TATAU POUNAMU
Ki Te Tai o Poutini

MANAWHENUA ADVISORY GROUP

Friday 03 September 2021

@ 10.00 am Te Nikau Hospital – WCDHB Meeting Room 1

Join Zoom Meeting https://cdhbhealth.zoom.us/j/83840286816 Meeting ID: 838 4028 6816

Agenda and Meeting Papers

All Information Contained In These Committee Papers Is Subject To Change

AGENDA OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU MANAWHENUA ADVISORY MEETING

Te Nīkau Hospital – Meeting Room 1

Zoom Link: https://cdhbhealth.zoom.us/j/83840286816
Meeting ID: 838 4028 6816

Friday 03 September - 10.00am – 12.30pm

KARAKIA			
ADMINISTRATION			
	Apologies		
1.	**Interest Register** Update Interest Register.		
2.	**Confirmation of Minutes of Previous Meetings** Previous meeting minutes – 09 July 2021 – *Chair.*		10.00am
3.	**Carried Forward/Action List Items**		
4.	**Discussion Items** ▪ Covid 19 Update ▪ Pae Ora o Te Tai o Poutini. – *Kylie Parkin update.* ▪ Ra Whanau 50th – *Kylie Parkin update.* ▪ Working group and committee vacancies. ▪ Tumu Whakarae – *Gary Coghlan update.* ▪ Annual Plan – *Hauora Team update.* ▪ Consumer Council		10.15am
REPORTS			
5.	**GM Māori Health Update**	Gary Coghlan - *General Manager* only	FYI
6.	**Chairs Update**	Susan Wallace - *Chair* only	FYI
Discussion			
7.	**Discussion on Draft Health Needs profile.**	Janice Donaldson 10.30am	
Transition Planning			
8.	**Discussion on Transition Plan**	All	

Tatau Pounamu - Disclosure of Interest

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

TATAU POUNAMU ADVISORY GROUP MEMBERS INTEREST REGISTER

Susan Wallace - Chair Te Runanga o Makaawhio

- Member, Te Runanga O Makaawhio
- Member, Te Runanga O Ngati Waewae
- Director, Kati Mahaki ki Makaawhio Ltd
- Director, Kohatu Makaawhio Ltd
- Co-Chair, Poutini Waiora Board
- Area Representative – Te Waipounamu Maori Women's Welfare League
- Representative, Te Runanga O Ngai Tahu (Makaawhio)
- Trustee, Te Pihopatanga O Aotearoa Trust

Ned Tauwhare - Ngati Waewae Representative

- West Coast community Response Forum (MSD) Ngai Tahu Rep
- Te Runanga O Ngati Waewae Member
- Te Runanga O Ngati Waewae Advisor – Kawatiri Role
- Te Runanga O Ngati Waewae Advisor – Te Ha O Kawatiri Role
- Te Runanga O Ngati Waewae Advisor – Buller Inter Agency
- Te Runanga O Ngati Waewae Advisor – Reefton Partnership Forum
- West Coast District Health Board Consumer Council – Maori Representative
- Te Whare Akoanga Committee (Grey High School)

Chris Auchinvole – Board Representative

- Director Auchinvole & Associates Ltd
- Justice of the Peace
- Daughter-in-law employed by Otago DHB

Joseph Mason - Ngati Waewae Representative

- Greymouth High School – Te Reo Teacher

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY MEETING

MINUTES OF THE TATAU POUNAMU MANAWHENUA ADVISORY COMMITTEE MEETING
FRIDAY 09 JULY 2021
Te Nīkau – IFHC MEETING ROOM 10.15 AM

PRESENT: Susan Wallace, Te Rūnanga o Makaawhio Representative (Chair) (Zoom)
Chris Auchinvole, WCDHB Board Representative (In person)
Ned Tauwhare, Te Rūnanga O Ngāti Waewae Representative (In person)
Joseph Mason, Te Rūnanga O Ngāti Waewae Representative (In person)
Gary Coghlan, General Manager Māori Health (In person)
Marie Mahuika-Forsyth, Te Runanga O Makaawhio Representative (In person)
Richelle Schaper, Kawatiri Representative (Zoom)
Anne Ginty, Mawhera Community Representative (In person)
Kyle Parkin, Portfolio Manager, Māori Health (In person)

MINUTE TAKER: Melanie Wilson

APOLOGIES: Marion Smith, Portfolio Manager, Māori Health

Mihi Whakaatu/Karakia
Joseph Mason

AGENDA

1. **DISCLOSURES OF INTEREST**
   1. Updates/amendments discussed.

2. **MINUTES OF LAST MEETING.**
   1. Minutes of the previous meeting (28th May 2021) agreed as a true and correct record.
      Moved: Chair **Second**: All present

3. **ACTION POINTS FROM PREVIOUS MEETINGS.**
   1. **Disclosure of Interest**
      Members to email any updates of disclosures of interest before the next meeting.
   2. **Suicide Prevention.**
      Reschedule presentation by Suicide Prevention Co-ordinator
   3. **Covid 19 recruitment**
      Continue to source and support Māori nurses to become vaccinators.
   4. **WCDHB Staff Hui**
      Māori Staff Hui dates to be provided to Tatau Pounamu members.
   5. **Working Groups**
      Hauora Team to prioritise working groups/committees and email to members prior to next meeting.
   6. **Consumer Council (CC)**
      a. CC Terms of Reference are currently being reviewed. The Chair and Co-Chair attended the 9th May Tatau Pounamu meeting and there was a kōrero on what a genuine Treaty partnership approach could look like and what values and principles underpinned the approach.

b. Tatau Pounamu to be guided by Te Tiriti O Waitangi, Consumer Engagement QSM framework, and Whakamaua principles to lead their thinking when approving a partnership/relationship agreement document.
c. Using the above as a reference point, with equity as the key message, the GM Hauora Māori and Portfolio Manager to create a draft values and principles document and circulate to Tatau Pounamu members for comment and review.
d. GM Māori noted there is an opportunity for Tatau Pounamu to lead this kaupapa as it is difficult to find any robust models with the key objective to improve Māori Health outcomes by eliminating health inequities for Māori.

4. DISCUSSION ITEMS / A G E N D A.

1. COVID 19

a. Discussed West Coast DHB Covid 19 response, vaccination program and Whanau Day.
b. The Whanau Day, 104 plus partners and extended Māori Whanau registered to attend 10th July Clinic. Clinic being run in collaboration with Poutini Waiora. Poutini Staff: Whanau Ora nurse/vaccinator, Kaiatataki (2), Whanau Ora Navigator and Covid Vaccination team Kaiarahi.

c. **Key aspects, objectives and Strategies**

- Pamphlet now available and included in the minutes for easy reference.
- Second vaccinations can now be booked at time clients make their first booking.
- Data received from MoH re uptake of vaccination is reported daily and weekly updates provided to Hauora team.
- Discussed Funding tranches received from the MoH for Māori provision.
- Ensure information being released is informative and encouraging to Whanau.

2. Pae ora o Te Tai o Poutini

a. Discussed next steps for Pae Ora work to progress. Next stage will be dependent on availability of WCDHB workforce to participate in focus groups with Fiona and Tim. The WCDHB are committed to the model of care and see the potential to transform the way we currently work with Maori and alignment with the Rural Generalism model of care.
b. The first meeting of the steering group was facilitated by Fiona Pimm where they presented progress to date and next steps. Robust discussion and feedback were given. The WCDHB are very engaged in the partnership and the vision of Pae Ora and see the benefits and opportunity to position this model well to align with the recommendations of the Health & Disability review.

Key aspects points

- Pae Ora is still in its initial phase.
- Fiona Pimm has been contracted to further develop the model of care in partnership with the DHB
- Steering Group has been created and has now meet to provide feedback and guidance
- Hauora Maori will work closely with Fiona to co-ordinate focus groups and provide data to inform the programme of work

3. Ra Whanau Rima Tekau, 50s

Hauora Maori shared the initial blueprint of the 50th health check process and are working with a small team of Māori and Clinicians.

a. **Key aspects, objectives and Strategies**

- Maori will be invited to a free health assessment which will include a comprehensive screening and clinical assessment
- Matauranga Māori will underpin the approach and focus groups with Māori in the cohort will be undertaken

- Data identifies approximately 40 Maori turn 50 per year on the West Coast.
- Team are still scoping clinical component, necessary tests will be dependent on result of assessment but could include; ultrasound, full blood work up, chest x-ray, bone density testing, prostate, cervical, bowel and breast cancer screening.
- Care will be undertaken by a small team led by skilled Navigator
- Working towards November start date.

4. Working Groups

a. List of working groups, committees requiring Māori representation is currently being evaluated and prioritised as many groups were identified as operational. Priorities identified: Mental Health, Suicide Prevention, Central Alliance Work Stream and Alliance Leadership Team (ALT).
   - Alliance Leadership Team: GM currently attends but has asked Tatau Pounamu to consider nominating Dr Jo Baxter as their representative. Jo has the necessary skills and knowledge to have meaningful input.
   - Chair of the Alliance Leadership Team to be invited to the next Tatau Pounamu meeting.
   - Mental Health was identified as another work area that needs Māori representation. Liz Lilly to be approached.
   - Governance Group for Mental Health is not currently operational. Invite WCDHB General Manager and Integrated Health Services (Central) Operations Manager to discuss.

Representation

- Crucial to build capacity of Māori who can contribute and to develop a strategy to ensure representatives are supported and mentored by Hauora Māori.
- Succession planning important for continuity to make sure there is always a voice advocating positive outcomes of Whanau.

b. Discussed Manaaki – Education program for mental health for children at school level.

5. **Tumu Whakarae**

Overview given to meeting by GM.
Further report to be submitted to the next meeting.

6. Health Reforms – Iwi Māori Partnership Boards

- Key focus is Equity for our people on the West coast.
- Tatau Pounamu are looking forward to the outcomes – By Māori for Māori.
- Timeframe: implementation July 2022.

7. **Cancer Hui – Te Ahau Tekahau – Portfolio Manager**

- Workshops/Hui being held throughout the country looking at issues for Māori working through their Cancer journey.
- They are looking to bring these Hui into other areas and Portfolio Manager is in contact with the Hui leaders advocating for the hui to come to the West Coast.

8. Annual Plan

- Discussed the Annual Plan Hui, which was led by Planning and Funding staff - Melissa McFarlane and Sarah Fawthrop
- List of priorities and actions has been received.
- Look into holding a Hui at the Marae, to include leaders from CDHB. Tatau Pounamu would like to also include the review of the MOU with the WCDHB.

5. GM Māori Health Update.

a. Report taken as read.

6. Chairs Update.

a. Nil received

7. Facilities Team – Margo Kylie - Facility Development Program Director

1. Excerpt from Minutes – Tatau Pounamu meeting 9 July 2021
   Facilities – Margo Kyle – Project Manager
   Update on the business case for the proposed Mental Health Facility.

- Verbal update provided of the proposed new Mental Health facility and the status of the second business case that has been developed.
- Engagement with consumers needs to be key. Seeking support and guidance from Tatau Pounamu to approach Māori consumers and their Whanau to learn about their experiences and view of the current facility to understand what we can improve e.g. admissions, space, activities, entertainment.
- Tatau Pounamu require a genuine co-design process that must be undertaken with their input and guidance.
- The new facility in Counties Manakau, promoting wellness was a model that was presented. A feature is that the courtyard is in the centre of the building. The Whare Whakatu is a key feature and we would like to see something similar in the West Coast facility.

Key points:

- Survey has been completed of all facilities throughout New Zealand and after second seismic testing the Greymouth Mental Health facility is no longer seismically compromised.
- Data shows clearly that the proportion of Māori seeking wellness in the Inpatient Unit is likely to be twice that of Māori per proportion of the population.
- The current facility has very little that would appeal to Māori. Hinengaro is a priority for Tatau Pounamu and there have been concerns for a long time regarding the inequities that exist within the current model.

Key outcomes:

- Agreement that whanau voice is crucial to feed into the future design. This must be done in partnership with Tatau Pounamu and the Hauora Māori team as there are multiple factors to consider before contacting whanau.
- Ensure that the WCDHB consult with Ned Tauwhare and Marie Mahuika-Forsyth and the Hauora team before approaching Whānau (linked to the point above).
- Model of care – co-design with Iwi is necessary. Te Tiriti partnership will underpin the approach, further discussion to decide the parameters of the partnership moving forward.
- Phil and Margot to be invited to the next hui to discuss moving forward in partnership with Tatau Pounamu.

8. Covid Update – Helen Gillespie

a. **Key Messaging**

- Moving from start-up to sustainability and moving towards a sustainable work force.
- Māori will have equitable access to vaccinations.
- Review of the current Whanau strategy as initiated at start-up.
- Poutini Waiora are increasing their capability to be able to set up as a Vaccination Centre
- Whanau Days: run in collaboration with Poutini Waiora have been successful.
- Comms: all Covid communications comes directly from the MoH and we have limited ability to add our local flavour to messages. This has raised challenges.
- Rest homes have now been completed
- Kawatiri Covid clinics – Weekly Tuesday to Saturday

- Mawhera Covid clinics – Weekly Tuesday to Saturday
- Hokitika – Currently one day a week, moving towards three days.
- Haast, Karamea, Reefton – Mass vaccination.
- Future sites Franz Joseph, Whataroa, Hari Hari, and Fox Glacier.
- Looking at vaccination workplaces e.g. Hokitika Milk treatment and large workplaces.

b. Eligible Population over 16 – Information (accurate as at 5th July)

- 16.2% Māori 24.5% Pacific 22.4% of our total population, 12,000 doses over the coast.

c. Mobile team

- One Mobile team currently established with a second team being set up.

d. Māori strategy

- Investigating utilising the national booking centre to call all Māori on the West Coast.
- Looking at ways to capturing clients who are unable to fill in the form as research shows 35% of population are uncomfortable filling in forms, or are unable to read, write, or see the form.
- Look at ways to capture Māori who come in with their Kaumatua, allow them to be vaccinated too, or give them a date to come back in.

Meeting ended at 1.30pm.
Next meeting is to be held at Te Nikau IFHC on the Friday 3rd September 2021.

TATAU POUNAMU

ACTION LIST ITEMS 09 April 2021

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
1.	July 09	1. DISCLOSURES OF INTEREST - Action: Members to email any changes re their disclosures of interest, before the next meeting.	**All Members** (To email to PA – MW)	September Meeting
2.	July 09	3.2 Suicide Prevention. Action: Reschedule Suicide Prevention Coordinator to the next meeting.	Gary Coghlan	September Meeting
3.	Ongoing	3.3 Covid 19 - Action: Continue to source Māori nurses to become vaccinators	Hauora Team	September Meeting
4.	May 28	3.4 WCDHB Staff Hui - Action: Dates of Māori Staff hui to be sent to Tatau Pounamu members	Marion Smith	September Meeting
5.	May 28	3.5 Working Groups - Action: Alliance leadership Team, Mental Health and Central Alliance Work Stream – nominations to be confirmed.	Tatau Pounamu	September Meeting
6.	May 28	3.6 Consumer Council - Action: Create a draft set on principles and values for a relationship document send out to Tatau Pounamu members for review. - Action: Email to CC Chair and Christine Robertson has been drafted and Susan will send out today. - Action: Once agreed arrange a Wananga with both parties to discuss. - Action: Advise Tatau Pounamu dates and venues of Consumer Council meetings	Gary Coghlan, Kylie Parkin Susan Wallace Gary Coghlan / Susan Wallace Melanie Wilson	September Meeting

Item No	Meeting Date	Action Item	Action Responsibility	Reporting Status
8	July 09	4.3 Working Groups - Action: The Chair of the Alliance Leadership Team be invited to the next Tatau Pounamu meeting. - Action: ALT terms of reference to be sent out to Tatau Pounamu members. - Action: Invite Phil Webble and Mary Harrington to discuss current Mental Health and potential to form a Governance Group	Gary Coghlan Marion Smith / Melanie Wilson Gary Coghlan	September Meeting
9	July 09	4.6 Cancer Hui – Te Ahau Tekahau - Action: Kylie Parkin to contact Karen Keyline to find out if they are considering bringing this Hui to the West Coast.	Kylie Parkin	September Meeting
10	July 09	7. Facilities Team – Margo Kylie - Facility Development Program Director - Action: Chair to send an email with the renderings to Ngati Waewae, Ned Tauwhare and Joseph Mason requested a motif for frosting (new or the same as Te Nikau) and also to consider the naming of this facility. - Action: Margo to send through the rendering of the new facility to Gary Coghlan and Kylie Parkin. To be disseminated to Tatau Pounamu members for review.	Chris Auchinvole Margo Kylie / Kylie Parkin	September Meeting

GM UPDATE TATAU POUNAMU

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

TO: **Tatau Pounamu Chair & Members**

SOURCE: **General Manager, Maori Health**

DATE: **Friday 3rd September 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

ORIGIN OF THE REPORT

This report is provided to Tatau Pounamu Manawhenua Advisory Group as a regular update

Delivery of Planned Care

Hauora Māori are involved in the planning to ensure a strong equity focus across the delivery of Planned Care to understand and ensure that inequities for Māori are not compounded by the deferral of planned care during Hospital Level Yellow. Scoping options to support use of technology to support Māori engagement in planned care.

Transitioning to the new health system

The first of many hui has been held with the existing Iwi Partnership Boards to understand the programme of work required for the transition to the new health system. The transition unit has developed and defined a very clear road map for the boards to guide them through the process.
Iwi Māori Partnership Boards will have statutory powers to influence the system locally, regionally and nationally.

Purposes of IMPBs

1. Exercise Tino Rangatiratanga as the tangata whenua partner with HNZ and MHA, in planning around health priorities and services at the locality level, within their rohe or coverage area. Iwi Māori Partnership Boards (IMPBs) will approve Locality Plans for the localities in their coverage area.
2. Ensure the voices of whanau Māori are elevated and made visible within the health system.
3. Embed matauranga Māori within locality plans, which then influences regional and national planning.

The transition Unity and MoH have resources available to support IMPBs to undertaken the transition work and will allow for unique circumstances such as large coverage geography. There is immediate work to be undertaken to develop and submit a Transition Plan. DHBs are encouraged to support IMPBs to develop and implement their Transition Plans where possible.

Transition planning and resources

The Transition Unit and Ministry of Health have resources available to fund IMPBs to undertake their transition work. Allocation of available funds will be carried out in a manner that is equitable to each IMPB and allowing for unique circumstances such as large coverage geography (requiring extended engagement costs and travel); higher population numbers; and developmental needs.

The Transition Unit also plans to convene two further rounds of engagement with IMPBs to check in on progress with implementation of Transition Plans and to understand any challenges or issues faced by IMPBs.

Food Security

The Food Secure Communities programme was funded in Budget 2020 ($32 million over two years). This fund is to help meet the additional demand during Covid-19 lockdowns on foodbanks, food rescue and other community providers.

The West Coast Food Security Group lead by the WCDHB has members from Community providers: (Salvation Army, CPH, WCEOC, Civil Defence, Poutini Waiora, MSD, Social Workers) who have a key role to play in taking care of people who need help during lockdowns. The group – which includes Hauroa Māori was pulled together to ensure there were processes developed in relation to those people (whether medically vulnerable, or self-isolating etc) who have no way of accessing food through natural networks.

WCDHB Welfare is co-ordinating the creation of a "Pathways to Kai" document (for Welfare and SIQ (Self Isolation Quarantine)) purposes to include all options in a way that supports conversations between staff (from whatever agency) and community members to access kai as independently as possible.

We have anecdotal evidence that many whānau are being supported by others outside the group, (Whare Manaaki, Schools – through the West Coast Principals Association) and we are connecting with these people to ensure they are now part of the wider food security network.

A coordinated approach is absolutely necessary to ensure no one within Hapori Māori Iwi goes without basic needs; food or essential items such as medicine through COVID-19 lockdowns.

Covid-19

Hauora Māori continue to fully support the Covid -19 Vaccination roll out. There have been ongoing discussions with Programme Management on a Prioritisation strategy to progress vaccinations for Hapori Māori Iwi. One very successful strategy was to have dedicated timeslots were allocated for Māori at the Drive through Clinic held on Sunday 29th August and following a huge effort from our team 124 Māori were booked, of those 98 were under the age of 50.

Overall our numbers (MoH data as at 25 August) are tracking well, although we can always do better.

Māori vaccinations:

First dose:	31%
Second dose:	20%

Kaumatua 65+

First dose:	73%
Second dose:	56%

The following clinics are being run:

Drive through clinics 2nd, 3rd, ad 4th September
Daily clinics Tuesday – Saturday: Greymouth and Westport
Daily clinics: 2 days per week (days vary) Hokitika

Gary Coghlan
GENERAL MANAGER HAUORA MĀORI

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

HEALTH TRANSITION UNIT

MINISTRY OF HEALTH
MANATŪ HAUORA

GUIDELINES FOR IWI MĀORI PARTNERSHIP BOARDS

Transitioning to the new health system

August 2021

Background

In April 2021, the Minister of Health announced significant changes to the health and disability sector, following the Health & Disability Services Review (HDSR) completed in 2020. Despite many positives in the system (including the response to Covid-19), the system is under serious stress and does not deliver equally for all. The aim of the HDSR was to develop options to reform the system to address two major challenges: **equity** and **sustainability.**

Vision for the health system

The guiding vision is for a health system delivering pae ora / healthy futures for all New Zealanders, where people live longer in good health and have an improved quality of life. The health reforms need to focus on how to achieve five outcomes, above others. These are:

- **Partnership** – through **embedding the voice of Māori** and other consumers of care into how the system plans and makes decisions, **ensuring that Te Tiriti o Waitangi principles are meaningfully upheld.**
- **Equity for all New Zealanders** – so everyone can achieve the same outcomes, and have the same access to services and support, regardless of who they are or where they live.
- **Excellence** – ensuring consistent, high-quality care is available when people need it, and harnessing leadership, innovation and new technologies to the benefit of the whole population.
- **Sustainability** – focusing the health system on prevention and not just treating people when they are unwell – 'wellness not illness' – and ensuring that we use resources to achieve the best value for money.
- **Person and whānau-centred care** – by aiming to empower people to manage their own health and wellbeing and put them in control of the support they receive.

The Case for Change

The system must make changes to tackle the persistent inequity in health outcomes. Around half of Māori and Pacific deaths are potentially avoidable, compared to under a quarter of those for other New Zealanders. The Government is committed to re-thinking how Māori and Pacific communities get access to healthcare and think about how healthcare services are delivered, including supporting kaupapa Māori services. Improving outcomes for those traditionally underserved by our health system – for Māori, Pacific, disabled and rural communities, among others – is central to the reforms we undertake.

Iwi and Māori communities are frequently consulted, but often in an advisory rather than decision-making capacity. The system will need to take a stronger population health approach in the future,understanding what the population needs from services and the best ways to deliver on these needs. It also means working together to address the wider determinants of health.

Transforming the System (from Minister Little's speech)

(1) The health system will reinforce Te Tiriti principles and obligations. The way the system presently delivers for Māori is inadequate. We must ensure partnership and effective iwi and Māori leadership at all levels. **Māori involvement in determining direction, priorities, service design and delivery to address Māori health needs will be the norm, not the exception**. And to ensure that support is appropriate and accessible, **the system will provide more kaupapa Māori services** and options as part of integrated service arrangements. At the core of our reform is a by Māori, for Māori approach - our role as the Crown is to be the enablers of change, and the not the barriers to it. Addressing inequities to remove disadvantage and ensuring everyone has access to the same level of high-quality care and the same opportunity to experience good health outcomes. Creating a Māori Health Authority to centre the Tiriti o Waitangi partnership. It will also be key to shaping how Māori exercise rangatiratanga over their own healthcare.

(2) All people will be able to access a comprehensive range of support in their **local communities** to help them stay well. This means ensuring a better range of integrated primary and community services in all areas, with increased access and protected funding. Services will be designed around the needs and priorities of communities and will work together to improve the health of their local population.

(3) Everyone will have access to high quality emergency or specialist care when they need it. Services will be planned across the whole New Zealand population to ensure the best distribution of care and equitable access for people in different regions.

(4) Digital services will provide more people the care they need in their homes and local communities. Digital technology must become a key feature of the system for patients and professionals.

(5) Health and care workers will be valued and well-trained for the future health system. A key element of these reforms is helping to ensure we have enough trained people who are resourced to provide better services for our communities.

New entities

(1) The 20 DHBs will be merged to create a single national organisation called Health New Zealand with four regional offices. Health NZ will focus on delivering / commissioning:

   a. Community and primary care services
   b. Hospital and Specialist services

(2) A new Māori Health Authority, with its own budget, will be established to lead Hauora Māori across the system. It will also have four regional offices.

(3) Iwi Māori Partnership Boards will have statutory powers to influence the system locally, regionally and nationally

(4) The Ministry of Health will develop a Public Health capability and will focus on policy and stewardship of the system. Any current funding functions will be transferred to HNZ / MHA.

The Transition Unit

The Transition Unit was set up in September 2020 to manage the transition from the current system to the new system which will take effect on 1 July 2022.

In the meantime an Interim Health NZ and Interim Māori Heath Authority will be set up within the Ministry of Health. The current system continues to operate until 30 June 2022, although some functions from the Ministry of Health and District Health Boards may transfer early to the interim agencies if it makes sense.

The Transition Unit has already managed the process of advertising for the Boards of the interim agencies and decisions on appointments are expected in September 2021. From there, CEOs for each of the interim agencies and additional staff will start being recruited. The two new agencies need to be ready to function fully from 1 July 2022.

There are a number of other workstreams that are being worked on by the Transition Unit so that the new system is "ready" on 1 July 2022:

- Legislation to create the system and supporting policy work especially to embed Te Tiriti o Waitangi into the system
- Creating a NZ Health Plan and Māori Health Plan to implement Whakamaua – the Government's Māori Health Strategy
- Supporting the transition of Iwi Māori Partnership Boards to be ready for 1 July 2022
- Developing the service models for 'Community & Primary Care' and for 'Hospital and Specialist Services'
- Developing and starting to implement new commissioning frameworks
- Strengthening methods for increasing whānau and consumer voice
- Developing budgets and funding bids for the HNZ and MHA
- Preparing to transfer contracts from the Ministry and DHBs – to Health NZ and the MHA
- Developing accountability arrangements for all entities including HNZ, MHA and IMPBs

As this work is taken over by the interim HNZ and MHA entities, the functions of the Transition Unit will decrease and eventually stop, once the new entities are operational.

Iwi Māori Partnership Boards (IMPBs) in the future

Characteristics of IMPBs

Cabinet has already agreed to the fundamental characteristics of Iwi-Māori Partnership Boards:

(1) they will be independent, without government character. They do not report to the Crown – they are accountable to Iwi and hāpori Māori within their respective coverage areas

(2) they will operate predominantly at the locality level of the health system but will also have a role at the regional and national level to influence regional and national policy, strategy, frameworks and commissioning. The locality layer of the system is where tino rangatiratanga and mana motuhake are most emphasised. This is fitting, as it is where mana whenua are best placed to directly influence the care made available in their rohe and communities.

(3) they will be closely involved in locality commissioning, having rights of consultation at the locality level. Locality plans will need to be agreed between Health NZ commissioners and Iwi-Māori Partnership Boards to proceed to implementation. Where the two disagree, disputes are escalated to Health NZ and the Māori Health Authority at the regional level.

Purposes of IMPBs

(1) exercise tino rangatiratanga as the tangata whenua partner with HNZ and MHA, in planning around health priorities and services at the locality level, within their rohe or coverage area. IMPBs will approve Locality Plans for the localities in their coverage area

(2) ensure the voices of whānau Māori are elevated and made visible within the health system

(3) embed mātauranga Māori within locality plans, which then influences regional and national planning.

Core Functions

To deliver on these purposes, IMPBs are intended to play several core roles to be outlined in the Health Reform Bill:

(1) <u>Locality Whānau Engagement and Locality Assessment:</u> Engage with whānau and hāpori Māori, and share insights and perspectives resulting with Health NZ, the Māori Health Authority and others. This would ensure that IMPBs' views reflect local priorities and insights and would act to magnify the perspectives of Māori within localities. Assess, evaluate and report on the current state of hauora Māori in their locality or localities from their perspective, drawing on the qualitative and quantitative information they acquire (some of which may be from the HNZ and MHA)

(2) Determine Locality Priorities: Develop and document locality priorities in a "Hauora Māori Wellness Priorities": (or whatever name preferred by the IMPB) for locality performance, for the HNZ and MHA locality commissioners. These would include identifying strategic health outcomes and priorities, service-level priorities, unique or significant local issues, innovative opportunities, and broader observations on wellbeing and social determinants of health in the locality. [note where an IMPB has multiple localities (and/or Locality Commissioners) in their coverage area, only one "Hauora Māori Wellness Priorities" document would be required from the IMPB, which would identify any specific locality requirements if needed.

Engage with the Māori Health Authority on wider priorities for kaupapa Māori investment and innovation. This would support a 'ground up' approach to investment by the Authority, which will not have a significant presence in localities.

NOTE: Combined IMPB priorities in the four regions would be analysed for region-wide themes and common interests of Iwi Māori. Combinations of the four regional IMPB analysis will be analysed for nation-wide themes and common interests of Iwi Māori nationally. These will become the basis of IMPB regional and national engagement with the HNZ and MHA on priorities, frameworks and commissioning.

(3) Review draft Locality Plans: Review the draft Locality Plans prepared by Local Commissioners and negotiate enhancements and changes as partners.

(4) Approve Locality Plans: Approve Locality Plans developed by Health NZ and MHA commissioners, and approve these according to a statutory power.

(5) Monitor implementation and impact of approved Locality Plans: IMPBs would monitor the performance of the health system in their locality or localities against the locality plan. This may include gathering ongoing engagement and feedback from whānau (consumers/p□tients) to g□in their perspectives on loc□l he□lth services; reviewing of perform□nce d□t□ from HNZ □nd MHA; reviewing of □ny rese□rch or other evidence being gener□ted in the loc□lities; □nd □ny other me□ns th□t the IMPB m□y choose to utilise to understand how effective the local health services are for hāpori Māori.

(6) Report to whānau and hāpori Maori: Produce an annual report (or equivalent) of activities carried out to whānau and hāpori Māori, and other partners (HNZ and MHA). This ensures a measure of accountability of IMPBs to Māori in each locality.

Beyond these core functions, there are further functions which some or all Iwi-Māori Partnership Boards may grow over time or may take on in some areas. These could include intersectoral collaboration (e.g. with other social sector agencies), communications (e.g. health promotion), data sovereignty, training and education, crisis or risk management, innovation, provider capability and market-building, and workforce development.

Legislation is expected to permit further roles for IMPBs without defining them. These would be negotiated with HNZ or MHA on an individualised basis by IMPB, as maturity and capability develop.

Support for IMPBs to carry out core functions

(1) To deliver on the above roles, it is acknowledged that Iwi-Māori Partnership Boards will need a measure of resourcing and support in addition to the membership of the board. This support includes secretariat functions, the provision of data analysis, writers and policy advice, as well as support to influence locality planning (e.g. to provide Health NZ and Māori Health Authority commissioners with clear articulations of iwi, hapū, whānau and hāpori Māori expectations).

(2) Health NZ is expected to provide the majority of this support. The Māori Health Authority could provide Matauranga Māori, research, best practice or other Māori subject-matter support including support with policy advice and drafting in locality planning, if the IMPB desires it.

(3) In the course of engaging with today's IMPBs, it was highlighted that in some instances current IMPBs already have significant infrastructure supporting them (e.g. from iwi / health organisations) that has been negotiated with their DHB, which can meet these needs. In such circumstances, requiring IMPBs to draw this support only from HNZ and MHA is acknowledged as representing a step backwards away from mana motuhake for these boards. At the same time, other IMPBs highlighted that significant capability growth will be needed to fulfil the proposed new roles.

(4) Therefore, IMPBs will all be offered the supports from HNZ/MHA but may choose, where they are at a more mature point in their development and/or have a record of self-supporting through any prior DHB arrangement, to support themselves. The appropriate approach would be negotiated between each IMPB, Health NZ and the Māori Health Authority, applying a scaling approach as IMPBs grow capability and take increasingly autonomous approaches over time.

Composition and constitution of IMPBs

(1) We have considered and discussed with Māori a range of options for the composition and identification of Iwi-Māori Partnership Boards. Our engagements with Māori have highlighted that the paramount criteria for any approach is that Māori be able to determine for themselves how they organise, and how boards are composed – including the extent to which mana whenua, hapori Māori and hauora Māori expertise are included on each board. From engagements to date, several IMPBs have indicated a desire to consolidate along the lines of iwi rohe in future.

(2) We therefore recommend that Māori be permitted to organise Iwi-Māori Partnership Boards in a manner of their choosing, including determining where boundaries are drawn and who makes up any given Board. We recommend three minimum requirements:

(3) that Board boundaries must be mutually exclusive – no two boards may have the same area included within their boundary

(4) that all recognised iwi groups within the Board's boundary must have the opportunity to nominate a member to the Board (though they may choose not to be represented)

(5) that each Board must evidence how they will include hapori Māori perspectives and voices in the Board's activities, which might include providing evidence of sufficient engagement, and/or providing hapori Māori seat/s on the Board.

(6) These requirements would need to be met for each Iwi-Māori Partnership Board to exercise their statutory powers, including to approve locality plans.

(7) At the same time, it is necessary that Iwi-Māori Partnership Boards can be identified with sufficient certainty to give them statutory powers. To ensure this, we recommend that at commencement, the Iwi-Māori Partnership Boards be recognised as a list, based on those currently constituted to support DHBs, operating along district boundaries. The Bill would permit these Iwi-Māori Partnership Boards to then vary their membership at their discretion (subject to the minimum requirements above), and to re-negotiate boundaries – including merging, de-merging or shifting boundaries – by mutual agreement between affected Boards, confirmed by way of written notice to the Minister of Health. This allows Māori maximum flexibility to constitute the Boards in the manner they deem most appropriate, and to adjust boundaries and approaches over time, while ensuring legal certainty.

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Transitioning toward the new system 1 July 2022

Transition planning and resources

The Transition Unit and Ministry of Health have resources available to fund IMPBs to undertake their transition work. Allocation of available funds will be carried out in a manner that is equitable to each IMPB and allowing for unique circumstances such as l□rge cover□ge geogr□phy (requiring extended eng□gement costs □nd tr□vel); higher popul□tion numbers; □nd developmental needs.

In order to have these funds released (to be paid from the Ministry of Health), IMPBs will need to:

a) Complete and submit a Transition Plan (template attached) – approved at a meeting of the IMPB and signed by the Chair(s)

b) Nominate a legal entity to whom funds will be paid on behalf of the IMPB, and who will provide financial reports to the IMPB and Ministry of Health

We will be encouraging DHBs to support (such as resource, including but not limited to people and financial) IMPBs to develop and implement their Transition Plans where possible, and the Ministry of Health will also arrange for regional contractors / facilitators to be made available upon request – to support implementation of Transition Plans for any IMPBs that request such support.

There is a designated budget set aside for 2022-2023 and beyond. Arrangements for the support and resourcing process from 1 July 2022 will be carried out by the HNZ and MHA with each IMPB.

Ongoing engagement and support

The Transition Unit also plans to convene two further rounds of engagement with IMPBs to check in on progress with implementation of Transition Plans and to understand any challenges or issues faced by IMPBs that need to be resolved by the Transition Unit, interim HNZ or interim MHA and Ministry of Health.

Over the next 10 months, functions of the Transition Unit may be transferred to the interim HNZ and MHA, and it is possible that support for IMPB development may be assumed by these entities from the Transition Unit. This should not affect the level of support being available to IMPBs.

Any question on this Guideline please contact:

Bernard Te Paa: Bernard.tepaa@dpmc.govt.nz

OR Cheree Shortland-Nuku: cheree.shortland-nuku@health.govt.nz

OR Mara Andrews: mara@kahuitautoko.com

DRAFT TRANSITION PLAN TEMPLATE: *Delete the italics when you complete and before you send your Transition Plan. We anticipate that this plan should be no longer than 4-6 pages*

NAME OF IMPB: _____

FOCUS AREA	ACTIVITY TO BE CARRIED OUT BY 31 DEC 2021	ACTIVITY TO BE CARRIED OUT BY 31 MARCH 2022	ACTIVITY TO BE CARRIED OUT BY 30 JUNE 2022
Planning for "business as usual" within DHB partnerships *For existing IMPBs, what work still has to be done that has been agreed? Will this need to be reviewed / revised? Does the IMPB need to start/stop an activity over next 10 months?*	*Write in these sections the tasks you will carry out to address the issues you have considered and in which quarter you will do them, to be ready by 30 June 2022*		
Composition / constitution of IMPB *Undertake an assessment (IMPB capability assessment tool) of the IMPB. Acknowledging the core functions of IMPBs, does the IMPB have the right skill mix and competencies? Is a recruitment process needed within the rohe to bring on new skills? It is timely also to look at*	*What process/tasks to bring on new members or replace existing members?*		*If current members are leaving before the DHBs are replaced, what process to exit and thank those members?*

FOCUS AREA	ACTIVITY TO BE CARRIED OUT BY 31 DEC 2021	ACTIVITY TO BE CARRIED OUT BY 31 MARCH 2022	ACTIVITY TO BE CARRIED OUT BY 30 JUNE 2022
refreshing any mandate from the Iwi Māori Authorities and organisations who originally nominated or appointed current IMPBs. Are they still happy to mandate the representatives on the IMPB to act on their behalf in the new system ?			
Reflecting Iwi and Hāpori Māori *Does the composition of the IMPB include Iwi and representation of your local Hāpori Māori? Or what mechanism is proposed to reflect the voice of hāpori Māori? What process is used to appoint and replace members?*			
IMPB Terms of Reference *Plan to refresh any current TORs or other documentation that were negotiated with DHBs so that they are ready for operating alongside HNZ and*			

FOCUS AREA	ACTIVITY TO BE CARRIED OUT BY 31 DEC 2021	ACTIVITY TO BE CARRIED OUT BY 31 MARCH 2022	ACTIVITY TO BE CARRIED OUT BY 30 JUNE 2022
the MHA. Are there any name changes of your IMPB planned – esp if boundaries have changed? Define the boundaries (map appended is fine). If there is no current TOR, look to develop one that covers name, membership (who, how appointed, replaced), mandates, numbers, roles, meeting protocols, Chairing meeting, frequency of meetings, conflict resolution, etc. Examples/templates can be provided if needed.			
Training and development *Identify training needs desired by IMPB members to prepare for new environment. What knowledge, information, training might the DHB provide to support?* *What information would help any members feel confident*			

FOCUS AREA	ACTIVITY TO BE CARRIED OUT BY 31 DEC 2021	ACTIVITY TO BE CARRIED OUT BY 31 MARCH 2022	ACTIVITY TO BE CARRIED OUT BY 30 JUNE 2022
they understand the system and the transformational changes?			
Preparing to undertake Core Functions *What work does the IMPB want to do over the 10-month period (and beyond) on the core functions (1) and (2) in order to inform & develop the Hauora Māori Wellness Priorities?* - *Whānau Engagement and Locality Assessment* - *Determining Locality priorities. Are there locations the IMPB needs to study further? Are there areas where whānau voice hasn't been gathered? Are there communities with significant issues?* - *Does the IMPB need to request and review data from the DHB and other sources?*			

FOCUS AREA	ACTIVITY TO BE CARRIED OUT BY 31 DEC 2021	ACTIVITY TO BE CARRIED OUT BY 31 MARCH 2022	ACTIVITY TO BE CARRIED OUT BY 30 JUNE 2022
- *For the "Hauora Māori Wellness Priorities", are there key recommendations to HNZ and MHA (collectively or individually)?*			

Note: Please add further information if your IMPB wants to plan beyond 30 June 2022 into the following year, especially if you plan to carry out some of your transitionary tasks in the 2022-2023 year (this is perfectly acceptable if you feel you want to take more time to reach full operational status)

Submitted by the _____ IMPB, and approved at a duly constituted meeting held on / /

Signed: _____

Chair Name(s) who signed: _____

Nominated Legal Entity for payment: *Name, address, phone and contact person*

Email this completed document to:

Bernard.tepaa@dpmc.govt.nz and cheree.shortland-nuku@health.govt.nz

IWI MĀORI PARTNERSHIP BOARD CAPACITY ASSESSMENT TOOL

August 2021

Iwi Māori Partnership Board: Capacity Assessment Tool

The following Iwi Māori Partnership Board Capacity Assessment Tool (IMPBCAT) is a self-assessment tool that will help guide Iwi Māori Partnership Boards to identify the capacity needed to function at a high-level once these Boards are established and functioning on 1 July 2022. Iwi Māori Partnership Boards (IMPB) will play an influential role in the system. With this role comes an increased workload and responsibility that will require expertise in a number of areas. This tool was developed to identify the key areas where IMPBs will need to have high expertise in the reformed health system. This tool will also analyse the areas where IMPBs should be supported to be developed in the reformed health system, as well as provide a useful assessment of how existing IMPBs can grow their capacity now to meet the requirements of their new roles.

Instructions

You will be rating your current IMPB on a variety of capacity elements. Each of these capacity elements will have a series of sub-elements that will explore specific aspects of each area. These being:

1. Tikanga and Te Ao Māori
2. IMPB foundations
3. Current state whānau and hāpori Māori needs assessment
4. Establishing Hauora Māori Wellness Priorities
5. Financial management and accountabilities
6. Communications / Information Technology
7. Anticipated Health New Zealand relationship
8. Anticipated Māori Health Authority relationship

For each capacity element, there will be four levels that describe the capacity your organisation is currently at with said element. These being:

1. **Unfamiliar** – Little awareness of this competency or how to develop capability in this area
2. **Comfortable** – Knows basics, able to engage appropriately in a short-term transactional setting, but not yet developed strategic capability
3. **Confident** – Confident in being able to determine what is important based on thorough analysis of qualitative and quantitative information
4. **Capable** – Able to lead and advise others, has deep knowledge in the subject area, can speak on the matter confidently to others and needs little support to perform function

The objective of the Health and Disability System Transition Unit and Ministry of Health is to support IMPBs to reach a **'confident' level of capacity (Level 3) in all capacity elements before 1 July 2022**, and then for HNZ, MHA and the MOH to continue to support IMPBs to achieve 'capable' status across all areas.

Summary Assessment

Complete at end once tool fully reviewed – TICK RELEVANT RATING FOR EACH DOMAIN

Capacity elements	Level one: Unfamiliar	Level two: Comfortable	Level three: Confident	Level four: Capable
1. Tikanga and Te Ao Māori				
1.1 Tikanga				
1.2 Te Ao Māori				
2. IMPB Foundations				
2.1 Understanding of health reforms / HNZ & MHA				
2.2 Documented protocols				
2.3 Governance capability				
3. Community needs assessment				
3.1 Community & whānau engagement				
3.2 Presence / visibility in community				
3.3 Ability to gather Iwi aspirations				
3.4 Ability to assess quantitative information				
3.5 Ability to assess qualitative information				
3.6 Relationship with Māori & non-Māori service providers				
3.7 Relationship with other sectors, agencies & local authorities				

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
3.8 Ability to consolidate and report information				
4. Strategic wellness priorities				
4.1 Ability to assess & identify needs and opportunities				
4.2 Ability to develop & communicate priorities				
5. Financial acumen				
5.1 Financial acumen				
6. Communications & technology				
6.1 Capability with technology				
6.2 Communications / online				
7. Anticipated HNZ relationship				
7.1 Understanding and readiness for HNZ relationship				
8. Anticipated MHA relationship				
8.1 Understanding and readiness for MHA relationship				
TOTAL # FOR EACH COLUMN				

1. Tikanga and Te Ao Māori

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
1.1: Understanding of basic tikanga Māori	The Board as a whole has very limited or no understanding or competency in tikanga Māori at present	The Board as a whole has a basic level of understanding of tikanga Māori; the Board is not confident in leading its facilitation of this, and Board capability needs to improve in this area	The Board as a whole has a reasonable level of understanding of tikanga Māori. The Board is somewhat confident in leading its facilitation of this, and Board capability needs to improve in this area	The Board as a whole has a strong level of understanding and capability in tikanga Māori, and how it applies across the Iwi / mana whenua within the coverage area.
1.2: Lived experience of te ao Māori	The Board has limited or no understanding of the lived experience of Māori.	The Board has a basic understanding of the lived experience of Māori; the Board struggles to represent the views of whānau and communities.	The Board understand the lived experience of Māori; the Board is able to represent some of the views and experiences of whānau and communities.	The Board has a comprehensive understanding of the lived experience of Māori; the Board confidently represents the views and experiences of whānau and Māori.

2. Iwi Māori Partnership Board foundations

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
2.1: Clear overall understanding of roles and responsibilities in relation to Health NZ and the Māori Health Authority	The Board has limited or no understanding of its place in the reformed health system; there is limited or no understanding of its potential accountabilities to the community.	The Board has an adequate understanding of role in the health system; Board understands its responsibility to create meaningful outcomes for the community	The Board has a clear understanding of its role in the health system; the Board understands it has powers and levers in its role; the Board understands it has a responsibility for creating	The Board has a comprehensive understanding of its role in the reformed health system and to its community; Board understands how it will use its powers and levers to develop

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
in the future system		but is unsure of its levers to achieve these outcomes.	meaningful outcomes for its community.	meaningful outcomes for whānau and communities.
2.2: Documented roles and protocols	The Board is unfamiliar with their roles and protocols; they do not have a Terms of Reference; they do not possess a Conflicts of Interest policy.	The Board is somewhat familiar with their roles; they have a Terms of Reference that explains simple processes and roles of Board members; they possess a Conflicts of Interest policy.	The Board is familiar with their roles; they have a Terms of Reference that clarifies key roles and protocols of the Board; they possess a Conflicts of Interest policy.	The Board confidently understands their roles and protocols and how to perform them; they have a Terms of Reference that clarifies all roles and protocols of the Board; they possess a Conflicts of Interest policy
2.3 Board has strong experience and capability in governance and partnering with Government and others	The Board has limited or no understanding of requirements of good governance, and understanding of its potential accountabilities as a governing body	The Board has an adequate understanding of requirements of good governance, and understanding of its potential accountabilities as a governing body	The Board has a clear understanding of requirements of good governance, and understanding of its potential accountabilities as a governing body	The Board has a comprehensive understanding of its role of requirements of good governance, and understanding of its potential accountabilities as a governing body

3. Current state assessment of whānau & hāpori Māori needs and aspirations across the coverage area of the IMPB

In the future this is a role required to inform Locality Plans

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
3.1 Community and whānau engagement strategy	The Board currently does not regularly engage with whānau and communities.	The Board engages with the community on an ad-hoc basis.	The Board has processes established for semi-regular engagement with the community.	The Board has processes established for regular engagement with the community and has done this work regularly each year over a long period of time.
3.2 Presence in local community(s) in the coverage area	The Board's presence is not recognised or may not be highly regarded or recognised in the local community OR the Board does not know the Māori community perception of its role and the membership.	The Board's presence is somewhat recognised and is generally regarded as positive in the local community	The Board is reasonably well-known within the community, and is perceived to be responsive to the needs of the community.	The Board is widely known amongst the community and is perceived as actively engaged and highly responsive to the needs of the community
3.3 Gather and consolidate Iwi Māori aspirations to reflect Iwi Māori priorities within the rohe	The Board's links with local Iwi are un-developed in terms of understanding Iwi aspirations for Pae Ora, and their expectations of the Board as an advocate for Iwi aspirations in health	The Board's links with local Iwi are somewhat developed in terms of understanding Iwi aspirations for Pae Ora, and their expectations of the Board as an advocate for Iwi aspirations in health – but needs improvement	The Board's links with local Iwi are well developed in terms of understanding Iwi aspirations for Pae Ora, and their expectations of the Board as an advocate for Iwi aspirations in health – but there is still room for improvement	The Board's links with local Iwi are highly developed and strongly linked. The Board is fully aware of and understands Iwi aspirations for Pae Ora, and their expectations of the Board as an advocate for Iwi aspirations in health
3.4 Ability to access and review quantitative data and identify trends and	The Board as a whole does not have strong capability or experience yet in being able to receive, review and consider a range of quantitative data / statistics to	The Board as a whole has variable capability and experience yet in being able to receive, review and consider a range of quantitative data / statistics to	The Board as a whole has variable capability or experience yet in being able to receive, review and consider a range of quantitative data / statistics to	The Board as a whole has well developed and strong capability or experience in being able to receive, review and consider a range of quantitative data / statistics to

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
opportunities (data from DHB/HNZ, MOH, Public Health etc)	determine issues and opportunities for hāpori Māori & whānau	determine issues and opportunities for hāpori Māori & whānau. There is much room for improvement so that Board is stronger in this area	determine issues and opportunities for hāpori Māori & whānau. There is still room for improvement so that the full Board is highly capable	determine issues and opportunities for hāpori Māori & whānau
3.5 Ability and experience in reviewing qualitative data and reports and to identify trends and opportunities (e.g. Māori research reports, Iwi reports	The Board as a whole does not have strong capability or experience yet in being able to receive, review and consider a range of qualitative data / research reports / literature on Māori health in its coverage area, to determine issues and opportunities for hāpori Māori & whānau	The Board as a whole has variable capability in being able to receive, review and consider a range of qualitative data / research reports / literature on Māori health in its coverage area, to determine issues and opportunities for hāpori Māori & whānau. There is much room for improvement so that Board is stronger in this area	The Board as a whole has reasonably strong capability or experience yet in being able to receive, review and consider a range of qualitative data / research reports / literature on Māori health in its coverage area, to determine issues and opportunities for hāpori Māori & whānau. There is still room for improvement so that the full Board is highly capable	The Board as a whole is highly experienced and capable at being able to receive, review and consider a range of qualitative data / research reports / literature on Māori health in its coverage area, to determine issues and opportunities for hāpori Māori & whānau
3.6 Board has developed strong relationships with providers (Māori and mainstream) in the coverage area, to gather information from them about whānau needs and aspirations that they see, experience and respond to	The Board as a whole does not have strong relationships or visibility among Kaupapa Māori and non-Māori service providers in the coverage area – where it can source information on whānau health needs and aspirations	The Board as a whole has variable relationships or visibility among Kaupapa Māori and non-Māori service providers in the coverage area – where it can source information on whānau health needs and aspirations. There is much room for improvement.	The Board as a whole has fairly strong relationships or visibility among Kaupapa Māori and non-Māori service providers in the coverage area – where it can source information on whānau health needs and aspirations. However not all key providers are connected with the Board yet to provide advice and information on whānau health needs and aspirations	The Board as a whole has very strong and well-developed relationships and visibility among Kaupapa Māori and non-Māori service providers in the coverage area – where it can source information on whānau health needs and aspirations. These relationships are sustained through regular forums, engagement and/or communications.

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
3.7 Have developed or established partnerships or relationships with other sectors, agencies and local authorities to receive information about whānau needs, aspirations, state of environmental wellbeing & opportunities	The Board as a whole does not have strong or established relationships or visibility among other sectors/agencies within the coverage area – where it can source information on whānau health needs and aspirations and seek joint opportunities for collaboration to address whānau needs and environmental wellbeing	The Board as a whole has variable relationships or visibility among some other sectors/agencies within the coverage area – where it can source information on whānau health needs and aspirations and seek joint opportunities for collaboration to address whānau needs and environmental wellbeing. There is much room for improvement to connect with other agencies and to build a focus on environmental wellbeing	The Board as a whole has reasonable relationships or visibility among some other sectors/agencies within the coverage area – where it can source information on whānau health needs and aspirations and seek joint opportunities for collaboration to address whānau needs and environmental wellbeing. There is some room for improvement to connect with other agencies and to build a focus on environmental wellbeing	The Board as a whole has very strong established relationships and visibility among other sectors / agencies within the coverage area – where it can source information on whānau health needs and aspirations and seek joint opportunities for collaboration to address whānau needs and environmental wellbeing. There are several examples of joint initiatives and collaborations.
3.8 Capability to consolidate all of the above information into a cohesive documented assessment of whānau, hapu, Iwi and hāpori Māori needs across the coverage area	The Board does not yet have any experience or track record of producing local needs assessment reports from an Iwi-Māori perspective, that identifies whānau, hapu, Iwi and hāpori Maori needs and aspirations across the coverage area	The Board has minimal and variable experience or track record of producing local needs assessment reports from an Iwi-Māori perspective, that identifies whānau, hapu, Iwi and hāpori Maori needs and aspirations across the coverage area. The work has been inconsistent and is not a routine competency of the Board	The Board has fairly well-developed experience or track record of producing local needs assessment reports from an Iwi-Māori perspective, that identifies whānau, hapu, Iwi and hāpori Maori needs and aspirations across the coverage area. The work has been a regular deliverable of the Board.	The Board has significant experience and track record of producing local needs assessment reports from an Iwi-Māori perspective, that identifies whānau, hapu, Iwi and hāpori Maori needs and aspirations across the coverage area. The work has been consistent over a number of years.

4. Developing "Hauora Māori Wellness Priorities" document for HNZ and MHA (to contribute to locality plans and regional plans)

In the future this is a role required to inform Locality Plans

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
4.1: Assessing opportunities and priorities	The Board does not yet have any experience in drawing conclusions from a myriad of data (such as outlined in 3. above) to identify priorities for whānau and hāpori Māori in its coverage area – and to identify desired outcomes	The Board has some experience in drawing conclusions from a myriad of data (such as outlined in 3. above) to identify priorities for whānau and hāpori Māori in its coverage area – and to identify desired outcomes. There is however much room for improvement in this area	The Board has fairly well-developed capability to draw conclusions from a myriad of data (such as outlined in 3. above) to identify priorities for whānau and hāpori Māori in its coverage area – and to identify desired outcomes. There is some room for improvement in this area	The Board has very well-developed capability and experience in drawing conclusions from a myriad of data (outlined in 3. above) to identify priorities for whānau and hāpori Māori in its coverage area – and to identify desired outcomes. The Board is experienced at tracking progress against the desired outcomes.
4.2: Developing Position Statements & advocating for whānau needs and priorities	The Board does not yet have experience in developing position statements; reports; or communications to funders (e.g., DHB) to advocate for whānau needs and aspirations within its coverage area	The Board has variable experience in developing position statements; reports; or communications to funders (e.g., DHB) to advocate for whānau needs and aspirations within its coverage area. At times it has been done, but not in any consistent and regular way	The Board has experience in developing position statements; reports; or communications to funders (e.g., DHB) to advocate for whānau needs and aspirations within its coverage area. This has been done on a fairly regular basis over the years.	The Board has significant experience in developing position statements; reports; or communications to funders (e.g., DHB) to advocate for whānau needs and aspirations within its coverage area. This has been done on a very regular basis over many years.

5. Financial management and accountabilities

In the future, IMPBs will need to review financial budgets and information within Locality Plans to assess appropriateness of budget allocations to priorities

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
5.1 Financial acumen	Limited or no confidence in review and analysis of financial information & data;	Reasonable confidence in financial decision-making; decision-making is achieved in an adequate amount of time; decisions are informed.	Confidence in financial decision-making is expressed; decisions are made in an acceptable amount of time, but could be improved	Strong confidence in financial decision-making; quick turn-around on decision-making; decisions are well-informed.

6. Communications and Information Technology

In the future IMPB meetings may be frequently online, with paperless meetings. IMPB members need to be able to communicate effectively online.

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
6.1 Information technology	No members of the Board can confidently use technology; Limited or no use of computers and other technology in day-to-day activity.	Some members of the Board can confidently use technology; Computers and technology seldom used in day-to-day activity.	Most members of the Board can confidently use technology; technology is sometimes used in day-to-day activity.	All members of the Board can confidently use technology; technology is often used in day-to-day activity.
6.2 Communications technology (capability for virtual / online meetings locally, regionally, nationally)	No members of the Board can confidently use communications technology.	Some members of the Board can confidently use communications technology.	Most members of the Board can confidently use communications technology.	All members of the Board can confidently use communications technology.

7. Understanding the anticipated Health New Zealand relationship

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
7.1 Clear understanding of the anticipated future relationship with Health NZ	The Board has no understanding of what its working relationship with the future Health NZ might look like from an IMPB perspective.	The Board has limited or variable understanding of what its working relationship with the future Health NZ might look like from an IMPB perspective.	The Board has a fairly clear understanding of what its working relationship with the future Health NZ might look like from an IMPB perspective. There are still many unanswered questions that the Board needs to know.	The Board has a clear understanding of what its working relationship with the future Health NZ might look like from an IMPB perspective. The Board is ready from a proactive standpoint to enter into that relationship and be clear on upholding its mana motuhake on behalf of whānau in its coverage area. This includes have a clear expectation of its Tiriti o Waitangi relationship with Health NZ as a Crown agent, and the aspirations of both settled and non-settled Iwi.

8. Understanding the anticipated Māori Health Authority relationship

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
8.1: Clear understanding of the anticipated future relationship with	The Board has no understanding of what its working relationship with the future Māori Health Authority	The Board has limited or variable understanding of what its working relationship with the future Māori Health	The Board has a fairly clear understanding of what its working relationship with the future Māori Health Authority might look like from an IMPB	The Board has a clear understanding of what its working relationship with the future Māori Health Authority might look like from an IMPB

Capacity elements	**Level one:** Unfamiliar	**Level two:** Comfortable	**Level three:** Confident	**Level four:** Capable
the Māori Health Authority	might look like from an IMPB perspective.	Authority might look like from an IMPB perspective.	perspective. There are still many unanswered questions that the Board needs to know.	perspective. The Board is ready from a proactive standpoint to enter into that relationship and be clear on upholding its mana motuhake on behalf of whānau in its coverage area. This includes have a clear expectation of its Tiriti o Waitangi relationship with Māori Health Authority as a Crown agent, and the aspirations of both settled and non-settled Iwi.

Hauora Māori Hopuāhua ki te Poari Hauora o Tai Poutini/West Coast DHB

Introduction

This snapshot provides a view of the health and wellbeing of Māori who live in the West Coast District Health Board in 2021 and provides information about the West Coast health system's responsiveness to Māori.

A range of data sources – preferably reported nationally and enabling reproducibility - have been used. The data sources are noted, along with any caveats.

The snapshot is organised into sections:

Te Taupori	Population
Mauri Ora	Wellbeing, Life Force
Whanau Ora	Life Stages
Hauora Whakautu	Health System Responsiveness [to be completed]
Pae Ora	Healthy Futures: Priorities [to be completed]

Contents

Te Taupori Population Overview

Population

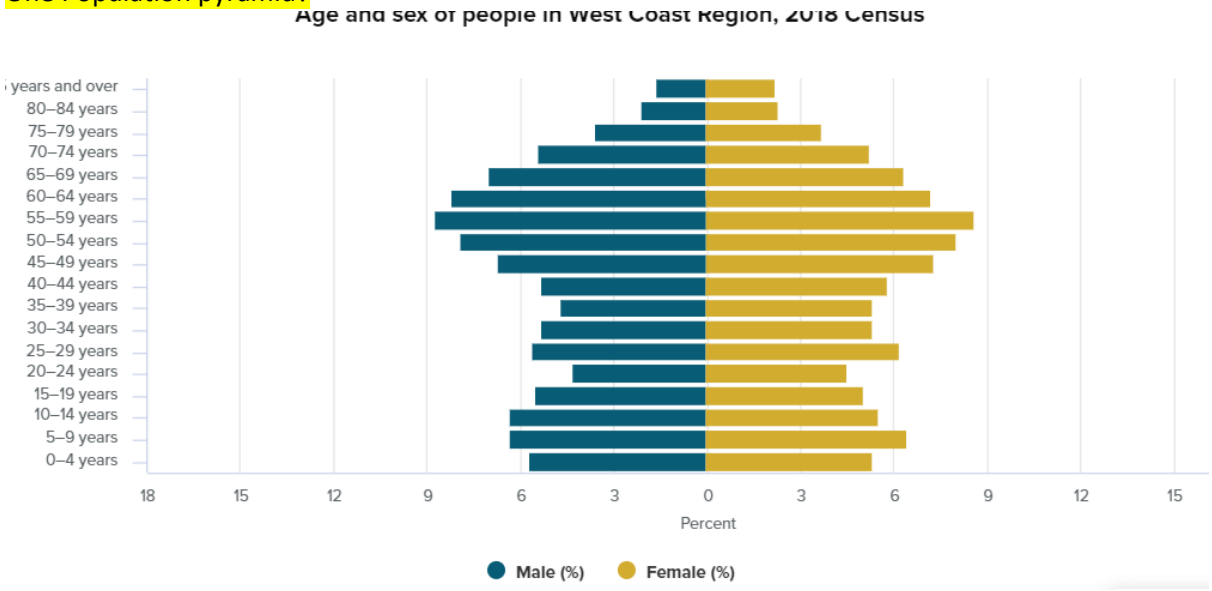
West Coast DHB's projected 2020/21 population is 32,550 people, 3,980 (12%) of whom identify as Māori[1][2].

The West Coast population has been static for a number of years with 21.8% of the population over 65 years. The Māori population is expected to grow by 0.8% by 2025.

The Māori population has a considerably younger age structure, with 10.3% aged under five, compared to 5.6% of the total population. The median age of the Maori population at the 2018 Census of 27.7 years compared to 45.7 years for the overall population[3].

West Coasters overall have a slightly a lower life expectancy (80.7 years) compared with the national average (81.4 years). Māori life expectancy is 77.6 years.

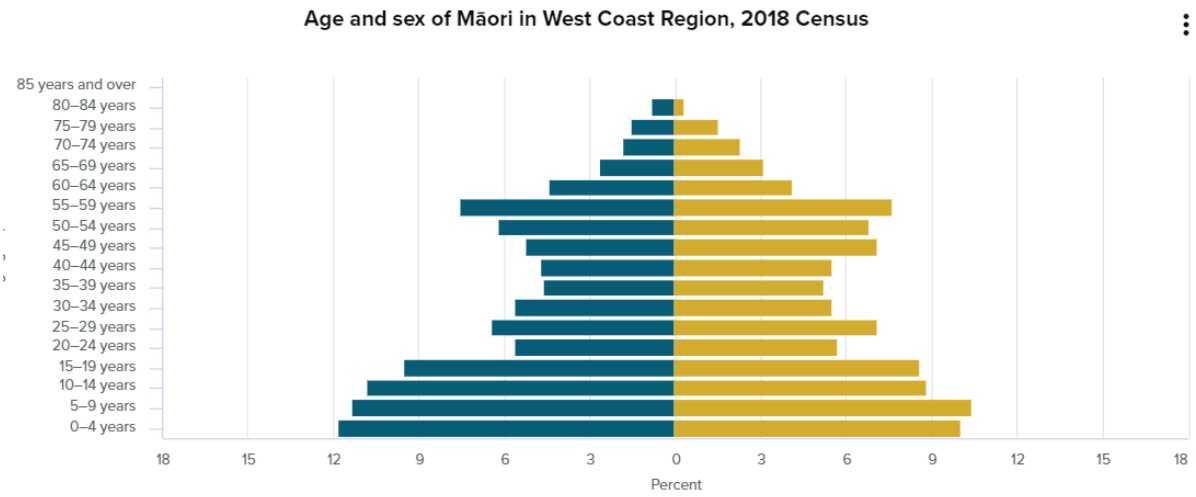
One Population pyramid?



[1] Māori population estimates: At 30 June 2020 | Stats NZ

[2] West Coast District Health Board Annual Plan - Incorporating the 2020/21 Statement of Performance Expectations (wcdhb.health.nz)

[3] Place Summaries | West Coast Region | Stats NZ



Each of West Coast's three Territorial Local Authorities [TLAs][4] has different population pyramids. Population distribution across the TLAs at the 2018 Census was:

TLA	Buller[5]	Grey[6]	Westland
Total Census 2018 Population	9,591	13,344	8,640
Total Census 2018 Māori population	1,077	1,365	1,425
Māori population %	11.25%	10.25%	16.5%

Search for "population buller" - Figure.NZ

Search for "population grey" - Figure.NZ

Search for "population westland" - Figure.NZ

Decile Distribution [NZDep Index[7]][8]

Most people, including Māori, on the West Coast live in the more deprived Quintiles 3 to 5.

[4] Territorial Local Authorities within the West Coast District Health Board area: Buller, Grey District, Westland

[5] Place Summaries | Buller District | Stats NZ

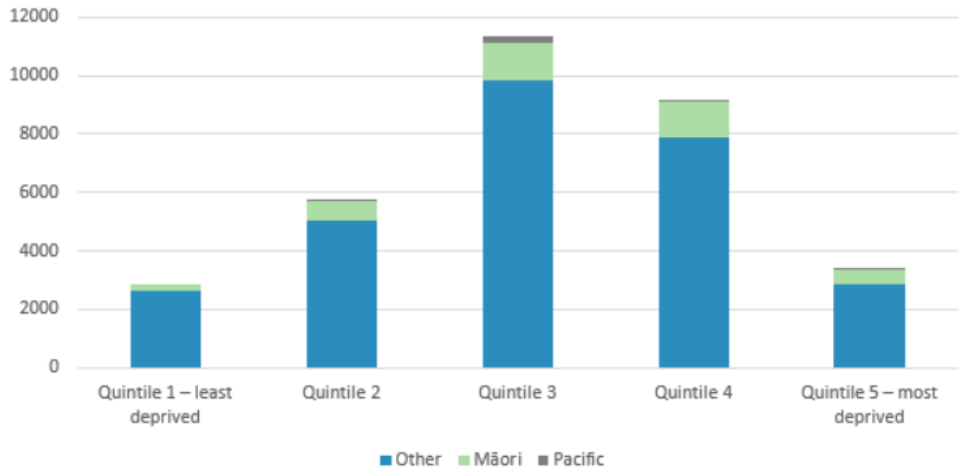
[6] Place Summaries | Grey District | Stats NZ

[7] Deprivation Index Socioeconomic Deprivation Indexes: NZDep and NZiDep, Health Inequalities Research Programme (HIRP), University of Otago, Wellington, University of Otago, New Zealand

[8] Population of West Coast DHB | Ministry of Health NZ

Deprivation, 2020/21

West Coast has proportionally more people in the middle sections of the population, and fewer in the most and least deprived sections.



Education[9]

Early Childhood Education

In West Coast there are similar participation rates in early childhood education across ethnicities, geographical areas and gender. Total population participation is 96.1%; Māori population participation is 96.1%.

Secondary School Achievement[10] [11] [12]

The percentage of Māori achieving NCEA Level 1 veers from year to year: 80.0% in 2018, 92.5% in 2019 and 72.5% in 2020, compared to 88.3%, 87.6% and 82.6% respectively for the total West Coast region population.

[9] Know your Region | Education Counts
[10] West Coast Region: NCEA level 1 | Education Counts
[11] West Coast Region: NCEA level 2 | Education Counts
[12] West Coast Region: Retention | Education Counts

School leavers with at least NCEA level 1 or equivalent by gender and ethnic group (2018-2020)

Group	Below NCEA level 1			NCEA level 1 or above			Percentage with NCEA level 1 or above		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Female	8	15	21	149	130	119	94.9	89.7	85.0
Male	28	21	36	123	124	152	81.5	85.5	80.9
Māori	12	4	21	48	49	55	80.0	92.5	72.4
Pacific	0	1	1	5	4	8	100.0	80.0	88.9
Asian	0	1	1	7	5	4	100.0	83.3	80.0
MELAA	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x
European/Pākehā	28	32	44	234	228	238	89.3	87.7	84.4
Region Total	36	36	57	272	254	271	88.3	87.6	82.6
New Zealand Total	6,355	7,030	7,003	54,682	52,973	53,326	89.6	88.3	88.4

The picture for NCEA Level 2 or above attainment shows Māori at 68.3% in 2018, 71.7% in 2019 and 61.8% in 2020, compared to the region total of 76.9%, 74.5% and 71.6% in the same years.

School leavers with at least NCEA level 2 or equivalent by gender and ethnic group (2018-2020)

Group	Below NCEA level 2			NCEA level 2 or above			Percentage with NCEA level 2 or above		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Female	22	28	32	135	117	108	86.0	80.7	77.1
Male	49	46	61	102	99	127	67.5	68.3	67.6
Māori	19	15	29	41	38	47	68.3	71.7	61.8
Pacific	1	2	3	4	3	6	80.0	60.0	66.7
Asian	0	1	1	7	5	4	100.0	83.3	80.0
MELAA	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x
European/Pākehā	61	69	77	201	191	205	76.7	73.5	72.7
Region Total	71	74	93	237	216	235	76.9	74.5	71.6
New Zealand Total	11,847	12,271	11,563	49,190	47,732	48,766	80.6	79.5	80.8

School leavers with at least NCEA level 3 or equivalent by gender and ethnic group (2018-2020)

Group	Below NCEA level 3			NCEA level 3 or above			Percentage with NCEA level 3 or above		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Female	77	62	64	80	83	76	51.0	57.2	54.3
Male	98	101	119	53	44	69	35.1	30.3	36.7
Māori	38	35	53	22	18	23	36.7	34.0	30.3
Pacific	3	2	4	2	3	5	40.0	60.0	55.6
Asian	0	1	1	7	5	4	100.0	83.3	80.0
MELAA	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x
European/Pākehā	147	148	154	115	112	128	43.9	43.1	45.4
Region Total	175	163	183	133	127	145	43.2	43.8	44.2
New Zealand Total	27,463	26,975	24,697	33,574	33,028	35,632	55.0	55.0	59.1

18-year-olds with a minimum of NCEA level 2 or equivalent, by the age they left school (2018)

Group	Left school at age 15		Left school at age 16		Left school at age 17		Left school a age 18 or abo	
	Level 2 or above	Percentage with Level 2 or above	Level 2 or above	Percentage with Level 2 or above	Level 2 or above	Percentage with Level 2 or above	Level 2 or above	Perce with 2 or a
Female	1	100.0	14	58.3	58	95.1	64	
Male	1	25.0	23	53.5	45	88.2	49	
Māori	1	100.0	7	41.2	17	85.0	19	
Pacific	0	-2.0	0	-2.0	3	100.0	3	
Asian	n	n	n	n	n	n	n	
MELAA	n	n	n	n	n	n	n	
Other	n	n	n	n	n	n	n	
European/Pākehā	2	40.0	35	60.3	87	93.5	97	
Total	2	40.0	37	55.2	103	92.0	113	

18-year-olds with a minimum of NCEA level 2 or equivalent (2016-2018)

Group	Below level 2			Level 2 or above			Percentage with level 2 or above		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Female	14	14	16	133	115	137	90.5	89.1	89.5
Male	32	42	33	125	129	118	79.6	75.4	78.1
Māori	15	15	15	45	52	44	75.0	77.6	74.6
Pacific	x	1	0	x	4	6	x	80.0	100.0
Asian	1	0	x	7	6	x	87.5	100.0	x
MELAA	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x
European/Pākehā	32	47	39	223	194	221	87.5	80.5	85.0
Total	46	56	49	258	244	255	84.9	81.3	83.9

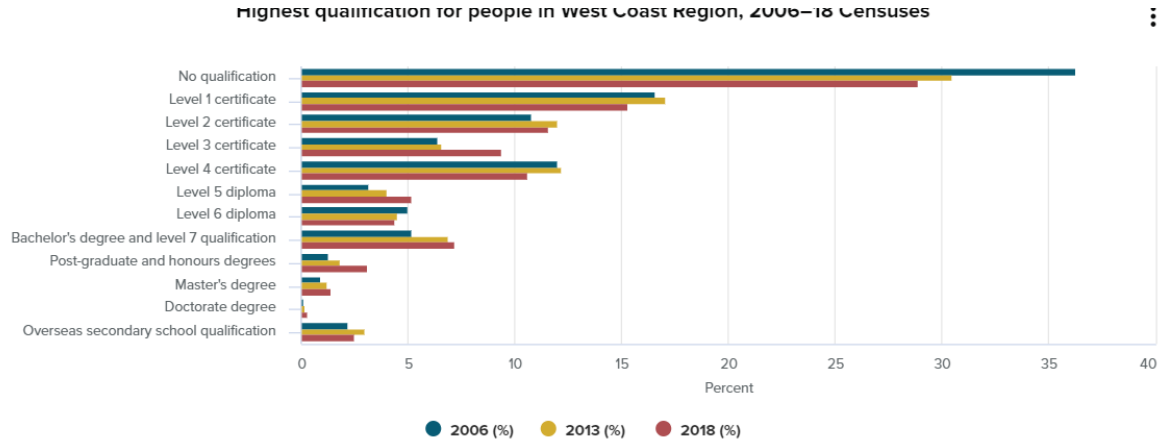
More Māori stayed at school until their 17th birthday each year from 2018 -2020: 69.6% in 2018, 70.2% in 2019 and 72.1% in 2020. The total region percentage was 84.3% in 2018, 83.9% in 2019 and 84.4% in 2020.

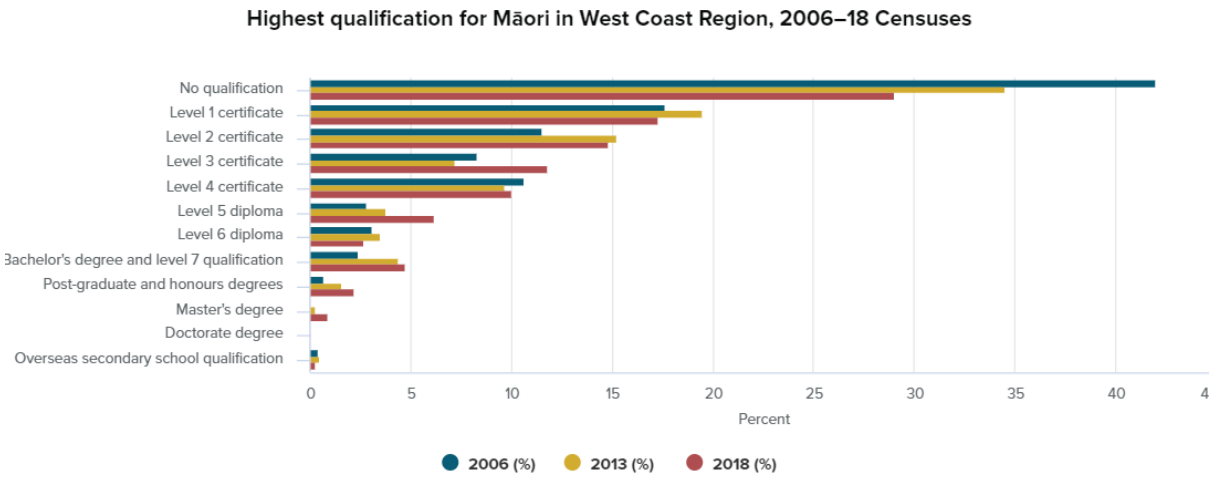
Percentage of school leavers staying at school until at least their 17th birthday (2018-2020)

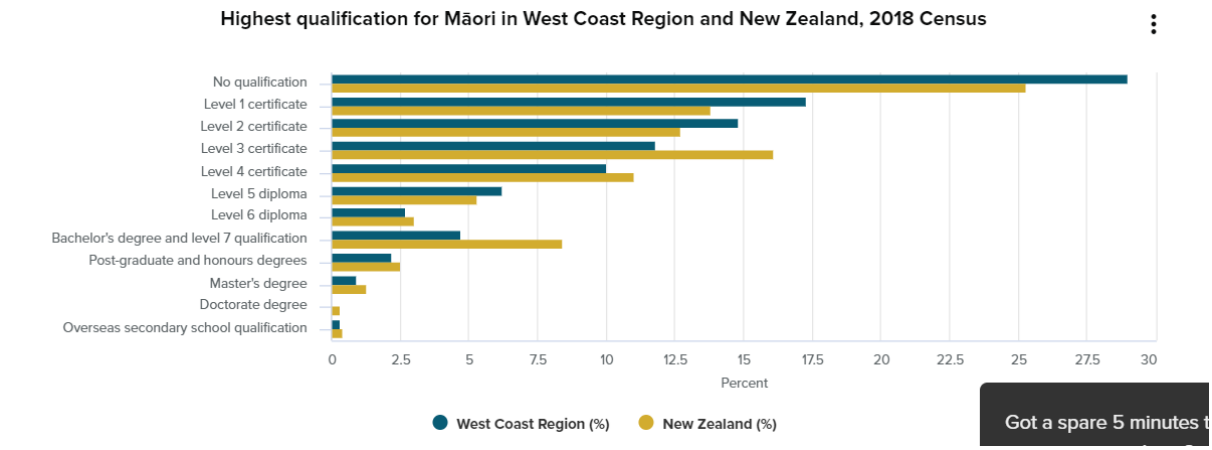
Group	Left before 17th birthday			Stayed until 17th birthday			Percentage staying until at least 17th birthday		
	2018	2019	2020	2018	2019	2020	2018	2019	2020
Female	409	421	404	3,031	3,078	3,018	88.1	88.0	88.2
Male	722	738	716	3,029	2,968	3,062	80.8	80.1	81.0
Māori	320	324	308	732	762	794	69.6	70.2	72.1
Pacific	74	79	73	273	309	310	78.7	79.6	80.9
Asian	28	36	27	595	657	660	95.5	94.8	96.1
MELAA	9	10	5	108	104	118	92.3	91.2	95.9
Other	3	4	7	17	18	23	85.0	81.8	76.7
European/Pākehā	861	879	876	4,896	4,804	4,817	85.0	84.5	84.6
Region Total	1,131	1,159	1,120	6,060	6,046	6,080	84.3	83.9	84.4
New Zealand Total	9,869	10,336	9,945	51,168	49,667	50,384	83.8	82.8	83.5

Highest Qualification

In 2006 approximately 42% of the Māori population aged 15 years and over had no qualification, but this had reduced to 29% by 2018 Census compared to 36% and 28% of the total population in the same period.







Employment

Employment is important for individual and community wellbeing and employment opportunities are built on educational attainment. Employment opportunities for young people, women and low/unskilled workers are particularly sensitive to external drivers like economic conditions. Māori have generally poorer labour market outcomes compared to the rest of New Zealanders.

Participation in the Labour Market[13][14]

The Ministry of Business Innovation & Employment [MBIE] publishes monthly labour market fact sheets but they do not have district or ethnicity breakdowns.

MBIE published a report of Maori trends *Māori in the labour market 2012–2017* that provided an overview of Māori labour market performance looking at both trends over time and comparisons with other ethnicities.

This is the most recent comprehensive report (although it doesn't have district data) as the Department of Statistics Household Labour Force Survey [HLFS] does not include ethnicity data. The HLFS identifies a current overall labour force participation rate in West Coast of 70.7% similar to rest of NZ [CHECK FOR MAORI]

[13] Monthly Labour Market Fact Sheet - April 2021 (mbie.govt.nz)

[14] Māori labour market trends | Ministry of Business, Innovation & Employment (mbie.govt.nz)

The MBIE report recorded 303,400 Māori employed in the labour market, a labour participation rate of 69.7%, the highest for Maori on record. The number of Māori employed in 2017 was 20.5% (or 51,600 workers) higher than in 2012. Particularly strong increases were observed for youth, older workers and women. Māori in employment represented 12.0% of total national employment. Māori were over-represented in the unemployed (28.1% or 36,800) and underutilised (79,000 or 23.5%) categories, with nearly a third of youth 'not in employment, education and training' (NEET).

Compared to the rest of the workforce:

- Māori workers, not unexpectedly given the population distribution, are younger. The 15-24 year olds represent a higher (21.0%) percentage of employed compared to New Zealand Europeans (14.5%).
- Māori have higher proportion of workers employed in lower-skilled occupations and in industries particularly vulnerable to changes in technology and economic cycles (e.g. manufacturing, wholesale and retail trade and construction).
- The Māori unemployment rate (10.8%) remains the highest and well above the national unemployment rate (4.9%). The Māori unemployment rate is particularly high for youth (20.4%) and women (12.0%) even though rates fell during this period, again being led by women and youth.
- The Māori workforce is shifting towards more skilled*occupations (from 39.0 in 2012 to 43.0% in 2017) as Māori employment in business services expand.

The Labour Market Trends report from MBIE to June 2020 does not have West Coast information. It has Canterbury and South Island excluding Canterbury.

Employment by region

Region	Jun-2020	Change Annual	Three-year
Northland	24,400	10.9%	28.4%
Auckland	66,100	7.8%	4.3%
Waikato	39,200	0.5%	1.3%
Bay of Plenty	36,400	2.0%	25.5%
Gisborne/Hawke's Bay	33,300	7.8%	9.5%
Taranaki/Manawatū-Whanganui	35,900	6.8%	5.5%
Wellington	33,700	14.2%	13.5%
Canterbury	23,900	1.3%	7.7%
South Island (excluding Canterbury)	26,800	4.6%	10.3%
South Auckland#	20,900	8.7%	11.2%
West Auckland#	13,400	13.5%	6.9%
Rest of Auckland~	31,800	4.2%	5.0%
Total Māori employment	**319,700**	**n/c**	**8.5%**
Total New Zealand employment	**2,654,000**	**1.2%**	**5.8%**

Māori representation in skilled occupations has increased

Māori in skilled occupations totalled 174,800 in June 2020, an increase of 10,300 workers (up 6.3 per cent) from a year ago.

Over the year to June 2020, employment in most occupation groups increased. The biggest increases in employment were for Professionals (up 11.3 per cent or 5,900 workers), Managers (up 11.6 per cent or 5,200 workers), and Technicians & trades (up 1.3 per cent or 400 workers). These groups made up most of the total increase in Māori employment for June 2020. In contrast, the biggest falls in employment were for Clerks (down 14.7 per cent or 5,100 workers), and Labourers (down 3.9 per cent or 2,100 workers).

Just over half (54.7 per cent) of Māori employed in New Zealand were in skilled occupations, compared to 66.9 per cent of all workers nationally. A greater proportion of Māori (16.9 per cent) were in low-skilled occupations compared to all workers (11.7 per cent).

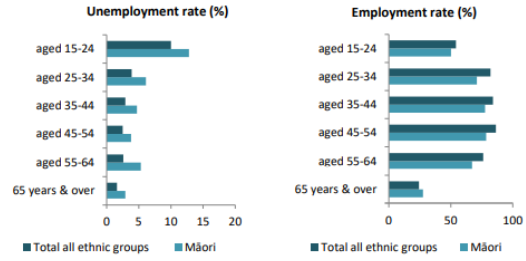
Unemployment and employment rates by age groups

Unemployed people as a proportion of the labour force

The unemployment rate for Māori (6.7 per cent) was higher than for the total of all ethnic groups (3.9 per cent), with the biggest difference for Māori aged 15 to 24 years (2.8pp above the national average of 10.0 per cent for that age group).

Employment as a proportion of the working age population

The employment rate for Māori (62.3 per cent) was lower than for the total of all ethnic groups (66.6 per cent). The employment rate was lower for most age groups, except for people aged 65 years and over. The biggest difference in the employment rate was for Māori aged 25-34 years (11.0pp below the national rate of 82.0 per cent for that age group).



Youth NEET rate

The proportion of young people who are Not in Education, Employment or Training (NEET) is used as an indicator of youth disengagement.

As at June 2020, there were about 136,400 Māori aged 15 to 24 years, an increase of 7,300 people (contributing to the increase of 8,700 young people who are not in the labour force). Of these, about 24,200 were NEET, higher than a year ago (21,200 people). Among Māori aged 15-24 years, 16.6 per cent of males and 19.0 per cent of females were NEET in June 2020.

The NEET rate of 17.8 per cent for Maori aged 15 to 24 years increased by 1.4pp over the year, but fell by 1.7pp over the past three years to June 2020. Over the year, the NEET rate grew the most for females by 1.6pp to 19.0 per cent, while the NEET rate for males grew by 1.2pp to 16.6 per cent. The NEET rate for all ethnic groups was up 2.0pp from last year to 11.6 per cent.

The NEET rate for Māori aged 15-19 years rose by 0.7pp to 13.4 per cent in the year to June 2020. The rate for Māori aged 20-24 years rose by 2.2ppp to 22.8 per cent in the year to June 2020. Overall, Māori have higher NEET rates than other ethnic groups, except for Pacific Peoples.

Youth unemployment rate*

The proportion of young Māori aged 15 to 24 years who are unemployed as a percentage of the labour force

There are around 10,000 young Māori who are officially unemployed.

In the year to June 2020, the youth unemployment rate for Māori (12.8 per cent) was higher than other ethnic groups, except for Pacific Peoples. However, the youth unemployment rate for Māori fell by 2.7pp over the year to June 2020 and by 11.1pp over the last three years.

**Unemployed young people are people aged 15 to 24 years who during the reference week, were without a paid job and had either actively sought work in the past four weeks ending with the reference week, or had a new job to start within the next four weeks.*

Unemployment[15][16][17][18]

In the year to the December 2017 quarter, Statistics NZ reported the unemployment rate for Māori fell to a nine-year low, at the same time as 19,000 more Māori, especially rangatahi (young people), moved into work, Stats NZ said today.

The unemployment rate for Māori fell to 9.0 percent, compared with 11.9 percent a year ago. This is the lowest Māori unemployment rate since the December 2008 quarter; however, unemployment for Maori is double the national rate.

In the December 2017 year, the number of Māori unemployed fell 8,600 (down 21.4 percent). Fewer Māori men were unemployed (down 6,300), while the number of unemployed Māori women also

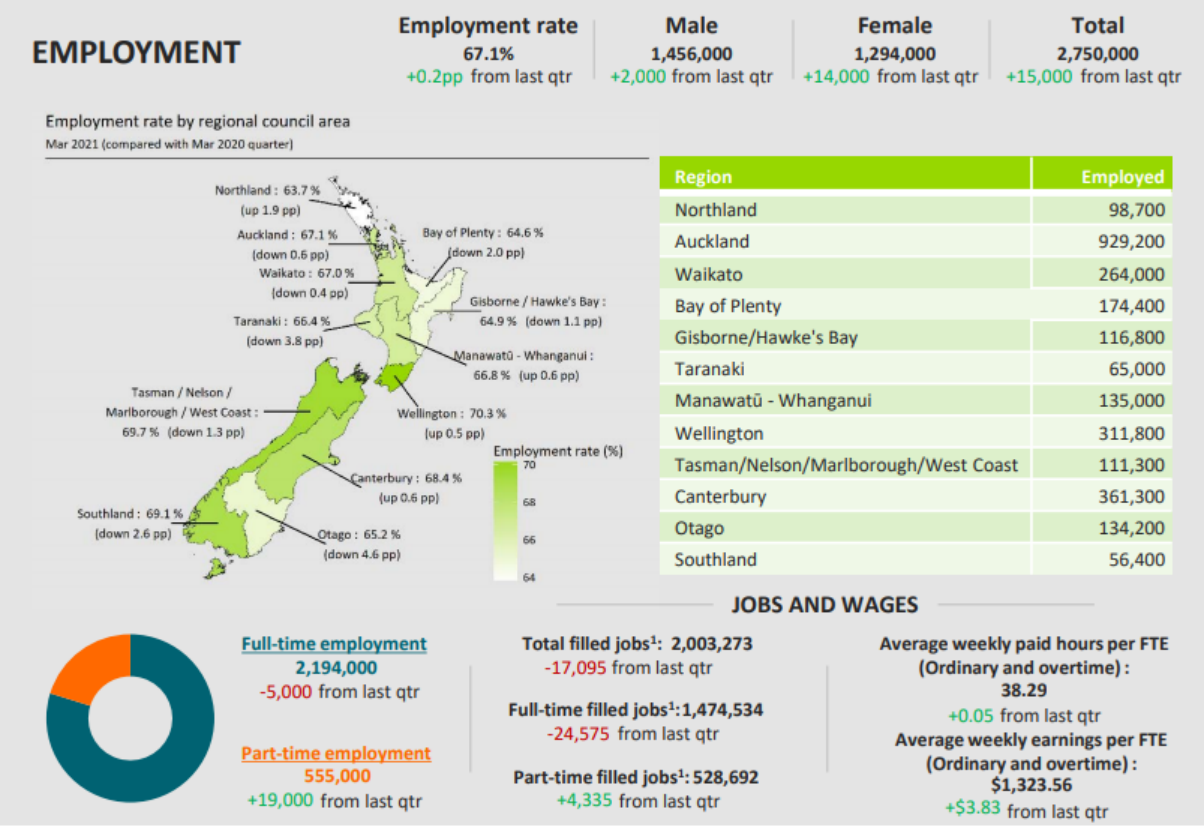
[15] Māori unemployment rate at nine-year low, but twice New Zealand rate | Stats NZ
[16] Unemployment rate | Stats NZ
[17] https://ecoprofile.infometrics.co.nz/West Coast Region/Employment/Unemployment
[18] Labour market statistics snapshot – March 2021 (mbie.govt.nz)

dropped (down 2,300). The decrease in unemployed Māori was mainly from those aged 20–29 years, which contributed two-thirds of the decrease.

The underutilisation rate for Māori fell to 21.6 percent, from 23.1 percent a year ago. By comparison, the underutilisation rate for New Zealand overall is 12.1 percent.

In 2018 the West Coast unemployment rate was 3.2% [Stats NZ Census place summaries]; 47.4% of Maori 15-64 were employed full time; 19.4% employed part time, 5% unemployed and 29.5% not in the labour force.

In 2021 the NZ seasonally adjusted unemployment rate is 4.7%. The Marlborough Tasman West Coast region rate is 3.5% overall with the Māori rate 6.2% (NB there is no separate West Coast data). The employment rate is 69.7% (the highest in NZ) and the under-utilisation rate is 12.2%. The West Coast NEET rate is 14.5% cf NZ 15.25%. CHECK and insert extra section from later version + benefit section

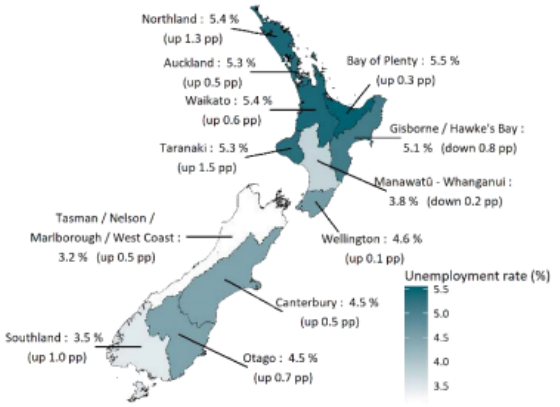


UNEMPLOYMENT

Unemployment rate	Male	Female	Total
4.7%	71,000	64,000	135,000
-0.2pp from last qtr	+3,000 from last qtr	-8,000 from last qtr	-5,000 from last qtr

Unemployment rate by regional council area

Mar 2021 (compared with Mar 2020 quarter)



Region	Unemployed
Northland	5,600
Auckland	52,200
Waikato	15,000
Bay of Plenty	10,100
Gisborne/Hawke's Bay	6,300
Taranaki	3,600
Manawatū - Whanganui	5,300
Wellington	14,900
Tasman/Nelson/Marlborough/West Coast	3,700
Canterbury	17,000
Otago	6,300
Southland	2,000

UNDERUTILISATION

Total underutilisation rate: 12.2%
+0.4pp from last qtr

Male underutilisation rate: 10.1%
+0.4pp from last qtr

Female underutilisation rate: 14.7%
+0.4pp from last qtr

Persons unemployed
135,000
-5,000 from last qtr

Persons underemployed
124,000
+8,000 from last qtr

Not in labour force: avaliable potential jobseekers
85,700
+11,000 from last qtr

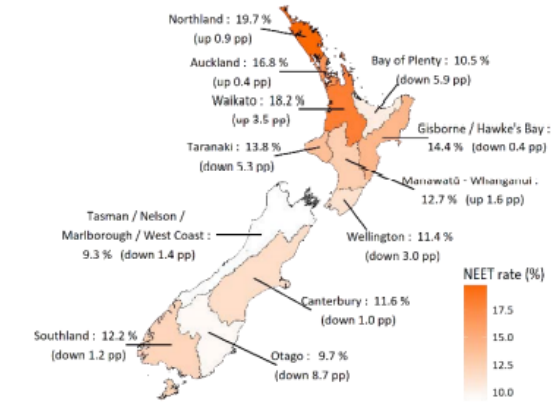
Not in labour force: Unavaliable jobseekers
21,000
+1,000 from last qtr

NOT IN EDUCATION, EMPLOYMENT OR TRANING (Aged 15-24 years)

NEET rate	Male	Female	Total
13.1%	42,000	43,000	85,000
+0.7pp from last qtr	+2,000 from last qtr	+2,000 from last qtr	+4,000 from last qtr

NEET rate by regional council area

Mar 2021 (compared with Mar 2020 quarter)



Region	NEET total
Northland	3,600
Auckland	39,200
Waikato	11,700
Bay of Plenty	3,900
Gisborne/Hawke's Bay	3,900
Taranaki	1,800
Manawatū - Whanganui	4,500
Wellington	8,000
Tasman/Nelson/Marlborough/West Coast	1,900
Canterbury	9,600
Otago	3,400
Southland	1,800

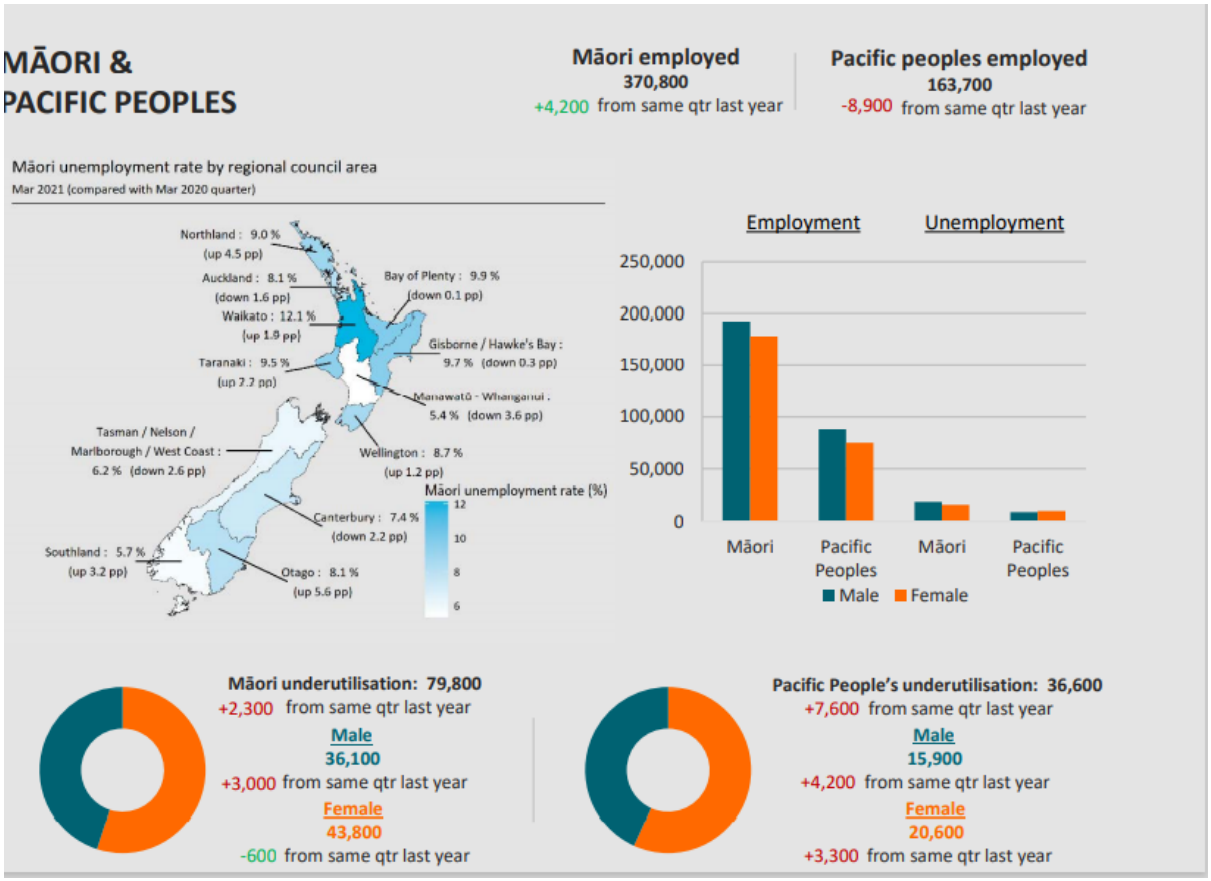
Male NEET rate: 12.5%
+0.7pp from last qtr

Female NEET rate: 13.8%
+0.7pp from last qtr

Not in the labour force not in education – no caregiving: 39,000
+3,000 from last qtr

Unemployed, not in education: 32,000
+1,000 from last qtr

Not in the labour force not in education – caregiving: 15,000
No change from last qtr



Income Disparity[19]

The mean NZ household income in NZ was $114,062. The West Coast mean was $91,180. There were differences between the 3 TLAs.

Buller	Grey	Westland
$77,227	$90,598	$108.839

Housing[20]

Housing is an important determinant of health and wellbeing. The key issues are affordability, availability and quality.

Census 2018 data identified that 60.5% of West Coast's households lived in owned or partly owned occupied dwellings [n=12,021 higher than for NZ 51.3% with 7.7% held in a family trust (cf 13.3% NZ).

The median rent in 2018 was $200 (same as 2013 Census), cf NZ $360. 37.7% of renters were paying $200-299 per week.

In April 2021, it was reported that the number of Airbnbs on the West Coast had doubled in the past three years, from 452 to 861, according to the team drafting rules for the new Te Tai o Poutini

[19] https://ecoprofile.infometrics.co.nz/West Coast Region/StandardOfLiving/Household_Income

[20] Place Summaries | West Coast Region | Stats NZ

combined district plan[21]. Of those, 629 are entire home rentals, with the largest numbers at Franz Josef, Hokitika, Punakaiki and Westport.

In 2021[22] the average asking price for a home on the West Coast was $325, 341, down 4.8% up 26% in stock (Real Estate Institute)

In the 2018 Census, 23.1% of dwellings were sometimes or always damp (cf NZ 21.5%), with 15.2% having mould all or some of the time (cf NZ 16.9%).

Environment

Alcohol Licence Density[23] CHECK WITH CPH WHETHER THIS STILL THE POSITION -noting information from Annual Plan which says less hazardous

A report to the Grey District Council from the Medical Officer of Health in 2013 stated that: *Overall, the West Coast has a disproportionately high number of alcohol outlets per head of population relative to the rest of New Zealand with just over 60% as many on and off licenses and approximately 50% more club licences. The proportion of alcohol outlets by head of population also differs by district with the highest proportion being in the Westland District and the lowest in the Grey District, though the Grey District's proportion is still just under twice the New Zealand average. All three districts of the West Coast have higher rates of alcohol-related deaths than the national rate with the Grey District's rate being the second highest for the Coast after Westland and twice the national rate. The West Coast also has higher rates of alcoholrelated hospitalisation than the national rate and again, the Grey District's rate is the second highest after Buller. West Coast young people aged 15-24 have almost two and half times the rate of alcohol-related hospitalisation of New Zealand as a whole and Canterbury. The West Coast overall has higher than the New Zealand average rate of alcohol-involved road traffic crashes (11.6 vs 7.8/10,000 population). The rates vary between the districts with the Grey District having the highest rate (13/10,000), followed by Westland and Buller. Ambulance data on alcohol-related harm on the West Coast have only recently become available but the trends observed so far are broadly consistent with national data, including: higher numbers of males than females, highest numbers of cases in age 15-19 and 20-24 age groups. However, despite the above, there are high levels of alcohol involvement across 4 a wider range of age groups (15-19, 20-24, 25-29, 30-34, 35-39 and 49-44) and high levels of alcohol involvement by location in houses, on the road and in public places. West Coast health professionals report that they deal frequently with a wide range of health impacts from alcohol ranging from acute intoxication and its effects on behaviour to its chronic effects on mental and physical health across the age range. Several observe that these effects are widespread and pervasive and create a significant burden on local health services, families and whānau and the wider community. West Coasters have higher rates of hazardous drinking than the national rate. The West Coast Community Alcohol survey found that, in common with New Zealand as a whole, the majority of West Coasters (85%) drink alcohol. Significant proportions also reported risky drinking behaviours like binge drinking, heavy drinking and frequent drinking. All these behaviours increase the*

[21] Te Tai o Poutini Plan | West Coast District Plan (ttpp.nz) ather than each of the three West Coast District Councils preparing individual plans, Te Tai o Poutini Plan Committee is now responsible for preparing and approving a new combined district plan covering the whole of the West Coast. Te Tai o Poutini Plan Committee is a joint committee comprising: Buller District Council, Grey District Council, Westland District Council, West Coast Regional Council, Te Rūnanga o Ngāti Waewae, Te Rūnanga o Makaawhio. The draft plan is due in January 2022 with the expectation it will be notified in July 2022.

[22] Houses have never been more expensive in most parts of New Zealand, new figures show | Newshub

[23] The Health Impacts of Alcohol in the Grey District and the West Coast (cph.co.nz)

risk of adverse health impacts significantly. At least one in five West Coasters exceeded the safe limits for drinking in the last year and met the criteria for binge drinking. Males were significantly more likely to report drinking 13 or more alcoholic drinks on one occasion compared to females (18% vs 7%, p<0.01).

Alcohol is estimated to contribute to 800 deaths a year in New Zealand, of which nearly half are injuries, almost one third are from cancer and over a quarter are from other diseases.16 In 2012 in New Zealand, alcohol was a factor in motor vehicle crashes that resulted in 93 deaths, 454 serious injuries and 1,331 minor injuries.

Nationally, one in four (25%) patients who present to Emergency Departments (ED) do so as a result of the harmful use of alcohol.

Alcohol has been identified as a driver of inequalities. An example of this is alcohol outlets, which are more heavily concentrated in socially deprived areas. People living in these areas are more likely to have harmful drinking patterns and to suffer alcohol-related harms. In New Zealand, there are different patterns of drinking according to social deprivation. For example, those who live in less deprived areas tend to drink more frequently. However, they are less likely to drink enough to feel drunk. By comparison, people who live in more deprived areas drink less frequently, but are nearly twice as likely to get drunk when they drink. That is, "people living in the most deprived areas drink alcohol less frequently but become intoxicated more often". Similarly, more alcohol-related harm is reported in the most deprived areas of New Zealand.

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Mauri Ora Wellbeing

NZ Health Survey[24]

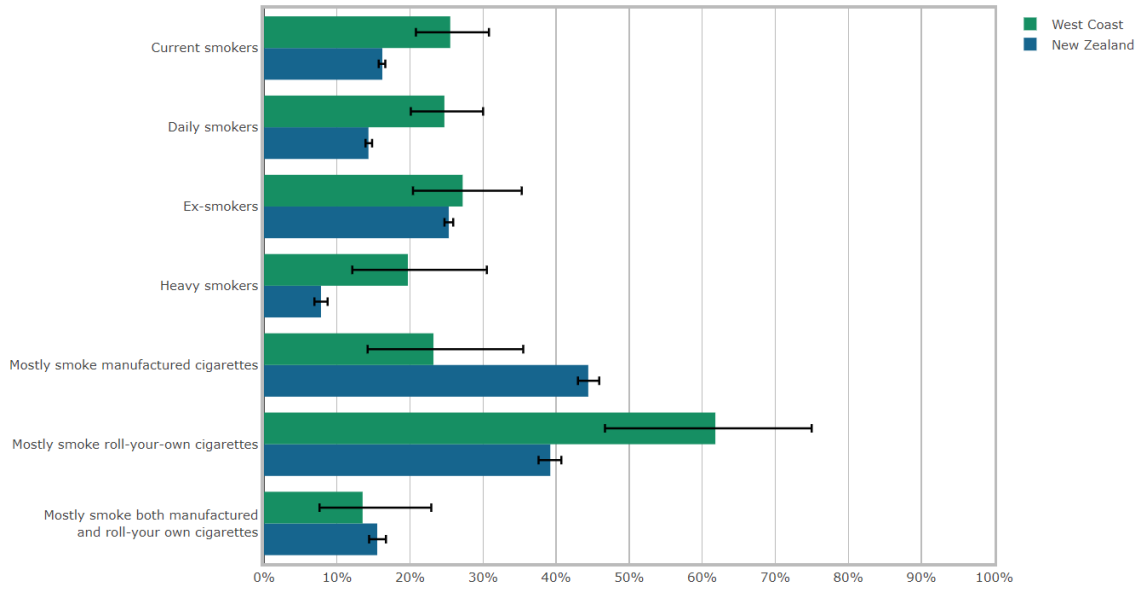
The New Zealand Health Survey (NZHS) has been in continuous operation since July 2011. Key health indicators have been compiled using annual NZHS data. A pooled West Coast dataset is available for 2014-17. The latest results for the past 3 years are due in June 2021.

The most recent combined results from the New Zealand Health Survey (2014-2017) found that:

26% of the population are current smokers, much higher than the national average of 16.2%. Smoking rates amongst Māori are higher at 44%.

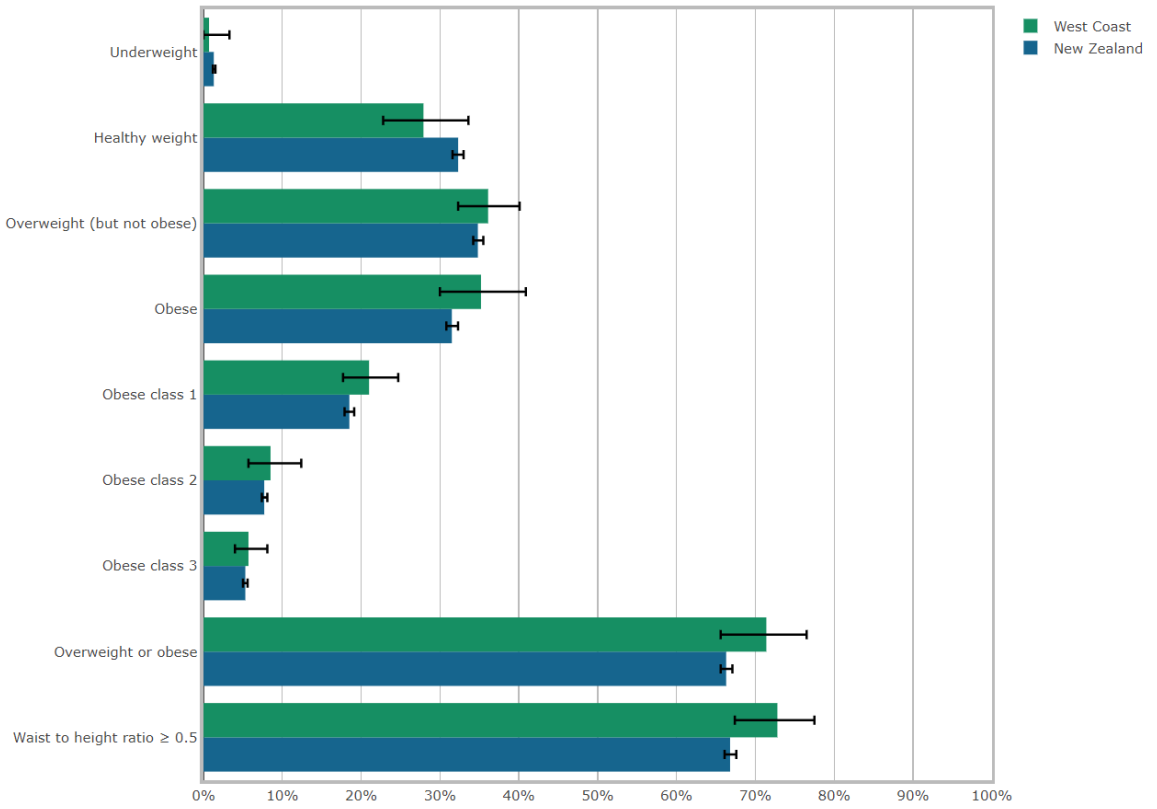
Prevalence for indicators in selected topic

This chart gives the prevalence, or percentage, in the specified population. Hover over an area to find out more about it.

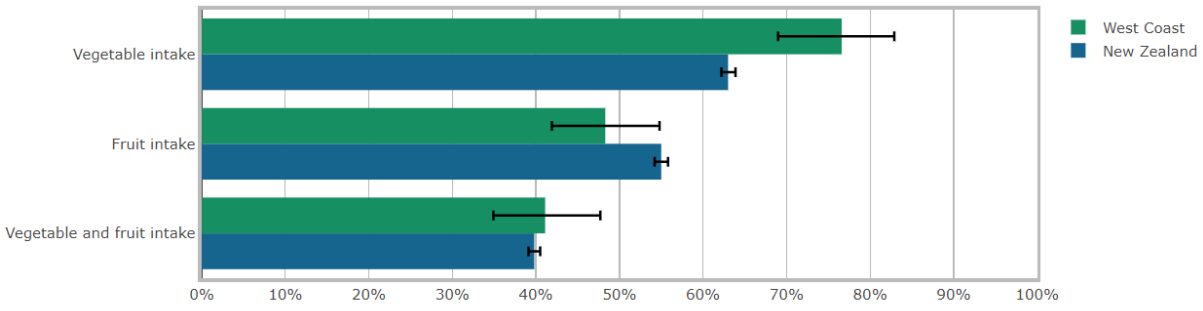


More than a third (35%) of the total adult population are classified as obese. Rates for Māori population are higher at 56%.

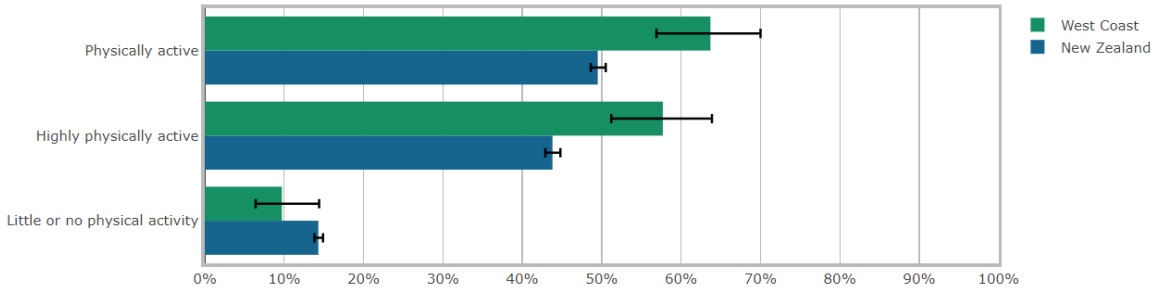
[24] https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_360fae8e/#!/home



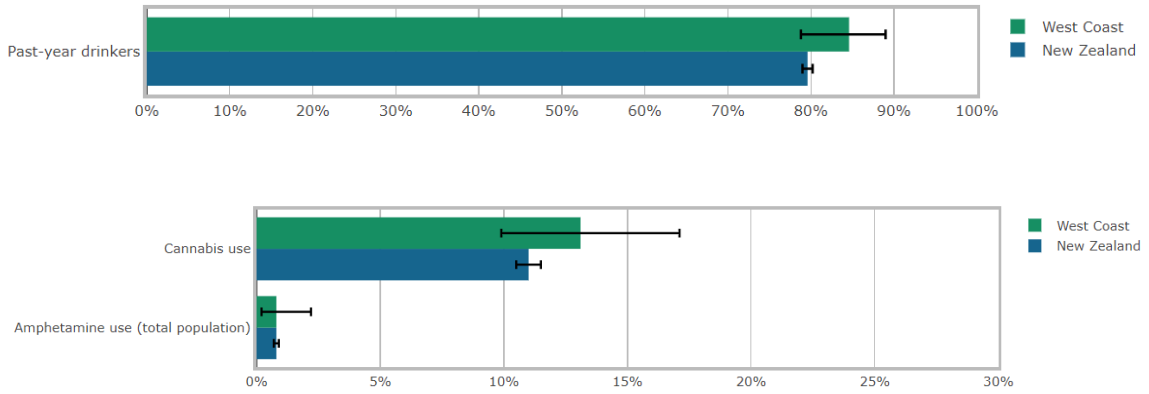
Fruit and vegetable intake is similar to the national average (41.1% vs 39.8%) however Māori rates were lower at 30.8%.



10% of the total adult population were identified as inactive (little or no physical activity). Rates for Māori were slightly higher at 13%.



16% of the adult population are likely to drink in a hazardous manner. While this rate is lower than the national average, it reflects hazardous drinking habits for one in every eight adults on the Coast.



Current smoking

Almost all cigarette smoking begins before 18 years of age (on average, by 15 years of age in New Zealand). Smoking causes more loss of health in New Zealand than any other risk factor and up to two-thirds of regular smokers will die as a direct result of their smoking. Smoking contributes to six of the eight leading causes of death: ischaemic heart disease, cerebrovascular disease, lower respiratory infections, chronic obstructive pulmonary disease, tuberculosis, and lung cancer.

In West Coast, Māori smoking rates have been lowering. However, current and past smoking prevalence will continue to contribute to Māori health inequalities for a long time yet.

Year 10 Smoking and Vaping[25]

The proportion of Year 10 students (aged 14 or 15 years) in West Coast who smoke every day has XXX (XXX% for West Coast and 2.1% for New Zealand in 2019). However, there is a possible upswing in youth smoking in New Zealand.

The proportion of Year 10 students (aged 14 or 15 years) in West Coast who vape every day has XXXX from XXX percent in 2015 to XXXX in 2019.

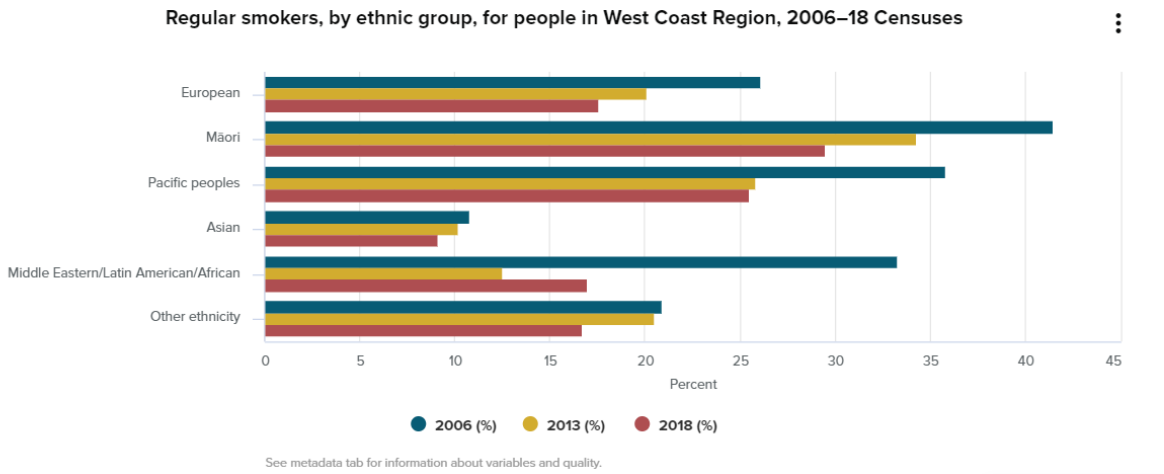
Further data points are required to ascertain any ongoing patterns or trends in youth smoking and vaping in New Zealand.

Adults[26]

Census 2018 identified 18.1% of West Coast's adult population as regular cigarette smokers with the adult Maori smoking rate at 29.5% (a marked decrease from the 2006 Census when 41.5% of the Maori adult population identified themselves as smokers).

Note also Health Promotion Agency material – but not specific to West Coast

[25] ASH Year 10 Archive Action for Smokefree 2025 PowerPoint Presentation (d3n8a8pro7vhmx.cloudfront.net)
[26] Place Summaries | West Coast Region | Stats NZ



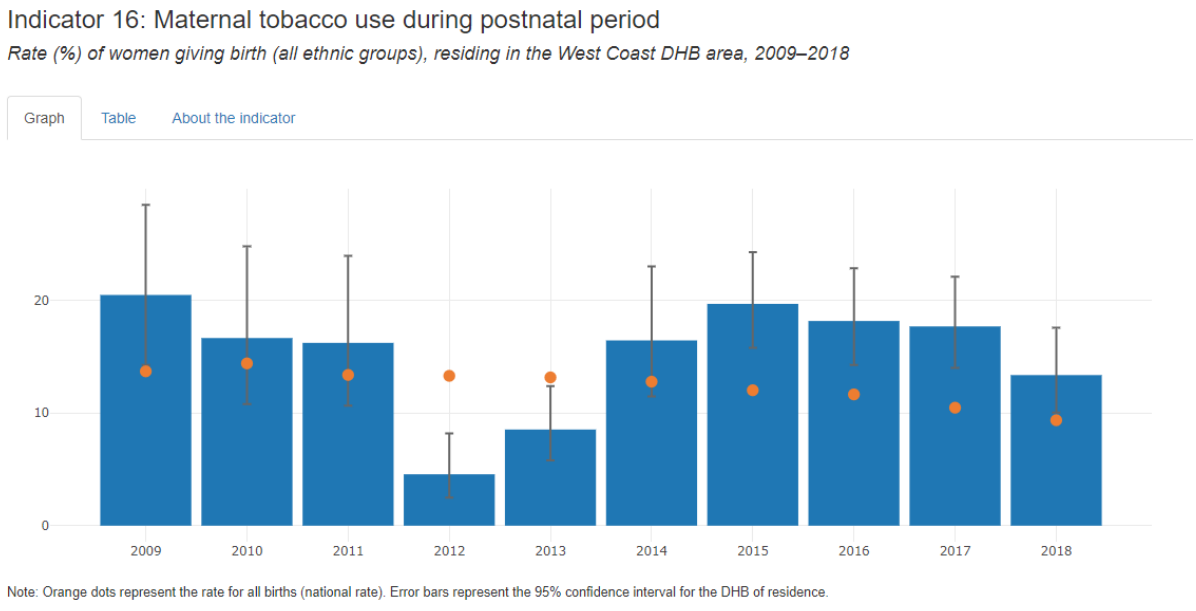
Pregnant Women

14% of West Coast women were smoking at time of registration with their LMC [WCDHB Maternity report]

xx per cent (xx%) of Māori pregnant women identified as current smokers when they registered with a lead maternity carer in West Coast in 2019, compared to xx% in 2014. This smoking rate is still more than double the rate in the total population.

Maternal Tobacco Use during Post-Natal period[27]

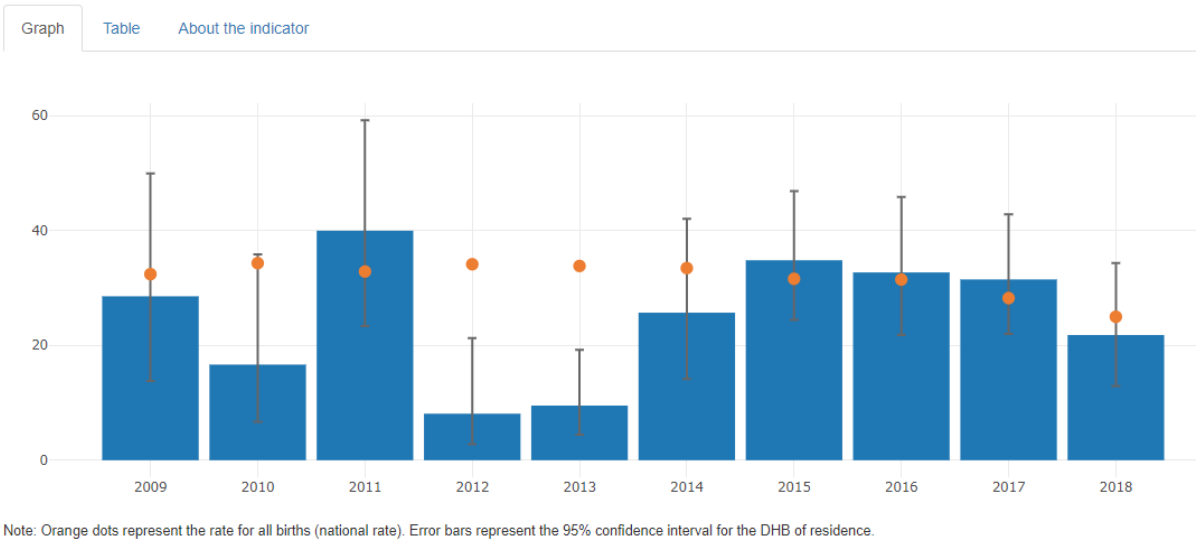
Quality indicator 16 in the Ministry of Health Maternity Quality Indicator Trends series measures maternal use of tobacco at 2 weeks after birth.



[27] Maternity CI (shinyapps.io)

Indicator 16: Maternal tobacco use during postnatal period

Rate (%) of women giving birth in the Maori ethnic group, residing in the West Coast DHB area, 2009–2018



Overall, from 2009-2018 postnatal smoking decreased from 20.5% to 13.4% for all women and from 28.6% to 21.8% Māori women in this cohort.

This smoking rate is significantly lower however than the rate of smoking at registration with a lead maternity carer. CHECK THINK THIS CANTERBURY ONLY

Obesity

More than a third (35%) of the total adult population are classified as obese. Rates for Māori population are higher at 56%.

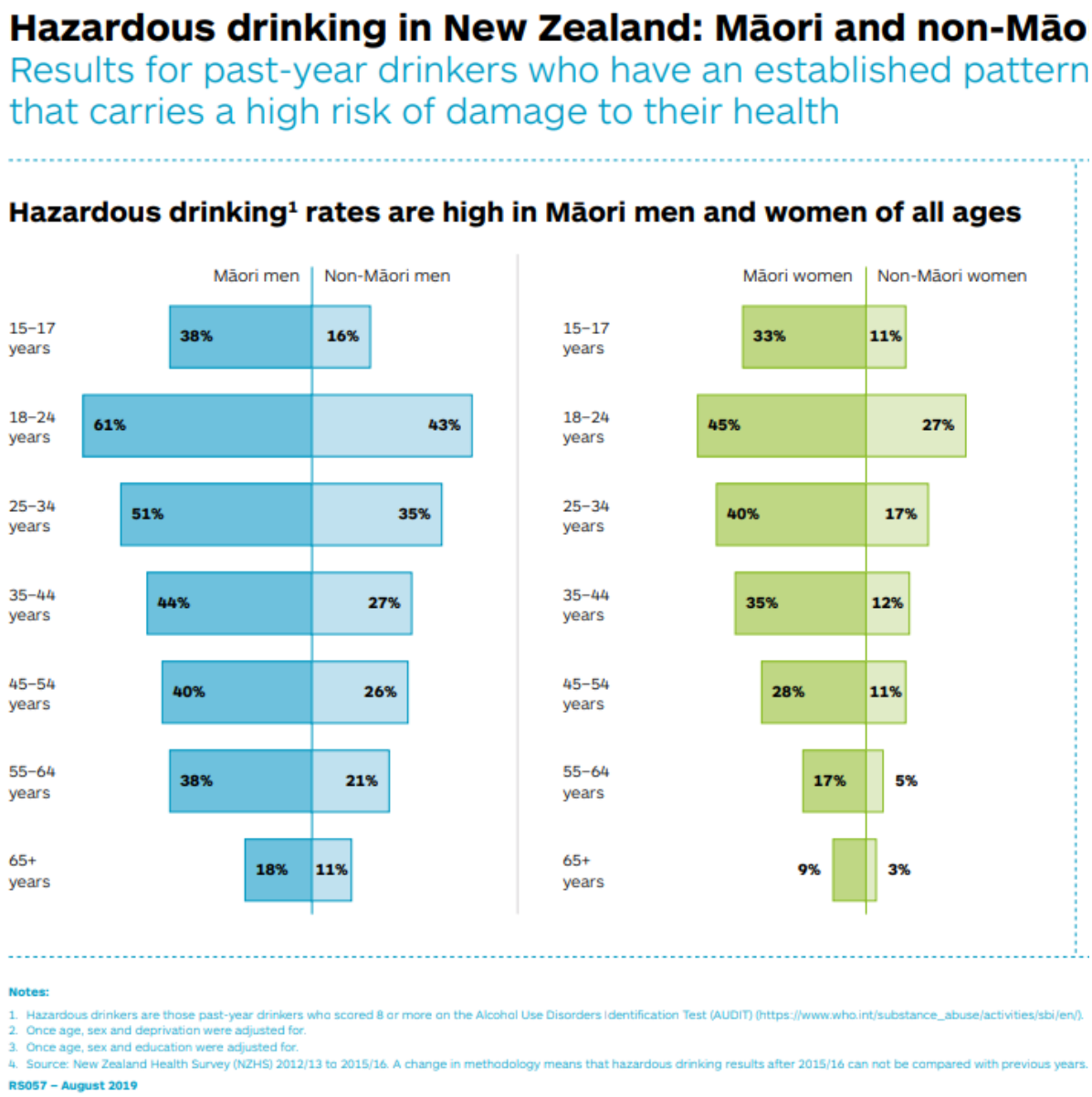
Hazardous drinking[28][29]

Alcohol is the most commonly used recreational drug in New Zealand, and approximately one-in-five people over the age of 15 drink alcohol at levels that may be considered hazardous. Alcohol is causally related to over 60 different health conditions and for almost all of these conditions, heavier alcohol use means higher risk of disease or injury. It is estimated that between 600 and 1,000 people die from alcohol-related causes each year in New Zealand.

There are no specific figures for West Coast since the 2013 report. The Health Promotion Agency 2019 factsheet shows Māori/non-Māori hazardous drinking figures by age bands.

[28] Hazardous drinking - West Coast Wellbeing Index

[29] Hazardous-drinking-Maori-non-Maori-factsheet.pdf, Health Promotion Agency

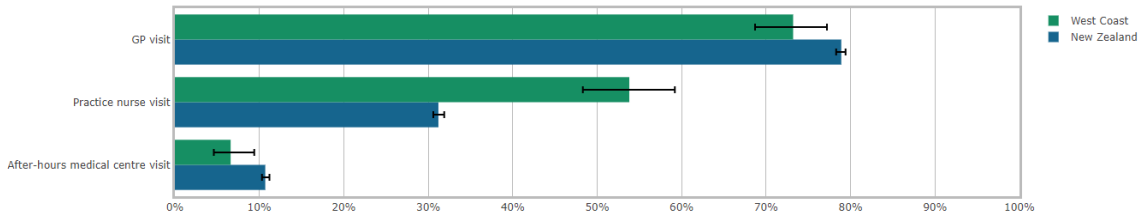


Unmet need for primary care[30]

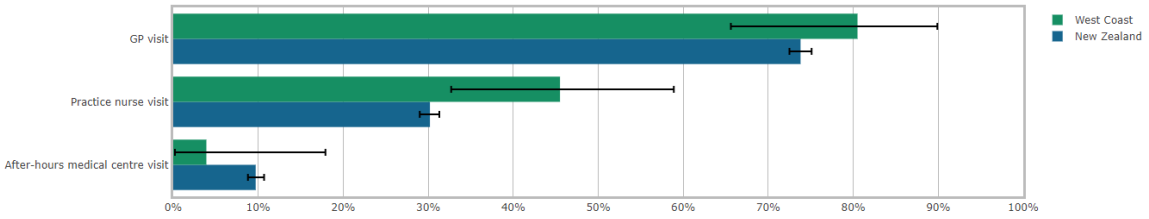
- XX% of the total population identified unmet need for primary care compared to XX% of Māori respondents
- Adult respondents in the most deprived areas had statistically significant higher rates of unmet need for primary care

All West Coast

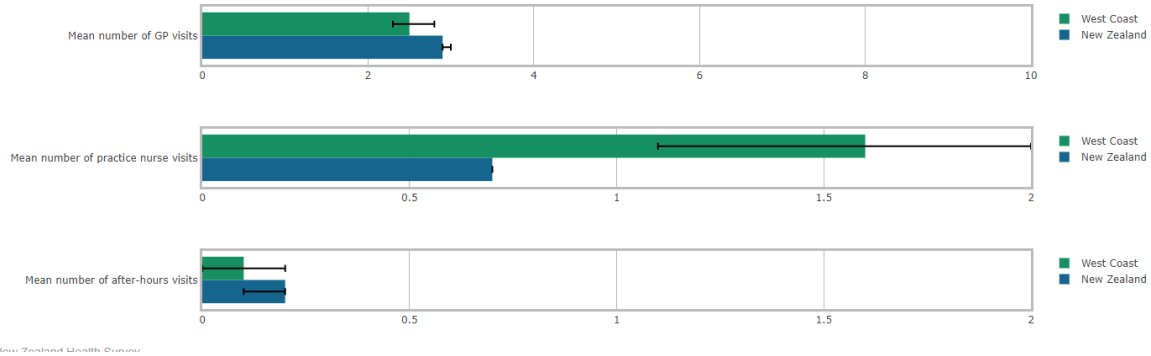
[30] https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_ea7e7c71/#!/compare-indicators



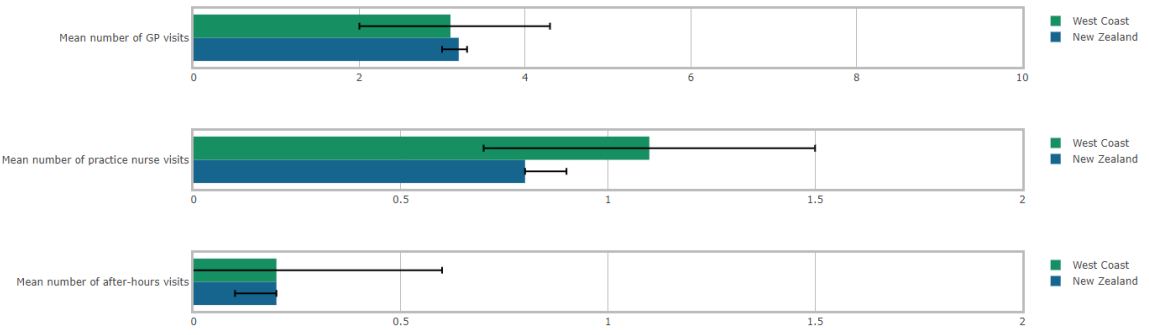
Maori West Coast



All West Coast

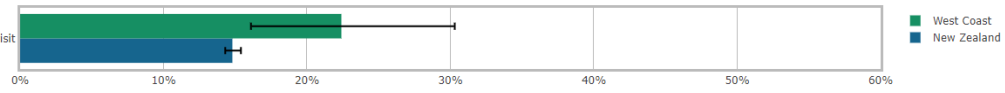


Maori West Coast

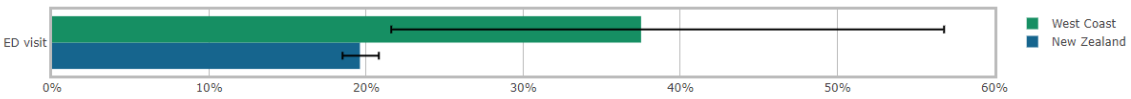


ED Visit use

All West Coast

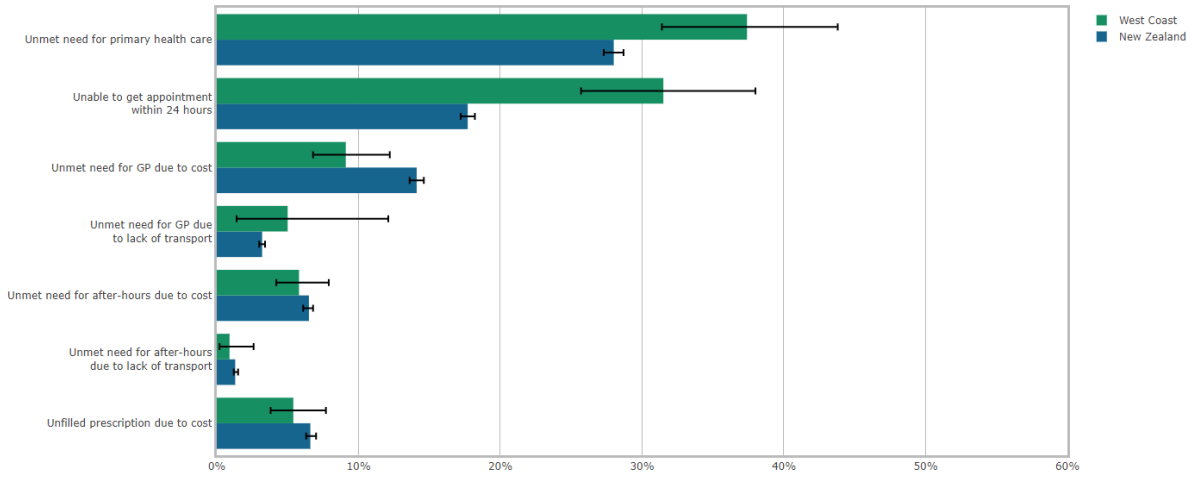


Maori West Coast

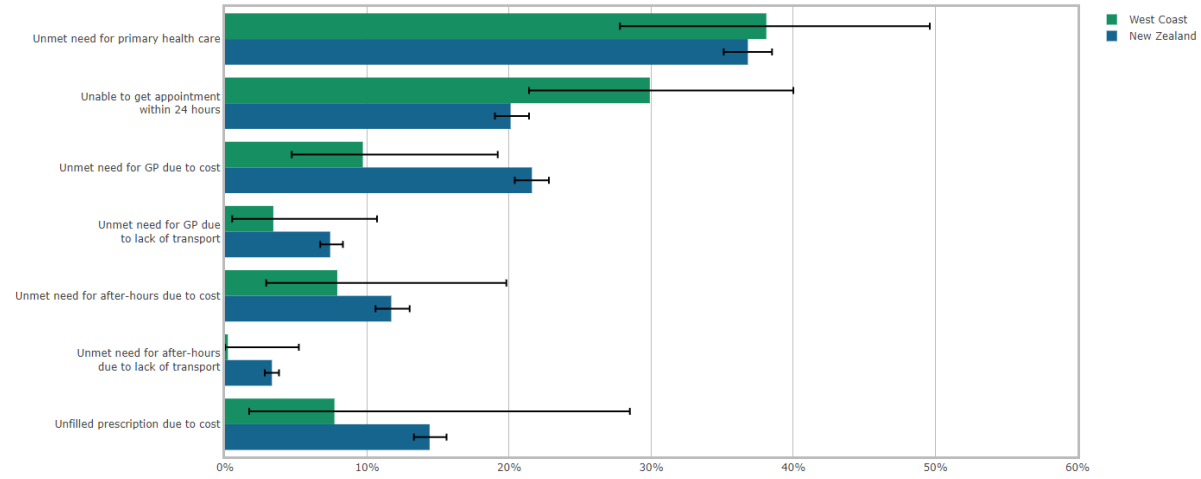


Barriers to accessing health care

All West Coast

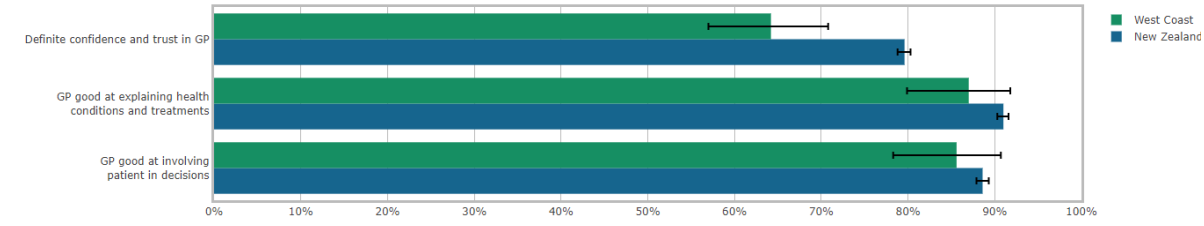


West Coast Maori

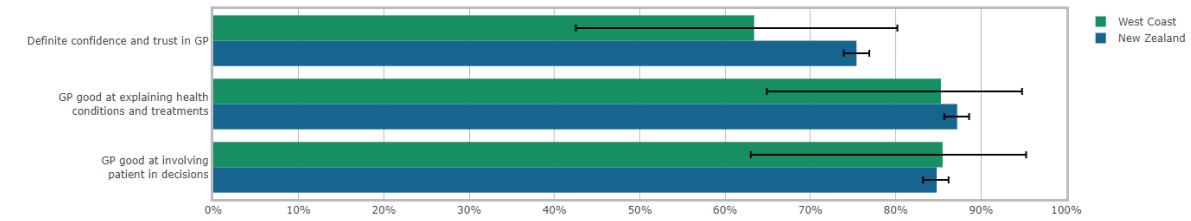


Patient experience

All West Coast

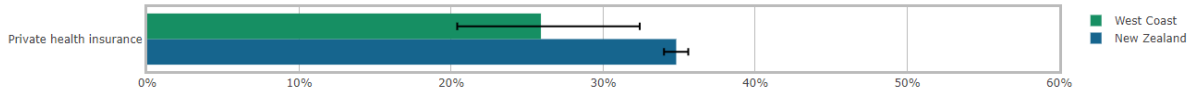


West Coast Maori

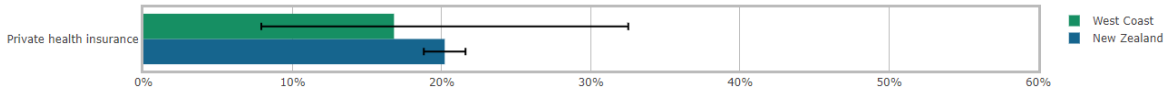


Health Insurance

All West Coast



West Coast Maori



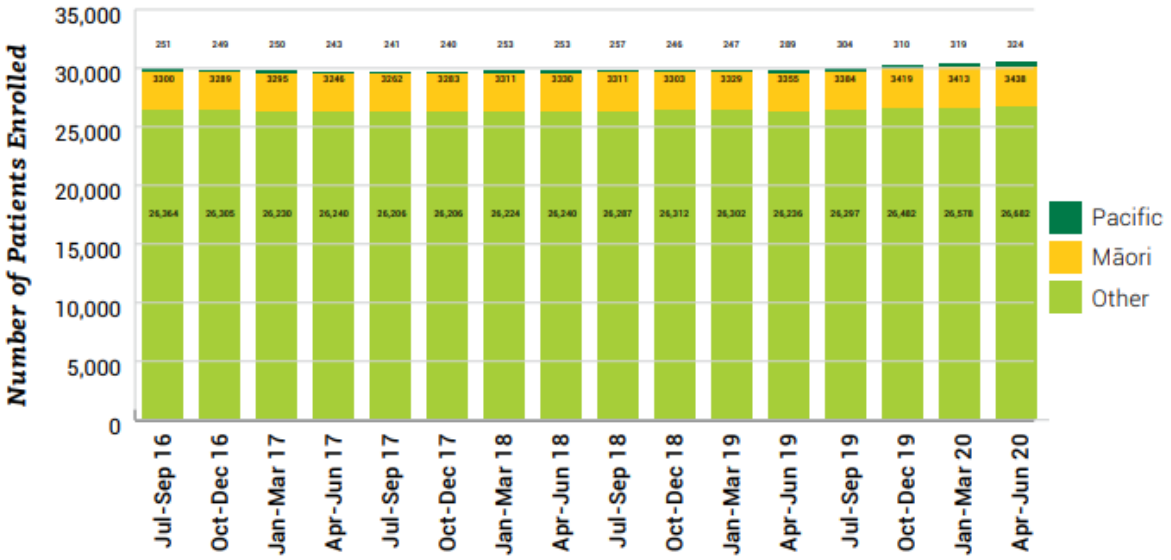
PHO Enrolment/GP Registration[31]

West Coast PHO Enrolled Population

For the April to June 2020 quarter, **30,444** people were enrolled with the West Coast PHO. This is an increase of 564 compared with the same time last year.

The average number of people enrolled in the PHO during the year was **30,167.**

Enrolments over time by ethnicity



[31] Westcoast PHO Annual Report 2019-2020 Web.pdf

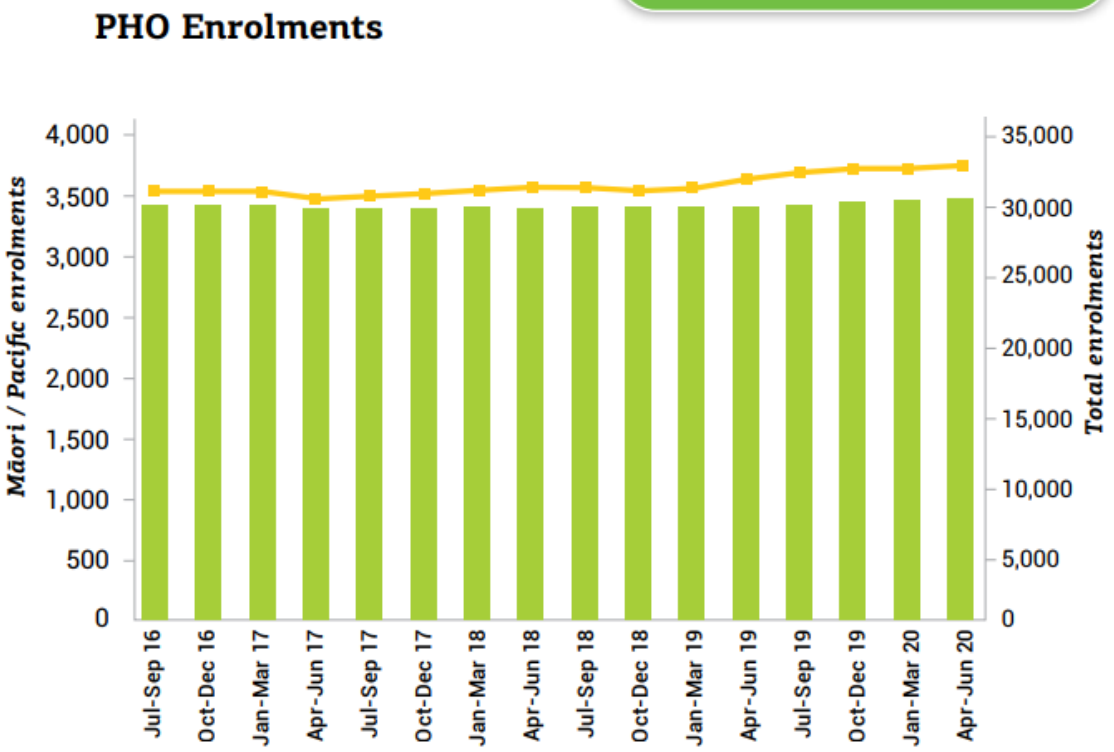
Access for Māori

Total enrolments have increased 2% over the three-year period from 1 July 2017 to 30 June 2020, while Māori and Pacific enrolments have increased 7% over the same period.

11% of total enrolments Māori

1% Pacific

3% Asian



Access to GP

Refer to HQSC Atlas of Healthcare Variation [below]

Whanau Ora

The Whanau Ora section provides some insights across the life course for Māori living in West Coast.

Ukaipo Source of Sustenance: Fertility, Pregnancy, Birth, Breastfeeding

The Ministry of Health oversees 20 national Maternity Clinical Indicators. Maternity CI (shinyapps.io) with trends available covering the period 2009-2018. West Coast DHB also reports its own data[32].

Fertility Rates[33]

In the year to December 2020 57,573 live births and 32,613 deaths were registered in New Zealand, resulting in a natural increase (live births minus deaths) of 24,960. There were 2,064 fewer births, and 1,647 fewer deaths compared with 2019.

In 2020 there were 291 babies born to West Coast mother at Grey Base Hospital 78%, Kawatiri Maternity Unit 2%, Christchurch Women's 9%, Home Birth 11%. (most at Gloriavale). Thirty four per cent were first time mothers.

The total NZ fertility rate hit a record low of 1.61), well below the annual average of 1.97 over the last 30 years. (West Coast 1.99 births per woman). The infant mortality rate was 4.0 deaths per 1,000 live births.

40% of women who were smoking at registration with their LMC were no longer smoking 2 weeks postnatal 60% of women smoking at registration were smoking 2 weeks postnatal.

For example, we know that our Māori mums are more likely to be smokers aged between 26 and 30 years of age and have more than one child. WCDHB report 2020

[32] Annual Maternity Quality and Safety Programme Report 2020 - 2021 (wcdhb.health.nz)

[33] Births and deaths: Year ended December 2020 (including abridged period life table) | Stats NZ

Analysis of Individual Indicators for West Coast during 2018

Indicator No.	Title	2017 WCDHB Rate (n)	2018 WCDHB Rate (n)	Change from 2017	Higher or lower than national average	National Average 2018
1	Registration with an LMC in the first trimester of pregnancy	80.3% (286)	81.1% (264)	▲ +0.9%	▲	72.7%
We continue to promote early registration with an LMC via posters in GP practices, links to Find Your Midwife on the WCDHB maternity pages and consistent messages via social media. This is a significant improvement (>80%) compared to 2014 when we changed our model of midwifery care.						
2	Standard primiparae who have a spontaneous vaginal birth	65.3% (32)	61.2% (30)	▼ -12.9%	▼	64.7%
Low numbers impact on our statistics; however, we are within the national figures. Remains stable.						
3	Standard primiparae who undergo an instrumental vaginal birth	12.2% (6)	24.5% (12)	▲ +12.3%	▲	17.0%
This increase in instrumental births is offset by the lower number of caesarean sections.						
4	Standard primiparae who undergo caesarean section	22.4% (11/49)	14.3% (7/49)	▼ -8.1%	▼	17.2%
We routinely audit all caesarean sections and discuss the cases. This decrease in this figure correlates to increased number of instrumental births.						
5	Standard primiparae who undergo induction of labour	8.2% (4)	6.1% (3)	▼ -2.1%	▼	7.8%
Rates remain stable and within national levels. We review all induction of labour indications annually and do not find any inductions without indication.						

6	Standard primiparae with an intact lower genital tract (no 1st – 4th degree tear or episiotomy)	28.9% (11)	26.2% (11)	▼ -2.7%	▼	26.5%

36

WCDHB sits almost at the national average. No significant change in our rate.						
7	Standard primiparae undergoing episiotomy and no 3rd or 4th degree perineal tear	23.7% (9)	26.2% (11)	▲ +2.5%	▲	24.6%
Slight increase; however relates to only two cases; impact of low numbers.						
8	Standard primiparae sustaining a 3rd or 4th degree perineal tear and no episiotomy	2.6% (1)	2.4% (1)	▼ -0.2%	▼	4.5%
Numbers remain stable. More perineal care and identifying the risk of tear earlier; providing episiotomy prior to tear may have contributed to slight reduction in numbers.						
9	Standard primiparae undergoing episiotomy and sustaining a 3rd or 4th degree perineal tear	0	0			2.1%
We have no women within this group.						

10	Total number of women having a general anaesthetic for caesarean section	9.0% (9)	4.4% (4)	▼ -4.6%	▼	8.5%
General anaesthetics are used only when birth needs to be imminent; the baby is distressed and there is no time for epidural or spinal pain relief or there are other reasons we need to move to GA. The unit policy is for regional anaesthetic unless it is clinically contraindicated or the clinical situation dictates the need for general anaesthetic.						
11	Women requiring a blood transfusion with caesarean section	6.0% (6)	4.4% (4)	▼ -1.6%	▲	3.0%
Noted slight changes in need for blood transfusion with increased PPH during C/section. Introduced policy to give regular tranexamic acid for emergency c/sections and C/sections for women with higher BMIs. Tranexamic Acid is part of our surgical safety checklist.						
12	Women requiring a blood transfusion with vaginal birth	2.7% (4)	2.5% (5)	▼ -0.2%	▲	2.1%
WCDHB sits within the national average.						
13	Diagnosis of eclampsia at birth admission	N = 0	N = 0			
14	Women having a peripartum hysterectomy	N = 0	N = 0			
15	Women admitted to ICU and requiring ventilation during the pregnancy or postnatal period	N = 0	N = 0			
We have no women meeting the criteria for indicators 13, 14 and 15.						
16	Maternal tobacco use during postnatal period	17.7% (60)	13.4% (42)	▼ -4.3%	▲	9.4%

We have extended the smoking cessation incentivisation programme period to 4 months post birth and ncluded partners. Changes introduced in 2021 will see all women smoking at registration being referred :o smoking cessation unless they opt out. We expect to see this have an impact in the future as it has in)ther DHBs.						
17	Preterm birth (under 37 weeks gestation)	9.2% (33)	3.7% (12)	▼ -5.5%	▼	7.5%
We had no babies born under 34 weeks during this period.						
18	Small babies at term (37-42 weeks' gestation)	2.5% (8)	2.6% (8)	▲ +0.1%	▼	3.1%
19	Small babies at term born at 40-42 weeks' gestation	37.5% (3/8)	50.0% (4/8)	▲ +12.5%	▲	29.9%
We are reviewing our data to determine whether these low birthweight babies have been diagnosed during pregnancy and appropriately managed.						
20	Babies born at 37+ weeks' gestation requiring respiratory support	0.6% (2)	1.3% (4)	▲ +0.7%	▼	2.1%
WCDHB sits below the national average for this indicator.						

Gestation at Delivery	2019		2020		Trend
	Number	%	Number	%	
Extremely preterm (<28 weeks)	3	1%	0	0%	
Very preterm (28-31 weeks)30	2	1%	0	0%	
Moderately preterm (32-33 weeks)	2	1%	2	1%	No Change
Later preterm (34-36 weeks)	3	1%	4	2%	
Term (37-41 weeks)	266	96%	220	96%	No Change
Prolonged (>42 weeks)	1	0%	4	2%	

Type of Labour	2019		2020		Trend
	Number	%	Number	%	
Spontaneous	178	64%	132	57%	
Induction	32	12%	31	13%	
Artificial Rupture of Membranes	11	4%	15	7%	
Augmented	28	10%	21	9%	
Did not labour	28	10%	31	13%	

Method of Delivery	2019		2020		Trend
	Number	%	Number	%	
Elective Caesarean	32	12%	30	13%	
Vaginal	156	56%	115	50%	
Vaginal Water Birth	7	3%	8	3%	No Change
Kiwi Cup	11	4%	8	3%	
Ventouse	0	0%	3	1%	
Forceps	5	2%	16	7%	
Emergency Caesarean	60	22%	44	19%	
VBAC	6	2%	6	3%	

Neonatal Outcomes	2019		2020		Trend
	Number	%	Number	%	
Well Neonates	273	99%	227	99%	No Change
Neonatal admissions	5	2%	5	2%	No Change
Stillbirth	3	1%	2	1%	No Change
Small for Gestational Age	3	1%	9	4%	

Feeding Method	2019		2020		Trend
	Number	%	Number	%	
Bottle	8	3%	7	3%	No Change
Breast	265	96%	218	96%	No Change
Mixed	4	1%	3	1%	No Change

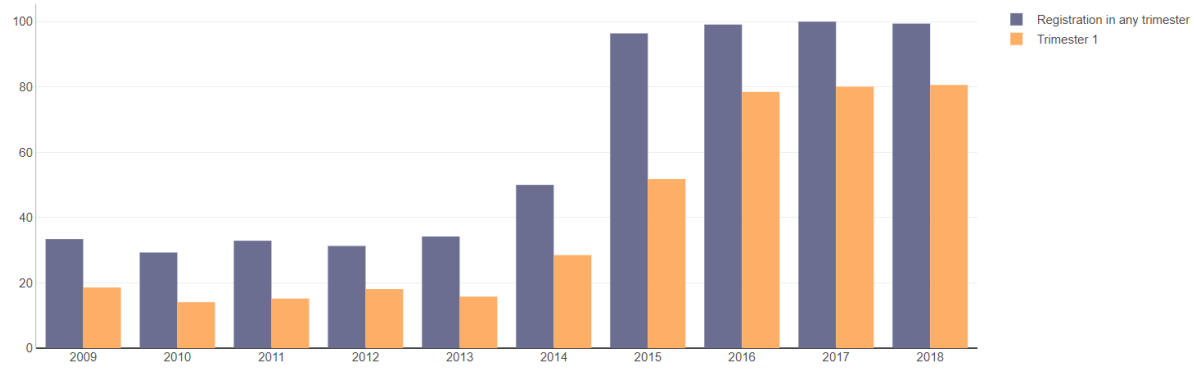
Registration with a Lead Maternity Carer[34]

In 2018 80.6% of all women and 66.2% of women who gave birth to babies of Māori ethnicity in West Coast were registered with a Lead Maternity Carer (LMC) in the first trimester of pregnancy.

[34] Maternity CI (shinyapps.io) Indicator 1: Registration with an LMC in the first trimester of pregnancy: *Rate (%) of women giving birth / live-born babies (all ethnic groups), by DHB of residence, 2009-2018*

Note this indicator does not identify whether there was a difference in rates of registration with a LMC between all women and Māori women having their first or subsequent pregnancy as this information is not collected on the registration form[35].

Percentage of women giving birth registered with a LMC, residing in West Coast DHB, 2009 - 2018



Gestational Diabetes update for West Coast

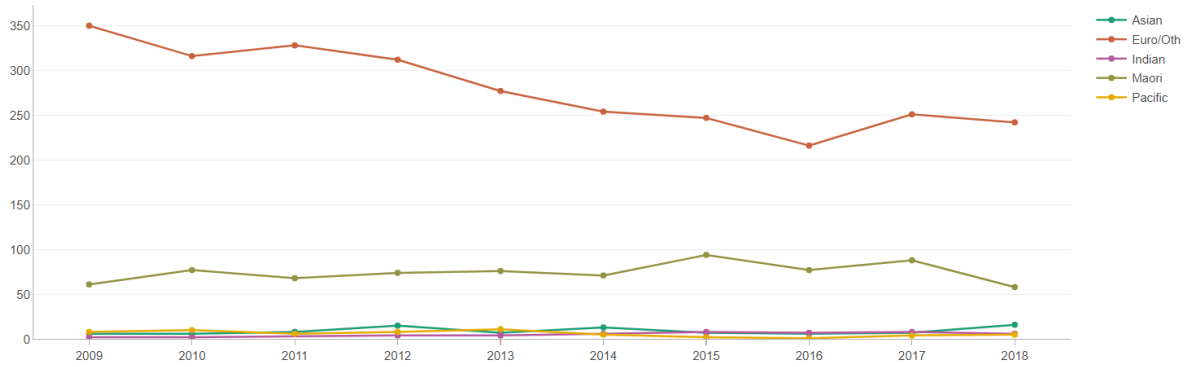
All women with pre-gestational Diabetes (Type1 and type 2) get referred early by their GP, LMC or diabetes specialist and seen as soon as possible in the high-risk obstetric clinic by physician. We provide regular diabetes and pregnancy care for the whole duration of their pregnancy with the help of Obstetric team and their LMC. Postdelivery their treatment is reviewed prior to discharge and discharged back to their usual care. Those women diagnosed with GDM in pregnancy get diet and exercise advice, glucose monitoring and targets by the Dietician team and then get referred to physician and obstetrician in the high risk medical obstetric for further care.

Births[36]

Statistics NZ reports 312 live births for the West Coast region in the year ended December 2020.

In 2018 there were 321 babies residing in West Coast born, 58 of whom were identified as Māori (18%). MOH shiny apps [see below]: Maori 58

Number of babies born residing in West Coast DHB, by baby ethnicity, 2009 - 2018



In 2019/20 West Coast DHB data shows XX babies of Māori ethnicity born, XX% of all births in West Coast.

[35] Registration with a Lead Maternity Carer (health.govt.nz)

[36] Births and deaths: Year ended December 2020 (including abridged period life table) | Stats NZ

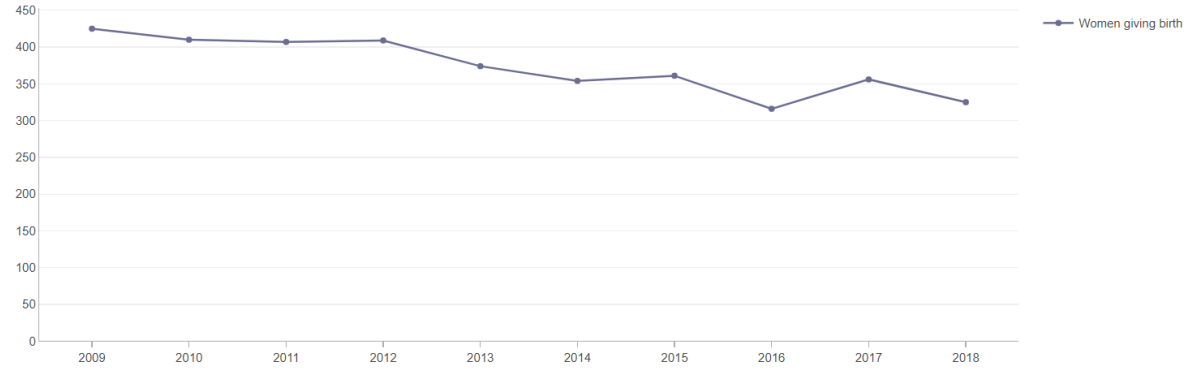
Highest proportion of West Coast mothers are in the 25-29 years bracket (33%)

In 2020, 19% of mothers identified as Māori, 74% European / other descent 6% Asian 1% Pacific People

The age distribution and percentage of the Māori mothers **WCDHB 2019/20** can be seen in the table below:

15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40 + years
12	64	118	86	56	12

Number of women giving birth, residing in West Coast DHB, 2009 - 2018



Live births and fertility rates by regional council areas

2018

	Age of mother (years)							All ages
	Under 20	20–24	25–29	30–34	35–39	40–44	45+	
Northland Region	145	469	654	594	284	73	7	2,226
Auckland Region	595	2,725	5,589	7,225	4,087	888	61	21,170
Waikato Region	295	1,108	1,870	1,859	830	193	11	6,166
Bay of Plenty Region	193	734	1,181	1,210	584	123	8	4,033
Gisborne Region	53	149	215	180	79	20	2	698
Hawke's Bay Region	119	403	617	574	290	68	6	2,077
Taranaki Region	59	262	449	471	210	41	2	1,494
Manawatu-Wanganui Region	156	633	957	839	363	89	5	3,042
Wellington Region	174	714	1,478	2,015	1,223	266	19	5,889
Tasman Region	11	59	131	149	82	22	3	457
Nelson Region	18	76	146	172	91	24	1	529
Marlborough Region	21	85	142	142	84	18	1	493
West Coast Region	12	64	118	86	56	12	0	348
Canterbury Region	170	910	1,993	2,421	1,283	260	19	7,056
Otago Region	58	254	581	782	456	99	4	2,234
Southland Region	49	213	338	357	164	37	2	1,160
New Zealand[2]	2,129	8,862	16,463	19,081	10,168	2,235	152	59,089

Birth Type[37]

The following distribution of the three main birth types occurred in the 2019/20 year in West Coast for primiparae women [Maternity Clinical Indicators 2,3,4, note wide confidence indicators):

Birth Type	All primiparae	Māori primaparae
Vaginal birth	61.2%	63.6%
Instrumental birth	24.5%	36.4%
Caesarean	14.3%	0%

Māori women were more likely to have a vaginal birth or an instrumental birth.

Gestation at Birth

Table 2. Gestation at Birth 2018 Maternity Indicators 17-20 (note wide confidence intervals)

Note these figures relate to all West Coast resident babies

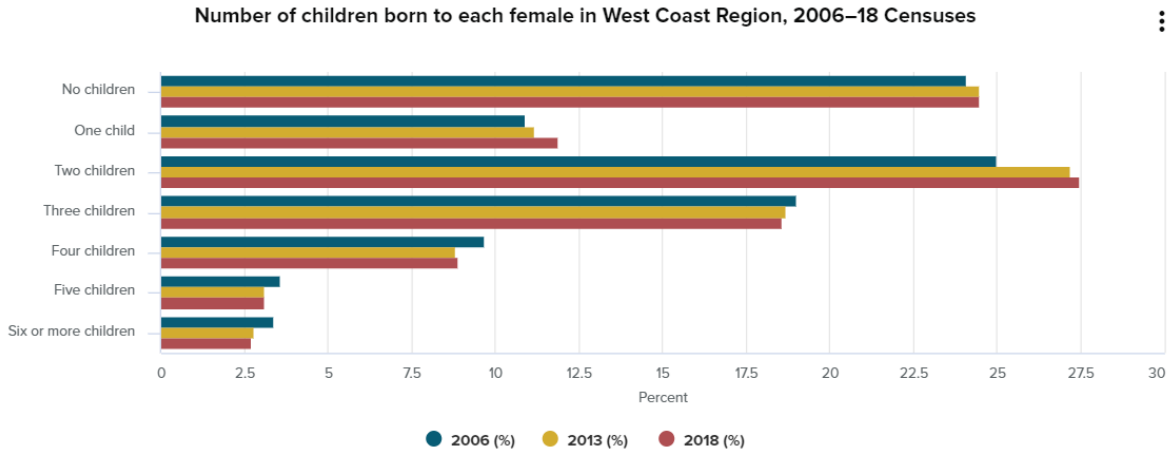
Gestation at Birth	Māori	All
Preterm	1.7%	3.7%%
Small 37-42 week)	8.8%	2.6%
Small 40-42 weeks	40%	50%
Respiratory support 37 weeks +	1.3%	1.8%

Neo Natal Intensive Care Unit

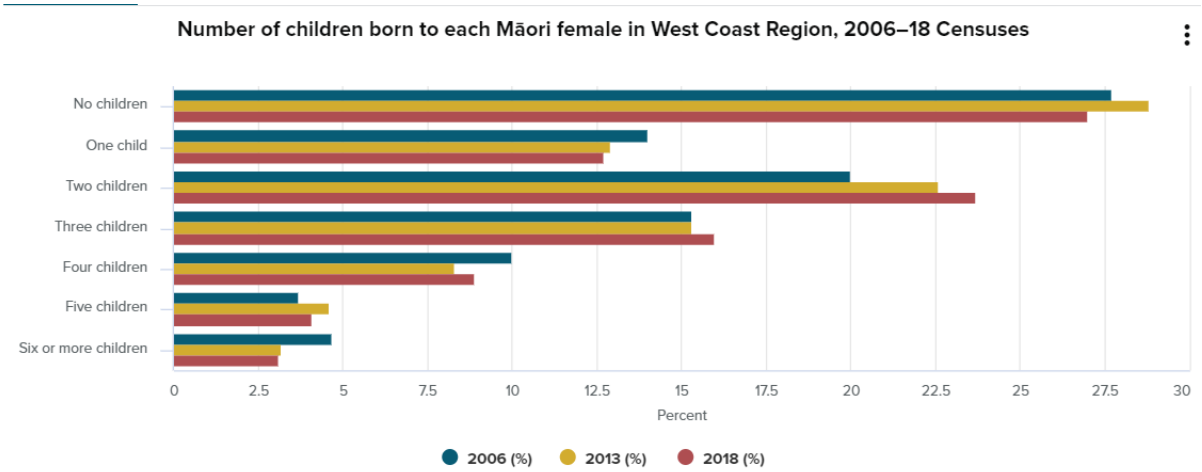
Include NICU by Ethnicity

Number of children born to each female

The 2018 Census shows that the trend from the previous 2 censuses (2006 and 2013) of fewer children being born to women in West Coast continues for Māori and all women.



[37] Maternity CI (shinyapps.io)



Number of children	Maori	All
0	27.0%	24.5%
1	11.9%	12.4%
2	23.7%	27.5%
3	16.0%	18.6%
4	8.9%	8.9%
5	4.1%	3.1%
6	3.1%	2.7%

Number of children born to each male INSERT SIMON BERRY DATA

Breastfeeding

84.72% exclusively fed on discharge on West Coast + 2.18% fully breastfed + 8.73% partially breastfed.[38]

Maori data is national only.

> The exclusive breastfeeding rate for Māori infants is slightly higher than the national average (79.88% compared with 77.48%). The artificial feeding rate for Māori infants has increased slightly from 5.88% to 6.14%.
>
> The **exclusive breastfeeding rate for Māori infants has decreased** by 1.8%. Concurrently, the partia breastfeeding rate for Māori infants has increased to 11.25% (compared with 9.54% in 2019). The artificial rate for Māori has increased to 6.14% (compared with 5.88% in 2019).

https://minhealthnz.shinyapps.io/Maternity_report_webtool/

Breastfeeding data comes from the National Maternity Collection and is only available for babies of women registered with an LMC or DHB primary maternity service so the data may be incomplete. The denominator used to calculate percentages is the total number of live-born babies (of women registered with a LMC or DHB), residing in the selected area, excluding those with unknown breastfeeding status at 2 weeks after birth.

[38] NZBA: Breastfeeding data (babyfriendly.org.nz)

The rate of women exclusively breastfeeding at two weeks post birth increased slightly from 83% (18/19) to 84% (2019/2020). WCDHB 2020 report

81.5% of all babies in West Coast were exclusively breast-fed at 2 weeks (cf 79.8% in 2009); 10.7% partially breast fed (8.7% 2009). [2018 MOH DATA]

62% of Māori babies were exclusively or fully breastfed at discharge from the Lead Maternity Carer at 6 weeks [CHECK WCDHB DATA]

West Coast PHO data[39]

[39] Westcoast PHO Annual Report 2019-2020 Web.pdf

Breastfeeding Support

deprivation areas, young and Māori women.

Health professionals

This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment on the West Coast (because the evidence shows that infants who are NOT breastfed have a higher risk of developing chronic illnesses).

The service is delivered by Breastfeeding Advocates with a combined 0.8 FTE.

Data is now obtained from all providers, whereas previously only Plunket data was available. The following table shows collated West Coast breastfeeding results for the 4th quarter only from all providers.

It is also important to note that the Ministry of Health target for 6 months (65%) is for babies receiving any breastmilk; exclusively, fully or partially breastfed. The results below include those who are exclusively or fully breastfed for 6 weeks and 3 months. The 6-month result includes babies receiving any breastmilk. The results are shown as an average taken from the results of each quarter.

	6 Weeks exclusively or fully breastfed	3 Months exclusively or fully breastfed	6 Months exclusively, fully or partially breastfed
West Coast Result	57.6%	55.2%	65.1%
West Coast Targets	75%	70%	65%
Māori Result	100%	87.5%	61.5%

It is pleasing to see the increase in Māori babies receiving breastmilk at 6 months of age.

55 were living in high deprivation areas

48 living rurally

9 <20 years of age

There were **227** Lactation Consultancy clients in 2019/20

19% (42) of contacts made with Māori mums

1,181 Lactation Consultancy contacts

"I just wanted to say thank you because without your support I wouldn't have managed to go so far breastfeeding. You do amazing stuff for people and I'm proud to be one of them."

22 ante-natal sessions in groups and 1:1

10 Mum4Mums trained

3 of these mums were Māori

Sudden Unexpected Death in Infants[40]

There were X SUDI deaths in West Coast in 2017 the most recent reported year. CHECK WITH CATHERINE CRICHTON

[40] MOH Fetal and Infant Deaths web tool (shinyapps.io)

Child Health

Well Child Tamariki Ora Quality Improvement Framework[41]

The NZ Well Child Tamariki Ora (WCTO) Quality Improvement Framework, with its 18 quality indicators, has three aims: focusing on family/whānau experience; population health and best value for the health system; and setting quality indicators to audit health system performance. The indicators commenced in 2015 and there is reporting from March 2015. [could compare to see if progress]

The Ministry of Health has reported the following performance for West Coast DHB [Māori/non-Māori] to September 2020.

Indicator	National Target	Māori	Total population
WCTO referral by 28 days	95%	83%	88%
Core contact 1 by 50 days	90%	88%	88%
All core contacts by age 1	90%	59%	71%
Breastfed at 2 weeks	85%	82%	87%
Breastfed at LMC discharge at 6 weeks	75%	59%	70%
Breastfed at 3 months	70%	54%	59%
Babies living in smokefree homes at first WCTO contact[42]	90%	39%	51%
Screened for family violence	90%	80%	64%
SUDI prevention information provided before 50 days	90%	100%	92%
Newborn enrolled with general practice	90%	88%	84%
Children 0-4 enrolled with oral health service	95%	77%	88%
Reduce DMFT in 5 year old children	4	4.59	4.70
Fully immunised at age 5	95%	93%	84%
B4SC started before 4 ½	95%	83%	89%
Children with healthy weight at age 4	75%	96%	92%
Children with BMI> 98 percentile are referred	95%	100%	100%
Children have low SDQ-P scores	n/a	92%	96%
Children with high SDQ-P scores are referred	n/a	100%	100%

Note SLM data for Babies July to December 2020 living in smokefree homes at 6 weeks postnatal is substantially different for Maori: **57.5% total and 36.4% for Māori.**

Note Quality Dashboard shows the percentage of pre-school children 0-4 years enrolled for the community oral health service has increased significantly since 2010/11 for the total population and for Māori: CHECK

Total Enrolled % 2010/11	Māori Enrolled % 2010/11	Total Enrolled % 2019/20	Māori Enrolled % 2019/20

[41] Well Child / Tamariki Ora Quality Improvement Framework | Nationwide Service Framework Library (health.govt.nz)

[42] Babies Living in Smoke-free Homes SLM data | Nationwide Service Framework Library (health.govt.nz)

54%	%	88%	%

Note Quality dashboard May 2021 shows a steady decline in DMFT for all children living in non-fluoridated areas in West Coast. The percentage of children who are caries-free in 2019 was 44 per 100 for Māori, compared to 58 per 100 for non-Māori, non Pacific children.

Average number of DMFT is 2.2 for Maori and 1.7 for non-Māori, non Pacific children.

Pre-School Children (0-4) Enrolled for Community Oral Health Service

Calendar Year: 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

Breakdown by DHB, Enrolment Coverage

DHB	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Auckland	65%	70%	73%	75%	75%	74%	85%	91%	90%	97%
Bay of Plenty	56%	42%	68%	84%	86%	95%	93%	92%	101%	102%
Canterbury	66%	59%	71%	71%	69%	61%	62%	76%	83%	86%
Capital and Coast	38%	40%	42%	43%	59%	95%	97%	94%	90%	95%
Counties Manukau	61%	66%	71%	76%	76%	74%	84%	84%	80%	89%
Hawkes Bay	50%	62%	71%	70%	74%	87%	89%	91%	96%	91%
Hutt	40%	41%	47%	47%	55%	96%	97%	94%	93%	98%
Lakes	55%	57%	57%	57%	69%	70%	105%	98%	99%	94%
MidCentral	35%	46%	64%	86%	93%	100%	95%	102%	96%	100%
Nelson Marlborough	46%	47%	58%	71%	80%	82%	83%	86%	93%	95%
Northland	58%	62%	62%	67%	68%	69%	72%	79%	82%	96%
South Canterbury	78%	67%	77%	71%	70%	82%	85%	74%	70%	77%
Southern	97%	82%	84%	89%	82%	80%	81%	79%	*	85%
Tairawhiti	57%	78%	81%	89%	93%	95%	101%	107%	105%	104%
Taranaki	75%	78%	75%	73%	74%	94%	95%	92%	104%	108%
Waikato	56%	64%	70%	67%	72%	73%	72%	75%	92%	84%
Wairarapa	75%	79%	78%	77%	82%	91%	83%	85%	92%	87%
Waitemata	65%	71%	80%	81%	83%	84%	93%	95%	95%	98%
West Coast	54%	68%	85%	75%	100%	87%	97%	108%	101%	88%
Whanganui	72%	92%	89%	94%	99%	101%	104%	120%	125%	127%
Total	**60%**	**63%**	**70%**	**73%**	**76%**	**80%**	**85%**	**88%**	**91%**	**93%**

Immunisation[43]

January-March 2021

12 months: 81.1% all; 82.4% Māori

24 months: 78.5% all; 78.9% Māori

5 years: 74.4% all; 76.5% Māori

Same period **2011** @ 12 months: All 86%, 89% Māori; 24 months: 82% All; 100% M; 5 years 85% All; 95% M

Ambulatory Sensitive Hospital Admission rates per 100,000 Children 0-4 years old[44][CHECK SIMON/ROSS]

In the reporting period to 31/12/2020 the Māori rate for ASH admissions was 3,500/100,000 compared to 3,521/100,000 for non-Māori, non-Pacific children) in this age cohort [non age

[43] National and DHB immunisation data | Ministry of Health NZ

[44] Health system quality dashboard May 2021 | Tableau Public [Health Quality & Safety Commission]

standardised] 14 admissions for both. This is the lowest it has been since data collection commenced in Quarter 1, 2013. Small numbers mean big fluctuations.

Children admitted with a primary diagnosis of asthma or wheeze per 1000 population
NONE IN EQUITY DASHBOARD – small numbers?

ENT – DNA and other figures DISCUSS WITH PETER MAC

Youth, Adolescents

Adolescent Oral Health[45] BRIDGET LESTER/GINNY B PLEASE REVIEW

The Quality dashboard sets out adolescent utilisation of DHB-funded Dental Services (Year 9-17 year olds). A breakdown by ethnicity is not available.

Adolescent (Year 9 to 17 Year-Olds) Utilisation of DHB-Funded Dental Services

Calendar Year: 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

Breakdown by DHB, Estimated Utilisation Rate

DHB	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Auckland	72%	81%	84%	85%	76%	79%	69%	77%	81%	87%
Bay of Plenty	68%	71%	70%	74%	68%	70%	67%	68%	73%	70%
Canterbury	67%	65%	65%	64%	62%	62%	62%	63%	67%	63%
Capital and Coast	51%	62%	70%	73%	74%	77%	78%	80%	79%	77%
Counties Manukau	68%	71%	74%	77%	74%	73%	72%	74%	73%	72%
Hawkes Bay	77%	81%	81%	85%	78%	76%	69%	67%	68%	57%
Hutt	59%	68%	70%	69%	73%	73%	68%	69%	67%	74%
Lakes	57%	71%	65%	69%	68%	73%	73%	80%	66%	63%
MidCentral	79%	82%	83%	82%	82%	82%	81%	80%	81%	83%
Nelson Marlborough	84%	87%	85%	85%	79%	80%	81%	81%	82%	83%
Northland	59%	59%	61%	61%	58%	57%	54%	51%	47%	47%
South Canterbury	91%	91%	89%	89%	86%	84%	83%	84%	81%	78%
Southern	82%	82%	85%	83%	82%	75%	73%	81%	75%	75%
Tairawhiti	72%	63%	63%	71%	69%	62%	67%	55%	52%	50%
Taranaki	71%	78%	77%	79%	73%	74%	71%	70%	69%	67%
Waikato	70%	73%	73%	71%	70%	70%	71%	70%	70%	67%
Wairarapa	82%	82%	70%	64%	67%	67%	64%	65%	71%	70%
Waitemata	61%	61%	64%	65%	67%	67%	73%	68%	68%	68%
West Coast	77%	81%	77%	74%	70%	77%	78%	77%	76%	73%
Whanganui	71%	79%	77%	78%	79%	81%	79%	80%	69%	77%
Total	**68%**	**72%**	**73%**	**74%**	**72%**	**72%**	**71%**	**71%**	**71%**	**71%**

Total Enrolled % 2010/11	Total Enrolled % 2019/20
77%	73%

Youth Experience of the Health System[46] - Child and Adolescent Mental Health Services (CAMHS) Real-Time Survey results for 10-24 year olds, last updated 6 October 2020

West Coast Surveys: 17 responses from 389 clients 12-24 years.

Sexual and Reproductive Health – Chlamydia testing coverage for 15-24 year olds[47][Melissa Kerdemelidis help to interpret please]

In 2019

[45] Access to Preventive Services - Adolescent oral health utilisation for school year 9-17 years of age | Nationwide Service Framework Library

[46] Youth SLM Data | Nationwide Service Framework Library (health.govt.nz)

[47] Sexual and Reproductive Health - Chlamydia testing coverage for 15-24 year olds | Nationwide Service Framework Library

Sexual and Reproductive Health - Chlamydia testing coverage for 15-24 year olds Last updated 9 March 2021.

Table 1. Number of specimens tested for chlamydia, number of laboratory-confirmed cases, chlamydia rates, percentage of specimens tested that were positive and percent of people tested by age group and sex, 2019

Ethnicity	Age group (years)																			
	Total Specimens				Number of Laboratory-confirmed cases[a]				Rate per 100,000 population[b]				Test positivity (%)[c]				Coverage (% of age group tested)[d]			
	15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Māori	9	41	5	41	≤5	≤5	0	6	-	-	-	5862	11.1%	9.8%	0.0%	17.1%	3.2%	18.0%	4.3%	30.3%
Pacific peoples	0	2	2	1	0	0	≤5	0	-	-	-	-	-	0.0%	50.0%	0.0%	0.0%	21.2%	6.9%	7.2%
Asian	0	0	0	8	0	0	0	0	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	8.1%
MELAA	0	3	0	1	0	0	0	0	-	-	-	-	-	0.0%		0.0%	-	Inf	0.0%	21.5%
European or Other	7	138	27	187	≤5	12	≤5	12	-	1983	-	2345	14.3%	8.7%	14.8%	6.4%	0.9%	15.0%	4.2%	29.1%
Unknown	44	70	56	50	3	8	6	4	-	-	-	-	6.8%	11.4%	10.7%	8.0%	-	-	-	-
Total	**60**	**254**	**90**	**288**	**5**	**24**	**11**	**22**	**-**	**2051**	**699**	**2687**	**8.3%**	**9.4%**	**12.2%**	**8.0%**	**1.3%**	**15.8%**	**4.1%**	**27.6%**

[a] Excludes repeat tests

[b] Repeat tests for an individual excluded if test date is <6 weeks after a positive test

[c] Calculated using the number of positive specimens (includes repeat tests)

[d] Unique people based on NHI and patient ID numbers.

Where there are ≤5 cases detected in one field the specific number is not reported for privacy reasons and reported as ≤5 - subsequent rates are also not reported

Table 1. Number of specimens tested for gonorrhoeae number of laboratory-confirmed cases, gonorrhoeae rates, percentage of specimens tested that were positive and percent of people tested by age group and sex, 2019

Ethnicity	Age group (years)																			
	Total Specimens				Number of Laboratory-confirmed cases[a]				Rate per 100,000 population[b]				Test positivity (%)[c]				Coverage (% of age group tested)[d]			
	15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24		15 to 19		20 to 24	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Māori	9	38	5	44	0	0	0	0	-	-	-	-	0.0%	0.0%	0.0%	0.0%	3.2%	16.8%	4.3%	32.2%
Pacific peoples	0	1	2	2	0	0	≤5	0	-	-	-	-	-	0.0%	100.0%	0.0%	0.0%	21.2%	6.9%	7.2%
Asian	0	0	0	8	0	0	0	0	-	-	-	-	-	-	-	0.0%	0.0%	0.0%	0.0%	8.1%
MELAA	0	3	0	1	0	0	0	0	-	-	-	-	-	0.0%		0.0%	-	Inf	0.0%	21.5%
European or Other	7	138	26	186	0	0	0	0	-	-	-	-	0.0%	0.0%	0.0%	0.0%	0.9%	15.0%	4.2%	28.9%
Unknown	44	69	56	51	0	1	1	2	-	-	-	-	0.0%	1.4%	1.8%	3.9%	-	-	-	-
Total	**60**	**249**	**89**	**292**	**0**	≤5	≤5	≤5	**-**	**-**	**-**	**-**	**0.0%**	**0.4%**	**3.4%**	**0.7%**	**1.3%**	**15.5%**	**4.1%**	**27.8%**

Self-harm hospitalisations for people 10 to 24 years old[48]

age standardised youth (10-24 years) self harm hospitalisation rates: Māori XX], compared to the Total population XX.

Using Standard Population: Census 2013 Usual Resident Population

	Population	Number of Self Harm Hospitalisations - Total			Actual Self Harm Hospitalisation Rate (per 10,000 population)			Age Standardised Self Harm Hospitalistion Rate (per 10,000 population)		
DHB of Domicile	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Auckland	102,375	410	441	526	40.3	43.2	51.4	39.6	42.8	52.0
Bay of Plenty	45,685	227	281	297	50.8	62.1	65.0	54.2	66.2	68.8
Canterbury	112,235	644	616	524	58.7	55.4	46.7	58.4	55.4	47.0
Capital and Coast	69,350	394	399	481	57.7	58.0	69.4	56.3	55.8	69.1
Counties Manukau	126,885	545	465	509	43.8	37.0	40.1	44.2	37.7	41.2
Hawke's Bay	33,140	208	188	224	64.3	57.3	67.6	68.0	60.9	70.9
Hutt	29,270	160	171	196	54.9	58.6	67.0	55.2	59.3	68.5
Lakes	22,450	113	107	128	51.6	48.2	57.0	54.0	50.4	60.2
Midcentral	37,755	204	199	189	54.8	53.0	50.1	55.0	53.7	50.8
Nelson Marlborough	26,300	149	163	187	57.5	62.4	71.1	60.6	66.8	75.8
Northland	33,795	152	177	166	46.0	52.9	49.1	48.1	57.0	53.5
South Canterbury	10,153	46	48	35	45.4	47.3	34.5	46.6	50.0	35.0
Southern	70,700	398	503	461	57.4	71.8	65.2	55.8	70.4	64.2
Tairawhiti	10,128	48	48	46	47.7	47.4	45.4	49.9	50.5	49.4
Taranaki	22,773	160	134	160	72.5	59.6	70.3	75.0	63.6	74.6
Waikato	87,570	568	554	583	66.4	64.0	66.6	67.8	65.7	68.9
Wairarapa	8,060	45	39	56	56.5	48.6	69.5	59.6	52.3	76.9
Waitemata	121,715	563	517	620	47.3	42.9	50.9	47.6	43.6	51.9
West Coast	5,053	25	19	23	49.0	37.4	45.5	50.2	39.3	47.6
Whanganui	12,455	67	88	59	54.7	71.1	47.4	56.6	73.9	49.4
National	987,845	5,126	5,157	5,470	52.8	52.6	55.4	53.3	53.4	56.6

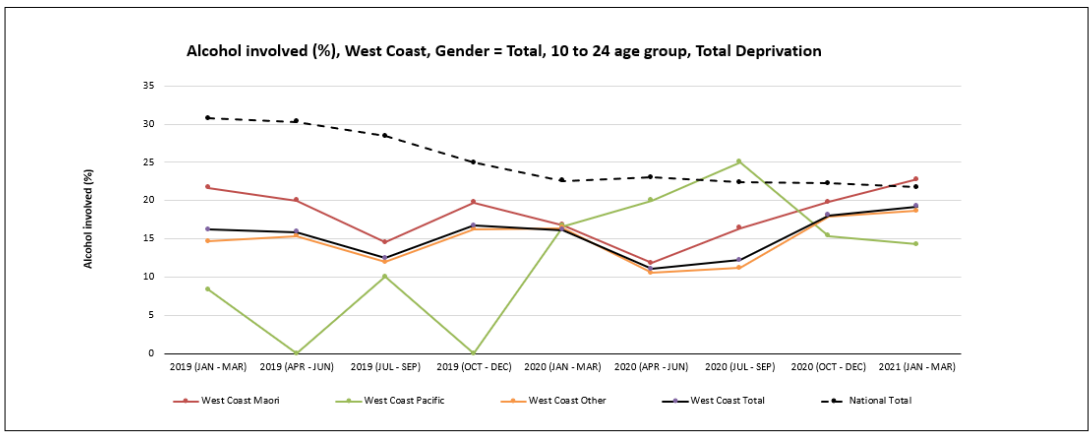
[48] Youth Population Aged 10 to 24 Years | Nationwide Service Framework Library (health.govt.nz)

Using Standard Population: Census 2013 Usual Resident Population

DHB of Domicile	Population	Number of Self Harm Hospitalisations - Total			Actual Self Harm Hospitalisation Rate (per 10,000 population)			Age Standardised Self Harm Hospitalistion Rate (per 10,000 population)		
	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Auckland	11,195	94	113	96	85.6	101.8	85.8	86.0	103.7	87.0
Bay of Plenty	17,690	83	119	108	48.6	68.5	61.1	53.1	74.9	67.2
Canterbury	16,250	108	133	116	69.5	83.7	71.4	72.0	87.2	75.2
Capital and Coast	11,115	67	72	99	61.2	65.0	89.1	61.0	65.5	94.0
Counties Manukau	27,770	182	147	181	68.9	54.2	65.2	71.1	57.6	68.6
Hawke's Bay	13,550	102	91	106	80.5	69.3	78.2	86.2	75.5	84.6
Hutt	7,750	53	67	71	71.0	87.9	91.6	72.0	90.1	94.9
Lakes	11,655	59	54	61	53.5	47.6	52.3	58.3	52.0	56.7
Midcentral	11,550	56	44	50	51.4	39.2	43.3	53.2	41.5	44.8
Nelson Marlborough	4,910	36	43	58	79.1	90.7	118.1	84.2	97.7	131.4
Northland	18,150	79	86	93	46.1	48.8	51.2	47.9	54.0	56.3
South Canterbury	1,710	10	10	9	64.1	61.5	52.6	68.2	63.8	51.5
Southern	11,450	69	115	101	63.4	103.0	88.2	64.5	106.7	90.6
Tairawhiti	6,615	36	34	31	55.6	51.8	46.9	58.8	56.8	52.9
Taranaki	7,180	56	60	53	85.1	87.1	73.8	91.0	92.7	81.0
Waikato	29,770	214	168	206	75.5	57.8	69.2	78.4	60.4	72.9
Wairarapa	2,600	21	21	19	87.3	83.0	73.1	93.1	87.6	77.0
Waitemata	18,580	129	107	142	72.7	59.1	76.4	75.3	61.4	79.4
West Coast	965	3	3	8	32.1	31.7	82.9	28.4	34.4	87.5
Whanganui	5,030	34	41	34	70.5	83.0	67.6	73.9	87.4	70.8
National	235,485	1,491	1,528	1,642	66.4	66.4	69.7	69.4	70.2	73.8

Alcohol-related ED presentations for people 10-24 years old[49]

The alcohol-related ED presentations for Maori were XX% the level compared to the total cohort (XX%) for the year to March 2021 [XX% people compared to XX% people].



DHB /National	Ethnicity	19 (JAN - MA	2019 (APR - JUN	2019 (JUL - SEP	019 (OCT - DEC	020 (JAN - MAR	20 (APR - JUN	020 (JUL - SEP	20 (OCT - DE	021 (JAN - MAR)
West Coast	Maori	21.68	20.00	14.50	19.74	16.78	11.83	16.38	19.83	22.78
West Coast	Pacific	8.33	0.00	10.00	0.00	16.67	20.00	25.00	15.38	14.29
West Coast	Asian	20.00	0.00	16.67	0.00	0.00	11.11	0.00	0.00	0.00
West Coast	Other	14.68	15.38	11.95	16.23	16.38	10.53	11.18	17.91	18.67
West Coast	Total	16.20	15.87	12.46	16.69	16.11	11.03	12.20	18.03	19.22
National	Total	30.77	30.26	28.43	24.97	22.56	22.99	22.39	22.22	21.75

[49] Alcohol and Other Drugs - Alcohol-related ED presentations for 10-24 year olds | Nationwide Service Framework Library (health.govt.nz)

Report for DHB of Domicile to March 2021

Ethnic Group Comparison - Youth ED Alcohol involved Rates

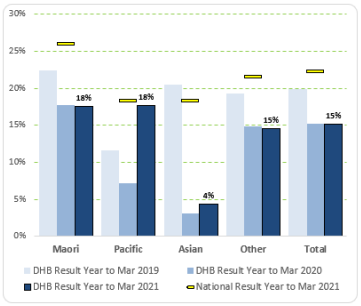
West Coast DHB of Domicile

Ethnicity	ED Attendance Year to Mar 2021	Alcohol Screened Year to Mar 2021	Alcohol Involved Year to Mar 2021	Alcohol Related Emergency Department (ED) Presentations Rates Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Maori	404	404	71	22.4%	17.8%	17.6%
Pacific	34	34	6	11.6%	7.1%	17.6%
Asian	23	23	1	20.5%	3.1%	4.3%
Other	1,565	1,565	228	19.3%	14.9%	14.6%
Total	2,026	2,026	306	19.9%	15.3%	15.1%

National

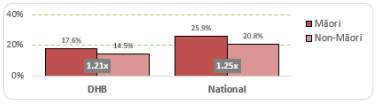
Ethnicity	ED Attendance Year to Mar 2021	Alcohol Screened Year to Mar 2021	Alcohol Involved Year to Mar 2021	Alcohol Related Emergency Department (ED) Presentations Rates Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Maori	59,488	58,584	15,427	39.3%	31.4%	25.9%
Pacific	18,052	17,945	3,292	27.1%	20.2%	18.2%
Asian	12,923	12,868	2,353	23.1%	22.5%	18.2%
Other	114,724	112,928	24,648	34.4%	25.7%	21.5%
Total	205,187	202,325	45,720	34.8%	26.7%	22.3%

Trend Analysis



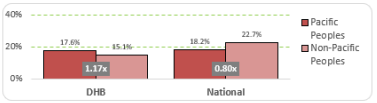
Please note that 'Other' category on this graph shows the results for people who are not Māori, not Pacific, and not Asian.

Māori vs Non-Māori



For the DHB, alcohol-related ED presentation for their Māori population is 1.21 times the level compared to their non-Māori population for the Year to Mar 2021. Nationally, alcohol-related ED presentation for the Māori population is 1.25 times the level compared to non-Māori.

Pacific vs Non-Pacific Peoples



For the DHB, alcohol-related ED presentation for their Pacific population is 1.17 times the level compared to their non-Pacific population for the Year to Mar 2021. Nationally, alcohol-related ED presentation for the Pacific population is 0.80 times the level compared to non-Pacific.

Pakeke, Kaumatua

Influenza Immunisation[50] BRIDGET LESTER PLEASE REVIEW

Immunisation for influenza increased from 44.69% for Māori in 2019 to 56.57% in 2020 and from 59.51% for non-Māori, non-Pacific in 2019 to 75.08% 2020.

Cervical Screening[51]

The measure for this is: women aged 25-69 years who have had a cervical smear in the last three years. The target is = 80%.

The three year coverage to May 2021 was: Overall 75% (NB: best ever performance May 2014 of 75.9%) ; Māori 71% (May 2009 77.2% best ever performance). Change possibly due to a drop in rescreening.

Breast Screening[52]

The measure for breast screening is: women aged 50-69 years who have had a breast screen once in the last two years. The target = 70%

The 2 year coverage to May 2021: Overall 74.1%; Māori 66.3%.

NB: participation in May 2016 was the highest ever for Māori at 68% and May 2013 77.3% overall.

Bowel Screening

The measure for bowel screening is: men and women aged 60- 74 years who have completed a bowel screening test kit in the past 2 years. The target is 60%.

West Coast DHB rolled out the National Bowel Screening Programme in May 2021. Participation figures will not show accurate trends for 6 months.

Atlas of HealthCare Variation[53] [what would be most useful]

Currently, analyses are available for the following Atlas domains

asthma
community use of antibiotics
diabetes
gout
mental health in primary care
opioids
polypharmacy in older people.

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[50] Wehipeihana, N., Sebire, K. W., Spee, K. & Oakden, J. (2020). *More than just a jab: Evaluation of the Māori influenza vaccination programme as part of the COVID-19 Māori health response.* Wellington: Ministry of Health.

[51] National Cervical Screening Programme Coverage Report (shinyapps.io)

[52] https://minhealthnz.shinyapps.io/nsu-bsa-coverage-dhb/

[53] Health Quality & Safety Commission | Primary health organisation analyses (hqsc.govt.nz)

Maori Health Equity Dashboard HQSC[54]

Access & Experience [small numbers so no information published]

No information about percentage of respondents who couldn't get health care from a GP or nurse

No information about people who could not visit a GP or nurse because of cost.

No information about people who couldn't pick up a prescription because of cost\

No information about people who felt involved in decisions about their care and treatment.

No information about whether patients felt their GP or nurse spent enough time with them.

Overall Health Status

Diabetes

The diabetes prevalence rate on the West Coast for Māori is 3.3 per 100 population compared with 2.4 per 100 for non-Māori, non Pacific [age standardised to the 2013 Māori population]. The Māori rate has been stable over time.

The number of West Coast people in the Virtual Diabetes Register [55] increased from 1195 in 2010 to 1549 in 2019. There are currently 155 Māori (10%) on the VDR. The number seems lower than expected given the prevalence rate. Note people not registered with a GP, or who died during the year are excluded.

Quality Standards for Diabetes Care[56]

The recent WCDHB response to the Quality Standards for Diabetes Care identified

[54] Health system quality dashboard May 2021 | Tableau Public

[55] Virtual Diabetes Register (VDR) | Ministry of Health NZ

[56] Quality Standards for Diabetes Care 2020 | Ministry of Health NZ

Data from Diabetes Stocktake June 2021

1. How many people with diabetes in your DHB received a retinal screen in the last 12 months? 2. How many people with diabetes have not had a retinal screen in the last 3 years? 3. What percentage of your diabetes population are engaged in a retinal screening programme? 4. Please describe how your DHB provides retinal screening services. 5. What is the median time interval for referral from retinal screening to an ophthalmic appointment? 6. Describe your COVID response / recall process?	1. 61.2% (in the last 2 yrs) /24% no date recorded. Age: we don't report age. Ethnicity: Maori 63.6% (14 people), Pacific 33% (1 person) Indian 0%, Other 25% (1 person, European 63% (137 people/23% no date recorded). 2. For those enrolled with the PHO and have had a DAR in the last 12 months - by ethnicity: Maori 4 people, Pacific 2 people, Indian 2 people, Other 2 people, NZ European 50 people. 3. 61.2% of those had a DAR in general practice. (Noting that numbers have slipped due to Covid impact in 2020) There are also people under ophthalmology and, private optometrist. 4. West Coast PHO provide retinal screening clinics (4-5 week-long sessions per year) that rotate between the major towns on the West Coast. The PHO keep a recall register and work with practices to update recall lists and those due/overdue. Priority is given to those on 6 monthly/annual recall (i.e. they have retinopathy) and those overdue. Reporting needs to be pushed out to 3 yrly instead of 2 yrly for those with no retinopathy and being placed on 3 yrly screening by optometrist.* 5. Specific data not available; however, our ESPI compliance for referral to FSA for specialist ophthalmology service is within compliance for the 120 day maximum wait time target. 6. COVID response – Services were by necessity reduced while the general practices concentrated on Covid swab testing work and limiting non-urgent patient contact as much as possible in direct response to the pandemic. As consequence, LTC programme work fell behind as noted in Q3 above. Practices currently focussed on catch-up work.

*This is actively managed on a case-by-case basis by the optometrist. Younger patients, those with a high HbA1c and 'first timers' are prioritised. Patents with good control or those who are older and those in residential care (ie lower requirement for own transport) are allocated a longer interval.

Personalised support All people with diabetes will receive personalised expert advice on lifestyle choices such as good nutrition and regular physical activity together with behaviour change, smoking cessation advice and support if required.	1. How many people with diabetes smoke? 2. What percentage of people with diabetes have been offered a smoking cessation conversation? (National SLM targets) 3. How many dietitians who see people with diabetes do you have working? i. FTE in primary care ii. FTE in secondary care 4. How many health psychologists who see people with diabetes do you have working? i. FTE in primary care ii. FTE in secondary care	1. Available in quarterly reporting from 56.5% YTD who have had an annual review. Smokers YTD av 10% By ethnicity: Maori av 28%, Pacific av 17%, Other 0%. YTD 2. Data available in quarterly reporting. YTD 92%. By ethnicity: Maori 89% (7 people to 90%), Pacific 85% (2 people to 90%), European 92%, Asian 91%, Other 90%, unknown 100%. YTD	Continue with current work focus on diabetes based or the West Coast PHO long term conditions programme and the Whakakotahi mode of care interface between general practice and Poutir Waiora (Maori heath servic provider), with support from the DHB's Diabetes Nurse Specialists.
Annual assessment All people with diabetes will be offered, as a minimum, an annual assessment for the risk and presence of diabetes-related complications and for cardiovascular risk (CVDRA). They will be provided with the outcome of the risk assessment and should participate in making their own care plans. They should set agreed and documented goals/targets with their health care team, including a specific target for glycaemic control.	1. Does your DHB provide a funded Diabetes Annual Review (DAR) and/or CVDRA? 2. What percentage of people with diabetes have a DAR and or CVDRA? 3. How many people with diabetes are on a statin?	1. Yes 2. Quarterly report data. YTD DAR 57%, CVDRA 81% DAR By ethnicity: Maori 53%, Pacific 40%, Indian 50%, other Asian 55%, Other 64%, European 57% YTD CVDRA By ethnicity: Maori 73.2%, Pacific 63.5%, European 82.7%, Asian 59.1%, Other 83.1%, Unknown 72.4% YTD 4. 42% YTD By ethnicity: Maori 42%, Pacific 33%, Other 42% YTD	People identified with diabetes have an annual review of their condition as part of the Long Term Conditions (LTC) management programme. As at the end of March 2021, LTC Programme activity is still significantly reduced due to the combined impacts of Covid in 2020. Practices are now focussing on catch-up work for diabetes reviews. 56.5% of the population identified with diabetes (1519) have had their diabetes annual review.
Insulin Initiation When insulin is required, it should be initiated by trained health care professionals within a structured programme that, whenever possible, includes education in dose titration by the person with diabetes.	1. How many people with diabetes had poor or uncontrolled glycaemic control (defined as HbA1c > 65 mmol/mol?) continuously over the last 3 years? 2. What percentage of your primary care practices provide insulin initiation and optimisation services? 3. How is your workforce prepared and supported to initiate and optimise insulin?	1. 44% av YTD: By ethnicity: Pacific av 78% (6 people), Maori av 44% (30 people), Other av 34% (individual people = 3 Other, 1 Indian, 210 European). YTD and age: we don't report age 2. Unsure, as practices are heavily reliant on locums. 3 private practices do, and DHB	West Coast DHB's Diabetes Clinical Nurse Specialists do a lot of insulin initiation, education and ongoing management.

etinal Screening ll people with diabetes will have ccess to regular retinal photography r an eye examination at nationally ecommended intervals, with prompt ubsequent specialist phthalmological treatment if ecessary.	1. How many people with diabetes in your DHB received a retinal screen in the last 12 months? 2. How many people with diabetes have not had a retinal screen in the last 3 years? 3. What percentage of your diabetes population are engaged in a retinal screening programme? 4. Please describe how your DHB provides retinal screening services. 5. What is the median time interval for referral from retinal screening to an ophthalmic appointment? 6. Describe your COVID response / recall process?	1. 61.2% (in the last 2 yrs) /24% no date recorded. Age: we don't report age Ethnicity: Maori 63.6% (14 people), Pacific 33% (1 person) Indian 0%, Other 25% (1 person, European 63% (137 people/23% no date recorded). 2. For those enrolled with the PHO and have had a DAR in the last 12 months - by ethnicity: Maori 4 people, Pacific 2 people, Indian 2 people, Other 2 people, NZ European 50 people. 3. 61.2% of those had a DAR in general practice. (Noting that numbers have slipped due to

There were 110 new referrals to the DHB podiatry service seen in the 12 months to 31 March 2021. New referrals are routinely seen at next available clinic.
5. No. However, it is noted that of the four patients who have had lower limb amputations in the last 12 months, none had been under DHB podiatry care for their Diabetes

DNA data for Specialist Diabetes outpatient clinics in 2020 = 10.3%.
Whakakotahi WCPHO Diabetes project
Gestational diabetes: average 5-7 women at a time

Cardiovascular Disease[57]

The Māori population, when compared with non-Māori New Zealanders, are:

1. More than twice as likely to die from cardiovascular disease, and 1.5 times as likely to be hospitalised for cardiovascular disease.[1]
2. Twice as likely to die from ischaemic heart disease, and 1.3 times as likely to be hospitalised for ischaemic heart disease. The disparity is even greater for females; Māori females are almost twice as likely to be hospitalised for ischaemic heart disease as non-Māori females.[1]
3. 1.5 times more likely to die from stroke, and 1.5 times more likely to be hospitalised for stroke. The disparity is greater for females; stroke hospitalisation among Māori females is more than twice as high as that among non-Māori females.

Much of the burden caused by cardiovascular disease is preventable. Major modifiable risk factors for Māori people and non-Māori include tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, overweight and obesity, diabetes, poor nutrition, and excessive intake of alcohol. Other risk factors that are beyond our control include age, gender, family history and ethnicity.

[57] Heart Disease and Maori • Heart Research Institute NZ (hri.org.nz)

- Obesity rates among Māori children and adults are twice the rate of non-Māori children and adults. Around 19 per cent of Māori children and 48 per cent of Māori adults are obese.
- Māori adults are twice as likely to have diabetes and 1.4 times more likely to have high blood pressure.
- Māori adults are more than twice as likely to smoke as non-Māori adults. Around 41 per cent of Maori adults are smokers.

Heart failure hospitalisation, 35 plus years, rate per 100,000 population

During reporting period 2020 the rate of Māori hospitalisations for health failure was 439.2 per 100,000 compared to 167.4 per 100,000 hospitalisations for health failure for non-Māori, non Pacific. This fluctuates a lot due to small numbers.

Total cardiovascular disease hospitalisation, 35 plus years, rate per 100,000 population

During reporting period 2020 the rate of Māori hospitalisations for cardiovascular disease was 2,502 per 100,000 compared to 1,876 per 100,000 hospitalisations for health failure for non-Māori, non Pacific. Again this fluctuates due to small numbers.

Cardiac Surgery[58] SIMON BERRY WEST COAST MAORI FIGURES?

2,625 cardiac surgeries were performed in New Zealand in 2018. Nationally, Māori received 289 surgeries (11%). Obesity, diabetes and smoking history were distinguishing features for Māori. Nationally, 74% of cardiac surgery was performed on men. In terms of ages, about 50% of surgery was performed on people aged 50-69 years and about 40% on people more than 69 years.

Total cardiovascular disease mortality rates, 35 plus years, rate per 100,000 population

In the 2016 reporting period, Cardiovascular mortality rates for Māori in West Coast (per 100,000 population, 35 years plus, age standardised to the 2013 Māori population) was XXX per 100,000 compared to XXX per 100,000 for non-Māori, non-Pacific. NOT ON EQUITY DASHBOARD FOR WCDHB

Cardiovascular Disease and Palliative Care[59]

This article provides a perspective on cardiovascular disease (CVD) and palliative care need among Māori New Zealanders, given CVD is New Zealand's leading cause of premature deaths and disability among Māori. High Māori CVD risk factors will contribute to a sharp increase in older Māori deaths which has implications for health and palliative care service provision. However, accessing palliative care and obtaining and understanding information can be challenging for families who are already often overburdened with high social and economic disadvantages. Meeting the high financial costs associated with end-of-life care make living with CVD challenging. Engaging with the health system's biomedical approach when holistic care is preferable can be a major barrier.

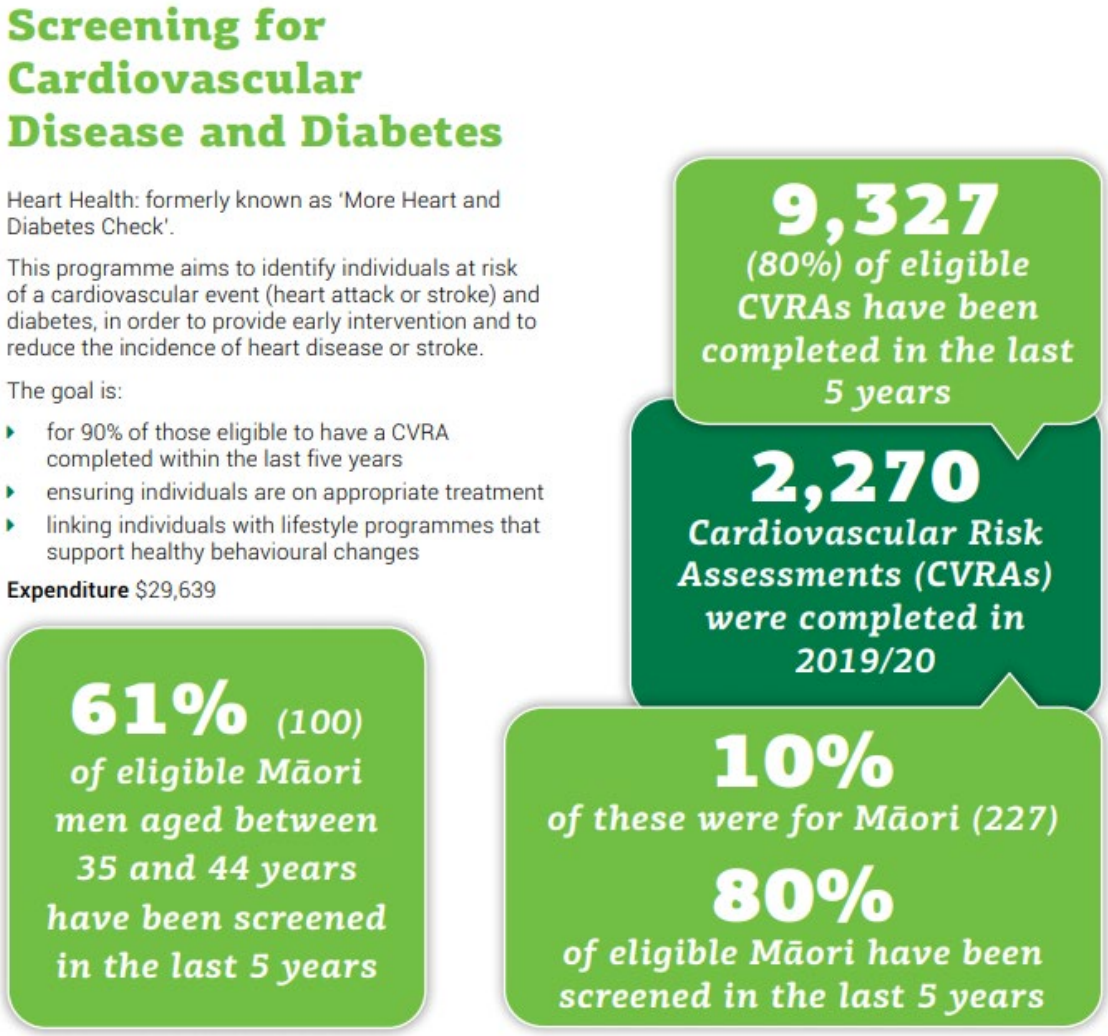
Summary: Māori families provide the bulk of care at end-of-life, but they can become fatigued with the challenges that accompany long-term progressive illnesses, such as CVD. They are also burdened by the financial costs associated with end-of-life. It is often difficult for Māori to access palliative care and to obtain and understand information about the illness and treatment. Navigating an unfamiliar and complex health system, low health literacy among Māori and poor relationship building and communication skills of health professionals are significant barriers. Cultural safety training would help to increase health and cardiovascular professionals' cultural understanding of Māori and their

[58] New Zealand Cardiac Surgery National Report 2018 (health.govt.nz)

[59] 2019 Mar;13(1):Māori: living and dying with cardiovascular disease in Aotearoa New Zealand Kathleen Mason[1], Frances Toohey, Merryn Gott, Tess Moeke-Maxwell

holistic end-of-life preferences; this could go some way to strengthen rapport building and communication skills necessary for effective engagement and informational exchanges. Increasing the Māori palliative care workforce and introducing cultural safety training among health professionals could help to bridge the gap. A current study to gather traditional care customs and present these to whānau and the health and palliative care sectors in the form of an online resource could contribute to this decolonizing objective.

West Coast PHO[60]



Stroke Hospitalisation

The stroke hospitalisation rate, 35 plus years, per 100,000 in 2020 (age standardised against the 2013 Māori population) was XX for Maori compared to XX for non-Māori, non Pacific. NOT ON EQUITY DASHBOARD FOR WEST COAST

Asthma Hospitalisation

The adult asthma as primary diagnosis hospitalisation admissions rate per 1,000 population in 2018 (age standardised against the 2013 Māori population) was XX Māori and XX non-Maori, not Pacific NOT ON EQUITY DASHBOARD

[60] Westcoast PHO Annual Report 2019-2020 Web.pdf

Safety: note these indicators do not have Māori/all

Selected indicator: In hospital falls causing FNOF per 100,000 admissions

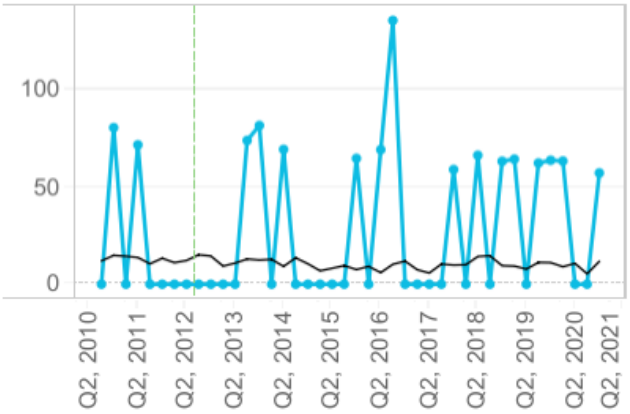
Lower is better

Measure

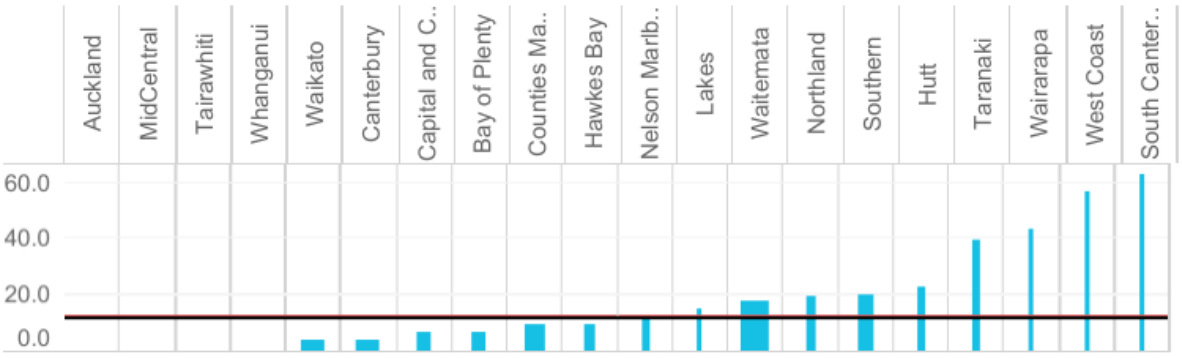
DHB of service
57.3 rate per 100,000 admissions
worse than NZ baseline by
2.3 Z scores, Q4, 2020

NZ baseline: 12.7
Jul 2010 - Jun 2012

Change

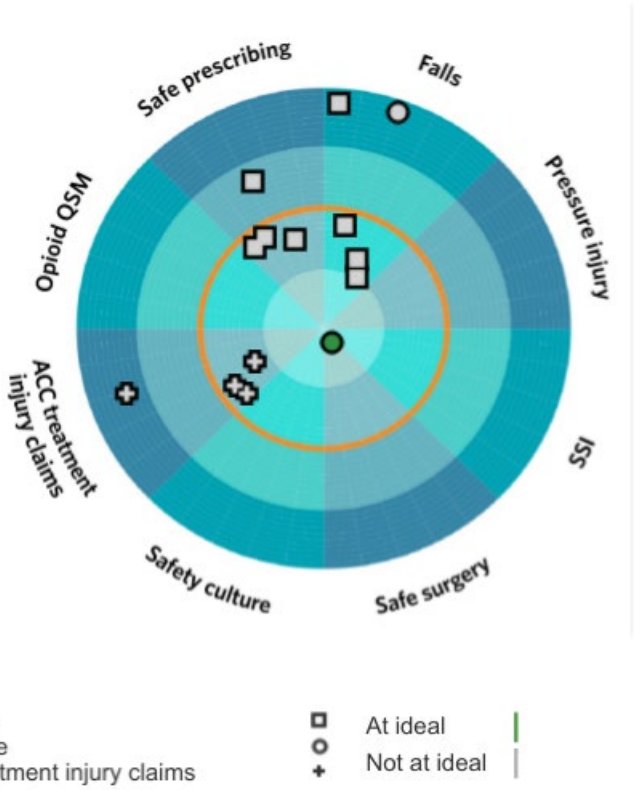


Variation



Missing indicates zero value or suppression due to small sample.

Higher is better | Lower is better | ACC claims | NZ baseline | NZ current



Emergency Department, Admissions to Hospital Soledad Labbe-Hubbard/Simon Berry/Peter MacIntosh or…..

XXX

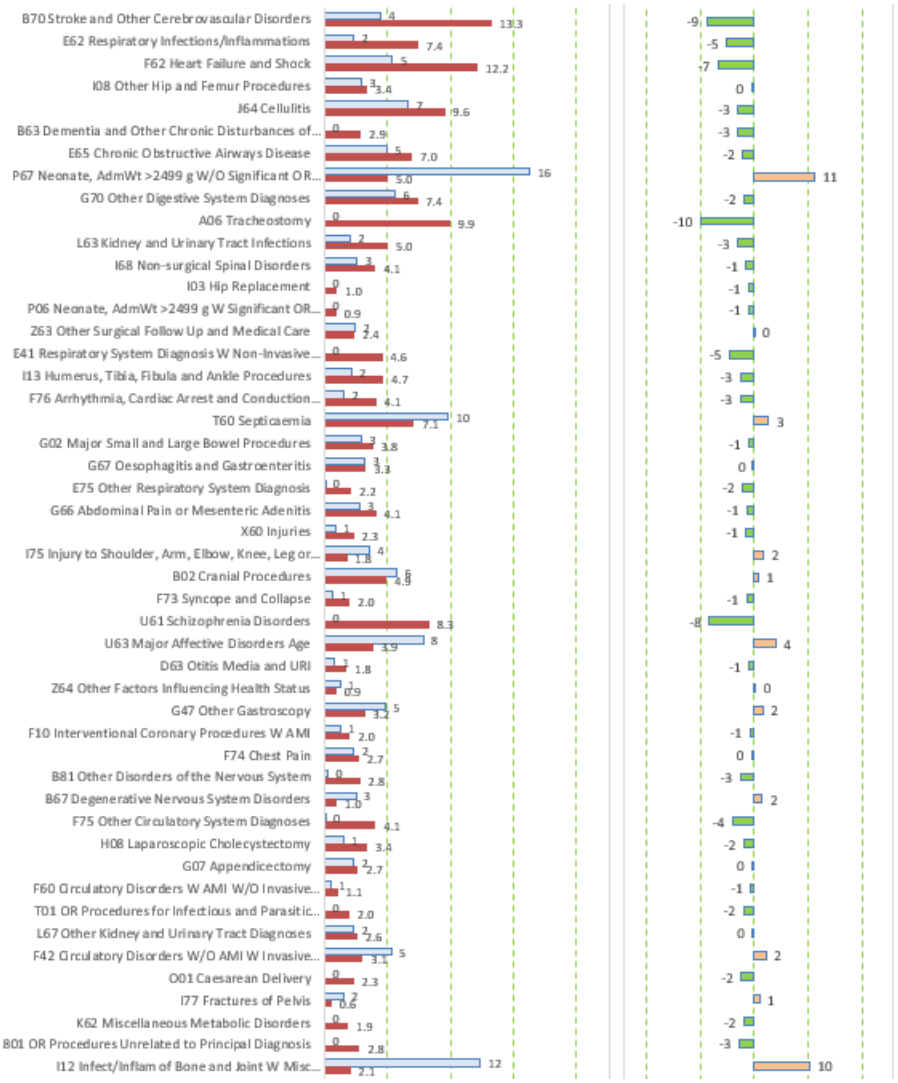
Standardised Acute Hospital Bed Days per 1,000 population[61]

The age standardised acute hospital bed days rate per 1,000 to March 2021, was 428 for the total population; 311 for Māori [SLM measure]

2.8/1000 cf 3.8 national; Maori 0.9 cf 2.3 national.

West Coast green in table below [all population]

[61] Acute Hospital Bed Days SLM Data | Nationwide Service Framework Library (health.govt.nz)



Ethnic Group Comparison - Actual Acute Bed Days per Capita Rates

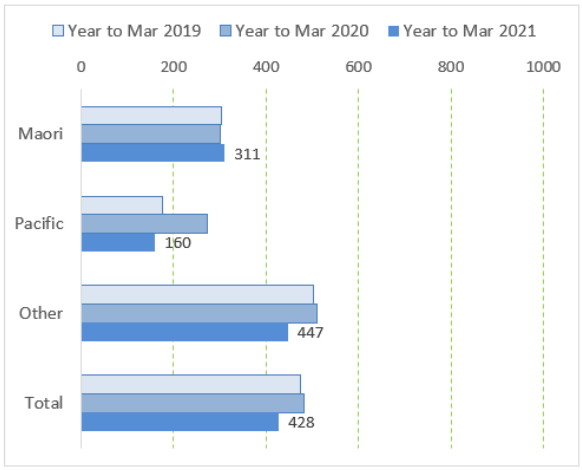
West Coast DHB of Domicile

Year	Estimated Popn Year to Mar 2021	Acute Stays Year to Mar 2021	Acute Bed Days Year to Mar 2021	Actual Acute Bed Days per 1,000 Popn Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Maori	3,890	445	1,209	303	301	311
Pacific	385	30	62	177	274	160
Other	28,300	3,528	12,658	502	510	447
Total	32,575	4,003	13,929	475	483	428

National

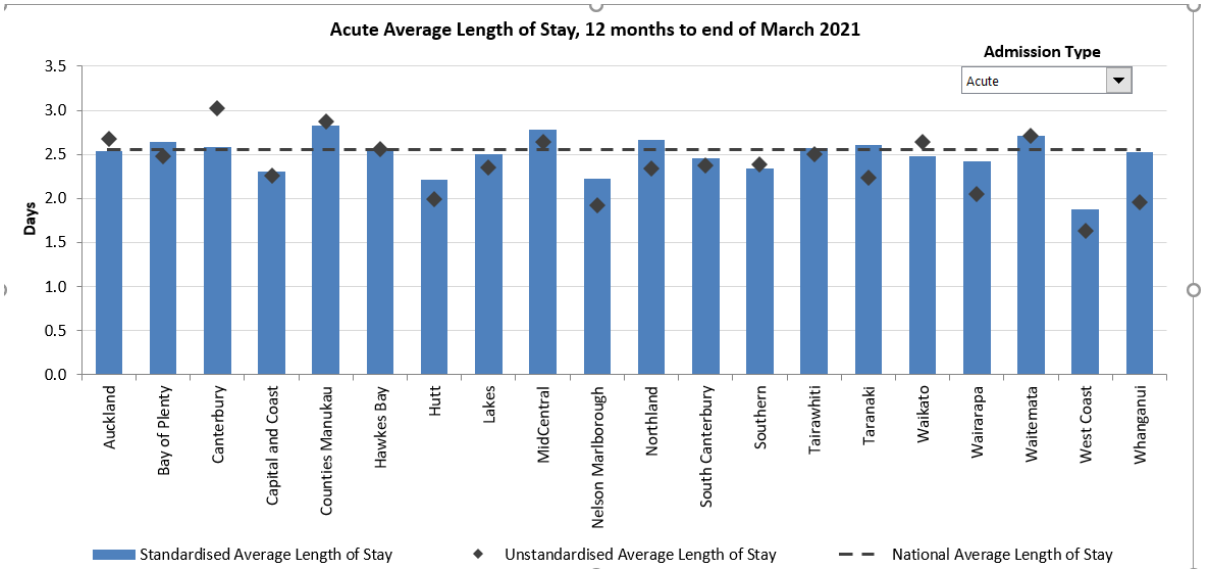
Year	Estimated Popn Year to Mar 2021	Acute Stays Year to Mar 2021	Acute Bed Days Year to Mar 2021	Actual Acute Bed Days per 1,000 Popn Year to Mar 2019	Year to Mar 2020	Year to Mar 2021
Maori	831,295	107,564	314,790	407	413	379
Pacific	332,115	46,839	140,988	489	492	425
Other	3,835,715	433,545	1,489,047	436	426	388
Total	4,999,125	587,948	1,944,825	435	428	389

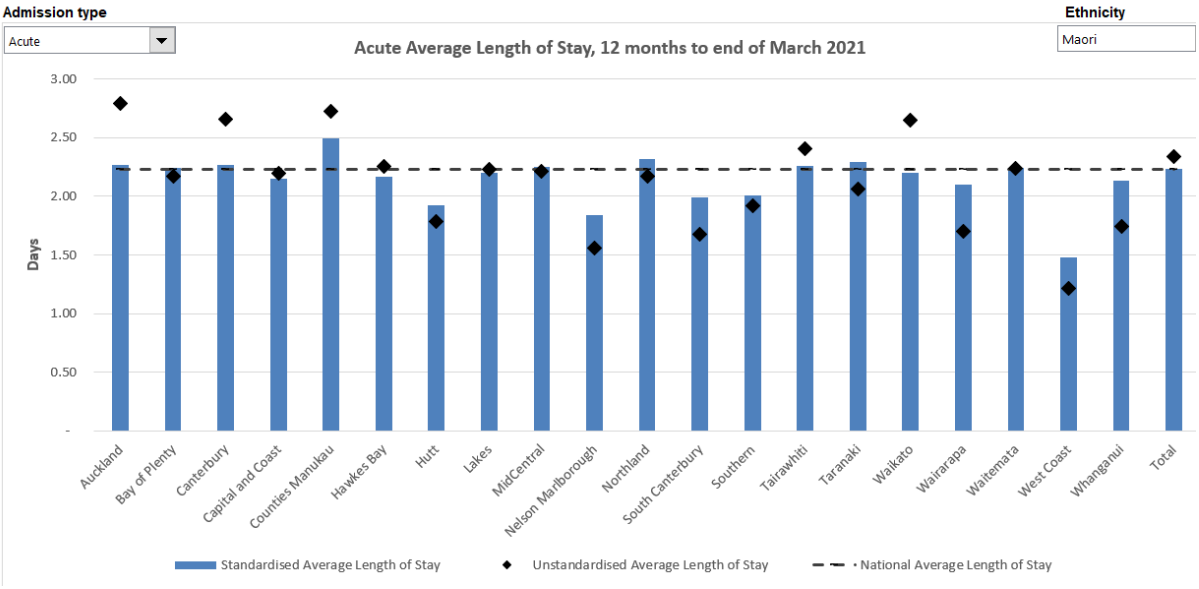
West Coast DHB of Domicile



Select Population for DHB Comparison: Total <= Select Age Group Total

DHB of Domicile	Year to Mar 2021	Year to Mar 2021	Year to Mar 2021	Year to Mar 2019	Year to Mar 2020	Year to Mar 2021	Rank (Year to Mar 2021)
Auckland	112,177	9,911	30,400	294.9	299.3	271.0	7
Bay of Plenty	31,465	2,849	9,644	307.5	318.9	306.5	6
Canterbury	176,329	16,306	60,443	354.9	361.2	342.8	2
Capital and Coast	100,666	9,560	24,655	266.2	275.2	244.9	10
Counties Manukau	100,559	6,865	24,454	271.0	269.5	243.2	11
Hawke's Bay	25,628	1,900	5,846	191.8	207.2	228.1	13
Hutt	35,295	3,346	8,462	262.9	244.6	239.7	12
Lakes	12,436	604	1,984	161.2	205.7	159.5	17
Midcentral	24,399	1,444	4,450	184.4	186.7	182.4	15
Nelson Marlborough	28,075	1,684	4,562	173.3	164.4	162.5	16
Northland	12,223	274	594	73.7	63.5	48.6	20
South Canterbury	10,864	972	3,432	468.3	379.5	315.9	5
Southern	80,358	6,833	21,609	295.8	297.4	268.9	9
Tairawhiti	4,645	245	730	118.9	150.6	157.2	18
Taranaki	16,117	2,461	7,003	486.5	515.4	434.5	1
Waikato	62,933	5,683	20,087	336.5	346.4	319.2	4
Wairarapa	7,146	661	1,936	247.0	245.4	270.8	8
Waitemata	163,660	16,420	52,473	369.0	328.1	320.6	3
West Coast	2,851	288	617	244.0	317.0	216.3	14
Whanganui	5,346	279	623	204.5	248.6	116.6	19
National	1,013,172	88,585	284,001	304.1	301.0	280.3	





Did not attend at a glance: ??

Mental Health[62] who on West Coast is registered to see this data?

Population under Mental Health Act: section 29 Community Treatment Orders, rate per 100,000 population

A community treatment order requires a patient to receive services as an outpatient. The most recent data available [Quarter 3 to 31/3/2017 showed the rate of Māori as XX and non-Māori XX.

plit by Maori and other ethnicity

HBs only

ervice Organisation	Quarter C Jul15-Jun16				Quarter D Oct15-Sep16				Quarter A Jan16-Dec16				Quarter B April16 - March17			
	Maori		Non-Maori		Maori		Non-Maori		Maori		Non-Maori		Maori		Non-Maori	
	Number of clients under	Rate per 100,000 population	Number of clients under	Rate per 100,000 population	Number of clients under	Rate per 100,000 population	Number of clients under s29	Rate per 100,000 population	Number of clients under	Rate per 100,000 population	Number of clients under	Rate per 100,000 population	Number of clients under	Rate per 100,000 population	Number of clients under s29	Rate per 100,000 population
uckland	189	463	647	142	178	436	598	131	215	521	633	136	217	526	635	137
ay of Plenty	102	182	70	42	104	186	77	46	108	191	81	48	109	193	82	49
anterbury	102	213	412	85	104	217	397	82	102	209	392	80	100	205	398	81
apital & Coast	288	835	599	223	284	823	606	225	142	407	374	138	150	430	370	137
ounties Manukau	321	382	422	95	326	387	424	95	343	403	446	99	346	407	441	98
awkes Bay	139	338	112	94	143	347	113	95	146	351	123	103	155	373	135	113
utt	62	250	116	97	59	238	117	98	65	259	129	108	64	255	127	106
akes	156	426	76	111	122	333	59	86	145	394	76	111	139	377	75	110
idCentral	72	212	113	81	72	212	126	91	76	222	132	95	73	213	126	90
elson Marlborough	44	295	141	108	42	281	145	111	28	185	101	77	26	172	96	73
orthland	262	452	177	159	265	458	173	156	261	446	173	155	259	443	161	144
outh Canterbury	8	166	50	93	9	187	53	98	8	164	51	94	8	164	54	100
outhern	61	195	250	88	63	202	232	81	72	227	261	91	76	239	260	91
airawhiti	71	300	26	109	77	325	26	109	79	332	27	113	80	336	27	113
aranaki	38	174	76	80	35	160	75	79	37	167	75	79	40	181	76	80
aikato	348	387	319	105	356	396	322	106	373	411	334	109	386	425	349	114
airarapa	22	294	30	83	22	294	30	83	23	303	32	89	23	303	32	89
aitemata	204	349	617	118	203	347	625	119	216	365	655	123	185	313	608	114
est Coast	6	158	33	114	8	211	34	117	7	181	31	106	6	155	32	110
hanganui	28	171	47	102	27	165	42	91	33	200	48	104	31	188	48	104
Z	2,210	303	3,976	102	2215	303	3,947	101	2164	293	3840	97	2178	295	3,819	97

Self Harm Hospitalisations

In December 2020, the self harm age standardised (against 2013 Census population) hospitalisations rate per 10,000 population was XX%, a decrease over the previous two years. SEE ABOVE

[62] MH&A KPI Programme – KPIs for the NZ Mental Health & Addiction Sector (mhakpi.health.nz)

Actual Acute Bed Days per capita rates

West Coast had the XX acute bed rates per capita in NZ to March 2021 with XX per 1,000 total population and XXth highest in NZ at XX for Māori

Accessing Mental Health & Addictions Services[63]

Data for 2019/20 year shows the following for West Coast:

Total clients		Māori clients		%
Total child & youth 0-19 years		Māori child & youth 0-19 years		
Total adults 20-64 years		Māori adults 20-64 years		
Total older people 65 years +		Māori adults 65 years +		

This compares to XX total clients in 2009/10 and XX Māori clients.

[63] Mental Health, Alcohol and Drug Addiction Sector Performance Monitoring and Improvement | Nationwide Service Framework Library

Select your DHB → West Coast DHB

West Coast DHB Clients accessing Mental Health & Addictions service 2002/03 - 2020/21 Q2

Actuals

		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Total Clients	Total Clients	1,536	1,556	1,450	1,430	1,386	1,435	1,453	1,484	1,551	1,459	1,625	1,629	1,576	1,582	1,706	1,635	1,592	1,623	1,606
	Total Child & Youth (0-19 yrs)	407	378	373	346	335	387	415	429	515	456	524	495	525	430	442	434	407	398	391
	Total Adults (20-64 yrs)	959	1,024	941	945	906	911	896	935	926	910	987	1,035	958	1,026	1,132	1,072	1,061	1,083	1,072
	Total Older People (65+)	170	154	136	139	145	137	142	120	110	93	114	99	93	126	132	129	124	142	143

		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Māori Clients	Total Māori Clients	155	155	147	162	173	195	231	244	230	222	286	293	295	261	256	266	299	289	294
	Māori C&Y Clients (0-19 yrs)	63	61	58	54	63	79	111	107	111	101	132	115	134	95	89	88	98	85	91
	Māori Adult clients (20-64 yrs)	88	92	85	102	107	112	115	132	116	118	152	175	156	161	161	173	197	196	195
	Māori Older Clients (65+)	4	2	4	6	3	4	5	5	3	3	2	3	5	5	6	5	4	8	8

		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Other Clients	Total Other Clients	1,381	1,401	1,303	1,268	1,213	1,240	1,222	1,240	1,321	1,237	1,339	1,336	1,281	1,321	1,450	1,369	1,293	1,334	1,312
	Other C&Y Clients (0-19 yrs)	344	317	315	292	272	308	304	322	404	355	392	380	391	335	353	346	309	313	300
	Other Adult clients (20-64 yrs)	871	932	856	843	799	799	781	803	810	792	835	860	802	865	971	899	864	887	877
	Other Older Clients (65+)	166	152	132	133	142	133	137	115	107	90	112	96	88	121	126	124	120	134	135

		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Pacific Clients	Total Pacific Clients	10	8	7	7	5	8	11	12	6	10	9	10	9	13	20	13	21	15	13
	Pacific C&Y Clients (0-19 yrs)	3	2	3	3	1	3	4	5	3	5	4	3	2	3	4	4	9	4	3
	Pacific Adult clients (20-64 yrs)	7	6	4	4	4	5	7	7	3	5	5	6	7	10	16	9	11	11	10
	Pacific Older Clients (65+)	0	0	0	0	0	0	-	-	-	-	-	1	-	-	-	-	1	-	-

West Coast DHB Mental Health Access rates 2002/03 - 2020/21 Q2

Percentage %

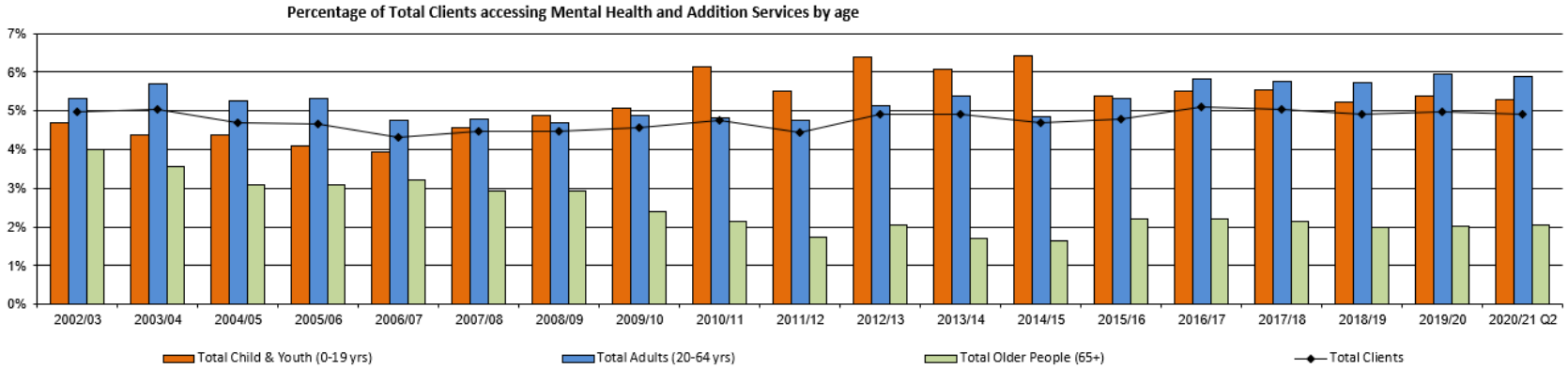
		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Total Clients	Total Clients	5.0%	5.0%	4.7%	4.7%	4.3%	4.5%	4.48%	4.55%	4.7%	4.5%	4.9%	4.9%	4.7%	4.8%	5.1%	5.0%	4.9%	5.0%	4.9%
	Total Child & Youth (0-19 yrs)	4.7%	4.4%	4.4%	4.1%	3.9%	4.6%	4.88%	5.07%	6.1%	5.5%	6.4%	6.1%	6.4%	5.4%	5.5%	5.5%	5.2%	5.4%	5.3%
	Total Adults (20-64 yrs)	5.3%	5.7%	5.3%	5.3%	4.8%	4.8%	4.68%	4.88%	4.8%	4.7%	5.1%	5.4%	4.8%	5.3%	5.8%	5.8%	5.7%	5.9%	5.9%
	Total Older People (65+)	4.0%	3.6%	3.1%	3.1%	3.2%	2.9%	2.95%	2.41%	2.2%	1.8%	2.1%	1.7%	1.6%	2.2%	2.2%	2.1%	2.0%	2.0%	2.0%

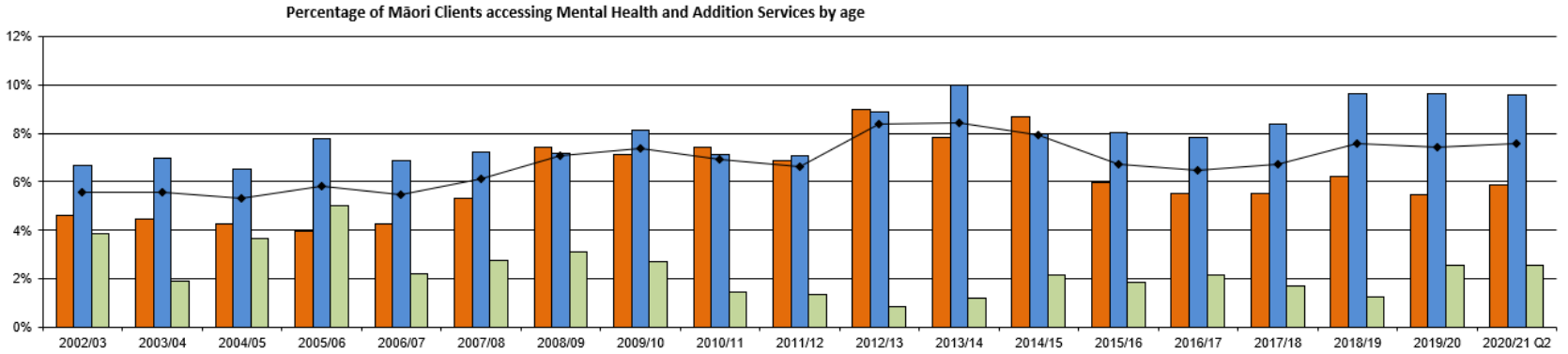
		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Māori Clients	Total Māori Clients	5.6%	5.6%	5.3%	5.8%	5.5%	6.1%	7.10%	7.38%	6.9%	6.6%	8.4%	8.4%	7.9%	6.7%	6.5%	6.8%	7.6%	7.4%	7.6%
	Māori C&Y Clients (0-19 yrs)	4.6%	4.5%	4.3%	4.0%	4.3%	5.3%	7.42%	7.13%	7.4%	6.9%	9.0%	7.8%	8.7%	6.0%	5.5%	5.5%	6.2%	5.5%	5.9%
	Māori Adult clients (20-64 yrs)	6.7%	7.0%	6.5%	7.8%	6.9%	7.2%	7.19%	8.15%	7.1%	7.1%	8.9%	10.0%	8.0%	8.0%	7.9%	8.4%	9.7%	9.7%	9.6%
	Māori Older Clients (65+)	3.8%	1.9%	3.7%	5.0%	2.2%	2.8%	3.13%	2.70%	1.5%	1.3%	0.9%	1.2%	2.2%	1.9%	2.1%	1.7%	1.3%	2.6%	2.6%

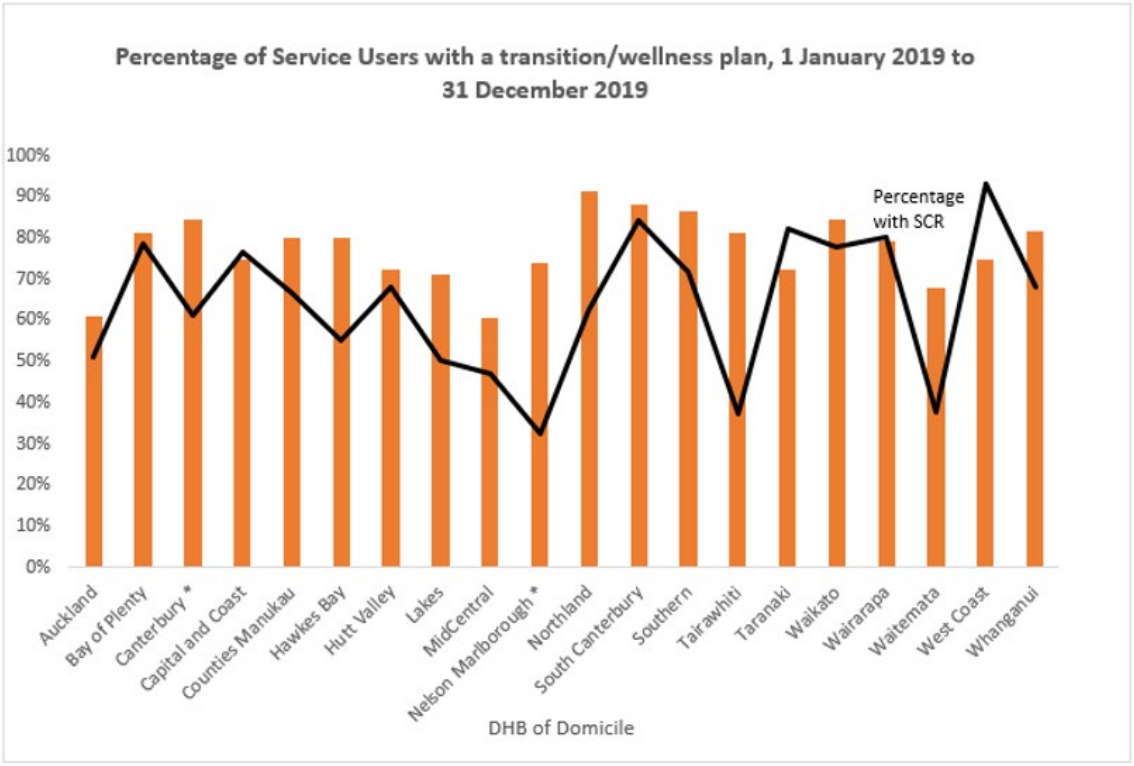
		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Other Clients	Total Other Clients	4.9%	5.0%	4.6%	4.5%	4.2%	4.3%	4.19%	4.23%	4.5%	4.2%	4.5%	4.5%	4.3%	4.5%	4.9%	4.8%	4.5%	4.6%	4.6%
	Other C&Y Clients (0-19 yrs)	4.7%	4.4%	4.4%	4.1%	3.9%	4.4%	4.34%	4.62%	5.9%	5.2%	5.8%	5.7%	5.9%	5.3%	5.5%	5.5%	5.0%	5.4%	5.1%
	Other Adult clients (20-64 yrs)	5.2%	5.6%	5.2%	5.1%	4.6%	4.6%	4.46%	4.58%	4.6%	4.5%	4.8%	4.9%	4.5%	5.0%	5.6%	5.4%	5.3%	5.5%	5.4%
	Other Older Clients (65+)	4.0%	3.6%	3.1%	3.0%	3.2%	2.9%	2.94%	2.40%	2.2%	1.8%	2.1%	1.7%	1.6%	2.2%	2.2%	2.2%	2.0%	2.0%	2.0%

		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 Q2
Pacific Clients	Total Pacific Clients	6.5%	5.3%	4.6%	4.7%	2.2%	3.4%	4.73%	5.00%	2.5%	4.1%	3.5%	3.6%	2.6%	3.5%	4.9%	3.4%	5.3%	3.9%	3.4%
	Pacific C&Y Clients (0-19 yrs)	4.8%	3.2%	4.9%	5.6%	1.1%	3.3%	4.57%	5.71%	3.5%	6.5%	4.6%	3.1%	1.4%	1.9%	2.4%	2.7%	6.2%	3.0%	2.2%
	Pacific Adult clients (20-64 yrs)	7.8%	6.7%	4.4%	4.3%	3.0%	3.5%	4.83%	4.59%	1.9%	3.1%	3.0%	3.5%	3.9%	5.1%	7.4%	4.4%	5.1%	4.8%	4.3%
	Pacific Older Clients (65+)	0	0	0	0	0	0	0.00%	0.00%	0.0%	0.0%	0.0%	13.3%	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%

West Coast DHB Mental Health Access rates Charts by age & Ethnicity 2002/03 - 2020/21 Q2







[64] [Mental Health, Alcohol and Drug Addiction Sector Performance Monitoring and Improvement | Nationwide Service Framework Library]

Shorter Waits for Non-Urgent Services PP8

Report run on 25 Jun 2020

Select your DHB - West Coast

West Coast DHB Mental Health and Addictions Non-Urgent Waiting Times

Mental Health Provider	12-19 Years			0-19 Years			20-64 Years			65+			Grand Total		
	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %
<=3 weeks	52	62.7%	62.7%	86	55.8%	55.8%	151	86.3%	86.3%	31	91.2%	91.2%	268	73.8%	73.8%
3-8 weeks	21	25.3%	88.0%	42	27.3%	83.1%	18	10.3%	96.6%	3	8.8%	100.0%	63	17.4%	91.2%
>8 weeks	10	12.0%		26	16.9%		6	3.4%		-	0.0%		32	8.8%	
Total	83	100.0%		154	100.0%		175	100.0%		34	100.0%		363	100.0%	

Provider Arm & NGO (Alcohol and Drug)	12-19 Years			0-19 Years			20-64 Years			65+			Grand Total		
	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %
<=3 weeks	3	25.0%	25.0%	11	36.7%	36.7%	32	46.4%	46.4%	3	60.0%	60.0%	46	44.2%	44.2%
3-8 weeks	2	16.7%	41.7%	2	6.7%	43.3%	26	37.7%	84.1%	2	40.0%	100.0%	30	28.8%	73.1%
>8 weeks	7	58.3%		17	56.7%		11	15.9%		0	0.0%		28	26.9%	
Total	12	100.0%		30	100.0%		69	100.0%		5	100.0%		104	100.0%	

Provider Arm Alcohol ar	12-19 Years			0-19 Years			20-64 Years			65+			Grand Total		
	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %
<=3 weeks	2	100.0%	100.0%	2	100.0%	100.0%	32	46.4%	46.4%	3	60.0%	60.0%	37	48.7%	48.7%
3-8 weeks	0	0.0%	100.0%	0	0.0%	100.0%	26	37.7%	84.1%	2	40.0%	100.0%	28	36.8%	85.5%
>8 weeks	0	0.0%		0	0.0%		11	15.9%		0	0.0%		11	14.5%	
Total	2	100.0%		2	100.0%		69	100.0%		5	100.0%		76	100.0%	

NGO Alcohol and Drug	12-19 Years			0-19 Years			20-64 Years			65+			Grand Total		
	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %
Grand Total															
<=3 weeks	1	10.0%	10.0%	9	32.1%	32.1%	0	0.0%	0.0%	0	0.0%	0.0%	9	32.1%	32.1%
3-8 weeks	2	20.0%	30.0%	2	7.1%	39.3%	0	0.0%	0.0%	0	0.0%	0.0%	2	7.1%	39.3%
>8 weeks	7	70.0%		17	60.7%		0	0.0%		0	0.0%		17	60.7%	
Total	10			28			0			0			28		

Forensic	12-19 Years			0-19 Years			20-64 Years			65+			Grand Total		
	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %	Client seen	Percentage	Cumm %
<=3 weeks	0	0.0%	0.0%	0	0.0%	0.0%	2	100.0%	100.0%	0	0.0%	0.0%	2	100.0%	100.0%
3-8 weeks	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%	100.0%	0	0.0%	0.0%	0	0.0%	100.0%
>8 weeks	0	0.0%		0	0.0%		0	0.0%		0	0.0%		0	0.0%	
Total	0	0.0%		0	0.0%		2	100.0%		0	0.0%		2	100.0%	

Identifies all those NGOs who have greater than 20% of clients waiting for >8 weeks

In 2018 across NZ 91% of service users were accessing services in the community; 8% were accessing both community and inpatient services and 1% inpatients services only.

64

Cancer[65] [more work to be done here: Southern hub may have data already: Nicholas Glubb]

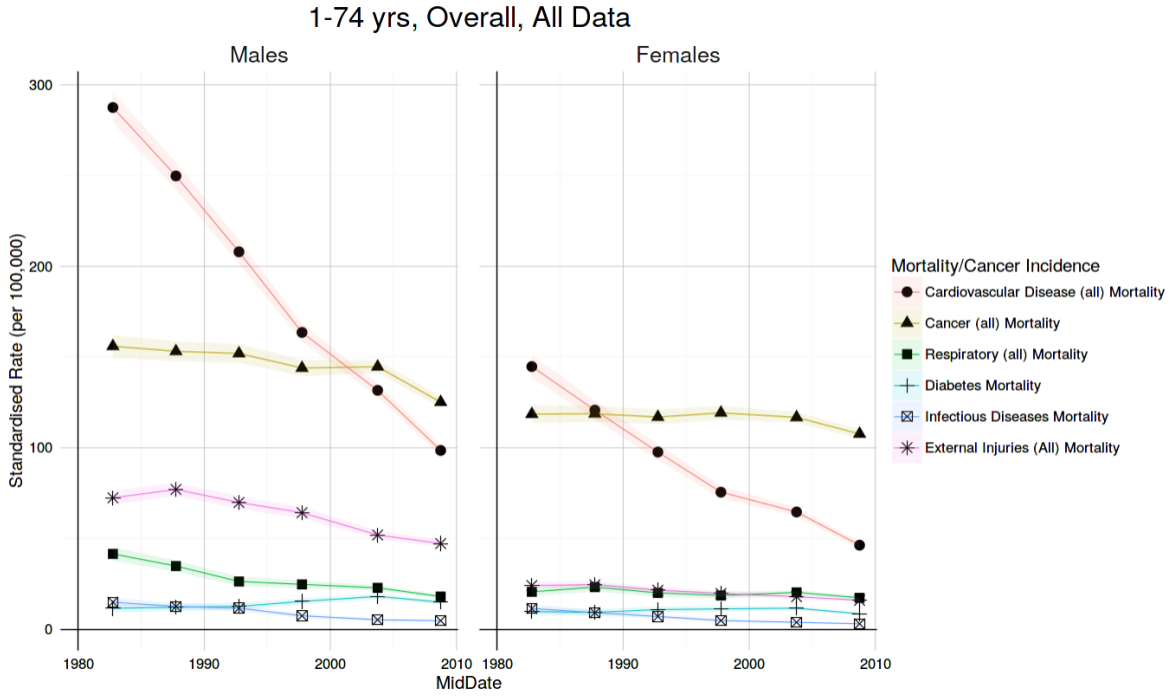
Te Aho o te Kahu, Cancer Control Agency, was established in 2019 to provide increased focus on the impact cancer has on the lives of New Zealanders.

There were 155,958 cancer registrations in NZ in XX (Maori 15,536, ~ 10%)[66].

In West Coast in 2018 XX% of all cancers were diagnosed in the Emergency Department.

The radiation oncology intervention rate[67] in West Coast for all cancers is higher than the national average for the total population and for Māori.

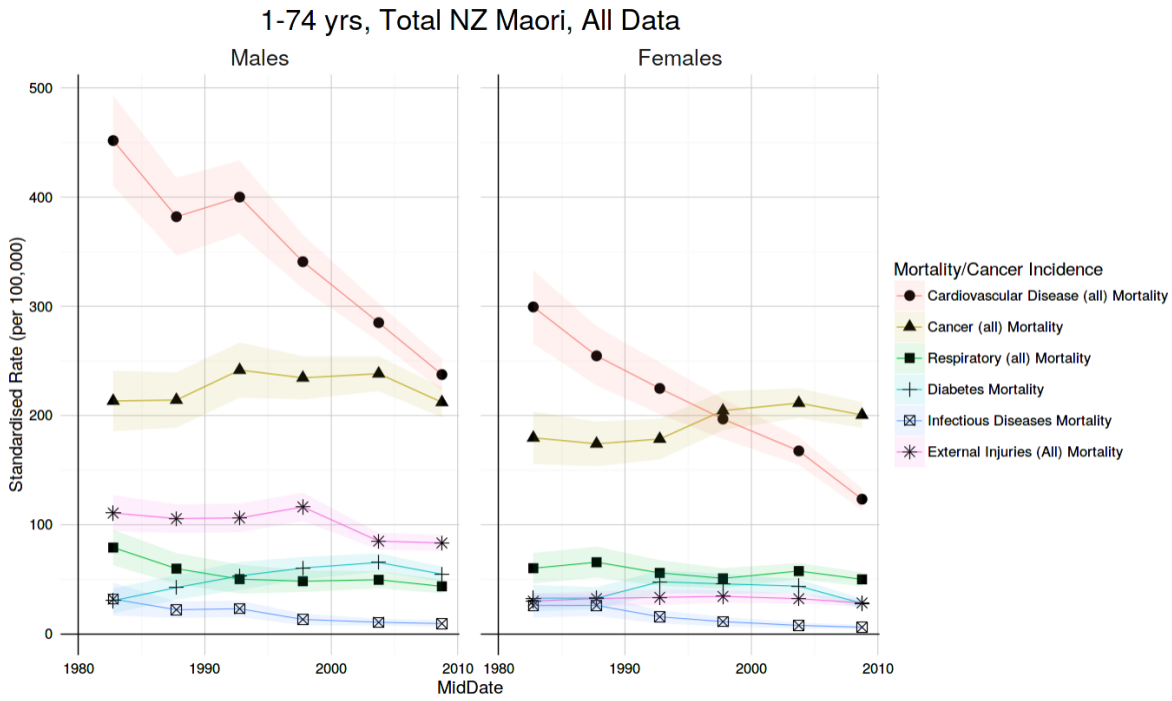
NZ Census Mortality and Cancer Trends Study Data Explorer https://nzcms-ct-data-explorer.shinyapps.io/version8/



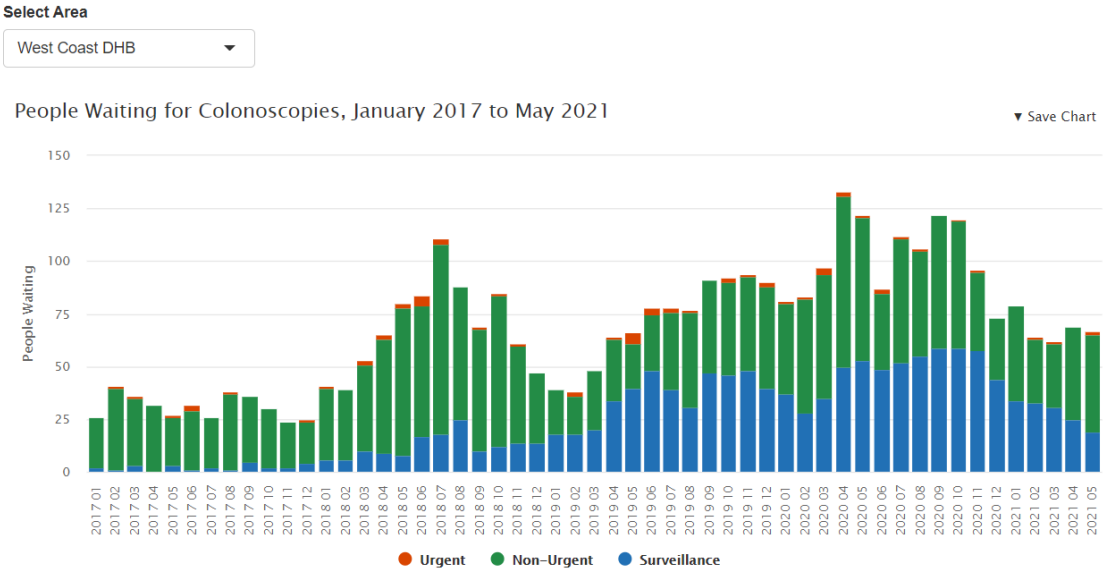
[65] Te Aho o Te Kahu – The state of cancer in New Zealand 2020

[66] Home | Cancer Care Data Explorer (shinyapps.io)

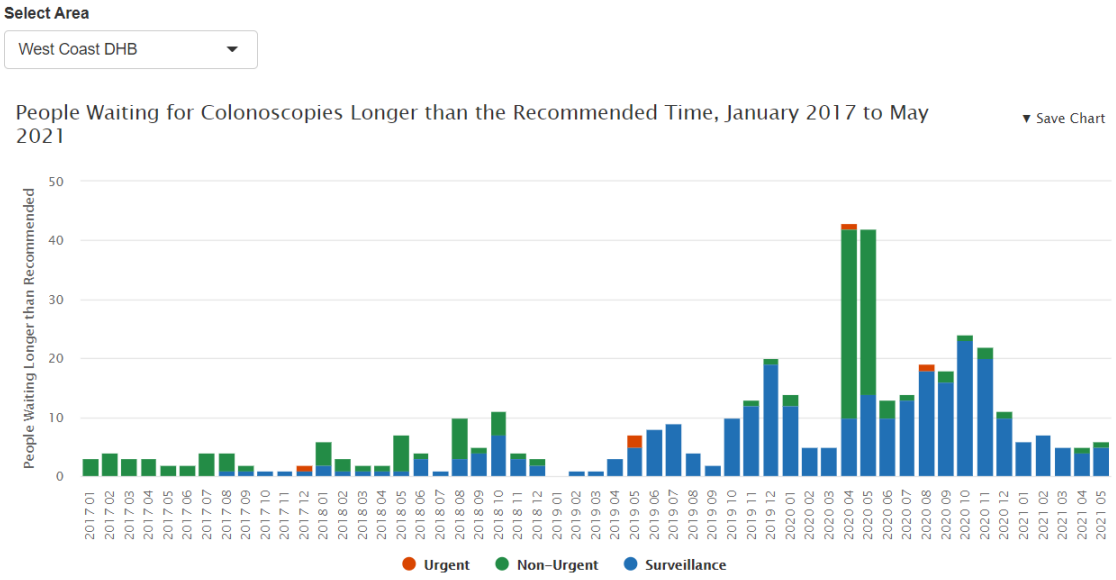
[67] Radiation oncology online tool - Test version 0.2 - In development (shinyapps.io)



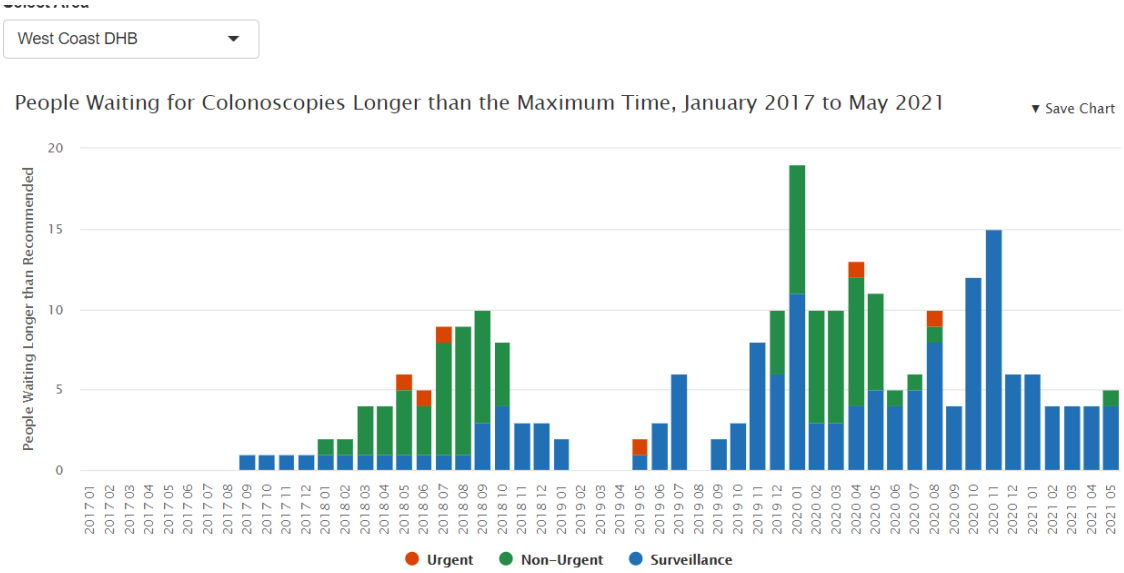
National Colonoscopy Wait Time Indicator https://minhealthnz.shinyapps.io/nsu-bsp-colonscopywaittime/



2 urgent, 46 non urgent, 19 surveillance



1 non-urgent and 5 surveillance



1 non-urgent and 4 surveillance

Older People[68][69][70]

In 2018 6,300 people in West Coast were estimated to be over 65 years of age; 280 of whom were Māori. However, Māori are more likely to be younger with comorbidities. There were estimated to be 1,140 Māori in the 40-64 year band in 2018.

Hospital admissions, age, type ethnicity etc SIMON BERRY

Refer above for acute admission DRGs

[68] Predictive factors for entry to long-term residential care in octogenarian Māori and non-Māori in New Zealand, LiLACS NZ cohort | BMC Public Health | Full Text (biomedcentral.com)

[69] Estimated population of the West Coast Region, New Zealand - Figure.NZ

[70] Older Persons' Health | Community & Public Health (cph.co.nz)

Home Based Support Services XXX?

Aged Residential Care[71]

In 2017/18 there were 31,600 people living in aged residential care in NZ; 4.7% identified as Māori (1,485). The average age of first assessment in aged residential care is 85 years.

In 2019/20 in West Coast there were XX funded aged residential care bed days for XX people. There were XX funded bed days for Maori (X%) for XX people (X%).

Amenable Mortality Rate

The (WHO) age standardised amenable mortality rate per 100,000 in 2016 year was 156 for Māori and 69 for non-Māori, non Pacific. This rate has been declining steadily for non-Māori, non-Pacific from 2009, but not for Māori.

Mortality[72] [73]

There were XX deaths in West Coast in the year to December 2018:

	00-04	05-19	20-39	40-54	55-64	65-74	75-84	85+
All								
Māori								

[71] Aged-Residential-Care-FINAL.pdf (interrai.co.nz)

[72] https://minhealthnz.shinyapps.io/mortality_webtool/;

[73] Mortality web tool | Ministry of Health NZ

Deaths by regional council areas
2007–2020

Regional council area	December year													
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Northland region	1,224	1,344	1,287	1,233	1,365	1,374	1,365	1,377	1,443	1,563	1,611	1,692	1,662	1,644
Auckland region	7,218	7,404	7,386	7,227	7,692	7,665	7,566	8,034	8,175	8,007	8,577	8,586	8,619	8,328
Waikato region	2,787	2,871	2,760	2,772	2,937	2,931	2,919	2,955	3,105	3,066	3,378	3,420	3,393	3,357
Bay of Plenty region	2,139	2,241	2,226	2,139	2,202	2,211	2,238	2,352	2,517	2,403	2,676	2,583	2,787	2,526
Gisborne region	378	387	360	381	366	396	399	387	351	378	432	429	456	393
Hawke's Bay region	1,281	1,200	1,251	1,206	1,269	1,326	1,269	1,377	1,467	1,368	1,527	1,515	1,584	1,440
Taranaki region	939	912	897	909	978	948	888	963	1,008	981	1,017	1,026	1,041	1,002
Manawatu-Whanganui region	1,812	1,920	1,941	1,905	1,911	1,920	1,947	2,064	2,016	2,082	2,262	2,190	2,178	2,052
Wellington region	2,865	3,015	2,955	2,916	3,123	3,123	3,024	3,186	3,150	3,237	3,300	3,330	3,693	3,282
Tasman region	324	297	300	309	348	342	372	339	375	384	372	402	450	366
Nelson region	381	411	360	372	375	417	411	402	447	447	468	441	474	444
Marlborough region	366	381	378	360	378	393	396	381	411	426	405	450	414	423
West Coast region	255	273	264	249	291	252	291	279	294	267	309	291	300	273
Canterbury region	4,107	4,017	4,206	4,272	4,473	4,359	4,098	4,422	4,305	4,158	4,494	4,431	4,608	4,476
Otago region	1,530	1,617	1,560	1,392	1,542	1,635	1,581	1,689	1,641	1,536	1,647	1,626	1,695	1,677
Southland region	783	786	765	744	807	783	780	816	879	855	849	804	888	894
Region not stated/ area outside region	132	108	66	48	27	21	24	42	24	24	21	15	21	30
New Zealand	28,521	29,190	28,962	28,437	30,081	30,099	29,568	31,062	31,608	31,179	33,342	33,225	34,260	32,613

Notes:

a. Deaths are based on deaths registered in New Zealand of New Zealand residents by date of registration.

b. This data has been randomly rounded to protect confidentiality. Individual figures may not add up to totals, and values for the same data may vary in different tables.

MATCH THIS AGAINST AGE/SEX PYRAMID?

Health Workforce

Increasing the Maori workforce is a national priority [agreement between Tumu Whakrae and DHB CEOs].

Medical Education Auckland and Otago Universities

Nursing Education

Nursing Education Pre-Registration Pipeline, June 2021

The Nursing Pre-Registration Edu

Allied, Scientific & Technical Education

DHB Employed Workforce [74]

The DHB Distribution of Employees, March 2021 shows that West Coast DHB had xx employees in March 2021 [845employed, 241 Others (maternity/parental leave or otherwise not reported with an employment status code]. This represents 1.2% of the DHB workforce nationally.

The distribution of ethnicities by DHB looks as follows:

[74] DHB-Employed-Workforce-Quarterly-Report-Mar-2021.pdf (tas.health.nz)

ETHNICITIES BY DHB

The following chart shows the proportion of ethnicities within each DHB employee population (ordered by descending proportion of 'unknown' ethnicities). It does not represent the actual number of people by each ethnicity; this is detailed in the table further below.

Figure 9: Proportion of reported ethnicities by DHB

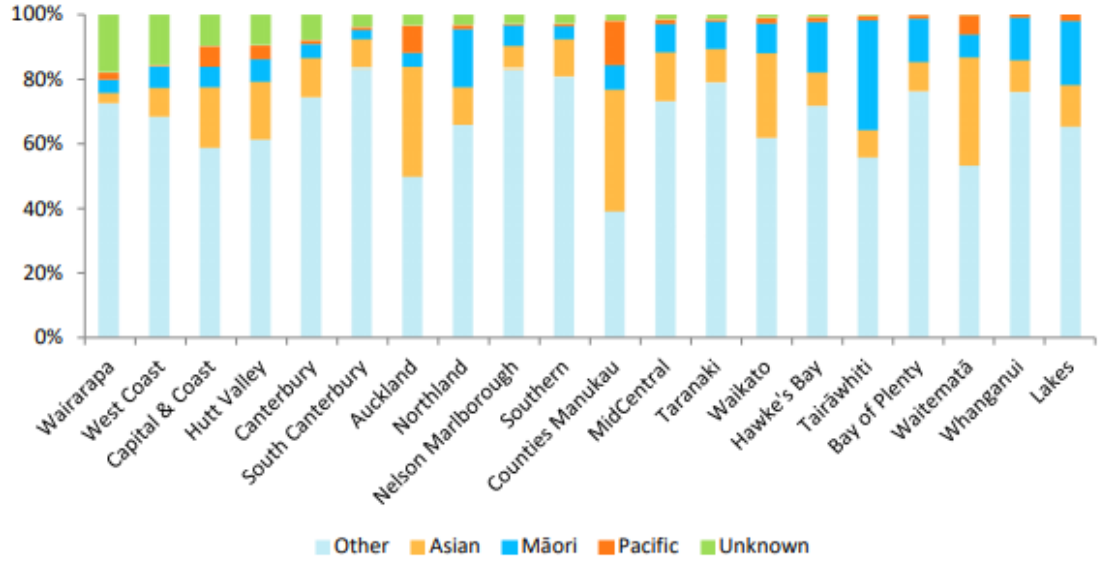


Table 8: Distribution of reported ethnicities by DHB

DHB	Other*	Asian	Māori	Pacific	Unknown	Total
Wairarapa	416	19	24	13	102	574
West Coast	577	77	55	4	132	845
Capital & Coast	3,580	1,144	364	410	591	6,089
Hutt Valley	1,291	379	146	92	198	2,106
Canterbury	7,627	1,262	450	132	803	10,274
South Canterbury	650	73	24	7	30	784
Auckland	5,439	3,646	520	918	362	10,885
Northland	2,282	408	625	43	112	3,470
Nelson Marlborough	2,207	200	170	14	76	2,667
Southern	3,771	545	197	38	129	4,680
Counties Manukau	3,209	3,064	621	1,115	152	8,161
MidCentral	2,013	421	242	40	41	2,757
Taranaki	1,460	193	158	15	25	1,851
Waikato	4,824	2,039	721	140	75	7,799
Hawke's Bay	2,249	328	488	51	23	3,139
Tairāwhiti	508	78	308	13	3	910
Bay of Plenty	2,652	324	465	44	2	3,487
Waitematā	4,153	2,601	559	471	4	7,788
Whanganui	777	102	135	10	-	1,024
Lakes	999	198	303	30	-	1,530
Grand Total	**50,684**	**17,101**	**6,575**	**3,600**	**2,860**	**80,820**

* 'Other' is a group amalgamation of all ethnicities that do not fall into the groups Asian, Māori or Pacific.
** Data suppressed (headcounts less than 5)

ANALYSIS BY DHB AND OCCUPATION GROUP

LENGTH OF SERVICE BY OCCUPATION GROUP AND DHB

The following table shows the mean length of service for each occupation group by DHB. To read this table, look at the occupation column. The green colours represent a longer than national average length of service, the yellow colours are similar to the national average while red colours are lower than the national average. The final column (all staff) has ordered the DHBs by longer to shorter lengths of service.

Table 9: Mean length of service by occupation group and DHB

DHB	Nursing	Corporate and other	Allied and scientific	Care and support	SMO	RMO	Midwifery	All staff
Whanganui	10.2	9.7	10.9	9.6	10.0	1.2	10.6	9.7
Southern	10.5	9.6	8.5	8.2	11.0	2.2	8.7	9.2
Taranaki	10.0	10.1	9.2	9.9	7.8	1.4	8.4	9.2
Canterbury	9.9	8.0	9.5	9.2	11.2	2.2	9.1	9.0
MidCentral	10.1	9.0	8.5	8.5	10.8	1.3	8.3	9.0
West Coast	9.8	6.9	9.5	10.1	5.7	1.5	8.2	8.7
South Canterbury	9.3	8.5	8.3	9.7	7.1	1.0	6.5	8.5
Tairāwhiti	10.0	7.5	7.9	8.3	8.0	0.8	6.1	8.4
Lakes	9.5	8.4	8.3	7.2	8.1	1.4	7.3	8.2
Bay of Plenty	9.2	9.0	7.3	7.2	9.1	1.5	7.2	8.1
Nelson Marlborough	9.4	7.3	7.7	8.2	10.2	1.2	6.2	8.1
Waikato	8.3	8.2	8.3	7.0	10.1	1.9	6.6	7.8
Hutt Valley	8.5	8.5	7.9	8.7	9.0	0.7	7.4	7.8
Auckland	7.7	8.1	8.0	8.6	10.5	0.7	7.1	7.8
Wairarapa	8.8	6.7	8.2	7.4	8.0	0.3	3.8	7.7
Hawke's Bay	8.0	8.3	8.3	7.3	9.7	1.5	6.9	7.7
Northland	8.1	8.8	8.5	5.3	8.4	1.1	7.0	7.6
Counties Manukau	6.9	8.2	6.9	6.6	10.1	0.6	7.5	7.0
Waitematā	6.9	7.0	7.7	6.7	9.7	0.7	6.7	6.9
Capital & Coast	6.9	6.7	6.7	7.9	10.1	1.2	7.0	6.7
Grand Total	**8.4**	**8.1**	**8.1**	**7.7**	**10.0**	**1.3**	**7.4**	**7.9**

ETHNIC REPRESENTATION OF WORKFORCE TO RESIDENT POPULATION

The following charts look at the ethnic representation of DHB staff to the resident population.

The calculations look at the percentage of staff with a known ethnicity and compare it to the percentage of DHB residents with a known ethnicity. This latter data has been interpolated from data produced by Statistics New Zealand and is representative for the quarter being reported on. The proportion of staff with a known ethnicity this quarter was 96.5 percent, compared to 89.6 percent in March 2016.

The four ethnicity groups used are: Other, Asian, Māori and Pacific – 'Other' is an amalgamation of all other ethnicities but is primarily European including the 'New Zealander' ethnicity. Throughout these charts this is the order of presentation.

When a bar on a chart is green it means the proportion of that ethnicity in the DHB workforce is greater than the population. If a bar is red then the proportion of the DHB workforce is less than that of the resident population. All charts use the same axis scale (as these are spark lines the numbers are not written against the axes), which range from -25% to +26% - so comparisons between DHBs are possible. The data for 2016 has also been added to show any changes over the last five years.

It is important to note that some DHBs have very small counts by ethnicity; for example West Coast has fewer than five Pacific employees. This means the data can be quite volatile. Also, those DHBs that are heavily weighted towards a particular ethnicity in their population such as Pacific people in Counties Manukau or Māori in Waikato, will tend to show greater deviations between the DHB workforce ethnicities and the resident population.

Note: The four bars are ordered as: Other, Asian, Māori and Pacific

For some DHBs the ethnic distribution of their staff closely mirrors that of the resident population, such as Capital & Coast. Overall, the distributions have changed only slightly between 2016 and 2021; the 'Other' ethnicities have reduced closer to zero (from nine down to three percentage points difference), whereas Māori have marginally less under-representation (from negative nine to negative seven percentage points difference).

FIND REFERENCE – and check whether applicable to WCDHB

Did not attend Procedures – Summary of Findings

Definition – A patient is categorised as a DNA if they did not attend the outpatient clinic or surgical appointment and there was no communication before the appointment. If there was communication, this is deemed to be a reschedule or cancellation.

Purpose – The purpose of carrying out a stock take of DNA procedures within each Medical /Surgical department is to review what policies/protocols each department is using or currently has in place.

Overview of the Issue – Every department/service will have a number of patients who do not turn up for an appointment. Patient DNA's result in the under-use of resources, as well as the disruption of the flow of patients through the treatment pathway. This subsequently results in major impacts in cost and quality.

Aim – The aim is to align the procedures and protocols that are in place and to create a **maximum** of 3 robust policies that each department can adhere to. This will allow for a streamlined and efficient method of reporting and will enable improvement on how best to support the patient in ensuring that appointments are kept and will ultimately provide an equitable service to all patients.

Goal – The goal for the CDHB should be to facilitate appointments on dates, and at times that are suitable for patients. It has been demonstrated that patients who have been involved in negotiating their appointment date and time are less likely to DNA. (Ministry of Health).

DNA Procedures across Services/Departments

	Current procedures utilised
Diabetes	" 2 strikes and you are out"
Cardiology	"2 strikes and you are out"
Gastroenterology	"2 strikes and you are out"
Endocrinology	" 2 strikes and you are out"
Oral Health	No policy
Plastic Surgery	No policy/guidelines
Neurosurgery	Specialist Discretion
Eye Outpatients	Follow instructions by Consultant/Registrar, if no instructions then contact patients and ensure details are correct; send a new

	appointment. Diabetic patients who DNA are sometimes given 3 or so chances
Neurology	As per Hagley OPD Clerical Procedure Manual
ENT Outpatients	Patient is DNA'ed on PMS – Consultant to decide whether a new appointment is issued
Rheumatology	DNA patients are offered at least one, usually two follow up appointments
Sexual Health	DNA protocol is built into clinical and receptionist processes. An action plan is created depending on review of DNA notes
Respiratory	2 separate processes for a FSA (check patient details on PMS, call patient to discuss reason for DNA, complete first time DNA letter) and a FU (check patient details on PMS, call patient to discuss reason for DNA, complete first time DNA letter, place back on FU list with appropriate triage code)
Nephrology /Dialysis	Patient is usually offered one or even two further appointments following a DNA
Vascular & Cardiothoracic	All patients are telephoned 2 days in advance to ensure attendance
Urology	"2 strikes and you are out"
Lipids	As per Hagley OPD clerical Manual
Dermatology	As per Hagley OPD clerical Manual
Infectious Diseases	As per Hagley OPD clerical Manual
General Surgery	First DNA – check that patient got appointment Second DNA – return to care of GP
Haematology & Oncology	No protocol
Radiology	DNA'ed on PMS – Notes given to Consultant to decide – most cases are sent back to GP

Protocol/procedure	Number of services/Depts utilising	Service area
2 Strikes and you are out	5	• Diabetes • Cardiology • Gastroenterology • Endocrinology • Urology
As per Hagley OPD Clerical Manual	5	• Lipids • Dermatology • Infectious Diseases • Neurology • Sexual Health
Specialist/Consultant Discretion	4	• Radiology • Neurosurgery • Eye Outpatients • ENT outpatients
No Protocol/Policy in place	4	• Haematology • Oncology

		• Plastic Surgery • Oral Health
Telephoned 2 days in advance	2	• Vascular • Cardiothoracic
1st DNA – check patient got appointment 2nd DNA – return to care of GP	1	• General Surgery
Patient offered at least one, sometimes 2 further appointments	3	• Nephrology • Dialysis • Rheumatology
Separate protocols for FU and FSA	1	• Respiratory

DNA Procedure Guidance

DHB's should define a policy or service policies that best meet the current needs of their DHB.

Some suggested actions should include:

a. Clinical review of the patient's records/referral following DNA to confirm whether a re-appointment is necessary.
b. If no re-appointment is required, DNA letters generated and sent to both the patient, and the primary health care physician.
c. If the patient does require a second appointment, administration staff will contact the patient, confirm contact details, and agree a suitable time/date for the new appointment.
d. If the patient requires s second appointment, but administration staff cannot contact them by phone, some alternative methods to reach the patient include:

    I. Try at different times of the day
    II. Check/confirm the phone number in the phonebook, with the GP, other involved health professional, computer system, or contact details provided on the Patient Information Form
    III. Checking old medical records for alternative contact details
    IV. Checking local schools (if appropriate)

e. Consider use of forms to support communication with GPs. For example email or fax back form. The GP will contact the patient to determine why they did not attend the appointment and verify that the appointment is still required.
f. If the patient has been discharged to GP care, but the GP feels an assessment is still indicated, s/he can contact the patient to determine why

they did not attend the appointment. If the patient still wants/needs an appointment, and has agreed to attend, a new referral is sent.

g. Administration staff to update systems to reflect the outcome of the DNA – e.g. Re-appointment, returned to GP care (event closed), unable to contact – no further appointments

Reporting and auditing of DNAs

- DNA volumes should be monitored and reported against at least quarterly, preferably monthly
- DHBs should consider introducing a KPI to support management of DNAs, for example: “DNAs are maintained at 5% or less”.
- Active intervention and review of DNA management strategies should occur if DNA numbers increase more than three months in succession. It is recommended that DNA trends are analysed/audited at least quarterly, with issues identified that related to referral management or patterns in patient behaviour.
- Improved DNA management strategies should be developed as a response to DNA auditing and customer feedback to support Service Quality Improvement initiatives.

Suggested strategies to prevent DNAs

- Patient focused booking
- Use of acknowledgement letters
- Improved appointment letters
- More timely scheduling
- Reminder letters
- Reminder telephone calls
- Booking by telephone to negotiate appointment time, with letter confirmation
- Information brochures and maps
- Text reminders
- Transport options/support
- Use of interpreters, or appointment letters translated into different languages