Taurite Ora

Māori Health Strategy
2019—2030

Capital & Coast
District Health Board
UPOKO KI TE URU HAUORA

Kua Takoto te Rau Tapu

The challenge of
health equity for Māori
is laid down

Taurite Ora

Māori Health Strategy
2019—2030

Contents

Capital & Coast District Health Board
Ūpoko ki te uru hauora

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Mihimihi

E aku nui, e aku wehi, e aku whakatamarahi ki te rangi

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Tēnā anō hoki ō tātou tini aitua, rātou kua huri ki tua o te ārai

E ngā mate huhua, haere, haere, haere oti atu

Tātou te urupā o rātou mā, tēnā huihui mai tātou

Nei rā te mihi a te waiora ki ngā manatapu, ki ngā reo, huri noa

He mahi taumaha, he mahi whakapau ngoi, te whakatinana i ngā tini āhuatanga e ū ai te hā o te ora

Engari he mahi hei oranga ake mō tātou

Kua takoto te mānuka

Nā reira ko tā tātou he hiki ake te wero

ka kawea atu ai ki ngā tihi o te ao waiora

Ko aua tihi rā

ko te oranga tinana

ko te oranga wairua

ko te oranga hinengaro

ko te oranga whānau

Arā he oranga tangata tērā kei te whāia nuitia

Kāti ake i konei

ki konā mai rā koutou i roto i ngā mihi

Mā Rongo, mā Tāne koutou katoa e whakaruruhau

Glossary

Hapū Pregnant

Iwi Tribe

Kaiāwhina Helper, assistant

Kaiārahi Navigator

Kaiārahitanga Leadership

Kaitiakitanga Stewardship

Kaumātua Elder

Kaupapa Māori Taking a Māori approach

Kōwhaiwhai Painted scroll ornamentation

Māmā Mother

Manaakitanga Respect, care, generosity

Manawanui Commitment

Marae Meeting area; central area of a Māori village and its buildings

Mātua Parents

Mauri ora Healthy individuals

Mirimiri Massage

Motuhaketanga Authority, self-determination

Ngākau tapatahi Integrity

Pae ora The Government's vision for future Māori health

Pēpē Baby

Pou Post, pillar, support

Pūkengatanga Pursuit of excellence

Rangatahi Youth

Rangatiratanga Self-reliant, determine your own way

Rongoā Traditional Māori medicine and treatment

Tamariki Children

Tangata whaiora me tangata whaikaha Māori with lived experience of disability

Taurite ora Tau (to arrive), rite (to be prepared), ora (health/wellbeing)

Tauritetanga Balance, justice

Te ao Māori The Māori world

Tiriti o Waitangi Treaty of Waitangi

Tikanga Correct manner, rule or protocol

Tūrangawaewae Place where one has rights of residence and belonging through kinship

Wahakura Woven baby's bassinet

Wai ora Healthy environments

Wero Challenge

Whakamana Empowerment, influence

Whakapakari Strengthen, develop

Whakatipuranga Growth, development

Whanaungatanga Building relationships

Whānau Family

Whānau ora Healthy families

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Foreword

Ultimately, everything we do at the Capital & Coast District Health Board (CCDHB) is focused on achieving healthy outcomes for our people – all 320,000 of them. Whether they live on the Kāpiti Coast, Porirua or Wellington City, we aim to everyone with the best health care services we can.

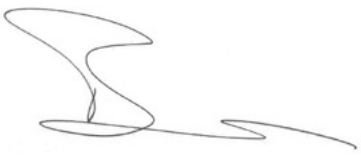
Twelve percent, or 38,000, of the population are Māori and they are not getting our best. This is a problem we need to tackle. In our current state our systems, policies and services have failed Māori. Taurite Ora draws a line in the sand and says that, from now on, we are going to do better.

Many of the statistics here evidence the wide and, in some cases, widening gap between Māori and non-Māori. This stark inequity of health outcomes is systemic, avoidable and unfair. Māori experience inequity across all social and economic markers of wellbeing, not just health. This suggests that our current systems, policies and services support inequity. We need to address this.

The pathway to doing better is challenging and will require significant shifts, not just in the way we operate or in the processes and policies we follow but also in our attitude and our thinking.

Delivering on the key outcomes outlined in Taurite Ora is foundational to our strategy, and we will measure and report on our progress regularly. By definition, a Māori health strategy must have its starting point in te ao Māori. The wero laid down for the CCDHB is to draw on the knowledge and expertise of our workforce, our Māori partners, iwi, communities and whānau to work with us to become a pro-equity organisation. We believe that a strengths-based approach, concentrating our effort toward building fit-for-Māori health services, will inevitably strengthen Māori capability across the health sector and have a flow-on effect into policy and practice design. But we will not rely on that alone. We will introduce overt, clear measures that demonstrate our progress.

By partnering with Māori, we can move beyond our predominantly monocultural delivery systems to form a health service that understands and welcomes solutions underpinned by kaupapa Māori, emboldened by tikanga and supported by whanaungatanga – in other words, the conditions most likely to enable Māori to thrive.



Andrew Blair
Chairperson
Capital & Coast District Health Board

Teresa Wall
Chairperson
Māori Partnership Board

Executive Summary

Capital & Coast District Health Board (CCDHB), together with the Māori Partnership Board (MPB), has set its sights on achieving the following critical goal:

Pae ora mō ngā iwi i te Ūpoko ki te uru hauora

Health equity and optimal health for Māori by 2030

Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the Ministry of Health's He Korowai Oranga: Māori Health Strategy.[1] This overarching framework and its underlying themes of Pae Ora (Healthy futures for Māori) founded on Whānau Ora (Healthy families), Mauri Ora (Healthy individuals) and Wai Ora (Healthy environments) guide us.

In 2019, the Government announced its commitment to recognising people's wellbeing as the most important driver of its priorities and funding decisions. With that announcement comes an expectation that the CCDHB will be able to measure and report against a broader set of indicators than previously to monitor our progress around improving wellbeing[2].

The CCDHB strategy is tailored to the identified health needs of Māori living in its district. We developed this action plan, *Taurite Ora: Māori Health Strategy 2019–2030* (Taurite Ora), to describe the outcomes and impacts we will be measured against. We intend to establish a governance group to oversee the implementation of this action plan.

We must also plan for the projected growth of the Māori population of CCDHB, forecast to increase by almost 40 percent over the next 20 years, from 38,000 to 52,000. What we do now will lay down the foundations for getting it right today, in five, 10, and 20 years. We must continuously measure our progress to ensure that we are improving, and we must be agile and courageous enough to take the lessons from our evidence and change what we're doing if it's not working.

Taurite Ora highlights the most critical priorities to improve health outcomes for Māori. Success is dependent on working with our partners to improve Māori interactions with our services and address the poor experiences many Māori have told us about.

The strategy focuses on:

Equity

Equity, as a value that underpins everything we do

Workforce

System change through workforce development

Commissioning

Funding prioritisation through commissioning of services.

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Key equity measures

From our foundation up, we must rebuild ourselves as a ***pro-equity*** organisation. In doing so, we will:

- redevelop supportive organisational structures, policies and processes
- actively counter racism and discrimination
- actively include Māori in decision-making, particularly where it relates to Māori
- develop a strategy to improve proportionality across all our employment groups
- improve the quality and efficacy of our data.

We will focus on five ***key measures of equity*** that are within the CCDHB area of responsibility and where we can have an early positive impact on Māori outcomes. These five key measures are:

- amenable mortality (deaths that are potentially preventable given the appropriate effective health care)
- avoidable hospital admissions
- accessible appointments
- primary care utilisation
- community-based services.

Priority service areas

Taurite Ora has also selected ***two service areas*** that would benefit from directing efforts and measuring positive service changes to improve outcomes for Māori, whānau and communities. These two services are:

- maternal, child and youth health
- mental health and addictions.

The choice of these two services does not preclude positive work continuing across other service areas.

Section 1

Introduction

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Introduction

Despite our best efforts, the Capital & Coast District Health Board (CCDHB) has made no progress across the 10 national indicators of population health status as listed in our 2016–2017 Māori Health Plan.[3] Our evidence suggests that a major barrier to achieving better health outcomes is the institutional restrictions Māori experience when they try to access our services. At a national level, it has become clear that the perennial failure of policies and interventions to make more than small dents in Māori privation levels require us to look at the systems we use to deliver change.

Taurite Ora tackles this head on by emphasising the importance of reshaping CCDHB as a pro-equity organisation. We will do this by undertaking initiatives that improve the cultural safety and cultural competency of our organisation. We will invite our partners and stakeholders to help us achieve the change we need to improve Māori health outcomes.

Taurite Ora looks ahead 10 years from now, and we will report against each of our outcomes on a three-year cycle.

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Our vision: Pae ora mō ngā iwi i te Ūpoko ki te uru hauora

"A health system that will enable Māori to live with good health and wellbeing in an environment that supports a good quality of life."

We share the Government's vision of building "a health system that will enable Māori to live with good health and wellbeing in an environment that supports a good quality of life".[4]

We can achieve this by thinking beyond narrow definitions of health and changing the way we deliver hospital, mental health and commissioned services under our direct control. We can also become more active participants in joined-up actions to improve Māori health and wellness in areas of shared responsibility.

The Taurite Ora framework describes the direction for change that we are seeking. It values te ao Māori and kaupapa Māori as key elements that speak to the heart of Māori wellbeing and the pathways to achieve that wellbeing.

Taurite Ora also recognises that Māori health is inclusive of a diversity of Māori realities. It strives to address the health needs and aspirations of our pēpē, tamariki, rangatahi, mātua, kaumatua and tangata whaiora me tangata whaikaha (Māori with lived experience of disability).

Taurite Ora has been developed in collaboration with Māori community leaders, kaupapa Māori providers, Māori researchers and academics, staff of CCDHB and with the support of the Māori Partnership Board (MPB).

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Laying down the challenge

The left pou holds the key to Māori expressions of wellbeing and the right pou, those of the Crown.

The Taurite Ora framework is a kaupapa Māori-centred framework. It has been designed as a sequence of interconnected and interdependent foundation blocks that set the direction and purpose of the strategy and the action plan. The pou to the left and the right reflect Māori and Crown roles and influences. The left pou holds the key to Māori expressions of wellbeing and the right pou, those of the Crown.

Taurite Ora follows true to the form and intent of He Korowai Oranga: Māori Health Strategy.

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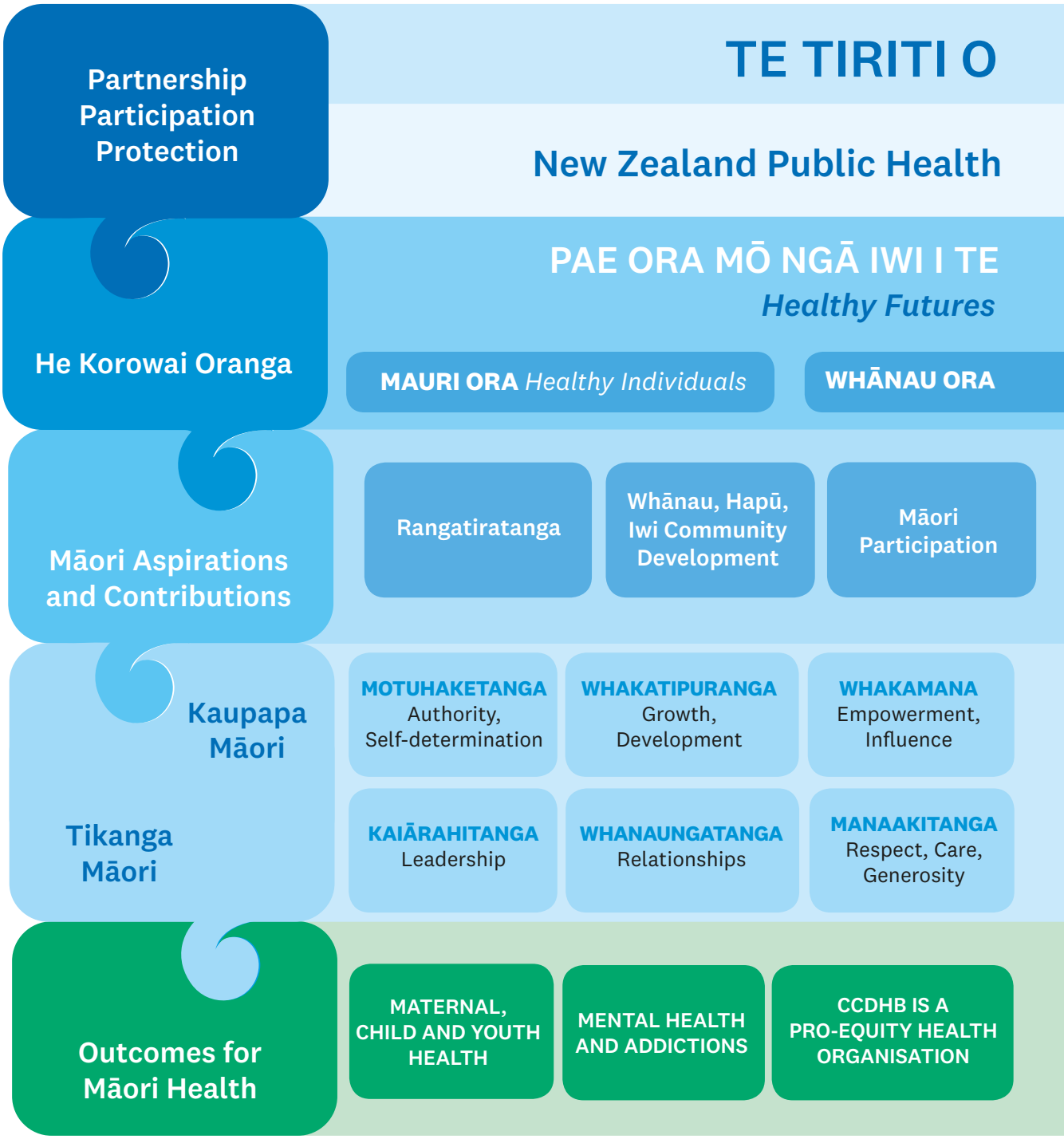
Taurite Ora: CCDHB Māori

Kua Takoto te Rau Tapu



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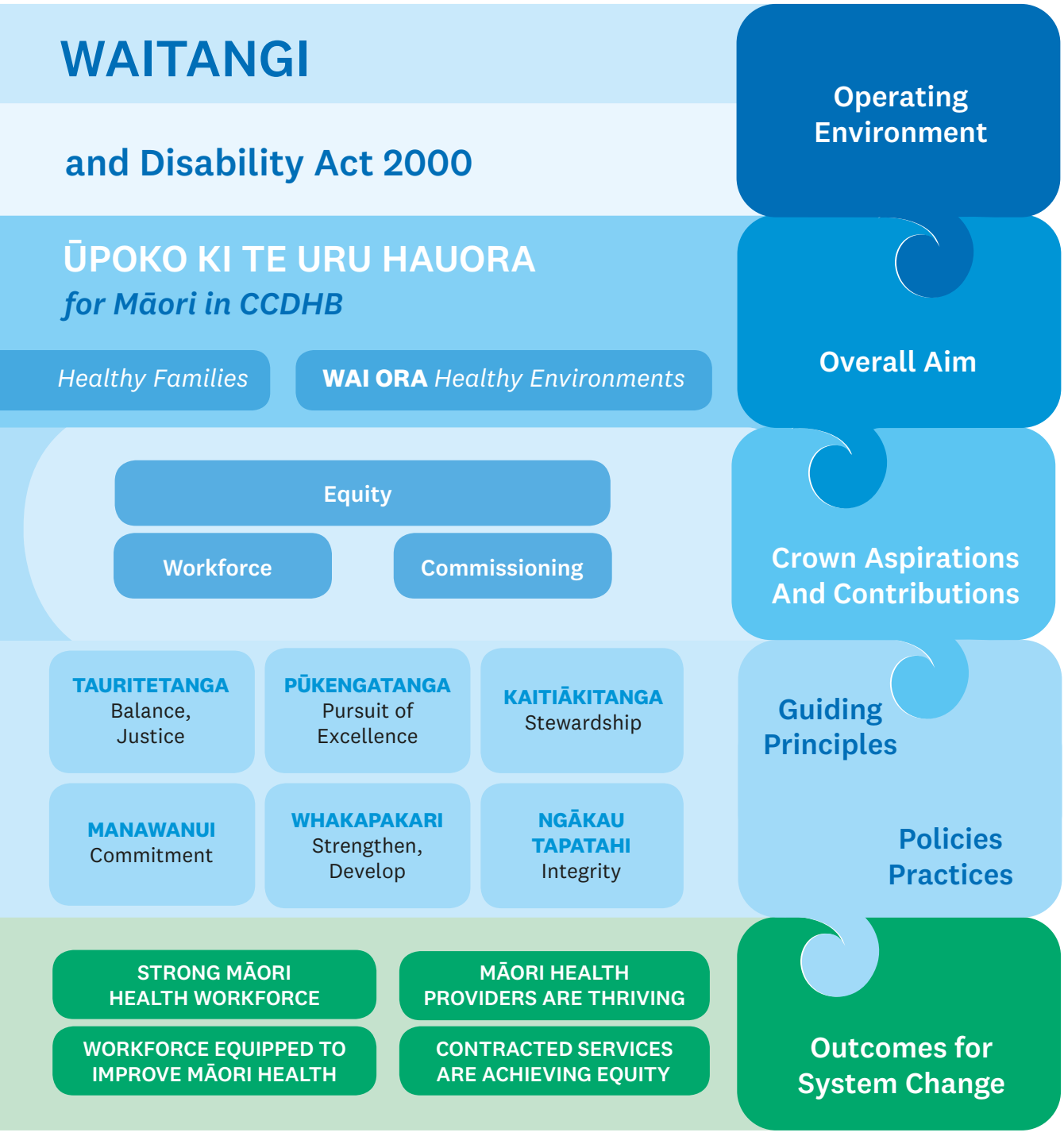
Health Strategy 2019–2030

The challenge of health equity for Māori is laid down



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The legal foundation

Taurite Ora is underpinned by Te Tiriti o Waitangi. The New Zealand Public Health and Disability Act 2000 provides a statutory link between Te Tiriti and Māori health by requiring DHBs to work with and be responsive to Māori when developing, planning, managing and investing in services that impact on Māori communities. This obligation encompasses an expectation by Māori that a te ao Māori perspective will be evident in policy and service design. In this context, Te Tiriti principles of partnership, participation and protection are at the core of Taurite Ora.

Partnership

The principle of partnership between Māori and the Crown is well established in law. Within the context of Taurite Ora, we will look at how we can strengthen the relationships with mana whenua and strengthen the role of the MPB.

Partnership also means applying a te ao Māori perspective to Māori service design. This will be challenging and requires CCDHB to proactively seek co-design opportunities and guidance and advice on matters of tikanga and whanaungatanga. Partnerships should apply across all levels of our organisation.

Participation

The principle of participation refers to Māori collaboration at all levels of the health and disability sector – in decision-making, planning, development and delivery of health and disability services.

In practice, this means ensuring that Māori are a vital and visible element throughout CCDHB as health planners, professionals and advocates for improving Māori health outcomes. In particular, this requires us to strengthen the role of our Māori health providers and recognise their unique contribution to pae ora.

Protection

The principle of protection encompasses an obligation to protect the interests of Māori. The scope of this duty includes CCDHB ensuring Māori have at least the same level of health as non-Māori, while actively protecting Māori cultural concepts, values and practices in developing successful health policies.

In practice, this mean placing the concepts of health equity at the forefront in respect to the planning, management and delivery of health services within the CCDHB area.

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Te ao Māori

Kaupapa Māori

Kaupapa is about ensuring that Māori ways of working are recognised and embraced in how we plan and deliver health services.

Tikanga Māori

Tikanga is about recognising and responding positively to values, beliefs and practices that are essential to Māori wellbeing. This includes matters affecting taha tinana (physical health), taha hinengaro (mental health), taha wairua (spiritual health) and taha whānau (family health).

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Section 2

A Snapshot: What we Know

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The following tables and figures have been specifically designed to provide a snapshot 'whole' view of the CCDHB Māori population, key wellbeing factors, and system and health equity. They are aligned to the strategy.

A full copy of the data report is available on the CCDHB website.

A Snapshot

What we Know

The data shows that:

Our Māori population is comparatively young

There are many positive aspects to the wellbeing of Māori

The socio-economic status of Māori results in disproportionate impacts

We need to change what we do and how we do it if we are to achieve health equity and optimal health for Māori by 2030

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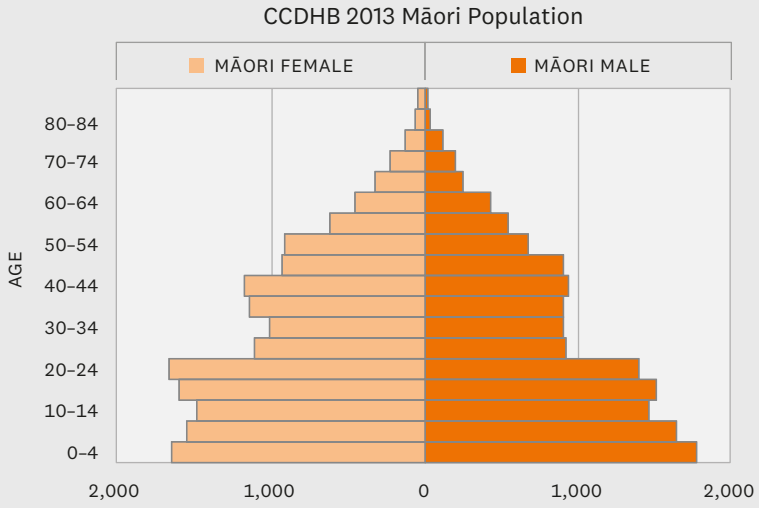
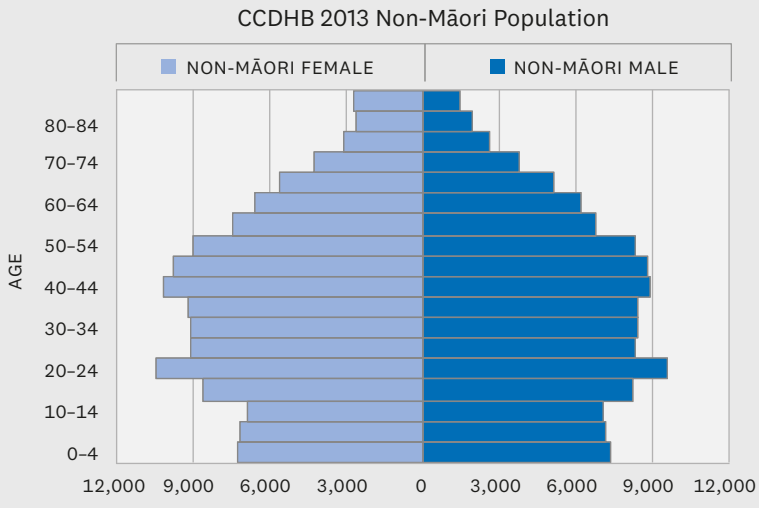
CCDHB population

In 2016/17 there were approximately 35,300 Māori living in CCDHB, comprising 11.5% of the total population. Most Māori live in Wellington City, with smaller numbers in Porirua and Kāpiti Coast, although the proportion of Porirua residents who are Māori is high (20%).

Māori are considerably younger than non-Māori; over 30% are under 15 years (cf 17% of Māori) and only 4% are over 65 years (cf 13% of Māori).





Source: Statistics NZ, 2013 Census

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Māori wellbeing

Data from the 2013 Census showed many positive aspects of Māori wellbeing that are often overlooked.

Most (88%) Māori adults reported that their **whānau is doing well**, although 4% felt their whānau was doing badly.

Many (79%) of Māori adults find it easy or very easy to **access whānau support** in times of need.

Being **involved in Māori culture** was important to 69% of Māori adults.

One in five Māori could have a **conversation in te reo Māori** in 2013.

Most (90%) of Māori adults did **voluntary work**.

The **14 kōhanga reo** have spaces 409 (10%) of Māori children up to age 5 in CCDHB.

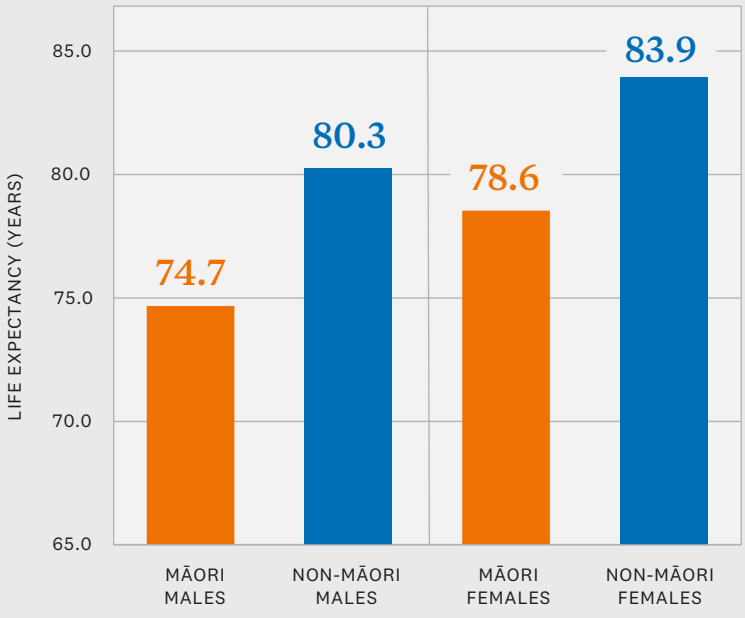
At age 5, 88% of Māori were **fully immunised**.

Among Māori youth, **smoking rates dropped** significantly from 2006 to 2013, although rates remain considerably higher than for non-Māori.

Source: CCDHB Māori Health Profile 2015

Life expectancy

Life expectancy is shorter for Māori than non-Māori, by 5.6 years for males and by 5.3 years for females.



Source: Stats NZ, based on mortality rates 2012–2014, Wellington region

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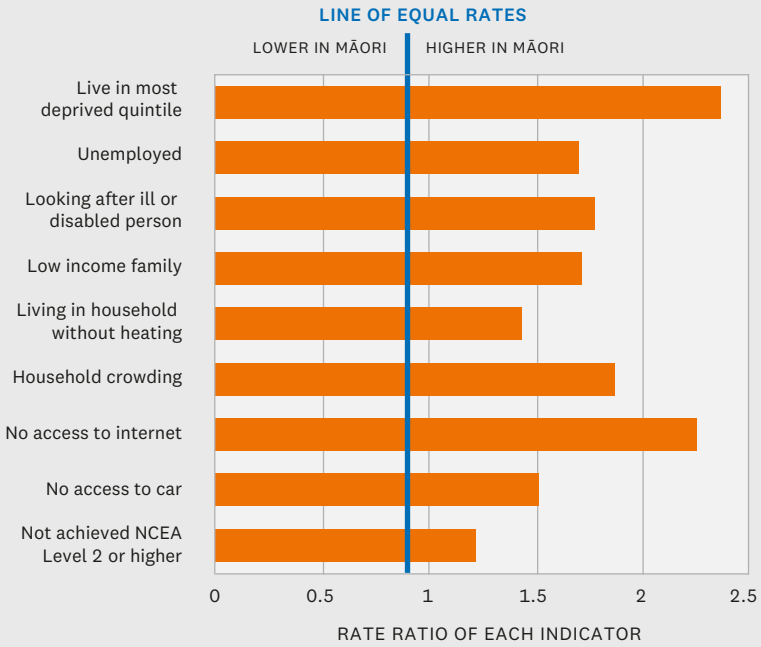
Socio-economic profile of Māori

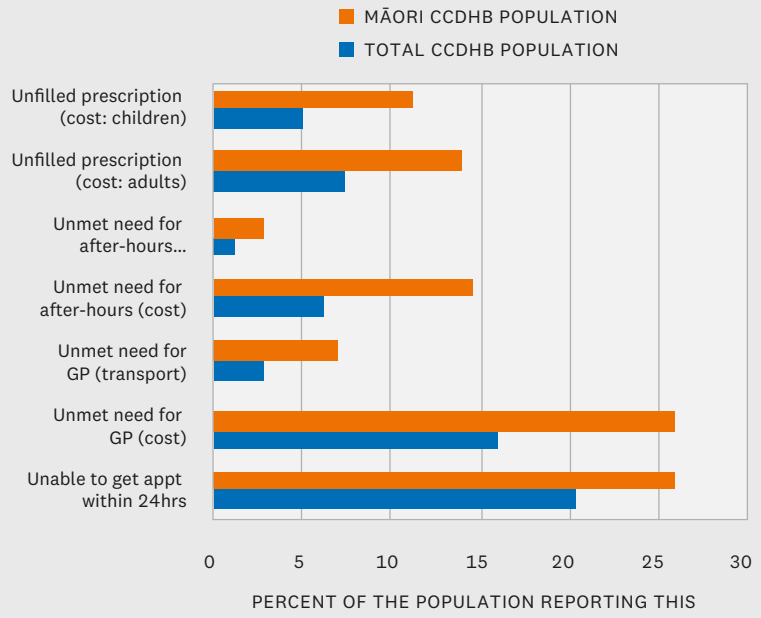
Māori are disproportionately impacted by socioeconomic deprivation in CCDHB. In 2013, compared to non-Māori, Māori living in CCDHB were more likely to live in deprived areas, be unemployed, look after an ill/disabled person, live in a low income family, live with no heating or in an overcrowded house, not have access to a car or the internet, and not have NCEA Level 2 education.



Source: CCDHB Māori Health Profile, 2015

Barriers to health for Māori

Māori report experiencing significant barriers to accessing health care, specifically due to cost and lack of transport.



Source: NZ Health Survey 2014–17

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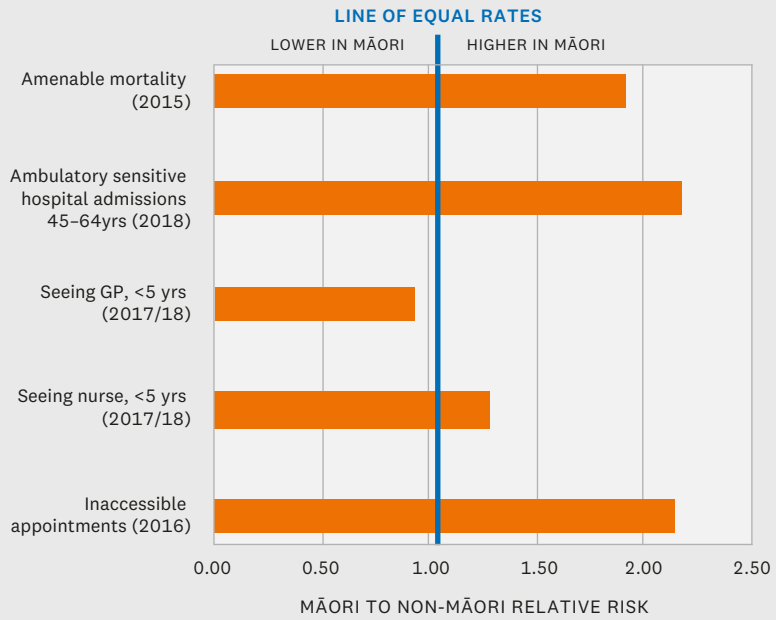
CCDHB as a pro-equity organisation

A pro-equity organisation would show equity in outcomes that are amenable to change at DHB level, allowing Māori to live long and live well.



Amenable mortality measures the performance of a health system. Māori have twice the rate of non-Māori people.

Ambulatory sensitive hospital admissions measure the failure of primary or community care. Māori adults have over twice the rate of ASH than non-Māori, non-Pacific peoples.

Māori children are more likely to see a nurse but less likely to see a GP than non-Māori, indicating lower access to care.

Māori are more than twice as likely as the total population to find CCDHB appointments inaccessible.

Additional measures of a pro-equity organisation also include a range of health measures, in which significant inequity is seen, and are described in the main data chapter.

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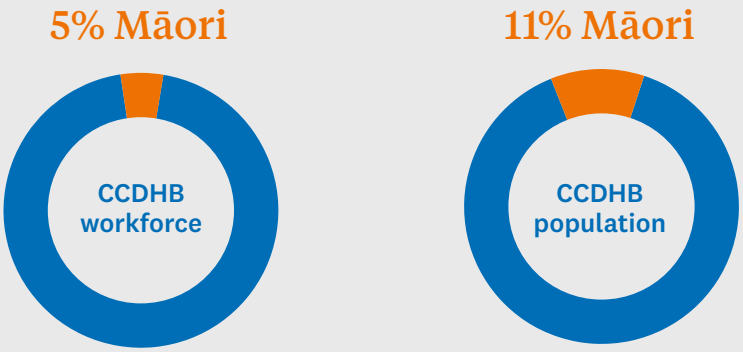
Workforce and commissioning

The CCDHB workforce does not reflect the population it serves: 5% of employees are Māori, compared to over 11% of the population.



CCDHB Māori Health portfolio funds three 'By Māori for Māori' and two mainstream providers delivering services specifically targeting Māori, to the value of $2.2 million. This represents 0.45% of the DHB budget.

The majority of Māori receive most of their health care from mainstream services. Currently these are failing Māori. Conversely, Māori providers meet targets that general services fail to meet for Māori.

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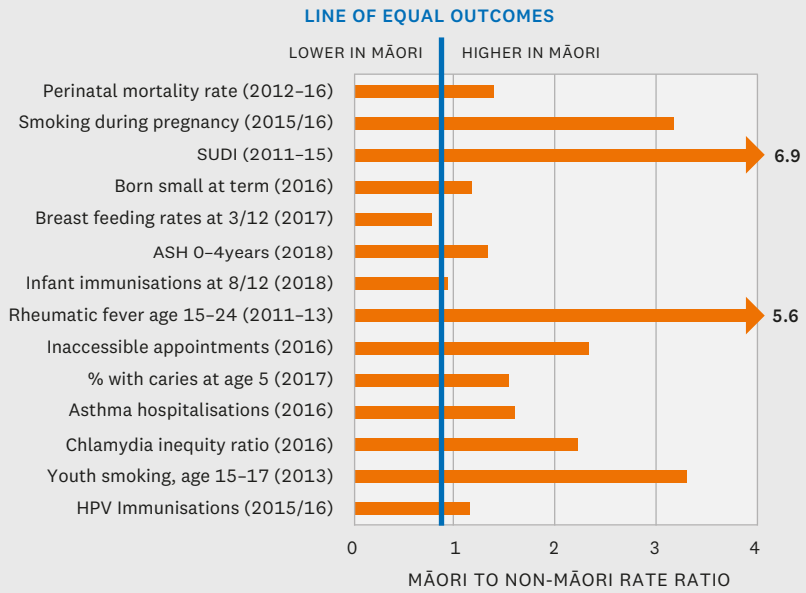
Maternal, child and youth health

For almost all indicators, Māori do less well than non-Māori.



Māori have had higher perinatal mortality rates than NZ European mothers.

Māori mothers are more likely to smoke when pregnant.

Māori have 4.5 times higher risk of Sudden Unexpected Death in Infancy.

Born small at term: Māori have a 20% higher risk, and hence are more likely to suffer adverse consequences of this.

Māori are 25% less likely to be breastfeeding at three months.

Ambulatory Sensitive Hospitalisations (ASH 0–4 years): Māori children are 30% more likely to be admitted for an avoidable reason.

Infant immunisations are not quite as likely to be up to date.

Māori have much higher rates of rheumatic fever.

Inaccessible appointments are much more common among Māori.

Māori children have a 50% higher risk of caries at age 5.

Māori have a much higher rate of hospitalisation for asthma.

Chlamydia inequity ratio: Māori are slightly more likely to be tested for, but considerably more likely to be diagnosed with chlamydia. This shows inadequate testing on the basis of need.

Smoking in young people is much higher in Māori.

HPV immunisation rates are similar in Māori and non-Māori girls, but recent data has not been published for boys.

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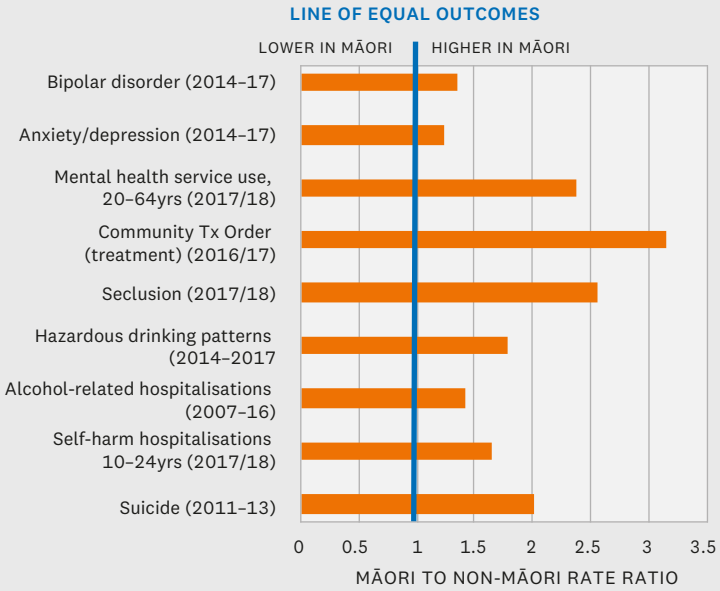
Mental health and addictions

Māori have a high risk of mental health problems and alcohol and drug addictions.

The Mental Health Commissioner has stated that "greater Māori participation and leadership in the design and delivery of services is needed to address disparity".



Māori report higher rates of bipolar disease, anxiety and depression.

Māori are over twice as likely to use mental health services.

Māori are over three times more likely to be treated under a Community Treatment Order and 2.5 times more likely to experience seclusion than non-Māori.

Māori are 75% more likely to report hazardous drinking patterns than non-Māori.

Hospitalisations wholly attributable to alcohol are higher in Māori adults than non-Māori.

Self-harm rates in youth, and suicide (all ages) are considerably higher in Māori than non-Māori.

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Section 3

The Challenge

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The Challenge

A context for poor health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes.[5,6] This applies to many Māori individuals and whānau. Life expectancy for Māori males (75 years) and females (79 years) living in the CCDHB area continues to lag about five years behind non-Māori,[7] and the evidence shows that Māori continue to be over-represented in a number of critical health care areas.

The starting point for Taurite Ora is to address the inequities endured by Māori who use CCDHB services. To be effective, we must first look within our organisation to see what changes we can make to support better health outcomes for Māori. Our first priority is to reshape ourselves as a pro-equity health organisation.

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Manaakitanga

CCDHB is here to serve the people of our district. Part of that ethos is to ensure that we have created an atmosphere and a physical environment where those who use and need our facilities are welcomed and their presence is valued and respected.

The Health Quality & Safety Commission New Zealand paper *Quality Improvement: No quality without equity?*,[8] which has taken findings from the Commission's original report, *A Window on the Quality of New Zealand's Health Care*, states:

> *"Māori consumers are consistently and significantly less likely to always feel staff treated them with respect and dignity while they were in the hospital."*

What we recognise

As the district's largest health provider, we are failing to provide an equitable level of care for Māori. This is reflected in our most recent performance against national Māori health targets.

In part, this is due to higher overall demand for services from Māori, but structural considerations also apply.

Our mainstream health services are not addressing Māori health need, and there is minimal expenditure and support for services based on tikanga Māori and kaupapa Māori ways of working.

Our current system supports bias in the forms of institutional, personal and internalised racism. By this we mean:

- **Institutional racism**

  Refers to differentiated access to goods, services and opportunities based on a person's race. Often, it operates at a service level supported by the institution's policies and practice frameworks.

- **Personal racism**

  Refers to situations where assumptions and actions are in response to a person's race. Negative stereotyping of a person who is Māori may lead to them receiving lesser or no services.

- **Internalised racism**

  One of the most powerful forms of racism occurs when a person internalises racial stereotyping, believing them to be true or not having the confidence to challenge them.[9]

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What we know

The number of Māori living in the CCDHB area is projected to grow by almost 40 percent (14,000) over the next 20 years, from about 38,000 to 52,000. This compares with a projected growth of about 10 percent for our non-Māori population.[10]

Māori population

↑ 40%

projected increase over next 20 years

Non-Māori population

↑ 10%

projected increase over next 20 years

Measuring impact

Strong baseline data will help us measure the impact of our services. We are aiming for high-quality data, including ethnicity data, to help inform all decisions. Currently, there are gaps in our data that need to be addressed, otherwise the effectiveness of this strategy will be hard to determine.

While we have good data against some outcomes; our ability to collect quality data that justifies targeting our services is currently very limited. To be truly effective, we must integrate te ao Māori perspectives into our measurement framework. It is important that we 'walk the talk', measuring wellbeing through a Māori lens and meeting the same standards of tikanga and engagement we seek from our commissioned providers. We will consider investing in activities that support good data collection – gaining trust or social licence from Māori to collect and use information about them cannot be done instantly.

A commitment to improve Māori health outcomes across specific priorities by 2030 encourages us to build up longitudinal data. We expect that a deeper, more comprehensive understanding of what does and doesn't work in our service design and delivery will emerge over time. For that reason, Taurite Ora focuses on a four-year horizon, after which it will be revisited to ensure its effectiveness.

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Outcome 1

A stronger and more responsive CCDHB health system

As a district health board, we are accountable for delivering health services across our district. We can improve the services we provide for Māori by making changes in the way we engage with and include Māori in our service design and delivery.

We can achieve this by focusing on the three strategic priorities discussed below.

Strategic priority 1

Become a pro-equity health organisation

This priority challenges CCDHB to reset our foundation by doing some internal work starting at the top with the Board and our executive leadership team.

Strategic priority 2

Grow and empower our workforce

Our current workforce

We have a great team at CCDHB, most of whom are committed to improving health and wellbeing outcomes for Māori. Many non-Māori staff members are undergoing cultural competency training to give them a better understanding of tikanga and kaupapa Māori approaches to health. However, the fact remains that Māori are substantially under-represented at all levels of the CCDHB health system.

- Only a handful of Māori fill strategic or clinical leadership roles at the management level.
- Māori make up less than 1 percent of medical staff (7 out of 856 doctors in October 2018).
- Māori make up only 5 percent of all nursing (149 out of 2,776) and allied health professionals (44 out of 812).

We have made gains over the past decade, but it is hard to hear Māori voices when there are so few.

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CCDHB will support a strong Māori health workforce

Currently 5 percent of the CCDHB workforce identify as Māori. This figure must increase if we are to transform ourselves into a pro-equity organisation.

The projected increase in our Māori population – to 52,000 over the next 20 years – provides further impetus for us to make changes now. At the foundation level, the proportion of the workforce that is Māori should mirror the population it serves, as well as the complex needs of that population. This issue is going to become more acute as the Māori population is growing at a faster rate than the non-Māori population and the CCDHB is struggling with unmet need. A skilled Māori workforce is a key element in our future success.

CCDHB will support a workforce equipped to improve Māori health

Approximately 95 percent of CCDHB's workforce is non-Māori. To support a fit-for-purpose workforce, we will focus on cultural competency as a necessary best practice standard for all health workers. The training will comprise core Māori cultural competencies, including cultural safety in health practices, Te Tiriti o Waitangi, patient- and whānau-centred care, health literacy and implementing equity in the workplace.

Within the next two years we will implement a staff development plan that sets out how all staff will access cultural competency training and cultural leadership and support.

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Strategic priority 3

Strengthen our commissioned services

Despite clear differences in patterns of Māori ill-health compared with non-Māori, the vast bulk of CCDHB's in-house and commissioned services are delivered through mainstream services and providers with limited scope to vary their delivery approach to meet the individual needs and aspirations. For example:

- of the over $1 billion health services budget, only 0.45 percent is spent on services designed to reach Māori
- CCDHB currently contracts with four kaupapa Māori providers to deliver community health services in areas of greatest need.

It is no surprise therefore that 'commissioning' is one of the three systems areas that Taurite Ora focuses on. To truly tackle the issue of equity of service, it is critical that *all* commissioned providers identify and work to develop equity outcomes. Anything less risks failing Māori who are not enrolled with a kaupapa Māori provider.

If we emphasise the importance of more and better care within the community, effective prevention and management will reduce the need for hospital care. An increased allocation of funding to primary health care and Māori services is essential to see a reduction in the number of Māori tamariki and older people in particular presenting at hospitals with preventable health issues.

We will also look at our current contracting model and decide whether it is appropriate in an equity-focused environment. If we are working towards 'on the ground' changes with whānau, establishing kaiārahi roles and expanding the role of commissioned partners; our current performance measures may no longer be relevant. We must favour measuring effectiveness over enumerating services delivered.

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Outcome 2

Improved health and wellbeing outcomes for Māori

To optimise the impact of adopting a pro-equity approach, we have selected two services areas that are will be our priority and that, based on the evidence, will achieve the greatest health gains for Māori over the next 10 years. These are:

- maternal, child and youth
- mental health and addictions.

Our objectives for both priority areas are:

- Years 1–4
  - Processes are in place and improving service performance.
- Years 5–6
  - Hospital and community service delivery for these priority areas have improved Māori health outcomes.
- By 30 June 2025
  - The strategy has delivered incremental reductions in each priority area, with the result that the gap between Māori and non-Māori health outcomes has decreased by 80 percent.

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Service focus area 1

Maternal, child and youth health

We will focus on actions we believe will have an early and positive impact. We acknowledge that many whānau are dealing with multiple issues beyond the scope of health services. Wherever possible, we will work alongside other agencies and providers to navigate solutions that support the whole whānau.

Māmā me pēpē

The stage from conception through childhood provides a unique opportunity in a person's development. This is when the foundations of optimal health, growth and neurodevelopment across the lifespan are developed.[11] Optimising the first 1,000 days is critical and warrants special protections and provisions for māmā, mātua, pēpē and their whānau.

- Monitor early childhood health, development and equity with a comprehensive set of indicators and use the data to improve service delivery and inform and evaluate public health interventions.
- Invest in more community-based initiatives to promote early childhood development.
- Reduce the cost of accessing health supports and remove cost-related barriers to health support.
- Ensure that whānau with high and complex needs have kaiārahi to act as a single point of contact with the health system and other services.
- More actively monitor unhealthy whānau behaviour that has a direct impact on mother and child health, including smoking, breastfeeding and better screening for family violence.
- Participate more actively in initiatives to improve living conditions for whānau by providing warm, dry housing and helping to build safer communities.

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Tamariki: up to 14 years of age

- Between 2007 and 2011, tamariki were three times more likely compared to non-Māori to be admitted to hospital for injuries arising from assault, neglect or maltreatment.[12]
- Self-reported data from the New Zealand Health Survey suggests that asthma rates in this age group are only marginally higher than for non-Māori in the same age group (18 percent of Māori aged under 15 years reported that they have asthma, which is currently medicated, compared with 16 percent for the total population),[13] but this may be because Māori are less likely to be diagnosed or treated than non-Māori.
- The CCDHB rate of hospitalisation for skin infections in Māori aged 0–14 years is 60 percent higher than for non-Māori in the same age group.[14]
- Fifty percent of all five-year-old tamariki have caries,[15] compared with less than 25 percent for non-Māori in the same age group.

Rangatahi: 15–24 years of age

- Rangatahi have much higher rates of rheumatic fever than non-Māori youth in the same age group.[16]
- Rangatahi are more likely to smoke than non-Māori youth in the same age group.[17]
- Suicide rates are three times as higher for rangatahi than for other population groups (this is national data, not CCDHB).[18]
- Hospitalisation as a result of self-harm is over 1.5 times higher in 20- to 24-year-old rangatahi compared with non-Māori, non-Pacific youth.[19]
- Rangatahi aged 15–19 years experience higher rates of admission to hospital for hazardous alcohol abuse than non-Māori youth.[20]

Research reflects the desire of rangatahi to have services and programmes developed with them for them: Rangatahi ki Rangatahi peer support. As 29 percent of this group live in Porirua, investment in the development of a service here should be prioritised.

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Service Focus area 2

Mental health and addictions

Māori experience a disproportionately high level of mental health and addiction issues. The report of the Government Inquiry into Mental Health and Addiction, *He Ara Oranga*,[21] identified that almost one in three Māori will experience mental illness and/or addiction in a given year, compared with one in five in the general population. The same report noted that Māori are also more likely than non-Māori to access services later and to experience serious disorders and/or co-existing conditions. Māori also have the highest rate of suicide of all groups.

CCDHB's Mental Health, Addictions and Intellectual Disability Services arm (MHAIDS) is the largest provider of mental health and addictions services to Māori in our region. Currently, one of our three kaupapa Māori providers is funded through MHAIDS. We will consider how we can strengthen those services as they come under increasing pressure and fail to keep up with access demand. We also need to collect better information to guide our investment in the sector.

As is the case for the CCDHB generally, Māori are under-represented in this workforce, particularly in clinical roles. Workforce shortages and workforce aging and retention are a continuing challenge across the sector that we need to address.

- Māori are more than three times more likely to be subject to a Community Treatment Order under Section 29 of the Mental Health Act.[22]
- Māori aged 25–64 years are almost two and a half times more likely to use mental health services[23] and be kept in seclusion.[24]
- Self-harm rates in Māori youth[25] and Māori suicide (all ages)[26] are more than twice those of non-Māori in the same age groups.
- One in three Māori will experience mental illness and/or addiction issues in a given year compared with one in five in the general population (based on New Zealand-wide data).[27]
- Māori are more likely than non-Māori to have later access to services (based on New Zealand-wide data). [28]
- Alcohol involvement in youth emergency department (ED) presentations is similar in Māori and non-Māori, but hospitalisations wholly attributable to alcohol are higher in Māori adults than non-Māori adults.[29]
- The proportion of frequent methamphetamine users who are Māori increased from 22 percent in 2006 to 32 percent in 2014.[30]

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Kaupapa Māori mental health services

At present, CCDHB contracts with three community providers that offer kaupapa Māori mental health services (only one of which is funded from within the MHAIDS budget). We need to invest more in kaupapa Māori services that:

- offer treatment and services based on whanaungatanga and empowerment of tangata whaiora and their whānau
- work alongside general practitioners (GPs) and other community mental health services to assess the needs of tangata whaiora and plan pathways towards wellness.

What Māori have said they value

Māori wellbeing

While many statistics reflect poor health outcomes for Māori, how Māori view themselves is a strength that CCDHB should use when designing and delivering services to Māori whānau and communities. The data from the 2013 Census may be dated, but it is still relevant in that it shows many positive aspects of Māori wellbeing that are often overlooked.[31]

- Most Māori adults (88 percent) reported that their whānau were doing well, although 4 percent felt their whānau were doing badly.
- Many Māori adults (79 percent) reported finding it easy or very easy to access whānau support in times of need.
- Being involved in Māori culture was important to 69 percent of Māori adults.
- One in five Māori could have a conversation in te reo Māori.
- Most Māori adults (90 percent) did voluntary work.
- As at 2013, 88 percent of Māori 5-year-olds were fully immunised.
- Among Māori youth, smoking rates had dropped significantly since 2006, although rates remain considerably higher than those for non-Māori youth.

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Capital & Coast
District Health Board
Orderly & Security

Section 4

Taurite Ora: Action Plan

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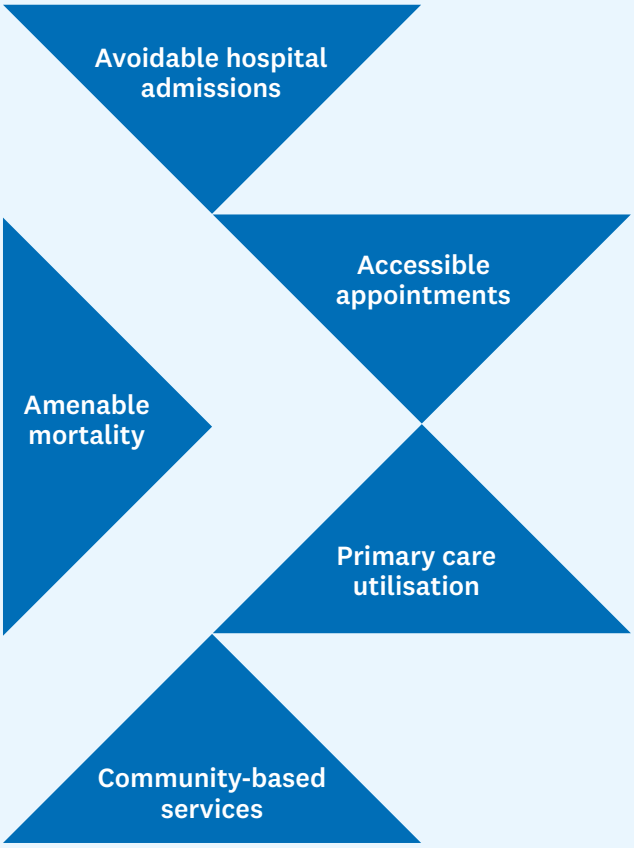
Taurite Ora: Action Plan

This section of Taurite Ora presents the action plan for 2019–2030. Its aim is to capture information to show the effectiveness of the pro-equity strategy in reducing the five key measures of equity.

5 key measures of equity



The plan also refers to the three overall Taurite Ora framework imperatives and describe the actions that have been agreed on to reach our goal of:

Health equity and optimal health for Māori by 2030.

This will be achieved through:

- equity (as a value that underpins everything we do)
- workforce development
- commissioning of services.

Oversight of the implementation of the Taurite Ora strategy and action plan will be the responsibility of a Taurite Ora governance group that is yet to be established. Core membership of this group will come from the CCDHB Executive Leadership Team (ELT).

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Set up of the action plan

The action plan is set out as follows:

Equity

Strategic priority 1: Become a pro-equity health organisation

Workforce

Strategic priority 2: Grow and empower our workforce

CCDHB will support:

- a strong Māori health workforce
- a workforce equipped to improve Māori health.

Commissioning

Strategic priority 3: Strengthen our commissioned services (Māori health providers are thriving)

Priority service focus areas

Service focus area 1: Maternal, child and youth

Service focus area 2: Mental health and addictions

Action Plan owners

3DHBCCIO	3DHB Chief Clinical Information Officer
GM3DHBMHAIDS	General Manager, 3DHB Mental Health, Addictions and Intellectual Disability Service
CE	Chief Executive
CAHO	Chief Allied Health Officer
CFO	Chief Financial Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
EDCS	Executive Director, Corporate Services
EDMH	Executive Director, Māori Health
EDMCC	Executive Director, Medicine, Cancer and Community
EDPC	Executive Director, People and Capability
EDQIPS	Executive Director, Quality Improvement and Patient Safety
EDSIP	Executive Director, Strategy, Innovation and Performance
EDSWC	Executive Director, Surgery, Women and Children
ELT	Executive Leadership Team

We are currently developing an indicator framework to monitor the actions in the Action Plan.

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The action plan

Key

Measurement
By how much/ to do what

Time frame
By when

Owner
By who - first role identified owns the action

Strategic priority 1

Become a pro-equity health organisation

The overall aim of the CCDHB as a pro-equity organisation is to ensure that Māori live long and well. This is clearly not happening at the moment, as is shown by the low levels of health across a range of key indicators, reflecting the breadth of the inequities experienced by Māori. Many of the indicators reported on are areas of the DHB's remit that are directly amenable to change, and, if addressed, could benefit Māori health.[32]

Outcome 1

CCDHB demonstrates its commitment to being a pro-equity organisation

Action		
1	Adopt health equity for Māori as a strategic priority for the CCDHB Board and ELT.	**All ELT members have Māori health equity key performance indicators (KPIs).** **First year** **CCDHB Board** **CE**
2	Commit to a pro-equity programme of work that delivers: a) a clear CCDHB equity goal and direction b) an agreed set of equity principles c) an operational framework that translates principles into policies and practices d) a performance framework to monitor and guide progress e) an agreed target-staged implementation.	**Indicators to be developed** **First year** **Commences 1 July 2019** **CE** **ELT**

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3	Establish and set KPIs for Māori health equity, including improved Māori health outcomes, as annual performance expectations of the CE and ELT.	All ELT members have Māori health equity KPIs. 1–4 years CCDHB Board CE
4	Share and discuss annual performance for Māori health equity KPIs as a regular agenda item for ELT meetings.	Report annually to ELT meetings. First year CE
5	Establish a Taurite Ora governance group to oversee and report on implementation of the action plan. The core membership will comprise ELT members.	A governance group is established. 2019 CE EDMH
6	Make every member of the ELT responsible for ensuring that the Māori workforce numbers, across all levels of the CCDHB, reflect the community we serve and the needs of that community and that all staff are supported to provide culturally safe and competent services to Māori.	The Māori workforce is expanded across all levels of the CCDHB. All staff provide culturally safe and competent services to Māori. 1–4 years CE ELT
7	Include an explicit accountability in the performance plans of all clinical leaders and senior managers for promoting health equity and optimal health for Māori.	All clinical leads and tier 2 managers have Māori health equity KPIs. First year Each ELT member for direct reports
8	Develop and distribute a range of communications to support, encourage and integrate pro-equity initiatives.	A communications strategy is developed and implemented. First year EDCS

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Outcome 2

The relationship between the Māori Partnership Board (MPB) and the CCDHB Board and ELT is strengthened

1	Engage with the MPB, including MPB attendance and agenda item at each Board meeting and regular Board member and CE attendance at MPB meetings, and facilitate MPB representation on all statutory and organisational boards.	There is an MPB member on all statutory committees. The CCDHB Board and CE attend every MPB meeting. 1–4 years CCDHB Board CE EDMH
2	Provide regular updates to the MPB and CCDHB Board on the implementation of Taurite Ora to track progress and seek MPB advice as necessary.	The framework is reported on as it is being developed. Report to each meeting of the MPB and CCDHB Board. First year and ongoing CE ELT

Outcome 3

CCDHB's partnerships are strengthened with a range of Māori stakeholders

1	Design and implement a CCDHB policy to provide guidance on strengthening relationships with a range of Māori stakeholders (including Māori health and health equity experts) at every level of the organisation, including enhanced representation on governance and advisory groups.	The policy is developed and implemented. First year EDQIPS
2	In implementing the health system plan, commit to a specific plan of action to ensure comprehensive engagement with Māori health providers, communities and whānau.	A Māori engagement plan is developed. 1–4 years Report six-monthly to the MPB and CCDHB Board EDSIP

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3	In implementing the sub-regional disability strategy 2017–2022, uphold the principles of Whāia Te Ao Mārama by engaging Māori disabled people and engaging comprehensively with Māori health providers, communities and whānau.	A Māori engagement plan is developed. 1–4 years EDSIP

Outcome 4

CCDHB has the foundations in place for achieving health equity and improving health outcomes for Māori

1	Implement an improvement programme to ensure CCDHB has high-quality, complete and consistent ethnicity data for performance, monitoring and workforce development (see also Strategic priority 2: Grow and empower our workforce, CCDHB will support a strong Māori health workforce, Outcome 1, actions 1 and 3).	An ethnicity data programme for the whole of CCDHB is completed. First year ELT
2	Initiate processes to ensure all performance data reported to the CCDHB Board is analysed by ethnicity.	All data is reported by Māori, Pacific and Other, aligning with HISO 10001: 2017 Ethnicity Data Protocols. First year CE, ELT
3	Implement a health literacy programme of work using the Children's Clinics Service Improvement Project and Children's Clinics Health Literacy Review Projects (see also Maternal, child and youth services) to inform implementation across the organisation.	CCDHB is recognised as a health literate organisation. Indicators relevant to the health literacy programme will be developed. First year CE, ELT EDSWC, EDMH
4	Implement a range of IT initiatives to support CCDHB's commitment to being a pro-equity organisation and improve equity through digital systems and investments, including: a) improving access to data and analytical reporting, including level 4 ethnicity data capture and reporting; and the Whānau Care Services (WCS) smoking cessation project b) developing a business case to provide multilingual, including te reo Māori, versions of an electronic patient experience survey c) extending free patient wifi to outpatients d) making the te reo Māori keyboard the standard profile (including the ability to add macrons).	All data is reported by ethnicity. First year 3DHBCCIO

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5	Implement a range of communications initiatives to enable and support CCDHB's commitment to being a pro-equity organisation and focused on improving Māori health outcomes, including: a) updating the CCDHB style guide for te reo Māori, macrons use and translation b) developing guidelines for the use of the CCDHB kōwhaiwhai and other Māori design work c) supporting, promoting and encouraging key Māori-focused events throughout the organisation with culturally competent communications.	A communications plan is completed and implemented. First year and ongoing EDCS, EDMH
6	Consider Māori health equity and improved Māori health outcomes as part of all quality improvement discussions and activities, including co-design and patient experiences.	All quality initiatives include Māori health equity. 1–4 years EDQIPS
7	Specific patient- and service-focused initiatives will ensure patient-experience information is collected, analysed and reported by ethnicity, including: a) a complaints/compliments procedure b) adverse events c) death review d) Care Capacity Demand Management (CCDM), including Improvement Movement project and leadership programmes.	Indicators to be developed. 1–4 years EDQIPS
8	Incorporate cultural competency and cultural safety requirements into the competency framework for quality managers and quality facilitators and adverse events management.	A competency framework is completed. 1–4 years EDQIPS

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Outcome 5

CCDHB implements specific programmes of work to achieve health equity and improved health outcomes for Māori

1

The Māori Health Development Group's Whānau Care Services (WCS) implements a range of actions as CCDHB's principal pro-equity, anti-racist, culturally safe service, including:

a) addressing system issues (eg, inaccessible appointments) for Māori patients and their whānau and enhancing the patient/whānau care journey using a whānau-centred model of care approach. This includes managing system failures for Māori patients and whānau, influencing change and implementing targeted solutions

b) reviewing all data collected by WCS to determine future data priorities and to streamline WCS' data collection, collation, analysis and reporting to efficiently align with Taurite Ora

c) providing culturally safe social work services on request from patients, whānau and services across the organisation and district to facilitate practical solutions and support the wellbeing of Māori patients and whānau

d) delivering targeted speciality clinical nursing and system navigation for Māori patients and whānau with cardiac and/or long-term conditions

e) providing kaiāwhina support for Māori patients, whānau and all health care workers in response to Māori patient requests for cultural and spiritual assistance and pastoral care

f) providing a collaborative smoking cessation programme, including WCS working with Māori patients, whānau and staff, and addressing system barriers to improve access and uptake

g) providing and strengthening bereavement care to ensure CCDHB's bereavement processes are culturally safe for whānau Māori and the Māori experience of the health system during culturally sensitive events is facilitated in such a way to encourage ongoing re-engagement

h) facilitating whānau Māori use of Te Peehi Parata Whare Whānau for temporary accommodation for whānau from outside the CCDHB district who are supporting patients. The whare has a limited capacity of 16 beds, so whānau with urgent needs are prioritised. Where demand exceeds the capacity of the whare, WCS facilitate finding alternative and affordable accommodation for Māori patients and whānau. Providing this service increases access to health services for Māori and improves engagement with patients and whānau.

System barriers for Māori patients and whānau are addressed.

Referral rates to WCS are increased.

The Māori patient and whānau experience is improved.

The number of complaints from Māori patients and whānau is reduced.

Access for Māori patients and whānau to culturally safe practices and cultural leadership is increased.

Further relevant indicators to be developed.

1–4 years

EDMH

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2	Strengthen the current MHDG and Research Advisory Group-Māori (RAG-M) strategic and operational research activities, including working with the CCDHB research centre to ensure any research associated with the DHB appropriately involves Māori at every stage.	Ensure any research associated with the DHB appropriately involves Māori at every stage. 1–4 years EDMH
3	Implement a range of actions through the 'Equity for Māori in Wellington Regional Hospital Emergency Department (ED)' project including: a) using health literacy and culturally competent initiatives to provide a supportive environment for Māori patients, whānau, new staff, current staff and non-ED hospital staff b) demonstrating and measuring delivery of culturally competent care and equitable outcomes through planning, implementation and reporting c) promoting and protecting time for staff to attend cultural competency training as a necessary component of professional development for all Wellington emergency department (ED) staff d) implementing processes, practices, environments and resources in ED to acknowledge te reo Māori as the first language of Aotearoa/New Zealand e) using co-design initiatives and patient experience feedback to ensure meaningful engagement with Māori.	A plan is developed and implemented. 1–4 years EDMCC, CMO
4	Implement the Te Wai Bereavement Symbol & Quilt Project in ED.	Relevant indicators will be developed EDMCC CMO
5	Implement a range of actions through the programme 'A Proposed New Way of Working for Allied Health' including: a) undertaking a review of all data sources and processes to ensure Allied Health Department has high-quality, complete and consistent performance and workforce data for analysis and reporting in partnership with our People and Capability Department b) capturing data and developing dashboards to monitor quality, equity and impact; explicitly and routinely monitoring equity of access and the delivery of Allied Health services for Māori c) using that data to understand Māori health needs and to drive improvements in equity of access, delivery and outcomes for Māori in all new and existing services, and to measure our progress d) using the workforce data to increase the numbers, and skills, of Māori working in Allied Health; eliminate recruitment barriers; strengthen recruitment enablers; and increase the rate of retention across the spectrum of Māori Allied Health workers; focusing in the first instance on the kaiāwhina Māori workforce to enable greater reach and access for Māori individuals, whānau and communities	A data review is completed. A dashboard is developed. The dashboard is used in service development. The dashboard is used in recruitment. Māori engagement is increased. 1–4 years CAHO

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5 Cont.	e) seeking to understand the barriers for Māori in accessing Allied Health services and being committed to addressing these issues f) working in new ways to address barriers to services for Māori using health literacy initiatives and to develop technologies, where appropriate, skill sharing and other ways to deliver services g) working in partnership with Māori, whānau and communities to develop pro-equity, anti-racist, culturally safe services that drive improvements in Māori health outcomes h) engaging with the MHDG to consider options for supporting the Allied Health leadership to grow their proficiency to implement Allied Health actions that are focused on pro-equity, anti-racist and culturally safe services for Māori, including understanding and use of data i) ensuring that the cultural intelligence of the Allied Health workforces increases so that the pro-equity agenda is progressed smartly in the new way of the working project.	
6	The Medicine, Cancer and Community Directorate's (MCCD) Wellington Blood and Cancer Centre (WBCC) will undertake the following through the Programme to Improve Cancer Services: a) Take an approach that emphasises the need to reduce health inequities for Māori and ensure the programme is driven by a strong equity approach. b) Adopt a co-design methodology with Māori consumers and stakeholders, including Māori health professionals, to ensure the programme addresses equity, opportunities, priorities and options available to deliver good health for Māori, achieve health equity and improve health outcomes for Māori patients receiving cancer treatment across the health system. c) Develop a data strategy that can be compared against national and international data sets and includes: › clinical benefits the programme is achieving for Māori patients › monitoring the reduction of health inequities using equity and ethnicity data › patient reported outcomes. d) In all work to make improvements for ambulatory services, consider the implications for Māori patients and Māori patient flows across the sub-region, in particular: › how the proposed service changes will affect the safety and quality of care for Māori patients › how health inequities for Māori will be affected › whether the proposed changes will reduce the travel burden on Māori patients.	A set of indicators will be developed 1–4 years EDMCC

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6 Cont.	e) In all work to implement the tumour stream approach, engage with Māori stakeholders to discuss all aspects, including what implementing a tumour stream model in an outpatient setting requires and how it can best be achieved. Wellington Blood and Cancer Centre (WBCC) will engage with the CCDHB Māori Health Development Group in the first instance to seek advice on which other key Māori stakeholders to include in identifying improvements that will reduce health inequities for Māori. f) In all work to Improve the Senior Nursing Structure of Ward 5 North, WBCC will consider the recruitment, retention and professional development of Māori nursing staff. g) In all work to Improve Cancer Leadership, WBCC will engage with Māori health experts and Māori communities and in any strategic planning work include a specific focus on Māori who have demonstrably worse outcomes. h) Instigate ongoing monitoring of progress and cancer outcomes for Māori, including: › the ELT's KPIs › reviewing the national quality performance indicators under tumour streams to make a plan for data collection and reporting by ethnicity › inpatient ward improvements for Māori › Māori patient reported measures and experiences, systematically evaluated on a regular base.	
7	Through a joint initiative between the Māori Health Development Group (MHDG) and the EDMCC, establish a Māori Health Cancer Navigator/Nurse Coordinator to intensify skills and resources to support Māori patients and whānau through their cancer care journey. a) In particular, the nurse coordinatorwill focus on improving timeliness of access for Māori to all CCDHB cancer services, coordinating care and providing culturally safe services. Access barriers will be identified and, working in collaboration with Cancer Services team, these issues will be addressed. b) This position will be based in Whānau Care Services, MHDG, and it will work closely with the cancer nurse coordinator team. Collaboration with primary health care and community non-governmental organisations (NGOs), including Māori health providers, will also be crucial to focus interventions on early cancer detection and entry into secondary health care.	**A set of indicators will be developed.** **1–4 years** **EDMCC** **EDMH**

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8	Increase the percentage of Māori enrolled in a primary health organisation (PHO) to match that of the total population by: › providing enrolment processes that are easy to follow › following up with people who are using DHB services (ED, accident and medical, inpatient) to support enrolment in primary health care as part of a warm handover back to their primary health care provider › developing models of care in general practice that support Māori to be well, get well and stay well.	**The Māori enrolment rate is equal to the non-Māori rate.** **1–3 years** **EDSIP**
9	Invest in intensifying services in primary health care and community for populations of concentrated complexity (very low cost access (VLCA) practices). These services will support people with higher health needs to be well, get well and stay well; enabling them to live their lives how they wish rather than spending lots of time engaging with the health system.	**There is a reduction in:** **› Māori ED presentations** **› Māori accident and medical presentations** **› Māori (ASH) admissions for populations of VLCA practices (adult and child).** **1–4 years** **EDSIP**
10	Develop and implement a DHB investment plan for long-term conditions. It will be focused on prevention, early intervention and coordinated management for people with one or more long-term conditions. Within the first three years, we will develop new models of care for: › people with respiratory disorders › people with cardiovascular disease › people with diabetes and associated conditions (for example, renal failure, podiatry) › people at risk of developing long-term conditions (that is, prevention programmes). These models of care will be focused on care close to home, provided through community health networks, and empowering people to be active participants in managing their health.	**There is a reduction in Māori hospitalised for diagnosed long-term conditions.** **Health/life expectancy is increased and onset of long-term conditions and complications as a result of those long-term conditions is delayed.** **Short term: 1–4 years** **Long term: 5+ years** **EDSIP**

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Strategic priority 2

Grow and empower our workforce

CCDHB will support a strong Māori health workforce

The CCDHB workforce does not reflect the population it serves. Of the 5,767 employees (as at October 2018), only 5 percent of the workforce were Māori, compared with over 11 percent of the population (10 percent of the working age population, age 15–64 years).[33]

As per the CE's actions:

> *"It is the responsibility of every member of ELT to ensure that the Māori workforce numbers, across all levels, reflects the community we serve and the needs of that community, and that all staff are supported to provide culturally safe and competent services to Māori."*

Outcome 1

CCDHB demonstrates its commitment to attracting and retaining more Māori staff, particularly in clinical and leadership roles

1	Report regularly to CCDHB Board and ELT on workforce data by ethnicity.	There is regular reporting to the CCDHB Board, MPB and ELT. 1–2 years EDPC
2	Collaborate with the Māori Health Development Group and agree on an overarching Māori workforce strategy to re-establish and update the Tū Pounamu Workforce Programme with aspirations and targets for the recruitment, retention and professional development of Māori staff.	A Māori health workforce plan is completed. First year EDPC
3	Review and strengthen current workforce data systems, including staff ethnicity data collection, to ensure consistency and accuracy of collection, analysis and reporting. This includes ensuring Māori/Māori Health Development Group representation in the Workforce Systems Improvement Programme.	Workforce data systems are reviewed and strengthened. Resources are allocated to ensure Māori input. First year EDPC EDCLS, CFO, 3DHBCCIO, EDMH

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4	Ensure that all planning and analysis of workplace engagement initiatives includes the use of ethnicity data and provides Māori staff with a voice in their workplace, for example, staff surveys and exit interviews.	Māori participation in workplace engagement initiatives is increased. 1–2 years EDPC
5	Take a pro-equity approach, and use a priority populations lens in developing the organisational wellbeing framework to ensure improved health and wellbeing for Māori staff.	The organisational wellbeing framework includes a focus on equity and improved health and wellbeing for Māori staff. First year EDPC

Outcome 2

The numbers and skills of Māori working in health in the CCDHB district are increased, recruitment barriers are eliminated, recruitment enablers are strengthened and there is an increased rate of retention across the spectrum of Māori health workers

1	Review and strengthen current attraction, recruitment, hiring and 'on-boarding' practices, and continue to review and refine regularly to attract Māori applicants to all roles, retain Māori staff and support their professional development.	All recruitment policies and practices are reviewed and updated as necessary. The Māori health workforce is increased. 1–2 years Ongoing EDPC EDMH
2	Implement a targeted scholarship and support programme to support higher learning and development for Māori in the health workforce across the district in priority areas.	A scholarship programme is developed. 100% of scholarship funding is used. 1–4 years EDMH
3	Strengthen links with training and education providers to support the workforce pipeline and increase the Māori health workforce overall (for example, collaboration with Kia Ora Hauora). This includes implementing workforce exposure strategies for rangatahi Māori.	Links and partnerships are increased. 1–2 years EDPC EDMH

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4	Proactively support the implementation of professional Māori health networks.	Indicators to be developed 1–4 years CNO CAHO CMO

Outcome 3

CCDHB attracts Māori applicants to all roles and is seen as an employer of choice for Māori health professionals

1	Implement in CCDHB and track CCDHB progress on the Central Region Māori & Pacific Nursing & Midwifery Workforce Programme 2017–2021 for Māori nurses and midwives including: a) identifying and developing CCDHB Māori advanced practice roles b) meeting the Central Region target for nursing annual practising certificates c) ensuring all CCDHB services with Māori staff include professional development and care pathways for those staff d) maintaining the CCDHB Māori nurses database e) providing support for CCDHB Māori nurses to attend the annual Māori & Pacific nurses' forum and the national forum (Ministry of Health) f) working with tertiary education providers to ensure support for Māori graduates in interview skills g) offering all CCDHB Māori graduates an interview via Advanced Choice of Employment (ACE) application to promote 15 percent Māori graduate recruits h) retaining 95 percent of CCDHB Māori graduates following their completion of graduate programmes i) placing 80 percent of Māori students in CCDHB's dedicated education unit j) providing peer support training for Māori students in CCDHB k) providing culturally competent mentorship including career pathways for upskilling CCDHB Māori nurses and students l) identifying Māori staff working in health of older people, long-term conditions, registered nurse prescribers and nurse practitioner development to provide Health Workforce New Zealand funding and mentoring for development into the senior workforce m) supporting three Māori nurses/midwives to attend Ngā Manukura o Apōpō to optimise Māori nurses working to top of scope to improve care delivery n) ensuring culturally competent contact people for Māori nurses/midwives to approach re bullying and discrimination.	An increase in new level 1 certificated Māori. All Māori graduates are interviewed. 15% of Māori graduates are recruited. There is a 95% Māori retention rate. 80% of Māori nurses are in the DE unit. 3 Māori nurses attend annually. 1–4 years CNO

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2	Māori Health Development Group's capability team implements a range of actions focused on strengthening the Māori health workforce, including: a) growing and coordinating the workforce development programmes run through Māori Health Development Group including: Hauora Māori Training Fund, Kia Ora Hauora, TAS Workforce b) surveying the Māori health workforce across the CCDHB district to determine career aspirations and capability development needs and consider options for providing professional development opportunities for this workforce c) collaborating with CCDHB People & Capability to re-establish and update the Tū Pounamu Workforce Programme with aspirations and targets for the recruitment, retention and professional development of Māori staff d) collaborating with People & Capability on a range of workforce initiatives to ensure CCDHB has a strong Māori health workforce e) reviewing all workforce data collected by the People & Capability team to determine future data priorities and to streamline the team's data collection, collation, analysis and reporting to efficiently align with Taurite Ora.	**Māori workforce programmes are supported.** 1–4 years EDMH

Outcome 4

The Māori health workforce across the CCDHB district (employed by both the DHB and in the community) reflects the demographic make-up of the projected working-age population

1	Increase Māori staff numbers in each of the medical, nursing and allied health professions, along with support staff and management, in both hospital and health services and primary health care to reflect the Māori population of CCDHB district.	**The increase in the Māori health workforce is tracked by hospital and health services and community health.** 1–4 years EDPC CNO
2	Increase the percentage of Māori in the nursing and midwifery workforce to reflect the CCDHB Māori population (13%) as per the action in the CCDHB Nursing & Midwifery Priorities 2018–2019.	**Māori nursing and midwifery increases to 13 percent.** 1–4 years CNO

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CCDHB will support a workforce equipped to improve Māori health

Approximately 95 percent of CCDHB's workforce is non-Māori. Having the competency to engage with the people one serves is critical in the health sector.[34]

As per the CE's actions:

> *"It is the responsibility of every member of ELT to ensure that the Māori workforce numbers, across all levels, reflects the community we serve and the needs of that community and that all staff are supported to provide culturally safe and competent services to Māori."*

Outcome 1

CCDHB demonstrates its commitment to employing staff with the skills and attributes necessary to achieve Māori health equity

1	Set core competencies and expectations for all staff to achieve health equity and improve Māori health outcomes.	**All position descriptions include Māori health equity competencies.** **1–2 years** **EDPC** **EDMH**
2	Review recruitment practices to employ and retain staff who have the necessary skills and attributes. (Note: this review may be incorporated with the review in Strategic priority 2: Grow and empower our workforce : CCDHB will support a strong Māori health workforce, Outcome 2: Action 1).	**All recruitment policies and practices are reviewed and updated as necessary.** **1–2 years** **EDPC** **EDMH**
3	Use the findings of the review (2 above) to inform the development and implementation of a recruitment strategy to attract and retain more staff with the necessary skills and attributes for achieving health equity and improving Māori health outcomes.	**1–2 years** **EDPC**

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Outcome 2

All CCDHB staff understand and can demonstrate their responsibilities around achieving health equity and improving Māori health outcomes

1	Review and revise all position descriptions, performance discussions and monitoring (for example, adherence to best practice in clinical decision-making) to reflect the responsibility of all staff (including all CCDHB health professionals) to achieve health equity and improve Māori health.	All position descriptions are reviewed and revised to include health equity and Māori health improvement competencies. 1–4 years EDPC

Outcome 3

Cultural safety and competency is a requisite best-practice standard for all CCDHB health workers, including all staff in clinical and leadership roles

1	In re-establishing and updating the Tū Pounamu Workforce Programme in collaboration with Māori Health Development Group, CCDHB includes workforce development for all staff in Māori health and equity, including cultural leadership, safety and competency, anti-racism and health literacy.	The Tū Pounamu Workforce Programme is re-established and updated. 1–2 years EDPC EDMH
2	Embed the Tū Pounamu Workforce Programme in systems and processes.	The Tū Pounamu Workforce Programme is embedded in CCDHB's People and Capability team. 1–4 years EDPC
3	Increase the cultural competency of People and Capability staff by ensuring every People and Capability staff member and particularly every new staff member attends and completes Te Tohu Whakawaiora.	100% of P&C staff complete the Te Tohu Whakawaiora programme. First year and ongoing EDPC EDMH
4	Māori Health Development Group's Capability team implements a range of actions focused on equipping the CCDHB workforce to improve Māori health outcomes and quality improvement across the organisation including: a) centralising and coordinating the response to requests from across the organisation for cultural safety and competence training	Indicators to be developed. 1–4 years EDMH

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4 Cont.	b) exploring options for centralising te reo Māori translation services for all CCDHB services within the Capability team c) providing cultural leadership d) providing ongoing development and quality improvement in a suite of education and training options for cultural safety and competency, including Te Tohu Whakawaiora, Treaty of Waitangi, te reo Māori, Tikanga: A Guide for Health Care Workers e) collaborating with our People and Capability Department when re-establishing and updating the Tū Pounamu Workforce Programme to include workforce development for all staff in Māori health and equity, including cultural leadership, safety and competency, anti-racism and health literacy f) partnering with training providers that include robust health equity, health literacy and anti-racism practices to support any new and updated workforce development initiatives.	

Strategic priority 3

Strengthen our commissioned services

Contracted services are achieving equity

Although other domains of equity may also be important in addressing this question, our data demonstrates that for virtually every health outcome, Māori experience poorer health outcomes than non-Māori.[35] As the majority of Māori continue to receive most of their health care from mainstream services, considerable effort is required to ensure that mainstream services make it a key priority to reduce the health inequities that affect Māori and to work effectively for Māori.[36]

Outcome 1

All new and renewing investments will support Māori health equity and improved Māori health outcomes

1	The EDMH and EDSIP will develop a work plan that phases all of the actions that are led by Strategy, Innovation and Performance.	A phasing plan is completed. First year EDMH EDSIP

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2	Develop an equity plan with a focus on Māori health, including but not limited to: a) using a health equity framework and tools to prioritise new and renewing investments b) having equity for Māori as a target for all priorities in service-level measures plans c) having PHOs provide actions to address/achieve equity for their enrolled Māori population.	An equity plan is completed and implemented. First year EDSIP
3	Develop and implement a monitoring and reporting framework to track the progress of Māori health equity.	A monitoring and reporting framework is completed and implemented. Reporting is six- monthly. First year EDSIP EDMH
4	Include targets for Māori health equity and improved health outcomes for Māori, and expectations for service delivery, in all new and renewing service contracts.	100% of contracts include Māori health equity targets. 1–4 years EDSIP
5	Design a CCDHB commissioning policy and framework in partnership with Māori providers and communities, primary health care and community providers and ensure it is fit for purpose to support pro-equity approaches and improved Māori health outcomes.	A commissioning policy and framework is developed. All Māori providers are involved in the framework development. 1–4 years EDSIP
6	Undertake regular self-audits to ensure the commissioning processes are followed.	Self-audits are undertaken annually. Ongoing EDSIP
7	Explore opportunities to make available training and development opportunities within CCDHB to share with all providers (see also Strategic priority 3: Strengthen our commissioned services, Māori health providers are thriving, Outcome 2, action 2).	Training and development opportunities for all providers are explored. 1–2 years EDPC

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Māori health providers are thriving

The CCDHB Māori Health Portfolio funds three 'by Māori for Māori' and two mainstream providers delivering services specifically targeting Māori to the value of $2.2 million, of the total DHB budget of $689.6 million. This represents 0.45 percent of the DHB budget, to serve 11 percent of the population.[37]

Outcome 1

CCDHB demonstrates its commitment to supporting Māori health providers to deliver health services

1	Review the CCDHB Māori health funding portfolio to: a) identify gaps, change and/or opportunities b) align to the Taurite Ora strategic direction.	All CCDHB Māori health funding portfolio contracts are reviewed. First year EDMH
2	Design and implement a CCDHB policy to provide guidance on strengthening relationships with a range of Māori providers at every level of the organisation, including more representation on governance and advisory groups (see also Strategic priority 1: Become a pro-equity health organisation, Outcome 3, action 1).	Māori engagement is increased. First year EDMH ELT
3	Implement processes to ensure annual planning, and other CCDHB planning and service design work is informed by strong and increased engagement with all local Māori health providers.	100% of Māori providers are included in planning. 1–4 years EDSIP ELT
4	Develop communications including, for example, profiles of providers, to ensure the contribution of Māori providers to the health of the CCDHB population is well understood throughout the organisation.	Two-monthly communication is developed and distributed. First year EDMH EDCOS, ELT

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Outcome 2

CCDHB has a planned approach to supporting Māori health provider capacity and capability

1	Support Māori health providers seeking to expand capacity and strengthen capability by: › supporting Māori Provider Development Scheme (MPDS) applications › supporting Health Workforce New Zealand Hauora Māori applications › connecting to Haoura Māori scholarships › promoting other development opportunities.	100% of MPDS funding is allocated. 100% of Health Workforce New Zealand Hauora Māori funding is allocated. First year EDMH
2	Identify options to make available and share training and development opportunities within CCDHB with staff in Māori health providers (Note: this review may be incorporated with the review in Strategic priority 3: Strengthen our commissioned services: Contracted services are achieving equity, Outcome 1, action 1).	Options for sharing training and development opportunities with Māori providers are identified. 1–2 years EDPC
3	Survey Māori health providers to identify capacity and capability strengths and opportunities for support.	A survey is designed and undertaken. First year EDMH
4	Explore opportunities to collaborate with Māori providers to support the capacity and capability of their staff. Consider a secondment initiative as part of this programme between CCDHB staff and Māori health providers (Note: this review may be incorporated with the review in Strategic priority 3: Strengthen our commissioned services: Contracted services are achieving equity, Outcome 1, action 1).	Collaboration with Māori health providers to support the capacity and capability of their staff is explored. 1–4 years EDMH EDPC

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Outcome 3

CCDHB Māori health providers are supported and funded equitably from DHB investment in community-based services to demonstrate a genuine commitment to a thriving Māori provider sector

1	Implement a system to track Māori health provider funding.	A system is developed and implemented. First year EDSIP
2	Report Māori health provider funding regularly to ELT and the CCDHB Board.	Reports are completed annually. First year EDSIP
3	Place greater emphasis on commissioning community health services from Māori health providers, especially in those areas identified as priority focus areas.	There is an increase in Māori portfolio funding. 1–4 years EDSIP
4	Increase funding to Māori health providers (as a proportion of total funding). In this increased funding, consider adequate funding for Māori health providers to serve clients with complex needs and review the Very Low Cost Access (VLCA) scheme funding formula to ensure adequate funding for 'doing more'.	There is an increase in Māori portfolio funding. 1–4 years EDSIP
5	Increase the number of Māori health providers.	1–4 years EDSIP
6	Ensure there are culturally competent audits and reviews of Māori health providers.	Māori health providers are audited appropriately. 1–4 years EDSIP

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Service focus area 1

Maternal, child and youth

In almost all of the maternal, child and youth health indicators, Māori do less well than non-Māori.[38]

Outcome 1

CCDHB shows a genuine commitment to equity and improved maternal, child and youth health outcomes for Māori

1	CCDHB applies an equity lens to its Maternity Quality Safety Programme work programme. The work programme is approved by the Ministry of Health and aligns to the New Zealand Health Strategy and the Minister of Health's expectations. 2019–2020 deliverables and timelines are detailed in the MQSP work programme, with a focus on hapū Māori under 25 years of age (specific aspects are ethnicity data collection, antenatal education close to home, registering early for maternity care, breast feeding support, smoking cessation, healthy lifestyles, reducing and managing diabetes and safe sleep for babies). This is a long-term deliverable (multi-year).	The contractual report to the Ministry of Health against planned actions and deliverables is completed. Quarters 1–4 Multi-year EDSWC EDMH
2	Women's Health Service (WHS) co-designs an improvement project relating to equitable access and acceptability of care. This involves: › developing a survey that is accessible in all WHS maternity facilities on iPad – with questions in te reo (to be critiqued by Māori consumer input) › providing survey results to support service and practice improvement.	Survey document service practices and improvements are implemented. First year EDSWC
3	Community health services and WHS undertake an initiative that improves Māori outcomes for maternal wellbeing and child protection. This involves reviewing: › the current uplift policy for pēpē – changing the focus to Pae Manaaki (translation of care) › CCDHB's meeting structure, terms of reference and processes – with involvement across sectors and strong Māori input.	Meeting structures are reviewed. First year EDSWC EDMH

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4	Review progresses and complete activities across two work streams of the Children's Clinics Service Improvement Project: › Health Literacy: Communication and information › Health Literacy: Workforce development.	As per previous project guidelines. 1–2 years EDSWC EDMH
5	The new Children's Hospital design and model of care has an equity and health literacy approach to support improved outcomes for Māori. This includes: › ongoing consultation with the Māori Partnership Board for two work streams (interior theming and indoor activity spaces) › consultation with the Māori Partnership Board around the "models of care" workstream, including a health literacy approach › consultation with other Māori stakeholders as appropriate › consumer engagement, including Māori, as part of the new Hospital Project work streams.	Planning and decision-making is conducted in consultation with the Māori Partnership Board and other Māori stakeholders as appropriate. 2019–2021 until new hospital opening EDSWC EDMH
6	Commit to equitable achievement of child system-level measures for Māori, including child ASH rates, newborn babies living in smoke-free homes and youth-appropriate services.	There is a 6 percent reduction in child ASH rates. 70 percent of all Māori babies live in smoke-free homes. First year EDSIP
7	Develop and implement an integrated mātua, māmā, pēpē, tamariki service for mothers, babies, children and families to provide culturally responsive primary health care for Māori.	The model is implemented. Outcomes and measures are developed. First year EDSIP
8	Develop and commission wahakura wānanga programmes to hapū, māmā and whānau, including focused messages around safe sleep, immunisation, breastfeeding and smoking cessation.	There is an increase in the number of safe-sleep devices provided for the care of Māori pēpē. Engagement with Māori is increased. December 2019 EDSIP

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9	Implement and monitor a smoking cessation incentives programme, focused on hapū, māmā and their whānau.	The number of pēpē in smoke-free homes is increased. First year EDSIP
10	Develop and implement a culturally responsive integrated youth services model.	The model is implemented. Outcomes and measures are developed. 1–4 years EDSIP
11	Develop a project focused on achieving equitable and improved maternal health outcomes for Māori women under 25 years, which looks at: › rates of preterm labour (PTL), sexually transmitted infection (STI), urinary tract infection (UTI), small for gestational age (SGA), antepartum haemorrhage (APH) › lead maternity carer (LMC) and family violence (FV) screening › Neonatal Intensive Care Unit (NICU) › Postnatal (PN) contraception › gestation at birth and booking › smoking rates › adverse outcomes › other relevant data	Relevant indicators will be developed. 1–4 years CMO
12	Develop communications to remind LMC's and community midwifery teams (CMT) about best practice for ethnicity data collection (follow Ministry of Health guidelines)	LMC and CMT collect high quality ethnicity data. 1–4 years CMO
13	Undertake a stocktake of what services are available to Māori women under 25 years in the CCDHB district including extra support for young pregnant women – schools, primary health organisations, Family Planning clinics	A review is completed. 1–4 years CMO EDMH
14	Design research with LMCs and midwives in Porirua on ways to improve services to Māori under 25 years	Research project is undertaken. 1–4 years CMO
15	Use the information collected, including data, stocktake and engagement with young Māori women, LMCs and midwives to develop recommendations and a five-year work plan to improve services for Māori women under 25.	1–4 years CMO

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Outcome 2

CCDHB services, including funded providers, are reaching all targets as co-designed with whānau, rangatahi and tamariki

1	Co-design ambitious targets with whānau, rangatahi and tamariki that reflect Māori families' health and wellbeing aspirations.	Planning and decision-making processes include whānau Māori. 1–4 years EDMH
2	Set new benchmarks for delivering hospital and community-based services to achieve equity and improved health outcomes for Māori.	All annual plan equity of outcome measures are achieved. 1–4 years EDMH
3	Put in place the infrastructure to deliver significant improvements in service performance for achieving equity and improved health outcomes for Māori.	A report framework is developed. Reports are given every six months to the Māori Partnership Board and CCDHB Board. 1–4 years EDMH
4	Increase funding to maternal, child and youth health services, including Māori health providers, as appropriate for achieving equity and improved health outcomes for Māori.	Funding is increased. 1–4 years EDSIP EDMH
5	Develop and implement a monitoring framework focused on equitable and optimum health outcomes for pēpi, tamariki and rangatahi Māori through the best possible start in life.	A report framework is developed. Reports are given every six months to the Māori Partnership Board and CCDHB Board. 1–4 years EDSIP EDMH
6	Provide routine updates to the Māori Partnership Board (MPB) and CCDHB Board, tracking spending on maternal, child and youth services and progress on the DHB's targets for pēpi, tamariki and rangatahi.	A report framework is developed. Reports are given every six months to the Māori Partnership Board and CCDHB Board. 1–4 years EDSIP EDMH

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Service focus area 2

Mental health and addictions

Māori at all ages use CCDHB mental health services more, compared with non-Māori, non-Pacific peoples.[39] For both Māori and non-Māori, non-Pacific peoples, older adults tend to use mental health services less than children, youth or middle aged adults. The inequity between Māori and non-Māori is greatest for adults aged 20–64 years. Within this large age bracket, accounting for age (standardisation) would probably increase the inequity, since the burden of mental health is higher in younger than older adults and Māori form a greater proportion of younger rather than older adults.[40]

Outcome 1

CCDHB's commitment to responding to the recommendations of the Government's Inquiry into Mental Health and Addiction prioritises health equity for Māori and improving Māori mental health and addictions (MHA) outcomes

1	Involve Māori with lived mental health and/or addictions experience in priority setting, decision-making and service responses when responding to the Mental Health Inquiry.	Planning and decision-making processes include whānau Māori. First year GM3DHBMHAIDS EDSIP
2	Prioritise health equity for Māori and improving MHA outcomes when implementing the 3DHB strategy for planning and funding MHA responses 2019–2025, Living Life Well, which is to be informed by CCDHB's response to the Mental Health Inquiry.	A prioritisation matrix is developed and implemented. GM3DHBMHAIDS EDSIP
3	Provide routine updates to the MPB and CCDHB Board, tracking progress on CCDHB's responses to the Mental Health Inquiry and implementation of Living Life Well (as above), in particular initiatives to increase health equity for Māori and improve Māori MHA outcomes.	A report framework is developed. Reports are given every six months to the Māori Partnership Board and CCDHB Board. 1–4 years GM3DHBMHAIDS

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4	Scope service development and improvements that support achieving health equity and improved health outcomes for Māori using mental health services. This includes: › alcohol and other drug (AOD) modelling › suicide prevention.	Scoping has been completed. Improvements are implemented. First year 2–3 years GM3DHBMHAIDS EDSIP
5	Our 3DHB Mental Health, Addictions and Intellectual Disability Service (MHAIDS) will have a stronger focus on growing and building a Māori workforce across all levels within its service.	A report is completed on the current numbers of Māori in the workforce and the positions they hold. A workforce development plan is completed that clearly shows how the increases will occur. 1–3 years GM3DHBMHAIDS
6	Review Te Ara Pai mental health services and develop improved service responsiveness and access for Māori.	The review is completed. Service changes are completed. First year 2–3 years EDSIP

Outcome 2

The pace of change in the mental health provider arm is accelerated

1	Develop and implement a project to improve MHA services by: a) exploring how services connect from a client's first point of entry and throughout the service journey b) understanding the landscape and identifying gaps and opportunities for improvements.	The project is implemented. Engagement with Māori is increased. First year GM3DHBMHAIDS
2	CCDHB develops a partnership-based approach with Māori providers and communities to delivering services and integrating Māori models of MHA care in service delivery.	Engagement with Māori is increased. First year GM3DHBMHAIDS
3	Implement a capability programme that provides targeted training and development opportunities for all Māori in Mental Health, Addictions and Intellectual Disability Service.	There is an increase in Māori uptake of training and development and 100 percent use of Health Workforce New Zealand Hauora funding. 1–4 years GM3DHBMHAIDS

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Outcome 3

CCDHB has a target of zero for seclusion and compulsory treatment for Māori

1	Develop and implement a plan focused on how to achieve the target of zero seclusion and compulsory treatment, including: a) undertaking a case review of every episode of seclusion or compulsory treatment to identify how these might have been avoided and opportunities for system improvement b) encouraging treatment services to partner closely with other social services and agencies to ensure that all determinants of mental health are addressed holistically c) involving Māori (including tamariki and rangatahi) with lived experience of the impacts of mental illness and addictions in all planning and service design work d) expanding and making the mental health workforce more fit-for-purpose, including exploring options such as peer health coaches e) reporting regularly to the ELT and CCDHB Board on progress.	100% of seclusion and compulsory treatment episodes are reviewed. Planning and decision-making processes include whānau Māori. Reports are given every six months to the Māori Partnership Board and CCDHB Board. 1–4 years GM3DHBMHAIDS

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Section 5

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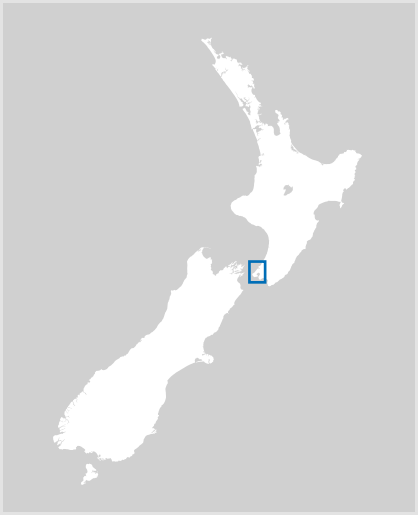
Capital & Coast District Health Board



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Appendix

Our environment

CCDHB is the largest district health board in the Central Region and the sixth largest in New Zealand. Our district covers an area of 739 square kilometres, from Wellington City in the south to the Kāpiti Coast in the north.

We are hosted by three main iwi:

- Ngāti Toa Rangatira
- Te Āti Awa
- Te Ati Awa Ki Whakarongotai.

Wai ora – living environments

Based on data from the 2013 Census, reported in the CCDHB Māori Health Profile[41], most CCDHB Māori believe that they and their whānau are doing well, but many face substantial environmental barriers on the pathway to good health and wellness.

- In 2013, 26 percent of CCDHB Māori lived in the most deprived neighbourhoods, compared with 11 percent of non-Māori.
- Māori tamariki are 70 percent more likely to be living in low-income families compared with non-Māori tamariki.
- Māori are 70 percent more likely to be unemployed compared with non-Māori.
- Māori whānau are almost twice as likely to be living in overcrowded conditions, and 40 percent are more likely to live in a house with no heating.
- Māori whānau are 70 percent more likely than non-Māori to be caring for a sick or disabled person in their home.
- Despite substantial improvements in youth smoking numbers, rangatahi are more than twice as likely to smoke regularly compared with non-Māori youth. Upwards of 10 percent lived in a home without a motor vehicle in 2013, and Māori were more likely to have limited access to phone and internet.

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- On a more positive note, data from the 2013 Te Kupenga survey found that most Māori (79 percent) could access whānau support in times of need.
- Most Māori (69 percent) living in the CCDHB area believe that being involved in Māori culture is important to them. Spirituality is also important.

Who we serve

CCDHB spans three territorial authorities: Wellington City, Porirua City and most of the Kāpiti Coast District, with a combined population of 320,000 people. About 38,000 (12 percent) of our population are Māori.

Ninety-nine percent of CCDHB's health consumers live in urban areas, although the make-up of the population varies widely by location. Wellington City, for instance, has a high proportion of younger working-age residents due to its role as the region's principal employment centre and tertiary education hub. By contrast, Porirua has a higher proportion of tamariki aged under 15 years, while Kāpiti Coast has a higher proportion of older residents.

Our regional role

Through the regional hospital and other facilities, CCDHB also provides a range of specialist services to the wider Central Region, which comprises six DHBs: CCDHB, Hutt Valley, Wairarapa, MidCentral, Whanganui and Hawke's Bay. The region currently has a population of about 900,000 people, of whom about 170,000 (18.5 percent) are Māori.

The 3DHB sub-region

CCDHB is also part of the sub-regional grouping of three DHBs: CCDHB, Hutt Valley and Wairarapa, known as 3DHB. The three DHBs share services in a number of areas, the largest of which are Mental Health, Addictions and Intellectual Disability, (MHAIDS), and Information and Communications Technology (ICT).

The 3DHB sub-region currently has a population of about 500,000, of whom approximately 72,000 (14 percent) are Māori.

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Māori communities

Māori living within the CCDHB area differ markedly from non-Māori in their demographic and socio-economic profile.[42]

- More than 10 percent of Māori living in the CCDHB area are under five years old.
- More than 30 percent of Māori are aged under 15 years (17 percent for non-Māori).
- More than 50 percent of Māori are aged under 25 years (32 percent for non-Māori).
- By contrast, only about 5 percent of all Māori living in the CCDHB area are over 65 years of age, compared with about 13 percent for non-Māori.

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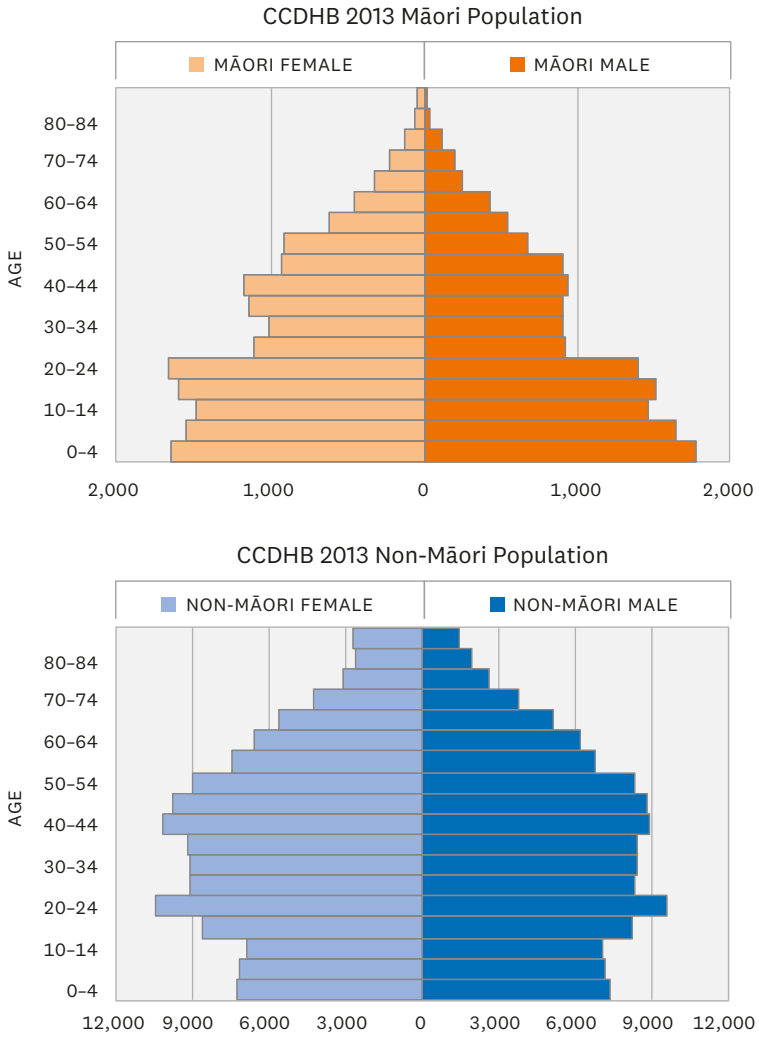
Age distribution of Māori and non-Māori in CCDHB area, 2013



Source: New Zealand Census of Population and Dwellings, 2013
Note: Due to data availability, the numbers in the graphs above are based on residents of Wellington City, Porirua City and the whole of the Kāpiti Coast District (including Ōtaki and surrounds).

About half of all Māori living in the CCDHB area live in Wellington City (8 percent of the total Wellington City population). A higher proportion of younger adults live in Wellington as a result of increased employment and tertiary education opportunities in the city.

By contrast, about 35 percent of our Māori health consumers live in Porirua City and make up more than 20 percent of the Porirua City population – including a higher proportion of tamariki and younger families living in low-decile housing areas.

The 2013 census suggests that approximately 7 percent of Māori living in the CCDHB area are affiliated to the three main tribal groups in the region.[43] Work and family commitments have put a physical distance between most Māori living here, although many maintain a strong relationship with their home marae, hapū and iwi.

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Pae ora mō ngā iwi i te Ūpoko ki te uru hauora

Health equity and optimal health for Māori by 2030

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