Capital & Coast District Health Board

Māori Health Plan

2016 - 17

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

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Introduction

CCDHB is committed to improving the experience of Māori who need to access health services in Wellington, Porirua and Kapiti.

With the view to positively impact on measures of wellbeing for Māori, the New Zealand Māori Health Strategy, He Korowai Oranga has been updated to respond to this by setting the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the Māori population. It builds on the initial foundation element of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

He Korowai Oranga provides invaluable guidance on how to approach reducing disparities and progressing aspirations for Tangata Whenua and Māori health improvement. Reducing the disparities that exist for Māori in the Capital & Coast 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 and Pae Ora (Healthy Futures).

Section 6 of the Operational Policy Framework (OPF) requires District Health Boards to develop and submit a 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. DHBs are required to partner with Primary Health Organisations (PHOs), as a critical stakeholder, in the planning and development of the DHB Māori Health Plan. It is equally that improvement in Māori Health outcome is a collective responsibility of DHBs, PHOs, Māori Health Providers, Mainstream Health and wider Social organisations. These organisations are all directed by legislation and contractual quality requirements to contribute to Māori health gains.

Capital & Coast District Health Board (CCDHB), as one of the twenty DHBs, is committed to meeting its statutory objectives, and recognises and respects the Treaty of Waitangi, with the intention of bringing to life the principles of partnership, participation and protection in our everyday interactions and work. CCDHB wants Maori patients to have experiences that feel that they are leading the decisions around their health care; feel supported to access services and have the confidence to access services in a timely way. At a local level, CCDHB works with its Māori Partnership Board to ensure Māori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Māori. There are also consultation with Maori providers and PHOs to ensure that actions within plans are achievable within the timeframes.

This plan is directly aligned to CCDHB's Draft Annual Plan for 2016/17 and highlights the specific areas to be targeted. It describes the activities to be undertaken by CCDHB during 2016/17 aimed at progressing He Korowai Oranga, reducing the disparities experienced by Māori and improved Māori health outcomes.

Abbreviations

3DHB	3 District Health Board	GP	General Practice
ABC	An approach to smoking cessation requiring health staff to ask, give brief advice, and facilitate cessation support.	IGT	Impaired glucose tolerance
ACPPs	Accelerated Chest Pain Pathways	IHD	Ischaemic heart disease
ACS	Acute Coronary Syndrome	IMAC	Immunisation Advisory Center
ALT	Alliance Leadership Team	ISDR	Indirectly standardised discharge rate
AOD	Alcohol and Other Drugs	KCDC	Kapiti Coast District Council
ASH	Ambulatory sensitive hospitalisation	KOH	Kia Ora Hauora
BFHI	Baby friendly hospital initiative	LMC	Lead Maternity Carer
BPAC	Best Practice Advocacy Centre	LTC	Long Term Conditions
BSA	Breast Screen Aotearoa	MH&A	Mental Health & Addiction
BSC	Breast Screen Central	MOH	Ministry of Health
CAMHS	Child & Adolescent Mental Health Service	NCSP	National Cervical Screening Programme
CCDHB	Capital & Coast District Health Board	NIR	National Immunisation Register
CEP	Co-Existing Problems	NRT	Nicotine Replacement Therapy
COPD	Chronic obstructive pulmonary disease	OIS	Outreach Immunisation Service
CPHAC	Community & Primary Health Advisory Committee	OSA	Obstructive Sleep Apnea
CVD	Cardiovascular disease	PDSA	Plan Do Study Act - Planning tool
CVRA	Cardiovascular risk assessment	PHO	Primary Health Organisation
DHB	District Health Board	PHOAG	PHO Advisory Group
DIF	District Immunisation Facilitator	RFPP	Rheumatic Fever Prevention Programme
DMFT	Diseased, Missing, or Filled Teeth	RPH	Regional Public Health
DNA	Did Not Attend	SIDU	Service Integration & Development Unit
DNR	Did Not Respond	SUDI	Sudden Unexpected Death of an Infant
ED	Emergency Department	VTC	Vaccinator Training Course
ELT	Executive Leadership Team	VWUB	Vulnerable Pregnant Women and Unborn Baby
GAS	Group A Streptococcus	WCTO	Well Child Tamariki Ora
HbA1C	Glycosylated haemoglobin	WDHB WaiDHB	Wairarapa District Health Board
HHS	Hospital & Health Services	YOSS	Youth One Stop Shop
HVDHB	Hutt Valley District Health Board		

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 CCDHB Māori Health Profile 2015[1], Draft Sub Regional Health Needs Assessment and the 2015 / 16 Annual Plan. Data for the Māori Population pyramids has been sourced from Statistics New Zealand. ASH data has been sourced from the ASH SI1 Report to Q3 September 2015

Based on this data there needs to be a focus on supporting Maori targets, outcomes and ensuring Maori have access to health services in a timely way. Otherwise the burden of ill health will increase.

Population

CCDHB has a population of 283,704 people. It includes the Territorial authorities of Wellington City, Porirua City, and the majority of Kapiti Coast District.

The age distribution in CCDHB population is dominated by a large proportion of people of working age. Around half of the population is between the ages of 25-64 years. Of note also is that about 9% of the population is aged 20-24 years

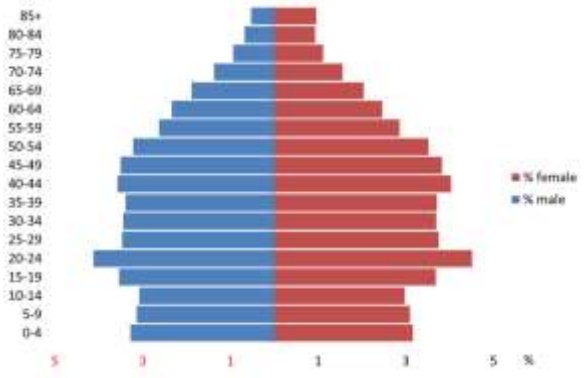
The age distribution also differs across the three territorial authorities:

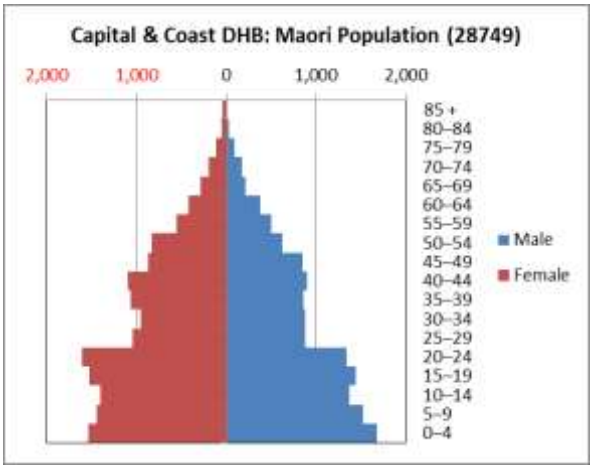
- Wellington City is dominated by a large proportion of people in the younger working age groups (20-44 years).
- In Porirua City the population is young with a high proportion of under 15 years olds.
- The Kapiti Coast District population is characterised by a larger aging population compared to the other two territorial authorities.

The Other ethnic group makes up the largest ethnic group in CCDHB in 2013, comprising 72% of the population. Māori, Pacific people and Asian populations are relatively small in comparison (10%, 6.7% and 11.2% respectively).

The largest proportion of Māori is children

CCDHB population by age and gender, 2013

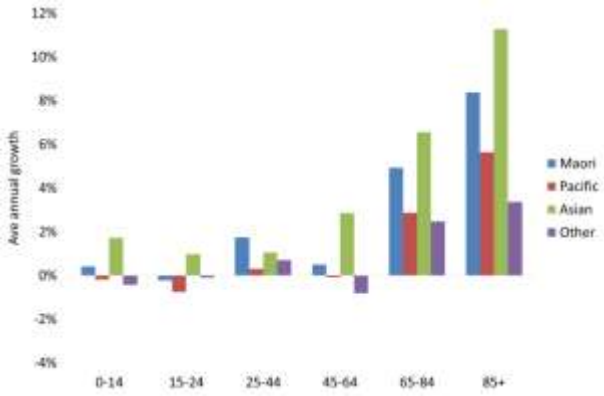




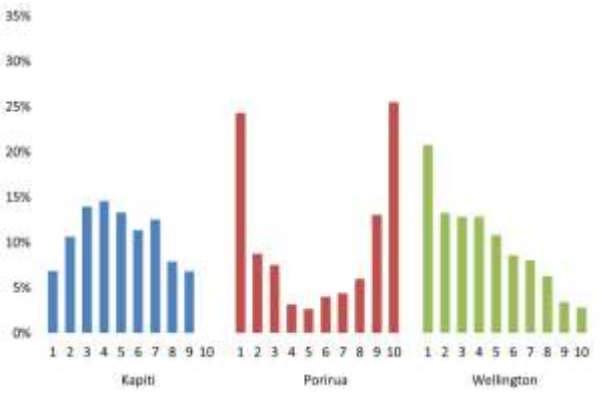
[1] Robson B, Purdie G, Simmonds S, Waa A, Faulkner R, Rameka R. 2015, Andrewes J. *Capital and Coast District Health Board Māori Health Profile 2015.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

under 15 years (31%), and of these 11% are under the age of 5. Only around 15% of Māori living in CCDHB are over the age of 50. Porirua City has a greater proportion of both the Māori (20%) and Pacific people 21%), than other territorial authorities.	

Population Growth

In CCDHB: - The Māori population is expected to increase by about 1% per year. Annual growth rate is highest in the over 65s, and particularly the over 85s although overall numbers remain small. - In the Pacific people population only a small increase of 0.2% per year expected. Small decrease expected in all age groups except those over 65 - In the Asian population an increase in all age groups is expected. An overall annual growth rate of 2.2% - The overall Other population is only expected to grow slowly overall (annual growth rate of 4%) but younger age groups under 25 are expected to decline while age groups 65-84 are expected to grow 2.5% per year and the very old older population by 3.4% per year.	CCDHB average annual growth rates by ethnicity 2013-2033 

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 Porirua City (eastern Porirua and areas to the west of the state highway. In the Porirua territorial authority about 35% of the population live in highly deprived areas (deciles 9 and 10) and about 40% live in the areas of least deprivation (deciles 1 and 2). In contrast, the Wellington territorial authority population predominantly lives in the least deprived areas.	Capital & Coast population distribution across deprivation deciles, 2013 

Capital and Coast population

- In 2013, an estimated 32,800 Māori lived in the Capital and Coast District Health Board region, 11% of the District's total population.
- The Capital and Coast Māori population is youthful, but showing signs of ageing. In 2013, the median age was 24.3 years, compared to 35.7 years for the total DHB. Almost a third of the District's children and young people are Māori. The Māori population aged 65 years and over will increase by 44% between 2013 and 2020.

Whānau ora – Healthy families

- In 2013, most Capital and Coast Māori adults (88%) reported that their whānau was doing well, but 4% 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 (79%).
- Being involved in Māori culture was important (very, quite, or somewhat) to 69% of Māori adults. Spirituality was important to 66%.
- Practically all Capital and Coast Māori (98%) had been to a marae at some time. Most (60%) had been to their ancestral marae, with 30% having been in the last 12 months and 66% stating they would like to go more often.
- One in eight had taken part in traditional healing or massage in the last 12 months.
- One in five Capital and Coast Māori could have a conversation about a lot of everyday things in te reo Māori in 2013.

Wai ora – Healthy environments

Education

- Among Māori children who started school in 2013, 96% had participated in early childhood education.
- In 2013, 64% of Māori adults aged 18 years and over had at least a Level 2 Certificate, a higher proportion than in 2006 (56%). However the proportion was only four-fifths that of non-Māori (77%).

Work

- In 2013, 10% of Māori adults aged 15 years and over were unemployed, 70% higher than the non-Māori rate (6%).
- Most Māori adults (90%) do voluntary work.
- In 2013, Māori were nearly four-fifths more likely than non-Māori to look after someone who was disabled or ill within the home, and 57% more likely to look after someone outside of the household without pay.

Income and standard of living

- In 2013, 29% of children and 25% of adults in Māori households (defined as households with at least one Māori resident) were in households with low equivalised household incomes (under $15,172), compared to 17% of children and 19% of adults in other households.
- Ten percent of Capital and Coast Māori adults reported putting up with feeling the cold a lot to keep costs down during the previous 12 months, 9% had often gone without fresh fruit and vegetables, and 13% had postponed or put off a visit to the doctor.
- Residents of Māori households were 52% more likely than non-Māori to live in a home without a motor vehicle (12% compared to 8%).
- People in Māori households were less likely to have access to telecommunications than those living in other households: 18% had no internet, 24% no telephone, 10% no mobile phone, and 2% had no access to any telecommunications.

Housing

- The most common housing problems reported to be a big problem by Māori adults in 2013 were finding it hard to keep warm (18%), needing repairs (12%), and damp (11%).
- Just over half of children in Capital and Coast Māori households were living in rented accommodation, 80% higher than the proportion of children in other households.
- Capital and Coast residents living in Māori households were nearly twice as likely as others to be in crowded homes (i.e. requiring at least one additional bedroom) (17% compared to 9%).

Area deprivation

- Using the NZDep2013 index of small area deprivation, 26% of Capital and Coast Māori lived in the most deprived neighbourhoods (NZDep quintile 5) compared to 11% of non-Māori.

Mauri ora – Healthy individuals

Pepi, tamariki – Infants and children

- On average almost 800 Māori infants were born per year during 2009 to 2013, 21% of all live births in the DHB. Six percent of Māori and non-Māori babies had low birth weight.
- In 2013, 70% of Māori babies in Capital and Coast were fully breastfed at 6 weeks.
- An estimated 80% of Māori infants were enrolled with a Primary Health Organisation by three months of age.
- In 2014, 92% of Māori children were fully immunised at 8 months of age, 93% at 24 months.
- In 2013, 56% of Capital and Coast Māori children aged 5 years had caries, compared to 32% of non-Māori children. At Year 8 of school, 42% of Māori children and 33% of non-Māori children had caries. Māori children under 15 years were 55% more likely than non-Māori children to be hospitalised for tooth and gum disease during 2011–2013.
- During 2011–2013, on average there were 81 hospital admissions per year for grommet insertions among Māori children (at a rate 81% higher than non-Māori), and 451 admissions per year for serious skin infections, with a rate 64% higher than non-Māori.
- On average, one Māori and three non-Māori children under 15 years of age were admitted to hospital each year with acute rheumatic fever. Among those aged 15–24 years there was one Māori and one non-Māori admitted per year (with the Māori rate 5.6 times the non-Māori rate).
- On average, 544 hospitalisations per year of Māori children were potentially avoidable through population-based health promotion and intersectoral actions, at a rate 26% higher than that of non-Māori.
- The rate of hospitalisations that were potentially avoidable through preventive or treatment intervention in primary care (ambulatory care sensitive hospitalisations, or ASH) was 25% higher for Māori than for non-Māori children, with an average of 370 hospital admissions per year among Māori children.

Rangatahi – Young adults

- There has been a significant increase in the proportion of Capital and Coast Māori aged 14 and 15 years who have never smoked, and a decrease in the proportion of Māori aged 15–24 years who smoke regularly. However, Māori youth remain twice as likely as non-Māori to smoke regularly.
- By September 2014, 54% of Māori girls aged 17 years and 70% of those aged 14 years had completed all three doses of the human papilloma virus (HPV) immunisation.
- Rates of hospitalisation for serious injury from self-harm were similar for Māori and non-Māori among both 15–24 year olds and 25–44 year olds during 2011–2013.

Pakeke – Adults

- An estimated 64% of Māori adults in Capital and Coast reported having excellent or very good health in 2013, and 26% reported good health. One in nine (11%) reported having fair or poor health.
- Smoking rates of adults are decreasing, but remain over twice as high for Māori (26%) as for non-Māori (11%).

Circulatory system diseases

- Māori adults aged 25 years were 50% more likely than non-Māori to be hospitalised for circulatory system diseases (including heart disease and stroke) during 2011–2013.
- Capital and Coast Māori were just as likely as non-Māori to be admitted to hospital with acute coronary syndrome, 31% more likely to have angiography, with no differences in rates of angioplasty or coronary artery bypass and graft.
- Heart failure admission rates were 3.3 times as high for Māori as for non-Māori.
- Stroke admission rates were 39% higher for Māori as for non-Māori.
- Chronic rheumatic heart disease admissions were 8.3 times as common for Māori women as for non-Māori women and admissions for heart valve replacements 3.7 times as common.
- Māori under 75 years were 2.8 times as likely as non-Māori to die from circulatory system diseases during 2007–2011.

Diabetes

- In 2013, 4% of Māori and 5% of non-Māori were estimated to have diabetes. Just over half of Māori aged 25 years and over who had diabetes were regularly receiving metformin or insulin, 86% were having their blood sugar monitored regularly, and 69% were being screened regularly for renal disease.
- On average, three Capital and Coast Māori with diabetes per year underwent lower limb amputation during the 2011–2013 period.

Cancer

- Compared to non-Māori, cancer incidence was 54% higher for Māori females and cancer mortality was twice as high.
- Breast, lung, uterine, and colorectal cancers were the most commonly registered among Capital and Coast Māori women. The rate of lung cancer was 3.8 times the rate for non-Māori women, uterine 2.7 times as high, and breast cancer 1.5 times as high.
- Breast screening coverage of Māori women aged 45–69 years was 61% compared to 69% of non-Māori women.
- Cervical screening coverage of Māori women aged 25–69 years was 64% over 3 years and 79% over five years (compared to 83% and close to 100% of non-Māori respectively).
- Cancers of the lung, prostate, colon and rectum, and leukaemias were the most common cancers among Capital and Coast Māori men. Lung cancer registration rates were 3 times as high for Māori as for non-Māori men, leukaemias 4.2 times as high, while the prostate cancer rate was 29% lower.
- Cancer mortality was twice as high for Māori women, and 37% higher for Māori men compared to non-Māori.
- Lung, breast, colorectal and stomach cancers were the most frequent causes of death from cancer among Māori women. Lung cancer mortality was nearly 4 times as high for Māori as for non-Māori women, breast cancer mortality 85% higher, and stomach cancer mortality notably 11 times the non-Māori rate.
- Cancers of the lung, digestive organs, and prostate were the leading causes of cancer death among Māori men, with lung cancer mortality twice as high for Māori as for non-Māori.

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).
- Asthma hospitalisation rates were higher for Māori than non-Māori in each age group.
- Māori under 75 years had 3.6 times the non-Māori rate of death from respiratory disease during 2007–2011.

Mental disorders

- Māori were twice as likely as non-Māori to be admitted to hospital for a mental disorder during 2011–2013.
- Schizophrenia type disorders was the most common category of disorders, followed by substance use disorders.

Gout

- In 2011 the prevalence of gout among Capital and Coast Māori was estimated to be 5%, which was 1.9 times the rate for non-Māori.
- Forty percent of Māori with gout regularly received allopurinol, a preventive therapy to lower urate levels. Of those who received allopurinol, only a third had a lab test for serum urate levels in the following six months. These rates were similar to non-Māori. However, in 2011–2013 the rate of hospitalisations for gout was 3 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 20% higher for Māori than for non-Māori during 2011–2013.
- More than 1,500 Māori hospital admissions per year were potentially avoidable, with the rate 35% higher for Māori than for non-Māori. The ASH rate was 55% 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 Capital and Coast Māori was 1.8 times the non-Māori rate in 2008–2012.
- Leading causes of death for Māori females were ischaemic heart disease (IHD), lung cancer, COPD, breast cancer and stroke. Leading causes of death for Māori males were IHD, accidents, diabetes, lung cancer, and COPD.
- Rates of potentially avoidable mortality and mortality amenable to health care were 2.4 times as high for Māori as for non-Māori in Capital and Coast during 2007–2011.

Injuries

- The rate of hospitalisation for injury was 19% higher for Māori than for non-Māori during 2011–2013. Males had a higher rate than females.
- The leading causes of injury resulting in a hospital admission were falls, exposure to mechanical forces complications of medical and surgical care, assault, and intentional self-harm.
- The rate of hospitalisation due to assault was 2.8 times as high for Māori males as for non-Māori males and 6.2 times as high for Māori females compared to non-Māori females.
- Injury mortality was 62% higher for Māori than for non-Māori in Capital and Coast.

Ambulatory Sensitive Hospitalisations (ASH)[2]

For Capital & Coast DHB, ASH rates for children 0-4 years of age are lower than the national ASH rates for children. Similarly, 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 Capital & Coast DHB have decreased by 4% compared to a national increase in ASH rates of 3%. For Capital & Coast DHB, the ASH rate for adults has increased by 14% 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 Capital & Coast DHB, compared to Other and Pacific children and adults. Māori children are more likely to be admitted for an ASH condition than Other children, although less likely than Pacific children. For the year ending September 2015, Māori children were 1.5 times more likely to be admitted for an ASH condition compared to Other children. Māori adults are significantly more likely to be admitted for an ASH condition compared to Other adults.

For Capital & Coast DHB, some ASH conditions are of particular concern for Māori children and Māori adults:

Māori children (0-4 years)

1. *Dental conditions*
   In the year up to September 2015, dental conditions were the leading cause of ASH admissions amongst Māori children. These admissions account for a quarter of all ASH admissions for Māori children. Over the last five years, ASH admissions for dental conditions amongst Māori children increased by 49%. There was a steady increase in admissions from 2011 to 2014, although a decrease of 8% between the years ending September 2014 and 2015.

2. *Upper respiratory & ENT infections*
   For Capital & Coast DHB, upper respiratory & ENT infections were the second greatest cause of ASH admissions amongst Māori children in the year ending September 2015. During this period, 48 Māori children were admitted with for upper respiratory & ENT infections. These admissions account for 22% of total Māori children ASH admissions. ASH admissions for upper respiratory and ENT infections for Māori children have increased by 41% in the last five years.

3. *Asthma – wheeze*
   Asthma (wheeze) was the third leading cause of ASH admissions amongst Māori children in the Capital & Coast DHB area. In the year up to September 2015, 56 Māori children were admitted for this condition, equivalent to one-fifth of all ASH admissions amongst Māori children. ASH admissions for asthma amongst Māori children have increased by 60% between the year ending September 2011 and 2015. ASH admissions have also decreased by 37% between the years ending September 2014 and 2015.

Māori adults (45-64 years)

1. *Angina and chest pains*
   In the year up to September 2015, angina and chest pains were the leading cause of ASH admissions amongst Māori adults. In this year, 57 Māori adults were admitted for angina and chest pains, which represent a quarter of all Māori adult admissions. On average, 76 Māori adults are admitted each year for these conditions, although the number of admissions has decreased by 10% between the years ending September 2011 and 2015.

[2] MOH, January 2016, ASH SI1 Report to Q3 September 2015.

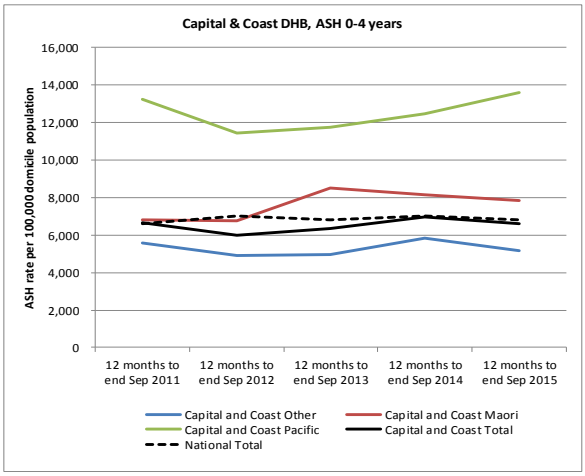
2. *Cellulitis*
Cellulitis was the second greatest cause of ASH admissions in the year ending September 2015. Thirty-four Māori adults were admitted for cellulitis during this period which accounted for 15% of Māori adult ASH admissions. On average, 29 Māori adults have been admitted each year for over the last five years for cellulitis. ASH admissions for cellulitis for Māori adults have increased by 100% from 2011.

3. *COPD*
For Capital & Coast DHB, COPD was the third leading cause of ASH admissions amongst Māori adults. In the year ending September 2015, 31 Māori adults were admitted for COPD, which is equal to 14% of total Māori adult ASH admissions. COPD admissions for Māori adults have increased by 15% between the years ending September 2012 and 2015. Although, ASH admissions for COPD for Māori adults also decreased by 16% between 2014 and 2015.

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

Rank	Capital & Coast	
1	Dental conditions	25%
2	Respiratory infections - upper and ENT	22%
3	Asthma - wheeze	20%
4	Gastroenteritis/dehydration	11%
5	Cellulitis/Asthma	6%

Capital & Coast ASH rates by ethnicity, 0-4 yrs (ASH Report to Q3 2014/15)

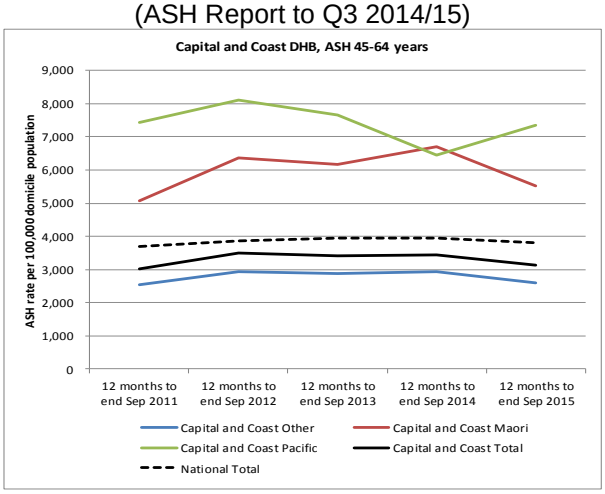


ASH rates for all children 0-4 years of age in Capital & Coast are below the national ASH rate. The ASH rate for Other children has been consistently below the national rate over the five year period from September 2011 to September 2015. The ASH rate for Māori children is currently greater than the national average and Other children in the Capital & Coast DHB area. The ASH rate for Māori children has increased by 15% in the last five years. Although, has decreased by 8% between 2013 and 2015. In Capital & Coast, Māori children had an ASH rate 1.5 times greater than Other children, and 1.7 lower than Pacific children.

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

Rank	Capital & Coast	
1	Angina & chest pains	25%
2	Cellulitis	15%
3	Respiratory infections - COPD	14%
4	Epilepsy	13%
5	Respiratory infections - pneumonia	11%

Capital & Coast ASH rates by ethnicity, 45-64 yrs (ASH Report to Q3 2014/15)



ASH rates for adults 45-64 years of age in Capital & Coast are below the national average; this is also true for Other adults. ASH rates for adults in Capital & Coast have increased by 4% compared to an increase of 3% in the national ASH rate for adults. The ASH rate for Māori adults is significantly higher than Other adults. ASH rates for Māori adults have increased by 9% between the years ending September 2011 and 2015. Although, have also decreased by 18% between 2014 and 2015. The ASH rate for Māori adults is 2.1 times greater than Other adults.

Amenable Mortality[3]

There were 94 Māori deaths per year on average in Capital and Coast from 2008 to 2012. The Māori mortality rate was almost twice the non-Māori rate, or 142 more deaths per 100,000.

Leading causes of death for Māori, all ages, Capital and Coast DHB, 2007–2011

	Māori	**Non-Māori**		
Gender and cause	Age-standardised rate per 100,000 (95% CI)	Age-standardised rate per 100,000 (95% CI)	Māori/non-Māori ratio (95% CI)	Rate difference
Female				
IHD	35.7	14.4	**2.48**	21.3
Lung cancer	30.9	8.0	**3.85**	22.9
COPD	19.5	4.3	**4.51**	15.2
Breast cancer	17.6	9.5	**1.85**	8.1
Stroke	13.5	9.1	**1.47**	4.3
Male				
IHD	73.0	33.5	**2.18**	39.5
Accidents	24.5	12.2	**2.01**	12.3
Diabetes	22.5	5.3	**4.26**	17.2
Lung cancer	18.9	9.3	**2.03**	9.6
COPD	19.6	6.3	**3.09**	13.3
Total				

[3] Robson B, Purdie G, Simmonds S, Waa A, Faulkner R, Rameka R. 2015, Andrewes J. *Capital and Coast District Health Board Māori Health Profile 2015.* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

IHD	54.4	24.0	**2.27**	30.4
Lung cancer	24.9	8.7	**2.87**	16.2
COPD	19.5	5.3	**3.67**	14.2
Accidents	15.5	9.5	**1.64**	6.1
Diabetes	14.9	4.2	**3.55**	10.7

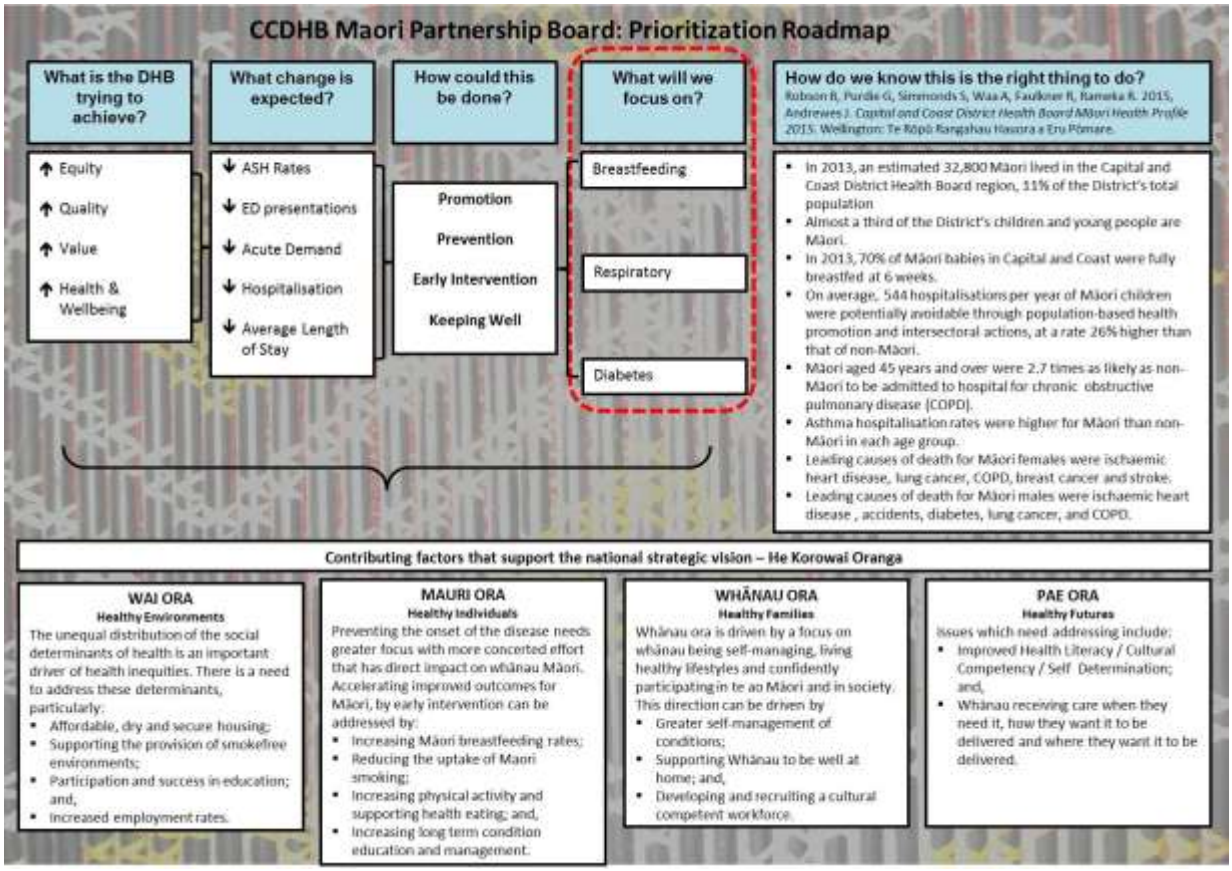
Māori Partnership Board Prioritisation

Planning workshops have been held with the CCDHB Māori Partnership Board in October 2015, December 2015 and March 2016. Discussions resulted in paring down the MPB priorities, from seven to three. Although there is a reduced local prioritisation, The CCDHB Māori Partnership Board will continue to monitor performance of the national indicators within this plan. The three key priorities are as follows:

- Breastfeeding
- Respiratory
- Diabetes

A roadmap has been developed to support the determination of the reduced number of priorities and identify how these priorities can:

- Support accelerated improvement and impact in Māori Health outcome; and,
- Support CCDHBs direction, in the current environment.



Health Service Provision

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.

Regional Screening Services

The National Screening Unit provides funding for subregional screening services, via Hutt Valley District Health Board. Services include:

- National BSA programme – BreastScreen Central
    - Service provision of all aspects of BSA screening programme
- Cervical Screening
    - Colposcopy services
    - NSCP Regional Coordination
    - NSCP Recruitment and Retention
    - NSCP Register services
    - Cervical Smears for Priority Group Women

Regional Screening Services contract Mana Wahine Incorporated to assist in recruitment, delivery, follow up and support to screening for Breast and Cervical. Across the sub region there are six member providers to Mana Wahine.

Hospital Based Services

CCDHB directly provides a complex mix of secondary and tertiary services via its Hospital and Health Services (HHS) provider arm which is located across the main regional hospital site in Newtown, the Kenepuru Community Hospital and Mental Health Services site in Porirua, and the Kapiti Health Centre in Paraparaumu.

Community Based Services

CCDHB 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.

PHO

CCDHB provides funding to four PHOs across the three territorial authorities comprising of:

- Compass Health 53 practices
- Cosine PHO 1 practices
- Ora Toa PHO 4 practices
- Well Health PHO 3 practices

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

NATIONAL INDICATORS

Indicator 1: Ethnicity Data Quality

Accuracy of ethnicity reporting in PHO registers

Outcome Sought	Greater accuracy of ethnicity data in PHO enrolment databases.
Measures	Ethnicity data accuracy will increase as measured through implementation of the General Practice self-auditing. At the time of patient enrolment / re-enrolment, General Practice administration requires patients to confirm / re-confirm their ethnicity. Any anomalies are investigated to ensure accurate ethnicity recording. On a regular basis, and where opportunities arise, General Practices check all patient records to ensure ethnicity has been coded correctly and accurately.
Current Status	

Ethnicity	Current Baseline	Target	Variance to Target
Māori	85%	100%	15%
Other	94%	100%	6%

Planned Actions	Owner	Timeframe
Develop and promote an information sheet to ensure the importance of ethnicity data recording remains a focus within primary care	DHB PHO	Q1
DHB to work with PHOs to produce an ethnicity data quality guide for PHOs to support ethnicity data collection training	DHB PHOs	Q1-4
DHB to support one PHO to provide ethnicity data collection training to 90% of their general practices	DHB PHOs	Q1
DHB to support PHOs to ensure that 100% of practices are using enrolment forms that are aligned with the Ethnicity Data Collection Protocols.	DHB PHOs	Q2-3
DHB to support all PHOs to set up systems for all new practice staff (and, where relevant, new practices coming into their PHO) to be provided with training on the Ethnicity Data Protocols, the importance / relevance of ethnicity data, accuracy in recording ethnicity and tips on how to ask patients about their ethnicity.	DHB PHOs	Q1-4
DHB to support all PHOs to conduct an annual query on each of their practices' Patient Management System to find the number of 54 and 61 'Other' codes (often used when the patient's ethnicity is unknown). PHOs will work with each practice to follow up with patients to ask about and update their records with accurate ethnicity details.	DHB PHOs	Q2-3
Report at the end of quarter one an update on DHB activity in Data Quality.	DHB	Q1
Monitor and report PHO Enrolment indicator performance by	DHB	Q1-4

ethnicity including improvement in accuracy and enrolment gaps on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards		

Indicator 2: Access to Care

Percentage of Māori enrolled in PHOs

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

Ethnicity	Current Baseline	Target	Variance to Target
Māori	85%	100%	15%
Other	94%	100%	6%

Planned Actions	Owner	Timeframe
DHB and PHOs review, compare and monitor Māori enrolment data on a quarterly basis	DHB	Q1-4
Work with Māori community health services providers to raise awareness of the importance and benefits of enrolment with a PHO	DHB	Q1
Work with PHOs and other health services to share enrolment data for the purpose of identifying those not enrolled in primary care and offering enrolment.	PHO DHB	Q1-2
Monitor the enrolment of Māori children at birth process into a general practice.	DHB	Q1-4
Implement a follow up process for Māori children not enrolled on leaving hospital.	DHB PHO	Q1-4
Use community events (such as Creekfest) to promote and encourage PHO enrolment by Māori	PHO	Q3-4
Track PHO enrolment, by Ethnicity, Age Band and Gender, on a quarterly basis	DHB	Quarterly
Monitor and report indicator performance by ethnicity on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

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

<table>
<tr><td>Outcome Sought</td><td>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.

Capital & Coast DHB has a slightly lower ASH rate to the National rate, however a gap still exists. ASH rates for 0-4 years will be a priority.</td></tr>
<tr><td>Measures</td><td>DHB-specific based on current equity gap for Māori.

Reduction of equity gap by minimum 50% with an expectation of equitable rates for Māori within 5 years.

Note: Targets to be confirmed/worked through with each DHB before March 2016.</td></tr>
<tr><td>Current Status</td><td>
<table>
<tr><th></th><th>Ethnicity</th><th>Current Baseline Non-standardised ASH Rate</th><th>Target</th><th>Māori rate relative to National Total rate as at March 2016</th></tr>
<tr><td rowspan="4">0-4</td><td>Other</td><td>5,329</td><td rowspan="4">≤7128</td><td></td></tr>
<tr><td>Māori</td><td>7,444</td><td>9.7%</td></tr>
<tr><td>Pacific</td><td>13,186</td><td></td></tr>
<tr><td>Total</td><td>6,594</td><td></td></tr>
</table>
<table>
<tr><th></th><th>Ethnicity</th><th>Current Baseline Standardised ASH Rate</th><th>Target</th><th>Māori rate relative to National Total rate as at March 2016</th></tr>
<tr><td rowspan="4">45-64</td><td>Other</td><td>2,478</td><td rowspan="4">≤4655</td><td></td></tr>
<tr><td>Māori</td><td>5,750</td><td>61.5%</td></tr>
<tr><td>Pacific</td><td>7,607</td><td></td></tr>
<tr><td>Total</td><td>3,042</td><td></td></tr>
</table>
</td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
General Hold a Māori focus symposium to highlight the top ASH conditions for children 0-4 years old and adults 45-64 years old to identify actions for 2017 / 18 implementation.	ICC Long Term Conditions Group DHB	Q3
Hold three workshops, one each in Wellington, Porirua and Kapiti, to develop joint community and hospital approaches to reduce the top two ASH admission conditions for Māori in each location.	ICC Long Term Conditions Group DHB	Q1-2

RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Maori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness.	RPH	Q1-4
Children Increase newborn enrolment rates with PHOs, general practice and Well Child Tamariki Ora – refer Indicator 2	DHB	Q1-4
Improve enrolment with and access to oral health services for Māori tamariki – refer Indicator 9	Bee Healthy	Q1-4
Monitor 0-4 year olds enrolment in the free dental services. Repeat the enrolment data sharing between the Bee Healthy Dental Service and primary care to ensure full capture of Māori children eligible for enrolment.	Bee Healthy Dental Service PHOs	Quarterly
Promote 'hand hygiene' health messaging across health events and within Kohanga Reo, early childhood centres and primary schools	RPH PHOs WCTO	Q1-4
Promote 'skin care' health promotion messaging across health events and within Kohanga Reo, early childhood centres and primary schools	RPH PHOs WCTO	Q1-4
Improve the care of children from Porirua presenting to the hospital with respiratory conditions through improved referral process between the hospital and primary care services [linkage with Service Integration, CCDHB Annual Plan]		
- Establish referral process between ED and the Porirua Asthma Service	DHB Porirua Asthma Service	Q1
- Linkage with the Porirua Social Sector Trial to establish a communication approach for the families of children who are presenting to the hospital with respiratory	DHB PSST	Q1-2
Establish a communication approach for the families of children who are presenting to the hospital with respiratory conditions	PSST	Q3
Implement a Skin and Respiratory project with a focus on reducing acute readmissions to hospital	DHB	Q2
Expand the childhood skin and respiratory project, which provides targeted follow-up for children admitted to hospital with respiratory or skin infections, to all general practices	DHB	Q3
Adults Undertake action research in the Emergency Department to: – Identify / understand reasons for Māori attending ED – Develop recommendations for action – Work with services to implement actions	DHB PHO	Q1-2
Reduce smoking prevalence and smoking related-harm with a particular focus on pregnant Māori women – refer Indicator 6	PHO	Q1-2

Monthly monitoring of the IPIF framework, with a focus on Diabetes and CVDRA performance for Māori (Refer – Local Priorities: Cardiovascular disease)	DHB	Monthly
Provision of Point of Care Testing (POCT) equipment to a practice with limited laboratory access for patients (Refer – Local Priorities: Cardiovascular disease)	Compass Health	Q1
Health Care Home – Primary Care Practice Development [linkage with Service Integration, CCDHB Annual Plan] The transformation of primary health care practices to Health Care Homes (HCH) is a key element to driving better proactive, planned and acute care in the community. There is a higher proportion of Maori and Pacific in the Tranche 1 primary care practices, in comparison to the overall population of CCDHB. The selection process for further HCH is yet to be determined but		
HCH progress continues as follows: - Tranche 1 HCH Practice: ▪ On-going support through HCH Steering Group & Acute Demand Steering Group.	DHB	Q1
- Tranche 2 HCH Practice Development: ▪ Selection process established with endorsement from the ALT and ELT ▪ Selection process completed ▪ Practice change and development support	DHB DHB DHB	Q1 Q2 Q3
- Tranche 2 HCH launch	DHB	Q3
- Tranche 3 HCH Practice Development: ▪ Selection process established and completed ▪ Practice change and development support initiated.	DHB DHB	Q3 Q3-4
Monitor and report indicator performance by ethnicity on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

Indicator 3: Child Health

Breastfeeding

- **Exclusive or fully breastfed at LMC discharge (4-6 weeks)**
- **Exclusive or fully breastfed at 3 months**
- **Receiving breastmilk 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 breastmilk at 6 months
Current Status	Data for this indicator has been sourced from the Indicators for the Well Child/Tamariki Ora Quality Improvement Framework – September 2015[4]. The current baseline is as at 01 March 2016

Breastfeeding: Exclusive or Fully breastfed at LMC discharge			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	66%	75%	9%
Pacific	59%	75%	16%
Total	68%	75%	7%
Breastfeeding: Exclusive or Fully breastfed at 3 months			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	49%	60%	26%
Pacific	45%	60%	30%
Total	63%	60%	12%
Breastfeeding: Exclusive, Fully or Partially breastfed at 6 months			
Ethnicity	Current Baseline	Target	Variance to Target
Māori	57%	65%	18%
Pacific	60%	65%	15%
Total	72%	65%	3%

Planned Actions	**Owner**	**Timeframe**
Universal Activities CCDHB will continue to fund / support WCTO providers to deliver the Well Child schedule with a particular focus on improving Māori breastfeeding rates. Each WCTO provider is directly aligned to a PHO. They will support PHOs to implement initiatives aimed at promoting / raising the awareness of breastfeeding.	DHB	Q1-4
Maintain BFHI accreditation.	DHB	Q2
Targeted Activities Fund a Community Lactation position targeted specifically at increasing Māori breastfeeding rates. This service will provide breastfeeding support, targeting Māori and other high needs populations. The aim is to increase breastfeeding rates, particularly among Māori, by providing an accessible drop in centre, and follow up services in the community. This service will be monitored internally on a quarterly basis.	DHB	Q1-4
Review and strengthen breastfeeding support for Māori women in the DHB facilities to ensure seamless continuity of breastfeeding support from birthing facility into the community	DHB	Q1-2
In partnership with LMC, WCTO providers and other key stakeholders develop a joint Breastfeeding Action Plan to improve breastfeeding rates in Capital & Coast DHB with a focus on Māori	DHB WCTO PHO	

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

mothers and whanau • Joint workshop to discuss and develop draft plan • Finalise plan • Implement plan		 Q1 Q2 Q3-4
Implement a procurement process for antenatal and early parenting education. The programme will be required to include a core focus on actively supporting breastfeeding, safe sleep practice and smoke free health literacy. (Refer Indicator 11)	DHB	Q1-3
Implement the 'Health 4 Life' programme	Compass Health PHO	Q1-2
Implement workforce development for workers within Child Health, such as Early Child Education, Health, NGOs, for early engagement with pregnant Māori mums to promote breastfeeding and smokefree.	PHO WCTO Providers DHB	Q1-2
The DHB will liaise with and have representation at the local Breastfeeding Networks to discuss and identify key areas to improve Māori breastfeeding rates.	DHB	Q1-4
Implement a Request for Proposal for the provision of Green Prescription. This will include the new Maternal Green Prescription (MGRx) and Pre School Active Families (PSAF) programmes. The new Maternal Green Prescription (MGRx) encompasses suite of interventions projected across the continuum of preconception, maternity, and early childhood, based on the above priorities that will: • Promote healthy gestational weight gain • Improve full and exclusive breastfeeding rates • Support mothers post-natally to achieve and maintain healthy lifestyle choices • Encourage timely and appropriate introduction of solids Maternal Green Prescription (MGRx) looks to target women of childbearing age and their children with particular reference to: • Pregnant woman diagnosed with pre-diabetes (HbA1c 41-19) as identified through the first antenatal bloods • Pregnant women at risk of pre-diabetes • Maori and Pacific • Young Mothers <24 years • Body Mass Index >30	DHB	Q1-2
Monitor and report indicator performance by ethnicity on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

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.

<table>
<tr><td>Outcome Sought</td><td>Lower cervical cancer morbidity and mortality among Māori women through better utilisation of the national cervical screening programme for women aged 25-69 years</td></tr>
<tr><td>Measures</td><td>Cervical screening rates for Māori women will have reached the national target of 80%.</td></tr>
<tr><td>Current Status</td><td>NCSP coverage (%) in the three years ending 31 March 2016 by ethnicity, women aged 25–69 years
<table>
<tr><th>Ethnicity</th><th>Current Baseline</th><th>Target</th><th>Variance to Target</th></tr>
<tr><td>Māori</td><td>63.1%</td><td>80%</td><td>16.9% (1,305 to target)</td></tr>
<tr><td>Total</td><td>87.3%</td><td>80%</td><td>-7.3%</td></tr>
</table></td></tr>
</table>

Planned Actions	**Owner**	**Timeframe**
Engage with primary care through the Regional Screening Coordination Group to identify women who currently don't get screened. Target promotion of screening services to these women	RSS	Q1-2
Evaluate the effectiveness of Regional Screening Services support to primary care	RSS	Q1
Ensure that Māori and Pacific women are referred to other providers e.g. Mana Wahine and Pacific Health Service for support.	RSS PHO	Q1-4
Implement a joint approach with Mana Wahine / PHOs / NGOs to increase Māori screening rates.	RSS DHB	Q1-2
Implement a Cervical Screening incentive trial programme targeting Māori.	Compass Health	Q1-2
Promote cervical screening at a minimum of four community events where priority women gather	RSS	Q1-4
Provide staff to undertake active follow up and support of colposcopy services for priority women	RSS	Q1-4
Support Primary Care through assistance with - Use the PHO Cervical Screening Data Match Report to work intensively with a minimum of 4 general practices to improve coverage in Maori women - Provide staff to undertake follow up and recall of priority women	RSS RSS	Q1-4 Q1-4
Support Primary Care and other relevant providers through providing - Annual colposcopy training - Two education evenings - Quarterly smear taker workshops	 RSS RSS RSS	 Q4 6 monthly Q1-4
Provide quarterly priority women breast and cervical screening	RSS	Q1,2,3,4

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

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

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

Ethnicity	Current Baseline	Target	Variance to Target
Māori	63.9%	70%	6.1%
Total	70.5%	70%	-0.5%

Planned Actions	**Owner**	**Timeframe**
Promote breast screening at a minimum of four community events where priority women gather	RSS	Q1-4
Provide staff to undertake active follow up and support of breast screening services for priority women - Well Women - Assessment and Symptomatic services	RSS	Q1-4
Support Primary Care through assistance with - Data matching with a minimum of four GP practices - Provide staff to undertake follow up and recall of priority women	 RSS RSS	 Q1-4 Q1-4
Provide quarterly priority women breast and cervical screening days	RSS	Q1,2,3,4
Engage with primary care through the Regional Screening	RSS	Ongoing

Coordination Group to identify women who currently don't get screened. Target promotion of Breast Screening services to these women		
Re-set the mobile unit roster to locations closer to high needs communities to reach women who currently don't get screened through: - Data matching the specific area to identify women not enrolled to BSA - Invite unscreened and screened women to access the mobile unit - Provide community promotion of the mobile service in collaboration with Primary Care	RSS PHOs	Q1 Ongoing Assessed[5]
CCDHB will support collaborative working relationships between providers across breast screening pathway: - attend Regional Coordination Group meetings twice a year, or as required. - work with Mana Wahine, Regional Screening Services and Primary Care to ensure a smooth referral process to access Support to Services for BSA priority women.	DHB RSS	Q1-4
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

Indicator 5: Smoking

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

Outcome Sought	The percentage of Māori women who were pregnant and were offered smoking cessation advice and support and who are smokefree at two weeks postnatal will increase over 2015/16 as a result of our efforts.		
Measures	95% of pregnant Māori women who are smokefree at two weeks postnatal.		
Current Status	Baseline to be determined		
Planned Actions		**Owner**	**Timeframe**
Implement workforce development for workers within Child Health, such as Early Child Education, Health, NGOs, for early engagement with pregnant Māori women to promote breastfeeding and smokefree.		PHO	Q1-2
Develop and implement a 'priority referral' process for pregnant Māori women to access smoking cessation services early.		PHO	Q1
Monitoring and analysis of Māori, Pacific and pregnant women referrals and service uptake, to ensure that there is no disparity of care, and to inform service planning for priority populations.		DHB	Q2 Q4
Enhance current Smokefree policy and contractual obligations for		DHB	Q1-4

[5] The location of the Mobile Unit will be assessed ongoing to ensure it is placed in the best location for access by target group women.

service providers to provide effective cessation support to smokers.		
Update and improve ABC data collection processes and systems to capture advice and support being offered to identified smokers	DHB Providers	Q1-4
Review, update and promote referral pathways to quit smoking services	DHB Providers	Q1-4
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

Indicator 6: Immunisation

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

<table>
<tr><td>Outcome Sought</td><td colspan="2">Reduced immunisation-preventable morbidity and mortality.</td></tr>
<tr><td>Measures</td><td colspan="2">95% of infants fully immunised by eight months of age</td></tr>
<tr><td>Current Status</td><td colspan="2"><table>
<tr><th>Ethnicity</th><th>Current Baseline</th><th>Target</th><th>Variance to Target</th></tr>
<tr><td>Māori</td><td>91.4</td><td>95%</td><td>3.6%</td></tr>
<tr><td>Other</td><td>95.1</td><td>95%</td><td>-0.1%</td></tr>
</table></td></tr>
<tr><td>Planned Actions</td><td>Owner</td><td>Timeframe</td></tr>
<tr><td>Maintain the Immunisation Governance Group that is responsible for monitoring and maintaining actions across the sub-region to continue to deliver on the national Health Target</td><td>DHB
PHO
Outreach Imms</td><td>Q1-4</td></tr>
<tr><td>Deliver immunisation programmes including a focus on education, training, delivery, data collection and promotion of immunisation in the community</td><td>PHO
Outreach Imms</td><td>Q1-4</td></tr>
<tr><td>Support health professionals and community agencies to provide positive immunisation messages.</td><td>DHB</td><td>Q1-4</td></tr>
<tr><td>Work with WCTO providers / Outreach Immunisation / PHOs / NIR to collaboratively:
- Increase immunisation rates at Core 1 check by:
▪ Monitoring the immunisation status of Māori babies
▪ Identifying Māori babies requiring immunisation
▪ Providing options to whānau for immunisation delivery
- Identify and visit ‘Overdue’ immunisation status babies for follow up prior to Core 2 check
- Provide ‘mop up’ immunisation services</td><td>WCTO
Outreach Immunisation
PHO
NIR
DHB</td><td>Q1-4</td></tr>
<tr><td>Work with WCTO providers / Outreach Immunisation / PHOs / NIR to undertake a mapping exercise to identify gaps in service delivery to address the decrease in 8 month immunisation rates for Māori</td><td>DHB
WCTO
Outreach Imms
PHO
NIR</td><td>Q1-2</td></tr>
</table>

Develop and implement Information / Data Sharing pathways for NIR and Immunisation providers	DHB NIR WCTO Outreach Immunisation	Q1-2
Implement a planned approach to target Māori via the Information / Data Sharing pathways	DHB NIR WCTO Outreach Imms	Q3-4
Monitor immunisation performance on a monthly basis within SIDU	DHB	Q1-4
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	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	61%	75%	14%
Other	65%	75%	10%

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
Deliver 6 Influenza training modules to: - PHOs - NGOs - Pharmacists	PHO	Q1-4
Develop and implement a home based Influenza programme for High Need clients who are home bound	PHO	Q2
Engage with key Māori organisations, such as Māori Womens Welfare League, Kohanga Reo, Whānau Care Services, by providing immunisation education information	PHO DHB	Q1-2
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	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 2015 a sub-regional Rheumatic Fever Prevention Plan (RFPP) was revised with the aim to reduce the incidence of Rheumatic Fever through a programme of work focussed on prevention, treatment, and follow-up. The plan has been updated to reflect:
The decline in rates of rheumatic fever across the 3 DHBs
A reduced funding package from the Ministry of Health from 2016
Preliminary findings of the national evaluation of school-based throat swabbing and rapid response sore throat management programmes.
Capital & Coast District Health Board, 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 (3year 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, Hutt Valley, and Capital & Coast DHBs:<table><tr><th rowspan="2">DHB</th><th>2009/10-2011/12</th><th rowspan="2">2015 actual</th><th>2016/17</th></tr><tr><th>Baseline (3-year average rate)</th><th>Target 2/3 reduction from baseline</th></tr><tr><td>Wairarapa</td><td>0.0</td><td><4 events</td><td>0.0</td></tr><tr><td>Hutt Valley</td><td>4.9</td><td>2.8</td><td>1.6</td></tr><tr><td>Capital& Coast</td><td>3.1</td><td><4 events</td><td>1.0</td></tr></table>Data from MOH at http://www.health.govt.nz/about-ministry/what-we-do/strategic-direction/better-public-services/progress-better-public-services-rheumatic-fever-target</td></tr>
</table>

Planned Actions	Owner	Timeframe

Sub-regional actions
• Additional ways to ensure rapid access and effective treatment of sore throats for all high risk populations, including strengthening rapid response services:
  ○ Ensuring access to free sore throat swabbing, assessment and treatment for symptomatic children and youth, including:
  ▪ Supporting primary care, outreach workers and the school public health nurse workforce to work at the top of their scope by developing and encouraging wider use of standing orders for management of sore throats.
  ○ Ensuring that community outreach and primary care
	Primary Care
	RPH
	PHOs
	SIDU
	ICC
	clinical development pathway group
	CCDHB
		Q1-4

providers in areas with high rates of rheumatic fever continue to be aware of and implement best practice for management of sore throats ○ Maintaining best practice clinical pathways for rheumatic fever, from early diagnosis to discharge from Bicillin Prophylaxis ○ Building on existing successful models of primary care / public health / secondary care / Social Sector Trial integration e.g. Porirua Kids Project. • Maintaining focus on ensuring Healthy Homes coordination and initiatives are supported and working well across the sub-region • Community awareness-raising and active promotion of primary and community based services • Sore throat management services that actively promote antibiotic adherence • Flexibility within the sub-regional plan to make changes to programme implementation should new evidence come to light. **Local actions** • Strengthened model for effective assessment of sore throats (rapid response) across Porirua • Six month post-cessation review of the sore throat programme in schools review to see if there were any impacts of not continuing with the school programme		
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report)	DHB	Q1-4

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 by December 2016			
Current Status	**Ethnicity**	**Current Baseline (2015 Baseline to be added)**	**Target**	**Variance to Target**
	Māori	27%	95%	68%
	Pacific	34%	95%	61%
	Other	43%	95%	52%
Planned Actions			**Owner**	**Timeframe**
Use the balance scorecard to ensure all enrolled children older than 2 years have a dental examination			Bee Healthy	Q1-4

Implement the recommendations from the 2015 Data-match project plan	Bee Healthy
Engage with private dentists (who participate in the Combined Dental Agreement) to identify and reach adolescents who currently don't get annual examinations	Bee Healthy
Increase preschool enrolment rates and access to services, particularly amongst Maori and Pacific children	Bee Healthy
Participate in the Oral Health forum focussed on Porirua	DHB
Monitor 0-4 year olds enrolment in the free dental services. Repeat the enrolment data sharing between the Bee Healthy Dental Service and primary care to ensure full capture of children eligible for enrolment.	Bee Healthy Dental Service PHOs
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB

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**[6]
Māori	568
Non-Māori	167

Planned Actions	**Owner**	**Timeframe**
Support the targeting of Primary Mental Health Services to Maori communities, especially Maori young people 10-24 years	PHOs DHB	Q1-2
Develop and implement packages of care for Māori Mental Health with a focus on community early interventions, including Rongoa Maori	PHO DHB	Q2-4
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	DHB	Q1-4

[6] Rate per 100,000

Health Act, to support Māori to receive non-compulsory treatment.		
Continue to monitor and develop (where necessary) solutions for the reduction rate of Māori on the Mental Health Act: section 29 community treatment orders relative to other ethnicities	DHB	Q1-4
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

Indicator 10: SUDI

<table>
<tr><td>Outcome Sought</td><td>Reduced SUDI mortality of Māori children.</td></tr>
<tr><td>Measures</td><td>1. Most recent five year average annualised SUDI infant deaths by DHB region of domicile, Māori and total population
2. Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1</td></tr>
<tr><td>Targets</td><td>1. 0.4 SUDI deaths per 1000 Māori live births
2. 70% caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1</td></tr>
<tr><td>Baselines</td><td>Table 1: Five Year Annualised Average Rate of Sudden Unexpected Death in Infancy, Māori and non-Māori 2010-2014.
<table>
<tr><th colspan="3">Māori</th><th colspan="3">Non-Māori</th></tr>
<tr><th>Deaths</th><th>Rate</th><th>Confidence Interval</th><th>Deaths</th><th>Rate</th><th>Confidence Interval</th></tr>
<tr><td>9</td><td>2.35</td><td>1.08 - 4.47</td><td>3</td><td>0.2</td><td>0.04 - 0.58</td></tr>
</table>
Table 2: Caregivers provided with SUDI information at Well Child Tamariki Ora Core Contact 1, Māori and non-Māori, 2014.
<table>
<tr><th colspan="3">Māori</th><th colspan="3">Non-Māori</th></tr>
<tr><th>% of SUDI info provided at Core Contact 1</th><th>% of Core 1 but no SUDI info</th><th>% No Core 1 Contact by 49 days</th><th>% of SUDI info provided at Core Contact 1</th><th>% of Core 1 but no SUDI info</th><th>% No Core 1 Contact by 49 days</th></tr>
<tr><td>43.3%</td><td>23.1%</td><td>33.7%</td><td>61.0%</td><td>22.4%</td><td>16.6%</td></tr>
</table></td></tr>
<tr><td>Current Status</td><td>Previously CCDHB had not been considered as having a five year average Māori SUDI rates which are significantly above the national non-Māori SUDI rate for the same period.

Recent data shows that the confidence interval of CCDHBs five year Māori SUDI rate overlaps with the confidence intervals of the national non-Māori SUDI rate therefore the DHB is required to take additional actions for Māori, with the view to reduce preventable mortality.

To support improvement in SUDI rates, CCDHB look to HVDHB expertise to identify and implement best practice that will contribute to reducing the risk of SUDI, including breastfeeding, Māori antenatal</td></tr>
</table>

	education, tobacco cessation and access to maternity and well child services that support increased knowledge of safe infant care practices including safe sleep.

Planned Actions	**Owner**	**Timeframe**
Work with HVDHB to identify Best Practice models of early engagement with a focus on SUDI, particularly safe sleep practices	DHB	Q1
Implement a safe sleep action plan, informed from learnings from the Hutt Valley 2015/2016 Sudden Unexpected Death of an Infant (SUDI) plan	DHB	Q1-4
Implement the HVDHB 'Safe Sleep' pathway as a 3DHB initiative	DHB	Q1-4
Work with Well Child / Tamariki Ora providers to develop and implement safe sleep policies.	DHB	Q1
All Well Child / Tamariki Ora providers staff will undertake Whakawhetu SUDI Prevention training. LMC and PHOs will be strongly encourage to attend Whakawhetu training	WCTO DHB	Q2
All Well Child / Tamariki Ora provider staff, LMCs and PHO staff will be strongly encouraged to undertake / complete the Whakawhetu SUDI Online workshop and/ or the online workforce development tools available through Ministry of Health Learn Online Website.	WCTO DHB	Q2
Implement a procurement process for ante-natal and early parenting education.to ensure Health services provide accessible and appropriate antenatal and early parenting education to Māori women and whanau (which incorporates safe sleep practice, breastfeeding and smoke free health literacy).	DHB	Q2-4
Implement a: - Well Child / Tamariki Ora Quality Improvement Framework with a particular focus on early enrolment to Well Child / Tamariki Ora services - WCTO Monitoring dashboard which includes alerts for safe sleep environments and safe sleep discussions at all core contacts	DHB	Q1-4
CCDHB will monitor WCTO provider SUDI data reporting via KARO reporting	DHB	Q1,2,3,4
Conduct an audit of CCDHB 'Safe Sleep' policy and procedure	DHB	Q1
Implement audit recommendations with a focus on ensuring appropriate DHB staff are trained and using 'Safe Sleep' procedures.	DHB	Q2-4
Work with Whakawhetu to implement Whakawhetu SUDI Prevention training to a minimum of 10 DHB staff working with at risk infants in priority clinical settings.	DHB	Q2-3
Monitor and report indicator performance on a quarterly basis to: - CCDHB Māori Health Partnership Board - CPHAC (Equity report) - PHO Quality Boards	DHB	Q1-4

WHĀNAU ORA

Whānau (kuia, koroua , pakeke, rangatahi and tamariki) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively. He Korowai Oranga: the Māori Health Strategy asks the health and disability sectors to recognise the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms.

A Whānau Ora approach to health and social service delivery has been developing since 2010 in response to persistent disparities in well-being between Māori and non- Māori populations. Underpinned by Māori values, the whānau (family) centred approach seeks to achieve the goal of whānau ora (well-being of the extended family) and requires health services to work across traditional sector boundaries to improve client health.

Whānau Ora is a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development. It is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services. The programme of work is led by Te Puni Kōkiri to support whānau to build their capacity and capability, and empower whānau to determine their own aspirations and take control of their own futures. Three Whānau Ora Commissioning Agencies operate to purchase a range of whānau-centred initiatives at a local level.

CCDHB have made some positive gains for Māori, nonetheless, inequalities still exist. With a collective approach from across the health system, we are determined to make further progress. CCDHB will continue to support the capacity and capability growth Te Runanga O Toa Rangatira Inc. and, where appropriate, Taeaomanino Trust, as Whānau Ora Providers and by ensuring that the organisation is involved in strategic and planning discussions directed at the implementation of Whānau Ora.

Because Whānau Ora is a key cross-government work programme, CCDHB will also continue to support inter-agency relationships with Te Puni Kōkiri, the Ministry of Health, the Ministry of Social Development and Te Pou Matakana (North Island Commissioning Agency) and, where appropriate, Pasifika Futures, (Pacific Commissioning Agency) to ensure that Whānau Ora remains linked into the health services of CCDHB.

The DHB has a Māori Health Action Plan which provides more detail on areas of focus for the coming year.

Actions	Indicators of Success
Maintain key links with Māori bodies at local, regional and national forum where there is a focus on Whānau Ora.	Report learning / achievements of Māori / Māori health at local, regional, national and international levels.
The DHB is committed to engaging with local commissioning agencies, in particular Te Pou Matakana (North Island Commissioning Agency) and Pasifika Futures, to identify and implement opportunities in planning, service development and funding of joint programmes.	Invite all relevant commissioning agencies to a sub-regional joint hui/fono to discuss and agree the mechanism(s) and timing for on-going collaborative relationships between each of the Capital & Coast, Hutt Valley and Wairarapa DHBs and the relevant commissioning agencies (Q1) We will be represented at the July

	2017 Whānau Ora Conference for North Island Whānau Ora Partners. This will assist our three sub-regional DHB's to engage with Commissioning Agencies and to determine where our opportunities lie in the future for joint planning, funding and implementation Additional engagement with relevant Commissioning Agencies at least three times a year through the Tumu Whakarae forum to identify areas of collaboration in planning, joint funding and service development.
Where appropriate, engage with local commissioning agencies, in particular Te Pou Matakana (North Island Commissioning Agency) and Pasifika Futures to identify and implement opportunities in planning, service development and funding of joint programmes.	Initiate regular engagement with Te Pou Matakana and, where appropriate, Pasifika Futures (Q1) Work towards formalising collaboration with Te Pou Matakana and, where appropriate, Pasifika Futures (Q4) Ongoing engagement with government agencies (Q1-4)
Engage with local Whānau Ora providers to identify and implement planned areas of provider development with a particular focus on workforce initiatives to improve whānau health outcome and accessing Whānau Ora resources.	Continue to support Scholarship programmes and Hauora Māori opportunities to grow local Māori health workforce through tertiary study and training.
Maintain the Whānau Ora Integrated Care Collaborative[7] to identify health priorities across planning, services, and programme evaluation opportunities to accelerate improved Māori Health outcome.	A minimum of: - Four meetings per annum (Q4) - Two reports on Māori Health plan indicators. (Q1, Q3)
Work with Ministry of Health and Māori providers to identify one-off programme of work aligned to Whānau Ora	Identify MPDS[8] / MPCAT[9] opportunities and options (Q4)
Continue to participate in national processes to obtain a broader sector view on Whānau Ora implementation.	Support Te Runanga O Toa Rangatira Inc in the implementation of the Whānau Ora Information System as required (Q4)
Engage with local Whānau Ora collectives to ensure the priorities and actions identified within the CCDHB Māori Health Plan are aligned with the direction of Whānau Ora.	A minimum of four meetings per annum (Q1-4)
Engage with local Whānau Ora collectives and government agencies to identify and implement	A minimum of four meetings per annum (Q1-4)

[7] Whānau Ora Integrated Care Collaborative membership includes current Whānau Ora Collectives, CCDHB Māori Partnership Board members, PHOs and Māori Health providers. The purpose of this group is to best utilise the relatively small critical mass of Māori Health intelligence to provide advice and guidance to the CCDHB wide Integrated Care Collaborative in the planning, funding and hospital/community level services.
[8] Māori Provider Development Scheme
[9] Māori Provider Capacity Assessment Tool

shared health promotion initiatives. Initiatives will be aimed at supporting whānau to determine their health pathway with a focus on reducing the impact of long term conditions and improving child health.	Support at least 2 shared health promotion initiatives which promote whanau access to services and aim to promote wellbeing to address ASH (Q2, Q4)
Engage with PHOs to identify and implement shared health promotion initiatives focused on obesity – Implement a 'Better Health' challenge via Social Media with a focus on Māori lifestyle change – Design a Child Obesity programme with an emphasis on Māori world view delivery	Support at least 2 shared health promotion initiatives which promote whanau access to services and aim to promote wellbeing (Q2, Q4)
PHO to undertake Stanford Leadership training to deliver marae based Long Term Condition programmes	Support at least 2 participants (Q2, Q4)

Measures (Note: References align to CCDHB Annual Plan)

Minister's Health Target: Childhood Obesity (see Appendix 1):

- By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

3DHB Outcome 4: Children have a healthy start in life (see Appendix 1):

- An increase in the proportion of children caries free at five years.

3DHB Outcome 3: Lifestyle factors that affect health are well-managed (see Appendix 1)

- An increase in the proportion of mothers who are smokefree two weeks post-natal
- An increase in the proportion of dispensed asthma medications that were preventers rather than relievers.

Statement of Performance Expectations measures (see Module 3):

- The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit.

DHB Performance Measures (see Module 7):

- SI5: Delivery of Whānau Ora:
- PP11: Children caries-free at 5 years of age
- SI1: Ambulatory Sensitive Hospitalisations

Maori Health Plan National Indicators (see section 2B.2.2 Māori Health):

- Rate of Māori Mental Health Compulsory Assessment and Treatment Act: Section 29 community treatment orders relative to other ethnicities.
- Smoking cessation: Percentage of pregnant Māori women who are smoke free at two weeks postnatal.

LOCAL PRIORITIES

Māori Health Development

Outcome Sought	Improved Capacity and Capability of Māori Health services and provision	
Planned Actions	**Owner**	**Timeframe**
Implement planned developments of Māori providers (including Community Mental Health services) and / or programmes of work that support improved Māori Health addressing ASH and access to primary care	DHB	Q1-4
Referral Pathways Undertake a project to ensure that Māori who are discharged from hospital have appropriate referral pathways for services and supports	DHB PHO	Q4
Health Literacy - Support organisational initiatives to support workforce health literacy capacity - Explore integration of 'A.B.C' strategies into other programmes	DHB	Q1-4
DNA - Work with DNA Steering Group to improve data collection and systems and improve DNA capability - CCDHB Whānau Care Service continue to provide Outpatient Clinics Attendance support to reduce Māori DNA in priority areas	DHB DHB	Q2 Q1-4
Workforce - Increase the capacity and capability of the Māori Health Workforce at CCDHB so that the health workforce is reflective of the community we serve - Support DHB activity to recruit, develop and retain Māori health workforce - Support DHB activity to improve cultural competence	DHB	Q1-4
- Reviewing and embedding initiatives that profile health careers to secondary school students - Priority to KOH continue to supply Māori students into health careers profiling initiatives - Continue to support KOH as an effective component of Māori workforce development - Work with Directorates to ensure Māori workforce capacity is increased to better support the health needs and reflect the Māori population that we serve	DHB Youth2Work Porirua Education City Councils	Q1-4
- Work with priority directorates to ensure Māori new entry to practice are supported to support Māori workforce sustainability	DHB	Q1-4
Te Tohu Whakawaiora: Embed the Certificate in Health Care Capability Raising Capability to Accelerate Māori Health Gain - NZQA approved, will result in a National Certificate in Māori Management – Generic (workplace practices) Level 3	DHB	Q1-4

- Designed for non-Māori and Māori with minimal knowledge of Māori paradigms - Support engagement of DHB Boards, ELT and workforce to engage with training		

Respiratory 0-14yr

Support the Child Health Integrated Care Collaborative Respiratory project in Porirua	ICC Child Health	Q2
Improve the care of children from Porirua presenting to the hospital with respiratory conditions through improved referral process between the hospital and primary care services [linkage with Service Integration, CCDHB Annual Plan]		
- Establish referral process between ED and the Porirua Asthma Service	DHB Porirua Asthma Service	Q1
- Linkage with the Porirua Social Sector Trial to establish a communication approach for the families of children who are presenting to the hospital with respiratory	DHB PSST	Q1-2
Implement a Skin and Respiratory project with a focus on reducing acute readmissions to hospital	DHB	Q2
Expand the childhood skin and respiratory project, which provides targeted follow-up for children admitted to hospital with respiratory or skin infections, to all general practices	DHB	Q3
Establish a communication approach for the families of children who are presenting to the hospital with respiratory conditions	PSST	Q3
RPH will continue to strengthen the sub-regional healthy housing coordination service and interventions programmes, in partnership with the Tu Kotahi Maori Asthma Trust, the Sustainability Trust and He Kainga Oranga, to improve housing and health for our most vulnerable communities. This will reduce functional and structural overcrowding, and improve in home warmth and dryness.	RPH	Q1-4

Diabetes

The CCDHB Diabetes Clinical Network and Long Term Conditions Service Level Alliance will monitor the continued implementation of the diabetes care improvement plan, ensuring alignment with the priorities set out in Living Well with Diabetes.	CCDHB Diabetes Clinical Network	Q1-4
<u>Sub-regional Actions</u> • Retinal screening service agreements to be updated to incorporate revised guidelines due to be published in 2015/16 • Health Pathways for diabetes will be developed and implemented • Implement a Self-Management Support framework across the sub region.	CCDHB Diabetes Clinical Network	
<u>Local Actions</u>		

• Primary Health Organisations will start monitoring and reporting (Q3) to practices the number and profile of patients that have 'pre-diabetes', to encourage referral / provision of dietary and lifestyle advice
• The CCDHB Diabetes Clinical Network will:
  ○ Assess the services against four of the Quality Standards for Diabetes Care and recommend actions to address gaps
  ○ Assess the remaining 16 Quality Standards for Diabetes Care and recommend actions to address the gaps
  ○ Monitor key clinical indicators at general practice level and identify any improvement activities to improve clinical outcomes and reduce disparities.
• The diabetes nurse practice partnership and the case collaboration services will continue to improve the linkages between primary and secondary care.
• The CCDHB diabetes service will continue to:
  ○ Be the key providers for children and adults with type 1 diabetes
  ○ Provide Carbohydrate Counting (self-management courses for Type1 diabetes) as a pre-requisite for consideration to insulin pump therapy
  ○ Provide insulin pump courses for those children and adults approved for a PHARMAC funded insulin pump and consumables
  ○ Provide outsourced psychological services to people who are struggling to meet the demands of tight diabetes control.
	CCDHB Diabetes Clinical Network
	
	PHOs	

Cardiovascular disease

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	86.3%	90%	3.7%
Other	91.3%	90%	-1.3%

Planned Actions	Owner	Timeframe
Monitor CVRA practice via progress reports / graphs with identified numbers of CVRAs to be completed for the Practice teams to reach target via the provider portal	PHOs DHB	Quarterly
Monthly monitoring of the IPIF framework	DHB	Monthly
Disseminate common key messages and learnings from across Primary and Secondary Care around CVR assessment activities	DHB PHOs	Quarterly

One on one support to practice teams in need of additional clinical support	PHOs	Ongoing
Provision of Point of Care Testing (POCT) equipment to a practice with limited laboratory access for patients	Compass Health	Q1
Promote the use of the Provider Portal to enable practices to access supporting data and information that will help with targeting patients in need of CVRA. CVRA information to be shared across primary care.	Compass Health	Q1-4
Primary Health Organisations will continue their activities to achieve and maintain the 90% target, with a particular focus on reducing equity gaps and Māori men aged 35-44 years	PHOs	Ongoing