TE MANAWA TAKI

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REGIONAL EQUITY PLAN 2020-2023

Version: Final

Date: 16 October 2020

Piki mai kake mai rā, hōmai te waiora,
Kia a ahau e tūtehu ana, koia te moe a te kuia i te pō,
Te pō i raru ai a Wairaka.
Papaki tū ana ngā tai ki te paepae o Aotea, rere kau ana te tangi ki te puia o Whakaari,
Ki a koutou i hinga i taua parekura, e moe mai rā, e moe mai rā, e moe okioki ana.

To those who lost their lives on Whakaari and to their whānau who grieve for them, you have enduring love and support.

Acknowledgements: Te Manawa Taki Governance Group wishes to acknowledge the previous regional (Midlands) Chairs group for setting the pathway toward this Regional Equity Plan. We also thank Shea Pita & Associates for the contribution to this Regional Equity Plan.

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 territorial 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: 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

Ko te hā te tūmanako o te ora Ko te ora te kikokiko o te Ao Ko te Ao te whakaruruhau Mō te tangata Ko te Manawa Taki O te oranga Tihei mauri ora!	Hope is the breath of life life is the sustenance of creation Creation is the shelter of the people Manawa Taki the heart beat of wellbeing The essence of life!
I te tīmatanga o te kupu Ko te Atua te kupu Ko te Atua anō taua kupu ko ia te tīmata Me te whakaotinga o ngā mea katoa	In the beginning is the Word and the Word is God and God is the Word for God is the beginning and the end of all creation
E mihi kau ana ki te Kīngi Māori a Tuheitia Potatau Te Wherowhero te tuawhitu O te whare o Potatau Paimarire.	Greetings and salutations to the Māori king Tuheitia Potatau Te Wherowhero the seventh of the house of Potatau Peace.
Ka huri hoki ki te whare tapu O Te Heuheu Te Ariki O Ngāti Tūwharetoa	Salutations to the sacred house of Te Heuheu the paramount chief of Ngāti Tūwharetoa
E mihi ana ki ngā tini aituā Kua wehe ki a Rangiwhetu mā Kia pīataata koutou i te rangi Ki tua o te ārai a Rehua Haere, haere, haere atu rā	We acknowledge those who have passed to Rangiwhetu ma / the heavens to be seen like a shining light upon the veil of Rehua travel, travel farewell

He mihi maioha tēnei ki a koutou katoa e ngā rangatira, e ngā iwi whānui o te takiwā o Te Manawa Taki mai i Tauranga moana ki Te Arawa, peka atu ki Te Tairāwhiti, whakawhiti ki Te Tai Hauāuru i Taranaki tae noa ki Waikato / Tainui. Ko tā mātou e whai nei he hāpai ake i te oranga o tō tātou iwi mā te ara hauora. Ko tā mātou whāinga kia mahi tahi ngā rōpū e rima i runga i te whakaaro he pai ake ngā upoko tokorima tērā i te upoko takitahi. Arā, ko tō mātou tirohanga whakamua “He Kapa Kī Tahi”. Nō reira, ki a koutou rau rangatira mā, nō mātou te hōnore ki te āwhina i a koutou. Mā te Atua koutou e manaaki, e tiaki. Pai mārire.

Greetings and a warm welcome to you our esteemed elders and people within our various rohe of Te Manawa Taki. From Tauranga to Te Arawa, and on to Te Tairāwhiti; from there across to the western coast to Taranaki, and up to Waikato / Tainui. It is our intention and desire to up-lift the standard of wellbeing for our people, through health. Our goal, of course, is to work as one, now that we are a collective of five rōpū, and five heads have to be better than one. Thus, the vision “He Kapa Kī Tahi”. Therefore, to you our most esteemed people, it is our humble honor to serve. May God look after you and keep you all safe and well. Peace.

Hon Chris Hipkins

MP for Remutaka
Minister of Education
Minister of Health
Minister of State Services
Leader of the House
Minister Responsible for Ministerial Services

16 October 2020

Nick Saville-Wood
Lead Chief Executive for
Midland Region District Health Boards
nick.saville-wood@lakesdhb.govt.nz

Dear Nick

Te Manawa Taki Regional Equity Plan 2020/21

This letter is to advise you that I have agreed the Te Manawa Taki Regional Equity Plan.

Your region has produced a Regional Equity Plan this year which demonstrates an excellent collaborative approach between Māori and Iwi leaders working in unison with DHBs. I acknowledge that this is a significant milestone for the region and is the direct result of an enhanced Te Tiriti o Waitangi based partnership between Iwi and the five DHBs. In addition to this, the COVID-19 pandemic has presented extraordinary challenges to the health system, and your region has responded well with rapid escalation and early engagement in the early stages, laying the foundation for recovery and a transition to the "new normal".

My approval of your plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health (Ministry). Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you and your staff for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of the 2020/21 plan.

Please ensure that a copy of this letter is attached to the copy of your signed plan held by each DHB Board and to all copies that are made available to the public.

Ngā mihi nui

Chris Hipkins
Minister of Health

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Agreed by Te Manawa Taki Governance

DHB BOARD CHAIRS AND IWI GOVERNANCE

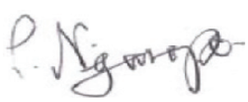
SHARON SHEA, MNZM

Bay of Plenty DHB

POUROTO NGAROPO, MNZM

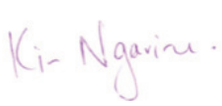
Māori Health Runanga

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

DAME DR KAREN POUTASI, DNZM

Commissioner

Waikato DHB

TE PORA THOMPSON-EVANS

Iwi Māori Council

Waikato DHB

TE MANAWA TAKI DHB CHIEF EXECUTIVES

PETE CHANDLER

Bay of Plenty DHB

JIM GREEN

Hauora Tairāwhiti

NICK SAVILLE-WOOD

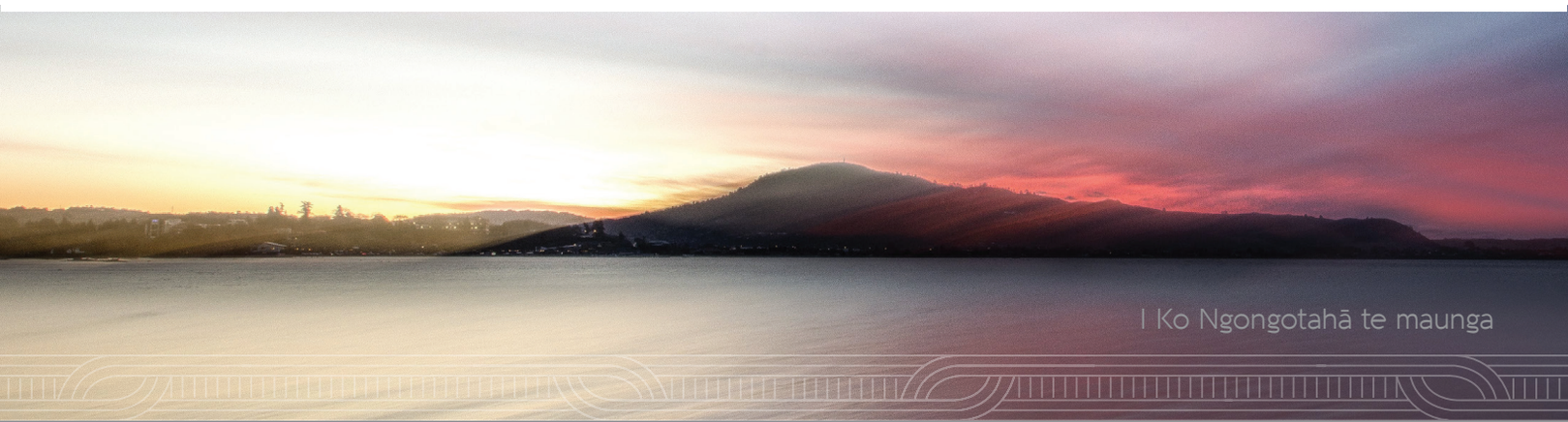
Lakes DHB

ROSEMARY CLEMENTS

Taranaki DHB

DR KEVIN SNEE

Waikato DHB



CONTENTS

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.

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[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

21%

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.

5 DHBs

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

Lakes DHB

Te Arawa, Ngāti Tuwharetoa, Ngati Kahungunu ki Wairarapa

Hauora Tairāwhiti

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

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

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.


| Ko Taranaki te maunga

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
A
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
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
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
H
Hauora
Ihi
I

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.

[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

Child health

Vaccination rates

At **six months** of age

Māori	Non-Māori
63%	83%

At **twelve months** of age

Māori	Non-Māori
91%	94%

At **five years** of age

Māori	Non-Māori
86%	89%

5x higher

percentage of Māori pregnant women who identify as smokers than Non-Māori women

Māori	Non-Māori
40%	8%

PHO enrolment rates

At **six weeks** of age

Māori	Non-Māori
57%	83%

At **three months** of age

Māori	Non-Māori
75%	83%

1.2x

as many decayed, missing and filled teeth than Non Maori children at five years of age (on average)

Infants exclusively or fully breastfed at three months

45.7% of Māori children

61.8% of Non-Māori children

Maori obesity rates in before school checks

2.2x higher

than Non-Māori obesity rates

Percentage of caries free children at 5 years

Māori	Non-Māori
36%	67%

Trauma for children 14 years and under
from 2012 -2018 in the Midland region

Total injury risk for Māori children is **1.1x** that of Non-Māori

Risk of hospitalization from burns in Māori children is **1.8x** that of Non-Māori

Risk of hospitalisation from contact with sharp objects and from injury related to bicycles in Māori children are both **1.7x** that of Non-Māori

Risk ratio for severe injury (ISS = 25+) in Māori children was **1.8x** that of Non-Māori

Cancer

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

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

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;

- 19% Lung
- 19% Breast
- 16% Urological

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

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

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

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

- 31.1% Māori
- 21.4% 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

- 38.9 Māori
- 40.7 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
One-year survival	96%	96%
Five-year survival	83%	84%

Faster Cancer Treatment Indicators:

	2013/14		2018/19	
	Māori	Non-Māori	Māori	Non-Māori
31 day indicator	81%	78%	90%	87%
62 day indicator	49%	53%	93%	91%

Maori achievement against FCT targets better than Non-Maori.

Mental health

Māori adults are

1.7x more likely to have **experienced psychological distress** as Non-Māori

1.5x 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
30%	17%

Mental Health Contacts

All services and all ages % of population

Māori	Non-Māori
7%	4%

All services 20-50 year olds % of population

Māori	Non-Māori
12%	6%

Seclusions

per 100,000 population

Māori	Non-Māori
14.5	1.12

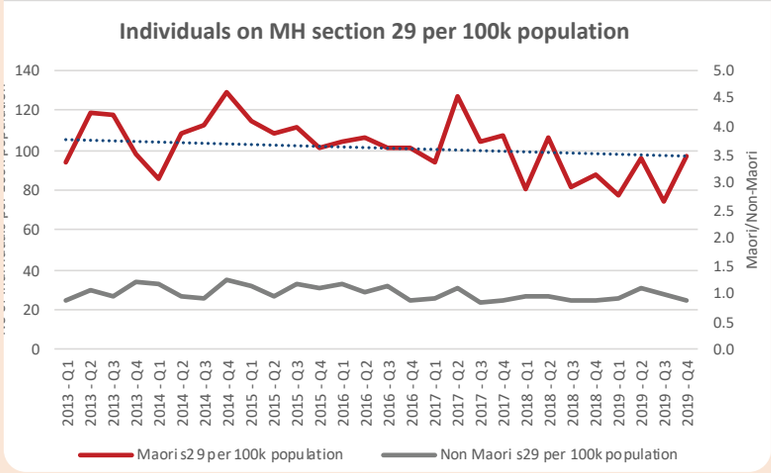
Alcohol & Drug Contacts

All ages% of population

Māori	Non-Māori
6%	2%

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

291.4 Māori **85.4** Non-Māori



Suicide rates

per 100,000 population

All ages

Māori	Non-Māori
16.9	9.1

Males 15-24yo

Māori	Non-Māori
52.4	23.5

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)

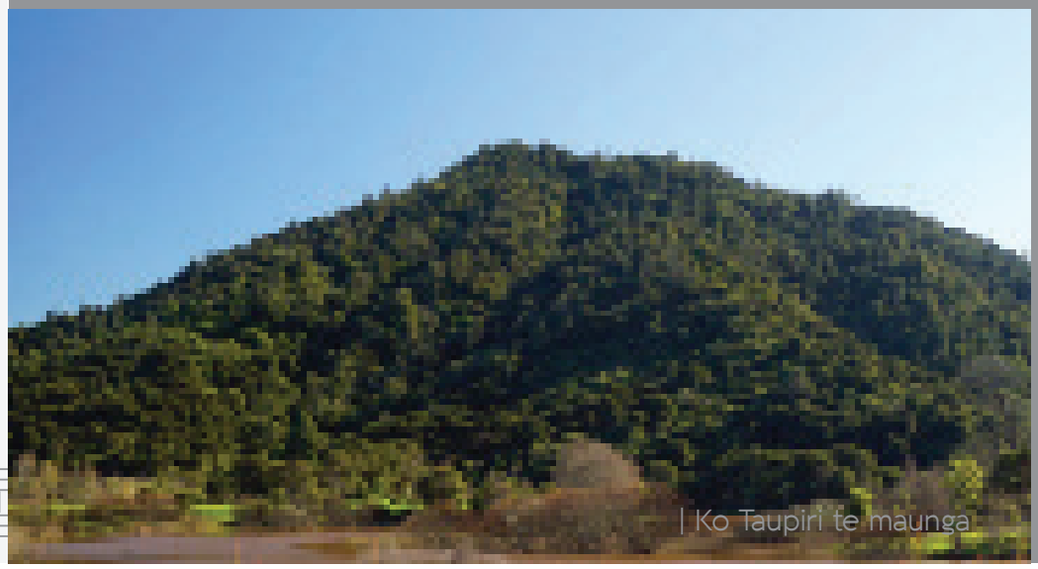
Services	Connector groups	Te Manawa Taki DHBs
Regional service areas & Networks, and shared services • Cancer • Cardiac • Child Health • Healthy Ageing • Hepatitis C • Mental Health & Addictions • Planned Care • Public Health Network • Radiology • Renal • Stroke • Trauma	• Pathways of Care • Quality • 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 - Kia momoho, Te Hāpori Oranga, 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	
Te Manawa Rahi 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	The Taranaki vision is Taranaki Whanui He Rohe Oranga – Taranaki Together, a Healthy Community. The Plan outlines the Taranaki goal of Kia tū rangatira ai ngāi Māori ki te ora kakariki – our journey from the red to the greens on our dashboard of Māori health priority indicators.
	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.


| Ko Taupiri te maunga

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.

Te Manawa Taki Governance Group*

DHB Board Chairs

Iwi Relationship Board Chairs

* representation and accountability of members are to individual boards

Te Manawa Taki Chief Executive Group

HealthShare Board

Regional Cancer Hub, Te Aho o Te Kahu – Cancer Control Agency
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.

[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.

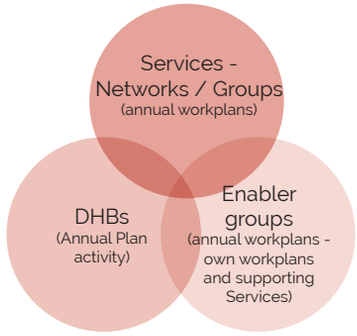
Services:	
Action Plans: Oversight and monitoring to ensure action plans are implemented on time: - Plans to be explicit about how to improve Māori health equity unless this requirement is formally excluded by Te Manawa Taki Governance Group within the next three years. - Plans to align with agreed Māori 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.

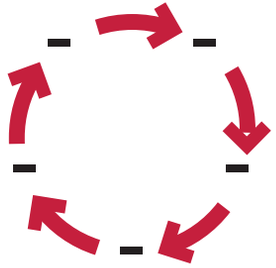
4.2 RELATIONSHIP BETWEEN REGIONAL STRATEGIC PRIORITY WORK AND ANNUAL WORKPLAN ACTIVITY/IMPLEMENTATION
TE WHANAUNGATANGA I WAENGANUI I TE MAHI WHAKAAROTAU RAUTAKI Ā-ROHE ME TE WHAKATINANA I TE MAHERE MAHI Ā-TAU

Te Manawa Taki Governance Group

Regional groups & relationships



Projects & initiative level



Each project/initiative - life cycle

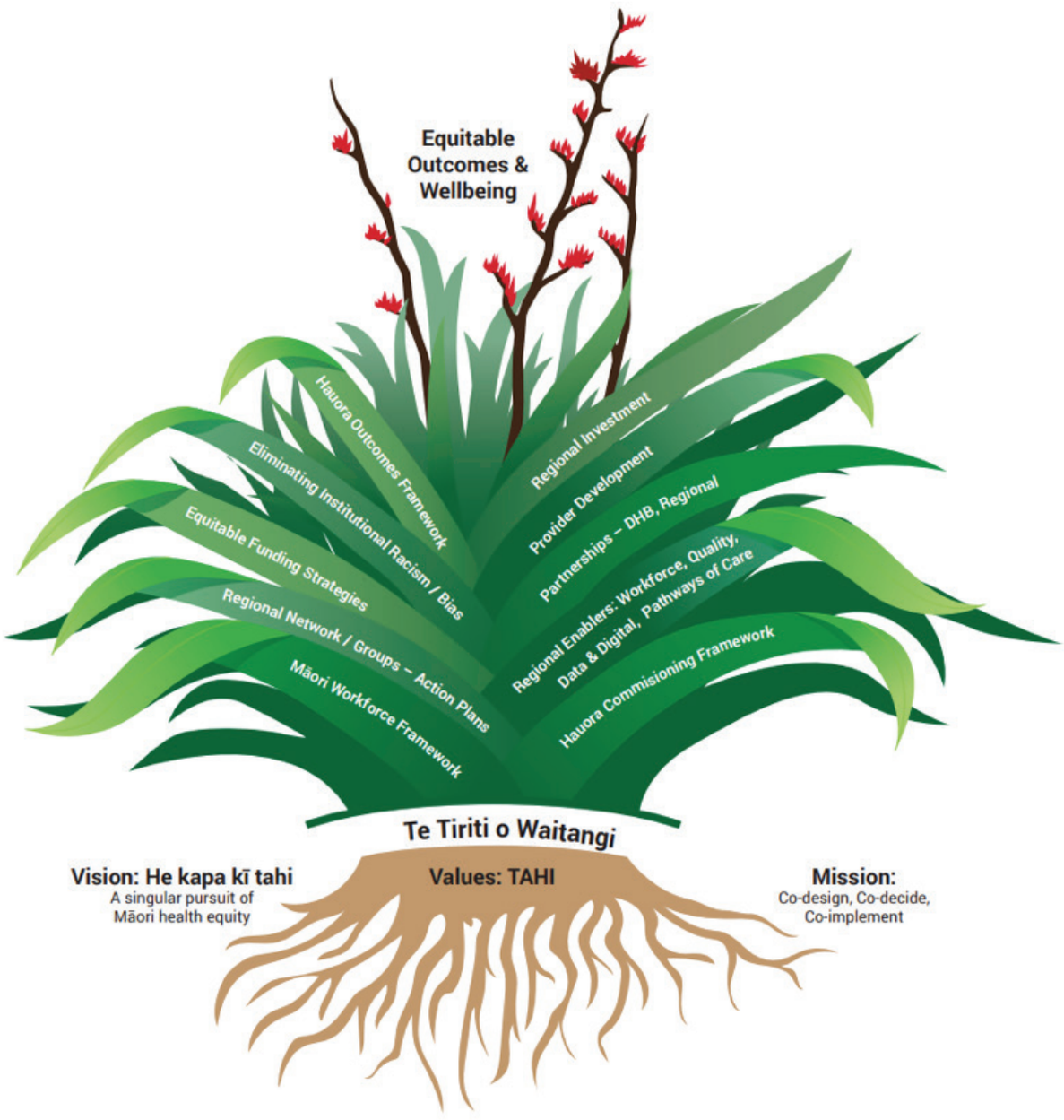
SETTINGS			
Hauora outcomes framework	Ensures a common Hauora view and strategy.	Interpret and define priorities.	Implement priority outcomes.
Commissioning framework			Apply optimal cultural/clinical mix.
Data	Shared data definitions, targets, status view.	Monitoring, collation/reporting, data-driven 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 A

- 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

H HAUORA

- 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.

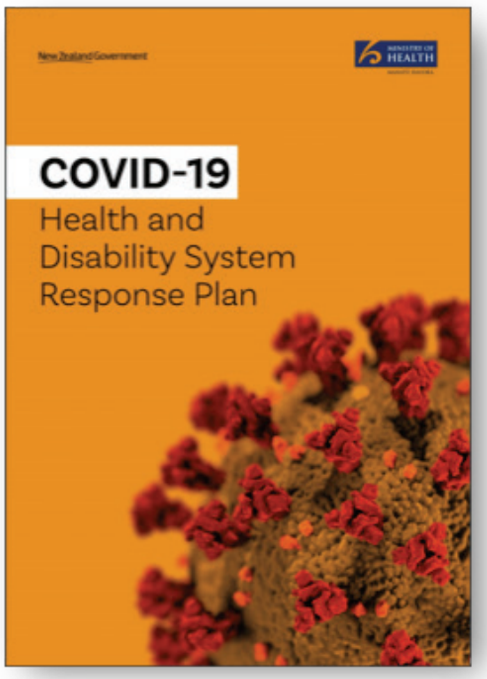
IHI I

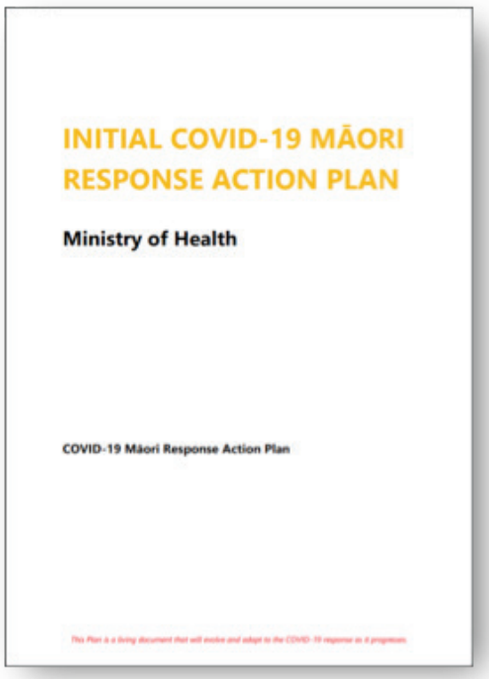
- Mutual support and readiness for any future COVID-19 surge.
- Relationships, iwi partnerships and iwi-led initiatives.
- DHB responsibility as a major employer and local economic driver.
- An environment of trust at all levels.
- Ongoing coordinated work broadens and deepens relationships.

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

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.

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.

DHB Annual Plans outline the role and functions of DHBs, to::

- work with key stakeholders to plan the strategic direction for health and disability services,
- plan regional and national work in collaboration with the National Health Board and other DHBs,
- fund the provision of the majority of the public health and disability services in the district, through the agreements with providers,
- provide hospital & specialist services primarily for our population and also for people referred from other DHBs,
- promote, protect and improve 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, 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

2.1.1 BAY OF PLENTY DHB

The Bay of Plenty DHB Annual Plan 2020/21[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.

Evolving 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 2020/21[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 and Aroha/compassion. These values form the acronym 'WAKA'. They reflect our past while guiding us on our journey[7].

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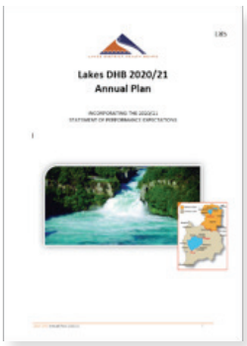
[3] BoP DHB Annual Plan 2020/21 - https://www.bopdhb.govt.nz/media-publications/a-z-publications/
[4] Bay of Plenty Strategic Health Services Plan 2017-2027 - https://www.bopdhb.govt.nz/media/60567/bop-strategic-health-services-plan.pdf
[5] Te Toi Ahorangi – Te Rautaki a Toi Ora 2030 – Te Reo and English versions - https://www.bopdhb.govt.nz/m%C4%81ori-health/m%C4%81ori-health/
[6] Hauora Tairāwhiti Annual Plan - https://www.hauoratairawhiti.org.nz/news-and-events/publication-and-consultation-documents/published-documents/annual-plan/
[7] Hauora Tairāwhiti kaupapa and values - https://www.hauoratairawhiti.org.nz/about-us/who/our-kaupapa-and-values/

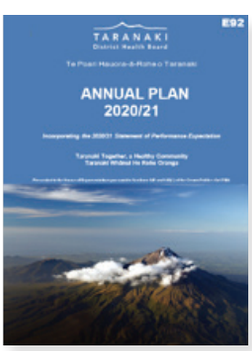
2.1.3 LAKES DHB



Te Manawa Rahi – the Lakes DHB Strategy 2020/21[8] and the Lakes DHB Annual Plan[9] outlines the vision of **Healthy Communities – Mauri Ora!** 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 2020/21[10] outlines the shared vision of **Taranaki Whanui He Rohe Oranga – Taranaki Together, a Healthy Community.**

The Taranaki Health Action Plan 2017-20[11] 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.

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

[9] Lakes DHB Annual Plan 2020/21 - http://www.lakesdhb.govt.nz/Article.aspx?ID=3012

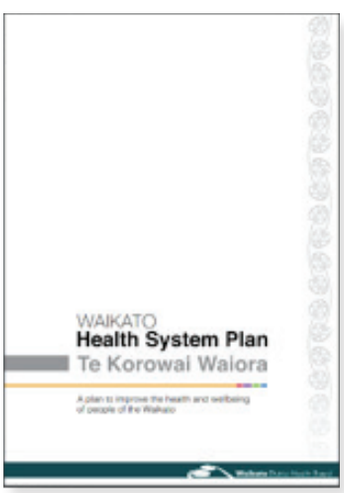
[10] Taranaki DHB Annual Plan 2020/21 - https://www.tdhb.org.nz/misc/document_library.shtml

[11] 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 2020/21[12] is developed in alignment with the vision of **Healthy people, excellent care**, outlined in the Waikato DHB Strategy[13] , 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'. Ki te Taumata o Pae Ora – the Iwi Māori Health Strategy, is under development and will be the organisation's driver for achieving the strategic priority of radical improvement in Māori health outcomes by eliminating health inequities for Māori.

The Waikato Health System Plan – Te Korowai Waiora[14] translates the DHB 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.



[12] Waikato DHB Annual Plan 2020/21 - https://www.waikatodhb.health.nz/about-us/key-publications-and-policies/

[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

[14] The Waikato Health System Plan – Te Korowai Waiora - https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Plans/7bf3d1e7ca/Waikato-Health-System-Plan-Te-Korowai-Waiora.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[15] , 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.

[15] 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[16]. • 100% of regional priorities are reported quarterly by ethnicity[17] .
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.

[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	Rajesh Nair, Waikato 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	Jo Scott-Jones - Interim Chair	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.

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

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

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.*

Health Outcome objective: New Zealanders have better cancer survival – Te huanga 4: He hiki ake i te oranga

Workplan Outputs	***Equity aims/outcomes for this work:***
• **Facilitate and support Te Manawa Taki DHBs with colonoscopy demand and capacity production planning.** (SS16-MoH tbc)	• Improvement in colonoscopy wait time indicators (urgent and non-urgent diagnostic colonoscopy, and surveillance colonoscopy).

Enablers:	*Quality*	**Who:**	*Te Manawa Taki DHBs & BSRC, NBSP*
Measures/ validation:	*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.*		

- **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).**

	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.**	• 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.** *(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)		

Workplan Outputs		***Equity aims/outcomes for this work:***	
Measures/ validation:	• *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.*		
Health Outcome objective: A coordinated approach to Child Development Services (CDS)			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **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.**		• 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).	
Enablers:	*Quality, Workforce, Data & Digital Services*	**Who:**	*CHAG CDS providers/network (TBC)*
Measures/ validation:	• *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*		
Health Outcome objective: Health outcomes supported through priority child health pathways			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Child health pathways prioritised and supported by CHAG, with a focus on Māori health priorities.**		• 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.	
Enablers:	*Pathways of Care, Quality*	**Who:**	*CHAG, HealthPathways*
Measures/ validation:	• *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.*		

	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.* ▭ *(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.** ▭ *(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. ▭ *(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.

▬	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, 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

Category: Service delivery and systems improvement			
Health Outcome objective: New regional KPIs will be developed and monitored to identify regional inequities in service provision			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **Quarterly reports will be produced, analysed and issues identified.**		• Consistent, effective regional service provision – including timeliness of MRI and CT scans (incl. CT Colonoscopy). *(SS15)*	
Enablers:	*Data & Digital Services*	**Who:**	*MRAG*
Measures/ validation:	• *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).*		
Health Outcome objective: Improve Health Equity for Māori through the reduction of DNAs			
• **Proposal outlining recommended strategies will be developed including actions, to reduce the number of Māori DNA in one DHB radiology service.**		*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.	
Enablers:		**Who:**	*MRAG / DHB project teams for past and current DNA pieces of work*
Measures/ validation:	• *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.*		
***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)*			
Workplan Outputs		***Equity aims/outcomes for this work:***	
• **MRAG will attend the NRAG meetings and provide support through the completion of assigned tasks.**			
Enablers:	*Pathways of Care, Quality*	**Who:**	*MRAG*
Measures/ validation:	• *MRAG will action requested appropriate tasks and outcomes will be documented.*		
***Health Outcome objective*: Strategies for addressing specialist shortages will be investigated**			
• **Strategies will be explored for addressing service gaps due to specialist shortages.**			
Enablers:	*Quality*	**Who:**	*MRAG*
Measures/ validation:	• *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).*		

	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 team 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.*		

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	Māori health indicators		Minister's priority		SLM (/CM)		

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.*		

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	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)		

Category: Regional trauma system infrastructure including information systems			
Health Outcome objective: Highest possible quality care to patients and whānau is supported with appropriate regional trauma infrastructure			
• **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			
Enablers:	*Quality, Data & Digital Services*	**Who:**	*MTS, Waikato IS, Public Health*
Measures/ validation:	• *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.*		
Category: Injury prevention & awareness (Midland Trauma Research Centre) – through collaborative research & design			
Health Outcome objective: Regional Injury prevention is targeted for populations of Te Manawa Taki			
• **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.**		• 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*	

	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*		

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

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. ■ Improving internal & external relationships and increased regional awareness and visibility of health equity. ■	
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. ■ ■ *(DHB annual plan guidance – Sustainability: Māori workforce)*	
Enablers:	*See above*	**Who:**	*See above*
Measures/ validation:	• *Elimination of institutional racism & bias – perceived institutional racism.* ■ ▨ *(CM-incl. via adult in patient survey)* ■ *(data via PH01)* ■ *(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

■	3-year plan	■	DHB Perf. Measure	■	He Korowai Oranga	■	Other
▭	Māori health indicators	▨	Minister's priority	▨	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.*		

	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:*	
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 2020*		
	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
■	Māori health indicators	■	Minister's priority	■	SLM (/CM)		

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)