Nelson Marlborough District Health Board

Te Tau Ihu Māori Health Plan

2016/17

NELSON BAYS PRIMARY HEALTH

Kimi Hauora Wairau
Marlborough Primary Health Organisation
SEEKING WELLBEING IN MARLBOROUGH

Nelson Marlborough District Health Board

Te Piki Oranga
MĀORI HEALTH SERVICES

No.1 The Terrace
PO Box 5013
Wellington 6145
New Zealand
T+64 4 496 2000

12 September 2016

Mr Peter Bramley
Chief Executive Officer
Nelson Marlborough District Health Board
chris.fleming@nmdhb.govt.nz

Tēnā koe Peter

Approval of District Health Board (DHB) Māori Health Plan 2016/17

We are pleased to approve your Māori Health Plan for the 2016/17 period. Your staff have worked hard to develop the Māori Health Plan and have worked well with the Ministry during this time.

In particular I would like to congratulate your team on exceeding the target (70%) for breast screening. The DHB has achieved 73 percent screening coverage for Māori women.

I would also like to acknowledge the effort the DHB is making towards achieving the 95 percent coverage for eight month old Maōri babies fully immunised. Between March 2015 and March 2016 the coverage has increased nine percent to 93 percent.

The next step is for your DHB to make your Māori Health Plan publicly available on your website. Please also send the link to Delphina Gray who will ensure it is linked on the MYDHB website (delphina_gray@moh.govt.nz).

We look forward to seeing your progress in achieving the targets for the 2016/17 year. Thank you for your continued commitment to improving health equity for Māori.

Nāku noa, nā

Jill Lane
Director
Service Commissioning

cc Ms Jenny Black, DHB Board Chair – jenny.black@nmdhb.govt.nz

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1. EXECUTIVE SUMMARY

E ngā reo, e ngā mana, tēnā koutou katoa ngā rau rangatira

Improved service delivery and health equity continue to be the focus of the partnership that exists through the Nelson Marlborough Health System. Nelson Marlborough DHB working with Nelson Bays Primary Health, Kimi Hauora Marlborough PHO and Te Piki Oranga will see our focus being geared towards demonstrating our shared commitment to Māori health improvement.

Underpinning this direction is the 30 year vision for Māori health *'Kia korowaitia aku mokopuna, ki te korowaitanga hauora', 'wrapping our future generations in a korowai of health and wellness'.*[1] Through the vision this plan seeks to embed the ownership and accountability for achieving change within the generations to follow. Our combined efforts as a health system will ensure there is planned improvement both for the short and long term benefit of Māori living across Nelson Marlborough.

The 2016/17 year has as its focus sector leadership and shared accountability. The actions and priorities are intended to show what we are doing in leading change. There is greater alignment to the Annual Plan and through this planning process to the revised NZ Health Strategy and National Māori Health Strategy, He Korowai Oranga. Delivering coordinated services regardless where they are being provided within the community should improve the opportunities that are available to Māori communities.

The overall aim as we move forward into 2016/17 is to demonstrate stronger leadership, strengthen the shared reporting across the Nelson Marlborough Health System and show our combined performance against the National Māori Health Targets. We look forward to releasing and promoting our results to show-case our achievements against this plan.

Beth Tester
Chief Executive
Marlborough Primary Health

Peter Bramley
Acting Chief Executive
Nelson Marlborough Health

Anne Hobby
Tumuaki/General Manager
Te Piki Oranga

Angela Francis
Chief Executive
Nelson Bays Primary Health

[1] Nelson Marlborough Māori Health and Wellness Strategy 2008

2. NELSON MARLBOROUGH MĀORI POPULATION

Te Tatauranga o te Iwi – Population Demographic

3.1 Population Profile

Tasman District Council, Nelson City Council and Marlborough District Council are the three territorial authorities which are part of the Nelson Marlborough DHB service coverage area. Ten percent of the Nelson Marlborough population are of Māori descent.

Table 1 – Māori ethnic population medium projections by regional council area. (* 2006 baseline)[2]

Territorial Local Authority	2006*	2013 Actual	2016 Projected	2021 projected
Tasman District	3063 (28%)	3441 (28%)	3800 (26.5%)	4100 (26.5%)
Nelson City	3615 (33%)	4167 (34%)	5000 (35%)	5500 (35.5%)
Marlborough District	4275 (39%)	4776 (39%)	5500 (38.5%)	5900 (38%)
Nelson Marlborough (2006 base)	**10,953**	**12,384**	**14,300**	**15,500**
Nelson Marlborough (2013 base)			**14720**[3]	**15850**[3]

Data from the Nelson Marlborough DHB Māori Health Profile 2013 and Nelson Marlborough Health Needs and Service Profile 2015:

- There is an expected increase in the Māori population to 9.5% of the total population based on population projections. This still remains less than the national average of 15%.
- Maata Waka represents the largest portion of Māori living in Te Tau Ihu.
- Marlborough district has the highest proportion of the total Māori population (39%), followed by Nelson, then Tasman.

2.2 Age/ Gender

- The Māori population is relatively young, with a median age of 24.8 years, compared to 43.5 years for the total Nelson Marlborough population. In 2013, Māori comprised 18% of the district's children aged 0–14 years and 16% of those aged 15–24 years.
- The age structure for Te Tau Ihu Māori and the region's total population differ significantly.
- The gender distribution for Nelson Marlborough Māori is split evenly (50%/50%).

Whānau Ora – Health Families

2.3 Whānau Well-being

- Almost 85% of Māori adults in Nelson Marlborough, Canterbury, West Coast and South Canterbury DHBs combined reported that their whānau was doing well or extremely well in 2013. However 5% felt their whānau was doing badly or extremely badly. These were similar to the national findings of Te Kupenga.

2.4 Whānau Support

- In 2013, the majority of Māori adults across the Nelson Marlborough and three other DHBs combined (77%) reported having easy access to whānau support in times of need. However, an estimated 4,500 (8%) had

[2] Statistics New Zealand

[3] Statistics New Zealand projections for Ministry of Health 2014 update for 2015/16 & 2020/21 populations

difficulty getting help. A smaller proportion found it easy to get help with Māori cultural practices (61%), with 23% finding it hard or very hard. Few (1%) reported not needing help.

2.5 Importance of participation in Māori Culture

- Being involved in Māori culture was important (very, quite, or somewhat) to the majority (59%) of Māori adults. Spirituality was important to a similar proportion (59%).

2.6 Te Reo Māori

- According to the 2013 Census, 15% of Māori adults in Nelson Marlborough and nearly 1% of non-Māori adults could have a conversation about a lot of everyday things in te reo Māori.
- Just over one in eight Māori adults across the four DHBs (13%) reported that Māori language was used regularly in the home in 2013.

2.7 Access to marae

- In 2013, most Māori in Nelson Marlborough and the three other DHBs (89%) had been to a marae, with just over a third (36%) having been in the last 12 months. Forty-four percent had been to at least one of their ancestral marae, 12% within the previous 12 months, but the majority (56%) reported that they would like to go more often.

2.8 Traditional healing or massage

- In 2013, an estimated 3,000 Māori adults (5%) in Nelson Marlborough and the three other South Island DHBs had taken part in traditional healing or massage during the previous 12 months.

Wai Ora – Healthy Environments

2.9 Education

- The proportion of Māori adults aged 18 years and over with at least a Level 2 Certificate increased from 43% to 50% between 2006 and 2013. The proportion of non-Māori with this level of qualification was 63% in 2013.

2.10 Work

- Between 2006 and 2013 the proportion of Māori adults employed full-time decreased, while the proportion employed part-time did not change. The unemployment rate increased from 5% to 8%.
- There was also an increase in the proportion of the working age population who were not in the labour force (from 25% to 27%).
- Among employed Nelson Marlborough Māori women, the leading occupational groupings were labourers (22%), professionals (18%), and community and personal service workers (15%). The next most common occupations were managers, sales workers, and clerical and administrative workers.
- Māori men were most likely to be employed as labourers (31%), technicians and trade workers (18%), and managers (16%). Machinery operators and drivers, and professionals were the next most common occupations.
- Ninety percent of Māori adults worked without pay in 2013. Māori were 60% more likely than non-Māori to look after someone who was disabled or ill without pay within the home, and around 40% more likely to look after a non-household member who was disabled or ill.

2.11 Income/ Standard of Living

- An estimated 5,000 Māori adults (9%) across the four DHBs reported putting up with feeling cold a lot during the previous 12 months to keep costs down, 3,000 (5%) had gone without fresh fruit and vegetables, and 5,000 (9%) had often postponed or put off visits to the doctor.
- There was an increase of 4% in the proportion of children living in Māori families where the only income was means-tested benefits between 2006 and 2013 (from 14% to 18%). Children in Māori families were 3 times as likely as non-Māori children to be in this situation in 2013.
- A third of the children in Māori households (over 1,600) were in households with low equivalised household incomes in 2013, 1.8 times the proportion of other children. Over a quarter (28%) of adults in Māori households (over 2,700) lived in low income households, 1.5 times the proportion of other adults.
- Seven percent of Māori households in Nelson Marlborough had no access to a motor vehicle, a third more than the proportion of non-Māori households. The proportion of people living Māori households without a vehicle was twice that of people living in non-Māori households.
- Twenty four % of people in Māori households in Nelson Marlborough had no access to the internet, 12% did not have a cell phone, 22% had no telephone (landline), and 2.5% had no access to any telecommunications in the home. The largest absolute gaps between Nelson Marlborough Māori and non-Māori households were in access to the internet (12%) and telephone (11%).

2.12 Housing

- Housing problems reported to be a big problem by Māori adults in Nelson Marlborough and three other South Island DHB areas in 2013 included difficulty keeping the house warm (15%), needing repairs (14%), and damp (9%). Five percent felt their house was too small, and 4% stated that pests were a big problem in their house.

2.13 Housing Security

- Just over 2,700 Māori households in Nelson Marlborough were rented, close to half of all Māori households, and twice the proportion of non-Māori households.
- Among children living in a Māori household, 52% (over 3,100) were living in rented homes, compared to 30% in non-Māori households.
- Half of adults living in Māori households were living in rented accommodation (around 5,300), compared to a third of adults living in non-Māori households.

2.14 Household Crowding

- In 2013, Māori households were over 4 times more likely than non-Māori households to be classified as crowded using the Canadian National Occupancy Standard, with 438 homes needing at least one additional bedroom, affecting over 2,200 people. People living in Māori households were two-and-a-half times as likely as people living in non-Māori households to be living in crowded conditions.

2.15 Fuel Poverty

- In 2013, 2% of Māori households (96 homes) had no heating, compared to 1% of non-Māori households (396 homes).

2.16 Area of Deprivation

- Nelson Marlborough Māori and non-Māori have a less deprived small area profile than the national population, but Māori were more likely than non-Māori to live in the most deprived areas. In 2013, 45% of Māori and 30% of non-Māori lived in the four most deprived decile areas (7 – 10 being the most deprived).

Mauri Ora – Healthy Individuals

2.17 All Ages

Hospitalisations

- The all-cause rate of hospital admissions was 4% higher for Māori than for non-Māori during 2011–2013.
- On average, 626 Māori hospital admissions per year were potentially avoidable, with the rate 23% higher for Māori than for non-Māori. The ASH rate was 42% higher.
- The six leading causes are (in order ranked highest to lowest) for Māori 0 to 74 years of age are dental conditions; upper respiratory/ear nose and throat; angina and chest pain; asthma; pneumonia; and cellulitis.

Mortality

- Life expectancy at birth for Māori females in the Tasman, Nelson, and Marlborough Regions during 2012–2014 ranged from 81.0 years in Marlborough, to 81.3 in Nelson, and 81.9 years in the Tasman Region, between 2.4 and 2.9 years lower than for non-Māori females. For Māori males, life expectancy at birth was between 77.1 years (Marlborough) and 78.0 years (Tasman) and between 2.7 and 3.0 years lower than for non-Māori males.
- The all-cause mortality rate for Nelson Marlborough Māori was 40% higher than the non-Māori rate during 2008–2012.
- In 2007–2011, the leading causes of death for Māori females were lung cancer, ischaemic heart disease (IHD), and stroke. For Māori males, the leading causes were IHD, lung cancer, and accidents.
- Potentially avoidable mortality was 74% higher for Māori than for non-Māori, and mortality from causes of death amenable to health care 81% higher.

Injuries

- Just under 300 Māori per year were hospitalised for injury, at a similar rate to non-Māori during 2011–2013.
- The most common causes of injury resulting in hospitalisation among Māori were falls, exposure to mechanical forces, and transport accidents.
- The rate of hospitalisation for assault for Māori was 2.45 times that of non-Māori.
- On average, five Māori per year died from injuries during 2007–2011, at a rate similar to non-Māori.

3. PRIORITISING MĀORI HEALTH TARGETS FOR TE TAU IHU

In 2015 two reports were produced to guide and inform ongoing health planning for the Nelson Marlborough Health System. Nelson Marlborough DHB commissioned the Nelson Marlborough Health Needs and Service Profile. At the same time this work was being undertaken, the Ministry of Health was developing for each district health boards the DHB Māori Health Profiles. Both reports where released at similar times late in 2015.

The task now is to set and integrate this source of information into the Nelson Marlborough Health System as we move to 2016/17 and out years. Aligning to this will be the Nelson Marlborough Māori Health & Wellness Strategic Framework which outlines the 30 year vision for achieving further gains for Māori health. The vision reads:

"Kia korowaitia aku mokopuna ki te korowaitanga hauora"
Healthy As!! Healthy Whānau are wealthy whānau - achieving our full potential and determining our future

Both the Iwi Health Board and District Health Board will continue to hold the kaitiakitanga/stewardship for the vision as it is implemented and monitored to show real progress and results. More importantly, it's now to say that Māori health is the responsibility of all and with this in mind, the governance of the stewardship should be extended to include the Nelson Marlborough health system partners which are Nelson Bays Primary Health, Kimi Hauora Wairau – Marlborough Primary Health Organisation and Te Pikl Oranga.

The districts Māori Health Outcomes Framework and the national Māori health targets will be used as part of the 'score card' to report how we are progressing as a district and what actions we will take to improve our progress. The Iwi Health Board has made it clear that its focus will be towards strengthening the measurement of Māori health gain and creating strategic opportunities around accountabilities and ownership of results. The IHB will also support strengthening of intersectoral linkages, recognising the impact of the wider determinants on health overall health status.

4. NATIONAL MĀORI HEALTH PRIORITIES AND INDICATORS

Health System Outcomes for Māori:

- Māori living longer, healthier and more independent lives.
- Good health and independence are protected and promoted.
- Māori receive better health and disability services.
- A more unified and improved health and disability system.
- Improved access and earlier intervention to timely treatment.
- Improved connectivity across the whole of system.
- Increased productivity and better use of financial resources.

National priorities for Māori Health are:

1. Access to Care (page 8) (PHO Enrolment and Ambulatory Sensitive Hospitalisations)
2. Cancer Screening (page 11)
3. Child Health – Breastfeeding
4. Ethnicity Data quality
5. Immunisation
6. Mental health – community treatment orders
7. Oral health – preschool enrolment
8. Rheumatic Fever
9. Smoking Cessation
10. Sudden Unexplained Death in Infancy (SUDI)

Local Priorities for Nelson Marlborough

11. Promoting Health ((Healthy weight; Youth Health; Alcohol Harm Reduction)
12. Workforce Development
13. Health of Older Māori
14. Maternal & Child Health

4.1 Access to Care

PHO Enrolment

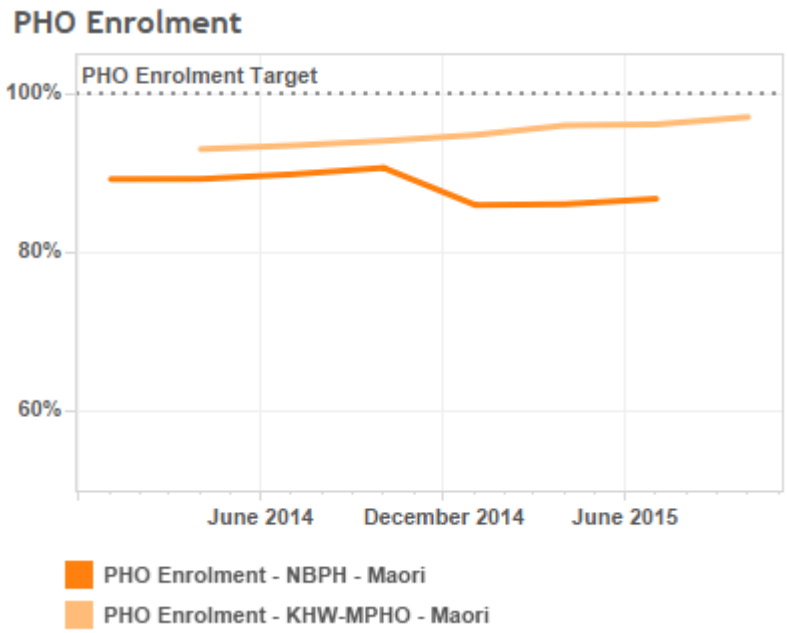
Rationale:
PHO enrolment is the first step in ensuring all population groups have equitable access to primary health care services and is therefore a critical enabler first point of contact health care. Differential access to and utilisation of healthcare services plays an important role in health inequities, and for this reason it is important to focus on enrolment rates for Māori and Pacific populations.

Current Services and Activity
The Newborn Enrolment process and form aims to enroll all newborn babies with PHOs/General Practice (as well as other key child health services) within a few weeks of birth. The current process of newborn enrolment is manual, and we will begin to move to an electronic system during 2016/17. The National Immunisation Register is increasingly being used to identify people whose children and immunised, but are not enrolled with a PHO. This is particularly valuable in Nelson Marlborough where Māori child immunisation rates are higher than non-Māori .
For the wider population, there are many points on the health care continuum with which individuals and whānau will interact, at which opportunities can be taken to ask about enrolment and if necessary facilitate enrolment.

PHO Utilisation
Māori have lower utilisation of general practice than non-Māori as outlined in the table opposite showing the average number of GP visits per capita.

Indicators

% of the Māori Population enrolled with PHOs



PHO Utilisation

	Māori			Non Māori		
Average number of GP visits per patient, per annum.	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
NBPH	2.93	2.93	3.05	2.68	2.63	2.64
KHW	2.99	2.71	2.74	3.81	3.63	3.73

Data source: PHOs

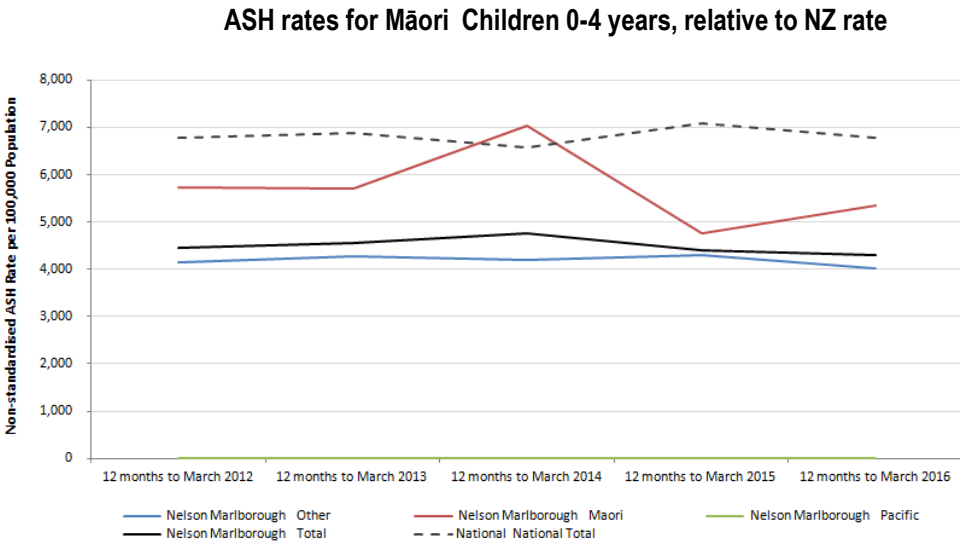
Ambulatory Sensitive Hospitalisations (ASH)

Rationale: ASH is a proxy measure for avoidable hospitalisations and for unmet healthcare need in a community based setting. There are significant differences in ASH rates for different population groups and a key focus on activities to reduce ASH must address the current inequities

Key conditions driving ASH for 0-4 year olds are: Dental, Respiratory and Gastroenteritis/dehydration.
Key conditions driving ASH for 45-64 year olds are: Respiratory infections – pneumonia; Myocardial infarction; Angina and chest pain.

Current Services and Activity
Nelson Marlborough Health has seen continued improvement is ASH rates for 0-4 year olds which can be attributed to improvements in the community oral health service, and the ongoing roll-out of the Healthy Homes projects which has positively impacted dental and respiratory ASH rates for children (see the Oral Health plan on page 22). Nelson Marlborough Health is now achieving the ASH target for this age group.
For adults aged 45-64 years, heart related conditions are the key driver for ASH rates. Many of the hospitalizations for heart related conditions for this age group are entirely appropriate. Cardiovascular Disease (CVD) risk assessments have been useful to identify those at risk, and are a local priority for Nelson Marlborough Health. A healthy BMI is critical for good heart health, and we will promote nutrition and physical activity in settings that reach Māori whānau, and will continue to promote CVD risk assessments (see Promoting Health Action Plan on page 30).

Indicator:



Target: Improvement on baseline ASH rates for Maori children aged 0-4 years and adults 45-64 years. The targets below represents a goal to achieve a reduction in ASH rates in the Nelson Marlborough region.

	12 months to March 2012	12 months to March 2013	12 months to March 2014	12 months to March 2015	12 months to March 2016	Target 16/17
NM Māori 0-4yrs	5,723	5,714	7,024	4,765	5,349	<4009
NM Other 0-4	4,448	4,552	4,749	4,397	4,009	<4009
NM Māori 45-64yrs	4,949	4,586	5,227	4,233	4,196	<3,878
NM Other 45-64yrs	2,395	2,451	2,403	2,378	2,313	<3,878

Access to Care Action Plan

OUTCOME GOAL 1: Māori whānau are enrolled with and can utilise general practice

OUTCOME MEASURES: 100% of eligible population are enrolled with PHOs/ General Practice

ACTION 1: Newborn enrolment rates are increased, including a focus on ensuring enrolment for Māori newborns, & Te Piki Oranga & other providers facilitate enrolment with PHOs/GPs for clients not already enrolled.

MEASURE 1: Timely newborn enrolment rates increase.

ACTION 2: Extend the referral pathway for St John to refer to non-emergency health services for identified health needs to Marlborough.

MEASURE 2: Pathway implemented by 30/11/16; Referrals monitored by ethnicity to ensure Māori are referred & linked to health services.

ACTION 3: Monitor PHO population coverage & ASH rates quarterly & report to Clinical Governance Groups (incl Te Tumu Whakaora) & Iwi Health Board

MEASURE 3: Monitor ASH rates & report 6-monthly. Quarterly monitor & report on number of Māori enrolled in a GP service - report to DHB/ IHB/PHOs number of Māori enrolled & activities to improve.

ACTION 4: Pūkenga Manaaki (Navigators) support clients to access services & DHB implements clinical service administrative processes to support attendance of Māori at appointments

MEASURE 4: Monitor 'Did not attend' rates quarterly – seeking reduction by 5 percentage points in those specialties with highest rates, with a view to sustaining the reduction to rates comparable to non-Māori within 2 years

OUTCOME GOAL 2: Integrated services* ensure early and appropriate access to services

OUTCOME MEASURES: Key indicators show improving equity of access for Māori; Reduction in equity gap in ASH by 50% & equitable rates within 5 years

ACTION 5: Implement oral health improvement initiatives, including reducing barriers to accessing oral health services for children (see Oral Health p22)

MEASURE 5: Monitor ASH for reduction in children's oral health conditions

ACTION 6: Continue the Healthy Homes project, targeting Māori families with respiratory conditions; Roll-out the COPD primary care management process district-wide; Establish a pulmonary rehab service across the district

MEASURE 6: Monitor and report ASH rates for respiratory conditions for Māori 6-monthly, including progress towards equity

ACTION 7: Undertake an **e**quity assessment audit of the ED Chest Pain pathway

MEASURE 7: Equity assessment completed by 31/12/16

ACTION 8: Develop & implement System Level Measures workplan for ASH

MEASURE 8: ASH reduction plan developed by 20/10/16; Commence implementation

SEE ALSO NMDHB Annual Plan – Whānau Ora

**The World Health Organisation Technical Brief No.1, May 2008, defines integrated service delivery as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."*

4.2 Cancer

A. Cervical Cancer Screening

Rationale:

In 2012, Māori women were twice as likely as non-Māori to develop cervical cancer, and 2.3 more likely to die from it. Regular cervical screening detects early cell changes that would, over time, lead to cancer if not treated. Nationally, cervical screening coverage for Māori is 62.2%, compared to coverage in European/Other populations with coverage at 82.2%. Improving screening coverage in Māori women is therefore an important activity to improve this equity gap.

The National Cervical Screening Programme is available to all women in New Zealand between 20 and 70 years old. All women who have ever been sexually active should have regular cervical smear tests from the time they turn 20 until they turn 70.

Current Services and Activity

In Nelson Marlborough, coordination of services is managed by NMDHB Public Health Service and NMDHB also manage the Cervical Screening Register. Most general practices provider smear-taking and there are also two NGOs contracted by NMDHB to provide smear-taking with a focus on priority women. They recall women due for a smear. The Register Service work together with general practices and other providers to identify women who have not been screened, have not been screened in the last 5 years (under screened) or who are overdue.

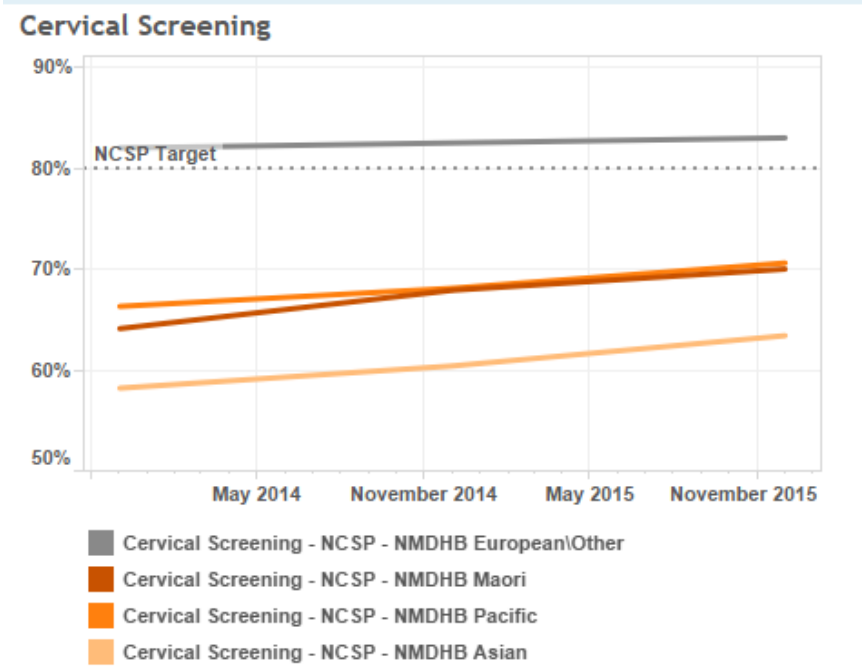
In conjunction with PHOs and training providers, regular cervical screening updates are provided in the district. We are actively working to recruit more Māori smear-takers.

NMDHB has had a number of small subcontracts with NGOs to provide Invitation and Recall (I&R) services and is in the process of consolidating I&R services into a consistent district-wide service. I&R services support priority women who face challenges in accessing cervical screening services and follow-up colposcopy services where necessary.

Indicator:

Cervical Screening rates for Māori in Nelson Marlborough are currently below the national screening programme target of 80%, although rates are increasing.

Cervical Screening Coverage Rates by Ethnicity, NM



Data source: National Screening Unit reports, www.nsu.govt.nz

B. Breast Cancer Screening

Rationale:

Historically, Māori women have significantly higher incidence and mortality from breast cancer compared to non-Māori. Inequities in access to screening services need to be addressed to ensure Māori women experience the benefits of early detection of breast cancer.

Women who can have a free screening mammogram every two years through Breast Screen Aotearoa are those:

- aged 45 to 69 years of age
- who have no symptoms of breast cancer
- who have not had a mammogram in the last 12 months
- not pregnant
- eligible for public health services in New Zealand.

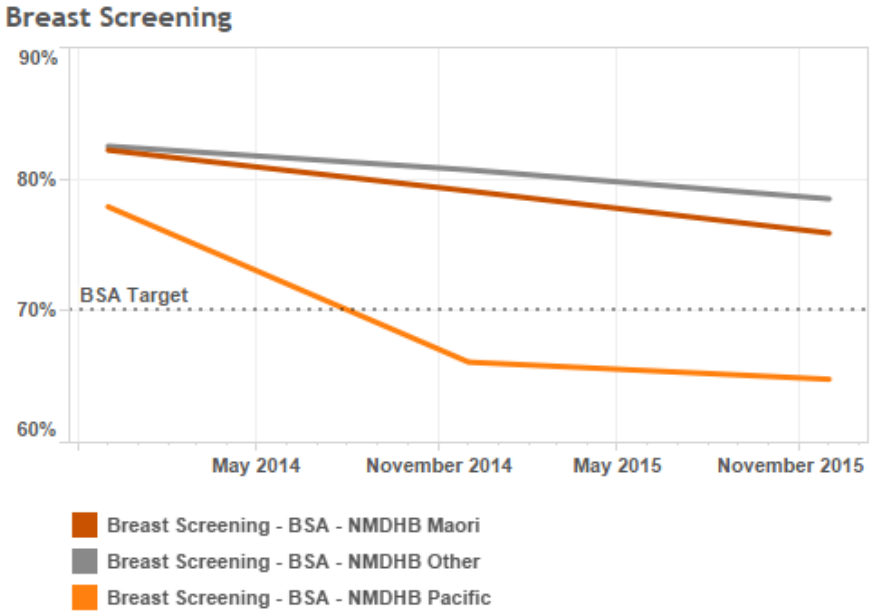
Current Services and Activity

Breast Screen South manage the breast screening programme in the South Island. They work effectively with general practice and other providers to promote screening, recall women due for a screen and to identify and reach women who have not been screened, are under screened or overdue. While the DHB is not contracted by the Ministry of Health to provide breast screening services directly, NMDHB is working to develop greater linkages with BSA and work together with PHOs, general proactive, Te Piki Oranga and others to maintain coverage. The mobile screening unit visits Motueka and Takaka annually.

Indicator:

Breast screening rates for Māori women in Nelson Marlborough are above the programme target of 70% and we will maintain or increase the 70% coverage, and have a stretch target of 75%. The slight reduction in the rate, while still being above target, may be due to updating the population base against which it is measured, subsequent to the 2013 Census. The population increase means there are more women in the age groups targeted for screening. Rates for Pacific women are lower than target.

Breast Screening Coverage Rates by Ethnicity, NM



Data source: National Screening Unit reports, www.nsu.govt.nz

C. Faster Cancer Treatment

Rationale:

Lung cancer is the second leading cause of avoidable mortality for Māori in Nelson Marlborough. Smoking is the leading cause of lung cancer, and is also a major cause of heart disease, stroke and other cancers (see the Better Help for Smokers to Quit plan on page 24 and 25).

A report commissioned in 2014 revealed only 33 per cent of Māori with a high suspicion of cancer in the Nelson Marlborough region were getting cancer treatment within 62 days, compared with 64 per cent of non-Māori patients.

Despite a decline in cancer mortality and an increase in cancer survival over time, it remains the most important cause of preventable mortality and illness alongside CVD.

Current Services and Activity

The Nelson Marlborough Faster Cancer Treatment team aims to improve the quality and timeliness of services for patients along the cancer pathway by ensuring patients have timely access to appointments, tests which detect cancer and cancer treatment.

A review of the cancer care continuum for Māori patients in the Nelson Marlborough district included a map of the current patient pathways for Māori cancer patients and identified issues and proposed solutions that support and enhance the journey for Māori cancer patients. During 2016/17 we will continue to implement the 'Improving the Cancer Pathway for Māori Faster Cancer Treatment (FCT) projects in conjunction with the Southern Cancer Network & other South Island DHBs. The Māori cancer pathway nurse educator is a key person in the team who will work with clinical staff in the Nelson Marlborough region, including oncologists, general practitioners and specialist nurses, to enhance cultural competency skills. The nurse will also work with Māori communities to improve health literacy in relation to cancer.

Indicator

Health Target: 85% of patients referred urgently with high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016.

Ethnicity	% Within 62 Days	Within 62 Days	% Exceeded 62 Days	Exceeded 62 Days	Total Records
European not further defined	57%	4	43%	3	7
Latin American /Hispanic	100%	1	0%	0	1
not stated	#DIV/0!	0	#DIV/0!	0	0
NZ European	76%	136	24%	44	180
NZ Maori	73%	8	27%	3	11
Other Asian	100%	1	0%	0	1
Other Ethnicity	100%	2	0%	0	2
Other European	80%	8	20%	2	10
response unidentifiable	100%	1	0%	0	1
Southeast Asian	100%	1	0%	0	1
Tongan	100%	1	0%	0	1
Grand Total	76%	163	24%	52	215

Source: FCT data, NMDHB year to date, Mar2016

2016/17 Plan

Cancer Action Plan

OUTCOME GOAL 1: Reduced incidence and impact of Cervical & Breast Cancer for Māori Cancer through early detection

OUTCOME MEASURES: 80% coverage of Cervical Screening for Māori women; Maintain or 70% coverage of Breastscreening for Māori women or increase coverage (stretch target 75%)

OUTCOME GOAL 2: Faster Cancer treatment leads to better outcomes

OUTCOME MEASURE 2: Health Target: 85% of patients referred urgently with high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016.

ACTION THEME 1: Support and promote equitable coverage in cervical screening

ACTION 1: Improve district-wide consistency & reach of Cervical screening Invitation & Recall (I&R) services, working with providers to improve service delivery, address inequity in coverage rates & improve access to assessment/treatment (colposcopy)

MEASURE 1: Monitor coverage, I&R services and colposcopy DNA rates quarterly; At least one service improvement implemented to improve colposcopy service access or experience for Māori women.

ACTION 2: Contract Kimi Hauora Marlborough PHO and Te Piki Oranga to improve I&R services across the Top of the South Island

MEASURE 2: Improve cervical screening coverage rates for Māori women

ACTION 3: Formalise relationships and referral pathways between general practice and I&R services

MEASURE 3: Formal linkages in place between GPs and I&R services by 30/11/16

ACTION 4: Arrange access to training to enable more community nurses to become smear-takers and/or update their knowledge and skills

MEASURE 4: At least one smear-taker training or update held in the district by 31/03/17

ACTION 5: Cervical Screening Register Services give ongoing support for data matching to each general practice to identify & reach unscreened, under-screened & overdue women

MEASURE 5: Undertake data matching with selected high needs practices

ACTION THEME 2: Support and promote equitable coverage in breast & cervical screening

ACTION 6: Continue to develop working relationships between NMDHB, Register Services, PHOs, TPO, Breast screen South, GP services, Māori & Pacific communities & other services (e.g. Radiology), including arranging opportunities to provide screening services for Māori & Pacific women

MEASURE 6: Two targeted promotion & provision events by 30/06/17. NMDHB will work with BreastScreen South to monitored success and inform future events.

ACTION 7: Undertake a project with Te Waipounamu Māori Leadership Group for Cancer, Te Herenga Hauora and South Island Southern Cancer Network to increase cervical screening coverage for Māori women

MEASURE 7: Literature review, stocktake and analysis undertaken & improvements proposed.

ACTION 8: Support the Lead Provider, BreastScreen South, to work effectively with general practice and other providers to identify unscreened or under screened women; Monitor coverage rates quarterly and jointly develop an action plan if coverage rates continue to decrease

MEASURE 8: Improved breast screening coverage rates for Māori women

ACTION THEME 3: Cancer Pathway Improvement

ACTION 9: Continue implementation of the 'Improving the Cancer Pathway for Māori Faster Cancer Treatment (FCT) projects in conjunction with the Southern Cancer Network & other South Island DHBs

MEASURE 9: Project plans are implemented with the Nurse Educator supporting service improvements in cancer services and education for Māori communities

ACTION 10: Work with the other Service Improvement projects with the Southern Cancer Network (SCN) and South Island DHBs to identify and address improvements to achieve equity of access and care for Māori.

MEASURE 10: Collaborative working with SCN and South Island DHBs

SEE ALSO Immunisation (promoting the HPV vaccination)

4.3 Child Health - Breastfeeding

Rationale

Breastfeeding helps lay the foundations of a healthy life for a baby and also makes a positive contribution to the physical, social, emotional and mental health and wellbeing of infants, mothers, fathers/partners and whānau/families. Exclusive breastfeeding is recommended until babies are around six months. Research shows that children who are exclusively breastfed for around 6 months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of SUDI, asthma and childhood obesity. Breastfeeding is an important area of focus because there is significant room for improvement, and breastfeeding has wide-reaching benefits and potentially results in reduced cost for families.

The influences on breastfeeding rates are complex. Measures to improve breastfeeding rates need to involve families, communities, and government and non-government groups and agencies.

Indicators

Nationally, breastfeeding rates for Māori infants start at a similar (although slightly lower) rate as the total population, but drop off more quickly than the total population at the 3 and 6 month time points. However, in Nelson Marlborough the breastfeeding rates for Maori infants start at a lower rate, and continue at a similar lower rate (see the table below). We know there is work to be done and are committed to improving breastfeeding rates among Maori women. In particular, the focus is on encouraging women to start breast feeding their babies, and then creating a supportive environment to continue breastfeeding their babies.

Breastfeeding Rates for Nelson Marlborough DHB	Target	Maori Breastfeeding Rate	Variance to Target	Non-Maori Breastfeeding Rate	Equity Gap
Exclusive or fully breastfed at LMC discharge (4-6 weeks)	75%	49%	26%	61%	12%
Exclusive or fully breastfed at three months	60%	46%	14%	60%	14%
Receiving breast milk at six months	65%	48%	17%	67%	19%

Source: Well Child Tamariki Ora Quality Improvement Framework data from all providers, Ministry of Health 2015

Current Services and Activity

The Lead Maternity Carers (LMCs) provide early support for mothers to breastfeed. Education is available regularly for LMCs to update them and enable them to offer the best advice and support to parents. All Nelson Marlborough maternity units maintain Baby-Friendly Hospital Initiative (BFHI) accreditation, creating an environment that encourages and supports breastfeeding. There are high rates of breastfeeding at discharge across all population groups.

Lactation Consultants are available to provide specialist support to women with breastfeeding issues, on referral from LMCs, WCTO, GPs or other services.

Well Child Tamariki Ora providers provide ongoing advice and support for parents and the nurses also receive education updates. Community-based and collaborative initiatives also aim to create environments that are supportive of breastfeeding (e.g. the annual Big Latch On) and some peer support is available for individual women.

A recent report by the Associate Director of Midwifery at Nelson Marlborough Health identified some breastfeeding challenges. These included the influence of extended family, the introduction of formula early to allow return to work and /or so other family can care for baby, media / societal pressure with formula feeding more acceptable socially, and access to a breast pump. A plan to address these challenges will be jointly developed by Midwifery and Māori Health teams during the 2016/17 year.

2016/17 Plan

SEE ALSO:
DHB Annual Plan: Child Health

Breastfeeding Action Plan

OUTCOME MEASURES: 80% of Māori infants are exclusively or fully breastfed at 2 weeks by 30/06/17, 75% are exclusively or fully breastfed at 6 weeks/LMC discharge; 60% are exclusively or fully breastfed at 3 months; 65% receiving breast milk at 6 months.

ACTION THEME 1: Improve breastfeeding promotion & increase access to breastfeeding support services for Māori women

ACTION 1: Breastfeeding week promotion undertaken as a collaborative action across DHB, PHOs, Māori health and community services

MEASURE 1: Māori health and community providers participate in breastfeeding promotional activities

ACTION 2: Increase support to Māori women to breastfeed, including teen parents

MEASURE 2: Lactation Consultant hours increased in Marlborough by 31/7/16. Increased education during pregnancy and postnatally. Opportunities to increase peer support are explored.

ACTION 3: Explore ways to expand the reach of antenatal programmes to increase access for Māori & Pacific women

MEASURE 3: Antenatal programme framework agreed by 30/11/16

ACTION 4: Maintain Baby Friendly Hospital accreditation in NMDHB, Motueka & Golden Bay maternity facilities

MEASURE 4: BFHI accreditation maintained

ACTION 5: Ongoing workforce development opportunities

MEASURE 5: Opportunities provided for breastfeeding education for providers working with Māori women

ACTION 6: Jointly develop a plan to address breastfeeding challenges, such as socio-economic (return to work, access to a breast pump) and media/societal pressures

MEASURE 6: Joint plan agreed by 31/03/17

4.4 Data Quality

Rationale:
High quality ethnicity data has been an ongoing concern for the health and disability sector in New Zealand. While ethnicity data has been collected for a number of years, there have been variable levels of data completeness and quality. Collecting accurate ethnicity data in accordance with the Ethnicity Data Collection Protocols will improve the quality of ethnicity health data.

Current Services and Activity
All key targets and quantitative reporting is increasingly including ethnicity data breakdown.

Indicators:

Target: % of PHO enrolments with valid ethnicity recorded

Target: 95% data accuracy for ethnicity data collected in the hospital.

New NHI registrations with non-specific ethnicity

	Target 2013/14	Actual (Sept-Nov13)	Target 14/15	Actual March 2015	Target 15/16	Actual Feb 16	Target 16/17
NMDHB	<5%	0%	<5%	0.38%	<5%	0%	<5%

2016/17 Plan

Data Quality Action Plan

OUTCOME GOAL 1: Quality ethnicity data facilitates planning, service delivery & monitoring

OUTCOME MEASURES: All key indicators reported by ethnicity

SEE ALSO DHB Annual Plan: Maternal & Child Health; Better Help for Smokers to Quit

ACTION 1: Report all key health status and service performance indicators by ethnicity to understand any inequities, to inform future actions to address these.

MEASURE 1: Increase the ethnicity-specific reporting on key indicators to inform the DHB, Iwi Health Board and PHOs (quarterly) from 1 October 2016

ACTION 2: Reinforce the use of the *Ethnicity Data Protocols for the Health and Disability Sector* and the *Primary Care Ethnicity Data Audit Toolkit* to improve ethnicity data collection across providers

MEASURE 2: Quarterly sample audits to identify accuracy of ethnicity data quality & recording – report to DHB/ IHB/PHOs on ethnicity data quality & activities to improve; one audit by 30/06/2017 (NES)

ACTION 3: Monitor ethnicity on new NHI registrations & PHO enrolments & report to Clinical Governance Groups and the Iwi Health Board

MEASURE 3: Report against targets & number of Māori enrolled with PHOs & activities to improve this – quarterly to DHB/IHB/PHOs from October 2016

4.5 Immunisation

Rationale:

Childhood immunisation coverage shows that in 2014, at the age of eight months, 88.0 percent of Māori children had completed age-appropriate immunisations compared with 91.9 percent of the total New Zealand children. Health equity for Māori has not yet been achieved. The current equity gap at 8 months is around 2 to 3%

In 2014 Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75 percent influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. Only 69% of those aged over 65 years were immunised against influenza in 2014. For the 2016 Influenza Immunisation Programme NIR reports are being developed to more accurately measure influenza immunisation coverage by ethnicity.

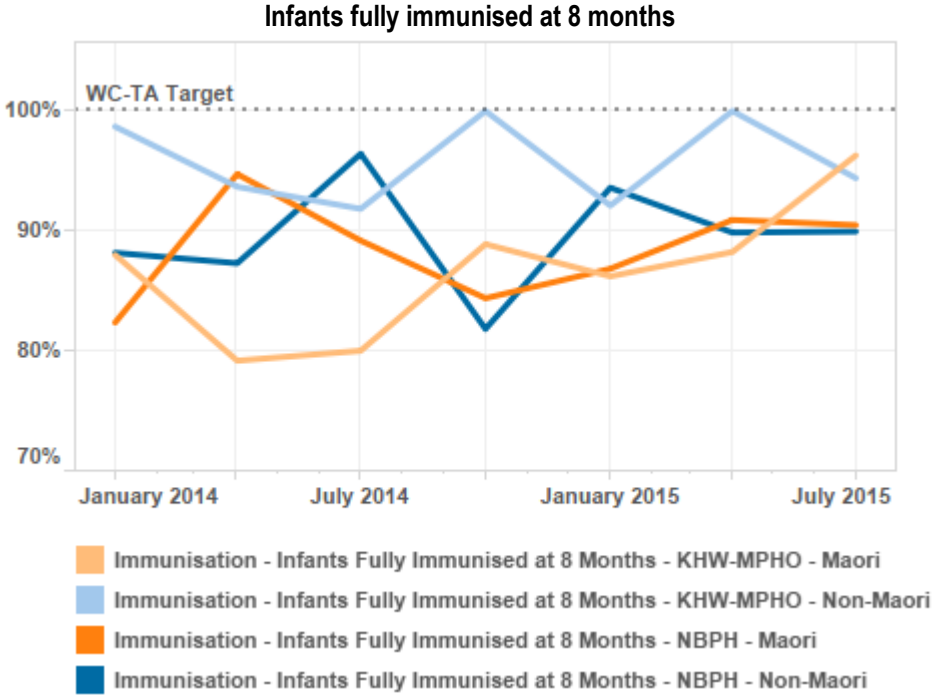
Current Services and Activity

Immunisation can prevent a number of diseases. It not only provides individual protection but also population-side protection by reducing the incidence of infectious diseases and preventing the spread to vulnerable people. Our district-wide Immunisation Facilitation Plan (refer to the Nelson Marlborough Health Annual Plan 2016/17) provides the operational activity we will undertake to ensure high vaccination rates, including Māori . A key focus of the plan is to understand why people decline immunisations and to work to provide people with clear, consistent information about immunisations.

To help families keep their kids well by connecting with the right services, including immunisation, the Well Child app was launched in March 2016. This will support families to get the best possible protection, by having the immunisations on time, every time.

We will provide 'opportunistic immunisation' when children who are not immunised present at ED or are admitted as inpatients.

Indicator:



2016/17 Plan

Immunisation Action Plan

OUTCOME GOAL 1: Reduced incidence of vaccine-preventable disease

OUTCOME MEASURE 1: 95% of 8 month olds and 2 year olds are fully immunised

OUTCOME GOAL 2: Reduction in death and health consequences in vulnerable populations

OUTCOME MEASURE 2: 75% of the eligible population 65 years & over complete seasonal influenza immunisation

ACTION THEME 1: Childhood immunisations

ACTION 1: Promote pathways for referrals to Te Piki Oranga (TPO), OIS and PHO navigation services to improve immunisation uptake

MEASURE 1: 95% of Māori, Pacific and high needs population are immunised on time, reported quarterly.
Monthly meetings between Outreach Immunisation Services & Register Services to determine caseload & prioritisation

ACTION 2: Implement other actions from the Annual Plan, including the collaborative Immunisation Governance & Operations groups and immunisation for children presenting at hospital services.

MEASURE 2: Immunisation Governance Group monitors immunisation coverage at least quarterly and guides actions, including actions to address inequities

SEE ALSO: Access to Care – Action 1: Newborn Enrolment

ACTION THEME 2: Influenza

ACTION 3: Work with Te Piki Oranga and PHO Liaison Services to ensure capacity to deliver immunisation clinics, focusing on influenza, on Marae and in community clinics and promote immunisation

MEASURE 3:
Marae based immunisations and community clinics delivered
Training (including 'talk immunisation' and promoting national standards for vaccinator courses) for Māori , Pacific and refugee health providers

SEE ALSO: DHB Annual Plan: Increased Immunisation

ACTION THEME 3: Other immunisations

ACTION 4: Increase HPV immunisation rates by promotion and workforce development to expand the range of organisations promoting immunisations.

MEASURE 4:
Te Piki Oranga promotes HPV vaccinations
Online learning tools are promoted
Health provider education and PHO newsletters include HPV information addressing known parental concerns

4.6 Mental Health & Addictions

Rationale:
New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.

Current Services and Activity
All mental health enquiries can be made via single point of entry (SPOE). SPOE is a collaborative service delivered by Nelson Bays Primary Health and Nelson Marlborough Mental Health and Addictions Service. The primary aim is to provide a single point of initial contact to ensure effective considerations, triaging and allocation of people referred to Adult Community Mental Health Services in the Nelson Tasman area.

There is a small dedicated Māori Mental Health team within the Community Mental Health Services who are part of the Mobile Community Team. They are qualified and experienced clinicians who culturally assess and consider intervention pathways for Māori who are over the age of 18 years with severe psychiatric conditions. Referrals are made by general practitioners, self, hospital, community agencies, and family or friends with the client's permission.

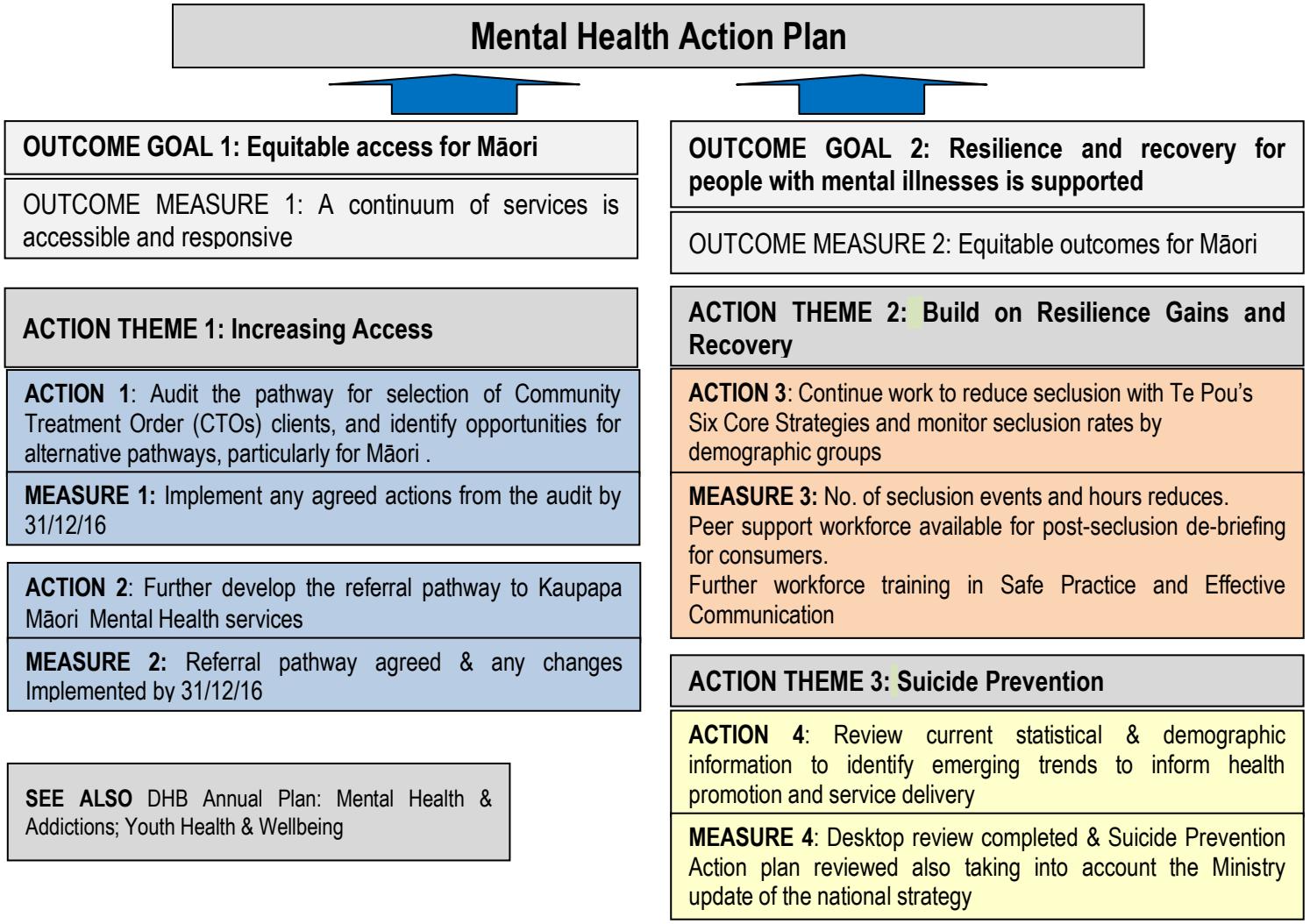
Mental Health & Addictions services works for continuous improvement in the integration between primary care, NGOs and Specialist Mental Health and Addiction services. The Directorate has a Reference Group of key stakeholders from across the Mental Health & Addictions continuum, which supports planning and decision-making on strategic developments.

Indicator:

Number of clients under S29 Community Treatment orders / Rate per 100,000 population

	Base 2012/13	Target 14/15	Actual Oct14-Sep15	Target 15/16
Māori	26 people 194 per 100,000	< 180 per 100,000	42 people 285 per 100,000	< 180 per 100,000
Non-Māori	82 people 64 per 100,000		150 people 115/100,000	

2016/17 Plan


Mental Health Action Plan
OUTCOME GOAL 1: Equitable access for Māori
OUTCOME MEASURE 1: A continuum of services is accessible and responsive
ACTION THEME 1: Increasing Access
ACTION 1: Audit the pathway for selection of Community Treatment Order (CTOs) clients, and identify opportunities for alternative pathways, particularly for Māori .
MEASURE 1: Implement any agreed actions from the audit by 31/12/16
ACTION 2: Further develop the referral pathway to Kaupapa Māori Mental Health services
MEASURE 2: Referral pathway agreed & any changes Implemented by 31/12/16
SEE ALSO DHB Annual Plan: Mental Health & Addictions; Youth Health & Wellbeing
OUTCOME GOAL 2: Resilience and recovery for people with mental illnesses is supported
OUTCOME MEASURE 2: Equitable outcomes for Māori
ACTION THEME 2: Build on Resilience Gains and Recovery
ACTION 3: Continue work to reduce seclusion with Te Pou's Six Core Strategies and monitor seclusion rates by demographic groups
MEASURE 3: No. of seclusion events and hours reduces.
Peer support workforce available for post-seclusion de-briefing for consumers.
Further workforce training in Safe Practice and Effective Communication
ACTION THEME 3: Suicide Prevention
ACTION 4: Review current statistical & demographic information to identify emerging trends to inform health promotion and service delivery
MEASURE 4: Desktop review completed & Suicide Prevention Action plan reviewed also taking into account the Ministry update of the national strategy

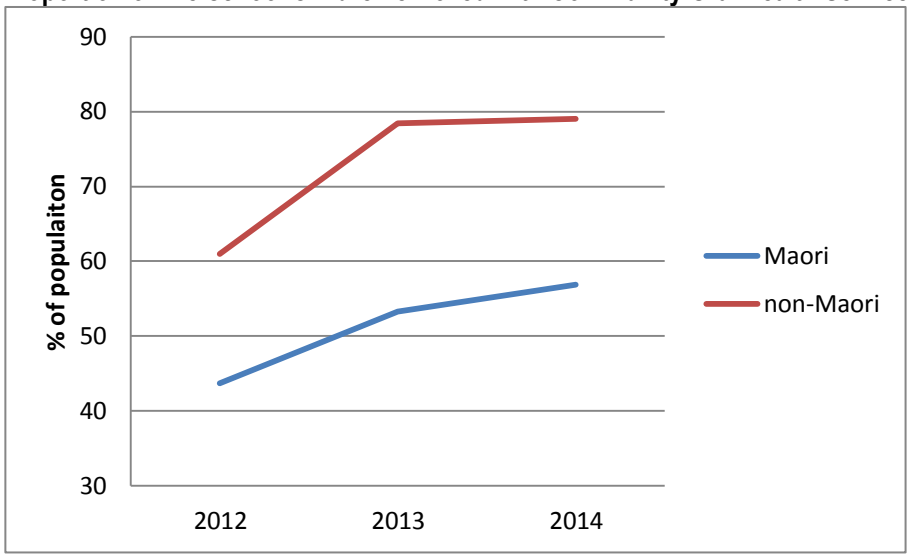
4.7 Oral Health

Rationale:
Nationally at December 2014, 76% of all pre-schoolers and 64% of Māori pre-schoolers were enrolled in the COHS. The target of 95% enrolment, while difficult for many DHBs to achieve by December 2016, is considered to be achievable through a combination of strategies including multiple enrolment programmes at birth via maternity providers, general and targeted promotion of the COHS, and work with community groups to ensure whānau awareness of and enrolment of children into the COHS.

Current Services and Activity
Newborn enrolment process notifies Community Oral Health Services (COHS) of the baby's birth – the service contacts the family when the child is around 12 months old to engage them with the service. This is helping to enrol children at an earlier age than was previously the case – and is reflected in the increase in enrolment rates for pre-school children.
The COHS works with families to make appointment at times that suit the family. There is concern about children not accessing the service and efforts are being made to improve this.
NMDHB also has oral health improvement projects in place to encourage and support the reduction in consumption of sweetened beverages and to explore fluoridation of water supplies.

Indicator:

Proportion of Pre-school Children enrolled with Community Oral Health Service



2016/17 Plan

Oral Health Action Plan

Outcome Goal: Pregnant women, babies, children and their families have improved health outcomes

OUTCOME MEASURE: Improve oral health status for Māori children at 5 years (% caries-free & reduced inequity)

ACTION 1: Infants are enrolled and engaged in primary health care services (GP, Well Child/Tamariki Ora (WCTO, NIR, Community Oral Health (COHS), Universal Newborn Hearing screening)

MEASURE 1:
- 98% of 3 month olds, included Māori, are enrolled with a GP & WCTO by 1/9/16
- 95% of preschoolers, including Māori, are enrolled in the community oral health service by December 2016

OUTCOME MEASURE: Increased % of preschool Māori children enrolled & utilising the Community Oral Health Service

ACTION 2: Investigate options to improve tamariki attendance rates at community oral health hubs

MEASURE 2:
- Agreed options are implemented by 31/12/16
- Reduce the rates of Māori tamariki who 'do not attend' COHS appointments by 50% by 31/07/17

ACTION 3: Continue work to reduce consumption of sweetened beverages) to reduce ASH for children's oral health conditions.

MEASURE 3: Number of settings that adopt healthy beverage policies, including pre-schools and schools.

OUTCOME MEASURE: All populations are supported to improve oral health

ACTION 4: Review enrolment processes for transfer of young people to adolescent oral health providers

MEASURE 4: Higher adolescent enrolment rates by 31/03/17

ACTION 5: Support the DHB's work to encourage fluoridation of local water supplies

MEASURE 5: Initiatives implemented

SEE ALSO NMDHB Annual Plan: Child Health; Whānau Ora

4.8 Better Help for Smokers to Quit

Rationale: Māori pregnant women have very high smoking prevalence (three times higher than the national prevalence). Smoking during pregnancy increases the risk for pregnancy complications and tobacco smoke harms babies before and after they are born. **Current Services and Activity** DHB-based smoking cessation services have been consistently achieving the health target of hospitalised patients receiving brief advice and help to quit smoking. Smokefree coordination within the DHB aims to support the ABC approach includes education, audits and ongoing support. General practice based services began achieving the health target of primary care patients receiving brief advice and help to quit smoking in December 2014, and are now comfortably achieving higher than the health care target. This has been done with the support of the PHO Smokefree Coordinators and IT systems have been developed to assist making the ABC approach part of business as usual. Cessation support services are provided through General Practices. There are also currently community-based cessation services provided through Whakatu Marae Committee Ltd, Te Awhina Marae o Motueka Society and Te Hauora o Ngati Rarua also provide cessation services through contracts with the Ministry of Health as well as the Quitline. Cessation services will provide pharmacological treatment and offer behavioral and/or emotional support. Services collaborate through Smokefree Coalitions.	**Indicator:** Smokefree pregnancies remain a point of focus, particularly in the Māori population. Well over 10% of pregnant women are smoking, with Māori rates varying quarter to quarter from over 30% to over 50%. Smoking during pregnancy contributes to higher rates of miscarriage, low-birth weight babies, still birth, complication during childbirth including increased interventions due to pregnancy complications, sudden infant death syndrome, asthma and glue ear, as well as the health risks for the mother.

2016/17 Plan

Better Help for Smokers to Quit Action Plan

OUTCOME GOAL 1: Smokefree Aotearoa 2025

OUTCOME MEASURE 1: By 2025, less than 5% of the DHB's population will be a current smoker

ACTION THEME 1: Promotion of Smokefree lifestyles

ACTION 1: Work with Māori & Pacific leadership to role model smokefree behaviours; undertake engagement and health promotion activity at Hui, sporting events & marae

MEASURE 1: Promotion & engagement activities undertaken each quarter

ACTION 2: Work with agencies that work with Māori youth to support smokefree messages and develop ABC & cessation support capability

MEASURE 2: Youth agencies deliver smokefree messages by 31/3/17

SEE ALSO DHB Annual Plan (Maternal & Child Health; Better Help for Smokers to Quit); Tobacco Control Plan

OUTCOME GOAL 2: Reduction in the harm to people caused by smoking

OUTCOME MEASURE 3: 95% of pregnant Māori women is smokefree at two weeks postnatal

ACTION THEME 2: Pregnant women are offered advice and support to quit

ACTION 3: Provide education tailored to midwives to support their conversations, in particular with Māori women & whānau.

MEASURE 3:
At least 2 education sessions with midwives held by 30/6/17
Patient story video available by 31/12/16

ACTION 4: Monitor efficacy of smokefree pregnancies initiatives

MEASURE 4: Evaluation completed by 30/6/17

ACTION 5: Further staff training to support quality ABC interactions

Measure 5: Training programme for primary care is completed by 30/6/17

4.9 Rheumatic Fever

Rationale

Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children and young people aged 4 to 19 years. Reducing rheumatic fever will contribute to achieving equity of health for Māori.

Current Services & Activities

Because of the low rates of rheumatic fever in the South Island the SI DHBs address this through a regional plan with a focus on population prevention and effective follow-up of cases.

The region has developed the South Island Rheumatic Fever Prevention Plan which will be implemented via the South Island Health Services Plan. Nelson Marlborough Health is committed to the Plan which provides a consistent approach in the management of patients with rheumatic fever. The plan ensures Nelson Marlborough patients receive a high standard of patient care, with free dental care, general practice care, and annual specialist review, for all patients who are or should be on penicillin prophylaxis. This package of care aims to optimize patients' health, and minimize the chance of relapse, bacterial endocarditis.

The South Island Public Health Partnership continues to provide a surveillance function for rheumatic fever and plays a facilitative role in ensuring each DHB has mechanisms in place to ensure the Rheumatic Fever Prevention and Management Plan is being implemented as intended. The partnership also has a Communicable Diseases Protocol Group.

At a local level, for the cases reported to the Medical Officer of Health, we will undertake case reviews of all rheumatic fever cases (both first episode and recurrent). Patients with a history of rheumatic fever will receive monthly antibiotics not more than five days after their due date, and we will complete an annual audit of rheumatic fever secondary prophylaxis coverage by quarter four of 2016/17. Any systems failures identified will be reported on, and any audit issues identified will be addressed.

Indicator:

Number and rate of first episode rheumatic fever hospitalisations for the total population

District Health Board	Rates				
	2009/10–2011/12 Baseline rate (3-year average rate)	2013/14 Target: 10% reduction from baseline level	2014/15 Target: 40% reduction from baseline level	2015/16 Target: 55% reduction from baseline level	2016/17 Target:
Southern region	0.4	0.4	0.3	0.2	0.1

District Health Board	Numbers				
	2009/10–2011/12 Baseline numbers (3-year average rate)	2013/14 Target: 10% reduction from baseline level	2014/15 Target: 40% reduction from baseline level	2015/16 Target: 55% reduction from baseline level	2016/17 Target:
Southern region	5	4	3	2	2

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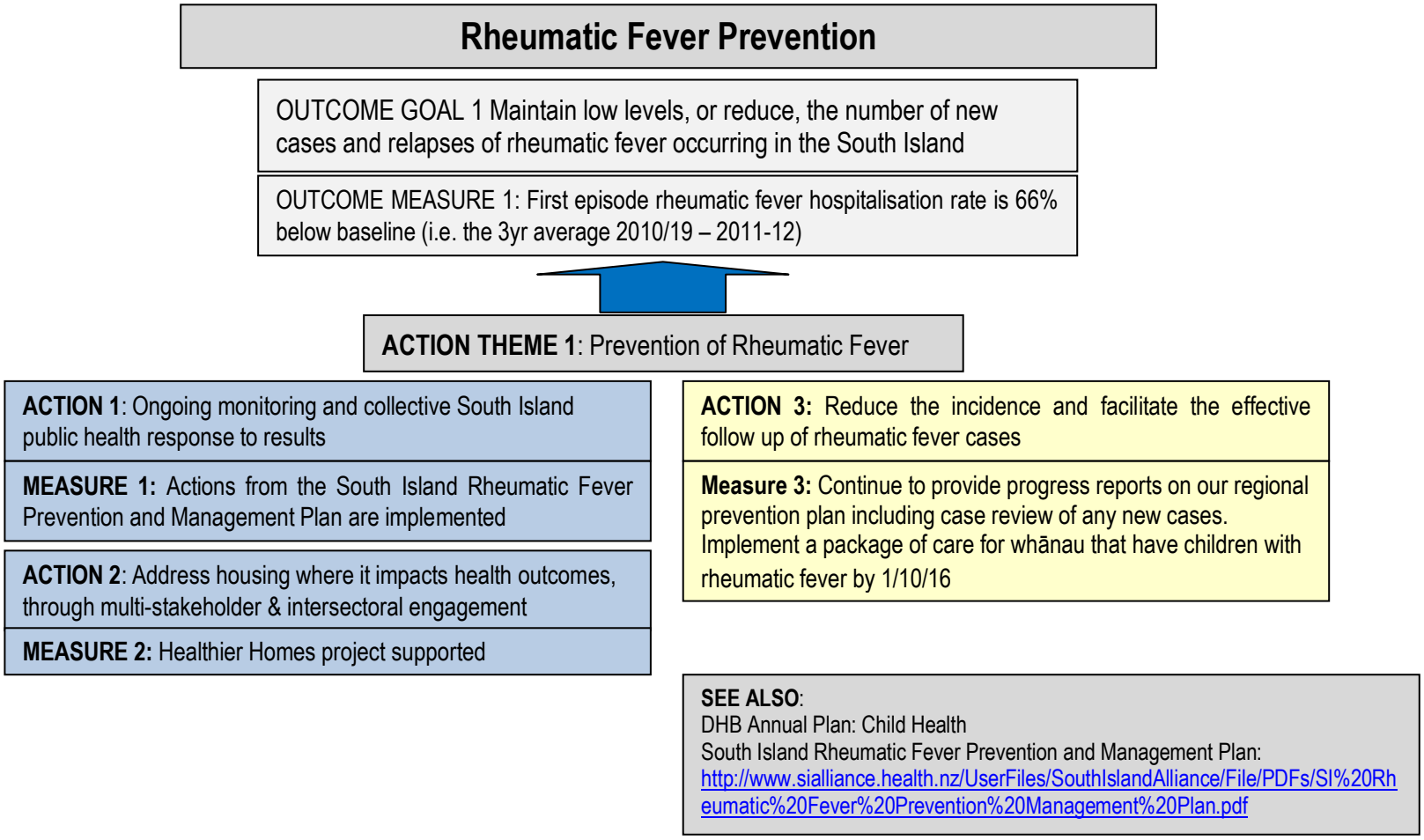

Rheumatic Fever Prevention
OUTCOME GOAL 1 Maintain low levels, or reduce, the number of new cases and relapses of rheumatic fever occurring in the South Island
OUTCOME MEASURE 1: First episode rheumatic fever hospitalisation rate is 66% below baseline (i.e. the 3yr average 2010/19 – 2011-12)
ACTION THEME 1: Prevention of Rheumatic Fever
ACTION 1: Ongoing monitoring and collective South Island public health response to results
MEASURE 1: Actions from the South Island Rheumatic Fever Prevention and Management Plan are implemented
ACTION 2: Address housing where it impacts health outcomes, through multi-stakeholder & intersectoral engagement
MEASURE 2: Healthier Homes project supported
ACTION 3: Reduce the incidence and facilitate the effective follow up of rheumatic fever cases
Measure 3: Continue to provide progress reports on our regional prevention plan including case review of any new cases.
Implement a package of care for whānau that have children with rheumatic fever by 1/10/16
SEE ALSO:
DHB Annual Plan: Child Health
South Island Rheumatic Fever Prevention and Management Plan:
http://www.sialliance.health.nz/UserFiles/SouthIslandAlliance/File/PDFs/SI%20Rheumatic%20Fever%20Prevention%20Management%20Plan.pdf

4.10 Sudden Unexpected Death in Infancy (SUDI)

Rationale

Sudden Unexpected Death in Infancy is the leading cause of preventable post-neonatal death in infancy. Māori infants are 5 times more likely to experience SUDI than non-Māori infants in New Zealand, with around 40 SUDI deaths among Māori per year. These deaths can be prevented through access to a safe sleep space, smoke free pregnancy and environment, placed on back to sleep, and breastfeeding. Less than one in two Māori babies (47.9%) had a caregiver provided with SUDI information at a Well Child Tamariki Ora Core Contact in the first 7 weeks of life in 2014. The greatest contribution to this lower level of information provision is non-provision of Core Contact 1 within 49 days.

The NMDHB population has recently shown a significantly elevated rate of SUDI among Māori. The high rate of SUDI has occurred firstly because of an increase in the number of Māori babies dying from SUDI among the population, and secondly because of a significant reduction in SUDI deaths among non-Māori babies nationally. This means that additional action is required in our area to improve outcomes for Māori babies and reduce the inequality that whānau experience with the sudden, unexpected and preventable deaths of their infants.

Measures and Targets

SUDI Rates

Target: 0.4 SUDI deaths per 1000 Māori live births. This is the five year rate achieved by non-Māori (95%CI 0.34-0.52)

Five Year Annualised Average Rate of Sudden Unexpected Death in Infancy, Māori, non-Māori and Total Population, by District Health Board, 2010-2014.

	Māori			Non-Māori			Total Population		
	Deaths	Rate	Confidence Interval	Deaths	Rate	Confidence Interval	Deaths	Rate	Confidence Interval
Nelson Marlb	4*	2.32	0.63-5.93	<3	s	-	6	0.76	0.28-1.65
NZ	155	1.75	1.48-2.03	83	0.38	0.3-0.47	238	0.78	0.68-0.87

*In the previous 5 years 2005-2009, there were no Māori baby deaths from SUDI; non-Māori was <3

SUDI Information Provision

Interim Target: 70% of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1

Caregivers provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1

	Māori			Non-Māori			Total Population		
	% SUDI info @ Core 1	% Core 1 but no SUDI info	% no Core 1 contact by 49 days	% SUDI info @ Core 1	% Core 1 but no SUDI info	% no Core 1 contact by 49 days	% SUDI info @ Core 1	% Core 1 but no SUDI info	% no Core 1 contact by 49 days
NM	40.5%	19.6%	39.9%	62.6%	14.8%	22.5%	59.0%	15.6%	25.4%
NZ	48.0%	18.6%	33.5%	62.6%	18.4%	19.0%	59.5%	18.4%	22.1%

Local Activity

NMDHB has a Safe Sleep Policy that has been developed in conjunction with the South Island Child Health Alliance (SI CHA) to be consistent across all DHBs. This took into account information and recommendations from the local Child and Youth Mortality Review Committee (CYMRC) and the Perinatal and Maternity Mortality Review Committee (PMMRC). The SI CHA has recently developed an audit tool to assess implementation of the policy.

There are Safe Sleep champions in the Maternity, Paediatric and neo-natal units and NMDHB provides education to DHB and community workforce. There is also a pathway through which those meeting specific criteria can access pepi-pods and associated education. A SUDI risk-assessment checklist and Safe Sleep Planner has been developed.

2016/17 Plan

SUDI Prevention

OUTCOME GOAL 1 Maintain low levels, or reduce, the rate of SUDI for Māori babies

OUTCOME MEASURE 1: Rate of SUDI for Māori is <0.4 per 1,000 per live births

OUTCOME MEASURE 2: 70% of Caregivers of Māori infants are provided with SUDI information at Well Child Tamariki Ora Core Contact 1

ACTION THEME 1: Prevention of SUDI

ACTION 1: Implement the South Island Child Health Alliance agreed Safe Sleep Audit Tool

MEASURE 1: Safe Sleep audit completed in NMDHB maternity and child inpatient settings by 30/11/16

ACTION 2: Promote & support adoption of Safe Sleep policies & practices by community-based maternity & child health providers

MEASURE 2: At least 2 providers supported to adopt/review a safe sleep policy

ACTION 3: Investigate themes associated with SUDI deaths to inform SUDI prevention activities within Well Child Tamariki Ora services

MEASURE 3: Themes highlighted in education for WCTO & other services.

ACTION 4: Promote utilisation of the pepi-pod pathway for whānau at higher risk of SUDI

MEASURE 4: Uptake of the pepi-pod pathway is increased by 20%

ACTION 5: Update & implement the SUDI risk assessment & Safe Sleep planner in Maternity units & promote utilisation by community maternity & child health providers

MEASURE 5: Risk assessment and planner implemented by maternity units by 30/06/17

ACTION 6: Promote utilisation of the Well Child Tamariki Ora App as a source of information for parents

MEASURE 6: Uptake of the App increases

ACTION 7: Review the full referral process for maternity care, from initial LMC referral to ante-natal programme and Well Child Tamariki Ora service

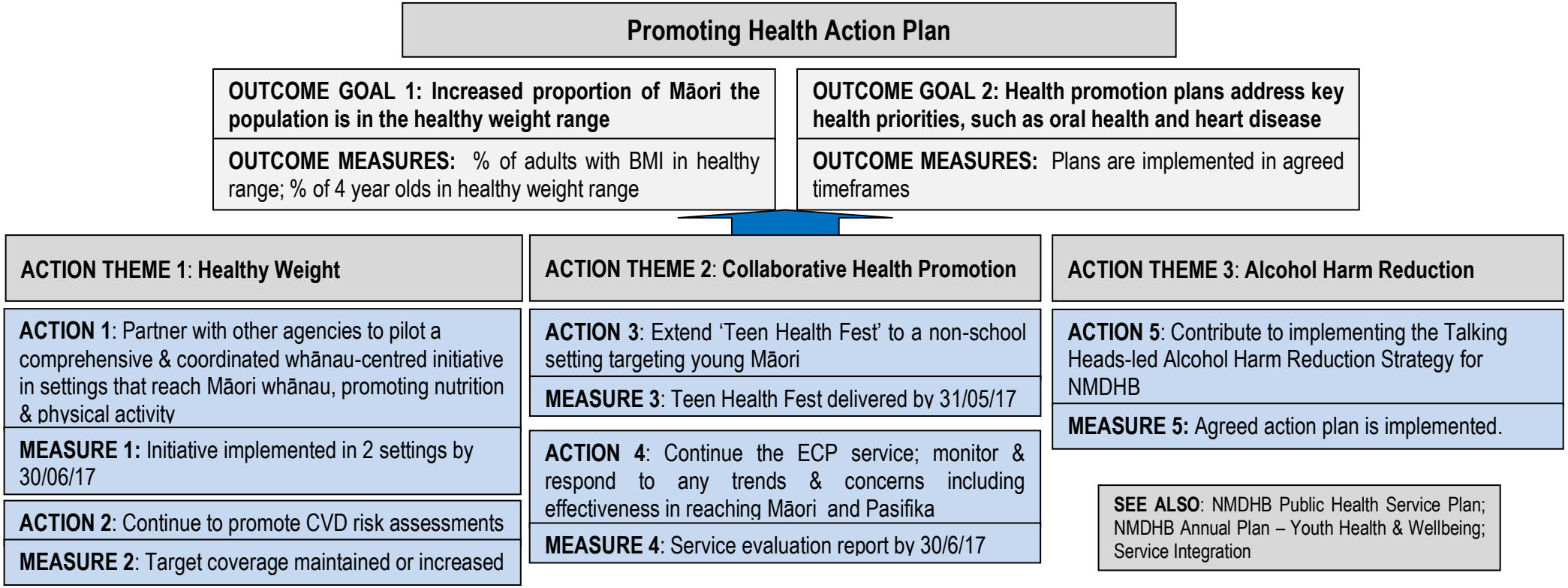
MEASURE 7: Process improvement plan developed

5. LOCAL PRIORITIES

Local priorities are:

- Promoting Health (Healthy weight; Youth Health; Alcohol Harm Reduction)
- Workforce Development
- Health of Older Māori
- Maternal & Child Health

5.1 Promoting Health



5.2 Workforce Development

Rationale
There are benefits from increasing the diversity of the workforce – Including socio-economic benefit for the ethnic groups in the community and opportunities to improve the quality of care for patients.

Current Services & Activities
In 2014, NMDHB undertook a planning process to strengthen the health and disability workforce to better meet the present demands and future needs of its population. It was noted that the ethnic makeup of district wide health service staff does not adequately mirror the ethnic makeup of the regional it is serving. It was identified that Nelson Marlborough could do more to recruit and retain Māori and Pasifika staff members.

Indicator:

NMDHB workforce ethnicity			
Ethnic group	2012	2013	2014
NZ European #	58.31%	59.31%	59.66%
Unknown	25.59%	23.60%	22.20%
Other	12.37%	12.43%	13.72%
Māori	2.73%	3.32%	2.88%
Asian	1.22%	1.21%	1.42%
Pacific	0.08%	0.13%	1.12%

2016/17 Plan

Workforce Development Action Plan

OUTCOME GOAL 1: Increased diversity of the workforce, and representation of Māori, Pasifika, and migrant populations

OUTCOME MEASURE 1: 5% increase in Māori staff

ACTION THEME 1: Implement the NM Health Sector Workforce Development plan

ACTION 1: Establish strategic partnerships to recruit Māori, Pasifika, and migrant health and disability workforce

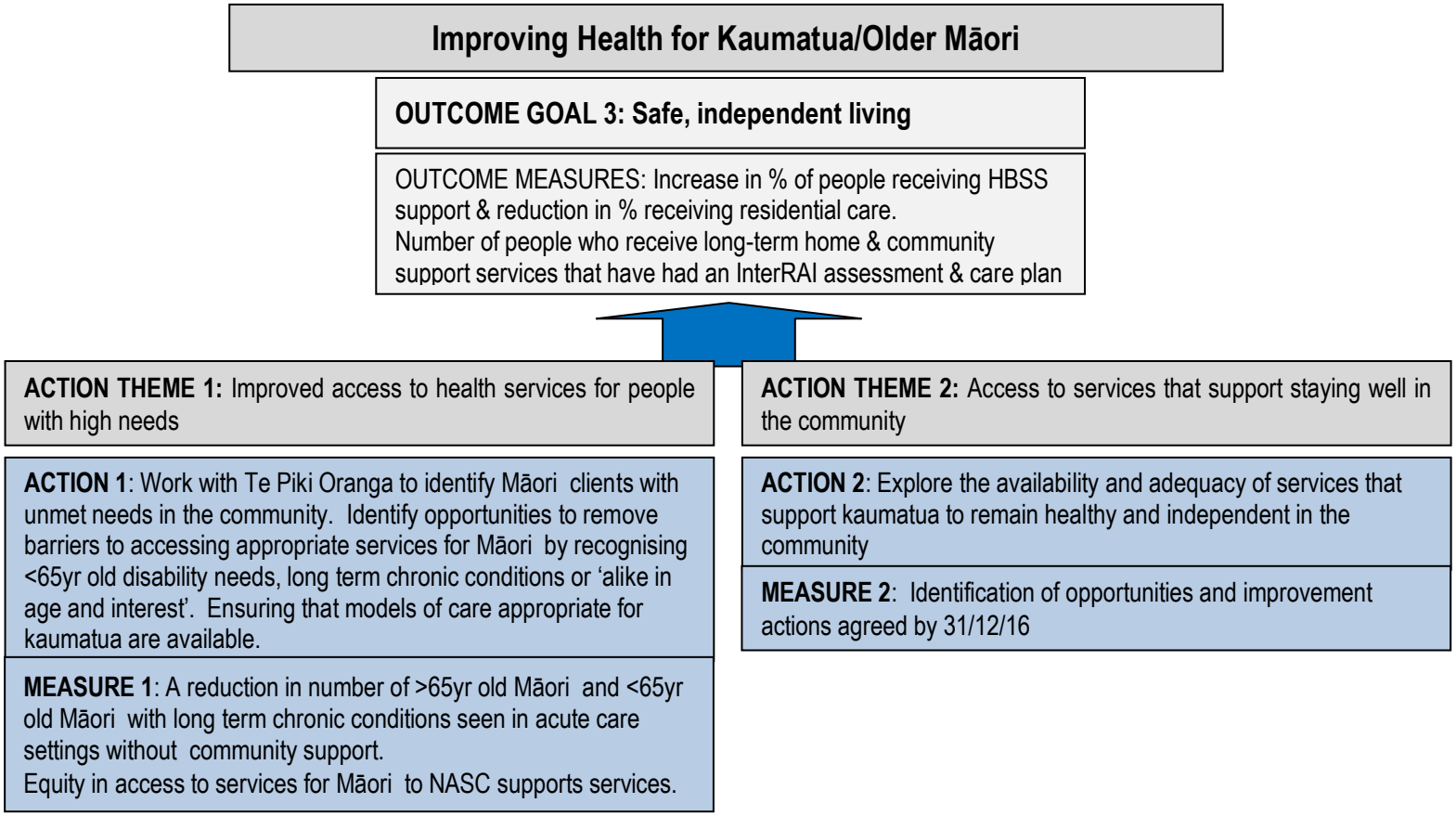
MEASURE 1: Partnerships developed by June 2017

ACTION 2: Establish system-wide recruitment targets for Māori, Pasifika and migrant populations to match our community demographics

MEASURE 2: Targets developed by December 2016

SEE ALSO:
Cancer, page 17; Immunisation, page 25; Better Help for Smokers to Quit, page 31.
NMDHB Annual Plan – Workforce Development.

5.3 Health of Kaumātua



5.4 Maternal & Child Health

Promoting healthy weight in children

- **Health Target:** 95% children identified by the B4SC as >98th percentile of the BMI are referred to an appropriate service by 30/6/17

B4 School Check Coverage

(a) At least 80% of Māori children receive a B4 School Check before their 5th birthday

B4 School Checks	Base (6mths to Dec2012)	Target 2013/14	Actual 2012/13	Target 2014/15	Actual 2013/14	Target 2015/16	Actual 2014/15	Target 2016/17
Māori	70.5%	80%	66%	90%	91%	90%		
Non-Māori	91%	80%	83%	90%	91%	90%		

Child and Maternal Health Action Plan

OUTCOME GOAL 1: Women, babies, children and their families have improved health outcomes through access to high quality maternal and child health services

OUTCOME MEASURES:
More equitable result on quality indicators
Early enrolment of women with LMCs & babies with GPs & Well Child services
Breastfeeding rates improve

ACTION THEME 1: Ongoing quality improvement to improve access and outcomes for Māori tamariki

ACTION 1: Well Child/Tamariki Ora Quality Improvement initiatives implemented

MEASURE 1: Quarterly regional activities achieved

ACTION 2: Investigate ways to increase Māori and Pacific access to antenatal maternity and parenting services, giving opportunities to support health-promoting lifestyles that contribute to healthy weight in pregnancy, smokefree pregnancies and breastfeeding, including exploring the value & viability of Kaupapa Māori pregnancy & parenting education

MEASURE 2: Options identified and at least 2 initiatives implemented by 30/06/17

SEE ALSO: Access to Care (Newborn enrolment); NMDHB Annual Plan - Child Health

ACTION THEME 3: A healthy weight is achieved for more children in Nelson Marlborough

ACTION 3: Referral processes to nutrition, activity and lifestyle interventions for children are embedded in B4SC programme

MEASURES 3: 95% children identified by the B4SC as >98th percentile of the BMI are referred to an appropriate service by 30/6/17
Single point of entry for child referrals achieved by 30/6/17
Consumer champions available for whānau by 30/11/16

ACTION 4: Existing primary care providers supported to realign services to further support healthy weight in children

MEASURES 4: Primary providers trained in Triple P by 31/8/17
Healthy weight health literacy project completed by 30/6/17
Kaiatawhai service has healthy weight focussed KPIs by 1/9/16
Clued up Kids introduced to Nelson with a healthy weight component by 31/12/16

ACTION 5: Support pregnant women to maintain a healthy weight

MEASURES 5: CME session on guidelines held for GPs by 30/11/16
National guidelines for the screening, diagnosis & management of gestational diabetes implemented in primary care by 30/6/17

ACTION 6: Sugar-sweetened beverage policies promoted in childcare and schools including Kohanga reo and Kura Kaupapa

MEASURE 6: Childcare and schools have policies implemented by 1/2/17

5.5 Healthy Hearts and Living Well with Diabetes

Rationale

The burden of cardiovascular disease (heart and stroke) is greatest among the Māori population, and mortality is more than twice as high compared to non-Māori. CVD risk assessments are an important tool to enable early identification and management of people at risk of heart disease and diabetes. Fast access to treatment for heart related attacks is essential to achieve health equity and improve health outcomes for Māori.

Current Services & Activities

Both PHOs work this general practices to actively identify those eligible and due for a CVD Risk Assessment (CVDRA) ands supporting practices with recall systems. They also support practices through workforce development and providing resources. PHOs work with Te Piki Oranga to support TPO to complete CVDRAs and offer assessments in community clinics and settings.

For people with diagnosed diabetes, the PHOs and TPO work with practices to ensure that a high proportion attend a diabetes annual review. Additional support, such as diabetes education sessions or referral to specialist services, is offered as required. The Specialist Clinical Nurses work in partnership with general practices to progress and will support patient care being delivered closer to home and increase the capability and capacity of primary care.

Indicator:

Percentage of eligible Māori PHO who have had a CVD risk recorded within the past five years. (2015/16)

PHO	Maori	Total Population	Target
Kimi Hauora Wairau (Q3)	87.0%	93.0%	90%
Nelson Bays Primary Health (Q2)	85%	90%	90%

Diabetes Management

The proportion of patients with HbA1c above 64mmol/mol (as at September 2015)

PHO	Maori	Total Population
Kimi Hauora Wairau (Q3)	31.2%	19.6%
Nelson Bays Primary Health (Q3)	44.1%	25.5%

Healthy Hearts and Living Well with Diabetes Action Plan

OUTCOME: All people with Cardiovascular Disease (CVD), at risk of CVD, and those with diabetes & pre-diabetes receive

MEASURE: Maintain 90% of the eligible population have had their CVD risk assessed in the last 5 yrs

MEASURE: The proportion of patients with HbA1c above 64mmol/mol decreases in 2016-17

ACTION THEME 1: Engagement between providers and improved quality of care contribute to improved outcomes

ACTION 1: Continue integration of primary and secondary services to increase the capability & capacity of the primary care workforce & develop advanced nursing models of care

MEASURES:
Maori Health Providers receive training and expert nurse support for diabetes and cardiac care from 1/7/16
Specialist nurses are linked to Practices and provide education and support for diabetes and cardiac care from 1/7/16
Increase in Practices undertaking insulin initiations in 16-17
Education plan for diabetes and CVD is developed encompassing an integrated approach to education for primary and secondary services by 31/7/16

ACTION 2: Health pathways developed for pre-diabetes, CVD and diabetes focussed on integrated care and an approach for Maori and groups with inequitable health outcomes

MEASURE 2: Pathways in place by 31/12/16

ACTION THEME 2: People at risk of CVD and diabetes have excellent Access to Primary Health Care

ACTION 3: Maori Health Providers undertake CVD risk assessments and link with General Practice

MEASURES 3:
90% of Maori men in the 35-44 age group have had a risk assessment in the last 5 year by 31/12/16
Referral pathways to Kaupapa Maori/Pacific services are further developed

ACTION THEME 3: Self management is enhanced by ensuring people have access to appropriate education and information

ACTION 4: Self management pathways are established for those with pre-diabetes, type 1 & 2 diabetes, high risk CVD/with established disease, & those with established disease

MEASURE 4: Pathways in place by 30/11/16