Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 11 May 2017**

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:

Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Dallas Adams
Kylarni Tamaiva-Eria
Jim Morunga
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Rachel Ritchie
Sarah Hansen
Sami McIntosh

Apologies:

In attendance:

Kate Coley, Executive Director People & Quality (EDP&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to EDP&Q
Jeanette Rendle, Consumer Engagement Manager
Debs Higgins, Clinical Council Representative
Linda Dubbeldam, Health Hawke's Bay Representative

HB Health Consumer Council
Agenda

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.	Chair's Report (verbal)	
8.	Consumer Engagement Manager's Report (verbal)	
9.	Youth Consumer Council Report (verbal)	
	Section 2 – For Discussion	
10.	Final Draft Annual Plan 2017 (presentation) – Tracee TeHuia and Carina Burgess	4.30
11.	Clinical Services Plan (presentation) – Tracee TeHuia	4.45
12.	Health Literacy Principles & Implementation – Kate Coley and Adam McDonald	5.05
13.	Membership Update – Ken Foote	5.20
14.	Recognising Consumer Participation – Jeanette Rendle	5.35
15.	Consumer Engagement Strategy Final – Kate / Jeanette	5.45
	Section 3 – For Information only – no presenter	
16.	Establishing Health and Social Care Localities in HB	-
17.	Consumer Experience Feedback Quarterly Report (Oct-Dec 2016)	-
18.	Best Start Healthy Eating and Activity Plan – Yearly Review	-
19.	Te Ara Whakawaiora / Cardiology (national indicator)	-
20.	Annual Maori Health Plan (Dashboard) Q3 Jan-Mar 2017	-
	Section 4 – General Business	
21.	Topics of Interest - Member Issues / Updates	5.55
22.	Karakia Whakamutunga (Closing)	

NEXT MEETING: Thursday 15 June 2017 at 4 pm

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

Interest Register

Hawke's Bay Health Consumer Council

Apr-17

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**
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	
	NZ Sustainable Business Council	Deputy Chair	Sustainable Development	No	
	HB Diabetes Leadership Team	Chair	Leadership group working to improve outcomes for people in HB with diabetes	No	Group is sponsored by HBDHB
	Advancing life cycle management thinking across NZ	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
	U Turn Trust	Trustee	Relationship and and may be contractural from time to time	Yes	Could be a perceived conflict, however will not take part in any discussions relating to any contract matters if these arise.
	Integrated Pharmacist Services in the Community (National Committee)	Steering Group Member	Health and wellbeing	No	
Rosemary Marriott	YMCA of Hawke's Bay	President	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.			No	
	Age Concern Hawke's Bay	Board Member		No	
	Positive Aging Trust	Committee Member		No	
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.

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**
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
Jim Morunga	Nil				
Malcolm Dixon	Hastings District Councillor Sport Hawke's Bay Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Board of Trustees Allocation Committee Hastings District Council Rep	Non paid role	No No No No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE ON 9 MARCH 2017 AT 4.00 PM

PUBLIC

Present: Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Jim Morunga
Jenny Peters
Olive Tanielu
James Henry (4.10 pm)
Sarah Hansen
Rachel Ritchie
Dallas Adams
Kylarni Tamaiva-Eria

In Attendance: Ken Foote, Company Secretary
Jeanette Rendle, Consumer Engagement Manager
Debs Higgins, Clinical Council Representative
Tracy Fricker, Council Administrator and EA to Executive Director - People & Quality

Apologies: Sami McIntosh and Malcolm Dixon

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

The Chair welcomed everyone to the meeting. Tessa Robin provided the Karakia. The Chair advised that Deborah Grace, Chair of PAG is an observer at today's meeting.

2. APOLOGIES

The apologies as above were noted.

3. INTERESTS REGISTER

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

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 9 February 2017 were confirmed as a correct record of the meeting.

Moved and carried.

Jenny Peters commented that at a previous meeting she had asked under the Orthopaedic Review for more explanation of how the DHB was going to get its threshold potential to health standards.

The Chair advised the orthopaedic reports have been provided by Andy Phillips, Chief Allied Health Professions Officer in previous meeting papers.

Action: ***Orthopaedic review papers to be re-sent to Jenny Peters.***

5. MATTERS ARISING AND ACTIONS

Item 1: ***Topics of interest / member issues / updates***

Question raised regarding change to start of visiting hours from 1 pm to 2 pm. Jeanette Rendle advised that the visitor policy is due for review and visiting times can be looked at as part of this work. As part of the review we will have some consumer and staff feedback groups. Jeanette invited Rosemary Marriott to be part of the policy review. *Item can now be closed.*

Item 2: ***Te Whakawaiora / Access (local indicator)***

The Chair advised that he discussed this report with Drs Peterson and Wills. Other groups had feedback about this report. There will be some significant improvement in this report for the next quarter including more information on what is working and what is not working. *Item can now be closed.*

The Chair had a conversation with Barbara Arnott following the Board meeting and raised the Consumer Council's concerns about the lack of connection with the Pacific Health Leadership Group (PHLG). Ken Foote, Company Secretary advised that the PHLG is a governance group which reports to the Board to advise them on pacific issues. The concerns raised have been noted and will be discussed outside of this meeting. *Item can now be closed.*

Item 3 ***Tenure List for Members***

The tenure list was sent out to members with the February meeting minutes. The Chair advised that membership renewal will be disused under item #12 on today's agenda. *Item can now be closed.*

6. WORK PLAN

The Chair advised the work plan is included in the meeting papers for information.

Jenny Peters noted that the Red Cross will assist patients with transportation to appointments as will the Cancer Society for those patients with cancer treatment appointments. People may not be making the best use of these services that are available. The Chair advised that feedback on this should be sent to Andrea Bettie who leads the GoWell Travel Plan work. Contact email: andrea.beattie@hbdhb.govt.nz.

7. CHAIR'S UPDATE

The Chair thanked those members who were involved in the Executive Director interview panels last Thursday and Friday. The announcements regarding these appointments are due this week.

The Chair has also been involved with the community pharmacy national contract negotiations. The DHBs spend collectively around $400M each year on this contract. They are trying to transform the way the contract works, similar to that with the PHO and aged residential care.

The Chair did a quick round the table survey asking the two following questions:

- When I pick up a new prescription from the pharmacy I receive proactive advice from the pharmacist on what I am taking?

- When I pick up a repeat prescription from the pharmacy, I receive proactive advice from the pharmacist about what I am taking?

It is interesting what the perception of the pharmacists at the negotiating table think happens and what actually does.

8. CONSUMER ENGAGEMENT MANAGER'S UPDATE

Jeanette Rendle, Consumer Engagement Manager advised that the Quality Accounts have been printed and sent out and she has copies for each member.

Parking exemption forms are also available for members to complete and return and she will organise parking permits.

SECTION 2: FOR DISCUSSION

9. HB PALLIATIVE CARE STRATEGY (FINAL)

The Chair welcomed Mary Wills, Head of Strategic Services, Dr Martyn Horsfall, Cranford Hospice, Karen Franklin, Clinical Services Manager, Cranford Hospital and Dr Emma Merry, Palliative Medicine.

Mary Wills provided an update on the changes to the document since it was last presented to the Consumer Council. A number of workshops and meetings have been held with primary care, palliative care stakeholders and consumers in rural areas. A meeting is still to be held with Wairoa consumers, this is being organised prior to the Board meeting at the end of the month and this feedback will be incorporated in the draft document.

The key changes to the document are:

- Changing the name to emphasise early intervention and "Living Well"
- A clearer focus on equity
- Describing the role of primary care and the relationship with specialist services
- The implementation plan will use the feedback from consumers and rural areas to inform the detailed action plan
- Outcomes measures have been changed to enable the ability to measure them
- Patient engagement and feedback measures

It was noted that timeframes for implementation will be determined by the National Palliative Care Strategy, the Healthy Ageing Strategy and budget announcements in May.

Feedback:

- Terminology advance care planning and advance care plan could be confusing (page 25).
- Pleased to see that the Aged Residential Care Resource Nurse position has increased from 0.6fte to 1.2fte. Some staff in aged residential care think that palliative care is only for cancer patients, not realising they can call on palliative care for help.
- Need the ability to capture feedback from aged residential care, other providers, people in their homes the hospital etc. This is one of the challenges we have there is not one system for capturing this information. There is a recommendation in the strategy to have one information system across primary and secondary.
- Good to see previous feedback included into this document. Concern is the continuity of care. The care provided in the hospice is amazing for the patient and whanau, the home care can be restrictive due to the needs of the whanau, the care in the hospital was needing improvement and did not have that continuation of care between the hospice and hospital. This is written in the strategy under the actions required. Need to see the action happening.

- The outcome measure about increasing the Maori workforce. It should be about having the best workforce. If the intent of this is about working effectively with people from a cultural perspective then this should be challenged, as everyone should be treated the same and best regardless. Mary Wills noted there is also a challenge with our workforce and the reason for this target is the low number of Maori working in palliative care. We still want to have a quality workforce. In regard to age, we need to plan for our aging workforce in nursing and GPs, we need to plan to bring new people through
- No mention of the aging in the community projects in the strategy. Can this be referenced in the document
- One of the challenges in the hospital is that the RMO workforce is consistently changing and what training/education/support is around for this workforce? Dr Merry advised that she has been involved with training for a number of years building on what they learn in medical school. There is training they do before they get to the professional paid workforce. We provide ongoing interactive training, a lot of what they learn is by experiencing and observing their senior colleagues managing patients who are at their end of life. Senior doctor's role model good practice. Dr Horsfall also advised that five year medical students visit Cranford for 1:1 teaching and observation. The Medical Council has also identified that it is important for RMOs in their first two years to spend time in a community attachment and we are keen that we establish that between the Cranford and the hospital palliative care team so they get that exposure.

The changes to the strategy were noted and the HB Palliative Care Strategy was **endorsed** by the Consumer Council.

10. ANNUAL PLAN 2017/18 (DRAFT)

The Chair advised that the annual plan is currently in draft. Feedback should be provided to Carina Burgess, Head of Planning at: carina.burgess@hbdhb.govt.nz. There was a brief discussion about the budget at the Clinical Council meeting yesterday. The DHB will not know what budget will be available until May.

Feedback:

- Query regarding the gaps on pages 56-57 – bowel screening, mental health and healthy aging. This should be raised with Carina Burgess.
- What has changed since last year? One key addition is the supporting vulnerable children target with KPIs now included
- Find the document difficult to read and the size of the font too small. Could they have had a summary instead of this document? The Company Secretary advised that this is a compliance document and follows the Ministry template. A group will look at developing an action plan and a two page summary document.

The Consumer Council noted the content of the draft report and timeline and **endorsed** the draft annual plan.

11. CONSUMER ENGAGEMENT STRATEGY (FIRST DRAFT)

The Chair advised that this is the first draft of the document, the audience is the health sector and the strategy is a starting point.

Jeanette Rendle, Consumer Engagement Manager advised that the strategy sets a foundation for the work ahead. The audience is the sector, and it is a document that services can refer back to. It is not a detailed work plan but it does set out what the work plan will involve. We would like feedback on the strategy and the elements of the work plan. Are the priorities right, is there anything missing?

Feedback:

- Introduction page needs to be formatted better, the author, who the document is for etc. The document is too long, needs to be a more accessible length
- The definition of health literacy needs to be updated, check www.healthliteracy.co.nz
- The document was not clear or concise on who the intended audience was
- Suggestion that the front of the document includes a summary on what it is for, key outcomes and also includes a timeline on how we got to this point, then focus on the key strategies yet to be done and tools for people working in the sector
- We know what we want to achieve but putting into a document that the sector can use is difficult and may take a couple of goes. This is new, it is a good starting point
- Words are easy, it is the actions. It is interesting that we need to know how to interact with each other. All parties are responsible
- Commend that the DHB is trying to help to guide staff to engage better
- If staff lived the values, we would have better engagement with consumers
- Flaw in the system, respect for technology. The tools are there but are not being used appropriately. Having to repeat the same information multiple times is frustrating for consumers
- Not every staff member requires a strategy to deal with their behaviour. You need to identify the staff that need to engage better rather than blanketing it. There are many staff out there that do a wonderful job already
- Technology can work when its used appropriately
- Under challenges consumers don't always know what they are not getting, or if perceived problems are worth mentioning. What is important is having conversations with consumers so staff get the whole picture.

12. CONSUMER COUNCIL MEMBERSHIP RENEWAL

The Chair advised that his term as Chair is up and will be extended for a few months and there are also five current members whose term expires in June. The expectation is there will be a public recruitment process for the recruitment of the chair and members. Those members who wish to renew are encouraged to put themselves forward. The process with recommendations is currently with the Chief Executive Officer. This change is not a reflection on the Chair or the current members.

The Company Secretary advised that when the Consumer Council was set up it was the intention to get stability and the foundations laid. In the Terms of Reference there are two year appointments with a maximum of three terms (six years in total) for members. It is now appropriate to broaden the profile of this group through a more public process and this year is the first year we will do this. As the Chair advised, this is no reflection on the current members it is part of a democratic process; the Board is subject to elections every three years. We don't want wholesale changes if we can avoid it. It is a way to ensure we refresh this group with new faces and acknowledge and value the experience gained from those who have been sitting around the table for a while. We want to maximise the exposure of this group to the general community.

The Chair commented that there are also opportunities to be involved with other groups for the consumer voice in the health sector, not just the Consumer Council. Part of the consumer engagement strategy is to develop a register of people and their topics of interest who want to be involved in service and directorate level activities. The Chair advised that once the knows what the Chief Executive Officer's decision on process is, he will send out to the group.

SECTION 3: PRESENTATION

13. ADULT INPATIENT EXPERIENCE SURVEY RESULTS (Q4: OCT-DEC 2016)

Jeanette Rendle, Consumer Engagement Manager provided a presentation on the national survey results and Hawke's Bay District Health Board's for the fourth quarter.

The survey was developed by the Health Quality & Safety Commission and all DHBs take part. It is a random survey sent out to 400 patients each quarter. The information is collated on a national level and the DHBs are sent individual commentary which can be used for their own purposes, which can be more useful than the scores.

A report will be provided each quarter on the survey results and also consumer feedback received during the quarter.

SECTION 4: INFORMATION ONLY

14. TE ARA WHAKAWAIORA / BREASTFEEDING (NATIONAL INDICATOR)

The Te Ara Whakawaiora / Breastfeeding (national indicator) paper was included for information only. No issues discussed.

15. TRAVEL PLAN UPDATE

The Travel Plan report is an update on progress since the previous report in November 2016. It was noted that the patient car park has between 30-50 free spaces each day. Positive feedback has been received from patients/visitors. Some issues with staff but progress is being made.

16. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***Rachel Ritchie*** – Following the Executive Director – Primary Care interview panel on Thursday it was insightful on what they are looking for. Would like to see more consumer council members on these panels.

- ***Rosemary Marriott*** – Totara Health do not have any youth members on their consumer panel and she enquired if the youth council members had someone from their group that could attend.

- Reminder to members to send their response to the invitation to the Health Sector Leadership Forum on 15 March to Brenda Crene, Board Administrator.

17. KARAKIA WHAKAMUTUNGA (CLOSING)

The Chair thanked everyone for their attendance and input.

The meeting closed at 6.10 pm.

Confirmed: _____
Chair

Date: _____

5

HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising
Reviews of Actions

Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	9/03/17	***Previous Minutes*** • Question raised by Jenny Peters re: orthopaedic threshold to health standards. Papers to be resent to Jenny.	Admin	March	Actioned
2	9/03/17	***Annual Plan 2017/18 (Draft)*** • Feedback on plan to be sent to Carina Burgess	All	?	
3	9/03/17	***Topics of Interest / Member Issues/ Updates*** • Rosemary Marriot enquired whether the Youth Council members could raise in their group if there was interest for someone to be part of the Totara Health consumer panel.	Dallas Adams / Kylarni Tamaiva-Eria	March/April	

OURHEALTH HAWKE'S BAY Whakawateatia

HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

Meetings 2017	Papers and Topics	Lead(s)
14 Jun	Youth Health Strategy Update for information Consumer Experience Results (qtly) Social Inclusion ***Monitoring (info only)*** Te Ara Whakawaiora / Oral Health (national indicator)	Nicky Skerman Kate Coley /Jeanette Tracee TeHuia -
12 July	Quality Accounts (draft)	Kate Coley / Jeanette
10 Aug	People Strategy (2016-2021) final Quality Annual Plan – Annual Review 2015/16 year Clinical Pathways Update	Kate Coley Kate Coley Leigh White
6 Sept 9am-3pm	**HB Health Sector Leadership Forum, East Pier, Napier**	
14 Sept	Orthopaedic Review – phase 3 draft Quality Accounts (Final) Quality Annual Plan 2017/18 year Consumer Experience Results Qtly ***Monitoring (info only)*** Te Ara Whakawaiora / Healthy Weight Strategy TBC	Andy Phillips Kate Coley /Jeanette Kate Coley Kate Coley /Jeanette
12 Oct	People Strategy Quarterly Report Health and Social Care Localities in HB	Kate Coley Tracee TeHuia
9 Nov *With Clinical Council*	Tobacco Annual Update against Plan ***Monitoring (info only)*** Te Ara Whakawaiora / Oral Health TBC	Tracee TeHuia / Johanna Wilson
7 Dec	Work in progress	

CHAIR'S REPORT

Verbal

CONSUMER ENGAGEMENT MANAGER'S REPORT

Verbal

YOUTH CONSUMER COUNCIL REPORT

Verbal

DRAFT ANNUAL PLAN 2017/18

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Services Plan Introduction**
	For the attention of: **Māori Relationship Board, Clinical Council, Consumer Council**
Document Owner: Document Author(s):	Tracee Te Huia – Executive Director Strategy and Health Improvement Carina Burgess – Head of Planning Sapere Research Group
Reviewed by:	Clinical Services Plan Steering Group
Month:	May, 2017
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical Council and Consumer Council:

1. Note the final Terms of Reference for the Clinical Service Plan Project
2. Note the approach to be taken by Sapere Research Group

OVERVIEW

Sapere Research Group, on behalf of the Hawke's Bay District Health Board are developing an integrated Clinical Services Plan covering the Hawke's Bay health system to align service delivery with current and projected population need, and to make the most effective use of available and future resources.

The project will explore service delivery in primary, community, and hospital settings. Opportunities will be identified to reduce hospital demand, reduce time spent in hospital and improve the patient flow through the system with a focus on improving health outcomes and health equity.

The plan will be realistic and implementable in Hawke's Bay within funding projections.

The plan will be developed "bottom up" from the patient's perspective. That is starting from how our population's requirements are met through supported self-care through to Primary Care, then moving into more expensive and specialist services and interventions, that is sequentially from community to local hospital and then to "out of area" hospital services.

FURTHER INFORMATION

The Terms of Reference for the Project are attached in appendix 1 and Sapere Research Group will be in attendance to give more insight into the approach they plan to take to develop a Clinical Services Plan that meets the requirements.

APPENDIX 1: CLINICAL SERVICES PLAN TERMS OF REFERENCE

HAWKE'S BAY District Health Board Whakawāteatia

Project Terms of Reference

Project Details

Project Name:	Clinical Services Plan
Version:	2.0
Date:	May 2017
Document Storage Address:	TOR_Clinical Services Plan_v2.0.docx
Template Version:	V0.2_Dec2016
Senior Responsible Owner:	Kevin Snee Chief Executive Officer
Project Sponsor:	Tracee Te Huia Executive Director of Strategy and Health Improvement
Author:	Tim Evans, Executive Director of Corporate Services Carina Burgess, Head of Planning
Reviewed By:	Executive Management Team

Authorisation

This document authorises the Project Manager to undertake the delivery of this project. There can be no changes to this document without Project Sponsor sign off of any amendments. This is a formal written process utilising the HBDHB project templates and procedures for change control.

Kevin Snee		
Senior Responsible Owner	Signature	Date
Tracee Te Huia		
Project Sponsor	Signature	Date
Carina Burgess		
Project Manager	Signature	Date
Kate Rawstron		
Project Management Office Manager	Signature	Date

1. Background / Business Case Outline

The District Health Board is on the threshold of a further step in its development. In our first step we recovered from a period of financial, and governance turmoil to achieve relative stability through a 3 year “Revitalisation” programme. In our second step we opened up to innovation and shifted our perspective to integration and the wider health system with a 5 year “Transform & Sustain” strategy. As we move into the second half of Transform and Sustain and look forward to our next strategic horizon we want to establish a clear long term clinical plan.

The first two steps have given the Hawkes Bay Health sector a sound platform to move forward with experienced leadership, transformed clinical and consumer engagement, a sound balance sheet, novel and effective governance structures, and a track record of tangible achievement.

This Clinical Service Plan will be a lynchpin for further progress and increasing system maturity. It will be consistent with Ministry of Health planning requirements, and will underpin and enable long term financial, capital investment, and Human Resource plans.

The approval for this project was provided by EMT and the final Plan will be approved by the Board

2. Project Goal

This project will deliver an integrated Clinical Service Plan covering the Hawke’s Bay health system to align service delivery with current and projected population need, and to make the most effective use of available and future resources. The project will explore service delivery in primary, community, and hospital settings. Opportunities will be identified to reduce hospital demand, reduce time spent in hospital and improve the patient flow through the system with a focus on improving health outcomes and health equity.

The plan must be able to be realistically implemented in Hawke’s Bay within funding projections. We do not want a proposal that is not evidence based, realistic and implementable.

The plan will be developed “bottom up” from the patient’s perspective. That is starting from how our population’s requirements are met through supported self-care through to Primary Care, then moving into more expensive and specialist services and interventions, that is sequentially from community to local hospital and then to “out of area” hospital services.

3. Scope Inclusions

We anticipate the following to be described in the plan:

- Current position of capability and capacity of services through document review, interviews/ workshops and analysis/ assessment
- Assess possible capability and capacity of services given the current models of service
- Research international, regional and national models of care and trends in clinical practice. Assess the options for adapting these to HBDHB environment.
- Develop and consult on a draft clinical services plan, engaging buy in through the process
- Finalise the clinical services plan and present the plan to required forums and committees, including HBDHB Board.

Project Scope

No.	Objectives	Deliverables / Outputs
1.	To describe our current position of capability and capacity of services through document review, interviews/ workshops and analysis/ assessment.	Detailed stocktake document. Summary included in Final Clinical Services Plan.
2.	To assess capability and capacity of services given the current models of service	Excel or equivalent Demand Forecast model Summary Included in Final Clinical Services plan.
3.	To research and document international, regional and national models of care, and trends in clinical practice. To assess the options for and benefits of adapting these to the HBDHB environment.	Documented literature review of models and trends. Summary included in Final Clinical Services Plan.
4.	To develop and consult on a draft clinical services plan, engaging buy in through the process	Documented interviews with stakeholders. Documented Patient journey workshops. Documented Stakeholder workshops. Summary included in Final Clinical Services Plan.
5.	To develop the costings for the plan which demonstrates that it can be delivered within reasonably anticipated financial resources	Costings documented and achievable Test the plan against the Three E's of VFM
6.	To achieve approval for the finalised Clinical services plan	Presentations on the plan to appropriate forums and committees, including HBDHB Board.

4. Scope Exclusions

This exercise is about developing a plan, not implementing it. It will almost certainly be necessary to implement through a number of follow on projects in specific disease pathways.

5. Benefits

Successful completion of this project is expected to result in the following high level benefits:

Project Benefits

No.	Benefit	Measure (KPI)
1.	A plan for clinical services which can be used as a blueprint for a number of consequent detailed service redesigns and implementations.	Endorsement of the plan by Clinical Council. Endorsement of the plan by Consumer Council. Delivery of top priority detailed plans.
2.	A plan for clinical services which is economic, efficient, effective, and affordable.	Overall costing of the plan which demonstrates that it can be delivered within reasonably anticipated financial resources. Test the plan against the Three E's of VFM.
3.	A plan for clinical services which is underpinned by evidence for better quality service.	Test the plan against the TEPEES Quality dimensions.
4.	A plan for clinical services which is underpinned by evidence for improved population health.	Test the plan against key requirement from the Health Inequity report.
5.	A plan for clinical services which evidences: • Clinical Council engagement • Wider clinical and staff input • Consumer experience input, and • Consumer Council engagement • Consideration of inequity, and • Maori Relationship Board engagement.	Check the plan for evidence of these inputs and engagements.
6.	A plan for clinical services which is consistent with this health sector's values and mission.	Test the plan against the mission statement and our 4 values.

It is important to note that benefits are constrained by the fact that this is an enabling exercise. The Plan in itself does nothing. In theory we could secure a very good plan, do nothing with it, and realize no benefits.

It is only implementation, probably requiring a number of consequent projects that will deliver real benefits in terms of population health, better outcomes, and better value.

6. Strategic Alignment

Successful completion of the project will enable significant improvements across the Triple Aim as follows:

Triple Aim Outcome Profile

Aim	Measure
1. Best Quality Care	Test the plan against the TEPEES Quality dimensions.
2. Better Health and equity	Test the plan against key requirement from the Health Inequity report.
3. Best Value for system resources	Test the plan against the Three E's of VFM.

7. Assumptions and Constraints

Assumptions

- All required participants will engage and will fully participate as required
- There will sufficient data available to complete initial analysis

Constraints

- Availability of data and analysis
- Availability of Clinical Staff / Participants
- Financial resources

8. Project Interdependencies

- The CSP will be consistent with National and Regional health strategies.
- The CSP will provide a platform for our strategic plan following on from "Transform & Sustain".
- The CSP will form a base for the development of underpinning plans for Finance, Human Resources and Capital Investment.

9. Delivery Approach

Quality coordination and support for delivering an agreed Clinical Services plan

The approach is based around data rich discussions with front line Hawke's Bay health staff, patients, and population and starting in primary and community first.

In the first stage, data and trends will be presented to clinicians in primary and secondary care with a view to establishing issues and challenges as well as the likely future implications of current models of care.

The second stage will challenge those models of care with patient journey workshops and structured discussions around key issues in service delivery. Integrative workshops will bring stakeholders together to discuss, challenge and validate the themes and the possible

directions. Finally, possible future directions will be discussed and alternative ways of organising the local health sector discussed.

A change process of listening, reflecting and challenging that is most likely to support any future change in direction underpins the approach.

The project oversight process you will follow HDBHB Project Management methodology which is based on PRINCE2 principles.

10. Project Timeline

No.	High Level Milestone	Estimated Date of Completion
1.	Project Start Up and Initiation – Management confirms mandate for project – HBDHB appoints project sponsor and project manager – Project Manager works with Project Sponsor to develop final TOR document for sign off – Steering Group formed and introduced to the project TOR agreed – Team engaged - Prepares detailed plan for project	May 2017

2.	Preparatory work: Desktop review of documents including relevant strategies, reports and working papers	May 2017
3.	Understanding the current state. a. Quantitative analysis of service data b. Forecasting demand c. Semi-structured interviews with stakeholders d. Report on current state	May 2017
4.	Challenging the status quo. a. Patient journey workshops b. Review and workshop material with clinical leadership group	May, June, July 2017
5.	Transforming the sector. a. Integrate quantitative forecasts and opportunities for change identified from patient journeys and current state interviews. b. Additional modelling as appropriate to explore impacts of options on workforce *c. Additional modelling as appropriate to explore cost impacts and affordability.* d. Stakeholder engagement in priorities and scope for change. e. Prepare draft clinical services plan including priorities for change and investment.	August, September, October, November 2017
6.	Formal acceptance. a. Present and explain Clinical Service Plan to District Health Board, and other governance bodies as required. b. Achieve formal adoption and endorsement.	December 2017
7.	Project closure - Project completion evaluation prepared including Benefits Realisation Assessment - Project completion Evaluation signed off - Administrative closure of project completed	February 2018

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11. Financial Profile

Cost Type	Itemised Description	Planned Cost$	Budget Source
Senior Responsible Owner	Kevin Snee	$0	Prioritised in established FTE so opportunity cost.
Project Manager	Carina Burgess	$0	Prioritised in established FTE so opportunity cost.
Operational support team	CEO's EA and administration support Named Management Accountant Named Business Intelligence analyst	$0	Prioritised in established FTE so opportunity cost.
Project delivery	External consultancy - Sapere	Around $280k	Budgeted for 2016-18
Project engagement	Time for Clinician and Consumer engagement.	TBA	Some prioritised in established FTE so opportunity cost. Some (TBA) likely to be extra cost for backfill/ attendance.
TOTAL		**Around $280k**	

12. Engagement

The project will use one to one meetings, workshops, patient journey events, existing Executive management team, Clinical Council, Consumer Council, Maori Relationship Board, and District Health Board meetings to ensure appropriate clinical and consumer input is received during the identification of service requirements, in the approval of outputs and to validate outcomes:

The project team will ensure appropriate engage with consumers and providers during the life of the project to better understand their needs and cultural requirements of the project.

13. Communication Management

During the early initiation of the project, the Project Manager will ensure the development of an appropriate communication plan to guide communication with stakeholders throughout the project. This will include:

- Identification of all stakeholders and an analysis of their stake in the project.
- Key communication points and methods with all stakeholders as well as responsibilities for that communication management

14. Reporting

The Project Manager will provide monthly project progress reports to the Project Sponsor (cc. HBDHB Project Management Office) using the HBDHB template

15. Issue and Risk Escalation

Risks and issues will be managed in accordance with the processes and procedures specified by the HBDHB Project Management Office:

- The Project Manager will notify the Project Sponsor of all issues and risks that cannot be managed within the Project Manager's delegated authority – this will be in a timely way

16. Risk Management

The purpose of the risk management system is to effectively and efficiently manage project risk in order that project deliverables may be met within plan. A separate risk register is maintained during the project lifecycle as a living document.

Preliminary Risk Analysis:

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
If key clinical participants are not available to attend workshops/ meetings then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Forward planning and scheduling (e.g. 8 weeks in advance) 2. Effective communications planning 3. Build in 'value' for the participants where possible 4. Consider incentivising attendance
If communications are not clear and/or delivered in a timely fashion then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Effective, upfront communications planning 2. Use of multiple channels i.e. Face to face meetings 3. Clinical Leadership
If data is not available / made available as required then the quality of analysis will less robust impacting on decision making and the overall quality of the CSP	Med	High	1. Early engagement with BI team 2. PHO to take lead with GPs
If Primary Care / NGOs are not bought into the vision then the project will not achieve the necessary engagement required to successfully meet the desired outcomes	High	High	1. Build vision and engagement 2. Clear / timely comms regarding how the process will work (e.g. who will be involved and when) 3. Integrated planning
If stakeholder expectations around the scope & purpose of the project are not well managed then this may result in delays, stakeholders disengaging and project seen as unsuccessful.	Med	High	1. Clearly define project purpose and scope managed under change control 2. Effective communications action plan 3. Agreed up-front who will be involved (e.g. how wide the engagement will be)
If stakeholders view this plan as unwelcome change, retain entrenched views or are unable to agree then decision making may be stalled and as result 'standed' MOC developed	Med	Med	1. Effective, upfront communications planning and deliver of action plan 2. Clinical Leadership 3. Change Management planning 4. Effective project governance

If we do not identify and manage the potential challenges from CSP on in-flight activity (e.g. H&SCL) appropriately then we will lose the integrated 'Health System' view and benefits will not be fully realised.	Med	High	1. Integrated planning approach 2. Effective dependency management 3. Communication around potential impacts and need to remain flexible
If we do not ensure the reduction of equity is a theme within the CSP then we will not support our strategic intention and fail to realise full benefits	Med	High	1. Build into planning and approach e.g. Patient Journey 2. Selection of appropriate workshop participants
If the CSP is not aligned to our current and future financial resources then the plan developed is unlikely to be feasible/ sustainable resulting in a CSP that cannot be fully implemented	Med	High	1. Benefits realisation planning
If the impact on the workforce is not well understood then the plan developed may not be feasible/ sustainable resulting in a CSP that cannot be fully implemented	High	High	1. Representation of ED People & Quality on Steering Group 2. Benefits realisation planning
If we do not identify and plan for the transition of IP, techniques and tools effectively then the value of the CSP and process will not be fully realised and maintained going forward	Med	High	1. Effective transition planning 2. Training identified
If the competing priorities (i.e. clinical workloads) are not managed appropriately then this may result in significant delays to the delivery of the CSP and further planning developments (e.g. Long Term Investment Plan).	High	Med	1. Communication and early planning 2. Flexibility of consultant support

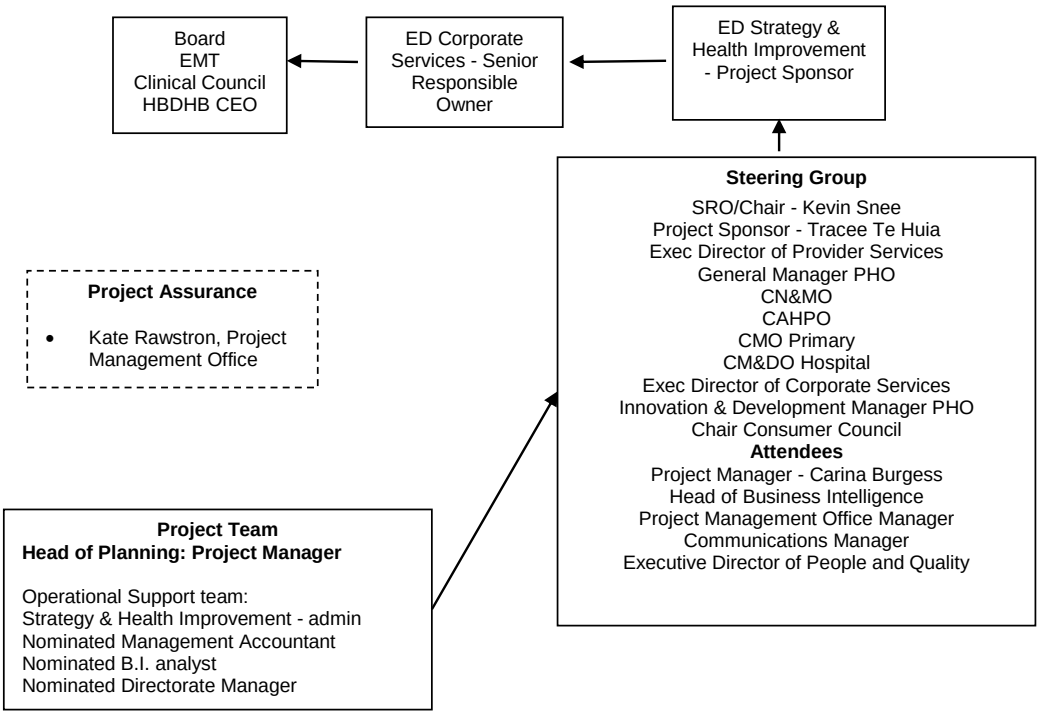
17. Quality Management

Project activity and deliverables will be consistent with:

- The agreed TOR for the project and work streams
- HBDHB Project Management Standards
- HBDHB Capital Investment Policies
- Relevant mandatory and industrial Health and Safety Standards
- HR Policies and Procedures
- Building Codes and Requirements
- Best Practice Contract Management
- Best Practice Change Management and Communication
- Generally accepted accounting practice (as defined in the Crown Entities Act 2004)
- Electronic transactions to comply with e-government standards
- Integration of systems with existing and future intended infrastructures.

All deliverables will undergo appropriate quality control and customer acceptance procedures.

18. Project Management Team Structure



Appendix 1: Project Role Descriptions

Senior Responsible Owner

- EMT Conduit and support for Project Sponsor
- Provides active support and leadership if required
- Resolves issues at Executive level

Project Sponsor

- ACCOUNTABLE for project delivery
- Acts as line manager for the Project Manager in relation to the project
- Escalates issues to the Senior Responsible Owner so no surprises
- Ensures expectation for delivery and outcomes are translated into the project plan
- Enables resources for the project
- Ensures resolution of barriers to progress

Clinical Lead

- Chief Medical Officer (Hospital).

Steering Group

- Represents those who will use the deliverables of the project to realise the benefits after the project is complete
- Works together with the Project Sponsor to resolve strategic and directional issues within the project which need the input and agreement of senior stakeholders to ensure the progress of the project.

Consumer Rep

- Chair of Consumer Council.

Project Manager

- Plan, delegate, monitor and control all aspects of the project
- Motivation of those involved to achieve the project objectives within the expected performance targets for time, cost, quality, scope , benefits and risks

Project Delivery Resources

- Completes tasks as required
- Works to agreed timeframes
- Report progress and elevates issues in a timely way
- Effective team member demonstrating pro-active and constructive problem solving

Project Management Office

- Provides pro-active project *assurance input* to support the project to use best practice processes to create the deliverables and appropriately follow the project management processes

HAWKE'S BAY District Health Board Whakawāteatia	**Health Literacy Principles & Implementation Approach**
	For the attention of: **Health Literacy Steering Group, Executive Management Team, Māori Relationship Board, HB Clinical Council, HB Consumer Council and HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Adam McDonald, Health Literacy Advisor
Month:	May 2016
Consideration:	For information

RECOMMENDATION

That the respective committees noted above:

- Note the Health Literacy principles for the Hawke's Bay health sector
- Note the summary of the Quigley & Watts review report (Appendix 1 & 2). Full copy of report Appendix 3.
- Note the proposed action plan for the development of a set of health literacy products, tools and guidance/advisory to support the implementation of the health literacy principles

PURPOSE

The purpose of this paper is to provide a summary of the work that has been undertaken to date in regards to health literacy, a review of the report provided by Quigley & Watts (Q&W) and to outline the approach and programme of work to begin the implementation of the health literacy principles.

EXECUTIVE SUMMARY

The focus is to create a health literate Hawke's Bay health sector and an empowered and health literate population. This will be achieved through:

1. Reducing the health literacy demands and complexities that the health system places on people to obtain, understand and use health services and information.
2. Increasing the skills and abilities of people to access, navigate, understand and use the health system.

The ministry of health report Korero Marama (2010) found that 56% of New Zealanders have low levels of health literacy. Further to this, health literacy had a much greater impact on Māori contributing to greater health challenges and health inequities. Low levels of health literacy can impact negatively on the health of people and their whānau. International research has shown the relationship between a person's level of literacy and their health status[1] (Ministry of Health, 2010).

Phase 1 of the initial project was to undertake a stocktake of the HB health sector in regards to health literacy. A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of

[1] (Canadian Council of Learning 2008; Kickbusch et al 2005; Knight 2006; Korhonen 2006; Institute of Medicine 2004; Nutbeam 2008).

the health literacy strengths and weaknesses of the Hawke's Bay health sector. (A full copy of the report is provided in Appendix 3)

The report provided a good overview of where the HB health was at in regards to health literacy summarising our strengths, weaknesses and made a number of recommendations. (Appendix 1 & 2). These recommendations have been incorporated into the development of principles, the implementation approach and action plan detailed in this report.

The report identified the following key themes and opportunities:

- Strong leadership commitment at a strategic and senior level to health literacy
- Prioritise health literacy in a programme of work
- Focus now on the development of an overarching and co-ordinated wide action plan
- Linkages to creating a culture shift and link to the philosophy of person & whānau centred care
- Need to create an impetus to gain commitment across all levels of the sector

Since the report was finalised a number of related activities have been undertaken. The first, is the appointment of a Health Literacy Advisor who will be the Project lead for the implementation of health literacy across the sector. In addition to this appointment, the DHB has also been developing and designing training for all staff (aligned to that being offered in GP Practices) to support the improvement of health literacy. This model of Relationship Centred Practice incorporates Māori principles and frameworks including the Hui Process and is being made available to all Central region DHBs and potentially will be utilised at a national level through HQSC. Workshops and education sessions to support the building of awareness have also been taking place alongside the development of tools and guidance material for all teams across the sector. Ongoing advice and support has been provided to individuals and teams on an ad hoc basis and there has been an increase in these requests over the last few months.

The intent of the first phase of the project was to undertake a stocktake and develop a HB Health Literacy Framework. In completing this work, it is clear that health literacy is complex and it was felt that if we were going to be able to achieve the outcomes then we needed to ensure that we were not increasing the complexity with the introduction of another framework. To that end it is recommended that the HB utilises a simple model of creating a health literate organisation/system and sets out its commitment to health literacy in the form of a set of core principles. These would be easily understood by staff, patients, and the community, and will inform the programme of work.

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

BACKGROUND

SUMMARY OF QUIGLEY & WATTS REPORT

A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via face to face group discussions, telephone interviews, a literature scan and document review.

In assessing the health sector strengths and weaknesses Q&W utilised the MOH Six Dimensions framework for creating a health literate organisation and the findings are summarised below. A more detailed summary of the findings can be found in Appendix 1 & 2.

- Need for a clear and better understanding of health literacy. Health literacy often referred to as a confusing topic that contributes to the lack of clear understanding of the concept.
- Good intentions at a leadership and strategic level and some good pockets of practice, however overall there is poor and inconsistent practice across the HBDHB.
- Need for the culture within the health system to change, with re-organisation towards a more person and whānau centred system.
- Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.
- The need for the DHB to support change to make health literacy business as usual, this includes embedding health literacy into expected practice and behaviour and creating accountability.
- Workforce development and resourcing for better health literate practice for health professionals.
- Increase the Māori and Pacific health workforce.
- Effective communication from a systems to an operational level.
- Linked up clinical pathways and a health system that ensures easy access and navigation.
- More joined up and co-ordinated way of working within the health system.

Overall, whilst there is room for improvement across the six dimensions, it was Q&W's view that the HB health sector should feel optimistic about the future for health literacy as there was an absolute commitment to creating a health literat environment and it was felt that thei approach to health literacy identified in Transform & Sustain was a platform for real transformation.

CREATING A HEALTH LITERATE SECTOR

A health literate sector makes health literacy a priority. It makes health literacy part of all aspects of service planning, design, delivery and performance evaluation to reduce the health literacy demands on consumers.

A health literate sector:

- Makes health literacy everyone's business – leaders, managers, clinical and non-clinical staff
- Designs systems, processes and services that allow consumers to access services easily
- Supports operational staff to use health literacy approaches and strategies
- Eliminates confusing communication that could prevent consumers from accessing treatment easily
- Actively builds health literacy in consumers to help them to manage their health
- Makes operational staff understand that no matter how high a consumers level of health literacy is, stress and anxiety affect their ability to understand and remember new information

Q&W recommended that the concept of health literacy should embrace:

- A dual focus - on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the principles are underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Drawing on international best practice, the following six dimensions have been developed in New Zealand and describe the attributes of a health literate organisation that make it easier for people to navigate, understand and use health information and services to take care of their health. These six dimensions exemplify a health literate organisation/system and an organisation/system that embodies these dimensions creates an environment that enables people to benefit optimally from

healthcare services and information. Each dimension highlights ways in which health literacy can be embedded.

These dimensions have informed the development of a set of guiding principles and an action plan for health literacy, rather than create a framework which could potentially add greater complexity to an already complex area.

New Zealand's Six Dimensions		Rationale
1.	**Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans?	Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved.
2.	**Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?	A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience.
3.	**Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?	The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy.
4.	**Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?	Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance.
5.	**Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?	Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems.
6.	**Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?	Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on.

HEALTH LITERACY PRINCIPLES

Rather than utilise the MOH framework, a set of core principles (aligned to the framework) have been developed so that staff, consumers, our whānau/families and our community can easily understand them. The below outlines those principles and links to the sector wide values.

Six Dimensions	Health Literacy Principles	HB Values
Leadership and management	Leadership is needed to champion a culture change to ensure that Hawkes Bay becomes a health-literate sector	He Kauanuanu Ākina Tauwhiro
Consumer involvement	Creating a health literate sector happens in partnership, where consumers and whānau are viewed as important and equal partners with health professionals.	He Kauanuanu Raranga te tira
Meeting the needs of the population	Reducing complexities and demands of the health system is the most practical way to achieve a health literate sector	He Kauanuanu Raranga te tira Tauwhiro
Workforce	We need to invest in building skills and knowledge of our health professionals so that they with consumers build positive relationships, communicate effectively and understand one another	He Kauanuanu Ākina Tauwhiro
Communication	Communication is a critical component to ensure that health services and information is delivered so that it is understood by the consumer and can be used to make informed decisions	He Kauanuanu Ākina Raranga te tira Tauwhiro
Access and navigation	Our aim is to ensure that health services and information can be easily accessed and navigated, understood and then used to improve the health and wellness of our consumers	He Kauanuanu Ākina Raranga te tira Tauwhiro

HEALTH LITERACY ACTION PLAN

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

	Work streams	Proposed timeframes Start	 End
1.	**Change management** Position the health literacy programme of work within the People strategy, with the aim of shifting the culture across the HBDHB. Collaborate and co-ordinate the health literacy programme of work with the following activities; o Person and whānau centred care o Workforce engagement o Health equity o Cultural competency	**December 2016**	**July 2018**

	○ HBDHB values ○ Quality improvement and patient safety ○ Consumer and community engagement ○ Relationship centred practice ○ Long term conditions strategy ○ Community and primary healthcare strategy		
2.	**Establish a Project Advisory Roopu** The advisory roopu is to model a partnership approach towards improving health literacy across the health sector. Given that health literacy has a greater impact on Māori and contributes towards health inequities, the group will ensure there is adequate representation from Māori consumers, workers and the community. See Appendix 4 for the draft terms of reference and Appendix 5 for the project structure	**March 2017**	
3.	**Raise awareness for health literacy** *(Process to be developed in partnership with staff and consumers)* Develop marketing material (that is delivered through effective channels) that can effectively reach people working in the health sector and within the community to raise awareness and improve understanding of health literacy. The marketing material may require the use of alternative titles or terminology for health literacy, given the lack of association between health literacy and what it truly means. For example – understanding healthcare (for consumers), making healthcare easy to understand (for clinicians).	**January 2017**	**May 2017**
4.	**Health literacy leadership (across sector)** Ensure that leadership and management training programmes include creating a health literate sector. Advise on the approach to improving organisational health literacy that contributes to the change in health sector culture.	**March 2017**	**September 2017**

5.	**Creating a health literate environment** Develop guidelines with a set of resources for organisations (or large services) across the health sector to use to create a health literate environment*. (Potentially an e-book).* The guidelines may include the following steps; Step 1: Complete a health literacy assessment for the six dimension of a health literate organisation. This assessment will be based on the following; ▪ ENLIVEN: Health literacy self-assessment tool ▪ Harvard University: The health literacy environment of hospitals and health centres ▪ Ministry of Health: Staff survey for health literacy Step 2: Develop a health literacy action plan based on the findings from the assessment across the six dimensions of health literacy. Step 3: Implementing toolkits and resources that improve health literacy in your service or organisation. ▪ Health literacy promotion / marketing ▪ Hawke's Bay health literacy toolkit – based on the universal precautions health literacy toolkit. ▪ Developing health literate communications and resources - rauemi atahwhai (in video format) ▪ Links to other resources including three steps to better health literacy, P.L.A.N, safe to ask (increase consumer confidence to ask questions). Step 4: Continually improving health literacy. ▪ Repeat steps 1 – 3 annually	**November 2016**	**June 2017**
6.	**Workforce development (across sector)** Develop a health literacy workforce education programme that is positioned within the HBDHB peoples and work force development strategy*. (Linkage to current RCP programme)* The programme requires coaching in effective health literacy communication methods with an emphasis on improving quality relationships with consumers	**March 2017**	**February 2018**
7.	**Consumer and community health literacy** Create a consumer and community strategy that adopts a co-design methodology to improve consumer and community health literacy. *(Working with PHO, Staff and Consumers)*	**September 2017**	**February 2018**
8.	**Address health literacy priority areas within the HBDHB** Health literacy innovation: Investment in projects that aim to improve health literacy across the health sector Particular areas of interest, such as hospital discharge / readmission, consumer and community health literacy, Māori and Pacifica health.	**March 2017**	**July 2018**

9.	**Monitor, evaluate and continual improve health literacy** Review, evaluate and continually improve health literacy across the Hawke's Bay region ▪ Ministry of health – health literacy review framework ▪ QIPS measures ▪ Health outcome and output measures ▪ Workforce knowledge survey ▪ Consumer knowledge survey ▪ Health literacy self-assessment	**June 2017**	**July 2018**

APPENDIX 1 – SUMMARY OF FINDINGS

Dimension	Findings
Leadership	The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans. Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area. Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work
Consumer Involvement	The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery. Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking. Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.
Workforce	The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated. There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to up skill in this area, a key challenge will be getting all staff to see it as a priority. Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Meeting the needs of the population	Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored. There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it. Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy. Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.
Access & Navigation	The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined. There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers. Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.
Communication	The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated. As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills. Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

APPENDIX 2 - SUMMARY OF POTENTIAL OPPORTUNITIES

Domain	***Opportunity***	***Commentary***
Leadership	HBDHB needs to lead the work on health literacy	Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension).
	Underpin the framework with Māori principles	The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy.
	A multi-faceted, long-term approach is needed	Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time. The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy.
	Consider health literacy within the bigger issue of reorienting the health system	Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue. *Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT). *Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group).

		Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values (Staff Discussion Group).
Consumer Involvement	Partner with consumers in the development of the framework	Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework.
	Importance of a patient/whānau-centred approach	The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome. *The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board).
	Co-design a useful framework for involving consumers in service design and delivery	Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012).
Workforce	Workforce development needs to be a priority within the framework/plan for health literacy	Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes. *It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member). Staff identified the following areas as important for workforce development: • the meaning of health literacy to create a shared understanding • the consumer/whānau and health practitioner relationship

		• how to communicate more effectively with consumers (including culturally appropriate communication) • resources/pathways that are available for consumers
	Getting all staff on board could be challenging	While there is a way to go in terms of up skilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority.
	Make health literacy as much of a priority as other aspects of clinical work	Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training. *Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member).
	Support workforce development with a system that values and enables change	A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important.
	Increase the Māori and Pasifika workforce	Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension).
Meeting the needs of the population	Build health literacy using a Universal Precautions approach	Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear

		information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010). This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension.
	Focus on reducing inequities particularly for Māori	Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities.
	Create monitoring to measure whether needs are being met	It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services.
	Reorient the health system so it is consumer focused	This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in up skilling some staff about this model, there are opportunities to further develop knowledge in this area.
Communication	A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships	Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand. *Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member). Components of effective communication to consider are: • use clear, plain language that reflects the audience's own common language • use a range of mediums e.g. face-to-face discussions, DVDs or online video • use visual prompts to explain complex issues

		Rauemi Atawhai: A guide to developing health education resources in New Zealand has some good advice for developing written resources (Ministry of Health, 2012).
	Involve consumers in the development of health resources	It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above.
	Skills to improve communication are needed on both sides for consumers and health professionals	Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity. The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services.

APPENDIX 3 – HEALTH LITERACY STRATEGIC REVIEW

Health Literacy Strategic Review

April 2016

Prepared for the Hawke's Bay District Health Board

By Quigley and Watts

Carolyn Watts, Kate Marsh and Jen Margaret

Acknowledgments

Improving health literacy is central to improving the health of people living in the Hawke's Bay. This work to support health literacy was funded by the Hawke's Bay District Health Board (HBDHB) on behalf of the sector.

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Nāu te rourou, nāku te rourou ka ora ai te iwi

With your basket and my basket the people will thrive

Contents

Executive Summary

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary, on its own will not be sufficient to create an equitable and sustainable health system.

The relevant question is how consumer literate is the health sector. How well does the sector know its consumers? The definition is around the wrong way and needs to be turned on its head – what is the capacity to communicate so consumers can use information and health services to make effective decisions (Consumer Council).

The initial steps in development of the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015):

Leadership and management

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of

development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

Consumer involvement

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

Workforce

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Meeting the needs of the population

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

Communication

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involving consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

Access and navigation

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

Overall, while there is considerable room for improvement across the six dimensions, HBDHB should feel optimistic about the future for health literacy as the commitment and approach to health literacy is a platform for real transformation.

Next steps

To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy (Staff discussion group).

1. **Clarity on meaning**

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

2. **Clarity on purpose**

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

3. Clarity on action

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

Introduction

Purpose of this review

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

This review supports the key intention of transforming health promotion and health literacy as identified in the Hawke's Bay strategic direction for the health system, *Transform and Sustain* (2014-2017) (HBDHB, 2014).

Report content and structure

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

Details of the data collection methodology are included in Appendix 1. The literature review to understand New Zealand and international frameworks for health literacy is included in Appendix 2.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework. The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015). Considerations to inform the development of an appropriate framework for improving the health literacy of the Hawke's Bay health sector and community are included under each dimension.

Limitations

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary on its own will not be sufficient to create an equitable and sustainable health system.

Overarching considerations

Clarifying understandings of health literacy

A shared responsibility

As the concept of health literacy has evolved, it has shifted from poor health literacy being seen as an individual deficit to acknowledging the health system as a key enabler or barrier to health literacy (NAS, 2015). Rather than an either/or focus on health systems or individuals, health literacy is situated as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. As illustrated by Parker (2009):

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy*. Washington, DC, National Academies Press, 2009:91–98.

A 2015 US National Academy of Science roundtable on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward (NAS, 2015). The final discussion of the National Academy of Science Roundtable on Health Literacy concluded, '*patients are the experts and the field must figure out how to partner with them'* (NAS, 2015).

Similarly, the Australian Commission on Safety and Quality in Health Care (2013) identifies that for consumers to contribute to a safe and high-quality health system, by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them.

The shift in focus from health literacy being an individual responsibility to being one that is shared with the healthcare system is critical. While the onus for improving health literacy should not be placed on the individual it is important that consumers/whānau are partners in systems changes to improve health literacy (WHO, 2013). This requires dramatic change within the system as a whole and amongst those who make up the system.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

In moving to an understanding of health literacy as a shared responsibility, power imbalances between consumers and health professionals need to be understood and addressed. Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.

Situating health literacy in a population health context

The information gathered from all sources for this review highlights inconsistency in definitions and understandings of health literacy. Central to this is the definition and framing of health. Health can be viewed through the lens of health care which focuses primarily on the treatment and management of illness involving the interaction of individuals with the health system. Health can also be understood more broadly from a population health perspective as wellbeing (physical, emotional, mental and spiritual health) determined by many societal factors, mostly outside of the health system. A population health approach recognises the social determinants of health, and focuses on addressing inequities, building strong community/whānau connections, and empowering people to take control of, and improve, their own health. Central to this is understanding that many determinants of health are situated beyond the health sector (e.g. education, housing, income etc.) and responding to this by fostering collaborative cross-sectoral approaches to address social inequities which impact on health.

Importantly, the Hawke's Bay health sector, in its key strategic documents, recognises that the responsibility for health includes but extends beyond treatment to one of improving population health.

> *We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required* (Health Hawke's Bay, 2014).

The challenge, as identified in the sector's key strategic documents and the interviews, is to transform a system which is currently structured on understandings of health as healthcare and in which health literacy is in the main, understood to be a consumer deficit.

Defining health literacy

In addition to issues relating to the broader understanding of health literacy, the interviews highlighted that the specific term is problematic and contributes to misunderstanding. Many interviewees considered the term to be confusing jargon which leads to most health professionals focusing on the health literacy of consumers rather than the role they play as of health professionals in supporting health literacy. The word 'literacy' can also lead to a narrow focus on the reading and numeracy skills of individuals.

> *Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health* (WHO, 2013).

Clearly defining health literacy was seen by interviewees as critical, along with ensuring the concept is understood sector-wide.

> *We are at the stage of defining the problem. All too often it is defined as 'How do we empower people out there to understand what's going on in here.' Rather than how do we empower people in here to understand what is going on out there. That is as big an issue* (Staff member).

At a framework level, a critical dimension of defining the concept of health literacy is an understanding of the systems barriers and broader transformation required. Health literacy needs to be understood in the context of not only of inequities in the determinants of health—the impacts of income, education, social capital, and living conditions on health literacy—but also the wider determinants of the health system which include: clinical expertise being valued over cultural competence, health literacy and EQ in health professionals training; the funding distribution within Vote Health (prioritisation of treatment over prevention); and, the relative value placed on health vs economic prosperity. Given this complexity, undertaking a structural analysis exercise[2] in order to aid understanding of this complex issue and support a strategic approach to systemic change could be a useful step for those involved in developing the health literacy framework.

Embedding health literacy

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015). The alignment of health literacy with organisational values and existing strategies is discussed in more detail below under the dimension of leadership and management.

Developing the framework

Process

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content. As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau drive* (Māori Relationships Board).

[2] See http://awea.org.nz/spaghetti-junction for an example of a structural analysis exercise which aids problem definition.

In addition, the framework itself should be an example of a health literate document – it needs to be simple, focused and accessible. This in itself is a challenge, as the discussion in this section illustrates, health literacy is complex yet by definition demands simplicity.

Measuring success

One of the challenges in developing a health literacy framework is determining how to measure success. While interviewees mentioned the importance of tangible targets as a driver for change, there was recognition that multiple factors that will contribute to any particular change; some of which may be able to be attributed to the health literacy initiative and others not.

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012). Interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014). Creativity and innovation are central to health literacy initiatives and therefore evaluation needs to encourage rather than stifle innovation.

This suggests that a mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy, for example developmental evaluation.3

Based on the findings of the review there are a number of interventions that could be undertaken as building blocks for wider transformative change for example, workforce development using the HQSC *Three Steps to Health Literacy* and a policy and process for the development of health literate resources.

Framework structure

As outlined above, the framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014). Current New Zealand frameworks and tools designed specifically for health literacy are of limited usefulness to developing a sector-wide health literacy framework for the Hawke's Bay in that they do not fully reflect a population health approach or the shared responsibility for improving health literacy. For example, a key tool, the Ministry of Health's (2015) *Framework for Health Literacy* discusses how each part of the health system can contribute to building health literacy so individuals and whānau can obtain, process and understand health materials and access and navigate appropriate, quality and timely health services. While useful to the process of organisational change, this framework does not adequately reflect a transformative agenda in which individuals, whānau and communities are seen as central and are empowered to take control of, and improve their own health, through being active in the design and delivery of health systems, organisations and initiatives.

It is beyond the scope of this review to suggest a particular model for the framework, however the following two framework examples are provided as relevant examples to stimulate thinking.

He Korowai Oranga: The Māori Health Strategy

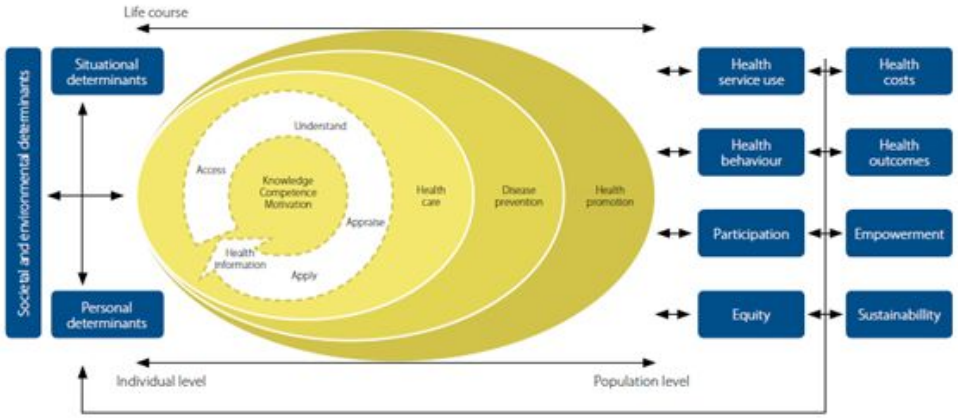
The overarching aim and three key elements of He Korowai Oranga: Māori Health Strategy (2014) provide a local, population health approach which aligns with the central tenets of health literacy and could usefully inform a health literacy framework for the Hawke's Bay.

Pae ora [healthy futures] is a holistic concept and includes three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. All three elements of pae ora are interconnected and mutually reinforcing. (Ministry of Health, 2014)

Sorensen et al's integrated model

This international model from Sorensen et al (2012) depicts the continuum of population health from health care to health promotion. This model also recognises the personal and broader social determinants of health literacy and the situational determinants (barriers and enablers of health systems).

[3] See http://whatworks.org.nz/frameworks-approaches/developmental-evaluation/ for background.



Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

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Summary

The discussion above suggests that the initial steps in development the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Within this work it is necessary to ensure the concept of health literacy embraces:

- A focus on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Given the complexity of the task of creating a sector-wide health literacy framework, using existing models from related contexts to stimulate thinking and undertaking a structural analysis exercise in order to aid understanding of this complex issue and support a strategic approach to systemic change may be useful early steps for those involved in developing the health literacy framework.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

Overall assessment - the six dimensions

The six dimensions of a health-literate organisation developed as part of *Health Literacy Review: A Guide* draw on international best practice. They were designed as a New Zealand framework for a health literacy review (Ministry of Health, 2015). The dimensions overlap in content and potential solutions and should be considered as an interdependent whole.

Leadership and management

Summary:

The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans.

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

Sector strengths and weaknesses

Strategic health literacy focus evident in key documents

The findings highlight HBDHB's evolving interest in, and commitment towards, building health literacy and becoming a more health literate sector. A strategic focus on health literacy for the Hawke's Bay health system is signalled in Transform and Sustain (HBDHB, 2014) and in Mai: Māori Health Strategy 2014-2019 (2014).

The Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014b) and the Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014) both build on Transform and Sustain (HBDHB, 2014) and embed the sectors commitment to health literacy.

Health literacy was identified as one of three key strategic objectives for the sector at a strategic planning workshop of the HBDHB Board, Health Hawke's Bay Ltd Board and the Māori Relationship Board, and is to be an area of focus within the 2015/16 Annual Plan (Terms of Reference Health Literacy - Framework Establishment, HBDHB, 2015).

Health literacy is consistent with the values and key strategic documents of HBDHB

Health literacy is consistent with the values of HBDHB.

> *Health literacy is values in action e.g. he kauanuanu (showing respect), ākina (continuous improvement)* (Executive Management Team).

Findings indicate that health literacy needs to be tied to existing frameworks, strategies and concepts e.g. Triple Aim, patient-centred care, whānau ora.

A strong strategic platform developed to build other work off

Findings show that health literacy is supported at a leadership level and there have been some practical steps, at the strategic level, towards addressing it. The document review revealed that the Alliance Leadership Team established the Health Literacy Leadership Group in July 2015 to develop a coordinated and collaborative approach, structure, framework, principles and communications strategy for addressing health literacy issues in Hawke's Bay. The Health Literacy Leadership Group put forward a detailed business case for this work on health literacy and funds were secured at the end of September 2015 (Health Hawke's Bay, 2015). A number of strategic development projects have been undertaken including a review of health literacy and health promotion capability (Quigley and Watts, 2014) and a health literacy information paper (Foote, 2015).

As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action and filter out to the wider health workforce, with the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed.

Barriers and opportunities for improvement

HBDHB needs to lead the work on health literacy

Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension).

Underpin the framework with Māori principles

The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy.

A multi-faceted, long-term approach is needed

Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time.

The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy.

Consider health literacy within the bigger issue of reorienting the health system

Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue.

> *Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT).
>
> *Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group).
>
> *Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values* (Staff Discussion Group).

Consumer Involvement

Summary:

The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery.

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

Sector strengths and weaknesses

There is limited consumer involvement in designing, developing and evaluating the organisation's values, vision, structure and service delivery

The findings indicate there is limited consumer involvement in the Hawke's Bay health system at present. Most of the discussion around consumer involvement centred on consumers interactions with the health system and health professionals. Much of this discussion was focused on what is currently not working well e.g. lack of communication with consumers (this is discussed in more detail below under the 'communications' dimension). The Consumer Council discussed the paradigm shift required suggesting the real change needed was consumer literate health professionals rather than health literate consumers.

> *We need focus on consumer experience of the system and the attributes of the people they are communicating with in the system. There are a lot of changes needed* (Consumer Council).

Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking (NAS, 2015).

The Consumer Council is a positive step forwards

While there is still a way to go to really involve consumers, the Consumer Council is an important step in the right direction.

> *It is big step forward having the Consumers Council. I feel we've been listened to. The journey is well and truly underway. It is evolving* (Consumer Council).

The varying levels of consumer involvement were discussed as this quote from a staff member highlights:

> *Consumer involvement is so much more than the Consumer Council although that is a good start. We need to think about the community taking ownership of this framework* (Staff member).

Barriers and opportunities for improvement

Partner with consumers in the development of the framework

Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework.

Importance of a patient/whānau-centred approach

The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome.

> *The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board).

Co-design a useful framework for involving consumers in service design and delivery

Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012).

Workforce

Summary:

The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated.

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

Sector strengths and weaknesses

No coordinated approach to improving the health literacy of HBDHB's health workforce yet

There has been no coordinated approach to improving the health literacy of the workforce yet which is no surprise given the focus of the HBDHB has been at the strategic level thus far. This means that overall, there has been little encouragement and support for the health workforce to develop effective health literacy practices, no identification of the workforces needs for health literacy development and capacity, and no evaluation of health literacy performance.

In the absence of a coordinated approach inconsistent understandings of health literacy exist. While some health professionals have a broad understanding of health literacy, many comments reflected a narrow understanding of health literacy e.g. the need to educate patients rather than looking at the systems in place that impact on a patient's ability to understand the information being imparted to them. Similarly, this has impacted health literacy practice; while there were pockets of good health literacy work happening, some of it was confused with health education i.e. focusing on distributing pamphlets to patients.

Health Hawke's Bay is taking a coordinated workforce development approach

Health Hawke's Bay is a notable exception in health literacy workforce development having undertaken a thorough review of health literacy workforce needs in 2015. A two-tier training programme for PHO staff has been developed based on the needs identified in the review. It was noted by an interviewee that the rest of the sector can learn a lot from the work of the PHO.

Barriers and opportunities for improvement

Workforce development needs to be a priority within the framework/plan for health literacy

Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes.

> *It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member).

Staff identified the following areas as important for workforce development:

- the meaning of health literacy to create a shared understanding
- the consumer/whānau and health practitioner relationship

- how to communicate more effectively with consumers (including culturally appropriate communication)
- resources/pathways that are available for consumers

Getting all staff on board could be challenging

While there is a way to go in terms of upskilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority.

Make health literacy as much of a priority as other aspects of clinical work

Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training.

> *Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member).

Support workforce development with a system that values and enables change

A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important.

Increase the Māori and Pasifika workforce

Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension).

Meeting the needs of the population

Summary:

Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored.

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

Sector strengths and weaknesses

Strategic intent to address inequities but no coordinated approach across services

Findings show there is intent at the strategic level to address inequities - this is set out in key documents and was highlighted by many participants. However, there is no coordinated approach across services to identify needs, address them and monitor whether those needs are being met. This coupled with health literacy systems barriers means that, as the system currently stands overall, consumers with low health literacy are unlikely to bet able to participate effectively in their care. As noted above, there are pockets of good things happening and some services may meet needs better than others but there is no coordinated approach across services to meet these needs.

The system is currently set up to meet the needs of those working within it not those accessing it

One of the biggest challenges is that the health system is not consumer focused and is set up to meet the needs of those working within it rather than those accessing it e.g. appointments are based on a fixed length rather than on patients' needs. Time was a key barrier mentioned by both consumers and health professionals.

> *If a GP is explaining things adequately then they are the ones you end up waiting to see as they take more time with their patients. Time equals money – need time and money to improve health literacy* (Consumer Council).

Transform and Sustain (2014) acknowledges *the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*

Everyone experiences poor health literacy at some point

Less than half of all adults in New Zealand have the basic health literacy skills to cope with everyday demands of life and work let alone understand complex medical conditions. This means not being able to do things like read labels on medicines or workout how much medicine to give a child. Eighty per cent of Māori males and 75 per cent of Māori females have poor health literacy skills (Ministry of Health, 2010).

People with low health literacy are more likely to have ongoing difficulties in making informed health decisions, but even people with good health literacy skills can also find it difficult to understand health care information. This is especially true when a person is first diagnosed with an illness or is unwell or stressed. The Institute of Medicine report (2004) concluded that even highly skilled individuals may find the systems too complicated to understand, especially when these individuals are made more vulnerable by poor health. This was supported by participants views, even health professionals that work in the system, can experience low health literacy not just those who are most at risk.

Barriers and opportunities for improvement

Build health literacy using a Universal Precautions approach

Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010).

This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension.

Focus on reducing inequities particularly for Māori

Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities.

Create monitoring to measure whether needs are being met

It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services.

Reorient the health system so it is consumer focused

This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in upskilling some staff about this model, there are opportunities to further develop knowledge in this area.

Access and navigation

Summary:

The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined.

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

Sector strengths and weaknesses

Integrated services for seamless service delivery

The need for better transitions between parts of the system was mentioned by many participants. Methods of communication with consumers and transitions between parts of the system were highlighted as areas for improvement. This included the relationship between the health professional and the patient, as well as getting into the system in the first place e.g. appointment letters can be difficult to understand. It was thought that pockets of the system have good communication processes but transitioning between parts of the system, with variable quality processes, meant that some patients 'dropped off'. This relates strongly to the communication dimension.

> *There is a lack of continuum of care for patients – no collaboration with other services. Services need to be connected to help with patient care* (Consumer Council).

Improve physical access

Interviewees discussed physical and coordination aspects that could be improved e.g. visible signage and prompts in different languages; consumers and whānau knowing where to park and what part of the hospital they need to visit to access services on time.

Barriers and opportunities for improvement

Allow for further discussion

This dimension relates strongly to all of the other dimensions and is somewhat difficult to separate out. For instance, the concepts of seamless service delivery and transitions between services need to be led at a management and leadership level as they relate to the structure of the organisation. The physical aspects of access do need to be addressed and these strongly relate to the communication dimension. More discussion is required around this dimension and what it means for the framework.

Communication

Summary:

The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated.

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

Sector strengths and weaknesses

No coordinated approach to identifying information needs – for consumers and staff

The review found no coordinated approach to identifying consumer information needs or staff information needs. Some staff talked about the lack of resources in a range of formats for them to use with their patients, which they felt limited their ability to impart all of the information required. While some staff talked at length about education resources, few talked about the need to involve consumers in the resource development process or to ask consumers about their information needs. This reflects more of an education approach rather than a partnership approach, situating the health professional as the teacher and the consumer as the student.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is*

> *engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

Most health information is written by health professionals with no consumer involvement

Most of the health information was reported to be written by health professionals. Currently there is no requirement for consumers to be involved in the design or evaluation of information or resources. Health professionals were reported to assume a level of understanding that some of their colleagues even found difficult to comprehend.

> *Health professionals use a lot of terminology and we don't ask patients what they understand* (Clinical Council).

No systematic approach for assessing the readability of resources

While some communication staff use an assessment tool to check the readability of some resources, there is no requirement for this to happen with all resources so it happens on an ad hoc basis with no coordination within or across services.

Health practitioners generally communicate poorly with consumers

The poor communication between health professionals and consumers was a common theme in the review and identified as a key barrier to improving health literacy. The review findings highlight a lack of training, skills and tools available to support health professionals to improve their communication.

> *'A lot of health professionals are not as literate as we think we are. We are very bad at communicating with patients and should be better'* (Clinical Council).

Barriers and opportunities for improvement

A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships

Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand.

> *Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member).

Components of effective communication to consider are:

- use clear, plain language that reflects the audience's own common language
- use a range of mediums e.g. face-to-face discussions, DVDs or online video
- use visual prompts to explain complex issues

Rauemi Atawhai: A guide to developing health education resources in New Zealand has some good advice for developing written resources (Ministry of Health, 2012).

Involve consumers in the development of health resources

It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above.

Skills to improve communication are needed on both sides for consumers and health professionals

Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity.

The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services.

Next Steps

To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy (Staff discussion group).

1. Clarity on meaning

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

2. Clarity on purpose

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

3. Clarity on action

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

Appendix 1: Data collection methods

Literature Review
A brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

1. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
2. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

Document Review
Documents are an important source of information about how an organisation positions and delivers on health literacy in terms of its infrastructure, policies, systems, processes, information and communications. The purpose of this high-level document review was to identify the DHB's commitment to health literacy and look at whether health literacy has been operationalised throughout the DHB and the processes through which that has happened. This was not an audit of all DHB documents, instead, the focus was on mapping out the DHB's approach to addressing health literacy through reviewing documents that explicitly referred to health literacy. This was an information gathering exercise to look at how all of the documents/information linked up rather than an assessment as such.

The document review aimed to answer the following questions:

1. How is health literacy guided and operationalised within the DHB? E.g. Is there any direction that flows through the funding on HL? Is it coordinated or random? Anything in the area of workforce? Workforce training? Communication?
2. What documents around infrastructure, policies, systems, processes, information and communications are in place within the DHB that address and support health literacy? Is there a consumer panel that all the resources go through?

The documents were located through key contacts at the DHB as well as a Google search. Two types of documents were collected and analysed:

1. Key organisational documents, which explicitly referred to health literacy.
2. Specific consumer-facing documents HBDHB had redeveloped/redesigned to be more health literate.

Key documents:

- Transform and Sustain: the next five years (Hawke's Bay DHB, 2013)
- Mai: Māori Health Strategy 2014-2019 (HBDHB, 2014)
- Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014)
- Improving the Health of Pacific People in Hawke's Bay: Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014)
- Hawke's Bay Health Consumer Council Annual Plan 2014/15 (Consumer Council, 2014)
- Health Promotion and Health Literacy Capability Report (Quigley and Watts, 2014)
- Health Literacy Information Paper – what does it mean and what can be done? (Foote, 2015)
- Health Literacy Update (Foote, 2015)
- Bay DHB Position Profile: Health Literacy Advisor (HBDHB, 2015)
- Terms of Reference - Health Literacy Framework Establishment (Health Hawke's Bay, 2015)
- Health Literacy Needs Assessment (Quigley and Watts Ltd, 2015)
- Patient-Client Information and Education Policy (Hawke's Bay DHB, 2008)

Interviews

Interviewees were in a range of clinical and non-clinical roles throughout the DHB and the broader health sector. They included those in senior management, clinical team leaders, iwi executives, practice managers, practice nurses, midwife, general practitioners, cultural navigators and kaitakawaenga, public health physician, publications advisors, and coordinators in particular areas of health and wellbeing e.g. breastfeeding. Many interviewees had multiple roles. In total, 12 interviewees were directly employed by the DHB and 6 interviewees were employed by service providers.

The HBDHB sent out an email informing interviewees about the project and giving them advance notice that they may be contacted for an interview. Interviewees were then contacted by email and a follow up phone call if necessary where they were asked to participate in 30 minute phone interview. They were informed that:

- they could stop the interview at any time
- the interview would be recorded for note-taking purposes
- their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed
- they would be provided with the interview questions prior to the interview
- they would have access to the final report

Group meetings

Half hour group meetings were undertaken with the following groups:

- Executive Management Team
- Clinical Council
- Māori Relationship Board
- Consumer Council

These groups were emailed the questions prior to the discussion and the groups were recorded for note-taking purposes. In order to capture the views of other DHB staff interested in health literacy, an email was sent out to all staff inviting them to attend one of two group meetings which were attended by 22 people in various roles throughout the hospital. Prior to the discussions, the project was introduced and participants were informed that the discussion would be recorded for note-taking purposes, their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed, and they would have access to the final report.

Appendix 2: Literature review

LITERATURE REVIEW TO INFORM THE DEVELOPMENT OF A REGIONAL FRAMEWORK FOR HEALTH LITERACY

Introduction

This brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

3. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
4. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

Background

In New Zealand, health literacy has been defined as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health 2010). In this definition the focus is most obviously on consumer capability. However, internationally support is growing for a stronger focus on how health systems, health care providers and practitioners can support consumers to access and understand health services (Ministry of Health, 2015).

Definitions for health literacy vary internationally and there is no unanimously accepted definition of the concept or its constituent dimensions (Sorensen et al 2012). The World Health Organization definition of health literacy identifies *capacity* as 'the social and cognitive skills which determine motivation and ability' (ref).

Sorensen et al 2012 argue making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them. This requires the simultaneous use of a complex and interconnected set of abilities, such as reading and acting upon written health information, communicating needs to health professionals, and understanding health instructions (Sorensen et al, 2012).

Health literacy is also dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant. An individual's health literacy may also change over their life course as their skills set becomes subject to different information processing demands. To reflect this, a recent Canadian Expert Panel adopted the following definition of health literacy:

The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (D'Eath, Barry & Sixsmith, 2012).

As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. Systemic issues exist across New Zealand's healthcare system. In many cases the system is primarily organised to meet the needs of the system not the user. For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them. This means that responsibility for addressing health literacy rests with policy makers, healthcare providers and consumers (Australian Commission on Safety and Quality in Health Care, 2013).

This fits with the concept of health literacy as a shared responsibility between consumers and health professionals (within the overarching system). Acknowledging the important role health professionals play in communicating effectively and supporting the development of patient's health literacy.

There is now a growing focus on the demands health services and systems place on people using them. A new understanding has emerged that patients and health professionals cannot address health literacy needs independently. Healthcare services and systems need to support health professionals to build patient health literacy by reducing the demands placed on patients and by supporting health professionals to communicate more effectively with patients (Lambert, Luke, Downey et al, 2014).

The relationship between people as citizens, consumers or as patients with the institutions that affect their health is significantly influenced by two interacting factors: their levels of health literacy and the willingness of such institutions to recognize diversity and share or give power for more equal, inclusive and accountable relationships. A high level of health literacy allows for an expansion of decisions and actions through control over resources and decisions that affect one's life (WHO, 2013).

Evidence internationally and in New Zealand shows:

1. Navigating increasingly complex health care systems is a major challenge for patients and their families.
2. Patients face multiple literacy requirements and increasingly difficult decisions.
3. Health information materials are often poorly written and literacy demands are excessive.
4. Health providers' written and spoken communication has insufficient clarity and quality.
5. New "business" models can create new obstacles.
6. Health literacy affects the use of health services (WHO, 2013).

Becoming a health-literate organisation is a long-term commitment. Leaders of health-literate organisations make health literacy a priority and integrate health literacy in all aspects of service planning, design, delivery and performance evaluation.

Health-literate organisations:

- redesign systems, processes and services to remove barriers to consumer access
- address communication problems that exist at all stages of the patient journey – such as confusing treatment pathways and jargon-filled discussions with health practitioners
- make health literacy everyone's business, including leaders, managers, clinical and non-clinical staff
- take an active role in building health literacy with consumers in order that consumers can better manage their health and achieve improved health outcomes
- take into account that consumers, who might usually have good health literacy, will have less health literacy knowledge and fewer health literacy skills when they are unwell or receive a new diagnosis
- support operational staff to use health literacy approaches and strategies.

Some definitions for health literacy have explicitly included a population health approach arguably widening the remit for health literacy. For example the definition developed by the European Health Literacy Consortium in 2012 (WHO, 2013):

Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in every-day life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.

Realising the goals in *Transform and Sustain* of keeping the general population well and healthy, enabling those with complex conditions to live well and supporting older people at the end of their lives will require a transformational change to the 'health system' (Watts, Murphy & Quigley, 2014).

Health literacy as a determinant of health is closely related to other social determinants of health such as general literacy, education, income and culture (WHO, 2013).

One of the challenges of this work will be the scope. At one end of the spectrum the DHBs role in health literacy can be seen as primarily as an access issue to treatment (access to information and access to services) at the other end of the spectrum is a population health approach, including treatment but extending to staying well and disease prevention. A population health approach to health literacy would place the DHB as a partner with individuals, whānau and communities to strengthen people's ability to take responsibility for their own health as well as their family health and community health.

Context

This work will support Hawke's Bay strategic direction for the health system *Transform and Sustain* (2014-2017) (Hawke's Bay District Health Board, 2013). *Transform and Sustain* guides service planning and development.

Transform and Sustain outlines three main challenges:

- *Responding to our population: We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau.*
- *Delivering consistent high-quality health care: The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting.*
- *Being more efficient at what we do: Reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.*

The strategy acknowledges "*the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*"

The DHB's responsibility for health includes but extends beyond medical treatment to one of improving population health.

We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required (Health Hawke's Bay, 2014).

A population health approach to health literacy requires a partnership with the people of Hawke's Bay.

Transform and Sustain recognises the need for a broad definition and framework for health literacy*:*

Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).

Summary and recommendations

- There is no unanimously accepted definition of health literacy (Sorensen, 2012).
- The Ministry of Health defines health literacy as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health, 2015).
- Making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them (Sorensen et al 2012).
- Health literacy is dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant (D'Eath, Barry & Sixsmith, 2012).
- As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy (NAS, 2015).
- Health professionals play an important role in communicating effectively and supporting the development of patient's health literacy (Ministry of Health 2015a).

- For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them (Australian Commission on Safety and Quality in Health Care, 2013)
- Some definitions for health literacy have explicitly included a population health approach, including treatment but extending the concept of health to staying well and disease prevention (WHO, 2013)
- Transform and Sustain recognises the need for a broad population health definition and framework for health literacy*:*
  Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).

Recommendations

The framework for health literacy has a:

- Population health approach acknowledging health extends beyond treatment and the 'health system' and health organisations to include staying well and preventing disease.
- Partnership approach to health literacy seeing the health system and health professionals as partners with people and whānau.
- Equity approach to health literacy ensuring the needs of those currently not experiencing good health or accessing services are given priority.
- Partnership with Māori, Iwi and Hapu to accelerate the performance of Māori health.

Frameworks and tools

Internationally health literacy is moving from an either/or focus on health systems or individuals to seeing health literacy as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. A 2015 US National Academy of Science round table on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward that (NAS, 2015).

Experts at the round table acknowledged that real progress in health literacy would be limited without true collaboration with consumers, which to date had been lacking in the USA. They also believed to get traction health literacy and cultural competence needed to be seen as an essential part of patient safety (NAS, 2015).

There is significant activity across New Zealand in the area of health literacy and also in areas directly related to health literacy. This is occurring at a national, regional and organisational level. In 2015 the Ministry of Health published two documents *A framework for health literacy* (Ministry of Health, 2015a) and *Health Literacy Review: A Guide* (Ministry of Health, 2015b).

A number of District Health Boards have also commenced programmes of work in health literacy. Counties Manukau DHB has a commitment to health literacy action within its Annual Plan for 2015/16 and Statement of Intent agreement with the Government (Counties Manukau Health, 2015) as does Hawke's Bay DHB (Hawke's Bay DHB, 2014). We found no integrated regional strategies for health literacy spanning sectors of health in New Zealand.

For health literacy initiatives to be of maximum effectiveness they need to be based on evidence, implemented in a coordinated and sustainable way and evaluated.

Addressing health literacy in a coordinated way has potential to increase the safety, quality and sustainability of the health system by building the capacity of consumers to make effective decisions and take appropriate action for health and health care, and building the capacity of the health system to support and allow this to occur (Australian Commission on Safety and Quality in Health Care, 2013).

Frameworks

Framework: the basic structure of something - a set of ideas or facts that provide support for something. Three broad levels of frameworks have been identified:

1. Population health level

These frameworks focus on improving health literacy in order to improve population health at all levels including health promotion, disease prevention, treatment of illness and end of life care. They acknowledge the important role of the health system and institutions within it and also that health occurs in everyday life and not in institutions or systems.

2. Health system level

These frameworks focus on health literacy at the level of the health system. The system is primarily viewed as the institutions and health professionals that diagnose and treat illness.

3. Health organisation level

These frameworks focus on health literacy at the level of institutions that diagnose and treat illness.

New Zealand frameworks

Population health level

No existing frameworks located.

Health system level

A Framework for health literacy

This framework reflects how each part of the health system can contribute to building health literacy so that all New Zealanders can make informed decisions about managing their health, or the health of those they care for (Ministry of Health, 2015b).

The framework was developed by the Te Kete Hauora with consultation from the health sector. The framework outlines expectations for the health system, health organisations and all of the health workforce to take action that:

- supports a 'culture shift' so that health literacy is core business at all levels of the health system
- reduces health literacy demands and recognises that good health literacy practice contributes to improved health outcomes and reduced health costs.

The framework sets out three key areas for action with outcomes and actions identified at the levels of the health system, health organisations and the health workforce:

Leadership and management

Championing health literacy and taking the lead on a 'culture shift' towards a health-literate health system.

Knowledge and skills

Improving our knowledge of how health literacy demands can be reduced and health equity achieved.

Health system change

Being committed to a 'culture shift' so that change occurs at all levels of the health system, leading to better health outcomes for individuals and whānau and reduced health costs.

Health organisation level

Health Literacy Review: A Guide

The Guide sets out an approach for reviewing a health service or organisation's current performance based on a framework identifying six key dimensions of health literacy in the New Zealand context. The framework was developed by the authors from an extensive review of national and international tools and frameworks. The New Zealand six dimensions framework is modelled on the US Ten Attributes framework (Brach et al 2012) which encompasses the seminal work of three earlier tools (Rudd and Anderson 2006; Jacobson et al 2007; Agency for Healthcare Research and Quality 2010).

From the Ten Attributes Framework, the following Six Dimensions were developed for the New Zealand context. These Dimensions form the framework for this Guide.

1. **Leadership and management.** How is health literacy an organisational value, part of the culture and the core business of an organisation? How is it reflected in strategic and operational plans?
2. **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
3. **Workforce**. How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
4. **Meeting the needs of the population.** How does service delivery make sure that consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?
5. **Access and navigation**. How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
6. **Communication**. How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

The Six Dimensions are applied to examine how staff, consumers and families interact, and to review relevant policies, processes, structures and culture in a particular health service or health care organisation. The aim of these activities is to identify the causes of health literacy barriers and opportunities for improvement.

The following table provides the rationale for each dimension.

New Zealand's Six Dimensions		Rationale
1.	**Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans?	Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved.
2.	**Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?	A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience.
3.	**Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?	The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy.
4.	**Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?	Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance.
5.	**Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?	Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems.
6.	**Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?	Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on.

12

International frameworks

Population health level

WHO European Conceptual Model

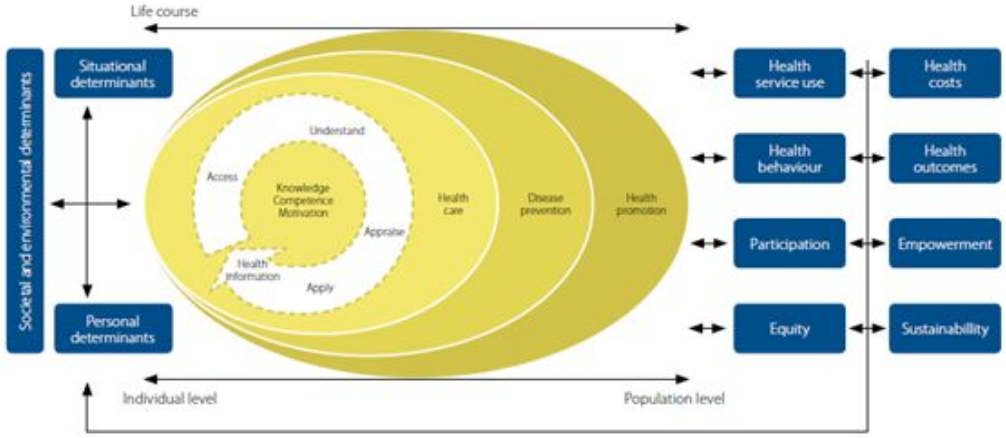
In 2013 the WHO Regional Office for Europe published Health Literacy: The Solid Facts (WHO, 2013). The publication presents a review of the evidence for interventions in health literacy. It supports a relational concept of health literacy that considers both an individual's level of health literacy and the complexities of the contexts within which people act (Figure 1). Both need to be measured and monitored (WHO, 2013).

Figure 1: Interactive Health Literacy Framework (WHO, 2013)

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy.* Washington, DC, National Academies Press, 2009:91–98.

The conceptual model seen as most comprehensive and based on evidence is shown below in figure 2. It is adapted from Sorensen et al 2012 and integrates medical and public health views of health literacy. The model was developed through a systematic literature review and content analysis of 17 peer-reviewed definitions and 12 conceptual models (frameworks) found in extensive literature reviews.

Figure 2: Conceptual Model of Health Literacy



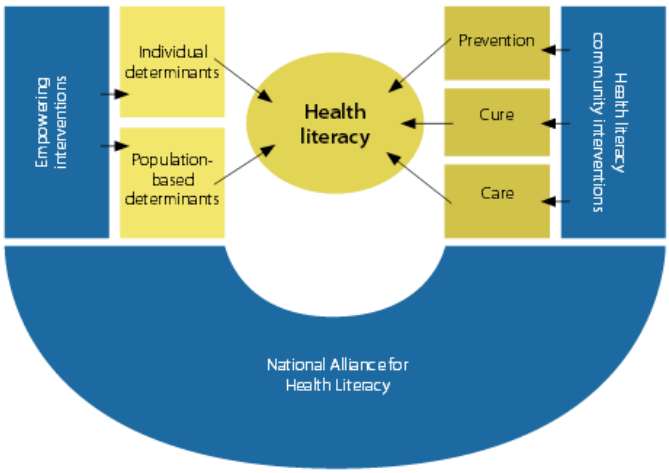
Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

This model is a population level model enabling a person to navigate three domains of the health continuum being ill or as a patient in the healthcare setting, as a person at risk of disease in the disease prevention system, and as a citizen in relation to the health promotion efforts in the community, where people live, play, work and learn (Sorensen et al, 2012).

Netherlands Model

In the Netherlands, the Alliance for Health Literacy found a combined effort of empowerment of individuals or communities with improvement of health sector communication yields the best results in improving health literacy. Tackling health literacy in the Netherlands is based on a strong lobby for patients' rights, which resulted in clear legislation as well as longstanding programmes for improved communication in the health care sector (WHO, 2013).

Figure 3: Netherlands Model



Source: Netherlands National Alliance for Health Literacy (WHO, 2013)

Health organisation level

ISLHD Health Literacy Framework: A Plan for Becoming a Health Literate Organisation 2012 – 2015

(Illawarra Shoalhaven Local Health District (ISLHD), (2014))

The Framework sets out the following five key goals to guide the ISLHD to becoming a health literate organisation:

1. Embed health literacy into high-level systems and organisational policies and practices
2. Integrate health literacy into planning and evaluation for clinical and quality improvement
3. Have plain English health information that is easy to access, read, understand and use
4. Partner with consumers in the evaluation of health information and access and navigation of services
5. Have effective and evidence based health literacy strategies in interpersonal communication

An Action Plan with specific strategies and monitoring was developed and continues to guide action in 2016. An example of the action plan strategies for goal 5 is shown below in Figure 4:

Figure 4: **GOAL 5: Have Effective and Evidence Based Health Literacy Strategies in Interpersonal Communication**

Strategies	Measurement	Timeframe	Progress
a) Develop and implement a consistent Teach-back training program in line with best practice for all ISLHD staff	i. Teach-back information presented to all new staff at Corporate Orientation ii. 100% of all new staff attending Corporate Orientation receive basic training in health literacy and the 'teach-back' communication	2013 Ongoing	Achieved, 2013 Achieved, 2013
	iii. ISLHD Teach-back training program developed (including audio-visual and written resources)	2013 ongoing	Video resources developed, 2013
	iv. Teach-back training calendar developed	2014/2015	

Optimising Health Literacy (Ophelia) Victoria, Australia

Ophelia is a partnership between two Universities, eight service organisations and the Victorian Government. The project is designed to assist agencies to identify and respond, in a planned way, to the varied health literacy needs of their clients. The project will assess the potential for targeted, locally developed health literacy interventions to improve access, equity and outcomes (Batterham, Buchbinder, Beauchamp et al, 2014).

The Ophelia project uses a methodological foundation of three systems:

1. Intervention Mapping (IM)

IM is a tool for the planning and development of health promotion interventions. It maps the path from recognition of a need or problem to the identification of a solution. Although Intervention Mapping is presented as a series of steps, Bartholomew and colleagues (2011) see the planning process as iterative rather than linear. Program planners move back and forth between tasks and steps. The process is also cumulative: Each step is based on previous steps, and inattention to a particular step may lead to mistakes and inadequate decisions.

The Ophelia project uses IM steps of:

a) Needs Assessment
   HLQ and semi-structured interviews, assess health literacy needs, and organisational assessment to determine contextual enablers and barriers.
b) Identify performance objectives, determinants and change objectives
   Structured workshop format to engage key stakeholders, consider data and needs and possible ideas to meet needs
c) Selection of interventions
   Each site generates program logic and selects appropriate interventions to test. Communities of practice formed.
d) Detailed design and planning of interventions
   Create, test and evaluate interventions using Plan-Do-Study-Act (PDSA) cycles
e) Adoption and implementation of interventions
   PDSA cycles are implemented and results considered
f) Implementation trial
   Conduct trials and evaluate those pilot interventions demonstrating potential to improve health literacy

2. Quality Improvement Collaboratives (QIC)

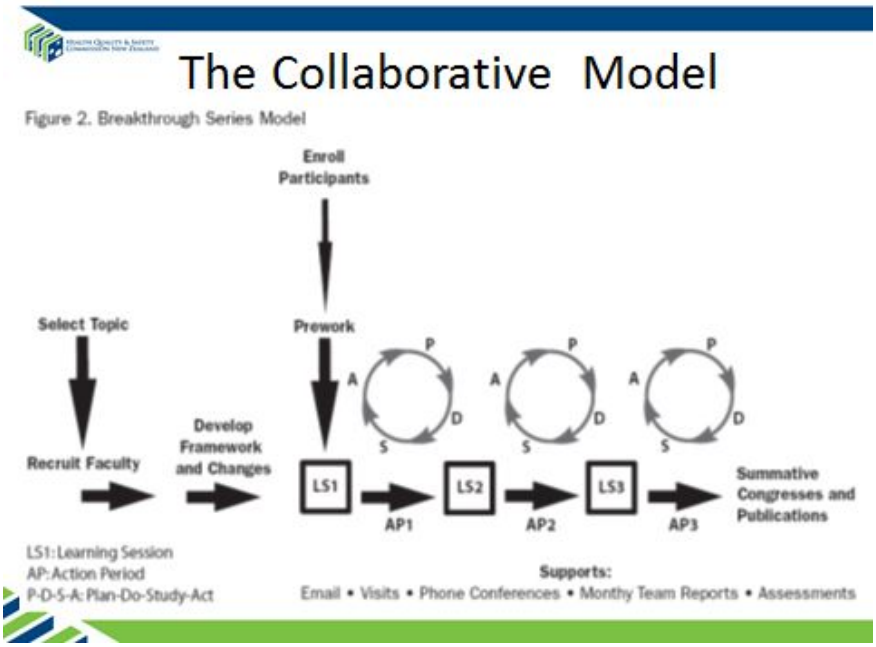
QIC (Figure 5) is a quality improvement methodology that "brings together groups of practitioners from different healthcare organisations to work in a structured way to improve one aspect of the quality of their service. It involves a series of meetings to learn about best practice in the area chosen, about quality methods and change ideas, and to share their experiences of making changes in their local settings" HQSC, 2012).

QIC have been shown to be effective in primary care delivering some real improvements in the systems of care for people with long-term conditions and a change in culture among participating practices in New Zealand (Palmer, Bycroft, Healey et al 2102). HQSC also advocates the use of QIC (HQSC, 2012) and has set these up to work on different issues, for example the safe use of opioids collaborative project (HQSC, 2014).

QIC essential components include:

- Ensuring leadership commitment
- Setting clear aims (including changes to be spread, target level of performance, target population, and time frame)
- Identifying and packaging proved ideas and practices
- Developing and executing a plan to communicate and implement the ideas
- Creating a system for measuring progress
- Establishing a process for refining the plan in response to learning during implementation (HQSC, 2012).

Figure 5: Quality Improvement Collaboratives



3. Realist synthesis

Realist synthesis is an increasingly popular approach to the review and *synthesis* of evidence, which focuses on understanding the mechanisms by which an intervention works (or not).The realist approach is particularly suited to the synthesis of evidence about complex implementation interventions (Rycroft-Malone, McCormack, Hutchinson et al, 2012).

Tools

Health Literacy Questionnaire

This is a validated tool containing 44 questions across nine domains:

1) Feeling understood and supported by healthcare providers
2) Having sufficient information to manage my health
3) Actively managing my health
4) Social support for health
5) Appraisal of health information
6) Ability to actively engage with healthcare providers
7) Navigating the healthcare system
8) Ability to find good health information
9) Understand health information well enough to know what to do

The HLQ domains cover a broad range of issues pertinent to an individual's life and can be interpreted as intrinsic and extrinsic dimensions of health literacy. Some domains more strongly reflect: a) the capability of an individual to understand, engage with, and use health information and health services; or b) more strongly reflect the capability of an organisation to provide services that enable a person to understand, engage with and use their health information or services. The latter is based on the users' lived experience of using health services (Osborne, Batterham, Elsworth et al, 2013).

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy. Further research is needed on the impact of health literacy interventions in the public health field, paying particular attention to evaluating communication about communicable diseases, and determining the most effective strategies for meeting the needs of population groups with low literacy levels, and those who are vulnerable, disadvantaged and hard to reach (D'Eath, Barry & Sixsmith, 2012).

Health literacy tools for improving communication

A number of tools/resources have been developed to assist communication for health professionals and for consumers. These include:

Three Steps to Health Literacy

Developed by the Health Quality and Safety Commission in 2014 *Three steps to better health literacy* combines a range of practical tools including *Teach Back* and *Ask Me 3* for the New Zealand context.

http://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf

Let's PLAN

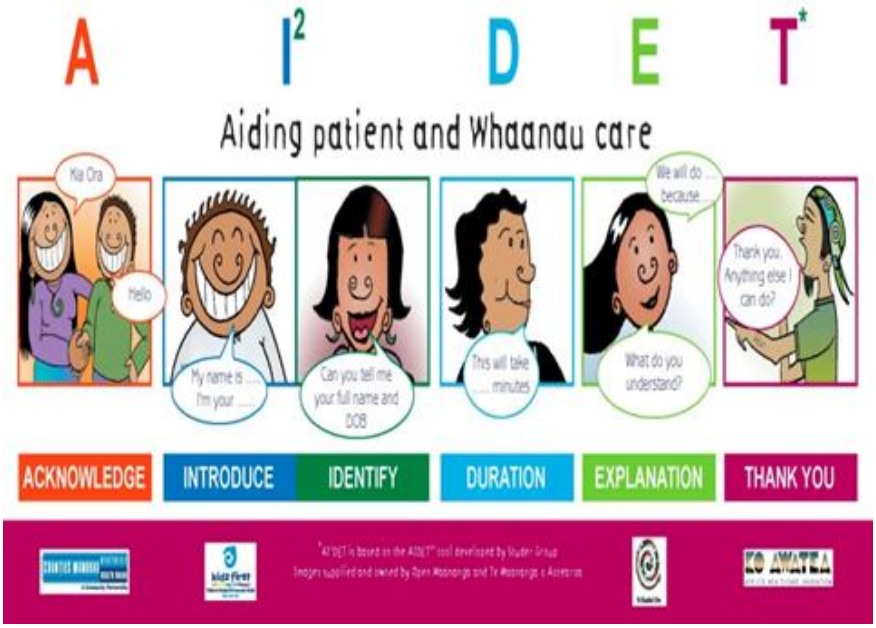
Let's PLAN is a health literacy initiative to help consumers prepare well for their visit to the GP or other primary care health professional.

The A4 flyer, with an accompanying promotional poster, encourages people to plan ahead for practice visits and to ask questions when there so they fully understand their diagnosis and treatment. It also suggests questions they can ask pharmacy staff when they pick up their medicine. Available for HQSC http://www.open.hqsc.govt.nz/patient-safety-week/publications-and-resources/publication/1826/.

Aiding Patient and Whānau Care (AI^{2}DET)

(Counties Manukau DHB, nd)

AI2DET is a communication tool adapted by Counties Manukau DHB to improve face-to-face engagement experiences for patients and whānau using services.



AI2DET emerged through the establishment of an Operational Group focusing on Patient and Family Centred Care. This led to the development of a number of workstreams, of which one was Face-to-Face Patient and Whānau Engagement.

Tools and frameworks from related areas

There are a number of quality improvement areas related to health literacy which are important to consider in a framework for health literacy. We have covered some of these below however recommend the DHB consider other work in the area of cultural competence, consumer experience and patient safety. Many of the frameworks or models sit under the area of consumer engagement. The Health Quality and Safety Commission has a stream of work dedicated to consumer engagement called *Partners in Care*. *Partners in Care* includes health literacy, co-design, patient and family centred care and shared decision making.

Cultural competence is a key area in health literacy, both at the system level and the level of health professionals. It overlaps with the several key dimensions of health literacy, particularly communication. Cultural competence is also central to addressing indigenous health inequalities.

Cultural Competence

The Indigenous Health Framework developed by the University of Otago translates the principles of cultural competency and safety into an approach that health practitioners can use in everyday practice. The framework consists of the *Hui Process* for enhancing the doctor-patient relationship and the *Meihana Model* to guide the interaction (Pitama, Huria & Lacey, 2014).

Framework for consumer engagement

Health literacy is fundamental to patient engagement. If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make sound health-related decisions (HQSC, 2015).

Figure 6: A New Zealand framework for consumer engagement (HQSC, 2015)

Patient and family centred care (PFCC)

The core elements of patient and family centred care are:

- **Dignity and Respect.** Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care (Boon, 2012).

Patient and Family-Centred Care (PFCC) is a method of improving health care quality that changes the perspective of staff delivering care, and helps them reconnect with their values and motivation for working in health care. PFCC is a simple, low-technology health care quality improvement approach designed to tackle two parallel aspects of health care: processes of care and staff–patient interactions. Together, these have a profound effect on how patients and staff experience health care (Kings Fund, nd).

PFCC helps tackle issues in:

- the organisation of care (care 'transactions' – how care is delivered)
- 'relational' aspects of care (the human interactions that take place between patients and families, and their professional carers).

Rather than blaming staff when things go wrong, PFCC seeks to understand where care systems and processes prevent them from providing the kind of care they would wish for themselves or their families. This understanding helps staff to see where improvements are possible, and enables them to reconnect with their motivation for working in health care, promoting a new workforce culture (Kings Fund, nd).

Patient and whānau centred care is a key element of the Hawke's Bay health strategy:

We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau (Hawke's Bay DHB, 2014).

Patient and family centred care toolkits

Bay of Plenty DHB

The Bay of Plenty DHB (Bay of Plenty DHB, nd) has an online toolkit for PFCC containing:

- Literature Review
- Facilitators Guide
- Organisation Leaders Self-Assessment
- Organisational Self-Assessment Templates
- Stakeholder & Communication Plan
- Getting Internal Stakeholders Involved 01
- Getting Internal Stakeholders Involved 02
- Volunteer Patient Advisor Information
- Volunteer Patient Advisor Application Form
- Orientation for Patient Advisors

Kings Fund

The Kings Fund (Kings Fund, nd) has an online toolkit, tools available in the PFCC toolkit:

- **Process mapping** – A process map is a visual representation of what happens to the patient at each stage of their care experience. It enables teams to identify which steps in the care process add value for patients and who is responsible for each step.
- **Shadowing** – This method forms the core part of the PFCC approach. It involves accompanying a patient throughout their care experience – for example, from arriving at reception to leaving at the end of the day – and taking notes and discussing experiences with patients. It is this aspect of the PFCC approach that has had the greatest impact on staff.
- **Patient stories** – This approach involves interviewing patients to gather their insights into the service they have received. It is a useful adjunct to shadowing.
- **Driver diagrams** – These are used to identify the 'drivers', or main influences, on patients' experiences. This then helps to identify the aspects of care that need to be influenced if improvements in patients' experiences are to be achieved. A driver diagram is a conceptual framework that helps teams to set an aim and then identify the key drivers (main areas of focus) and subsequent interventions they need to put in place that will align to support the achievement of the overall goal.
- **Measurement** – Measurement is an essential part of any quality improvement initiative. It must be carried out beforehand, to set the baseline, and then again at stages throughout and following the intervention. This enables you to demonstrate the impact and to identify any aspects that may need tweaking during the project.
- **The model for improvement** – This well-established approach to improvement incorporates Plan, Do, Study, Act (PDSA) cycles – also known as small tests of change, or rapid cycle improvement – which make it possible to test interventions on a small scale, and to tweak these, before rolling out more widely.
- **Snorkelling** – A group activity that enables a wide variety of health care staff to think creatively and develop their own ideas for changes that will improve patients' care experiences.

Co-design

Patient experience is positively associated with clinical effectiveness and patient safety which supports the inclusion of patient experience as one of the central pillars of quality in health care (Doyle, Lennox & Bell, 2013).

The HQSC has a co-design programme under *Partners in Care* which offers a co-design course based on the NHS Experience-based design approach (NHS, 2009). Further information about the course is available at http://www.hqsc.govt.nz/our-programmes/partners-in-care/work-streams/co-design-partners-in-care/.

Waitemata DHB has developed a toolkit and guide for co-design, *Health service co-design: working with patients to improve healthcare services* available on line at http://www.healthcodesign.org.nz/.

Many service improvement projects have patient involvement but co-design focuses on understanding and improving patients' experiences of services as well as the services themselves.

This toolkit includes a framework and tools for undertaking co-design:

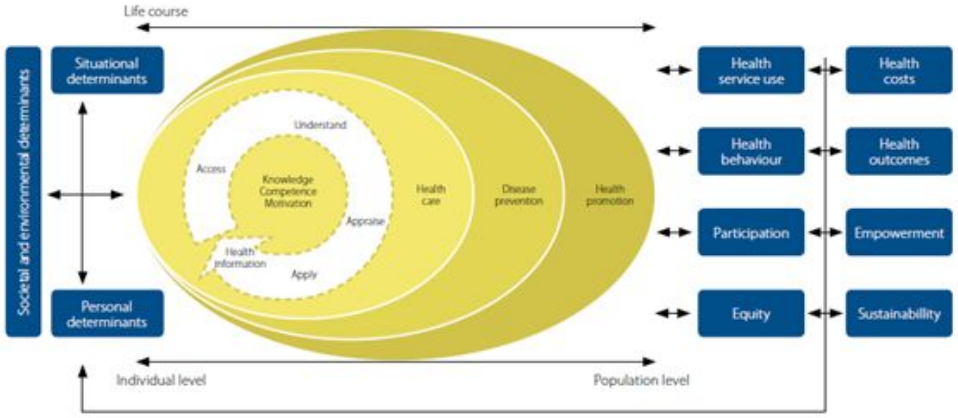
- Understanding the patient experience:
- Patient shadowing - identifying what happens during a patient visit to a service
- Patient journey mapping - summarising the service experiences patients have over time
- Experience-based surveys - learning about patients' reactions to services based on their journeys
- Patient stories - assessing patients' service experiences in their life context (Boyd, McKearnon & Old, 2010).

Summary and recommendations

- The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015).
- While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013).
- Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).

Source: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy*. Washington, DC, National Academies Press, 2009:91–98.

- The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).
- A good starting point is the conceptual model adapted from Sorensen et al 2012. This model is based on evidence and integrates medical and public health views of health literacy.



Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

- Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).
- There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012).
- Any interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014)..
- The framework should drive the workstreams (actions) of the DHB to address health literacy. These could include:
  - ✓ Providing leadership/champions for health literacy.
  - ✓ Raising awareness and building the skills of the workforce about health literacy.
  - ✓ Raising awareness and building the skills of the consumers and their families/whānau about health literacy.
  - ✓ An internal commitment to build health literacy into all DHB decisions, processes and policies.

- ✓ A comprehensive policy and support for the development of health literate resources/material for patients.
- ✓ Training for health professionals using effective and evidence based health literacy strategies in interpersonal communication.
- ✓ Guidance and support for services and organisations within the region on how to assess the degree to which they are supporting health literacy (integrating the *Health Literacy Review: A guide* and the Ophelia model including the Health Literacy Questionnaire)
- Guidance and support for services and organisations on the co-design of new processes/interventions to address health literacy.
- Oversight and guidance on the evaluation of changes made to improve health literacy (possibly using the quality improvement collaboratives (QIC) model).

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APPENDIX 4 – PROJECT ADVISORY GROUP DRAFT TERMS OF REFERENCE

Health Literacy Project Advisory Roopu – Terms of Reference

Background

Health literacy is about health organisations ensuring health services and information are easy for people to find, understand and use to make effective decisions for their health. Health literacy has come into focus after the Ministry of health reported that 56% of New Zealander's and a majority of Māori have difficulties understanding the healthcare that the health system delivers.
HBDHB has taken action to improve health literacy. A review was commissioned that uncovered a number of areas that we need to address. With these recommendations in mind, the health literacy project team has adopted a number of health literacy principles that will help to guide the health literacy work (see appendix A). Furthermore, we are using these principles to help our local health organisations look at the health literacy environment, to assess where they need to make changes, so that healthcare is easy for whanau to understand and use.

Purpose

This roopu has been established to look at how we can advise organisations in Hawke's Bay to improve health literacy. This will involve a number of ways, including how organisations approach health literacy to find out where and what it is they need to do to make improvements. Then, how can we provide them with resources that make it easy for them to make the changes to deliver health information and services to whanau that is easy to find, access, understand and use.

Role and responsibilities

The people in this roopu will be expected to:

- Provide advice and expertise on how the health system can make it easier for people and whanau to find, access, understand and use healthcare
- Provide direction to the project manager to achieve the goals of the health literacy project
- Provide advice into the process and products needed to improve organisational health literacy and the overall health literacy environment
- Communicate progress to key stakeholders and other interested parties
- Provide final endorsement of the process and products developed to improve the health literacy environment

Scope

The project includes:

- Positioning health literacy within the HBDHB peoples strategy and overall objectives of 'changing the culture' within the DHB
- How we communicate health literacy across the health sector, which is easy to understand, provides some clarity and direction on how we go about improving health literacy
- Developing a process and a set of products that help organisations to review / audit their health literacy status (or current performance), how they go about improving health literacy performance with resources to assist them in this process.
- Educating the workforce about health literacy and the impact of poor health literate practice on whanau, utilising health literacy specific strategies including the Universal precautions approach, effective communication and building quality relationships with whanau
- Advising the health sector on innovative ways to increase consumer and community health literacy skills and knowledge
- Addressing particular health literacy problem areas
- Understanding how we evaluate the health literacy programme of work to ensure we achieve the objectives and goals of the project.

And excludes:

- Decisions regarding the distribution of financial or human resources
- implementing of products into organisational BAU

Each member will have:

- Knowledge and breadth of experience with or within the health system
- Connections with whanau and people living in Māori / Pacific communities or areas of high deprivation
- Demonstrated leadership capability

Members will be appointed from the following categories:

- The health workforce
- Māori health providers, experts, academics and kaimahi
- Consumers and whanau
- Key stakeholder groups

Responsibilities of members

Project manager:

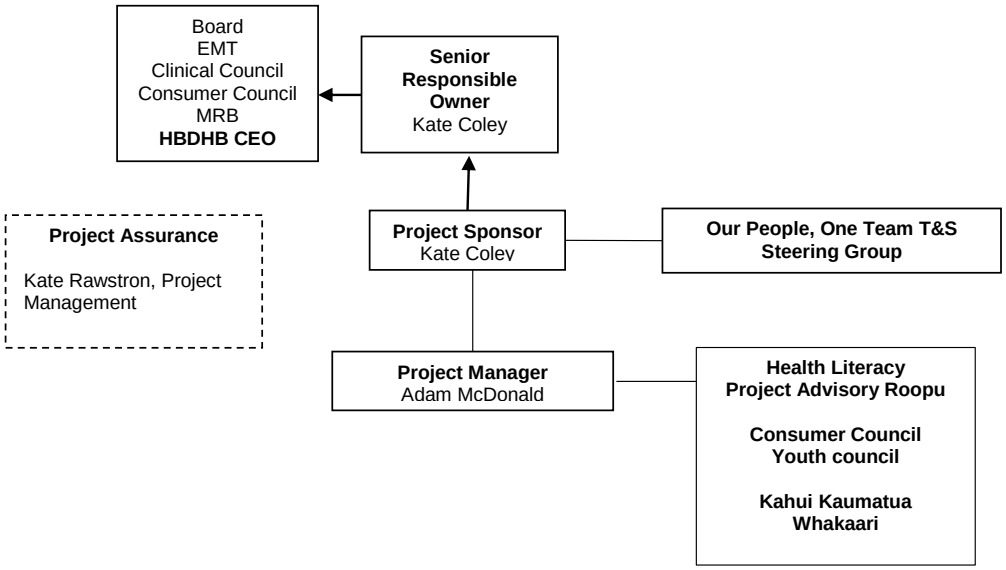
- Leads meetings effectively
- Sets and adheres to meeting protocols and ground rules
- Ensures that minutes properly reflect the input of members.
- Ensure meetings are organised and facilitated effectively
- Prepare and disseminate agenda and related papers, schedule of meetings
- Meeting records; documents required for approval
- Collate feedback from consultation

All advisory roopu members will:

- contribute positively and openly to the work of the group
- maintain regular attendance
- respond to communications
- be prepared and informed
- consult with and report to, as appropriate, the stakeholders they represent

Meetings will be held monthly until the project is completed.

APPENDIX 5 – PROJECT MANAGEMENT TEAM STRUCTURE



MEMBERSHIP UPDATE

13

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Recognising Consumer Participation**
	For the attention of: **Hawke's Bay Health Consumer Council**
Document Owner/Author:	Jeanette Rendle, Consumer Engagement Manager
Reviewed by:	Kate Coley, Executive Director People & Quality Ken Foote, Company Secretary
Month:	April 2017
Consideration:	For Discussion

RECOMMENDATION

That Consumer Council

Note the contents of this discussion paper and attached policy example.

Start the discussion and provide comment and feedback on how we might recognise consumer contribution in HBDHB activities.

OVERVIEW

Engaging and partnering with consumers is an important part of ensuring that the Hawke's Bay Health Sector is meeting the needs of our community. Why and how we do this is currently being pulled together as part of a comprehensive Consumer Engagement Strategy. One of the key issues to be addressed in this strategy will be how we value and recognise such consumer participation and engagement.

The purpose of this paper is to start the discussion on this topic and get some high level answers/direction to key questions.

Currently the only formal policy on this issue is contained within the policy on 'Payment of Fees and Expenses' (HBDHB/OPM/108), a copy of which is attached as Appendix 1. Essentially this policy provides for the payment of fees to consumer council members only, and reimbursement of justifiable expenses by other stakeholders and advisors (including consumer representatives) in exceptional circumstances. The policy does however include a number of principles that address other more intangible ways of recognising and valuing consumer input.

With the more recent heightened awareness and interest in engaging consumers, the appropriateness of this current 'narrow' policy has been raised as an issue by consumers and services alike. In lieu of a broader policy, discretionary ways of recognising consumer contribution are being employed. There is a risk that this could lead to potentially unsustainable precedents being set and unrealistic expectations being created. It is appropriate now therefore, to review and/or establish an organisation wide policy on this that acknowledges the 'new' environment, incentivises and acknowledges the desired level of engagement and balances the expectations of both consumers and the organisation. This also needs to be mindful of the financial constraints of the system, be realistic, sustainable and easy to understand and apply.

The three Auckland District Health Boards have been working together to apply consistent principals and processes across their region. Their "Recognising Community Participation" Policy is attached as a starting point for comments and discussion regarding what and how we might recognise consumer participation and the resulting implications. This policy is attached as Appendix 2

Based on the assumption that HBDHB does value and wishes to encourage consumers, whānau and community input and participation in HBDHB work, the key questions to be answered at this early stage are:

- Does the current policy HBDHB/OPM/108 need to be changed?

- IF so, do we need to look to introduce additional/more detailed provisions for recognising consumer participation such as :

    - Respect/Manaaki
    - Koha/Gifts
    - Refreshments
    - Reimbursements
    - Payments/Fees
    - Other?

- Does the Auckland DHBs policy provide a useful template/starting point for the development of a similar HBDHB policy?

- If not, what other approaches could be taken?

- What other issues need to be taken into account in developing such a policy?

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Operational Policy Manual
	Doc No:	HBDHB/OPM/108
Payment of Fees and Expenses	**Issue Date:**	July 2012
	Date Reviewed:	December 2013
	Approved:	Company Secretary
	Signature:	Ken Foote
	Pages :	1 of 4

PURPOSE

This policy sets out the basis for the payment (or non payment) of fees and expenses to members of HBDHB committees, advisory groups, stakeholder groups and project teams.

SCOPE

This policy will apply to everyone who attends meetings or who otherwise provides input into any governance, clinical or management committee, advisory group, stakeholder group or project team (as defined below) regardless of whether they are appointed, co-opted or otherwise asked to be involved.

PRINCIPLES

The fundamental intent of this policy is to set out very clearly HBDHB's position on the payment (and non payment) of fees and expenses in such a way that the expectations of any person contemplating getting involved in such activities, can be managed at the outset.

Significant principles on which the policy is based include:

1. HBDHB will pay remuneration, fees and expenses (as appropriate) to all those individuals who have (either individually or collectively) been formally appointed to a role that has delegated authority or a contractual responsibility to make decisions and/or recommendations, provide services or otherwise act on behalf of HBDHB. Such payment recognises not only the value of the input or service provided but also the legal responsibility and accountability attached to it.

   Such individuals include:
   - HBDHB Board and Board Committee Members
   - Hawke's Bay Clinical Council Members
   - Hawke's Bay Health Consumer Council
   - HBDHB Staff and Contactors
   - Contracted Professional and Specialist Advisors

2. For these individuals, such involvement in relevant committees, advisory groups, stakeholder groups and project teams is usually required as part of their appointment responsibilities (either directly or indirectly), or because HBDHB requires their advice based on their particular clinical knowledge, skills or experience.

3. HBDHB significantly appreciates and values the time, commitment and input of other stakeholders and advisors (as defined below) into various committees, advisory groups, stakeholder groups and project teams.

4. Such appreciation does not however, extend to the payment of fees and expenses to these individuals due to:
   - Participation is purely voluntary.

- There is no responsibility or accountability expected or required.
- With technical, clinical, professional and community representational input being provided by those appointed and accountable members identified above, participation of other stakeholders and advisors is normally invited to provide additional views, perspectives, opinions and experience to add balance and depth to the discussions and recommendations.
- There is no objective basis for putting a dollar value on such input that would be fair and equitable to the range of stakeholders and advisors involved.

5. Genuine appreciation for the input of other stakeholders and advisors will be expressed and demonstrated on an ongoing basis.

6. The non-payment of "other stakeholders and advisors" will be taken into account in the setting of the timing, frequency, location etc., of meetings and the means of maintaining communications.

   A key consideration will be minimising the disruption and potential costs and/or losses incurred by such members.

7. Applications for justifiable reimbursement of expenses from other stakeholders and advisors may be considered and approved in exceptional circumstances.

POLICY

In relation to the payment of fees and expenses for involvement in HBDHB committees, advisory groups, stakeholder groups and project teams:

HBDHB will pay for:

- HBDHB Board and Board Committee Members:
  - Paid under the provisions of the Crown Entities Act as set out in Schedule 4 of the HBDHB Governance Manual. (Cabinet Fees Framework)
- Hawke's Bay Clinical Council:
  - Paid as part of HBDHB employment agreement (if HBDHB employee) or through individual contract/agreement.
- Hawke's Bay Health Consumer Council
  - Paid in accordance with the Cabinet Fees Framework applicable to HBDHB statutory Committees. Additional fees and allowances may be paid to the Independent Chair depending on the level of commitment involved in addition to Consumer Council meetings.
- HBDHB Staff and Contractors:
  - Paid in accordance with employment agreement or (direct or indirect) contract for services.
- Contracted Professional and Specialist Advisors:
  - For primary care clinician advisors (where appropriate), paid an agreed fee as partial compensation for lost earnings as a result of attending relevant meetings
  - For all others, paid in accordance with contracted terms and conditions.

HBDHB will not pay for:

- Other stakeholders and advisors.

The above seven principles shall be applied as part of this policy.

DEFINITIONS

"HBDHB Committees, Advisory Groups, Stakeholder Groups and Project Teams"

Includes all those committees, groups and teams established from time to time (whether formally in accordance with specific terms of reference or not), for a specific HBDHB purpose requiring the provision of information, discussion, analysis, opinions, perspectives, advice, experience etc., into the decision making and performance monitoring structures and processes of HBDHB.

"HBDHB Board Committee Members"

Includes the members formally appointed by the Board to those committees established by HBDHB under the provisions of the New Zealand Public Health and Disability Act 2000 i.e.:

- Community and Public Health Advisory Committee (CPHAC)
- Disability Support Advisory Committee (DSAC)
- Hospital Advisory Committee (HAC)
- Finance Risk and Audit Committee (FRAC)
- Maori Relationship Board (MRB)
- Pacific Health Leadership Group (PHLG)
- Appointments and Remuneration Advisory Committee (ARAC)

"Hawke's Bay Clinical Council"

Includes only to those individual members formally appointed by the Board to the HBDHB Clinical Council i.e., does not include those clinicians invited to attend all/or part of the Clinical Council meetings from time to time, or those non-Clinical Council members invited to participate in Clinical Council Committees or Sub-Committees.

"Hawke's Bay Health Consumer Council"

Includes only those (15) individual members and the independent Chair formally appointed to the Consumer Council. It does not include those consumers invited to participate in Consumer Council sub-committees or as consumer representatives on other HBDHB advisory groups or project teams.

"HBDHB Staff and Contractors"

Includes all those who are engaged full time, part time, temporarily or casually by HBDHB through either an employment contract or a (direct or indirect) contract for services.

"Contracted Professional and Specialist Advisors"

Includes those businesses and/or individuals who provide professional or specialist services or advice, not otherwise available to the DHB from any of the above, who are engaged by an authorised manager of HBDHB on a contracted fee for service basis for a designated purpose and/or fixed period of time. Includes also those primary care clinicians formally appointed from time to time to provide relevant clinical advice through a Hawke's Bay Clinical Council Committee or an HBDHB Project Team.

"Other Stakeholders and Advisors"

Includes all those other health sector, business, public service, consumer and/or community members who have voluntarily become involved in the structured decision making, advisory, information gathering, monitoring or consultative processes of HBDHB.

MEASUREMENT CRITERIA

Measurement Criteria/Success indicators are measureable aspects which provide evidence of effective implementation of the policy e.g. staffs knowledge of policy content, staff's knowledge of how to access the policy, critical factors within the policy that can be audited. The measurement criteria describes how the policy compliance will be monitored that is; audit survey etc e.g. There is an annual audit undertaken to measure compliance with this policy.

This policy will be reviewed every three years.

REFERENCES

Governance Manual for Hawke's Bay District Health Board, December 2013 (as amended).

KEY WORDS

Advisor
Advisory
Board
Committee
Contracted
Contractors
Expenses
Fees
Payment
Professional Advisor
Reimbursement
Specialist Advisors
Stakeholder

For further information please contact the Company Secretary.

Policy: Recognising Community Participation

Background /Overview

The policy provides guidance for all DHBs to apply consistent princples and processes relating to recognition of Community engagement and participation. This revised version includes a number of changes to ensure wording is clear, there is alignment with key financial and strategic requirments and greater use of examples to clarify terminology.

Purpose

Auckland, Counties Manukau and Waitemata DHBs value and encourage patients, families and communities' feedback, input and participation in DHB work. In addition, we financially recognise the contribution of people who are specifically invited by either DHB to contribute their expertise and advice. This policy explains how we financially recognise this contribution in a way that is principles-based and compliant with financial and other regulations.

Scope of Use

This policy is applicable to all Auckland, Counties Manukau and Waitemata DHBs' Board members, employees (full time, part time, casual and temporary) who engage with the community to involve the community voice in planning, improvement and decision making processes. This policy also applies to employees from the Northern Regional Alliance and Health Alliance. For ease of use, this policy will use the term 'the DHBs' when referring to these organisations.

This policy will be implemented when:
- Consulting patients and other community stakeholders
- Engaging the wider public and/or key stakeholders about important decisions

Out of Scope

This policy does not apply to employment matters.
This policy does not apply to engaging contractors or consultants providing professional services.

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Counties Manukau Health			

Definitions

Community	Community can be defined by place, identity and shared interest. For the purposes of this policy, a community member is anyone who may be interested and/or affected by a health□related activity, proposal or decision to be made.
Consultation	Consultation is identified as part of developing and implementing health and disability services and programmes in section 22 of the New Zealand Public Health and Disability Act 2000 and the Local Government Act 2002. The process includes soliciting public feedback on a proposal and decision□makers being able to demonstrate that they have taken that feedback into account when finalising a proposal. The objectives of District Health Boards under section 22 include: … (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders: (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services: (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services: … The term consultation also has a particular meaning with the context of the Treaty of Waitangi.
Consumer	By consumer we mean patients or service users and their families or whānau.
Consumer representative	A consumer representative is a person with healthcare experiences relevant to the project or management group. A consumer representative provides advice based on either his/her own personal experience of services or care, or on behalf of others[1].

[1] It should not be assumed that a consumer representative is representing the views of others unless a defined group of consumers or service users has specifically given him/her the mandate to do so (such as through election/ appointment to a position of spokesperson, for example). A connection to an established consumer network is particularly useful for consumers participating at a governance level, because in addition to personal experience of a health care service, they can draw on the knowledge and understanding of a wide range of people with similar, relevant experience. In appointing external people to participate in reference, advisory, working groups or special projects, it should be clearly stated from the outset whether the person has been invited to contribute as a representative of their organisation or established community network, or as an individual.

Engagement	Engagement is not a legislated process. It can take many forms and serve many purposes that allow consumers, stakeholders and other community members to inform and/or participate in decisions that affect their health and the development of services. Informing the community does not, in itself, constitute engagement. Engagement requires dialogue and building relationships.
Stakeholder	A stakeholder is a person or collective that has something of value that may be affected by a project's outcome.
One-off	For the purposes of this policy and in the context of activities and expenses, one-off means irregular, unpredictable or unusual. Examples: *Activities*: If a project team cannot predict what kind of activity a community member will need to participate in and when during his/her engagement with the DHB than those events are considered to be 'one-off'. *Expenses:* If a community member cannot predict how much she/he will have to pay and for what type of good or service during his/her participation, that expense is considered to be a 'one-off'.
On-going	For the purposes of this policy and in the context of activities and expenses, ongoing means predictable. Examples: *Activities:* if a meeting is scheduled to occur regularly with the same group of people as part of business as usual, that activity is classified as 'on-going'. *Expenses*: if a community member can predict that s/he will pay the same amount of money for the same good or service more than twice during the term of his/her participation, that expense is defined as 'on-going'.

Policy

Policy Statement

The DHBs value and encourage consumers, families and communities' feedback, input and participation in DHB work. In addition, we financially recognise the contribution of people who are specifically invited by the DHBs to contribute their expertise and advice.

This policy covers people from the consumer, stakeholder and community sectors who are not otherwise receiving remuneration for their time and participation in DHB activities. It includes invitations to people to participate and contribute in one□off initiatives as well as people who contribute their expertise to longer-term projects.

The underlying principles for this policy include:

- Active engagement of DHBs with people in the community adds value by improving decision making, building knowledge and enabling fair and informed judgments.
- The DHB will invite people from the community to participate in one-off or ongoing events, focus groups, advisory and reference groups and in special project work.
- The DHB will ensure that the time and effort of people in contributing to the development of DHB initiatives will be appropriately resourced in all respects.
- All expenditure decisions in recognition of community participation in DHB activities will be made with integrity and transparency.
- All people participating will be considered equal, irrespective of their profession, qualifications, experience or background.

The team coordinating consumer representatives at the relevant DHBs should be notified of all appointments of consumer representatives – for example, this could be the Patient Experience or Engagement team.

Respect/Manaaki

Manaaki is defined as "to support, take care of, give hospitality to, protect, look out for".

Recognition of people invited to participate in DHB activities requires that they are positively valued and shown respect. It requires sensitivity to people's cultural and social diversity and an awareness of issues for people with disabilities. It means that people assisting the DHB should be provided with sufficient resources to enable and support effective contribution. It includes the provision of sufficient information, support with transport or other needs as required, ensuring that the venue and the information are fully accessible, providing refreshments, formally acknowledging people for their participation and providing feedback on the community input

The DHBs recognise community input by demonstrating to participants that their input is seriously considered and is reflected in health planning and funding decisions.

Koha/gifts

Koha/Gift is defined as an 'unconditional gift', and may be presented as a token of appreciation for contributions made to DHB activities. Gifts may be given in the form of petrol vouchers or other tokens of appreciation. The value of a gift for a person involved in any one project should not exceed $50.00.

Gifts should not be given regularly to the same person, as they may then constitute taxable income.

People already on a salary or a contract, which covers their participation, should not receive a gift.

Refreshments

It is appropriate to provide light refreshments for those who inform or advise the DHB through activities such as consultation events or forums. Reference should be made to the DHB's healthy food and catering policies.

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Payments and Reimbursement

People who participate in DHB activities should be reimbursed for reasonable expenses associated with their participation.

The table below provides a guide to the kind and level of reimbursements and recognition payable. The table is based on activities that are attended in-person but payments can also be made when people participate in in other ways, for example teleconferences or work done by individuals from home.

In all cases, the amount and type of on-going expenses must be approved by a GM (or other role with the relevant delegated authority) in advance of the project with the upper limit established.

For ongoing activities, there must be a letter of agreement sent to the participant and a terms of reference agreed for the project/committee activity with GM/appropriate sign off. The agreement should include an outline of expectations of the consumer representative's contribution, e.g. if a consumer representative chairs a meeting or is expected to seek wider community views on a topic, consider what additional time would be required to be able to fulfil this function well . The agreement should outline any processes for recompense, including a process for compensating expenses for last minute change to meeting dates or times.

Eligible people, i.e. those involved in on-going activities should itemise their out of pocket expenses by invoice, providing receipts where possible, and should also acknowledge receipt of the payment.

People receiving vouchers to cover their expenses should also acknowledge receipt of the payment and this should be kept on record.

People already on a salary or a contract which covers their participation should not receive any reimbursement for out of pocket expenses for participating in a project/activity.

The DHB will not compensate people for taking time off work or for loss of income or costs of a locum etc. as a result of providing input to DHB projects.

Reimbursement and recognition details

	Type of activity	Type and extent of financial support or recognition DHB can provide	Paid by
1	**General invitation to a public meeting/hui** Participation in a public consultation e.g. attending a public meeting, hui, fono or discussion group	• No honorarium or koha[2] • Assistance for people who would otherwise not be able to attend, e.g.: mobility taxi service (see also Travel Expenses Table, below). • Assistance if requested with interpreters, or other supports that are essential for participation • Refreshments	• Taxi vouchers or other travel vouchers (e.g. ferry tickets) posted out prior to the meeting where possible • Carpark pass if meeting is on hospital grounds
2	**Personalised invitation to one-off events** Participation in focus group, forum, workshop or meeting	• A koha or gift may be appropriate • Reimbursement of reasonable out-of-pocket expenses up to $125.00 per meeting • Assistance if requested with taxis/transport for people who would otherwise not be able to attend • Expenses may include travel, childcare and special aids for participation.	• In form of petrol, supermarket or Westfield vouchers etc. (it is helpful to provide a choice as not everyone drives) • Carpark pass if meeting is on hospital grounds • Taxi vouchers or other travel vouchers (e.g. ferry tickets) posted out prior to the meeting where possible
3	**Invitation to ongoing group membership, partnership or collaboration**	• Reimbursement of reasonable out-of-pocket expenses up to $125.00 per meeting (see Travel Expenses Table). • A maximum payment for both expenses and honorarium of $250 per person per meeting. • Expenses may include travel, childcare and special aids for participation but must be agreed prior **Consumer representative working at a project level** • Payment of an honorarium for time is recommended at between $40 and $60 per hour (before tax). **Consumer representative working at a governance level** • Payment of an honorarium for time is recommended at between $75 and $100 per hour (before tax).	• An Honorarium is paid in recognition of time made as tax deducted payment. • Expenses reimbursed are tax exempt. Paid retrospectively on invoice. • Carpark pass if meeting is on hospital grounds

Note 1: Exemptions for payments above this level of remuneration can be approved at the discretion of the General Manager or persons with delegated authority

[2] Note that community organisers/ networks that help host and bring people from the community to a public meeting or hui may receive a koha in recognition of their time and effort.

Note 2: This policy does not preclude paying a lesser hourly rate for attendance.
Note 3: Compliance with internal DHB processes for paying suppliers is required. This includes setting up suppliers with accounts payable prior to invoices being presented. This is the DHB's responsibility not the invitee's.

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Travel expenses

Note 1: The basis for reimbursement of travel expenses for those participating in one-off events and activities is set out in the table below. The amounts to be reimbursed represent the reasonable costs of travelling by car (IRD mileage rate of $0.72 per kilometre has been used as the basis for the calculation) within the distances specified. (NOTE: For those who are eligible to invoice for out of pocket expenses specific mileage should be used). The table provides a guide to aid administrative processes, particularly for those participating in one-off events and activities:

Return Trip distance	Expenses reimbursement
0□40km	$30
41□60km	$50
61□90km	$70
91□120km	$90
120km+	$125

• References

Associated Documents

The table below identifies associated documents.

Type	Title / description
DHB Documents	WDHB Engagement Strategy Finance policies and procedures Healthy food and catering policies
Inland Revenue Advice	Inland Revenue Department 2011 legislative advice – "Tax treatment of reimbursements and honoraria paid to volunteers" Fact Sheet IR278 "Payments and gifts in the Māori community"
Legislation	New Zealand Public Health and Disability Act 2000
Strategies	NZ Health Strategy 2016 Disability Strategy 2001
Ministry of Health	Operational Policy Framework Consultation Guidelines for the Ministry of Health and District Health Boards relating to the provision of health and disability services (2011) A Guide to Community Engagement with People with Disabilities (2016)
Health Quality and Safety Commission	Engaging with Consumers – A Guide for District Health Boards (2015)

Further guidance on community participation; and how to implement this policy is available through:

- Community Engagement Manager – Waitemata DHB
- Patient and Whānau Care Advisor, Counties Manukau DHB
- Participation and Experience team, Auckland DHB
- Corporate and Business Support Manager, Northern Region Alliance

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HAWKE'S BAY District Health Board Whakawāteatia	**Consumer Engagement Strategy** **FINAL DRAFT**
	For the attention of: **HB Health Consumer Council**
Document Owner/Author:	Jeanette Rendle, Consumer Engagement Manager
Reviewed by:	Kate Coley, Executive Director People & Quality
Month:	May 2017
Consideration:	For Endorsement

RECOMMENDATION

That HB Health Consumer Council

1. Note the contents of this paper and attached strategy
2. Endorse the Consumer Engagement Strategy – Final Draft subject to any changes required
3. Note the matters to be resolved and proposed action plan to support the implementation of the strategy.

PURPOSE

The purpose of this paper is to present the final draft of the Consumer Engagement Strategy for endorsement, to highlight the matters yet to be resolved and to outline the proposed action plan which will spport effective implementation of the strategy.

OVERVIEW

It is our ultimate aim to create a culture which puts people at the centre of everything that we do, and one that is respectful of, and responsive to the needs, preferences, and values of our community. Consumer engagement is one enabler of a people centred culture.

The attached consumer engagement strategy has been developed as a key piece of work alongside others to:

- Achieve culture change.
- Strengthen and embed consumer participation at all levels in the health sector
- Ensure consumers are active partners in how we design, deliver and improve services
- Drive improvements - experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture'. It should be linked to other organisational plans and build on existing skills and the work we are already doing. The strategy supports the Hawke's Bay Health Sector vision of *"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

MATTERS TO BE RESOLVED

To ensure a systematic approach to working with the people of Hawke's Bay is developed and implemented the following questions will need thorough consideration and to be practically worked through:

- How will we develop success measures?

The collection of consumer feedback over time is in itself a measure of increasing engagement. At a systems level measuring success will mean looking at all areas in which consumers have been involved. To measure how well engagement is being embedded we could consider building it in to performance reviews, regularly review the diversity of consumer representatives and publicly report quality initiatives that have involved consumers.

- How will we recognise consumer participation and engagement?
- Will there be a budget for consumer engagement and where does it sit?

Based on the assumption that we value and wish to encourage consumer, whānau and community input and participation in our work, a discussion paper has been written to work through how we might recognise consumer participation and the budget required to do so. This is being considered by consumers and management.

A review of our current narrow policy ('Payment of Fees and Expenses' (HBDHB/OPM/108) and/or the establishment of an organisation wide policy that incentivises and acknowledges the desired level of engagement and balances the expectations of both consumers and the organisation is required. This needs to be mindful of the financial constraints within the system, be realistic, sustainable and easy to understand and apply.

This should include tangible and intangible recognition of participation as well as investment in training and support. Tangible recognition may include koha/gifts, refreshments, reimbursements, payments and fees. Intangible recognition my include consideration of timing/place of meeting, sincere and valued acknowledgment of contribution. Processes need to be developed to support the implementation of this.

- What information systems are required to support this work?

Currently there is not one electronic source of the truth when it comes to understanding the depth of existing engagement initiatives and information, communications and databases to support engagement work. This will need to be linked up to reduce duplication and waste.

- Based on the assumption that everyone has a part to play in consumer engagement, who will be specifically responsible for what?

For consumer engagement to be effective, clear roles and responsibilities need to be clearly defined. Partnership roles should be well thought through and support will be required from leaders and champions within the system. Consideration will need to be given to how we resource and support administration and coordination of consumer representatives and engagement activities.

WHAT IS REQUIRED?

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring however there is also a lack of guidance, practical resources and tools to support effective engagement. A systematic approach needs to be developed and implemented to support engagement being effortless and part of business as usual. Consistent processes, policies and guidelines for engagement need to be developed.

Six key work stream themes have been identified. The following proposed action plan provides more detail around the streams of work that need to be developed and considered to embed and practically support the implementation of the consumer engagement strategy.

1. Culture change
2. Roles and responsibilities
3. Consumer Engagement Framework
4. Consumer Leadership
5. Consumer Feedback
6. Working in Partnership

CONSUMER ENGAGEMENT ACTION PLAN (draft)

	Work streams	Proposed timeframes Start	End
1.	**Culture Change** Position the consumer engagement strategy within the people strategy, with the aim of shifting culture.		
2.	**Roles and Responsibilities** • Identify leaders, champions and partners in the system • Clearly define roles and responsibilities for everyone that plays a part in consumer engagement • Consider how we resource and support administration and coordination of consumer representative and engagement activities	ongoing	
3.	**Consumer Engagement Framework** Support the consumer voice to be a formal part of any planning or redesign process through developing guidelines and resources to embed consumer engagement activities into current and future work. This may include: • Consumer Engagement toolkit including processes, policies, decision tree and flowchart • Guidelines for engagement within projects • Training and education to support staff and build capability in co-design • Recognition of consumer participation • Coordination with Māori Health Service to ensure greater representation of Māori consumers • Development of success measures	May 2017	Dec 2017
4.	**Consumer Leadership**	May 2017	June 2018

	Empower consumer leadership through developing consumer representative selection, orientation and training guidelines Build and strengthen existing relationships and structures within the sector, such as clinical committees and cross sector quality forums. For example: • Guidelines for engaging with consumer council • Clinical governance committee structure (ie: patient experience committee) • Develop subgroups of consumer council • Database of available consumer representatives and community groups		
5.	**Consumer Feedback** Improve the process of gathering and monitoring consumer feedback • Ensure clear ownership and accountability • Share stories, outcomes and recommendations for improvement purposes. • Reporting calendar – from Services through to Board • Consumer Feedback process redesign • Implementation of new feedback system • Further develop patient experience survey to include outpatient areas • Online community engagement platform	ongoing	
6.	**Working in Partnership** • Work with the Health Quality and Safety Commission (HQSC) to implement consumer engagement programmes eg: patient safety week, patient experience week • Continue involvement in the HQSC sponsored National collective of Consumer Councils	ongoing	

ATTACHMENT

Consumer Engagement Strategy.

CONSUMER ENGAGEMENT STRATEGY

EXECUTIVE SUMMARY

Consumer engagement refers to the wide range of approaches in which consumers are involved in the planning, service delivery and evaluation of healthcare. Done well, it contributes to fostering a culture of people centred care. It supports active, ongoing partnership and communication that benefits consumers, staff and will ultimately transform the system.

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring. This is particularly strong at governance level and in some areas of direct patient care and service development. However, in other cases this is not always structured or consistent. There is confusion as to when, how and at what stage we should be engaging with consumers, which consumers to approach and how we recognise the contribution of consumers. There is currently a lack of guidance, practical resources and tools to support effective engagement.

This strategy is not a detailed work plan. It provides direction for the future and a framework for making decisions. It provides guidance around types and levels of engagement and the benefits of engaging. The goal being that consumer engagement at all levels is an embedded way of working and a driver for achievement of the 'Triple Aim'.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture', rather than additional work on top of an already demanding workload. It should be linked to other organisational plans and build on existing skills and the work we are already doing. Effective consumer engagement supports the Hawke's Bay Health Sector vision of "*Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

PURPOSE

The goal of this strategy is to strengthen and embed consumer participation at all levels in the health sector, ensuring consumers are active partners in their own care and how we design, deliver and improve services. It is a driver for improving experience of care, quality and safety of care, health outcomes and best value. The strategy also exists to build knowledge and educate health sector staff about the value of consumer engagement.

Ultimately, our aim is to create a people centred culture which puts our people at the centre of everything that we do, and one that is respectful of, and responsive to their needs, preference, and values. The health system has developed in a way that has encouraged passivity in consumers, where they present with problems for clinicians to fix. Increasingly there has been a recognition of the need to shift from traditional interactions to collaborative partnerships where consumers play an active role in improving systems and services by

making them more aligned to their needs. Consumer engagement is one enabler of a people centred culture and this strategy exists alongside others to achieve culture change.

WHAT IS CONSUMER ENGAGEMENT?

Consumer engagement refers to the wide range of strategies in which consumers are involved in the planning, service delivery and evaluation of healthcare. It can be at an individual, service, governance or community level.

Consumer refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

BACKGROUND

The Hawke's Bay Health Consumer Council was established to provide a strong voice for the community and consumers on health service planning and delivery. In partnership with Hawke's Bay Clinical Council they initiated a quality improvement and safety framework with priorities identified to support consumer engagement. In partnership, the vision and plan for consumer engagement was discussed and developed as one piece of a multi layered approach to shifting our culture. The establishment of the People and Quality Directorate further cements the overarching focus of shifting organisational culture to be people centred. Further detail on the background can be read in Appendix 1.

Legislative background

The Code of Health and Disability Services Consumers' rights and Te Tiriti o Waitangi underpin consumer engagement in New Zealand. Te Tiriti o Waitangi describes the principles of partnership, participation and protection. The New Zealand Health and Disability Act (2000) upholds these principles and specifically addresses the need to provide mechanisms to enable Māori to contribute to decision making and participate in the delivery of health and disability services, which are at the heart of consumer engagement.

Health Quality and Safety Commission

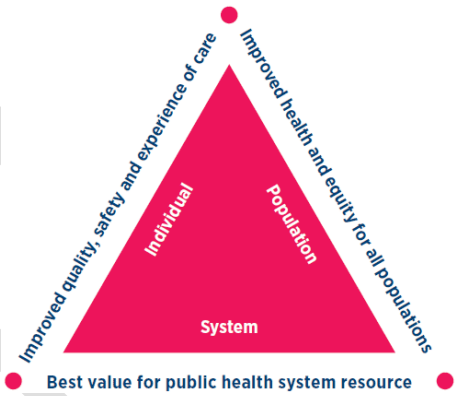
The Health Quality and Safety Commission takes a leadership role in building consumer partnerships in healthcare. They provide examples of best practise and work with health provider organisations and consumers to build recognition of the benefits of consumer engagement. They have developed "Engaging with Consumers: A guide for district health boards" and provide tools and support for effective engagement.

WHY ENGAGE WITH CONSUMERS?

Consumer engagement done well fosters a culture of people centred care. It supports active, ongoing partnership and communication that will benefit consumers, staff and ultimately transform the system.

There is evidence to support the benefits of engaging with consumers. These include improvements, such as more responsive services, improved clinical quality outcomes, and improved patient experience. In addition, safer care, less waste, reduced length of stay, lower costs, better consumer and health provider satisfaction and staff retention.

Consumer Engagement supports the New Zealand Triple Aim framework (right) for quality improvement at individual, population and system levels. One of its aims is improved health and equity for all populations. Hawke's Bay is a great place to live, but not everyone has the same opportunity to be healthy. Health inequities exist in some parts of our community. Successful consumer engagement will focus on how to be effective within this broader context.



Without proactive consumer engagement, the drive for change is usually either motivated through system failures (eg adverse events) or from external advocacy to improve the quality and safety of care. Waiting until there is a problem creates avoidable costs for consumers (physical, psychological and economic) and organisations (review processes, staff morale and more expensive treatments).

HOW DO WE ENGAGE?

Engaging with consumers can and should happen at different levels depending on the situation, and as early as possible. How we engage will be determined by the purpose, timeframes and level of impact of different projects, initiatives or programmes of work. Many will require multiple engagement methods at multiple levels.

Principles of engagement

The Health Quality and Safety commission developed a number of practical key principles that in conjunction with our shared values of He kauanuanu/Respect, Ākina/Improvement, Rāranga te tira/Partnership and Tauwhiro/Care underpin effective consumer engagement.

1. **Being open and honest -** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. **Providing support -** Support for consumer engagement means being welcoming when meeting consumers, valuing their expertise, and acknowledging and taking consumer viewpoints seriously.

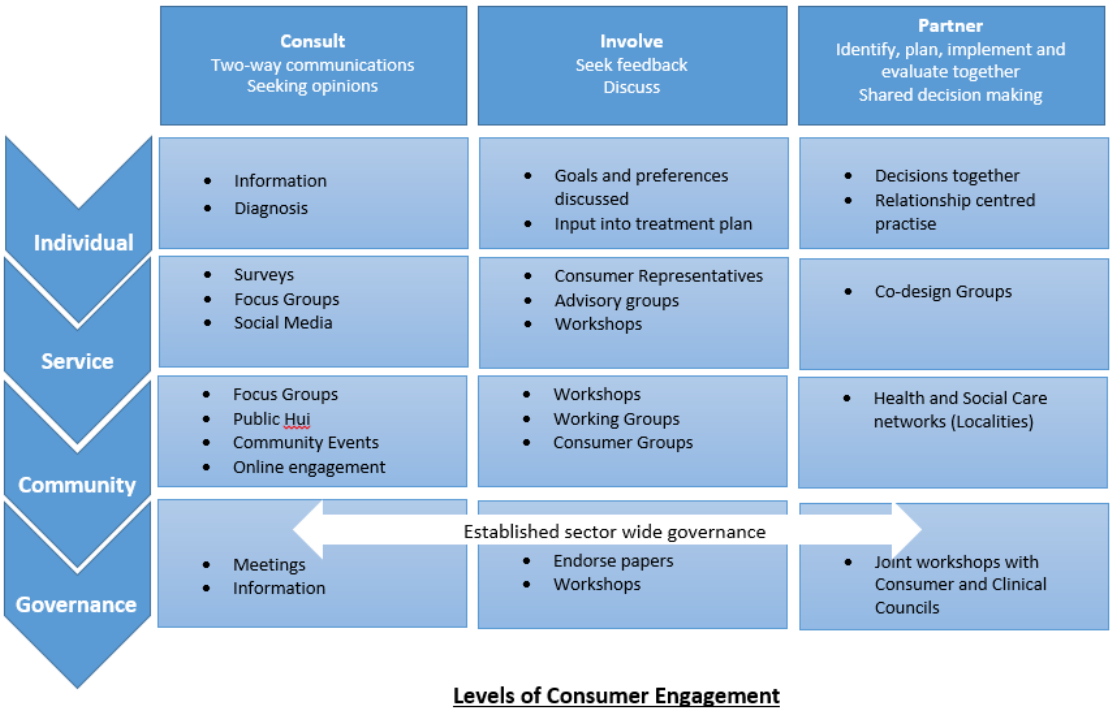
3. **Being real -** Consumers and providers know when we are simply going through the motions of consulting with consumers. Consumer engagement needs to be genuine. All parties should know the purpose of why engagement is taking place and real possibilities for change and improvement.

4. **Patient and whānau focus -** All consumer engagement needs to keep the focus on patient and whānau centred care. It is important that providers and staff are supported to maintain their focus on patient/family/whānau as a core aspect of care.

Levels of engagement

Individual engagement includes consulting, involving and partnering with individuals in shared decision making about their own health. Put another way – *" 'my say' in decisions about my own care and treatment".* This is covered in more detail within the work being undertaken in the health literacy project, engaging effectively with Māori, and relationship centred practice training.

Collective engagement includes consulting, involving and partnering with individuals or groups of consumers at a service, community or governance level. Put another way – *" 'my' or 'our say' in decisions about planning, design and delivery of services".*



Levels of Consumer Engagement

It is easy to see and value the role of consumers at an individual level – engaging in and contributing to decisions about their own care, or that of loved ones. However, the case is also

strong for involvement of consumers at more collective levels, to ensure that our organisation and health sector is people centred. Consumer participation extends beyond attending meetings.

As seen in the previous diagram, consumers can be engaged collectively in various ways, at multiple levels including:

- As equal partners when redesigning services through co-design groups
- As members of committees, advisory and governance groups
- Through workshops, working groups, steering groups, focus groups and public hui's
- Through consumer and patient experience surveys and feedback mechanisms
- Involvement in consumer interviews, patient stories, patient journey mapping

LINKS TO OTHER STRATEGIES

It is important to acknowledge other strategies and frameworks that to the implementation of this strategy:

- The Quality Improvement and Safety framework "working in Partnership for Quality Healthcare in Hawke's Bay" (2013) outlines priorities that support consumer engagement in Hawke's Bay.

- Patients and Whānau at the centre and services developed around the needs of our patients is a core principle of Hawke's Bay Health System – Transform and Sustain 2013 – 2018

- Youth involvement is a core principle of The Youth Health Strategy 2016 – 2019 in building health system resiliency through youth participation in governance, leadership, design and delivery of work.

- The Mai Māori health strategy focuses on engaging better with whānau and responding to the needs of Māori in the way they prefer services and care.

- The Pasifika Health Action Plan 2014 – 2018 supports a collaborative approach with pacific communities.

- Significant consumer input will be required to make a 'health literate sector' a reality.

- The People Strategy will address the development of a culture for the health sector that will need to include respecting and communicating effectively with consumers

- The development of Health and Social Care Localities includes significant requirements to consult with and engage local communities in decision making.

SUMMARY

The solutions to challenges in the health care sector won't come from doing business as usual. They will come from fostering a people centred culture and building equal and sustainable partnerships with consumers who care about improving the health and wellbeing of our people and reducing inequities within our community. Effective consumer engagement that is embedded in our "way of working" and part of our 'culture' will benefit consumers, staff and will ultimately transform the system.

APPENDIX 1

Background to Consumer Engagement in Hawke's Bay

2013 – The Hawke's Bay Health Consumer Council was established to provide a strong voice for the community and consumers on health service planning and delivery.

2013 - Hawke's Bay Clinical Council, in partnership with the Hawke's Bay Health Consumer Council initiated a quality improvement and safety framework: Working in Partnership for Quality Healthcare in Hawke's Bay. The document divided quality improvement and safety into four areas to provide a focus for our work and help us identify opportunities for improvement. These domains and the priorities within them support consumer engagement in Hawke's Bay.

2014 - To realise the objectives and direction outlined in the Quality Improvement and Safety Framework it was identified that change was required in the way services to support this framework were structured. This led to the development of the Quality Improvement and Patient Safety Service and the new role of Consumer Engagement Manager, appointed in July 2015.

2015 - Partners in Care: Consumer Engagement – a case for change was presented to Clinical and Consumer Councils for feedback and consideration. Workshops were held and the vision and plan for consumer engagement discussed. This was further developed where Consumer Engagement was identified as one piece of a multi layered approach to shifting our culture to being people centred - putting consumers and their whānau at the centre of everything we do.

2017 - The establishment of the People & Quality Directorate through the merger of the Human Resource and Quality Improvement and Patient Safety Services in February 2017 further cements the overarching focus of shifting organisational culture to be people centred.

OURHEALTH HAWKE'S BAY Whakawateatia	**Update on Establishing Health and Social Care Localities in Hawke's Bay**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner:	Tracee Te Huia (Executive Director of Strategy and Health Improvement)
Document Author:	Jill Garrett (Primary Care Strategic Services Manager)
Reviewed by:	Paul Malan (Acting General Strategic Services Manager); Te Pare Meihana (Change Leader Wairoa Locality) and Executive Management Team
Month:	April 2017
Consideration:	For Information

16

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Councils:

1. Note the contents of this report.

PROGRESS TO DATE ON LOCALITY DEVELOPMENT

Work is underway to establish Health and Social Care Localities in Central Hawke's Bay and Wairoa. The work in both localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. The Change Leadership roles are proving effective in growing the locality stakeholder membership, trust in the processes that are being followed and building effective relationships across the sector providers, both in health and the wider social sector.

Each locality has worked within a co-design, consumer driven approach. Projects have begun that address priority areas identified within health needs assessment, equity reporting and consumer consultation findings.

The range of initiatives are diverse within each of the localities. Where appropriate, direct links are made to contributing to existing DHB initiatives that are focused on rationalising the use of resources.

The benefits of attending the NUKA training in November last year is evident in the momentum that is growing within each of the localities. The confidence in where the process can lead and the autonomy of design is intrinsic to the NUKA model.

Strategic Leadership Established

In both Wairoa and Central Hawke's Bay, a DHB-sponsored Change Leader role has been established and they have the confidence of their multiple and diverse stakeholder groups.

The Change Leaders have worked within existing networks to establish and or strengthen provider networks, which have included both the health sector and wider social and local government agencies.

Confidence in their abilities in relationship management, project management and as change agents who can effectively manage the challenges that the locality work presents, is evident in the progress to date that has been made in each locality.

Activities and Progress in each Locality:

CENTRAL HAWKE'S BAY (CHB)

The Strategic Plan developed by the CHB Health Liaison Group (HLG) has provided a good foundation for prioritising ideas that present to the group on health reform for the area. The four areas aligns current work to the following mission statements of the locality:

- Reducing barriers to access
- Establishing and maintaining effective communication lines
- Facilitating a dynamic workforce
- Strengthening trust between providers

Locality strength continues to grow through the trust that is building amongst the local providers and HLG members. The HLG are working under a collective impact model (see Appendix 1 for an overview). Assessment against the model illustrates strength in Governance and Infrastructure. More work needs to be done in Community Involvement and Evaluation and Improvement before they can be confident in moving towards phase 2 – impact and action.

The HLG are working towards developing principles, similar to those of NUKA that reinforce the branding logo of "Living Well in CHB". The focus will be building an expectation of what wellness looks like at home, in the workplace, in the community and recovering and managing your own health in times of acute illness

CHB initiatives currently underway are:

- Contributions to 'Saving 4000 bed days'**:** the Change Leader is brokering the process by which transitioning of care to CHB is activated based on agreed levels of acuity. The model is proactive rather than only activated when Hastings Hospital is in crisis. Evidence is being gathered to monitor bed utilisation rates as well as looking ahead to readmission rates. The thinking behind this is patients managed closer to home will have:
    - increased confidence in self-management;
    - fewer acute episodes; and
    - lower readmission rates.

- CHB Workforce Wellness Package. This involves working with Silver Fern Farms, Workforce NZ, The DHB Health Promotion team and Central Health to design and implement a wellness package of care that would reinforce "Living Well in Central Hawke's Bay" brand. It would be informed by successful work place models currently in operation in other large employers in the wider Hawke's Bay district.

- Communication and signage using the DHB "Choose Well" branding. Currently the Change Leader is working through issues specific to the locality. Adequate signage has been a request of the community for some time in relation to access to urgent care and after hours care.

- Broadening the membership of the Health Liaison Group. Membership now includes representation from the GPs of Tukituki Medical. Pharmacy have also signaled interest in being part of the group. Current membership includes: Local Government – Deputy Mayor, Consumer Council, MRB, Māori Health Provider, CHB Health Centre Operations Manager, Mayoral leadership forum, Aged Residential Care, CHB Māori Iwi representative, Nursing leadership, PHO and DHB.

CHB initiatives currently being scoped;

- A whānau wellness model, focusing on 10 whānau to demonstrate how to improve health collaboration and connected care across providers (moving towards a whānau ora approach

and the eventual utilisation/support of shared care record)

- Using ideas from the NUKA model to improve consumer voice in the design and evaluation of current service provision, "Consumer Circles" are being set up to provide context on current issues brought to the attention of the HLG. The first was palliative care. The second will be access to primary care.

WAIROA

The Locality Leadership team is formed and has a wide membership representative of the community approach to this development. The structure of the locality framework includes information and design teams' in the following;

- Consumer/whanau – are involved as partners in co-design processes using a NUKA system approach. Wairoa stakeholders who attended the NUKA training agreed to the benefits adopting this system of change to support the development of the locality as the way forward to improving health and social outcomes for the community.
- Clinical Governance – responsible for developing and monitoring implementation of clinical pathways of care
- Whānau Oranga – responsible for establishing an integrated model for addressing social issues within whānau using the Tairawhiti children's team Director as an advisor to the process.
- Pakeke – responsible for ensuring any design processes include marae, hapū and iwi, provide tikanga oversight to the developments.
- Rangatahi – responsible for concept testing any design changes from a rangatahi perspective. Feed in to the developments and oversee decision making processes to ensure the rangatahi voice has been heard.
- Integration staffing forums – will be provided with regular communications and ability to support work streams and provide feedback to any developments as they are occurring.

Wairoa activities currently underway are:

- An initial co-design workshop to understand the collective journey towards improving community and whānau outcomes in Wairoa has been held. Outcomes of the day included a vision statement and set of values and a draft set of community outcomes linked to the health and social care aspects for the Wairoa community. Next steps to be confirmed.
- A proposal to create a single general practice is currently being considered by the DHB and if this is approved will provide a new beginning for primary care in Wairoa. A single practice provides a platform to address many of the challenges smaller practices currently face and the Model of Care will be further explored as a priority project of the locality work streams.
- The Change Leader is currently working with Kahungunu Executive on three main areas – integration opportunities internally and across its three business units, implementation of a single point of entry for Whānau Ora, organisational culture development and contracts and reporting review.
- Wairoa continues to build on local integration and collaborative activities as well as progress more strategic developments under the Health and Social Care framework.

The locality has progressed the following:

- The co-location of services on the Health Centre site. Including Māori healing services and other natural therapies.
- A close working relationship between the three general practices and the two year general practice alliance contract with Health Hawkes Bay.
- The inter-sectoral E Tu Wairoa Family Violence Network.
- Establishing professional roles that work across primary care and interface with secondary care

e.g. Rural Nurse Specialist, Clinical Pharmacy Facilitator and Social Worker

- Planning to align district nursing with primary care
- Integrated diabetes management between primary and community services
- Integrated Clinical Governance committee.

Wairoa initiatives currently being scoped:

- Links have been made with the asset mapping process undertaken by Victoria University for Ngati Pahauwera
- Review of the Health Needs Assessment Report and aligning its recommendations with the strategic plan of the locality
- A briefing paper and business model to be prepared for EMT/Board re scoping of the single general practice model that has been reworked.
- Relationships forged with Social Investment Initiatives - Tairawhiti Children's Team and MSD Leadership

EMERGING CHALLENGES

The work in both of the localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. Some emerging challenges include:

- Creating natural synergies between district wide and local strategies without compromising the principles and objectives of both. i.e formal mechanisms that link REDS[1] and SIS[2] with the Change Leaders in each locality.
- The role of the Change Leaders in intrinsically linking and influencing strategic plans and models at a district level without compromising individual strategies being developed at a local level.
- CHB have chosen Collective Impact (see Appendix 1) as its change methodology, however Wairoa will have different priorities. No one methodology should be used to drive the strategy of each locality. The selection and inclusion of what fits each will be key in maintaining local ownership of the process whilst achieving district wide outcomes.
- Building the confidence in the process requires dedicated resource. This is currently being identified as projects are developed. Formalising the process of resource allocation will be required in the future through new investment.
- "Back bone functions" (planning, contracting, analysis, reporting, etc.) are needed to support the work as it develops. Establishment of these functions will assist in avoiding duplication of resources, however a degree of autonomy is needed to create local ownership of outcomes.
- The quality assurance and research and development functions that will need to be in place to ensure best practice must be supported throughout the locality development and sustained over time.

[1] Regional Economic Development Strategy

[2] Social Inclusion Strategy

STRATEGIC DEVELOPMENT OF HAWKES BAY LOCALITIES:

In looking beyond CHB and Wairoa, three key questions have emerged that will require significant discussion and resolution before the wider strategy is developed and implemented further. These questions are:

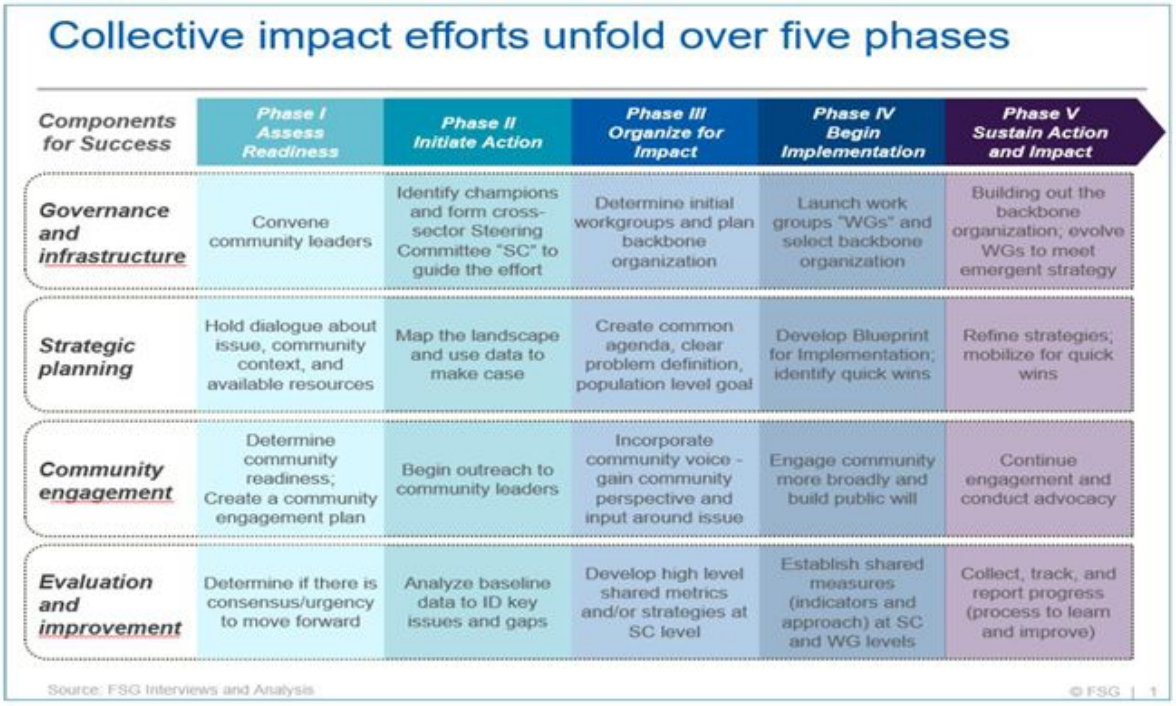
- Is health best placed to act as the lead agency in the development of health and social care localities?
- What are the mechanisms that will ensure the success of the locality work both district wide and locally?
- What form will research and development take and how will it be supported?

Answers to these questions will only be obtained through working with our community partners and other agencies in a collaborative way, and by identifying and implementing resources and processes that will enable the desired outcomes to be achieved. Answering them will also require a style of leadership that encourages bold thinking, tough conversations and experimentation. Evaluation and quality assurance will need to reflect this by looking for the planned and unplanned outcomes of the locality work. A balance therefore will need to be reached in identifying outcomes (success indicators) that both reassure and challenge the work that is being done in this space.

APPENDIX 1: THE COLLECTIVE IMPACT MODEL

The roles and responsibilities that fall out of a collective impact model – to support the work on the ground are outlined in diagram 1.0 below.

Diagram 1.0 – The Four Tiers of Collective Impact



At varying stages throughout both the locality development and the development of individual projects within each locality differing levels of input from a variety of roles will be required.

HAWKE'S BAY District Health Board Whakawāteatia	**Consumer Experience Feedback Quarterly Report**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner/Author:	Jeanette Rendle, Consumer Engagement Manager
Reviewed by:	Kate Coley, Executive Director People & Quality
Month:	April 2017
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council and HB Health Consumer Council:

Note the contents of the presentation.

OVERVIEW

The National Adult inpatient experience quarterly report was shared last month. Comment was received requesting that this information be presented alongside other patient experience measures including the Real Time Survey in Mental Health Services, the Waioha Survey in the Primary Birthing Centre and all feedback received direct to the DHB through the consumer engagement team.

As requested, the information was updated and presented to the Board on 29 March and will be presented to Clinical Council on 12 April and Consumer Council on 13 April.

The presentation includes feedback mechanisms, respondent and demographic details, themes, trends and next steps.

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan- Healthy Weight Strategy**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Māori Relationship Board**
Document Owner: Document Author(s):	Tracee Te Huia, ED Strategy, Health & Improvement Shari Tidswell, Team Leader/Population Health Advisor
Reviewed by:	Executive Management Team
Month:	May 2017
Consideration:	For information

RECOMMENDATION:

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

- **Note** progress in the implementation of this Plan.

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawairoa and the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for all this work.

The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Plan's delivery.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix One provides further detail of the progress on the Plan's activities to date.

1) Increasing healthy eating and activity environment

There has been progress in collecting data to provide benchmarks to measure change in healthy eating environments. Schools were contacted re 'water only policies' and the school environments mapped (part of Auckland University Informus Programme). This work was completed by the Public Health Nurses.

2) Develop and deliver prevention programmes

Prevention resources and staff training have been delivered. The breastfeeding resource is systematically provided to all whānau birthing at Hastings Hospital. This resource integrates key maternal messages (i.e. breastfeeding, smokefree, safe sleep) and is well received by whānau and staff supporting whānau. Healthy First Food resource and education sessions are business as usual for WellChild and Plunket. A new healthy food resource for 3-5 year olds and their whānau supports

conversations and co-creating a whānau healthy weight plan. This included training for B4 School Check nurses.

3) Intervention to support children to have healthy weight

Screening for gestational diabetes, WellChild Checks and B4 School Checks is supported. Tools are provided to support whānau with healthy weight messages and behaviours at these screening points. Maternal Green Prescription and Active Families continue to have high levels of referrals. These programmes show good outcomes with 80% of families completing Active Families programme increasing healthy eating and activity. All children with a BMI in the 98th percentile at the B4 School Check are receiving a healthy eating conversation and support to develop a whānau plan – whānau feedback is positive.

4) Provide leadership in healthy eating

HBDHB Board endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH's guideline. Food Services have completed a review of food served in Zacs café and are leading the roll-out to comply with the 'traffic light' system in the policy. The Strategy has been shared widely and there has been support from a range of sectors. The work with the B4 School Check programme demonstrates an effective HBDHB-led collaboration with primary care.

CHANGING CONTEXT FOR CHILDHOOD HEALTHY WEIGHT

Since HBDHB endorsed the Plan, MoH have:

- Released a "Childhood Obesity Plan".
- Required HBDHB to review the recently approved Healthy Eating Policy to comply with the national guidelines.
- Set a Raising Healthy Kids target (1 July) reports on referrals to a health professional for children in the 98th weight percentile.

This MoH direction aligns with or was planned for in the Best Start Plan. However, has meant reprioritisation of the Best Start Plan's work and will now impact on planned work with the early childhood education sector, primary schools pilot programme and engagement with new settings.

HBDHB entered into a Memorandum of Understanding with the Hawke's Bay Community Fitness Centre Trust that was established in November 2016. This Trust sets out to establish a two stage development for a facility at the regional sports park to provide community and elite athlete programmes. Alongside this will be research projects that look at early childhood and school programmes, as well as a longitudinal study. HBDHB have been invited to attend the launch and workshops delivered by the Trust with HBDHB sharing their information and plans with the Trust.

Again this aligns with the Best Start Plan and will require that the activities are coordinated. To achieve this, we are working closely with Sir Graeme Avery and others engaged with the HB Community Fitness Trust. In the planning phase, we have contributed to the information and discussion forum. Moving forward we will be actively involved in the research projects and collaborating on the schools based programme by integrating programmes developed by the Trust with the primary schools programme.

CONCLUSION

Overall, we are on track with some adjustment made to respond to changes. There has been significant work completed and/or embedded as business as usual, i.e. Healthy First Food and breastfeeding support. New work has focused on MoH lead areas including; supporting the new Raising Healthy Kids target, water only policies in schools and the HBDHB Healthy Eating Policy.

New developments offer opportunities including new partnerships and potentially increased investment in healthy weight projects. MoH-led initiatives have increased the impact of this Plan's activities i.e. more schools with water only policies and a HBDHB policy with wider coverage.

NEXT STEPS

1. Address the identified need for a nutrition and physical activity advice/resource for early childhood education. This will reinforce key messages whānau receive via maternity services, WellChild/Plunket and B4 School Checks.

2. Continue the work to develop a primary schools programme – working with community partners, MoE East Coast, Health Promoting Schools, Hawke's Bay Community Fitness Centre Trust and schools.

3. Continue work with Councils to support healthy weight environments, investigate engagement with supermarkets to promote healthy eating choices, using the findings from the Auckland University healthy environment survey to support changes.

Appendix One

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

The data we have is improving, there is now policy information recorded in HealthScape showing an increase in school policies and data for the school environments has been collected with Auckland University (Informas).

Activity to deliver objective one				
	What	**How**	**Progress**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going water only. • Water only messaging promoting in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. event to provide health messages.	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools,	• 50% increase in schools with "water only" policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually	• Exceeded with all primary schools having a water only policy • Project lead in place, workshop held • Presented Healthy Weight Strategy to Hastings and Napier Council. • Food Environment data collection complete	Reported annually to 2020

Activity to deliver objective one				
	• Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke's Bay • Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually		

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% (Dec 2015) for total population, 66% Māori and 78% Pasifka (December 2015 Ministry of Health), these sho slight increases
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay), this will be refreshed with 2016 data at the end of the year.

Actions and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources	• Healthy Conversation workshops delivered for LMCs and others engaging with whānau and young children. Session delivered for B4 School Check nurses and GPs. • Active Families contracts in place and delivered by Iron Māori and Sport HB.	Reported annually until 2020

Actions and Stakeholders				
	• Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	• Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	• 3-5 year old messages developed – Healthy Food resource- food choices, portion size and promoting water. • Resources launched with B4 Schools Check nurses • Project manager appointed.	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI over 21

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 55 Hawke's Bay children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health Hawke's Bay)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan.

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target is on track to reach target in quarter 4. • Active Families under 5 is funded and Health HB will support with additional funding • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training • Active Families – delivered by Iron Māori and Sport HB	Annually until 2020

Activities and Stakeholders				
	• Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	• Reviewing pathway development – potentially included in Long Term Conditions pathway • Delivered the Health Food conversation tool. Investigating new training opportunities	

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB.

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website • Policy has been replaced with one aligning with the national Food and Nutrition Policy and for implementation in place	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Reviewed policy reflects the healthy eating guidelines • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • HBDHB policy review is complete and aligns to MoH Nutrition Guidelines.	Ongoing until 2020

Activities and Stakeholders				
	• Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	• Shared Healthy Eating Strategy with Intersectorial Forum • Messaging is "water only" and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and achieved promoting water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff).	

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Report from the Target Champion for Cardiovascular Disease**
	For the attention of: **Maori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner:	John Gommans, Chief Medical Officer
Document Author(s):	Paula Jones (Service Director) and Gay Brown (CNM Cardiology Services)
Reviewed by:	Health Service Leadership Team & Executive Management Team
Month:	April, 2017
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical and Consumer Councils:

Note the contents of this report.

OVERVIEW

This report is from Dr John Gommans CMDO-Hospital and champion for the acute cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators, which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14 - high risk ACS patients accepted for angiogram within three days of admission and ACS patients who have completed data collection.

Priority	Indicator	Measure	Champion	Reporting Month
Cardiovascular	• Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. • Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	April 2016

There continues to be positive result with the HBDHB and all DHBs within the central region meeting these target indicators.

WHY IS THIS INDICATOR IMPORTANT?

Acute coronary syndromes are an important cause of mortality and morbidity in patients admitted to hospital, which can be modified by appropriate and prompt intervention including urgent angiography (within 3 days) for those identified as at high risk.

To provide a national consistent reporting framework, all regions are required to report measures of ACS risk stratification and time to appropriate intervention using ANZACS-QI system for data collection. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern.

REGISTRY DATA COLLECTION INDICATOR

Regional Data – up to Quarter 2, 2016/17

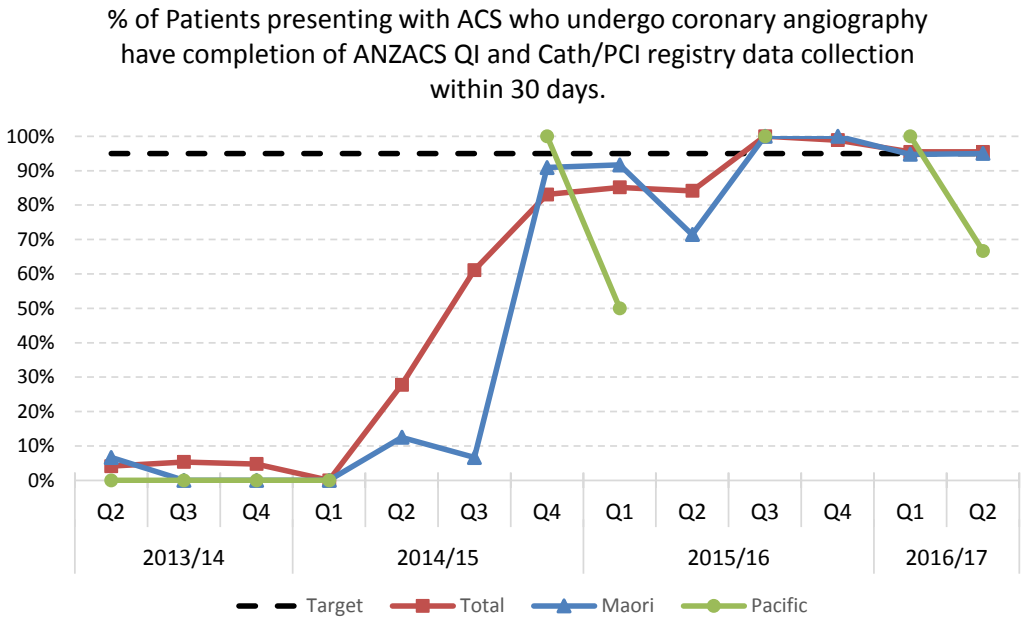
% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

Registry Completion Quarterly Report - Jan 2017

Central Region DHBs

Period *	Central Region DHB Performance							Regional Performance				National Performance
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI	Northern	Midland	Central	Southern	
2015/2016 Q1 (Jun 2015 - Aug 2015)	68/68 (100.0%)	74/74 (100.0%)	47/47 (100.0%)	66/68 (97.1%)	64/66 (97.0%)	16/16 (100.0%)	21/21 (100.0%)	708/727 (97.4%)	407/414 (98.3%)	356/360 (98.9%)	497/542 (91.7%)	1968/2043 (96.3%)
2015/2016 Q2 (Sep 2015 - Nov 2015)	82/83 (98.8%)	83/83 (100.0%)	52/52 (100.0%)	52/53 (98.1%)	59/69 (85.5%)	16/16 (100.0%)	24/24 (100.0%)	691/712 (97.1%)	394/399 (98.7%)	368/380 (96.8%)	533/543 (98.2%)	1986/2034 (97.6%)
2015/2016 Q3 (Dec 2015 - Feb 2016)	75/75 (100.0%)	82/82 (100.0%)	43/43 (100.0%)	81/81 (100.0%)	66/66 (100.0%)	15/15 (100.0%)	33/33 (100.0%)	735/751 (97.9%)	427/436 (97.9%)	395/395 (100.0%)	495/500 (99.0%)	2052/2082 (98.6%)
2015/2016 Q4 (Mar 2016 - May 2016)	104/105 (99.0%)	88/89 (98.9%)	40/40 (100.0%)	61/61 (100.0%)	44/44 (100.0%)	23/23 (100.0%)	22/22 (100.0%)	703/732 (96.0%)	434/442 (98.2%)	382/384 (99.5%)	518/531 (97.6%)	2037/2089 (97.5%)
2016/2017 Q1 (Jun 2016 - Aug 2016)	82/82 (100.0%)	84/88 (95.5%)	52/53 (98.1%)	70/72 (97.2%)	60/65 (92.3%)	15/15 (100.0%)	32/33 (97.0%)	749/776 (96.5%)	475/492 (96.5%)	395/408 (96.8%)	471/483 (97.5%)	2090/2159 (96.8%)
2016/2017 Q2 (Sep 2016 - Nov 2016)	102/103 (99.0%)	84/88 (95.5%)	46/46 (100.0%)	78/78 (100.0%)	43/55 (78.2%)	22/22 (100.0%)	30/31 (96.8%)	603/719 (83.9%)	413/538 (76.8%)	405/423 (95.7%)	513/562 (91.3%)	1934/2242 (86.3%)

Hawke's Bay Data – by ethnicity, up to Quarter 2, 2016/17



Hawke's Bay Data – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	12/12 (100.0%)	2/2 (100.0%)	0/0 (100.0%)	0/0 (100.0%)	60/60 (100.0%)

Summary

There has been significant improvement since interventions to address this target were first put in place in 2015. Satisfactory performance against the indicator has been sustained for the last year with Hawke's Bay meeting the >95% target for Maori and the total population for five consecuitive quarters.

ACCESS TO ANGIOGRAMS INDICATOR

Regional Data – up to Quarter 2, 2016/17

% of all patients with high risk ACS Who Receive an Angiogram within 3 days of Admission (data upto Quarter 2 20016/17).

Quarterly ANZACS-QI KPI Detailed Report

ANZACS-QI

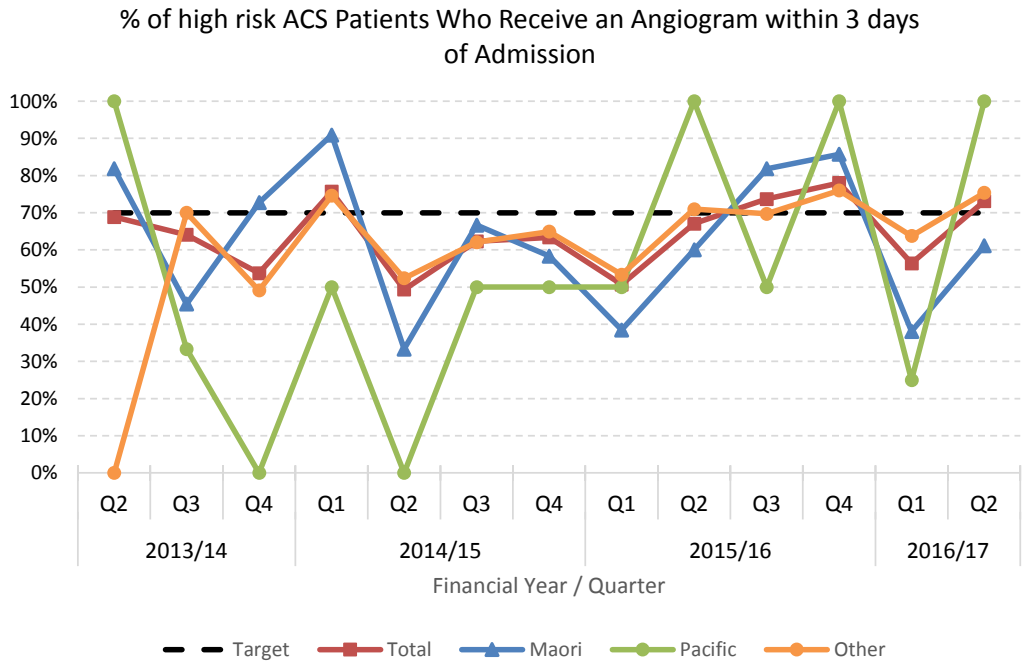
Door to Cath < 3-Days Quarterly KPI Report by DHB - Jan 2017

Central Region DHBs

Period	Central Region DHB Performance							Regional Performance				National Performance
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI	Northern	Midland	Central	Southern	
2015/2016 Q1 (Jul 2015 - Sep 2015)	65/73 (89.0%)	38/76 (50.0%)	41/51 (80.4%)	52/69 (75.4%)	59/67 (88.1%)	11/19 (57.9%)	13/21 (61.9%)	557/707 (78.8%)	272/408 (66.7%)	279/376 (74.2%)	472/557 (84.7%)	1580/2048 (77.1%)
2015/2016 Q2 (Oct 2015 - Dec 2015)	76/83 (91.6%)	57/85 (67.1%)	32/50 (64.0%)	46/58 (79.3%)	62/68 (91.2%)	11/13 (84.6%)	14/27 (51.9%)	628/767 (81.9%)	284/435 (65.3%)	298/384 (77.6%)	440/513 (85.8%)	1650/2099 (78.6%)
2015/2016 Q3 (Jan 2016 - Mar 2016)	78/86 (90.7%)	56/79 (70.9%)	41/43 (95.3%)	58/78 (74.4%)	54/58 (93.1%)	18/21 (85.7%)	23/32 (71.9%)	577/727 (79.4%)	324/457 (70.9%)	328/397 (82.6%)	451/530 (85.1%)	1680/2111 (79.6%)
2015/2016 Q4 (Apr 2016 - Jun 2016)	88/98 (89.8%)	71/91 (78.0%)	38/46 (82.6%)	49/59 (83.1%)	42/43 (97.7%)	16/21 (76.2%)	22/30 (73.3%)	560/725 (77.2%)	321/435 (73.8%)	326/388 (84.0%)	417/504 (82.7%)	1624/2052 (79.1%)
2016/2017 Q1 (Jul 2016 - Sep 2016)	82/87 (94.3%)	53/94 (56.4%)	33/46 (71.7%)	56/78 (71.8%)	72/73 (98.6%)	13/17 (76.5%)	16/28 (57.1%)	601/800 (75.1%)	385/497 (77.5%)	325/423 (76.8%)	456/526 (86.7%)	1767/2246 (78.7%)
2016/2017 Q2 (Oct 2016 - Dec 2016)	94/105 (89.5%)	68/93 (73.1%)	34/39 (87.2%)	59/80 (73.8%)	56/58 (96.6%)	18/23 (78.3%)	15/25 (60.0%)	551/701 (78.6%)	402/536 (75.0%)	344/423 (81.3%)	432/497 (86.9%)	1729/2157 (80.2%)

The dates are based on the dates of admission. Number (%) of all ACS patients where door to cath time is between -2 to 3 days. Target is 70%. Those with < -2 days are excluded from numerator but included in denominator.

Hawke's Bay Data – by ethnicity, up to Quarter 2, 2016/17



Hawke's Bay Data – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of patients with high risk ACS who receive an angiogram within 3 days of admission

Total	Maori	Pacific	Indian	Asian	Eur/Oth
68/93 (73%)	11/18 (61.1%)	2/2 (100%)	1/1 (100.0%)	0/0 (0.0%)	54/72 (75%)

Summary

While Hawke's Bay met the overall >70% target for the total population in the second and third quarters of 2016-2017, consistently maintaining compliance and across all ethnic groups is challenging as many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays for patients admitted to Hawke's Bay Hospital regarding transport and access to regional beds.

For Maori, in the 2016-2017 year, progress is being made with improvement from 40% in Quarter 1 to 61% in Quarter 3, which is still below the 70% target. Due to small numbers there is also wide variation in the results of the non-European ethnicity groups. For Maori in quarter 3, just two cases would have resulted in a >10% improvement in result and achievement of the target.

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

Regarding the Registry Data Collection Indicator; Hawke's Bay has continued its satisfactory performance against this indicator for the last year, consistently meeting the >95% target for both Maori and the total population. The actions that were instituted two years ago will continue and ensure that we sustain this.

Regarding the Access to Angiograms Indicator; Hawke's Bay has struggled to consistently meet this target for both Maori and the total population. Many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays regarding transport and access to regional beds for Hawke's Bay patients.

Strategies already in place to improve local compliance include an additional local angiography list (now three times per week) and improved communication between CCDHB and HBDHB to support timely transfers of patients. In addition locum Cardiologists have been and will continue to be employed to complete additional angiography sessions.

In 2016 the Regional Cardiology Network membership was revised to include representation from Central Region DHB Service Managers to aid regional planning focus on improving compliance and reinforce the importance of Wellington supporting access from the provincial centres.

For the longer term solution, the Regional Cardiology Network has recommended to the regional CEOs that consideration be given to the implementation of an Interventional Angiography Service on site in Hawke's Bay within 3-4 years. Local provision of this service would remove the current delays awaiting transport to or beds in Wellington.

RECOMMENDATIONS FROM TARGET CHAMPION

The Medical Directorate leadership team in conjunction with the local and regional cardiology services will continue to monitor and review it's strategies to achieve and ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in the regional cardiac network activities to align with regional and national strategies.

Key Recommendations	Description	Responsible	Timeframe
Access to specialist tertiary service angiography services will be actively monitored.	Delays with transport and/or access to Cardiology Services in Wellington will be actively monitored and escalated to senior management if/when impacting on patient care.	Gay Brown CNS Cardiology	Ongoing
A strategic assessment of options for provision of interventional cardiology services to people of Hawke's Bay be done.	That HBDHB under-takes a strategic assessment of options for provision of interventional cardiology services to the people of Hawke's Bay, including the possibility of implementing an on site service at Hawke's Bay Hospital within 3-4 years in line with the regional cardiac network's recommendation and the DHBs Clinical Services Plan to be developed in the coming year.	EMT	2019

CONCLUSION

There has been a positive and sustained result for the data collection indicator. Challenges remain in meeting the access to angiograms indicator that require ongoing local and regional actions in the short term pending a definitive long-term solution including possible local provision of this service within 3-4 years.

ANNUAL MAORI PLAN Q3 DASHBOARD

Will be provided as soon as it is available

TOPICS OF INTERESTS
MEMBER ISSUES

GLOSSARY OF COMMONLY USED ACRONYMS

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

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

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

SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent
SUR	Service Utilisation Report
TAS	Technical Advisory Service
TAW	Te Ara Whakawaiora
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date