Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 11 April 2019**

Meeting: **4.00 pm to 6.00 pm**

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

Council Members:

Rachel Ritchie (Chair)
Malcolm Dixon (Co-Deputy Chair)
Dr Diane Mara (Co-Deputy Chair)
Sami McIntosh
Deborah Grace
Jenny Peters
Olive Tanielu
Jim Henry
Sarah Hansen
Dallas Adams
Wayne Taylor
Les Cunningham
Gerraldine Tahere
Denise Woodhams

Apologies:

In Attendance:

Ken Foote, Company Secretary (Co Sec)
Kate Coley, Executive Director – People & Quality (ED P&Q)
Caryn Daum and Nancy Barlow – Consumer Experience Facilitators
Debs Higgins, Clinical Council Representative
Tracy Fricker, Council Administrator / EA to ED P&Q

Public

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4:00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	

5.	Matters Arising – Review Actions	
6.	Consumer Council Workplan	
7.	Board Report for March (Consumer & Clinical Councils' Combined)	
8.	Chair's Report – Rachel Ritchie	
9.	Consumer Experience Facilitators Report – Nancy Barlow / Caryn Daum	
10.	Committee Representatives Feedback	
	Section 2 – Presentation	
11.	Consumer Engagement in Primary/Community Health - where to from here? Chris Ash, Wayne Woolwich, Emma Foster and Karyn Bousfield	4:30
	Section 3 – Discussion	
12.	Progress on Consumer Council Annual Plan Goals	5.00
13.	Future of Youth Consumer Council – Marie Beattie	5.10
14.	Consumer Engagement Discussion Paper – Diane Mara	5.30
	Section 4 – For Information Only (no presenters)	
15.	Matariki HB Regional Development Strategy and Social Inclusion Strategy (update)	-
16.	Violence Intervention Programme Report (update)	-
17.	**Section 5 – Recommendation to Exclude**	

Public Excluded

	Section 6 – Routine	
18.	Minutes of Previous Meeting (public excluded)	5.50
19.	Joint Consumer and Clinical Councils' Workshop Notes (for information only)	
20.	Topics of Interest – Member Issues / Updates	
21.	Karakia Whakamutunga (closing)	6:00

NEXT MEETING:

Thursday, 9 May 2019, 4.00 pm
Boardroom, HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

Interest Register

Hawke's Bay Health Consumer Council

Dec 18

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon (Deputy Chair)	Hastings District Councillor	Elected Councillor		No	
	Scott Foundation	Allocation Committee		No	
	HB Medical Research Foundation Inc	Hastings District Council Rep		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara (Deputy Chair)	Napier Family Centre	Chair	Social Service Organisation	Yes	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
	IHC Member Council	Member		No	
	Anglican Diocese Standing Committee	Lay Member		No	
	PACIFICA Inc Pacific Women's Council : Tiare Ahuriri Branch	Branch Chair	Development Leadership for Pacific Women	No	
Denise Woodhams	Nil to declare				
Geraldine Tahere	Nil to declare				
Les Cunningham	Stroke Central Inc	Employee / Field Officer	Working with stroke patients and clients	No	
Wayne Taylor	Wairoa Waikaremoana Māori Trust	Trustee	Legal Entity for Ngati Kahungunu owners in bed of Lake Waikaremoana	No	
	Wairoa Services Integrated Governance Group	Consumer Council member	Group of professionals discussing health in Wairoa		

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	Wairoa Renal Working Group	Consumer Council member	Looking at relocation of dialysis unit to Wairoa Hospital		
	Moeangiangi Part 42N Ahuwhenua Trust	Trustee	Māori Land block		

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL HELD IN THE SEMINAR ROOM, HAVELOCK NORTH FUNCTION CENTRE, TE MATA ROAD, HAVELOCK NORTH ON WEDNESDAY, 13 MARCH 2019 AT 1.00 PM

PUBLIC

Present: Rachel Ritchie (Chair)
Dr Diane Mara (Co-Deputy Chair)
Malcolm Dixon (Co-Deputy Chair)
James Henry
Sarah Hansen
Deborah Grace
Wayne Taylor
Les Cunningham
Denise Woodhams
Jenny Peters

In Attendance: Ken Foote, Company Secretary
Caryn Daum – Consumer Experience Facilitator

Apologies: Sami McIntosh, Jemma Russell, Olive Tanielu, Gerraldine Tahere, Dallas Adams

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Rachel Ritchie (Chair) welcomed everyone to the meeting. A karakia/reflection was provided by James Henry to open the meeting.

2. APOLOGIES

Apologies were noted as above.

3. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 14 February 2019 were confirmed as a correct record of the meeting.

Moved by Les Cunningham and seconded by Denise Woodhams.

Carried.

5. MATTERS ARISING AND ACTIONS

Item 1: Consumers on Projects
Actioned. *Item can now be closed.*

Item 2: Primary Care – PHO Consumer Input
Currently on hold.

Item 3: Violence Intervention Programme
Consumer input on VIP being reviewed. To remain on matters arising.

Item 4: MoH Teleconference re: Planned Care Approach/Framework
Teleconference with MoH held on 26 October. Awaiting feedback from MoH. To remain on matters arising.

Item 5: IT Project Priorities
Chair to follow up with Anne Speden.

***Item 6:* Consumer Engagement**
Small group of consumer council members agreed to work through the summarised feedback and plan.

6. CONSUMER COUNCIL WORK PLAN

The monthly work plan provided in the meeting papers was noted.

- Suggestion that topics of interest raised at the start of the meeting
- Discussion around more clarity in papers, headings to advise if papers are for information only or to be actioned.

7. CONSUMER COUNCIL'S BOARD REPORT

The February report for the Board was provided in the meeting papers for information.

8. CHAIR'S REPORT

Rachel Ritchie provided an update on activities and information for Council:

- Graeme Norton went to Palmerston North on the Chairs behalf for the Heather Simpson review meeting. Chair to draft a submission and send to consumer council. Advocate for PWCC as an important structure of health care. Company Secretary has sent an email to Heather Simpson's office.
- Thank you for contributions at last week's Leadership forum, the objectives to explore, share perspectives and drive forward the strategic direction. Governance groups were brought together information is being collated and will be used in the development of strategy and implementation.
- Consumer Council messages are getting through and there is movement in the right direction
- All new projects must start with PWCC, this was the case with the Disability Strategy a great example has been set here and needs to continue.
- Community Governance in Wairoa is a great example of place based planning which is driven by the community.
- Looking for a new Consumer Experience Committee representative from Consumer Council, as Jim Henry is no longer able to attend.

9. YOUTH CONSUMER COUNCIL (YCC) REPORT

No report available. Jemma Russell has resigned effective immediately and Dallas Adams was absent.

10. CONSUMER EXPERIENCE FACILITATORS REPORT

An update on activities was provided in writing.

- Integrated Pharmacy Strategy – Di Vicary has sent forms to Denise Woodhams
- Pharmacy Redesign at Totara Health, Consumer Representative is Rosemary Marriott.

The update reports were moved by Deborah Grace and seconded by Wayne Taylor.

Carried.

11. COMMITTEE REPRESENTATIVE FEEDBACK

No meetings held.

SECTION 2: DISCUSSION

12. PROGRESS ON CONSUMER COUNCIL ANNUAL PLAN GOALS

The action/progress report template included in the meeting papers was noted and items reviewed, noting that progress on all but 3 & 4 where work is ongoing. The template can be used to monitor Council's progress against the goals in the Consumer Council Annual Plan for 2108/19.

13. GENERAL DISCUSSION

Chair requested new consumer council members to provide some feedback on their experiences to date. Members shared:

- Thought the leadership forum was excellent.
- Would like follow up on groups they have registered interest for but not been contacted about. Les Cunningham noted list of groups where no response was received. ***Action: CE Facilitators to follow up with these groups.***
- Consumer driven future starts with consumer council as the foundation, not top down
- It takes time to get projects and ideas off the ground
- Community Partnership Group had a Powhiri in Wairoa to welcome several DHB members to Wairoa. Consumer Council members advised they would like to have been invited. Interest to go to Wairoa and be involved in how they are re designing their services. ***Action: Company Secretary to review so that those involved know for next time a consumer rep is appropriate and consumers are interested.***
- A good, positive committee.

Other general discussion included

- Discussions about reducing the length of reports. Ken Foote advised that an overview of full reports is provided for all members. The overview document was deliberately designed to allow consumer council members to get an understanding of each document, if they are unable to read the full document prior to Consumer Council meetings. The full papers are distributed to all members. This is a genuine attempt to give all governance groups visibility of what is happening.
- Diane Mara raised she is not comfortable asking the community for consumer representatives anymore as some consumers have not had a good experience. Diane has offered to develop a strategy and write a paper, 'What does Consumer Engagement look like for consumers' (replicating the Disability Strategy).

SECTION 3: RECOMMENDATION TO EXCLUDE

The Chair moved that the public be excluded from the following parts of the meeting:

14. Minutes of Previous Meeting (public excluded)
15. Topics of Interest – Member Issues / Updates

Moved by Wayne Taylor and seconded by Jenny Peters.

The meeting closed at 1.55 pm.

Confirmed: _____
Chair

Date: _____

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	13/9/18	**Primary Care – PHO Consumer input** A query arose and would be emailed to Chris Ash directly. The question will be formulated by Jenny and Malcolm and would only come back to Consumer Council if there is a need.	J Peters and M Dixon	Feb/Mar	On Hold
2	11/10/18	**Violence Intervention Programme** Consumer input on VIP. VIP being renewed. *(Note: to be kept on matters arising for follow up in the New Year)*.	G Tahere	Feb/Mar 2019	Included on workplan
3	11/10/18	**MoH Teleconference re: Planned Care Approach/Framework** Awaiting feedback post teleconference from MoH	Company Secretary	Ongoing	Information to be sent to members when received
4	06/12/18	**IT Project Priorities** Email to request input to be sent to members	Chair	Feb/Mar	Chair to follow up
5	14/02/19	**Consumer Engagement** "What consumer engagement should look like in the future" Small group agreed to work through summarised feedback and plan	CE Facilitators	TBC	TBC

GOVERNANCE WORKPLAN PAPERS

Updated: 2 April 2019

CLINICAL & CONSUMER MEETING 10/11 APRIL 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				10-Apr-19			
IS updates/presentations 30 mins - Bi-monthly (Feb-Apr-Jun-Aug-Oct-Dec)		Anne Speden				10-Apr-19		24-Apr-19	
Matariki HB Regional Development Strategy and Social Inclusion Strategy update - 6 monthly (Sep-Mar)	E	Bernard TePaa	Shari Tidswell	5-Mar-19	13-Mar-19	10-Apr-19	11-Apr-19		27-Mar-19
Violence Intervention Programme Report (Committees reviewed in July - EMT Nov - April-19)	E	Colin Hutchison	Russell / Cheryl Newman	26-Mar-19	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19

CLINICAL & CONSUMER MEETING 8/9 MAY 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				8-May-19			
Collaborative Pathways - update (Nov & May) 6 mthly Clinical Council	E	Mark Peterson	Penny Rongotoa	21-May-19		8-May-19			
Early Supportive Discharge Service (EMT & CC only)		Colin Hutchison	Allison Stevenson	2-Apr-19		8-May-19			
Te Ara Whakawaiora - Access Rates 0-4 (local indicators) CHILD HEALTH		Chris Ash	Mark P/ Jil Garrett / Patrick	30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
After Hours Urgent Care Service Update 6mthly (Sep-Mar-Sep)	E	Wayne Woolrich		30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19

CLINICAL & CONSUMER MEETING 12 /13 June 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)		Chris Ash	Robyn Richardson	4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				12-Jun-19			
IS updates/presentations 30 mins - Bi-monthly (Feb-Apr-Jun-Aug-Oct-Dec)		Anne Speden				12-Jun-19		26-Jun-19	
People Plan Progress Update Report - 6 monthly (Dec-Jan)		Kate Coley		4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

CLINICAL & CONSUMER MEETING 10/ 11 July 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				10-Jul-19			

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council & Health Consumer Council** 25
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair) Rachel Ritchie (Chair)
Month:	March 2019
Consideration:	For Information

PERSON & WHANAU CENTRED CARE

Person & Whanau Centred Care is working 'w**ith'** people & whanau, rather than just doing **'to'** or **'for'** them.

RECOMMENDATIONS

That the HBDHB Board:

- **Notes** the contents of this report
- **Notes** HBDHB commitments to Person and Whanau Centred Care (PWCC) in the Clinical Services Plan (CSP) and initial drafts of the Strategic Plan
- **Advocates** for national changes and considers local changes to current funding models and other disincentives to providing PWCC in primary and community care
- **Ensures** PWCC becomes the norm; to do that, **requests** management to present a paper to the June 2019 Board meeting that:
  - **Enables** the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector
  - **Prioritises** the provision of specific education and training to the HB health workforce on implementing PWCC
  - **Facilitates** raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments

HB Clinical Council & Health Consumer Council held a combined three hour workshop on Wednesday 13 March 2019. The theme and objectives for the workshop were:

Primary & Community Healthcare

Implementing Person & Whanau Centred Care (PWCC) in line with Clinical Services Plan and People Plan

> *"Person and Whanau Centred care is working **'with'** people and whanau, rather than just doing **'to'** or **'for'** them'*

Objectives

- Discuss what is transferrable from the NUKA System of Care into HB primary and community care.
- Develop a vision/picture of what PWCC will look and feel like in HB primary and community healthcare in 5 to 10 years time.
- Agree what we need to do to get there.

Background reading sent out to participants included:

- Clinical Services Plan – Overview and key extracts
- Clinical and Consumer Council Joint Meeting Minutes 13 June 2018 – PWCC discussion extract
- Progress/Action Plan on PWCC from previous discussions
- Article on South Central Foundation (NUKA) approach to General Practice
- EMT Paper on 'Nuka System of Care – What is Transferrable to HB Health System'
- People Plan – Extracts Relating to PWCC and Values Based Culture/ Behaviours

WORKSHOP OUTCOMES

A detailed write up of all the ideas and discussion points captured at the workshop has been completed. Overall, these were very consistent with previous general discussion around 'Person and Whanau Centred Care' (PWCC), with an additional level of detail drawing on learnings from Nuka and current PHO discussions around Health Care Home (HCH).

A very high level summary of the points noted includes:

Vision - What should PWCC look/feel like in 10-15 years in primary and community care

- Everyone has ability to enrol with a healthcare provider of their choice
- No hierarchy - within teams/empowered
- Communication / consumers involved in decision making / not necessarily face to face e.g. telephone, email, virtual assessments
- Consumers are empowered to participate/partner at all levels
- Continuity of care
- Building relationships / responsive / personal / flexible / removing the time barrier of 15 minute appointments
- One stop shop
- Workforce working to their full potential, happy, healthy and wanting to be at work / skilled
- One system / lead carer / wrap around / triage - seeing right clinician at the right time
- Value time – clinicians and consumers
- Enhanced IT – access
- Health coaching/primary mental health advisors embedded

How Do We Get There? What do we need to do / stop doing?

- Importance of communication and continuing to use technology, enabling use, virtual consultations
- Resourcing professional development
- Eligibility for services, doing advance care planning which will take care of some eligibility and in turn may save money
- Getting the consumer voice in decisions going forward, in plain English, more sustainable multidisciplinary care etc
- Whanau wellness approach across sectors / social agencies; getting people to do the right thing e.g. health; education
- 'Close' the hospital and have services in the community
- Reduce outpatient appointments by 50%
- Community commissioning and ownership - different needs and models for the community – staged approach
- Stop using funding models as a barrier and think about what the model of care should be
- Primary care/secondary care one stop shop. Build a super clinic - concept central part to wraparound services for the community
- Make choices easier to change
- Create time and headspace of clinical leaders to work with consumers and look at the drivers for acute demand and different ways of working
- Time is need to stop and plan to look at change
- Investing in HCH, primary care
- Invest in clinical staff to enable keeping up on demand and changing to a new system
- Expectations in the community if I am sick, I am seen or if I need an operation it will be done
- Embed consumer engagement
- Every discussion comes back to funding and structures ? is it a wider conversation that needs to go to the MoH – consumers are frustrated at the lack of progress. Need to understand the process to be able to change the process

How do we know we've got there?

- Measures and goals to be SMART, in real time e.g. using Marama; identify by ethnicity, disability; self-identification care rather than coded
- Joy in healthcare; the community is thriving, equity is BAU, consumer input is BAU
- No more workshops / joint meetings on this topic
- Milestones vs done; journey vs destination
- Consumers understand the model and process
- Consumers perspective – right care, place, time and clinician
- Same day appointments of any length of time
- Healthy workplaces
- Healthcare is accessed in an equitable way
- Consumers have a greater sense of ownership of their own health
- Where there is consumer input / co-design there is ability and will to make the change
- You said / we did

All these outcomes will be fed into the strategic plan implementation phase when it commences in the new financial year.

BIGGER PICTURE

Although the workshop could be deemed a success as it achieved it's objectives, a number of issues came up during discussions which have caused us as Chairs, to look at the bigger picture and in turn, raise these with the CEO and Board. In doing this we also believe it is important to recap on the context and background to the whole issue of PWCC, with a particular focus on PWCC in primary and community care..

PWCC DIRECTION

The concept of PWCC has now been under discussion for several years, and has recently been incorporated into a number of commitments within the Clinical Services Plan, eg:

- *'Person and whanau centred care will become 'the way we do things around here'.*
- *'People and whanau will be equal partners in the planning and codesign of services'.*
- *'Person and whanau centred care is a core principle of commissioning'*
- *'We will support people to make good choices by making health easy to understand and navigate'*
- *'Consumers and whanau have choice to meet their needs and wants, with services easily accessed when they want them'*
- *'As well as ensuring our workforce is culturally competent, we need two key things to be happening: better design of all services and resourcing that is geared towards meeting the needs of underserved, plus targeted services that are wrapped around whanau with complex needs, supporting them to achieve their goals and aspirations and independently manage their own health and wellbeing'*

The CSP also includes a 'picture' of what a person and whanau centred system looks like in the future. This 'picture' is attached.

HCH is noted in the CSP as a model that has many of the features we want in primary care services. One of the six core attributes of HCH is:

> *Person & whānau centred: supports people to manage and organise their own care based on their preferences, and ensures that consumers, whānau, and caregivers are fully included in the development of their care plans and ultimately the design of primary care services.*

CSP references to Nuka include:

> *We have learnt a lot from the Nuka System of Care at the Southcentral Foundation in Alaska. We will take the lessons from Nuka but create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture. The Nuka System of Care incorporates key elements of the Health Care Home model, with multi-disciplinary teams providing integrated health and care services in primary health centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services—for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle family harm, abuse and neglect across the population through education, training and community engagement. Traditional healing is offered alongside other services, and all services build on indigenous culture (The King's Fund, n.d.).*

One of the key themes contained within the CSP is 'Evolving Primary Health Care'. Much of the discussion within this theme relates to PWCC:

'Evolving primary health care

A fundamentally different primary health care system is the lynchpin of this CSP. There are large expectations for a primary care response to burgeoning health need, and the model of general practice will continue to evolve to respond to this demand. There is a groundswell of readiness for a new approach and we already have examples of practices doing things differently. Some are implementing telephone triage to better manage appointments, holding daily team 'huddles', and there is good uptake in places of the patient portal. Strong relationships between primary care and the DHB need to be developed and nurtured to amplify the scale of this change.

Our health system needs to work with communities and people who need services to improve access, remove barriers and deliver proactive care and preventative strategies. This is particularly important for under-served populations with long term physical and mental health conditions, with an expectation of an integrated service. We know that cost can be a barrier to accessing primary care; some people delay or do not seek care when they need it, or access hospital services instead. As we expand and evolve primary care, embedding a wider range of services and specialism within it, we will develop equitable funding models that ensure costs are not shifted to consumers. Primary health centres will operate within community networks that are planned and developed as part of place-based planning.

Primary care teams will be expanded with new roles and capabilities

Traditional primary care is based on a medical model, focused on the role of general practitioner and practice nurse. This workforce is ageing, under significant workload pressure, and is unable to address all the health and related social needs of consumers. In future, the primary care team will be expanded with new roles including (for example): specialist long term conditions therapists or nurses, midwives, district nurses, care navigators or key workers, health promoters, social workers, behavioural practitioners, dietitians, mental health workers, clinical pharmacy facilitators as well as community pharmacists, therapists and home support carers. For example, community pharmacist skills will be harnessed to provide public health interventions and triage services and we will work to increase the number of non-medical prescribers. Behavioural practitioners will work with other team members such as dietitians and pharmacists. The full range of practitioners will not necessarily be employed by practices but will be a core part of a multi-disciplinary team around them, enabled by shared IT and providing holistic and culturally appropriate stepped care. Changes will be required to business models and/or funding models to ensure new and team-based workforce models can be developed.

PROGRESS

All the above sets out a very clear direction of what we need to do, and how, to embed PWCC in primary and community care, all of which is fully supported by both Councils. It does not however answer the questions of who will 'do' all this and when. A number of frustrations and concerns were raised during the workshop that relate to these two questions:

- *Create time and headspace of clinical leaders to work with consumers and look at the drivers for acute demand and different ways of working*
- *Time is need to stop and plan to look at change*
- *Every discussion comes back to funding and structures ? is it a wider conversation that needs to go to the MoH – consumers are frustrated at the lack of progress. Need to understand the process to be able to change the process*
- *Invest in clinical staff to enable keeping up on demand and changing to a new system*
- *Consumer view that we have been talking about this for long enough – it is time we saw some real change*

Within this context, Councils have acknowledged positive progress and planned organisational level processes such as:

- 'Person and Whanau Centred Care' is one of the six Core Goals currently incorporated into the developing Strategic Plan
- The development of an Implementation Plan for the Strategic Plan will formally commence in the new financial year
- Further work on transferring Nuka concepts into the HB health system is ongoing
- Implementation aspects of the People Plan will include socialisation and raising awareness of PWCC
- A number of 'operational issues' such as making health easy to understand, consumer feedback, and consumer engagement are being progressed

The general feeling from the workshop however, was that this is not sufficient 'if we really want to make a difference' for the benefit of all stakeholders. The belief was that HBDHB needs a greater level of commitment and needs to do more to advance PWCC across the sector. This needs to be done with consumers and communities working in partnership with clinicians, managers and providers.

RECOMMENDATIONS

Taking all this into account, we recommend that the HBDHB Board requests steps to be taken to:

- Continue to advocate for national changes and consider local changes to current funding models and other disincentives to providing PWCC
- Free up appropriate resources to prioritise the development of PWCC across the HB health sector
- Provide specific education and training to the HB health workforce on implementing PWCC
- Raise the levels of PWCC awareness within HB communities and empower consumers to partner in their own care and contribute to service developments

Problem with the current state	What a person and whānau centred system looks like in future
Services are not accessible or appropriate to the needs and wants of all groups.	Services are designed with communities, whānau and consumers to reflect their needs and wants, and are delivered as close to home as possible. Nobody misses out on the care they deserve because of affordability, transport, or other social issues.
A shortage of safe, warm and dry homes means children experience an unnecessary burden of childhood illness.	Issues of housing supply and affordability are addressed so that all children, including those in rental and social housing grown up in a safe, warm and dry home.
Lack of clear communication tailored to people and their whānau.	Health workers are friendly and welcoming and take time to develop relationships with people. Communication is clear and health information is easy for all people to understand.
Cultural competency is variable across services and workforce.	People and whānau have their cultural needs met no matter which health service they engage with.
Care is organised around the service rather than the people it serves and it tends to be focussed on a single issue and not holistic.	People have a broad range of services in the community, designed with them, to help them achieve their objectives and keep them well. Longer consultations are available when necessary and specialist services support primary care to manage people closer to home.
Care is not coordinated well, with too many referrals, delays, and discontinuity. There are multiple points where people can be lost in the system.	Everyone has a care plan that is developed with them and based in primary care. The consumer and whānau, and all health workers involved in their care can view and update the plan. Referrals are minimised by having a wider range of services available in primary care. Navigators support people and whānau with complex needs through the system.
Physical spaces are not well designed, lack privacy and can be inappropriate for children, older people, and whānau.	Assessments and interventions are delivered in appropriate spaces, both in primary care and the hospital. Health facilities are whānau friendly—consumers have whānau and support people on site, with specific areas for group conversations and meetings.
Workforce and services are stretched too thinly across both primary and secondary care. Hospital and theatres are full.	The hospital has a narrower scope in the future. People and whānau are empowered to self-care at home and can access services virtually when appropriate. Primary care consultations are targeted to those who need them most, and services are delivered by a range of different professionals working to the top of scope. Proactive care reduces the occurrence of acute events.
Discharge from hospital is not well planned and some people have poor experiences.	If people are admitted to hospital, their transfer back home is well supported and planned from day one, and involves the consumer, their whānau or support people, and other professionals involved in their care. People are able to return home as soon as they are medically fit, with appropriate care and support in place at home.
Expenditure is focussed at the hospital end of care.	The system is designed to deliver care when and where it will make best use of health system resources, meeting people's needs at the earliest and lowest cost opportunity and reducing the onset of complex health need.
Lack of IT development hinders service productivity.	Consumers, whānau and health professionals have access to modern IT infrastructure (hardware and applications) that supports self-care, access to services, and appropriate sharing of information. Tele-health supports equal access to specialist services for people living in remote or rural locations.

CHAIR'S REPORT

CONSUMER EXPERIENCE FACILITATORS REPORT

Verbal

COMMITTEE REPRESENTATIVE FEEDBACK

CONSUMER ENGAGEMENT IN PRIMARY / COMMUNITY HEALTH – WHERE TO FROM HERE?

Presentation

HAWKES BAY HEALTH CONSUMER COUNCIL
ANNUAL PLAN 2018/19

ACTION/PROGRESS REPORT

OBJECTIVE	PROGRESS TO MAR 19
1. Actively promote and participate in' co-design processes for: - Mental Health, Youth	Mental Health ongoing through PAG Need to support YCC – Jemma just resigned
2. Participate in the evolution of primary care and the work of the Te Pitau Health Alliance.	Ongoing - Rachel Consumer Council rep on Governance Group
3. Promote and support work on the development of a Disability Strategy for the HB Health sector.	Completed
4. Hold active membership in Clinical Council committees including Consumer Experience Committee.	Happening
5. Actively participate in the People Strategy and Clinical Services Plan development and implementation.	Happening
6. Promote and assist initiatives that make health easy to understand within the sector and community.	Coming along – need visibility of current initiatives/improvements
7. Facilitate and promote the implementation of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council.	Combined workshop on PWCC in primary care held 13 March 2019
8. Oversee the provision of consumer feedback and the use of 'consumer stories'.	Consumer feedback coordinated through Consumer Experience Committee Consumer stories now only used as management tool for lessons learned
9. Require regular provision of and monitor all 'Consumer Experience' performance measures/indicators as co-sponsor of the 'Consumer Experience Committee' within the clinical governance structure.	Consumer experience Committee functioning – ongoing development of measures/indicators
10. Facilitate a focus on disability issues	Disability strategy developed & approved by HBDHB Board
11. Support the implementation of the Consumer Engagement Strategy and principles in Hawkes Bay	'What will consumer engagement look like in the future? – discussed and feedback provided being summarised
12. Further develop and maintain connections with Youth within the community.	Need to review structure, effectiveness and relationships of YCC given recent changes – broader base may be required

OBJECTIVE	PROGRESS TO MAR 19
13. Influence the establishment and then participate in regional and national Consumer Advisory Networks.	Graeme still working on raising profile and support for national network. Regional coordination limited due to lack of support by Boards in some DHBs but regional meeting being discussed

FUTURE OF YOUTH CONSUMER COUNCIL

13

Discussion

CONSUMER COUNCIL PERSPECTIVES ON CONSUMER ENGAGEMENT DISCUSSION PAPER

Dr Diane Mara, April 2019

Background

1. The Clinical Services Plan, the HB DHB Health Equity Report, the People Plan and the forthcoming Strategic Plan feature effective consumer engagement as the best way to achieve equitable health outcomes for all. Whilst there is universal agreement on the pivotal importance of including the voices of consumers in the planning, delivery and outcomes of health provisions, how this will happen requires shared understanding and knowledge about how consumer engagement will operate at different levels of the HB DHB organisation and its relationships with all stakeholders and consumers.

2. Successful consumer engagement means that a collaborative power sharing relationship exists between those providing services (clinicians and others) and those accessing services. Changes must be more community-led and communities will come to have a sense of ownership of their own health outcomes and engagement in the design of their health services.

3. This paper describes the meanings and levels of consumer engagement arguing that what happens going forward in the name of consumer engagement must look completely different to former processes. Past approaches to consumer engagement have failed to engage effectively with the most vulnerable and most disadvantaged groups of health consumers.

4. Approaches to consumer engagement that aligns with person and whanau-centred care will need to be more responsive and appropriate to those for whom it is provided. The aim is that all health services will be carried out according to the specific purposes and outcomes while being designed and implemented in collaboration with those most affected.

A Case in point: The HB DHB Disability Strategy 2019

5. The HB DHB Disability Strategy was approved by the DHB Board on Wednesday 27 February 2019. The Strategy now belongs to the HB DHB and the Board has the responsibility to carry it forward under the auspices of the Directorates of Primary Care and Health Improvement and Equity.

6. The Disability Strategy: The Implementation Steering Group held its first meeting on 28 March 2019. This group is deciding which priority area of the Strategy the group will "steer" first to put into effect. These will be few in number and chosen from the priorities recommended in the approved Strategy. The group is considering its size and membership as it operates as an internal DHB project to ensure representative staff involvement to monitor progress within their areas. Going forward the work of the group now needs to be informed through relationships that they have already established within the relevant disability networks in the Hawke's Bay during initial consultation.

7. Background: During 2018 as part of the development of the Strategy DHB staff went into the community and met with disability networks and individuals to share the DHB's intentions. Through a series of meetings the DHB staff collected an indication of priorities within this very diverse sector. There was widespread support for the establishment of the Strategy and these initial contacts now need to be contacted again. In the first instance those consulted will be sent a copy of the approved Strategy with an indication of where Steering Group work will begin and how they need immediate assistance. DHB needs to seek out the most useful disability contacts appropriate to the areas of health service under development planned during the coming year.

8. It will be important for the Steering Group to work alongside stakeholders from the very beginning of projects. One example is the training initiative: Relationship Centred Care (RCC). The staff currently redeveloping the RCC will now need to ensure disability considerations are embedded in training of staff on patient relationships. The DHB personnel responsible for that staff development initiative will need to reach out to disability sector leaders for assistance in authentically changing RCC training to include disability perspectives and consumer empowerment.

9. It is accepted that the resources and funding limitations must be taken into account however, communities in my experience prefer honesty and realism. As long as some of their ideas are implemented and not dismissed out of hand solely because of budget limitations then a measure of trust can be built across all parties. Communities also deserve respectful feedback and acknowledgement of their contributions at all times.

The HB DHB takes ownership as a basis to invite consumer partnerships

10. Changes in mind set and present conventions need to be made internally by HB DHB staff in transforming the consumer engagement paradigm. Instead of retaining

present structures and processes that are set up where consumers are asked to "fit" into the provision of health services it is time for the services to be developed based upon and around consumers' needs and priorities.

11. The NUKA model of consumer engagement is our standard to measure success in consumer engagement. The DHB will always have to work within resource limitations imposed upon it but within those through honest and trustful dialogue person and whanau-centred care can still flourish. Savings can be made when consumers have increased information and knowledge of health literacy that enables them to be more actively involved in and more responsible for their own health outcomes.

Relationship building and consumer autonomy

12. There will need to be training for staff to ensure listening and negotiating skills are evident in all their consumer relationships. Most community networks and NGOs are skilled in advocacy and communication and HB DHB can learn and collaborate in developing a range of consumer engagement approaches. Community networks are already resilient and innovative due to the pressures operating on them in regards to funding and resourcing (including voluntary contributions).

The ongoing role of the HB DHB Consumer Council

13. We are a governance body comprised of members with links to a range of community networks and interests. We are presented with work plans and initiatives in order to ensure that consumer voice is fully integrated. The Council can initiate and sponsor work such as the Disability Strategy but its full implementation once approved is lead by the DHB.

14. The Council can expect to have progress reports on the Strategy at regular intervals with a specific brief to ensure and provide feedback on the ways in which consumer engagement continues to be relevant and appropriate.

15. The Consumer Council should hear about feedback received from Hawke's Bay health consumers (which is more specific than the national surveys) with a focus on local equitable outcomes and responsiveness. We would like to hear about "success" stories and positive consumer experiences through the Consumer Experience Committee as well as directly through our own community networks.

HAWKE'S BAY District Health Board Whakawāteatia	**Matariki HB Regional Economic Development and Social Inclusion Strategy** 29
	For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Equity and Health Improvement
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Executive Management Team
Month/Year	March 2019
Purpose	This report provides and update on progress for the Matariki Strategies and the HBDHB's contribution to these.
Previous Consideration Discussions	This is reported six monthly.
Summary	The emphasis has shifted for the Matariki forum with partner agencies working on and sharing proposals for the Provincial Growth Fund (PGF). The Executive Leadership and Governance Groups are discussing alignment and their role in the PGF process. Business Hawke's Bay continues to work on establishing the supporting structure for the forum, with all staff support in place. HBDHB continues to support current projects and there has been particular success for the Rangatahi Ma Kia Eke project.
Contribution to Goals and Strategic Implications	Improving Health and Equity. Contributing to an intersectoral approach
Impact on Reducing Inequities/Disparities	Matariki as a cross-sector initiative focusses on the impacts of economic development in reducing equity amongst our communities.
Consumer Engagement	Completed in the development of both Strategies and the ongoing development of projects.
Other Consultation /Involvement	Not applicable for this report.
Financial/Budget Impact	Not applicable for this report.
Timing Issues	Not applicable
Announcements/ Communications	Link to the Matariki website on the Hawke's Bay DHB website

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

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HAWKE'S BAY
District Health Board
Whakawāteatia

Board Six Month Update
Matariki – Regional Economic Development and Social Inclusion Strategies.

Author(s):	Shari Tidswell, Intersector Development Manager
Designations:	As above
Date:	**March, 2019**

OVERVIEW

Matariki includes two regional strategies designed to achieve regional development via economic development and social inclusion. Through the delivery of projects, these complementary strategies will support the regional, economic vision:

> *"Every household and every whānau has activity engaged in, contributing to and benefiting from a thriving Hawke's Bay economy."*

And social inclusion vision:

> *"Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has the opportunities that result in equity of outcomes."*

Underpinning this is the understanding that regional economic growth and supporting equitable opportunities for individuals, whānau and community go hand in hand.

An intersectoral approach is being used to deliver actions to support the strategies, including; community, Iwi, hapū, business and Government partners. The leadership structure reflects this approach with a two tiered leadership structure – Governance and Executive Leadership Groups, with membership including Iwi and Hapū governance and executive representatives.

Governance Group membership includes; five council (Mayors and Chair), five Māori leadership representatives and five business leaders providing leadership and overall direction for Matariki.

The Executive Leadership Group consists of senior officials and managers from all stakeholder groups including Government agencies. This group provides operational direction, project support and monitors progress on the strategy's actions. Administrative support is provided via Business Hawke's Bay.

HBDHB is the lead and/or contributing agency for the following actions:

Regional Economic Development

- Contributor - Project 1,000 (placing 1,000 youth into work)
- Contributor - coordinating infrastructure

Social Inclusion

- Lead agency – Social Responsible Employers
- Co-lead agency – Housing
- Contributor – Whānau centric places connected to the community
- Contribute – Develop a new sustainable operating system

PROGRESS ON ACTIONS LED OR CONTRIBUTED TO BY HBDHB

The Regional Growth Fund is stepping up with scheduling of Ministerial announcements in 'surge regions' including Hawke's Bay. Matariki partners have been working on proposals including a joint proposal from the local territorial authorities. The Executive Leadership Group is providing a process for reviewing funding applications – this will require proposals to demonstrate how they contribute to Matariki actions. The process for reviewing youth employment programmes has received positive feedback from central government.

The HBDHB continues to provide 'in kind' support for the Social Inclusion Working Group and via this support, has completed:

- Updates to the Executive Leadership Group
- Integrated the actions table from both strategies
- Updating of the Matariki website to reflect the aligned strategies https://www.hbreds.nz/
- Presented the Clinical Services Plan to the Governance and Executive Leadership Groups

The HBDHB is contributing to actions as noted below:

Theme	Action	Update
Social Inclusion		
Growing social responsible employers and enterprise	Support the employment of people with challenges that may impact on their capacity to obtain and retain employment.	• HBDHB and MSD lead this action • Rangatahi Ma Kia Eke project has placed 25 youth and has secured another year of funding • Evaluation is underway • HBDHB has completed a Disability Plan which will reduce barriers for people with disabilities
Whānau, households and communities driving social inclusion	Develop a new sustainable operating system to deliver social support services.	• HBDHB and Oranga Tamariki lead this action • Clinical Services Plan – co-design process is an example of moving to a sustainable operating system for health • HBDHB are members of the Wairoa Community Partnership Group, this is supporting an integrated/community-based response for funding services in Wairoa
	Review Housing Coalition's Terms of Reference	• HBDHB and TToH lead this action • Completed
	Undertake an analysis of social housing	• HBDHB and TToH lead this action • This is now part of a Government activity - HBDHB will contribute
	Develop a plan to address issues affecting housing supply and consider innovative approaches	• HBDHB and TToH lead this action • Currently working with Government policy and housing programme

Theme	Action	Update
Regional Economic Development		
Improve pathways to and through employment	Project 1,000	• HBDHB are key partners • Supporting the delivery of Rangatahi Ma Kia Eke with partner agencies; TPK, MSD, EIT, HDC, and OT • Establishing a support pathway for youth "failing drug test" • Working with TToH and Work and Income to provide referrals and support
	Ensure all major infrastructure development projects are optimising local employment	• HBDHB are key partners • Employment in building projects – working with Contracts Team and Facilities to support this process
	Increase the number of youth with driver licences	• Completed a map of driver licensing and provides support to develop the project plan

COMMENTS

Progress has been gradual due to the focus on the Provincial Growth Fund and the time required for Business Hawke's Bay to establish the supporting structure. The Governance and Executive Leadership Groups are operational and meeting regularly.

The Minister's expectations include intersectoral work. Matariki provides a framework for intersectoral work. Work on the Annual Plan for 2019/2020 includes links to Matariki actions and projects, which will support the Social Inclusion Strategy to be delivered and continues to deliver projects in the Regional Economic Development Strategy.

Through our membership on Matariki, we continue to grow our cross-sector opportunities and relationships.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
HBDHB continues to contribute to Governance and ELG	• Attend monthly meetings and contribute to actions	Kevin Snee Kevin Atkinson	Ongoing
Continue to support actions areas with 'in kind' support	• Support the ready for work actions. • Contribute to the work delivering whānau centric approaches • Complete the Housing Actions	Shari Tidswell	1 July 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

HAWKE'S BAY District Health Board Whakawāteatia	**Haumaru Whanau/Violence intervention programme update** For the attention of: **Executive Management Team**
Document Owner	**Cheryl Newman, Haumaru Whanau Team Leader**
Document Author(s)	**Cheryl Newman, Haumaru Whanau Team Leader**
Reviewed by	Russell Wills
Month/Year	March 2019
Purpose	Monitoring
Previous Consideration Discussions	No
Summary	Key Issues/Actions There is ongoing review of the Violence Intervention Programme. Four key work streams have been identified as being of particular importance to building a broader and more comprehensive family harm programme for HBDHB. The details of these work streams is contained in the paper below.
Contribution to Goals and Strategic Implications	What are the implications and contributions of this issue on any major goal or strategy eg: Improving quality, safety and experience of care Improving Health and Equity for all populations Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	What impact will this have on reducing inequities and has a HEAT Tool been applied? If yes, what are the implications / outcomes? A key work stream is ensuring that we understand the needs of Maori and Pacific groups in our community. Their feedback and engagement will form the foundations of our strategy and training models so a great deal of investment is being made in this work stream.
Consumer Engagement	What level of consumer engagement has been undertaken? Please see comments in paper below for details.
Other Consultation /Involvement	Who else was consulted / involved? How was consultation undertaken and input incorporated? N/A
Financial/Budget Impact	Nil

Timing Issues	N/A
Announcements/ Communications	Does any outcome need to be announced or communicated? If yes, please provide details: N/A

RECOMMENDATION:

It is recommended that the HBDHB Board, HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and/or Pasifika Health Leadership Group:

1. **Note progress as outlined below and seek a further update in six months.**

HAWKE'S BAY
District Health Board
Whakawāteatia

Haumaru Whanau/Violence intervention programme update to EMT

Author:	**Cheryl Newman**
Designation:	**Haumaru Whanau Team Leader**
Date:	**20 March 2019**

FAMILY HARM REVIEW - Focus areas:

- ***Equitable services – responding to Maori and Pacific families.***

There is progress in developing a better understanding of community needs from health services where there are family harm concerns. This is a crucial foundation to the development of a strategy so is the greater part of our work. We are waiting for the final proposal from Hohou Rongo who we have approached to work with their established community groups to gather this impartial feedback, predominantly from the Maori community.

Talalelei Taufale is supporting us to develop a framework to gather feedback from our Pacific community groups.
A number of consumer council members are also been consulted and we expect that this piece of work will continue through 2019.
These actions are also included in the family violence and sexual violence focus area for the annual plan 2019-20.

- ***Wellbeing model***

We continue to support the view that a possible mechanism for improving responses to family harm and child protection concerns is to develop a wellbeing model for screening and brief intervention. Considering the wide range of harms impacting our community, challenges with resourcing sufficient services for each of the individual harms, numerous overlapping governance structures in place, we believe a broader 'Are you ok?' approach for families will better meet their needs, and that of the different services responding to these harms.

We are currently exploring the possibility of funding a position from our budget in 2019/20 to pilot a 'wellbeing warrior' role in the areas of highest need, possibly emergency department. We know that consistent face to face contact with staff is improving practice and therefore responses to patients. Alcohol Harm reduction have already been involved in discussions about the scope of the position and are supportive of trialling this. The joining of the suicide harm prevention programme with Haumaru Whanau adds further opportunities for growth of the wellbeing model.
In addition, we continue to invest in our programme champions and advocate with their management to ensure they attend training and development opportunities we have planned over the year. The champions offer us an opportunity to further trial a wellbeing warrior approach if we are successful in protecting their work time to undertake this role in their specific service area.

- ***Inter-sectorial family harm responses***

Oranga Whanau Government agencies group are continuing with their focused work on redesigning the community wide response to family harm, and ensuring Government agencies are prepared to address systems issues that impact on delivery of services. We continue to support this work and have added actions to the family violence and sexual violence focus area for the annual plan 2019-20. We are particularly seeking support to resource Oranga Whanau's coordination and membership growth, and more crucially ensure there is an equity focus to the actions. Our investment in the Oranga Whanau work is also informing possible future Governance structures. Upcoming events include a wānanga to increase community awareness of Oranga Whanau and create an opportunity for feedback on our purpose and framework, and also the establishment of regular briefings to make the groups work transparent to a wider audience.
We are in the very early stages of mapping possible joint training opportunities across our community, who may be involved and what level of resourcing this would require. We already have a number of organisations eager to pilot training for their employees, and some previously delivered joint training to further develop. This is likely to be followed up further towards the end of 2019 once we have a clear pathway established for DHB employees.

- ***Training structure***

There is a draft structure for training delivery that we are in the process of consulting with the VIP national training manager on. We will also be discussing this with the VIP improvement group at the next meeting to ensure it is viable for CNMs to support staff to participate in. MoH are still supportive of us exploring a training model that is compatible with our DHB but are clear on a deadline for disruption to the delivery of the contract being June 2019.

We continue to offer service specific training on request and there has been some positive feedback on this approach. It does mean that we will cover lower numbers of staff, but smaller group training means content is specific to their skill level and working environment.
We are still to establish how a family harm training programme could be supported and enhanced alongside the DHB's other training packages, especially in light of us pursing a wellbeing approach when screening for harms.

- ***Challenges***

Operational support is compromised whilst we focus on these areas of work; it is therefore not surprising that we are still seeing incidents of patient harm occurring due to insufficient application of the policy and procedures. We are following these up as and where we can with the expectation that Team Leaders/CNMs/ACNMs etc address any identified practice issues.
There has been no change in screening and disclosure rates. This includes in E.D where we have invested additional face to face support over the last 5 months. Via the VIP improvement group we have offered support with auditing to support more accurate data collection but this has not been taken up as yet.
We have not been able to recruit to the 6 month backfill position to date and this is impacting on the progress of the review. We are currently trying to identify funding that will allow us to re-advertise this position.
We have not yet established a steering group to support the development of a family harm strategy due to limited interest. The impact of this is that those services who are struggling the most with responses to vulnerable families are no further forward in improving practice.

We anticipate that further discussion and clear expectations in planning (Annual Plans, Clinical Services Plans etc) at a senior leadership level will assist in clarifying for operational leaders their obligations to support a review of responses.

- ***Next steps:***

Finalise the proposal for the relocation of Haumaru Whanau from Communities, Women and Children directorate.

Explore restructure of Haumaru Whanau to allow for development of the wellbeing model.

RECOMMENDATION:

It is recommended that the Board, Clinical Council and/or other:

1. **Note** update as provided
2. **Approve** further update to EMT in six months' time.

ATTACHMENTS:

Hawke's Bay District Health Board Violence Intervention Programme Evaluation: 2017-2018

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

VIP
violence intervention programme

Hawkes Bay District Health Board
Violence Intervention Programme Evaluation: 2017-2018

Attention: Dr Kevin Snee, Chief Executive
Claire Caddie, Director of Women, Children and Youth Services

Family Violence Intervention Coordinators (FVIC):
Yvette MacDonald
Cheryl Newman

Date: 13/12/ 2018

Introduction

The Ministry of Health's Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This report reviews VIP evaluation documents submitted to the AUT evaluation team by Hawkes Bay staff in September 2018.

The evaluation period was 1st July 2017 – 30st June 2018. This report addresses the following evaluation activities:

1. Delphi audit of programme infrastructure (inputs) assessed against criteria for an ideal programme
2. VIP Snapshot clinical audits (outputs) to measure programme delivery in the Ministry of Health designated six services
3. Model for Improvement Plan-Do-Study-Act (PDSA) cycles to foster system learning and quality improvement

Evaluation tools and national evaluation reports are available at www.aut.ac.nz/vipevaluation.

1. Delphi audit of programme infrastructure

In 2018 a new Delphi audit tool (Table 1 in the Appendix) was implemented, replacing the previous tools for child abuse and neglect (CAN) and intimate partner violence (IPV). This was to reduce reporting burden, eliminate the ceiling effect and introduce new elements of infrastructure identified as important to programme sustainability. A new Ministry of Health target score will be established for 2019 based on the 2018 Delphi data. DHB Delphi range and medians will be available in the 2018 national report released early 2019, however DHB scores will not be identified in this inaugural year.

- Hawkes Bay DHB scored 43 (possible range 0-100). This is compared to a median of 72 based on the 95% of DHBs who have submitted data to date.
- The domain scores for Hawkes Bay were varied. Resource funding for the VIP was the strongest domain score whereas practice service delivery criteria were not met at all. A number of domains require focus particularly cultural responsiveness for Māori, collaboration with outside agencies and visible and accountable DHB leadership for the VIP.

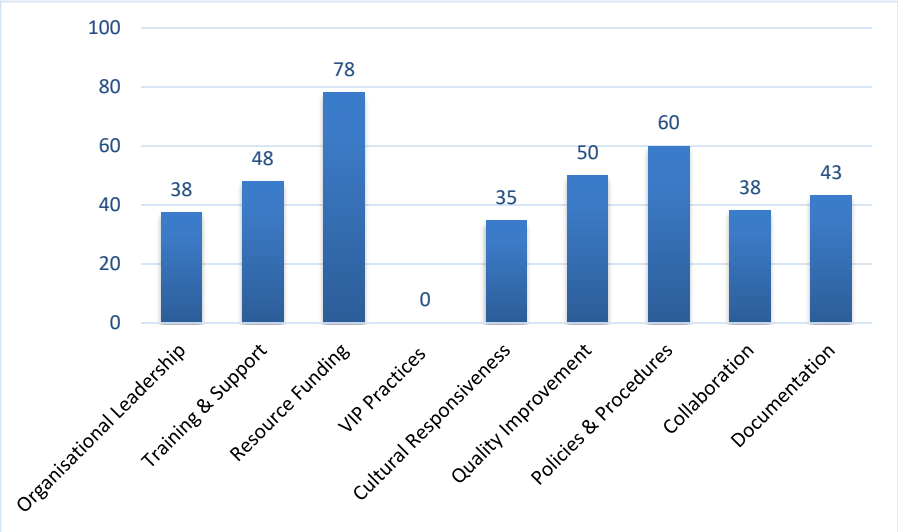


Figure 1. *Hawkes Bay DHB Delphi Domain Scores 2018*

2. Clinical Snapshot Results

Child Protection Assessment and Concerns

The national 2016 Guideline[1] supports the use of a child protection checklist to increase the quality of child protection assessment and documentation for **all** children under 2 years of age presenting to emergency departments. Random samples of 25 charts during the April to June quarter in 2018 indicates that children under two years of age presenting to Hawkes Bay Emergency Department are not routinely assessed for child protection concerns. Although there was a notable increase from 0 in 2016 to 15% in 2017, this has fallen to 4% in 2018, well below the current Ministry of Health target of ≥ 80%.

[1] Fanslow, J., & Kelly, P. (2016). *Family violence assessment and intervention guideline: Child abuse and intimate partner violence* (2nd ed.). Wellington: Ministry of Health.

VIP expects the rate of child protection concern identification to be ≥ 5%. Within the random audit samples (2014-2018), the indicative rate of child protection concerns for children under the age of two presenting to the Hawkes Bay DHB was zero. This has consistently fallen below the national mean (see Table 2 in the Appendix) and the result is clearly attributable to the lack of routine assessment occurring in the DHB.

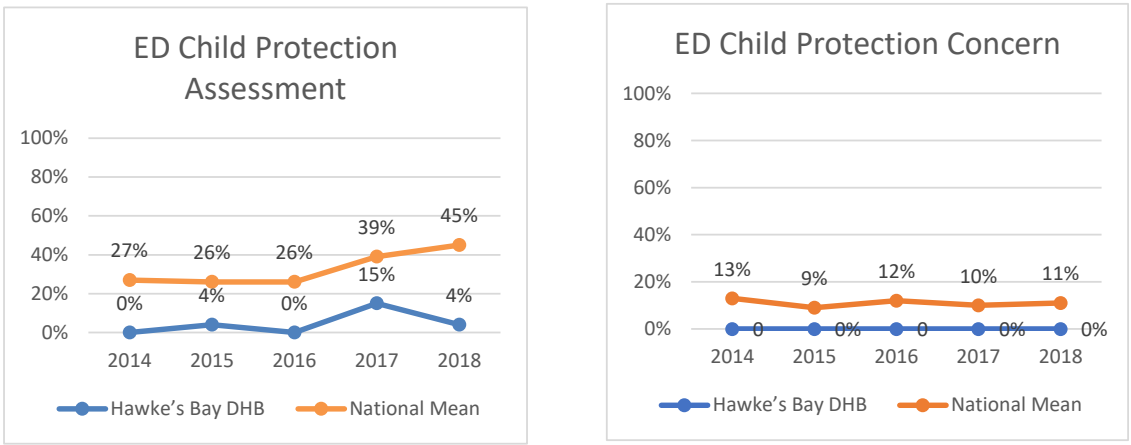


Figure 2. *Hawkes Bay Emergency Department Child Protection Assessment & Concern Rates for Children under Two Years (April-June 2014-2018)* Figure notes: Based on a random sample of 25 charts for each audit period. Includes children under two years of age presenting to the ED for any reason.

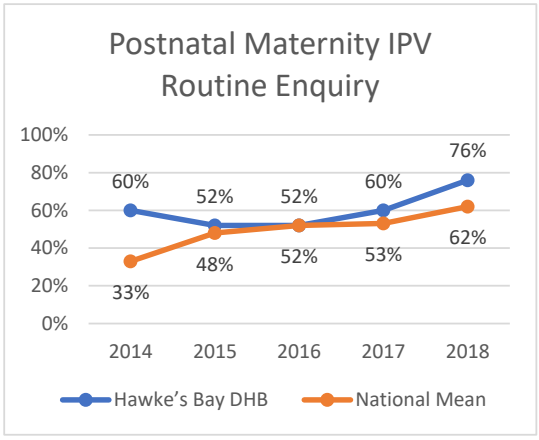
IPV Routine Enquiry and Disclosure

Successive services have been added to Snapshot IPV clinical audits beginning in 2014. Snapshot data from Hawkes Bay DHB is available for all six Ministry of Health designated services. Hawkes Bay DHB IPV routine enquiry and disclosure rates based on clinical audits of random samples of 25 charts per service, during the April to June quarter 2014 to 2018, are shown below.

The VIP aims for reliable IPV routine enquiry, indicated by screening rates ≥ 80%. Results suggest that there is inconsistent service delivery of VIP at the Hawkes Bay DHB with routine enquiry below target in all services, although Postnatal Maternity (76%) and Sexual Health (77%) are only slightly below. Rates in all services have remained relatively steady over the past two years. With the exception of Postnatal Maternity, the routine enquiry rates are below the national mean for the designated service (see Table 3 in the Appendix).

Research indicates that the quality of IPV screening influences women's decision whether or not to disclose IPV to a health worker.[2] The VIP expects IPV disclosure rates among women seeking health care to be at least as high as the population prevalence of 5%, given the negative impact of IPV on health and associated increase in health visits. Child Health Inpatient, Emergency Department, Alcohol and Drug, and Community Mental Health had disclosure rates above 5% of those screened (13%, 25%, 44% and 9% respectively). With the exception of Community Mental Health these disclosure rates exceeded the national mean. The high rate of disclosure in the Emergency Department despite lower rates of routine enquiry suggests assessment may be occurring selectively based on staff concerns of IPV.

[2] See Spangaro J, Koziol-McLain J, Zwi A, Rutherford A, Frail MA, Ruane J. Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. *Soc Sci Med.* 2016;154:45-53; and Feder G, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006;166(1):22-37.



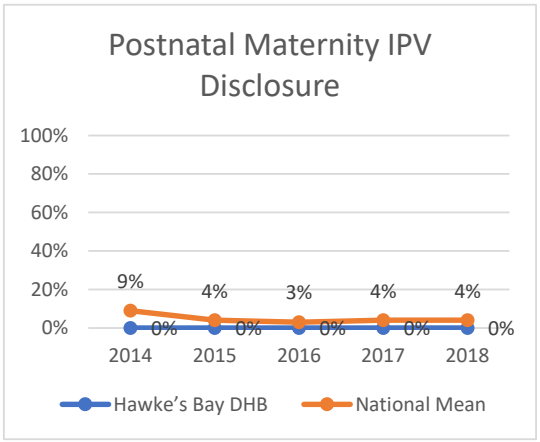
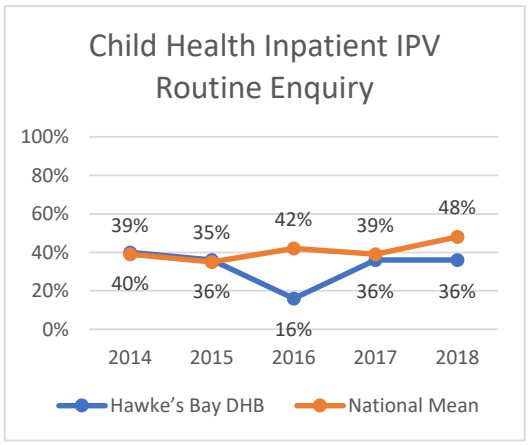


Figure 3. *Hawkes Bay Postnatal Maternity IPV Routine Enquiry & Disclosure rates 2014-2018*



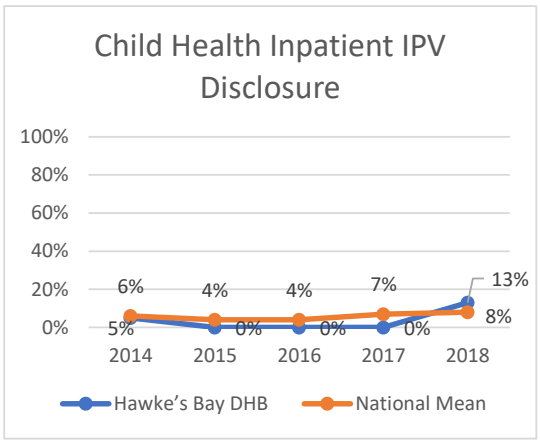
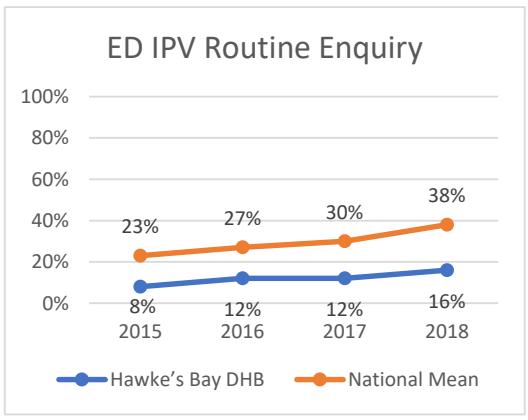


Figure 4. *Hawkes Bay Child Health Inpatient IPV Routine Enquiry & Disclosure rates 2014-2018*



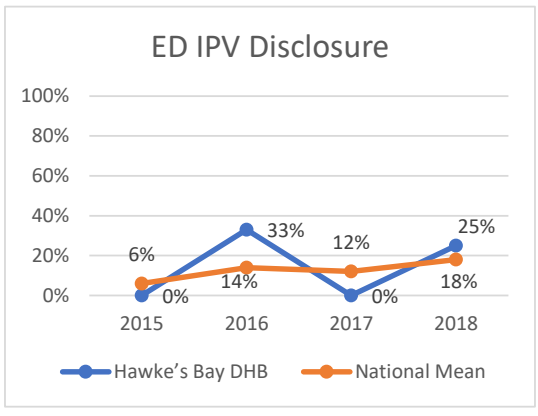


Figure 5. *Hawkes Bay Emergency Department IPV Routine Enquiry & Disclosure rates 2015-2018*

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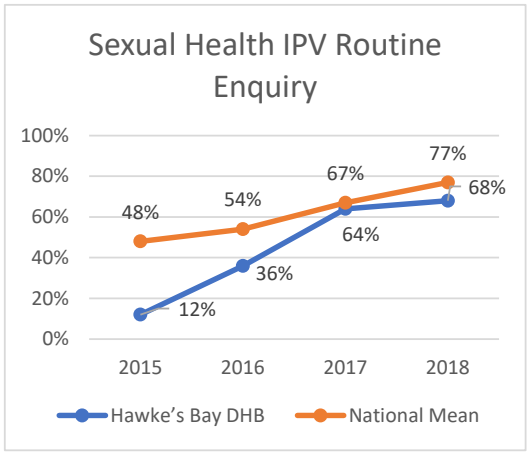


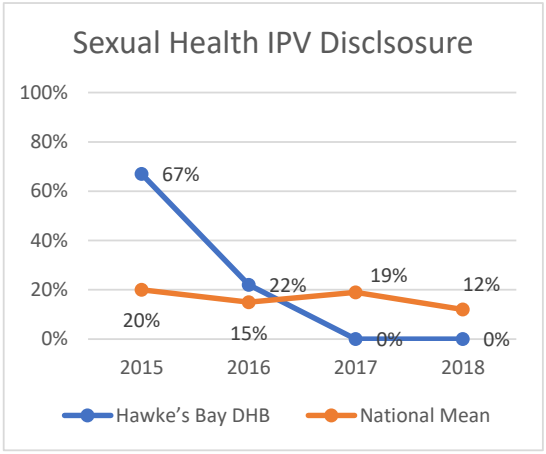
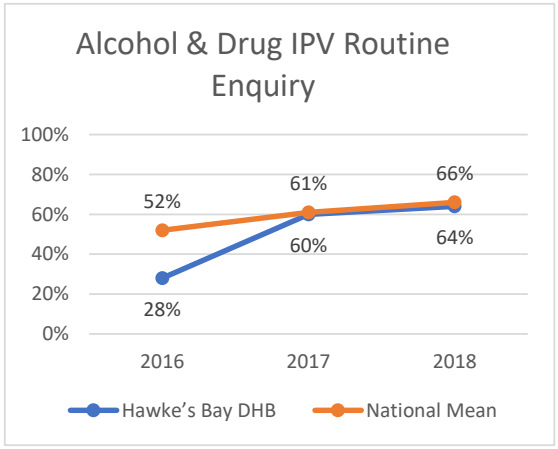


Figure 6. *Hawkes Bay Sexual Health IPV Routine Enquiry & Disclosure rates 2015-2018*



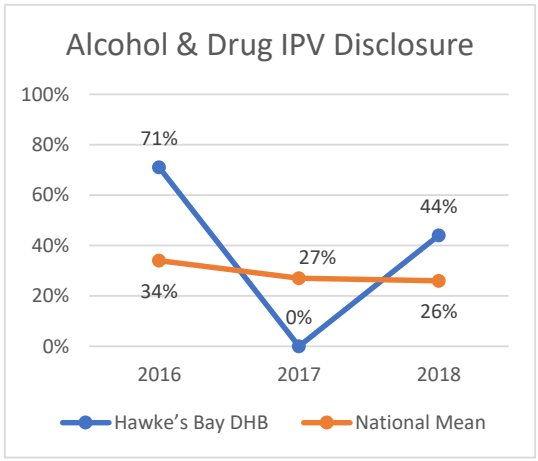
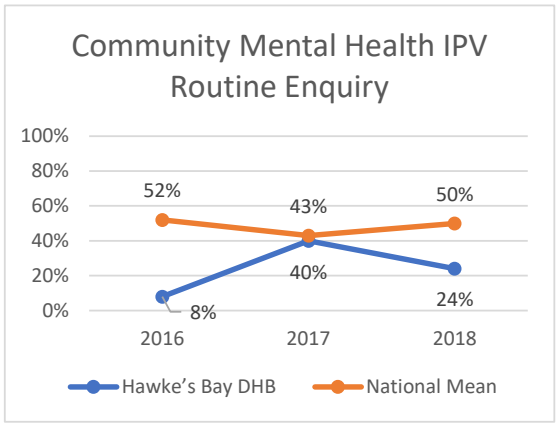


Figure 7. *Hawkes Bay DHB Alcohol & Drug Services IPV Routine Enquiry & Disclosure rates 2016-2018*



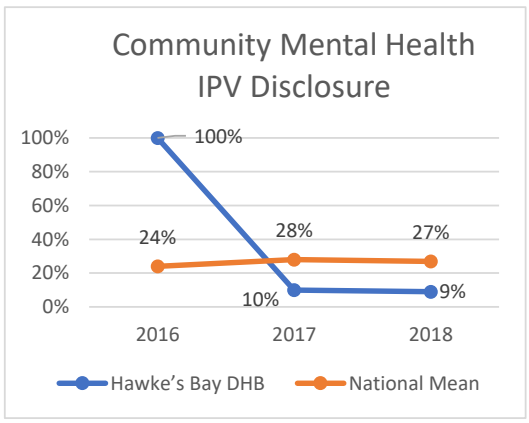


Figure 8. *Hawkes Bay Community Mental Health IPV Routine Enquiry & Disclosure rates 2016-2018*

3. Model for Improvement

Two PDSA plans were submitted in October 2018. The first aims to improve safety planning following an IPV disclosure by upskilling the social work team through an assessment of current knowledge and skills, observations and audit, followed by training in CAN and IPV safety planning and intervention practices. The second aims to ensure transfer of skills from core VIP training to practice through on-the-job follow up. These are good and clear efforts to enhance VIP practice which were not provided to us last year. If these are the first cycle and initiatives, we recommend that the DHB quality improvement and safety resource provide support to the VIP team in implementing the Model for Improvement (and PDSA cycles). PDSA resources on HIIRC may also be useful.

Summary

The Violence Intervention Programme team is to be recognised for the steady rates of IPV routine enquiry in most designated services and disclosure rates that indicate some of the women experiencing IPV are identified. The revised Delphi has highlighted a number of areas where the VIP requires support including organisational leadership, resourcing, collaboration with external agencies and a focus on cultural responsiveness for Māori. Quality improvement initiatives in these areas will help the VIP meet the guideline for effective practice. Organisational governance and leadership have an important role in communicating the Ministry's expectation of consistent quality family violence assessment and intervention across the DHB.

Please do not hesitate to contact us if you have any questions or comments.

Respectfully submitted,

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cc: Helen Fraser (Portfolio Manager, Ministry of Health), Miranda Ritchie (National VIP Manager for DHBs, Health Networks Limited), Kara-Dee Morden (VIP National Trainer, SHINE), Helen Garrick (VIP Education & Training Manager, SHINE)

Appendix

Table 1: *2018 Delphi domain definitions*

Domain	*Definition*	*Weight*	*# items*
Organisational leadership	Ownership, leadership and support evidenced through participation, communication and connection	14	9
Training and support	Staff receive the appropriate training, reinforcement and support to effectively implement VIP	11.8	8
Resource funding	VIP funding is fully allocated, supporting continuous and sustained coordinator/s with dedicated cultural resource	11.5	3
VIP practices	Intervention services including routine enquiry, health and risk assessment, safety planning, referrals and support, follow the Ministry of Health Family Violence Assessment and Intervention Guideline (FVAIG) procedures and are implemented at all levels of the DHB	11	8
Cultural Responsiveness	The programme includes education, support and services informed by people's diverse needs: Māori, multicultural, disabled and gender identity when living with family violence	10.9	7
Quality improvement	Strategic and continuous monitoring to ensure effective programme delivery	10.8	10
Policies and procedures	Policies and procedures exist, are reviewed, aligned to guidelines and legislation and are culturally responsive	10.6	5
Collaboration	Internal and external collaboration throughout programme and practice	10.5	5
Documentation	Easily accessible standardised documentation tools, aligned with FVAIG, are used	8.8	3
Total		**100**	**58**

Table 2. *Child protection assessment for children under two years of age presenting to the Hawkes Bay emergency department for any reason* (April – June, 2014-2018).*

		2014	*2015*	*2016*	*2017*	***2018***
Child Protection Assessment	*Hawke's Bay DHB*	0%	4%	0%	15%	4%
	National Mean	27%	26%	26%	39%	45%
	National Range	0%-61%	0-76%	0-96%	4-88%	0-100%
Child Protection Concern	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	13%	9%	12%	10%	11%
	National Range	0-100%	0-75%	0-100%	0-50%	0-40%
Specialist Consultation	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	89%	100%	93%	100%	92%

*Based on a random sample of 25 charts for each audit period

Table 3. *Intimate partner violence (IPV) routine enquiry, disclosure and referral of women presenting to Hawkes Bay DHB Ministry of Health VIP designated services (April - June, 2014-2018)*

Service		***2014***	***2015***	***2016***	***2017***	***2018***
Postnatal Maternity						
IPV Assessment	*Hawke's Bay DHB*	60%	52%	52%	60%	76%
	National Mean	33%	48%	52%	53%	62%
	National Range	0-72%	0 – 100%	16-96%	24-96%	16-96%
IPV Disclosure	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	9%	4%	3%	4%	4%
	National Range	0-32%	0-33%	0-17%	0-21%	0-17%
IPV Referral	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	67%	100%	83%	60%	86%
Child Health Inpatient						
IPV Assessment	*Hawke's Bay DHB*	*40%*	*36%*	*16%*	*36%*	36%
	National Mean	*39%*	*35%*	*42%*	*39%*	48%
	National Range	*0 -100%*	*12-92%*	*12-96%*	*0-80%*	12-84%
IPV Disclosure	*Hawke's Bay DHB*	5%	0%	0%	0%	13%
	National Mean	6%	4%	4%	7%	8%
	National Range	0 - 100%	0-33%	0-33%	0-63%	0-33%
IPV Referral	*Hawke's Bay DHB*	0%	0	0	0	100%
	National Mean	70%	100%	75%	69%	80%
Adult Emergency Department						
IPV Assessment	*Hawke's Bay DHB*	N/A	8%	12%	12%	16%
	National Mean		23%	27%	30%	30%
	National Range		0 – 68%	0-64%	4-64%	4-80%
IPV Disclosure	*Hawke's Bay DHB*		0%	33%	0%	25%
	National Mean		6%	14%	12%	18%
	National Range		0-100%	0-33%	0-100%	0-100%
IPV Referral	*Hawke's Bay DHB*		0%	100%	0%	100%
	National Mean		75%	94%	78%	70%

Service		2014	2015	2016	2017	2018
Sexual Health						
IPV Assessment	*Hawke's Bay DHB*	N/A	12%	36%	64%	68%
	National Mean		48%	54%	67%	77%
	National Range		0 – 88%	8-96%	43-94%	40-92%
IPV Disclosure	*Hawke's Bay DHB*		67%	22%	0%	0%
	National Mean		20%	15%	19%	12%
	National Range		0 – 100%	4-33%	0-44%	0-33%
IPV Referral	*Hawke's Bay DHB*		50%	100%	0%	0%
	National Mean		83%	69%	55%	69%
Alcohol & Drug						
IPV Assessment	*Hawke's Bay DHB*	N/A	N/A	28%	60%	64%
	National Mean			52%	61%	66%
	National Range			0-100%	0-100%	0-92%
IPV Disclosure	*Hawke's Bay DHB*			71%	0%	44%
	National Mean			34%	27%	26%
	National Range			0-48%	0-46%	0-44%
IPV Referral	*Hawke's Bay DHB*			40%	0%	57%
	National Mean			59%	88%	83%
Community Mental Health						
IPV Assessment	*Hawke's Bay DHB*	**N/A**	N/A	8%	40%	24%
	National Mean			52%	43%	50%
	National Range			0-84%	0-82%	0-90%
IPV Disclosure	*Hawke's Bay DHB*			100%	10%	9%
	National Mean			24%	28%	27%
	National Range			0-100%	0-50%	0-100%
IPV Referral	*Hawke's Bay DHB*			0%	100%	100%
	National Mean			64%	87%	76%

*Based on a random sample of 25 charts for each audit period.

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:

18. **Minutes of Previous Meeting (Public Excluded)**
19. **Joint Clinical and Consumer Councils' Workshop Notes**
20. **Topics of Interest – Member Issues / Updates**

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).