Wairarapa DHB Māori Health Plan 2016 / 17

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INTRODUCTION

The Wairarapa District Health Board is committed to improving Māori health outcomes alongside our iwi partners Rangitāne o Wairarapa and Kahungunu ki Wairarapa. Te Oranga o Te Iwi Kainga (Iwi Kainga) is the Māori Relationship Board appointed by both iwi that engages directly with the DHB Board to ensure that our health initiatives are having the best gain for Māori across the Wairarapa health spectrum.

Wairarapa Māori feature amongst the worst statistically for health outcomes in Aotearoa. This is captured in the Health Needs Assessment for Wairarapa Māori and Te Ara Whakawaiora, which is a tool that tracks the key health indicators for Māori across all 20 DHB's.

Iwi Kainga has also identified priority areas, again based on the available data but also from what they see in and know about their communities and providers. Iwi have also said that we should focus not just on the diseases but also on the determinants/conditions that lead to the prevalence of disease and inequities e.g. poor housing, lack of employment/suitable income, underachievement in education, and cultural deficiency across the health workforce.

The purpose of this Māori Health Plan is to identify the priority areas for the DHB, Primary Health and NGO's to focus their efforts to reduce Māori Health inequities. The plan sits alongside the WDHB District Annual Plan with a clear focus on Māori Health actions

This plan is required by the Ministry of Health through the Operational Policy Framework and provides a framework for measuring a range of initiatives aimed at reducing inequalities and improving Māori health gain.

Structure of this plan

The 16/17 Māori Health Plan will have a slightly different structure than previous editions. As always we begin with the **Health Needs Assessment**. The 2013 census data is still our relevant data set. The remainder of the assessment is taking directly from the Wairarapa District Health Board – Māori Health Profile 2015 report.

The next two sections are the **National Indicators** which are required by the Ministry of Health followed by '**Other Key Indicators**' which are in addition to the national requirements.

The final section is labelled **Local Priorities** which traditionally identify what we want to do here in the Wairarapa over and above the national indicator actions. This year we will follow the approach led by Iwi Kainga to focus on addressing the contributing factors to inequities in Māori health. So this section will mirror those priorities and where appropriate, identify actions that meet some of these goals.

Iwi Kainga Priorities

In January 2016 - Iwi Kainga (the Māori Relationship Board to the Wairarapa District Health Board) developed their strategic priorities for Māori Health. This is reflective of how iwi see their communities and the issues that they are dealing with but also recognises the health data for our community. Iwi Kainga has challenged WDHB to address the contributing factors to inequity alongside achieving better health outcomes for Māori.

Iwi Kainga understands that many of these priorities are captured within this Māori Health Plan and the District Annual Plan and they will advocate for those initiatives where appropriate.

However, there may be areas and initiatives that sit outside the plan where iwi may demand further attention.

The Vision for Iwi Kainga is ***Wairarapa Mauri Ora – Vibrant, strong and confident whānau.***

Population priorities

The three key population groups identified by Iwi Kainga were tamariki (children), rangatahi (youth) and tane (men). Wherever an initiative appears in the Māori Health Plan or the District Annual Plan that relates to any of these groups, iwi will take a strong interest and advocate for better health outcomes.

Clearly, tamariki and rangatahi health is critical to iwi as Māori have proportionately greater population growth than non-Māori. The health of Tane has been highlighted because iwi are not seeing as many initiatives to improve health outcomes for our Māori men; therefore Iwi Kainga want to see this emerge as a priority for the District Health Board.

Priority disease focus

Iwi Kainga identified four priority diseases. These are:

- Mental Health and AOD,
- Smoking,
- Obesity; and
- Oral Health

These four areas are captured within the National Indicators for the Māori Health Plan and the Local Priorities and also in the District Annual Plan.

Iwi Kainga has expressed concern with the increasing numbers of whānau presenting with mental illness and addiction issues. Alcohol and drug issues remain prevalent in our communities and the impact on whānau remains a real issue.

Smoking rates amongst our Māori whānau remain high. Recent data suggests that smoking for Māori aged 15-24 in Masterton (particularly the East Side) and Featherston are amongst the highest in the country.

Obesity is seen as an increasing issue amongst our whānau especially in our tamariki. This issue has also been signalled by the Ministry in the New Zealand Health Strategy review 2015.

Finally, oral health is an important issue for iwi/Māori. The DHB has several strategies working with tamariki but Māori oral health issues span across all ages.

Access

Iwi Kainga have determined that access issues that need addressing include:

- Health Literacy / Cultural Competency / Self Determination,
- Whānau care outside of our region; and
- Sooner, Better, More convenient services including opening hours of service.

Quality

The quality of services have direct impact on outcomes for whānau: Iwi Kainga has determined that quality includes:

- Workforce Development including mentoring, study time, active recruiting, cultural competent workforce; and
- Māori Provider development including equitable funding.

Social Determinants

WHO defines the social determinants of health are *"the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."* The unequal distribution of the social determinants of health is an important driver of health inequities. Iwi Kainga seeks to address these determinants particularly:

- Affordable, dry and secure housing,
- Air and water quality; and
- Regional employment.

Prevention

Preventing the onset of the disease needs greater focus with more concerted effort that has direct impact on whānau Māori. The prevention of diseases such as lung cancer, diabetes and oral disease can be addressed by;

- Reducing the uptake of smoking,
- Increasing physical activity and supporting healthy eating; and
- Good oral health care and fluoridation
- Child Protection and Family Safety

The local priorities actions will only be constrained by our limited resources both budget wise and people availability.

Jason Kerehi
Director Māori Health
Wairarapa District Health Board

Abbreviations

3DHB	*3 District Health Board*	*HHS*	*Hospital & Health Services*
ABC	*An approach to smoking cessation requiring health staff to: **ask**, give **brief** advice, and facilitate **cessation** support.*	*HVDHB*	*Hutt Valley District Health Board*
ALT	*Alliance Leadership Team*	*IHD*	*Ischaemic heart disease*
AOD	*Alcohol and Other Drugs*	*IMAC*	*Immunisation Advisory Centre*
AP	*Annual Plan*	*LMC*	*Lead Maternity Carer*
ASH	*Ambulatory sensitive hospitalisation*	*MHAIDS*	*Mental Health, Addictions and Intellectual Disability Directorate*
BFHI	*Baby friendly hospital initiative*	*MOH*	*Ministry of Health*
BSA	*Breast Screen Aotearoa*	*MMWL*	*Māori Women's Welfare League*
BSC	*Breast Screen Central*	*NCSP*	*National Cervical Screening Programme*
CAMHS	*Child & Adolescent Mental Health Service*	*NGO*	*Non-Government Organisation*
CCDHB	*Capital & Coast District Health Board*	*NIR*	*National Immunisation Register*
COPD	*Chronic obstructive pulmonary disease*	*NRT*	*Nicotine Replacement Therapy*
CPHAC	*Community & Primary Health Advisory Committee*	*NSU*	*National Screening Unit*
CVD	*Cardiovascular disease*	*NZQA*	*New Zealand Qualifications Authority*
CVDRA	*Cardiovascular risk assessment*	*OIS*	*Outreach Immunisation Service*
DAP	*District Annual Plan*	*OSA*	*Obstructive Sleep Apnoea*
DCIP	*Diabetes Care Improvement Programme*	*PHO*	*Primary Health Organisation*
DHB	*District Health Board*	*RFPP*	*Rheumatic Fever Prevention Programme*
DIF	*District Immunisation Facilitator*	*RPH*	*Regional Public Health*
dmft	*diseased, missing, or filled teeth*	*RSS*	*Regional Screening Services*
DNA	*Did Not Attend*	*SIDU*	*Service Integration & Development Unit*
DNR	*Did Not Respond*	*VTC*	*Vaccinator Training Course*
ED	*Emergency Department*	*WCTO*	*Well Child Tamariki Ora*
ENT	*Ear, Nose and Throat*	*WDHB WairDHB*	*Wairarapa District Health Board*
GP	*General Practice*	*WOHS*	*Wairarapa Oral Health Service*

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 Draft Sub Regional Health Needs Assessment and the Draft 2015/16 Annual Plan. Data for the Māori Population pyramids has been sourced from Statistics New Zealand.

Population

Wairarapa DHB has a population of 41,109 people. It includes the territorial authorities of Masterton District, Carterton District and South Wairarapa District.

The age distribution in Wairarapa DHB is noted for a smaller population of young working adults compared to the other two DHBs. Around 20% of the population is less than 15 years, and nearly a further 20% are over the age of 65 years.

Eighty-one percent of the Wairarapa DHB is of the Other ethnicity, with a large proportion being aged 50-70 years, reflecting an older population.

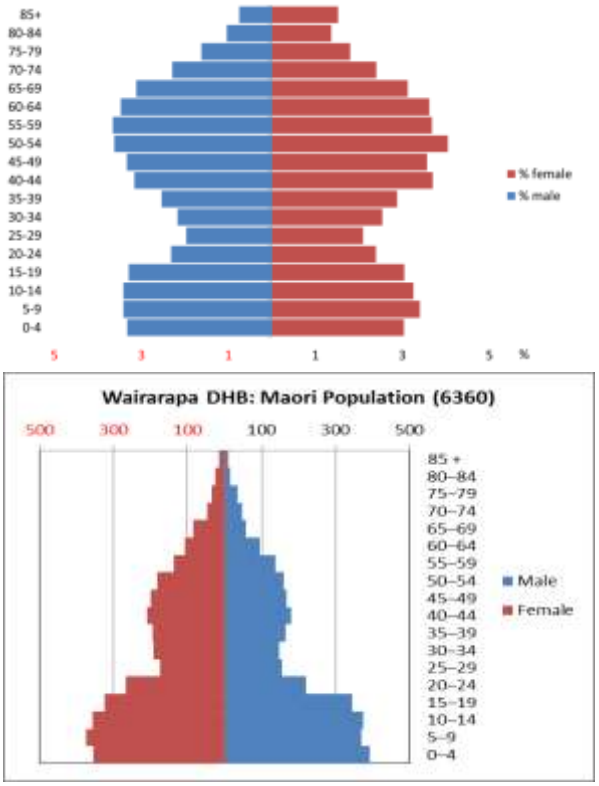
Māori make up 16% of the population, and Pacific people and Asian groups make up a very small percentage.

Amongst Māori, a large proportion (35%) is children, and a further 40% are of working age.

The predominant ethnic group as the population ages is the Other ethnic group, with 22% of this population being over 65 years in age.

The largest proportion of Māori live in Masterton District (18%)

Wairarapa population by age and gender, 2013



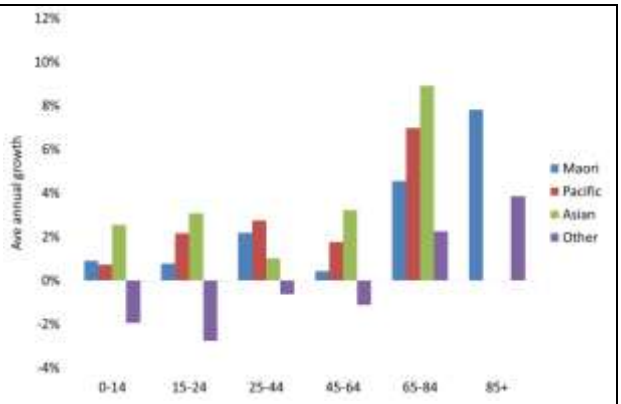
Population Growth

In Wairarapa DHB:

- *The Māori population is expected to increase by about 1.4 % per year. Annual growth rate is highest in the over 65s, and particularly the over 85s although overall numbers remain small.*

Wairarapa average annual growth rates by ethnicity, 2013-2033

- *The small 'Pacific' people population in the Wairarapa is expected to increase about 2.2% per year, but in total is estimated to be only about 1300 people by 2033.*
- *The small 'Asian' population in the Wairarapa is expected to grow slightly faster than the Pacific people's population, at about 3% per year. By 2033 it is estimated there will be slightly more Asian than Pacific people in the Wairarapa.*
- *The overall 'Other' population is expected to decrease slightly overall (at annual rate of 0.2%) and in all age groups under 65. The population from 65-84 is expected to continue to grow at about 2.5% per year and the very old population by 3.9% per year.*

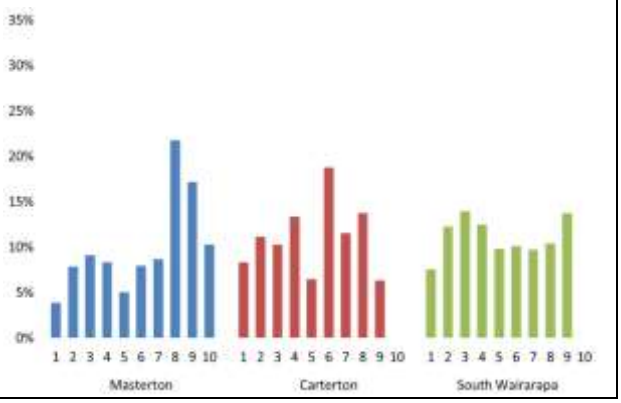


Deprivation

The NZDep2013 index of deprivation reflects eight dimensions of material and social deprivation. These dimensions reflect lacks of income, employment, communication, transport, support, qualifications, owned home and living space.

The most deprived areas are concentrated in central Masterton, and Featherston.

Wairarapa population distribution across deprivation deciles, 2013



HEALTH SERVICE PROVISIONS

Public Health Services (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.

Hospital Based Services

Wairarapa DHB provides secondary services via its Hospital and Health Services (HHS) provider arm which is located in Masterton.

Community Based Services

Wairarapa DHB 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.

Primary Health Organisation

Compass Primary Health Care Network provide PHO services in the Wairarapa district.

Health Status

Wairarapa population

- In 2013, 7,010 Māori lived in the Wairarapa District Health Board region, 17% of the District's total population. Twenty-nine percent of the District's children aged 0–14 years and 28% of the District's youth aged 15–24 years were Māori.
- The Wairarapa Māori population is youthful, but showing signs of ageing. The median age in 2013 was 24 years. The number of Māori aged 65 years and over will increase by 38% between 2013 and 2020.

Whānau ora – Healthy families

- Te Kupenga data (NZ Census) is presented for Wairarapa and Hutt DHBs combined. In 2013, most Wairarapa and Hutt Māori adults (80%) reported that their whānau was doing well, but 7% felt their whānau was doing badly. A small proportion (7%) found it hard to access whānau support in times of need, but most found it easy (76%).
- Being involved in Māori culture was important to the majority of Māori adults (76%) and spirituality was important to 66%.
- Practically all Wairarapa and Hutt Māori (98%) had been to a marae at some time. Most (68%) had been to their ancestral marae, with 76% stating they would like to go more often.
- Eleven percent had taken part in traditional healing or massage in the last 12 months.
- One in six Wairarapa and Hutt Māori (17%) could have a conversation about a lot of everyday things in te reo Māori in 2013.

Wai ora – Healthy environments

Education

- In 2013, 96% of Wairarapa Māori children starting school had participated in early childhood education.
- In 2013, 45% of Māori adults aged 18 years and over had at least a Level 2 Certificate, a higher proportion than in 2006 (37%). The proportion of non-Māori with this level of qualification in 2013 was 63%.

Work

- In 2013, 11% of Māori adults aged 15 years and over were unemployed, compared to 6% of non-Māori.
- Most Wairarapa Māori adults (90%) do voluntary work.
- In 2013, Māori were 87% more likely than non-Māori to look after a household member who was disabled or ill, and 44% more likely to care for someone outside of the home, without pay.

Income and standard of living

- In 2013, just over one in three children and adults in Māori households (defined as households with at least one Māori resident) were in households with low equalised household incomes (under $15,172), compared to just under one in five children and one in six adults in other households in the Wairarapa District.
- In 2013 16% of Wairarapa and Hutt Māori adults reported putting up with feeling the cold a lot to keep costs down during the previous 12 months, 7% had gone without fresh fruit and vegetables, and 16% had postponed or put off a visit to the doctor.
- In 2013, 9% of residents of Māori households in Wairarapa DHB had no motor vehicle compared to 4% of residents in other households.
- Residents of Wairarapa Māori households were less likely to have access to telecommunications than those living in other households: 32% had no internet, 26% no telephone, 13% no mobile phone, and 3% had no access to any telecommunications.

Housing

- The most common housing problems reported to be a big problem by Wairarapa and Hutt Māori adults in 2013 were finding it hard to keep warm (23%), needing repairs (17%), and damp (16%).
- Just over half of children in Wairarapa Māori households were living in rented accommodation, almost twice the proportion of children in other households.
- Wairarapa residents living in Māori households were three times as likely as others to be in crowded homes (i.e. requiring at least one additional bedroom) (14% compared to 5%).

Area deprivation

- Using the NZDep2013 index of small area deprivation, 65% of Wairarapa Māori lived in the four most deprived decile areas compared to 44% of non-Māori. Conversely 8% of Māori lived in the two least deprived deciles compared to 17% of non-Māori.

Mauri ora – Healthy individuals

Pepi, tamariki – Infants and children

- On average, 186 Māori infants were born per year during 2009–2013, 53% of all live births in Wairarapa DHB. Six percent of Māori and 5% of non-Māori babies had low birth weight.
- In 2013, 67% of Māori babies in Wairarapa were fully breastfed at 6 weeks.
- Nine in ten Māori infants were enrolled with a Primary Health Organisation by three months of age.
- In 2014, 94% of Māori children were fully immunised at 8 months of age, and 97% at 24 months.
- In 2013 half of Wairarapa Māori children aged 5 years and a quarter of non-Māori children had caries. At Year 8 of school, three in five Māori children and two in five non-Māori children had caries. Māori children under 15 years were 65% more likely than non-Māori to be hospitalised for tooth and gum disease.
- During 2011–2013, on average there were 17 hospital admissions per year for grommet insertions among Māori children (at a rate 79% higher than non-Māori) and 10 admissions per year for serious skin infections (with the rate 2.4 times that of non-Māori children).
- On average, 142 hospitalisations per year of Māori children were potentially avoidable through population-based health promotion and intersectoral actions, at a rate 52% higher than that of non-Māori.

- Just over 100 hospitalisations per year of Māori children were potentially avoidable through preventive or treatment intervention in primary care (ambulatory care sensitive hospitalisations, or ASH), with a rate 54% higher than for non-Māori children.

Rangatahi – Young adults

- There has been a significant decrease in the proportion of Wairarapa Māori aged 15–17 years who smoke regularly, but no change in smoking rates among Māori aged 20–24 years. In 2013 48% in this age group were smoking cigarettes daily, compared to 27% of non-Māori.
- By September 2014, 57% of Māori girls aged 17 years and 77% of those aged 14 years had received all three doses of the human papilloma virus (HPV) vaccine. Māori aged 16 years had the highest coverage at 93%.
- Among Māori aged 15–24 years there was an average of nine hospitalisations per year for serious injury from self-harm during 2011–2013.

Pakeke – Adults

- Just under half of Māori adults in Wairarapa and Hutt DHBs reported having excellent or very good health in 2013, and just over a third reported having good health. One in six (17%) reported having fair or poor health.
- Smoking rates are decreasing, but remained twice as high for Māori (38%) as for non-Māori (19%) in 2013.

Circulatory system diseases

- Māori adults aged 25 years and over were 49% more likely than non-Māori to be hospitalised for circulatory system diseases (including heart disease and stroke) during 2011–2013, with 73 admissions per year.
- Wairarapa Māori were 57% more likely than non-Māori to be admitted with acute coronary syndrome, 48% more likely to have angiography, and just as likely to have angioplasty or a coronary artery bypass and graft.
- Heart failure admission rates were 3 times as high for Māori as for non-Māori.
- Stroke admission rates were similar for Māori and non-Māori, with seven Māori admitted per year.
- On average, one Māori per year was admitted to hospital with chronic rheumatic heart disease.
- Māori under 75 years were 3 times as likely as non-Māori to die from circulatory system diseases during 2007–2011, with an average of six Māori deaths per year.

Diabetes

- In 2013, 4% of Māori and 5% of non-Māori were estimated to have diabetes. Half of Māori aged 25 years and over who had diabetes were regularly receiving metformin or insulin, four-fifths were having their blood sugar monitored regularly, and two-thirds were being screened regularly for renal disease.
- In 2011–2013 Māori with diabetes were over 4 times as likely as non-Māori to have a lower limb amputated (with one person per year having an amputation).

Cancer

- Compared to non-Māori, cancer incidence was two-thirds higher for Māori females while cancer mortality was just over twice as high.

- Breast, lung, genital organs, and colorectal cancers were the most commonly registered cancers among Wairarapa Māori women in 2008–2012. The rate of lung cancer was fourfold the non-Māori rate, and cancers of the genital organs were 2.5 times the rate for non-Māori women.
- Breast screening coverage of Māori women aged 45–69 years was 66% compared to 69% of non-Māori women during the two years to December 2014.
- Cervical screening coverage of Māori women aged 25–69 years was 69% over 3 years and 86% over five years (compared to 76% and 90% of non-Māori respectively).
- Cancers of the digestive organs and of the breast were the most common causes of cancer death for Māori women in 2007–2011. Māori mortality rates for these cancers were 3 times the non-Māori rates.
- Among Wairarapa males, overall cancer incidence was 49% higher for Māori than for non-Māori, while the cancer mortality rate was similar.
- Colorectal, lung, and prostate cancers were the most frequent cancers among Wairarapa Māori males. The colorectal cancer rate was 2.5 times the rate for non-Māori men, and lung cancer was 3 times the non-Māori rate.
- Cancers of the digestive organs and of the lung were the most common causes of death from cancer among Māori males.

Respiratory disease

- Māori aged 45 years and over were 2.7 times as likely as non-Māori to be admitted to hospital for chronic obstructive pulmonary disease (COPD) during 2007–2011.
- Asthma hospitalisation rates were more than twice as high for Māori as for non-Māori in each age group, particularly for males. Among Māori aged 35–64 years the rate was notably 10.5 times the non-Māori rate.
- Māori under 75 years of age had 10 times the non-Māori rate of death from respiratory disease in 2007–2011.

Mental disorders

- Māori were 63% more likely than non-Māori to be admitted to hospital for a mental disorder during 2011–2013. Schizophrenia related disorders were the most common disorders, followed by substance use disorders. The rate of admission for schizophrenia disorders was 4.2 times the non-Māori rate.

Gout

- In 2011 the prevalence of gout among Wairarapa Māori was estimated to be 6%, higher than the prevalence among non-Māori (4%).
- Thirty-nine percent of Māori with gout regularly received allopurinol, a preventive therapy to lower urate levels. Of those who received allopurinol, only 25% had a lab test for serum urate levels in the following six months. Forty-eight percent of Māori with gout were using non-steroidal anti-inflammatory medication.
- In 2011–2013 the rate of hospitalisations for gout was 3.6 times as high for Māori as for non-Māori, indicating a higher rate of flare-ups.

All ages

Hospitalisations

- The all-cause rate of hospital admissions was 21% higher for Māori than for non-Māori during 2011–2013.

- On average, 418 Māori hospital admissions per year were potentially avoidable, with the rate 40% higher for Māori than for non-Māori. The ASH rate was 62% higher.

Mortality

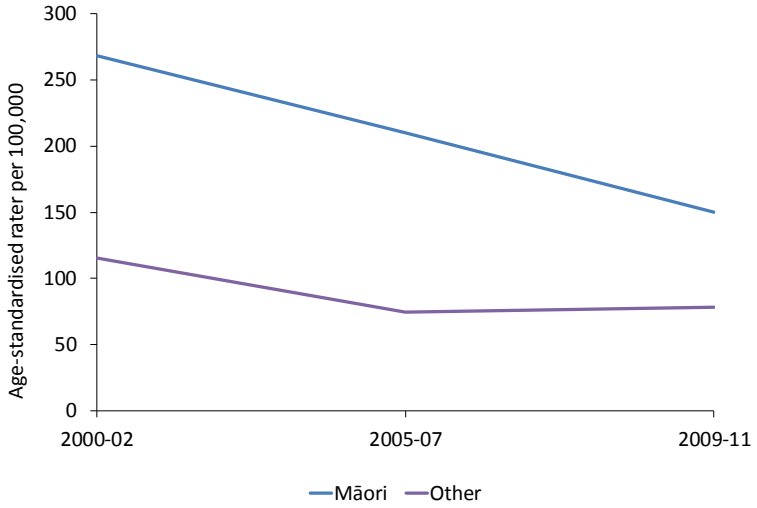
- In 2012–2014, life expectancy at birth for Māori in the greater Wellington Region was 78.6 years for females (5.3 years lower than for non-Māori females) and 74.7 years for males (5.6 years lower than for non-Māori).
- The all-cause mortality rate for Wairarapa Māori in 2008–2012 was 87% higher than the rate for non-Māori.
- Leading causes of death for Māori females during 2004–2011 were COPD, diabetes, ischaemic heart disease (IHD), stroke, and lung cancer.
- Leading causes of death for Māori males were IHD, diabetes, accidents, COPD, and lung cancer.
- Potentially avoidable mortality and mortality amenable to health care were over twice as high for Māori as for non-Māori in Wairarapa during 2007–2011.

Amenable Mortality

Amenable mortality is defined as premature deaths from those conditions for which variation in mortality rates reflects variation in the coverage and quality of health care. From an equity perspective it is possible to use the amenable mortality construct to ask what contribution to social inequality in health is currently being made by inequality in access to and quality of health care. Premature deaths have been defined as deaths under 75 years of age. The conditions included in amenable mortality fall within six categories: infections, maternal and infant conditions, injuries, cancers, cardiovascular disease and diabetes, other chronic diseases.

Amenable mortality rates in the Wairarapa DHB area decreased by 30% between 2000-02 and 2009-11. Amenable mortality for Māori in Wairarapa has declined by 44% alongside a 32% decline in the amendable morality for Other. However, there remains a significant disparity between the Māori and Other populations. The amenable mortality rate for Māori females (123.65) was significantly lower than males (175.92). There has been a 55% decrease in the amendable mortality rate for Māori males between 2000-02 and 2009-11 and a 34% decrease for Māori women. Amenable mortality declined by 37% and 26% for Other males and females, respectively, over the same period.

Wairarapa DHB amenable mortality by ethnicity, 0-74 years (HNA, 2015)



Injuries

- The rate of hospitalisation due to injury was 25% higher for Māori than for non-Māori during 2011–2013.
- The most common causes of injury resulting in hospitalisations among Māori were falls, exposure to mechanical forces, complications of medical and surgical care, transport accidents, and assault.
- Māori rates of hospital admission for injury caused by assault were almost treble those of non-Māori.
- Injury mortality was similar for Māori and non-Māori in Wairarapa DHB, with four Māori per year dying from injuries during 2007–2011.

ASH: 0–4 and 45–64 years

[0-74 years no longer reported]

For Wairarapa DHB, ASH rates for children 0-4 years of age are higher than the national ASH rates for children. Although historically higher, ASH rates for adults 45-64 years of age are currently lower than the national ASH rate for adults. Over the last five years, ASH rates for children in Wairarapa DHB have increased by 14% compared to a national increase in ASH rates of 3%. For Wairarapa DHB, the ASH rate for adults has increased by 16% compared to five years previous, whereas the national ASH rate for adults increased by 3% over the same period.

There are disparities in the ASH rate for Māori children and adults in Wairarapa DHB, compared to Other children and adults. Māori children are significantly more likely to be admitted for an ASH condition than Other children. For the year ending September 2015, there was a 58% difference between the ASH rates for Māori children and Other children. Māori adults are also significantly more likely to be admitted for an ASH condition compared to Other adults. Over time, there has been some reduction in the disparity between the Māori population and Other population in Wairarapa DHB.

For Wairarapa 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, upper respiratory and ENT infections were the leading cause of ASH admissions amongst Māori children. In 2014-2015, 21 Māori children were admitted with upper respiratory and ENT infections. Over a five year period from September 2011 to September 2015, 14 Māori children are, on average, admitted each year. In the last five years there has been a 91% increase in ASH admissions for these conditions amongst Māori children, compared to a 56% increase amongst Other children. There has also been a 133% increase in ASH admissions for this condition for Māori children from the lowest count in 2013 to 2015, compared to 34% for Other children.

2. *Asthma*

   In the year up to September 2015, five Māori children were admitted for asthma. These admissions accounted for 20% of ASH admissions amongst Māori children. Over a five year period from September 2011 to 2015, 11 Māori children are, on average, admitted each year for asthma compared to 12 Other children. There has been a 350% increase in ASH admissions for asthma for Māori children from September 2011 to 2015. However, asthma admissions for Māori children also decreased by 74% between September 2012 and 2014, and significantly increased by 260% in 2015 from

2014. For Other children, there has been a 32% decrease in ASH admissions for asthma.

3. *Cellulitis*

For Wairarapa DHB area, cellulitis was the third leading ASH condition amongst Māori children for the year up to September 2015. In 2015, 14 Māori children were admitted for this condition. Over the five year period ending September 2015, seven Māori children are, on average, admitted each year for cellulitis. For Māori children, ASH admissions for cellulitis increased by 40% between September 2011 and 2015, compared to a 250% increase for Other children. Although, the count of cellulitis admissions for Other children were 2 and 7 for these years. There was, however, a 250% increase in cellulitis admissions for Māori children between 2014 and 2015.

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 resulting in admission for Māori adults. Eighteen Māori adults were admitted for angina and chest pain for the year 2014-2015, which equates to 26% of ASH conditions. On average, 19 adults are admitted each year for angina and chest pain. In the last five years, ASH admissions for angina and chest pains amongst Māori adults increased by 13%. ASH admissions for angina and chest pain amongst Other adults also increased by 13% over the same period. However, ASH conditions have also observed a significant decrease of 33% from a peak of 27 admissions in the year ending September 2013.

2. *Respiratory infections - COPD*

COPD was the second leading cause of ASH admissions amongst Māori adults. In the year ending September 2015, ten Māori adults were admitted for COPD accounting for 14% of Māori adult ASH admissions. On average, ten Māori adults are admitted annually for COPD with a variance of ± 2 admissions each year. ASH admissions for COPD amongst Māori adults has decreased by 9% over a five year period for the years ending Septemeber 2011 to 2015. ASH admissions for Other adults decreased by 19% over the same period.

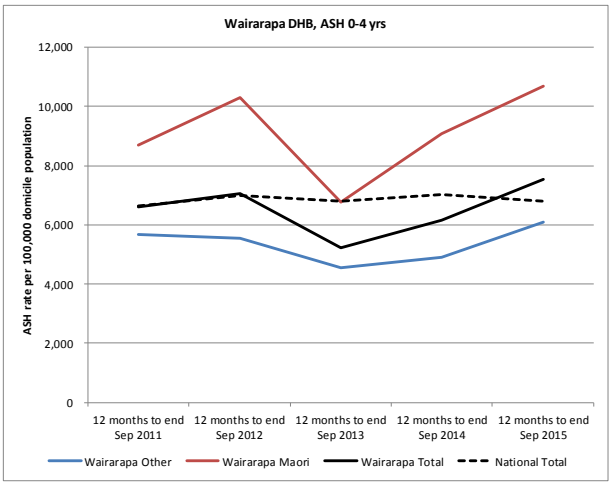
3. *Cellulitis*

Cellulitis was the third leading ASH condition leading to admission in the year ending September 2015 for Māori adults. Nine Māori adults were admitted for cellulitis, accounting for 16% of total ASH admissions. Nine Māori adults are, on average, admitted for cellulitis each year. Over a five year period from September 2011 to September 2015, cellulitis admissions increased by 50% for Māori adults, however this is only a nominal increase of 3 admissions in the Wairarapa. In comparison, Other adults' admissions for cellulitis increased by 40% over the same period; this was a nominal increase of 6 admissions.

Top 5 ASH diagnoses for Māori 0-4 years, 12 months to September 2015

Rank	*Wairarapa*	
1	*Upper respiratory & ENT infections*	*24%*
2	*Asthma*	*20%*
3	*Cellulitis*	*16%*
4	*Dental conditions*	*15%*
5	*Asthma – wheeze*	*8%*

Wairarapa ASH rates by ethnicity, 0-4 years (SOURCE)

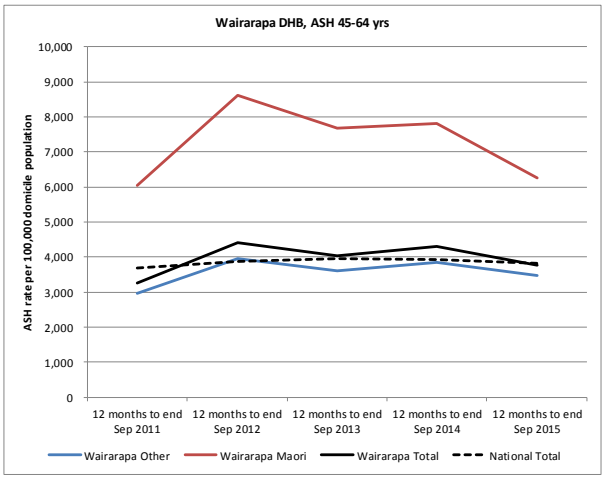


ASH rates for children 0-4 years of age in Wairarapa demonstrate a marked variation to national trends. In the last five years, there has been a 14% increase in total ASH admissions for the Wairarapa, compared to a 3% increase in National ASH admissions. The ASH rate for Other children in Wairarapa has increased by 7% over the same period. ASH admissions for Māori children have, however, increased by 23% in the last five years. The ASH rate for Māori children has increased by 57% from the year ending September 2013 to September 2015. This follows a 34% decrease between years ending September 2012 and September 2013.

Top 5 ASH diagnoses for Māori 45-64 years, 12 months to September 2015

Rank	*Wairarapa*	
1	*Angina & chest pain*	*26%*
2	*Respiratory infections – COPD*	*14%*
3	*Cellulitis*	*13%*
4	*Diabetes*	*10%*
5	*Congestive heart failure*	*9%*

Wairarapa ASH rates by ethnicity, 45-64 years (SOURCE)



ASH rates for adults 45-64 years of age in Wairarapa follow similar trends to ASH rates for adults nationally. However, over the last five years the ASH rate for all adults in Wairarapa has increased by 16%. ASH rates for Other adults in Wairarapa are currently slightly below the national rate, although ASH rates for Other adults follow a similar trend to the ASH rate for all adults and have increased by 17% in the last five years. Māori ASH rates are, however, higher in comparison to other adults. While Māori ASH rates have increased by 3% over a five year period, Māori adult ASH admissions have decreased by 27% in 2015 from September 2012 to 3,776 for the year ending September 2015. This decrease represents a 27% decrease in ASH admission for Māori adults from 2012 to 2015 and a 20% decrease between 2014 and 2015.

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>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.</td></tr>
<tr><td>Notes</td><td>It is important to note that where there are commonalities of work programmes between CCDHB, HVDHB and WairDHB; one programme of work will be developed and agreed as a combined 3DHB approach.</td></tr>
<tr><td>Current Status</td><td>
<table>
<tr><th>Ethnicity</th><th>Current Baseline</th><th>Target</th><th>Variance to Target</th></tr>
<tr><td>Māori</td><td>100%</td><td>100.0%</td><td>0.0%</td></tr>
<tr><td>Other</td><td>100%</td><td>100.0%</td><td>0.0%</td></tr>
</table>
</td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
Support hospital projects, programmes and services to improve quality of ethnicity data collection	DHB	Q1-4
Review ethnicity data collection protocols in selected services and ensure ethnicity reporting by provider arm service area and included in the quarterly Māori Health Indicators reporting framework.	DHB	Q1-4
PHO to work with General Practices to undertake self audits to ensure the ethnicity is recorded accurately, and as per protocol, on: - Enrolment; and, - 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.		
Report at the end of Q1 an update on DHB activity in Data Quality		
Monitor and report PHO Enrolment indicator performance by ethnicity including improvement in accuracy and enrolment gaps on a quarterly basis to: - *Iwi Kainga Māori Relationship Board* - *CPHAC (Equity report)*	DHB	*Q1-4*

Indicator 2: Access to Care

Percentage of Māori enrolled in PHOs

<table>
<tr><td>Outcome Sought</td><td colspan="3">Increased access for the Māori population to primary health care services.</td></tr>
<tr><td>Measures</td><td colspan="3">100% of Māori in WairDHB will be enrolled with a PHO.</td></tr>
<tr><td>Current Status</td><td colspan="3"><table>
<tr><th>Ethnicity</th><th>Current Baseline</th><th>Target</th><th>Variance to Target</th></tr>
<tr><td>Māori</td><td>95.0%</td><td>100.0%</td><td>-5.0%</td></tr>
<tr><td>Other</td><td>99.0%</td><td>100.0%</td><td>-1.0%</td></tr>
</table></td></tr>
<tr><td colspan="2">Planned Actions</td><td>Owner</td><td>Timeframe</td></tr>
<tr><td colspan="2">Work with PHOs and NIR to identify children not enrolled with a PHO.</td><td>DHB
PHO
NIR</td><td>Q1-2</td></tr>
<tr><td colspan="2">PHOs to work with NIR, General Practice, WCTO and other community health providers to locate and encourage PHO enrolment.</td><td>PHO
NIR</td><td>Q3-4</td></tr>
<tr><td colspan="2">Continue to deliver the 3DHB triple newborn enrolment programme</td><td>All</td><td>Q1-2</td></tr>
<tr><td colspan="2">Work with Tihei Wairarapa Leadership and Whānau Ora Providers in the Wairarapa to identify and enrol whānau</td><td>All</td><td>Q1-4</td></tr>
<tr><td colspan="2">Track PHO enrolment, by Ethnicity, Age Band and Gender, on a quarterly basis</td><td>DHB/PHO</td><td>Q1-4</td></tr>
<tr><td colspan="2">Monitor and report indicator performance by ethnicity on a quarterly basis to:
- Iwi Kainga Māori Relationship Board
- CPHAC (Equity report)</td><td>DHB</td><td>Q1-4</td></tr>
</table>

Ambulatory sensitive hospitalisation rates per 100,000 for the age groups of 0–4 and 45–64 years.

Outcome Sought	ASH accounts for nearly **a fifth of acute** and arranged hospital admissions. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. This indicator can also highlight variation between different population groups that will assist with DHB planning to reduce disparities. Wairarapa DHB is very close to the national level of ASH rates however a gap still exists. ASH rates for 0-4 years will be a priority

Measures	Reduce ASH rates for Wairarapa Māori equal to the national average.

Current Status

	Ethnicity	Current Baseline Non-standardised ASH Rate	Target	Māori rate relative to National Total rate as at March 2016
0-4	Other	6,050	≤8,218	
	Māori	9,647		42.1%
	Pacific	n/a		
	Total	7,211		

	Ethnicity	Current Baseline Standardised ASH Rate	Target	Māori rate relative to National Total rate as at March 2016
45-64	Other	2,970	≤4311	
	Māori	5,061		42.2%
	Pacific	n/a		
	Total	3,210		

Planned Actions	**Owner**	**Timeframe**
Hold Whānau Education workshops with a focus on Māori children, 0-4 years, in the areas of: - Respiratory; and, - Skin Conditions	PHO Provider	Q1-4
Deliver a Whānau resource pack focused on: - Respiratory; and, - Skin Conditions	PHO Provider	Q1-4
Collaboratively develop and implement initiatives to support improved Māori health with a range of organisations including, yet not limited to: - PHO - Māori Community Providers - Māori Women's Welfare League	PHO Provider	Q1-4
PHO to provide General Practices with patient analysis focused on: - Risk of hospitalisation - CVDRA - Influenza immunisation - Smoking cessation - Cervical Screening - Diabetes This work will be undertaken to identify unmet need, develop and implement appropriate interventions.	PHO	Q1-4
Trained PHO staff will promote Stanford Self-Management tools to support patients with multiple Long Term Conditions.	PHO	Q3-4
PHO to support Stanford Self Management Facilitators from Whaiora to implement self management programmes focused on Māori and high needs patients with long term conditions.	PHO	Q4

DHB to work with Primary Care and WCTO providers to use the 'Lift the Lip' protocol at each scheduled WCTO visit and each GP/Nurse appointment (as appropriate). Appropriate referrals will be made as required for enrolment or specialist work.	PHO DHB	Q1-4

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.	 DHB DHB	 Q1-2 Q3
Implement revised annual practice plans and monitor quality indicators at a practice level	DHB	Q1-4
Wairarapa DHB will report and update on each planned activity in the ASH section of this Māori Health Plan, by ethnicity at the end of each Quarter. The report will include performance against any contractual measures highlighting Māori participation and service utilisation. This will be reported to the Iwi Kainga Māori Relationship Board quarterly.	DHB	Q1
Monitor and report indicator performance by ethnicity on a quarterly basis to: - PHO Board - Tihei Wairarapa/Alliance Leadership Team - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)	DHB/PHO	Q1-4

Indicator 3: Child Health – Tamariki

Breastfeeding

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

Outcome Sought	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.
Measures	75% Exclusive or fully breastfed at LMC discharge (4-6 weeks) 60% Exclusive or fully breastfed at 3 months 65% Receiving breast-milk at 6 months

Current Status

Breastfeeding: Exclusive or Fully breastfed at LMC discharge			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	59%	75%	-16%
Pacific	71%	75%	-4%
Total	66%	75%	-9%
Breastfeeding: Exclusive or Fully breastfed at 3 months			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	49%	60%	-11%
Pacific	n/a	60%	
Total	57%	60%	-3%
Breastfeeding: Exclusive, Fully or Partially breastfed at 6 months			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	49%	65%	-16%
Pacific	n/a	65%	
Total	63%	65%	-2%

Data for this indicator has been sourced from the Indicators for the Well Child/Tamariki Ora Quality Improvement Framework [1].

Planned Actions	Owner	Timeframe
Universal Activities Wairarapa DHB will continue to fund and support 'Well Child - Tamariki Ora' (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 and raising the awareness of breastfeeding.	DHB	Q1-4
Maintain BFHI accreditation.	DHB	Q2
Targeted Activities 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	All	Q1-4
Implement a local community forum to support the provision of breast feeding education: - In group; - In home; and, - Discuss and identify key areas to improve Māori breastfeeding rates.	PHO	Q1-4
Encourage and support Māori to undertake Peer Counselling training (Breastfeeding) and run two courses in 16/17	DHB PHO RPH	Q1-4
Monitoring Monitor and report indicator performance by ethnicity of Well Child/Tamariki Ora provider data and Plunket data (where	DHB	Q1-4

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

available) on a quarterly basis to: - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)		

Indicator 4: 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.

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 February 2016 by ethnicity, women aged 25–69 years

Ethnicity	Current Baseline	Target	Variance to Target
Māori	68.3%	80%	-11.7%
Total	74.5%	80%	-5.5%

Planned Actions		**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
Provide free cervical smear vouchers to practices to screen priority group women, in particular Maori.	PHO	Q1-4
Assist practices to establish systems that will enable them to reach the targeted population and to establish an efficient and robust recall system.	RSS	Q1-4
Continue to support Primary Care in identifying Māori clients through an evolving data-matching process between the PHO register and the NCSP register with the aim to decreasing the number of women who are unscreened or under screened (not screened in the last 5 years). Provide dedicated resources to follow up with women and audit and update patient records as required. A minimum of four practices per annum. This work will be linked to Indicator 1: Accuracy of Ethnicity Reporting	RSS PHO	Q1-4
HVDHB will support collaborative working relationships between providers to actively engage and support hard to reach Māori women through the cervical screening pathway including colposcopy. - Two WDHB NCSP and Colposcopy Clinic meetings per year. - Monitor colposcopy DNA's , share learning and support	DHB RSS	Q1-4

initiatives aimed at reducing DNA's - 1x meeting per annum with five specialist Colposcopy Clinics in greater Wellington Region offering support if required		
Support Primary Care and other relevant providers through providing: - Annual colposcopy training - Two (2) education evenings	RSS	Q1-4 Q4 Six monthly
Monitor and report indicator performance by ethnicity on a quarterly basis to the Iwi Kainga Māori Relationship Board	DHB	Q1-4

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

Outcome Sought	Lower breast cancer morbidity and mortality among Māori women through better utilisation of the national breast screening programme for women aged 50-69 years.
Measures	Screening rates for Māori women (50-69 years) will have reached the national target of 70%.
Current Status	BSA coverage (%) in the two years ending 31 March 2016 by ethnicity, women aged 50–69 years [NB: this data as at Dec 2015]

Ethnicity	Current Baseline	Target	Variance to Target
Māori	72.5%	70%	+2.5%
Total	78.7%	70%	+8.7%

Planned Actions	**Owner**	**Timeframe**
Engage PHO's to data match General Practices (GP's) with high numbers of priority women in WDHB	RSS PHO	Q2-3
Identify and target BSA eligible women not enrolled or overdue for breast screening	RSS PHO	Q2-3
Promote and support the breast screening mobile unit visits as per the BSC mobile schedule.	DHB	Q1-4
Wairarapa DHB will support collaborative working relationships between providers across the breast screening network: - Attend Regional Coordination Group meetings as required. - Work with Outreach Services, Regional Screening Services and Primary Care to ensure smooth referral processes for BSA priority women.	DHB RSS	Q1-4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)	DHB	Q1-4

Indicator 5: Smoking

Smoking cessation: Percentage of pregnant Māori women who are smoke-free 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 smoke-free at two weeks postnatal will increase over 2015/16 as a result of our efforts.		
Measures	95% of pregnant Māori women who are smoke-free at two weeks postnatal.		
Current Status	Baseline to be determined		
Planned Actions		**Owner**	**Timeframe**
Continue to offer ABC and NRT Competency training to Health professionals with a particular focus on LMCs		DHB	Ongoing
Deliver ABC and provide NRT options to pregnant Māori women at - First contact registration - 2 weeks post-partum - Each of the first two Well Child core contacts		PHO DHB	Ongoing
Provide bulk access to Nicotine Replacement Therapy (NRT) for health service providers offering cessation services to Māori and Pacific communities within the greater Wellington Region, where at least three providers are accessing the bulk supply of Nicotine Replacement Therapy (NRT) through RPH		DHB	Ongoing
Monitor Smokefree status of pregnant Māori women and, where relevant, provide cessation advice at each antenatal appointment: General Practice and Specialist Appointments		PHO	Ongoing
Monitor and report by ethnicity smoking cessation advice provision performance and smokefree rates at two weeks postnatal on a quarterly basis to the Iwi Kainga Māori Relationship Board		DHB	Quarterly

Indicator 6: Immunisation

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

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		95%	
Other		95%	

Planned Actions	Owner	Timeframe
Sub-Regional Action Maintain an immunisation alliance steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit; that identifies service delivery gaps, participates in regional and national forums and takes the lead on monitoring and evaluating immunisation coverage at DHB, PHO and practice level.	DHB	Q1-4
Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date.	DHB	Q1-4
Local Action Continue with the 3DHB newborn triple enrolment programme	DHB PHO	Q1-4
Datamart reports are reviewed monthly and overdue reports fortnightly with OIS receiving referrals when required.	NIR PHO	Q1-4
Concerto database to be checked each day for inpatients and also checks NIR to see if there are any children due or overdue for immunisation and action as requited.	NIR PHO	Q1-4
IMAC sessions will continue to be held annually for Nurses and Midwives, in addition the DIF goes to Wellington to present at VTC sessions. Additional educational sessions on immunisations will be held if required.	DHB	Q1-4
Monitor immunisation performance on a monthly basis within SIDU	DHB PHO	Q1-4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)	DHB	Q1-4

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

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	66.0%	75%	-9%
Other	67.0%	75%	-8%

Planned Actions	Owner	Timeframe
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 Māori.	HHS PHO NGO	Q1 Q3

Promote Kaumatua / Kuia wellness with a focus on Influenza Immunisation. Promote to Wairarapa Kaumātua Council This work will link with the General Practice flu campaigns	DHB PHO	Q1-2 & 4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)	DHB	Q1-4

Indicator 7: 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 1.4 cases per 100,000 people by June 2017.

Wairarapa 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) for Wairarapa DHB
<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>Wairarapa</td><td>0.0</td><td>0.0</td></tr>
</table></td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
1. To prevent the transmission of Group A Streptococcal throat infections in the Wairarapa, Hutt Valley and Capital & Coast DHB region, through: – The implementation of a pathway across the sub-region to identify and refer high risk children to comprehensive	DHB PHO RPH	Q4

housing, health assessment and referrals services – The development of the Housing and Health Capability Building Programme throughout 2016/17 and implementation of insulation referral process for high-risk patients – Raising community awareness throughout 2016/17		
2. Actions to treat Group A Streptococcal infections quickly and effectively. This will be achieved through: – The provision of training and information for primary care providers, throughout 2015/16 and on-going. – Development and implementation of an audit tool for the treatment of sore throats in primary care	DHB PHO	Q4
3. Actions to facilitate effective follow-up of identified rheumatic fever cases. This will be achieved through: – The tracking of the timeliness of antibiotics through the rheumatic fever register with annual audit and stakeholder meetings – Appropriate mechanisms for annual training of hospital medical staff to be explored and implemented – The implementation of an audit process to follow up on all cases of rheumatic fever (root cause analysis process undertaken) by Regional Public Health. – The development and implementation of a clinical pathway from diagnosis through to the end of bicillin course	DHB PHO	Q4
4. In 2016/17 there will be increased focus on consistent communication messages to the public and health professionals, education of health professionals in primary and secondary care and antibiotic adherence.	DHB	Q1-Q4
5. RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness	RPH	Q1-Q4

Indicator 8: 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	95% of Māori pre-school children enrolled in the community oral health service

Current Status				
	Ethnicity	**Current Baseline**	**Target**	**Variance to Target**
	Māori	81%	95%	-14%
	Other	83%	95%	-12%
Planned Actions			**Owner**	**Timeframe**
Continue with the DHB enrolment programme (Oral Health)			DHB	Q1-4
Improving oral health in our tamariki • Run regular "Baby Talk" sessions with all babies/pepi aged six-weeks and their whānau • See every pre-schooler (from birth) annually with a focus on low-decile, high-deprivation communities • Hub and mobile planning based on high-need			Wairarapa Oral Health Service (WOHS)	Q1-4
Deliver oral health education and support to health professionals and ECE providers to ensure consistent, high-quality and wide-reaching advice around oral health care			WOHS	Q1-4
Work with and support the Waha Pai, Waha Ora (Māori Oral Health project) based at Te Hauora Runanga o Wairarapa			Te Hauora All	Q1-4
Monitor and report indicator performance: - Monthly reporting on key indicators [Internally DHB] - Annual data to Iwi Kainga Māori Relationship Board - Annual data to CPHAC			DHB SIDU	Q 3

Indicator 9: 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.

Outcome Sought	Appropriate rates of use of Section 29 of the Mental Health Act (community treatment order).			
Measures	No targets set for 2016/17			
Current Status	As at March 2016			
	Ethnicity	**Current Baseline**[2]		
	Māori	284		
	Non-Māori	76		
Planned Actions			**Owner**	**Timeframe**
Support the targeting of Primary Mental Health Services to Māori communities, especially Māori young people 10-24 years			PHOs DHB	
Develop and implement packages of care for Māori Mental Health with a focus on community early interventions, including Rongoa Māori			PHO DHB	Q2-4

[2] Rate per 100,000

Analyse the degree of variance in use of Section 29 within the DHB by reviewing the rationale for its use	DHB	Q2
Report findings of analyses to practitioners and a clinically-led multidisciplinary mental health forum.	DHB	Q2
Monitor guidelines and regular auditing processes to support standardised application of Section 29	DHB	Q2-4
Develop short and long term recovery plans (Client and Clinician based) for Extension and Indefinite clients, under the Mental Health Act, to support Māori to receive non-compulsory treatment.	DHB	Q1-4
Monitor and report indicator performance by ethnicity on a quarterly basis to Iwi Kainga Māori Relationship Board	DHB	Q1-4

OTHER KEY INDICATORS

Did Not Attend

Outcome Sought	Decrease in DNA rates for Māori via increased attendance to Hospital appointments	
Planned Actions	**Owner**	**Timeframe**
Ensure literacy and system review for OPD letters and reminders is completed	DHB	Q1-2
Develop media campaign for Wairarapa DHB DNA	DHB	Q1-2

Respiratory

Outcome Sought	Reduced admissions / re-admissions for respiratory conditions	
Planned Actions	**Owner**	**Timeframe**
Develop and implement a 'Follow Out to Community' referral process specifically targeted at Paediatric Respiratory	DHB	Q1-2
Three respiratory pathways will be completed and implemented; COPD, Cough, Pneumonia and OSA, with additional pathways will be prioritised by the ALT	DHB	Q1-4
Improving and embedding pathways for primary care access to specialist nurse and/or doctor advice, by progressing the Sub-regional alignment of respiratory pathways	DHB	Q1-4

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 population will have had their cardiovascular risk assessed in the last five years.
Current Status	

Ethnicity	Current Baseline	Target	Variance to Target
Māori	84.1%	90.0%	-5.9%
Other	92.1%	90.0%	+2.1%

Planned Actions	**Owner**	**Timeframe**
Ensure the expertise, training and tools needed are available to successfully complete the CVD risk assessment and management to meet clinical guidelines	PHO	Q1-4
Ensure that IT systems that have patient prompts, decision support and audit tools exist, are used and fully report performance.	PHO	Q1-4
Work with Māori Women's Welfare League to identify and locate at risk men to undertake CVRA	DHB PHO	Q1-4
Support Health Promotion Agency in its work on CVD awareness and publicity campaigns	PHO DHB	Q1-4
PHO will continue current approach which includes: – Provision of patient dashboard to all practices – Provision of weekly lists of patients requiring checks – Unblended Peer group comparison reports – Quarterly site visits and review of performance with each practice – Financial incentives for performance – Patient information campaign – Provision of technical assistance	PHO	Q1-4
PHO to provide subsidy for Māori, Pacific and High Needs patients to receive free CVDRA	PHO	Q1-4
PHO to fund a CVD Risk Assessment programme specifically targeted at increasing the number of Māori men aged 35-44 years	PHO	Q2-3
Monitor and report indicator performance by ethnicity on a quarterly basis to: - Iwi Kainga Māori Relationship Board - CPHAC (Equity report)	DHB	Q1-4

LOCAL PRIORITIES

This section will mirror the priorities identified by Iwi Kainga and include actions agreed to by the Wairarapa DHB and Te Oranga o Te Iwi Kainga.

Population Priorities

Outcome Sought	Identify actions that focus on the three key populations identified by Iwi Kainga. They being: tamariki (children), rangatahi (youth) and tane (men).

Planned Actions	Owner	Timeframe
Focus on health for tamariki (children) - Reduced immunisation-preventable morbidity and mortality (Indicator 6) - Improved oral health outcomes (Indicator 8)	DHB	Q1-4
Focus on health for rangatahi (youth) - Ensure all rangatahi have access to health services - Taonga Takoro programme to be run with rangatahi through Whaiora	PHO Whaiora	Q1-4
Focus on health for tane (men) - Māori NGO provider programme to focus on Māori Men's health - Whaiora to run wellness sessions for Māori men - Whaiora to lead men's focus groups on diabetes - WaiWaiA (Te Hauora and Whaiora to run hunting/fishing programme for Tane and Tama	PHO Whaiora Te Hauora	Q2-4

Priority Disease Focus

Outcome Sought	Iwi Kainga identified four priority diseases. These are: Mental Health and AOD; smoking, obesity and oral health. Improved health outcomes for Wairarapa Māori

Planned Actions	Owner	Timeframe
Mental Health – reduction in the number of Section 29 referrals - refer to National Indicator 9 and Māori Mental Health in (Other Key Priorities) Earlier presentation of Māori to Mental Health Services	DHB MHAIDS	Q1-4
AOD – refer to Māori Mental Health in (Other Key Priorities) TBC	DHB MHAIDS	
Smoking – 95% of pregnant Māori women are smoke free at two weeks post-natal – refer to National Indicator 5	DHB	Q1-4
Obesity – By December 2017, 95% of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions - refer to Obesity provisions in DAP and Whānau Ora section	DHB	Q1-4
Oral Health – Increase in the number of children aged 5 caries free - refer to National Indicator 8	DHB WOHS	Q1-4

Access

Outcome Sought	Improved access to services for Māori

Planned Actions	Owner	Timeframe
Health Literacy - work with Outpatients Department (OPD) to review appointment letters and reminders	DHB	Q1-2

Cultural Competency – work with three Provider Arm service units to implement the Wairarapa District Health Board Tikanga Best Practice model	DHB	Q1-3
Self-determination – See 2020 Project below		
Improved whānau care outside of region – identify appropriate accommodation options and key contacts in HVDHB, CCDHB and MCDHB	DHB	Q 4
Sooner, Better, More convenient services including opening hours of service – provide cultural input into the review of Acute Services	DHB	Q1-3

Quality

Outcome Sought	Improved quality of service	
Planned Actions	**Owner**	**Timeframe**
Workforce Development initiatives – active recruiting to increase % Māori workforce (+1%) – ensure a culturally competent workforce (targeted training across the health workforce)	DHB PHO	Q1-4
Māori Provider Development – full allocation of MPDS funding in 16/17	DHB	Q 3

Social Determinants

Outcome Sought	Improved wellness of whānau through an intersectoral approach to wellbeing	
Planned Actions	**Owner**	**Timeframe**
Focus on whānau with the most need: 2020 Project – Work with the PHO and other stakeholders to identify the whānau with the greatest health and social needs and highest chance for change and implement a longer-term intersectoral approach to improve wellness – Provisionally called the 2020 project where we focus on 20 whānau over the next four years – Develop a Multi-Disciplinary Team across sectors to work alongside these whānau – Follow the principles of whānau ora including whānau determining their pathway to wellness	DHB PHO	Q1-4
The DHB will take a lead role in driving Wairarapa intersectoral discussions around reducing inequities for high-need populations including Māori	DHB	Q1-4

Prevention

Outcome Sought	Prevention of disease through a targeted campaign aimed at reducing Māori	
Planned Actions	**Owner**	**Timeframe**
Reduce the uptake of smoking – promotion amongst whānau, hapu, iwi	DHB PHO Whaiora	Q1-4
Increasing physical activity and supporting healthy eating	DHB	Q3-4
Good oral healthcare and promoting fluoridation Support the Waha Ora Waha Pai Initiative	DHB Te Hauora	Q1-4
Child protection and family safety	TBC	