
Chair: Rowena Lewis
Members: Frank Bristol, Mary Schnackenberg, Russ Aiton, Maine Johnson, Jodie Bennett
In attendance: Dr Chris Walsh, Deon York, DJ Adams, (Partners in Care team)
Apology: Muriel Tunoho, Delphina Soti, Dez McCormack

The meeting commenced at 10.00am

1. Welcome & karakia

Rowena welcomed the group and DJ opened with a karakia.

2.1 Previous minutes

The minutes were moved as correct and accepted.

2.2 Interests register

There are some updates to the register. Russ to advise Dez. Mary has subsequently sent an email.

3. Partners in Care (PIC) report, budget, and deliverables. Progress on health review contract

Deon gave the update. Our team is now at full capacity with the final person starting last week. Brittany Jones is the new data co-ordinator working on the Consumer engagement QSM working with DHB to get them to commit to submitting data. Brittany will also be involved in a range of other projects, for example – Māori experiences of the system through primary care and the in-patient adult survey.

Meeting papers were sent providing some early thoughts for the PIC programme plan for 2022/23, prepared by Allison. This lists the things we want to do and achieve. It will be presented as a more final document for feedback at your next hui in May. The consumer network will also have the opportunity to comment on the plan.

The plan is dependent on the budget available. We will have to prioritise the Guide on the code implementation and promoting the new on-line co-design resource. If funding is available, we plan visits by the Māori & Pacific advisors to hard-to-reach communities.

Further explanation was provided on the new on-line co-design course.

Questions were asked around the proposed consumer leadership academy and how the QSM reporting etc. maybe affected with the new health entities come 1 July. The QSM will still be a requirement in the new health system. The academy idea is only in its infancy.

4. Members environmental scan

Mary

The Independent monitoring mechanism (Ombudsmen's, HRC and DPO coalition) holding a forum with Govt. officials about how NZ is implementing the United Nations convention on the rights persons with disabilities. There is a range of questions being asked of govt. officials. NZ

is being re-examined again in August 2022 and the updated report being produced from this forum will be feed back to the UN committee. This is a first internationally for this type of forum. Auckland transport responding to how buses are hailed for disabled people.

Frank

Mental health expert advisory group EOI closed today. Group of 14 to 15 people expected. Diverse membership.

MHW commission had some strong things to say about the sector and its lack of progress.

There is a draft MH framework out for the new NZ health plan. Big shortages of mental health clinical staff.

Consumer peer support lived experience action plan steering group is underway.

There has been an offer of up to \$90K per peer consumer run service for Covid vaccination and other issues that closes this week.

5. Adverse Events - a consumer centred policy

Glen Mitchell explained why we are going thru this process and what we hope to achieve. This policy is not a regulation, but it is a requirement for DHB's thru the MoH district plans for DHB to abide by it. We encourage and educate in the policy's implementation. The policy is designed not only for hospitals but all health providers. Principles of Te Tiriti need to be embedded more in the policy.

There is room for recommendations to be made for improvement including an increased focus on learning from mistakes.

The Whānau Māori experience of adverse events document highlighted that there is a big gap in perception of what constitutes an adverse event. i.e., the medical community vs the consumer. Very little thought given to psychological or cultural harm.

In the past there's been lack of engagement with the consumer that has been harmed. The updated policy aims to address these.

We need increased consumer engagement to assist in the update of the policy.

Feedback on lived experience by some CAG members was provided and discussed.

Peer support has a role to play in this. Perhaps thru advocacy services. Sometimes there is fear in complaining as that may eventuate in a (further) lack of care.

Clinicians who are aware of something that has gone wrong should front foot and instigate a review of what has happened and what went wrong.

Create champions for positive change within units.

Glenn added that restorative practice is to be included in the policy to change the complaints process.

6. Board paper feedback

MRC review report - a good document but it's very top down not bottom from the point of view from a consumer engagement lens.

There was a wide ranging and passionate discussion around consumer engagement or lack thereof in producing this report.

Here is the summary of what was provided back to the authors of the paper:

Family Violence Death Review Committee report

While there was a lot of information contained in this report, and there were some good reflective questions it was noted that there could have been more information about sharing safely and holding safe spaces. The voice of people affected by family violence was silent in this report, and therefore the important topic lacked empathy.

Review of mortality review committees

The group agreed with the recommendation of creating one national mortality review committee, and the role of the secretariat is the right direction.

It was noted that consumers and whānau have been involved too late for meaningful input into this process. It appears that there is a disconnect between the intentions of the MRC secretariat and the external report produced by Francis Health. Many of the concerns raised later in the process by both the secretariat and the consumer advisory group have not been adequately taken into consideration. The importance of the consumer and whānau voice in the work of the Commission has been lost, and Francis Health did not seem to have a true understanding of this. The Terms of Reference were light on the current changes taking place as part of wider health reforms and seemed to make some assumptions that Francis Health had more context than is evident.

There needs to be further development in terms of 'how are you going to get equity'? and ensuring Te Tiriti is truly enacted. CAG noted that Māori are more likely to die, on average, seven years earlier than non-Māori, and die from diseases that healthcare can address at a rate two and a half times higher than non-Māori. The prioritising area was vague. Māori, their whānau and communities, as well as their health providers must be heavily involved in the setting of priorities.

CAG agree that NMAG should set priorities and they say that the only way that this can be done is by NMAG having the benefit of National Mortality data from which to set the priorities along with an independent membership that prioritises looking at mortality in an area that health care improvements can address. There is no detail as to how Māori are to be involved in setting priorities in fields that matter to them. Without having the benefit of the national data, it is difficult to see that cancer mortality in at least one area would not be an area to report on.

Involvement of more consumers, including consumer and whānau organisations will assist with priority setting and making recommendations, focusing on both what the data is saying, and how communities can respond to it.

6. Other business. Karakia & close

DJ closed with a Karakia

Next hui: 17 May 2022 – 10 to 12 noon via zoom.

Actions List:

There are no action items