Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 14 February 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
Jemma Russell
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.	Consumer Council's Board Report - December 2018 (public)	
8.	Chair's Report – Rachel Ritchie	
9.	Youth Consumer Council Report – Jemma Russell	
10.	Consumer Experience Facilitators Report – Nancy Barlow / Caryn Daum	
11.	Committee Representatives Feedback	
	Section 2 – Presentation	
12.	Strategic Planning Update Post Clinical Services Plan – Kate Rawstron	4:15
13.	It's Hard to Ask – Merryn Jones	4:25
	Section 3 – Discussion	
14.	HBDHB Draft Disability Plan – Shari Tidswell / Diane Mara	4:55
15.	Joint Workshop Discussion – Meeting with Clinical Council in March on "Person & Whanau Centred Care in Primary Care" – Rachel Ritchie	5:25
16.	Consumer Engagement (following homework, will be tabled) – Nancy Barlow/Caryn Daum	5:35
	Section 4 – For Information Only (no presenters)	
17.	Ngātahi Progress Report – End of Year Two "Vulnerable Children's Workforce Development" (annual update)	-
18.	HBDHB Alcohol Harm Reduction Strategy 2017-22 (six month update)	-
19.	**Section 5 – Recommendation to Exclude**	

Public Excluded

	Section 6 – Routine	
20.	Minutes of Previous Meeting (public excluded)	5.55
21.	Matters Arising – Review Actions (public excluded)	
22.	Consumer Council's Board Report – December 2018 (public excluded)	
23.	Topics of Interest – Member Issues / Updates	
24.	Karakia Whakamutunga (closing)	6:00

NEXT MEETING:

Wednesday, 13 March 2019
Havelock North Function Centre, Te Mata Road, Havelock North

1-2 pm Separate Consumer Council Meeting, Lantern Room
2-5 pm Joint Workshop with Clinical Council, Magdalinos Room

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 TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD
CORPORATE OFFICE ON THURSDAY, 6 DECEMBER 2018 AT 4.00 PM

PUBLIC

Present:	Rachel Ritchie (Chair) Dr Diane Mara (Co-Deputy Chair) James Henry Sarah Hansen Deborah Grace Wayne Taylor Dallas Adams Les Cunningham Olive Tanielu Denise Woodhams Jenny Peters Sami McIntosh
In Attendance:	Ken Foote, Company Secretary Caryn Daum – Consumer Experience Facilitators Nancy Barlow – Consumer Experience Facilitator Tracy Fricker, Council Administrator / EA to ED P&Q
Apologies:	Gerraldine Tahere, Malcolm Dixon and Jemma Russell

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 and from attendee member Kate Coley.

3. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda. Wayne Taylor provided his interests to be noted on the register.

Action: Interests to be recorded for Wayne Taylor.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 15 November 2018 were confirmed as a correct record of the meeting.

Moved by Wayne Taylor and seconded by Les Cunningham.

Carried.

5. MATTERS ARISING AND ACTIONS

Item 1: Consumers on Projects
The CE Facilitators provided the current list of consumers involved on projects. A copy of the document will be sent to members for their information. The list is a work in progress.

Action: All members to review the list and send feedback to CE Facilitators.

Item 2: Primary Care – PHO Consumer Input
The Chair has left a message with Chris Ash for a meeting time.

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: Scoping Report - Addictions
Shari Tidswell and Shirley Lammas invited to attend today's meeting to discuss the report – item #14 on agenda. *Item can be closed.*

6. CONSUMER COUNCIL WORK PLAN

The work plan provided in the meeting papers was noted. No issues discussed.

7. CONSUMER COUNCIL'S BOARD REPORT

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

The Company Secretary advised that the Clinical Services Plan (CSP) was approved at the November Board meeting. All governance groups were concerned around the implementation of the CSP, it will be a substantial transformational change for the health sector.

8. CHAIR'S REPORT

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

- Malcolm Dixon attended the Board meeting last month on behalf of the Chair. A lot of discussion was had around the DHBs current financial situation.
- Discussion had with Rosemary Marriott about the Health Awards criteria, judging and the Consumer Council having more influence in the process. The criteria should be consistent with the aims and objectives of our new approach to consumer engagement. A joint approach with Clinical Council has merit. The Chair to organise a meeting to discuss the shortlisting process to understand what is involved.

  Action: Chair to discuss Consumer Council involvement with Health Award shortlisting process and judging with Chief Executive Officer.

- A group met with Anne Speden, Chief Information Officer (CIO) following her presentation to Council in October. The CIO would find it helpful for ideas from Consumer Council on what they see as priorities for solving IT issues from a consumer point of view. Ideally some small projects, which could be done that will make a difference for consumers.

  Action: Chair to send email to members to seek their feedback.

- Primary Care Development Partnership Meeting – representation at the meeting, the Chair can now send a delegate if she is unable to attend. This is important to provide consistent consumer input.

- Christmas function for members to be held at Jarks on Thursday, 13 December at 5.30 pm.

9. YOUTH CONSUMER COUNCIL (YCC) REPORT

No report from the YCC this month.

10. CONSUMER EXPERIENCE FACILITATORS REPORT

An update on activities was provided by Nancy Barlow and Caryn Daum:

- Continuing to introduce themselves around the DHB
- Parallel Groups looking at Alcohol Harm and Family Violence – looking for consumer involvement on both these groups. It was noted that it is important not to put these two groups together it is a dangerous message that alcohol causes domestic violence
- Feedback from WIT – they are asking their community for volunteers for the database
- Making Health Easy to Understand Toolkit – looking for consumer reviewers, interested groups other than Consumer Council to provide feedback
- The Consumer Feedback system is being updated – template letters are in draft and would appreciate some input to ensure they are good letters
- Attended the Relationship Centred Practice Training – Part 2. The CE Facilitators have provided some feedback and will be meeting with the trainers to review and simplify some of the material
- Have met with The Collective to look at their volunteer platform
- A patient story in the medical directorate has been captured, working with them to deliver to the staff involved then the wider organisation as a learning opportunity
- Attended to the HQSC Consumer Representative Training in Wellington.

Carried.

11. COMMITTEE REPRESENTATIVE FEEDBACK

- ***Diane Mara - Disability Strategy Group:*** Meeting held in October, an issue raised about no disability plan for Wairoa, but they are keen to be involved. Meeting being held on 13 December to get the document ready for review by the governance groups.

- ***HQSC Consumer Representatives Train the Trainer Workshop*** – overall members who attended were disappointed with the training. There was a lack of clarify, purpose and outcomes from the training. The information given was complicated and would have been helpful to receive prior to the training. They did make some good contacts with other attendees. Feedback has been provided to HQSC.

The feedback reports were moved by Wayne Taylor and seconded by Les Cunningham.

Carried.

SECTION 2: PRESENTATIONS

12. DHB FUNDING OVERVIEW

The Chair welcomed Carriann Hall, Executive Director - Financial Services (EDFS) to the meeting. A high level presentation was provided of the funding arrangements for the DHB. Keys points noted:

- Annual allocation of operational funding - $18.2 billion budget for DHBs
- Ministry of Health and Other External - population based funding formula (PBFF) is used, weighted average; HB 3.88%; equals $547.5M for 2018/19 from MoH and $21.7M from ACC
- HBDHB forecast expenditure is $579.6M to provide hospital services, funding other providers (i.e. GPs, aged residential care, mental health), inter district flows and corporate overheads. HBDHB is planning for a $5M deficit for 2018/19
- Providing Health Services = $287M (nursing personnel 29%; medical/locum personnel 23%; allied health personnel 13%; other personnel 9%; clinical supplies 14%; infrastructure/non clinical 8% and outsourced services 4%)
- Funding Other Providers $243M (health of older people 27%; primary health organisations 15%; pharmaceuticals 18%; other personnel health 9%; mental health 5% and other funding payments 2%)

General question and answer discussion had around overspending in IDFs; outsourcing of services; funding for disability services; funding for special projects / new builds and impact on capital programme when running a deficit rather than a surplus.

The Company Secretary commented to put it into perspective the DHB spends $1.5M each day to provide health services for the people of Hawke's Bay.

The Chair thanked the EDFS for the presentation which was helpful for Council to understand the funding constraints.

13. MOBILITY ACTION PLAN IMPLEMENTATION – PROGRESS UPDATE

Andy Phillips, Executive Director – Health Improvement & Equity did not attend the meeting to provide his presentation as arranged.

Action: ***A copy of the presentation will be sent to members for their information.***

SECTION 3: DISCUSSION

14. SCOPING REPORT - ADDICTIONS

The Chair welcomed Shari Tidswell, Equity & Intersector Development Manager and Shirley Lammas, Planning & Commissioning Manager – Integration to the meeting. An overview of the report was provided. The Mental Health Inquiry Report was released this week and aligns with the scoping report and that nationally and locally we are on the same page. For clarity, this report is an assessment of the "current status" rather than a full review of any changes required.

General discussion held around the practical realities of methamphetamine (meth) in the community; treatment beds/services available not being used (either people are not presenting; or there are barriers to them presenting); supporting people/the families/communities with addictions not just meth; getting government organisations and communities working together, importance of having a local and timely response; prevention education and training; gaps in the current system and wanting to strengthen current services which are working well.

The Mental Health & Addiction Service is to be redesigned. Overwhelmingly the message has been that people do not know where to go to get services. Everything from prevention, health promotion and discharge is in the scope. The first re-design workshop has been held and will be meeting again in January.

The Chair thanked Shari and Shirley for attending the meeting to discuss the report and advised Council look forward to seeing the re-design occur and being kept updated.

Link to report: https://mentalhealth.inquiry.govt.nz/

SECTION 4: RECOMMENDATION TO EXCLUDE

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

16. Minutes of Previous Meeting (public excluded)
17. Consumer Councils
18. Topics of Interest – Member Issues/Updates

The meeting closed at 5.50 pm.

Confirmed: _____
Chair

Date: _____

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	12/09/17	**Consumers on Projects** List to be provided to members for their review (Excel document) Provide feedback / advise if any gaps etc to CE Facilitators	CE Facilitators All Members	Dec Dec/Jan	Actioned
2	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	Dec/Jan	Chair to follow up with Chris Ash for response to meeting request
3	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
4	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
5	06/12/18	**Interests Register** Interests to be added for Wayne Taylor	Admin	Dec	Actioned
6	06/12/18	**Mobility Action Plan** Copy of presentation to be sent for members information	Admin	Dec	Actioned email 12/12/18
7	06/12/18	**IT Project Priorities** Email to request input to be sent to members	Chair	Dec	
8	06/12/18	**Health Awards Shortlisting / Judging Process** Discussion to be had with CEO re: Consumer Council involvement	Chair	Jan/Feb	

CONSUMER COUNCIL Workplan as at 7 February 2019 (subject to change)	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19** (annual update)	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Alcohol Harm Reduction Strategy (6 monthly update) **Feb -** Aug	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
HBDHB Draft Disability Plan	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
"Its hard to Ask" Presentation	5-Dec-18		14-Feb-19	
Strategic Planning Update post CSP	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-**March**-May	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Joint Clinical/Consumer Workshop		13-Mar-19	13-Mar-19	
Person & Whanau Centred Care workshop		13-Mar-19	13-Mar-19	
People Plan Progress **Presentation**	13-Mar-19	13-Feb-19	11-Apr-19	19-Dec-18
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend) moved to April 19	10-Apr-19	10-Apr-19	11-Apr-19	27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	10-Apr-19	10-Apr-19	11-Apr-19	24-Apr-19
Violence Intervention Programme Report Committees reviewed in July - EMT Nov - April19	10-Apr-19	10-Apr-19	11-Apr-19	24-Apr-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-**May**	8-May-19	8-May-19	9-May-19	29-May-19
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)	12-Jun-19	12-Jun-19	13-Jun-19	26-Jun-19
People Plan Progress Update Report (6 monthly - Dec, **Jun 19**)	12-Jun-19	12-Jun-19	13-Jun-19	26-Jun-19
HB Health Awards - preparation for judging **2019**-2020		14-Aug-19	15-Aug-19	28-Aug-19
Annual Plan 2019/20 draft to the Board	14-Aug-19	14-Aug-19	15-Aug-19	28-Aug-19
Alcohol Harm Reduction Strategy (6 monthly update) Feb **- Aug**	14-Aug-19	14-Aug-19	15-Aug-19	28-Aug-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	11-Sep-19	11-Sep-19	12-Sep-19	25-Sep-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	11-Sep-19	11-Sep-19	12-Sep-19	25-Sep-19
Joint Clinical/Consumer Workshop		13-Nov-19	13-Nov-19	
People Plan Progress Update Report (6 monthly - **Dec 19**, Jun)	11-Dec-19	11-Dec-19	12-Dec-19	18-Dec-19

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 184
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month:	December 2018
Consideration:	For Information

RECOMMENDATION

That the Board

Note the contents of this report.

Council met on 6 December 2018. An overview of matters discussed is provided below:

CHAIR'S REPORT

Significant issues noted in the Chair's verbal report to Council included:

- Based on feedback from the Consumer Council representative on the Health Awards judging panel, the Chair intends to discuss with the CEO:
  - Enhanced Consumer Council involvement on the judging panel and/or in the shortlisting process (potentially in conjunction with Clinical Council).
  - Requirement that all nominations for awards indicate consistency with the aims and objectives of the new (CSP) approach to consumer engagement.
- A follow up meeting with the CIO to discuss a consumers view on priorities for ICT developments.
- Brief overview of PCDP Governance Group meeting held on 15 November 2018, including agreement for 'single' representative members (MRB, Clinical and Consumer Council's) to have appointed alternatives attend meetings where necessary."

COMMITTEE REPRESENTATIVE FEEDBACK

Updates were provided on:

- Disability Strategy Group
- HQSC Consumer Representatives Train the Trainer Workshops
  - Members who attended this training expressed some frustration and disappointment with aspects of this training. Feedback has been provided to HQSC.

DHB FUNDING OVERVIEW

Carriann Hall, Executive Director Financial Services, provided Council with a high-level presentation on funding arrangements for DHBs, and for HBDHB in particular.

Council members found the presentation useful in helping to understand better the HBDHB financial environment and funding constraints.

SCOPING REPORT - ADDICTIONS

Council received and discussed the report presented that provided current information about meth and the impacts on the user and their whanau, and current services available to support them. It was noted that the findings in this report were very similar to those in a very recently released Mental Health Inquiry Report.

From discussion, the overwhelming message was that people do not know where to go to get help/services. This issue will need to be addressed in the pending redesign of Hawke's Bay Mental Health and Addiction Services.

CHAIR'S REPORT

Verbal

Brenda Crene

From: Rachel Ritchie
Sent: Tuesday, 5 February 2019 08:58
To: Brenda Crene
Subject: Cons ccl

8.1

Chairs Report

Happy New Year wishes to everyone - all the best for 2019 . A snapshot of what's been happening since December:

Health awards - I have met with Kevin Snee to discuss the changes Council would like to see in the awards criteria, assessment and judging. Kate Coley is about to do a refresh of the awards and so our requests/ interest wit be taken up by her in that process.

Primary Health- I have met with Wayne Woolrich CEO PHO to discuss how our groups could work more closely together. My expectation is that we will see and hear more from Wayne at both our next meeting and the joint meeting.

Strategic plan - this is progressing internally and we will be updated as the process unfolds. A big part of this is drawing on the priorities identified in the CSP and people plan.

Joint meeting - plans for this are in train. Our thinking is it should centre around the 'primary care' end of PWCC as that area has the most potential for improved health outcomes . There is also recognition that involving more members of the primary care community would help ' socialise' our messages.

We have a very full meeting so hence the extra reports in writing rather than in person at the meeting. Our agenda setting meeting was an exercise in chopping out many reports and making sure we had the most relevant discussions and presentations for the group. Thanks to Nancy and Caryn for their assistance on that front and collating the Consumer Engagement homework which will form the basis for an interesting discussion at our meeting too. Thanks to those who have responded or put in apologies at short notice.

Sent from my iPhone

YOUTH CONSUMER COUNCIL REPORT

Verbal

CONSUMER EXPERIENCE FACILITATORS REPORT

February 2018

Positive action example

The Community Oral Health Service is working with schools in the Flaxmere area in a trial to increase the number of children who attend oral health appointments.

The total number of eligible children is 2691, and of those, 1483 have not had due treatment.

The trial aims to increase access by moving the service into areas familiar to whānau.

At the moment services are located at Totara health hub. The hub will remain open in the school holidays and treat pre-schoolers and older children to relieve pain.

The trial will see the service move into schools, using a mobile van.

Staff will treat children attending the school(s) and where possible pre-schoolers related to the whānau group(s).

The team is working through the logistics with the school and other communities e.g. school board of trustees, the Taiwhenua, Plunket.

As an example of the logistics in schools, the space to park the mobile clinic in the school is fine, but the larger (and preferable) treatment clinics do not always fit through the school gates. The team will use the smaller mobile clinic in the interim.

The time that the vans spend at each school is still an unknown as some children have missed treatments and there will be a period of 'catch up'.

It is expected that by the end of 2021 that children will be on a more 'standard' appointment cycle.

- Have a couple of services that want to talk through projects they are doing, e.g. pharmacy contract renewal performance measures to include Making health easy to understand, consumer satisfaction.

- Re parallel groups Family Violence and Alcohol Harm Reduction Steering group – met with Rebecca Peterson, Cheryl Newman and end point was their intent to inform each other of developments in case of overlap / possibility for synergy etc.

- Complaints advisor role still to be filled – Caryn will provide support once this is done

- Work continues on the Consumer Feedback, Event Management and Risk system. The Consumer Feedback work stream has sent taxonomy and workbooks to the vendor. Template consumer response letters will be sent to CEC 11 Feb to seek endorsement at CEC meeting on 25 Feb.

- Met with Dan Henderson Director Stakeholder Development - Be Collective Platform (way to manage and engage with volunteers and consumers) as we continue to explore this.

- Met with Andrea Beattie to look at Wayfinding.

- HQSC Consumer rep training – train the trainer in Co design - Dates 20 March 2019 Chch and 14 May 2019 Auckland – places available. HQSC intended to make improvements based on feedback after the Wellington session. ***Please let Caryn or Nancy know if you are interested in going to one of these.***

- Met with Anne McLeod and the RCP trainers to discuss the RCP training and material. This will happen regularly. Intent to include a consumer voice in the training material, probably as video clips. Have recommended refresh of the RCP slides and have provided suggestions to make, the link to PWCC overt, the slides easier to understand, and also to align with other programmes such as MHEtU, Engaging effectively with Maori and BUILD.

- **BUILD training -** give feedback in a way that enhances mana – Nancy & Caryn have arranged **for Council Members to attend a session**. This feeds into PWCC. Opportunity to experience staff development initiative and enhance own communication skills. ***Please let Caryn and Nancy know if you are interested.***

11

COMMITTEE REPRESENTATIVE FEEDBACK

From a PAG member

My dream for PAG members is to actually see the real people who live with mental illness day by day, night by night, hour by hour sitting alongside the DHB decision makers.

They are the ones who should be driving the delivery and designing the services for their peers. The DHB would improve outcomes if they relinquished control and moved away from the total medical model of care they currently cling to.

The Mental Health Inquiry findings were conclusive and the time is right for change. The DHB should now be "feeding back" to PAG and allowing us into their planning meetings. PAG should be at the forefront of policy writing, staff recruitment and the re design and delivery of community mental health and Nga Rau Raukau.

I have feedback fatigue. I'm totally over the tokenism that PAG experience at the moment and the disrespect shown by DHB staff who don't show up to meetings or even bother to send apologies.

The DHB are not supporting PAG in any tangible way at all and are sending the message that they want PAG to go away.

This is the award winning PAG they were once proud of, and even boasted about.

My dream would be to see trained and qualified peer support workers actually supported by the DHB to work alongside people in mental distress.

From another PAG member

Thanks for the jolt to get us all thinking again, and there's lot s to think about. My brain is all but fried in this heat, like everyone else.

There is a huge need for help with budgeting, cooking simple meals, and buying food on special. When the Mad Butcher has drumsticks on special, they work out at 50 cents each!!!! Forget the takeaways please.

I don't know much about Women's clinics for contraception advice, but that's a no brainer. If Totara Health can offer free medical appts to women this could alleviate needless births to those who do not know how to look after the kids they already have. Perhaps there needs to be some incentive to attend.

Health and Safety or whoever need to pull their horns in by not being so precious about where the Meals on Wheels are cooked. Maybe the Hospital could extend their kitchen hours to provide meals for the elderly

Really everywhere we look we see a need for help, mental health, and disabled folk, horrendous rent charges. The list is never ending.

12

STRATEGIC PLANNING UPDATE POST CLINICAL SERVICES PLAN

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Renal "Its Hard to Ask"** **Presentation**
	For the attention of: **HB Health Consumer Council**
Document Owner:	Colin Hutchison, Executive Director Provider Services
Presenter:	Merryn Jones, Clinical Nurse Specialist, Renal Transplant
Reviewed by:	Colin Hutchison, ED Provider Services; Executive Management Team and Maori Relationship Board (December 2018)
Month:	February 2019
Consideration:	For Discussion and Feedback

RECOMMENDATION

That the HB Health Consuemr Council

1. **Note** the contents of this report and the presentation and provide feedback

PURPOSE

The purpose of this presentation in December to MRB was to gauge support for hosting a half-day renal transplant hui to upskill and inform health providers about renal transplant; in particular, ways in which we can raise the rates of renal transplant for Māori.

OVERVIEW

The presentation will discuss research conducted in Hawkes Bay of renal patients who are eligible for transplant, and their experience of recruiting living kidney donors. The research findings highlight that it is difficult for many to approach living donors. Limited recruitment opportunities, poor health literacy and self-efficacy, values and attitudes towards transplant, as well as cultural considerations may also act as barriers. Many participants also talked about not wanting to cause harm (surgical and long term health risks) to their loved ones, and would put concern for the welfare of their loved ones above their own more immediate health needs.

This reseach also highlighted disparities. While 69% of our dialysis patients are Māori, fewer transplant recipients are Māori. For many Māori renal patients, identifying suitable living kidney donors within their networks can be a challenge due to whanau comorbidities. While living kidney donation may not be an option for such patients, transplant needs may be met through deceased organ donation.

One of the proposed strategies that arose from this research is that we need to increase our conversations about transplant, whether it be deceased donation or living kidney donation. Having up to date information, and reinforcing positive messages about how transplant can transform lives for those who are eligible to be transplanted, is important if we want to see an improvement in rates of transplant for Māori. A positive culture between health professionals leads to congruent messages being relayed to the patient, and studies have shown that opinions and attitudes influence the uptake of living kidney donation.

I would like to gauge support for a half day hui as a shared project between Māori Health Services and Renal Services, focussing on kidney transplant. The hui would invite Māori health professionals working for Māori health providers and Iwi groups who may see renal patients and their whanau in the community, but may lack knowledge about what is involved in kidney transplant, and the benefits it could provide to their patients. I believe that talking about the lived experiences of patients with other health professionals who interact with renal patients and their whanau each day will provide valuable knowledge and give meaning to their interactions with their patients.

Speakers who have already offered to present include Dr Emma Merry, Intensivist, and Nayda Hayes, a Māori ICU Link Nurse with ODNZ who are experienced in deceased organ donation and those difficult bedside conversations. One of our nephrologists will also present. Nurse Practitioner Janine Palmer will give a case presentation about one of our renal patients who had a transplant, and what her life might have looked like had she not had the transplant. Sheyne Te Hau, Kaitakawaenga, has been working with our renal service for years, and knows our patients and their needs well. He has also offered to present. I would like to present my research findings into the lived experience of recipients trying to recruit a living kidney donor.

Tanira Te Au has offered to contact Lady Arapera and Sir Pita Sharples to invite them to come and talk about their journey - from renal failure, then dialysis and ultimately transplant from a deceased donor, which for Arapera, occurred in 2015. As keynote speakers, they would be a great drawcard for Ngati Kahungunu. I would like to also invite a living kidney transplant recipient to speak about their experience of having a loved one worked up to donate to them. The lived experiences and the challenges these recipients faced regarding their values, cultural and spiritual beliefs will be invaluable. I would also ask a living donor to present, who would talk about the considerations they faced in order to donate.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Draft Disability Plan**
	For the attention of: **Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner	Chris Ash, Executive Director Primary Care Bernard Te Paa, Executive Director, Health Improvement & Equity
Document Author(s)	Shari Tidswell
Reviewed by	Executive Management Team Working Group members
Month/Year	February 2019
Purpose	Presenting the co-designed Disability Plan to HBDHB governance groups.
Previous Consideration Discussions	Responds to a paper presented by Consumer Council requesting a disability response for the Hawke's Bay DHB
Summary	The HBDHB Draft Disability Plan supports the HBDHB to implement the National Strategy. All government agencies are required to do this. It also supports the achievement of the HBDHB vision and work toward equity. People with disabilities experience barriers when accessing health services in a range of ways. Having a systematic approach to addressing and reducing these barriers is vital to achieving equity and improving health outcomes. The Plan provides a systematic approach through the delivery of actions. This Plan's actions are delivered via a key piece of HBDHB developing and existing work. This includes the; Clinical Services Plan, Person and Whānau Centered Care and the People Strategy. For this reason the Plan is aligned and integrated with the National Strategy and other plans, and HBDHB strategies and plans.
Contribution to Goals and Strategic Implications	Improving health and equity for all populations National Disability Strategy
Impact on Reducing Inequities/Disparities	People with disabilities experience considerable inequity. Disabled Pasifika people have low utilisation rates of disability services and Māori (Tangata Whaikahu) also experience a double set of barriers to accessing services. There is a need to ensure we are monitoring equity for people with a disability. This Plan will guide our investment to ensure equitable outcomes for people with disabilities.
Consumer Engagement	The Working Group included consumer representatives. The draft Plan was presented to the disability reference groups in Napier, Hastings, Central Hawke's Bay Wellbeing reference group and Wairoa IDEAL Services (based in Gisborne).

Other Consultation /Involvement	Representatives from Clinical and Consumer Councils have been involved in the Working Group. The Working Group also sought input from Taranaki Disability Resource Centre.
Financial/Budget Impact	Potential cost for training and establishing a monitoring system. This should be business as usual work and will reduce cost associated with consumer complaints and late access to services.
Timing Issues	None
Announcements/ Communications	The Plan will be made available on the HBDHB website and shared with stakeholders.

RECOMMENDATION:

It is recommended that the Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board:

1. **Note** the contents of the Plan and Paper.
2. **Endorse** the Key Recommendations.

Hawke's Bay District Health Board
Draft Disability Plan

Author(s):	Shari Tidswell
Designations:	Intersector Development Manager
Date:	February 2019

BACKGROUND

To deliver effective services and achieve our Vision it is vital to ensure people with disabilities and their whānau are able to access and engage with services and do not experience inequities in health outcomes. The HBDHB is a lead provider and contractor of disability services in Hawke's Bay and has a vision of "Excellent health services working in partnership to improve the health and wellbeing of our people and the reduction of health inequities within our community".

Consumer Council championed the development of a Disability Plan in 2018. They identified a need:

- To have people with disabilities taken into account in our health system
- To have a Person and Whānau-Centred Care approach inclusive of people with disabilities
- For integration in the Clinical Services Plan implementation
- To be integral in achieving equity in health outcomes

For these reasons, this Plan does not sit in isolation and is linked to the National Disability Strategy, is aligned to key HBDHB Strategies and Plans (People and Capability Strategy and Clinical Services Plan) and is informed by Whaia Te Mārama and Faiva Ora Disability Plans.

The Plan's actions will support HBDHB in delivering effective services and our vision for people with disabilities and their whānau. According to census data, 23% of the population have a disability with the highest rates in older populations – making people with disabilities a significant population engaging with health services. National data identifies that people with a disability experience significant unmet need, much of which is the result of access and attitude issues experienced in health services. People with disabilities also experience inequity in education, employment and justice outcomes.

Like other marginalised populations, people with disabilities and their whānau benefit from increased awareness of issues and a focused response to achieving equity. A plan increases awareness and provides the actions to be responsive and ultimately reduce inequity.

Plan Development Process

The following process was followed to develop this Plan:

- A paper was presented by Consumer Council requesting the development of a Disability Plan, endorsed by HBDHB Board
- A Working Group established with the first workshop held in March 2018
- A series of workshops and meetings to design and draft a plan held between April–November 2018
- A draft Plan was presented to community stakeholders (including people with disabilities) and feedback from HBDHB managers November–December 2018
- Response to feedback and re-drafting of the Plan – December 2018
- A Final Draft Plan was written and reviewed by the Working Group - January 2019

Co-design

The Working Group included people with disabilities, whānau of people with disabilities, local Council leads for disability plans and HBDHB staff (Planning and Commissioning Manager – Integration, NASC Manager, Consumer Experience Facilitators and Intersector Relationship Manager). This group processed the responses,, information and feedback to draft the Plan's content.

Disability consumer groups were engaged across the region via the Central Hawke's Bay Disability Reference Group, Hastings Disability Reference Group, Napier Disability Advisory Group and Ideal Services – Wairoa to provide feedback on the drafts of the Plan. Through feedback processes and representation, consumers and key stakeholders developed the Plan.

Plan Structure and Content (see Appendix One for the full Plan)
This Plan covers services and the work of HBDHB. The Working Group discussed a regional disability plan approach, however each local authority has its own plan and the Working Group determined that developing a HBDHB plan would place us in a better position to develop a regional plan in the future. The Working Group chose to use the definition for 'disability' provided by the Office for Disability Issues, as it informs the National Strategy and provides consistency with other disability plans. Whānau and caregivers have been included in the Plan due to the critical role they undertake in supporting people with a disability. This also aligns with the Person and Whānau Centered Model of Care.

Disability is defined as "something that happens when people with impairments face barriers in society; it is society that disables us not our impairments…" The Plan's vision was developed by the Working Group and aligns to the HBDHB's visions and the National Strategy's vision.

"People with a disability and their whānau engaging with HBDHB, experience no barriers, are involved in the decision making, and engaged in services design and development." The Plan's principles link to HBDHB Values and include:

People with disabilities in Hawke's Bay:
- Experience respectful, mana enhancing engagement with HBDHB services
- Have a clear voice for people with disabilities in planning, service development and the care they receive. "No decision about me without me"
- Clear process for feedback and responding to feedback

HBDHB has a commitment to:
- Addressing barriers; to be inclusive and responsive to people with disabilities, including Tanagata Whaikaha and disabled Pasifika people
- Changing attitudes by being consistently inclusive and responsive to people with disabilities and their whānau, including Tangata Whaikaha and disabled Pasifika people

The Plan's coverage includes; services and work of the HBDHB, people with disabilities and their whānau engaging with HBDHB services and whānau and caregivers supporting people with a disability.
The Plan describes key outcomes directly linked to the National Strategy and detailed actions. These actions support the delivery of the outcomes and includes monitoring steps. To commence monitoring, the HBDHB will be required to record 'impairment' in consumer/patient records. It is currently not possible to identify how many of our patients have a disability, nor do we systematically identify their needs to support effective access to HBDHB services.

Linkages to Other Strategies and Plan *(see diagram on page 3 of the Plan)*
As outlined above, this Plan is developed to align, deliver and link with a range of national and local documents that relate to supporting people with disabilities to access health services and achieve equity.

Monitoring and ongoing delivery
Critical to this Plan's effectiveness in achieving equity is monitoring engagement of people with disabilities. This will require recording impairment on a patient's record and where applicable, notes to support access. This can then be used to measure access, refine training and support HBDHB staff to ensure needs can be met and to measure equity in health outcomes.

Priority Actions for 2019/2020 Annual Plan
To commence the implementation, the Working Group have identified 10 actions from the Plan (noted below) to be delivered over the 2019/20 financial year. The remaining actions will be roll-out over the following five years. Reference the "Outcomes and Actions" section of the Plan.

Education and Employment and Economic Security – implemented under Matariki actions

Health and Wellbeing
1) Establish practice that ensures the rights of people with disabilities to have whānau/support people when engaging with HBDHB services.

Accessibility
1) Service design and improvement will include people with disability and their whānau.
2) Services will have feedback mechanisms that enable people with disabilities to provide feedback and this is responded to.
4) Ensure barriers that could result in people with disabilities not being able to engage, participate or utilise HBDHB services are removed or addressed.

Attitudes
1) HBDHB Core Values are evident in all interactions with people with disabilities and their whānau.
3) Develop a training programme in partnership with the disability community and HBDHB.

Choice and Control
2) Connect with a wide range of disability communities.

Leadership
1) Include actions in annual planning
2) Implement actions from this Plan
3) Report to disability communities and their whānau on the Plan's progress, health outcomes and engagement.

RECOMMENDATIONS

Key Recommendations	Description	Responsible	Timeframe
Appoint a lead from EMT	An EMT lead is identified who is able to champion the Plan's actions, provide reporting on implementation and equity	EMT	April 2019
Priority actions included in the 2019/20 annual planning	Key actions are incorporated into HBDHB Annual Plan at the HBDHB level and service level	HBDHB Planner	May 2019
Establish formal links with consumer representative groups	Ensure HBDHB membership on existing disability groups and develop a feedback loop	Consumer Experience Facilities	March 2019
Establish a reporting framework	Framework to measure plan delivery and impact for people with disabilities	HIED	June 2019
HBDHB Disability Plan endorsed by HBDHB governance groups	Plan endorsed by all HBDHB governance groups	HIED	March 2019

RECOMMENDATION:

It is recommended that the Māori Relationship Board, HB Clinical Council; HB Health Consumer Council and HBDHB Board:

1. **Note** the contents of the Plan and Paper.
2. **Endorse** the key recommendations.

HAWKE'S BAY DISTRICT HEALTH BOARD – DRAFT DISABILITY PLAN

BACKGROUND

Consumer Council have championed this Disability Plan and the development was endorsed by the HBDHB Board in 2018. The HBDHB are a lead provider and funder of disability services and deliver health services for the whole population – including those with a disability. Supporting equitable outcomes for people with disabilities will contribute to the HBDHB's overall vision "Excellent health services working in partnership to improve the health and wellbeing of our people and the reduce health inequities within our community".

The development process was led by a working group made up of HBDHB Consumer Council representatives, HBDHB staff, local authority staff and community stakeholders to develop a disability plan for Hawkes' Bay DHB consumers, staff and services. To gain further input from the community, particularly people with disabilities and their whānau, a draft document was presented to community groups, HBDHB service managers and consumers to seek further input and feedback. This feedback has been incorporated into this Plan.

This Plan sits within the context of a national strategy and plans, local plans delivered by local authorities and HBDHB strategic documents. The Plan ensures actions are complementary, aligned or deliver the visions and outcomes of these documents. There is a focus on equity including by ethnicity and people with a disability - it is noted that people can experience inequity via both. To inform this plan, the working group used:

- National Disability Strategy
- HBDHB Core Values
- Draft Clinical Services Plan
- Whaia Te Mārama and Faiva Ora disability plans

The Plan aims to reduce the barriers experienced by people with disabilities when engaging with HBDHB services and staff. The Plan will focus the HBDHB on meeting the needs of people with disabilities by providing tangible actions and measures to monitor progress. The Plan uses principles informed by the HBDHB values, outcomes from the National Strategy and actions to enable the HBDHB to respond to the needs, reduce barriers for and engage effectively with people with a disability. The actions are also informed by the Clinical Services Plan, Health Equity Report (2018) Whaia Te Mārama and Faiva Ora Disability Plan – ensuring an equity approach and alignment with HBDHB's service delivery direction.

INTRODUCTION

The Plan is set out as follows:

- Background information including definitions, population and supporting documents
- Vision, principles and coverage. The principles align with the HBDHB Core Values and other key documents which will support equity. This provides a clear process to integrate the actions into HBDHB practice.
- Outcomes to deliver each action.

As a key service provider and employer in the Hawke's Bay, HBDHB supports social inclusion, equity in health outcomes, access to services and wellbeing of the Hawke's Bay community. HBDHB has a role in reducing the barriers and attitudes that contribute to those with an impairment being disabled. Having a planned systematic approach is vital in delivering these aspirations. To know what we are doing is making a difference for people with disabilities, we need to measure health outcomes for people with disabilities and monitor feedback.

We acknowledge the role whānau and caregivers have in supporting the wellbeing of people with disabilities and the Plan seeks to ensure their engagement by reducing barriers they may encounter, whilst maintaining the person with a disabilities right to privacy and safety.

BACKGROUND INFORMATION

Defining Disability

The National Strategy defines "disability" as "something that happens when people with impairments faces barriers in society; it is society that disables us not our impairments…" This has a similar meaning to "disability" as the International Convention – "…those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others…" (Article one)

Disability is defined by the Office for Disability Issues as:

> *"Disability is the outcome of the interaction between a person with impairment and the environment and attitudinal barrier he/she may face. Individuals have impairment; they may be physical, sensory, neurological, psychiatric, intellectual or other impairments." (Minister for Disability Issues, 2001).*

These definitions are consistent and are applied to this Plan. People with physical, mental, intellectual and sensory impairments make up the population target of the Plan. Their whānau and caregivers supporting them to achieve "normal lives" and their potential are also covered in the actions.

Population with Disabilities

Nationally 24 percent of the population identify as having a disability, a total of 1.1 million people (2013 data).

- The increase from the 2001 rate (20 percent) is partly explained by our ageing population.
- People aged 65 or over were much more likely to be disabled (59 percent) than adults under 65 years (21 percent) or children under 15 years (11 percent).
- Māori and Pacific people have higher-than-average disability rates, after adjusting for differences in ethnic population age profiles.
- For adults, physical limitations were the most common type of impairment. Eighteen percent of people aged 15 or over, 64 percent of disabled adults, were physically impaired.
- For children, learning difficulties were the most common impairment type. Six percent of all children, 52 percent of disabled children had difficulty learning.
- Just over half of all disabled people (53 percent) had more than one type of impairment.
- The most common cause of disability for adults was disease or illness (42 percent). For children, the most common cause was a condition that existed at birth (49 percent).[1]

Hawke's Bay data

Data was collated for Gisborne/ Hawke's Bay – people identifying with a disability is 23 percent of the population. The 23 percent breaksdown into the following types of impairment. The highest is mobility (13 percent), followed by hearing (9 percent), agility (7 percent) and psychological and learning (6 and 5 percent respectively).

[1] 2013 Disability Survey, June 2014, produced by the Government Statistician

Fifty-eight percent of people with a disability have multiple impairments. Disease and illness (42 percent) and then accidents (37 percent) are the highest causes. Using the 23 percent, the estimate for people with a disability in Hawke's Bay would mean approximately 34,770 people with disabilities (based on 151,179 total Hawke's Bay population 2013).

DOCUMENTS THAT INFORM THIS PLAN

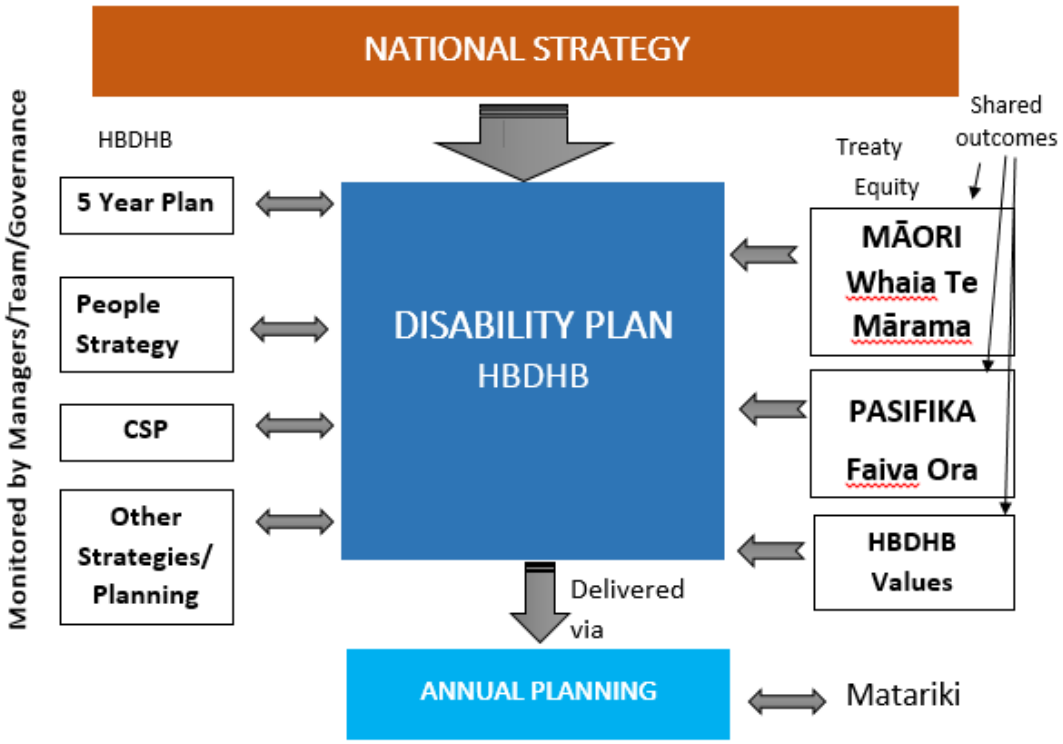
The Clinical Services Plan (CSP)[i] themes, Core Values and National Strategy are based on similar principles -Te Tiriti o Waitangi, ensuring whānau are involved in decision making, social investment and addressing unmet need. The Health Equity report illustrates the inherent differences in health outcomes for specific groups within our Hawkes Bay population.

This Plan uses the outcomes from National Strategy[ii]:

- Education
- Employment and economic security
- Health and wellbeing
- Right protection and justice
- Accessibility
- Attitudes
- Choice and control
- Leadership

Each of these actions have been developed to deliver an outcome. These actions have clear links to the CSP and HBDHB core values[iii]. In the table below the Actions are colour-coded to note the 'HBDHB value' being delivered via each action. Actions are also aligned to the Māori Disability Plan (Whaia Te Māraama)[iv] and Pasifika Disability Plan (Faiva Ora)[v] (Ministry of Health). This alignment supports an equity approach for the actions.

The diagram below illustrates how the informing documents, Plan and delivery of mechanisms relate to each other.



HAWKE'S BAY DISTRICT HEALTH BOARD – DISABILITY PLAN

VISION

People with a disability and their whānau engaging with Hawke's Bay District Health Board, experience no barriers, are involved in decision-making, and engaged in service design and development

PRINCIPALS

People with disabilities in Hawke's Bay:

- Experience respectful, mana enhancing engagement with HBDHB services
- Have a clear voice in planning, service development and the care they receive.
- Have a clear process for feedback and their feedback is responded to

Hawke's Bay District Health Board:

- Has a commitment to address barriers; being inclusive and responsive, including Tangata Whaikaha and disabled Pasifika people and their whānau
- Is committed to changing attitudes by being consistently inclusive and responsive to people with disabilities and their whānau, including Tangata Whaikaha and disabled Pasifika people
- Involves people with disability and their whānau in decision –making, development and design of services. "No decision about me without me".

COVERAGE

- Services and work of the Hawke's Bay District Health Board. This is wider than clinical services and includes, contracted services, service design, planning and governance functions.
- People with disabilities engaging with these services and work of the HBDHB and staff employed by HBDHB.
- Whānau and caregivers, where their engagement supports and maintains the safety of the person with a disability.

OUTCOMES:

EDUCATION

HBDHB supports education outcomes that ensure people with a disability are engaged in education, achieving and transitioning to further education and employment equitably with non-disabled people.
Linked to Matariki

EMPLOYMENT & ECONOMIC

HBDHB leads by example as a socially responsible employer and supports people with disabilities to engage in employment leading to financial security for all people with disabilities including Tangata. Whaikaha and Pasifika
Linked to People Plan and Matariki

HEALTH & WELLBEING

Delivering person and whānau-centered care that is responsive to the diversities of people with disabilities including Tangata Whaikaha and Pasifika.
Linked to Clinical Services Plan

RIGHTS PROTECTION & JUSTICE

Deliver equitable outcomes for all people with disabilities engaging with HBDHB services. Establish monitoring

ACCESSIBILITY

Services design and continuous improvement will meet the diverse needs of disabled people.

ATTITUDES

We have a workforce that demonstrates our core values in every encounter they have with a person with a disability and their whānau.

CHOICE & CONTROL

Support people with disabilities to make choices and have control over their health care and outcomes.
Linked to Clinical Services Plan

LEADERSHIP

Ensure that people with disabilities experience equitable health outcomes and are consistently engaged in decision-making.

OUTCOMES AND ACTIONS

Outcomes	Actions	Measures	Linked Documents	Reporting
EDUCATION HBDHB supports education outcomes that ensure people with a disability are engaged in education, achieving and transitioning to further education and employment equitably with non-disabled people.	1. Work with education providers including Kahui Ako (Communities of Learning) to review and co-create career development and career pathways that are localised, responsive and future-facing for all learners in Hawke's Bay including those requiring additional support to achieve sustainable employment	Measured via the Matariki outcomes and project tool	Matariki- Social Inclusion Strategy HBDHB Annual Plan	Board 6 monthly
EMPLOYMENT & ECONOMIC SECURITY HBDHB leads by example as a socially responsible employer and supports people with disabilities to engage in employment leading to financial security for all people with disabilities including Tangata. Whaikaha and Pasifika	1. Support the employment of people with challenges that may impact on their capacity to obtain or retain employment. (Social Inclusion) 2. Project 1,000: link local people on benefits to 1,000 new jobs (Regional Economic Development) 3. Ensure major infrastructure development projects consult with and optimize employment. (Regional Economic Development)	Measured via the Matariki outcomes and project tool	Matariki - Social Inclusion Strategy HBDHB Annual Plan	Board 6 monthly
HEALTH & WELLBEING Delivering person and whānau-centered care that is responsive to the diversities of people with disabilities	1. Establish practice that ensures the rights of all people with disabilities to bring whānau or support person when engaging with services. 2. Ensure the disability sector is provided with opportunities to participate in service and policy development.	Establish a baseline for the quality of service delivered to people with disabilities. Measure services on the level of delivery (using baseline measure), with Board monitoring via annual reporting.	Clinical Services Plan People and Capability Strategy HBDHB Annual Plan	

Outcomes	Actions	Measures	Linked Documents	Reporting
including Tangata Whaikaha and Pasifika. Additional activity will be delivered under the Clinical Services Plan and subsequent operational plans. There is also a link to the workforce training under the "Attitudes" outcome in this Plan	3. Increasing control for tangata whaikaha to choose the support they need and when, where and how this support occurs (self-determined). 4. Ensuring whānau are supported so that they are in the best position to support their whānau member with a disability. Including having their expectations met and achieving and maintaining mana and wellness. 5. In any service, the person is not only defined by their disability but also their other cultural, familial, linguistic and gender identities. 6. Transitions between services and to the community are easy and understood by people with a disability and their whānau.			
RIGHTS PROTECTION & JUSTICE Deliver equitable outcomes for all people with disabilities engaging with HBDHB services. Establish monitoring	1. Develop monitoring and measurement approaches that include outcomes for people with disabilities by ethnicity. 2. Implement "Accessibility" outcome and actions. 3. Contracted providers are supported to develop policy and practice that delivers equity outcomes for people with disabilities. 4. Monitor the implementation of the plan through management KPIs and reporting to governance	Measurement frameworks include measures for people with disabilities Manager performance plans have KPIs to improve or maintain equitable outcomes for people with disabilities. Contract review process includes support for providers i.e. to develop disability plans, policy and audits All reporting frameworks including outcomes for people with disabilities	HBDHB Annual Plan, including the IS work plan and	

Outcomes	Actions	Measures	Linked Documents	Reporting
 ACCESSIBILITY Services design and continuous improvement will meet the diverse needs of disabled people.	1. Service design and improvement will engage people with disabilities and their whānau from the beginning. 2. Services will have feedback mechanisms that enable disabled people to provide feedback and this is responded to. 3. Services ensure that disabled people and their whānau get a fair deal. 4. Ensure barriers that could result in disabled people not being able to engage, participate or utilise HBDHB services are removed or addressed. This could include; environment audits being part of standard practice, and/or national guidelines.	People with disabilities and their whānau are involved in service design and improvement. Feedback processes reviewed to ensure people with disabilities and their whānau are able to and are providing feedback. Audits are completed to monitor compliance.	Policies – Building/Facilities, Consumer Feedback, Disability Audit (to be developed)	
 ATTITUDES We have a workforce that demonstrates our core values in every encounter they have with a person with a disability and their whānau.	1. HBDHB Core Values are evident in all interactions with disabled people and their whānau. 2. Establish mandatory disability training – linked to Values and Behaviour in context of disability. 3. Develop and deliver training programme in partnership with disability community. 4. Measures how embedded Values and Behaviours are via DHB systems (e.g. PDR, peer review). 5. Deliver feedback loops at every level using multiple systems (e.g. surveys, real time feedback) to inform training and staff practice.	Training agreed and set up in PAL$ annual performance plan. Training programme developed and feedback collated. Number and percentage of staff have completed training. Demonstrates evidence at application of training in PDR.	People and Capability Strategy	
 CHOICE & CONTROL Support people with disabilities to make choices and have control over their health care and outcomes.	1. Support accessible services by: • Developing peer support for people with a disability and their whānau to navigate services • Make information available and accessible – health literacy for every person with a disability.	Design and deliver a peer support navigation programme, in partnership with people with disabilities. Measure impact and effect of the programme.	Clinical Services Plan HBDHB Annual Plan	

Outcomes	Actions	Measures	Linked Documents	Reporting
	2. Connect with a wide range of disabled communities: • Via existing disability representative groups Hawke's Bay-wide • Clarifying and establish representative roles and their link with people with disabilities 3. All services actively seek feedback from people with a disability engaging with services. 4. People with a disability are consulted and actively involved in policy, planning, governance, service development and implementation via Intentional represented on forums.	Document connections made and the outcome of these connection with disabled community based groups. Audit feedback process to evaluate effect. Audit consultation and engagement with people with disabilities. Set targets for improvement		
LEADERSHIP Ensure that people with disabilities experience equitable health outcomes and are consistently engaged in decision-making.	1. Include actions in the annual plan. 2. Implement the actions for this Plan. 3. Report to disabled communities and their whānau on the Plan progress, health outcomes and engagement.	1. Reporting to communities and their whānau 2. Reporting to governance groups	Board work programme Annual Planning	

Key for Hawke's Bay District Health Board – core values (actions are coded by the Core Values colour below to indicate how this Plan delivers Core Values).

Tauwhiro (Care) Rāranga te tira (Partnership) He kauanuanu (Respect) Ākina (Improvement)

[i]

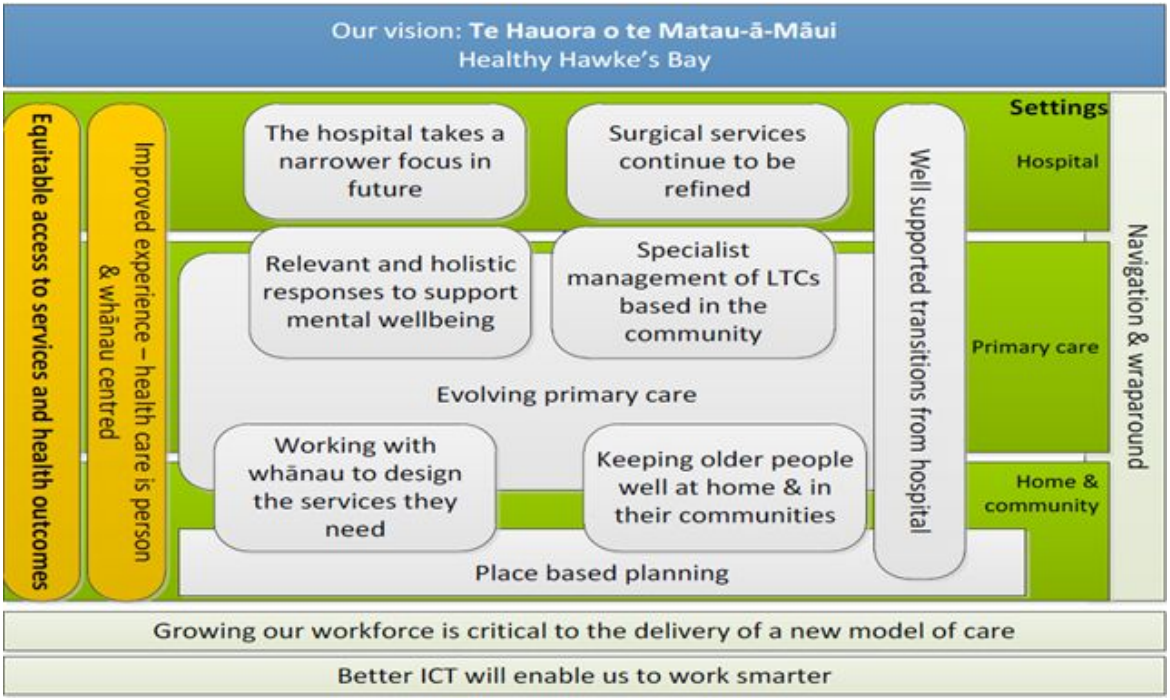
HBDHB Clinical Services Plan (Draft)
This Plan provides the direction for clinical services delivered by HBDHB for the next 10 years.

The key themes from the Clinical Services Plan are designed to address the overarching commitment to achieving equity. This included addressing the inequities and unmet need experienced by Māori, Pasifika peoples, **people with disabilities**, experiencing mental illness and those living in socio-economic deprivation. A new approach including "person and whānau centered system and building on pockets of excellence.

The CSP establishes a firm commitment to **prioritising and designing services to meet the needs of populations with the poorest health and social outcomes.** This means:

- Up-skilling of health professionals, with particular regard to cultural competence, mental health and addictions, wellness focus, family violence and poverty. The workforce reflects the population it serves
- Commissioning for equitable outcomes
- Multi-disciplinary and team-based approaches which more holistically consider and address health and social needs and aspirations for whānau
- Re-framing our approach to focus on wellness, preserving mana and building on existing strengths of whānau, communities, and population groups
- Whānau wellness models in addition to an expectation that core services will meet the needs of those with poorer outcomes
- A rights-based approach to health meeting our responsibilities under Te Tiriti o Waitangi
- Incorporating the guiding principles of the Nuka System of Carewhilst giving primacy to Māori indigenous thinking, values and solutions.

http://www.ourhealthhb.nz/news-and-events/clinical-services-plan-transforming-our-health-services/



[ii] **National Disability Strategy 2016 - 2026[ii]**

The Strategy includes principles used to guide this Plan – Te Tiriti o Waitangi, Convention on Rights of the Person with Disabilities, and ensures disabled people are involved in decision-making that impacts them. With the following approaches - whole of life (long term approach) to social investment and specific and mainstream supports and services (twin-track approach).

The National Strategy is designed to guide the work of government agencies on disability issues. The Working Group were clear that this document provides the strategic direction for the HBDHB. This Plan is designed to implement this Strategy.

[iii]

HBDHB Values

The HBDHB has a commitment to living our values in the workplace and in the community. The best outcomes for patients and staff can be achieved if we all work together with the same values. These valueswe show commitment to and demonstrate the behaviours of the health sector are:

- Tauwhiro (delivering high quality care to patients and consumers)
- Raranga 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)

These values are at the core of ensuring people with disabilities are experiencing effective engagement with our health services. Including having equitable health outcomes, experience no barriers to accessing services and are participating in the development and design of our health services.
https://ourhub.hawkesbay.health.nz/our-place/our-values/

[iv]

Whāia Te Ao Mārama (Māori Disability Action Plan)[iv]

Introduces the term tangata whaikaha to describe a Māori person with a disability – whaikaha meaning to have ability and be enabled. This Plan also aligns with the vision and outcomes from the New Zealand Disability Strategy. There are six goals:

1) Participate in the development of health and disability services
2) Have control over their disability support
3) Participate in Te Ao Māori
4) Participate in their community
5) Receive disability support services that are responsive to Te Ao Māori
6) Have informed and responsive communities.

These also align with our HBDHB Values. Our Plan acknowledges the need to have equity outcomes and that currently tangata whaikaha experience barriers in health services in HB both as a person with disability and as Māori. Finally this Plan acknowledges our commitment as a DHB to the Treaty of Waitangi.

[v]

Faiva Ora, National Pasifika Disability Plan[v]

This notes a clear under representation of Pasifika disabled people engaging with disability services and the plan is focused on the services delivered by the healthy sector for people with disabilities. The vision is "Pasifika disabled people and their families are supported to live the lives they choose." This plan is informed by New Zealand Disability Strategy, New Zealand Health Strategy and Pacific Health Strategy and the United Nations Convention on the Rights of Persons with Disabilities.

Faiva Ora has the following principals which guide the planned actions:

- Self-determination
- Beginning early
- Person and family centred
- Ordinary life outcomes
- Equity
- Enhancing Pasifika cultural identity
- Easy to use
- Building relationships

Faiva Ora focuses on services delivered in the health sector, for this Pland that is further refined to services delivered by HBDHB. Both Plans share outcomes relating to equity, access (easy use) and person and family centered.

DISCUSS JOINT WORKSHOP BEING HELD WITH CLINICAL COUNCIL IN MARCH ENTITLED "PERSON & WHANAU CENTRED CARE" IN PRIMARY CARE

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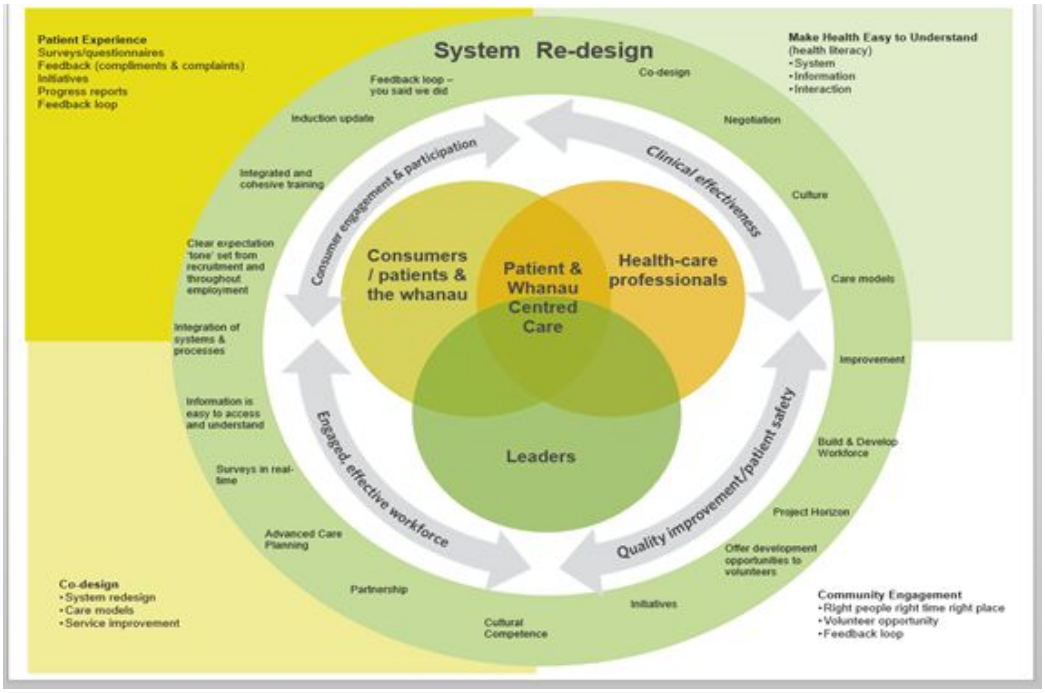
Person Whanau Centred Care - for discussion

Work Stream	Aim	Objectives to achieve our aim
Governance & Socialisation	**PWCC as viewed by the HBDHB, in concept and in practice, is defined in a way that is easy to grasp, understand, and put into use.**	Socialise the definition of PWCC as viewed by the HBDHB
		Socialise the HBDHB core concepts
		Socialise a campaign to raise awareness internally of PWCC definition, Core Concepts and MHEtU (see work stream below)
Make Health Easy to Understand	**Our interaction with, and the information we provide to, our consumers/patients and their whanau is easy to access, understand, and use.**	Increase percentage of staff attend training using current material until new training material is available
		Complete the 'Make Health Easy to Understand' framework
		Socialise an internal campaign to raise awareness for MHEtU
		Integrated training programmes that form a cohesive package that reflect HBDHB's view of PWCC, and its Core Concepts
		To have specific training for reception (and/or similar) staff
		Pilot Service has completed an MHEtU review
		At least 50% of Services commit to complete MHEtU review in period June 2019 - June 2020
Consumer/Patient and their Whanau Experience	**Consumers / patients and their whanau know how their feedback leads to improved services.**	The Consumer Feedback process is accessible and simple for all.
		A local survey to capture more immediate and real time feedback
		Completion rate of national survey increased by 15% (Baseline Aug 2018)
		Feedback is used by services to identify improvements
		Publication distributed 1/4ly 'You said, we did'. How feedback was used to improve services
Community Engagement	**Right people, Right place, Right time.**	We have a cohesive view of projects and programmes across the DHB
		We have a view of the community agencies in our region We know which community agencies we wish to actively partner with (Reach)
		We have a cohesive view of our volunteer pool, their areas of interest and activities
		Consumers/patients and/or their whanau are involved in relevant projects and programmes
		Volunteers are utilised effectively
		Volunteers know what is expected of them when they participate in projects and/or programmes
		We provide personal and professional development opportunities to our volunteers
System Redesign	**Our systems and processes support our goals and**	We promote the concept of Advanced Care Planning across the sector as a norr We have technology that suits our requirements Services use models of care that are fit for purpose

Person Whanau Centred Care - for discussion



15

Consumer Engagement – February 2019

"What will consumer engagement look like in the future based on CSP?"

Draw a parallel with shopping for clothes. You browse from shop to shop or through the catalogues or websites. Once you enter the shop it is the shop assistants task to convince you that the piece you have chosen is right for you. You purchase and go out one happy satisfied customer. Your friends and family admire what you are wearing, ask where you got it from, they go to same shop and you return and again because of the service and the personal attention"

"A visit to the Doctor should be a similar experience as shopping in Harrods."

Appoint a Disability Consumer Advisory Person (hopefully all DHB's). Important that people appointed to this role have a Disability as this enables more awareness of needs and requirements consumers with disabilities may require while receiving service/healthcare from the DHB's if the correct support and services are in place the consumer is more relaxed and comfortable with hopefully means recovery etc. is quicker.

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Trained and qualified peer support workers actually supported by the DHB to work alongside people.

There needs to be continuous engagement, not on off, off on, except on specific projects. Engagement needs to be done in real time. Seek information, discuss, and affirm what is being heard. Then progress…

Needs to' start' on sustainable basis AND importantly, have an organisation that is willing and able to make changes based on the feedback. Unless that 2nd limb is there it is a waste of everyone's time and the expectation built for change 'in the Ask' is destroyed.

Provide specific opportunities for people to engage and be heard. Real consumer stories, told by real consumers with the challenges and solutions laid out as a model of how things did/did not work and how they were resolved

There is little point in having yet more meetings if no action is taking place. This has to be sustainable for consumers and staff alike. People become feed backed out. They are tired of talking taking place and no action.

All this applies to staff as well.

Be more outcome based, pick opportunities where desired change likely to happen and we can influence it easily. Focus on getting us and DHB to work on priority outcomes when based on equity, early intervention to reduce costly late admission/appointments, and other CSP programs. Initiatives around planning and putting into practice pathways for the elderly instead of just covering off MOH requirements.

Proper consumer input is mandatory when the DHB has identified (or got money for) projects and need to set up. Projects could be numbered so it's easier to keep track. Personnel changes, things get dropped and we don't know

What changes CAN /WILL the DHB make if it asks consumers for feedback? Put another way how CHANGE READY is it before asking any questions of consumers?

Engagement might look very different to what it looks like now.

Engagement is all about creating dialogue. The digital era has led to shorter attention spans and more abrupt one directional conversation.

Consumers like it when the messaging is personalized and the conversation is two way and is targeted to meeting their needs.

Relationships and communication are key to consumer participation on both sides. Personalised communication in a modern way, in the way the consumer feels comfortable with.

We need to think of ways of developing the conversation not simply just sending the message.

We need to focus on the complete customer journey as either and individual or in conversational sized groups.

Language needs to be simple, concise, directive and inclusive of all. Do away with terms like Ophthalmology and use eye clinic, bone clinic etc.

We need to think of ways to influence other members of committees on which we sit, meetings and seminars we attend and also to listen to our communities in their various health-need forms. We're not going to immediately change the way things are done, there'd be no staff left, but we can encourage persuade, be resolute and well informed to earn respect and influence change.

Start by educating everyone on understanding consumer's engagement once it is decided what that looks like.

With resources as they are we can't be everything to everyone.

To start-target small vulnerable groups i.e. Teenage suicide and mental health issues. Use the community hubs in Camberley, Raureka, Flaxmere, Mayfair, Whakatu, Maraenui, Te Awa, and Tamatea in addition to a selection of local Intermediate and Secondary schools.
Target the young so that it becomes part of their lives and their expectations.
Working with the peer / class group in my opinion is much easier and more beneficial than working with the ethnic group. You have some instant role models and leaders and they are usually comfortable in each other's company.

The other very vulnerable group is the rural farmer. Stock firms could be approached to assist with funding of suitable programmes and venues.

Every day, waiting rooms in our hospital are full of consumers and their supporters.
Is there a better place to start the conversation, make the contact and arrange a time for the follow up conversation.
Anyone who participates could be encouraged to take on a consumer representative role for their medical condition. Consumer groups could build on that. You only need one champion to start (thinking Graeme Norton!)

The Board and DHB Governance groups (GGs):

Connect with governance groups of consumer organisations /NGO's and PHO and champion PWCC values at that level

Go out into the 'community'. Start in the hospital and medical centers, outpatient clinics, one to one feedback on the experience people are having. Catch people while they are 'in the experience' again in real time, progress this to consumer groups. Starting small like this could bring together a group of people like minded about their condition

Talk in pre op clinics, Te Ara Manapou, ZAC's, staff meetings, 5 mins at the end of each seminar in the education center. Have 2 or 3 touch points on a consumer's journey when they are engaged with individually, not asking for or waiting until feedback comes in. Be responsive to those touch points and make the findings known to consumers in that area.

Meet with people on their turf, take a consumer rep or two to talk instead of them (Board or GG) but the Board/Consumer Council/Clinical Council/EMT/Youth CC would support the consumer rep fully. Where defined by the consumer group referenced. Ideally have place based meetings in communities. They (communities) recognise their own challenges to meet their health care needs

I think for the DHB to meet in their own space could be intimidating for some. So I'm all for the boffins to get out and meet people and engage with whatever groups are in need.

CC could take the lead to publicise our Council and meetings better

Engage with collectives of people and whānau with similar needs and/or aspirations

Operational services should connect with consumers of that service and any relevant consumer organisations. E.g. age concern, cancer society, diabetes Hawke's Bay.

Reframe the material that group members are expected to read, digest and comment on. What is the information trying to do? Change what for what, Introduce…? How will it affect consumers and their families as well as the costs, staff etc.? What response is expected and is that clearly stated? What is the change time-frame? Send a one pager with the relevant information for the particular meeting. Provide a link to the full paper/information for those that might want the full. Include names of those on the project/workgroup etc. especially Community reps.

Slides limited to8 (I know that means 10) and viewable at the end of the room. Not cluttered with info and available a day before the meeting if possible for better understanding, questions and feedback wins all round. Also resend papers after inputs from all consulting shown ASAP in italics so we can see what happens.

Changes should automatically be reported back, series of reminders set up when a project starts, 'fines' or penalties for non-reporting

Respect the group or groups that you are in (ALL members - DHB/Consumers/etc.) Show up to meetings, read information, ask for help if you are unsure, respond when asked or let people know if you can't.

Be well informed, understand the financial and MOH constraints imposed on the DHB and if we don't know what these are then ask to become well informed not only of the perceived needed

outcome but also of the processes, measurements constraints of those doing the work... Also we get to know the size of our change.

Enablers:

The RCP training is very good, how do we encourage all staff to attend to improve their communication skills?

How do we influence staff in the DHB that may be resistant to change?

How do we encourage staff to respect consumers, put aside personal prejudice and be firm but fair?

How do we make the best use of capacity without having a negative impact on consumers e.g. to manage capacity/workload anecdotally some appointments are overbooked to compensate for DNA's/FTS's

" It always seems impossible until it's done." Nelson Mandela.

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Project – progress report, end of year two**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Kate Coley, Executive Director People and Quality
Document Author	Dr Russell Wills, Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor
Reviewed by	Executive Management Team; & Bernice Gabriel, Project Manager
Month/Year	January/ February 2019
Purpose	For information/ noting only
Previous Consideration Discussions	Previously discussed at EMT, MRB, Clinical and Consumer Councils and Board, who supported the project.
Summary	The Ngātahi Project has met nearly all milestones for year two and we are on track to deliver all remaining requirements by May. <u>How we will change practice</u> The three work streams (Mental Health and Addictions (MH&A), Trauma-Informed Practice (TIP) and Engaging Effectively with Maori (EEWM)), have agreed on the same approach to upskilling practitioners, namely: • Online learning for core knowledge, followed by • One-day wānanga to model and practice new skills, followed by • Wānanga Ita – peer coaching groups meeting regularly to embed the new skills into practice. <u>Mental Health and Addictions</u> • Partnered with Werry Whāraurau to develop online learning for MH&A and TIP. • Finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners. • Evaluation demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching. • Formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice <u>Trauma-informed practice (self-care)</u> • TIP (self-care) online module is written and will be reviewed by local leaders in January. • Russell and Bernice will write the one-day wānanga for leaders and for practitioners.

	Engaging Effectively with Māori • Agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content • Agreed to contract out writing/ co-constructing the one-day wānanga. One tender received, met contractor Thursday 17th January. Due diligence in progress at time of writing. CAFS • Continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services in 2018. • Agreed to not begin new training until current competencies are embedded. • Mechanisms are in place to ensure newly appointed staff obtain core skills through the Auckland University postgrad paper and in-house training. o Turnover has affected many vulnerable children's services in the past two years, of which CAFS is one. Most staff move within HB to other services, in particular to private practice and other community mental health teams (CAFS) and to Oranga Tamariki (NGOs), so their skills are not lost to the sector. This reinforces the value of skills that are transportable between services, which is a Ngātahi goal. Evaluation • EIT (Professors Kay Morris-Matthews and David Tipene-Leach) appointed as evaluators. First report received. The evaluators recommend the evaluation focuses on the immediate outcomes of the programme (staff wellbeing and practice change). We will not report on population-level outcomes as it will not be possible to demonstrate cause-and-effect relationship between the programme and outcomes, because population-level outcomes (referrals to Oranga Tamariki, substantiations, children in care, % receiving NCEA L2, etc) vary from year to year due to multiple, constantly changing, inter-related influences on outcomes and we do not have a comparison group. Report available on request. • First paper for publication accepted by *Policy Quarterly*, for publication February 2019. Funding • Project costs secured until completion end of 2019. Objectives for 2019 • Write, deliver and evaluate 24 more one-day wānanga o Trauma-Informed Practice (self-care) ▪ 4 to leaders ▪ 7 to practitioners o Engaging Effectively with Maori – 8 o Mental Health and Addictions 4 more

	• Launch website and online registration system • Assess likely ongoing running costs for Ngātahi to become business as usual • Final report assessing impact of programme due early 2020. • Further papers, publications and presentations.
Contribution to Goals and Strategic Implications	Contributes to HBDHB Statement of Intent 2015-19 (p8, Fig 3): Working with Others; People better protected from harm; Health issues and risks detected early; Longer, healthier and independent lives; High quality, timely and accessible services; Sustainability. Contributes to NZ Health Strategy 2016 goals: Closer to Home; Value and High Performance; One Team; Smart System.
Impact on Reducing Inequities/Disparities	70% of vulnerable children are Māori so this project has been created with tamariki and whānau Māori at the fore: early and regular consultation with Māori providers and leaders, specific domain on Working Effectively with Māori (WEWM), co-constructed with Māori service leaders; cultural *and* clinical competency in teaching and learning; EEWM work stream to have oversight of other work streams.
Consumer Engagement	Early consultation with caregivers of children and young people in care and with care-experienced young people, facilitated by MVCOT. Strong support for the competencies and process, no additional competencies identified.
Other Consultation /Involvement	MRB, Māori providers, facilitated by HBDHB Māori Health Unit. Support for project, helpful advice regarding tikanga, added several additional competencies to the EEWM domain, EEWM work stream has oversight of other domains to ensure cultural competency.
Financial/Budget Impact	Y1 $250,000 Y2 $232,500 Y3 $212,500
Timing Issues	Wānanga: • TIP (self-care) will be written in time for first wānanga April 11th. • EEWM will be co-constructed by contractor, Ngāti Kahungunu iwi representatives and Ngātahi team. Due date dependent on negotiations. Final evaluation report due early 2020
Announcements/ Communications	Outcomes from evaluation will be shared: Internally — Project Sponsor Dr Wills Key Stakeholders — Meetings, conferences, papers Community — Through HBDHB communications team
RECOMMENDATION: It is recommended that MRB, Clinical Council, Consumer Council and the HBDHB Board: 1. **Note** the progress of the Ngātahi Project in the second year.	

HAWKE'S BAY
District Health Board
Whakawāteatia

Ngātahi Project
Progress report - end of year two

Author:	**Dr Russell Wills**
Designation:	**Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor**
Date:	**26 January 2019**

SUMMARY
The Ngātahi Project is about Hawke's Bay health, education and social services (the "vulnerable children's workforce") working together as one to deliver excellent care and interventions to vulnerable children and their families.

In the first year of the project (2017) we:

- partnered with iwi and kaupapa Māori providers, and established the tikanga for the programme
- engaged with, and mapped the skills and learning needs of 441 professionals from the vulnerable children's workforce
- agreed the three priority training areas for 2018 and 2019
- established three work streams to develop, implement and monitor training and development programmes in these three priority areas to improve the confidence and competence of the vulnerable children's workforce, and improve collaboration
- completed an independent research programme of interviews with a representative group of managers and practitioners, which provides assurance on the current direction, lessons learnt and important pointers for the following two years of the programme.

In the second year of the project (2018):

- The three work streams (Mental Health and Addictions (MH&A), Trauma-Informed Practice (TIP) and Engaging Effectively with Maori (EEWM)), have agreed on the same approach to upskilling practitioners, namely:
    - Online learning for core knowledge
    - One-day wānanga to model and practice new skills
    - Wānanga Ita/ Learning Circles – peer coaching groups meeting regularly to embed the new skills into practice.
- We finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners.
- We formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice.

- We partnered with Werry Whāraurau to develop online learning form MH&A and TIP.
    - MH&A reviewed by local leaders, is appropriate for use and completed by most practitioners who attended the M&A wānanga
    - TIP (self-care) module written and will be reviewed by local leaders in January
- The EEWM work stream agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content
- We agreed to contract out writing the EEWM wānanga, ran an EOI process and met a prospective provider. At the time of writing due diligence is underway before appointing the provider.
- Our evaluation of the three wānanga demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching.
- We have scheduled 24 wānanga across all three work streams for 2019
- We continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services this year
- EIT (Professors Kay Morris-Matthews and David Tipene-Leach) were appointed as evaluators for the second phase and their first report was received in January.
- Project costs secured for years 2-3
- Our first paper for publication accepted by *Policy Quarterly*, for publication February 2019.

Our Objectives for 2019 are:

- Complete and deliver a further 24 one-day wānanga
    - Trauma-Informed Practice (self-care) wānanga
        - 4 to leaders
        - 7 to practitioners
    - Engaging Effectively with Maori – 8
    - Mental Health and Addictions 4 more
- Form 48 more wānanga ita – we believe these will become the “engine room” for practice change
- Launch the Ngātahi website and online registration system
- Assess likely ongoing running costs for Ngātahi to become business as usual and formulate a business case to funders for that
- Final report assessing impact of programme is due early 2020.

We are a step nearer to our vision of better collaboration between disciplines and sectors, sharing of effective practices, development of a common language and improved workforce capacity.

This briefing paper describes the context and progress to date.

BACKGROUND

In 2015 an expert panel reviewed Child, Youth and Family. There were a number of reasons that the care and protection system failed vulnerable children and their families[1] and recommendations were made to address these issues. Children of parents with mental illness, addictions and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/ whānau and both the previous and current Governments accepted all of the Panel's recommendations.

A new programme was created to reform the way these families are supported, including:

- changes to legislation and accountabilities of Ministry Chief Executives
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children Oranga Tamariki
- implementation of multi-agency Children's Teams in ten sites
- additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families. See Appendix Two for a roadmap of these changes.

There are now many reports[2],[3],[4],[5] that recommend a focus on additional knowledge and skills ("competencies") for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved.

The Ministry of Social Development Children's Action Plan Directorate therefore began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. Hawkes Bay is piloting the Ngātahi Project, leveraging the draft Vulnerable Children's Core Competency Framework.

PURPOSE

The Ngātahi Project aims to assess the skills and development needs of health, education and social service professionals in Hawke's Bay who are working predominantly or exclusively with vulnerable children and families. Over a three year period Ngātahi and its partners will design, implement and evaluate a workforce development plan to support practitioners. By improving practitioners' competencies, including their ability to practice collaboratively and share information, in conjunction with the structural changes above, outcomes for vulnerable children and their families should improve.

PROGRESS in 2017 (year one)

Funding was obtained in 2016 from the Hawke's Bay District Health Board (HBDHB), Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Dr Bernice Gabriel, a senior psychologist at the HBDHB Child, Adolescent and Family Service (CAFS) was appointed as project manager in March 2017. Additional funding was secured from the Royston Health Trust in 2017. The funding is sufficient to see the project through to completion at the end of 2019, when, depending on the findings of the current evaluation, a business case will be prepared to take the project to a business-as-usual programme.

HBDHB CAFS

CAFS' staff completed their competency assessment against the Ngātahi framework and the Real Skills Plus CAMHS competency framework early in 2017[6]. Five training sessions have been completed to date:

- Assessment & Formulation
- Attachment & Trauma
- Emotional Regulation/Dialectical Behaviour Therapy*
- Acceptance & Commitment Therapy†
- Family Therapy supervision.

Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau and advise on subsequent activities to support CAFS' staff to integrate the new competencies into everyday practice.

Peer review groups continue to meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice.

At this point we have agreed to defer further training until we are confident that the new competencies are embedded into practice. CAFS is also working through how to provide the previous training to several new staff before progressing to further training.

Wider vulnerable children's workforce

In 2017 leaders from health, education and social services, kaupapa Māori, mainstream, Government and NGO services met and agreed the competencies each sector required of its staff. Four hundred and forty one staff from 27 agencies were surveyed and asked to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N).

Three priorities for development were agreed:

- Engaging effectively with Māori (EEWM)
- Mental health and addictions (MH&A)
- Trauma-informed care (TIP) – initially focusing on developing resilience skills in the workforce (see research findings below).

Professors Kay Morris-Matthews and David Tipene-Leach (Eastern Institute of Technology) are contracted to provide the evaluation. Key themes from staff interviews included:

- High levels of engagement of managers and staff:
- The value of clinical leadership
- High levels of practitioner stress: High levels of stress, burnout and fatigue were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

A detailed research report was completed in January 2018 and is available on request.

PROGRESS IN 2018 (year two)

Sector leaders joined or nominated staff to join one or more of the three work streams (EEWM, MH&S and TIP). Work streams were empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice and how each competency should be assessed. The EEWM work stream has supported the other two work streams to advise on the cultural competency aspects of the training.

* Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, DBT is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, and borderline personality.

† ACT is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.

We estimate 800 registrations (40 one-day wānanga) to meet the current demand for these three areas of competency. We delivered three pilot wānanga in 2018 and have scheduled 24 more for 2019. This is 50% of the target.

Mental Health and Addictions

- Partnered with Werry Whāraurau to develop online learning for MH&A and TIP.
- Finalised, delivered and evaluated first three one-day wānanga in Mental Health and Addictions (MH&A) to 40 practitioners.
- Evaluation demonstrates strong support for the kaupapa Māori (pōwhiri poutama) approach to assessment and formulation, and that the six Ngātahi pou were effectively integrated into teaching.
- Formed six wānanga ita, who continue to meet regularly to embed the new MH&A skills into practice.

Trauma-informed practice (self-care)

- TIP (self-care) module written and will be reviewed by local leaders in January
- Russell and Bernice will write the one-day wānanga for leaders and for practitioners
- First wānanga scheduled for April.

Engaging Effectively with Māori

- Agreed that the Mauri Ora online learning is appropriate for our needs for EEWM core knowledge content
- Agreed to contract out writing/ co-constructing the one-day wānanga. One tender received, met contractor Thursday 17th January. Due diligence is underway.

CAFS

- Continued peer coaching at CAFS to embed new competencies learnt in 2017, included practitioners from other services this year
- Agreed to not begin new training until current competencies are embedded
- Working through how to ensure newly-appointed staff also receive the above core training.

Evaluation

- EIT (Professors Kay Morris-Matthews and David Tipene-Leach) appointed as evaluators. First report received.
- Project costs secured for years 2-3
- First paper for publication accepted by *Policy Quarterly*, for publication February 2019.

Objectives for 2019

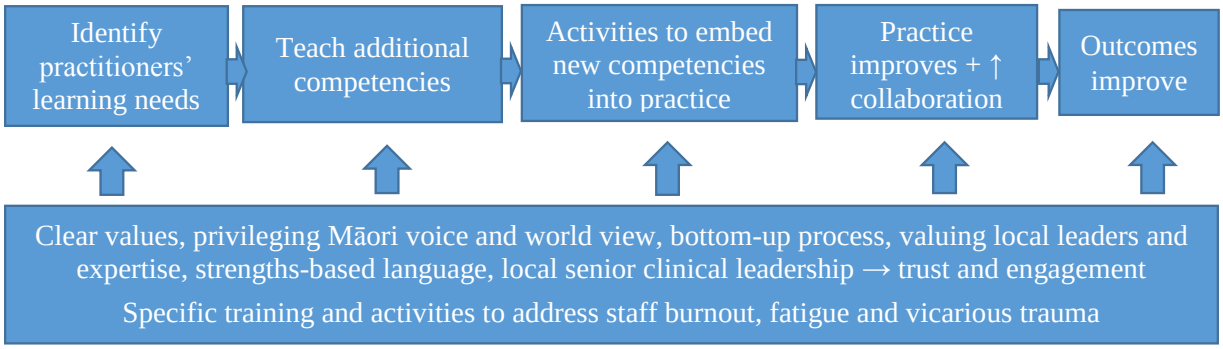
- Complete and deliver 24 more one-day wānanga
    - Trauma-Informed Practice (self-care) wānanga
        - 4 to leaders
        - 7 to practitioners
    - Engaging Effectively with Maori – 8
    - Mental Health and Addictions 4 more
- Launch website and online registration system
- Assess likely ongoing running costs for Ngātahi to become business as usual
- Final report assessing impact of programme due early 2020.
- Further papers, publications and presentations.

Why does this matter?

Hawke's Bay is the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership

with the Ministry for Children Oranga Tamariki and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MCOT, MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Our theory of change is essentially:



Measures and indicators

Outcome sought	**Demonstrated by**
Engagement	Research interviews year one with practitioners and managers
Practitioners' learning needs identified	Survey Monkey results Research interviews year one with practitioners and managers
Competencies taught	Number of attendees at training, number of trainings provided Evidence of programme delivery with fidelity Pre-post self-report of competence and confidence
New competencies embedded into practice	Description of activities and attendance at these Manager report of initial practice change with examples
Practice improved	Manager report of practice change with examples Practitioner self-report of competence and confidence New evidence-based programmes delivered, description, attendance Direct observation by evaluators
Collaboration improved	Manager report of improved collaboration with examples Practitioner self-report of improved collaboration with examples Direct observation by evaluators Reports from collaborative bodies (e.g., FVIARS, Strengthening Families, High and Complex Needs Interagency Management Group, Maternal Wellbeing Programme, Intensive Wraparound Service)
Reduced staff burnout, fatigue & vicarious trauma	Practitioner self-report HR indicators, e.g. recruitment, retention, turnover Direct observation by and feedback to evaluators
Improved outcomes for children and families	Client direct feedback within services Direct observation by and client feedback to evaluators

All outcomes to be assessed by independent researchers contracted to Ngātahi Programme.
All outcomes dis-aggregated by ethnicity.

ASSUMPTIONS

- Children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for children.
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whānau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies.

RISKS and MITIGATIONS

Risk	Mitigation
If agency leaders do not contribute their agency's time and skills to work streams this risks losing the mandate for that training.	At the hui on 6th November a clear message was given that it is important to engage or will not be able to influence the training. It was also made clear that all contributions are welcome
If work stream members do not agree on the content and implementation approach by the deadline this will impact negatively on the project timeline.	The work stream chairs will be supported to facilitate work stream well, value all contributions and look at best practice evidence. If no agreement in work stream this will be escalated to the governance group.
If non-Maori organisations and practitioners use kaupapa Maori approaches or methodology inappropriately, this could mean culturally inappropriate engagement with Maori whanau	Raise the issues with one, more or all of the following as required: HBDHB Maori Health and kaumatua; iwi mandated representatives on the work streams and steering group; kaupapa Maori evaluators. Co-construct workshops with tuakana from kaupapa Maori agencies.
If we do not manage, train and support the facilitator pool, the fidelity and continuity of the training programmes may be compromised	Facilitators to attend training programme prior to facilitating, new facilitators are paired with expert facilitators, project manager spends time with facilitators to discuss the training if needed, facilitators have handbook they can refer to, and facilitators debrief after each training. It is planned that facilitators will meet at least twice a year to discuss the training and any revisions.
If we do not implement processes around practitioner turnover in participating agencies, the competency mapping and training aspects of the project are not sustainable	Develop excel-based competency framework mapping for new staff to complete and managers to identify their learning needs, ensure new staff are given the opportunity to attend training programmes that are available to meet their learning needs.
If we do not implement processes around manager turnover in participating agencies, the continuity of the project is compromised.	Liaise with new managers to socialise them to the project as soon as possible.

BUDGET HBDHB Ngātahi Project Financials				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Senior clinical leadership	0.5 FTE	$55,000	$55,000	Clinical leadership is required to engage managers and staff in the learning programme, identify, recruit and brief the trainer, support managers and staff to arrange peer review groups, and support the evaluation.
Event management	0.5 FTE	$27,500 ($55k pro rata)	$27,500 ($55k pro rata)	Experience in the first year suggested that we needed event management capacity for the following: website design; online registration, tracking and reporting attendance and feedback; venue hire, IT, catering and certificates. The HBDHB EDC team is a multidisciplinary team with considerable experience in the above tasks.
External trainers		$50,000	$50,000	We would take a train-the-trainers approach with external trainers but a small budget will be required to bring in external trainers initially and for follow-up peer review.
Evaluation To be sought from HBDHB Transform and Sustain Fund		$80,000	$80,000	Ngātahi is a pilot project that, if successful, is likely to be taken up nationally. There is therefore a strong obligation to ensure the programme is evaluated independently and thoroughly, so clear documentation of lessons learnt and areas to improve are essential. Measures and indicators for 2018 and 2019 are noted above. The budget for 2017 was $80,000. We estimate that a credible evaluation could be expected for $80,000/year in 2018 and 2019.
Training costs		$20,000	$0	See table below re training costs
TOTAL COST		**$232,500**	**$212,500**	

Costs to participating services				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Training costs		$0	Contribution per agency to be determined	There will be costs for venue hire, IT, photocopying, catering and certificates. We will ask services, whenever possible, to donate venues for training and staff to bring their own lunch. Work streams will be asked, wherever possible, to identify local leaders to deliver training and support ongoing activities such as peer review. While this a cost to services (time spent training is time not spent in practice), reciprocity occurs because these services also gain from their staff attending training provided by others, and improving their practice.

RECOMMENDATION

That the MRB, Clinical Council, Consumer Council and the HBDHB Board:

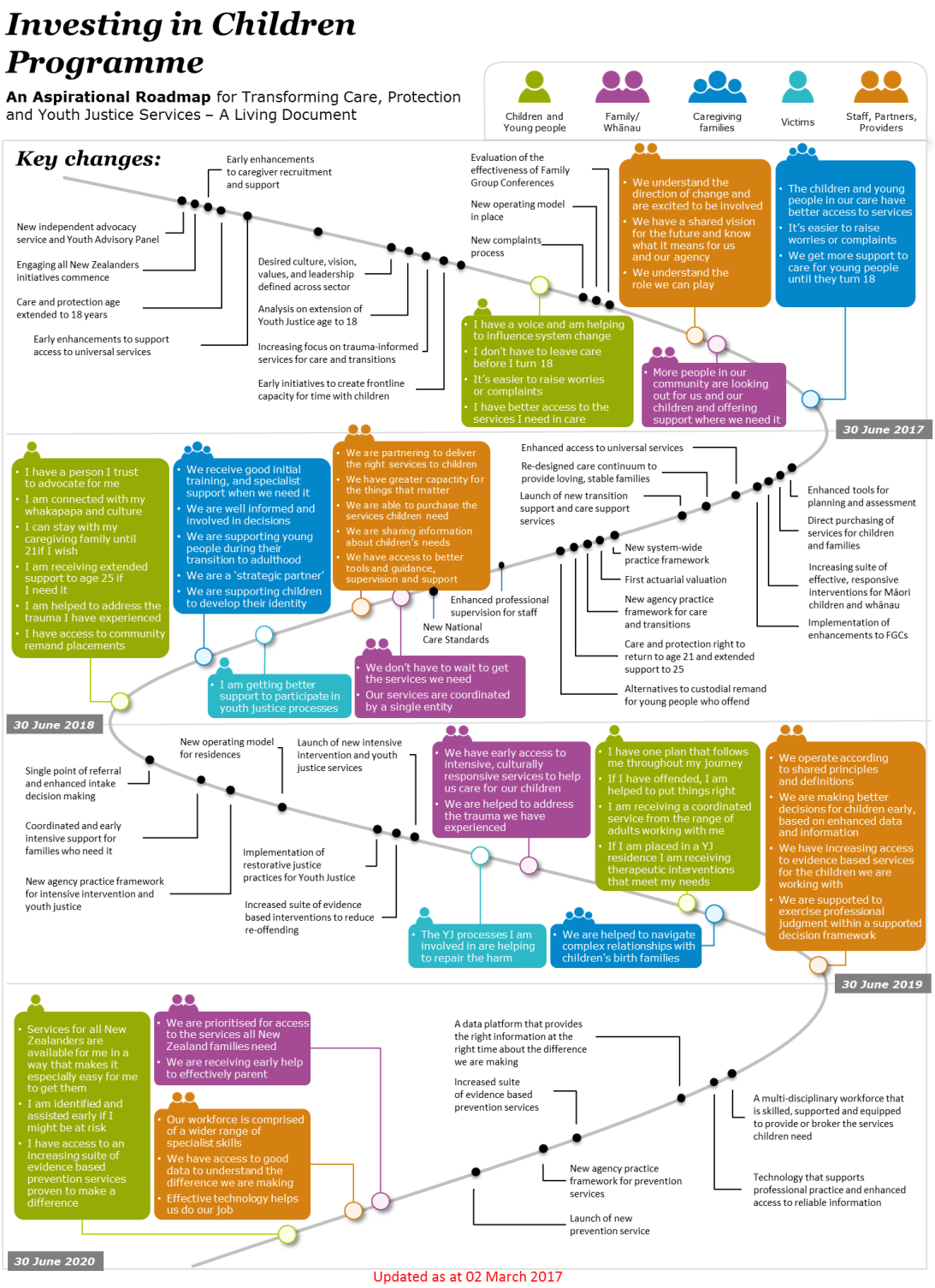
- **Note** the progress of the Ngātahi Project in the second year.

Appendix 1: Agencies/Services Participating in the Ngātahi Project

1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket
25 Wellstop
26 Explore
27 Women’s Refuge

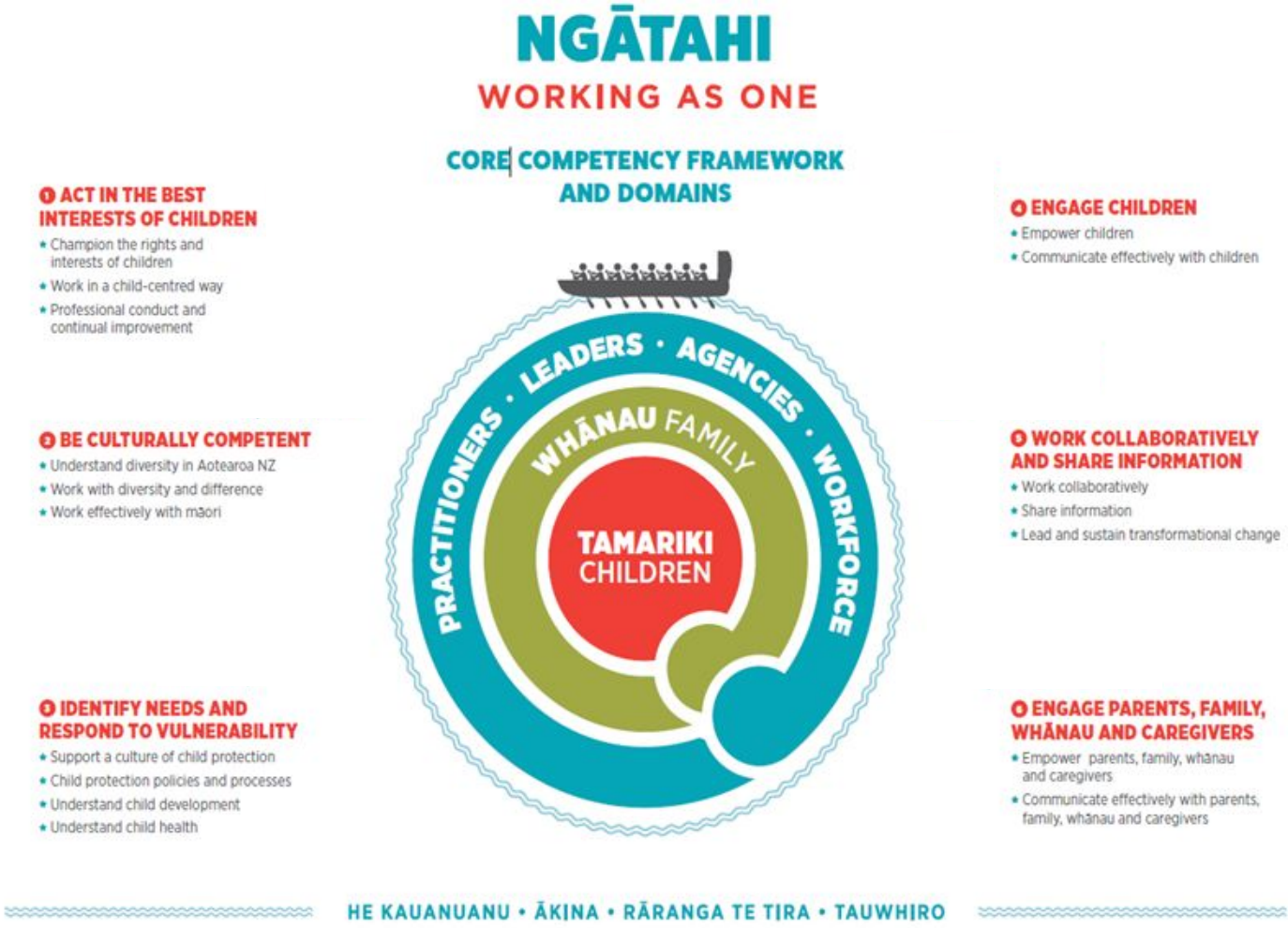
Appendix 2: Investing in Children Aspirational Roadmap

http://www.msd.govt.nz/about-msd-and-our-work/



Updated as at 02 March 2017

Appendix 3: Core Competency Framework Summary



[1] https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf
[2] Office of the Children's Commissioner. Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru. Wellington, Office of the Children's Commissioner, 2000
[3] Office of the Children's Commissioner. Report of the Investigation Into the Deaths of Saliel Jalessa Aplin and Olympia Maria Aplin. Wellington, Office of the Children's Commissioner, 2003
[4] Laming Lord. The Victoria Climbie Enquiry. London, HMSO, 2003. http://vcf-uk.org/wp-content/uploads/2010/07/laming-report.pdf
[5] Smith Mel. Report to the Hon. Paula Bennett Minister for Social Development and Employment. Following an Enquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to Welfare, Safety and Protection of Children in New Zealand. Wellington, Ministry of Social Development, 2011.
http://www.beehive.govt.nz/sites/all/files/Smith_report.pdf
[6] http://www.werryworkforce.org/real-skills-plus-camhs

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Alcohol Harm Reduction Strategy 2017-22 Progress Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Health Improvement & Equity
Document Author(s)	Rachel Eyre, Medical Officer of Health Rebecca Peterson, Acting Team Leader/Population Health Advisor
Reviewed by	Chris Ash, Chair Alcohol Harm Reduction Steering Group; Alcohol Harm Reduction Steering Group; Laurie Te Nahu, Health Gains Advisor ; Rowan Manhire-Heath, Population Health Advisor and the Executive Management Team
Month/Year	February 2019
Purpose	The Board requested six monthly progress reports to Clinical Council. This report provides an overview of progress and changes impacting on the HBDHB Alcohol Harm Reduction Strategy.
Previous Consideration Discussions	Alcohol harm reduction position statement (Nov 2016), steering group establishment and strategic framework and priorities were endorsed in September 2017.
Summary	*Work delivered under the Alcohol Harm Reduction Strategy involves a range of activities (Refer to Appendix One) :* • *addressing the drivers of alcohol use* • *shifting attitudes towards alcohol* • *limiting availability and exposure* • *providing appropriate and accessible health service response to alcohol harms* *Whilst health services response to alcohol harm, particularly alcohol screening and brief intervention (SBI) was identified as a priority, progress has been slow. Population Health have achieved a number of successes in relation to intersectoral action and community engagement detailed in this report.*
Contribution to Goals and Strategic Implications	This work contributes to the following: Hawke's Bay DHB Alcohol Harm Reduction Strategy 2017-2022 Joint Alcohol Strategy (2017) across Napier City and Hastings District Councils – HBDHB is a key stakeholder Improving health equity – note: Māori experience more harm from alcohol overall than non-Māori. Evidenced by higher hospitalisations wholly attributable to alcohol. System Level Measure/HBDHB Annual Plan (2018-19) - Youth are healthy, safe and supported; ED alcohol presentations for 10-24 year olds. Clinical Services Plan - primary and community care future vision encompasses relevant and holistic approaches to mental wellbeing including addiction issues.

	Social inclusion /REDS/ Matariki – to reduce the negative impact of drug use on individuals and their whanau /reduce the rate of violence experienced by individuals and whānau.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika using targeted (e.g. social supply to youth project in Wairoa) and universal approaches with greater proportional impact on the most vulnerable (e.g. reducing availability / 'alcohol and schools don't mix' initiative, monitoring licence applications, supporting community to oppose licences in high deprivation areas). Equity measures / tools will be applied to individual initiatives and programmes as they are planned and implemented.
Consumer Engagement	Steering Group membership includes Consumer Council and Youth Council members.
Other Consultation /Involvement	Steering Group membership includes provider services – Medical, Community Women and Children, Maternity, Mental Health, Primary Care Directorate, Health Improvement & Equity Directorate including Public Health, Māori and Pacific health leadership and youth representation. Hawke's Bay DHB and Health Hawke's Bay designed an Alcohol Screening & Brief Intervention Survey disseminated widely to health services and general practice. Results were shared with the Steering Group and will inform next steps. Community mobilisation project (see "shift attitudes to alcohol" section).
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that MRB, Clinical Council, Consumer Council and the HBDHB Board:

1. **Note** the substantial activity led by population health.
2. **Note** the new landscape to obtain buy-in from Clinical Services using a broad based social harm reduction approach, especially for screening and brief intervention.
3. **Approve** the next steps.

HBDHB Alcohol Harm Reduction Strategy 2017-22 | Progress Report

Author(s): **Designation:**	Rachel Eyre, Medical Officer of Health Rebecca Peterson, Acting Team Leader/Population Health Advisor
Date:	**February 2019**

OVERVIEW

A Position Statement on reducing alcohol-related harm was adopted by the HBDHB Board in November 2016. In September 2017 the Board endorsed the alcohol harm strategic framework (refer to Appendix One) and priorities and supported the establishment of a steering group reporting to Clinical Council. The strategy informs a broad programme of work including public health regulatory functions under the Sale and Supply of Alcohol Act 2012, intersector activities, work in key settings e.g. schools, sports clubs and community led initiatives e.g. social supply. The Steering Group agreed to focus initially on reviewing and improving the health service response to alcohol-related harm in the form of screening and brief advice (SBI)[1]. Due to competing pressures, limited resourcing and capacity for clinical leadership this component of the programme of work has not progressed.

System-wide solutions are currently being sought to resolve how alcohol harms can best be addressed by our DHB, alongside a number of other 'social harm' issues, which may have more political traction and community/stakeholder resonance. This should be balanced against the need to maintain focus on alcohol related impacts on the community.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives on the activities to date. Refer to Appendix Two for a summary on the progress on implementation of the Alcohol Harm Reduction Strategy.

1) Address underlying drivers of alcohol use

Population Health and Māori Health (Health Improvement & Equity Directorate) advocate for strong policy levers to reduce alcohol-related harm through the writing of submissions that target Central and Local Government. The following submissions have been completed over the past year

- Joint Alcohol Strategy (Napier City and Hastings District Councils)
- Energy Labelling of Alcohol Beverages
- Sale & Supply of Alcohol (Renewal of Licences Amendment Bill (No 2)
- Tax Working Group on 'The future of tax'
- Mental Health & Addictions Inquiry

The interim outcome for the Tax Working Group is yet to be confirmed, with recommendations made to include reviewing the rate structure of alcohol excise with the intention of rationalising and simplifying it. This will continue to require public health input.

[1] SBI has proven to be an effective prevention intervention, particularly in primary care. It is demonstrated to be effective for young people, men, pregnant women and general populations. It has also shown to be cost effective in the ED. (full references available on request)

The Mental Health & Addictions Inquiry report has delivered strong recommendations regarding alcohol reform; most importantly for Government to take a bolder approach to the sale and supply of alcohol. Reference has been made to the recommendations laid out in the New Zealand Law Commission's report in 2010, including to:

- Increase the price of alcohol through excise tax increase
- Regulate promotions that encourage increased consumption or purchase of alcohol
- Regulate alcohol advertising and sponsorship
- Increase the purchase age of alcohol to 20 years
- Reduce availability, such as the hours that licenced premised are open or the proliferation of outlets.

Internally, Population Health have made recommendations to the current HBDHB's Drug and Alcohol Free Policy (2014) including provision of alcohol at the Hawke's Bay Health Awards. Additional to this, the DHB Communications team were also provided with feedback on the proposed questions within the HB Health Awards survey. The outcome was to allow alcohol to be sold at the event but no longer provided free.

2) Shift attitudes towards alcohol

Community mobilisation workshops have been delivered to a range of community leaders with the aim of increasing knowledge and understanding of the Sale and Supply of Alcohol Act 2012, targeting Māori and high deprivation communities, informing them on how they can have more say. Following this, the HBDHB population and public health staff designed an Alcohol Networks e-newsletter that has an extensive distribution list, keeping the audience abreast of opportunities, hot topics and research findings.

Public Health staff have requested Hastings District Council to make licence applications more visible to communities by asking for placement of these on their website and further work of this nature is planned e.g. designing an alcohol harm reduction advocacy toolkit for community. This is in response to a Hawke's Bay community survey data gathered in 2015, indicating people wanted fewer bottle stores, more alcohol free events and entertainment and shorter alcohol outlet hours. Another joint activity across Population Health, Māori Health and the Child Development Services included a presentation to Kahui Kaumatua on alcohol licensing and availability.

3) Limit availability and everyday exposure

Alcohol and schools don't mix: Young people and under age exposure literature review was presented and endorsed by HBDHB Board in May 2018. The intent was to provide evidence on exposure to alcohol and harms to young people and share data around special licence applications made by schools over the past few years. The proposed outcome of the project was to work more closely with the education sector to advance a whole of school approach to alcohol. The target is to have no schools applying for alcohol special licences for fundraising events where minors are present.

Subsequently, the Population Health alcohol team has developed and publicised widely the *Healthy Events and Fundraising Guide* and planned and delivered a comprehensive 'Alcohol and Schools Don't Mix' Communication and Risk Management Plan. The success of the latter piece of work was strong clinical leadership, an evidence base, tools to support schools and encourage effective communication.

The 'Alcohol and Schools Don't Mix' report and a subsequent school special licence opposition (Port Ahuriri School Food and Music Festival) received significant media attention and provided an opportunity for our DHB to show leadership nationally. We received national support from the Health Promotion Agency, Ministry of Health and the current Children's Commissioner. Dr Russell Wills was our front-line champion who was interviewed extensively in the media. The DHB continues to work with the Child Health Team, Ministry of Education and Ministry of Health to support alcohol-free schools. A presentation on alcohol and young people was made to the Secondary Schools Principals Association. Preliminary data suggests a high proportion of schools in Hawke's Bay have now developed an alcohol policy.

Reducing the availability of, and exposure to alcohol in our highest needs communities, is a core activity for the Population Health alcohol team. A recent example of this work is the Medical Officer of Health's opposition to a new off-licence store in a high deprivation suburb of Hastings (Akina, Parkvale). Opposing such a licence application requires comprehensive research and data analysis and working with the community to ensure their views are heard. The decision has been to allow this particular off-licence with an expectation of closer monitoring by Police. This decision is now being appealed by the Medical Officer of Health to the Alcohol Regulatory Licensing Authority.

The 'One for One' host responsibility campaign (encouraging one non-alcoholic drink/preferably water for every alcoholic beverage) has been successfully transitioned to a more sustainable model. The Hawke's Bay Hawks Basketball Club and Church Road Winery have both shown leadership by using promotional material (flags, bar mats, poster, and hand sanitisers) during season events. The Hawks also instituted an 'alcohol-free family zone'. In addition, the Napier City and Hastings District Councils' Joint Alcohol Strategy Reference Group (of which the DHB are a key member) are currently progressing a project to create branding to promote an increase in 'alcohol-free events' and 'alcohol-free family zones' at events. This project is funded by the Health Promotion Agency's 'Community Action on Alcohol Partnership Fund'.

Discussions have occurred at CEO level across local government and with local MPs, Police, HBDHB executives and Medical Officer of Health raising concerns around the ineffectiveness of the current legislation, especially in regards to the Local Alcohol Policy process at minimising alcohol-related harm. All four of our territorial authorities have Local Alcohol Policies with variable status. Concerns have also been raised identifying mechanisms to increase quality data collection and community voice and to influence legislative change e.g. increasing excise tax and reducing marketing (especially via digital media targeting young people). A Private Members Bill is currently being drafted that would dispense with the LAP appeal process.

The tri-agencies (Police, Councils, Health) are holding discussions on how the licensing process is working and how we engage more effectively to reduce alcohol related harm through our joint agency working. A Joint Agency Protocol / Memorandum of Understanding is being considered.

4) Providing appropriate and accessible health services

To raise awareness, engage health services and identify workforce needs regarding alcohol screening and brief intervention, the Steering Group requested we administer a health sector wide screening and brief intervention survey. We partnered with Health Hawke's Bay to design a survey and disseminated this via Survey Monkey across health services and general practices (maternity and the child development service were excluded as they were surveyed in 2017). Findings endorsed the level of concern regarding alcohol harm from health services, with over 72.5% either very or extremely concerned about alcohol related harm. Refer to appendix three for detailed findings.

General practice (Health Hawke's Bay) screening & brief intervention

Health Hawke's Bay are working to review and update alcohol screening and brief intervention patient dashboard. Discussions are underway on adapting the Whanganui PHO's dashboard, revising resources, tools and referral pathways. Testing with initial practices will occur before wider rollout.

Workforce development

The Health Promotion Agency (HPA) are in discussion with the Ministry of Health and Matua Rāki to review how best to provide screening and brief intervention information and training to the health sector. This work will involve a review of what is currently available, what is missing and what could be better packaged for delivery at a local or national level. There will be an opportunity for HBDHB to act as a pilot site, informing and testing the design of this information including content and format. An integrated approach that achieves consistent messaging about alcohol and other drug harms and how to minimise these harms for whānau is essential.

Integration
It has been proposed that we facilitate alcohol screening and brief intervention across clinical services. The context is that we are facing competing health service and resource pressures, with strategic perspectives to take an integrated "social harm reduction" approach to address a range of harms such as alcohol and other drugs, family violence, suicide prevention and smoke free. The conversation was raised at the Steering Group in November 2018 and there was general support for an integrated approach. Further discussions will be required to understand the implications of an integrated approach, in particular, the impact this may have on implementation of the HBDHB Alcohol Harm Reduction Strategy.

To explore integration as well as continue to implement the strategy, we propose to take opportunities at both the management and operational level to join across other harm prevention initiatives, with a view to develop an integrated, whānau centred approach. This will result in regular meetings between coordinators to explore through joint planning, agreed shared measures/outcomes and initiatives, linking key messages and workforce opportunities. This will require discussion as to which groups are best brought together and what the synergies might be and how the various interest groups will be represented. We will need to understand what mix of topic-specialist and strategic expertise will be required, what level of mandate and decision making around use of resource/commissioning. Clarity will be required to understand how any changes to structure will enable more effective and efficient use of resources at all levels to optimise health gain. Overall management of this work will continue to be overseen by the Executive Director, Heath Improvement and Equity.

The opportunity to connect with local place based initiatives will allow more community development approaches that are positive and asset based and which are meaningful to the communities who are most affected. At the same time there may be merit in forming an overarching group to consider an integrated approach to screening (e.g. for domestic violence, depression, alcohol and tobacco use).

In addition, the need for our collective leadership, advocacy for policy change and systems change are essential to make real progress, aside from identifying service solutions. The wider political context is important across a number of commercial determinants of health through the marketisation of alcohol, tobacco and unhealthy food, driving our current increase in long term conditions.

Leadership
At a local level, there are two key areas for our DHB to lead and influence. Firstly, there is evidence based public health/population preventive initiatives that in essence support the policy changes advocated by the Law Commission. Secondly, there is the more bio-medical early intervention and treatment related aspects, such as improving access to screening, brief intervention and treatment options to cater from mild through moderate to serious addiction issues.

Health professionals need to have an increased awareness of alcohol harms as a health issue so that they can support both areas. For the second, health professionals need to be comfortable to have the conversation about alcohol as a normal part of patient and whānau interaction, akin to the smoking question and brief advice introduced over 20 years ago. Professional development, screening tools and referral pathways need to be developed to support a better co-ordinated early intervention approach, resource for which will need to be sourced. It is noted that smoking cessation has had significant funding attached, while alcohol SBI is still under-resourced.

By investing in both population prevention strategies and early intervention for individuals there is the opportunity to reduce the costs to our DHB (conservative estimate of $3 million in 2016 due to bed days only from wholly attributable conditions and not injuries). This allows us to prevent hospitalisations due to the 200+ acute and chronic conditions related to alcohol. A significant benefit from reducing alcohol harms is to reduce the social costs and misery to families and whānau caused by inappropriate alcohol consumption, enabling safer communities for all.

(Note: Harms from alcohol outweigh all other drugs and harms to others outweighs harm to self[2] and Berl economist Ganesh Nana has estimated that alcohol harm costs the country $7.85 billion a year, including factors such as unemployment, the labour market, the costs on the court and health systems and road crashes[3]). Working more closely with Police in particular will strengthen what we do for community gain and currently we are exploring how we can improve our sharing of data.

WIDER CONTEXT

Consideration is now being given by EMT members to consolidate work across a number of areas within the wider context of social harm, whilst ensuring that the work on alcohol harm is not side-lined. Recent results have identified alcohol as the leading cause of health loss (from death and disability) in New Zealand adults, age 15-49 years. It is estimated that approximately half of serious violent crimes are related to alcohol and it is well known that alcohol is a risk factor for suicide through either acute intoxication or through the effects of heavy chronic use, especially among young men. Recent results from the NZ Health Survey demonstrate that Hawke's Bay hazardous drinking levels are still significantly higher than nationally (one in four adults, compared to one in five in New Zealand as a whole) and amongst the highest in the country.

It is also highly important to note the Treaty of Waitangi WAI 2575 Health Services Outcomes Kaupapa Inquiry[4] claim is currently progressing through the Waitangi Tribunal. Stage two will address alcohol or *waipiro* (alcohol was referred to as 'stink water' by Māori) as a key factor driving social, health and economic inequities between Māori and non-Māori. The claim cites a breach of the Treaty of Waitangi as a result of the Crown's failure to enact the recommendations made by the Law Commission report in 2010. In particular, increasing the price of alcohol, raising the drinking age to 20 and restricting alcohol advertising and sponsorship. The claimants objected to the Government failing to ensure the Sale and Supply of Alcohol Act was consistent with the Treaty of Waitangi. This hearing is expected to begin from mid-2019.

NEXT STEPS

1. The Steering Group and programme manager to continue to maintain focus on reducing alcohol harms, while discussing and developing a perspective to broaden its focus to include a range of harms.
2. Continue to progress with Health Hawke's Bay screening and brief intervention programme.
3. DHB leadership to support the continuation of the Alcohol Harms Steering Group (or its equivalent) to oversee progress on Alcohol Harm Reduction Strategy implementation including its structural position within the organisation.
4. Seek input from the Clinical Council and governance groups on how best to implement SBI and achieve health services engagement.
5. Continue to prioritise the target populations as identified within the Strategy (children and young people, pregnant women, Māori, Pacific, high deprivation populations).

[2] King, L., Nutt, D., & Phillips, L. (2010) *Drug Harms in the UK: a multicriteria decision analysis.* The Lancet, Volume 376, 1558-65.
[3] https://www.radionz.co.nz/news/national/364192/higher-alcohol-tax-needed-to-reduce-harm-economist
[4] https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/

RECOMMENDATION

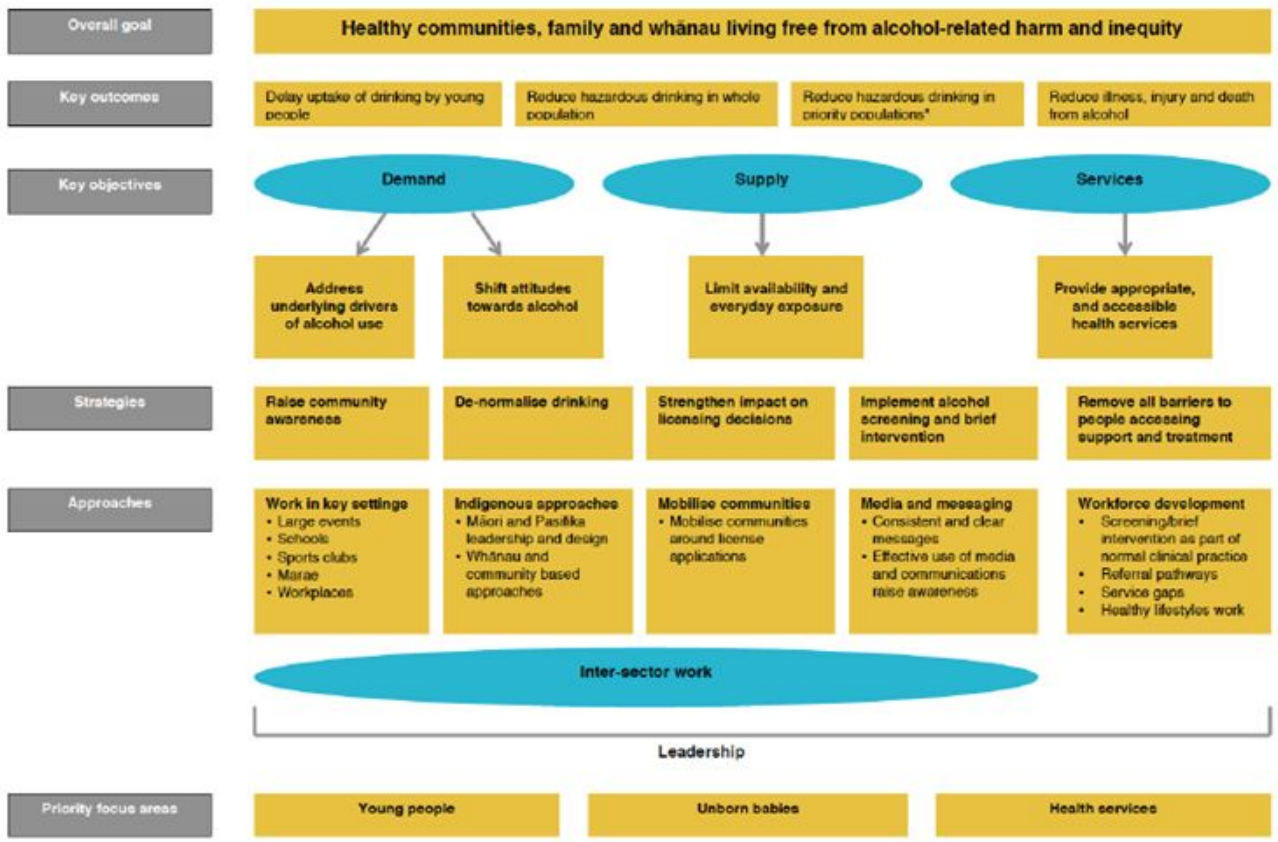
It is recommended that MRB, Clinical Council, Consumer Council and the HBDHB Board:

1. **Note** the substantial activity led by population health.
2. **Note** the new landscape to obtain buy-in from Clinical Services using a broad based social harm reduction approach, especially for screening and brief intervention.
3. **Approve** the next steps.

ATTACHMENTS

- Appendix One: Hawke's Bay District Health Board Alcohol Harm Reduction Strategy 2017-2022
- Appendix Two: Alcohol Harm Reduction Strategy Progress Report Summary Table
- Appendix Three: The place of Alcohol in Schools: Alcohol & Young People Report and Communications Plan (available on request)
- Appendix Four: Hawke's Bay Alcohol Screening & Brief Intervention Survey 2018 Findings (available on request)

Appendix One: HBDHB Alcohol Harm Reduction Strategic Framework and Timeline



* Priority populations: Young people, Māori, Pasifika, Pregnant women

HBDHB Alcohol Harm Reduction Timeline 2016- 2019

Activity	**Date**
"First" DHB alcohol strategy planning workshop with key DHB alcohol stakeholders (subsequently referred to as 'Alcohol Advisory Group')	4 Feb 2016
Second meeting of Alcohol Advisory Group	21 March 2016
Production of video clip to support Position Statement https://vimeo.com/174437689	April-June 2016
Dr Paul Quigley presented to HBDHB Grand Round on screening and brief intervention in the Wellington Emergency Department	May 2016
Professor Jennie Connor and Doug Selman visit to Hawke's Bay on causal relationship between alcohol and cancer	Aug 2016
Presentations to DHB committees (two rounds) including Issues/Discussion paper followed by a draft Position Paper	June-Sept 2016
Fetal Alcohol Awareness Day - awareness raising by HBDHB	Sept 2016
DHB Board adopts Position Statement	Nov 2016
Alcohol Advisory Group reconvened to oversee stakeholder engagement process and strategy development	2 May 2017
Stakeholder engagement process	May/June 2017
Alcohol Advisory Group meeting to review results of stakeholder engagement process	7 June 2017
Stakeholder workshop – stakeholder engagement results and draft strategic framework presented	5 July 2017
Strategy to DHB Committees and Board for approval	July/Sept-2017
Steering Group formed	December 2017

Appendix Two: Alcohol Harm Reduction Strategy Progress Report Summary Table

OBJECTIVE 1: ADDRESS UNDERLYING DRIVERS OF ALCOHOL USE (POLICY, LEGISLATION)		
Progress	**Activity**	**Progress**
	• Submissions focused on policy reform e.g. alcohol advertising, sponsorship and taxation • HBDHB Alcohol & Drug Policy review • HDC alcohol licence applications notification on website	• 5 alcohol specific submissions completed • Policy control group received feedback *Led by Health Improvement & Equity Directorate*
Planned	• HBRC removal of alcohol advertising from public buses and support positive messaging • Ethics of association policy for the DHB to demonstrate leadership • Submit on private Members Bill removing LAP appeal rights (if drawn)	*To be led by Health Improvement & Equity Directorate (primarily Population Health)*

OBJECTIVE 2: SHIFT ATTITUDES TOWARDS ALCOHOL (COMMUNITY INITIATIVES)		
	Activity	**Progress**
Progress	• Mobilising communities project – workshops for communities to learn about the licensing process • Alcohol networks e-newsletter • Social supply community action project *Te Wairoa He Hāpori Haumaru*	• 12 workshops held with range of agencies and/or groups • 4 newsletters, distribution list • Rangatahi programme, whānau hui, alcohol free events e.g. Wairoa Sports awards, Wairoa A& P show *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Community Advocacy Guidelines • Māori wardens project • Samoan Rugby Club initiative • *Te Wairoa He Hāpori Haumaru* Whānau champions project planning • *Pre-testie bestie* localisation campaign	*To be led by Health Improvement & Equity Directorate*

Objective 3: Limit availability and everyday exposure (Settings e.g. schools, events…)		
	Activity	**Progress**
Progress	• Alcohol and schools don't' mix: young people and under age exposure report and presentations including to Secondary School Principals • Port Ahuriri School special licence opposition • Bottle-O new licence opposition • One for One host responsibility campaign at large and small events • Data and public health expertise provided for all territorial authorities developing and negotiating Local Alcohol Policies (LAP) • CEO discussions across territorial authorities, police, MP's, HBDHB executives and Medical Officer of Health regarding the ineffectiveness of the LAP process in limiting harms of alcohol	• Endorsed by Board; Communication & Risk Management Plan • Schools fundraiser guide • National support from Health Promotion Agency, Ministry of Education, Ministry of Health, Children's commissioner, Primary Principals Association (HB) Chair • One for One collateral accessible and promoted as part of the host responsibility licensing process • Wairoa District Council LAP in draft; Central HB LAP approved; Hastings and Napier LAP appealed, negotiations underway *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Alcohol free events project (Joint Alcohol Strategy Project- NCC / HDC)	*To be led by Health Improvement & Equity Directorate (primarily Population Health)*

Objective 4: Providing appropriate and accessible health services		
	Activity	**Progress**
Progress	• Steering Group formed, Terms of Reference agreed priority to focus on health services response to alcohol harm reduction • Screening & brief intervention survey • Health Hawke's Bay refreshing dashboard for general practice screening and brief advice • Working with Maternity services to review the Alcohol & pregnancy "*top 5 for my baby to thrive'* messaging to include zero alcohol	• 5 meetings since Dec 2017. Inconsistent chair / leadership during this time • Survey findings shared with Steering Group, inform future activity • Updated messaging, to be socialized *Led by Health Improvement & Equity Directorate (primarily Population Health)*
Planned	• Primary care screening & brief intervention workforce development plan – delivered in the community • Communication plan to ensure consistent messaging across health services • Alcohol Activation Wall 'ease up on the drink' campaign • Potential for health practitioner awareness raising campaign such as Dry July, Sober October	*To be led by Health Hawke's Bay* *To be led by Health Improvement & Equity Directorate (primarily Population Health)* *To be led in partnership between Health Improvement & Equity Directorate (primarily Population Health) & Emergency Department* *To be led by People and Quality with Health Improvement & Equity Directorate support*

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:

20. Minutes of Previous Meeting (Public Excluded)
21. Matters Arising – review of actions
22. Consumer Council's Board Report
23. 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).