WHANGANUI DISTRICT HEALTH BOARD

Māori Health Plan

2013/2014

Whanganui District Health Board

'Better health & independence'
'He hauora pai ake, he rangatiratanga'
www.wdhb.org.nz

Version 8

Contents

MINISTRY OF HEALTH
MANATŪ HAUORA

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19 June 2013

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Chief Executive Officer
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Tēnā koe Julie

District Health Board Māori Health Plans 2013/14

This letter is to advise you that the Ministry of Health has approved Whanganui District Health Board's Māori Health Plan for the 2013/14 period. We appreciate the considerable work that goes into preparing such an extensive planning document and would like to thank you for the effort put into this plan.

You will know that the March 2012 report from the Office of the Auditor-General identified Māori health as a key area for improvement in DHB initiatives and planning. As such, the DHB Māori Health Plan is viewed as the primary vehicle for demonstrating your planned activity towards improving health outcomes for Māori. It is essential that these plans are comprehensive, robust and align with DHB's Annual and Regional Service Plans. It is encouraging to see that this is reflected in your Māori Health Plan.

We look forward to seeing your progress in achieving the desired outcomes for the year.

Nā māua noa, nā

Teresa Wall
Deputy Director-General
Māori Health

Michael Hundleby
Director – DHB Performance
National Health Board

cc Rowena Kui – Whanganui DHB, Service Planning, Primary Care

1 Māori Health Plan

The Māori Health Plan (MHP) is a document produced by the Whanganui District Health Board (WDHB) that describes our approach for Māori health and reducing inequalities. The MHP is informed by the District Health Boards (DHBs) Māori health needs and identified priorities, within the context of the DHB's strategic objectives, annual plan and its commitments under the regional clinical services plan (refer appendix 1).

The Ministry of Health's Operational Performance Framework 2013/14 outlines the specific requirement for the MHP. The Ministry of Health (MoH), Māori Health Directorate has developed a MHP template which requires all DHBs to provide a summary of their DHBs Māori population and their health needs. It sets out national and local Māori health priorities and is submitted to the Ministry for approval and publication.

2 Whānau Ora

In June 2009 Cabinet approved the establishment of the Whānau Ora Taskforce. Its role has been to develop the framework for a whānau-centred approach to whānau wellbeing and development. The WDHB continues to support the Whānau Ora policy directive as articulated in He Korowai Oranga: Maori Health Strategy (MoH, 2002). Improving Māori health and contributing to Whānau Ora for Māori living in Whanganui are priorities for the WDHB. The WDHB has undertaken three pieces of work in 2012/13 that supports the progression of Whānau Ora implementation by this DHB:

- development of the Whānau Ora Concept Paper
- review of WDHB Huarahi Oranga, Maori Health Strategy 2007/12
- WDHB Whānau Ora Maori Health Needs Assessment.

The concept of Whānau Ora has been used in many ways by Māori and government. The Whānau Ora Concept Paper aims to provide a clear conceptual basis for the WDHB to advance Whānau Ora locally within the context of the range of current Whānau Ora policy, provision and activity. The paper will better enable informed, consistent and evidence-based planning, programming, contracting and provision of Whānau Ora services by:

- providing an up-to-date assessment of the Whānau Ora policy context with particular reference to the role of the health sector
- articulating the meaning of Whānau Ora from a WDHB perspective
- identifying key issues with regard to local Whanganui Whānau Ora provision in health
- discussing the degree of alignment between Whānau Ora within the local implementation of Better, Sooner, More Convenient Primary Health Care and the TPK led Whānau Ora provision.

The review of the WDHB Huarahi Oranga, Māori Health Strategy 2007/13 aims to develop the next five year Māori health strategic direction for the DHB to improve responsiveness to Māori, whanau centred care and improved health outcomes.

The Whānau Ora health needs assessment provides the DHB with an understanding of the health needs of Māori living in Whanganui, which is necessary in order to determine priority areas for service planning that will lead to improved health outcomes and reduced health inequalities. The Whānau Ora health needs assessment will provide a systematic method to assess the health needs of Māori to inform planning and service delivery developments.

The WDHB is committed to supporting Whānau Ora provider collectives to transform to a whānau-centred integrated approach. This aims to maximise the opportunities to support and build capacity and capability of provider collectives to work in a seamless and integrated way with other parts of the social services sector and deliver improved outcomes and results for whānau.

The WDHB will work with the Whānau Ora lead agency provider Te Oranganui Iwi Authority (TOIHA) to implement year 3 of their Whānau Ora business case including:

- implementation of the Information System Strategic Plans (ISSP)
- horizontal integration of TOIHA services to support whānau to meet their identified goals
- continue to implement the Whānau Ora workforce development plan across all TOIHA service groups
- strengthen relationships with other community agencies and organisations
- focus on high need whānau and work with them to identify and achieve their goals towards wellness and improved health outcomes
- develop multidisciplinary team approaches with other primary care (general practice teams) and community services to implement shared Whānau Ora care plans to meet whānau goals
- participate in the Whānau Ora research projects
- increase awareness of Whānau Ora in the community
- strengthen local Māori health provider networks and work towards involvement in Whānau Ora provider collectives
- continue to work with the MoH to move contracts included in the TOIHA integrated Whānau Ora contract to outcomes based contracts.

The WDHB will also continue to represent the other three DHBs across the Te Tai Hauāuru region on the Whānau Ora Regional Leadership Group. It will continue to support the central region DHBs approach to Whānau Ora with the establishment of a repository of Whānau Ora intelligence and information with view to agreeing to a regional position within the next two years.

3 Iwi Relationships

The Iwi within the WDHB region have worked together since the 1980's with the formation of initiatives such as Te Korimako and Waipuna O Te Awa. In 2002 these Iwi came together more formally as Hauora A Iwi and established a memorandum of understanding in 2006 with the WDHB under the requirements set out in the New Zealand Public Health and Disability Act 2000. The memorandum of understanding was last reviewed on 30 November 2012.

Iwi that have signed up to this agreement include:

- Whanganui
- Ngā Rauru
- Ngāti Apa
- O' Taihape
- Ngāti Hauiti
- Ngāti Rangi

The primary and agreed function of Hauora A Iwi is to uphold the principles of the Te Tiriti o Waitangi/Treaty of Waitangi specific to Māori health across the WDHB district:

- to contribute from a Iwi Māori perspective to the strategic and annual planning processes of the WDHB
- undertake strategic monitoring of all services provided to Māori by the WDHB and seek evidence of health improvement for Māori
- maintain a focus on reducing health disparities by improving the health and wellbeing outcomes of Māori and reaffirming a kaupapa Iwi Māori approach to service development

Hauora A Iwi articulated it's identified Māori health priorities to the board of the WDHB at a meeting held on 7 December 2012. The Iwi partners outlined a clear focus for the 2013/14 MHP specific to maternal/newborn engagement and enrolment. It includes the continuity of care for women and infants identified as experiencing multiple adversities before and after birth. In addition to these priorities oral health, mental health, renal, SUIDI and asthma were also identified as priorities for Hauora A Iwi.

4 Health Service Providers

Key health providers in WDHB area include:

- Wanganui Hospital, Inpatient, Mental Health, Community and Public Health Services
- WDHB Rural Health Centre and Services are based in:
  - Marton
  - Raetihi.
- Taihape Health Services (Integrated Family Health Centre)
- Whanganui Regional Primary Health Organisation
- Te Oranganui Iwi Health Authority (Whānau Ora Provider)
- aged related care and community support services
- community mental health services
- Wanganui Hospice
- youth health services
- hospital and community pharmacy
- Kaupapa Māori health providers (refer section 5).

5 Kaupapa Māori Health Providers

The Māori Health Outcomes Advisory Group (MHOAG) was established to improve relationships between local contracted Kaupapa Māori providers and the WDHB. The focus for the development of MHOAG acknowledges

that iwi health provider organisations are the local experts in reaching and working with Māori communities to provide health services in a way that will work towards reduced inequity and improved health outcomes for Māori over time.

They bring strong and effective advice and support to the planning and decision making processes for the district health board. They collectively increase our capacity and capability in responding to the needs of Māori in our community. A secretariat for MHOAG funded by WDHB is run under Te Oranganui Iwi Health Authority.

The membership of MHOAG includes the senior managers of the following Kaupapa Māori Health Providers:

- Ngāti Rangi Community Health Centre
- Otaihape Māori Komiti Taumatua Atawhai Hauora
- Te Kotuku Hauora O Rangitikei
- Te Oranganui Iwi Health Authority
- Te Puke Karanga Hauora.

In December 2012 MHOAG reconfirmed the need to focus on long term conditions including: diabetes, respiratory, cancer, cardiac, smoking, nutrition, immunisation, cervical and breast screening, mental health and oral health. Additional health priorities outside the long term conditions includes: tane ora, physical activity, healthy homes and transport and accommodation.

6 Demographic

Whanganui DHB serves a population of 63,520 (Ministry of Health DHB Population for 2011, September 2010) which includes the Wanganui and Rangitikei Territorial Authority areas, and the Ruapehu Territorial Authority area wards of Waimarino and Waiouru, known as South Ruapehu.

TLA Geographic Distribution

	Whanganui TLA	Rangitikei TLA	Ruapehu TLA[i]
Total Pop.	43,500	14,860	4,920
Māori Pop.	10,300	3,800	1,840
Māori (%)	23.7%	25.6%	37%

Māori TLA populations and percentage compared to total population 2006

[i] Waimarino and Waiouru ward of the Ruapehu TA. Populations estimated from Statistics NZ

The district covers a total land area of 9,742 square kilometres, much of which is sparsely populated. The terrain is mountainous with two major centres, Wanganui City with a population of 39,990 and Marton with a population of 4,680. The major centres are supported by five smaller towns with a population less than 2000, Waiouru 1,380, Taihape 1,790, Bulls 1,660, Ohakune 1,100 and Raetihi 1,040.(Census 2006, Statistics New Zealand).

Compared to the New Zealand average, the population of Whanganui is characterised by a large percentage of Māori (23%), small but growing population of Pacific peoples and Asian people (2% each group), a higher percentage of young people under 15 years of age (22%) and a relatively large percentage of older people (16%).

The district is also home to a higher percentage of children and young people, with 22.2% less than 15 years of age (as compared to 21.5% for New Zealand), of which 37% are of Māori ethnicity. This reflects the younger Māori population structure as in the rest of the country.

Whanganui has a higher than average population of older aged citizens – with 15.7% older than 65 years of age (compared to 12.3% for the rest of the country in 2006). It is forecast that in the next 10 years, 20% of the Whanganui population will be older than 65 years of age. As older people, like young people, are high health care users, this demographic change has real implications for future provision of health services.

The Whanganui District Health Board population profile is changing. There is a projected slow decline in the general population numbers, however, a projected increase in the Maori population, whilst at the same time the proportion of people over 65 years old is increasing.

The 2009 Social Report tells us that the life expectancy for males living in Whanganui/ Rangitikei/Ruapehu is 76.5 years. Māori and Pacific males have a lifespan that is approximately 11 years shorter than their Pakeha counterparts in this region. The life expectancy for females across this region is 81.4 years. Māori and Pacific females have a lifespan that is approximately 8 years shorter than their Pakeha counterparts in this region. 26.3% of the population across Whanganui/ Rangitikei/ Ruapehu are smokers with an overall inpatient smoking prevalence of 21.4%. This is more evident in young females (under 25 years across all ethnic groups) and Māori with 46% being smokers.

7 Māori Health Status

WDHB Births

The recent regional women's health service developments provide an excellent opportunity for the WDHB to focus on the quality of maternal services. The DHB will look to focus on our antenatal and post natal educations and services as directed by its Iwi relationship board, Hauora A Iwi. This table highlights the large numbers of Māori births being delivered in WDHB facilities. Māori women tended to give birth at a younger age than other ethnicities with approximately 35 percent of all Māori women giving birth were aged 22 years or younger.

		Births			
		Maori	**Other**	**Maori %**	**Other %**
2012	1	21	46	31.34%	68.65%
	2	27	33	45%	55%
	3	17	34	33.33%	66.66%
	4	29	30	49.15%	50.84%
	5	36	39	48%	52%
	6	29	36	44.61%	55.38%
	7	23	37	38.33%	61.66%
	8	22	26	45.83%	54.16%
	9	17	26	39.53%	60.46%
	10	33	37	47.14%	52.85%
	11	32	38	45.71%	54.28%
	12	30	31	49.18%	50.81%
	Totals	**316**	**413**	**43.14%**	**56.66%**

Total WDHB births delivered in DHB facilities 2012

ED Presentation and Admissions

Māori emergency department (ED) presentations and admissions evidence a high volume of Māori patients and need. This table highlights the high number of Māori ED presentation and subsequent hospital admissions compared to the general Māori population of 23%. High numbers of avoidable Māori ED presentations reflects a lack of integrated approach to care across services and sectors. Māori continue to experience high morbidity and mortality when compared to non- Māori, however, when Māori enter hospital they are more likely to be discharged earlier.

		Māori				Other			
		No Presented	% Presented	No Admitted	% Admitted	Presented	% Presented	Admitted	% Admitted
2012	1	432	27.91%	164	25.43%	1116	72.09%	481	74.57%
	2	472	29.37%	191	29.89%	1135	70.63%	448	70.11%
	3	419	26.69%	137	22.39%	1151	73.31%	475	77.61%
	4	405	28.99%	170	28.01%	992	71.01%	437	71.99%
	5	465	28.65%	198	28.09%	1158	71.35%	507	71.91%
	6	406	26.45%	141	22.67%	1129	73.55%	481	77.33%
	7	501	29.82%	206	26.96%	1179	70.18%	558	73.04%
	8	504	26.65%	224	27.25%	1387	73.35%	598	72.75%
	9	430	25.75%	162	22.91%	1240	74.25%	545	77.09%
	10	431	26.47%	159	23.63%	1197	73.53%	514	76.37%
	11	451	27.89%	171	24.71%	1166	72.11%	521	75.29%
	12	436	25.78%	141	22.10%	1255	74.22%	497	77.90%

Total ED presentations and admissions Māori compared to other 2012

Whanganui Hospital DNAs

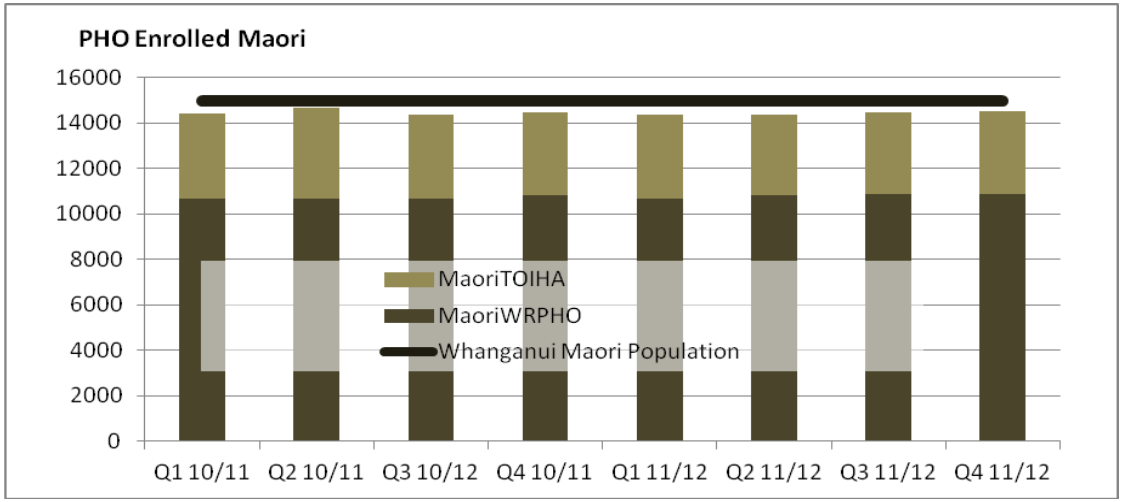
The WDHB do-not-attend (DNAs) are significant and must remain a priority for 2013/14 MHP. This table highlights a disproportional number of Māori not attending their prearranged inpatient or outpatient appointments. The high volume of missed appointments and the financial costs associated with DNAs reinforces the need to review our systems and processes with view to lowering the number of DNAs.

		Maori DNAs			Other DNAs			Grand Total
		New	Subsequent	Total	New	Subsequent	Total	
2012	10	69	81	150	63	155	218	**368**
	11	77	88	165	55	111	166	**333**
	12	73	79	152	63	90	153	**305**
	Totals	219	248	467	181	356	537	**1006**
	%			**46%**			**53%**	

Total DNAs Māori *compared to other October to December 2012*

Primary Health Care

Enrolment in a primary health organisation (PHO) is voluntary and people are encouraged to join a PHO in order to gain the benefits, which include lower cost visits and reduced costs on prescription medicines. There are two PHOs in place across the Whanganui district and as the table below suggests we have a small proportion of the Māori community that are not enrolled with a PHO.



Total numbers of Māori patients enrolled with each PHO by quarters 2011/12

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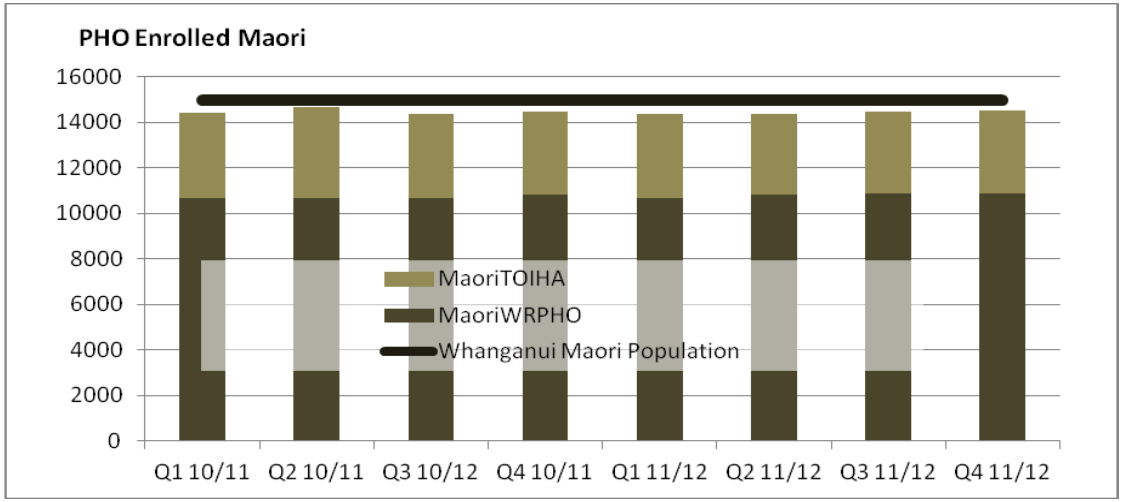

Total numbers of Māori patients enrolled with each PHO by quarters 2011/12

The National Hauora Coalition and their local practice Te Oranganui Iwi Health Authority has a total enrolled population of 6,179, inclusive of one urban practice in Whanganui city and two rural practices in Ohakune and Waverley. The Whanganui Regional PHO has a total enrolled population of 57,239, at 1 April 2012. These enrolments are spread across 14 urban practices and four rural practices. PHO enrolment numbers have remained constant over the last two years and as at December 2012, 14,493 Māori patients were enrolled with a PHO. The 2013 census will provide the DHB with updated population figures that can then be applied to the Māori PHO enrolment numbers.

Leading Causes of Avoidable Hospitalisation

The leading causes of avoidable hospitalisation and amenable mortality are ranked below based on 2011-2012 data.

	Amenable Mortality		Avoidable Hospitalisation	
	WDHB	**NZ**	**WDHB**	**NZ**
Māori	1 CVD	CVD – IHD	Dental Conditions	Respiratory infections
	2 Lung cancer	Lung cancer	Cellulitis	Cellulitis
	3 Stroke	Diabetes	Angina & chest pain	Angina
	4 COPD	COPD	Asthma	COPD
	5 Diabetes	Road traffic injuries	Respiratory infection	Asthma
Non-Māori	1 CVD - IHD	CVD – IHD	Angina & chest pain	Angina
	2 COPD	Lung cancer	Gastroenteritis	Respiratory infections
	3 Stroke	Colorectal cancer	Cellulitis	Cellulitis
	4 Prostate	Suicide & self harm	Respiratory	Road traffic injuries
	5 Colon Cancer	Road traffic injuries	Upper Respiratory	ENT infections

Top five amenable mortality and avoidable hospitalisations WDHB compared to national Māori and non- Māori 2011-2012

8 Māori Health Priorities 2013/14

The following Māori health priorities will be the focus of the Maori Health Priorities 2013/14:

1. Focus on maternal and child health as agreed with Hauora A Iwi:
   a. increase access to antenatal care
   b. increase access to antenatal education
   c. reduce avoidable hospitalisation (ASH) and repeat presentations to hospital
   d. reduce child hospital admissions associated with social factors
   e. maintain Māori participation on the Child and Youth Health Governance Group.

2. Implementation of the Regional Women's Health Services (RWHS) Plan and lead the RWHS Cultural Advisory Group.

3. Implementation of Whānau Ora across the WDHB district and DHB regional representation on the Te Tai Hauāuru, Whānau Ora Regional Leadership Group.

4. WDHB representation on the Hei Ahuru Mowai, the National Māori Cancer Control Network.

5. Focus on participation of joint WDHB/Whanganui Regional Public Health Organisation (WRPHO) clinical boards' various work streams, including pathway developments, continuous quality improvement initiatives, and monitoring of standards of practice.

6. Reduce Māori hospital inpatient and outpatient DNAs.

7. Consider the impact of Māori health in every strategy development across the district.

8. Implementation of the agreed recommendations from the reviews of the Whānau Ora.

9. Concept Paper, Whānau Ora Health Needs Assessment and evaluation of the WDHB Huarahi Oranga, Maori Health Strategy 2007-2012.

9 National Indicators

	Health Issue	Indicator	Baseline	Target	Rationale[†]	Activities
N1	Data Quality	Accuracy of ethnicity reporting in PHO registers (by ethnicity).	98.7% (total accuracy of registers).	Increase by 0.5-2%.	▪ The accuracy of ethnicity data in PHO and DHB databases is variable. ▪ Accurate ethnicity data is essential for tracking progress in Māori health outcomes. ▪ Ethnicity Data Protocols Supplementary Notes (MoH 2009).	▪ Meet quarterly with PHOs to assess ethnicity accuracy of registers. ▪ Tender for the MoH Primary Care Ethnicity Data Audit Tool Kit with PHOs to assess the quality of ethnicity data and systems for data collection, recording and output within primary health care settings and quality improvement – 2013-14. ▪ Implement the recommendation from the above evaluation.
N2	Primary Care Access	Percentage of Māori enrolled in PHOs.	88% (total enrolled population).	100 % (total population)	▪ Total population enrolled April 2013 96%. Total Maori enrolments April 2013 88%. ▪ PHO enrolment rates vary throughout the country. ▪ PHO enrolment facilitates easier access to preventative health care and early condition management.	▪ Advance targeted strategies to increase Māori PHO enrolments in primary care – Q1 2013-14. ▪ Monitored by TAS consolidated central regional reporting quarterly. ▪ Maori liaison services that identify non-enrolled Maori patients and whanau and link them to general practice prior to discharge. ▪ Maori health unit participation in the repeat hospital presenters/ admissions project with focus on Māori non-enrolment and Māori ASH rate disparity Quarter One 2013-14. ▪ Develop a business case aimed at reducing inpatient and outpatient hospital DNAs by October 2013. ▪ Continue to implement of Stanford

[†] Unless stated otherwise, mortality and morbidity data have been sourced from the latest edition of Tatau Kahukura

<table>
<tr>
<td></td>
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<td>Ambulatory sensitive hospitalisation rates per 100,000:

0-74 years
<table><tr><td>Maori DHB rate</td><td>3,914</td></tr><tr><td>National all rate</td><td>1,983</td></tr><tr><td>Baseline %</td><td>197%</td></tr><tr><td>Target actual 2013/14</td><td>3,331
168%</td></tr></table>
45-64 years
<table><tr><td>Maori DHB rate</td><td>3,082</td></tr><tr><td>National all rate</td><td>1,661</td></tr><tr><td>Baseline %</td><td>186%</td></tr><tr><td>Target actual 2013/14</td><td>2,624
158%</td></tr></table>
0-4 years
<table><tr><td>Maori DHB rate</td><td>12,174</td></tr><tr><td>National all rate</td><td>5,641</td></tr><tr><td>Baseline %</td><td>216%</td></tr><tr><td>Target actual 2013/14</td><td>10,323
183%</td></tr></table>
*note for 2013/14 change in denominator from estimation of census 2006 data to actual PHO enrolled population per age band</td>
<td>0-74yrs
197%

45-64 yrs
186%

0-4yrs
216%</td>
<td>0-74yrs
168%

45-64yrs
158%

0-4yrs
183%</td>
<td>▪ ASH rates for Māori reflect lower socio-economic issues and opportunities to enhance shared care pathways between the hospital and primary health.
▪ Effective primary care can reduce ASH rates.</td>
<td>model of self management for chronic disease across general practice in the WDHB area Quarter one 2013-14.
▪ Paediatric services and ED to work more closely with the paediatric kaupapa Maori Nursing liaison service to reduce repeat admissions.
▪ Monitor implementation of ASH related clinical guidelines and patient pathways including childhood respiratory, asthma and skin conditions.
▪ Maintain equitable access to free after hours services for children under six years.
▪ Monitor the implementation of the front door/acute demand management initiative for more efficient use of resources across Emergency Department and Whanganui Accident and Medical clinic and linking children and whanau back to community based services (kaupapa Maori services and primary care).
▪ Maintaining access to mobile school based oral health services for preschool and school age children and adolescents.
▪ Report the following specific measures/outcomes as outlined in the Whanau Ora programme provider 6 monthly reporting:
▪ Number of whanau (including tamariki under five years)actively engaged in the local Whanau ora programme broken down by:
▪ Percentage of whanau whose level of need has dropped at a review period through whanau planning</td>
</tr>
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N3	Child Health	Full and exclusively breastfeeding at: Six Weeks Three months Six months	Provisional data as at Q4 2011/12- awaiting MoH update 57%(Maori) 62%(Total) 45%(Maori) 46%(Total) 10%(Maori) 13%(Total)	 64% 48% 15%	▪ Māori breast-feeding rates remain consistently lower than non-Māori rates. ▪ Fertility rates for Māori women are higher than those for non-Māori. ▪ MoH Breastfeeding Targets.	▪ Increase Māori breastfeeding rates by increasing Māori access to antenatal and parenting education- monitor reporting each quarter. ▪ Māori representation on: Maternal & Perinatal Review: Maternity Safety and Quality; RWHS Governance; RWHS Cultural Advisory Group that increases cultural responsiveness of this service- commencing quarter one 2013-14. ▪ Appoint breastfeeding baby friendly community coordinator under the WRPHO by 1 July 2013.
N4	Tertiary cardiac interventions Cardio vascular disease	70% of high-risk patients will receive an angiogram within three days of admission. Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANAC Q1 ACS and Cath/PCI registry data collection within 30 days. Percentage of eligible population who have completed a cardiovascular risk assessment (CVRA) with in the past five years.	Baseline to be established 2013-14 Baseline to be established 2013-14 51.5%	70% 95% 90% by 30 June 2014	▪ Cardiovascular disease is the leading cause of mortality for Māori, with rates 2.5 times those of non-Māori. ▪ Māori hospitalisation rates are almost double those of non-Māori. ▪ Diabetes complication rates are highly disparate - renal failure is eight times greater in Māori.	▪ Implement the joint clinical governance Cardiac Clinical Pathway including recommendations completed in 2012/13 i.e. mapping the patient experience and outcome, review of cardiac DNAs and whanau ora navigation support to high risk cardiac patients and their whanau in quarter two 2013-14. Work with clinical champion and primary care stakeholders effective 1 July 2013 to: ▪ identify eligible populations (including any demographic

						changes) ▪ proactively contact/invite people due for CVD risk assessment ▪ build systems to ensure people attend CVD risk assessments (eg, efficient recall systems) and fully report performance ▪ ensure the expertise, training and tools they need to successfully complete the CVD risk assessment to meet clinical guidelines ▪ develop effective services tailored to the needs of targeted patients ▪ explore Maori concepts and models of care to reduce DNA rates for Maori, improve awareness and uptake of screening and intervention ▪ report progress on each initiative quarterly.
N5	Cancer	Breast screening – two years' coverage of wahine aged 50 – 69 years. WDHB PPP report 31 March 2013 Cervical screening- three years' coverage for wahine aged 20-69.	74% (high needs women) 76%	70% 80% by December 2014	▪ Population screening for breast and cervical cancer improves both morbidity and mortality from these cancers. ▪ Cancer screening aims to detect cancer before symptoms appear. The benefits of cancer prevention, early detection and subsequent treatment must be weighed against any harms.	▪ Placement of WDHB public health cervical screening coordinator with the WRPHO to work closely with all general practice teams to improve data collection , recall systems, education and training support to practice nurses to increase focus on reaching vulnerable women and monitor screening uptake – quarter one 2013-14. ▪ Maintain Maori health provider support for wahine enrolled in whanau ora services to access screening services – mobile clinics, rural clinics and transport to group clinics. ▪ Continue the provision of outreach screening services in rural areas. ▪ Continue to participate on Hei Ahuru Mowai Hui, National Māori Cancer Control Network that connects Whanganui to national cancer priorities continuing from

						1 Juy 2013 ▪ Initiate sub regional Māori community hui as part of the Hei Ahuru Mowai MPDS contract with MoH before 1 October 2013. ▪ Ensure Māori participation on Whanganui Cancer Control Network and CCN activities regionally – ongoing through 2013-14. ▪ Increase access to breast screening for high needs women and those living in rural areas rural communities, through dedicated resource to promote screening services to Maori wahine, transport wahine to screening opportunities, liaise with mobile screening services and work with general practice services and Maori health services (joint initiative between BSA, WDHB and Te Oranganui Maori health provider services). Maximise the usage of the vehicle provide by BSA for this initiative: effective 1 July 2013. ▪ Monitor by TAS consolidated central regional reporting quarterly.
N6	Smoking	Hospitalised smokers provided with advice and help to quit (ht) (by ethnicity). Current smokers enrolled in PHO and provided with advice and help to quit (ht) (by ethnicity).	95% 37%	95% 90%	▪ Māori adults are 2.3 times as likely to be current smokers as non-Māori. ▪ Nationally 50% of Māori female adults are smokers. ▪ Smoking prevalence for Māori women utilising WDHB maternity services	▪ Restructure WDHB smoke free staff into a virtual multidisciplinary team including medical champion; nurse managers; mental health and health promotion to improve DHB smoke free coordination in collaboration with PHOs, quit clinic, Maori health providers and communities effective 1 July 2013. ▪ Increase numbers of Māori referred to cessation services

					was 56% (May 2012). ▪ National average 41% at April 2013.	from general practice by working with quit clinic and Te Orangan Whanau ora ui Maori provider cessation services effective 1 July 2013. ▪ Improve linkages back to community cessation support services once people are discharged form hospital services commencing 1 July 2013. ▪ Facilitate a quit clinic for staff on the WDHB campus commencing 1 July 2013. ▪ Establish new signage on WDHB campus, which includes an audio messaging and a linked up health TV system within the hospital commencing 1 July 2013. ▪ Facilitate a community 'think tank' based on the NZ tobacco 2025 vision that establishes a smoke free plan for Whanganui with the WRPHO Quit Clinic before 1 October 2013. ▪ Maintain the Director Māori Health tobacco sponsor for EMT. ▪ Embed medical champion role across clinical areas within the hospital commencing 1 July 2013. ▪ Focus on an initiative to reduce smoking for pregnant women commencing 1 July 2013. ▪ Tender for MoH integration of maternity and child services EOI commence as agreed with the MOH if successful. ▪ Monitor by TAS consolidated central regional reporting quarterly and monthly internal WDHB reporting by service.
N7	Immunisation	Percentage of infants fully immunised. By eight months of age (ht) (by ethnicity).	Baseline 93%	95%	▪ Improved immunisation coverage leads directly to reduced rates of vaccine	▪ Improve flow of maternal to child health services including % of babies by ethnicity enrolled with GPs at six weeks, monitor quarterly.

		Seasonal influenza immunisation rates in the eligible population 65 years and over (by ethnicity).	72%	>65%	preventable disease, and consequently better health and independence for children. ▪ Fewer Māori are fully immunised when compared with non-Māori. ▪ High need 65+ population target per WDHB Annual Plan. Note no Māori specific data collection.	▪ Continue to increase Māori participation in antenatal education services – quarterly reporting. ▪ Review the coordination of immunisation services from general practice, outreach, school, hospital and other community settings before 1 October 2013. ▪ Improve health literacy of Māori aged 65+ years in relation to influenza immunisation by working with local Whanganui kaumatua groups commencing 1 July 2013.
N8	Rheumatic Fever	2013/ 2014 Hospitalisation rates (per 1000,000 total DHB population) for acute rheumatic fever are 10% lower than average over the last three years.	New Indicator	2.9 per 100,000	▪ Rheumatic fever can result from a throat infection caused by Group A Streptococcus (GAS) bacteria if not identified and treated early enough. It can also cause permanent heart damage and reduce life expectancy. ▪ Children between 5 and 14 years of age are particularly affected and Maori and Pacific children nationwide have 20 to 40 times higher rates of the disease than other groups.	▪ WDHB will develop and implement a rheumatic fever prevention plan by 20 October 2013. ▪ Facilitate an awareness campaign in the Māori community on the connection between inflammatory disease that may develop after an infection with streptococcus bacteria and this link to rheumatic fever.

10 Local Priorities

The local WDHB health indictors have been worked up with the intent that the new maternity data base that will come on line in July 2013 will be able to provide additional information DHB based on identified priorities. These health indictors apart from SUDI are new data sets and therefore baseline and target measures are yet to be developed. Please note that the MoH Operational Policy Framework requires DHB to only identify three local health indictors as part of the MHP template.

	Health Issue	Indicator	Baseline	Target	Rationale	Activities
L1	Child and maternal health, including access to antenatal care and education	Percentage of women who are pregnant who have attended antenatal education by ethnicity, first and subsequent pregnancies and rural and urban programmes. Number of hapu women who are linked to whānau ora services with a shared care plan between the LMC and the whānau ora navigator by ethnicity.	New indicator New indicator	Baseline to be established in 2013-14 Baseline to be established in 2013-14	▪ Hauora A Iwi has agreed with the the WDHB to focus on postnatal health services as part of the child health continuum including maternal/newborn engagement and enrolment. ▪ This includes the continuity of care for women and infants identified as experiencing multiple adversities before and after birth. ▪ Hauora A Iwi is concerned that risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression, arise in childhood. ▪ Iwi recognise that child health, development and wellbeing also has broader effects on educational achievement, violence, crime and unemployment. ▪ The Māori wahine rate for use of neonatal hospital services is the highest diagnosis related group coded at 40% of all admissions to that unit. ▪ The Māori infant mortality rate is one and a half times that of non-Māori.	▪ Increase participation in antenatal education services being delivered to Māori – monitor quarterly. ▪ Initiate strategies that will reduce tobacco prevalence with Māori who are hapu - plan developed to commence before 1 October 2013. ▪ Implement a cultural competency programme as part of the new RWHS – planned commencement date by 30 June 2014. ▪ Review the implementation of the newborn enrolment form and timeliness of enrolment to wellchild/ tamariki ora services by ethnicity- quarterly monitoring and annual review. ▪ Review infant hearing screening rates and referral for diagnostics by ethnicity – quarterly. ▪ Review the following child health indictors: ▪ status of maternal registration with a lead maternity carer at 12 weeks by ethnicity -annually ▪ proportion of eligible children receiving B4 school checks by ethnicity – quarterly ▪ dental service attendances under 5 by ethnicity- quarterly. ▪ Ensure Māori participation in key advisory service and quality groups effective 1 July 2013 : ▪ Maternal & Perinatal Mortality

						Review Committee ▪ Regional Women's Health Service (RWHS) Governance Group ▪ Chair RWHS Cultural Advisory Group ▪ Maternity Safety and Quality Whanganui locality group.
L2	Sudden Unexplained Death of Infants Syndrome	SUDI death rate per 1,000 live births by ethnicity	3.77	0.5 SUIDI deaths rate per 1,000 live births (by ethnicity).	▪ The SIDS rate for Māori infants was 2.0 deaths per 1,000 live births, over 5 times the non-Māori rate of 0.4 per 1,000 live births, accounting for half the overall mortality disparity. ▪ Monitor SUDI by MoH mortality reporting and yearly publications of the 'Health Status of Children and Young People' by Otago University for WDHB.	▪ Strengthen tobacco cessation support in pregnancy and on maternity and children's wards by restructuring smoke free coordination services effective 1 July 2013. ▪ Māori participation on the Maternal & Perinatal Mortality Review Committee (currently vacant) 1 July 2013. ▪ Connect SUDI work stream as part of the RWHS development. ▪ Coordination of local activity with Whakawhetu National SUDI Prevention for Māori education to sector – effective 1 July 2013.

Appendix 1

Context of Māori Health Plan

1. Background

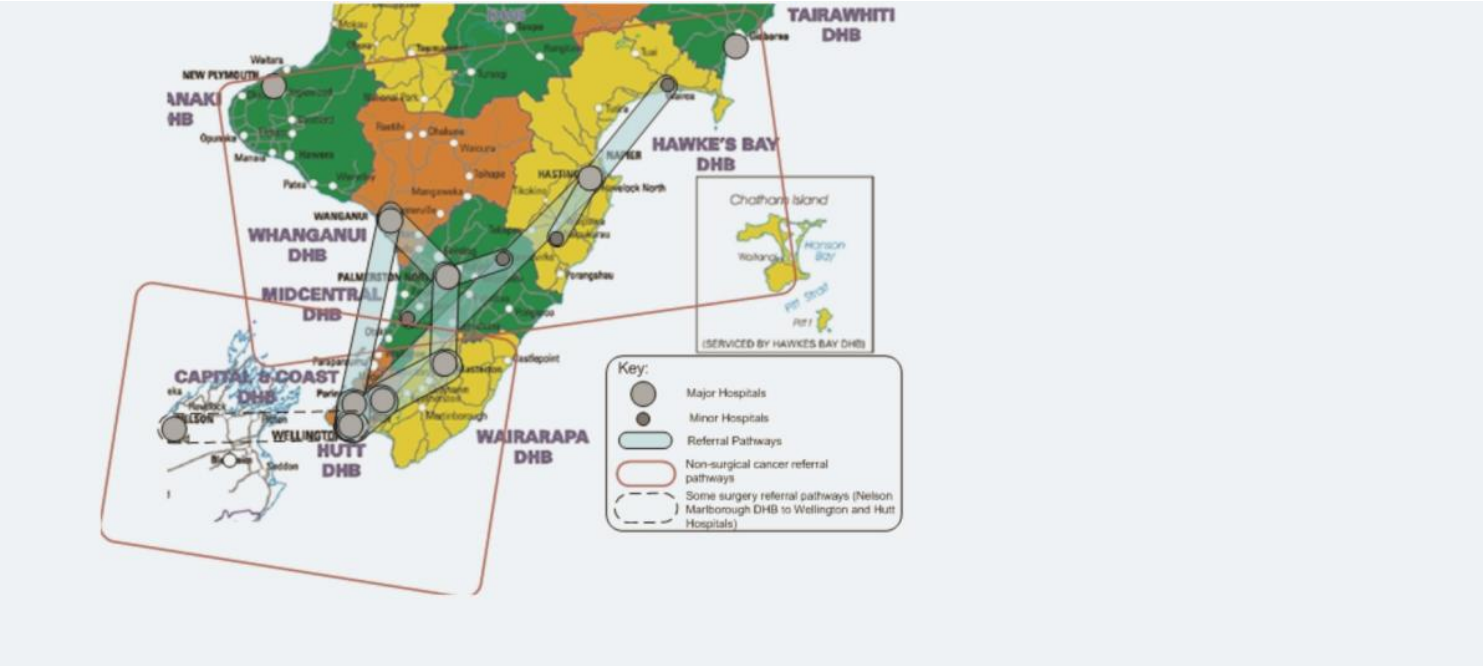
Whanganui is one of twenty DHBs in New Zealand, and was established under the New Zealand Public Health and Disability Act 2000. This Act sets out the roles and functions of DHBs. District Health Boards, as Crown Agents, are also considered Crown Entities, and covered by the Crown Entities Act 2004. The statutory objectives of DHBs include:

- improving, promoting and protecting the health of communities
- promoting the integration of health services, especially primary and secondary care services
- promoting effective care or support of those in need of personal health services or disability support

2. Regional Priorities

Whanganui is one of the six DHBs in the Central Region which have responsibility to ensure the provision of primary, secondary and community services for their respective populations. The Central Region is committed to delivering health services that are configured to best meet the needs of its population, and is sustainable in the longer term which means managing a workforce to sustainably deliver services. To maintain services the region will need to focus on building partnerships with providers to maintain the accessibility and affordability of services as it transitions to more localised care. This will require the region's health services to evolve and change. Consumer involvement and community consultation are an important part of this development.

Fostering partnerships with community service and primary care providers will be increasingly important. The majority of primary care services will be provided at a local level. This is in line with the Government's expectations of improving access to services by providing them closer to home while increasing the provision of services and reducing waiting times.
To meet the immediate challenges of increasing demand, cost pressures and government expectations, service areas that have been prioritised by the six Central Region DHBs for 2013/14 are: cancer, cardiac, stroke, electives, Maori health, population health, quality and safety, radiology, renal and clinical networks.



Central DHB Region Networked Hospital & Associated Referral Pathways

The Central Region Māori DHB Managers continue to meet on a regular basis and support regional service priorities and provides a leadership function. The agreed Māori regional priorities for 2013/14 including the following areas:

1. Whānau Ora Outcomes
2. Māori Workforce Development
3. Annual Māori Health Plan Indicators

3. Whanganui DHB Vision

The vision of this DHB is:

'Better health and independence' through integrity – fairness – looking forward – innovation'

To the DHB, achievement of this vision means:

- people enjoy healthy lifestyles within a healthy environment
- the healthy will remain well
- health and disability services are accessible and delivered to those most in need
- the health and wellbeing of Māori is improved
- the quality of life is enhanced for people with diabetes, cancer, respiratory illness, cardiovascular disease and other chronic (long duration) conditions
- people experiencing a mental illness receive care that maximises their independence and wellbeing
- the needs of specific age-related groups, e.g. older people, children/youth, are addressed
- the wider community and family supports and enables older people and the disabled to participate fully in society and enjoy maximum independence
- oral health is improved
- people's journey through the health system is well managed and informed.

Whanganui DHB's strategic direction is underpinned by section 38(2d) of the New Zealand Public Health & Disability Act 2000. Whanganui DHB's Annual Plan gives effect to that direction.

4. Local Priorities

Whanganui DHB has identified a number of local priorities that are consistent with the national, regional and sub-regional directions.

- Fostering clinical leadership.
- Improving quality and safety.
- Improving health for priority populations through service integration.
- Improving financial performance.