Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 13 April 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

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 Update (verbal)	
8.	Consumer Engagement Manager's Update (verbal)	
	Section 2 – For Discussion / Information	
9.	Establishing Health and Social Care Localities in HB – Tracee TeHuia and Jill Garrett	4.20
10.	Membership Update – Ken Foote	4.40
11.	Recognising Consumer Participation – Jeanette Rendle	4.55
12.	Consumer Experience Feedback Quarterly Report (Oct-Dec 2016) - Jeanette Rendle	5.15
	Section 3 – For information only – no presenter	
13.	Te Ara Whakawaiora / Cardiology (national indicator)	-
	Section 4 – General Business	
14.	Topics of Interest - Member Issues / Updates	5.25
15.	Karakia Whakamutunga (Closing)	

NEXT MEETING: Thursday 11 May 2017
(Ordinary meeting commencing at 4.00 pm – Boardroom)

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

6

Meetings 2017	Papers and Topics	Lead(s)
11 May	People Strategy (2016-2021) draft – public excluded Values & Culture Business Case Health Literacy Update for information Legislative Compliance Clinical Services Plan Presentation Final Draft Annual Plan 2017 Best Start Heatlhy Eating Plan (yearly Review)	Kate Coley Kate Coley Kate Coley Kate Coley Carina Carina Shari Tidswell
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

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

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:

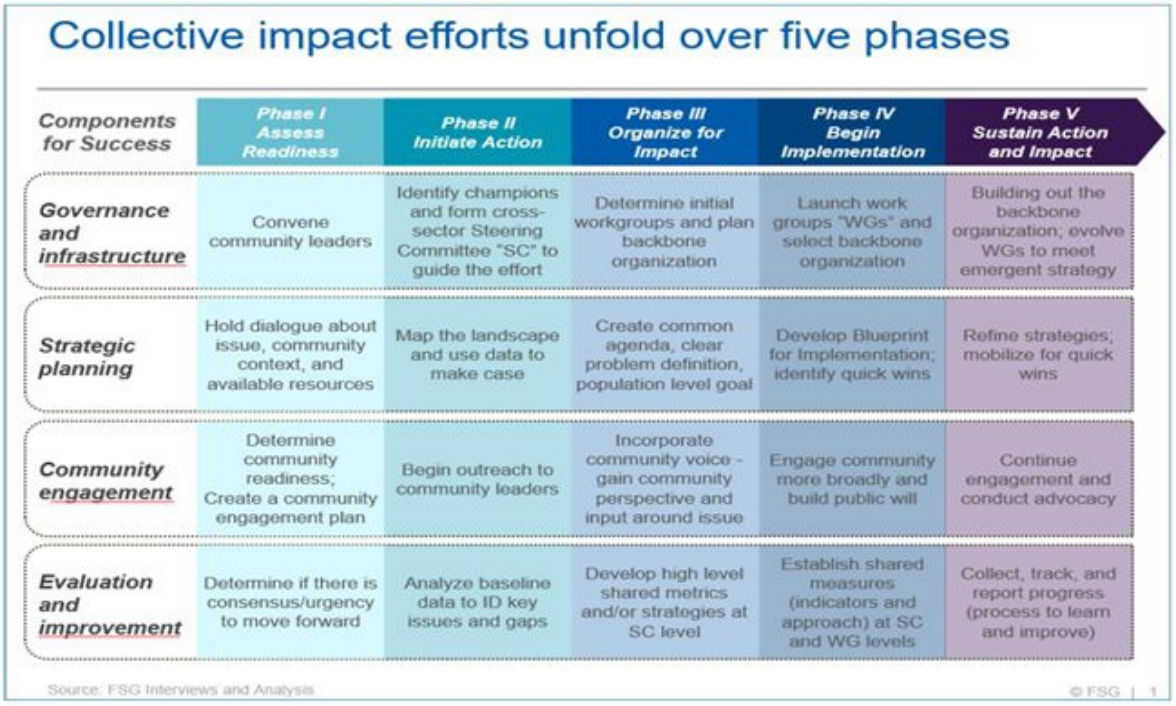
- Is health best placed to act as the lead agency in the development of health and social care localities?
- What are the mechanisms that will ensure the success of the locality work both district wide and locally?
- What form will research and development take and how will it be supported?

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.

MEMBERSHIP UPDATE

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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Division :	Executive Management	**Last Review Date :**	21/12/2016
Document Owner:	Patient and Whanau Care Advisor	**Next Review Date:**	21/12/2019
Approved by:	Executive Leadership Team (ELT)	**Date First Issued:**	02/05/2008
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.

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Division :	Executive Management	**Last Review Date :**	21/12/2016
Document Owner:	Patient and Whanau Care Advisor	**Next Review Date:**	21/12/2019
Approved by:	Executive Leadership Team (ELT)	**Date First Issued:**	02/05/2008
Counties Manukau Health			

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.

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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Counties Manukau Health			

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

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	**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

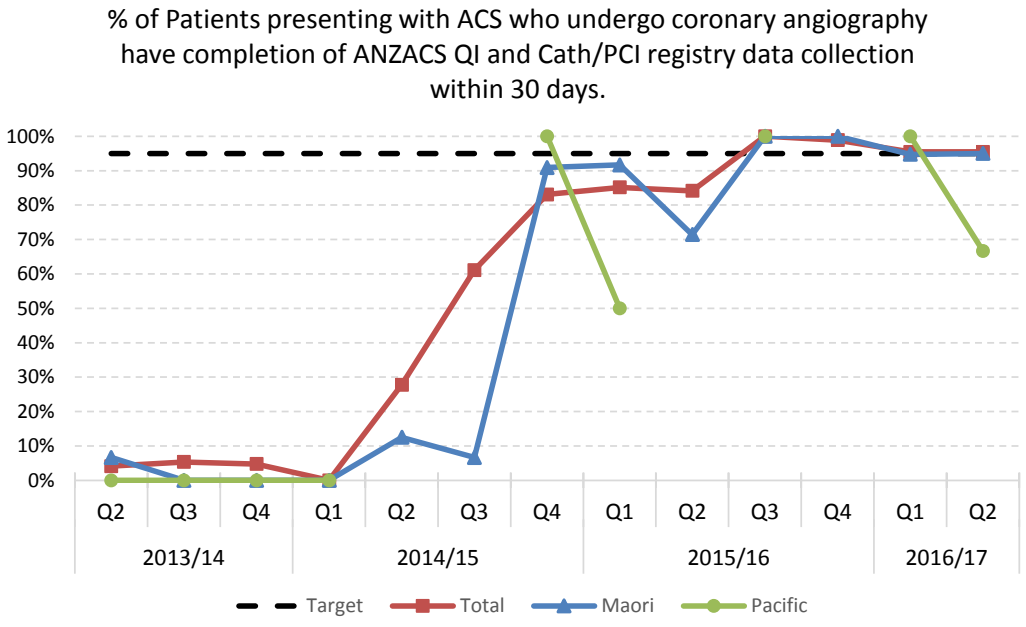
Central Region DHBs

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%)

Quarterly ANZACS-QI KPI Detailed Report

Quarter containing the date of admission signifying the start of each episode of care; Number (%) with both complete Cath Lab and ACS forms (Target is >95%); Denominator: Cath Lab patients with "STEMI<12h" or "other suspected/confirmed ACS" who have coronary angiogram.

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

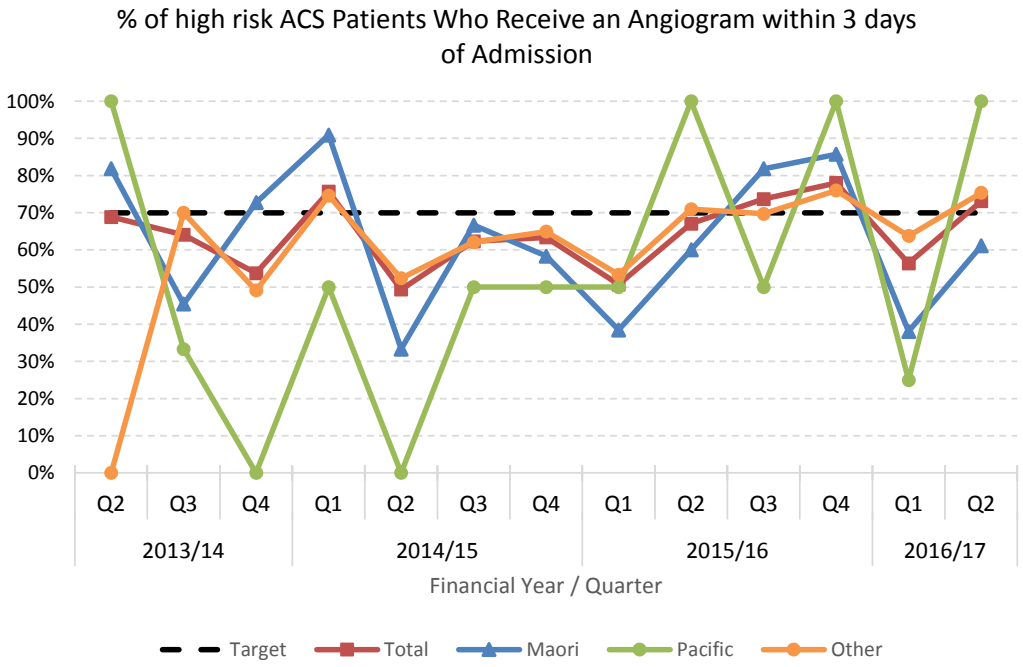
Door to Cath < 3-Days Quarterly KPI Report by DHB - Jan 2017

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 undertakes 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.

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