Māori Relationship Board Meeting

Date:	**Wednesday, 14 June 2017**
Meeting:	**9.00am to 12.00pm**
Venue:	**Te Waiora (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Board Members:

Ngahiwi Tomoana (Chair)
Heather Skipworth (Deputy Chair)
George Mackey
Na Raihania
Kerri Nuku
Dr Fiona Cram
Lynlee Aitcheson-Johnson
Trish Giddens
Tatiana Cowan-Greening (Teleconference)
Hine Flood
Ana Apatu

Apologies:

In Attendance:
Member of the Hawke's Bay District Health Board (HBDHB) Board
Members of the Executive Management Team
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 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.

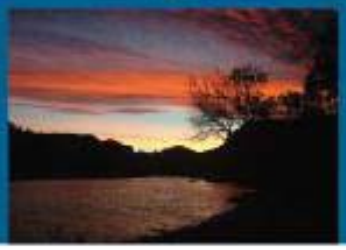
Our values

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



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 2017	
8.	MRB Chair's Report	
9.	Acting General Manager Māori Health Report	
10.	Clinical Council Verbal Update - Kerri Nuku	
	Section 2: Presentation	**10.00am**
11.	Te Ara Whakawaiora / Oral Health (national indicator) – Dr Robin Whyman	15-mins
12.	Consumer Experience Feedback Quarterly Report – Jeanette Rendle	15-mins
	Section 3: For Discussion	**10.30am**
13.	Youth Health Strategy Update – Nicky Skerman / Paul Malan	10-mins
	Section 4: For Information only (no presenter)	**10.40am**
14.	Health Hawke's Bay Culture Competency Framework	
15.	Central Region AOD Model of Care	
	Section 5: General Business	
16.	**Section 6 – Recommendation to Exclude**	

PUBLIC EXCLUDED

Item	Section 7: For Discussion	11.00am
17.	People Strategy (2016-2021) first draft – Kate Coley	25-mins
18.	Karakia Whakamutunga (Closing)	
	Light Lunch	**12.00pm**

Māori Relationship Board Interest Register - 31 May 2017

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
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Tatiana Cowan-Greening	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
	Active	Director Te Pou Matakana	Whanau Ora Commissioning Agency	No conflict	The Chair	27.03.17
Kerri Nuku	Active	Kaiwhakahaere of New Zealand Nurses Organisation	Nursing Professional / Industrial Advocate	Will not take part in any discussions relating to industrial issues	The Chair	19.03.14
	Active	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 (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions relating to the Trust	The Chair	19.03.14
	Active	Wife Annette is a Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions relating to Iron Maori Limited	The Chair	04.08.16
	Active	Trustee of Te Timatanga Ararau Trust (a Trust aligned to Iron Maori Limited)	The Trust Holds several contracts with the HBDHB	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.06.14
	Active	Director and Shareholder of Iron Maori Limited (since 2009)	The company is aligned to a Trust holding contracts with HBDHB	Will not take part in any discussions or decisions relating to the Contract aligned to Iron Maori Limited).	The Chair	04.08.16
	Active	Employee of Te Puni Kokiri (TPK)	Working with DHB staff and other forums	No conflict	The Chair	19.03.14
Lynlee Aitcheson [married 12 May 2016] now Lynlee Aitcheson-Johnson	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 Inc.	Maori Womens Refuge	No conflict	The Chair	22.12.15
	Active	Trustee, Kahuranaki Marae		No conflict	The Chair	14.07.16
	Active	wahine co-Chair for Ikaroa Rawhiti Electorate for the Maori Party	Political role	No conflict	The Chair	14.07.16
Na Raihania	Active	Wife employed by Te Taiwhenua o Heretaunga	Manager of administration support services.	Will not take part in any discussions or decisions relating to the Contract.	The Chair	19.03.14
	Active	Member of Tairawhiti DHB Maori Relationship Board		Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	19.03.14
	Active	Employeed as a Corrections Officer		No conflict	The Chair	19.03.14
	Active	Board member of Hauora Tairawhiti	Relationship with Tairawhiti may have contractural issues.	Will not take part in any matters that may to any perceived contracts with Tarawhiti	The Chair	27.03.17
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	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

Maori Relationship Board 14 June 2017 - 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
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	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	Chair, Health Promotion Forum (previously Deputy Chair from 12.08.15)	Relationship	No conflict	The Chair	12.08.15 04.08.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	23.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	23.02.17
Dr Fiona Cram						

MINUTES OF THE MĀORI RELATIONSHIP BOARD (MRB) MEETING HELD ON WEDNESDAY, 10 MAY 2017, IN TE WAIORA MEETING ROOM, DISTRICT HEALTH BOARD (DHB) ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS COMMENCING AT 9.00AM

Members:	Ngahiwi Tomoana (Chair) Ana Apatu Des Ratima Kerri Nuku Lynlee Aitcheson-Johnson Na Raihania Tatiana Cowan-Greening (teleconference) Trish Giddens
Apologies:	Hine Flood Heather Skipworth (Deputy Chair) George Mackey
In Attendance:	Dr Kevin Snee (CEO HBDHB) Dr Adele Whyte (CEO Ngāti Kahungunu Iwi Incorporated) Graeme Norton (Chair of HB Clinical Council) Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB) Kevin Atkinson (Chair Hawke's Bay District Health Board) Peter Dunkerley (Board Member Hawke's Bay District Health Board) Patrick Le Geyt (Acting General Manager/Programme Manager, Māori Health HBDHB) Chrissie Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Incorporated) Matiu Eru (Pouahurea, Māori Health HBDHB) Linda Dubbeldam (Manager Innovation & Development, Health Hawke's Bay PHO)
Minute Taker:	Amy Martin (MRB Administration Coordinator, Māori Health HBDHB)

SECTION 1: ROUTINE

1. KARAKIA

Matiu Eru (Pouahurea, Māori Health HBDHB) opened the meeting with karakia.

2. WHAKAWHĀNAUNGATANGA

The MRB Chair welcomed everyone to the meeting.

3. APOLOGIES

Apologies were received from H Skipworth, H Flood and G Mackey. T Cowan-Greening, joined the meeting by teleconference.

4. INTERESTS REGISTER

No MRB members declared any additional conflict of interest to the register or with today's agenda items.

5. MINUTES OF THE PREVIOUS MEETING

The minutes of the MRB Board meeting held 12 April 2017 were taken as read and confirmed as a correct record, pending the following amendments:

Health & Social Care Localities Update
T Giddens advised that John Barry and Zac Makaore were having difficulty making the meetings possibly due to the time of the meeting. The MRB Chair suggested T Giddens endeavour to find a kuia (female elder) who might be able to join the committee and to assist.

Moved: D Ratima
Seconded: T Giddens
CARRIED

6. MATTERS ARISING FROM THE PREVIOUS MINUTES

There were no matters arising from the April minutes.

REVIEW OF ACTIONS

The Action and Progress List as at April 2017 was taken as read. The following actions were discussed.

April 2017 Meeting
Māori Representatives in the Workforce
Kate Coley (Executive Director of People and Quality) will present the full Human Resources Recruitment Plan to MRB at the July meeting.

HB Clinical Council Update
Feedback and discussion on today's agenda.

Health & Social Care Localities Update – Nuka Training
In respect of the current financial position, HBDHB could not contribute to anyone attending the NUKA training scheduled for June 2017.

Financial Position
Subsequent to the above confirmation, Kevin Atkinson (HBDHB Board Chair) provided an overview on the financial constraints and the anticipated savings per month until financial year end. Kevin spoke about the HBDHB assets being the oldest of the DHBs, including the Tower Block which has many inefficiencies. There are plans in place to upgrade the Tower Block and reconfigure Level 2 of the Corporate Administration Building to ultimately increase productivity and efficiencies. MRB supported the suggestion to view the upgrade plans for the Tower Block and the Corporate Administration Building at the June meeting.

Facilities to present to MRB the plan for the upgrade of the Tower block and reconfiguration of Level 2 Corporate Administration Building. **ACTION Trent Fairey**

February 2017 Meeting
Fluoridation
C Hape (Iwi/CYF Partnership Advisor, Ngāti Kahungunu Iwi Incorporated) to provide L Aitcheson-Johnson a date to present to Ngāti Kahungunu Iwi Inc.

Te Ara Whakawaiora: Access (Local Indicator)
ASH report to formulate better recommendations that improves the performance of the indicator. An updated report to be presented today.

September 2016 Meeting
MRB hosting the next Te Whiti ki te Uru:
Tatiana will attend the meeting on June 7th and follow up with Patrick to discuss agenda items for October.

Dr Adele Whyte (Chief Executive Officer, Ngāti Kahungunu Iwi Incorporated) joined the meeting at 9.25am.

7. MRB WORKPLAN 2017

The MRB Workplan May – December 2017 was taken as read.

8. MRB CHAIR'S REPORT

The Chair's Report for April 2017 was taken as read and the contents noted. The following matters were discussed and information advised:

MRB Representation at HB Clinical Council
MRB discussed representation on Clinical Council. Kerri Nuku (MRB Clinical Council representative) stated that Clinical Council is largely an operational committee and most agenda items were unrelated to governance issues or concerns. The MRB Chair confirmed that MRB representation at HB Clinical Council meetings is valued and recommended that when there is a strategic issue on Clinical Council agenda that could potentially impact on Māori populations, an appropriate MRB member will be present at Clinical Council. N Tomoana (MRB Chair) stated MRB to develop a process and present at the June HB Clinical Council **ACTION MRB**

There was further discussion around Māori representation on DHB committees and emphasis on ensuring the right person and expertise represent accordingly, ultimately providing strategic recommendations to the Board.

9. GENERAL MANAGER (GM) MĀORI HEALTH REPORT

The GM Māori Health report for April 2017 was taken as read and the contents noted.

The following matters were discussed and information advised:

Ante-natal Education
A kaupapa Māori Ante-natal Education Programme is being developed, taking a wellbeing approach whilst addressing a large range of issues and to be held on local marae.

DNA Statistics
MRB were concerned with the increase in DNA rates. The increase seems to be related to both systemic and patient related issues. DNA will be reintroduced into the Te Ara Whakawaiora programme with a renewed focus. There is a project in place to improve patient processes.

Cultural Competency
The significance of training in cultural competency for midwives and clinicians to ensure cultural competency is maintained in the pregnancy and parenting service was discussed. The MOH have funding for such a service and a steering committee is currently in the development stage insistent on cultural competency. In addition, there is a project focusing on influencing the early handover to Lead Maternity Carers (LMCs) and WCTO. Dr James Graham (Senior Advisor Cultural Competency, Māori Health Service) will continuously work on HBDHBs cultural competencies.

Dr Kevin Snee (Chief Executive Officer, HBDHB) joined the meeting at 9.58am

10. CLINICAL COUNCIL UPDATE

As per the earlier discussion regarding MRB representation at HB Clinical Council meetings.

SECTION 2: FOR DISCUSSION

11. ANNUAL MAORI PLAN Q3 JAN-MAR 2017

Patrick Le Geyt (Acting General Manager/Programme Manager, Māori Health HBDHB) provided a brief update on the following indicators:

- Improvement in Māori children being referred to nutritional advice.
- Disparities in rangatahi accessing Mental Health and Drug and Alcohol services has improved.
- Caries Rates (oral health) have improved however under target but trending in the right direction.
- Areas for improvement are Cultural Competency training of Medical staff and Breast screening Aotearoa service.

The MRB were concerned with the lack of traction with RMO's participating in Cultural Competency Training. The Cultural Competency framework is currently being refreshed by Dr James Graeme (Senior Advisor Cultural Competency, Māori Health Service). MRB are interested in reasons why RMOs and SMOs are not attending cultural competency training and have asked GM Māori Health to investigate and report back to MRB the current Cultrual Competency training restrictions of RMO and SMOs.

Report to MRB June meeting providing an explanation and analysis on the current Cultural Competency training restrictions of RMOs and how to solve them. **ACTION Acting GM Māori Health**

Report to MRB how primary care manage Cultural Competency. **ACTION Acting GM Māori Health** and **L Dubbledam (HHB PHO)**.

12. TE ARA WHAKAWAIORA PRIORITIES AND REPORTING SCHEDULE JUN17 – JUN18

MRB **noted** the contents of the report including the reporting frequency change from annual reporting to 6 monthly, to provide regular updates on progress.

The Healthy First Foods /Healthy Weight Strategy is included in the Annual Plan report and Lactation Consultants will work with WCTO early to initiate change and development.

There was a discussion on the effectiveness and process of the Mental Health residential programmes for rangatahi. MRB are interested in reviewing the Central Region Model of Care paper presented to MRB in 2016.

Provide MRB with the Central Region Model of Care paper presented in 2016. **ACTION Acting GM Māori Health**

13. MĀORI STAFFING RECRUITMENT ACTION PLAN

The Māori Staffing Recruitment Plan 2016 / 2017 was taken as read.

It was clarified that staff are encouraged to participate in Exit Surveys however it is not mandatory. Staff who elect to participate in an exit survey have the option to conduct the survey with either their manager, a Human Resources representative or a Māori Health Service representative.

Linda Dubbledam (Manager Innovation & Development, Health Hawke's Bay PHO) advised Primary Care have a very low representation of Māori and raised the question how do we ensure the workforce staff representation reflect the consumers.

Further discuss Māori Nursing recruitment **ACTION Acting GM Māori Health** and **L Dubbledam (HHB PHO**)

SECTION 3 – FOR INFORMATION (NO PRESENTERS)

14. HEALTH LITERACY PRINCIPLES & IMPLEMENTATION APPROACH

Adam McDonald (Health Literacy Advisor) and Kate Coley, (Executive Director of People and Quality) were in attendance to discuss the Health Literacy Principles. MRB acknowledge that Health Literacy is a priority for the health system and particularly the impact on Māori community. MRB

want to see health knowledge built into the community and recommend this be a priority for the Health Literacy project implementation.

There was a lengthy discussion about the evidence base strategy and impact of appropriate communication to the community. Identifying the positive impact and less burden when Health Knowledge is increased within communities, engaging with the communities and building on Health Knowledge. It is evident the community are unaware of the many resources available and that there is a need for better access to physiotherapists and better engagement with the community.

The MRB supported the Executive Director of People and Quality to develop and evolve a system to assist the consumer becoming health literate and build the health knowledge within the community.

Present to MRB in June an update of the PHO Health Literacy Programme. **ACTION Linda Dubbledam (HHB PHO)**

15. BEST START HEALTHY EATING & ACTIVITY PLAN UPDATE

Shari Tidswell (Intersectoral Development Manager) was in attendance to discuss the Best Start Healthy Eating and Activity Plan update, providing an overview of the report, highlighting the following points:

- Statistics moved from 40 percent to 80 percent as Hawke's Bay received only one referral for three months' worth of data therefore this dropped the percentage down. However the MOH were really impressed with the work on referrals and support for nursing staff.

- The marketing approach was designed by working closely with the group it was intended for, and receiving feedback from whānau and providers as to whether it is appropriate. The aim is to get the consumer voice in there.

MRB noted the contents of the report.

16. HEALTH EQUITY UPDATE 2016

Nick Jones (Clinical Director of Population Health and Medical Officer of Health) was in attendance to provide a further update on the Health Equity Update that was presented at MRB in June 2016. Research findings from a study by Otago University, Wellington Campus, reports that Māori requiring palliative care return home to the less urban areas. Nick advised there are some distinct models of care around this however more work needs to be done.

Discuss further with Suzanne Pitama (Associate Professor Associate Dean Maori University of Otago, Christchurch, University of Otago) and come back to MRB June meeting with a more detailed report. **ACTION Nick Jones** (Clinical Director of Population Health and Medical Officer of Health)

17. TE ARA WHAKAWAIORA: ACCESS (LOCAL INDICATOR)

Jill Garrett (Strategic Services Manager Primary Care), was in attendance to discuss the Te Ara Whakawaiora: Access (local indicator), providing an overview of the report, highlighting the following points:

- Long term conditions framework due to be launched
- Currently recruiting a nurse practitioner
- Screening for Cardio Vascular Risk Assessment is on track
- Cardiology report is trending towards target

MRB noted the contents of the report.

SECTION 4: PRESENTATION

18. DRAFT ANNUAL PLAN 2017

Tracee Te Huia (Executive Director of Strategy & Health Improvement HBDHB) was in attendance and provided a brief overview of the Draft Annual Plan.

19. CLINICAL SERVICES PLAN

Sapere Research Group, David Moore (Managing Director) and Rebecca Drew (Principal) were in attendance to present the approach and process for the Clinical Services Planning for Hawke's Bay DHB. Statistical data and examples from Dunedin Clinical Services Plan were provided.

MRB was supportive of the work being undertaken by Sapere and look forward to viewing the model of care plan.

T Cowan-Greening excused herself from the meeting via teleconference at 11.41am

SECTION 5: GENERAL BUSINESS

There were no items for General Business.

The meeting was closed by Matiu Eru (Pouahurea Māori Health HBDHB) with Karakia at 12.00pm.

Signed: _____

Chair

Date: _____

Date of next meeting: 9.00am Wednesday 14 June 2017
Te Waiora (Boardroom), HBDHB Corporate Administration Building

MĀORI RELATIONSHIP BOARD
Matters Arising – Review of Actions

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
10/05/17	**1) Upgrade plan** Present the upgrade plan of the Tower Block and reconfiguration of Level 2 Corporate Administration Building	Trent Fairey	July	**IN PROGRESS**
	2) MRB Representation at HB Clinical Council MRB to develop a process	MRB	June	**IN PROGRESS**
	3) Cultural Competency training restrictions of RMOs a) Investigate and report back to MRB the current cultural competency training restrictions of RMOs and SMOs b) Report to MRB Health Hawke's Bay Cultural Competency Framework	Patrick Le Geyt Linda Dubbledam	June June	**IN PROGRESS** **AGENDA ITEM 14**
	4) Central Region AOD Model of Care paper Provide MRB with the Central Region Model of Care paper presented in 2016	Patrick Le Geyt	June	**AGENDA ITEM 15**
	5) Māori Staffing Recruitment Action Plan Further discuss with PHO the Māori Nursing recruitment plan.	Patrick Le Geyt /	June	**COMPLETE** Patrick to provide a verbal update.
	6) Health Hawke's Bay Health Literacy Programme Present to MRB an update of PHO Health Literacy Programme	Linda Dubbledam	August	**IN PROGRESS**

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
12/04/17	**7) Māori representatives in the workforce** a) Statistics on percentages of all ethnicities being employed at the DHB. b) A brief update of feedback from exit interview of Māori staff including the position/income level data. c) The Māori workforce recruitment plan to review.	Patrick Le Geyt Chris McKenna Kate Coley	June June July	**Refer below** **IN PROGRESS** **IN PROGRESS**
	8) Clinical Council Update Further discussion to be had and to bring back a number of options to the MRB meeting.	Patrick Le Geyt / Kerri Nuku	May	**COMPLETE**
	9) Health & Social Care Localities Update Discuss further the possibility of a Wairoa representative attending NUKA training and bring an update to the MRB meeting.	Patrick Le Geyt / Chrissie Hape	May	**COMPLETE**

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
08/02/17	**10) Fluoridation** Coordinate an independent workshop/wānanga with MRB to discuss the impacts of Fluoridation on populations and any recommendations to be bought back to a formal MRB meeting.	L Aitcheson-Johnson	May 2017	**IN PROGRESS** 12/04/17 L Aitcheson-Johnson and N Tomoana to meet and discuss L Aitcheson-Johnson presenting to NKII
	11) Te Ara Whakawaiora: Access (Local Indicator) ASH report to formulate better recommendations that improves the performance of the indicator.	Strategic Services Manager Primary Care	April 2017	**COMPLETE**

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
14/09/16	**12) MRB hosting the next Te Whiti ki te Uru:** a) Develop the agenda and discussions b) Consider future MRB representation to the Māori Caucus.	MRB	Nov 2016	**IN PROGRESS** Hawke's Bay is scheduled to host the TWkTU meeting 2 October 2017.

20

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
08/06/16	**13) Health Equity Update 2016** ***NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14*** 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	Acting DPH/ HE	Oct 2016 June2017	**IN PROGRESS** Acting DPH/ HE discuss further with Suzanne Pitama (Associate Professor Associate Dean Maori University of Otago, Christchurch, University of Otago) and come back to MRB June meeting with a more detailed report.

Date Issue Entered	Action to be Taken	By Whom	By When	Status as at March 2017
12/05/16	**14) Review form and function of MRB and Youth Representative** NKII and MRB are reviewing MRB including the composition and consideration of a Youth Representative.	CEO NKII	Sept 2016	**IN PROGRESS**
	15) Bariatric Surgery Investigation Request for an investigation of the evidence to rationalise the increase of surgeries per annum.	Strategic Services Manager	Oct 2016	**DEFERRED** The report was presented at EMT on 30/05/17 and has been deferred. Date to be confirmed.

Item 7 The following detail was provided by Human Resources: Figures as at 31 May 2017.

	% of workforce
NZ Māori	14.10%
Pacific Islands	1.01%
NZ European	62.72%
British & Irish	7.08%
Asian	2.99%
Other	9.87%
Unknown	2.24%
Total	**100.00%**

Target = 13.75%	% Māori
Medical	5.08%
Nursing	11.98%
Allied Health	14.06%
Support	31.75%
Management & Admin	19.66%
Total	**14.10%**

MĀORI RELATIONSHIP BOARD

WORKPLAN JUNE 2017- DEC 2017

NOTE: This workplan is still in draft therefore is subject to change.

Date/ Month 2017	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
14 Jun	Te Ara Whakawaiora: Oral Health (national indicator) Consumer Experience Feedback Q4 Report	Robin Whyman Kate Coley	Youth Health Strategy (For Information) People Strategy (2016-2021) First Draft Public excluded	Tracee Te Huia Kate Coley
	Te Whiti Ki Te Uru Meeting – 7 June 2017, Hutt Valley DHB			
14 Jul	Quality Accounts Draft	Kate Coley	Final Operational Budget update to committees (timing to be confirmed) Recognising Consumer Participation - Policy Amendment - review by EMT Consumer Engagement Strategy (worked up with Consumer Council - review by EMT Review of Engaging Effectively with Maori (AMHP Dashboard Q3 response)	Tim Evans Kate Coley Kate Coley Kate Coley
9 Aug	Te Ara Whakawaiora: Culturally Competent Workforce (Local Indicator) Te Ara Whakawaiora: Mental Health and AOD (National and Local Indicators) Annual Maori Health Plan Q4 April-June 17	Kate Coley Sharon Mason Tracee Te Huia	Social Inclusion People Strategy 2016-2021 (First Draft Public Excluded) Metabolic (Bariatric) Survery - in the context of a Healthy Weight Strategy for Adults (Timing to be confirmed)	Tracee Te Huia Kate Coley Tracee Te Huia
6 SEPT	***Hawke's Bay Health Leadership Forum, 8.30-3.00pm, East Pier, Napier***			
SEPT	**NO MEETING FOR MRB IN SEPT – email papers below to MRB for feedback**			
	Quality Accounts Final Consumer Experience Feedback Q4 Report Te Ara Whakawaiora: Healthy Heathly Weight (National Indicator)	Kate Coley Kate Coley Tracee Te Huia	Orthopaedic Review Phase 3 DRAFT	Andy Phillips
11 Oct	Establishing Health and Social Care Localities Update People Strategy 2016-2021	Tracee Te Huia Kate Coley		
8 Nov	Te Ara Whakawaiora: Smoking (national indicator) Tobacco Annual Update against Plan Annual Maori Plan (MRB only) Q1 July-Sept 17	Tracee Te Huia Tracee Te Huia	Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May)	Tracee Te Huia

Date/ Month 2017	Performance Monitoring and for Information and Discussion	EMT Lead	Strategic / Decision Papers	EMT Lead
DEC	NO MEETING FOR MRB IN DEC - – email papers below to MRB for feedback			
	Consumer Experience Feedback Quarterly Report Q1 March, Jun, Sept, Dec, Mar18 - incorporating Annual Review Board actionsa	Kate Coley		

HAWKE'S BAY District Health Board Whakawāteatia	**Chair's Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Ngahiwi Tomoana, Chair
Month:	June 2017
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board
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 May 2017 pertaining to Māori health.

INTRODUCTION

For this month, I provide an overview of the Chief Executive Officer's (CEO) report including:

- Ministerial Targets
- Financial Performance
- Best Start: Healthy Eating and Activity Plan
- Māori Representatives in the Workforce
- Appointment of Member to the Māori Relationship Board

MINISTERIAL TARGETS

This month there have been high numbers presenting in ED and admissions. However there was continued improvement in Shorter Stays in Emergency Departments. Elective activity remains below plan. Faster Cancer Treatment continues to improve, however in comparison to other DHBs over a six month period, HBDHB are the worst performing DHB. Raising healthy kids, smoking targets and immunisation have all seen improvements

FINANCIAL PERFORMANCE

The outstanding effort from managers and staff on the budgetary control was acknowledged. It was reiterated to continue this effort until year end.

BEST START: HEALTHY EATING AND ACTIVITY PLAN

There has been substantial progress over the 12 month period. The plan has proved to be robust and has been able to adapt to external changes such as responding to the joint Water Only Schools request from Ministry of Education and Ministry of Health and also developing the process for the national Raising Healthy Kids target linked to Reducing Childhood Obesity Plan.

MĀORI REPRESENTATIVES IN THE WORKFORCE

In further response to the MRB recommendation to lift the target to 25 percent over 5 years, statistics were presented. As at 31 May Māori representation now sits above the target at 14.1% (of our workforce). It was further noted that historically job applications received from Māori was at 5%, this has now doubled to 10%.

The future workforce needs to reflect the diverseness of the HB community. There will be a workshop and following this workshop detail will be brought back to the Board in July.

APPOINTMENT OF MEMBER TO THE MĀORI RELATIONSHIP BOARD

Succeeding Des Ratima JP, resignation from the Māori Relationship Board (MRB), the board approved the recommendation to appoint Dr Fiona Cram as the Ahuriri District Health representative.

HAWKE'S BAY District Health Board Whakawāteatia	**General Manager Māori Health Report**
	For the attention of: **Māori Relationship Board (MRB)**
Document Owner:	Patrick LeGeyt, Acting General Manager Māori Health
Month:	June 2017
Consideration:	For Information

RECOMMENDATION

That the Māori Relationship Board

Note the content of this report.

PURPOSE

The purpose of this report is to update MRB on implementation progress of the Māori Annual Plan objectives for May 2017.

INTRODUCTION

Over the last month the Māori Health Services have provided Māori health expertise in a number of health areas. Key areas of involvement include, planning, sector responsiveness, workforce development, service development and service improvement projects.

SYSTEM LEVEL MEASURES

Māori Health, alongside a number of DHB, PHO, and Community stakeholders recently participated in a series of workshops to discuss and identify possible actions for achieving the System Level Measures (SLMs). The SLMs are: reducing ASH rates, Acute hospital bed days per capita, patient experience of care, amendable mortality rates, proportion of babies who live in a smokefree household at 6 weeks postnatal, and youth access to and utilisation of youth appropriate health services.

The SLM provides an opportunity for the DHB to align our activities in a more coordinated and cohesive approach to system and service design to achieve equity in health for Māori. The workshops identified a lot of current activities and presented opportunities to improve cohesiveness between programmes and services in order to maximise health gain for Māori Identifying system and service barriers are often led by and for the DHB, and could benefit from more substantial input from Māori consumers. For example, in the most recent (in) patient survey experience results, only 40 (9%) of the 440 respondents identified as Māori. To ensure a responsive and appropriate health system for Māori, improved consumer input processes are needed to address this gap.

Māori Health will have input on the proposed actions which is due by 7 June 2017.

ANNUAL MĀORI HEALTH PLAN Q3 REPORT – HBDHB COMPARISONS

At the February 2017 HBDHB Board meeting, the Board requested that they would like to know how HBDHB compare HB with other comparable populations (e.g., BoP, Northland and Lakes). The following DHBs were chosen for comparative purposes based on their regional characteristics - population's sizes and Māori population sizes/percentages. Performance data has been collated from Trendly NZ website and comparative tables have been developed as below:

DHB	Total Population (NZ Census 2013)	Total Māori Population	Māori Population Percentage
Hawkes Bay	151,695	34,977	23%
Northland	151,692	44,928	29.6%
Lakes	98,187	31,440	32%
Bay of Plenty	205,995	42,277	23%
Mid Central	162,564	28,347	17.4%

DHB	Immunisation		
Target	95% (8 months)		
	Performance	Ranking - All DHBS	Ranking – Comparative DHBs
Hawkes Bay	95.4%	6	1
Mid Central	92.0%	7	2
Lakes	89.5%	8	3
Northland	88.9%	13	4
Bay of Plenty	81.3%	19	5

DHB	Cervical Screening		
Target	80% (25 – 69 Years)		
	Performance	Ranking - All DHBS	Ranking – Comparative DHBs
Hawkes Bay	73.3%	1	1
Lakes	71.3%	4	2
Northland	68.5%	7	3
Bay of Plenty	68.3%	8	4
Mid Central	60.9%	16	5

DHB	Breast Screening		
Target	70% (50 - 69 Years)		
	Performance	Ranking - All DHBS	Ranking – Comparative DHBs
Northland	70.3%	4	1
Hawkes Bay	66.2%	11	2
Mid Central	65.2%	12	3
Lakes	62.0%	16	4
Bay of Plenty	59.7%	19	5

DHB	PHO Enrolment		
Target	100%		
	Performance	Ranking - All DHBS	Ranking – Comparative DHBs
Lakes	101.0%	1	1
Northland	99.0%	3	2
Hawkes Bay	97.0%	5	3
Bay of Plenty	95.0%	7	4
Mid Central	86.0%	11	5

ANNUAL MĀORI HEALTH PLAN MONITORING

Māori Health have been monitoring the implementation of the AMHP through a review and provision of feedback on each quarterly report. The objective of the review is to determine the extent by which the Action Leads have progressed the implementation of the activities in their respective plans as well as the impact such plans may be having on reducing health inequalities betweem Māori and non-Māori. Following finalization of Q3 report review individual meetings were held with Action Leads as needed to provide further clarification on the issues from the report as well as support on how to improve on future reporting.

MAI STATEGY EVALUATION

The Māori Health Service has been working with an external contractor in the preparation and initiation of the mid-term evaluation of MAI. Data collection is scheduled to be carried out through the end of June with a final report expected in July/August this year. The information from this evaluation will be used to inform future implementtaion of the strategy.

AHURIRI DISTRICT HEALTH

ADH is the settlement entity for the WAI 692 Claim lodged as a consequence of the closure of the Napier Hospital. In the settlement which was signed by the Crown in 2008 there were four aspects of the deed, an ongoing relationship with DHB as part of the Māori iwi relationship, transfer of ownership of 2 properties: 3 Longfellow and 65 Geddis Avenue, an endowment fund and funding for contracts with the DHB. ADH is using that last part of the deed to upgrade their facility in which the Maraenui Medical Centre operates - everyone agrees that it is not fit for purpose.

As part of a governance to governance meeting action, HBDHB and Health HB have also provided ADH with a health profile report, including:

- Demographic profile and population projections
- Primary care utilisation rates
- Ambulatory Sensitive Hospitalisation Rates
- Chronic Disease Hospitalisation Rates
- Injury Hospitalisation Rates
- Child Health issues
- Comparative data with other HB TLAs

The report is aimed to help ADH understand their population health needs and help them with their organisational planning.

ALCOHOL HARM REDUCTION STRATEGY

A stakeholder engagement process and stock take is underway and will be used to inform the development of an Alcohol Harm Reduction Strategy. Māori health will provide input into this process to ensure appropriate considerations are given to ensure the strategy prioritises, and is responsive, and relevant, to Māori. Māori Health providers will also have the opportunity for input with a workshop planned for 15 June 2017.

SUDDEN UNEXPECTED DEATH IN INFANCY PREVENTION PROGRAMME

MOH has developed a new National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP) to be implemented from 1 July 2017. The new NSPP will continue to build on the Ministry's campaign to 'make every sleep a safe sleep' for babies with the aim of working with the wider Government sector to reduce the toll from SUDI. The NSPP includes a national SUDI Prevention Coordination Service and Regional SUDI Prevention Programmes delivered by DHBs and coordinated regionally. Each DHB will have a CFA variation that will agree how they support delivery of the Regional component of the NSPP and will detail reporting requirements.

The national SUDI Prevention Coordination Service will be responsible for providing oversight, monitoring, support, and resources to the Regional SUDI Prevention Coordinators and DHBs to establish and implement their Regional SUDI Prevention programmes.

The central region DHBs have recommended that Technical Advisory Services (TAS) assume the role of the regional coordinator. Once the Regional SUDI Prevention Coordinator is in place, the central region will develop a Regional SUDI Prevention Plan by the end of quarter one 2017/18.

MOH REVIEW OF WELL CHILD TAMARIKI ORA PROGRAMME

As part of a continued focus on ensuring all children and their families receive core services, Cabinet has directed MOH to review the content, timing and delivery of the core/universal health services for 0-5s to ensure they are built on evidence about what works, reflect key priorities, and are able to be delivered in sufficient intensity to meet identified need, beginning with the Well Child Tamariki Ora programme. Further information will be provided once the review has been scoped.

ANTE NATAL EDUCATION

Māori Health, with input from Maternity, and Women's Children's and Youth, has finalised the Programme description for developing and implementing a HBDHB Pregnancy and Parenting Information and Education Programme. A procurement process is underway, with the intention of full service delivery in place by January 2018.

ASH RESPIRATORY 0-4 YEARS PROJECT

A working group involving Māori Health, Population Health Strategist (WC&Y), Paediatric Respiratory services, and Health Hawkes Bay are carrying out a review of the respiratory pathway for tamariki – 4 years presenting to the Emergency Department. The purpose of this work is to identify system and service areas for improvement. To date, audits of case files have been completed, meetings with Primary Care Respiratory Nurse Champions have been held, and a review of internal HBDHB processes undertaken. The next step is to talk to whānau about their experiences with primary and secondary services, and how well these services met (or not) their and their child's needs. A summary, identifying areas for improvement will be presented to the working group by 30 June 2017.

ORAL HEALTH 0-5 YEARS PROJECT

Māori Health is a contributor to the Oral Health Equity for Tamariki <5 years project. The aim of the project is to improve the oral health status of Māori, Pacific, and tamariki who live in low

socioeconomic areas. Workstreams include: Influency Policy, Partnerships and Collaboration, Data Collection and Quality Improvement, Consumer Pathways, and Consumer Engagement. A key development in this work has been the establishment of a Māori Health Advisory Group (Te Roopu Matua) who provide advice and expertise to the project. Te Roopu Matua includes representatives from the Māori community, who have specific expertise in terms of their experiences, relationships, and activities with Māori communities. Members have also been selected to ensure the inclusion of the voice and views of young Māori mothers, fathers, and kaumatua.

Other oral health areas of contribution include:

- input into an oral health survey for Kōhanga to identify possible areas of support needed
- examining the referral pathway for tamariki assessed as high risk by WCTO and referred to the Community Oral Health Service for follow up

NGĀTAHI WORKFORCE DEVELOPMENT PROJECT

Māori Health Service are supporting the Ngātahi Project being led by Dr Russell Wills and managed by Dr Bernice Gabriel including, governance membership, inter-sectoral workshop planning, facilitation and follow up, and in the critique of the core competency framework (values, themes, threads and competencies across foundational, practitioner and leader contexts) that the Ngātahi project is aiming to develop.

The Core Competency Framework

The 'Core Competency Framework' for the vulnerable children's workforce uses the same six domains and 17 sub-domains of the Core Competency Framework for the Ministry for Vulnerable Children – Oranga Tamariki in order to:

- Make sense in practice, e.g., child protection and family violence; adolescent development and mental health.
- Are sensibly taught together, e.g., consent, privacy and information sharing; reflective practice, supervision and appraisal.
- To clearly define the competencies within each sub-domain in tiers/roles.
- For leaders in each service or group of services to decide which tiers/roles are appropriate for their practitioners.
- To give guidance to leaders to work with their practitioners to appraise their current and desired future competency tiers/roles.
- To identify leaders who can support others to achieve their desired level of competency.
- For services and practitioners that would like to achieve a new tier/role of competency to understand what that looks like and how that competency can be achieved.

Domain

Act in the best interests of children (Vulnerable Children's Workforce Core Competencies)

The Sub-domains

Champion the rights and interests of children, Work in a child-centred way, and Professional conduct and continual improvement. A profile of a worker competent in this domain include;

- Understands relevant ethical codes, competency framework, and legislation that govern practice and service delivery.
- Promotes the rights of children and respects their dignity.
- Committed to urgency when responding to children's needs and persistence to achieve outcomes.
- Recognises the principle that welfare and best interests of a child must be the first and paramount consideration, when making decisions that may affect their welfare.
- Able to put the child at the centre, and demonstrates child-centred decision-making that informs action, including recognising and responding to the vulnerability of children.
- Works in a child-centred way.
- Applies the least intrusive intervention necessary to protect vulnerable children.
- Reflects upon and improves professional practice.

Domain

Be culturally competent (Vulnerable Children's Workforce Core Competencies).
Sub-domains

- Understands diversity in Aotearoa New Zealand.
- Work with diversity and difference.
- Work with Māori.

The profile of a worker competent in this domain:

- Recognises and respects diversity within Aotearoa New Zealand.
- Communicates and engages in culturally appropriate and inclusive ways.
- Reflects upon own values, and their impact on professional practice.
- Cultural awareness and sensitivity underpins culturally competent practice.
- Recognises bi-cultural partnership in Aotearoa New Zealand and is able to reinforce the values, rights and mana Māori, underpinned by the principles of Te Tiriti o Waitangi.

Constitutional Platforms

The Māori Health Improvement Team are working on a constitutional platform to inform the domains and sub-domains as the basis of key references and the application of the Vulnerable Children's Workforce Core Competencies. The references and documentation intends to add value to the education and learning for people undertaking workforce core competencies. It is anticipated that subject matter to be covered in this regard include, but not limited to;

1. Cultural foundations (Shared common characteristics of social organisation. Individuals living in kindred groups belonged to a whānau. The most relative characteristics being those supportive of the health, safety, harmony and prestige of the clan. Those characteristics were known as tikanga).
2. The Declaration (Te Whakaputanga) of Independence 1835.
3. Te Tiriti o Waitangi (The Treaty) 1840.

4. The Declaration of Indigenous Rights 2007
5. The Constitution Act 1852.
6. Puao-te-Ata-Tū 1984.
7. Kahungunu Treaty Deeds of Settlement (contemporary claims).

It is envisaged that these references will be supportive to the educative role of the workforce competencies and to the health and social workforce as a whole. In essence, the programme should transmit a distinctive Kahungunu lens which reflects its journey and experience.

APPOINTMENT OF NETP COORDINATOR

Donna Foxall has been appointed to the role of NEtP (Nurse Entry to Practice) coordinator. The purpose of NEtP is to support new nurse graduates transition into their first year of practice. Donna is a registered nurse and has been a lecturer within the Bachelor of Nursing Degree at EIT for 13 years. Donna has strong links with Tūruki and supported the Rapai Pohe Scholarship students throughout their under graduate degree. Donna also initiated the tuakana/teina programme at EIT for Māori nursing students and registered nurses. Her most recent achievement has been as the Tumuaki or Chair of Te Kaunihera o Neehi Māori, the national Māori Nursing Council. Currently there are 40 students participating in NEtP within age residential care, primary health, secondary services and Māori health providers. Congratulations Chris McKenna on a great appointment!

MĀORI HEALTH OPERATIONS TEAM RECRUITMENT

Māori Health Service is pleased to announce the appointment of Taina Puketapu to the role of DNA Kaitakawaenga (filling the vacancy left by Speedy White in February). Taina has a start date of July 3rd 2017.

ACTING GENERAL MANAGER MĀORI HEALTH

Patrick LeGeyt

HB CLINICAL COUNCIL

Update from Kerri Nuku

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Oral Health**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author:	Sharon Mason, Executive Director Health Services Dr Robin Whyman, Clinical Director Oral Health
Reviewed by:	Executive Management Team
Month:	June 2017
Consideration:	For Monitoring

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Councils:

- **Note** the contents of this report.

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from Dr Robin Whyman Champion for the Oral Health Indicators.

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Reporting Month
Oral Health *National Indicator*	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are caries free at 5 years of age	≥95% ≥67%	Robin Whyman	**JUN 2017**

MĀORI HEALTH PLAN INDICATOR: Oral Health

Oral health, general health and quality of life

Dental decay (dental caries) is one of the most common preventable chronic diseases. It is an important public health problem because of its prevalence, impact on individuals, society, and the public health system.

Severe early childhood caries reduces a child's quality of life: causing pain and discomfort, it affects eating and sleeping, prevents healthy growth and weight gain and reduces immunity to disease. Dental caries in early childhood is strongly predictive of an ongoing childhood and adulthood risk of dental caries.

Management of dental caries occupies considerable DHB resources to treat children and adolescents and private resources to manage the effects in adulthood. Untreated acute and chronic infections lead to a higher risk of hospitalisation and loss of school days and work days which may impact of a child's ability to learn and adult's ability to work.

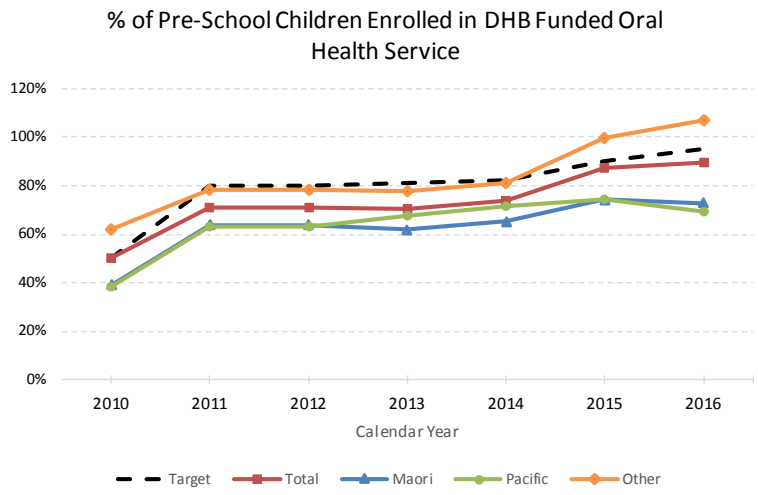
The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Effective population health strategies and clinical prevention methods have substantially reduced the amount of dental caries in the child population and reduced the impact of dental caries for the community. However, substantial inequities in oral health outcomes remain.

Inequality in outcomes in oral health status for Māori

Māori and Pacific children, and those living in socioeconomic disadvantage experience poorer outcomes in oral health status (National Health Committee, 2003). They have also tended to enrol for oral health services, and utilise services later, when compared to non-Māori.

WHY IS THIS INDICATOR IMPORTANT?

Percentage of preschool children enrolled in DHB Funded Oral Health Service



	Target	Total	Māori	Pacific	Other
2010	50%	50.4%	39.2%	38.3%	61.9%
2011	80%	71.1%	63.8%	63.3%	78.4%
2012	80%	71.1%	63.8%	63.3%	78.4%
2013	81%	70.4%	61.9%	67.4%	78.0%
2014	82%	73.9%	65.3%	71.7%	81.3%
2015	90%	87.1%	74.1%	74.2%	99.8%
2016	95%	89.2%	72.7%	69.1%	107.0%

2

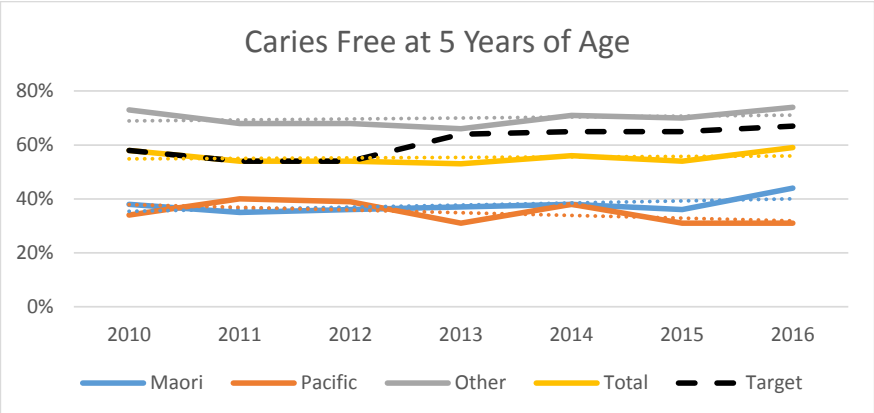
Early preschool enrolment and engagement with Oral Health Services is considered a key preventive strategy to improve preschool oral health. Earlier engagement raises the profile of good oral health for whanau, enables a relationship to develop between whanau and the Community Oral Health Service teams, increases the preventive care provided by clinical teams and increases the provision of anticipatory advice to parents and guardians prior to the development of early childhood dental caries.

Preschool children enrolled in DHB oral health services have increased rapidly as the DHB has focused on the national priority of earlier preschool enrolment in oral health services. However, as the DHB gets close to the overall target of 95% of children enrolled, quality of the ethnicity coding is becoming of concern. The 2016 data suggests that over 100% of non-Māori and non-Pacific children are enrolled. Meanwhile there has been a small drop in the percentage of Māori and Pacific children indicated as enrolled.

These data are obtained from the Community Oral Health Service's Titanium clinical record database. Enrolment data is now populated by parental self-declared ethnicity data obtained through a quadruple enrolment alongside enrolment for primary care, Well Child Tamariki Ora and Immunisation. However, this has operated for only 2 years. It is likely that the discrepancy is in part a legacy issue that relates to the older (3-4 years) preschool children and will improve as quadruple enrolment has been the basis of data for all age groups, in a further 2 years time. The denominator for the numbers in each ethnicity group are based on Statistics New Zealand data provided through the Ministry of Health and based on census projections. It is also possible that the denominators are providing misleading percentages.

The overall level of preschool enrolment and improvement is very pleasing. The discrepancy with Māori and Pacific enrolment is concerning and will require ongoing attention to data quality and checking the system/ quadruple enrolment.

Percentage of children who are caries free at 5 years of age



	Target	Total	Maori	Pacific	Other
2010	58%	58.4%	38.1%	34.2%	72.5%
2011	54%	54.0%	35.1%	39.8%	67.5%
2012	54%	54.1%	36.9%	39.2%	65.5%
2013	64%	54.2%	36.7%	31.2%	66.3%
2014	65%	56.5%	38.7%	38.0%	71.2%
2015	65%	54.4%	36.0%	30.5%	70.1%
2016	67%	59.0%	44.0%	31.0%	74.0%

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education, without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth.

Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

The 2016 results represent a substantial improvement in outcomes for all groups except Pacific where only a small improvement is noted. Results for Māori represent an 8% improvement and non-Māori , non-Pacific a 4% improvement meaning, that there has also been a small improvement in a long standing inequity for Māori .

Results for Māori and non-Māori , non-Pacific represent the best outcomes for Hawke's Bay DHB that have been achieved. Trend analysis also indicates that the inequity between Māori and non-Māori , non-Pacific is slowly closing, albeit very slowly.

However, the target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for Pacific children remain particularly concerning.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?

Activity planned to support these indicators has been

1 *Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Ora and immunisation services.*
This initiative has now been operating since early 2016 and is now business as usual for lead maternity carers (LMCs) and oral health services. The strong flow of information from the quadruple enrolment process to oral health services is believed to be the primary reason behind the ongoing increases in the first indicator in this report (percentage of preschool children enrolled in DHB Funded Oral Health Service).

2 *Changing the relationships with Māori health providers*
With the advent of quadruple enrolment the focus of activity for the Māori health provider services working with oral health is changing. Traditionally these services have helped to engage with enrolment, and focus is now changing to supporting hard to reach whanau and Oral Health Services to connect.

Changes to the operation of the Titanium database operated by the Community Oral Health Service were put in place for the start of the 2017 calendar year.

Changes to incorporate additional visits for high risk whanau through the Well Child Tamariki Ora providers are currently being made to contracts between Te Taiwhenua o Heretaunga, Kahungunu Executive, Plunket NZ and Māori Health and will be finalised by 1 July 2017.

3 *Improving preventive practice in the Community Oral Health Service*
Work with the clinical teams of dental therapists to improve the utilisation of fluoride varnish, bite wing radiography and fissure sealants to prevent dental decay is ongoing. All of the indicators show improvement and work is currently focussed on reducing variation between clinical teams across the service.

4 *Community water fluoridation*
The DHB noted in 2016 that the government has signalled legislation to provide decision making ability to district health boards. The benefits of community water fluoridation to reducing dental caries were also noted from the Te Ara Whakawaiora report in 2016.

4

The Bill to make the decision making change was introduced in late 2016 and a submission supporting the Bill was made by the DHB, after consideration and approval of the Board. A verbal submission was made to the Select Committee by Dr Whyman in March 2017 and it is understood the Select Committee is due to report back in June 2017.

5 Population health strategies

Population health strategies are an important contributor to improving child oral health, and in particular:

HBDHB's *Best Start Healthy Eating and Activity: A Plan (2016-2020),* with 4 interlinking objectives:

1) Increasing healthy eating and activity environments – Collection of data is underway to provide benchmarks to measure change in healthy eating environments. All HB primary schools have been contacted re status of 'water only policies' and a 500m zone mapped around each school (via Auckland University INFORMAS study) to provide a baseline of unhealthy food and drink advertising sites.

2) Develop and deliver prevention programmes - "Healthy Foods- Healthy Teeth and eating for under 5's" was launched in March for use in the B4SC. Initial feedback from this design will be sought in July and then will be tailored for use in WCTO visits and ECE settings.

3) Intervention to support children to have healthy weight – Raising Healthy Kids is the new Health Target linked to the BMI measure at the B4SC which support referrals for overweight and obesity to primary care and Pre School Active Families where oral health messages are linked.

4) Provide leadership in healthy eating - HBDHB Board has endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH's guideline – we are sugar sweetened beverage free and soon will be mostly confectionary free.

Healthy Housing

The Child Health Housing Programme is fully operational and aims to reduce preventable illness among low income families/whanau who are living in cold, damp and unhealthy homes. Eligible families typically live in sub-standard housing and have a history of health issues associated with cold damp housing and overcrowding. Homes are assessed by the team and an intervention plan is implemented to improve the quality of the house and to address structural and functional crowding.

Breastfeeding

The March 2017 Te Ara Whakawaiora: Breastfeeding report acknowledged that currently challenges exist meeting the 6 week target and that a drop off occurs between 6 weeks and 3 months. Initiatives to improve and sustain early breastfeeding are important to early childhood oral health. Recent literature (Gussy et al 2016) has demonstrated that early introduction of sugary beverages (before 18 months) is significantly associated with early development of dental caries. Initiatives associated with breastfeeding have been reported in the Te Ara Whakawaiora: Breastfeeding report.

Oral health promotion

The national campaign and TV advertisement run by the Ministry of Health and Health Promtion Agency "Baby Teeth Matter" and brushing teeth with fluoride toothpaste 2x a day are being supported locally with posters and repeated on the HBDHB Facebook page.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR?

Māori and Pacific preschool enrolment and engagement with Oral Health Services and improvements in the proportion of Māori and Pacific children caries free at 5 years represent a complex interplay of societal, environmental and service delivery factors.

1 Under 5 years equity project

In late 2016 the Communities, Women and Children directorate commenced a project focussing on delivering equity in oral health outcomes for 5 year-olds with a 5 year time frame.

The project is aiming to

- strengthen consumer engagement and participation with Oral Health and to substantially improve consumer input to Oral Health Services and to oral health strategies to improve child oral health.
- Coordinate consistent messaging and health promotion activity focussing on improving equity in early childhood oral health.
- trial initiatives to improve whanau engagement with early childhood oral health services commencing in the Hastings Central community clinic hub.
- spread innovation that is successful within the service.
- work in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery
- Influence policy change, particularly for water only enviornments

The project sponsors are the Service Director Communities Women and Children and Clinical Director for Oral Health, the Project Manager is the Communities Women and Children Deputy Service Director and a Project Steering Group with broad representation from services, Māori Health, PHO and consumer has been established.

2 Workforce change and kaiawhina engagement

Community Oral Health Services have changed the service's workforce mix by redeploying a clinical vacancy within the service to employ a kaiawhina to support the service's engagement with the community and other providers. This initiative will commence at the Hastings Central hub clinic and will be monitored for effectiveness.

3 Clinical quality indicators

Community Oral Health Services are continuing to monitor the implementation of a greater preventive focus in the clinical activity of the service. This involves monitoring 3 quality indicators (fluoride varnish, bitewing radiography and fissure sealants). Levels of use of fluoride varnish and fissure sealants are satisfactory but clinical variation remain. Focussing on improvements to utilisation with appropriate children is the current priority. Use of bitewing radiography remains lower than optimal as it represents a significant clinical practice change. Six-monthly reporting to the service and peer discussion is being used to effect these changes to clinical practice.

RECOMMENDATIONS FROM TARGET CHAMPION

The primary concerns associated with these preschool oral health outcomes relate to

1 Enrolment data quality

Work needs to continue to improve the proportion of Māori and Pacific 5-year-old children enrolled for oral health services. That work also needs to further understand the reasons underlying the over representation of non-Māori and non-Pacific children in the enrolled numbers. This will start with comparsion with services also using quadruple enrolment, particularly national immunisation register

(NIR), checking enrolments for ethnicity against ECA data and evaluation of denominators being used to calculate the percentages.

2 Accelerating equity in caries free status Māori and Pacific children

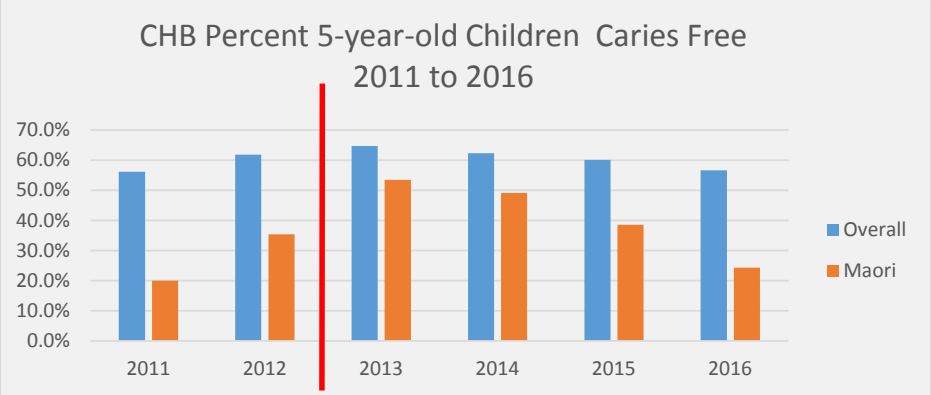
The project to improve equity in 5-year-old caries free status is ambitious and aims to take a cross sector focus. It will require ongoing support over 3-4 years to achieve the planned outcomes.

3 Community water fluoridation

A substantial risk exists with achieving the indicator of improved 5-years-olds caries free as a result of the loss of community water fluoridation in Hastings in August 2016 following the campylobacter outbreak in Havelock North.

Hastings District Council infrastructure used to deliver community water fluoridation is currently being used to chlorinate the water. A timeframe to return to fluoridation, which can be in conjunction with chlorination, has not been provided by the Hastings District Council at this time.

Community water fluoridation was lost in Central Hawke's Bay (CHB) in late 2012 and monitoring of the 5-year-old caries free rates is ongoing. The 2016 data confirms that loss of community water fluoridation in CHB has been particularly detrimental to Māori 5-year-old caries free outcomes in CHB, as the following graph indicates.



Dr Snee wrote to the Central Hawke's Bay and the Hastings District Councils in March 2017 expressing the DHB's concerns at the CHB outcomes, and the potential outcomes in Hastings. He also met with the CHB Mayor in April 2017.

Action on fluoridation will not completely remove the oral health inequities outlined in this paper, but it is important that the DHB continues to act on this issue both within the current legislative framework and the potential framework outlined in the earlier section.

The identified areas for improvement and timeframes are outlined in the following table

Description	Responsible	Timeframe
Review the ethnicity coding and accuracy within the oral health patient management system (Titanium)	Team Leader Oral Health Clinical Director for Oral Health Children, Women and Communities Deputy Service Director	June 2018

Under 5 years of age caries free equity project		Phase 1 Feb – Nov 2017 and Total project 2017-2019
Consumer engagement, participation and feedback. Te Roopu Matua.	Project Manager and Project Steering Group	April – Nov 2017 and ongoing
Relationship Centre Practice training for all Community Oral Health Staff	Team Leader Oral Health	Jul- Aug 2017
Seek feedback on the Healthy Foods - Healthy Teeth and eating for under 5s prevention programme and tailor it for use in WCTO and ECE settings	Population Health	July 2018
Environmental scanning of water only policies and decisions about next steps	Oral Health Population Health Advisor	July 2018
Early intervention in general practice in conjunction with Systems Level Measures work.	Project Manager and SLM group	Dec 2017
Well Child Tamariki Ora provider outreach services	Māori Health Services	July 2017
Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service perfomance	Clinical Director for Oral Health Team Leader Oral Health	June 2018
Community water fluoridation Monitor legislative change timetable Build relationships with communities of interest	Clinical Director for Oral Health	2017-2018 Legislative change 2017-2019 Relationship development communities of interest
Breastfeeding initiatives to improve and sustain early breastfeeding	Breastfeeding Champion	July 2018

CONCLUSION

Improving early childhood oral health eliminating inequity in dental caries levels has been described as a “wicked problem” (Thomson 2017) because it is difficult to solve, has multiple causes, is continually developing and changing and has no universal solution. It represents the outcome of complex societal inequities in social conditions and health services.

However, significant steps to control early childhood dental caries would be made with region-wide access to optimally fluoridated water and removal of sugar sweetened beverages from all early childhood environments.

Improvement in both of these indicators will require focus on collaborative activities to improve social and economic environments, including community water fluoridation and sugar-free environments,

a greater understanding of data quality and corrections to data quality issues, particularly related to enrolment, a continued to move to a preventive clinical focus for the Oral Health Services and a willingness by Oral Health Services to continue to question the best model of care for delivery of preschool oral health while maintaining very positive outcomes that are being achieved for oral health outcomes in the primary school child population.

Dr Robin Whyman
Target Champion for Oral Health
Clinical Director Oral Health

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HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER EXPERIENCE FEEDBACK

12

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Update of the Youth Health Strategy 2016-19**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Councils**
Document Owner:	Tim Evans, Executive Director Corporate Services
Document Author:	Nicky Skerman, Population Health Strategist; Women, Children and Youth
Reviewed by:	Executive Management Team
Month:	June 2017
Consideration:	For information

RECOMMENDATION

That the Māori Relationship Board, Clinical and consumer council

- **Note** the contents of this report.

OVERVIEW

The Hawke's Bay community is invested in youth services across multiple levels and sectors, frequently sharing common population groups and mutual visions. Hawke's Bay DHB funds the majority of contracts for youth health services, alongside other funding sources such as; Ministry of Health, Ministry of Social Development, Ministry of Education, Ministry of Youth Development and Councils.

The HBDHB Youth Health Strategy has the potential to create opportunities across the Hawke's Bay district to improve the responsiveness of services for youth. It aims to convey a shared vision from Hawke's Bay youth and stakeholders by identifying a common set of youth outcomes and indicators that cut across the work of many organisations and services working with youth.

Though there are many commonalities in how organisations and services talk about their goals and impact, the lack of shared knowledge can lead to missed opportunities for collaboration and collective impact.

BACKGROUND

Consultation on the Youth Health Strategy commenced in October 2015. The final version was endorsed by the HBDHB Board after going through the committees in June 2016.

Youth Strategy Update

Over the last year, the Youth Health Strategy has been presented in many forums within the district health board and to some community groups. These include the; Woman Child and Youth Strategic group, paediatric study days, the Suicide Prevention Fusion group and the Child Adolescent and Family Service (CAFS).

As a strategic document we are ensuring a shared vision whilst setting youth focused outcomes and indicators. The document also encourages an increase in profile around this age group and promotes some common principles about how services are provided.

Feedback from CAFS

> "I think that it has highlighted themes we are seeing, around the complexity and co-morbidity. In the front of our minds and energy are the needs to work together with other agencies (e.g., Directions, Oranga Tamariki, School Guidance Counsellors) to create a more cohesive approach across the sector."

Feedback from Paediatric Study day

> Good ideas & strategies hearing the voice of youth
> Interesting to know strategy. Valuable info
> Interesting discussion, more info in adolescent secondary health needed/identified.

Model of Youth Health
In October 2016, HBDHB began a two phase competitive procurement process.

The first phase was a call for "Registrations of Interest" (ROI). As part of that process there were two stakeholder and youth consultation meetings with forty people in attendance from across the sector. The purpose of the meetings was to consider different models for delivering youth health services in Hawke's Bay. These meetings were supported with a panel of representatives from general practice, mental health, personal health services, Ministry of Social Development and Māori Health Services.

The second phase is a competitive "Request for Proposals" (RFP) that will be open to those suppliers who responded to the ROI. The RFP, aimed at procuring several youth services to commence January 2018, was launched on the Government Electronic Tender Service (GETS) in April.

Youth Consumer Council
At the end of 2016, HBDHB formed a Youth Consumer Council following a nomination process across the district. There are currently eight members representing mixed age and ethnicity and areas of interest covering; mental health, suicide prevention, education, Hauora Māori, alcohol and drugs, rural health, cultural health and disability.

The Youth Consumer Council is a committee of HBDHB consumer council supported by HBDHB, Directions Youth Trust and Te Taiwhenuia O Heretaunga. The Youth Consumer Council have developed a terms of reference that has been signed off by HBDHB Consumer Council. The group meets monthly and have been approached to be participate in many projects and initiatives across Hawke's Bay. During March, two of the group attended the Hawke's Bay Health Sector Leadership Forum.

We are in the process of developing a pathway for access to Youth Consumer Council. Support from HBDHB is being provided by Jeanette Rendle (Consumer Engagement Manager) and Nicky Skerman (Strategic Services).

Various HBDHB staff and other youth representatives from around the country have attended Youth Consumer Council meetings to provide support to the group, such as the communication team who are supporting the group in the area of social media. The group have set up a Facebook page to support connection with other Hawke's Bay youth.

The group were also profiled in the HBDHB March CEO newsletter and have produced their own brochure promoting themselves , stating their three priorities:

- Teen Suicide Awareness
- Drugs and Alcohol Culture
- Mental Health

A meeting was held with the Chief Information Officer around the vision youth have given for the digital future of some youth services. This will be a future project that will potentially change the way youth access services and receive information. During our consultation, the youth voice raised digital media as an important area for development.

Free under 18s Primary Care

The Youth Strategy's vision around positive youth development, increase and early access to services and no door is the wrong door (connection of youth services) has been integral as part of the free under 18 services in general practice. This service is expected to be in place in 2017.

NEXT STEPS

- Youth services stakeholder group: To be set up in 2018 once all youth services are in place
- Continue to support the Youth Consumer Council
- Continue to work with the Ministry of Health helping to share with other DHBs the work we are engaged withinin the youth space.
- Develop a dashboard looking at outcome measures when data from June 2016 becomes available. e.g. teenage pregnancy and suicides rates.

Health Hawke's Bay - Te Oranga Hawke's Bay
Hawke's Bay District Health Board Māori Relationship Board
He Taura Tieke Update
For Information

Background

He Taura Tieke was initially introduced to Health Hawke's Bay and three general practices in 2015. He Taura Tieke is a quality self-audit tool used by health services wanting to improve their responsiveness to Maori whanau who access their service.

The 'tool' broadly identifies the attributes of effective health services for whānau and presents them in a checklist framework that indicates performance outcomes for each attribute.

In 2016 Health Hawke's Bay's Clinical Advisory Group (CAG) and Board of Directors included He Taura Tieke as a Quality Measure on HHB's Clinical Quality Score Card. The Clinical Quality Score Card will be released in September 2017 to general practices and HHB's Board for review and comment.

2016 – 17 Project Progress

2016 Baseline Assessment	2016 Action Plan Developed and Implemented	2016 Decline to Participate	2017 Re-assessment completed	2017 Decline to Participate	2017 Action Plan Developed and Implemented	2017 Cultural Competency Attendance
- 10/22 completed	- 10/22 completed	- 4/22	- 2/22 Completed	3/22	- 2/22 Completed	- 13/22
	- 8/22 engaged with contractor, action plans to be submitted and implemented		- 6/22 due June 2017 - 2/22 due Sept/Oct 17			- 07/22 to attend Cultural Competency Session

- Three of the four declining general practices are Very Low Cost Access (VLCA) practices
- One VLCA general practice has completed audit cycles in 2016 and 2017
- One non-VLCA Napier based practice has completed the audit cycle and has implemented a 3 year action plan
- Most general practices are have not been able to commit due to restructures and work demands

The contracted provider (with the support of Health Hawke's Bay) will continue to encourage general practices to engage with He Taura Tieke.

delivery. For the purpose of this information paper please find included Appendix A which is the self-audit tool to assist providers to complete an assessment of current service

Lillian Ward
Senior Māori Advisor/Equity Project Manager

Appendix A

He Taura Tieke

2017

Measuring Effective Health Services for Maori

A Practical, Quality Self-Audit Tool

Service: _____

He Taura Tieke Leader: _____

Service Manager: _____

Number of people working in service? _____

Number who participated in this audit? _____

Contents

1. Frequently Asked Questions

What is He Taura Tieke?

He Taura Tieke is a quality tool based on the key attributes that make services effective for Maori. It broadly identifies the attributes of effective health services for whanau and presents them in a check list framework that indicates performance outcomes for each attribute.

What are the Key Features of He Taura Tieke?

- Identifies key health service attributes that are effective for Maori and their whanau who access your health service.
- Measures how effective health services are for Maori.
- A self-audit and self-measuring tool for quality and effectiveness.
- A planning tool that is action focussed as the service identifies actions to implement.
- A regular annual cycle that assists the service to monitor progress in implementing the actions identified.

What are the 4 Key Steps for your Service?

1. Ask the Question - what could our high performance service for Maori look like? what are we doing well? what else could we do?
2. Record the answer - informed by the questions provided.
3. Identify actions - practical effective steps to improve your service.
4. Monitor implementation of actions - review annually and identify new actions.

What makes He Taura Tieke work in your service?

Key success factors include:

- High level champion committed to making service more effective for Maori.
- Positive promotion to service team.
- Dedicated time for He Taura Tieke leader/s.
- A regular in-service team meeting agenda item.
- Access to effective external support for leaders.
- Monitoring and completion of actions identified.
- Links to other Quality Improvement tools and processes
- On the organisation's Quality and Safety Framework (or equivalent)

Do Non Clinical services participate?

Yes.
Non clinical services have a significant impact on making health services more effective for Maori. Some examples include administration roles, front line reception, quality, data, coding, planning, research, policy, education and training, and funding health services.
This audit tool is designed for both clinical and non clinical services to answer the questions in the context of their work related to health and health service delivery.

What is the experience of other services?

Many District Health Board services, and community services in hospices and PHOs, find He Taura Tieke a useful and positive experience. Their feedback included:

- He Taura Tieke provided an opportunity to focus on Maori Health and our team's contribution.
- Increased awareness of health issues that Maori face and increased awareness of how our service responds to help improves health outcomes for Maori.
- Useful for identifying gaps and subsequent actions to work on - encourages us to think about whether our service provision in this area does meet the need.
- We would never had made these changes to our service without the use of this tool
- Learned more about Maori health, cultural issues, traditional Maori healing.
- Challenged our thinking and way of doing things - learning new wisdom.
- Beginning to form relationships with Maori within and without our service
- Amended our satisfaction survey forms to reflect ethnicity and Maori culture.
- Increased support for Maori patients.
- Made us think and be more responsible for our practice and find out and research aspects of Maori health relevant to our service.
- Showed a number of areas we are good at and a number of areas to improve - gives a good handle on 'where service is at'.
- Identified education and training we need to focus on e.g cultural awareness, ethnicity data, whanau ora, disparities in Maori health and how to set service goals and objectives for Maori.
- Provided ideas for more quality improvement projects and link Maori health to them.
- Encouraged participation and ownership by all the team even though their point of views differ.
- He Taura Tieke has given us a written record of issues and goals to work towards to make our service more effective for Maori.

2. Summary of He Taura Tieke Process

Phase 1: Getting Ready

- Key Champion identified – e.g. manager or other key service leader
- He Taura Tieke leader/s identified.
- Dedicated time agreed - for leader role and for service meeting agenda item
- Team informed about He Taura Tieke audit and timeline

Phase 2: Answering Review Questions

- Team engages and participates in audit.
- First step is to review actions from previous year.
- Leader records responses for where the service is at right now.
- Service identifies actions to improve or change, completes Action Plan.
- Leader reports progress regularly to the team and to the manager.
- Draft audit response and action plan is sent to Joanne Doherty Project Manager
- Feedback from Project Manager is sent back to service, and may identify ideas and experiences from other services
- Service reviews the feedback and begins to implement actions

Phase 3: Implementing Change and Actions

- Identified actions documented in Action Plan are discussed with manager and service team.
- Actions are added to Operational Plan by manager.
- He Taura Tieke remains a key agenda item at all team meetings.
- Timeline and person/s responsible for actions confirmed.
- He Taura Tieke leader/s and manager meet regularly to monitor actions.

3. Checklist for He Taura Tieke Leaders

Phase 1: Initial Decision Steps for Your Team

- ☐ The key champion is identified ----------(name)
- ☐ Team has discussed why He Taura Tieke is being actioned
- ☐ Non clinical staff are included
- ☐ He Taura Tieke leader/s identified ----------(name/s)
- ☐ He Taura Tieke leader has dedicated time for the role
- ☐ If coordinating more than one service response, additional support and time is available
- ☐ Process for participation and input by team is confirmed - Timeline is agreed
- ☐ He Taura Tieke is a regular agenda item at service/team meetings
- ☐ He Taura Tieke leaders know where to access support and additional information

Phase 2: Answering the Questions

- ☐ He Taura Tieke leader/s engage with service staff
- ☐ Consensus is reached and responses recorded for the service
- ☐ Leader/s report on progress regularly to the team and to the manager
- ☐ Key actions are identified and recorded in Action Plan
- ☐ He Taura Tieke leaders know where to access support and additional information
- ☐ Draft response sent to Project Manager for feedback
- ☐ Feedback reviewed and actions finalised

Phase 3: Monitoring and Implementing Actions

- ☐ Identified actions are discussed with the manager and team
- ☐ Identified actions included in operational plans
- ☐ He Taura Tieke remains on team meeting agendas
- ☐ Confirmed timeline and person/s responsible for monitoring actions
- ☐ He Taura Tieke leader and manager meet regularly to report on and monitor progress
- ☐ Manager receives report of progress
- ☐ He Taura Tieke leaders know where to access support and additional information

4. Checklist for Service Managers

You have a key leadership role to be the champion for this significant self - audit of your service. It is a useful planning and monitoring tool for your service and will help the service be more responsive to Maori whanau who access it.

- ☐ Ensure all staff know why He Taura Tieke is important
- ☐ Support He Taura Tieke leader/s for your service
- ☐ Check He Taura Tieke leader has dedicated time for the role
- ☐ Include everyone in the response, clinical and non clinical staff members
- ☐ Retain He Taura Tieke as a regular agenda item at service/team meetings
- ☐ Discuss the actions identified with the team
- ☐ Add the identified actions to operational plans
- ☐ Meet regularly with HTT leader to report on and monitor progress
- ☐ Include HTT progress in your monthly reporting

5. Taura Tieke Questionnaire

There are three specific sections to the questionnaire, four questions in each section. Each question covers a different theme and has some useful examples to use as 'prompts' to help inform your answer.

Section One Clinical and Cultural Competency

1. Maori Service Users
2. Physical Environment
3. Staff Competency
4. Cultural Practice

Section Two Key Health Strategies and Frameworks

1. Social, Cultural and Political Factors – Models of Care and Frameworks
2. Whanau Ora
3. Maori Health Disparities
4. Maori Health Workforce Recruitment and Retention

Section Three Participation and Engagement of Maori Service Users

1. Access
2. Information and Informed Choice - Trust and Respect
3. Participation and Evaluation
4. Seamless Health Services

Section 1: Clinical and Cultural Competence

Section 1 Questions

1.1 Maori Service Users
1.2 Physical Environment
1.3 Staff Awareness
1.4 Cultural Practice

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
1.1 Maori Service Users **How do you identify and engage with Maori service users?** **Examples:** • Who are the Maori consumers who access your service? • Are you engaged with other services in the community to enhance health services for Maori? • Who are the local Maori providers you could develop relationships with? • What could be a next step for your service to develop or strengthen these key relationships?	
1.2 Physical Environment **How does the physical environment your service is based in acknowledge and support other cultures and their beliefs and practices?** **Examples:** • Consider entrance, reception area and internal layout - and consulting rooms • Does the area and use support cultural beliefs and practices? (e.g. space /facilities for whänau) • What else could be done? • What could be a next step for your service?	
1.3 Staff Awareness **How are staff supported to be personally and professionally trained or competent to provide services for Maori?** **Examples:** • What training and education is provided to staff, managers and governance members to understanding Maori health concepts and health service delivery to Maori? • Is cultural awareness a Key Performance Indicator? (KPI) • How is cultural safety or competency measured?	

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
• Identify examples of relevant self directed learning that staff have undertaken • What could be a next step/s for your service	
1.4 Cultural Practice **Are you aware of practices in your service that need to be culturally safe for Maori – why would this be important or significant for whanau?** **Examples** • Consider treatment processes, non clinical policy development, administrative roles • Who do you seek guidance, input and support from about cultural safety? • Do you know of any best practice guidelines your service could access? • How are Māori service users protected from further illness or danger? • Consider medications, staff knowledge and respect for karakia, traditional kai, and Te Reo • What could be a next step/s for your service?	

14

Section 2: Key Health Strategies and Frameworks
(Understanding the Bigger Picture)

Section 2 Questions

2.1 Social, cultural and political factors – models of care or frameworks
2.2 Whanau Ora
2.3 Maori Health Disparities
2.4 Maori Health Workforce Retention and Development

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
2.1 Social, cultural and political factors - models of care and/or frameworks **What social, cultural and political factors have an impact on Maori health and well being?** **What models of care or frameworks is your service using to support Maori views of health?** **Examples:** • Identify and discuss examples of social, cultural and political factors that impact on Maori health – e.g. Maori TV, Te Wiki oTe Reo, local Treaty of Waitangi settlements, Matariki, local Waitangi Day events • How could your service respond and participate to assist Māori or iwi groups to lead health improvements? • What models of care or frameworks is your service using to support Maori health? E.g. Maori frameworks like Te Whare Tapu Wha and others - Ministry of Health and DHB frameworks, Treaty of Waitangi, Ottawa Charter etc • What could be a next step/s for your service? What could be a next step/s for your service	
2.2 Whanau Ora **What does your service know and understand whanau ora to be?** **Examples:** • Whanau ora is a significant aspiration in Te Ao Maori – understanding the concept • Whanau Ora as a government programme • Whanau Ora in your locl area - what's happening? • How could your service interconnect?	

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
• What could be a next step/s for your service?	
2.3 Maori Health Disparities **What are the key Maori health disparities your service is aware of?** **Examples:** • What do you know about local and national health inequalities? Where do you access this information? • Is ethnicity data collected in your service? • Do all staff know and understand why it is important and useful to collect ethnicity data? • Do all staff know how to collect ethnicity data accurately and sensitively? • Do staff know the ethnicity codes identified on the patient label? • Based on your knowledge of inequalities is there a need for your service to set some key goals or objectives for Maori whanau? • What could be a next step/s for your service?	
2.4 Maori Workforce **How does your service recognise and support Maori staff?** Examples: • How many Maori staff work in the service? • Are Maori staff in the service aware of the support available for Maori employees? (This may include professional development and accessing support for spiritual, social and cultural needs) Does the service have a plan for addressing Māori staff recruitment and retention? • What would be the benefits to your service to have Maori designated position/s? • Do you make Māori staff available to Māori consumers throughout the service? If Māori staff are not available do you ensure that support is available for Māori consumers? How? • Is it possible for your service to invite Maori health students for work experience or summer cadet ships? • What could be a next step/s for your service?	

Section 3: Participation and Engagement of Maori Service Users

Section 3 Questions

3.1 Access
3.2 Information and Informed Choice - Trust and Respect
3.3 Participation and Evaluation
3.4 Integration of Health Services

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
3.1 Access **What are the access barriers for Maori service users and their whanau that your service is aware of?** **Examples:** • How do you ensure your services are easily accessed by Māori and their whanau? • Do you deliver some services from within the community? (e.g. marae, kohanga reo) • Do you offer flexible access times? • How do you respond to consumers' requests about access? e.g. transport, cost, opening hours • What could be a next step/s for your service?Identify next step/s for your service	
3.2 Information, Trust and Respect **How do Maori service users, and whanau and caregivers, receive appropriate information about their health?** **What do you know about Maori healing processes and how do you respect their use? (e.g. karakia, rongoa)** **Examples:** • How do your respect the culture, privacy, and confidentiality of Maori service users? • Do staff members know about Maori views of health and wellness and the use of healing processes? • Are staff committed to ensuring names of people and local place names are spelt and pronounced correctly?	

Question	Notes – use this space to record comments or actions that arise from the question
Non clinical services - answer the questions in the context of your work related to health and health service delivery.	
• Are there Maori patient advocacy services you can refer people to? Who are they? Where are they based? Do you have referral processes in place? • Identify next step/s for your service	
3.3 Participation and Evaluation **What are some effective methods for gathering feedback from Maori service users, their whanau and Maori health providers in the community?** **NB: Do you use the Evaluation and Feedback Form for Maori patients and their whanau introduced at NMDHB in 2015 ?** **(Contact Joanne Doherty for copy)** **Examples:** • How do you evaluate your service? Is ethnicity recorded? • How does your service gather feed back from Maori using the service? • Is this paper based and /or oral ? • How do you know your complaints procedures are user friendly and effective for Māori? • How do you keep Māori aware and informed about the service? • Could Māori be more involved in the planning, delivery and monitoring of your service? How? • What other Quality Improvement (QI) tools does your service use? • How can He Taura Tieke be linked to other QI? • Identify next step/s for your service	
3.4 Integration of Services **How are Maori service users linked to other services they need?** **Examples:** • Who is involved in discharge planning for Maori users of your service? • Do you inform consumers about other related services, including Māori providers? Do you know about other relevant services available? • What steps has your service taken to build relationships and develop mutual referral protocols with Maori health providers? • Does the service have links to non-health agencies (e.g. MSD, Justice, Housing). What could be a next step/s for your service? • Identify next step/s for your service	
Please Complete: **Number of People working in your service:** **Number of people participating in this response:**	

6. Implementation of He Taura Tieke Actions

Key Steps to Monitoring and Implementing Actions

- ☐ Complete Action Implementation Plan using template – discuss actions with manager and team
- ☐ Manager signs off final He Taura Tieke Audit and Action Plan and adds actions to Operational Plan
- ☐ He Taura Tieke remains on team meeting agendas - He Taura Tieke leader and manager meet regularly to report on and monitor progress
- ☐ Actions are monitored and reported on, to the service team, to the service manager and the District Manager
- ☐ He Taura Tieke leader and manager know where to access support and additional information

Review of Actions identified in last year's audit - Have the actions been implemented? What is required to complete any incomplete actions?

	HTT Ref No	Action	Key Steps	Timeline	Who is Responsible?	Measuring the Outcome We will know this action has been completed because……
1						
2						
3						
4						
5						
6						

14

7. Research and Background Information

He Taura Tieke is a quality, measuring tool that uses a self auditing and self measuring process to determine how effective a service is for Maori. The initial assessment provides a baseline about what the service is doing now, and identifies the key actions or changes to be implemented. This is measured and reviewed, developments are acknowledged, and new or revised goals and actions are identified during subsequent reviews.

Based on combined research results[1] about Maori consumers' views of health service priorities and health service effectiveness, He Taura Tieke identifies key health service attributes for Maori and presents them in a checklist framework to help you as a service meet the needs and expectations of Maori consumers. In particular, He Taura Tieke assists managers, service leaders and all health workers to plan, develop and provide better health services for Maori consumers.

'Whare tapa wha' is a model of health widely accepted by Maori. This model compares health to 'four walls of house, all four being necessary to ensure strength and symmetry, each wall representing a different dimension of health – taha wairua, taha tinana, taha hinengaro and taha whanau.' (Durie,M, *Whaiora: Maori Health Development*, 1994)

Traditionally, a taura tieke was a measuring line used in the building of a house. It was designed to check the symmetry of the diagonals so that the walls would be even and the house would be strong. The aim of this particular taura tieke is to contribute to the strengthening of the 'whare hauora'.

Maori expectations of health services they access may be the same, similar or different to expectations of other populations or communities. Most health service providers are aware that Maori clients have particular needs. The focus of He Taura Tieke is on certain attributes that enable some services to be more effective for Maori clients.

8. Attributes that Make a Health Service Effective for Maori

Maori consumers have clear expectations of the health services they use and certain attributes enable services to be more effective for Maori. By meeting the needs and expectations of Maori, providers will improve access to health services, support independence and improve Maori health.

Based on research[2] He Taura Tieke identifies these key health service attributes that are effective for Maori consumers and presents them in a checklist framework. The following key questions have been addressed in He Taura Tieke questions:

- What are Maori expectations of effective health services?
- What attributes of effective health services are highly rated by Maori consumers
- What features of care and service contribute most to Maori consumer satisfaction?

The major expectation of Maori is that their health will be improved as an automatic consequence of using a health service. While most health service providers are aware that Maori consumers have particular needs He Taura Tieke is an opportunity for them to self-audit their service response to Maori and identify steps for change and improvement.

The attributes of effective health services valued by Maori are:

1. Technical and Clinical Competence – includes safety and monitoring and health frameworks.
2. Structural and Systemic Responsiveness – includes strategies and frameworks that support Maori development, Maori workforce development and preferred providers.
3. Consumer Satisfaction – how Maori whanau engage, access and use health services - reviews access, information, trust and respect, informed choice, seamlessness and participation.

Key Markers of Effective Health Services for Maori

1. Technical and Clinical Competence for Maori – Clinical and Cultural Competency

- Maori expect service will be safe, appropriate and timely.
- Safety includes fitness of staff to serve Maori consumers sensitively.
- Service will be technically and clinically competent – and culturally competent.
- Service will be monitored and evaluated to meet legal and regulatory standards.
- Maori expect to be able to register concerns or complaints if expectations unmet.
- Primary responsibility – professional organisations, providers and MOH.

2. Improving Structural and Systemic Responsiveness to Maori – Key Health Strategies and Frameworks

- Maori expect health services to be responsive to Maori needs and expectations.
- Providers consider how health sector strategies can maximise the effectiveness of a health service for Maori consumers.
- Key frameworks and strategies in place impact on service delivery - e.g NZ Cancer Control Strategy, He Korowai Oranga and DHB Maori Health Strategy.
- Contribution to Maori development and developing Maori workforce.

- Clear processes for monitoring and evaluating the service – including and responding to Maori views.
- Primary responsibility - MOH and DHB.

3. Improving Maori Consumer Satisfaction – Participation and Engagement of Maori Service Users

- Access.
- Communication and information.
- Informed choices.
- Trust and respect.
- Participation by Maori.
- Seamless service provision.
- Primary responsibility – service providers and DHB.

9. Key Websites and Links

Treaty of Waitangi

www.treatyofwaitangi.net.nz www.waitangi.co.nz (Waitangi Associates)

- **HEALING OUR HISTORY - The challenge of the Treaty of Waitangi**
  Robert Consedine & Joanna Consedine
- **Pakeha and The Treaty – why it is our Treaty too**
  Pat Snedden
- **An Illustrated History of the Treaty of Waitangi**
  Claudia Orange
- **The Penguin History of New Zealand**
  Michael King
- **Three Treaty Booklets - The Story of the Treaty, The Journey of the Treaty and The Timeline of the Treaty**.

  Copies of the booklets can be obtained from The Treaty of Waitangi Information Programme, State Services Commission, PO Box 329, Wellington, New Zealand, or by calling 0800 TREATY.

Treaty of Waitangi Wallchart

An information wall chart available Reed Publishers.

Treaty Resources for Children www.waitangi-tribunal.govt.nz

The Treaty Of Waitangi: Questions and Answers

http://nwo.org.nz/files/QandA.pdf

This 56 page publication is a revised and updated edition of Treaty Questions and Answers which was first published in 1989 by Network Waitangi. Covering many historical and contemporary issues, it is for people who want to gain a basic knowledge about the Treaty of Waitangi and its implications, as well as for those who want to refresh and update their understanding. It includes a summary of legislation and events since 1840 which have breached the Treaty, and a comprehensive reading list for further information. It is available for you to download from www.nwo.org.nz and permission is given for this publication to be copied, distributed or transmitted, providing it is properly attributed, not altered in any way, and is not sold for profit.

Te Reo

www.kupu.maori.nz
He Kupu o te Rā – receive a word in Te Reo Māori by daily email

www.korero.maori.nz
speaking Te Reo-useful tips and resources

"He Pukapuka Reo Hauora Māori" Dr David Jansen

- a Māori medical phrase book designed to assist health professionals when working with whānau. Available from **www.mauriora.co.nz**.

Education and Training

Ministry of Health www.moh.govt.nz www.maorihealth.govt.nz

Ministry of Health Website has numerous publications and reports about Maori health, including:

- He Korowai Oranga: Maori Health Strategy
- Whakatataka Tuarua: Maori Health Action Plan
- Whakatataka: Maori Public Health Action Plan
- Te Puawaitanga: Maori Mental Health National Strategic Framework
- Health and Wellbeing of Older People and Kaumatua
- Taonga Tuku Iho – treasures of our Heritage:Rongoa Development Plan
- He Pa Harakeke: Maori Health Workforce Profile (2006-2011)
- Tatau Kahukura. Maori Health Chart Book 2006
- Decades of Disparity III
- Whanau Ora Health Impact Assessment
- Ethnicity Data Protocols
- Health Equity Assessment Tool

Tikanga Maori - a guide for Health Care Workers www.ccdhb.org.nz

Mauri Ora Associates www.mauriora.co.nz
Courses in cultural competency - healthcare and the Treaty of Waitangi - healthcare and Tikanga in practice

District Health Board, Maori Health Providers, PHO
Check your local health organisation websites to identify strategies and policy documents developed to support services to become more effective for Maori.

Maori Health Review **www.maorihealthreview.co.nz**
Māori Health Review - important medical studies with commentary from NZ specialists. Subscribe for free and receive quarterly articles

NZ Medical Council **www.mcnz.org.nz**
NZ Medical Council Resources that related to cultural competency include

- Statement on Cultural Competence
- Statement on Best Practices when providing care to Maori patients and their whanau
- Resource Booklet 'Best Health Outcomes for Maori: Practice Implications'
- Resource Booklet 'Best Health Outcomes for Pacific Peoples: Practice Implications'

14

Best Practice NZ **www.bpac.org.nz**
Best Practice evidence based educational material for primary care professionals
Improving Maori Health – Rongoa Maori – older Maori people's health – rheumatic fever - asthma

NZ Nurses Organisation **www.nzno.org.nz**
Extensive list of information and resources on Maori health, Tikanga Maori and Treaty of Waitangi issues.

Nursing Council of New Zealand www.nursingcouncil.org.nz
Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing education and practice

National Council of Maori Nurses **www.maorihealth.co.nz**
Te Kaunihera O Nga Neehi Maori o Aotearoa

Nga Maia - NZ College of Midwives - Midwifery Council of New Zealand
www.ngamaia.co.nz **www.midwife.org.nz** **www.midwife.org.nz**
Nga Maia, a national body that represents Maori Birthing, developed Turanga Kaupapa as guidelines for cultural competence. They have been formally adopted by both the Midwifery Council of NZ and the NZ College of Midwives.

Health Promotion - Maori health promotion **www.hpforum.org.nz**

Other professional bodies that have developed cultural competency guidelines include: Pharmacy, Physiotherapists, Social Workers, Occupational Therapists, Dietetics

10. Glossary

hauora	health
He Korowai Oranga	'the cloak of wellness' – New Zealand's Maori Health Strategy
He Taura Tieke	Traditionally a measuring tool used in building – in this context an audit tool used to guage how effective a health service is for Maori
hinengaro	mind, thought, intellect
iwi	tribe
Kai	food
karakia	prayer
kaupapa	platform or agenda kaupapa Maori = Maori ideology
korowai	cloak
manawhenua	those with trusteeship, guardianship of land in a local region
ora	life
oranga	health, wellbeing
tangata whenua	'people of the land'; the indigenous Maori population of this country
Te Tau Ihu	the top of the South Island
Te Upoko o te Ika	Wellington region
te reo	Māori language
tikanga	cultural practice – correct procedure or custom
tinana	body
wairua	spirit
whānau	family, extended family
whānau ora	family wellbeing
whare	House or home

11. References

Cunningham, C.W. Dual Goals Framework, Palmerston North, 2000.

Cunningham C. W. A Framework for Addressing Maori Knowledge in Research, Science and Technology 1998.

Durie, Mason. Whaiora: Māori Health Development. Auckland: Oxford University Press, 1994.

Ministry of Health. 1995. He Taura Tieke: Measuring Effective Health Services for Maori. Wellington; Ministry of Health; 1995.

AOD Residential Review Project – Service Model Report

REGIONAL SERVICES PROGRAMME

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Contents

Introduction

Existing resource dedicated to AOD residential treatment beds within the Central Region has historically and continually been under-utilised, with utilisation averaging between 50-60% over previous years.

A working group was established in June 2013 by Central TAS (shared service agency for Central Region) to review the service model in place. This included a specialist group with a constituency that included Planning and Funding representatives, accredited clinicians, consumer advisory (including Māori and Pacific consumer advisory), and some NGO members. Recognition was given that conflict of interest issues existed, including those of clinicians (not working in the NGO sector). All conflicts were addressed where possible.

The major findings from working group discussions and questionnaires to clinicians and providers of services and focus groups with consumers are as follows:

- Consumers, families and clinicians have consistently asked for more local options such as respite beds and for services to be less geographically isolated.
- There is consensus agreement that both co-existing and peer support with AOD experience is important for the service user's recovery and is not currently funded or available.
- Failure of treatment in residential care is often due to co-existing mental health conditions which are not adequately treated, or insufficient community-based treatment prior to entry into the service.
- High rates of relapse following discharge from residential care have commonly been linked to a lack of a seamless quality of treatment and support post discharge, particularly in cases where residential treatment is out of the domicile region.
- Whānau Ora care has been difficult to achieve within a residential care pathway and remains challenging due to geographical restrictions. Services need to be responsive to Māori and Pasifika.

A new service model of care was produced by the working group and presented to the Mental Health and Addictions Network (MHAN) in May 2014 for consideration. The model proposes to stage levels of care to reduce waste of resource and enhance care pathways.

It was then recommended that further feedback on the model be sought from Central Region DHBs. This was summarised and tabled at the August 2015 MHAN meeting.

This report is shaped on the 'conversation' held with the Central Region, through the process of the review (Section 1), and through the discussions held on the resulting proposed model of care presented to all relevant stakeholders for the Central Region.

Section 1 – Background to development of the model

Purpose

The objective for the review was to develop a comprehensive service model for addiction services across the Central Region (including residential, respite and withdrawal services). This included a review of residential services in accordance with overall treatment service provision for AOD and to develop a service model. The service model needed to fit with existing respite, withdrawal and wider community services to enhance seamless pathways of care for consumers with meaningful stages of support.

Strategic context

Strategic direction of the model is guided by the current review of the NZ Health Strategy, the Alcoholism and Drug Addiction Act 1966 (proposed Bill due October 2015, MoH), Blueprint II, and the mental health Service Development Plan – Rising to the Challenge (RTTC). Concurrently, the Ministry has highlighted the intention to devolve Withdrawal Management (methamphetamine) funding to DHBs to manage withdrawal management locally in the wider AOD setting, and with a proposed regional model to be agreed with the Ministry in September 2015.

The Alcoholism and Drug Addiction (ADA) Act Review

The new ADA Act will change considerably from the current 1969 Act, and will effect change for capacity and potential length of treatment. This new proposed model of care has to be able to accommodate the provisions of the revised/new ADA Act currently going through legislative processes in Parliament. It is understood that this new Act will be similar in many respects to the Mental Health equivalent (particularly regarding human and consumer rights), and will focus more on clients' capacity to change and make decisions on achieving/maintaining abstinence and sobriety. It is anticipated that the proposal for legislation will be going to Cabinet in August. The Bill will then be introduced in the House and referred to Select Committee. The Ministry is planning for commencement from either of two possible dates – 1 July 2016 or 1 December 2016 (Meeting with MOH 28 July 2015 – P Kennerly).

Blueprint II (2012)

This document presented a ten year strategy for Government. Blueprint II recognised that the Government is focused on developing a better-performing public sector. There is an expectation that the health sector would become more innovative, efficient and focused on delivering what New Zealanders really want and expect. At the same time, public services would need to have a sharper focus on costs and ensure value for money.

Rising to the Challenge (RTTC)

RTTC is a service development plan for mental health and addiction treatment services and operationalises Blueprint II through set direction for 2012-2017. Primarily, it is about using our resources more effectively and articulates Government expectations about the changes needed to

build on and enhance the gains made in the delivery of mental health and addiction services in recent years.

It is also about system-wide change to make service provision more consistent across the country and to improve outcomes both for people who use primary and specialist services as well as their families and whānau. The model responds to this strategy in particular by using a model of care approach and enhancing service integration across the community to intensive residential spectrum.

Review of the New Zealand Health Strategy

Consideration should also include the work currently underway to revise the New Zealand Health Strategy from a funding and capacity and capability perspective. It is expected that the Ministry, DHBs and the sector will be informed on the implementation of this review prior to December 2015.

Additional factors

Withdrawal management funding devolvement by region

The Ministry would like to explore within the sector the devolution of this funding and the development of an integrated system for withdrawal management for the Central Region DHBs with effect from 1 July 2016 (negotiable for Central Region). The new ADA Act will pose challenges for the withdrawal management system and it is important that this is considered in the wider context of addiction treatment services.

Nationally, there is $846,800 (GST excluded) per annum available for devolution ($296,000 for Central Region). Feedback received is that we are well advanced nationally with progress of our model of care for AOD treatment. This progress stems from recent work on the AOD residential review and modelling with Tom Flewett and the working group, along with the regional road show supported by Portfolio Managers across the six DHBs in the Central Region.

National Service Framework (NSF)

It is important to note that expectations expressed at Tier 2 level of the specifications for Addictions include principals that are captured also in the proposed model of care. These include:

- Supporting recovery.
- Acknowledge and address co-existing problems.
- Inclusiveness of family and whānau.
- A continuum from harm reduction to abstinence.
- Integrated care, collaboration, engagement and access.
- Treatment options for young people and their families.
- Offering choice.
- Treatment must adequately address people's needs, not just their addiction.
- Continuing care services.

- Ability to re-engage with services.

The current Nationwide Services Framework contains a number of individual service specifications at Tier 3 that apply to the AOD treatment pathway and also the existing proposed model. These are all identified as needing review at a national level (MOH meeting P Kennerly, July 2015).

Current Addiction Treatment Services specifications include (among others):

- Alcohol and Other Drug Community Support Services.
- Alcohol and Other Drug Acute Package of Care.
- Alcohol and Other Drug Day Treatment Programme.
- Early Intervention Alcohol and Other Drug Service.
- Intensive Alcohol and Other Drug Service with Accommodation.
- Managed Withdrawal Home/Community.
- Managed Withdrawal Inpatient Service.

Methodology

The review of the model of service delivery was initiated by the establishment of a Central Region working group. The working group was a specialist group and all attempts were made to ensure fair representation where possible (by DHB, appropriate skill base, including cultural and consumer focused), and tasked specifically to consider an improvement on the service model. Representation from all NGOs was difficult to facilitate within the NGO sector, so wider consultation was conducted by the Regional Portfolio Manager, Central TAS and the Chair of the working group. This consultation included public forums and meetings with NGOs where identified.

A stocktake of existing residential services (adult), which informed the review, included regionally funded services but not locally funded ones (see Table 1. below). This includes beds with Nova, Odyssey, Springhill and The Bridge. Youth AOD was excluded in recognition of the needs of youth being very different from the needs of adults. The level of youth expertise required was beyond that of the adult review working group.

Table 1 Level of service funded for Central Region

Provider	Location of service facility	Service Description	Volume	Vol type
Central Health - Te Waireka	Hawkes Bay	Child and Youth Community Alcohol and Drug Residential Services	13.0	beds
Spring Hill	Hawkes Bay	Residential Treatment – Alcohol and Drug Service Central Region (12 Beds)	12.0	beds
Nova Trust Board	Christchurch	Intensive and other drug services with accomodation	11.4	beds
Odyssey House Trust	Auckland	Residential Alcohol and other Drug beddays (Adult)	7.6	beds
Odyssey House Trust	Auckland	Residential Alcohol and other Drug beddays (Children)	0.4	beds
The Salvation Army (Wellington Bridge)	Upper Hutt	Alcohol and other drug day treatment programme - Upper Hutt	1	FTE
The Salvation Army (Wellington Bridge)	Wellington	Alcohol and other drug day treatment programme - Wellington	4.3	FTE
The Salvation Army (Wellington Bridge)	Wellington	Intensive AOD Service with Accomodation -Adult	20	beds
The Salvation Army (Wellington Bridge)	Wellington	Intensive AOD Service with Accomodation -Parent & Child	2	beds
The Salvation Army (Wellington Bridge)	Wellington	Mental Health support fund	1	Fund

The intention to review the current care model required good evidence-based research in recognition of past and existing service culture, where the history of service provision may be challenging to summarise in the context of what is 'good practice'. This included the fact that much of what existed in terms of good service based practice was mostly anecdotal from individual and shared experience. A literature review assisted in guiding this by highlighting that with a relatively equal level of resource input, equal outcomes are achievable, regardless of whether the treatment was 'residential' or 'community' based.

The working group considered six specific but variable consumer scenarios, using people with differing needs to highlight current consumer challenges found amongst Central Region clients. This gave rise to consistent themes on what effective levels of treatment would be, within current resource, and what an idealised type of treatment would be for the six scenarios via a green fields approach. This process assisted significantly in developing a service model.

Consumer feedback was gathered from separate sessions held with consumer groups within each DHB region. These sessions included those consumers currently or recently in recovery and with experience of treatment services from community to residential. Each group had an approximate participant range of between 8-10 participants and up to 35-40 participants. Consumers that participated also included service users of the Central Region funded services.

Family/whānau sessions were not held due to a restriction on resourcing and time. Evidence was gathered and based on previous information available from DHBs or which had been undertaken by consumer representatives who held such information relating to these groups.

In terms of Māori participation and input, the working group included an expert consumer advisor for Māori and AOD recovery. Additionally, each of the six funder DHBs have individual iwi relationship constructs in place. It is expected that each DHB will be basing their response to this model (and future proposed service changes) in conjunction with the respective arrangements with their Māori and Iwi stakeholder entities. The intention to run the sessions within each DHB region was to seek feedback from all stakeholders inclusively.

Working group summary of findings

The core rationale of the review was to reduce waste of resource, based on low utilisation of residential beds, and to enhance treatment outcomes. Consideration of why utilisation of residential beds was remaining low included possibility of location of services (beds) geographically distant, level of community service provision being adequate and possible need for residential treatment in relation to this provision being lessened. Some examples also included the need to detox prior to transfer to residential treatment and some pressure on availability of detox beds/facilities.

Other challenges included approaches required for treating co-existing problems, relapse issues and challenges with treatment outside of area of domicile.

- **Co-existing problems (CEP)** is an important aspect in recognising that AOD clients more often than not require successful treatment for co-existing issues. We are mindful of what the requirements might be for patients with co-existing problems attending residential treatment.

Moderate to severe addiction disorders, with mild to moderate mental illness issues, are considered in scope. However where greater severity of mental health issues occur, then more formal service treatment/support would be required.

- **Peer support** is an important aspect for clients with addiction problems and currently remains a challenge in seeking effective provision. We need to incorporate this wherever possible.
- **Whānau ora s**ervices operate better, particularly from a whānau inclusive approach, when they are not geographically isolating. However, some individuals also may show clear preference to receive treatment away from DHB of domicile. Overall significant challenges remain in providing services that are culturally responsive. A whānau inclusive approach will be a key aspect of service, and will need to be defined appropriately by service level and location.
- **Varying models** of treatment exist, including a differential in types of treatment by existing providers. This creates challenges in achieving consistent treatment modalities and outcomes across the region.
- **Literature review summary of findings** show there is no good research that states that residential treatment is better than community treatment (that is, outcomes achieved are generically the same). Strong anecdotal evidence states that residential treatment is good and sometimes lifesaving. However there is some indication that given equal resourcing, community-based treatment can produce outcomes equally as well as inpatient/residential settings.

Proposed model

The working group's model of treatment and pathways for adult consumers into and from residential addiction services includes:

- a greater focus on respite care
- capacity to treat co-existing mental disorders
- development of addiction peer support services
- capacity to manage the proposed provisions of the new Alcohol and Drug Act.

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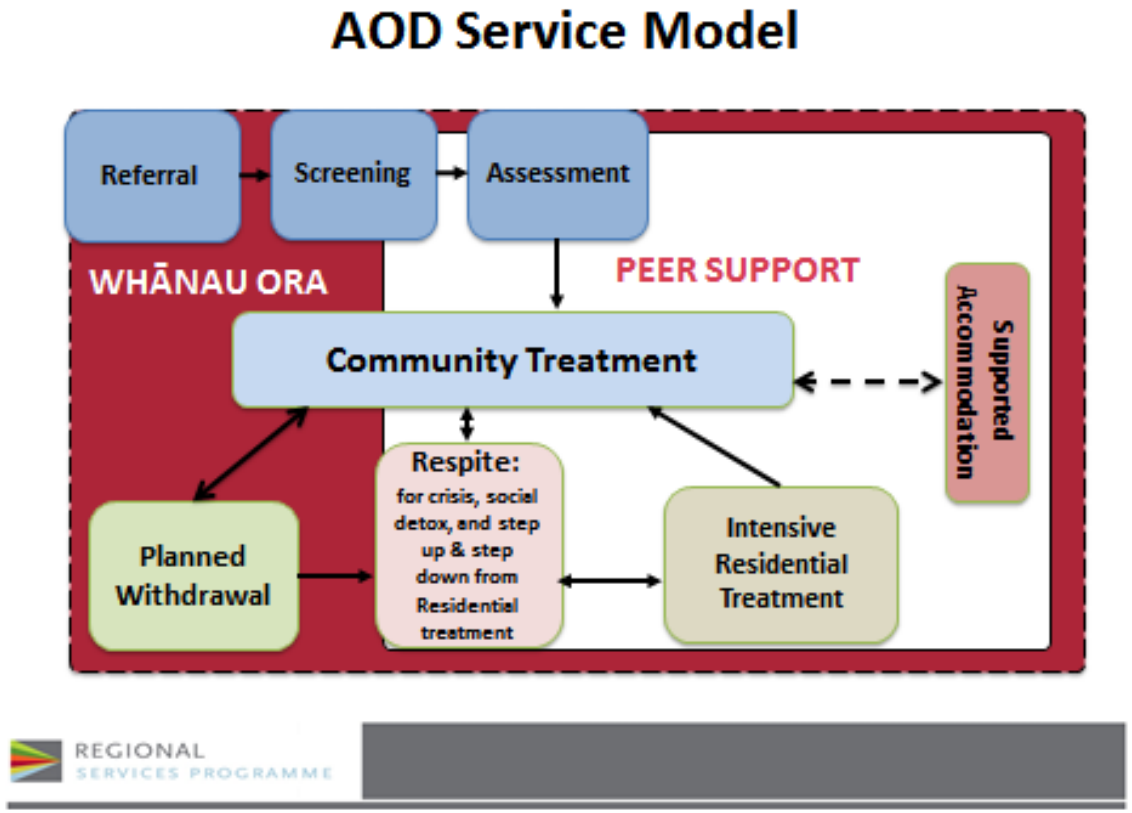
Diagram 1 – AOD Treatment Pathway



Section 2 – Feedback on model from the central region

Peer support and whānau ora

Peer support and whānau ora are the key supporting aspects of this model, particularly with peer support at community, respite and residential level. Whānau ora care needs to be part of the culture of service delivery and inherently throughout the model. The value of people's lived experience was acknowledged and celebrated on aspects of whānau inclusion. It was widely agreed that whānau ora needed to be defined for each stage of the service model and considered in context of whānau inclusion and holistic approaches to treating individuals by including their wider whānau, which should include the recovery whānau. Peer support should also be included throughout the stages of the model, particularly in the community/home settings and respite/residential.

Co-existing problems

Discussions held with residential providers estimate that anecdotally, approximately 70-80% of clients at a residential service level would have co-existing AOD and MH problems. PTSD, anxiety and depression are the three major co-existing MH problems that most frequently occur with addiction.

Community treatment/support interventions

Community service delivery, whether it be DHB, NGO and/or primary care based, with clear lines of clinical responsibility across respite and residential services, is key to this model and approach. This ensures the level of quality and consistency of care with the respective community service remains intact and part of the overall care continuum.

Several tangata whaiora praised the range and quality of community treatment/services available in Whanganui and surrounding region. In addition, Lower Hutt, Napier and Palmerston North have community-based addiction (and MH) treatment/support models.

Potential remains to review community based services to ensure continuity of care through improved clinical competencies, targeted service delivery and defined outcomes.

Respite and social withdrawal

Respite can (and does in Wairarapa, for example) include social detox/withdrawal. It is expected that respite will be flexible by region and include potential packages of care/home based support. It is suggested that for a respite bed arrangement, length of stay could vary from 1-3 days to periods up to 1-2 weeks, depending on specific need and type of respite options developed. In this model, the community clinicians will be required to maintain clinical responsibility, including oversight of a client into, during and out of respite care.

Respite should follow hospital withdrawal and precede intensive residential treatment. This acknowledges the period needed for social/physical withdrawal prior to intensive treatment at a residential level.

Examples of the referral to respite discussed at seminars may include a client has identified that

their husband has come to the end of his tether, or having a crisis; or a client has all triggers lined up in a row and needs to be in respite care over the weekend because there is an expectation of a relapse. This is similar to mental health respite currently.

Step up and step down

Facilities for step down and step up need to be identified and established. It is recognised that stabilisation does not occur in a community setting alone.

It was proposed that after assessment there is a period of community treatment for stabilisation, further assessment and then further consideration of the level of treatment required.

Intensive residential treatment

Residential treatment may not be for as long as current average lengths of stay and will be specific periods for specific treatment needs. Concern was expressed (by tangata whaiora) about rumoured curtailment of length of stay in residential under this new model. It was explained that this model proposes shifting towards treatment modalities (including length of stay) that are appropriate to meet individual tangata whaiora needs rather than those of service providers' models and systems. Length of stay in each phase of the model should remain as guided by clinicians within the six DHB regions.

Length of stay in intensive residential treatment may be informed by the review of the Act where 4-8 weeks of treatment is followed by a review, and possibly a further 4-8 weeks of treatment. This would be assessed on each individual's circumstances, including options for respite and community level support. The individual's needs, capacity and prospects are part of the client-centred, personalised care options, and need to be considered when assessing length of treatment.

After any particular period of residential treatment was completed, the client would return to the care of a community service provider. A period of engagement with the community provider would occur before and after residential treatment.

Intensive residential treatment facilities may be expected to be certified under the new ADA Act, the details of which are yet to be advised. Competency of clinicians at residential treatment settings will require specific skills, which will be challenging for our workforce capacity. Psychiatric interventions will also be required under the Act. Psychiatric facilities may be able to be used for short periods of time, should our clients need this, and this is a discussion to occur amongst the DHBs. Clients in residential treatment under the new Act may require intermittent input of psychologists or psychiatrists for capacity assessments.

Planned withdrawal/hospital level withdrawal

Data suggests that use of detox services nationally are primarily for alcohol withdrawal.

This form of withdrawal is hospital based and medically supervised. There is no standard model of care across the country for services managing alcohol and other drug withdrawal. However, it is noted that demand remains steady for access to withdrawal beds across the central region. It is envisaged that local access should be developed or ascertained where possible whilekeeping

regional solutions to appropriate medical withdrawal support in scope to assist the demand for this level of care.

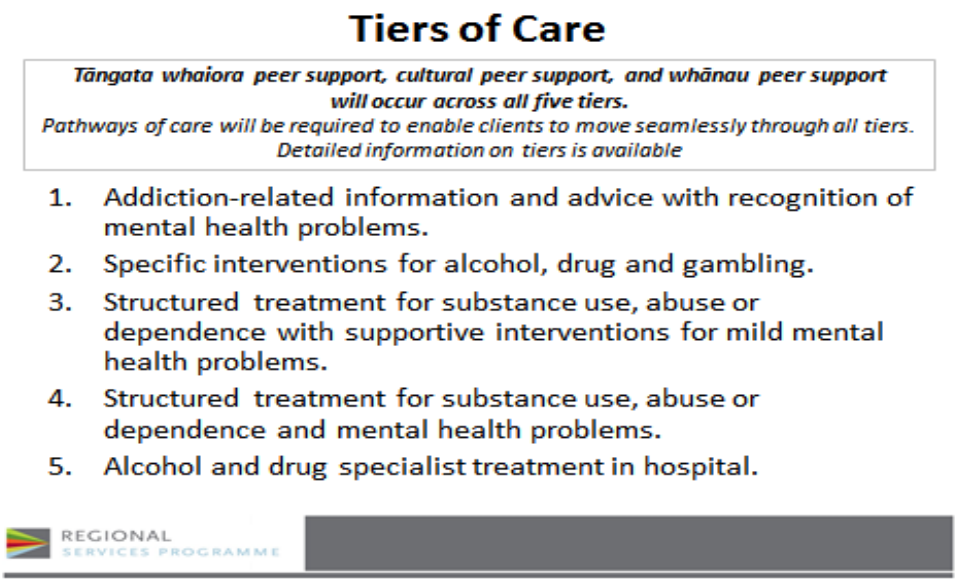
Supported accommodation (Long-term support)

We know there is a group of patients that receives treatment for alcohol related brain injury and a small number of patients across the region that will require longer periods of supported treatment. This treatment would not be provided in routine residential treatment settings, utilising routine models of care (for example, relapse prevention). This is more focused on daily activities like healthy living, occupational therapy, social support, reassessment of cognitive capacity and consideration. This may well be a shared responsibility across health and other sectors, and our role might be the addiction treatment/care component. It is important to recognise that this may not be needed on a long-term or ongoing basis. This would be a discussion with Health of Older Persons and associated services for this client range.

Tiers of Care

This is also part of the Addiction Planning for 3DHB and is particularly relevant to the commissioning of services and experience level of clinicians working with clients with CEP challenges.

Figure 2 Tiers of Care



The model refers to Tiers of Care, not in terms of stepped care where this means moving from one service to another based on clinical need. It relates to services where you know the level of capacity of service, and to what level of expectation that clinicians can cope with varying clinical scenarios.

For example, Tier 1 service – where practitioners can provide information and advice, have the skill to screen and/or provide lower level treatment and offer supported interventions for mild to moderate mental health problems.

The five tiers help guide referrals to the level of competency required. So there would be different levels of funding required by level of competency required and associated service specification. This would guide the commissioning of services appropriate to the type of service.

Developing and assessing competencies of clinicians is being further guided by national work, included recent work by Matua Raki (*Te Whare o Tiki*). There are no benchmarks that guide competencies currently, so there is much occurring in this area, including work yet to be completed on validity of assessment tools.

Considerations for development and discussion

- The current pathways of care in place differ for each respective DHB region. However some DHBs do have similar approaches in place that have a strong correlation to this proposed model of care. Therefore these DHBs could implement the model more readily than others.
- Should respite facilities be certified? Are the new Act provisions going to include provisions of care in the community as the MH Act does? These are all current unknowns. We are reasonably clear that residential facilities will need to be certified.
- Most residential facilities would be required to provide Tier 3 level care. Tier 5 is hospital level care.
- Do we need to be guided by the recommendation of four weeks Length of Stay duration for residential treatment? We are expecting a period of support during residential treatment to ensure that mental health issues do not worsen.
- Evaluation will mirror the proposed evaluation framework for the methamphetamine residential treatment programme proposed by Ministry of Health, and we are seeking to adopt the same evaluation model.
- Success of the model is predicated on a high level of committed collaboration. Are there any perceived barriers to implementation?
- Do we have three facilities with a set level of beds for need – one South, one Central and one North? This is important to understand in terms of affordability and DHB Portfolio Managers are able to support this process in terms of developing a business case supporting recommended direction and for GM approval across the region.

Summary

Overall, participants across all the consultation sessions were positive about the new model proposed. Comments were mostly about perceived issues to do with implementation rather than criticism of the principles, values and assumptions underpinning the model. There will need to be further consultation and exploration as to how we put the model into practice. This will need input from all components and parts of the sector, particularly regarding affordability and evolution of

design and practice for positive change.

The following service matrix highlights the existing service and potential service design for consideration.

Service Type	Whanganui DHB	MidCentral DHB	Hawkes Bay DHB	Capital & Coast DHB	Hutt Valley DHB	Wairarapa DHB
Community Treatment / Support Interventions	*Local provision in place – future service alignment to the regional treatment model required*					
Respite / Social Withdrawal	*Local facilities to be identified / established*	*Local facilities to be identified / established*	*Local facilities to be identified / established*	*Local facilities to be identified / established*		
Intensive Residential Treatment	*Review of investment for sub region*		*Review of investment for sub region*	*Review of investment for sub region*		
Medical Detox / Hospital level withdrawal	*in place for social withdrawal Local respite facilities to be identified / established*	*Local facilities to be identified / established*	*Local facilities to be identified / established*	*Local provision in place*		
Peer led and support services (across all services)	*Some local provision in place*	*Some local provision in place*	*Some local provision in place*	*Development intended*	*Development intended*	*Development intended*
Withdrawal Management (MOH devolvement 2016)	*To be advised by DHB and/or linked regionally or sub-regionally*	*To be advised by DHB and/or linked regionally or sub-regionally*	*To be advised by DHB and/or linked regionally or sub-regionally*	*To be advised by DHB and/or linked regionally or sub-regionally*	*To be advised by DHB and/or linked regionally or sub-regionally*	*To be advised by DHB and/or linked regionally or sub-regionally*
Supported Accommodation (ARBI / long term care / Aged Care)	*Some local provision already occurring – other Local services to be identified / established*	*Local services to be identified / established*	*Local services to be identified / established*	*Local services to be identified / established*	*Local services to be identified / established*	*Local services to be identified / established*

Appendix 1 – Additional comments/queries

General comments expressed by stakeholders

- A significant gap identified in current services mix. In this model it is that of kaupapa Māori service provision. We need to use existing models for this – for example Taha Māori – to enhance delivery. Good practice in this area is already there – we just need to use it more, to reflect the numbers of Māori accessing or wanting/needing to access services.
- It's great that community elements are being strengthened and expanded, but don't cut the residential element to pay for this – need to find more money.
- Family/Whānau services missing from model – similar to former Hanmer service – offering intensive one-week programme for family members.
- Older people who need assistance and support as well as addiction treatment – existing services do not cater well for this. Packages of care might be a way to do this.
- Community provision can (and where already available, does) assist in getting people physically, mentally and motivationally ready for more intensive residential treatment.
- Whānau Ora needs strengthening and defining, as tangata whaiora families are part of the solution (but may also be part of the problem). Also need to incorporate Mason Durie's Pae Ora (see http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures) model, as an extension/development of Whānau Ora.
- Specialist Whānau Ora and Peer Support reference/working groups might be useful to contribute expertise and advice into the model.
- Connectivity (with common data and platforms) and linkages across all parts of the sector – for example community, primary, secondary, specialist – is vital. Tangata whaiora should have easy access to (and ownership of) their health records – for example memory sticks (flash drives) that tell their story and chart their progress through their recovery journey.
- Peer support competencies need further development – in tangata whaiora, whānau and cultural areas especially.
- The model needs to use recovery and strengths-based language throughout.
- Need to specify how clinical input/oversight/responsibility will be provided in Respite phases.
- Salvation Army is undertaking (through Otago University) an evaluation of all its residential services, and MASH is also commissioning a similar exercise for their services. Springhill has recently conducted evaluation of services.
- Peer support is also important in recognising that, for some, peer support also exists as the recovery whānau, in cases where there is the absence of a biological whānau.
- Respite options will need to be considered in terms of what is available as a resource, and what the optimal configuration might be across the Central Region.

- Whānau Ora and peer support will be separate and considerable areas of work for development, particularly in terms of competencies and training. There is recognition that underlying competencies are the lived experience, and that some areas are using peer support services in primary/GP practice.
- Community treatment, as a hub providing the first step in engagement, should be the focus for establishing a therapeutic alliance.
- The Peer-led/Respite element of the model is already in place in Whanganui, MidCentral, Wairarapa and Hawke's Bay.
- The Accredited Clinician system as currently operated is seen as an obstacle to linkages between community and intensive residential service, and to the appropriate meeting of tangata whaiora needs for residential services.
- We need to re-look at medical vs community detox/planned withdrawal models, as the community/home setting is often more effective.
- A greater level of skill and care required at community and respite level is implied. Will this resourcing be supported in the model rollout? Greater respite care requires greater resource.
- We would encourage you to look at the Auckland model and the peer support respite in CMDHB.
- The role of community treatment key working function will need some detailed work, particularly in how it relates to how the local CADS work. You indicated that community treatment would be broader than the just CADS and this is important as a traditional clinical approach may not work for all people and may be a barrier to treatment. The model does not take into account what fundamental changes will be required within CADS (some of the issues appear to be well known) or outline how these changes will occur.
- We both acknowledged that if this new model is what consumers of services want it must be progressed and it must align with the triple aim benefits, although I am skeptical re: a single point of entry providing better value for money and being service user centric and enabling choice.
- Again whilst the focus is on residential services I consider that the planned approach may be blind to what is actually occurring on the ground in Wellington and the real difficulties some of the most vulnerable people in the community have in accessing CADS. If you are truly going to effect change across the system then you must look at the system as a whole not just one part of it.
- Our main provider is The Bridge. We do not use the Odyssey beds because we have to wait so many months for clients to get in that they have dropped out, and literature says that the longer a client has to wait for treatment the higher the likelihood they will drop out, or they will get so sick that it becomes too late. A lot of the referrals to Odyssey actually never happen, and average treatment is 12-15 months once in, so I know we are under-utilising service there.
- My experience over 20 years or so of AOD treatment was that most treatment examples were not effective as I was mostly attending for someone else other than myself, and nothing worked

until I was ready to do it for me (myself). Whanganui, in my opinion, is the best service providers I have worked with, from detox, to engaging a 9 week course, which has now been 2 years in engagement. I am pleased to be here this morning to share this.

- I come from a rural community (Ohakune) and attended a 6 week programme here locally, so have had a mixture of types of treatment including a residential treatment at Te Oranganui, and I have been able to attend services because of the local set up here. Some local community providers have residential treatment options available also.
- Level of peer support and community service provision provided locally is critical, as relapse prevention is key at community level, particularly on discharge from residential treatment.
- My experience since being engaged as a consumer in 2002 is that there is a lack of Māori support in a residential setting, particularly coming from a community model like Te Oranganui Te Taha Māori (Kaupapa Māori) programme. It raises questions like "Why did you send me there (residential programme)?" Models like Te Taha Māori programme is a good example of what is working, including the peer support programme funded and supported by Te Oranganui. Peer support has been established in the past and then left unsupported due to people not understanding the relevance. Peer support needs to be recognised as a profession and not a voluntary based programme. Key relevance for consumer recovery pathway via a peer support approach.
- My concern is over the reduction in investment into residential services, and an increase into the community level support requirements, which may potentially increase referrals to residential. Please look at increased resources rather than repurposing.
- I refer to the Hanmer model where individuals are challenged on their own contribution to the problem, and the intensive week programme with family members was a considerable example, and this seems lost with other treatment centres. We seem to have lost our capacity for intensive family/whānau involvement.
- Older people with co-morbidities – needing additional personal assistance outside of the normal AOD treatment range, could be considered as a package of care arrangement.

Appendix 2 – Queries with responses recorded where answered

- Does MHAN have a whānau rep? And how do the tangata whaiora rep(s) feedback to other tangata whaiora across the region?
- How and where will the model be piloted if it is a pilot –in one place/sub-region or in stages across the whole region?

  Response: Implementation is yet to be advised.
- Recognised competencies under the Tiers of Care will also encourage pay parity, and including between AOD and MH clinical rates?

  Response: Possibly only when we can demonstrate the level of skill required in the Addictions field. Peer support competencies will also assist the level of recognition required for this workforce.
- The proposal is silent around the interface with Justice and Corrections.

  Response: The interface is via the single point of entry. We must also acknowledge that interface is required at primary care level also, so work here to be done.
- Whilst a large focus seems to be on those who might be subject to any future addictions compulsory treatment, we expect volumes will be small so the focus needs to be rebalanced to consider this
- This raises more questions on how training, credentialing and competencies are conducted. Would this include gambling, where previously this was excluded? Smoking cessation and gambling are funded separately.

  Response: Current discussion is about the model, and further design of service specification would depend on design requirements leading into specification development.
- Utilisation will increase and especially where addictions are occurring earlier in the age spectrum, and where our services have been operating at 80% on average over previous terms. Other services have also seen this increase. We are a triage facility as well, so we do not turn clients away. So sustainability and capability remain a challenge. This current intention is utilising existing dollars, rather than encouraging new funding to be included.
- Current community service workers are treating up to 25 people. How will this level of capacity demand be managed with increased demand?

  Response: The model is a cost neutral model as directed by the initial rationale based on the utilisation figures and initial guidance.
- Funding implications for respite – will the beds be capacity funded as we consider RSS benefits as well (in the residential bed arrangement), and we consider the overall income? There may be a funding deficit if this discontinues. The DHB level funding only subsidises the actual cost of delivery. WINZ subsidises also. So people who are on benefits, and are on a short term respite,

will become very difficult to manage within WINZ. Respite could be funded on a bed night rate or FTE rate, preferably FTE rate, and then you don't have any involvement with WINZ and you keep the accommodation. Long term residential/supported accommodation we are funded to provide staff, and clients pay rent as they would any other accommodation arrangement. So there may well be implications for short term respite (maximum 2 weeks). This may require an FTE funded rate.

- In the Wairarapa we are unique, and this model exists and what we already do. I have concern, in my experience, where respite (represented as a neat little box here) very rarely stays respite. It evolves into other things and I guess I have concern about respite funded and modeled with peer support workers in the core and experience level, where respite evolves into something greater. We have many clients, with planning support entering a respite phase, end up turning into a withdrawal or a mental health psychosis or a range of other things, and I have concern where the funding is simply for peer support oversight on respite. There does need to be greater oversight of respite, as exists in the Wairarapa (clinical oversight over respite), where there is a clinical nurse that oversees all respite as well as withdrawal management, so she is available for that, so if the funding differs between location, it would be very hard to maintain oversight.

  Response: So if you place respite facilities into any specific region, clinical oversight remains a requirement. For the Wairarapa, funding for the local facilities differs from Wellington and the Hutt, so how the model fits for each DHB will be unique. Some locally funded facilities may be funded for clinical staff. How each aspect of the local service range is utilised will differ by DHB based on existing capacity. In mental health, the majority of clinicians supporting clients in respite are DHB funded. In this model, the community clinicians will need to maintain oversight.

- Whānau ora – how do you envisage the whānau ora process happening in this? Previously for example, rangatahi who are under care under CYF, there is no provision for whānau ora, in assessment and referral; will we have competent people to do this? It holds great potential combined with navigators.

  Response: Culturally competent people to implement this model are key. There is an expectation that all providers will have this inherent and be able to demonstrate effective implementation of the whānau ora concepts in their provision of care. Evaluation of service should include this as well, at each stage of the model, hence why it remains as a clear background (feature) in the model diagram.

- Will this model support pregnant mother needs? We have issues with mothers and pre-natal meth exposure.

  Response: We have not asked this question specifically so we cannot respond.

- How much input will a consumer have into deciding length of stay in treatment? Particularly under the influence of budget constraint.

  Response: This will be inclusive in the personalised care approach, and there will be consideration on resource availability, including respite and residential. I t makes sense that if

treatment is succeeding, then extension would occur where identified as beneficial or needed.

- Currently Kenepuru is the location for detox, so what are the proposed changes here? Will there be an in-house bed available for withdrawal from opiates, alcohol, and meth? Community mental health has a respite facility, so will this be similar (for AOD treatment pathway)? There is need for a structured recovery programme at community level.

  Response: Important to understand the requirement for general hospital care for withdrawal, and where there is a place for social detox where there is no need for medical input. Consensus is that planned withdrawal should be based in the hospital setting. Currently there are two beds for the sub-region of Wellington. The ability to set up a planned withdrawal bed facility in each region needs to be negotiated due to cost restrictions.

- Over 65s (example, with co-morbidities and emphysema) that may benefit from some residential treatment do not currently have clear options for treatment. They don't meet rest home criteria, and may have some support at home, so where can these people go? Respite facilities would have been good previously in this instance, but what happens particularly if treatment is out of town (support care does not go with them)?

  Response: Creative solutions to this may include the type of input into the support care phase of the service specifications and service contract for the new proposed model. This will need to be defined for each region.

- How do you measure success rates outside of bed utilisation, as spare beds can be incredibly valuable, and transfer can occur immediately when there are beds available? Delay to treatment may be a perceived risk.

  Response: In an environment where resourcing is limited, it remains difficult to carry empty beds. It is possible to run 100% occupancy and manage demand for early stages of need relating to treatment. Overall, there has been a shift for substance use related issues to a community level treatment and recovery support. Wait list management can be balanced through prioritisation. In terms of length of treatment, prolongation of treatment, if this is succeeding would be assumed as a remaining option.

Appendix 3 – Response from National Committee for Addiction Treatment

18 May 2015

Jeremy Tumoana

SIDU

Jeremy.Tumoana@sidu.org.nz

Kia ora Jeremy

On behalf of NCAT we would like to provide feedback on the proposal to reconfigure the central regional residential addictions treatment beds as outlined in various meetings over the past month.

Issues with the process of this project were voiced by key stakeholders and conceded by the project team within these meetings so will not be raised here. There is considerable agreement that change is required in order to address some apparent long standing issues with client pathways in treatment and care within the central region. The presentation outlined one approach and we accept that we do not have access to all the information that supports this approach including the literature review which was not made available for distribution. The following points are made based on the information we were provided at the presentations attended:

We note the following:

- The project was outlined as being initiated to identify the reasons for the underutilisation of addiction residential beds within the central region and included identifying the barriers to access and retention in these facilities. It was unclear whether this objective had been addressed as there was no further reference to these issues. What has been developed instead is a system to manage client flow in much the same way it is currently and an indication that the purchase of beds would be based on current utility. This assumes that the current utility of residential beds is actually meeting client needs but no evidence was provided to support this.
- The model presented seems to replicate much of the current Mental Health delivery model and focuses on areas of development including peer run respite services. This model while it has some logic seems to require considerably more attention to detail to ensure that it is responsive and flexible enough to meet consumer needs and choices. Currently, it appears to be 'service centric' and is very prescriptive about the throughput based on clinical assessment and oversight by one service.
- There is considerable attention paid to meeting the needs of the high needs group of people who will be committed under the revised Compulsory Treatment Act yet to be introduced and it seems all services including respite services will need to be able to manage this client group.

While we agree this group has been ignored to some degree, this approach seems out of balance with the numbers expected and the high needs they will present with (given the intended introduction of a capacity to consent test). This means it will be inappropriate for all services to be staffed to the appropriate levels required to meet the needs of this group.

- The stated intent to fund 11 residential beds in three locations throughout the region does not seem to be supported by any demographic, population or consumer base or economic rationale. This has raised concern about the viability of services of this size. While we support the 'closer to home' strategy for service delivery, this has to be balanced by economic realities and note that 'out of region' services are unaffected.
- While whānau ora and peer support appeared in the visual representation of the model, the implications for either of these aspects were not able to be articulated and had no detail as to how they fit in the design. Considerable work and liaison with local iwi to ensure that this framework is reflected appropriately within the service delivery system is required and was noted as absent from this project.
- The approach taken seems to be out of step with other current developments and we would strongly encourage consideration of the opportunity to make change across the "whole of delivery system" including the community based addiction service to really make a difference.

We reiterate that stakeholders that have communicated with us in regards to this project are in agreement that change is required and services are keen to be part of the solution to developing a 21st century system which is client centred, responsive, well integrated and flexible to meet a wide range of needs.

We appreciate the invitation for feedback and the opportunity to provide a response. We are happy to discuss the points raised with you further.

Regards

Vanessa Caldwell
Co-chair
NCAT
CC: Dr Alison Masters, Chair, MHAN

Appendix 4 – Region participants by organisation

Please note that consumer participants are not identified in this list below. Also, DHB clinicians, including CAMHS and AOD clinicians are included in the DHB identified in the list.

1. PACT Group NZ
2. Atareira
3. Ora Toa Mauriora
4. The Salvation Army NZ
5. Pathways
6. Teaomanino Trust
7. Care NZ
8. Te Awaikairangi Health Network
9. Matua Raki
10. National Committee Addictions Treatment (NCAT)
11. Central Health Ltd
12. Mash Trust
13. Springhill
14. Te Taiwhenua o Heretaunga
15. Whatever It Takes Trust
16. Te Runanga o Ngati Raukawa
17. Whakapai Hauora
18. St Dominics
19. Mana o te Tangata Trust
20. Supporting Families
21. Compass PHO
22. Central PHO
23. Whanganui DHB
24. MidCentral DHB
25. Hawkes Bay DHB
26. Capital and Coast DHB
27. Hutt Valley DHB
28. Wairarapa DHB
29. Tairawhiti DHB
30. Te Whai Oranga
31. Te Oranganui Iwi Health Authority
32. Balance Whanganui
33. Ngati Rangi Community Health Centre
34. Odyssey Auckland
35. Nova Trust

Appendix 5 – Previous reorts and presentation

AOD Regional Residential Addictions

Item 10_MHAN Residential Addictions

Central Region Residential Addictions Services Model

15.1

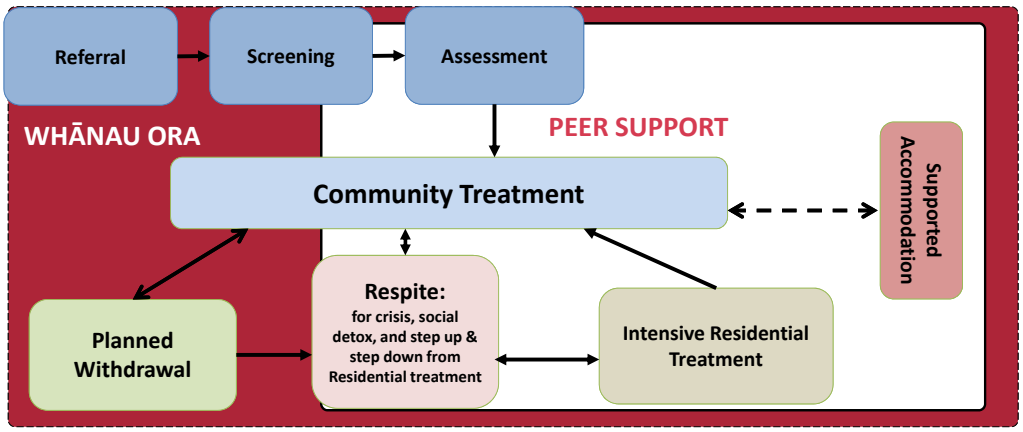
REGIONAL SERVICES PROGRAMME

Objective

To develop a comprehensive service model for addiction services across the Central Region (including residential, respite and withdrawal services).

REGIONAL SERVICES PROGRAMME

AOD Service Model



REGIONAL SERVICES PROGRAMME

Tiers of Care

Tāngata whaiora peer support, cultural peer support, and whānau peer support will occur across all five tiers.

Pathways of care will be required to enable clients to move seamlessly through all tiers.

Detailed information on tiers is available

1. Addiction-related information and advice with recognition of mental health problems.
2. Specific interventions for alcohol, drug and gambling.
3. Structured treatment for substance misuse with supportive interventions for mild mental health problems.
4. Structured treatment for substance misuse and mental health problems.
5. Alcohol and drug specialist treatment in hospital.

REGIONAL SERVICES PROGRAMME

Respite Facilities

- Step up and step down from residential treatment
- Possibility to occur within the same facility
- Maintain engagement with current treatment team
- Acute – 2-3 days
- Sub-acute – up to 21 days
- All respite facilities to be certified to meet requirements of new Substance Abuse Compulsory Assessment and Treatment Act (SACAT)

REGIONAL SERVICES PROGRAMME

Supported Accommodation

- Similar provision to Mental Health supported accommodation beds
- For Service Users /Tangata Whaiora with residual alcohol-related brain injury needing longer term recovery
- Differs from residential treatment in terms of intensity of treatment
- Input from:
  - Psychologists undertaking cognitive testing
  - Psychiatrists for pharmacological treatments
  - Occupational therapists and social workers for needs assessments and longer term social supports
- Approx. 1-2 beds per DHB
- Minimal focus on structured AOD work

REGIONAL SERVICES PROGRAMME

Planned Withdrawal

- Either hospital or community-based
- May be supported by respite care
- Requires community AOD provider to maintain clinical responsibility
- May be followed by respite care on route to planned intensive residential treatment

Respite / Social Withdrawal

- To be staffed by peer support workers
- May be used in the following situations:
  - To support crisis management during routine community treatment
  - Step down from planned withdrawal
  - Step up to residential treatment
  - Step down from residential treatment
  - Planned respite – additional work needed
  - Community treatment provider retains clinical responsibility in all these scenarios.

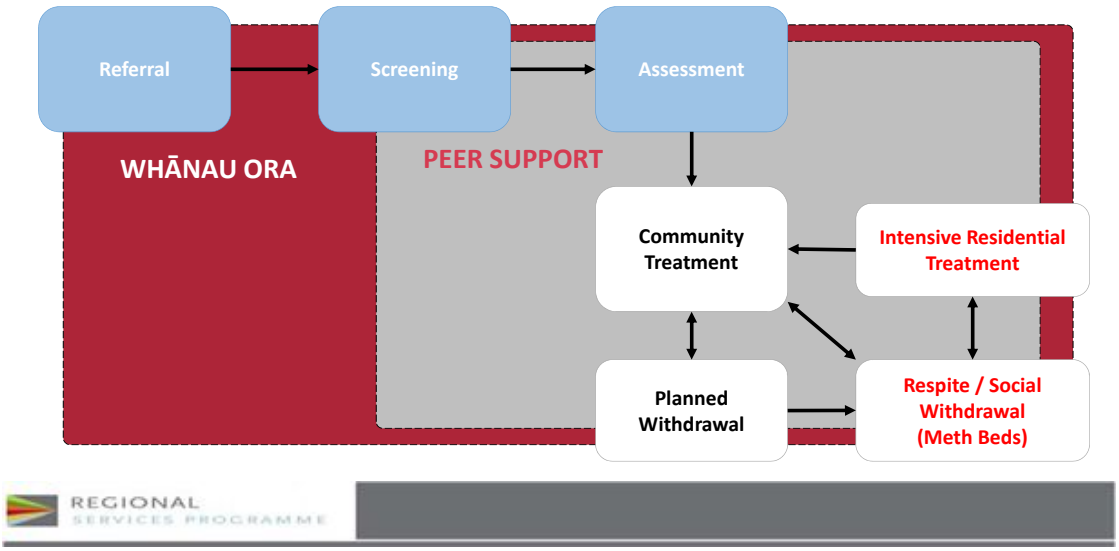
Intensive Residential treatment

- Treatment to support people experiencing moderate to severe substance use problems plus mild to moderate mental health problems.
- Alcohol-related Brain Injury (ARBI) – residential treatment followed by transfer to longer term supported accommodation
- Defined lines of clinical responsibility
- Incorporated whānau ora and peer support approaches

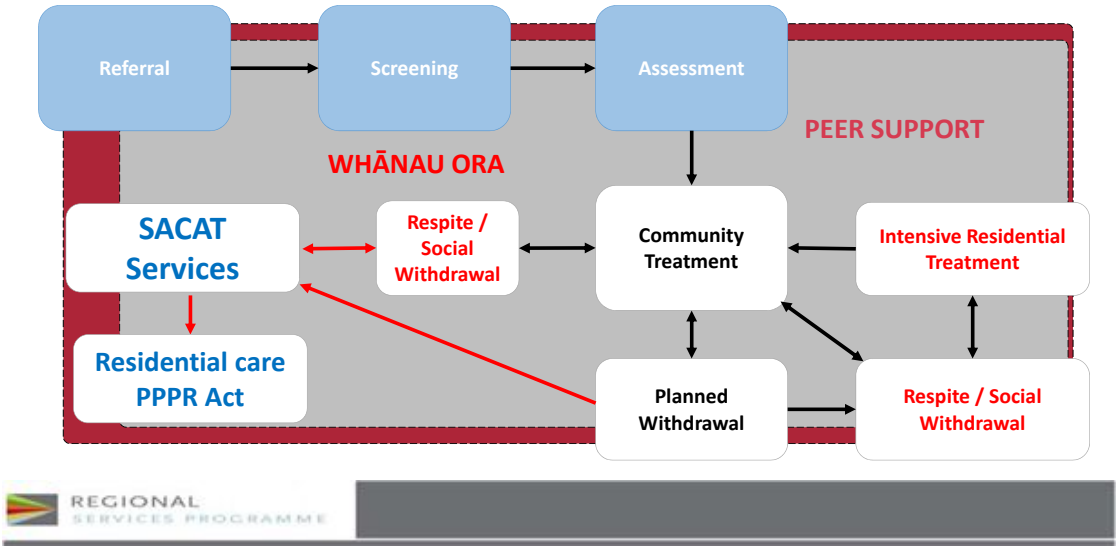
Co-existing Problems (CEP)

- Better support overall for a CEP approach with AOD service configuration should align more with mental health services configuration
- Clinicians within residential facilities to have competency in CEP approach

AOD Service Model



AOD Service Model



National progress in continuation

- SACAT Act going live 20 Feb 2018
- Proposed SACAT Unit(s) and services to be agreed by DHB
- Central Region proposal underway
- Service Specifications for all facilities and new services
- Certification (SACAT) – DHBs are automatically enabled but NGOs need to be certified
- Workforce and training issues and opportunities ongoing

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

17. People Strategy (2016-2021) first draft

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

PEOPLE STRATEGY (2016-2021)
First Draft

Late Paper