Corporate : Population Health & Disability
Proactive Release: 08 April 2020

18 March 2020

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Dear 9(2)(a)

Official Information Act (1982) Request

I write in response to your Official Information Act request, received by us on 24 January 2020. You requested information related to WAI 2575 Health Services and Outcome Kaupapa Inquiry (request attached to this response). Thank you for acknowledging our notice of extension on 04 February to prepare this response.

As context for this response, Counties Manukau Health (CM Health) provides health and support services to people living in the Counties Manukau region (approx. 569,400 people). Our services are delivered via hospital, outpatient/ ambulatory and community-based models of care. We employ more than 7,500 staff, and see more than 118,000 people in our Emergency Department each year. We receive more than $1.6 billion from the Government to deliver these services.

Based on the scope of questions, we have worked to provide as much information as we have available at this time, noting cases where we do not have information available. Should any of our response require further clarification or details, we welcome further opportunities to discuss this with you. In the first instance, contact the CEO Office, who can identify the most appropriate DHB points of contact.

As a District Health Board, Counties Manukau DHB (and CM Health as provider of key services, alongside our contracted partners), recognise and adhere to a number of Statutory and Legislative requirements, and work closely with the Ministry of Health on regular and comprehensive reporting.

Our strategy and planning cycle consistently reference the importance of health equity, both in provision and outcomes. However, in providing services to the entire community of Counties Manukau as our core business, we do not currently routinely distinguish services provided to people with disability (Māori or non-Māori), and recognise that a variety of other agencies both directly and indirectly fund and support this community (including Ministry of Health for provision of Disability Support Services to those aged under 65 years, and ACC for those with disability due to accidents, along with the services of Ministry of Social Development, primary care and NGO/ voluntary sectors).

Along with a number of documents referred to in this response, we believe the CMDHB Annual Plan, Annual Report, and Māori Health Plans – all publicly available on our website:

- https://www.countiesmanukau.health.nz/about-us/performance-and-planning/planning-documents/.

We have also provided initial information under the Official Information Act process in 2019 to the Waitangi Tribunal Kaupapa Inquiry, and this is publicly available on our website.

- https://countiesmanukau.health.nz/about-us/official-information-act-requests/publicly-released-oias//show/87

Our responses to each of your questions are attached (**appendix 1**)

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive Officer
Counties Manukau Health

Appendix 1

RE: OFFICIAL INFORMATION ACT 1982 REQUEST – WAI 2575 HEALTH SERVICES AND OUTCOMES KAUPAPA INQUIRY ("THE HEALTH INQUIRY")

DISABILITY SUPPORT SERVICES

4. What eligibility restrictions for accessing disability support services does Counties Manukau District Health Board ("CMDHB") use?

In New Zealand, the Ministry of Health defines that:
To be eligible to access publicly-funded *Disability Support Services* (DSS) in the health and disability system, a person must have a disability - as defined by the NZ Government's definition of disability:

> *"A person identified as having an age-related, physical, intellectual, psychiatric, or sensory disability (or a combination of these) that is likely to continue for a minimum of six months, result in a reduction of independent functioning to the extent that ongoing support is required."*

In New Zealand, all District Health Boards (DHBs) fund:

- Mainstream health services (e.g. primary, secondary, tertiary healthcare) for disabled people with health needs, and also:
- Long-term support services for people with psychiatric/ mental health and addiction needs,
- Long-term support services for people with chronic health conditions, and ongoing support needs for people aged under 65,
- Health services and disability supports for people with age-related disability needs, including younger people aged 50 to 64 assessed with age-related needs, and people with disability aged 65 and over and assessed as requiring aged residential care,

DHBs are not required to fund support services for conditions or situations covered by other government funders, including where people:

- Have long-term physical, intellectual and sensory disabilities, or a combination of these, and some developmental (e.g. autism spectrum disorder) and neurological conditions, which result in permanent disabilities, and are generally aged under 65 years. Disability support services for these situations are funded by the Ministry of Health.
- Require environmental support services, which includes equipment and modifications (housing and vehicles), services and support for people with vision and/or hearing impairments, specified specialist assessment and training services, and specified subsidies and supports, for people of all ages, which are funded by the Ministry of Health
- require services provided under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, which are funded by the Ministry have a short-term illness or personal health need require support for less than six months
- have impairments caused by accident or injury, and are funded under ACC

Confirmation of eligibility is made by the relevant funder, and there can be situations with agreed 'shared' funding of support needs by funders reached in special circumstances.

Counties Manukau Health (CM Health) provides and funds health and support services to people living in the Counties Manukau region (approx. 569,400 people). Our services are delivered via hospital, outpatient/ ambulatory and community-based models of care. Some services that support

people living with disability in the community are delivered on a regional basis in Auckland, or by other DHBs (for example, Wilson Home in Waitemata DHB, ACC-funded Acquired Brain Injury services, the Limb Services and Orthotics Centre).

CM Health also delivers some specialist adult disability rehabilitation services (with contracted DSS funding from the Ministry of Health), including an inpatient and outpatient Spinal Impairment Rehabilitation service (for those with a diagnosis of spinal cord impairment), and General Adult Rehabilitation service - for those with a physical disability that will benefit from ongoing multidisciplinary team rehabilitation (typically following a stroke, amputation, or other medical or surgical related disability needs) in hospital or the community. These services see people of all ages, and are accessed via a Medical Specialist or General Practitioner referral.

CM Health also provides (with contracted DSS funding from the Ministry of Health) specialist support services to children from birth up to 16-years with a disability, and their families, including home nursing services, the Child Development Clinic, and specialist community allied health and outpatient services (for example, for congenital disability, autism spectrum), and screening services (new-born hearing etc.). Screening services are provided to all young people, referral to other services is via a medical professional. The service works with children in schools, kindergartens, home, community, clinics and recreation centres.

Children accessing the service must meet the national criteria for access to disability services, and have diagnoses, including but not limited to, cerebral palsy, global developmental delay, muscular dystrophy, chromosomal abnormalities, spina bifida, children with plagiocephaly who also have a disability, premature or low birth weight infants who are 'at risk'.

Further details on referral criteria are available publically via HealthPoint via links below.

- https://countiesmanukau.health.nz/our-services/a-z/disability-services/
- https://www.healthpoint.co.nz/public/neurology/counties-manukau-health-adult-general-rehabilitation/
- https://countiesmanukau.health.nz/our-services/a-z/kidz-first-outpatient/

Other government funded community disability support services (such as in home care, respite etc.) for these individuals may be accessed via Ministry of Health, ACC or other funding steams.

5. What is the process that a person in the Counties Manukau region would have to follow in order to access disability support services?

To access Ministry of Health-funded Disability Support Services, including community care (residential, in-home support, respite etc.) a referral (by individual, family or health care provider) needs to be made to Taikura Trust as they are the metro-Auckland regional Needs Assessment/ Service Coordination (NASC) provider contracted by the Ministry of Health.

They will confirm eligibility, complete a Support Needs Assessment and co-ordinate/ fund relevant service provision via contracted providers.

- https://www.healthpoint.co.nz/community-health-services/community-health/taikura-trust/

For people aged over 65 years, with *age-related* disability support needs to access DHB-funded support services a referral (by individual, family or health care provider) needs to be made to the CM Health (DHB) Needs Assessment/ Service Coordination (NASC) which provides this function for older people living in the Counties Manukau region.

They will confirm eligibility, complete a Support Needs Assessment and co-ordinate/ fund relevant service provision via contracted providers (such as home-based care, aged residential care etc.).

Our Child Development Services interdisciplinary, allied health team (including physiotherapists, occupational therapists, speech language therapists, neurodevelopmental therapists and social workers) works with parents and whaanau/ families of children with special needs and disabilities. The service aims to identify and provide appropriate advice, information, and support. We aim to empower families to support their children to achieve their potential and access their environment. Parents and whaanau/ family are encouraged to be fully involved in a treatment plan for their child and this plan is reviewed at regular intervals.

Services include:

- Assessment of the child's development, and provision of appropriate therapy.
- Parent education and encouragement of whanau / families to be fully involved in the plan for their child.
- Social Workers provide counselling, information, advocacy, connection with community services and support to help meet the needs of the whanau/family.
- Assessment and prescription of equipment or housing modifications to support independence and care
- Liaison with specialists and agencies that are involved with the child, (e.g. Paediatricians, GPs, nurses and education providers).

For the CM Health delivered Specialist Rehabilitation and Community Home Health Care services, there is additional information on accessing these services available on Healthpoint:

- https://www.healthpoint.co.nz/

6. How does the CMDHB ensure disability support services and primary medical services extend to those living in rural communities in your region? In particular, we ask that this response includes details on how services are provided to persons with disabilities who are located near Orere Point, Clevedon, Mercer, and Awhitu.

For the entire CM Health region, the process and eligibility for Ministry of Health-funded services for access to community support for people under-65 years, including for children are summarised in question 4.

Most DSS community delivered services (home and personal care), are provided by contracted providers, and assessed via Taikura Trust, to match needs of individuals. These providers deliver these services in individual's homes and communities across our district.

Rehabilitation services are currently mainly provided at Middlemore Hospital and the Auckland Spinal Rehabilitation sites (Baird's Road). We provide Community (Home Based Rehabilitation) for adult Stoke patients, and tele-health services are available for some spinal rehabilitation outpatient services.

Community-based nursing and allied health services are based across the CM Health region, and can provide in-home nursing and therapy services and assessment. More information on the locality model for community primary health care is available on our website

- https://countiesmanukau.health.nz/for-health-professionals/primary-care-information/localities/

Some therapists living near the outlying areas such as Awhitu will start their day from their home address to avoid unnecessary travel, as well as maximise local networks.

The CM Health team primarily based at Pukekohe Hospital cover the Port Waikato, Awhitu Peninsula and Clevedon/ Miranda area. Services provided in Pukekohe Hospital are not considered to be truly rural, due to the close proximity to major urban areas (less than an hour). Community delivered services are funded, and provided by the DHB in the rural areas of the Franklin (i.e. Port Waikato, Waiuku, Tuakau and Mangatangi), and Eastern (i.e. Clevedon, Kawakawa Bay and Orere Point) localities in our district.

A range of DHB services are provided in homes in the rural areas of the Eastern, and in the Franklin localities. These include:

- Community health and Nursing services;
- Allied health services (Physiotherapy, Occupational Therapy, Social Work etc);
- Rehabilitation services;
- Palliative care;
- Mental Health services;
- Needs Assessment and Service Coordination (NASC) services for those over 65 years or assessed as eligible;
- Screening and School based services,
- Maternity, Well Child and Outreach immunisation services, and
- Healthy Homes and SmokeFree services.

These are services are part of integrated DHB specialist services delivered to our entire community, irrespective of their residential locations.

There are a range of providers that have contracts to deliver services, which include for some of our rural communities, as part of wider service contracts with the DHB. These are providers are described below. There are three General Practices that are identified as rural. Information regarding the additional funding of rural general practices can be found in the national PHO Services Agreement.

Service	Location of Rural Services	Business Structure
The Kawakawa Bay - Orere Health Clinic – Practice Nursing Services:	Eastern locality - Kawakawa Bay/ Orere Point	NGO
General Practice - Tuakau Health Centre:	Franklin locality - Tuakau	Privately owned rural general practice
General Practice - Waiuku Health Centre:	Franklin locality - Waiuku	Privately owned rural general practice
General Practice - Pokeno Family Health:	Franklin locality - Pokeno	Privately owned rural general practice
Integrated Whaanau Ora Services - Whaanau Oranga:	A range of rural locations in the Franklin locality, including at local Marae.	Iwi Provider / Charitable Trusts

Service	Location of Rural Services	Business Structure
• **Huakina Development Trust** • **Health Through the Marae – Te Whakaorangatanga o Nga Tangata** • **Port Waikato Community Health and Support Services Trust**		
Rural Outreach Nursing Services Contract: • **Huakina Development Trust**	Three rural Marae in the Franklin locality: • Mangatangi Marae • Ng Hau E Wha Marae • Ooraeroa Marae	Charitable Trust

7. How does the CMDHB ensure people with disabilities living in rural communities in your region can access appropriate transport services to get to and from general health services, health and disability services, specialist appointments and other relevant appointments?

a. How much of CMDHB disability support service funding is allocated to providing transport to specialist appointments alone, and what percentage of that amount relates to transport for those living rural communities in your region?

There is no separate budget / funding allocated for patients to access transport to appointments, irrespective of locations. Some community based services (Child and Nursing) provide specialist and therapy clinics in Manukau, Otara, Mangere, Botany and Pukekohe to minimise travel for families

The National Travel Assistance Scheme provides a contribution for travel and accommodation costs, if criteria are met. For some people living rurally in CM Health region, this is applicable.

- https://www.health.govt.nz/our-work/hospitals-and-specialist-care/national-travel-assistance-scheme

The NASC assessment process may also identify that formal (Total Mobility card), contracted provider, volunteer agency or informal support options are needed to enable attendance at community appointments, or that funded environmental modifications (vehicles) to support this.

b. What proportion, and include a figure if possible, of your disability support service funding is allocated to providing transport for GP visits for persons with disabilities in your region?

No DHB monetary allocation of funds is made to provide transport for visits to General Practice.

c. What proportion, and include a figure if possible, of your disability support service funding is allocated to providing transport for GP visits for persons with disabilities in rural communities in your region.

As per question 7b.

d. How many persons with disabilities do you have in your region?

We do not collect or hold this information on our community. However, we know that approximately 1 in 5 New Zealanders experience disability, because of a wide-range of conditions, accidents and medical and congenital conditions. Disability can be a very broad concept; however work addressing the issues for people living with disability is relevant to a much larger part of the community, who may not fall within commonly considered definitions of disability; (e.g. senior citizens, those with temporary injuries or illness, and those caring for ageing parents and young children). We accept that there is also a link between the impact of disability and socio-economic circumstances that impact overall health and wellbeing.

The most appropriate source of information on people living in New Zealand, and the proportion with a disability is the Statistics NZ.

- https://www.stats.govt.nz/information-releases/disability-survey-2013
- https://www.stats.govt.nz/topics/disability

Data for the NZ Health Survey also identifies some key disability/ function impairment information, and is used by DHB staff to inform planning - but is not comprehensive for all types of disability.

A number of DHB community Health Needs Assessments (both for geographic communities, and for specific health needs/ diagnoses) have been completed or commissioned by the DHB. These are published –

https://countiesmanukau.health.nz/about-us/performance-and-planning/health-status-documents-2/

We also note the Waitangi Tribunal received the Māori Health Disability Statistical Status Report, crown-funded research reports in 2019.

e. How many of those persons with disabilities are Maori?

As above, this is not information we collect or hold.

We have completed more in-depth work on key conditions and life-stages (for example, Diabetes, Mental Health, Youth and Young People), and in most cases these will consider the particular needs for our diverse community, including for Māori, and those living with life-long impact of health conditions.

- https://countiesmanukau.health.nz/about-us/performance-and-planning/health-status-documents-2/

f. What type of disabilities are present in your region?

We do not collect or hold this information, however given an overall population of more than 569,400 individuals, we anticipate that a full range of conditions, disability and impairments are present in our community. These will include congenital, injury/trauma, degenerative and sensory conditions and disability.

g. Do you provide a shuttle bus for persons with disabilities in your region to access specialist treatment, appointments or access emergency services?

No, however there are community provided services (St Johns Ambulance, Age Concern and Cancer Society volunteer drivers) that provide some support with transport in metro-Auckland either free or

low cost. People eligible for a Total Mobility scheme card may use this option to subside travel costs to attend appointments.

- https://www.transport.govt.nz/land/the-total-mobility-scheme/

h. What involvement have you had with the Ministry of Transport and Regional Councils, Total Mobility Scheme, if any?

We work closely with Auckland Transport to advocate for public transport services to connect communities to health services, and to create healthy environments. Our hospital and community Allied Health and Social Workers can assist patients to identify transport and funding options.

CMDHB BOARD AND COMMITTEES

8. Have any of your board members experienced any type of disability, or have a family member who has lived experience with disability?

Yes, of our current Board Members, eleven responded to this request, and five identify as having a lived experience/ family member with lived experience of disability.

9. Do any of your Disability Support Advisory Committee members have a lived experience of disability?

Yes, all three members of the Counties Manukau DHB Disability Support Advisory Committee identify as having lived experience of disability. Four members of our Board also participate in the Regional Disability Support Advisory Committee, representing Counties Manukau.

In addition, both our Hospital Advisory Committee and our Community and Primary Care Advisory Committee include three members each who identify as having lived experience of disability, including both Chairpersons. The most current Board member profiles and committee memberships are available:

- https://countiesmanukau.health.nz/about-us/who-we-are/governance/

10. What engagement has the CMDHB had with local iwi, hapū and whanau in relation to the development of disability related support, strategies and policy?

CM Health recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. This is also reflected in the Minister of Health's Letter of Expectation to all DHBs.

Our current 'Māori Health roadmap' (**attached**) is the DHBs key strategy setting document in this regard

The Disability Strategy and regional (metro-Auckland) Implementation Plan (**attached**) are also important for this work. The development of this Implementation plan included a series of community and sector engagement sessions in 2017/18. The implementation plan is to be reviewed in 2020, and will be updated to be more explicit around our commitment on achieving equity for disabled people and disabled Māori, as well as our obligations the Treaty of Waitangi.

We work closely with Mana Whenua on our overall DHB strategy. Mana Whenua i Tamaki Makaurau is a collective body which represents the iwi that are resident in our District. Since 2001, the DHB has a formal Memorandum of Understanding (MOU) in place with the coalition.

- The Counties Manukau District Health Board meets with the Mana Whenua i Tamaki Makaurau Board once a quarter, to discuss emerging issues, risks and priorities.
- The DHB Board Chair and CEO meet monthly with the Mana Whenua i Tamaki Makaurau collective Chairs to discuss operational issues. The DHB CEO and the GM Māori Health also meets with the Board to agree and action operational matters agreed by both Boards.

Current Mana Whenua priorities and objectives focus on use of co-design, Māori research and matauranga, workforce development, assessing effectiveness of DHB services, and contributing to the development of DHB strategy and planning. We have built on this engagement in tangible ways, including via specific service consultation and co-design, to contribute to the identification of priorities which informs strategy development.

The CM Health consumer council has members who identify and represent the views of Māori in our community, including those living with Disability. More information on the Council is available on our website:

- https://countiesmanukau.health.nz/about-us/who-we-are/patient-and-whaanau-centred-care/consumer-council/

11. What are your standards for consultation with the local community in relation to disability support, strategies and policies?

Our Community Engagement and consultation policy and guideline ***(attached)*****.** This applies to all public consultation and engagement across our services and community.

COMMUNITY COMMUNICATION

12. How does the DHB communicate the availability and process to accessing disability support services to members of the community?

Our hospital and community-based Allied Health and Social Work services will support individuals and families to identify and access appropriate services, when they are receiving health care. For many individuals, living in the community with a disability, information will be provided by Primary Care services (General Practice, NGO groups etc), rather than by the DHB provided services.

We employ NZ sign-language interpreters, to support communication for the hearing impaired during visits to our services.

The metro DHBs also have made a commitment to improve health literacy across our organisations. Health Literacy means that "*people can obtain, understand and use the health information and services they need to enable them to make the best decisions about their own health, or the health of a dependant family member/ friend*"

This work focusses on two areas:

- improving health literacy of both organisations and their staff.
- enabling communities to become more health literate.

A variety of community engagement, hui and fono are arranged each year with communities and provider NGOs, to promote services, access to health information and co-design of initiatives.

The information on accessing our specialist services is available on our website.

- https://countiesmanukau.health.nz/for-patients-and-visitors/

We have recently completed an upgrade of both the CM Health website and intranet, to support full compliance with Web Accessibility and Usability Standards.

The NZ Disability Strategy and our regional (metro-Auckland) Disability Strategy Implementation Plan (**attached**) outline a range of long term priorities and measures.

13. How does the DHB communicate the availability and process to accessing disability support services to Māori?

As above, support is available via allied health, nursing or social work services, who are working directly with individuals and families.

Te Kaahui Ora Māori Health services (our Māori Health teams); CM Health Kaumatua and regional Whaanau Ora service providers can enable additional supports and networks to support connection with other services. These services also provide support and training to CM Health employees who provide daily 'frontline' services to our community, across a range of issues and needs.

14. Are funds being allocated towards the encouragement and attraction of Māori to the health and disability workforce in your region? If so, where and how does this take place?

Yes, there are a range of initiatives to promote, train, recruit and retain Māori in our workforce. This is led by our Māori workforce development team, in conjunction with Human Resources.

Key Focus Areas

Māori Workforce Development is the process of strengthening the capacity and capability of the Māori health and disability workforce in order to maximise its contribution to improved health outcomes for Māori. The primary purpose of Māori development is to contribute to building a representative New Zealand health and disability workforce that through evidence-based practice facilitates the best possible health outcomes for Māori. The six key focus areas for Māori Workforce Development are:

1. Promotion of health as a career
2. Supporting Rangatahi Māori achievement in NCEA
3. Supporting Tauira Māori success in tertiary education
4. Increasing the number of Māori employed at CM Health
5. Improving the retention of Māori employees
6. Building Māori leadership

There is further information on our recent work in this area in our most recent 2018/19 Annual Report, in particular pg 43-52.

- https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Annual-reports-and-plans/2019_CM_Health_Annual_Report.pdf

Specific Counties Manukau initiatives targeting Māori workforce development within our community include:

- Health Science Academy (in Secondary Schools)
- Māori Health Science Academy (TOH)
- Pu Ora Matatini (Midwifery)
- Taiohi Whai Oranga (marae-based youth development initiative, including new Māori Science Academy, Nga Tai Hirenga)
- Puhoro STEM Academy (in conjunction with Massey University)
- Māori Allied Health initiatives, including advisory and mentoring group
- Māori Nursing Workforce, including Nga Manukura o Apopo (national Māori Nursing and Midwifery clinical leaders network and workforce development programme)
- Whakamana Takuta (Māori Medical Workforce)

In addition, we work closely with other DHBs, Kia Ora Hauora (the national Māori health workforce development programme), government agencies (such as Te Pou), and tertiary education providers (in particular for nursing and Allied Health groups), to ensure a pipeline of future graduates who are supported and mentored, have access to financial (scholarship) assistance and are culturally competent.

CMDHB SYSTEMS

15. Does the CMDHB have a centralized format or system where health information is stored? If so, how does it operate? Information is kept electronically and in paper based clinical records

Yes, CM Health uses an electronic health record (called Clinical Portal), for holding health information, in conjunction with paper-based records. The Clinical Portal application allows access to the majority of health information held for Counties Manukau residents. The Clinical Portal enable clinicians to access all Radiology and other imaging results, Laboratory results, and all other test results. It also contains all Clinic appointment details, letters and discharge summaries; as well as referral information from primary care providers. It is integrated with our Patient Management System, to include all national medical warnings, alerts and allergies information.

The same system as used at Waitemata DHB, allowing information to be shared across both DHBs. Auckland and Northland DHBs will join the same system during 2020, and this will see a regional shared portal, accessible and used by health services across the entire Northern Region.

16. What is your system for managing specialist referrals for persons with lived experience of disability?

There are nationally consistent processes for managing referrals for planned care, defined by the Ministry of Health. These include 'grading/triage' of all referrals on receipt for urgency, based on the information provided by referrers, and in some cases against national prioritisation criteria for a speciality. Clinicians will consider other medical/ disability information in making that referral review.

Information is sent at the time of appointment scheduling, including providing details on access to clinics, requesting patient/ family directly contact the service if there are particular access requirements to be considered (e.g. mobility, cognitive deficits), and supporting the option to have a support person/ EPOA also attend the appointments. NZ Sign and language interpreters are available if requested. As much as possible, these considerations are accommodated at some clinic and

diagnostic appointments, acknowledging that at times this may need rescheduling to coordinate the best outcome.

Within some ambulatory services, with a high number of very severely disabled individuals needing input, options including home-visiting by technical/ allied health staff may be considered (e.g. for assessment and diagnostics), to reduce complexity of attending at a clinic.

17. How does the CMDHB interact with the Ministry of Health and disability support providers to collect, transfer and make information available on a patient?

Relevant information about an individual is shared (via secure systems) with other agencies, with individual consent. This is primarily done at referral between agencies or to contracted services. Most patient information is held in systems used by healthcare provider (e.g. GPs, hospitals) or disability support providers (e.g. residential care facilities) that the disabled person is using.

DHB services clinical information is available to/ routinely shared with primary care providers (General Practice) regarding discharges, clinic appointments, and diagnostic results. For situations requiring complex community care planning arrangements, effort will be made to engage with community providers, family, and other agencies involved, via family meetings or correspondence. Information sharing between providers may be more limited.

Service providers will have policies and procedures, which guide their management of information to support their service users, support their business functions and that ensure security of shared information with other providers and agencies.

Practitioners should seek the permission of the patient or a representative of the patient to share relevant information with other health practitioners, providers and agencies involved in their care. However, there may be instances where information will be required by law, requiring compliance by providers, (for example, information sharing provisions for the safety of tamariki).

In most situations, health information should not be passed on without consent. However, some situations exist in which information can be shared across the health and disability system without consent. In these situations, consumers should be informed of this sharing, but there may not have been the opportunity to consent (e.g. a patient is unconscious, or otherwise unable to give consent).

The Health Act 1956 has provisions allowing DHBs and the Ministry to request data - see

- http://www.legislation.govt.nz/act/public/1956/0065/118.0/DLM306636.html.

There are strict requirements for ensuring the safe, secure and purposeful exchange of patient information between healthcare professionals, providers and agencies. A person's National Health Index (NHI) number is their health identity. An NHI number is fundamental for services to link information and get a better understanding of each person's needs. Only authorised providers can access the information in the NHI – see

- https://www.health.govt.nz/our-work/health-identity/national-health-index/national-health-index-overview

There are guidelines for the health and disability sector on the safe sharing of health information – see

- https://www.health.govt.nz/publication/hiso-100642017-health-information-governance-guidelines

The *Health Information Privacy Code 1994* regulates how health agencies (e.g. doctors, nurses, pharmacists, Primary Health Organisations and District Health Boards) and disability support providers collect, hold, use, and disclose health information about identifiable individuals.

The Privacy Commissioner has issued guidance on people's rights and health agency obligations regarding information sharing – see:

- https://privacy.org.nz/news-and-publications/guidance-resources/health-information-privacy-fact-sheet-1-overview/:
- People have rights over health information about themselves.
- Rule 6 - gives individuals the right to access information about themselves
- Rule 7 - gives them the right to seek correction of that information if they think it is inaccurate or misleading.
- Health agencies have obligations over the health information they hold. These obligations are set out in the 12 rules of the code.

There are contractual expectations of contracted services to use and engage with assessment tools (including InterRai for older people support services), and regular reporting by agencies as to demographics and outcomes for service users (usually aggregated/ anonymised data only).

Appendix 2 - Strategy

Maaori Health Roadmap 2018/19

PRIORITY FOCUS AREAS: 2018/19 to 2020/21	YEAR 1 ACTIONS (2018/19)	YEAR 1 MILESTONES (2018/19)	MEASURES
Long term conditions and complex needs More integrated and equitable services to support Maaori with long-term conditions and complex needs to live well.	**1.** Ensure that Maaori patients with long term conditions are prioritised for planned proactive care (PPC). **2.** Implement SLM Improvement Plan and other activities to improve CVD/diabetes outcomes and increase smoking cessation among Maaori **3.** Deliver integrated whanau centred long term conditions packages of care to high needs and hard to reach Maaori. **4**. Re-orientation of the Whaanau Ora service model of care, to re-align with strategic priorities for Maaori, and improve integration with PHC providers. **5.** Ensure equity of access to timely cancer diagnosis and treatment for Maaori	**1.** Q1- Quality improvement approach embedded, including specific strategies to prioritise Maaori for PPC. **2.** Q2 – Target practices with high numbers of Maaori patients that are not meeting diabetes targets, and mobilise expert teams to support improved performance. Q1 – Set equity targets for access to allied health services, and increase referrals to cessation support **3.** Q1- Q4 - Provision of 500 packages of care per annum, monitor delivery of services to high needs populations **4.** Q4 - Implementation of new model is completed **5.** Actions from regional and local strategies, and review of the Maaori Cancer Nurse Specialist role, are completed	PP22: Delivery of actions to improve system integration including SLMs PP33: Improving Maaori enrolment in PHOs PP20: Improved management for long term conditions SLMc: Increase the percentage of current smokers who accept cessation support by 10% SI7: SLM total acute hospital bed days per capita SI9: SLM amenable mortality PP30: Faster cancer treatment
Mental health Earlier intervention through improved integration of primary and mental health care and equitable service delivery for Maaori.	**1.** Reconfigure and redesign specialist community mental health teams to reflect local population need, with a focus on meeting the needs of Maaori. **2.** Establishment of the Wellness Support programme. Options will be explored for enhanced cultural services that meet the needs of Maaori **3.** Extension of Mental Health & Addictions (MH&A) Integrated Locality Care (ILoC) resource, including into marae-based clinics, all general practices, and additional schools. **4.** Suicide prevention and postvention work to continue a range of activities focussed around mental health literacy, education, community engagement and mental promotion	**1.** End of Q2- Establish new Kaupapa Maaori District-wide team to provide Maaori clinical and cultural consultation to CM Health MH&A services & clinicians, and support for Maaori whanau on entry to mental health services. **2.** End of Q2- Complete co-design of the Mindfulness and Awareness Aotearoa Wellness Course (for adults and youth) with Te Ao Maaori to enrich cultural appropriateness. **3.** Q4- Marae-based ILoC engagement to include cultural, clinical, and non-clinical capability. **4.** Q4- Deliver 75 Mental Health First Aid workshops	PP6: Improving the health status of people with severe mental illness through improved access Development Plan PP25: Youth mental health initiatives PP36: Mental health Act: section 29 community treatment order rate per 100,000 PP43: Population mental health PP26: The Mental Health & Addiction Service Average time spent in seclusion
Child wellbeing and maternal health Improving Maaori child and maternal health outcomes including a focus on pregnant women's enrolment with a Lead Maternity Carers, immunisations, and oral health	**1.** Develop an integrated approach to increase the percentage of Maaori women registered with a midwife by 12 weeks. **2**. Ensure all health care professionals promote & refer eligible Maaori women & whaanau into the incentivised smoking cessation programmes. **3.** Ensure all eligible Maaori women have access to appropriate safe sleep advice and devices. **4.** Early identification and monitoring of Maaori pepe with incomplete immunisations and implement an incentives scheme for engagement. **5.** Support activities of the regional oral health Pre-school Strategy aimed at improving outcomes for tamariki Maaori. **6.** Work to ensure Maaori children receive appropriate sore throat management	**1.** Q4- Increase the percentage of Maaori women registered with a midwife at 12 weeks by 5% **2.** Q1-Q4 - Monitor the number of women who join the antenatal or postnatal programme Q4: 100% eligible women receive safe sleep devices **4.** Q4- achieve 95% coverage at the milestone ages of 8 and 24 months for Maaori pepe. **5.** Q1-Q4 Activities to improve outcomes for Maaori children planned as part of the pre-school strategy are completed **6.** Q4 - Reduction in incident RF rate in Maaori and Pacific children and young people (rate/100,000)	SI13: SLM number of babies who live in a smoke-free household at six weeks post-natal SI9: SLM amenable mortality PP21: Immunisation coverage SI1: Ambulatory sensitive hospitalisations (ASH) for 0-4 year olds PP11: Children caries-free at five years of age PP13: Improving the number of children enrolled in DHB funded dental services PP28: Reducing the Incidence of First Episode Rheumatic Fever

Maaori Health Roadmap 2018/19

PRIORITY FOCUS AREAS: 2018/19 to 2020/21	YEAR 1 ACTIONS (2018/19)	YEAR 1 MILESTONES (2018/19)	MEASURES
Equitable systems and services To ensure our policies, resources and services are equitable for Maaori and improve the wellbeing of whanaau	**1.** Development and implementation of Manawhenua Hauora Plan including health equity measures and whanau-centred indicators.	**1.** Q1-Q4 Draft plan submitted	Quarterly Narrative Progress Report for each deliverable
	2. To review and implement a Manawhenua led Te Tiriti o Waitangi Audit Tool with a focus on assessing the whaanau experience of health services being delivered to Maaori and whaanau living in Counties Manukau.	**2.** Q4 Development of audit tool	
	3. Contribute to examining and improving the CM Health Planning and Funding procurement systems and processes with a Maaori health equity lens	**3.** Q4 Draft tool developed	
	4. Contribute a Maaori health equity lens to the development of CMDHB Annual Plan for 2019/2020	**4.** Q3 Review of draft Annual Plan completed	
	5. In partnership with Manawhenua, establish a whaanau centred co-design process with CMDHB services.	**5.** Q4 Planning of co-design process completed	
Workforce Development Increase the size of the Maaori Health Workforce to reflect the CMDHB community, and improve organizational cultural competency for Maaori	**1.** Develop a Te Reo Maaori Strategy in partnership with Manawhenua which is intended to promote the active use of Te Reo Maaori in everyday services offered through CMDHB.	**1.** Q4 - Draft strategy submitted	Quarterly Narrative Progress Report for each deliverable
	2. Develop a Manawhenua led Maaori capability program through incorporating Tikanga best practice principles, Treaty of Waitangi, & cultural competency development.	**2.** Q1-Q4 Development of programme	
	3. Increase the number of Maaori employed at CMDHB through recruitment and retention strategies	**3.**Q1-Q4 1250 Maaori applying for employment target , and 588 Maaori employed at CM Health	
	4.Suppport the development of Maaori leadership	**4**. Q1-Q4 25 Maaori staff supported onto leadership training and programmes	
	5. Increase the number of secondary schools with access to CM Health NCEA and NCEA Science Programmes and community led initiatives.	**5.** Q1-Q4 609 Secondary Schools providing CM Health Funded NCEA Support Programmes.	

Waitemata District Health Board
Best Care for Everyone

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

COUNTIES MANUKAU HEALTH

Metro- Auckland District Health Board's Implementation of the New Zealand Disability Strategy 2016-2026

Waitemata & Auckland District Health Boards and Counties Manukau Health have a shared vision of being fully inclusive.

Being fully inclusive means ensuring the rights of disabled people, eliminating barriers so that people can get to, into and around our physical spaces; and everyone can access information and services that they need.

The New Zealand Disability Strategy 2016-2026 provides a framework for organisations to focus on enabling the full participation of disabled people. It has a vision of New Zealand as a non-disabling society – a place where disabled people have an opportunity to achieve their goals and aspirations and all of New Zealand works together to make this happen.

The Vision, principles and approach of the NZ Disability Strategy 2016-2026, with input from the disability sector and disability community, have shaped our joint District Health Board (DHB)s ***Disability Strategy Implementation Plan 2016-2026.***

Our ten year implementation plan aligns with the timeline of the NZ Disability Strategy 2016-2026. There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.

New Zealand Disability Strategy 2016-2026

Figure 1 | Disability Strategy Framework

The Disability Strategy identifies eight outcome areas -

The outcome areas that will contribute to achieving the vision of the Strategy are:

Outcome 1 – Education
We get an excellent education and achieve our potential throughout our lives

Outcome 2 – Employment and economic security
We have security in our economic situation and can achieve our full potential

Outcome 3 – Health and wellbeing
We have the highest attainable standards of health and wellbeing

Outcome 4 – Rights protection and justice
Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system

Outcome 5 – Accessibility
We access all places, services and information with ease and dignity

Outcome 6 – Attitudes
We are treated with dignity and respect

Outcome 7 – Choice and control
We have choice and control over our lives

Outcome 8 – Leadership
We have great opportunities to demonstrate our leadership

All eight outcomes are relevant to the work of the District Health Boards and will drive our core work over the next ten years. Our work will have a particular focus on five outcomes – Employment & economic security, Health & wellbeing, Accessibility, Attitudes and Choice & control.

Influences

There are a number of other principles, disability strategies and action plans that influence the DHB's Implementation Plan. These include:

- Te Tiriti o Waitangi / The Treaty of Waitangi
- Disability Action Plan 2014-2018
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- Whāia Te Ao Mārama: The Māori Disability Action Plan 2017-2022
- Faiva Ora: National Pasifika Disability Plan 2016–2021
- Auckland DHB, Waitemata DHB & Counties Manukau Health Annual Plans

Disability Action Plan 2014-2018

This is a key document in the implementation of the Disability Strategy. The Disability Action Plan presents priorities set by the Ministerial Committee on Disability Issues for actions that advance the implementation of the UN Convention on the Rights of Persons with Disabilities and the New Zealand Disability Strategy 2016-2026. These priorities emphasise actions requiring government agencies to work together, as well as with disability sector organisations and others.

Five Person Directed outcomes:

-Safety/autonomy
-Wellbeing
-Self-determination
-Community
-Representation

Four main areas of focus:

- Increase employment opportunities
- Ensure personal safety (includes decision making and consent)
- Transform Disability Support system
- Promote access in the community

'Promote access in the Community' includes 11c – Access to health services and improve health outcomes for disabled people with a focus on people with learning disabilities.

Values

The Values of Waitemata & Auckland DHBs and Counties Manukau Health reflect a shared vision for equity and inclusion of disabled people in their care and in the design of patient facilities and services.

Welcome | Haere Mai
We see you, we welcome you as a person

Respect | Manaaki
We respect, nurture and care for each other

Together | Tūhono
We are a high performing team

Aim High | Angamua
We aspire to excellence and the safest care

Monitoring and Reporting

Work is underway at the Office for Disability Issues to ensure that progress toward achieving the outcomes of the New Zealand Disability Strategy can be measured. This will involve the development of an Outcomes Framework which will specify targets and indicators that will be regularly reported on. Work on this will include getting advice from disabled people, the disability sector and other government agencies.

The metro-Auckland DHBs' New Zealand Disability Strategy Implementation Plan 2016-2026 will be monitored internally and progress of actions will be reported to the Disability Support Advisory Committee (DSAC) on a quarterly basis.

We will ensure that the DHB Disability Strategy Implementation Plan continues to align with the NZ Disability Strategy, as well as other government strategies and action plans.

There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.

Current Priorities

The three metro-Auckland DHBs are committed to the vision of being fully inclusive and non-disabling. Current work that will continue across the DHBs as part of the Disability Strategy Action Plan includes improving health literacy and enhancing the patient experience.

<u>Health Literacy</u>

The three District Health Boards have made a commitment to improve health literacy across both organisations. Health Literacy means that "*people can **obtain**, **understand** and **use the health information and services** they need to enable them to make the **best decisions** about their own health or the health of a dependant family member/friend*"

This work focusses on two areas:

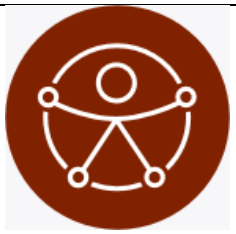
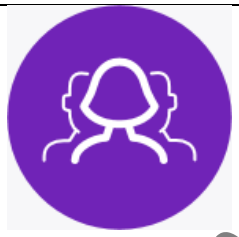
- improving health literacy of both organisations and their staff
- enabling communities to become more health literate

<u>Patient Experience</u>

There is a focus on Patient Experience and Community Engagement across the three DHBs. This has led to greater inclusion of disabled people in design and planning of both facilities and services. Examples of this are the Public Spaces work at Auckland DHB and the Waitemata 2025 commitment to universal design as a core design principle. Counties Manukau Health has included disability experience questions to their Inpatient Patient Experience Survey to learn from the experiences of disabled patients.

Outcomes

Of the eight outcome areas of the New Zealand Disability Strategy 2016-2026, there are five key outcome areas that align with the work of District Health Boards.

				
Outcome 2: employment & economic security	**Outcome 3: health & wellbeing**	**Outcome 5: accessibility**	**Outcome 6: attitudes**	**Outcome 7: choice & control**
We have security in our economic situation and can achieve our potential	*We have the highest attainable standards of health and wellbeing.*	*We access all places, services and information with ease and dignity.*	*We are treated with dignity and respect.*	*We have choice and control over our lives.*

Outcome 2: employment & economic security

We have security in our economic situation and can achieve our potential

1. Increase the number of disabled people in paid employment.
2. Increase the confidence of Hiring Managers to recruit disabled people.
3. Record the number of staff with impairments working for the DHB.
4. Ensure Diversity & Equity work includes disabled people.
5. Awarded the Accessibility Tick.

Outcome 3: health & wellbeing

We have the highest attainable standards of health and wellbeing.

5. Improve the health outcomes of disabled people.
6. Robust data and evidence to inform decision making.
7. Barrier free and inclusive access to health services.
8. Increased understanding of the support needs of people with learning disabilities.
9. Better understanding of the needs of Deaf people. This includes access to interpreters, information available in NZSL and knowledge of Deaf culture.
10. Better support for young people moving from child to adult health.

Outcome 5: accessibility

We access all places, services and information with ease and dignity.

11. Barrier free and inclusive access to health services.
12. The principles of universal design and the needs of disabled people are understood and taken into account.
13. Improve & increase accessible information across the DHBs.
14. Ensure information is available in different formats, eg. Easy Read
15. Ensure physical access to DHB buildings and services, including signage and way finding.

Outcome 6: attitudes

We are treated with dignity and respect.

16. All health and well-being professionals treat disabled people with dignity and respect.
17. Disabled people and their families respected as the experts in themselves.
18. Provide a range of disability responsiveness training.
19. Promote the Disability Responsiveness e-Learning module to all staff.
20. Ensure disabled people are able to access supports that they need in hospital.
21. Increase cultural awareness of disability.

Outcome 7: choice & control

We have choice and control over our lives.

22. Engage regularly with the disability sector and community.
23. Ensure a diverse range of disabled people are identified as stake-holders.
24. Ensure the voice of disabled people from the community is included.
25. Enable supported decision making and informed consent.
26. Ensure services are responsive to disabled people and provide choice and flexibility.
27. Improve access to screening services for disabled people.
28. Continue the implementation of the Health Passport across the DHBs.

Appendix 4 - Policy

Policy: Public Consultation

Purpose

The purpose of this policy is to set out Counties Manukau DHB's (CMDHB's) obligations in relation to public consultation with the Counties Manukau community. It provides the rationale for consultation, and sets out some of the broad requirements for carrying out valid and effective consultation.

Note: **This policy must be read in conjunction with the Guideline: Public Consultation.**

Scope

References to community in this document means the entire Counties Manukau community including, but not limited to, the general public, providers and businesses working in Counties Manukau and stakeholder groups and agencies.

Internal consultation with Counties Manukau DHB employees is not within the scope of this document. Policy and processes for consulting with employees regarding proposals that may impact on their work with Counties Manukau DHB are outlined in other documents (refer 'Associated Documents').

Policy

What is consultation?

Consultation is part of the broader concept of community involvement – effective interactions between planners, decision makers, and individual and representative stakeholders in the community to identify issues and exchange views on a continuous basis.[1]

Consultation is a subset of community involvement and engagement. It is the process of seeking the views of the community on a particular matter under consideration, and genuinely taking account of those views before deciding on the matter.. Merely providing information to the community is not consultation as it does not engage stakeholders or seek their views.

Why does CMDHB need to consult?

In some circumstances DHB's have a legal obligation to consult. In other circumstances it may be desirable to consult in order to avoid overlooking relevant considerations or making material mistakes of fact. Such errors could give rise to a challenge to the decision under

[1] Public Consultation Guidelines for District Health Boards (Ministry of Health, 2011)

administrative law. This factor goes to the very purpose of consultation: ensuring that the decision maker has all the relevant information it needs to make a decision, and giving those affected by the decision a chance to put relevant information before the decision maker.[2]

Involving the public in relevant DHB decisions is vital: it increases the relevant information available to the DHB, allows the public to participate in decision making by the DHB and promotes buy-in from the public for the final decision. Open, constructive dialogue with affected parties and the use of a sound consultation process also minimises the potential for legal challenges to DHB decisions.[3]

DHB's have the mandate to improve the health of their population through local and regional initiatives and are accountable for their investment decisions and consultation processes. Well managed service change and consultation provides the government and DHB's with confidence that a robust process is followed (as per the Minister's expectations of DHB's), that there are sufficient controls in place to avoid unnecessary service instability, and the change is clinically appropriate and public confidence is managed by the DHB.[4]

When does CMDHB need to consult?

A legal obligation to consult with the public may arise through legislation such as the New Zealand Public Health and Disability Act 2000 which imposes a number of specific consultation requirements on DHBs, including where a DHB:

- Is preparing an annual plan and the Minister considers that the plan proposes changes to services, including to service eligibility, access, or the way services are provided, and the proposed changes will have a significant impact on the recipients of the services, their caregivers, or providers;[5] or,
- Is preparing a regional services plan and the Minister considers that the plan proposes changes to services, including to service eligibility, access, or the way services are provided, and the proposed changes will have a significant impact on recipients of services, their caregivers, or providers[6], or,
- Proposes to change the geographic area of a DHB[7] or
- Proposes to sell or exchange any land.[8]

[2] Public Consultation Guidelines for District Health Boards (Ministry of Health, 2011).
[3] Public Consultation Guidelines for District Health Boards (Ministry of Health, 2011).
[4] Operational Policy Framework, chapter 4: Service Change. (Ministry of Health).
[5] Regulation 9(1) of the New Zealand Public Health and Disability (Planning) Regulations 2011.
[6] Regulation 7(1) of the New Zealand Public Health and Disability (Planning) Regulations 2011.
[7] Section 20 of the New Zealand Public Health and Disability Act 2000.

An obligation to consult may also arise because a DHB has created a legitimate expectation of consultation through its communications or actions.

A contract may also impose a legal obligation to consult on one or more contracting parties.

More general obligations to consult are contained in the statutory objectives of DHBs. These obligations include consultation in order to reduce health disparities, improve health, and plan for service provision.[9]

Health service funders must follow appropriate planning and consultation processes to avoid adverse financial, resource and clinical impacts on the affected population(s) and avoid unnecessary service instability when undertaking significant service change. 'Significant service change' is defined as:

Includes a service shift and service reconfiguration where there is a significant change for the affected population, such as:

a. a material change to the level, nature or volume of services provided, or
b. a material change to funding method or contracting arrangement, or
c. a significant impact on recipients of services, their caregivers or service providers, particularly a material change in access and/or eligibility of the recipients of services.

A DHB must consider that a significant service change means any of a. to c. above when assessing whether a proposal is one that must be discussed with the National Health Board (NHB) Regional Relationship Manager.[10]

The Ministry of Health's 'Operational Policy Framework' provides a 'Decision Tool for Triggering Service Change Protocols' that identifies the level of service change that requires a DHB's early engagement with the Regional Relationship Manager. When it is required, the Relationship Manager will facilitate the Ministry of Health's involvement to ensure effective decision making of the proposed service change, and

[8] Schedule 3, clause 43(4) of the New Zealand Public Health and Disability Act 2000; The High Court reinforced this obligation in *Napier Public Health Action Group Inc v The Minister of Conservation* [2007] 3 NZLR 559 at [102].
[9] Section 22(1)(f) (g) and (h) of the New Zealand Public Health and Disability Act 2000.
[10] Operational Policy Framework, chapter 4: Service Change. (Ministry of Health).

provide support and scrutinise funding and purchasing methods proposed by a DHB.[11]

Examples of levels of service change and guidance are provided in the following chart, for considering if early discussion with the (National Health Board -NHB) Regional Relationship Manager is required or Ministerial involvement is needed:

[11] Operational Policy Framework, chapter 4: Service Change. (Ministry of Health).

Examples of Service Change/Reconfiguration[12]

	Nature of change	Service Cover (Funder)	Service Change (Provider)	Example	National Health Board (NHB) vetting/ Ministerial involvement
a	Minimal – changing where service is provided (within the district)		✓	**Closing X hospital, centralising services on DHB campus**	NHB informed. NHB judgement to advise Minister.
b	Major – changing where service is provided or based	✓	✓	**Service to be based in another DHB as a regional service.**	DHB(s)/NHB informed. Check if in line with government strategies or Ministerial priority area. NHB judgement to advise Minister.
	Regional/National			**Service to be totally outsourced to the private sector in new locations**	Minister: - agrees in principle - agrees implementation process - agrees to further development Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan
c	Type of service provided		✓	**Day-patient or outpatient rather than inpatient services**	NHB vetting unlikely to be needed. NHB may be informed.
d	Funder and planning role of a service provided	✓	✓	**Transfer of the funding and planning role of a DHB funded national service to the NHB**	NHB informed. NHB judgement to advise Minister. Check if in line with government strategies or Ministerial priority area. Minister: - agrees in principle - agrees implementation process - agrees to further development Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan.
e	Limiting growth in a service	✓		**Holding certain interventions perceived to offer limited health gain to current levels**	NHB informed. NHB vetting judgement to advise Minister. Minister informed where service levels are impacted or are expected to be impacted. If Ministerial priority area, the Minister: - agrees in principle - agrees implementation process - agrees to further development Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan.

[12] Operational Policy Framework, chapter 4: Service Change. (Ministry of Health).

	Nature of change	Service Cover (Funder)	Service Change (Provider)	Example	National Health Board (NHB) vetting/ Ministerial involvement
f	Reprioritisation of one service for another of higher priority	✓		**Cease funding of flu vaccine in favour of multiple organ transplants**	NHB informed. NHB vetting judgement to advise Minister. Check if in line with government national strategies or Ministerial priority area. Minister: - agrees in principle - agrees process - agrees to further development Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan.
g	Reduction in the level of service cover provided below the nationally agreed minimum described in the Service Coverage Schedule or service specification	✓		**Limit access to one cycle of fertility treatment (rather than two or more)**	NHB informed. NHB judgement to advise Minister. Check if in line with government strategies or Ministerial priority area. Minister: - agrees in principle - agrees implementation process - agrees to further development. Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan
h	Reduction in the level of service cover provided to the nationally agreed minimum described in the Service Coverage Schedule or service specification	✓		**Regional analysis indicates over delivery compared to other regions – limit access to MRI diagnostic services to specialist referrals only**	NHB informed. NHB judgement to advise Minister if perceived community of interest and manage anticipated risk. Check if in line with government strategies or Ministerial priority area. Minister: - agrees in principle - agrees implementation process - agrees to further development. Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan.
i	Service provider		✓	**Significant change for the affected population that is a material change to funding method or contracting arrangement resulting from the change in the service provider, and a material change in access of the recipients of services e.g., Laboratory Services DHBs service to be totally outsourced to the private sector**	NHB informed. NHB judgement to advise Minister if perceived community of interest, anticipate and manage risks. Minister: - agrees in principle - agrees implementation process - agrees to further development. Note: prior approved service changes may be incorporated into DHB Annual and/or Regional Services Plan.

Consultation with Maaori

Under the Operational Policy Framework and the New Zealand Public Health and Disability Act 2000, DHBs are required to carry out consultation and manage stakeholder expectations. In addition there are particular requirements to work with Maaori at both governance and operational levels. This includes establishing and maintaining processes to enable Maori to participate in and contribute to strategies for Maaori health improvement; fostering the development of Maaori capacity for participating in the health and disability sector and for providing for the needs of Maaori; and providing Maaori with the relevant information to promote participation.

CMDHB has two mechanisms to engage with Maaori – Manawhenua i Tamaki Makaurau, and a Maaori Health Advisory Committee[13]; these entities have important strategic roles. Any staff planning to undertake consultation with Maaori should approach the General Manager Maaori in the first instance for advice and guidance on appropriate mechanisms for consultation with Maaori, and the correct channels to advance this.

Who should make the decision to consult?

Deciding whether to consult must be discussed with your Manager, and the decision to conduct public consultation should be made at a General Manager or Director level.

How to consult

Guidance on how to consult is covered in CMDHB's 'Guideline: Public Consultation'. This guideline summarises best practice principles for consulting, outlines 6 key phases of consultation, and provides broad guidance on the relevant considerations and possible actions for effective consultation.

[13] The Maaori Health Advisory Committee is a committee of the Counties Manukau District Health Board. It provides advice, strategic direction and recommendations to the Board aimed at accelerating Maaori health gains and addressing Maaori health inequities.

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation	New Zealand Public Health and Disability Act 2000; New Zealand Public Health and Disability (Planning) Regulations 2011.
CMDHB Clinical Board Policies	None
NZ Standards	None
Organisational Procedures	Guideline: Public Consultation.
Other related documents	Ministry of Health Public Consultation Guidelines 2011; New Zealand Health Strategy; Crown Funding Agreement; Operational Policy Framework; Regional DHB Contracting Guidelines; Policy: Procurement Policy; Procedure: Provider Arm Contracting Process. Funder Arm Services Procurement - Guideline; Memorandum of Understanding Between Manawhenua i Tamaki Makaurau and Counties Manukau District Health Board (2001); Strategic Relationship Agreement Between Counties Manukau District Health Board and Manawhenua i Tamaki Makaurau (2004); He Korowai Oranga: Maori Health Strategy (2002) Ministry of Health; Management of Organisational Development (MOOD document); Human Resources Toolkit – Management of Change; Collective and Individual Employment Agreements.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Change	Change on which consultation should occur incorporates a wide variety of situations. It includes, but is not limited to, changes to the way services are delivered, new services being developed, and existing services being removed.
Community	Community means the entire Counties Manukau community, and in addition to the general population includes providers and businesses working in Counties Manukau and other specific stakeholder groups and agencies.
Consultation	A subset of community engagement that encompasses the seeking of views from the community on a specific proposal or issue. Merely providing information to the community is not consultation.
Stakeholders	People / groups who could be affected by the outcome of a decision.

Guideline: Public Consultation

Purpose

This guideline is intended to outline when public consultation may be required, and what to do in order to carry out valid and effective consultation. It is not intended as a detailed, step-by-step process, as each proposal for change will have specific circumstances that impact on the public consultation requirements; however, it does provide broad guidance on the relevant considerations and possible actions. You should always seek specific advice from your manager about individual cases.

This Guideline does not cover internal consultation with Counties Manukau DHB employees. Policy and processes for consulting with employees regarding proposals that may impact on their work with Counties Manukau DHB are outlined in other documents (refer 'Associated Documents').

References to community in this document mean the entire Counties Manukau community, including but not limited to the general public, providers and businesses working in Counties Manukau and stakeholder groups and agencies.

Note: **This guideline must be read in conjunction with the Policy: Public Consultation.**

Responsibility

This guideline is applicable to all CMDHB employees (full time, part time, casual and temporary) and contractors who are involved in any change of service provision that requires public consultation.

Associated Documents

Other documents relevant to this guideline are listed below:

NZ Legislation	New Zealand Public Health and Disability Act 2000; New Zealand Public Health and Disability (Planning) Regulations 2011.
CMDHB Clinical Board Policies	Counties Manukau District Health Board Policy for Recognition of Public Participation (2013)
NZ Standards	None

Organisational Procedures or Policies	Policy: Public Consultation; Management of Organisational Development (MOOD document); Human Resources Toolkit – Management of Change; Conflict of Interest Policy/Procedures
Other related documents	CMDHB Community Engagement Strategy (December 2012); Ministry of Health Public Consultation Guidelines 2011; New Zealand Health Strategy; Crown Funding Agreement; Operational Policy Framework; Regional DHB Contracting Guidelines; Policy: Procurement Policy; Procedure: Provider Arm Contracting Process. Funder Arm Services Procurement - Guideline; Memorandum of Understanding Between Manawhenua i Tamaki Makaurau and Counties Manukau District Health Board (2001); Strategic Relationship Agreement Between Counties Manukau District Health Board and Manawhenua i Tamaki Makaurau (2004); He Korowai Oranga: Maori Health Strategy (2002) Ministry of Health; Management of Organisational Development (MOOD document); Human Resources Toolkit – Management of Change; Collective and Individual Employment Agreements.

Guideline

In some circumstances DHB's have a legal obligation to consult. In other circumstances it may be desirable to consult in order to avoid overlooking relevant considerations or making material mistakes of fact. Such errors could give rise to a challenge to the decision under administrative law. This factor goes to the very purpose of consultation: ensuring that the decision maker has all the relevant information it needs to make a decision, and giving those affected by the decision a chance to put relevant information before the decision maker.[1]

Consultation gives stakeholders an opportunity to influence decisions before they are made and implemented. It is crucial that this opportunity is made available, as it assists with:

- Improving CMDHB's relationship with the Counties Manukau community;
- Encouraging public confidence in CMDHB; and
- Managing stakeholder expectations

CMDHB has a legal obligation to consult with the community to: [2]

- reduce health disparities;
- improve health; and
- plan for service provision.

The legal requirement to consult exists under the:

- New Zealand Public Health and Disability Act 2000;
- Operational Policy Framework;
- New Zealand Health Strategy; and
- Crown Funding Agreement.

Who should make the decision to consult?

Deciding whether to consult must be discussed with your Manager, and the decision to conduct public consultation should be made at a General Manager or Director level.

[1] Public Consultation Guidelines for District Health Boards (Ministry of Health, 2011)
[2] Section 22(1) (f), (g) and (h) of the New Zealand Public Health and Disability Act 2000.

Consultation Principles

The following principles summarise best practice for DHB's when consulting:[3]

1. Consultation must be genuine and conducted with an open mind.
2. Consultation should have a clear purpose. There should be clarity around who is being consulted, why, what the timeframes are and what questions are being asked.
3. Those consulted should be provided with sufficient information in a form that allows them to understand the subject of the consultation, its significance and its likely outcomes. A consultation document should be appropriate for the people it is intended to reach. It should be as precise as possible, without leaving out relevant information.
4. Sufficient time should be allowed for considered responses from all groups with an interest. The amount of time will depend on the complexity and volume of the material to be considered and the number of people to be consulted.
5. The decision maker should properly consider the responses and allow sufficient time for doing so.
6. The consultation process should be evaluated so lessons can be learned about what did and did not work.

Consultation Phases

Consultation involves 6 key phases:

1. Planning –identifying what you need to consult on, who to involve and how to best involve them, and what budget you need. This is also the stage where you need to gather information to provide to people being consulted.
2. Engagement –engaging stakeholders and carrying out the planned consultation.
3. Analysis –carefully considering the feedback that has been received. Has it met your requirements? Do you need to carry out further consultation?

[3] The Court of Appeal identified these principles in *Wellington International Airport Ltd v Air New Zealand* [1993] 1 NZLR 671 at 675.

4. Decision – the results of the feedback need to be considered in relation to the proposed change. Will the same changes that were anticipated go ahead, or will you need to amend plans? If you change what was initially proposed as a result of the feedback received, then you may need to re-consult.
5. Feedback –provide feedback to the stakeholders who were involved in consultation, and thank them for their contribution to the decision making process.
6. Evaluate – reflecting on the consultation process to inform future consultation.

1. Planning

Step	Action
1.1 When to consult	Careful planning is an essential element of effective consultation. Planning should be approved by your manager/General Manager before you proceed with consulting. You will need to provide your manager with a written plan outlining how you intend to carry out consultation. Your plan should reflect the stages in this Guideline and should have draft timeframes allocated to each stage. In some situations, your manager may elevate approval processes for the consultation plan to the CMDHB Executive Leadership Team, therefore you must factor in additional time to allow for this to occur.
1.2 Level of Consultation	The level of consultation that is required will depend on the nature and significance of the proposed change, in terms of how it will affect the community, the costs involved and the duration of the change (e.g. will there be a contract for services that lasts one year, or will the change be permanent?). The level of significance must be addressed early on as it will impact other considerations (e.g. timeframe, the number and range of media used to convey information, the budget necessary for consultation, the impact on other DHB's). If the issue to be decided has changed significantly from that consulted on, or a long time has elapsed since consultation, further consultation may be required. The Ministry of Health's 'Operational Policy Framework' is a critical document necessary to guide DHB's who are proposing service change. It describes how DHB service change and public consultation is to be managed within the DHB planning framework. It outlines service change protocols and processes for DHB's when planning and implementing local/regional/national service change and service reconfiguration and provides:

1.2 Level of Consultation (cont)	▪ An explanation of '*significant service change'* and other related terms. ▪ Some tools and resources for DHB's to support sound, clinically appropriate decision making and determine the need for public consultation and, ▪ Some tools and examples of what level of service change needs engagement with the DHB's Regional Relationship Manager (to clarify if the Minister of Health is to be notified and to facilitate the Ministers approval, or approval in principle).[4]
1.3 Who to consult	Generally speaking, those who could be affected by the outcome of the decision ("stakeholders") should be consulted. Consideration may need to be given not only to current stakeholders, but to those who may become stakeholders in the future. Some projects may require regional consultation. Where district, regional or national service changes are proposed, CMDHB will likely have to consult on proposed (Northern) Regional Service Plans.[5] In such cases all of the DHBs concerned will have to use their collective judgement in determining the best consultation process to follow. Ideally consultation should be consistent across a region on a particular issue. However if there are particular communities or localities that need the consultation process tailored, this should be done to ensure their views are heard.[6] The Implementation component of the Regional Service Plan will outline how the region will manage consultation needs across any proposed major service reconfiguration or change.[7] Where consultation is required it is necessary to consult with sections of the community or their proper representatives who may be affected by a contemplated change. When identifying the stakeholders you may wish to consider representative groups who may be more accessible than individuals. In deciding who should be involved, it would be useful to canvas opinions from the CMDHB Community Panel and potential stakeholders.

[4] Operational Policy Framework. Chapter 4: Service Change. (Ministry of Health).
[5] Operational Policy Framework. Chapter 4: Service Change. (Ministry of Health).
[6] Operational Policy Framework. Chapter 4: Service Change. (Ministry of Health).
[7] Operational Policy Framework. Chapter 3: Planning and Accountability. (Ministry of Health).

1.3 Who to consult (cont)	Involving community in consultation includes engaging different groups within the community, such as Maaori, Pacific people, other ethnic groups, people with disabilities, and Non Government Organisations (NGOs). You will also need to consider who has a legitimate expectation that they will be consulted, for example, where a group of people have a particular interest in the outcome of a decision because they will be affected. You must consider the potential involvement of the following stakeholder groups: ▪ Manawhenua[8] ▪ Ethnic specific groups, particularly Maaori and Pacific ▪ Special interest groups (e.g. maternity, disability, older people, mental health, high needs groups,– low socio-economic groups) ▪ Provider organisations ▪ Subject Matter Experts (e.g. Cultural Advisors) You may also want to consider wider involvement of the community through: ▪ Public fora, fono, hui ▪ Polling communities (e.g. through electoral roll selection or speaking to community members). ▪ Focus groups. **Maaori** - CMDHB has two mechanisms to engage with Maaori – Manawhenua i Tamaki Makaurau[9] and a Maaori Health Advisory Committee[10]; these entities have important strategic roles. Any staff planning to undertake consultation with Maaori should contact the General Manager Maaori in the first instance for advice on appropriate mechanisms for consultation with Maaori, and the correct channels to advance this. **Pacific** – Any staff planning to undertake consultation with Pacific should contact the General Manager Pacific in the first instance for advice on appropriate mechanisms for consultation with Pacific peoples, and the correct channels to advance this (e.g. Pacific Cultural Advisor, Lotu Moui).

[8] As articulated through the CMDHB Memorandum of Understanding between Manawhenua i Tamaki Makaurau and CMDHB (2001)

[9] Manawhenua can be contacted directly through their administrator. See the General Manager Maaori for current contact details.

[10] The Maaori Health Advisory Committee is a committee of the Counties Manukau District Health Board. It provides advice, strategic direction and recommendations to the DHB aimed at accelerating Maaori health gains and addressing Maaori health inequities.

1.3 Who to consult (cont)	You should consider methods of thanking people for their contributions, e.g. a morning tea for stakeholders who have been involved. It may also be necessary to compensate some people who have been specifically invited by the DHB to contribute advice and expertise and you should consider the most appropriate way to do this (see the CMDHB 'Policy for Recognition of Public Participation').
1.4 Budgeting	You will need to consider who you are going to consult with, and appropriate forms of communication for each group, as this will impact on the required budget. For example, if you need to consult with older people, the disabled community or people with English as a second language you will need to consider how best to meet their needs so that they can be fully involved in the consultation process. This may include providing consultation information in a range of media, providing interpreters (including sign language interpreters) and ensuring that meetings are held at times and in venues which are accessible for the population to be consulted (e.g. access to lifts, ramps, close to public transport, held at different locations and during the day as well as evening). You may want to consider a community partnership approach and invite community input (e.g. a representative from the CMDHB Community Panel) onto the Consultation Project Team to enable a community perspective of the 6 key phases of consultation.
1.5 Timeframes	Stakeholders need to be provided with sufficient time to return properly considered responses. The timeframe will depend on the significance of the proposed change and the number of relevant stakeholders. For proposed changes with high significance it has been suggested that at least 6 working weeks should be allowed for consultation. Provide allowance for a potential one to two week extension of time. Timeframes may need to be extended if consultation is carried our over a busy time of year or a major holiday period (e.g. Christmas). It is also important to make sure that timelines are clear to stakeholders. In establishing a timeline the following questions may be helpful:

1.5 Timeframes (cont)	• Are there any special reasons for allowing additional time o • r restricting time to be spent consulting? • Is advance notice needed for interested parties? • Do key stakeholders have timing constraints such as board meeting cycles or the need for representative bodies to distribute information and collate responses? • Does the DHB have timing requirements such as Board meetings for hearing submissions? • How will requests for an extension to the submission deadline be dealt with? • Has enough time for analysis of submissions been factored in?
1.6 Information	"Health literacy" has been recognised as an issue for a significant portion of the population of Counties Manukau and CMDHB are committed to improving the health literacy of our population. To develop a "health literacy" approach all communication should be simplified to the greatest extent possible and communication should be verified with everyone – avoiding making assumptions about who understands or needs extra assistance, and avoid relying on written materials to communicate information. In the population of Counties Manukau there are many different languages spoken. The use of interpreters or translated materials can potentially increase people's level of understanding where their most fluent language is other than English. When designing a consultation discussion document it is simplest and clearest to provide one key discussion document which points to extra information sources and specific individuals who can be asked for further information. Language should be jargon-free and simple enough to be understood by a wide audience. Information should be provided in an 'accessible, easy read' format. If appropriate the discussion document should be translated into languages relevant to the target audience. Information should be tailored to specific audiences. For example, detailed technical information may be appropriate for health professionals but not for the general community.

1.6 Information (cont)	In designing a consultation document, ensure that it: ▪ Is written appropriately for the relevant stakeholders (consider both language and jargon); ▪ Has a simple and understandable name; ▪ Clearly sets out its purpose; ▪ Outlines the main issues, the possible options, the option preferred by CMDHB and the rationale for selecting this option; ▪ Notifies readers that the information that is provided to the DHB may be subject to the Official Information Act; ▪ Informs readers that information that is provided will become the property of CMDHB, and state how the information will be used; ▪ Includes the date of release, the date by which submissions are to be returned, and who they are to be returned to; ▪ Provides a short (1 to 2 page) feedback form to make it easy both for stakeholders to respond and for you to collate the feedback. **Maaori** To enable effective engagement with Maaori, consultation should ideally be face to face. Messages, Use Maaori messages written by Maaori for a Maaori audience, rather than using a literal Maaori translation. **Pacific** To enable effective engagement with Pacific people, consultation must be face to face utilising an ethnic specific interpreter. Messages must be given in an ethnic specific language and context. The 'right' people need to be identified to deliver the message/s. It's also necessary to check with the audience that they have understood the message/s and why they are being consulted, and that they are clear about the consultation process and their part in it.

2. Engagement

Step	Action
2.1 How to consult	The first step will be to clearly identify what you want to achieve from consultation as this will instruct the content of the consultation documents that you develop, and the process that you work on. Develop a communication strategy with input from the Communications team to provide a structure for informing people about the consultation and how they can become involved.

2.1 How to consult (cont)	Consider whether a public notice is needed to inform the community about the Public Consultation. Also consider supplying public notices about a consultation discussion document to the Foundation For the Blind; they can provide the information to people with visual impairments via their telephone information service. The DHB's consultation process and expectations of public participation must be transparent. The DHB must be clear about the 'goal of public participation' i.e. whether it is to Inform, Consult, Involve, Collaborate or Empower (see CMDHB Community Engagement Strategy and 'Planning for Effective Public Participation – IAP2's Public Participation Spectrum').[11] You will need to make clear to people what the purpose of the consultation is and how they can become involved, and how their participation will contribute to the decision that is being made. While all feedback received must be considered with an open mind, it will not always be possible to act on advice from the community. It is important to manage the expectations of the community members who are being consulted. Sufficient information must be provided to those being consulted, so that they are able to provide meaningful and useful responses. CMDHB staff must consider whether they need to carry out further investigation or research prior to commencing consultation. Consultation information must also be appropriately pitched, at a level that is easily understood by the targeted stakeholders. In some circumstances, this may mean adapting consultation information for different groups – e.g. for consumers as opposed to NGOs.

[11] **Inform**: To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.
Consult: To obtain public feedback on analysis, alternatives and/or decisions.
Involve: To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.
Collaborate: To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
Empower: To place final decision-making in the hands of the public.
'IAP2's Public Participation Spectrum – International Association for Public Participation', 2006.

2.1 How to consult (cont)	You will need to consider who will manage the consultation process, and who should be involved in leading it. There will be situations where people external to the DHB can facilitate the consultation process more effectively[12], or third parties need to be included to ensure that the target stakeholders are appropriately contacted. For example, in some situations it may be appropriate to involve kaumatua, church ministers or local government staff to reach some parts of the community. Consider whether any conflicts of interest need to be managed.
2.2 Consultation media	As noted in the budgeting section (1.4), it is important to consider who you are consulting and the most appropriate range of media to meet the needs of these stakeholders. Some consultation methods include: ▪ Letters and associated hard copy documents ▪ Electronic surveys and information on websites ▪ Meetings, hui or fono ▪ Oral discussions with smaller groups, such as particular stakeholders ▪ Radio / newspaper notification about consultation documents or meetings: ▪ Maaori radio e.g. Radio Waatea ▪ Pacific radio e.g. Niue FM, Samoan radio, Flava ▪ Maaori publications e.g. Mana magazine ▪ Maaori television e.g. Marae ▪ Pacific television e.g. Tagata Pasifika ▪ Free local papers e.g. Manukau Courier, Howick & Pakuranga Times, Samoa Observer, Pacific Today ▪ Media stories ▪ Community network groups e.g. Council of Social Services ▪ Involvement of the community through other government agencies (Central and local government) ▪ Local community markets e.g. Otara, Mangere, Otahuhu markets (where public engagement is 'soap box' style); Farmers Market

[12] Church ministers and staff from the Ministry for Pacific Peoples are additional resources staff might consider approaching to assist the consultation process with Pacific communities.

2.2 Consultation media (cont)	Consultation includes providing appropriate ways for stakeholders to respond to the proposed changes, and listening to their responses when they provide them. In some situations it will be necessary to allow more time at a meeting for stakeholders to articulate their views. You need to consider whether those stakeholders have the capacity to participate meaningfully in the process. People's access and understanding could be affected by the language the information is presented in, disabilities stakeholders may have, times and locations of meetings, and the cost for stakeholders to be involved.

3. Analysis

3.1 Analysis and feedback preparation	Analysis of submissions is not a vote counting exercise. Once consultation responses have been received they must be thoughtfully evaluated. Staff involved in the evaluation process must keep an open mind about the anticipated change. Such staff must also declare any conflicts of interest, so that these can be appropriately managed in accordance with the CMDHB Conflicts of Interest policy. You must ensure that feedback is carefully and objectively summarised. In some situations it may be useful to verify your interpretation of feedback provided with the stakeholders who were involved. The following questions may be helpful: • How will you organise, analyse and present feedback from the consultation? • Will the analysis be able to determine how representative the responses are of particular groups? • What level of detail from submissions will be recorded? • How will substantial volumes of submissions be handled? • Do significant new options emerge from consultation? If so, these options may need to be discussed with relevant experts, including the submitters?

4. Decision

4.1 Decision making	Having considered the community feedback, a decision must be made about what, if any, changes should be made to the anticipated plan.
4.2 Re-consulting	If the decision made involves significant changes being made to the change proposed in consultation documents, or if the consultation has taken longer than expected, it may be necessary to re-consult.

5. Feedback

5.1 Feedback	Being open, honest, responsive and respectful assists with engagement as well as the development of trust between the community and the DHB. The feedback received from stakeholders who are consulted must be genuinely considered. Final decisions should not be made prior to consultation, and participants must have an opportunity to influence the proposed change. Those undertaking consultation must consult with an open mind, and be prepared to make changes in response to feedback, even if they have a work plan in mind. It is important to acknowledge the contribution of those who take part in the consultation process and clarify the next steps in the process. Submissions should be acknowledged on receipt. Once the final decision has been made by the DHB, feedback and thanks must be provided to the stakeholders who were involved in consultation. Feedback could also include: • A summary, analysis or full copy of the submissions • How and why the decision was arrived at • What influence submissions/feedback had on the decision, and why • Comments on points made by individual stakeholders. In some cases it may be more appropriate to provide feedback in person (for example to those most affected by the proposal, to those who have made a major contribution to the project or to those who have a cultural expectation of face-to-face contact).

6. Evaluation

Evaluation	Evaluation reflects on the consultation plan and its implementation, to build a body of knowledge and experience that will inform future consultation exercises. Planning the evaluation at the same time as the project will allow collection of useful data during the process so there is an adequate basis on which to judge the consultation.

Evaluation (cont)	All members of the project team should contribute to the evaluation. An evaluation report could cover: • Assessment of the consultation aims against the outcomes • The methods used and their effectiveness • The communication plan and its effectiveness • The overall planning and implementation of the consultation • Evaluations by participants • Cost • How information and views gained in the process changed the proposal • Recommendations for future consultations.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Change	Change on which consultation should occur incorporates a wide variety of situations. It includes, but is not limited to, changes to the way services are delivered, new services being developed, and existing services being removed.
Community	Community means the entire Counties Manukau community, and in addition to the general population includes providers and businesses working in Counties Manukau and other specific stakeholder groups and agencies.
Consultation	A subset of community engagement that encompasses the seeking of views from the community on a specific proposal or issue. Merely providing information to the community is not consultation.
Stakeholders	People / groups who could be affected by the outcome of a decision.

Consultation

Outline of the process and relevant considerations:

1. Planning

- When do you need to consult? (1.1)
- What level of consultation is required? (1.2)
- Who should you consult? Think about who you should involve in making these decisions. Do you need a steering group and if so who should be included in the group? (1.3)
- What budget is required? (1.4)
- What timeframes are you going to set? (1.5)
- What information do you need to provide to stakeholders? (1.6)

2. Engagement

- How are you going to carry out the consultation? (2.1)
- What different media are needed to ensure stakeholders can meaningfully participate? (2.2)

3. Analysis and Evaluation

- What results do you have from the collated feedback? (3.1)
- Have you consulted widely enough?
- Do you need further consultation with additional

4. Decision

- What decision have you made, having reflected on the stakeholders' feedback? (4.1)
  - If you decide to proceed with the preferred option that people were informed about, then progress to implementation.
  - If the feedback has resulted in a significant change to the original plan or concept, you need to consider whether re-consultation is necessary. (4.2)

5. Feedback

- Have you provided feedback to stakeholders? (5.1)

6. Evaluation

- Have you/the consultation project team assessed and critiqued all phases of the consultation process in a written report together with a recommendations for future consultations?