

Ministry of Health

Refresh of rheumatic fever  
prevention plans: Guiding  
information for high incidence  
District Health Boards

June 2015

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## Introduction

The rheumatic fever prevention programme (RFPP) has supported many new initiatives to reduce the incidence of rheumatic fever in priority population groups. These new initiatives have been delivered through district health boards (DHBs) and through them many other providers across the health and social sectors. As we move towards the end of the dedicated Ministry-led programme it is critical that the learnings are utilised and the focus and momentum are maintained. A key vehicle for supporting this focus and momentum is the refreshed rheumatic fever prevention planning process.

DHBs have already developed rheumatic fever prevention plans for the period 20 October 2013 to 30 June 2017 that describe their approach and commitment to delivering a range of actions which will contribute to achieving their rheumatic fever target. The plans were endorsed by the Minister of Health.

This document outlines expectations and provides guidance to high incidence DHBs<sup>1</sup> on the review and refresh of these rheumatic fever prevention plans. The refreshed plans will again be endorsed by the Minister of Health and will be effective from **1 January 2016**.

Low incidence DHBs are not required to update their rheumatic fever prevention plans.

The RFPP has provided funding for high incidence DHBs to trial initiatives on different ways to reduce the rate of rheumatic fever in their area. Annual funding will continue to the programme end in 2017. After this time funding will be available for 5 years to the high incidence DHBs to 2021/22 with a review in 2018/19 to assess whether funding will continue post-2021/22.

Key findings from the RFPP to date suggest that it will be important that the DHBs consider the following points in refreshing and implementing their plans:

- Setting a vision, gaining stakeholder commitment to it and harnessing collective action to deliver new ways of working.
- Defining problems and outcomes from the family's perspective rather than from the organisation's perspectives. Once we buy into the family's view of the world we focus on what we share rather than where we differ.
- Getting the balance right between efficient targeting and having a broad enough reach to achieve a population level outcome.
- Ensuring the plan is a living document by having a relentless focus on evidence-informed action at the same time as being agile when new learnings emerge.

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<sup>1</sup> Auckland, Bay of Plenty, Capital & Coast, Counties Manukau, Hawke's Bay, Hutt Valley, Lakes, Northland, Tairāwhiti, Waikato, and Waitemata have been identified as high incidence DHBs.

- Active stakeholder engagement to ensure we all “own” the desired outcomes and proposed solutions and will commit to sustaining them beyond the end of the programme funding.

High incidence DHBs are expected to review their rheumatic fever prevention plans, highlight initiatives that have been successful and they believe are sustainable beyond 2017, as well as document their learnings from those initiatives that have been less successful and that may not be taken forward. The Ministry expects the plans to demonstrate the active involvement of local stakeholders (including Māori and Pacific communities) and of their ownership of local solutions.

The DHBs will continue to be accountable to the Minister of Health for achieving their 2017 rheumatic fever target through their commitment in the DHB Annual Plans.

Appendix 1 outlines the criteria that need to be met for the Minister of Health’s endorsement of the rheumatic fever prevention plan.

Appendix 2 outlines the baseline and target numbers and rates for each DHB to 2016/17.

## Guidance for update of Rheumatic Fever Prevention Plans

This guidance document identifies the key information required by the Ministry of Health regarding the DHB's investment in reducing rheumatic fever.

Key considerations when reviewing and updating the rheumatic fever prevention plan should be:

- Key learnings from the implementation of the current plan
- Progress to date towards the DHB's 2017 rheumatic fever incidence target
- The development of sustainable interventions to be implemented beyond 2017
- How the DHB has engaged with other stakeholders (both in and outside the health sector) to design interventions that will be sustainable in the long term, ensuring that the prevention of rheumatic fever remains a priority locally
- How the DHB has engaged with Māori and Pacific communities and organisations in order to improve rheumatic fever outcomes for Māori and Pacific.
- How the DHB will continue to engage with other stakeholders (both in and outside the health sector) to ensure a coordinated integration of interventions
- How the DHB will continue to engage with Māori and Pacific communities and organisations in order to ensure continued relevance of the interventions for Māori and Pacific peoples

The update of the rheumatic fever prevention plan should include the following sections:

1. Overview of the review and refresh of the rheumatic fever prevention plan
2. Governance
3. Stakeholder engagement
4. Achieving the 2017 Better Public Service rheumatic fever target (to June 2017)
5. Ongoing investment in rheumatic fever prevention (July 2017 onwards)

The focus of the refreshed plan is on preventing rheumatic fever, so it is not expected that DHBs update the section in the current plans on 'Actions facilitating the effective follow-up of identified rheumatic fever cases'.

## Review of rheumatic fever prevention plan – overview

Please include an outline on:

1. Learnings from the implementation of the DHB's current rheumatic fever prevention plan. Please discuss the following:
  - Which activities does the DHB believe were successful? Why?
  - Which activities does the DHB believe were cost-effective? Why?
  - What would the DHB have done differently? Why?
2. How the DHB has involved and obtained commitment of local stakeholders in the review and update of their rheumatic fever prevention plan.

The **minimum requirements** of this section are:

1. A summary of learnings from the implementation of the DHB's current plan
2. Demonstrated evidence of stakeholder involvement in the review of the rheumatic fever prevention plan

## Governance

Appropriate governance will help to ensure good collective decision making.

Please include a description of the governance group which will ensure collective decision making about the priorities and co-ordinated implementation of your refreshed plan. You may wish to consider that this governance group:

- is led by the CEO or senior manager of the DHB or key stakeholder organisation
- has membership of CEOs or senior managers of partner organisations who will champion rheumatic fever prevention within their spheres of influence
- ensures communication and ideas sharing between all partners, at all levels regardless of organisational boundaries

The **minimum requirements** of this section are:

1. A commitment to the establishment of a governance group overseeing the development and implementation of the updated plan
2. A continued commitment to a rheumatic fever champion at a senior executive level
3. A commitment to review governance arrangements annually to ensure appropriate membership and that sustainable change is being delivered.

## Stakeholder engagement

Increasing stakeholders' understanding of rheumatic fever prevention and encouraging their active involvement and ownership of local solutions is important in a sustainable plan to reduce rheumatic fever. Focus must be given to Māori and Pacific stakeholders such as DHB Māori Health teams, local iwi and community groups.

A one-off amount of \$25,000 is available for each high incidence DHB to ensure that local priority populations (Māori and where relevant Pacific peoples) are actively engaged in

developing the refreshed plan. Further details on how to access this funding will be made available separate from this guidance document.

The **minimum requirements** of this section are:

1. Evidence that the DHB has worked and actively engaged with local Māori and, where relevant, Pacific communities and obtained active involvement and ownership of sustainable actions to achieve low levels of rheumatic fever.
2. Evidence that the DHB has worked with other local stakeholders (including primary health organisations, Māori and Pacific health and social organisations, health and social sector providers and other agencies) to obtain active involvement and ownership of local solutions to achieve and maintain low levels of rheumatic fever.

## **Achieving the Better Public Service target (1 January 2016 to 30 June 2017)**

This section should include a review of progress to date towards the DHB's 2017 Better Public Service rheumatic fever target. Please include discussion on the following questions:

1. Where is the DHB in relation to meeting the 2017 target? What is the expected trend with and without new actions?
2. What actions will be continued or introduced to ensure that the 2017 target is met? You need to consider a broad range of activities including:
  - raising awareness of rheumatic fever and how to prevent it among priority populations
  - preventing the transmission of Group A streptococcal throat infections in households
  - treating Group A streptococcal throat infections quickly and effectively

The **minimum requirements** of this section are:

1. An outline of the DHB progress to date to their Better Public Service rheumatic fever target for 2017.
2. Planned interventions to increase awareness of rheumatic fever and how to prevent it, to June 2017.
3. Planned interventions to prevent the transmission of Group A streptococcal throat infections within households, to June 2017.
4. Planned interventions to treat Group A streptococcal throat infections quickly and effectively, to June 2017.

5. An outline of the DHB's planned investment in interventions until 30 June 2017. Please include:
- any resources (financial and staffing) the DHB has committed to reducing the incidence of rheumatic fever, including funding allocated by the Ministry of Health
  - any new investments or initiatives the DHB is planning that aim to reduce the incidence of rheumatic fever
  - any resources (financial and staffing) other stakeholders have committed to reducing the incidence of rheumatic fever
  - whether and how the investments will be sustained into the future.

## **Ongoing investment in rheumatic fever prevention (July 2017 onwards)**

From 1 July 2017, there will be funding for rheumatic fever prevention for the 11 high incidence DHBs, totalling \$5 million. The funding will be available for 5 years to 2021/22 with a review in 2018/19 to assess whether funding will continue post-2021/22.

Each DHB has been notified individually about funding available to them from 1 July 2017.

The funding is for primary (including primordial) prevention of rheumatic fever only and cannot be used for other purposes, such as:

- Delivery of antibiotic prophylaxis service for rheumatic fever cases
- Development of surveillance to follow-up rheumatic fever cases
- Echocardiographic screening of RHD

Please include an outline of the activities the DHB and other stakeholders are planning to invest in rheumatic fever prevention from 1 July 2017.

The **minimum requirements** of this section are:

1. Any activities the DHB is planning to undertake to achieve levels of first episode rheumatic fever to less than 1.4 per 100,000 total population.
2. Any resources (financial and staffing) the DHB has committed to reducing the incidence of rheumatic fever, including funding allocated by the Ministry of Health
3. The investment (financial, people, other) from other stakeholders to achieving and maintaining low levels of rheumatic fever

## **Monitoring of rheumatic fever prevention plans**

Up to 1 July 2017, the Ministry of Health will continue to manage the monitoring of the rheumatic fever prevention plans through the DHB quarterly reporting process. Reporting against the rheumatic fever prevention plans is in line with the DHB quarterly reporting process: 20 January, 20 April, 20 July and 20 October.

All DHB performance against the Better Public Service rheumatic fever targets will also continue to be monitored through the DHB Quarterly reporting process.

Reporting requirements post 1 July 2017 are currently being developed by the Ministry of Health.

# **Appendix 1 – Endorsement criteria for District Health Boards with a high incidence of acute rheumatic fever hospitalisations**

This section outlines the criteria that are required to be met with each section for the endorsement of the DHB rheumatic fever prevention plans by the Minister of Health.

## **Review and update of the plan**

1. A summary of lessons learnt to date on the implementation of the DHB's plan
2. Demonstrated evidence of stakeholder involvement in the review and refresh of the rheumatic fever prevention plan

## **Governance**

3. A commitment to the establishment of a governance group overseeing the development and implementation of the updated plan
4. A continued commitment to a rheumatic fever champion at a senior executive level
5. A commitment to review governance arrangements annually to ensure appropriate membership and that sustainable change is being delivered.

## **Stakeholder engagement**

6. Evidence that the DHB has worked with other local stakeholders (including primary health organisations, Māori and Pacific health and social organisations, health and social sector providers and other agencies) to obtain active involvement and ownership of local solutions to achieve and maintain low levels of rheumatic fever.
7. Evidence that the DHB has worked and engaged with local Māori and, where relevant, Pacific communities and obtained active involvement and ownership of sustainable actions to achieve and maintain low levels of rheumatic fever.

## **Achieving the 2017 Better Public Services target**

8. An outline of the DHB's progress to date to their Better Public Service rheumatic fever target for 2017.
9. Planned actions to increase awareness of rheumatic fever and how to prevent it, to June 2017. A clear rationale is given for the proposals including demonstrating that they are:
  - consistent with local need
  - consistent with available evidence of effectiveness
  - coherent / integrated with other actions in the plan

10. Planned actions to prevent the transmission of Group A streptococcal throat infections, to June 2017. A clear rationale is given for the proposals including demonstrating that they are:
  - consistent with local need
  - consistent with available evidence of effectiveness
  - coherent / integrated with other actions in the plan
  
11. Planned actions to treat Group A streptococcal throat infections quickly and effectively, to June 2017. A clear rationale is given for the proposals including demonstrating that they are:
  - consistent with local need
  - consistent with available evidence of effectiveness
  - coherent / integrated with other actions in this plan
  
12. An outline of the DHB's planned investment in actions to reduce the incidence of rheumatic fever until 30 June 2017, including:
  - any resources (financial and staffing) the DHB has committed to reducing the incidence of rheumatic fever, including funding allocated by the Ministry of Health
  - any new investments or initiatives the DHB is planning that aim to reduce the incidence of rheumatic fever
  - whether and how the investments will be sustained into the future.

### **Ongoing investment in rheumatic fever prevention**

13. Any activities the DHB is planning to undertake to achieve levels of first episode rheumatic fever to less than 1.4 per 100,000 total population. A clear rationale is given for the proposals including demonstrating that they are:
  - consistent with local need
  - consistent with available evidence of effectiveness
  - coherent / integrated with other actions in this plan
  
14. Any resources (financial and staffing) the DHB has committed to reducing the incidence of rheumatic fever, including funding allocated by the Ministry of Health
  
15. The investment (financial, people, other) from other stakeholders to reducing the incidence of rheumatic fever

## Appendix 2 – District Health Board target rates and numbers

Table A1: Acute rheumatic fever initial hospitalisation target rates per year by District Health Board (per 100,000 total population), 2012/13 to 2016/17<sup>1, 2</sup>

District Health Board	2009/10– 2011/12 Baseline rate (3-year average rate)	2012/13 Target: Remain at baseline level	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: 2/3 reduction from baseline level
Northland	10.5	10.5	9.4	6.3	4.7	3.5
Waitemata	2.2	2.2	2.0	1.3	1.0	0.7
Auckland	3.3	3.3	3.0	2.0	1.5	1.1
Counties Manukau	13.6	13.6	12.2	8.2	6.1	4.5
Waikato	3.5	3.5	3.2	2.1	1.6	1.2
Lakes	7.8	7.8	7.0	4.7	3.5	2.6
Bay of Plenty	3.8	3.8	3.4	2.3	1.7	1.3
Tairāwhiti	8.5	8.5	7.7	5.1	3.8	2.8
Taranaki	0.9	0.9	0.8	0.5	0.4	0.3
Hawkes Bay	4.4	4.4	4.0	2.7	2.0	1.5
MidCentral	1.8	1.8	1.6	1.1	0.8	0.6
Whanganui	3.2	3.2	2.9	1.9	1.4	1.1
Capital and Coast	3.1	3.1	2.8	1.9	1.4	1.0
Hutt	4.9	4.9	4.4	2.9	2.2	1.6
Wairarapa	0.0	0.0	0.0	0.0	0.0	0.0
Southern region	0.4	0.4	0.4	0.3	0.2	0.1
<b>New Zealand</b>	4.0	4.0	3.6	2.4	1.8	1.4

1. Targets updated in May 2015 using 2013 Statistics New Zealand population estimates for 2010 to 2013 for numbers and rates for 2009/10-2012/13 and 2014 Statistics New Zealand population projections for numbers and rates for 2013/14 - 2016/17
2. Numbers and rates have been calculated using the criteria for acute rheumatic fever initial hospitalisation outlined in Appendix 3

**Table A2: Acute rheumatic fever initial hospitalisation target numbers per year by District Health Board (total population), 2012/13 to 2016/17<sup>1, 2</sup>**

District Health Board	2009/10– 2011/12 Baseline numbers (3-year average rate)	2012/13 Target: Remain at baseline level	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: 2/3 reduction from baseline level
Northland	17	17	16	11	8	6
Waitemata	12	12	11	8	6	4
Auckland	15	15	14	9	7	5
Counties Manukau	66	66	62	42	32	24
Waikato	13	13	12	8	6	5
Lakes	8	8	7	5	4	3
Bay of Plenty	8	8	7	5	4	3
Tairāwhiti	4	4	4	2	2	1
Taranaki	1	1	1	1	0	0
Hawkes Bay	7	7	6	4	3	2
MidCentral	3	3	3	2	1	1
Whanganui	2	2	2	1	1	1
Capital and Coast	9	9	8	6	4	3
Hutt	7	7	6	4	3	2
Wairarapa	0	0	0	0	0	0
Southern region	5	5	5	3	2	2
<b>New Zealand</b>	<b>177</b>	<b>177</b>	<b>163</b>	<b>110</b>	<b>84</b>	<b>63</b>

1. Targets updated in May 2015 using 2013 Statistics New Zealand population estimates for 2010 to 2013 for numbers and rates for 2009/10-2012/13 and 2014 Statistics New Zealand population projections for numbers and rates for 2013/14 - 2016/17
2. Numbers and rates have been calculated using the criteria for acute rheumatic fever initial hospitalisation outlined in Appendix 3

## Appendix 3 – First episode rheumatic fever hospitalisation data definition

The following criteria have been used to define first episode rheumatic fever hospitalisations.

ICD codes used:	ICD-10-AM diagnosis codes: I00, I01, I02 (Acute rheumatic fever) ICD 9 CM-A diagnosis codes: 390, 391, 392 (Acute rheumatic fever) ICD-10-AM diagnosis codes: I05-I09 (Chronic rheumatic heart disease) ICD 9 CM-A diagnosis codes: 393-398 (Chronic rheumatic heart disease)
Inclusions:	Principal diagnoses (Acute rheumatic fever) only Overnight admissions Day-case admissions
Exclusions:	Previous acute rheumatic fever diagnosis (principal and additional) from 1988 Previous chronic rheumatic heart disease diagnosis (principal and additional) from 1988 New Zealand non-residents
Transfers:	Transfers with a principal diagnosis of acute rheumatic fever are counted as one acute rheumatic fever hospitalisation episode
Timeframe:	Trends from 2002 onwards