

Agenda

Health Consumer Council

Venue: Property Services Meeting Room
Date and Time: Tuesday 8 August 2018 at 11:00am

Item No.	Item	Page
1	Apologies	
2	Presentation 2.1 <u>Health Services Plan Overview</u> – Simon Everitt – 11am	3
3	Minutes of Meeting - 11 July 2018	9
4	Matters Arising	12
5	Papers for Decision 5.1 <u>Draft Terms of Reference</u>	13
6	For Discussion 6.1 <u>Consumer Engagement Framework</u> 6.2 <u>Draft Contributions re “Patients” Terminology Document</u>	16 43
7	Papers for Noting 7.1 <u>Interest Register</u> 7.2 <u>Correspondence for Noting</u>	45 48
8	General Business	

Item No.	Item	Page
9	Next Meeting - Wednesday 12 September 2018	

Planning for Bay of Plenty's Health System

BAY OF PLENTY
STRATEGIC HEALTH SERVICES PLAN
2017 - 2027

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Planning for the Future...

About us

Health Trends for the Bay of Plenty

Emerging Models

Strategic Health Services Plan

ABOUT US

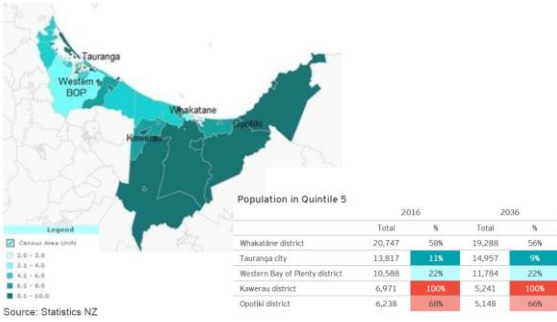
The Bay of Plenty District Health Board (BOPDHB) is one of 20 DHBs in New Zealand, and one of five DHBs that make up the Midland region. We serve a population of 225,320 for the major population centres of Tauranga, Kaitiaki, Te Puke, Whakatane, Kawerau and Opotiki. Of this 225,320, 32% are under 25 and 25% identify as having Māori ethnicity, and like the national population, our population is ageing (currently 19% aged 65 or over, and forecast to reach 24% in 2026). Eighteen Iwi are located within our district.

The Bay of Plenty (BOP) population has generally good health compared to others in New Zealand, and generally good access to health and disability support services. Future projections (based on current state) indicate the largest potential health gains for BOP people over the next 10-20 years lie in:

- eliminating smoking
- addressing obesity
- reducing Māori inequalities in health

Social inequities across the Bay
Ethnicity and geography closely co-relate with deprivation

Deprivation profile (NZ Dep13) for Bay of Plenty, 2013



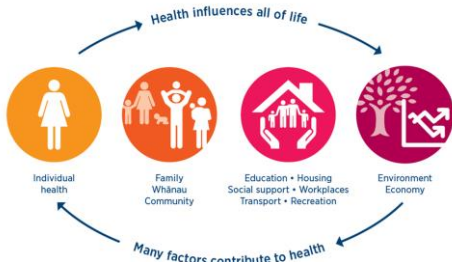
Population Health and Risk Factors

- Bay of Plenty’s population lead relatively healthy lives. Areas for improvement include:
 - Smoking (38,000 people could stop)
 - Hazardous drinking (31,000 people could reduce)
 - Nutrition (57,000 people would benefit from losing weight)
- Long-term conditions (eg. Diabetes, heart disease) account for 80% of early deaths



Emerging Models

-What Influences our health?



Strategic Health Services Planning

The health system sustainability challenge...
...how to provide ongoing access to appropriate quality of care in a cost-efficient and health-effective manner



Strategic Health Services Plan 2017-27



LIVE WELL

Empowering our populations to live healthy lives for as long as possible. This means we want to encourage people to stop smoking, encourage people to eat well and be active, and increase the number of healthy warm homes.



STAY WELL

Improving the way the Bay's health system provides care for people and their family/whānau closer to where they live, learn, work and play. This means we want to invest more in community services so that we don't need to grow our hospital capacity.



BAY OF PLENTY DISTRICT HEALTH BOARD H A S U O R A A T O I

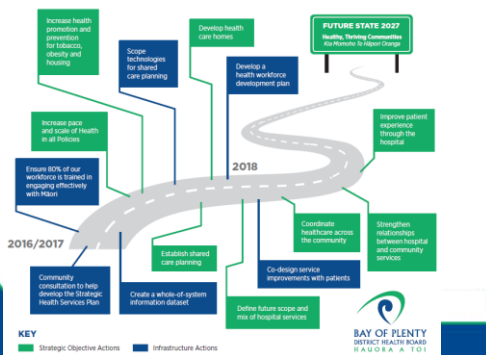
GET WELL

Ensuring our hospital services are patient-centred, well connected to community-based health services and focused on delivering care that enables our patients to return home as quickly as possible. This means we want to make the patient's journey through the hospital as quick and easy as possible.



BAY OF PLENTY DISTRICT HEALTH BOARD H A S U O R A A T O I

Strategic Health Services Plan Implementation Roadmap 2017/18





For copies of the Strategic Health Services Plan, the Bay of Plenty Health and Service Profile 2016 and summary documents go to:

<http://www.bopdhb.govt.nz/media-publications/a-z-publications/>



Health Consumer Council

Venue: Education Centre, Tawa Room

Date: 11 July 2018 at 11:00am

Attendees: John Powell (Chair), Susan Horne, Julia Genet, Wol Hansen, Rosalie Liddle Crawford, Tessa Mackenzie, Susan Matthews, Maz McKeivitt, Lisa Murphy, Florence Trout, Adrienne von Tunzelmann, Debbie Brown, Averil Boon and Cherie Martin

Item No.	Item	Action
1	<p>Apologies</p> <p>Apologies were received from Helen Mason who would have liked to have met with the committee however with the strike action she is currently in Wellington. Debbie Brown will leave the meeting at 12pm as she is involved in the strike planning.</p> <p style="text-align: right;">Moved: J Genet Seconded: S. Horne</p>	
2	<p>Introductions</p> <p>The committee members introduced themselves. It was noted that whilst there are a number of members with an interest in Maori health there is currently no Maori representation on the committee however Tricia Keelan General Manager Maori Health Gains and Development is available for input.</p>	
3	<p>Presentation</p> <p>3.1 <u>Overview of BOPDHB Strategic Priorities and Q & A Session</u> – Averil Boon</p> <p>Averil showed the committee the BOPDHB website and ran through where and what information is shared on the BOPDHB website.</p> <p>The BOPDHB Strategic Priorities overview. Invitations are being arranged for the lead exec for each of our strategic priorities to come and discuss. Cherie will be inviting Simon Everitt GM Planning and Funding to go over the BOP Health Services Plan at the August Health Consumer Committee meeting if he is available.</p> <p>The committee agreed that they need to look at their priorities and devote some time to working through that.</p> <p>Consumer Engagement Handout was well received and the Consumer Committee asked this be added to the next agenda.</p>	<p style="text-align: center;">Cherie</p> <p style="text-align: center;">Cherie add to August agenda</p>
4	Minutes of Meeting - Nil	
5	Matters Arising – Nil	

Item No.	Item	Action
6	Papers for Decision – Nil	
7	<p>Papers/Items for Discussion</p> <p>7.1 <u>Interest Register</u> Debbie ran through the requirements. It was raised that the Auditor General is cracking down on full disclosure. It was agreed to put everything down. The committee will complete their interests and return to Cherie by the end of next week. The interests register will be a quarterly item on the agenda.</p> <p>7.2 <u>Terms of Reference</u> The committee want to promote HCC as a BOP wide focus not just a Hospital focus. It will need to enable effective pathways with the “Consumer” to the DHB. It will be helpful to look at other Health Consumer Council Terms of Reference for guidance. Committee discussed the need for a central directory of health services.</p> <p>7.3 <u>Re: Is there an alternative to the word patient</u> Health User was put forward as a more generic word for people seeking wellness and not necessarily a “patient” Tangata Whaiora “seeking wellness” was also a term the committee found to be of interest in addition to patient. Adrienne / Rosalie offered to write up notes on the discussion as reference for a response to the Board on this matter.</p>	<p>Cherie</p> <p>Adrienne and Rosalie</p>
8	Papers for Noting - Nil	
9	<p>General Business</p> <ul style="list-style-type: none"> Inwards correspondence received from Health Quality and Safety Commission congratulating the committee on the new launch and looking forward to sharing information www.hqsc.govt.nz <p>Received: J. Powell Seconded: W. Hansen</p>	
10	Next Meeting – Wednesday 8 August 2018	

The meeting closed at 1:12pm

The minutes will be confirmed as a true and correct record at the next meeting.

Unconfirmed



Health Consumer Council

Matters Arising – August 2018

Meeting Date	Item	Action required	Action Taken
17.07.18	3.1	<u>Overview of BOPDHB Strategic Priorities</u> Cherie to liaise with Simon Everitt to present at August meeting	Completed
17.07.18	7.3	<u>Is there an alternative to the word patient</u> Adrienne write up a paper for submission to the Board	

<p>Purpose:</p>	<p>The Bay of Plenty Health Consumer Council (BOPHCC) will be a voice for the consumers of the health system and the people of the Bay of Plenty District Health Board (BOPDHB).</p> <p>The BOPHCC will work collaboratively with the BOPDHB as an advisory body to advance their vision of “Enabling communities to achieve good health, independence and access to quality services”.</p>
<p>Functions:</p>	<p>The BOP Health Consumer Council will:</p> <ul style="list-style-type: none"> • Enable meaningful consumer participation across the Bay of Plenty • Identify and advise on issues requiring consumer and community participation, including input into the development of health service priorities and strategic direction • Participate, review and advise on reports, developments and initiatives relating to provision of health services • Ensure regular communication and networking with the community and relevant consumer groups • Link with special interest groups as required, for specific issues and/or problem solving • Maintain an overview of consumer engagement activity across the BOPDHB for transparency benefits • Challenge planned services for any omission or disadvantage to those in most need, should it occur • Adhere to the BOPDHB’s policies and protocols. <p>For the avoidance of doubt, the BOPHCC will NOT:</p> <ul style="list-style-type: none"> • Provide clinical evaluation of health services • Be involved in the BOPDHB’s contracting processes • Be held accountable for decisions made by BOPDHB’s management and/or governance whether compatible with BOPHCC's views or not • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust BOPDHB processes exist • Represent any specific consumer interest group or organisation nor enter into communication with a clear conflict of interest.
<p>Level of Influence</p>	<p>The BOPHCC has the authority to give advice and make recommendations to the BOPDHB senior management and the Board according to the levels of impact shown in the BOPDHB Consumer Engagement Framework – 2016.</p>
<p>Secretariat</p>	<p>Secretariat support provided, in collaboration with the BOPDHB Programme Manager, Quality & Patient Safety will convene the BOPHCC</p>
<p>Membership:</p>	<p>The BOPHCC will comprise ten to twelve consumer representatives. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible health care and services from the Bay of Plenty DHB.</p>

	<p>Members will be selected to cover a range of areas e.g. Maori health, women’s health, child health, long term conditions, mental health, and disability. Although appointed to reflect the consumer voice in a particular area of interest, an individual member will not be regarded as a representative of any specific organisation or community, nor an “expert”.</p> <p>One BOPHCC member will be appointed from the Consumer Health Liaison Group</p> <p>Membership composition will include the following principles:</p> <ul style="list-style-type: none"> • Reflect the requirements of the Bay of Plenty Health Services Plan • Reflect the population that uses health services • Recognise the need to address inequalities and disparities in health outcomes • Act to recognise BOPDHB responsibilities under the Treaty of Waitangi <p>When selecting members, consideration must be given to maintaining a demographic balance that reflects the population; Speciality, ethnic, rural/urban, east/west geography.</p> <p>The BOPHCC may co-opt other people from time to time for a specific purpose.</p> <p>Inaugural members will be appointed for a one or two year terms to stagger end of term dates, and thereafter appointments will be for a two year term commencing in June each year. Members may be reappointed for no more than three terms.</p> <p>Members will be provided with training and support by the BOPDHB to undertake their role successfully.</p> <p>Remuneration shall be paid based on the BOPDHB Consumer engagement payment and reimbursement of expenses guidelines.</p> <p>All Members who reasonably believe they may have an actual or potential conflict of interest is to disclose their interest to the chair immediately they become aware of it. Any conflict in interest will be recorded.</p> <p>Membership may be terminated or full dissolution of the BOPHCC may be undertaken by the Chief Executive Officer (CEO) of BOPDHB in consultation with the chair of BOPHCC. Termination will be requested within 3 months from when performance is found to be seriously unacceptable.</p> <p>Members who fail to attend three consecutive meetings without an apology will be asked by the chair to step down from the BOPHCC.</p>
<p>Chairperson</p>	<p>The inaugural chair will be appointed by the BOPDHB CEO (or delegate) for a term of one year. Thereafter the chair will be appointed by the CEO following consultation with BOPHCC members.</p>
<p>Meetings:</p>	<p>A minimum of ten meetings per year will be held February to November.</p> <p>Should more meeting time be required, this will be treated as an ‘out-of-session’ consultation.</p> <p>The Secretariat will provide administrative support.</p>

<p>Issue Date: January 2018 Review Date: January 2020</p>	<p>Page: 2 of 3 Version No: 2</p>
<p>Authorised by: BOP HCC Chair & BOPDHB CEO</p>	<p>Document Steward: BOPDHB CEO</p>

BOP Health Consumer Council
Terms of Reference - 2018

	<p>A quorum will be half the current membership, including the chair or delegate.</p> <p>Others may attend as Invited Persons to facilitate the business on hand by invitation of the chair.</p> <p>Minutes and agendas will be circulated at least a week prior to each meeting, with any reading material attached.</p> <p>Meetings will be up to two hours, held at an agreed time, to enable all members to participate.</p> <p>Meetings will be published on the BOPDHB website and be open to staff and the public. On occasion when there are issues of confidentiality or other risks, meetings may be closed in full or part at the discretion of the chair.</p>
Reporting:	<p>The BOPHCC will report and make recommendations to CEO quarterly or more often when requested. Relevant information is then reported to the Board by the CEO.</p> <p>Reports and minutes will be placed on the BOPDHB website once approved by members.</p> <p>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 to the chair.</p>
Terms of Reference Review:	<p>Members will review the Terms of Reference (TOR) biannually and make any recommendations for change to the CEO. BOPHCC TOR will be reviewed and confirmed by CEO biannually.</p>

Issue Date: January 2018

Review Date: January 2020

Authorised by: BOP HCC Chair & BOPDHB CEO

Page: 3 of 3

Version No: 2

Document Steward:
BOPDHB CEO

BOPDHB Consumer Engagement Framework

2016

Bay of Plenty District Health Board
Quality & Patient Safety



Contents

<i>CARE – Compassion, Attitude, Responsiveness and Excellence</i>	4
Section 1: Introduction.....	4
1.1. Background.....	4
1.2. Defining consumer and community engagement.....	4
1.3. Legislation and strategies that underpin consumer engagement.....	5
1.4. Purpose, scope and benefits of consumer and community engagement.....	5
1.5. Health literacy.....	5
Section 2: Key components of consumer and community engagement.....	6
2.1 Principles of Consumer Engagement.....	6
2.2 Levels, Domains and Elements of Consumer Engagement.....	7
2.3 Levels of Consumer Engagement.....	7
2.4 Elements of the Public Participation Spectrum.....	8
Section 3: Current informal and formal BOPDHB mechanisms.....	9
Section 4: Using the Consumer Engagement Framework.....	10
4.1 Involving consumers.....	10
4.2 Prepare and plan.....	11
4.3 A Multidimensional Framework Tool for Patient and Family Engagement in Health Care.....	11
4.4 Continuum of engagement.....	12
4.5 Method selection.....	13
4.6 Decision Tree.....	14
4.7 Method Guides.....	15
References.....	18
Consent and Authority to use Patient Story Form.....	20
A Multidimensional Framework Tool for Patient and Family Engagement in Health and Health Care.....	22
Capturing Patient Stories – Quick Guide.....	25

BOPDHB Consumer Engagement Framework

CARE – Compassion, Attitude, Responsiveness and Excellence

Section 1: Introduction

1.1. Background

The Bay of Plenty District Health Board (BOPDHB) is one of 20 District Health Boards (DHBs) in New Zealand, and one of five DHBs in the Midland region. BOPDHB is charged with the responsibility of delivering health services for the people of the Bay of Plenty.

In 2011 the BOPDHB introduced CARE - Compassion, Attitude, Responsiveness and Excellence as their Values and made a commitment to deliver patient and family centred care that puts the needs of patients and carers at its heart. Health Excellence is our commitment to performance excellence, using the internationally recognised *Health Care Criteria for Performance Excellence* framework. The vision for health excellence is 'striving to achieve the highest quality healthcare' and is a practical tool to guide continuous improvement, delivering a positive patient experience and our organisational culture based on quality outcomes.

The [He Pou Oranga Tangata Whenua framework](#) was developed by Māori Health Rūnanga with BOPDHB (2007) to provide organisations with a framework that can assist in the expression and application of kaupapa Māori principles to reflect traditional tangata whenua values are recognised as key indicators of *toiora*: optimum health and well-being.

This Consumer Engagement framework demonstrates BOPDHB's commitment across the whole of the organisation and provides a mechanism to coordinate, prioritise and share consumer engagement activities and resources across BOPDHB's many services and sites.

The vision for consumer engagement at BOPDHB is to be a health service that integrates consumer engagement into every part of the organisation, so that consumers are active partners in how BOPDHB undertakes business and care provision. BOPDHB want consumers to be given meaningful opportunities to actively engage and ensure that the consumers' perspective is listened to and valued in the planning, service delivery and evaluation of our health service. BOPDHB is committed to fostering a positive organisational culture where consumers and staff have access, support and the tools they require for active consumer engagement.

1.2. Defining consumer and community engagement

Consumer engagement refers to the wide range of strategies in which consumers are involved in the planning, service delivery and evaluation of our health care. It covers partnerships between health professionals, patients and their family and/or carers when care is planned and provided. This can be at an individual, service, network and/or system level.

There is growing evidence about the importance of engagement with patients, consumers, families, carers and the community for health service planning, delivery and evaluation. Whilst consumer and community engagement are commonly used terms, they are rarely defined in the health literature. The New Zealand (NZ) Health Quality and Safety Commission (HQSC) have defined consumer engagement as:

'... a process where consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organisation.'

There is no 'one size fits all' approach for consumer engagement, and good communication is the cornerstone to effective engagement at all levels. There has been some willingness demonstrated to

engage with our local communities and BOPDHB has some established engagement processes which provide an excellent basis for ongoing engagement. This framework aims to maintain and enhance the channels of communication and engagement between our facilities/services and the consumers and communities we serve.

1.3. Legislation and strategies that underpin consumer engagement

- Health and Disability Consumer Rights
- Treaty of Waitangi
- NZ Health and Disability Service Standards
- NZ Triple Aim
- NZ Ministry of Health Framework for Health Literacy
- Criteria for Performance Excellence Health Care
- BOPDHB Strategic Priorities
- BOPDHB Integrated Care Strategy
- BOPDHB Annual Plan 2015
- BOPDHB Clinical School Education Strategy
- He Pou Oranag Tanagata Whenua
- Whānau Ora

1.4. Purpose, scope and benefits of consumer and community engagement

The purpose of this framework is to strengthen and improve consumer engagement processes across BOPDHB. It identifies BOPDHB's current position regarding the significance and value of engaging with consumers and community, provides guidance and resources and is written for all employees.

As BOPDHB seeks improved health outcomes and healthier lifestyles for the Bay of Plenty population, the patient is a critical stakeholder and must become an engaged partner. Even the most capable and caring of clinicians cannot unilaterally improve a patient's health without their engagement; it is a team effort involving providers, patients, families, caregivers and health plans. Involving patients in making decisions about their own care and not treating them merely as passive recipients of health care is the basic building block for consumer engagement (ACSQHC, 2011).

Research has shown that together, the multiple individual benefits of patient and family engagement can improve multiple aspects of hospital performance, including quality, patient safety, financial performance, patient experiences of care and patient outcomes. Patient and family engagement strategies also help improve employees' satisfaction with their work and this, in turn, leads to higher levels of staff retention and an improved ability to recruit quality talent.

1.5. Health literacy

Health literacy is the extent to which consumers can obtain process and understand information about their health care, services and health system. It also refers to a consumer's capacity to effectively use that information to make decisions about their own health care. This includes, but is not limited to, consumers with limited English proficiency, those from a culturally and linguistically diverse (CALD) backgrounds, children and young people.

The traditional view of health literacy has been focused on changing the skill level of the patient or consumer. However, recent research suggests that to effectively make improvements in health literacy organisations need to look at strategies that focus on activities that minimise the complexity of healthcare as well as those that focus on improving individual skills.

People with poorer levels of knowledge and limited understanding about their condition, are less likely to attend appointments, are less adherent to medication regimens and health behaviour advice, make more medication errors and perform worse at self-care activities. Studies have shown that those with poor health literacy and are not able to effectively exercise their 'choice' or 'voice' when it comes to making health care decisions.

More information:

Ministry of Health: Framework, Review and other publications

- <http://www.health.govt.nz/publication/framework-health-literacy>

Health Quality & Safety Commission: Three steps to better health literacy booklet, *Let's PLAN for better care* leaflet

- <http://www.hqsc.govt.nz/our-programmes/partners-in-care/work-streams/health-literacy/>

Section 2: Key components of consumer and community engagement

The framework includes a set of nine principles; a model which describes five elements and four levels of engagement across four domains of health service operation; and a set of practice examples to support effective engagement.

2.1 Principles of Consumer Engagement

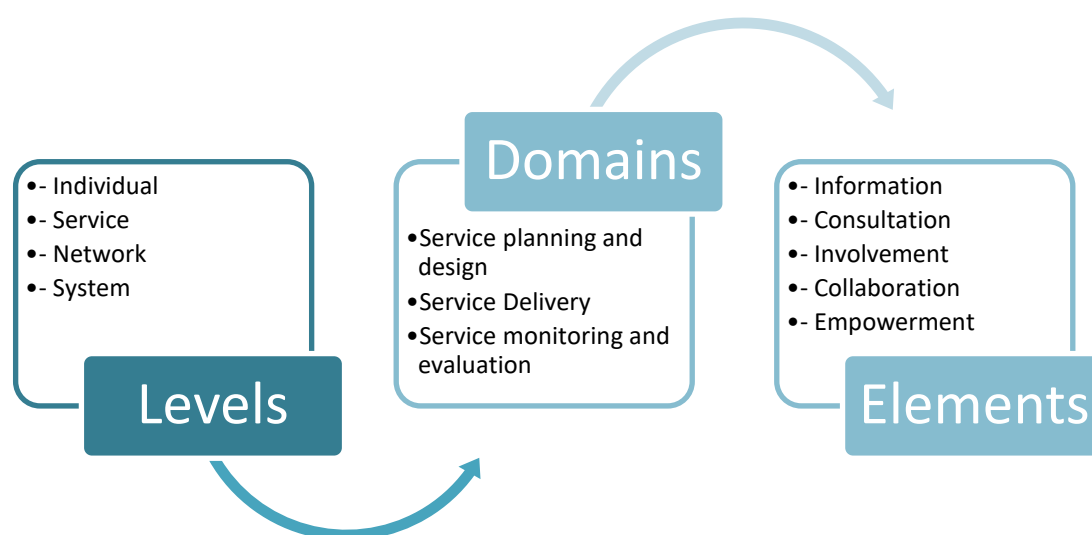
There are nine principles of consumer and community engagement contributes to enhancing the services and healthcare that is delivered by health service organisations.

PRINCIPLE	PRINCIPLE STATEMENT	PRINCIPLE IN PRACTICE
1. Participation	Consumers and communities participate and are involved in decision making about the health care system.	BOPDHB involves consumers and communities in decision making and demonstrates how it uses consumer and community feedback to plan, design, deliver and monitor and evaluate services.
2. Person-centred /whānau-centred	Engagement processes are consumer and community centred	BOPDHB enhances the way it undertakes engagement in a way that is person-centred and values the needs of consumers, their families/carers and the community.
3. Accessible and inclusive	The needs of consumers and communities who may experience barriers to engage effectively are considered to enhance their accessibility and inclusion.	BOPDHB examines barriers that consumers and communities experience to engage meaningfully and develops strategies to increase access and inclusion for people who are marginalised and experience poorer health outcomes.
4. Partnership	Consumers, community and BOPDHB work in partnership.	BOPDHB partners with consumers and the community at all levels of engagement around the planning, designing, delivery and monitoring and evaluation of services.
5. Diversity	The engagement process values and supports the diversity of consumers and communities.	BOPDHB understands the different populations of consumers and communities and engages with a diverse range of individuals and groups, for example people with a disability, older persons, Māori, young people, people with a mental illness and people from culturally and linguistically diverse backgrounds.
6. Mutual respect and value	Engagement is undertaken with mutual respect and valuing of each other's experiences and contributions.	BOPDHB works with consumers and communities in a respectful way that values the contribution consumers and communities bring to improving service planning, provision, monitoring and review as well as overall system outcomes.
7. Support	Consumers and communities are provided with the support they need to engage meaningfully with the healthcare system.	BOPDHB undertakes a process to understand the needs of consumers and the community, and implements processes to provide them with the support that they need to engage.
8. Influence	Consumer and community engagement influences health policy, planning and system reform, and feedback is provided about how the engagement has influenced outcomes.	BOPDHB utilises the information and feedback gained through engagement to improve health policy, planning, and service delivery and design, and ensures that consumers and communities are provided with feedback about the changes their input has achieved.
9. Continuous improvement	Consumer and community engagement is reviewed and evaluated to drive continuous improvement.	BOPDHB uses information from the review and evaluation of its engagement activities to improve future engagement and share learnings and knowledge with staff members of the organisation.

2.2 Levels, Domains and Elements of Consumer Engagement

The BOPDHB Consumer Engagement Framework supports:

- Engagement occurring at all of the four organisational levels on an ongoing basis;
- The involvement of consumers and community throughout the continuum of the engagement process, from planning, commencement of initiatives/activities through to the monitoring, evaluation and review phases;
- The use of a variety of mechanisms and methods that are tailored to meet the needs and purpose of the engagement;
- The engagement of consumers that are representative of the population that accesses and utilises any service, including culturally-diverse and marginalised groups;
- Early engagement of consumers, enabling the identification of objectives and focus of the activities to achieve positive outcomes;
- The provision of information to consumers and communities within BOPDHB using a supportive, mentoring approach;
- The provision of feedback to consumers and communities about how their contribution has influenced the end results.



2.3 Levels of Consumer Engagement

Partnering with consumers and the community can occur on different scales and levels of engagement. The four scales of engagement are Individual, Service, Network and System.

Level of engagement	Where the engagement level occurs	Explanation of level
1. Individual/whānau	<ul style="list-style-type: none"> • Individual /whānau healthcare 	This level focuses on engaging with the individual consumer and/or their family/carer as partners in their own healthcare, support and treatment.
2. Service	<ul style="list-style-type: none"> • Programme delivery • Service delivery • Facility / hospital 	This level focuses on engaging with consumers and the community to have input into how programmes, services, or facilities are delivered, structured, evaluated and improved.
3. Network	<ul style="list-style-type: none"> • Local BOPDHB healthcare and Community Services networks 	This level focuses on how health service organisations engage with consumers and community at the regional level.
4. System	<ul style="list-style-type: none"> • Local government • Midland Region DHBs • Hapu/Iwi • National government 	This level focuses on how consumers and communities engage to influence and input on health policy, reform and legislation at the system level across local, Midland and National jurisdictions.

2.4 Elements of the Public Participation Spectrum

Engaging with Consumers; a guide for district health boards (NZ HQSC) has adapted the International Association for Public Participation (IAP2) spectrum of public participation table (below) showing increasing levels of consumer impact that relates to health consumers engaging in decisions about their care and health services. The elements of engagement occur along a spectrum, and involve an increasing level of consumer and community participation from information through to empowerment.

INCREASING LEVEL OF CONSUMER IMPACT

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public participation goal	To provide consumers with balanced and objective information to assist them in understanding the issue, alternatives, opportunities and/or solutions.	To obtain consumer feedback on issues, alternatives and/or decisions.	To work directly with consumers to ensure that consumer concerns and aspirations are consistently understood and considered.	To partner with consumers in each aspect of decision-making, including in the development of alternatives and identification of the preferred solution.	To place final decision-making in the hands of the consumer.
Promise to consumers	We will keep you informed.	Consumer councils working in parity with clinical governance.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how consumer input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example techniques	Information fact sheets, websites.	Consumer feedback and comments, focus groups, patient experience surveys, community meetings.	External advisory groups, focus groups, patient experience surveys, shared decision-making.	Consumer councils reporting to clinical governance, consumer representation in clinical governance.	Consumer councils working in parity with clinical governance.

Section 3: Current informal and formal BOPDHB mechanisms

There are many existing mechanisms in use across all levels of the organisation and these should be considered as a possible source to obtain consumer feedback information before initiating a new process. The table below includes many of the informal and formal mechanisms currently in use but there may be more.

LEVEL	TYPE
Individual: Patients / Families / Carers	<ul style="list-style-type: none"> • Assessment and care planning • Intentional Patient Rounding • Bedside Handover • Case Management • Tracer methodology (audit) • National Quarterly & BOPDHB Fortnightly Patient Experience Surveys • Mental Health - Marama Real Time Feedback • Ad hoc Surveys / Feedback • Collection of patient / family / carer stories • Feedback received by online form, email, verbal (phone & in person), paper (letter & Do you want to tell us something forms)
Department level: Unit / Ward / Team	<ul style="list-style-type: none"> • Ad hoc Surveys / Feedback • Intentional Patient Rounding • Bedside Handover • Focus groups • Co-design projects • National Quarterly & BOPDHB Fortnightly Patient Experience Surveys data • Mental Health - Marama Real Time Feedback data
Service / Cluster	<ul style="list-style-type: none"> • Ad hoc Surveys / Feedback • Focus groups • Co-design projects • Mental Health Community Advisor • National Quarterly & BOPDHB Fortnightly Patient Experience Surveys data • Mental Health - Marama Real Time Feedback data
Provider Arm	<ul style="list-style-type: none"> • Ad hoc Surveys / Feedback • Focus Groups • Co-design projects • Advisory Groups – Volunteer Patient Advisor Group, Community Health Liaison Group • Consumer representation on organisational committees • Volunteers • National Quarterly & BOPDHB Fortnightly Patient Experience Surveys data • Mental Health - Marama Real Time Feedback data
DHB	<ul style="list-style-type: none"> • He Pou Oranga Tangata Whenua Framework • Stakeholder consultation • Consumer representation / focus Groups / projects • Co-design projects • BOPDHB Pulse Employee Survey • National Quarterly & BOPDHB Fortnightly Patient Experience Surveys / Mental Health - Marama Real Time Feedback data

Section 4: Using the Consumer Engagement Framework



4.1 Involving consumers

Why involve patients and the public? The simple answer to the question is because it is their Health Service.

There is now a widespread realisation that patients' involvement in care improvement is not optional but essential to achieving high quality of care. Understanding the patients' perspective about their experience in the health services can offer great insight to the gaps in service delivery and ways to improve it.

In order to involve patients and the public in a truly meaningful and sincere way, first of all it is necessary to be aware of what actually matters to them - what do they care about and what do they consider to be important elements of service that can make the difference between an excellent patient experience and an average one or a poor one?

NHS research has shown that there are several elements of what matters to patients and that they fall into two categories – Functional and Relational:

<i>What matters to patients? Themes from patient interviews</i>			
		Functional	Relational
Being treated as a person, not a number			<input checked="" type="checkbox"/>
Staff who listen and spend time with patient			<input checked="" type="checkbox"/>
Individualised treatment with no labelling			<input checked="" type="checkbox"/>
Using language that is easy to understand			<input checked="" type="checkbox"/>
Finding out about the latest technologies and innovations medications		<input checked="" type="checkbox"/>	
Feeling informed, receiving information and being given options			<input checked="" type="checkbox"/>
Patient involvement in care and being able to ask questions			<input checked="" type="checkbox"/>
More public awareness about condition		<input checked="" type="checkbox"/>	
Efficient processes		<input checked="" type="checkbox"/>	
Knowledgeable health professionals			<input checked="" type="checkbox"/>
Aftercare support			<input checked="" type="checkbox"/>
Positive outcomes		<input checked="" type="checkbox"/>	
Continuity of care			<input checked="" type="checkbox"/>
Good relationships and positive attitudes among staff			<input checked="" type="checkbox"/>
The value of support services			<input checked="" type="checkbox"/>

4.2 Prepare and plan

Preparing and planning for any consumer and/or community engagement is essential to success. The table below summarises the key features to consider when preparing, planning, engaging, implementing and evaluating.

CONSUMER AND COMMUNITY PARTICIPATION	
Prepare and plan	<ul style="list-style-type: none"> Identify and understand the aims and objectives to be explored and how the stakeholders are affected. Identify risks and benefits Identify internal and external stakeholders – consumers, carers, community, organisations and seek advice and feedback as appropriate Identify health literacy requirements and any health literacy tools Consider timeframe e.g. minimum of six weeks but could be longer depending on complexity of issue
Design	<ul style="list-style-type: none"> Identify communication strategies, agenda, issues, expectations, resources, tools and methods
Engage and report	<ul style="list-style-type: none"> Identify the method of engagement (see Method selection table below), forums, feedback mechanisms and action/task list to meet the objectives through the engagement plan with the stakeholders
Implement	<ul style="list-style-type: none"> Identify time, budget and milestones in accordance with engagement plan and identify lessons learnt
Evaluate	<ul style="list-style-type: none"> Evaluate and assess against the expected outcomes for BOPDHB and stakeholders against the specific aims and objectives Share the learning and integrate the outcomes into relevant practice

Adapted from the Queensland Health Consumer and Community Participation Toolkit 2002

When planning any project, consider any existing mechanisms to capture feedback that may have data/information available for use in quality improvement projects e.g. BOPDHB Patient Experience Surveys, online feedback form, Quality and Patient Safety email address, staff, “Do you want to tell us something” forms etc.

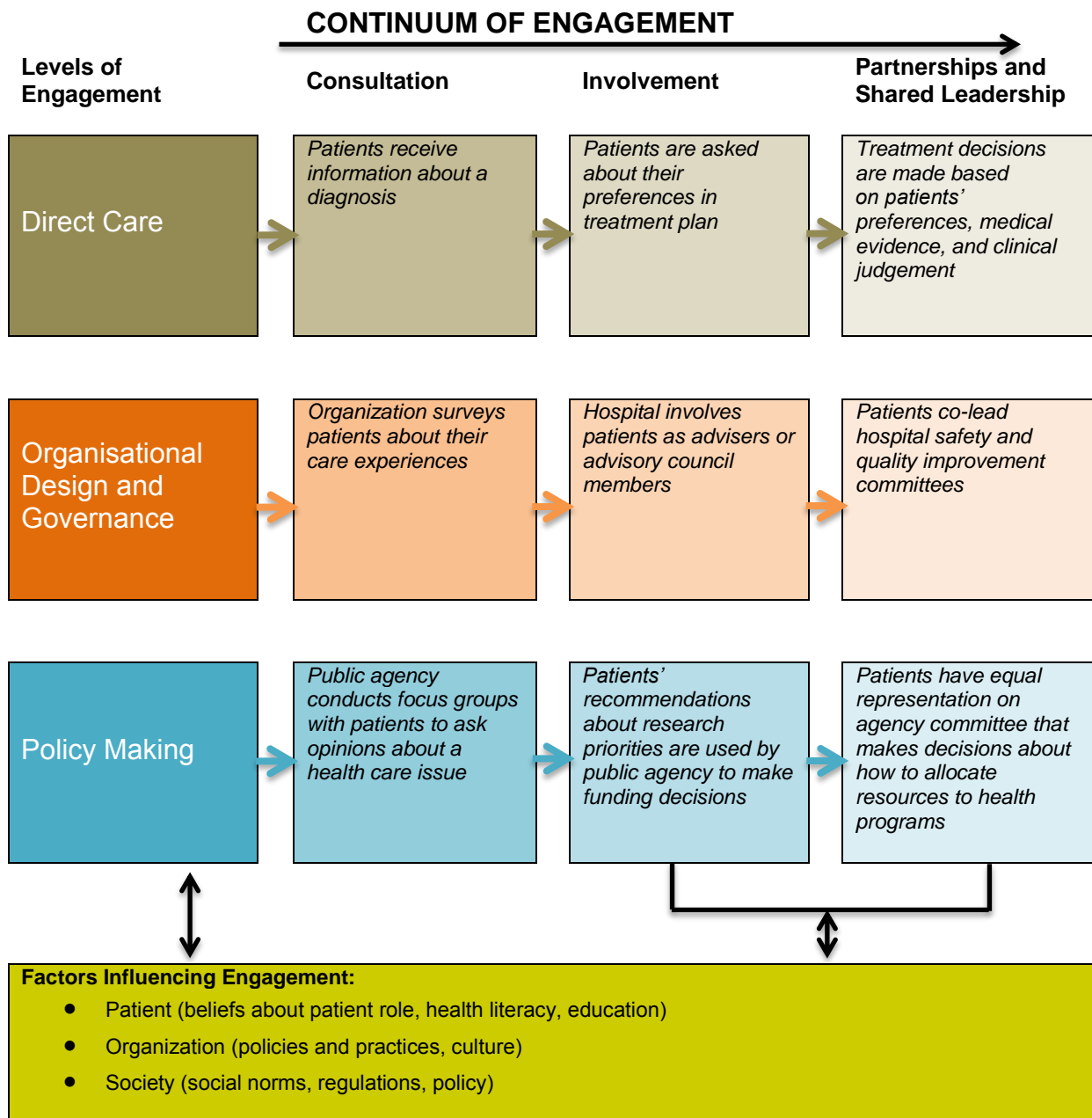
4.3 A Multidimensional Framework Tool for Patient and Family Engagement in Health Care

This multidimensional framework tool demonstrates that patient and family engagement exists in multiple forms along the continuum of engagement. Traditionally, consultative interaction has taken place solely on the lower end of the continuum of engagement. However by moving along the direct care continuum, patient input and shared decision-making increases to involvement and, finally, leads to partnership and shared leadership. The partnership and shared leadership at the higher end of the continuum has communication moving in both directions, and responsibility for decision making is shared. Moving along either the level of engagement or the continuum of engagement axis requires culture change that consists of support and commitment of leadership and providers, patient education, and potential changes to workflow, policies, and procedures.

The framework tool highlights that engagement is not confined to individual health behaviour or direct care interactions, but can include organisational design, governance, and policy making. Consumers can interact in a variety of settings, including community-based services, clinics, and hospitals. Patient and family needs, desires, and preferences can be included in each of these settings along the continuum of engagement.

Using the blank framework tool at the end of this document can assist planning the level of consumer engagement required for any project.

4.4 Continuum of engagement



Source: Kristin L.Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel, and Jennifer Sweeney, "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," *Health Affairs* 32, no. 2 (2013): 223-31.

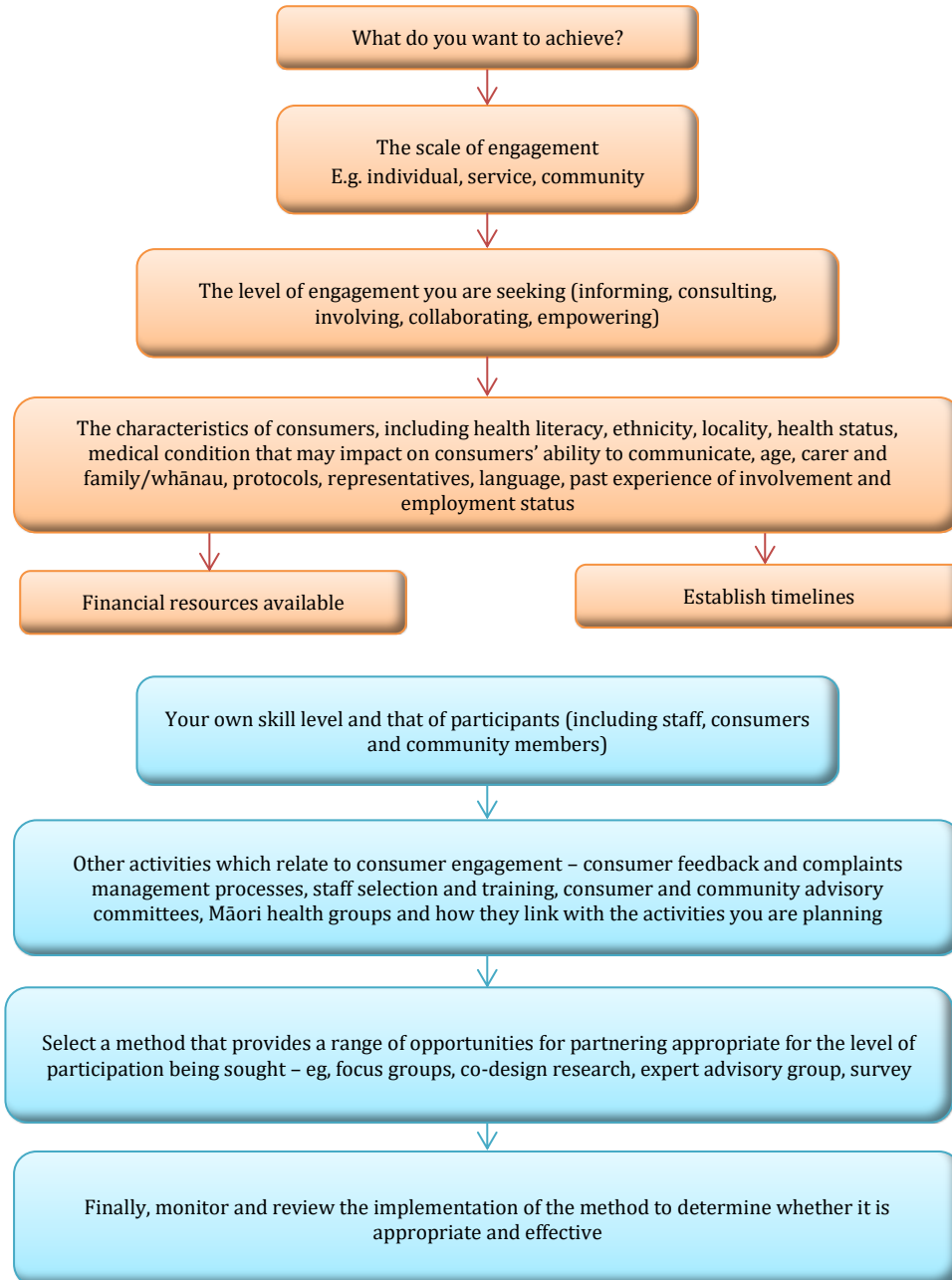
4.5 Method selection

This method selector table is adapted from the Consumer and Community Participation Toolkit, Queensland Health, 2002 and describes some of the more commonly used methods, their strengths and limitations along with tips for their use:

METHODS	STRENGTHS	LIMITATIONS
Survey – can be written, telephone, Email, face to face	<ul style="list-style-type: none"> Email and mail out questionnaires are inexpensive Can cover a wide geographic area Useful for gathering quantifiable information 	<ul style="list-style-type: none"> Questions need to be structured, straight forward and unambiguous Literacy may be an issue Often low response rates Limited opportunity to probe in telephone/written surveys Consumers may not be able to afford or access internet facility.
In-depth interviews	<ul style="list-style-type: none"> Useful to follow up specific issues Provides in-depth information from selected stakeholders 	<ul style="list-style-type: none"> Requires skilled interviewer Time consuming Small numbers – requires careful selection of consumers
Focus groups	<ul style="list-style-type: none"> Quick and low cost Allows exploration of issues identified through surveys Useful for collecting information on a specific issue 	<ul style="list-style-type: none"> May not be representative of consumers Not suitable for information dissemination Not suitable for decision-making Requires skilled facilitator Language barriers
Public meetings and forums	<ul style="list-style-type: none"> Opportunity for anyone to attend New networks created A forum for debating issues Opportunity for information dissemination and sharing 	<ul style="list-style-type: none"> Poor attendance Confidentiality issues Risk of domination by particular individuals or groups Not representative of population or views May be difficult to stay focussed on issue Requires skilled facilitator People with a disability may be disadvantaged (hearing, sight, language)
Consumer representatives on Committees	<ul style="list-style-type: none"> Medium to long term perspective Encourages debate Ensures accountability 	<ul style="list-style-type: none"> Requires orientation and ongoing support Costs / reimbursements Requires organisational commitment to meaningful participation
Workshops	<ul style="list-style-type: none"> Can develop a shared approach to a specific issue Brings together selected people from diverse groups Structured session can produce a plan or recommendations 	<ul style="list-style-type: none"> Small numbers – needs careful consideration of participants Requires skilled facilitator Participants may need particular skills, knowledge or experience
Social Media	<ul style="list-style-type: none"> Effective tool to help engage and disseminate information and resources to large audiences Delivers messages to those who want to receive it Can amplify messages and Celebrate successes Can build and strengthen reputations 	<ul style="list-style-type: none"> Organisational confidentiality and privacy guidelines extend to use of social media Low cost, low time commitment, no advertising required Limited current BOPDHB use of social media (2015)

4.6 Decision Tree

The decision chart below has been adapted for New Zealand by the HQSC and may help you plan for your consumer engagement co-design projects. The selection of methods and techniques will take into account a range of issues including the level of partnering sought, desired outcomes, resources available, views and the needs of consumers and the community, the locality and the skill levels of participants.



4.7 Method Guides

4.7.1 Patient Experience Surveys

All BOPDHB staff can access to the BOPDHB Patient Experience Survey Dashboard through direct login on OnePlace and this is an extremely useful mechanism for inviting feedback from a large number of people using our services. The survey results including free text comments from respondents are available for use and may provide the information you are looking for.

- The National Adult Inpatient Experience Survey is undertaken quarterly when 400 inpatients discharged in the previous two weeks are invited to complete a survey.
- BOPDHB also conducts the fortnightly survey using the same questions

Additional questions can be added to the survey for a period of time. There is a cost involved but this may be of use for large projects to provide a baseline or evaluate results. For more information about the surveys contact your service's Quality & Patient Safety Coordinator.



4.7.2 Co-design Resources

A comprehensive New Zealand co-design resource is available <http://www.healthcodesign.org.nz/> which provides practical information regarding how to effectively plan co-design projects with patient, family and/or carer focus groups/discussions including identifying your target group, inviting participation and selecting a facilitator. There is a hard copy version of this resource available through BOPDHB Tauranga and Whakatane Hospital libraries.

Other external toolkits and sources of information:

- HQSC Partners in Care: <http://www.hqsc.govt.nz/our-programmes/partners-in-care/>
- The Kings Fund Experience Based Co-design: <http://www.kingsfund.org.uk/projects/ebcd>
- NHS Experience Based Design: [http://www.institute.nhs.uk/quality and value/experienced based design/the ebd approach \(experience based design\).html](http://www.institute.nhs.uk/quality%20and%20value/experienced%20based%20design/the%20ebd%20approach%20(experience%20based%20design).html)

4.7.3 Collecting Patient Stories

a) Patient rights, privacy and ethics approval

Contacting patients, families and carers for quality improvement purposes is accepted practice in health care and this framework outlines different ways to engage with patients, families and carers for service improvement purposes while maintaining due respect for the ethical principles of:

- Avoiding undue pressure or coercion
- Informed consent
- Maintaining privacy and confidentiality
- Providing a mechanism for withdrawing

Collection of patient stories can only be undertaken with consent. The consent and registration form included in this framework. At the beginning of any discussion, staff are encouraged to ensure the participant fully understands the process and formally consents to participation. Staff should explain the purpose of collecting a story, answer any questions the participant may have, confirm the mechanisms available to protect the confidentiality of the story and ensure the participant knows how to withdraw their consent if required. Participants can also nominate an 'alias' for use in their story if they prefer.

Ethics approval is only required in situations in which people will be asked for confidential information about their condition, medical history, clinical treatment or clinical outcomes. For further information please contact BOPDHB Ethics Committee.

b) Staff Responsibilities

Any staff member collecting patient stories is responsible for:

- Gaining consent and registering the collection of the story with the Quality and Patient Safety Administrator (qualityandpatientsafety@bopdhb.govt.nz).
- Recognising own limitations and acknowledging when they need advice and support

If the participant reveals something during the interview that may necessitate further discussion, investigation or action, the BOPDHB Complaints and Incident Reporting policies should be followed:

- Recognising when issues revealed need to be acted on and how to do so
- Discontinuing the interview if the participant is distressed and indicates that they wish to terminate the interview
- During the interview the interviewer will not react at the time, but may raise an issue again once the interview is completed
- If immediate action is required, the participant can be asked whether they have raised their issue/concern with anyone in the organisation and provide information to the participant on how this may be done
- Information obtained at the interview is confidential, it may not be appropriate for the interviewer to take matters forward without the participant's specific consent to do so.
- For more support or advice please contact the Quality and Patient Safety Team.

c) Sharing Patient Stories

Not all BOPDHB staff trying to improve care processes will have the access, skills, time and ability to run patient focus groups, undertake surveys or interview patient groups. It is important, therefore, to ensure that any stories that are collected can be shared to ensure knowledge, learnings and solutions are to be shared with other areas experiencing similar issues.

If you have already conducted (or you are planning to conduct) interviews with patients please consider gaining the participants permission to share these stories across the organisation. Once consent is gained stories may be submitted to Quality and Patient Safety in the form of written transcripts, and/or patient surveys where qualitative comments have been provided. Notation of audio or digital (AV) recordings can also be stored but these files will be stored by the Digital Communication Team.

All submissions for inclusion on the Patient Stories database must include a completed consent and registration form, information on when and how they have been collected, how they can be used and emailed to: qualityandpatientsafety@bopdhb.govt.nz.

Staff accessing a Patient Story from the request a transcript or file, providing that:

1. The story is not altered or modified in any way
2. Acknowledgement is given to the project team that provided the patient

3. Feedback is provided to the Patient Stories team via email when a patient story has been used and whether the story was successful in achieving the desired result (qualityandpatientsafety@bopdhb.govt.nz).

d) Should we talk to patients and carers together

There are advantages and disadvantages to talking to both the patient and carer together. By talking to both, you often hear from both perspectives at once, however, the relationship between the patient and carer may make it difficult for one or the other to be completely forthright. For example, carers may not be completely honest or provide adverse information about the journey for fear of upsetting the patient or vice versa. Be guided by the preference of the patient and carer.

e) Guidance for Video or Digitally Recorded Stories

Videoining or audio-recording conversations may have some advantages in improving transcription; however it may also act as a barrier to open discussion and make the process too formal. Therefore, recording discussions is not generally necessary or recommended. This method of recording stories should only be chosen when the desired finished product is a video or audio recording of the patient/family member/carer talking about their experiences e.g. a video of the patient (video story), or as a photographic slideshow overlaid with an audio recording of the patient (audio story). There are additional issues to be considered by both the story taker and participant.

- ***Technical issues***

In order to record good quality audio-visual (AV) material, the interviewer will need to work with a Multi-Media Designer. Equipment to produce the recording may include a video camera with inbuilt microphone, an external microphone and an audio field recorder. As the set-up and use of AV equipment is a specialist role in its own right, interviewers must approach and organise with appropriate staff with the time and skills to assist them, advice can be sought from the BOPDHB Digital team.

- ***The interviewing space***

As the equipment will record all sound as it is heard within the interviewing space, a number of issues become significant. The identified space should be quiet and unlikely to be disturbed, away from sources of noise, such as photocopiers, ticking clocks and loud computers or busy roads outside the window. Consideration should also be given to the weather, as rain on the roof or a howling wind will also affect the sound recording. The space must also be acoustically suitable, in that the space does not echo e.g. spaces with soft furnishings have fewer echoes than spaces with hard surfaces and windows.

All of the above apply to audio recordings. If the story is to be video recorded, the space should also have a plain wall or suitable backdrop for the video and be well and softly lit, so that harsh shadows are not cast.

- ***Interviewing techniques suitable for audio-visual recording***

As a good digital story will not give any indication of the interviewer, the importance of asking open questions is paramount while remembering that whatever is said by the interviewer will also be recorded, and so the interviewer must avoid things like giving verbal encouragement to the storyteller. Before starting the interviewer should encourage the storyteller to phrase their story in whole sentences as this makes the editing work easier.

- ***Translation and bilingual issues***

Participants may want to give their stories in their own language of choice, options for translation should be discussed with the participant and they should be matched with an interviewer who is able to communicate with them in their language of choice and has the ability to translate if required (<http://oneplace/Org/Pages/Interpreters.aspx>). Some of the issues encountered may be:

- a. Participants who are fluently bilingual may be happy to record their experiences in different languages, which will ensure that the participant's own words and emphasis are retained.
- b. Dubbing another language over the video or photographic slideshow will require the original story to be transcribed verbatim, translated and then recorded in another language by a fluent speaker. This new audio track will then need to be edited with the video to create a new version of the patient story.

- c. Subtitling the original story will need transcribing and translating and then edited into the video by a Multi-Media Designer or transcribing to provide as a bilingual written version.

f) Timescales

Producing a video or audio story can be a time consuming process. An hour-long interview may be cut down to two or three minutes of the most powerful material and additional time will be required to edit the recording.

g) Formats, storage and archiving

To make digital patient stories as accessible as possible across the organisation, each finished story is saved both as an .AVI file at high resolution, and as a .mpg lower resolution file that can be played by Windows Media Player. Stories which have been produced purely on audio, with no accompanying video or graphic images, are saved in mp3 format.

Both the finished product and the original recording are saved to a designated standalone space held by the digital team, or to DVD. Consideration should be given to the confidentiality and sensitivity of the information of both the original and finished story when arranging how to save and store the files, as well as any specific instructions the participant has given as to the handling of their story. A copy of the finished product on DVD can also be sent to the Patient Stories Administrator, Quality and Patient Safety

For further Information about collecting your patient audio-visual (AV) story please contact the BOPDHB Digital Team.

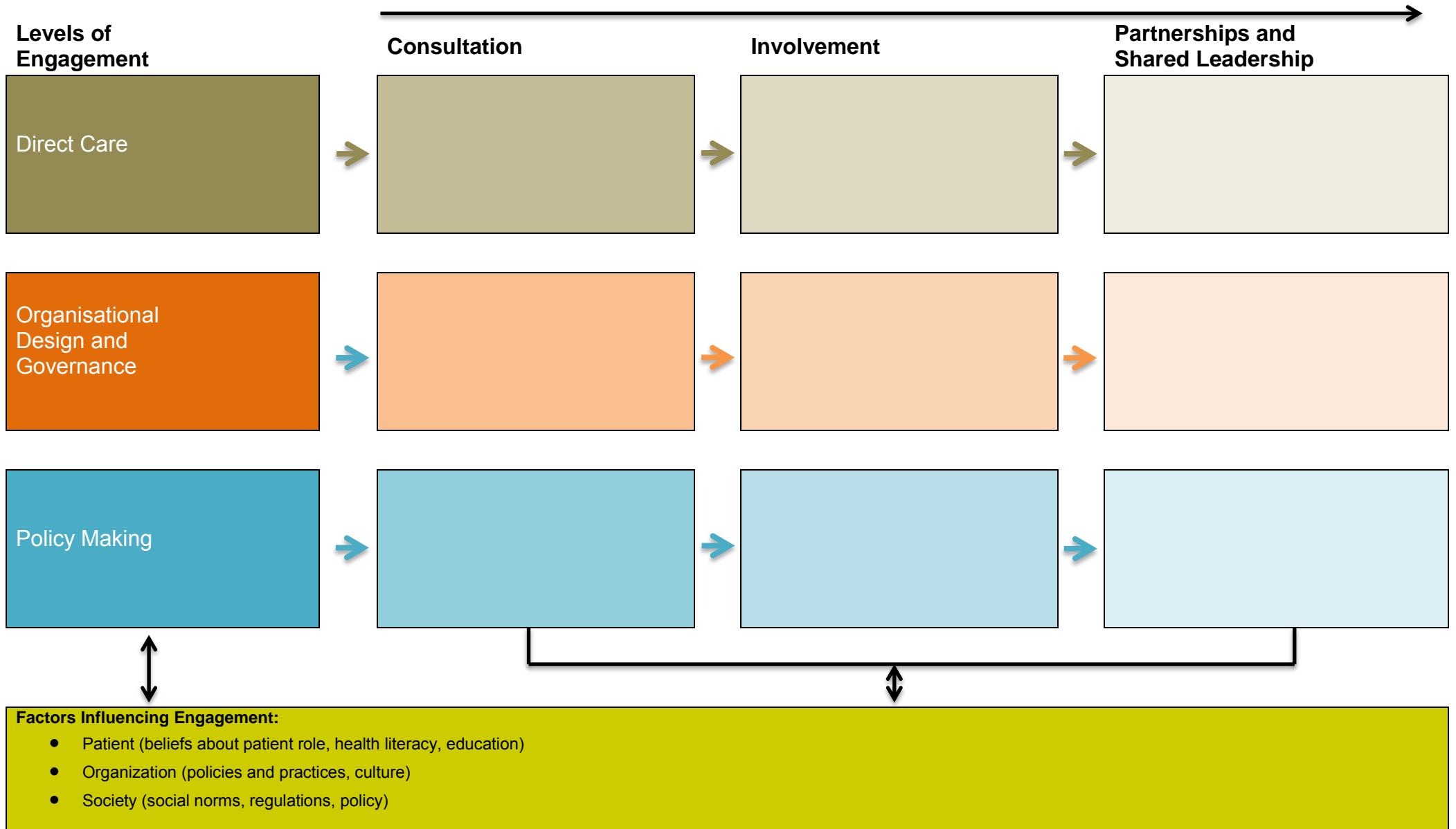
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2. Health Consumers Queensland. (2012). [Developing a consumer and community engagement strategy: a toolkit for Hospital and Health Services](#). Brisbane, Australia: Queensland Government.
3. South Australia Health (2013). [Guide for Engaging with Consumers and the Community](#). N.p.: Government of South Australia.
4. Kristin L. Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel, and Jennifer Sweeney, "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," *Health Affairs* 32, no. 2 (2013): 223-31.
5. Bay of Plenty District Health Board. (2015). *Annual Plan 2015/16*. Tauranga, New Zealand
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7. Bay of Plenty District Health Board. (2015). *Health Excellence Strategic Plan 2015-17*. Tauranga, New Zealand
8. Bay of Plenty District Health Board. (2007). *He Pou Oranga Tangata Whenua Framework*. Tauranga: Design and Print Management Limited.

Consent and Authority to use Patient Story Form			
<i>Copy for patient/Carer and copy to Quality and Patient Safety</i>			
<p>1. I have read and understand the Patient Stories - Information for Patients sheet and have had the opportunity to consider the information, ask questions and have these answered satisfactorily.</p> <p>2. I understand that my participation is voluntary and I am free to withdraw at any time and I can ask for any comments I have made on tape, in writing or on film to be removed.</p> <p>3. I understand that my story (or part of it) may be used in different formats such as video, paper and/or electronic and be share with others for the benefits of designing services and education.</p> <p>4. I understand that transcripts of my story will be stored in a safe environment and disposed of in a confidential manner.</p>			
Patient / Carer Name:		Contact number:	
Address or email:			
Patient / Carer Signature:		Preferred Alias	
Signature of witness:		Date:	
For Internal Use Only			
Staff member (print name):			
Department / Service		Extension:	
Email:			
Staff member Signature:		Date:	
Purpose and planned use of story collected:			
File name and location:		Content identifier:	
<p><i>Completed Patient Stories Consent and Registration forms must accompany all submissions of Patient Stories – scan and email to: qualityandpatientsafety@bopdhb.govt.nz</i></p>			
<i>Date consent withdrawn by storyteller:</i>		<i>Date story removed from database and disposed:</i>	

A Multidimensional Framework Tool for Patient and Family Engagement in Health and Health Care

CONTINUUM OF ENGAGEMENT



Capturing Patient Stories – Quick Guide

Checklist for Opening Discussion	Capturing Patient Stories – Quick Guide		Checklist for Closing Discussion
<ul style="list-style-type: none"> • Introduce yourselves (name, position/role, business unit) • Thank participant(s) for their time, honesty and willingness to speak with you • Advise participant how their story will be used, confirming that their information will assist in developing solutions to improving services, provide overview of project • Refer to contacts within the consent form if they have any questions or concerns and reaffirm their privacy will be protected and confirm their ability to withdraw their story at any time by returning portion of consent • Obtain written consent if not already received • Ask if participant has any questions or concerns prior to conducting the discussion 	1. Contact the Patient &/or Carer Telephone / Letter / in person		<ul style="list-style-type: none"> • Thank the participant • Explain the process of what will happen next and that a draft copy of the story will be sent to them for verification and/or editing • Ensure participant has copy of consent form and Patient information sheet • Ensure you have obtained a signed copy of consent from participants prior to departure • Ask if participant has any questions or concerns prior to concluding the discussion
	2. Schedule Discussion Invite patient/Carer to determine date, time & venue Schedule two staff to attend, allow at least an hour		
	3. Conduct Discussion Ensure a quiet, private space to maintain confidentiality		
	4. Resources to take Identification, mobile phone (in silent mode), transcript & consent form		
	5. Analyse Results Write up the story in the patient & carers voice using as many direct quotes and phrases as possible Follow up on any issues or concerns raised within agreed timeframes		
	6. Provide Feedback Send Thankyou letter to patient/carers with a copy of their story for verification and/or editing – enclose postage paid envelope to facilitate return of amended story		
	7. Contact the Patient &/or Carer Complete Patient Story Registration & Transcript forms Scan & email all with consent form to qualityandpatientsafety@bopdhb.govt.nz		
	Practical Tips		<ul style="list-style-type: none"> • Take extra pens • Take a clipboard to support you as you write • Ask the participant if they have any pets and ensure it will be safe for staff to enter the participant’s residence (if required), also consider that some staff may be affected by cigarette smoke and pets when making arrangements • Choose attire that is professional and will not be intimidating to the patient/carers

From John Powell

Please see below a document put together by Adrienne and Rosalie. Thanks to you both for your input.

Please read so we can discuss at the next meeting.

HEALTH CONSUMER COUNCIL

SUBJECT: Agenda Item 11 July 2018: Is there an alternative to the word patient?

Draft response to BOP DHB Board

Background

At the first meeting of the Health Consumer Council on 11 July a paper was presented on the question of whether a new word for 'patients' was needed – a matter that had been discussed at a DHB board meeting in April and deferred for further thought.

In discussion around the Consumer Council table, two counteracting views in past debate around the world were noted:

- the perceived 'negative' connotations associated with the word 'patient' which supported the case for a new term;
- the lack of an obvious alternative, along with the time, effort and resources that would be involved in introducing a different term.

Of the options suggested in the paper ('client', 'customer', 'consumer', 'user'), none found favour with Council members as a replacement for 'patient', although wide acceptance of the term 'consumer' was noted and seen as appropriate where referring to the public as users of health services, and past or future patients and/or their whānau.

Also noted from the paper was the progressive move towards reframing the use of the word 'patient' in ways that emphasise patient benefit, as for example in patient-centred care, patient experience (including patient stories), patient rights, and patient safety. The paper suggests this shift might be 'the better way to go'.

Discussion of the concept of patients as people seeking to be made well through healthcare services, and in their interactions with healthcare workers, led to the suggestion of proposing the phrase 'Tangata Whaiora' ("people seeking wellness"), either as an alternative to, or to be used in conjunction with, 'patient'. Depending on the context, usage options could thus be:

- 'patient' on its own
- 'tangata whaiora' on its own
- 'patient/tangata whaiora'.

Draft recommendations for consideration

The Health Consumer Council recommends/proposes that:

1. The word 'patient' be retained as the primary generic word defining the person seeking wellness, receiving medical treatment or registered to receive medical treatment.
2. The term Tangata Whaiora which means 'seeking wellness' be integrated into the terminology used by the BOP DHB and staff.
3. The focus shift from shaping terminology around care to shaping a care culture, where there is an emphasis on respect shown from medical staff to patients, where patients are not treated dismissively, or spoken about in their hearing, but included in conversations about their wellbeing and care.

Points for further discussion at August meeting of Consumer Council:

1. Do Council members wish to make specific recommendations to the Board?
2. Should our response include suggestions as to how a new term ('tangata whaiora') might be applied in practice, eg would it work in the context of medical usage, as in the example in the paper 'ambulatory health seeker'? Or might we propose the use of 'tangata whaiora' and 'patient/tangata whaiora' in particular situations – eg signage, pamphlets, forms?
3. What protocol should be followed if/before we were to propose the adoption of a te reo Māori term? DHB staff advice to be sought.

**Bay of Plenty District Health Board
Health Consumer Council Committee Interests Register**

(Last updated 12/07/18)

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST	DATE INTEREST EXPIRED
GENET, Julia					
Healthcare Rehabilitation Tauranga	Employee	Heath			
Access Ability Charitable Trust	Trustee	NASC & L.A.C			
Imagine Better	Director	LAC / Health and disability			
New Breeze Limited	Director	EIF Health and disability			
Training as a Registered Career force Assessor	Trainee	Health			
HANSEN, Wol					
HORNE, Susan					
**	Employee	Education			
**	Member (previous) management team	Strengthening families			
LIDDLE CRAWFORD, Rosalie					
Sun Media	Independent contractor	News/Media			
BOP Film	Volunteer	Film making	None		
Curate Church	Member	Community/religious	None		
MACKENZIE, Tessa					
Natural Assets Limited (can include working for the DHB at times)	Director	Social Change and Professional Development			
Social Link	Board Member				
MATTHEWS, Susan					

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST	DATE INTEREST EXPIRED
Toi Ohomai Institute of Technology – 4 month contract Nursing Lecturer BN Year 2		Education			
Health Practitioner Disciplinary Tribunal – Nursing					
Paengaroa Community Association	Chair				
Western Bay Museum	Trustee				
BOP Community Response Forum (Oranga Tamariki)	Deputy Chair	Health			
MCKEVITT, Maz					
Husband Jim McKeveitt is an employed GP as Greencross owned practice “The Doctors – Phoenix” in Whakatane	Wife	Health			
Husband Jim McKeveitt is on the EBOP Hospice Board of Trustees	Wife	Health			
CABNZ National Board member	Trustee				
CAB Whakatane Board member	Trustee				
McKeveitt Family Trust	Trustee	Trust	Low		
Hoed	Secret Shopper				
Teams in Business	Independent Contractor				
Phoenix Health Centre	Independent Contractor				
MURPHY, Lisa					
John Goss, former Parliamentary Members & Associate Member Commonwealth Parliamentary Association, Queensland Branch, Australia	Business Association				
POWELL, John					

INTEREST	NATURE OF INTEREST	CORE BUSINESS	RISK OF CONFLICT	DATE OF INTEREST	DATE INTEREST EXPIRED
U3A Tauranga	President				
St Johns	Volunteer				
Justice of the Peace	Volunteer				
Positive Ageing forum Tauranga City Council	Committee Member				
BOPDHB Health Liaison group	Committee Member				
TROUT, Florence					
Te Wang Quality Program	Advisor and Reviewer Quality Certification	None			
VON TUNZELMANN, Adrienne					
Pharmac Consumer Advisory Committee	Committee Member				
Age Concern NZ	Vice President				
Age Concern Tauranga	Board Member				
Tauranga Community Housing Trust	Patron				
Te Whare Wananga o Awanuiarangi	Council Member				
Ageing Well National Science Challenge	Governance Group Member				



CORRESPONDENCE FOR NOTING

SUBMITTED TO:

Health Consumer Council: 8 August 2018

Prepared by: Cherie Martin, Legal Executive

Endorsed by: John Powell, Chairperson

RECOMMENDED RESOLUTION:

That the committee note the inward and outward correspondence:

- Email from Arana Pearson, Peer Support Worker, Whakatohea Social & Health Services to BOPDHB dated 17 July 2018.
- Email from Averil Boon, BOPDHB to Arana Pearson dated 19 July 2018.
- Email from Arana Pearson to Averill Boon dated 23 July 2018.

Cherie Martin

From: Cherie Martin
Sent: Friday, 27 July 2018 09:32
To: Cherie Martin
Subject: FW: Introducing the new Bay of Plenty Health Consumer Council

From: Arana Pearson [mailto:Arana.Pearson@whakatohea.co.nz]
Sent: Monday, 23 July 2018 9:41 AM
To: Averil Boon
Subject: RE: Introducing the new Bay of Plenty Health Consumer Council

Thank you. I am in regular contact with Sherida Davy re: mental health consumer participation coordinator, and I trained that group in participation last year in Tauranga. However, Sherida remains clear with me that she works with Tauranga and not the eastern bay with the consumer participation group.

There is a systemic gap in the DHB regarding consumer participation in the Eastern bay.

How are we going to remedy this gap I wonder? Any ideas? It appears to me the lack of systemic participation in the Eastern Bay is something that is pervasive and probably stems back from when the two health authorities merged into the one BOP DHB. It plays out in both practice and access owing to less resource available also, so the more east one travels, the less health access to services. The closer to Tauranga one gets, the more concentration of resources. The lack of participation means there is no representation.....and so the systemic gap is perpetuated. The Majority of Maori live in the East, and it is interesting the BOP health consumer council has yet to secure participation of Maori on its membership. In Opotiki Maori make up 56% of the population (a majority).

These three areas: mental health participation, Eastern Bay participation and also Maori participation appear to me systemically neglected in the establishment process for the BOP health consumer council and also in the other BOP DHB consumer groups. This needs urgent solutions or we will continue to have a DHB that continues to marginalize these three populations in the health district.

Ngā Mihi

Arana Pearson

Peer Support Worker



**TE POU ORANGA O
WHAKATŌHEA**

Whānau Ora, Hapū Ora, Ka Ora ai te Iwi

Whakatōhea Social & Health Services

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From: Averil Boon [mailto:Averil.Boon@bopdhb.govt.nz]
Sent: Thursday, 19 July 2018 7:20 AM
To: Arana Pearson <Arana.Pearson@whakatohea.co.nz>
Subject: FW: Introducing the new Bay of Plenty Health Consumer Council

Hi Arana,

Thank you for contacting us with your queries for the BOP Health Consumer Council (BOPDHB) which was forwarded to me from the Communications Team.

The establishment of the has been a lengthy process over the last year, with expressions of interest called for in January & February this year. We received a great response and the selection process looked at all sorts of criteria of the applicants before confirming the members for the inaugural council.

All members have established networks with their communities. The council will also have this [page](#) on the BOPDHB website which will develop as the Council becomes more established. The Terms of Reference will also be available on this page once they are confirmed and ratified by the Council and CEO – these are currently being developed by the Council. An email link is also provided on this page to contact the council through the Quality and Patient Safety email.

It was decided to get the Council up and running, rather than waiting till we had things “perfect” and let the Council develop and grow over the first year and then review. We are aware that some areas are underrepresented e.g. Maori and Eastern Bay but are currently looking at ways to strengthen Maori membership with the General Manager Maori Health Gains and Development and it is planned to have an additional 2 or 3 members to represent Maori at every Council meeting. We also plan to target specific area of representation if/when future vacancies arise.

In regards to the individual members life experience and their personal experience of using health services for themselves, family members or other loved ones, this is not included in their published profiles but I can assure you it is there, it is extensive and it is varied.

BOPDHB also has several other groups/committees where those with experience of the DHBs services can be involved:

- [Volunteer Patient Advisory Committee](#)
- Community Health Liaison Group – representatives of community organisations – contact through communications@bopdhb.govt.nz
- For Mental Health Consumer Participation Coordinator contact Sherida.Davy@bopdhb.govt.nz

I hope this has responded to your queries.

Regards

Averil

Averil Boon

Programme Manager

Quality and Patient Safety

Bay of Plenty District Health Board, Private Bag 12024, Tauranga 3143

Phone 07-5798968

averil.boon@bopdhb.govt.nz

From: Arana Pearson [mailto:Arana.Pearson@whakatohea.co.nz]
Sent: Tuesday, 17 July 2018 4:22 p.m.
To: James Fuller
Subject: FW: Introducing the new Bay of Plenty Health Consumer Council

Thank you James for letting us know about the BOP health consumer council which has just now come to my attention. I have a background in consumer / service user perspectives and have worked in the sector in consumer roles for twenty years now including the mental health commission.

I'm wondering whether or how Mental Health is included in this kaupapa? There appears many people on the council have a background in education, and I do not read anything here about people identifying as consumers of services themselves in the C.V's here below. I would have thought that a consumer health council might have sought out people with personal experience of being consumers of services and how to use that experience to develop better services. I currently work in an iwi provider in the Eastern bay (Opotiki) where none of the clients with mental health services have shared services plans at all, and our measure for integration this year is us reporting on how many clients in common with secondary BOP health services have shared services plans. It is information such as this that may enhance the work of a consumer council. So my questions include a) how is the consumer council proposing to network with consumers of services in the BOP? B) What is the terms of reference for the consumer council and what input from consumers of services has there been to develop those terms of reference? d) is the council sure it has good input and networking from consumers of mental health services across the BOP and how does the council demonstrate that participation? d) how does the consumer council demonstrate networks and effective representation of iwi Maori on the council?

I look forward to a fruitful and ongoing dialogue with you and the BOP health consumer council in the hope for better integration of health services for our people.

Ngā Mihi

Arana Pearson

Peer Support Worker



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Monday 9 July, 2018

Introducing the new Bay of Plenty Health Consumer Council

Eleven people have been selected to the newly established Bay of Plenty Health Consumer Council (BOPHCC).

The council will work in partnership with the Bay of Plenty District Health Board (BOPDHB) as an advisory body ensuring patient and community perspectives are a core ingredient of how services are developed.

It aims to enhance consumer experience and service integration across the sector. It also intends to promote equity and ensure that services are organised around the needs of the people in our communities.

The council will have input, and advise, on issues including development of health service priorities, enhancing patient safety and clinical quality and reducing inequities.

The council will meet monthly and holds its first meeting on Wednesday (11 July 2018). John Powell will act as Chair and Sue Horne as Deputy Chair. The 11 members are profiled below.

BOP Consumer Council members

Adrienne von Tunzelmann

QSO, M.A. (Hons) Canterbury, Master of Public Policy

Adrienne has an extensive public sector background, and has held governance positions at both a community and national level. She currently sits on the boards of Osteoporosis NZ, Age Concern NZ and Age Concern Tauranga. She is on Pharmac's Consumer Advisory Committee; the Ageing Well National Science Challenge's Governance Group, is a patron of the Tauranga Community Housing Trust and is on Te Kaunihera o Te Whare Wānanga o Awanuiārangi.

Her health-related roles have convinced her that the easier it is for the voices of consumers to be heard, and for them to influence the services they use, the better the health and wellbeing outcomes for patients, their whānau and communities.

Adrienne is a Chartered Fellow of the Institute of Directors and in 2016 was awarded the QSO for services to governance and the community.

Florence Trout

RGON, RM, Tutor Cert (CIT), Plunket Nurse, Service Quality Auditor, BA (Massey, NZ), MPhil (Massey, NZ).

Florence has a solid health background as a public health nurse, midwife, nurse educator and quality improvement practitioner. Her experiences as a primary healthcare professional, NGO board member, and life experiences with family, confirm her belief that healthcare requires compassion and respect for dignity. She also believes in easy access of healthcare for a growing population, distinguishing universal healthcare from other healthcare options.

Florence currently serves as an advisor to the community quality accreditation program Te Wana, recognised by the Ministry of Health. She has a diverse range of interests including rural and agricultural lifestyles, travel, and the arts.

John Powell

MBA

John served in the NZ Army Medical Corps as a territorial force officer, retiring as a Major (ED). He has worked in both the public and private health sector in management roles. John is an active volunteer. Currently he's enjoying serving as a Justice of the Peace and as President of U3A Tauranga. John moved to Tauranga with his wife Elizabeth nearly 12

years ago. He has a passion to see inequalities experienced by New Zealanders across a range of health matters reduced.

Julia Genet

Julia has worked in the health and disability sectors for four decades. She is currently a Trustee of AccessAbility and Director of Imagine Better. She is a founding director of a family governed service established in 2004 to manage her son's Enhanced Individualised Funding.

A Registered Nurse, Julia was a government appointee to the Hawke's Bay Area Health Board and worked in the communications team for the Central Regional Health Authority. She has been a member of voluntary organisations both nationally and locally.

Julia attributes her passion in the health and disability sector, to experience and knowledge gained from her autistic son, and from supporting her husband who sustained a severe brain injury in 2000.

Lisa Murphy

Lisa has a background in Diagnostic Haematology and Sports Medicine. Building on these skills, she furthered her studies with an Associate Diploma in Business Management before embarking on a corporate career within the finance and insurance sectors for multinational companies.

Lisa has strong organisational and risk management skills, and possesses a forward-thinking approach to strategic planning. Committed to the retention and harnessing of lasting relationships with stakeholders, patients, and intermediaries with respect, dignity, and delivery of quality service being paramount.

Lisa has a particular interest in investigative research and advocacy, ensuring everyone can access quality healthcare and approaches to maintain effective governance and compliance. She lives with her daughter in Tauranga.

Maz McKevitt

B.A. (Otago) Dip.Tchng (Christchurch) Dip.BusSt (Massey)

Maz has lived and worked in Whakatāne for 30 years, appreciating all it has to offer she is a committed supporter of the Eastern Bay. She has an extensive background in education and health administration working for a number of local schools and organisations.

Volunteering for the Whakatāne Citizens Advice Bureau (CAB) for the past three years she is a member of the local Board and the CAB National Board. Maz has a keen interest in governance and is focussed on ensuring that strategic decisions accurately reflect local level needs. She enjoys the team approach to problem solving and is motivated to make a difference to the effective delivery of healthcare across the Bay to improve the well-being of its people.

Rosalie Liddle Crawford

NZCS (Paramedical), Specialist in Immunohaematology, Cert.Medical Microbiology, PGDip.Management Studies (Waikato), ATCL (Music Teaching)

Rosalie is a medical scientist and lecturer who has specialised in Immunohaematology and Medical Microbiology. She began her career at Tauranga Hospital, before moving to the Wellington region where she continued working in medical laboratories and lecturing at Central Institute of Technology (CIT).

Returning to the Bay, she took up a role developing an online health and social services directory for both the BOP and Lakes DHB regions, before helping launch a similar directory for Canterbury. Her work has involved engaging with iwi, councils, health and social service organisations and businesses; providing service navigation; and setting up the volunteer project 'Rise Up Tauranga'; which assisted Cantabrians relocate into the Western BOP as a result of the 2011 earthquakes.

Rosalie's utilisation of technology, plus her adaptive influence across sizeable networks, has resulted in channelling the resources and drive of ordinary people like herself with something to contribute; turning their energy into effective action that improves lives.

Sue Horne

Dip Teaching

Sue is currently Principal of Maungatapu School, a role she has enjoyed for 16 years. Her education career spans more than 40 years teaching in Palmerston North, South Auckland, and Tauranga. She has a particular interest in supporting children with additional needs. Sue has experience working alongside teachers, families and whānau, developing programmes and strategies to assist students with special needs to access the curriculum and to be able to participate confidently and successfully in school and community activities.

Maungatapu School is a dual medium school offering education in both Māori and English. Sue has supported the ongoing development of the dual medium status of the school and has fostered initiatives and opportunities for staff, pupils, and their families and whānau, to access quality learning opportunities in both English and Māori medium contexts.

Sue Matthews

RN, BN, BA (Education major), MEd

Sue is strongly committed to making a positive contribution to improving health outcomes and strengthen each patient's journey throughout the health system. Until recently she was employed as a Community Health Lead for Eastern Bay Primary Health Alliance in Whakatāne and is now employed as a Bachelor of Nursing lecturer at Toi Ohomai Institute of Technology.

Sue is a member of the Health Practitioners Disciplinary Tribunal for Nursing and Deputy Chair of the BOP Community Response Forum - Oranga Tamariki and she volunteers as Paengaroa Community Association Chair and Western Bay Museum trustee.

In 2013 Sue was made a Member of the New Zealand Order of Merit for her contribution to community health – including Māori. She has previously been on the National Child & Youth Mortality Review Committee and was a trustee for Poutiri Charitable trust. Sue also has an understanding of community from a local body perspective as a Western Bay District Councillor from 2007-16.

Tessa Mackenzie

BA (Soc Pol); Dip Hom NZ; PGCert Prof Sup (Soc Wrk & Couns)

Tessa has worked in the community and social sector for 20 years, from grass roots to governance positions. She has been a Strengthening Families coordinator facilitating hundreds of meetings for families. This experience has given her insight into what works and where issues arise when it comes to accessing and receiving a wide range of healthcare options.

Sue has often been a voice for others, and is not afraid to challenge the status quo to support people to have a say in their own health journey.

Wol Hansen

Psychologist, MSS (Psychology)

Wol is a psychologist, currently working at Whaioranga Trust in Welcome Bay and Tauranga. He has worked for Māori Hau Ora services for the last eight years. Prior to that he was with Relationship Aotearoa and BOPDHB. The community is his focus and he brings to the position a wide range of life skills and experiences.

For more details contact:

James Fuller

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