training. 5. Maori Health Service Provider Management forums identify MPDS / MPCAT opportunities and options 6. Participate and support Secondary and community based services and Primary care presence at annual festival Te Ra O Te Raukura, TRY-athalon events, Kaumatua Olympics and other Maori/Iwi led activities 7. Established pathways and referral systems in place, with regular monitoring and measuring of improvements reported on.

PRIORITY	Whānau Ora	
Area	Action	Indicators of success
	planning and programme evaluation opportunities to enhance professional development and Mäori health workforce development i.e Summer Public Health Programmes, Tu Kaha Central Regional bi-annual Maori Health Workforce conference, PHA, Nursing, NZIM, Mauri Ora specific to health and other determinants of health • Continue local work between primary care and Whanau Ora collectives to expand shared health promotion initiatives, reduce the impact of long term conditions and improve child health through collaborative initiatives that identify and support whanau to determine their health pathway of Whanau Ora journey. • Continue to improve on the pathways 'referrals and information sharing' across services at Primary health care level, secondary and tertiary care services to support whanau presenting to ED, ASH, Patient Clinics etc picked up within the DNA project led by Maori Health Unit • Align and ensure the priorities and actions identified within the HVDHB Maori Health Plan are realised as a joint DHB, Primary care and Whanau Ora action plan	8. Maori Health Plan priorities and actions agreed, supported and enabled across joint DHB, Primary care and Whanau Ora/Maori Health Service sector

<table>
<tr><th>PRIORITY</th><th colspan="2">Diabetes</th></tr>
<tr><td>Area</td><td>Action</td><td>Indicators of success</td></tr>
<tr><td>Improved Diabetes</td><td>The current DCIP includes:

• Funded annual reviews for targeted groups
• More individual patient education sessions
• Continued access to podiatry, retinal screening and dietetic services
• Workforce development (including additional workforce development from 2013/14)
• Self management programmes

We plan to continue at least the current service levels in 2014/15 (including the services provided with additional funding)

It is now timely to review the DCIP with a view to providing more flexibility for practices to provide services to meet the needs of their populations. There has also been identified a need for additional community podiatry services and outreach services.

We plan to:

• Review the DCIP in Q1 and present findings to Hutt INC for a decision on any changes
• Implement agreed changes from Q2.</td><td>Number of referrals to self-management programmes</td></tr>
</table>

PRIORITY	Diabetes	
Area	Action	Indicators of success
	When the Atlas of Health Care Variation for Diabetes is published we will review the information and adjust our DCIP if required. Additionally, Primary care will develop an integrated model for Long Term Conditions management with an initial focus on diabetes. This will include the following actions: 1. Develop specific improvement plans with practices and their clinicians; 2. Assist practices to invite patients overdue for annual reviews including a text reminder system; 3. Continue promotion activities that encourage people from the target populations to seek a Heart and Diabetes Check 4. Promote self–management strategies and tools to people with diabetes; 5. Investigate a shared care approach across general practices, pharmacies and other providers 6. Implement a Primary Options coordination function to support general practice in managing patients with acute and complex needs 7. Update education programmes for general practitioners, practice nurses and other primary care staff; 8. Invest in further Decision Support and Reporting Tools for both practices and other service providers within the	

PRIORITY	Diabetes	
Area	Action	Indicators of success
	Primary Care network. 9. An integrated provider approach e.g. with Pharmacies, Kokiri, and Pacific Health workers will be investigated and implemented if effective.	

PRIORITY	Prime Minister's Youth Mental Health Project	
Area	Action	Indicators of success
Youth Health Primary Care Workforce Development Plan	Develop a Youth Health Primary Care Workforce Development Plan, to build primary health workforce capacity and capability in responding to youth health issues. Focusing on: • Improving youth mental health and AOD identification and intervention • Work with PHOs and practices to make practices more youth-friendly • Consideration of youth focused positions within general practice • Combining training resources across the sub-region and train a wider range of health professionals on youth health issues. • Integrating training to ensure those working in NGOs, general practice, DHB provider arms and youth	• Youth Health Primary Care Workforce Development Plan by December 2014 • Quantify some development eg primary mental health workforce by 30 June 2015 • Clinical Pathways for three youth health services • Improved the follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction • Improved follow-up care for those discharged from CAMHS and Youth AOD services. • Mental Health providers from primary and secondary services attending Strengthening Families, Youth Offending Team, and High and Complex Needs meetings, participating in Gateway Assessments and the

PRIORITY	Prime Minister's Youth Mental Health Project	
Area	Action	Indicators of success
	speciality services have the opportunity to learn from each other. • Building the youth health workforce and the number of trained youth specialist health professionals • Developing strategies to retain competent staff • Developing career pathways in youth health • Developing a workforce that is able to meet the needs of Maori and Pacific young people • Improving access to training and post graduate study within the sub-region	functions of the Children's Action Plan. • Improved services for Maori and Pacific populations who choose to use mainstream services.
	Support the Alliance Leadership Team – Hutt INC Support the Alliance Leadership Team Hutt INC to implement its work programme with the objective to improve the responsiveness of primary care to youth. Hutt INC is establishing a mental health workstream, with the first initiative being a discharge planning project which will cover adult and youth service users. The Mental Health Discharge Planning (Adult and Youth) Project aims to smooth transitions and improve outcomes for adult and youth service users discharged from secondary mental health services to primary care through clearer information, increased collaboration and integration across the mental health sector, and to increase confidence for all involved. Support youth health pathway development and	

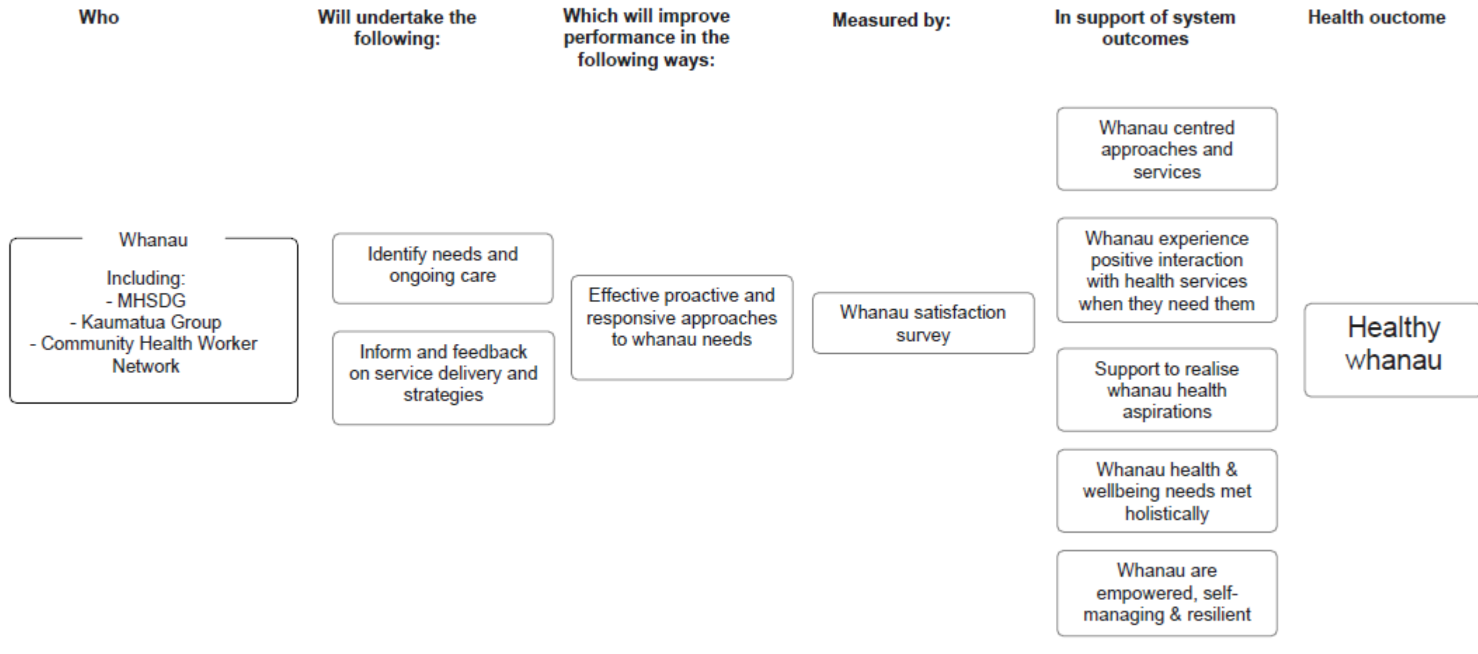
PRIORITY	Prime Minister’s Youth Mental Health Project	
Area	Action	Indicators of success
	implementation; tailor for Hutt Locality (TeAHN and VIBE); identify issues that will be needed to provide follow up to issues Facilitate training and upskilling of general practice staff (GPs, practice nurses, community health workers) in youth health responsiveness, tools, referrals to and from other services (VIBE, School health, specialists services) Access to primary care to specialists youth health advice, included adolescent physician and adolescent psychiatrist Increase enrolment of young people with general practice and monitor uptake Support further youth mental health service delivery as new funding becomes available, ensure services are responsive to Māori and Pacific young people	

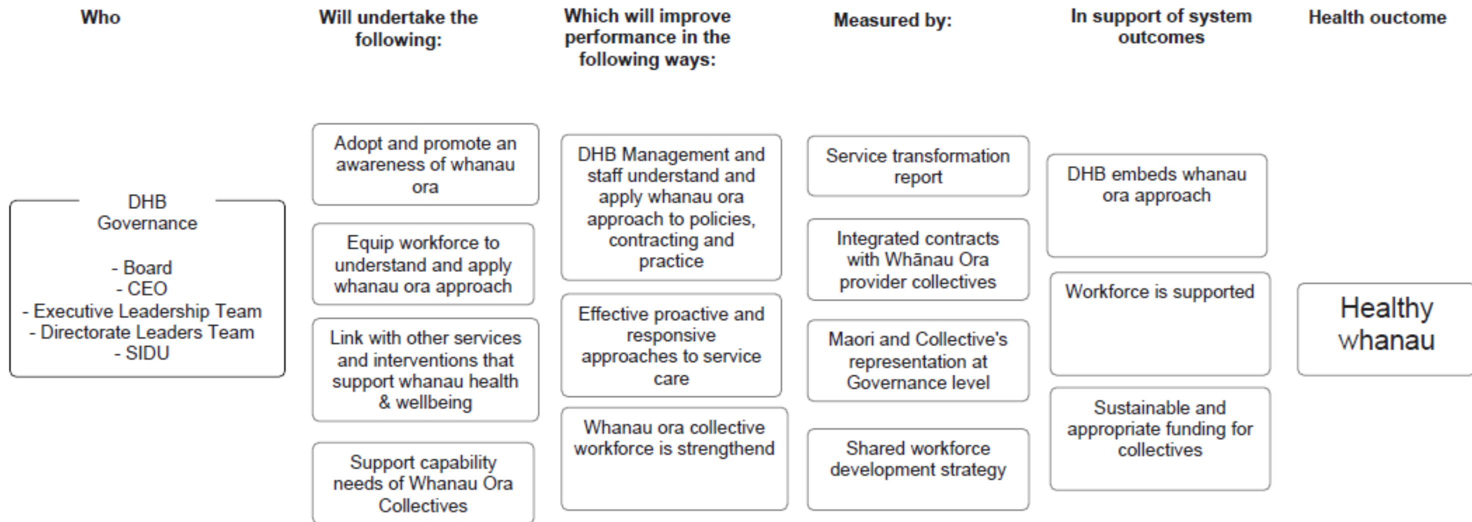
PRIORITY	People with Disabilities	
Area	Action	Indicators of success
Improved access to services by vulnerable population groups Improved health and well-being outcomes within vulnerable population groups	Sub-regional Disability Advisory Group with support from Maori and Pacific representatives integrates needs of Maori and Pacific people with disability into existing plans Identify research findings to analyse gaps in access to disability support services for Maori and Pacific people led by Maori and Pacific disabled people Disability icon data increases and dashboard of indicators is developed	Maori Partnership Board and Sub Regional Pacific Health Group endorse representatives on Sub-regional Disability Advisory Group

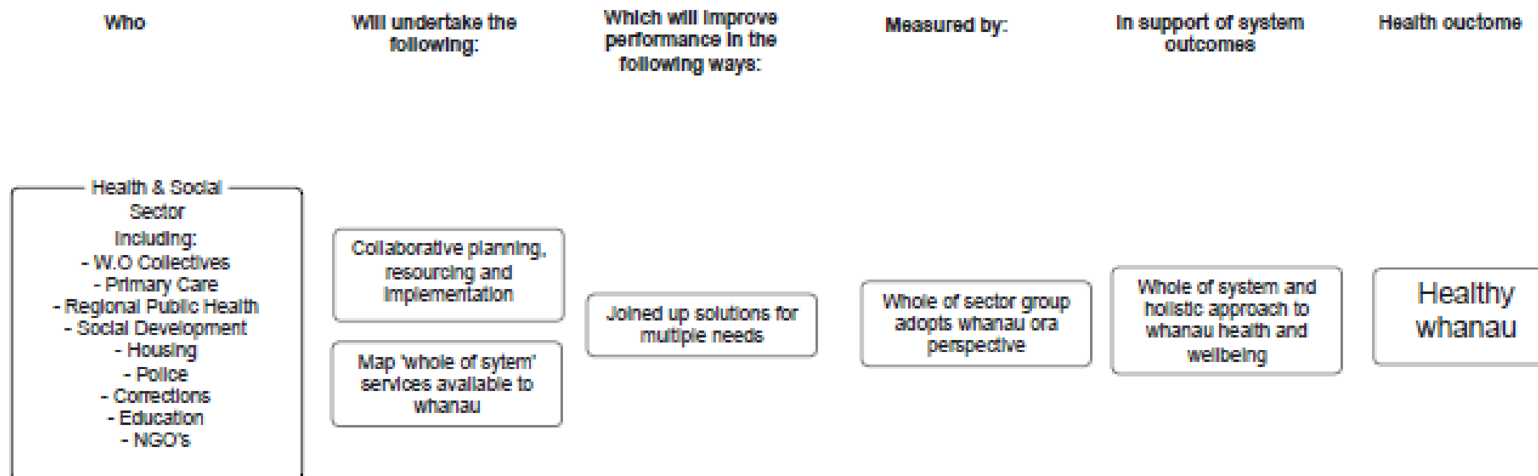
13. Appendices

13.1. Hutt Valley DHB Whânau Ora Intervention Logic

Whanau Ora - Hau Ora o Te Awakairangi
Whanau

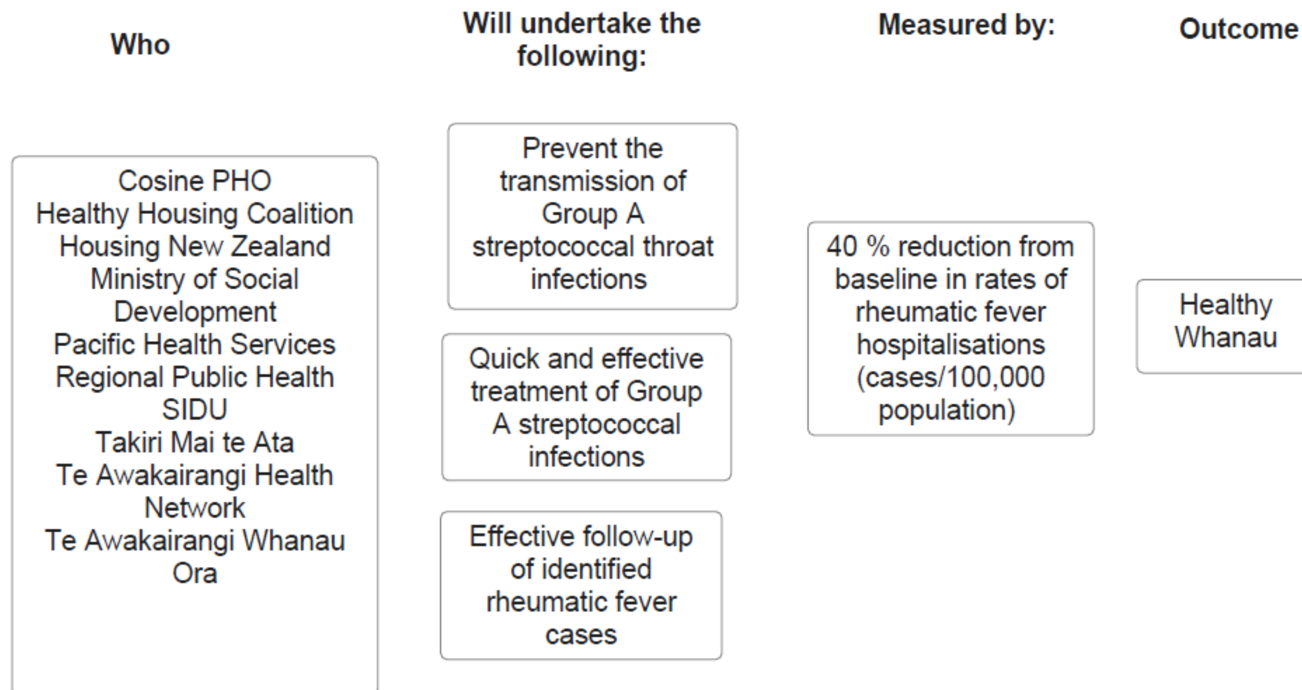



Whanau Ora - Hau Ora o Te Awakairangi
DHB
Who
Will undertake the following:
Which will improve performance in the following ways:
Measured by:
In support of system outcomes
Health ouctome
DHB
Governance
- Board
- CEO
- Executive Leadership Team
- Directorate Leaders Team
- SIDU
Adopt and promote an awareness of whanau ora
Equip workforce to understand and apply whanau ora approach
Link with other services and interventions that support whanau health & wellbeing
Support capability needs of Whanau Ora Collectives
DHB Management and staff understand and apply whanau ora approach to policies, contracting and practice
Effective proactive and responsive approaches to service care
Whanau ora collective workforce is strengthend
Service transformation report
Integrated contracts with Whānau Ora provider collectives
Maori and Collective's representation at Governance level
Shared workforce development strategy
DHB embeds whanau ora approach
Workforce is supported
Sustainable and appropriate funding for collectives
Healthy whanau



Whanau Ora - Hau Ora o Te Awakairangi
Health and Social Sector
Who
Will undertake the following:
Which will improve performance in the following ways:
Measured by:
In support of system outcomes
Health ouctome
Health & Social Sector
Including:
- W.O Collectives
- Primary Care
- Regional Public Health
- Social Development
- Housing
- Police
- Corrections
- Education
- NGO's
Collaborative planning, resourcing and implementation
Map 'whole of sytem' services available to whanau
Joined up solutions for multiple needs
Whole of sector group adopts whanau ora perspective
Whole of system and holistic approach to whanau health and wellbeing
Healthy whanau

13.2. Hutt Valley DHB Rheumatic Fever Intervention Logic

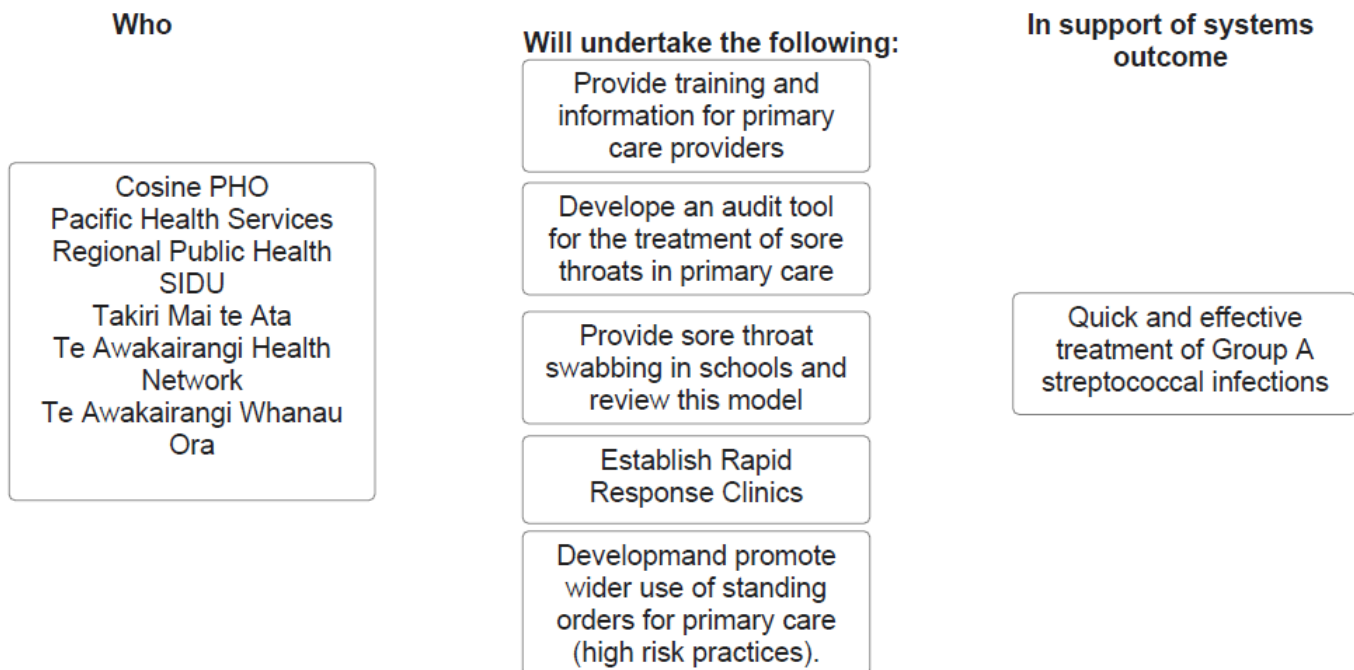


HVDHB Maori Health Action Plan - Rheumatic Fever

TRANSMISSION PREVENTION

Who	Will undertake the following:	In support of systems outcome
Cosine PHO Healthy Housing Coalition Housing New Zealand Ministry of Social Development Pacific Health Services Regional Public Health SIDU Takiri Mai te Ata Te Awakairangi Health Network Te Awakairangi Whanau Ora	Develop and implement a pathway to identify and refer high risk children to comprehensive housing, health assessment and referrals services. Develop a Housing and Health Capability Building Programme and implement an insulation referral process for high-risk patients. Raise community awareness	Prevent the transmission of Group A streptococcal throat infections

doview.com model


HVDHB Maori Health Action Plan - Rheumatic Fever
QUICK & EFFECTIVE TREATMENT
Who
Will undertake the following:
In support of systems outcome
Provide training and information for primary care providers
Cosine PHO
Pacific Health Services
Regional Public Health
SIDU
Takiri Mai te Ata
Te Awakairangi Health Network
Te Awakairangi Whanau Ora
Develope an audit tool for the treatment of sore throats in primary care
Provide sore throat swabbing in schools and review this model
Quick and effective treatment of Group A streptococcal infections
Establish Rapid Response Clinics
Developmand promote wider use of standing orders for primary care (high risk practices).
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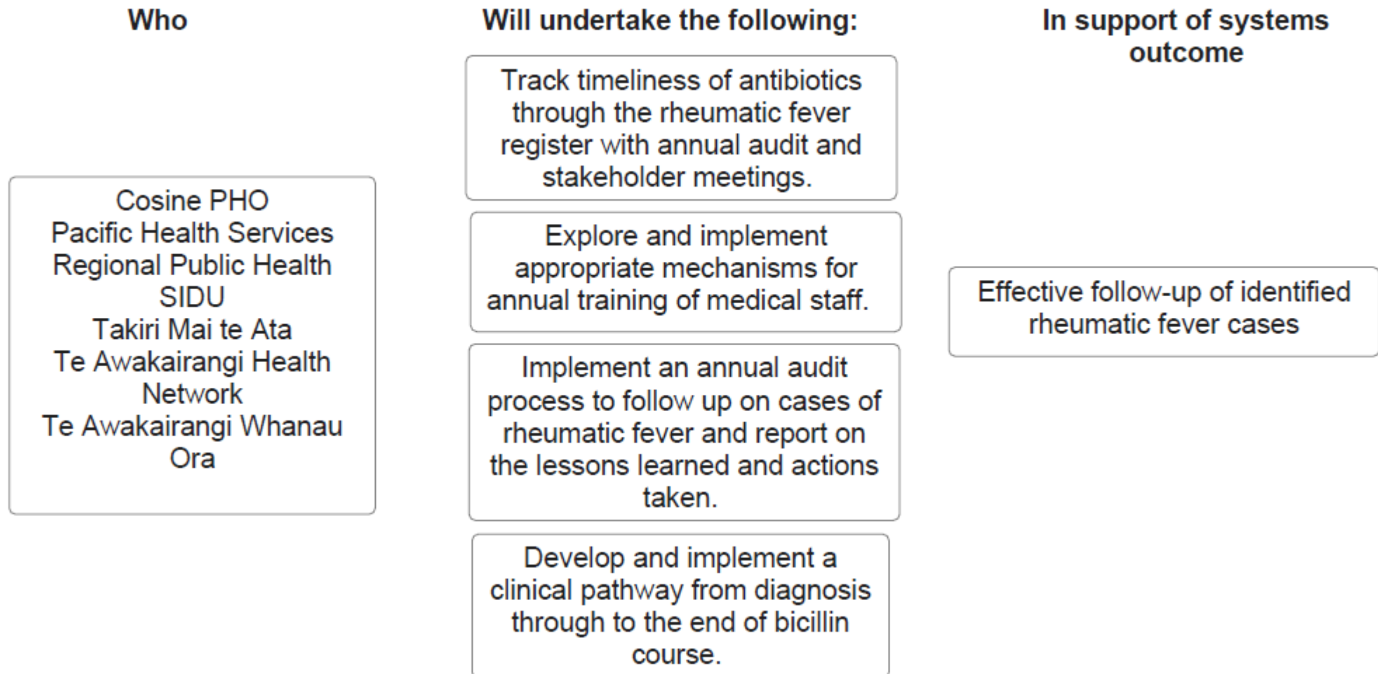
HVDHB Maori Health Action Plan - Rheumatic Fever
EFFECTIVE FOLLOW UP
Who
Will undertake the following:
In support of systems outcome
Track timeliness of antibiotics through the rheumatic fever register with annual audit and stakeholder meetings.
Cosine PHO
Pacific Health Services
Regional Public Health
SIDU
Takiri Mai te Ata
Te Awakairangi Health Network
Te Awakairangi Whanau Ora
Explore and implement appropriate mechanisms for annual training of medical staff.
Effective follow-up of identified rheumatic fever cases
Implement an annual audit process to follow up on cases of rheumatic fever and report on the lessons learned and actions taken.
Develop and implement a clinical pathway from diagnosis through to the end of bicillin course.
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