Waitematā
District Health Board

Best Care for Everyone

# Consumer Council

## Wednesday

## 25 November 2020

## 2:00pm – 4:00pm

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**VENUE**

**Matepo and Manuka Rooms**
**Lower Ground Floor, Waitakere Hospital**

# CONSUMER COUNCIL
# 25 November 2020

Venue: Matepo and Manuka Rooms, Lower Ground Floor, Waitakere Hospital
Time: 2:00pm – 4:00pm

| Consumer Council Members | Ex-officio - Waitematā DHB staff members |
|---|---|
| David Lui (Council Chair)<br>DJ Adams(Ngati Maniapoto, Ngati Kahungunu)<br>Neli Alo<br>Alexa Forrest-Pain (Te Rūnanga o Ngāti Whātua)<br>Lorelle George<br>Insik Kim<br>Ngozi Penson<br>Jeremiah Ramos<br>Ravi Reddy<br>Kaeti Rigarlsford<br>Lorraine Symons (Te Whānau o Waipareira)<br>Vivien Verheijen | Dr Dale Bramley – Chief Executive Officer<br>David Price – Director of Patient Experience<br><br>Counties Manukau DHB<br>Renee Greaves - Experience and Engagement Advisor<br><br>Lived Experience Advisory Council (LEAC)<br>Nicola Peeperkoorn – Co-Chair LEAC<br>Elizabeth Baird – Co-Chair LEAC<br><br>Other Waitematā DHB Staff members<br>Dr Dean Manley Phd - Consumer and Family/Whānau Consultant<br>Chris Cardwell - Facilities Director<br>Matthew Knight - Project Services Director |

**APOLOGIES:**

**AGENDA**

**Disclosure of Interests** (see page 5 for guidance)

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

**KARAKIA**
**WELCOME**

| | | |
|---|---|---|
| | **1. AGENDA ORDER AND TIMING** | |
| | **2. CONFIRMATION OF MINUTES** | |
| 2:00pm | 2.1 | Confirmation of the Minutes of Meeting (14/10/20)<br>Actions Arising from Previous Meeting |
| 2:05pm | **3. CHAIR'S UPDATE** | |
| | **4. DISCUSSION ITEMS** | |
| 2.10pm | 4.1 | Verbal: Counties Manukau Consumer Council experience |
| 2.35pm | 4.2 | Consumer Council Selection, appointment and re-appointment |
| 2.50pm | 4.3 | Specialist Mental Health and Addiction Services: Lived Experience Advisory Council (LEAC) |
| 3.15pm | --- | Break |
| 3.20pm | 4.4 | Consumer Engagement for Future Facilities Design |
| | **5. INFORMATION ITEMS** | |
| 3.45pm | 5.1 | Patient Experience Report (for noting) |
| | **6. ANY OTHER BUSINESS** | |
| 3:50pm | 6.1 | Community concerns |
| 3.55pm | 6.2 | Agenda for future meeting |

**Waitematā District Health Board**
**Consumer Council**
**Member Attendance Schedule 2020-2021**

| NAME | Jul 2020 | Sep 2020 | Oct 2020 | Nov 2020 | Feb 2021 | Mar 2021 | May 2021 | June 2021 |
|---|---|---|---|---|---|---|---|---|
| David Lui (Chair) | ✓ | ✓ | ✓ | | | | | |
| DJ Adams (Deputy Chair) | × | ✓ | ✓ | | | | | |
| Neli Alo | ✓ | ✓ | ✓ | | | | | |
| Alexa Forrest-Pain | | ✓ | ✓ | | | | | |
| Lorelle George | ✓ | ✓ | ✓ | | | | | |
| Insik Kim | ✓ | ✓ | ✓ | | | | | |
| Ngozi Penson | ✓ | ✓ | ✓ | | | | | |
| Jeremiah Ramos | ✓ | ✓ | ✓ | | | | | |
| Ravi Reddy | × | ✓ | ✓ | | | | | |
| Kaeti Rigarlsford | ✓ | × | ✓ | | | | | |
| Lorraine Symons | ✓ | ✓ | × | | | | | |
| Vivien Verheijen | ✓ | ✓ | ✓ | | | | | |
| +Dale Bramley | × | ✓ | ✓ | | | | | |
| +David Price | ✓ | ✓ | ✓ | | | | | |

✓ *attended*
× *apologies*
* *attended part of the meeting only*
^ *leave of absence*
\+ *ex-officio member*

# WAITEMATĀ DISTRICT HEALTH BOARD
# CONSUMER COUNCIL

## REGISTER OF INTERESTS

| Board/Committee Member | Involvements with other organisations | Last Updated |
|---|---|---|
| David Lui<br>(Chair) | Director, Focus on Pacific Limited<br>Board Member, Walsh Trust<br>Chair - Board of Trustees, Henderson High School | 25/08/20 |
| DJ Adams | No declared interest | 02/09/19 |
| Neli Alo | No declared interest | 24/09/19 |
| Alexa Forrest-Pain | No declared interest | 03/07/19 |
| Lorelle George | No declared interest | 03/07/19 |
| Insik Kim | No declared interest | 03/07/19 |
| Angela King | An employee of Royal District Nursing Service which has a contract with Auckland District Health Board | 03/07/19 |
| Ngozi Penson | Board member for Neuro Connection Foundation<br>Board member Mata of Hope NZ<br>Member, Ethnic Advisory Group (EAG), English Language Partners | 09/10/20 |
| Jeremiah Ramos | No declared interest | 03/07/19 |
| Ravi Reddy | Board Member – Hospice West Auckland<br>Senior Lecturer – Massey University<br>Honorary Academic – University of Auckland | 19/02/20 |
| Kaeti Rigarlsford | No declared interest | 03/07/19 |
| Lorraine Symons - Busby | MOU Liaison – Waipareira Trust | 24/09/19 |
| Vivien Verheijen | Member, Consumer Advisory Committee - PHARMAC<br>Board member, Companionship & Morning Activities for Seniors (CMA) | 31/08/20 |

# Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out responsibilities, then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a majority of other members of the Board permit the member to do so. If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned. Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board's integrity.

## IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

Ensure the nature of the interest is disclosed, not just the existence of the interest.

*Note: This sheet provides summary information only.*

# 2. CONFIRMATION OF MINUTES

2.1 Confirmation of the Minutes of Meeting 14 October 2020
Actions Arising from Previous Meeting

**DRAFT Minutes of the meeting of the Consumer Council**

**of the Waitematā District Health Board**

**Wednesday, 14 October 2020**

held at the Waitematā Room, Whenua Pupuke Clinical Skills Centre and by video conference

commencing at 2.06pm

**CONSUMER COUNCIL MEMBERS PRESENT**:

David Lui (Chair)
DJ Adams (Deputy Chair) (Ngati Maniapoto, Ngati Kahungunu) - *by video conference*
Neli Alo - *present by video conference*
Alexa Forrest-Pain (Te Rūnanga o Ngāti Whātua) – *present from 2.25pm*
Lorelle George
Insik Kim
Ngozi Penson
Jeremiah Ramos
Ravi Reddy - *present by video conference*
Kaeti Rigarlsford – *present by video conference*
Vivien Verheijen

**ALSO PRESENT:**

Dr Dale Bramley (Chief Executive) - *present by video conference from 2.29pm*
David Price (Director of Patient Experience)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

**KARAKIA**

DJ Adams opened the meeting with a Karakia.

**APOLOGIES**:

Apologies were received and accepted from Lorraine Symons, Prof Judy McGregor and for late arrival from Alexa Forrest-Pain and Dr Dale Bramley.

**WELCOME:**

The Consumer Council Chair welcomed everyone to the meeting and acknowledged the presence of representatives from St John, Pete Loveridge (Deputy Chief Executive - Customers and Supporters) and Natalie Davis (Head of Brand and Customer Experience) who will observe the meeting of the Consumer Council to learn more about the meeting process as they look into establishing a similar consumer group.

**DISCLOSURE OF INTERESTS**

There were no interests declared that might involve a conflict of interest with an item on the agenda.

## 1 AGENDA ORDER AND TIMING

Items were discussed in same order as listed in the agenda.

## 2 CONFIRMATION OF MINUTES

### 2.1 Confirmation of Minutes of the Consumer Council Meeting held on 2 September 2020
(Agenda pages 7-11)

**Resolution** (Moved Ngozi Penson / Seconded Lorelle George)

**That the Minutes of the Consumer Council Meeting held on 2 September 2020 be approved.**

**Carried**

Actions arising from previous meetings (Agenda page 12)

The updates listed were noted.

Additional updates were requested on future meetings related to the following topics:
- In the next six months, an update on the progress of the Consumer Engagement Health Quality and Safety Marker for Waitematā DHB.
- Update on the establishment of a consumer group that will provide input to facilities/capital projects.
- Update from the Planning and Funding related to the hiring of a Community Engagement Manager.

## 3 DISCUSSION ITEMS

### 3.1 Informed Consent: Gynaecology Patient Information Package

Lisa Sue (Project Manager, i3) and Dr Fiona Connell (Senior Medical Officer, Obstetrics & Gynaecology) were present for this item. Fiona Connell gave presentation on the development process and an overview of the proposed information package. The following were highlighted in the presentation:

- The information package will be a 'blue print' for development of similar information for other surgical services.
- Information materials include video, information leaflets and webpage.
- Information package aim to cover patient pathway for the most common gynaecology procedures which includes information on what to expect, questions that patient could ask, post-procedure care and recovery.
- Consumer feedback were also secured and incorporated in the development process.

*Dr Dale Bramley joined the meeting by video conference at 2.29pm.*

Matters covered in the discussion and response to questions included:

- Videos are under three minutes and will be provided with sub-titles. Following the suggestion from the group, the service will look into working with WATIS to provide videos with voice-over in different languages.
- Ensuring that the information provided on all platforms (video, leaflet and webpage) are consistent.
- Informed consent is secured from patients booked for surgery. In response to a query, i3 is working collaboratively in relation to other projects related to patient focused booking. At the moment, there is no plan to integrate the platform for the outpatient booking process with informed consent but this will be looked into in the future.
- It was suggested that pamphlets and information on website should come in simplified text, easy-read, in plain language and imagery should be consistent with the text. Information package should also consider patients with learning disabilities.
- In response to the recommendation to look into the diversity of the project team to ensure representative outcomes, it was noted that the project team is diverse and represent different background and skills; however, it currently does not have Māori representation in the team.

The Chair thanked Lisa and Fiona for their time.

**3.2 Auckland Regional Dental Service (ARDS) : Effective Communication and Community Engagement to Promote Equity in Accessing Children's Dental Services** (Agenda pages 16-17)

Frances Cullinane (Service Delivery Manager, ARDS) was present for this item. She provided an overview of the services provided to the region by ARDS.

Matters covered in the discussion and response to questions included:

- It was noted that there is a growing list of long-waiting children compounded by the COVID-19 alert level restrictions.
- The service has been using all available means to establish contact with parents/caregivers including inter-agency coordination, social services and schools to increase engagement.
- While current restrictions have been relaxed, there is a current requirement by the Medical Council New Zealand to secure response of parent/caregiver to COVID-19 screening questions. Without this, they will be unable to see the child for treatment resulting to cancellations and children with overdue routine dental examinations. There is a three-day window for the questionnaires to be valid.
- Communications have been provided to the schools and via the website and Facebook videos but there is still a need to increase engagement with the community.

Suggestions received from the group to help improve access included:

- Removing cost barrier. This could be through sending of text messages and the parent/caregiver being able to respond free of charge. Service could look into software or website links where they could also provide response.
- Removing time barrier by providing late service to 8pm. There was a suggestion to look into providing weekend clinics. It was noted that this was previously considered and the downside is the reduction of capacity during weekdays.
- Removing the language barrier by simplifying the COVID-19 screening questionnaire. Questionnaire should also be translated to different languages. The screening questionnaires will be sent to the Consumer Council for further comment. It was noted that a barrier to translating the screening questionnaire was due to funding of translation. David Price suggested a discussion with ARDS on these barriers for resolution.
- To advise caregiver or parent timeframes where they could expect calls as some may not have access to their phones while working.
- Engagement should be treated as a collective effort with the rest of the community. Community engagement coordinator role could look into using messaging via community houses, notice boards, churches, markets and other community events which could provide greater venue and avenue for engagement.
- Consider plans to better engage children about oral care such as providing small incentives such as stickers and badges and joining school assemblies.

The Chair thanked Frances for her time.

*Session went on break 3.03-3.10pm*

**3.3 Disability: General Discussion** (Agenda pages 18-30)

Samantha Dalwood (Disability Advisor) was present for this item. She noted that the paper was to provide the Consumer Council an update on the progress of the New Zealand Disability Strategy 2016-2026 and provide an overview of the four key areas of interest identified by the Consumer Council during its strategic planning. The report was taken as read.

Matters covered in the discussion and response to questions included:

- The Consumer Council acknowledged the update provided in the report in particular the implementation of the New Zealand Disability Strategy 2016-2026 as the information is easy to follow and the language is simple.
- The Disability Responsiveness e-module is available to all DHB staff and has received great feedback from staff. Key takeaway message from the module is 'don't assume' and to 'ask'. There is also cultural competency training within disability which looks into how disability is viewed in different cultures.
- While there were suggestions to make the module mandatory for all staff, there was a consensus from the group that it should be offered as continuous learning (not just as one-off to 'tick the box') that will focus on practical tips and how learning could be applied in different situations or settings.
- To consider unconscious bias (a result of experience) and that on-going learning may help in addressing it. There should also be recognition of other biases such as gender and age.
- Other training suggested include programmes that will cover topics on disability beyond the physical sense, to be mindful of behaviour, mental health and

learning disabilities. A survey to staff on training/modules that will best benefit their work was suggested.

- There are improvements but there are still access issues with facilities such as the height of the reception area in Waitakere Hospital.
- The DHB has also recently hired a New Zealand Sign Language interpreter. This provides an opportunity to support patients and other work programmes of the DHB.
- It was observed that there has been a shift in messaging in particular during the response to the COVID-19 pandemic.
- It was noted that there is also a need to revisit how people with disabilities are employed to look into what they are able to do and through apprenticeship. An example of this is Project SEARCH in the United States which has been successful in securing employment for people with disabilities. This would support 'normalisation' of disability in the workplace. There is work by the DHB related to employment of people with disabilities.

The Consumer Council requested for regular updates to be provided by Samantha and thanked her for her time.

## 4 INFORMATION ITEM

### 4.1 Patient Experience Report (Agenda pages 32-33)

David Price (Director Patient Experience) provided a summary and update on the Patient Experience report noting the following:

- Peter Taylor, a DHB volunteer, was awarded the Health Care Provider Service Individual Award at this year's Minister of Health Volunteer Awards.
- Volunteers are in full roster during COVID-19 Alert Level 1 with additional COVID-19 related training provided. The Patient Experience Team regularly kept in touch during Alert Levels to provide support when needed.
- The revision of the Friends and Family Test (FFT) questionnaire was noted.
- The low number of Korero Mai calls received could be a good indication of service provided.

Matters covered in the discussion and response to questions included:

- Noting the low number of responses of Māori and Pacific respondents relative to other ethnicities, work is underway to identify different methodologies that will capture feedback and experience.
- Results of the Net Promoter Score (NPS), as well as feedback regarding the services, are posted on publicly displayed 'quality boards'. The Patient experience team also work with the wards and services to communicate and address particular comments.
- There is a process for the management of Korero Mai calls. Calls are received by the Hospital Operations Manager or the Duty Nurse Manager. The person answering the call undertakes the initial response and resolution with the patient/whānau. Outcomes from the resolution and issues raised are reported to the ward/service. An Incident report is written which will feed into general learning, policy and training to staff.

**4.2 Recommendations Follow-up List** (Agenda pages 34-48)

The updates were noted by the Consumer Council.

*Neli Alo retired from the meeting at 3.42-pm*

**5 OTHER BUSINESS**

Dr Dale Bramley provided some commentary on the some of the items discussed as follows:

- Further promotion of the Friends and Family Test form to potentially capture more comments from the patient's whānau.
- The DHB will look into reviewing and understanding its current workforce, undertaking job carving, reviewing the selection process and identifying potential barriers to employment of people with disabilities.

**Agenda for the next meeting and Community Concerns**

The following topics were suggested to be considered in the Consumer Council's future agendas:

- Diversity in the recruitment process, how the DHB is addressing barriers to employment of people from ethnic minorities and how workforce planning would respond and reflect the communities the DHB serves.
- An update on the Health and Quality Safety Markers.
- Plans to address services that have been disrupted during the Alert Level lockdown restrictions.
- Public Parking challenges at North Shore Hospital.

The Chair thanked the members and attendees for their time.

The meeting adjourned at 4.06pm.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD – CONSUMER COUNCIL MEETING HELD ON 14 OCTOBER 2020.

_____CHAIR

**ACTIONS ARISING FROM THE MINUTES OF THE MEETING OF THE CONSUMER COUNCIL AS AT 16 NOVEMBER 2020**

| Minutes ref. | Topic | Person responsible | Action / Status |
|---|---|---|---|
| 02/09/20 | It was suggested that the DHB looks into how to better engage with communities from North Shore and Rodney in view of the lack of consumer advocacy group (similar to Waitakere Health Link) for these areas | David Price | An update to be provided in the 03.02.21 meeting |
| | Selection, appointment and re-appointment process of other DHBs | David Price | Please refer to Item 4.2 of this Agenda. |
| | To incorporate a process for securing consumer input on facilities and capital projects that will directly benefit patient experience | David Price /Matthew Knight/Chris Cardwell | Update provided in Item 4.4 of this Agenda. |
| 21/10/20 | Update on the progress of the Consumer Engagement Health Quality and Safety Marker for Waitematā DHB | David Price | An update to be provided in the 17.03.21 meeting |
| | Update from the Planning and Funding related to the hiring of a Community Engagement Manager | David Price | Verbal update to be provided in the meeting |
| | Update on planned care and services that have been disrupted during the COVID-19 lockdown restrictions | Mark Shepherd | An update to be provided in the 03.02.21 meeting |
| | Public Parking Challenges at North Shore Hospital | David Price | Noted for consideration |

**Update on accessibility of videos for the hearing-impaired**

Following the suggestion from the Consumer Council, captions are now included on Waitematā DHB videos to aid accessibility for the hearing-impaired.

The videos can be viewed here:
https://www.facebook.com/WaitemataDistrictHealthBoard/videos/2874737066094221

# 3. CHAIR'S UPDATE (verbal)

# 4. DISCUSSION ITEMS

4.1 Verbal: Counties Manukau Consumer Council experience

4.2 Consumer Council Selection, appointment and re-appointment

4.3. Specialist Mental Health and Addiction Services: Lived Experience Advisory Council (LEAC)

4.4 Consumer Engagement for Future Facilities Design

## 4.2 Discussion: Consumer Council Selection, appointment and re-appointment

**Recommendations:**

The recommendations are that you:

a) Review the current provisions related to the appointment of members of the Consumer Council's Terms of Reference

b) Reflect on the process of other Consumer Council Groups related to selection, election and appointment.

c) Discuss the process for the selection of the Consumer Council seats to be vacated.

d) Discuss the process for selection and appointment of new members.

**Background**

The approved Terms of Reference (TOR) of the Consumer Council states that two years after the inaugural appointment, each year, one third of seats of the Council will be vacated a selection or election process will take place with the potential to be re-elected. The details of the election and re-election process would be determined by the Consumer Council.

In line with the TOR, selection of members should maintain the demographic balance and the structure. The relevant sections of the TOR is below:

*Structure*

*The Consumer Council should be lay people and should live within or have strong connections to the Waitematā area, recognising the discrete areas of Waitakere, North Shore and Rodney, and reflect our MOU partnership with both Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira.*

*There are up to 13 consumer members and 2 ex-officio staff on the Consumer Council. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care.*

*The following minimum representation will be sought to establish the foundation Council*

- *Māori – two members with strong connections to the local Māori community*
- *Pacific – one member with strong connections to the local Pacific community*
- *Asian – one member with strong connections to the local Asian community*
- *Health Link – two Health Link Board members*
- *Disability – one member with strong connections to the local disability community*
- *Youth – one member with strong connections to local youth*
- *Mental health and Addiction – two members with lived experience and/or strong connections to the local community of mental health and addiction service users.*

*Remaining members will be appointed to reflect the following areas of interest:*

- *Child health*
- *Women's health*
- *Older persons health*

- *Chronic conditions*
- *Rural health*
- *Primary health*
- *High deprivation populations*

*When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population, to provide a good cross-section of age groups, health experience and geographical locations of the local community and representation from the Lesbian Gay Bisexual Transgender Transsexual Intersex (LGBTTI) community would be welcome. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community.*

Appointment of Chair

Appointment of the Chair will be conducted every 12 months. Any member of the Consumer Council may put forward their expression of interest to the Council Secretariat. The election of the will be conducted in a scheduled regular meeting of the Council and the Chair will be selected based on majority of votes.

The Chair can be elected any number of times as long as he/she remains a member of the Consumer Council.

**Review of other Consumer Group Selection, Election, Appointment process**

A review of the selection and appointment process of other DHBs and agencies have been pasted below for reference. Attached are copies of relevant documents for additional information

Appointment and Selection

*The Consumer Council appointment process will be open and transparent. The message about the Consumer Council and the request for applications will be promoted using all available communication channels – newspapers, community groups, networks, information evenings, newsletters and social media. Applicants will be short-listed using the competency matrix criteria, followed by an interview with the Chief Executive, Board Chair and community leaders.* (Nelson Marlborough Health, see Appendix 1[a])

*Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate*. (Hawke's Bay Health DHB, see Appendix 2[b])

*Consumer Council Members will be appointed by the CEO or their delegate.*
*Consumer Council members will be recruited via an open Expression of Interest process.* (Waikato DHB, See page 3 Appendix 3a[c])

Review of Performance and re-appointments

*The Consumer Advisory Chair, in consultation with the Chief Executive, will assess the performance of each Member. The performance of the CAC Chair will be assessed by the Chair of the Board*.(PHARMAC, See page 9 of Appendix 4[d])

*The CEO may at any time on written notice to the Chair and relevant member, remove a member from the Consumer Council if he considers that the member is failing to adequately perform the*

*duties of the role as defined in position descriptions and Code of Conduct. In addition, if a member fails to attend three meetings in a row without an apology, they will be asked by the Chair to step down as a Consumer Council member.* (Waikato DHB, see page 3 of Appendix 3a. Position description is attached as Appendix 3b)

*Reappointments will be on the recommendation of the Council Chair and with approval of the Chief Executive and the Board Chair* (Nelson Marlborough Health, see Appendix 5[e])

Term of appointment

Waikato DHB – Term of appointment is for two years with further appointments not exceeding two additional terms (see Appendix 3a)

Hawke's Bay Health DHB – Term of appointment is for two years with further appointments for a maximum of three terms (see Appendix 2)

Counties Manukau Health Consumer Council Experience

Following an exploration through community expressions of interest, Counties Manukau Health commenced recruitment with special attention placed on the membership being representative of the local community. The inaugural chair was appointed in December 2014 and nine core members were established in February 2015 with four additional positions added to include a representative of demographic localities. Renee Greaves (Experience and Engagement Advisor) of Counties Manukau Health will be joining the meeting to provide insights and the experience of Counties Manukau Health's Consumer Council.

**Questions for Discussion**

The following questions are posed for discussion:

- Are there other considerations to be taken into account on selection of seats to be vacated?
- What should we consider to evaluate performance of the members?
- What should we consider in the selection of Consumer Council seats to be vacated?
- Are there other considerations to be to be taken into account when evaluating applications/conducting the selection process?

**Contacts for further discussion (if required)**

| Name | Position | Telephone | Suggested first contact |
|---|---|---|---|
| **David Price** | **Director of Patient Experience** | **021 715 618** | ✓ |

References

[a] https://www.nmdhb.govt.nz/assets/Uploads/NMDHB-November2016-5.1-Consumer-Council-Fact-Sheet.pdf

[b] http://www.hawkesbay.health.nz/assets/HB-Health-Consumer-Council/2018-Consumer-Council/2018-8-HB-Health-Consumer-Council-TOR.pdf

[c] https://www.waikatodhb.health.nz/assets/Docs/About-Us/Consumer-Council/c5a50c66cd/Terms-of-reference.pdf and https://www.waikatodhb.health.nz/assets/Docs/About-Us/Consumer-Council/f0e6eba180/Position-description.pdf

[d] https://www.pharmac.govt.nz/assets/cac-terms-of-reference-2010.pdf

[e] https://www.nmdhb.govt.nz/assets/Uploads/NMH-Consumer-Council-Terms-of-Reference.pdf

Waitematā District Health Board
Best Care for Everyone

# Purpose & Brief

## Purpose

The Waitematā District Health Board (DHB) Consumer Council works collaboratively with the Waitematā DHB Chief Executive, and Board to develop effective partnerships in the design, planning and delivery of high quality, safe and accessible health care services for the Waitematā community.

The focus of the Consumer Council is:

- informing decision making about safety and quality;
- informing the design and redesign of health services;
- review organisational safety and quality performance;
- ensuring the patient/community voice is heard by the DHB;
- review patient, whānau and family feedback data;
- improving patient, whānau and family experience;
- recommending quality activities that relate to patient and community feedback.

The People Powered theme in the NZ Health Strategy reflects the Government's priority of delivering 'better public services' and the opportunity to achieve this through taking more people-centred approaches to providing health services. Through meaningful partnerships, the Waitematā DHB Consumer Council provides a strong and viable voice for the community and consumers on healthcare planning, quality improvement and delivery of services that meets the needs of the people. The Waitematā DHB Consumer Council will enhance consumer engagement and experience across all services. The establishment of a Consumer Council is part of our ongoing commitment to be a patient and whānau-centred organisation that works in partnership with its community.

The Waitematā DHB Consumer Council will develop an effective process to communicate their activity and meeting outcomes to the community. The Consumer Council also has a quality improvement role to advise and encourage better, best, brilliant practice and innovation.

## Scope

All Waitematā DHB services and divisions.

## Brief / Responsibilities

To represent the interests of consumers by objectively communicating their views, by raising issues for discussion and recommending action to the Chief Executive. Areas of DHB work would include:

*Patient experience*

- Overview and monitoring of patient experience strategy (ensure accountability for Patient Experience team meeting strategy objectives)

- Report, identify, highlight patient experience/community feedback – identify priority areas for Patient Experience activity
- Understand and critically review feedback themes from Patient Experience surveys and improvement activities

*Quality*

- Understand and critically review complaint and adverse event themes and recommendations that impact on patient experience
- Advice and ongoing input into the direction and implementation of the Quality Strategy

*Governance*

- Advice and support through regular reports to the Board to ensure Waitemata DHB is engaging with consumers at all levels of governance.

*Associated functions*

- Recruitment and management of consumer council members ensuring far-reaching community representation
- Training and mentoring of all committee members
- General advice to teams/services who present their work to the Council, seeking advice about direction and/or engagement

### Exclusions

The council will not:

- Have access to personal identifiable information
- Provide clinical evaluation of health services
- Be involved with individual complaints
- Be involved with WDHB contracting processes.

### Accountability

The Waitematā DHB Consumer Council is accountable to the Waitemata DHB Chief Executive with operational support from the Director of Patient Experience. The Council would also work closely with the Quality and Risk Team.

## Structure

The Consumer Council should be lay people and should live within or have strong connections to the Waitematā area recognising the discrete areas of Waitakere, North Shore and Rodney and reflect our MOU partnership with both Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira.

There are up to 13 consumer members and 2 ex-officio staff on the Consumer Council. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care.

The following minimum representation will be sought to establish the foundation Council

- Māori – two members with strong connections to the local Māori community
- Pacific – one member with strong connections to the local Pacific community
- Asian – one member with strong connections to the local Asian community
- Health Link – two Health Link Board members
- Disability – one member with strong connections to the local disability community
- Youth – one member with strong connections to local youth
- Mental health and Addiction – two members with lived experience and/or strong connections to the local community of mental health and addiction service users.

Remaining members will be appointed to reflect the following areas of interest:

- Child health
- Women's health
- Older persons health
- Chronic conditions
- Rural health
- Primary health
- High deprivation populations

When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population, to provide a good cross-section of age groups, health experience and geographical locations of the local community and representation from the Lesbian Gay Bisexual Transgender Transsexual Intersex (LGBTTI) community would be welcome. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community.

Waitematā DHB staff involvement would include the Chief Executive, the Director of Patient Experience, and representatives from the Quality and Risk team.

### Appointment & Term of Office

After the initial two years, each year a third of the consumer members terms would end and a selection or election process will take place with the potential to be re-elected. Details of the election and re-election process would be determined by the Consumer Council once established.

## Meetings

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|---|---|
| **Chair** | Consumer member who is elected by the Council every 12 months |
| **Quorum** | 50% of consumer members |
| **Frequency** | Six weekly meetings (at least seven meetings per annum) – two hours in length<br>No meetings to be held in January or during school holidays.<br>Meeting venue to alternate between North Shore & Waitakere Hospital sites. |
| **Minutes &** | Agenda to be circulated within one week of schedule meeting |

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| **Agenda** | Minutes to be sent out within one week post meeting and made available on the Waitematā DHB Consumer Council webpage for public access once endorsed by Council members. |
| **Reporting** | Consumer Council reports and minutes to be presented by the Consumer Council Chair at appropriate Waitematā DHB committee meetings. |
| **Meeting Fees** | Consumer payment for attending meetings will be set at Waitematā DHB rate for consumer representatives. |

## MEMBER REQUIREMENTS

Members are to attend all meetings and are responsible for sending apologies to the Waitematā DHB Consumer Council Chair. It is expected that the agenda and all papers are read prior to the meeting.

The Chief Executive and Director of Patient Experience are to organise a Senior Management Team member replacement if unable to attend. Quality representatives are to be in attendance at their scheduled quarterly updates. Other DHB staff members attend meetings to listen to the discussions, provide updates from the organisation and answer questions as required. In addition, their experience of attending the meetings will enable active promotion of the Consumer Council function.

## DECISION MAKING / ESCALATION

The Council has the authority to give advice and make recommendations to the Waitemata DHB Chief Executive, as well as other services or divisions who seek the Council's advice and guidance.

The Consumer Council does not have executive powers or authority to implement actions and does not have delegated financial responsibility.

## Appendix 1

**Consumer Council Fact Sheet**

**Nelson Marlborough Health**

**Consumer Council**

### Why do we need a Consumer Council?

Consumers (patients, clients, services users, family/whanau) are at the heart of our services. We aim for every part of our health system to be shaped and improved by involving those who use and care about our services.

We currently hear the voices of patients, carers and the public through a variety of feedback mechanisms. We need to build on what we have and progress from listening and understanding the perspectives of the public, patients and carers, to partnership, collaboration and responsiveness.

The next step in our journey towards collaboration and partnership is to provide the public with a stronger voice in key decision making.

### What is the role of a Consumer Council?

Through true partnership, the Council would provide a strong and viable voice for the community and consumers, on health service planning and delivery. The Council will enhance consumer engagement and experience through promotion of service integration across the sector, the promotion of equity, and ensuring that services are organised and provided to meet the needs of all consumers, now and in the future.

### What skills will Consumer Council members need?

Establishing a Consumer Council creates the opportunity to select people who are experts by experience with diverse backgrounds, contacts, knowledge and skills, to provide the Board and management with a wide-ranging consumer view.

Members will also be selected to reflect:

- Our responsibilities under the Treaty of Waitangi
- Maori health views
- The population that uses health services
- The need to address disparities in health outcomes
- The requirements and priorities within strategic documents
- A range of interest areas e.g. women's health, mental health, and so on.

### How will Consumer Council members be appointed?

The Consumer Council appointment process will be open and transparent. The message about the Consumer Council and the request for applications will be promoted using all available communication channels – newspapers, community groups, networks, information evenings, newsletters and social media.

Applicants will be short-listed using the competency matrix criteria, followed by an interview with the Chief Executive, Board Chair and community leaders.

**Appendix 2**

**TERMS OF REFERENCE**

**Hawke's Bay Health Consumer Council**

**August 2018**

| | |
|---|---|
| **Purpose** | The Hawke's Bay Health Consumer Council (Council) works collaboratively with the Hawke's Bay District Health Board (HBDHB) and Health Hawke's Bay governance and management teams, and the Hawke's Bay Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawkes Bay that meets the needs of the people.<br><br>Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer engagement and experience through service integration across the sector, the promotion of equity and ensuring that services are organised and provided to meet the needs of all consumers.<br><br>Through effective processes and communications, the Council receives, considers and disseminates information from and to HBDHB, Health Hawke's Bay, consumer groups and communities.<br><br>The Council also has a quality improvement role to advise and encourage best practice and innovation. |
| **Functions** | The functions of the Council are to:<br>• Ensure, coordinate and enable appropriate consumer engagement across the Hawke's Bay, Central Region and national health systems.<br>• Identify, advise on and promote a 'Partners in Care' approach to the implementation of 'Person and Whanau Centred Care into the Hawkes Bay health system, including input into the development of health service priorities and strategic direction, the reduction of inequities, and the enhancement of consumer engagement, patient safety, clinical quality and making health easy to understand.<br>• Participate, review and advise on reports, developments and initiatives relating to Hawkes Bay health services and the availability and/or dissemination of health related information.<br>• Ensure regular communication and networking with the community and relevant consumer groups.<br>• Link with special interest groups, as required for specific issues and problem solving.<br><br>For the avoidance of doubt, the Council will not:<br>• Provide clinical evaluation of health services<br>• Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exists.<br>• Be involved in the HBDHB or Health Hawke's Bay contracting processes. |
| **Level of Authority** | The Council has the authority to give advice and make recommendations to HBDHB and Health Hawke's Bay senior management and Board. |

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| **Membership** | There shall be fourteen (14) members on the Council, plus an independent Chair. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care from the Hawke's Bay health sector. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community.<br><br>Members will be appointed to reflect the following areas of interest:<br>• Women's health<br>• Child health<br>• Youth health<br>• Older persons health<br>• Chronic conditions<br>• Mental health<br>• Alcohol and other drugs<br>• Sensory and Physical disability<br>• Intellectual and Neurological disability<br>• Rural health<br>• Maori health<br>• Pacific health<br>• Primary health<br>• High deprivation populations<br><br>When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population.<br><br>Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate.<br><br>Members shall be appointed for terms of two years. Members may be reappointed but for no more than three terms.<br><br>Remuneration shall be paid based on the Cabinet Fees Framework applicable to HBDHB Statutory Committees. |
| **Chair** | The Chair shall be appointed by the HBDHB Board on the recommendation of the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the Health Hawke's Bay Board) following consultation with Council members.<br>Appointments shall be for terms ending no later than four months after the end of the term of the HBDHB Board that appointed them (Note: The full term of a Board is three years).<br><br>The Chair may be paid additional fees and allowances, depending on the level of commitment involved in addition to Council meetings. |
| **Meetings** | Meetings will be held monthly, excluding January, or more frequently at the request of the Chair.<br><br>Meetings will generally be open to the public but may move into "public excluded" where appropriate, and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee.<br><br>A standing reciprocal invitation has been extended to the Hawke's Bay Clinical Council for a representative to be in attendance at all meetings. |

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| **Reporting** | The Council will report to the CEOs of HBDHB and Health Hawke's Bay, and through the CEOs to the respective HBDHB and Health Hawke's Bay boards.<br><br>A monthly report of Council activities and recommendations will be placed on HBDHB and Health Hawke's Bay websites once approved. |
| **Minutes** | Minutes will be circulated to all members and Chair of the Council, within one week of the meeting taking place.<br><br>Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc, on request. |

**Appendix 3a**

# Waikato District Health Board Consumer Council - Terms of Reference

*"Mehemea ka moemoeā ahau*
*Ko au anake*
*Mehemea ka moemoeā e tātou, Ka taea e tātou"*

*"If I am to dream*
*I dream alone*
*If we all dream together*
*Then we will achieve"*

Te Puea Herangi

## Purpose and scope

The Consumer Council works in partnership with the Chief Executive Officer (CEO) and senior management at Waikato DHB to ensure the planning and delivery of health services is people centred and responsive to the needs of consumers and communities. In other words keep People at heart – *Te iwi Ngakaunui*, which encompasses the DHBs values.

The Consumer Council works with senior management to provide advice:

- On the direction and strategic priorities of the DHB from a consumer perspective
- At an operational level on service design and delivery from a consumer perspective (Note: The Consumer Council may guide the DHB on whom to engage with for specific pieces of work. It will not be an expectation that the Consumer Council will become involved in all operational improvement projects).

The Consumer Council has an over-arching role to promote and have oversight of consumer involvement in the planning and delivery of Waikato DHB services. In doing so, it supports the achievement of the Waikato DHBs strategic imperatives, specifically:

- Health equity for high-needs populations
- Safe, quality health services for all
- People-centred services
- Effective and efficient care and services
- A centre of excellence in learning, training, research and innovation
- Productive partnerships

The Consumer Council supports improved consumer engagement, consumer experience, patient safety, health literacy and clinical quality.

The Consumer Council encompasses all services the Waikato DHB provides. It also includes Primary Health Organisations (PHOs).

## Functions

The Consumer Council will:

- Provide advice on key strategic documents and plans
- Promote consumer engagement across the Waikato DHB and ensure the organisation remains focused on the delivery of people-centred care
- Ensure a focus on improving health equity for high-needs populations (Māori, people living in rural communities and people living with disabilities)

- Guide DHB services to engage with consumers in service design and delivery (sign-posting to appropriate consumer networks/groups and advising on best approaches)
- Advise on people-centred care approaches to service design and delivery
- Identify opportunities where consumers should become involved in specific improvement projects
- Ensure regular communication and networking with consumer groups, communities and consumers about the work of the Consumer Council (with support)
- Maintain an overview of consumer engagement activity across the Waikato

The Consumer Council will not:

- Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exist
- Be involved in Waikato DHB contracting processes
- Provide clinical evaluation of health services from a purely clinical perspective. It may provide evaluation of services from a consumer experience perspective

## Responsible to

The Consumer Council will be responsible to and report to the Chief Executive Officer. The Consumer Council has a relationship with the Board and Iwi Māori Council, and will report to the Board through the CEO.

## Membership

There will be 14 members on the Consumer Council, plus a Chair. A Co-Chair arrangement is possible.

Members will have diverse backgrounds, knowledge, skills and contacts. All will be committed to ensuring that consumers are able to access the best possible services and care from Waikato DHB.

Members or those close to them will:

- Have lived experience of health services either personally or as whānau OR
- Have recently accessed health services directly or for whanau (ideally within the previous 2-3 years) OR
- Be actively engaged in a specific area of health interest in your community

Although appointed to reflect the consumer voice in a particular area of health interest, members will not be regarded as representatives of any specific organisation or community.

Membership must broadly reflect the demographics of the priority populations as outlined in Waikato DHBs Strategy, that is Māori, people in rural communities and people living with disabilities. This will support the strategic imperative of achieving health-equity for high-needs populations and means that membership of the Consumer Council will include as a priority, members who have particular experience, interest, understanding and knowledge in at least one of the following areas:

- Māori health
- Rural communities health
- Disabilities

To ensure diversity there will be a mixed approach to membership, which in addition to the above will seek to include members who each have a particular experience, interest, understanding and knowledge in at least one of the following areas*:

- One of the rural Community Health Forum areas
- Pasifika peoples
- Mental Health and Addictions
- Youth health
- Older persons health
- Refugee and migrant health
- Patient support (by carers/family members/loved ones)

*This is not a full list and we will try to ensure a diverse group with interests in other disability and health areas.

Initially half of the members will be appointed for a one year term, and the remaining half for two years, with all further appointments being for terms of two years. Members may be re-appointed, but for no more than two additional terms.

The CEO may at any time on written notice to the Chair and relevant member, remove a member from the Consumer Council if he considers that the member is failing to adequately perform the duties of the role as defined in position descriptions and Code of Conduct.

In addition, if a member fails to attend three meetings in a row without an apology, they will be asked by the Chair to step down as a Consumer Council member.

Consumer Council Members will be appointed by the CEO or their delegate.

Consumer Council members will be recruited via an open Expression of Interest process.

To avoid doubt, Consumer Council members are not employees of Waikato DHB. The appointment as a member does not alter the member's employment status prior to the appointment (e.g. self-employed, employee, not employed).

## Chair

An interim Chair of the Consumer Council will be appointed by the CEO. The initial term will be for one year, with further terms being for two years. The Chair may be re-appointed, but for no more than two additional terms. A Co-Chair arrangement is possible.

## Quorum

A quorum will be half of the membership plus one.

## Meetings

Meetings will be held monthly, excluding January or more frequently at the request of the Chair. Meetings will generally be open to the public however, on occasion meetings may be closed in full or part due to issues of risk, confidentiality or the needs of the Consumer Council, as determined by the Chair.

DHB staff members are encouraged and welcomed to be "in attendance" for meetings or parts of meeting which are open to the public.

Meetings will be scheduled to ensure that members who work are able to attend.

Video-conferencing facilities will be made available where possible to support virtual participation for people living in rural areas. Video-conferencing should always be considered as an option for any meeting to provide choice for members and ensure maximum use of the financial investment in the Consumer Council.

## Reporting

The Consumer Council will provide a regular report to a range of internal and external stakeholders, including:

- CEO
- The Board and its committees
- Relevant Quality Governance Forums
- Executive Group
- Iwi Māori Council
- Community Health Forums

A regular report of Consumer Council activities will be placed on Waikato DHB websites once approved by the Chair.

## Key relationships

The Consumer Council will maintain relationships with the following, as illustrated in the Key Relationships Diagram:

- CEO
- Board and its committees
- Iwi Māori Council
- Board of Clinical Governance
- Executive Group
- DHB Services
- Consumers and groups
- Community Health Forums
- NGOs
- Interested individuals
- The public

## Agendas and minutes

Agendas and minutes will be circulated to all members and the Chair of the Consumer Council within one week of the meeting taking place. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc., only on request. Summaries will be published on the Waikato DHB website.

## Code of Conduct

### Principles

Members of the Consumer Council must abide by the following general principles of good governance in their role. Members must:

- Serve only the interests of the community as a whole and must never improperly confer an advantage or disadvantage on any one person, or group of persons. (Mauri pai – Fair play)
- Not place themselves in situations where their honesty and integrity may be questioned, must not behave improperly and must on all occasions avoid the appearance of such behaviour. (Whakamana – Give and earn respect)
- Must make decisions on merit.
- Take account of the views of others, but should reach their own conclusions on the issues before them, and act in accordance with those conclusions. (Whakarongo – Listen to me, talk to me, Kotahitanga – Stronger together)
- Treat people, including each other, management and the public, with respect, regardless of their race, age, religion, gender, sexual orientation, or disability, and must not unlawfully discriminate against any person or group of persons. (Whakamana – Give and earn respect, Mauri pai – Fair play)
- Uphold the law. (Mauri pai – Fair play)

### Dealings with other members and staff

Members must conduct their dealings with other members and Waikato DHB staff:

- With courtesy and respect (Whakamana – Give and earn respect)
- In a way that maintains public confidence in the role (Whakarongo – Listen to me, talk to me, Kotahitanga – Stronger together)
- In a way that is open and honest (Mauri pai – Fair play, Whakarongo – Listen to me, talk to me)
- In a way that focuses on issues rather than personalities (Kotahitanga – Stronger together)
- In a way that avoids aggressive, offensive or abusive conduct. (Whakamana – Give and earn respect, Mauri pai – Fair play)
- In a way that observes any guidelines that the Chief Executive puts in place regarding contact with employees

- In a way that does not compromise, or could be seen as compromising, the impartiality of an employee
- In a way that avoids publicly criticising any employee in any way, but especially in ways that reflect on the competence and integrity of the employee (Whakamana – Give and earn respect, Mauri pai – Fair play)

### Conflict of Interest

All members will be required to declare potential or actual conflicts of interest. In the course of their duties members may receive information that they need to treat as confidential. Confidential information includes information that officers have judged there is good reason to withhold under the Official Information Act. Where this is the case, members must keep such information confidential (and not disclose it to any third party) and only use that information for the purpose of fulfilling their duties.

### Ethics

Waikato DHB seeks to promote the highest standards of ethical conduct. Accordingly, members must:

- Claim only for legitimate expenses
- Not influence, or attempt to influence, any employee to take actions that may benefit the member, or the member's family or business interests
- Not use Waikato DHB resources for personal business
- Not abuse the advantages of their official position for personal gain, or solicit or accept gifts, entertainment, rewards or benefits that might compromise their integrity
- Make it clear in any public forum if they are representing the Consumer Council, presenting their views and lived experience as a Consumer, or acting in a professional capacity.

## Remuneration

Consumer Council members will be remunerated at a fixed rate for Consumer Council meeting attendance, additional reading, and any community engagement not otherwise categorised in the Remuneration Guidelines. This will be at a rate of $250 per Consumer Council month. The Chair will receive a stipend as per the Consumer Engagement Remuneration Guidelines. Mileage expenses will also be paid. Remuneration for work associated with Consumer Council activities which is in addition to Consumer Council preparation and attendance, can also be made, for example other meeting attendance, project work etc.

This remuneration will be made in accordance with Waikato DHBs Consumer Engagement Remuneration Guidelines which states:
All requests for payment for meeting attendance other than for attendance at Consumer Council Meetings (and other DHB agreed committees/groups) must be approved by the Chair and signed off by the Director, Quality and Patient Safety (or delegate) in advance. Chair's attendance requires sign off in advance by the Director, Quality and Patient Safety (or delegate). This will ensure equity of access, appropriate engagement of consumers, and for monitoring purposes.

Consumer Council members who attend within their work capacity and time and with the support of their employer shall not be remunerated.

## Orientation, training and support for Consumer Council Members

Consumer Council members will be provided with orientation and support by a DHB staff member to undertake their role, including assistance with communication and networking, both within the DHB and externally.

Members will be supported with accessible communications, including interpreters, as required.

# Appendix 3b

| | |
|---|---|
| Title | **Waikato District Health Board Consumer Council**<br><br>**Member Position Description** |
| Responsible to | **Chief Executive Officer** |

## What the Consumer Council will do

The Consumer Council will work in partnership with leaders of the Waikato District Health Board (Waikato DHB) to make sure its services are as good as they can be and meet the needs of people in our communities. The different voices and experiences of Consumer Council members will collectively help shape what Waikato DHB does and how we do it, making sure we remain focused on the needs and experiences of people using its services.

Specifically, it will work with senior management to provide advice on:

- The direction and strategic priorities of the DHB
- How we can improve specific aspects of some DHB services

The Consumer Council will cover all services the Waikato DHB provides.

## Key tasks of a Consumer Council member

- Read relevant reports and documents prior to Consumer Council meetings
- Attend Consumer Council meetings and:
    - provide advice on key strategic documents and plans from a consumer perspective
    - promote consumer engagement across Waikato DHB and make sure it remains focused on the people we deliver services to
    - focus on improving health outcomes for Māori, people living in rural communities and people living with disabilities (high-needs populations)
    - guide DHB services to engage with consumers in service design and delivery (sign-posting to appropriate consumer networks/groups and advising on best approaches)
    - identify opportunities where consumers should become involved in specific improvement projects
    - advise on people-centred care approaches to service design and delivery
    - ensure regular communication and networking with consumer groups, communities and consumers about the work of the Consumer Council (with support)
    - maintain an overview of consumer engagement activity across the Waikato
- Work constructively with other Consumer Council members and all other associated professionals and consumers
- Support the decisions of the Consumer Council
- Not approach media about any aspect of the Consumer Council's work without specific agreement from the Chair of the Consumer Council and CEO
- Maintain confidentiality. Some aspects of the work of the Consumer Council may be highly sensitive and as a member of the Consumer Council, you will be required to sign a confidentiality statement/agreement
- Declare any conflicts of interest immediately
- To avoid doubt, Consumer Council members are not employees of Waikato DHB. The appointment as a member does not alter the member's employment status prior to the appointment (e.g. self-employed, employee, not employed)

**Please note** that the Consumer Council will be supported in its work by a DHB staff member. This will include assistance with communication and networking, both within the DHB and externally.

## Duration of term

This will vary amongst members. Initially half of the members will be appointed for a one year term, and the remaining half for two years, with all further appointments being for terms of two years. Members may be re-appointed, but for no more than two additional terms.

The CEO may at any time on written notice to the Chair and relevant member, remove a member from the Consumer Council if he considers that the member is failing to adequately perform the duties of the role.

## Time commitment

- Meetings will be held monthly (except January) and typically run for two hours
- Video-conferencing facilities will be made available at each rural hospital to allow members who live in these areas to participate in meetings (please note that some meetings will need to be attended in person – to be negotiated with Chair)
- Pre-meeting and post-meeting reading will be expected
- Attendance at other meetings may be necessary. This will be negotiated between the Chair and delegated member

## Qualities, skills and experience

### Personal Qualities

- Passion and commitment to help improve public health services in the Waikato
- Passion and commitment to help eliminate health inequities for Māori, people in rural communities and people experiencing disabilities
- Confidence, maturity and reliability

### Knowledge and skills

- Relationships and connections within your health interest area or as a result of your personal or family healthcare experiences
- Good listening and communication skills with a wide range of people
- Able to think creatively, critically and strategically
- Confidence to interact positively with senior health professionals and managers
- Some knowledge of the New Zealand health and disability sector
- Knowledge and appreciation of the Treaty of Waitangi and its application in health
- Able and willing to see "the bigger picture" and think beyond your own experience
- Good analytical skills
- Able to read and review reports
- Able to work positively and constructively in a group, share insights, thoughts and opinions
- Able to use sound and ethical judgment
- Able and committed to maintaining confidential information
- Able to conduct yourself professionally at all times

### Experience

- Live in the Waikato and have experience of using health services (within the last 2-3 years), either directly, or via family or whānau OR
- Be actively engaged in a specific area of health interest in your community
- Some experience of committee work would be desirable, but not essential

**Please note** that we do not expect every person to have all of the above knowledge, skills and experience. We appreciate that some of these are learnt through experience and support and mentoring can be made available.

## Code of Conduct

### Principles

Members of the Consumer Council must abide by the following general principles of good governance in their role:

- Members must serve only the interests of the community as a whole and must never improperly confer an advantage or disadvantage on any one person, or group of persons (Mauri pai – Fair play)

- Members must not place themselves in situations where their honesty and integrity may be questioned, must not behave improperly and must on all occasions avoid the appearance of such behaviour (Whakamana – Give and earn respect)
- Members must make decisions on merit (Mauri pai – Fair play)
- Members must take account of the views of others, but should reach their own conclusions on the issues before them, and act in accordance with those conclusions (Whakarongo – Listen to me, talk to me, Kotahitanga – Stronger together)
- Members must treat people, including each other, management and the public, with respect, regardless of their race, age, religion, gender, sexual orientation, or disability, and must not unlawfully discriminate against any person or group of persons (Whakamana – Give and earn respect, Mauri pai – Fair play)
- Members must uphold the law (Mauri pai – Fair play)

**Dealings with other members and staff**

Members must conduct their dealings with other members and Waikato DHB staff:

- With courtesy and respect (Whakamana – Give and earn respect)
- In a way that maintains public confidence in the role (Whakarongo – Listen to me, talk to me, Kotahitanga – Stronger together)
- In a way that is open and honest (Mauri pai – Fair play, Whakarongo – Listen to me, talk to me)
- In a way that focuses on issues rather than personalities (Kotahitanga – Stronger together)
- In a way that avoids aggressive, offensive or abusive conduct. (Whakamana – Give and earn respect, Mauri pai – Fair play)
- In a way that observes any guidelines that the Chief Executive puts in place regarding contact with employees
- In a way that does not compromise, or could be seen as compromising, the impartiality of an employee
- In a way that avoids publicly criticising any employee in any way, but especially in ways that reflect on the competence and integrity of the employee (Whakamana – Give and earn respect, Mauri pai – Fair play)

**Conflict of Interest**

In the course of their duties members may receive information that they need to treat as confidential. Confidential information includes information that officers have judged there is good reason to withhold under the Official Information Act. Where this is the case, members must keep such information confidential (and not disclose it to any third party) and only use that information for the purpose of fulfilling their duties.

**Ethics**

Waikato DHB seeks to promote the highest standards of ethical conduct. Accordingly, members must:

- Claim only for legitimate expenses
- Not influence, or attempt to influence, any employee to take actions that may benefit the member, or the member's family or business interests
- Not use Waikato DHB resources for personal business
- Not abuse the advantages of their official position for personal gain, or solicit or accept gifts, entertainment, rewards or benefits that might compromise their integrity
- Make it clear in any public forum if they are representing the Consumer Council, presenting their views and lived experience as a Consumer, or acting in a professional capacity.

## Support and payment to undertake the role

Orientation to the role, guidance and support will be provided to Consumer Council members, as required. This will include:

- Initial orientation meeting to Waikato DHB and the role of the Consumer Council
- Identified key contact person(s) within the DHB for the role
- Adequate and timely communication regarding meetings
- Consumer Council members will be paid at a fixed rate of $250 per meeting for Consumer Council attendance. Mileage expenses will also be paid
- Expenses beyond core work can also be claimed (e.g. other meeting attendance, project work) in accordance with Waikato DHBs Consumer Engagement Remuneration Guidelines
- Members will be supported with accessible communications, including interpreters, as required.

**Appendix 4**

New Zealand Government

# Terms of Reference

## for the PHARMAC Consumer Advisory Committee

**April 2010**

CAC | Consumer Advisory Committee

PHARMAC
Pharmaceutical Management Agency

# CONTENTS

## Glossary of terms

**"CAC"** means the Consumer Advisory Committee.

**"CAC Chair"** means the Chairperson of the CAC.

**"CAC Secretary"** means the Secretary of the CAC.

**"CE Act"** means the Crown Entities Act 2004.

**"Chief Executive"** means the Chief Executive of PHARMAC, or their delegate.

**"Deputy Chair"** means the Deputy Chairperson of the CAC.

**"Member"** means a member of the CAC.

**"Minute(s)"** means the written record of discussion and recommendations made at a CAC meeting (including meetings by teleconference and recommendations made by other means of communication) which have been finalised by the CAC Chair.

**"NZPHD Act"** means the New Zealand Public Health and Disability Act 2000 and includes any regulations, amendments, re-enactments and replacements thereof.

**"PHARMAC"** means the Pharmaceutical Management Agency, a Crown Entity established under the NZPHD Act.

**"Pharmaceutical(s)"** means, as defined in the NZPHD Act, a medicine, therapeutic medical device, or related product or related thing.

**"Published Minute"** means that part of the CAC Minute published on the PHARMAC website at http://www.pharmac.govt.nz/patients/CAC/ CACminutes.

**"Terms of Reference"** means these Terms of Reference for the CAC.

# 1 Establishment

## 1.1 The CAC

The CAC is an advisory committee established by the PHARMAC Board as required by the New Zealand Public Health and Disability Act 2000 to '*provide input from a consumer or patient point of view'.*[1]

# 2 Terms of Reference

## 2.1 Purpose of the CAC

The primary purpose of the CAC as described in the legislation is to provide the Board of PHARMAC with input from a consumer or patient point of view on matters related to PHARMAC's activities. Recognising the difficulties representing the wide range of disparate views held by consumers, it is not intended that the CAC represent all consumer views. The CAC's primary functions, therefore, are to provide advice to PHARMAC on how it can best access the diversity of consumer views and consider these when carrying out its role.

The CAC does not have a role in pharmaceutical funding decisions. Consumers are able to provide input directly into the funding decision making process by making a funding application and/or contacting PHARMAC directly about an active funding application or through consultation.

## 2.2 Activities of the CAC

The CAC's activities shall include, but not be restricted to, providing advice to PHARMAC from a consumer or patient point of view on:

- how PHARMAC can canvass and consider consumers' views on the processes involved in the assessment, prioritisation and funding of medicines and related issues of special concern to consumers and patients, and PHARMAC's operational policy and business improvement processes;
- PHARMAC's strategy, policy and operational activities which relate to funding decisions, and access to and optimal use of medicines, but not specific funding decisions;
- how PHARMAC's implementation of its funding decisions, policies and strategies, including information and education related to those funding decisions, policies and strategies would be best communicated to consumers;
- how the CAC can engage with consumers and patients to ensure it is aware of, and able to reflect their views (on the relevant matters as described in these Terms of Reference), in its advice to the PHARMAC Board; and

[1] Section 50(1)(a), NZPHD Act.

- other activities required by PHARMAC, or proposed by the CAC and agreed to by PHARMAC.

# 3 Relationship Management

## 3.1 Relationship with PHARMAC

3.1.1 The CAC is an advisory committee established by PHARMAC to provide advice to PHARMAC from a consumer or patient point of view. The CAC may advise PHARMAC on matters described in these Terms of Reference. PHARMAC will consider the recommendations of the CAC along with any other advice and information it holds, before deciding whether to follow or implement any CAC recommendations or advice.

3.1.2 Minutes of each CAC meeting shall be provided to the PHARMAC Board. The PHARMAC Board's response to the CAC's recommendations will, where possible, be provided to CAC at its next meeting.

3.1.3 The CAC Chair (or in their absence, a delegated Member of the CAC approved in advance by the PHARMAC Board Chair) has the right to attend all meetings of the PHARMAC Board as an observer. The CAC Chair may participate in discussion at the invitation of the Board Chair but may not vote on any matter at that meeting. The CAC Chair may, subject to any specific confidentiality undertaking they have signed with the PHARMAC Board in relation to their participation as an observer, report back to the CAC on the discussions of the Board.

3.1.4 The PHARMAC Board Chair (or in their absence, a delegated PHARMAC Board member, approved in advance by the CAC Chair) has the right to attend all meetings of the CAC as an observer. The PHARMAC Board Chair may participate in discussion at the invitation of the CAC Chair but may not vote or have any role in determining recommendations on any matter at that meeting. The PHARMAC Board Chair may report back to the Board on the discussions of the CAC.

## 3.2 Relationship with PHARMAC staff

3.2.1 PHARMAC's Chief Executive or a delegate may attend part of or all of each CAC meeting to discuss consumer-related issues which are of concern to either the CAC and/or PHARMAC.

3.2.2 In addition to 3.2.1, PHARMAC staff member(s), may attend and participate in meetings of the CAC while reports or recommendations relevant to their area of work are discussed. In general, PHARMAC staff may respond to questions from the CAC and clarify understanding of discussion and recommendations as necessary.

3.2.3 PHARMAC staff will provide administrative and support services for the CAC (see below).

***The CAC Secretary***

3.2.4 A CAC Secretary is to be provided by PHARMAC to support the CAC and assist the CAC Chair in performing his or her role.

3.2.5 The agenda for each CAC meeting shall be set after consultation between the CAC Chair and the CAC Secretary, taking into account matters referred by PHARMAC to CAC for advice and any other relevant matters.

3.2.6 The agenda and related papers will be sent to Members of the CAC (subject to the deletion of any papers from a Member's pack due to a conflict of interest of that Member), ordinarily two weeks before the relevant meeting.

3.2.7 The CAC Secretary is responsible for ensuring a Minute of each meeting of the CAC (including by teleconference or other means of communications) is kept and for preparing the Published Minute.

3.2.8 The CAC Secretary, in agreement with the CAC Chair, is responsible for managing correspondence between the CAC Members and third parties.

3.2.9 The CAC Secretary is not a Member of CAC.

**3.3 Relationships with Consumers**

3.3.1 While noting it is not intended that the CAC represent all consumer views or act as a conduit for consumer opinion, it is important that Members are able to engage with consumers to increase Members' understanding of consumer/patient perspectives.

3.3.2 Recognising 3.3.1 above, CAC Members may seek funding for costs incurred in attending conferences and meetings where consumers and consumer/patient groups will be in attendance. With the prior approval of PHARMAC, CAC members may be remunerated for time spent at such events. PHARMAC will assess such requests and may take into account the following criteria, giving such weight to each criterion as it sees fit:

- the opportunity for engaging and networking with consumers and patients;
- attendance at the CAC meetings;
- number of other CAC Members attending;
- relevance to the CAC's activities described in these Terms of Reference;
- cost and available budget;

- balance of opportunities across the CAC members; and
- relevance to consumer issues of concern at the time.

3.3.3 Members who attend such meetings/events will be expected to report back to the CAC.

### 3.4 Indemnity for Members

3.3.1 PHARMAC indemnifies all Members against all costs, liabilities, expenses and claims Members may incur as a direct or indirect result of advice given in their capacity as Members. This indemnity only applies to circumstances where a Member has acted in good faith and in performance or intended performance of the CAC's functions.

## 4 Membership

### 4.1 Appointment of the CAC Members

4.1.1 The appointment process will be appropriate for the cultural background of the individual, but generally PHARMAC staff will advertise widely (including to all individual consumers and consumer/patient groups listed on the PHARMAC consultation database) for applications from the general public for new Members.

4.1.2 PHARMAC will provide a position description for all potential applicants.

4.1.3 A short-list of applicants will be drawn up by the CAC Chair assisted by PHARMAC staff (usually two staff members). The candidates on the short-list will be interviewed by a panel which will comprise the CAC Chair, PHARMAC staff (usually two) and others as appropriate. Recommendations for appointment will then be made to the PHARMAC Board. The Board will be advised of any differences of opinion between panel members and will make the final decision as to who should be appointed.

4.1.4 The CAC will consist of up to nine Members, including at least two Maori and at least one Pacific people's representatives. Where no suitable Maori or Pacific people's candidates are nominated, the Board will seek to identify a member with appropriate skills and experience from those communities. In making appointments to the CAC, the Board will endeavour to ensure the CAC has an appropriate mix of people:

- who can demonstrate a connection to a particular community of consumers or patients;
- who can reflect interests broader than those of a specific group;
- who can demonstrate an understanding of issues related to medicine use;

- who can demonstrate an understanding of issues associated with the use of medicines within a wider health context;
- from different age groups and genders;
- from different locations (urban and rural); and
- from different cultures.

In general, PHARMAC intends the focus to be on appointing members who can provide input from a consumer, patient and community perspective, not the perspective of health professionals or commercial enterprises.

4.1.5 The term for CAC members will be up to three (3) years. Recognising the need to balance regularly refreshing consumer input with developing an understanding of PHARMAC's processes, the CAC members may, at the discretion of the PHARMAC Board, be reappointed for an additional term(s); however the maximum term of membership will be no longer than six (6) years. When deciding whether to reappoint a member PHARMAC may consider, among other things, the mix of the committee's experience, and the performance of the individual member.

4.1.6 The Board will appoint the Chairperson and the Deputy Chairperson of the CAC, after consultation with the CAC.

**4.2 Review of Appointment**

4.2.1 Concerns about the process followed in making an appointment should be addressed to the Chief Executive in writing and must be submitted within three months of the announcement of an appointment. PHARMAC may then undertake a review of the process followed. The results of the review will be discussed with the complainant including what, if any, resulting action will be taken.

4.2.2. PHARMAC will seek to undertake any review of an appointment process within three months of concerns being raised as described in paragraph 4.2.1 above, and can be made in respect of:

- an individual's experience of the appointment process as an applicant;
- the appointment process followed; and
- a challenge to the appointment of the successful candidate, where there appears to be a breach of the appointment process.

**4.3 Termination of Appointment**

4.3.1 Members will inform the PHARMAC Board Chair and the CAC Chair in writing of their intention to resign from the CAC at the earliest possible opportunity.

4.3.2 The PHARMAC Board Chair may at any time remove a Member (including the CAC Chair or Deputy Chair) from the CAC. The Chief Executive will inform the Member in writing of the termination of his/her membership.

4.3.3 In accordance with section 91 of the NZPHD Act, PHARMAC may not make any payment to, or otherwise compensate, any person in respect of the person ceasing to be a Member.

## 5 Induction and support of CAC Members

5.1 Every new Member will participate in an orientation and induction programme at the beginning of his or her appointment in order to gain an understanding of PHARMAC's structure, operations and processes. The induction will also aim to ensure that a new member has an understanding of the total environment (i.e. the public sector) in which CAC operates, and thus is able to contribute confidently to his or her work on the Committee.

5.2 The CAC Chair will, at PHARMAC's discretion, be provided with training in effective chairing skills when he/she takes over the role or as required.

5.3 Effective committee process training will, at PHARMAC's discretion, be facilitated by PHARMAC for the whole of CAC as required.

## 6 Review of Member Performance

6.1 The performance of each Member will be assessed, preferably at the end of the first year of the Member's term and at the end of the three years if the Member is seeking reappointment. The CAC Chair, in consultation with the Chief Executive, will assess the performance of each Member. The performance of the CAC Chair will be assessed by the Chair of the Board.

## 7 Remuneration of the CAC

7.1 The CAC Members will be remunerated in recognition of the services they provide to PHARMAC, including attendance at meetings and time spent preparing for meetings and for performing any other work as requested by PHARMAC or requested by the CAC and approved by PHARMAC prior to that other work taking place.

7.2 The Cabinet Office Fees Framework determines the level of fees paid.

7.3 PHARMAC will cover travel and accommodation expenses for Members to attend meetings[2].

[2] Travel & Expense Policy for Board Members and Committee Members

7.4 PHARMAC will meet agreed expenses for engagement activities that PHARMAC has approved under section 3.3.

# 8 Responsibilities of the CAC Chairperson

## 8.1 Responsibilities of the CAC Chair

8.1.1 The CAC Chair is responsible for:

- consulting with the CAC Secretary to set the agenda for the CAC meetings;
- presiding at each meeting of the CAC;
- deciding on the appropriateness of a meeting being held via teleconference;
- permitting Members to disconnect from a meeting via teleconference;
- signing off the final version of the Minute of each meeting of the CAC in a timely manner following each meeting and prior to these being provided to the Board;
- liaising with PHARMAC with regard to the resources to be allocated to the CAC and its members;
- assisting with the assessment and management of all actual and potential conflicts of interest, noting and signing interest declaration forms and ensuring consideration by the PHARMAC Board. For completeness, it should be noted that this does not remove or detract from Members' obligations to properly disclose interests;
- approving communications by Members related to the activities of the CAC with the media, professional associations, researchers and research organisations, having first obtained the consent of the PHARMAC Chief Executive to the act of communication and having first consulted with PHARMAC on the content;
- attending meetings of the Board of PHARMAC, where appropriate (as an observer) and, subject to confidentiality requirements, reporting back to the CAC Members on the discussion;
- delegating, in writing, any of his or her responsibilities where appropriate and in accordance with any PHARMAC delegation policy;
- determining who may attend the CAC meetings as an observer;
- working with the CAC Secretary to manage correspondence addressed to the CAC;

- consulting with the Chief Executive on the review of Members;
- working with Members to review the CAC's work/effectiveness as required;
- participating in the training/induction of new Members as appropriate; and
- attending Chair training as required.

### 8.2 Responsibilities of Deputy Chair of the CAC

8.2.1 The Deputy Chair is responsible for acting as the Chair of the CAC when the CAC Chair is unable to, or delegates this role to the Deputy Chair.

## 9 Responsibilities of all Members

### 9.1 Full participation in CAC

9.1.1 All Members are responsible for:

- complying with all obligations set out in the CE Act (refer to Appendix B);
- reading and considering their response to all material provided relating to items on meeting agendas prior to each meeting;
- reviewing, in a timely manner, the draft Minute, providing feedback to the CAC Secretary and confirming that the Minute is an accurate record of the discussion prior to finalisation of the Minute, for meetings that they have attended;
- attending meetings;
- providing apologies if attendance at meetings is not possible;
- being available to attend teleconferences and/or responding by email between face to face meetings;
- attending, if available, PHARMAC events involving external stakeholders e.g. PHARMAC Forum, Access and Optimal Use events;
- acting as a discussion leader for any items allocated to them by the CAC Chair; and
- attending induction and training.

## 9.2 Conflicts of interest

9.2.1 Members are to, at all times, fully disclose and appropriately manage any interests and conflicts of interest in the performance of their duties and obligations, consistent with their role as Members of a committee of a statutory entity. Members are to avoid, to the greatest extent possible, any conflict with the performance of their duties and obligations as Members. The legislative requirements for disclosure and management of conflicts are set out in Appendix B. Section 62 of the CE Act sets out the legal definition of being "interested in a matter". Further guidance on this issue is attached to the interests disclosure form set out in Appendix B.

9.2.2 A Member who reasonably believes they may have an actual or potential conflict of interest is to disclose the nature of that interest to the CAC and the PHARMAC Board as soon as practicable after they become aware of it.

9.2.3 Where a Member declares or discloses an interest of any kind or an actual or potential conflict of interest, this shall be recorded in an interest register, which is to be circulated prior to each meeting of the CAC. The interests register is to be considered and confirmed as up to date at the commencement of each meeting.

9.2.4 Following the setting of the agenda for a meeting Members are to update the interests disclosure form set out in Appendix B with any actual or potential conflicts of interest arising as a result of the specific agenda items for that meeting, or otherwise. Members are to provide their updated interests disclosure form to the CAC Secretary prior to the papers being sent to Members and in any event no later than three weeks prior to the date of the relevant meeting.

9.2.5 Where a Member is "interested in a matter" (as defined in section 62 CE Act) relating to PHARMAC, they must not take part in any discussion or decision of the CAC relating to the matter, or otherwise participate in any activity of PHARMAC that relates to the matter. The Minutes of the meeting will record this fact.

9.2.6 The Member is to be disregarded for the purposes of forming a quorum for that part of the meeting of the CAC during which a discussion or decision in relation to the matter occurs or is made. If a quorum cannot be maintained, then the relevant matter is to be deferred to the next meeting.

9.2.7 Should the CAC Chair (or Deputy Chair, when the CAC Chair is "interested in a matter") consider that it is in the public interest to permit one or more Members, or Members with a specified class of interest, or take part in any discussion or decision of the CAC relating to a matter, or otherwise participate in any activity of PHARMAC that relates to a matter, they should apply for such permission from the PHARMAC Board Chair. The PHARMAC Board Chair may give such permission if they are satisfied it is in the public interest to do so and may state conditions that the Member(s) must comply with.

9.2.8 Where the PHARMAC Board Chair determines that it is "in the public interest" for a Member to continue to participate in a matter, despite any declared conflict of interest, this will be documented in the Minutes.

### 9.3 Confidentiality

9.3.1 Subject to any public law obligations of PHARMAC in relation to the disclosure of information (including under the Official Information Act 1982 ("OIA"), all information, documents and other material relating to matters on the CAC's agenda, as well as the proceedings of the CAC, which are marked as confidential, are confidential to the CAC and to PHARMAC. Members must comply with any communications regarding confidentiality obligations issued by PHARMAC and will, if required, sign confidentiality undertakings.

9.3.2 Members are required to store all confidential material received from PHARMAC in a secure place until the matter has been finally determined by PHARMAC, after which time Members must either destroy the confidential material (by secure destruction) or return it to PHARMAC.

### 9.4 External Communications and Public Statements

9.4.1 Members may only speak to the media, researchers or research organisations in relation to the activities of the CAC or PHARMAC and any matters discussed at or considered by the CAC at its meetings, if they have the prior agreement of the CAC Chair and the PHARMAC Chief Executive.

## 10 Management of meetings

### 10.1 Meetings of the CAC

10.1.1 The CAC Chair or the Deputy Chair is to preside at each meeting of the CAC unless the CAC Chair delegates authority to another CAC Member.

10.1.2 CAC meetings are normally held in Wellington no less than twice a year. CAC may also meet by teleconference or provide advice or make recommendations using email discussion for matters that arise between the regular face to face meetings. The CAC Secretary, PHARMAC Chief Executive and the CAC Chair will, acting together, select the dates for the CAC meetings.

10.1.3 The quorum for meetings of the CAC is five Members, of whom one Member must be either the CAC Chair or the Deputy Chair. In exceptional circumstances (for example where time is of the essence) the Chairperson may direct that the quorum for a particular meeting is to be four Members.

10.1.4 Members can request leave of absence from any particular CAC meeting.

10.1.5 Subject to the above, the CAC may regulate its internal procedures in such manner as it thinks fit.

## 10.2 Remote Media Conferences

10.2.1 In some circumstances, (e.g. when there is a single agenda item that needs urgent discussion or when a member cannot attend a full meeting but may be able or wish to take part in the discussion on a particular agenda item(s)), it may be appropriate for the CAC to hold a meeting by contemporaneously linking together by remote media conferencing (such as teleconference or videoconference). Such a meeting should be at the agreement of the CAC Chair and have a quorum. To the extent practicable, the rules and procedures relating to the CAC meetings set out in section 10.1 will apply to a meeting held by remote media conference. In addition, the following rules shall apply

(a) notice must have been given to every Member entitled to receive notice of a meeting of the CAC; and

(b) each Member taking part in a meeting by remote media conference must:

- at the start of the meeting, acknowledge the Member's participation in the meeting to the other Members taking part;
- be able to hear the other Members taking part at all times throughout the meeting; and
- be able to individually express his or her view on advice or recommendations.

10.2.2 A Member may not leave a meeting held under this section by disconnecting his or her remote media connection unless they have first obtained the permission of the CAC Chair.

10.2.3 A Member is to be presumed to have been present, and to have formed part of the quorum, at all times during a remote media meeting unless he or she has been expressly permitted to leave.

10.2.4 A Member must ensure their participation in a meeting is confidential and, in the event that their comments may be overheard by a third party they must declare this to other Members at the commencement of the meeting.

## 10.3 Observers and Invited Guests

10.3.1 Observers may attend meetings at the invitation of the CAC Chair. The number of observers will be restricted to two per meeting. A potential observer must notify the CAC Chair of their desire to be invited to attend a CAC meeting and no later than one week prior to the meeting date. Attendance at a meeting is at the discretion of the Chair and an invitation will be given only for a single specified meeting. Meeting dates for the year will be published on the PHARMAC website at the beginning of each calendar year and the agenda for each meeting will be posted on the website two weeks prior to the meeting to assist observers to decide whether or not any agenda items are relevant for them. The CAC Chair may also invite an observer from a consumer interest group(s) to attend a CAC

meeting if he or she considers that an agenda item covers a topic of concern to that group. Observers would normally be expected to meet the costs of their attendance.

10.3.2 Observers are not CAC Members and, unless the CAC Chair of the particular meeting otherwise agrees, observers will not have any rights to speak at or otherwise participate in the meeting.

10.3.3 Observers will be required to sign confidentiality undertakings, prior to attending any meeting of the CAC. At the discretion of the CAC Chair observers may be excluded from any discussions of a confidential or commercially sensitive nature. The attendance of observers at a meeting will be documented in the Minutes.

10.3.4 Observers should not, by their presence, affect any recommendations or advice of the CAC, either by influencing or constraining discussion at any the CAC meeting. If the CAC Chair determines that the presence of an observer is having such an effect, the CAC Chair may require the observer to leave the meeting.

10.3.5 The CAC Chair may also invite representatives from consumer or other groups to present to the CAC and/or to participate in the Committee's discussion on a particular issue if the CAC is interested in that group's view on that issue.

### 10.4 Publication of the CAC Advice

10.4.1 Once the CAC Chair has received comments from Members and signed off the Minutes the Minutes will be provided to the Board for consideration.

10.4.2 PHARMAC will endeavour to publish the Minutes of the CAC meetings on the PHARMAC website within a month of the Board meeting at which the CAC minutes are considered by the Board.

10.4.3 Portions of the Minute may be withheld from publication in accordance with the Official Information Act 1982. The names of all observers and attendees at a meeting will be published where PHARMAC considers it appropriate.

10.4.4 In addition to the Published Minute the CAC Chair may provide a summary report of, or commentary on, the discussion at meetings, particular topics of interest to consumers, recent activities of the CAC and/or responses from the PHARMAC Board. This information may be published on the PHARMAC website or disseminated electronically.

## 11 Variation of Terms of Reference

11.1 These Terms of Reference set out the CAC's roles and responsibilities, but are not intended to cover every eventuality. They are to be interpreted flexibly and pragmatically, to allow CAC the scope to adapt as the need arises. These Terms of Reference may be varied or revoked (which may, where PHARMAC considers it appropriate, involve consultation) from time to time, by the PHARMAC Board.

## 12 Disputes

12.1 Any dispute or disagreement as to the meaning or application of any section in these Terms of Reference (except in relation to the appointment of the CAC referred to in section 4.1 above) is to be determined by the PHARMAC Board, whose decision is final.

## 13 Transitional Provisions

13.1 Each member of the CAC in office at the commencement of this Terms of Reference may continue in office for the remainder of his or her current term of appointment.

# Appendix A: Relevant Statutory Provisions

**New Zealand Public Health and Disability Act 2000**

*50 Board of PHARMAC to establish advisory committees*

(1) The board of PHARMAC must establish the following advisory committees under clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004:
  (a) a pharmacology and therapeutics advisory committee to provide objective advice to PHARMAC on pharmaceuticals and their benefits:
  (b) a consumer advisory committee to provide input from a consumer or patient point of view.
(2) [Repealed]
(3) [Repealed]
(4) Despite clause 14(1)(a) of Schedule 5 of the Crown Entities Act 2004, the members of the pharmacology and therapeutics advisory committee are appointed by the Director-General in consultation with the board of PHARMAC.

**Crown Entities Act 2004**

*43 No compensation for loss of office*

A member of a statutory entity is not entitled to any compensation or other payment or benefit relating to his or her ceasing, for any reason, to hold office as a member.

**Remuneration and expenses**

*47 Remuneration of members*

(1) A member of a statutory entity is entitled to receive, from the funds of the entity, remuneration not within section 48 for services as a member at a rate and of a kind determined by—
(a) the responsible Minister, in the case of a member of a Crown agent or autonomous Crown entity, in accordance with the fees framework; or
(b) the Remuneration Authority in accordance with the Remuneration Authority Act 1977, in the case of—
  (i) a member of an independent Crown entity; or
  (ii) a member of a Crown agent or autonomous Crown entity that is a corporation sole.
(2) The following office holders are not entitled to any remuneration for services as a member of the statutory entity in addition to his or her remuneration in respect of that office:
(a) a Judge:
(b) a member of Parliament:
(c) an employee (including a chief executive) within any part of the State services who is acting as a member of the statutory entity as a representative of all or any part of the State services.

*48 Expenses of members*

A member of a statutory entity is entitled, in accordance with the fees framework, to be reimbursed, out of the funds of the entity, for actual and reasonable travelling and other expenses incurred in carrying out his or her office as a member.

**Individual duties of members**

*57 Duty not to disclose information*

(1) A member of a statutory entity who has information in his or her capacity as a member that would not otherwise be available to him or her must not disclose that information to any person, or make use of, or act on, that information, except—
  (a) in the performance of the entity's functions; or
  (b) as required or permitted by law; or
  (c) in accordance with subsection (2); or

(d) in complying with the requirements for members to disclose interests.

(2) A member may disclose, make use of, or act on the information if—

(a) the member is first authorised to do so by the board or, in the case of a corporation sole, by the responsible Minister; and

(b) the disclosure, use, or act in question will not, or will be unlikely to, prejudice the entity.

**Conflict of interest disclosure rules**

*62 When interests must be disclosed*

(1) In this section, matter means—

(a) a statutory entity's performance of its functions or exercise of its powers; or

(b) an arrangement, agreement, or contract made or entered into, or proposed to be entered into, by the entity.

(2) A person is interested in a matter if he or she—

(a) may derive a financial benefit from the matter; or

(b) is the spouse, civil union partner, de facto partner, child, or parent of a person who may derive a financial benefit from the matter; or

(c) may have a financial interest in a person to whom the matter relates; or

(d) is a partner, director, officer, board member, or trustee of a person who may have a financial interest in a person to whom the matter relates; or

(e) may be interested in the matter because the entity's Act so provides; or

(f) is otherwise directly or indirectly interested in the matter.

(3) However, a person is not interested in a matter—

(a) only because he or she is a member or an officer of a wholly-owned subsidiary of the entity or of a subsidiary that is owned by the entity together with another parent Crown entity or entities; or

(b) because he or she receives an indemnity, insurance cover, remuneration, or other benefits authorised under this Act or another Act; or

(c) if his or her interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities under this Act or another Act; or

(d) if an entity's Act provides that he or she is not interested, despite this section.

*63 Obligation to disclose interest*

(1) A member who is interested in a matter relating to the statutory entity must disclose details of the interest in accordance with section 64 as soon as practicable after the member becomes aware that he or she is interested.

(2) A general notice of an interest in a matter relating to the statutory entity, or in a matter that may in future relate to the entity, that is disclosed in accordance with section 64 is a standing disclosure of that interest for the purposes of this section.

(3) A standing disclosure ceases to have effect if the nature of the interest materially alters or the extent of the interest materially increases.

*64 Who disclosure of interests must be made to*

The member must disclose details of the interest in an interests register kept by the statutory entity and to—

(a) the chairperson or, if there is no chairperson or if the chairperson is unavailable or interested, the deputy or temporary chairperson; or

(b) the responsible Minister, if there is neither a chairperson nor a deputy or temporary chairperson, or if both the chairperson and the deputy or temporary chairperson are unavailable or interested.

*65 What must be disclosed*

The details that must be disclosed under section 64 are—

(a) the nature of the interest and the monetary value of the interest (if the monetary value can be quantified); or

(b) the nature and extent of the interest (if the monetary value cannot be quantified).

*66 Consequences of being interested in matter*

A member who is interested in a matter relating to a statutory entity—

(a) must not vote or take part in any discussion or decision of the board or any committee relating to the matter, or otherwise participate in any activity of the entity that relates to the matter; and

(b) must not sign any document relating to the entry into a transaction or the initiation of the matter; and

(c) is to be disregarded for the purpose of forming a quorum for that part of a meeting of the board or committee during which a discussion or decision relating to the matter occurs or is made.

*67 Consequences of failing to disclose interest*

(1) The board must notify the responsible Minister of a failure to comply with section 63 or section 66, and of the acts affected, as soon as practicable after becoming aware of the failure.

(2) A failure to comply with section 63 or section 66 does not affect the validity of an act or matter.

(3) However, subsection (2) does not limit the right of any person to apply, in accordance with law, for judicial review.

*68 Permission to act despite being interested in matter*

(1) The chairperson of a statutory entity may, by prior written notice to the board, permit 1 or more members, or members with a specified class of interest, to do anything otherwise prohibited by section 66, if the chairperson is satisfied that it is in the public interest to do so.

(2) The permission may state conditions that the member must comply with.

(3) The deputy or temporary chairperson may give the permission if there is no chairperson, or if the chairperson is unavailable or interested.

(4) The responsible Minister may give the permission if there is neither a chairperson nor a deputy or temporary chairperson, or if both the chairperson and the deputy or temporary chairperson are unavailable or interested.

(5) The permission may be amended or revoked in the same way as it may be given.

(6) The board must disclose an interest to which a permission relates in its annual report, together with a statement of who gave the permission and any conditions or amendments to, or revocation of, the permission.

*69 Entity may avoid certain acts done in breach of conflict of interest rules*

(1) A statutory entity may avoid a natural person act done by the entity in respect of which a member was in breach of section 66.

(2) However, the act—

(a) may be avoided only within 3 months of the affected act being disclosed to the responsible Minister under section 67; and

(b) cannot be avoided if the entity receives fair value in respect of the act.

(3) An act in which a member is interested can be avoided on the ground of the member's interest only in accordance with this section.

*70 What is fair value*

(1) The entity is presumed to receive fair value in respect of an act that is done by the entity in the ordinary course of its business and on usual terms and conditions.

(2) Whether an entity receives fair value in respect of an act must be determined on the basis of the information known to the entity and to the interested member at the time the act is done.

*71 Onus of proving fair value*

(1) A person seeking to prevent an act being avoided, and who knew, or ought reasonably to have known, of the member's interest at the time the act was done, has the onus of establishing fair value.
(2) In any other case, the entity has the onus of establishing that it did not receive fair value.

*72 Effect of avoidance on third parties*

The avoidance of an act under section 69 does not affect the title or interest of a person to or in property that that person has acquired if the property was acquired—
(a) from a person other than the entity; and
(b) for valuable consideration; and
(c) without knowledge of the circumstances of the act under which the person referred to in paragraph (a) acquired the property from the entity.

**Miscellaneous provisions relating to board**

*77 Vacancies in membership of board*

The powers and functions of a statutory entity are not affected by any vacancy in the membership of its board.

**Employees**

*118 Crown entity to be good employer*

(1) A Crown entity must, if it employs employees,—
(a) operate a personnel policy that complies with the principle of being a good employer; and
(b) make that policy (including the equal employment opportunities programme) available to its employees; and
(c) ensure its compliance with that policy (including its equal employment opportunities programme) and report in its annual report on the extent of its compliance.
(2) For the purposes of this section, a good employer is an employer who operates a personnel policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment, including provisions requiring—
(a) good and safe working conditions; and
(b) an equal employment opportunities programme; and
(c) the impartial selection of suitably qualified persons for appointment; and
(d) recognition of—
(i) the aims and aspirations of Maori; and
(ii) the employment requirements of Maori; and
(iii) the need for involvement of Maori as employees of the entity; and
(e) opportunities for the enhancement of the abilities of individual employees; and
(f) recognition of the aims and aspirations and employment requirements, and the cultural differences, of ethnic or minority groups; and
(g) recognition of the employment requirements of women; and
(h) recognition of the employment requirements of persons with disabilities.
(3) For the purposes of this section, an equal employment opportunities programme means a programme that is aimed at the identification and elimination of all aspects of policies, procedures, and other institutional barriers that cause or perpetuate, or tend to cause or perpetuate, inequality in respect of the employment of any persons or group of persons.

**Protections from liability of members, office holders, and employees**

*120 Protections from liabilities of statutory entity*

A member, office holder, or employee of a statutory entity is not liable for any liability of the entity by reason only of being a member, office holder, or employee.

*121 Immunity from civil liability*

(1) A member of a statutory entity is not liable, in respect of an excluded act or omission,—
(a) to the entity, unless it is also a breach of an individual duty under any of sections 53 to 57:
(b) to any other person.
(2) An office holder or employee is not liable to any person in respect of an excluded act or omission.
(3) Nothing in this section affects—
(a) the making of an order under section 60:
(b) the liability of any person that is not a civil liability:
(c) the right of any person to apply, in accordance with the law, for judicial review.

*122 Indemnities in relation to excluded act or omission*

(1) A statutory entity may only indemnify a member, office holder, or employee in respect of an excluded act or omission.
(2) An indemnity under subsection (1) is limited to—
(a) liability for conduct; and
(b) costs incurred in defending or settling any claim or proceeding relating to that liability.

*123 Insurance for liability of member, office holder, or employee*

A statutory entity may effect insurance cover for a member, office holder, or employee of the entity in relation to his or her acts or omissions, except an act or omission that is—
(a) in bad faith:
(b) not in the performance or intended performance of the entity's functions.

*124 Saving of judicial protections from liability*

A Judge who is appointed as a member of a statutory entity has the same immunities and limitations or other protections from liability when acting as a member of that entity as he or she would have as a Judge.

*125 Breach of indemnity and insurance limits*

(1) A member, office holder, or employee who is indemnified or insured by a statutory entity in breach of this Act must repay to the entity the cost of providing or effecting that indemnity or insurance cover, to the extent that the indemnity or insurance cover exceeds that which could have been provided or effected under this Act.
(2) The entity may recover the amount as a debt due in a court of competent jurisdiction.

*126 Definitions for protections from liability*

In sections 120 to 125,—
**effect insurance** includes pay, whether directly or indirectly, the costs of the insurance
**employee** includes a person who was an employee at any time after the commencement of this Act but who is no longer an employee
**entity's functions** includes any function that an Act confers separately on a member, office holder, or employee of the entity
**excluded act or omission** means an act or omission by the member, office holder, or employee in good faith and in performance or intended performance of the entity's functions
**indemnify** includes relieve or excuse from liability, whether before or after the liability arises, and indemnity has a corresponding meaning
**member** includes a person who was a member at any time after the commencement of this Act but who is no longer a member
**office holder** includes a person who was an office holder at any time after the commencement of this Act but who is no longer an office holder.

### *Subpart 3—Miscellaneous provisions*

*135 Members, office holders, and employees are officials*

(1) This section applies to—
(a) members, office holders, and employees of the following Crown entities:
(i) a statutory entity:
(ii) a Crown entity company:
(iii) a school board of trustees:
(iv) a Crown entity subsidiary that is wholly owned by 1 or more Crown entities referred to in subparagraphs (i) to (iii):
(b) office holders and employees of—
(i) a tertiary education institution:
(ii) a Crown entity subsidiary that is wholly owned by 1 or more tertiary education institutions or by 1 or more tertiary education institutions and 1 or more Crown entities referred to in paragraph (a)(i) to (iii).
(2) A person to whom this section applies is an official for the purposes of sections 105 and 105A of the Crimes Act 1961.
(3) This section does not limit the meaning of **official** in section 99 of the Crimes Act 1961.

**Reporting: Annual report**

*152 Disclosure of payments in respect of members, committee members, and employees*

(1) The annual report must include, in respect of the Crown entity or, in the case of a Crown entity group, for each Crown entity in the group,—
(a) …
(b) …
(c) …
(d) …
(e) details of any indemnity provided by the entity during the financial year to any member, office holder, or employee; and
(f) details of any insurance cover effected by the entity during the financial year in respect of the liability or costs of any member, office holder, or employee.
(2) In subsection (1), member and office holder and employee include a person who was a member or office holder or employee at any time after the commencement of this Act but who is no longer a member, office holder, or employee.

**Transitional and savings provisions**

*189 Existing protection from liability provisions*

(1) This section applies to a member, an office holder, or an employee of a Crown entity who is entitled, immediately before the date of commencement of this section, to be indemnified by a Crown entity in respect of any proceedings for any liability or costs arising from any act or omission as a member, office holder, or employee that occurred before that date.
(2) This Act does not affect the member, office holder, or employee's entitlement to an indemnity if that entitlement is, in its overall effect, as favourable to that person as, or more favourable to that person than, the entitlement provided for in this Act.

*190 Existing insurance cover*

(1) This section applies to a member, office holder, or employee of a statutory entity who has insurance cover at the commencement of this section in respect of any liability or costs arising from any act or omission as a member, office holder, or employee.
(2) The insurance cover is not affected by the enactment of this Act.
(3) However, if the insurance cover expires, or the member, office holder, or employee is reappointed or re-employed, the insurance can be renewed or effected only if permitted by this Act or the entity's Act.

**Schedule 5 - Board procedure for statutory entities (other than corporations sole)**

**Procedure of board**

14 Board may appoint committees

(1) The board may, by resolution, appoint committees—

(a) to advise it on any matters relating to the entity's functions and powers that are referred to the committee by the board; or

(b) to perform or exercise any of the entity's functions and powers that are delegated to the committee, if the committee includes at least 1 member of the board and any other person or persons that the board thinks fit.

(2) A person must not be appointed as a member of a committee unless, before appointment, he or she discloses to the board the details of any interest the person may have if he or she were a member of that committee.

15 Provisions relating to committee members

(1) Sections 43, 47, 48, 57, 77, 118, 120 to 126, 135, 152(1)(e), (f), and (2), 189, and 190 apply to each member of a committee who is not a member of the board with necessary modifications.

(2) Sections 62 to 72 apply to each member of a committee who is not a member of the board as if the committee member were a board member and as if the disclosure must be made to both the committee and the board, and with other necessary modifications.

## Appendix B: Conflicts of Interest declaration guidance for Members & Chairs

***Members***
In making a declaration please consider that your role or position may extend to a range of contexts and different issues will arise according to the context. Therefore please carefully consider the following questions, treating them as a prompt to help identify possible conflicts when contemplating a declaration:

1. *What sectors do I work in / what bodies, groups or associations am I a member of / what personal or financial interests do I or members of my family have / what business or personal relationships do I have (including past involvement)?*

   Consider (without limitation):
   - official positions e.g. director, shareholder, trustee;
   - personal and social relationships;
   - consultant/advisory roles (including provision of expert evidence or opinion);
   - involvement in clinical research/development;
   - political affiliations;
   - your sources of income and other areas of financial benefit or opportunity(or that of your close family members);
   - attendance at events funded by industry.

2. *Thinking about my role(s) for PHARMAC or one of PHARMAC's committees, what types of information can I expect to see / what responsibilities will I have / what types of judgements or decisions will I be expected to make?*

   For example:
   - Advice to Ministers of Parliament;
   - Confidential commercial information from pharmaceutical suppliers;
   - Confidential information about PHARMAC strategies;
   - Patient information;
   - PHARMAC Legal advice in relation to (but not limited to) commercial matters, litigation, intellectual property;
   - Operational/financial information;
   - Unpublished study information (i.e clinical research).

3. *Is there any foreseeable possibility that one of my roles / duties / responsibilities with PHARMAC or a committee might intersect with one of my other interests / relationships / roles and that the latter might influence the way I carry out my PHARMAC/committee role?*

Consider specifically whether confidential information you may see could be relevant to another role that you have, or whether your views or interests as a result of another role or relationship could potentially affect your role with PHARMAC or the committee.

When you have considered the above questions, determine whether there are any potential (though realistic – not purely hypothetical and remote) conflicts of interest that should be

declared to the PHARMAC Board and the CAC. This includes any potential for a perceived conflict, whether or not you would actually be influenced by the interest. It may be useful to bear in mind the perspective of someone negatively impacted by a decision and how they might argue that there was a conflict of interest that prevented you acting objectively in the event they wanted to challenge the process by which a particular outcome was reached. You should always err on the side of caution, and disclose more rather than less. If in doubt, disclose. In each case disclose in such a way that an independent party could properly understand the true nature and extent of the interest.

***Chair***
When assessing a declared actual or potential conflict of interest consider:

*It is unmanageable?*

- The person cannot or will not divest themselves of the conflict i.e. unavoidable; and
- is serious; or
- is pervasive and would affect so many of PHARMAC's/the committee's decisions that management mechanisms are not practical.

*Is it Manageable?*

- Where the person is prepared to divest themselves of or sever connection with the conflict; or
- the conflict is so minor or remote that it cannot reasonably be regarded as likely to influence the person in carrying out their responsibilities; or
- there is little risk of a negative public perception; or
- the conflict affects a confined area of PHARMAC's/the committee's operations and can be adequately "ring-fenced" from other aspects that it could, or could be seen to, affect.

*What are the management and mitigation strategies?*

- Divestment – where the person agrees to divest themselves of the interest creating the conflict (this is likely to be necessary where the conflict of interest is serious and pervasive but avoidable through divestment).
- Severing connections – resignation from one or other position or entity (this is likely to be necessary where the conflict of interest is serious and pervasive but avoidable by severence).
- Blind trust – where assets can be transferred to a trust managed by trustees with nearly complete autonomy and the person retains very little knowledge or control over the transferred assets.
- Withdrawing from discussion – must be declared and noted on each occasion in the meeting minutes.
- Abstaining from voting – must be declared and noted on each occasion in the meeting minutes.
- Non-receipt of relevant information – in addition to declaring an interest, withdrawing from the discussions and voting, the person agrees not to be given any information (written or oral) relating to the interest.

- Agreement not to act – where the person does not participate in any other action concerning the interest e.g. signing documents relating to the interest on behalf of PHARMAC/the committee.
- Transferring the person (temporarily or permanently) to another position or project.
- Re-assigning certain tasks or duties to another person.
- Seeking a formal exemption (e.g. from the Board) to allow participation.
- Enquiring as to whether all affected parties will consent to the person's involvement.
- Declarations of interest – where the interest is retained but is declared when related issues arise for discussion or decision (must be declared and noted on each occasion in the meeting minutes).
- Confidentiality agreements – where the person agrees not to pass on confidential information.
- Imposing additional oversight or review over the person (e.g. peer review, where for example a person's role can only be performed by that particular person and the conflict is not viewed as particularly serious).

These methods can be used singly or in combination depending on the nature and extent of the conflict being considered. There may be some situations where a conflict is inevitable and unavoidable, and the matter cannot reasonably be dealt with without the person's involvement.

# Terms of Reference

## Purpose

The Nelson Marlborough Health Consumer Council (Council) works collaboratively with Nelson Marlborough Health's governance and management teams to develop effective partnerships in the design and function of an effective health system in Nelson Marlborough that meets the needs of the people.

Through true partnership the Council provides a strong and viable voice for the community and consumers so that they can engage in health service planning and delivery. The Council seeks to enhance consumer experience and service integration across the sector, promote equity and ensure that services are organised around the needs of consumers, now and in the future.

Through effective processes and communications, the Council receives, considers and disseminates information from and to Nelson Marlborough Health, Nelson Bays PHO and Kimi Hauora Wairau Marlborough PHO, Non-Government Organisations, and all healthcare providers, consumer groups and communities.

All levels of consumer engagement are necessary to enable a truly patient-centred health system, and the role of the Council to provide formal advice and participate in co-design is supplemented by the active involvement of consumers in developing and delivering transformation at a service level.

The Council also has a quality improvement role and will advise and encourage best practice and innovation.

## Functions

The functions of the Council are to:

- Ensure and enable appropriate consumer engagement across the Nelson Marlborough, Southern region and national health systems.
- Identify and advise on issues requiring consumer and community participation, including input into the development of health service priorities and strategic direction, the elimination of inequities, and the enhancement of safety and quality of services to patients and whanau.
- Review and advise on reports, developments and initiatives relating to health service delivery and the availability and / or dissemination of health related information.
- Ensure regular communications and networking with the community and relevant consumer groups.
- Link with special interest groups, as required for specific issues and problem solving.

For the avoidance of doubt, the Council will not:

- Provide clinical evaluation of health services or individual patient care plans.
- Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exist.
- Represent any specific consumer interest group or organisation.
- Normally be involved in the Nelson Marlborough Health contracting processes.

## Level of Influence

The Council has the authority to give advice and make recommendations to all healthcare providers, consumer groups and committees through Nelson Marlborough Health.

The level of influence of the Council is considered to be equivalent to the Clinical Governance Committee and the Iwi Health Board. All three groups are complementary in their roles.

## Membership

The Council will initially consist of seven (7) expert consumers. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care from the Nelson Marlborough health sector. In selecting members we will cover a range of interest areas e.g. Maori health, women's health, child health, long term conditions, mental health, and so on. Although appointed to reflect the consumer voice in a particular area of interest, an individual member will not be regarded as representatives of any specific organisation or community.

Membership composition will take the following principles into account:

- Reflect the requirements and priorities within strategic documents
- Reflect the population that uses health services
- Take into account the need to address disparities in health outcomes
- Recognise our responsibilities under the Treaty of Waitangi.

The term of a Council member is two years[1]. Members may be reappointed for one additional term of two years. Reappointments will be on the recommendation of the Council Chair and with approval of the Chief Executive and the Board Chair.

Members who do not attend a minimum of eight (8) meetings within a 12 month period, will be asked to resign from the council, unless it is due to extenuating circumstances or by prior agreement with the Council Chair.

[1] Initially five members of the Council were appointed for a term of three years (end date of 31/12/2020) and two members for two years (end date of 31/12/2019)

Individual membership on the Council may be terminated or full dissolution of the Council may be undertaken by the Board Chair and Chief Executive of Nelson Marlborough Health.

## Chair

The Chair shall be appointed by the Board Chair and Chief Executive of Nelson Marlborough Health following consultation with the Council.

The Chair may be paid additional fees and allowances, depending on the level of commitment involved in addition to Council meetings.

The Chair and Deputy Chair shall be appointed for a two year term. Subsequent appointments (or reappointments) shall be made following consultation with Council members, for longer terms as agreed with the Chief Executive.

## Recruitment

Membership may be sought through various methods of advertising and multimedia. Consideration will be given to ensure a broad diversity of members are appointed.

Candidates will submit an application through <link> or by submitting a hard copy of the application via email or mail. Within 10 working days all applications are to be acknowledged.

The panel to review applicants for a short-list will include a Consumer Council member.

The interviewing or decision panel will include a Consumer Council member.

The Panel is to agree at the completion of the interviews who they recommend be offered a position on the Consumer Council. This selection will be approved by the Board Chair and Chief Executive of Nelson Marlborough Health.

## Quorum

A quorum will be four people.

## Meetings

Meeting will be held monthly, excluding January, or more frequently at the request of the chair (up to a maximum of 12 meetings per annum). Meeting will usually be for two hours and held at an agree time that enables members to participate.

Meetings will be held in both Nelson and Blenheim, and while attendance in person is preferred, options such as phone and video conference will be available.

## Training

Council members will be provided with training and support to undertake their role.

## Reporting

The Council will report to the Chief Executive of Nelson Marlborough Health, and through the Chief Executive to the Board. The Chair of the Council will submit a monthly report of Council activities and recommendations directly to the Board Chair. A copy of the report will also be placed on the website of Nelson Marlborough Health once approved.

## Minutes

Minutes will be circulated to all members and Chair of the Council prior to the next meeting.

## 4.3 Discussion: Waitematā Mental Health and Addictions Lived Experience Advisory Council (LEAC)

## Recommendations:

The recommendations are that you:
a) Note the information provided in the paper.
b) Discuss the best way to form an ongoing relationship.

**Background**

**About LEAC**

All members of the Lived Experience Advisory Council (LEAC) have lived experience of personally using Waitematā District Health Board (WDHB) Adult Mental Health & Addiction Services or through supporting a loved one who is using the services (or both). The views of LEAC are based on the collective knowledge and experience of its members over many years, of a wide range of existing WDHB Mental Health (MH) services (including inpatient, community and specialist services).

We provide a forum for voicing the needs and concerns of consumers and their family/whānau and are a source of advice to the WDHB on all matters relating to those needs and concerns. Our aim is to increase consumers and family/whānau involvement in all stages of the planning and development of the Mental Health and Addiction Service and to improve the quality and resourcing of consumer, family/whānau engagement and experiences while using the services.

Responsibilities include providing consultation and feedback on new and changed documentation, policy and procedures and on key quality and improvement project groups that affect consumers and their family/whānau.

**Our Vision Statement**

Kia whakakotahi i roto te kaha whakapiri
To be united in strength and come together

LEAC brings together people with lived experience of Waitematā Mental Health and Addiction services, to be united in strength together. Through the collective voice of service users and family/whanau, LEAC works in partnership with the WHDB to add a lived experience perspective to the development of quality MH services which support people towards recovery*: "a life worth living".
*Please see the attached document for our definition of recovery.

**Why We Are Necessary**

In the Letter of Expectations for DHB's for 2020/2021 the Minister outlined the following:

- Improving Mental Wellbeing is a priority. Service User Councils are a key area that contributes to performance and should be strengthened.
- That 'DHB's have a social responsibility' to *'empower communities to engage in the transformation of New Zealand's approach to mental health and addiction'*.
- There is reference to the clear direction of He Ara Oranga, which states in Chapter 4 - Putting People at the Centre - *"DHBs should be required to include and support people with lived experience in mental health and addiction governance, planning, policy and service*

*development."*

He Ara Oranga, in Chapter 8 Putting People at the Centre, highlighted the following:

## Main points

- People accessing services must be at the centre of the mental health and addiction system.
- Instead, many people receive treatment that does not meet their needs and find it hard to navigate the system. People with lived experience are on the periphery of service design and delivery – rather than at its centre.
- Consumer voice needs to be supported, strengthened and included in all aspects of the system, from governance to service delivery.
- Families and whānau want to be treated as a crucial part of the support network for their family members with mental health and addiction challenges.
- Instead, the mental health and addiction system focuses on the treatment of individuals, without seeing their family and social context. Family and whānau are often excluded from communication and decisions.
- Services need updated guidance on how to share information and partner with families and whānau. Families and whānau need better support, so they can maintain their own wellbeing.

Two of the core recommendations from He Ara Oranga were:

## Strengthen consumer voice and experience in mental health and addiction services

20. **Direct** DHBs to report to the Ministry of Health on how they are including people with lived experience and consumer advisory groups in mental health and addiction governance, planning, policy and service development decisions.
21. **Direct** the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened in DHBs, primary care and NGOs, including through the development of national resources, guidance and support, and accountability requirements.

**Where we are at currently**

LEAC is an independent council sitting outside the DHB that meets fortnightly – our meetings alternate between physical meetings and meetings via Zoom. The council has co-chairs – designed to represent both the service user and family/whānau voice in our leadership, although our two current chairs are both.

The Executive Leadership Team (ELT) of WDHB Mental Health Services are very supportive of our initiative and we agreed the terms of a formal MOU with them.

This MOU sets out the key points of our relationship which will include monthly meetings with a representative of the ELT and the co-chairs, as well as a standing agenda item on the ELT meeting on a quarterly basis.

As a newly formed group, we are working to build our networks and membership. LEAC has also begun work on a few projects including, a peer support volunteer project, Mental Health 101 education evenings, information pack additions. In addition to this MH services have already involved us in their own reviews and projects.

## Key Issues

LEAC would like the opportunity to introduce ourselves to the Consumer Council and discuss the best way to form an ongoing relationship.

We can see how this could be beneficial to both parties, as LEAC has specialist insights into Mental Health Services and relationships in the same, while the Consumer Council represents the wider community and brings a broader perspective.

**Contacts for further discussion (if required)**

| Name | Position | Telephone | Suggested first contact |
|---|---|---|---|
| **Nicola Peeperkoorn** | **Co-Chair** | [redacted] | ✓ |
| **Elizabeth Baird** | **Co-Chair** | [redacted] | ✓ |


**WHO WE ARE**

All members of the Lived Experience Advisory Council (LEAC) have lived experience of personally using Waitemata District Health Board (WDHB) Mental Health & Addiction Services or through supporting a loved one who is using the services (or both). The views of LEAC are based on the collective knowledge and experience of its members over many years, of a wide range of existing WDHB Mental Health (MH) services (including inpatient, community and specialist services).
We provide a forum for voicing the needs and concerns of service users and their family/whānau and are a source of advice to the WDHB on all matters relating to those needs and concerns. Our aim is to increase service users and family/whānau involvement in all stages of the planning and development of the Mental Health and Addiction Service and to improve the quality and resourcing of consumer, family/whānau engagement and experiences while using the services. Responsibilities include providing consultation and feedback on new and changed documentation, policy and procedures and on key quality and improvement project groups that affect service users and their family/whānau.

**OUR VISION STATEMENT**

Kia whakakotahi i roto te kaha whakapiri
To be united in strength and come together

LEAC will bring together people with lived experience of Waitemata Mental Health and Addiction services, to be united in strength together. Through the collective voice of service users and family/whanau, LEAC aims to work in partnership with the WHDB to add a lived experience perspective to the development of quality MH services which support people towards recovery*: "a life worth living".

*We define recovery as:
Recovery focused MH services focus on generating and sustaining the key concepts of 'recovery', these being:

- Hope - optimism, the belief that a fulfilling future is possible even with residual illness/symptoms.
- Agency – empowerment, autonomy, self-determination, self-management, choice and responsibility.
- Opportunity – for social inclusion, to participate and contribute to wider society, access to opportunities that exist in the community.

Recovery is described as a non-linear, continuing process or journey of personal growth and change, that is unique to each individual according to their own personal recovery goals which may or may not be illness focused. It is important to note that recovery in MH refers to 'personal recovery' based on a client's perspective, involving factors related to personal wellbeing and social inclusion, as distinct from 'clinical recovery' which refers to the elimination of clinical symptoms as determined by measurements traditionally used by researchers and clinicians.
*From: Models of Care for an Integrated Recovery-orientated Adult Community MH Service – Kim Fong – October 2018*

**OUR GOALS**

There is a very strong feeling within LEAC that MH services need to be rebuilt entirely. People who have experienced MH services have valid thoughts and ideas about how the services can be improved and ideal MH service will need to be achieved using a collaborative approach, which includes the perspective of service users and family/ whānau.

Our goal is to help the WDHB to revolutionise its MH services over the next five years so that service users and their family/ whānau will have the best possible experience to obtain the best possible outcome. LEAC has set out below what we consider an ideal service will look like together with the sort of feedback that could be expected if that ideal is achieved.

**Person-focused:**

*"When my family first became worried about my behaviour and approached MH services, I was afraid about what was going to happen next. But the people we dealt with explained everything to us as we went along so that we were properly informed about the process."*

- MH services will exist to support people who experience MH distress/crisis towards recovery i.e. 'a life worth living'.
- The WDHB will recognise that people accessing MH services are individuals with personal strengths and abilities.
- All people accessing MH services will be treated with dignity and respect. This includes respecting peoples' ability to understand information, participate in assessment and treatment planning, and the right to manage their own recovery, as much as possible.
- All services will value the primary role family/whānau/friends play in supporting their loved one and acknowledge that family/whānau are integral to a person's recovery.

**Guided by recovery and holistic models:**

*"My view of recovery doesn't mean having no 'symptoms'. I want to be free of distress, have a feeling of belonging and achieve my goals. Luckily, my doctor respects the fact that I have different experiences and beliefs to other people, which means that I trust her and feel like I can tell her anything. She is also not entirely focused on medication as the only treatment and is happy to look at other options."*

- All MH services will be guided by the **recovery model** because it emphasises that recovery is possible, even for people most severely affected by MH and addiction issues. Services will focus on enabling people 'to thrive, rather than just survive'. This offers hope of recovery and supports people to have a sense of responsibility for their own health (self-agency). It also supports people towards engaging and participating in personally meaningful activities, study, work, and social life in the community.
- MH services will work from a **holistic perspective** because mental illness affects all aspects of a person's wellbeing. Services will promote all dimensions of health including mental (thoughts, feelings, communication); physical (nutrition, sleep, exercise); social (relationships with whānau/family, friends and others), and spiritual (life energy, sense of purpose, hope).
- Physical health issues arise for a person due to psychiatric medication side effects e.g. metabolic disorder. MH issues impact on the psychological and social aspects of a person's well-being e.g. sense of self, family relationships, social inclusion, housing, work. All health issues will be addressed within the individual's recovery plan.

- Clinical staff will go beyond the biomedical approach of 'managing symptoms' through the use of medication by offering 'talking therapies' as early as possible, alongside medication. Counselling will be provided to help identify and understand a person's experience of distress/trauma i.e.
- The model **Te Whare Tapa Whā,** which considers all aspects of a person's health, will be central to guiding holistic MH treatment approaches because it is a good fit for a New Zealand health context. Using a holistic model, which ensures bicultural governance for health services, not only better meets Māori cultural needs, but also improves services for everyone.
- **Sensory Modulation approaches** will be used to help people who experience sensory and mood dysregulation regain a sense of self-control and stability, and to eliminate the use of restraint and seclusion practices. This also promotes safe practice for both service users and staff.

**Work in partnership with service users and family/whānau:**
*"After my last episode, when there were some problems with my medications, I was encouraged to write an advance directive. It was a very empowering experience and helped me to trust that the doctors would abide by my wishes if I could not make decisions for myself. It also covered issues like who should have access to information about me and the role I wanted my family to play in my recovery. After all, when I am well I know what works best for me."*

- WDHB managers and clinical staff will lead the provision of quality MH services with a willingness to work in partnership with consumer and family/whānau advocates and representatives.
- Consumer advisors and lived experience representatives will be included in the management of WDHB MH services. To be able to truly work together, inclusion will be reflected at all management levels and not just as a token gesture. (Lived experience representatives will be reimbursed for this role).
- Ongoing development of WDHB MH services will be via the principles and processes of co-design. New policies and services will be designed using a collaborative approach, in partnership with consumer advocates and lived experience representatives, and changes made with accountability in place.
- At a consumer level, WHDB staff will work collaboratively with service users and families/whānau to plan and manage individualised care and recovery plans. This gives service users an opportunity to share their perspective on how things are for them and how they might move towards recovery. It acknowledges the primary role family/whānau play in supporting their loved one and values the information they can contribute.
- Clinicians will be cognisant of the Privacy Act and respect service users' rights to privacy, especially in relation to adults. However, it will not be used as an excuse to exclude family/whānau from assessment and treatment planning.
- Collaboration between clinical staff, service users and family/whānau will be helped through the use of **advance directives** which allow people with mental illness to specify what intervention they agree to, and what intervention they do not consent to receive, if they become unwell, including what will help based on past experiences.
- Opportunities will be available for basic education on the services, terminology used and the different facets of treatment so both service users and their family/whanau are able to make informed choices and participate fully in care.

**Straightforward access for service users:**
*"My doctor always asks in meetings 'What else can we do to support you or your family and whanau?' It makes me feel like I am in control and my family and friends are included. When we first met the team we didn't know what support was available until they told us. Now we know and we generally get what we need because the resources are there and well-managed."*

- Service users will have access to the type of MH service they need, at the time they need it including acute care, community support, specialist and rehabilitation programmes, respite care, and assisted living in the community. Service users and family/whānau will not have to wait for stressful situations to escalate before they receive a response from services or support.
- Information will be communicated to the client and the family/whānau about service options that are available and steps that they need to take to access appropriate support.
- For clients who have been discharged from MH services, and have not used them over some years, there will be an easy access back into the services they require.
- There will be a smooth transition (access) between primary care (GP services) and secondary care (WDHB services) as peoples' MH issues change.
- There will be unfettered access to specialist services such as intensive rehabilitation services in the community e.g. Buchanan Rehabilitation Centre to support people with significant and complex MH issues to establish more worthwhile and independent lifestyles.

**Empathy during the hospital admission process (acute care):**
*"My first hospital admission was the scariest time of my life. I needed people around me who were kind and compassionate. I was particularly impressed with the staff in the ED who took me to a special quiet room where I met a lovely lady who had been in the same situation I was in. She stayed with me until my family arrived and then talked to them also. My family, who were as scared as I was, were able to see that unwellness is only temporary and a full recovery is possible."*

- Admission to hospital, especially first-time admissions, can be particularly challenging for service users and families when there is heightened distress and often reluctance or resistance to the admission. The WDHB will offer admission processes that are respectful and considerate of the person needing acute care.
- Ideally, people in acute distress needing hospital care will be assessed and admitted through an inpatient unit where qualified MH staff are able to respond appropriately to their mental distress, as well the concerns of family/whānau.
- Another option is to provide admission for acute care via community MH facilities, which can also provide qualified MH staff able to respond appropriately to peoples' mental/emotional distress. These facilities can also provide private and comfortable waiting areas.
- Consumer and family/whānau experiences of admission via Emergency Departments (ED) in physical health care hospitals have often been less than ideal. People are often treated in a way that is not empathetic and therefore does not help to de-escalate distress. There can be a lack of privacy and long wait times to be seen by qualified MH professionals.
- If ED is to be used as an admission option, WHDB will ensure that ED clinical staff have specific education in how to respectfully monitor and support a patient in acute mental distress. Patients and their family/ whānau, will be shown consideration while they wait i.e. privacy provided in a non-public waiting area and highly personal information not discussed in a public reception area.
- There will be prompt access to MH clinicians e.g. Psychiatric Registrar is also required, so that service users and families/whānau do not experience long wait times for assessment. Long wait times tend to escalate peoples' acute distress and compromise the safety of patients and staff.

- Peer support workers will provide service users and their families with support as they wait for an admission assessment. They will talk with service users and family about their concerns, explain MH service processes and provide general reassurance.

**High Standards of Care in a Hospital Setting:**
*"The admission process was seamless. There was a helpful information pack for me, written by someone who had obviously been in hospital before, and a separate pack for my parents. We were welcome to ask as many questions as we wanted and never felt like we were taking up too much of the peer support worker's time. The atmosphere was friendly and relaxed. Everyone seemed to get on really well. There were plenty of activities so that none of us got bored and we were able to all vape in the courtyard."*

- The MH Act states patients' rights (No. 4.): "*you have a right to appropriate treatment. This is treatment of a professional standard that will benefit your condition. The treatment does not have to cure your condition but should at least relieve your symptoms and stop you from becoming more unwell*".
- MH services will do good rather than harm. A consistent, safe standard of care will be provided to people, particularly in times of acute mental/emotional distress.
- Many service users and their family/whānau report experiences of harm, including traumatic incidents, during periods of hospital stay. This causes fear around accessing further MH services and does not meet criteria for an 'ideal' service.
- The focus in hospital MH units will be on care and healing, leading to recovery in a safe environment. To achieve this, inpatient units will have sufficient levels of appropriately trained staff. When units are short-staffed (and staff doing double shifts), the communal environment has seemed to be 'chaotic' rather than safe and calm.
- The physical environment in hospital units will provide a place of healing e.g. safe, clean, calm and comforting. Standards of cleanliness will be maintained. Visitor facilities are clean, comfortable and family friendly.
- Service users and families/whānau will be given information on admission, both verbal and written (information packs), about patient rights and the care and treatment that hospitalisation will offer. If a person is being held under a compulsory treatment order, the legal procedure will be explained to them and their family/whānau, and relevant documentation provided.
- People have a right to be fully informed about medication they are prescribed, and any side effects. This right will be respected and upheld. Use of medication will be through informed consent, rather than coercion. Experiences of being held down and forcibly injected are traumatic for people, even if this is considered 'necessary' by staff.
- Physical restraint will no longer be practiced. Seclusion will no longer be seen or used as 'punishment' and will have been discontinued, as was intended by 2020. Alternatives to managing escalation of a person's distress, before it reaches extreme levels, will be routinely used e.g. use of one-to-one support, counselling and sensory modulation techniques, alongside medication.
- Family/whānau will be given the opportunity to speak with clinicians regarding their family member's progress, while they are in hospital. Clinicians will include patients and families in a team approach in relation to assessment, treatment and discharge planning. Service users and families can offer staff a perspective of who their 'patient' is as a person, as well as discuss cultural needs.
- A more therapeutic inpatient environment will be provided for patients through the use of better recreational facilities and programmes which are supervised and monitored by occupational therapists. Activities can be offered by volunteers who have special skills e.g. in gym training, exercise, tai chi, music, art, drama, journal writing.

- Experienced peer support workers can provide inpatients with an added level of empathetic support due to their understanding of lived experience with MH challenges e.g. spending time talking with them and/or engaging in meaningful activities.
- The care provided in the High Care Area (HCA) will have been reviewed as this is often not a healing environment. Often the only activity for patients in HCA is to watch TV. There will be a better understanding about the difference between 'low stimulus' and 'no stimulus' because sensory deprivation is actually counterproductive to a person's well-being.
- Visiting will not be restricted in the HCA so there is ample social contact with loved ones, which, if not provided, can cause distress for some patients, particularly during a first admission.
- The appropriate use of sensory modulation techniques to help a patient manage their distress will be required of staff in the HCA.
- The DHB smoking policy and the way it is managed in inpatient units will have been reviewed. How the smoking policy is managed is often a factor underlying stressful incidents. The WDHB will recognise inpatient units provide a different context to physical hospitals. A very significant percentage of MH patients are addicted to smoking, or become addicted as inpatients. Further consideration will be given to how smoking addictions are best managed in a MH context, in the best interest of service users and staff.

**Community Services that Provide Suitable Support**

*"When I had my first episode at 19-years-old, instead of being locked up and being forced to have medication I was offered care in a house staffed by people who had experienced psychosis themselves and knew how to support me through it. After I came out the other side, without medication, I received support from community MH services who provided me with anything and everything I needed to stay stable and live independently in the community."*

- Community services are essential to supporting people who experience mental illness towards recovery. As well as supporting people to re-engage in living in the community following hospitalisation, services are essential to support people towards recovery without the need for hospitalisation. Medication is not used as a long-term solution or as the main intervention, and there will be a recognition that sometimes it is not required at all.
- Service users are currently allocated a keyworker when they access community MH services, but in future they will have support provided by a specific multi-disciplinary team (i.e. psychiatrist, psychologist, psychiatric nurse, occupational therapist) because no one professional holds all the knowledge or experience that service users may need to support their recovery.
- A genuine multi-disciplinary team approach will be used to ensure a person's health needs are addressed holistically. For example, they will ensure that physical health needs are recognised and addressed, particularly when medication side effects can lead to metabolic disorder. Social needs such as financial support and housing will be appropriately addressed.
- Early intervention 'wrap around' services provided through community MH will provide empathetic, intensive multi-disciplinary support, particularly for young people, which reduces the 'revolving door' of acute admission/discharge i.e. repeated hospitalisations from MH services in general. The current system of providing only home visits from a social worker, based with the Early Psychosis Intervention team, does not provide early intervention or 'a wraparound service'.
- Intensive early intervention support will be linked to a 'life course' focus for young people, enabling them to have a life worth living, linking early intervention to ongoing support plans, as they mature through their adult years.

- Home visits will continue to be part of community services for all clients to obtain a more holistic picture of the person and their social context. For some service users this may be preferable to clinic visits.
- Service users will have access to community MH services on a 'needs basis'. For example, some people with mild to moderate MH issues may not need long-term support and may be able to be 'discharged' back to primary care support (GP). Those with more significant moderate-severe issues may need ongoing support, over their life course, to be able to sustain their life in the community and prevent 'revolving door' admission/discharge from services.
- Service users and family/whānau will be informed about the availability of respite care as this type of community support can help reduce the need for hospitalisation. Ideally the DHB will fund more respite care including specialist services i.e. family respite units for Maternal MH.
- In-home respite care will be provided by qualified MH support staff for adults. This would reduce the need for extra beds in respite facilities. For vulnerable adults this can provide a safe option. For families with young children, in-home support can be offered that promotes infant/ child parental bonding rather than separating them.
- Assisted living accommodation (housing) in the community will be available for adults with long-term MH challenges who live at home with family/whānau, but need to gain more independence as their family members age.
- Peer Support workers are vital in providing community support to service users because the relevant understanding and support they offer is based on lived experience. While peer support workers are usually funded by Non-Government Organisations (NGO), they need to have strong links with WDHB community services.

**'Linked up':**
*"My daughter has high needs and I doubted whether the DHB would be able to cater to them. But her key-worker and the community team is helping us access every service that can assist her in living her best life. For the moment that means staying at home with me but, thankfully, I am well supported so that I can be her primary care-giver."*

- MH services will be linked up with established links and liaison between acute, community, specialist and rehabilitation services to provide support for complex conditions and continuity of care.
- Key workers will have the skills to act as a liaison person between different MH services on behalf of/in partnership with service users and family/whānau, to support smooth transition between services.
- Staff in different DHB services will be knowledgeable about other MH services. Staff working in community services will receive updated education in what support is available to service users and whānau/family e.g. NGO services.
- While service users are supported by community MH services, information will be provided to service users and families/whānau about the range of other support services e.g. respite facilities.
- MH services will be linked up so families are informed when their loved one's MH intervention is escalated from community teams to the crisis team/acute care, to ensure families have the opportunity to provide their loved one with additional support.
- Community MH staff will work together with staff in NGO services who are providing service users with peer support, engagement in leisure activities, vocational support towards work opportunities and housing.
- MH staff will also be aware of NGO services like Supporting Families, who can provide families and whānau with support, including group and individual support.

- Many service users have multiple and complex life issues which have a direct impact on their MH e.g. housing, unemployment and physical health. A 'one stop shop' in the community, with multiple agencies working together within the same building, can make access to co-ordinated support easier for service users.

**Professional support for family/whānau:**
*"When my son committed suicide we were all completely blind-sided. I knew he was depressed but I had no idea how bad. We received so much support through the DHB. They put us in touch with all the right groups and even provided some counselling for our family."*

- Access to specialist professional support e.g. counselling will support children and young people living in families with parents who experience MH challenges, as well as children and young people living with siblings with MH challenges.
- Access to family/whanau therapy as part of the overall treatment plan where appropriate.
- For parents supporting young people and adult children with significant and complex MH issues, access to professional support, such as counselling, can also help maintain their own MH and well-being.
- Family/whānau will be offered the services of a social worker to assist them to develop a family support network, which will assist them to better support their loved ones. This includes advice about practical matters i.e. assisting loved ones to apply for the supported living allowance through MSD and/or assisted living accommodation.
- Education workshops and opportunities such as the **Awe Mātau** workshop, developed by the Auckland DHB, will be provided for families to enable them to develop the knowledge and skills to support their loved one through experiences of significant mental and emotional distress, and towards recovery.
- Support for families/whānau bereaved by suicide will be provided and be easy to access. Supporting those left behind, through the best evidence-based practice programmes, is also seen as important for preventing further harm.

**Regularly reviewed:**
*"My husband and I were put in touch with a consumer advisor who explained his role and said that he would pass on any feedback he had about the services provided. We were pleased to have the opportunity and to be in a position to say positive things. The consumer advisor said he would include this comment in a report to one of the managers. ;-)"*

- Collecting and collating regular feedback from service users and family/whānau is a way for WDHB to value the perspective and experiences of service users and whānau. Collating feedback will highlight themes that can be used to improve and develop existing services and design new services.
- A formal process will be put in place to review services contracted to the DHB (i.e. Respite facilities and NGOs) to ensure they are delivering services that meet the requirements.
- The adverse event review process will genuinely include family/whānau involvement. Families will be informed about how the process proceeds and where the review is at every step of the way. Family/whānau will be informed of service changes made as a result of the review process.
- There will be transparency and an independent panel in the investigation of adverse events to understand what has occurred and establish accountability. Interviewing of family whānau during an investigation will be carried out with transparency and compassion.

**Work more closely with Police/Ambulance services:**
*"My behaviour got out of hand one night and my wife had to call the Police. When they arrived they stood well back while the MH people talked to me at the door so that I did not feel threatened. One of the MH people was a peer support worker who was able to help reduce my paranoia so that I trusted the others enough to let them in the house. Eventually I was taken to hospital in the police car. They were decent blokes and I felt comfortable talking to them on the way."*

- WHDB MH professionals will work more closely with police, and ambulance staff to respond to MH 111 callouts. Police, ambulance and MH professionals working together, as a team, will ensure people experiencing significant MH distress are treated appropriately, including with respect and dignity. An example of how this can work may be provided by the NZ government funded trial to be carried out by the Capital and Coast DHB (announced 17/3/2020). Police personnel, paramedic staff and a MH professional will respond to MH crisis callouts as a team, using the same vehicle. Similar trials in Sydney, Australia have proved successful with significant results reported, suggesting 'better outcomes for both the individuals in need of assistance and police staff'.
- The WDHB will work more closely with local police staff to offer education, support and information about local MH services. Police are often at the front line and need further training and continual upskilling in working with those experiencing mental distress and their whanau/family.
- Upskilling in communicating with clearly distressed clients will also be offered to ambulance teams. This includes how to restrain clients safely without causing physical injury (multiple bruises). Restraint will only be used as a last resort, in the interests of the client's and ambulance staff safety.
- If family/whānau are with their family member during crisis callouts, and accompany them to hospital, they will be offered support i.e. offered a quiet room and tea or coffee. This can be a role for a skilled peer support worker.

## 4.4 Consumer Engagement for Future Facilities Design

## Recommendations:

The recommendations are that you:

a) Note the information paper
b) Endorse the Consumer Council sub group with Facilities Design focus
c) Nominate one to two members to lead the sub group and link with Consumer Council

### Background

Waitemata DHB facilities continue to grow, expand or be repurposed to meet the needs of our community and accommodate changes in healthcare delivery. The design of facilities and services require consumer engagement as part of co-design to ensure they provide positive experiences for our consumers.

In the past, certain facilities have been created or designed with limited community engagement which has led to critical consumer feedback, and facilities that do not meet consumer expectations. By building in consumer engagement into our facilities design processes, we hope to include end user views and perspectives early in the process.

We hope to create a sub group of consumers that is linked to the Consumer Council to provide feedback and support decision making in future facility redesign.

Facilities team currently have over 50 projects that would benefit from consumer input together with my engagement with consumers we can ensure that the consumer voice is a part of the design decision making.

The future development of Waitakere Hospital is a key focus for mobilisation of our consumers to support us in providing facilities that meet the needs of community in West Auckland. In addition, way finding and the external environment of the site will also be a key focus in coming years.

### Key Recommendation

It is recommended that a sub group of consumers led by one to two members of the Consumer Council is created and attends specific project design meetings to support facility design and development. The one to two members of the Consumer Council will report back to the Council at each consumer council meeting to provide an update of key projects and pose any specific questions to the council for further feedback.

The sub group of up to six consumers will be expected to attend up to 10 meetings per year and may be required to attend other meetings dependent on their role in specific projects or interest. The six members will represent different cultural groups and disability groups to enable us to design facilities that are accessible and are culturally significant to our community.

The sub group will have access to all plans as they are available and accountability for consumer recommendations will be created to ensure there is a record of how consumer feedback has been used in the design and/or justification for why the feedback could not be integrated into the design.

Consumers will be remunerated for their time in line with the DHB consumer engagement remuneration policy.

For all Waitakere Hospital development, it is recommended that the Waitakere Healthlink Executive will be updated at each of their meetings and invited to participate in any aspect of the process that they are able to contribute.

| |
|---|
| We will advertise for sub group consumers through specific NGOs, local consumer networks, local newspapers and social media. Members of the Consumer Council and Facilities Team will be a part of the recruitment panel. We hope this sub group will be in place by late January 2021. |

**Contact for telephone discussion (if required)**

| Name | Position | Telephone | Suggested first contact |
|---|---|---|---|
| **David Price** | **Director of Patient Experience** | **021 715 618** | ✓ |

# 5. INFORMATION ITEMS

## 5.1 Patient Experience Report

# Patient Experience Report

**OCTOBER 2020**

Waitematā District Health Board
Best Care for Everyone

## BACKGROUND

The Patient Experience Team supports the organisation by collecting, listening to and analysing patient, whānau, staff and community feedback to provide a better understanding of what matters to our diverse community. This informs organisational strategic direction and highlights local service improvements to enhance the patient experience and achieve better health outcomes for our community. The Patient and Whānau Centred Care Standards Programme and Chaplaincy Services are also supported within the Patient Experience Team.

## KEY STATISTICS – OCTOBER 2020

**NPS 81**
Continues to score well above target

**NPS Target 65**

**854**
responses

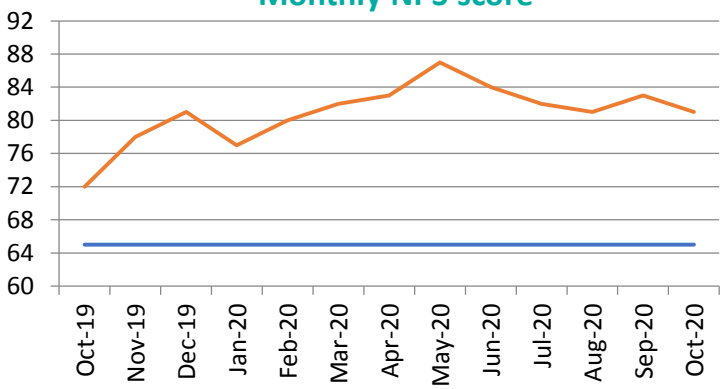
**NPS 87**
'Welcoming & Friendly ' Strongest performer

**NPS 85**
Māori patients and whānau

## Net Promoter Scores (NPS) by ward /service

| Exceptional NPS | Location | NPS |
|---|---|---|
| Ward 8 | NSH | 100 |
| Hine Ora | NSH | 100 |
| Cullen Ward (ESC) | NSH | 100 |
| **Low NPS** | **Location** | **NPS** |
| Maternity | NSH | 64 |

## Monthly NPS score




## NPS Scores by ethnicity

| October 2020 | NZ European | Māori | Overall Asian | Overall Pacific | Other/ European |
|---|---|---|---|---|---|
| Responses | 513 | 64 | 60 | 41 | 163 |
| NPS | 83 | 85 | 59 | 77 | 75 |

## Highlights

- Roll out of new NPS Patient feedback tool went live on 2nd of November
- Volunteer Peter Taylor – won a Ministry of Health Volunteer Award.
- Work has begun on creating a new Front of House experience at Waitakere Hospital
- Working with Emergency Department staff to promote 'Kia ora' as greeting for all patients on arrival to the department.
- Two strategic planning days with the Emergency teams at both sites where there will be a practical focus on the experience of whānau and implementation of the Tikanga Best Practice policy.

## Areas for improvement

1. Unhelpful /Rude Staff  2. Car parking  3. Long discharge process

# Patient Experience Report

**OCTOBER 2020**

Waitematā District Health Board
Best Care for Everyone

## Feedback

*"All staff members made us feel comfortable and took good care of us."*

***Short Stay Ward, NSH***

"All staff were lovely plus friendly and caring. Very relaxed environment. Very efficient."

***Titirangi Ward, WTH***

*"Informative, respectful, positive, appointments on time, knowledgeable, spoke through options.*

***New Lynn Paediatric Outpatient Clinic***

## Patient Experience Highlight in October

Health Care Provider Service Outstanding Achievement by an Individual

**Peter Taylor**

Nominated by Waitematā District Health Board

Peter Taylor is one of Waitematā District Health Board's sustainability volunteers. Every fortnight he collects polyvinylchloride (PVC) IV bags throughout North Shore Hospital and takes them to the basement in a special bin. From there, the PVC waste goes to Otaki, where a recycling company turns it into industrial and children's playground matting for distribution locally and overseas.

Peter's work is part of the PVC recycling programme initiated by Baxter Healthcare in late 2014 to help hospitals across the country reduce their environmental footprint. Baxter collects about 100 tonnes of PVC waste each year.

Peter is legally blind and catches a bus to his shift at North Shore Hospital. He spent his early time as a volunteer there familiarising himself with the hospital's 10 floors to be sure he could successfully complete his duties. He has now been supporting the hospital for three years.

Peter's contribution not only reduces the amount of waste that goes into landfill but also gives clinical staff more time to focus on patients.

## Kōrero Mai Calls in October

Kōrero mai
Talk to me

0

# 6. OTHER BUSINESS

6.1 Community concerns
6.2 Agenda for next meeting