



# Māori Relationship Board Meeting

**Date:** Wednesday, 13 July 2016

**Meeting:** 9.00am to 12.00pm

**Venue:** Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings

**Board Members:**

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

**Apologies:**

**In Attendance:**

Members of the Executive Management Team

Member of the Hawke's Bay District Health Board (HBDHB) Board

Member of Hawke's Bay (HB) Consumer Council

Member of HB Clinical Council

Member of Ngāti Kahungunu Iwi Inc.

Member of Health Hawke's Bay Public Health Organisation (HHB PHO)

Members of the Māori Health Service

Members of the Māori Providers

Members of the Public



## 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



## Maori Relationship Board 13 July 2016 - Agenda

## PUBLIC MEETING

Item	Section 1 : Routine	Time
1.	Karakia	9.00am
2.	Whakawhanaungatanga	
3.	Apologies	
4.	Interests Register	
5.	Minutes of Previous Meeting	
6.	Matters Arising - Review of Actions	
7.	MRB Workplan 2016	
8.	MRB Chair's Report	
9.	General Manager Māori Health Report	
	<b>Section 2: Presentation</b>	<b>9.10am</b>
10.	Increasing Māori Staff Representation (John McKeefry)	20-mins
	<b>Section 3: For Discussion</b>	<b>9.30am</b>
11.	Reducing Alcohol Related Harm (Rachel Eyre) • Position Statement example	20-mins
12.	Last Days of Life (Leigh White) • Care Plan • Toolkit	20-mins
13.	Wairoa Health Needs Assessment Report (Patrick LeGeyt and Justin Nguma)	15-mins
	<b>Section 4: General Business</b>	<b>10.25am</b>
14.	DHB Whānau Centric (G Mackey)	20-mins
	<b>Section 5: Workshop with Māori Providers</b>	<b>10.45am</b>
15.	Transform and Sustain Refresh Update (Tim Evans)	15-mins
16.	Health & Social Care Networks - Purpose and Principles (Belinda Sleight) Health & Social Care Networks - Geographic Localities Proposal Health & Social Care Networks - Business Case – Phase One	20-mins
17.	Weaving Communities Together (Jean Te Huia) Maternity Services (Example Proposal for Chatham Islands)	20-mins
	<b>Light Lunch</b>	<b>12.00pm</b>



## Māori Relationship Board Interest Register - 21 May 2016

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	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
		Patron and Lifetime Member				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 appropriate 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 appropriate 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	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	Kaumata - 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-Green	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
	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

# Maori Relationship Board 13 July 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	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 Tairāwhiti DHB Maori Relationship Board		No conflict	The Chair	19.03.14
	Active	Employee 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 Health Trust	Maori health post settlement equity group	Potential Conflict if contractual arrangements in place	The Chair	Dec 13
	Active	Chair Whakatu Kohanga Reo	Early Childhood	No conflict	The Chair	Dec 13
	Active	Chair Wānautahi 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 Committee	Maori Community Issues	No conflict	The Chair	Dec 13
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship	No conflict	The Chair	12.08.15
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	12.08.15
	Active	Member of Heart Foundation	Cardiac Strategic Advisory Group	No conflict	The Chair	12.08.15
	Active	Deputy Chair Health Promotion Forum	Relationship	No conflict	The Chair	12.08.15

**MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING  
HELD ON WEDNESDAY, 8 JUNE 2016 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 (teleconference)  
Denise Eaglesome  
Ana Apatu  
Tatiana Cowan-Greening (teleconference)  
Lynlee Aitcheson-Johnson  
Trish Giddens  
Diana Kirton  
Helen Francis  
Des Ratima  
George Mackey  
Na Raihania
- Apologies:** George Mackey  
Denise Eaglesome  
Ngahiwi Tomoana  
Helen Francis  
Des Ratima, arriving late  
Lynlee Aitcheson-Johnson, arriving late  
  
Graeme Norton (Chair Hawke's Bay Consumer Council HBDHB)  
Peter Dunkerley (HBDHB Board member), overseas  
Adele White (CEO Ngāti Kahungunu Iwi Inc), arriving late
- In Attendance:** Matiu Eru (Pouahurea Māori Health Service HBDHB)  
Tracee Te Huia (General Manager Māori Health Service HBDHB)  
Andrew Phillips (Director Allied Health HBDHB)  
Dr Tae Richardson (Hawke's Bay Clinical Council member)  
Caroline McElroy (Director Population Health/ Health Equity Champion HBDHB)  
Dr Robin Whyman (Clinical Director Oral Health HBDHB)  
Sharon Mason (Chief Operating Officer HBDHB)  
Carina Burgess (Acting Head of Planning HBDHB)  
Gavin Carey-Smith (Energy and Capital Projects Manager HBDHB)  
Jill Foley (Food Service Dietitian HBDHB)  
Penny Thompson (Suicide Postvention and Prevention Coordinator HBDHB)  
Johanna Wilson (Smokefree Health Promoter HBDHB)  
  
Patrick Le Geyt (Programme Manager Māori Health Service HBDHB)  
Chrissie Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Inc.)  
Adele White (CEO Ngāti Kahungunu Iwi Inc.)
- Minute Taker:** Lana Bartlett (MRB Administrator Māori Health Service HBDHB)

**SECTION 1: ROUTINE**

**1. KARAKIA**

Matiu Eru (Pouahurea Māori Health HBDHB) opened the meeting with a karakia and mihi.

**2. WHAKAWHANAUNGATANGA**

Heather Skipworth, Acting MRB Chair welcomed everyone to the meeting.

**3. APOLOGIES**

Apologies were received from G Mackey, D Eaglesome, H Francis and N Tomoana. Also, D Ratima and L Aitcheson will be arriving late.

In addition, Graeme Norton (Chair Hawke's Bay Consumer Council) and Peter Dunkerley (HBDHB Board member) apologies were received. An apology was received from Adele White (CEO NKII) who will be arriving late.

#### 4. INTERESTS REGISTER

There were no amendments to the Interest Register.

Two Conflict of Interests with Agenda Items were declared as follows:

- A Apatu declared a conflict with agenda item 12. Youth Health Strategy 2016-19 Final with her role as the Chair of Directions.
- H Skipworth declared a conflict with agenda items 10. Mobility Action Plan and item 11. Health Equity Update 2016: Tackling Health Inequities with her role as the Founder of Iron Māori.

#### 5. MINUTES OF THE APRIL MEETING

The minutes of the Special MRB Board meeting held on 13 April 2016, were confirmed as a correct record.

MRB agreed the issues raised at this meeting need further discussion and the actions need to be revisited.

**Moved:** N Raihania

**Seconded:** D Kirton

**CARRIED**

#### 6. MINUTES OF THE MAY MEETING

The minutes of the MRB Board meeting held on 12 May 2016, were confirmed as a correct record.

The minutes were presented well and N Raihania thanked the team on behalf of MRB.

**Moved:** A Apatu

**Seconded:** N Raihania

**CARRIED**

*Andrew Phillips (Director Allied Health HBDHB) and Dr Tae Richardson (Hawke's Bay Clinical Council member) joined the meeting at 9.15am.*

#### 7. MATTERS ARISING FROM THE PREVIOUS MINUTES – REVIEW OF ACTIONS

##### Minutes of the Meeting 13 April 2016

'Strengthening the Māori Health Services to provide more clinical and analytical advice to assist the system, both secondary and primary, on how it needs to better respond to customers and their whānau' was discussed briefly. This matter has been actioned through the Māori Health Service Proposal for Change.

##### **Whānau Centric Paper by G Mackey**

MRB agreed to move this paper for discussion to the July meeting.

#### REVIEW OF ACTIONS

The Action and Progress List as at May 2016 was taken as read. The following updates were provided:

##### **Date Issue Entered 12/05/16**

##### **1. MRB Youth Representative**

This will be considered as part of the next round of appointments made to MRB. Process is being discussed with NKII in July and will be finalised ready to implement by October.

##### **2. Bariatric Surgery**

Strategic Services is developing a paper headed up by Mary Wills who will submit this to MRB for Augusts meeting



**8. MRB WORKPLAN 2016**

The MRB Workplan was taken as read pending the amendment of the Equity Process to be added for August.

**ACTION: MRB Admin**

The Equity Process is being led by Dr Caroline McElnay (Director Population Health/ Health Equity Champion HBDHB). Patrick LeGeyt and Mary Wills are working with Caroline to ensure the Equity Lens has been applied to all papers before being presented to MRB. MRB will sign-off the paper regarding the process and how this will be embedded into the system.

It was noted the number of agenda items for the July meeting exceeded MRBs request for no-more than six agenda items per meeting. MRB agreed all items are of significance to MRB and decided Programme Incubator 3-Monthly Student Uptake July Report be changed to 'For Information Only' unless there are any red flags. Considering the number of agenda items, the Acting Chair emphasised members read their papers and provide feedback via email prior to the meeting to ensure time is utilised well. The following topics were discussed briefly:

**Workshop with Māori Providers**

MRB agreed Māori Providers set the agenda for their part of the meeting. Lana will call for agenda items for the agenda in preparation.

**Vulnerable Whānau and Indicators**

There was a request to add Vulnerable Whānau and Indicators to the MRB workplan to discuss what we can do to progress this Kaupapa and consider discussing further with Providers. Refer to General Business.

K Nuku reported issues receiving emails and MRB members also reported issues sending emails to Kerri. The correct email address is [KerriN@nzno.org.nz](mailto:KerriN@nzno.org.nz)

**9. MRB CHAIR'S REPORT**

The Chair's Report for June 2016 was taken as read. The following feedback regarding the Chair's Report was received:

**HR KPIs Quarter 3 Report – Increasing the Māori Workforce within Health**

- It was recommended a MHS staff member become a compulsory member of all hiring panels
- Integrated approach for initiatives is an excellent result.

**10. GENERAL MANAGER (GM) MĀORI HEALTH REPORT**

The GM Māori Health report for June 2016 was taken as read. There was a brief discussion regarding the following:

**Fluoridation**

For discussion in General Business.

**Engaging Effectively with Māori Training**

While there has been improvement, there is still a lot of work to be done and every EMT member is working extremely hard to identify staff that need to complete the training. The contract end date has been extended to August. Winter months are traditionally hard to get staff to training. This will be addressed as part of the priority for 100% staff attending the training.

**NUKA Training**

This training is scheduled for 23-24 November 2016. The training will be prioritised for primary care who requested it. Invites will be circulated shortly. MRB stated their interest in attending.

**SECTION 2: PRESENTATION****11. MOBILITY ACTION PLAN**

Due to a conflict of interest the Chair was unable to participate in the discussions about the Mobility Action Plan.

Andrew Phillips (Director Allied Health) and Dr Tae Richardson (Board Member Clinical Council) provided an excellent presentation demonstrating how inequities will be eliminated in this service. MRB was in strong support of the Mobility Action Plan and impressed by the following key points presented:

- The active partnership and involvement of local communities in the co-design of the new programme, Request for Proposal (RFP) and proposed model
- Improved access by not charging patients for the duration of intervention; a more streamlined referral pathway reducing the need for GP or secondary care intervention
- A service that is more culturally responsive and flexible around the needs of the customer and lifestyle by taking the services to the whānau whether it be at home, work or in the community or the option of a 'Drop-in Clinic'
- Accessibility to 'Core' Mobility Action Team (MAT) services that consists of three strands of healthcare; physiotherapy, the 'Stanford Programme', and the 'Māori Lifestyle Collective' comprising of community grassroot organisations; and non-Core MAT services (co-designed self management plan)
- Strengthening and empowering community capability and capacity by utilising local existing professionals
- Encouraging community leaders, primary care clinicians, and providers to work in partnership to empower existing programmes and remove barriers to targeted populations
- Outcome/Exit Measures that support Whānau Ora Outcomes

Dr Richardson emphasised the DHB has the opportunity to implement this programme and the learnings if successful across other communities. A copy of the tailored 'Stanford Programmes' was requested **ACTION**

MRB provided the following feedback:

- With 'eliminating' inequity being one of MRBs priority objectives it was encouraged to use the word 'eliminate' rather than reduce
- By using existing professionals within targeted communities this would have a positive impact on unemployment disparities within the targeted high deprivation areas
- Health Literacy being a key component for the whānau throughout the process to ensure whānau are fully informed about their diagnosis; treatment plans; medication and the side effects, and the discharge plan so they have the confidence and courage to question a health professional

MRB acknowledged Dr Phillips and Dr Richardson for their great work.

## 12. HEALTH EQUITY UPDATE 2016: TACKLING HEALTH INEQUITIES

MRB received the Health Equity Update 2016: Tackling Health Inequities. Dr Caroline McElnay (Director Population Health/ Health Equity Champion) emphasised that this presentation provides an update on the progress in key areas and outlines the ongoing challenges. Dr McElnay acknowledged the leaders of Iron Māori, Heather Skipworth and Lee Grace for their input to the update. But more importantly for providing an understanding about the Iron Māori philosophy and how Kaupapa Māori is contributing to addressing health inequity.

Dr McElnay identified that limitations have been a challenge due to incomplete data; a clear description of the core issues to be able to develop solutions and identifying what is missing. Only one of the 18 health indicators achieved equity with a further three indicators making good progress. We could be doing better in 9 of the health indicators and five remain unchanged or worse off.

There was considerable discussion about the NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14 slide. The slide demonstrated the life expectancy gap for Māori who lived in Canterbury that was higher in comparison to Māori who lived in Hawke's Bay. This highlighted for Māori that where you live has a significant impact on your life expectancy in comparison to non-Māori. Possible explanations for the causes of longer life expectancy were discussed at length:

- The genetic composition of modern Māori who nowadays have more European genes than Māori could contribute to a longer life expectancy
- Higher employment rates and opportunities in Canterbury than Hawke's Bay. Employment gives you better access e.g. education, medical treatment, lifestyle

- Better housing conditions and lifestyles
- Socio-economic differences in Hawke's Bay in comparison to Canterbury
- Majority of the Canterbury population live and work in the broader population. Quintile 5 in Canterbury are 'lifestylers'
- Iwi settlement alignment and claims
- The public health services change from being SMO led
- The colour of your skin if you are Māori from the South

MRB were extremely interested in the reasons for the longer life expectancy of Māori in the Canterbury region and requested that Dr McElnay conduct further research to provide an update on the findings **Action**

MRB provided the following advice on the Health Equity Update for Dr McElnay (Director Population Health/Health Equity Champion) to consider:

- Regarding the limitations, the 'description' of the issues could be identified through interfacing rather than relying solely on data
- The power of Māori for Māori services should never be underestimated and perhaps we should look at this concept more in-depth across the various activities in the health sector. When Māori deliver to Māori the outcomes are more successful such as Iron Māori and Patu
- Progress has been made in the areas of 'access'. Where we are not making good progress are areas with socio-economic issues. Therefore, we should be prioritising working with other agencies
- Employment is an enabler of better health and longevity. Employment builds self-confidence, therefore this should be a focus.
- Analyse the Canterbury region data to make a comparison of employment rates between Canterbury and Hawke's Bay by ethnicity
- Provide a breakdown of the context of the violent crime statistics including age groups
- Celebrate the successes.

The presentation is available on request. MRB requested a copy of the 'Equality versus Equity' slide **MRB Admin**

There was further discussion about employment being key to achieving equity and the following points were highlighted:

- As the largest employer of the Hawke's Bay region we just need to get on with it
- Māori make up 24% of the population in the Hawke's Bay region and around 46% of the hospital utilisation identifies as Māori (as per the 2015 data). Increasing Māori staff has to be a priority action
- The viewpoint that an applicant with the highest grades is the right person for the job needs to change. Life experience is of equal significance and value
- Do Hiring Managers clearly understand the purpose of the target to Increase Māori Staff and fully support the target to Increase Māori Staff
- What are the repercussions if the target is not achieved, no repercussion currently exists

John McKeefry (GM Human Resources) is developing a strategy to be presented to FRAC. It was requested the strategy be presented to MRB to provide feedback and advice before going to FRAC.

MRB strongly felt that employment is a priority action required to further reduce health inequity in Hawke's Bay and will request the HBDHB Boards approve of the following recommendations:

- a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period
- b) Present the strategy to Increase Māori Staff to MRB for feedback and advice before going to the Finance, Risk and Audit Committee (FRAC)
- c) Review the current HBDHB hiring protocols and processes
- d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now

- e) Broaden the scope of the target to all disciplines, not just medical, nursing and allied health
- f) Shift the responsibility of achieving the target to Hiring Managers set KPIs for them
- g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved
- h) Train Hiring Managers to efficiently and effectively use the Managers Toolkit
- i) Māori Health Service involved in the recruitment processes from the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels
- j) Ensure the equity process is completed and implemented.

**Moved:** N Raihania

**Seconded:** D Ratima

**CARRIED**

While progress has been slow and gains are not significant, we still need to celebrate the successes. The Chair thanked Dr McElnay for bringing these achievements to the attention of MRB.

### **SECTION 3: FOR ENDORSEMENT**

#### **13. YOUTH HEALTH STRATEGY 2016/19**

MRB noted the responses to the committee's previous feedback and endorsed the Youth Health Strategy 2016/19 to go to the Board for final endorsement.

**Moved:** N Raihania

**Seconded:** D Ratima

**CARRIED**

#### **14. HBDHB MĀORI HEALTH ANNUAL PLAN 2016/17**

MRB endorsed the Final Draft of the HBDHB Annual Māori Health Plan 2016/17 subject to any minor changes that may occur from the final feedback received from the Ministry of Health on 13 June 2016, in addition the amendments below:

##### ***Whānau Ora (WO)***

Add the five indicators and where they are located under the other targets.

##### ***Māori Workforce and Cultural Competence***

The target for 'Maintaining target focus and promote recruitment of Māori to all hiring managers' will be set today. If and when approved by the HBDHB.

##### ***Treaty Statement***

Strong consistent messages throughout the plan. Therefore, replace the word 'reduction' with 'removal'.

##### ***Obesity***

Bariatric Surgery added as an activity into the plan. The HBDHB are funded to provide seven surgeries. MRB requested the surgeries be tracked by ethnicity on their dashboard **ACTION**

**Moved:** D Ratima

**Seconded:** L Aitcheson

**CARRIED**

#### **14. TE ARA WHAKAWAIORA: ORAL HEALTH**

MRB noted the contents of the report and approved the Target Champions recommendations 1, 2 and 3.

MRB *did not* approve recommendation number 4 of the Te Ara Whakawaiora: Oral Health paper instead noted the recommendation and approved the following actions:

- a) Target Champion to present information about the benefits and side effects of Fluoridation to get a clearer understanding of Fluoridation

- b) HBDHB champion sugar free beverage events and challenge all other organisations to do the same.

**Moved:** N Raihania

**Second:** D Ratima

**CARRIED**

In addition, MRB provided the following advice for the Target Champion to consider:

- Include the safe consumption levels of sugar. Dr McElroy will also ensure the right information is included in the Best Start: Healthy Eating and Activity Plan
- Apply the same emphasis on sugar as we do on Fluoride.

It was noted that L Aitcheson-Johnson opposed the recommendation for HBDHB to implement community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place. I was agreed by MRB that more education was required before MRB could make a stand either for or against.

#### **SECTION 4: FOR DISCUSSION**

##### **15. FOOD SERVICES OPTIMISATION REVIEW**

MRB noted the contents of the report, supported the Food Service team in investigating and implementing the recommendations, and noted the capital applications that arise from the recommendations that will be put through the capital plan for approval.

**Moved:** T Giddens

**Seconded:** D Kirton

**CARRIED**

MRB provided the following feedback for Sharon Mason (COO HBDHB) and Deborah Chettleburgh (Nutrition and Food Manager) to consider:

- Visual information about sugar levels both good and bad displayed in Zac's Café
- Food Wastage – leftovers to be donated to the homeless

MRB support 'Sugar Free' and requested the food provided for the meetings contain no more than 3gms per serving per person.

##### **16. SUICIDE PREVENTION AND POSTVENTION PLAN REPORT**

MRB noted the contents of the report and supported the re-application of the New Investment Funding Bid for a Suicide Prevention Coordinator to the Hawke's Bay Clinical Council. As there was no quorum at this time of the meeting, the Chair stated that MRB had given verbal agreement of the proposal.

*D Kirton and A Apatu excused themselves from the meeting at 12.00pm and T Cowan-Greening and K Nuku also left the meeting.*

#### **SECTION 5: GENERAL BUSINESS**

The following items were discussed for General Business:

##### **1. MRB REPRESENTATIVE FOR CLINICAL COUNCIL**

The issue of payment is yet to be decided by the CEO HBDHB and Chair of the HBDHB Board. MRB received two Expressions of Interest to date. An email will be circulated to members requesting Expressions of Interest once the decision on payment is made.

##### **2. VULNERABLE WHĀNAU AND INDICATORS**

There was a discussion about categorising or defining 'vulnerable whānau' as follows:

- Plan what we are going to do in terms of strategic work around these whānau in the next year
- Ranges of criteria exist and are used by the DHB and also Tamariki Ora
- There are massive issues related to 'historical trauma' particularly for more vulnerable families. This is not being considered when developing programmes or services. The impact of the 'trauma' has an impact on the effectiveness of programmes or services and a reduction in longevity. More work is

needed to be done to respond to historical trauma. Possible solutions included clustering behavioural services and looking at the tools to assess trauma.

- The learnings from the four suicides was that their environments were similar. The cumulative trauma in their communities was the most telling factor about the vulnerability of our communities and we need to learn from this
- Develop a platform and clear pathway so that when decision-making we can understand what that pathway means for the vulnerable whānau.
- Consider discussing vulnerable whānau with Providers at the next workshop in November. Will need informed discussions leading up to the workshop and flag the Providers to feedback their ideas prior to the workshop.

Place Vulnerable Whānau on the MRB Workplan for August 2016 **ACTION: MRB Admin**

#### **SECTION 6: RECOMMENDATION TO EXCLUDE THE PUBLIC**

##### **17. Under Clause 32, New Zealand Public Health & Disability Act 2000**

Public were excluded from item 18 of the Public Excluded meeting at 12.10pm.

**Signed:**

\_\_\_\_\_  
Chair

**Date:**

\_\_\_\_\_  
**Date of next meeting: 9.00am Wednesday 13 July 2016**  
**Te Waiora (Boardroom), HBDHB Corporate Administration Building**

**MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING  
HELD ON WEDNESDAY, 8 JUNE 2016 IN TE WAIORA MEETING ROOM,  
DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS  
COMMENCING AT 12.10PM**

**PUBLIC EXCLUDED**

- Members:** Ngahiwi Tomoana (Chair)  
Heather Skipworth (Deputy Chair)  
Kerri Nuku (teleconference)  
Denise Eaglesome  
Ana Apatu  
Tatiana Cowan-Greening (teleconference)  
Lynlee Aitcheson  
Trish Giddens  
Diana Kirton  
Helen Francis  
Des Ratima  
George Mackey  
Na Raihania
- Apologies:** George Mackey  
Denise Eaglesome  
Ngahiwi Tomoana  
Helen Francis  
  
Graeme Norton (Chair Hawke's Bay Consumer Council HBDHB)  
Peter Dunkerley (HBDHB Board member), overseas
- In Attendance:** Tracee Te Huia (General Manager Māori Health Service HBDHB)  
Matiu Eru (Pouahurea Māori Health Service HBDHB)  
Patrick Le Geyt (Programme Manager Māori Health Service HBDHB)
- Minute Taker:** Lana Bartlett (MRB Administrator Māori Health Service HBDHB)

**SECTION 7: FOR DISCUSSION / DECISION**

**18. MINUTES OF THE PREVIOUS MEETING**

The minutes of the MRB Board meeting held on 12 May 2016 were confirmed subject to endorsement via email due to there not being enough members in attendance to form a quorum.

Matiu Eru (Pouahurea Māori Health HBDHB) closed the meeting with a karakia.

**Signed:** \_\_\_\_\_  
Chair

**Date:** \_\_\_\_\_

**Date of next meeting: 9.00am Wednesday 13 July 2016  
Te Waiora (Boardroom), HBDHB Corporate Administration Building**





## MĀORI RELATIONSHIP BOARD

### Matters Arising – Review of Actions

#### June MRB Meeting

6

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at July 2016
08/06/16	<b>1. Stanford Programme</b> MRB requested a copy of the Stanford Programme customised for Māori.	Dr Tae Richardson	Jul 2016	<b>COMPLETE</b> Stanford Programme emailed to MRB 10 June 2016.
	<b>2. Health Equity Update 2016</b> <i>NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14</i> MRB were interested in the reasons for the longer life expectancy of Māori in the Canterbury region and requested that Dr McElnay conduct further research to provide an update on the findings	DPH/ HE	Oct 2016	<b>POSTPONE OCT 2016</b> Dr McElnay will present to MRB in October 2016 as she is now on leave until then.
	<b>3. Add Bariatric Surgery to MRB Dashboard</b> Track bariatric surgery by ethnicity on the dashboard.	Programme Manager MHS and Planner	Nov 2016	<b>COMPLETE</b> Figures will be reported in Q4.
	<b>4. Fluoridation</b> Present information about the benefits and side effects of Fluoridation to get a clearer understanding of Fluoridation.	Clinical Director Oral Health	2017	<b>ON HOLD 2017</b> Until the legislative requirements for DHBs is made clear in 2017.

#### May MRB Meeting

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at July 2016
12/05/16	<b>1. MRB Youth Representative</b> MRB to consider having a youth representative.	MRB	Jul 2016	<b>IN PROGRESS</b> NKII is reviewing MRB in July with the composition included.
	<b>2. Bariatric Surgery Investigation</b> Request for an investigation of the evidence to rationalise the increase of surgeries per annum.	Head of Strategic Services	Oct 2016	<b>IN PROGRESS</b> Bariatric Surgery added to Annual Māori Health Plan 2016-17 as well as the overall Annual Plan.  A draft paper to be presented in October 2016.
	<b>3. Annual Māori Health Plan (AMHP)</b> - reduce the use of the term 'obesity'	Programme Manager MHS and Planner	Aug 2016	<b>COMPLETE</b> Use of the term 'obesity' has been reduced where possible in the plan. There are restrictions within the Ministry of Health guidelines.
	<b>4. Profile for MRB Representative on Clinical Council</b> Request a profile from Clinical Council Chairs. Once Profile complete, MRB Administrator to email MRB members requesting 'Expressions of Interest' (EOI).	Clinical Council co-Chairs	Jun 2016	<b>COMPLETE</b> Call for EOIs emailed to MRB 30/06/16 and close 3.00pm 8 July 2016.  Confirmation that this is an unpaid role was confirmed by the CEO in July

#### April MRB Special Meeting


Date Issue Entered	Action to be Taken	By Whom	By When	Status as at July 2016
13/04/16	<b>1. Communication</b> Share stories and promote successes.	Communications Manager/ NKII Communications	Aug 2016	<b>IN PROGRESS</b>
	<b>2. Review form and function of MRB</b> MRB to be involved in the discussions.	GM Māori Health/ CEO NKII	Aug 2016	<b>IN PROGRESS</b> NKII and DHB are reviewing MRB in July.
	<b>3. Māori leadership and capability development</b>	GM Māori Health/ CEO NKII	Aug 2016	<b>COMPLETE</b> Māori Leadership Training now being managed by Te Hono (NKII)
	<b>4. Change the system to accelerate Māori Health</b> a) Tell the stories – good and bad, to add value to the customer voice b) Shift contracts to be more of a whānau focus with less constraints c) HEAT tool for all strategic papers to all governance groups d) Reduce financial cost barriers to primary care for whānau. A paper on Primary Care developments.	Head of Strategic Services/ Head Health Services HBPHO	Aug 2016	<b>IN PROGRESS</b> a) Underway  b) High Trust Contracts being implemented. Learnings are being had. c) Being completed by Mary Wills and Patrick LeGeyt d) Agenda item for July's meeting.
	<b>5. Change the prevalence of unconscious systemic bias that does a dis-service to all.</b> Tease the pilot funding model out further to get more detail of how this could be rolled-out before testing the pilot on a strategy	G Mackey/ D Ratima/ Head Health Services HBPHO/ Chair HB Clinical Council	Aug 2016	<b>COMPLETE</b> Agenda item for July's meeting.



# MĀORI RELATIONSHIP BOARD WORKPLAN 2016

Meetings 2016	Papers and Topics	Lead(s)
13 Jul	Reducing Alcohol Related Harm DISCUSSION Last Days of Life Health and Social Care Networks Update and Geographical Localities Proposal Wairoa Health Needs Assessment Report Increasing Māori Staff Representation Presentation  <b>Monitoring – for information - no presenters:</b> Programme Incubator 3-Monthly Student Uptake July Report  WORKSHOP with Māori Providers	Rachel Eyre Leigh White Liz Stockley  Patrick LeGeyt John McKeefry
13 Jul	<i>First Public Notice of Election</i>	
15 Jul	<i>Nominations Open / Roll Open for Inspection</i>	
10 Aug	Quality Accounts DRAFT Travel Plan Quarterly Update VERBAL PRESENTATION HB Integrated Palliative Care DRAFT DISCUSSION Equity Process (Caroline on leave until October) Free Primary Care for 13 – 18 year olds Vulnerable Whānau and Indicators  <b>Monitoring – for information - no presenters:</b> Annual Māori Health Plan Q4 Apr-Jun 2016 Te Ara Whakawaiora: <b>Culturally Competent Workforce</b> (local indicator) <b>Presented to FRAC 27 July</b> Te Ara Whakawaiora: <b>Mental Health and Alcohol and Other Drugs (AoD)</b>  <i>Nominations Close / Electoral Roll Closes</i>	Kate Coley Sharon Mason Mary Wills  Patrick LeGeyt
12 Aug	<i>Public Notice of Candidates</i>	
19 Aug		

Meetings 2016	Papers and Topics	Lead(s)
8 Sept	<ul style="list-style-type: none"> <li>HB Health Sector Leadership Forum – venue to be confirmed</li> </ul>	
14 Sept	Orthopaedic Review - Closure of Phase 1 Orthopedic Review Phase 2 DRAFT Family Violence Strategy Effectiveness FOR NOTING Reducing Alcohol Related Harm DRAFT Developing a Person Whānau Centered Culture DRAFT Quality Accounts FINAL Health and Social Care Networks Update  <b>Monitoring – for information - no presenters:</b> Te Ara Whakawaiaora: <b>Obesity</b> (local indicator)	Andrew Phillips Andrew Phillips Nicky Skerman Rachel Eyre Kate Coley Kate Coley Liz Stockley
16 Sept	<i>Delivery of Voting Documents</i>	
8 Oct	<i>Election Day – voting closes at Noon</i>	
12 Oct	Reducing Alcohol Related Harm FINAL Programme Incubator 3-Monthly Student Uptake Oct Report	Caroline McElnay John McKeefry
13 Oct	<i>Official Result Declaration</i>	
9 Nov	Tobacco - Annual Update FOR NOTING Travel Plan Quarterly Update VERBAL PRESENTATION Developing a Person Whānau Centered Culture FINAL  <b>Monitoring – for information - no presenters:</b> Annual Māori Health Plan Q1 Jul-Sept 2016 Te Ara Whakawaiaora: <b>Smoking</b> (national indicator)  <b>WORKSHOP</b> with Māori Providers	Caroline McElnay Sharon Mason Kate Coley
5 Dec	<i>New Board comes into office.</i>	
DEC	<b>No Meeting in December</b> The following papers will be emailed to MRB:  HBDHB Workforce Plan – DISCUSSION DOCUMENT Health and Social Care Networks Update	John McKeefry Liz Stockley

	<b>Māori Relationship Board Chair's Report</b>
	For the attention of: <b>Māori Relationship Board (MRB)</b>
Document Owner:	Heather Skipworth, Deputy Chair
Month:	July 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 meeting held in June 2016 pertaining to Māori health.

### INTRODUCTION

For this month, I provide a very short overview on the CEO's report regarding our performance over the past month, and the Regional Economic Development Strategy that the DHB supported the development for. I comment briefly about the Elections and how 'not' to swing votes.

This month's report provides an update of the Board's response to MRBs recommendations about the Health Equity Update 2016 and Te Ara Whakawaiora: Oral Health papers, and a response to our advice for the donation of leftovers to the homeless.

I provide updates on progression of the Youth Health Strategy 2016-19 and Suicide Prevention and Postvention Plan. I also give a brief spiel about the Pasifika Dashboard 'Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018, plus the HB Clinical Council who are now replaying MRBs feedback about strategies needing to be connected and report writers needing to avoid the use of negative wording, terminology and connotations.

### Chief Executive Officers (CEO) Report - Performance Indicators`

The CEO provided the following performance updates for the month of June:

- Immunisation continued above target
- Elective activity continues ahead of plan and there continues to be a reduction in the Number of Patients Waiting Longer Than Four Months
- Faster Cancer Treatment performance significantly improved for the month. But there was a small deterioration in our six month rolling average
- Smoking Cessation in Primary Care showed marginal improvement. The most recent preliminary data for Smoking Cessation we have is 78.8 percent with a projection of 83 percent for end of year which remains significantly below expectations. The CEO requested further effort to improve our performance before year end
- Heart and Diabetes Checks demonstrated a determination for quarter three
- Shorter Stays in the Emergency Department (ED) continued to depreciate.

Kevin Snee (CEO) is confident we will see progress in our performance in the near future because of the improvements recently put in place. The financial result for May is favourable making the year-to-date result \$110 thousand favourable.

### ***Regional Economic Development Strategy (REDS)***

As a member of the REDs Group, the DHB has been key in the development of the REDS plan. Not only are we the largest employer in the region but the health sector drives around 10 percent of local Gross Domestic Product (GDP), which is a good contribution. Through Dr Kevin Snee the plan was halted while better engagement was had with Māori. This enabled stronger relationships between business and Māori Economic Development. The strategy will be formally launched next month.

### **2016 Elections and Briefing from Electoral Officer**

The HBDHB Electoral Officer, Warwick Lamp attended the Board meeting and provided a verbal briefing on relevant issues associated with this year's DHB Elections. I found this presentation very informative particularly around ensuring members do not use their status to influence votes. For example, having photographs with staff or using social media like Facebook to drive your campaign for the elections.

### **MRB Chairs Report to Board for June**

This month's report was well received by the Board. I would like to highlight that since been elected as a member of the Governance Board, MRBs advice and recommendations submitted to the Board have never been declined except the recommendation in Junes meeting for fluoridation which the Board approved however was not endorsed by MRB due to more education required.

### ***Health Equity Update 2016: Tackling Health Inequities***

The DHB Board noted all nine of MRBs recommendations regarding priority actions required to further reduce health inequity in Hawke's Bay, and requested the CEO HBDHB to further investigate and report back on these.

Approve the following as priority actions required to further reduce health inequity in Hawke's Bay:
a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period
b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).
c) Review the current HBDHB hiring protocols and processes
d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now
e) Broaden the scope of the target to all disciplines, not just medical, nursing and allied health
f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring
g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved
h) Train Hiring Managers to efficiently and effectively use the Managers Toolkit
i) Māori Health Service involved in the recruitment processes from the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels

The DHB Board provided the following additional feedback:

- MRBs new target of 'Increasing Māori Staff' to 25% over a five year period, may take longer than five years

- John McKeefry (GM Human Resources) to provide a response to MRB about the concerns raised and present a strategy of how the issues will be addressed. Furthermore, the Board supported the strategy be presented to MRB for feedback before going to the Finance, Risk and Audit Committee (FRAC) in July.

The Board asked Dr Caroline McElnay (Director Population Health/ Health Equity Champion) to provide a report on solutions to reduce inequity. Caroline will be providing a progress report in six or seven months' time and is willing to partner with the community on strategic matters to establish solutions.

### ***Te Ara Whakawaiaora: Oral Health***

I updated the DHB Board about the discussions regarding fluoridation and the new literature now available that was brought to our attention by MRB member Lynlee Aitcheson-Johnson, who should be given the opportunity to present these findings. The Board approved MRBs recommendation for the Target Champion to present information about the benefits and side effects of Fluoridation to get a clearer understanding. Additionally, the Board adopted the Te Ara Whakawaiaora Champion's recommendation dependent on legislation.

Lastly, the Board were pleased with MRBs recommendation for the HBDHB to champion sugar free beverage events and challenge all other organisations to do the same.

### **Food Services Optimisation**

MRBs advice to donate the leftovers to the homeless was discussed briefly. Further investigation about food regulations is required. An update will be provided once the information has been gathered.

### **Youth Health Strategy 2016-19**

The Board approved the strategy. However, there was a lot of discussion resulting in the Board agreeing that gangs and solo parents be added to the strategy. Nicky Skerman (Population Health Strategist, Women Children and Youth) was encouraged to engage with the gangs and solo parents.

### **Suicide Prevention and Postvention Plan**

The Board was happy with the HB Clinical Council decision to approve the funding bid for a Suicide Prevention Coordinator. Tim Evans (General Manager Planning, Informatics and Finance) and Dr Caroline McElnay (Director Population Health/ Health Equity Champion) are relooking at the budget for further funding for when the contract runs out because of the value of this position. MRB was supportive of this position so it was good to see the funding decision reversed and funding approved.

### **HB Clinical Council Report**


It was good to see the HB Clinical Council echoing what MRB have been saying for some time about the disconnectedness between strategies and seeing papers written in a more positive manner by removing negative wording, terminology or connotations from strategies and plans.

### **Pasifika Data and Reporting**

'Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018 is the Government's national plan for improving health outcomes for Pacific peoples in New Zealand. The dashboard has been adopted by the Pasifika Health Leadership Group as the foundation upon which we will measure and review improvements in Pacific health moving forward. This dashboard will be reported to the Board six monthly.





	<b>General Manager Māori Health Report</b>
	For the attention of: <b>Māori Relationship Board (MRB)</b>
Document Owner:	Tracee Te Huia, General Manager (GM) Māori Health
Month:	July 2016
Consideration:	For Information

### Recommendation

**That MRB** note the content of this report.

## PURPOSE

The purpose of this report is to update the MRB on implementation progress of the Māori Annual Plan objectives for June 2016.

## INTRODUCTION

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

- Relocation of Māori Health Operations Team
- Mandatory Cultural Training Figures to 30 June 2016
- 2016 Enrolments for Programme Incubator, and Earn and Learn
- Ministry Of Social Development (MSD) and Rest Home Initiative
- Tūruki Māori Workforce Development (MWFD) Steering Group
- Under 18 Primary Care Co-Payment Subsidy Project
- Māori Child Oral Health Access Improvement Project
- Healthy Weight (Child Obesity) Māori Whānau Lifestyle Programme
- School Nursing - Service Specifications Review

### Relocation of Māori Health Operations Team

The month of May saw preparations commence for the restructure and subsequent relocation of the Operations Team for Māori Health from the main Māori Health Service to the Tutorial Building. This space is conducive to housing the perceived increase in the team size which the current space could not accommodate.

Anxiety amongst the team has now been replaced with excitement as the Operations team now understands the new model of practice, and see the possible impact that their efforts will have for whānau as they will now have input into not only the development of the Discharge/Wellness Plan for whānau, but also the implementation of these plans, as well as reconnecting the whānau to services within the community across health, social services, education and employment sectors.

The vacated space in Māori Health will be the new base for the Māori Workforce Team, the new Nurse Director Māori, the new Cultural Competency Advisor and the Tūruki Māori Workforce Development Senior Coordinator.

### Mandatory Cultural Training

Below are the Mandatory Cultural Training figures to 30 June 2016:

#### DHB:

	Total Employees	Engaging effectively with Maori 3 yearly	Treaty of Waitangi Once
<b>Frequency</b>			
CEO Office	4	100.0%	25.0%
Chief Nursing Officer	13	92.3%	53.8%
CMO Hospital	1	100.0%	0.0%
Company Secretary	9	66.7%	33.3%
Health Services	2638	63.4%	43.5%
Human Resources	30	66.7%	70.0%
Maori Health	22	100.0%	100.0%
Planning Informatics & Finance	148	82.4%	79.7%
Population Health	53	96.2%	62.3%
Primary Care	1	0.0%	0.0%
Quality Improvement & Patient Safety	17	82.4%	82.4%
<b>DHB Total</b>	<b>2936</b>	<b>65.6%</b>	<b>46.5%</b>

#### Health Services:

	Total Employees	Engaging effectively with Maori 3 yearly	Treaty of Waitangi Once
<b>Frequency</b>			
Acute & Medical Services	826	53.9%	39.5%
COO Office	4	50.0%	50.0%
Director of Allied Health	1	100.0%	0.0%
Facilities & Operational Support	341	63.0%	42.2%
Health Service	1	100.0%	0.0%
Laboratory	77	37.7%	20.8%
Older Persons & Mental Health	403	72.5%	49.4%
Oral Rural & Community	304	78.3%	69.1%
Surgical	429	60.1%	32.9%
Women Children & Youth	252	76.2%	43.3%
<b>Health Services Total</b>	<b>2638</b>	<b>63.4%</b>	<b>43.5%</b>

### 2016 Programme Incubator, Earn and Learn Enrolments

The following tables are the enrolments for Programme Incubator and Earn and Learn Programme for 2016. This report is an annual report as the Programme Incubator and Earn and Learn programmes have annual enrolments only.

#### Programme Incubator

School	Students registered	Māori Students registered	% Māori registered
CHB College	18	4	22%
Flaxmere College	4	4	100%
Hastings Boys High School	7	2	29%
Hastings Girls High School	25	14	56%
Havelock North High School	25	2	8%
Hukarere Girls College	5	5	100%

Iona College	23	2	9%
Karamu High School	42	13	31%
Lindisfarne College	11	2	18%
Napier Boys High School	17	2	12%
Napier Girls High School	29	5	17%
Sacred Heart College	21	4	19%
St Johns College	13	1	8%
Taikura Rudolf Steiner School	28	2	7%
Tamatea High School	5	3	60%
Taradale High School	25	4	16%
TKKM Te Ara Hou	9	9	100%
Wairoa College	14	11	79%
William Colenso College	17	7	41%
Woodford House	14	4	29%
<b>TOTAL TO DATE</b>	<b>352</b>	<b>98</b>	<b>28%</b>

### **Earn and Learn Programme**

<b>School</b>	<b>Students registered</b>	<b>Māori Students registered</b>	<b>% Māori registered</b>
Hastings Girls High School	8	4	50%
Napier Girls High School	10	6	60%
Tamatea High School	1	1	100%
Taradale High School	2	1	50%
Te Kura – NZ Correspondence School	4	1	25%
William Colenso College	12	7	58%
<b>TOTAL TO DATE</b>	<b>37</b>	<b>20</b>	<b>54%</b>

### **Ministry of Social Development (MSD) and Rest Home Initiative**

Tūruki, MSD and Totara Health collaborated to assist people working under a flexi-wage agreement to complete part-time hours as Practice Care Associates or Administrators. After six months Totara Health employed the staff on a permanent basis. Tūruki coordinated the programme and provided pastoral care with a view to integrating them into the Tūruki programme with further study.

As a continuation from the initiative between Totara Health and Tūruki, rest homes have shown an interest in participating in a similar project. The initiative involves students working under a flexi-wage agreement where they complete part-time hours as Healthcare Associates. After six months, the rest homes will employ the staff on a permanent basis. Tūruki are involved in a coordination role and will also provide pastoral care for the staff with a view to integrating them into the Tūruki programme with further study. Eastern Institute of Technology (EIT) will be involved in this particular project with a view to enrolling students working within the rest home sector on the Healthcare Assistant Certificate which is funding by Health Workforce New Zealand (HWFNZ).

### **Tūruki MWFD Steering Group**

The Tūruki MWFD Steering Group has been important in guiding the development and implementation of the programme since its inception in 2008. Workstreams within the programme have become business as usual and integrated within Mai – Māori Health Strategy and the Māori Health Annual Plan. The steering group has therefore ceased and the coordinator of the programme will continue engaging with key stakeholders on a six monthly basis to ensure industry and educational goals, and aspirations are maintained. The Tūruki Annual Plan for 2016-2017 will be circulated for comment with stakeholders before implementation in July.

### **Under 18 Primary Care Co-Payment Subsidy Project**

The project manager, Health Hawke's Bay (HHB) PHO Head of Services and DHB Portfolio Manager Primary Care completed the engagement with general practice and rangatahi focus groups. The following groups were consulted with:

- The Doctors Hastings and Napier

- Hastings Health Centre
- Totara Health
- Hauora Heretaunga
- Tamatea Medical Centre
- Taradale Medical Centre
- Te Mata Peak Practice
- Queen Street Medical Wairoa
- Directions Youth Health Services
- HHB PHO Priority Population Committee
- Rangatahi in Flaxmere and Wairoa

Feedback has been positive with preference for a targeted approach to Māori, Pacific and high needs youth. However, a focus on clinical indicators is not favoured with a preferred approach being increased utilisation and engagement with youth. A revised paper is to be completed by the project manager detailing the feedback from the engagement process and the preferred implementation option. A paper will be developed for Hawke's Bay Clinical Council's consideration for the August meeting.

#### **Māori Child Oral Health Access Improvement Project**

The appropriate DNA information has been received from Information Services. This has enabled the determination of the actual NHI patient numbers related to DNAs.

A process is being developed for referrals to Well Child Tamariki Ora (WCTO) Providers to facilitate access to whānau centred dental treatment appointments for Tamariki by 12-months of age and follow-up DNAs to ensure treatment appointments by 15-months of age. Furthermore, additional visits have been scheduled for WCTO Providers to facilitate access to whānau centred dental treatment appointments for Tamariki by 30-months of age and 42-months of age. These are over and above their scheduled dental appointments at 24-months and 26-months of age.

#### **Healthy Weight (Child Obesity) Māori Whānau Lifestyle Programme**

The Healthy Lifestyle Collective 'Mananui' has initiated the development of a Healthy Weight Māori Whānau Lifestyle Programme. All organisations engaged have agreed to fund a consultant to work with the collective pending the funding being released from Hawke's Bay DHB Māori Health Portfolio.

The collective has been meeting weekly and are making steady progress towards an Active Whānau Programme designed to support healthy weight amongst tamariki Māori. It is expected that the programme will be developed by mid-July 2016 ready for implementation.

#### **School Nursing - Service Specifications Review**

The MOH Child and Family Programmes, Sector Capability and Performance, who are responsible for the development of national service specifications development have provided very favourable responses to HBHDB reviewed service specifications for School Nursing Services. Specifically they have commented that:

"It also reflects the direction of travel of the Ministry and the child and youth sectors (outcomes based accountability, equity, culturally responsive care, integrated services). The current national service specification is primarily focused on inputs and the particular services that need to be provided. Hawke's Bay seems to be looking to use Results Based Accountability to develop a service specification that provides flexibility for providers around the specific services required, but requires providers to achieve a set of outcomes. I also like that it's got a strong focus on equity, cultural

responsiveness and integration between school health services, wider primary care and other health and social services.”

**GENERAL MANAGER MĀORI HEALTH**

Tracee Te Huia






## **MĀORI RELATIONSHIP BOARD**

PRESENTATION  
Increasing Māori Staff Representation  
by John McKeefry, General Manager Human Resource





 <p><b>HAWKE'S BAY</b> District Health Board Whakawāteatia</p>	<b>Discussion paper on Reducing Alcohol-Related Harm</b>
	For the attention of: <b>HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board</b>
Document Owner:	Dr Caroline McElnay, Director Population Health
Document Author(s):	Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Discussion and Endorsement

#### RECOMMENDATION

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

1. **Note** the contents of this report.
2. **Feedback** on the questions.
3. **Endorse** the proposed approach of developing a HBDHB Position Statement.

#### OVERVIEW

The purpose of this paper is to facilitate discussion amongst HBDHB committees on alcohol-related harm. Alcohol-related harm is a critical issue for our DHB, creating a significant burden of harm to individuals, to communities and to our health system.

Following a first round of discussions among the committees, it is proposed that a Position Statement on alcohol-related harms be drafted for the second round. The Position Statement would outline the DHB's priorities to reduce alcohol-related health harms in the next three to five (3-5) years (this timeframe being consistent with the National Drug Policy). This would be the DHB's opportunity to develop a common agenda on alcohol harms and to outline actions to address them. A final Position Statement would be put forward to be endorsed by the HBDHB Board.

An example of a Position Statement from the combined Wellington region of three district health boards is attached.

A short film has been produced and will be presented to the committees with this discussion paper.

## BACKGROUND

### ***Why we need to take alcohol-related harm seriously***

- There are a high number of hazardous drinkers<sup>1</sup> in New Zealand and Hawke's Bay is no exception
- Every year around 1000 New Zealanders die from alcohol-related causes
- Alcohol-related harm in New Zealand is estimated to cost an overall \$6.5 billion per year
- Alcohol is a toxin, an intoxicant, a carcinogen and an addictive psychotropic drug
- Hazardous drinking patterns can create both acute and chronic health problems
- Alcohol not only affects the individual but also those around them. It has detrimental effects e.g. lifelong brain damage to young people and to the foetus when a woman drinks whilst being pregnant
- Lack of systematically collected data on 'alcohol-related harm' including 'harm to others' limits our ability to estimate the true cost to communities and prevents adequate resources and effective strategies being assigned

### ***What alcohol-related harm looks like in Hawke's Bay (based on current health data<sup>2</sup>)***

Alcohol related harm in our DHB region is demonstrated by:

- Rates of hazardous drinking in Hawke's Bay are higher than the national average (by 60%)
- Increasing rates of hazardous drinking over time (by almost 10% from 2006/07 to 2011/14)
- Highest rates of hazardous drinking among young people (41% in the 15-24 year age group)
- Higher rates of hazardous drinking and increased hospitalisations among Māori
- Increased hospitalisation rates for alcohol-related conditions among women
- Slight increase in women exceeding the alcohol and other substance legal limits while driving
- Hawke's Bay has slightly higher rates than New Zealand for alcohol related crashes resulting in non-fatal injuries but the percentage of alcohol-related crashes resulting in fatal injuries have dropped below national average

In 2015, a Hawke's Bay community survey<sup>3</sup> showed wide-spread recognition of alcohol harm and some pointers for change in the alcohol environment, as follows:

- Two-thirds feel the drinking of alcohol has a negative impact in their community
- Nearly 90% of people agree that alcohol affects family violence in the community and over 80% agree it affects community safety
- The majority of respondents want fewer bottle stores. Bottle stores and supermarkets selling alcohol are the most commonly identified as having the greatest impact on alcohol harm in communities
- Almost 80% want more alcohol-free entertainment options

### ***What works to reduce alcohol related harm (based on the evidence) and what opportunities do we have:***

Policy:

- The strongest measures to reduce alcohol-related harm are at the policy level and involve increasing price, reducing availability and reduced advertising. The Sale and Supply of Alcohol Act (2012) requires Medical Officer of Health input and enables more community say to reduce alcohol availability at a local level e.g. via the Local Alcohol Policy (LAP) process and licensing decisions.

---

<sup>1</sup> Hazardous drinkers are defined as adults who obtained an Alcohol Use Disorders Identification Test (a validated tool) score of 8 or more representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

<sup>2</sup> Includes latest NZ Health Survey (Ministry of Health) results, HBDHB hospitalisation data and Massey data (Environmental Health Indicators NZ programme).

<sup>3</sup> This 2015 HBDHB led survey involved 1000 adult respondents from across Hawke's Bay.

#### Community:

- The next most effective and cost-effective measures at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, pregnant women, and Pasifika, encourage moderation in older adults and seek to reduce availability (limiting both demand and supply)
- Interventions need to be whānau and community focussed and not just focussed on individual choice
- A focus on settings where target groups are found allows for integrated approaches
- Community-level interventions need to be community-led but communities often lack resources to do this and to focus on alcohol harm
- It is critical to find ways to delay drinking as long as possible, especially under 18s, to prevent alcohol's harmful effects on growing brains (up to the age of 25 years old)
- The message that there is no safe amount of alcohol which can be drunk in pregnancy needs to be widely understood - including by health professionals
- Reducing the exposure of young people to alcohol promotion, marketing and sponsored events particularly associated with sport is important

#### Screening:

- Screening and brief intervention approaches in hospital (ED), primary care, with pregnant or reproductive age women, and in settings with a wider community reach is a proven cost-effective strategy
- A screening/data collection initiative in ED may be able to gain support from other funders, (such as from the Health Promotion Agency and ACC), to inform a business case for the DHB to undertake the next phase (brief intervention and referral)
- There is scope for improving screening and brief intervention in primary care and wider settings, to include midwives (currently being looked at under Foetal Alcohol Spectrum Disorder), and others (Police, aged care sector, etc.). Achieving the buy-in from primary care around the importance of screening and brief intervention is key

#### Collaboration:

- There are a range of opportunities to build on and strengthen existing initiatives in the community, for example as led by Safer Communities Networks
- The DHB is a signatory to the Joint Alcohol Strategy (by Napier City Council and Hastings District Council) and is involved in the review
- There is an opportunity to support partnerships with local Iwi to better meet Māori needs. Māori often take more notice of whānau and friends' messages and support than health professionals
- A range of frameworks and plans can help guide our actions. Our DHB's Position Statement can be used as our platform to promote our common agenda with other groups

#### ***How can our DHB improve what it does – future actions?***

Suggested areas for future investment include:

- Enable screening (initially) and brief intervention in ED (with possible external funding)
- Improve uptake of brief intervention in primary care, encouraging greater buy-in by primary care health professionals (e.g. use of incentives)
- Investigate brief intervention training opportunities in wider community settings, including midwives
- Develop a process for communication/community engagement to facilitate conversation on alcohol health impacts and to inspire and support community action
- Enhance support for Safer Communities projects, ensuring those projects which reduce inequity are prioritised and adequately resourced (which target for example, delayed drinking/reducing social supply for Māori youth)
- Develop more Iwi partnership approaches to reducing alcohol-related harm
- Provide health leadership by being alcohol-free at health sector events such as award ceremonies and other health events
- Collaborate with other agencies, particularly councils, during development of LAPs. The DHB is working alongside Napier City and Hastings District Councils to implement their Joint Alcohol Strategy - an opportunity exists to become a signatory to the revised strategy

- Establish usefulness of a review of current Mental Health and Addiction Services and whether they are accessible, appropriate and sufficient to meet the needs of target groups
- Align alcohol strategies with other work in the area of social needs, as alcohol harm is often connected with poverty and stress e.g. vulnerable children and CYF review
- Establish a dedicated Alcohol Harm Minimisation Coordinator role to: help identify champions to promote key messages and counter resistance; develop a supportive structure including a high level steering group; write and co-ordinate a three to five (3-5) year plan with an associated monitoring framework to report back to Board level.

(Please note that the data, evidence for what works and rationale for improvement suggestions are detailed in a background report (currently in draft) available on request from the author).

## **QUESTIONS FOR THE COMMITTEES**

Your feedback is sought on the following questions to help guide the next steps.

1. Is there an appetite to tackle this issue of alcohol related harms?
2. What are your ideas about how we go about this e.g. the process for getting buy-in and commitment to actions from across our DHB, how we engage intersectorally and how we work with communities to bring about the necessary social change?

## **ATTACHMENT**

Position statement on reducing alcohol related harm from Wairarapa DHB, Hutt Valley DHB, Capital and Coast DHB, Regional Public Health (2012-13) provided as an example.



## Position statement on reducing alcohol related harm

The District Health Boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to reducing the alcohol-related harm. Our efforts to do so will be based on the best available evidence and we will undertake the following actions within our available resources.

1. We support the adoption of the most effective population-based strategies to reduce harmful use of alcohol, as identified by the World Health Organisation, including; reducing the availability of alcohol, increasing the purchase age, reducing the legal blood alcohol concentration for driving, increasing the price, and reducing alcohol advertising and marketing.
2. We support government policy to:
  - i) Reduce excessive drinking by adults and young people;
  - ii) Reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes;
  - iii) Support the safe and responsible sale, supply and consumption of alcohol;
  - iv) Improve community input into local alcohol licensing decisions;
  - v) Improve the operation of the alcohol licensing system.
3. We will actively work towards reducing alcohol and other drug-related harm inequalities in identified high-risk populations.
4. We will promote harm reduction strategies for alcohol and other drugs through the provision of information to health care professionals and the public.
5. We will work to increase access to treatment options for alcohol and other drugs across the region, particularly for high-risk populations.
6. We will work to increase opportunities for screening and brief interventions in appropriate health settings such as emergency departments and primary care.
7. We will actively work to increase our capacity to monitor the impact of alcohol and drug-related harm on health services.
8. We will link with Primary Health Organisations, Non-Government Organisations, Justice and Education sectors and other parts of the Health sector and communities to ensure that we have a full understanding of the alcohol and other drug issues as experienced by our population and can then determine the best interventions to address any emergent issues.
9. We will support our public health and clinical staff in their work to; plan for, promote, support and deliver alcohol and other drug harm reduction and treatment strategies appropriate for our regions' communities.
10. We will engage with local government and communities to identify alcohol issues and support the implementation of local solutions.
11. We will actively work to increase our capacity to assess the impact of our interventions.

11.1

## Background and rationale

### The impact of harmful use of alcohol on health and health services

Hospital services face daily the outcomes of harmful consumption of alcohol across the lifespan. Emergency departments, trauma wards, operating theatres and intensive care units bear the brunt of providing care for injury, violence and acute conditions. Other services carry the burden of care for patients with mental illness or chronic disease and cancer brought about by harmful alcohol consumption over the longer term. Others deal with the developmental problems arising from alcohol use in pregnancy such as foetal alcohol spectrum disorders.

New Zealanders' pattern of drinking is of concern. We live in a society that supports harmful drinking and where consuming alcohol is seen as a normal accompaniment to our everyday activities. While there are many people who drink at low risk levels or do not drink alcohol at all, drinking at harmful levels and getting drunk is accepted. Such behaviour is frequently celebrated and glamorised. Our young people drink the way they do because they see this behaviour as "the norm". What they see and hear from adults and the community promotes this message.

It is vital then, that more people adopt the recommended guidelines for low risk drinking (see appendix 1). Following these guidelines can be difficult due to alcohol consumption being used and accepted as a means of dealing with stress, Further the social pressure to drink, the vast range of alcohol products, the way it is promoted, its availability during most hours of the day and days of the week, and the number of settings for drinking and purchase make it easy to drink large amounts.

The increasing scientific evidence regarding the health outcomes influenced by alcohol indicates the importance of tackling societal attitudes and behaviours towards alcohol. In particular historical liberalisation of policy has been accompanied by increases in the quantity of alcohol consumed<sup>1</sup>.

- In 2007 in New Zealand alcohol is estimated to have been responsible for 802 deaths (5.4% of all deaths) and 13,769 years of life lost (YLLs) under 80 years of age. Much of the harm (43%) was due to injury (unintentional, violence and self-harm), but alcohol also contributed to a range of chronic non-communicable diseases, including cancers, liver disease and cardiovascular diseases<sup>2</sup>.
- Alcohol related admissions to hospital transition from injury as the primary cause to increasing presentations of chronic conditions such as cancer, cardiovascular disease and digestive disorders<sup>3</sup> as age increases.
- Men have roughly twice the rate of death and hospital admissions attributable to alcohol. Deaths from injury were more common in men, contributing to 73% of all years of life lost from drinking in men and 42% in women<sup>4</sup>.
- 82% of New Zealand women report consuming alcohol prior to conception and 34% report drinking during pregnancy<sup>5</sup>.

<sup>1</sup> Huckle, T., R. Q. You, et al. (2011). "Increases in quantities consumed in drinking occasions in New Zealand 1995-2004." *Drug and Alcohol Review* 30(4): 366-371.

<sup>2</sup> Connor J, Kydd R, Shield K, Rehm J. (2012) *Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007*. Wellington: Alcohol Advisory Council of New Zealand

<sup>3</sup> Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). *Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007*. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.

<sup>4</sup> Connor, J., Kydd,R.,Rehm, J.,Shield,K. (2013). *Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007*. Research report commissioned by the Health Promotion Agency. Wellington, Health Promotion Agency.

<sup>5</sup> Mallard S, Connor J, Houghton L. 2013 Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. *Drug and Alcohol review* vol 32 issue 3

- Hazardous drinking is more common in the most deprived areas of New Zealand<sup>6</sup> and there is a clear association between overall alcohol outlet density and socioeconomic deprivation, with more alcohol outlets situated in deprived areas<sup>7</sup>
- In the Wellington Region 22% of men and 11% of women have a hazardous drinking pattern scoring 8 or more on the 10-question AUDIT test<sup>8</sup>.

## Legislative and Policy Environment

### National Drug Policy

Government policy recognises that no single strategy can address the harms from drug and alcohol use and that multiple strategies are needed. The strategies are captured in a single framework of three core areas<sup>9</sup>:

- Supply control – control or limit the availability of drugs, including alcohol
- Demand reduction – limit the use of drugs and alcohol by individuals, including abstinence
- Problem limitation – reduce the harm from existing drug and alcohol use

### The Law Commission

In 2008 The Law Commission was engaged to evaluate the existing laws and policies relating to the sale, supply and consumption of alcohol. The final report released in 2010 - *Alcohol In Our Lives, Curbing the Harm* made 153 recommendations to government for change in law.<sup>10</sup>

Major recommendations included: raising the purchase age to 20, sweeping reform to the self-regulation of advertising and marketing, an immediate increase in the tax on alcohol and the introduction of a minimum pricing regime, and regulations to allow restriction on the supply of alcohol. Of these major recommendations government chose to implement significant change to the supply of alcohol allowing for greater restrictions predominantly through control of hours, density and location. Communities were given some control over licensing matters with councils able to adopt Local Alcohol Policies.

### The Sale and Supply of Alcohol Act 2012

In December 2012, the government introduced a new act regulating the supply of alcohol. This act has significant changes from the previous Sale of Liquor Act 1989. Particularly pertinent to health services are:

- A broader definition of alcohol related harm

*“alcohol related harm –*

*(a) means the harm caused by the excessive or inappropriate consumption of alcohol; and*

*(b) includes –*

<sup>6</sup> Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846

<sup>7</sup> Connor, J. L., K. Kypri, et al. (2010). Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *Journal of epidemiology and community health* 65(10): 841-846

<sup>8</sup> Ministry of Health (2013) Regional results from the 2011/12 New Zealand Health Survey <http://www.health.govt.nz/publication/regional-results-2011-12-new-zealand-health-survey>

<sup>9</sup> Ministry of Health (2007) *National Drug Policy 2007-2012*, Downloaded from <http://www.ndp.govt.nz>

<sup>10</sup> The NZ Law Commission (2010) NZLC R114 *Alcohol in our lives: Curbing the harm*. Downloaded from <http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor>

- (i) *any crime, damage, death, disease, disorderly behaviour, illness, or injury, directly or indirectly caused, or directly or indirectly contributed to, by excessive or inappropriate consumption of alcohol: and*
- (ii) *any harm to society generally or the community, directly or indirectly caused, or directly or indirectly contributed to, by crime, damage, death, disease, disorderly behaviour, illness, or injury of a kind described in subparagraph (i)*<sup>11</sup>

- An increased role for the medical officer of health
  - (a) The medical officer of health is required to enquire into all licensing applications and report on those of concern
  - (b) All territorial authorities must consult with the medical officer of health while drafting their local alcohol policies.

*Local alcohol policies are implemented through local council (they are voluntary, not compulsory) and guide all alcohol licensing applications in the district. They can place restrictions on the availability of alcohol by stipulating controls on the hours of operation, density of premises, the types of premises etc for given locations. The policy is both a tool for harm reduction and enables a community to have a say in licensing matters.*

- A requirement to respond to territorial authorities request for alcohol related health information, particularly the health of the districts residents and the nature and severity of the alcohol-related problems arising in the district.

The district health boards of Wairarapa, Hutt Valley and Capital and Coast and Regional Public Health are committed to playing an active role in informing local alcohol policies as part of their efforts to reduce alcohol-related harm.

#### **Evidenced based strategies**

Alcohol problems are not restricted to a small proportion of heavy/dependent drinkers or to the young. Therefore action at all levels of society by all means is required to bring a societal change in attitudes to consumption. There is no single factor that contributes to the development of alcohol-related problems and a multi strand evidenced based approach addressing supply control, demand reduction and harm minimisation is required.

As a member state of the World Health Organisation, New Zealand health services are expected to demonstrate commitment to advancing alcohol harm reduction both locally and nationally. This includes advocating for more effective policy and intervention strategies suitable for the New Zealand context.

The most effective strategies for reducing the harmful use of alcohol include population based strategies such as reducing the availability of alcohol, increasing the purchase age, lowering the blood alcohol concentration for driving, increasing the price and reducing alcohol marketing and advertising<sup>12</sup>. At the individual level brief interventions are of assistance<sup>13</sup>.

<sup>11</sup> *Sale and Supply of Alcohol Act 2012*. Public Act 2012 No. 120

<sup>12</sup> World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy

<sup>13</sup> World Health Organization (2010). Sixty-third world health assembly. Strategies to reduce the harmful use of alcohol: draft global strategy



	<b>Last Days of Life Care Plan and Toolkit</b>
	For the attention of: <b>Māori Relationship Board (MRB) and Clinical and Consumer Council</b>
Document Owner: Document Author:	Mark Peterson Leigh White
Reviewed by:	Paul Malan (Strategic Services Manager Older Health and Mental Health Services) and Mary Wills (Head of Strategic Services), Executive Management Team
Month:	July 2017
Consideration:	For Information

## RECOMMENDATION

**That the Māori Relationship Board, Clinical Council and Consumer Council:**

1. **Review** and Provide Feedback.
2. **Endorse** Ongoing Work

## EXECUTIVE SUMMARY

Last days of life care planning is an integral component of aged care services, medical and surgical care, management of chronic and complex illness. It is imperative that all health professionals should be competent to provide care to people who are approaching the end of their life and the tools (attached) are to be used as a guide. Last days of life care planning is a replacement for the phasing out of the Liverpool Care Pathway.

The impact of delayed last days of life planning can lead to a number of adverse outcomes:

- continued aggressive, unwanted and/or unwarranted life-sustaining measures instigated;
- poor experiences for families where distraught family members are called on at a time of grieving to engage in last days of life decisions;
- potentially avoidable conflicts between families and the health care team, or within the health care team; about the best course of treatment and care for the dying person;
- care being delivered in acute settings when better outcomes could be delivered in supported community or home environments;
- stress for health professionals balancing their obligation to act in the best interests of the dying person, sometimes differing views amongst treating clinicians and families.

The purpose of the enclosed document is to provide an update on the progression of work.



## SUMMARY UPDATE

- Last Days of Life Care Plan with supporting documents (Toolkit) are in final draft (attached) and signed off by the HBDHB Working Group (Refer to Attachment 3) to support a trial.
- Trial of documents in Aged Residential Care to be completed.
- Last Days of Life Care Plan with supporting documents (Toolkit) sent to MoH for example of.
- HBDHB LTC Portfolio Manager to participate in the National Advisory Group for implementation of Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life.

## CONSULTATION UPDATE

A cross-sector representative group was formed to collectively document updates: Trish Freer & Faye Milner (PHO), Jill Garrett (HBDHB Primary Strategic Service Manager), Janice Byford-Jones, Karen Franklin, Sarah Nichol, Jo Loney (Cranford Hospice) and Anne Gray (Secondary Care Services). The group has developed documents, informed their stakeholders and presented (or will present) to the following committees:

Committee	Date	Feedback
Consumer Council	Consumer input has been received with regard input into the documents (refer enclosed Attachment - Appendix 2)	
PHO I'ND	June 2016	Acknowledged paper
PHO Leadership Team (PHOLT),	June 2016	Presenting Monday 4 July 2016
PHO Clinical Advisory Governance Group		To present July 2016
Palliative care Sector Integration	4 July 2016	To present 4 July 2016
Maori Relationship Board	13 July 2016	To present July 2016
Clinical Council	13 July 2016	To present July 2016
Consumer Council	14 July 2016	Included in Documents as Information

## EXPECTED ROLE OF HBDHB

The Last Days of Life Care Plan and Toolkit are at the point of a trial and this has been agreed within five Aged Residential care facilities. Trial will commence post consultation – aiming for end of July 2016. Funding for the development of the tools and 500 copies for the trial will be provided by Strategic Services.

## EXPECTED ROLE OF HEALTH HB

To endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. To support the introduction and adoption in primary care. Note: Symptom Management for last days of life Algorithms are currently well embedded into general practice and these will not change.

Note:

- during the trial phase, General practice will be business as usual except for those GPs who are providing oversight for the trial in ARC.
- assumption of expected costs will be evaluated post trial and further consultation will occur with regard to wider implementation. It is expected the cost implication for PHO will be socialisation and education at CME sessions.

## **EXPECTED ROLE OF SECONDARY SERVICES**

Because of internal changes occurring in secondary care, a trial at this point is delayed.

## **EXPECTED ROLE OF CRANFORD**

In consultation with Cranford no trial will need to occur in the community as the forms will not be used in this area of practice at this time. Trial implementation, oversight in ARC and findings may be supported by Cranford (funding and date of commencement to be confirmed). To ensure the workforce is educated and skilled to provide quality care for people in their last days/hours of life. Cranford will ideally undertake workforce development in ARC, secondary care and present to Primary Care in CME sessions.

## **EXPECTED ROLE OF RESIDENTIAL CARE**

A proposed trial of 3 months (dates and timeframes not as yet agreed).

- ARC Facilities: Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
- GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames

## **EXPECTATION OF TRIAL OUTCOMES**

Even though the aim of the trial is to trial the documents it is hoped that use will result in:

- improved decision making;
- a positive impact on multi-professional team communication and working;
- increased confidence of nurses about when to approach medical colleagues to discuss treatment plans;
- people being treated with greater dignity and respect;
- greater clarity around preferences and plans about how these can be met.

Will await national approach with regard to audit process – but early thoughts:

- Determine how death audits will be reviewed at a local level, based on predicted, as well as unexpected, hospital deaths.

## **WHAT WILL SHOW IMPROVEMENT**

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau. It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

## **ATTACHMENT(s)**

- Appendix 1 Heat Tool
- Appendix 2: Copy of Consumer Feedback
- Appendix 3: Working Group Members
- Appendix 4: Care Plan
- Appendix 5: Toolkit

## Appendix 1

## Key Performance Indicators against the Health Equity Assessment Tool (HEAT)

Health Equity Assessment Tool - Questions	Assessment of the proposal using the Health Equity Assessment tool
<i>What health issue is the policy/programme trying to address</i>	<p>That people are aware of the essential components and considerations required to promote quality care at the end of life for all adults in New Zealand.</p> <p>Feedback will be taken into account from a consumer review: (e-mail)- <i>"I spoke with whanau from a range of cultural backgrounds such as Māori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage. The key area of concern for all was "trust". Trust in the system, trust in the people and trust in the word (written and verbal)."</i></p> <p>The tool is to provide consistency and quality of care taking into consideration the individual person's/whanau choice.</p> <p>It is a tool that is worked through with the person/whanau, vs a process that is "done to" the person(s) receiving care. (see email below) <i>"Whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting."</i></p>
<i>What inequalities exist in this health area?</i>	<p>The Planning for Last Days of Life Care Plan is for care for adults and excludes children. This is being addressed in another process.</p> <p>Without a standardised tool, the risk of substandard, fragmented care, and or variations in care is a risk.</p> <p>The tool caters to the individual and eliminates the risk of 'stereotypical applications of care to ethnicities- see comment below.</p> <p><i>email - "Also acknowledging that the tool is for all cultures - Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Māori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the individual (whanau) rather than their ethnicity alone."</i></p>
<i>Who is most advantaged and how?</i>	<p>The Planning for Last Days of Life Care Plan is for care for adults and the advantage is to have a better quality of care experience in their last phases of life. It also empowers the work force to work individually with the person to ensure care and management meets their individual needs</p>
<i>How did the inequality occur? (What are the mechanisms by which this inequality was created is maintained or increased?)</i>	<p>The equity has occurred with the national consensus of the removal of the LCP leaving a gap in standardisation of care services. Removing the LCP without replacement of a suitable alternative that is endorsed centrally would lead to multiple variation, and the absence of agreed standards.</p>
<i>What are the determinants of this inequality?</i>	<p>(Lack of) Participation in decision making by providers Attitudes of Care Planning for last days of Life</p>

<i>How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?</i>	<p>The Last Days of Life Care Plan is underpinned by Te Whare Tapa Whā, an holistic approach to care that addresses a person's physical, family/whānau, mental and spiritual health. It is person centred tool based on a partnership and full participation by the person and whanau in care management.</p> <p>Providing an individualised care plan helps to guide and prompt the care of the person who is dying and support for their families/whanau and other people who are significant to them. The individual nature of the tool allows for culturally appropriate care to be provided. A core purpose of the document is to support consistent care across organisations regardless of the setting.</p> <p>It is predicted that it may become evident that those that die in their own homes may also benefit from the use of the care plan document, this is particularly important when considering the higher percentage of Maori that die in the community. This factor will be considered after the trial??</p>
<i>Where/how will you intervene to tackle this issue?</i>	<p>Adopting the seven overarching principles outlined in Te Ara Whakapiri: Principles and Guidance for the last days of life will truly reflect the needs of a person and their family/whānau at the end of life. In essence, the plan, path or guidance encompasses the fundamentals of Te Whare Tapa Whā, namely the mental, physical, spiritual and social principles of well-being.</p> <p>The Last Days of Life Care Plan provides guidance, instructions and prompts to clinicians and the wider multi-disciplinary team that will assist them with their assessment and decision making regarding a person's deterioration and the possible outcome/s and indicated management. The plan ensures all necessary assessment, planning and monitoring are documented in line with the person's preferences. This provides evidence of appropriate care and communicates individualised care to all involved.</p>
<i>How could this intervention affect health inequalities?</i>	<p>Champions within providers of services. Agreed competencies and standards. Consistency in the implementation of the last days of life management.</p>
<i>Who will benefit most?</i>	Adults and whanau in HB and health care providers supported in their management of care by a reputable and endorsed tool.
<i>What might the unintended consequences be?</i>	Lack of adoption of the tool and default to the previous LCP
<i>What will you do to make sure it does reduce/eliminate inequalities?</i>	<p>Develop a process of monitoring outcomes for diverse population groups represented in the HB demographic.</p> <p>Monitoring uptake and engagement with the tool by providers.</p> <p>Attendance of ongoing CME-CNE.</p>
<i>How will you know if inequalities have been reduced/ eliminated?</i>	Evaluations of outcomes for patients / whanau inclusive of case studies – whanau stories.

## Appendix 2

-----Original Message-----

From: [REDACTED]  
Sent: Wednesday, 25 May 2016 12:07 p.m.  
To: 'Graeme Norton Hme'  
Subject: FW: Last days of Lire documents for comment

Kia ora Graeme

Well I have had some very interesting conversations and feedback, but the email below covers off the feedback from others very well.

I spoke with whanau from a range of cultural backgrounds such as Maori, Samoan, Cook Island, Tongan, mixed European and those that were not raised within their cultural heritage.

The key area of concern for all was "trust". Trust in the system, trust in the people and trust in the word (written and verbal). The past experiences of our whanau have left some lasting "bad" impressions. However, some advise that there has been some definite improvements over the years. There is some cynicism that in today's hospital environment, whereby some whanau have felt they have been pushed into making a decision due to the need to free up a bed; lack of staffing support; and implied costs of maintaining life in a hospital setting. Whanau have been told that it is more cost effective for the hospital if they took their whanau member home to look after themselves.

Another important aspect is to ensure that health workers do not assume that because of the ethnicity of the whanau that they fit within the expected cultural criteria. For example, not every Maori whanau are connected to their whanau, hapu, marae, iwi or cultural heritage. It must be what is acceptable and applicable to the whanau rather than their ethnicity alone.

In sharing these examples there were also a number of "happy" examples shared, but of course it is the bad experiences we remember and voice.

I hope this helps with development of the final plan.

Nga mihi,  
[REDACTED]

12

## Appendix 3

### Acknowledgement of the HB Integrated Working group:

Dr Carol McCallum (*Palliative Physician*)  
Karyn Franklin (*Clinical Services Manager, Cranford Hospice*)  
Sarah Nichol (*Quality Co-Ordinator Cranford Hospice*)  
Sue- Mary Davis (*Palliative care nurse Liaison with Aged Residential Care*)  
Anne Gray/Lorna Hulkes (*shared*) (*Palliative CNS Secondary Care*)  
Joan McAsey (*Practice Nurse, Hastings Health Centre*)  
Irene O'Connell (*Clinical Manager, Eversley Aged Residential Care*)  
Jo Loney (*Education Service Manager, Cranford Hospice*)  
Liz Beattie (*Clinical Manager, Masonic Aged Residential Care*)  
Trish Freer (*Health Programmes Manager – HHB*)  
Faye Milner (*Secretarial Support – PHO*)

### Request critique of documents:

Dr Mark Peterson  
Graeme Norton (sent to the Consumer Council)  
Dr Liz Whyte  
Dr Eames  
Mrs Jacqui Thomas (*Consumer*)





Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## LAST DAYS OF LIFE CARE PLAN

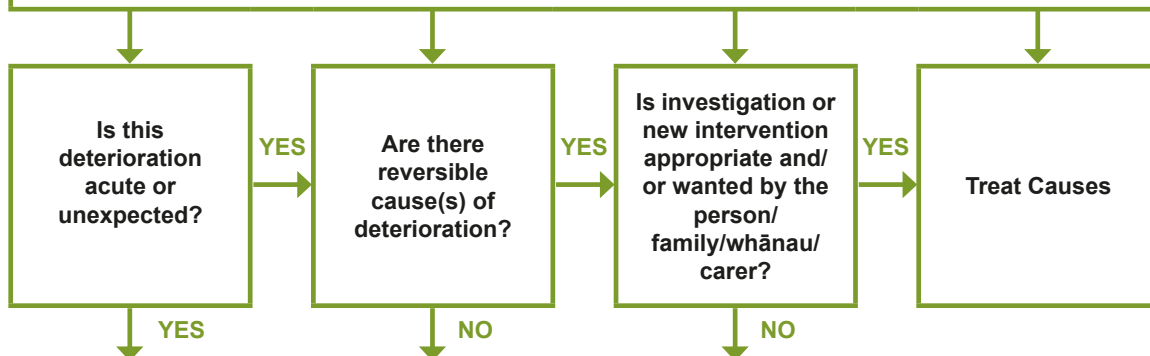
Identifying the Dying Person

### Flowchart

#### RECOGNITION OF PERSON DETERIORATION

##### DOES THE PERSON SHOW 2 – 3 OF THE FOLLOWING SIGNS/SYMPTOMS?

- ☐ Profound weakness
- ☐ Reduced intake food/fluids
- ☐ Difficulty swallowing/taking oral medications
- ☐ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
- ☐ Bed bound after progressive decline over days and weeks
- ☐ Peripherally shut down



- Family notified (if not already aware of person's condition); family involvement in care and allowances made for them to remain with person.
- Psychological support: plan of care discussed with person(if able) and family/whānau /carer
- Spiritual/religious/cultural beliefs: addressed with person (if able) and family/whānau /carer – facilitate any identified rituals around death. Referral to cultural/spiritual/religious support people if required.
- Medication: non essential medications discontinued, anticipatory PRN medication prescribed - consider route (refer to your organisation's symptom management algorithms)
- Discontinue unnecessary interventions: e.g. IV antibiotics, blood tests, observations/Early Warning Symptoms Score
- Ensure DO NOT RESUSCITATE order is documented.

#### DOCUMENT ABOVE INFORMATION AND COMMENCE END OF LIFE CARE PLANNING

As with all clinical guidance this document aims to support but does not replace clinical judgement



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## INSTRUCTIONS

This plan is an integrated care document that can be used across all settings, including the home, aged residential care, hospital and hospice

The term "last days of life" defines the period of time in which a person has been assessed and diagnosed as dying by a multi-disciplinary team and that death is expected within hours or days.

The goals of care are optimal symptom management and support for the person/family/whanau. The person should be assessed and a individualised care plan developed in line with the person (if able), family/whanau wishes and needs.

### CRITERIA FOR THE USE OF THE CARE PLAN

A health practitioner undertakes assessments when recognising a person may be entering their last days of life, planning priorities of care and continually assessing care needs. Any changes in condition act as a prompt to ensure conversations occur with the person and with their family/ whānau.

### INSTRUCTIONS FOR USE

This document is organised in three parts and must link with the person's clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations.

**Preparing for last days of life:** Baseline assessment to identify priorities of care

Pages 3 to 5

**Planning for care:**

Person centred priorities of care

Pages 6 to 7

**Ongoing assessment:**

Regular assessments (*recommend 4 hourly or more often if required*) of the persons condition to ensure that changes are addressed in a timely manner.

Pages 8 to 11

**Care after death:**

Checklist

Page 12

### LEAD HEALTH PRACTITIONER/S

Doctor:..... Page contacts (HBDHB): .....

*If GP - See Page 3 for Contact Details*

Nurse Practitioner: .....

Work number: ..... After hours number: .....

Primary Nurse: .....

### THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS

Date of Life Care Plan commencement ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....

Reassessment date: ..... Reassessment time: ..... Signed .....



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## CONTACTS

### FAMILY/ WHĀNAU

<p>If the person's condition changes, who should be contacted first?</p>	<p><b>1st Contact:</b></p> <p>Name: .....</p> <p>Relationship: .....</p> <p>Telephone Number: .....</p> <p>Mobile Number: .....</p>
<p>If the person's condition changes, when should they be contacted?</p>	<p>At any time <input type="checkbox"/></p> <p>Not at night time <input type="checkbox"/></p>
<p>If the first contact is unavailable, who should be contacted?</p>	<p><b>2nd Contact:</b></p> <p>Name: .....</p> <p>Relationship: .....</p> <p>Telephone Number: .....</p> <p>Mobile Number: .....</p>
<p>When to contact</p>	<p>At any time <input type="checkbox"/></p> <p>Not at night time <input type="checkbox"/></p>
<p>Next of Kin if different from above</p>	<p>Name: .....</p> <p>Relationship: .....</p> <p>Telephone Number: .....</p>

### KEY SERVICE PROVIDERS

<p>Name of General Practitioner</p> <p>Notified of change in person's condition</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>In what circumstances do they want to be contacted?</p> <p>If unavailable, which GP should be contacted?</p>	<p><b>1st Contact:</b></p> <p>Name: .....</p> <p>Mobile Number: .....</p> <p>At any time <input type="checkbox"/> Not at night time <input type="checkbox"/></p> <p><b>2nd Contact:</b></p> <p>Name: .....</p> <p>Mobile Number: .....</p> <p>At any time <input type="checkbox"/> Not at night time <input type="checkbox"/></p>																																
<p>Community Providers are notified of "Last Days of Life" if applicable</p>	<table border="0"> <tr> <td>Cranford Hospice</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>District Nurses</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>NASC Agency</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Home Support Agency</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Other</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td colspan="4">.....</td> </tr> <tr> <td colspan="4">.....</td> </tr> <tr> <td colspan="4">.....</td> </tr> </table>	Cranford Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	District Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	NASC Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Home Support Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	.....				.....				.....			
Cranford Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																														
District Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																														
NASC Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																														
Home Support Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																														
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																														
.....																																	
.....																																	
.....																																	



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## INITIAL ASSESSMENT PAGE 1 OF 2

### RECOGNITION OF DYING: Goal: Both the person/family/whānau have awareness and understanding of the diagnosis

The person is aware they are dying?  <i>See guidelines on "Identifying the dying person"</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unconscious Date: ..... Signature: .....
--	---

Is the family/whānau aware their family member is dying?  <i>See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: ..... Signature: ..... Document clearly in <b>PROGRESS NOTES</b> what was said and by whom.
---	--

### Advance Care Plan: Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them

Does the person have an existing Advance Care Plan?  <i>If Yes – where is it located</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Located: ..... Date: ..... Signature: .....
--	--

Does the person have an existing Directive/ Do Not Resuscitate Order documenting their wishes at end-of-life?  <i>If Yes – where is it located</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Located: ..... Date: ..... Signature: .....
--	--

Does the person have nominated Enduring Power of Attorney (EPOA) for Health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Name: ..... Relationship: ..... Contact No.: .....
--	---

Has the EPOA been activated? Copy sighted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Document clearly in <b>PROGRESS NOTES</b> what was said and by whom.
---	--

### Preferred Place of Care: Goal: person and family/whānau choice if appropriate

Person's preferred place of care	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care
Family/whānau preferred place of care <i>If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"</i>	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care

### Information and Explanation: Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.

Family/whānau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.  <i>Information brochure "What to expect when someone is dying" explained and given to family/whānau if appropriate.</i>  <i>Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No    Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No    Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Funeral Director (if known) ..... If for cremation/burial ..... Specific death certificate questions: Previous occupation..... Ethnicity..... Marital Status.....
--	---



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## INITIAL ASSESSMENT PG 2 OF 2

### Cultural:

If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death.

Date and time of conversation: .....

Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death.

Date and time of conversation: .....

*Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.H.A.N.A.U: Personalising care at end of life.*

Names of services involved: .....

Document clearly in **PROGRESS NOTES** what was said and by whom.

### Religious and Spiritual:

If able, the person is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)

☐ Yes ☐ No

Date and time of conversation: .....

The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)

☐ Yes ☐ No

Date and time of conversation: .....

*Refer to Chaplain Service or contact person's preferred support person if required. See Spiritual care assessment tool based on FICA approach.*

Names of services involved: .....

Document clearly in **PROGRESS NOTES** what was said and by whom.

### MUST BE COMPLETED BY MEDICAL PRACTITIONER

• Active acute medical treatment is no longer in the person's best interest

☐ Yes ☐ No Date: ..... Signature: .....

• Non-essential medications discontinued and current medications reviewed

☐ Yes ☐ No Date: ..... Signature: .....

• PRN subcutaneous anticipatory medications charted.

☐ Yes ☐ No Date: ..... Signature: .....

*See Symptom Management Algorithms*

• Inappropriate interventions discontinued e.g blood tests, routine observations, blood glucose monitoring, oxygen therapy

☐ Yes ☐ No Date: ..... Signature: .....

• The need for artificial hydration/nutrition has been discussed

☐ Yes ☐ No Date: ..... Signature: .....

• Not for Resuscitation status recorded

☐ Yes ☐ No Date: ..... Signature: .....

• Implantable Cardioverter Defibrillator (ICD) is deactivated

☐ Yes ☐ No Date: ..... Signature: .....

• Organ donation considered and information given to person/family

☐ Yes ☐ No Date: ..... Signature: .....

*See Tissue Donation brochure*

### Individual/Specific Requests

.....

.....

.....





Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## CARE PLAN PAGE 1 OF 2

*Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.*

Person PROBLEM / FOCUS	GOAL	ACTIONS
<b>Te Taha Tinana</b>		
<b>PAIN</b>	Person is pain free <ul style="list-style-type: none"> <li>• Verbalised by person if conscious</li> <li>• Pain free on movement</li> <li>• Appears peaceful</li> </ul>	e.g. Consider need for positional change <input type="checkbox"/> ..... ..... .....
<b>AGITATION</b>	Person is not agitated <ul style="list-style-type: none"> <li>• Person does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)</li> </ul>	e.g. Exclude retention of urine as cause <input type="checkbox"/> e.g. Consider need for positional change <input type="checkbox"/> ..... .....
<b>RESPIRATORY TRACT SECRETIONS</b>	Excessive secretions are not a problem	e.g. Medication to be given as soon as symptoms arise <input type="checkbox"/> e.g. Consider need for positional change <input type="checkbox"/> e.g. Symptom discussed with family/other <input type="checkbox"/> ..... .....
<b>NAUSEA AND VOMITING</b>	Person does not feel nauseous or vomits <ul style="list-style-type: none"> <li>• Person verbalises if conscious</li> </ul>	..... ..... .....
<b>DYSPNOEA</b>	Breathlessness is not distressing for person <input type="checkbox"/> Person verbalises if conscious	e.g. Consider need for positional change <input type="checkbox"/> ..... .....
<b>OTHER SYMPTOMS (E.G. OEDEMA, ITCH)</b>	.....	..... ..... .....
<b>MOUTH CARE</b>	Mouth is moist and clean <ul style="list-style-type: none"> <li>• See mouth care guidelines</li> </ul>	e.g. Ensure mouth is kept moist <input type="checkbox"/> e.g. Family/whānau/other involved in care given <input type="checkbox"/> ..... .....
<b>MICTURITION DIFFICULTIES</b>	Person is comfortable	e.g. Urinary catheter if in retention <input type="checkbox"/> e.g. Urinary catheter or pads, if general weakness creates incontinence <input type="checkbox"/> ..... .....
<b>MEDICATION</b>	All medication is given safely and accurately	e.g. If syringe driver in progress check rate and site <input type="checkbox"/> .....

Plan of care continued onto next page



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## CARE PLAN PAGE 2 OF 2

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
<b>MOBILITY / PRESSURE AREA CARE</b>	Person is comfortable and in a safe environment	Mattress: ..... Position changes: ..... Personal Hygiene needs: .....
<b>BOWEL CARE</b>	Person is not agitated or distressed due to constipation or diarrhoea	..... ..... .....
<b>Taha hinengaro</b>		
<b>PSYCHOLOGICAL SUPPORT</b>	Person becomes aware of the situation as appropriate	e.g. Person is informed of procedures <input type="checkbox"/> e.g. Touch, verbal communication is continued <input type="checkbox"/> ..... .....
	Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance	e.g. Check understanding of nominated family/whānau/ others/younger adults / children <input type="checkbox"/> e.g. Check understanding of family/whānau/others not present at initial assessment <input type="checkbox"/> e.g. Ensure recognition that the person is dying and of the measures to ensure comfort <input type="checkbox"/> ..... .....
<b>Te Taha Wairua</b>		
<b>RELIGIOUS/ SPIRITUAL SUPPORT</b>	Appropriate religious / spiritual support has been given	e.g. Support from Chaplaincy team may be helpful <input type="checkbox"/> e.g. Consider cultural needs <input type="checkbox"/> ..... .....
<b>Te Taha Whānau</b>		
<b>CARE OF THE FAMILY/ WHANAU/ OTHER</b>	The needs of those attending the person are accommodated	e.g. Consider health needs and support <input type="checkbox"/> ..... .....
<b>CULTURAL SUPPORT</b>	Consider the cultural needs of the person/ family/whānau	..... ..... .....
<b>OTHER</b> E.G. COMMUNICATION		..... ..... .....
Health Professional Name: .....		
Signature: ..... Date: .....		

Please turn over for on-going assessment / outcome monitoring chart





Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns(not a signature))  
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours  
C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal  
If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

GOALS FROM CARE PLAN	Date:	Day:	Date:	Day:	Date:	Day:
TIME						
<b>PAIN</b> <i>Person is pain free</i> • Verbalised by person if conscious • Pain free on movement						
<b>AGITATION</b> <i>Person is not agitated</i> • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)						
<b>RESPIRATORY TRACT SECRETIONS</b> <i>Excessive secretions are not a problem</i>						
<b>NAUSEA AND VOMITING</b> <i>Person does not feel nauseous or vomits</i> • Person verbalises if conscious						
<b>DYSPNOEA</b> <i>Breathlessness is not distressing for the person</i> • Verbalised by person if conscious						
<b>OTHER SYMPTOMS (E.G. OEDEMA, ITCH)</b>						
<b>MOUTH CARE</b> <i>Mouth is moist and clean</i>						
<b>MICTURITION DIFFICULTIES</b> <i>Person is comfortable</i>						
<b>MEDICATION</b> <i>All medication is given safely and accurately</i>						
<b>MOBILITY / PRESSURE AREA CARE</b> <i>Person is comfortable and in a safe environment</i>						
<b>BOWEL CARE</b> <i>Person is not agitated or distressed due to constipation or diarrhoea</i>						
<b>PSYCHOLOGICAL SUPPORT</b> <i>Person becomes aware of the situation as appropriate</i> <i>Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance</i>						
<b>RELIGIOUS / SPIRITUAL SUPPORT</b> <i>Appropriate religious / spiritual support has been given</i>						
<b>CARE OF THE FAMILY /WHANAU/OTHER</b> <i>The needs of those attending the person are accommodated</i>						
<b>CULTURAL SUPPORT</b> <i>Consider the cultural needs of the person/ family/whānau</i>						
<b>OTHER E.G. COMMUNICATION</b>						
<b>HEALTH PROFESSIONAL INITIAL</b>						
<b>DESIGNATION</b>						

ONGOING ASSESSMENT

12.1



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns(not a signature))

A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours

C = Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal

If code C is used – details MUST be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

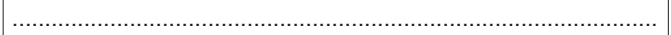
GOALS FROM CARE PLAN	Date:	Day:	Date:	Day:	Date:	Day:
TIME						
<b>PAIN</b> <i>Person is pain free</i> • Verbalised by person if conscious • Pain free on movement						
<b>AGITATION</b> <i>Person is not agitated</i> • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)						
<b>RESPIRATORY TRACT SECRETIONS</b> <i>Excessive secretions are not a problem</i>						
<b>NAUSEA AND VOMITING</b> <i>Person does not feel nauseous or vomits</i> • Person verbalises if conscious						
<b>DYSPNOEA</b> <i>Breathlessness is not distressing for the person</i> • Verbalised by person if conscious						
<b>OTHER SYMPTOMS (E.G. OEDEMA, ITCH)</b>						
<b>MOUTH CARE</b> <i>Mouth is moist and clean</i>						
<b>MICTURITION DIFFICULTIES</b> <i>Person is comfortable</i>						
<b>MEDICATION</b> <i>All medication is given safely and accurately</i>						
<b>MOBILITY / PRESSURE AREA CARE</b> <i>Person is comfortable and in a safe environment</i>						
<b>BOWEL CARE</b> <i>Person is not agitated or distressed due to constipation or diarrhoea</i>						
<b>PSYCHOLOGICAL SUPPORT</b> <i>Person becomes aware of the situation as appropriate</i> <i>Family/whanau/other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance</i>						
<b>RELIGIOUS / SPIRITUAL SUPPORT</b> <i>Appropriate religious / spiritual support has been given</i>						
<b>CARE OF THE FAMILY / WHANAU/OTHER</b> <i>The needs of those attending the person are accommodated</i>						
<b>CULTURAL SUPPORT</b> <i>Consider the cultural needs of the person/ family/whānau</i>						
<b>OTHER E.G. COMMUNICATION</b>						
<b>HEALTH PROFESSIONAL INITIAL</b>						
<b>DESIGNATION</b>						

.....

[illegible]

## PROGRESS NOTES

## 12.1





Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

## CARE AFTER DEATH

**NOTE:** This section is to be used if advised by your organisation. It may be more appropriate to use your services Care of the Deceased Checklist or Forms

TIME OF DEATH																																																	
Person has died	Date/ Time/ Signature: .....																																																
People in attendance at time of death	.....																																																
Person has been verified dead	Date/ Time/ Signature: .....																																																
Person certified (Medical)	Date/ Time/ Signature: .....																																																
AFTER DEATH CARE																																																	
Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
Bereavement support has been discussed	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
<i>See Organisation Policy on Care at death and after death</i>																																																	
ACTIONS COMPLETED																																																	
Notify Next of Kin	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
Notify Attending Doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
Clinical records complete	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
Ensure body correctly identifiable	<input type="checkbox"/> Yes <input type="checkbox"/> No																																																
Sign off Release of Body form (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																																																
WINZ notified/form printed (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																																																
Ministry of Health (MoH) notification/form printed (Death only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																																																
Options HB notified (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																																																
Community Providers are notified of Death (if applicable)	<table border="0"> <tr> <td>Cranford Hospice</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>District Nurses</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>NASC Agency</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Home Support Agency</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr> <td>Other</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> N/A</td> </tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> <tr><td colspan="4">.....</td></tr> </table>	Cranford Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	District Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	NASC Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Home Support Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	.....				.....				.....				.....				.....				.....				.....			
Cranford Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																																														
District Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																																														
NASC Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																																														
Home Support Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																																														
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																																														
.....																																																	
.....																																																	
.....																																																	
.....																																																	
.....																																																	
.....																																																	
.....																																																	

CARE AFTER DEATH

12.1



# TOOLS AND RESOURCES TO GUIDE THE CARE OF PEOPLE IN THEIR LAST DAYS OF LIFE





## ADDITIONAL TOOLS

to assist with decision making and providing information to ensure the physical (tinana), psychological (hinengaro), spiritual (wairua) and family (wairua) wellbeing for all people is upheld.

TOOL	WHERE TO ACCESS
1. Identifying the dying person - Flowchart	Information Pack In hospital: Via Nettie Map of medicine
2. Symptom Management Algorithms Hawkes Bay Algorithms	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
3. Hospital Discharge checklist	In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
4. W.H.Ā.N.A.U: personalising care	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
5. Spiritual care assessment tool (FICA)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
6. Breaking bad news flow chart (SPIKES)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine
7. List of cultural support	Access organisations own resources

BROCHURES AVAILABLE	WHERE TO ACCESS
What to expect when someone is dying - information for family/whānau	For supplies of brochure contact : ?? Cranford Hospice Telephone 06 8787047
Tissue Donation - information for persons and family/ whānau	For supplies of brochure contact: Donor Co-Ordinator Organ Donation of New Zealand Ph 09 630 0935
What to do after death, grief and bereavement support - practical information for family/ whānau	For supplies of brochure contact: Funeral Directors Association of NZ (Inc) P O Box 10888 Wellington 6143 Email: info@fdanz.org.nz Website: www.funeralsnewzealand.co.nz

## BREAKING BAD NEWS FLOWCHART

## BREAKING BAD NEWS FLOWCHART

### PREPARATION

Check the person's notes to assess what has already been discussed (*don't assume prior discussions have been remembered or understood*)  
Check who should be present e.g. family, other health professionals  
**Set time aside with no distractions e.g. pager, mobile phone**  
Set the scene and ensure privacy

### WHAT DOES THE PERSON KNOW?

It would help me to know what you understand about your illness, how did it all start, what is happening now?  
(*this is about gaining the person's level of understanding and engagement, ACP and EPOA*)

### IS MORE INFORMATION WANTED?

"Would you like me to give you more details about your illness?"

### GIVE AN ALERT!.... AND.....PAUSE!

"I am afraid that it looks more serious than we hoped"

### ALLOW PERSON TO REFUSE INFORMATION AT THIS TIME

"It must be difficult to accept this?" (*Determine how much they want to know at this time*)

### GIVE EXPLANATION (IF REQUESTED)

A narrative of events may be helpful

### ELICIT AND LISTEN TO ANY CONCERNS

"What are the main things that you are worried about?" (*Reassure that support is paramount*)

### SUMMARISE AND PLAN

"Your main concerns at the moment seem to be...."

### OFFER AVAILABILITY AND SUPPORT

Offer follow up discussion, e.g. social work referral, church minister, chaplain, cultural support services

### COMMUNICATE WITH MULTIDISCIPLINARY TEAM AND DOCUMENT

Clearly document conversation in clinical notes and who was present at this discussion



## ADAPTATION OF SPIKES\*

<b>S</b>	<b>SETTING</b> up the discussion	<ul style="list-style-type: none"> <li>• read notes/test results</li> <li>• check who should be present ; involve significant others; is a translator needed?</li> <li>• arrange privacy; think of tissues/water</li> <li>• set time aside with no distractions e.g. pager</li> <li>• mentally prepare self how news will be shared and how to respond to reaction</li> <li>• sit down and make a connection with person/family/whanau</li> </ul>
<b>P</b>	Assessing the <b>PERCEPTION</b> of condition/seriousness	<ul style="list-style-type: none"> <li>• use open ended questions to gather how person perceives the situation e.g. What have you been told so far?</li> <li>• listen to their level of comprehension, accept denial but do not confront at this stage; this can correct any misinformation and tailor breaking news to what they already understand</li> </ul>
<b>I</b>	<b>INVITATION</b> from person to give information	<ul style="list-style-type: none"> <li>• how much do they want to know "Are you the sort of person who likes to know everything?"</li> <li>• accept the person's rights not to know - "Would you like me to give you all the information or sketch out what has happened and spend more time discussing the treatment plan?"</li> </ul>
<b>K</b>	<b>KNOWLEDGE:</b> giving facts and information to person	<ul style="list-style-type: none"> <li>• warning the person that bad news is coming lessens the shock and can facilitate information processing "I'm sorry to tell you that..." "The results are not as good as we hoped"</li> <li>• use language intelligible to person; use diagrams if helpful</li> <li>• consider their emotional state</li> <li>• give information in small chunks; avoid jargon and acronyms</li> <li>• Avoid excessive bluntness and avoid "There is nothing more we can do" as this maybe inconsistent with their own goals such as good pain relief and control</li> </ul>
<b>E</b>	<b>EXPLORE</b> emotions and empathize	<ul style="list-style-type: none"> <li>• observe and identify emotions expressed by person "You appear sad" "I can see how upsetting this is for you"</li> <li>• what strategies/mechanisms have they used in the past to deal with bad news?</li> <li>• do they have a particular outlook on life/cultural/spirituality that helps</li> <li>• who are the important people in their life</li> </ul>
<b>S</b>	<b>STRATEGY &amp; SUMMARY</b>	<ul style="list-style-type: none"> <li>• draw up plan with person "Your appointment to see Mrs Brown the oncologist is on..." "You are going to contact the funeral director..."</li> <li>• consider immediate plans – what are you doing next; who will you tell/ how will you tell them; how will they cope?</li> <li>• have person repeat key points to ensure that they have understanding</li> <li>• does anything need to be clarified or any other questions?</li> <li>• by understanding person's goals, hope can be fostered to help them accomplish their goals</li> <li>• offer other professional support e.g. Chaplain, cultural support, social work referral, funeral director</li> <li>• document/communicate discussion/plan with other professionals that need to know</li> <li>• close the meeting</li> </ul>

- Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the person with cancer. *Oncologist* 2000;5(4):302-311.
- Kayleigh Steel, Michael Kennedy, Sean Prendergast, Christina Newton, Andrew MacGillivray and Aileen D'Arcy
- [www.physio-pedia.com/File:SPIKES\\_Table.jpg](http://www.physio-pedia.com/File:SPIKES_Table.jpg)



Fill in only if person label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

## DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

CHECKLIST	YES	NO	N/A	SIGNED	DATE	COMMENT
Does the person have a preferred place of care						
Person/family are aware of prognosis						
Person's main nominated contact supports decision for discharge						
Not for Resuscitation complete						
Ambulance booked – aware of Not for Resuscitation						
GP or nominated other aware of discharge and arrangements made for GP to visit.						
Hospice is aware of discharge						
District Nurse updated of care needs and discharge date and time (inclusive of Rural/CHB and Wairoa)						
Aged Residential Care updated of care needs and discharge date and time						
Assessment completed by Needs Assessment Co-Ordination Agency (Options HB) and individual care package in place						
Other MDT members aware e.g. social worker, OT, physio						
Current medication assessed and non essential medication discontinued						
Discharge medication/s ordered:  Appropriate subcutaneous AND anticipatory medication prescribed and faxed to pharmacy.						
If person is being discharged with a continuous infusion pump. Complete appropriate Discharge Checklist.						
Person/family understand the discharge medication						
Equipment delivered/planned e.g. electric bed, mattress,						
Oxygen arranged if applicable.						
Circle of Support has been completed and documented who is the first point of contact.						

DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE



## W.H.A.N.A.U: PERSONALISING CARE AT END-OF-LIFE

This has been designed as a prompt card providing potential conversation starter questions to guide conversations about end of life. The background image of Te Whare Tapa Whā (Durie 1985) reminds of the need for a holistic approach to care and W.H.A.N.A.U. guides conversations to ensure that care for people can be personalised.

### 'W.H.Ā.N.A.U' - PERSONALISING CARE AT END-OF-LIFE

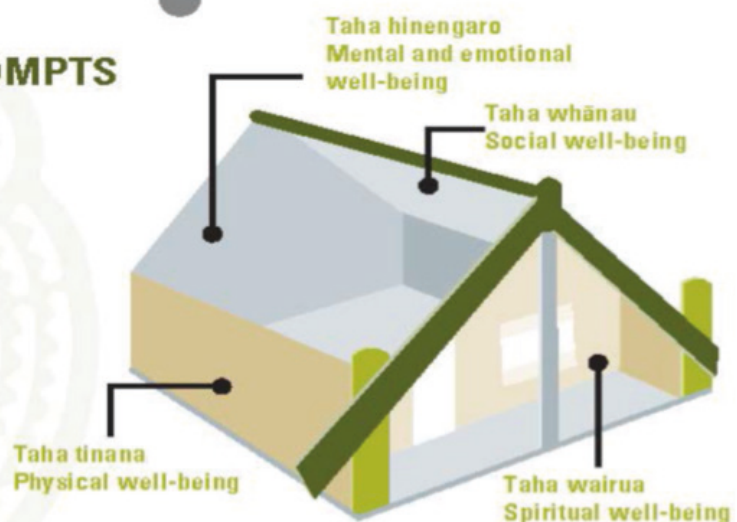
- ✓ **WHO TO ASK?** It may be better to talk with a whānau spokesperson, or with the whānau or family all together
- ✓ **HAVE** *time* and *space* to talk and *offer* thinking time
- ✓ **ASK** - don't assume what's important to you is the same for others
- ✓ **NEED** others to join these conversations? – friends, whānau
- ✓ **AGAIN** - people's needs change, so ask again
- ✓ **UNCOMFORTABLE** asking or responding to these questions?  
Ask for help – colleagues, chaplains, cultural advisors

### SOME USEFUL PROMPTS

What can we do now to help you and those people important to you to feel safe and comfortable?

Do you have beliefs and family traditions that are especially important to you?

What are the important things about you and your whānau that we need to know right now?







## SPIRITUAL CARE ASSESSMENT TOOL BASED ON FICA APPROACH

### BACKGROUND

The FICA Spiritual History Tool was developed by Dr Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with persons. Spiritual histories are taken as part of the regular history during an annual exam or new person visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

### SUGGESTED QUESTIONS

These should be adapted to suit each person and revisited as person circumstances change.

<b>Faith</b>	What things do you believe in that give meaning/value to your life? <b>and/or:</b> Do you consider yourself spiritual or religious? <b>and/or:</b> <b>and/or:</b> What is your faith or belief?
<b>Importance</b>	In what ways are they important to your life? <b>and/or:</b> What influences do they have on how you take care of yourself?
<b>Influence</b>	<b>and/or:</b> How are your beliefs/values influencing your behaviour during your illness? <b>and/or:</b> In what ways do your beliefs/values help you in regaining your health/wellbeing?
<b>Community</b>	Is there a person or group of people who you love or who are very important to you? <b>and/or:</b> How is this supportive to you? <b>and/or:</b> Do you belong to a religious/cultural community?
<b>Address</b>	Is there anything we can do to help you while you are with us? <b>and/or:</b> Would it help to talk to someone about these issues?

### An example of a spiritual assessment in a non-religious person

<b>F</b>	Naturalist
<b>I</b>	Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose'
<b>C</b>	Close friends who share her values
<b>A</b>	After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness

**You can refer to the faith leader or Chaplaincy Department at any time, but some specific situations may include:**

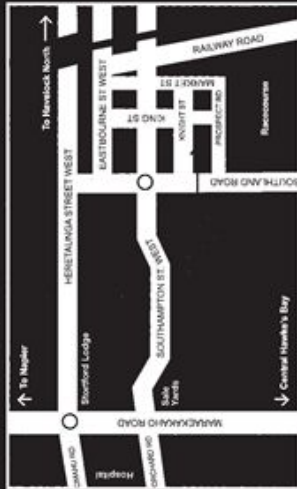
- When one's own belief system prohibits involvement in the spiritual/religious/cultural care of the person
- When spiritual or religious/cultural issues seem particularly significant in the person's suffering
- When spiritual or religious/cultural beliefs or values seem to be particularly helpful or supportive for the person
- When spiritual or religious/cultural beliefs or values seem to be particularly unhelpful for the person
- When addressing the spiritual or religious/cultural needs of a person exceeds your comfort level
- When specific community spiritual or religious/cultural resources are needed
- When you suspect spiritual or religious/cultural issues which the person denies
- When the person or family have specific religious needs e.g. Confession, Holy Communion, Sacrament of the Sick, needs a prayer mat or private space to pray, sacred texts, etc
- When the person's family seem to be experiencing spiritual/emotional pain or trauma
- When members of staff seem to be in need of support.

Source: Puchalski and Larson (1998)





"You may want a friend, someone from your family or whānau or a minister to be with you now."



WHAT TO  
EXPECT  
WHEN  
SOMEONE  
IS DYING

## What to do when your loved one dies

You don't have to do anything straight away. There's no need to call the police or an ambulance. You will need to call the hospice nurse or your GP at some stage to tell them your loved one has died. A doctor will need to prepare a death certificate. If death occurs at night and you are comfortable being at home with your loved one, make these calls in the morning – usually after 7am.

Your loved one's body can stay at home for several hours for relatives and friends to visit and pay their respects. Phone the hospice nurse if you need help at this time. If not, you'll need to lie your loved one on their back. Cover them only with a light sheet. Make sure electric blankets and heaters are off and the room is cool. You may want a friend, someone from your family or whānau or a minister to be with you now.

Cranford Hospice  
24 hour contact number  
06 878 7047

300 Knight Street  
Hastings 4122

P 06 878 7047

F 06 878 3799

E [reception@cranfordhospice.org.nz](mailto:reception@cranfordhospice.org.nz)

W [cranfordhospice.org.nz](http://cranfordhospice.org.nz)



Cranford  
**hospice**  
howe's bay

A Service of  
**Presbyterian Support**  
East Coast

Living Every Moment

Cranford  
**hospice**  
howe's bay  
Living Every Moment



This brochure describes some of the typical features of the process of dying. It may help to reduce anxiety about the unknown.

The dying process is unique to each person, but in most cases there are common characteristics or changes that help to indicate that a person is imminently dying.

Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end. Most that occur at this time are normal and don't need any special treatment, hospitalisation, or professional help.

If you are unsure about anything, please call Cranford Hospice or the health professional supporting you at this time.

Here are some of the changes that may occur when someone is dying:

Not eating or drinking

As people get closer to dying, the body does not need fluid to function. Your loved one is likely to lose interest in food and drink to the point that they're not eating or drinking anything at all. They may have lost the ability to swallow, so don't try to give them drinks at this stage because liquid will only pool at the back of their throat. Moistening the mouth with ice chips or a wet cloth may be all that is needed.

Increased confusion and restlessness

It is common for dying people to be quite restless or agitated in the last 24 to 48 hours before they die. Try to reassure them by talking calmly and telling them who you are. Don't make sudden noises or startle them. Constant touching or stroking may be disturbing, try gently holding their hand. Playing their favourite music may help to calm them.

Breathing

As your loved one finds it harder to swallow, saliva and secretions may collect at the back of their throat and make a noise when they breathe – it's sometimes called the 'death rattle'. This isn't distressing for them, but it might be to you. Raising the head of the bed with pillows may help.

As death approaches, you'll notice your loved one's breathing pattern changes. There may be gaps of seconds or minutes between breaths. When the gaps between breaths get longer and longer, it's a sign that death is close.

Sometimes when a person is taking their last breaths, they may seem to grimace. This isn't because they're uncomfortable, it's just the muscles in the upper part of their body and face contracting and relaxing.

Changing colour

As blood circulates more slowly, your loved one's arms and legs will start to feel cool and may look patchy/mottled and dark. Their face may be pale and pinched, their nose may feel cold and the beds of their fingernails and toenails may turn blue. You may notice their skin is clammy and marks easily where they're touched. There's no need to put on

"Death usually comes gradually and peacefully, and there are many changes that signal life is coming to an end."

a lot of extra bedding or an electric blanket – this might just make them restless. Depending on the weather, a sheet and a few warm blankets should be enough.

Incontinence

Sometimes there is a loss of control of bowels or bladder. It will be important to discuss this with your nurse in order to get appropriate supplies.

How to tell if your loved one has died:

Their breathing stops

Their chest stops moving up and down

They will have no heartbeat or pulse

They don't respond when you shake them or talk loudly

Their eyes are fixed and their pupils are dilated – sometimes their eyelids stay open

Their jaw relaxes – sometimes their mouth stays open

They may have lost control of bladder or bowels

## Appointments

---

---

---

---

---

---

---

---

---

---

## Notes

---

---

---

---

---

---

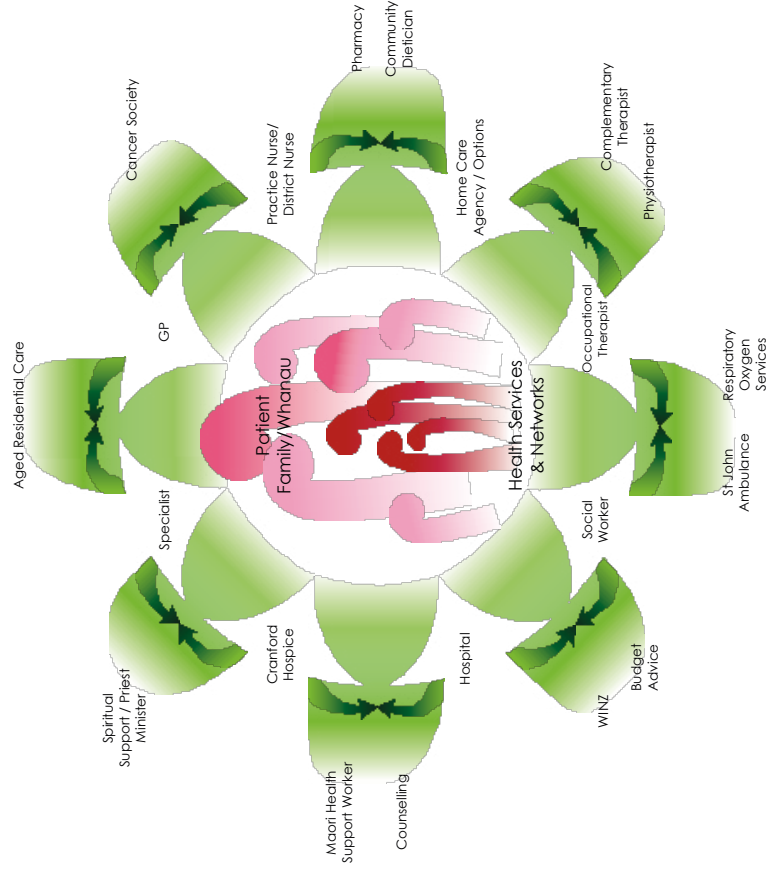
---

---

---

---

'Palliative care is a sacred encounter for any culture'



## Referral into Partnership of Care Services

Acknowledgement: This resource was produced in Wairoa by Gae Redshaw RN-Hawkes Bay District Health Board



## Important Contact People:

## Phone Numbers:

GP Practice \_\_\_\_\_

\_\_\_\_\_

Doctor \_\_\_\_\_

\_\_\_\_\_

Practice Nurse \_\_\_\_\_

\_\_\_\_\_

Hospital / Acute Ward \_\_\_\_\_

\_\_\_\_\_

District Nurse \_\_\_\_\_

\_\_\_\_\_

Pharmacy \_\_\_\_\_

\_\_\_\_\_

Cranford Hospice \_\_\_\_\_

\_\_\_\_\_

Nurse / Kaitakawaenga \_\_\_\_\_

\_\_\_\_\_

Social Worker \_\_\_\_\_

\_\_\_\_\_

Maori Health Provider \_\_\_\_\_

\_\_\_\_\_

Cancer Society Support Care \_\_\_\_\_

\_\_\_\_\_

Spiritual Support \_\_\_\_\_

\_\_\_\_\_

Occupational Therapist \_\_\_\_\_

\_\_\_\_\_

Home Care Agency \_\_\_\_\_

\_\_\_\_\_

Care Person \_\_\_\_\_

\_\_\_\_\_

Physiotherapist \_\_\_\_\_

\_\_\_\_\_

Ambulance \_\_\_\_\_

\_\_\_\_\_

(Are you a member of St Johns Ambulance?)

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_


\_\_\_\_\_

\_\_\_\_\_

**(Keep this information inside your diary)**

12.2



 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>DRAFT Wairoa Health Needs Assessment Report</b>
	For the attention of: <b>Māori Relationship Board</b>
Document Owner: Document Author(s):	Tracee Te Huia, General Manager Māori Health Patrick LeGeyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Māori Health
Reviewed by:	N/a
Month:	July, 2016
Consideration:	For Information/ Discussion

## RECOMMENDATION

**That the Māori Relationship Board:**

Note the contents of the report

## Introduction

District Health Boards are required to regularly carry out health needs assessments and monitor the health status of their resident population to guide delivery of health services. Traditionally, Health Needs Assessments are prepared and written to a nationally accepted format and generally present data of the health status and conditions for a District Health Board population. The current assessment differs slightly from the traditional health needs assessment format.

Hawke's Bay District Health Board (HBDHB) decided to commission a Health Needs Assessment to determine '*what is working, what is not working and ideas for improvement*' of the health services in Wairoa.

Specifically HBDHB wanted the assessment to:

- Provide a report on the health needs of the Wairoa community.
- Determine the extent of service coverage and consumer experience to support the development of the Wairoa Locality Plan (Community Network Model).
- Provide recommendations on the potential health service reconfigurations and redesign.

The purpose of the Wairoa Health Needs Assessment 2016 is to provide a guiding document to inform Hawke's Bay DHB planning in Wairoa.

## Summary

The Wairoa District covers a large geographic area and, in comparison to its Hawke's Bay neighbours, has a small and declining population characterised by a higher density of Māori population and widening health inequities. For years Wairoa district has consistently been showing poorer health status across key national and local indicators.

The health status of the Wairoa population is well reflected in the rates of Ambulatory Sensitive Hospitalizations (ASH) measured through the key health indicators. Higher ASH rates are symptoms of poor timely access to quality health care services; poor health service co-ordination; lack of health service continuity; or a broader problem with the health system investment and commissioning<sup>1</sup>.

There are major gaps in health service coverage in addressing key health problems facing Wairoa population. Data from interviews with consumers/whānau and other key stakeholders revealed a number of challenges facing health service delivery and utilization in Wairoa which need to be addressed. These challenges are related to: health systems; health strategies and programmes; primary health care services delivery; access to services and quality of health services.

Based on the emerging themes from the analysis of the quantitative and qualitative data the report provides some tentative recommendations, aligned with the NZ Triple Aim Framework, to support the planning and design of the Wairoa health services.

---

<sup>1</sup> Hawke's Bay District Health Board Ambulatory Hospitalisation Rates 2010 - 2014



## MĀORI RELATIONSHIP BOARD

DHB Whānau Centric  
by George Mackey





**“There is a prevalence of unconscious systemic bias within the Hawkes Bay District Health Board that does a dis-service to Māori”.**

**Background**

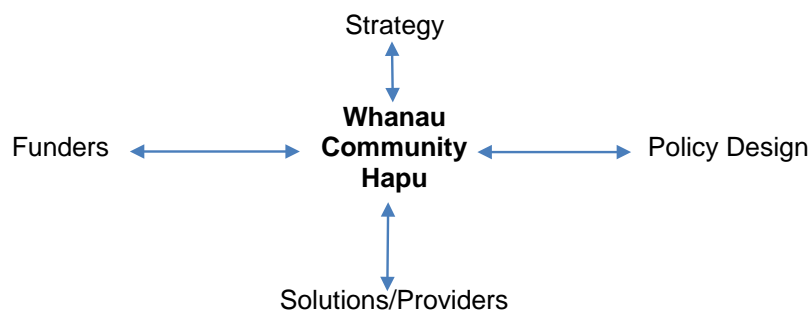
Health outcomes being achieved for Māori within the HB DHB region are improving however there are aspects of Māori health within Hawkes Bay that need urgent attention. This poses an exciting opportunity for improvement by making system changes around policy development and service delivery.

We can't expect to get different results by doing the same thing. There is a level of funder comfort by continuing to fund existing providers as they are seen as a 'safe pair of hands' and are familiar with reporting processes, even when results may not be hitting the mark.

The recently developed Obesity Strategy highlights serious concerns for Māori and Pacific Peoples living in Hawkes Bay which provides an opportunity to consider a different approach to dealing with this significant Māori and Pacifica health issue. It also highlights that current solutions are not achieving the desired results.

A whanau centric approach would see Māori whanau engaged in the development of the strategy, informing policy, defining outcomes and selecting/creating the solutions.

In simple diagrammatic form:



The Consumer & Clinical Councils along with MRB currently provide strategic advice and support to the DHB to ensure the view of the Hawkes Bay population is considered from strategy development and planning through to service delivery. There may now be an opportunity to create similar Councils that provide operational advice and support to DHB service teams.

The Population Health Team would then have a reference point for to test potential solutions before finalising service delivery models and potential providers.






## MĀORI RELATIONSHIP BOARD

PRESENTATION  
Transform and Sustain Refresh  
by Tim Evans, GM PIF



	<b>Health and Social Care Networks – Purpose and Principles</b>
	For the attention of: <b>Māori Relationship Board, Clinical and Consumer Council</b>
Document Owner:	Liz Stockley, GM Primary Care
Document Author(s):	Belinda Sleight, Project Manager Strategic Services
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Decision

## RECOMMENDATION

### That the Māori Relationship Board, Clinical and Consumer Council:

1. Review and endorse the purpose set out for the development of networks.
2. Review and endorse the principles against which networks will be developed.

16.1

## OVERVIEW

In February the Health and Social Care Networks Programme was presented to EMT, Clinical Council, Consumer Council, MRB, Priority Populations Committee (HHB) and the HBDHB Board, and in March 2016 to the Health Hawke's Bay Board and Clinical Advisory Group. In general, the vision and direction of the programme were supported by management and governance, with feedback given, particularly regarding health consumer involvement and the need to improve readability (essentially a request to better communicate the initiative as we roll it out).

This current paper seeks to more clearly articulate the purpose of a network (i.e. what a network is set up to achieve) and the principles by which each network will be designed and implemented.

## BACKGROUND

Under the umbrella of Transform and Sustain, the goals within the Primary and Community Strategic Health Care Framework (the framework) drafted in 2014 were set out to enable a primary and community health care sector that is:

- Well positioned to respond to the growth in demand from long term conditions and increasing numbers of older people
- Capable and has capacity to contribute to improving equity in access and outcomes
- Pulling together as a single system, so that people who use services find them seamless and easy to navigate.

The opportunities that are being targeted by the development of networks (why are we doing this) are:

- Collectively making a greater impact on health and well-being outcomes – especially for those most in need
- Redesigning services to be more appropriate and accessible to patients against defined outcomes that matter
- Ensuring services are delivered in the most appropriate setting

- Sustainability of services – ensuring resources are appropriately used, and fit to meet future population demands (such as aging and chronic disease)
- Supporting local clinical and consumer driven decision making
- Collectively raising standards of service to meet quality expectations
- Improving communications and the co-ordination between services
- Allowing us to do more with the resources we have.

### **NETWORK PURPOSE AND PRINCIPLES**

The purpose and design principles of Health and Social Care Networks are presented in the attached two-page document.

### **PREREQUISITES**

In order to successfully establish a series of networks, EMT recognises the need for the following:

- Support to identify what matters to communities
- Improved communication and collaboration between organisations and individuals in the health and social care communities
- Shared electronic care record and access to information at the right time for the care of the patient
- Review of facilities for each network – infrastructure may need to be developed
- Those involved in network development will need support and access to evidence about models of care that work and translate these into local services
- There is a culture of tolerance for not getting things right the first time, provided those mistakes are learned from

### **RECOMMENDATION**

EMT is being asked to do two specific things:

1. Review and endorse the purpose for the development of networks.
2. Review and endorse the principles against which networks will be developed.

## Health and Social Care Networks

### Vision

Consumers accessing a wide range of coordinated services closer to home.

### Purpose

To empower and support people to keep themselves and their whānau well

To ensure services are well co-ordinated and aligned to local need

To eliminate population inequities experienced by groups within our communities

To provide sustainably for today whilst preparing to meet future demands

To enable care as close to home as possible


### What does success look like? A phased approach

Phase One 2016-2018	Phase Two 2018-2020	Long Term 2020-
<ul style="list-style-type: none"> <li>• More health services are community-based within appropriate geographic networks</li> <li>• Communities are engaged</li> <li>• Providers are collaborating</li> <li>• Primary care models of care are developed</li> <li>• Services focused on appropriateness and access</li> <li>• Tools and infrastructure development underway</li> <li>• Individuals and whānau decide care plans</li> </ul>	<ul style="list-style-type: none"> <li>• Health and social care providers work together</li> <li>• Primary care workforce is more sustainable</li> <li>• Scopes of practice have increased in the community</li> <li>• All appropriate services are delivered in community</li> <li>• Individuals more engaged with care</li> <li>• Whole workforce is culturally responsive</li> <li>• Individuals are health literate and can access services as and when they need</li> </ul>	<ul style="list-style-type: none"> <li>• Local governance frameworks are established</li> <li>• Shared funding pools exist across health and social budgets</li> <li>• Co-design is used to redesign services</li> <li>• Voluntary services are included</li> <li>• More community involvement in health and social care</li> <li>• Community drives agenda and priorities</li> <li>• Community ownership of some services</li> <li>• Individuals and whānau drive their whole health journey</li> </ul>
What this looks like for consumers (examples)		
<p>Consumers are working with providers to develop and implement a plan to improve community wellness.</p> <p>People with complex conditions have a care plan, developed by them, their whānau, and the professionals that support them.</p> <p>It is easy to book an appointment online or by phone, and appointments are available when needed.</p>	<p>People are able to self-manage because they are supported, can understand health information, and know who to ask for help when they need it.</p> <p>Fewer trips to hospital are required as more services are available close to home.</p> <p>People don't repeatedly explain their symptoms or history because providers can access this information.</p>	<p>Services are linked up so that a person seeking help for a medical issue will also be offered assistance to improve other aspects of their health and wellness, including the socio-economic determinants of health.</p> <p>Health and social care is under the leadership of a community-owned and directed organisation; people can easily have their say and get involved.</p>

## Design principles

Network Structure	Focus	Governance and decision making	Service
<p>Networks are geographic-based, however cross-boundary service provision is also allowed where this is existing or makes sense to develop.</p> <p>Led by a Network Leadership Team, consisting of consumer, provider and funder stakeholders, which is the key conduit between the sector, the network and the community.</p> <p>Each network will be supported by a lean management and administration team.</p> <p>Network drivers are determined by consumers, providers, and sector advisors.</p> <p>The population is supported by effective and efficient delivery of services: providers may be internal or external (e.g. visiting services).</p> <p>Provider-partners include, but are not limited to, general practice, Māori providers, NGOs, voluntary, and broader public sector organisations (i.e. inter-sectoral).</p> <p>Network partners will work as an integrated, cohesive whole, within a high-trust environment; not just co-location.</p>	<p>Focusing on prevention, early intervention, and self-management.</p> <p>Strengthening resilience of individuals, whānau, and communities (supported by clinical and organisational expertise).</p> <p>Promoting sustainable practices: resources, funding, and workforce.</p> <p>Promoting health literacy – consumers and providers speaking a shared language.</p> <p>Utilising the skills sets and passion that sits within the network (working on principles of sustainability), seeking out champions to spearhead action (enablement and empowerment).</p> <p>The network will reflect the Treaty principles of partnership, protection and participation.</p> <p>Eliminating health inequity is a central focus of all network operations; this will be reflected in the KPIs developed to report on and monitor impact across the triple aim dimensions.</p> <p>Networks will commit to continuously improving quality, shared learning, and effective change management.</p>	<p>The Network Leadership Team (or Alliance) will be responsible to the community and DHB for agreed outcomes.</p> <p>The Leadership Team will initially recommend approaches and activities to the DHB for implementation. As expertise and experience is built, the Team will gain further operational control and exert greater influence across the health sector.</p> <p>Partners will align with the overall vision, and must be willing to develop their services to contribute to collaborative models (work with the willing).</p> <p>Each network will link directly with the community it serves to define outcomes that matter.</p> <p>Membership will include consumers, clinicians, sector leadership, and community leaders.</p> <p>Input from the health and social care sectors will provide advice to the Network Leadership Team.</p> <p>Leadership will be legitimised by meaningful provider engagement and partnership with consumers.</p>	<p>The network understands the needs of the local community and reflects this through the services it provides (a population health approach).</p> <p>Services must be accessible to the community and be evidence based and outcomes focused.</p> <p>Services will be provided by the most appropriate provider (e.g. clinician, allied health or social care professional, community volunteer), in the most appropriate place and at the right time for the consumer or whānau.</p> <p>Where appropriate, services will be multi-disciplined and integrated vertically and horizontally across health and social care / community sectors.</p> <p>Quality of services will be standardised, delivery will be locally tailored to each network as appropriate.</p> <p>Data will be used to stratify consumers in each practice so that proactive, relevant interactions promote wellness, and prevent illness.</p> <p>Technology will be utilised to augment and expand the services available by more traditional means.</p>



	<b>Health and Social Care Networks – Geographic localities proposal</b>
	For the attention of: <b>Māori Relationship Board, Clinical and Consumer Council</b>
Document Owner:	Liz Stockley
Document Author(s):	Belinda Sleight
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For Decision

**RECOMMENDATION**

**That the Māori Relationship Board, Clinical and Consumer Council:**

1. Review and endorse the proposed basis for network localities.

**16.2****OVERVIEW**

The Health and Social Care Networks programme will cluster community-based health and social services that serve a geographically defined location. The purpose of which is to promote and support; collaboration, information sharing and joint initiatives to enable better health outcomes for the population.

Four such networks are proposed across Hawke's Bay; one for each of Wairoa, Napier, Hastings, and Central Hawke's Bay. The geographic boundaries for the networks will be those of the territorial authorities (District and City Councils).

This approach builds upon the existing sense of community that is apparent in Hawke's Bay, a region which recently confirmed the continuing relevance of its four-district structure. We will work with each network locality to determine local priorities, including working with the two larger urban localities to identify areas of interest/need in which to focus specific actions with smaller, more targeted stakeholder sub-groups (e.g. youth health, mental health).

Work to establish networks will be staggered, such that we learn from the early adopters. Wairoa will be the first network to set up, as it is the locality in which the population is most ready and willing to engage. Progress in each locality will also proceed at different rates, again depending on stakeholder readiness. For example, in Central Hawke's Bay, we are proposing to set up a network, but will not establish a leadership structure until some collaborative projects and priority setting activities have built the relationships and trust in that community. For Napier and Hastings, we consider that the network structure will have merits for these larger localities, but we will delay the start of establishment activities until we have crystallised the learnings from the rural –based networks and can see that expected benefits are being achieved.

**BACKGROUND**

In February, we presented a proposal to establish a series of networks, consisting of services that collaborate (are joined up) to provide care for patients that they have in common. The intent of these

networks is to facilitate the coordinated and collaborative activity that is necessary to achieve our vision. The direction of travel signalled by this proposal was supported by EMT and the various governance groups.

In this paper, we are further defining key aspect of the networks, that is, the geographic area encompassed in each. Governance feedback on the previous paper has been incorporated into this document.

## PROPOSAL – FOUR NETWORKS

*Wairoa and Central Hawke's Bay (CHB)* – for both of these districts, rurality and relative isolation are defining features which set them apart from the urban areas and tend to shape the concerns of community members (e.g. transport issues, lack of locally-available services, population decline). From discussions with stakeholders in each location, it is clear that a sense of community readiness exists in Wairoa, whereas in Central Hawke's Bay a range of shared priorities for change is emerging.

- *Wairoa*: 7,890 population (2013 census); ~7,676 enrolled with general practices located in Wairoa, ~184 enrolled elsewhere.
- *Central Hawke's Bay*: 12,720 population (2013 census; a June 2015 estimate suggests 13,450); ~10,717 enrolled with general practices located in Waipukurau and Waipawa, ~2,241 enrolled elsewhere.

*Hastings and Napier* – Initial discussions regarding Health and Social Care Networks indicated that these urban areas could be divided up based on general practice locations, much like the clusters developed for the EngAGE initiative currently being rolled out. However, the wider scope of the networks initiative, which is envisioned to incorporate health and wellness providers across a range of organisations and contracts, suggests that a simpler overarching structure would better serve the stakeholders involved. In particular:

- **Strategic partnerships**: the health and social care networks initiative seeks to build collaboration across health services, Ministry of Social Development (MSD) - funded social services, WINZ, CYFS, some services of the justice and education sectors, related NGOs, and various council initiatives (e.g. community and business development activities). Many of these organisations base their operations on territorial authority boundaries and/or have strong links with their relevant District or City Council. Using the territorial authority model will also facilitate integrated action by the Hawke's Bay Intersectoral Leadership Group, currently consisting of health, MSD and council leaders.
- **Secondary services delivered in the community**: a number of secondary services are delivered in the community, and we want to preserve the way workloads are currently divided across team members, as this brings consistency for patients and primary care staff who gain assistance or interact with these services. Most services pursue a geographic division of workloads, with the Wairoa/Napier/Hastings/ Central Hawke's Bay groups being most common (see Appendix 1).
- **Building collaboration cross general practices** is likely to be challenging, as they are private businesses competing for customers (enrolled patients). Therefore, it makes sense to build upon existing relationships where these exist. For example, in Napier, the provision of after-hours services is an example of city-wide coordination/collaboration.
- **Splitting each urban area into smaller localities** would potentially require assigning to different networks the separate branches of a multi-location practice (e.g. The Doctors Napier and The Doctors Greenmeadows). This is likely to cause difficulties if each network requires of the individual branches different service specifications or funding models in response to the needs of their local population.
- Within the Napier and Hastings networks, we propose to encourage formation of 'communities of interest' that wrap services around particular consumer groups. For example, a 'neighbourhood alliance' of local providers and the community could work together to achieve the specific aspirations of people living in Camberley and Flaxmere. Providers with

specific expertise could work with consumers to develop 'centres of excellence' for a condition or life stage; the multi-disciplinary EngAGE clusters are prototypes of this model focusing on improving outcomes for older people. A number of whānau or hapu could work with community providers to develop a wellness approach that incorporates their kaupapa.

- The larger network geographies could better support professional development via mentoring and secondment activities between providers in the network. Some clinicians had voiced concern for colleagues working in the relative isolation of a few general practices within the smaller network geography model.
- Averaging across the urban practices, around 13% of the enrolled population lives greater than 10km (as the crow flies) from their practice<sup>1</sup>. Defining smaller network geographies makes it more likely that these people will live outside of the area in which services collaborating and sharing information with that practice will be focused.
- *Napier*: 57,240 population (2013 census)
- *Hastings*: 73,245 population (2013 census)

## Issues

As with any mechanism for defining network geographies, the four-locality model does not solve all issues, and brings forth others. As we establish the networks, we need to be aware of the following:

- There will still be some people resident in one locality but enrolled at a practice elsewhere; this could potentially lead to a situation in which they gain services from two networks. For example, a person living in Wairoa may habitually visit a general practice that is close to their workplace in Napier however, for other services (e.g. district nursing or a budget advisor meeting with the family as a group) the Wairoa network would be better placed to help. We need to understand how these inter-network interactions would work, including any flow of funding that is needed to support the right service/right place approach for these people.
- The four locality model still requires the splitting of The Doctors Hastings across two networks (Hastings and Central Hawke's Bay).
- Each network may need an 'anchor' location that acts as a focal point and at which a wide range of services and providers may be accessed. Similar to the South Central Foundation's Nuka headquarters at Anchorage, or Counties Manukau's 'super centres', Wairoa has the IFHC, and the Napier and Central Hawke's Bay Health Centres could act as hubs for each of these networks. We need to consider the options for Hastings, particularly now that the "Kauri" initiative is no longer progressing.
- Community of interest activities could potentially add complexity to network management and operations; any such initiatives would need to be written into business plans and budgets of the wider network as part of the annual and forecast planning. A range of network structures could facilitate these initiatives and options need to be considered by the DHB (Ken Foote's expertise).
- Community of interest activities must not result in inequities between networks (we need to ensure the same quality and availability of services to avoid 'poorer' networks).

## RECOMMENDATION

That EMT:

1. Review and endorse the proposed basis for network localities.

1. Information supplied by Adrian Rasmussen, Health Intelligence Team, Health Hawke's Bay.

## APPENDIX 1

Division of workloads across team members – secondary services delivered in the community

Service	Alignment structure	Notes
Respiratory services, pulmonary rehabilitation, Māori health, cardiac rehabilitation, physiotherapy, occupational therapy, child development services	Four clusters (Wairoa, Napier, Hastings (incl. Havelock North), and Central Hawke's Bay).	Some specialists work across all four clusters. Education-based services may be only offered online to Wairoa and CHB residents.
Dieticians, speech-language therapy (SLT)	Two clusters (Wairoa and Napier / Hastings and Central Hawke's Bay).	SLTs cycle between community and hospital-based work to ensure skills currency. Also practice-based dieticians at Totara Health.
EngAGE	Six clusters, three in each of Hastings and Napier. Central HB and Wairoa not covered currently.	Roll out to Wairoa and Central HB would involve one cluster in each area.
District nursing	Four clusters (Wairoa/Napier/Hastings/CHB), but the urban ones are each split into three sub-clusters, with multiple staff (nurses and assistants) covering each.	Napier cluster split as per EngAGE although Napier Central locality is too big to service; Hastings cluster split Hastings Health Centre; Totara Health plus Havelock North; rest of Hastings.
Ostomy service, continence service, antenatal, neonatal (nurses and social workers)	Small number of staff and FTEs cover all of Hawke's Bay.	
Social work	Mix of general practice employees working in specific practices and DHB employees working broadly across Hawke's Bay. Wairoa and Central Hawke's Bay have dedicated DHB staff domiciled in those localities.	General practice employees work with practice only (e.g. HHC). Māori Health social worker (DHB employee) works across four practices. Other DHB social workers tend to support specialist areas (e.g. renal, cancer, paediatrics).
Clinical pharmacy	Linked to individual practices, but groupings are likely to follow EngAGE cluster format.	One staff member is currently positioned across two engAGE clusters; likely to be several pharmacists associated with each cluster, especially where these include large practices.
Diabetes service	No clear geographic approach.	Six Diabetes CNS are active across Hawke's Bay.



## **Business Case**

### **Health and Social Care Networks Phase One**

**16.3**

**June 2016**

**Prepared by Belinda Sleight  
Project Manager, Strategic Services**

## Table of Contents

<b>1.0 EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>2.0 PURPOSE .....</b>	<b>4</b>
<b>3.0 BACKGROUND .....</b>	<b>4</b>
<b>4.0 SITUATIONAL ANALYSIS .....</b>	<b>4</b>
4.1 <i>Current Situation / Problem .....</i>	4
4.2 <i>Requirements to be met by this project .....</i>	5
4.3 <i>Stakeholders Requirements .....</i>	6
4.4 <i>Strategic Alignment .....</i>	7
<b>5.0 OPTIONS ANALYSIS .....</b>	<b>7</b>
5.1 <i>Funding an Existing Initiative .....</i>	7
<b>6.0 PROPOSAL RELATED TO IMPLEMENTING THE RECOMMENDED OPTION.....</b>	<b>7</b>
6.1 <i>Objectives .....</i>	7
6.2 <i>Benefits .....</i>	8
6.3 <i>Assumptions .....</i>	8
6.4 <i>Business Impact .....</i>	8
6.5 <i>Approach .....</i>	9
6.6 <i>Estimated Timeline (Stage One, Phase One) .....</i>	10
6.7 <i>Interrelated Projects .....</i>	10
6.8 <i>Risk Analysis .....</i>	11
6.9 <i>Financing the Project .....</i>	11
6.10 <i>Next Steps .....</i>	12
<b>APPENDICES .....</b>	<b>13</b>

## 1.0 EXECUTIVE SUMMARY

This business case recommends that a budget of \$130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers. The purpose of these networks is to provide holistic, joined up care focused on patients/consumers and their family/whānau as partners in their health journeys.

Currently, the health system in Hawke's Bay is not well positioned to respond to emerging challenges and, therefore, we need to design new ways of working that will enable care that is person-centered, sustainable, and effective. Particular challenges include providing care for the growing number of frail older people and those people living with complex long term conditions. Further effort is required to deliver equitable outcomes or access to services for Māori and Pacific populations, and those who are unable to afford, access or navigate the health sector.

The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in a range of health governance, management and community forums, and there is now support for networks as a change vehicle under the auspices of Transform and Sustain strategic framework. A programme team is now developing overarching principles by which the networks will be designed, and is working with providers and service users in two early-adopter communities to scope projects that will establish networks in their communities.

Key benefits of the programme include:

- Consumers and their families/whānau get the assistance they need from the right person, right time, right setting.
- Closing gaps between services so that people experience joined up care – not having to explain history to each provider, being able to group interventions to single visits, a holistic approach to wellness that addresses health and the social determinants to health.
- Redesigning services so that they suit consumers and are able to be provided sustainably. Also moving services into the community where they are closer to where people live.
- Building upon existing community strengths; not just current services and infrastructure, but also community spirit, individuals with influence and local knowledge.

Sustainable service provision is a key principle of this programme and, therefore, the focus is on lean managerial structures and redesigning services that fit within current budgets despite the growing demand. This funding will support change leadership, stakeholder engagement and input required for a collaborative community-up programme, and seed funding towards the early activities (initial small collaborative projects that will deliver quick wins and buy-in to the collaborative process). The intention is not to build permanent cost increases into the sector, but to work with what we have in more effective and creative ways.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. It is also an opportunity to revitalise our sector and increase sustainability through service affordability, infrastructure and workforce. This collaborative environment will be challenging as it will require us to work differently, listening to diverse points of view, building and delivering a shared vision (future state) and devolving decision making. This will not happen in one step- we will take a staged approach and build capability within the networks so that the DHB, PHO have confidence in their contractual partners.

## 2.0 PURPOSE

This business case recommends a budget of \$130,000 p.a. be approved to support establishment of collaborating networks of health and social service care providers (termed 'Health and Social Care Networks'). The paper is presented to Executive Management and Clinical Council for approval and release of funds.

## 3.0 BACKGROUND

In December 2013, the Hawke's Bay health sector released *Transform and Sustain*, which set a strategic direction for health service provision over the next five years. In *Key Intention 8 Transforming Primary Care*, the strategy describes a need to redesign primary and community services so that they become fully integrated, provide care closer to the person's home and are able to provide higher quality through more expansive services. Subsequently, a strategic framework *Transforming Primary and Community Health Care in Hawke's Bay* was developed, in which the concept of clustered service provision and collaboration across providers was first presented.

A Steering Group of senior DHB and PHO management and clinicians, has since spent approximately six months developing the network concept and determining how it could be implemented. Related projects and activities have also begun, that have informed the Group's thinking. These include:

- The HBDHB Health Services Directorates considered services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka).
- The Hastings Health Centre and Totara Health joint development included a survey of community requirements, and engaged consumers in consideration of the general practice model of care. Whilst the joint development will now not go ahead, learnings will inform the programme regarding consumer requirements and also how to gain consumer viewpoints.
- The key Wairoa providers are now meeting regularly and have agreed to work together to improve population outcomes. A community meeting in March has solidified support for a network, and a leadership group is now being formed.
- Several stakeholder meetings in Central Hawke's Bay have resulted in a collective of provider and consumer representatives that is now meeting regularly to prioritise service development.
- The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialling networks of services in Napier and Hastings. Lessons will be learned from these.
- The DHB and PHO are currently considering how primary care infrastructure should be developed. A single shared care record will be a priority and some research has been undertaken for solutions that may work in Hawke's Bay.
- Training courses in co-design and quality improvement, plus ongoing work by QIPS staff, are increasingly focusing on collaborative models and tools for service redesign.

We are now seeking to identify and secure funding to support a coordinated programme of work that will bring together the learnings and facilitate change projects. This budget will consist of new investment, business as usual, and redirection of existing spend, plus cash and in-kind contributions from other organisations as partners with us in the networks.

## 4.0 SITUATIONAL ANALYSIS

### 4.1 Current Situation / Problem

The health system in Hawke's Bay, like 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.

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.

We have proposed to establish a number of networks of collaborating health and social care services that are clustered around geographical communities that work closely together to care for patients that they have in common. Implementation of this proposal 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.

A programme of work is now underway, using a phased approach that will enable us to learn as we go and work with those communities and stakeholders that are most ready to engage. Initially the 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 is 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.

16.3

#### **4.2 Requirements to be met by this project**

Key requirements of Phase One are:

- The DHB, Health Hawke's Bay and each community will have a shared view of the outcomes required of networks and how we will achieve them. This will involve an agreed 'standard' approach to network development, and appropriate tailoring to fit population needs.
- A variety of channels will be in place for stakeholder engagement, and stakeholders (providers and consumers) are co-design partners in vision, planning, service redesign and delivery.
- The communities of Wairoa and Central Hawke's Bay are supported to establish the first Health and Social Care Networks. This includes channelling resources into the networks and developing tools to assist establishment and operation.
- A range of organisations providing services that impact health or the social determinants of health (e.g. education, justice) will be partners in the networks. These organisations will increasingly commit resources to the collaborative networks.
- Progress towards a collaborative environment – a model of care that supports self-care, multidisciplinary teams working with people and families with complex needs, sharing of information across providers to facilitate joined-up care.

#### **High-level time line**

In Phase One of the programme (2016-2018) we will:

1. Background work – review examples of good practice from other places to avoid reinventing the wheel; align various projects, existing and new initiatives; review services and considering the most appropriate delivery models; review systems and processes to reflect the collaborative working environment; develop a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay.
2. Establish a network in Wairoa
3. Motivate collaboration in Central Hawke's Bay

4. Support the identification of sensible network groupings in Napier and Hastings
5. Initiate the development of the technology platform in primary care.

Each of the 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.

#### **What success will look like?**

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 evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whānau with complex health and social needs.
- General practice clinicians have the time to work with patients who need it. Patients at risk are proactively identified and supported.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise.
- Technology and information is increasingly used for joined up service delivery and to support self-management.
- 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.

#### **4.3 Stakeholders Requirements**

Stakeholders grouped as:

Health Consumers / community: This project must deliver better access to a comprehensive range of health services that are joined up, so that health and socio-economic determinants of health are approached holistically. The work must focus on health equity across our population, as significant groups (particularly Maori) are over-represented in our poor health statistics. Tackling these issues must include working with the people (individuals, family/whānau, communities) to design and deliver services that work for them and address the things that matter to them.

Providers of health and social care (primary and secondary health care, community social care): This project must enable providers of health and social care to innovate, so that they are able to better provide for the current needs of our population and anticipate and respond to expected future requirements. We must work with providers to effect sustainable change.

Funders: This stakeholder group requires ways of meeting increasing demand for health care within an environment of constrained budgets. This means that networks must be robust vehicles for change that will deliver the required outcomes in a sustainable manner. To this end, we have designed a staged approach, in which responsibility (devolved decision making) will be stepped up as networks gain experience in managing and commissioning services.

First-mover networks: These communities each have a core group of people (providers and consumers) who recognise that change is needed and who are willing to engage in the change process, albeit to varying extents. These communities (individuals, groups) require support such as managerial expertise, seed funding, tools and systems for collaboration.

#### 4.4 Strategic Alignment

The programme has been established under the auspices of Transform and Sustain, particularly contributing to *Key Intention 8: Transforming primary health care*, and *Key Intention 7 Transforming through integration of rural services*. It has been designed to implement the *Transforming Primary and Community Health Care in Hawke's Bay Strategy*.

To deliver outcomes across the three health triple aim dimensions, the programme will:

- Use a population health approach to identify the needs and aspirations of each community, then design and deliver services that are tailored to meet those requirements.
- Work with health consumers to ensure that services are co-designed to meet their needs, both in terms of the type of care available (the services offered), and also the approach to care (e.g. the model of care).
- Develop and enable smarter working within available funding levels.

The programme is broadly aligns with initiatives and strategic directions nationally. Aspects will be informed by activities achieved by other DHBs – for example, the locality-based grouping of services from Counties Manukau, progressive general practice models of care led by Midlands, and the focus on data and information sharing from Canterbury. The programme's focus on joining up health and social care anticipated the recently refreshed Health Strategy's call for better alignment and collaboration for services working across health and the social determinants of health.

16.3

## 5.0 OPTIONS ANALYSIS

### 5.1 Funding an Existing Initiative

This business case has been developed to support a funding allocation for an existing initiative.

Options for funding the initiative include using business as usual funds, redirecting existing spend, and identifying other sources of funding (particularly cash and in-kind support from potential or actual network partners). We will use each of these sources for various parts of the work programme. However, as there is considerable project-based work to be done, we are requesting investment to support the early-stage innovation and community engagement aspects.

## 6.0 PROPOSAL RELATED TO IMPLEMENTING THE RECOMMENDED OPTION

### 6.1 Objectives

The objective of this programme is to support services to work collaboratively across the health and social care spectrum to cluster existing services around geographical communities and to reshape services so that:

- 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 and community groups
- 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.

**6.2 Benefits**

Benefit	Value or Measure
Delivering more health services in the community	Consumer satisfaction from improved access Multi-disciplinary teams are in place to work with people with complex needs
Services are working collaboratively with other organisations across health and social care	Providers find it easy to refer clients to other relevant services across health and social determinants of health
People find it easy to identify and access the help they need	There are improvements in health outcomes and equity of health outcomes because assistance is holistic and there are less gaps to fall through
Improved sustainability of the primary care workforce	Better staff satisfaction Greater variety of 'generalist' roles that help people navigate services Clinicians have more time available to work with those people who need it most
Technology and information is used effectively to support new ways of working	Greater use of technology for accessing expertise (e.g. teleconference FSAs) Individuals and families/whānau are risk stratified and offered help proactively
Sector-wide improvement in which providers and communities are pulling in the same direction towards improved wellness and equitable health outcomes	Communities are actively engaged in prioritising, planning and delivering wellness initiatives Providers are sharing information that enables holistic, timely intervention and assistance across health and social determinants of health

**6.3 Assumptions**

1. This is the first phase in a series of activities which will result in establishment of health and social care networks in Hawke's Bay. This is a long term (5+ years) programme of work.
2. The DHB and PHO are philosophically willing to change and are willing to embrace a process of co-design to effect that change.
3. This programme will affect a number of existing projects, initiatives and business-as-usual; these will need to align with the change direction established by this programme.
4. We will work with stakeholders to confirm requirements and relevant models for Hawke's Bay Health and Social Care Networks that empower each community; whilst there will be a 'minimum standard' of requirements (e.g. services offered, reporting requirements) to meet sector and national expectations, tailoring to fit the needs of the locality is a key principle of this initiative.

**6.4 Business Impact**

Successful implementation of the programme as a whole will have wide-ranging effects across the DHB as a business unit and the health and social care sectors. It will also impact other sectors that provide services that contribute to health and wellness (e.g. education, justice).

Business Management: review of a range of business processes to ensure that they are aligned with collaborative actions. Examples could be those processes used for contracting, human resources planning and recruitment, and budget allocation

**People and human resources:** movement of service delivery into the community setting, seven-day services, working at top of scope, recruitment of more 'generalists' and enabling roles (case managers, social workers, behaviourists, navigators, primary care assistants). Many of these would be associated with general practice rather than within the hospital/DHB remit, but interacting with the broader range of 'health care professionals' will become normal.

**Infrastructure and operation support:** A focus on community service delivery/care closer to home and information sharing will create the need for investment in infrastructure, particularly IT tools for collaboration.

**Consequential:** it is possible that the proposed proactive identification of people at risk may increase demand for services in the short-to-medium term. The programme's premise is that earlier intervention will decrease demand for higher-acuity services, however it may take some time to achieve this state.

### 6.5 Approach

This is a programme of work involving a number of projects, namely the high-level design of a standard network configuration (the "Core Network Expertise" project) plus network establishment projects in each of the localities (four in total). Additional work will centre on better aligning primary care IT (patient management systems) with collaborative activity.

The overall programme is summarised in the diagram below; this business case relates to **Phase One** activities, broken into two stages aligned to the planning calendar as follows:

1. Stage One: Jan 2016 – June 2017 (18 months)
2. Stage Two: July 2017 – June 2018 (one year)

The focus of Phase One will be to cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGOs and voluntary organisations in the concept of community networks. We will begin with health services and social care providers that are ready to act, and will invite other community partners to also review their services through an aligned approach.

Phase One 2016-2018	Progress 2018-2020	Long Term 2020 -
<ul style="list-style-type: none"> <li>• More health services community based within appropriate geographic networks</li> <li>• Communities are engaged</li> <li>• Providers are collaborating</li> <li>• Primary care models of care are developed</li> <li>• Services focused on appropriateness and access</li> <li>• Tools and infrastructure development underway</li> <li>• Individuals and Whānau decide care plans</li> </ul>	<ul style="list-style-type: none"> <li>• Health and social care providers work together</li> <li>• Primary care workforce is more sustainable</li> <li>• Scopes of practice have increased in the community</li> <li>• All appropriate services are delivered in community</li> <li>• Individuals more engaged with care</li> <li>• Whole workforce is culturally responsive</li> <li>• Individuals are health literate and can access services as and when they need</li> </ul>	<ul style="list-style-type: none"> <li>• Local governance frameworks are established</li> <li>• Shared funding pools exist across health and social budgets</li> <li>• Co-design of services</li> <li>• Voluntary services are included</li> <li>• More community involvement in health and social care</li> <li>• Community drives agenda and priorities</li> <li>• Community ownership of some services</li> <li>• Individuals and Whānau drive whole health journey</li> </ul>

**6.6 Estimated Timeline (Stage One, Phase One)**

High Level Milestone	Finish Date
<b>1. Programme Start up and planning</b> <ul style="list-style-type: none"> <li>Project Manager appointment / TOR signed off/ Steering Group established</li> <li>Stakeholder analysis and Comms Plan/ Website completed</li> <li>Project Planning documentation created: Risk Plan, Benefits Plan; Quality Plan; Project Budget</li> <li>Project Plan acceptance</li> </ul>	March – April 2016
<b>2. Core Network Expertise Project: Project Management</b> <ul style="list-style-type: none"> <li>Agree TOR – Establish project groups – communication plan etc.</li> <li>Engagement and communication with Stakeholders</li> <li>Complete work required and confirm acceptability of deliverables / Monitor and demonstrate benefits</li> <li>Project closure including Project Completion Evaluation</li> </ul>	Mar – Sep 2016
<b>3. Establishing a network project in Wairoa</b>	Jul – Dec 2016
<b>4. Motivating collaboration in Central Hawke's Bay</b>	March – Dec 2016
<b>5. Supporting the identification of sensible network groupings in Napier and Hastings</b>	Aug – Dec 2016
<b>6. Initiating the development of the technology platform in primary care.</b>	March – Dec 2016
<b>7. Review work to date and develop plan for Jan – Dec 2017.</b>	Nov 16 – Jan 17
<b>8. Complete Work as outlined in plan for Jan – Dec 2017.</b>	Jan – Dec 2017
<b>9. Phase Close - Next Phase Plan</b> Review work to date and develop / approve next steps action plan e.g. programme completion evaluation or refreshed TOR	Oct – Dec 2017

**6.7 Interrelated Projects**

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	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 Care	PHO project to develop a centre of knowledge regarding general practice models of care. Will inform and assist general practices

**6.8 Risk Analysis**

<b>Risk</b>	<b>Risk Mitigation Approach</b>
Lack of primary care engagement	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	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	Ensure there are ways to gather the consumer voice in each locality. Ensure that there is good consumer representation on the Stakeholder Group; this group must be representative of our population and/or have strong networks into our population.
Project, programme and change fatigue	Communicate the vision and engage stakeholders at an early stage so that they own the solutions.
Scale of what we're trying to achieve	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	Adequately resource the project (staff time, cash) 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)	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.
Governance of networks; how do we account for them?	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)	Project Manager to get a good understanding of results from other projects, and synthesise the lessons.

**6.9 Financing the Project**

The requested funding allocation of \$130,000 will be used to support (a) across-programme enablers and (b) specific activities within the network establishment projects. An indicative budget of Phase One (covering two years) is presented below.

	2016/17	2017/18
<b>Programme enablers</b>		
Consumer engagement tools	\$ 15,000	\$ 15,000
Communications, meeting costs, travel	\$ 15,000	\$ 15,000
<b>Wairoa establishment</b>		
Backfill / project lead	\$ 50,000	\$ 50,000
Meeting costs (e.g. koha, facilitation, catering)	\$ 5,000	\$ 5,000
Initial projects/ quick wins	\$ 20,000	\$ 20,000
<b>Central Hawke's Bay establishment</b>		
Meeting costs (e.g. koha, facilitation, catering)	\$ 5,000	\$ 5,000
Initial projects/ quick wins	\$ 20,000	\$ 20,000
<b>Napier establishment</b>		
Meeting costs (e.g. koha, facilitation, catering)		\$ 5,000
Initial projects/ quick wins		\$ 20,000
<b>Hastings establishment</b>		
Meeting costs (e.g. koha, facilitation, catering)		\$ 5,000
Initial projects/ quick wins		\$ 20,000
	<b>\$ 130,000</b>	<b>\$ 180,000</b>

## Assumptions/notes:

- All other costs associated with this programme will be met by redirection of existing spend (including staff) into the networks.
- We propose to second 0.5 FTE to act as Wairoa change leader for the establishment phase. This commitment is proposed 2 years (24 months), beginning as soon as possible. A position description for the Change Leader role is attached (Appendix 1); responsibility for the backfill position resides with the Acting Service Director Rural Oral & Community.
- Direct employment costs of staff involved in the programme will be covered from existing budgets and redirection of resources.
- In year 2, we will cover the additional spend either through further redirection of resources or a further investment bid.

**6.10 Next Steps**

The next steps for implementation include:

- Recruiting back-fill for the Wairoa Integrated Family Health Centre Manager, so that resource is available for leading Network establishment activities.
- Establishing Network Leadership teams in each of Central Hawke's Bay and Wairoa, to lead the early-stage activities (e.g. identifying priorities, analysing data (needs/gaps and strengths/assets), community engagement, shared locality-based vision and values).
- Establishing various stakeholder groups as required by the community (this may be a provider group, a consumer liaison group, special interest groups (e.g. youth health collective); these groups will inform priorities for action, will be key channels for communication with stakeholders, and will be partners in co-design activities.



## APPENDICES

### Appendix 1: Position Profile – Wairoa Network Establishment Change Leader



#### Hawke's Bay District Health Board Position Profile / Terms & Conditions

<b>Position holder (title)</b>	Wairoa Network Establishment Change Leader 0.5 FTE for 2 years
<b>Reports to (title)</b>	Head of Strategic Services Work plan accountability to Wairoa Network Leadership Team
<b>Department / Service</b>	Strategic Services; Planning, Informatics and Finance
<b>Purpose of the position</b>	<ul style="list-style-type: none"> <li>To use relationship, motivation and negotiation skills to build trust between stakeholders and drive change within the health and social care sectors that serve the Wairoa community.</li> <li>To lead and project manage transformational change projects, including the planning, delegating, monitoring, and motivating functions, to achieve the required outcomes and benefits within the expected targets for time, cost, and quality.</li> <li>To lead the development of the leadership model and programme plan that will set up and implement a Health and Social Care Network for Wairoa.</li> <li>To recognise and support the Transform and Sustain Strategy by delivering real change in service delivery in Wairoa, through innovative leadership, business model development, and models of care that will improve health and wellness outcomes for the population. This work in Wairoa will directly inform the design and implementation of similar models across Hawke's Bay.</li> <li>To embed across Wairoa's health sector providers a culture of person and whānau centred care as per the agreed model of care and business model.</li> <li>To build and maintain relationships across the stakeholder community, including consumers, providers and funders, ensuring that stakeholder partnership is central to all redesign efforts, identification of priorities, and decision making.</li> <li>To work intersectorally, being recognised as a leader of positive transformation across a range of sectors and organisations that impact health and wellness; examples are social care, education, and justice sectors, iwi groups, and community groups (NGOs, churches, etc).</li> </ul>

16.3

## Working Relationships

Internal	External
<ul style="list-style-type: none"> <li>▪ Chief Executive Officer</li> <li>▪ Chief Operating Officer</li> <li>▪ Company Secretary</li> <li>▪ HBDHB and Health Hawke's Bay leadership teams as sponsoring groups for the project.</li> <li>▪ Health and Social Care Programme Manager</li> <li>▪ Project sponsors, steering committees and stakeholders</li> <li>▪ HBDHB Programme Management Office Manager</li> <li>▪ Project Support service staff including: Finance, Quality and Patient Safety, Communications, Information Services, Business Intelligence; Facilities, Procurement, Planning, Strategic Services, Consumer groups, Human Resources</li> <li>▪ Māori Health</li> <li>▪ Committees, teams and groups involved in the governance of the health sector &amp; related Project Managers (DN GP Alignment; Urgent Care; engAGE; Clinical Pharmacy Facilitators; Patient Experience)</li> <li>▪ Wairoa Health Centre</li> </ul>	<ul style="list-style-type: none"> <li>▪ Wairoa Network Leadership Group</li> <li>▪ Wairoa project team members and support resources</li> <li>▪ Stakeholders of the development of Health and Social Care Networks, specifically general practice teams, Māori and other community providers, rangatahi advisory group, whānau and the community.</li> <li>▪ Taiwhenua o te Wairoa</li> </ul>

## Dimensions

<b>Expenditure &amp; budget / forecast for which accountable</b>	None currently. However, the Change Leader will be expected to competently manage any resources allocated to the projects during their lifecycle. This will include effective processes associated with project budget management including development of funding applications for resource outside any allocated project budget.
<b>Challenges &amp; Problem solving</b>	<p>Challenges for the role include:</p> <ul style="list-style-type: none"> <li>▪ To work autonomously with minimum supervision but within a clear project process (maintained by the Project Management Office), and a strategic framework and direction (the "Transform &amp; Sustain" strategy).</li> <li>▪ To be a dynamic change agent, getting things done with a sound application of change management methodologies.</li> <li>▪ To deal with complexity and diversity across the varying stakeholder views.</li> <li>▪ To have excellent interpersonal skills as the approach involves achieving things through the coordination and alignment of staff both internal and external to the organisation, without direct line management authority.</li> <li>▪ To have sufficient gravitas, and authority to gain the respect of senior managers and clinicians who will be involved in, or affected by, project delivery. To be able to communicate clearly and effectively in writing (including business case development) and in presentation to audiences.</li> <li>▪ To be methodical, systematic, and persistent in working through problems issues, and obstacles to achieve progress.</li> <li>▪ To have the intellectual capacity and flexibility to move between, and lead or facilitate complex change and projects covering a diverse range of issues and services.</li> <li>▪ To be able to work to deadlines in delivering project milestones, progress reports, and evaluations.</li> </ul>
<b>Number of staff reports</b>	No Direct Reports but requires coordination of many staff both internal and external to the organisation and the wider community through the project process.
<b>Delegations &amp; Decision</b>	<ul style="list-style-type: none"> <li>▪ Delegated authority may be transferred to this role.</li> <li>▪ Must be confident to make decisions or recommendations relating to the project as per agreed delegated authority.</li> <li>▪ Discretion is required to be exercised in releasing confidential information to the appropriate parties.</li> </ul>
<b>Other Indicators</b>	<p>Works with formal, informal and virtual teams in a collaborative structure.</p> <p>With stakeholders, establish a workplan for Wairoa network that includes outcome measures to assess results end of year one and end of year two.</p>

16.3



## 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





## Key Accountabilities

CORE ROLE	
Tasks (how it is achieved)	How it will be measured (KPI):
<p>Relationships and Leadership:</p> <ul style="list-style-type: none"> <li>Build and maintain relationships across the varied stakeholder groups.</li> <li>Use relationship and negotiation skills to gain buy-in and partnership across diverse stakeholder groups.</li> <li>Is available to engage with stakeholders at all levels to gain alignment, progress projects and initiatives, and champion a collaborative working environment.</li> <li>Resolve issues proactively and sensitively.</li> <li>Act as the first point of contact for the Network Establishment work programme.</li> </ul>	<p>Is recognised as the leader of the programme of work that will establish a Health and Social Care Network in Wairoa.</p> <p>Maintains a positive working environment in which stakeholder partnership is recognisable in all processes, outputs and outcomes.</p> <p>Effective relationships and risk management processes ensure that the project remains on track despite the complexity of the changes envisaged by the work plan. Effective escalation processes are followed when required.</p> <p>Programme stakeholders understand and buy into the programme plan. Successful delivery of the programme is accomplished</p> <p>Programme benefits are demonstrated in the organisation and communicated across the sector.</p>
<p>Lead change:</p> <ul style="list-style-type: none"> <li>Work with service providers, consumers and funders to develop an implementation and change management strategy based on population health and asset mapping approaches.</li> <li>Work with stakeholders to foster participation in the project to ensure their on-going ownership of the change. This will include championing co-design and appreciative inquiry methodologies as key tools for change.</li> <li>Use influence appropriately to champion and progress positive change.</li> <li>Communication strategies demonstrate effective engagement of all key stakeholders in an appropriate way including: effective meetings / minutes, formal communications and adhoc communications.</li> <li>Timely and smooth transition from the old systems to the new.</li> </ul>	<p>Robust stakeholder analysis and implementation of a communication plan has resulted in a community of varying viewpoints actively engaged in the project, and contributing to the work plan.</p> <p>Stakeholders requirements for effective service and service delivery change are identified, documented and signed off.</p> <p>Positive feedback from stakeholders on participation opportunities.</p> <p>A commitment to person and whānau-centred care is perceptible in all project processes and outputs.</p> <p>Use of change impact analysis is evident during project planning, such that impacts are known and can be mitigated to facilitate smooth transition.</p>
<p>Deliver project implementation:</p> <ul style="list-style-type: none"> <li>Manage project resources effectively including engagement, delegation, and performance management.</li> <li>Ensure delivery of the expected project deliverables on time, within budget and meeting the requirements that have been agreed.</li> <li>Effective communication with project sponsor, steering group and all project stakeholders through coordinated implementation of the agreed communication plan.</li> <li>Managers the day to day work delivery and provides timely reporting of progress as per HBDHB project management standards.</li> </ul>	<p>Demonstrates application of evidence based approaches in preparing project implementation plans.</p> <p>Project resources work effectively or performance management is in place.</p> <p>Reporting requirements are met.</p> <p>Expected benefits accruing throughout the project and after its completion are identified in the project planning process, and realisation of these benefits is achieved according to the timeframes envisaged by the benefit realisation plan.</p> <p>Implementation timelines are met.</p>

	Establishes measures to monitor and demonstrate success of the project throughout its duration.
--	---

OCCUPATIONAL HEALTH & SAFETY	
<p><b>Tasks (how it is achieved):</b></p> <p>Displays commitment through actively supporting all health and safety initiatives.</p> <p>Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision.</p> <p>Ensures own and others safety at all times.</p> <p>Complies with policies, procedures and safe systems of work.</p> <p>Reports all incidents/accidents, including near misses in a timely fashion.</p> <p>Is involved in health and safety through participation and consultation.</p>	<p><b>How it will be measured (KPI):</b></p> <p>Evidence of participation in health and safety activities.</p> <p>Demonstrates support of staff/colleagues to maintain safe systems of work.</p> <p>Evidence of compliance with relevant health and safety policies, procedures and event reporting.</p>

## Key Competencies

DRIVE FOR RESULTS	
<p><b>Tasks (how it is achieved):</b></p> <p>Demonstrates the ability to drive self and others to deliver results e.g. MOH targets, KPI's, service plans</p> <p>Consistently and constantly fosters joint problem solving and decision making across the team and wider</p> <p>Manages the balance between meeting both organisational wide targets and budget requirements</p> <p>Demonstrates the following:</p> <ul style="list-style-type: none"> <li>▪ Strong prioritisation skills</li> <li>▪ Communication skills (both verbal and written) and</li> <li>▪ The running of effective meetings</li> </ul>	<p><b>How it will be measured (KPI):</b></p> <p>Organisation meets the defined targets within budget</p> <p>Team meetings held on a monthly basis are effective and results focused</p> <p>Monthly reports and business case's presented professionally, with effective decision making</p>
BUILDING EFFECTIVE TEAMS	
<p><b>Tasks (how it is achieved):</b></p> <p>Staff performance development plans are aligned with the approved service/continuum plan.</p> <p>Creates strong morale and spirit in his/her team to foster a feeling of belonging.</p> <p>Demonstrates the ability to blend people into teams when needed to work autonomously e.g. leading project teams, participation in projects, forums.</p> <p>Fosters open dialogues and joint problem solving and decision making.</p> <p>Defines success in terms of the whole team and shares wins and successes.</p> <p>Demonstrates the ability to effectively lead and participate in organisational wide project teams as required.</p>	<p><b>How it will be measured (KPI):</b></p> <p>90% of performance appraisals are completed on time with objectives and plans incorporated.</p> <p>Team meetings are run on a monthly basis.</p> <p>Successes are recognised and celebrated on both an individual and team level.</p> <p>Projects are implemented effectively within the parameters of the terms of reference.</p>
CUSTOMER SERVICE	
<p><b>Tasks (how it is achieved):</b></p> <p>Open and responsive to customer needs.</p> <p>Demonstrate an understanding of continuous quality improvement.</p>	<p><b>How it will be measured (KPI):</b></p> <p>Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers.</p> <p>Identifies customer needs and offers ideas for quality improvement.</p> <p>Effective management of customers/situations.</p>

16.3



HONOURING TREATY OF WAITANGI OBLIGATIONS	
<b>Tasks (how it is achieved):</b>  Demonstrates understanding of the principles of the Treaty of Waitangi.  Ensure the principles of partnership, protection and participation are applied to day to day work.  Ensures procedures do not discriminate against Māori.	<b>How it will be measured (KPI):</b>  Evidence of the principles applied in work practice.

### Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
<b>Treaty of Waitangi Responsiveness</b> (cultural safety)	Demonstrates the ability to engage with people in manner that the person(s) determines to be culturally safe.  Demonstrates ability to apply the Treaty of Waitangi within the Service.
<b>Qualifications</b> (e.g. tertiary, professional)	<ul style="list-style-type: none"> <li>▪ Tertiary level qualification (minimum BA level)</li> <li>▪ Formal training or qualification in Project Management (prefer PMI PMP, PRINCE2 Practitioner, MSP)</li> </ul>
<b>Business / Technical Skills</b> (e.g., computing, negotiating, leadership, project management)	<ul style="list-style-type: none"> <li>▪ Ability to write coherent meaningful project briefs, project implementation documents; business cases and other relevant documents.</li> <li>▪ Good Facilitation Skills (Vision development etc.).</li> <li>▪ Competent User of Microsoft Office applications especially: Word; Excel; Outlook</li> <li>▪ Evidence of applied skills and successful outcomes in negotiating, and leadership roles.</li> <li>▪ Evidence of strong written and presentational skills.</li> <li>▪ Evidence of managing complex programmes to time and budget to deliver required outcomes.</li> <li>▪ Evidence of self-awareness, and emotional and political intelligence.</li> <li>▪ Good level of numeracy and evidence of working with financial and informatics analysis.</li> <li>▪ Evidences awareness of project lifecycles for construction, IT and service improvement or redesign projects.</li> </ul>
<b>Experience</b> (technical and behavioural)	Shows commitment to, and demonstrates the behaviours of the health sector: <ul style="list-style-type: none"> <li>▪ Tauwhiro (delivering high quality care to patients and consumers)</li> <li>▪ Rāranga te tira (working together in partnership across the community)</li> <li>▪ He kauanuanu (showing respect for each other, our staff, patients, and consumers)</li> <li>▪ Ākina (continuously improving everything we do)</li> </ul> A track record of leading and delivering projects and change in a complex environment.  Familiarity with project management software.



Desirable	
	<ul style="list-style-type: none"> <li>▪ Formal Training or qualification in Change management</li> <li>▪ Experience of working with other agencies on the wider determinants of health Previous experience in leading and delivering projects and change in a health environment</li> <li>▪ Experience of working with other agencies on the wider determinants of health.</li> </ul>

#### Recruitment Details

Position Title	Change Leader
Hours of Work	40 hours per fortnight. Fixed term 2 years (24 months)
Salary & Employment Agreement Coverage	Secondment.
Date	June 2016

16.3





## MĀORI RELATIONSHIP BOARD

17

Chatham Island Proposal  
Weaving Communities Together  
by Jean Te Huia



Draft Concept Proposal Plan; Jean Te Huia



# **Chatham Island Proposal Weaving Communities Together**

17.1

*Te raurutanga o te whitau  
Te ki tuhono ia tatou mo ake tonu*

---

*The plaiting of the flax fibre  
Binds lasting relationships*

Draft Concept Proposal Plan; Jean Te Huia

**Moriori**



**Pine Pine Te Kura**

*(he waiata tawhito)*

Pine Pine te kura, hau te kura

Whanake te kura, i raro i awarua

Ko te kura nui, ko te kura roa

Ko te kura o tawhiti na tuhaepo

Tenei te tirahou, tenei haramai nei

Ko te umu-rangi, na te whatuiapiti

Nau mai e tama ki te tai ao nei

Kia whakangunua koe ki te kahikatoa

Ki te tumatakura, ki te tara ongaonga

Nga tairo ra e nahau, e kupe

i waiho i te ao nei

Piki ake kake ake i te toi huarewa

te ara o tawhaki, i piki ai ki runga

i rokohina atu ra, Maikuku-Makaka

Hapai o maui, he waha i pa mai

“Taku wahine puroto, take tane puroto”

Korua ko te tau e.....

(Maori Lullaby)

Draft Concept Proposal Plan; Jean Te Huia

## Table of Contents / Raranga Take

Pine Pine Te Kura Maori Lullaby	P3
Community Health Proposal Mission Statement	P4
Overview of proposal	P5
Proposal Information	P6
Personal Profile Background Information	P7
Background Information Chatham Islands	P8-P13
Training Plan	P 14
Performance Plan	P 15
Contracts and Agreements	P 16
Risk Management	P 16
Professional Development	P 17-18
Stakeholder Group Support	p 19-21
Delivery of Training, Time Lines / Responsibilities	P22-24
Budget	P 25

Proposal to Increase The Nursing and Midwifery Personnel on The Chatham Islands

3 -

17.1

Draft Concept Proposal Plan; Jean Te Huia

## **Weaving Communities together Proposal**

moemoea  
Mission statement

**To provide a Training Opportunity to Ngā Tangata Katoa (all people) of the Chatham Islands**

---

**Which takes into account the Tino Rangatiratanga of the Tangata Whenua of the Chatham Islands**

**Kaupapa**  
Mission Statement

**To empower Nga Tangata Katoa of the Chatham Islands to improve their own health status**

---

**And that of their whanau  
Through the delivery of a Midwifery and Nursing Programme  
Which acknowledges and guarantees the principles of  
Te Tiriti o Waitangi  
That encompasses  
Participation, Partnership and Protection**

This will be achieved by;

### **Whakamana Te Tiriti o Waitangi**

---

*Upholding and promoting Te Tiriti o Waitangi to enable them to act independently in terms of community aspirations*

### **Kotahitanga**

---

*Actively promoting and forging unity of purpose, voice and action engaged in local issues and aspirations*

### **Ngā ahua reka**

Our values, behaviours and actions will lead positive change and connect people to achieve a greater voice and visibility

<b>Kanohi ki te Kanohi</b>	<i>face to face</i>
<b>Pokohiwi ki te Pokohiwi</b>	<i>shoulder to shoulder</i>
<b>Ka Whawhai tonu atu</b>	<i>work without end</i>

Based on the following principals and values:

**Tino Rangatiratanga  
Mana whenua Kawa  
Whakamana  
Whakawhanaungatanga  
Whakapono  
Manākitanga  
Mana tangata**

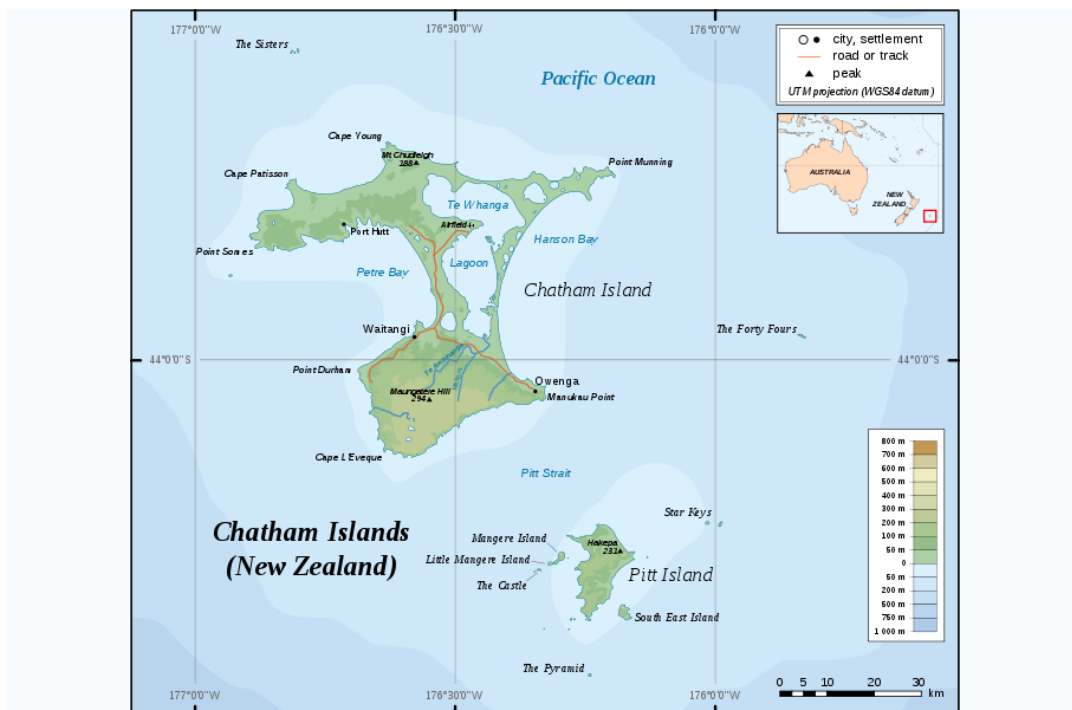
Proposal to Increase The Nursing and Midwifery Personnel on The Chatham Islands

4 -



Draft Concept Proposal Plan; Jean Te Huia

## MIDWIFERY AND NURSING TRAINING WORKFORCE DEVELOPMENT PROGRAM FOR THE CHATHAM ISLAND COMMUNITY.



17.1

This object of this proposal is to assist the Tangata Whenua (Home people) of the Chatham Islands to develop a Nursing and Midwifery Training Program in Partnership with The Chatham Islands Maori Provider Organisation.

This proposal seeks to facilitate a meaningful exercise for those people isolated on the Chatham Islands where no current Nursing or Midwifery Service exists.

This proposal identifies the unique and special individual needs of an island community environmentally isolated; where the health needs of the community can be enhanced by supporting 'Workforce Development' whereby individuals on the Chatham Islands will complete a Nursing and Midwifery Training Program, which respects the principals of Tino Rangatiratanga (self-determination) (Durie, 2005).

Proposal to Increase The Nursing and Midwifery Personnel on The Chatham Islands

5 -

Draft Concept Proposal Plan; Jean Te Huia

## Proposal Information

Location For Proposal	Chatham Islands, Hastings, Whitireia and Christchurch
Name of Organisations	Chatham Island Maori Providers and Community in Partnership with Others
Coordinator Contact Person	Jean Te Huia, CEO. Kahungunu Health and Community Services Charitable Trust.
Postal Address	P O Box 901 Hastings
Physical Address	500 Maraekakahou Road CRN Frances Hicks Ave Hastings
Email	<a href="mailto:tehuia@extra.co.nz">tehuia@extra.co.nz</a>
Phone	(06) 878 7616 021709083



Proposal to Increase The Nursing and Midwifery Personnel on The Chatham Islands

6 -

Draft Concept Proposal Plan; Jean Te Huia

## Personal Profile Background Information

<b>a. Coordinator</b>	Jean Te Huia
<b>b. Address</b>	P O Box 901 Hastings
<b>c.i Physical Address</b>	500 Maraekakahou Road Crn Frances Hicks Ave Hastings
<b>c.ii Phone</b>	(06) 878 7616
<b>c.iii Facsimile</b>	(06) 878 7927
<b>c.iv Email</b>	tehuia@xtra.co.nz
<b>d. Qualifications</b>	Current CEO. Maori Provider Registered Practicing Midwife Registered Practicing Comprehensive Nurse PG Dip Midwifery MA Nursing PG Dip Public Health
<b>e. Proposal Outline</b>	To support and work alongside the Tangata Whenua of The Chatham Islands to assist them to develop their own Nursing and Midwifery Programme
<b>f. The Philosophy of Primary Health Care in New Zealand and the Impact for the Tangata Whenua of The Chatham Islands.</b>	<p>The World Health Organisation (WHO) defines primary healthcare as healthcare made accessible, affordable and appropriate to individuals and whanau in communities, at a cost that the community and country are able to afford and to sustain (WHO, 1978). This philosophy is further enhanced by the Ottawa Charter (WHO, 1986) which developed further the direction of primary healthcare health promotion into five key areas for priority action; building healthy public policy; creating supportive environments for health; strengthening community action for health; developing personal skills and re-orienting health services (Halliday, 2006). Supported by legislation in 1985, the Standing Committee on Maori Health recommended that the Treaty of Waitangi be regarded as a foundation for good health, and therefore the parent body, the New Zealand Board of Health, according to Durie (pg81, 2006) responded by recommending that;</p> <p><i>'All legislation relating to health should include recognition of the 'Treaty of Waitangi'</i></p> <p>An obligation by the crown under the terms of the Treaty of Waitangi describes the principals; Partnership, Participation and Protection for Maori.</p>



17.1

Draft Concept Proposal Plan; Jean Te Huia

## 1.1 Background information Chatham Islands



“Chatham Island is the largest, Pitt Island is the second largest, and South East Island is the small island to the right of Pitt. (*The Chatham Islands from space*).

The archipelago of the Chatham Islands (*Rekohu* in Moriori; *Wharekauri* in Māori) consists of ten islands, the largest of which are Chatham Island and Pitt Island, within a 40 kilometers (25 mi) radius. The remote islands are over 800 kilometers (500 mi) east of Christchurch in southern New Zealand and have officially belonged to New Zealand since 1842. There is a total of 966 square kilometers (373sq mi), almost all of which are within the two main islands. Chatham and Pitt are the only inhabited islands, with the remaining islands being conservation reserves with



access restricted or prohibited.

Private vessels planning to sail to the Chatham Islands are required to check first that they meet the requirements of the New Zealand's Maritime Safety Authority:



Draft Concept Proposal Plan; Jean Te Huia

**Some** of the islands, once cleared for farming, are now preserved as nature reserves to conserve some of the flora and fauna that are unique to the Chathams. Most of the islands are covered in fern or pasture and there are patches of forest, notably macrocarapa whose branches trail almost horizontally with the lee of the land due to the effects of strong winds. The islands are generally hilly, with numerous lakes and lagoons, interconnected with streams.



Chatham Island nikau  
(millennium peace palm)



Chatham Island  
giant forget-me-not



Farming on Chatham Islands



The Islands are also home to one of the world's great conservation success stories - the Chatham Island black robin. Other species are Chatham Island Oyster catcher

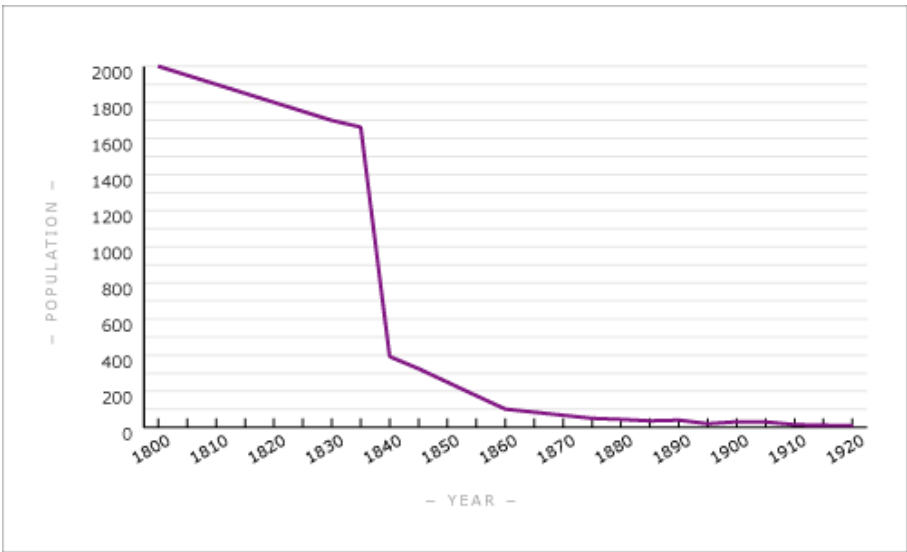
Draft Concept Proposal Plan; Jean Te Huia



The Chathams provide spectacular and ever changing scenery. The often rugged Island landscape contains an astonishing array of volcanic peaks, original forest remnants, rolling sandy beaches as a backdrop to the Pacific ocean.



**Moriori population of the Chatham Islands, 1800–1920**



**History;**



The Chathams were originally settled around 1500 by Polynesian tribesman, Moriori, whose origins have been debated for years. As a peaceful tribe their numbers grew to about 2000. Without the resources to build vessels' capable to navigate off the islands they developed an intricate infrastructure, as hunters and gatherers. The islands were eventually re-discovered in 1791, and renamed Chatham Islands, after HMS Chatham whose captain William Broughton claimed possession for Britain.

Draft Concept Proposal Plan; Jean Te Huia

**Sealers and whalers** soon arrived on the islands, bringing with them disease and pestilence, which reduced the indigenous population by about 20-30%.



South seas whaling British Sailing Vessel.



17.1

New Zealand 1840. (Accessed online 2009, Chatham Islands Google).

Draft Concept Proposal Plan; Jean Te Huia

### **Current Population and Health Services;**

The population of 609 individuals lives on the two main islands Chatham and Pitt . The main settlement is Waitangi, which has a population of 200 residents. There are other villages such as Owenga, Te One and Kaingaroa, where there are two primary schools. A third school is on Pitt Island. There are also the fishing villages of Owenga and Port Hutt which are the islands main industry.



Waitangi facilities include a hospital with resident doctor, bank, several stores, and engineering and marine services. The health services of the hospital have been funded through the Hawkes Bay District Health Board. Staff recruitments are difficult to fill. There are no midwives currently residing on the island, and no maternity facility available locally on the Island. Pregnant women are flown off the island at 37weeks gestation to

reside in Christchurch to await their birth. There have been no birthing services available for the local women for many years. This has given rise to a loss of mana and Tangatawhenua status and is a significant 'Tribal Concern' for their people.

**Transportation;** Visitors to the Chatham's usually arrive by air from Christchurch, Auckland or Wellington (around 1.5 – 2 hrs). Freight generally arrives by ship (4–5 days' sailing time), the sea journey takes too long for many passengers, and is not always available. The Chathams are part of New Zealand so there are no border controls or formalities on arrival, but visitors are advised to have prearranged their accommodation on the islands. There is no scheduled



Draft Concept Proposal Plan; Jean Te Huia

public transport but accommodation providers are normally able to arrange transport.

## **Impact on Health Culture and Status of Tangata Whenua for the Chatham Island People;**

Traditionally the birth of a local baby on the Chatham Islands was celebrated. Locally born babies, are referred to as 'Weka' endearing the baby to the Chatham Islands, as 'Tangata Whenua'. Babies born on the mainland, New Zealand, are referred to as 'Kiwi'. The loss of maternity and birthing services to the Chathams has resulted in an increase of 'kiwi' babies and a complete reduction of 'Weka' babies, which has resulted in a loss of 'Tangata Whenua' (People of the land).

The cultural connectedness experienced by women who traditionally birthed on the island, has now been eroded. The consequence for families, babies and the people has resulted in a feeling of loss within the concept of 'Mana Whenua'. "Mana Whenua' is described by Durie (2006) as the lore of the land, It contributes to sustenance, wealth, resource development, tradition, land strengths, whanau, hapu and Iwi solidarity, and adds value to personal and tribal identity. In a real sense the loss of birthing connection with the island has resulted in a separation of people, land and identity. 2008 witnessed two women, who against medical advice, elected to remain on the island to give 'birth' unsupported by medical assistance, in order for their babies to be 'weka'.

This proposal supports the right for Mana Whenua to regain their birth rites.

17.1

Draft Concept Proposal Plan; Jean Te Huia



Chatham Island Flag

## **Professional Development Program Supervision and Training of Nursing and Midwifery Personnel.**

### **Stage 1;**

The Development of a Nursing and Midwifery training team supported by CHOICES. The team will consist of Chatham Island Representatives, Whitireia Polytechnic (Wellington) and Co-ordinator Jean Te Huia. This model will be developed jointly. Policies and procedures will also be developed jointly to support the program with performance management, performance appraisal, clinical and cultural training and mentoring and practicum supervision for midwifery/nursing.

The nursing and midwifery program will be delivered extra murally, by attendance at block training sessions and by clinical placement supported by supervision of students at Christchurch, Wellington and Hawkes Bay District Health Board Areas over a period of three years. Clinical and cultural supervision will be provided jointly by the team, Jean Te Huia and Whitireia Polytechnic personnel and the Chatham Island Maori Provider Group.

### **Stage 2;**

**Recruitment;** Prospective students from the local community of the Chatham Islands will be invited to participate. An introduction and induction program will consist of evening and afternoon seminars, presented to the local community jointly

Draft Concept Proposal Plan; Jean Te Huia

by the Chatham Island Maori Provider and co-ordinator Jean Te Huia over a period of two weeks. A description of the Program will be presented by a member of Whitireia. Support program outlines offered through the DHB's will be discussed. It is important to foster an environment of continuous development and learning within the team to enable students to develop personally and professionally.

### **Performance Planning;**

Students will have performance plans that are discussed bi-annually with the team. Together they will agree on targets and goals for the upcoming year and discuss any further training and development needs. The targets and standards are aligned with the description of student outcomes as defined for each student, and support team member required to meet the outcomes of the Nursing and Midwifery Training to obtain their APC. (Annual Practicing Certificate).

All members, including the team, and students will also have a Training and Development Plan. This is an essential component of the Performance Plan. The Training and Development Plan identifies:

- Skills and qualifications needed to maintain the training program, and to assist student's requirements to the best of their ability, will include, computer literacy, time management, stress management, accessing library resources off-line, completed assignment writing, referencing.
- Identify complimentary Training courses students may like to attend during the year to up-skill and to assist them to perform their duties to an optimum level. Funding for travel and accommodation required for students, is to be met from this proposal.

Draft Concept Proposal Plan; Jean Te Huia

- Skills and qualities students would like to develop further for their professional development. This may be to increase their employment, promotion or career prospects which may include but not limited to, cervical screening, immunisation and sexual and reproductive health education, health promotion and nurse practitioner training.

### **Contracts;**

Once the performance plan and training and development plans have been fully discussed and agreed, it is signed by the team members and the Co-ordinator in partnership with individual students. The contract plan then becomes the basis upon which the students' performance is measured over the duration of the training program. It will include an outline program of how the student and the co-ordinator will engage, how the student will engage with the Whireia and Chatham Island Provider and also explain clearly the role and function of the District Health Board relationships.

A signed copy of the individual's performance plan and training and development plan is retained by the student, as well copies will be retained on file by each team member.

### **Risk Management;**

An agreement between the 'Team' will also include a 'Risk Management Plan' which will be developed jointly between the team and the students in partnership, to identify any and all issues, pending or not so obvious, that would potentially harm this project. This document will set out clear boundaries for the supervisor and the supervise (students). A mediation process is also documented and

Draft Concept Proposal Plan; Jean Te Huia

considered an important aspect of the supervision contract, where either recipient may identify any conflict of interest within the relationship.

### **Ongoing Management of Career Opportunities;**

Students will be encouraged to identify their own career development and personal growth opportunities. Flexible arrangements will assist students to also cover leave for courses, conferences and seminars. As well also to have two nominated flexi days a month to work from home.

Students may wish to initiate their own training that is of benefit to their professional development and would be beneficial for the families that they would serve. Some of these training courses may include:

- Awareness and prevention of child abuse
- Safety (of workers and clients)
- Rights of children
- Interactive Drawing Therapy
- Parenting Skills
- Early Childhood Development
- Child Behaviours, Assessments and Referral Processes'
- Parents as First Teachers
- Health Promotion Activity and Recreation
- Team Building
- Floristry and Decorative Weaving with Flax
- Cultural Safety and the Treaty of Waitangi

Draft Concept Proposal Plan; Jean Te Huia

### **Professional Development Strategy for Students;**

It is recognised that as an Island, many of the issues confronting mainland New Zealand may not be an issue for the residents of the Chatham Islands, however to allow the transfer of training to be used by the student, should her career take her off the island the following programs may be made available through the 6 wk induction program which is part of the Nursing and Midwifery Training Program.

The Induction Training Programme for students will include the following topics (as a minimum):

- Child abuse indicators and dynamics
- Cross cultural service delivery
- Professional ethics and boundaries
- Alcohol and drug dependency and abuse
- Child and adult mental health
- Child development and learning
- Child health issues
- Parenting Skills
- PAFT training
- Common childhood illnesses
- Confidentiality and Privacy Act 1993
- Domestic Violence and the Domestic Violence Act 1995
- Family violence interventions
- Dynamics of whanaungatanga
- Family Planning – contraception, sterilisation and abortion
- Maori and Pacific family an community structures and dynamics
- Post-natal depression
- Sexually transmitted diseases
- Youth health, spiritual, mental and suicidal risks.
- Assessment skills
- Crisis intervention

#### Draft Concept Proposal Plan; Jean Te Huia

- Planned intervention
- Interviewing techniques
- Management of documentation
- Stress and time management
- Complaints procedures
- Safety for clients and workers
- Early childhood development
- Ahuru Mowai and Born to Learn
- Individual Family Plans (Role of Whanau Worker, Development of IFP)
- Crisis Management and the IFP
- Documentation, database and legal requirements for case management

If required, all students will also undertake training to gain a P Class driver's licence to enable them to transport themselves and their families.

17.1

### **Registration with Professional Organisations;**

We will ensure that students are registered as Students with a professional organisation such as the New Zealand Nursing Council, Aotearoa New Zealand Association of Maori Nurses, Nga Mai, Maori Midwives, New Zealand College of Midwives.

### **Stakeholder Group;**

It is imperative that the students receive support and interact with other stakeholders and interested parties when engaged within this training program. As well to think ahead at what services they will be delivering for the community of the Chatham Islands. This enables the team, and the students an opportunity to form partnerships with the community and to plan for future service delivery based on service needs of families and to ensure their needs are being met. It also helps to build a positive view of the future planned health services within the community by

Draft Concept Proposal Plan; Jean Te Huia

providing other stakeholders with confidence that families referred to the students will be looked after responsibly, and in partnership with them.

We will establish a Stakeholder Group that will provide a forum to introduce the Training program, the students and the team to the community. It will also serve as an arena for stakeholders and the community to raise any issues that may arise.

The Stakeholder Group will consist of:

- Other Kahungunu Health & Community Service workers
- Midwifery and Midwife stakeholder groups.
- Lead maternity carers (midwives, general practitioners, obstetricians)
- General practitioners
- DHB, Hospital maternity services (neo-natal units, paediatrics etc)
- Well Child providers (all Tamariki Ora providers, Plunket, vaccinators, dental therapists, hearing and vision testers)
- Early childhood education providers (kohanga reo, kindergarten, play centres etc
- Hawkes Bay DHB
- Other social services and health providers working in Hastings, Wellington, Christchurch and the Chatham Islands.
- Iwi representatives
- Tangata Pasifika representatives
- Consumer representatives
- Ministry of Social Development staff/representative
- Work & Income staff/representative



Draft Concept Proposal Plan; Jean Te Huia

The Stakeholder group will either meet bimonthly as determined by the group to discuss the students/programs progress, as well any issues that have arisen for students and to ensure community involvement of the Chatham Island residence as a priority for the service.

The Stakeholder group will provide governance for the service and be a forum for any issues as they may arise..

**Other opportunity for further funding this Programme;**

- MPDS; Maori Provider Development Scheme
- DHB; Capacity and Capability Support; Primary Health. Maori Health
- PHO; SIA Funding. Services to Increase Access Funding.
- Nursing and Midwifery Workforce Development
- CHOICES LMC Midwifery team in partnership with DHB maternity Staff funded under section 88

17.1

## Draft Concept Proposal Plan; Jean Te Huia

## Work Programme – Delivery of Training program;

[illegible]

Draft Concept Proposal Plan; Jean Te Huia

Component	Outputs	Responsibility	Due Date
Scheduled meeting with Stakeholder Group	Meeting of Stakeholder group to update progress to date. Identify any issues, plan for next stage	Co ordinator	June 2017
<ul style="list-style-type: none"> <li>Establishing Training Programme</li> </ul>	<ul style="list-style-type: none"> <li>a) Meeting between students and negotiating with appropriate DHBs for student placements</li> <li>b) Setting up Training venue at Maori Provider Rooms Chatham Island.</li> <li>c) Purchase resources, computer network, telecom, IT system software</li> <li>d) Purchasing furniture, office equipment, computers etc hard ware</li> <li>e) Set computers, printers, photocopier, software, PROFILE database etc</li> <li>f) Set up security for buildings</li> <li>g) Set up insurance (buildings, contents, students, workers and cars)</li> <li>h) Signage (buildings, cars)</li> <li>i) Marketing profile of students, cards, ID and travel bags, uniforms, wet weather gear</li> </ul>	Co ordinator and Students, DHB's.	1 April 2017 – 31 May 2017
<ul style="list-style-type: none"> <li>Policies and Procedures for Engagement Students and Team</li> </ul>	<ul style="list-style-type: none"> <li>a) Review of current policies and procedures</li> <li>b) Develop policies and procedures for the Family Start Service</li> <li>c) Implementation of new policies and procedures</li> <li>d) Training for staff on new policies and procedures</li> </ul>	Co ordinator, Team, students	1 April to 30 June 2017
<ul style="list-style-type: none"> <li>External Supervision</li> </ul>	<ul style="list-style-type: none"> <li>a) Contract negotiated and signed with External Cultural Supervisor</li> <li>b) Develop and coordinate supervision programme plan</li> </ul>	External Cultural Supervisor	By 30 June 2017
<ul style="list-style-type: none"> <li>Public Relations</li> </ul>	<ul style="list-style-type: none"> <li>a) Communication with stakeholders (Plunket, GPs, Well Child Providers, DHB, Child, Youth and Family Services, MoE, Early Childhood Development Centres, Maternity Services, NZ Police, Work and Income NZ, Housing NZ, Ministry of Justice – Courts, budgeting services, mental health providers etc)</li> <li>b) Set up of Stakeholder Committee (Plunket, ECD, GPs Well Child Provider, CYFS, DHB)</li> <li>c) Communication with referral agents (Lead Maternity Carers, DHB, GPs, Well Child Providers, ECE Providers, Maternity Services etc)</li> <li>d) Develop all brochures and information for the public and stakeholders</li> </ul>	Team Co ordinator	1 – 30 May 2017  By 31 May 2017  By 31 May 2017 By 30 June 2017

Draft Concept Proposal Plan; Jean Te Huia

Component	Outputs	Responsibility	Due Date
<ul style="list-style-type: none"> <li>Monitoring and Reviewing</li> </ul>	<ul style="list-style-type: none"> <li>a) Develop monitoring and reviewing process of program provision (including Individualised Student Plans monitoring)</li> <li>b) Develop status review process every 3 months for each student</li> <li>c) Develop casework plan process every 3 months for each student</li> <li>d) Develop ongoing learning plans independence plans</li> </ul>	Co-ordinator, Whitireia	By 30 September 2017
<ul style="list-style-type: none"> <li>Reporting and Monitoring Systems</li> </ul>	<ul style="list-style-type: none"> <li>a) Develop monthly reporting and three monthly reporting processes and forms (coaching supervision, narrative, funder reports, management reports)</li> <li>b) Financial management reporting and systems in place</li> <li>c) Organisational monitoring in place</li> <li>d) External Supervision Reporting in place</li> <li>e) Student Reporting in place</li> </ul>	Co-ordinator	By 30 September 2017
<ul style="list-style-type: none"> <li>Training Plan</li> </ul>	<ul style="list-style-type: none"> <li>a) Students engaged with programme, feedback from stakeholder group, co-ordinator, Maori Provider Chatham Island, Whitireia Polytechnic, and Students.</li> <li>b) Training Plan for following year,</li> <li>c) Negotiate student placements for 2017.</li> </ul>	Co-ordinator; team, and Students.	1 Nov 2016

Draft Concept Proposal Plan; Jean Te Huia

## 1 Annual Budget

---

### Nursing and Midwifery Training Budget;

Co-Ordinator, Team, Chatham island	\$ 25,000.00
Travel/Accommodation	\$ 10,000.00
Stakeholder Travel and Accommodation	\$ 25,000.00
Supervision, cultural, Clinical	\$ 5,000.00
Stakeholder Group Meetings	\$ 5,000.00
Administration	\$ 20,000.00
Students Training Resources Including soft ware, hardware, IT	\$ 15,000.00
Students Travel and Accommodation	\$ 10,000.00
Total excluding GST	\$115, 000.00

17.1