Health New Zealand
Te Whatu Ora

Health Quality &
Safety Commission
Te Tāhū Hauora

‘The path of making things right: Te ara whakatika’ project

This project is from the Trauma National Clinical Network, a partnership between Health New Zealand | Te Whatu Ora (Health NZ), ACC and the Health Quality & Safety Commission Te Tāhū Hauora (the Commission). It is part of a broader work programme to establish a contemporary trauma system of care in Aotearoa New Zealand.

Purpose

The purpose of ‘The path of making things right: Te ara whakatika’ is to ensure all patients (tūroro) with major trauma receive the post-acute community rehabilitation and support they need following discharge from hospital – with a focus on those experiencing greater levels of unmet health need, as identified through data and lived experience.

Evidence shows Māori experience disproportionately high levels of unmet health need related to major trauma and greater burden of injury. The focused approach of this project is proportionate and appropriate to the level and type of need identified. Future phases may consider extending learning to other groups experiencing high levels of unmet health need.

What the data tells us

Evidence shows Māori experience disproportionately higher levels of unmet health need related to major trauma injuries. Māori aged 15–64 years have more than double the risk of dying and more than 1.5 times the risk of hospitalisation due to accidental injuries, compared with non-Māori of the same age.[1]

Māori are also more likely to experience disability from all types of injury,[2] including higher rates of physical, psychological and financial disability at 3 and 12 months after their injury,[3] with long-term effects on their lives.[4]

Despite the high rates of injury, disability and mortality, Māori have traditionally had lower rates of access to ACC services than non-Māori. Māori are less likely to access or receive rehabilitation services that support full recovery.[5] When Māori do engage with these services, it can take them longer to access, and they have fewer interactions with services. This reflects systemic barriers in service access and design, where indigenous peoples or ethnic minorities often have lower rates of accessing and using health care services.[6]

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[1] Wyeth EH, Derrett S, Nelson V, et al. 2021. POIS-10 Māori: outcomes and experiences in the decade following injury. *Methods and Protocols* 4(2), 37. DOI: 10.3390/mps4020037.

[2] Lambert M, Wyeth EH, Brausch S, et al. 2021. ‘I couldn’t even do normal chores’: a qualitative study of the impacts of injury for Māori. *Disability and Rehabilitation* 43(17): 2424–30. DOI: 0.1080/09638288.2019.1701102.

[3] Kandelaki T, Evans M, Beard A, et al. 2021. Exploring admissions for Māori presenting with major trauma at Christchurch Hospital. *New Zealand Medical Journal* 134(1530).

[4] Tāhū Hauora Health Quality & Safety Commission. 2022, *op cit.*

[5] Te Tāhū Hauora Health Quality & Safety Commission. 2022. Ngā whānau Māori wheako ki te tauwhiro pāmamae me te whakaoranga / Whānau Māori experiences of major trauma care and rehabilitation report.

[6] Marrone S. 2007. Understanding barriers to health care: a review of disparities in health care services among indigenous populations. *International Journal of Circumpolar Health* 66(3): 188–98. DOI: 10.3402/ijch.v66i3.18254.

These differences in outcomes highlight the need for injury prevention and rehabilitation approaches that are culturally responsive and grounded in Māori knowledge (mātauranga Māori).

This focus is proportionate and appropriate to the level and type of need identified. While current data highlights significant unmet need for Māori, further evidence is needed to understand how similar patterns may affect other groups experiencing high levels of unmet health need, such as Pacific peoples, rural communities and those facing socioeconomic disadvantage.

About the project

This project follows a quality improvement collaborative methodology that tests and measures improvements, and then shares and implements the changes.

There is an initial co-design and quality improvement phase running over approximately 10 to12 months (phase one) and then scaling up and spreading the improvements and learning with other regions and organisations (phase two).

Improvements to care quality and access are in scope, but changes to ACC's internal processes are not. The project focuses on service delivery within existing frameworks, guided by collaboration and co-design with stakeholders.

This initiative ensures that focus and resources are proportionately directed towards groups experiencing greater levels of unmet health need – in particular Māori, where evidence highlights significant disparities. Accordingly, the support and methodology outlined in the following sections are designed to reflect this approach, ensuring that focus and resources are proportionately directed toward addressing unmet health need for vulnerable communities.

How we will support you

The Commission has established a national team and national expert advisory group to support this project. The national team includes a project manager/quality improvement advisor, external project lead, rehabilitation-focused clinical lead and project coordinator.

The national team will support participating services by helping to:

- work through the quality improvement process
- identify ideas for testing
- develop measures (the Commission team is working to provide data where possible to reduce some of the burden for project teams)
- engage with stakeholders
- share ideas and lessons learned.

What you need to do

For the project to be successful, we are asking participating services to commit to:

- securing support from a senior executive(s) sponsor to participate in the project
- forming a project team comprising a project lead, expert clinicians (from trauma and/or rehabilitation backgrounds), patients or whānau with lived experiences, rehabilitation providers and, where possible, data support
- identifying and approaching other services or organisations that may be involved in the project (eg, rehabilitation providers, kaupapa Māori community services or family and whānau groups) and seek their endorsement and agreement to participate

- providing project team members with enough time to:
    - take part in co-design (mahitahi) and quality improvement activities, and attend online workshop(s) and virtual meetings during the project timeline
    - collect baseline data, collect co-design data, test change ideas and collect testing data.

Methodology

With the Commission's support, project teams will participate in a quality improvement collaborative designed to support proportionate, evidence-informed responses to unmet health need. This comprises two phases.

Phase one (10–12 months)

Activities include:

- connecting trauma services with community rehabilitation providers that have responded to this expression of interest that operate in the same area, to coordinate quality improvement efforts and collaborate as a team where appropriate
- a national learning event to launch and introduce the project
- a co-design process (involving health professionals, consumers, family and whānau) that include national workshops, online sessions and coaching
- developing ideas for change using the literature and co-design process
- two to three (to be confirmed) online learning sessions where participating project teams come together to share learning and progress from local activity, supported by the Commission's trauma programme team
- supported action periods between learning sessions where project teams test and measure change ideas for using the model for improvement and plan-do-study-act (PDSA) cycles (see Appendix 1 for a PDSA cycle diagram)
- a suite of key outcome, balancing and process measures
- implementing successful changes and planning for local sustainability.

Suggested change ideas (see Appendix 2 for an example of a driver diagram)

These change ideas are designed to address unmet health need in a way that is proportionate, culturally grounded, and informed by lived experience – particularly for Māori communities, where evidence shows the greatest need.

- **Co-design and collaboration**: work alongside Māori health experts, cultural advisors, and Māori consumers to co-design service improvement initiatives that uphold cultural values, social structures, and spiritual beliefs. This collaborative approach helps ensure the services are effective, culturally grounded, and guided by consumer and cultural voices from the very beginning.

- **Patient information:** develop resources for patients and whānau. This could include patient information about the importance of rehabilitation, local options for rehabilitation, clarity on the support ACC can provide. Ensure resources are accessible, culturally grounded and written in plain language.

- **Monitoring and feedback**: develop a system to track the progress of patients (tūroro) with major trauma during their rehabilitation. Use culturally relevant feedback mechanisms where indicated, such as whānau meetings or cultural evaluation tools, to gauge satisfaction and areas for improvement.

- **Ongoing support and follow-up**: ensure that after management and discharge processes with the hospital, support major trauma patients with ongoing needs to receive appropriate follow-up care, both physical and mental that, where relevant, integrates the four pillars of the Te Whare Tapa Whā model.

Phase two (6–8 months)

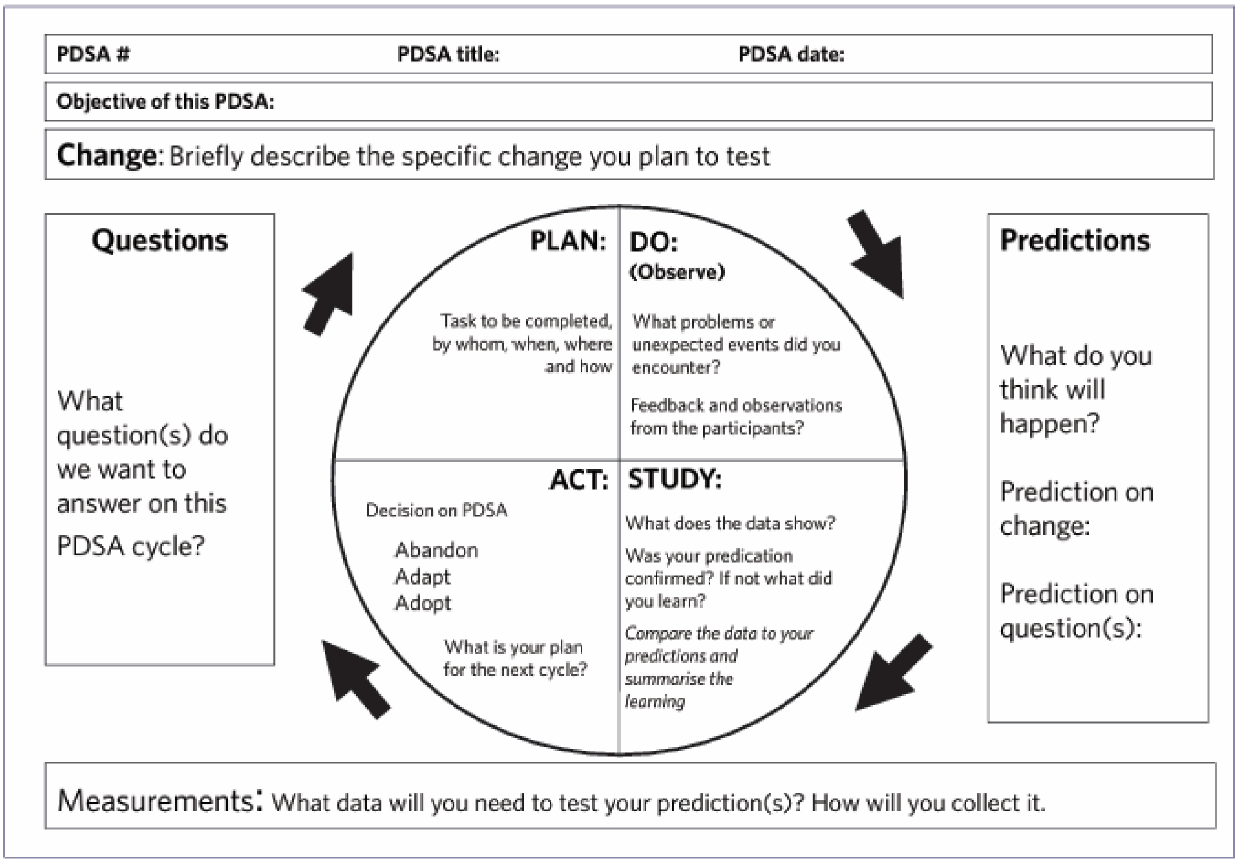
Scale successful changes from phase one co-design and quality improvement and spread this learning to other regions/districts.

It is expected that monitoring of participating sites and outcome measures will continue for two years beyond completion of the project.

Indicative timeline

Date	Activity
October 2025	• Project promotion • Open enrolment for participating project teams
November 2025	• Enrolment for participating project teams closes • Sponsor meeting • Participating project team preparation (ie, establishing project team)
February 2026	• Online learning session one with all participating project teams • Participating project teams prepare for co-design phase and engagement with consumers and whānau
February to April 2026	• Action period one, understand and diagnose the problem, co-design, identify change ideas to test • Monthly virtual meetings
May 2026	• Online learning session two with all participating project teams
May to July 2026	• Action period two, testing change ideas using plan-do-study-act (PDSA) cycles, data collection and analysis • Monthly virtual meetings continue • Participating sites plan for testing change ideas • Site visit as required
August 2026	• Online learning session three
September to October 2026	• Action period three, complete testing, develop an implementation plan, implement changes, audit • Quality improvement testing ends
December to January 2027	• End of phase one report prepared by the Commission

Appendix 1: PDSA cycle diagram



Plan-do-study-act template

PDSA #	**PDSA title:**	**PDSA date:**

Objective of this PDSA:

Change: Briefly describe the specific change you plan to test

Questions

What question(s) do we want to answer on this PDSA cycle?

PLAN:

Task to be completed, by whom, when, where and how

DO:
(Observe)

What problems or unexpected events did you encounter?

Feedback and observations from the participants?

STUDY:

What does the data show?

Was your predication confirmed? If not what did you learn?

Compare the data to your predictions and summarise the learning

ACT:

Decision on PDSA

Abandon
Adapt
Adopt

What is your plan for the next cycle?

Predictions

What do you think will happen?

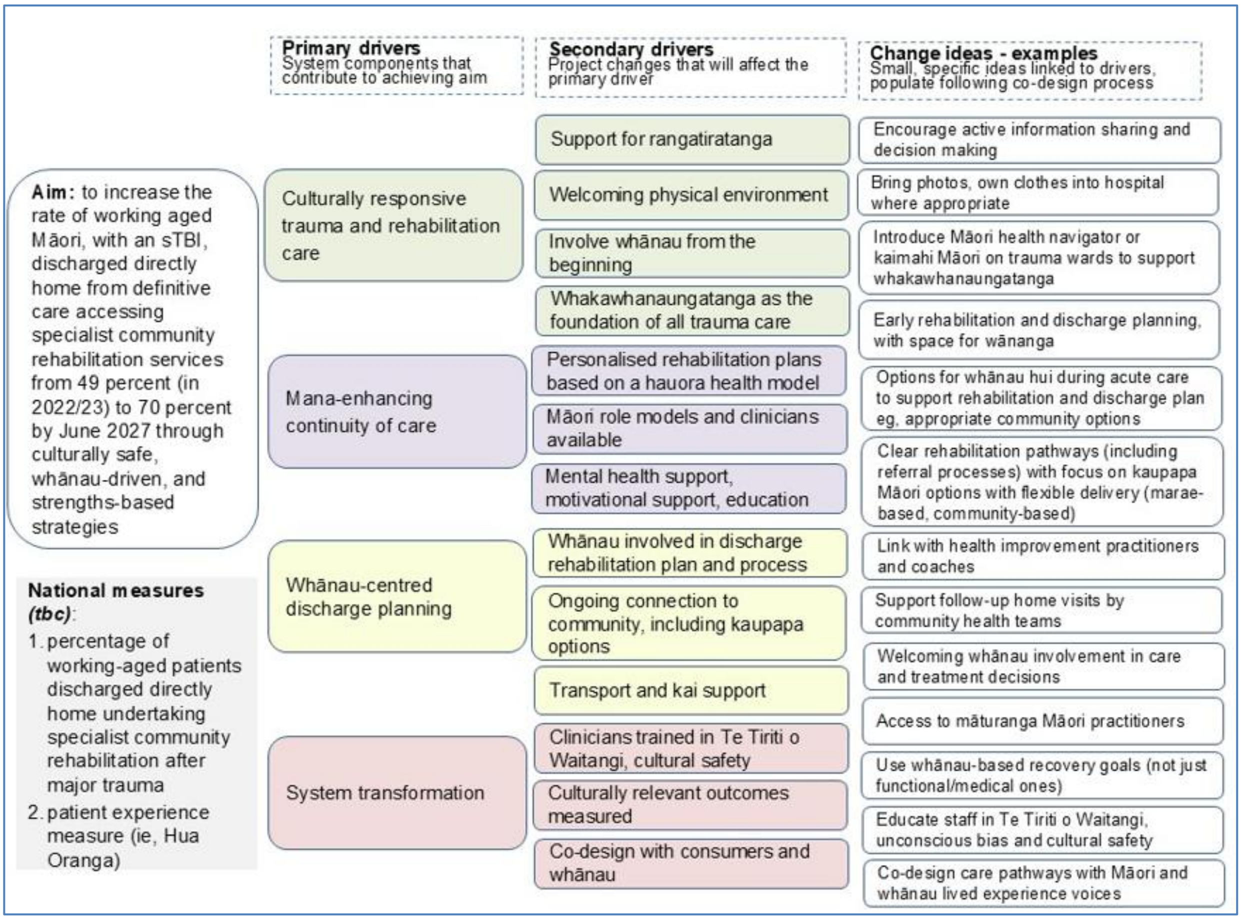
Prediction on change:

Prediction on question(s):

Measurements: What data will you need to test your prediction(s)? How will you collect it.

Appendix 2: Example of a driver diagram

A driver diagram is a visual tool used in quality improvement – especially in health care – to show how specific improvement goals are connected to the key factors (or drivers) and change ideas needed to achieve them (Langley GJ, Moen, RD, Nolan KM et al. 2009. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* 2nd ed.).



Aim: to increase the rate of working aged Māori, with an sTBI, discharged directly home from definitive care accessing specialist community rehabilitation services from 49 percent (in 2022/23) to 70 percent by June 2027 through culturally safe, whānau-driven, and strengths-based strategies

National measures *(tbc)*:

1. percentage of working-aged patients discharged directly home undertaking specialist community rehabilitation after major trauma
2. patient experience measure (ie, Hua Oranga)

Primary drivers
System components that contribute to achieving aim

Culturally responsive trauma and rehabilitation care

Mana-enhancing continuity of care

Whānau-centred discharge planning

System transformation

Secondary drivers
Project changes that will affect the primary driver

Support for rangatiratanga

Welcoming physical environment

Involve whānau from the beginning

Whakawhanaungatanga as the foundation of all trauma care

Personalised rehabilitation plans based on a hauora health model

Māori role models and clinicians available

Mental health support, motivational support, education

Whānau involved in discharge rehabilitation plan and process

Ongoing connection to community, including kaupapa options

Transport and kai support

Clinicians trained in Te Tiriti o Waitangi, cultural safety

Culturally relevant outcomes measured

Co-design with consumers and whānau

Change ideas - examples
Small, specific ideas linked to drivers, populate following co-design process

Encourage active information sharing and decision making

Bring photos, own clothes into hospital where appropriate

Introduce Māori health navigator or kaimahi Māori on trauma wards to support whakawhanaungatanga

Early rehabilitation and discharge planning, with space for wānanga

Options for whānau hui during acute care to support rehabilitation and discharge plan eg, appropriate community options

Clear rehabilitation pathways (including referral processes) with focus on kaupapa Māori options with flexible delivery (marae-based, community-based)

Link with health improvement practitioners and coaches

Support follow-up home visits by community health teams

Welcoming whānau involvement in care and treatment decisions

Access to māturanga Māori practitioners

Use whānau-based recovery goals (not just functional/medical ones)

Educate staff in Te Tiriti o Waitangi, unconscious bias and cultural safety

Co-design care pathways with Māori and whānau lived experience voices