Agenda

Bay of Plenty District Health Board

Venue: Via Zoom

Date and Time: Wednesday 19 August 2020 at 10.00 am

Please note: Board Only Time – 9.00 am

Minister's Expectations

- Primary Care Access
- Mental Health
- Improving Equity
- Public Delivery of Health Services
- Health and Wellbeing of Infants, Children and Youth
- Improving Population Health
- Long Term Capital Planning
- Workforce
- Climate Change
- Accountability for Improved Performance

Minister's COVID-19 Expectations

- **Financials**
- **Health and Safety**
- **Clinical Quality**
- **Planning and Reporting**

Priority Populations

- Māori
- First 1000 Days of Life
- Vulnerable Children and young People
- Vulnerable Older People
- People with Long Term Severe Mental Health and Addiction Issues

The Quality Safety Markers

- Falls
- Healthcare Associated Infections
- Hand Hygiene
- Surgical Site Infection
- Safe Surgery
- Medication Safety

Strategic Health Services Plan Objectives:

- **Live Well:** Empower our populations to live healthy lives
- **Stay Well:** Develop a smart, fully integrated system to provide care close to where people live, learn, work and play
- **Get Well:** Evolve models of excellence across all of our hospital services

Item No.	Item	Page
1	**Karakia** Tēnei te ara ki Ranginui Tēnei te ara ki Papatūānuku Tēnei te ara ki Ranginui rāua ko Papatūānuku, Nā rāua ngā tapuae o Tānemahuta ki raro Haere te awatea ka huri atu ki te pō (te pō ko tenei te awatea) Whano whano! Haere mai te toki! Haumi ē, hui ē, tāiki ē! This is the path to Ranginui This is the path to Papatūānuku This is the path to the union of Ranginui and Papatūānuku From them both progress the footsteps of Tānemahuta [humanity] below Moving from birth and in time carries us to death (and from death is this, birth) Go forth, go forth! Forge a path with the sacred axe! We are bound together!	
2	**Presentation**	
3	**Apologies**	
4	**Interests Register**	**4**
5	**Minutes** 5.1 Board Meeting - 15.7.20 Matters Arising 5.2 CPHAC/DSAC Meeting - 5.8.20	 **9** **15** **18**
6	**Items for Decision**	
7	**Items for Discussion** 7.1 Chief Executive's Report 7.2 Primary Care Overview 7.3 Dashboard Report (to be circulated) 7.4 Te Tumu Whakarae Handover Report	 **24** **35** **37**

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8	**Items for Noting**	
	8.1 Te Manawa Taki Regional Equity Plan 2020-2023 – Final	**86**
	8.2 Board Member Attendance - Jan - June 2020	**159**
	8.3 Chief Executive Expenses - 1.7.19 - 30.6.2020	**160**
	8.4 Choosing Wisely	**173**
	8.5 Advice from State Services Commission re Public Service Commission	**227**
	8.6 Correspondence for Noting	**231**
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9	**General Business**	
10	**Resolution to Exclude the Public** Pursuant to clause 33(3) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo who is the Chair of the Maori Health Runanga is permitted to remain after the public have been excluded because of his knowledge of the aspirations of Maori in the Bay of Plenty that is relevant to all matters taken with the public excluded. Pursuant to clause 33(5) of the NZ Public Health & Disability Act 2000 Mr Pouroto Ngaropo must not disclose to anyone not present at the meeting while the public is excluded, any information he becomes aware of only at the meeting while the public is excluded and he is present.	
11	**Next Meeting** – Wednesday 23 September 2020.	

Bay of Plenty District Health Board
Board Members Interests Register

(Last updated August 2020)

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
AHOMIRO, Hori				
Tapuika Int Authority	Board Director	Fisheries Trust	LOW	22/10//19
BOP ANZASW Branch	Member & Kaumatua	Executive Leadership	LOW	22/10/19
NZ Social Work Registration Board	Board Member	Social Workers Registration	LOW	May 2020
ARUNDEL, Mark				
Pharmaceutical Society of New Zealand	Member	Professional Body	NIL	1980
Armey Family Trust	Trustee	Family Trust	NIL	28/07/2005
Markand Holdings Ltd	Director	Property	NIL	2016
TECT	Trustee	Community Trust	LOW	July 2018
EDLIN, Bev				
Magic Netball/Waikato BOP Netball	Board Chair	Sports Administration	LOW	Member since March 2015/ Chair Sept 2017
Valeo International Limited	Co-owner/director	Education	LOW	20/12/2007
Governance NZ	Fellow	Governance	LOW	2011
Boardroom360 Limited	Co-owner/director	Education – Governance	LOW	10/3/2011
Edlin Enterprises Limited	Owner/director	Business Consultancy	LOW	17/03/1987
Alleyne Trust	Trustee	Family Trust	LOW	
Phae – non trading	Director	Education	LOW	07/12/2005
NJ Family Trust	Trustee	Trustee	LOW	
Tauranga City Council	Licensing Commissioner	Local Authority	LOW	16/01/2018
Park2Park Trust	Trustee	Community Artworks	NIL	18/09/2018
Omanawa Hidden Gorge Charitable Trust	Chair	Environmental / eco-tourism Venture	LOW	December 2018
Western Bay of Plenty District Council	Licensing Commissioner / Chairperson	Local Authority	LOW	February 2019
Institute of Directors	Fellow	Professional Body	LOW	June 2019

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST
ESTERMAN, Geoff				
Gate Pa Medical Centre Ltd	Director, Manager & GP	Health	LOW – DHB does not contract directly with General Practices and as a Board Member Geoff is not in a position to influence contracts.	28/11/2013
Gate Pa Medical Centre Ltd	Practice Manager is on WBOP PHO Board	Health	NIL	December 2019
GM and P Esterman Family Trust	Trustee	Family Trust (kiwifruit)	NIL	28/11/2013
Whakatohea Health Services	Wife Penny works part-time as Nurse	Health Services Provider	Contracts to DHB LOW	Sept 2019
FINCH, IAN				
Visique Whakatane	Director	Optometry	LOW	1/11/19
Lakes DHB	Wife Sue works in Clinical Quality and Risk, previous Director of Midwifery	Health Management	LOW –Health Management MOD- Midwifery	Jan 2020
GUY, Marion				
Chadwick Healthcare	Casual Employee	Health	NIL	06/1996
Bay of Plenty District Health Board	Employee	Health	LOW	03/10/2016
NZNO	Honorary and Life Member	Nursing Union	LOW	
NGAROPO, Pouroto				
BOP Maori Health Runanga	Chair	DHB BHealth Partner	LOW	2018
BOP Maori Health Runanga	Member	DHB Health Partner	LOW	25/02/2005
Te Rūnanga of Ngati Awa	Deputy Chairman		NIL	1990
Te Tohu o Te Ora o Ngāti Awa	Cultural Adviser		NIL	2007

Mental Health Awareness	Trustee	Supporting families	NIL	2010
Pou Whakaaro Trustee	Trustee		NIL	2001
Golden Pond	Cultural Advisor		NIL	2009
Tūtei o Te Hau-a-kiwa	Trustee		NIL	2010
Te Kupenga-a-Irakewa	Chairman Kaumatua Council		NIL	2000
Whakatane District Council	Director	Waters Plains Committee	NIL	2004
Whakatane District Council	Director	Museum & Gallery Board	NIL	2000
Whakatane District Council	Cultural Advisor		NIL	2001
Iramoko Marae Matata	Chairman		NIL	1999
Mary Shapely Old People's Home	Cultural Advisor		NIL	2009
Ngāti Awa Research & Archives Trust	Trustee		NIL	2000
Ngāti Awa Whakapapa Committee	Trustee		NIL	2000
James Street School	Cultural Advisor		NIL	2010
Apanui School	Cultural Advisor		NIL	2006
Pāroa School	Cultural Advisor		NIL	2009
Te Umuhika Lands Trust	Trustee		NIL	2001
Pōkerekere Lands Trust	Chairman		NIL	2002
Te Awakaponga Urupa	Trustee		NIL	2004
Joint Advisory Committee	Deputy Chairman		NIL	2010
Te Ramaapakura Trust	Chairman		NIL	2003
Regional Iwi Relationship Board	BOP Representation		NIL	2010
Resource Disability Centre	Cultural Advisor		NIL	2010
Sun FM 96.9	Cultural Advisor		NIL	2010
IXX Radio Station 2008	Cultural Advisor		NIL	2008
SCOTT, Ron				
Stellaris Ltd and Stellaris PTE Ltd	Director	Business Education and Training organisation	LOW	2005
SILC Charitable Trust	Chair	Disabled Care	Low – As a Board Member Ron is not it the position to influence funding	July 2013

			decisions.	
AA Bay of Plenty District Council	Council Member	Transport and Road Safety	LOW	March 2018
Volunteering Bay of Plenty	Chair	Volunteer organisation	NIL	October 2019
Establishment Board of Trustees – Suzanne Aubert Catholic School, Papamoa	Member	Education	NIL	March 2020
SHEA, Sharon				
Shea Pita & Associates Ltd	Director & Principal	Consulting	LOW	18/12/2019
Manawaroa Ltd	Director & Principal	Service Provider	LOW	18/12/2019
MAS Foundation	Board Member	Philanthropic Funder	LOW	18/12/2019
HealthShare	Consultant	Strategy	MEDIUM	18/12/2019
Maori Expert Advisory Group (MEAG)	Chair	Health & Disability System Review	LOW	18/12/2019
Iwi	Whakapapa		LOW	
A Better Start – E Tipu E Rea	Board Member	National Science Challenge – Auckland University	LOW	6/3/2020
EY - Department of Corrections Project	Member	Consulting - Corrections	LOW	April 2020
Mental Health Commission	Consultant	Mental Health Outcomes Framework	LOW	May 2020
ACC	Consultant	Accident Compensation Commission	LOW	May 2020
Wai 2575 Claimants	Consultant	contracted via the National Hauora Coalition to support Wai 2575 claimants cost historic underfunding of Māori PHOs. Short-term project.	LOW	August 2020
Tairawhiti DHB	Consultant	support to facilitate service design and development hui linked to mental health and addictions sector. Short-term project.	LOW	August 2020
Husband – Morris Pita - Health Care Applications Ltd - Shea Pita & Associates Ltd	 CEO Director	 Health IT Consulting	 LOW LOW	 18/12/2019 18/12/2019

SIMPSON, Leonie				
Te Runanga o Ngati Awa	Chief Executive	Iwi Entity	LOW	23/12/2019
Toi Ohomai	Kahui Matahanga Member	Iwi representation	LOW	23/12/2019
TUORO, Arihia				
Whakatohea Mussels	Director	Mussel Farming	LOW	15/12/2019
Poutama Trust	Trustee	Maori Economic Development	LOW	15/12/2019
Kaikou Gold Kiwifruit	Director	Kiwifruit	LOW	15/12/2019
Waikeke Farms Ltd	Director	Dairy Farm	LOW	15/12/2019
Oranga Marae Lotteries	Committee Member	Lotteries	LOW	15/12/2019
Toi EDA	Committee Member	Eastern bay Economic Dev	LOW	15/12/2019
Lotteries Americas Cup	Committee Member	Lotteries	LOW	15/12/2019
Whakatohea Pre Settlement Claims Trust	Project Manager	Negotiate Whakatohea Settlement	LOW	15/12/2019

Minutes

Bay of Plenty District Health Board

Tawa Room, Education Centre, 889 Cameron Rd, Tauranga

Date: Wednesday 15 July 2020, 10.00 am

Board: Sharon Shea (Interim Chair), Ron Scott, Hori Ahomiro, Mark Arundel, Bev Edlin, Geoff Esterman, Marion Guy, Ian Finch, Arihia Tuoro

Attendees: Pete Chandler (Acting Interim CEO), Owen Wallace (GM Corporate Services), Mike Agnew (Acting GM Planning & Funding and Population Health), Hugh Lees (Chief Medical Advisor), Julie Robinson (Director of Nursing), Jeff Hodson (GM Facilities & Business Operations), Sarah Mitchell (Exec Dir Allied Health Scientific & Technical), Debbie Brown (Senior Advisor Governance & Quality), Marama Tauranga (Acting Manukura, Maori Health Gains & Development),

Item No.	Item	Action
1	**Karakia** The meeting was opened with a Karakia.	
2	**Presentations** 2.1 <u>Care Capacity Demand Management (CCDM)</u> Ros Jackson, Associate Director of Nursing There are 3 Main components in the CCDM Programme: • Core Data set • Staffing Methodology • Variance Response Management underpinned by Governance, Partnership with Unions and a validated Patient Acuity Tool (TrendCare). The 3 components work together as a joined up approach with a core data set. 'Variance' identifies a mismatch between the service demand level and the nursing capacity to provide care. In order to respond to variance we decrease demand (e.g. by moving patients), increase capacity (by increasing staff hours) or as a last resort constraining nursing case to essential care levels. Variance Response management (VRM) tools include the Integrated Operations Centre (IOC), Hospital status at a glance, variance indicators and standard operating procedures. IOC is a bird's eye view of whole of our hospitals, patient and staff co-ordination for core teams and services. Hospital at a glance screens are all around the hospitals showing a visual representation of all inpatient areas and activities. The screens are updated every 12 minutes and can be reviewed in different sequences, eg yesterday, today, tomorrow, or last year, this year, next year etc. The Variance Indicator System is an electronic tool which comprises data on capacity and demand input by staff in each area. It is assessed at least once per shift and at changeover.	

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	The score of the staff assessment is placed in a variance indicator colour ranging from Purple (excess staff for current clinical demand) through to Orange and Red (Red showing a serious deficit in staffing resource requiring intervention). The indicator flag is important, the response is key. CCDM is on a continuous quality improvement pathway. The Board thanked the Associate DON for her informative presentation.	
3	**Apologies** Apologies were received from Pouroto Ngaropo and Leonie Simpson **Resolved** that the apologies from P Ngaropo and L Simpson be accepted. Moved: A Tuoro Seconded: M Guy	
4	**Interests Register** Board Members were asked if there were any changes to the Register or conflicts with the agenda. No changes or conflicts were advised.	
5	**Minutes** 5.1 Minutes of Board meeting An amendment was raised, for Item 7.4 relating to the Dashboard Report, to be listed on Matters Arising. **Resolved** that with the above amendment, the Board receive the minutes of the meeting held on 17 June 2020 and confirm as a true and correct record. Moved: A Tuoro Seconded: B Edlin 5.2 Matters Arising Exec discussion had occurred yesterday to improve the process and responsiveness to Matters Arising. 7.1 *Te Manawa Taki Equity Plan*. Second version going out to Midland Group and will then come back to the Board. 7.2 *CEO's Report - Oranga Tamariki*. BOPDHB has a good process that teams are comfortable with if there was to be a potential newborn uplift, which is not a common event but sometimes unavoidable because of extreme risk for the baby. We believe that all uplifts over the last two years have resulted in the newborns being placed in the care of whanau. Query was raised with regard to what might challenge the good relationship with Oranga Tamariki. Is there an MOU in place? The Family Violence team has been working closely with Police and Oranga Tamariki. There is a shared commitment to working together in the interests of whanau and this is based on strong relationships. *Influenza Data*. Good ethnicity data is required. The figures will be rechecked with the analysts and discussed with PHOs. There is some additional funding with MHGD to focus on Maori. Query was raised with regard to inequity with regard to Maori Over 65s when it is recognised that Maori might be affected at an earlier age.	

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Item No.	Item	Action
	5.3 BOPHAC Meeting 17.7.20 The Board received the Minutes of the meeting held on 1 July 2020. Comment was made on difficulties with Child Oral Health. A further report is scheduled for next BOPHAC meeting	
6	**Items for Decision** Nil	
7	**Items for Discussion** 7.1 Chief Executive's Report *Child Development Service (*CDS) - is integrating very well and there is discussion occurring across services around a more connected model of support for children, eg single point of access and Trans-disciplinary care co-ordination. Query was raised with regard to the free lunch service and how that might expand out of school hours, eg in school holidays. There were a lot of such examples that came out of COVID work. The food parcels given out to Whanau was given as an example. *Incredible Years Programme.* There is an intention through future service connectedness to take the area of autism out of the label of Mental Health. *Keeping Me Well* - the programme staff were congratulated for the 3 months reduction in wait time and on the optimal utilisation of skill mix. There is a focus on non-duplication of services and single point of contact which has assisted the 3 months reduction in wait time. There has been a lot of engagement with the community and staff which has proved very positive. *LifeCurve* - has been launched and is an exciting story. BOPDHB is first to adopt the LifeCurve. It is a powerful tool to have at BOPDHB's disposal. Planned Care also links into this programme. It is being tested with Age Concern and Nga Kakano. Discharges from the Orthopaedic Ward are also being followed through. *Immunisation* - There are multiple threads of activity underway. With the COVID situation, a lot more people have had their influenza injections. How to continue that momentum and maintain it is something to consider. Followup is key. *Protected and Proud* - This group has national presence and is very strong in Kawerau, trying to drive social change. It is a different way of doing things involving youth. *Future Leaders - a seat at the table*. The Board will have two seats at the Board table for emerging young leaders. *Health Intelligence* - Direction of travel was noted in relation to working across the PHO and DHB, connecting data, informatics and health intelligence for the future. *Whakatane Acute Flow (E3*) - this programme started two years ago when acute demand started to rise, leveraging the learning from the Tauranga acute flow improvement programme led by the COO.	

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E3 has become a much wider scope, including Eastern Bay PHA, considering the future model of care which reaches beyond the hospital and building this on the essence of Te Toi Ahorangi. A presentation is being planned for a Board meeting in coming months.

COVID - BOPDHB, Lakes and Waikato DHBs are in discussion, sharing information and learnings in relation to isolation facilities.

Query was raised on catchup with Elective Surgeries. Negotiations are nearing conclusion with private providers and increased operating hours are also a consideration however there is not huge appetite for additional work across many of our teams.

Query was also raised on how Toi Te Ora (TTO) are coping with COVID and Business as Usual. Other groups from across the DHB are continuing to support TTO with staff.

Te Whare Maiangiangi (TWM.) There is need to consider the learnings from the COVID situation that occurred in TWM and a full reflective assessment is being undertaken currently.

Election requirements - Reminder was made of the need to be neutral in the upcoming elections.

Query was made on Staff vaccinations in comparison to previous years. Midwifery improvement is particularly pleasing and this year has seen a significant increase in maternity staff vaccinations.

The Board wanted to convey congratulations to Drs Kate Grimwade and John Malcolm on their awards.

Financials - YTD deficit of -$18m which includes approximately $5-6m of COVID unreimbursed costs. Underlying operational deficit is as predicted. The forecast is sitting at around -$24m with COVID comprising $8-9m. This excludes the Holidays Act adjustments.

Resolved that the Board receive the report
Moved: R Scott
Seconded: M Guy

7.2 <u>Primary Care Overview</u>
Funding for Tuapapa. - BOPDHB has committed to Tuapapa and it has been planned and budgeted for. Acting GMPF will follow up and report back.

7.3 <u>Dashboard Report</u>

7.4 <u>Maori Health Dashboard Report</u>
The Dashboard was taken as read, and noted.
</td><td>Acting GMPF</td></tr>
<tr><td>8</td><td>
Items for Noting

8.1 <u>Hand Hygiene Results - June 2020</u>
Discussions are scheduled to be had with areas with poorer results. Two areas in particular will be followed up for improvement and reported back to the Board.

8.2 Correspondence for Noting
8.2.1 <u>Letter from Peter Hughes, State Services Commissioner, re Board Members Standing for Parliament, dated 30 June 2020</u>
</td><td>DON/CMA</td></tr>
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Item No.	Item	Action
	8.2.2 Letter from Hon Peeni Henare, Associate Minister of Health, re Maori Health equity – COVID-19 response and recovery planning and BOPDHB response dated 6.7.20 8.2.3 Letter to Lakes Board Chair re Lakes DHB representatives to BOPDHB Committees and nomination of BOPDHB representatives to Lakes DHB. 8.2.4 Letter from the Chief Medical Officer Ministry of Health and the Director Health Quality Intelligence re Key Acute Coronary Syndrome Indicators by DHBs – 8.7.20 8.3 Work Plan The Board noted the reports and correspondence	
9	**General Business** 9.1 Tirohanga Oranga o Mataatua document The document contains excellent information and an overview of the challenges people have faced during COVID. Manukura advised that the survey was approached in a Kaupapa Maori manner. 9.2 CARE Badges. A Board Member advised of comment he had received from a Cleaner that they were not able to wear the CARE Badge because of being a contractor rather than a DHB employee. Cleaning staff are contracted services not BOPDHB employees, however name badges can be discussed with the contracting service. GMFBO to explore provision of CARE logo badges to Catering and Cleaning Contractors.	GMFBO
10	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting: Board Minutes FARM Meeting - 10.6.20 FARM Meeting - 1.7.20 BOPHAC Meeting - 1.7.20 Whakatane and Tauranga Mental health & Addiction Service New Build Projects Commissioning the Second Cardiac Catheter Lab BOPDHB Board Members Code of Conduct That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Pete Chandler	

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Item No.	Item	Action
	Owen Wallace Mike Agnew Debbie Brown Hugh Lees Julie Robinson Jeff Hodson Marama Tauranga Sarah Mitchell **Resolved** that the Board move into confidential. Moved : B Edlin Seconded: M Arundel	
11	**Next Meeting –** Wednesday 19 August 2020	

The open section of the meeting closed at 11.30 am
The minutes will be confirmed as a true and correct record at the next meeting.

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RUNNING LIST OF ACTIONS

Key	Completed on time	Work in progress, to be completed on time	Not completed within timeframe

	Task	Who	By When	Status	Response
15.1.20 Item 5.2	**Chief Executive's Report – Clinical School** CEO advised that it would be good for the Head of Clinical School, Prof Peter Gilling to meet with the Board at a future meeting. One of the Clinical School's priorities was to give students an experience that made them want to work for BOPDHB. – Board Secretariat	HOCS	Sept		
15.1.20 Item 5.4	**Dashboard Report – Maori Health Dashboard** Board Chair queried availability of information on inequity. There is a Maori Health Dashboard that comes to the Board. Next report is due in February. Board Chair considered the dots need to be connected from the information contained within the Dashboard and how to implement improvements. The reporting does not give a strategic approach. – Manukura	Manukura	Sept		
17.6.20 Item 7.1	**Te Manawa Taki Equity Plan (Draft)** The process by which individual DHBs can monitor and influence to keep the plan on track. With the plan being signed off by the Regional Governance Group there will be further discussion on monitoring. For BOPDHB the Regional Plan and TTA should go forward together, with perhaps quarterly updates to the Board. – Acting Manukura	Manukura	Sept		In progress
The final plan is approved, MHGD had significant input into the development of the regional equity plan and therefore there are clear connect points to TTA change principles, au rangi and to our own DHB strategic priorities e.g. Toi Oranga Mokopuna and Toi Oranga Ngākau					
17.6.20 Item 7.1	**Te Manawa Taki Equity Plan (Draft)** It was suggested that the plan could be an agenda item for the next Joint Meeting in August – Acting Manukura / Board Secretariat	Manukura	Aug		In progress – as below
Has been discussed with Chair of Runanga and will be shared with Runanga in first instance for their August meeting. Will come to Nov Joint Meeting					
17.6.20	**Chief Executive's Report**	Manukura	July		As below –

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	Task	Who	By When	Status	Response
7.1	BOPDHB has a good relationship with Oranga Tamariki. Recent determination has been that uplifting of children cannot occur on DHB premises. The Board requested an update on BOPDHB's position – Acting Manukura				As below – Completed
BOPDHB has a good process that teams are comfortable with if there was to be a potential newborn uplift. Query was raised with regard to what might challenge the good relationship with Oranga Tamariki. Is there an MOU in place? The Family Violence team has been working closely with Police and Oranga Tamariki. There is a shared sense of cause.					
17.6.20 Item 7.1	**Maori Health Dashboard** Board Members requested the opportunity for an education session on the data provided to better understand. To be arranged. – Interim CEO	Manukura	Sept		Intent is for 2 Sept Committee day
17.6.20 Item 7.4	**Dashboard Report** The impact of COVID across the Board is reflected. Comment was made on the equity gap in the Mental Health Data. This will be reviewed and a report will come back	Acting GMPF	Aug		Response in Board Agenda 19.8.20 - Completed
15.7.20 Item 7.1	**CEO's Report** The Board wanted to convey congratulations to Drs Kate Grimwade and John Malcolm on their awards. Congratulatory letters to be sent on behalf of the Board – Interim Chair	Interim Board Chair	Aug		Completed
15.7.20 Item 7.1	**CEO's Report – A Seat at the Table** The Board will have two seats at the Board table for emerging young leaders. It was suggested that Whaiora Patrick from Future Leaders could be approached in relation to the Board seats	Manukura/ SAGQ	Aug		In Progress
17.6.20 Item 7.4	**Dashboard Report** The impact of COVID across the Board is reflected. Comment was made on the equity gap in the Mental Health Data. This will be reviewed and a report will come back. – Acting GMPF	Acting GMPF	Aug		Update in Board Agenda 19.8.20 - Completed

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	Task	Who	By When	Status	Response
15.7.20 Item 7.4	**Primary Care Overview – Funding for Tuapapa** BOPDHB has committed to Tuapapa and it has been planned and budgeted for. Acting GMPF will follow up and report back. – Acting GMPF	Acting GMPF	Aug		
15.7.20 Item 9.2	**General Business – CARE Badges** To explore provision of care logo badges to catering and cleaning contractors.	GMFBO	Aug		
15.7.20 Item 8.1	**Hand Hygiene** Discussions are scheduled to be had with areas with poorer results. Two areas in particular will be followed up for improvement and reported back to the Board.	DON/CMA	Aug		

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Minutes

Bay of Plenty Combined
Community & Public Health Advisory Committee/
Disability Services Advisory Committee Meeting

Venue: 889 Cameron Road, Tauranga
Date and Time: 5 August at 10.30 am

Board: Arihia Tuoro (Chair), Hori Ahomiro, Mark Arundel, Bev Edlin, Ian Finch, Paul Curry,

Attendees: Mike Agnew (Acting GM Planning & Funding and Population Health), Debbie Brown (Senior Advisor, Governance and Quality), Hugh Lees (Chief Medical Advisor), Marama Tauranga (Manukura, Maori Health Gains & Development), Stewart Ngatai (Pou Umanga, Maori Health Gains & Development), Janet Hanvey (Business Leader, Toi Te Ora)

Item No.	Item	Action
	Karakia	
1	**Presentation** Toi Te Ora – COFID-19 Response Dr Phil Shoemack, Medical Officer of Health, Janet Hanvey, Business Leader, Toi Te Ora, Perspective of TTO' role relative to COVID was given. MOH is advised of any patients being treated for a notifiable disease which includes COVID. The nasopharyngeal swab is the gold standard for identifying COVID 19. It is incredibly sensitive. A problem with the test is that patients have no recall of being unwell and test symptomatic because of the sensitivity, but not have the disease. 30,000 swabs have been taken and there have been 63 (0.2%) confirmed cases across the Bay of Plenty. Each case is followed up and people are put into isolation for 10 days, usually at home. All of their close contacts are put into quarantine for 14 days. They are kept in contact with on a daily basis. The 63 cases led to 3,500 daily calls to trace close contacts. MOH set up a National contact tracing service which allowed referral to them, based in Wellington. Last confirmed case in the Bay of Plenty was mid April. The suspect case definition changed in July, due to impending Winter ills which would have overwhelmed the health system if people presented because of a symptom. There are three isolation hotels in Rotorua. There have been 1253 guests for 14 days of managed isolation. They are New Zelanders returning home. Swabs are taken on Days 3 and 11.	

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	9 individuals have tested positive and were transferred to Jet Park Hotel isolation hotel in Auckland. Isolation hotels are chosen on their suitability eg how many exits they have, and they need to be of a certain standard and be able to supply meals. Supportive health services also need to be available. There has been a report undertaken on contact tracing which indicated an upscaling to be able to cope with 1000 cases per day nationally should there be a second wave. BOPDHB is considering how to cope with 25 new cases per day which would translate to 5,000 calls per day. Because of New Zealand's current Level 1 status, the contacts could be wide ranging. Query was raised on what the likely issues would be. TTO normally has a staff of 50 across both sites. Staff can be recruited from across both organisations for COVID, but would not be able to undertake their usual roles. Pinchpoints would be the testing of people and whether CBACs need to be reinstated. The capacity of the laboratory is also a consideration. Query was raised as to whether it is considered that New Zealanders appear to becoming complacent. The difficult question is how and when New Zealand relaxes its border. TTO will be testing the system on 18 August as to ability to cope with numbers should the second wave occur. There is a Health Needs Assessment at a Community level being undertaken. Query was raised as to whether an equity lens and a disability lens specifically is being applied. eg People with disability require support people to come to their homes. The virus has provided an opportunity for review of many aspects of health care and business as usual will never be the same again. For BOPDHB, apart from the international border there is an issue in the local area with regard to the sea border. Crews are not permitted to leave their ship for 28 days following their last port of call. Committee Chair queried what the Committee could take away from the presentation. It was considered that keeping a watch on things like advice of when the border will open will be critical. MOH is confident that plans are in place, however TTO is reliant on other areas of the health system, to manage. The message should be to currently relax but be ready for a second wave. The Committee thanked the Medical Officer of Health and Toi Te Ora Business Leader for their informative presentation	
2	**Apologies** Apologies were received from Sharon Shea **Resolved** that the apology from S Shea be received Moved: I Finch Seconded: B Edlin	
3	**Interests Register** The Committee was asked if there were any changes to the Register or conflicts with the agenda. No conflicts were advised.	

UNCONFIRMED

	Community Representative P Curry advised of a change that he will email to the Board Secretariat. Board Member H Ahimiro also advised of a change in his Interests.	
4	**Minutes** 4.1 Minutes of Previous CPHAC/DSAC Meeting **Resolved** that the minutes of the meeting held on 5 February 2020 be confirmed as a true and correct record. Moved: A Tuoro Seconded: B Edlin	
5	**Matters Arising** There were no outstanding Matters Arising	
6	**Matters for Discussion / Decision** 6.1 Disability Action Plan 2019 – 2023 There are three DHBs who have developed a Disability Strategy around 3 aspects: • Developing guiding principles • Identifying Actions • Defining outcomes Acting GM requested feedback from the Committee on the principles and outcomes. Comment was made of cross reference to the Health and Disability review. Disability will transfer to the new DHB model. To be ready for that, the direction of the review should be picked up. The Guiding Principle for the Disability Sector is 'Nothing about us Without us', enabling good lives, and requires a co-design rather than an advisory aspect. It is not considered that a Disability Strategy will happen unless responsibility is allocated for developing. Request was made that BOPDHB puts some accountable resource to progress. Reference was made to the Maori Disability Action plan which may be helpful. The Committee accepted the guiding principles in principle, changing the word design to co-design, aligning to the Health and Disability Review report and with link to the Health Consumer Council It was considered that a timeline should be put in place. **Resolved** that the Committee recommends to the Board that it supports the approach proposed in the development of the BOPDHB Disability Strategy. Moved: B Edlin Seconded H Ahomiro 6.2 COVID-19 Psychosocial response Liz Gourlay, Social Work Professional Lead, Psychosocial Support in attendance Liz explained that she was a Social Worker and that Social Work is about connecting communities and meeting communities wellbeing needs.	Acting GMPF

UNCONFIRMED

Under the welfare pillar of the SIMs structure there is a psychosocial responsibility, with a team that sits under that responsibility. Psychosocial work has been active since the Whakaari event in December 2019. Work is undertaken in conjunction with Civil Defence.

COVID is a much longer psychosocial response working with Civil Defence, local Councils and other agencies. There have been regular Zoom meetings with key agencies in the community. Civil Defence has currently been stood down and the responsibility has transitioned to MSD.

Immigrants and foreign nationals are part of the support structure as it is very difficult for them.

The Psychosocial role is to work with other agencies across all agencies, eg Maori and Mental Health providers, understanding what the needs are, where they are required and how to provide.

What is emerging in response to COVID is that the measures taken to prevent spread, have created huge stress. The impact of the economic issues is a major factor.

There are also people in the community, some vulnerable, who have been under the radar, being self-dependent, not visiting GPs and have not accessed support or assistance, but have been severely impacted.

While in a lull period, consideration is being given to the setup of Welfare Centres in the community, in liaison with local Councils. There is a lot of online resource, however it is considered that both online and face to face will be required as online access is not available to all.

Query was raised on the principles indicated and what the biggest issues were. Advice was given that we cannot keep going to communities without being able to deliver their requirements. There has not been a lot of change in resource. Community lead solutions was considered a key factor.

There is a Regional Leadership Group lSpanning Bay of Plenty and Waiariki made up of police, MSD, MoE, Health and Iwi leaders that will be looking to identify community and sector leads to navigate across the sector. There will be a regional proposal compiled and put forward to the various Ministries involved.

The hotel isolations are very difficult for people across a range of issues.
Psychosocial support is still in early stages. 8 months after Whakaari, issues are still being worked through and all consequences have not come to light as yet.

Resourcing for COVID and Business Usual is an issue.

The Committee noted the paper and thanked Liz for her attendance and helpful information.

UNCONFIRMED

	6.3 Child Health and Wellbeing – First 2000 Days Programme There has been impact from COVID in the last quarter and there are 2019 activities that will push out to 2020 eg Maternal Services and Midwifery changes. There have been recent positive changes in the midwifery space. It is considered there may need to be flexibility around intended 2000 days period. Query was raised on capacity and how long recruitment to the vacant role had taken. It was considered the delay was around 6 months. The person in the role is returning from parental leave. Achievables have been in the breastfeeding, vulnerable mothers and maternity areas. It was considered that measureables from First 2000 days need to be included within the Annual Plan. The programme needs to go out into and be owned by the Community, community lead. Manukura advised of Te Mokopuna strategic objective. There has been a discussion and a stocktake is to be undertaken which includes First 2000 days. Action plans move strategy to implementation via a programme of work and need to be undertaken with the same rigour as applied to TTA. The Committee noted the paper	
7	***Matters for Noting:*** 7.1 Te Teo Herenga Waka & Toi Te Ora report 7.2 CPHAC/DSAC Work Plan 2020 The Work Plan going forward will need to reviewed and the impacts of COVID considered. Discussion was had on the topics for next CPHAC/DSAC. The Disability Strategy work needs to be included with formulation of a strategy. The Committee noted the papers	Acting GMPF
8	**General Business** There was no general business	
9	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: TTHW and TTO Report Letter re Campaign for Change That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records.	

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	This knowledge will be of assistance in relation to the matter to be discussed: Mike Agnew Debbie Brown Marama Tauranga Stewart Ngatai **Resolved** that the Committee move into confidential. Moved: A Tuoro Seconded: B Edlin	
9	**Next Meeting –** Wednesday 7 October 2020	

The meeting closed at 12.20 pm

The minutes will be confirmed as a true and correct record at the next meeting.

UNCONFIRMED

CEO's Report (Open) – August 2020

COVID-19

Toi Te Ora

Surge Capacity Planning
Toi Te Ora is working closely with its two District Health Boards to ensure there are an adequate number of trained personnel available to respond to a second wave of the virus. To date the focus of the local public health response has been on developing and training staff on contact tracing, including using the new national contact tracing system. Toi Te Ora has a surge capacity plan in place to ensure this region is ready to respond to any second wave of the virus. The plan has been agreed with the Ministry of Health and will be exercised with newly trained staff as part of their training.

Recovery Planning
Toi Te Ora has developed a COVID-19 Public Health Recovery Strategy and Action Plan, which is now being implemented within the service. This strategy covers organisational recovery, staff recovery and wellbeing, and community recovery.

The strategy will align with the two Bay of Plenty and Lakes DHBs' plans as these are developed, including psychosocial recovery.

INTEGRATION / COMMUNITY

Te Teo Herenga Waka

Housing
Funding commitment over 3 years ($1.545m) has been made through the Healthy Housing Funders Accord (between BOPDHB Planning and Funding, Western Bay of Plenty District Council and Philanthropic funders (Bay Trust, TECT and Rotorua Trust) for essential home repairs and maintenance. This work has now commenced in the Bay of Plenty. The goal remains that we will support the improvement of housing stock (homes to be able to reach 20 degrees) in the Bay of Plenty, including provision of funds.

Allied Health

Keeping Me Well - Western Bay Ngā Kākāno Practice Test Team
The Ngā Kākāno trial continues with ongoing progress with community engagement and reaching clients who have not had community services to support their wellbeing.
The model is starting to demonstrate the following outcomes;

- By working in a kāupāpā model and utilising local health navigators, programmes have been initiated with clients who are at high risk of admission but have not received community based, recovery intervention previously – these are clients with high need, significant distrust of the system and frequent attenders to ED.
- Clients with chronic conditions are being picked up immediately for services such as respiratory physiotherapy intervention rather than waiting on a specialist physician waiting list – that is a reduction of 3 months wait time. They are also picking up clients that have not been offered any additional recovery intervention for their chronic health condition.
- 90% of client requests resolved on the day of or the day after the request was made.

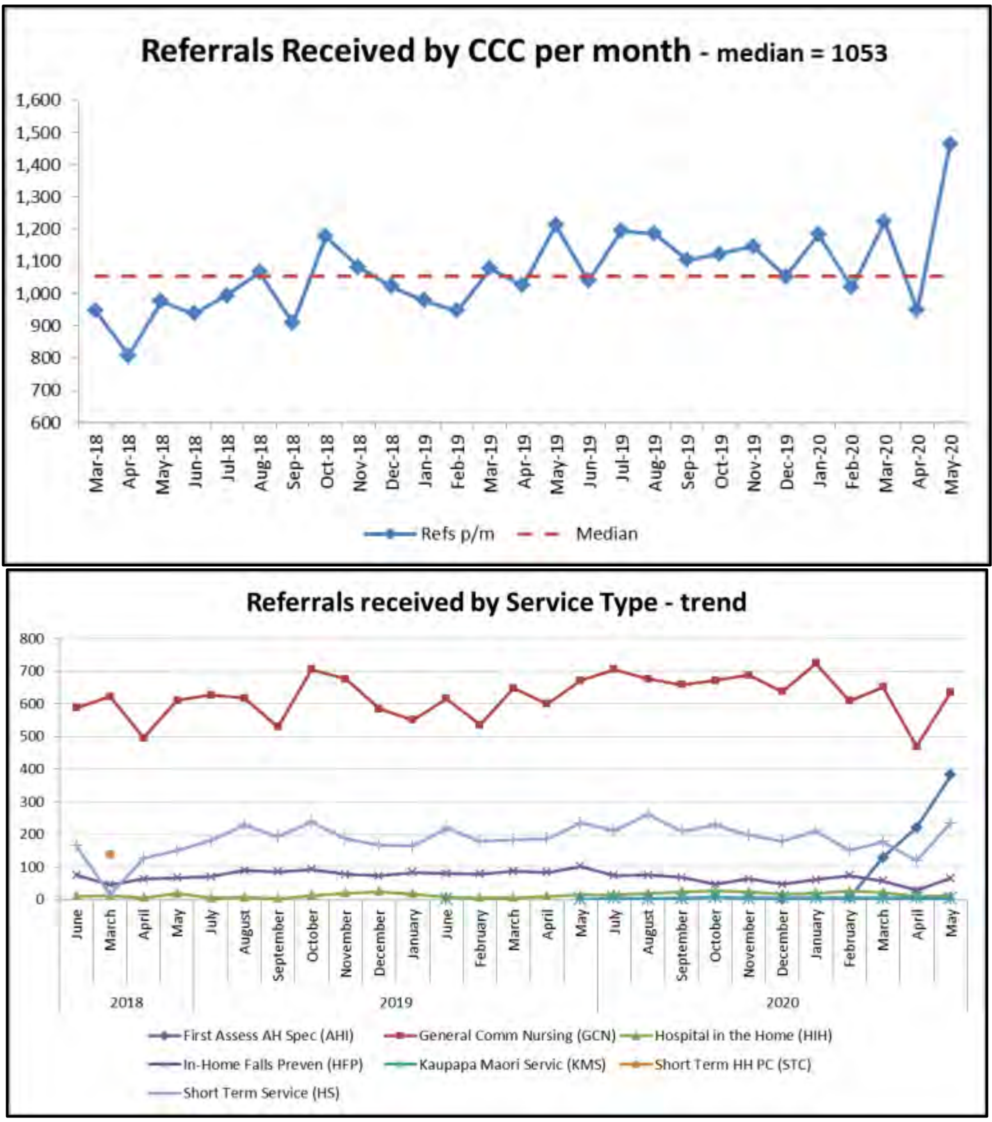
The 3 staff seconded to be the practice test team has had their secondment extended to July 2021 to enable the model to be extended out into the wider communities.

Community Care Coordination (CCC)
CCC is now the single point of access for all:

- District Nursing referrals
- all in home falls and prevention
- Short Term Support (STS) across the east and western bay, this includes being able to access STS from the community (historically patients were required to have a hospital admission before accessing)
- Community Allied Health/Community Response Team and Community Geriatric Services requests to be fully through CCC by the end of August 2020.

CCC is slowly gaining support from Eastern Bay of Plenty to accept new process especially in Short term Services and there has been good support and positive feedback from providers and external parties.

CCC have linkage to Mental Health clinicians for psychosocial support, this started during lockdown and is continuing until review.



The LifeCurve™
The aims of this implementation project is to support healthy aging in our communities, to facilitate early intervention, link communities to support services available closer to home and to work alongside Professor Ngaire Kerse in support of the AWESSoM programme.

Progress to date:

- Test App, hosted in the United Kingdom (UK), is being trialled by a small group of DHB Allied Health staff. Usability, language, the "look" of the App are being tested in order to produce a custom built "live" App. Testing has been set down for 2 months.
- Body in Motion and Aged Concern are the community partners working with the DHB to test the App. Their clients will complete the LifeCurveTM to see how well they are aging.
- A Project Manager is being recruited to oversee the LifeCurveTM implementation and to liaise between staff, business analyst, the software developer and community organisations.

DISTRICT HEALTH BOARD

Provider Arm

Acting Chief Operating Officer
This month with the influence of winter and increased post lockdown presentations hospital capacity at both sites has been under significant pressure particularly in the ICU and ED areas.

ICU experienced unprecedented demand driven by both acute, three high acuity long term ventilated patients the large numbers of overdue complex elective patients that were deferred during the COVID response. This has resulted in patients having to be deferred for elective surgery, and also impacted on senior nurse staffing levels throughout Tauranga hospital.
The recovery of deferred planned care continues to be very challenging however it is fantastic that Radiology has recovered the post COVID19 backlog and is within six-week timeframes for all modalities except ultrasound at Whakatane.

A group of Bay of Plenty nurses have been supporting Lakes DHB with their managed isolation facilities (MIF). These nurses are only working in Lakes MIF and do not also work in other areas at this time.

Bay of Plenty DHB, Lakes DHB and Toi Te Ora have formed a joint COVID Recovery and Response team which is working well. Transition/recovery tasks are being handed back to departments within the DHB and incorporated within normal business. A small team continues to focus on ensuring that there is a coordinated, multiagency response to the community's welfare and psychosocial needs.

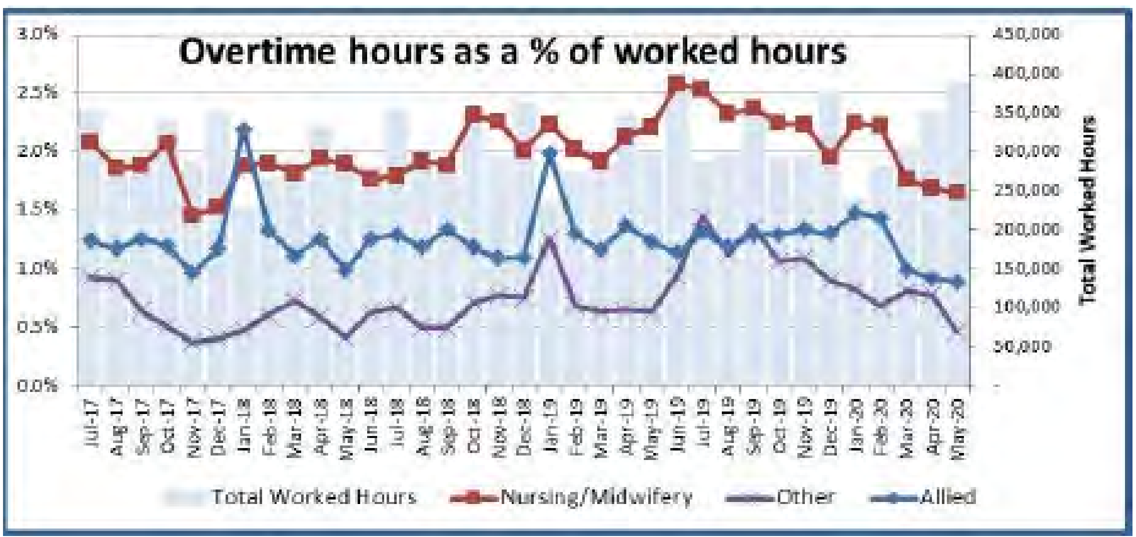
Improved access to Elective Surgery
A 3 year planned care plan is in development, for completion by the end of July 2020. The DHB has embraced the flexibility afforded under the new initiative, moving away from an inpatient/discharge focus. New purchase units that encourage more patient centric thinking are in development. Expansion of the Community Orthopaedic Triage pathway is also planned with interventions set to more than double in 20/21, with access spread over a wider Geographic area.

Director of Nursing

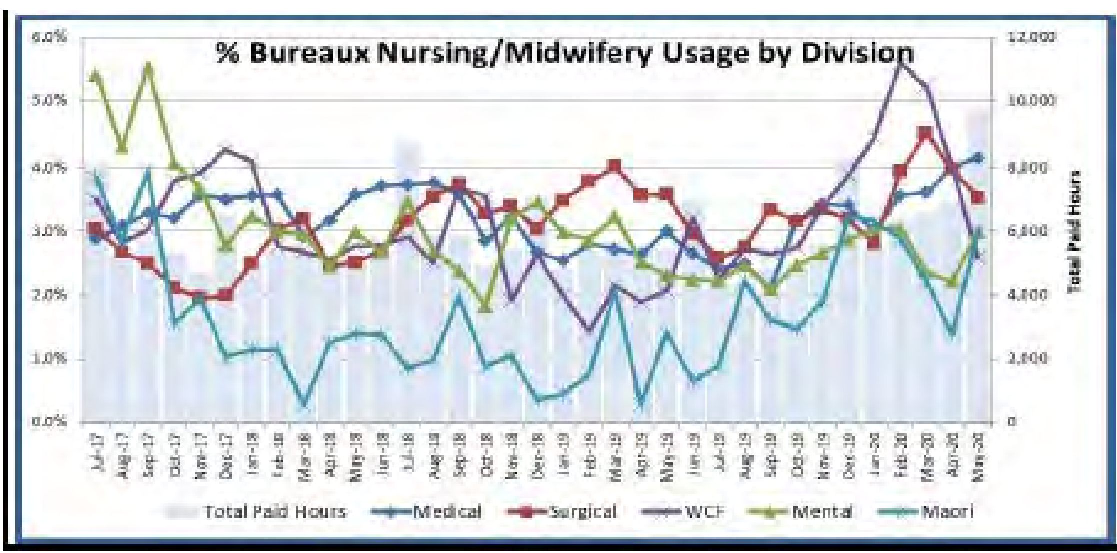
Care Capacity Demand Management (CCDM)
Standards Assessment: There is a requirement to complete an annual assessment against the CCDM standards in partnership with the engaged unions, NZNO, PSA and MERAS. The unions have completed and signed-off the assessment giving BOPDHB the highest rating of continuous improvement in four of the five standards. The core data set remains a partial achievement.

The CCDM programme has 23 measures which reflect quality of patient care, quality of work environment and best use of health resources. Following are two examples of the measures

from the CDS. Noting the report is always a month behind. Timeliness of information will improve when the electronic CDS is implemented.



Overtime is a quality of the work environment measures. Overtime should be used in exceptional circumstances only. Excessive overtime is associated with adverse outcomes for staff. Overtime until the end of May was the lowest it has been since December 2017.



Casual (Bureau) use is a best use of health resources measure. Casual staff play an important part in variance response, so persistent high use means they are not able to be redeployed on the day. High casual use also impacts on team functioning as the staff may be less familiar with the work area. Casual use is trending upwards. Note there was a peak for Maternity in February – March, Corporate Services

<u>NZNO/DHB Accord Update</u>

The DHB commitment to full employment of new graduates, under the NZNO/DHB Accord, came with additional Health Workforce funding for new graduate support. A Registered Nurse coach is now employed 0.5 FTE to work alongside the new graduate coordinator to enhance support for the graduates in their first year.

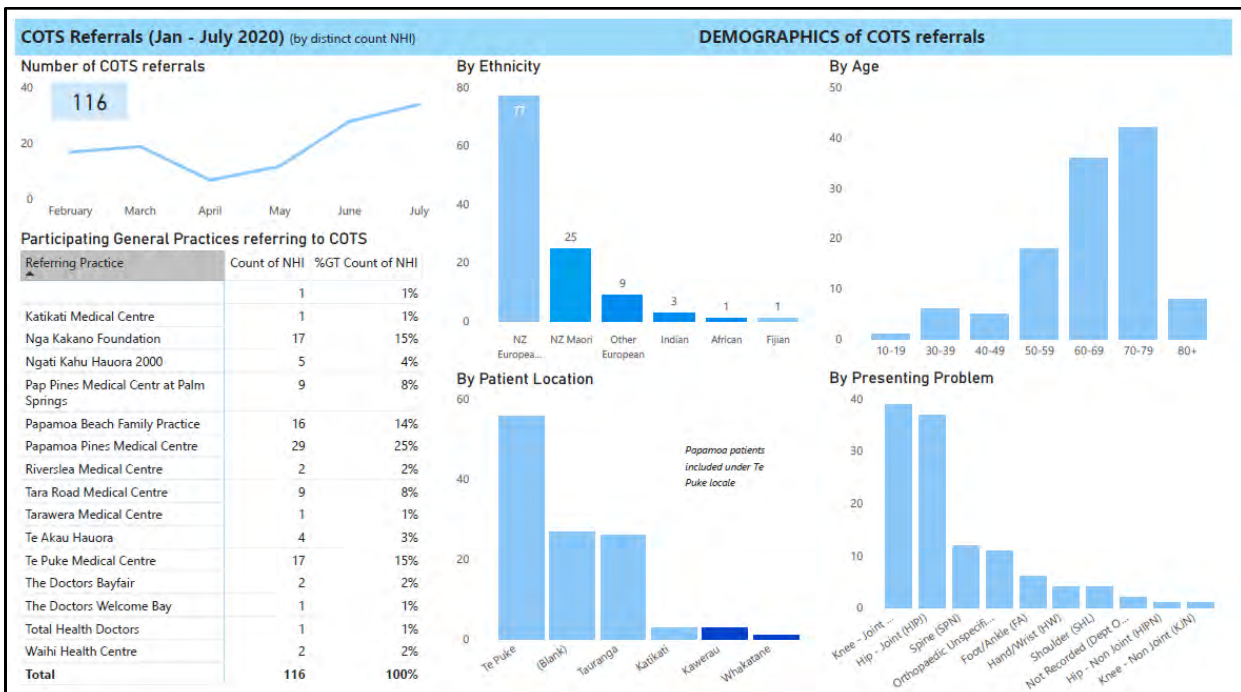
BOPDHB is committing to a total of 72 new graduate registered nurses between January and March 2021 (the same number of places as this year). BOPDHB is additionally committing to three new graduate Enrolled Nurses. Some DHBs have signalled they will need to reduce their intake of new graduates with lower turnover following COVID.

Allied Health

<u>The Community Orthopaedic Triaging Service (COTS)</u>
This projects aim is to enable people to manage their health and well-being (specifically their musculoskeletal conditions) through a proactive recovery-based pathway and includes:

- adults with musculoskeletal problems are able to access appropriate triage, assessment and early intervention closer to home;
- providing self-management information to optimise health and wellbeing
- ensuring only those individuals requiring specialist orthopaedic assessments in secondary care setting are referred from primary care.

The project has gained momentum during Alert Level One as shown in the following table. Te Puke and Whakatane COTS Clinics are now fully operational. Six GP practices in Whakatane/Ohope/Taneatua have accepted invitations to join the pilot and a clinical lead has been recruited to and is to develop clinical pathways for the COTS physiotherapy.



Referring Practice	Count of NHI	%GT Count of NHI
	1	1%
Katikati Medical Centre	1	1%
Nga Kakano Foundation	17	15%
Ngati Kahu Hauora 2000	5	4%
Pap Pines Medical Centr at Palm Springs	9	8%
Papamoa Beach Family Practice	16	14%
Papamoa Pines Medical Centre	29	25%
Riverslea Medical Centre	2	2%
Tara Road Medical Centre	9	8%
Tarawera Medical Centre	1	1%
Te Akau Hauora	4	3%
Te Puke Medical Centre	17	15%
The Doctors Bayfair	2	2%
The Doctors Welcome Bay	1	1%
Total Health Doctors	1	1%
Waihi Health Centre	2	2%
Total	116	100%

Surgical Services

<u>Planned Care initiatives</u>
<u>Ōpōtiki outreach</u>:
Business Leader, ENT Head of Department, Acting COO, Outpatients Manager and Eastern Bay Locality Lead had a very positive meeting with the Opotiki Medical Hub General Practitioners and Practice Managers to discuss improved access to secondary services for Opotiki. An agreement was reached to commence outreach ENT clinics commencing in October. Additional opportunities will be followed up.

<u>Theatre Capacity</u>
Operating theatres are at capacity across both sites and the following are in progress to help with throughput;

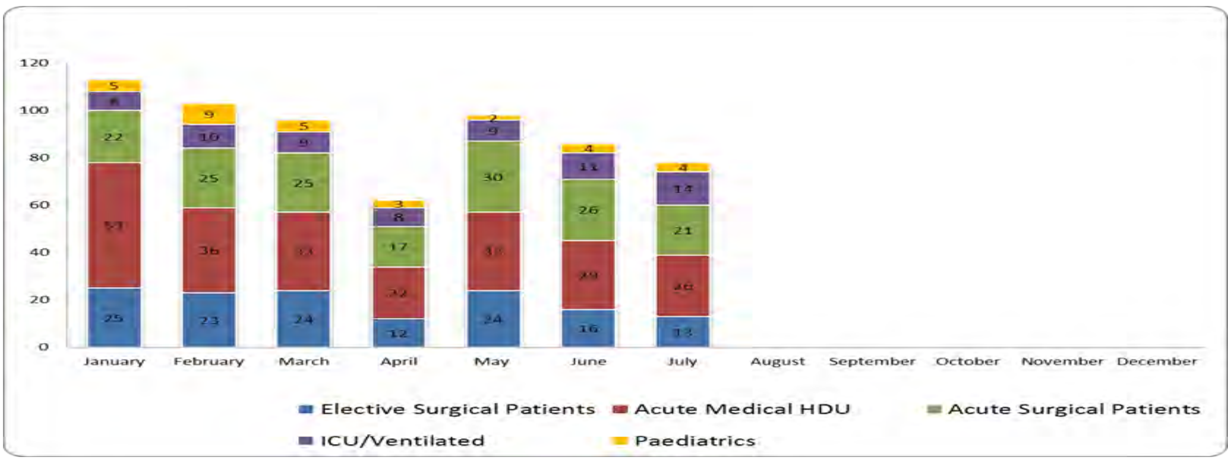
- Extended operating hours – begins both sites 27 July, identified Orthopaedic lists extended by 1 hour
- Specialty lists – feasibility with identified ENT lists in progress
- Carpal Tunnel cases to ambulatory setting – first test of change completed early July.
- 23 hour PACU – first test of change completed Monday 13 July x 1 Parathyroid case.

Discovery meeting with PHO/PHA Clinical leads
As part of progressing the Planned Care strategy the service met with a group of primary care clinical leads for an initial exploration around improved pathways.

Agreed first priority areas include:

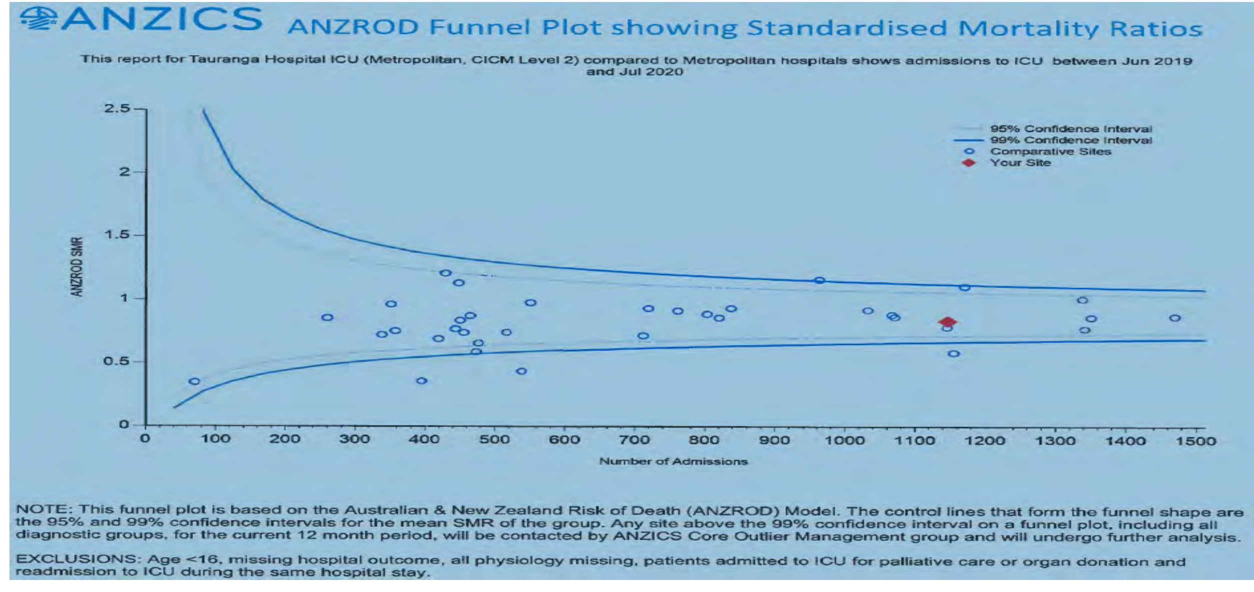
- Improved direct access to diagnostics – discussed with Radiology Manager, who will do some pre work prior to planning second meeting
- ENT/Audiology pathway review – in progress.

ICU/HDU Capacity
During June and July 2020 capacity of ICU has experienced unprecedented ventilator hours and High Dependency Unit demand driven by both acute and planned demand.
ICU Service is very aware of the need to provide support for patient flow as there are large numbers of overdue elective patients with declining health and increased pressure to meet demand since COID-19 Alert levels. However due to the volume of long stay ventilated patients the capacity to do this has been significantly impacted.
The following graph shows 2020 volumes of patients admitted to ICU/HDU volumes. This reflects the large volume of patients with extended length of stays (hence the lower admissions and has resulted in numerous cancellations of elective surgery requiring postoperative ICU care).



Ventilation hours are calculated for each ICU patient dependent on a ventilator device for breathing. July 2020 continues the trend of exceptionally high ventilation hours due to the existing long term ventilated patients and the admission of additional patients arriving daily requiring ventilator beds.

For Noting: Tauranga ICU Standardised mortality ratio (2019) demonstrates the mortality of the patients within the ICU service is within expected parameters.



Radiology

Radiology has recovered the post COVID19 backlog and is within six-week timeframes for all modalities except ultrasound at Whakatane.

Mental Health and Addictions Services

MICAMHS Redevelopment

Significant work is in progress developing a new model of service for MICAMHS. Supported by the COO and DOMN, the MH&AS Cluster Leadership has been working closely with the Clinical Lead and Team Leaders within MICAMHS in the absence of a new service manager. The proposed new service model will see the Adolescent and SORTED Teams reformed as a Youth Service operating out of a new clinical space; the corner of 2nd Ave and Cameron Road.

The Child Team will remain in the current MICAMHS space. Clinical stakeholders are also reviewing co-location options. Initial information has been shared with PSA, NZNO and APEX in our joint union meeting. Meetings are planned with the MICAMHS teams to introduce the concept of a service improvement programme around developing the 2 different teams on the 2 sites in the middle of July.

Eastern Bay of Plenty Integration

EBPHA has been working with stakeholders including Adult Community Mental Health and Addiction and Voyagers Team Leaders to discuss how a more integrated approach to referral review and triage. An initial test of change includes a joint triage of referrals with primary care, Voyagers and ACMH&A teams. The aim is ensure that referrals are accepted and clients receive the best service first time. Integration with other stakeholders will be required and this is being discussed – specifically with MHGD in the Eastern Bay.

Health Quality and Safety Service (HQSS)

Projects underway to strengthen clinical governance systems and processes across Organisation, Service and Committee levels are being undertaken;

- Health Intelligence Systems planning and development
- New HQSS team members and in-house service planning workshops

Service focus and priorities to establish and strengthen;

- Quality Management systems and processes with a customer-centric focus (e.g. incident/ adverse event investigation and learning)
- Clinical governance across services (e.g. service excellence metrics)
- Clinical governance across committees (e.g. scorecards, action plans, projects)
- Patient and whānau experiences (e.g. Council refresh, co-design).

Patient Safety Focus and Priorities

- Patient safety measurement & monitoring development: using the Datix dataset initially to identify key patient safety themes, reviewing information on knowing how you are doing boards
- Wrong patient for procedures: in partnership with Allied Health (Orderlies) and Radiology to improve patient identification process
- Improving clinical governance systems across patient safety committees (e.g. scorecards and improvement plans for falls, deteriorating patient, medication review, etc.)
- Pressure Injuries: Trial project occuring in 4B, HIA, and Medical Whakatane.
- Deteriorating Patient Project

Clinical Effectiveness and Equity Focus and Priorities

- Paediatric service excellence metrics development.
- Quality of ethnicity data in provider arm in conjunction with MHG&D
- Choosing Wisely: involvement with community of practice, and scoping potential foci

Person-centred experiences Focus and Priorities

- Consumer Council: terms of reference refresh and recruitment of new members
- Consumer and Whānau Feedback system: supporting several teams in considering how to gather feedback which has highlighted the need for a single system to gather and analyse customer experience at a team, service, and DHB and system level.
- People (whānau and consumer) engagement framework and systems refresh to further focus on consultation, partnership, experience-based co-design and mahi tahi
- Adult Hospital Patient Experience Survey (AHPES) has been delayed and is moving provider. The next survey will take place in August. It is notable that the period where the DHB has achieved the highest domain scores was during the CARE values introduction which demonstrates need for linkage and partnership with People & Culture and Patient Experience improvement programs. NB: the current domains measured by the AHPES are limited and do not align well with Te Toi Ahorangi. Work with Māori Health Gains and Development currently underway to establish experience domains based on He Pou Oranga Tangata Whenua.
- Development of co-design approaches and systems needed post review of existing resources (eg, website, print resources, signage, social media, etc. not always developed with a focus on the needs of consumers and whānau. There is a need for a DHB wide programme to review these and introduce co-design approaches that focus on experience, health literacy and information needs

Quality Management Systems and Processes

- Hospital certification coordination, self-assessment & preparation –10-13 Aug 2020
- Adverse Event & Always Review & Report Reporting 2019-2020
- Restorative Practice project in partnership with Maori Health Gains & Development
- Quality systems refresh: trialing new Adverse Event investigation tool and template (starting in maternity)
- Individual patient and whanau support: development of integrated care plans for complex patients (e.g. chronic conditions, no fixed abode, no GPs, family violence/abuse concerns)
- Support auditing Colposcopy service, reviewing Colposcopy service protocols.
- Datix – reporting, system maintenance & data integrity as required.

Corporate Services

People & Culture - Influenza Vaccination Campaign
Influenza vaccination uptake is slowing as we get through the bulk of staff. The total percentage of staff vaccinations for 2020 at this point is 76.4% (74.6% at prior month). Letters have been sent to all the staff we currently have listed as not having had a vaccination encouraging them to have one. The campaign continues through until September 2020.

Occupation	July 20	June 20
Nurses	79.6%	78.2%
Doctors	85.5%	82.7%
Midwives	61.2%	61.2%
Allied Health	73.2%	70.8%
Health Care Assistants	69.7%	67.3%
Other staff	71.3%	70.2%
Total	**76.4%**	**74.6%**

People & Culture - Health and Safety Manager Recruitment Update
The new Health & Safety manager has been appointed and starts 3rd August. Key aspects for the new manager is to get a good understanding of where the H&S service is currently at – having been operating for 4 months without a H&S Manager. From there work will start with stakeholder engagement and developing a H&S plan and assurance programme.

People & Culture – People Strategy
The work on development of the DHB's People Strategy continues with the current focus being on stakeholder engagement and addressing critical areas arising from the recent emergency events – Whakaari and COVID. Key areas progressing are advancing flexible work arrangements and developing and implementing aspects of a wellbeing programme to support Whakaari and COVID recovery.

The development of resources to support the DHB's Flexible Working arrangements continues. Draft principles have been established and a communication campaign has commenced centred on a series of stories with staff who have embraced flexible working during COVID lockdown being used to promote the options and shift mindsets around traditional work settings. The next steps are to develop "Flexible by Choice" toolkit and further engagement with Unions in regards to this work.

The initial focus of the Wellbeing workstream is on individual and team resilience. A one month intervention programme of in-house workshops has been scheduled as well as a pilot using third party provided specialist programmes. The intention is to develop complimentary approaches to building resilience across the DHB. The first two days of the inhouse workshops were held in late July and were fully subscribed to with requests for additional sessions. A number of team leaders have asked for team specific workshops to be held. Next steps will be to develop a Wellbeing Portal of resources and move resilience pilot forward for more intensive interventions.

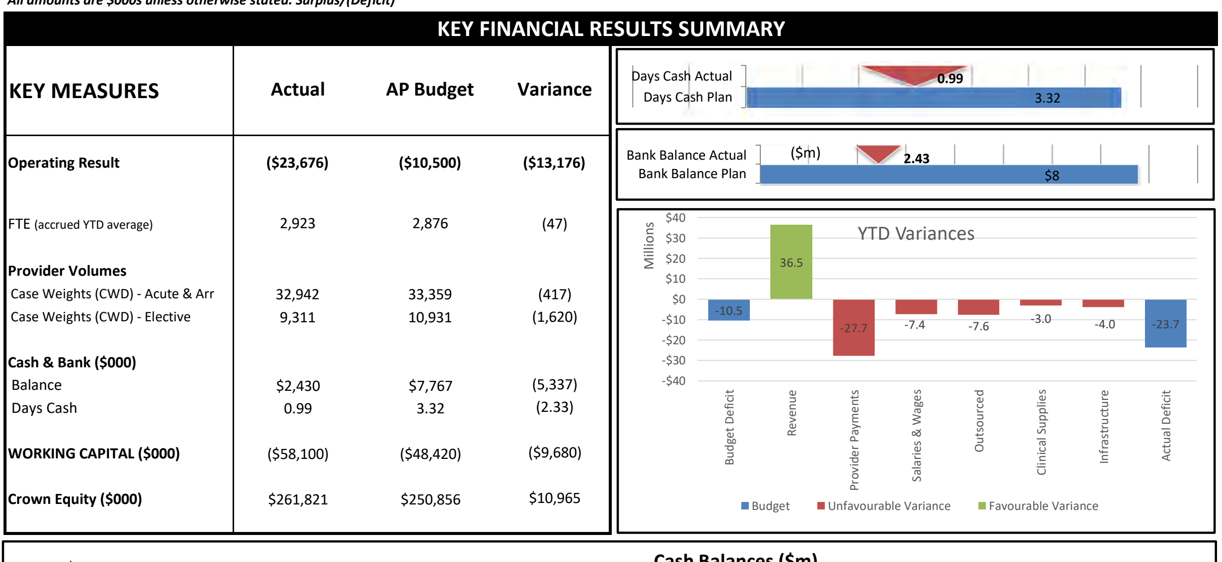
Information Management - Microsoft Modern Workplace
The roll out of the new Microsoft product to the organisation continues. By the end of July over 400 devices of the 3000 desktop, laptop and tablet devices had been upgraded (approx. 13.5%). The roll out is being undertaken on a department by department basis so that teams are on the same operating system, receive the same training and are able to support one another with the change process. A number of technical issues continue to be encountered and resolutions developed.

FINANCIALS
The DHB has not achieved its Annual Plan (AP) budget for the YTD period ending 30 June 2020. Our YTD result is a deficit of $23.676m which is $13.176m unfavourable against the phased AP deficit of $10.5m.

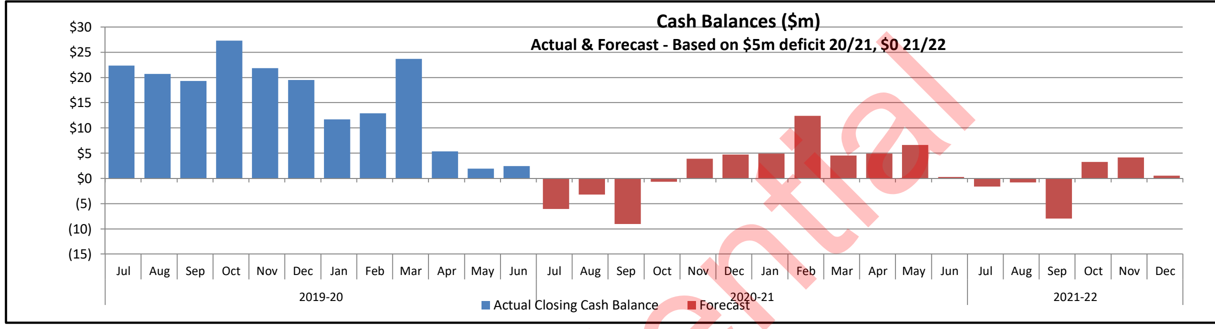
BAY OF PLENTY DISTRICT HEALTH BOARD
PRELIMINARY RESULTS FOR THE MONTH ENDED 30 JUNE 2020

All amounts are $000s unless otherwise stated. Surplus/(Deficit)

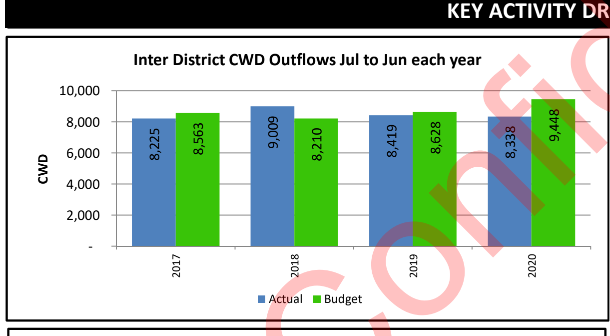
KEY FINANCIAL RESULTS SUMMARY

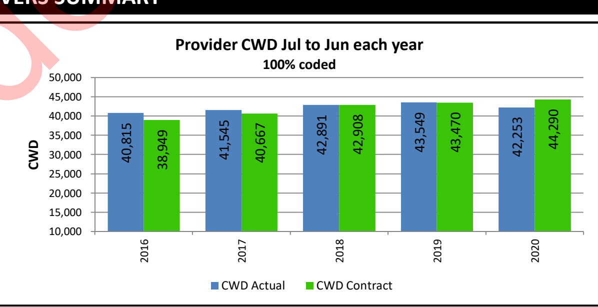


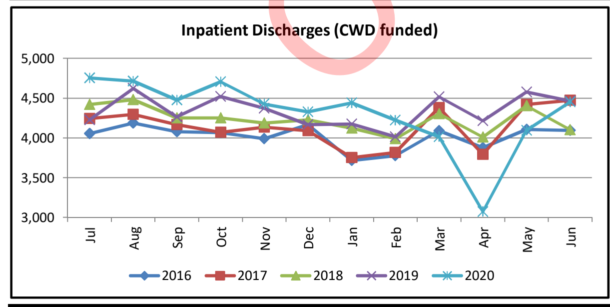
KEY MEASURES	Actual	AP Budget	Variance
Operating Result	**($23,676)**	**($10,500)**	**($13,176)**
FTE (accrued YTD average)	2,923	2,876	(47)
Provider Volumes			
Case Weights (CWD) - Acute & Arr	32,942	33,359	(417)
Case Weights (CWD) - Elective	9,311	10,931	(1,620)
Cash & Bank ($000)			
Balance	$2,430	$7,767	(5,337)
Days Cash	0.99	3.32	(2.33)
WORKING CAPITAL ($000)	($58,100)	($48,420)	($9,680)
Crown Equity ($000)	$261,821	$250,856	$10,965

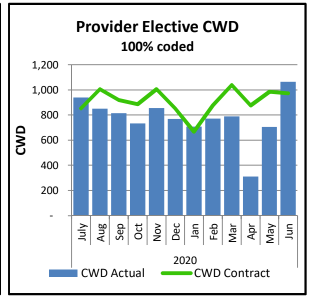


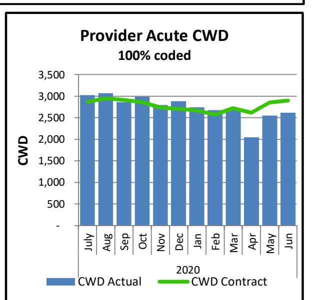
KEY ACTIVITY DRIVERS SUMMARY





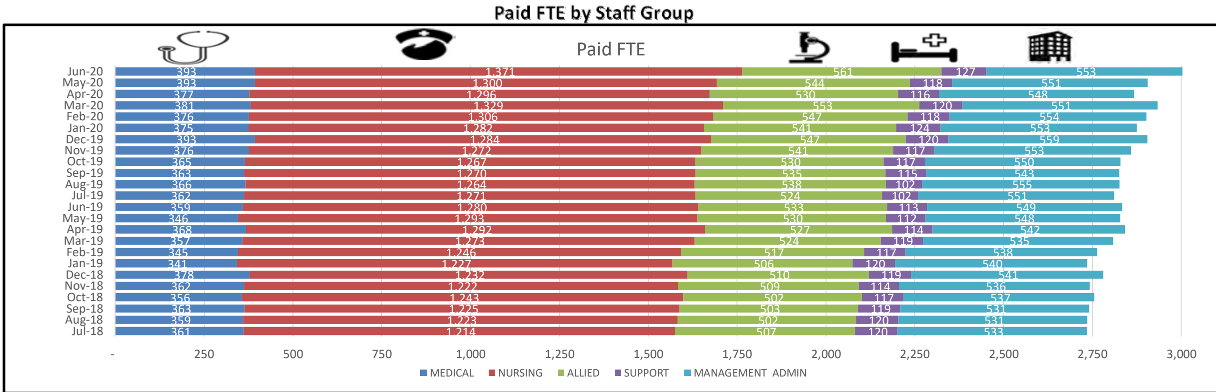






KEY STAFF FIGURES

Paid FTE by Staff Group



Confidential

Excellence

CE Newsletter

Simon Everitt – Interim Chief Executive

30 July 2020

62 years of service - Rona Stanley retires

I had the great privilege this week of being asked to speak at a very special occasion, the retirement celebration of Rona Stanley. It was wonderful to see so many people gathered at Whakatāne Hospital to recognise and celebrate Rona's incredible 62 years' of service.

In my speech on Monday I confessed to Rona that I wasn't born, or even a twinkle in my parents' eyes, when she first started work with this organisation all those years ago. I'm told Rona may in fact be one of the longest serving staff members across all the DHBs in this country.

She was born in Whakatāne Hospital and by her own admission she made the hospital her life. Rona's husband Maurice also worked at the hospital before retirement.

Rona started working at the hospital on Monday 12 May 1958 and occupied a variety of roles throughout her working life. She started in the Supplies Department and, in those days, she tells me you had to have a chest x-ray and polio vaccine before starting work, which was compulsory due to the polio epidemic.

The first building she worked in though was in fact a wooden house which was moved to Port Ōhope in the early 1960s to make way for the Dawson Block. The house remains at port Ōhope today. At one time she started work every day at 4am and worked through until 3pm. A hard worker – one of her bosses gave her a Workaholic Certificate – which she has kept and clearly truly deserved.

Among her many interesting jobs she has been secretary to former CEO Kevin O'Leary and former Chairman Thomas Godfrey Stanton, and most recently has been a buyer in the purchasing team. When working for Mr Santon, Rona was involved in the planning for the 'new' five storey hospital building named after him, The Santon Block, which opened in 1974.

Rona's colleagues describe her as a warm and kind person who takes an interest in other people within the team, which is something others have admired about you.

Rona is bidding farewell to spend more time at home with her husband, Maurice. On behalf of this organisation, myself and the Board and all 3500 of us,

I would like to take this opportunity to wish her all the best once more. Thank you sincerely for 62 years of hard work and commitment to improving the health and wellbeing of the Eastern Bay of Plenty population. You are deeply appreciated and will be remembered fondly by all those that have worked alongside of you.

Director General of Health pays tribute to Rona

Dr Ashley Bloomfield describes Rona Stanley's contribution to the hospital as, "an amazing length of service and quite possibly unparalleled in New Zealand."

Dr Bloomfield was a trainee intern at Whakatāne Hospital in 1990.

"When I did my paediatrics attachment as a trainee intern in Whakatāne in 1990 (with Chris Moyes), Rona would have already been there for 32 years - longer than my career to date!

"Thank you, Rona, for your dedication and hard work that will have helped so many people, and I wish you all the best for your retirement."

Primary Care Overview

Eastern Bay Primary Health Alliance

Key achievements for this month:

Childhood Immunisation

- EBPHA is leading and progressing the primary HPV testing pilot programme (self-swabbing for cervical cancer). A working group has been established with key personnel across both primary and secondary. The group has drafted a letter to the ministry and had a positive response back in regard to progressing the Eastern Bay Pilot.
- Health Targets including Brief Advice, Diabetes Annual Review and CVRA were met during Quarter 4 despite the interruption covid-19 had on BAU.
- Eastern Bay general practices completed 687 covid-19 assessments and 591 covid-19 swabs in general practice during June 2020.

Key challenges for this month:

- Our counselling service is experiencing a 35% increase in referrals from general practice in comparison to the same period last year. Additional resources have been reallocated to maintain service standards.
- EBPHA supports the Health Care Homes model in principle, but acknowledges that a lack of Eastern Bay representation across the practices indicates a failure in improving health for Māori in the Eastern Bay.
- WBoPPHO , Health Care Homes contract holder, response-three Eastern Bay GP practices (high Māori enrolled populations) were selected to become Health Care Homes in the original Request for Proposal, however, two of those practices withdrew from the HCH process citing challenges with the Health Care Home Collaborative requirements to attain Health Care Home status over three years. Suggest WBoPPHO and EBPHA CEOs meet to discuss an approach going forward.

Nga Mataapuna Oranga

Key achievements for this month:

- COVID-19 and in particular, the 'lockdown' has highlighted the need to do things differently in the future including the way that Tūāpapa is conveyed to all staff. On-line self-directed learning has been pursued as part of a supportive learning environment for the Network providing opportunity for staff to take control over their own orientation to Tūāpapa. This training is currently being rolled out across the network.
- Since 1 January 2020 and as of 28 July 2020, 946 whānau members in the 65+ age group have received the flu vaccination. Thirty-seven percent of this number have identified as Māori. In comparison, 820 whānau members in the 00-64 age group have been vaccinated with over 68% who identified as Māori.
- Since last month, the total number of whānau with chronic conditions sits at 6,493 with just under 70% who have identified as Māori.
- The number of whānau with fully activated patient portals is 170.

Key challenges for this month:

- Funding to support the ongoing implementation of Tūāpapa remains an issue.

Western Bay of Plenty Primary Health Organisation

Key achievements for this month:

- Childhood immunisations. Coverage for Māori has remained static for the 8- month group at 87% (equity gap -4%) but has improved by 2% for the 24--month age group from 83% to 85% (equity gap improved from -5% to -4%)
- Coverage for Pacifica has improved from 89% to 95% for the 8- month group (equity gap changed from -1% to +4%) and from 91% to 92% for the 24 -month group (with no change to equity gap at -3%)
- The decline rate has also improved for the 8month olds from 7.1% to 5.7%

This is an amazing achievement at any time – but given the recent events (and the current data reflecting part of level 4 lockdown) this is particularly noteworthy.

Health Care Homes
Work has progressed nationally to develop a revised HCH model of care. This work was led by Dr Bryan Betty and Lance Norman. Kiri Peita, WBOP PHO Director of Māori Health participated as a member of the subgroup.

The revised model aims to further enhance the model's equity focus, honour Te Tiriti o Waitangi and strengthen consumer engagement and co design. The revised model aligns well with WBoP PHO strategy-*Te Toi Huarewa* and BOPDHB Māori Health Strategy-*Te Toi Ahorangi*. A draft will be published for consultation at the end of July/early August.

Health Round Table Integrated Care Improvement Group
Health Roundtable's Integrated Care Improvement Group is specifically focused on bringing together hospital and community providers of care for the purposes of improving care through innovation, collaboration and benchmarking. WBOP PHO, with support from the COO has recently joined the group as a key partner in this space. WBOP PHO looks forward to participating in a series of webinars in August alongside BOP DHB.

Key Challenges this month:

Covid-19 Swabbing
Demand for swabs has come down significantly, people are not so keen to be swabbed now there is no prevalence in the community. This has highlighted the need for clearer messaging to the public about remaining vigilant and presenting for swabbing if symptomatic. We are using our social media and other communication platforms to encourage attendance where needed.

Primary Mental Health

Demand for PMH services remains high after the Covid crisis and capacity for counselling packages of care is full. We are working with general practice teams to maximise extended consult opportunities for mental health consultations, encouraging referrals to our social worker and / or group therapies whilst we look to increase our counselling / brief intervention therapy capacity. Priority groups for funded sessions remain Māori, Pacific Island people, youth and pregnant/postnatal women.

Service delivery continued through Covid-19 lockdown. Service providers delivered interventions via phone/video during the Covid response and have recommenced face to face contact. Covid and lockdown certainly created many issues with access and not all people have access to technology, so it was often difficult in early days to engage and we are now playing catch up. Challenges are presented by carrying a small caseload when demand is so high.

Flu Vaccinations

WBOP PHO is working closely with its network, Iwi partners and the DHB to ensure the access to flu vaccination and coverage achieved during the lockdown is continued.

Mobile outreach and pop-up clinics proved extremely popular with the public, so we are looking at ways to continue these with the limited resource we have available.

Pūrongo Whakamutunga: Tumu Whakarae Chair Handover Report

SUBMITTED TO:

Executive Committee 18 August 2020

Prepared by: Marama Tauranga, Manukura, Māori Health Gains and Development

Endorsed by: Simon Everitt, Interim Chief Executive, BOPDHB

Submitted by: Simon Everitt, Interim Chief Executive, BOPDHB

☐ **For Decision** ☐ **For Discussion** ☒ **For Noting**

RECOMMENDATION:
That the Board note Te Tumu Whakarae Chair Handover Report.

RECOMMENDED RESOLUTION:
That the Board;

1. **Notes** the kaupapa of Te Tumu Whakarae is about excellence in Māori Health, to provide leadership and influence in policy, strategy and advice to the Māori Directorate and or Ministry of Health.
2. **Notes** the outgoing chair of Tumu Whakarae: Riki Nia Nia has been appointed to Waikato DHB as the Executive Director of Equity and Improvement.
3. **Notes** the Manukura is a member of Tumu Whakarae and in 2021 has been asked to assume the Chair of the Midland GM Māori Group: Ngā Toka Hauora which is currently held by Phyllis Tangitu, Lakes DHB.

ASSURANCE:
N/A

ATTACHMENTS:
Pūrongo Whakamutunga: Tumu Whakarae Chair Handover Report

DEFINITIONS USED:

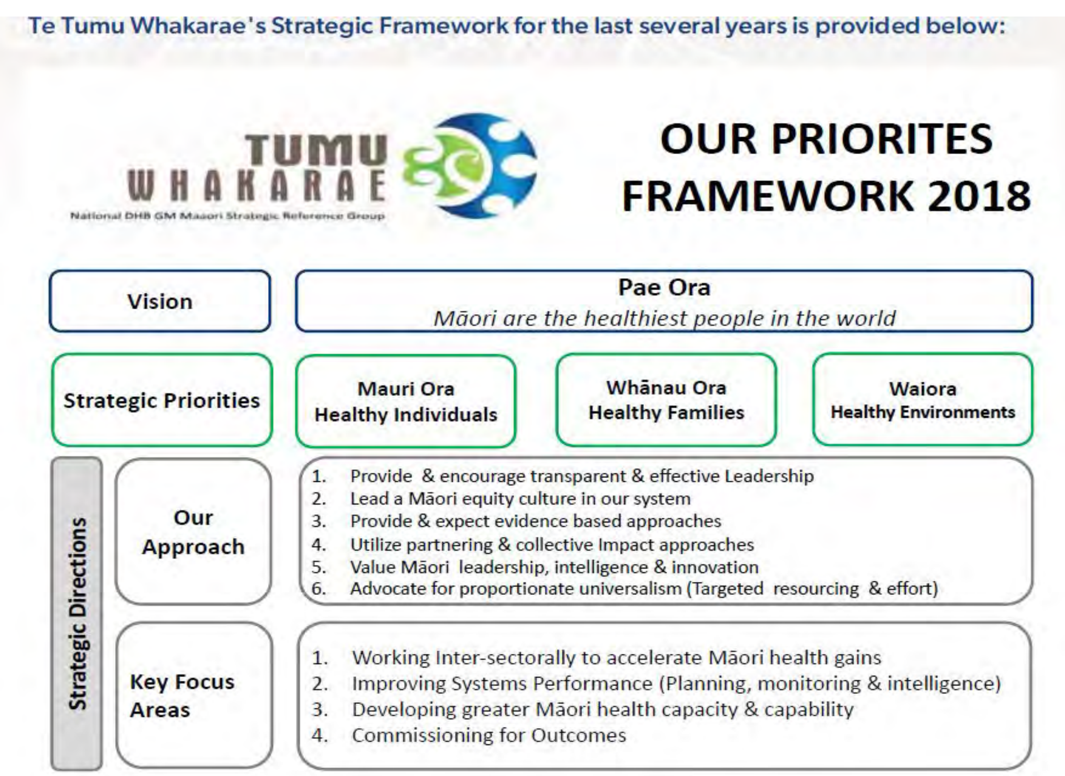
Term	***Definition***
“the Board”	Bay of Plenty District Health Board, the Board
“the organisation”	Bay of Plenty District health Board, the organisation
“the DHB”	Both the Board and the organisation of Bay of Plenty District Health Board

BACKGROUND:

Tumu Whakarae was formed in 2001, originally by Wikepa Keelan, who was then GM for Māori Health in the Hawkes Bay. His establishing leadership was crucial to the development of the group including its founding pillars which reflected Te Tiriti o Waitangi, Māori health excellence and Māori led system transformation. The group was brought about by the presence of the Treaty of Waitangi in the Public Health and Disability Act 2000.

This new platform facilitated accelerated Māori health development including quality improvement, investment and the coordination and sharing of intelligence and innovation across the country. Te Tumu Whakarae members are involved in many different pathways toward rebuilding healthy futures for Māori in alignment with He Korowai Oranga.

STRATEGIC FRAMEWORK & PRIORITIES



The strategy priorities for Tumu Whakarae were reviewed in 2019 and it is these priorities the report is structured upon:

1. Leveraging strategic relationships and technology to influence breakthroughs.
2. Influencing and informing Māori health policy and intersectoral developments
3. Fostering Māori and health workforce development
4. Creating and sharing innovation and indigenous health excellence.

BOP Contributions to Tumu Whakarae:
Bay of Plenty DHB has contributed or lead a number activities on behalf of Tumu Whakarae; Influencing policy and intersectorial developments e.g. Mental Health Inquiry submissions which our board endorsed as a foundation for transformation of our mental health system in 2018/19, Waitangi Tribunal (Wai2574 Claim) BOPDHB GM Maori and the Chair of Tumu Whakarae were leads in the Crown Team and in members of the expert Māori advisory group for the Health and Disability Review, supported chair in the COVID 19 response supporting the development of the priorities framework and action plan, involving Tumu Whakarae in Australasian College of Emergency Medicine Māori Strategy development: Te Rāutaki Manaaki Mana, COVID 19 Joint statement.

Next Steps and Actions for Tumu Whakarae:
The new Chair for Tumu Whakarae is Hector Mathews (CDHB), TOR and work programs are being finalised and pending endorsement from members, administration / program resource has been secured from TAS, strategic relationships are in transition between the outgoing and incoming chair.

The group will implement the COVID 19 action plan with the MOH, continue to monitor the implementation of the Mental Health and Addiction inquiry, assess and contribute to the implications of the Health and Disabilities Service Review, reset Kia Ora Hauora (review date imminent), continue to provide support to innovation, sharing excellence through conferences and thought leadership hui, continue oversight and monitoring of system performance including enhancement of Trendly and advancement through technology.

Pūrongo Whakamutunga

15 July 2020

Tumu Whakarae Chair
Riki Nia Nia

MIHI

Haere mai tūpuna, te wairua tapu me ngā Atua.

Whakatau te mauri, waerea te whakaaro, whakakoia te hinengaro, whakamāhakitia te ngākau,

kia pūtohe ai te rere.

Whakamarutia, whakakaha ai, whakaorangatia te matinitini!

Uhi, Wero, Tau mai Te Mauri, Haumi ē, Hui ē, Taīki ē!

Ka heke ngā roimata mō te hunga kua haere atu ki te pō. I te mea, nā rātou i paratia mai te huarahi mō te ānga whakamua. Rātou te hunga wairua ki a rātou, tātou te hunga ora ki a tātou. Tēnā koutou!

E te whānau o Tumu Whakarae. Whakamihia! Mihi whakaute ki a koutou katoa, ōku tuahine, ōku tuakana! Whakamihia hoki ki ngā ururangi tawhito o Tumu Whakarae, nā rātou i pakari te tūāpapa mō to mātou kaupapa. Ko te oranga o te Iwi Māori! Aue Pae Ora e!

He mihi manahau, he mihi maioha ki a Wikepa Keelan, te tiamana tuatahi o Te Tumu Whakarae. Nāu te ringa tuitui, nāu i whakakaupapa Te Tumu Whakarae mō te rangi ināianei. Ka rere tonu ngā mihi ki ngā tiamana i ngā tau kua pahure nei, ko Te Aniwa Tutara, ko Marty Rogers, ko Gary Coghlan, ko Grant Berghan koutou ko Bernard Te Paa. Tēnā rā koutou katoa!

E kore rawa e mutu ngā mihi ki ngā kaitiaki o Te Tumu Whakarae. Ko Matua Eru George, ko Whaea Mihi Namana koutou ko te Kahurangi, ko Whaea Naida Glavish. He mihi aroha ki a koutou, nā koutou ahau i poipoia, nōku te waimarie, nōku te whiwhi.

Ka tukua tēnei pūrongo ki a koutou katoa, hei whakaatu atu te mahi o Te Tumu Whakarae. Ko te kaupapa matua ko te whakamanahia ngā whānau, ngā hapū,me ngā Iwi o Aotearoa!

Ahakoa, i heke au mai te turuwera o Tumu Whakarae, ka tū tonu tōku aroha mō tēnei kaupapa mō koutou hoki e te whānau o Te Tumu Whakarae!

E te whānau, kia tū kaha, kia tū ora, kia tū pūmau, kia whakaoratia ngā whānau, ngā hapū, me ngā Iwi o te motu! Mā te aroha, ka manaaki! Mā te manaaki, ka ora! Mā te ora, ka puāwai!

Aue, Tumu Whakarae e!

Nō reira, tēnā koutou, tēnā koutou, tēnā tātou katoa!

Riki Nia Nia, Tumu Whakarae Chairperson (2013-2020)
(Ngāti Kahungunu, Tūhoe)

RIKI NIA NIA
NGĀTI KAHUNGUNU, TŪHOE

Outgoing Chairperson of Tumu Whakarae (Combined DHBs Māori Health Leadership Group

3 July 2020

I have been the Chair of Tumu Whakarae since March 2013. This report provides my handover as the outgoing Tumu Chair including the new strategic priorities and draft work programme. It also highlights some of the kaupapa that I have been privileged to lead and support in my chairmanship.

On 3 July 2020 I left my role as General Manager of Māori Health for Auckland and Waitematā DHBs. This was in order to take up my appointment to a newly created role as the Executive Director Māori, Equity and Health Improvement with Waikato DHB. I subsequently made the decision to stand down as Chair of Tumu Whakarae and Kia Ora Hauora in order to fully focus on my new role.

I will be retaining the following governance roles:

- Chair: Te Mana Taneora o Aotearoa - Māori Men's Health Coalition
- Chair: Waka Hourua National Māori and Pacific Suicide Prevention
- Member: ACEM Māori Health Equity Expert Advisory Group

Chair Start Date	March 2013
Chair End Date	July 2020

The Chair is elected by the members of Tumu Whakarae. Although the Chair role is for a term of 2 years, Tumu Whakarae members requested that I remain in the Chair role for the past 8 years.

Acknowledgements

I would like to acknowledge the support of Tumu Whakarae members over the years.

Special thanks to Kahurangi Naida Glavish and our kaumātua, Whaea Mihi Namana and Matua Eru George for their wisdom and ngākau aroha.

I would also like to acknowledge the strong leadership and tautoko demonstrated by Hector Matthews and Tricia Keelan in my time as Chair. Tapatapahi ana kōrua!

This is an exciting time as we move forward with the COVID 19 recovery and front foot the recommendations of WAI 2575, the He Ara Oranga Report and the Simpson Report.

I'm looking forward to my new role and continuing to take every opportunity to improve the health and wellbeing of our people.

I offer the incoming Chair my support and all the best for the future.

PART ONE

ABOUT TUMU WHAKARAE

Tumu Whakarae is the National Reference Group of Māori Health Strategy Managers within District Health Boards (DHBs)

Te Tumu Whakarae was formed in 2001, originally by Wikepa Keelan, who was then GM for Māori Health in the Hawkes Bay. His establishing leadership was crucial to the development of the group including its founding pillars which reflected Te Tiriti o Waitangi, Māori health excellence and Māori led system transformation. The group was brought about by the presence of the Treaty of Waitangi in the Public Health and Disability Act 2000. This new platform facilitated accelerated Māori health development including quality improvement, investment and the coordination and sharing of intelligence and innovation across the country.

Te Tumu Whakarae members are involved in many different pathways toward rebuilding healthy futures for Māori in alignment with He Korowai Oranga.

The membership of Tumu Whakarae has changed over the years as the incumbents of Māori Health leadership positions change within DHBs, but the kaupapa of Tumu Whakarae has not changed, it has and continues to be about excellence in Māori Health. Fundamentally as Māori Health leaders in their respective regions, the group comes together to elevate that leadership to a national level to influence the sector. A current Membership List is provided in Appendix 1.

Wikepa Keelan - Ngāti Porou, Ngāti Kahungunu
Establishing Chair of Te Tumu Whakarae

2001
Tumu Whakarae starts
Wi Keelan elected as inaugural Chair

2008
Tū kaha Conference initiated

2009
Kia Ora Hauora initiated

2012
Trendly monitoring report initiated

2013
Riki Nia Nia elected as Chair

2014
Te Tohu Whakawaiora initiated

2015
Ngā Hikoi Rangahau initiated
Hui Kaikookiri Pae Ora

TUMU WHAKARAE OPERATIONS

Meetings: Tumu Whakarae meetings were typically held 3-4 times each year with hosting rights rotated around the DHBs. However with the evolution of a Secretariat and a DHB-specific meeting space on Tory Street in Wellington, all meetings now occur in Wellington. Clearly during events such as the Covid-19 epidemic, meetings became much more frequent and were convened online. Future meetings could be held in the regions from time to time to connect and engage with mana whenua.

Decisions: Decisions of the group when needed are made by consensus. At times some individual members may not be able to support national agenda items where they have unique circumstances within their own DHB, this position is respected. Where decisions need to be made in between meetings, the Chair will arrange for the matter to be circulated by email for feedback, any objections or changes and set a final date for decisions / support for a matter.

Costs: DHBs share the cost of operational expenses and meetings. In the future Central TAS will provide Secretarial support and some targeted project support.

Work Programme: Tumu Whakarae has a draft Work Programme in place (Appendix 2). This will need to be finalised at the next meeting by the incoming Chair and members as this will provide a guide for Central TAS to keep track of our activity and report on activity and progress.

Tumu Whakarae Leads

Chairperson: Riki Nia Nia

CEO Lead: Dr Dale Bramley

Regional Leads:

Northern: Harold Wereta
Midland: Phyllis Tangitu
Central: Rowena Kui
Southern: Hector Matthews

2016
International Indigenous Health Collaborative begins
He Huliau Indigenous Health Conference

2018
TW Submission on Government Mental Health & Addictions Inquiry
TW Relationship with ACEM
Te Ara Whakawaiora initiated

2019
DHB Te Reo Māori programme with Te Wānanga o Awanuiārangi
DHB Workforce Statement for Māori Staffing Proportionality
Wai 2575 Waitangi Tribunal Report
HQSC Dashboard reporting redesign

2020
Central TAS Secretariat begins
Health & Disability Services Review
TW Response on Covid-19

Bernard Te Paa - Ngāti Whātua (Previous Tumu Whakarae Chair) Chief Advisor - MOH.

Hector Matthews - Te Rarawa and Te Aupōuri. Executive Director, Māori and Pacific Health, Canterbury DHB.

SECRETARIAT

Secretary: Phyllis Tangitu

Taituara: Jacque-Ann Heta

Prior to July 2020, most of the administrative functions for maintaining Tumu Whakarae, rested with the members. Different members led specific portfolios, hosted meetings, took minutes, managed projects and maintained documentation. As from 1 July 2020, Tumu Whakarae will now have a 1 FTE position based with Central TAS in Wellington and funded by DHBs dedicated to Tumu Whakarae. The position reports to the Director of Workforce Development and has a 'dotted line' report to the Chair of Tumu Whakarae. Key functions of the Tumu Whakarae position are helping to organise and minute the quarterly (or more frequent) meetings each year; supporting strategic priorities and supporting achievement of the Work Programme. I recommend that the new Te Tumu Whakarae 1 FTE secretariat arrangement is reviewed in 6 months time to ensure effectiveness and comparative equity within the emerging context of WAI 2575, the Simpson Report and He Ara Oranga work.

POST HOLDERS

I acknowledge the key Tumu Whakarae post holders and thank each of them for their support, leadership and valuable contributions.

Kaumātua: Eru George, Tūhourangi

Lakes DHB

Mihi Namana, Ngāti Kahungunu, Ngāti Porou

Wairarapa DHB

Iwi Lead, Dame Naida Glavish, Ngāti Whātua

Chief Advisor, Tikanga, Waitematā and Auckland DHBs

Secretary, Phyllis Tangitu, Tūhourangi, Ngāti Wāhiao General Manager, Lakes DHB

STRATEGIC PRIORITIES

1) Leveraging strategic relationships and technology to influence breakthroughs

2) Influencing and informing Māori health policy and intersectoral developments

3) Fostering Māori and health workforce development

4) Creating and sharing innovation and indigenous health excellence

PART TWO

STRATEGIC OVERVIEW

The Tumu Whakarae members conducted several workshops in 2019 to review and update the strategic priorities of the group. This handover report is structured around the new strategic priorities:

- Leveraging strategic relationships and technology to influence breakthroughs
- Influencing and informing Māori health policy and intersectoral developments
- Fostering Māori and health workforce development
- Creating and sharing innovation and indigenous health excellence

Te Tumu Whakarae's Strategic Framework for the last several years is provided below:

OUR PRIORITES FRAMEWORK 2018

Vision	**Pae Ora** *Māori are the healthiest people in the world*		
Strategic Priorities	**Mauri Ora** **Healthy Individuals**	**Whānau Ora** **Healthy Families**	**Waiora** **Healthy Environments**

Strategic Directions

Our Approach

1. Provide & encourage transparent & effective Leadership
2. Lead a Māori equity culture in our system
3. Provide & expect evidence based approaches
4. Utilize partnering & collective Impact approaches
5. Value Māori leadership, intelligence & innovation
6. Advocate for proportionate universalism (Targeted resourcing & effort)

Key Focus Areas

1. Working Inter-sectorally to accelerate Māori health gains
2. Improving Systems Performance (Planning, monitoring & intelligence)
3. Developing greater Māori health capacity & capability
4. Commissioning for Outcomes

STRATEGIC RELATIONSHIPS AND TECHNOLOGY TO INFLUENCE BREAKTHROUGHS

Tumu Whakarae works with many groups and organisations in its endeavour to achieve Māori Health excellence throughout the health system in Aotearoa. As such, continuing to forge and maintain strategic relationships should remain a top priority. Tumu Whakarae's relationships are also international, since 2015 we have developed excellent relationships with our indigenous whānau in the USA and Canada. They have similar health inequities to Māori and our shared learnings have been immense. Through this collaboration we have developed an informal network called the International Indigenous Health Collaboration (IIHC).

Australasian College of Emergency Medicine (ACEM)

Lead: Riki Nia Nia

As Chair of Tumu Whakarae I was invited to, and participated, as a representative of the Equity Advisory Group for ACEM. Through this we developed their Māori Equity Strategy called Manaaki Mana![1] The Manaaki Mana strategy is built upon the pillars of Pae Ora (healthy futures for whānau), Whānau Ora (healthy families), Wai Ora (healthy environments) and Mauri Ora (healthy individuals) aligning to He Korowai Oranga.

Manaaki Mana seeks to redress some of the imbalances and misunderstandings in culture and care for Māori that contribute to disparate health outcomes. As part of the strategy, ACEM will conduct training for trainees, members and staff to understand tikanga and how it fits into Te Ao Māori and can contribute to the safety of Māori in emergency departments. Another outcome during Covid-19 was the partnership between Tumu Whakarae and ACEM to develop a strong joint statement to protect whānau during Covid-19 in EDs and ICUs. Thanks to Marama Tauranga who contributed to the ACEM work.

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1 https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand

New Zealand College of Public Health (NZCPH)

Lead: Riki Nia Nia

The NZCPH, College for Public Health Physicians has played a major role in the Covid-19 response. The College is fortunate to have several Māori Public Health leaders such as Dr David Tipene-Leach and Dr Papaarangi Reid who continue to bring a wealth of knowledge and expertise to the sector. Tumu Whakarae is currently supporting the college with the development of its Māori Health Equity Strategy.

Royal Australian and New Zealand College of Ophthalmologists (RANZCO)

Lead: Riki Nia Nia

Another College where Tumu Whakarae has become involved is RANZCO and as Chair I have been sitting on their Expert Advisory Group helping the College to develop a Māori Equity Strategy. One visible sign of this partnership is the jointly developed statement related to Covid-19 and Māori communities.

Amorangi Tā Mason Durie (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa) and Riki Nia Nia

Tumu Whakarae Indigenous Health Study Tours 2015 -2019

Tumu Whakarae: Ngā Hikoi Rangahau 2015 - 2019

	LOCATION	STATE/PROV	INSTITUTION
1	Honolulu	Hawaii	Papa Ola Lokahi
1	Honolulu	Hawaii	Queens Health System
1	Honolulu	Hawaii	He Huilau Indigenous Health (conference 2016)
2	Kapolei	Hawaii	Blue Zone Project
3	Kaunakakai	Hawaii	Na Pu'uwai (Molokai)
4	Manoa	Hawaii	University of Hawaii at Manoa
5	Maui	Hawaii	Hui No Ke Ola Pono (Native Hawaiian Health)
5	Maui	Hawaii	Haleakalaa (Volcano)
6	Anchorage	Alaska	South Central Foundation (SCF): Nuka System
6	Anchorage	Alaska	National Tribal Public Health Summit (conference 2017)
6	Anchorage	Alaska	Alaska Native Tribal Health Consortium (ANTHC)
7	Kenai	Alaska	Kenaitze Tribal Health and Social Services, Denaina
8	Surrey	BC Canada	Fraser Regional Health Authority
9	Vancouver	BC Canada	St Paul's Hospital (Providence Health)
9	Vancouver	BC Canada	First Nations Health Authority (FNHA)
10	Victoria	BC Canada	Ministry of Health, British Columbia
11	Seattle	Washington	Seattle Indian Health Board (SIHB)
12	Portland	Oregon	North West Portland Area Indian Health Board (NWPIHB)
13	Las Vegas	Nevada	Evidence-Based Leadership (EBL) Conference
14	Chinle	Arizona	Chinle Comprehensive Care Center (IHS)
15	Hopi	Arizona	Hopi Health Care Center
16	Phoenix	Arizona	Phoenix Indian Medical Center (PIMC)
16	Phoenix	Arizona	Desert Vision Youth Residential Treatment Center
16	Phoenix	Arizona	Gila River Health Corporation (GRHC) - Tribal
17	Pinon	Arizona	Pinon Health Care Center
18	Tuba City	Arizona	Tuba City Regional Health Care Corporation
19	Window Rock	Arizona	Navajo Nation HQ
20	Albuquerque	New Mexico	National Congress of American Indian (conference 2019)
21	Gallup	New Mexico	Gallup Indian Medical Center (IHS)
22	Orlando	Florida	National Tribal Self-Governance Conference (2016)
23	Saint Lucie	Florida	Seminole Tribes of Florida
24	Nashville	Tennessee	United South and Eastern Tribes (USET)
25	Cleveland	Ohio	Cleveland Clinic
25	Cleveland	Ohio	Global Center for Health Innovation
25	Cleveland	Ohio	Cuyahoga Health Improvement Project (Collective Impact)
25	Cleveland	Ohio	Cleveland Leadership Center (CLC)
26	Washington DC	Maryland	National Congress of American Indian (Embassy)
26	Washington DC	Maryland	National Indian Health Board (NIHB)
26	Washington DC	Maryland	National Council of Urban Indian Health (NCUIH)
26	Washington DC	Maryland	Indian Health Service (IHS) HQ
26	Washington DC	Maryland	Senate Committee on Indian Affairs (SCIA)
27	Queens	New York	Department of Health & Mental Hygiene (Health Equity Dept)

Center For Health Equity

"Inequities in health are unfair, unnecessary and avoidable. New York City is one of the most unequal cities in the United Sates and one of the most segregated. It is no surprise that these everyday realities are reflected in our health. A more deliberative effort to name and address these disparities will frame all that we do."
- Health Commissioner Mary T. Bassett, MD MPH

VALUES

Social Justice	We work to undo racism and injustices in order to advance just and fair outcomes for all New Yorkers, particularly those most marginalized.
Community Power	We prioritize the expertise and agency of communities in identifying health challenges and developing lasting solutions to those challenges.
Accountability	We build trust through open and transparent processes that are responsive to the needs and feedback of communities, partners, and allies.
Diversity and Inclusion	We honor participation and leadership arising from many sources, life experiences, identities, and sectors of the community.
Data and Community Informed Practice	We use theory, research, evidence, stories, and community expertise to inform bold innovations in programs to break down inequitable systems.

VISION

Every New Yorker will live in a thriving neighborhood, where resources work well and systems are equitable. These conditions will nurture and sustain healthy individuals and communities across our city.

MISSION

We will strengthen and amplify the Health Department's work to eliminate health inequities rooted in historical and contemporary injustices and discrimination, including racism.

GUIDING FRAMEWORKS

TAKE CARE NY
TCNY 2020 is the City's blueprint for giving everyone the chance to live a healthier life. Its goal is twofold – to improve every community's health, and to make greater strides in groups with the worst health outcomes, so that our city becomes a more equitable place for everyone.

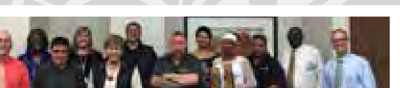
ONENYC: OUR JUST AND EQUITABLE CITY
Healthy Neighborhoods are a key element of OneNYC, our City's vision for growth, equity, sustainability, and resiliency. As a City, we are committed to reduce the premature mortality rate by 25 percent, and infant mortality 20 percent, by 2040, so as to dramatically decrease disparities among racial/ethnic groups.

THE APPROACHES WE TAKE TO ADVANCE EQUITY IN HEALTH

- **REFORM**: Become a racial justice and multi-cultural organization
- **NAME**: Make injustices visible via data and storytelling
- **TARGET**: Invest in key neighborhoods via place-based efforts
- **MOBILIZE**: Advance a health equity in all policies approach
- **CHANGE**: Amplify community power via collective action and volunteerism

#NYCHealthEquity

NYC Health



International Indigenous Health Collaborative (IIHC)

Leads: Riki Nia Nia and Dame Naida Glavish

A positive outcome of our initial engagements in the US and Canada, has been a strong alignment of our shared histories of colonisation, and detrimental impacts on our indigenous population across almost every indicator. However our US cousins have also, in the past 30 - 60 years, achieved a great deal of success from their nationwide collaboration as Tribes and communities, and in the self-governance space. While the Native Hawaiian and Canadian experiences are different, overall we all agree we share similar philosophies and aspirations for better health for our respective peoples.

As a result of the ongoing relationship building, indigenous health leaders from the US and Canada, have joined with Tumu Whakarae to create an informal relationship known as the 'International Indigenous Health Collaborative' (IIHC). This is made up of senior indigenous health 'peers' from the US Federal Indian Health Service, indigenous health leaders from Native American Tribes, Alaska Native communities and Native Hawaiian communities; National and regional / provincial health organisations. This informal network includes:

- Canada: Dr Evan Adams, First Nations Health Authority and Leslie Bonshor, Vancouver Coastal Health, Dr. Gertie-Mai Muise, ED, Ontario Indigenous Primary Care Council
- USA (mainland): Stacey Bohlen (National Indian Health Board)
- USA (Hawai'i): Sheri Daniels (Papa Ola Lokahi) and Professor Keawe Kaholokula (University of Hawai'i at Manoa)
- USA (Alaska): Andy Teuber (President ANTHC)
- Aotearoa: Dame Naida Glavish, Ngāti Whatua & ADHB/WDHB), Riki Nia Nia (ADHB, WDHB, TW)
- Australia: Mick Brown, Australian Aboriginal Infonet and Dr. Neil Drew, Edith Cowan University

INFLUENCING AND INFORMING POLICY AND INTERSECTORAL DEVELOPMENTS

Government Inquiry into Mental Health & Addictions 2018/19

Leads: Tricia Keelan and Riki Nia Nia

You can access the document here.

Te Tumu Whakarae's Submission to the Inquiry was led by Tricia Keelan. Tricia was also the lead author of the document which sought revolutionary transformation of the MHA system. I worked alongside Tricia providing peer review and co-leading the Submission presentations and communications. The Submission set out clear recommendations for the transformation of the MHA system, positing ten power principles and actions for change. The authors stressed the relentless unequal burden of MHA for tangata whenua, driven by the impacts of colonisation: ongoing oppression of rangatiratanga, land loss, denigration of lore, culture and language, all exacerbated by modern pressures including pervasive structural and personal racism and poverty.[2]

The paper highlighted the fact that despite the alarming Māori MHA evidence, over the last decade DHBs have halved investment in Kaupapa Māori services. MHA funding increased by a third, from $1.1 billion in 2008/09 to $1.4 billion in 2015/16 with Kaupapa investment stripped from a high of $73m in 2010 to just $36.9m in 2017, a mere 2.5% of total funding. The Inquiry report, He Ara Oranga was presented to Government by the Inquiry Panel in November 2018. Tricia provided an assessment of the report with the following key points:

1) He Ara Oranga had failed to uphold Te Tiriti o Waitangi, Indigenous rights and equity for whānau. The report itself was a continuation of the oppression of rangatiratanga.

2) The Reports' shortcomings were a disservice to (not a reflection of) iwi, hapū, whānau, Māori providers and all communities who mobilised and gave powerful voice to the need for a revolution of the MHA system, and, the exceptional leadership of Amorangi Tā Mason Durie and Dean Rangihuna.

3) Recommended that Tumu provide critical feedback on the document and influence the implementation of He Ara Oranga to ensure equity, effectiveness, Te Tiriti and indigenous rights activation.

Recent movements have provided some positive signals in the MHA such as the strong tangata whenua leadership in the interim Mental Health and Wellbeing Commission Chaired by Haydon Wano. Tumu should continue to monitor/review progress.

Tricia Keelan - Ngāti Porou, Te Aupōuri, Rongomaiwahine
Pou Ārahi - Human Rights Commission. Previous Manukura, Executive Director, BOP.

2 Keelan, T. & Porter, J. (2018). Tumu Whakarae Submission to the Government Inquiry into Mental Health and Addiction. Retrieved 10 July from https://www.karawhiua.com/portfolio/project-two-dlsbl

Waitangi Tribunal (Wai 2575 Claim)

Leads: Tricia Keelan, Hector Matthews, Riki Nia Nia

The Waitangi Tribunal Health Services and Outcomes Inquiry (known as Wai 2575) commenced in November 2017 to hear all claims concerning grievances relating to health services and outcomes which are of national significance. With such a broad agenda, the Tribunal agreed on a phased approach based on themes with health-related issues to be heard in stages according to priority. Stage one, which concluded in March 2019, inquired into aspects of primary care. Tricia Keelan and I were the Stage one leads in the Crown team. I acknowledge Tricia's strong leadership within the Crown team and Crown evidence development. Also acknowledge Hector Matthews who gave compelling evidence for the Stage One hearings.

On 1 July 2019 the Waitangi Tribunal released their report on Stage One (linked here). The report includes several findings and recommendations for the Crown to consider including Crown failings to properly fund the primary health care sector to pursue equitable health outcomes for Māori and serious Treaty breaches concerning the way the Crown holds the primary health care sector to account and reports on its performance. The findings and recommendations are being worked through and will be built on in further stages of WAI 2575. Tracee Te Huia is the Tumu lead for Stage two which will cover three priority areas encompassing mental health (including suicide and self-harm), Māori with disabilities, and issues of alcohol, tobacco, and substance abuse. The Tribunal commissioned the following reports:

- Māori mental health including suicide and self-harm (filed 30 August 2019)
- Issues of alcohol, tobacco and substance abuse for Māori (filed 20 December 2019)
- Māori with disabilities part one and two (filed 28 June 2019)

2019-2020 Health and Disability Services Review

Leads: Riki Nia Nia and Tricia Keelan

This review report was released on 16 June 2020.[3] Tumu Whakarae as a forum met with the Māori Expert Advisory Group who worked within the review and provided input from a DHB Māori Health leaders perspective. At the time of preparing this handover report, Tumu Whakarae has not yet met to consider the ramifications of the review and to consider implications however the suggestion of fewer DHBs in NZ will ultimately impact the Tumu Whakarae membership if there are to be fewer Māori GMs / Directors within a re-designed system.

Wai 2575 Stage one hearings

3 https://systemreview.health.govt.nz/

Covid-19 Response and Decision Paper 2020

Lead: Riki Nia Nia

With the advent of the Covid-19 epidemic, a number of Tumu Whakarae members mobilised quickly with the aim of ensuring that all DHBs would respond appropriately and effectively to support whānau and their communities. Iwi, hapū, whānau and other Māori groups also mobilised very quickly, in some cases, much faster than the health system in order to protect and care for their most vulnerable members. For example: the National Iwi Chairs Forum established a Pandemic Response group; Iwi, hapū and whānau established and promoted protective tikanga protocols, rohe road check-points, whānau ora welfare packages and household whanaungatanga and oranga check ins. It is a testament to iwi, hapū and whānau leadership and the dual response by both government and Māori, that the impact of our combined efforts resulted in only 3 of the 22 deaths, and 130 (9%) of infections impacting Māori. I noted the influence of Iwi and the Human Rights Commission (HRC report here) calling for rangatiratanga based Te Tiriti partnership decision-making and equity in the COVID response and ongoing recovery.

Due to the imminent threat to the lives of Māori and all populations in Aotearoa, I prioritised my focus on the local, regional and the national COVID 19 approach, including providing leadership as a member of the National Māori Pandemic Expert Advisory Group for the Ministry of Health (MOH). This group has now become the Māori monitoring group for Covid-19 and is being led by John Whaanga, DDG at the MOH. The MOH's updated Māori COVID-19 Response plan is linked here.

At the national level I led Tumu Whakarae to develop guiding principles for the Māori Covid-19 response within DHBs. As the Alert Levels reduced, I focused on developing a Decision Paper for the DHB CEOs recommending ways forward based on learnings from earlier Alert Levels. This resulted in a joint work programme being endorsed and approved by the MOH and DHB CEOs with Te Tumu Whakarae. This is being progressed and will require ongoing implementation and monitoring by the incoming Chair. Thanks to Hinewai Pomare and Roimata Tipene who assisted with the development of this work. Thanks also to Tracee Te Huia and Marama Tauranga who gave helpful feedback and assisted in communications with other roopu.

TUMU WHAKARAE

COVID-19 Guiding Principles

Ngā Mātāpono Mate Korona o Tumu Whakarae

1. Arahinatia, kia kore tētahi Māori e hinga
2. Kia mataara, i ngā wā katoa, ahakoa te Pae Mataara
3. Hononga – hono atu, hono mai
4. Whakamana i ngā whānau i roto i ō tātou whāinga
5. Ko te aroha ki ō tātou whānau e noho mātāmua ana
6. Ahakoa te Pae Mataara, kei konā ngā āheinga e marumaru ai te Iwi

Ngā Mātāpono o Te Tiriti

Tino Rangatiratanga
Partnership
Active Protection
Options
Equity

TUMU WHAKARAE

COVID-19 Priorities Framework

E hāngai ana ngā mātāpono ki ngā Pae Mataara katoa

Ngā Pae Mataara	Ngā Whāinga	Ngā Whakaarotau
Pae Whā: Lockdown	WHAKAMARU	***Protect our whānau from COVID-19 in all alert levels*** 1. Champion COVID-19 testing and surveillance of the Māori population, including Māori led case & contact management 2. Whānau Ora pathway of care for whānau who test positive for COVID-19 3. Champion Māori led COVID-19 communication & engagement strategy for whānau 4. Ensure whānau support services in Hospitals (including virtual options) 5. Champion the influenza vaccination of whānau
Pae Toru: Restrict /Recover **Pae Rua:** Reduce /Recover	WHAKAKAHA	***Enable our whānau to stay well in all alert levels*** 1. Champion Whānau Ora pathways of care for whānau 2. Champion removing barriers to Primary Care access for whānau 3. Champion hospital services to address unmet whānau need 4. Champion the implementation of a Māori intelligence & data team for COVID-19 5. Champion a system-wide approach with partners to address the social and economic barriers to health equity for whānau
Pae Tahi: Prepare/Recover	WHAKAORA	***Accelerate whānau recovery in all alert levels*** 1. Champion Māori Health Provider led innovation and Māori Health Provider sustainability 2. Champion Iwi led innovation and COVID-19 recovery strategies 3. Implement a Māori health COVID-19 learning stream to capture, advance and shape the new normal 4. Champion Māori Health Equity measures and priorities for accelerated post pandemic recovery 5. Champion Māori Health Equity expectations & measures for all new COVID-19 funding allocations

Ngā Hua

- *Whānau are engaged & informed at every level of the Pandemic*
- *Māori Health Equity expectations & measures applied to the Pandemic response e.g. Funding*
- *Whānau Ora pathways of care are in place at every level of the Pandemic*
- *Whānau can access Primary Care at every level of the Pandemic*
- *Hospital services are responsive to Whānau at every level of the Pandemic*
- *Intelligence and data is available to inform the Māori health response at every level of the Pandemic*

Prepared by the NRHCC Māori Response Team | 26/04/2020

FOSTERING MĀORI AND HEALTH WORKFORCE DEVELOPMENT

Tumu Whakarae Leadership Development

Lead: Riki Nia Nia and Tricia Keelan

Members of Tumu Whakarae are acutely aware of the need to maintain their own individual skills and competencies as Māori Health leaders, but also to share with others where their skills and interests lie, so that this expertise can be drawn upon for specific projects or policy work. In the work plan, there is a task to complete a Tumu Whakarae Skills and Interests inventory for all members. This is work in progress and is part of the work plan moving forward, for completion. Maintenance of this inventory will be a role for the Secretariat.

Kia Ora Hauora

Leads: National: Riki Nia Nia. Northern: Harold Wereta. Midlands: Phyllis Tangitu. Central: Jason Kerehi. Southern: Hector Matthews

Kia Ora Hauora (KOH) was established in 2009 to increase the overall number of Māori working in the health and disability sector in response to the national shortage of health sector workers and the demand for more Māori health professionals in that sector. KOH supports growth in the Māori health workforce that is more reflective of the communities the workforce serves and supports.

The KOH website as a tool www.kiaorahauora.co.nz that contains a range of helpful information targeted at various Māori audiences. Students can access health careers information and support aimed at encouraging a health career, staying in study and understanding the variety of employment opportunities in health. KOH encourages adults to enter the health workforce, no matter what range of experience you may currently have. KOH's website also provides information on support available for study and finances. The site enables access to Māori student mentors, information and updates on regional initiatives, as well as scholarships.

Since 2009, a total of 10,265 have registered with Kia Ora Hauora.

Kia Ora **Hauora**

HIGHLIGHTS SINCE OCTOBER 2018

HAUORA MĀORI SCHOLARSHIPS

DELIVERED NATIONALLY TO OVER

900 TERTIARY STUDENTS

19 TERTIARY INSTITUTIONS

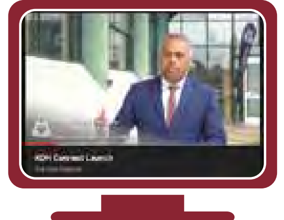
A KEY OUTCOME FROM GM HR HUI IS A BOLD TARGET AND AGREEMENT IN PRINCIPLE THAT

"ALL KOH REGISTERED STUDENTS WILL BE EMPLOYED UPON GRADUATION"

SECURED ADDITIONAL NCC + RCC FUNDING

MOH FUNDED KOH SERVICE ENHANCEMENT CONTRACTS

FIRST FUNDING INCREASE SINCE 2009



KOHCONNEC

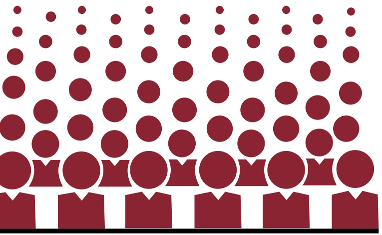
OFFICIALLY LAUNCHED BY THE HON PEENI HENARE, ASSOCIATE MINISTER OF HEALTH

Kia Ora **Hauora**

Supporting Māori into Health

3,568

CURRENTLY REGISTERED WITH KIA ORA HAUORA



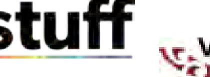
40

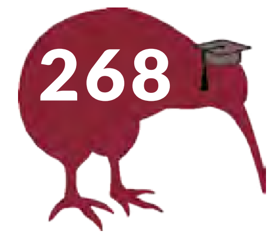
TERTIARY SUPPORT GROUP APPLICATIONS RECEIVED

24 APPROVED
11 INCOMPLETE
2 DECLINED
3 WITHDRAWN

9

PRESS RELEASES





TOTAL STUDENTS SUPPORTED ON **SEE THE SOLUTIONS**

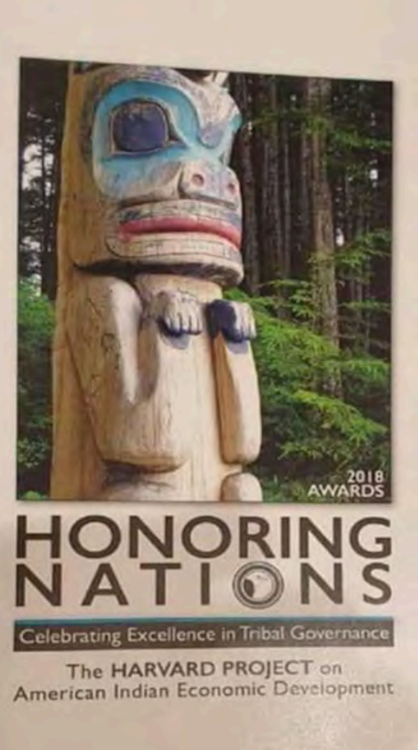
Te Tohu Whakawaiora: Māori Health Qualification

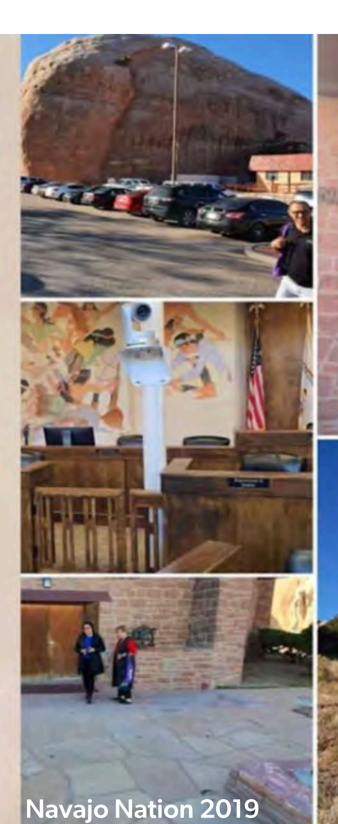
Leads: RIki Nia Nia and Cheryl Goodyear

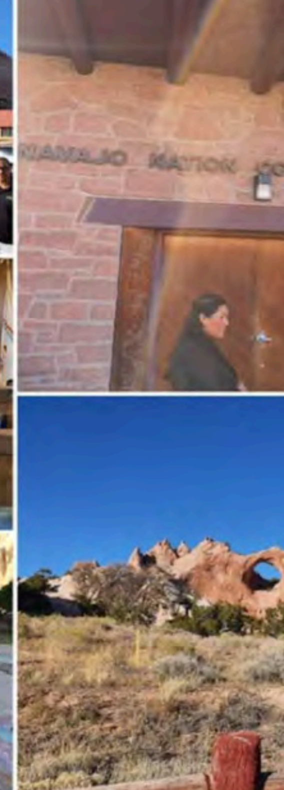
Te Tohu Whakawaiora is a workplace-focused Māori cultural competence course. Originally developed for staff at Capital Coast DHB, it was intended to give staff a grounding in Te Reo and tikanga Māori so they could offer culturally safe care.

Graduates are awarded an NZQA-aligned qualification in a ceremony, possible through a partnership with Skills Active (contacts Cheryl Goodyear at CCDHB and Ron Taukamo at Skills Active). The course was developed several years ago but has since rolled out to other DHBs such as Wairarapa and Counties Manukau DHBs.

As a NZQA-eligible course, the Health Workforce NZ Scholarship Funding is able to pay for staff to participate. Over time it would be hoped to roll this qualification out nationally to all DHBs since the curriculum and qualifications framework has already been developed.







Navajo Nation 2019

Te Reo Māori Programme for DHB Staff

Leads: Riki Nia Nia, Dame Naida Glavish, and Tricia Keelan

A Te Reo Māori programme started as a pilot at Auckland DHB in 2019, and now, in partnership with Te Wānanga o Awanuiārangi, it is available to hundreds of staff across NZ with several DHBs having staff participate (e.g. Auckland, Waitematā, Counties-Manukau, Taranaki, Bay of Plenty and Waikato).

Te Whare Wānanga o Awanuiārangi tracks participation numbers across the country on behalf of Tumu Whakarae.

Key highlights from this programme include:

- Cohort 1 (2019) recruited 192 staff and whānau across the four hospitals of Auckland DHB
- Cohort 2 (2020) recruited 140 staff and whānau across the four hospitals of Auckland DHB
- Cohort 3 there is a waiting list for another cohort, pending timetable approval

Other DHB's that have followed the lead of Auckland/Waitematā DHB include:

- Bay of Plenty DHB (3 classes) started in 2019
- Counties/Manukau 2019 and 2020 (2 classes)
- Lakes DHB 2020 (2 classes) starting June 2020
- Taranaki DHB 2020 (2 classes) starting July 2020

Three key learnings from the programme: having a consistent kaiako is important for a positive learning relationship with the students; the number of tauira (students) in the classes is critical (ideally no more than 30); centralised communications and resource deployment works well, including a point of contact for each DHB for logistics and communications.

A graduation ceremony and evaluation process is scheduled for later in 2020. To respond to Covid-19, classes moved to an eLearning platform.

Workforce Statement and Reporting

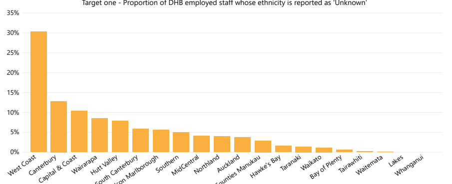
Leads: Hector Matthews and Riki Nia Nia

Tumu Whakarae developed a Workforce Statement seeking support from all DHB CEOs to work towards achieving proportionality of their workforce based on their regional Māori populations. All CEOs agreed to commit to this direction and are now tracking and monitoring their results. There is a dashboard report with a set of reporting (copy in appendices) which is now being coordinated for Tumu Whakarae by Central TAS as part of their workforce and secretariat support. A Workforce Symposium was meant to be planned for 2020 to provide an avenue for those DHBs experiencing success with these targets, to share their achievements and strategies with others, however this was deferred due to the Covid-19 epidemic.

All reports for workforce proportionality targets are now stored on the Central TAS website (under Workforce reports). This will be a project requiring continual monitoring by Tumu Whakarae if the targets for 2025 are to be achieved. Central TAS now monitors and issues the dashboards.

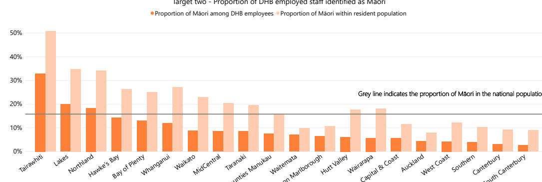
Māori representation within DHB employed workforces as at 31 December 2019

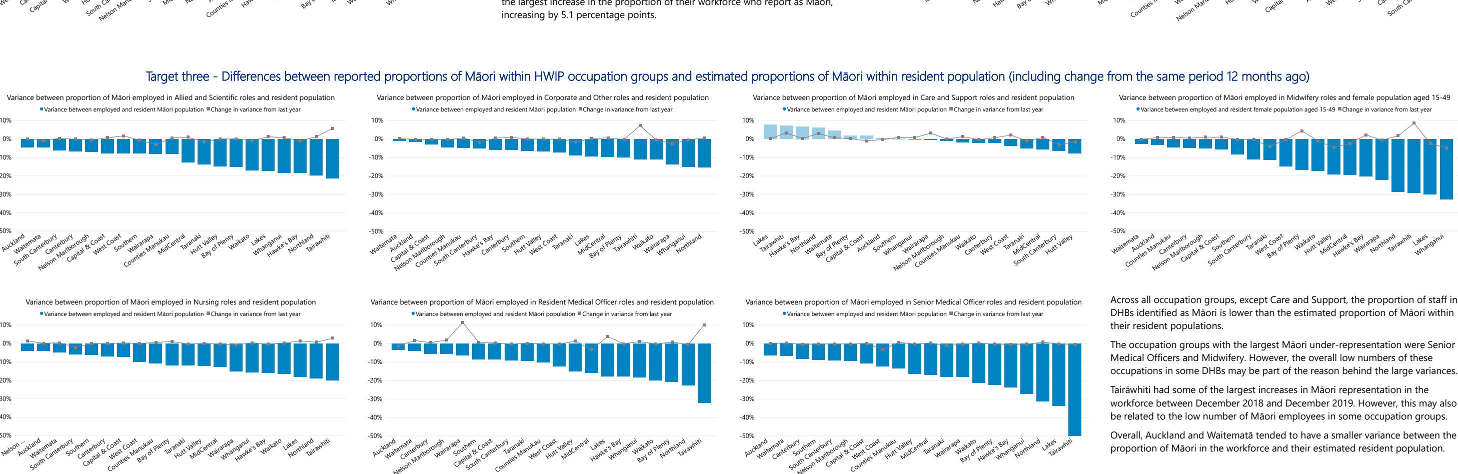
(Informing the Te Tumu Whakarae position statement and Workforce Strategy Group targets)



Compared to the September 2019 quarter, West Coast DHB had the largest decrease in the proportion of employees reported with 'unknown' ethnicity, decreasing by almost 16 percentage points. Six other DHBs decreased their 'unknowns' around 2-3 percentage points (sorted from largest to smallest decrease): Bay of Plenty, Northland, Canterbury, MidCentral, Waitematā, and Nelson Marlborough. The other DHBs reduced their 'unknowns' by less than one percentage point. The 'unknowns' in Wairarapa increased by 0.3 percentage points.

In terms of Māori representation in the workforce, all the DHBs have a lower proportion of people reported as Māori in their workforce than in their estimated resident populations. Compared to December 2018, Tairāwhiti had the largest increase in the proportion of their workforce who report as Māori, increasing by 5.1 percentage points.



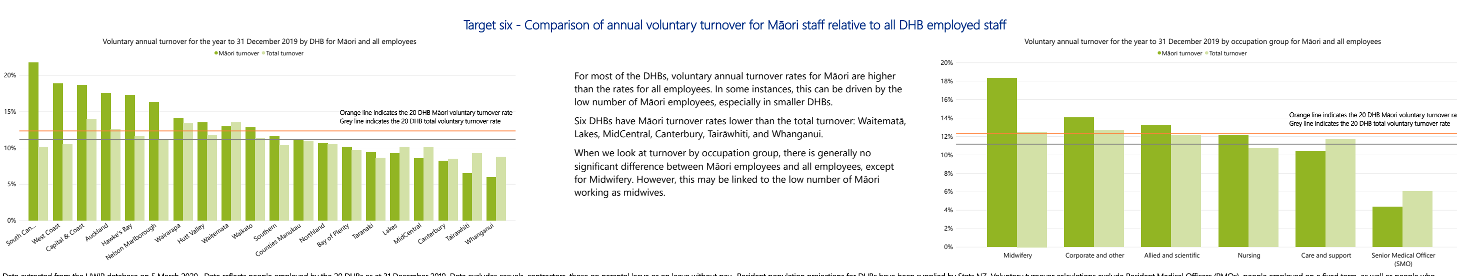


Across all occupation groups, except Care and Support, the proportion of staff in DHBs identified as Māori is lower than the estimated proportion of Māori within their resident populations.

The occupation groups with the largest Māori under-representation were Senior Medical Officers and Midwifery. However, the overall low numbers of these occupations in some DHBs may be part of the reason behind the large variances.

Tairāwhiti had some of the largest increases in Māori representation in the workforce between December 2018 and December 2019. However, this may also be related to the low number of Māori employees in some occupation groups.

Overall, Auckland and Waitematā tended to have a smaller variance between the proportion of Māori in the workforce and their estimated resident population.



For most of the DHBs, voluntary annual turnover rates for Māori are higher than the rates for all employees. In some instances, this can be driven by the low number of Māori employees, especially in smaller DHBs.

Six DHBs have Māori turnover rates lower than the total turnover: Waitematā, Lakes, MidCentral, Canterbury, Tairāwhiti, and Whanganui.

When we look at turnover by occupation group, there is generally no significant difference between Māori employees and all employees, except for Midwifery. However, this may be linked to the low number of Māori working as midwives.

Data extracted from the HWIP database on 5 March 2020. Data reflects people employed by the 20 DHBs as at 31 December 2019. Data excludes casuals, contractors, those on parental leave or on leave without pay. Resident population projections for DHBs have been supplied by Stats NZ. Voluntary turnover calculations exclude Resident Medical Officers (RMOs), people employed on a fixed term, as well as people who ceased employment due to restructure/redundancy, dismissal, death or for health reasons.

CREATING AND SHARING INNOVATION AND INDIGENOUS HEALTH EXCELLENCE

Ngā Hikoi Rangahau 2015 - 2019

Leads: Riki Nia Nia and Dame Naida Glavish. Convenor: Kāhui Tautoko Consulting

Since 2015 Tumu Whakarae [see appendix for list of annual attendees] has implemented annual study tours to sites in the northern hemisphere including USA (mainland, Hawai'i & Alaska) and Canada (see appendix for list of annual attendees from Tumu Whakarae, and summary of learnings) for the purposes of:

- Indigenous health knowledge exchange based on learning from several decades of experience by North American Tribes and Nations in this area
- Gaining first-hand exposure to international indigenous examples of leadership, services and innovation associated with accelerating indigenous health gains, particularly in the health equity and disparities area
- Strengthening relationships with indigenous peers, leaders and experts in relevant fields of work sitting within and outside of indigenous health
- Expanding learning on health innovations and / or best practice that may impact Māori or offer other relevant opportunities, particular in the development space
- Learning about specific workforce and leadership development initiatives
- Creating a mechanism for ongoing meaningful international engagement and collaboration between our Indigenous health networks

As well as the study tours, Tumu Whakarae also hosted the September 2015 Indigenous Health Symposium in Auckland, and with our Hawaiian partners also jointly led He Huliau in October 2016 which were both attended by several individuals from the northern hemisphere Tribes and Nations. Tumu Whakarae members have benefitted greatly at both a strategic level and an operational level with exposure to new knowledge and valuable engagement with Native Hawaiian, Native American and Alaska Native tribes. Reciprocally the networks Tumu Whakarae have engaged with have also reported that they have benefitted from the knowledge and experience of Tumu Whakarae. Continuing to strengthen these relationships and accessing new knowledge in a reciprocal way will always be of great benefit to the planning and service delivery capabilities of DHBs for their respective Māori populations.

TUMU WHAKARAE MEMBERS WITH THE (USA) DIRECTOR OF THE INDIAN HEALTH SERVICE (IHS)

Rear Admiral Michael Wee-ahkee, (USA Director IHS), Kahurangi Naida Glavish, Riki Nia Nia, Tricia Keelan and Benjamin Smith (Deputy Director for Intergovernmental Relations IHS).

Photographed at the National Congress of American Indians Annual Conference in Albuquerque, 2019.

PANEL MEMBER INDIGENOUS HEALTH LEADERS PANEL

Ron Allen, Chairman (Tribal Self -Governance Advisory Group, USA); Riki Nia Nia (NZ), Benjamin Smith (Indian Health Service) at podium, Dr Diane Paloma (Hawai'i) and Dr Evan Adams (Canada).

Photographed at the Tribal Self-Governance Conference 2016: Orlando.

Hui Kaikookiri Pae Ora - September 2015

Leads: Riki Nia Nia and Dame Naida Glavish

Convenor: Kāhui Tautoko Consulting

In an endeavour to share the findings of our study tours and to expose our health system to indigenous health excellence, Tumu Whakarae in partnership with Counties Manukau Health implemented the Hui Kaikookiri Iwi Taketake: Whakatairanga Paeora at Ko Awatea (Middlemore Hospital) from the 21st - 23rd of September 2015.

The symposium brought together champions for accelerating indigenous health gains from around the world, including some of those engaged on the 2015 Tumu Whakarae Study tour. The symposium was oversubscribed and provided a unique learning opportunity for all who attended. The audience was diverse and included four DHB CEOs and many health executives, clinicians and health workers.

He Huliau: Indigenous Health Conference, Hawai'i – October 2016

Lead: Riki Nia Nia

Co-Convenor: Kāhui Tautoko Consulting

Following on from the success of the indigenous health symposium in Auckland in 2015, international indigenous health peers agreed to meet again at the He Huliau conference in Hawai'i the following year.

This conference saw many insightful presentations showcasing the excellent work being done by indigenous health leaders, youth, providers and advocates across all jurisdictions. New Zealand's own Māori youth group presented an amazing online-based youth health initiative among many other international speakers including Stacey Bohlen from the National Indian Health Board, USA and Dr. Evan Adams from Vancouver Canada.

Central Region: Two Yearly Tū Kaha Conference

The Tū Kaha conference series began in 2008. It has been a collaboration of all the Central Region District Health Boards (DHBs) designed to promote health as a career, share and celebrate Māori health innovation and achievement, demonstrate the strengths of indigenous intelligence as a catalyst for positive change within our whānau; and accelerate the improvement of the status of Māori health.

The conference series began to provide a platform to celebrate excellence in Māori health particularly within the Central Region. The Central Region General Managers and Directors of Māori Health have remained committed to the Tū Kaha kaupapa and have continued to provide opportunities for collaboration, strategising, learning and celebration. The conference series has been New Zealand's longest standing Māori health conference and continues to be the largest Māori health development conference in the world. Conference have been held as follows. I led the development and implementation of the first 4 Tū Kaha conferences:

- 2008 Mid Central - Riki Nia Nia lead
- 2010 Wairarapa - Riki Nia Nia lead
- 2012 Hawkes Bay - Riki Nia Nia lead
- 2014 Whanganui - Riki Nia Nia lead
- 2016 Capital Coast & Hutt Valley - Kuini Puketapu and Jim Wiki leads
- 2018 Manawatu - Stephanie Turner lead
- 2020 Wairarapa - Jason Kerehi lead

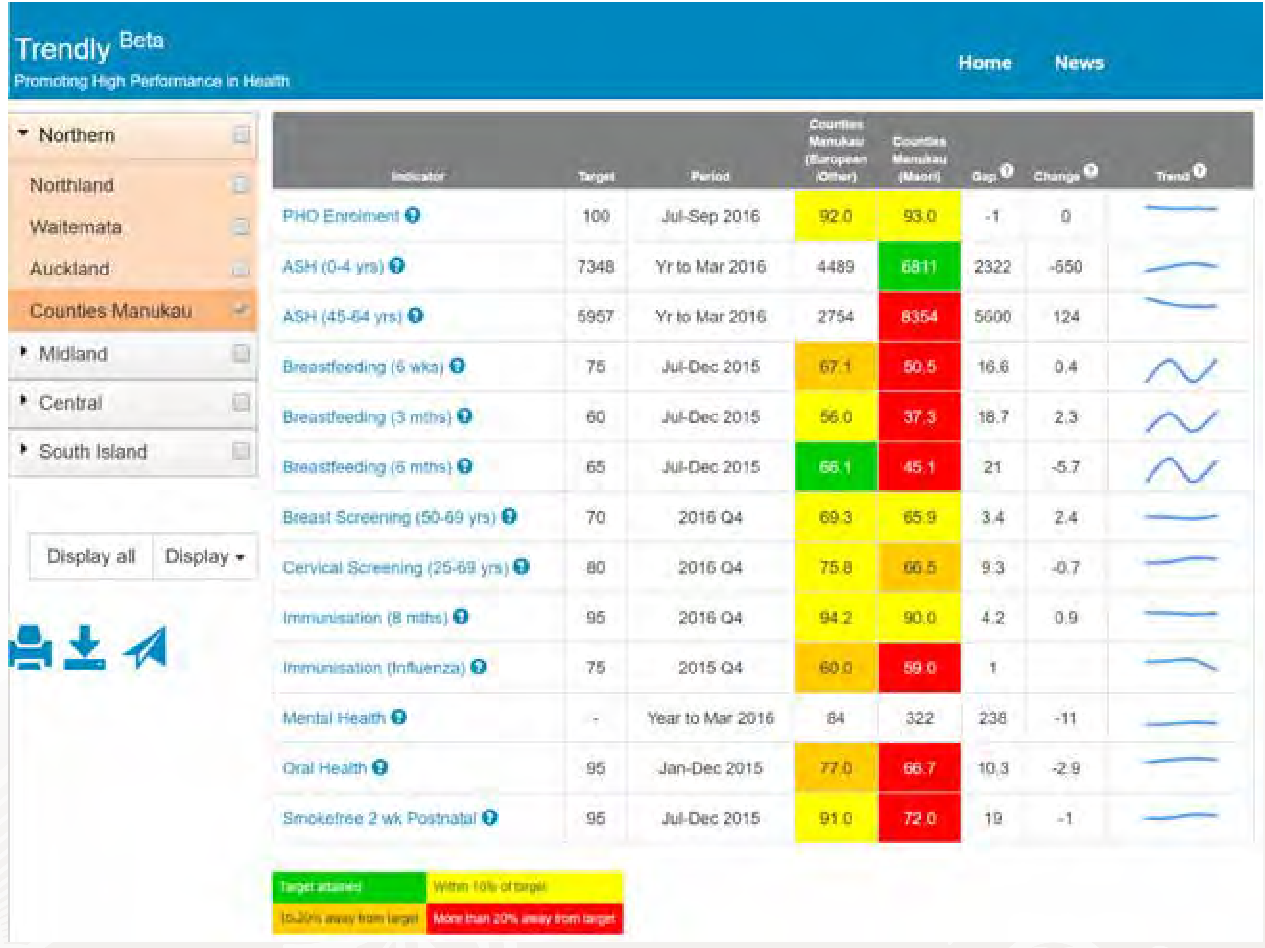
Trendly Indicator Monitoring Tool

Leads: Dr George Gray and Riki Nia Nia

A lack of access to data and intelligence and particularly Māori data, has been an ongoing and burning issue within the health system for many years. Following the Ministry of Health's implementation of mandatory DHB Māori Health Plans in 2011, I facilitated the development of summary performance reports for Tumu Whakarae members. These initial reports were static PDF summaries of performance data and over time we built on these beginnings to create the Trendly web-based reporting tool that was prototyped for members over 2012-2013. I led this work with Dr George Gray who was contracted to design and build the platform. Trendly has grown over time and for many years has been the only interactive Māori health performance monitoring website in Aotearoa. Tumu leaders contribute to the funding of the site with the contract hosted in BOP DHB. The major transformative purpose of this project was to improve health outcomes for all New Zealanders by providing the right information, to the right people, at the right time.

Trendly is an enabler for people in the system to do great work, make a difference, and empower healthy thriving individuals and communities. The tool is accessible by all DHBs and tracks performance of each DHB against a set of proxy indicators of performance (such as immunisation or screening rates). It provides a mechanism for national monitoring, comparing performance of DHBs and PHOs against this discrete set of indicators. It is dependent on annual support from DHBs with all but one of the 20 DHBs signaling their continued support. In the absence of Trendly there is no replacement ethnicity data platform, noting that the HQSCs new equity tool serves a different purpose and data set. I recommend that Tumu continue to support and enhance Trendly which is a low cost high value intelligence asset into the future.

Tumu Whakarae has also hosted online Health Excellence webinars to provide a space for top performers in specific indicators to share strategies and methods they have used to achieve their good results. While highlighting top performers, the Trendly tool also illuminates non-performers by highlighting DHBs and PHOs who are not achieving national standards in performance against the specific indicators. A total of ten seminars were delivered and covered topics such as increased immunisation, reaching diabetes performance targets, and quality improvement methodology. The seminars were regularly attended by 30-50 people, with many more people viewing the seminars around the country by video livestream.



Indicator	Target	Period	Counties Manukau (European /Other)	Counties Manukau (Maori)	Gap	Change	Trend
PHO Enrolment	100	Jul-Sep 2016	92.0	93.0	-1	0	
ASH (0-4 yrs)	7348	Yr to Mar 2016	4489	6811	2322	-650	
ASH (45-64 yrs)	5957	Yr to Mar 2016	2754	8354	5600	124	
Breastfeeding (6 wks)	75	Jul-Dec 2015	67.1	50.5	16.6	0.4	
Breastfeeding (3 mths)	60	Jul-Dec 2015	56.0	37.3	18.7	2.3	
Breastfeeding (6 mths)	65	Jul-Dec 2015	66.1	45.1	21	-5.7	
Breast Screening (50-69 yrs)	70	2016 Q4	69.3	65.9	3.4	2.4	
Cervical Screening (25-69 yrs)	80	2016 Q4	75.8	66.5	9.3	-0.7	
Immunisation (8 mths)	95	2016 Q4	94.2	90.0	4.2	0.9	
Immunisation (Influenza)	75	2015 Q4	60.0	59.0	1		
Mental Health	-	Year to Mar 2016	84	322	238	-11	
Oral Health	95	Jan-Dec 2015	77.0	66.7	10.3	-2.9	
Smokefree 2 wk Postnatal	95	Jul-Dec 2015	91.0	72.0	19	-1	

what people are saying about Trendly...

"Always accurate and informative much appreciated"

"I wanted the Board to use Trendly as a means of monitoring its performance, to think about how they might enhance the best-practice component and talk to their fellow DHBs"

"Such a simple and visual update that is easy to view and to understand."

"It is the only web-site where I can easily compare DHB performance for Māori"

"I refer to Trendly when I need info at a glance, it is a very good tool. I look forward to seeing Trendly development in line with the new service level measures"

"Supports planning within the organisation and better informs strategies to achieve good to great Māori Health. An excellent monitoring tool to refer to regularly."

Te Ara Whakawaiora: Quality Improvement Model

Lead: Riki Nia Nia

Tumu Whakarae developed a quality improvement approach based on the Institute of Health Improvement (IHI) PDSA (Plan Do Study Act) approach to quality improvement but tailored for use in a Māori Health setting. The tool is now expected to be implemented by all DHBs however we know there is variation as to how wide-spread the rollout applies in practice. Along with other quality improvement and performance measurement tools such as Trendly and Health Excellence seminars, Te Ara Whakawaiora (TAW) provides a platform for measuring performance on a quarterly basis across several indicators. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to the Board of the respective DHB.

The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of the TAW programme is to provide the DHB Board with a report each month from one of the indicator champions.

TUMU WHAKARAE

Te Ara Whakawaiora

Accelerating Māori Health Gains

Vision	Pae Ora *Māori are the healthiest people in the world*		
The Enablers	Accountable Leadership	Transparent & Timely Reporting	Continuous Quality Improvement

Elements

The Approach

1. Agree relevant Māori health priority areas and performance measures
2. Appoint Executive Champions to take accountability for performance
3. Develop, implement & resource robust plan of action to accelerate performance
4. Systemic and timely performance reporting to relevant Governance group/s
5. Share and receive performance learnings with related health networks

The Focus

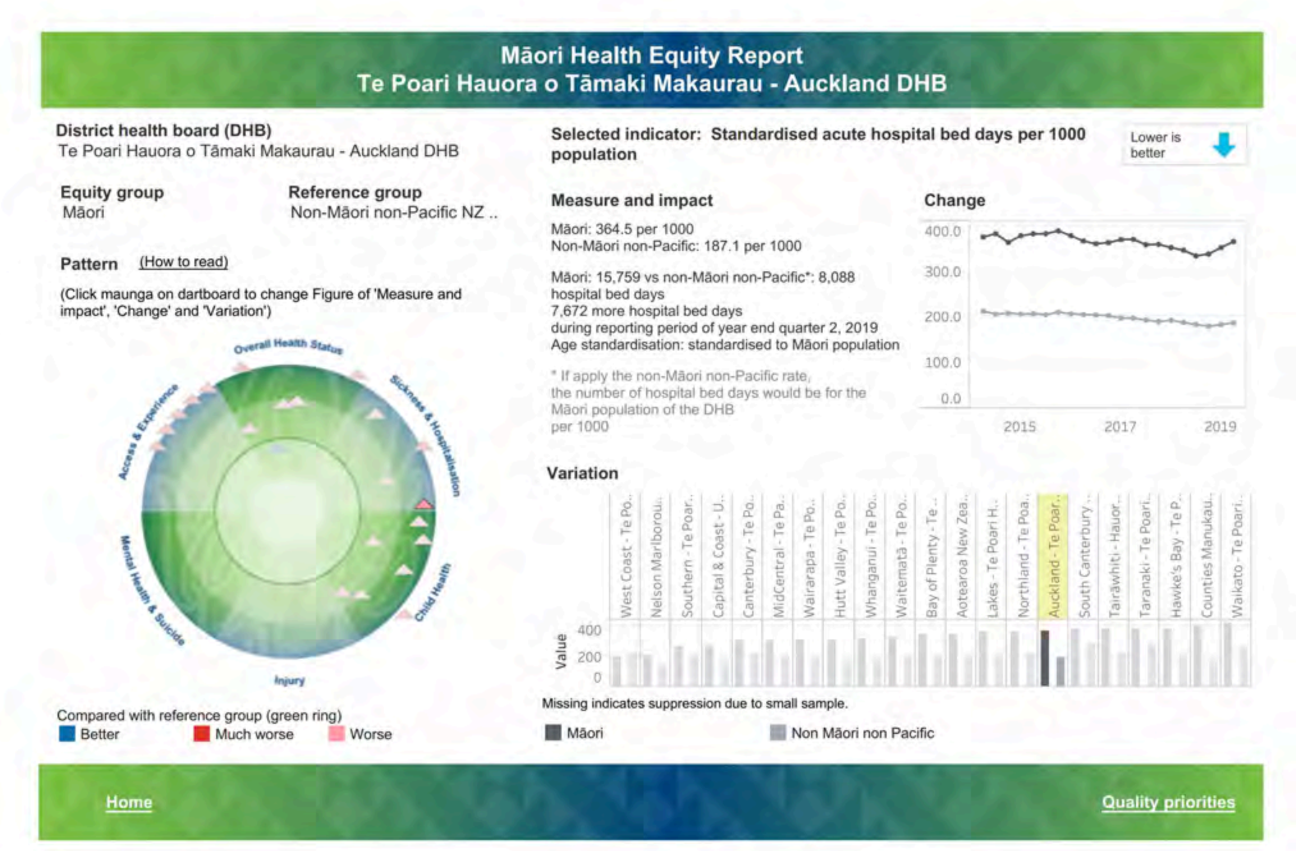
1. Accelerate Māori Health Gains
2. Eliminate Māori Health Inequities
3. Deliberate & Intentional
4. Value Māori Intelligence
5. Outcomes focused

Health Quality and Safety Commission (HQSC)

Leads: Riki Nia Nia and Tricia Keelan

Illuminating health inequities within the health system has been a priority for Tumu Whakarae. To advance this, we have been working closely with the Health Quality and Safety Commission (HQSC) to lead a tangata whenua redesign of the Health System Quality Dashboard so that it incorporates a specific tangata whenua health equity focus.

This is work is well advanced and once launched, will create a better approach nationally to illuminate the health inequities for Māori across all DHBs. It will also show up where much stronger performance of DHBs and the system is required and improve accountability for outcomes for Māori.



RECOMMENDED NEXT STEPS AND ACTIONS

1. OPERATIONS

- Tumu Whakarae to appoint new Chair – complete handover from former Chair (including with Central TAS Secretariat)
- Review Terms of Reference for Tumu Whakarae (Phyllis Tangitu from Lakes DHB leading)
- Finalise Tumu Whakarae draft work programme – and seek endorsement by members
- Confirm work schedule for Secretariat based on approved work programme

2. STRATEGIC RELATIONSHIPS

- Outgoing and incoming Chair to arrange transition of current Chair roles (where necessary) for existing entities, Colleges and international forums
- Continuation of Māori Health Equity joint work with ACEM, RANZCO and NZCPH

3. HEALTH POLICY

- Implement Māori Covid-19 Decision paper (joint work programme with MOH)
- Continue monitoring of implementation of Mental Health and Addictions Inquiry
- Assess implications of Health and Disabilities Services Review on DHBs and Tumu Whakarae

4. WORKFORCE DEVELOPMENT

- Complete Tumu Whakarae member Skill Set and Interests inventory (Central TAS lead)
- Reset Kia Ora Hauora (review date imminent)

5. INNOVATION AND SHARING EXCELLENCE

- Provide support for continuation of Tū kaha conference
- Discussion on next Hikoi Rangahau and IIHC session

6. HEALTH SYSTEM PERFORMANCE

- Continue oversight and monitoring of performance (Trendly, Te Ara Whakawaiora and Health Excellence tables)

He Kaupapa Hōu - Waiora, Waikato DHB

I have been privileged to be the Chair of Te Tumu Whakarae for the last 8 years.

On the 7th of July I was warmly welcomed to the Waikato DHB and rohe at Rangiaowhia marae, Te Wānanga o Aotearoa in my new role as Executive Director Māori, Equity and Health Improvement. The pōwhiri was a moving and humbling experience and I am very grateful for the amazing welcome and support of my whānau and colleagues.

Stepping down from my national roles allows me to give my full attention to the challenges and opportunities facing whānau in the Waikato. It will also allow me to work closely with my new DHB colleagues and tribal leaders.

It is an honour to serve the whānau, hapū and iwi of the Waikato region.

APPENDICES

APPENDIX 1:
Current Membership List – Tumu Whakarae

APPENDIX 2:
Tumu Whakarae 2020- 2021 Draft Work Programme

APPENDIX 3:
Ngā Hikoi Rangahau - Summaries

ATTENDEES FOR PAST ANNUAL STUDY TOURS

KEY LEARNINGS FROM EACH INSTITUTIONAL OR CONFERENCE VISIT

Appendix 1: Current Membership List – Tumu Whakarae

In alphabetical order by DHB

1. **Auckland & Waitematā:** GM Māori Health, Riki Nia Nia (outgoing Chair and outgoing GM, July 2020), Chief Advisor Tikanga, Dame Rangimarie Glavish
2. **Bay of Plenty:** Acting GM Māori Health Gains & Development, Marama Tauranga
3. **Canterbury:** Exec Director Māori and Pacific Health, Hector Matthews
4. **Capital and Coast:** Director Māori Health Services, Arawhetu Gray
5. **Counties-Manukau:** GM Māori Health, Sharon McCook
6. **Hawkes Bay:** GM Māori Health, Patrick LeGeyt
7. **Hutt Valley:** Director Māori Health, Kerry Dougall
8. **Lakes:** GM Māori Health, Phyllis Tangitu
9. **MidCentral:** Director of Māori and Pacific Health, Tracee Te Huia
10. **Nelson Marlborough:** GM Māori Health, Ditre Tamatea
11. **Northland:** GM Māori Health, Harold Wereta
12. **South Canterbury:** Director of Māori Health, Joseph Tyro
13. **Southern:** Chief Māori Health Strategy & Improvement Officer, Gilbert Taurua
14. **Tairāwhiti:** Pouwhakahaere Hauora Māori, Peter Brown
15. **Taranaki:** Chief Advisor Māori Health, Ngawai Henare
16. **Waikato:** Acting GM Māori Health, Janise Eketone
17. **Wairarapa:** GM Māori Health, Jason Kerehi
18. **West Coast:** GM Māori Health, Gary Coghlan
19. **Whanganui:** Director of Māori Health, Rowena Kui

Appendix 2: Tumu Whakarae 2020- 2021 Draft Work Programme

TUMU WHAKARAE: DRAFT WORK PROGRAMME 2020 - 2021

Lead: Riki Nia Nia

KEY FOCUS AREAS	ACTIONS & ACCOUNTABILITIES	LEAD	TIMELINE
TUMU WHAKARAE OPERATIONS			
Tumu Whakarae Leadership	1. Appointment of new Chair for Tumu Whakarae	ALL members	Position effective 1 July: priority
Taituarā Tumu Whakarae (Central TAS) position	2. Welcome to Jacque-Ann Heke and TW orientation / introduction to Tumu Whakarae role and activity & work plan	Lead: Chair / Hector	July 2020
Tumu Whakarae Work Programme	3. Discuss and finalise / endorse this Work Programme and complete allocation of positions TBA (leads and tautoko)	Lead: Chair ALL members	By 15th July 2020
Review of Tumu Whakarae Terms of Reference	4. Review Terms of Reference (support TBA)	Lead: Phyllis Tautoko: TBA	By 31 July 2020
LEVERAGING STRATEGIC RELATIONSHIPS			
Implementation of Maori Equity lens with ACEM	5. Continue supporting / monitoring implementation of Maori Equity Strategy (Manaaki Mana)	Lead: Riki Nia Nia Tautoko: Marama	Ongoing
RANZCO (Ophthalmologists)	6. Continue supporting RANZCO to develop Maori Equity strategy and implement	Lead: Riki Nia Nia	Ongoing
NZ College of Public Health	7. Develop relationship with NZCPH and develop shared approach to Equity, TOW and increasing Maori PH Physicians	Lead: Chair Tumu Whakarae	Ongoing
Reset Central TAS to be a high performing enabler of DHBs to achieve their Te Tiriti obligations (WAI 2575) and Maori Health Equity aspirations. Infrastructure needed. TAS needs to be Centre of Excellence for DHBs PDF 2020 TAS Māori Cultural Assessment F	8. Identify Tumu Whakarae team to work on this activity 9. Implement an assessment of the current capability of Central TAS from a Te Tiriti / Maori Health Equity perspective to determine what improvements are required. Reset Central TAS to be a high performing enabler of DHBs to achieve their Te Tiriti obligations (WAI 2575) and Maori Health Equity aspirations.	Lead: Phyllis & Tracee Tautoko: TBA	Team by 15th July Central TAS development plan by 30th September 2020
International Indigenous Health Collaborative (IIHC)	10. On hold at present (Covid-19) – pending next Hikoi Rangahau	Lead: Dame Naida Glavish, Riki Nia Nia	Suspended for now with inability to travel (Covid-19)

KEY FOCUS AREAS	ACTIONS & ACCOUNTABILITIES	LEAD	TIMELINE
INFLUENCING MAORI HEALTH POLICY			
He Ara Oranga: Mental Health and Addictions Inquiry Report	11. Continue monitoring implementation of the report recommendations and report out. Identify any areas requiring TW advocacy	Lead: TBA	Ongoing
Provide direct leadership to prepare DHBs to fully participate in the WAI 2575 Hauora Maori Hearings – and to align to recommendations where desirable	12. Work with the MOH to ensure DHBs are engaged in a timely and effective way to ensure they are enabled to fully contribute too and participate in the WAI 2575 Hauora Māori Hearings. 13. Identify areas for alignment with Tribunal recommendations which can be implemented in DHBs within current policy and legislative frameworks	Lead: Tracee Te Huia Tautoko: Hector Matthews & Tumu Chair Marty Disability support Mental Health and Addictions – Phyllis, Arawhetu	Ongoing
Prepare DHBs for potential changes relating to the Health & Disability review report https://systemreview.health.govt.nz/final-report	14. Immediately establish a TW Review Team to assess and provide a report on the H&D Review Report in terms of potential impacts and opportunities for DHBs moving forward (an assessment of the Review and provision of some clear guidelines for CE's also supporting MOH Maori Health)	Lead: TBA Tautoko: Phyllis, Gary, Tracee, Karen McCook, Matt Kiore	Immediate
Tumu Whakarae Decision Paper_2605? Draft Minute from CEOs meeting relatec	15. Implement the Tumu Whakarae decision paper on Covid-19 approved by CEOs on the 11th of June, 2020 in partnership with the MOH Māori health leadership (work with the MOH to ensure DHBs are better prepared to respond to serious incidents in the future such as COVID-19)	Lead: New Tumu Chair, Riki Nia Nia Tautoko: Marama	Immediate

Appendix 2: Tumu Whakarae 2020- 2021 Draft Work Programme (cont)

KEY FOCUS AREAS	ACTIONS & ACCOUNTABILITIES	LEAD	TIMELINE
Set an investment target for Māori health providers at DHB level.	16. Work in partnership with GMs Planning and Funding to develop investment target (Possible development of a position statement for sign off by CEOs)	Lead: Aroha Haggie Tautoko: Sharon McCook	
FOSTERING WORKFORCE DEVELOPMENT			
Review the current Tumu Whakarae skills and capabilities with a view to both strengthening and proactively recruiting essential capability to te wider Tumu Whakarae network. TW Skill and Interest matrix - October 201	17. Implement a Tumu Whakarae skills matrix and report on: a. Current skills b. Current responsibilities c. Current memberships d. Current aspirations (Inventory template completed and circulated. To be completed by all GMs)	Lead: Taituarā Tumu Whakarae (Central TAS)	By 31st August 2020
Kia Ora Hauora	18. Reset the KOH programme to ensure it is focussed on accelerating an increase in the supply of the future Māori health workforce to the health system.	Lead: Hector Tautoko: Regional leads (Hector, Harold, Phyllis, Jason)	By 30th September 2020
Maori workforce dashboard December	19. Implement an annual Māori health workforce symposium that brings together high performers in Māori health workforce development and exposes the system to this intelligence	Lead: Hector Tautoko: Phyllis, and Kerry McDougall	Proposed plan to TW by 30th September
Workforce Statement and Reporting Tumu Whakarae Position Statement or	20. Gather and review workforce KPIs on workforce (led by National CEOs table) and report on progress to TW	Lead: Taituarā Tumu Whakarae (Central TAS) Tautoko: Hector, Phyllis and Patrick	Quarterly (summary DHB report)

KEY FOCUS AREAS	ACTIONS & ACCOUNTABILITIES	LEAD	TIMELINE
Te Tohu Whakawaiora	21. Gather DHB-specific reports, summarise for TW members (# enrolled / completed, by DHB)	Lead: Taituarā Tumu Whakarae (Central TAS)	Quarterly summary report by DHB
Te Reo Maori programme	22. Review implementation of programme with Te Wananga o Awanuiarangi and report number of students by DHB	Lead: Taituarā Tumu Whakarae (Central TAS) Tautoko: Marama	Quarterly summary report by DHB
SHARING INDIGENOUS INTELLIGENCE AND EXCELLENCE			
Te Hikoi Rangahau	23. Discussion on next Hikoi Rangahau – potential timing and location	Lead: Naida Glavish, Riki Nia Nia	By 30th September
Tu Kaha Conference	24. Determine support needed from TW, and contingency plan, for convening Tu Kaha conference (originally planned for 2020)	Lead: Jason	By 31st July
HEALTH SYSTEM PERFORMANCE			
Trendly and Health Excellence Seminars	25. Disseminate Trendly reports monthly 26. Discuss findings and identify Health Excellence webinar plan for 2020 – 2021 (topic and timeline)	Lead: Dr George Gray Tautoko: Marama, Taituarā Tumu Whakarae (Central TAS)	Health Excellence Plan by 31st August
HQSC Equity Dashboard	27. Launch & implementation	Lead: Riki Nia Nia	By 30th September
Te Ara Whakawaiora	28. Summary of DHB status / reporting	Taituarā Tumu Whakarae (Central TAS)	Quarterly

Appendix 3: Ngā Hikoi Rangahau - Summaries

ATTENDEES FOR PAST ANNUAL STUDY TOURS

Tumu Whakarae Member	DHB	2015 Canada, Seattle, Portland, Alaska Hawai'i	2016 Orlando, Florida, Washington DC	2017 Alaska, Phoenix	2018 Hawai'i, Cleveland, Nashville, New York	2019 Albuquerque, New Mexico, Arizona, Nevada
1) Riki Nia Nia	CMDHB/ADHB/WDHB	✓	✓	✓	✓	✓
2) Tracee Tehuia	HBDHB	✓	✓			
3) Pania Coote	SDHB	✓				
4) Hector Matthews	CDHB	✓			✓	
5) Stephanie Turner	MCDHB	✓		✓		
6) Kim Tito	NDHB	✓				
7) Naida Glavish	ADHB/WDHB	✓	✓	✓	✓	✓
8) Jim Wiki	CCDHB	✓				
9) Gary Coghlan	WCDHB				✓	
10) Tricia Keelan	BOPDHB				✓	✓
11) Jason Kerehi	Wairarapa DHB				✓	
12) Shayne WiJohn	ADHB/WDHB					✓

Appendix 3: Ngā Hikoi Rangahau - Summaries

KEY LEARNINGS FROM EACH INSTITUTIONAL OR CONFERENCE VISIT FROM STUDY TOURS

STATE / PROVINCE	PLACE	INSTITUTION	KEY LEARNINGS
Alaska	Anchorage	South Central Foundation (SCF): Nuka System	Values-based recruitment; family-centred care (customer-owner), Nuka model
Alaska	Kenai	Kenaitze Tribal Health and Social Services, Denaina	Effective health, justice & social service integration [adapted Nuka model]
Alaska	Anchorage	National Tribal Public Health Summit (conference 2017)	Shared commitment to indigenous approaches to Public Health. Enablers and disenablers of indigenous health and wellbeing
Alaska	Anchorage	Alaska Native Tribal Health Consortium (ANTHC)	Tele-health to address remote needs; State-wide oversight models. Vision: Alaska Natives are the healthiest people in the world
Arizona	Phoenix	Phoenix Indian Medical Center (PIMC)	Largest Federally operated Indian Hospital. Relationship-Based Care model. Effective hospital monitoring systems (dashboard reporting)
Arizona	Phoenix	Desert Vision Youth Residential Treatment Center	Indigenous spiritual models of residential addiction treatment (Federal facility)
Arizona	Window Rock	Navajo Nation (Headquarters)	Tribal Government, lawmaking, investment & economic development. Exercising Sovereign Immunity
Arizona	Gallup	Gallup Indian Medical Center (IHS)	Federal Facility. Balancing walk-in client needs with scheduled care in a high need population
Arizona	Chinle	Chinle Comprehensive Care Center (IHS)	Applying the indigenous "Tapestry of Wellness" model of care
Arizona	Tuba City	Tuba City Regional Health Care Corporation	Tribally-governed; inclusion of Navajo native speaking navigators. Started own Cancer Centre
Arizona	Pinon	Pinon Health Care Center	Integration of sweat lodge with typical primary care services

Appendix 3: Ngā Hikoi Rangahau - Summaries (CONT'D)

KEY LEARNINGS FROM EACH INSTITUTIONAL OR CONFERENCE VISIT FROM STUDY TOURS

STATE / PROVINCE	PLACE	INSTITUTION	KEY LEARNINGS
Arizona	Hopi	Hopi Health Care Center	Remote health centers serving dispersed populations
Arizona	Phoenix	Gila River Health Corporation (GRHC) - Tribal	Influence of tribal leadership approach to hospital management. Ability to re-prioritise resources (e.g. tobacco taxes for health promotion)
BC Canada	Victoria	Ministry of Health, British Columbia	Resolving Federal/Provincial Health policy jurisdictions with First Nations indigenous needs
BC Canada	Surrey	Fraser Regional Health Authority	Integration of tribal leadership & culture (Blanket Ceremony of CEO to symbolize CEO commitment) with a Provincial Health Authority
BC Canada	Vancouver	St Paul's Hospital (Providence Health)	Trying to embrace cultural intelligence. Integrating faith-based hospital care models with First Nations models of care
BC Canada	Vancouver	First Nations Health Authority (FNHA)	First Nations governance of a Province-Wide First Nations health system
Florida	Orlando	National Tribal Self-Governance Conference (2016)	Tribal leaders informed and knowledgeable on legislative and policy aspects of health. Highly organised collective - use this to influence policy
Florida	Saint Lucie	Seminole Tribes of Florida	Wealth can create similar problems to poverty (e.g. access to drugs). Concierge health system doesn't protect you from risks
Hawai'i	Honolulu	Papa Ola Lokahi, Hawai'i	Coordinating State-wide efforts in Native Hawaiian health. Huge potential
Hawai'i	Manoa	University of Hawai'i at Manoa	Workforce development: Growing the Native Hawaiian medical workforce. Joint He Huliau Conference

STATE / PROVINCE	PLACE	INSTITUTION	KEY LEARNINGS
Hawai'i	Honolulu	Queens Health System	Ali'i Trust hospital system challenged to include indigenous voice in a US-governed State
Hawai'i	Maui	Hui No Ke Ola Pono (Native Hawaiian Health)	A Native Hawaiian model of care integrating medical and traditional healing
Hawai'i	Kapolei	Blue Zone Project	Multi-agency community-specific approaches to wellbeing (food supply & choices)
Hawai'i	Maui	Haleakalaa (Volcano)	Meaningfulness of significant sacred sites to indigenous wellness
Hawai'i	Kaunakakai	Na Pu'uwai (Molokai)	Indigenous-managed Kupuna day care programme example
Hawai'i	Honolulu	He Huilau Indigenous Health (conference 2016)	Evidence of indigenous approaches to health care gains that work!
Maryland	Washington DC	National Congress of American Indian (Embassy)	560 tribal national governance body: generating a collective voice on national issues / influencing policy. Very skilled
Maryland	Washington DC	National Indian Health Board (NIHB)	National Health advocacy for 560 Tribes: Policy, advocacy and coordination of voice
Maryland	Washington DC	National Council of Urban Indian Health (NCUIH)	National health advovacy for 30+ Urban indigenous health organisations
Maryland	Washington DC	Indian Health Service (IHS) HQ	Federal delivery system for Native Americans and Alaska Natives on-reservations
Maryland	Washington DC	Senate Committee on Indian Affairs (SCIA)	Political decision-making approaches to indigenous and health affairs
Nevada	Las Vegas	Evidence-Based Leadership (EBL) Conference	Using data to drive performance and oversight

Appendix 3: Ngā Hikoi Rangahau - Summaries (CONT'D)

KEY LEARNINGS FROM EACH INSTITUTIONAL OR CONFERENCE VISIT FROM STUDY TOURS

STATE / PROVINCE	PLACE	INSTITUTION	KEY LEARNINGS
New Mexico	Albuquerque	National Congress of American Indian (conference 2019)	560 tribal national governance body: generating a collective voice on national issues. Sovereign Immunity discussion
New York	Queens	Department of Health & Mental Hygiene (Health Equity Dept)	Taking a neighborhood approach to addressing equity in a metropolitan city
Ohio	Cleveland	Cleveland Clinic	International excellence; growing leadership in health care; equity approaches. 'Director of Diversity' position emphasis
Ohio	Cleveland	Global Center for Health Innovation	The shift in health technology from serving providers to serving patients
Ohio	Cleveland	Cuyahoga Health Improvement Project (Collective Impact)	Using Collective Impact to coordinate multi-agency approaches to high need communities
Ohio	Cleveland	Cleveland Leadership Center (CLC)	Creating a pipeline from school-age to grow civic leaders in a city like Cleveland
Oregon	Portland	North West Portland Area Indian Health Board (NWPIHB)	Coordinating 28 Tribal health activities to contribute to national agenda on health
Tennessee	Nashville	United South and Eastern Tribes (USET)	Using political advocacy and positioning to drive Treaty rights and obligations of Government. Highly organised
Washington	Seattle	Seattle Indian Health Board (SIHB)	Patient accessible Health Records (online patient access) in an urban setting.

Te Manawa Taki Equity Plan – Final Draft

SUBMITTED TO:

Board 19 August 2020

Prepared by: Marama Tauranga, Manukura, Māori Health Gains and Development

Endorsed and Submitted by: Simon Everitt, Interim Chief Executive, BOPDHB

☐ **For Decision** ☐ **For Discussion** ☒ **For Noting**

RECOMMENDATION:
That the Board note the final version of the Te Manawa Taki Regional Equity Plan: 2020-2023.

RECOMMENDED RESOLUTION:
That the Board notes the Regional Plan vision has a single vision of achieving Māori Health Equity which is consistent and complimentary to Te Toi Ahorangi 2030 which is fully endorsed by the Bay of Plenty District Health Board.

ASSURANCE:
N/A

ATTACHMENTS:
Draft –Te Manawa Taki Regional Equity Plan 2020-2023

DEFINITIONS USED:

Term	***Definition***
"the Board"	Bay of Plenty District Health Board, the Board
"the organisation"	Bay of Plenty District health Board, the organisation
"the DHB"	Both the Board and the organisation of Bay of Plenty District Health Board

BACKGROUND:

Te Manawa Taki is a collaborative of Māori and Iwi leaders working in unison with DHB CE's and Board Chairs who are committed to building credible, safe and competent Te Manawa Taki systems which build on strengths, prioritise kauapa Māori and mātauranga Māori solutions and models of care. Te Manawa Taki is committed to workforce, continuous quality improvement, whanau/consumer voice, investments in workforce wellbeing and building infrastructure that is agile and fit for purpose.

The Regional Equity Plan is the direct result of an enhanced, Te Tiriti o Waitangi based partnership between Iwi and five DHBs. It epitomises the value of DHBs and Iwi engaging in respectful ways, not only to embed Te Tiriti in our health and disability system but also to do what is tika/right with regard to tackling one of New Zealand's most persistent problems: Māori health inequity. Improving equity for Māori is an imperative of Article III and the Equity Principle of Te Tiriti o Waitangi.

The Regional Plan is similar in vision and philosophical underpinning to the strategic vision for Te Toi Ahorangi is 'Toi Ora' – flourishing descendants of Toi; whereby our strategy encapsulates the needs and aspirations of tangata whenua, strategically aligning with He Korowai Oranga: New Zealand Māori Health Strategy. Our vision of Toi ora and our mission Toi Tū for Te Toi Ahorangi 2030 is aligned to that of Te Manawa Taki; He kapa kī tahi - a singular pursuit of Māori health equity.

The Bay of Plenty District Health Board (BOPDHB) commitment to Te Tiriti o Waitangi articles and to meaningful engagement in decision-making with Tangata Whenua at strategic, operational and service levels is delivered through:

- Active pursuit of the Ngā Toi Au Rangi to implement Te Toi Ahorangi 2030 to transform the system.
- Prioritise people and whanau utilising a Toi Ora wellness approach to improve and address systemic issues.
- Partnering with Iwi and Māori to achieve their aspiration for health and wellbeing.
- Ensuring He Pou Oranga practice in all services of the BOPDHB; and
- Commitment to eliminating inequities in health between Māori and non-Māori.

The eight (8) Au Rangi of Te Toi Ahorangi are:

- uphold Te Tiriti o Waitangi & our indigenous rights; and
- be a Toi Ora change leader; and
- illuminate & advance Toi Ora system performance; and
- elevate Wai Ora approaches & reduce acute demand; and
- whakamana whānau with solutions embedded in aroha; and
- support iwi led development; and
- develop our Toi Ora leaders, workforce & providers; and
- invest in Toi Ora innovation.

TE MANAWA TAKI

TE MANAWA TAKI

REGIONAL EQUITY PLAN 2020-2023

Version: Final Draft

Date: July 10 2020

TE MANAWA TAKI LOGO Designed by Denise Morgan-Koia | Nativei Creative

The logo in this document has been designed for the Regional Equity Plan 2020-2023. A process is currently underway to determine a logo to be used on behalf of all iwi and DHBs in the region.

Logo Explanation

Main Shape: Manawa/Heart
Represents and more specifically, embodies the vision and values of Te Manawa Taki.

Right Side: 5 "Pulsating" Hearts
5 separate hearts (3 white, 2 grey or implied) sit inside each other to depict each DHB who make up Te Manawa Taki. Together they make up one heart, to reflect the vision and values of Te Manawa Taki.

Left Side: Ngā Pou o Te Manawa Taki.
Pouwhenua: used by Māori to mark territiorial boundaries or places of significance. Used here to represent an association between the people and the land. Specifically pouwhenua reflect the relationship between the ancestors, environment and the reputation or standing of the tangata whenua.

Within this logo 5 pouwhenua depict Te Manawa Taki - working together - He kapa kī tahi.

Cover and back page images / Ko Hikurangi te maunga: Maunga Hikurangi is the highest non-volcanic mountain in the North Island, and the first place on the New Zealand mainland to see the sun each morning.

Mihi whakataukī to be added to final version

| Ko Mauao te maunga

ENDORSEMENT WHAKAMANA

Agreed by Te Manawa Taki Governance

DHB BOARD CHAIRS AND IWI GOVERNANCE

SHARON SHEA, MNZM

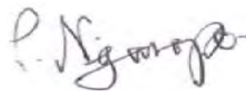
Interim

Bay of Plenty DHB

POUROTO NGAROPO, MNZM

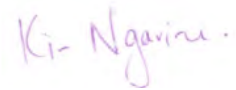
Māori Health Runanga

Bay of Plenty DHB



KIM NGĀRIMU

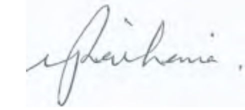
Hauora Tairāwhiti



NA RAIHANIA

Te Waiora o Nukutaimemeha

Hauora Tairāwhiti



DR JIM MATHER

Lakes DHB

AROHA MORGAN

Te Rōpu Hauora o Te Arawa

Lakes DHB

CASSANDRA CROWLEY

Taranaki DHB

TE PAHUNGA (MARTY) DAVIS

Te Whare Pūnanga Kōrero Trust

Taranaki DHB

DR KAREN POUTASI, CNZM

Commissioner

Waikato DHB

TE PORA THOMPSON-EVANS

Iwi Māori Council

Waikato DHB

TE MANAWA TAKI DHB CHIEF EXECUTIVES

SIMON
EVERITT

Bay of Plenty DHB

JIM
GREEN

Hauora Tairāwhiti

NICK
SAVILLE-WOOD

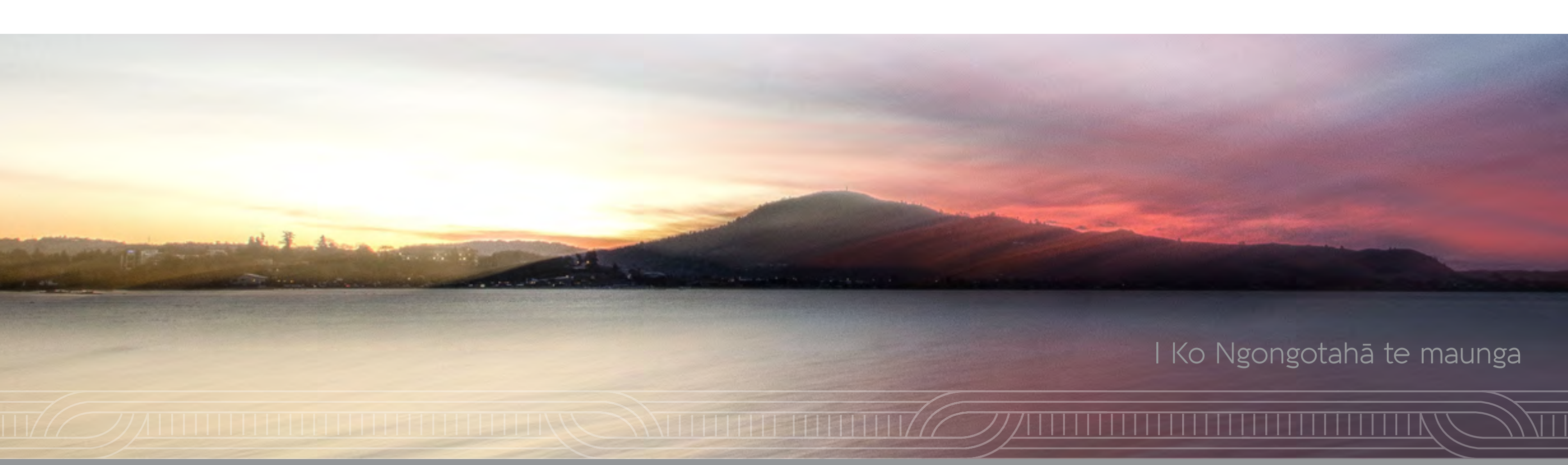
Lakes DHB

ROSEMARY
CLEMENTS

Taranaki DHB

DR KEVIN
SNEE

Waikato DHB



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27% of people in the region are Māori
(approx. 265,360 of 985,285 people; 2020/21 projections)

1 INTRODUCTION WHAKATAKINGA

Te Manawa Taki Governance Group acknowledges the support of former Governance leads in the development of this Regional Equity Plan. The equity priorities of previous Regional Services Plans and the 2019 Memorandum of Understanding between Te Manawa Taki DHBs Region Governance Group and Te Manawa Taki Iwi Relationship Board are the foundations of this Plan. The vision of Te Manawa Taki is:

He kapa kī tahi - a singular pursuit of Māori health equity.

This vision reflects that we will work in unison to achieve equity of Māori health outcomes and wellbeing through multiple means. 'Te Manawa Taki' ('the heartbeat') represents that we are always 'ready to go' and that we are willing to lead change that works, so that others may follow a proven path. To be effective regional change catalysts, we need a strong 'heartbeat' and this plan represents our next three-year journey.

This Regional Equity Plan is a significant milestone. It is the direct result of an enhanced, Te Tiriti o Waitangi based partnership between Iwi and five DHBs. It epitomises the value of DHBs and Iwi engaging in respectful ways, not only to embed Te Tiriti in our health and disability system but also to do what is tika/right with regard to tackling one of New Zealand's most persistent problems: Māori health inequity. Improving equity for Māori is an imperative of Article III and the Equity Principle of Te Tiriti o Waitangi.

The Regional Equity Plan also acknowledges that Iwi have their own aspirations over and above this plan; and DHBs have numerous accountabilities they need to meet. Within this reality, DHBs and Iwi will seek mutual ways to support each other's aspirations and accountabilities.

As a collaborative of Māori and Iwi leaders working in unison with DHBs, we are committed to building a credible, culturally safe, and competent Te Manawa Taki system. We will build upon our current strengths, prioritise kaupapa Māori and mātauranga Māori solutions and models of care, continue to build a committed workforce, challenge ourselves in terms of what we can do better and solve issues that we all know we need to work on including; continuous quality improvement, prioritising consumer/whānau voice, continuing to invest in workforce wellbeing and building a system infrastructure that is fit for purpose and agile.

We will prioritise our collective effort towards enabling people who need our support the most, to flourish, to meet their self-determined aspirations and to achieve equitable health status (as a minimum). We are clear that Māori are our priority population for this plan as they are affected by inequities the most in our region. However, we also know that we have other populations or cohorts with high needs, such as people with low socio-economic status, Pacific peoples, some rural populations, people with disabilities, and others. We will continue to support all people with high needs however, we are determined to 'shift the dial' for our valued Māori population and believe that if we can make traction for Māori, we will learn valuable lessons along the way that will support equity for all populations.

1.1 OUR DEFINITION OF 'EQUITY' | MANA ŌRITE

Our definition of Equity is aligned with all Articles and Principles in Te Tiriti o Waitangi, in particular Article III (which has an Equity focus) and the Principle of Equity[1] . It is also aligned with the United Nations Declaration on the Rights of Indigenous Peoples, which affirms the rights of Māori to determine, develop, maintain, access and administer their own institutions, programmes, medicines and practices that support optimal health and wellbeing[2] . Finally, it incorporates and enhances the Ministry of Health's definition[3] .

Te Manawa Taki's definition of Equity is focused on ensuring all people have a fair opportunity to attain their full health potential. In Te Manawa Taki, this means prioritising service delivery to achieve equity of access, equity of quality and equity of outcomes for Māori that reflects their own aspirations and needs in the context of advancing overall health outcomes. This is an urgent priority if we are to demonstrate good faith in our Te Tiriti o Waitangi-based partnership, given the status of Māori health compared with other populations:

"Equity is purposeful investment of resources that transforms pathways of disadvantage to advantage:

1. **Supports rectifying differences that are avoidable, unfair, and unjust:**
   It recognises that avoidable, unfair, and unjust differences in health are unacceptable.
2. **Proportionate investment of resources based on rights and needs:**
   It requires that people with different levels of advantage, receive proportionate investment of resources and approaches based on rights and need.
3. **Implements Te Tiriti o Waitangi in contemporary ways at system and service levels:**
   It demands a health and disability system that is committed to implementing Te Tiriti o Waitangi in contemporary ways as a catalyst for success; that our system is culturally safe, competent, and enabling of wellbeing.
4. **Success is measured by equity of access, quality and/or outcomes:**
   We will know we have achieved Equity when we see equity of access, quality and outcomes in the region; particularly for Māori and then for all others who are affected unnecessarily by disadvantage."

Equity for Māori recognises the value of tikanga (values and practices) and mātauranga Māori (worldview/traditional knowledge). We will integrate te Ao Māori into systems design, health policy, models of care and delivery of all health services. This includes recognition that patients and whānau are experts in their own right, and should have more control over their own wellbeing, and consequently, over the care they receive.

---

[1] This definition also aligns with the equity principles described in the Hauora Report on Stage One of the (Wai 2575) Health Services and Outcomes Kaupapa Inquiry - https://www.health.govt.nz/our-work/populations/Māori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry

2 United Nations Declaration on the Rights of Indigenous Peoples, Articles 23 & 24 - https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[3] The MOH definition is "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage *require different approaches and resources to get equitable health outcomes (italics added for emphasis).*"

2 ASPIRATIONS OF WHANAU NGĀ WAWATA O NGĀ WHĀNAU

Establishing a foundation for the Regional Equity Plan begins by reflecting the aspirations and expectations of Māori. The word cloud below is from the DHB Māori Health plans, which have been developed in partnership with iwi.

About | Te Manawa Taki

Te Manawa Taki covers an area of 56,728 km^2, or 21% of New Zealand's land mass.

Stretches from Cape Egmont in the West to East Cape and is located in the middle of the North Island.

Five District Health Boards: Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki, and Waikato.

Includes major population centres of Tauranga, Rotorua, Gisborne, New Plymouth and Hamilton.

985,285 people (2020/21 population projections), including 265,360 Māori (27%) and 43 local iwi groups.

Te Manawa Taki Iwi

Bay of Plenty DHB

Ngai Te Rangi, Ngāti Ranginui, Te Whānau ā Te Ēhutu, Ngāti Rangitihi, Te Whānau ā Apanui, Ngāti Awa, Tūhoe, Ngāti Mākino, Ngāti Whakaue ki Maketū, Ngāti Manawa, Ngāti Whare, Waitahā, Tapuika, Whakatōhea, Ngāti Pūkenga, Ngai Tai, Ngāti Whakahemo, Tūwharetoa ki Kawerau

26%

Lakes DHB

Te Arawa, Ngāti Tuwharetoa, Ngati Kahungunu ki Wairarapa

37%

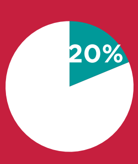
Hauora Tairāwhiti

Ngāti Porou, Ngāi Tamanuhiri, Rongowhakaata, Te Aitanga-a-Mahaki, Ngāti Kahungunu, Ngā Ariki Kaiputahi, Te Aitanga-a-Hauiti

53%

Taranaki DHB

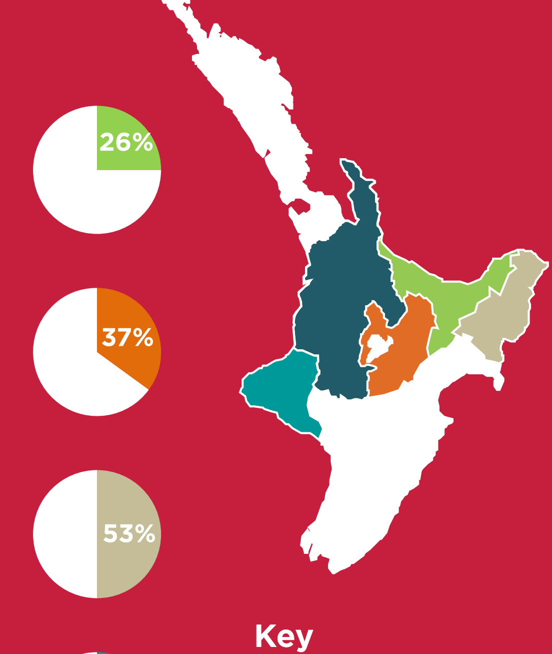
Ngāti Tama, Ngāti Mutunga, Te Atiawa, Ngāti Maru, Taranaki, Ngāruahine, Ngāti Ruanui, Ngā Rauru Kiitahi



Waikato DHB

Hauraki, Ngāti Maniapoto, Ngāti Raukawa, Waikato, Tuwharetoa, Whanganui, Maata Waka

24%



Key

- Bay of Plenty DHB
- Lakes DHB
- Hauora Tairāwhiti
- Taranaki DHB
- Waikato DHB

3 WORKING IN UNISON TE MAHI TUKUTAHI

In June 2019, Te Manawa Taki DHBs Region Governance Group and Te Manawa Taki Iwi Relationship Board signed a Memorandum of Understanding at Te Papaiouru Marae, Rotorua, to advance our working together.

3.1 OUR VALUES | Ō MĀTAU UARA

The Values of Te Manawa Taki are represented by the acronym T.A.H.I, which is also the Māori kupu (word) for the number 1. T.A.H.I reflects our commitment to achieve Equity, Māori health gain and a successful Te Tiriti embedded Partnership. These issues and those in this plan are our combined #1 priority.

T	Tautoko (mutual support) – of each other; supported by our commitment to mahi tahi (a united cause).
A	Auahatanga (innovation) – is at the centre of what we want to do; supported by our kaitiakitanga (shared guardianship of our mahi/work) role.
H	Hauora (Māori health and wellbeing) – is our priority; supported by our commitment to equity and rangatiratanga (partnered leadership) role.
I	Ihi – the power of our integrity towards each other and what we do; supported by manākitanga (mutual support), whakawhānaungatanga (working together) and whakapakari (strengthening each other).

It is through these values that we can continue to improve outcomes for Māori, where Māori have at least the same health outcomes as Non-Māori. T.A.H.I also aligns with our Vision statement, which reflects our singular commitment.

3.2 OUR VISION | **TŌ MĀTAU TIROHANGA WHAKAMUA**

Te Manawa Taki's vision is **He kapa kī tahi - a singular pursuit of Māori health equity**. It reflects that, as a region, we will work in unison in a Tiriti o Waitangi based partnership to achieve equity of Māori health outcomes and wellbeing through multiple means, including:

- A regional health system that actively prioritises achieving Māori health equity.
- Mutual respect for braiding the best of kaupapa Māori and western science best practice evidence, thinking and worldviews to benefit Māori health equity.
- Shared accountability for measuring and achieving success.
- Shared decision-making and authority.
- Shared resources (financial, technical, human, other).
- Working in partnership to create a system that enables Māori to lead solutions that are based on kaupapa Māori and mātauranga Māori.
- Creating and enabling champions to lead solutions that drive equitable outcomes for Māori.

T Tautoko

Even through sickness and illness people just kept coming [to the programme] and retaining it because they had that sense of ownership, that real connection that **it was something that they wanted and it worked for them.**

Chae Simpson *– He Pikinga Waiora Coordinator*

It's not us doing unto them, I think that's what we have to really keep in mind. It is **how do we partner**, how do we work in a way that actually facilitates the continued care of the person in the community.

Waikato DHB staff member

We need to be acknowledged and supported as we hold a **key role in the care of our whānaunga whaiora**.

Let's Talk *– Me Kōrero Tātou participant*

Auahatanga

My whānau, support people and I need **more of this education** to lessen my stress and help me recover.

Kia ora e te iwi programme participant.

We should bring services together – we should be **working together as one**.

Care in the Community wānanga (Te Kuiti) participant

As in life, **the most important thing is people**, working with people, engaging with people, constantly asking and just **being flexible enough to change things** when it doesn't work how you thought it would.

Chae Simpson *– He Pikinga Waiora Coordinator*

He kapa ki tahi

A singular pursuit of Māori health equity

Hauora

My whānau... **gathered together** with my extended whānau. They were thrust into all night and daily vigils of karakia and a lava flow of aroha.

Colleen Prentice

Knowing that **I have been given a waka to be able to row with**, now with this programme I am quite rapt with it.

Vic *- He Pikinga Waiora participant*

As Māori, we need to **exercise our guardianship over our people.**

Let's Talk *– Me Kōrero Tātou participant*

Ihi

We want to go back to the basics of spending time together and celebrating each other as a whole whānau; so, **we need the system to support and respect us** through a wellbeing approach.

Let's Talk *– Me Kōrero Tātou participant*

They **accepted and acknowledged** my Māoritanga, Ringatū faith and whānaungatanga. Having my whānau and friends at my bedside gave me strength. **For me, that was everything and a key part of my recovery.**

Thomas Mitai

We need to have a **sense of belonging** within our whānau and be supported to always have this."

Let's Talk *– Me Kōrero Tātou participant*

3.3 OUR MISSION - C3 - Co-design, Co-decide, Co-implement | TŌ MĀTAU WHĀINGA

Our Mission reflects the way we will work together to implement true Te Tiriti o Waitangi based relationships to effect sustainable and positive partnered change over time.

3.4 TE TIRITI O WAITANGI

Te Tiriti o Waitangi is the foundation of our partnership. The partnership of Te Manawa Taki iwi is realised through our governance and management structures as well as our ongoing dialogue with communities around the region. Patients and whānau have their own thoughts, feelings and desires for a health system that works for them, and it is through that conversation that we can deliver a system that people can fully engage with.

The Waitangi Tribunal[4] recommends the following principles (the recommendations below were provided in the context of primary health care delivery), which reflects the evolution in the interpretation of giving proper and full effect to Te Tiriti:

(a) The guarantee of **tino rangatiratanga**, which provides for Māori **self-determination** and mana motuhake in the design, delivery, and monitoring of primary health care.

(b) The principle of **equity**, which requires the Crown to commit to achieving equitable health outcomes for Māori.

(c) The principle of **active protection**, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

(d) The principle of **options**, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all [primary health care] services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

(e) The principle of **partnership**, which requires the Crown to work in partnership with Māori in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the [primary health] system for Māori.

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[4] Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry – pages 163-164. https://www.health.govt.nz/our-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry

The Ministry of Health's draft Te Tiriti o Waitangi framework acknowledges the text of Te Tiriti, including the preamble and the three articles, along with the Ritenga Māori declaration[5] – as the foundation for achieving the following four goals, each expressed in terms of mana[6] :

- **Mana whakahaere**: effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.
- **Mana motuhake**: enabling the right for Māori to be Māori (Māori self-determination), to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.
- **Mana tangata**: achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori**: enabling ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

Appendix 1 is an infographic of the Ministry of Health's draft Te Tiriti o Waitangi framework. This position on Te Tiriti o Waitangi was endorsed by the Director-General of Health on 9 January 2020[7].

3.5 MĀORI HEALTH EQUITY | MANA HAUORA ŌRITE

Within Te Manawa Taki, as across the nation, there are persistent inequities within different populations, especially for Māori. Key to our regional strategy is achieving Māori health equity, as well as identifying and addressing equity gaps in other populations. Many complex factors lead to poor health status. However, as a population group, Māori have on average the poorest health status of any group in New Zealand. This is unacceptable to us.

Factors such as income, employment status, housing and education can have both direct and indirect impacts on health. These impacts can be cumulative over lifetimes, and disproportionately affect Māori. It is important for the health sector to partner and provide leadership to improve the social context of health outcomes.

Based upon evidence of inequities, we will prioritise our effort in three key areas: Child Health, Cancer, and Mental Health.

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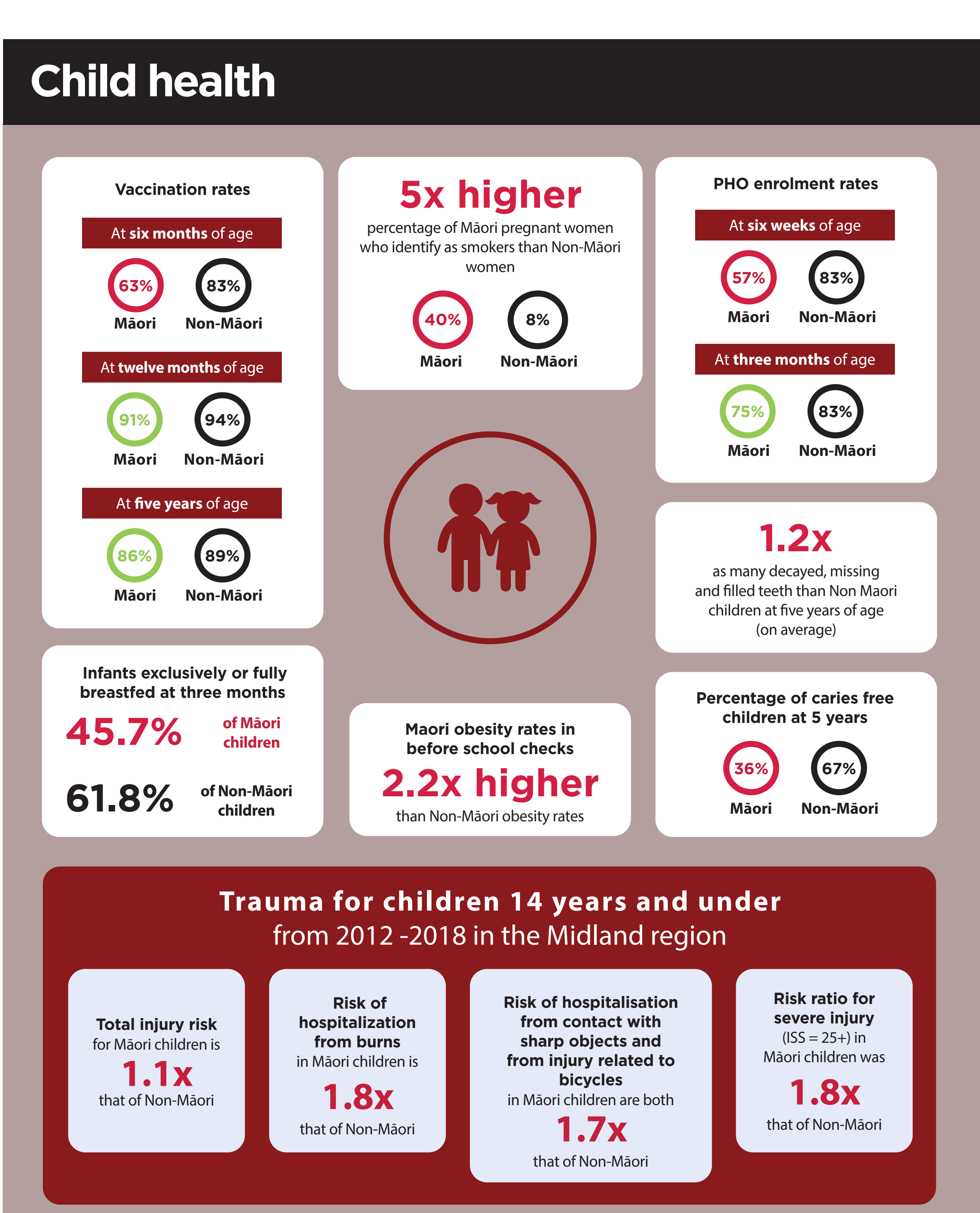
[5] Often referred to as the 'fourth article' or the 'verbal article'.

[6] Mana is a uniquely Māori concept that is complex and covers multiple dimensions.

[7] Further detail can be found in the Cabinet Officer circular CO (19) 5: Te Tiriti o Waitangi/Treaty of Waitangi Guidance 22 October 2019. https://dpmc.govt.nz/publications/co-19-5-te-tiriti-o-waitangi-treaty-waitangi-guidance

Statistics for Māori

In Te Manawa Taki



Cancer

Cancer **incidence rate** is **1.3x higher** than for Non-Māori

Lung cancer **incidence rate 3.3x higher**
Lung cancer **mortality rate 3.4x higher**
than for Non-Māori

Cancer **mortality rate** is **1.8x higher** than for Non-Māori

Of all cancers, the highest incidence for Māori are;

Lung

Breast

Urological

Breast cancer **incidence rate 1.7x higher**
Breast cancer **mortality rate 1.6x higher**
than for Non-Māori

Liver cancer **incidence rate 2.6x higher**
Liver cancer **mortality rate 3.4x higher**
than for Non-Māori

Māori

Non-Māori

Have their cancer first diagnosed following an emergency department presentation.

There is evidence that if cancer is diagnosed through an acute pathway via the emergency department, one year survival is poorer than for the elective referral pathway.

Colorectal Cancer **Incidence Rate** per 100,000

Māori

Non-Māori

Prostate cancer **mortality rate** is **1.4x higher** than for Non-Māori.

5 year survival for Māori with colorectal cancer is **lower by 11.7%** compared to Non-Māori.

Breast cancer survival (all cause mortality)

Māori

Non-Māori

Māori

Non-Māori

Faster Cancer Treatment Indicators:

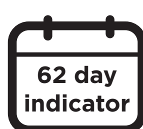
2013/14 | **2018/19**

Māori

Non-Māori

Māori

Non-Māori



Māori

Non-Māori

Māori

Non-Māori

Maori achievement against FCT targets better than Non-Maori.

Mental health

Māori adults are

more likely to have **experienced psychological distress** as Non-Māori

more likely to report a high or very high probability of having an **anxiety or depressive disorder**.

Whānau support

Increase in contacts last 5 years

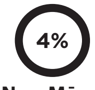
Māori

Non-Māori

Mental Health Contacts

All services and all ages
% of population

Māori



Non-Māori

All services 20-50 year olds
% of population

Māori

Non-Māori

Seclusions

per 100,000 population

Māori

Non-Māori

Alcohol & Drug Contacts

All ages% of population

Māori

Non-Māori

Number of clients under section 29 (compulsory community treatment order) per 100,000 people per year

291.4 Māori **85.4** Non-Māori

Individuals on MH section 29 per 100k population

Left axis: 0, 20, 40, 60, 80, 100, 120, 140
Right axis: Maori/Non-Maori 0.0, 0.5, 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, 5.0

Quarters: 2013 - Q1 to 2019 - Q4

Maori s29 per 100k population — Non Maori s29 per 100k population

Suicide rates

per 100,000 population
All ages

Māori

Non-Māori

Males 15-24yo

Māori

Non-Māori

Māori have the **highest rate** of mental health and addiction service use

3.6 LINE OF SIGHT | TIROHANGA TŌTIKA

National

Te Tiriti o Waitangi	Government Goal	Government Priority outcomes	Health System Vision	Health and Disability priority areas	Minister of Health system priorities
• Partnership • Tino rangatiratanga • Active protection • Options • Equity	Improving the wellbeing of New Zealanders and their families.	• Ensure everyone who is able to, is earning, learning, caring or volunteering. • Support healthier, safer and more connected communities. • Make New Zealand the best place in the world to be a child.	• Pae Ora Healthy Futures.	• Governance • Sustainability • Service performance • Embed Te Tiriti o Waitangi and achieve pae ora (healthy futures) for Māori. • Achieving equity • Financial performance and responsibility • Capital investment • National Asset Management Plan • Service user councils	• A strong and equitable system • Support wellbeing through prevention • Primary care support • Child wellbeing activities • Mental wellbeing activities • Areas of high inequity, and priority equity measures/targets

Te Manawa Taki

Values	Vision	Mission	Settings	Three-year Action Plan
Tautoko mutual support Auahatanga innovation Hauora Māori health & wellbeing Ihi power of our integrity	He kapa kī tahi – A singular pursuit of Māori health equity.	C3 Co-design Co-decide Co-implement	Governance structures	Regional Equity Action Plan (REAP)

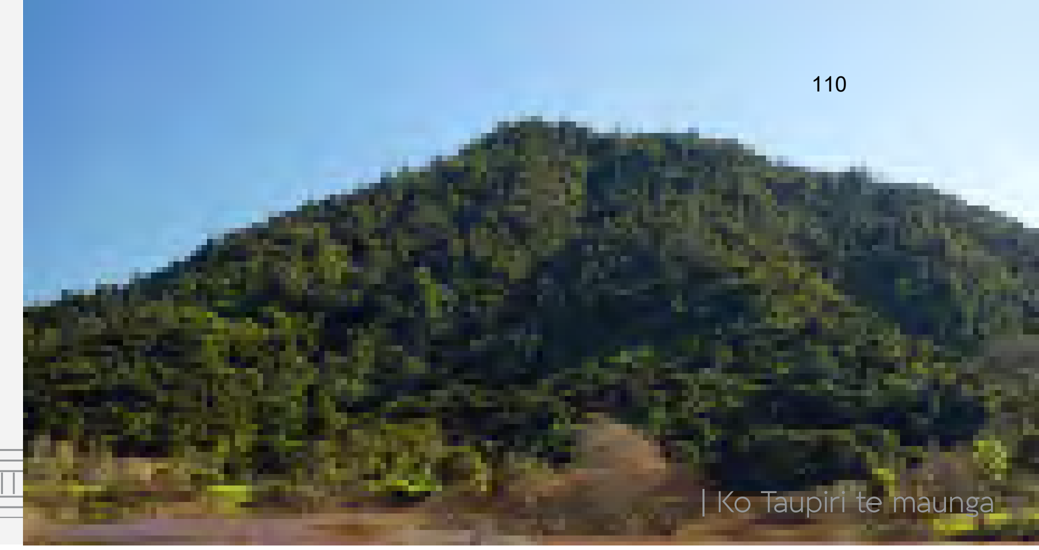
Services	Connector groups	Te Manawa Taki DHBs
Regional service areas & Networks, and shared services • Cancer • Cardiac • Child Health • Healthy Ageing • Hepatitis C • Mental Health & Addictions • Planned Care • Public Health Network • Radiology • Renal • Stroke • Trauma	• Pathways of Care • Quality • Workforce • Data & Digital	• Vision • Mission • Values • Goals and aspirations • Strategic focus & priorities • Overarching outcomes

Line of sight – DHB region strategic vision, values and plans

Appendix 2 includes a description of the key regional Plans and Strategy documents in each DHB region.

Bay of Plenty	
Bay of Plenty three strategic objectives	Live Well: Empower our populations to live healthy lives. Stay Well: Develop a smart, fully integrated system to provide care close to where people live, learn, work and play. Get Well: Evolve models of excellence across all our hospital services.
	Working collaboratively, we will create healthy, thriving communities by proactively addressing the needs of our family and whānau with services that are well-coordinated, holistic and provided as close to home as possible.
Te Toi Ahorangi – Te Runanga Hauora Māori o te moana ā toi / Bay of Plenty DHB	Pou Ora, change principles that affirm our intent and determination towards Toi Ora – flourishing descendants of Toi – the shared vision of the seventeen iwi of Te Rūnanga.
	Toi Tu te Kupu – Uphold our Word: Affirms we will uphold our word and aspirations as iwi and the Crown through an authentic Te Tiriti o Waitangi partnership. Toi Tu te Mana – Uphold our Power: Affirms He Pou Oranga, the sources of mana that lead to Toi Ora. Tangata whenua self-determination, aspirations and worldview will be valued and invested in across Te Moana a Toi. Toi Tu te Ora – Uphold our Vision: Guides our direction towards Toi Ora. Toi Ora drives a whole of system approach that enables flourishing from preconception throughout the lifecourse.
Hauora Tairāwhiti	
Hauora Tairāwhiti values	The Values form the acronym WAKA. They reflect our past while guiding us on our journey to create a healthier Tairāwhiti by working together - Whāia te hauora i roto i te kotahitanga (the Tairāwhiti vision). Whakarangatira/enrich: Enriching the health of our community by doing our very best. Awhi/support: Supporting our ruroro/patients and their whānau/families, our community partners and each other. Kotahitanga/togetherness: Together we can achieve more. Aroha/compassion: Empathy, we care for people and people want to be cared for by us.
Lakes	
Lakes DHB Strategy	Vision: Healthy Communities – Mauriora! Values: Manaakitanga, Integrity, Accountability
	Strengthen people, whānau & community wellbeing – Te whakareinga i to oranga o te tāngata, te whānau me te hapori. Achieve equity in Māori health – Te taeatanga tika o te hauora Māori. Build an integrated health system – Nga Herenga tika i roto i te pūnaha.

Taranaki	
Taranaki Health Plan	Collectively the Plan's six focus areas will rebalance capacity through resource reallocation across the system and contribute to the following benefits; Enhanced patient experience, Improved population health and equity, Improved value for money, Strengthened system resilience.
	Helping our people to live well, stay well and get well. Integrating our care models through a one team, one system approach. Using our community resources to support hospital capacity. Using analytics to drive improvements in value. Developing a capable, sustainable workforce matched with health need and models of care. Improving access, efficiency, and quality of care through the manage uptake of new technologies.
Waikato	
Waikato DHB Strategy	Vision: Healthy people, excellent care. Values: People at heart – Te iwi Ngakaunui;Give and earn respect/Whakamana, Listen to me talk to me/Whakarongo, Fair play/Mauri Pai, Grow the good/Whakapakari, Stronger together/Kotahitanga. Mission: 'Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery'
	Whanaketanga – Productive partnerships Pae taumata – A centre of excellence in learning, training, research and innovation Ratonga a iwi – Effective and efficient care and services Manaaki – People centred services Haumaru – Safe, quality health services for all Oranga – Health equity for high need populations
Waikato Health System Plan – Te Korowai Waiora	Putting the Waikato DHB Strategy and the Waikato DHB Iwi Māori Health Strategy, Ki te Taumata o Pae Ora, into action. Vision for the future – a whānau and family focussed approach to health and wellbeing. Goals for the next ten years; Partner with Māori in the planning and delivery of health services, Empower whānau to achieve wellbeing, Support community aspirations to address the determinants of health, Improve access to services, Enhance the capacity and capability of primary and community health care, Strengthen intermediate care, Enhance the connectedness and sustainability of specialist care. Supporting activities to achieve the goals; Leadership & partnerships, Commissioning, Workforce development, Technology & information, Quality improvement.
Waikato DHB Iwi Māori Health Strategy	Ki te Taumata o Pae Ora A focus on the Whānau Ora approach to improving the wellbeing of whānau as a group and addressing individual needs within the context of whānau and iwi.



3.7 GOVERNANCE STRUCTURES | HANGANGA WHAKAHAERE

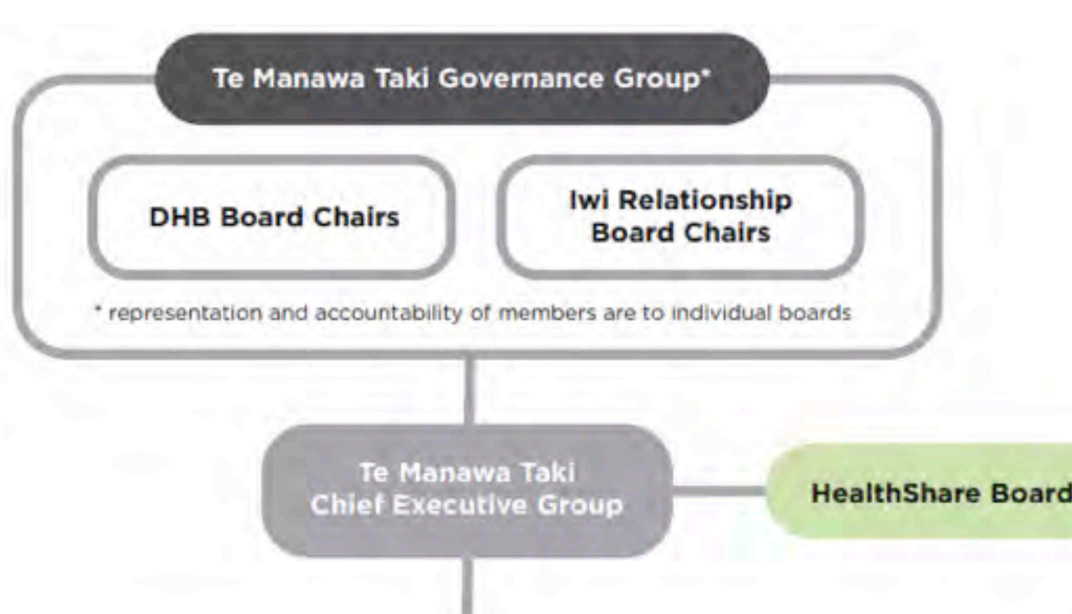
Te Manawa Taki Governance Group is the overarching governance group for the region, overseeing and holding accountability for regional direction, strategy, and key programmes of change. Membership is the five Chairs of Te Manawa Taki DHBs and five Chairs of Te Manawa Taki Iwi Relationship Board. This 50:50 composition reflects a Te Tiriti of Waitangi-based partnership.

Each DHB Chair is accountable to their DHB Board and is responsible for informing their DHB of matters of significance, including risk and mitigation strategies, for matters arising from the group's deliberations.

Te Manawa Taki Iwi Relationship Board comprises the five Chairs and Deputy Chairs of each mandated DHB iwi group collective: Bay of Plenty – Te Rūnanga Hauora Māori o te Moana Ā Toi; Lakes – Te Rōpu Hauora o Te Arawa and Ngāti Tūwharetoa; Hauora Tairāwhiti – Te Waiora o Nukutaimemeha; Taranaki – Te Whare Pūnanga Kōrero Trust; Waikato – Iwi Māori Council.

The Te Manawa Taki Chief Executive (CE) Group oversees regional collaboration. The five DHBs of Te Manawa Taki - Bay of Plenty, Lakes, Hauora Tairāwhiti, Taranaki and Waikato – have a history of co-operating on issues of regional importance and on new programmes of change. Regional clinical networks and forums, executive forums, and workforce are linked to Te Manawa Taki CE Group through a DHB CE lead (as sponsor) and through regular reporting to the Te Manawa Taki CE Group.

HealthShare Ltd is the shared services agency for Te Manawa Taki DHBs and is a limited liability company with the five DHBs holding equal shares.



Cancer Control Authority
Cardiac Clinical Network
Child Health Action Group
Health of Older People Action Group
Regional Integrated Hepatitis C Service
Regional Mental Health & Addiction Network
Pathways of Care
Planned Care
Regional Public Health Network
Radiology Action Group
Stroke Network
Midland Trauma System

Regional DHB Executive Forums:
Includes Chief Operating Officers, GMs, Planning & Funding, Nga Toka Hauora (GMs Māori Health), Chief Financial Officers, Chief Information Officers (Information Services Leadership Team), Information Security, Privacy Governance Group, GMs Human Resources, Regional Quality & Safety and Data Governance Group

4 WORKING TOGETHER TE MAHI NGĀTAHI

4.1 THREE-YEAR STRATEGIC PLAN | **MAHERE RAUTAKI TORU TAU**

The table below shows a three-year plan which sets out the region's priorities and direction[8] . Part of this work is the Regional Equity Plan (this document), which describes the region's annual operational plan to achieve equity.

Through the 'Settings' work, Te Manawa Taki's Te Tiriti inspired governance group (Te Manawa Taki Governance Group) demonstrates shared leadership and decision-making which contributes to Māori health equity.

'Services' relates to the Governance-level oversight of activity undertaken by regional Networks and Groups (as per regional annual workplans). Te Manawa Taki Governance Group have identified three priority Service areas for achieving equitable health outcomes for Māori: mental health, child health and cancer.

'Collaboration' describes Governance-level oversight of activity that achieves equitable systems and connectivity within the regional health sector. This work is in alignment with the annual workplans of the relevant regional groups – such as regional HR and workforce leads for activity relating to workforce development and institutional racism/bias.

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[8] A programme plan will be developed Q1 20/21. Individualised project plans will include milestones, timeframes & completion dates.

Priority work that will contribute to Māori health equity:	What are the equity aims for this work?
Settings:	
Hauora outcomes framework: Nga Toka Hauora (via CEOs) to work with colleagues and iwi to co-design and co-decide a hauora outcomes framework. - All regional action plans and data collection/reporting to align. Equity strategies: Developed & incorporated into regional planning (Lead: Nga Toka Hauora) - Ensure plans based on a common regional strategy and definition of Māori health equity.	- Prioritises a te ao Māori worldview and whānau voice, ensuring the framework and data is relevant and is meaningful for Māori iwi, hapū and whānau. - Clear and evident data supports regional effort to measure achievement (or not) of Māori health equity. - Data is available and relevant to iwi in Te Manawa Taki.
DHB Planning & Funding Managers (via CEOs) to work with Nga Toka Hauora and iwi to co-develop a new and innovative Hauora Commissioning Framework. - CEOs to apply the framework to commission health services using the optimal mix of cultural and clinical specificity.	
Data: Data is used to monitor and improve performance, and to measure impact: - All regional action plans to include Māori health needs analysis, outputs and outcomes data, and Māori health equity targets. - Data sets to align with Māori health priorities and include supporting information such as ethnicity and iwi affiliation.	
Equitable funding strategies: Funding strategies agreed, implemented, and monitored. - CFOs (via CEOs) with GMs P&F and COOs to complete a current state analysis of existing investment in kaupapa Māori[9] health services, primary and community care and secondary/tertiary/quaternary care.	- Investment strategies to support equitable funding[10], result in measurable increased investment in services and/or enablers for Māori health. - Enhanced ability of DHBs and the regional system to invest equitably & strategically (including based on multi-year investment targets) in services that prioritise Māori health outcomes.

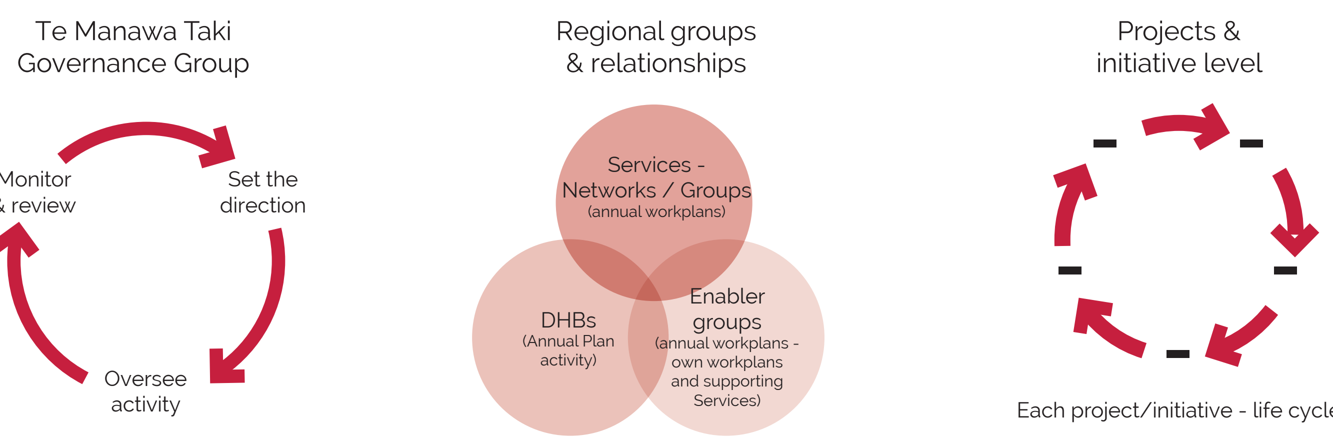
[9] Kaupapa Māori health services are those that are delivered by Māori health providers and aligned with a te ao Māori worldview.

[10] Examples, ringfencing, top-slicing, disinvestment and reinvestments, formulaic analysis, etc.

Services:	
Action Plans: Oversight and monitoring to ensure action plans are implemented on time: - Plans to be explicit about how to improve Māori health equity unless this requirement is formally excluded by Te Manawa Taki Governance Group within the next three years. - Plans to align with agreed Māori health priorities and health priority indicators.	- Practical implementation of Te Tiriti o Waitangi obligations and opportunities. - Clear and evident plans support collaborative regional effort to achieve Māori health equity. - Implementation of wellbeing plans – with agreed investment options – for priority Māori health equity areas of mental health, child health and cancer.
Regional investment: Prioritised investment into agreed services to improve outcomes. - Collaborative development of regional wellbeing plans (including aims, priorities, and investment options) for priority areas of mental health, child health and cancer. - Regional investment pool agreed.	
Collaboration:	
Māori workforce framework: Develop and implement the national targets, at a regional level, for Māori workforce development. - Strategies identified based on current status and needs assessment across the recruitment and retention pipeline.	- Implementation of strategies to ensure a DHB workforce that reflects the needs and aspirations of Māori communities[11]. - Māori capacity built to meet whānau Māori health needs and regional Māori population.
DHB Human Resources Managers (via CEOs) to work with Nga Toka Hauora to co-develop a regional plan to eliminate institutional racism/bias. - A shared regional plan with strategies from culture shift through to workforce development and human resource processes, provider development, service delivery expectations, and contractual requirements.	- A culturally safe health system that optimises Māori health outcomes and equity, including equity as a KPI in employment contracts. - Reports show strategy targets are on track for actual and continued reduction in perceived institutional racism.
Provider development: Purposefully build provider capacity and capability with the view to scale investment and targeted growth. - Common and unique Māori and Non-Māori health provider strategies identified and implemented based on current provider landscape, needs assessment, fiscal and service implications.	- Māori provider capacity built to meet whānau Māori health needs. - Māori providers are sustainable, and people have more choice to access providers who deliver (amongst other things) kaupapa Māori models of care. - More opportunity for integrated care and partnerships between Māori and other healthcare providers in the system.

[11] Note that, in time, we would like to expand this analysis and targets to the whole system, not just DHBs.

4.2 RELATIONSHIP BETWEEN REGIONAL STRATEGIC PRIORITY WORK AND ANNUAL WORKPLAN ACTIVITY/IMPLEMENTATION
TE WHANAUNGATANGA I WAENGANUI I TE MAHI WHAKAAROTAU RAUTAKI Ā-ROHE ME TE WHAKATINANA I TE MAHERE MAHI Ā-TAU



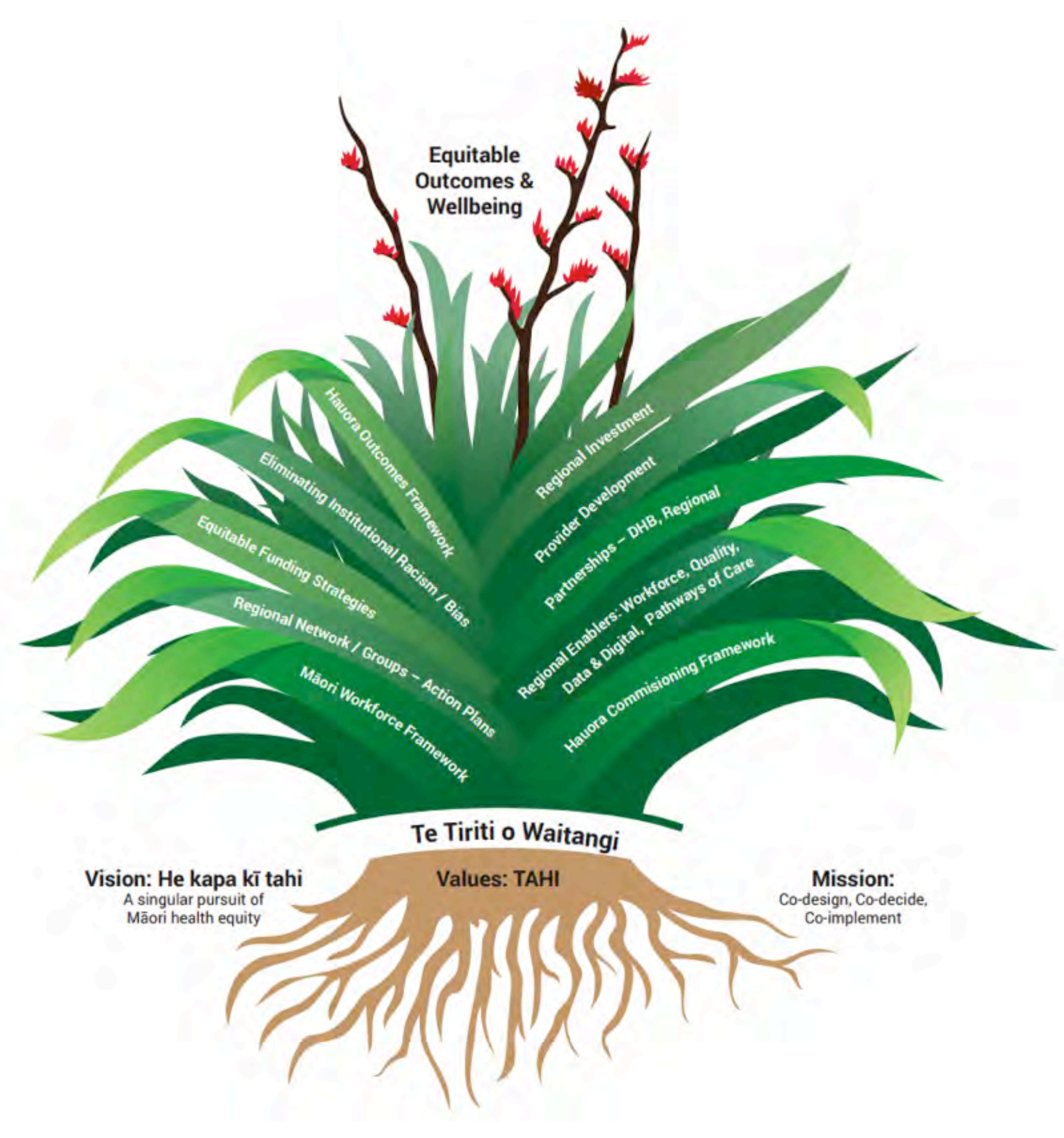
SETTINGS			
Hauora outcomes framework	Ensures a common Hauora view and strategy.	Interpret and define priorities.	Implement priority outcomes.
Commissioning framework			Apply optimal cultural/clinical mix.
Data	Shared data definitions, targets, status view.	Monitoring, collation/reporting, data-driven improvement	Data collection and reporting.
Equitable funding strategies	Shared strategy agreed, implemented, monitored.	Prioritise available funding in line with Hauora frameworks.	Implementation of agreed approach.
SERVICES			
Action plans	Ensure equity focus in all plans, & priority Services.	Develop/align all action plans with Māori health priorities.	Achieve tangible health outcomes.
Regional investment	Monitor investment aligned with funding strategy.	Responsible for implementation and reporting.	Increase priority services/enablers.
COLLABORATION			
Māori workforce framework	Strategies to implement national targets.	Establish approach across recruitment/retention pipeline.	Attract & retain workforce.
Eliminate institutional racism/bias	Agreement and implementation of workforce/other multi-year strategies for cultural change at all levels.		
Provider development	Provider strategies	Sustainability, capacity development, integrated care & partnerships.	Implement and localise strategies.

* Refer to the Addendum to the Regional Equity Plan for detail of priority annual workplan activity related to the REAP and Māori health equity.

4.3 CONNECTIONS AND PARTNERSHIPS | HONONGA, RANGAPŪTANGA

A unified approach is critical to achieving health equity for our Māori populations, and hauora (health and wellbeing) for everyone in Te Manawa Taki. The regional vision, values and mission guide our common work, with Te Tiriti o Waitangi as the foundation of our partnership with Māori iwi and whānau.

Through the Three-year Strategic Plan, Te Manawa Taki Governance Group sets the direction and strategies we deliver through the annual workplans of our regional groups, networks, and partnerships. The addendum to the REP includes the Māori health equity elements of Network and regional group workplans for Te Manawa Taki.



4.4 COVID-19 RESPONSE | URUPARE MATE KORONA

The COVID-19 response demonstrates Te Manawa Taki values and partnership in action. This includes local solutions using kaupapa Māori models to enhance health and wellbeing. A rapid escalation and engagement at the early stages of the COVID-19 response has laid the foundation for recovery and a transition to the 'new normal'. Iwi, health sector staff, other essential services and community, private and government stakeholders continue to put in an exceptional effort to ensure the region is ready and resilient, which includes the following activities:

T TAUTOKO

- Recovery planning, including electives and outpatient clinics.
- Risk mitigation.
- Governance relationships and stakeholder engagement.
- Expanding circles of influence through coordination between iwi, DHBs, Council, PHOs/primary care, local stakeholders.
- Rapid, coordinated co-design between DHBs and iwi.
- Blended and shared resources, facilities, and teams.

AHUATANGA

- Māori health engagement with incident management to maintain an equity lens on all activities.
- Recovery planning, including electives and outpatient clinics and operational & quality improvement.
- Maintaining/transitioning activities to telehealth and online technology.
- Flexibility & focus on remote Māori health through mobile Community Based Assessment Centres (CBACs).
- Development of health and wellbeing centres and outreach services alongside CBACs.

HE KAPA KĪ TAHI - A singular pursuit of Māori health equity

- Strategic focus on Māori health.
- Supporting remote communities through telehealth/online connectivity and access.
- Iwi and Māori community leaders as connectors for health engagement with many communities.
- Use of localised Harti Hauora/whānau ora models of care.
- Service and programme development that centres around whānau, strengthening Kaupapa Māori and Whānau ora approaches.

HAUORA

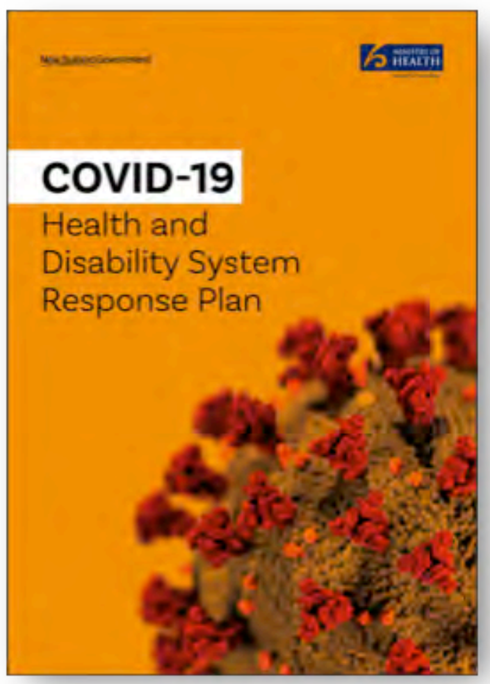
- Mutual support and readiness for any future COVID-19 surge.
- Relationships, iwi partnerships and iwi-led initiatives.
- DHB responsibility as a major employer and local economic driver.
- An environment of trust at all levels.
- Ongoing coordinated work broadens and deepens relationships.

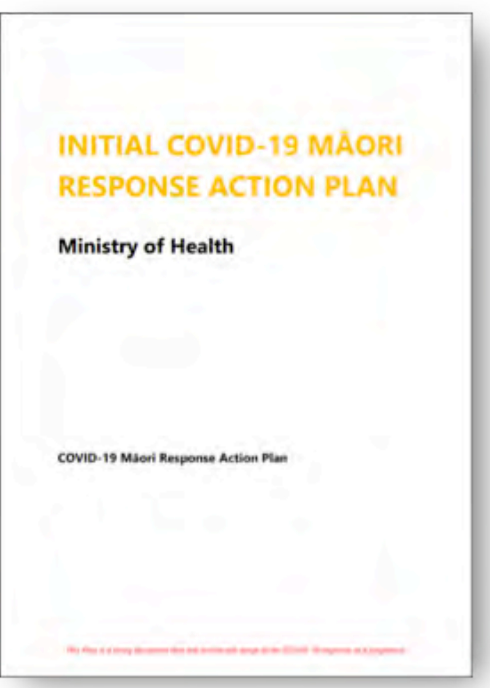
IHI

NATIONAL COVID-19 GUIDANCE

The national and international response to the pandemic is quickly evolving. Te Manawa Taki continues to respond to this event with a unified approach – sharing initiatives and learnings, clarifying opportunities for shared preparedness and to assist each other, and as well as monitoring the impact of this pandemic on our regional strategic goals and annual workplans.

The COVID-19 Health and Disability System Response Plan[12] identifies Māori as a priority for support, emphasises equity and active protection as central to the national response, and reiterates the obligations of the Crown under Te Tiriti o Waitangi.
The Initial COVID-19 Māori Response Action Plan[13] sets out a strategic approach and suite of actions that the COVID-19 response can adopt to uphold Te Tiriti o Waitangi and support the achievement of Māori health equity.



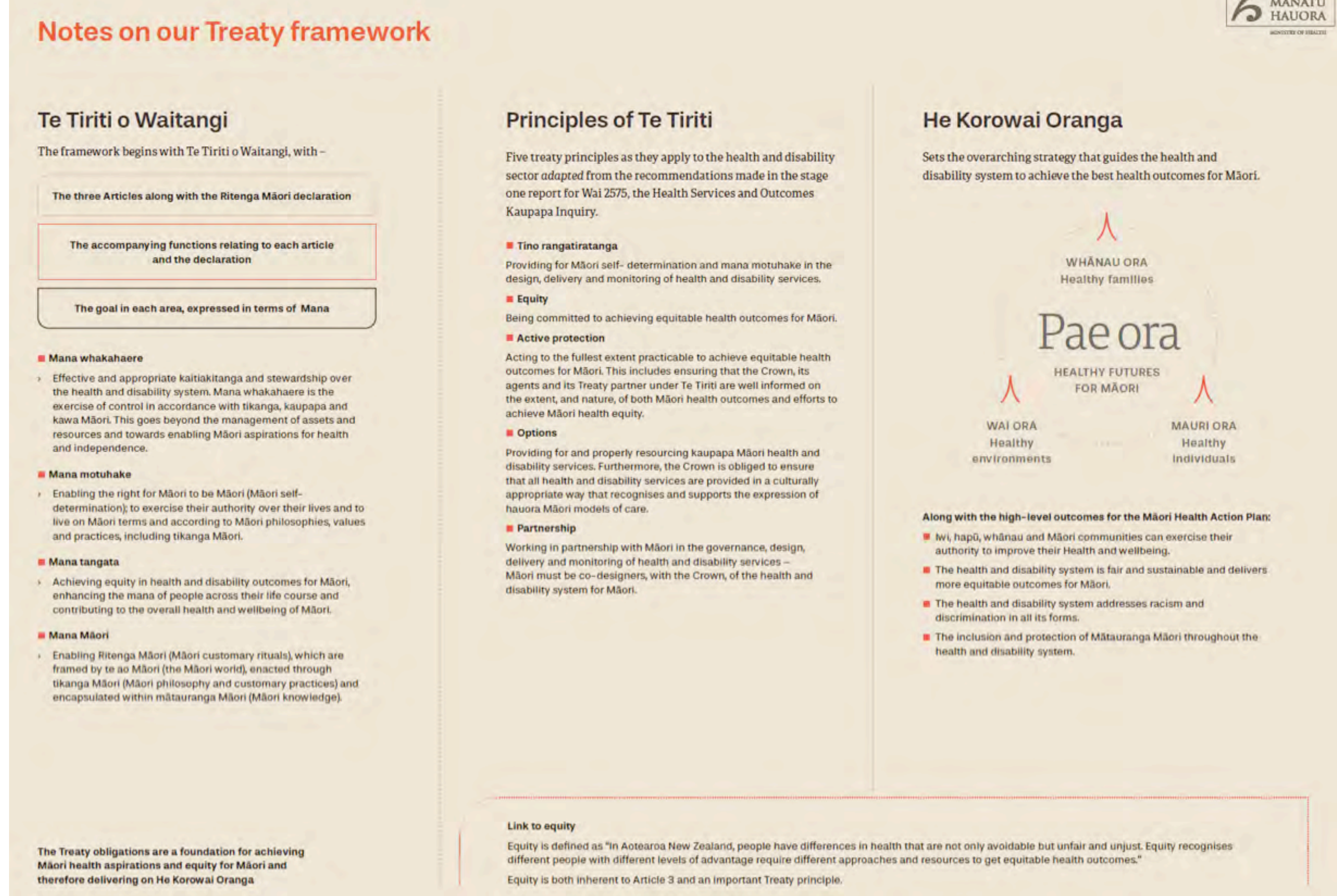


[12] COVID-19 Health and Disability System Response Plan (2020). Wellington: Ministry of Health – first published online 15th April 2020 - https://www.health.govt.nz/publication/covid-19-health-and-disability-system-response-plan.

[13] Initial COVID-19 Māori Response Action Plan (2020). Wellington: Ministry of Health – first published online 16th April 2020 - https://www.health.govt.nz/publication/initial-covid-19-Māori-response-action-plan.

APPENDIX 1

Ministry of Health's draft Te Tiriti o Waitangi framework


MANATŪ HAUORA
Notes on our Treaty framework
Te Tiriti o Waitangi
The framework begins with Te Tiriti o Waitangi, with –
The three Articles along with the Ritenga Māori declaration
The accompanying functions relating to each article and the declaration
The goal in each area, expressed in terms of Mana
Mana whakahaere
Effective and appropriate kaitiakitanga and stewardship over the health and disability system. Mana whakahaere is the exercise of control in accordance with tikanga, kaupapa and kawa Māori. This goes beyond the management of assets and resources and towards enabling Māori aspirations for health and independence.
Mana motuhake
Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives and to live on Māori terms and according to Māori philosophies, values and practices, including tikanga Māori.
Mana tangata
Achieving equity in health and disability outcomes for Māori, enhancing the mana of people across their life course and contributing to the overall health and wellbeing of Māori.
Mana Māori
Enabling Ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).
The Treaty obligations are a foundation for achieving Māori health aspirations and equity for Māori and therefore delivering on He Korowai Oranga
Principles of Te Tiriti
Five treaty principles as they apply to the health and disability sector adapted from the recommendations made in the stage one report for Wai 2575, the Health Services and Outcomes Kaupapa Inquiry.
Tino rangatiratanga
Providing for Māori self- determination and mana motuhake in the design, delivery and monitoring of health and disability services.
Equity
Being committed to achieving equitable health outcomes for Māori.
Active protection
Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
Options
Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
Partnership
Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the health and disability system for Māori.
He Korowai Oranga
Sets the overarching strategy that guides the health and disability system to achieve the best health outcomes for Māori.
WHĀNAU ORA
Healthy families
Pae ora
HEALTHY FUTURES FOR MĀORI
WAI ORA
Healthy environments
MAURI ORA
Healthy individuals
Along with the high-level outcomes for the Māori Health Action Plan:
Iwi, hapū, whānau and Māori communities can exercise their authority to improve their Health and wellbeing.
The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
The health and disability system addresses racism and discrimination in all its forms.
The inclusion and protection of Mātauranga Māori throughout the health and disability system.
Link to equity
Equity is defined as "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."
Equity is both inherent to Article 3 and an important Treaty principle.

APPENDIX 2 REGIONAL CONNECTIONS AND PARTNERSHIPS

2.1 DHB AND REGIONAL PARTNERSHIPS

The annual Service-level workplans of regional Networks and Groups align with the priorities and initiatives in DHB Annual Plans and Strategic Plans. DHBs identify significant individual DHB actions in Annual Plans that contribute to the Ministry's Regional Services Plan priorities[1] .

Senior DHB management roles and groups confirm priorities and direction, endorse regional Network and regional group workplans and strategy, define, review and agree on the scope of priority work, provide funding, and support, resource, oversee and monitor the implementation of workplan activity as appropriate.

Key DHB partners include DHB General Managers Strategy/Planning and Funding, Chief Operating Officers and Chief Financial Officers. This regional partnership is also expressed through DHB membership within regional Networks and Groups, including the role of DHB Chief Executive Leads and clinical Chairs.

The Lakes DHB Annual Plan[2] outlines the role and functions of DHBs:

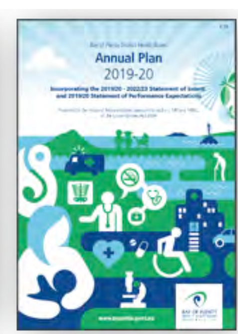
- works with key stakeholders to plan the strategic direction for health and disability services,
- plans regional and national work in collaboration with the National Health Board and other DHBs,
- funds the provision of the majority of the public health and disability services in the district, through the agreements with providers,
- provides hospital & specialist services primarily for our population and also for people referred from other DHBs,
- promotes, protects and improves our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

The Regional Equity Plan priorities align with DHB Annual Plans and strategic planning, in particular with a focus on Māori health equity. This aligns with the Government's expectations for DHBs and their subsidiary entities, including ensuring that actions that DHBs commit to in plans "contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention."

[1] Hon Dr David Clark – Letter of Expectations for district health boards and subsidiary entities for 2020/21, emailed 10/03/2020 - https://nsfl.health.govt.nz/system/files/documents/pages/2020-21_ministers_letter_of_expectation.pdf

[2] Lakes DHB Annual Plan 2019/20 - http://www.lakesdhb.govt.nz/Resource.aspx?ID=48964

2.1.1 BAY OF PLENTY DHB



The Bay of Plenty DHB Annual Plan 2019/20[3] outlines its vision of **Healthy, Thriving Communities – Kia Momoha Te Hāpori Oranga**. The Bay of Plenty Strategic Health Services Plan 2017-27[4] sets the scene for what the Bay of Plenty DHB's focus is on to support its communities to be healthy and thriving, and to live well, stay well and get well.

The Bay of Plenty and the Māori Health Rūnanga (the seventeen iwi governance representatives of Te Moana ā Toi), are affirming their Te Tiriti o Waitangi partnership by advancing a new Māori Health strategy. Endorsed by the Bay of Plenty Board, Te Toi Ahorangi 2030[5] provides a strategic framework that describes a unified vision, voice and intention to successfully influence health and wellbeing outcomes for tangata whenua and all people living in Te Moana ā Toi, from preconception throughout the life course.

Creating our Culture and Clinical Governance and Quality are the other two strategic priorities guiding the work at the Bay of Plenty DHB.

2.1.2 HAUORA TAIRĀWHITI

The Hauora Tairāwhiti Annual Plan[6] outlines the Board's vision **of Whāia te hauora i roto i te kotahitanga – a healthier Tairāwhiti by working together.**

The primary area of focus for Hauora Tairāwhiti is achieving equity, with a goal to achieve the happiest, healthiest children in the world in Tairāwhiti within one generation. .

Hauora Tairāwhiti has four key ingredients to achieving equity; Supporting iwi to take a leadership role, Enhancing understanding of equity, Questioning current disparities at every opportunity, Recognising that large proportions of the population are leading privileged lives. Other areas of focus are sustainability, workforce, and collaboration.

The Hauora Tairāwhiti values are Whakarangatira/enrich, Awhi/support, Kotahitanga/togetherness, Aroha/compassion. These values form the acronym 'WAKA'. They reflect our past while guiding us on our journey[7].

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[3] BoP DHB Annual Plan 2019-20 – https://www.bopdhb.govt.nz/media/62907/bopdhb-annual-plan-2019_20-b.pdf

[4] Bay of Plenty Strategic Health Services Plan 2017-2027 - https://www.bopdhb.govt.nz/media/60567/bop-strategic-health-services-plan.pdf

[5] Te Toi Ahorangi – Te Rautaki a Toi Ora 2030 – Te Reo and English versions - https://www.bopdhb.govt.nz/m%C4%81ori-health/m%C4%81ori-health/

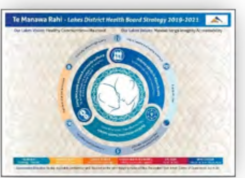
[6] Hauora Tairāwhiti Plan - https://www.hauoratairawhiti.org.nz/assets/Uploads/2019-20-Hauora-Tairawhiti-Annual-Plan.pdf

[7] Hauora Tairāwhiti kaupapa and values - https://www.hauoratairawhiti.org.nz/about-us/who/our-kaupapa-and-values/

2.1.3 LAKES DHB

Te Manawa Rahi – the Lakes DHB Strategy 2019-2021[8] outlines the vision of **Healthy Communities – Mauriora!** and Values of Manaakitanga – Integrity, Accountability. Lakes DHB identifies the interlinking mechanisms in the path to achieving equity in Māori health; Health System Improvement, Population Health Improvement and Social Determinants of Health Improvement.

The Strategy identifies work towards the following objectives; Te taeatanga tika o te hauora Māori – achieve equity in Māori health, Ngā Herenga tika I roto I te pūnaha hauora – build an integrated health system, te whakareinga I te oranga o te tāngata, te whānau me te hapori – strengthen people, whānau & community wellbeing.



2.1.4 TARANAKI DHB

The Taranaki DHB Annual Plan[9] outlines the shared vision of **Taranaki Whanui He Rohe Oranga – Taranaki Together, a Healthy Community.**

The Taranaki Health Action Plan 2017-20[10] provides an overarching framework for the Taranaki health system, with a 10-year vision, underpinned by a targeted three-year programme of work.

Through its six focus areas and their headline actions, the following benefits are expected; Enhanced patient experience, improved population health and equity, improved value for money, and strengthened system resilience.

The DHB is committed to Kia tū rangatira ai ngāi Māori ki te ara kakariki – journey to the greens, a metaphoric reference to transforming the dashboard of Māori health priority indicators from red to green.

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[8] Te Manawa Rahi – Lakes DHB Strategy 2019-2021 - http://www.lakesdhb.govt.nz/Resource.aspx?ID=47625

[9] Taranaki DHB Annual Plan 2019/20 - https://www.tdhb.org.nz/misc/documents/Annual_Plan_2019-2020.pdf

[10] Taranaki Health Action Plan 2017-2020 - https://www.tdhb.org.nz/misc/documents/TDHB-Health-Action-Plan-2017.pdf

2.1.5 WAIKATO DHB

The Waikato DHB Annual Plan 2019-20[11] is developed in alignment with the vision of **Healthy people, excellent care**, outlined in the Waikato DHB Strategy[12] , which also outlines the Mission of the DHB to 'Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery'. The Iwi Māori Health Strategy, Ki te Taumata o Pae Ora, is under development and will sit alongside the Waikato DHB Strategy.

The Waikato Health System Plan – Te Korowai Waiora[13] translates this vision into a set of strategic goals and actions that will be implemented over the next ten years. The goals are: Partner with Māori in the planning and delivery of health services, Empower whānau to achieve wellbeing, Support community aspirations to address the determinants of health, Improve access to services, Enhance the capacity and capability of primary and community health care, Strengthen intermediate care, Enhance the connectedness and sustainability of specialist care.

[11] Waikato DHB Annual Plan 2019/20 - https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Plans/Waikato-DHB-Annual-Plan-2019-20.pdf

[12] Waikato DHB Strategy – Healthy People Excellent Care - https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Strategies/4750ac5a11/Waikato-DHB-Strategy-2016.pdf

[13] Waikato DHB Strategy – Healthy People Excellent Care - https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Strategies/4750ac5a11/Waikato-DHB-Strategy-2016.pdf

2.2 NGA TOKA HAUORA PARTNERSHIPS

Nga Toka Hauora (Te Manawa Taki DHB GMs Māori Health) will work with HealthShare and with regional and local Networks and Groups to guide the application of the four commitments below, in accordance with the 'Health Equity Template' on the following page. The approach is to focus efforts on supporting DHBs, including its agencies, to build a culture which is enabling of attaining health equity for Māori. To achieve this there is a commitment to:

- Health equity assessment using the Health Equity Assessment Tool[14] , or an appropriate tool, being scheduled and/or carried out to assess the effectiveness for Māori, of existing regional services and/or new regional service models, programmes, policies and projects identified in the Regional Equity Plan.
- Applying whānau-centred health information management to regional services that supports whānau to better self-manage their own health and wellbeing.
- Setting, monitoring, and reporting 'no differential' targets for Māori and Non-Māori for all monitored regional activity.
- Increasing the Māori health and disability workforce across Te Manawa Taki DHBs, including its agencies; and providing support to increase the responsiveness of the health workforce to Māori.

Table 1: Health equity template, over the page, shows priority outcomes and milestones.

Table 2 shows a summary of national Māori health indicator measures as they relate to regional planning. The summary of regional workplans table (further in this document) shows the link between annual workplan objectives and Māori health equity priorities in regional and national resources.

[14] The Health Equity Assessment Tool: A User's Guide (2008) – University of Otago, Wellington - https://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide

TABLE 1: HEALTH EQUITY TEMPLATE

	Outcome reported	Who	Milestones reported against
Building the evidence base	Establish & embed ethnicity data reporting by: Carrying out detailed analysis of relevant data and information relevant to each clinical regional priority to establish whether, and where, inequalities exist and to: • establish baseline performance data, • monitor and report on progress towards targets and inequality, • inform health equity assessment of current or future services as appropriate.	Regional groups supported by Nga Toka Hauora (Chair GM)	• 100% of regional priorities have baselines established that measure inequality between Māori and Non-Māori[15]. • 100% of regional priorities are reported quarterly by ethnicity[16] .
Building a culture of equity	Health equity assessment either scheduled or undertaken • health equity assessment using HEAT, or an appropriate tool, will be carried out on existing services to assess the effectiveness of current delivery models for meeting needs of Māori. or • health equity assessment using HEAT, or an appropriate tool, will be carried out on proposed services to assess the likely impact of proposed delivery models on meeting the needs of Māori.	Regional groups supported by Nga Toka Hauora (Chair GM), HealthShare	• All regional groups will have carried out a health equity assessment of their work plan initiatives and activities or will have scheduled a health equity assessment.
Health literacy	Improve health literacy by: • assessing the need to review existing information resources within the department or service using Rauemi Atawhai: A guide to developing health education resources in New Zealand[17] with a view to improving information available to patients and whānau, • undertaking a health literacy review with a view to improving information available to patients and whānau so that they can obtain, process and understand.	Regional groups supported by Nga Toka Hauora (Chair GM)	• All regional services have carried out a health literacy review. • Scope the opportunities for development of a health literacy app, working together collaboratively.
Workforce	Build Māori health workforce • each Te Manawa Taki DHB provides a workforce profile report that identifies the number and percentage of Māori employed by professional group within each of the DHBs. This workforce profile is utilised to track building Māori health workforce capacity development, • establish a strategy to increase the Māori health and disability workforce, by DHB.	RDOW GMs HR supported by Nga Toka Hauora (Chair GM)	• A regional workforce profile will be established for all Te Manawa Taki DHBs that identifies the Māori and Non-Māori workforces. • Strategy in place across Te Manawa Taki DHBs for Māori workforce increase in priority areas (refer workforce section). • Quarterly reporting of regional workforce by DHB are routinely produced and distributed.

[15] In year one we will determine whether this can be achieved.

[16] In year one we will determine whether this can be achieved.

[17] Rauemi Atawhai: A guide to developing health education resources in New Zealand. 2012. Wellington: MoH - https://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand

TABLE 2: SUMMARY OF NATIONAL MĀORI HEALTH INDICATORS – AS THEY RELATE TO REGIONAL PLANNING[18]

National Priorities	Māori Health Indicators	Regional Alignment	Why this issue is important
Data Quality	1. Ethnicity data accuracy	All services	Collecting accurate ethnicity data in accordance with the national Ethnicity Data Collection Protocols will improve the quality of ethnicity health data enabling us to effectively measure working towards health equity for Māori.
Access to care	2A. 100% of Māori enrolled in PHOs	Pathways of Care Child Health	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 for first point of contact health care. Differential access to and organisation of healthcare services plays an important role in health inequities, and for this reason it is important to focus on enrolment rates for Māori.
	2B. Ambulatory sensitive hospitalisation (ASH) (0-4yrs / 45-64yrs)	Child Health Healthy Ageing	ASH is a proxy measure for avoidable hospitalisations, and unmet healthcare need in a community-based setting. There are significant differences in ASH rates by population group and a focus on activities to reduce ASH must address the current inequities.
Child health[19]	3. Exclusive or fully breastfed; at LMC discharge (6 weeks 75%); (at 3 months 60%) Ethnicity data accuracy 4. Receiving breast milk at 6 months (65%)	Child Health	Breastfeeding provides infants with nutritional needs and builds infant immunity against a range of infectious diseases within the first 6 months of life.
Diabetes/ Cardiovascular Disease	5. 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had a CVD risk recorded within the past five years	Cardiac Services	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.
Cancer	6. Breast screening rate 70% of eligible women	Cancer Services	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 benefits of early breast cancer detection.
	7. Cervical screening rate 80% of eligible women	Cancer Services	In 2012, Māori women were twice as likely as Non-Māori to develop cervical cancer, and 2.3 times 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 European/ Other with coverage at 82.2%. Improving screening coverage in Māori women is therefore an important activity to improve this equity gap.

[18] This table relates to the 'DHB performance data by ethnicity' equity actions listed https://nsfl.health.govt.nz/dhb-planning-package/equity-actions-dhb-annual-plans/dhb-performance-data-ethnicity by the MoH (although the latest MoH measures do not include measure #5, #12 or #13 below), the measures collated within the Trendly https://www.trendly.co.nz/Home/Performance portal (which does not include #1, #4, #5 or #13). Measure #5 is still included in the table as this Amenable Mortality measure has been identified as a regional priority.

[19] Ministry of Health. 2016. Indicators for the Well Child / Tamariki Ora Quality Improvement Framework: March 2016. Wellington: Ministry of Health. https://www.health.govt.nz/publication/indicators-well-child-tamariki-ora-quality-improvement-framework-march-2016.

National Priorities	Māori Health Indicators	Regional Alignment	Why this issue is important
Smoking	8. 95% of pregnant Māori women who are smoke free at two weeks postnatal	Child Health	Hapū Māori wāhine 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.
Immunisation	9. 95% of infants fully immunised by 8 months of age.	Child Health	Immunisation is the most effective way to actively protect your child from preventable diseases, ranging from whooping cough to meningitis and measles (Immunisation Advisory Centre, 2013). Although immunisation rates are high there is still a large health equity gap between Māori and Non-Māori. Initiatives need to target Māori pēpi in order to achieve health equity.
	10. 75% of the eligible population (>65 years) are immunised against influenza annually	Planned Care: Infectious Diseases	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. If we can increase immunisation rates for Māori, we will see a significant reduction in overall influenza cases.
Rheumatic Fever	11. 55% reduction in the number and rate of hospitalisations for acute rheumatic fever rate 1.2 per 100,000	Child Health	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.
Sudden Unexplained Death in Infancy	12. National SUDI target – 0.4 SUDI deaths per 1,000 live births	Child Health	The target for SUDI will be lowered from 0.5 to 0.4 SUDI per 1,000 live births. The target has been lowered to match the reduced rate of S UDI among Non-Māori infants (0.38 SUDI per 1,000 live births during 2010-2014). Yet there is still a significant difference in SUDI rates between Māori and Non-Māori families living in Te Manawa Taki.
	13. All caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1 (minimum of 70%)	Child Health	
Oral Health	14. 95% of Māori preschool tamariki are enrolled in the community oral health service	Child Health	The inequity between Māori and Non-Māori enrolments is significant; therefore, the need for more Māori targeted initiatives and programmes is crucial.
Mental Health	15. Mental Health Act: section 29 community treatment order comparing Māori rates with other (per 100,000)	Mental Health & Addiction	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.

2.3 WORKING TOGETHER

Regional collaboration (working together as a region) forms a small but important part of the New Zealand Public Health System. Regional collaboration can occur in several ways. In general, it is work on a shared issue(s) that may be progressed more efficiently, collectively, as a region. Examples include:

1. Equity and visibility: Monitoring equity of activity and outcomes as a region (e.g. oral health of children). This then enables DHBs to progress actions specific to their communities, share learnings from activities, etc.
2. Very highly specialised services: To monitor equity of access to services and to ensure the pathways of care for very highly specialised clinical services are streamlined and effective (e.g. Midland Trauma System, vascular surgery, cardiothoracic surgery, cancer services).
3. Resourcing: Ensuring the resources of specialised services are coordinated and sustainable (e.g. Internal Audit and Audit & Assurance services, Taleo IS services for recruitment).
4. Coordination for consistent care: Coordination of 'like' clinical services in hospitals across the region, where this is needed to support timely access (e.g. cardiac services, renal services) and to ensure care is delivered consistently.
5. Workforce: Coordinated workforce planning, where collective development/delivery of training is more efficient.
6. Systems: ICT systems development, deployment, and service coordination.
7. Initiatives and activities: Activities that have a finite life in their resourcing and are small, yet common, to each DHB (e.g. Hepatitis C eradication programme).

A regional clinical matter is likely to result from the health decline of an individual to the point of needing specialised treatment and care. One of the opportunities in working regionally is to examine the origins of specialised health issues, then for DHBs to work with partners to reduce their incidence.

Figure 1: Relationship of partnerships with iwi and regional collaboration to the DHB health system. *Figure 1 shows some of the services a patient may interact with in their journey through the health system for support and treatment. To illustrate, issues relating to diabetes are used as an example.*

Regionally, this includes services responding to microvascular disease, e.g. renal, ophthalmology, orthopaedic surgery. Regional renal services (and associated vascular surgery) can coordinate to provide these services. There is also a need to ensure GPs refer in a timely manner. An important need is to work with iwi, community, and Primary Care about how best to reduce obesity, to self-manage diabetes through well-being strategies, and reducing the number of people getting diabetes.

Service	Network/Group	DHB Chief Executive Lead	Clinical Chair	Project Manager Lead
Cancer Services	Cancer and Palliative Care Services	Kevin Snee, Waikato DHB	Humphrey Pullon	Jan Smith – Manager
	Bowel Screening Regional Centre	Kevin Snee, Waikato DHB	Ralph Van Dalen	Brent McMillin – Manager
Cardiac Services	Cardiac Clinical Network	Kevin Snee, Waikato DHB	Jonathan Tisch, Bay of Plenty DHB	Natasha Gartner
Child Health Services	Child Health Action Group	Jim Green, Hauora Tairāwhiti		Richard Simpson
Healthy Ageing Services	Health of Older People Action Group			Kirstin Pereira
Hepatitis C Services	Hepatitis C Service	Jim Green, Hauora Tairāwhiti	Frank Weilert, Waikato DHB	Jo de Lisle
Mental Health & Addiction Services	Mental Health & Addiction Network	Nick Saville-Wood, Lakes DHB	Sharat Shetty, Taranaki DHB	Eseta Nonu-Reid – Director
Planned Care Services	Vascular	Rosemary Clements, Taranaki DHB	David Ferrar and Mark Morgan	Jocelyn Carr
	Ophthalmology	Rosemary Clements, Taranaki DHB	Stephen Ng	Jocelyn Carr
	Infectious Diseases	Rosemary Clements, Taranaki DHB	Kate Grimwade	Jocelyn Carr
Radiology Services	Radiology Action Group		Roy Buchanan, Bay of Plenty DHB	Natasha Gartner
Stroke Services	Stroke Network	Rosemary Clements, Taranaki DHB	Mohana Maddula, Bay of Plenty DHB	Kirstin Pereira
Trauma Services	Midland Trauma System	Rosemary Clements, Taranaki DHB	Grant Christey	Alaina Campbell
Regional Enabler groups				
Pathways of Care	Pathways of Care Governance Group	Jim Green, Hauora Tairāwhiti		Chris Scott – Manager
Quality	Regional Quality Network	Rosemary Clements, Taranaki DHB	Sharon Kletchko	
Workforce				Ruth Ross – Director
Data & Digital Services		Kevin Snee, Waikato DHB	Steven Parrish – Chair, IS Leadership Team	Debbie Manktelow – Director, Information and Technology /CDO
			Bryce O’Kane – MCP Programme Leader	

2.3.2 Line of sight – alignment with Te Manawa Taki three-year workplan and national priorities

Health equity (in particular achieving Māori health equity) is a priority in all workplans. The table and key in the following pages show the alignments between annual workplan items and the Māori health and wellbeing priorities of Te Manawa Taki (three-year plan) and national guidelines.

KEY – Alignment with key regional/national priority areas, measures and targets			
	3-year plan: Direct alignment (i.e. as a priority or dependency) with Te Manawa Taki **Three-year Strategic Plan** (in REP main doc)		**Māori health indicators:** Māori health indicators (as per **table 2** above)
	DHB Perf. Measure: https://nsfl.health.govt.nz/accountability/performance-and-monitoring/performance-measures/performance-measures-201920 *(measure) (i.e. in addition to alignment with SS17 Whānau Ora & SS12 Engagement and obligations as a Treaty partner)*		**Minister's priority:** Ministerial planning priority area per https://www.health.govt.nz/publication/he-korowai-oranga-maori-health-strategy
	He Korowai Oranga: https://www.health.govt.nz/publication/he-korowai-oranga-maori-health-strategy Māori health & disability priorities *(Population Objectives with real potential to reduce Māori disparities (P) / Māori Health Priorities (M))*		**SLM (/CM):** https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework *(/Contributory Measure (CM))*
			Other: Other *(source of target/measure)*

2.3.3 Costings

The CE Leads, Network/Group Chair and Project Manager leads (refer table on previous page) are responsible for oversight of costings for the services to be implemented. Implementation – including some shared operating costs if relevant – is undertaken in partnership with the groups listed in the 'Enablers' and 'Who' sections of the annual workplans below.

Also refer to the HealthShare Ltd and DHB Annual Plans for additional costing information.

Annual workplans - Regional Networks

2.4 Cancer Services

2.4.1 Cancer and Palliative Care Services

Workplan Outputs	Equity aims/outcomes for this work:
Cancer is a regional priority for Te Manawa Taki *– refer to the REP infographic for an overview of Māori health equity issues and priorities.* • *The top three cancers for Māori are lung, breast, and urological cancers (urological, skin, and lower gastrointestinal for Non-Māori).* • *Cancer incidence among Māori is 1.3 times higher than for Non-Māori, with the cancer mortality rate at 1.8 times higher for Māori than for Non-Māori.*	
Health Outcome objectives: • **New Zealanders have a system that delivers consistent and modern cancer care – Te huanga 1: He pūnaha atawhai** • **New Zealanders experience equitable cancer outcomes -Te huanga 2: He taurite ngā huanga** • **New Zealanders have fewer cancers – Te huanga 3: He iti iho te mate pukupuku** • **New Zealanders have better cancer survival, supportive care, and end-of-life care – Te Huanga 4: He hiki ake i te oranga**	
• **Support the Cancer Control Agency implementation of the Cancer Control Action Plan 2019-2029 and the establishment the agency Regional Hub.**	• Achievement of strategic goals of the New Zealand Cancer Action Plan 2019-2029 - *Te Mahere mō te Mate Pukupuku o Aotearoa.* • Drive quality improvement and reflects our commitment to achieving equity, national consistency of standards, QPIs and person-centred care for whānau and deliver better outcomes for people diagnosed with cancer. ***Measures/validation:*** Validation of outputs align with the National Cancer Control Plan 2019-2029.
• **Support Te Manawa Taki DHBs with implementing bowel cancer quality improvement plans based on national quality performance indicators (2019) and BOP, Taranaki and Waikato symptomatic colorectal cancer improvement project recommendations (2019).**	*Colorectal cancer in New Zealand occurs less frequently for Māori compared to Non-Māori, however once diagnosed, Māori are more likely to die from colorectal cancer than Non-Māori.*

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Workplan Outputs	Equity aims/outcomes for this work:
• **Support Te Manawa Taki DHBs with regional FCT analysis including equity focused reporting and local DHB cancer service improvement work groups.**	There is a longer delay in diagnosing cancer among Māori, with 31.1% of Māori having their cancer first diagnosed at an emergency department (21.4% for Non-Māori). • Improvement in FCT wait time indicators. *(SS01, SS11).* • Equitable achievement of the FCT wait time indicators. • Te Manawa Taki DHB achievement of the FCT wait time indicators: o SS1: 85% of Te Manawa Taki DHB patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision-to-treat. o SS2: 90% of Te Manawa Taki DHB patients referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days.
• **Facilitate the National Lung Cancer Work Programme as required.** • **Support Te Manawa Taki DHBs with implementing lung cancer quality improvement plans based on national quality performance indicators (2020).** • **Facilitate and support Te Manawa Taki DHBs to improve lung cancer access and outcomes.** • **Facilitate and support Te Manawa Taki DHBs to implement the National Early Detection of Lung Cancer guidance and toolkit.** • **Facilitate and support Te Manawa Taki DHBs to implement the National Follow-up and Supportive Care Following Curative Lung Cancer Treatment guidance.**	*Lung cancer rates are 3.3 times higher for Māori and the mortality rate is (34%) 3.4 times higher than for Non-Māori.* • Improving lung cancer outcomes and increased access to services. • Increasing awareness of lung cancer symptoms and ensuring support for those patients currently on a curative lung cancer pathway.
• **Support Te Manawa Taki Cancer Societies and DHBs to facilitate Kia Ora e te Iwi programme hui's with Māori health providers, iwi community, consumer-whānau. In partnership with the Cancer Societies and DHBs deliver hui's (minimum of one per DHB). Promote Cancer Korero booklet.**	• Kaupapa Māori and Māori led programmes for whānau affected by cancer. • All Te Manawa Taki DHBs utilise information from kōrero to inform DHB FCT improvement planning. • Deliver support and information for people with cancer and increase public awareness of possible signs/symptoms of cancer.

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Workplan Outputs		Equity aims/outcomes for this work:	
• **Support District palliative care implementation of local strategies as required.** • **Complete implementation of regional palliative care community health pathways and e-referral initiative.** • **Improved timely and early access, quality palliative care and end-of-life services.** • **Facilitate the implementation of the Specialist Palliative Care Workforce Plan 2018-2025 recommendations, focus on Māori workforce and whānau requirements.**		*Te Manawa Taki specialist palliative care Māori workforce is only 8% of total. In addition, by 2025 it is predicted that the specialist palliative care workforce will need a 31.5% increase (57.34 FTE) to cope with demand.* • Increase workforce with a goal of at least representative of Māori population.	
• **In partnership with HSL and regional stakeholders support the development of Community Health Pathways and e-referral on publication of national prostate cancer standards of service provision (tbc).**		*Prostate cancer rates are 1.4 times higher for Māori than for Non-Māori.*	
• **Implementation of phase 2 of the Clinical Pathway and MDM Management System project.** • **In partnership with Regional IS and DHBs explore the feasibility to develop an oncology e-prescribing system. Support SACTNZ initiative to collect detailed data to identify and address inequities and inefficiencies in anti-cancer therapy as required.** • **Support Agency and Te Manawa Taki DHBs with regional medical oncology and/or radiation oncology service/capacity planning and improvements as required.** • **Take an oversight and leadership approach to Te Manawa Taki DHB 2019-20 HQSC patient co-design initiatives that are still in progress.** • **Take an oversight and leadership approach to regional research initiatives to ensure learnings shared and incorporate agreed recommendations into future planning:** • Support the regional Reducing Delay and Increasing Access to Early Diagnosis for Colorectal Cancer HRC three research initiatives (end Sept 2020). Support DHBs to incorporate recommendations into local cancer service improvement plans. • Support the regional Improving Early Access to Lung Cancer Diagnosis for Māori and Rural Communities HRC three-year research initiatives (end Oct 2020). Support DHBs to incorporate recommendations into local cancer service improvement plans. • To look at difference of lung cancer survival outcomes between Māori and Non-Māori. • Prostate co-design project following on from the Prostate Research funded by Movember to develop a video and cultural health literacy resource and hope to gift it to Kia ora e te iwi programme and potentially can be used for inservice and students.		Developing community health pathway and e-referral will standardise processes.	
Enablers:	*Pathways of Care, Quality, Workforce, Data & Digital Services*	**Who:**	*Cancer Control Agency, Ministry of Health , Regional Hub, Cancer Control Agency, Te Manawa Taki DHBs / HealthShare / regional Hospices*

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.4.2 Bowel Screening Regional Centre

<table>
<tr><td colspan="4">Bowel screening is a regional priority for Te Manawa Taki – refer to the REP infographic for an overview of Māori health equity issues and priorities.
• Colorectal cancer in New Zealand occurs less frequently for Māori compared to Non-Māori, however once diagnosed, Māori are more likely to die from colorectal cancer than Non-Māori.
• Bowel screening reduces the mortality rate from bowel cancer, by diagnosing and treating bowel cancer at an early curable stage, as well as identifying and removing pre-cancerous advanced adenomas from the bowel before they become cancerous.
• The National Bowel Cancer Working Group Māori Equity Statement describes its approach as 'get it right for Māori, get it right for all'.
• Te Manawa Taki DHBs are utilising Kaupapa Māori ideologies and methodologies to ensure awareness of Māori systems, knowledge, people and processes across the NBSP to achieve equitable participation rates.</td></tr>
<tr><td colspan="4">Health Outcome objective: New Zealanders have better cancer survival – Te huanga 4: He hiki ake i te oranga</td></tr>
<tr><td colspan="2">Workplan Outputs</td><td colspan="2">Equity aims/outcomes for this work:</td></tr>
<tr><td colspan="2">• Facilitate and support Te Manawa Taki DHBs with colonoscopy demand and capacity production planning. (SS16-MoH tbc)</td><td colspan="2">• Improvement in colonoscopy wait time indicators (urgent and non-urgent diagnostic colonoscopy, and surveillance colonoscopy).</td></tr>
<tr><td>Enablers:</td><td>Quality</td><td>Who:</td><td>Te Manawa Taki DHBs & BSRC, NBSP</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">Progress on Te Manawa Taki DHBs achievement of the colonoscopy wait time indicators:
• 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.
• 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.
• Surveillance colonoscopy – 70% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.</td></tr>
<tr><td colspan="2">• Hauora Tairāwhiti NBSP go live June 2020 (tbc) including go live with new NSS.
• Waikato DHB phase 2 readiness assessment completed Nov-December 2020 and go live March 2021 (tbc).
• Bay of Plenty DHB phase 2 readiness assessment completed Feb-March 2021 and go live May 2021 (tbc).
• Taranaki DHB phase 2 readiness assessment completed March-April 2021 and go live June 2021 (tbc).
• Support Lakes DHB NBSP roll out, including transition from BSP to NSS (tbc).
• Support Te Manawa Taki DHBs ProVation version upgrades and ProVation Data Centralisation as required.
• Implement NBSP BSRC Report recommendations as required (tbc).</td><td colspan="2"></td></tr>
</table>

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Workplan Outputs		**Equity aims/outcomes for this work:**	
Enablers:	*Quality, Data & Digital Services*	***Who:***	*Te Manawa Taki DHBs &BSRC, NBSP, Primary, Community*
Measures/ validation:	*Progress on Te Manawa Taki DHB bowel screening indicators:* • *95% of participants who returned a positive FIT to have a first offered diagnostic date within 45 working days of their FIT result being recorded into the NBSP IT systems is consistently met.* • *Achieve participation of at least 60% of people aged 60-74 years in the most recent 24-month period (Te Manawa Taki DHBs are striving for 75% Māori participation rate).*		

Workplan Outputs	**Equity aims/outcomes for this work:**
• **National lead for the National Māori Bowel Screening network, share learnings.** • **Facilitate the NBSP Māori network.** • **Participate in the national Māori and Pacific bowel screening networks.** • **Te Manawa Taki Māori health provider, community provider and whānau centred hui to provide opportunity to kōrero and plan around what will work in the regional DHB communities to promote community engagement, participation.**	The NBSMN provides a mechanism for collaboration to support and share practice that promotes access to, and through, the bowel screening pathway for Māori. The NBSMN undertake 2 face to face Hui each year with quarterly newsletters to share practice, resources and lessons learned across the NBSP pathway. • Share learnings and promote engagement of those working for NBSP Māori / Pacific equitable outcomes for priority groups. • Number of hui held (current target is two) and integration of information from kōrero into planning. • The National Bowel Screening Programme (NBSP) will be beneficial for Te Manawa Taki by reducing mortality from bowel cancer.
• **Continue to develop the Te Manawa Taki bowel screening equity framework to support Te Manawa Taki DHBs.** [Minister's priority]	• The NBSP has an overarching 60% participation rate; the region is aiming for 75% participation rate for Māori to achieve an equity neutral outcome. • Improvement in bowel screening indicators.
• **Liaison with Ministry of Health toward bowel screening Māori at a younger age in order to achieve equity-neutral outcomes.** [Minister's priority] [DHB Perf. Measure] *(SS15)*	Modelling found that to achieve the same number of years of health gain for Māori, compared with Non-Māori, the screening age range would need to be 10 years wider (50 – 74 years for Māori, 60 – 74 years for Non-Māori). Doing this alone would make the NBSP equity neutral. • Widening of the screening age range for Māori.

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.5 Cardiac services (Cardiac Clinical Network)

- ***Cardiovascular disease mortality: From 2000-2004**, cardiovascular disease mortality rates among Māori are 2.3 higher than for Non-Māori. Cardiovascular disease is the most common cause of death for Māori, accounting for a third of all Māori deaths.*
- ***Cardiovascular disease risk:** At all ages, Māori have an increased prevalence of cardiovascular disease and cardiovascular risk factors compared with non-Māori. Cardiovascular disease mortality rates among Māori are more than twice as high as that among non-Māori.*
- ***Atrial fibrillation (AF):** People with AF are five times more likely to have a stroke than people without AF and strokes associated with AF are more severe. Māori experience higher rates of AF compared with Non-Māori and develop the condition earlier.*

Health Outcome objective: Improved Health Equity for Māori			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **The regional Cardiac Services Plan 2020-2025 will be completed by June 2020 – the recommendations will be prioritised and include the promotion of equity of cardiac outcomes across ethnicities and geographical areas.** • **Māori health equity prioritised in new Cardiac Services Plan 2020-25 – to inform regional assessment.** (P)		Various areas including equity across geographic areas, access to diagnostics and interventions. *(RSP guidance – Cardiac and Stroke Equty)*	
Enablers:	*Data & Digital Services*	**Who:**	*Project Manager*
Measures/ validation:	*An Implementation Plan for the regional Cardiac Services Plan 2020-2025 will be completed.* • *Recommendations will be prioritised and include the promotion of equity of cardiac outcomes across ethnicities and geographical areas.* • *Implementation plan will be endorsed by Cardiac Clinical Network.* • *Use National Health data such as; ANZACS-QI data and MOH ASH data to highlight inequities for Māori in terms of access to diagnostics, interventions and over-representation in poor cardiovascular health outcomes.*		

Health Outcome objective: The vulnerable Cardiac Physiologist workforce will be supported			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **An approach to addressing the vulnerable cardiac physiologist workforce will be agreed.**			
Enablers:		**Who:**	*Project Manager*
Measures/ validation:	• *The approach is endorsed by the Cardiac Clinical Network.* • *Quarterly updates are provided to the Cardiac Clinical Network.* • *Work with the other 3 Cardiac Regional Networks to determine the future supply and demand for Cardiac Physiologists.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Health Outcome objective: **The rate of stroke due to undiagnosed Atrial Fibrillation will be reduced** *(Cardiovascular disease (CVD) is a leading cause of death in New Zealand. The three significant categories of CVD are arrhythmia, heart failure and coronary artery disease).*			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **An agreed plan for the regional Stroke and Cardiac networks to work together on Atrial Fibrillation, with a focus on improving Māori Health Equity.**		• *Reduced variation in services provided between DHBs.* • *Reduced variation in access to tertiary services, between DHBs.* • *Improved access to treatment services.* *(SS13)*	
Enablers:		**Who:**	*Project Manager*
Measures/ validation:	• *The approach is endorsed by the Cardiac Clinical Network by the end of Q4.* • *Rates of stroke due to undiagnosed AF.* *(CM-PHO-enrolled eligible people with CVD risk recorded in last 5 years)* *(RSP guidelines)*		

2.6 Child health services - Child Health Action Group (CHAG)

Includes relationship with newly established **Child Development Services (CDS) collaborative group** (refer below).

Child health is a regional priority for Te Manawa Taki *– refer to the REP infographic for an overview of Māori health equity issues and priorities.*			
Health Outcome objective: DHBs and Alliances are supported to improve the First 1000 days			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Validation of a standardised regional primary care First 1000 days assessment and referral tool.**		• Access, engagement and utilisation of support services & resources for hapū māmā, pēpi and whānau. *(CM-data via primary care patient experience survey)* • Enrolment and registration rates – PHO/GP, Lead Maternity Carer and Well Child/Tamariki Ora *(P)*, including timely antenatal clinical checks and ensuring adequate support for the birth. *(Enrolment ref CW07, PH03)*	
Enablers:	*Quality*	**Who:**	*CHAG*
Measures/ validation:	• *Confirmation from CHAG members on adoption, validation and/or trial of a completed tool. Q4* • *Components of the first 1,000 days tool is integrated with any completed HealthPathways. Q2* • *CHAG encouragement and endorsement of HealthPathway development in line with first 1,000 days priorities.*		
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Implementation of a standardised regional primary care First 1000 days outcomes framework.** • **Coordination to identify and agree action plan to address primary care sector risks and priorities for First 1,000 days.**		• Targeted implementation of primary care initiatives based on collaboration on joint objectives, local needs, staff retention, engagement options and best practice approaches.	
Enablers:	*Quality, Data & Digital Services*	**Who:**	*CHAG*

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

<table>
<tr><th colspan="2">Workplan Outputs</th><th colspan="2">Equity aims/outcomes for this work:</th></tr>
<tr><td>Measures/ validation:</td><td colspan="3">
• Endorsement of the outcomes framework by CHAG member groups, including DHB GMs Planning & Funding and PHOs. Q2
• Confirmation of DHB role and responsibilities in alignment with outcomes framework, including alignment with relevant DHB models of care. Q4
• Circulation of agreed data reports and/or summary of regional primary care trends, risks and priorities, to support localised planning.</td></tr>
<tr><td colspan="4">Health Outcome objective: A coordinated approach to Child Development Services (CDS)</td></tr>
<tr><th colspan="2">Workplan Outputs</th><th colspan="2">Equity aims/outcomes for this work:</th></tr>
<tr><td colspan="2">• Ongoing collaboration, oversight and reporting arrangements with CDS Providers on utilising additional ($1.829m p/a) MoH funding for regional FTE – including regional monitoring and KPIs.</td><td colspan="2">• Improvement in provision of CDS to Māori – including waiting lists and additional children seen – through additional FTE funding based on Māori 0-19yo population by DHB region (total target 340 additional children seen p/a).</td></tr>
<tr><td>Enablers:</td><td>Quality, Workforce, Data & Digital Services</td><td>Who:</td><td>CHAG CDS providers/network (TBC)</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">
• Agreement & implementation of regional CDS reporting including equity measures and KPIs. Q4
• Establishment of CDS collaborative group or similar with formal relationship with CHAG. Q4
• Coordinated approach to priority setting and regional reporting/sharing of CDS measures, including revision of annual Implementation and Innovation Plans for additional funding (supported through CHAG). Q3
• Liaison, support and advice (as appropriate) with CDS group to ensure CDS annual Implementation Plan and Innovation Plans are on track, and that additional initiatives and FTE recruitment/employment progress as per the agreed regional funding allocations, and according to agreed regional priorities.
• CDS measures – 340 additional children served p/a through FTE allocation utilising $1.829m additional CDS funding p/a from FY 20/21 to 22/23. Regional measures/KPIs TBC. Q1-4</td></tr>
<tr><td colspan="4">Health Outcome objective: Health outcomes supported through priority child health pathways</td></tr>
<tr><th colspan="2">Workplan Outputs</th><th colspan="2">Equity aims/outcomes for this work:</th></tr>
<tr><td colspan="2">• Child health pathways prioritised and supported by CHAG, with a focus on Māori health priorities.</td><td colspan="2">• Opportunistic assessment and support in identified high-priority areas – including maternal & whānau smoking, sexual violence screening, breastfeeding, early immunisation.
• Reduced waiting times and continuity of support for complex cases for Child Development Services.</td></tr>
<tr><td>Enablers:</td><td>Pathways of Care, Quality</td><td>Who:</td><td>CHAG, HealthPathways</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">
• Confirmation of priority health pathways in the region for child health, with a focus on Māori health equity – Q4.
• CHAG provision of technical review and advice on prioritised child HealthPathways Q1-4.</td></tr>
</table>

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

High-level child health equity measures
• *CHAG produces a quarterly regional Child Health report which includes detailed equity analysis. As well as the measures and validation above, CHAG actively monitors these measures with a focus on priority equity outcomes including:* • *Decrease in Ambulatory Sensitive Hospitalisation (ASH) 0-4yo.* • *Early childhood immunisations. (CW05, CW08) (M)* • *Breastfeeding rates. (CM-Breasfeeding) (CW06)* • *Maternal/household smoking rates. (CW09, PH01, PH03) (P,M)* • *Environmental and whānau health through coordinated assessment and referral – including:* o *living condition (NZDep2018), nutrition (P), healthy lifestyle (CW10), (P) (CM-child high BMI referral), trauma and household safety, rheumatic fever, (CW13), oral health. (CM-Dental) (CW01-3) (P)*

2.7 Healthy Ageing services (Health of Older People Action Group)

• *Regional priorities for dementia services – Identify impact on Māori and their whanau. The inclusion of Māori in this discussion is key and in any subsequent development of a regional approach.* • *The workplan for the national ACP team includes ensuring the national Advance Care Plan programme meets the obligations under Te Tiriti o Waitangi. The national workplan is influenced by the regional and DHB ACP groups and then in turn, outputs from that workplan inform the way in which these groups work.*			
Category: Dementia			
Health Outcome objective: Improved access to dementia services for people with dementia, and their family and whānau			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **An agreed approach to implement the identified regional priorities from 2019/20** • **Support Regional DHBs to implement the regional priorities and to ensure a kaupapa Māori approach is included.**		*Inclusion of kaupapa Māori approach. (RSP guidelines - NZ Dementia Care framework) (SS04)*	
Enablers:	*Pathways of Care, Quality, Workforce*	**Who:**	*HealthShare Project Manager, DHB Planning and Funding Health of Older People Portfolio Managers*
Measures/ validation:	• *Approach endorsed by the Portfolio Managers – Q2.* • *Work commenced on Regional priorities – Q4.*		
Category: Advance Care Planning			
Health Outcome objective: People living in the Region can develop an advance care plan, no matter where in Te Manawa Taki they live, their ethnicity or socioeconomic status			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Representing the Region, provide feedback and input into the National ACP Steering Group. Review of national Advance Care Planning programme to ensure it meets the needs of Māori.** • **Minutes and Agreed Actions for the regional Facilitators Group.**		*Complete the review. (NZ Health Strategy Action 11)*	

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Workplan Outputs		Equity aims/outcomes for this work:	
Enablers:	*Pathways of Care, Quality, Workforce*	**Who:**	*HealthShare Project Manager, ACP Facilitators Group*
Measures/ validation:	• *ACP Facilitator Group has an agreed view of ACP in the region – Q3.* • *Four face to face meetings held of the ACP Facilitators Group.* • *Attendance at the National ACP Steering Group meetings Q1-Q4.*		

2.8 Hepatitis C – Integrated Hepatitis C Service

• *Hepatitis C incidence: Māori are over- represented on the regional HCV Point of care database sitting at 4% HCV Antibody positivity rate versus the general positivity rate of HCV Antibody 3%.* • *Targeted and opportunistic testing: Māori represent approximately one third of the total number of people tested within the community. The community hepatitis C services is co-designed with, and taken to, populations who have an increased risk of infection, e.g. OneStopShop hep C clinics are provided at Needle Exchanges, probation services and community events.*			
Category: Education and Awareness			
Health Outcome objective: Improved community awareness and workforce competency in managing hepatitis C			
Workplan Outputs		**Equity aims/outcomes for this work:**	
• **Deliver hepatitis C education and awareness to people with hepatitis C and the community.** • **Deliver hepatitis C education and awareness services health care providers.**		Create **awareness:** Delivery of hepatitis C information and education for people with hepatitis C, the community, and health care providers.	
Enablers:	*Pathways of Care, Quality, Workforce.*	**Who:**	*HealthShare Project Manager / Community hepatitis C service / hepatitis C working groups.*
Measures/ validation:	• *Each Te Manawa Taki DHB region has developed a work plan.* [Other] *(RSP guidance – regonal hepatitis C objectives).*		
Category: Patient Experience of Care – identify, test and treat			
Health Outcome objective: Increased identification, diagnosis and treatment of people with hepatitis C			
Workplan Outputs		**Equity aims/outcomes for this work:**	
• **Targeted testing based on engagement with Māori and other priority groups and alignment with regional hepatitis C work plan.** • **Finding people with hepatitis C who are lost to follow up.** [Other] *(RSP guidance – regonal hepatitis C objectives).*		• **Test**: Identification and targeted hepatitis C testing. • Number of people diagnosed with hepatitis C, and proportion being followed up. [Other] *(Regional hepatitis C guidance)* • Provide **education**: Improved community and individual engagement through targeted initiatives as well as education and training (and partnership) with health providers and new services or organisations (e.g. Probation Officers and people they care for). • **Treat** – work in partnership with the person to develop their treatment pathway, based within the community wherever possible.	

[black]	3-year plan	[red]	DHB Perf. Measure	[grey]	He Korowai Oranga	[blue]	Other
[orange]	Māori health indicators	[yellow]	Minister's priority	[orange diagonal]	SLM (/CM)		

Workplan Outputs		**Equity aims/outcomes for this work:**	
Enablers:	*Pathways of Care, Quality, Workforce, Data & Digital Services*	**Who:**	*HealthShare Project Manager / Community hepatitis C service / hepatitis C working groups*
Measures/ validation:	• *Update and monitor Te Manawa Taki region HCV Point of Care database.* • *Quarterly narrative report on progress of the key actions.* • *Using the template below provided by the Ministry, report six monthly at the end of quarter two and quarter four on the following measure*		
	Measure	***Data collection process***	
	Number of people diagnosed with hepatitis C.	• *DHB regions to obtain data (by age bands) from reference labs, and in future from community labs who perform antigen tests, on the total number of people with a positive HCV PCR and/or antigen test and report to the Ministry of Health via six monthly RSP reports.*	
Category: Integrated service			
Health Outcome objective: Engagement and collaboration across the region of hepatitis C stakeholders			
Workplan Outputs		**Equity aims/outcomes for this work:**	
• **Continuous improvement of activities to support the successful implementation of an integrated hepatitis C assessment and treatment service in Te Manawa Taki.**		Continuous improvement (identification of options, and implementation) in integrated hepatitis C assessment and treatment services.	
Enablers:	*Pathways of Care, Quality, Workforce, Data & Digital Services*	**Who:**	*HealthShare co-ordinating on behalf of Te Manawa Taki DHBs*
Measures/ validation:	• *Each DHB region has a hepatitis C working group with Māori representation.* • *Establish regional hepatitis C steering group.*		
Category: National Hepatitis C Action Plan			
Health Outcome objective: Support the implementation of the National Hepatitis C Action Plan			
Workplan Outputs		**Equity aims/outcomes for this work:**	
• **People will experience more standardised resources and care.**			
Enablers:	*Pathways of Care, Quality, Workforce*	**Who:**	*HealthShare Project Manager, Te Manawa Taki hepatitis C working groups*
Measures/ validation:	• *Obtain regional agreement to implement.* • *Sign off by regional working groups.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.9 Mental Health & Addiction services (Regional Mental Health & Addiction Network)

Workplan Outputs		***Equity aims/outcomes for this work:***	
Mental health & addiction is a regional priority for Te Manawa Taki – refer to the REP infographic for an overview of Māori health equity issues and priorities.			
Health Outcome objective: Improved addiction service capacity and capability for implementation of substance abuse legislation			
• **Implementation of the Addiction pathways, and regional Addiction Model of Care if funding secured.**		Availability of addiction services through increased capacity and capability. *(CM-Bed occupancy, overnight admissions, discharges & community service contact)* *(MH01, MH03)* Improvements in addiction rates due to increased engagement with support services. *(P)* Coordinated implementation (based on funding) of He Ara Oranga: Pathways to Wellness recommendations. *(DHB annual planning guidance)* *(P)*	
Enablers:	*Quality, Pathways of Care, Workforce, Data & Digital Services*	**Who:**	*Regional Director and Clinical Governance.*
Measures/ validation:	• *New funding is received and implemented as per Te Manawa Taki DHB proposals.* • *Monitoring of new funding is developed and reported quarterly.*		
Health Outcome objective: Health outcomes based on implementing recommendations from He Ara Oranga			
• **Support local DHB implementation of He Ara Oranga: Pathways to Wellness.**		Health outcomes as prioritised through He Ara Oranga.	
Enablers:	*Quality, Pathways of Care, Workforce*	**Who:**	*Regional Director and Clinical Governance*
Measures/ validation:	• *New funding is received and implemented as per Te Manawa Taki DHB proposals.* • *Monitoring of new funding is developed and reported quarterly.*		
Health Outcome objective: The successful implementation of modern clinical workstations across Te Manawa Taki			
Inclusion of MH&A within Clinical Portal.			
Enablers:	*Quality, Pathways of Care, Workforce, Data & Digital Services.*	**Who:**	*Clinical Governance and Te Manawa Taki Clinical Portal.*
Measures/ validation:	• *Lakes go live in 2020 is successful.* • *Tairāwhiti go live in 2020 is successful.* • *Taranaki go live in 2020 is successful.*	• *BOP go live in 2021 is successful.* • *Waikato go live in 2021 is successful.*	
Health Outcome objective: Health equity for Māori in mental health outcomes			
• **Implementation of Māori mental health equity strategies.**		• Mental health outcomes through coordinated work with communities and stakeholders. *(MH02)*	
Enablers:	*Quality, Workforce*	**Who:**	*Regional Director and Regional Stakeholder Groups*
Measures/ validation:	• *Reduction in Māori placed on a compulsory treatment order.* *(MH05)* • *Feedback Informed Treatment analysis is undertaken and presented to the sector.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.10 Planned Care services (SS07)

Areas of focus for 2020/21 are equity of access, regional collaboration, workforce utilisation & quality of service delivery.

2.10.1 Vascular

Category: Planned Care: Access and service delivery (Areas of focus for the 2020/21 year are equity of access, regional collaboration, workforce utilisation and quality of service delivery).			
Health Outcome objective: Improve the regional delivery of vascular services			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Development of Vascular nursing services to strengthen existing services and address issues of workforce vulnerability within the service.**		• Intervention rates for vascular services. • Continuity of service provision in region. • Accessibility of consistent services throughout region.	
Enablers:	*Workforce, Quality, Data & Digital Services*	**Who:**	*Regional Vascular Network*
Measures/ validation:	• *Develop baseline set of measures/indicators to establish intervention rate for individual DHBs and Māori/ Non-Māori.*		
Category: Renal services			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Short terms actions to mitigate the current capacity pressure on renal and associated health services across the region. A long-term regional strategy to deliver equitable, culturally appropriate services across Te Manawa Taki.**		• Co-design of regional renal strategy about responsibilities and possible contributions to improving outcomes. • Increase in people receiving home-based treatment. • More patients (target 90%) treated at a dialysis unit within one hour travel time of their home.	
Enablers:	*Workforce, Quality, Data & Digital Services*	**Who:**	*Regional Vascular Network*
Measures/ validation:	• *A target of 90% of patients treated at a dialysis unit within 1-hour travel time of their home.* • *Increased numbers of those receiving home-based treatment.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.10 Planned Care services

2.10.2 Ophthalmology

Health Outcome objective: Improve access to the treatment of Age-related Macular degeneration (AMD) Glaucoma and Diabetes related Eye Disease			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Cost effective and timely delivery of intraocular eye injections as per RANZCO guidelines.**		*Increased rates of diabetes are resulting in increased rates of eye disease, especially for Māori.* • Waiting times for treatment of Age-related Macular Degeneration (AMD), Glaucoma & Diabetes related Eye Disease. • Accessible, cost effective and timely AMD treatment.	
Enablers:	*Workforce, Quality, Data & Digital Services*	**Who:**	*Regional Ophthalmology departments and COO group*
Measures/ validation:	• *Data collected from the Acuity Index and Ministry of Health measure waiting times for treatment for Māori and Non-Māori.* • *Rates of saved vision.*		

2.10.3 Infectious diseases

Category: Planned Care: Access and service delivery			
Health Outcome objective: Improve the regional delivery of Infectious Diseases			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Twice yearly multi-disciplinary meetings are held.** (DHB annual planning guidance – antimicrobial resistance) • **Enable sharing of regional laboratory results.** • **Expand home I.V. service.** • **Improve HIV services.**		• Accessibility of home IV services.	
Enablers:	*Workforce, Quality, Data & Digital Services*	**Who:**	*Regional Infectious Diseases Collaborative*
Measures/ validation:	• *Waiting times for HIV services measured. Volumes of those receiving home I.V. therapy (as per OPIVA) and their ethnicity counted.* • *Sharing of regional I.D. laboratory results achieved. Multi-disciplinary meetings held in May and November 2020.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.11 Radiology services

<table>
<tr><td colspan="4">Category: Service delivery and systems improvement</td></tr>
<tr><td colspan="4">Health Outcome objective: New regional KPIs will be developed and monitored to identify regional inequities in service provision</td></tr>
<tr><td colspan="2">Workplan Outputs</td><td colspan="2">Equity aims/outcomes for this work:</td></tr>
<tr><td colspan="2">• Quarterly reports will be produced, analysed and issues identified.</td><td colspan="2">• Consistent, effective regional service provision – including timeliness of MRI and CT scans (incl. CT Colonoscopy). (SS15)</td></tr>
<tr><td>Enablers:</td><td>Data & Digital Services</td><td>Who:</td><td>MRAG</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">• CT- 90% of accepted referrals from primary care or outpatients for CT scans will receive their scan within six weeks (42 days).
• CT Colonoscopy (a subset of the CT KPI above) – 95% of accepted referrals from primary care or outpatients for CT Colonoscopy scans will receive their scan within six weeks (42 days).
• MRI - 90% of accepted referrals from primary care or outpatients for MRI scans will receive their scan within six weeks (42 days).</td></tr>
<tr><td colspan="4">Health Outcome objective: Improve Health Equity for Māori through the reduction of DNAs</td></tr>
<tr><td colspan="2">• Proposal outlining recommended strategies will be developed including actions, to reduce the number of Māori DNA in one DHB radiology service.</td><td colspan="2">Māori have significantly higher DNA rates, than other ethnicities, for accessing Health services including services which offer treatment, diagnostics & imaging
• Reduction of DNA rates for Māori.</td></tr>
<tr><td>Enablers:</td><td></td><td>Who:</td><td>MRAG / DHB project teams for past and current DNA pieces of work</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">• A national stocktake of initiatives trialled will be undertaken.
• Quarterly update of stocktake to MRAG members.
• An agreed approach to reducing the number of Māori DNA will be developed by Q4.</td></tr>
<tr><td colspan="4">Health Outcome objective: National initiatives and regional projects (The MRAG regional services plan will include and support both those initiatives which are identified on the National Radiology Action Group (NRAG) plan and other relevant Healthshare regional plans which require radiology input)</td></tr>
<tr><td colspan="2">Workplan Outputs</td><td colspan="2">Equity aims/outcomes for this work:</td></tr>
<tr><td colspan="2">• MRAG will attend the NRAG meetings and provide support through the completion of assigned tasks.</td><td colspan="2"></td></tr>
<tr><td>Enablers:</td><td>Pathways of Care, Quality</td><td>Who:</td><td>MRAG</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">• MRAG will action requested appropriate tasks and outcomes will be documented.</td></tr>
<tr><td colspan="4">Health Outcome objective: Strategies for addressing specialist shortages will be investigated</td></tr>
<tr><td colspan="2">• Strategies will be explored for addressing service gaps due to specialist shortages.</td><td colspan="2"></td></tr>
<tr><td>Enablers:</td><td>Quality</td><td>Who:</td><td>MRAG</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">• CT- 90% of accepted referrals from primary care or outpatients for CT scans will receive their scan within six weeks (42 days).
• CT Colonoscopy (a subset of the CT KPI above) – 95% of accepted referrals from primary care or outpatients for CT Colonoscopy scans will receive their scan within six weeks (42 days).
• MRI - 90% of accepted referrals from primary care or outpatients for MRI scans will receive their scan within six weeks (42 days).</td></tr>
</table>

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.12 Stroke services (Stroke Network)

Health Outcome objective: *Incidence of stroke: Stroke is the leading cause of adult disability in NZ. In general, stroke admission rates across NZ are increasing (more than 5% over the last four years, and in those age 45-65 it has increased by 12% over 4 years).*

- *The stroke admission rates in Māori have risen two and a half times faster than in other ethnicities over this time.*
- *Māori have been shown to suffer stroke about 10 years younger than other ethnicities.*

The regional Stroke Network has a continued focus on providing timely and accessible high-quality stroke services within the hospital setting and on providing appropriate rehabilitation in the acute and post discharge periods. Improving equitable health outcomes for Māori will be achieved through the;

- *continued production of the Stroke Network Quarterly Data Reports not only assists with reviewing progress against the Ministry of Health indicators but also identifies the equity between Māori and Non-Māori,*
- *improvements/changes that will be worked on under the Patient Experience of Care category were identified at the Māori Consumer Wananga held in 2019,*
- *improved access to specialist stroke services and ensuring these services are available across Te Manawa Taki. As Māori have a higher rate of strokes, improved access to specialist services that are closer to home should reduce the impact on consumers and their whānau,*
- *reduction in numbers of strokes caused by Atrial Fibrillation (AF). Māori experience higher rates of AF compared with Non-Māori and develop the condition earlier. People with AF are five times more likely to have a stroke than people without AF and strokes associated with AF are more severe.*

Workplan Outputs		Equity aims/outcomes for this work:	
Category: Rehabilitation			
Health Outcome objective: Increased access to stroke rehabilitation services that are consistent, and equity based			
• **Implementation plan for the strategies that are being developed and agreed to in the 2019/20 year.** • **Quarterly Stroke Network Data Report.**		• Access to consistent, equity-based stroke rehabilitation services. (RSP guidelines) (SS13) • Percent (target 60%) of patients referred for community rehabilitation seen face-to-face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. • Percent (target 80%) of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within seven days of acute admission.	
Enablers:	*Quality, Workforce, Data & Digital Services*	**Who:**	*HealthShare Project Manager, Stroke Network, Allied Health Stroke Group, HealthShare Senior Analyst*
Measures/ validation:	• *Implementation plan agreed, Q2.* • *60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation tea within 7 calendar days of hospital discharge.* • *80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred with 7 days of acute admission.* • *Quarterly reporting includes rates for Māori and Non-Māori.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
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Workplan Outputs		***Equity aims/outcomes for this work:***	
Category: Equitable access to acute specialist services			
Health Outcome objective: Improved access to specialist stroke services			
• **Signed contracts and agreed start dates for the provision of out of hours telestroke services in the DHB regions where telestroke is not currently available.** • **Quarterly Stroke Network Data Report.**		• Improved access to acute specialist stroke service. (RSP guidelines)	
Enablers:	*Quality, Workforce, Data & Digital Services*	**Who:**	*HealthShare Project Manager, Stroke Network, HealthShare Senior Analyst*
Measures/ validation:	• *Contracts signed by end of Q3.* • *10% or more of eligible stroke patients are thrombolysed 24/7.* • *80% of stroke patients are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.* • *Quarterly reporting includes rates for Māori and Non-Māori.*		
Health Outcome objective: Improved access to Stroke Clot Retrieval services for the regional population			
• **Feasibility data on Waikato Hospital providing a Stroke Clot Retrieval service for the Region.**		• *Equitable access to specialist stroke services & Stroke Clot Retrieval services. (RSP guidelines)*	
Enablers:	*Quality, Workforce,Data & Digital Services*	**Who:**	*HealthShare Project Manager, Stroke Network*
Measures/ validation:	• *Feasibility analysis completed – Q3.* • *10% or more of eligible stroke patients are thrombolysed 24/7.* • *80% of stroke patients are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. (SS13) .* • *Identify feasibility of a Stroke Clot Retrieval service at Waikato Hospital, closer to home.*		
Health Outcome objective: Improved access to stroke imaging			
• **Agreement from Te Manawa Taki DHB Radiology Services to provide CT, CTA and CTP 24/7.**			
Enablers:	*Quality, Workforce, Data & Digital Services*	**Who:**	*HealthShare Project Manager, Stroke Network*
Measures/ validation:	• *Agreed start dates at each of the five secondary/tertiary hospitals for access to imaging - Q4.*		
Category: Patient Experience of Care			
Health Outcome objective: Culturally competent standards of care are provided for Māori consumers of stroke services			
• **Implementation plan for the improvements/ changes agreed to in the 2019/20 year.**		• Provision of culturally competent stroke services to Māori consumers, including specialist stroke services that are closer to home. *(RSP guidelines)*	
Enablers:	*Pathways of Care, Quality*	**Who:**	*HealthShare Project Manager, Stroke Network*
Measures/ validation:	• *Implementation plan is endorsed by the Stroke Network by the end of Q2.* • *Implementation has started – dk Q4.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Category: Awareness, Prevention and Workforce			
Health Outcome objective: People living in Te Manawa Taki remember the FAST message			
• **DHB Plans for promoting the FAST message.**			
Enablers:	*Quality*	**Who:**	*HealthShare Project Manager, Stroke Network*
Measures/ validation:	• *Plans are developed by DHBs – Q4.*		
Health Outcome objective: Reduced number of strokes caused by Atrial Fibrillation (2020/2023)			
• **An agreed plan for the regional Stroke and Cardiac networks to work together on Atrial Fibrillation, with a focus on improving Māori Health Equity.**		• Reduce the rate of strokes resulting from Atrial Fibrillation. *(RSP guidelines)*	
Enablers:	*Quality, Workforce and Data & Digital Services*	**Who:**	*HealthShare Project Manager, Stroke Network, Cardiac Clinical Network*
Measures/ validation:	• *The plan is endorsed by the regional Stroke and Cardiac Clinical Networks – Q4.* • *Reduced number of strokes caused by Atrial Fibrillation.* *(RSP guidelines)*		
Health Outcome objective: Identified vulnerable stroke workforce are supported (2020/2023)			
• **Vulnerable and isolated stroke workforce members that are linked to the Outcomes in this 2020/21 Regional Equity Plan are identified.**			
Enablers:	*Workforce*	**Who:**	*HealthShare Project Manager, Stroke Network, Allied Health Group*
Measures/ validation:	• *Vulnerable and isolated stroke workforce members identified – Q4.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

2.13 Trauma services (Midland Trauma System – MTS)

Workplan Outputs	Equity aims/outcomes for this work:
• ***MTS Equity Statement:*** *The Midland Trauma System (MTS) and its staff view variation in trauma incidence and access to care as inequities in healthcare. Our clinical and prevention programmes are focused on identifying and defining these inequities so they can be addressed and resolved by MTS and our partners that are responsible for healthcare delivery and injury prevention.* • *Māori are over-represented in many injury statistics.*	
Category: Clinical care	
Health Outcome objective: Injured patients in Te Manawa Taki will receive equitable, highest quality trauma care	
• **Revised regional clinical guidelines are implemented in all Te Manawa Taki DHBS.** Objective 3.3 • **Inequities in the delivery of trauma care are identified and reported.** (Data) • **Trauma patient and whānau experience/feedback is collected and used to improve services.** Objective 3.2, (Experience of care) • **MTS clinicians are supported to have adequate time and resources to provide expert clinical care to patients and whānau.** • **Regional trauma education and training programme is supported.** • **Develop a "one-call" system for urgent referral of trauma patients across Te Manawa Taki to definitive care.**	• Equity of care is better defined and understood by trauma care providers. • Inequities of trauma care are identified and addressed with monitoring to track improvement. • Patients and whānau go directly to the right facility for definitive care. • Improved patient/whanau access and experience of care. • Childhood Preventable admissions for children (0-4). • Patients go directly to the right facility for definitive care. *Objective 3.3* • Improvement in patient/whānau experience of care. *Objective 3.2, SLM experience of care*

Enablers:	*Quality*	**Who:**	*MTS*
Measures/ validation:	• Reduction in avoidable mortality and morbidity. *(Acute hospital bed days – CM-Falls & fractures) (M)* • Reduction of time spent in ED by trauma patients. *(CM-ED stay <6hrs) (SS10)* • *Non-adherence to agreed protocol's and best practice are identified and investigated.* • *Trauma equity measures are defined. (Collaboration and data)* • *Areas for improvement identified by patients and whānau and co design principles applied to address. SLM experience of care* • *Staff experience is captured and used to improve service and process.* • *Dedicated regional trauma education and training role is established.* • *Access and uptake of trauma education and training for regional clinical staff is improved.* • *Trauma patient discharge information is available to primary health clinicians and continuing care agencies.* • *The number of calls between referring and accepting clinicians is significantly decreased leading to faster, more efficient patient transfers.*		

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

<table>
<tr><td colspan="4"><u>Category:</u> Regional trauma system infrastructure including information systems</td></tr>
<tr><td colspan="4">Health Outcome objective: Highest possible quality care to patients and whānau is supported with appropriate regional trauma infrastructure</td></tr>
<tr><td colspan="2">Trauma data is readily available to DHB staff.
Maximise the use of technology to reduce FTE for data management.
MTS registry and data systems support quality improvement initiatives.
Adequate FTE is available for MTS staff to address agreed work plans in Te Manawa Taki DHBs.
Midland Trauma Research Centre (MTRC) research provides an evidence base for increased levels of local and regional decision making.
Health Research</td><td colspan="2"></td></tr>
<tr><td>Enablers:</td><td>Quality, Data & Digital Services</td><td>Who:</td><td>MTS, Waikato IS, Public Health</td></tr>
<tr><td>Measures/ validation:</td><td colspan="3">All data is entered within agreed timeframes.
Registry upgrade 2020 is completed.
Qliksense server version is functional in all Te Manawa Taki DHBs and accessible to MTS staff.
Te Manawa Taki major trauma data is uploaded to Major Trauma National Registry.
Trauma registry information is translated for clinical care and system improvement.
Automated non major data collect trial is completed.
Trauma service resource allows for agreed work plans to be progressed.</td></tr>
<tr><td colspan="4"><u>Category:</u> Injury prevention & awareness (Midland Trauma Research Centre) – through collaborative research & design</td></tr>
<tr><td colspan="4">Health Outcome objective: Regional Injury prevention is targeted for populations of Te Manawa Taki</td></tr>
<tr><td colspan="2">Inequities in the incidence of trauma are defined in detail for prevention activities. (Data)
DHBs are informed of the trauma risk profile of their communities. (Data)
Regional Paediatric Trauma Study is delivered and disseminated. Improved child wellbeing
Ethnicity injury study commenced 2020 in partnership with Māori leads. Equity of outcomes, Data quality Data
Targeted trauma education for youth at risk is delivered.
Increased collaboration of MTS with other regional services.</td><td colspan="2">Trauma inequities are identified in each DHB and presented for planning and actions
DHBs are informed of the injury risk and inequities of their communities.
Ethnicity injury study commenced 2020 in partnership with Māori leads. (data quality)
Targeted trauma education for youth at risk is delivered.
Increased engagement with agencies and groups who can impact on inequities identified (e.g. community groups and schools).
Childhood Injury risks identified and communicated preventable admisions for 0-4 yrs</td></tr>
</table>

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
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Enablers:	*Workforce*	**Who:**	*MTS*
Measures/ validation:	• *Infographic snapshots detailing issues are delivered quarterly.* • *Inequities in trauma incidence are communicated to DHBs and responsible community agencies for injury prevention action. e.g. council and road safety groups.* *(Data)* • *Trauma issues are highlighted at safety partner meetings e.g. NZTA, councils, etc.* • *Critical point programme is delivered to Te Manawa Taki Schools.* • *Right track programme delivered in Te Manawa Taki.* • *Childhood injury data is incorporated into Child Health initiatives and injury prevention.* *Improved child wellbeing,* *Preventable admissions for 0-4 years,* *(Data)*		
Category: Quality improvement			
Health Trauma Quality Improvement Program (TQIP) improves the efficiency and effectiveness of trauma care delivery to Te Manawa Taki patients and whānau Objective 3.3			
• **Trauma systems and processes are monitored with an emphasis on equity.** (Data) • **Audits are developed to identify inequities of access to trauma services.** (Data) • **Data systems are optimised to allow efficient assessment of quality processes.** • **Review current ethnicity data collection and reporting practices against national protocols** Data quality • **Annual Trauma Symposium delivered.**		• Validated ethnicity reporting. *(data quality)* • TQIP reporting identifies inequities and are used to inform service improvements. • Avoidable mortality and morbidity is identified and reported. • Inequitable clinical, system and process issues addressed through loop closure process.	
Enablers:	*Quality, Workforce*	**Who:**	*MTS*
Measures/ validation:	• *DHB's receive regular trauma QI information to review performance against targets.* • *TQIP reporting identifies inequities and are used to inform service improvements.* • *Progress against binational indicators is measured and improved.* *RACS Bi National Trauma indicator* • *Loop closure process is enacted and measured on identified clinical, system and process issues.* Objective 3.3 • *Avoidable mortality and morbidity is identified and reported.* • *Registry/system generated red flag reports on trauma issues developed.* • *Each DHB participates in data quality programme.* • *MTS staff complete quality improvement training with HQSC.* • *Quality improvement activities and reporting meet national standards.* • *Trauma morbidity and mortality meetings are structured with loop closure applied.* • *Quarterly regional case reviews are conducted with inequities of care identified.* • *Process indicator targets are monitored and reported.*		
Line of Sight			
• *Te Manawa Taki DHB Annual Plans, section 2 – delivering on priorities and targets.* • *Major Trauma National Clinical Network Strategic Plan.* • *SLM and Māori Health plans as indicated.*			

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

Annual workplans – Enabler groups

2.14 Enabler: Pathways of Care

Workplan Outputs		***Equity aims/outcomes for this work:***	
The Regional Pathways of Care work plan is over a three-year period focusing on the patient journey from primary care to secondary care. The Pathways of care team do not support the patient pathway within the secondary setting. The plan indicates initiatives to be undertaken in the coming year, however this is contingent on financial ability across the region to fund the initiatives. Also refer service workplan items that include 'Pathways of Care' as an enabler.			
Category: Pathways of Care Team outputs			
Health Outcome objective: Strong, integrated regional pathways of care increase the prompt, identification, referral and treatment of health conditions			
• **Connecting high priority services to HealthPathways and eReferral.**		• Reducing barriers and increasing referral numbers to and from high-priority services, incl. kaupapa Māori services. *(DHB annual plan guidance – Māori Health Action Plan), Well Child/Tamariki Ora providers, Community Mental Health*	
Enablers:	*Pathways of Care, Data & Digital Services*	**Who:**	*Pathways of Care Team*
Measures/ validation:	*Number of services connected via the enablers of HealthPathways and eReferrals. Increase in referral numbers to and from high priority services e.g.: Kaupapa Māori Services, Tamariki Ora/Well Child Providers, Community Mental Health.*		
• **Strengthen Pathways of Care Programme through clinical champions and resourcing.** *(Continued increase in clinical engagement, collaboration and leadership in regional and local Programme)*			
Enablers:	*Pathways of Care*	**Who:**	*Pathways of Care Team*
Measures/ validation:	• *Improved utilisation of HealthPathways.* • *Localised HealthPathways used in the delivery of education sessions.* • *Improved networking between regional GPs involved in Pathways of Care initiatives.*		
• **Continue to work on the priority pathways identified by the region. (Refer Category list below)**			
Enablers:	*Pathways of Care*	**Who:**	*Pathways of Care Team*
Measures/ validation:	• *Publishing of localised:* • *Child Health Pathways identified by CHAG,* • *Chest Pain Pathway,* • *Renal pathways,* • *Identified Mental Health Pathways,* • *Prostate Cancer Pathway and eReferral,* • *Support the regional Cardiac five-year strategic plan, with improved referrals and triage*		

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2.15 Enabler: Quality (Regional Quality Network)

Also refer service workplan items that include 'Pathways of Care' as an enabler.			
Health Outcome objective: System and people receive Quality Care			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Working with Te Manawa Taki Iwi Relationships Board, and Nga Toka Hauora Māori (GMs Māori) with a commitment to te Tiriti o Waitangi, to develop the necessary tools and enablers to achieve systems changes – people-driven; co-produced in authentic relationships; power distributing[20].**		Influence decisions on allocation of health resources, incl. divestment from strategies that do not promote equity and increasing resourcing for equity-focused actions. [3-year plan] Improving internal & external relationships and increased regional awareness and visibility of health equity. [3-year plan]	
Enablers:	*Pathways of Care Quality*	**Who:**	*Regional Quality Network (with guidance and leadership from Te Manawa Taki Iwi Relationship Board and GMs*
Measures/ validation:	• *Partnering with the Te Manawa Taki Iwi Relationship Board and Nga Toka Hauora to ensure equity is routinely considered in planning processes by including the Health Equity Assessment Tool (HEAT) questions are addressed for all Te Manawa Taki Regional Services planning and procurement.* • *Developing a dual HEAT approach across Te Manawa Taki Regional Services through using a 'rapid desktop assessment' or, a full-scale HEA[21]. The full-scale HEA would only be used if the 'rapid desktop assessment' was significant in terms of health equity gains.* • *Prioritising planned regional HEAs using Taranaki's dual approach for 2021 onwards.*		

2.16 Enabler: Workforce

Also refer to service workplans for all Outputs that include Workforce as an Enabler, in particular • *Cardiac Services* • *Stroke Services*			
Health Outcome objective: Career framework for Allied, Scientific and Technical Workforce			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Career framework that enables transportability and consistency of professional workforce across Te Manawa Taki, and compliance with employment agreement.**			
Enablers:	*Workforce development*	**Who:**	*Directors of Allied Health in DHBs, RDOW*
Measures/ validation:	• *Engagement of workforce in development of career framework. Delivery of framework.*		
• **Alignment with Health and disability workforce strategic priorities**		Māori workforce capacity built to meet whānau Māori health needs, to match the population. [3-year plan] [Other] *(DHB annual plan guidance – Sustainability: Māori workforce)*	
Enablers:	*See above*	**Who:**	*See above*
Measures/ validation:	• *Elimination of institutional racism & bias – perceived institutional racism.* [3-year plan] [SLM (/CM)] *(CM-incl. via adult in patient survey)* [DHB Perf. Measure] *(data via PH01)* [Other] *(DHB annual plan guidance – Māori health action plan – Shifting cultural and social norms)* • *Link with strengthening shared skills and values across the professions and working better as teams across the system priority.*		

[20] A Window on the Quality of Aotearoa New Zealand's Health Care 2019 – HQSC Chapter 3a
[21] A Taranaki DHB health equity assessment process - www.tdhb.org.nz/services/public_health/health_equity_assessments.shtml

[black]	3-year plan	[red]	DHB Perf. Measure	[grey]	He Korowai Oranga	[blue]	Other
[orange]	Māori health indicators	[yellow]	Minister's priority	[orange diagonal]	SLM (/CM)		

2.17 Enabler: Data & Digital Services

Workplan Outputs					*Equity aims/outcomes for this work:*
Equitable health & wellbeing outcomes: Ethnicity data benchmark & data quality. *(PH02)* Also refer to service workplans for Outputs that include Data & Digital Services as an Enabler.					
Health Outcome objective: Improved patient outcomes through implementation of national strategies and initiatives for digital health					
IT Security maturity enhancement.					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	• *The successful introduction, and implementation, of a suite of sector-wide IT Security maturity initiatives.* • *Regular security testing performed.*				
Regional and national collaboration (where appropriate) including shared learnings and other collateral.					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	• *Where relevant collateral is re-used.* • *Lessons learnt are considered when developing designs and undertaking projects.*				
National standards and architecture design considerations for all digital initiatives					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	• *Continue involvement in Ministry standards – Connected Health, Interoperability, Identity Access.*				
Regional ICT Investment Portfolio.					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	• *Quarterly regional Portfolio reporting to Ministry of Health, Data and Digital Team.* • *Regional ICT asset management framework and plan developed and approved.*				
National Digital Services.					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	1	• *Business cases consider cloud based solutions and "as a Service" offerings.* • *Implementations adhere to national and regional standards.*			
	2	• *Regional Oral Health Service Schedule agreed.* • *Nationally agreed standards adopted regionally.* • *Regional reporting capability enabled.*			
Digital Maturity.					
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*	
Measures/ validation:	• *Digital Maturity assessments completed as requested by the Ministry.* • *Agreed approach to address any opportunities identified as regional.*				

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Workplan Outputs		Equity aims/outcomes for this work:	
Health Outcome objective: Shared Clinical Information (Smart Systems)			
Creation of an integrated view of Cardiology imaging and results.			
Enablers:	*Data & Digital Services*	**Who:**	*All DHBs*
Measures/ validation:	• *Waikato DHB, Lakes DHB and Hauora Tairāwhiti DHBs on regional ISCV.* • *Feasibility case produced for Bay of Plenty and Taranaki DHBs.* • *Business Case approved (if feasibility favourable).* • *Cardiology imaging and results implemented for all DHBs regionally (if business case approved).*		
Oncology e-Prescribing solution feasibility.			
Enablers:	*Data & Digital Services*	**Who:**	*All DHBs*
Measures/ validation:	• *Business case(s) approved where applicable.*		
Continued digital enablement of Cancer services			
Enablers:	*Data & Digital Services*	**Who:**	*All DHBs*
Measures/ validation:	• *Head & Neck and Breast cancer pathways and MultiDisciplinary Meetings using the regional Clinical Pathways and MDM Management solution.*		
Creation of an integrated view of patient information. One Patient, One Record, One Region.			
Enablers:	*Data & Digital Services*	**Who:**	*All DHBs*
Measures/ validation:	• *Business case(s) approved where applicable.* • *Regional design, functions and features approved.* • *Implementation of a regional Clinical Portal solution with read/write capability.*		
Clinical Portal Implementation of solutions to support the regional objectives (One patient, One record, One Region) and replace legacy systems.			
Enablers:	*Data & Digital Services*	**Who:**	*All DHBs*
Measures/ validation:	1	• *Bay of Plenty MCP go live – Sept 202*	
	2	• *Hauora Tairāwhiti MCP go live – Feb 2021*	
	3	• *Regional eResults stage one deployed.* • *Lakes DHB business case signed off and project initiated.* • *Regional Mental Health and Addiction Services Business Case signed off and project initiated.* • *Community Access business base signed off and project initiated.* • *Regional eOrdering business base signed off and project initiated.*	

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
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Medicines Management Digital Services.				
Enablers:	*Data & Digital Services*		**Who:**	
Measures/ validation:	1	• *All providers to adopt the NZF/NZULM.* • *All regions to have an action plan for the adoption of NZePS across general practices and ePA for hospital pharmacies in a way that protects and ensures a person's safety, security and privacy.*		
	2	• *eMedicines pilot business case approved.* • *PID (Implementation) plan is approved.* • *Pilot solution deployed to a single hospital and evaluated.* • *Full regional deployment of the eMedicines solution approved in principle.*		
Regional Data Platform for Analytics and Insights.				
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*
Measures/ validation:	• *Approved toolsets are able to connect (securely) to the platform.* • *Data and Privacy Governance Groups manage compliance.* *Note: This initiative also improves Equitable Outcomes Actions (EOA) by ensuring data and information is available to analyse information for equitable outcome actions.*			
Agreed common practices across the region to data management and standards aligning with national direction where available.				
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*
Measures/ validation:	• *Workplan is agreed.* • *Objectives/outcomes are delivered as agreed.*			
Enhanced integration and interoperability of data/ information flows.				
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*
Measures/ validation:	• *Data flows are enhanced across Te Manawa Taki (and nationally where applicable).*			
Health Outcome objective: Shared Clinical Information (Smart Systems)				
Development and utilisation of Virtual Care technologies and practices.				
Enablers:	*Data & Digital Services*		**Who:**	*All DHBs*
Measures/ validation:	• *Telehealth work plan progresses as per plan (via regional Telehealth Forum).*			

	3-year plan		DHB Perf. Measure		He Korowai Oranga		Other
	Māori health indicators		Minister's priority		SLM (/CM)		

SIX MONTHLY BOARD ATTENDANCE REPORT
1 January – 30 June 2020

SUBMITTED TO:
Board Meeting 19 August 2020

Prepared by: Maxine Griffiths, Board Secretariat
Endorsed by: Debbie Brown, Senior Advisor, Governance & Quality
Submitted by: Simon Everitt, Interim Chief Executive

RECOMMENDED RESOLUTION:
That the Board notes the information

Board Members	Board		FARM		CPHAC/DSAC		BOPHAC	
	(Attended / Did Not Attend)							
	A	DNA	A	DNA	A	DNA	A	DNA
Mark Arundel	6	0	4	1	1	0		
Marion Guy	6	0	5	0			1	0
Ron Scott	6	0	5	0			1	0
Geoff Esterman	6	0	5	0			1	0
Bev Edlin	6	0	5	0	1	0		
Pouroto Ngaropo	3	3						
Hori Ahomiro	5	1			1	0	1	0
Michael Cullen *	2	0	1	1	1	0		
Ian Finch	6	0	5	0	1	0		
Leonie Simpson	6	0					1	0
Sharon Shea	6	0	4	1			1	0
Arihia Tuoro	6	0	5	0	1	0		
Total number of scheduled meetings	6		5		1		1	

* Sir Michael Cullen resigned due to ill health in March 2020

** The Strategic Health Committee was ceased in October 2019

Varying numbers of meetings and attendances is due to incoming new Board Members and reallocation of membership of Committees.

Chief Executive Expenses
1 July 2019 – 30 June 2020

SUBMITTED TO:

Board Meeting 19 August 2020

Submitted by: Simon Everitt, Interim Chief Executive

RECOMMENDED RESOLUTION:
That the Board note the information.

BACKGROUND:
Chief Executives of Public Service departments and statutory Crown entities regularly disclose their expenses to provide transparency and accountability for their discretionary expenditure. The State Services Commission has issued model standards. The disclosures make transparent the standards of probity and financial prudence and provide public assurance about the propriety of the expenditure. This requirement is in line with international practice, and in New Zealand, Ministers, MPs and Mayors are all subject to disclosure provisions.

Chief Executives make this information publicly available annually on the BOPDHB website and www.data.govt.nz.

Disclosures containing information for the financial year (ending 30 June) are published by 31 July each year.

ATTACHMENTS:
- Helen Mason's CEO expenses disclosed for the period of 1 July 2019 to 15 November 2019.
- Simon Everitt's Interim CEO expenses disclosed for the period of 11 November 2019 to 30 June 2020.

Chief Executive Expenses, Gifts and Benefits Disclosure - summary & sign-off*

Organisation Name	Bay of Plenty District Health Board
Chief Executive**	Simon Everitt
Disclosure period start***	11 November 2019
Disclosure period end***	30 June 2020
Agency totals check	Data and totals checked on all sheets
Chief Executive approval****	This disclosure has been approved by the Chief Executive
Other sign-off****	Sharon Shea, Interim Board Chair

This summary page updates automatically from the 'Travel', 'Hospitality', 'All other expenses', and 'Gifts and benefits' tabs.

Throughout this workbook, input cells are shaded light green.

Summary of expenses	Cost in NZ$	GST inc / exc		Gifts and benefits	Count
Travel expenses	**$4,751.59**	Figures include GST (where applicable)		**Number offered**	**0**
Hospitality	**$0.00**	Figures include GST (where applicable)		**Number accepted**	**0**
Other expenses	**$3,179.50**	Figures include GST (where applicable)		**Number declined**	**0**
International Travel	$0.00	Figures include GST (where applicable)			
Domestic Travel	$4,751.59	Figures include GST (where applicable)			
Local Travel	$0.00	Figures include GST (where applicable)			

Notes

* Headings on following tabs will pre populate with what you enter on this tab

** Create a new workbook for a new Chief Executive

*** Update if a shorter or different period is covered

**** This disclosure must be approved by the Chief Executive and another appropriate party, e.g. Board Chair, Chief Financial Officer or Audit and Risk Committee member

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Simon Everitt
Disclosure period start	11 November 2019
Disclosure period end	30 June 2020
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

International, domestic and local travel expenses

All expenses incurred by chief executive during international, domestic and local travel. Group expenses relating to each trip.

International Travel (including travel within NZ at beginning and end of overseas trip)

Date(s)*	Cost in NZ$**	Purpose of travel (e.g. attending XYZ conference for 3 days)***	Type of expense (e.g. hotel, airfares, taxis, meals & for how many people)	Location(s)
Nil	$0.00			
Subtotal - international travel	**$0.00**	**Check - there are no hidden rows with data**	**Not all lines have an entry for "Cost in NZ$" and "Type of expense"**	

Domestic Travel (within NZ, including travel to and from local airport)

Date(s)*	Cost in NZ$	Purpose of travel (e.g. visiting district office for two days...)***	Type of expense (e.g. hotel, airfares, taxis, meals & for how many people)	Location(s)
15/11/2019	$ 142.20	Staff Service Recognition	Travel	Whakatane
19/11/2019	$ 142.20	Meetings in Whakatane	Travel	Whakatane
25/11/2019	$ 142.20	Meetings in Whakatane	Travel	Whakatane
5/12/2019	$ 149.00	Midland CEO Meetings	Accomodation	Hamilton
10/12/2019	$ 142.20	Meetings in Whakatane	Travel	Whakatane
12/12/2019	$ 142.20	Meetings in Whakatane	Travel	Whakatane
17/12/2019	$ 716.99	Meeting with MPs - Wellington	Flights	Wellington
17/12/2019	$ 83.70	Meeting with MPs - Wellington	Taxis	Wellington
17/12/2019	$ 15.00	Meeting with MPs - Wellington	Parking	Tauranga
17/12/2019	$ 15.10	Meeting with MPs - Wellington	Meal	Wellington
10/01/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
20/01/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
23/01/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
12/02/2020	$ 343.00	National CEO Meetings	Flights	Wellington
12-14/02/2020	$ 610.20	National CEO Meetings	Accomodation	Wellington
12/02/2020	$ 53.90	National CEO Meetings	Taxis	Wellington
19/02/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
21/02/2020	$ 235.42	Meeting in Opotiki	Travel	Opotiki
12/03/2020	$ 507.99	National CEO Meetings	Flights	Wellington
12/03/2020	$ 77.90	National CEO Meetings	Taxis	Wellington
12/03/2020	$ 15.00	National CEO Meetings	Parking	Tauranga
2/04/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
22/04/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
7/05/2020	$ 64.78	Maketu Covid support	Travel	Maketu
9/06/2020	$ 142.20	Meetings in Whakatane	Travel	Whakatane
18/06/2020	$ 157.21	Meeting in Taneatua	Travel	Taneatua

Subtotal - domestic travel	**$4,751.59**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Local Travel (within City, excluding travel to airport)				
Date(s)*	**Cost in NZ$**	**Purpose of travel** (e.g. meeting with Minister)***	**Type of expense** (e.g. taxi, parking, bus)	**Location(s)**
Nil	$0.00			
Subtotal - local travel	**$0.00**	**Check - there are no hidden rows with data**	**Not all lines have an entry for "Cost in NZ$" and "Type of expense"**	

Total travel expenses	**$4,751.59**	

Notes

* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
** Note that GST may not apply to overseas purchases.
*** Please include sufficient information to explain the trip and its costs including destination and duration.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
Group expenditure relating to each overseas trip.
Subtotals and totals will appear automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A) for each travel category (local, domestic and international).

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Simon Everitt
Disclosure period start	11 November 2019
Disclosure period end	30 June 2020
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

Hospitality Offered to Third Parties*

All hospitality expenses provided by the chief executive in the context of his/her job to anyone external to the Public Service or statutory Crown entities.

Date(s)**	Cost in NZ$	Purpose of hospitality (e.g. hosting delegation from China, building relationships, team building)	Type of expense (what and for how many e.g. dinner for 5)	Location(s)
Nil	$0.00			
Total hospitality expenses	**$0.00**	**Check - there are no hidden rows with data**	**Not all lines have an entry for "Cost in NZ$" and "Type of expense"**	

Notes

* Third parties include people and organisations external to the public service or statutory Crown entities.
** Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
Total cost will appear automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Simon Everitt
Disclosure period start	11 November 2019
Disclosure period end	30 June 2020
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

All Other Expenses

All other expenditure incurred by the chief executive that is not travel, hospitality or gifts.
Include e.g. phone and data costs, subscriptions, membership fees, conference fees, professional development costs, books and anything else.

Date(s)*	Cost in NZ$	Purpose of expense (e.g. subscription part of employment agreement, development as agreed with SSC)	Type of expense (e.g. phone and data costs, membership fees)	Location(s)
28/01/2020	$ 603.25	David Bennett Coaching	Professional Development	Tauranga
2/03/2020	$ 402.50	David Bennett Coaching	Professional Development	Tauranga
30/04/2020	$ 402.50	David Bennett Coaching	Professional Development	Tauranga
27/05/2020	$ 1,092.50	David Bennett Coaching & Leadership Circle Profile 360 Survey	Professional Development	Tauranga
22/06/2020	$ 603.75	David Bennett Coaching & Leadership Circle Profile 360 Survey debriefing	Professional Development	Tauranga
25/05/2020	$ 75.00	Case	Technology	Tauranga
Total other expenses	**$3,179.50**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Notes
* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
Total cost will appear automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

Chief Executive Gifts and Benefits Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Simon Everitt
Disclosure period start	11 November 2019
Disclosure period end	30 June 2020
GST on values	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

Gifts and Benefits over $50 annual value

***Include all gifts, invitations to events and other hospitality**, of $50 or more in total value per year, offered to the chief executive by people external to the organisation.*
*Include all gifts, invitations or other hospitality **whether accepted or declined**.*

Date(s)*	Description (e.g. event tickets, etc.)	Was the gift accepted? (drop-down list in cell)	Offered by (who made the offer?)	Estimated value in NZ$ (drop-down list in cell but provide specific value if possible)	Other comments (e.g. if given to others, whom?)
Nil					
Total count of gift/benefit entries:	**Offered**	**0**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	
	Accepted	**0**			
	Declined	**0**			

Notes
* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
A one-off offer of something worth $25 is not included, but if the offer is made more than once a year, it should be disclosed.
Include items such as invitations to functions and events, event tickets, gifts from overseas counterparts and commercial organisations (including that accepted by immediate family members).
Include gifts and benefits that are declined.
Number of gifts/benefits will update automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

Chief Executive Expenses, Gifts and Benefits Disclosure - summary & sign-off*

Organisation Name	Bay of Plenty District Health Board
Chief Executive**	Helen Mason
Disclosure period start***	1 July 2019
Disclosure period end***	15 November 2019
Agency totals check	Data and totals checked on all sheets
Chief Executive approval****	This disclosure has been approved by the Chief Executive
Other sign-off****	Sharon Shea, Interim Board Chair

This summary page updates automatically from the 'Travel', 'Hospitality', 'All other expenses', and 'Gifts and benefits' tabs.

Throughout this workbook, input cells are shaded light green.

Summary of expenses	Cost in NZ$	GST inc / exc		Gifts and benefits	Count
Travel expenses	**$8,676.85**	Figures include GST (where applicable)		**Number offered**	**0**
Hospitality	**$0.00**	Figures include GST (where applicable)		**Number accepted**	**0**
Other expenses	**$322.00**	Figures include GST (where applicable)		**Number declined**	**0**
International Travel	$1,776.47	Figures include GST (where applicable)			
Domestic Travel	$6,900.38	Figures include GST (where applicable)			
Local Travel	$0.00	Figures include GST (where applicable)			

Notes

* Headings on following tabs will pre populate with what you enter on this tab
** Create a new workbook for a new Chief Executive
*** Update if a shorter or different period is covered
**** This disclosure must be approved by the Chief Executive and another appropriate party, e.g. Board Chair, Chief Financial Officer or Audit and Risk Committee member

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Helen Mason
Disclosure period start	1 July 2019
Disclosure period end	15 November 2019
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

International, domestic and local travel expenses

All expenses incurred by chief executive during international, domestic and local travel. Group expenses relating to each trip.

International Travel (including travel within NZ at beginning and end of overseas trip)

Date(s)*	Cost in NZ$**	Purpose of travel (e.g. attending XYZ conference for 3 days)***	Type of expense (e.g. hotel, airfares, taxis, meals & for how many people)	Location(s)
18-21/09/2019	$ 898.73	Learning Set - Professional development	Flights	Sydney
18-21/09/2019	$ 877.74	Learning Set - Professional development	Accommodation	Sydney
Subtotal - international travel	**$ 1,776.47**	Check - there are no hidden rows with data	Check - each entry provides sufficient information	

Domestic Travel (within NZ, including travel to and from local airport)

Date(s)*	Cost in NZ$	Purpose of travel (e.g. visiting district office for two days...)***	Type of expense (e.g. hotel, airfares, taxis, meals & for how many people)	Location(s)
18-19/07/2019	$ 129.00	Whakatane meetings	Accomodation	Whakatane
18-19/07/2019	$ 158.08	Whakatane meetings	Travel	Whakatane
22/07/2019	$ 142.20	Whakatane meetings	Travel	Whakatane
1-2/08/2019	$ 192.76	Midland Meetings and Wananga	Travel	Hamilton
7-8/08/2019	$ 409.00	National CEO Meetings	Flights	Wellington
7-8/08/2019	$ 198.00	National CEO Meetings	Accomodation	Wellington
7/08/2019	$ 78.80	National CEO Meetings	Taxis	Wellington
7-8/08/2019	$ 30.00	National CEO Meetings	Airport Parking	Tauranga
7/08/2019	$ 57.00	National CEO Meetings	Meal	Wellington
21/08/2019	$ 142.20	Whakatane meetings	Travel	Whakatane
22/08/2019	$ 605.98	WSG / HSRA Meetings	Flights	Wellington
22/08/2019	$ 233.10	WSG / HSRA Meetings	Accomodation	Wellington
22/08/2019	$ 94.30	WSG / HSRA Meetings	Taxis	Wellington
22/08/2019	$ 50.00	WSG / HSRA Meetings	Meal	Wellington
22-23/08.2019	$ 30.00	WSG / HSRA Meetings	Airport Parking	Tauranga
12/09/2019	$ 598.00	National CEO Meetings	Flights	Wellington
12/09/2019	$ 82.00	National CEO Meetings	Taxis	Wellington
12/09/2019	$ 15.00	National CEO Meetings	Airport Parking	Tauranga
4/10/2019	$ 90.06	Midland CEO meetings	Travel	Hamilton
10/10/2019	$ 612.03	National CEO Meetings	Flights	Wellington
10/10/2019	$ 75.50	National CEO Meetings	Taxis	Wellington
10/10/2019	$ 17.00	National CEO Meetings	Airport Parking	Tauranga
25/10/2019	$ 531.99	National CEO Meetings	Flights	Wellington
25/10/2019	$ 95.40	National CEO Meetings	Taxis	Wellington
25/10/2019	$ 15.00	National CEO Meetings	Parking	Tauranga
31/10/2019	$ 149.00	Midland CEO meetings	Accomodation	Hamilton
31/10-1/11/2019	$ 159.58	Midland CEO meetings	Travel	Hamilton

6-11/11/2019	$ 727.00	National CEO Meetings	Flights	Wellington
6-11/11/2019	$ 1,070.10	National CEO Meetings	Accomodation	Wellington
6/11/2019	$ 55.70	National CEO Meetings	Taxis	Wellington
6/11/2019	$ 30.00	National CEO Meetings	Airport Parking	Tauranga
11/11/2019	$ 26.60	National CEO Meetings	Taxis	Wellington
Subtotal - domestic travel	**$ 6,900.38**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Local Travel (within City, excluding travel to airport)				
Date(s)*	**Cost in NZ$**	**Purpose of travel** (e.g. meeting with Minister)***	**Type of expense** (e.g. taxi, parking, bus)	**Location(s)**
Nil.				
Subtotal - local travel	**$ -**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Total travel expenses	**$ 8,676.85**

Notes
* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
** Note that GST may not apply to overseas purchases.
*** Please include sufficient information to explain the trip and its costs including destination and duration.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
Group expenditure relating to each overseas trip.
Subtotals and totals will appear automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A) for each travel category (local, domestic and international).

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Helen Mason
Disclosure period start	1 July 2019
Disclosure period end	15 November 2019
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

Hospitality Offered to Third Parties*

All hospitality expenses provided by the chief executive in the context of his/her job to anyone external to the Public Service or statutory Crown entities.

Date(s)**	Cost in NZ$	Purpose of hospitality (e.g. hosting delegation from China, building relationships, team building)	Type of expense (what and for how many e.g. dinner for 5)	Location(s)
Nil.				
Total hospitality expenses	**$0.00**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Notes

* Third parties include people and organisations external to the public service or statutory Crown entities.

** Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.

Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.

Total cost will appear automatically once you put information in rows above.

Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

Chief Executive Expense Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Helen Mason
Disclosure period start	1 July 2019
Disclosure period end	15 November 2019
GST on costs	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

All Other Expenses

All other expenditure incurred by the chief executive that is not travel, hospitality or gifts.
Include e.g. phone and data costs, subscriptions, membership fees, conference fees, professional development costs, books and anything else.

Date(s)*	Cost in NZ$	Purpose of expense (e.g. subscription part of employment agreement, development as agreed with SSC)	Type of expense (e.g. phone and data costs, membership fees)	Location(s)
8/07/2019	$ 322.00	David Bennett Coaching	Professional Development	Tauranga
Total other expenses	**$ 322.00**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	

Notes
* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
Total cost will appear automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

Chief Executive Gifts and Benefits Disclosure

Organisation Name	Bay of Plenty District Health Board
Chief Executive	Helen Mason
Disclosure period start	1 July 2019
Disclosure period end	15 November 2019
GST on values	Figures include GST (where applicable)
Agency totals check	Data and totals on this worksheet checked and confirmed

Gifts and Benefits over $50 annual value

Include all gifts, invitations to events and other hospitality, *of $50 or more in total value per year, offered to the chief executive by people external to the organisation.*
Include all gifts, invitations or other hospitality ***whether accepted or declined***.

Date(s)*	Description (e.g. event tickets, etc.)	Was the gift accepted? (drop-down list in cell)	Offered by (who made the offer?)	Estimated value in NZ$ (drop-down list in cell but provide specific value if possible)	Other comments (e.g. if given to others, whom?)
Nil.					
Total count of gift/benefit entries:	**Offered**	**0**	**Check - there are no hidden rows with data**	**Check - each entry provides sufficient information**	
	Accepted	**0**			
	Declined	**0**			

Notes
* Any non-standard date format or date outside 1 July - 30 June will raise an alert. Check entry and select 'Yes' to accept/continue.
Insert additional rows as needed: right click on a row number (left of screen) and select Insert - this will insert a row above selected row.
A one-off offer of something worth $25 is not included, but if the offer is made more than once a year, it should be disclosed.
Include items such as invitations to functions and events, event tickets, gifts from overseas counterparts and commercial organisations (including that accepted by immediate family members).
Include gifts and benefits that are declined.
Number of gifts/benefits will update automatically once you put information in rows above.
Mark clearly if there is no information to disclose - provide a note to this effect in the 'Date' column (column A).

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Cnr Clarke St & 20th Ave
Private Bag 12024
Tauranga 3143
New Zealand
Phone 07 579 8000
Fax 07 571 5434

3rd August, 2020

Derek Sherwood, Clinical Lead, Choosing Wisely
Professor David Tipene-Leach, Chair, Te Ohu Rata o Aoteraroa
PO Box 10375
The Terrace
WELLINGTON 6143

Tēnā kōrua Derek & David,

CHOOSING WISELY MEANS CHOOSING EQUITY 2020

E aku nui, e aku rahi, e rere atu rā te mihi i te Moana nui ā Toi, e ngā matanga hauora, tēnā koutou. E te heamana, ka mihi atu rā mātou ki a koe, e te whanaunga o te waka Takitimu. Kia tika, ka mihi ki te kaupapa nei, he oranga mō te iwi.

Thank you for your letter of the 17th July 2020 about the 'Choosing Wisely Means Choosing Equity 2020' report.

The Bay of Plenty District Health Board is very aware that given the inequitable healthcare processes and outcomes for Māori (in contravention of both Te Tiriti o Waitangi and UN Declaration on the Rights of Indigenous Peoples) that any Choosing Wisely projects in the Bay of Plenty DHB will need to actively avoid increasing inequities.

Further, the Clinical Effectiveness and Equity Lead (Dr Hayley Bennett) of the BOP DHB Quality and Safety Service has proposed that any data analysis to inform local Choosing Wisely projects should be analysed by ethnicity. This is to ensure that under-testing and treatment as well as over-testing and treatment are addressed; and to provide the opportunity to review whether Māori are receiving evidence-based care at the same rate as non-Māori.

Te Toi Ahorangi sets the BOP DHB's strategic commitment to a Tiriti partnership with Bay of Plenty Iwi, and a commitment to a journey of transformation toward achieving health equity and Toi Ora for whānau, hāpu, and Iwi in the region. Thus shared decision-making is at the forefront of minds both at the organisational level and at the health professional-patient/consumer level.

More specific initiatives that the Bay of Plenty DHB is doing around 'Choosing Wisely Means Choosing Equity' include:

- Utilising local evidence to support the campaign:
- work to improve health intelligence system capability and capacity to help us understand and identify gaps and allow for more precise improvement; assessment to improve the quality of ethnicity data in provider arm in conjunction with Māori Health Gains and Development;
- active engagement with proactive clinicians to see which of the Choosing Wisely interventions to potentially implement

- Promoting cultural safety, patient-centred care, quality improvement, and equity based training: this includes the unconscious bias module HQSC, Te Tiriti O Waitangi training, Engaging Effectively with Maori workshops, IHI Improvement Open School
- Undertaking work to ensure that consumers know that they have the right to ask questions. Including the important role Advocates, whānau members, friends, community health workers, and navigators, can play an in supporting shared decision-making:
- work to refresh our consumer and whānau engagement framework and systems to further focus on consultation, partnership, experience-based co-design and mahi tahi; better capture of care experiences and review of existing resources (eg, website, print, signage, social media) that are not always focussed on the needs of consumers and whānau. There is a need for a DHB wide programme to review these and introduce co-design approaches that focus on experience, health literacy and information needs.

Heoi anō,

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17 July 2020

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Tauranga

Tēnā koutou katoa,

We are delighted to send you a copy of the report *Choosing Wisely means Choosing Equity 2020*, commissioned by *Choosing Wisely* and Te Ohu Rata o Aotearoa (Te ORA).

Choosing Wisely is an international campaign that aims to reduce unnecessary tests/treatments to ensure high-quality health care by promoting better shared decision-making between health professionals and consumers/patients.

Choosing Wisely Aotearoa New Zealand was launched in 2016 by the Council of Medical Colleges (CMC), and has been implemented by many district health boards (DHBs) and medical colleges. It is very important that a *Choosing Wisely* approach is not at the expense of equity. Unless equity is explicitly considered, new health care interventions or campaigns have the tendency to widen inequities, as they are taken up first by those in society with the most resources and the least need.

Although the health system in Aotearoa New Zealand acknowledges Te Tiriti o Waitangi principles of partnership, participation, and protection, and aspires to health equity, Māori experience marked inequities in health outcomes, mortality, health care access, and satisfaction with health services. Choosing Wisely partnered early on with Te ORA to ensure that it is implemented in an appropriate way for Māori and does not increase inequity

This research aimed to develop an in-depth understanding of Māori health consumers and health providers/practitioners' perspectives on health care shared decision-making, and make recommendations for strategies to inform an equity focused *Choosing Wisely* campaign.

The research was funded by the Australasian College for Emergency Medicine, the College of Intensive Care Medicine of Australia and New Zealand, the New Zealand College of Public Health Medicine, the Royal Australian and New Zealand College of Obstetrics and Gynaecology, The Royal Australasian College of Physicians and Evolve, the Royal New Zealand College of Urgent Care Medicine, the Health Quality and Safety Commission, PHARMAC and the Eastern Institute of Technology.

The report recommendations will be considered by CMC in partnership with Te ORA and findings shared with the health sector.

We hope you find this report and recommendations relevant and informative for your work.

Ngā mihi

Dr Derek Sherwood
Clinical Lead
Choosing Wisely

Professor David Tipene-Leach
Chair
Te Ohu Rata o Aotearoa

Choosing Wisely Means Choosing Equity 2020

7 JULY 2020

Council of Medical Colleges and
Te Ohu Rata o Aotearoa
Anna Adcock and David Tipene-Leach

A COUNCIL OF MEDICAL COLLEGES
IN NEW ZEALAND CAMPAIGN
and part of Choosing Wisely international

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Disclaimer

Care has been taken in the quotes used in this report to accurately report what participants said. Our apologies if this is found not to be the case. Some editing of quotes has occurred to assist readability.

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He Mihi

E ngā mana, e ngā reo,

E ngā karangatanga maha,

Tēnā koutou katoa,

He mihi maioha tēnei ki a koutou e awhi nei i tēnei kaupapa,

Nō reira, e rau rangatira mā,

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

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Special thanks to the consumers and health providers who participated in the study and shared their views. We would also like to acknowledge the substantial input of those who supported various stages of the research, including its development, implementation, and the interpretation of findings. In particular, we thank Bridget Robson, Sarah Sciascia, Jordanna Hermens, and the Thiyani whānau for their thoughtful feedback and suggestions. Finally, many thanks to Sue Ineson and Dr Derek Sherwood from the Choosing Wisely team for their support. Ngā mihi maioha ki a koutou.

Notes

This research was commissioned by Choosing Wisely and Te Ohu Rata o Aotearoa. Choosing Wisely is supported by the Council of Medical Colleges, Te Kaunihera o Ngā Kāreti Rata o Aotearoa. The research was funded by the Australasian College for Emergency Medicine, the College of Intensive Care Medicine of Australia and New Zealand, the New Zealand College of Public Health Medicine, the Royal Australian and New Zealand College of Obstetrics and Gynaecology, The Royal Australasian College of Physicians and Evolve, the Royal New Zealand College of Urgent Care Medicine, the Eastern Institute of Technology, the Health Quality and Safety Commission, and PHARMAC. The research was reviewed by the New Zealand Ethics Committee, Te Roopu Rapu i te Tika, and was endorsed on 15th October, 2019 (ref 2019_46).

In early 2020, Aotearoa New Zealand (like many other nations) experienced the impacts of the global COVID-19 (novel coronavirus) pandemic. Respondent validation of the research findings took place during this time. Concerns were raised about the potential impact of COVID-19 on health inequities for Māori, and on the dissemination and knowledge translation of this research. Participants emphasised the importance of supporting opportunities for shared decision-making during the COVID-19 pandemic and beyond.

Executive Summary

Although the health system in Aotearoa New Zealand acknowledges Te Tiriti o Waitangi principles of partnership, participation, and protection, and aspires to health equity, Māori (the Indigenous peoples) experience marked inequities in health outcomes,[1-4] mortality,[5] health care access,[6 7] and satisfaction with health services.[5 8] Choosing Wisely is an international campaign that aims to reduce unnecessary tests/treatments and ensure high quality care in healthcare settings by promoting better shared decision-making between health professionals and consumers/ patients. The idea is that sometimes doing less is better. The five principles of the campaign are that it must be: health professional led, consumer focused, multi-professional, evidence-based, and transparent. Choosing Wisely Aotearoa New Zealand was launched in 2016 by the Council of Medical Colleges, and has been implemented by many District Health Boards (DHBs) and medical colleges.

As Choosing Wisely is adopted, care must be taken to ensure that the 'do less' aim does not increase existing inequities for Māori. For example, Māori children and adults are more likely (than non-Māori) to experience unmet need for primary health care, including not being able to get an appointment at their usual medical centre within 24 hours, not being able to attend because of cost or lack of transport, or to miss out on prescription medication because of cost.[7] Māori also tend to receive fewer tests and referrals.[6] During consultations, Māori are less likely to get satisfactory answers when they do ask questions, less likely to have things explained to them well, and less likely to feel listened to by health professionals.[8] Health campaigns, such as Choosing Wisely New Zealand, must be careful to not exacerbate these existing inequities.

Implementing healthcare decision-making in a culturally safe fashion has the potential to address inequities among Indigenous populations by facilitating participation in health care that better meets self-identified need.[9-13] The focus of the present research was whether or not Choosing Wisely Aotearoa New Zealand could be implemented in a way that serves the interests of Māori by promoting culturally safe shared decision-making with Māori consumers that maintains a focus on equity. The research aimed to develop an in-depth understanding of Māori health consumers and health providers/practitioners' perspectives on healthcare shared decision-making, and make recommendations for strategies to inform an equity focused Choosing Wisely campaign in Aotearoa New Zealand. It had three objectives:

1. To explore Māori health consumers' and Māori health providers/professionals' feelings and advice about the Choosing Wisely campaign.

2. To explore Māori health consumers' and Māori health providers/professionals' experiences of and recommendations for shared decision-making in healthcare settings.

3. To make recommendations for practical, cost-effective, and evaluable strategies (i.e., tools and/or resources and/or approaches) to improve shared decision-making with Māori in healthcare settings.

Methods

This qualitative research drew on Kaupapa Māori (by Māori, for Māori) Research (KMR) methodologies. KMR centres the experiences and aspirations of Māori, and seeks to be transformative, by identifying structural inequities and working to address them.[14-17] The research was developed and implemented with support and guidance by Māori experts - whānau (families), health providers, and academics. Key informants were also provided a summary of research findings and asked for their feedback before the report was finalised.

Fifteen key informants, eight Māori consumers of health care and seven Māori providers of health care, were interviewed between November 2019 and February 2020. Interviews were conducted in person, by telephone, or by Zoom (online video call), and were semi-structured.

The interviews involved discussion about the origin and principles of Choosing Wisely, and reviewing a consumer resource. Key informants were asked about their perspectives on the Choosing Wisely campaign, including its principles, aims, and potential value for Māori; and their experiences of and recommendations for shared decision-making in healthcare settings. Each interview took between 25-90 minutes and was audio-recorded and transcribed. The data were analysed thematically.

Findings

This report presents the findings from the key informant interviews, organised into two sections: feedback on Choosing Wisely, and feedback on shared decision-making in healthcare settings. Following the findings and discussion/conclusion, recommendations for Choosing Wisely and shared decision-making in Aotearoa are given.

Feedback on Choosing Wisely

Key informant feedback about Choosing Wisely is grouped into three themes: governance and decision making, messaging, and resources/tools.

Feedback about Choosing Wisely was mixed. Concerns were raised, by health provider key informants in particular, about its governance and decision-making - that it has not engaged with Māori communities and Māori health professional groups, and that it lacks any reflection of mātauranga Māori (Māori knowledge systems) and tikanga Māori (Māori practices and customs). These are all important for not undermining the principles of Te Tiriti o Waitangi.

Key informants indicated that narrow campaign messages that focus on reducing tests/treatment and on Māori themselves questioning medical advice are problematic. Both groups did, however, see value in Choosing Wisely, especially if it promotes better communication between Māori consumers and their health provider/s. The caveat is that health providers must be delivering appropriate care and encouraging shared decision-making.

Choosing Wisely resources/tools were described by both groups as needing to be simple and realistic at a health literacy level, and both socially and culturally engaging for Māori. I.e., incorporating the target audience in their design.[13]

Feedback on shared decision-making in healthcare settings

Drawing inspiration from Fiona Cram's report on improving Māori access to health care,[18] key informant talk about shared decision-making in healthcare settings is grouped into four health domain themes: consumer, provider, organisation, and health system – although they are all interconnected. Each domain has between one to four subthemes.

Inequities in access to health care for Māori consumers are well documented,[1-8] therefore, it was not surprising that key informants from both groups frequently discussed the lack of access to resources experienced by many Māori as a barrier to shared decision-making. Both groups stressed the importance of consumer trust, a sense of autonomy (knowing one's rights to question and be informed, to not feel coerced, and to expect to be treated as an equal), good relationships/rapport with health providers, and culturally appropriate tools/resources.[10-13] Advocates and support people, and collective decision-making strategies, such as whānau hui (gatherings), were promoted as supporting shared decision-making.

Provider clinical competence and efficacious communication – encouraging collaboration, consideration, discussion, and mutual understanding,[11 12] were described as critical for shared decision-making by key informants in both groups. Being thorough and proactive in sharing information, rather than waiting for questions, were viewed as good practice, as was health provider cultural safety - being non-judgemental, genuine, supportive, and understanding of context.[9-12] This research indicates that, for Māori, culturally safe care involves health providers acknowledging the validity of te ao Māori (the Māori world), such as the importance of whanaungatanga (connecting/ relationships) and holistic models of health.

Organisational culture, in particular - the business model of primary care resulting in short appointment times, and workforce shortages disrupting continuity of care - were discussed as barriers to shared decision-making by both groups of key informants. Training programmes that teach skills to identify biases and build cultural empathy,[10-12] such as the Meihana model and hui models (e.g., the Hui Process), were suggested by health provider key informants as good for supporting the health workforce to be more culturally safe.

Both groups of key informants contributed feedback that relates to health system failures to fulfil Te Tiriti o Waitangi obligations. Health provider key informants in particular highlighted rampant health inequities for Māori and the lack of Māori input into issues that affect Māori, and promoted tino-rangatiratanga (self-determination/autonomy) of communities and whānau to determine their own health needs. Consumers were concerned with the lack of Māori in the health workforce. The findings suggest that to address systemic inequities in health requires a centring of Māori and Te Tiriti o Waitangi in the health sector. This would improve Māori access to appropriate care, and therefore, access to shared decision-making.

Conclusion

The current research corroborates themes found in the extant literature on shared decision-making (and healthcare decision-making) with Indigenous peoples - that shared decision-making has the potential to address health inequities among Indigenous populations by facilitating participation in health care that better meets self-identified need.[9-12] However, there is work to be done to ensure that Māori consumers know they have the right to ask questions, and that health providers are open to and encouraging of two-way dialogue. The research highlights several key elements required for optimal healthcare shared decision-making with Māori. First, equity must be prioritised. This includes committing to eliminating inequities, as well as privileging the mātauranga (knowledge) and tikanga (practices, customs) Māori that are part of a holistic understanding of Māori health and wellbeing. Second, the importance of developing whanaungatanga - connections and relationships between Māori consumers and health services cannot be stressed enough. Trust and cultural safety were deemed vital to enabling the right kind of environment for shared decision-making to occur. Finally, given the significance of autonomy for shared decision-making, the tino-rangatiratanga of Māori consumers and communities to actively participate in health care and healthcare decision-making must be supported. Any national health campaign, such as Choosing Wisely, would benefit from centring Te Tiriti o Waitangi and committing to equity by prioritising the needs and aspirations of Māori.

Recommendations for Choosing Wisely and shared decision-making in Aotearoa

Recommendations for the Choosing Wisely Aotearoa New Zealand campaign and resources, and for improved shared decision-making for health providers and consumers, which have been drawn from the data, are summarised here. They are listed in full on pages 34-35.

Choosing Wisely Aotearoa New Zealand campaign

1. Uphold Te Tiriti o Waitangi and centre Māori in governance and decision-making.

2. Acknowledge and incorporate mātauranga Māori (Māori knowledge systems) and tikanga Māori (Māori practices and customs) in Choosing Wisely work. For example, Māori health models.

3. Along with the main message of the campaign being ‘Choosing Wisely’, consider including other messages that encourage health providers to consider the best options for consumers and to instigate shared decision-making, such as, ‘Advise Wisely’.

4. Utilise local evidence to support the campaign.

5. Promote cultural safety, patient-centred care, quality improvement, and equity based training.

6. Undertake work to ensure that consumers know that they have the right to ask questions. Advocates, such as whānau members, friends, community health workers, and navigators, can play an important role in supporting shared decision-making in healthcare settings.

Choosing Wisely Aotearoa New Zealand resources

1. Work with Māori to design resources/tools that are engaging and relatable for Māori. Use realistic, plain, simple, relatable messaging. Consider different levels. Use visual aids/graphics.
2. Develop resources/tools to encourage health providers to communicate efficaciously.
3. Create resources/tools for advocates, to support/promote shared decision-making.
4. Support the development of decision-making tools for specific health issues.
5. Advertise and supply resources/tools and key messages among networks and within health settings so that they become routine. Consider media/online tools.
6. Seek user feedback (from providers and consumers) about resources/tools through networks, such as Te Ohu Rata o Aotearoa, and health services (e.g., through DHBs and primary care).

Health providers and consumers

Health providers

1. Avoid assumptions about consumers, instead talk through issues/concerns.
2. Build relationships with consumers, develop trust.
3. Instigate shared decision-making by using tools to guide consumers through different options. Do not wait for consumers to ask.
4. Be open to questions and willing to engage.
5. Check understanding in an affirming way (e.g., the teach-back method).
6. Utilise visual aids/tools to guide discussions.
7. Connect consumers to relevant information and services/support.
8. Encourage the role of advocates and support people in decision-making.

Consumers

1. Expect respect. If you are not happy with the care you receive, talk to someone about it.
2. Ask questions. It is your right to have things explained to you in a way you understand.
3. Check if there are resources (e.g., brochures or online information) that you can see.
4. Talk to whānau and friends about any health concerns or worries.
5. Take support (e.g., whānau, friends, or health workers/navigators).

Background

Health Equity

Te Tiriti o Waitangi (Te Tiriti) sets the expectations for the relationship between Te Tiriti partners, in particular Crown or Government entities and Māori (Indigenous peoples). As acknowledged by the Ministry of Health, the three principles of Te Tiriti are: partnership, participation, and protection. Partnership refers to the responsibility to engage in meaningful collaboration with Māori Iwi (tribes), hapū (kinship groups), and whānau (families) to develop health strategies. Participation requires Māori to be involved in all levels of health and disability services. Protection refers to the obligation of Crown and Government to work towards equity in health outcomes for Māori, and to protect Māori assets, values, and practices.[19]

Despite these principles, Māori continue to experience marked inequities in health outcomes,[1-5 13] access,[6 7] and satisfaction.[5 8] Māori children and adults are more likely (than non-Māori) to experience unmet need for primary care, including not being able to get an appointment at their usual medical centre within 24 hours, not being able to attend due to cost or transport issues, and to miss out on medication because of cost.[7] Māori receive fewer tests and referrals;[6] are less likely to get satisfactory explanations or answers to questions, or feel listened to by health professionals;[8] and are more likely to experience racism/discrimination.[20] These inequities are well documented, uncontested, and persistent.[21] And are also reflected in the lack of equitable Māori representation in the health and disability sector workforce. For example, in mid-2019, Māori made up 3.4 percent of doctors, and between 4.8-13.9 percent of District Health Board employees around the country.[22]

The recent Waitangi Tribunal Report WAI 2575 recommended the expansion of Te Tiriti principles to include the *Principle of Equity* (the right to expect equitable outcomes) and the *Principle of Option*s (the right to expect good service at mainstream health outlets as well as access to Kaupapa Māori (by Māori, for Māori) services). This was based upon the Crown systematically defaulting to 'Participation' and under-mining the effectiveness of 'Partnership'.[21] Continued work is required to address these issues and realise the intrinsic principles of Te Tiriti.

Equity has become a top-level strategic priority of agencies such as the Ministry of Health,[23 24] the Health Quality and Safety Commission (HQSC),[5 25] and PHARMAC[26] over the last five years. While equality promotes sameness, the Ministry of Health definition of equity recognises that, "people have differences in health that are not only avoidable but unfair and unjust… [and] different people with different levels of advantage require different approaches and resources to get equitable health outcomes" (p 7).[24] The Ministry of Health has, acknowledging the shortcomings of our health system, previously said that it "can struggle to give all New Zealanders equitable access to health services: some population groups continue to benefit less from the health system than the population as a whole" (p 1).[27] The 2016 New Zealand Health Strategy, however, was criticised strongly for not addressing obligations to Te Tiriti, or the existence of institutional racism explicitly.[28]

In 2019 the Medical Council of New Zealand released He Ara Hauora Māori – a Pathway to Māori Health Equity.[29] In the same year, they released a statement on cultural safety, explaining that medical practitioners are now expected to be culturally safe, not just culturally competent.[30] Cultural competence is defined as when a doctor or health professional has the right attitude, skills, and knowledge to work with people of different backgrounds.[30] However, cultural safety, as defined by nursing scholar Irihapeti Ramsden and now taken on by the Medical Council, is more about examining biases and assumptions, respecting and recognising difference, and is centred on the experience of consumers or patients, i.e., they are to decide whether they feel safe and whether trust has been established. This puts the obligation on the health provider and requires constant reflexivity[31] and an exercise of critical consciousness around their practice.

Choosing Wisely

Choosing Wisely is an international campaign, launched by the American Board of Internal Medicine and Consumer Reports in 2012, in the United States of America (USA). It aims to reduce unnecessary tests/treatments and ensure high quality care in healthcare settings. The idea is that sometimes doing less is better. The five core principles of Choosing Wisely are that it must be health professional led, consumer focused, multi-professional, evidence-based, and transparent.[32]

The mission is to promote conversations that enable shared decision-making.[33] It is assumed that if consumers make well-informed decisions about treatment options together with their health professional (shared decision-making), unnecessary treatments/tests can be avoided. Recommendations to reduce unnecessary treatments/tests or low value care are aimed at both health professionals and consumers.

Choosing Wisely Aotearoa New Zealand was launched in 2016 by the Council of Medical Colleges, and has been implemented by District Health Boards (DHBs) and medical colleges. For example, the streamlining of physiotherapy and vascular services in Hutt DHB,[34 35] recommendations from the New Zealand Microbiology Network around unnecessary urinalysis,[36] as well as general resources for consumers, such as, 'Four Questions For Patients To Ask':[37]

1. Do I really need this test or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?

The 'Four Questions' above are intended to aid shared decision-making for consumers in Aotearoa. However, health campaigns, such as Choosing Wisely Aotearoa New Zealand, need to be cognisant of health contexts in Aotearoa, in order to not exacerbate existing inequities.

Although most evidence indicates that Māori are underserved by the health system, research from the USA shows that Black and Hispanic consumers, who routinely do not receive enough care also

receive overtreatment with unnecessary care.[38] Māori may also experience a double burden of under-treatment/overtreatment.[39] The Health Quality and Safety Commission (HQSC) highlights potential areas of overtreatment for Māori, although questions remain over the causes of the higher rates of treatment and whether they do indicate overtreatment or higher need.* The notion of appropriate care is complex, requires a nuanced approach, and must prioritize equity.

Shared Decision-Making

The concept of shared decision-making has been used in the field of medicine since the 1970s, with early contributors such as Veatch discussing the roles of patient-provider relationships in informing health care decisions.[44] As a process that aims to improve communication and reduce conflict and unnecessary treatment, shared decision-making is now seen as a key part of patient-centred care.[45-50] It involves health professionals/providers and patients/consumers sharing information, exploring options, and agreeing on an appropriate treatment or plan.[48 51-53]

Studies have indicated shared decision-making can increase patient satisfaction as they feel more informed and that their values are incorporated.[54 55] The emphasis is on ensuring patients understand that there is choice and that the health provider is there to support decision-making.[45 56] In this way it promotes consumer self-determination or empowerment.[51 57 58] However, it relies on a certain amount of health literacy and good relationships - involving active participation, openness, and respect. [45 57 59 60] This puts underserved groups at increased risk of not experiencing shared decision-making, when health literacy is considered low and health services lack cultural safety.[13 45]

The Connecticut Choosing Wisely Collaboration explored Choosing Wisely as an equity tool for promoting health and shared decision-making with underserved consumers. They held four consumer focus groups to ask about health care experiences, trust, and provider relationships; and to evaluate a patient resource (similar to the 'Four Questions For Patients To Ask'). They then developed a pilot with resources including scripts to help train health providers to encourage shared decision-making. They found the resources helpful but suggested staff training must be ongoing, with the aim of creating a question friendly environment. They implore Choosing Wisely campaigns to work on cultural appropriateness, including language, literacy, and consumer empowerment.[61]

Studies evaluating shared decision-making with Indigenous peoples are limited.[9 62] However, recent publications from Aotearoa and comparatively high-income settler-colonial nation states, which explore shared decision-making or healthcare decision-making with Indigenous peoples, highlight several key themes.

* Māori children under 15 years have higher rates of antibiotic use than New Zealand Europeans/NZE, and although this may be explained by higher infection rates, there is no data to explain whether the use is appropriate. Rates of antibiotic dispensing within 30 days of major or acute surgery in a public hospital are also significantly higher for Māori and the reason are unknown.[40] Māori with diabetes, particularly younger people, have higher rates of angiotensin-converting enzyme inhibitor (ACEI) and angiotensin II receptor blocker (ARB) medicine use than NZE and the HQSC offers that may be because of higher rates of end-stage renal disease.[41] Māori also experience higher rates of gout than NZE but are less likely to regularly receive urate-lowering therapy and more likely to receive non-steroidal anti-inflammatory drugs (NSAID) associated with kidney damage. As kidney disease is more common for Māori, the HQSC calls for more research on the use of these drugs.[42] In polypharmacy, the 'triple whammy' is a term used to describe a combination of ACEI, ARB and NSAID use – a combination that indicates an increased risk of acute kidney failure. Māori under 75 years have significantly higher rates of the triple whammy. The HQSC recommends this combination be avoided.[43]

Systemic issues impact shared decision-making for Indigenous peoples. Health models that do not reflect the values and knowledge systems of Indigenous peoples or take strengths-based approaches to care undermine and negatively impact Indigenous health and wellbeing.[62-64] Health services need to avoid the deficit modelling that blames Indigenous consumers for negative health outcomes, and understand how the dominance of biomedical language/discourses marginalise Indigenous knowledge systems and holistic understandings of health and wellbeing.[10 65] The biomedical model lacks understanding and acknowledgment of diverse cultures and differences, and thus inhibits effective information exchange and mutual understanding.[64 66] Western ideas of individual decision-making and autonomy also conflict with Indigenous views of collective decision-making,[12 67] which arguably also involve a large degree of autonomy.

When health providers do not acknowledge Indigenous worldviews and attempt to build trust, they will likely fail.[11 68] Health providers' lack of cultural awareness, differing medical beliefs/values, lack of resources/training, and time constraints, as well as linguistic communication and cost barriers inhibit shared decision-making with Indigenous peoples.[65 69 70] For example, health providers may rely on stereotypes or biases about Indigenous peoples unless trained otherwise, preventing shared understanding and increasing the likelihood of poor outcomes. Whereas, cultural safety training and educational interventions for health providers can increase effective care for Indigenous consumers, by teaching skills to identify and address biases, and build cultural empathy.[10-12 71 72]

Culturally safe strategies, tools, and practices are crucial for shared decision-making, and can mitigate the negative impacts of historical and systemic inequities, and discrimination. They are culturally adapted, and support autonomy, informed consent, and consumer empowerment by acknowledging Indigenous perspectives, values, preferences, and self-identified needs.[9-13 62-69 72-75] They should be developed in partnership with Indigenous communities,[62 72 75] support Indigenous workforces,[10 11] and promote health equity.[63 64 69 71-74] For example, community-governed health services strengthen capacity for shared decision-making.[10 69 72] Additionally, family-centred health models that recognise the importance of collective decision-making for Indigenous peoples, and that accommodate and support family involvement, facilitate shared decision-making.[12 67 69 72 76]

Efficacious communication (that which achieves what is intended) is important for shared decision-making. Shared decision-making requires a supportive and inclusive environment, a relationship-centred two-way information exchange, where power is more equalised and health literacy is supported. This involves high-quality information and education, openness, collaboration, consideration, discussion, mutual agreement, and importantly, empathetic and compassionate care built on reciprocity and trust.[9-13 45 53 62-68 72-75] Decision-making tools, aids, and decision-coaching enhance engagement in the decision-making process.[13 62 72 75] However, they need to be consistent with Indigenous communication precepts, such as, accounting for avoidance of hostile confrontations and respect for authority, and value for warm interactions and family support and inclusion.[11 12 72] They should be affirming of cultural identity, incorporating language, culture, spiritual beliefs and practices, and respect for Indigenous health and healing approaches.[10-12 62 63 65-73] Relationship building, utilising visual aids with plain engaging language/design, using teach-back to check understanding, and creating an empowering environment are recommended.[13]

Shared decision-making has the potential to improve quality of care, and reduce health inequities for Indigenous peoples, by facilitating engagement in health care that better meets self/community-identified need. In Aotearoa New Zealand, where Māori have expressed the need for culturally appropriate and congruent medication information,[74] shared decision-making can support tino-rangatiratanga (self-determination/autonomy) of health and wellbeing.[12] Listening to the voices of Māori consumers, learning from their experiences, is important for identifying the variables that impact health inequities so that they can be addressed.[10] Achieving health equity for Māori is important, as if we get it right for those currently missing out, the whole nation will benefit.[74]

Choosing Wisely Means Choosing Equity

The focus of the research was whether or not Choosing Wisely could be implemented in a way that serves the interests of Māori by promoting culturally safe shared decision-making and equity. It aimed to develop an in-depth understanding of Māori health consumers and health providers' perspectives on healthcare shared decision-making, and make recommendations for strategies to inform an equity focused Choosing Wisely campaign. It had three objectives:

1. To explore Māori health consumers' and Māori health providers/professionals' feelings and advice about the Choosing Wisely campaign.

2. To explore Māori health consumers' and Māori health providers/professionals' experiences of and recommendations for shared decision-making in healthcare settings.

3. To make recommendations for practical, cost-effective, and evaluable strategies (i.e., tools and/or resources and/or approaches) to improve shared decision-making with Māori in healthcare settings.

Methods

A Kaupapa Māori Research Methodology

This qualitative research drew on Kaupapa Māori (by Māori, for Māori) Research (KMR) methodologies. KMR centres the experiences and aspirations of Māori, and seeks to be transformative, by identifying structural inequities and working to address them.[14-17]

An initial focus group with six Māori medical students explored perceptions of the Choosing Wisely campaign and gave the researchers a starting point for the research design. To hold the research to account, a Reference Group of Māori medical/public health professionals and Māori consumers of health guided the design, implementation, and interpretation of the research. Key informants were also provided a summary of research findings and asked for their feedback before the report was finalised.

Key Informant Interviews

Fifteen key informants, eight Māori consumers of health care and seven Māori providers of health care (Figure 1), were interviewed between November 2019 and February 2020. Interviews were conducted in person, by telephone, or by Zoom (online video call), and were semi-structured.

Key informants were asked about their perspectives on the Choosing Wisely campaign, including its principles, aims, and potential value for Māori; and their experiences of and recommendations for shared decision-making in healthcare settings. Each interview took between 25-90 minutes and was audio-recorded.

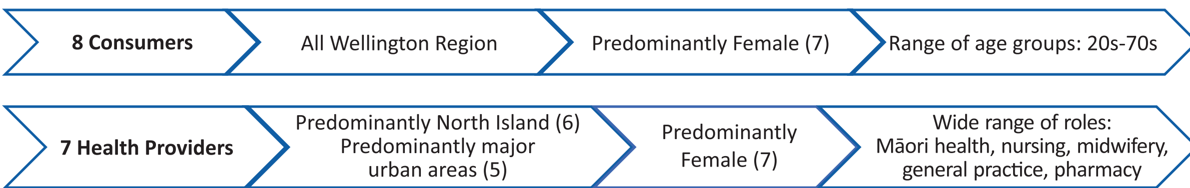

Figure 1: Overview of participants

Analysis

Transcripts of the key informant interviews (the data) were analysed thematically.[77] This entailed reading, rereading, and coding the transcripts for an emergent conceptual framework, themes, and subthemes. The feedback from the key informants was then arranged to group together views that were shared or interrelated.

In writing the report we have decided to use the term health 'provider' rather than 'professional', as it is inclusive of non-medical health workers, i.e., Māori health provider employees like community health workers and 'navigators'. To ensure confidentiality when using quotes, key informants are identified as either 'C' (for consumer) or 'HP' (for health provider), along with an identifying number, e.g., C1.

Findings

This section presents the findings from the key informant interviews, organised into two sections: feedback on Choosing Wisely, and feedback on shared decision-making in healthcare settings.

Feedback on Choosing Wisely

The interviews involved discussion about the origin and principles of the Choosing Wisely campaign, and reviewing one of the Choosing Wisely Aotearoa New Zealand resource sheets - 'Communicating with your health professional'[37] (Figure 2).

Communicating with your health professional

Before your appointment

Make a longer appointment if the problem you want to discuss is complex, or you need to discuss several issues.

Prepare a summary of your health problems, prioritise the issues you want to discuss, and make a list of questions as you think of them.

Let your health professional know if you need an interpreter or other assistance with communicating.

During your appointment

You should expect to be listened to – and be given clear and adequate explanations of your condition, any recommended tests, treatment options and the expected results.

When you describe your problems, be as accurate, complete and honest as possible.

If your health professional recommends a test, treatment or procedure and you are not clear of its purpose or benefits, you may want to discuss this.

- Asking the following questions around potential tests or procedures
- Do I really need to have this test, treatment or procedure?
- What are the risks?
- Are there simpler safer options?
- What happens if I do nothing?

If you don't understand anything, tell your health professional - and ask them to repeat or clarify the information until you do understand.

If you don't feel confident about your appointment, take a family/whānau member or friend with you. Take notes if you think you may have trouble remembering important details (or ask your health professional or support person to take notes for you).

If you want to know more, ask your health professional for some written information, or suggestions of where you might find it.

After your appointment

You may want to make a follow-up appointment to ask further questions, discuss continuing issues or talk to your health professional about your decisions after you've had time to consider the options.

If you want to discuss the issues with another health professional, don't hesitate to get another opinion.

Figure 2: Communicating with your health professional (consumer resource)

Key informant feedback about Choosing Wisely is grouped into three themes: governance and decision making, messaging, and resources/tools (Figure 3). Themes are described and illustrated with selected quotes.

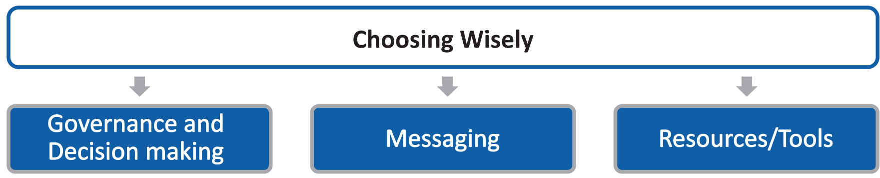

Figure 3: Feedback on Choosing Wisely (themes)

Governance and decision-making

Health provider key informants in particular questioned the appropriateness of Choosing Wisely to Aotearoa, given that it is an international campaign originating in the United States of America. Concerns were raised about governance and decision-making - that Choosing Wisely has not involved appropriate consultation with Māori professional groups, and that it excludes Māori community-based ('non-professional') organisations that support whānau (family) health and wellbeing. For example, a health provider talked about the important role that Whānau Ora navigators play in supporting whānau to make healthcare decisions –

> *Who's part of those decision-making processes? Is there good Māori representation?... Terms like health professional, what does that mean? We have Whānau Ora navigators, who our whānau trust in giving them information… it's not always a health professional that will be the person the whānau want to share their journey with. (HP1)*

They went on to talk about the need for community-based health strategies, emphasising that one-size-fits-all approaches often do not work. Rather, different groups and communities have different needs and aspirations. This view was shared by several other health providers.

It was suggested the Choosing Wisely campaign incorporate a Māori lens, acknowledging the importance of mātauranga Māori (Māori knowledge systems) and tikanga Māori (Māori practices and customs) to Māori health and wellbeing. These include: holistic models of hauora and oranga (health/wellbeing), rongoā (medicines), karakia (prayers/ incantations), and community input/ governance. One health provider spoke of the importance of centring Māori knowledge systems and practices, rather than trying to adapt non-Māori models -

> *Choosing Wisely hasn't taken into consideration our mātauranga, our own hauora practices, and oranga practices, our rongoā, our karakia… treatment that consists of te ao Māori… These campaigns go, 'Oh well that's great we'll put that in New Zealand and that'll work,' and they haven't addressed the existing issue. If those campaigns came from us in an Indigenous way we wouldn't have to tweak around the edges, to try and make it fit. (HP3)*

It was highlighted that mātauranga Māori and tikanga Māori need to be viewed as legitimate (or at least accepted) by health practitioners, the medical discipline, and campaigns such as Choosing Wisely. For example, a health provider articulated this as not being 'disparaging' -

> *Some whānau want to use rongoā. And usually that's not considered... And sometimes I think when they come to the health system… they don't feel comfortable. Because the whole emphasis is on medical procedures… All they [health providers] need to do is not be disparaging about it, it is understanding people's contexts and being accepting.* (HP7)

While most consumer participants did not query the governance or decision-making of Choosing Wisely, one did talk about how the campaign seemed to lack a Te Tiriti based 'equitable approach', which they described as being typical of health campaigns in Aotearoa.

Messaging

Key informants were critical of the campaign messaging that focuses on reducing tests/treatments. The focus on reducing tests and treatments, and therefore costs to the health system, for Māori, who tend to be under-served, caused concern for key informants from both groups. One health provider described this as inducing 'alarm bells', while a consumer described it as raising a red flag -

> *When you first started talking about cutting costs and things that was an immediate red flag to me... would that compromise the kind of advice that they would get if they're not getting all those tests done in some situations? (C8)*

Health provider key informants emphasised that what is needed is to have Choosing Wisely framed as being about more evidence based, equitable care, rather than cut-backs. For example, a health provider stated -

> *I think that the explicit focus on overtreatment and over utilization of resources can over shadow the other important aspects that make up good quality care for any person…. So how about shifting it towards being about the right thing, at the right time, and the right way, for the right person? (HP5)*

Several health providers talked about current inequities in care for Māori and the fear that a focus on reducing over-treatment will see Māori miss out more. It was emphasised that health providers need to have the appropriate communication skills and respect to engage with Māori. One health provider talked about this as a need to change the focus from whānau to providers -

> *I don't think this is about our whānau asking those questions, I think that it's about the medical staff having the appropriate people skills…. the communication tools and respect needed to engage with Māori.* (HP3)

The campaign messaging about 'Choosing Wisely' was also questioned by both key informant groups. For some Māori it can be hard enough to even access services, without then being

expected to challenge the provider. Key informants from both groups talked about the fear, dislike, and whakamā (reticence) associated with attending health services and communicating with health providers. For example, a consumer talked about some Māori lacking confidence to ask questions –

> *I think some Māori would be a bit reticent if that's the word, to ask these questions... Some might be shy, whakamā… maybe they just don't feel confident and don't want to appear to be ignorant or not confident.* (C4)

It was suggested that while the campaign promotes consumer autonomy and decision-making, there needs to be more emphasis on the role of health providers in providing appropriate care and creating environments that are welcoming of discussions about treatment options for Māori. A health provider suggested more onus should be put on the provider –

> *Even the name Choose Wisely that puts so much onus back on whānau. Why should they Choose Wisely? Why shouldn't it be that they're given the best possible pathway? I think it should be Advising Wisely, and it should be communicating with your whānau, not communicating with your health professional. We need to put the onus back on the health professionals to ensure that they are providing a quality service for Māori. (HP1)*

Another health provider suggested the message for health providers to 'Act Wisely'. This sentiment was shared by many of the consumers and health providers. For example, when discussing the notion of 'Choosing Wisely', a consumer suggested that health providers should be responsible for instigating discussions and providing good advice -

> *I hate going to the doctors. I would never ask any of those other things because I would just assume that the doctor is right… I don't think the onus should be on the patient to ask all these things, I think the doctor should definitely be telling you all these things. (C1)*

As shown above, a common assumption discussed by key informants, is that Māori consumers believe their health provider is the expert and therefore will be making the best recommendation for them. Therefore, to question them seems unnecessary, or even disrespectful.

Questioning the health provider was posed as especially problematic (by both groups of key informants) for Māori who frequently experience health provider bias (some called it implicit or unconscious), and are labelled tricky, resistant, non-compliant, or aggressive if they ask questions or challenge advice. For example, one health provider talked about the assumptions made about Māori and medicine use, and how this could result in practitioners being dismissive of open dialogue -

> *If there's the assumption that [Māori] can't or won't engage with discussion around better use of medicines, or they're tricky… if you've got this practitioners' implicit bias that Māori are less likely to want intervention, are less likely to want to access care, then I can see the practitioner saying, 'Oh well, that's fine, if you don't want to, that's fine.'* (HP6)

Another expressed similar concerns that health providers have the power to react to questions like 'Do I really need to have this test?' with a discriminatory attitude, effectively 'silencing' consumers by ending the conversation. A consumer talked about being made to feel bad for offending the 'white privilege' of health providers by correcting them on the pronunciation of their Māori name. Concerns were raised that the focus on consumers questioning more could further negatively impact health interactions for Māori unless health providers create a question friendly environment.

Despite concerns about messaging, both groups of key informants saw potential value in the campaign if it encourages open communication with health providers and promotes consumers' rights to ask questions. A consumer talked about this as promoting autonomy -

> *I think it is something that is required for Māori to bring them in to a partnership at the decision-making table. Rather than being told what their treatment is, what's going to happen, and just sort of not having any autonomy in that process. Allowing them, encouraging, and informing them to be part of it can only be a good thing. (C2)*

Both groups of key informants generally agreed with the five principles of the campaign (being health professional led, consumer focused, multi-professional, evidence-based, and transparent), as this seems to put the onus on health professionals. However, some health providers stressed that it needs to be more about partnership, or tailored to individual consumer preferences.

Resources/tools

When key informants were shown the resource (Figure 4), it elicited a lot of discussion about the barriers that exist for whānau in order to access care, and the aspects of the resource that were deemed to need more consideration. Key informants from both groups talked about some of the language being too complex, confusing, not relatable, or negative. A consumer described the resource as being too wordy -

> *Sometimes words just straight like this it's harder to understand… Sometimes if I just read these words I need more to understand and relate, to get a better picture… if I were to pick this up it would just be hard for me to be interested in reading it… You gotta make sure you can relate to it, be informative. (C7)*

The resource also asks consumers to be honest about their health issues, which was perceived by some key informants as insinuating that the consumer would be dishonest. For example, a health provider talked about the implicit judgement in the suggestion –

> *I don't like it when they tell people to be honest because who are they to say that they're dishonest. It's not a good term to use, and often the only time that whānau aren't upfront is because they're in an environment where they feel that they can't be up front in, because lots of judgement… first of all for their ethnicity and second of all, like, 'You're fat...'* (HP2)

Some of the other resource suggestions were deemed unrealistic. For example, asking consumers to make a longer appointment if their health issues are complex is unfeasible for many due to cost, and it assumes that consumers will know if their health issue is complex, which is not always the case. The suggestion that consumers prepare a list of issues to talk about was viewed as potentially unrealistic by some key informants, but was proposed by others as a good idea to promote.

As well as suggestions for improving the resource (Figure 5), both groups of key informants also gave positive feedback about it, in particular how the resource could be used as a tool for preparing for appointments and asking questions. One consumer said that they thought the resource is 'awesome' because they had never thought about asking such questions before –

> *I feel like it is your patient right to ask all these questions and until today I was never really aware of them if I think about it... I'd actually love to be asked or offered these sort of things… these are really good questions. (C5)*

A health provider talked about the benefits of reinforcing expectations –

> *I think it's a good idea for people to come in with a list of questions… because often you forget what your question is... I think it's really good to reinforce to people that they should expect to be listened to and be given good information… I personally think they're good questions. (HP4)*

It was emphasised that health providers should use the resource as a tool to instigate discussions around treatment options, and be welcoming of questions and consumer perspectives. Key informants' talk about the resource suggests that it has beneficial aspects, but could do with fine-tuning to be more consumer friendly.

Feedback on shared decision-making in healthcare settings

Drawing inspiration from Fiona Cram's report on improving Māori access to health care,[18] key informant talk about shared decision-making in healthcare settings is grouped into four health domain themes: consumer, provider, organisation and health system – although they are all interconnected. Each domain includes 1-4 subthemes (Figure 4) that are described and illustrated with selected quotes.

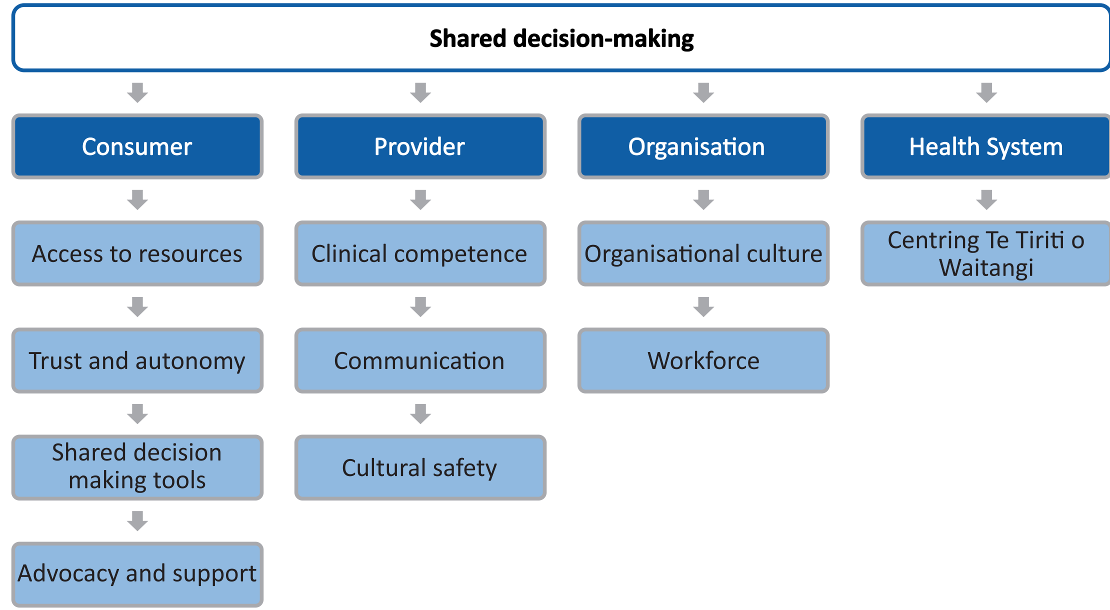

Figure 4: Feedback on shared decision-making (domain themes and subthemes)

Consumer

Access to resources

A barrier to shared decision-making that was frequently discussed is the lack of access to resources experienced by many Māori. This includes the cost of attending health services, availability of transport and childcare, and the impact of trauma and life stresses that left unaddressed may inhibit proactive health seeking behaviour. One health provider talked about this as 'emotional overload' –

> *Because of the emotional overload in people's lives due to housing problems, stress, domestic violence, past history of trauma, it sounds terrible but this is a reality…. prioritizing health issues, it's very difficult. (HP5)*

While a consumer noted -

> *Some Māori just can't even afford to go to the doctor in the first place. (C1)*

These issues can be compounded when health services are not organised in a way that support whānau. For example, when appointments are booked at bad times or tricky locations, and no support is offered –

> *There's the cost as well of having to travel… And that's happening quite a bit now with some of our whānau, they have to go all the way out there for some of their appointments. Nobody ever asks them if they can get out there, or if it's appropriate for them to get out there.* (HP2)

This was talked about as frustrating for consumers and those who support them, such as Whānau Ora navigators, especially when it comes to chronic conditions or illnesses that require frequent health appointments in different locations.

Both groups of key informants discussed the benefits of free or subsidised health care and health insurance for improving access to health services, and in doing so, providing the opportunity for shared decision-making to take place. These included, free/low cost health services, such as university-based student health services, pharmacies offering free prescriptions, and marae (tribal/pan-tribal Māori community centres) or community-based care. A health provider gave an example of specialists providing care as a koha (gift) in a community setting –

> *They are absolutely valuable, and it's all koha, they come because they see a huge gap for Māori… They provide the clinics for us on a monthly basis… And of course, it's free. Whānau who have been sitting on waiting lists for months have come into the clinic and gone straight through to have procedures… because suddenly the pathway has opened up more. (HP2)*

This service was described as being of value because it is free for whānau, because the specialists seem to really care and look after the whānau medically, and because it is provided on a marae, where whānau may feel more comfortable and supported culturally.

Some consumer key informants talked about the advantages of being able to access Iwi (tribe) health services and/or Iwi health insurance. For example, one consumer talked about their Iwi reimbursing their medical care –

> *You can go to any health provider… take a photo of the receipt and they'll pay for it. I've been going to the [after hours]… They're so expensive, I didn't even realise they're like one of the more expensive ones, but [it's] paid for anyway so this it's fine… Free health care for everyone I think would solve so many problems. (C1)*

Other health insurance was talked about as well, although the cost barrier was acknowledged. Key informants suggested that when health care is too costly it places a burden on individuals, who may avoid care out of necessity, and on whānau, who may take on costs to look after their loved ones.

Trust and autonomy

Key informants talked about how, for shared decision-making between health providers and consumers to happen, there needs to be a connection there, some kind of positive communication – in short - trust. For consumers who find it difficult enough to even access health services (due to cost or other access issues), when that communication is negative or disparaging, this can start a snowball effect of disengagement, distrust, and even fear.

Autonomy was also frequently talked about as an important facilitator of shared decision-making by both groups of key informants. Talk about autonomy included the importance of knowing

one's rights to be able to question, to not feel coerced, to expect to be informed, to have clear explanations, and to expect to be treated as an equal.

Descriptions of fearing or distrusting health services included: hating going, being scared of/daunted, being whakamā (reticent), feeling the opposite of respected, feeling powerless, and being dissatisfied with services, time given, or explanations. For example, a consumer talked about how some Māori are "whakamā to ask questions or to even open up and communicate" (C5) in health settings, as they are worried about coming across as not knowledgeable.

These feelings were often described as preventing shared decision-making for two reasons. First, they create a level of anxiety that may discourage consumers from attending health services to begin with. Secondly, they are likely to inhibit the open communication that is necessary for healthcare shared decision-making to take place. It was emphasised that it is the responsibility of health providers to ensure that whānau are supported to understand and make positive health decisions, and promote health literacy in strengths-based ways. One health provider talked about this as giving whānau the right 'tools' for success –

> *From the patient's perspective, from the whānau perspective, they've always been taught that they're passive. And then they're encouraged to be another way which is great, to take control. But you have to give them some tools so you don't set them up to fail. (HP7)*

Another health provider key informant emphasised the importance of health providers taking responsibility for the communication of health information, rather than defaulting to blaming consumers for a lack of health literacy. They talked about health literacy being closely tied up in the trust relationship and how well health providers listen and understand consumers' talk and feelings.

Autonomy was frequently, as we have noted, talked about as the right to question, to be informed, to have clear explanations, to not feel coerced, and to expect to be treated as an equal. The importance of being given options, space to think about them, and time to ask questions was emphasised. Some consumer key informants talked about age playing a role in feeling autonomous and confident in their health interactions. They talked about acutely feeling the power imbalance between health providers and themselves when they were younger. One consumer described taking 10 years to realise they have the right to question their care –

> *I'm assuming that everyone wants to have authority and autonomy over their health, their life… So I'm a total fan of shared decision-making… There should be ongoing correspondence and check-ins… that's the kind of communication you need when the power dynamics aren't even... It's taken me 10 years to work out how to speak to medical people… to figure out what I'm entitled to, how to ask for information. So that's 10 years of feeling like crap. (C8)*

Similar to the need for autonomy, trust was discussed as a key facilitator of shared decision-making. Key informants talked about the benefits of consumers feeling comfortable and unpressured during consultations, and being able to take time to develop relationships with health

providers. This was frequently referred to as rapport, which was deemed to be crucial for building a trust relationship. For example, a consumer spoke of the benefits of seeing the same health provider for many years –

> *I've been with my GP's for a very long time. Built up quite a rapport… I've been at the same GP clinic since I was around seven… I know them so well. Like we're not friends outside of that but we do have a good relationship… They've just got my whole history and I know them so well, I don't want to switch. (C2)*

From the key informants' talk, when rapport is established, advice that is given is much more likely to be taken on board even if it is challenging. For example, one consumer reported, "I have a positive relationship with my doctor… I feel comfortable, I can ask her anything… she's been good, she listens, lets me have my say, and then tells me if I'm wrong. Which is fine" (C4). Another consumer talked about the importance of trust, rapport, and not feeling coerced –

> *[It's good when] you feel comfortable, you don't feel coerced, don't feel pressured or pushed into a decision... Definitely think seeing a regular doctor would help… Rapport would make it a lot easier… It definitely comes down to how comfortable you feel with someone. (C5)*

According to the key informants, trust in health providers, that they know and understand the context and lived realities of whānau, facilitates communication that is important for shared decision-making to occur.

Shared decision-making tools

Both groups of key informants talked about the benefits of appropriate shared decision-making tools and resources. These were described as needing to be culturally appropriate/friendly, and including text and graphics/visuals that are relevant and engaging for Māori. Other important aspects given were having simple text, and messages that are gently guiding.

Shared decision-making tools were also described as needing to be health literacy appropriate - to be tailored to different levels of understanding and suited to the activity, be it self-directed or aided by a health provider, whānau member, or other support person. One health provider described a shared decision-making tool that was designed to be used with provider support, and how using such a structured tool can help manage bias -

> *If you have a shared decision-making tool with a lot of the information then it might be that a nurse could go through it and then the patient could make the decision… But it needs to be health literacy appropriate, culturally friendly… And the person doing it needs to be culturally safe and a really good communicator… I like things that structure what health professionals do because that's one way of dealing with implicit bias. (HP4)*

Although providing tools/resources for consumers to read and use as guides was talked about positively, it was emphasised that health providers need to be trained in how to engage with

whānau and assist with using tools when needed. I.e., the tools do not replace the need for discussions with health providers, they should enhance them.

Advocacy and support

Most key informants emphasised the importance of advocates in healthcare settings, as supporters and facilitators of shared decision-making. Key informant talk about advocates included talk about whānau members, representatives, nurses, and community support workers, such as Whānau Ora navigators. These advocates were deemed important for many reasons.

When decision-making capacities are compromised or if someone is not in the 'right frame of mind' to take in a lot of information, an advocate can ensure that the right questions get asked, and help to clarify any misunderstandings. For young people, who might be shy to ask questions, or for anyone uncomfortable to challenge health provider advice, it is beneficial to include someone trusted like a parent or other advocate as support. For example, a consumer talked about their mother supporting them at a consultation when they were feeling vulnerable and not up to asking questions –

> *Have someone to advocate for you when you aren't necessarily in that right frame of mind to ask those questions, when you're just vulnerable… when you're really uncomfortable and not thinking along the right lines. I had my mum with me and so she was asking a lot of these questions. (C3)*

They recommended that other whānau do the same if they are feeling unsure and want extra support. Another consumer talked about their daughter going with them to consultations because their GP had told them that if they wanted anybody to accompany them, they were welcome to do so.

Not only were individual whānau members talked about as key advocates and support, some key informants suggested group settings, such as a whānau hui (gathering), for discussing serious health issues. Having a hui in a safe, comfortable environment, where multiple whānau members can attend, would ensure that the whānau are informed and involved, and would prevent overburdening the consumer with repeating information to different people.

Health provider key informants talked about three additional benefits of involving advocates in consultations. First, is having another person to contribute information when the consumer is asked about their history or the history of their condition, in case they have not covered everything that is pertinent. Second, is having another 'set of ears' to help interpret the information that has been shared, in case the consumer has misunderstood anything. Third, is having a support person there to ensure that rights and wishes are met. For example, a health provider talked about this as having an 'extra face in the room' to ensure that the consumer is taken more seriously -

> *[Advocacy] works magic for anything: navigators, community workers, nurses, because often what happens when you're dealing with the health system or even like WINZ, people tend to sort of sit up and think, 'Oh yes I better give them their*

entitlement.' It makes a big difference, even just an extra face in the room makes a difference. (HP7)

It was noted that some people may not feel comfortable having whānau members in consultations, but this was given as a reason supporting the role of community support workers. For example, a health provider talked about the important role of Whānau Ora navigators –

Community health workers play a massive role, have huge input into the support and advocacy for our whānau… Often they break down what's been said so that whānau can understand. Quite a few of our whānau prefer to have navigators because they're not ready for their own whānau to come with them on that journey. (HP2)

Advocates were described as playing an important role in ensuring consumers receive appropriate care, but it was emphasised that it should be about consumer preference.

Provider

Clinical competence

Key informants talked about providers needing to demonstrate clinical competence, to take their time and be thorough. Consumer key informants in particular talked about negative personal or whānau experiences, where health providers appeared lazy or were not thorough in their care, and so shared decision-making did not take place. One consumer talked about the impacts of this on their whānau –

Whānau have gone to the doctor and the GP's just pooh-poohed it… and not really delved in further to do a proper investigation... they miss the underlying issue. And for a couple of people I know that's turned out to be a fatal error… they're just lazy health professionals… … The process of elimination, to me that's a good doctor, they'll go through every possible scenario to figure out what is wrong, they're thorough. (C2)

Another consumer described discovering that a whānau member had not been looked after properly in hospital overnight when they were not in the right head space to challenge the care they were receiving. Another talked about finding out that the medicine prescribed to their infant was above the recommended dose, and that they had obviously not been given adequate information –

I'd seen a new doctor [about my baby's skin]… and they prescribed another cortisone but a different strength. I didn't realise at the time, see this is when information should've been shared… He did tell me not to use it longer than a week so I knew it was going to be quite strong. But then I saw the specialist and she freaked out, she's like, 'Whoa! I never would've prescribed that!' (C5)

Consumer key informants discussed feeling like they were able to make good decisions when their health providers were thorough and informative. This included when health providers go through different scenarios and demonstrate their knowledge of health issues and treatment options. Health provider key informants emphasised the importance of demonstrating competent judgement and providing opportunities for shared decision-making with all consumers regardless of whether their conditions are acute or chronic. For example, a health provider suggested taking the time to talk about any other/outstanding issues with consumers who present with acute illness, in order to utilise preventative care measures.

Communication

Both groups of key informants often talked about poor communication on the part of health providers being a barrier to shared decision-making. Descriptions of when health providers do not communicate well with whānau included: communication that is not positive, consistent, friendly, understandable, acknowledging, or empowering. Or, when it is incomprehensible, negative, abrupt, harsh, or disempowering. One consumer stated, “You should be treated like a human… And be acknowledged, because sometimes you feel like you aren’t actually… because you’re not a qualified professional, you don’t know anything” (C7). It was emphasised that poor communication inhibits shared decision-making, as it silences consumers and deters them from engaging in healthcare services in the future (as discussed earlier).

In contrast, efficacious communication was described as being a key facilitator of shared decision-making. This was described as being when health providers open up dialogue, seek the views and aspirations of consumers, and create space for them to feel comfortable, valued, and safe to ask questions. It was also described as being when health providers proactively provide key information that is tailored to consumers and their level of understanding, rather than waiting for questions. For example, a consumer talked about the importance of good communication –

> *Different health professionals… the way that they offer advice and treatment can be night and day from one to the next… There’s a way of communicating with people and sharing so that they become informed and empowered to be part of that decision-making process… Whereas, if it comes from an aggressive, confrontational point of view it’s obviously not going to get the uptake that is actually needed. (C2)*

Key informants talked about good communication sometimes involving connecting whānau up to services outside the health system, e.g., housing assistance, financial assistance, or social workers. It can also involve providing take-home information or follow-up care. For example, one consumer talked about recent positive experiences with their new dentist. The dentist emailed them a report after each appointment, including photographs of any treatment, so they can check their understanding and keep record. This was described as being an unexpected and much appreciated example of good communication after many negative experiences of health providers not communicating well. Seeing the same health provider regularly was frequently talked about as being important.

Health provider key informants talked about the importance of discussing options, checking understanding, and continuity of care. One health provider talked about the importance of health providers being able to "translate information into messages that are going to be appropriate for who's sitting in front of them" (HP7). Another talked about the importance of using the 'teach-back method' to ask consumers to repeat key information in order to check that communication has been clear. They emphasised that this needs to be done in a way that ensures that the focus is on making sure the health provider has explained things properly, rather than testing the consumer.

According to the key informants, when health providers communicate in efficacious ways, they support consumers to feel empowered, autonomous, knowledgeable, and respected. Subsequently, trust relationships are established and nurtured. For example, a consumer talked about this as demonstrating flexibility -

> *It's important that health professionals are flexible to adjust to the different people they're serving… giving answers or responses in a way that they understand… to use the right terminology... Different people digest information differently, and so it is one thing to ask questions, it's another to understand the answers…and have the confidence to challenge… Because shared decision-making is a two-way conversation, it is about opening the lines of communication both ways.* (C3)

Key informants from both groups frequently emphasised the importance of two-way, reciprocal communication. The significance of efficacious communication was talked about more frequently than health literacy, and was sometimes directly ventured as more important for shared decision-making.

Cultural safety

Key informants talked about shared decision-making being compromised by health providers lacking cultural safety, including acting in discriminatory ways based on assumptions about ethnicity, age, gender, weight, and/or lifestyle. A lack of cultural safety was usually described as being when health providers communicate judgement rather than understanding or care. For example, a consumer key informant described feeling racially profiled in a hospital –

> *I actually didn't feel heard at all. If anything, I was put into a box… Yeah it was quite bad. It just all felt very dramatic having a small child that's struggling to breathe and no one listening to you because you've pretty much been racially profiled… it felt really horrible. (C5)*

Health provider key informants expressed frustration that despite training, non-Māori health providers are often not culturally safe. One health provider key informant spoke of their disappointment with this -

> *I've been battling all of my career to try and make [providers] appropriate and then new ones come in and you'll start from the beginning and so in the end we get nowhere. We just end up training [non-Māori from] over the place who are*

interested in our culture but we don't get anything out of it… and all they do is make fun and ostracize the way we do things. (HP3)

Cultural safety, cultural literacy, and cultural competency were frequently discussed as key to shared decision-making with Māori. In line with aspects of good communication, this was talked about as existing when a trust relationship is established and nurtured. Being non-judgemental, genuine, supportive, and understanding context were described crucial for these trust relationships. A consumer key informant talked about bringing in culture as "bringing in comfort, support, and a safe environment" (C6). A health provider key informant talked about the importance of health providers being role models for establishing relationships -

As a health professional you're taught to not show too much of yourself. But what we're talking about is cultural safety, and realizing how you can impact on people… For Māori it's really important - engaging and encouraging them to be part of the planning and decision-making… You have to establish and maintain trust for it to be effective… Health professionals sometimes don't realise how much they can be a role model by being a nice, caring person. (HP7)

Another health provider described this work as whanaungatanga (connecting/relationships) - a foundational concept in te ao Māori (the Māori world). They called this whānau-centred care, and emphasised the importance of a holistic view of health and wellbeing (often referred to as Te Whare Tapa Whā/the four dimensions of wellbeing), including the spirit, mind, and family, as well as the body/physical. They saw this as a way of improving shared decision-making for Māori -

If you know the person and their goals, their aspirations, their family, what they value, what's important to them, and where they're from, that means you're much more likely to be able to get that shared decision-making. (HP5)

A consumer key informant described requesting a specific GP in her local practice who is non-Māori because they have a good reputation for working with Māori and Pacific peoples. Even though the GP had a closed list, they accepted taking on the consumer when the consumer explained that they were Māori and wanted someone who was culturally safe. The GP was described as being awesome, patient (never interrupting), interested in the consumer's opinion, and really understanding their life context. The consumer said that this made them feel more confident, and that subsequently they always came up with a treatment plan together.

Organisation

Organisational culture

Key informants from both groups talked about organisational culture, in particular the business model of primary care health services, as an organisational barrier to shared decision-making. Consumers and health providers frequently discussed feeling rushed to get through consultations due to short appointment times, with needs left unmet. A lack of opportunity for whānau to follow-up on concerns without paying extra was also discussed. For example, a consumer key informant talked about turning to Google to decipher information –

There have been times I've gone to the doctor and they've just kind of skipped over a whole bunch of detail… but I felt out of line to question, I felt a bit rushed… Quite often after I go to the doctor I end up going home and Googling everything all over again, because I felt like it was rushed or I almost need to go in with a tape recorder and a pen and paper. (C8)

A health provider key informant talked about the stress of short appointment times from their perspective -

People do come in with lists of things which can be difficult particularly if they've got 5 or 6 things, some of which are quite important and you've got a 15-minute appointment. That situation is quite stressful because you actually don't have enough time to deal with each thing properly. (HP4)

Another talked about how the business model of general practice enables gatekeepers, who further inhibit access to care for whānau -

The GP service is like a little empire… The receptionists weed people out… can put people off from coming in, because they'll look at Medtech and go, 'Oh you owe $150.' So, they can be the barrier… And the receptionist is probably not getting much money but they have a certain amount of power in their community because they've got that ability to shut people down. (HP7)

Health provider key informants often suggested that the business model of primary care conflicts with aspirations of health equity. They also talked about the reluctance of organisations and the individuals within them to change culture and practices to be more responsive to Māori and health equity. One described their frustrations at trying to affect some change -

[They] think that if you ask them to do anything new, they just have to add that on top of what they already do. They don't think about changing what they already do in some way to actually bring about this improvement… 'We've always done it this way, we're not going to change, and now you're asking us to do this as well?' HP4

This resistance to change was talked about as inhibiting efforts to improve standards of care.

Workforce

Key informants from both groups talked about workforce issues that inhibit the relationship building process that is important for shared decision-making. In particular, workforce shortages and the subsequent reliance on casual or temporary staff were frequently discussed. Health provider key informants suggested that these shortages are caused by high provider turnovers and burnout rates. Relying on casual or temporary staff disrupts the continuity of care that is important for building trusting relationships. For example, a health provider expressed concern that this affects both access to and quality of care for whānau –

> *There's GP shortages all over the country so whānau are struggling to get in, and the other thing is about the consistency of the GP you're seeing. [If you're] seeing locums there's no consistency in what the messages will be.* (HP2)

Consumer key informants often talked about the importance of seeing the same health provider and developing a relationship over time, and the disruption that changes cause.

Health provider key informants emphasised the need for continuous training for health providers, especially to enhance cultural safety. Māori health models, such as the Meihana model (a clinical assessment framework), hui models (such as the Hui Process - a framework to enhance the doctor–patient relationship with Māori), and Mason Durie's Te Whare Tapa Whā (a holistic model of health) were suggested as key resources for training health providers to be more responsive to Māori. For example, a health provider talked about the importance of putting resources into training the workforce –

> *I'd be putting more around the health professional working and using good principles of quality improvement in primary care… That's going to help drive the reduction in these tests... I think that if it happens in a peer environment and we've got access to the data it will start to encourage a reflection rather than just then lumping it on the consumer. (HP5)*

A consumer key informant talked about the differences they have observed in clinician approaches over the years. They suggested that the training must be better than before, as clinicians seem more open to shared decision-making. The importance of professional development training, continuing medical education, and quality improvement programmes were discussed as tools to encourage the reflection and communication skills that are vital for shared decision-making with Māori.

Health system

Centring Te Tiriti o Waitangi

Throughout the interviews Te Tiriti o Waitangi and aspects that relate to the principles of protection, partnership, and participation were frequently discussed. Health provider key informants in particular described the health system as dysfunctional and designed inequitably, thus failing to protect the health of Māori. For example, one referred to it as 'sick' -

> *[Māori] don't know they're going to be labelled because they act a certain way too, so they're in a really powerless position. Can't win unfortunately, so our health system is quite sick at the moment… Our health system isn't working well enough, it's not set up that way at the moment. (HP7)*

Another argued that the recent WAI 2575 report is a long awaited "platform for articulating how inequitable" (HP5) the health system is for Māori. This health provider key informant, as well as others, talked about the detrimental impacts of the underfunding of health services that serve Māori communities, and their wishes for these to be addressed. It was suggested that more

resources need to be put into Māori models that “give us more identity and security around who we are” (HP3), rather than into non-Māori models that do not reflect Māori values.

The failures of the health system to fulfil partnership obligations were talked about as being role-modelled from ‘the top’ in Government, filtering right throughout the health system. For example, a health provider key informant talked about the lack of recognition of the important role that Māori health providers play in supporting whānau in secondary care –

> *And often we’re the silent voices behind our whānau. We’re not recognised as being part of their journey, but we play such a crucial role in ensuring that they actually have a test or procedure.* (HP1)

Talk about the lack of Māori in the health sector workforce is related to a failure of the health system to fulfil participation obligations. Some consumer key informants lamented not seeing any Māori doctors. For example, one thought it would help them relax –

> *Honestly, I don’t ever think I’ve had a Māori or Pasifika doctor, and I think we just need more of them, because I feel like if I saw that I had a Māori or Pasifika doctor I would just completely relax and I would not be scared anymore. (C1)*

The importance of whanaungatanga (connections/relationships) within healthcare settings and tino-rangatiratanga (self-determination/autonomy) of communities and whānau to determine their own health needs and aspirations were highlighted. For example, a health provider key informant talked about the critical role of community leadership –

> *Ask the community… ‘So, what are you going to need to be able to do better for you and your whānau? How do you want to be involved with your care? What ways do you want us to communicate with you? What sorts of things would you like in the resources that we provide?’ I think that’s really important… those ideas around consumer involvement, and how that influences the leadership of health care. (HP5)*

Key informants’ talk emphasised the need to address systemic inequities in the health system and centre Māori and Te Tiriti o Waitangi in all domains. Doing so was positioned as key to improving Māori access to appropriate care, and therefore, access to shared decision-making.

Discussion

Māori consumer and health provider key informants were asked to provide feedback about the Choosing Wisely campaign and, more broadly, healthcare shared decision-making for Māori.

Feedback about Choosing Wisely was mixed. Concerns were raised, by health provider key informants in particular, about its governance and decision-making - that it has not engaged with Māori communities and Māori health professional groups, and that it lacks any reflection of mātauranga Māori and tikanga Māori. These are all important for not undermining the (latest) principles of Te Tiriti o Waitangi (partnership, participation, protection, equity, and options).[21]

Key informants indicated that with current inequities in health,[1-8 13] narrow campaign messages that focus on reducing tests/treatment and on Māori themselves questioning medical advice are problematic. Both groups did, however, see value in Choosing Wisely, especially if it promotes better communication between Māori consumers and their health provider/s. The caveat is that health providers must be delivering appropriate care and encouraging shared decision-making.

Choosing Wisely resources/tools were described as needing to be simple and realistic at a health literacy level, and both socially and culturally engaging for Māori. When utilised as such, these can enhance engagement in the decision-making process.[13 62 72 75] The key informant feedback supports the findings of the Connecticut Choosing Wisely Collaboration's research with underserved consumers. I.e., Choosing Wisely tools/resources are helpful, but require the ongoing training of health providers to work in ways that are culturally, linguistically, and health literacy appropriate, and supportive of consumer empowerment.[61]

Feedback about healthcare shared decision-making related to consumer, provider, organisation, and health system domains. Inequities in access to health care for Māori consumers are well documented,[21] therefore, it was not surprising that key informants from both groups frequently discussed the lack of access to resources experienced by many Māori as a barrier to shared decision-making. As found in the literature, both groups stressed the importance of consumer trust,[10 11 66 68] autonomy,[49 58 70] good relationships/rapport with health providers,[10 12 45 58 66 68] and culturally appropriate tools/resources.[11 12 62 72] The findings highlight the importance of advocates and support people for Māori in healthcare settings, in assisting both consumers and health providers in their understanding and confidence. Collective decision-making,[12 67 69 72 76] such as whānau hui, were encouraged.

Provider clinical competence and efficacious communication – encouraging collaboration, consideration, discussion, and mutual understanding,[11 12 45 53 62 63 66 70 73] were described as vital for shared decision-making by both groups. Being thorough and proactive in sharing information, rather than waiting for questions, were viewed as good practice. The importance of health provider cultural safety[30 31] - being non-judgemental, genuine, supportive, and understanding of context, was highlighted. Much research asserts that culturally safe shared decision-making strategies acknowledge Indigenous perspectives, values, preferences, and self-identified needs.[9-13 62-69 72-75] For the participants in the present study, this involves health providers acknowledging the validity of te ao Māori, such as the importance of whanaungatanga and holistic models of health.

Organisational culture, in particular - the business model of primary care resulting in short appointment times, and workforce shortages disrupting continuity of care - were discussed as barriers to shared decision-making by both groups of key informants. Health provider key informants also emphasised the importance professional development, so that organisations and individuals can change their culture and practices, and especially address deficit biomedical discourses that marginalise Māori experience, knowledge, and understandings of health and wellbeing.[10] Workforce training programmes that teach skills to identify biases and build cultural empathy,[10-12 71 72] such as the Meihana model and hui models (e.g., the Hui Process), were suggested.

Local and international literature indicates that health systems and models that do not reflect the values and knowledge systems of Indigenous peoples or take strengths-based approaches to care undermine and negatively impact Indigenous health and wellbeing.[62-64] In this research, the health system was described as inequitable and as failing to fulfil Te Tiriti o Waitangi obligations of protection, partnership, and participation – evidenced in Māori health inequities, in the lack of Māori input into issues that affect Māori, and in the lack of Māori workforce. It is not good enough to simply aspire to bring more Māori into the workforce, Māori need to be included in governance and decision-making as well.[21] Key informants highlighted the importance of tino-rangatiratanga of communities and whānau to determine their own health needs and health services. The findings suggest that centring Te Tiriti o Waitangi in the health sector would improve Māori access to appropriate care and, therefore, access to shared decision-making.

In conclusion, the current research corroborates themes found in the extant literature on shared decision-making (and healthcare decision-making) with Indigenous peoples - that shared decision-making has the potential to address health inequities among Indigenous populations by facilitating participation in health care that better meets self-identified need.[9-12 62 63 76] However, there is work to be done to ensure that Māori consumers know they have the right to ask questions, and that health providers are open to and encouraging of two-way dialogue. The research highlights several key elements required for optimal healthcare shared decision-making with Māori.
First, equity must be prioritised. This includes committing to eliminating inequities, as well as privileging the mātauranga (knowledge) and tikanga (practices, customs) Māori that are part of a holistic understanding of Māori health and wellbeing. Second, the importance of developing whanaungatanga - connections and relationships between Māori consumers and health services cannot be stressed enough. Trust and cultural safety were deemed vital to enabling the right kind of environment for shared decision-making to occur. Finally, given the significance of autonomy for shared decision-making, the tino-rangatiratanga of Māori consumers and communities to actively participate in health care and healthcare decision-making must be supported. Any national health campaign, such as Choosing Wisely, would benefit from centring Te Tiriti o Waitangi and committing to equity by prioritising the needs and aspirations of Māori.

Limitations of the research

The focus of this qualitative research was to explore Māori consumer and health provider feelings, advice, and recommendations about Choosing Wisely and shared decision-making for Māori. While consumers from a range of age groups and health providers from a range of disciplines

participated, the majority of participants were urban-based and female. We may have missed an important data opportunity by not having more rural-based and male or non-binary informants.

Strengths of the research

This qualitative Kaupapa Māori Research, utilising semi-structured interviews, enabled an in-depth exploration of a diverse range of Māori views. The research is the first to examine the Choosing Wisely campaign from a 'by Indigenous, for Indigenous' methodology. While diverse views were sought, common themes around equity, whanaungatanga, and tino-rangatiratanga arose. These add to the growing body of local and international literature that seeks to improve healthcare shared decision-making for Indigenous peoples.

Recommendations for Choosing Wisely and shared decision-making

The feedback from the key informants suggests that there is much work to be done to ensure that Māori consumers know they have the right to ask questions and expect equitable care, and that health providers are open to and encouraging of two-way dialogue. Culturally safe care and positive relationships between health providers and consumers are vital to shared decision-making, and are thus essential to the Choosing Wisely mission.

Recommendations drawn from the data, for the Choosing Wisely Aotearoa New Zealand campaign and resources, and for improved shared decision-making for health providers and consumers, are listed here.

Choosing Wisely Aotearoa New Zealand campaign

1. Uphold the principles of Te Tiriti o Waitangi and centre Māori in governance and decision-making, and encourage Colleges and DHBs to do the same in their Choosing Wisely work. For example, involve community and Iwi (tribal) based health providers, and develop strategies with communities that reflect their needs and aspirations.

2. Acknowledge and incorporate mātauranga Māori (Māori knowledge systems) and tikanga Māori (Māori practices and customs) in Choosing Wisely work. For example, Māori health models promote relationship building (e.g., the Meihana model, the Hui process, Te Whare Tapa Whā), and in doing so can improve shared decision-making.

3. Along with the main message of the campaign being 'Choosing Wisely', consider including other messages that encourage health providers to consider the best options for consumers and to instigate shared decision-making, such as, 'Advise Wisely'. While the campaign's promotion of consumer autonomy was viewed positively, health providers should retain responsibility for ensuring that they are creating a question friendly environment and providing appropriate care. Focus on the provision of appropriate care rather than over-treatment.

4. Utilise local evidence to support the campaign. This could involve applying a logic model, or moving towards a quality improvement or assurance framework that recognises local contexts that impact shared decision-making and access to appropriate care for Māori.

5. Promote cultural safety, patient-centred care, and equity based professional development training, continuing medical education, and quality improvement programmes. For optimal shared decision-making to happen, the right environment is required. Trust and cultural safety are important.

6. Undertake work to ensure that consumers know that they have the right to ask questions and expect equitable care, promoting autonomy and confidence to ask questions. As emphasised by the participants in this research, advocates, such as whānau members, friends, community health workers, and navigators, can play an important role in supporting shared decision-making in healthcare settings.

Choosing Wisely Aotearoa New Zealand resources

1. Work with Māori to design resources/tools that are engaging and relatable for Māori.
   a. Be realistic with suggestions, i.e., can consumers book longer appointments?
   b. Use plain, simple, relatable messaging, i.e., consider whether consumers understand that their health issues are complex, or whether it is appropriate to tell them to be honest. Consider different resources pitched to different levels of understanding.
   c. Ensure the layout of resources for consumers are engaging with visual aids/graphics.

2. Develop resources/tools to encourage health providers to communicate efficaciously with whānau and create a question friendly environment (rather than just educating whānau on how to communicate with health providers).

3. Create resources/tools for advocates, be they whānau members, friends, community health workers, or navigators, so that they can support/promote shared decision-making.

4. Support the development of decision-making tools for specific health issues, in line with College recommendations, which can be self-directed or aided by a health worker or advocate.

5. Advertise and supply shared decision-making resources/tools and key messages widely among networks and within health settings so that they become part of routine care. Consider the use of media and online resources/tools that are simple and accessible.

6. Seek user feedback (from providers and consumers) about the resources/tools through networks, such as Te Ohu Rata o Aotearoa, and health services (e.g., through DHBs and primary care). Web based feedback could be utilised.

Health providers and consumers

Health providers

1. Avoid assumptions about consumers, instead talk through issues/concerns.
2. Build relationships with consumers, develop trust.
3. Instigate shared decision-making by using tools to guide consumers through different options. Do not wait for consumers to ask.
4. Be open to questions and willing to engage.
5. Check understanding in an affirming way (e.g., the teach-back method).
6. Utilise visual aids/tools to guide discussions.
7. Connect consumers to relevant information and services/support.
8. Encourage the role of advocates and support people in decision-making.

*Consumers**

1. Expect respect. If you are not happy with the care you receive, talk to someone about it.
2. Ask questions. It is your right to have things explained to you in a way you understand.
3. Check if there are resources (e.g., brochures or online information) that you can see.
4. Talk to whānau and friends about any health concerns or worries.
5. Take support (e.g., whānau, friends, or health workers/navigators).

* The recommendations for consumers closely align with some of the messages of the current Choosing Wisely Aotearoa New Zealand resource (Figure 2), as these were affirmed in the key informant interviews.

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THE PUBLIC SERVICE WE ARE BUILDING TOGETHER - PUBLIC SERVICE ACT 2020

SUBMITTED TO:

Board Meeting		18 August 2020
Prepared and Endorsed by:	Debbie Brown, Senior Advisor Governance and Quality	
Submitted by:	Simon Everitt, Interim Chief Executive	

☐ **For Decision** ☐ **For Discussion** ☒ **For Noting**

RECOMMENDATION:
That the Board note the paper and is aware of its obligations for the future.

ASSURANCE:
Compliance with the Public Service Act 2020 is an enabler to equity.

ATTACHMENTS:
Letter to Board Chair.

BACKGROUND:
The Public Service Act 2020 (The Act) repeals the State Sector Act 1988 and makes a small number of related amendments to the Public Finance Act 1989 and provides a modern legislative framework that enables a more adaptive, agile and collaborative public service and includes stronger recognition of the role of the public service in supporting the partnership between Māori and the Crown.

The Act expands the types of agencies that comprise the Public Service, unified by a common purpose, ethos, and strengthened leadership arrangements.

The Act supports change already underway and aims to ensure a modern, more joined-up and more citizen-focused public service.

ANALYSIS:

COVID-19 showed how agencies can join forces and move with agility to solve complex challenges facing New Zealanders in a crisis. We now need to be able to do this all the time.

The 1980-90s public service reforms improved individual agency efficiencies, accountability and responsiveness, which saw us become a world leader in public management.
But it also fostered silos that made it hard to collaborate and design comprehensive services and solutions for New Zealanders across agencies.

The public service being built will be unified, reflective of and responsive to the people we serve - and grounded in a commitment of service to the community. We'll be better positioned to deal

with social, economic and technological changes that have created expectations around what we do and deliver.

Work already underway includes: digital transformation, better data collection, Māori Crown relationship building, diversity and inclusion, leadership development, new organisational forms, open government and reconnecting the public service with its core values. The Act provides additional momentum.

Principles - politically neutral, free and frank advice to Ministers, merit-based appointments, open government and stewardship.

Values - impartial, accountable, trustworthy, respectful, and responsive.

What changes will public servants need to make in their routine work because of the reference in the Act to Te Tiriti o Waitangi/the Treaty of Waitangi?

Guidance will be issued to agencies on what it means to support and strengthen the relationships between Māori and the Crown under Te Tiriti/the Treaty. Te Arawhiti (the Office of Māori Crown Relationships) has issued guidance to public servants on how they should consider Tiriti/Treaty implications in policy development and implementation, alongside a range of guidance, tools and training for agencies on how engagement with Māori should be approached.

Who is responsible for making sure public servants can deliver these expectations?

The Public Service Commissioner and public service chief executives will be responsible to their Minister for delivering on these expectations.

Do the new responsibilities apply to Crown agents and the boards of the Crown agents?

No. However, many Crown agents already recognise special relationships with Māori. For example, district health boards have specific obligations and responsibilities set out in their governing legislation.

Factsheets are available if more information sought https://www.publicservice.govt.nz/our-work/reforms/public-service-reforms-factsheets/

7 August 2020

Ms Sharon Shea
Chair
Hauora A Toi | Bay of Plenty District Health Board

By email: sharon@sheapita.co.nz

Tēnā koe Ms Shea,

I am very pleased to announce the enactment of the Public Service Act 2020, and to welcome you, and all Crown agents, to our unified public service. This is a significant milestone in our public service reforms, replacing a 30-year old statutory framework.

As a Public Service, we have an enviable international reputation for our integrity, responsiveness to government and effectiveness for New Zealanders. I'm delighted that Crown agents now formally join with departments and departmental agencies to create our Public Service under the new Act.

As leaders within this Public Service, we are all charged with upholding public service principles and values, and preserving, protecting, and nurturing the spirit of service to the community that public servants bring to their work.

The Act gives statutory recognition to, and an enduring foundation for, our public service principles of political neutrality, free and frank advice, merit-based appointments, open government and stewardship. It explicitly recognises that public service values underpin our work as we aspire to be impartial, accountable, trustworthy, respectful and responsive. The new Act better enables a collective way of working.

However, legislation can only take us so far. It is up to Public Service leaders to continue to drive and implement these changes for the collective interests of New Zealanders. For many people, Crown agents are the 'face of government', trusted to deliver important services responsive to the needs of those who we serve.

Over the next twelve months you will see tools, guidance and resources to support a phased implementation across the Public Service, notifying you well in advance of any changes. If you wish to know more, fact sheets are available on the Public Service Commission's website. I will also be online with you at the Chairs' forum in October and would welcome discussion then.

Finally, I would like to thank you for your ongoing engagement with this important mahi, and for taking on the responsibility to lead this new era of public service in Aotearoa New Zealand. We are all charged with enabling efficient and effective public services that respond to the current and future needs and aspirations of New Zealanders. The new Public Service Act is intended to make it easier for us to achieve this together.

Nāku noa, nā

Peter Hughes
Public Service Commissioner

Copy to: Simon Everitt
simon.everitt@bopdhb.govt.nz

CORRESPONDENCE FOR NOTING

SUBMITTED TO:

Board Meeting 19 August 2020

Prepared by: Maxine Griffiths, Board Secretariat

Endorsed and
Submitted by: Simon Everitt, Interim Chief Executive

RECOMMENDATION:
That the Board notes the correspondence

ATTACHMENTS:

- Letter to Dr Kate Grimade re Dennis Pickup Clinical Education Award - 22.7.20
- Letter to Dr John Malcolm re Dennis Pickup Clinical Education Award - 22.7.20
- Letter from Lakes DHB re BOPDHB Board Committee Representatives - 24.7.20
- Letter to Tauranga District Council re Totara Street Upgrade – 6.8.20

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22 July 2020

Dr Kate Grimwade
Physician / Medical Leader
Medical Services
TAURANGA HOSPITAL

Tena koe Kate

At the BOPDHB Board Meeting of 15 July 2020, Board Members learned of your recent Teaching accolade, in being awarded the Dennis Pickup Clinical Education Award, by the University of Auckland.

It is fantastic to see such well deserved recognition. The description of the award indicates that it is for individual Clinical teachers who are judged by staff and students to have made an outstanding contribution by way of their qualities as role models and their contribtion to the relationship between the health professions and the Faculty of Medical & Health Sciences.

There are many facets to attaining such an award that epitomise our CARE values. We are very fortunate to have a Clinician of your expertise, both in practice and teaching, within our organisation. The Board extends its congratulations to you and thanks you for your commitment to this community.

Nga mihi nui

SHARON SHEA
Interim Board Chair

Cc Simon Everitt, Interim Chief Executive

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22 July 2020

Dr John Malcolm
Paediatrician
Woman, Child & Family
WHAKATANE HOSPITAL

Tena koe John

At the BOPDHB Board Meeting of 15 July 2020, Board Members learned of your recent Teaching accolade, in being awarded the Dennis Pickup Clinical Education Award, by the University of Auckland.

It is fantastic to see such well deserved recognition. The description of the award indicates that it is for individual Clinical teachers who are judged by staff and students to have made an outstanding contribution by way of their qualities as role models and their contribtion to the relationship between the health professions and the Faculty of Medical & Health Sciences.

There are many facets to attaining such an award that epitomise our CARE values. We are very fortunate to have a Clinician of your vast experience and wealth of knowledge teaching and guiding the new wave of young talent who can only benefit from the number of years service you have given to our Bay of Plenty Communities. Your passion for rural and remote community health services and all that you have attained in those fields, is a credit to you. The Board extends its congratulations to you and thanks you for your commitment to this community.

Nga mihi nui

SHARON SHEA
Interim Board Chair

Cc Simon Everitt, Interim Chief Executive

Lakes District Health Board
Corner Arawa and Ranolf Streets (Pukeroa Street)
Private Bag 3023, Rotorua Mail Centre
Rotorua 3046, New Zealand
Telephone 07 348 1199
www.lakesdhb.govt.nz

24 July 2020

Sharon Shea
Interim Board Chair
Bay of Plenty DHB
Private Bag 12024
Tauranga 3143

Tēnā koe Sharon

Thank you for your letter 6 July 2020 regarding Bay of Plenty DHB representatives on the Lakes DHB committees.

At the Lakes DHB Board meeting 17 July 2020, Board members resolved to accept Bay of Plenty DHB representatives on the Lakes DHB committees as follows:

Lakes CPHAC, DSAC and combined CPHAC/DSAC Meeting
Board Member Ian Finch.

Lakes HAC Meeting
Board Member Dr Geoff Esterman.

Letters of appointment will now be sent to Ian Finch and Dr Geoff Esterman.

Ngā mihi nui

Dr Jim Mather
Chair, Lakes District Health Board

c.c. Simon Everitt, Interim Chief Executive, Bay of Plenty DHB
Nick Saville-Wood, Chief Executive, Lakes DHB

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6 August 2020

Tauranga City Council
Private Bag 12022
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info@tauranga.govt.nz

Re: Totara Street Safety Upgrade

The Bay of Plenty District Health Board (Bay of Plenty DHB) is required by the Public Health and Disability Act 2000 to improve, promote, and protect the health of people and communities, to promote the inclusion and participation in society and independence of people with disabilities and to reduce health disparities by improving health outcomes for Māori and other population groups.

Whilst health care services are important health interventions, their primary purpose is to manage disease, ill-health and trauma at an individual level. The health and wellbeing of a community is more strongly influenced by a wide range of influences beyond the health sector, including the transport system.

A transport system supports the health of the population by enabling safe and convenient mobility for all residents who need access to jobs, schools, commercial activity, and leisure, regardless of whether they own a private vehicle. Such mobility should minimise health risks from pollution and injuries and enhance opportunities for healthy physical activity and communal interactions across all sectors[i].

A healthy transport system ensures equitable access to well-designed, safe and attractive active transport options for a broad range of users and results in everyday convenience, as well as health and environmental benefits for individuals and the population[ii]. As per the 2019 Keeping Cities Moving plan from the NZ Transport Agency (NZTA)[iii] we need to increase the wellbeing of our cities by improving travel choice and reducing car dependency. Inevitably this will mean growing the share of everyday travel by public transport, walking and cycling. Of note the NZTA report identifies Tauranga as one of the six high-growth urban areas with the highest potential to achieve mode shift.

Feedback on the Totara Street Safety Upgrade proposal

There is no doubt that Totara Street is in urgent need of an upgrade, from the perspective of safety, as well as the extent to which it currently supports active transport modes. As stated in the Council proposal, Totara Street is the most direct route for people to travel in either direction between Tauranga and Mount Maunganui town centres. However, the existing infrastructure is unsafe and unappealing for people who choose to ride a bike or walk. Even with this strong deterrent to cycling, it is noted that more than 100,000 people biked along Totara Street in 2019, indicating strong demand for, and the convenience of, cycling. It is a tragic consequence of this current situation, that a cyclist recently died at this location in their attempt to rightfully use this transport corridor.

The Bay of Plenty DHB is broadly supportive of the proposed changes to Totara Street. The DHB agrees that different modes of transport should be separated as much as possible, particularly motorised from non-motorised. The DHB recommends that Totara Street be viewed as a transport corridor, rather than as a road, and that priority be given to the movement and safety of people along this corridor. Given such an approach, efforts should

be taken to reduce the volume of heavy trucks using Totara Street – for instance by restricting access to the Port of Tauranga to the entrance via Tasman Quay off Hewlett's Road. Designing Totara Street as a transport corridor for people will also result in the removal of all on-street car storage currently in place towards the Rata Street end. Prioritising safety for all users will also mean reducing the speed limit.

With regards to the specifics of the proposal, the DHB supports all six key features of the proposal highlighted on the Council website. The DHB makes the following additional recommendations:

- Provide a signalised crossing for Totara Street at the Hewletts Road end (option B).
- That the slip lane into Waimarie Street be removed. Slip lanes, even with a priority crossing, create risks for cyclists and pedestrians, especially when associated with a bi-directional shared path. Slip lanes also reduce cyclist and pedestrian convenience.
- That the crossing on Triton Ave be closer to the intersection so it is direct and convenient for cyclists and pedestrians, and that the crossing be the same design as on Hull Road, with priority given to cyclists and pedestrians.
- It is excellent to see priority for cyclists and pedestrians on Hull Road but moving the crossing closer to the intersection would improve convenience.

The Bay of Plenty DHB is supportive of Council making it legal for people to ride on the footpath as an interim measure, but this must not result in any delay in implementing a permanent solution as soon as possible. The DHB has similar safety concerns for people cycling around much of the remainder of Tauranga City and therefore suggests that Council make it legal to ride a bike on other footpaths, too.

Thank you for this opportunity to provide feedback on the Totara Street Safety Upgrade.

Yours sincerely

Simon Everitt
Interim Chief Executive Officer

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[i] Healthy Transport in Developing Cities. Health and Environment Linkages Initiative (HELI), United Nations Environment Programme, World Health Organization, 2009
[ii] Active Transport Position Statement, Bay of Plenty District Health Board. https://www.bopdhb.govt.nz/your-dhb/position-statements/
[iii] Keeping Cities Moving, NZTA 2019. https://www.nzta.govt.nz/assets/resources/keeping-cities-moving/Keeping-cities-moving.pdf

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

BOARD WORK PLAN 2020

Activity	Source	15 Jan	19 Feb	18 Mar	15 Apr	20 May	17 Jun	15 July	19 Aug	16 Sept	21 Oct	18 Nov	Dec
Venue – Tawa Room, Tga		√		√		No Mtg		√		√		√	No Meeting
Venue – Conference Hall, Whk			√		√		√		√		√		
Board only Time (*with CEO)		√ *	√	√ *	√		√	√ *	√	√ *	√	√ *	
Board Strategic Sessions				√			√			√			
Joint Bd/Run – Te Waka O Toi			√						√			√	
Patient Experience / Story	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Manaakitanga Visits (2.30 pm)	Bd Sec	√		√			√	√		√	√		
Approve Committee Resolutions	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Monitor Interest Declarations	Bd Sec	√	√	√	√		√	√	√	√	√	√	
Midland CEOs Meeting Minutes	CEO		√	√	√		√	√	√	√	√	√	
Reports from Reg / Nat Forums		√	√	√	√		√	√	√	√	√	√	
6 monthly Board Attendance	Bd Sec	√						√					
CEO Report	CEO	√	√	√	√		√	√	√	√	√	√	
Dashboard Report	GMPF	√	√	√	√		√	√	√	√	√	√	
PHOs Report	GMPF	√	√	√	√		√	√	√	√	√	√	
Maori Health Dashboard Plan	GMMGD		√				√		√			√	
Employee Health & Safety Report	GMCS	√			√			√			√		
Quarterly IDP Ratings	GMPF	√		√			√			√			
Risk Report	GMCS			√			√			√			
Draft Annual Plan 19/20 – Minister's Priorities			√										
Annual Plan – approve Draft	GMCS				√		√						
SHSP and Annual Plan 2018/19 6 month progress report	GMPF			√					√				
Annual Report										√			
Exec/Board/Runanga Planning Workshop											√		