Māori Relationship Board Meeting

Date:	**Wednesday, 10 February 2016**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings.**

MRB Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Des Ratima
Kerri Nuku
Ana Apatu
Lynlee Aitcheson
Diana Kirton
Helen Francis
Trish Giddens
Denise Eaglesome (teleconference)
Tatiana Cowan-Greening (teleconference)

Apologies:

In Attendance:

Kevin Atkinson, Chair HBDHB Board
Kevin Snee, Chief Executive Officer (CEO) Hawke's Bay District Health Board (HBDHB)
Ken Foote, Company Secretary HBDHB
Tim Evans, General Manager Planning, Informatics and Finance (GM PIF) HBDHB
Chris McKenna, Chief Nursing Officer (CNO) HBDHB
Tracee Te Huia, General Manager Māori Health Service (GM MH) HBDHB
Peter Dunkerley, Board Member HBDHB
Graeme Norton, Chair HB Health Consumer Council
Matiu Eru, Pouahurea Māori Health Service HBDHB
Patrick LeGeyt, Programme Manager Māori Health HBDHB
Lana Bartlett, MRB Administrator HBDHB
Liz Stockley, CEO Health Hawke's Bay Public Health Organisation (HHB PHO)
Nicola Ehau, Head of Health Services Health HB Public Health Organisation (HHB PHO)

Our vision

HEALTHY HAWKE'S BAY

TE HAUORA O TE MATAU-Ā-MĀUI

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

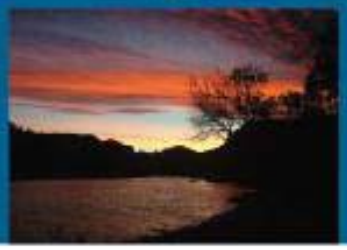
Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do



Māori Relationship Board Meeting
Agenda

PUBLIC MEETING

Item	Section 1 : Agenda Items	Time
1.	Karakia	**9.00am**
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting – November 2015	
6.	Workshop Notes – November 2015 (with Māori Providers - for noting)	
7.	Minutes of the Special Meeting – December 2015	
8.	Matters Arising - Review of Actions	
9.	MRB Chair's Report	
10.	General Manager Māori Health Report	
	Section 2: Presentation	**9.20am**
11.	New Investment Process (Peter Kennedy)	20-mins
	Section 3: Performance Monitoring - Discussion Papers	**9.40am**
12.	Te Ara Whakawaiora: ACCESS Ambulatory Sensitive Hospitalisation	20-mins
	Section 4: Strategic/Service Development – Decision/ Discussion	**10.00am**
13.	Health Literacy Strategic Review (Quigley & Watts)	30-mins
14.	Health and Social Care Networks (Liz Stockley)	**10.30am** 30-mins
15.	Wānanga MRB Workplan 2016-17 (Patrick LeGeyt)	**11.00am** 50-mins
	Section 5: General Business	**11.50am**

Date of next meeting: 9.00am Wednesday, 9 March 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Māori Relationship Board Interest Register - 22 December 2015

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
Ngahiwi Tomoana (Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The HBDHB Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The HBDHB Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The HBDHB Chair	01.05.08
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Daughter-in-law, Eve Fifield, Paediatric Registrar with HBDHB	Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB Awarded Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14 25.03.15
Tatiana Cowan-Greenir	Active	Husband, Parris Greening, Service Manager of Te Kupenga Hauora (TKH)	Contracted health provider of HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14

Maori Relationship Board 10 February 2016 - Interest Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict (if any)	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Declared
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	19.03.14
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	Director of Hei Nursing	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any discussions relating to Hei Nursing	The Chair	19.03.14
	Active	Trustee of Maunga HaruruTangitu Trust	Nursing Services - Clinical and non-Clinical issues	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
George Mackey	Active	Wife, Annette Mackey is an employee of Te Timatanga Ararau Trust	Maori Health Focused organisation	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson	Active	Chair, Maori Party Heretaunga Branch	Political role	Will not engage in political discussions or debate	The Chair	19.03.14
	Active	Chair of Te Whare Whanau Purotu Women's Refuge		No conflict	The Chair	22.12.15
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		No conflict	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
Trish Giddens	Active	Trustee, HB Air Ambulance Trust	Management of funds in support of HB Air Ambulance Services	Will not take part in discussions or decisions relating to contracts with HB Air Ambulance Service.	The Chair	19.03.14
	Active	Manager, Taruna College		No conflict	The Chair	15.04.15
	Active	Assistant Director Governor, Rotary District 9930		No conflict	The Chair	15.04.15
	Active	Member of the Lotteries Board		No conflict	The Chair	15.04.15
Des Ratima	Active	Chair Takitumu Maori District Council	Maori Community Development Act 192	No conflict	The Chair	Dec 13
	Active	Chair Ahuriri District Heatlh Trust	Maori health post settlement equity group	Potential Conflict if contractural arrangements in place	The Chair	Dec 13
	Active	Chair Whakatu Kohanga Reo	Early Childhood	No conflict	The Chair	Dec 13
	Active	Chair Wanautahi Charitable Trust	Community Trust	No conflict	The Chair	Dec 13
	Active	Deputy Chair Maori Wardens NZ Maori Council	Maori Community issues	No conflict	The Chair	Dec 13
	Active	Chair of the kaupapa Maori Comittee	Maori Community Issues	No conflict	The Chair	Dec 13

MINUTES OF THE MāORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 11 NOVEMBER 2015 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members: Heather Skipworth (Deputy Chair)
Ngahiwi Tomoana (Chair)
Kerri Nuku (teleconference)
Denise Eaglesome (video conference)
Ana Apatu
Tatiana Cowan-Greening (teleconference)
Lynlee Aitcheson
Trish Giddens
Diana Kirton
Helen Francis
Des Ratima
George Mackey
Na Raihania

Apologies: Helen Francis, leaving early
Ngahiwi Tomoana, leaving early
Ana Apatu
Lynlee Aitcheson
George Mackey

In Attendance: Kevin Snee (CEO HBDHB)
Peter Dunkerley (HBDHB Board member)
Graeme Norton (Chair Consumer Council HBDHB)
Katie Kennedy (Women, Children and Youth Portfolio Advisor HBDHB)
Andi Crawford (Clinical Psychologist Child Development Service HBDHB)
Querida Whatuira-Strickland (Kaitakawaenga Māori Health HBDHB)
Penny Thompson (Smoking Cessation Manager HBDHB)
Shari Tidswell (Team Leader/ Population Health Advisor HBDHB)
Sharon Mason (Chief Operating Officer HBDHB)
Andrea Beattie (Property & Service Contracts Manager Facilities HBDHB)
Carina Burgess (Acting Head of Planning HBDHB)
Matiu Eru (Pouahurea Māori Health Service HBDHB)
Patrick LeGeyt (Programme Manager Māori Health Service HBDHB)
Justin Nguma (Health & Social Policy Advisor Māori Health Service HBDHB)
Liz Stockely (CEO Health Hawke's Bay PHO)
Nicola Ehau (Head of Health Services Hawke's Bay PHO)

Minute Taker: Lana Bartlett (MRB Administrator)

SECTION 1: AGENDA ITEMS

1. KARAKIA

Matiu Eru, Pouahurea Hawke's Bay District Health Board (HBDHB) opened the meeting with karakia and mihimihi.

2. WHAKAWHANAUNGATANGA

The Deputy Chair welcomed Anne Heast, Coach for Tracee Te Huia (GM Māori Health) to the meeting and asked everyone to give a brief introduction.

3. APOLOGIES

Apologies were received from G Mackey, L Aitcheson and A Apatu as well as H Francis and N Tomoana who are leaving the meeting early.

4. INTERESTS REGISTER

N Raihania declared his reappointment as a Trustee for Te Runanganui o Ngāti Porou which is an Iwi Authority for the East Coast of Gisborne. And that there is no conflict of interest.

There were no conflict of interests declared regarding today's agenda items.

5. MINUTES OF PREVIOUS MINUTES

The minutes of the MRB meeting held 9 September 2015 were confirmed as a true and correct record.

Moved: N Raihania
Seconded: H Francis
CARRIED

6. MATTERS ARISING – REVIEW OF ACTONS

The following matters were raised:

Health Needs Assessment – Wairoa, page 3 of 8

N Raihania enquired about the request for Te Pare Meihana (Manager Wairoa Health Centre) to present the Health Needs Assessment (HNA) to MRB. In addition, the facilitation of a MRB meeting in Wairoa to conduct a stocktake of the funding going into Wairoa, status of Wairoa, the networking model and what this would look like for Wairoa.

The meeting is on hold until the workplan and meeting dates have been decided by the DHB Board. A meeting date will be set once the timing issues are resolved.

Tūruki Māori Workforce Development, page 3 of 8

N Raihania also enquired about the 3-monthly reports of the uptake of student's data for Programme Incubator by John McKeefry (GM Human Resources). Place back onto MRB workplan **Action: MRB Administrator**

Recommendation Culturally Competent Workforce Māori staff report to include actual numbers, page 5 of 8

The initial conversation was about 'real' numbers by ethnicity and position. MRB would like both real numbers and percentages for the reports.

REVIEW OF ACTIONS

09/09/15
MRB Workplan 2016 – *On hold*

Drafting of the MRB workplan had commenced but has been put on hold due to the review of the Committee Structure and Meeting Schedule for 2016 by the Board.

18/06/14
Review of Māori Bachelor of Nursing Students at EIT – *In progress*

It was understood that MRB members K Nuku and D Kirton would be a part of the review. D Kirton was advised by Jenny Smith (Director Health & Wellbeing NKII) that NKII would initially meet with EIT and then bring in MRB members. This needs to be reflected in the action. Jenny Smith no longer works for NKII. Tracee Te Huia (GM Māori Health) has a meeting with Adele White (CEO NKII) to discuss all matters regarding health and what's happening from an Iwi perspective.

7. MĀORI RELATIONSHIP BOARD CHAIR'S REPORT

The report from the MRB Chair for November 2015 was taken as read. The report provided an update on relevant discussions at the DHB Board meetings in September and October.

This report demonstrates the amount of activities going to the Board relating to Māori and also reflects what MRB are doing. Tracee Te Huia (GM Māori Health) acknowledged and congratulated MRB for their accomplishments. N Tomoana highlighted that the commonality of each individual report is the whānau focus and that when whānau centric methods are applied changes in reporting will be noticeably evident.

8. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The report from the GM Māori Health for November 2015 was taken as read. Patrick LeGeyt (Programme Manager Māori Health) provided commentary pertaining to Oral Health and the Annual Māori Health Plan Review.

Oral Health Project

The DNA rates were a concern and part of the reason for going into an internal project. Moving into project provides the opportunity to acquire some resources and gain better support to improve access to care. The factors contributing to the DNAs includes a lack of engagement at the right stages plus system issues in terms of the booking system. The findings of the DNA project have been integrated into this project. However, it was emphasised that the values of the DNA project should also be incorporated.

Annual Māori Health Plan Review

The objective of the review of the Annual Māori Health Plan was to reduce the level of reporting to be more focused, increase ownership by services, plus reporting by exception focusing on non-performing indicators.

Quality Accounts

Each year, as a requirement of the Ministry of Health, the DHB has to supply some quality accounts to provide information to our community about our performance against quality and safety standards e.g. hand hygiene and falls requirements. A working group was established of representatives from Consumer and Clinical Councils, the Māori Health Service and Clinical teams to write a document publishing positive stories and the impacts on health outcomes of our community. The aim is to include as many areas of professional groups and the population we are representing and the community within our quality accounts. A communication plan is being developed of how to share the Quality Accounts with the community. The plan will be circulated to MRB when complete. **Action: QIPS**.

There are different interpretations of 'whānau centric'. Therefore, MRB has requested for the Māori Health Service to define what whānau centric is for the DHB **Action GM Māori Health**

SECTION 2: STRATEGIC/SERVICE DEVELOPMENT – FOR DISCUSSION

10. FETAL ALCOHOL SYNDROME DISORDER PRESENTATION

Katie Kennedy (Women, Children and Youth Portfolio Advisor), Andi Crawford (Clinical Psychologist Child Development Service) and Querida Whatuira-Strickland (Kaitakawaenga Māori Health) were in attendance to provide a presentation on the impact and implications of Fetal Alcohol Spectrum Disorder (FASD). The aim of the presentation was to get guidance and feedback to progress development around prevention and post-diagnosis support, and funding.

FASD is not a new problem but because there has been more traction awareness has increased. Research suggests that around 50% of women could be drinking *before they know they are pregnant* and that FASD can occur when an expectant mother drinks *at any time during pregnancy*.

Clinical Psychologist Andi Crawford reported that 60-70% of the children seen for FASD at the Child Development Service are Māori. HBDHB are leading in the diagnosis area. There are some inconsistent messages so there needs to be a variety of approaches. There was an emphasis for everyone to be responsible and not place the responsibility solely on the woman. Prevalence data is required at a national level however, Hawke's Bay do not have prevalence statistics. Promotion is underway through a national campaign that encourages young woman to make a choice not to drink if they suspect they are pregnant. Prevention is key. Young people become sexually active at 13 and 14 years of age. With this in mind, schools need to be a target area to promote FASD. More resources are needed to promote the impacts and implications of FASD, and to progress the development around prevention and post-diagnosis support.

MRB recommended Katie Kennedy (Women, Children and Youth Portfolio Advisor), Andi Crawford (Clinical Psychologist Child Development Service) and Querida Whatuira-Strickland (Kaitakawaenga Māori Health) develop a plan of implementation that brings the systems together to promote and communicate FASD messages to the community. Then MRB could provide more feedback and guidance. **Action: Director Population Health/ Health Equity Champion (DPH/ HE)**

11. REGIONAL TOBACCO STRATEGY FOR HB, 2015-2020

Penny Thompson (Smoking Cessation Manager) and Shari Tidswell (Team Leader/ Population Health Advisor) were in attendance to give a presentation.

The following feedback was received:

- Feature the demographics in the foreword
- Include the research by Smokefree Nurses and Whakaue particularly the reasons people smoke
- Tobacco is addictive. Investigate further the addictive behaviour and the supports available especially for Māori

- Could the definition of a smoker 'one puff in 28 days' be skewing the data?
- Nga Maia (Māori Midwives) is not the only midwifery service that Māori use. It is everyone's responsibility and not just the responsibility of the health professional
- The current programmes need to be reviewed and refreshed to reduce the smoking statistics

MRB felt there has been ample discussion and that it is time to advance the strategy. With this in mind MRB endorse the strategy pending the above feedback.

12. BILLINGUAL SIGNAGE

Sharon Mason (Chief Operating Officer) and Andrea Beattie (Property & Service Contracts Manager Facilities HBDHB) were in attendance to speak to the paper.

RECOMMENDATION

Māori Relationship Board:

Do not endorse the changes proposed to the Signage and Display (HBDHB/OPM/095) and Te Reo Māori Translation (HBDHB/OPM/113) policies, as described in this document.

Instead MRB recommended for Te Reo Māori to appear before English, that both internal and external signage follow the same format and that the policies; Signage and Display (HBDHB/OPM/095) and Te Reo Māori Translation (HBDHB/OPM/113) are amended to reflect MRBs recommendations before final approval and sign-off.

Moved: D Eaglesome
Seconded: N Raihania
CARRIED

In summary, the following advice was provided:

- Te Reo Māori (Māori Language) to appear before English. This supports the revitalisation of Te Reo in Kahungunu and is supportive of the Kahungunu Reo strategy
- The rationale of having Te Reo Māori before English is the preservation and longevity of the Māori language
- This is an opportunity for the DHB to be leaders that could influence other organisations and regions to do the same
- There is an issue of cultural competency in mainstream, and Te Reo Rangatira plays an important part in developing cultural competency
- Te Reo Māori is an official language of New Zealand and therefore should have the same prominence as the English language.

SECTION 3: FOR INFORMATION ONLY

13. HEALTH LITERACY UPDATE

MRB were directed to email all feedback regarding the Health Literacy Update directly to Ken Foote (Company Secretary). However, the following discussions occurred:

The original intent of the $250k was to invest into the community to promote health literacy. N Raihania was somewhat disappointed the funding is being used to create two positions and office equipment. It was understood Health Hawke's Bay PHO already had a consumer group. Is the Health Literacy Consumer Advisory Group a duplication of Health Hawke's Bay PHO Consumer Advisory Group, what are the roles of the two groups and are they working in contrast with each other?

There was confusion in the Steering Group about what they wanted to achieve and how the funding was going to be used. Some members were discussing the development of a framework that would lead into an action plan. Others wanted to continue with the Health Hawke's Bay PHO work and programme itself. The Steering Group decided to develop a framework and an action plan whilst at the same time support the existing programmes. Health Hawke's Bay PHO Consumer Advisor Group continues to support the groups, and activities that are already operating and near completion. As well as provide information and support to the DHB.

SECTION 4: GENERAL BUSINESS

There being no further discussion, the Deputy Chair accepted a motion to move into the Workshop with the Māori Providers.

The public section of the MRB meeting closed at 10.30am.

Signed: _____

Deputy Chair

Date: _____

Date of next meeting: 9.00am Wednesday, 10 February 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

NOTES OF THE MĀORI RELATIONSHIP BOARD (MRB) WORKSHOP WITH MĀORI PROVIDERS HELD ON WEDNESDAY, 11 NOVEMBER 2015 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 10.30AM

Members:
Heather Skipworth (Acting Chair)
Ngahiwi Tomoana
Kerri Nuku (teleconference)
Denise Eaglesome (video conference)
Ana Apatu
Tatiana Cowan-Greening (teleconference)
Lynlee Aitcheson
Trish Giddens
Diana Kirton
Helen Francis
Des Ratima
George Mackey
Na Raihania

Apologies:
Helen Francis, leaving early
Ngahiwi Tomoana, leaving early
Ana Apatu
Lynlee Aitcheson
George Mackey

In Attendance:
Kevin Snee (CEO HBDHB)
Peter Dunkerley (HBDHB Board member)
Graeme Norton (Chair Consumer Council HBDHB)
Rob Ewers (Nurse Manager Central Health)
George Reedy (CEO Te Taiwhenua o Heretaunga)
Lewis Ratapu (General Manager Business Growth & Design Te Taiwhenua o Heretaunga)
Waylyn Tahuri-Whaipakainga (Chief Operating Officer Te Taiwhenua o Heretaunga)
Tim Evans (General Manager Planning, Informatics and Finance HBDHB)
Matt Overton and Raj Dolamulla (Davanti Consulting)
Matiu Eru (Pouahurea Māori Health Service HBDHB)
Patrick LeGeyt (Programme Manager Māori Health Service HBDHB)
Justin Nguma (Health & Social Policy Advisor Māori Health Service HBDHB)
Liz Stockley (CEO Health Hawke's Bay PHO)
Nicola Ehau (Head of Health Services Hawke's Bay PHO)

Minute Taker: Lana Bartlett

SECTION 5: WORKSHOP WITH MĀORI PROVIDERS

WHAKAWHĀNAUNGATANGA

The Deputy Chair welcomed the Māori Providers to today's workshop. Board members were asked to give a brief introduction.

APOLOGIES

Apologies were received from Audrey Robin (Chief Executive Te Kupenga Hauora Ahuriri), Jean Te Huia (CEO Kahungunu Health Services - Choices) and Beverley Te Huia (Integration Manager Choices and Totara Health).

14. INFORMATION SYSTEMS FUNCTIONS BY DAVANTI CONSULTING

Tim Evans (General Manager Planning, Informatics and Finance), Matt Overton and Raj Dolamulla from Davanti Consulting were in attendance. The aim of today's meeting was to get better understanding of the needs of the HBDHB health system, primary and secondary care, GP services, the community and Māori Providers. Understanding the current challenges to improve the experience and outcomes, strengthen communication and collaboration. Clarify the current state of the technology capabilities of the current information systems to provide advisory governance.

The following feedback was received:

- Providers utilise a number of systems for the different health and social services such as Medtech, ECA and PRIMHD. These systems do not communicate with one another and it is difficult obtaining permission to retrieve more in-depth information.
- Reporting is arduous for Māori Providers with the current system due to the systems inability to make enquiries, analyse data and generate reports.
- The ability to measure social outcomes is difficult to capture so there is a need for a system with this capability
- Medtech, the most commonly used system by Māori Providers and GP services is costly and the technology issues are constant. The issues do not get resolved and Māori Providers have learnt to work with the problems. Māori Providers requested a collective approach to address the issues with Medtech.
- The current information systems used by Māori Providers do not work in a compatible way with the DHB when building in levels of targets. Therefore, the DHB and Māori Providers are not on the same page. There needs to be an understanding and awareness of each other's annual plans for health indicators and targets.
- Support from the DHB Business Intelligence team to help with working out information to get best results for our population
- Use smartphone technology and ensure the applications are accessible to everyone e.g. WIFI hotspots
- Need a system that allows the consumer access to their own health record and a contractual relationship that is useful for patients.
- Need to meet with the users i.e. Māori Providers early in the process. There are a number of stakeholders that also should be included into this conversation, such as the Pharmacy.
- Need a system that works across the systems and joins agencies together. Also how the DHB can succession plan to move forward with Providers infrastructure. Aggregating information and analysing it to make use of a lot of information.

Māori Providers were encouraged to email any further feedback to Lana Bartlett (MRB Administrator) who will then forward to Tim Evans (GM PIF). **Action: MRB Administrator**

The next step for Tim and his team is to draft a report and an action plan to share with groups and stakeholders. MRB requested a full report. **Action: GM PIF**

15. LOCALITY NETWORKS PLANNING

Liz Stockley (CEO Health HB PHO/ General Manager Primary Care) was in attendance and provided the following commentary about the Locality Networks Planning.

A lot of information has been received from the community, Māori Providers, patients, through the Health Inequity Report and our own data about what is not working with the current system. We identified from this information that what we are currently doing isn't working for the people. The national picture has changed as well as the Draft Updated Health Strategy that says we will be working together as a single team to deliver better outcomes.

The Locality Networks Planning programme has not started yet as the concept is still being socialised. Relationships with the community need to be developed by understanding and establishing what matters to the community, partnering with the health community better by including the community in decision making, changing the way we work, and including clinical and community leadership in this process. Once there is an idea of what this will look like, we will need to ensure the infrastructure supports the concept, and contracts match what we are trying to achieve as well as being sustainable.

The Health and Social Care Networks chart illustrates 6-8 localities in Hawke's Bay; one in Wairoa and CHB, 3-4 in Napier and 2, 3 or 4 in Hastings based on the need of specific communities. The aim is to achieve a collaboration of Providers and community. Working together with providers and meaningful relationships that will result in things being done differently for a specific community. Clinically, for primary health care to support GP teams to be more accessible and freeing up capacity to ensure they have ability to deliver to their communities. Also looking at broadening skills in primary care, not just GP, by working with Health of Older People, EnGAGE Project, District Nursing, Community Pharmacists as well as Clinical Pharmacists working with GP and Social Workers team. We need to look at services traditionally delivered through the hospital and Villa's to identify services that can be better delivered in the community e.g. first specialist appointments, specialist clinics, and services delivered in the community that are not connected to a community provider

including home based care and maternity services. Also, we need to get better at communicating, referring and ensuring a patient's journey is more seamless.

There is a workshop 15 November 2015 with GPs. MRB and Providers were invited to attend. It is vital the design process does not happen in a hospital or GP services but must happen in the community first because it has to be based on the needs to the community and the data needs to be analysed.

Feedback from the Leadership Forum was collated with some key work around the principles for developing a network between the community, with the Māori and Provider voice being imperative. We can only achieve what we want to achieve if we are joined up with Social Services and if we treat the patient and whānau holistically. We are not just trying to administer an immunisation. We are actually seeing the needs of the whānau collectively.

MRB raised the following points:

- The Integrated Health and Social Services diagram showed a 'people centred' whare (house) in the centre encircled by health and social services. This is a good illustration of 'Whānau centric care' that MRB have been talking about for some time now. However, MRB suggested progress would look like services waiting in line to see the Whānau instead of Whānau wait-listed to see the services.
- When Whānau centric methods are applied outcomes should be noticeably evident. Whānau Ora plans provide clear messages of where the Whānau want to be in terms of their health and wellbeing. There are different interpretations of 'Whānau centric care'. To ensure we are all of the same understanding, MRB have requested the Māori Health Service provide a definition of what 'Whānau centric care' is for the HBDHB.
- GPs are one of the key organisations of the collaboration. There is a challenge in terms of a culture change for private business to operate as part of the public sector. If we make it attractive enough to encourage everyone on board.
- Whānau does not appear strongly in this version of the Health and Social Care Networks chart that was updated at the HB Health Sector Leadership Forum.
- How the locality networks planning will affect the community and Māori Providers is still not clear. Therefore, MRB would like to call a Special Meeting in December to discuss the Locality Networks Planning further along with Whānau centric care. MRB would also like to utilise this opportunity to discuss the local priorities for the 2016-17 Annual Māori Health Plan. **Action: MRB Administrator**

N Tomoana excused himself from the meeting at 11.55am followed by D Eaglesome at 11.58am.

16. POLICY PRESENTATION AND FEEDBACK

Patrick LeGeyt (Programmes Manager) was in attendance to present the two policies; Consultation Guidelines – Working with Māori Communities and Organisations and Programme/ Service Planning Guidelines – Māori Communities and Organisations. The objective today is to get feedback on these policies from MRB and the Māori Providers.

Transform and Sustain (T&S) has 11 intentions and the very first intention is transforming our engagement with Māori communities. This is where these to policies come into effect. The MH Strategy seeks to respond to the T&S Strategy through the Annual Māori Health Plan. Two strong statements from T&S:

- Need strong processes that enables the DHB to partner with Māori, Iwi, hapu to accelerate the performance of Māori health - *Engagement*
- To gain better improvements of Māori Health we need to listen to our communities and ensure they are engaged in both planning and delivery of services to our people – *Co-design*

This is how the Annual Māori Health Plan will feed into Transform and Sustain.

Consultation Guidelines – Working with Māori Communities and Organisations

We need Consultation Guidelines to ensure we have effective responsive services delivered to Māori. And we need active participation of Māori. The purpose of Consultation Guidelines is to provide guidelines on requirements and expectations in planning or co-designing and other related activities with whānau, hapu, Iwi, Māori communities and organisations during consultation. These guidelines will ensure consultation occurs right from the beginning on all matters related to the whānau health and wellbeing.

Programme/ Service Planning Guidelines

We need Programme/ Service Planning Guidelines to ensure Māori are effectively engaged in both planning and delivery of services to the people. The purpose is to provide guidelines on how to ensure Māori are involved in the process of service planning, development and implementation that is whānau centric. The policy provides a decision making tool to guide the HBDHB to analyse, produce evidence and document the process of planning programmes delivered to Māori whānau, hapu, Iwi and Māori communities.

The following feedback and discussions occurred:

- There is an imbued message in the kōrero about the information for consultation to be disseminated in a timely manner to ensure whānau can read the information and be fully informed. This message needs to be clearly stated in the policies.
- Is this an opportunity to talk about Māori values and methodology?
- Need to ensure messages are simple, clear and concise especially with the differing interpretations of 'Equity' and 'Equality'.
- Do we have the right mix at the table to reduce inequalities?
- The HEAT tool is applied to the funding process. There is no similar tool like the HEAT tool or the HIA tool to measure equity across projects. There is work to be done in this aspect about a tool. The Whānau Ora Assessment Tool was suggested.
- Projects seem disconnected and at different stages in comparison to one another or how we are bedding things down. Therefore K Nuku suggested a review the entire organisations on how the DHB abides by the principles and values and applies these across the organisation. Principles and values set our policy promise and we need to measure it against an actual practical application like the Treaty of Waitangi. A review or an audit will assure the principles and values are embedded and reflected in our policies. There is a cultural component within Accreditation for all DHBs. Over and above that is the TOWRF agreed by all GM Māori across the country. However, if MRB feel there is something more the DHB needs to do then this can be discussed at the Special Meeting.

These policies are about the way Māori communities will be consulted. The Programme/ Service Planning is about the process and following it. We need to ensure that projects and services follow these guidelines, hence the importance of streamlining the policies. The Programme/ Service Planning Guideline is relative to the Funding Management Group who present a concept or business plan and need to ensure the guidelines have been implemented to get approval. MRB and the Māori Providers were encouraged to email any further feedback to Lana Bartlett (MRB Administrator) by the end of the month **Action: MRB Administrator**.

SECTION 6: MĀORI PROVIDER FEEDBACK

Alcohol and Drugs-16

One in four adults in Hawke's Bay is a hazardous drinker. The effects of Alcohol & Drug (A&D) addiction causes a number of health issues such as cardiovascular disease. A&D is so profound and more than just a health problem and should be included into the 2016-17 AMHP. Tracee Te Huia (GM Māori Health) and Patrick LeGeyt (Programme Manager Māori Health) were in full support of this considering the implications of alcohol and drug use, both short and long-term and would advocate for this to occur. MRB were also in support of Alcohol and Drugs becoming a Māori health priority with the inclusion of FASD as a result issue.

RECOMMENDATION

That the Board

Approve Alcohol & Drugs as well as FASD be added as a priority to the Annual Māori Health Plan for 2016-17.

Moved: N Raihania
Second: H Francis
CARRIED

Patrick LeGeyt (Programme Manager Māori Health), Justin Nguma (Social Health & Policy Advisor Māori Health) and Carina Burgess (Acting Head of Planning) will be meeting with Providers and MRB in February 2016 to discuss priorities for the next plan. Draft in March and final in June 2016. Need to have the Māori Providers involved to develop those priorities. Patrick will continue conversations with Māori Providers.

The workshop closed at 1.00pm with a Karakia by M Eru.

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) SPEICAL MEETING HELD ON FRIDAY, 11 DECEMBER 2015 IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Heather Skipworth (Deputy Chair) Kerri Nuku Denise Eaglesome Ana Apatu Tatiana Cowan-Greening Lynlee Aitcheson Trish Giddens Diana Kirton Helen Francis Des Ratima George Mackey Na Raihania
Apologies:	Heather Skipworth Kerri Nuku Diana Kirton Helen Francis Denise Eaglesome
In Attendance:	Kevin Snee (CEO HBDHB) Peter Dunkerley (HBDHB Board member) Graeme Norton (Chair Consumer Council) HBDHB Sharon Mason (Chief Operating Officer HBDHB) Andrea Beattie (Property & Service Contracts Manager Facilities HBDHB) Carina Burgess (Acting Head of Planning HBDHB) Matiu Eru (Pouahurea Māori Health Service HBDHB) Patrick LeGeyt (Programme Manager Māori Health Service HBDHB) Justin Nguma (Health & Social Policy Advisor Māori Health Service HBDHB) Liz Stockley (CEO Health Hawke's Bay PHO) Nicola Ehau (Head of Health Services Hawke's Bay PHO)
Minute Taker:	Lana Bartlett (MRB Administrator)

SECTION 1: AGENDA ITEMS

1. KARAKIA

Matiu Eru, Pouahurea Hawke's Bay District Health Board (HBDHB) opened the meeting with karakia and mihimihi.

2. APOLOGIES

Apologies were received from H Skipworth, K Nuku, D Kirton, H Francis and D Eaglesome.

SECTION 2: PRESENTATIONS

3. BILINGUAL SIGNAGE

Sharon Mason (Chief Operating Officer) and Andrea Beattie (Property & Service Contracts Manager Facilities) provided a presentation on the Bilingual Signage that included a summary of the feedback from MRB, Clinical and Consumer Councils, and a new proposal of the principles as follows:

- A commitment to incorporate bilingual signage around the HBDHB hospital and health facilities
- Te Reo Māori placed first, followed by English
    - Rationale - preservation of language, reducing inequalities (improving Māori health is about making services and the environment more inviting for Māori so they'll actually feel ok about coming here to receive services)
    - Either Te Reo Māori above with English below, or both languages side-by-side (decision required – see examples appended)

- Font to be bold, upright roman style (no italics)
- Signage contents to simple, clear and consistent, using plain English terms
- Applies to new signage; transition of existing signage to new form will be phased through capital projects

RECOMMENDATION

MRB endorse the above principles of the Bilingual Signage pending the following additions:

- The original concept of bilingual signage was to support the growth of a culturally competent workforce
- Acknowledge that in some instances Māori kupu does not require a translation. For example Ata Rangi, Tahekeroa and the names of the rooms in the new Mental Health Inpatient Unit
- The Māori kupu 'Mauri' to be inclusive of the principles. Mauri **(noun)** meaning life principle, vital essence, special nature, a material symbol of a life principle, source of emotions - the essential quality and vitality of a being or entity
- Look at including a taonga, image or Māori artefact alongside Te Reo Māori.

Placement of Te Reo Māori first and English underneath would be more practicable. Matiu Eru (Pouahurea HBDHB) who has provided a number of translations for services within the DHB and in the community affirmed that in most instances both languages side by side is incompatible because of the size.

Moved: L Aitcheson
Second: A Apatu
CARRIED

Sharon Mason (Chief Operating Officer) and Andrea Beattie (Property & Service Contracts Manager Facilities) were acknowledged for demonstrating great leadership through their efforts and their appreciation for the work undertaken to acknowledge te reo rangatira in DHB.

SECTION 3: STRATEGIC/SERVICE DEVELOPMENT

4. LOCAL PRIORITIES FOR THE 2016-17 ANNUAL MĀORI HEALTH PLAN

Carina Burgess (Acting Head of Planning) was in attendance to present the Local Priorities for the 2016-17 Annual Māori Health Plan along with Patrick LeGeyt (Programme Manager Māori Health).

MRB priorities are largely the same as 2015-16. The four local priorities to be added to the plan are:

- Obesity
- Addictions – alcohol and other drugs
- Child Health and
- Whānau Ora

Māori Workforce is to remain a MRB priority along with Obesity. Obesity is now a national indicator as well as regional that will continue to be reported by exception through the Te Ara Whakawaiora programme. Consumer Council and the Population Health Team have agreed to meet next year to look at how to progress the Obesity Strategy. Graeme Norton (Chair Consumer Council) suggested MRB attend that workshop. Co-design Training in early March 2016. In 2016 Population Health, Consumer Council and MRB to look at obesity and alcohol and drugs to develop a more effective strategy to address these issues **Action: DPH/HE**

There was a brief discussion about Whānau Centric which is included in Whānau Ora. Whānau Centric is not the Whānau Ora concept but more of a Whānau Ora service. Whānau Plans shape the entire system to identify how Whānau Centric is triggered. The delivery system is the definition, data source and measuring tool. A discussion about a strategy needs to take place.

Non-performing indicators of the Annual Māori Health Plan will move into the Te Ara Whakawaiora programme to be reported annually. Reporting by exception through the Te Ara Whakawaiora programme will continue with a view to strengthen the communication for the quarterly results.

Suicide is a national and regional priority but not a Māori health priority. MRB approved the implementation of the Suicide Prevention Plan earlier this year and request the following:

1. A report that describes progress to date
2. Information on what's working well and what's not working well, incorporated into the report and
3. A list on who delivers services related to Suicide Prevention (this would assist them in knowing who to refer organisations and whānau to

Action: Director Population Health/ Health Equity Champion (DPH/HE)

5. QUALITY ACCOUNTS

A link **http://www.hawkesbay.health.nz/file/fileid/51089** to the latest draft of the Quality Accounts for review and comment/feedback was emailed to MRB on the 30 November 2015 by Brenda Crene (Board Administrator) on behalf of Kate Coley (Director Quality Improvement Patient Service). Feedback was due by 9 December 2015.

6. BUSINESS CASE TO IMPLEMENT A TRAVEL PLAN

Sharon Mason (Chief Operating Officer) and Andrea Beattie (Property & Service Contracts Manager Facilities) were in attendance and asked to speak to the Business Case to Implement a Travel Plan that was also emailed to MRB for feedback by the Board Administrator on the 3 December 2015.

The following is a summation of the feedback received by the MRB Administrator via email from L Aitcheson 10 December 2015 and D Ratima 11 December 2015:

- The Plan is a process to implement parking charges and does not offer anything that is not already available or doable. Option 3 is about car parking charges. Statistics that highlight the issues for Māori pertaining to transport has not been identified as an issue or their views. The Plan fails to deliver options against a Māori perspective or makes poor assumptions. MRB representation is not included in the steering group and the entire Māori perspective is placed on the role of the General Manager Māori Health.
- Contribution by the Human Resources is absent. For example; administrators working from home and access to internet etc., enticing local recruitment, grooming successful applicants providing transport tickets to employee inductions, incorporating travel as part of the induction process, incentive programmes to encourage walking to work e.g. walkers allowance or discount for footwear and coats, and converting preferential parking spaces to bike shelters.

The following feedback was communicated at today's meeting:

- It should be made clear how this strategy will improve the health outcomes of Māori
- An equity tool/lens should be placed over big projects like this to pick up any unintended consequences
- The logo and green prescription inclusion is good
- A bus service for long distance parking running back and forth to the hospital and car park may be useful
- An exemption for parking for long term stayers should be considered
- It's crucial that decision makers determining who qualifies for an exemption be culturally competent. Exemption principles should be based on inequity of access to services and poorer health outcomes. They should be clearly monitored against criteria. Freeing up parking and who needs it most needs to be discussed.

Staff who are not on the living wage raised some interest around the reasons why these staff are not on the living wage and about the ethnicity of this group. In relation to exemptions, this group should be exempt.

RECOMMENDATION

Māori Relationship Board

Recommendation that the Board approve:

The business case to implement the "Go Well" Travel Plan (Option 3) from 1 July 2016 was decided however, not without the raised concerns by MRB relating to insufficient information regarding the detail i.e. exemptions knock on effects, and in addition MRBs involvement excluded at a project level. And although MRB endorse the business plan, MRB requests the following considerations be reflected into the finalisation of the paper to the Board:

1.	Use the Health Equity Assessment Tool (HEAT) over the project to identify any unintended consequences for Māori health
2.	Categorically consider exemptions and penalties for low income whānau
3.	Develop a clear monitoring system of the strategy to manage potential negative impacts where least expected.

MRB also request that Sharon and Andrea provide a response to the issues identified today and deliver an update at the next MRB meeting in February 2016.

Moved: N Raihania
Second: A Apatu
CARRIED

Sharon Mason (Chief Operating Officer) apologised to MRB for the exclusion and reassured them that the inclusion of a MRB representation was duly noted. The next step will be setting up the stakeholder groups to implement the Go Well Plan. The objectives of the Travel Plan will transform over time pending on the demand. Should the plan be approved next week appropriate representation and consultation going forward with MRB will be ensured.

MONITORING PAPERS – FOR INFORMATION (PREVIOUSLY EMAILED)

MRB noted the contents of the following monitoring papers that were emailed to MRB on the 3 December 2015 by the Board Administrator:

Te Ara Whakawaiora: Access – Breast Screening
Te Ara Whakawaiora: Access – Cervical Screening
Annual Māori Health Plan Quarter 1 July – September 2015

GENERAL BUSINESS

1. EFFECTIVENESS OF MRB

With 2016 being the last year in this term for these members, MRB highlighted the importance of ensuring the pathway for improvement of Māori health be set-up for the next Board. They highlighted good progress to date by the DHB however the difficulty of being accountable to the Māori communities when some areas of progress have been slow is hard. To assist in preparing the next MRB Board the following was listed:

- The agenda for MRB needs MRBs ownership. Everything that passes through MRB should identify how it will reduce inequity and improve health outcomes for Māori. MRB needs to consider how it will work more collaboratively with leaders in the intersectoral field at an MRB level to progress Whānau Ora
- MRB needs to work from a Kahungunu plan for better health as well as the DHBs plan.
- All processes should use a HEAT Tool and Whānau Ora Health Impact Assessment (WOHIA) tool assessment. This should be a standard practice. What tools are in place to monitor accountability and measure whether initiatives are achieving equity? What do they look like? **Action: Director Population Health/ Health Equity Champion (DPH/HE)**

The meeting closed at 12.00pm with a Karakia by M Eru.

Signed: _____
Chair

Date: _____

Date of next meeting: 9.00am Wednesday, 10 February 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

December Special Board Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at 27 January 2016
11/12/15	**1. Suicide Prevention Plan Report** Report to MRB in Feb 2016 on implementation progress	DPH/ HE	Jun 2016	**Complete** Added to MRB Workplan 2016.
	2. Obesity and Alcohol & Drugs Strategy Population Health, Consumer Council and MRB asked that the plan be further developed so that it is an effective strategy.	DPH/ HE		Population Health is leading out on ensuring the strategies are supported by all governance groups
	3. "Go Well" Travel Plan Issues As requested by MRB, provide a response to the issues identified by MRB at the December Special Meeting and deliver an update at the next MRB meeting Feb 2016.	COO	Feb 2016	**Complete** Refer to Appendix 1, Travel Plan Feedback to MRB by Sharon Mason (Chief Operating Officer).
	4. Equity and Accountability Tool MRB requested the use of the HEAT tool and Whānau Oroa Health Impact Assessment (WOHIA) tool be used in relevant processes.	DPH/HE	Feb 2016	**Complete** Dr Fiona Cram has been contracted to provide training on all equity tools in Feb 2016 to senior funders, portfolio managers, service directors and PHO members. Refer to Appendix 2, Workshop Outline.

November Board Meeting & Workshop with Māori Providers Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at 27 January 2016
11/11/15	**1. Programme Incubator Student Data Uptake Report** Add 3-monthly reporting by John McKeefry (GM Human Resources).	MRB Administrator	Feb 2016	**Complete** Added to the MRB Workplan 2016. First report due April 2016. No meeting in April therefore report will be emailed to MRB.
	2. Quality Accounts Communication Plan Circulate Communication Plan of how to share the Quality Accounts with the community to MRB through MRB Adminstrator.	QIPS	Dec 2015	**In Progress** Communication Plan being developed.
	3. Defining Whānau Centric As requested by MRB, the Māori Health Service to define what Whānau Centric is for the DHB.	GM Māori Health	Jun 2016	**Complete** Added to the MRB Workplan 2016. Workshop to be scheduled
	4. FASD Implementation Plan As recommended by MRB, develop an implementation plan and return to MRB to provide feedback and guidance.	DPH/HE	TBD	**Complete** Board approved FASD as a local priority of the Annual Māori Health Plan 2016-17 and has been included in the overall Alcohol & Drug Strategy.
	5. Feedback to IS Functions Presentation By Davanti Consulting Collate feedback received from Māori Providers via email then forward to GM PIF.	MRB Administrator	Dec 2015	**Complete** No additional feedback received. A stocktake of Māori Health Provider Information Systems is being undertaken.
	6. Draft IS Review Report and Action Plan Share report and plan with groups and stakeholders. MRB requested a full report.	GM PIF	Mar 2016	**Complete** Presentation of the draft report is scheduled for March 2016. Now added to MRB Workplan 2016.
	7. Special Meeting in December Arrange a special meeting in December to discuss Locality Networks Planning including Whānau centric care and Local Priorities for the 2016-17 Annual Māori Health Pan.	MRB Administrator	Dec 2015	**Complete** Meeting held 11 Dec 2015. Health & Social Networks agenda item 10 Feb 2016.
	8. Guidelines Policies – Consultation Working with Māori Communities and Organisations, Programme/ Service Planning Collate feedback then forward to Senior Health & Social Policy Advisor and Programme Manager Māori Health	MRB Administrator	30 Nov 15	**Complete** Feedback received. Now going through the DHB policy formalisation process.

October 2015 Board Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at 27 January 2016
09/10/15	**1. MRB Workplan 2016** Develop a work plan through to June 2016, including MRB meetings dates for presentation at the November MRB meeting.	GM Māori Health	11 Nov 15	**Complete** Agenda item for 10 Feb 2016.

June 2014 Board Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at 27 January 2016
18/06/14	**1. Review of Māori Bachelor of Nursing Students** NKII and EIT have a partnership agreement to work through the issues in Māori nursing and will keep DHB informed through the Chief Nursing Officer.	T Keepa EIT / A White NKII	Sept 14	**Complete** Tri-partite partnership formed between NZNO, EIT and HBDHB who are working on solutions to support the Māori nursing training pathway through the Tūruki Steering Group.

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Appendix 1

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Feedback to MRB**
	For the attention of: **Māori Relationship Board**
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property & Service Contracts Manager)
Reviewed by:	N/a
Month:	February 2016
Consideration:	For Information

RECOMMENDATION

That Māori Relationship Board:

Note the contents of this report

OVERVIEW

This paper reponds to the feedback from the Māori Relationship Board regarding the HBDHB Travel Plan business case that was presented to them in December 2015.

BACKGROUND

Feedback # 1

The Plan is a process to implement parking charges and does not offer anything that is not already available or doable. Option 3 is about car parking charges. Statistics that highlight the issues for Māori pertaining to transport has not been identified as an issue or their views. The Plan fails to deliver options against a Māori perspective or makes poor assumptions. MRB representation is not included in the steering group and the entire Māori perspective is placed on the role of the General Manager Māori Health.

Response to # 1

It is true that some of the recommendations that were contained in the business case are already available or doable, but to allow the DHB to fully implement the travel plan, then funding is required to allow, for example, a parking officer to be appointed, parking areas and cycling facilities upgraded and for opportunities to provide subsidised transport for staff and patients.

We ackowledge that MRB was not represented on the Steering Group, however there was operational input from GM Maori Health. We certainly require respresentation on the implementation project team. As part of the consultation phase we will be seeking input from a Māori perspective and will take guidance from the GM Maori Health re nominations for the project team.

Feedback # 2

Contribution by the Human Resources is absent. For example; administrators working from home and access to internet etc., enticing local recruitment, grooming successful applicants providing transport tickets to employee inductions, incorporating travel as part of the induction process, incentive programmes to encourage walking to work e.g. walkers allowance or discount for footwear and coats, and converting preferential parking spaces to bike shelters.

Response to # 2
As part of the consultation phase we will be seeking input/feedback from unions and staff, including ideas about what measures/initiatives will be included in the travel plan. If there is a strong desire this could well include options to provide subsidised clothing for walkers and cyclists or other incentives.

Feedback # 3
a. It should be made clear how this strategy will improve the health outcomes of Māori
b. An equity tool/lens should be placed over big projects like this to pick up any unintended consequences
c. The logo and green prescription inclusion is good
d. A bus service for long distance parking running back and forth to the hospital and car park may be useful
e. An exemption for parking for long term stayers should be considered
f. It's crucial that decision makers determining who qualifies for an exemption be culturally competent. Exemption principles should be based on inequity of access to services and poorer health outcomes. They should be clearly monitored against criteria. Freeing up parking and who needs it most needs to be discussed.

Response to # 3
a. noted.
b. refer to feedback # 4.
c. noted.
d. noted.
e. Exemptions for long term and high needs patients have been allowed for within the business case.
f. noted. The implementation team proposes to work closely with MRB, Māori Health Service and other stakeholders to establish the exemption and penalty criteria/policy.

Feedback # 4
Use the Health Equity Assessment Tool (HEAT) over the project to identify any unintended consequences for Māori health.

Response to # 4
After attending the MRB meeting in December the business case project team obtained a copy of the HEAT tool and with the assistance of the Māori Health Service developed a draft document. This initial assessment was completed based on the *Health Issue: parking congestion on and around the hospital campus.* This identified the main inequalities as difficulties accessing parking in the right place at the right time, and access difficulties for mobility impaired, elderly, parents with children and those with temporary injuries. This demonstrated that the current issue generally affects the community as a whole, including patients, visitors and staff.

We expect that as the implementation progresses that we will review the Health Issue to establish if specific groups, such as Māori or low income facmilies, are being disadvantaged by the travel plan measures.

It should also be noted that the DHB's Equity Champion has also offered her assistance in the use of the HEAT tool.

Feedback # 5
Categorically consider exemptions and penalties for low income whanau

Response to # 5
Exemptions and penalties will be considered and agreed as part of the consultation phase of the project, and in conjunction with MRB and other representation on the project team. Any agreed exemptions and penalties will be documented in the relevant policies, which will be reviewed regularly.

Feedback # 6
Develop a clear monitoring system of the strategy to manage potential negative impacts where least expected.

Response to # 6
The HEAT tool will be used to monitor the Travel Plan, together with several key performance indicators such as:

- DNA rates
- Complaints about parking and transport
- Infringements of the parking policy
- Number of staff reported injuries associated with transport (to ensure uptake of active transport modes does not increase risk of injury)

NEXT STEPS

- Appoint the Travel Plan and Parking Project Manager.
- Develop detailed plan to implement the scope.
- Establish Travel Plan Implementation project team, stakeholder/user groups and engage with untions and staff.

Appendix 2

Health Equity

A workshop with Fiona Cram, PhD, Katoa Ltd.

Introduction

Hawke's Bay DHB has a strong history of utilising equity tools in its work to provide health care for all peoples in the Hawke's Bay region. Questions from the HEAT (Health Equity Assessment Tool), for example, have been embedded into funding and planning templates, and Māori health planning has been undertaken in collaboration with Ngāti Kahungunu Iwi Inc. This commitment to health equity has extended to regional initiatives that have the potential to impact on health, with relationships forged with numerous stakeholders to enable health impact assessments (HIA) of draft plans. HIA and Whānau Ora (Māori family wellness). HIAs have been undertaken on, for example, the draft air quality plan change and the cultural and clinical nursing support and training programme. There are now a number of tools available for assessing the potential or realised equity of health care initiatives that can support the work of the DHB to ensure that all their constituency lives well, stays well and gets well. This workshop examines a selection of these tools, along with when it is appropriate to use them.

Workshop Description

There are now a number of health equity tools that have been developed and promoted by the Ministry of Health, including: HIA, Whānau Ora HIA, HEAT, Whānau Ora Tool, Logic Model, and the recent Equity of Health Care for Māori: A framework. This workshop will provide an overview of these tools, with a particular focus on how they support equitable health outcomes for Māori.

The workshop is structured in three main sections: 1. Understanding Māori health, 2. Overview of equity tools, and 3. Equity of health care for Māori.

The workshop will involve discussion as well as group work and feedback on the utility of different tools. Participants are encouraged to bring their own projects to the workshop and work on these during the group activity times.

Understanding Māori Health

Inequitable outcomes from health care challenge the right to health of Māori, yet many equity tools begin with preconceived notions of Māori health needs, priorities and aspirations. This section of the workshop looks to Māori models of health to gain an understanding of Māori health disparities and reasons for inequalities in the distribution of the determinants of good health. Participants' knowledge and experience will be called upon to construct a more nuanced understanding of Māori health inequities, and potential intervention points.

Overview of Equity Tools

An overview will be provided of a range of equity tools, including their similarities, differences and limitations. Examples of the use of the tools will be described, and a decision-making flowchart presented to guide the appropriate use of the tools. Workshop participants will be encouraged to share their feedback on tools they have used.

HEAT & Health Equity Framework

The HEAT and Health Equity Framework will be explored in more depth, including the application of each to participants' own work. Examples will be provided and participants will be encouraged to share with one another to ensure the optimal implementation of each tool. Small group work and feedback to the wider group will provide further examples of the utility of each tool.

Continued...

Learning Objectives

At the conclusion of this workshop participants will be able to:

- **Identify** principles and values underpinning Māori health
- **Explain** the complexities of Māori circumstances and the need for culturally responsive initiatives that engages Māori communities
- **Select and use** appropriate equity tools to assist with initiative planning and plan assessment
- **Describe** the rationale for equity-based initiatives, including their limitations and opportunities for evaluation
- **Generallse** workshop knowledge beyond Maori, to other other ethnic and cultural groups

Workshop Outline

9.00-9.30am	Welcome and Introductions
9.30-10.30am	1. Understanding Māori Health
10.30-10.50am	Morning tea
10.50-12.30pm	2. Overview of Equity Tools
12.30-1.15pm	Lunch
1.15-3pm	3. HEAT & Health Equity Framework
3.30-3.15	Afternoon tea
3.15-4pm	Group feedback and discussion
4-4.30pm	Workshop concludes, evaluations completed

Workshop Presenter

Fiona Cram, has a PhD in Social Psychology from the University of Otago. She is currently Director of Katoa Ltd, an independent research and evaluation consultancy based in Auckland. Katoa Ltd conducts Kaupapa Māori (by Māori, for Māori) research, evaluation and training. Prior to this she worked with Professor Linda Smith in IRI (International Research Institute for Māori and Indigenous Peoples), University of Auckland. Fiona's prime interests are in Māori health and whānau ora, Māori wellbeing assessment, and Māori health research methodology and ethics. She recently co-edited a book with Donna Mertens and Bagele Chilisa that documents the stories of how Indigenous peoples became researchers and what their methodological approaches are.

Fiona has provided health equity workshops for the Ministry of Health for the past eight years. She has also worked with Louise Signal and colleagues on the user's guide for the HEAT (Health Equity Assessment Tool), and has helped deliver training in Health Impact Assessment (HIA) and Whānau Ora (HIA). In 2014 Fiona completed a project for the Ministry of Health on improving Māori access to diabetes, cardiovascular and cancer. The reviews of initiatives that have improved the access of Māori, Indigenous peoples, and minority groups to health care underpinned the Ministry of Health's Equity of Health Care for Māori: A framework.

Also see the Katoa Ltd website: www.katoa.net.nz

HAWKE'S BAY District Health Board Whakawāteatia	**Chair's Report**
	For the attention of: **Māori Relationship Board**
Document Owner:	Ngahiwi Tomoana, Chairman
Month:	February 2016
Consideration:	For Information

Recommendation

That MRB

Note the content of this report.

PURPOSE

The purpose of this report is to update the Māori Relationship Board (MRB) on relevant discussions at the Board meetings held in November and December 2015 pertaining to Māori health.

INTRODUCTION

In this month's report with assistance from operations, I comment about our performance over the past six months. Previous to the six months, I have asked the General Manager Māori Health to list the previous 12 months recommendations of MRB to Board with the results. I will have this report to table on the day of the February hui as well. It is important that we understand the impact we make as a group to the District Health Board.

ACCELERATING MĀORI HEALTH

On reflection of last year, the voice of MRB has been influential in ensuring health equity is achieved by holding HBDHB to account and prompting the need for policies, strategies and plans to be reviewed to better accommodate the health gains of Māori. Whilst the campaigns may seem laborious, the results have meant that we are on the right path to improving health equity for the population within the Kahungunu rohe. These achievements are highlighted in the following tables dating from June through to December 2015. Of note, the gains achieved through the Te Ara Whakawaiora programme are not included:

June	MRB	Impact
Health Literacy – Framework Establishment	Endorsed Terms of Reference and provided the following advice: • Too DHB focused and recommended wider representation from the community and primary care to the group. • In addition, the appointment of GM Māori Health over and above the MHS representative. Requested the addition of a health literacy component to the DNA project.	Kaitakawaenga DNA made a member of the Health Literacy group. GM Māori Health now a member on the Steering Group.

Māori Nursing Recruitment	Resolve issues for Māori nurse graduates.	Partnership between NZNO, EIT, NKII and HBDHB who are working on resolving issues. 40% of last intake into the NEtP programme were Māori. EIT Head of School for Nursing is now on the Steering Group for the Tūruki programme. Monthly meetings now occurring between EIT and Chief Nursing Officer. Nurse Director Māori Health has been propped up to a full FTE through the Clinical Council process for new funding bids. First round of recruitment was unsuccessful. Second round begins in February 2016.

July	**MRB**	**Impact**
Tobacco Control Plan	Agreed a Tobacco Control Plan is needed and provided feedback summarised below: • Strategy description and how goals are achieved is Whānau Ora and should be promoted as a Whānau Ora initiative. • Add Matatini to Year 2 of the Planned Activities 2015/16 as an event to empower organisers to be tobacco free, conduct screening, deliver the educational packages targeting Māori women and rangatahi, and engage providers. • 'Other Linkages' - huge emphasis on the hospital per se. The greatest chance for change is in the community. This will require an increase in resources to the Provider network. More thought needs to be given to a Provider led strategy for greater coverage and better projected results. • Design is too top heavy. More evidence is needed for a co-create co-design process in the plan with the consumer. • Cessation practices conducive to Whānau quitting. With the high prevalence rate of smoking, encourages the efficacy of the cessation services that are commonly practiced with Whānau. This could be a joint action group with the Ngāti Kahungunu Iwi Inc.	DHB Board endorsed the Tobacco Control 5 year strategy agreeing that innovative concepts to support whānau to be Smokefree is vital. In addition Providers engaged and participated in the development of the strategy and are working in partnership to realign smoking cessation services. This partnership is currently creating an RFP to table to MOH on the 10th February. The intention is that providers will collaborate more strongly as a result. The HBDHB are working with Ngāti Kahungunu Iwi developing healthier messages for this 2016 Waitangi Day. This years Waitangi Day celebrations is preparing us for Matatini in 2017. There are strong Smokefree messages and interactive activities planned. Consumer engagement is a function of the new Smokefree Māori Support Worker role within the Smokefree Team. We hope to utilise the feedback received to make changes to services and inform planning.

	• Target the Chamber of Commerce to get support. • Smoking is a result of people needing their own space as they were disenfranchised out of health and employment. The only space to call their own was when they went for a smoke. Reason why the highest proportion of smokers are Māori women who are most deprived of all their statuses.	

August	MRB	Impact
Suicide Prevention Plan	MRB endorsed the plan and provided the following advice: • DHB to provide more intervention training for communities • Plan to have more of a whānau engagement process and inclusion. • Include a cultural response as well as clinical. • Increase Rangatahi involvement and upskilling. • DHB to make drugs substance abuse a priority. • Build community resilience through building community leadership • With relationship breakdowns a key trigger, how can the DHB support his issue?	Three face to face QPR Gatekeeper Trainings have taken place in Flaxmere, Central Hawkes Bay and Wairoa. A total of 57 people attended (51 submitting evaluations). 44 stated that the overall programme was above average or outstanding. The HBDHB have been involved in the coroner's inquest and had the opportunity to sit with whānau to hear what they thought may help whānau engage with each other and minimise the risk for rangatahi. The support model has a strong cultural and clinical approach. The membership reflects their cultural competency There are various community driven suicide prevention activities. Examples of these are HOPE – Hold On Pain Ends, Fight for life running under Anahera o Te Rangi, Talk to Us – Flaxmere Community Group, MATES in Farming. All assisting with building resiliency in those communities.
Quarterly Reporting against the Annual Māori Health Plan	Align with Board quarterly reporting. CEO write to the MoH to request quarterly Plunket data and any other indicator data where it is not provided in a timely fashion.	Board approved letter by the CEO sent to the Ministry. Plunket data is inclusive of the breastfeeding indicator. In addition the Business Intelligence Team and Māori Health are working on reporting timelines that synchronise with all other governance reporting.

September	MRB	Impact
Rheumatic Fever Prevention Plan	MRB accepted the plan under the proviso engagement with the Māori community section be enhanced.	Agreed changes made and returned to MRB for endorsement.

	Highlighted concerns about the changes to the Healthy Homes criteria impacting on a number of whānau who sit outside this criteria in particular the Bridge Pa community.	
Implementation of Obesity Strategy	Supportive of strategy but raised concern that the strategy was more of a health and nutrition strategy rather than an obesity strategy.	Paper deferred. Key leaders are attending a Summer School in Wellington on the 14th Feb with the intention of returning and workshopping with other key stakeholders on how to strengthen the strategy. In addition the WHO report on Obesity has just been released in January. The results of these findings need to be included into the plan.

October	**MRB**	**Impact**
Rheumatic Fever Prevention Plan	Plan was amended and disseminated to MRB to demonstrate agreed changes discussed at the previous meeting. The plan received further feedback. In light of this, MRB endorsed the refreshed plan with a letter of support from the MRB Chair.	Board approved the refreshed Rheumatic Fever Prevention Plan that was submitted to the Ministry of Health on 20 October 2015.

November	**MRB**	**Impact**
Alcohol and Other Drugs (AOD)	Add as a priority to the Annual Māori Health Plan 2016-17	Board approved AOD to be added as a priority to the 2016-17 Annual Plan. This is to be led by Population Health
Fetal Alcohol Spectrum Disorder (FASD)	Include FASD as a priority under AOD.	Board also approved FASD as a priority. Population Health will include FASD into the Alcohol and Drug strategy
Regional Tobacco Strategy for Hawke's Bay 2015-20	MRB endorsed the strategy because they felt there had been ample discussion regarding the strategy and that it was time for some action.	Board endorsed the draft strategy. It was agreed the strategy would be reviewed yearly. First update in November 2016.
Bilingual Signage Policy	MRB recommended Te Reo Māori first followed by English and for this format to apply to both internal and external signage. In addition, MRB requested and the format to be reflected in the organisational policies; Signage and Display and Te Reo Māori Translation.	Consumer and Clinical councils agreed with MRB followed by the approval of the Board to have Te Reo Māori first on all signage. The policies are now aligned with MRBs recommendations and signage display is now being considered.
Locality Networks Planning	Called a special meeting in December to get clarity around how Locality Network Planning will affect the community and Māori Providers.	The model was pulled back for further discussion. A Terms of Reference developed for Health and Social Networks development for feedback and advice by MRB today.

December	**MRB**	**Impact**
Bilingual Signage Principles	Endorsed principles and requested inclusion of MRBs additional principles.	Board noted MRBs principles. Executive Team has taken these principles and applied them to the policy for implementation

Obesity Strategy	Recommendation for further consultation with key stakeholders on co-design.	Paper deferred. Consumer Council, Population Health and Māori Health to work on making the strategy more effective before returning to MRB for endorsement.
Travel Plan	Noted several considerations to be reflected in finalisation of the paper. Issues were fed back and a response from the COO was requested.	Board noted MRBs considerations and approved the plan and requested the COOs feedback to issues highlighted. Refer to Appendix 1, Travel Plan Feedback to MRB by Sharon Mason (Chief Operating Officer).
Living Wage in HBDHB	Concerns about some staff who are on less than the living wage (This was included in the Travel Plan feedback).	Discussions commenced to address this matter. A funding bid has been prepared by the GM Māori Health and Director Allied Health for consideration in the new funding bid round. This will need to be considered against all other demand driven costs. After its request, MRB is now included into the process for new funding bids

PREPARATIONS FOR THE NEXT BOARD

In my report to the Board in December, I mentioned our discussion about 2016 being our final year for this term and the importance of ensuring the pathway for improvement of Māori health be set-up for the next MRB Board. Listed was what we considered valuable to assist in preparing the next MRB Board:

- MRB having ownership of its own agenda co designing it with DHB.
- Papers passing through MRB to clearly identify how it will reduce inequity and improve outcomes for Māori.
- MRB to consider how we will work more collaboratively with leaders in the intersectoral field at an MRB level to progress Whānau Ora
- MRB to work from both a Kahungunu Plan and the DHB Plan for better health outcomes for the entire Hawke's Bay population.

Whilst there is still a lot to do, we should celebrate what we have achieved and what effect we are having on services. The health system is a big one spending over $1 million dollars a day. Our changes may be slow but they are significant. Your leadership and determination to ensure our people get the best services in health in my mind, is making a difference.

HAWKE'S BAY District Health Board Whakawāteatia	**General Manager Māori Health Report**
	For the attention of: **Māori Relationship Board**
Document Owner:	Tracee Te Huia, General Manager (GM) Māori Health
Month:	February 2016
Consideration:	For Information

10

Recommendation

That MRB

Note the content of this report.

PURPOSE

The purpose of this report is to update the Māori Relationship Board on implementation progress of the Māori Annual Plan objectives for November and December 2015.

INTRODUCTION

This month's report provides an update on the following matters:

- Māori Health Service Statistics for November and December 2015
- New Zealand Health Strategy Consultation
- Māori Provider Capacity Assessment
- Māori Provider Development Scheme
- Annual Māori Health Plan 2016–17
- Māori Health Portfolio Plan 2016–17
- Child Obesity
- Māori Oral Health Project
- Tūruki Māori Workforce Development
    - *Health Workforce NZ Hauora Māori Fund*
    - *Ministry of Social Development and Health Hawke's Bay PHO Initiative*

Māori Health Service Statistics For November And December 2015

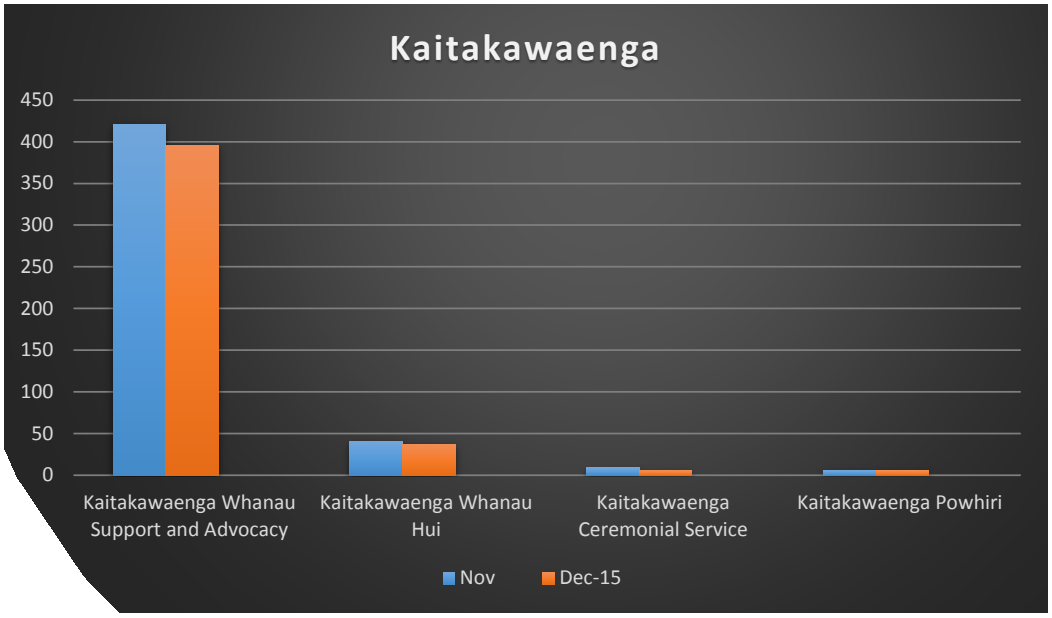
For the month of November, the Māori Health Service (MHS) had 1347 Patient/Whānau contacts that have been split out into the various work streams of Māori Health.

In December 2015, Patient/Whānau contacts decreased to 1080. The reason for the reduction was due to the service commencing a rostered end of year leave plan that saw the team operate with a skeleton staff from the second week of December. Cases were prioritised with urgent cases seen immediately. In addition to this, the Outpatient Villa's offered 17-day appointments which is reflected in the reduction of DNA pre-emptive reminder calls and DNA tracing during the month of December.

The graphs indicate role specific workloads, and in most cases the narrative is not reflective of the cultural support offered to the staff and patients of the hospital. This includes but not limited to the following, Staff Pōwhiri and induction, Whakawātea, Karakia, Waiata, Treaty of Waitangi

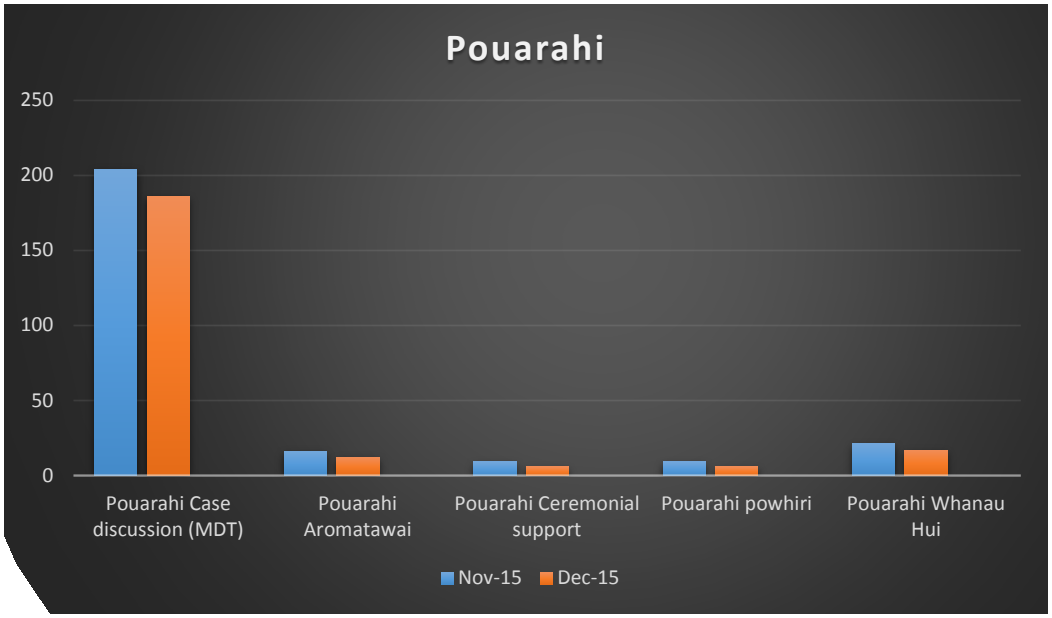
Responsiveness support, team meetings, project work and trainings/in-services led by the Māori Health Operational team.

Graph 1. Kaitakawaenga



The graph above illustrates that during the month of November and December 2015 the Kaitakawaenga provided a total of 817 (Nov 421/ Dec 396) Whānau Support and Advocacy bedside contacts in hospital, from which Kaitakawaenga led a total of 78 (Nov 41/ Dec 37) Whānau Hui. In December, of the 37 Whānau Hui, 17 were palliative patients.

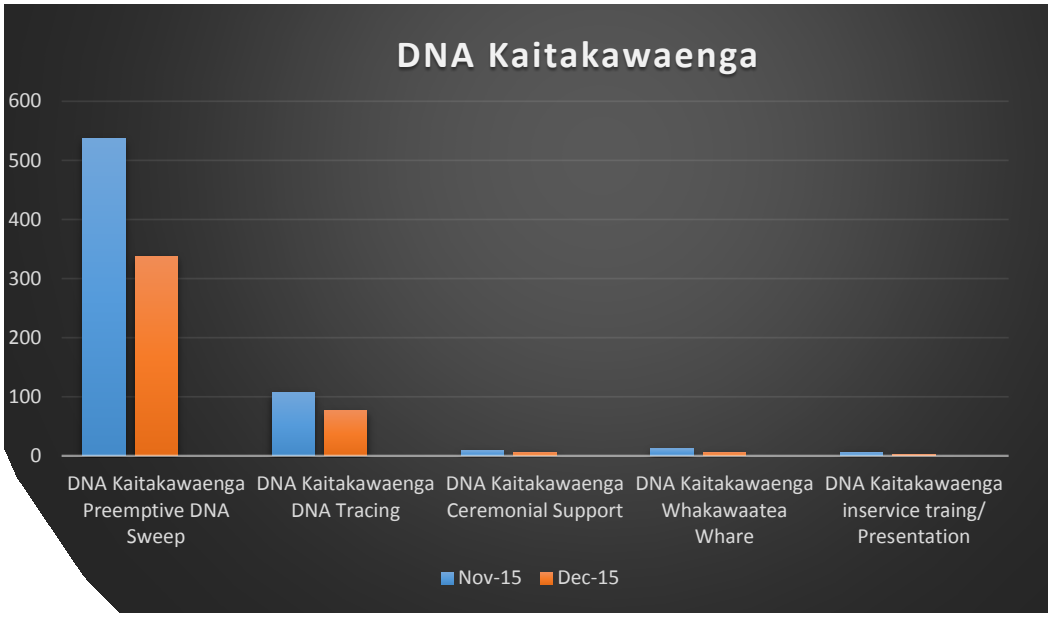
Graph 2. Pouarahi



Graph 2 illustrates during November and December 2015 the Pouarahi were involved in a total of 390 (Nov 204/ Dec 186) case presentations and MDTs where their role is to provide cultural input into the 'Wellness Plans' of whānau accessing mental health services. A total of 28 (Nov 16/ Dec 12) Aromatawai (cultural assessments) were also provided to Whānau in the Mental Health Inpatient

Unit (MHIPU). From the total of 390 cases, 38 Whānau required further Whānau Hui which were led and coordinated by Pouarahi.

Graph 3. DNA Kaitakawaenga



For November and December 2015, a total of 875 (537 Nov/ 338 Dec) pre-emptive DNA sweeps and a total of 183 (Nov 107/ Dec 76) DNA tracing (follow up patients) were carried out by the DNA Kaitakawaenga.

New Zeland Health Strategy Consultation

The MHS hosted the MoH consultation team for the New Zealand Health Strategy in November 2015 at Te Aranga Marae in Flaxmere. Approximately 40 people attended the consultation hui and a number of local health system priorities were reprioritised into the top three priorities, including:

1. Intersectoral collaboration
2. Working together
3. Access to services

In addition, Māori Health ran an on-line consultation with the health and social sector to feed into the HBDHB submission. Some stakeholders chose to make individual submissions. However, general feedback centered around the following themes:

1. Not enough emphasis on reducing inequalities
2. The Treaty statement is just that ‘a statement’ with no correlation to the content of the themes or actions.
3. He Korowai Oranga themes need to be included
4. The actions in the action plan don’t necessarily reflect the themes and look to be ‘business as usual’.

Māori Provider Capacity Assessment

The MoH initiated an information request to the DHB regarding HBDHB contracted Māori Providers that met the MoH criteria and definition of a Māori Provider as part of a wider MoH stocktake of NGO Provider effectiveness. Furthermore, the Ministry requested that the assessment information be completed within a one week timeframe. Assessments were made on the following Māori Providers:

- Te Taiwhenua o Heretaunga (TTOH)
- Te Kupenga Hauora Ahuriri

- Kahungunu Executive ki Te Wairoa
- Kahungunu Health Services (Choices)

The assessments were made against 28 contracts held by the above Māori Providers and included data fields such as:

- Contract description, service type, funding amount and duration
- Client group, target population
- Outcomes sought, achieved or not
- Value for money – low, medium, high, or very high
- Capacity and capability
- Provider contribution to DHB strategies
- Overall effectiveness; and
- Added value

Māori Provider Development Scheme

The MHS met with MoH on the 24 November 2015 about the direction of the Māori Provider Development Scheme (MPDS) direction. Māori Health provided the Ministry a strategic overview of where the HBDHB was heading with Transform and Sustain and Māori Provider involvement (Locality Networks and provider integration etc.). The MoH stated that most Māori Providers, except those with expiring Māori Innovation Contracts, will be offered three year MPDS contracts. The Māori Providers will also be given the opportunity to receive 'bulk funding' contracts with an emphasis on achieving the result. The MoH were advised given the direction of HBDHB, the funding emphasis will be on supporting Māori Provider's 'integration', 'workforce development' and 'best practice' initiatives.

Annual Māori Health Plan 2016–17

The process is underway for the development of the Annual Māori Health Plan 2016-17. The plan will be integrated into the overall Annual Plan for the District Health Board to support better collaboration of services and implementation.

In November, the local priorities were presented to the Māori Relationship Board (MRB). Vulnerable Children, Alcohol and Other Drugs (AOD), Obesity, Whānau Ora and Māori Workforce were the main themes. The MoH have recommended up to 3 local priorities. The following priorities were recommended; AOD including Fetal Alcohol Syndrome Disorder (FASD), Obesity, and Māori Workforce.

The rationale for the non-inclusion of 'vulnerable children' is that the DHB already reports on a number of indicators for vulnerable children:

- ASH Rates 0-4 years
- PHO enrolment rates
- Oral Health enrolment and caries free rates (0-5 years)
- Breastfeeding rates
- SUDI rates
- Rheumatic Fever hospitalisation rates
- Immunisation rates
- Young mother smoking cessation advice.

'Whānau Ora' was also not inlcuded as a local indicator. The rationale for this is that we do not have a clear definition or indicator for Whānau Ora and there are no reliable data sources for Whānau Ora.

The priorities recommended have been included into the plan and are included onto the Board workplan.

Māori Health Portfolio Plan 2016–17

The Māori Health Portfolio Plan 2016-2017 was submitted to Strategic Services in December 2015. The portfolio plan reflects the MAI Māori Health Strategy 2014-2019 strategic focuses of responding to our community, delivering consistent high quality health care and becoming more efficient at what we do. Moreover, there is an emphasis on prevention, early intervention, and supporting the alignment of Māori Providers with social and primary care networks.

The overall focus for transformation (disinvestment and new investment) activities includes:

Vulnerable Children

- Working closer with Women's, Children and Youth Portfolio
- Reorienting of oral health resources to improve service utilisation for Māori 0-4 year olds
- Reorienting of social support resources for the most vulnerable Māori children
- Reorienting of breastfeeding support resources to improve Māori breastfeeding rates
- Reorienting of KHW and health promotion resources to develop a Māori whānau obesity intervention

System Integration

- Enable Māori Provider capacity to participate in the development of Primary Health and Social Service Networks
- Assist Kahungunu Executives integration with Wairoa Health Centre
- Reorienting of nursing resource and new investment for the development of rural nursing model in CHB
- New investment for the development of a marae-based health service in Napier

Clinical Leadership

- Enhance clinical skills and leadership in Māori Health
- Use MoH Māori Provider Development Scheme (MPDS) resource to develop clinical leadership and best practice across Māori providers

Child Obesity

The prevalence of childhood obesity in New Zealand and Hawke's Bay is an urgent public health concern. MoH figures show that one in five children under 14 years is now overweight, one in 12 is obese and the rate of obesity for Māori is twice that of European New Zealanders. The World Health Organisation (WHO) has long identified major links between childhood obesity and chronic diseases in adulthood, and this is accepted by most international public health experts.

The Ministry's expectation of DHBs is that 95% of obese children identified in the Before School Check (B4SC) will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention. Additional funding will be provided to DHBs to extend Green Prescription or other evidence based programmes to cater for obese 4 year old children. HBDHB has developed a preventative strategic approach and now need to take meaningful action to address this issue.

Māori Health, Population Health and a group of Māori physical activity and nutrition experts will be attending the Ending Childhood Obesity Public Health Summer School Symposium at Otago University in Wellington the 18 February 2016. Speakers include Professor Sir Peter Gluckman, Prime Minister's Chief Science Advisor and Co-chair of WHO Commission on Ending Childhood Obesity. Following the symposium, Māori Health, Population Health and a group of Māori Providers will hold a workshop in March 2016 to develop an evidence based child obesity programme. The

programme will be funded from disinvestment of KHW and other health promotion resources within the Māori Health Portfolio. The March workshop is open to MRB members should they wish to attend.

Māori Oral Health Project

The Māori Oral Health Educator contract review has been incorporated into a wider project entitled "Improving Access to Community Dental Services for Māori Tamariki (0-5 years)". A meeting between HBDHB, Te Taiwhenua o Heretaunga management and the Regional Manager of Plunket was held 8 December 2015 to explore interest in incorporating the facilitation to appointments into the Tamariki Ora Well Child (TOWC) work schedule. Both agreed that it was more effective and efficient use of resources to achieve the health outcome.

Māori Health, Information Services and Community Oral Health Services are working to determine actual DNA patient numbers and recall processes. This will determine the numbers of children requiring follow up and an improved appointment scheduling system for oral health appointments.

Tūruki Māori Workforce Development

Health Workforce New Zealand Hauora Māori Fund

Last year, HWNZ and HBDHB were in negotiations to confirm volumes to purchase 2016 tertiary education programmes. Adjustments to the cultural support component of the contract are yet to be confirmed. HBDHB have been asked by MoH to present our model for success with Tairawhiti, Mid Central, Capital and Coast, Whanganui and Wairarapa DHBs. Key learnings from HBDHB include sustained engagement with training providers and health providers. The HBDHB model will also be presented to a combined MoH and DHB network of meetings.

Ministry of Social Development and Health Hawke's Bay PHO Initiative

The Kaiawhina Tikanga roles that Tūruki is supporting with Totara Health and Ministry of Social Development (MSD) progressed in November last year. Two wahine (female) have been successfully employed by Totara Health to support the nurses working with families while visiting the GP. An orientation programme will commence early December so that the successful applicants can appreciate the health sector industry in its entirety.

GENERAL MANAGER MĀORI HEALTH
Tracee Te Huia

HAWKE'S BAY
District Health Board
Whakawāteatia

MĀORI RELATIONSHIP BOARD

PRESENTATION
NEW INVESTMENT PROCESS
BY PETER KENNEDY

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and HBDHB Board**
Document Owner: Document Author(s):	Dr Mark Peterson Mary Wills
Reviewed by:	Executive Management Team
Month:	February 2015
Consideration:	Performance Monitoring

RECOMMENDATION

That Clinical and Consumer Council, Māori Relationship Board and HBDHB Board

Note the contents of this report.

OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from Dr Mark Peterson, Champion for the Access Indicators.

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH):	TBC	Mark Peterson	Mary Wills	Feb 2016
	0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections.	TBC			
	45-64 year olds - heart disease, skin infections, respiratory infections and diabetes	TBC			
Breastfeeding *National Indicator*	Improve breastfeeding rate for children at:		Caroline McElnay	Nicky Skerman	Mar 2016
	6 weeks,	>75%			
	3 months;	>60%			
	6 months of age	>65%			

Cardiovascular *National Indicator*	Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	Paula Jones	Apr 2016
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	Patrick LeGeyt	Jun 2016

OVERVIEW

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflects hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access. However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

The Ministry of Health ASH definition and methodology has been revised for ASH reporting from quarter one of the 15/16 year. A group of Ministry and health sector subject matter experts made several consensus recommendations for changes to the ASH definition. Implementation of these recommended changes to the Ministry ASH definition have taken effect for all Ministry ASH reporting from Quarter 2 of the current (15/16) year. There was no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning.

However there is an expectation that baseline ASH data (with the revised methodology) be reviewed by DHBs in order to better understand present performance, and in particular variation in DHB performance for different population groups. This will inform the 16/17 planning and appropriately targeted activities for each district. This paper highlights findings from this review.

At the end of June 2014 the results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga reo and e introduced new-born oral health enrolment with the aim to reduce hospitalisations for these conditions. We can see from the results outlined in this paper that Maori rates in these conditions have improved.

The highest ASH rates for 45-64 year olds are cardiac conditions and respiratory (including COPD) and cellulitis. Our focus is on development of Clinical Care Pathways.

MĀORI PLAN INDICATOR

Target 0-4 year age group

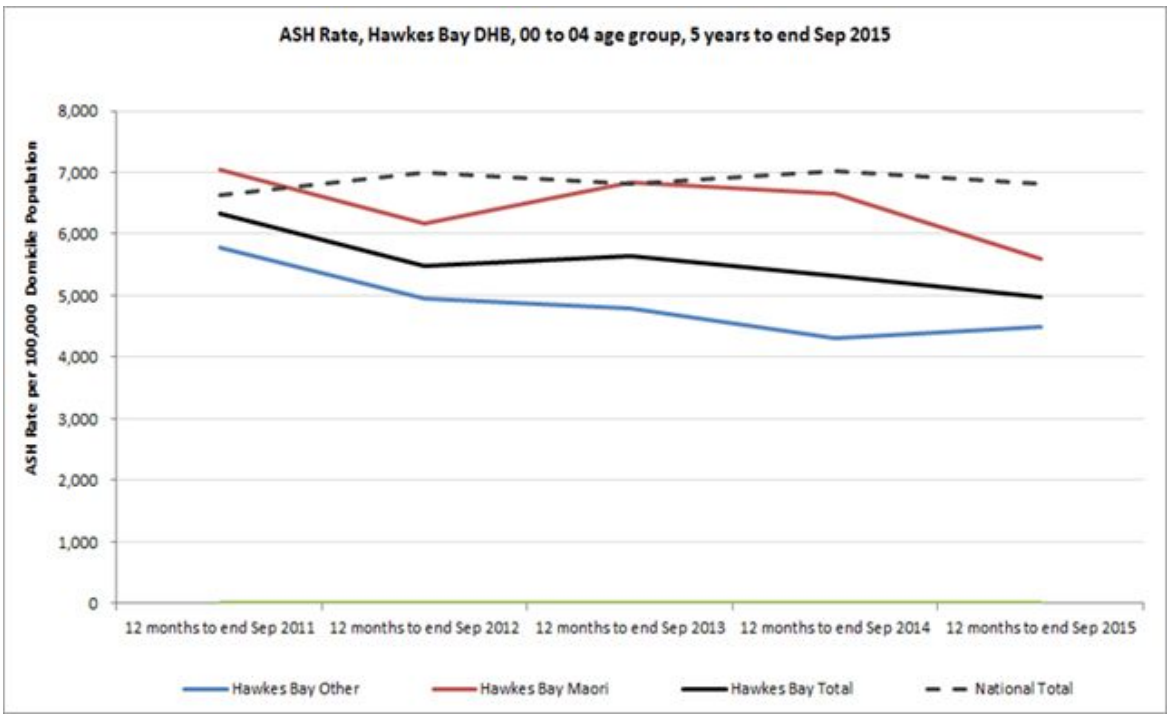
There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHBs have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. These results gives us an opportunity to examine performance over a 5 year period.

At the end of June 2014 the ASH results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga Reo and the introduced of new-born oral health enrolment with the aim to reduce hospitalisations for these conditions.

12

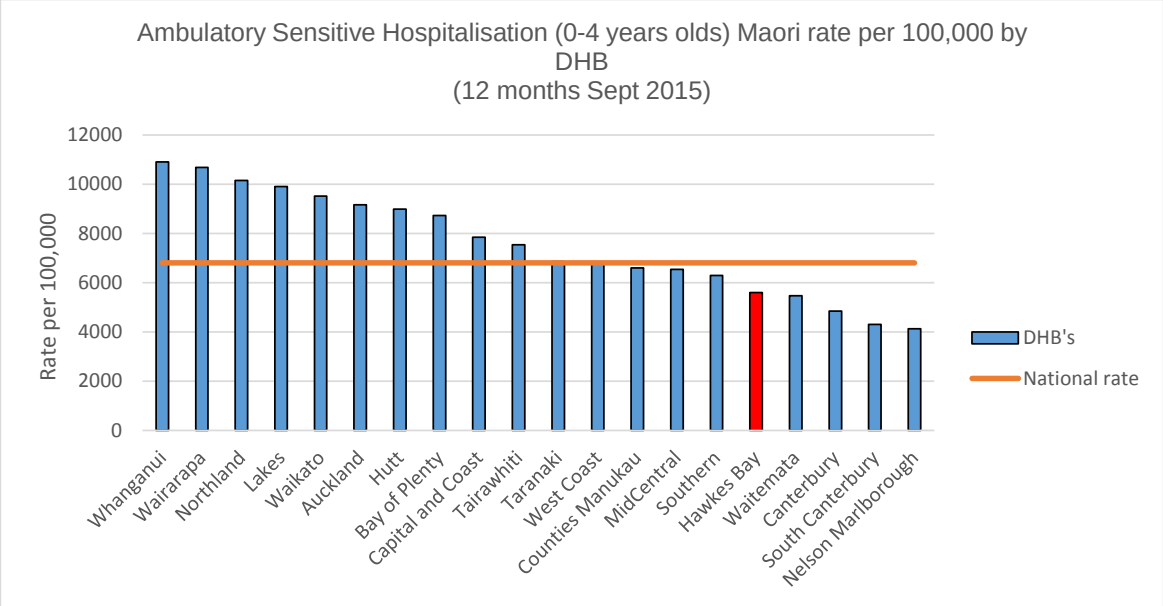
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 0-4 year age group– 12 months to end Sept 2011-2015



Hawkes Bay tamariki have lower rates of ASH compare to national rates for both Maori and Non Maori. There has been a reduction in the gap between the Maori ASH rate and the National rates particularly in the 12 months to Sept 2015. By 2015 the Top 5 ASH conditions for Maori in the 0-4 year age group are Asthma, Dental conditions, Respiratory Infections- Upper and ENT,Respiratory Infections – Lower, Gastroenteritis/Dehydration and Cellulitis (5th equal).

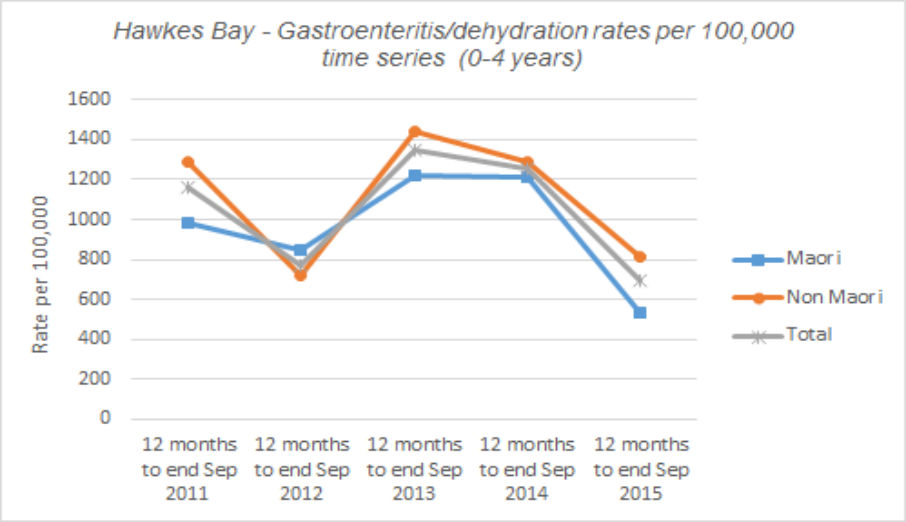
Māori ASH rates 0-4 year age group by DHB's – 12 months to end Sept 2015



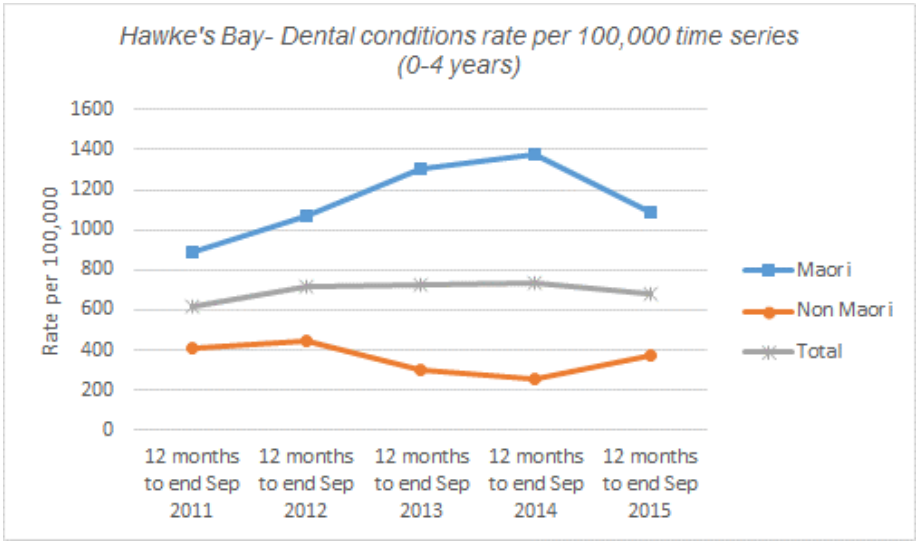
In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 82 % of the national rate and Hawkes Bay DHB was the 5 th best performer of all DHB's with Maori rates substantially lower than national rates in this age group.

In 2015 the largest differences between Hawkes Bay Maori rates and national rates in the 0-4 year age group are in the conditions Asthma and Respiratory infections- lower.

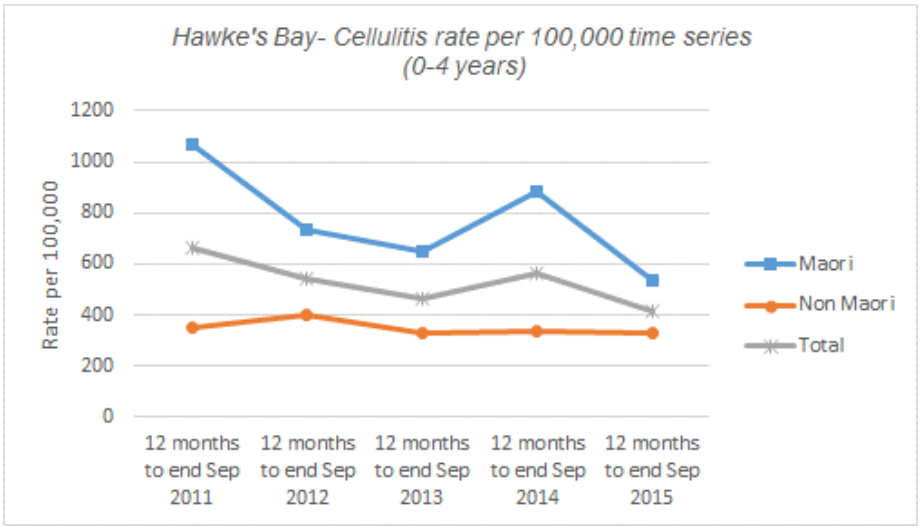
ASH conditions where Maori rates are improving



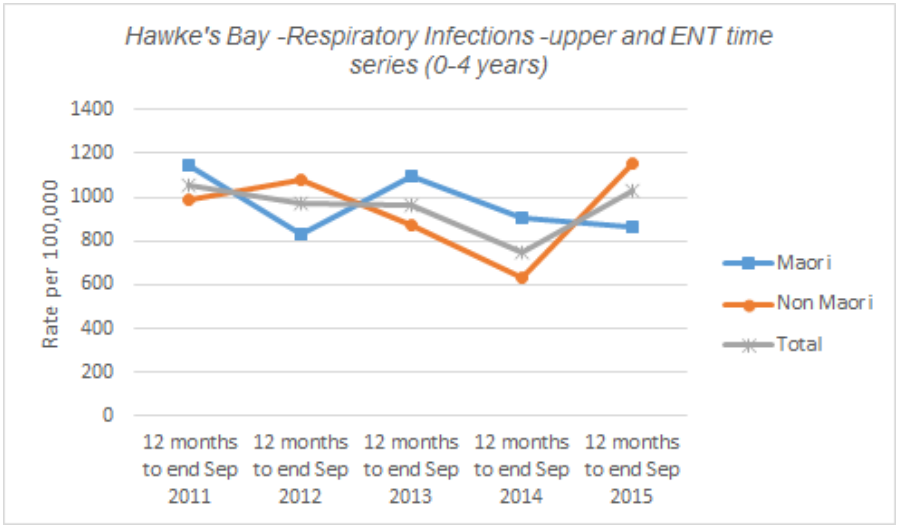
Gastroenteritis/dehydration rates in the 0-4 years have declined in the last 2 years. The Hawke's Bay Maori 0-4 year rate is half the national rate.



Dental is the 2nd ranked Maori ASH condition in the 0-4 year olds. Rates have dropped in the last 12 months to Sept 2015 and the gap has narrowed between Maori and non Maori. In the 12 months to Sept 2015 Hawke's Bay Maori rates are 2.9 times the Hawke's Bay Non Maori rate and 1.1 times the national rate.

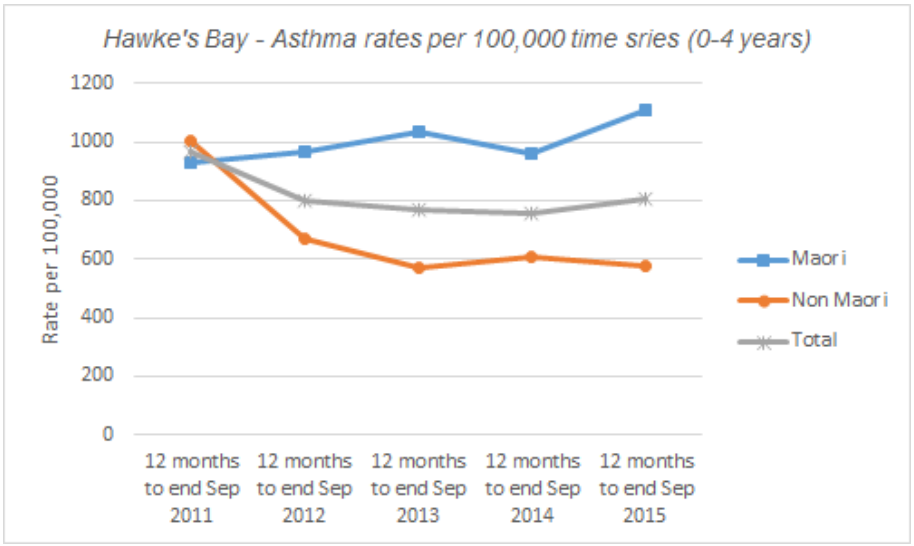


Cellulitis rates for both Maori and Non Maori have improved Maori rates are 1.6 times the Non Maori rates in the 12 months Sept 2015 and 1.2 times the national rate .

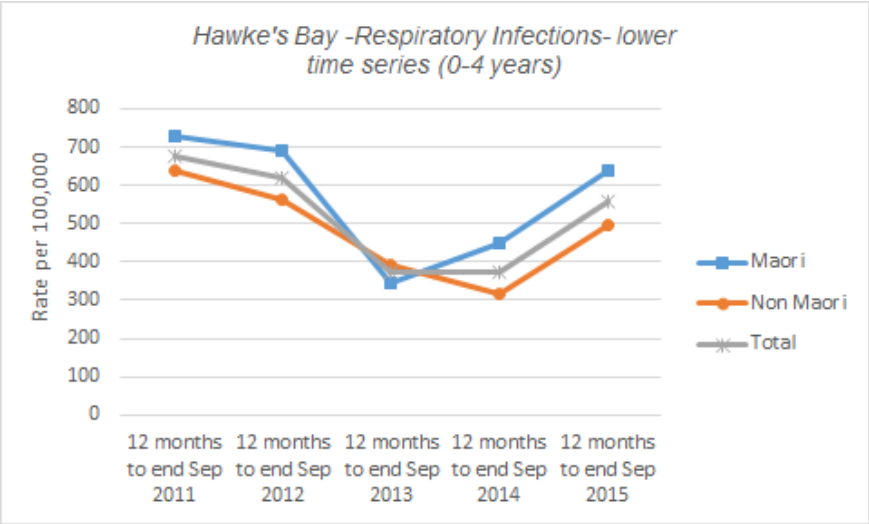


Respiratory Infections – upper and ENT are the 3rd highest ASH conditon for Maori 0-4 year old children. Maori rates have dropped particularly in the last 2 periods. Maori rates are lower than Non Maori rates and national rates in the 12 months to end of Sept.

ASH conditions where rates are not improving



Asthma is the top ASH condition for Maori 0-4 years and rates have been increasing over time and the gap between Maori and Non Maori have widened. By 12 month to end of September 2015 Maori rates were 90 % higher than Non Maori rates.



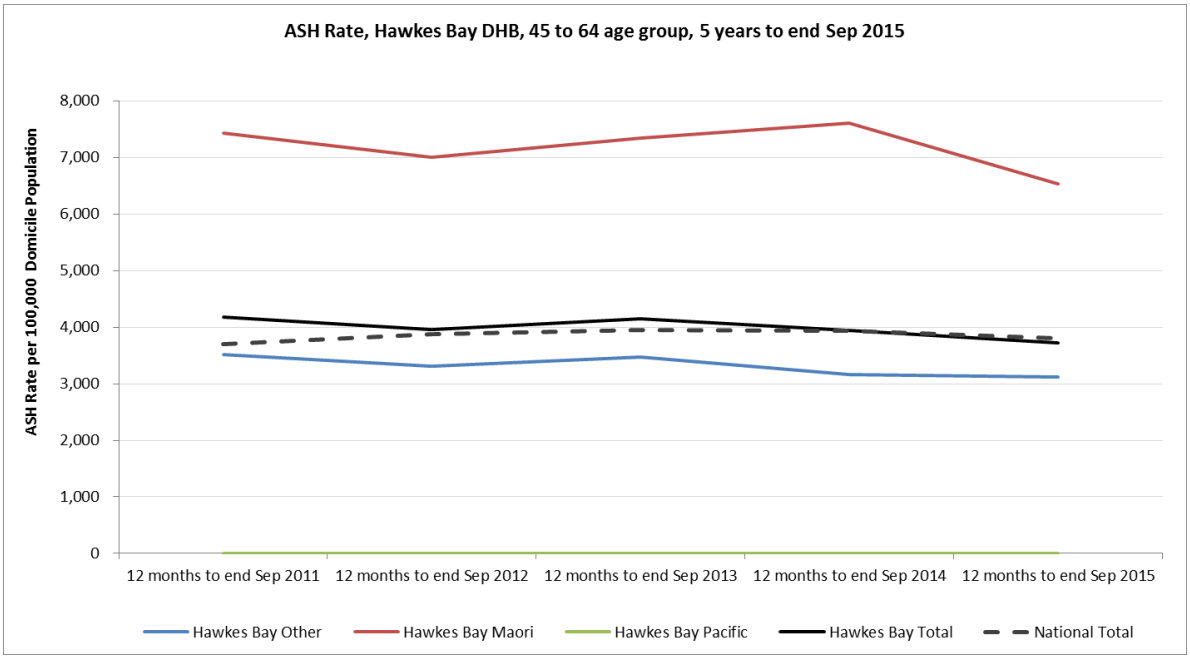
Respiratory infections – lower are the 4th ranked ASH condition in Maori children and rates have increased in the last 2 years.

Target 45-64 age group

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHB's have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. This has also given us an opportunity to examine performance over a 5 year period.

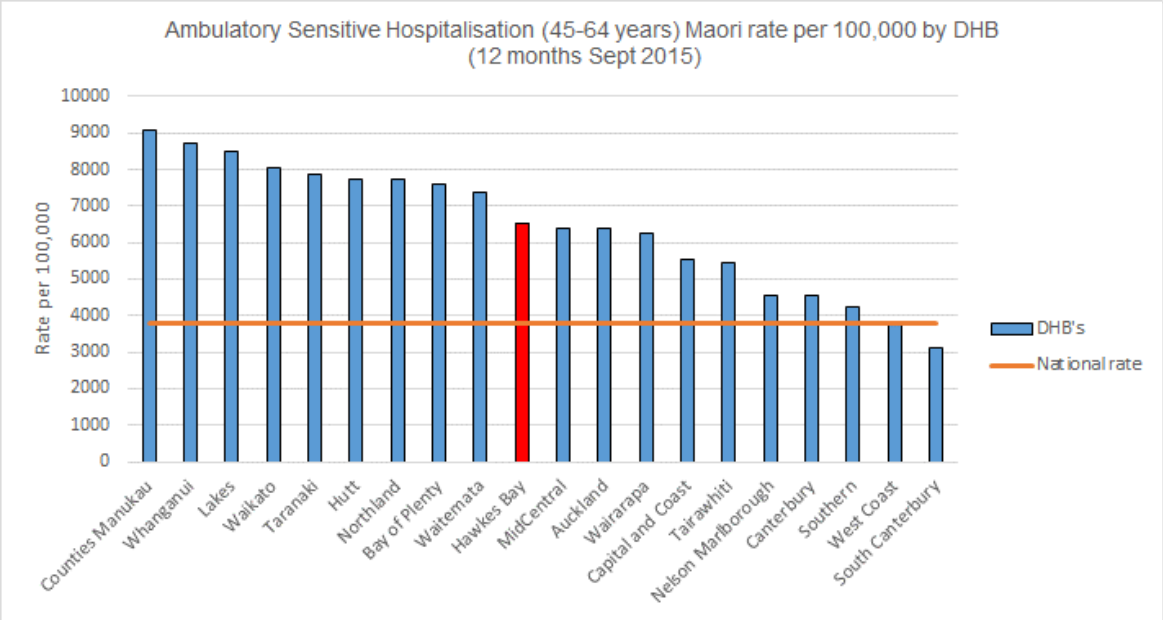
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 2010/11 – 12 months Sept 2015



There has been improvement in Hawke's Bay ASH rates in the 45-64 year age group in both Maori and Non Maori. The gap between the Hawke's Bay Maori rate and the Hawke's Bay Non Maori rate has narrowed between 2011 and 2015 as has the gap between the Hawke's Bay Maori rate and the national rate. In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 2.1 times the Hawke's Bay Non Maori rate and 1.7 times the national rate. The top 5 ASH conditions for Maori in this age group are Angina and Chest pain, Congestive Heart Failure, Respiratory Infections- COPD, Cellulitis and Myocardial Infarction.

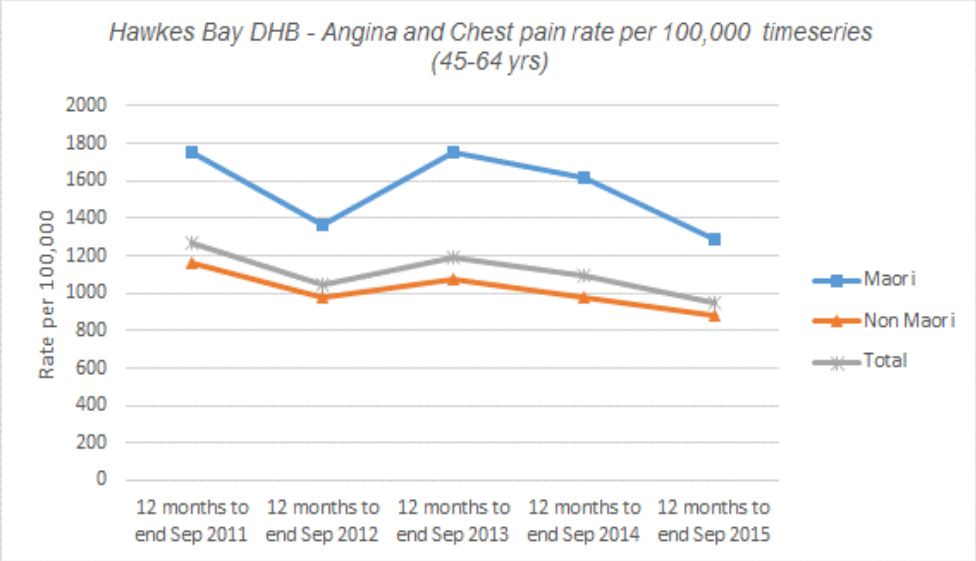
Māori ASH rates 45-64 year age group by DHB's – 12 months to end Sept 2015



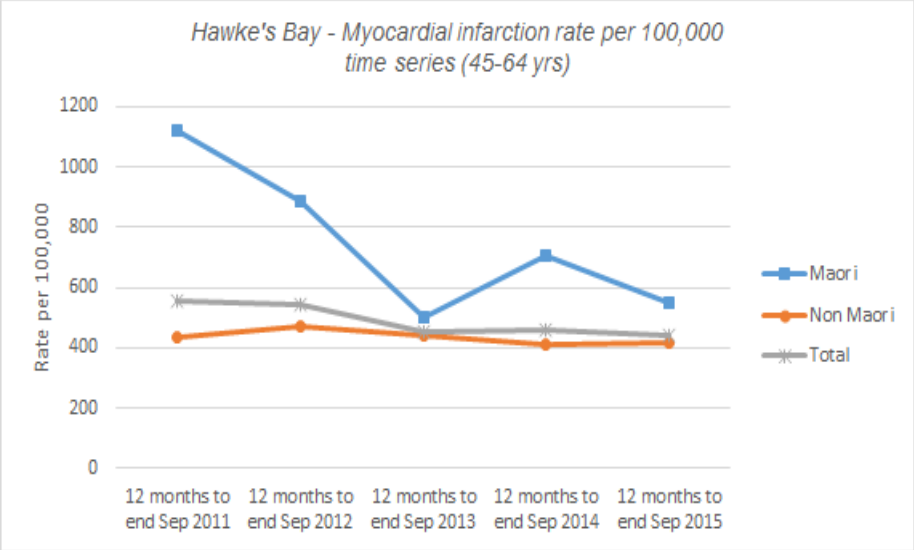
In the 12 months to Sept 2015 the Hawke's Bay Maori rate was 72 % higher than the national rate and Hawkes Bay DHB is ranked 11 th out of 20 DHBs. Maori rates are substantially higher than national rates in this age group across the majority of DHB's.

The largest differences in Maori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

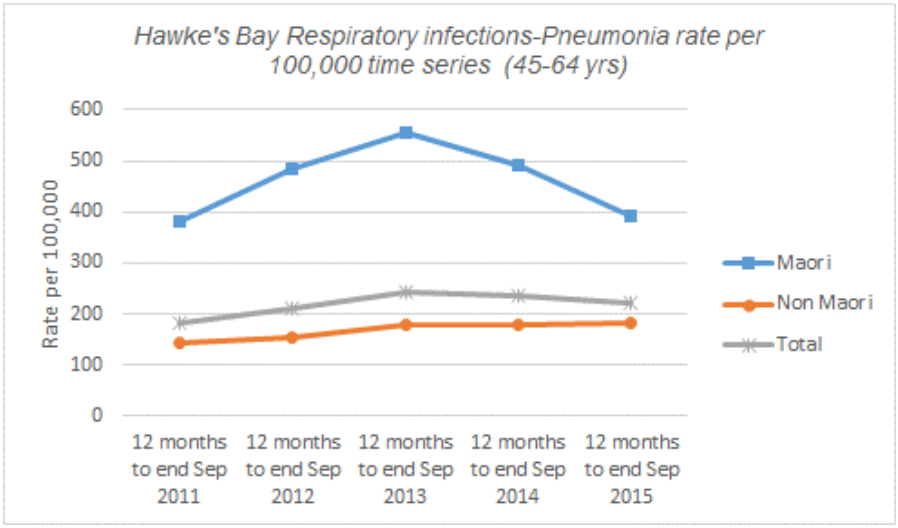
ASH conditions where Maori rates are improving



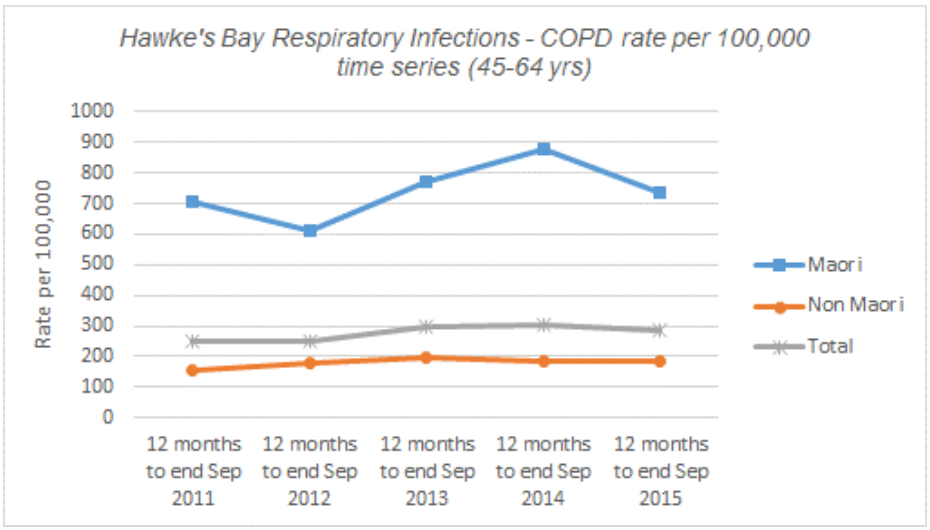
Angina and Chest Pain is the top ASH condiiton for Maori in the age group contributing 20 % of all Ambulatory Sensitive Hospitalisations in Maori in the 45-64 year age group. We have seen Maori rates decline and the gap between Maori and Non Maori narrow. In the 12 months to Sept 2015 Maori rates were 50 % higher than Non Maori rates.



Maori rates in the ASH condition Myocardial Infarction have also improved and by 12 months to end Sept 2015 Maori rates were 30% higher than Non Maori rates.

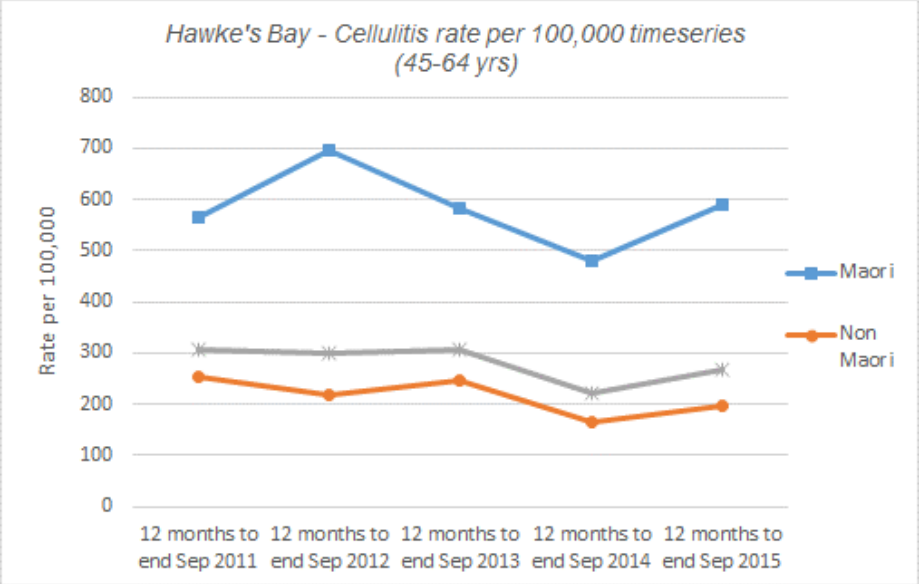


Maori rates in the ASH condition Respiratory Infections – Pneumonia have also improved in the last 2 years.

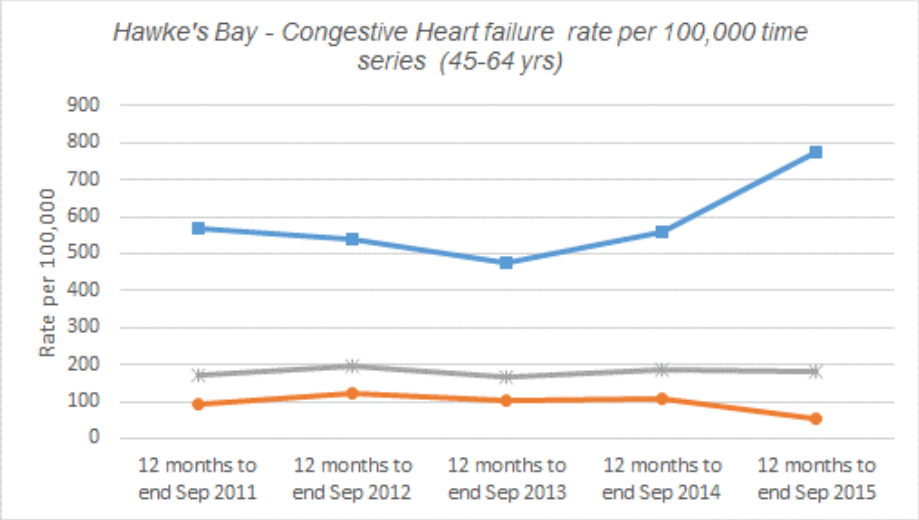


Respiratory Infections – COPD is the 3rd ranked ASH condition in terms of volume of hospitalisations for Hawke's Bay Maori in the 45-64 years age group. There has been some improvement in rates in the last reported period. In the 2015 period Maori rates are 3.9 times the Non Maori rates and 2.9 times the national rates for this condition and age group.

ASH conditions where rates are not improving



Cellulitis contribute 10 % of total Maori ASH hospitalisations in the 45 -64 year age group and is the 4th ranked ASH conditon for Hawke's Bay Maori in the age group. Maori rates have deteriorated in the last 12 month reporting period. Maori rates are 3 times the Non Maori rates and 2.9 times the national rates.



Congestive heart failure is the 2nd ranked ASH condition for Hawke's Bay Maori in the age group 45-64 years. Maori rates have deteriorated in the last 2 years and the gap between Maori and Non Maori rates has widened.

ACTIVITY TO SUPPORT THIS INDICATOR
0-4 YEAR OLDS

New Born Enrolment Programme

All children are linked to general practice as part of the new born enrolled programme with nearly 98% of children linked by 8 weeks. Quadruple enrolment with General Practitioner; Well Child/Tamariki ora; National Immunisation Register and Oral Health is now standard practice.

Kohanga Reo

Public Health Nurse Visits and Vision/Hearing screening for Kohanga continues. Public health nurse's offer education and advice to whānau, tamariki and Kohanga staff around key ASH conditions including gastroenteritis/dehydration and skin conditions.

The recent re-establishment of DHB service provision within HB Kohanga reo enable's the provision of education and advice to whānau, tamariki and Kohanga around the management and treatment of skin conditions. 2015/2016 will see the development of

A skin resource has been translated to be used in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission.

Co-Ordination of Child Health Data Systems

Excellent communication is maintained between different child health programmes databases in Hawke's Bay due to the goodwill of the NIR/immunisation team, however this is relationship based rather than a reflection of good systems. It is clear that what is required is a national child health database developed at the Ministry of Health level.

Hawkes Bay Child Interagency Network Group

This group is co-ordinated by the HBDHB child health team and meets bi-monthly with a wide range of key stakeholders include representatives from early childhood centres, kindergartens and home-based care for pre-school children. Each meeting a different topic is covered to ensure information provided around the prevention of conditions and promotion of initiatives and services is consistent.

Healthy Homes Programme

HBDHB and HHB continue to fund a programme providing insulation and a range of safety measures for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Maori and Pacific whānau.

ACTIVITY TO SUPPORT THIS INDICATOR
45-64 YEAR OLDS

Collaborative Clinical Pathways

Health Hawke's Bay and Hawke's Bay DHB are developing clinical care pathways across a range of services to increase consistency of practice in Hawke's Bay. In 2015/16 there will be another 24 pathways. Our focus is on promoting the use of the pathways in primary care, ensuring easy access for GPs and developing more pathways for high priority conditions.

Atrial fibrillation and chest pain pathways have been developed and were published in December. Asthma Pathways through Map of Medicine have been completed for children and adults and are currently being published. The next phase is to socialise the pathways into general practice. Key outcomes are evidence based practice, standardisation across Hawke's Bay, care planning continuity of care and reduced hospitalisations. Currently co-ordinating a multi-disciplinary group to work on community acquired pneumonia.

Nurse-Led Respiratory Pilot

Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics located in General Practices from 1 September 2014 to 30 June 2015. The project has been jointly implemented by Health Hawke's Bay, Hawke's Bay District Health Board and Asthma Hawke's Bay. Key goals of the project are to reduce unnecessary hospital admissions, emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level. Evaluation of this Project has been undertaken by EIT and results are to be presented to EMT January 2016. In summary:

- nurse-led clinics are effective in co-ordination and self-management.
- the majority of clients enrolled in the pilot were identified as being in Quintiles 4 and 5 (45% Maori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- higher representation of women compared with men;
- nurses working in the pilot felt empowered and autonomous in their respiratory practice highlighting a high level of professional development in the management of chronic respiratory conditions.

The pilot has proven that costs and spirometry charges have been a barrier to access. It is clear that for the pilot to continue with success is to have security of ongoing funding (business case will be presented at next bid rounds).

Sharing Primary Care Practice Information

Business Intelligence has produced reports for several general practices on their admission rates to hospital and emergency department attendances. This is now available as a regular report. We are working with Health Hawke's Bay to extend this to all practices, with appropriate oversight.

RECOMMENDATIONS FROM TARGET CHAMPION

The data provided shows quite a bit of variability in the change in rates of ASH in both age groups in the different diagnostic criteria. With the 0-5 age group there is a pleasing drop in the overall Maori ASH rates and a significant narrowing of the disparity gap. It is also notable that HB rates are among the lowest in the country.

Most notable is the change in gastroenteritis admissions in the last two years, and that HB rates are about half the national average. This will need to be correlated with the uptake of the Rotavirus immunisation. HB's high immunisation rate, especially among Maori children may be part of the answer to this (pleasing) improvement.

The ASH rates for the 45-65 age group show higher levels of disparity between Maori and the total population than for the 0-5 group. While rates have come down the disparity gap remains very similar.

Most concerning is the very large difference and climbing rates of admission for congestive heart failure. While the myocardial infarction rate has improved this is not reflected in CHF, which is often a longer term complication of IHD.

A clinical pathway for CHF should be developed and introduced as soon as possible.

CONCLUSION

Kohanga Reo targeted initiatives focussing on specific conditions have seen a decline in cellulitis ASH rates for 0-4 year olds. In addition whanau will have increased awareness of the need for early intervention with skin issues for all family members which includes the 0-4 year age group. The focus of public health nurses on early intervention with skin issues in low decile schools and Kohanga Reo is likely to have contributed to improvements in rates.

Health Literacy Strategic Review

Information for the Māori Relationship Board

As you may already be aware, Quigley and Watts Ltd (www.quigleyandwatts.co.nz) have been commissioned by the Hawke's Bay DHB to do a high level review of health literacy within the DHB and across the sector to inform the development of a sector-wide health literacy framework. As part of the high level review, feedback is being gathered from a variety of sources on how health literate the sector is currently as well as opportunities to improve going forward.

Internationally there is no unanimously agreed definition of health literacy. The Ministry of Health defines health literacy as the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing. As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. This review focuses on the health literacy of the system and not of the individual consumer/patient.

Jen Margaret and Kate Marsh, senior researchers from Quigley and Watts, will be gathering your feedback for half an hour during your next meeting. Your feedback will be presented to the DHB who will use it to develop a sector-wide health literacy framework.

As our time with you is limited, it would be much appreciated if you could consider the questions below prior to attending the meeting and come prepared to provide your feedback.

1. **Where do you think the Hawke's Bay health sector is currently at in terms of health literacy?**
2. **How should iwi/Māori perspectives and aspirations be reflected in the development and content of a sector-wide health literacy framework?**
3. **What are the key challenges to be addressed in creating and implementing a sector-wide framework for health literacy that meets the needs of Māori?**
4. **What are some solutions to the challenges you just mentioned?**

Please direct any queries about these questions to Jen Margaret – jen@quigleyandwatts.co.nz and any queries about this review process to Jeanette Rendle - Jeanette.Rendle@hawkesbaydhb.govt.nz.

HAWKE'S BAY District Health Board Whakawāteatia	**Health and Social Care Networks Programme Brief**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board**
Document Owner: Document Author(s):	Steering Group – Health and Social Care Networks Kevin Snee
Reviewed by:	Executive Management Team
Month:	February 2016
Consideration:	For Discussion

RECOMMENDATION

That HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board:

1. Endorse the content of this Programme Brief
2. Provide feedback and input on its content and strategic direction

INTRODUCTION

Under the auspices of Transform & Sustain, we are proposing a new programme of work that will significantly change the structure of the Hawke's Bay health sector. This work is transformational in nature, requiring new ways of operating and strong relationships across all stakeholders.

The programme will take a staged approach, with an initial project that will establish the DHB's processes and standard requirements for network development, plus develop standardised documentation and templates. These resources will be available for use in later projects, by stakeholder groups (including patients and community leaders) that wish to establish geographically-based provider networks ("Health and Social Care Networks") that will work collaboratively to better address the needs of their combined enrolled population. One such group is already considering network development (Wairoa), and two others are in the early stages of considering the potential to work together (Central Hawke's Bay and central-Hastings); these groups will be supported and encouraged within the overall programme.

This paper introduces the programme (the Programme Brief) and provides further information on the development of standard tools and processes (Appendix 1), an intial stakeholder analysis (Appendix 2) and a terms of reference for the Steering Group that will oversee all programme work, ensuring alignment and synthesis across all projects (Appendix 3).

BACKGROUND

The health system in Hawke's Bay, as with the rest of New Zealand, will experience significant challenges in meeting the future needs of our population, particularly in terms of the aging cohort and a rise in conditions requiring long term and complex care. To better prepare our sector for these challenges, an alternative service delivery model that integrates primary, secondary and social services has been proposed; this model seeks to increase effectiveness and efficiency of health care delivery closer to where people live, whilst recognising and addressing the key role of socio-economic factors in determining health outcomes.

Recent discussions have centred upon how this integration could be effected, focussing on the establishment of clusters of health and social service providers working closely together with the patients that they have in common; these clusters have been termed *Health and Social Care Networks.*

Initially networks will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians and community leaders. The time frame to achieve this expanded vision may be different for different communities.

Stakeholder engagement and input will be essential to the success of the Health and Social Care Networks Programme. In Phase One, outlined in Appendix 1, this engagement will focus on DHB and PHO stakeholders. This is because the work focuses on determining these organisations' approach to networks, including a proposal on how networks could be structured, the level of decision-making that could be devolved to communities and developing supporting resources to assist communities on this journey. Where possible, Phase One deliverables will be over-arching, rather than prescriptive, as each Network will result from a co-design process and will be as individual as the community it serves. In later projects, in which communities establish networks that meet their needs and aspiations, co-design will be the key process by which a much wider range of stakeholders will be involved in a partnership to design and implement their network. Such projects will be the subject of separate Terms of Reference.

ATTACHMENTS – Programme Brief, Appendix 1, 2 and 3

Programme Brief

Establishing Health and Social Care Networks

January 2016

Purpose of this document

The purpose of this document is to outline the scope and activities required to enable Health and Social Care Networks to be established in Hawke's Bay.

This document is for:

- The Health and Social Care Networks Steering Group – to describe a way forward for sector redesign, providing a clear statement of intent, leadership and responsibility
- EMT – to gain managerial approval and support for this initiative and approach

Background

The health system in Hawke's Bay, as the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources across the board.

Transform and Sustain has established a strategic framework and an environment under which significant change can be achieved, and is already underway in some areas. There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up. The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in several forums.

This journey will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. We propose to begin this journey by delivering current services differently, to respond to the community more effectively and to encourage and motivate collaboration. This journey will be challenging because of the number and breadth of stakeholders, because it requires changes to the status quo and because the day to day operations of a complex health sector need to continue whilst this vision is realised. It is also an opportunity to revitalise our sector and increase sustainability in terms of service affordability, infrastructure and workforce.

Proposal

We propose to establish a number of networks of collaborative services that are clustered around geographical communities that work closely together to care for patients that they have in common.

Initially networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This will be the focus of Phase One.

This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

Phase One

We will cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGO's and voluntary organisations in the concept of community networks. We will begin with health services and invite community partners to also review their services through an aligned approach.

In Napier and Hastings the clustering of services will be based on populations of around 30,000 people, in an aligned geographical area. The 30,000 figure represents a likely lower limit at which a network would be viable; an upper limit, although not specified, would be a figure at which a sense of community is lost. In Wairoa and Central Hawke's Bay remoteness rather than population size determines each to be a sensible geographical network and, therefore, smaller network populations are envisaged for these areas.

In order to reshape services so that they are appropriate for the community the HDBHB and HHB teams will work with local general practice teams and other local clinicians, consumers and community partners to:

- Ensure services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

To achieve this first phase the programme of work detailed below proposes:

1. Background work - understanding ourselves (services, processes and models) and the potential benefits to be gained from networks, developing expertise through a central repository of knowledge, tools and resources that will support sector change. Key activities include:
    - ensuring various projects, existing and new initiatives, are aligned
    - reviewing our services and considering the most appropriate delivery models
    - analysing our systems and processes to reflect the collaborative working environment
    - developing a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay
    - reviewing examples of good practice from other places to avoid reinventing the wheel
2. Establishing a network in Wairoa
3. Motivating collaboration in Central Hawke's Bay
4. Supporting collaborative general practice initiatives in Hastings (e.g. Totara health and Hastings Health Centre)

5. Supporting the identification of sensible network groupings in Napier and Hastings
6. Initiating the development of the technology platform in primary care.

Each of the associated individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

Progress to date:

A proposed scope, deliverables and high-level milestones for item 1 above is provided in Appendix 1. Progress to date in this space has included the health services directorates considering services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka). Work has also been done to review what the community wants from services – what have we already been told, and to engage consumers in consideration of the general practice model of care.

On the back of the development of the new facility in Wairoa there have been positive discussions between community providers about working together in a smarter way. This will be nurtured and furthered through joined-up activity. Establishing a network in Wairoa is being developed under separate Terms of Reference document.

An initial meeting was held at the end of 2015 in Central Hawke's Bay which was attended by representatives of the key providers. A further meeting will be held in February to identify what the local priorities for service development are.

Whilst the Totara Health and Hastings Health Centre programme has stalled temporarily the opportunity for collaboration between general practices in Hastings remains. The PHO and DHB will continue to motivate collaboration and initiatives such as urgent care will support a collaborative approach.

The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialing geographical groupings of services in Napier and Hastings. Lessons will be learned from these.

The DHB and PHO are currently considering what the next steps with the development of primary care infrastructure should be. A single shared care record will be a priority and some research has been undertaken as to solutions in this space.

Interdependencies

A range of other existing projects will also inform and support the network programme:

Project Name	**Interdependency description**
Patient Experience	Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area
EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators roll out	Information on existing models of service delivery and potential geographical networks
Urgent Care	Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration
Customer Focused Booking	Influenced by, and influences, models of care that could be adopted by practices within a network
Health Literacy	Health literacy will be a key component of models of care implemented by general practices within networks
Model of Care support in primary	PHO project to develop a centre of knowledge regarding

Project Name	Interdependency description
Care	general practice models of care. Will inform and assist general practices

What success will look like

Success in the short term will mean we are delivering more health services in the community and we are supporting services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

For phase one networks will have a standard set of services but these may be delivered against different models of care depending on the needs and resources (such as clinical skill, capacity and facilities) of the community.

During the implementation of phase one, we will analyse information and engage with consumers and providers within communities to better understand the needs and cultural requirements of the community. We will understand what approach will support successful outcomes for each network. This will set up a solid foundation for progressing networks beyond mechanisms for service delivery to meet our longer term vision.

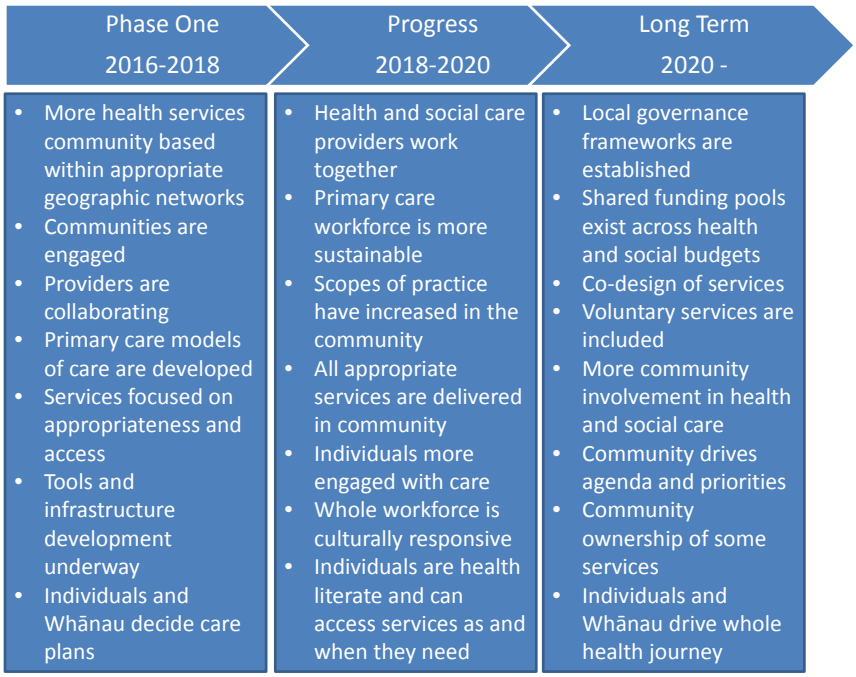
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are increasingly evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whanau with complex health and social needs.
- There is reduced need for hospital visits because many services are conveniently accessed in a community setting. This has led to reduced waiting times for necessary hospital-based treatment.
- General practice clinicians have the time to work with patients who need it.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise
- General practice business models are motivated to support sector activity
- Patients at risk are proactively identified and supported
- Technology and information is used effectively for joined up service delivery and for to support self-management
- Health outcomes, codified in a set of performance indicators covering central and local expectations, have improved.
- Continuous improvement and innovation is a central tenet of the system,

- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

High-level time line

The following diagram highlights the journey networks will take. The dates are indicative only, setting the direction of travel that we intend to take. Some networks may progress more quickly, particularly where geographic locality is clear and there is a group of existing engaged stakeholders. The detail highlights the key anticipated achievements of each phase.



Appendices

The appendices to this document provide additional information on the following:

- Appendix 1 – High level plan for Phase 1 (timelines, financials, deliverables, risks and communication)
- Appendix 2 – Stakeholder Analysis
- Appendix 3 – Terms of Reference for the Steering Group

APPENDIX 1: Phase One – timelines, financials, deliverables, risks

Phase One (Core Network Expertise project) is proposed to run for 7 months (February – August 2016). It will establish minimum/standard requirements of networks and support network establishment in localities.

Deliverables and high-level milestones

Objectives	Deliverables/ high level milestones
1. Set the scene	1. Agreed set of over-arching principles for Network design, operations and benefits realisation • Get approval for progress from EMT • Determine the governance and approvals processes required by HBDHB • Get input/feedback from a wide range of stakeholders (this will get their input and also socialise the ideas) to finalise the principles 2. Review of other current projects (engAGE, Pharmacy and DN) to ensure alignment across these and the Networks programme and identify lessons learned so far 3. Establish an appropriate project management framework, appropriate roles and responsibilities and resources. This will include a communications framework.
2. Geographic groups / communities	1. Localities proposal: proposed geographic regions ('localities') for networks • Analyse HB data (health, economic, other) to characterise the population, identify areas of shared needs or opportunities etc • Propose localities, using principles and interests (populations they serve) to guide boundaries; Wairoa and Central HB are geographically distinct, so work will focus on defining Napier and Hastings groupings • Map current capacity, capability, service provision and facilities in each proposed locality
3. Services and service delivery	2. Standardise a list of services that could be delivered in the community in an integrated way • Map those services for which we have some control over (i.e. DHB and PHO-funded), bring in others as we socialise the networks. • Identify how these services fit with each locality (appropriateness, resources, capability, priorities, local motivations etc.) • With network input identify how individual service lines might work differently to deliver more effective, efficient services in the community that are better of the patient and support a collaborative approach. 3. Service delivery models – options document • Research existing models of integrated services to inform the options (e.g. Nuka, Kaiser Permanente, NHS CCGs, Counties Manukau) • Determine appropriate delivery models (these will be tailored during implementation in each locality) • Create a centre of Knowledge and information around models of integration and primary and community models of care
4. Network development processes and guidelines	1. Document a standard set of requirements and standards that each network will work within. Some of these will be relevant from day one, others will be prepared for when they are needed. These will include: • Governance mechanism • KPIs/targets (minimum standards) and accountability mechanisms • Contracting mechanisms (between funder and provider, between network partners, etc) • Levels of delegated authority and mechanisms to increase autonomy over time • Budget tools and financial accountability requirements

Objectives	Deliverables/ high level milestones
	• Asset mapping tool • Network stakeholder analysis • Communications templates 2. Analyse existing DHB and PHO systems and processes and review/redraft these to reflect the collaborative working environment; develop new systems and processes where required. Examples include funding and contracting arrangements – to enable and support different ways of working. 3. Once we are ready for some decision making to be devolved to networks there will need to be a standard mechanism/pathway for 'applications' from locality groups wishing to establish a network (by submission of an outline business case or similar process). It is prudent to begin drafting what this may look like. 4. Tools and templates as required by locality groups who wish to form a network. Examples could be: • High-level 'how to' plan providing a suggested pathway/series of steps for network establishment (include alternatives/not prescriptive but indicates the minimum requirements) • 'Business Case' application template (for point 3 above) • Terms of Reference template to support establishment project scoping and planning • Terms of Reference for project Steering Groups, Partnership Advisory Groups, etc • Risk identification and management plan • Infrastructure/resource map and plan • budget template • Guide to co-design • Community asset mapping tool (beyond health and social service providers)

Risk Analysis and Management

Preliminary Risk Analysis:

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Lack of primary care engagement	M	H	Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities.
Lack of engagement with secondary care	M	H	Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process.
Project doesn't adequately address consumer priorities	L	H	Consumer input based on a co-design approach will be integral to the establishment and operation of networks.
Project, programme and change fatigue	M	M	Communicate the vision and engage stakeholders at an early stage so that they own the solutions. Communicate regularly.

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
			Promote and celebrate success
Scale of what we're trying to achieve	M	L	Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience.
Too busy keeping the current state afloat	H	H	Adequately resource the project (staff time, resourcing and financials) to ensure that there is enough 'space' to effect change.
New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers	M	H	Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs. Support relationship building opportunities.
Governance of networks; how do we account for them?	M	M	Build robust processes based on best practice.
Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc)	H	M	Project Manager to get a good understanding of results from other projects, and synthesise the lessons.

Financial Profile

This budget covers the Phase One 'Core Network Expertise' project, and is expected to be conducted during February-August 2016 inclusive (7 months). The project manager role is in addition to this budget. Further budgets will need to be supported by business cases to support implementation of health and social care networks.

As the timing of this project spans two financial years, the indicative spend in each year is as follows:

- 2015/16: $71,400
- 2016/17: $28,600

Item	Itemised Description	Cost$	Budget Source and Status (approved / approval in process etc.)
Project resources and operating expenses	o DHB staff (existing resources) o Incidental travel o Catering at meetings o Printing o Room hire o Patient engagement costs	Time $50,000 (combined items) $20,000 (combined items)	Existing staff budget New New

	o Research costs		
External advice	o Specialist advice (e.g. legal and governance); DHB expertise o Graphic design o Qualitative Engagement software and support (Cognise)	Time $30,000 (combined items)	Existing staff budget New
	Total cash investment:	**$100,000**	**New**

APPENDIX 2: Stakeholder Analysis

Stakeholder group	What they may like	What they may not like	Risks
Consumers	Opportunity to fix the problems they experience re choice, access, etc Potential to be involved in the changes/have a voice More responsive to consumer needs and wants	Shared patient records – perceived confidentiality breaches Change Additional expectations for self management	Perception that this is yet another sector restructure (waste of time/money) Rumours / media stories (negative perception or incorrect info)
General practices	General practices are key partners in this initiative – seen as progressive More influence over what services are commissioned Meritocratic increase in authority as networks prove themselves Opportunity to expand general practice scope/ potential for job enrichment May offer opportunities for succession planning Opportunities for efficiencies Opportunities to be seen to do more for patients Opportunities to improve sustainability of business and workforce	Likely to disrupt current business models Uncertainty of funding in the short-term Collaborating with competitors, particularly if there is ill will Shareholders may have other priorities for their business Business needs may be at odds with required network outcomes Out of their depth (planning etc)	Lack of practice leadership may mean that staff don't engage/ get the wrong story Staff uncertainty re jobs, scope of their role Competitive behaviour leads to perverse outcomes May not share data/info Shared geography may not mean aligned aims/objectives/philosophy Poor use of data for strategic planning – can't see the SWOT
General practitioners	Potential to decrease time pressures Ability to specialise in an area of interest Better able to refer patients with non-medical issues to other network providers Sustainability	May be expected to network with practices or people they don't like or respect May feel forced by the DHB Feel out of control	Stall progress by continually bringing up issues and/or avoiding engagement Curmudgeons promulgate negative stories/perceptions Keeping the current state going uses up all their time/energy
Community-based nurses	Work at top of scope in a new model of care; less admin/low level tasks Introduces new roles and development opportunities	Potential for loading a lot more responsibility on them	Nursing workforce in primary care may not want to change
Health Hawke's Bay	Decrease complexity and variability across practice offerings	Changes potentially conflict with nationally-determined priorities	Inability to get cross-practice information sharing and shared IT

Stakeholder group	What they may like	What they may not like	Risks
	More responsive primary care sector Joined up system, improve access, address inequity Doing better for patients More engagement across the sector Efficiency More services in the community Sustainable workforce	Out of our depth? Resource requirements and effort to achieve this change	platform Lose support of practices Communities/providers not wanting to engage
DHB	Keep the hospital the same size despite increased demand for services Local responsibility for infrastructure and resourcing (??) Address equity gap	Devolving control to communities due to lack of certainty/ track record of delivery Has invested in the current state Resource requirement to make this happen If things don't move at the right pace	Could lead to more complexity of 6-8 'different' systems (networks) to interact with Too prescriptive, meaning that communities don't feel that they own the network
Hospital services	Sustainable workloads Efficient service collaboration with primary care	Keeping the current going doesn't allow time for change Scared about jobs/instability? Might have to travel to work remotely? Worry about community capability Effort in addition to day job	Risk adverse, so will 'dig in their heels'? Perverse behaviour re network vs private patients? Services fail / community-based services don't work
MSD (funder)	Collective impact is greater than working in silos Keep people well; keep people in work Fit with national agenda	Potential lack of clarity re budgets (split between H&SC) Conflict between network outcomes and MSD policy directions? Never been done before Control issues?	Change seen as too difficult, too soon, or only benefitting the health sector Targets / national picture gets in the way of local decision making
MSD-funded services	Better access to the health resources available in the health sector, ability to cross-refer patients/clients Clarity of service provision	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Skills to engage in doing things differently	Service failure Don't meet targets
Maori providers	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Focus on Maori – close gaps, decrease inequities More holistic approach fits with Maori	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term How does this fit with current initiatives? Mistrust of HBDHB gets in the way of progress	Fear of losing autonomy

Stakeholder group	What they may like	What they may not like	Risks
	way of approaching things (e.g. whanau ora) Opportunities for collaboration Opportunities to think strategically	A lot going on with post settlement groups – this is 'another thing'	
NGOs	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Potential to re-direct their services/service delivery to become an integral part of the network Better integration / collaboration with voluntary organisations	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Potential for more referrals; will need to see $$ coming their way	Overloading them No resources to engage Don't have sustainable funding streams

APPENDIX 3

TERMS OF REFERENCE

Health and Social Care Networks Programme Steering Group

Purpose	The purpose of the Steering Group is to ensure sound decision making in the Health and social care network programme, to ensure the programme brief is adhered to and to communicate messages as appropriate.
Functions	At a programme level, the steering group is responsible for achieving the high level strategic vision of the Networks programme. This includes the following responsibilities: • Oversees all deliverables in Phase One - Health and Social Care Networks Programme to ensure strategic fit. • Actively champions the Networks Programme and provides leadership for change • Understands the desired outcomes, and tracks progress towards these, taking corrective action where necessary. • Monitors the management of major programme issues and risks and provides advice on the best approach to resolving these. • Owns the process and the deliverables of the programme. • Maintains a high-level view of project work being conducted across the health sector so that potential synergies with, or impacts on, the Networks Programme can be identified and addressed appropriately. • Reports to HBDHB Executive Management group on a monthly basis. • Holds and allocates the programme budget. • Ensures programme benefits KPIs are tracking positively. • Ensures sound decision making processes are followed • Establishes the brief or terms of reference for subsequent phases • Support and endorse Terms of Reference documents for network establishment projects in each geographic locality.
Decision Making	A consensus is required for any decision. Where meeting attendance is not possible a member will endorse/reject a deicision electronically either before a meeting or upon receipt of the minutes.l
Membership	The Core Membership of the steering group is: GM Primary Care/CEO HHB COO HBDHB GM PIF HBDHB DAH GM Māori Health HBDHB Head of Innovation and development HHB

	CMO (Primary) Chief Nursing Officer Medical Advisor Sector Development HHB (GP to be appointed) Manager, Wairoa Health Centre Service Director, Rural, Oral and Community Health Services Medical Director HBDHB Consumer representative Ministry of Social Development representative Other individuals will be invited to provide expertise as and when appropriate. These will include: HHB leadership team members Health Service Directors Specific service or facility managers
Chairperson	The Chair will be the GM Primary Care
Administration	The Project Manager - Network Development will: • administer the steering group • maintain an accurate and up to date record of decisions and activities • Set up meetings of the group • Draft Reports on behalf of the group • Monitor progress against programme plans
Meetings	Meetings will be held on at least a monthly basis, although additional meetings may be set up as required. Meeting attendance will be restricted to the Group members only (and appropriate support staff) with other persons attending only by specific invitation. Matters may be dealt with between meetings through email exchange with a record being maintained by the project manager.
Reporting	The steering group will report to the CEO HBDHB and to the executive management team on a monthly basis.
Minutes	Notes and action points will be circulated to all members of the Group and a summary of discussion from each meeting will be provided to EMT and the HHB Leadership team for information by email.

MĀORI RELATIONSHIP BOARD

DRAFT WORKPLAN FEB – DEC 2016

NOTE: The HBDHB Workplan is currently being developed. Therefore, this draft MRB workplan 2016 and 2017 is subject to change. The final MRB Workplan will be tabled in March 2016 along with the HBDHB Workplan.

Date/ Month 2016	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
10 Feb	Te Ara Whakawaiora: **Access** (local indicator) Ambulatory Sensitive Hospitalisations (ASH): 1. Reducing acute admissions 2. Dental 0-4 year olds 3. Heart Disease 45-64 year olds	CMO Primary	Health Literacy - Strategic Review Health & Social Networks Terms of Reference	Com Sec CEO HHB CEO HBDHB
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
9 Mar	Te Ara Whakawaiora: **Breastfeeding** (national indicator) Annual Māori Health Plan Q2 Oct-Dec 2015 Wairoa Health Needs Assessment Report Māori Health Service Review	DPH/ HE GM MH GM MH GM MH	Draft Report Information System Review 2016 MRB Workplan 2016 HBDHB Workplan DRAFT Annual Plan and Statement of Intent (for information only)	GM PIF GM MH Comp Sec GM PIF
APR	**NO MEETING THIS MONTH** Te Ara Whakawaiora: **Cardiovascular** (national indicator) 1. Total number (%) of all ACS patients where door to cath time is between 2 to 3 days of admission 2. Total number (%) with complete data on ACS forms ***Email to MRB*** Incubator Programme 3-Monthly Student Uptake Apr Report ***Email to MRB***	 CMO GM HR		
20 Apr	***Hawke's Bay Health Leadership Forum (timing and venue to be confirmed)***			

Date/ Month 2016	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
11 May	Annual Māori Health Plan Q3 Jan-Mar 2016 Active Whānau Programme Free Primary Care for 13 – 18 year olds Consumer Story	GM MH GM MH GM MH DQIPS		
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
8 Jun	Suicide Prevention Plan Report Defining Whānau Centric Consumer Story	DPH/ HE GM MH DQIPS		
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
13 Jul	Incubator Programme 3-Monthly Student Uptake Jul Report Consumer Story	GM HR DQIPS		
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
10 Aug	Annual Māori Health Plan Q4 Apr-Jun 2016 Consumer Story	GM MH DQIPS		
SEPT	**NO MEETING THIS MONTH**			
7 Sep	***Hawke's Bay Health Leadership Forum (timing and venue to be confirmed)***			
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
12 Oct	Incubator Programme 3-Monthly Student Uptake Oct Report Consumer Story	GM HR DQIPS		
Date/ Month 2016	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
9 Nov	Annual Māori Health Plan Q1 Jul-Sept 2016 Consumer Story	GM MH DQIPS		
DEC	**NO MEETING FOR MRB IN DEC** Te Ara Whakawaiora: **Smoking** (national indicator) ***Email to MRB***	DPH/HE		

MĀORI RELATIONSHIP BOARD

DRAFT WORKPLAN FEBRUARY - JUNE 2017

Date/ Month 2017	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
8 Feb	Te Ara Whakawaiora: **Access** (local indicator) Ambulatory Sensitive Hospitalisations (ASH): 1. Reducing acute admissions 2. Dental 0-4 year olds 3. Heart Disease 45-64 year olds Annual Māori Health Plan Q2 Oct-Dec 2016	CMO GM MH		
Date/ Month 2017	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
8 Mar	Te Ara Whakawaiora: **Breastfeeding** (national indicator)	DPH/ HE	DRAFT Annual Plan and Statement of Intent	GM PIF
APR	**NO MEETING THIS MONTH** Te Ara Whakawaiora: **Cardiovascular** (national indicator) 1. Total number (%) of all ACS patients where door to cath time is between 2 to 3 days of admission 2. Total number (%) with complete data on ACS forms ***Email to MRB*** Incubator Programme Monthly Student Uptake Report Mar 2017 ***Email to MRB***	 CMO GM HR		
	Hawke's Bay Health Leadership Forum (date, timing and venue to be confirmed)			
Date/ Month 2017	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
10 May	Annual Māori Health Plan Q3 Jan-Mar 2017	GM MH		
Date/ Month 2017	**Performance Monitoring and for Information and Discussion**	**EMT Lead**	**Strategic / Decision Papers**	**EMT Lead**
14 Jun	Te Ara Whakawaiora: **Oral Health** (national indicator)	COO		

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

July . 2014

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date