Waitematā
District Health Board

Best Care for Everyone

Consumer Council

Wednesday

19 February 2020

2:00pm – 4:00pm

Venue

Waitematā Room, Whenua Pupuke
North Shore Hospital

CONSUMER COUNCIL
19 February 2020

Venue: Waitematā Room, Whenua Pupuke North Shore Hospital
Time: 2:00pm – 4:00pm

Consumer Council Members	Ex-officio - Waitematā DHB staff members
David Lui (Council Chair)	Dr Dale Bramley – Chief Executive Officer
DJ Adams	David Price – Director of Patient Experience
Neli Alo	
Boyd Broughton (Te Rūnanga o Ngāti Whātua)	Other Waitematā DHB staff members
Lorelle George	Dean Manley – Case Coordinator
Insik Kim	Jacqueline Kenyon – Consumer Advisor
Angela King (Healthlink North)	Brenda Witt – Complaints and Adverse Events Manager
Jeremiah Ramos	Jacky Bush – Quality and Risk Manager
Kaeti Rigarlsford	
Ravi Reddy	
Lorraine Symons (Te Whānau o Waipareira)	
Vivien Verheijen	

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

1.	**AGENDA ORDER AND TIMING**	
2.	**CONFIRMATION OF MINUTES**	
2:00pm	Confirmation of the Minutes of Meeting 6 November 2019 Actions Arising from Previous Meeting	
3.	**INFORMATION ITEMS**	
For noting 2.05pm 2.10pm	3.1 3.2 3.3	Patient Experience Report Strategy Meeting Updates (David Price) PHARMAC (presentation: David Lui)
4.	**DISCUSSION**	
2:25pm 2.55pm 3.00pm 3.30pm	4.1 ----- 4.2 4.3	Consumer and Whānau Advisory Team Update (Dean Manley and Jacqueline Kenyon) Break Discussion: Outpatient Experience(David Price) Discussion: Expectation from the complaints process (Brenda Witt and Jacky Bush)
5.	**ANY OTHER BUSINESS**	
3:50pm 3.55pm	5.1 5.2	Agenda for next meeting Community concerns

Waitematā District Health Board

Consumer Council

Member Attendance Schedule 2019-2020

NAME	Jul 2019	Aug 2019	Sep 2019	Nov 2019	Feb 2020	Mar 2020	Apr 2020	Jun 2020
David Lui (Chair)	✓	✓	✓	✓				
DJ Adams	✓	✓	✓	✓				
Neli Alo	✓	✓	✓	✓				
Boyd Broughton	✓	✓	✓	×				
Lorelle George	✓	✓	×	✓				
Insik Kim	✓	✓	✓	✓				
Angela King	✓	×	×	✓				
Jeremiah Ramos	✓	✓	✓	✓				
Ravi Reddy	✓	✓	✓	✓				
Kaeti Rigarlsford	✓	✓	×	✓				
Lorraine Symons	×	×	✓	✓				
Vivien Verheijen	✓	✓	✓	✓				
+Dale Bramley	✓	✓	✓	×				
+David Price	✓	✓	✓	✓				

✓ *attended*
× *absent*
* *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 (Chair)	Director, Focus on Pacific Limited Chair, Consumer Advisory Committee, PHARMAC Board Member, Walsh Trust Board Member, Mental Health Foundation Chair - Board of Trustees, Henderson High School	18/09/19
DJ Adams	No declared interest	02/09/19
Neli Alo	No declared interest	24/09/19
Boyd Broughton	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
Jeremiah Ramos	No declared interest	03/07/19
Ravi Reddy	Board Member – Hospice West Auckland	03/07/19
Kaeti Rigarlsford	No declared interest	03/07/19
Lorraine Symons - Busby	MOU Liaison – Waipareira Trust	24/09/19
Vivien Verheijen	No declared interest	03/07/19

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.

DRAFT Minutes of the meeting of the Consumer Council of the Waitematā District Health Board

Wednesday, 6 November 2019

held at the Kawakawa Room, Waitakere Hospital
55-75 Lincoln Rd., Henderson, Auckland
commencing at 2.03pm

CONSUMER COUNCIL MEMBERS PRESENT:

David Lui (Chair)
DJ Adams (Ngati Maniapoto, Ngati Kahungunu)
Neli Alo (present until 3:40pm)
Lorelle George
Insik Kim
Angela King
Jeremiah Ramos
Kaeti Rigarlsford
Ravi Reddy
Lorraine Symons (Te Whānau o Waipareira) – present from 2:08 to 3.15pm
Vivien Verheijen

ALSO PRESENT:

Dr Jonathan Christiansen (Chief Medical Officer)
David Price (Director of Patient Experience, Ex-officio member)

PUBLIC AND MEDIA REPRESENTATIVES:

There were no public or media representatives present.

WELCOME:

The Consumer Council Chair welcomed everyone to the meeting and acknowledged Dr Jonathan Christiansen (Chief Medical Officer) who is in attendance on behalf of Dr Dale Bramley (Chief Executive Officer).

APOLOGIES:

Apologies were received and accepted from Dale Bramley and Boyd Broughton.

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.

The meeting started with a Karakia.

2 CONFIRMATION OF MINUTES

Confirmation of Minutes of the Consumer Council Meeting held on 25 September 2019 (agenda pages 6-10)

Resolution (Moved Ravi Reddy/Seconded Neli Alo)

That the Minutes of the Consumer Council Meeting held on 25 September 2019 be approved.

Carried

Actions arising from previous meetings (agenda page 11)
The council noted the updates and no issues were raised.

3 DISCUSSIONS

3.1 Patient Deterioration Program – Shared Goals of Care

Jeannette Bell (Project Manager, i3) and Peter Groom (e-Vitals Clinic Lead) presented this item to the Consumer Council members. They presented the report to the consumer council members while David Price facilitated the discussion. In response to a clarification, it was noted that the context of the shared goals of care programme is within the patient's stay in the hospital, however, the decision is recorded and considered in the patient's records should there be future visits. The members were asked to provide feedback on how to achieve effective conversations, involving families, the type of support to be provided and having patient-centred care.

Matters covered in the discussion are as follows:

Timeliness and environment

- Members suggested that clinicians consider the timeliness of the goals of care discussion noting that conversation should be on-going and reviewed regularly with the patient and whānau.
- Patient should also be provided with options and 'if and then' scenarios. Clinicians should also recognise the pace of the conversation and taking care not to provide them with too much information. Patients are usually overwhelmed and need time to think and/or consult with their loved ones.
- The physical space and environment where these conversations are held are also important. These conversations should be discussed where there is enough privacy.

Cultural competency

- Clinicians should recognise the cultural context of each patient. Some patients will prefer to nominate key decision maker, a family member, Chief/Kaumatua or a support person to assist in the decision making.
- Approach each case without assumptions as each family and situation is different. In response to this, Peter commented that there is on-going awareness for staff to consider implicit bias which is this year's focus during 'patient safety week'.

- Cultural context also recognises that language can become a barrier as such the use of interpreters would be vital to ensure the patient and whānau have clear understanding.

Patient-centred

- The chair commented that it is important that these discussions are anchored on trust as such having an open, honest and transparent conversation will influence the outcome of the discussion. He highlighted that patients can recognise sincerity and the manner in which these messages are conveyed should be considered.
- It was also highlighted that there should be recognition of the patient's capacity to decide for themselves as a priority. This is particular for older patients and for patients with disabilities, in that while they may have some limited capacities, most patients are still fully capable and are able to decide their 'goals of care' than welfare guardians or persons holding power of attorney.
- Members also shared their personal experiences wherein 'respect' was lost during discussion with patients. There is a need to keep 'humanity' in the conversation by learning more about the patient, their background, their beliefs and hence to treat them with compassion.
- Rights of the patient should be embedded during the conversation.

The 'Understanding Resuscitation Status' brochure was also discussed. Detailed comments will be sought from the members via email. Initial comments discussed included the following:

- It was suggested that the form is made available in different languages and in 'easy-read' format for people with learning disabilities. This can also be useful for people whose first language is not English.
- It was suggested that the wording considering the timing of making the resuscitation decision (ideally within the first 24 hours and reviewed depending on condition) should be specified on the document.
- It was suggested to re-phrase the sentence "unfortunately most resuscitation will be unsuccessful".
- Rights of the patient should be included and referred to in the brochure. Embedding the Korero Mai (Patient Escalation) service or include a reference to patient rights within the brochure was also suggested.

Jeannette and Peter thanked the members for their comments.

3.2 Quality and Risk Report

Jacky Bush (Quality and Risk Manager) presented an overview of the activities of the Quality and Risk Team which includes handling of complaints, adverse events reporting, risk identification, compliance against standards (such as the Health and Disability Service Standards). She highlighted that the outcomes of these activities ensure that improvements are done and policies are in place and implemented across the organisation.

Jacky also tabled the brochure "What will happen with your complaint?" and provided an overview of the complaint process highlighting that services have been able to provide responses within ten calendar days against a 14 calendar-day target. The team also encourages the service to phone complainants and ensure a patient-centred response.

Matters covered in the discussion included the following:

- In response to queries, it was noted that the current format of the quality report is in compliance with the requirement of the Health Quality and Safety Commission (HQSC) and that performance are tracked and compared with other District Health Boards (DHBs).
- Complaints can be made in other languages and the team secures the support of in-house translators to address and respond to concerns. It was also suggested by the members that that the brochure be available in different languages and in 'easy-read' format.
- A complaints response survey is also on-going to identify improvements in the process.

Jacky thanked the members for their suggestions.

3.15 – 3.25pm session on break.

3.3 Health Literacy Programme Update

Leanne Kirton (Project Manager, Planning and Funding) presented the update on the Health Literacy Programme of Waitematā DHB noting the progress made in particular, the development of the Health Literacy Policy and the Annual Health Literacy Symposium attended by clinicians and consumers alike. David Price assisted in facilitating the discussion with the council particularly on what should the programme consider as next steps.

In response to a query, it was also clarified that complaints received from users also guide them but there is recognition that it still needs to be a 'better connection' with the programme. Matters covered in the discussion included the following:

- It was suggested that the concept of Health Literacy should be treated as a 'two-way street' wherein the understanding of health-related information should be the responsibility not only of the patient but also of the provider. Leanne acknowledged this comment as such the approach considered when developing the Health Literacy Policy is to ensure that people are able to access, understand and act on health-related information.
- The members suggested that the programme also focus on equity. Leanne informed the members that this is on-going work and can be a priority for next year.
- It was suggested that the programme focus on specific areas. Pharmaceutical safety was proposed to be a priority area particularly ensuring that patients are able to understand the proper use of medication as this influences patient outcomes.
- It was also suggested to consider a 'whole-of-New-Zealand' approach wherein partnerships with Ministry of Education and other agencies can be explored to educate consumers before accessing the services (for example in schools) or to learn about diseases and conditions with the aim of disseminating information.
- Members suggested exploring other ways of communicating and disseminating information particularly using videos on YouTube to reach and engage more consumers, using QR codes that will link to a specific page on the Waitematā DHB website as well as to make the website user-friendly and easier to navigate.
- In response to a clarification on patients receiving reminders, David Price explained that the text and email reminders are optional and the reason why there was limited information on the previous format was due to the privacy act.

- The programme will also explore the possibility of having the Consumer Council co-present at the next Health Literacy Symposium (scheduled in 2020).
- It was also suggested that a 'Teach Back' methodology should be used with patient conversations to ensure that patients understand what is being said – rather than using 'closed' questions.

4 STANDARD REPORT

4.1 Patient Experience Report (September 2019)

The report was noted by the council members.

4.2 Update on Consumer Engagement Quality System Measure (QSM) Framework

DJ Adams gave a summary of the outcome of the meeting with the HQSC held in Wellington. He highlighted that the current version of the Quality System Measure has improved and that the central theme during the discussion is weaving the Te Tiriti o Waitangi in the framework.

David Price also noted that the pilot DHBs will be responsible for uploading evidence identified by the markers and that the DHB's consumer councils will be signing off the evidence and how the DHB score themselves using the framework. This will ensure that consumers and the community are engaged with the process and ensure DHBs are accountable.

Detailed comments will be sought from the members via email with the aim of submitting to the HQSC before 12 November 2019.

5 OTHER BUSINESS

5.1 Consumer Council Membership Vacancy

David Lui opened the discussion on the vacancy and filling the gap in terms of representation of the consumer council. The members acknowledged the gap in youth representation and the middle-eastern community represented by the former member of the council, Doaa Bayoumy. Matters covered in the discussion included the following:

- The vacancy will be for the position vacated by Doaa Bayoumy. David Price is exploring the possibility of youth representation on the council including the possibility of another position being created.
- The criteria will be the same as with the current consumer council members. The same process will also be used in the recruitment process.
- It was suggested to use other media when advertising the vacancy in particular for the youth (for example using the Student Services in the universities, social media promotion etc.). Communities already engaged with Waitematā DHB such as through the existing Memorandum of Understanding (MOU) with Youth services will also be explored.

5.2 West Auckland Hospice

Ravi Reddy extended the gratitude from the Board of the West Hospice Auckland and thanked them for their feedback.

5.3 Strategic Session

This was discussed after item 5.4.

The Chair discussed that in order for the consumer council to focus on work that will align with the DHB's priorities, a strategic planning session is recommended to be conducted in the next calendar year. The plan will be to identify and workshop topics and issues that the council would like to discuss in depth and what the council would like to achieve in the upcoming months. There was consensus from all the members about the plan and more details and updates will be provided to the members after discussion meeting between David Price and the Chair to work out details.

5.4 Last Meeting for the Year

This was discussed before Item 5.3 Strategic Session

In consideration of the upcoming holidays and availability of the consumer council members, the members decided to cancel the last meeting of the year scheduled for 17 December 2019. The Chair noted that should there be urgent concerns for the council, communication lines are open or can be put forward by email.

5.5 Waitematā Health Excellence Awards (HEA)

Lorelle George updated the council on the recently concluded Waitematā Health Excellence awards which she attended along with DJ Adams. She acknowledged the work that the Institute for Innovation and Improvement (i3) is doing and that it was great to see that excellence in health care being celebrated by events such as the HEA.

David Lui thanked the members for their time.

The meeting concluded at 4.10pm.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD – CONSUMER COUNCIL MEETING HELD ON 06 NOVEMBER 2019.

_____CHAIR

ACTIONS ARISING FROM THE MINUTES OF THE MEETING OF THE CONSUMER COUNCIL AS AT 11 FEBRUARY 2020

Minutes ref.	Topic	Person responsible	Action / Status
25/09/19	The council requested that an update is provided with respect to the corrective actions taken to address comments on the Friends and Family Test received by the DHB and to be included as part of the patient experience report	David Price (Director, Patient Experience)	- Included as part of the Agenda Item 3.2 discussion on complaints process
25/09/19	The council requested WDHB to review the procedures on the return of body parts (particularly for those patients who were in tragic events and accidents)	David Price (Director, Patient Experience)	- An update will be provided at the next meeting

3.1 Information Item: Patient Experience Report (December 2019)

Recommendation:

That the Consumer Council notes the Patient Experience Report.

Executive Summary

The Waitematā DHB Patient Experience Team is led by Director of Patient Experience. This team supports all divisions and services of 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 Experience team works with divisions, teams and services to deliver innovative, responsive, accessible and flexible care that meets the individual needs of our patients and their whānau throughout the whole patient journey.

The Director of Patient Experience also supports Chaplaincy Services and the Asian Health Services Team. Waitematā DHB's Asian Health Services (AHS) provides a range of services and programmes for Asian patients, families and community members. These services include: iCare Health Information Line, Asian Breast Screening Support Service, Asian Patient Support Service, Asian Mental Health Service, WATIS (Waitemata Translation & Interpreting Service) and Health Promotions. The Asian Health Services Team has many aims including: providing communication (language) support to Waitematā DHB staff and non-English speaking patients/clients and their families; providing cultural, emotional and coordination support to Asian patients/clients. The Interchurch Council for Hospital Chaplaincy (ICHC) provide seven Chaplains and a part time Administrator across North Shore Hospital, Waitakere Hospital and Mason Clinic to support pastoral care and spirituality support for our inpatients, whānau and staff.

Highlights

- In December, Waitematā DHB achieved its highest NPS Score of 81 since the survey began in 2013.
- Asian Health services supported The Inaugural Health Forum on International Collaboration with Asian Countries
- Volunteers receive more compliment and acknowledgement from Waitematā employees.
- Two new patient stories are available to share with staff and our community – stroke and endometriosis.

- *Memory quilt donation*

Sands Auckland central collaborated with Highbury Community House and early learning centre's quilting group to lovingly create a handmade memory quilt. It's been designed to

provide a place of remembrance for grieving families who have lost their babies. Parents will be given the chance to write on a paper heart in memory of their child. The hearts will then be attached to the quilt that is positioned at the entrance of the chapel at north shore hospital. Ann Clearly and Sandy Watson (pictured below) are the creators of the quilt and attended the unveiling event this month.

- *The inaugural health forum on international collaboration with Asian countries*

The Inaugural Health Forum on International Collaboration between New Zealand and Asian countries was held at Whenua Pupuke Clinicanal Centre, Waitematā DHB on 8 November 2019. Asian Health Services supported the DHB's international collobration team and will support future collaboration acitivities as a partnership organisation.

The forum was attended by representatives of the Ministry of Health of New Zealand, Consulate General of the People's Republic of China in Auckland, New Zealand China Council, the New Zealand – China Non-Communicable Diseases Research Collaboration Centre (CRCC), Section of Epidemiology & Biostatistics of the University of Auckland, Shandong Provincial Health Commission, Shandong Mental Health Center, School of Public Health and Healthcare Big Data Research Institute of Shandong University, Department of Oncology of Ruijin Hospital (Shanghai Jiaotong University), iFLYTEK, New Zealand Health Research Council (HRC), New Zealand Health Foundation for Asian and Ethnic Communities and Waitematā DHB.

There were active discussions on future opportunities for sharing experience, expertise and information in areas such as digital health, the use of big data and artificial intelligence in healthcare, system integration, leadership and talent development, facility building, medical research and the use of new technologies.

Key issues

- Long wait times, cost of parking, poor communication/explanations, poor care and short staffed are some reasons for patients giving a low score on the Friends and Family Test in December.
- On-call support from chaplaincy service continues not to be available across the organisation – due to shortage of people who can cover 24/7 roster.

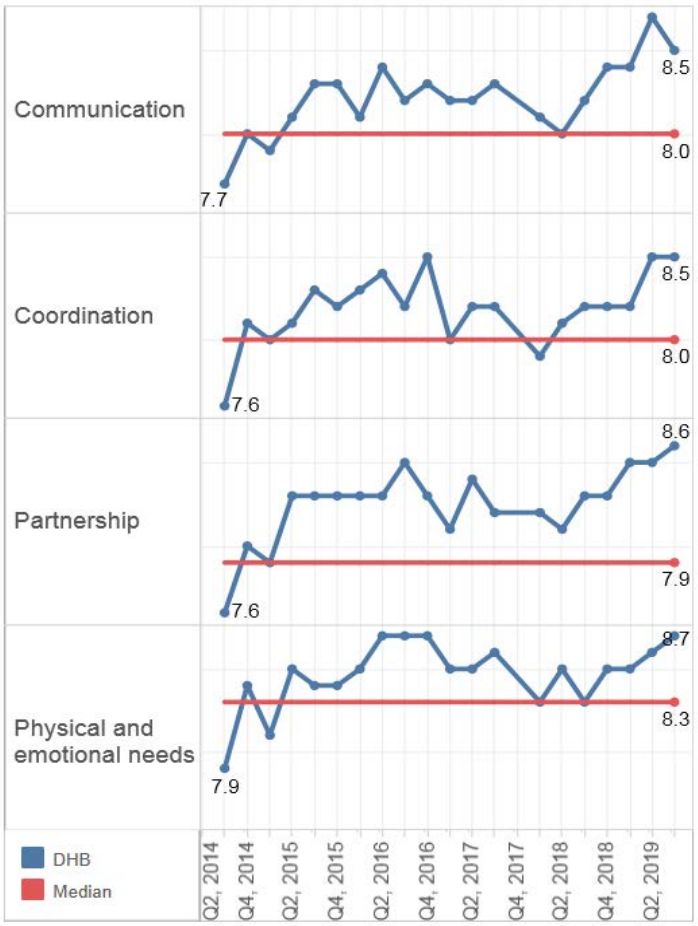
Patient Experience Feedback

NATIONAL INPATIENT SURVEY

HQSC weighted results			
Communication	**Partnership**	**Co-ordination**	**Needs**
8.5 WDHB	**8.6 WDHB**	**8.5 WDHB**	**8.7 WDHB**
8.4 National Average	**8.6 National Average**	**8.4 National Average**	**8.6 National Average**

Table 1: National Survey Quarter One (July - August 2019)

Quarter 3 (Q3) results include patients discharged between the 29th of July and 11th of August 2019. The response rate for Q3, 2019 was 32% (the highest response rate of all DHBs). All surveys were distributed via email. The national response rate for this quarter was 22%. Waitematā DHB results continue to improve with our best results ever recorded for the domains of Partnership, Co-ordination and Needs. The Communication domain decreased by 0.2 from the previous quarter, however is above the National average. The final weighted report for Quarter 4 (Q4) is due 7th February 2020.



Graph 1: Waitematā DHB run chart for all domains, 2014-19

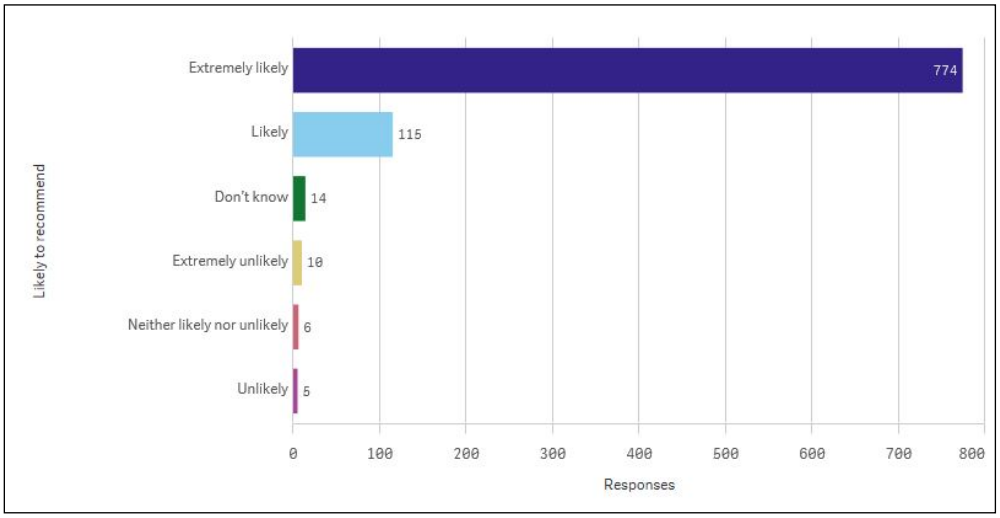
Cemplicity will stop providing the quarterly survey capture and reporting mechanism from quarter 1 2020. The new provider (Ispos) was formally announced by the Health Quality & Safety Commission in mid-January. A review of the current questionnaire is in progress.

Friends and Family Test

In December 2019, we achieved our highest ever Net Promoter Score (NPS) of 81. The previous high score of 80 was first achieved in June 2018. This month we received feedback from 924 people (down from 1,096 people the previous month). The NPS continues to consistently perform well and score above the DHB target of 65.

Friends & Family Test Overall Results

Figure 1: Waitematā DHB overall NPS



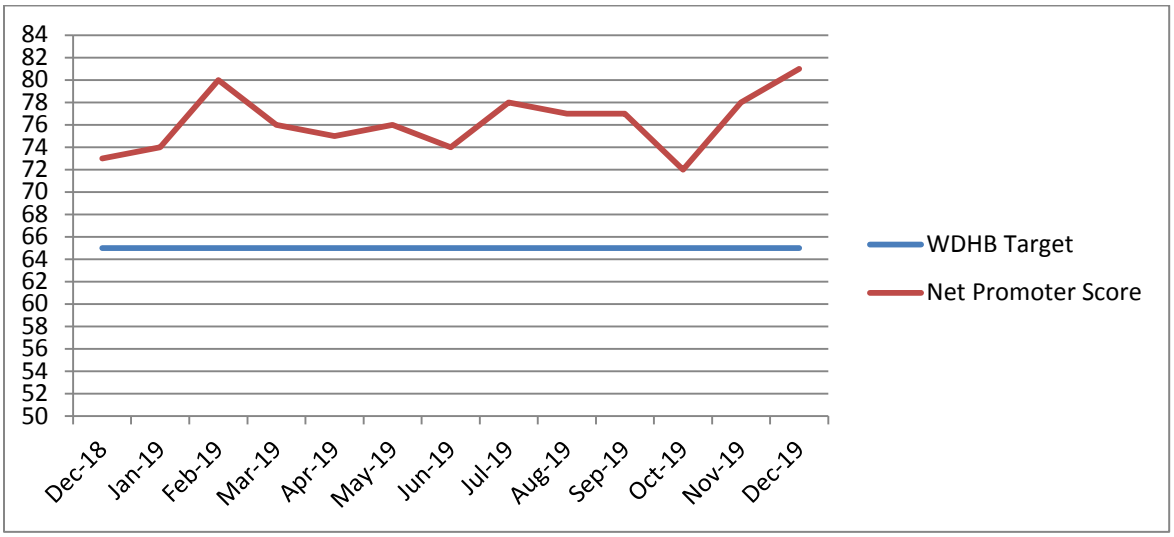
Graph 2: Waitematā DHB overall FFT results

Pt Experience Survey by Period

Month & Year	Surveys	How likely are you to recommend our ward?	Did we see you promptly?	Did we listen and explain?	Did we show care and respect?	Did we meet your expectations?	Welcoming and friendly?
Totals	922	81	79	86	91	83	93
Dec-2019	922	81	79	86	91	83	93

Table 2: Waitematā DHB FFT results (each question)

The net promoter scores in December have met target for all Friends and Family Test questions. All measures are up on the previous month, performing well above the target. The highest performers are once again 'welcoming and friendly' and 'care and respect' achieving scores of 93 and 91 respectively. Our lowest performer this month was 'did we see you promptly' which scored 79.



Graph 3: Waitemata DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

December 2019	NZ European	Māori	Overall Asian	Overall Pacific	Other/ European
Responses	616	73	87	56	213
NPS	81	86	77	80	81

Table 3: NPS by ethnicity

In December, all ethnicities met the Waitemata DHB NPS target and score 65 and above.

December 2019	NZ European	Māori	Overall Asian	Overall Pacific	Other
Did we see you promptly?	78	85	84	84	84
Did we listen and explain?	85	89	82	88	86
Did we show care and respect?	91	95	87	88	90
Did we meet you expectations?	82	84	83	88	85
Were we welcoming and friendly?	93	93	91	86	91

Table 4: NPS for all questions by ethnicity

This month, all measures score well above the DHB target. The lowest score was for 'did we see your promptly' (score 78, NZ European) and the highest scores was for 'welcoming and friendly' (score 93 for NZ European and Māori).

Friends and Family Test Comments

- *"I loved the care and support that I received on the ward. Genuine happy staff. Clean environment and the food was nutritious."* ***Elective Surgery Centre Cullen Ward, NSH***
- *"Excellent all round care and a wealth of information from a diverse range of disciplines – physical therapists, psychologist and social welfare (social worker)"* ***Child Rehabilitation Service***
- *"Amazing job. From my admission up to discharge, they made sure everything is in order."* ***Ward 7, NSH***
- *"Professional, caring environment, clear communication. Felt safe and looked after – great team"* ***Surgical Unit, WTH***
- *"Excellent responses and follow up for the appointment and then a time to attend was very quick. Great front desk staff."* ***Outpatients, NSH***
- *"Amazing staff, great team work. Supported family as well as rehab of our mum. Thanks to nurses, social worker, needs assessor and doctors"* ***Muriwai Ward, WTH***
- *"The whole team from doctors to the nurses were informative, caring and respectful making the stay in hospital as enjoyable as it can be."* ***Lakeview Cardiology, NSH***
-

Friends and Family Test by ward

		December-2019	
Division	**Ward**	**Responses**	**NPS**
AH	Allied Health Community Adults North	11	82
AH	Allied Health Community Adults West	11	73
AH	Allied Health EDARS	16	88
ESC	Elective Surgery Centre Cullen Ward	20	95
A&EM	North Shore Hospital Assessment Diagnostic Unit (ADU)	13	15
A&EM	North Shore Hospital Emergency Department (ED)	42	64
SMHOP	North Shore Hospital Haematology Day Stay	20	90
S&AS	North Shore Hospital Hine Ora Ward	13	92
S&AS	North Shore Hospital Intensive Care Unit/High Dependency Unity (ICU/HDU)	18	94
A&EM	North Shore Hospital Lakeview Cardiology (LCC)	66	91
CWF	North Shore Hospital Maternity Unit	95	81
S&AS	North Shore Hospital Outpatients	30	48
CWF	North Shore Hospital Special Care Baby Unit (SCBU)	15	80
S&AS	North Shore Hospital Short Stay Ward	20	70
A&EM	North Shore Hospital Ward 2	22	82
A&EM	North Shore Hospital Ward 3	25	100
S&AS	North Shore Hospital Ward 4	31	90
A&EM	North Shore Hospital Ward 5	7	71
A&EM	North Shore Hospital Ward 6	21	86
S&AS	North Shore Hospital Ward 7	42	98
S&AS	North Shore Hospital Ward 8	11	100

S&AS	North Shore Hospital Ward 9	9	100
A&EM	North Shore Hospital Ward 10	19	89
A&EM	North Shore Hospital Ward 11	13	85
SMHOP	North Shore Hospital Ward 14	20	85
SMHOP	North Shore Hospital Ward 15	16	100
CWF	Wilson Centre	7	71
A&EM	Waitakere Hospital Anawhata Ward	22	82
A&EM	Waitakere Hospital Huia Ward	17	71
CWF	Waitakere Hospital Maternity Unit	18	72
SMHOP	Waitakere Hospital Muriwai Ward	12	50
S&AS	Waitakere Hospital Outpatients	44	59
S&AS	Waitakere Hospital Radiology	14	79
CWF	Waitakere Hospital Rangatira Ward	16	81
CWF	Waitakere Hospital Special Care Baby Unit (SCBU)	11	100
S&AS	Waitakere Hospital Surgical Unit	68	88
A&EM	Waitakere Hospital Titirangi Ward	4	100
A&EM	Waitakere Hospital Wainamu Ward	8	63

Table 5: FFT results by ward

Key for table 5:
Service/Ward Responses: *Green – achieved response target, Red – did not achieve response target*
NPS: *Green – met NPS target (65+), Amber – nearly met target (50-64), Red – did not meet target (<50)*

This month, 63% of services and wards met their response targets. Of these wards/services, 85% scored at or above the Waitematā DHB target. The top three ranking wards are Ward 3 and Ward 15 at North Shore Hospital and Special Care Baby Unit at Waitakere Hospital (see table below). The main reasons for these positive scores include kind, caring, friendly, helpful and attentive staff, great service and care. Patients in Ward 15 were complementary about the breakfast group, gym and gardens.

This month, the lowest NPS scores are for Outpatients at North Shore Hospital and Muriwai Ward at Waitakere Hospital. There were only a couple of reasons given for the low scores and these include noise from other patients and feeling bored with nothing to do.

A summary of the FFT results can be seen below.

Ward/Service – Exceptional NPS	**Target Responses**	**Achieved**	**NPS Score**
Ward 3, North Shore Hospital	20	25	100
Ward 15, North Shore Hospital	10	16	100
Special Care Baby Unit, Waitakere Hospital	10	11	100
Ward/Service – Low NPS	**Target Responses**	**Achieved**	**NPS Score**
Outpatients, North Shore Hospital	20	30	48

Muriwai Ward, Waitakere Hospital	10	12	50

Table 6: FFT Results Summary

Kōrero Mai/Talk to Me Programme

Korero Mai is a patient and whānau-led escalation service that was launched in mid-November 2018. Patients are empowered to use a three step process to escalate their concerns. The third step instructs patients/whānau to call an 0800 number which is triaged by a Senior Nurse 24 hours/7 days a week who can request a medical review for a reported deterioration or intervene to support patient concerns. At the end of October we have had 24 phone calls, please see details of the latest Kōrero Main phone call below. Out of the 24 calls, four were not Kōrero Mai calls and were forwarded to the phone line via switchboard.

There were four calls to the Kōrero Mai phone line in December, taking the total number of calls to the phone line to 27. Most calls relate to a breakdown in communication and an unclear management plan of the patient. All calls have been resolved promptly by staff with 90% of callers reporting they would not hesitate in calling the Kōrero Mai service in the future. The response after calling the Kōrero Mai number has prevented a formal complaint and usually led to ongoing support from the Patient Experience team to ensure patient and whānau needs are met.

Ethnicity	**M /F**	**Department**	**Hospital**	**Caller**	**Reason for call (as stated in RiskPro)**
NZ European	M	Ward 5	North Shore	Patient Daughter	Poor Care
NZ European	F	ESC	North Shore	Patient	Delayed treatment
Indian	M	ADU	North Shore	Patient	Poor Care
NZ European	M	Ward 4	North Shore	Father	Treatment plan & Communication breakdown

Table 7: Kōrero Mai December Call Summary

4.1 Consumer and Whānau advisory team - lived experience leadership

Recommendations:

- To read the paper of He Ara Oranga recommendations (Government Enquiry into Mental Health and Addiction.

Other recommendations to consider are:

a)	Utilise the Consumer and Whānau advisory team (C&WAT) as a resource for input on mental health patient-centred initiatives and consultation	**Yes/No**
b)	Executive Leadership Team from Specialist Mental Health and Addictions present to Consumer Council	**Yes/No**
c)	Consider C&WAT as a support for mental health consumer representatives on Consumer Council in patient- and whānau-centred outcomes development	**Yes/No**
d)	Include Consumer and Whānau advisory team in agenda and minutes circulation	**Yes/No**

Key Issues
• *Communication and information sharing* • *He Ara Oranga recommendations* • *Community development* • *Workforce development; Peer support work competencies and equity* • *Consumer and Whānau volunteer project*

Contact for telephone discussion (if required)

Name	Position	Telephone	Suggested first contact
Dr Dean Manley (PhD)	**Consumer and Whānau consultant**	**021 552 879**	
Jacquie Kenyon	**Consumer advisor, North and Rodney**	**021 195 0392**	

Executive Summary

Presenters Dean Manley and Jacquie Kenyon will provide a brief introduction to the Consumer and Whānau advisory team: who we are, our roles, specialities, and networks. They will then

provide an overview of the attached *He Ara Oranga recommendations and then discuss opportunities to work together with:*

- *Service user-led research, education and evaluation*
- *Community development; AUT, Massey, Recovery College*
- *Communications: information sharing on salient issues*

Next Steps

If agreed by the Consumer Council the Consumer and Whānau advisory team (C&WAT) will request the Executive Leadership Team from Specialist Mental Health and Addictions present to the Consumer Council to determine how they can achieve effective communication and connection around issues/concerns highlighted by the community.

Background information

Executive summary

BACKGROUND

The Government Inquiry into Mental Health and Addiction was announced early in 2018. The catalyst for the inquiry was widespread concern about mental health services, within the mental health sector and the broader community, and calls for a wide-ranging inquiry from service users, their families and whānau, people affected by suicide, people working in health, media, Iwi and advocacy groups.

PURPOSE OF INQUIRY

The purpose of this Inquiry is to:

- hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction and what needs to change
- report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems
- recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

The full Terms of Reference can be accessed in this link.

INQUIRY PANEL MEMBERS

The members of the Inquiry panel are:

Professor Ron Paterson (Chair), Sir Mason Durie, Dr Barbara Disley, Dean Rangihuna, Dr Jemaima Tiatia-Seath, Josiah Tualamali'i

INQUIRY PROCESS

The Inquiry commenced work in February 2018 and reported to the Minister of Health in November 2018. The Inquiry process involved widespread public consultation and high media interest. In April 2018, a consultation document was released in multiple languages and formats. The level of public and mental health and addiction sector engagement with the Inquiry was remarkable.

Over 2,000 people attended public meetings at 26 locations around the country. Over 5,200 submissions were made to the Inquiry. Over 400 meetings were held with tāngata whaiora,[1] their families and whānau, other members of the public, health and other service providers, Iwi and Kaupapa Māori providers, community organisations, researchers and other experts.

The Inquiry obtained information from a wide variety of sources, including a stocktake of government-funded services and programmes and perceived gaps and opportunities. A report was commissioned from the University of Otago, Wellington, on the determinants of mental health and wellbeing, specific populations' experiences of mental health and wellbeing, and opportunities for service improvements and a move to a wellbeing approach.

APPROACH TO REPORT

We recognised from the start that this Inquiry represented a 'once in a generation' opportunity for change. All over the country, people told us they wanted this report to lead to real and enduring change – a 'paradigm shift'.

There has been no shortage of mental health inquiries and reviews in the 22 years since the last national mental health inquiry in New Zealand, led by Judge Ken Mason in 1995–1996. It too was born out of heightened public concerns and calls for change. It came in the wake of deinstitutionalisation in the 1980s and 1990s, with patients being moved out of psychiatric hospitals and into the community.

We note two important differences about this Inquiry. One is the breadth of its Terms of Reference, including mental health problems across the full spectrum from mental distress to enduring psychiatric illness, and a mandate to look beyond the health sector to other sectors and social determinants that influence mental health outcomes. We are also asked to advise how to promote mental health and wellbeing for the whole community. The inclusion of addictions and harmful use of alcohol and other drugs is also different from past reviews.

The second main difference that emerged during this Inquiry is the striking degree of consensus, from most parts of New Zealand society, about the need for change and a new direction: an emphasis on wellbeing and community, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau- and community-based responses and cross-government action.

Given the degree of consensus, why hasn't change occurred already? In many respects, we have the system we designed. The target set in the 1996 Mason Inquiry report, of having specialist services available for the 3% of people with the most severe mental health needs, has been achieved. But the subsequent goals of more prevention and early intervention, and more support in the community, have not been realised, despite worthy policies and strategies. Much time and effort has gone into planning, with lots of good work by hardworking people. Yet, apart from some pockets of success, little progress has been made. The fact that other countries are facing similar challenges and asking the same questions gives us no comfort.

So, we have taken a different approach. We have deliberately taken a 'people first' approach in writing this report, being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present.

We have sought to be bold and bring some fresh thinking to old and complex problems. Rather than develop a strategy or lay out a 'shopping list' of new services to be funded, we have analysed the underlying reasons why New Zealand's mental health and addiction system has not really shifted over the past two decades.

SOME FACTS AND FIGURES

Mental health and addiction problems touch the lives of many people in New Zealand. Each year around one in five of us experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition to the human costs, the annual cost of the burden of serious mental illness, including addiction, in New Zealand is an estimated $12 billion or 5% of gross domestic product.

Any one of us can be affected: over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. But some people are more at risk. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low-paid work, abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and, for Māori, deprivation and cultural alienation.

New Zealand has persistently high suicide rates. Annual suicide rates reported by the Office of the Chief Coroner have increased over the last four years, with the 2017/18 suicide rate the highest since 1999. Every year, 20,000 people attempt to take their own life. In 2015, 525 people died by suicide. Our suicide rate for

young people is among the worst in the OECD. The greatest loss of life through suicide occurs among people older than 24, particularly males aged 25–44. Every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community.

Addiction to alcohol and other drugs is causing widespread harm in New Zealand communities. A heavy drinking culture harms health and wellbeing. Harmful use of alcohol and other drugs is significantly implicated in crime – around 60% of community-based offenders have an identified alcohol or other drug problem and 87% of prisoners have experienced an alcohol or other drug problem over their lifetime. Well over half of youth suicides involve alcohol or illicit drug exposure. Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.

VOICES OF THE PEOPLE

Early on in the Inquiry, we consulted Judge Ken Mason. "Listen to the people", he said. "They will tell you what to do." We did, and the voices of the people were powerful and compelling. We have reported them faithfully and they have guided our approach.

Strong themes emerged from the people we met and submitters. People shared deeply personal experiences, motivated by a desire to tell their stories and bring about change. We heard a lot of heartache and sorrow, but also stories of hope and recovery.

This report records the main themes from the voices of the people: a call for **wellbeing and community solutions** – for help through the storms of life, to be seen as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self.

For **Māori health and wellbeing**, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and Iwi.

For Pacific peoples, the adoption of 'Pacific ways' to enable **Pacific health and wellbeing** – a holistic approach incorporating Pacific languages, identity, connectedness, spirituality, nutrition, physical activity and healthy relationships.

People said that unless New Zealand tackles the **social and economic determinants of health**, we will never stem the tide of mental health and addiction problems. There are clear links between poverty and poor mental health. People need safe and affordable houses, good education, jobs and income for mental wellbeing.

Addictions are recognised as a serious public health issue in New Zealand. Alcohol and other drugs are tearing families and communities apart. People and communities called for decisive action to limit the sale and promotion of alcohol, particularly around children and young people. As well as more treatment and rehabilitation services, people argued for a mature drug policy, with addiction treated as a health, not a criminal justice issue.

Families and whānau described patient privacy as a barrier used to exclude them from treatment and discharge planning, even though they are the ones there for the long haul. They asked for help for their family members, and more support for their own needs as carers. Families bereaved by suicide described a lack of support, and the delays and trauma of current suicide review processes.

Children and young people are exhibiting high levels of behavioural distress leading to deliberate self-harm, risk-taking, anxiety and other troubling behaviours. Parents are concerned about the harms of bullying and misuse of the internet and social media. School counsellors and teachers are overwhelmed by the number of students in distress. New Zealand's high rates of youth suicide are a national shame. Students and teachers highlighted the importance of learning about mental health as part of the health curriculum and helping young children develop resilience and learn how to regulate their emotions.

People wanted **support in the community**, so they can stay connected and receive help for a variety of needs – crisis support and acute care, addiction recovery, long-term support, respite care, drop-in centres, social support, whānau wrap-around services and employment support.

They sought access to an expanded range of therapies, and resources to shift from district health boards (DHBs) to non-governmental organisation (NGO) providers, which are closer to the community.

Problems of **access, wait times and quality** were reported all over the country – having to fight and beg for services, not meeting the threshold for treatment, and the cruelty of being encouraged to seek help from unavailable or severely rationed services. Gaps in services, limited therapies, a system that is hard to navigate, variable quality and shabby facilities added up to a gloomy picture of a system failing to meet the needs of many people.

Members of the **workforce** told us of their love of their jobs, but reported stress, burnout and exhaustion from overwork and an increasing risk of assaults. One manager warned, "All the dreams of the Inquiry will come to naught if we don't have a workforce". There were loud and clear calls for more peer-support workers; more staff trained in Māori culture and Pacific cultures; and more training in mental health and addiction within primary health care and other sectors (education, corrections, police and social work).

We heard that New Zealand needs a **human rights and mental health** approach to be recognised in law to honour our international treaty obligations. People called for repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) and an end to seclusion and restraint. Even in 2018, shame and stigma shape attitudes and act as barriers to seeking help. The Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control.

Submissions described a lack of clear **leadership and oversight** at a national level. People talked about what can be achieved when mental health and addiction is a priority area for government and there is clear leadership and direction from a mental health commission with a powerful statutory mandate. They asked for local leadership and innovation to be supported. We saw and heard about many examples of grass-roots leadership by people with lived experience.

OUR CONCLUSIONS

New Zealand's mental health and addiction problems cannot be fixed by government alone, nor solely by the health system. We can't medicate or treat our way out of the epidemic of mental distress and addiction affecting all layers of our society. We need to ensure practical help and support in the community are available when people need it, and government has a key role to play here. But some solutions lie in our own hands. We can do more to help each other.

Wellbeing has been a theme during this Inquiry and in national conversation in recent years. It's hard for people struggling with poverty, abuse and deprivation to take steps to become well – yet, every day, people recover from distress, overcome addictions and find strength in their lives. Sleep, nutrition, exercise and time outdoors help recovery. So too does strengthening one's cultural identity and helping others.

We have a solid foundation to build on: New Zealand's mental health and addiction system has valuable strengths. Many people in the system receive good care and we have a skilled and committed workforce. But the system is under pressure and unsustainable in its current form. Signs include escalating demand for specialist services, limited support for people in the community and difficulties recruiting and retaining staff.

Despite the current level of investment, we're not getting the outcomes we want for our people. The outcomes for Māori are worse than for the overall population, and Māori are subject to much greater use of compulsory treatment and seclusion. There are also unmet mental health needs for Pacific peoples, disabled people, Rainbow communities, the prison population, and refugees and migrants. The estimated reduction in life expectancy of people with severe mental health or addiction challenges is 25 years. Our persistently high suicide rates are of major concern.

Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed. Even when it responds to people with a mental illness, it does so through too narrow a lens. People may be offered

medication, but not other appropriate support and therapies to recover. The quality of services and facilities is variable. Too many people are treated with a lack of dignity, respect and empathy.

We do not have a continuum of care – key components of the system are missing. The system does not respond adequately to people in serious distress, to prevent them from 'tipping over' into crisis situations. Many people with common, disabling problems such as stress, depression, anxiety, trauma and substance abuse have few options available through the public system. By failing to provide support early to people under the current threshold for specialist services, we're losing opportunities to improve outcomes for individuals, communities and the country.

We also fail to address people's wider social needs. Initial expansion of culturally appropriate services has stalled, and there has been little investment in respite and crisis support options, forensic step-down services in the community, and earlier access to a broader range of peer, cultural and talk therapies.

Despite a lot of consensus about the need for reform, we are yet to take a bold, health-oriented approach to the harmful use of alcohol and other drugs and to provide a wider range of community-based services to help people recover from addiction. Our approach to suicide prevention and the support available to people after a suicide is patchy and under-resourced. Tackling the social and economic determinants of mental health and wellbeing requires a coordinated, integrated approach from social services.

It's time to build a new mental health and addiction system on the existing foundations to provide a continuum of care and support. We will always have a special responsibility to those most in need. They must remain the priority. But we need to expand access so that people in serious distress – the 'missing middle' who currently miss out – can get the care and support they need to manage and recover.

The new system should have a vision of mental health and wellbeing for all at its heart: where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing.

We set out Whakawātea te Ara, clearing the pathways that will lead to improved Māori health and wellbeing. We outline *Vai Niu*, a vision of Pacific mental health and wellbeing. We believe that many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach, point the way for all New Zealanders.

We describe a vision for mental health and addiction services, with people at the centre; responsive to different ages, backgrounds and perspectives; centred on community-based support and local hubs, using a mix of peer, cultural, support and clinical workforces; providing support for people in crisis; a comprehensive harm-minimisation approach to alcohol and other drug use; more community-based addiction services to help people recover; and a broader range of therapies for people who are detained and support for their transition back to the community. Psychiatrists and appropriate medications will continue to be important – but they are only part of the picture.

Honouring the voices of the people who shared their stories with the Inquiry means there must now be decisive action. Our approach is to focus on a few critical changes to shift the system.In addition to the gains in health and wellbeing, a strong economic case exists for further investment in mental health and addiction. The key principles that underpin our recommendations are a commitment to equity and the Treaty of Waitangi; putting people with lived experience and consumers at the centre of the system; recognising a shared responsibility for improving mental health and wellbeing in our society; and building on the foundations already in place, with mental health and addiction services remaining part of the health system.

RATIONALE FOR RECOMMENDATIONS

We propose major changes in current policies and laws, supported by significant increases in funding. Our recommendations cover 12 broad areas. They are summarised, with the supporting rationale, below.

Expand access and choice from the current target of 3% of the population being able to access specialist services to provide access to the 'missing middle' of people with mental illness or significant mental distress who cannot access the support and care they need. Given current prevalence data suggesting one in five people experience mental health and addiction challenges at any given time, an indicative access target may be 20% within the next five years. New Zealand has deliberately focused on services for people with the most serious needs, but this has resulted in an incomplete system with very few services for those with less severe needs, even when they are highly distressed.

An explicit new access target must be set, supported by funding for a wider range of therapies, especially talk therapies, alcohol and other drug services, and culturally aligned services. This expansion will transform mental health and addiction services. Making it happen requires the involvement of all key players in a co-design process and implementation support for the change process itself. It also requires workforce development, better information, a commitment to a clear funding path, new funding rules and expectations, and strong leadership. (Chapter 4, recommendations 1–12)

Transform primary health care so people can get skilled help in their local communities, to prevent and respond to mental health and addiction problems. Responding appropriately to people with these challenges should be part of the core role of any general practice or community health service. The capability of the primary care workforce needs to be enhanced, with additional mental health and addiction training for general practitioners, practice nurses and community health workers.

The transformation envisaged by the 2001 Primary Health Care Strategy is yet to happen. Affordability remains an issue, models of care have largely not evolved, and primary, community and secondary services are not well integrated. The Health and Disability Sector Review should focus on the wider transformation of primary health care as this will be a critical foundation for improved mental health and addiction care and support. (Chapter 5, recommendations 13 and 14.)

Strengthen the NGO sector to support the significant role NGOs (including Kaupapa Māori services) will play with the shift to more community-based mental health and addiction services. The NGO sector is an increasingly important contributor to the delivery of government-funded mental health, addiction and wider health and social services. But factors such as short-term contracts, high compliance costs and reporting requirements, multiple funders and contracts, and a power imbalance impact on the sustainability of NGO providers and the service they can provide. We recommend a clear stewardship role within central government to support NGO development and sustainability and improve commissioning of health and social services with NGOs. (Chapter 6, recommendation 15)

Take a whole-of-government approach to wellbeing to tackle social determinants and support prevention activities that impact on multiple outcomes, not only mental health and addiction. Despite the substantial benefits of focusing on prevention and promoting wellbeing, especially early in life, the balance of resources has not shifted to prevention and long-term investment in our future. Multiple agencies are engaged in fragmented and uncoordinated activities that target similar outcomes. A proposed social wellbeing agency would provide a clear locus of responsibility within central government for social wellbeing, with a focus on prevention and tackling major social determinants that underlie many inequitable outcomes in our society. (Chapter 7, recommendations 16 and 17)

Facilitate mental health promotion and prevention with leadership and oversight from a new commission, including an investment and quality assurance strategy for mental health promotion and prevention. Although there have been some excellent national campaigns, such as Like Minds, Like Mine, a plethora of different programmes are delivered by many organisations; some may not be sound. A more organised approach, with quality-assured programmes, would benefit schools, workplaces and local communities. (Chapter 7, recommendations 18 and 19)

Place people at the centre to strengthen consumer voice and experience in mental health

and addiction services. People with lived experience are too often on the periphery; they should be included in mental health and addiction governance, planning, policy and service development. Consumer voice and role should be strengthened in DHBs, primary care and NGOs. Families and whānau should be supported to be active participants in the care and treatment of their family member, subject to the wishes of the individual patient. Too often they are excluded by service practices, based on misconceived privacy concerns. New, consolidated guidance should be developed on information-sharing and partnering with families. A review is needed of the wellbeing support provided to families and whānau, given the high emotional and financial costs of caring for family members. (Chapter 8 , recommendations 20–25)

Take strong action on alcohol and other drugs by enacting a stricter regulatory approach to the sale and supply of alcohol; replace criminal sanctions for the possession for personal use of controlled drugs, with civil responses; support that law change with a full range of treatment and detox services; and establish clear cross-sector leadership within central government for alcohol and other drug policy. These steps are needed in response to the harmful use of alcohol and other drugs and the devastating impact on individuals, families and communities.

A much bolder approach to alcohol law reform is justified, given community concerns and evidence-based recommendations from the Law Commission and other agencies. The criminalisation of drug use has failed to reduce harm around the world. A shift towards treating personal drug use as a health and social issue is required to minimise the harms of drug use. Demand for addiction services is increasing and investment in more services is needed, from brief interventions in general practice and primary care settings to social and detox options and follow-up community-based services. Alcohol and other drug policy leadership and coordination also needs a clear home within government. (Chapter 9 , recommendations 26–29)

Prevent suicide. Urgently complete and implement a national suicide prevention strategy, with a target of a 20% reduction in suicide rates by 2030. New Zealand's persistently high suicide rates were one of the catalysts for this Inquiry. Suicide affects people of all ages and from all walks of life, with thousands of New Zealanders touched by suicide every year. Suicide prevention has suffered from a lack of coordination and resources. Reducing suicide rates should be a cross-party and cross-sectoral national priority. Suicide prevention requires increased resources and leadership from a suicide prevention office. Suicide bereaved families and whānau, who are at increased risk of suicide, need more support, and the processes for investigation of deaths by suicide, which are often slow, traumatic and costly, need to be reviewed. (Chapter 10 , recommendations 30–33)

Reform the Mental Health Act. Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992, to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimise compulsory or coercive treatment. The Mental Health Act is out of date, inconsistent with New Zealand's international treaty obligations and sometimes results in trauma and harm to compulsorily treated patients. The use of compulsory treatment orders varies around the country, and there is far too much use of seclusion and restraint, especially for Māori and Pacific peoples. Clinicians working under the Act have developed a culture of risk aversion and defensive practice. New Zealand needs a national level discussion, carefully crafted, to reconsider beliefs, evidence and attitudes about mental health and risk. (Chapter 11 , recommendations 34 and 35)

Establish a new Mental Health and Wellbeing Commission to act as a watchdog and provide leadership and oversight of mental health and wellbeing in New Zealand. There has been a general lack of confidence in leadership of the mental health and addiction sector over many years, since disestablishment of the original Mental Health Commission. A new Commission is needed to provide system leadership and act as the institutional mechanism to hold decision-makers and successive governments to account. It should publicly

report on progress in mental health and addiction, including on implementation of the Government response to this Inquiry's recommendations. (Chapter 12, recommendations 36–38)

Refer to the Health and Disability Sector Review for consideration, broader issues such as the future structures, roles and functions in the health and disability system, including the establishment of a Māori health commission or ministry. During the Inquiry, significant structural and system issues, including concerns about the current DHB model, and the transformation required in the primary health care sector, were raised. The Health and Disability Sector Review, announced part way through this Inquiry, has a wider scope and is better placed to consider those issues. (A final note, recommendation 39)

Establish a cross-party working group on mental health and wellbeing to reflect the shared commitment of different parties to improved mental health and wellbeing in New Zealand. Mental health is too important to be a political football. Similar initiatives are in place in the United Kingdom and Canada, and some support exists for a similar concept in New Zealand. A cross-party working group would provide an opportunity for members of the House of Representatives to collaborate and advocate for education, leadership and legislative progress on mental health and wellbeing. (A final note, recommendation 40)

CLOSING THOUGHTS

This is not simply a report calling for more money for mental health and addiction services – though it is clear further investment is needed in Budget 2019 and in the future. It is a whole new approach to mental health and addiction in New Zealand. It sets out He Ara Oranga – Pathways to Wellness.

The changes we have recommended, in a comprehensive set of 40 recommendations, are intended to transform our approach to mental health and addiction – to prevent problems developing, respond earlier and more effectively and promote mental health and wellbeing. Implementation will require policy decisions and legislative change backed by a commitment to a long-term funding path. We are confident of the cost-effectiveness of greater investment in the targeted areas.

Change will take time. It must be sustained over a long period, but we need to start now. Some of the necessary changes can and must happen promptly. People have waited long enough.

Acting collectively, we can improve our mental health and wellbeing.

In unity there is strength…
he toa takitini [2]
So'o le fau i le fau [3]

---

1 Literally translated, 'tāngata whaiora' means 'people seeking wellness', and is generally used in preference to 'service users' and 'consumers'. See also the explanation in Table 1.

2 The complete whakatauki is 'Ehara taku toa i te toa takitahi, engari he toa takitini' (My strength is not that of a single warrior, but that of many).

3 A well-known Samoan proverb that means to join the hibiscus fibre to hibiscus fibre. Metaphorically, it conveys that unity is strength

Waitematā District Health Board
Best Care for Everyone

4.2 Discussion: Outpatient Experience

Date: 19th *February 2020*

Recommendations:
The recommendations are that you:

a) Discuss the challenges of the outpatient clinics as a patient **Yes/No**
b) How do we support patients and whānau to leave their outpatient appointments fully informed and knowing what is next? **Yes/No**

Key Issues
• Waitematā DHB often receive feedback from patients reporting that when they leave their outpatient appointment they may: o leave not knowing what is happening next o arrive for appointment and are not clear what the appointment is for o not feel empowered to ask questions o understand who to contact if they have any further questions about • How can we better support our patients and their whānau get the best out of their outpatient appointments? How to we ensure that the appointment is meaningful for the patient?

Contact for telephone discussion (if required)

Name	Position	Telephone	Suggested first contact
David Price	**Director of Patient Experience**	**021715618**	✓

4.3 Discussion: Expectations from the Complaints Process

Recommendations:
The recommendations are that you:

c) Discuss your expectations from the Complaints process **Yes/No**
d) Discuss how we can 'close the loop' of the complaints process **Yes/No**

Background
All feedback (complaints and compliments) from patients, clients and their whānau are received by the Feedback Team and redirected to the appropriate service for investigation and response. Feedback can be given by telephone, in writing or by email (feedback@waitematadhb.govt.nz) , via *contact us* on the DHB website. You will be able to submit a complaint on behalf of a patient or family member. A complaints/compliments box is also situated in the main foyer of the hospital for patients to submit their feedback. It is DHB policy that all complaints are responded to within 14 calendar days of receipt. The team also encourages the service to phone complainants and ensure a patient-centred response.

Resource Persons

Brenda Witt – Complaints and Adverse Events Manager
Jacky Bush – Quality and Risk Manager