Wairarapa DHB

Māori Health Plan 2014/15

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Te Huarahi Oranga - Māori Health Plan

Wairarapa DHB is fully committed to maintaining, and further developing, our relationship agreement with Te Oranga O Te Iwi Kainga and is committed to increasing Maori health gain and reducing health inequalities.

In 2010 Te Huarahi Oranga, the DHBs Maori Health Plan was developed in partnership with Te Oranga O Te Iwi Kainga, who is the Iwi Partnership Board for Wairarapa DHB. The strategy of Te Huarahi Oranga spans 2010 - 2015.

Te Huarahi Oranga -The pathway to wellness, is the name given to this plan, it provides a context for understanding and implementing Māori health practice in the Wairarapa. It provides a strategic vision, proposes actions to improve Māori health gains and uses Māori strength based approaches within health service delivery. It includes actions for improving Māori health, many of which recognise that services need to be whānau-centred. Improving Māori health requires long term commitment and a concerted investment in the strengths of the whānau – hence the plan provides a pathway to wellness and a context for understanding and implementing Māori health practice in the Wairarapa.

Te Huarahi Oranga also highlights a need to focus on Māori who have the greatest need, and the importance of leadership. Strong leadership, at a DHB governance level and through Te Oranga O Te Iwi Kainga, is seen as another critical factor in ensuring that Māori health in the Wairarapa improves.

Te Huarahi Oranga recognises the importance of being able to measure whether we are achieving the very best outcomes for whānau. It includes a set of actions and performance measures grouped under three broad areas which together, will support our vision of vibrant, confident and strong whānau.

These three broad areas include:

1. Pouaro: actions required to develop the workforce and culture of Wairarapa health organisations, and measures to assess how well providers integrate Māori world views, values and tikanga into their daily activities.
2. Poutokomanawa: expectations for health providers as they deliver services across the four output classes – including measures to assess the effectiveness of promotion and screening services to keep Māori well and measures to assess the hands on work required to care for Māori when they have a long term condition and to heal them when they are unwell and are in need of support.
3. Poutuarongo: activities required to support and enable health services to be more effective for individuals and whānau, including measures to assess the responsiveness and connectedness of health providers to the people they serve.

National, Regional and local Maori Health initiatives and actions have been collated and summarised into this Maori Health Plan for 2014/15. This plan is required by the Ministry of Health through the Operational Policy Framework and provides a framework for measuring a range of initiative aimed at reducing inequalities and improving Maori health gain. This plan draws on Te Huarahi Oranga.

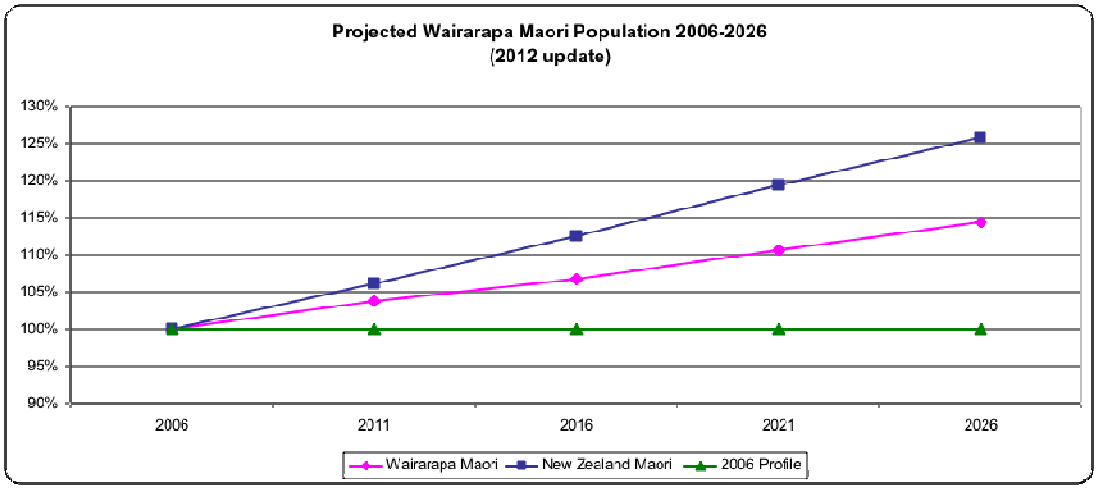
Demographic Information

Mana Whenua in Wairarapa comprise of Ngāti Kahungunu ki Wairarapa and Rangitaane o Wairarapa.

At the time of the 2006 census 5496 Māori were recorded as living in the Wairarapa. This is the same proportion, 14%, as the national average. However, in 2006 the proportion of Māori living in Masterton was 2.5% higher than the Māori proportion nationally. Ministry of Health projections indicate that Māori as a proportion of the Wairarapa population will increase following a national trend.

The following graph compares the Wairarapa Maori population change to the New Zealand Maori total. The graph illustrates both Wairarapa Maori and New Zealand Maori population projections against the Wairarapa 2006 population profile if the population remained static until 2026.

The Wairarapa Maori population is projected to increase by 20% between 2006 and 2026, compared with New Zealand Maori population which is projected to increase by 28% in the same period.



Projected Maori Population 2006 – 2026 (from 2012 projections update)

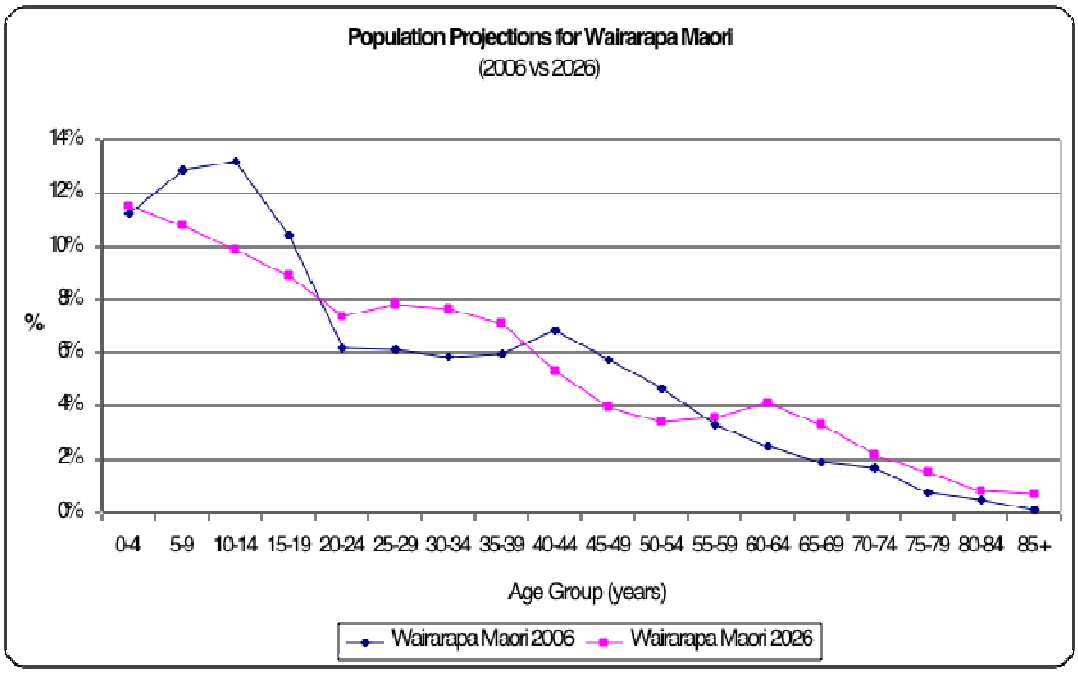
Location	2006	2011	2016	2021	2026
Wairarapa Maori	6,100	6,330	6,510	6,750	6,980
New Zealand Maori	630,300	668,900	709,500	752,000	792,800

Age Structure

The overall age distribution for Wairarapa Maori shows a peak in the 10-24 year age group. Māori aged under 15 years make up 34% of the Māori population in the Wairarapa and those under 25 years make up 55% of the Māori population. Of the Wairarapa Māori population 51% are females and 49% males. There are slightly greater numbers of females in the 20-54 year age group. Across the period from 2011 to 2026 the 2012 projections show a Wairarapa Maori population that is 320 less than that projected in 2006.

The pattern for Wairarapa Maori is very similar to that of New Zealand Maori.

The graph below shows the Wairarapa Maori population age distribution comparing 2006 census with the 2026 projections. The Wairarapa Maori population is expected to increase by 20% between 2006 and 2026 with the largest growth being for the 20-39 year age group and for those over 60 years of age. Both these groups are projected to increase by 6%.



Socioeconomic factors

The World Health Organisation defines the social determinants of health as:
"*..The circumstances, in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics*", (World Health Organisation, 2008).

Socioeconomic factors are major determinants of health and well-being. People with a more favourable socioeconomic position have better health than those who are less well off. Disease and poor health may have an impact on socioeconomic position. Personal health status can therefore be both contribute to and be an outcome of poor socioeconomic status. People with disabilities in particular are affected by the impact of socioeconomic factors.

The 2008 Living Standards Survey noted Maori people have hardship rates some two to three times that of those in the European or Other groups.

A major health challenge for New Zealand is the inequalities in health between Māori/Pacific and non-Māori/non-Pacific peoples. It is well documented that people of Māori and Pacific ethnicity and low socio-economic status (income, education, occupation, housing), have consistently poorer health outcomes in comparison with the rest of the population.

Health Status of Maori

- Wairarapa Maori females have a slightly longer life expectancy than Maori females in the rest of the country.
- There is no statistically significant difference between the Maori and non Maori aged standardised rates for avoidable hospitalisations or avoidable mortality.

- The top three causes of mortality for Wairarapa Maori is now Ischaemic heart disease, diabetes, and COPD. Cancers and external causes no longer rank in the top three, a change since the previous Health Needs Assessment in 2008.
- Wairarapa Maori Adults aged between 25-44 years - the leading cause of death for this age group between 1994 and 2004 was as a result of External causes. These were mainly due to car accidents and intentional self harm (suicide). Males comprised 86% of the deaths from External causes within this age group.
- Ischaemic heart disease, COPD, and diabetes were the leading causes of mortality for Māori aged 65+ years.

Access to Services and the Utilisation of Services

- There were 1,114 hospital discharges for Wairarapa Maori in 2009/10, decreasing to 1,090 in 2010/11 and up to 1,434 in 2011/12. Note that this data includes ED 3 hour admission patients which were not admitted in 2010 and 2011.
- The number of Elective Admissions to Wairarapa Hospital for Maori aged between 55 and 70 years of age has ranged from 31-39 people per year between 2009/10 and 2011/12.
- There has been a reducing trend in the rate of Maori Ambulatory Sensitive and Preventable Admissions to Wairarapa Hospital in the 0-74 year age group moving down from a rate of 4952/100,000 in 2007/08 to 3694/100,000 in 2011/12. (ASH report).

Risk and Protective Factors – Key Findings of the HNA

Smoking

- The current smoking prevalence among Maori adults is 40.4%, 37% among Maori men and 43.2% among Maori female.
- However smoking rates for all groups in Wairarapa exceed the national rate. According to PHO data 23.46% of enrolled patients over 15 years are current smokers, compared to 43.42% of enrolled Maori over 15.
- Most adults who smoke begin smoking before the age of 14.6 years, and there is evidence to show that the younger people begin smoking, the more likely they are to become strongly addicted to nicotine. Females are more likely to become smokers in this age group than males.
- Maori women have the highest smoking percentage in Wairarapa (47.4% smoke).
- Maori who have never smoked has increased from 30.5% in 2006 to 46.2% in 2011.
- The daily smoking rate among Maori is trending downwards. This is significantly observed among Maori women, reducing from 51% in 2002/03 to 40.1% in 2006/07.

Nutrition

- Maori have a lower prevalence of adequate fruit and vegetable intake compared to non Maori.

Obesity

- Levels of obesity of both males and females are worse in the Wairarapa than across New Zealand as a whole, with Maori being more obese than non Maori.

Physical Activity

- Local initiatives aiming to improve health and physical fitness in the Wairarapa include implementation of the Wairarapa Physical Activity Plan.

Drug and Alcohol

- Non-Maori were significantly more likely to have consumed alcohol in the last 12 months compared to Maori. Among past-year drinkers, non-Maori consumed alcohol significantly more frequently than Maori. However, Maori drinkers were significantly more likely to consume a large amount of alcohol on a typical drinking occasion, and to consume a large amount of alcohol at least weekly, compared to non-Maori drinkers.
- Wairarapa Maori have a higher prevalence of current hazardous drinking than their New Zealand counterparts.

Vaccination and Screening

- Childhood immunisation rates have increased significantly in the past three years. In the three months to 30 June 2013, 90% of all children 8 months of age and 92% at two years of age were fully immunised. Rates for Maori children, which had historically been much lower than other groups, were 84% and 90% respectively.
- In the same period 93% of Wairarapa Maori 8 month olds, both for Māori and Total population, were fully immunised and 93% of Wairarapa two year olds and 95% of Wairarapa Māori two year olds were fully immunised.
- The level of influenza vaccinations among Māori aged 65+ years (68%) was higher than the comparable New Zealand rate for high need (65.1%), and the local (70%) and national (66.1%) rates for Total population show a similar difference.
- Breast cancer screening for Māori women in Wairarapa DHB was 71% compared to 72% for the total population for the two years to 30 June 2013.
- As at 30 June 2013, a higher proportion of both Māori (80.2%) and and Total population (81.5%) women aged 25-69 years in the DHB had a cervical smear in the last three years compared to the comparable national averages (63.1% and 76.8% respectively).

Chronic Conditions - Key Findings for the Wairarapa

Circulatory System Disease

- Of the circulatory system diseases, Angina pectoris was the most frequent reason for hospitalisation in the Wairarapa between 2000 and 2006.
- The hospital admission rates for ischaemic heart and COPD for Māori were statistically significantly higher than the non-Māori rate.
- Mortality rate trends for Wairarapa Maori due to all types of Circulatory System diseases show decreases between 1994 and 2004 and are trending below their respective New Zealand rates.

Diabetes

- Diabetes is the most common cause of kidney failure in New Zealand.

- Hospitalisation rates due to all types of diabetes for Maori, both in the Wairarapa and New Zealand, have increased with the rate for Wairarapa significantly higher than the rate for New Zealand Maori.
- In 2011 there was a 3% improvement in diabetes management results for Maori according to the Wairarapa Diabetes Advisory Group.

Renal Failure and Kidney Disease

- Chronic kidney disease and its effects account for one third of New Zealand's health costs and numbers of sufferers are set to increase dramatically.
- Wairarapa hospitalisation rates due to Kidney disease and Renal failure are significantly below the New Zealand rates.
- Wairarapa Maori females had more hospitalisations (55%) due to Kidney disease and Renal failure than Wairarapa Maori males (45%) during the year 2000 to 2006 period. The highest number of hospitalisations occurred in the 40-44 year age group for both genders.
- The percentage of hospitalisations of Wairarapa Maori due to Renal Failure and Kidney Disease are similar to the Maori national percentages, although hospitalisations due to Calculus of kidney and ureter (kidney stones) were 9% higher in the Wairarapa. Research has found that risk factors for kidney stones include type II diabetes and obesity.
- During the 10 year period between 1994 and 2004 there were 4 deaths of Wairarapa Maori due to Kidney Disease and Renal Failure This accounted for 9% of the total Wairarapa population deaths due to this cause.

Respiratory Disease

- The percentage of Respiratory disease hospitalisations for Wairarapa Maori is similar to that of New Zealand Maori between the year 2000 and 2006. Wairarapa Maori have a slightly higher hospitalisation percentage for Acute bronchiolitis.
- Wairarapa Maori hospitalisation rates for both Acute bronchiolitis and Pneumonia are decreasing.
- Maori children (both genders) up to the age of 10 years of age have more hospitalisations due to Respiratory disease, accounting for 57% of the total. This decreases significantly from then and peaks again in the 65-69 age band.
- Between 1994 and 2004 Respiratory disease mortality rates for Wairarapa Maori show no change. The cause that resulted in the highest numbers of deaths for Wairarapa Maori was Other chronic obstructive pulmonary disease.

Cancer

- Wairarapa Maori cancer registration rates have increased, while the rate for New Zealand Maori has remained similar over the ten year period between 1994 and 2004.
- Among all malignant cancer registrations for Maori in the Wairarapa between 1994 and 2004, the most common was lung cancer, followed closely by breast cancer. Wairarapa Maori had a slightly higher registration for these two cancers than New Zealand Maori.
- Cancer hospitalisation rates have increased slightly for Wairarapa Maori and are above the New Zealand rate for Maori, but not significantly.

- It is evident that each ethnicity has different treatment requirements, eg: breast and lung cancer hospitalisations are higher for Maori, whereas neoplasms a of the skin are higher for those of Other ethnicities.
- Breast cancer registrations are forecast to increase further over the next decade, as a result of the Breast Screen Aotearoa Programme. Maori women have higher breast cancer registration rates, compared to women of either Pacific or Other Ethnicities.
- Among all malignant cancer deaths of Wairarapa Maori between 1994 and 2004, the most common was due to lung cancer, followed by stomach cancer.
- Lung cancer has the highest mortality, followed by cancer of the colorectum and anus. Maori were affected more by lung cancer, whereas those of Other ethnicities were affected more by cancer of the colorectum and anus. This is similar to New Zealand overall.
- Mortality rates for Wairarapa Maori due to Colorectal cancer decreased significantly between 1994 and 2004.
- The top three cancers causing avoidable mortality for Wairarapa Maori are Lung cancer, stomach cancer and breast cancer.

Mental Health

- The age-standardised self-harm hospitalisation rates, comparing Maori with Non-Maori shows the rate for Wairarapa Maori is significantly higher than the New Zealand Maori rate, and was 3rd highest compared to other DHBs in 2006. The rate for Wairarapa Non-Maori is very similar to the New Zealand rate.
- Hospitalisation rates for Wairarapa Maori due to Mental Health Conditions (all types) was above that of the New Zealand Maori rate in the year 2000 and has significantly decreased during the year 2000 to 2006 period.
- Schizophrenia is the main reason for mental health hospitalisations, both for Wairarapa Maori and New Zealand Maori, with the national percentage being 9% higher than Wairarapa. Schizophrenia affects significantly more Wairarapa Maori males than females.
- Hospitalisations due to Mental and behavioural disorders due to the use of alcohol were the second most common cause (13%) of mental health hospitalisations of Wairarapa Maori between the year 2000 and 2006.
- Hospitalisations due to either Depressive episodes or Mental and behavioural disorders due to use of alcohol are higher for Wairarapa Maori, while hospitalisations due to Bipolar affective disorder are higher for New Zealand Maori.
- Self-harm hospitalisation rates for Wairarapa Maori are significantly higher than the New Zealand Maori rate.

Injuries and Accidents

- Road traffic injuries and Suicide were the most common reasons for accident / injury related hospitalisations of Wairarapa Maori people between the year 2000 and 2006, accounting for 71% of this total.
- Wairarapa Maori males account for (68%) of the hospitalisations due to Road traffic injuries.
- The percentage of accident / injury hospitalisations for Wairarapa Maori males between the ages of 15-24 was 18%, compared to 10% for Wairarapa Maori females in the same age group.

- Between 1994 and 2004, 92% of accidental deaths of Wairarapa Maori were due to either transport accidents or Suicide.

Child, Youth and Maternal Health

- At the time of the 2006 census the total resident Wairarapa Maori Child and Youth population aged 0-24 years made up 54.1% of the total Wairarapa Maori population. The projections are that this population group will decrease by 5.6% by the year 2026.
- The most common cause of hospitalisations was due to factors influencing health (1,052 hospitalisations). Of this, there were 720 hospitalisations (68%) classed as ICD-10 code Z38, live-born infants according to place of birth. This refers to a newborn baby requiring admission to hospital immediately after birth or during the post natal period from the mother's bedside, whether born at hospital, home or elsewhere.
- Children in the 0-4 year age group had similar leading causes of hospitalisation, regardless of ethnicity and gender. Dental conditions and respiratory infections were the two leading causes of hospitalisations for both Māori and non-Māori children aged 5-14 years.
- Although the most common cause of hospitalisations was due to factors influencing health, the most common cause of hospitalisations for Wairarapa Maori females only in the 15-24 year age group was due to pregnancy complications.
- Marked ethnic differences in Oral Health status were evident with a lower proportion of Maori children being caries free at 5 years, and Maori children having higher mean DMFT scores at 12 years in both fluoridated and non-fluoridated areas. Increases in hospital admissions during 1996 – 2006 for serious bacterial infections were consistent with New Zealand trends. However, admission rates were lower than the New Zealand average. Rates remained consistently higher for Maori children and young people.
- During 1996 – 2006 teenage birth rates for both Maori and European women were similar to their respective New Zealand ethnic specific averages.
- During 2006, 9.8% of children and young people lived in crowded households compared to 16.5% nationally. However 19% of Maori children and young people lived in crowded households compared to 5.6% European. Crowding rates for Wairarapa children and young people were lower than the New Zealand Maori average.
- There were marked ethnic differences in educational attainment at school leaving during 1995 – 2006 with higher proportions of Maori than European leaving school with little or no formal attainment.
- No routine surveillance of overweight and obesity in New Zealand children and young people occurs at present.
- During 2006, 60.3% of Maori children were living in a household with a smoker, as compared to 37.5% of European children.
- Immunisation rates for Maori children were considerably higher than comparable national coverage rates.

Health of Older Maori

- The Older Wairarapa Maori population aged 65 years and over is projected to more than double during the 2006 and 2026 period.

- Wairarapa Maori females have a longer life expectancy than Wairarapa Maori males. Wairarapa Maori females live on average to the age of 77 years, while Wairarapa men live to the age of 68 years.
- While 5% of the Wairarapa Maori population is 65 years of age or older this group accounted for 10% of the entire Wairarapa population hospitalisations.
- The main reason for hospitalisations of Older Wairarapa Maori people was Respiratory System disease.
- Ischaemic heart disease, COPD and diabetes are now the leading causes of mortality amongst Wairarapa Maori.
- The use of residential care by Maori remains very minimal. It is likely that Older Wairarapa Maori people that require care would be cared for by their Whanau.
- No Wairarapa Maori people were hospitalised due to Dementia during this period.

Disability

- 5% of Maori children had special education needs and this was the most common type of disability for Maori children.
- Almost all Maori with a disability lived in households (99%) and less than 1% lived in residential facilities.
- Of Maori adults, 19% had a disability. The most common causes of disability for Maori adults were disease or illness.
- For those Maori adults with a disability, 38% had a single disability and 62% had multiple disabilities.

Whānau Ora

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

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

- Uses the opportunities to improve service delivery and build mature providers, and
- Requires the health sector to work in a more seamless way with other parts of the social sector and expects improved outcomes and results for New Zealand families

PRIORITY	Whānau Ora	
Area	Action	Indicators of success
Whānau Ora	Maintain key links with Māori bodies at local, regional and national forum Identify opportunities to support / promote the intent of Whānau Ora. In particular: • Work with the Whānau Ora Wairarapa Collective to support their Whānau Ora service delivery model and identify/progress enablers to progress Whānau Ora within Wairarapa; • Increase engagement of the DHB's clinical and wider health workforce with the Whānau Ora Wairarapa approach. • Support Whānau Ora collectives, groups and whānau to access Whānau Ora resources and improve service delivery;	• Report learning / achievements of Māori / Māori health at local, regional, national levels. • A minimum of two meetings with Whānau Ora Wairarapa Collective representatives • Two reports on Māori Health gain areas. • 2 wananga with DHB staff to understand the concept and philosophy of the Wairarapatanga model and it's implementation. • RBA and MBIE[1] strategies and actions implemented across all service development and contracts to support a focus on Whānau Ora • Outcomes based reporting framework developed • Whānau Ora Goals are visible and established across

[1] Ministry of Business, Innovation & Employment

PRIORITY	Whānau Ora	
Area	Action	Indicators of success
	• Develop and implement effective contracting, reporting and monitoring processes which enable 'Whānau Ora Outcomes' to be achieved and identifying potential opportunities for joint funding with PHO – primary care; • Support the Whānau Ora Wairarapa Collective to further develop the current outcomes based reporting framework; • Identify workforce capability and capacity needs across WO Collectives, DHB/SIDU and Primary care services and workforce to utilise Results / Outcomes Based Accountability tools and resources in conjunction with Health Quality & Safety Commission (HQSC) Triple Aim quality improvement across all health services; • Support the Whānau Ora Integrated Care Collaborative to identify health workforce priorities across services, planning and programme evaluation opportunities to enhance professional development and Māori health workforce development; • Continue local work between primary care and Whānau Ora collectives to identify and implement shared health promotion initiatives, reduce the impact of long term conditions and improve child health through collaborative initiatives that identify and support whanau to determine their health pathway; and, • Align and ensure the priorities and actions identified within the Wairarapa DHB Maori Health Plan are realised as a joint DHB, Primary care and Whānau Ora action plan.	Regional plans • Continue to support Scholarship programmes and Hauora Māori opportunities to grow local Māori health workforce through tertiary study and training and access HWNZ Hauora Maori funding.

Maori Health: National Priorities

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

National Priorities

<table>
<tr><th colspan="2">Priority One</th><th colspan="3">Data Quality</th></tr>
<tr><th>Indicator</th><th colspan="2">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td rowspan="4">1. Accuracy of ethnicity reporting across DHB services
2. Accuracy of ethnicity reporting in PHO registers as measured by Primary Care Ethnicity Data Audit Toolkit.</td><td></td><td>Baseline</td><td>2014/15 Target</td><td rowspan="4">Review ethnicity data collection protocols in selected services and ensure ethnicity reporting by provider arm service area and included in the quarterly Maori Health Indicators reporting framework.
Quarterly reporting to the Alliance Leadership Team on the implementation of the primary care ethnicity data tool, issues identified and strategies to address these</td><td rowspan="4">Ethnicity data by service area is visible and reported on quarterly
Ethnicity data accuracy targets at NASC and Care coordination services
Ethnicity data accuracy targets at PHO level.</td></tr>
<tr><td>M</td><td>7106</td><td>6460</td></tr>
<tr><td colspan="3">Note: This is the enrolment target, not a measure of accuracy of ethnicity reporting</td></tr>
</table>

<table>
<tr><th>PRIORITY TWO</th><th colspan="5">Access to Care</th></tr>
<tr><th>Indicator</th><th colspan="4">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td rowspan="4">1. Percentage of Māori enrolled in PHOs[2]</td><td></td><td>Baseline 12/13</td><td>Target 14/15</td><td>%</td><td rowspan="4">Work with Tihei Wairarapa Leadership and the Whanau Ora Wairarapa Collective to identify and enrol whanau

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

Work with primary care partners e.g.LMCs and hospital provider arm to encourage every pregnant woman to enrol with a PHO and register with a GP.</td><td rowspan="4">100% of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake)

Increased PHO enrolment

▪ Increase PHO enrolment by 1% total and

▪ 7% for the Maori population</td></tr>
<tr><td>M</td><td>103%</td><td>110%</td><td>7%</td></tr>
<tr><td>Total</td><td>103%</td><td>104%</td><td>1%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>2. Ambulatory Sensitive Hospitalisations rates per 100,000 for the 0-74, 0-4, and 45-64 age groups</td><td></td><td>Baseline 12/13</td><td>Target</td><td rowspan="4">Implementation of collaborative NHI level data analysis (PHO/DHB) will identify individuals not accessing primary care and be the basis for targeted initiatives to reduce ASH rates. Priority areas 2014/15:

Cellulitis (all ages)
Admissions for angina and chest pain
Children under 7 – tied to priority of Reducing Child DNA rates

The Tihei Wairarapa programme will extend to inclusion of maternal and child health. This will include a focus on reducing ASH rates for children aged 0-4, particularly Maori children.</td><td rowspan="4">ASH ratios for all age groups and ethnicities of Baseline Yr to June 13 Ratios
<table><tr><td>Age 0-74</td><td></td></tr><tr><td>Māori</td><td>3399</td></tr><tr><td>Pacific</td><td>1677</td></tr><tr><td>Total</td><td>1976</td></tr><tr><td>Age 0-4</td><td></td></tr><tr><td>Māori</td><td>6974</td></tr><tr><td>Pacific</td><td>3171</td></tr><tr><td>Total</td><td>4223</td></tr><tr><td>Age 46-64</td><td></td></tr><tr><td>Māori</td><td>4076</td></tr><tr><td>Pacific</td><td>1928</td></tr><tr><td>Total</td><td>2135</td></tr></table></td></tr>
<tr><td>Age 0-74</td><td>172%</td><td>99%</td></tr>
<tr><td>Age 0-4</td><td>153%</td><td><95%</td></tr>
<tr><td>Age 45-64</td><td>179%</td><td><95%</td></tr>
</table>

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

PRIORITY TWO	Access to Care		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		Acute demand and After hours Across the sub-region a whole of system approach is being taken to address ambulatory sensitive hospital presentations and acute demand and enable the achievement of the Shorter stays in ED Health Target. This will support quality clinical outcomes for patients such as decreased mortality and reduced lengths of stay in hospital. This programme of work is aligned with and includes the initiatives under the governance of the respective integrated Alliance leadership teams in each DHB. It includes: • Preventative and proactive care in primary and community care settings to avoid the necessity for ED presentation or acute admission eg clinical management of frail elderly in the community, diabetes care improvement plans, medication management • Alternatives settings for management of patients eg clinical pathways for the management of selected conditions in primary care eg cellulitis, DVT and gastroenteritis. • Alternative access to diagnostics eg access to radiology in the community • Discharge processes. eg ensuring	Reduced ASH rates Indicators of Success • Bed Days • Reduction in Length of Stay • Maintain or reduce ED Presentations • Maintain or reduce Hospital Admissions

PRIORITY TWO	Access to Care		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		community support services that respond rapidly (within 12 hours) for patients not requiring hospital admission or to enable discharge at the appropriate time **Diabetes and Long Term Conditions** Key Actions: • Progress work on a sub-regional Long term condition framework in 2014/15 • We will continue to progress the Diabetes Care Improvement Plans (DCIPs) developed in 2013/14 and work towards consistency of plans and implementation across the sub-region • Diabetes is the long term condition of focus and ensuring DCIPs are delivering the expected outcomes is the primary focus for DHBs. Successful models developed for DCIP can then be utilised for other services. **Primary Options for Acute Care** • To support the implementation of Clinical Pathways and other strategies to reduce inappropriate hospital admissions such as DVT and Cellulitis • Sub-regional approach to POACs including governance. Systems developed including funding mechanisms,	• Rate of enrolled people aged 15-74 in the PHO with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol) (PP20)

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

<table>
<tr><th>PRIORITY THREE</th><th colspan="3">Child health</th><th></th></tr>
<tr><th>Indicator</th><th colspan="3">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td rowspan="11">1. Exclusive breastfeeding</td><td colspan="3">Infants exclusively, fully breastfed at 6 weeks</td><td rowspan="11">Continue to support Community Lactation rates with their enrolled population

Continue to support Well Child/Tamariki Ora providers to improve breastfeeding rates with their enrolled population
• Maintain BFHI accreditation
• Maintain breastfeeding support (hospital delivered to age 6 weeks of age)
• Monitor Maori participation in newborn enrolment to publically funded services, which will include early alert to WCTO providers to foster early connection to WCTO support and planned handover and support for breastfeeding
• Monitor Maori participation in newborn enrolment to publically funded services, which will include the participation in pre-school Oral Health Services
• Establishment of a Vulnerable Pregnant Women's service Pathway sub-regionally, which will include the support to women during pregnancy to consider breastfeeding their infant</td><td rowspan="11">Increased utilisation of breastfeeding /specialist lactation services.

BFHI accreditation

Pathway developed to receive early referrals from LMC to WCTO providers

Exclusive breastfeeding at time of initial discharge from hospital: baseline (2012 calendar year) Maori – 80.8% , target (for 2014 calendar year) >75%

The rationale for the target is that 75% is required for the BFHI.</td></tr>
<tr><td></td><td>BLine</td><td>Target</td></tr>
<tr><td>Māori</td><td>66%</td><td>68%</td></tr>
<tr><td colspan="3">Infants exclusively, fully breastfed at 3 months</td></tr>
<tr><td></td><td>BLine</td><td>Target</td></tr>
<tr><td>Māori</td><td>47%</td><td>54%</td></tr>
<tr><td colspan="3">Infants exclusively, fully or partially breastfed at 6 months</td></tr>
<tr><td></td><td>BLine</td><td>Target</td></tr>
<tr><td>Māori</td><td>65%</td><td>59%</td></tr>
<tr><td colspan="3"></td></tr>
</table>

PRIORITY THREE	Child health		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		• Regular review of the Vulnerable Pregnant Women's teams data on Maori risk compared to others and acceptability of support offered/ provided • Encourage NGO providers and PHOs to continue their breastfeed support/ encouragement for pregnant women/ new mothers • Maintain PHO participation in delivering on QIF Indicators (note the sub-region inclusion of 2/52 post-partum smoke-free indicator, which will build relationships with LMC and WCTO and early 'additional visit'). Note that the chosen QIF Indicators will act as an entry point for smoke-free, support of breastfeeding, SUDI prevention etc. Monitor Quarterly. • Work with Maternity Governance Groups to ensure the inclusion of breastfeeding support within the maternity sector and the continuum to primary care as an important clinical focus Review sub-regional purchase of antenatal/ parenting programmes funding allocation with a focus on improving value and better outcomes during the 2014/15 year.	

<table>
<tr><th>PRIORITY FOUR</th><th colspan="3">Cardiovascular disease</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Percentage of the eligible population who have had their CVD risk assessed within the past five years</td>
<td>
<table>
<tr><th></th><th>Baseline</th><th>Target 14/15</th></tr>
<tr><td>Maori</td><td>76.7%</td><td rowspan="4">90%</td></tr>
<tr><td>Pacific</td><td>72.9%</td></tr>
<tr><td>Other</td><td>86%</td></tr>
<tr><td>Total</td><td>84.5%</td></tr>
</table>
</td>
<td>To maintain the target the PHOs will continue their current approach which includes:
Working with each individual practice on a business plan
Funded checks
IT support – further roll out of BPAC decision tools
Point of care testing
Text to remind
Publicity
An integrated provider approach will be investigated and implemented if effective.
Additionally, we will:
Utilise the funding increase in 2013 to enable ongoing support for primary care to deliver on the health target and ensure its sustainability 2014/15
Ensure the expertise, training and tools needed are available to successfully complete the CVD risk assessment and management to meet clinical guidelines
Ensure that IT systems that have patient prompts, decision support and audit tools exist, are used and fully report</td>
<td>90% of the eligible population have had their CVD risk assessed within the past five years</td>
</tr>
</table>

PRIORITY FOUR	Cardiovascular disease		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		performance. • Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care health targets More Heart and Diabetes checks and Better help for smokers to quit. • Support Health Promotion Agency in its work on CVD awareness and publicity campaigns • Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care health targets More Heart and Diabetes checks and Better help for smokers to quit. • PHO will continue to provide support and resources to practices to assist the achievement of the health targets • Implement practice-specific actions to increase the number of CVDRA, including an extended funding model that enables practices to provide free checks to a targeted population • Invest in further Decision Support and Reporting Tools for both practices and	

PRIORITY FOUR	Cardiovascular disease		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		other service providers within the Primary Care network • Continue promotion activities that encourage people from the target populations to seek a Heart and Diabetes Check.	
2. 70% of high-risk ACS patients accepted for coronary angiography will receive this within 3 days of admission. ('Day of Admission' being 'Day 0')	70%	• Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention • Develop processes, protocols and systems to enable local risk stratification and transfer of appropriate high risk ACS patients • Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for high risk ACS patients. • The Caths Lab element of ANZACS-QI has been implemented in 2013/14 and will continue to be embedded in 2014/15. • The service values the benefits for quality improvement that ANZACS-QI will enable. There is some challenge to resource the ACS component for which	• 70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') • Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
3. 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	95%		

PRIORITY FOUR	Cardiovascular disease		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		the service is continuing to seek solutions. As a tertiary service CCDHB has identified the need for an implementation champion to develop processes to embed data collection in day to day business practice.	

<table>
<tr><th>PRIORITY FIVE</th><th colspan="3">Cancer</th></tr>
<tr><th>Indicator</th><th colspan="2">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Breast Screening
70% of eligible women will have a BSA mammogram every two years.</td>
<td colspan="2">Eligible women (50-69 yrs) having breast screening in the last 24 months

BLine | Target
Māori | 71% | ≥70%</td>
<td>Continue to support BreastScreen Central to provide breast cancer screening for women aged 45 to 69 years from fixed and mobile sites throughout the Hutt Valley DHB, Wairarapa DHB and Capital & Coast DHB regions.

Work with Regional Screening Services to develop and implement a monitoring and reporting framework to support accelerated change in Māori breast screening rates.

Target Maori women in screening programmes by locating mobile Breast Screening bus in Marae or other Whanau Ora focussed locations

Continue to support current Mana Wahine providers, within HVDHB region, to provide assistance complimentary other contracted services

Identify a screening ‘Champion’ by building a strong interface with Primary Care and other stakeholders

Quarterly meetings with Primary Care and other stakeholders

Regular priority screening days at BSC and Kenepuru</td>
<td>Increased cancer screening rates.

Screening ‘Champion’ identified

Monitoring and reporting framework developed and implemented

Systematic reports received</td>
</tr>
</table>

<table>
<tr><th>PRIORITY FIVE</th><th colspan="3">Cancer</th></tr>
<tr><th>Indicator</th><th colspan="2">2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>2. Cervical Screening

Percentage of women (Statistics NZ Census projection adjusted for prevalence of hysterectomies) aged 25-69 who have had a cervical screen in the past 36 months</td>
<td colspan="2">Eligible women having cervical screening in the last 36 months

<table>
<tr><td></td><td>BLine</td><td>Target</td></tr>
<tr><td>Māori</td><td>80%</td><td>80%</td></tr>
</table>
</td>
<td>Continue to support providers, including primary and community care providers, to deliver National Cervical Screening Programme coordination services.

Continue to support current Mana Wahine providers to provide assistance

Identify a screening ‘Champion’ by building a strong interface with Primary Care and other stakeholders

Quarterly meetings with Primary Care and other stakeholders to ensure ease of access to screening and increase in the number of smears.

Data match with Primary Care to identify women unscreened/underscreened.

Develop agreed processes with Primary Care to engage women into screening in a sensitive and appropriate manner.

Monitor colposcopy DNAs and support the Colposcopy services with initiatives aimed at reducing DNAs</td>
<td>6 Monthly report of completed referrals by ethnicity, attendance, DNR, DNA, cancellations and reschedules.

Reduced DNA to Colposcopy services</td>
</tr>
</table>

<table>
<tr><th>PRIORITY SIX</th><th colspan="3">Smoking</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Hospitalised smokers are provided with advice and help to quit</td>
<td>95 percent of hospitalised smokers will be provided with brief advice and support to quit by July 2015
<table>
<tr><th></th><th>Baseline</th><th>Target 14/15</th></tr>
<tr><td>Maori</td><td>72%</td><td>95%</td></tr>
</table>
</td>
<td>The provider arm will
• promote ABC smoking cessation and NRT competency training for all health professionals to ensure they are competent to:
- ask their patients about their smoking status
- give identified smokers brief advice to quit,
- prescribe suitable pharmacotherapy, and
- make a strong recommendation to use support in addition to medication
- refer patients to smoking cessation support services
- document smoking status and support offered to patient
• provide regular feedback to wards and departments on their individual progress toward the target.
• ensure wards have appropriate documentation for smoking status and know how to capture it.
• devolve feedback and audit processes to</td>
<td>95% of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking</td>
</tr>
</table>

<table>
<tr><th>PRIORITY SIX</th><th colspan="3">Smoking</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td></td><td></td><td>CNMs and nurse educators.
• ensure smokefree champions are located within each health service
SIDU will:
• provide cessation referral processes through the 3DHB Health Pathways</td><td></td></tr>
<tr><td>2. Current smokers enrolled in a PHO and provided with advice and help to quit</td><td>90 percent of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit smoking.<table><tr><th></th><th>Baseline</th><th>Target 14/15</th></tr><tr><td>Maori</td><td>101%</td><td>90%</td></tr></table></td><td>SIDU will:
• Promote ABC smoking cessation training for all health professionals to ensure they are competent to:
• ask their patients about their smoking status
• give identified smokers brief advice to quit,
• prescribe suitable pharmacotherapy,
• make a strong recommendation to use support in addition to medication
• refer patients to smoking cessation support services.
• document smoking status and support offered to patient
• Promote the identification of smokefree champions within each health service</td><td>90% of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking</td></tr>
</table>

PRIORITY SIX	Smoking		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		• Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care health targets Better Help for Smokers to Quit and More Heart and Diabetes Checks. PHOs will continue to provide support and resources to practices to assist the achievement of the health targets	
	Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	We will: • Work with our maternity services, general practitioners and Well Child/ Tamariki Ora providers to raise awareness of the smoking in pregnancy issue and promote ABC or EBI training. • Establish a link between maternity services and the Quitline so that midwives are able to text patient details immediately to the Quitline pregnancy service • Help to develop local networks between LMCs, maternity services, and smoking cessation providers • Provide ABC smoking cessation training, through the CCDHB ABC Facilitator and HVDHB Smokefree	90% of pregnant women who identify as smokers at confirmation of pregnancy in general practice or booking with a Lead Maternity Carer will be offered advice and support to quit smoking

PRIORITY SIX	Smoking		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		Coordinator (working across Wairarapa and Hutt Valley) to 100% of in-house hospital midwives • Provide the Quitline "Quitting Smoking for Baby" resource • Provide all midwives and general practitioners and Well Child providers with ABC training that is specific to pregnant women	

PRIORITY SEVEN	Immunisation		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
1. Percentage of infants fully immunised by eight months of age	95% of eight month olds fully vaccinated Baseline Māori coverage 93%	Actions to support increasing infant immunisation rates (six weeks, three months and five months immunisation events) from 90 per cent of eight-month-olds to 95 percent by December 2014: • maintain an immunisation steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit; and that participates in regional and national forums • work with primary care partners to monitor and increase new born enrolment rates to 100% • monitor and evaluate immunisation coverage at DHB, PHO and practice level, manage identified service delivery gaps • identify immunisation status of children presenting at hospital and refer for immunisation if not up to date • in collaboration with primary care stakeholders develop systems for seamless handover of mother and child as they move from: maternity care services to general practice and WCTO	• 95% of eight month olds fully vaccinated by 31 December 2014. • 98% of newborns are enrolled with general practice by three months • 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) • Narrative report on DHB and interagency activities to promote immunisation week

PRIORITY SEVEN	Immunisation		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		services In collaboration with NGOs and government agencies, describe how the DHB is working across agencies to increase immunisation coverage A project to design a sub-regional system of enrolment to publically funded infant services is occurring in 2013/14. Recommendations for a sub-regional newborn enrolment system will be delivered June 2014, with implementation to follow as is feasible. Enrolment is targeted to B-enrol, NIR, WC/TO, Oral health, BCG, and NBHS. Continue to implement the WDHB Child Health Strategy, including improved coordination between maternal and child health providers and monitoring of child health indicators Maintain current systems for immunisation coordination and outreach services to ensure every child is offered immunisation. Target health promotion activities to parents and immunisation deliverers to increase knowledge and understanding of all vaccines and reduce current variable decline rates Maternity services and Antenatal Care undergoing a review 2014, ensure Maori	

<table>
<tr><th>PRIORITY SEVEN</th><th colspan="3">Immunisation</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr><td></td><td></td><td>worldview is integrated and services increase their responsiveness to whanau Maori

Work with generalist health providers to implement a Treaty of Waitangi and cultural competence training package</td><td></td></tr>
<tr><td>2. Seasonal influenza immunisation rates in the eligible population (65 years and over)</td><td><table><tr><td></td><td>Baseline</td><td>Target 14/15</td></tr><tr><td>Maori</td><td>68%</td><td>70%</td></tr></table></td><td>The DHB will continue its work with primary health care providers to reduce the burden of preventable hospitalisations and increase immunisation.

Support HHS, PHO and NGO services to undertake a minimum of two promotional activities to encourage the uptake of influenza immunisation for 65+ with a particular focus on elderly Māori .

Over 65 influenza vaccinations promoted through the PHO and Wairarapa General Practices and Whanau Ora Collective</td><td>% of 65+ eligible total population receive annual flu vaccination

% of 65+ Maori population receive annual flu vaccination

A minimum of two promotional activities to encourage the uptake of influenza immunisation for 65+ during Q2/3</td></tr>
</table>

<table>
<tr><th>PRIORITY EIGHT</th><th colspan="3">Rheumatic Fever</th></tr>
<tr><th>Indicator</th><th>2014/15 Target</th><th>Action</th><th>Indicators of success</th></tr>
<tr>
<td>1. Reduce incidence of rheumatic fever 2013/2014 rheumatic fever target - number and rate reductions, 10% below 3-year average</td>
<td>Rates at baseline and target rates for rheumatic fever hospitalisations (cases/100,00 population) for CCDHB, HVDHB and Wairarapa DHB
<table>
<tr><th>DHB</th><th>Baseline year (3-year average rate) 2009/10-2011/12</th><th>2014/15</th></tr>
<tr><td>Capital and Coast</td><td>2.9</td><td>1.8</td></tr>
<tr><td>Hutt</td><td>4.9</td><td>2.9</td></tr>
<tr><td>Wairarapa</td><td>0.0</td><td>0.0</td></tr>
</table>
</td>
<td>Implement the sub-regional rheumatic fever prevention plan to reduce the incidence of Rheumatic Fever in the region through a work programme of actions focused on prevention, treatment and follow-up of rheumatic fever.

To prevent the transmission of Group A streptococcal throat infections in the Wairarapa, Hutt Valley and Capital and Coast DHB region. This will be achieved through:
a. The development and implementation of a pathway to identify and refer high risk children to comprehensive housing, health assessment and referrals services, in 2014/15.
b. The development of the Housing and Health Capability Building Programme and implementation of insulation referral process for high-risk patients, in 2014/15.
c. Raising community awareness, in 2014/15 and ongoing.
2. Actions to treat Group A streptococcal infections quickly and effectively. This will be achieved through:
a. The provision of training and information for primary care providers, in 2014/15 and ongoing.</td>
<td>In 2014/15 a 40% reduction from baseline in rates of rheumatic fever hospitalisations (cases/100,000 population) is the target.</td>
</tr>
</table>

PRIORITY EIGHT	Rheumatic Fever		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
		b. Development of an audit tool for the treatment of sore throats in primary care c. Ongoing sore throat swabbing in schools, this will also include review of the model in 2014/15. d. The development and wider use of standing orders for primary care (high risk practices). 3. Actions to facilitate effective follow-up of identified rheumatic fever cases. This will be achieved through: a. The tracking of the timeliness of antibiotics through the rheumatic fever register with annual audit and stakeholder meetings. b. Appropriate mechanisms for annual training of medical staff to be explored and implemented in 2014/15. c. The implementation of an annual audit process to follow up on cases of rheumatic fever (root cause analysis process undertaken). This will include reporting on the lessons learned and actions taken. d. The development and implementation of a clinical pathway from diagnosis through to the end of bicillin course.	

PRIORITY NINE	Oral Health			
Indicator	**2014/15 Target**		**Action**	**Indicators of success**
1. Preschool Enrolments	Baseline	Target	Newborn Enrolment Project implements a single system that enables enrolment of newborns in to child oral health. Oral health services to work with Primary and Secondary services to identify initiatives that support increased enrolment Continue implementation of an integrated approach to preschool enrolment across the Wairarapa health provision continue; WCPHO-General Practice teams, Maternal Health team,Public Health, Whaiora, WOW-Whanau Ora Collective	Increase in enrolments
	74.6%	85%		

PRIORITY TEN	Mental Health		
Indicator	**2014/15 Target**	**Action**	**Indicators of success**
1. Mental health Act: section 29 community treatment order indefinites comparing Maori rates with other.	413 per 100,000 - Maori	Reduce the need for the use of CTO through early detection and interventions Develop a monthly report to monitor, review and identify areas of concern.	a. The impact of mental health illness and addictions on the tangata whaiora, their whanau and their community is reduced b. Monthly reports developed and monitored

Regional Priorities

Regional Māori Health Plan [3]

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

Change Enablers

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

1. Māori Workforce Development
2. Quality Service Provision
3. Collaborative Action
4. Sharing and Measuring Information

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

PRIORITY ONE	**Māori Workforce Development**	
Area	**Action**	**Indicators of success**
Increased Māori Capacity.	Continue to roll out 'Kia Ora Hauora' Māori workforce development programme.	Recruit 125 new Māori onto a health study pathway. Recruit at least 25 new Māori into 1st year tertiary study (including foundation programmes).

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

PRIORITY ONE	Māori Workforce Development	
Area	**Action**	**Indicators of success**
	Support current scholarship initiatives targeting Māori uptake of Health related study pathways.	A minimum of 20 scholarships per annum
	Support CRTAS to increase its Māori / Inequalities capacity & capability and advance regional inequalities work.	Quarterly meetings
Improved Māori Capability.	Provide regional support of the implementation of Ngā Manukura ō Āpōpō Emerging and Advanced Leaders in Māori nursing and midwifery Clinical Leadership Training.	A minimum of three places filled by Central Region Māori nurses annually
	Pilot the implementation of the Regional Capability Development Framework / Training programme.	Number of staff enrolled (Maximum 40 regionally). 90% of staff achievement. Report on Regional implementation.
	Implement a bi-annual Central Region DHB Maori health development conference: Tu Kaha.	Conference implemented

PRIORITY TWO	Collaborative Action	
Objective	**Action**	**Indicators of success**

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

Sub Regional Priorities

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

Table 1: Sub-regional Strategy

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

The establishment of a joint Service Integration and Development Unit (SIDU), across Capital and Coast, Hutt Valley and Wairarapa DHBs, provides the opportunity to undertake the planning and implementation of specific projects aimed at improving Māori Health outcome within the sub region.

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

Local Priorities

Wairarapa DHB Local Priorities

The establishment of a joint Service Integration and Development Unit (SIDU) provides the opportunity to advance a collective plan of action aimed at improving the sustainability, efficiency, effectiveness and equity of services for our individual communities and collective population.

In identifying the strategic priorities, WDHB will plan, configure and deliver services in a way which improves, promotes and protects the health of the populations of Wairarapa, but which also assists with meeting national and regional population needs.

Accordingly, in determining the DHB strategic priorities for 2014/15 WDHB have considered issues at each level of service planning – national, regional, sub regional, and local.

This process has led to the subregional DHBs determining the following operating priorities for 2014/15:

Financial and Clinical Sustainability – Advanced through our collaborative programme of integration (eg 3D, BSMC)

Reduction of Health Disparities / Improved Health Equity

Improving the Health and Well-being of our region's children

Optimising the health, well-being and independence of our region's older people

Optimising the quality of life for people with disabilities and their families

PRIORITY	Diabetes	
Area	**Action**	**Indicators of success**
Improved Diabetes	Key Actions: • Progress work on a sub-regional Long term condition framework in 2014/15 • We will continue to progress the Diabetes Care Improvement Plans (DCIPs) developed in 2013/14 and work towards consistency of plans and implementation across the sub-region • Diabetes is the long term condition of focus and ensuring DCIPs are delivering the expected outcomes is the primary focus for DHBs. Successful models developed for DCIP can then be utilised for other services. Actions to include: • Prevention of diabetes and other LTCs through improved services to promote healthy lifestyles, including nutrition and physical activity advice • Development of a diabetes nutrition pathway for pre diabetes and type 2 diabetes • Identification of populations at risk of diabetes or LTCs using risk stratification. Risk stratification is the systematic categorisation of patients at risk of, or with, any long term conditions, in order to provide appropriate management. • Long term condition practice plans, diabetes component, to identify at risk and known risk population progressively in place across all practices.	• Linkage with Ambulatory Sensitive Admissions to Hospital (ASH) rates (SI1) • Rate of enrolled people aged 15-74 in the PHO with diabetes and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol) (PP20) • Number of referrals to self-management programmes

PRIORITY	Diabetes	
Area	**Action**	**Indicators of success**
	• Management of people with diabetes or LTCs will be person/whānau centred. Develop localised diabetes clinical pathways (subject to prioritisation by the HealthPathways programme) encompassing whānau care and self-management to ensure appropriate and consistent access to all services and support. Self-management and other care plans will be developed in conjunction with people and their whānau/family • Enablers include ongoing workforce development across all members of the practice team in primary care, and clinical governance with a named clinical lead under the Alliance Leadership Team and Service Level Alliance. IT capability is to be maintained and improved including provision of audit tools and/or a dashboard reporting system. • Progressing to work on COPD/respiratory/CVD and Stroke conditions as a focus in 2014/15. • Review and update the Wairarapa Diabetes Care Improvement Plan taking into consideration new agreed models of care for Long Term Conditions Management	

PRIORITY	Prime Minister's Youth Mental Health Project	
Area	**Action**	**Indicators of success**
Improve responsiveness and accessibility of youth mental health services	Child and Youth Health Service Level Alliance The child and youth health service level alliance will be responsible for the local implementation of sub-regional developments in the area of youth health, including workforce development, clinical pathways and the quality improvement framework. The service level alliance will also act as a source for representatives into sub-regional planning groups or meetings related to youth health. Mental Health and Addictions Leadership Group The mental health and addictions leadership group as the local service level alliance will be responsible for developing and implementing improved models of care to ensure better integration between mental health service providers; CAMHS, AOD, NGOs and General Practice. Support Social Sector Trial Initiatives in Wairarapa A Social Sector Trial is operating in the Wairarapa (Masterton, South Wairarapa, and Carterton District Authorities). Health is responsible for two of the five outcomes – reduce risky sexual behaviour and reduced alcohol and other drug use. SIDU will continue working with local Trial Leads to implement identified actions to improve the responsiveness of primary care to youth, reorientate school-based health services to meet new service specifications and improve access to mental health and youth AOD services. A focus will be to improve pathways between existing services, addressing gaps and barriers. These will include the establishment of a clear pathway between school based health	School Based Health Services are delivered as per new service specifications Access to SBHS and HEEADSSS assessments is extend youth enrolled in Te Whare Kura, alternative education and teen parent units Youth aged 12-19 will make up at least 18% of referrals and approved PoC for primary mental health services. Maori, Pacific and high needs population will be identified within this group. Establishment of a clear pathway between SBHS, general practice, mental health and AOD specialist services.

PRIORITY	Prime Minister's Youth Mental Health Project	
Area	**Action**	**Indicators of success**
	services, primary health services, clinicians and specialist services e.g. Mental Health and Addictions	

PRIORITY	People with Disabilities	
Area	**Action**	**Indicators of success**
Improved access to services by vulnerable population groups Improved health and well-being outcomes within vulnerable population groups	Sub-regional Disability Advisory Group with support from Maori and Pacific representatives integrates needs of Maori and Pacific people with disability into existing plans Identify research findings to analyse gaps in access to disability support services for Maori and Pacific people led by Maori and Pacific disabled people Disability icon data increases and dashboard of indicators is developed Use alliance arrangements to improve data on those using the health passport.	Manage my health and read coding gives baseline of health passport users for information of health care providers

WDHB Māori Health Priorities

Improving Māori Health continues to be a priority for WDHB Te Huarahi Oranga – The Maori Health strategy 2010-2015 identifies goals and actions under 3 pou:

Pouaro: actions focus on development of the workforce and culture of Wairarapa health organisations, and measures to assess how well providers integrate Māori world views, values and tikanga into their daily activities.

Poutokomanawa: expectations for health providers as they deliver services across the four output classes – including measures to assess the effectiveness of promotion and screening services and measures to assess the quality and competence of hands on work

Poutuarongo: activities support and enable health services to be more effective for individuals and whānau, including measures to assess the responsiveness and connectedness of health providers to the people they serve.

The actions under these pou fall into the following priorities:

- Supporting Maori values, tikanga practice, and cultural competence in healthcare
- Maori health service development, effectiveness and connection across the continuum of health provision
- Building the workforce

The vision of Te Huarahi Oranga is “Vibrant, strong, confident whanau. WDHB will continue to apply/support strengths based approaches and build on gains.

PRIORITY	Māori Health	
Area	Action	Indicators of success
Workforce development	Increase Māori workforce capacity. Work with Wairarapa DHB Nursing Directorate to increase the number of Māori NEtP applications, interviews and appointments. Identify opportunities to support / promote the NEtP	Number of Māori applying for NEtP programme Number of Māori interviewed for NEtP programme Number of Māori accepted for NEtP programme

PRIORITY	Māori Health	
Area	Action	Indicators of success
	programme. In particular: – Work with the Tertiary Institution in our district; – Support eligible applicants to access resources and support to apply for the NEtP programme; and, – Support access and uptake of Hauora Maori funding	
Provider Development	The Wairarapa Whanau Ora Collective consists of the 2 Wairarapa Maori providers & both Iwi. The DHB will support the implementation of the WOW programme of action and provide whanau ora navigators access to wkforce dev funding &training.	Investments, developments and achievements are clearly identified and measured. Review Provider Capability status / need. Outcome measures in contracts linked to health targets / DHB priorities. All Māori Health portfolio contracts have been approved and contracted. Nil funding decrease in Māori Health portfolio.
Sector Integration	Maintain key links with Māori bodies at local, regional and national forum. Identify opportunities to support / promote the intent of Whānau Ora. In particular: – Work with the Whānau Ora collective in Wairarapa and in the subregion – Support the Wairarapa Whānau Ora collective to access Whānau Ora resources and improve service delivery Participate in opportunities to support / advise / influence	Report learning / achievements of Māori / Māori health at local, regional, national and international levels. Two reports on Māori Health gain areas. A minimum of two meetings with Whānau Ora Regional Leadership Group representatives A minimum of four provider meetings

PRIORITY	Māori Health	
Area	Action	Indicators of success
	Regional Māori Health Plan and Regional Services Plan development & implementation.	
	Monitor and report on Māori Health gain areas.	A minimum of two reports on Māori Health gain areas.
Smoking Cessation	Hospitalised smokers are provided with advice and help to quit.	100% of patients, who smoke and are referred to Whānau Care Services receive smoking cessation advice. All Whānau Care Services service delivery staff undertakes and completes ABC training.